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Substance Screening: Guidelines & Recommendations

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Division of Family Services

The Division of Family Services (DFS) introduces a resource for local departments of social services to reference and use to develop or revise drug screening guidelines. This guide was developed with participation across program areas. DFS would like to thank the following persons and agencies for their participation and support in the development of this resource:

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Most of the information in this document is from the National Center on Substance Abuse and Child Welfare. The NCSACW is a national resource center providing information, expert consultation, training and technical assistance to child welfare, dependency court and substance use treatment professionals to improve the safety, permanency, well-being and recovery outcomes for children, parents and families.

1 Purpose of Substance Screening/Testing in Child Welfare

Parental substance use affects many families who come to the attention of child welfare services. Alcohol and other drug use can impair a caregiver's judgement and ability to provide the consistent care, supervision and guidance that children need. Child Welfare is charged with ensuring the safety and well-being of children and must determine whether a caregiver's substance use jeopardizes a child's safety or creates risk. Child welfare professionals face the difficult tasks of:

- Collecting adequate information about families
- Making informed and insightful decisions based on that information
- Taking timely and appropriate action to keep children safe.[1]

Testing for substances is only **one** component of a comprehensive assessment of safety threats, protective capacities and treatment needs. It is a part of an overall assessment the Family Services Specialist (FSS) will complete when assessing for substance use/misuse and its impact on the following:

- Parental behavior and physical impairment
- Emotional responses/attachment to children
- Physical health and well-being of children
- Interactions and bonding between the children and adults
- Family finances, employment, and criminal activity

[1] National Center on Substance Abuse and Child Welfare (2021). Considerations for Developing a Child Welfare Drug Testing Policy and Protocol. https://ncsacw.acf.hhs.gov/topics/drug-testing-child-welfare.aspx

Drug tests are only ***tools***. They are limited to determining whether an individual has used a specific substance during a particular window of time. Drug tests alone cannot provide information on the severity of an individual's substance use, progress in recovery, or the effects on parenting capacity. Safety concerns must still be assessed by observing the home environment and the caretaker's demeanor and ability to safely care for the child. Above all, decisions and outcomes on cases should not rely solely on drug test results.

2 LEGAL BACKGROUND

The Virginia Administrative Code (VAC) provides the legal authority for conducting substance screenings.

(22 VAC 40-705-90 D). When a child protective services worker has reason to believe that the caretaker in a valid report of child abuse or neglect is abusing substances **and** such behavior may be related to the matter being investigated or assessed, the worker **may** request that person to consent to substance abuse screening or **may** petition the court to order such screening.
1. Local departments **must** develop guidelines for such screening.
2. Guidelines **may** include child protective services worker administration of urine screening.

3 SCREENING FOR SUBSTANCES VERSUS DRUG TESTING[2]

Technically, "screening" is different from "testing", although frequently the two terms are used interchangeably. For purposes in these guidelines, the term "screening" refers to a process of gathering information, which can include testing, to help determine a need for further evaluation or services. The term "testing" refers to the collection of a specimen to determine whether an individual has used a specific substance during a particular window of time. It is important to understand how these terms are used by the courts, Substance Use Disorder (SUD) treatment providers and other community partners.

[2] *Understanding Screening and Assessment of Substance Use Disorders- Child Welfare Practice Tips.* National Center on Substance Abuse and Child Welfare. https://ncsacw.acf.hhs.gov/files/tips-screening-assessment-508.pdf

All families should be screened for substance use as well as domestic violence and mental health issues. The purpose of screening is to determine the presence of substance use and identify the need for further clinical SUD assessment. Screening provides workers the opportunity to identify family strengths, develop services, monitor progress, address challenges and connect them to services. When screening, the Family Services Specialist (FSS) should gather information from a variety of sources including:

- Valid screening tools
- A review of corroborating reports
- Signs and symptoms
- Drug testing

3.1 Screening Tools

There are many screening tools available. Using standardized and validated SUD screening tools for all families helps reduce overidentification of people of color and disparity in outcomes for families. Screening tools should be culturally responsive and linguistically appropriate for accurate results.

The National Institute on Drug Abuse has a website devoted to Screening and Assessment Tools. The chart in this link will show what tool can be used, what substances are being screened for, the person's age who is being screened, and how the tool is administered.

Additional screening tools can be found at: https://dbhds.virginia.gov/library/mental%20health%20services/screener-perinatal.pdf .

3.2 Review reports

The FSS should review any available reports that indicate a potential concern for a substance use disorder such as police reports, criminal history, court records and prior CPS reports.

3.3 Signs and symptoms

What are some things to look for when conducting an assessment? Specific drugs have specific physiological effects. Potential signs and symptoms of substance use to look for include:

Personal Appearance	*Behavioral Signs*	*Physical Environment*
• Change in speech (such as slurred speech, more rapid than usual) • Nodding off • Disorientation • Tremors • Cold or sweaty palms • Dilated or constricted pupils • Bloodshot or glazed over eyes • Needle marks • Bruises • Poor personal hygiene • Disheveled appearance • Sores on face	• A change in usual attitude or behavior • Agitated behavior or mood • Excessive talking • Paranoia • Depression • Manic behavior • Lack of Motivation • Financial challenges • Missed appointments • Missing work; change in employment status	• Signs of drug paraphernalia (such as straws, rolling papers, razor blades, glass pipes, aluminum foil, needles, syringes, spoons, etc.) • Unusual smells or chemical odors • Reluctance to allow home visits

3.4 DRUG TESTING

In addition to drug testing within child welfare, drug testing is frequently done elsewhere such as the courts and SUD Treatment Settings. Courts typically use drug testing to monitor compliance and provide legal documentation. SUD treatment providers commonly use drug testing as a tool to help clinically diagnose a SUD, plan treatment, monitor progress, and support recovery. A collaborative, teamed approach is always recommended for working with this population. Having a clear understanding of drug testing across systems is important. Remember there are other key community partners serving parents affected by SUDs that child welfare can partner with. Other partners might include family treatment courts, birthing centers or hospitals that serve pregnant women with SUDs, mental health service providers, supportive housing, home visiting programs, and persons with lived experience. If one does not exist, consider establishing a diverse collaborative team to align their efforts, gain an understanding of how each system uses drug testing, develop an understanding of how drug testing results will be shared across systems, and align policies and practices to promote recovery for parents and caregivers.[3]

[3] https://ncsacw.acf.hhs.gov/files/drug-testing-brief-1-508.pdf

4 When Testing for Substances is Recommended

Screening or assessing for substance use should occur in all cases. Remember, **drug testing** is used to determine whether an individual has used a specific substance during a particular window of time. Drug testing cannot provide information on the nature or severity of someone's substance use or determine whether a child is safe. In child welfare, drug testing should be part of a **comprehensive approach** that includes evidence-based screening, comprehensive assessment, and collaboration with SUD treatment providers to determine if a caregiver has a SUD and the need for further treatment.

Recommend drug testing be done:

- When a valid CPS report includes allegations regarding substance use or misuse
- When investigating a child fatality, testing of caretakers at time of death
- When the court has ordered drug testing/screening to be completed by the agency
- When there is a reasonable suspicion of drug use and the FSS has reason to believe the use of substances affects the safety of the child or risk of future maltreatment
- If the service plan (In-home or Foster Care) specifies the need

4.1 Drug Testing and SDM Safety Assessment

Drug testing may be indicated due to identified safety concerns that have been reported and/or observed. The following safety factors found on the SDM Safety Assessment specifically take drug use/misuse into consideration. Drug testing is recommended if the safety assessment results in a **yes** response for any of these safety factors based on the highlighted definition:

Safety Factor 3: There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern. This can include - **Caretaker or infant's level of toxicity and/or type of drug present** suggests caretaker will be unable to meet the infant's basic needs upon discharge.

Safety Factor 5: Caretaker does not provide supervision necessary to protect child from potentially serious harm. This can include - **Caretaker's substance or alcohol use is having a serious impact** on ability to provide adequate supervision to the child.

Safety Factor 9: Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status. This can include - Dangerous **drugs are being manufactured** on premises with child present.

4.2 Drug Testing in Child Welfare, the Courts and SUD Treatment

Child welfare, the courts, and SUD treatment programs all play a unique role supporting parents and caregivers affected by SUDs. Each of these systems may have their own purpose for using drug testing. It is important to consider these different perspectives when creating a policy designed to achieve the shared goal of recovery for parents and caregivers.

Drug testing should not be the only tool that child welfare uses when there is a concern regarding a parent's substance use. It should be one part of a **comprehensive** approach that includes screening, assessment, and referral to treatment in a manner that facilitates recovery.

The following table illustrates what drug testing can provide to child welfare, court, and SUD treatment systems.

CHILD WELFARE	COURTS	SUD TREATMENT
• Information about whether a parent or caregiver is using a substance and what type(s) of substances they are using at a point in time • Monitor substance use or abstinence during an ongoing child welfare case • Motivation and positive reinforcement for parents/caregivers in the early stages of recovery	• Legal documentation of a parent's/ caregiver's substance use or lack thereof to guide decisions about reunification or termination of parental rights along with information from other assessments • Motivation and positive reinforcement for parents/caregivers in the early stages of recovery	• Objective data to assess substance use and monitor progress during treatment • An opportunity to engage a parent or caregiver about their substance use and increase motivation to change • Accountability for clients and agencies • To support therapeutic progress and identify at the earliest point when additional or different

• Information for the case planning process		treatment, services, and supports are needed

5 CONSIDERATIONS FOR WHEN TESTING FOR SUBSTANCES MAY NOT BE NECESSARY

There will be times when drug testing may not be indicated, recommended, or necessary. Absent a court order, drug testing may not be necessary when:

- No concerns of substance use in the valid CPS report
- No history of substance use concerns with any of the caregivers
- No observable suspicions that substance use is affecting the ability to safely parent the children (See Section III C: Signs and symptoms-above)
- Drug testing of relatives/fictive kin who apply for custody. (Unless there is reason to suspect usage)
- When the goal is NOT Return Home or reunification and no services provided to members of the home of origin
- When the caregiver is already an active participant in a SUD treatment program that performs drug testing
- When a parent self-reports a relapse, however it may help to identify substances and a baseline

Additionally, drug testing results should not be the sole factor to:

- Determine parent-child family time (visitation)
- Make decisions about child removal, reunification, or termination of parental rights
- Substantiate a child abuse or neglect allegation in the absence of a comprehensive investigation and family assessment

6 ENGAGING WITH THE FAMILY

When working with caregivers who may use or misuse substances, a critical part of engaging the family is having open and honest communication with them. Remember, punitive use of drug testing can inhibit recovery and prove harmful to families. The following approach is recommended to increase opportunity to **engage** with the family.

One of the first important steps to take before drug testing is to discuss the purpose of drug testing, the process, and any potential consequences with the caregiver. This discussion should allow the caregiver to self-disclose what the drug test results are likely to reveal along with their past use of illicit drugs and/or misuse of prescription drugs. The FSS should also make clear to the caregiver the possible consequences of positive and negative results; and explain that drug screening is **one** aspect of information gathered by the FSS to determine safety and risk factors for their child. FSS should explain that refusing to complete a requested drug test makes it more difficult to determine if a child is safe; or able to return home; or that the best drug treatment interventions have been put in place. A refusal to drug test is typically documented as a presumptive positive as a precaution to the child's safety.

After the drug test, the following open and honest communication is suggested:

1. Discuss the results with the parent as soon as possible to help assess the child's safety and risk. Results are only one indicator of potential safety and risk concerns. Determine the child's location when the parent engaged in substance use, if the parent used the existing safety plan to protect the child, and what protective factors are present that can mitigate any potential safety/risk concerns.
2. Use a strength-based approach to provide the parent an opportunity to discuss the results, either admitting to substance use, or challenging the results, in which case, it is recommended a lab test may be needed to confirm the results.
3. Provide responses geared toward motivating the parent to engage or re-engage with SUD treatment and recovery supportive services. If a parent is attending a recovery support group (e.g., Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery, etc.), encourage them to attend a meeting that day.
4. If the parent currently receives SUD treatment, ask their provider to discuss the drug test results and treatment progress. Explore how to develop a shared and consistent response that supports both child safety and parent recovery, and if the parent should be reassessed for a higher level of care.
5. Help the parent connect to a SUD treatment provider for an assessment if they are not currently engaged in SUD treatment services using motivational strategies.
6. Consider meeting with the family's informal (e.g., relatives, friends, etc.) and formal supports (e.g., therapist, other professionals, etc.) to discuss the return to use, potential safety and risk factors, the child's safety and well-being during family time, as well as next steps.
7. Help the parent determine next steps and talk through any challenges or anticipated barriers.
8. A lapse can ideally provide the parent with a chance to learn from the experience. It is a potential time for a parent to figure out what helps or hinders their recovery efforts while they still have a supportive network.

It is important for child welfare workers, SUD treatment staff, and dependency court professionals to view drug testing as a **therapeutic tool** that can inform decisions, help parents recognize the need for treatment, and/or promote discussions about what is and is not currently working for them to support recovery.

Substance misuse often stems from trauma and acts as a coping mechanism. When the coping mechanism disappears, it can result in fear, anxiety, guilt, and a return to substance use. Individuals with a SUD need time to fully heal and learn how to handle everyday life stressors using new, healthy coping skills.

Child welfare workers can use a strength-based, non-punitive approach with parents if there is a discrepancy between a test result and a parent's self-report. Start by asking the parent what they think would happen if the drug test was accurate in detecting a substance. Based on the parent's response, help them understand why there may be errors in their thought process. Stress that child welfare is there to support them and ensure their family receives the help and support they need. Using an empathetic approach of, "I am worried about you, how can I help?" may allow the parent to feel safe enough to confide.

7 Language Matters

The language we use has a profound effect on our attitudes and beliefs; our words can either perpetuate or overcome stereotypes, prejudice, and lack of empathy towards others. Defining key terms, using person first language and being mindful of stigmatizing language can prompt values discussions and serve as a starting point for this work.[4]

Words Matter: Preferred Language for Talking About Addiction from The National Institute on Drug Abuse

Words Matter: Terms to Avoid When Talking About Addiction by NIDAMED

The chart below can help you choose words to reduce stigma and use person-first language when talking about addiction.

[4] National Center on Substance Abuse and Child Welfare (2021). Considerations for Developing a Child Welfare Drug Testing Policy and Protocol. https://ncsacw.acf.hhs.gov/topics/drug-testing-child-welfare.aspx

When Talking About Yourself or Others with Substance Use Disorder (SUD)

Use…	Instead of…	Because…
▪ **Person with a substance use disorder**[10] ▪ **Person with an opioid use disorder (OUD) or person with opioid addiction**	▪ Addict ▪ User ▪ Substance or drug abuser ▪ Junkie	▪ Using person-first language shows that SUD is an illness. ▪ Using these words shows that a person with a SUD "has" a problem/illness, rather than "is" the problem.[6] ▪ The terms elicit negative associations, punitive attitudes, and individual blame.[6]
▪ **Person with alcohol use disorder** ▪ **Person who misuses alcohol/engages in unhealthy/hazardous alcohol use**	▪ Alcoholic ▪ Drunk	
▪ **Person in recovery or long-term recovery/person who previously used drugs**	▪ Former addict ▪ Reformed addict	
▪ **Testing positive (on a drug screen)**	▪ Dirty ▪ Failing a drug test	▪ Use medically accurate terminology the same way it would be used for other medical conditions.[8] ▪ These terms may decrease a person's sense of hope and self-efficacy for change.[6]

When Talking about Using Substances

Use…	Instead of…	Because…
▪ **Substance use disorder** ▪ **Drug addiction**	▪ Habit	▪ "Habit" implies that a person is *choosing* to use substances or can *choose* to stop. This implication is inaccurate.[5] ▪ Describing SUD as a habit makes the illness seem less serious than it is.
▪ **Use** (for illicit drugs) ▪ **Misuse** (for prescription medications used other than prescribed)	▪ Abuse	

When Talking about Recovery and Treatment

Use…	Instead of…	Because…
▪ **Medication treatment for OUD** ▪ **Medications for OUD** ▪ **Opioid agonist therapy** ▪ **Pharmacotherapy** ▪ **Medication for a substance use disorder**	▪ Opioid substitution ▪ Replacement therapy ▪ Medication-assisted treatment (MAT)	▪ It is a misconception that medications merely "substitute" one drug or "one addiction" for another. [5] ▪ The term MAT implies that medication should have a supplemental or temporary role in treatment. ▪ Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.

When Talking about Recovery and Treatment

Use…	Instead of…	Because…

Talking about Babies Born to Parents Who Used Drugs

Use…	Instead of…	Because…
▪ **Baby born to a parent who used drugs while pregnant** ▪ **Baby with signs of withdrawal from prenatal drug exposure** ▪ **Newborn exposed to substances** ▪ **Baby with neonatal abstinence syndrome**	▪ Addicted baby	▪ Babies cannot be born with addiction because addiction is a behavioral disorder. ▪ Using person-first language can reduce stigma. ▪ Use of medical terminology (the same way you would for other illnesses) can help reduce stigma.[8]

7.1 References for Language Matters chart

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5937046
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5854406
3. https://www.ncbi.nlm.nih.gov/pubmed/31140667

4. https://apastyle.apa.org/6th-edition-resources/nonhandicapping-language
5. https://obamawhitehouse.archives.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf
6. www.thenationalcouncil.org/wp-content/uploads/2016/10/Substance-Use-Teminology.pdf
7. https://journals.sagepub.com/doi/abs/10.1177/002204261004000403
8. https://jamanetwork.com/journals/jama/article-abstract/1838170
9. https://pubmed.ncbi.nlm.nih.gov/29863411/
10. https://pubmed.ncbi.nlm.nih.gov/31551647/

8 DRUG TESTING CONSIDERATIONS[5]

Child welfare staff must establish and understand the collection method, protocols, and chain of custody regardless of the type of test selected. If the agency chooses point-of-care testing, it is important to determine **who** will collect the samples. When agencies use laboratory testing and/or confirmation, particularly in cases with court oversight in which testing results may be used as evidence, they must determine **how** to collect samples using a chain of custody procedure. For more information on types of testing, tests panels, adulterants, and collection information, please refer to SAMHSA's Clinical Drug Testing in Primary Care – Technical Assistance Publication 32.

8.1 TYPES OF TESTING

TYPE OF TEST	*ADVANTAGES*	*DISADVANTAGES*
Urine	• Available in sufficient quantities • Higher concentrations of parent drugs and/ or metabolites than in blood • Availability of point-of care tests (POCTs) • Well-researched testing techniques	• Short to intermediate window of detection • Easy to adulterate or substitute • May require observed collection • Some individuals experience "shy bladder" syndrome and cannot produce a specimen
Oral Fluid	• Noninvasive specimen collection • Easy to collect • Reduced risk of adulteration	• Limited specimen volume

[5] National Center on Substance Abuse and Child Welfare (2021). Considerations for Developing a Child Welfare Drug Testing Policy and Protocol. https://ncsacw.acf.hhs.gov/topics/drug-testing-child-welfare.aspx

	• Directly observed specimen collection Parent drug rather than metabolite can be the target of the assay • Able to detect same-day use in some cases • Availability of POCTs • Detect residual drug in the mouth	• Possibility of contamination from residual drug in mouth that cannot be correlated with blood concentrations • Short window of detection • Requires supervision of patient for 10−30 minutes before sampling • Salivation reduced by stimulant use • Need for elution solvent to efficiently remove drugs absorbed to collection device • Cannabinoids in oral fluid have been shown to arise from contamination of the oral cavity rather than excretion in saliva from blood
Sweat	• Detects recent use (fewer than 24 hours with a sweat swipe) or allows for cumulative testing with the sweat patch (worn for up to 7–14 days) • Noninvasive specimen collection • Difficult to adulterate • Requires little training to collect specimen • May be an economical alternative to urine	• Few facilities and limited expertise for testing • Risk of accidental or deliberate removal of the sweat patch collection device Unknown effects of variable sweat excretion among individuals • Only a single sweat collection patch available so multiple analyses cannot be done if needed (i.e., more than one positive initial test) • May be affected by external contaminants • Requires two visits, one for patch placement and one for patch removal
Blood	• Generally, detects recent use • Established laboratory test method	• Expensive, except to detect ethanol Limited window of detection • Invasive specimen collection (venipuncture) • Risk of infection • Requires training to collect specimen • May not be an option for individual with poor venous access
Hair	• Longest window of detection	• Cannot detect use within the previous 7–10 days • Difficult to interpret results

	• May be able to detect changes in drug use over time (from 7–10 days after drug use to 3 months, depending on length of hair tested) • Directly observed specimen collection • Noninvasive specimen collection • Four tests will cover 1 year • Easy storage and transport • Difficult to adulterate or substitute • Readily available sample, depending on length of hair tested	• Costly and time consuming to prepare specimen for testing • Few laboratories available to perform testing • No POCTs currently available • Difficult to detect low level use (e.g., single-use episode) • May be biased with hair color (dark hair contains more of some basic drugs [cocaine, methamphetamine, opioids] due to enhanced binding to melanin in hair) • Possibility of environmental contamination • Specimen can be removed by shaving
Breath	• Well-established method for alcohol testing • Readily available	• Used only for alcohol and other volatiles • Short window of detection • May be difficult to obtain adequate sample, especially with patients who are very intoxicated or uncooperative • Uncommon in clinical setting
Meconium	• Can detect maternal drug use and fetal or infant exposure • Wide window of drug detection (third trimester of gestation) • Noninvasive collection from diaper • Generally, adequate specimen amount	• Narrow collection window can be missed, especially in babies with low birth weight • Testing not available in all labs • Requires extra steps (weighing and extraction) • Confirmation assays more difficult than for urine

The following chart may be useful in determining which type of drug testing is best. It is important to refer to the drug test manufacturer's information.

Detection Windows by Drug Test Type				
Substance	***Urine***	***Hair***	***Oral Fluid***	***Sweat***

Alcohol	*10-12 hours* *Up to 48 hours*	*n/a*	*Up to 24 hours*	*n/a*
Amphetamines	*2-4 days*	*Up to 90 days*	*1-48 hours*	*7-14 days*
Methamphetamine	*2-5 days*	*Up to 90 days*	*1-48 hours*	*7-14 days*
Barbiturates	*Up to 7 days*	*Up to 90 days*	*n/a*	*n/a*
Benzodiazepines	*Up to 7 days*	*Up to 90 days*	*n/a*	*n/a*
Cannabis (Marijuana)	*1-30 days*	*Up to 90 days*	*Up to 24 hours*	*7-14 days*
Cocaine	*1-3 days*	*Up to 90 days*	*1-36 hours*	*7-14 days*
Codeine (Opiate)	*2-4 days*	*Up to 90 days*	*1-36 hours*	*7-14 days*
Morphine (Opiate)	*2-5 days*	*Up to 90 days*	*1-36 hours*	*7-14 days*
Heroin (Opiate)	*2-3 days*	*Up to 90 days*	*1-36 hours*	*7-14 days*
PCP (Phencyclidine)	*5-6 days*	*Up to 90 days*	*n/a*	*7-14 days*
LSD, Mushrooms, Synthetic Cannabinoids, Ecstasy (MDMA) will NOT be detected by typical drug testing.				

Video for Drug Testing Cut off Levels and Detection Windows by National Drug Screening, Inc. :
https://www.nationaldrugscreening.com/blogs/drug-testing-cut-off-levels-and-detection-times/

8.2 Frequency of Testing

Testing guidelines should indicate **when** a drug test is administered throughout the life of a child welfare case—from the initial investigation/assessment to case closure. Guidelines need to clearly define **who** gets tested and **under what circumstances**. Initial investigation/assessment drug testing procedures may differ from those in an ongoing case.

At the beginning, drug testing is often used as **one tool** to identify substance use and determine the need for a referral to SUD assessment and treatment.

For in-home and foster care cases, drug testing informs case planning and acts as a monitoring tool.

Guidelines and practices must be equitable across subpopulations of parents, applied consistently, and provide thorough guidance if variations exist.

8.3 Prescription Medication

Drug Testing provides limited information about the use/misuse of prescribed medications. When a drug test detects prescription medications, child welfare workers need to determine if the parent is using them as prescribed. If the parent has obtained prescription medications through a physician, ask the parent to sign a Release of Information to verify. Then, speak with the physician to determine 1) the reason for the medication, 2) if they believe the parent is using the prescription in an appropriate manner, and 3) if they have any concerns regarding side effects that may impede daily living skills.

There are also prescribed medications that can cause false positive test results. One resource is Web MD: https://www.webmd.com/drug-medication/ss/slideshow-drugs-false-positive-test.

If there are concerns about positive results and the person being tested has prescription medications, it is recommended to have the sample tested at a laboratory and provide a list of all medications prescribed to confirm the test results.

9 Methods of Funding Considerations

*A*n important consideration when developing drug screening guidelines is the cost. This section may not need to be included in your guidelines but should be discussed internally. Consider the following:

- Drug testing can be expensive. Determining the budget at the start will help guide many of the decisions about who will conduct drug testing, who receives testing, the frequency of testing, and the type used. The agreed upon purpose should drive budget decisions. If drug testing is just one mechanism to determine whether substance use is a factor in a case, the budget will guide decisions about which (and how often) parents or caregivers undergo testing.
- As noted, when a parent or caregiver takes part in SUD treatment that includes frequent, random drug testing, it is both an inappropriate and unnecessary cost to have child welfare or the court test as well. Child welfare and SUD treatment providers should determine how they can work together to share results and collaboratively determine next steps to continue family engagement. Some courts may require testing for all participants, regardless of whether they are engaged in SUD treatment. If so, the collaborative team should discuss this overlap and find ways to streamline this process. Otherwise, drug testing may overwhelm parents and caregivers already facing other child welfare and SUD treatment requirements.

- Other considerations related to cost include the number of individuals referred for testing, the type of test (point-of-contact vs. laboratory), the number of tests conducted (including frequency), whether the test is for a single substance or a panel of substances, test specimens (hair follicle, urine, saliva, blood), confirmation testing, and who conducts the tests.

Funding sources for drug testing, SUD assessment and SUD services include Child Welfare Substance Abuse and Supplemental Services (BL830), Promoting Safe and Stable Families Funds (BL866), and Family Preservation and Support Program (BL829).

BL830: CHILD WELFARE SUBSTANCE ABUSE AND SUPPLEMENTAL SERVICES: Provides funds for substance abuse testing and treatment for children and families to ensure a child's safety, permanency, and well-being and to provide an informed decision regarding child removal, family support services, family reunification or termination of parental rights. If funds in this budget line are exhausted and requests for supplemental funds have been denied, localities may use funds from BL866 and BL829 to pay for services. Some reimbursable examples include:

- Substance abuse testing
- Substance abuse evaluation/assessment, diagnosis, and treatment
- Development or treatment goals and strategies including those that support a plan of safe care for infants exposed to substances during pregnancy
- Substance abuse counseling and treatment
- Pharmacological services
- Medical and remedial services to attain and maintain a favorable condition of health that are not covered through Medicaid.
- Substance abuse residential treatment
- Infant and child stimulation services that address both cognitive and motor development due to substance abuse/misuse
- Transportation services to and from needed community resources and facilities related to substance abuse services

10 CONFIDENTIALITY

10.1 CONFIDENTIALITY OF SUBSTANCE ABUSE PATIENT INFORMATION (CFR 42, PART 2)

Federal regulations protect the confidentiality of individuals who seek treatment for substance use disorders. Information that reveals a person is receiving, has received, or has applied for services for a substance use disorder cannot be released or disclosed without a valid written release from the patient.

A general consent form or medical release form is not acceptable. To be valid, a written consent form for the release of confidential information must specify:

- Patient's name
- Purpose of the disclosure
- Name of the person/organization/entity receiving the information
- Amount and kind of information to be released
- Patient's right to revoke consent at any time, except to the extent that action taken is irrevocable
- Patient's right to revoke consent verbally or in writing
- Date or condition when consent expires
- Date signed
- Patient's signature

The information disclosed must contain a written statement prohibiting re-disclosure and may not be used in a criminal investigation or prosecution.

Information sharing can be facilitated by developing policies and procedures that can in turn be incorporated into interagency protocols. HIPAA does permit sharing information with CPS and should be included in the procedures.

10.2 TREATMENT PROVIDERS

If a parent is referred to a SUD treatment provider, it is important for the LDSS and the provider to only share information when an appropriate Release of Information form is in place. Federal regulations, including Health Privacy Rule 42 CFR Part 2 (42 CFR 2), and

the Health Insurance Portability and Accountability Act (HIPAA), protect parents who receive a SUD assessment and engage in treatment. The purpose is to encourage individuals to seek and engage in treatment without fear of legal or social ramifications. The LDSS should collaborate with treatment providers on acceptable release forms that protect parents. The policy should indicate **who** will ensure the appropriate Release of Information, **how** parents/ caregivers will provide it, **with whom** they will share it, **and how long** the release is valid.

If a parent or caregiver receives a SUD diagnosis—and already participates in SUD treatment—the LDSS can collaborate with the SUD treatment provider. With an appropriate Release of Information in place, collaboration and coordination can determine the need for child welfare drug testing, particularly when the SUD treatment agency is conducting drug testing as well. Both agencies should determine the timeframes for communicating results, how the information will flow between system partners and the parent, and how results inform decisions and next steps. Under 42 CFR Part 2, a parent or caregiver can revoke their consent to exchange information, which can include drug test results.

10.3 Reports of Child Abuse and Neglect

The restrictions on disclosure by SUD treatment providers does not apply to the reporting suspected child abuse and neglect to CPS. This only applies to making the report. However, 42 CFR Part 2 restrictions continue to apply to the original alcohol or substance use patient records maintained by the treatment provider including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect [42 CFR § 2.12(c)(6)].

Also, a court order under 42 CFR Part 2 may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment if, among other reasons, the disclosure is necessary to protect against an existing threat of life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect [42 CFR § 2.63(a)(1)].

11 Documentation

Ensure all case documentation is non-judgmental. Judgment is the tendency to apply your own values, beliefs and opinions to others. When striving to document without using judgmental language, we need to be aware of both overt and subtle ways judgment is conveyed.

One word can make a big difference. Words like “but,” “just,” and “if” can change the tone of a sentence. The word “but” is problematic because it negates everything in the sentence before it. “Just” implies whatever you are referring to is not enough, and “if” indicates doubt about the ability to succeed at something. Of course, there are non- judgmental uses of these words, so when you use them, please ensure they are not changing the overall tone of the statement.

Avoid using intensifying adverbs that can exaggerate the statement. Intensifying words imply judgment because they give away how strongly you feel about something. Avoid words such as “very,” “really,” “always,” and “never.”

Using “I” statements can lead to opinions. “I” statements are useful in interpersonal communication, but not in documentation. We use “I” statements to communicate opinion. Avoid using “I think” or “I feel” at the beginning of a sentence because what follows could be construed as judgmental.

Command statements convey opinion. Commands imply that you (the writer) know more than the person you are writing about. While we must make recommendations in case notes, try to avoid words such as “must,” “should,” or “needs to.”

Don’t forget Language Matters!

12 Resources

12.1 Websites

Implementing the Substance Use Disorder Provisions of the Family First Act- A Toolkit for Child Welfare and Treatment Stakeholders: https://cffutures.org/files/aecf/SUD_Toolkit_Combined_FINAL.pdf

Marijuana and Public Health: Centers for Disease Control and Prevention https://www.cdc.gov/marijuana/index.htm

National Center on Substance Abuse and Child Welfare https://ncsacw.acf.hhs.gov/

National Institute on Drug Abuse: Clinical Resources: https://nida.nih.gov/nidamed-medical-health-professionals

Stop the Stigma™ - Tackling the Stigma of Addiction through Education: https://www.stopstigma.org/

Virginia Cannabis Control Authority: https://cca.virginia.gov/

Working with Families: Substance Use (Resources by Child Information Gateway)
https://www.childwelfare.gov/topics/supporting/mhsu/familysud/

12.2 VDSS Resources

- Numerous decision trees and other job aides can be found on the Fusion page: https://fusion.dss.virginia.gov/dfs/DFS-Home/Child-Protective-Services/CPS-Resources-and-Job-Aids.
- VDSS Addiction and Recovery Resources Portal link: https://fusion.dss.virginia.gov/addiction/Addiction-Home/Training
- Virginia Learning Center offers several courses to include:

  CWSE5501: Substance Abuse (four modules)

  CWSE6010: Working with Families of Substance Exposed Infants (two modules)