Colorado's Protocol

Improving Services to Families:
Strategies for Substance Abuse Treatment, Child Welfare, and Dependency Court

A Guide for Counties, Service Providers and Judicial Districts in Colorado

A Product of the In-Depth Technical Assistance to States Project Of the National Center on Substance Abuse and Child Welfare, in Collaboration with the Colorado Department of Human Services and the Office of the State Court Administrator

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COLORADO'S IN-DEPTH TECHNICAL ASSISTANCE PROJECT

The National Center on Substance Abuse and Child Welfare (NCSACW) was created by the US Department of Health and Human Services and funded by the Center for Substance Abuse Treatment (CSAT) and the Children's Bureau's Office on Child Abuse and Neglect (OCAN). NCSACW's mission is to help staff in the child welfare, substance abuse and dependency and neglect court systems achieve better outcomes for families. Colorado is one of four states to receive In-Depth Technical Assistance from the NCSACW in its first round of assistance.

The Technical Assistance Steering Committee is a multidisciplinary group comprised of representatives from substance abuse services, child welfare, dependency court, county administrators and practitioners, Native American organizations, psychologists, attorneys, and a consumer. A Core Team manages the project on a daily basis. A Consultant Liaison of the NCSACW guided the development of the project and this Protocol. A list of Steering Committee and Core Team members is included in Appendix A.

The Technical Assistance project started in August 2003 at a kick-off and planning meeting of the Steering Committee, the Consultant Liaison, and the Director of NCSACW. Phase I of technical assistance ran through July 2004 and ends with the issuance of this Protocol.

During Phase II of technical assistance, which runs from August 2004 through December 2004, a number of pilot counties and judicial districts applied and were selected to pilot the Protocol with some continued technical assistance from the NCSACW. Pilot site experiences will be overseen and guided by the Technical Assistance Steering Committee, whose membership will be changed to reflect some additional perspectives and to include representatives from each pilot site.

As pilot sites attempt to operationalize the concepts and recommendations included in this Protocol, their experiences will inform decisions regarding changes in state rules and modifications to the Protocol. The Protocol will be reissued to reflect the experiences of pilot sites, and it will be widely disseminated across the state.

At its initial kick-off and planning meeting, the Steering Committee agreed on a problem statement and a goal for Phase I of the Technical Assistance Project:

The problem:

"Line professionals within the substance abuse, child welfare and judicial systems have not been given adequate tools nor are they well prepared to assess whether, and the extent to which, children are unsafe at home when their parents use substances, and the managers of those systems do not know how to guide and support staff. Thus, without adequate preparation and support, both staff and families will realize only limited successes."

The goal:

"By July 2004, Colorado will have developed a protocol for screening, assessing, engaging and retaining families who are involved with the child welfare, substance abuse and court systems.

The protocol will be incorporated into a Memorandum of Understanding to guide program implementation."

The Steering Committee further agreed that the Protocol would:

- help child welfare staff make decisions regarding not only whether substance abuse exists but also whether and how substance use affects child safety and permanency decisions;
- help substance abuse treatment staff match treatment services to the needs of individuals, reduce treatment drop-out, and improve treatment outcomes;
- assure that judges and court staff receive complete and timely information about family progress and challenges, and that the information represents consensus among service providers.

Process by which Protocol was developed

At its kick-off meeting in August, 2003, the Steering Committee developed a work plan for the year, set a schedule of future meetings, and reached consensus on roles for the Steering Committee, the Core Team, and the Consultant Liaison. The Steering Committee recognized the value of a Memorandum of Support signed by the Director of the Colorado Department of Human Services and the Chief Court Administrator. That signed Memorandum was secured in October 2003 and became an important marketing and informational tool for the project.

Because Colorado affords great latitude to counties and judicial districts, it was essential that the Protocol reflect their interests, needs and priorities. Involving local jurisdictions early on, and throughout the project, was especially important because the state had little authority to mandate use of this Protocol. Therefore, much of the work during the year focused on soliciting perspective and insights from local staff and then providing feedback on how their contributions were reflected in the Protocol.

A Survey of Interests and Needs was developed and distributed to staff from child welfare TANF, substance abuse treatment providers, non-profit organizations, as well as judges, magistrates, and court facilitators. The survey was comprised of a list of items that might be addressed in a Protocol; respondents were asked to indicate whether each item was of high, moderate, or low interest. A total of 302 surveys were returned.

Overall, respondents were most interested in tools and strategies to address the needs of children whose parents were substance abusers. After children's issues, respondents indicated interest in clinical and practice issues, collaboration and systems issues, and training issues. The highest scores in the survey related to:

- engaging parents in changing risky behaviors;
- tools and techniques to assess risks to children in the context of parental substance abuse;
- working with parents with co-occurring mental health, domestic violence and substance abuse disorders;
- assessing child safety in the home of a caretaker who uses/abuses substances;

- child development in the context of parental substance abuse and the effect of parental substance abuse on children; and
- improving retention of parents and families in substance abuse treatment.

After the surveys were analyzed, the *Steering Committee convened ten regional meetings/focus groups across the state*. Held between March 31 and May 14, 2004 the meetings provided an overview of the NCSACW and the technical assistance project and facilitated discussions of the survey responses, values and beliefs; and preliminary positions that would be advanced in the Protocol. The regional meetings were attended by 275 people and were generally held in county social services offices, although one was held in a casino on a reservation, one was held in a courtroom, and one in a meeting room at an assisted living facility.

A focus group comprised of families with open child welfare cases in Denver was held on April 30, 2004.

The Protocol that follows reflects the work of the Core Team, the Steering Committee, the Consultant Liaison, and the hundreds of people who participated in the survey, attended a regional meeting, or attended one of several other meetings focused on this topic during the year.

Importantly, the Protocol is also heavily influenced by work underway at NCSACW. In particular, NCSACW developed a set of "Guidance Standards" that are based on research, promising practices, and the thinking of national leaders and experts. The SAFERR Guidance (Screening and Assessment for Family Engagement, Retention and Recovery) puts forth a series of fundamental practice standards, better practice standards, and SAFERR (optimum) standards for substance abuse, child welfare, and dependency court staff. A draft of the SAFERR Guidance chart is included as Appendix B. It should be a useful resource for Colorado staff in determining local standards and it complements the standards put forth in this Protocol.

This Protocol is a draft document developed based on the process described above. Its primary audience is the pilot sites that will work with it and test its usefulness through the end of 2004. Secondary audiences include any public or private agency or staff member across the state.

Organization of this report

This report is organized into two main sections: the Colorado Protocol, and Appendices. The Background section which was previously contained in this report, is now a separate document, in order to allow those who are interested an opportunity to learn about the context in which the protocol was developed. It provides some historical information, lists maor legislation affecting substance abuse and child welfare agencies, and describes Colorado's political, policy and practice environment.

The Protocol specifies some steps for local jurisdictions to use in getting started in designing new ways of working together on behalf of families. It details a series of community principles, practice standards, and action steps that local implementation teams should use in developing their approach to serving families involved with substance abuse services, child welfare, and dependency court.

The principles, standards, and action steps are categorized along three dimensions that generally reflect different points in time:

- Is there a problem? Initial Screening: Determining Presence and Immediacy;
- What are dimensions of the problem? In-depth Assessment: Determining Nature and Extent;
- How are we addressing the problem? Ongoing Services and Case Closure: Case Plan and Monitoring

These dimensions correspond to those identified in the SAFERR Guidance Standards. They are somewhat arbitrary and people move back and forth across them in a non-linear fashion. Nonetheless, they provide a framework for local jurisdictions to use in making improvements in policy or practice.

Note that the Protocol emphasizes the "community" aspect of principles and practice standards, rather than an agency or single system aspect. Implementation will be easier and more successful if the activities remain at the team or collaborative level as close to direct practice as possible. It is only at the specific action step level that activities are broken out by agency.

The Appendices include lists and examples of instruments for use by staff, a list of major funding sources for services to families, a template for training, and a variety of other tools that local teams can use in designing their pilots.

The Technical Assistance Steering Committee and the Core Team are very interested in learning what parts of this Protocol are most useful, what are less useful, and what is missing. Please take time to share insights and experiences with any member of the Steering Committee or Core Team. This will inform future versions of the Protocol and be helpful to other counties and jurisdictions across the state.

What's a Protocol anyway?

For purposes of this document, a Protocol is

> "A written document that puts forth a set of principles, standards, and behaviors to guide daily practice."

The principles, standards, and behaviors that are selected for inclusion in the Protocol will have implications for daily practice, systems of communication, training, financing, legislation, reporting, and evaluation.

When a Protocol affects the principles, standards, and behaviors of more than one agency, it requires the endorsement and support of all involved agencies. A Protocol that affects multiple agencies may address some, but not all, of the interactions across those agencies. However, it should reflect the interactions that the participating agencies deem most important to their effectiveness.

Getting started

Two elements will demand early and focused attention by members of the implementation team: How the team will communicate and what are the values of team members.

Communicating with each other

The process of deciding how child welfare, substance, abuse, and dependency court/legal staff work together on behalf of families will be less effective if implementation members are not clear about each other's roles, responsibilities, and how they should communicate. Questions for the team to consider at its first meeting include:

- Who should be invited to participate in guiding the implementation? In addition to the "usual suspects" consider mental health, domestic violence, school, and law enforcement personnel.
- How often should this group meet? At the first meeting, schedule several future meetings so people have the times set aside. Meet frequently at first (every week or two), and perhaps less frequently later on.
- How will information be shared among group members? Consider an Email group; assign someone to record key decisions and next steps and circulate that record shortly after each meeting.
- What is the scope and authority of the implementation group? Members should be senior enough so that decisions can be made during meetings and acted upon immediately thereafter, but also close enough to program operations to have a real understanding of practice issues and concerns.

Understanding each other's values and beliefs

People have differing values about poverty, addiction, dependence, parenting, and other factors that affect the way they live their lives and make decisions. People who work with families involved in substance abuse and child maltreatment come from a variety of organizations, personal and educational backgrounds and professional disciplines, each of which has its own perspectives on what is the "right" thing to do.

If members of the implementation team do not take time to explore and share their similarities and differences, they will nevertheless surface and generally in a less productive manner. The rationale behind discussing values and beliefs is to identify important areas where values are shared understand and respect how others think, and to connect policy decisions and practice standards to values. The point is not to convince others to change their beliefs.

This Protocol offers options for local implementation teams to consider in talking with each other about values.

The NCSACW website (http://www.ncsacw.samhsa.gov/, or http://www.cffutures.org) features a Collaborative Values Inventory (CVI) that can be taken on line and anonymously. *With advance permission from NCSACW*, the implementation team (and others if that is desired) can complete the CVI, and request the NCSACW to tabulate and analyze the results. Those results can form the basis for a values discussion at the next team meeting. The Colorado Steering Committee used the CVI and had a very productive and helpful discussion.
The Regional Meetings convened as part of preparing this Protocol included a discussion of values, and local teams could employ the same process. At these meetings, a list of values was circulated (See Appendix E) and participants were asked to agree on the five values that are most important to them, and then to list local practices that embodied those values (the purpose of listing local practice was to help participants make the connection between value and practice). Following is a summary of the values that participants at the regional meetings felt overall were most important or most controversial. A local implementation team could use these values as a starting point for discussion.

"All children deserve to live in safety" was the most universal shared value. However, there was concern and frustration regarding what "safe" means, whose rules and standards drive safety decisions, and how much weight to give cultural norms regarding child rearing.

"All families have strengths" was widely believed to be important, but many people felt that systems often give lip service to this value more than they practice it in reality. This means that family resources are often overlooked and that providers fail to recognize and reward small steps of progress.

"Children deserve to live in safe, stable, and loving families" (whether biological, foster or adoptive) was widely shared and generally integrated with the first value, regarding safety.

"Service providers work within a variety of limitations" was a widely shared value, and was often combined with values related to using an action-oriented approach and to strengthening families' natural and informal networks.

"Human services and legal professionals have a responsibility to strengthen families' natural and informal networks" within their own community and reduce reliance on professional systems was among the more controversial value statements. Staff from rural areas, while agreeing with this as a noble goal, felt it to be almost impossible in small towns, in which the family network is so often involved in drug abuse, and the larger community so severely stigmatized substance abusers.

"People providing services must learn about and respect gender, ethnic, racial, religious and cultural backgrounds of families" and tailor their programs and policies accordingly was voiced most clearly in the Denver, El Paso and Ignacio meetings, which were the meetings in which participants reflected the most cultural, racial and ethnic diversity. In Denver and Ignacio in particular, this value was felt to be of very high importance.

"Actions have consequences, and consequences should be fair, timely and appropriate" was a value expressed in several locations. Upon further discussion, it was agreed that "consequences" should include both positive and negative reinforcement, and that sanctions and incentives could and should be graduated, in order to reward and shape behavior effectively.

"Families should be encouraged to define 'the life worth living.'" It was felt that service planning should start with staff encouraging family members to think and dream about what kind of life they want for themselves. .

Is there a problem?

Initial Screening: Determining Presence and Immediacy

This represents the very early stages of an agency's involvement with a family: a call to the child welfare hotline or the initial investigation of a complaint; the first discussion between a substance abuse counselor and a parent; and the first meeting between the family and the attorney and/or judge.

Community Guiding Principles:

- In making decisions regarding child and family well being, practitioners from all systems should seriously consider the possibility of substance abuse and screen for substance abuse with all families who present for services, rather than waiting for obvious environmental or behavioral indicators to trigger a screen.
- Regardless of which system (child welfare, court, substance abuse) the family enters and what the presenting problem is, practitioners should systematically inquire about potential involvement with other systems.

Community Practice Standards:

- There should be a uniform tool for use by each system to screen for potential involvement with others, and the same tool should be used by all agencies screening for that condition
- Training curricula should be designed or adapted to support front line workers (including attorneys) in gathering information about substance use and abuse and to identify children with significant alcohol and other drug related disorders
- Front line workers should have clear and ongoing communication mechanisms to consult with other professionals in their field as well as in other systems
- Staff in all systems should have a fundamental knowledge of addiction, recovery and child welfare standards.
- Information, decisions and actions should be documented within each system's existing information systems and where appropriate, to facilitate collaboration, consents to share information between systems/agencies should be routinely signed.
- Agencies should develop written guidelines for staff to use in making decisions about the safety and well being of children when adults in the home are substance abusers. These guidelines should be shared with staff that work in other agencies and systems.

Recommended Action Steps to Implement Practice Standards:

Action Steps for Child Welfare Agencies and Staff:

- Use a standard tool or set of questions to screen for substance abuse for every child welfare case, starting when the initial call is made, and regularly thereafter. See Appendix E for a list and descriptions of selected screening instruments for substance abuse.

- Provide training to caseworkers on how to use the screening tool and on other strategies to gather information about substance use and abuse
- Provide training to caseworkers on how to identify children who may have significant alcohol/drug related disorders and how to refer them for further assessment (see Appendix F
- Develop strong relationships with substance abuse treatment agencies for consultation around ongoing and future child welfare cases
- Develop mechanisms allowing caseworkers access to special consultations on difficult cases
- Develop internal guidelines for caseworkers to use in making decisions when substance abuse exists within the family, and share those guidelines with other agencies and systems
- Provide ongoing training to child welfare administrators and front line staff on addiction and recovery
- Incorporate recommendation to obtain signed consents to release information to substance abuse treatment agencies into protective order recommendations made to courts at detention hearings

Action Steps for Substance Abuse Treatment Agencies and Staff:

- Use a standard tool to screen substance abuse clients for involvement in child welfare and court systems ("legal issues" section of the Addiction Severity Index should also ask about civil court involvement such as Dependency and Neglect or child custody cases)
- Train substance abuse counselors to identify situations within their clients' families that are potentially dangerous to children
- Train substance abuse counselors to identify children who may have significant alcohol and other drug related disorders including significant emotional, behavioral or cognitive problems and refer for appropriate assessment
- Develop strong relationships with child welfare and judicial systems for consultation around child welfare cases
- Develop mechanisms for consultation within substance abuse treatment agencies on issues of child well-being
- Develop internal guidelines for making decisions to ensure the emotional and physical well-being of children of adult clients and share those guidelines with other agencies and systems
- Provide ongoing training to substance abuse counselors and administrators on issues related to child safety and child development
- Incorporate standard screening for trauma into treatment protocols for all clients

Action Steps for Judicial Agencies and Staff:

- Encourage judges, magistrates, facilitators, and attorneys to inquire whether a standard substance abuse screen was completed;
- Require respondents to provide signed consents to release information to substance abuse treatment agencies in order to facilitate communication between substance abuse and child welfare staff

- Provide training for judges, magistrates, family court facilitators, and guardians ad litem to identify children who may have significant alcohol and other drug related disorders and refer for further assessment
- Develop standards that judges, magistrates, facilitators will use to inquire about how child welfare staff have screened for substance abuse. Require and look for documentation that SA screens have been conducted.
- Actively seek out comments, information, and perspectives from substance abuse treatment and child welfare professionals when making decisions
- Develop strong relationships with substance abuse treatment and child welfare agencies for consultation around ongoing and potential child welfare cases
- Develop mechanisms to obtain expert consultation within the judicial system on difficult cases
- Develop internal guidelines for making decisions when substance abuse is a factor and share those guidelines with other agencies and systems
- Provide ongoing training to judicial staff on addiction and recovery in the context of child welfare cases
- Provide ongoing training to judicial staff regarding child development

What are the dimensions of the problem?

In-depth Assessment: Determining Nature and Extent

This is the phase during which families receive a range of in-depth assessments and work with a variety of service providers to develop the "case plan" that will be presented to and ordered by the court. During this phase, clients meet with several different workers, each of whom is conducting a specific assessment. It is essential that information be shared among these workers and that the client participate in many of these discussions.

Community Guiding Principles:

- The team discussions are more critical than the tool used in determining the relationship between substance use and child safety or risk. Although a standardized tool is needed and should be used, decisions are made by a multi-disciplinary team whose members provide collective insight that goes beyond the "score" on the tool.
- Assessment should focus on children as well as adults. During the assessment process, children's needs should be identified
- Sharing information appropriately is desirable, helpful and feasible
- Professionals from all systems should understand the range of funding streams that are available and should know how to access those funds on behalf of the families they serve.

Community Practice Standards:

- Substance abuse and child welfare assessments should reflect professional opinions and the family's perceptions and beliefs about the circumstances that have led to their involvement with these systems
- Assessments conducted by one worker should be shared with other workers
- Children should be assessed for possible effects of prenatal exposure to alcohol and other drugs
- Case plans and information to courts should integrate and reflect all assessments as well as the client's perspective
- Lawyers and court staff should have complete and consistent information that allows them to comment on client progress and make informed judgments
- Procedures should be in place to utilize all potential funding sources for services
- Families should not experience delays in receiving services that have been recommended as a result of assessments
- Assessments and ensuing case plans should reflect and respect cultural, ethnic, and religious values of families

Recommended Actions to Implement Practice Standards Regarding In-Depth Assessment

Action Steps for Child Welfare Staff and Agencies:

- Staff should receive written guidelines specifying a list of factors that must be included in assessments, and formulate specific referral questions when requesting evaluations

- Staff should share copies of the Family Services Plans with the substance abuse treatment counselors assigned to treat parents, allowing adequate time for the substance abuse counselor to offer comments or ask questions
- Child welfare staff should incorporate information received from substance abuse counselors into case plans
- Child welfare staff should fully utilize other funding sources, and should refer families for Specialized Women's Treatment, Part C and Early Periodic Screening Diagnosis and Treatment (EPSDT) services; State to provide information to counties regarding funding sources (See Appendix G for a description of funding sources)
- Child welfare staff should invite and encourage substance abuse counselors to attend and participate in staffings
- Child welfare staff should accept information regarding a client's substance abuse treatment plan provided by the substance abuse counselor, and include information regarding progress in treatment and goal attainment in their reports to the court
- Institute interagency case staffings that involve families within the first 7 – 10 days following the opening of a child welfare case. If necessary, ask the Court to order these staffings as a part of reasonable or active efforts
- Train workers in how to use staffings to inform team judgments about risk and safety (see Appendix H)
- Child welfare workers should ask specific questions of substance abuse counselors when making referrals for assessments (see Appendix I for a suggested list of those questions)

Action Steps for Substance Abuse Treatment Staff and Agencies:

- Specify that counselor assessments must include, but go beyond, items included in the Addiction Severity Index (See Appendix I)
- The Alcohol and Drug Abuse Division will create a new licensing category for providers treating child welfare clients to include the following elements:
    - Agency holds current license to treat women;
    - Counselors treating clients referred by child welfare must document completion of on-line coursework in child protection via NCSACW;
    - Counselors treating clients referred by child welfare must have at least 24 hours of continuing education per year in issues of child development, child safety and family dynamics
    - Each client file should contain current copies of Family Services Plan Parts 1 and 2A, 3A and 5A, as well as case notes documenting attendance at staffings at a minimum of 90 day intervals for all cases referred by child welfare;
    - Each case file should include results of screening for child safety and discussion of child safety issues completed within 30 days of intake and at each treatment plan review thereafter (see Appendix J for suggested questions to screen for child safety issues);
    - Placement and custody status of each child should be clearly documented in case file, as well as developmental information and results of developmental screen used, date of screen and name of screener. If referred for assessment and services, results of assessment and current status of services should also be documented.

    - Signed consents to release information should be on file for client's caseworker, caseworker supervisor, guardian ad litem, CASA worker and respondent parent's attorney;
    - Case notes should contain documentation of every court hearing, whether as court minute order strip or summary documented through phone call with caseworker or attorney to include current court protective orders, visitation orders, custody orders and treatment orders, as well as date of next hearing and nature of next hearing.
    - Discharge planning should include documentation that plans have been made to assure child safety in case of relapse
- Substance abuse counselors should have standard information about Fetal Alcohol Spectrum Disorders (FAS) and should assist their clients in screening their children for FAS.
- Alcohol and Drug Abuse Division should issue simple guidelines on federal confidentiality regulations (42 CFR Part 2) and provide sample consents to facilitate sharing of information with child welfare agencies and the Courts
- Substance abuse providers should utilize Early Periodic Screening Diagnosis and Treatment funds through Medicaid to access services for children of clients in treatment
- Substance abuse treatment providers should attend and participate in staffings
- Substance abuse counselors should share copies of the substance abuse treatment plans and their updates with child welfare workers so that the workers and courts understand the client's treatment goals and the client's progress toward those goals.

Action Steps for Judicial Staff and Agencies:

- Judges, magistrates, and facilitators should require evidence that that client's perspectives have been discussed (see Appendix I)
- Attorneys should ask caseworkers and judges should ask attorneys whether assessment results have been shared and integrated into case plans
- Attorneys should ask judges to require staffings as part of reasonable or active efforts
- Urge/require legal and court staff to ask families and respondent counsel questions regarding progress in treatment, goals attained, and other questions that allow families to describe the progress they have made and the challenges they encountered. Legal and court staff should consider evidence in addition to results of abstinence monitoring.
- Court should prepare a template on case presentation for use by county staff and substance abuse agencies

How are we addressing the problem?

Ongoing Services and Case Closure: Case Plan and Monitoring

This period covers activities involved in delivering services in accordance with case plans and court rulings, monitoring and adjusting services as appropriate, and coming to decisions regarding permanency arrangements for children in foster care. As clients progress and perhaps falter, it becomes especially important for staff to communicate effectively with each other and with clients. Many of the community guiding principles, community practice standards, and recommended actions listed in "What are the dimensions of the problem" apply to this section as well.

Community Guiding Principles:

- Case plans can and should be modified as circumstances change
- Clients should understand that their actions have consequences that are fair, timely and appropriate to the action
- Consequences should apply to families and to staff; consequences should not be used solely as punishments, but should include incentives for staff and clients
- Family progress should be recognized, noted and shared with family members
- Relapse is not a treatment failure; the chronic nature of addiction requires that safety plans be put into place to minimize the consequences to children of a relapse

Community Practice Standards:

- Staff from all systems should know how the family is progressing in the other two systems
- Judges, magistrates and mediators should have adequate knowledge of child and family development and addiction and recovery to allow them to make informed decisions and ask appropriate and necessary questions of all parties to a case
- Ongoing case plans and proposed modifications to plans that go before the court should reflect perspectives of substance abuse counselors, other service providers, and the families themselves
- Workers representing the substance abuse and child welfare systems should have knowledge and skills to present credible information to attorneys and credible testimony in court
- Families should be active participants in discussions and decisions that affect them, and they should be included in all meetings and staffings
- All services to individuals and families should recognize and build upon cultural, ethnic and religious values of families

Recommended Actions to Implement Practice Standards Regarding Ongoing Case Monitoring and Case Closure

Action Steps for Child Welfare Staff and Agencies

- Child welfare staff should provide substance abuse treatment providers with copies of the Family Services Plans in a manner that allows time for discussion
- Child welfare agencies should train and support workers in holding/participating in staffings that draw from the expertise of the team in informing decisions about child well-being and safety
- Child welfare staff, with consultation from substance abuse counselors if necessary, should discuss relapse safety planning with parents, to provide documentation that treatment has provided parents with tools to keep their children safe if they relapse.
- Child welfare staff should incorporate treatment goals, compliance information and client progress into their reports to court, in addition to providing attendance and toxicology information
- Child welfare staff should provide training for court and legal staff to help them understand what is reasonable to expect from child welfare workers

Action Steps for Substance Abuse Treatment Staff and Agencies

- Substance abuse counselors should provide child welfare staff with treatment plans and information on client compliance with and progress in treatment. Counselors should not limit information to treatment expectations for attendance and urine screens
- Substance abuse counselors should be trained and supported in holding/participating in staffings that draw from the expertise of the team in informing decisions about child well-being and safety
- When substance abuse counselors begin discharge planning with clients/parents, those plans should include specific plans for their children's safety.
- Substance abuse staff should provide training for court and legal staff to help them understand what is reasonable to expect from substance abuse treatment counselors

Action Steps for Judicial Staff and Agencies

- Attorneys and court staff should ask workers about compliance and progress in treatment in addition to attendance or urine screen results
- Attorneys, magistrates and other judicial staff should provide training to child welfare and substance abuse staff in how to prepare and deliver evidence and testimony in court
- Magistrates and judges should specify that staffings or other team efforts are part of "reasonable efforts" when circumstances warrant

APPENDICES

Appendix A: Phase I Steering Committee and Core Team Members

Core Team Members

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Sherry Kester	Director, Office of Planning & Analysis, CO State Court Administration
Ted Trujillo	Director, Child Welfare Division, CO DHS
Janet Wood	Director, Alcohol & Drug Abuse Division, CO DHS

Steering Committee Members

Michael Allen	Signal Behavioral Health Network
Arthur Atwell	Office of Performance Improvement, CO DHS
Brenda Bellonger	North American Indian Legal Services
Christine Bess	Court Appointed Special Advocates--CASA
Phyllis Bigpond	Denver Indian Family Resource Center
Eileen Bisgard	Guardian Ad Litem
Palmer Boyette	Second Judicial District
Cynthia Butler	Eighteenth Judicial District
Melinda Cox	Child Welfare Division, CO DHS
Steven Clifton	Fremont County DSS
Fredrick Crawford	Logan County DSS
Jacqui Cunningham	Colorado Works, CODHS
William DeLisio	Seventeenth Judicial District
Jennifer Green	University of Colorado Health Sciences Center
Carol Johnson	Adams County DSS
Loretta Koehler	First Judicial District
Brian Matson	Jefferson County DSS
Barbara Mattison	Court Appointed Special Advocates--CASA
Carmelita Muniz	CO Association of Alcohol and Drug Service Providers
Amy Naes	City of Broomfield Attorney's Office
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Julia Polland	Savio House
Shirley Rhodus	El Paso County DHS
Michael Schiferl	CO State Judicial
Theresa Spahn	Office of the Child's Representative
Steven Stryyssar	Consumer
Melinda Taylor	CO State Judicial
Mary VanderWall	Alcohol and Drug Abuse Division, CO DHS
Regina Walter	Fourth Judicial District

Appendix B: The SAFERR Guidance

The following three pages contain the conceptual framework set forth in the document Screening and Assessment for Family Engagement, Retention and Recovery, to be published by the National Center on Substance Abuse and Child Welfare.

Identification through community or family awareness of signs, symptoms, behaviors

	Alcohol and Drug Service System		Child Welfare Service System		Dependency Court System	
Is there an issue?	***Screen***	Use of brief screening questions	***Child Abuse Report***	Questions posed to determine whether a report of abuse or neglect will be accepted for in-person response		Court may not be involved; If there is a prior history of court involvement by family it is important for both ADS and CWS to inquire
What is the immediacy of the issue?	***Immediate Need Triage***	Clinical determination of imminent risk	***In-Person Safety Assessment***	The use of a formal tool to determine imminent harm to child, whether child will be removed from or remain in the home	***Preliminary Protective Hearing***	Some jurisdictions require CWS worker to seek judicial approval for emergency removal of child—removal hearing is also referred to as shelter care hearing, temporary custody hearing, and protective custody hearing. (See Glossary).

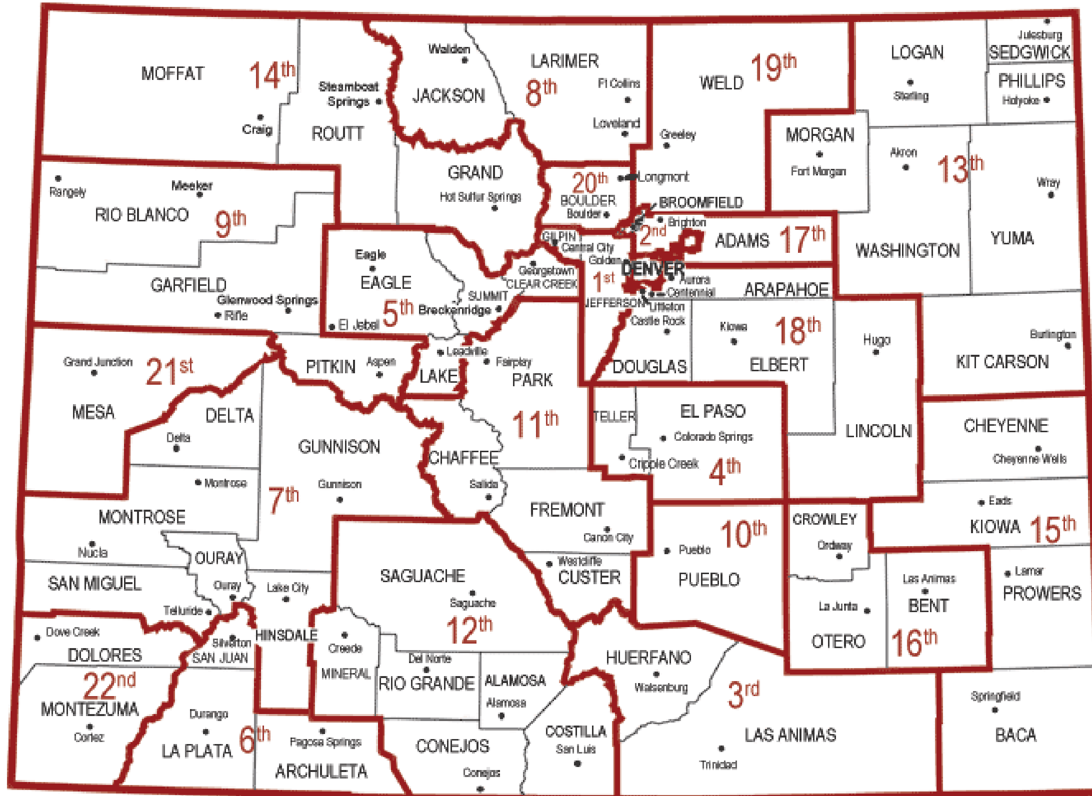
What is the nature of the issue?	***Diagnosis***	Use of standardized questions in an interview to differentiate between substance use, abuse or dependence	***In-Person Response/ Risk Assessment***	Use of an interview protocol and risk assessment tools to determine level of risk to child and whether services will be voluntary or court involved	***Court Findings***	If a Preliminary Protective Hearing is held, court will issue key written findings as mandated by ASFA, ICWA, and State statute
What is the extent of the issue?	***Multi-Dimensional Assessment***	Use of standardized set of questions by a staff member trained in alcohol and drug issues, including functioning, needs and strengths leading to a determination of level of care and needed services	***Family Assessment***	Family assessment of strengths and needs to determine the areas of family functioning requiring interventions for children to be safe in a permanent living situation that contributes to their well-being	***Petition Filed; Preliminary Protective Hearing (court process could begin here as well)***	A petition may be filed—it may or may not include allegations related to substance use; Court, attorneys, child welfare workers, CASAs, other treatment providers also become involved; Court must establish jurisdiction[1]

What is the response?	***Treatment Plan***	Individualized treatment plan with measurable objectives and outcomes	***Case Plan***	Individualized treatment plan with measurable objectives and outcomes	***Adjudication and Dispositional Hearing; Court Ordered Case Plan***	Court orders include Federally mandated findings regarding court review; Case plan and treatment plan may be incorporated into court order to varying degrees of specificity; Various court orders may be used to ensure parental compliance with services and to facilitate parent's visitation at placement facilities; Court oversight monitors provision of services by CWS and ADS
Are there demonstrable changes?	***Treatment Monitoring***	Conducting oversight and tracking of participants' progress in treatment and recovery	***Case Plan Monitoring***	Regularly reviewing the family case plan and reporting to the court (when applicable) on parents' progress and children's well-being when applicable	***Court Review Hearings***	ASFA requires that periodic review occurs within six months of foster care entry—reviews include receipt of written and oral reports from all stakeholders on progress of parents and well-being of children; Consideration of permanency needs of children at each hearing by the court, other stakeholders (e.g., CASA, attorneys, and community members); For eligible children the provisions of ICWA require specific placement preferences, rules of evidence, and the testimony of expert witnesses

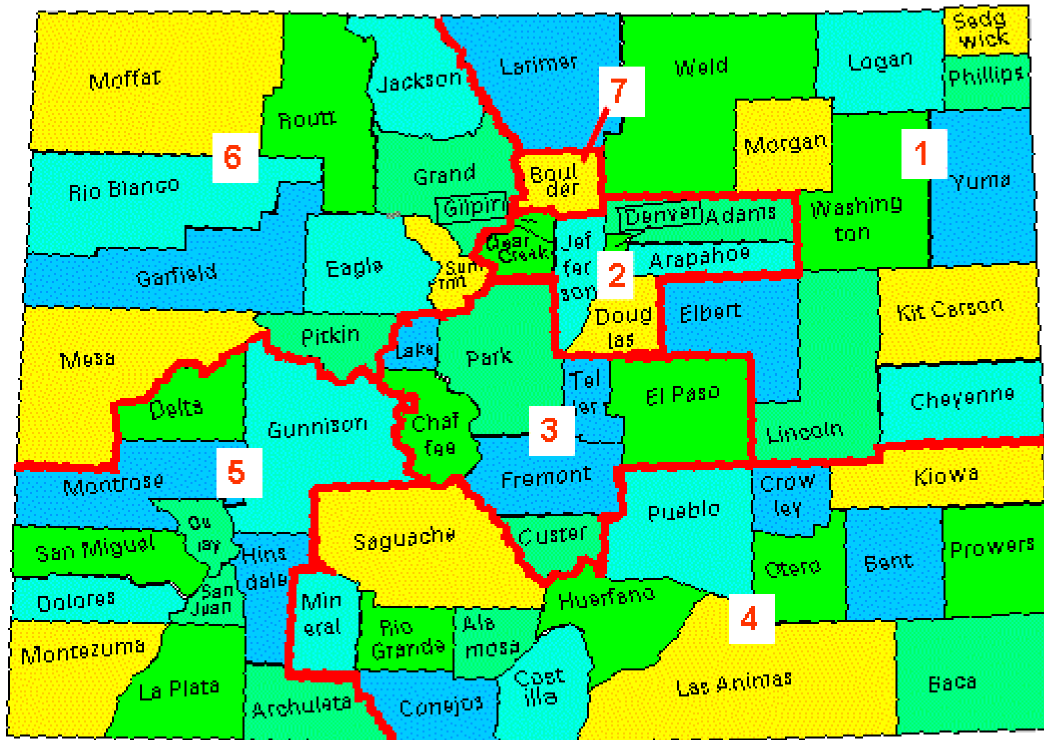
Is the family ready for transition?	***Transition Planning***	Assessment of on-going recovery plan, support systems and other needed services	***Permanency Determination***	Assessment of the most appropriate form of permanency for the child	***Permanency Hearing***	A Permanency Hearing is required within 12 months of entering foster care to determine whether a child should be returned home, file for TPR, freed for adoption, custody transferred to another individual or couple or another planned permanent living arrangement; Note: special rules apply for eligible children under ICWA
What happens after discharge or case closure?	***Recovery Management***	Ongoing self, and periodic professional, assessment as needed	***Family Well-Being***	Ongoing self assessment of enhanced capacity to care for children	***Case Closed***	In traditional courts, although the court case may be closed, parents and children may work with treatment providers in an aftercare program or with CWS for services; In a Drug Court program, the court may review parent's progress in aftercare six months after case is closed
Did the interventions work?	***Outcome Monitoring***	Data driven outcome monitoring of changes in life functioning and substance use-related consequences	***Outcome Monitoring***	Data driven outcome monitoring of recurrence of maltreatment and re-entry into child welfare system	***Outcome Monitoring***	Recidivism—re-abuse of child, re-filing of petition or sibling entry into child welfare system

Appendix C: State Maps of Counties, MSO Regions and Judicial Districts

Counties and Judicial Districts:



Appendix C (continued): Sub-state Planning Areas



Appendix D: Value Statements Regarding Substance Abuse and Child Well Being

The following values were used as the basis for discussion at the regional meetings convened as part of developing this Protocol. They may be useful for discussion by local implementation teams, although teams should not feel limited to use of these values. The discussion of values is more important than how that discussion is framed.

Following is a list of values and principles regarding children, families, and agencies. Let us know which you think are the most important.

1. Children deserve to live in safety.
2. Children deserve stable and loving families, biological, foster or adoptive.
3. All families have strengths.
4. People providing services must learn about and respect gender, ethnic, racial, religious, and cultural backgrounds of families and tailor programs and policies accordingly.
5. Families deserve help that meets all of their needs in a timely way.
6. Sometimes, for a variety of reasons, children are not able to live with their biological parents. When this happens, other arrangements must be made quickly and humanely.
7. Public and non-profit systems have a responsibility to overcome the barriers that prevent them from making difficult decisions regarding child placement and child well being.
8. On-going professional development is essential to policy making, organizational growth and service provision.
9. Service providers who share a common set of values and goals and who create a network of services will support families in need in a more comprehensive and effective way.
10. Human service and legal professionals have a responsibility to strengthen families' natural and informal networks within their own communities and reduce reliance on professional systems.

11. Families and helping professionals believe that setting realistic goals can lead to positive change and each step toward change should be recognized.

12. Service providers work within a reality of limitations (financial, time, legal, agency philosophy and goals, etc.)

13. Service providers, families, and legal professionals should respect each other to collaborate effectively. Respect can be demonstrated by taking time to understand each other.

14. Most often, families sincerely want to improve their lives. Similarly, service providers and legal professionals most often want to help families accomplish their goals.

15. Service providers and legal professionals have to make difficult, sensitive, emotional decisions about child safety. They need objective but competent and caring guidance in making these decisions.

16. Strengthening families in crisis, who are trying to stay together or reunite, requires an action-oriented approach.

17. Solutions focused on helping families are only implemented to the extent that there is accountability on the part of all team members involved. Therefore, every team member has the right to expect other members to follow-through with agreed upon goals. The team, not any one individual, is ultimately accountable for outcomes.

18. Services can only benefit families to the extent that there is a structure in place within which the coordination of those services can happen.

19. Open and honest communication among family members, service providers, and other community helpers is a prerequisite for success.

20. Service teams are in a constant process of learning about what can help strengthen families.

21. The type of caring work that is required to assist families in need cannot happen without caring for the people who deliver the services.

Appendix E: Tools/Questions to Screen for Substance Abuse Among Families Involved with Child Welfare

The following information regarding substance abuse screening instruments is taken from Nakashian, M. (2003) Talk and trust: identifying substance abuse among Colorado works families. Colorado Department of Human Services.

Selected Substance Abuse Screening Instruments

Instrument	Purpose	Features	Reference
Adult Substance Use Survey (ASUS) Used with the Self-Appraisal Survey (SAS) Used in Colorado for child protective services	A differential screening instrument designed to screen for an individual's perceived alcohol and drug use and abuse, mental health concerns, motivation for treatment, antisocial attitudes and behaviors, and level of defensiveness.	64 questions that can be self-administered or asked by another person. Available in Spanish. Takes 8-10 minutes to administer. Training is required and available. A Users Guide is available Free for use in Colorado but permission is required	Kenneth Wanberg, PhD Center for Addiction Research and Evaluation, Inc. 5460 Ward Road, Suite 140, Arvada, CO 80002 303-421-1261
Alcohol Use Disorders Identification Test (AUDIT)	A simple screening instrument designed to identify people whose alcohol use has become a danger to their health. Includes 3 subscales that assess amount and frequency of drinking, alcohol dependence and problems caused by alcohol.	10 questions that can be self-administered or asked by another person. Takes about one minute to complete. Targeted for adults. Free except for training materials.	Babor, T., de la Fuente, Saunders, J., & Grant, M. (1992). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary HealthCare.* The World Health Organization: Geneva, Switzerland. Babor. T.F. Alcohol Research Center University of Connecticut Farmington, CT 06030-1410

Instrument	Purpose	Features	Reference
CAGE (an acronym for four questions)	A simple screening in which questions pertain to lifetime drinking behaviors.	4 questions that can be self-administered or asked by another. Targeted for over 16. Questions can be incorporated into other questionnaires. Free.	Mayfield, D., McLeod, G. & Hall, P. (1974). The CAGE Questionnaire: Validation of a New Alcoholism Instrument. *American Journal of Psychiatry, 131*, 1121-1123.
CAGE-AID The CAGE or CAGE AID is used in Adams, Bent, Clear Creek Counties	A simple screening but expanded version of the CAGE that includes questions about the use of illicit drugs as well as alcohol.	9 questions that can be self-administered or asked by another person. Targeted for adults or teens over age 16. Questions can be incorporated into other questionnaires. Free	Brown, R.L. & Rounds, L.A. (1998). Conjoint Screening Questionnaires for Alcohol and Other Drug Abuse. Criterion Validity in Primary Care Practice. *Wisconsin Medical Journal, 94*, 135-140.
Drug-CAGE	Similar to CAGE but questions relate to illicit drug use in the past 12 months. The CIMH study found that only the first two of the 4 questions were necessary.	4 questions that can be self-administered or asked by another.	See CAGE
Drug Abuse Screening Test (DAST)	A simple screen designed to screen for the use of illegal drugs in the prior 12 months.	10 questions whose cumulative score indicates whether there is a drug problem, whether the person should be monitored, or whether the person should be further assessed.	The Addiction Research Foundation Center for Addiction and Mental Health 33 Russell Street Toronto, M5S2S1 Ontario, Canada 416-535-8501

Instrument	Purpose	Features	Reference
Michigan Alcoholism Screening Test (MAST)	Designed to screen for lifetime alcoholism related problems.	25 questions that can be self-administered or asked by another. Shorter version exists. Takes 5 minutes. Targeted for adults. Minor cost for original, then can be copied.	Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am. Jr. of Psychiatry, 127*, 1653-1658. Melvin L. Selzer, MD 6967 Paseo Laredo La Jolla, CA 92037 619-459-1035
Self-Appraisal Survey (SAS) Is a companion to the Adult Substance Use Survey (ASUS) Used in Colorado for child protective services	Designed to screen for alcohol and chemical dependency and to determine both extent of use and effects of use on aspects of life.	24 questions that can be self-administered by clients & 12 items for caseworkers using observation & other information. Client items take about 15 minutes. Free in Colorado but permission is required	Kenneth Wanberg, PhD Center for Addiction Research & Evaluation, Inc. 5460 Ward Road Suite 140 Arvada, CO 80002 303-421-1261
Substance Abuse Subtle Screening Inventory (SASSI) Used in Adams, Boulder, Clear Creek, Denver, Routt, Summit, Weld Counties	Designed to screen for chemical dependency and to resist efforts to fake or conceal problems. Has 8 subscales that can assess defensiveness and other dependency characteristics.	88 questions. Takes 10-15 minutes. Requires training to be administered but can be self-administered. Requires training to interpret and score. Must be purchased.	Miller, G. (1985). *The SASSI Manual.* Bloomington, IN Spencer Evening World. The SASSI Institute 201 Camelot Lane Springville, IN 47462 800-726-0526

Instrument	Purpose	Features	Reference
Triage Assessment for Addictive Disorders (TAAD)	Designed for both drug and alcohol use in face to face interviews where time commitment is minimal.	30 questions. 12-13 minutes to administer & score. Can be administered by anyone with good interviewing skills; requires expertise to score. Must be purchased	Norman G. Hoffmann, PhD Evince Clinical Assessments PO Box 17305 Smithfield, RI 02917 800-755-6299
TWEAK (an acronym for 5 questions regarding alcohol usage)	A simple screen developed and validated among women. Of alcohol tools tested by CIMH, this is the one they recommend.	5 questions that can be self-administered or asked by another. Takes 5 minutes to administer and score. No training is required. Free.	Marcia Russell, PhD Research Institute on Addictions 1021 Main Street Buffalo, NY 14203 716-887-2507
UNCOPE (an acronym for 6 questions)	A simple screen designed to detect alcohol or drug problems.	6 questions found in existing instruments and research reports. Can be self-administered or asked by another person. No training is required. Free.	Norman G. Hoffmann, PhD Evince Clinical Assessments PO Box 17305 Smithfield, RI 02917 800-755-6299

(This table was adapted from an earlier version included in A Look at State Welfare Systems Efforts to Address Substance Abuse, 2000.)

The Substance Abuse Screening/Information Form on the following page has been adapted from a similar form used by the Department of Children and Family Services in Connecticut. This form is used in <u>all</u> cases to screen for indicators of substance abuse within families, and any "yes" response on this list triggers a referral for an in-depth substance abuse assessment.

Substance Abuse Screening/Information Form*

Date:
Worker: phone:
Supervisor: phone:
Client Name
Date Client referred for assessment, if applicable:

This form shall be completed by the caseworker upon return to the office. Please circle "yes" or "no" for each item. If "yes" is circled for any item, a referral for a substance abuse evaluation should be made.

1.	YES	NO	Client appeared to be under the influence of drugs and/or alcohol.
2.	YES	NO	Client showed physical symptoms of trembling, sweating, stomach cramps, nervousness.
3.	YES	NO	Drug paraphernalia was present in the home, i.e., pipes, charred spoons, foil, etc.
4.	YES	NO	Evidence of alcohol abuse was present in the home, i.e., excessive number of visible bottles/cans whether empty or not.
5.	YES	NO	There was a report of a positive drug screen at birth for mother___ child___ List drugs detected:______________________________
6.	YES	NO	There was an allegation of substance abuse in the intake report.
7.	YES	NO	The child(ren) reports substance abuse in the home. When?
8.	YES	NO	The client has been in substance abuse treatment. When?
9.	YES	NO	The client has used the following in the last twelve months: __marijuana/hashish ___heroin/opiates: ___cocaine/crack: ___other drugs
10.	YES	NO	Client shared that s/he has experienced negative consequences from the misuse of alcohol, i.e., ___DUI/DWAI ___domestic fights ___job loss ___arrests ___other
11.	YES	NO	Client shared s/he has experienced trouble with the law due to the use of alcohol or drugs, i.e., ___DUI?DWAI ___domestic violence ___drug possession charge ___other
12.	YES	NO	There are adults who may be using drugs and/or misusing alcohol who have Regular contact with the client's child(ren).
13.	YES	NO	The client acknowledged medical complications due to the use of substances.
14.			Other

*This form was adapted from the one used by the state of Connecticut Department of Children and Families and is used with their permission.

Appendix F: Screening for Fetal Alcohol Spectrum Disorders in Children

A screening for fetal alcohol syndrome has been developed by Dr. Larry Burd for community-wide use. The 25-page training manual is clear and easily readable. Inservice training is strongly recommended in order to make the best use of this tool.

Available from Larry Burd, Ph.D., North Dakota Fetal Alcohol Syndrome Center, 1300 S. Columbia Road, Grand Forks, ND 58201 (701) 780-2477 or http://www.online-clinic.com

Additional information on fetal alcohol spectrum disorders, including training on recognition, prevention and treatment of children affected by FASD is also available at the newly formed FASD Center for Excellence at http://fascenter.samhsa.gov/

Appendix G: Funding Sources

Child Welfare funding from the Federal Government:
Title IV-E of the Social Security Act, established in 1980, is the largest source of Federal funding for child welfare services. Title IV-E Foster Care and Adoption Assistance provides funding to states to pay for part of the cost of room and board for foster care, subsidize adoptions of children with special needs, train public agency staff and foster and adoptive parents, and provide statutory protections assured for all children.

Title IV-B, Subpart 1, provides discretionary funding for child welfare services. Title IV-B, Subpart 2 (Promoting Safe and Stable Families) provides funding for family preservation, family support, reunification and adoption. The Child Abuse Prevention and Treatment Act (CAPTA) provides minimal funding to state agencies to improve prevention, investigation and treatment of child abuse and neglect. The Chafee Foster Care Independence Program provides funding for support services, job training, housing and other skills needed for older youth moving from foster care. Temporary Assistance for Needy Families (TANF) can also provide funding to support families so that children may be cared for in their own homes or in the homes of relatives

Core Services: This funding stream provides State General Fund dollars to prevent out of home placement of children who are at imminent risk of abuse or neglect, or to facilitate return home for children who are in out of home placement. Substance abuse treatment is funded as a part of most counties' Core Services allocations. Funding for treatment through Core Services is only available to families who have open child welfare cases through a county department of human or social services, in which one or more children are either at imminent risk of out of home placement or are in out of home care.

Substance Abuse Prevention and Treatment Block Grant funds treatment services to certain priority populations who do not have resources to pay for such treatment themselves. Pregnant women and women with dependent children are two of the top priority populations to receive services paid for out of this funding. In Colorado, the Alcohol and Drug Abuse Division of the Colorado Department of Human Services contracts with the Managed Service Organizations to administer this public funding. The Specialized Women's Services set aside requires provision of services to children of women in substance abuse treatment, and although the total amount of funding available to provide these services is rather small, it is a requirement that the programs that treat women also make arrangements for developmental assessments, medical assessments and treatment for the children in the care of the women receiving gender specific substance abuse treatment. More information regarding this can be found on the ADAD website at http://www.cdhs.state.co.us/adad/PDFs/postcard.pdf

The **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Any medically necessary health care service must be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. This service is administered by the Colorado Department of Health Care Policy and Financing,

and more information about EPSDT can be obtained from their website at
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254

Part C The Program for Infants and Toddlers with Disabilities (Part C of IDEA—Individuals with Disabilities Education Act, re-authorized in November, 2004) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through age 2 years, and their families. In order for a state to participate in the program it must assure that early intervention will be available to every eligible child and its family. In Colorado, Part C is administered by the Colorado Department of Education. More information is available at the
Early Childhood Connections Website: http://www.cde.state.co.us/early/

TANF, or Temporary Assistance for Needy Families, is a Federal Program that replaced the old Welfare, or Aid to Families with Dependent Children (AFDC) program. In Colorado, TANF is the Colorado Works Program. TANF can provide resources for substance abuse treatment for eligible TANF recipients, as well as many flexible options to assist families with children. Further information about the TANF program is available in each County Department of Social/Human Services, as well as on the Colorado Works website:
http://www.colorado.gov/coloradoworks

Appendix H: Guides and Resources to Aid in Team Building

A Template for Professional Development

Many of the standards and action steps included in this Protocol call for training. Training could better be framed as Professional Development experiences for staff, allowing them a range of development opportunities throughout their careers.

Training staff at child welfare, ADAD, and the Judicial Branch have all been heavily involved in developing this Protocol. These trainers are interested in assuring that staff receive training and ongoing professional development experiences that support them in implementing the Protocol in their communities. In addition, county social services staff, substance abuse treatment providers, and local attorneys, judges, magistrates, and court facilitators have roles to play in attending and leading training sessions.

While training content will vary depending on the subject matter, training goals, and the training audience, the following structure for training will promote the values and recommendations included in this Protocol. It also provides a template within which training content can be inserted.

Spend Time on Values
The Protocol and Appendix E include a list of values and techniques for having discussions about values that were used in developing the Protocol.

Model the Training Goal
If training is about working collaboratively in any fashion, people conducting the training should come from different systems, and participants from different systems should attend training together. For example, if there is training regarding how to conduct case staffings, both trainers and trainees should be drawn from agencies that participate in staffings.

Blend Theory with Practice
Training should provide trainees with both new knowledge and new skills. Time should be set aside during training and immediately following training for staff to practice using the knowledge that has been shared. Training curricula should build in structured time to provide feedback to staff regarding their skill levels. It is especially important that trainees have opportunities to practice applying some of the softer skills, such as understanding the way their values and the values of others influence practice; or how colleagues perceive their behavior during team meetings.

Leave the Training Room
Substance abuse counselors, child welfare workers, and court/legal staff should be allowed, encouraged, or required to visit each other's programs. While time constraints often make this strategy difficult to employ, it is possible for training sessions themselves to be held on-site at an agency or for site visits to be incorporated into new worker training, so that visits take place before workers have full caseloads.

Close the Loop

Knowledge and skills learned in training sessions need to be practiced, refined, and practiced again. In most cases, supervisors are charged with monitoring how well workers apply new skills, and there are few formal mechanisms whereby supervisors and trainers can talk about how well the training "took" with workers. These mechanisms should be incorporated into training curricula and could constitute the official "end" of the training.

Information on available training regarding substance abuse, child welfare and the juvenile courts can be found at http://www.cocwtraining.com

Appendix I: Special Issues in Assessing Families Involved with Substances

Child welfare staff frequently refer families for substance abuse treatment. The way these referrals are formulated and executed can influence the quality of the substance abuse assessment, how the family experiences (and therefore potentially complies with) the referral, and the kind of information that comes back to the child welfare caseworker.
Formulating appropriate referral questions is an important skill for child welfare staff when making referrals for substance abuse or other psychological assessment (see *Kayser, J., & Lyon, M. (2000). Teaching caseworkers to use psychological assessment information. Child Welfare, 79(2), 197-221.)*

Most substance abuse counselors are trained to answer the question "what ASAM level of care does this client need" in the written assessments they perform. This is a very different question than the one that many caseworkers want answered, which is "what is the impact of this person's substance abuse upon the safety of their children, and what treatment do they need to complete in order to assure that the children will be safe?" Most substance abuse counselors are not trained in issues of child safety and risk and do not have the expertise or the desire to make custody recommendations. Therefore, it is critical that caseworkers pose specific questions they want addressed in the substance abuse assessment.

Examples of questions that child welfare caseworkers might use in referring clients for substance abuse assessments include:

1. What is this person's current level and pattern of substance use?
2. What would be the most appropriate form of treatment in order to address this?
3. What other issues are impacting the client's current substance use?
4. What issues will need to be addressed in order to minimize risk of relapse?
5. What is the client's perspective about her/his substance use and its effect upon her/his life?
6. What strengths does the client have to draw upon in the course of treatment?
7. What is this client's current level of insight regarding the impact of her/his substance use on her/his ability to parent?
8. What are some good indicators of progress in treatment?

These referral questions may not be best addressed within the context of a written report, but may rather be good topics for discussion in a multi-disciplinary staffing. Most counselors do not have the time to devote to writing a lengthy report, but would be able to give the impressions and information outlined above based upon an in-depth clinical interview.

Appendix J: Tools/Questions to Screen for Child Safety Among Clients in Substance Abuse Treatment

Because parents who are in treatment for substance abuse tend to be fearful that their involvement in treatment may lead temporary or permanent loss of custody of their children, substance abuse counselors have to approach questions regarding child well being carefully. At the same time, substance abuse counselors have a unique opportunity and a responsibility to inquire about the safety of children whose parents are abusing substances. Screening for child safety, if done carefully and sensitively, can reduce parental concerns if parents and counselors conclude that children are safe, or if they are at risk, that parents are able to learn how to reduce risk. Substance abuse counselors should not become child protection experts, but they should have basic knowledge regarding child safety concerns that they can share with clients.

The next page includes some short questions that substance abuse counselors can ask clients as part of regular intake interviews or ongoing discussions.

POSSIBLE QUESTIONS TO ASK ABOUT CHILD SAFETY

(These questions are intended for use by substance abuse counselors or other service providers who are not child protection staff—please note these questions can be re-worded to make them easier to understand)

How are your children supervised during the day and at night? Who is the main caregiver of your children when you are home and when you are not at home?

How do you discipline your children? How do others in your household and/or family discipline them?

When do your children eat their meals and what are examples of food they often eat?

Do your children have a medical provider? If so, who is that person and when were they last seen? If your children do not have a medical provider, how do you handle medical situations or emergencies?

Have you had an open child welfare case before?

(for parents known to have open child welfare cases) What is the connection between your substance use and your child welfare case?

Appendix K: Glossary of acronyms

ACF Administration for Children and Families within the Department of Health and Human Services at the Federal level. This agency is responsible for oversight of child welfare activities at the State and Federal levels.

ADAD Alcohol and Drug Abuse Division of the Colorado Department of Human Services. ADAD is located within the Office of Behavioral Health and Housing, which also oversees the delivery of mental health services and housing services.

AFS Additional Family Service dollars carved out of the Federal Block Grant dollars funded to the Alcohol and Drug Abuse Division for support of publicly funded substance abuse/addiction treatment

ARD Administrative Review Division of the Department of Human Services ???add definition from website

ASAM PPC-2 American Society of Addiction Medicine Patient Placement Criteria Version 2 The framework used to make a decision about the level and intensity of treatment needed by a patient when placing that person into an addiction treatment program.

ASI Addiction Severity Index – the assessment tool most commonly used in Colorado addiction programs, this instrument is a standardized, structured interview which yields severity scores over 6 domains of life functioning with which addiction most often interferes

CAC Certified Addiction Counselor—the certification that indicates that a counselor has expertise in the treatment of addictive disorders in Colorado. CAC has three levels.

CAC Colorado Assessment Continuum—required documentation in Colorado child welfare cases consists of the safety assessment and safety plan, the risk assessment and reassessment and the North Carolina Family Assessment Scale.

CFSR Child and Family Services Review – the process of monitoring states' compliance with the Adoption and Safe Families Act at the Federal Level. Each CFSR consists of exhaustive reviews of data and individual case reviews as well as stakeholder interviews in order to ascertain how well the state is doing in assuring child safety, child permanency and child and family well being through the provision of child welfare services.

CSAT Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services

CWEST Child Welfare Eligibility and Services Tracking form The data and tracking system that existed before the transition to SACWIS/Trails in 2000.

DACODS Drug and Alcohol Coordinated Data System Colorado's data collection forms that feed information into TEDS

EPP Expedited Permanency Planning—legislation passed in Colorado in ??? which required shorter timeframes to achieving permanency for children under the age of 6 who are in out of home placement in Colorado.

EPSDT Early Periodic Screening, Diagnosis and Treatment program Add definition from website

MSO Managed Services Organization Private entities that contract with ADAD to administer the publicly funded treatment system Each MSO contracts with a group of substance abuse treatment providers in its area of the state in order to provide the full continuum of care (detoxification, outpatient and residential treatment as well as methadone maintenance services and opiate replacement therapy).

NCFAS North Carolina Family Assessment Scale – part of the CAC in Colorado, used to document areas of strength and need in families involved with child welfare.

NCSACW National Center on Substance Abuse and Child Welfare. Jointly funded by the Administration for Children and Families and the Center for Substance Abuse Treatment within the Department of Health and Human Services

PIP Program Improvement Plan A state's response to the Child and Family Services Review, in which the state spells out the activities it will undertake in order to address any deficiencies identified through the CFSR.

TEDS Treatment Episode Data Set Treatment data reported to CSAT by ADAD which contains demographic information, as well as information about treatment outcomes.

UA Urinalysis testing—the most common form of abstinence monitoring used in Colorado.

Appendix L: Interesting and Promising Things to Consider

CASA* Safe Haven Project

Safe Haven started as a pilot project of CASA, the National Center on Addiction and Substance Abuse. CASA developed the concept after a 1999 study showed the frequency of substance problems in child abuse cases.

Safe Haven uses a modified drug court model that combines the best of drug court and family court, along with a family conference and a multi-disciplinary approach. It is community-driven for children and families whose lives have been adversely affected by substance abuse by using combined resources to improve the capacity of social service agencies.   In addition to Alcoholics Anonymous or Narcotics Anonymous meetings, services through the program include stress management, life skills, career and money counseling, parents, mentoring and more. The Safe Haven program began as a pilot project when Pottawatomie County, Phoenix, Ariz., and The Bronx, N.Y., were selected by CASA to demonstrate the Safe Haven plan. More information about this project can be obtained from the CASA Columbia Website at www.casacolumbia.org.

(Note: *The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations, or any other organizations with the name of "CASA". © 2005, The National Center on Addiction and Substance Abuse at Columbia University)

Family Drug Courts

Family Drug Courts have become increasingly popular in Colorado, with active Family Drug Court programs in El Paso County, Adams County, and a number of other locations throughout Colorado. For more information on Family Drug Courts, see the 1996 publication *Juvenile and Family Drug Courts: An Overview*, put out by the Drug Courts Program Office of the Office of Justice Programs, U.S. Department of Justice.

Family to Family

This is an initiative of the Annie E. Casey Foundation to partner with families and communities to better serve children within those communities. This initiative represents a fundamental shift in the way that child welfare agencies have traditionally practiced in that the partnership with families and communities is emphasized over purchase of traditional institutional out of home placement of children. Colorado is one of the states currently implementing Family to Family.

Goals of the initiative are many, e.g. to reduce the number of children coming into out of home care by increasing neighborhood resources and relationships to enable children to remain within their communities; to decrease the amount of time children spend in out of home care; to decrease the number of moves children experience between one placement and another. More detailed information about Family to Family can be found on the Annie E. Casey Foundation website at http://www.aecf.org/initiatives/familytofamily/overview.htm.

Screening and Brief Intervention
Screening and Brief Intervention (SBI) refers to a set of skills being used currently in some medical settings, including doctor's offices and emergency rooms, to address potential alcohol problems among patients presenting for medical treatment in these settings. As alcohol use problems underlie many of the medical problems that bring people into doctor's offices and emergency rooms, physicians and other medical personnel are beginning to ask a series of questions about patients' alcohol use and then responding to the answers to those questions in very simple, proscribed ways with information about potential problems associated with at-risk drinking. SBI has also been used in college settings to decrease levels of problematic drinking on campuses.

At-risk drinking is defined as more than 2 drinks per day for men, or more than 4 drinks on any one occasion in the past month. For women, at-risk drinking is defined as more than one drink per day, or more than 3 drinks on any one occasion. Brief interventions consist of short conversations aimed at increasing clients' awareness about their alcohol use and motivating them to decrease their use before it progresses to a more problematic stage.

There has been some discussion in Colorado regarding the applicability of these same skills and approaches to alcohol use within the child welfare population, particularly with families whose level of alcohol use and child protection risk do not rise to the level that require an open child welfare case once the initial investigation is completed.

Further information on SBI is available from Altam Associates, Inc. 858-566-3709

Shared Family Care
This style of family care offers safety and supervision for children and their parents together through placement of the family into the home of a host or mentor family in order to provide an opportunity to increase effective parenting skills through hands on work and role modeling. This model offers a significant benefit to children who might otherwise be separated from their parents in that they remain together in the same household and therefore are not under the strict timelines dictated by Expedited Permanency and the Adoption and Safe Families Act. This can help children whose parents are in early recovery and who need additional time to solidify the gains made in treatment. Further information about Shared Family Care can be found at http://aia.berkeley.edu/information_resources/shared_family_care.html

Structured Decision Making
Structured Decision Making is a model that utilizes research-based risk assessment tools to increase the amount of consistency, validity and objectivity used to make child welfare case decisions, and then use these decisions to help agencies focus their resources on serving those families with the highest level of risk and need. Structured assessment tools are used at various points in the process of a case, with decision protocols guiding the agency's response to each family. The Colorado Assessment Continuum, which consists of the Family Safety Assessment and Plan, the Risk Assessment and the Risk Reassessment, followed by the North Carolina Family Assessment Scale, is an example of an array of evidence-based assessment tools currently in use in Colorado. Training in the use of these tools can be obtained by contacting the Division of Child Welfare within the Department of Human Services.