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Assessment:
Bridging Child Welfare and AOD Services

Throughout this guidebook, as we have examined the experience gained by the model projects (especially Sacramento's AODTI), we have stressed the importance of improved methods of assessing child safety and AOD treatment needs. This chapter discusses assessment and its importance to the process of developing closer links in responding to AOD-CWS problems.

Child welfare service professionals face many difficult challenges in carrying out their responsibilities. Each day they make critical decisions in assessing the safety of children who are at risk of maltreatment and in determining when children must be placed in out-of-home care to ensure their safety. A further function of CWS is to identify short- and long-term services that are needed to enhance the well-being of children and families. To help guide such important and difficult decisions, child welfare agencies have developed various screening and risk assessment practices and procedures. Indeed, in a recent series of meetings between child welfare agency professionals and AOD treatment administrators in California, assessment was the area of daily practice that received the greatest attention [Gardner & Young 1997].

The words "risk assessment" and "assessment" are used in ways that are sometimes confusing. CWS agencies conduct risk assessment, but many are also involved in broader assessments of family strengths, concerns, and needs of children and families that go beyond the immediate risks to a child.* Risk assessment generally refers to near-term threats to a child, while the broader conception of family assessment refers to the more comprehensive, long-term needs.

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* An excellent new source that clarifies these distinctions in more detail, as well as addressing the issues in this section of our paper in considerable depth, is a new CWLA publication, *Ours to Keep*. Day, P., Robison, S. & Sheikh, L. (1998).

Discussion has intensified about how to strengthen risk assessment strategies, but many policymakers and service personnel still lack adequate understanding of the risk to a child resulting from a parent's substance use. In practice, most CWS administrators view substance abuse as simply one more component of risk and do not devote specific attention or resources to understanding its threat to children in proportion to the incidence of AOD problems in their caseloads or its co-occurrence with family violence, mental illness, and employment problems.

Risk assessment protocols need to better integrate and link the best practices of child welfare services with those of AOD treatment agencies. Blending risk assessment in the child protective services system with the screening and assessment of AOD problems is an essential step to help ensure the well-being of children and families for two key reasons:

- *Risk assessment is the core of daily practice in both the child welfare and AOD systems*. It is the process by which critical judgments related to child safety and the need for and progress in AOD treatment services are made.

- *Family assessment serves as a primary leverage point for helping strengthen families who enter the child welfare system*. The process presents workers with some of their most important choices in determining the approach they will take with their clients.

The Basic Premises

Two premises inform this section, which should be made explicit:

- Assessing AOD problems is integral to the process of assessing risk to children and family functioning. It should not be seen as an optional add-on—it is part of the core of the basic process of assessing risk, as fundamental as the question of whether the family has been reported in prior incidents or looking for signs of physical abuse on the children.

- Within the child welfare system, it is possible and necessary to assess the level of AOD problems in enough depth to make a "good handoff"—to refer a client with a much better chance of getting treatment resources, because the referral comes with enough information about the CWS client to know what kind of services they need from the AOD system. Both AOD and CWS systems would view this as a major change, and not all agencies will agree with this premise.

The Problem

It is important to be clear about the shortcomings of the current screening and assessment process in CPS as it addresses AOD issues. There are three separable issues:

- *Screening for AOD problems is cursory and not standardized.* It usually involves a single question that the worker answers using subjective factors and her intuition. But without AOD training, a worker may find it hard to be objective in the case and to be able to interpret the subtle signs of AOD problems. When an attempt is made to use objective criteria, what is often used instead of a more thorough screening is the simple marker of a urine toxicological screen, which has many limitations, including the lack of any indication of severity of the AOD problem, since it only indicates recent use of some substances that can be reliably detected. More detailed screening is essential; not seeing drug paraphernalia, for example, is not an indication that there are no pervasive alcohol problems in the family.

- *Without standardized information in the file that includes reports on screening for AOD use, abuse, and dependence, it becomes impossible to weigh the importance of AOD factors for a single case or across thousands of cases in a*

regression analysis designed to revise risk assessment tools. Testing the models of risk, as has been proposed by several CWS agencies, leaves out the measures of one of the conditions that affects risk, which is AOD problems. The computer adage GIGO comes to mind: "garbage in, garbage out"— meaning that if it isn't entered into the file in the first place, finding a correlation between AOD abuse and risks to children is clearly impossible.

Here is where an important caveat is needed: As much as we believe that AOD screening and assessment should be expanded in the CPS process, we should not advocate for that expansion with a guarantee that it will lead directly to foolproof detection of dangerous abuse and neglect. We simply do not know enough yet about the connection between these obviously related factors to make that promise, in part because the issue has not been seen important enough for useful data to be collected over time. This is similar to the issues raised in the last section about the credibility of treatment itself—if we overstate the impact with excessive claims for effectiveness that cannot be supported, we will lose credibility.

- *When AOD abuse is detected, the typical referral to AOD treatment is not based on an assessment of the severity of the problem or the level of treatment needed to respond to the problem.* The typical referral, as discussed in Chapter 1, is a set of phone numbers of treatment centers or a call to the AOD agency to which a CPS client is referred without any detail as to the nature of the problem or the recommended level of treatment. Making an assessment of the AOD problem is not seen as a part of the basic CWS mission—it is the responsibility of the AOD agency and so a phone number of the local treatment agency is seen as enough to get the case over into that system. This often

"You're Making Lousy Referrals"

In one community where CWS and AOD staff have been making a genuine, good faith effort to work together more effectively, the dialogue in the early stages of their discussions became fairly heated, with AOD workers saying to their CWS counterparts "You're making lousy referrals, sending us people who don't want treatment at all, with no information for us about their problems, and then expecting us to do something with them."

results in a backlog on the AOD side and a failure of the CWS client to negotiate the gap between the two systems.

Once referral is made from CWS to AOD agency, the "layering" of assessment takes place, in which CPS assessment is followed by AOD assessment in a totally separate process. This can frustrate the client and the frontline worker, as repetitious questions are asked and answered. (In following the recommendations of this report and others with regard to family violence and mental health, the layering problem can become even more severe, with each of these agencies requiring its own, completely separate process on top of all the other ones.)

Responses to the Problem

- Screening for AOD problems should be a standard element of every CPS risk assessment and, of equal importance, should go beyond the single-question approach to include at least (1) a CAGE-type brief screening (described below) for the presence of AOD problems, and (2) a differentiation between use, abuse, and dependence, as a SASSI-type diagnostic tool can do. Some agencies would add the key markers that in their local experience strongly correlate with risk, such as stimulant use and heavy alcohol use associated with a history of violence.

- Following this level of screening, if positive for AOD problems, the CWS worker should use the family assessment to determine how AOD factors are affecting the needs of the family across all the domains in which AOD factors may be at work, including health, employment history, legal problems, parenting styles, etc. Knowing that a parent is chemically dependent should lead to the obvious question of how that affects the areas of life in that family—how severe are those problems and what kind of services are needed to address those problems?

If the head of the household has been unemployed for a lengthy period, taking AOD issues seriously would obviously lead to asking whether AOD use contributes to the job history. Yet many family assessment tools would merely record the fact of the job history and not seek to link it to the AOD problems, if any. In effect, what is needed is a kind of engagement of the client around AOD issues that raises—perhaps for the first time for some clients—the connections between AOD abuse and life events. The consequences of AOD abuse in the client's life may become clearer, and the basis for treatment may become more powerful as well. This can be seen as motivational interviewing connected with AOD assessment, as discussed in Chapter 2.

With this information, a CWS worker can negotiate the AOD system, knowing what kind of relapse history, needs for program, structure needs, or time limits in TANF are affecting this client. The worker is then armed with the information she needs on how to negotiate the AOD system on behalf of her client. The AOD system should then collect information on baselines for treatment planning that is linked with the family plan in the CWS system, relying on information from CWS on the severity of the problem and the full range of biopsychosocial issues.

If the entire AOD assessment happens over in the AOD system, as proposed by some CWS agencies, the disconnect from CWS may make it far more difficult to ensure that the full needs of the family can be met, since the AOD system will not weigh those needs as heavily as the CWS system might. Integrating AOD-related assessment with

existing CWS screening and assessments ensures that parents' first point of contact is with a CWS worker who is able to make an informed and in-depth judgment about clients' AOD problems, which leads in turn to much greater likelihood that those needs can be met in the AOD system, based on a better "handoff" from CWS to AOD.

The Changing Nature of Assessment

Initially, child protective service agencies investigated reports of child maltreatment with the primary intent of *substantiating* whether a specific incident of abuse occurred. Increasingly, states are trying to shift their philosophical focus from one of "investigations and policing" to assessing family needs and providing appropriate services [DePanfilis & Scannapieco 1994]. Child welfare agencies are seeking to establish a different kind of relationship with the families they see—one that is collaborative and supportive, based on the family strengths, rather than contentious and punitive, focused only on the family's deficits.

Both CWS and AOD agencies have begun to refine their screening and assessment processes to differentiate between functions within the systems. Child welfare agencies are looking at assessment in a broader framework that ties assessment practices to effective case planning and management of agency resources. Iowa's legislation, for example, states that while the primary purpose of an assessment is protection of the child's safety, the secondary purpose is "to engage the child's family in services to enhance family strengths and address needs" [Christian 1997].

In the AOD field, screening and assessment are also increasingly being viewed as distinct functions. Screening determines whether a client has an AOD-related problem and assessment determines which aspects of the client's life are affected by AOD use, abuse, or dependence. These areas of life functioning generally include patterns of alcohol use, characteristics of other drug use, physical problems, social relationships, family problems, legal problems and criminal behavior, psychological problems, environmental conditions including housing and community safety, and employment or economic support problems. The more physical, psychological, and social problems a per-

son experiences, the more intensive and structured their early recovery experiences need to be, as described above in discussing treatment.

CWS and AOD Assessment Processes and Tools

Both the CWS and AOD assessment and screening processes are complex, with varying definitions and different tools used for different purposes. Similarities across the two systems do exist, however, as shown in Table 11, with three discrete phases of the larger screening and assessment process.

CWS Risk Assessment Methods

Within the variety of risk assessment protocols is a wide range of assessment instruments. Some assess the immediate safety of the child, others help predict future maltreatment, and still others are designed to inform decisions about out-of-home care and family preservation. Models used by Illinois, California, Florida, Michigan, Missouri, New York, Texas, Washington, and Wisconsin are commonly cited in the risk assessment literature, as well as tools that address broader issues of family functioning and child well-being, such as the Child Well-Being Scales, Family Risk Scales, Family Assessment Form, Children at Risk Field, and Child Abuse Potential Inventory.

AOD Assessment Methods

Similar to the CWS system, AOD agencies use a number of different assessment methods and tools to screen and assess for AOD-related problems among juveniles, adults in the criminal justice system, hospitalized trauma patients, and others. The two *screening* tools referred to in this chapter are the CAGE questionnaire (described in Table 12 on page 126) and the Substance Abuse Subtle Screening Inventory (SASSI). Frequently used assessment tools include the Addiction Severity Index (ASI), the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, and the Individual Assessment Profile (IAP).

Extensive research has been conducted on screening and assessment instruments used in the AOD field, but no tools exist that were designed specifically for rating the risk of child abuse or neglect in terms of parental substance abuse. Most existing instruments there-

Table 11. The Phases of the Screening and Assessment Process

Child Welfare System	AOD Treatment System
• *Safety Assessment*—to determine the degree of *immediate* danger of maltreatment to the child	• *Safety Screening*—to identify if there is an AOD problem and whether an individual requires immediate attention
• *Risk Assessment*—to assess the likelihood that child is at risk of near-term abuse and/or neglect and the appropriate CWS programmatic response	• *Patient Treatment Placement*—to determine level of client functioning for the appropriate level of intensity and structure that is needed by the individual
• *Psychosocial Assessment/Family Functioning Assessment*—to evaluate the *long-term* risks to the child and develop and implement appropriate interventions and case plans for the family based on their strengths and needs	• *Psychosocial Needs Assessment*—to determine how AOD affects areas of life functioning and to develop case plans for specialized care and appropriate interventions

fore have limited use for families in the child welfare system [Olsen et al. 1996]. In both CWS and AOD fields, each state (or in some states, each county or provider) determines in its own unique way whether or not to adopt a particular protocol [Kern & Sheets 1996].

In fact, a recent survey of state public child welfare agencies by the Child Welfare League of America (CWLA) found that no more than 6% of the responding agencies use a standardized test such as the SASSI or Drug Use Screening Inventory (DUSI) to screen for alcohol and other drug use. Close to one-third (32%) said they use some "other" kind of tool when screening for AOD, and 11% reported that they used locally developed instruments [CWLA 1997].

One encouraging example of an instrument that assesses child abuse/neglect risk in AOD-abusing families was developed in Rhode Island. The Risk Inventory for Substance Abuse-Affected Families [Children's Friend & Service 1994] was developed by the staff of Project Connect, a home-based program serving families with substance abuse problems. The Inventory consists of eight scales, each of which is

anchored by either four or five descriptive statements that define corresponding levels of risk. Workers complete the inventory after conducting an initial assessment of the family and collecting all relevant data needed for case planning. Five of the eight scales focus directly on substance abuse issues and are presented below; three assess how a parent's self-efficacy, self-care, and quality of neighborhood may also affect the level of risk to the child:

- *Parent's commitment to recovery.* This scale assesses parents' stages of recovery, their willingness to change behavior, and their desire to live a life free from alcohol and other drugs.

- *Patterns of substance use.* This scale assesses the parent's patterns of alcohol and other drug use ranging from active use without regard to consequences to significant periods of abstinence.

- *Effect of substance use on child caring.* This scale assesses a parent's ability to care for his/her children and meet the child's emotional and physical needs.

- *Effect of substance use on lifestyle.* This scale assesses a parent's ability to carry out his/her everyday responsibilities and any consequences that may have for the family.

- *Support for recovery:* assesses parent's social network and how that network may support or interfere with recovery.

Challenges to Implementing a Linked CWS-AOD Assessment Strategy

Despite recent progress, successfully implementing risk assessment models has proven difficult [Kern & Sheets 1996]. Listed below are some of the key challenges to incorporating AOD elements in risk assessment models:

- *Difficulty in operationalizing risk to children.* No standard or accepted indicator determines how or when par-

ents' use of alcohol or other drugs becomes an increased risk factor to children [Day et al. 1998]. Our review of many risk assessment protocols found that there is no universal approach to ranking the risk that parental AOD abuse poses to children. In interpreting risk along the AOD continuum of use, abuse, and dependence, signs such as positive toxicology screens, birth of an AOD-exposed infant, or a prior child maltreatment incident involving use of alcohol or other drugs are at times difficult to interpret in relationship to child risk. Other AOD signs tend to be imprecise—examples of vague terms that need to be more clearly defined are "periodically" incapable of caring for the child (how often?); "reduced" ability to parent (to what extent?); or "discernible effect" on user or family (what kind of effect?).

- *Concerns about excessive caseloads.* Many child welfare practitioners and administrators have expressed concern that improved assessments will lead to an increased demand for AOD services that simply do not exist now and will not be funded. As a member of a multicounty group of AOD and CWS officials put it: "'Don't ask, don't tell' is a policy that protects the system from collapse."

- *Competency and training of staff.* Child welfare practitioners are typically ill-prepared to identify and respond to families where substance abuse is the predominant problem. Without skills in interviewing, assessment, decision making, time management, and other important competency areas related to AOD-using clients, even the best systems will not be effective [Depanfilis 1996].

- *Values and attitudes.* The best risk assessment system is not a good system unless workers will use it; attitudes about the importance of risk assessment within the child welfare system vary widely from site to site. Some states, for ex-

> ample, assign their best staff to the assessment process on the grounds that the screening decision is one of the most important that CWS will make, while others regard screening as a clerical function [Rosenkrantz & Waldfogel 1996]. Previous studies have documented that child welfare workers may discount the utility of risk assessment systems, refuse to use them, or complete the paperwork *after* making case decisions [Johnson 1996]. Nor is there a solid consensus on the need to step up efforts to screen for AOD problems in the risk assessment process. Some officials view AOD issues as simply one of several conditions that need to be assessed, while others worry that policymakers may adopt an extreme stance that declares that AOD abuse by parents always equates to child abuse, when in fact some individuals use alcohol and other drugs without putting their children at demonstrable significant risk of abuse or neglect [Young & Gardner 1997].

Though risk assessment can result in a meaningful snapshot that describes a family's situation and needs, it is rare that risk assessment findings form the basis for shared decision making across agency boundaries or promote increased collaboration on cases [Schene 1996]. Instead, what we find is that each agency involved with a family demands its own separate assessment by its own workers.

Unless AOD assessments are integrated with CWS assessments, multiple layers of assessments will be created for a myriad of issues each treated separately and assessed categorically. The result is an overburdened CWS system that addresses clients' needs in a fragmented rather than coherent manner. With the vast majority of CWS cases affected by AOD, there needs to be an understanding that risk assessment can and should include an AOD treatment needs assessment. This understanding requires a fundamental shift in prevailing CWS approaches, which currently work to screen out AOD problems, rather than acknowledging them and directly addressing them.

This shift would demand that risk assessment lead to early, accurate, and informed decisions regarding what kind of AOD services

would be most appropriate and effective for the *whole* family [Young & Gardner 1997]. A prime opportunity exists to join together with other agencies and other disciplines serving children and families to develop risk assessment models that are more powerful and address the wide range of needs of families and children in the child welfare system [Kern & Sheets 1996].

The assessment process must go the extra step to actually connect clients to treatment programs, rather than simply "refer out" with a phone number of the nearest treatment agency. As one CWS official put it: "We need to cross the border between assessments and treatment. We act at times as if we do the SASSI and then we have solved the AOD issues" [Young & Gardner 1997]. Stronger ties through the assessment process between the CWS and AOD systems will help ensure that treatment is more likely to be available on demand to parents with the motivation and support to succeed in treatment. Better linkages between CWS and AOD agencies will enable clearer targeting of CWS clients for treatment and monitoring progress of parents, and help in making critical decisions about child safety.

What this kind of assessment would mean is a major shift from the concern of CWS assessment with *immediate risk to the safety of the child* to a wider concern for the *overall risk to the child's well-being*. As Jacquelyn McCroskey and others have pointed out, this is—or should be—the essential difference between CPS and CWS: a deeper concern for family functioning that goes beyond immediate risk to the larger issue of how AOD problems affect the entire family. Without this wider concern, the immediate risk perspective will lead to CPS caring only about the most extreme cases of AOD abuse, rather than the more profound issues of how AOD abuse, family violence, mental health, and family income support are all affecting children and family functioning [McCroskey 1998].

Leverage Points That Promote Connection

To link CWS and AOD assessment practices requires a deeper understanding of the decision points at each of the three phases for both systems. This will help inform which elements of AOD screening need

to be incorporated at any given point in the larger assessment process. Though assessment by itself will not integrate the two systems, there are several important starting points where the two systems can intersect in serving clients that need both sets of services.

Screen all families for AOD problems. Within CWS, there needs to be an explicit assumption that AOD abuse and dependence pose a risk to children's safety and therefore should become a formal, deliberate, and expanded part of the CWS screening and assessment process. Some experts have even suggested the need for mandatory substance abuse screening in all cases of serious child abuse and neglect [Murphy 1991].

Strengthen workers' capacity with more appropriate assessment tools. Workers describe families so devastated by drugs that "risk" is constant and impossible to assess [CWLA 1991]. This task becomes even more difficult given the shortcomings of traditional CWS assessment tools. Furthermore, the more subtle indicators of AOD problems (such as health problems or impaired social functioning associated with dependence) are "clues easily overlooked when relying on a general risk assessment instrument" [Dore et al. 1995].

Assess for family strengths as well as problems. As CWS agencies step up their efforts to screen for AOD problems, they must remember to explore AOD in a broader context of family functioning. In particular, child welfare workers need to become more knowledgeable and balanced in assessing AOD abuse and its relationship to other issues and strengths in the family [Cole et al. 1996]. Cole and her colleagues caution: "The most damaging consequence of a preoccupation with the pathology of substance abuse is that family strengths are rarely identified or given the weight they deserve" [1996].

Broaden the lens through which AOD problems are viewed. The child protection system needs to broaden its focus on AOD issues in at least three fundamental ways.

- More attention must be focused on the significance of alcohol abuse—not just illicit drug use—and its effects on children. In addition, given the increasing body of evidence

on the prenatal impact of nicotine, both of these legal drugs should be addressed in greater depth.

- More emphasis must be placed on children affected by parental AOD abuse *after* birth. The attention given to services and supports for prenatally exposed infants is well justified, but many of the children environmentally exposed to AOD may be at higher risk for more severe consequences.

- The CWS system needs to accept more responsibility for the families who clearly have AOD problems but are screened out because they do not warrant formal investigations, or the investigation has been unable to substantiate the allegation. Without proper intervention, these families are likely to return as "high-risk" cases. This is an appropriate role for the community partnership models described in Chapter 2.

So the task is as clear as it is difficult: combining risk assessment in the CWS system with screening and assessment of AOD problems and combining assessment of an individual's AOD-related problems with measures of family functioning and risk to the children. In the CWS system, the threshold issue is whether to add an explicit assumption that AOD abuse and dependence always poses a risk to the child and therefore should become a formal, deliberate, and expanded part of the screening and assessment process in child protective services. If so, should levels of risk to the child be differentiated in terms of specific drugs, frequency of use, changes in behavior in association with use, or AOD use in conjunction with other high-risk situations (e.g., an unrelated male in a caretaker role who has a history of AOD problems or of violence)? We propose that the functions within CWS can be viewed in terms of their current assessment protocols and that specific AOD-related content must be added to these existing assessment processes. These are summarized in Table 12.

Table 12. Assessment Processes with AOD Considerations

CWS Phase	CWS Function	CWS Methods	Suggested AOD Content
Initial response to allegation of abuse or neglect	Investigate allegation of abuse or neglect	Risk assessment protocols measures such factors as the following: • Child (e.g., vulnerability, behavior) • Child abuse/neglect incident • Parent characteristics (e.g., parenting skills, mental health, history of abuse) • Parent-child interaction (e.g., attitude toward and expectations for child) • Family and social relationships (e.g., family violence, family stressors, crises) • Living environment (e.g., financial security, housing status) • Motivation to change behavior (e.g., willingness to cooperate with agencies) • General demographic factors	Simple screening questions, such as a modified CAGE: • Have you ever felt you should CUT DOWN on your drinking or drug abuse? • Have people ANNOYED you by criticizing or complaining about your drinking or drug use? • Have you ever felt bad or GUILTY about your drinking or drug use? • Have you ever had a drink or drug in the morning (EYE OPENER) to steady your nerves or to get rid of a hangover? • Do you use any drugs other than those prescribed by a physician? • Has a physician ever told you to cut down or quit the use of alcohol or drugs? • Has your drinking/drug use caused family, job, or legal problems? • When drinking/using drug, have you had a memory loss (blackout)? ✓ Two or more affirmative responses indicate with high likelihood that the person is a problem drinker and/or a drug abuser and requires further assessment.
	Determine risk to the child(ren)	Further analysis of risk assessment protocols and interviews with key informants.	Information on the type and frequency of substance abuse: • Is there use of stimulants (e.g., cocaine, crack, methamphetamine)? • Is the use of heavy alcohol accompanied by a history of violence? ✓ If yes, there is potential for higher risk to the child.

CWS Phase	CWS Function	CWS Methods	Suggested AOD Content
Triage and CWS program placement based on risk to the child	Determine if there is legal basis for petition and appropriate placement	Preparation of court report through review of CWS history, risk assessment, interview statement of child, parents, relatives, law enforcement, etc.	Discriminate between substance use, abuse, or dependence: • Diagnostic tools, such as the Substance Abuse Subtle Screening Inventory. • DSM-IV diagnostic criteria ✓ If substance abuse present, case requires further AOD-specific services and information should be evaluated in the CWS program placement decision.
Case planning and management	Create a service plan, provide referrals/service linkages Monitor progress Reassess and document progress Make decisions regarding case disposition	Assessment of such psychosocial and family functioning factors as the following: • Physical environment (e.g., housing) • Social environment (e.g., family support systems) • Financial environment • Caregivers' history • Personal characteristics • Child-rearing skills • Child(ren)'s developmental status • Child(ren)'s behavior • Interpersonal interactions among adults • Interpersonal interactions among adults and child(ren)	Determine appropriate AOD treatment services and areas of life functioning affected by AOD use (domains of the ASI): • Medical problems • Legal problems • Social problems • Family problems • Psychological problems • Employment/education problems • Treatment acceptance/resistance ✓ Use information on levels of functioning to make appropriate AOD treatment decisions regarding level of structure or intensity of services required and areas of life functioning requiring specific interventions in the treatment plan.

Guiding Principles for Effective Assessment

Clearly, improved risk assessment methods are needed to help child welfare workers make efficient and accurate decisions concerning AOD-involved families. Our experiences in cities across the country, together with a review of the relevant literature, point to a set of guiding principles for child welfare agencies as they seek to develop a blended CWS-AOD assessment strategy that includes risk assessment, but goes beyond it to a wider review of the family's overall capacity to deal with substance abuse and other problems.

Guiding Principles for Developing an Integrated CWS-AOD Assessment Approach

- Address both the problem of AOD use and child maltreatment.
- Assess the interaction between AOD use, abuse, or dependence, and child maltreatment, and what it means for risk to the child.
- Establish standards for intervention that relate explicitly to assessment(s), including appropriate level of AOD intervention(s).
- Include assessment of strengths inherent in the family, which leads to an appropriate service/treatment plan for the family as a whole.
- Conduct assessments in the broader context of overall family functioning and behavior (e.g., use and availability of support systems and community resources, desire and capacity to parent, child's attachment to the family, child's special medical/developmental needs) [Tracy & Farkas 1994].
- Develop assessment protocols that are sensitive to cultural, ethnic-, and gender-related concerns.

- View any assessment instrument as a tool to enhance—not substitute for—professional clinical judgment.

- Consider family violence, mental health, and job readiness assessments as part of related systems that affect CWS-AOD outcomes

- Link assessments to workload and budgeting—supervisors, managers, policymakers, budget analysts, and others should use assessment information about the levels of clients' needs to help manage agency resources and net increases in paperwork should be avoided.

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