Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

December 1, 2008

The Honorable Chester J. Culver
Governor
State Capitol
LOCAL

Dear Governor Culver:

Enclosed are copies of report to the General Assembly pursuant to the directive contained in SF 2425, Sec. 16. Child & Family Services, page 40, lines 12 through 20, item# 26. This report reviews the process for drug testing of persons responsible for the care of a child in child abuse cases, to evaluate the effectiveness of the testing, whether it is applied in the same manner in all Service Areas, identifies how the funding designated for drug testing is utilized, and addresses other issues associated with drug testing.

The purpose of drug testing in child welfare is to ensure the safety of children. However, drug testing alone will not protect children. Drug testing is viewed as one piece of information that the Department can use during child abuse assessments and ongoing child welfare cases to assess the safety of the child. Within all Service Areas, the decision to test a parent and the extent that drug testing results influence critical decisions around a child's safety is based on the information gathered during the child abuse assessment and/or during the monitoring phase of an ongoing child welfare case.

Currently, the Department has in place specific statewide drug testing methodology guidelines that prescribe the type of testing; the frequency of testing and the duration of testing that are available to Department staff. A new drug testing protocol is currently being developed in partnership between the Department, the Iowa Department of Public Health, and the Iowa Judicial Branch as part of the In-Depth Technical Assistance (IDTA) project through the National Center on Substance Abuse and Child Welfare (NCSACW). Once finalized and adopted by all three state agencies, these protocols will replace those described and attached in this report.

If you have any questions regarding this report please feel free to contact me.

Sincerely

Molly Kottmeyer

Molly Kottmeyer
Legislative Liaison

Enclosure

cc: Michael Marshall, Secretary of Senate
Mark Brandsgard, Chief Clerk of the House

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Dear Mr. Marshall and Mr. Brandsgard:

Enclosed are copies of report to the General Assembly pursuant to the directive contained in SF 2425, Sec. 16. Child & Family Services, page 40, lines 12 through 20, item# 26. This report reviews the process for drug testing of persons responsible for the care of a child in child abuse cases to evaluate the effectiveness of the testing, whether it is applied in the same manner in all Service Areas, identifies how the funding designated for drug testing is utilized, and addresses other issues associated with drug testing.

The purpose of drug testing in child welfare is to ensure the safety of children. However, drug testing alone will not protect children. Drug testing is viewed as one tool that the Department can use during child abuse assessments and ongoing child welfare cases to assess the safety of the child. Within all Service Areas the decision to test a parent and the extent that drug testing results influence critical decisions around a child's safety is based on the information gathered during the child abuse assessment and/or during the monitoring phase of an ongoing child welfare case. A drug testing decision is made after careful consideration and evaluation of the information gathered regarding a parent/caretaker's alleged drug usage, the known effects of the specific drug used and the potential impact on the parent/caretaker's ability to provide proper supervision of a child. It is the critical evaluation of this information that determines whether or not drug testing is needed, and if **so**, what method, type and the frequency of the drug testing.

Currently, the Department has in place specific statewide drug testing methodology requirements that prescribe the type of testing; the frequency of testing and the duration of testing that are available to Department staff. A new drug testing protocol is currently being written in partnership between the Department, the Iowa Department of Public Health, and the Iowa Judicial Department as part of the In-Depth Technical Assistance (IDTA) project. The National Center on Substance Abuse and Child Welfare (NCSACW) is being consulted on this guide. Once finalized all three state agencies will follow these new protocols. The protocols described and attached in this report will no longer be used.

If you have any questions regarding this report please feel free to contact me.

Sincerely

Molly Kottmeyer

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Legislative Liaison

Enclosure

cc: Legislative Service Agency
Kris Bell, Senate Majority Caucus
Russ Trimble, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus

REVIEW OF THE IOWA DEPARTMENT OF HUMAN SERVICES DRUG TESTING PROCESS FOR DRUG TESTING OF A PERSON RESPONSIBLE FOR THE CARE OF A CHILD IN CHILD ABUSE CASES

Executive Summary

This report outlines the current drug testing practices, guidelines, programs, and initiatives as currently implemented by the Department regarding the process for drug testing of a person responsible for the care of a child in child abuse cases.

Drug Testing Effectiveness Findings

Drug testing effectiveness is defined as the reliability of the drug testing results. To ensure effectiveness in drug testing the Department has set standards for collections and laboratory services. The Department's standards are those endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA). Where there are no current national standards offered, generally accepted industry standards have been instituted. The Department's standards have been subject to both internal and external expert review.

Drug Testing Consistency Findings

Consistency for this report is defined to whether drug testing is applied in the same manner in all Service Areas. The purpose of drug testing in child welfare is to attempt to ensure the safety of children. Drug testing is viewed as one tool the Department may use in assessing the safety of a child. Both similarities and differences in drug testing across Service Areas are discussed in this section.

Drug Testing Funding Findings

Drug Testing Funding identifies how funding designated for drug testing is utilized. Estimated expenditures for collections and laboratory drug testing services are:

- Child Protective Assessments (Investigations): $800,000
- Ongoing Child Welfare Cases: $500,000
- Court Ordered Services: $500,000

Discussion and Remarks

Discussions and Remarks addresses other issues associated with drug testing. The Department, the Iowa Judicial Department and the Iowa Department of Public Health have developed a joint protocol for drug testing in child abuse cases. Upon release this drug testing protocol will replace the Department's existing protocol.

Forward

This report summarizes the findings of the Iowa Department of Human Services (Department) drug testing process for drug testing of a person responsible for the care of a child in child abuse cases, as per SF 2425, Sec. 16. Child & Family Services, page 40, lines 12 through 20, item # 26. This report outlines the current drug testing practices, guidelines, programs, and initiatives as currently implemented by the Department regarding the process for drug testing of a person responsible for the care of a child throughout the life of the case.

The purpose of drug testing in child welfare is to ensure the safety of children. However, drug testing alone will not protect children. Drug testing is viewed as one tool that the Department can use during child abuse assessments and ongoing child welfare cases to assess the safety of the child.

To operate as efficiently as possible and conserve resources on excessive drug testing the Department has developed and adopted suggested drug testing protocols. The protocols indicate drug testing types and frequencies and provide a general guideline to Department staff as to what testing should routinely be followed. While the protocols offer drug testing guidelines they do not preclude using a lesser frequency or stopping testing altogether if the testing results or case circumstances warrant it.

Definitions

Drug Testing: the process by which samples of hair, sweat, saliva, urine, or fingernail clippings are chemically analyzed to determine the presence of substances, legal or illegal, in the sample.

Collections Drug Testing Services: the process by which a sample of a bodily substance is obtained for use in a chemical analysis to determine the presence of certain substances, legal or illegal in the sample.

Laboratory Drug Testing Services: the chemical analysis process used to determine the presence of certain substances, legal or illegal, in a specific sample of hair, sweat, saliva, urine or fingernail clippings.

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V. *Discussions and Remarks* addresses any other issues associated with the drug testing.

VI. Appendixes

A. Drug Testing Guidelines Developed for the Department of Human Services, *RC-0090.* Task Force Members of the Iowa Department of Human Services, the Iowa Department of Public Health and Substance Abuse Treatment Providers (June 10, 2005).
B. Drug Testing Types and Standards.
C. Default Drug Testing Protocols (September 4, 2007).
D. Drug Testing Finals.
E. Recovery Matrix –Intact Cases.

I. Background.

Legal Basis

It is the purpose and policy of the Department to provide the greatest possible protections to children who may have been abused or are at risk for abuse. Drug testing is one tool utilized by the Department in protecting children. The legal basis for the Department's policies and practices around drug testing are guided by the following provisions of the Iowa Code:

Iowa Code Section 232.73 Medially relevant tests
As used in this section and in sections 232.77 and 232.78, "medically relevant test" means a test that produces reliable results of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives of the illegal drugs, including a drug urine screen test.

Iowa Code Section 232.77 Photographs, X rays, and medically relevant tests
(2) If a health practitioner discovers in a child physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, which were not proscribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in section 232. 73, on the child. The practitioner shall report any positive results of such a test on the child to the department. The department shall begin an assessment pursuant to section 232.71B upon receipt of such a report. A positive test result obtained prior to the birth of a child shall not be used for the criminal prosecution of a parent for acts and omissions resulting in intrauterine exposure of the child to an illegal drug.

Iowa Code, Section 232.78, 1., b. Temporary custody of a child pursuant to ex parte court order:
(1) The refusal or failure of the person responsible for the care of the child to comply with request of a peace officer, juvenile court officer, or child protection worker for such person to obtain and provide to the requester the results of a physical or mental

examination of the child. The request for a physical examination of the child may specify the performance of a medically relevant test.

(2) The refusal or failure of the person responsible for the care of the child or a person present in the person's home to comply with a request of a peace officer, juvenile court officer, or child protection worker for such a person to submit to and provide to the requester the results of a medically relevant test of the person.

II. Drug Testing Effectiveness.

Methodology

For the purpose of this report the effectiveness of drug testing is defined as the reliability of the drug testing results. To evaluate effectiveness of the reliability of the Department's drug testing results, the Department's drug testing standards and protocols were subject to both an internal and external review by a Methamphetamine Specialist from the Department and substance abuse experts from the Iowa Department of Public Health (IDPH). In addition, technical assistance was requested from the National Center on Substance Abuse and Child Welfare (NCSACW) regarding drug testing standards and protocols used in other states for the purpose of comparison to Iowa's.

Findings

Internal Review

Currently, the Department has in place specific statewide drug testing methodology requirements that prescribe the type of testing; the frequency of testing and the duration of testing that are available to Department staff. To report the effectiveness of this testing a Methamphetamine Specialist from the Department was consulted regarding the reliability of the Department's drug testing results. It was reported that the statewide drug testing requirements set by the Department for collections and laboratory services do meet the minimum federal guidelines endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA) and that where there are no current national standards offered, generally accepted industry standards have been adopted by the Department. As such, the contractual arrangements for collections and laboratory services that are currently in place meet the regulatory, licensing, and industry standards that the Department requires and are those endorsed by SAMHSA and/or are reflective of generally accepted industry standards.

The Department's drug testing collections and laboratory services standards include:

- Laboratory Gas Chromatography/Mass Spectrometry (GC/MS) testing or better confirmation for substances in which instant result samples yield a presumptive positive result.
- All laboratory drug testing incorporate immunoassay technology and that all positive results are verifiable by GC/MS, Liquid Chromatography/Mass Spectrometry (LC/MS) or Liquid Chromatography-Mass Spectrometry/Mass Spectrometry (LC-MS/MS).
- Instant testing from adulterant tests for pH, specific gravity and temperature.

- All personal involved in the collections and laboratory services are trained and certified in various testing methodologies and the use of collection devices and procedures.
- The "chain of custody" or the legal protocol regarding the documentation of specimen transfer from the time of collection until reporting of the results is mandated. The "chain of custody" makes the drug results legally admissible.

External Review

At the request of the Department the Iowa Department of Public Health (IDPH) reviewed the Department's drug testing standards and protocols. IDPH supports the protocols as written with the notation that multiple protocols beyond the standard defaults listed within the protocols may be overly prescriptive. A stronger emphasis was suggested on the introductory language regarding the need for case-specific decision-making and collaboration across all involved parties.

Other states

The Department also requested technical assistance from the National Center on Substance Abuse and Child Welfare (NCSACW) regarding the drug testing standards and protocols in other states for the purpose of comparison to Iowa's. In reviewing the standards the Department found that Iowa's drug testing standards and protocols are comparative to those of other states.

Conclusions

The statewide drug testing standards set by the Department for collections and laboratory services meet the minimum federal guidelines endorsed by SAMHSA. Where there are no current national standards offered, generally accepted industry standards have been adopted by the Department.

III. Drug Testing Consistency.

Methodology

Consistency for this report is defined as how drug testing is applied across the state in child abuse cases. To determine whether drug testing is applied in the same manner in all Service Areas; Service Area Managers, Methamphetamine Specialists and local child welfare staff were consulted regarding drug testing policies and practices.

Findings

There are similarities and differences in regard to whether drug testing is applied in the same manner across in all Service Areas.

Similarities:

- ***Case Assessments:*** Within all Service Areas the decision to test a parent and the extent that drug testing results influence critical decisions around a child's safety is based on the information gathered during the child abuse assessment and/or during the monitoring phase of an ongoing child welfare case. A drug testing decision is

made after careful consideration and evaluation of the information gathered regarding a parent/caretaker's alleged drug usage, the known effects of the specific drug used and the potential impact on the parent/caretaker's ability to provide proper supervision of a child. It is the critical evaluation of this information that determines whether or not drug testing is needed, and if so, what method, type and the frequency of the drug testing.

- ***Staff Training:*** All Department staff are trained in the philosophy and approach to drug testing through the statewide child protection training program. This program includes training in the policies and procedures around substance abuse and drug testing. Courses include presentations by Iowa physician, Dr. Rizwan Shaw, who is nationally recognized for her work with drug-endangered children and with state narcotics law enforcement officers. Training and consultation services are also provided by the Service Area Methamphetamine Specialists who serve as a resource for Department staff. Consultation services include interpretation and consultation of drug screening results, treatment strategies, and monitoring techniques on case work with substance users with the goal of reducing the impact of substance abuse on the family to ultimately reduce repeat child abuse.

- ***Cutoff Levels***: All Service Areas use the same "cut off levels" or testing threshold. This is the level at or above which a test will be reported as positive. These standards reflect those endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA) and/or generally accepted industry standards.
- ***Random Testing:*** All Service Areas utilize random testing.
- ***Life of the Case:*** All Service Areas assess the need for drug testing at critical points (reunification, unsupervised visitation, case closure etc.) during the life of a case. Drug testing decisions are based on the assessment of individual cases.
- ***Supervisory Oversight:*** All Service Areas require supervisory oversight and consultation as part of the authorization process for drug testing. Consultation is around the necessity of drug testing, the behavioral indicators of drug usage in regard to the safety of children, what the testing will reveal, and how the results will be used.
- ***Substance Abuse Facilities:*** All Service Areas utilize, consult and make referrals to local substance abuse treatment facilities in their respective areas.
- ***Support Services:*** All Service Areas provide support services such as Safety Plan Services, and/or Family, Risk and Safety Services with drug related child abuse cases when appropriate to protect children.
- ***Drug Testing Authorization:*** All Services Areas may extend the standard three-month drug testing authorization period if a case situation warrants it.

Differences:

- ***Current Lab Contract:*** Service Areas have the option of using the statewide laboratory contract with CSS Test, Inc. Currently, six Service Areas utilize the services under this contract. Two Service Areas do not use this contract primarily due to existing contracts with other labs.
- ***Collections Services:*** Each Service Area has established a collections services system within their area. In five of the Service Areas families have to leave their particular county to get tested however, special arrangements can be made to have

testing available in the county if necessary. Three Service Areas have testing available in every county with their Service Areas.

- ***Frequency of Testing:*** All eight Service Areas use the *Default Drug Testing Protocols (Appendix D)* the majority of the time in determining the testing regimen to use. In addition, Service Areas reference the behavioral guidelines in the *Recovery Matrix-Intact Cases (Appendix E)* to adjust the frequency of testing based on the case situation. Four of the Service Areas use the Default Drug Protocols as their "starting off" point, and then use the Behavioral Guidelines to adjust the frequency up or down based on the case situation. The other four Service Areas have established a local "default protocol" that includes less frequent testing as their "starting off" point, and then use the Behavioral Guidelines to adjust the frequency up or down based on the case situation. Frequency of testing is also influenced by the practices of individual judges.

Conclusion

Similarities and differences in policies and practices across Service Areas were identified. The over reaching similarities are that the drug testing standards used by all Service Areas reflect those endorsed by Substance Abuse and Mental Health Services Administration (SAMHSA) or meet generally accepted industry standards, and that drug testing is based on the individual assessment of child abuse cases. One difference in drug testing practices between Service Areas involves the frequency of testing. Service Areas have the discretion to determine the testing regimen they follow based on the circumstances of a case. In determining the frequency of testing all Service Areas refer to the *Default Drug Testing Protocols (Appendix D.)* and the *Recovery Matrix – Intact Cases (Appendix E.)* for guidance. Frequency of testing is also influence by the orders of Juvenile Judges. Other differences are dependent on the availability and access to collections services and local resources rather than a result of a lack of consistency or standardization in drug testing.

IV. Drug Testing Funding.

An estimated $800,000 per year is being spent by the Department for the one time drug testing in connection with a child protective assessment (investigation). Approximately $500,000 per year is being spent on drug testing for ongoing child welfare cases in which periodic testing is required based on individual cases. In addition, approximately $500,000 per year is currently being spent for drug testing from the Court Ordered Services fund for both juvenile delinquents and children in need of assistance cases. These estimated amounts include both the costs of collection and laboratory services.

Findings

Timing of Testing

There are two points in the life of a case in which drug testing occurs. One is in connection with a child protective assessment (investigation) that is usually a one time test. The other condition is periodic testing for ongoing child welfare cases. These tests occur regularly as determined by the individual case.

Funding Sources

- ***Child Welfare Services*** – Child Welfare Services is the primary funding source for payment of drug testing services for ongoing case management services. It can also be used for drug testing done during child abuse assessments.

- ***Child Abuse Registry*** - The Child Abuse Registry will pay for drug testing when:
  A drug test is performed prior to a report of child abuse being made to DHS and the test was ordered by a health practitioner as it was determined to be medically indicated.

  The drug test is performed as part of a child abuse assessment on an adult that is named as an alleged perpetrator on an allegation of Denial of Critical Care; Failure to Provide Proper Supervision or on an allegation involving the Presence of Illegal Drugs in a Child.

- ***Court Ordered Services*** – Court Ordered Services funding for both juvenile delinquents and children in need of assistance cases is available to all Service Areas in cases where drug testing is ordered by the court.

- ***DECAT (Decategorization) - DECAT*** is a funding resource that Service Areas may use for drug testing where DECAT areas have established agreements with providers to handle collections and arrange for laboratory services.

This is summarized in the chart below:

Types of Cases	**Funding Sources**	**Estimated Expenditures**
Child Abuse Assessments	Child Abuse Registry (CAR) State Child Welfare Services	$800,000
Ongoing Child Welfare Cases	State Child Welfare Services Court Ordered Services Decategorization (DECAT)	$500,000 $500,000

Conclusion

The Department currently spends approximately $1.8 M annually on drug testing.

V. Discussions and Remarks.

National Center on Substance Abuse and Child Welfare (NCSACW)

Drug Testing; A "How To Guide" for a Treatment Tool is a resource guide that is currently being written in partnership with the Department, the Iowa Department of Public Health, and the Iowa Judicial Department as part of the In-Depth Technical Assistance (IDTA) project that is underway in Iowa. The guide is intended for administrators and field staff and provides information on the type, method, and frequency of drug testing. It discusses why drug testing is one tool that workers can use in assessing child abuse cases and discusses what variables to consider when deciding when to test and how to know when to stop testing. Other areas discussed in the guide are behavioral indicators regarding client progress and the importance of collaboration among agencies during the substance abuse recovery period to ensure the safety of children. In writing the guide the group has requested and is receiving technical assistance services from the National Center on Substance Abuse and Child Welfare (NCSACW). Once finalized all three state agencies will follow these new protocols. The Department will no longer use the protocols described and attached in this report.

VI. Appendixes

A. Drug Testing Guidelines Developed for the Department of Human Services, *RC-0090.* Task Force Members of the Iowa Department of Human Services, the Iowa Department of Public Health and Substance Abuse Treatment Providers (June 10, 2005).
B. Drug Testing Types and Standards.
C. Default Drug Testing Protocols (September 4, 2007).
D. Drug Testing Finals.
E. Recovery Matrix –Intact Cases.

DRUG TESTING GUIDELINES

DEVELOPED FOR

DEPARTMENT OF HUMAN SERVICES

TASK FORCE MEMBERS

DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF PUBLIC HEALTH

SUBSTANCE ABUSE TREATMENT PROVIDERS

JUNE 10, 2005

DPH/DHS

DECISION MAKING TOOL FOR DETERMINING DRUG TESTING METHOD

TYPE OF TEST	INDICATIONS FOR USE	PROS	CONS	WINDOW OF DETECTION
URINE	• When a child is removed from an active clandestine meth lab, a urine sample within 4 hours is critical for both medical care and for forensic evidence. • When use is suspected in the past few days. Except marijuana which could be in the last several days to weeks. • When same gender collector is available for observed collection or collector trained to DOT standards for unobserved collection. • When cost is an issue, use for regular, random and frequent testing. • To have results that are the most defensible in court. • As a deterrent to use or continued use of an illicit substance. • To identify those who are using illicit substances. • Wide range of possible drug use	• Highest assurance of reliable results. • Least expensive. • Most flexible in testing different drugs including alcohol and Nicotine. • Most likely of all drug testing methods to withstand legal challenge when observed. • SAMHSA approved	• Specimen can be adulterated, substituted or diluted. Adulteration and dilution can be detected; • Preventing substitution depends upon careful observation of sample collection • Limited window of detection. • Tests sometimes viewed as invasive or embarrassing. • Biological hazard for specimen handling and shipping to lab.	Typically 1 to 5 days.
	•	•	•	

HAIR	• When a non-intrusive method is necessary. • Children-for presence of drugs in the system. • To achieve a longer detection window- 1.5 inches of hair equals a 90-day window. • Hair is not significantly affected by brief periods of abstinence so it can be used to indicate periodic relapse. • When invasive collection is an issue. • To identify usage that occurred over 7 days in the past. • When there is a suspicion of repeated successful adulteration, dilution, tampering of urine samples.	• Longer window of detection. • Greater stability (does not deteriorate). • Can measure chronic use. Convenient shipping and storage (no need to refrigerate). • Collection procedure not considered invasive or embarrassing. • More difficult to adulterate than urine.	• More expensive. • Test usually limited to 5-drug panel. • Cannot detect alcohol use. • Will not detect very recent drug use. • Most recent use detected may be up to 7 days. • • Some drugs migrate through the hair, so presence may not indicate recent use. • Coarse hair retains more and longer evidence of use, so there is risk of racial bias. • Amount detected may vary across samples of hair from the same person. • Split sample technique should be used to differentiate environmental exposure from personal use. • Not SAMHSA approved	Depends on the length of hair in sample. Hair grows about half-inch per month, so a 1.5 inch specimen would show a 3 month history.
ORAL FLUIDS	• When a non-intrusive method is necessary. • When observed collection is necessary but no same gender collector is available. • For recent use (previous hour up to 24 hours marijuana, previous hour up to 48 hours all others). • Post incident/accident situations. • When there is a need to know if someone is "under the influence," shows presence of parent drug. • When marijuana is not a concern.	• Sample obtained under direct observation. Minimal risk of tampering. • Non-invasive. • Samples can be collected easily in almost any environment • Can detect alcohol use. • Reflects recent drug use	• Drugs and drug metabolites do not remain in oral fluid as long as they do in urine. • Less reliable than other testing methods in detecting marijuana use. • Very short detection period is a problem. • To enhance defensibility must use other methods for marijuana • Not SAMHSA approved	Approximately 10 to 24 hours.

Sweat Patch	• As a deterrent to use or continued use of an illicit substance. • To identify those who are using illicit substances. • When a non-intrusive method is necessary. • To achieve a longer detection window- drugs are detected up 2 days prior and for as long as the patch is worn. Typically 7-14 days. • When there is a suspicion of repeated successful adulteration, dilution, tampering of urine samples • When a visible deterrent to using is desirable. • When close monitoring is desired, gives 24/7 monitoring while worn. • When "shy bladder" is an issue. • When head hair has been shaved off. •	• Longer window of detection. • Sample obtained over 7 or more days. • 24 hour a day monitoring • Minimal risk of tampering, if removed by donor can't be reapplied. • Non-invasive, no same gender issues • Difficult to adulterate, attempts and tampering are evident to collector. • Not considered a bodily fluid/hazard, as is urine. • All positive screens are confirmed by GC/MS. • Positives are confirmed for parent drug and drug metabolite. • Can detect occasional use. • Recommended by DHHS for approval for use in federally mandated testing programs. • FDA approved. • Gives client good reason to refuse using opportunities.	• Is a storage device, can't tell if use was once or multiple times. • Collector needs to be attentive to condition of patch upon removal to detect tampering. • Chain of custody form needs to be completed. • Possibility of contamination via mishandling by collector. Need to follow application and removal protocols. • Not as court tested as urine. • More labs doing urine, hair and oral fluids, less choice in who to work with. • Tests only for 5 substances: cocaine, PCP, opiates, marijuana, and amphetamine/methamphetamine. • Not SAMHSA approved. •	• 1-2 days prior to application of patch and while being worn, typically 7+ days

ADULT UA FREQUENCY PROTOCOL

Suggestions:

- Unannounced random home visits
- If cost is an issue -- and more frequently drops are desired -- drops can be as frequent as every day. Then one or two of those drops are randomly selected for analysis. This saves on lab costs but not on the supervision of drops.
- Failure to appear for ANY reason or adultered specimen is regarded as a positive test result.
- The ideal is that all UA's must be observed.
- Repeated positive tests results consider substance abuse assessments.
- Random schedule
- Require a co-pay from client
- Recommend the client pay for confirmation
- Dirty results are not an indicator for increased UA's rather an indicator for increased interventions.

A 9-panel screen is recommended. (marijuana, amphetamine, cocaine, barbiturates, benzodiazepines, methadone, opiates, phencyclidine, propoxyphene).

There may be a need to check on Oxycontin use in selected cases.

	ASSESSMENT	ONGOING CASES			
	During CPA assessment	30 Days	30 to 60 Days	60 to 90 Days	90 + Days
Drug Tests or Breathalyzer (minimum)	Allegation and event linked in accordance with Central Abuse Registry	Twice a week/ random and or event linked	Once a week/ random and or event linked	One to two times a month/ random and or event linked	Once every other month/random and or event linked. If client clean for three months random or STOP

The Central Abuse Registry will pay for "drug testing" (or other "medical relevant test" when:

A. The "drug test" is performed before a report of child abuse is made to DHS AND the test was ordered by a health practitioner because they determined that it was "medically indicated"

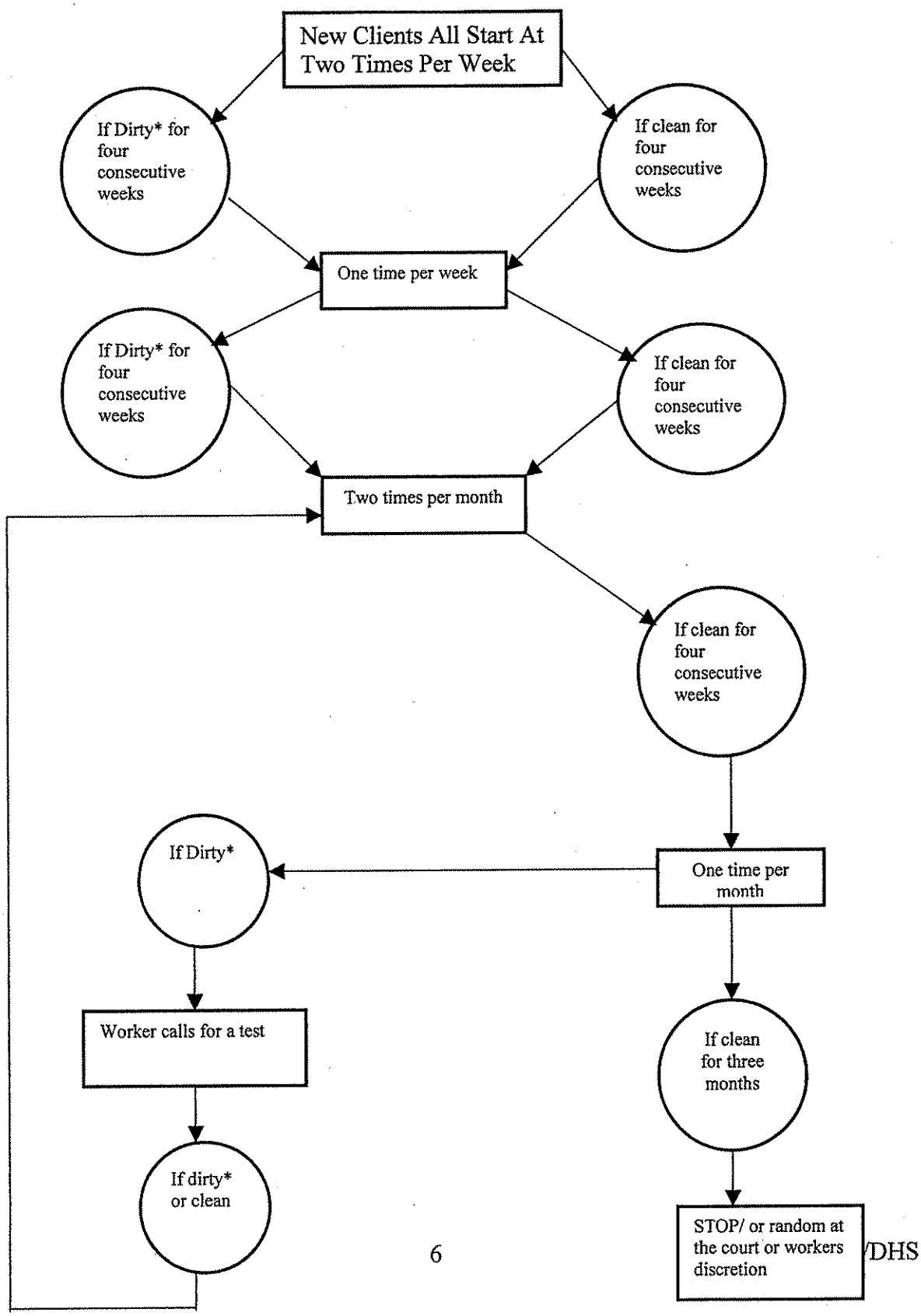
B. The "drug test" is performed during the child abuse assessment on an adult that is named as an alleged perpetrator on an allegations of Denial of Critical Care for Failure to Provide Proper Supervision or and allegation of Presence of Illegal Drugs in a Child.

C. B is true but the "drug test" is performed after the conclusion of the assessment, AND there is documentation in the written report that the worker requested or attempted to have the "drug test" done prior to completing assessment.

D. B is true AND the "drug test" is scheduled before but cannot be administered before the completion of the assessment AND the worker documents in the written report that an Addendum will be submitted that addresses the result of the "drug test".

PRACTICAL DRUG TESTING PROGRESSION FOR ADULTS

This flow chart is believed to provide an efficient use of drug testing resources while allowing an effective method of monitoring for drug use. It is not a tool to be used for child placement or visitation decisions.



* Dirty= missed or positive test

FEMALE UA PROCEDURE

Check ID to verify identity (if person is not known).

Complete a Breathalyzer (e.g. Alco-Sensor III) test and document results.

Client and staff enter collection area.

Client retrieves a UA collection "hat" (speci-pan)

UA collection "hat" placed over commode, client hands are visible and placed on either knees or sides of stall before urination begins.

Client pours 60 ml. of urine from collection "hat" into UA collection bottle with temp strip.

Staff complete necessary information on Chain of Custody form, including: date of collection; time of collection; breathalyzer test result; temperature of urine sample; listing of medications taken or drugs used in the last 72 hours; client identifier number; printed names of client/staff; and, client/staff signatures.

Label is placed over the lid of the collection bottle to ensure that no tampering occurs, client then initials the label verifying the specimen has not left her sight.

A label (from Chain of Custody form) with date of collection, client name, and collector's name is placed around bottle.

Bottle is placed in UA refrigerator until bagged for pick-up.

One copy of the Chain of Custody form is placed in filing, one in a bag to be sent to lab with UA specimen, and one is given to the client.

MALE UA PROCEDURE

Check ID to verify identity (if person is not known).

Complete a Breathalyzer (e.g. Alco-Sensor III) test and document results.

Client and staff enter collection area.

Client pulls outerwear (e.g. pants) and under garment(s) down to knees.

Client receives a (Dixie) collection cup and begins urinating into it.

Client pours 60 ml. of urine from collection cup into UA collection bottle with temp strip and gives the bottle to the staff person.

Staff complete necessary information on Chain of Custody form, including: date of collection; time of collection; breathalyzer test result; temperature of urine sample; listing of medications taken or drugs used in the last 72 hours; client identifier number; printed names of client/staff; and, client/staff signatures.

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A label (from Chain of Custody form) with date of collection, client name, and collector's name is placed around bottle.

Bottle is placed in UA refrigerator until bagged for pick-up.

One copy of the Chain of Custody form is placed in filing, one in a bag to be sent to lab with UA specimen, and one is given to the client.

DRUG TESTING

Screening Levels

The concentration in the urine sample has to be at or above the cutoff level to be reported as positive.

The screening cutoff concentrations are consistent with those set as a standard by SAMHSA (Substance Abuse and Mental Health Services Administration). Those cutoff levels are as follows:

Amphetamines .....1000 ng/ml
Barbiturates .....300 ng/ml
Benzodiazepines .....300 ng/ml
Cannabis/Marijuana/THC ..... 50 ng/ml
Cocaine .....300 ng/ml
Methadone.....300 ng/ml
Methamphetamines .....1000 ng/ml
Opiates. .....2000 ng/ml
PCP .....25 ng/ml
Tricyclic Antidepressants.....1000 ng/ml

These are the minimum concentrations for a drug test to come back as positive. Confirmation testing is much more sophisticated and may have a lower cutoff/sensitivity level.
There are not as of yet formal standards set for oral or hair tests.

In general, cut-off levels for urinalysis have been established to reduce the possibility of an evidential false positive result, and still be sensitive enough to reduce the number of false negatives.

Detection times

	Urine	Oral
Amphetamine	24-72 hours	minutes-48 hours
Barbiturates	1-21days	minutes-48 hours
Benzodiazepines	2-28 days	minutes-48 hours
*Cannabis/Marijuana/THC	1-21+ day'	minutes-24 hours
Cocaine	24-96 hours	minutes-48 hours
Methadone	72 hours	minutes-48 hours
Methamphetamines	24-72 hours	minutes-48 hours
Opiates	24-72 hours	minutes-48 hours
PCP	14-30 days	minutes-48 hours
Tricyclic Antidepressants	10 days	

Alcohol...after absorption (~1hour) blood alcohol decreases by ~0.02 %/hour

***Cannabinoids detection time-urinalysis**

Light smoker or acute dosage .....1-3 days
Moderate use (4x /week).....3-5 days
Heavy smoker (daily).....10 days
Heavy, chronic use (5+ joints/day) .....10-21+ days
Oral ingestion .....1-5 days

Passive inhalation -In general, routine passive exposure to marijuana smoke will not result in a positive result for carboxy-THC. Only under unrealistic conditions, a person may test positive for carboxy-THC, but concentrations are generally below the routine cut off levels.

GENERAL INFORMATION ON DRUG TESTS

Drug Detection and Identification

Screens (initial test at a lab) are performed by a variety of tests. These tests can include screening by enzyme immunoassay (EIA), radioimmunoassay (RIA), thin-layer chromatography (TLC). These tests largely detect a broad range of metabolites related to a drug. This test is sensitive to drug groups as opposed to a specific drug or its metabolite. It is good at detecting drugs when they are present but is subject to interference, which can result in false positives and false negatives. Positive screen results must be confirmed if the person denies use. Related drugs, as well as some other substances can cause false positive results on a screening test. Screening tests are intended to be broad screens, which then must be verified ("confirmed") by a more accurate and reliable method such as GC/MS.

Confirmation testing is most often performed by Gas Chromatography with Mass Spectrometry detection (GC/MS). This test is based on the physical and chemical properties of the specific drug or metabolite to be measured. Drug identification is achieved BOTH by chromatographic retention time and by mass spectrometry, which is the "drug fingerprint." This test is very specific and robust with respect to interference. This confirmation test is legally defensible evidence of drug use.

Reports from the lab will state the screen was negative or positive for the listed substances. Most will also report a concentration level. Labs express concentrations for urine and saliva tests in nanograms per milliliter (ng/ml), for hair the concentration is expressed in nanograms per milligram (ng/mg).

Higher concentration levels can indicate heavier use and/or use that is more recent. The urine drug level does not correlate well with the initial dose. Individuals metabolize substances at varying rates for a variety of reasons including body composition, level of activity, and diet. A positive result simply means that there has been use. Two or more serial determinations may be helpful in determining new verses prior use. "Fat-soluble" drugs (such as THC) are a particular problem because they are retained in the body for relatively long periods of time and metabolites are released into the urine at variable rates depending in part upon how, and the extent to which the fat is metabolized by the body.

Creatinine- Reports will also include a creatinine level. The urine creatinine level measure is useful, when performed with the drug screen because it is an indicator of specimen validity.
Creatinine is a muscle breakdown product, which is excreted in the urine at a steady rate. Therefore, the urine creatinine level changes, as the urine becomes more dilute or more concentrated. The urine becomes more dilute when a person drinks larger amounts of water. Most normal urine samples will have a creatinine value between 20 and 350 mg/dl (milligrams per deciliter). A specimen with a urine creatinine level less than 20 mg/dl is considered "dilute." It is recommended that negative drug test results be disqualified when the specimen has a creatinine level less than 20 mg/dl (substituted). A drug test result that has a creatinine level between 10.0 and 1.0 may be recollected to determine if the person was trying to dilute out the system. Conversely, a positive result on a dilute specimen should not be disqualified, because this shows that the drug was in such high concentrations that it was detected even though the urine is dilute.

The THC/CR ratio should decrease over time when there is no new use. The rule-of-thumb is that when comparing two results, the THC/CR ratio should decrease over relatively long periods of time depending on the individual. A light or infrequent user will decrease faster than a heavy or frequent user. The advantage and difficulty with detection of marijuana/THC use through urinalysis is that THC is fat-soluble and is stored in the body for longer periods of time than most other drugs of abuse. This results in the metabolites of THC being released into the urine long after the drug has been used. The distinct advantage to this is that we can detect use for rather lengthy periods. The disadvantage is that positive UA results can continue for lengthy periods with no additional use. Even more problematic is the positive results do not necessarily decrease in a linear manner. They can vary in quantity from test to test – sometimes increasing briefly over time. The metabolism of stored body fat (with its THC content) can vary from day to day and therefore THC content sloughed (given off by the body into the urine) today could be more than yesterday. The more body fat the person has, the more of a problem this presents

Once THC use is detected, UA screening for continued use is complicated by the fat solubility of THC and the non-linear rate in which the body sloughs the THC metabolites, which are detected by the UA screen. It is likely (though not always) that screens seven (7) days apart will show a linear decrease in THC quantity. It is likely that screens a few days apart will show variable results – sometimes lower, sometimes higher than the previous screening results. This becomes more unpredictable the lower the quantity and the closer together the UA samples are taken. The screening cut-off levels and concentration or dilution of urine coupled with the variability of THC sloughing by the body can contribute to inaccurate interpretation of results as indicating use.

Methamphetamine

When methamphetamine is used, some is metabolized to amphetamine, and both are excreted in the urine. Therefore, a report may show a positive for both methamphetamine and amphetamine, even if only methamphetamine was used. Also for methamphetamine to be called positive there must be at least 200 ng/ml of Amphetamine in the urine.

Hair tests- generally can detect use within 4-7 days of using. It takes approximately that long for affected hair to grow above the scalp. Hair grows at approximately ½ inch per month. Therefore, each ½ inch of hair length represents 1 month of history. Typically, hair is considered to show use within a 90-day period. Some drugs migrate through the hair, which means with those drugs that length of hair does not represent 1 month of history and could be longer or shorter. Coarse hair is more likely to retain drugs. Hair from different parts of the head may have variable amounts of the drug. Positive hair test results can be the result of environmental exposure or ingestion. Sophisticated labs can distinguish what is environmental versus ingestion by taking a large enough sample from one area of the body, splitting the sample, washing one half (which reduces environmental positives), testing both halves.

Meconium tests

These tests are on the first stool(s) of newborns and show the substance(s) ingested by the mother during the third trimester of the pregnancy. There have been no norms created to

give information about how much of a substance the mother consumed during that 3 month period and likewise, you cannot determine exactly when the using occurred.

Sweat Patch Information

These are FDA approved and recommended by the Department of Health and Human Services, along with hair and oral fluids for use in federally mandated testing programs. The patch consists of an adhesive plastic film that holds an adsorption pad in place against the skin and collects accumulating sweat on an absorbent cellulose pad. The patch acts as a collector for nonvolatile components excreted through perspiration, including drugs of abuse: cocaine, opiates PCP, amphetamines/methamphetamine, and marijuana.
The adhesive film of the patch is a semi-permeable barrier that allows oxygen, carbon dioxide, and water vapor to pass through so that the skin can breathe normally. Larger molecules (such as drugs) are trapped in the absorption pad. Contaminants from the environment cannot penetrate the adhesive barrier from the outside, so the patch can be worn during normal activities, including bathing and swimming.

The adhesive plastic film cannot be reapplied once removed, and a unique serial number prevents fraud and tampering. The sweat patch specimen cannot be diluted or altered without showing signs of tampering.
The patch is designed to be worn for several days and can be worn for up to 14 days. The patch retains drugs used at any time approximately 2 days prior to application and during its wear period until removal. It provides for continuous monitoring 24 hours a day throughout the wear period. The patch is gender neutral as it can be worn on the upper arm, the lower midriff, or the lower back. The skin where the patch will be worn is thoroughly cleaned with alcohol wipes prior to application. The Patch should be worn for a minimum of 24 hours to ensure that an adequate amount of sweat is collected. After the Patch is worn, the absorption pad is removed and sent with a completed chain-of-custody form to a lab for testing. Immunoassay (ELISA or RIA) technology is currently used for the screening test. A positive screening test is confirmed by GC/MS (Gas Chromatography / Mass Spectrometry). The confirmation test detects both the drug metabolite and the parent drug insuring that a drug was ingested and metabolized by the body.

Drug Testing Types and Standards

Drug Testing Types
Currently DHS prescribes the type of testing, frequency of testing, and the testing period duration. DHS requires submittal of sample collections to the laboratory facility designated by the state. DHS recognizes the following laboratory and collection methods by all approved organizations:

- Alcohol
- Fingernail
- Hair
- Saliva
- Sweat Patch
- Urine

The materials and supplies such as, sweat patches, mouth swabs, instant urine kits and instant alcohol kits are supplied to the collector so the cost for testing is for collections only.

Drug Testing Standards
Each test should be for at least the SAMHSA (Substance Abuse and Mental Health Services Administration) standards for a minimum of a 5-panel test, which must include: marijuana, cocaine, PCP, amphetamines (including methamphetamine), and opiates. The bid proposal should include a cost for additional drugs beyond the 5 panel such as a cost for a 7 or 9 panel test. This may also include an additional cost for a single additional drug. These would include, but not be limited to: barbiturates, Hydrocodone, Hydromorphone, benzodiazepines, oxycontin / Oxycodone, methadone, Propoxyphene, LSD, methaqualone, and alcohol. Additionally the labs will test at cut off levels at or below the minimums mandated for federal work place testing environments for urine testing. Testing should be for the presence of parent drug or it's metabolite as industry standards of practice dictate. The screening cutoff concentrations must be consistent with the standards set by SAMHSA (Substance Abuse and Mental Health Services Administration).

These are established for urine testing. For alternative tests the cutoff levels are suggested or the industry standard is given. Confirmation testing will be at or below screening test level.

Cutoff levels for lab based urine tests are as follows:
Amphetamines .....1000 ng/ml
Cannabis/Marijuana/THC .....50 ng/ml
Cocaine .....300 ng/ml
Opiates. .....2000 ng/ml
PCP..... 25 ng/ml

Cutoff levels for other tests:
Cutoff levels for instant result urine tests and those not set by SAMHSA standards:

Amphetamines .....1000 ng/ml
Barbiturates .....300 ng/ml
Benzodiazepines .....300 ng/ml
Cannabis/Marijuana/THC .....50 ng/ml
Cocaine .....300 ng/ml
Methadone .....300 ng/ml
Methamphetamine.....1000 ng/ml
Propoxyphene.....300 ng/ml
Opiates. .....300 ng/ml
PCP..... ...25 ng/ml
MDMA/Ecstasy..... .....500 ng/ml
Oxycodone..... ..... 100 ng/ml

Cutoff levels for saliva tests:
Amphetamines .....25 ng/ml
Benzodiazepines .....5 ng/ml
Cannabis/Marijuana/THC .....40 ng/ml
Cocaine .....20 ng/ml
Methamphetamine.....25 ng/ml
Opiates. .....10 ng/ml
PCP..... 4 ng/ml
MDMA/Ecstasy.....25 ng/ml

Cutoff levels for hair tests:
Amphetamines .....500 pg/mg
Cannabis/Marijuana/THC .....1 pg/mg
Cocaine .....500 pg/mg
Methamphetamine.....500 pg/mg
Opiates.....500 pg/mg
PCP.....300 pg/mg
Oxycodone.....500 pg/mg
Hydrocodone.....500 pg/mg
Hydromorphone.....500 pg/mg

Cutoff levels for sweat tests:
Amphetamines .....10 ng/ml
Cannabis/Marijuana/THC ..... .1.5 ng/ml
Cocaine ..... 10 ng/ml
Methamphetamines..... 10 ng/ml
Opiates. ..... 10 ng/ml
PCP..... .7.5 ng/ml

Cutoff levels for fingernail tests:
Amphetamines .....500 pg/mg
Cannabis/Marijuana/THC .....5 pg/mg
Cocaine ..... 500 pg/mg

Methamphetamine	500 pg/mg
Opiates	200 pg/mg
PCP	300 pg/mg
Oxycodone	200 pg/mg
Barbiturates	1000 pg/mg
Benzodiazepines	1000 pg/mg
Methadone	1000 pg/mg

Default Drug Testing Protocols

In order to operate as efficiently as possible and not to waste resources on excessive drug testing it is proposed that the following protocols for drug testing frequencies be accepted as the default protocols. That would mean that with the case status as described, specific protocols would be used the majority of the time unless the case situation can justify a different frequency.

Please see the universe of protocols below and refer to them with regard to the defaults. For most child protective assessments the frequency for testing is 1.

For UAs

For new cases the default protocol is number 4
For ongoing cases the default protocol is number 3

For Saliva

Same as for UAs

For the Sweat Patch

For new cases the default protocol is number 3
For ongoing cases the default protocol is also number 3

New cases are considered to be those cases that are just transferred from CPA to the case manager and for a 3 month period thereafter. After this 3 month period the case would be considered to be **ongoing**. None of these default protocols for ongoing cases should preclude using a lesser frequency or stopping testing if the results warrant that. Neither is it intended that the default protocol for ongoing cases continue to be used for the life of the case. These authorizations are usually for a 3 month period

The hair test is only valid once every 3 months and similarly for fingernails.

Urine testing protocols

1. One test
2. One test per month for 3 months
3. Two random tests per month for one month; then two random tests per month for two months **unless on ongoing cases there are two consecutive negative results, then the Social Worker is to change the authorization to stop further testing.**
4. Three random tests per month for one month; then two random tests per month for two months.
5. Four random tests per month for one month; then three random test for one month; then 2 random test for one month.
6. Five random tests per month for one month; then three random test for one month; 2 random tests for one month

7. Six random tests per month for one month; then 4 random test for one month; then 2 random tests for 1 month
8. Seven random tests per month for one month; four random tests for next month; two random tests per month for next month
9. Two random tests per week for one month; four random tests for next month; two random tests per month for next month
10. Three random tests per week for one month; four random tests for next month; two random tests for next month
11. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____
_____
_____
_____
_____
_____
_____
_____

Sweat patch testing protocols

1. One test
2. One patch per month for 3 months
3. Two random patches per month for 3 months **unless on ongoing cases there are two consecutive negative results, then the Social Worker is to change the authorization to stop further testing.**
4. Two consecutive patches
5. Four consecutive patches
6. Six consecutive patches
7. Six random patches for 3 months
8. Other, describe (must also indicate rational for choosing this option) _____ Total patches.

_____
_____
_____
_____
_____
_____
_____
_____

Hair Stat testing protocols

1. One Test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

Mouth Swab testing protocols

1. One test
2. One test per month for ____ months/90days
3. Two random tests per month for one month; then two random tests per month for two months
4. Three random tests per month for one month; then two random tests per month for two months
5. Four random tests per month for one month; then three random tests for one month; then 2 random tests for one month
6. Five random tests per month for one month; then three random tests for one month; 2 random tests for one month
7. Six random tests per month for one month; then 4 random tests for one month; then 2 random tests for 1 month
8. Seven random tests per month for one month; four random tests for next month; two random tests per month for next month
9. Two random tests per week for one month; four random tests for next month; two random tests per month for next month
10. Three random tests per week for one month; four random tests for next month; two random tests for next month
11. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

Fingernail testing protocols

1. One Test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

Breathalyzer testing protocols

1. One Test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

Instant Urine testing protocols

1. One test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

Instant Mouth Swab testing protocols

1. One test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____
_____
_____
_____
_____
_____
_____
_____

DRUG TESTING FINALS

1. Lab based UA 9 panel $14.95

Detects THC/marijuana, cocaine, opiates, PCP, benzodiazepines, barbiturates, methadone, propoxyphene, and amphetamine.

1. One test
2. One test per month for 3 months
3. Two random tests per month for one month; then two random tests per month for two months **unless on ongoing cases there are two consecutive negative results, then the Social Worker is to change the authorization to stop further testing.**
4. Three random tests per month for one month; then two random tests per month for two months.
5. Four random tests per month for one month; then three random test for one month; then 2 random test for one month.
6. Five random tests per month for one month; then three random test for one month; 2 random tests for one month
7. Six random tests per month for one month; then 4 random test for one month; then 2 random tests for 1 month
8. Seven random tests per month for one month; four random tests for next month; two random tests per month for next month
9. Two random tests per week for one month; four random tests for next month; two random tests per month for next month
10. Three random tests per week for one month; four random tests for next month; two random tests for next month
11. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____

2. Lab based UA 9 panel plus Alcohol $16.95

Detects THC/marijuana, cocaine, opiates, PCP, benzodiazepines, barbiturates, methadone, propoxyphene, and amphetamine. Plus alcohol adds a test for ethanol that detects alcohol use in the past 6-8 hours.

1. One test
2. One test per month for 3 months
3. Two random tests per month for one month; then two random tests per month for two months **unless on ongoing cases there are two consecutive negative results, then the Social Worker is to change the authorization to stop further testing.**
4. Three random tests per month for one month; then two random tests per month for two months.
5. Four random tests per month for one month; then three random test for one month; then 2 random test for one month.
6. Five random tests per month for one month; then three random test for one month; 2 random tests for one month
7. Six random tests per month for one month; then 4 random test for one month; then 2 random tests for 1 month
8. Seven random tests per month for one month; four random tests for next month; two random tests per month for next month
9. Two random tests per week for one month; four random tests for next month; two random tests per month for next month
10. Three random tests per week for one month; four random tests for next month; two random tests for next month
11. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____

3. Patch 5 panel $31.50

Detects THC, opiates, amphetamine, cocaine, and PCP.

1. One test
2. One patch per month for 3 months
3. Two random patches per month for 3 months **unless on ongoing cases there are two consecutive negative results, then the Social Worker is to change the authorization to stop further testing.**
4. Two consecutive patches
5. Four consecutive patches
6. Six consecutive patches
7. Six random patches for 3 months
8. Other, describe (must also indicate rational for choosing this option) _____ Total patches.

_____

4. Hair test 5 panel $43.50

Detects THC, opiates, amphetamine, cocaine, and PCP.

1. One Test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____

5. Lab based Saliva 5 panel $23.50

Detects THC/marijuana, cocaine, opiates, amphetamine, and PCP

1. One test
2. One test per month for ____ months/90days
3. Two random tests per month for one month; then two random tests per month for two months
4. Three random tests per month for one month; then two random tests per month for two months
5. Four random tests per month for one month; then three random tests for one month; then 2 random tests for one month
6. Five random tests per month for one month; then three random tests for one month; 2 random tests for one month
7. Six random tests per month for one month; then 4 random tests for one month; then 2 random tests for 1 month
8. Seven random tests per month for one month; four random tests for next month; two random tests per month for next month
9. Two random tests per week for one month; four random tests for next month; two random tests per month for next month
10. Three random tests per week for one month; four random tests for next month; two random tests for next month
11. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____

6. Fingernail test 12 panel $230.00

Detects THC, opiates, amphetamine, cocaine, barbiturates, benzodiazepines, methadone, meperidine, oxycodone, propoxyphene, tramadol and PCP.

1 One Test
2 . Other, describe (must also indicate rational for choosing this option) _____ Total tests.

_____

7. Saliva Alcohol -Alco Screen detects at various BAC levels $1.75

Test for alcohol only at 0.02, 0.04, 0.08, 0.30 BAC

1. One Test
2. Other, describe (must also indicate rational for choosing this option) _____ Total tests.

8. Instant Urine 5 panel dip with adulterant strip $4.25

Detects THC, cocaine, methamphetamine, benzodiazepines, and opiates screened at a lowered sensitivity of 300 ng/ml.

9. Instant Urine To detect Oxycontin use: 9 panel with adulterant strip $8.05

Detects THC, cocaine, opiates, meth, amp, benzodiazepines, propoxyphene, methadone, and oxycontin

10. Instant Saliva To detect use of prescription drugs except Oxycontin 10 panel with adulterant strip $8.25

Detects THC, cocaine, opiates, amphetamines, barbiturates, benzodiazepines, methadone, methamphetamine, PCP, and Tricyclic antidepressants.

11. Instant Saliva. Instant 6 panel Oratect HM 12 $10.50

Detects THC/marijuana, benzodiazepines, opiates, amphetamine, methamphetamine and cocaine.

12. Instant Saliva To add an alcohol test Oratect HMA 12 **$12.00**

The instant saliva (Oratect HMA12) adds a test for ethanol that detects alcohol use in the past 6-8 hours.

13. Urine GC/MS confirmation per drug $40.00

Used to confirm instant urine.

14. Saliva based confirmation per drug $45.00
Used to confirm instant salvia.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Recovery from substance abuse involves not only attaining and maintaining abstinence but also changing one's thinking, behavior, and sustaining those changes over time. When measuring progress in recovery, it is important to keep in mind a child's sense of time, the parent's progress in treatment, and the behaviors parents demonstrate that are consistent with good parenting, such as active participation in their child's health, educational and developmental activities. Moreover, in order to successfully close an intact case, the caseworker must document activities and observations that indicate a parent's progress in substance abuse recovery and the resumption of positive parenting responsibilities. The recovery matrix worksheets provide caseworkers, parents, and the court (when necessary) with criteria, guidelines and a visual representation for assessing and discussing a parent's progress in recovery and movement toward case closure over a 12-month period.

DIRECTIONS

- Following case opening, the assigned caseworker meets with the parent to introduce the recovery matrix and explain its use. There are five separate recovery matrix forms: Baseline 0-45 days, 45 - 90 days, 3-6 months, 6-9 months, and 9-12 months. These forms are used together sequentially to monitor and assess a parent's progress through the first 12 months following case opening. The caseworker completes these forms with and the parent at the designated time frames.

  In some instances, substance abuse issues are identified subsequent to the intact case being opened. Once identified, caseworkers are to complete the matrix worksheet that corresponds with the timeline following the case open date. For example, at eight months into the case, the caseworker identifies a substance abuse issue. The caseworker completes the six to nine month worksheet and indicates the date and circumstances surrounding how the substance abuse issue was identified in the Lack of Progress column. Any additional comments are to be made on the notes page.

- After introducing the recovery matrix at the caseworker's initial contact with the parent (e.g., 48 hour meeting), the caseworker meets with the parent to complete the appropriate Recovery Matrix worksheet (CFS 440-10) at the following times:

  - Prior to the 45 day Service Plan in order to establish a baseline – using the 0 – 45 day Baseline Matrix
  - At the end of 90 days – using the 45 - 90 day matrix
  - At the end of 180 (6 months) – using the 3 – 6 month matrix
  - At the end of nine months from case opening - using the 6 – 9 month matrix
  - At the end of 12 months from case opening – using the 9 to 12 month matrix NOTE: When the case is opened beyond 12 months, continue to use this matrix at three-month intervals as long as the case remains open.

- In addition to the parent's self report, the caseworker must examine additional sources of information to support completion of the recovery matrix: monthly treatment progress reports- completed by the substance abuse treatment agency, urinalysis reports, other professional collaterals, and family members.

- The caseworker should place check marks at the appropriate level of progress in both the Substance Abuse Treatment and Parenting Responsibilities columns. **Check all that apply.**

  Note: although the parent may be showing a lack of progress in one area, there may be partial progress in another. For example, a parent may be showing a lack of progress in parenting responsibilities and partial progress in substance abuse treatment. The Recovery Matrix provides the caseworker an opportunity to acknowledge the parent's strengths and progress as well as areas of needed improvement. Because recovery is not always a linear process a parent may experience periods of ambivalence and relapse. The goal is to complete substantial progress at the end of each interval in order to ensure the child's safety and to successfully close the intact case.

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State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

- The completed Recovery Matrix is signed by the caseworker and parent and then reviewed and signed by the supervisor. Each participant receives a copy before being filed. Caseworkers submit the completed Recovery Matrix with other required documentation to court personnel if court involved.

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State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Baseline Matrix-Zero – 45 days: (Complete prior to 45 day Service Plan)

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ☐ Continued to use and/or remains in denial of substance abuse/ addiction ☐ Had less than 50% clean urinalysis results ☐ Substance Exposed Infant born subsequent to case opening Date:_____ Other: _____	Parent: ☐ Failed to consistently meet with caseworker ☐ Completed substance abuse assessment but has not yet followed recommendations or entered treatment ☐ Had more than 50% clean urinalysis results ☐ Self-reported abstinence for_____ consecutive days Other: _____	Parent: ☐ Entered residential treatment- movement has not been restricted ☐ Entered recommended outpatient treatment ☐ Attending at least 80% of sessions ☐ Self-reported abstinence for the past 30 days ☐ Had all clean urinalysis for past 30 days Other: _____

Parenting Responsibilities

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent failed to: ☐ Be contacted/meet with caseworker ☐ Arrange for immunizations and medical care appointments ☐ Arrange for appropriate child care ☐ Enroll child in Head Start or other early intervention programs ☐ Attend school conferences ☐ Use non-physical forms of discipline Other: _____	Parent was inconsistently able to: ☐ Be contacted//meet with caseworker ☐ Arrange immunizations and/or schedule medical care appointments ☐ Ensure child's attendance in Head Start and school ☐ Attend school conferences ☐ Arrange for appropriate child care ☐ Use non-physical forms of discipline Other: _____	Parent consistently able to: ☐ Participate in the development of the Comprehensive Service Plan ☐ Complete all scheduled immunizations ☐ Engage in educational, health and developmental appointments ☐ Arrange/attend routine scheduled medical appointments ☐ Ensure child's attendance in Head Start and school ☐ Use non-physical forms of discipline ☐ Arrange for appropriate caregivers Other: _____

Caseworker tasks to be completed for up to 12 months: Remove barriers that would prevent entry into treatment or hinder participation in educational and medical appointments, such as childcare and transportation. Also, encourage parent's participation in these appointments and other engagement activities and significant court hearings if applicable.

Remember: Progress is measured on the matrix from time of case opening, **NOT** from time the parent became available or agreed to enter treatment. I.e. if a parent does not enter treatment until nine months following case opening, caseworkers would indicate "client continues to use and/or "failed to meet with caseworker" on the matrix worksheets for months 0-3, 3-6 and 6-9 and check lack of progress in treatment. Remind the parent that if they refuse to enter treatment and/or fail to follow treatment recommendations they might be putting their children at risk of harm and the case may be screened into court for an order of protection. Temporary Custody is sometimes the end result of these hearings. It is in the parent's best interest to deal with substance issues and fulfill parenting responsibilities while their children remain in their custody in order for the case to be closed successfully and avoid placement.

Caseworker's Signature & Date: _____

Supervisor's Signature & Date: _____

Parent's Signature & Date _____

This page of the form is to be:
- ✓ Introduced during the first contact with the parent
- ✓ Completed prior to the 45 day Service Plan
- ✓ Signed by parent, case worker and supervisor before being filed.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

45 – 90 Days from Case Opening (Complete at the end of 90 days- 3 months)

Please use Notes Section (final page) to document signifi cant events/concerns.

Substance Abuse Treatment

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ☐ Failed to meet with caseworker ☐ Continued to use and/or remains in denial of substance abuse/ addiction ☐ Had less than 50% clean urinalysis results ☐ Substance Exposed Infant born subsequent to case opening Date:_____ Other: _____	Parent: ☐ Failed to consistently meet with caseworker ☐ Completed substance abuse assessment but has not yet followed recommendations or entered treatment ☐ Had more than 50% clean urinalysis results ☐ Self-reported abstinence for_____ consecutive days Other: _____	Parent: ☐ Entered residential treatment- movement has not been restricted ☐ Entered recommended outpatient treatment ☐ Attending at least 80% of sessions ☐ Self-reported abstinence for the past 30 days ☐ Had all clean urinalysis for past 30 days Other: _____

Parenting Responsibilities

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent failed to: ☐ Be contacted/meet with caseworker ☐ Arrange for immunizations and medical care appointments ☐ Arrange for appropriate child care ☐ Enroll child in Head Start or other early intervention programs ☐ Attend school conferences ☐ Use non-physical forms of discipline Other: _____	Parent was inconsistently able to: ☐ Be contacted//meet with caseworker ☐ Arrange immunizations and/or schedule medical care appointments ☐ Ensure child's attendance in Head Start and school ☐ Attend school conferences ☐ Arrange for appropriate child care ☐ Use non-physical forms of discipline Other: _____	Parent consistently able to: ☐ Engage/participate in services recommended on the Comprehensive Service Plan ☐ Complete all scheduled immunizations ☐ Engage in educational, health and developmental appointments ☐ Arrange/attend routine scheduled medical appointments ☐ Ensure child's attendance in Head Start and school ☐ Use non-physical forms of discipline ☐ Arrange for appropriate caregivers Other: _____

Caseworker tasks to be completed for up to 12 months: Remove barriers that would prevent entry into treatment and/or hinder participation in educational and medical appointments, such as childcare and transportation. Encourage & support participation.

Remember: Progress is measured on the matrix from time of case opening, **NOT** from time the parent became available or agreed to enter treatment. I.e. if a parent does not enter treatment until nine months following case opening, caseworkers would indicate "client continues to use and/or "failed to meet with caseworker " on the matrix worksheets for months 0-3, 3-6 and 6-9 and check lack of progress in treatment. Remind the parent that if they refuse to enter treatment and/or fail to follow treatment recommendations they might be putting their children at risk of harm and the case may be screened into court for an order of protection. Temporary Custody is sometimes the end result of these hearings. It is in the parent's best interest to deal with substance issues and fulfill parenting responsibilities while their children remain in their custody in order for the case to be closed successfully and avoid placement.

Caseworker's Signature & Date:

Supervisor's Signature & Date:

Parent's Signature & Date

This page of the form is to be:
- ✓ Completed at the end of 3 months (90 days)
- ✓ Signed by parent, caseworker and supervisor before being filed.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Three to 6 Months from Case Opening (Complete at end of 6 months)

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ☐ Failed to meet with caseworker ☐ Continued to use and/or remains in denial of substance abuse/ addiction ☐ Failed to obtain substance abuse assessment ☐ Failed to follow recommendations of substance abuse assessment ☐ Had less than 50% clean urinalysis results ☐ Initially engaged in treatment but left against staff advice (ASA) ☐ Discharged from treatment program for antisocial behavior and/or numerous unexcused absences ☐ Failed to attended 12-Step or other community support groups ☐ Substance abuse issues were not identified until the following Date:_____ ☐ Substance Exposed Infant born subsequent to case opening Date:_____	Parent: ☐ Entered residential treatment & movement not restricted ☐ Entered outpatient treatment, attended 50% of outpatient treatment sessions with few unexcused absences ☐ Developed relapse prevention plan ☐ Identified relapse triggers and discussed them with worker and/or family members ☐ Identified and/or started attending 12-Step meetings or other community support groups ☐ Identified 12-Step sponsor or community support person(s) ☐ Able to self report relapse ☐ Self-reported abstinence for 30 days ☐ Had clean urinalysis for the past 30 days ☐ Began building a drug-free support network Program and/or family members have reported that parent: ☐ Acknowledged the impact substance abuse had on child's well being and the quality of family relations ☐ Improved insight into effects of substance abuse	Parent: ☐ Successfully completed treatment or stepped down to a lower level of treatment ☐ If still in treatment, attendance exceeds 80 % ☐ Informed worker and or family of aftercare & relapse plans ☐ Regularly attended 12-Step or other community support groups ☐ Has 12-Step sponsor or other community support person(s) ☐ Self-reported abstinence for the past 60 days ☐ Had all clean urinalysis for past 60 days ☐ Involved in drug-free/sober relationships and/or activities ☐ Established a drug-free support network (Include: job training, employment readiness, employment, school, YMCA, church, etc) ☐ Reciprocated positive support received from non-drug using family and friends have offered ☐ Continued improved insight into effects of substance abuse

Parenting Responsibilities

Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent failed to: ☐ Failed to meet with caseworker ☐ Arrange for immunizations and medical care appointments ☐ Arrange/attend 0-3 screen ☐ Arrange for appropriate child care ☐ Enroll child in Head Start or other early intervention programs ☐ Attend school conferences ☐ Use non-physical forms of discipline Other: _____	Parent was inconsistently able to: ☐ Be contacted//meet with caseworker ☐ Arrange immunizations and/or schedule medical care appointment ☐ Arrange/attend 0-3 screens ☐ Ensure child's attendance in Head Start and school ☐ Attend school conferences ☐ Arrange for appropriate child care ☐ Use non-physical forms of discipline Other: _____	Parent consistently able to: ☐ Engage/participate in Comprehensive Service Plan recommendation ☐ Completed all scheduled immunizations ☐ Volunteer (Head-Start, school, etc.) ☐ Attended 0-3 screen/recom. services ☐ Engage in educational, health and developmental appointments ☐ Arrange/attend routine scheduled medical appointments ☐ Ensure child's attendance in Head Start and school ☐ Use non-physical forms of discipline ☐ Arrange for appropriate caregivers Other: _____

Caseworker's Signature & Date: _____

Supervisor's Signature & Date: _____

Parent's Signature & Date _____

This page of the form is to be:
- ✓ Completed at the end of 6 Months
- ✓ Signed by parent, caseworker and supervisor before being filed.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Six to 9 Months from Case Opening (Complete at end of 9 months)

Please use Notes Section (final page) to document significant events.

Substance Abuse Treatment

Lack of Progress	Partial Progress	Substantial Progress
Parent: ☐ Failed to meet with caseworker Unable to be contacted/located ☐ Continued to use and/or remains in denial of substance abuse/ addiction ☐ Failed to obtain substance abuse assessment ☐ Participated in substance abuse treatment, but currently not in TX, or left against staff advice (ASA) ☐ Discharged from treatment for non-compliance, aggressive behavior, antisocial behavior and/or numerous unexcused absences ☐ Had less than 50% clean urinalysis results ☐ Substance abuse issues were not identified until the following Date:_____ ☐ Substance Exposed Infant born subsequent to case opening Date:_____	Parent: ☐ Consistently attended substance abuse treatment with few unexcused absences ☐ Self-reported abstinence for the past 60 days ☐ Identified 12-Step sponsor or community support person ☐ Inconsistently attended 12-Step meetings or other community support group ☐ Developed relapse prevention plan, including relapse triggers and discussed them with worker and/or family members ☐ If relapse occurred, parent able to self disclose and reengaged in treatment within one week ☐ Developed and shared relapse prevention plan with 12-Step sponsor and/or other informal support networks ☐ Support system confirmed drug free time ☐ Had all clean urinalysis for past 30 days Program and/or family members have reported that parent: ☐ Engaged in recommended after care services/activities	Parent: ☐ Successfully completed treatment ☐ Self-reported abstinence for the past 90 days ☐ Consistently worked self help group ☐ Attended self-help meetings and maintained regular contact with sponsor or mentor ☐ Accepted into a recovery home, transitional living program or is residing with non-drug using relative or friends ☐ Involved in drug-free/sober relationships and/or activities ☐ Established a drug-free support network (Incl. job or employment readiness training, employment, school, YMCA, church, etc) as evidenced by _____ ☐ Support network confirmed drug free time ☐ Had all clean urinalysis for past 90 days ☐ Reciprocated positive support from non drug using family and friends Program and/or family members have reported that parent: ☐ Demonstrated and understands new coping skills learned in treatment or in 12 step groups

Parenting Responsibilities

Lack of Progress	Partial Progress	Substantial Progress
Parent failed to: ☐ Failed to meet with caseworker ☐ Arrange for immunizations and medical care appointments ☐ Arrange/attend 0-3 screen ☐ Arrange for appropriate child care ☐ Enroll child in Head Start or other early intervention programs ☐ Attend school conferences ☐ Use non-physical forms of discipline Other: _____	Parent inconsistently able to: ☐ Be contacted/meet with caseworker ☐ Arrange for immunizations and schedule medical care appointments ☐ Arrange/attend 0-3 screen ☐ Ensure child's attendance in Head Start and school ☐ Attend school conferences ☐ Arrange for appropriate child care ☐ Use non-physical forms of discipline Other: _____	Parent was consistently able to: ☐ Engage/participate in Comprehensive Service Plan recommendation ☐ Completed all scheduled immunizations ☐ Arrange/attend 0-3 screen ☐ Engage in educational, health and developmental appointments ☐ Arrange/attend routine scheduled medical appointments ☐ Ensure child's attendance in Head Start and school ☐ Use non-physical forms of discipline ☐ Arrange for appropriate caregivers ☐ Volunteers (Head-Start, school, etc.) Other: _____

Caseworker' Signature & Date: _____

Supervisor's Signature & Date: _____

Parent's Signature & Date: _____

This page of the form is to be:
- ✓ Completed at the end of 9 Months.
- ✓ Signed by parent, caseworker, and supervisor before being filed.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services

Recovery Matrix – Intact Cases

Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Nine to 12 Months from Case Opening (Complete quarterly as long as case remains)*

Please use Notes Section (final page) to document significant events/concerns.

Substance Abuse Treatment

Lack of Progress

Parent:

- ☐ Failed to contact/meet with caseworker
- ☐ Continued to use and/or remains in denial of substance abuse/ addiction
- ☐ Failed to obtain substance abuse assessment
- ☐ Initially engaged in treatment but prematurely left against staff advice (ASA)
- ☐ Discharged from treatment for non-compliance, aggressive behavior, and/or numerous unexcused absences
- ☐ Had less than 50% clean urinalysis results
- ☐ Substance abuse issues were not identified until the following Date:_____
- ☐ Substance Exposed Infant born subsequent to case opening Date:_____

Partial Progress

Parent:

- ☐ Consistently attended substance abuse treatment with few unexcused absences
- ☐ Self-reported abstinence for the past 90 days
- ☐ Identified 12-Step sponsor or community support person(s)
- ☐ Inconsistently attended 12-Step or other community support group(s)
- ☐ Developed relapse prevention plan, including relapse triggers and discussed them with worker and/or family members
- ☐ If relapse occurred, parent able to self disclose and reengaged in treatment within one week of relapse
- ☐ Developed/shared a relapse prevention plan with 12-Steps sponsor other informal support networks
- ☐ Support network confirmed drug free time
- ☐ Clean urinalysis for past 60 days

Program and/or family members have reported that parent:

- ☐ Engaged in recommended after care services/activities

Substantial Progress

Parent:

- ☐ Successfully completed treatment
- ☐ Self-reported abstinence for the past 120 days
- ☐ Consistently worked 12-Step and other community support program, attended self-help meetings and maintaining regular contact with sponsor
- ☐ Accepted into a recovery home, transitional living program or is residing with non-drug using relative or friends
- ☐ Involved in drug-free/sober relationships and/or activities
- ☐ Support network confirmed drug free time
- ☐ Had all clean urinalysis for past 120 days
- ☐ Established a drug-free support network (Incl. job or employment readiness training, employment, school, YMCA, etc) as evidenced by _____
- ☐ Reciprocated positive support received from non drug using family and friends

Program and/or family members have reported that parent:

- ☐ Demonstrated and understands new coping skills learned in treatment or in 12 step or other self-help groups as evidenced by _____

Parenting Responsibilities

Lack of Progress

Parent failed to:

- ☐ Arrange for immunizations and medical care appointments
- ☐ Arrange/attend 0-3 screen
- ☐ Arrange for appropriate child care
- ☐ Enroll child in Head Start or other early intervention programs
- ☐ Attend school conferences
- ☐ Use non-physical forms of discipline

Other: _____

Partial Progress

Parent inconsistently able to:

- ☐ Contact/meet with caseworker
- ☐ Arrange for immunizations and /or schedule medical care appointments
- ☐ Arrange/attend 0-3 screen
- ☐ Ensure child's attendance in Head Start and school
- ☐ Attend school conferences
- ☐ Arrange for appropriate child care
- ☐ Use non-physical forms of discipline

Other: _____

Substantial Progress

Parent was consistently able to:

- ☐ Completed the majority of services recommended on the Comprehensive Service Plan
- ☐ Complete all schd. immunizations
- ☐ Arrange/attend 0-3 screen
- ☐ Engage in educational, health and developmental appointments
- ☐ Arrange/attend routine scheduled medical appointments
- ☐ Volunteer (Head-Start, school, etc.)
- ☐ Used non-physical forms of discipline
- ☐ Arrange for appropriate caregivers

Caseworker's Signature & Date: _____

Supervisor's Signature & Date: _____

Parent's Signature & Date: _____

This page of the form is to be:

- ✓ Completed at the end of 12 Months.*
- ✓ Signed by parent, caseworker and supervisor before being filed.

CFS 440-10
09/2006

State of Illinois
Department of Children and Family Services
Recovery Matrix – Intact Cases
Indicators for Progress in Substance Abuse Recovery and Parenting Responsibilities

Use this section to include information such as additional substance exposed births and other significant events and extenuating circumstances critical to the case. Also use this page to include examples for "as evidenced by."

Notes Section:

Case Name & DCFS ID: _____

Caseworker's Signature & Date: _____

Supervisor's Signature & Date: _____

Parent's Signature & Date: _____