

INDICATORS FOR PROGRESS IN THE SUBSTANCE ABUSE RECOVERY PROCESS

Illinois DCFS of the Inspector General¹

Purpose of the Progress Matrix

The purpose of the Progress Matrix is to assist child welfare decision makers to assess the level of progress over time of a parent involved in the substance abuse recovery process.² Assessing the level of progress in recovery is one critical piece of determining the parent's overall progress, whether it be toward return home of a child in substitute care or toward complying with an order of protection to allow the child to remain safely in the parent's custody. The child welfare worker may use the matrix as a visual tool for working with the parent to set goals and evaluate progress. The child welfare supervisor can use the matrix to structure supervision with workers on substance abuse cases. Both the child welfare and substance abuse caseworkers can use the matrix to structure discussions in collaborative service planning. Judges and attorneys can use the matrix to structure questions for in-court testimony, come to decisions and make findings regarding the level of progress during court reviews.

Progress Indicators

The Progress Matrix adopts the predominant model of substance abuse treatment, which views long term abstinence as primary goal. Abstinence alone, however, is insufficient to support recovery. Recovery also requires a long-term series of changes in thinking and behavior, and maintaining those changes over time. The Progress Matrix specifies measurable criteria for assessing whether those changes have been made.

¹ An earlier version of this matrix was published as part of a larger article in D'Aunno, L. and Chisum, G., Parental Substance Abuse and Permanency Decision Making: Measuring Progress in Substance Abuse Recovery, 18 (4) Children's Legal Rights Journal (1998). For reprints of this article, contact the American Bar Association Center on Children and the Law, Lisa Waxler, 202-662-1743

² **Substance abuse recovery** involves not only attaining and maintaining abstinence but also change in one's thinking and behavior. The **process of recovery** begins with a person's acceptance that there is a need to stop using alcohol or other drugs. The next step is entrance into and completion of formal substance abuse treatment, followed by participation in aftercare services. Recovery is maintained by involvement in recovery support systems, including fellowship meetings (AA, NA) or community support group. Treatment programs, aftercare and recovery support groups provide structure and support for developing insight into the person's addiction, identifying triggers for use, developing a relapse prevention plan, and developing competency in life skills, such as employment and parenting skills.

The progress matrix consists of four matrices which cover three month periods of time in recovery. The horizontal rows consist of up to nine indicators of progress in recovery:

- 1) substance abuse treatment;
- 2) substance abuse education;
- 3) participation in recovery support systems;
- 4) abstinence;
- 5) child welfare service plan compliance;
- 6) parent-child visiting (if the child is in substitute care);
- 7) parental skills/parental functioning;
- 8) other interpersonal relationships; and
- 9) life skills building.

Because some indicators are only relevant in the early or late phases of recovery, not all indicators appear on each matrix. Because the matrix focuses on cognitive and behavioral changes, it is applicable regardless of the parent's level of care (e.g., residential vs. intensive outpatient treatment). Nevertheless, the intensity of the treatment is likely to affect the rate of progress.

Determining Time in Recovery. The first step in using the progress matrix is to determine the client's length of time in recovery and locate the corresponding matrix. Time in recovery begins when the parent enters formal treatment and continues through discharge from treatment and the parent's progression through aftercare and ongoing community support. As long as the parent stays in treatment or follows recommendations for aftercare and/or support, the "recovery clock" keeps running even if the parent continues to use drugs intermittently. Continued drug use and/or periodic relapse will, however, affect the parent's level and rate of progress.

When a parent leaves and remains out of treatment for an extended period of time, the "recovery clock" should be viewed as having stopped at the point of leaving treatment. Once the parent again presents him or herself for treatment, and reassessment determines that the parent has retained some of the previous gains, the recovery clock

will resume ticking from the point at which the parents left treatment. Otherwise, recovery clock begins at zero months again.

Measuring progress toward abstinence. According to American heritage College Dictionary (3rd ed.) ,**abstinence** is the act of refraining from something by one's own choice. As described above, progress toward abstinence begins with decreased frequency of drug use, followed by short periods of "clean times" and relapse, followed by prolonged periods of abstinence with fewer episodic relapses. Achieving a period of abstinence involves making a cognitive and behavioral commitment to stop using drugs. Absent these changes, cessation of drug use for a brief period of time (e.g., because of lack of availability of the drug or brief period of incarceration) does not constitute progress toward abstinence. A period of one month without drug use is the first significant measure of progress toward achieving abstinence.

Because most drugs are quickly metabolized in the body, "clean time" cannot be reliably measured solely by blood or urine toxicologies or with a breathalyzer unless the client is confined in a tightly controlled setting and is tested daily at random intervals. Even if available, the utility of such measurements would be limited, because they would tell very little about the person's ability to maintain abstinence outside of a highly structured setting and certainly not under the daily pressures which face most child welfare clients. Likewise, although treatment researchers have established the reliability and validity of client's self reports of drug use to impartial researchers (where there is no negative consequence for truthfulness) , self report of clean time to one's own child welfare caseworker is apt. to be far less reliable. Therefore, the probability that the parent is actually experiencing "clean time" is best evaluated by a combination of random urine toxicologies, self reports, by observation by treatment providers and caseworkers of behavioral indicators such as positive changes in hygiene and grooming, improved functioning in daily life (absent underlying untreated psychological or physical disorder), and by improved consistency in compliance with drug treatment and child welfare service plan requirements.

Some people are able to achieve significant "clean time" but do not make the changes in behavior necessary to support long-term recovery which will be necessary for the parent to provide a safe environment for a child. The progress matrix provides a visual picture of the simultaneous changes in thinking and behavior which must be made in order to maintain recovery. In sum, no single category should be viewed in isolation, especially not abstinence.

Determining level of progress. Indicators of “poor”, “some”, “moderate”, and “substantial” progress are indicated by vertical rows. (n.b., in the Nine to Twelve Month matrix, the levels of progress are condensed the three—poor, some to moderate, and substantial). Since progress within and across spheres is not necessarily linear, the indicators for a parent may not line up perfectly within a single progress column, but should give an overall picture of the progress attained to date. Arrows between items within a cell indicate an expected progression over time. For example, the “some progress” cell on the Zero to Three Month matrix indicates that a client should be progress from reduction of initial resistance and defensiveness through completion of assessment and acceptance of the referral, to entry into treatment and perhaps sporadic attendance. Until attendance becomes more consistent (see “moderate progress” on the Zero to Three Months matrix), the client is considered to have made “some progress” in the first three months.

Whether “some”, moderate”, or “substantial” progress is sufficient to meet the legal tests of “reasonable progress” or “substantial progress” will depend on the reasons the children were removed from their homes, the parent’s progress in other service plan requirements, and the amount of time which has elapsed.

Inclusion of Alcoholics Anonymous/disease model expectations. The progress indicators for participation in recovery support systems include references to AA/NA/CA meeting and the “12 Steps”. Many, but by no means all, treatment programs use these strategies. We have included these indicators in the matrix in part because of their widespread use and because parents who are “working their programs” will use this language with their workers. More importantly, social support is critical in the recovery process, and if not attending meeting based on the AA model, parents should be maintaining frequent and regular contact with a community- or faith-based support group.

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