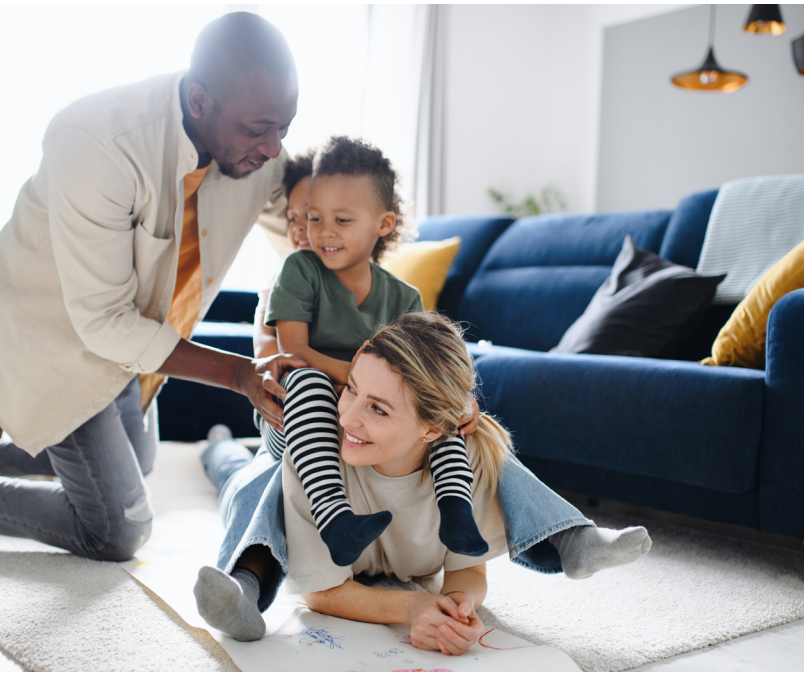
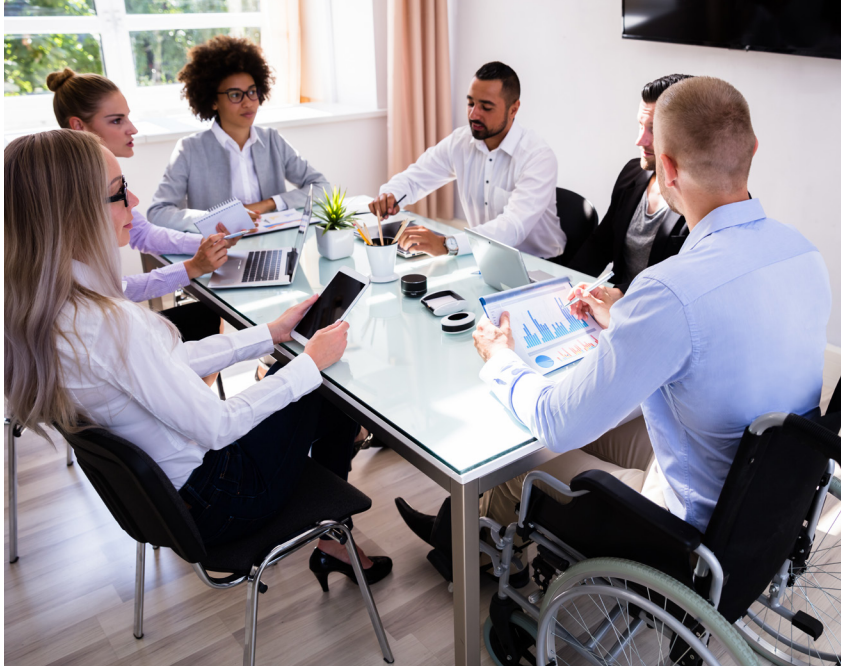
PRACTICE GUIDE 2

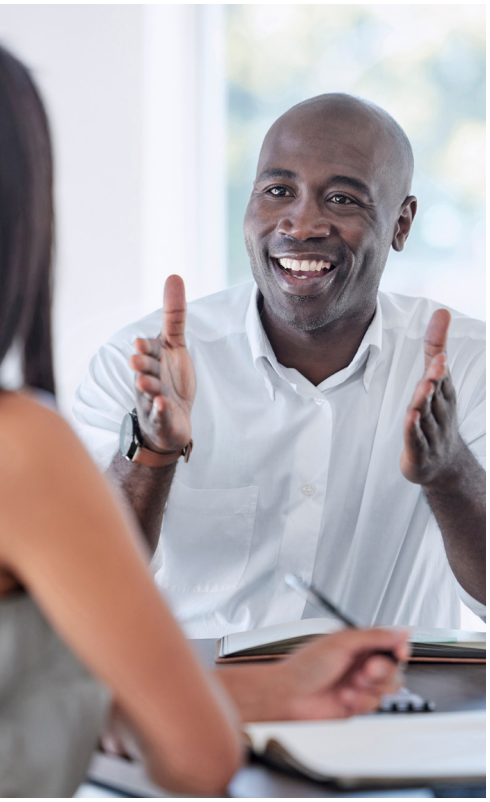
A CHILD WELFARE SUPERVISOR'S GUIDE TO Planning for Safety in Cases When Parental Substance Use Disorder is Present



National Center on Substance Abuse and Child Welfare



Contents



Introduction

Supervisors have a key role in enhancing child welfare casework practice by pairing didactic learning (e.g., e-learning, classroom, or educational videos) with transfer of learning activities to help child welfare workers integrate information and build their skill set to work more effectively with families.

The National Center on Substance Abuse and Child Welfare (NCSACW) developed two supervisors' practice guides, each as a supplement to the two safety and risk videos for child welfare professionals. The videos provide details on the safety and risk factors related to parental substance use disorders (SUDs) and considerations when planning for safety with children, parents, and family members:

- Engagement and Safety Decision-Making in Substance Use Disorder Cases—provides an overview of strategies and observations to support engagement with families affected by parental substance use disorders and involved in child welfare. This video includes considerations of parental protective capacities and protective factors to increase knowledge about the effect of parental SUDs on child safety and risk.
- Planning for Safety in Cases When Parental Substance Use Disorder is Present—discusses safety factors related to parental SUDs and unique considerations when planning for safety. The video provides an overview of strategies to increase protective capacities and factors for families affected by SUDs.

This guide provides supervisors with information on how to build upon the concepts in the video to strengthen child welfare workers' knowledge and skills when working with families when parental substance use is present.

The guide is structured with the following sections:

- **Knowledge Transfer**—Reviews key concepts from the video and describes how supervisors can incorporate the information into practice with families
- **Considerations for Case Discussions with Child Welfare Workers**—Provides strategies, techniques, and specific questions to use with child welfare workers during case discussions to help staff build their knowledge and enhance their skills when working with families
- **Supplemental Resource**
  - **Case Scenario Activity**—Creates the opportunity for child welfare workers to practice the application of key concepts and strategies from the video

Combining key concepts from the video with activities in the practice guide allows supervisors to have:

- An operationalized method for applying and using child welfare workers' critical thinking and practice skills
- Intentional use of resources and tools to improve engagement and outcomes for children, parents, and family members affected by SUDs

Knowledge Transfer

This section reviews key concepts from the video and how supervisors can help child welfare workers incorporate the information into their practice with families.

Assessing Ongoing Safety and Maximizing Family Engagement

Video's Key Concepts

- Assessing child safety is *not* a one-time event—it occurs at the initial contact with a family and at every contact thereafter until case closure (e.g., home visits, telephone calls, interactions with case participants).
- If the child welfare worker determines a child is unsafe—or safe with agreement*—the child welfare worker may use different interventions, parental protective capacities, and protective factors to develop safety plans with families. This process helps: 1) eliminate or mitigate immediate (or pending) danger to the child(ren) and 2) decrease the potential risk of maltreatment.

Role of Supervisor

Help child welfare workers differentiate safety threats from risk factors and understand how to use parental protective capacities and protective factors. Differentiating between a safety threat that requires immediate action to protect the child vs. a risk factor that *may* cause future maltreatment helps child welfare workers determine how to craft a safety plan that meets the needs of the entire family, identifies the parental protective capacities and protective factors, and outlines the steps needed to mitigate risk and ensure safety.

KNOWLEDGE TRANSFER STRATEGY
Provide child welfare workers with different scenarios and ask them to identify each scenario as a safety threat or risk factor. Talk about why they consider each situation a safety threat or risk factor. Help child welfare workers identify parental protective capacities and protective factors and assist child welfare workers in determining how to incorporate them into a safety plan.

Discuss with child welfare workers what to look for and evaluate in the home environment. The video reviews considerations for assessing the home environment initially and throughout the life of the case. While the conditions of the home may or may not indicate parental substance use, sudden negative changes in the home environment (e.g., the home is usually organized and well-kept but now is chaotic and unkept) may indicate the need for the child welfare worker to check in with the parent to determine if there are any unmet needs.

KNOWLEDGE TRANSFER STRATEGY
Facilitate a group discussion with child welfare workers and ask them to: 1) identify what they could observe in the home environment that may indicate parental substance use (e.g., lighters with missing or broken safety tabs, rolling papers, razor blades, or small pieces of foil), and 2) how they would discuss concerns with the parent (e.g., conversation starters and questions to ask).

* Safe with agreement means interventions mitigate the concern of maltreatment and unsafe indicates interventions will not resolve the concern and child must enter out-of-home (OOH) care. Child Welfare Information Gateway: https://www.childwelfare.gov/resources/use-safety-and-risk-assessments-child-protection-cases/

Reinforce with child welfare workers the need to identify and assess the safety and needs of all family members. Ensuring child safety is paramount. However, assuring the well-being and permanency of children requires child welfare to use a family-centered approach to identify, understand, and resolve presenting or underlying needs (e.g., domestic violence (DV), trauma, mental health, substance use) of all members within the family unit. Individuals who engage in substance use have an inherent risk to their health and well-being, and the progression of substance use may increase the risk for comorbidity[1] (e.g., physical and mental health).

KNOWLEDGE TRANSFER STRATEGY
Conduct a "pair and share" activity with child welfare workers to practice using a screening tool like the UNCOPE—one child welfare worker is the "parent" while the other child welfare worker practices incorporating the screening questions into a conversation with the "parent" and then they switch roles. Use a large group discussion afterward for child welfare workers to share their experience (e.g., How did they feel using the screening tool? What was challenging? How did they incorporate the questions? When playing the part of the parent, what felt less threatening and more conversational?).

Teach child welfare workers the benefits of medications for opioid use disorder (MOUD)*[,2]—including federal disability rights protections for certain parents with an opioid use disorder (OUD)/substance use disorder and involved with child welfare. Parents with a SUD in the postnatal period are at high risk of mortality from an overdose, with the highest risk of death at six weeks to nine months. Research has shown that 70% of substance-related maternal deaths occur postpartum, 20% within the first six weeks.[3] Stigma persists relative to the use of MOUD even though research shows a direct correlation between MOUD and 1) retention in SUD treatment, 2) reduction in substance use-related deaths, 3) positive birth outcomes for pregnant women and infants, and 4) improved overall well-being in a person's life.[4]

KNOWLEDGE TRANSFER STRATEGY
Consider external resources: 1) Ask a treatment provider to speak to child welfare workers about MOUD—myths and misconceptions, evidence of effectiveness, prenatal and postnatal considerations, dosing, benefits—and how to best support parents; 2) encourage a child welfare worker to visit an MOUD agency and bring information back to their peers; or 3) have child welfare workers review MOUD resources like NCSACW's, Opioid Use Disorder and Civil Rights Video and Webinar Series and facilitate a group discussion on how the information applies to their practice with parents and other family members.

Develop child welfare workers' skills to formulate questions for parents, children, and collateral contacts to determine child safety and make informed decisions about next steps. Several strategies, techniques, approaches, and questions appear in the video that child welfare workers can use to gather information from parents, children, family members, and collateral contacts (i.e., extended relatives and fictive kin,**[,5] non-custodial parent/caregivers, community providers) to determine if parental substance use affects child safety. Parental substance use, a SUD diagnosis, or a positive drug test does not automatically mean a child is unsafe; the substance use must connect to an immediate (or pending) safety threat. How child welfare workers ask and structure questions affects the accuracy of the safety assessment and the effectiveness of the safety plan.

* Shifting language from using medication-assisted treatment (MAT) to MOUD helps dismantle the stigma that a person on MOUD is substituting one substance for another and reinforces the use of medications as an adjunct tool to SUD treatment.

** The American Legislative Exchange Council defines fictive kin as *"an individual—unrelated to a child by birth, adoption, or marriage—who still has an emotionally significant relationship with the child."*

KNOWLEDGE TRANSFER STRATEGY
Brainstorm with child welfare workers to identify all the possible sources of information (i.e., who they can talk to). Then, facilitate a discussion about the various times to interview (i.e., when the best time is to speak with them) and what questions to ask in assessing child safety and determining the next steps. Review the different sources they can use to make informed decisions (e.g., screening results, behavioral indicators, and collateral details) and the state's confidentiality policy and procedure to ensure compliance with all legal requirements for obtaining and sharing information.

Ensure child welfare workers use a strength-based, family-centered approach when engaging families and assessing parental substance use to determine services. Families have varying views on mental health and substance use, parenting styles, and healing practices. Family history and trauma may directly affect how family members engage with child welfare workers and services. Use of a strength-based, family-centered approach can maximize family engagement because it seeks to identify, value, and respect that family members know their strengths, limitations, and challenges the best.[6]

KNOWLEDGE TRANSFER STRATEGY
Strategies include: 1) coach workers on how to use active and reflective listening to hear and incorporate family voice into service and case planning, 2) discuss the power differential between workers and families, and 3) review available data on family engagement to determine where in worker service delivery practice skills could be strengthened (e.g., percentage of parents involved in developing a case plan). See *Evaluating Family Engagement in Child Welfare: A Primer for Evaluators on Key Issues in Definition, Measurement, and Outcomes* for the different levels and key issues of family engagement and how to evaluate it in the context of child welfare.

Review the principles of harm reduction with child welfare workers in the context of child safety. When harm reduction is seen as part of the continuum of care, it allows child welfare workers to meet people where they are in their change process, reduces their risk of harm and lets them make small positive changes that strengthen their well-being. However, when working with a family, it is vital to apply harm reduction in a way that protects child safety. Using these strategies: 1) reduces the effects of stigma and punitive actions against substance use, 2) shows compassion while maintaining a holistic approach that prioritizes child safety and reinforces the parent's well-being; and 3) builds trust and rapport with the parent.

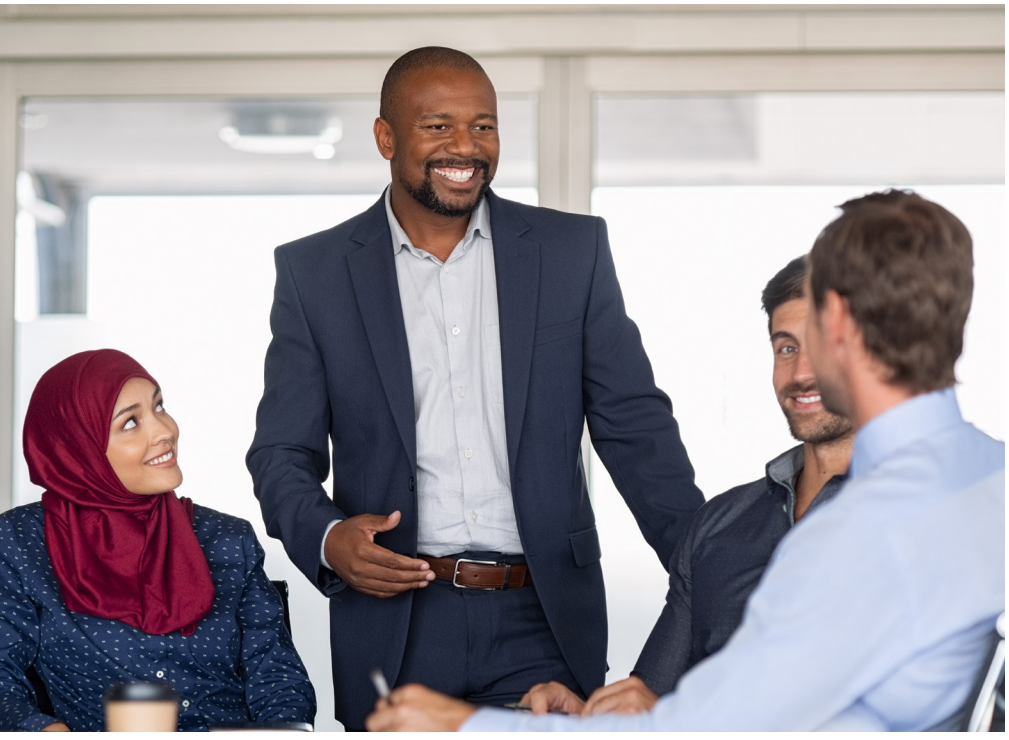
KNOWLEDGE TRANSFER STRATEGY
Provide educational opportunities to reduce the stigma associated with substance use and help child welfare workers identify how current practice reflects a harm reduction approach (e.g., helping parents access MOUD, using a SUD screening tool for early identification, parents having timely access to treatment, and connecting families to resources for naloxone* and overdose prevention and treatment). Discuss and clarify misconceptions about harm reduction strategies.

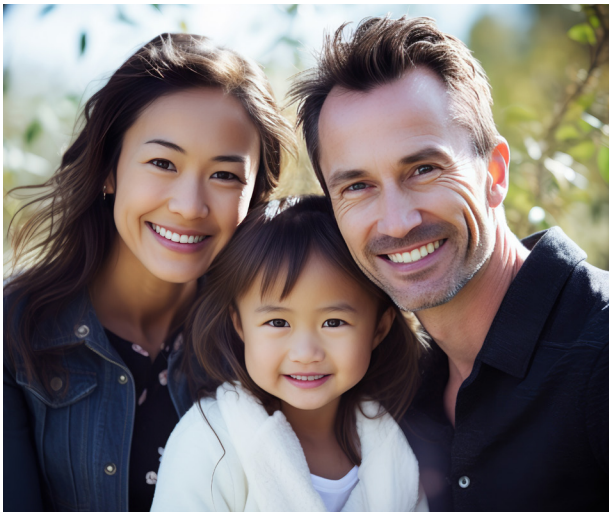
* Naloxone is an opioid antagonist medication that is used to reverse an opioid overdose.

Discuss the importance of identifying and engaging natural supports—including non-custodial parents—with the child welfare worker. Natural supports may include extended family members, significant others, friends, or others in the community involved with the family. Thirty-four percent of children in the U.S. live in single-parent households[7] and 26% live in a home with a mother only.[8] Research shows—when there is an identified father—children directly benefit from having their father involved in their life; children have: 1) better cognitive outcomes (applies to infants as well); 2) higher self-esteem and less depression as teenagers; 3) higher grades, test scores, and overall achievement; 4) lower levels of alcohol and other drug use; and 5) higher levels of empathy and other prosocial behaviors.[9,10] Family members, fathers (or non-custodial parents), and friends can help support child safety and monitor the safety plan.

KNOWLEDGE TRANSFER STRATEGY

Have child welfare workers—in a group—identify: 1) the benefits and importance of the father's (or non-custodial parent's) involvement in the child's life, 2) how to gather information on the family composition (i.e., whether there is an identified father or non-custodial parent), 3) strategies to engage fathers and other natural supports, and 4) what the father or non-custodial parent's role is in the safety plan.





Safety Plan Development

Video's Key Concepts

Safety planning clearly identifies the safety threat and risk factors and uses protective capacities and protective factors to mitigate child maltreatment. Plan development is a process that:

- Can prevent OOH placement
- Includes achievable steps
- Uses shared-decision-making and is collaborative
- Empowers the family to reach a resolution

A written safety plan clearly states

- **The safety threat and identified risk factors**
- **How the child will be protected from harm**
- **Action steps for parents**
- **The agreement by all individuals involved**
- **Specific timeframes**
- **How the child welfare worker and other individuals will monitor and support the plan**

Role of Supervisor

Review shared decision-making and how child welfare workers can use it in safety planning. As referenced in the video, using shared decision-making engages the entire family, helps build trust, and develops or rebuilds familial relationships.

KNOWLEDGE TRANSFER STRATEGY
Talk with child welfare workers about the benefits of using shared decision-making with families, when to use it (e.g., prior to a child entering out-of-home placement), how to structure the meeting, and model facilitation for them. Consider how child welfare workers trained in a shared decision-making model could help their peers strengthen their skillset (e.g., serve as a mentor).

Encourage innovative thinking to develop strategies that can help prevent OOH placement. Exploring alternative options to safety threats with parents and family members reinforces that they are the experts in their own lives and helps shift the power differential during these conversations. Staying open to and considering creative thinking or non-traditional approaches can help keep children from entering OOH care.

KNOWLEDGE TRANSFER STRATEGY
Facilitate a group discussion with child welfare workers about the strategies they've used in the past—or could use in the future—to help prevent OOH placement.

Help child welfare workers develop achievable action steps. The steps included in the safety plan need to be attainable; the plan should not set the parent up for failure. Ensure timeframes for action steps are specified and realistic. It may take time for parents who are actively using substances to stop; it is often unrealistic to expect them to stop at the beginning of a case before they've received treatment, and there may be barriers that prevent rapid access to treatment.

KNOWLEDGE TRANSFER STRATEGY

Assist child welfare workers in 1) developing attainable action steps (e.g., specific, measurable, achievable, relevant, time-bound[11]) in the safety plan and 2) including family member-specific steps on how to protect the child when the parent is activated (i.e., triggered) or engaged in active use. This will help the family understand how to best support the parent and provide the parent an opportunity to determine alternatives to protect the child.

Next, divide child welfare workers into groups, provide them with a mock or real case scenario, and ask them to write a safety plan. Use a facilitated discussion afterward to 1) identify the strengths of the plan, 2) learn what they incorporated into their safety plan and why, and 3) talk about what they felt was challenging about the plan's development.

Reinforce with the child welfare worker the importance of monitoring the safety plan and adjusting as needed. A signed safety plan is an important first step, but by itself, it does not mean a child is safe. Continuous and regular follow-up with the parents, children, and individuals monitoring the plan—as well as collateral contacts—is necessary until the safety threat dissipates. Discussions focused on what is and is not going well can help the family and child welfare worker know what needs adjusting. Safety plans are meant to be immediate and short-term but may need adjusted to ensure child safety and well-being.

KNOWLEDGE TRANSFER STRATEGY

Use a de-identified safety plan to facilitate a group discussion with child welfare workers on how they would assess the effectiveness of the safety plan, for example: monitoring frequency, who they would speak with, questions to ask, what they would look for, and how they would approach concerns.

Safety Planning During Family Time

Video's Key Concepts

Frequent family time—when an OOH placement has occurred—offers benefits to parents and children:

- Helps offset the stress and trauma experienced by the separation and maintains the parent-child bond
- Empowers parents by promoting accountability
- Provides parents an opportunity to learn and build capacity for new parenting skills and behaviors

Family time safety plans help ensure parents' and children's time together is a positive experience.

Role of Supervisor

Review the frequency of family time. Research shows a correlation between frequent family time and reunification outcomes.[12] Family time is an opportunity for parents to learn how to increase parental protective capacities and protective factors. Supervised or unsupervised family time can occur.

KNOWLEDGE TRANSFER STRATEGY
Brainstorm with child welfare workers: 1) when it is appropriate to provide supervised and unsupervised family time, 2) how to use natural supports or resources in the community to increase family time, and 3) how family time can be used to increase parental protective capacities and protective factors (e.g., helping parents prepare activities for a family time session or holding family time in the community like at a park).

Talk with child welfare workers about potential safety concerns during family time and how to mitigate concerns through safety planning. Incorporating family time into safety planning allows parents and the individual monitoring family time to have a clear understanding of expectations and what steps will occur if a safety concern arises. Some considerations to review with child welfare workers were included in the video. The best practice is to ensure families have regular and frequent family time. Parents may continue to use substances at the beginning of their case or treatment—and continued use should not affect their family time as long as child safety is ensured (e.g., individual monitoring the session remains in the room with the parent and child).

KNOWLEDGE TRANSFER STRATEGY
Facilitate an activity where child welfare workers identify potential safety concerns that can arise during family time and how they would mitigate the concern through safety planning (e.g., a parent arrives for a partially supervised family time session at the agency and shows signs of being under the influence).

Help child welfare workers determine how and when to reduce supervision during family time. Supervision levels for family time can gradually decrease as parental protective capacities increase. Reducing supervision and allowing parents to spend increased time with their child unsupervised helps assess the parent's ability to protect the child and sets them up for success as they navigate parenting in recovery. The video highlights three methods to use while deciding when to reduce family time supervision: 1) shared decision-making meetings, 2) discussions of parental protective capacity and protective factors, and 3) assessment of progress.

KNOWLEDGE TRANSFER STRATEGY
Strategies include: 1) using resources like the *Protective Factors Conversation Guides* and *Protective Factors: Action Sheets* to facilitate a discussion with child welfare workers about how they can help increase parental protective capacities and protective factors, 2) having child welfare workers identify how they will know when to reduce supervision (e.g., parental behaviors or other indicators), 3) discussing how progress is monitored and measured, and 4) reviewing the structure for family meetings and using shared-decision making to determine if it is appropriate to reduce supervision.

Safety Planning at Case Closure

Video's Key Concepts

Preparing for case closure begins the day the family's case opens with child welfare.

- Holding regular shared decision-making meetings and joint case reviews with treatment and service providers to review progress and concerns—and adjust the family's plan—helps reduce events that may affect child safety or the ability to reach permanency goals.
- Increasing and strengthening parental protective capacities and protective factors throughout the life of the case and creating a case closure plan can help prevent subsequent child welfare involvement after case closure.

Role of Supervisor

Facilitate discussions with child welfare workers about how to respond to a return to substance use. As parents enter substance use disorder recovery it is crucial that child welfare workers understand that recovery is not always a linear process and parents may experience challenges in their recovery journey. When a parent experiences a return to use during the child welfare case, it means that something about their recovery management plan* does not work for them. A return to use is the *last sign* that something is wrong. This is the time to work with the parent to strengthen their plan to ensure the parent can sustain long-term recovery and ensure child safety.

KNOWLEDGE TRANSFER STRATEGY

Facilitate a group discussion with child welfare workers and ask them to identify what signs may indicate a potential return to use in: 1) behaviors, 2) appearance, 3) attitude, 4) engagement levels, and 5) home environment. Then ask child welfare workers how they would approach a discussion with the parent to determine what is occurring (e.g., "I am worried about you because I've noticed…"; "I am concerned about you because you missed your appointment on…"; or "Tell me how life is going for you right now. How can I help you?").

Discuss with child welfare workers what services the family needs to sustain reunification. It is important for child welfare to: 1) help stabilize the family during the transition period, and 2) ensure both children and parents have time to adjust to a "new way" of being a family prior to case closure. Parents may experience challenges in the first year of recovery as they adapt to handling everyday stressors. At the point of reunification, temporarily increasing child welfare worker contacts or providing intensive family-centered services that gradually decrease contact over time allows: 1) the child welfare worker to monitor how the parents are doing; 2) parents to apply recovery management techniques while also acquiring or implementing new parenting skills; and 3) a foundation for parents, children, and family members to thrive.

KNOWLEDGE TRANSFER STRATEGY

Partner with an agency that employs peer support specialists and ask for a peer—that is a parent—to speak to child welfare workers about how to balance early recovery and parenting, including tips for how child welfare workers can help encourage and support parents reunifying with children (e.g., send encouraging texts, help arrange childcare or establish a schedule, and reinforce the need to use of recovery supports).

* Some SUD treatment providers may refer to a recovery management plan as a relapse prevention plan.

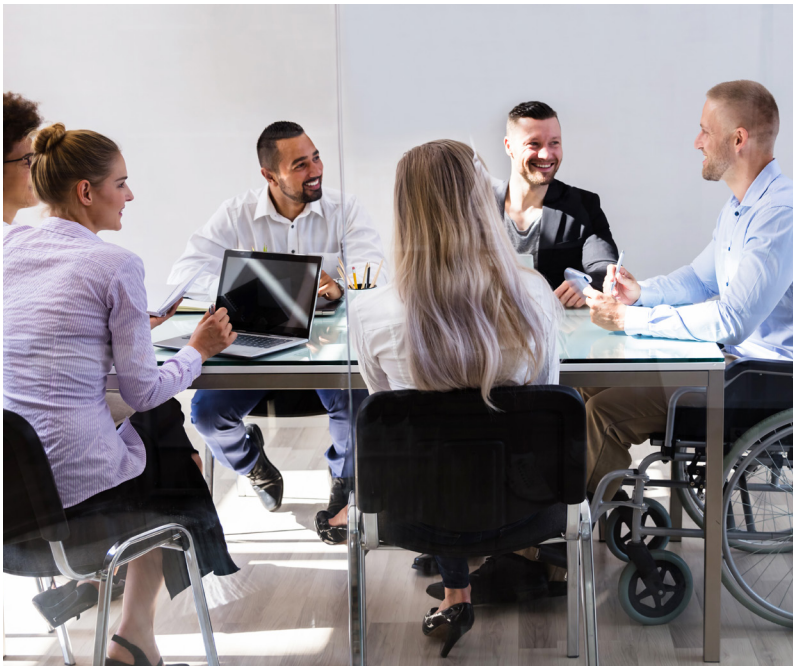
Help child welfare workers identify recovery indicators and other considerations for case closure. A series of negative drug tests or treatment completion does not in and of itself mean parent is in recovery or the family is ready for case closure. Child welfare workers can use a holistic approach to determine whether the parents and family have reached long-term stability that promotes the child's safety, well-being, and permanency (the video highlighted several elements to consider). Child welfare workers can transfer and provide a warm handoff to community-based services prior to case closure (e.g., mental health services).

SAMHSA uses a working definition of recovery with 10 guiding principles—recovery is a "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." The four dimensions of recovery highlighted are health, home, purpose, and community.[13]

KNOWLEDGE TRANSFER STRATEGY
Invite a SUD treatment clinician or a peer support specialist to speak with child welfare workers about recovery indicators. Ask child welfare workers to identify what indicators would show a parent is in recovery, a family is stable, and the case is ready to close.

Discuss concurrent planning with child welfare workers. The purpose of creating a plan at case closure is to ensure child safety and prevent the family from subsequent child welfare involvement. Developing a plan about what happens if the parent experiences a return to use or a crisis occurs (e.g., the family cannot pay their utility bills or rent) helps the family gain clear direction on their next steps to protect their child, avert a potential crisis, and reach a resolution on their own.

KNOWLEDGE TRANSFER STRATEGY
Facilitate a large group discussion on what potential situations a child welfare worker may want to talk through with a family and incorporate into a case closure plan (e.g., unable to afford MOUD medication). Include in the discussion what the plan would include to mitigate the situation (e.g., community resources). Discuss with child welfare workers the importance of exploring with the parent what the parent's greatest fear is or what crisis they are most worried about.



Considerations for Case Discussions with Child Welfare Workers

This section provides strategies, techniques, and specific questions to use with child welfare workers during case discussions to help staff work more effectively with families.

Assessing Ongoing Safety and Maximizing Family Engagement

- Help child welfare workers determine if what they see in the home environment constitutes a safety concern (e.g., conditions of the home, controlled substances, drug paraphernalia)
- Explore with child welfare workers what questions they can ask to determine how parental substance use affects child safety and how they can weave the following questions into the discussion:
  - What have your friends and family said about how you take care of your children when you engage in alcohol or drug use?
  - Why might someone be concerned about your children's well-being?
  - What concerns do you have about taking care of your children while using alcohol or drugs?
  - How do you think your alcohol or drug use affects your children?
  - How do you protect your children while using alcohol or drugs?
  - What treatment have you received in the past for alcohol or drug use? Have you been in recovery before? How long were you able to maintain recovery? What worked well for you?
  - How do you feel about getting a SUD assessment and entering treatment?
  - Whom do you have to use for family support nearby or in the home? Tell me about your relationship with them.
  - Tell me about your children's schedule. When do your children eat their meals? What are some examples of the meals you provide? How do they get to school? Do you have any challenges getting them to school on time? If so, what are they? What is their bedtime routine? Where do they normally sleep? What time do they go to bed?
  - How does your child sleep? How are they eating? When was their last well-child visit? How did it go? How is daycare, preschool, or school going? What concerns have others had about the child (e.g., family member, daycare provider)?
  - Has anyone expressed concerns, or do you have concerns with your child having developmental delays, chronic medical issues, learning disabilities, or fetal alcohol spectrum disorders (FASD)? If so, what are they? What treatment services does the child receive?
  - What challenges do you have paying for housing, utilities, food, etc.?
  - Have you and your family been involved with other agencies in the past because of concerns about your children? If so, what agencies?
- Help child welfare workers use their observation about young children to determine how parental substance use affects the parent-child relationship:
  - What is the child's body language?
  - Does the child answer questions and respond to interactions with the child welfare worker or look to their parent? Are they hesitant or uncertain on answering certain questions?

- Review potential age-appropriate questions with child welfare workers they can ask children that can provide insight about their well-being and parental substance use:
  - Tell me about your day! What do you do right after you wake up?
  - Have you ever seen your parent take medicine? Tell me what the medicine looked like. How does your parent act after they take the medicine?
  - Have you ever seen anyone in your family smoke? Tell me what the things they smoke look like. How do they act after they smoke?
  - Are you ever worried or scared something bad would happen to your parent? What makes you worried or scared?
  - What things do you and your parent do together?
  - Are there any things your parent does you do not like? Tell me about…
  - Whom do you like to spend time with who does not live in your home? What activities do you do together?
  - If you could have any three wishes (but not more wishes), what would you wish for?
- Talk with child welfare workers about FASD to help them determine if the child's social-emotional functioning, behaviors, or development could indicate fetal alcohol exposure; ensure they know where to refer the child for an assessment and treatment for FASD
- Help child welfare workers use a comprehensive approach when assessing the needs of all family members to include the safety and well-being of the parents and family:
  - Were all parents, including non-custodial parents, screened for a SUD using a standardized tool like the UNCOPE?
  - What has been done to rapidly connect the parent with SUD treatment?
  - Does the parent engage in opioid use? If yes, have they been provided education and resources on overdose prevention? Do they and people close to them have access to Naloxone and know how to administer it?
  - Is the parent in the postnatal period? Is there a Plan of Safe Care? Are they under the care of an obstetrician and making their appointments? Are they connected to a MOUD program?
  - Is the parent obtaining medications for a SUD without a prescription and oversight (e.g., buprenorphine, methadone, naltrexone)? What treatment program could the parent connect with for a prescription?
  - What is the parent's access to medical care? Do they have health insurance, Medicaid, or other resources to pay for medical care? Do they have unmet (physical) medical needs (e.g., screening/treatment for hepatitis C and human immunodeficiency virus (HIV) or bacterial/fungal infections due to intravenous use)? Does the parent have a chronic pain condition that requires additional medical management? How can the child welfare worker facilitate connection and remove barriers to accessing treatment (e.g., helping with Medicaid enrollment, making the appointment, assisting with transportation)?

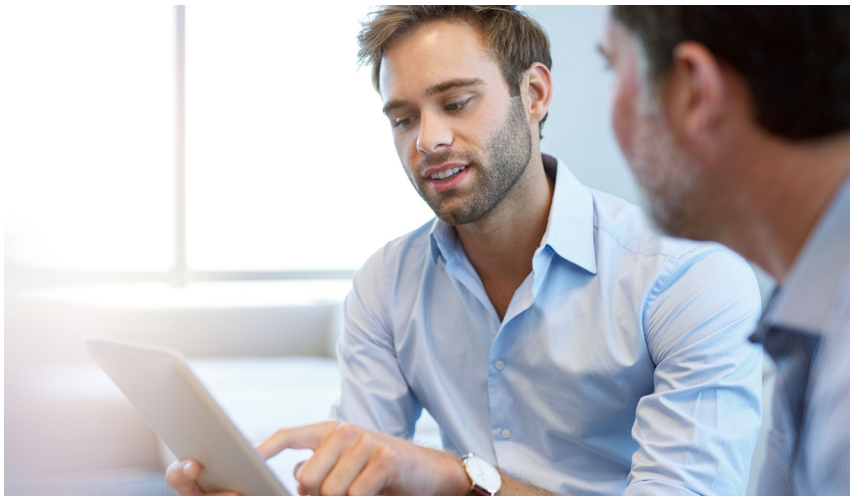
- Does the parent know how to access community resources for a mental health or medical crisis?
- How are concrete needs like housing, food, and clothing met? What resources are available (e.g., connection to Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), or public housing)?
- Are there concerns related to DV or human trafficking?
- What options are available for safe and stable housing? Can the parent access community programs designed to provide a safe space (e.g., a recovery center)?

Encourage child welfare workers to have honest conversations with older youth regarding substance use, mental health, and well-being; help them develop questions to ask:

- Who did you sit with at the lunch table today? Tell me about them.
- Tell me about your friends. What activities do you and [insert name] do to have fun?
- What extracurricular activities or hobbies interest you?
- How do you feel about what is happening with your family?
- Who do you go to when you need to talk about something? How do they support you?
- What do you do to feel better when you are feeling lonely, bored, stressed, or upset?
- What are your views on drugs and alcohol?
- What questions do you have about drugs or alcohol I could help answer?
- What are your goals this semester, this year, and in the next two years? How could drug or alcohol use affect those goals?

Discuss strategies with child welfare workers to explore and identify friends and family members—including fathers or non-custodial parents—and how to: 1) engage supportive persons in the case and safety planning, 2) ensure they are appropriate to monitor safety and understand their role, and 3) develop action steps if there is a child safety concern:

- How do they know the family, and for how long?
- How involved are they in the family's life? Do they see them regularly?
- What behaviors have they seen that indicate the parent may be engaging in substance use?
- How do they feel about contacting the child welfare worker if there is a concern?
- What concerns do they have about their role in being able to protect the child?



Safety Plan Development

- Speak with child welfare workers about how to engage parents in a conversation about 1) how substance use affects the child, and 2) safe storage of controlled substances and drug paraphernalia (e.g., use of lockboxes)
- Help child welfare workers determine if it is appropriate to incorporate the child in the safety planning process; ensure the child welfare worker speaks directly to the child to discuss their role and to provide information about whom to communicate concerns to and whether the parent understands the child is to inform the child welfare worker of any concerns
- Reinforce the need for child welfare workers to use shared decision-making to develop safety plans and use coaching and modeling to help build facilitation skills
- Explore with child welfare workers how to incorporate the family's voice into case plans:
  - What does the family view as important and a priority? How do these priorities fit into the family's plan?
  - How does the family function? For instance, what do they value and believe? What does their daily routine look like? What holidays, special occasions, or traditions do they celebrate? How do they view education and career choices? How do they interact with extended family and friends?
  - Are assumptions being made based on the parent, child, or family's non-verbal interactions, language, or expressions? How are these serving as barriers to engagement, planning, or treatment? What steps may help clarify the intention and move forward?
- Review different case junctures that suggest a review of the current safety plan (e.g., bringing a new baby home, reunification, transitioning from residential treatment to an outpatient program, changes in household composition, beginning to co-parent with a non-custodial parent, beginning a new job or school, case closure)
- Discuss with child welfare workers alternative arrangements to include in the safety plan to help prevent the child from entering OOH care:
  - Can a relative or other supportive person move in with the parent or child?
  - Can the parent and child move in with a relative or other supportive person?
  - What parent-child residential programs are available if residential treatment is needed?
  - Are relatives or other supportive persons able to check on the parent and child multiple times a day?
  - What combination of natural supports and community resources would help ensure consistent contact with the child and parent during the week?
  - How can child care assist the relative or other supportive person or otherwise ensure the child has a safe space while the parent attends treatment?
- Discuss how child welfare workers can help promote and develop parental protective capacities and protective factors (e.g., guiding parents through a problem to reach a resolution vs solving it for them).

Safety Planning During Family Time

- Explore with child welfare workers how frequently they are talking with individuals monitoring family time, what questions they are asking, and how the safety plan is working
- Review with the child welfare worker what potential safety concerns were identified, incorporated, and mitigated in the safety plan
- Determine how frequently the safety plan needs to be revisited
- Discuss when it is appropriate to lower the supervision level for family time:
  - How is the parent interacting with the child during family time (e.g., are they actively playing with the child or helping with homework)?
  - What behavioral indicators does the child welfare worker observe that show the parent is in recovery (e.g., regular attendance and active engagement in treatment or recovery support meetings, a support system, and knowledge of activators (i.e., triggers) and use of strategies to manage them)?
  - How is the parent progressing in treatment?

Safety Planning at Case Closure

- Help child welfare workers determine: 1) if there is a resolution for the initial reason of involvement, 2) what behavioral indicators suggest the parent is in recovery, and 3) if parental protective capacity and protective factors have increased:
  - How has the initial reason for involvement been resolved? What steps were taken to help ensure it will not cause subsequent maltreatment?
  - Has the parent completed SUD treatment, or is there an intent for treatment or other services to continue after case closure (e.g., aftercare services)?
  - What recovery supports do the parents regularly and actively use (e.g., a sponsor or other supportive person, recovery support meetings, another supportive network)? How do they describe their active engagement?
  - How has the parent demonstrated the use of their recovery support network during times of high stress or challenge? Can they articulate how they will use their network if they have not experienced a high-stress or challenging time?
  - How does the parent describe participation in substance-free activities (e.g., recreational or entertainment)?
  - If the parent has a significant other, is that person engaging in active substance use? How are they supporting the parents' recovery?
  - How have the friends and associates of the parent changed? Are they still engaging in a relationship with anyone they associated with when they were in active use? If the person cannot be excluded from their life (e.g., relative), what healthy boundaries are in place to protect their own recovery?
  - Can the parent articulate their activators (i.e., triggers) and how to use realistic strategies to avoid a return to use?
  - Have they informed their healthcare providers they are in recovery (e.g., told their primary care physician and dentist)?

- How has their knowledge of natural support systems related to SUD and recovery increased? Are family members connected to supportive services like Al-Anon, Alateen, or SMART Recovery Family & Friends?
- How have the concrete needs of the family members and the family as a whole been met (e.g., housing, food, clothing)? What is the plan if these needs are not met in the future (e.g., local food pantry, assistance for rent or utilities)?
- Does the parent have reliable employment that meets the family's needs? Are there public assistance services that could benefit the family (e.g., WIC, SNAP, child care vouchers)?
- What reliable child care does the parent have, and what financial support do they still need (e.g., child care vouchers)?
- How does the parent manage the responsibilities of their life and recovery (e.g., children, work, household, other commitments)?
- How does the parent manage everyday stress (e.g., talks with a friend or their sponsor)?
- What is the parent's understanding of how their substance use affected their child?
- What is the parent's understanding of their child's needs? How are they meeting the social, emotional, and developmental needs of the child?
- How has the parent articulated or demonstrated they can protect the child?
- How does the parent interact with and respond to the child? What is their response to discipline and behavioral challenges?

Encourage the child welfare worker to discuss with the parent how to sustain recovery when significant dates or events occur that may jeopardize their recovery (e.g., anniversary, holiday, medical procedures, loss of medical insurance that results in loss of MOUD)

Reinforce with the child welfare worker the need to hold a shared decision-making meeting with the parents, extended family and friends, and treatment/community-based service providers (if applicable) near case closure to develop a plan that: 1) aids the parent's recovery, and 2) protects the child's safety and well-being:

- What are the parent's activators (i.e., triggers)? How can family and friends help them through times of activation?
- If the parent feels they may experience a return to use, how will they protect the child? Who is a safe and willing person to care for the child? Who will care for the child if the parent needs to enter treatment?
- Does the family know how to access: 1) treatment resources, 2) crisis services for mental health (e.g., crisis hotline), and 3) community resources for concrete services (e.g., food), if needed in the future?
- What is a realistic plan to pay for MOUD (e.g., included on a budget or insurance)? What is the backup plan to pay for MOUD if the parent loses their Medicaid, insurance, or financial means to pay for it?
- What are the safeguards to limit a child's access to controlled substances (e.g., kept outside the house or stored in an out-of-reach lockbox with the key in an alternate location)?
- Who provides daily child care? Who is the backup if the regular caregiver cannot provide care? Who can the parent use for help if there is a crisis?
- What community-based resources does the family need past case closure (e.g., ongoing mental health treatment, home visiting services)? How will they be connected to them?

Supplemental Resource: Case Scenario Activity

Conducting a case scenario activity with child welfare workers and facilitating a conversation using the discussion questions allows child welfare workers the opportunity to: 1) practice applying key concepts from the video; 2) ask questions; and 3) discuss how they might incorporate the strategies, techniques, and information into their practice with families. Supervisors can use an actual case with the discussion questions instead of using the case scenario.

Case Scenario

Jones Family Constellation	
Mother	Mira Jones (21)
Father	Matthew Smith (22)
Children	Keegan Jones (14 months)
Maternal Aunt	Kara Allen

Assessing Ongoing Safety and Maximizing Family Engagement

The child welfare agency opened a case on 21-year-old Mira Jones after confirming allegations of Mira locking 14-month-old Keegan Jones in his bedroom while she hosted large parties and engaged in drug and alcohol use. Keegan's noncustodial father, Matthew Smith, does not live in the home and has not established paternity.

The child welfare worker developed an initial safety plan after holding a family meeting with Mira and her maternal aunt, Kara Allen. The plan stated: 1) Mira would stay with Keegan at Kara's home, 2) Mira would not be left alone with Keegan for any amount of time, 3) Mira would provide for Keegan's primary needs under the supervision of Kara, 4) Mira would obtain a substance use disorder assessment at the local treatment agency and follow the recommendations, 5) Kara would transport Mira to the SUD assessment, and 6) Kara would contact the child welfare worker immediately with any concerns regarding the safety and well-being of Keegan.

The child welfare worker managing Mira's case received Mira's SUD assessment recommendations of withdrawal management (i.e., detoxification) services and intensive outpatient treatment (IOP) with weekly drug testing. Mira admitted to long-term alcohol use and tested positive for opioids and marijuana at the time of her assessment. Mira was to enter the withdrawal management program three days after her assessment; however, she did not keep her appointment. The program was in a neighboring city 1-hour away.

The child welfare worker went to Kara's home to conduct an unannounced home visit. Mira answered the door after several minutes of the child welfare worker knocking. The child welfare worker heard Keegan crying when she entered the home. The child welfare worker noticed Mira's gait was uneven, her eyes were red with constricted pupils, she had slurred speech, and her coordination was unstable. Mira told the child welfare worker Kara had to run an errand and would be back soon. The child welfare worker followed Mira to a room in the back of the house and observed Keegan in a playpen, wearing a diaper and T-shirt. The diaper was sagging because it was so full. The child welfare worker observed dry cereal in the playpen with a sippy cup. The room appeared to be where Mira was sleeping by the personal belongings observed. The child welfare worker saw what was believed to be the end of a pipe sticking out from under a stack of papers on the dresser.

Safety Plan Development

The child welfare worker attempted to contact Kara by phone and could not reach her.

Mira insisted she was not under the influence of drugs or alcohol and was only tired from a lack of sleep the night before. Mira denied being unsupervised with Keegan prior to this instance and stated she can take care of Keegan for a short period of time without a "babysitter."

The child welfare worker consulted with her supervisor, and it was determined to place Keegan in out-of-home care. The child welfare worker contacted the father, Matthew Smith, and requested he meet the child welfare worker at the child welfare office—he agreed.

The child welfare worker previously determined Matthew was an appropriate caregiver—he has unsupervised contact in his home with Keegan, as his work allows, and a standardized screening tool did not indicate the need for a SUD assessment. He was aware of Mira's alcohol and drug use and told the child welfare worker her alcohol use increased after Keegan was born. He did not think she engaged in substance use when Keegan was in her care until child welfare became involved.

Keegan was placed with his father. The child welfare worker arranged for Mira to have supervised family time with Keegan. A family meeting occurred after the court hearing with Mira, Matthew, and Kara—a representative from the treatment agency joined by phone. Mira did not want anyone else from the family or her friends at the meeting.

The child welfare worker discovered Kara asked a friend to stay with Keegan because she was called into work. The friend had to pick up their grandchild unexpectedly and left Keegan with Mira after Mira returned home—the friend did not know child welfare was involved. Kara did not know Mira was with Keegan alone until she returned home. Kara said she was gone for about 7 hours.

The child welfare worker learned: 1) Kara was frustrated with Mira because she was Keegan's full-time caregiver; 2) Mira doesn't feel Keegan listens to her; 3) Mira doesn't feel bonded with Keegan; 4) there is maternal history for intergenerational substance use; 5) Mira engaged in substance use a few hours before the child welfare worker arrived at the home and is struggling with intense cravings; 6) Mira did not attend the intake appointment at the withdrawal management treatment agency because she did not have money to pay her friend for gas; 7) Mira does not want to attend IOP at the local treatment agency because of a previous bad experience and it is a small town where "everyone knows your business"; 8) Matthew is unsure of his own parenting abilities because Mira has been the primary caregiver and he has limited experience with young children; and 9) Matthew needs help with child care while he is at work.

The group discussed: 1) options for treatment (i.e., withdrawal management programs within driving distance to the community, residential treatment options, outpatient and telehealth treatment options, and medications for opioid use disorders (MOUD) programs); 2) securing child care; 3) resolutions to transportation barriers; 4) considerations for family time; and 5) contingencies to ensure Keegan could remain in placement with Matthew and what could happen if the safety plan is not followed

The group amended the original safety plan.

Safety Planning at Case Closure

The child welfare worker helped Mira reschedule her intake appointment for withdrawal management and transported her to the treatment agency. Prior to Mira's discharge from the treatment program, the child welfare worker and the treatment case manager met with Mira to discuss outpatient treatment options. Mira agreed to attend IOP in one of the surrounding towns and enroll in their telehealth program after IOP. The child welfare worker transported Mira home and provided Kara with a gas card to help with transportation to the IOP program. The child welfare worker transported Mira to the first couple of IOP sessions. Mira's peer recovery support specialist (PRSS) worked with Mira to identify people who could help her get to her treatment sessions. The PRSS also helped Mira identify online recovery support meetings because these meetings are limited in the local community.

Mira completed IOP and continues MOUD and mental health treatment via telehealth. The child welfare agency used a grant fund to help Mira purchase additional minutes on her phone plan to ensure she could attend her telehealth sessions and two online recovery support meetings per week; she attends a local meeting once a week. The telehealth therapist provides mental health services for Mira's anxiety and bipolar diagnosis. Mira is on medication but complains of the side effects. Mira received services to help strengthen the parent-child bond with Keegan. Mira and Kara received education on intergenerational substance use and its effects on families.

Matthew participated in a program for fathers to increase his confidence and ability to nurture his relationship and bond with Keegan; they helped him establish paternity and child support. Keegan receives early intervention services because he is behind on his developmental milestones. Keegan was reunified with Mira 2 months ago; Matthew gets Keegan one night a week and every other weekend.

Mira has not engaged in substance use for 11 months, as evidenced by her behaviors, drug test results, and reports from her telehealth clinician:

- She is actively engaged in recovery support meetings 3 times a week and has a sponsor
- She articulates the activators that could lead to a return to use
- She has a recovery management plan and has demonstrated she uses it (e.g., she told the child welfare worker she thought she may engage in substance use, so she called the identified person to keep Keegan, called her sponsor, and went to a recovery support meeting)
- She does not associate with certain people from her past
- She talks about doing activities with a new friend she met at a mom's group she attends at the community center

Mira's landlord evicted her a month ago; she currently lives with a cousin—the cousin agreed to have Mira live with her for 12 months. Mira has had difficulty finding full-time employment; she works part-time and receives child support. However, she has expressed concerns about meeting her financial obligations and balancing her recovery with everyday life.

Discussion Questions

Assessing Ongoing Safety and Maximizing Family Engagement

1. How does the plan ensure child safety?
2. What are the challenges with the initial safety plan?
3. Do you think the plan is realistic?
4. If anything, what else would you add to the plan?

Safety Plan Development

1. What changes need to be made to the initial safety plan?
2. How would you adjust the plan to ensure child safety?
3. What considerations should be incorporated for family time?
4. What safety and risk factors for family time should be considered?
5. Given the information you learned from the family, what services do you feel the family could benefit from?
6. Identify the strengths in the family. How can these be fostered to increase parental protective capacities and protective factors?
7. How could you use different family supports and community services to allow the child to remain with their parent?
8. What contingencies would you include in the plan?

Safety Planning at Case Closure

1. What indicators suggest the family is ready for case closure?
2. What risk factors are present at case closure?
3. How are the risk factors being responded to?
4. How can parental protective capacities or protective factors be incorporated into the case closure safety plan?
5. What discussions would you have with the family about maintaining child safety after case closure?
6. What family members, friends, or other supportive persons will help the family after case closure? What is their role in helping to ensure child safety and well-being?
7. What, if any, additional community support and connections does the family need before closure?
8. How would you make sure the family knows what resources are available and how they might access them in the future?
9. What is the safety plan at case closure?

References

1 National Library of Medicine. (2020, April). *Common comorbidities with substance use disorders research report.* Bethesda, MD: National Institutes on Drug Abuse (US).

2 National Institute on Drug Abuse. (2021, June 23). *Words matter: Preferred language for talking about addiction.*

3 Margerison, C. E., Roberts, M. H., Gemmill, A., & Goldman-Mellor, S. (2022). Pregnancy-associated deaths due to drugs, suicide, and homicide in the United States, 2010-2019. *Obstetrics & Gynecology*, *139*(2), 172-180.

4 Substance Abuse and Mental Health Services Administration. (2023, July 31). *Medications for substance use disorders.*

5 American Legislative Exchange Council. (2017, September 9). *The kinship care and fictive kin reform act*.

6 Administration for Children and Families. (2019, August 1). IM-19-03: *Engaging, empowering, and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement. U.S.* Department of Health and Human Services, Children's Bureau.

7 The Annie E. Casey Foundation, & Kids Count Data Center. (2021). *Children in single-parent families in United States*.

8 The Annie E. Casey Foundation, & Kids Count Data Center. (2021). C*hild population by household type in United States*.

9 National Fatherhood Initiative. (2019). Fatherhood Facts, 8th Edition. National Responsible Fatherhood Clearinghouse.

10 Primus, L. (2017). Changing Systems & Practices to Improve Outcomes for Young Fathers, Their Children & Their Families. Washington, DC: Center for the Study of Social Policy.

11 Substance Abuse and Mental Health Services Administration. (2023, June 5). *Section D: Developing goals and measurable objectives*.

12 Primus, L. (2017). Changing Systems & Practices to Improve Outcomes for Young Fathers, Their Children & Their Families. Washington, DC: Center for the Study of Social Policy.

13 Substance Abuse and Mental Health Services Administration. (2023, August 11). *Recovery and recovery support.*

CONTACT US

Email NCSACW at
ncsacw@cffutures.org

Visit the website at
https://ncsacw.acf.hhs.gov

Call toll-free at
866.493.2758

This resource is supported by contract number 75S20422C00001 from the Children's Bureau (CB), Administration for Children and Families (ACF), co-funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The views, opinions, and content of this resource are those of the authors and do not necessarily reflect the views, opinions, or policies of ACF, SAMHSA or the U.S. Department of Health and Human Services (HHS).

Children's Bureau

National Center on Substance Abuse and Child Welfare

SAMHSA
Substance Abuse and Mental Health Services Administration