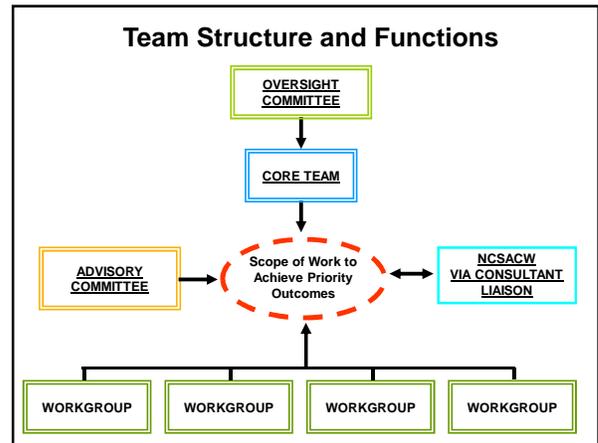


**National Center on Substance Abuse and Child Welfare**  
*Pamela Baston, MPA, CAP, CPP*

**Getting Substance Abuse Treatment Right the First Time:  
 Evidence-based Practices and Innovative Treatment Models**

This presentation is available at:  
<http://www.cfutures.org/presentations>



**NCSACW**  
 National Center on Substance Abuse and Child Welfare

A Program of the

**Substance Abuse and Mental Health Services Administration  
 Center for Substance Abuse Treatment**

and the

**Administration on Children, Youth and Families  
 Children's Bureau**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Substance Abuse and Mental Health Services Administration  
 Administration for Children and Families  
[www.samhsa.gov](http://www.samhsa.gov)

### Moral Failing vs. Disease

- When science began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower which led to an emphasis on punitive rather than preventative and therapeutic actions.

### CFF Primary Technical Assistance Programs

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graph TD
    CFF[CFF] --> NCSACW[NCSACW]
    CFF --> RPG[RPG]
    CFF --> OJJDP[OJJDP]
  
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[www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov)

### Addiction is a Disease

"A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking and use that interferes with, if not destroys, an individual's functioning in the family and in society. This medical condition demands formal treatment."

*Issues In Science and Technology, Spring 2001*

## Addiction is a Disease

“Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior. Some individuals are more vulnerable than others to becoming addicted, depending on genetic makeup, age of exposure to drugs, other environmental influences and the interplay of all these factors.”

NIDA

## Spectrum of Substance Use Disorders (SUDs)

A Problem for Child Welfare and Court Officers:  
The most frequently used marker of substance abuse problems in child welfare and family court does not tell you anything about the individual's place on the spectrum

Experiment and Use      Abuse      Dependence

## Addiction affects the brain

BRAIN RECOVERY WITH PROLONGED ABSTINENCE

Healthy Person      METH Abuser 1 month abstinence      METH Abuser 14 months abstinence

## Addiction and other Chronic Conditions

COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

Condition	Relapse Rate Range
Drug Addiction	40 to 60%
Type I Diabetes	50 to 50%
Hypertension	50 to 70%
Asthma	50 to 70%

## Addiction remains a challenging issue

- Despite the advances in the science and understanding of addiction, many people today do not understand why individuals become addicted to drugs or how drugs change the brain to foster compulsive drug abuse.
- Powerful myths and misconceptions still abound about the nature of addiction.
- Drug testing is often seen as a solution to addiction, or even worse, is misunderstood to be equivalent to or a form of addiction treatment.

## Reducing Relapse

- Science has taught us that stress, cues linked to the drug experience (e.g., people, places, things, moods), and exposure to drugs are the most common triggers for relapse.
- Medications are being developed to interfere with these triggers to help patients sustain recovery. Does your state Medicaid plan include medications to help persons seeking recovery from substance use disorders (SUDs)?



## Medications Used to Treat Addiction

- **Tobacco Addiction**
  - Nicotine replacement therapies (e.g., patch, inhaler, gum)
  - Bupropion
  - Varenicline
- **Opioid Addiction**
  - Methadone
  - Buprenorphine
  - Naltrexone
- **Alcohol and Drug Addiction**
  - Naltrexone
  - Disulfiram
  - Acamprosate




## Examples of values that influence practice:

- Whether child welfare parents with SUD are defined in policy as a “priority” population for treatment admission
- Defining “reasonable efforts” in terms of the scope and duration of substance abuse treatment
- How success is defined (abstinence only or inclusion of closely related domains such as mental health status, employment, social and family relationships/support, parenting abilities, legal issues, and stable housing.)




## Bumps in the Road we Often See



National Center on Substance Abuse and Child Welfare  
Bringing Systems Together for Family Wellbeing, Safety, and Stability



## Examples of values that influence practice:

- Family visitation policies in response to parental use of alcohol or drugs (use of sanctions versus supervision solutions and promotion of parental bonding)
- How relapse is handled
- How client data is gathered and used (e.g. missing boxes leading to data gaps)




## Examples of values that influence practice:

- Understanding addiction as a chronic (relapsing) disease
- Understanding differences between substance use, abuse and dependence and its varying impact on parenting behavior
- Understanding the role of Medication Assisted Treatment (MAT) including methadone
- How “the client” is defined
- How treatment is defined and the degree of family focus




## Examples of values that influence practice:

- Lack of agreement on cross-system data to be monitored
- Using confidentiality rules to restrict information access based on mistrust
- Lack of policy body to monitor results over time
- Whether the political will exists to redistribute funding to more effective services based on outcome monitoring



### Understand and Address Underlying Values

- Unless system differences in underlying values are understood, system partners will be less likely to sustain collaborative efforts as disagreements on policy and practice issues emerge.
- The principles for working together can be clarified and formalized through:
  - A Memorandum of Understanding
  - Administrative Policy
  - Legislation

### Early identification and rapid access

- The first step to effective treatment is early identification and timely access.
- How effective is NE’s screening process for substance use among NE’s parents who are reported for child maltreatment?
- Are the right questions asked (e.g. UNCOPE?)
- Is engagement maximized by recovery support assistance (e.g. STARS) and immediate assessment and treatment access (e.g. NIATx).

### The Five Clocks

Temporary Assistance for Needy Families (TANF)

- 24 months work participation
- 60 month lifetime

Adoption and Safe Families Act (ASFA)

- 12 months permanency plan
- 15 of 22 months in out-of-home care must petition for Termination of Parental Rights (TPR)

Recovery

- One day at a time for the rest of your life

Child Development

- Clock doesn’t stop
- Moves at the fastest rate from prenatal to age 5

### Timeliness of treatment access

- The “time to treatment” factor has a direct impact on: (a) whether the client ever makes it to treatment in the first place; (b) the length of time that children in out of home care stay in out of home care (timeliness of permanency); and the number of reunifications.
- Do you even know or look at the “time to treatment” factor in assessing reasonable efforts in your area?

### The Most Important Clock

- The 5<sup>th</sup> Clock: The one that’s ticking on us
- How long do we have to act if our families have
  - 24 months to work and
  - 12 months to reunify?
- Do NE’s SUD treatment providers understand ASFA timelines? Do NE’s CW and court staff understand addiction and treatment?
- Taking this clock seriously means that we take aggressive action to reconcile the clocks on children and families



### Reasonable Treatment Efforts

- What are “reasonable efforts” in terms of the scope and duration of treatment.
- For court purposes, “reasonable efforts” typically include helping families remedy the conditions that brought the child and family into the CW system (family therapy, parenting classes, drug and alcohol abuse treatment, respite care, parent support groups, and home visiting programs, etc.). What would “reasonable efforts” look like in NE if applied to SA treatment?

### Service intensity: Continuum of Family-Based Services (abbreviated)

Level 1: Women's Treatment with Family Involvement	Services for women with substance use disorders. Treatment plan includes family issues, family involvement. Goal: improved outcomes for women.
Level 2: Women's Treatment with Children Present	Children accompany women to treatment. Children participate in child care but receive no therapeutic services. Only women have treatment plans. Goal: improved outcomes for women.

### Sample Case History

- Single head of household mother
- Mother's age: 28 yrs old and 7 mos pregnant (and no prenatal care)
- 3 kids (ages 2, 4, and 8)
- Mother's drug use history: (12 year drug-history: heroin, cocaine, alcohol and marijuana)
- Co-occurring MH problems
- Criminal history: (drugs, panhandling, DV)
- Education history: 10<sup>th</sup> grade education no GED
- Employment history and current status: No stable employment- sanctions for no work

### Continuum of Family-Based Services (abbreviated)

Level 3: Women's and Children's Services	Children accompany women to treatment. Women and attending children have treatment plans and receive appropriate services. Goals: improved outcomes for women and children, better parenting.
Level 4: Family Services	Children accompany women to treatment; women and children have treatment plans. Some services are provided to other family members. Goals: improved outcomes for women and children, better parenting.

### Sample Case History cont.

- 2 prior involvements with CW system
- Type of family support available if any: 2 fathers, 1 in jail. Currently no child support. Mother on multiple economic assistance programs
- Living situation: Public housing (may now lose for drug charges)
- Other family challenges: One child has sickle cell anemia
- Family strengths: Unknown at this time

### Continuum of Family-Based Services (abbreviated)

Level 5: Family - Centered Treatment	Each family member has a treatment plan and receives individual and family services. Goals: improved outcomes for women, children, and other family members; better parenting and family functioning.
--------------------------------------	---

### With the case study family in mind.....

- Is it likely that drug testing or a drug education class is sufficient to address the addiction and addiction-related issues in this family?
- Is it likely that popping into an outpatient session once or twice a week will do the job? Does NE consider such an approach as meeting a "reasonable efforts" standard to address the kinds of problems described in the case study family?
- Does NE force such parents (typically moms) to choose between their recovery and their children (or some of their children)?



**With this case study family in mind.....**

- Does NE have sufficient residential capacity to serve this family? Can all kids join her in treatment to receive the services and support they need?
- Is there a better way?
- Will current or future behavioral health reforms have an adverse affect on the ability to pay for sufficient residential treatment?
- Are there models that constitute “reasonable efforts” that can successfully address these issues while serving the entire family?




**Engagement and Retention**

**Tools and Resources**

- Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)
- Substance Abuse Specialist Paper (SAS)

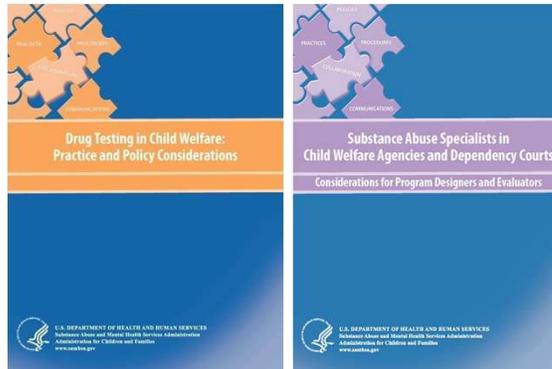
**Models**

- Arizona – Families F.I.R.S.T. (Families in Recovery Succeeding Together) Model
- Sacramento – Specialized Treatment and Recovery Services (STARS)
- Cuyahoga County – START



**With the case study family in mind.....**

- Does NE have other innovative treatment models?
- What services will her significant other receive if any?

<http://www.ncsacw.samhsa.gov/resources/default.aspx>



**Solutions and Resources**



Bringing Systems Together for Family, Economic, Safety, and Stability



**Joint Accountability, Shared Outcomes and Information Systems**

**Tools and Resources**

- Regional Partnership Grant (RPG) Data codebook
- Webinars on linkages

**Models**

- Michigan revised Statewide Automated Child Welfare Information System (SACWIS) to prioritize families with substance use disorders
- Children and Family Services Review (CFSR) and National Child Welfare Outcomes Indicator Matrix (NOMS) processes
- California Outcomes Measurement System (CaOMS) now tracks 7500 CW parents in treatment and knows which had positive outcomes (36%)

## Shared Outcomes System Reforms

**Tools and Resources**

- SAFERR communication protocols
- In-Depth Technical Assistance (IDTA) State communication protocols and examples of data system improvements
- A Review of Alcohol and Drug Issues in the States' Child and Family Service Reviews and Program Improvement Plans

**Models**

- Guide to Cross-System Data Sources for State and Tribal Child Welfare, Substance Abuse Treatment, and Court Systems (**Now Available!! -- email us**)
- May 16, 2008: Connecting the Dots: How States and Counties Have Used Existing Data Systems to Create Cross System Data Linkages
  - <http://www.cffutures.com/webinars.shtml#May16>

## Child Welfare Training Toolkit

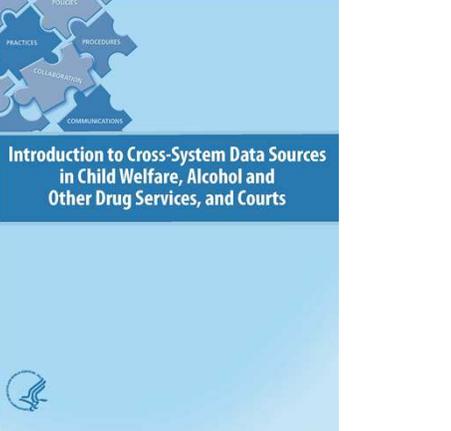
**NEW! Child Welfare Training Toolkit**

6 modules, each containing:

- Trainer Script
- PowerPoint Presentation
- Handouts
- Case Vignettes

Available at NO CHARGE!

<http://www.ncsacw.samhsa.gov/training/default.aspx>

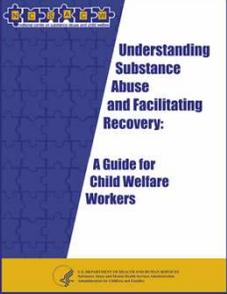
**Introduction to Cross-System Data Sources  
in Child Welfare, Alcohol and  
Other Drug Services, and Courts**

## A Guide for Child Welfare Workers

Understanding Substance Abuse and Facilitating Recovery:

A Guide for Child Welfare Workers

To obtain a copy, see:  
<http://www.ncsacw.samhsa.gov>



## Online Tutorials



## Innovative and Effective Engagement and Treatment Models



National Center on Substance Abuse and Child Welfare  
Bringing Systems Together for Family Assessment, Safety, and Stability

### Primary Substance Abuse Recovery Specialist Function

Engaging Parents into entering treatment and supporting them through treatment completion

WHY?

Without treatment most parents with genuine substance abuse issues will most likely fail leading to increased time away from home, foster care etc.

### Regardless of Model - Engagement Strategies are Universal

Goals For Parents

- Attend all required individual and group SUD treatment sessions
- Attend all scheduled Recovery Specialist (mentor/coach) meetings
- Attend specific number of support / 12-step meetings weekly
- Attend all required treatment activities
- Complete all treatment requirements of the court
- Drug Test Randomly
- Produce negative drug tests

Each of these areas should be considered a therapeutic intervention

### Why Should NE Use Substance Abuse Recovery Specialists

- Reduce costs of out-of-home placements and/or reduce time of children in foster care
- Remove barriers and improve linkages between CWS and treatment to better serve clients
- Improve the capacity of CWS to serve parents with substance use disorders
- Increase collaboration between agencies
- Ensure reasonable efforts

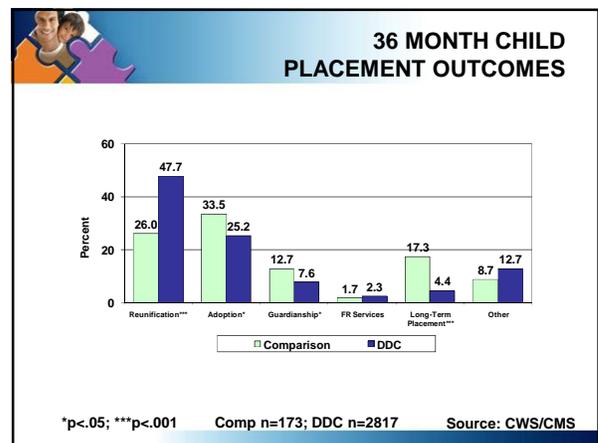
### Sacramento DDC Graduation Criteria

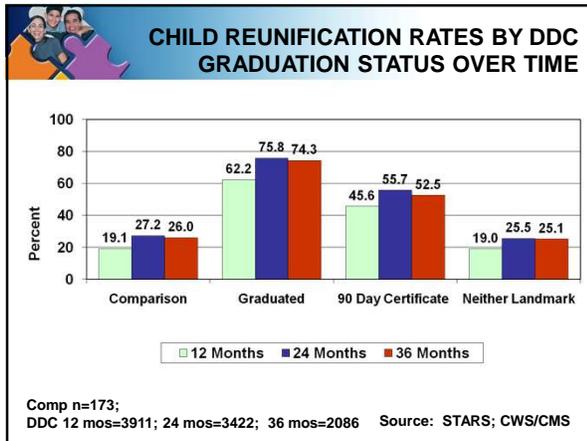
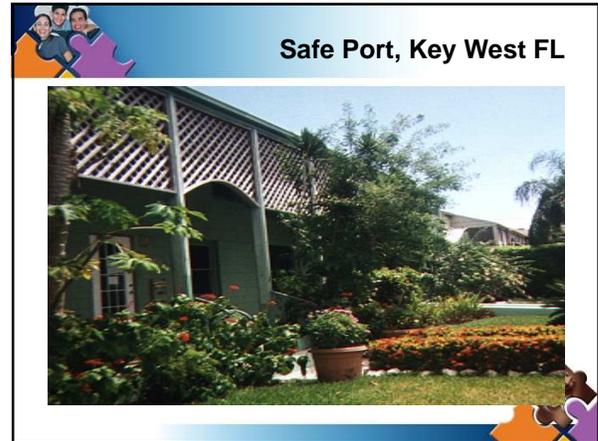
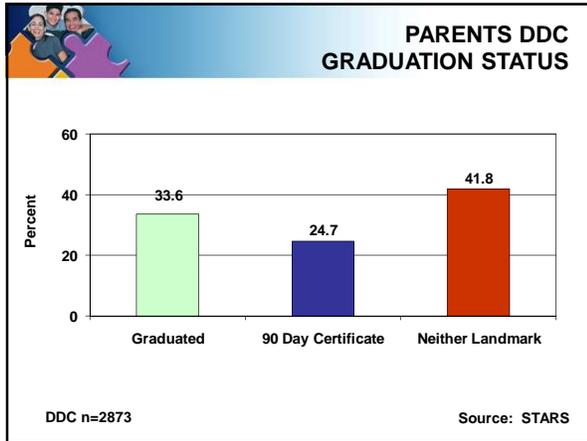
For 180 consecutive days, parent must:

- Produce negative drug tests
- Attend all required group and individual treatment sessions
- Attend all scheduled Recovery Specialist (STARS) meetings
- Attend at least 3 support / 12-step meetings weekly
- Attend all required DDC appearances
- Complete all requirements of the court

### Purpose Of Utilizing Substance Abuse Recovery Specialists

- Decrease time to assess and enter treatment (the ASFA clock may be ticking)
- Increase compliance with treatment
- Increase 12 month permanent placements
- Increase family reunification rates
- Decrease time in foster care





### A public housing “campus” model

- The program was the brain child of the Key West Housing Authority Executive Director Henry Haskins and utilized “conventional” public housing apartments.
- Several buildings were identified as ideal for a “treatment campus” and existing residents were relocated (incentivized to relocate to other public housing apartments).

### 24 MONTH COST SAVINGS DUE TO INCREASED REUNIFICATION

**What would have happened regarding out of home care costs in the absence of DDC?**

27.2% - Reunification rate for comparison children  
 49.6% - Reunification rate for DDC children  
**= 766 fewer DDC children would have reunified**

33.1 - Average months in out-of-home care for comparison children  
 8.98 - Average months to reunification for DDC children  
**= 24 months that DDC kids would have spent in out of home care (OHC)**

**\$1,828.92 – Out of home care cost per month**  
 $766 \times 24.12 \times 1,828.92 =$   
**\$33,790,979 Total Savings in OHC Costs**

### Used existing infrastructure

- This move was timed with an pre-scheduled “updating process” which eventually included remodeling, landscaping etc. all funded by HUD.
- The end result was a beautiful treatment campus that included a combination of 1, 2, 3, and 4-bedroom apartments as well as some communal (dorm-like) shared living arrangements for up to 45 families and 100 children.

### Funding model

- Residents paid rent for their assigned apartments based on their family size and ability to pay.
- Treatment or therapeutic services were supported with federal grants (SAMHSA) or Medicaid payments since the campus was "technically" a day treatment modality since the clients resided in their own homes. Length of residence on campus was about 1 year but varied by need.

### The Millennium Center (Cuthbert GA) "neighborhood"



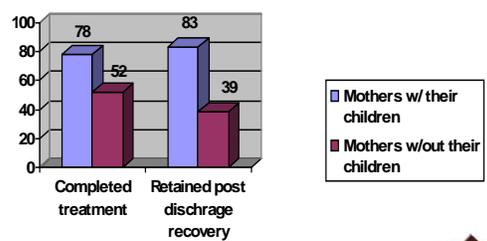
### Achieved safe and stable housing

- Residents graduating from Safe Port in good standing were given Section 8 certificates which allowed them to rent a home. A few qualified for HUD "rent-to-own" options.
- Based on a number of factors (including hurricane/disaster financial losses) Safe Port morphed into a program serving homeless women and eventually closed, though it continues to inspire new model development.

### Real homes ....



### Evaluation findings... affect of including children



Category	Mothers w/ their children	Mothers w/out their children
Completed treatment	78	52
Retained post discharge recovery	83	39

### The Playground





### Three-year-old Classroom





### Men's Services

- Assessment
- Addiction Treatment
- Life Skills
- Parenting
- Anti-Domestic Violence
- Job Readiness
- Medical and Health Services
- Case Management




### Women's Clinical Services

- Addiction Treatment (individual, group and family counseling)
- Trauma/Abuse Recovery
- Life Skills Development
- Parenting/Nurturing Program
- Sexuality Issues




### Children's Services ages 5-18

- Screening/Assessment
- Addiction Education
- Family Therapy
- Conflict Resolution Program
- Play Therapy
- Prevention Activities
- Activity Therapy




### Women's Clinical Services

- Vocational Training
- Job Readiness Skills
- Case Management
- Family Therapy
- Couples Therapy
- Health Education and Medical Services




### Children's Services ages 5-18

- Academic Success Activities
- Multicultural Exposure
- Case Management
- School Liaison Support
- Medical Services





### Child Development Center Infants and Toddlers

- Screening/Assessment
- Therapeutic Child Development Services
- Developmental Curriculum
- Academic Curriculum
- Parent Bonding Activities
- Nurturing Supportive Environment
- Play Therapy
- Medical/Health Services
- Case Management




### Bottom line....

- The fact that the majority of families in child welfare are affected by substance use problems means that timeliness of permanency and improved reunification rates cannot be achieved without making timely and effective services for substance abuse a priority!




### Apartment models

- There are many “apartment complex” models operating all over the country in which standard apartment housing stock is utilized to simulate a residential treatment campus but without the associated costs. While these models vary, many involve the families paying their own rent (often with economic assistance/TANF subsidies). The treatment provider rents an onsite unit(s) to house counselors and other program staff. A person in long-term recovery may also live onsite and be on call at night.




### Questions and Discussion



National Center on Substance Abuse and Child Welfare  
Bringing Customers Together for Health, Recovery, Stability and Wellbeing



### NE's IDTA Core Team

The core team assembled in NE identified needs and makes a strong case for:

- A wide array of support services provided by family treatment programs to parents with co-occurring problems including mental health, domestic violence and housing
- Improved engagement of parents through recovery support staffing
- An ongoing effort to fill in the data and information gaps that exist



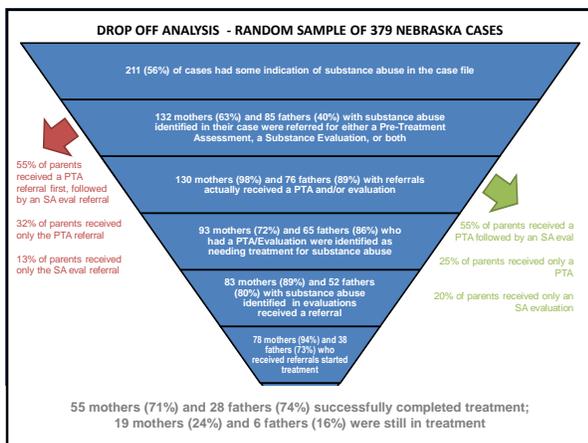


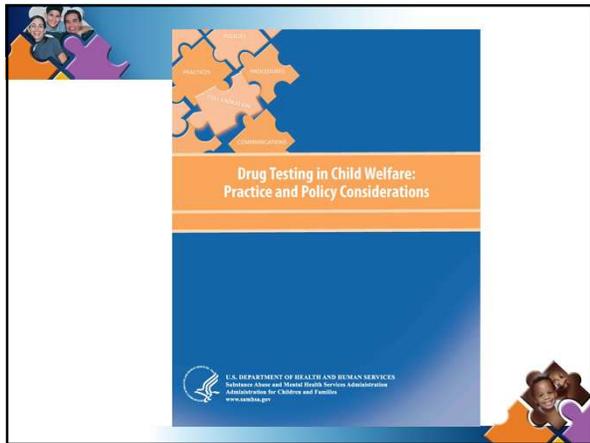
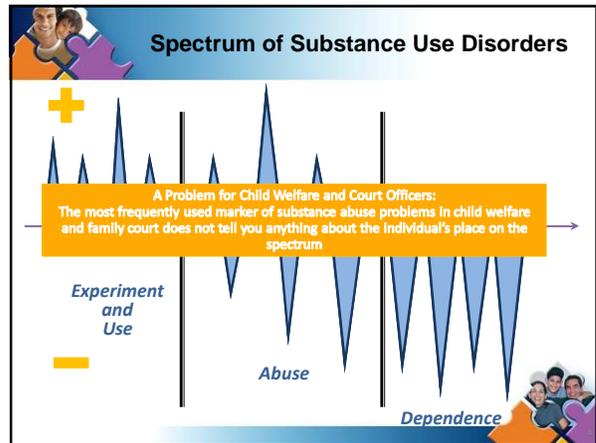
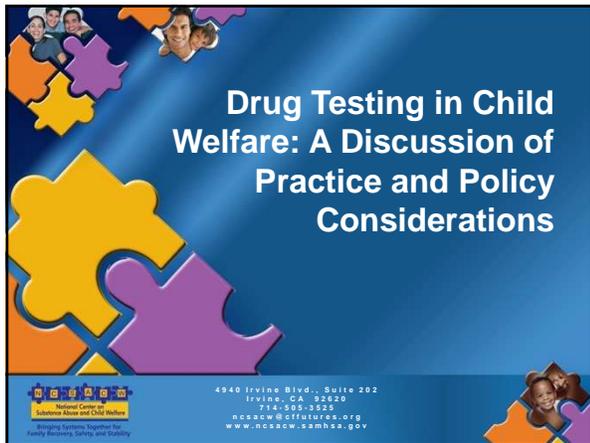
### Rates, Treatment, and Testing

	Number of cases	Percentage
Indication of Substance Abuse	211 of 379 cases	56%
Parents with indication of substance abuse receiving referrals to treatment	132 mothers 85 fathers	63% of mothers 40% of fathers
Parents with indication of substance abuse receiving UA tests	137 mothers 95 fathers	65% of mothers 45% of fathers
Parents WITHOUT indication of substance abuse receiving UA tests	8 mothers 15 fathers	4% of mothers 7% of fathers
Parents with an indication of substance abuse receiving UA tests WITHOUT a referral for assessment	34 mothers 34 fathers	25% of mothers 36% of fathers

- ### Project Overview
- Random selection of 400 cases from the 4616 3a cases that opened between July 1 and December 31 of 2009
  - Review of physical legal and social files for each case conducted at courthouses throughout the state
  - 379 cases reviewed successfully

**FULL REPORT COMING SOON...**





- What Questions Can Drug Testing Answer?**
- Whether an individual has used a tested substance within a detectable time frame

- Why Is This An Important Issue?**
- Drug testing is the most frequently used indicator for substance use in child welfare practice
  - Test results may influence decisions on child removal, reunification and Termination of Parental Rights
  - Courts often order drug testing as a standard protocol for parents in the child welfare system
  - Lack of standardized recommendations for drug testing in child welfare practice

- What Questions Can Drug Testing Not Answer?**
- A drug test alone cannot determine the existence or absence of a substance use disorder
  - The severity of an individual's substance use disorder
  - Whether a child is safe
  - The parenting capacity and skills of the caregiver

# Guidance for Implementing Drug Testing

National Center on Substance Abuse and Child Welfare  
Bringing Systems Together for Family Well-being, Safety, and Stability

## Key Action Steps: Considerations for Developing Policy

- Agency Values and Mandates**
  - 1: Partner agencies need to understand value differences across systems concerning approaches to families affected by substance use disorders
- Establish a Policy Framework**
  - 2: Determine how drug testing fits with agency's overall approach to working with families
- Understand the use of Drug Testing in Substance Abuse Treatment and Child Welfare Programs**
  - 3: Complete training on recognizing signs and symptoms of substance use disorders
  - 4: Identify clear purpose for using drug testing
  - 5: Determine how drug testing currently fits with the child welfare agency's overall risk and safety assessment protocols

## Policy and Practice Considerations

- Considerations for Using Drug Testing**
  - Agency Values and Mandates
  - Establishing a Policy Framework
  - Understanding current uses of Drug Testing in Substance Abuse and Child Welfare Programs
- Drug Testing Protocol Decisions**
  - Determine Who to Test
  - Type of Physical Specimen Collected
  - Window of Detection
  - Drug Testing Methods
- Incorporating Drug Testing in Child Welfare Casework**
  - Discussing Drug Testing with Parents
  - Frequency of Testing
  - Addressing Drug Test Results and Refusals
  - Coordination and Collaboration

## Drug Testing Protocol Decisions

- Determine Who to Test**
  - 6: Decide which individuals will be tested
  - 7: In the case of newborns, know how local hospitals determine which individuals will be tested and child welfare's response to the test results
- Drug Testing Methods**
  - 8: Select the type of specimen to collect and the testing device to use
  - 9: Determine when to use point-of-collection versus laboratory testing
  - 10: Establish the logistics for drug testing and observation
  - 11: Determine which drug(s) to include in the test
  - 12: Consider cost implications of the practice protocol and in choosing a vendor
  - 13: Determine the type of staff training to provide and the type of qualifications needed to administer the test

# Considerations for Developing Drug Testing Policy

National Center on Substance Abuse and Child Welfare  
Bringing Systems Together for Family Well-being, Safety, and Stability

## Pros and Cons of Specimen Sources

(Source: Office of National Drug Control Policy, 2004)

Specimen	Window of Detection	Pros	Cons
Urine	Up to 2-4 days	<ul style="list-style-type: none"> <li>Highest assurance of accurate results</li> <li>Least expensive</li> <li>Most flexibility in testing different drugs</li> <li>Most likely of all drug testing matrices to withstand legal challenge</li> </ul>	<ul style="list-style-type: none"> <li>Specimen can be adulterated, substituted or diluted</li> <li>Limited window of detection</li> <li>Sometimes viewed as invasive or embarrassing</li> <li>Biological hazard for specimen handling and shipping to laboratory</li> </ul>
Oral Fluids	Up to 48 hours	<ul style="list-style-type: none"> <li>Specimen obtained under direct observation</li> <li>Minimal risk of tampering</li> <li>Non-invasive</li> <li>Specimen can be collected easily in virtually any environment</li> <li>Can detect alcohol use</li> <li>Detects recent drug use</li> </ul>	<ul style="list-style-type: none"> <li>Drugs and drug metabolites do not remain in saliva as long as they do in urine</li> <li>Less efficient than other testing methods in detecting marijuana use</li> <li>pH changes may alter specimen</li> <li>Moderate to high cost</li> </ul>

**Pros and Cons of Specimen Sources**  
(Source: Office of National Drug Control Policy, 2004)

Specimen	Window of Detection	Pros	Cons
Sweat	Up to 1-4 weeks	<ul style="list-style-type: none"> <li>• Non-invasive</li> <li>• Variable removal date generally from 1 to 14 days</li> <li>• Quick application and removal</li> <li>• Longer detection window than urine</li> <li>• No specimen substitution possible</li> <li>• Useful for compliance monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• Limited number of labs able to process results</li> <li>• People with skin eruptions, excessive hair or cuts and abrasions cannot wear the patch</li> <li>• Moderate to high cost</li> </ul>
Hair	Up to 4-6 months	<ul style="list-style-type: none"> <li>• Long window of detection</li> <li>• Greater stability and does not deteriorate</li> <li>• Can measure chronic drug use</li> <li>• Convenient shipping and storage causing no need to refrigerate</li> <li>• Collection procedure not considered invasive or embarrassing</li> <li>• More difficult to adulterate than urine</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate to high cost</li> <li>• Cannot detect alcohol use</li> <li>• Will not detect very recent drug use between 1 to 7 days prior to drug test</li> <li>• Not effective for compliance monitoring</li> </ul>

**Pros and Cons of Specimen Sources**  
(Source: Office of National Drug Control Policy, 2004)

Specimen	Window of Detection	Pros	Cons
Breath	Up to 12-24 hours	<ul style="list-style-type: none"> <li>• Minimal cost</li> <li>• Reliable detector of presence and amount of alcohol using Blood Alcohol Concentration</li> <li>• Noninvasive</li> </ul>	<ul style="list-style-type: none"> <li>• Very limited time window of detection for ethanol concentrations</li> <li>• Only detects presence of alcohol</li> </ul>
Blood	Up to 12-24 hours	<ul style="list-style-type: none"> <li>• Detects presence of drugs and alcohol</li> <li>• Accurate results</li> </ul>	<ul style="list-style-type: none"> <li>• Invasive</li> <li>• Moderate to high cost</li> </ul>
Meconium	Up to 2-3 days	<ul style="list-style-type: none"> <li>• Able to detect long term use</li> <li>• Detects presence of drugs and alcohol</li> <li>• Easy to collect and highly reliable</li> </ul>	<ul style="list-style-type: none"> <li>• Short window of detection prior to infant's birth</li> </ul>

**Incorporating Drug Testing into Child Welfare Practice**

Discuss Testing With Parents	<ul style="list-style-type: none"> <li>• 14: Develop a parent engagement strategy</li> </ul>
Frequency of Testing	<ul style="list-style-type: none"> <li>• 15: Establish frequency and random protocol of testing</li> </ul>
Addressing Drug Test Results and Refusals	<ul style="list-style-type: none"> <li>• 16: Decide how to address positive results, negative results, refusals and adulterated specimens</li> <li>• 17: Develop a notification procedure for drug test results</li> </ul>
Coordination and Collaboration	<ul style="list-style-type: none"> <li>• 18: Establish drug testing coordination strategy with treatment agencies</li> </ul>