Screening and Assessment for Family Engagement, Retention, and Recovery

(SAFERR)

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Acknowledgments

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INTRODUCTION

This guidebook presents the *SAFERR* (Screening and Assessment for Family Engagement, Retention, and Recovery) *model* for helping staff of public and private agencies respond to families affected by substance use disorders. The *SAFERR model* and this guidebook were developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a training and technical assistance resource center established jointly by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration and the Office on Child Abuse and Neglect of the Administration for Children and Families. Both agencies are part of the U.S. Department of Health and Human Services.

NCSACW developed SAFERR in response to frequent requests from managers of child welfare agencies for a "tool" that caseworkers could use to screen parents for potential substance use disorders in order to make decisions about children's safety. This guidebook is that tool, and more. Although research findings and practical experience have established that no single checklist yields the kind of information caseworkers need to make difficult decisions about whether children are safe, they have identified an array of screening instruments and practice principles that, if used appropriately, can provide timely information to guide those decisions. Moreover, if these instruments and practice principles are used collaboratively by child welfare and substance abuse treatment staff, they not only inform urgent decisions about child safety, but they also improve the way staff engage and retain families in services over time and they point to policy changes that make it easier for families and workers alike to succeed (Day, Robison, & Sheikh, 1998).

SAFERR is based on the premise that when parents misuse substances and maltreat their children, the only way to make sound decisions is to draw from the talents and resources of at least three systems: child welfare, alcohol and drugs, and the courts.

Although there are a variety of tools for screening and assessing children and families and a range of substance abuse treatment and other services, it is only through collaboration and communication across the systems responsible for helping families that workers will get the information they need and that families will feel they have a chance at changing their lives.

Recent policy changes give new urgency to improving staff capacity to screen, assess, engage, and retain families. These include—

- The timelines in the Federal Adoption and Safe Families Act (ASFA) that "speed up the clock" when children have been removed from parental custody. These shorter timelines place pressure on child welfare workers to identify parental substance use disorders and then make decisions regarding their effects on child well-being, the likelihood that parents can recover, and the level of stability in the family. They also place pressure on dependency court judges to keep informed about parents' participation in treatment and the status of their recovery.
- The efforts of the Children's Bureau, through Child and Family Service Reviews (CFSRs), to assess each State's performance on child welfare outcomes and its level of conformity with Federal child welfare outcomes and to assist States in improving their outcomes. Findings of completed CFSRs indicate that many child welfare agencies are not adequately assessing substance use disorders or making timely referrals to treatment.

- The 2003 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) that place new requirements on hospitals to refer to child protective services (CPS) staff newborns identified as affected by illegal substances.

Research and practical experience repeatedly indicate that parental substance use disorders and child maltreatment are highly correlated and that many if not most children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. Although substance use, abuse, or dependence alone is not the sole determinant of risk to children, the *SAFERR model* holds that because so many families involved with child welfare have these problems, there is a need for child welfare policies that call for initial and ongoing screening and assessment of possible substance use disorders with an assumption that those disorders are likely to exist (i.e., that practice should be to "rule out" substance use disorders). Similarly, this correlation suggests a need for alcohol and drug policies that call for initial and ongoing assessment of child safety and risk of child maltreatment within families.

The *SAFERR model* further maintains that decisions from the court system about the future of children should not be made without sufficient information from the child welfare and alcohol and drug systems regarding the extent of substance use disorders, their impact on the children, and the potential for engaging parents into treatment and recovery.

What SAFERR and This Guidebook Offer States, Counties, and Localities

SAFERR puts forth an approach to help child welfare services, alcohol and drug services, and court staff promote child safety and family well-being within the practical realities and legislative mandates that drive their agencies. While SAFERR suggests standards of practice within each of the three systems, its focus is on the connections, communications, and collaborative capacities across them. These standards apply to the child welfare service, alcohol and drug service, and court systems. Because families involved with these systems are also likely to be known to other systems such as welfare, criminal justice, and mental health, the strategies suggested are relevant for coordinating services across a wide range of systems.

Each system has a process it uses to meet its responsibilities to families. These processes are somewhat parallel, unfolding in somewhat similar ways over about the same periods of time. For example, both the alcohol and drug and child welfare service systems screen people for potential problems, conduct assessments to determine the nature and extent of those problems, develop service plans, and monitor progress in meeting requirements of those plans. For families who become involved with the court system, courts review assessments regarding the nature and extent of problems in order to establish jurisdiction and adjudicate petitions, and they oversee and monitor the performance of agencies and families in meeting requirements of plans.

Traditionally, these processes take place independently of each other, but all three systems are using similar and parallel processes involving many of the same families, which strongly argues for strategies to reduce duplication, simplify work, save time, and make the processes more clear and practical for families to follow. The *SAFERR model* depicts these parallel processes in the form of the following questions that each system—child welfare, alcohol and drug, and courts—individually addresses during the time it works with families:

- Is there a substance use or child abuse or neglect issue in the family, and if so, what is the immediacy of the issue?

- What are the nature and extent of the substance use or child abuse or neglect issue?
- What is the response to the substance use or child abuse or neglect issue? Are there demonstrable changes? Is the family ready for transition and what happens after discharge?
- Did the interventions work?

The *SAFERR model*, as described in this guidebook, suggests strategies to help workers answer these questions in a more coordinated manner. Specifically, SAFERR will help staff—

- Create and guide collaborative teams charged with improving services to families through sharing information and coordinating services;
- Support the work of those teams through developing clear expectations regarding mission, authority, and accountability;
- Identify and address State-level policies that may block efficient practice;
- Select screening and assessment tools and strategies that can be incorporated into daily practice protocols;
- Support and oversee implementation of improved practices at the local level; and
- Monitor and evaluate successes and problems.

SAFERR Principles and Premises

The SAFERR model is based on three overarching *principles*:

1. The problems of child maltreatment and substance use disorders demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.
2. Success is possible and feasible. Staff in child welfare, substance abuse, and court systems have the desire and potential to change individual lives and create responsible public policies.
3. Family members are active partners and participants in addressing these urgent problems

These principles lead to the following fundamental premises that are addressed in detail throughout this guidebook:

1. **The team is the tool, and people, not tools, make decisions.** Paper and pencil tools to screen and assess for substance use disorders do just that. They do not provide information that allows child welfare workers, substance abuse counselors, attorneys, judges, or other staff to determine whether children are safe or whether there are substance use disorders or other problems in the family that put children at risk. Decisions regarding child safety and child placement are made by people, who draw on the expertise of multiple perspectives.

2. **The family is the focus of concern.** Although it is easy to understand how child welfare staff come to focus their attention primarily on the children and substance abuse counselors focus theirs primarily on the parents, isolating family members in this way tends to provoke tensions among

service staff and anger and alienation among family members. In order for staff and families to succeed, child welfare policies and workers have to acknowledge and address the implications of parental substance abuse on child safety, and substance use policies and counselors have to develop a family focus and incorporate the needs of children into treatment protocols.

3. **Problems don't come in discrete packages: they are jumbled together.** It is extremely difficult for workers to get an accurate picture of the ways that factors such as poverty, mental and physical illness, domestic violence, and lack of basic living skills interact with substance use disorders and child maltreatment. It is virtually impossible for managers to establish policies and procedures that address these constellations of problems in some coherent manner unless they work and communicate with colleagues from other systems with expertise in these fields.

4. **Assessment is not a one-person responsibility.** Assessments that are done separately by either child welfare or substance abuse staff, in parallel but not coordinated processes, run the risk of overlooking factors critical to recovery and family stability, thereby depriving families of needed services and reducing the likelihood that they will achieve their goals. In addition, as families become engaged in services, they resolve one problem and prepare to address the next, they may backslide, and they may face new situations requiring changes in their case or treatment plans. Throughout this process, child welfare and substance abuse treatment workers, attorneys, and family members must seek feedback from each other, reassess progress and needs, and change plans accordingly. Because assessment reports may be used in court as a standard for determining whether children remain with or return to their parents, it is essential that they include the perspectives of everyone involved and that they accurately represent the family situation at each point in time.

5. **Information is limited, and there is no research-based answer.** Even though identifying substance use disorders and identifying risk to child safety are inseparable, there is little research or practice that speaks to the connections between the two. Moreover, there is now no definitive research or evidence-based answer to determine how alcohol and drug use affects child maltreatment. In the practical environment in which child welfare, substance abuse, and court staff make decisions, it is enough to know that substance abuse or dependence is correlated with child maltreatment.

6. **There is no time to lose.** Recent child welfare policies emphasizing timely permanency decisions and the use of termination of parental rights hearings under ASFA have considerable impact on parents with substance use disorders who come under supervision of the child welfare and court systems. These parents face difficult challenges in managing many and at times conflicting requirements, and the stakes are high. Time is short for these families. Each day that assessments are deferred, service needs are overlooked, or services are not delivered is valuable time lost.

7. **The Indian Child Welfare Act (ICWA) creates specific guidelines for working with American Indian populations.** More than 560 federally recognized American Indian Tribes operate child welfare programs and may be resources for treatment for tribe members. Many tribes also operate their own dependency courts. Indian tribes and agencies are important partners in establishing both responsible frontline practices and agency-level policies.

8. **Developing and sustaining effective collaborations is hard work.** Outcomes for children and families depend on informed decisions by teams of people who work in disparate systems that are driven by unique funding, philosophical, and legislative mandates. While SAFERR lays out ways to help managerial and frontline staff make these decisions, it does so with an understanding that both the collaboration and the decisions to be made are difficult to come by and with a deeply felt respect and regard for the staff who work with troubled families.

The table on the next page, **The SAFERR Program Model**, is a graphical representation of the *SAFERR model*. The SAFERR principles lead to a series of collaborative structures, roles, responsibilities, and frontline practices indicated in the three "SAFERR Intervention" boxes. These boxes correspond to the next three sections of this guidebook. The SAFERR Intervention should yield outcomes listed in the bottom box of the diagram.

The SAFERR Program Model

SAFERR PRINCIPLES

- The problems of substance abuse and child maltreatment demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.
- Success is attainable and feasible. Staff in child welfare, substance abuse and court systems have the desire and potential to change individual lives and create responsible public policies.
- Family members are active partners and participants in addressing these urgent problems.

SAFERR INTERVENTION

Builds Collaborative Structures	Establishes Individual and Cross-System Roles and Responsibilities	Identifies Frontline Collaborative Practices
• **An Oversight Committee** • **A Steering Committee** • **Subcommittees** • **Mission and Principles** • **Shared Understanding and Language about Processes** • **Goals, Timetables & Products** • **Training Curricula & Strategy** • **Baseline Data** • **Progress Reports** • **Outcome Data**	• **Child Welfare System Understands—** – the basics of substance use and how use affects child development; – how to screen for substance use – the local treatment system and how to help families remain in treatment; and – the implications of tensions between substance use recovery and ASFA rules. • **Alcohol & Drug System Understands—** – how substance use puts children at risk and how child welfare must respond; – child maltreatment reporting requirements; and – how to screen for child safety. • **Court System Understands—** – the basics of substance use and child development; – its role in requiring substance use and child development assessments; and – its authority to prompt or require collaboration. • **Collaboratively, All Three Systems—** – establish joint policies and procedures for sharing information; – establish case plans; – develop shared indicators of progress; and – monitor progress and evaluate outcomes.	• **Child welfare, alcohol and drug, and court systems have collaborative policies, protocols and tools to:** – screen for substance use and child maltreatment; – assess for substance use and child maltreatment; – communicate across systems; – develop & implement collaborative case plans; and – monitor progress and evaluate results.

EXPECTED OUTCOMES

- Substance use disorders among families reported for child maltreatment will be identified more accurately and at earlier points in time.
- Potential child maltreatment among families assessed for or entering substance abuse treatment will be identified more accurately and at earlier points in time.
- Child welfare, alcohol and drug and court systems will communicate effectively in screening and assessing families for substance use disorders or child maltreatment.
- Child welfare, alcohol and drug and court systems will communicate effectively and collaborate in monitoring family progress in services.
- Staff will make informed, timely, and shared decisions regarding reunification, aftercare or continuing services, and filing of petitions for termination of parental rights.
- Families will enter and remain in alcohol and drug and child welfare services at higher rates.
- Work processes will be streamlined, resulting in reduced duplication and removal of inconsistent rules that create excessive burden in meeting case plan requirements.
- Families will enter and remain in treatment and other services at higher rates.
- Risks of child maltreatment will be reduced.
- Family stability, reunification, and well being will be increased.

The Layout of the SAFERR Guidebook

This guidebook is organized into 3 sections and 10 appendixes:

Section I: Building Cross-System Collaboration. This section describes ways in which collaborative groups differ from other kinds of work groups, creates a framework for selecting and guiding a Steering Committee, and offers ideas about how to establish the group's mission and mandate. It also describes two essential elements of successful collaboration: understanding each other's systems and communicating across systems.

Section II. Collaboration Within and Across Systems. This section first lays out elements that people in each system should know about their own system and about the other two systems—things they can do internally in preparation for working with other agencies. It then presents elements that require communication with the other two systems. It concludes with suggestions regarding how the Steering Committee should guide both the "within system" and the "cross-system" discussions.

Section III. Collaboration in Action: Working Together on the Frontline. This section presents activities that compose the daily work of substance abuse counselors and child welfare workers and offers guidance on how they can collaborate in these tasks. Activities include screening for substance abuse disorders and for child maltreatment, conducting initial and ongoing assessments, and developing techniques for engaging families and monitoring their progress. It concludes with suggestions regarding how the Steering Committee should guide these frontline practice changes.

These sections are followed by a series of appendixes that provide more detailed information, tools, and fact sheets to help program managers implement the SAFERR model.

Appendix A: Facilitator's Guide. This appendix presents managers with templates and techniques for creating and sustaining a Steering Committee or other multidisciplinary group.
It includes samples of Action Plans, instruments to help Steering Committee members assess their values and their capacity to collaborate, and other forms to make it easier for the Steering Committee to accomplish its goals. This appendix is a companion to Section I of the guidebook.

Appendix B: Fact Sheets. This appendix provides a series of fact sheets on topics such as the number of people involved with child welfare, substance abuse, and the court systems, the number of children born prenatally exposed to substances, and research findings on the extent of substance abuse problems in child welfare. These fact sheets may be useful in educating legislators and policymakers or heightening awareness among frontline staff. They are intended to complement and not replace more indepth training activities that should take place.

Appendix C: Understanding the Needs of Children in Families Involved in the Child Welfare System Who Are Affected by Substance Use Disorders. This appendix provides information about prenatal and postnatal substance exposure and the consequences of exposure on children, issues related to substance use among youth, and a description of resources for children who have been identified as affected by parental substance use disorders.

Appendix D: Examples of Screening and Assessment Tools for Substance Use Disorders. This appendix presents a sample of commonly used screening tools for substance use disorders and discusses the pros and cons of each tool for use by child welfare staff. Child welfare and substance abuse staff should jointly select the tools that best meet their needs.

Appendix E: Substance Use, Abuse, Dependence Continuum, and Principles of Effective Treatment. This appendix presents Federal principles of effective treatment for substance use disorders and a description of the continuum of substance use, abuse, and dependence. This appendix is a companion to Sections II and III of the guidebook.

Appendix F: Examples of Safety and Risk Assessments for Use by Child Welfare Staff. This appendix provides an annotated list of commonly used risk and assessment tools, including practice-based tools and the Strategic Decisionmaking tool. The purpose of these examples is to provide general information to substance abuse counselors regarding the issues addressed in child welfare safety and risk assessments.

Appendix G: Sharing Confidential Information. This appendix describes Federal rules regarding acceptable means for sharing confidential information. It includes information that can be incorporated into consent forms for use by multiple agencies and links to Federal resources for sharing information in ways that comply with HIPAA and other confidentiality regulations.

Appendix H: Glossary of Terms. This appendix provides short definitions of terms commonly used by child welfare, substance abuse services, and court staff.

Appendix I: A Guide to Compliance With the Indian Child Welfare Act. This appendix provides a short description of key provisions of the Indian Child Welfare Act, including when it applies, State/tribe jurisdictions, burden of proof requirements in removing children, and removals of children in emergency situations.

Appendix J: Acknowledgment of Contributors and Reviewers.