GUIDING PRINICIPLES

Interactions with Families Should Be:

✦Strengths-based ✦Needs-driven ✦Family-centered ✦Culturally competent

SCREENING AND ASSESSMENT

Comprehensive clinical assessments should be conducted by OASAS licensed AOD treatment providers, and should take into consideration levels of care, family member issues/concerns and the safety of the children. Upon receiving the necessary consents, results of assessments should be shared with CWS and the Court outlining a clinical diagnosis and recommendation for treatment.

AOD treatment providers, licensed through the OASAS are mandated child abuse reporters who must report any situation that poses imminent risk to the health and well being of children. Screening and possible subsequent assessment conducted by a Credentialed Alcohol and Substance Abuse Counselor (CASAC) through the DSS is mandatory for adults to remain eligible for DSS benefits.

When a family is applying for, or is in receipt of benefits, through DSS and any adult in the household screens positive for AOD abuse, there must be a mandatory assessment to remain eligible for benefits.

ENGAGEMENT AND RETENTION

The treatment provider should meet the client at the referring agency/court system and have the client sign the necessary consents to allow for information-sharing between systems. Additionally, the treatment provider should accompany the client to the facility immediately to reinforce engagement and demonstrate a sense of commitment to the client.

Family focused service plans should be developed in collaboration with the family and other agencies. These plans should be coordinated to ensure that child welfare activities do not conflict with AOD treatment and Family/Family Treatment Court mandates.

Individual system goals, mandates, and services should be woven into a single and comprehensive statement of services that is clear to families and service providers alike. Family members should be actively engaged in creating their plans. Families often have resources in the form of relatives, friends, churches, or other support networks that can participate in creating plans and support family members. Families should be welcomed as full participants in multidisciplinary team meetings during which decisions about their treatment will be made.

INFORMATION SHARING

Counselors and caseworkers should work collaboratively with family members to obtain the necessary consents to exchange information about screening, assessments, and service provision as early in the life of the case as possible. As soon as appropriate releases and confidentiality forms are signed, the systems can work together to ensure that all family members receive the help they need.

Child Welfare and the Courts Need to Know:

- Referral status: e.g. referral accepted; appointment kept or missed; admission approved, pending or denied; next scheduled appointment
- Assessment summary or recommendations
- Diagnosis
- Level of Care Determination
- Services to be provided
- Urinalysis results
- Progress and attendance in treatment
- Compliance with program, including toxicology screening results
- Identification of co-occurring issues
- Significant changes: address, level of care, diagnosis, etc
- Observations of parent-child relationship
- Discharge status and aftercare plans/needs

AOD SERVICES

TREATMENT PLANNING AND MONITORING

Child Welfare Services and AOD treatment providers, with facilitation from the Court, should collaborate to develop the most comprehensive and flexible plan possible to help the family succeed.

Treatment plans that reflect child welfare and ASFA timetables are important in helping parents demonstrate progress when they appear in court for case reviews. AOD treatment plans should be based on results of prior screenings, assessments, and diagnoses. They should draw from child welfare safety and risk assessments and relevant results of assessments conducted by other agencies.

Treatment plans should contain the following information:

- Problems to be addressed (substance use, family relationships, medical care, and educational and employment needs);
- Goals of the treatment process
- Objectives and strategies to reach the treatment goals
- People responsible for actions such as making referrals, attending treatment sessions, and preparing follow-up reports;
- Timeframe within which certain activities should occur; and,
- Expected benefits for the individual participating in the treatment experience.

Special consideration and supportive services should be given to the children of these families.

DISCHARGE PLANNING

Cross-system communication about the family's discharge planning needs should begin early in the treatment/Intervention/judicial process, and be continually reviewed and updated until treatment is completed or the case is closed. It is recommended that:

- Family intervention services are considered a priority in the discharge process within the cross systems collaboration;
- After treatment completion, the family's status is closely monitored to assure that the appropriate aftercare/recovery services needed to sustain parental recovery and child safety and wellbeing;
- A means to provide community-based supportive services is established that can meet the medical, mental health and social service needs of the caretaker and child(ren).
- Aftercare services should address parenting, child safety, stress management, relapse prevention/intervention, reunification issues, life skills and other needs of the family, to promote successful recovery management and healthy, safe child(ren).

SERVICES FOR CHILDREN

Children and adolescents impacted by parental substance abuse should receive comprehensive medical, mental health and risk and protective factor assessments. Developmentally appropriate screening and assessment of youth that have been severely neglected, physically or sexually abused, and/or exposed to family violence must be conducted to determine a sufficient level and duration of treatment and service provision that will facilitate recovery.

SPECIAL CONSIDERATIONS

Families involved with child welfare may be more at risk for relapse at certain points during their case involvement. Vulnerable points include:

- Before court hearings,
- After family visits,
- Shortly before regaining custody of children,
- Shortly before being discharged from residential treatment, and
- Shortly before exiting from the child welfare system.

Counselors and case workers can work together to use relapse episodes to help parents learn what factors trigger their cravings to use substances, and help them to accept the fact that relapse does not equal failure, so that they can be re-engaged in treatment immediately.