California Social Work Education Center

C A L S W E C

Pathways to Collaboration

Factors That Help and Hinder Collaboration Between Substance Abuse and Child Welfare Fields

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ABSTRACT

Research over the past decade has documented the importance of developing innovative models for collaborative practice between the fields of child welfare, substance abuse treatment, and dependency courts (U.S. Department of Health and Human Services [DHHS], 1999; Young & Gardner, 2002). Models of collaborative practice that appear to hold promise for effective intervention with substance-abusing families who are concurrently involved in the child welfare system include dependency drug courts; outstationed substance abuse specialists in child welfare agencies; recovery coaches to facilitate child welfare-involved parents to participate in substance abuse treatment; and institutionalization of formalized interagency agreements, cross-training, and information exchange systems (Hunter, 2003). In order to initiate, implement, and maintain collaborative practice, there is a need for greater understanding between both service providers and policy makers of the underlying factors that may both help and hinder successful collaborative programs, policies, and practice.

This study examined factors that help and hinder the process of collaboration based on in-depth interviews with respondents (N = 49) from substance abuse and child welfare fields working in five California counties with established formal collaborative policies and programs*. This curriculum, which is grounded in the findings from the study, provides highlights of research and experiential activities in four primary areas that may be used independently or in combination: (a) overview of research on cross-

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systems collaboration, (b) promising models and elements for collaborative practice, (c) factors that help and hinder collaboration, and (d) facilitating communication and dealing with confidentiality issues across systems.

* Note: A first phase of this study examined similarities and differences in values and perceived capacity for collaboration between substance abuse and child welfare fields based on survey data using a "Collaborative Values Inventory" and "Collaborative Capacity Instrument" from 350 respondents in 12 counties in California. A curriculum based on this study is available on the California Child Welfare Resource Library website (http://www.csulb.edu/projects/ccwr). The California Child Welfare Resource Library is a division of the California Social Work Education Center.

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state collation of social work educators and practitioners. It is a consortium of the state's 16 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC missions. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child

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welfare field, CalSWEC funds a series of curriculum sections that employ varied research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating schools and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

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ABOUT THE AUTHORS

Laurie Drabble, PhD, MSW, MPH, is an Associate Professor at the San José State University School of Social Work. Dr. Drabble was Principal Investigator for the research project *Pathways to Collaboration: Understanding the Role of Values and System-Related Factors That Contribute to the Adoption of Promising Practices Between Child Welfare and Alcohol and Drug Systems*. Dr. Drabble has been involved in a number of research projects related to alcohol and drug problems among marginalized populations of women and improvement of service delivery systems. She is an Affiliate Associate Scientist with the Alcohol Research Group and she was a Co-Investigator for the San José State University College of Social Work study *Factors Related to the Over-Representation of Children of Color in the Santa Clara County Child Welfare System*. She also conducted a study for the U.C. Davis Center for Human Services/Northern California Children and Family Services Training Academy examining the substance abuse training needs of child welfare professionals in 14 Northern California counties. In her earlier career, Dr. Drabble was Executive Director of the California Women's Commission on Alcohol and Drug Dependencies (CWCADD). She has a long history of working statewide on a wide range of projects related to collaboration including developing training curricula, conducting training needs assessments, and organizing trainings/conferences.

Kathy Lemon Osterling, PhD, MSW, is an Assistant Professor at San José State University School of Social Work. In addition to her contributions to the study on

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collaboration between substance abuse and child welfare systems, she has had experience on several research projects in the School of Social Work at San José State University, including a study on factors related to the disproportionate representation of children of color in Santa Clara County's child welfare system, an examination of factors related to college attendance among former foster youth, and most recently, a study examining mental health services among child welfare clients. Dr. Osterling has also served as a research assistant for the Bay Area Social Services Consortium at the School of Social Welfare, U.C. Berkeley, where she worked on reports reviewing evidence-based practice on promising programs for low-income families, interventions to reduce racial/ethnic disproportionality in the child welfare system, substance abuse interventions for parents involved in the child welfare system, and research on child welfare outcomes. Dr. Osterling's dissertation focused on examining the impact of poverty on immigrant children's mental health.

Marty Tweed, MSW, LCSW**,** was a full-time member of the faculty at San José State University from 1993-2003, serving in various capacities (Title IV-E Faculty Field Liaison, lecturer, and MSW Admissions Director). She was employed in public child welfare services from 1984-1993 and held positions including that of social worker and supervisor. Ms. Tweed is currently working as the Field Program Coordinator and lecturer at the Department of Health, Human Services and Public Policy of California State University Monterey Bay (CSUMB). Ms. Tweed's practice interests include public child welfare, permanency planning, mediation, adoptions, graduate admissions, and outcomes-based education. She is responsible for assisting with adaptation of the

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CalSWEC-funded *Pathways to Collaboration* research report into this curriculum. Ms. Tweed also developed curricula based on other research projects funded by the California Social Work Education Center (CalSWEC) including curricula for the first phase of the *Pathways to Collaboration* research project, a project on foster care youth, and a project about mental health service utilization and outcomes for children and youth in the child welfare system.

Carol A. Pearce, BA, MLIS, served as a Graduate Research Assistant for the *Pathways to Collaboration project* while a graduate student in the School of Library and Information Sciences at San José State University. Ms. Pearce assisted with a wide array of research activities at all phases of research and curriculum development including searching research literature, tracking and transcribing interviews, writing summaries of county case examples for inclusion in the curriculum, and reviewing draft documents. Ms. Pearce formerly served as consultant for the San José State University College of Social Work study on *Factors Related to the Over-Representation of Children of Color in the Santa Clara County Child Welfare System*. Among other projects, she continues to assist the Child Welfare Research Collaborative, School of Social Work, with web design.

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Contra Costa County
Amalia Gonzalez del Valle, Contra Costa County Alcohol and Other Drug Services Administration
Debi Moss, Contra Costa County Children and Family Services
Brenda Underhill, Alcohol and Other Drug Services Administration

Merced County
David Schilling, Merced County Human Services Agency
Troy Fox, Merced County Department of Mental Health, Alcohol and Drug Services

Sacramento County
Elizabeth English, Sacramento County Department of Health and Human Services, Alcohol and Drug Services Division
Toni Moore, Sacramento County Department of Health and Human Services, Alcohol and Drug Services Division

San Diego County
Rhonda Sarmiento, San Diego County Health and Human Services Agency, Child Welfare Services

Shasta County
Susan Hacking, Shasta County Alcohol and Drug Programs
Lynne Jones, Shasta County Social Services, Children & Family Services

To all the respondents who participated as interviewees, our research team extends our heartfelt appreciation. The interviewees from counties listed above (but not listed by name in deference to maintaining their confidentiality) were generous in their

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willingness to share openly of their time and insights in order to document “lessons learned” that might benefit others in future collaborative efforts. We honor them all for their contributions to this study and for their extraordinary dedication and perseverance in advancing collaborative programs in their own counties.

Special thanks are extended to Nancy Young, Executive Director of Children and Family Futures, for her assistance in conceptualizing and realizing this research project—as well as for her extraordinary ongoing work in advancing collaboration and improving services for children and families. Other staff members of Children and Family Futures (CFF), the collaborating organization for this project, offered valuable advice and assistance including Sharon Boles, Sid Gardner, and Deborah Werner.

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INTRODUCTION

Research over the past decade has documented a strong relationship between substance abuse and problems of child abuse and neglect (Curtis & McCullough, 1993; Karoll & Poertner, 2002; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Magura & Laudet, 1996; Maluccio & Ainsworth, 2003; McAlpine, Marshall, & Doran, 2001; Peterson, Gable, & Saldana, 1996; Smith, 2003; Sun, Shillington, Hohman, & Jones, 2001; Tracy & Farkas, 1994; Widom & Hiller-Sturmhofel, 2001). Although many data collection systems do not gather accurate data on substance abuse and child welfare, most studies in the U.S. suggest parental substance abuse is a factor in one third to two thirds of child involvement in the child welfare system (U.S. Department of Health and Human Services [DHHS], 1999). Lower estimates tend to be associated with initial reports of child abuse and higher estimates are generally associated with out-of-home placements (DHHS, 1999). Parental substance abuse appears to be strongly associated with higher rates of physical abuse or neglect among families in community (non-clinical) samples (Chaffin, Kelleher, & Hollenberg, 1996; Kelleher et al., 1994), higher rates of substantiated child maltreatment in cases referred into child welfare (Sun et al., 2001), higher rates of out-of-home placements (Barth, 1994; Maluccio & Ainsworth, 2003; Zuravin & DePanfilis, 1997), re-reports of abuse, and reentry into foster care (Berrick, Brodowski, Frame, & Goldberg, 1997; Government Accounting Office [GAO], 1998; Wolock & Magura, 1996).

Increased concern over the correlation between substance abuse and child

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welfare, as well as growing recognition of the importance of consistency in caretaking in child development, particularly among infants, has fueled a number of policy changes on both national and state levels. The Adoption and Safe Families Act (ASFA), which was enacted in 1997 and reauthorized in 2003, accelerates permanent placements of children in foster care. Some states in the U.S. have also enacted legislation that allows for further expedited permanency planning for children who meet specific criteria. These recent changes in national and state law that limit timelines for potential reunification, combined with the high prevalence of children of substance abusing families in out-of-home placements, have intensified the need for effective collaboration between substance abuse and child welfare fields (Young & Gardner, 2002).

Significant barriers to collaboration between systems are described in the literature (Feig & McCullough, 1997; Young & Gardner, 2002; Young, Gardner, & Dennis, 1998). One area of difference involves who is defined as a client (a perception of the child as the primary client in child welfare services and a focus on the substance-abusing parent in substance abuse treatment). Another issue involves conflicting attitudes and values about parents with alcohol or drug addiction. Significant differences in focus, policy, and practice between systems may also serve as barriers to collaboration. For example, systems may differ in relation to expected timing for reunification efforts, in which child welfare professionals focus primarily on the safety and developmental needs of the child and treatment staff are concerned primarily with the parental process of recovery and relapse.

Despite these barriers, there are a number of models of collaborative practice

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that appear to hold promise for effective intervention with substance-abusing families who are concurrently involved in the child welfare system. Some of these promising practices include dependency drug courts (Harrell & Goodman, 1999), outstationed substance abuse specialists in child welfare agencies (McAlpine et al., 2001), recovery coaches to facilitate child welfare-involved parents to participate in substance abuse treatment (Ryan, 2006), and institutionalization of formalized interagency agreements, cross-training, and information exchange systems (Hunter, 2003). Although the need for collaborative practice in these cross-cutting areas have been established (DHHS, 1999; Young & Gardner, 2002), research is needed to examine the practical mechanisms by which these fundamental collaborative strategies are developed and sustained toward creating and institutionalizing shared programs, policies, and practices between fields.

This curriculum is based on findings from the second phase in a research and curriculum development project funded with support from the California Social Work Education Center (CalSWEC): *Pathways to Collaboration: Understanding the Role of Values and System-Related Factors That Contribute to the Adoption of Promising Practices Between Child Welfare and Alcohol and Drug Systems*.[1] The primary aim of Phase II of the study was to examine factors that have helped and hindered the process of collaboration based on in-depth interviews with respondents (N = 49) from substance

[1] The first phase of this study examined values and perceived capacity for collaboration among child welfare and alcohol and other drug treatment professionals from counties that have adopted formal collaborative models and counties that are just starting collaboration. This research was based on survey data from managers, supervisors, and line staff from 12 counties in California using two inventories: a Collaborative Values Inventory (CVI) and a Collaborative Capacity Instrument (CCI). The final report and curriculum developed from Phase I is available through CalSWEC.

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abuse and child welfare fields working in counties with established formal collaborative policies and programs.

This curriculum provides a review of key research literature related to cross-systems collaboration between substance abuse and child welfare fields (Section I) as well as promising models for collaborative practice (Section II). The curriculum also provides a summary of findings and activities centered on factors that have helped and hindered collaborative practice in relation to developing effective collaborative relationships, structures, programming, and practices (Section III) as well as operational innovations to improve collaboration in daily practice, such as written memorandum of understanding between systems as well as forms and procedures for obtaining releases of information and sharing information about client progress or changes (Section IV). The curriculum also includes a general summary of the study and resources for continued learning about collaborative practice (Section V).

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CURRICULUM OVERVIEW

This curriculum has three overall goals: (a) help participants increase their understanding of the specific factors that help and hinder the collaborative process between the child welfare and substance abuse treatment systems by highlighting findings from current research, (b) increase the knowledge and skills necessary in the collaborative process by presenting specific collaborative models involving child welfare and substance abuse fields that appear promising, and (c) provide specific training in developing individual and organizational communication protocols to facilitate collaborative case planning.

Objectives

The curriculum objectives for each section are described below.

Section I – Literature Review: Collaboration Between Child Welfare, Substance Abuse, and Related Fields

By the end of this section participants will:

- Articulate a working definition of collaboration,
- Describe various models of collaboration,
- Develop an integrated service plan, and
- Identify 4-5 factors that impact the collaborative process between the child welfare and alcohol and drug systems.

Section II – Core Elements of Promising Collaborative Models Between the Child Welfare and Alcohol and Drug Systems

By the end of this section participants will:

- Be introduced to the 10 factors related to effective collaboration,

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- Be able to describe core elements of collaboration and apply to their own county practice, and

- Be able to articulate 1-2 examples of promising program models.

Section III – Overview of Qualitative Findings From the Study

By the end of this section, participants will:

- Become familiar with factors that both hinder and enhance collaboration as discussed in the research,

- Be able to view the perspectives of professionals from various disciplines in interdisciplinary work, and

- Identify strategies to advance collaboration and address potential resistance to collaboration.

Section IV – The Structure and Spirit of Collaboration: Building Pathways for Communication Across Systems

By the end of this section, participants will:

- Identify themes related to communication in daily practice,

- Understand the need for effective communication across systems in the context of legal timeframes,

- Understand federal confidentiality law in alcohol and drug treatment systems, and

- Have the ability to create a valid consent form with the correct elements.

Section V – Building Bridges Between Systems: Resources and Next-Steps

By the end of this section, participants will:

- Have increased knowledge of available resources and how to access those resources for more effective outcomes, and

- Identify and articulate “next steps” to implement new knowledge and skills into their own practice and in their local service delivery systems.

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Intended Audience

The primary audience for this curriculum is MSW Title IV-E students and entry-level child welfare professionals; however, some of the material may be used with more experienced practitioners. In addition, although some of the materials emphasize the child welfare field, many of the sections may be used or adapted to students and professionals in a variety of disciplines who may work with issues of substance abuse and child maltreatment. Material in this curriculum may also be adapted for use with BSW students at a more basic level.

The sections of this curriculum may be used together or independently. Instructors who elect to use a later section may find it valuable to cover the content from the first few overheads in Section I that review why collaboration is important. Each section also includes several experiential learning activities directly related to the content of the section. The length of time required to implement each section is flexible and largely dependent on how many activities a given instructor elects to use. Instructor guidelines at the beginning of each section contain suggestions about which activities may be most appropriate to different audiences and many of the activities include alternative options that instructors may use to easily adapt activities to the meet the educational or training needs of their audience.

The curriculum sections may be used in courses or training focused on practice, policy, or human behavior. Section I includes content that would be useful in both policy and practice instruction. The models presented in Section I may also be used in HBSE courses. Sections II, III, and the first part of Section IV contain content that may easily

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be used to examine collaborative practice on various levels: individual, group (task groups and case conferencing), organization, and service delivery systems. The second half of Section IV, which focuses on policy and practice related to confidentiality, may be most useful in practice classes and with professionals in the field. Section V, which focuses on resources and next steps for practice, may be used with any groups and in conjunction with any other Section in this curriculum.

Organization of Curriculum

The curriculum sections are intended to build upon one another; however, it is possible for instructors to use each of the sections independently or in combination. A brief description of each section follows:

Section I – Literature Review: Collaboration Between Child Welfare, Substance Abuse, and Related Fields. This section examines the literature on collaboration with a special focus on the implications for collaboration between child welfare and substance abuse fields. Specifically, this section identifies the core elements of collaboration and presents three models of collaboration that are useful in understanding characteristics of successful collaborative practice from different perspectives (i.e., systems, developmental, and process). The section concludes with a discussion of factors that affect collaboration between the child welfare and alcohol and drug systems.

- Introduction
    - Introduction of trainer(s) and participants (if not part of ongoing class)
    - Introduction to section content
    - Introduction to topic (basic facts and “why bother” of collaboration)

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    - Activity I-1: Introductory Activity (Definitions, benefits, and barriers to collaboration)

- Overview of Concept of Collaboration: Three Models of Collaboration

    - Definitions of collaboration
    - Models of collaborative practice
        - A systems/ecological perspective
        - A developmental perspective
        - A process perspective
    - Activity I-2: Models of Collaboration (small group review)

- Factors That Affect Collaboration Between the Child Welfare and Alcohol and Drug Systems

    - Review of factors
    - Activity I-3: Developing an Integrated Service Plan

Section II – Core Elements of Promising Collaborative Models Between the Child Welfare and Alcohol and Drug Systems. This section introduces participants to the core elements of successful collaboration and provides specific illustrations of successful collaborative programs models. This section addresses the following content:

- Overview of 10 dimensions of successful collaboration

    - Activity II-1: Application of the 10 Domains of Collaboration

- Core elements of collaboration in action: Descriptions of successful models

    - Activity II-2: Applying Elements of Effective Collaboration

Section III – Overview of Qualitative Findings From the Study. This section shares findings from recent research about the factors that both help and hinder collaboration between systems based on interviews with experts from five counties in California with a strong history of collaboration. This section describes each of these

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areas in detail and then concludes with an opportunity for participants to participate in a "mock collaborative." This section addresses the following content:

- Overview of findings from the research on factors that enhance collaboration
    - Activity III-1: Factors That Enhance Collaboration
- Overview of findings from the research on factors that hinder collaboration
    - Activity III-2: Mediation Exercise: Addressing Factors That Hinder Collaboration
- Implications for practice: Building collaborative programs
    - Activity III-3: The Mock Collaborative

Section IV – The Structure and Spirit of Collaboration: Building Pathways for Communication Across Systems. This section: (a) presents additional findings from the research on successful collaboration in daily practice related to communication, and (b) provides specific training related to working effectively across systems in the context of federal confidentiality regulations. Specifically, this section addresses the themes that emerged from the interviews with professionals from both child welfare and substance abuse treatment systems about communication and collaborative practice. This section also provides a review of federal confidentiality regulations and the types of documents, forms, and protocols used in cross-system communication.

- Overview of themes from the research about communication in daily practice
    - Why a special focus on communication and confidentiality
    - What each system needs to know from the other
    - Themes from the study: Development of communication protocols, building relationships, and acculturation to collaborative practice
    - Activity IV-1: Communication Protocols (small group discussions)

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- Demystifying and working effectively in the context of federal confidentiality regulations and substance abuse treatment

    - Provisions of 42 CFR (Handout IV-2)
    - Activity IV-2: Federal Confidentiality Law Quiz
    - Activity IV-3: Consent for the Release of Information Form (creating and using consent forms)
    - Optional Activity IV-4: Role Plays

Section V – Resources for Bridging Values Gaps and Enhancing Cross-Systems Collaboration. The final section provides participants an opportunity to explore resources for continued professional development in collaborative practice and reflect on how knowledge about collaboration gained from this curriculum may be translated into practice. This section addresses the following content:

- Overview of resources for advancing cross system collaboration

    - Activity V-1: Website Exercise

- Closing discussion on take home ideas

    - Activity V-2: Take-Home Ideas

Time Estimates and Tips for Training

Addressing issues related to improving collaboration across systems is an important component of any training related to working effectively with the child welfare and substance abuse treatment systems. As such, the sections in this curriculum may be used in conjunction with other training materials that focus on other facets of direct service with substance-abusing families or models of collaborative practice between the substance abuse and child welfare systems.

The time required to complete all sections of this curriculum is estimated at

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approximately 6 hours. Instructors may, however, elect to condense the background information (based on assessment of participant knowledge, skill, and experience) or to integrate components of this training into other training or class sessions on direct or indirect collaborative practice. The time estimates may also vary considerably based on which learning activities are selected and how the instructor chooses to adapt them for a specific class or training. Estimated time for completing the sections are as follows:

Section	Description	Estimated Time
Section I	Content: Literature review on collaboration between child welfare and substance abuse-related fields. Activity I-1: Introductory Activity (Definitions, Benefits & Barriers to Collaboration) Activity I-2: Models of Collaboration Activity I-3: Developing an Integrated Service Plan	75 minutes
Section II	Content: Core elements of promising collaborative models. Activity II-3: Application of the 10 Dimensions of Collaboration Activity II-1: Applying Elements of Effective Collaboration	75 minutes
Section III	Content: Overview of findings from the study: Factors that help and hinder collaboration Activity III-1: Factors That Enhance Collaboration Activity III-2: Mediation Exercise Activity III-3: The Mock Collaborative	90 minutes
Section IV	Content: Successful communication in daily practice Activity IV-1: Communication Protocols Activity IV-2: Federal Confidentiality Law Quiz Activity IV-3: Creating and Using Consent Forms Optional Activity IV-4: Role Plays	90 minutes
Section V	Content: Resources for advancing cross-systems collaboration. Activity V-1: Website Exercise Activity V-2: Take-Home Ideas	30 minutes

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Other Suggested Tools and Materials

Courses or trainings with graduate students or new workers may want to provide additional content on basic knowledge and skills in direct practice with substance-abusing families in addition to the material presented in this curriculum. It is recommended that instructors also review the CalSWEC curriculum based on the first phase of this study, which focused on understanding the role of values and system-related factors in collaboration between child welfare and substance abuse treatment. This curriculum is available in PDF format through the California Child Welfare Resource Library, which is a division of CalSWEC (http://www.csulb.edu/projects/ccwrl).

In addition, online tutorials are available at no cost through the National Center on Substance Abuse and Child Welfare. These tutorials are appropriate for both students and professionals in the field. *Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals* provides a primer on alcohol and drug addiction, substance abuse treatment and recovery, enhancing treatment readiness and treatment effectiveness, cross-system communication and collaboration, as well as contact information for other national resources. *Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals* is designed to provide comprehensive information regarding child welfare issues for the substance abuse treatment professional (both available at http://www.ncsacw.samhsa.gov/tutorials/index.asp).

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CALSWEC CURRICULUM COMPETENCIES

The list of CalSWEC Curriculum Competencies for public child welfare was created for use by the graduate schools of social work to prepare their child welfare students for effective work in this complex field of practice. These competencies reflect the common priorities of schools and agencies, yet allow each institution suitable autonomy. This curriculum address the competencies listed below for both MSW and BSW students. In addition, each section of this curriculum provides a list of competencies specifically addressed in that section.

MSW Competencies

I. Ethnic Sensitive and Multicultural Practice

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

II. Core Child Welfare Practice

2.4 Student is able to gather, assess, and present pertinent information from interviews, case records, and other collateral sources required to evaluate an abuse or neglect allegation.

2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

2.11 Student understands the process of the legal system and the role of social workers and other professionals in relation to the courts.

2.17 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations in which the worker's values are challenged.

2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

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IV. Workplace Management

4.2 Student is able to work effectively with agency personnel and clients in an environment characterized by human diversity.

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effects on services for children and families.

4.6 Student is able to seek client, organization, and community feedback for evaluation of practice, process, and outcomes.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

VI. Advanced Child Welfare Practice

6.1 Student demonstrates knowledge of the philosophy, purpose, requirements, and application of federal and state child welfare policy and legislation.

VII. Human Behavior in the Social Environment

7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families.

VIII. Child Welfare Policy, Planning, and Administration

8.2 Student understands how political activities and regulatory, legislative, and judicial processes at local, state, and national levels influence agency policies, procedures, and programs.

8.3 Student understands how leads/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

8.6 Student demonstrates basic knowledge of various federal, state, and local child welfare funding sources and consequent implications for agency policy, objectives, and service delivery.

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8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

BSW Competencies

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive services.

2.8 Student demonstrates a beginning understanding of legal process and the role of social workers and other professionals in relation to the courts, including policy issues and legal requirements affecting child welfare practice.

2.12 Student is developing the capacity to utilize the case manager's role in creating a helping system for clients, including working collaboratively with other disciplines and involving and working collaboratively with biological families, foster families, and kin networks.

2.15 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations.

4.4 Student has a working knowledge of collaboration with multidisciplinary teams and can work productively with team members in implementing case plans.

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SECTION I

LITERATURE REVIEW: COLLABORATION BETWEEN CHILD WELFARE, SUBSTANCE ABUSE, AND RELATED FIELDS

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SECTION I
INSTRUCTIONAL GUIDE

Learning Objectives

This section examines the literature on collaboration with a special focus on the implications for collaboration between child welfare and substance abuse fields. Specifically, this section identifies the core elements of collaboration and presents three models of collaboration that are useful in understanding characteristics of successful collaborative practice from different perspectives (i.e., systems, developmental, and process). The section concludes with a discussion of factors that affect collaboration between the child welfare and alcohol and drug systems.

By the end of this section, participants will be able to:

- Articulate a working definition of collaboration,
- Describe various models of collaboration,
- Develop an integrated service plan, and
- Identify 4-5 factors that impact the collaborative process between the child welfare and alcohol and drug systems.

Public Child Welfare Competencies

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

2.11 Student understands the process of the legal system and the role of social workers and other professionals in relation to the courts.

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4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

Agenda and Suggestions for Instructors

Time allocation: Approximately 75 minutes (depending on use of activities)

- Introduction
    - Introduction of trainer(s) and participants (if not part of ongoing class)
    - Introduction to section content
    - Introduction to topic (basic facts and "why bother" of collaboration)
    - Activity I-1: Introductory Activity (Definitions, benefits, and barriers to collaboration)
- Overview of Concept of Collaboration: Three Models of Collaboration
    - Definitions of collaboration
    - Models of collaborative practice
        - A systems/ecological perspective
        - A developmental perspective
        - A process perspective
    - Activity I-2: Models of Collaboration (small group review)
- Factors That Affect Collaboration Between the Child Welfare and Alcohol and Drug Systems
    - Review of factors
    - Activity I-3: Developing an Integrated Service Plan

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, instructors may elect to present all material in the section, or focus more specifically on one of the subsections for more in-depth analysis. For practice

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classes or for trainings with professionals, the instructor may elect to provide a brief review of the first two segments and focus more time on the last section and Activity I-3 (Developing an Integrated Service Plan Based on a Case Study). For MSW or BASW courses on human behavior and the social environment, the instructor may elect to emphasize the review of different models of collaboration. Instructors of policy courses may cover highlights of all three sections, but may elect to emphasize Activity I-1, with a special focus on macro facets of collaboration.

Materials Needed

- Either an overhead projector and PowerPoint presentation on transparencies or a computer and PowerPoint presentation online
- Markers and flip chart or white board (optional—for writing key points in response to small and full group discussions)

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SECTION I
LITERATURE REVIEW: COLLABORATION BETWEEN CHILD WELFARE, SUBSTANCE ABUSE, AND RELATED FIELDS

Introduction

Parental substance abuse is a pervasive problem within the child welfare system. Rates of substance abuse within child welfare cases range from approximately 30-80% (Bellis et al., 2001; Famularo, Kinscherff, & Fenton, 1992; Murphy et al., 1991; DHHS, 1999). The majority of substance abuse-related cases in the child welfare system involve an allegation of neglect, and although there is no difference in substance abuse prevalence between mothers and fathers, most child welfare cases involve substance-abusing mothers (DHHS, 1999). Research also suggests that children in the child welfare system with substance-abusing parents generally experience worse outcomes than children whose parents do not have a substance abuse problem. In general, children in the child welfare system with substance-abusing parents tend to be younger, have higher out-of-home placement rates, are more likely to have a case plan of adoption, and tend to spend more time in out-of-home care (U.S. Department of Health and Human Services Children's Bureau, 1997).

Child welfare practitioners, researchers, and policy makers are becoming increasingly aware of the problem of substance abuse in the child welfare system and the need to implement effective interventions within the time limits mandated by the Adoption and Safe Families Act (ASFA) of 1997. ASFA timelines combined with the increasing number of substance-abusing parents in the child welfare system have

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created a critical need to ensure that parents receive timely access to effective treatment. Research indicates that participation in substance abuse treatment is linked to higher reunification rates (Smith, 2003); however, some scholars suggest that systemic barriers between the child welfare (CW) and alcohol and other drug (AOD) systems interfere with parents' immediate access to accurate substance abuse assessments and effective treatment options (Young & Gardner 2002; Young, Gardner, & Dennis, 1998). As a result, many substance-abusing parents may not be receiving adequate assessment or treatment.

To improve linkages between the CW and AOD systems, many localities are implementing collaborative models that seek to ensure that substance-abusing parents have access to treatment and that both systems are working together to improve outcomes for children and families. A study was conducted to explore some of the "lessons learned" from several such localities in California. Specifically, professionals in the fields of child welfare, substance abuse treatment, and dependency courts from five California counties were interviewed to learn about factors that have helped and hindered their own successful collaborative programs, policies, and practices. Many of the interviewees who had been in practice before, during, and after implementation of collaborative practice were able to describe the impact of this change on both providers and consumers of services. The quote below typifies the "before and after" picture described by many interviewees.

> I can't imagine going back to the old school where you would interview someone and give them three names to treatment programs and say "take care of it."…

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> The difference is that they are reunifying quicker. Pre-[collaborative programs] our average was 36 months to reunification and now we are down to 14 months. The kids are getting the benefit and that is what we want.

The positive outcomes described by interviewees are supported by the research literature. If collaborative practice is more effective, there are several questions that might arise for practitioners in different fields:

1. What is collaboration and what are the some of the issues that arise in collaborative practice between substance abuse and child welfare fields? (addressed in the remainder of this section)

2. What are the elements of successful collaborative practice and what are some of the specific models that seem to "work"? (addressed in Section II)

3. What are the factors that facilitate or impede the development of these kinds of effective collaborative practices? (addressed in Section III)

4. What are some of the specific strategies that allow for collaborative case planning in daily practice, including issues related to confidentiality? (addressed in Section IV)

Activity I-1: Introductory Activity

Purpose:
This exercise gives participants an opportunity to interact, raise awareness about the complex process of collaboration, and identify common experiences and assumptions related to collaborative work.

Instructions:
Share the purpose of the exercise and the following assumption: The process of collaboration can be as frustrating as it is beneficial to effective practice…and to client outcomes.

Invite participants to form small groups. In the groups, they will have three topics to discuss, followed by a brief report back of highlights from each group. (See Handout I-1 for instructions that may be given to the small groups). Each small group should be instructed to:

1. Define collaboration in your own words.
2. Brainstorm the *benefits of collaboration* at different levels: micro (i.e., "What's in it for me?"), mezzo (groups, community) and macro (organizations, systems). Be sure to include specific examples to illustrate.
3. Despite potential benefits to collaboration, there are often barriers on micro, mezzo, and macro levels. Discuss what some of these barriers might be.

Groups briefly share their findings with the larger group to facilitate discussion. Instructor may also share definition of collaboration provided in Section I on page 9.

After the exercise, debrief with participants. Point out that the next two segments of this section will review models of collaboration and some of the factors that affect collaboration between the CW and AOD systems based on research, and that many of these ideas may well include, elaborate, or add to some of the ideas that they discussed in their small groups.

Core Elements of Collaboration

Collaboration between individuals and between organizations is becoming increasingly necessary in order to effectively serve clients (Bronstein, 2003). Certainly, collaboration between the CW and AOD systems has become a central issue within discussions of substance-abusing parents in the CWS (Young & Gardner, 2002).

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Although the term “collaboration” is used widely in the social service literature, a helpful starting point in the discussion of the core elements of social service collaboration is to provide a definition of the term. Whittington (2003) provides a definition of collaboration that draws on the concept of partnership: “Partnership is a state of relationship, at organizational, group, professional, or interpersonal level, to be achieved, maintained and reviewed. Collaboration is an active process of partnership in action” (p. 16). Further, collaboration is considered to be:

> …the collection of knowledge, skills, values and motives applied by practitioners to translate the following into effective practice:
>
> - formal systematic joint working arrangements (such as inter-disciplinary or integrated teams)
> - less formalized joint work between different professions and agencies arising in the course of assessing for, arranging, providing and evaluating services (sometimes called multi-agency or multi-professional networks)
> - the goals of participation, empowerment and social inclusion of service users and carers (Whittington, pp. 15-16).

From this definition, collaboration can be considered to involve an active process that draws on relationships; can be formal or informal; involves the use of knowledge, skills, values, and motives; and seeks to involve practitioners and clients. Bronstein (2003) also provides a useful definition of interdisciplinary collaboration “…interdisciplinary collaboration is an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual practitioners act on their own” (p. 299). In essence, collaboration encompasses the formation of relationships that promote the attainment of mutually beneficial goals.

A Systems/Ecological Perspective of Collaboration

Various models describing the core elements of social service collaboration have been proposed. Figure 1 provides a summary of three models of collaboration. Whittington (2003) proposes a model of collaboration that draws on systems theory. A synthesis of this model suggests that three system levels affect the collaborative process: (a) the micro system level (personal factors such as individual characteristics), (b) the mezzo system level (professional/interdisciplinary factors), and (c) the macro system level (organizational factors). This systems perspective on collaboration provides an overview of the main elements involved in the collaborative process.

Micro Level: Personal Factors. All people possess individual characteristics and experiences that shape their social identity, ideologies, and willingness and ability to form partnerships. Characteristics such as gender, race/ethnicity, religion, sexual orientation, politics, and general life circumstances all affect one's perceptions of the world and of the collaborative process. A key interpersonal process that is often affected by personal factors is the establishment of trust within a collaboration. Whittington (2003) suggests that personal factors and interpersonal processes related to the establishment of trust are fundamental within collaborations.

Mezzo Level: Professional Factors. Within interdisciplinary collaboration, professionals bring with them varying educational and training backgrounds that shape their understanding of their work. Social workers and other professionals form significant professional identities that are shaped by professional systems and structures (e.g., formal training, membership in professional organizations) that

reinforce the perspectives of one's particular profession. Interprofessional collaboration requires practitioners from various disciplines to understand the commonalities between professions, the unique contributions of each profession, how professions can complement one another, and areas of potential conflict (Whittington, 2003). In addition, interdisciplinary collaboration also requires practitioners to address the following demands:

- Maintaining one's professional identity while remaining flexible,
- Maintaining confidence in the distinctive contribution of one's profession, while not using this confidence as a barrier to working with others,
- Understanding when differences are legitimate and when they are merely a reflection of discipline differences, and
- Understanding and accurately representing the policies of one's agency, while also reconciling these priorities with one's own professional values.

Such competing demands within the context of interprofessional collaboration can create challenges in the collaborative process and collaborations may require support and assistance in overcoming some of these barriers (Whittington, 2003). Factors that can facilitate interdisciplinary collaboration include: equality among collaborating practitioners, shared values, flexibility, openness, commitment to the collaboration, making communication a priority, and encouraging a collaborative culture that empowers members to be creative (Molyneux as cited in Whittington).

Macro Level: Organizational Factors. The degree of organizational support for collaboration can greatly impact the success of a collaborative model. Organizational factors that can impact the effectiveness of collaboration are often centered on support

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provided by senior level administrators and managers. Moreover, the use of strategic plans or other planning documents may facilitate interorganizational collaboration (Whittington, 2003). Other key factors involved in successful collaborations between different organizations include:

- Recognizing and accepting the need for partnership,
- Developing a shared mission,
- Ensuring commitment and ownership, particularly at the upper management level,
- Developing and sustaining trust,
- Creating clear guidelines for working together, and
- Continual monitoring of the collaborative process and making changes as necessary (Hardy et al., as cited in Whittington).

A Developmental Perspective of Collaboration

Robertson (1998) proposes a developmental model of collaboration that incorporates specific processes needed to develop strong interorganizational collaborations. As such, his focus is largely on the macro level of collaboration between organizations. Robertson suggests that effective interorganizational collaboration depends largely on four key antecedents, including: (a) incentive to collaborate, (b) willingness to collaborate, (c) ability to collaborate, and d) capacity to collaborate.

Incentive to Collaborate. Interorganizational collaboration is often motivated by specific needs on the part of the collaborating parties. Collaborations can be motivated by a need to share resources, use existing resources more efficiently, gain access to information, address problems, or gain legitimacy and political advantage. In general,

organizations collaborate when the benefits of collaboration appear to outweigh the costs of collaboration (e.g., time and energy to form the collaboration, loss of autonomy; Robertson, 1998).

Willingness to Collaborate. Willingness to collaborate is based primarily on the level of interpersonal and interorganizational trust, respect, commitment, and shared values and norms between the collaborating parties. A sense of equity in the collaborative relationship and faith in the notion that all parties involved are fulfilling their commitments helps to establish trust, respect, commitment, and shared norms and values. In addition, open communication among all parties also helps to create a sense of trust within the collaboration. Commitment to the collaboration can be fostered by strong organizational support from senior management within the organization (Robertson, 1998).

Ability to Collaborate. The ability to collaborate is related to the types of skills and knowledge that participants bring to the collaboration. Being able to work together on a shared task, as well as the ability of participants to add the work of collaboration on top of their regular work duties are necessary skills required for effective collaboration. In order for these skills and knowledge to be acquired, training and education may be needed. Requiring practitioners to take on the added responsibility of collaboration without proper preparation can hinder collaborative efforts (Roberston, 1998).

Capacity to Collaborate. The capacity of organizations to collaborate may involve the establishment of systems and structures to facilitate the collaboration. The more mechanisms that are in place to facilitate the capacity to collaborate, the more

effective the collaboration will be. Robertson (1998) suggests three mechanisms to foster the capacity to collaborate among organizations: (a) the use of supraorganizational groups (e.g., task forces, advisory committees) that can serve as a forum for discussion of how to effectively collaborate and guide decisions affecting the collaboration, (b) the use of a broker or strategy maker who can coordinate activities and communication between collaborating parties, and (c) the use of rules and regulations to guide collaborative activities, including contracts or memorandums of understanding.

A Process Perspective of Collaboration

In addition to Robertson's model of collaboration, Bronstein (2003) proposes a model of interdisciplinary collaboration that draws on the types of processes that occur within effective collaborations. She suggests that effective interdisciplinary collaboration is reflected in five key factors: (a) interdependence, (b) newly created professional activities, (c) flexibility, (d) collective ownership of goals, and (e) reflection on process.

Interdependence. Interdependence within interdisciplinary collaboration is reflected in circumstances that make professionals dependent upon one another to accomplish a shared goal. Interdependence requires professionals to understand the differences between each others' roles and is characterized by formal and informal meetings, oral and written communication, and respect for the opinions of other professionals (Bronstein, 2003).

Newly Created Professional Activities. Collaborations between professionals can create widespread changes to existing service delivery, thereby creating new

professional activities. Such changes have the potential to increase service effectiveness above and beyond what each party acting independently could achieve. Often interdisciplinary collaboration can bring about changes in organizational policies, priorities, and services (Bronstein, 2003).

Flexibility. Flexibility in collaboration is characterized by the ability to blur professional roles, a willingness and ability to compromise during disagreements, and adaptability within the face of changing circumstances. Flexibility is fostered within collaborations that are egalitarian and non-hierarchical (Bronstein, 2003).

Collective Ownership of Goals. Collective ownership of goals is reflected in a process that allows participants to work together to develop and achieve common goals. Each participant shares in the responsibility of developing collective goals and ensuring that goals are met. Effective interdisciplinary collaboration involves shared goals that are clearly defined and widespread involvement in the decision-making process (Bronstein, 2003).

Reflection on Process. Successful collaborations also include participants' reflections on the collaborative process. A commitment to reflection on the collaborative process includes openly addressing any conflicts within the collaboration. Attention to and communication about the collaborative process, followed by incorporation of these reflections can improve collaborations (Bronstein, 2003).

Perspectives of Collaboration Summary

Taken together, the three models of collaboration provide insights into the core elements of effective collaboration. Collaboration can be viewed from a systems

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perspective as being influenced by micro-level factors related to the characteristics of each individual, mezzo-level professional factors related to the training and educational backgrounds of the professionals involved in the collaboration, as well as by macro-level organizational factors related to the level of support for the collaboration (Whittington, 2003). A developmental model of collaboration focuses on the types of conditions necessary in order for strong collaborations to develop. Essentially, collaborations must have an incentive to collaborate (often related to sharing resources or information); a willingness to collaborate that is characterized by trust, respect, commitment and shared values and norms; an ability to collaborate reflected in skills and knowledge related to collaboration, and a capacity to collaborate including the establishment of systems, guidelines, and structures to facilitate collaboration (Robertson, 1998). Last, a process model of collaboration stresses the importance of the types of processes effective interdisciplinary collaborations utilize. Interdisciplinary collaboration is characterized by interdependence in order to accomplish a shared goal, newly-created professional activities including widespread changes to existing service delivery, flexibility in professional roles, collective ownership of shared goals, and reflection on the collaborative process (Bronstein, 2003).

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Activity I-2: Models of Collaboration

Purpose:
The purpose of this exercise is to review foundation knowledge about different models of collaboration discussed in Section I.

Instructions:
Divide class into three groups and give each group Handout I-2 for reference. Assign each group to take the lead in reviewing one of the three models. Instruct the class that each group is charged with three tasks.

- Briefly summarize their assigned model
- Provide at least one example to illustrate each area of the model.

NOTE: For graduate level classes or trainings with professional, the instructor may elect to have small groups discuss the possible utility of their assigned model to understanding and improving collaborative capacity in social work practice.

Facilitate brief reports from each group. The three models are as follows:

1. Systems perspective model of collaboration (Whittington, 2003)
    a. Micro
    b. Mezzo
    c. Macro

2. Developmental model of collaboration (Robertson, 1998)
    a. Incentive
    b. Willingness
    c. Ability
    d. Capacity

3. Process model of interdisciplinary practice (Bronstein, 2003)
    a. Interdependence
    b. Newly created professional activities
    c. Flexibility
    d. Collective ownership of goals
    e. Reflection on process

Factors That Affect Collaboration Between the CW and AOD Systems

Although collaboration between the CW and AOD systems have been identified

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as an important mechanism to improve treatment outcomes for parents in the CWS, a number of systemic factors can be barriers to collaboration between the two systems (Feig, 1998; DHHS, 1999; Young & Gardner, 2002; Young et al., 1998). Most notably these factors include: differences in defining the client, differences in values and attitudes regarding substance abuse, structural constraints, differences in training and education among workers, and specific challenges unique to each system.

Defining the Client. Within the child welfare system, the child is generally viewed as the primary client, and ensuring the safety and well-being of the child is considered to be the central mission. Within the AOD system, clients are defined as the substance-abusing adult and their role as a parent is often not considered essential to their treatment. While children may be considered an incentive for the parent to remain sober, they are generally not viewed as central to the recovery process (Young et al., 1998). Yet, for substance-abusing parents involved in the child welfare system, the majority of whom are mothers, maintaining relationships with their children, and ultimately, regaining custody of their children may be of central importance to them while in treatment (DHHS, 1999). As a result, many substance-abusing mothers involved in the child welfare system who begin treatment may not be receiving the services they need, resulting in high dropout rates. Moreover, for those women who remain in treatment, services may not necessarily result in improved parenting. These differences in defining the client can result in conflicting service plans and an uncoordinated approach to treatment (DHHS).

Values and Attitudes Regarding Substance Abuse. Differences in values and

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attitudes regarding substance abuse between the CW and AOD systems can also contribute to conflicting case goals and interfere with collaboration between the two systems. Within the AOD field, many workers have themselves experienced substance abuse problems and, as a result, may strongly identify with clients. In addition, the AOD field typically considers substance abuse to be a chronic disease that can be managed, but not necessarily cured. From this perspective, relapse is often considered a normal part of many clients' recovery process (Feig, 1998; Young & Gardner, 2002; Young et al., 1998). However, within the child welfare system, substance abuse may be perceived as a bad choice, rather than a disease. From this perspective, substance-abusing parents may be viewed in an adversarial manner. Relapse may be considered an indication of the parents' unwillingness to care for their child, rather than as a normal part of the recovery process. As a result, parents may be treated with a "zero tolerance" approach that focuses on punishing parents for their bad behavior (Feig; Young & Gardner; Young et al.).

These differences in attitudes and values regarding substance abuse and the nature of substance abuse treatment can contribute to potentially conflicting treatment goals. Within the AOD field, the main goal of treatment is typically considered to be abstinence from drugs and alcohol and reduction in the consequences of drug and alcohol use (e.g., criminal behavior, health problems). Improvement of parenting or ability to provide a safe home environment is typically not a primary goal of AOD treatment (Feig, 1998; Hunter, 2003). Within the Child welfare field, the desired outcomes of treatment are generally focused on ensuring the safety, well-being, and

permanency of the child. While these case goals may not necessarily conflict, they also may not represent a coordinated treatment approach. It is possible that from the AOD perspective a substance-abusing parent who has a relapse, and then returns to treatment may be still be achieving case goals, whereas, from the child welfare's perspective, this parent may be viewed as incapable of caring for their children. Alternatively, a substance-abusing parent may achieve and maintain sobriety, while not improving parenting skills, thus from the AOD perspective, the client has achieved a successful outcome, while from the CW perspective the outcome is not successful (DHHS, 1999).

Structural Constraints. Structural constraints related to differences in timelines and problems surrounding confidentiality mandates can also affect collaboration between the CW and the AOD systems. Young and Gardner (2002) suggest that collaboration between the CW and AOD systems is affected by five "clocks," representing timeline constraints, including:

1. *TANF timelines:* Many child welfare parents are also receiving Temporary Assistance to Needy Families (TANF) benefits. TANF mandates that parents receiving cash benefits be involved in work activities within 24 months. This requirement may interfere with the ability of parents to participate in treatment and may also compromise their ability to meet the basic needs of their children should their cash benefits be reduced or denied.

2. *ASFA timelines:* The Adoption and Safe Families Act (ASFA) mandates that a permanency hearing be held when a child has been in out-of-home care for 12 months and that a petition for termination of parental rights be filed after a child is in out-of-home care for the past 15 of 22 months.

3. *Recovery timelines:* Recovery from substance abuse problems may be a lengthy process and may take longer than is allowed by substance abuse funding constraints, as well as the timeline constraints mandated by ASFA.

4. *Developmental timelines:* Long-term separation from primary caregivers and a lack of permanency may be harmful to children's development.

5. *System timelines:* Both the CW and AOD systems may not respond to the problem of substance-abusing parents in the CWS with the sense of urgency required to meet the needs of this population within the constraints of the above "clocks."

These five clocks affect the ability of parents to engage in treatment and also place pressure on both the CW and AOD systems to develop mechanisms to increase immediate access to substance abuse assessment and treatment.

In addition to the structural constraints represented in the five clocks, collaboration between the CW and AOD systems may also be negatively affected by problems surrounding confidentiality mandates. Confidentiality within both the CW and AOD systems may be especially important due to the stigma associated with involvement in either system. Both systems may be hesitant to share confidential information for fear of violating confidentiality mandates, particularly stringent regulations protecting the confidentiality of recipients of substance abuse treatment (DHHS, 1999). However, sharing certain information between the CW and AOD systems may be essential for a number of reasons: to ensure an accurate assessment of clients, to coordinate case goals, and to prevent overlap of services (DHHS). Although problems with confidentiality mandates are often cited as a barrier to collaboration between the two systems, Young and Gardner (2002) suggest that confidentiality barriers can be overcome and may simply reflect poor relationships between the CW system, the AOD system, and the courts.

Differences in Training and Education Among Workers. The differing

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educational and training backgrounds of CW and AOD workers may interfere with effective collaboration. Training within the CW and AOD fields generally does not include information on the connections between the systems or mechanisms to work together (Young et al., 1998). Moreover, cross training is generally lacking; CW workers often are not offered training and education in substance abuse issues, while AOD workers may also be unaware of issues within the CW system. These differences in training and education may interfere with effective communication between workers in each system (Young et al.).

Specific Challenges Unique to Each System. In addition to the barriers noted above, Young and Gardner (2002) suggest that both the CW and AOD systems face unique challenges that can also affect each system's ability to form effective collaborations. Within the child welfare system, these challenges include:

1. *Questions regarding the effectiveness of substance abuse treatment.* Although research has found that substance abuse treatment can be effective, some CW workers may still question the utility of substance abuse treatment.

2. *Information systems may not accurately reflect the extent of substance abuse problems within CW populations.* This lack of information on the extent of substance abuse problems within the CW system may prevent some CW agencies from understanding the seriousness of the problem.

3. *Difficulty accessing treatment for CW clients.* CW workers may refer clients to substance abuse treatment, yet due to shortages of available treatment, clients may not be served in a timely manner. Such barriers to accessing timely services can increase CW workers' uncertainty about substance abuse treatment.

4. *Confidentiality.* As mentioned above, concerns regarding confidentiality mandates may represent a challenge to effective collaboration and communication between the two systems.

Correspondingly, within the AOD system, certain systemic challenges can also

affect collaboration, including:

1. *Competing demands.* Substance-abusing parents within the CW system are simply one group that the AOD field must serve. Agencies providing substance abuse treatment also receive numerous referrals from other systems, most notably the criminal justice system. It may be difficult for substance abuse providers to prioritize treatment slots for CW parents due to these competing demands.

2. *Different tracking systems.* The CW and AOD systems typically do not track the same client outcomes. The AOD system generally does not track outcomes related to parenting, but rather whether the client completed treatment successfully.

3. *Treatment shortages.* There is generally a shortage of available treatment slots for clients needing substance abuse treatment. Waiting lists are often used when treatment slots are full. If a parent in the CW system does not attend treatment after being on a waiting list, they will likely lose their place on the list. This may be a particularly challenging problem for substance-abusing parents in the CW system, many of whom may be involuntary clients who may not be motivated to attend treatment.

4. *Prioritizing women and children.* Substance abuse treatment programs that specifically address the unique needs of women with children may be lacking. Competing demands for treatment that addresses the needs of other groups, such as those involved in the criminal justice system (many of whom are men), may prevent development of treatment options for mothers who represent the majority of CW system parents.

5. *Attitudes toward clients.* As mentioned above, the AOD and CW fields may have fundamentally different perspectives toward clients.

6. *Capacity problems.* There can be a time lag between when substance abuse funding becomes available and the actual implementation of new programs, contributing to a shortage of available treatment.

These barriers between the CW and AOD systems may interfere with effective collaboration between the two systems. Differences in defining the client, differences in values and attitudes regarding substance abuse, structural constraints such as timeline problems and confidentiality mandates, differences in training and education, and

specific challenges unique to each system may all interact to make the collaborative process between the CW and AOD systems all the more challenging.

Activity I-3: Developing an Integrated Service Plan

Background and Purpose:
Specific challenges affecting collaboration between child welfare and substance abuse treatment systems include defining the client. For CW, the primary client is considered to be the child. For AOD, the primary client is generally considered to be the chemically-dependent person. These differing perspectives may lead to conflicting service plans and failure to see improved parenting skills. The purpose of this exercise is to help participants develop increased awareness of these differing perspectives and learn some beginning skills in improving collaboration.

Instructions:
Read and distribute copies of the case scenario provided in Handout I-3. Break into small groups. Members of each group should be assigned a role of child welfare professional or substance abuse treatment professional. For this exercise, small groups are to create an ***integrated service plan*** that addresses both *sobriety and improved parenting skills*, while staying grounded in their respective professional disciplines. Instruct groups to make sure that their goals and objectives are listed in *behavioral terms*.

Debrief small groups. Invite groups to:

1) Briefly share their plans, and
2) Observe how their different professional perspectives helped or impeded development of an integrated service plan.

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SECTION II

CORE ELEMENTS OF PROMISING COLLABORATIVE MODELS BETWEEN THE CW AND AOD SYSTEMS

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SECTION II
INSTRUCTIONAL GUIDE

Learning Objectives

This section introduces participants to the core elements of successful collaboration and increases awareness of promising collaborative models between the child welfare and alcohol and drug systems. Specifically, this section begins by outlining 10 factors that are an indication of how well systems are working together as defined by Young and Gardner (2002). These 10 factors are then condensed and described in relation to five core elements that tend to be involved in successful collaborative models: (a) development of a shared vision through regular communication; (b) establishment of guidelines, memorandums of understanding, and protocols for sharing confidential information; (c) development of concrete programs; (d) training and cross training; and (e) joint case planning. The section also includes examples of various programs that demonstrate these core elements.

By the end of this section, participants will:

- Be introduced to the 10 factors related to effective collaboration as identified by Young and Gardner (2002),
- Be able to describe core elements of collaboration and apply them to their own county practice, and
- Be able to describe 1 - 2 promising collaborative program models.

Public Child Welfare Competencies

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

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2.4 Student is able to gather, assess, and present pertinent information from interviews, case records, and other collateral sources required to evaluate an abuse or neglect allegation.

2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effects on services for children and families.

8.2 Student understands how political activities and regulatory, legislative, and judicial processes at local, state, and national levels influence agency policies, procedures, and programs.

8.6 Student demonstrates basic knowledge of various federal, state, and local child welfare funding sources and consequent implications for agency policy, objectives, and service delivery.

Agenda and Suggestion for Instructors

Time allocation: Approximately 75 minutes (may vary depending on instructor preferences)

- Introduction
    - Introduction to section content
    - Introduction of participants (if not part of ongoing class)
- Overview of 10 dimensions of successful collaboration
    - Activity II-1: Application of the 10 Domains of Collaboration
- Core elements of collaboration in action: Descriptions of successful models
    - Activity II-2: Applying Elements of Effective Collaboration

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, the instructor may opt to focus on the more comprehensive description of elements of collaboration presented in the matrix of progress in linkages

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among alcohol and drug services, child welfare services, and the dependency court system presented in the first part of this section, particularly if working with more advanced students or trainees. It may also be helpful for the instructor to highlight descriptions of successful collaborative practice models in several core areas such as planning/development of shared vision, development of concrete programs, communication protocols, training, and case planning. To this end, instructors are provided with several options for activities that allow participants to review and reflect on illustrations of successful collaborative models.

Materials Needed

- Either an overhead projector and PowerPoint presentation on transparencies or a computer and PowerPoint presentation online
- Markers and flip chart or white board (optional—for writing key points in response to small group and full group discussions)

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SECTION II
CORE ELEMENTS OF PROMISING COLLABORATIVE MODELS BETWEEN THE CW AND AOD SYSTEMS

Matrix of Progress in Linkages: A Tool to Assess and Guide Collaboration

Despite the potential barriers to collaboration between the CW and AOD systems, several promising collaborative models have been developed and implemented. Young and Gardner (2002) identified promising CW and AOD collaborative models that incorporate many key elements of successful collaboration. Each collaborative model was described according to 10 factors that are considered to be an indication of how well the systems are working together. An updated version of these 10 factors are reflected in a *Matrix of Progress in Linkages Among Alcohol and Drug and Child Welfare Services and the Dependency Court System* (National Center on Substance Abuse and Child Welfare, 2003b; Handout II-1). These 10 factors include: (a) underlying values and principles of collaborative relationships, (b) daily practice related to client screening and assessment, (c) daily practice related to client engagement and retention in care, (d) daily practice related to services to children, (e) joint accountability and shared outcomes, (f) information sharing and data systems, (g) training and staff development, (h) budgeting and program sustainability, (i) working with related agencies, and (j) working with the community and supporting families. Various models place more or less emphasis on these 10 elements. These 10 factors represent a way for counties to assess aspects of CW and AOD collaboration.

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Activity II-1: Application of the 10 Domains of Collaboration

Purpose:
The purpose of this exercise is to use critical thinking skills by applying various domains of collaboration to practice.

Instructions:
This activity will focus on the 10 domains of collaboration. Each group will assess their own county/setting that they work in using the 10 domains discussed in Handout II-2. (If group participants are from different counties, they may confer and select one county/setting to utilize for this exercise).

What overall "report card grade" would you give to your county or setting? What are you basing this on? What grade would you give on specific selected domains?

If participants cannot complete this exercise due to lack of information, how might you go about assessing or finding the information you need? What specific steps would you recommend?

Core Elements of Collaboration in Action: Descriptions of Successful Models

Highlights of core elements of collaboration (extracted from the 10 dimensions described above and from the literature on collaboration) are described in greater detail in this section. Some of the core elements in successful CW and AOD collaborations include the following: development of a shared vision through regular communication; establishment of guidelines, memorandums of understanding, and protocols for sharing confidential information; development of concrete programs; training and cross training; and joint case planning. These core elements of effective CW and AOD collaboration are also congruent with the characteristics of collaboration noted by Whittington (2003), Robertson (1998), and Bronstein (2003), discussed in Section I.

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NOTE TO INSTRUCTOR:
The core elements of collaboration are described with illustrations below. Overheads for this section provide illustrations specific to the five counties interviewed for the study. The instructor may cover this content by providing brief descriptions of each area of collaboration with examples (as outlined below). As an alternative to a didactic presentation of these elements of collaboration, the instructor may elect to use Activity II-2, Alternative 3 to allow participants to define and illustrate each of the core elements of collaboration. The instructor may then augment the small group report using information and additional illustrations provided below.

Development of a Shared Vision Through Regular Communication. The development of a shared vision to improve services and outcomes for substance-abusing parents in the CWS appears to be a core element of many CW and AOD collaborative models. Many collaborations are first initiated when representatives from both systems begin to recognize that system changes are necessary in order to effectively serve clients involved in both systems. Often the development of a shared vision involves representatives from both systems changing their perspectives on each others' work.

Coming to a shared understanding of the types of changes necessary to improve access to services and outcomes for children and families often involves the use of task forces or other official committees that meet on a regular basis.

- For instance, McAlpine et al., (2001) described a CW and AOD collaborative model currently being implemented in Montgomery County, Maryland that is guided by a task force that includes representatives from CW and AOD service providers.
    - The task force assisted in the development of an overall philosophy shift involving training, cross-training, and skill building. A training curriculum was developed by both CW and AOD staff that addressed basic substance abuse information, assessment methods, information on treatment resources, the types of philosophical changes required to

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implement combined services, intervention skills, and ways to engage clients in treatment.

- In addition, a "Structured Response" approach was developed that included a framework for successful collaboration, including a commitment from AOD providers to emphasize treatment for CW-involved parents. The Structured Response approach also focused on providing varying levels of response to substance-abusing parents depending on the level of severity of substance abuse.

- This collaborative model also included an emphasis on standards and quality assurance. The task force researched substance abuse interventions and developed a "blended model of intervention" that included varying levels of service intensity and a focus on engaging clients in treatment. An AOD worker was outstationed within the central CW office and provided consultation to CW staff, intervention with substance-abusing parents, and assistance in referring parents to treatment or drug testing services. In addition, existing relationships between CW and AOD staff were described as important in ensuring the collaboration was successful and resulted in improvements in procedures to ensure timely access to drug testing and assessment services (McAlpine et al., 2001).

- Connecticut's Project SAFE (Substance Abuse Family Evaluation) formed a working group that developed 15 "guideposts" for collaboration, which clearly stated the needs and future directions that the collaboration expected to achieve.

  - A strategic plan was then created that further specified the expected activities and outcomes of the project. The primary goal of Connecticut's Project SAFE is to ensure that substance-abusing parents in the CWS receive immediate access to assessment and treatment services.

  - The underlying values and principles of this collaborative model include the establishment of a shared vision of the CW and AOD systems working together to effectively serve substance-abusing parents who require intervention from both systems. Ultimately, this collaboration seeks to share responsibility for clients served by both systems. Project SAFE also implemented a shared database that provides both systems with important information regarding the substance use patterns of clients and client characteristics associated with treatment completion. This information has been used to inform treatment interventions (Young & Gardner, 2002).

The development of a shared vision through regular communication reflects a

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number of core elements of successful collaboration. Specifically, professional factors are involved because workers in both systems are required to understand the commonalities between their professions and the unique contributions of each profession (Whittington, 2003). In addition, interdependence is also a factor because both systems came to understand that they needed one another in order to achieve their goals (Bronstein, 2003). Last, the capacity to collaborate was facilitated through the establishment of task forces or advisory groups that guided collaborative processes (Robertson, 1998).

Establishment of Guidelines, Memorandums of Understanding, and Protocols for Sharing Confidential Information. In addition to the development of a shared vision of the collaboration, many promising collaborative models also establish guidelines, memorandums of understanding, and protocols for communication between systems to help guide the collaborative process.

Memorandums of understanding (MOU) are also used by many collaborative models to establish clear expectations from collaborating parties.

- Miami/Dade County's Dependency Drug Court (DDC) uses MOUs between the court and AOD service providers to specify the types of reporting, screening, intake, and monitoring requirements that agencies will need to provide. These MOUs also indicate that programs cannot release clients from residential treatment without court consultation and a discharge plan. The overall goal of Miami/Dade County's DDC is to provide comprehensive services and intensive monitoring of substance-abusing parents in an effort to provide the best chances for reunification under the timelines mandated in the ASFA. The underlying values and principles of the DDC involve recognition that the underlying issues that cause substance abuse to occur must be identified and treated. The majority of women in the DDC have experienced some type of abuse and also struggle with poverty. One of the goals of the DDC is to provide a holistic evaluation of the issues facing the parent and to treat co-occurring problems, such as mental health problems (Young & Gardner, 2002). A DDC addiction specialist conducts

the initial assessment of AOD and mental health problems, and in conjunction with CWS workers a joint case plan is developed and implemented by both the AOD service provider and the CWS. Cases that require intensive services are given top priority for the DDC. Parents typically spend 15 months in the DDC during which they must comply with drug tests and treatment, and maintain daily contact with the DDC specialist. Similar to other DDCs, parents who are noncompliant receive sanctions such as jail time or fines. To graduate from the program, parents must complete their case plan, obtain housing and employment, complete a parenting class, complete four motivational workshops, and regain custody of their children (Young & Gardner).

Many collaborative models also establish protocols for sharing confidential information between systems. New Jersey's Child Protection Substance Abuse Initiative addressed the problem of sharing confidential information by developing protocols that specified the types of information that could be shared between the systems (Young & Gardner, 2002). Likewise, parents in Miami/Dade County's DDC are required to sign a consent form to release information between AOD service providers, the courts, and the CWS upon enrollment in the DDC. Core elements of collaboration that are reflected in the establishment of guidelines, MOUs, and protocols for sharing information include the capacity to collaborate, which is facilitated by the establishment of regulations to guide collaborative activities (Robertson, 1998).

NOTE:
See Section IV for detailed content and activities related to sharing information between systems.

Development of Concrete Programs

In addition to process elements of collaboration, many successful CW and AOD collaborative models also develop concrete programs to improve service delivery to substance-abusing parents in the CWS. Examples of program elements that are often

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included in effective CW and AOD collaborations are: outstationed AOD workers in child welfare offices, and the use of liaisons/specialized case managers to monitor client progress and improve engagement and retention in treatment. Drug dependency courts are an example of a specific program model that appears to improve outcomes for both children and parents.

Outstationed AOD workers in child welfare offices or dependency courts are typically funded by the CWS and provide a range of services, including consultation with CWS staff, assessment of parents, and referral to substance abuse services. Outstationed AOD workers help to ensure that parents are assessed quickly and assist in streamlining access to treatment.

- Connecticut's Project SAFE has placed an AOD worker in every CWS regional office to provide consultation and training to CWS workers and intervention services to parents (Young & Gardner, 2002).

- Similarly, Jacksonville's Treatment Agency Initiated Program uses outstationed AOD workers to provide consultation, assessment, and referral. Because parents are not required to make appointments at separate agencies, the use of outstationed AOD workers results in a more coordinated approach to entry into both the CW and AOD systems (Young & Gardner, 2002).

Another promising model is the use of *Drug Dependency Courts*. For example, both Sacramento and San Diego Counties have Drug dependency courts as well as special programs for joint case management (described later).

- The Sacramento County Alcohol and Other Drug Treatment Initiative (AODTI) includes the use of a dependency drug court (DDC). The DDC provides rewards and sanctions for compliance with treatment and abstinence from drugs and alcohol.

    - The goals of the DDC are to increase family reunification rates, increase parents' substance abuse treatment compliance rates, decrease children's time in out-of-home care, decrease out-of-home care costs, increase the

number of substance-abusing parents who are evaluated and placed in appropriate treatment, and increase collaboration between the court, CW, and AOD service providers.

- Parents with substance abuse problems are identified at the detention hearing by a CW worker who conducts an initial AOD evaluation and refers families to services and to the Specialized Treatment and Recovery Services (STARS) program. The STARS worker focuses on providing support to the parent in order to increase engagement and retention in services and also monitors compliance with treatment and random drug testing. Participating parents receive sanctions for noncompliance (e.g., failure to enroll in treatment, positive drug tests, missing a drug test, not participating in treatment, etc.). Sanctions can include a reprimand or jail time (Children and Family Futures, 2002; 2005).

- A recent evaluation on the effectiveness of Sacramento County's DDC found positive outcomes. Results indicated that parents participating in the DDC had significantly higher rates of entering AOD treatment than parents in a comparison group that did not participate in the DDC. Eighty-five percent of DDC participating parents in Years One and Two of implementation and 88.5% in Year Three entered treatment, compared to 50.5% in the comparison group. The DDC also appears to have beneficial effects on reunification rates. At 12 months, 33.3% of Year One DDC-participating children were reunified, and 28.9% of Year Two children were reunified, compared with 18.7% of the comparison children. At 18 months, 43% of the Year One DDC children reunified compared with 24.9% of the comparison children. Similar reunification rates were noted at 24 months. In addition, DDC children were less likely than the comparison group to be in adoption, guardianship, or long-term placement. Overall, the DDC resulted in cost savings as a result of increased reunification rates (Children and Family Futures, 2005).

The *use of liaisons or expert case managers to monitor client progress and improve engagement and retention in treatment* is also a core element of many collaborative models.

- For instance, within Sacramento County's Alcohol and Other Drug Treatment Initiative (AODTI), Intervention Specialists with experience in both the CW and AOD systems are located within the dependency court and provide outreach, support, assessment, and education for parents during their initial detention hearing. Trained workers also serve as liaisons between the CW and AOD service providers and provide parents with assistance in accessing and

participating in treatment and meeting court requirements.

- Similarly, San Diego County's Dependency Court Recovery Project (DCRP) uses Recovery Specialists who have special training in AOD issues to monitor parents' treatment progress and increase their engagement in services. The DCRP incorporates several program elements. Parents are assessed initially by a CW worker and if a substance abuse problem appears to be present, they are referred to the Substance Abuse Recovery Management System (SARMS). SARMS then provides an AOD worker who assesses the parent, provides case management, random drug testing, and regular reports to the CWS and the court on client progress. Parents who refuse treatment, have a positive drug test, refuse a drug test, or do not appear for a court hearing are subject to court sanctions. Parents who are repeatedly noncompliant may be referred to the dependency drug court (DDC), where they receive more intense monitoring and sanctions for noncompliance that include jail time or paying a fine (Young & Gardner, 2002). Information on outcomes of the DCRP indicate that 79% of SARMS clients were compliant with their case plans and the time from removal of the child to achievement of a permanent placement or reunification has decreased from an average of 34 months to 12-13 months (Young & Gardner, 2002).

There are other collaborative models such as co-location of services, enhanced services for children, specialized substance abuse treatment for child welfare-involved women and children, and use of paraprofessionals in recovery to provide peer support and recovery coaching in order to engage and retrain clients in treatment. For example:

- Cuyahoga County's Sobriety Treatment and Recovery Teams (START) use Family Advocates, who are workers who have been in recovery for a minimum of three years to help increase parents' engagement and retention in treatment. Overall, START is a collaborative model that provides services to pregnant substance-abusing women and mothers who deliver a drug-exposed infant. Mothers are referred to the START program by hospitals when a positive toxicology screen is found either prenatally or at birth. START workers assess and refer women to treatment approximately 3-4 days after the referral. Family advocates are then used to increase client engagement and retention in treatment (Young & Gardner, 2002). Information on the impact of the START program suggests that the program has been successful in engaging clients in treatment. During the first 2 years of implementation, 81% of START clients received substance abuse treatment, in comparison to just 45% of substance-abusing mothers not in the program. Young and Gardner (2002) suggest that the key elements of the START collaboration are the use of substance abuse

specialists, the immediate response to prenatal substance abuse, the ongoing training and education staff receive, and the services provided by AOD treatment agencies.

The development of concrete programs, including outstationed AOD workers and the use of liaisons to improve service delivery to substance-abusing parents in the CWS reflects the core collaborative element of newly-created professional activities that improve service effectiveness. These AOD and CW collaborations helped to create changes to existing service delivery, creating new professional activities designed to better meet the needs of clients (Bronstein, 2003).

Training and Cross Training. Training and cross training are key elements of most promising AOD and CW collaborative models. Examples are provided below (Young & Gardner, 2002):

- Connecticut's Project SAFE provides all new CW workers with 3 days of substance abuse training, and cross training is included during regional meetings involving both CW and AOD staff. Jacksonville's Treatment Agency Initiated Program provides 3-day training for both CW and AOD staff.

- New Jersey's Child Protection Substance Abuse Initiative also provides 3 days of substance abuse training to new workers, as well as in-service training to current CW workers.

- Similarly, Sacramento County's Alcohol and Other Drug Treatment Initiative trains all CW workers to conduct initial assessments of parents and make referrals to AOD services.

- Montgomery County, Maryland's Blended Model of Intervention uses a training curriculum that was developed by both CW and AOD staff and includes information on assessment methods, treatment resources, and intervention skills.

Training and cross training help to address the professional factors involved in successful collaboration. Specifically, training and cross training can improve each

profession's understanding of one another's roles, the commonalities and differences between professions, how professions can complement one another, and areas of potential conflict (Whittington, 2003).

Joint Case Planning. Another core element of many promising collaborative models is the use of joint case planning to coordinate treatment goals between the CW and AOD systems (Young & Gardner, 2002).

- Within New Jersey's Child Protection Substance Abuse Initiative, the CW and AOD workers develop a joint case plan that addresses the parents' substance abuse treatment needs.

- Similarly, within Jacksonville's Treatment Agency Initiated Program, an individualized course of action (ICA) plan is developed for families in the program. The ICA includes input from all agencies involved with the family.

- Miami/Dade County's DDC also uses joint case plans that are created and monitored by the DDC addiction specialist and the CWS worker.

In addition, a team approach to case planning is also a core element of many collaborative Family Drug Treatment Court (FDTC) models. Indeed, dependency drug courts have emerged as a promising collaborative model that may improve coordination and case planning between the CW, the AOD, and the court systems. The FDTC model involves the use of dependency drug courts to improve outcomes for substance-abusing families involved in the CWS (Young, Wong, Adkins, & Simpson, 2003). These models emphasize joint case planning and often integrate many other collaborative elements described above. A recent evaluation of five FDTC sites located in Jackson County, Missouri; San Diego County, California; Santa Clara County, California; Suffolk County, New York; and Washoe County, Nevada provides evidence for the effectiveness of this

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collaborative model.

- Parents involved in FDTC services entered substance abuse treatment at a significantly higher rate than substance-abusing parents not involved in the program.

- FDTC parents also accessed treatment more quickly; they had higher participation rates in treatment, attended more intensive treatment, and completed treatment at a higher rate than those parents not in the FDTC.

- Positive outcomes for children were also found. FDTC parents experienced fewer new child maltreatment reports or criminal arrests than parents in a comparison group, and 55% of FDTC parents reunified with their children, compared to 49% in the comparison group.

- In addition, among those children who did not reunify, those whose parents participated in the FDTC program achieved an alternative permanent placement in approximately 18 months, compared to approximately 2 years among comparison children (Young et al., 2003).

The use of joint case planning to coordinate treatment goals between the CW and AOD systems incorporates a key aspect of effective collaboration. Joint case planning reflects collective ownership of goals in which shared goals are clearly defined and there is widespread involvement in the decision-making process (Bronstein, 2003).

Conclusion

The increasing number of child welfare systems that are struggling with the problem of parental substance abuse has created an urgent need to identify promising collaborative models between the CW and the AOD systems. The core elements of successful CW and AOD collaboration reflect many of the core elements involved in any successful collaboration. Successful collaborative models between the CW and AOD systems bring together representatives to create a shared vision and understanding of the types of changes necessary to improve access to services and outcomes for

children and families, establish guidelines to structure the collaboration, create new programs and professional activities including outstationing AOD workers in CW offices and using liaisons to monitor client progress, use training and cross training to improve interdisciplinary collaboration, and use joint case planning to help develop collective ownership of goals.

Young and Gardner's (2002) description of the 10 factors considered to be an indication of how well the CW and AOD systems are working together represents a mechanism to measure the progress of CW and AOD collaborations. Assessing the quality of collaborative relationships between the AOD and CW systems according to these 10 factors represents a detailed way of understanding how well the two systems are collaborating.

Overall, research suggests that strong collaboration between the CW and AOD systems can increase timely access to treatment, improve client engagement and retention in treatment, improve reunification rates, speed up the reunification process, increase alternative permanent placements when reunification is not possible, and decrease the incidence of new child maltreatment reports (Young et al., 2003; Young & Gardner, 2002). Although certain barriers to effective collaboration between the CW and AOD systems can create challenges for both systems, the pervasiveness of substance abuse within the CW system combined with evidence indicating that collaboration does result in improved outcomes suggests that counties and states should invest time and resources into AOD and CW collaboration. The core elements of successful AOD and CW collaboration described in this review can serve as a model for systems to begin the

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process of collaboration.

Activity II-2: Applying Elements of Effective Collaboration

Purpose:
This exercise gives participants an opportunity to explore different elements of collaboration and critically examine how different elements might be adopted or adapted in their practice. NOTE: This activity may be more appropriate for more advanced classes or for professionals who are already working in a county setting.

Instructions:
This is a small group activity in which participants will brainstorm and identify elements of promising practices in collaboration across systems. Distribute Handout II-2 (which provides basic descriptions of some of the core elements of collaboration) and Handout II-3 (which provides concrete examples from five California counties). Have participants focus on practices that:

- Can be adapted to their own practice and,
- Can be strengthened or introduced in their own systems.

Participants will also identify *possible barriers* for adaptation of selected practices and how these barriers may be overcome.

***ALTERNATIVE 1 – Focus on programs*.** Small groups may be charged with identifying elements of collaboration programs (e.g., in development of concrete programs and training and cross training) that might be adopted or adapted in their counties and discuss what would be required to facilitate adoption.

***ALTERNATIVE 2 – Focus on practice*.** For advanced students not yet in practice or for participants in counties without formal collaborative practice, small groups may be charged with identifying elements of collaboration (e.g., in the areas of communication across systems and shared case planning) that they might be able to adopt or adapt in their practice.

***ALTERNATIVE 3 – Basic review of elements of effective collaboration*.** For undergraduate students who have not yet been in field placements, the instructor may invite students to divide into small groups and have each group *summarize* one of the five elements of effective collaboration described in the examples from California counties and *provide examples* to the larger group. (The five elements include: developing a shared vision through communication, establishing protocols for sharing information, sharing confidential information, development of concrete programs, training and cross-training, and joint case planning). The trainer can summarize group reports on the white board to facilitate further discussion.

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SECTION III

FACTORS THAT HELP AND HINDER COLLABORATION: FINDINGS FROM INTERVIEWS

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SECTION III
INSTRUCTIONAL GUIDE

Learning Objectives

This section shares findings from recent research about the factors that both help and hinder collaboration between systems based on interviews with experts from five California counties with a strong history of collaboration. This section describes each of these areas in detail and then concludes with an opportunity for participants to participate in a "mock collaborative." By the end of this section, participants will:

- Become familiar with the factors that both hinder and enhance collaboration as discussed in the research,
- Be able to view the perspectives of professionals from various disciplines in interdisciplinary work, and
- Identify strategies to advance collaboration and address potential resistance to collaboration

Public Child Welfare Competencies

2.17 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations in which the worker's values are challenged.

2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

4.2 Student is able to work effectively with agency personnel and clients in an environment characterized by human diversity.

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

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8.3 Student understands how leads/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

8.6 Student demonstrates basic knowledge of various federal, state, and local child welfare funding sources and consequent implications for agency policy, objectives, and service delivery.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

Agenda and Suggestions for Instructors

Time allocation: Approximately 90 minutes

- Introduction
    - Introduction of trainer(s) and participants (if not part of ongoing class)
    - Introduction to section content
- Overview of findings from the research on factors that enhance collaboration
    - Activity III-1: Factors That Enhance Collaboration
- Overview of findings from the research on factors that hinder collaboration
    - Activity III-2: Mediation Exercise: Addressing Factors That Hinder Collaboration
- Implications for practice: Building collaborative programs
    - Activity III-3: Mock Collaborative

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, the instructor may elect to focus on Activities III-1 and III-2 (which provide opportunities to consider how to enhance collaborative practice and address some of the factors that hinder collaboration). When the participant group consists of

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second year students or more experienced professionals, the instructor may opt to focus primarily on skill development through Activity III-3, the Mock Collaborative. The overheads for this section cover all of the key factors that help or hinder collaboration. Descriptions and examples are provided in the text; however, instructors may chose to augment discussion of these factors with observations from their own experiences, as they deem appropriate. Instructors who do not plan to cover all the content in Section V should be sure to briefly cover the three overheads in that Section that address *Themes From the Study: Factors That Helped Collaboration* in relation to communication and confidentiality.

Materials Needed

- Either an overhead projector and PowerPoint presentation on transparencies or a computer and PowerPoint presentation online
- Markers and flip chart or white board (optional—for writing key points in response to small group and full group discussions)

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SECTION III
FACTORS THAT HELP AND HINDER COLLABORATION: FINDINGS FROM INTERVIEWS

This section describes factors that both help and hinder collaboration between systems based on in-depth interviews with experts (N = 49) from five counties in California with a strong history of collaboration. The table below provides an overview of the factors that help and hinder collaboration, which are described in greater detail in this section and in the first part of Section IV.

Factors That Help Collaboration	Factors That Hinder Collaboration
Organizational Factors/Changes • Collaboration was often stimulated by *technology transfer* though accessing information from other states/counties or obtaining technical assistance from other county or state agencies. • Based on local need, successful counties *adopted specific models for collaboration*. • Formal and informal mechanisms for planning and problem solving such as collaborative planning teams, interdisciplinary case conference teams, and strategic planning sessions among collaborative leaders. • Use of *training and cross training* to support all stages of change. **Operational Factors/Changes (Addressed in Section IV)** • Development of communication tools and protocols • Formal and informal strategies for building and maintaining relationships • Acculturating staff to the collaborative process	• Conflicts in values, perspective, and expectations (addressed by deliberate, and sometimes difficult, series of meetings with different stakeholders in which these issues were surfaced and negotiated). • Communication problems (which required resolving differences and problem-solving in both formal collaborative meetings and through staff members in key liaison roles between systems). • Funding challenges and fragmentation of systems. • Problems with staff turnover/ inconsistency in participation of representatives in collaborative meetings. • Individual personalities.
NOTE: These factors are summarized in PowerPoint slides provided with this section.	

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What Helps Collaborative Practice

The respondents described a variety of collaborative practices and programs including dependency drug courts; special formalized collaborative case planning and review programs; intensive substance abuse treatment services (outpatient or residential) specifically for child welfare-involved parents; outstationed substance abuse experts in child welfare and/or courts; and multi-service agencies with co-located staff and services inclusive of child welfare, substance abuse, and other fields such as mental health. Although the specific programming varied by field, consistent themes emerged in the interviews about factors that facilitated the adoption, development, and maintenance of collaborative policies and programs.

Preconditions for Collaboration

Four primary themes emerged in relation to respondent reflection about how their collaborative efforts started, including: local history of collaboration in related areas, emergence of leader(s) or champion(s) who initiated collaboration, a collective realization that collaboration would better serve the mission of multiple service delivery systems, and a commitment to collaboration from both child welfare and substance abuse treatment fields.

- **History of Prior Local Collaboration.** Respondents who had been working as professionals in child welfare or alcohol and drug service delivery systems before the inception of the collaborative models described above typically traced the lineage of their innovative programs to earlier cross-system collaboration. For example, a manager in one county described how collaboration with child welfare grew out of cross trainings initiated by the county alcohol and drug program administration in support of new local treatment services designed for pregnant and parenting women. The cross trainings brought together leaders and providers in different systems and, over time, leaders identified “gaps” between substance abuse and child welfare fields as a priority. Respondents in another

county described collaborations between child welfare and mental health fields as providing a foundation for collaborative planning that bridged to the substance abuse field. Recognition of the need for stronger collaborative models between child welfare and substance abuse treatment were often born out of other innovations, trainings, or meetings that brought stakeholders together.

- **Leaders and "Champions."** Early innovations were often advanced by the vision and initiative of individuals in leadership. The source of innovation varied between counties. In one county, a dependency court judge sought information about collaborative models and strongly advocated for adoption of a dependency drug court and related collaborative case management services. In another county, a director of health and human services required that all social service providers be trained in understanding and intervening in substance abuse. The training initiative was coordinated by managers who were invested in this vision and, in turn, identified additional opportunities to create institutional policies and programs to address alcohol and drug problems among clients in child welfare. Similarly, a direct service provider in the substance abuse treatment field in a third county also described the importance of leadership provided by the county child welfare director, which was ultimately supported fully by the alcohol and drug administrator: "You need a true champion who really understands the problem from the client level; without that, the vision gets lost."

  Leadership at multiple levels was described as crucial to the development, and the maintenance, of collaborative efforts. Leadership and competency in middle managers or providers who facilitate collaborative planning meetings was identified as important to collaboration. Respondents made comments such as "you also need people on the second and third levels of staffing to see the value of collaboration" and "it can ruin the collaboration to include the wrong people in leadership; you can tell if they are going along because they are your subordinate or if they are really into it." Interviewees also frequently named specific collaborative leaders and line staff whose credibility and integrity were viewed as critical to successful collaboration.

- **Matching Collaboration to Mission.** A majority of respondents also described a process of recognizing that collaboration was essential to realizing the mission of their service delivery system or program. Whether described as an individual epiphany or a collective realization, respondents articulated a turning point that involved the willingness to step outside "organizational comfort zones," fueled by the belief that systems and practices could be better aligned to promote better client outcomes. Respondents often described their individual or collective motivation to make changes in their organizations as grounded in a recognition that "what we were doing was just not working" and, therefore, no longer tolerable. In addition to its role in the formative stages of collaboration, respondents described the connection to the mission of the organization as the

primary “selling point” to encourage other managers, staff, and service providers to embrace the collaborative process and become willing to invest time and other resources into collaborative planning and programming. Several interviewees described how pivotal this point was in overcoming resistance among staff members who were skeptical of collaborations and “who felt ‘we’ve done this before and it hasn’t worked, so why bother.’” Some even described the shift in attitudes among resistant staff in terms of a sudden conversion: “Even the most cynical worker gets that parents can recover when they come to a graduation.” As another interviewee stated, “Success sells.”

- **Commitment From Both Fields.** Another important pre-condition for collaboration and factor for continued collaboration is a genuine commitment to collaboration from leaders and representatives from both fields. Although the impetus for collaboration might originate from child welfare/social services, substance abuse treatment, or courts, interviewees often described an early process by which stakeholders in multiple systems commit to the collaborative process. This was also important to ongoing collaboration and some interviewees observed that momentum for collaborative policies and programs were stalled in their county when there was a change in key leadership positions. In these cases, leaders in other fields once again acted as “champions” by advocating for continued or renewed collaboration.

Factors for Advancing Collaboration

There were several themes that emerged across interviews describing key factors that were involved in the successful evolution of collaborative policies and programs between child welfare, substance abuse treatment, and dependency court systems. Some of these involved organizational change and some involved changed or new operational processes to support the organizational change. These are described below.

- **Technology Transfer.** Adoption of specific collaborative program models was often based on models from other counties or states. Interviewees frequently pointed to obtaining information and ideas from other counties or states as pivotal to the adoption of new policies and development of specific programs. For example, one county obtained a written memorandum of understanding from another county as a template for developing their own cross-systems policies and protocols. In several instances, leaders in different counties visited programs in other states or counties, such as drug dependency courts, to research how

such models might be adopted or adapted in their own settings. In turn, some of these counties have been hosting visitors from other parts of the state and country who are interested in jump-starting their own collaborative programs.

- **Adoption of Specific Models for Collaboration.** All the interviewees pointed to specific models that were institutionalized in their counties that have demonstrated success in improving reunification rates and in expediting permanent placement for children who may not reunify with biological parents. Interviewees described the underlying processes that facilitated adoption and expansion of collaborative programs.

    - Several interviewees *stressed the importance of selecting a specific program or model* to implement in order to initiate, solidify, and grow county collaboration. One manager captured the tone of many of these remarks when reflecting on local lessons learned: "Start small, meaning that if you want to start collaborative efforts don't start four at the same time. People need to get successes and then build on them."

    - *The "starting place" for models adopted in different counties generally began with recognition of a gap that was perceived* as pressing by leaders in child welfare, substance abuse, or dependency courts. For example, in one county a dependency court judge took a sabbatical to explore drug dependency court models and subsequently enlisted the support of administrators in child welfare and substance abuse fields to initiate changes in the county. Another county began with system-wide training and a third county began with a series of cross trainings and a single pilot position for an outstationed substance abuse expert in dependency court.

    - *Interviewees generally described a growing constellation of programming*. For example, one county began with creating an Early Intervention Outreach Specialist position that outstationed an alcohol and drug intervention expert in dependency court. This pilot project was later institutionalized through hiring other specialists to provide similar intervention services in different regions. Other "gaps" were noted by participants in the collaborative planning process and ideas were generated and eventually funded, including a treatment program for parenting women involved in child welfare. These programs were institutionalized and documented successes could be used, in turn, to support proposals for additional funding for expanded or new programming from county, foundation, or federal sources. In many cases, these programs had blended funding or, at minimum, required investment of time or other resources from both child welfare and substance abuse treatment fields.

- **Formal and Informal Mechanisms for Planning Problem Solving.** Consistent with research literature, one of the key elements for successful collaboration identified by interviewees involved institutionalized mechanisms for both planning and problem solving. All interviewees described some form of ongoing collaborative planning group, which included stakeholders from multiple systems.

    - Formal collaborative groups were crucial to developing new ideas, planning concrete activities such as trainings, and identifying potential problems and solutions in ongoing programs. Some of the elements that underlay the formation and maintenance of these groups were identified by interviewees.

        – Members of collaborative groups often pointed to *specific facilitators or leaders that helped guide the collaborative group through various phases of formation, maintenance, and change*. The group leaders were not necessarily the individuals who initiated collaborative efforts in their counties, but they were recognized by members as having a crucial role in the success of the groups.

        – *Having representation from all key systems* was identified as essential to the success of collaborative groups.

        – As part of the formal planning and problem solving process, a number of interviewees commented on the importance of *making clear how decisions are made and who has authority to make decisions.* A few interviewees specifically noted that it was important that individuals assigned to collaborative committees had the authority to make decisions and commitments for their department or agency. At minimum, successful collaborative efforts require that liaisons to committees have access to decision makers who can provide timely responses to requests.

    - In addition to core collaborative planning groups, interviewees described different models for collaborative case planning such as Team Decision Making (TDM), multidisciplinary case planning meetings, and family case conferencing. *Successful systems-level collaboration was informed, in part, by feedback from interdisciplinary case planning groups.* For example, several counties described initiating systems changes based on problems or gaps that emerged during interdisciplinary case planning sessions.

    - *In addition to these formal mechanisms for collaboration, interviewees stressed the importance of individuals, typically direct line staff, in serving as mediators between systems*. Outstationed staff members, who had

developed relationships and credibility with programs and people in child welfare, treatment, and the courts, were often identified as key players in mediating conflicts about specific cases or facilitating improved communication between systems. One interviewee noted that, "they have relationships on both sides of the house and they are highly regarded by everyone."

- **Training and Cross Training.** One of the important processes for building and maintaining collaboration involves continued training and cross training. Consistent with the literature, interviewees pointed to the importance of professionals in both systems understanding the mandates, policies, practices, and constraints of the other system(s). In addition, training was used to prepare professionals in both fields to work successfully in relation to specific collaborative programs and practices. Trainings were described as essential for providing knowledge and skills for collaborative practice; however, interviewees also pointed to specific ways that they used trainings to strategically advance collaborative practice or address barriers to collaboration that were specific to their own system or to the developmental phase of their collaborative efforts.

    - Several interviewees described trainings as *critical for fostering values that support collaborative practice and provide an opportunity for people from various systems to develop relationships with colleagues from multiple fields*. In this context, training was viewed as an important vehicle for fostering a culture of collaboration beyond the participants in formal collaborative committees.

    - *Training venues were also perceived as opportunities to emphasize the role of collaborative practice in improving success with clients*. These messages reinforce the role of collaborative practice in realizing the agency mission (as described above). For example, one county described how they used training about their newly adopted memorandum of understanding (MOU) to both inform providers about the provisions of the document *and overcome potential resistance*. In this case, training for alcohol and drug service providers (who had expressed skepticism about the MOU) included a presentation from a respected director of a local treatment agency that had experienced success with clients as a result of piloting the MOU. As described by the interviewee, the training was used to help answer the question: "How do we make this a win-win for clients? And by doing so, we make it a win for the agencies."

    - In the context of larger systems collaboration, many interviewees also described training as important to giving and receiving feedback with provider networks. Trainings provided an opportunity for collaborative leaders to communicate about evolving programs, planning, and policies

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and to learn about emerging issues from community partners.

The Everyday Workings of Collaboration: Communication, Relationship Building, and Creating a Culture of Learning

- Development of Communication Protocols
- Building Relationships
- Acculturation to Collaborative Practice

NOTE TO INSTRUCTOR: The themes listed above describe factors that help collaboration by enhancing communication and addressing confidentiality in daily practice. These are described in detail in Section IV. These themes should be covered briefly at this point in the class/training if the instructor does not plan to cover Section IV.

Activity III-1: Factors That Enhance Collaboration

Purpose:
To allow participants to reflect on implications for their own practice when considering the research findings about factors that help and hinder collaboration.

Instructions:
Invite participants to form small groups and discuss factors (that are highlighted in the study findings) that both help and hinder successful collaboration. Small groups will then share recommendations for enhancing collaboration in their own counties based on this discussion. Encourage participants to include specific examples from their own practice experience (as appropriate to the class or group).

Alternative 1: Brainstorming
Invite participants to brainstorm ideas about implications for practice in the full group.

What Hinders Collaborative Practice

Several themes emerged in relation to factors that hinder collaboration. These are outlined below:

- **Conflicts in Values, Perspectives, and Expectations.** Interviewees described conflicts between systems and stakeholders who were part of systems as a major issue, particularly in the early stages of collaboration. The conflicts that

interviewees described included differences in focal system (e.g., child or adult); mistrust between professionals; confusion about different constraints, mandates, and operations in other systems; and even hostility toward other systems. In general, interviewees described processes in which these differences were surfaced and addressed in group settings, such as collaborative meetings. In some cases, discussion of different values and expectations were facilitated directly. For example, in one county the collaborative team developed a written list of core values to guide their work. In other counties, these issues were addressed even if not labeled as such. "You don't just sit down and say we are going to do values clarification," observed one county manager. "We just identified projects that needed to be done and in the process we would see some of the values issues…we would even have some heated discussions. Ultimately, we had to work these through to get on with the mission of collaboration." Some of the specific conflicts in values mentioned by interviewees included concerns from child welfare about whether or not alcohol and drug staff would "protect" parents over concern about child safety, resistance from both child and adult attorneys to advocate for their clients in a collaborative context, concern from alcohol and drug treatment providers as well as child welfare staff about incarceration as a consequence for non-compliant parents, and whether or not a parent who relapses or uses drugs can be a good parent. The narratives from interviewees described a deliberate and sometimes difficult process of "starting up and then going through an evolution" that often began in a context where "everyone wanted to protect their turf and seemed out for their own agencies" and required "a lot of discussion that increased understanding and awareness of different disciplines."

- **Communication Problems.** "The biggest barrier was working out communication systems," noted one manager. Similar concerns were echoed in nearly all interviews. One concrete issue mentioned by multiple interviewees had to do with developing communication protocols that were consistent with federal regulations designed to protect the privacy of clients in substance abuse treatment. "We had a hard time sharing about specific cases," observed one interviewee. "Other fields have confidentiality requirements, but alcohol and drug treatment requirements are more restrictive. We needed to develop written releases that allowed for communication…this was a major hurdle." As outlined above, successes in addressing barriers to communication were critical to the growth of collaborative efforts and to the success of specific collaborative programs. Interviewees noted that communication protocols were important to collaboration, but that identification of problems or "glitches" in communication, brainstorming of ideas for remedying them, and follow-up by supervisors remained an important role for collaborative planning groups.

- **Funding Challenges.** Issues in funding and human resources were a universal barrier to collaboration. County departments and community-based non-profit

organizations described by interviewees were already "stretched" in relation to caseloads and other staff responsibilities. "If programs are stretched on staffing, every agency wants to take care of their own business first," typified remarks related to this problem. The demands on staff were perceived as a barrier to participation in collaborative planning and programming, at least until "they get that participating can, in the end, make their job easier or more effective." Several counties described collaborative efforts that were reduced because of budget cuts. Interestingly, none of the counties facing severe funding cuts completely eliminated collaborative programs once they were established. Instead, in several counties, collaborative members worked collectively to determine how to prioritize services and maintain core elements of their collaborative models in the context of reduced funding. Although these processes were painful, the collaborative process was used to reduce harm to services (and, by extension, clients) and, in one county, to identify alternative funding for a core collaborative staff position.

- **Fragmentation of Systems.** Interviewees noted that fragmentation of services was often a barrier to collaboration. Some counties, particularly smaller counties, worked to reduce fragmentation by creating co-located services. Collaborative planning groups in counties of all sizes functioned to identify strategies to address disconnections and communication problems between systems. However, core dynamics in which service delivery systems remain in "silos" because of separate funding, mandates, and staff were persistent issues that needed to be addressed. This was named not only as an issue for substance abuse and child welfare systems, but other systems that may serve the same clients (such as probation, public health, mental health, and domestic violence services).

- **Individual Personalities.** Many interviewees described the powerful influence that individuals could have on the success of collaborations—both helpful and harmful. Several interviewees described the problems that evolved in collaborative planning groups or processes when one or more key players behaved in a disruptive manner or held values or attitudes that were not conducive to collaboration. One county manager described these types of challenges:

  > In the child welfare system, we have four or five people who are loose cannons and make derogatory statements about AOD and mental health services. It's hard if the person across the table has been bad-mouthing services. Sometimes resistance is related to personal experience. It could be that people don't want to see alcohol and drug dependence as possible to change because they had an abusive alcoholic father who never got clean and sober and they believe that treatment doesn't work. Sometimes people in alcohol and drug treatment who are in recovery may not be

supportive because it makes them uncomfortable about their own past issues as parents.

Interviewees stressed the importance of developing respectful norms in their collaborative groups. In some instances, members would rely on informal strategies to "work around" problem members or would consider group processes that would allow for surfacing and solving issues that may be a collective problem that was amplified by specific individuals. In some cases, individuals could have a powerful role in impeding the advancement of collaboration. For example, several interviewees in one county described a judge who was skeptical of substance abuse treatment and was, in effect, obstructive in relation to efforts to extend collaborative practices more deeply into the judicial system.

- **Issues with Consistency.** Staff turnover and problems with consistency and leadership in collaborative planning groups or in county systems were described by several interviewees as a barrier to effective collaboration. One manager noted that their collaborative planning took longer in formation than initially planned because "the players changed a lot. Once we had a consistent group, we went through the process of learning from one other." Similar perceptions were echoed by other interviewees. For example, interviewees from another county expressed a belief that their collaborative planning group would be stronger if they had consistent representation from child welfare line staff (who were often unable to attend regularly because of court appearances). Consistency in leadership (as mentioned above in factors that facilitate collaboration) was deemed important by many interviewees and is illustrated by the following observation. "If the department head changes on one side, you have to go back and get buy in; it could, depending on the person, stop the collaborative."

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Activity III-2: Mediation Exercise: Addressing Factors That Hinder Collaboration

Purpose:
This exercise highlights strategies to use when working with staff in a system that might be resistant to the collaborative process.

Instructions:
The instructor should read the scenario below and may distribute copies to participants (Handout III-1) Participants are invited to discuss and brainstorm responses to the questions provided below. This activity may be facilitated in the full group or may be done in small groups with an opportunity to report back to the full group.

Scenario:
You have just completed training on the benefits of collaboration across systems and are excited about opportunities to put your new knowledge to practice. The issue of inter-agency collaboration has recently been a hot topic in the county you work in, and there is much support and interest by various agency leaders (both public and private sectors) to bring about positive changes in this area. Unfortunately, it appears some staff in the agency are resistant to change, believing the "old model" of practice is just fine. Because you are energetic, and a hard worker, your agency has asked that you be part of an inter-agency team to help move these changes forward.

1. How might you specifically approach this situation to help motivate both staff and agency systems to adopt more of a collaborative approach in the work?

2. What immediate changes in practice might the CW units adopt?

3. What immediate changes in the treatment agencies might be adopted?

4. How might inter-agency collaboration on a systems level be improved?

5. How might you employ the assistance of co-workers, supervisors, or others to facilitate your ideas?

(Tip: It might be helpful to invite respondents to refer back to findings from Activity III-1 *Factors That Enhance Collaboration* as groups brainstorm responses).

Discussion of Findings

Themes from these qualitative interviews pointed to several preconditions for the successful adoption of collaborative policies and practices between substance abuse

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and child welfare systems including a *prior history of collaborative activities* in the county and the emergence of *leaders who would "champion" the cause of collaboration*. In addition, counties with collaborative practice were able to convince stakeholders that collaborative practice was closely tied to and could contribute to *realizing the county and agency mission.* Furthermore*,* collaboration required a genuine *commitment to collaboration from key stakeholders in both fields* from multiple levels.

Several factors related to successful collaboration emerged and can be classified in two broad areas: organizational changes, and changes in operations for daily practice. Organizational changes were often stimulated by *technology transfer* though accessing information and, in some cases, technical assistance from other county or state agencies. Based on local need, successful counties *adopted specific models for collaboration*. Implementation of a specific program model provided a focal point for collaborative efforts, created a strong sense of success that often served to fuel continued collaboration, and frequently led to new collaborative initiatives. Counties with successful collaboration also described having both *formal and informal mechanisms for planning and problem solving* such as collaborative planning teams, interdisciplinary case conference teams, and strategic planning sessions among collaborative leaders. These counties also described use of *training and cross training* to support all stages of change from program initiation, through implementation, and into continued maintenance and growth.

Some of the changes in daily operations included strategies for *development of communication tools and protocols* such as written memorandum of understanding

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between systems as well as forms and procedures for obtaining releases of information and sharing information about client progress or changes. In addition, interviewees described formal and informal strategies for *building and maintaining relationships* between fields as well as *acculturating staff to the collaborative process*. Some of the operational strategies, such as those related to using releases appropriately to facilitate communication between systems in the context of confidentiality regulations and fostering working relationships to facilitate collaborative case planning, could be adopted by service providers even in counties that have not yet developed formal collaborative programs.

The interviews also revealed a number of factors that hinder collaborative practice, along with strategies for mediating problems associated with these factors. First, interviewees stressed the importance of resolving *conflicts in values, perspectives, and expectations* in developing collaborative programs. These issues were particularly salient early in the collaborative process and all interviewees described embarking on deliberate, and sometimes difficult, series of meetings with different stakeholders in which these issues were surfaced and negotiated. Addressing *communication problems* was also stressed by a majority of interviewees. In addition to development of specific forms and procedures to facilitate communication in daily practice (described above), interviewees acknowledged that resolving differences and problem-solving around new problems in communication was an important ongoing role for both formal collaborative meetings and staff members in key liaison roles between systems. *Funding challenges* and *fragmentation of systems* were also identified as challenges for collaborative

practice. However, once collaborative programs were firmly rooted, stakeholders in the county and new staff began to see these innovations in practice as normative rather than experimental. Even when funding was cut, which in some cases necessitated reductions or modifications in services, collaborative programs were sustained. Problems with staff *turnover or inconsistency in participation of representatives in collaborative meetings* often impaired or slowed collaboration, particularly when orientation of new members was a frequent necessity. Finally, *individual personalities*, particularly representatives who exhibited disrespectful attitudes toward other systems were disruptive to collaborative process, requiring leaders and participants in collaborative planning groups to put undue time and energy into "working around" these problematic individuals.

Interviewees described the evolution of their collaborative programs from early stages in which leaders became invested in the idea of change, through facilitated opportunities for addressing differences between systems and identifying models for change, to implementation of new programs and maintenance (as well as expansion) of efforts. The process that interviewees described are fairly consistent with literature that use "stages of change" models to describe organizational change (Prochaska, 2000; Simpson, 2002). Elements of these models include motivation to change (such as perceived need to change to address client needs and in response to policy changes), preparation for change through the development of a leadership team, implementation of change (including values clarification and other activities to create a climate for change and creation of institutional support to create structural support for change), and

maintenance of efforts. Insights about the factors that both help and hinder collaborative processes in each of these stages could be used to help other counties streamline their efforts in preparing for, implementing, and anticipating problems related to the development of collaborative policies and programs.

Limitations

There are a number of limitations to this study. First, the qualitative methodology, although suited to obtaining narrative data to answer the research questions, also limits generalizability of findings across different counties. Indeed the interviews suggest substantial variation among participating counties in terms of historical and political contexts, county size and demographics, as well as the constellation of collaborative programs that were adopted. It is of interest, and perhaps also a strength of the study, that common themes emerged despite these variations in county context. In addition, the study is based on a purposive sample. Although recruitment of appropriate individuals in the five target counties was made possible with the assistance of key leaders who were knowledgeable with the individuals and organizations involved in local collaborations, it is possible that selection bias occurred. For example, it is possible that interviewees identified through this process were particularly positive about local collaborations. The fact that different interviewees within the same counties tended to identify similar strengths and weaknesses as their colleagues suggests that this potential did not substantially impact the validity of the data. Finally, the resources available for the study precluded use of multiple researchers to code qualitative data and examine inter-rater reliability for the themes that were defined in this report.

Although the principle investigator reviewed emerging themes with student researchers who were involved in transcription, it is possible that the final themes may have been constructed slightly differently had more researchers been directly involved in data analysis. Despite some of the limitations of this study, the findings document some important factors that both help and hinder the process of collaboration between substance abuse and child welfare fields.

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Activity III-3: Mock Collaborative

Purpose:
The purpose of this exercise is to increase skills in working with professionals from various disciplines and to improve participants' ability to collaborate across systems.

Instructions:
Participants are assigned roles in a *mock collaborative* with representatives from child welfare, substance abuse, and the courts to map out initial steps in building collaborative planning and program development. The instructor should create slips of paper with a brief description of each role (See Handout III-2) and distribute them to the class/training participants. The distribution may be random (e.g., placing slips in a bag for participants to select a slip) or may be assigned by the instructor. Multiple copies of some roles may be copied to accommodate different class sizes.

After participants have briefly reviewed their "character" for the mock collaborative meeting, the instructor will convene the full group as a new collaborative in a California County that is charged with identifying plans and possible programs for stronger collaborative practice between child welfare services, substance abuse treatment services, and dependency courts. (Alternative: The instructor may select or invite two participants to co-facilitate the first "collaborative" meeting and serve as back up support as needed).

The "collaborative" is charged with developing both short-term plans and ideas for longer-term development of collaborative programs (e.g., dependency drug courts; outstationed AOD experts in dependency courts and child welfare offices, or creation of a program with specialized case managers/liaisons to monitor clients involved in all three systems). The facilitator(s) should begin with a round of introductions in which participants share their (real) names and their (assigned) affiliations. The facilitators should describe the purpose of the group and guide the group in discussion of the topics outlined below. The facilitators should list the topics with an approximate time frame assigned to each (dependent on time available – ideally at least 20-30 minutes).

- Hopes and concerns (about outcomes for clients and about their own work)
- Possibilities for short term and long term change
- Next steps for moving forward.

After the mock collaborative meeting, the instructor may facilitate a brief discussion with the full group including: (a) how the factors that help and hinder collaboration may have been reflected in the meeting and (b) what might help with future success of the collaborative.

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***ALTERNATIVE FOR FIRST-YEAR STUDENTS*:**
Discuss the different perspectives that may be held by professionals from different disciplines, backgrounds, and settings and how this may impact collaboration.

***CWS Roles*:**

- FR worker
- ER worker
- Adoptions worker
- Program analyst
- Unit supervisor

AOD Roles:

- Paraprofessional (recovering user)
- Treatment counselor
- Administrator

Court Roles:

- Judge or referee
- County Counsel
- Attorney for parents
- Probation officer

First-year students: Discuss the different perspectives that may be held by professionals from different roles and settings and how this may impact collaboration.

Second-year students: Role play the perspectives

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SECTION IV

THE STRUCTURE AND SPIRIT OF COLLABORATION: BUILDING PATHWAYS FOR COMMUNICATION ACROSS SYSTEMS

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SECTION IV
INSTRUCTIONAL GUIDE

Learning Objectives

This section presents additional findings from the research on successful collaboration in daily practice related to communication and provides specific training related to working effectively across systems in the context of federal confidentiality regulations. Specifically, this section addresses the themes that emerged from the interviews with professionals from both child welfare and substance abuse treatment systems about communication and collaborative practice. It also provides a review of federal confidentiality regulations and the types of documents, forms, and protocols used in cross-system communication.

By the end of this section, participants will:

- Identify themes related to communication in daily practice,
- Understand the need for effective communication across systems in the context of legal timeframes,
- Understand federal confidentiality law in alcohol and drug treatment systems, and
- Have the ability to create a valid consent form with the correct elements.

Public Child Welfare Competencies

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally-sensitive resources and services.

2.4. Student is able to gather, assess, and present pertinent information from interviews, case records, and other collateral sources required to evaluate an abuse or neglect allegation.

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2.11 Student understands the process of the legal system and the role of social workers and other professionals in relation to the courts.

2.20 Student understands the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.6 Student is able to seek client, organization, and community feedback for evaluation of practice, process, and outcomes.

7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families.

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

Agenda and Suggestions for Instructors

Time allocation: Approximately 90 minutes

- Introduction
    - Introduction to section content
    - Introduction of trainer(s) and participants (if not part of ongoing class)
- Overview of themes from the research about communication in daily practice
    - Why a special focus on communication and confidentiality
    - What each system needs to know from the other
    - Themes from the study: Development of communication protocols, building relationships, and acculturation to collaborative practice
    - Activity IV-1 Communication Protocols (small group discussions)
- Demystifying and working effectively in the context of federal confidentiality regulations and substance abuse treatment
    - Activity IV-2: Federal Confidentiality Law Quiz (see Handout IV-1)
    - Handout IV-2: Protecting Clients' Privacy (provisions of 42 CFR)
    - Activity IV-3: Consent for the Release of Information Form (creating and using consent forms)

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- Optional Activity IV-4: Role Plays

Instructors are encouraged to use this section in a range of ways that meet their needs. For example, the instructor may focus specifically on increasing the knowledge and skills of participants about federal confidentiality law by reviewing the elements of the law and facilitating companion activities. Instructors do not need to be experts in the federal regulations covered in this section. The PowerPoint slides, detailed handouts, and structured activities are designed to allow the instructor to teach primarily through facilitation.

Materials Needed

- Either an overhead projector and PowerPoint presentation on transparencies or a computer and PowerPoint presentation online
- Copies of handouts
- Markers and flip chart or white board (optional–for writing key points in response to small group and full group discussions)

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SECTION IV
THE STRUCTURE AND SPIRIT OF COLLABORATION: BUILDING PATHWAYS FOR COMMUNICATION ACROSS SYSTEMS

Importance of Addressing Communication and Confidentiality Issues

There are several reasons why addressing issues of communication and confidentiality between substance abuse and child welfare fields is important, including:

- As described above, laws such as the federal Adoption and Safe Families Act along with state laws related to permanency for children in the child welfare system make it imperative that substance abuse and child welfare fields are able to collaborate to work effectively with children at risk.

- Child welfare professionals often perceive confidentiality as a barrier to collaboration. For example, an earlier study of respondents from both substance abuse and child welfare fields in California found that child welfare professionals were over twice as likely to perceive confidentiality regulations as a barrier to collaboration (see Pathways to Collaboration, Phase 1, CalSWEC website referenced in this curriculum).

- Fortunately, it is possible for the substance abuse and child welfare systems to share information in the context of existing laws.

- Understanding existing law and how to facilitate communication between systems is useful in daily practice, even in counties where formal collaborative programs have not yet been developed.

According to the National Center on Substance Abuse and Child Welfare (2003a), some of the specific information needed by professionals in each field to work effectively are described below.

- Information needed by the child welfare worker from the treatment provider includes:

    - Whether the parents are actually involved in a treatment program
    - The degree of parental participation: whether they are regularly attending, not missing appointments, and demonstrating a willingness to engage in

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treatment
    - When parents are experiencing relapse or have left treatment
    - The continuing care plan of the parents if they are in residential treatment

- Information needed by substance abuse treatment counselors from child welfare workers includes:

    - Whether the family is an in-home case or if the child has been removed from the home
    - Whether some children have been removed while others remain at home
    - The permanency goal for the child
    - Whether reunification is a goal
    - Whether there is a concurrent plan for both foster care and adoption
    - The court requirements and deadlines for specific hearings and achieving necessary outcomes.

Themes From the Study About the Everyday Workings of Collaboration: Communication, Relationship Building, and Creating a Culture of Learning

This section describes a number of themes about factors that help collaboration between systems based on in-depth interviews with experts (N = 49) from five counties in California with a strong history of collaboration. There were several themes in relation to communication between systems that are described below. Across counties, interviewees stressed the importance of working out the logistics related to communication between fields, particularly in the context of federal confidentiality regulations designed to protect participants in alcohol and drug treatment programs.

- *Development of Communication Protocols.* Across all counties, respondents described the critical role of developing specific mechanisms for communication between fields. On a macro level, agreement about policy-level communication and conflict resolution were spelled out through written memorandum of understanding (MOU) between fields. On a day-to-day practice level, each county developed an array of mechanisms to facilitate communication between fields. Examples of these communication protocols, and some of the underlying factors that allowed for their successful implementation, are described below.

    - County-level MOUs were described by many interviewees as an important tool for documenting formal agreements between fields that could then be

articulated to providers and line practitioners. Some interviewees pointed to the utility of the MOU when leadership changed in the county. Establishing a formal agreement between systems created an opportunity to advocate for sustaining collaborative practice in the event of a major change in leadership (e.g., Director of child welfare or substance abuse services as occurred in more than one county).

- Release of information forms as well as protocols for obtaining signed forms (e.g., that professionals from both fields would take responsibility for obtaining forms). Confidentiality requirements, particularly in substance abuse treatment as mandated by federal law, were described as initial challenges that were overcome with development of appropriate release forms and training of staff about appropriate use of forms. A number of interviewees described a parallel process that was important to adoption of communications and protocols, which involved discussion of concerns about confidentiality and about how information would be used. For example, if substance abuse providers were to notify child welfare about a positive drug test, stakeholders worked to come to an agreement about how that information would be interpreted in relation to both substance abuse treatment and child safety goals.

- Progress report forms to facilitate communication between treatment programs and professionals in both child welfare and dependency courts. Frequently, these report protocols were implemented along with protocols for ensuring accuracy and accountability for the content of reports. Some counties described a history in which mistrust between fields fostered a culture of "stonewalling" information. The credibility of reports was perceived as critical to the functioning of collaborative processes. As a case in point, one interviewee noted that inaccuracy in reports resulted in dismissing a staff member from their liaison position.

- "Urgent notice" forms were adopted in one county (and similar processes were adopted in others) that would allow professionals to provide notification about an urgent problem or important change in status (e.g., client leaving treatment program).

- In addition to formal mechanisms for communication, which are also described in the literature, interviewees described other ways that professionals in both systems learned to communicate cooperatively and respectfully between systems. Many respondents described the use of these formal mechanisms as ways of operationalizing trust between systems and among professionals.

- *Building Relationships.* One of the critical processes for successful collaboration

involves developing and maintaining good working relationships between multiple stakeholders. In many counties, interviewees often identified specific leaders in their counties who were respected and who were perceived as instrumental in the success of collaborative program development and problem solving. These individuals were often facilitators, co-facilitators, or key members of collaborative planning groups. Relationship building within and between all levels of the organization was mentioned as important to the success of collaborative efforts, from administration/management, to collaborative planning group members, to key line staff in each system. Several interviewees noted the importance of role-modeling productive collaborative relationships among leaders from substance abuse treatment and child welfare fields. As a case in point, several interviewees from both child welfare and substance abuse treatment in one county noted that prior to formal collaboration, it had become normative for child welfare staff to dismiss input from substance abuse treatment professionals, in part, because of differences in training (e.g., child welfare staff typically had MSW degrees and substance abuse treatment staff typically had certification and life experience but not formal degrees). Interviewees noted that this dynamic began to change when a respected manager and co-facilitator of the collaborative "modeled respect" for her colleagues from the alcohol and drug field, "stood up for people from the alcohol and drug treatment field," and "made it clear that they [AOD staff] were the experts."

- *Acculturation to Collaborative Practice.* In relation to factors that facilitate ongoing collaborative practice, interviewees noted that existing and new staff were acculturated to collaborative models of practice. Staff members were acculturated to new norms in practice through training, supervision, coaching from key staff in liaison positions, and through modeling from peers. Several respondents observed that orienting new staff was not a major challenge once collaborative models were institutionalized because "when new people come on and get trained for their position it's not an issue, it's just the way that things are done." Interviewees also described the importance of creating a culture within their collaborative groups and organizations that allowed them to continue learning and problem solving. Some respondents pointed to mixed results in this area and expressed frustration over some systemic issues that had yet to change in permanent or meaningful ways and that might "get worse before it gets better" (such as heavy caseloads, barriers to blended funding, and gaps in staff training or supervision to ensure competence in collaborative practice or working with different cultural groups). Even after collaborative programs were started, interviewees noted that there was a need for ongoing efforts to address problems and ensure continuity and accountability in service provision. Collaborative participants would employ a combination of formal and informal efforts to address issues related to program implementation, funding, and conflict between people or programs as they arose.

Activity IV-1: Communication Protocols

Purpose:
This activity will help participants better understand system-level dynamics through an actual case demonstration. The case involves the process of working with a continuing FR case with a parent in treatment that requires cross-system communications.

Instructions:
Instructors may opt to use the same case that was presented in Section I, Exercise I-3, or may develop their own case based on experience. Groups will explore the case from two different perspectives:

1. Parent is in treatment and there *are* formal communication protocols in place
2. Parent is in treatment and there *are not* formal communication protocols in place.

Groups will have 15 minutes to discuss the following questions:

- How might the possible outcomes or impact on the worker, the parent, the child and the systems differ in each of these circumstances?
- Based on the findings of the study, what are one or two strategies that might help the development of formal communication protocols?

The instructor will facilitate a large group discussion based on the small group reports/findings.

Demystifying and Working Effectively in the Context of Federal Regulations Related to Confidentiality and Substance Abuse Treatment

Both the research literature and the findings from this study point to the importance of (a) assisting child welfare professionals to understand and work within the context of confidentiality regulations under which substance abuse programs operate, and (b) providing guidelines for consent forms and other formal mechanisms that allow for communication between substance abuse treatment programs and child welfare. This section provides a brief overview of the history and provisions of federal confidentiality regulations as well as an activity that allows participants to review

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required elements of a client release form.

History of Confidentiality Regulations

Social workers in many fields are familiar with the importance of confidentiality as a critical practice for protecting client privacy and adherence to confidentiality regulations is important to ethical practice. At the same time, there are variations in the regulations that govern different fields of practice. For example, confidentiality regulations governing substance abuse treatment programs are even more stringent than those guiding child welfare or mental health fields. In the 1970s the U.S. Congress passed comprehensive regulations to ensure confidentiality of clients seeking and entering substance abuse treatment (Legal Action Center, 2003; Popovits, 2001).

- These confidentiality regulations were enacted to encourage people to seek treatment despite the negative stigma associated with alcohol or drug dependence.

- Substance abuse treatment providers must adhere to these regulations or face criminal prosecution and other consequences, such as termination of funding, suspension or revocation of licensure, and civil liability (Popovits, 2001). Both agencies and individual staff can be fined for violations. Adhering to confidentiality regulations are considered a standard of practice in the AOD field.

    - The federal laws ensuring confidentiality of clients in substance abuse treatment are generally even more stringent than those for protecting mental health (Popovits, 2001) or, in some regards, attorney/client privilege (Legal Action Center, 2003).

    - Even if a court has mandated a parent into treatment or child welfare requires treatment completion for reunification, substance abuse treatment programs still must have a written authorization from the client in order for the program to share information.

- Fortunately, communication and collaboration is possible in the context of these federal regulations (Legal Action Center, 2003). For example, in family drug courts and other collaborative programs, the parent signs a consent form that allows for the comprehensive and ongoing communication between the treatment

program, child welfare, and the courts (Legal Action Center, 2003).

Obtaining a Release Form

Obtaining a release form is the most common and effective way of arranging for communication between systems. Most disclosures are permitted if a client has signed a release form, which has not expired or been revoked by the client, even if disclosure may not be in the best interests of the client (Legal Action Center, 2003). It is helpful to be sure that collaborative members work together to craft the consent form to meet federal confidentiality regulations, other federal regulations (such as HIPAA), and local requirements. Some recommendations for crafting and using consent forms in ways that maximize collaboration are outlined by the Legal Action Center (2003, p. 118-120).

- *Identify all necessary parties*. It may be helpful to be sure that the consent form authorizes communication between all parties who need to communicate about the client and case, providing that the purpose of the disclosure and information to be disclosed are the same. Appropriate parties to list may include the child welfare agency, court, treatment program, client's attorney, and child's attorney.

- *Define the information to be shared.* Confidentiality regulations require that information disclosed through the use of a consent form be limited to information needed to achieve the specific purpose(s) of the disclosure. Consequently, stating "all my records" would not be specific enough.

- *Duration of consent.* The consent should expire only when it is no longer needed. A consent form must have a date, event or condition on which it will expire if not previously revoked and it should not be longer than necessary for its intended purpose (Legal Action Center, p. 29). While some programs prefer to limit consent forms to a specific time period (e.g., 6 months), the regulations do not require limitation to a specific time period. Unless state law requires a time limitation, the consent can, instead, specify a condition upon which the consent should expire such as "upon termination of the child abuse/neglect case against me" (Legal Action Center, p. 119).

- *Obtain consent at the earliest possible point.* Ideally, a consent form should be collected at the earliest point possible, whether that initial contact is with the court, a child welfare worker, or the treatment program. This ensures that

communications can occur if, for example, the client makes an appointment for treatment but does not appear. “As long as the consent has all of the elements required by federal confidentiality regulations, it is valid no matter which party procured the patient’s signature” (Legal Action Center, p. 120).

- *Remember potential limits of consent.* It is important to remember that there are limitations to consent. They are only valid for the intended purpose and allow only for disclosure of specified information. In addition, a client may revoke consent at any time. (This revocation does not cover information that was already shared when the consent was in effect). A client who is not doing well in treatment could revoke consent, although clients are often reluctant to do so because of potential negative consequences. Substance abuse treatment programs and child welfare agencies should ensure that parents understand the consequences of revoking consent and the potential benefits of allowing the consent to remain in place.

As described above, consent forms must specify the purpose and type of information that may be disclosed. Specific ideas for such language are summarized below:

- A *statement of purpose* might authorize communication to “provide the [Child Welfare Agency], [Family Court], [children’s attorney (law guardian(s)] and [my attorney] with the information they need to determine whether I have made sufficient progress in my treatment so as to [retain] [regain] custody of my child(ren)” (Legal Action Center, p. 232).

- A consent form may allow the listed parties to:
  communicate with and disclose to one another the following information: (Nature and amount of information to be as limited as possible). Initial each category that applies:
  ____ my name and other personal identifying information;
  ____ my status as a patient in [alcohol and/or drug] treatment;
  ____ initial evaluation;
  ____ date of admission;
  ____ assessment results and history;
  ____ summary of treatment plan, progress, and compliance;
  ____ attendance;
  ____ urinalysis results;
  ____ changes in address, household composition, or personal relationships that could result in child neglect/abuse or domestic violence;
  ____ observations of visitation of children;
  ____ discharge plan;

____ date of discharge and discharge status; and
____ other (Legal Action Center, p. 231-232).

NOTE TO INSTRUCTOR:

The instructor does not need to be an expert on federal confidentiality regulations that govern substance abuse programs in order to facilitate this segment.

The activities that follow include ample reference materials that may be used by both participants and the instructor to identify the correct answers to the quiz and the correct elements of a consent form.

If questions arise that the instructor cannot answer, the instructor may point out that questions should be expected to emerge in the process of collaboration and such questions can be investigated. If part of an ongoing class, the instructors may chose to research the question for the next class or invite a volunteer student(s) to do so.

The purpose of the following activities is not to ensure that students can identify the correct answers or construct a perfect release form. Rather, the activities are designed to help students engage in critical thinking and dialog about the kinds of questions that they need to consider in order to be an effective member of a team concerned with collaborative practice.

The instructor may select one or a combination of the following three activities based on the participant's level of expertise and the purpose of the class or training.

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Activity IV-2: Federal Confidentiality Law Quiz

Purpose:
This activity will help participants better understand and work effectively in the context of federal confidentiality laws related to substance abuse treatment.

Instructions:
The instructor should explain that participants will engage in an active learning opportunity that will allow them to learn about the main provisions of federal confidentiality laws governing substance abuse treatment programs (42 CFR, part 2).

1. Hand out the quiz to all participants (Handout IV-1). Give participants approximately 10 minutes to respond with their best answers.
2. Give participants a copy of the article on confidentiality from the Substance Abuse and Mental Health Services Administration [SAMHSA] (Handout IV-2) and have participants break into small groups to consult with one another on their answers.
3. Review the correct answers with the group. The instructor may distribute the summary of regulations provided in a more abbreviated form (Handout IV-3)

OPTION 1: The instructor may elect to conduct the "quiz" as a full group activity by having volunteers attempt to answer the questions with the option of getting up to three consultations from classmates.

OPTION 2: The instructor may also divide the group into 6 small groups (1 for each question) to investigate the answer to their assigned question and then report back to the full group. The groups should be given the quiz and article about confidentiality (Handouts IV-1 and IV-2). The instructor may pass out handout IV-3 after the groups report back or as a supplemental reference material during the activity.

OPTION 3: The instructor may elect to cover this content in an abbreviated and more didactic format using Handout IV-3 as a general guide.

ANSWERS TO QUIZ:
1) d – The law is not intended to obstruct collaboration with child welfare
2) d – All of the above (See Handouts IV-2 and IV-3 for details)
3) e – All of the above are protected information
4) a, b, and d
5) None of the answers should be circled – All of the conditions listed would be considered a violation of federal confidentiality regulations.
6) b – See Handout IV-2 for details

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Activity IV-3: Consent for the Release of Information Form

Purpose:
This activity will help participants better understand and work effectively in the context of federal confidentiality laws related to substance abuse treatment, specifically in relation to developing and using appropriate consent forms.

Instructions:
Participants should be given the following handouts:

- A handout that provides a review of the main provisions of federal confidentiality regulations (42 CFR, part 2), such as Handout IV-2 and/or IV-3.

- Handout IV-4, which provides a sample of a release form that does not comply with regulation and has additional "tips" for development of consent forms for release of information.

The instructor should form small groups and provide the following instructions:

- Small groups will examine the sample consent for release of information form provided to you. Review your handout that lists the requirements for consent forms as well as the additional handout on tips for developing consent forms.

- Group participants will develop a list of suggestions for revision of the form and ideas for using the form. Groups should prepare to summarize their recommendations based on new knowledge

- REMINDER: The purpose of this activity is not to create the "perfect" form, but to practice critical thinking about confidentiality and skills in identifying the kinds of issues that might need to be addressed in order to advance collaborative practice in a county setting.

The instructor should facilitate small group reports and full group discussion.

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Optional Activity IV-4: Role Plays

Purpose:
This activity will build on new skills for participants by practicing the skills of cross-systems communication through role plays.

Instructions:
Participants are to use the case from Section I, Activity I-3 to apply skills in cross-systems communications. The trainer will divide the large group into smaller groups of four each. Each small group will then assume the roles of client, child welfare worker, alcohol/drug treatment provider, and observer. Each small group will conduct a role play for each stage of the case presented below:

1. Communication at the *initial stage* (obtaining release form about treatment progress from the client in collaboration with substance abuse). In this role play both a CW and AOD professional should practice explaining and obtaining the release form from the client. What elements specifically should the release include?

2. Communication about progress in treatment *before the 6 month review hearing:* In this role play the CW and AOD professionals should role play their dialogue with each other confirming what would be included in the hearing about a client and how it would be communicated.

3. Communication regarding a *change of status* (e.g., non-compliance with court mandates related to substance abuse, responding to relapse in conjunction with treatment programs). In this role play, the CW and AOD professionals would again role play their dialogue and agreements about what information would be included and how it would be communicated to the court and client.

If there is time, participants in each of the small groups can switch roles so each person has the opportunity to role play from a different perspective. The trainer will then ask for observations from the observers in each group.

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SECTION V

BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND NEXT-STEPS

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SECTION V
BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND "NEXT-STEPS"

INSTRUCTIONAL GUIDE

Learning Objectives

This final section provides participants an opportunity to explore resources for continued professional development in collaborative practice and reflect on how knowledge about collaboration gained from this curriculum may be translated into practice.

By the end of this section, participants will:

- Have increased knowledge of available resources and how to access those resources for more effective outcomes, and
- Identify and articulate "next steps" to implement new knowledge and skills into their own practice and in their local service delivery systems.

Public Child Welfare Competencies

4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effects on services for children and families.

4.6 Student is able to seek client, organization, and community feedback for evaluation of practice, process, and outcomes.

4.7 Student understands and is able to utilize collaborative skills and techniques in an organizational setting to enhance service quality.

Agenda and Suggestions for Instructor

Time allocation: Approximately 30 minutes

- Overview of resources for advancing cross system collaboration (Handout V-1)
    - Activity V-1: Website exercise

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- Closing discussion on take home ideas
    - Activity V-2: Take-home Ideas

Materials Needed

- One copy of Handout V-1 for each participant
- Markers and flip chart or white board (optional–for writing key points in response to small group and full group discussions)

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SECTION V
BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND "NEXT-STEPS"

Review of Highlights From the Study

Themes from these qualitative interviews pointed to several preconditions for the successful adoption of collaborative policies and practices between substance abuse and child welfare systems including a *prior history of collaborative activities* in the county and the emergence of *leaders who would "champion" the cause of collaboration*. In addition, counties with collaborative practice were able to convince stakeholders that collaborative practice was closely tied to and could contribute to *realizing the county and agency mission.* Furthermore, collaboration required a genuine *commitment to collaboration from key stakeholders in both fields* from multiple levels.

Several factors related to successful collaboration emerged and can be classified in two broad areas: organizational changes and changes in operations for daily practice. Organizational changes were often stimulated by *technology transfer* though accessing information and, in some cases technical assistance, from other county or state agencies. Based on local need, successful counties *adopted specific models for collaboration*. Implementation of a specific program model provided a focal point for collaborative efforts, created a strong sense of success that often served to fuel continued collaboration, and frequently led to new collaborative initiatives. Counties with successful collaboration also described having both *formal and informal mechanisms for planning and problem solving* such as collaborative planning teams, interdisciplinary

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case conference teams, and strategic planning sessions among collaborative leaders. These counties also described use of *training and cross training* to support all stages of change from program initiation, through implementation, and into continued maintenance and growth.

Some of the changes in daily operations included strategies for *development of communication tools and protocols* such as written memorandum of understanding between systems as well as forms and procedures for obtaining releases of information and sharing information about client progress or changes. In addition, interviewees described formal and informal strategies for *building and maintaining relationships* between fields and as well as *acculturating staff to the collaborative process*. Some of the operational strategies, such as those related to using releases appropriately to facilitate communication between systems in the context of confidentiality regulations and fostering working relationships to facilitate collaborative case planning, could be adopted by service providers even in counties that have not yet developed formal collaborative programs.

The interviews also revealed a number of factors that hinder collaborative practice, along with strategies for mediating problems associated with these factors. First, interviewees stressed the importance of resolving *conflicts in values, perspective, and expectations* in developing collaborative programs. These issues were particularly salient early in the collaborative process and all interviewees described embarking on deliberate, and sometimes difficult, series of meetings with different stakeholders in which these issues were surfaced and negotiated. Addressing *communication problems*

was also stressed by a majority of interviewees. In addition to development of specific forms and procedures to facilitate communication in daily practice (described above), interviewees acknowledged that resolving differences and problem-solving around new problems in communication was an important ongoing role for both formal collaborative meetings and staff members in key liaison roles between systems. *Funding challenges* and *fragmentation of systems* were also identified as challenges for collaborative practice. However, once collaborative programs were firmly rooted, stakeholders in the county and new staff began to see these innovations in practice as normative rather than experimental. Even when funding was cut, which in some cases necessitated reductions or modifications in services, collaborative programs were sustained. Problems with staff *turnover or inconsistency in participation of representatives in collaborative meetings* often impaired or slowed collaboration, particularly when orientation of new members was a frequent necessity. Finally, *individual personalities*, particularly representatives who exhibited disrespectful attitudes toward other systems were disruptive to collaborative process, requiring leaders and participants in collaborative planning groups to put undue time and energy into "working around" these problematic individuals.

Despite some of the limitations of this study, such as the qualitative methods and purposive sampling, which limit generalizability to counties throughout the state, the findings document some important factors that both help and hinder the process of collaboration between substance abuse and child welfare fields. Understanding these factors can serve to guide emerging collaborative efforts on local or state levels.

Training Tip: Invite class/training participants to brainstorm or discuss implications for everyday practice that they can identify from the study.

Resources/Websites

There are several valuable resources for obtaining information to strengthen practice, program development, and policy development related to working with substance-abusing families in the child welfare system. Resources include web-based information and documents that are available to helping professionals free of charge. Some examples of useful resources include the following:

- The National Center on Substance Abuse and Child Welfare (NCSACW) (www.ncsacw.samhsa.gov)
- Children and Family Futures/National Center on Substance Abuse and Child Welfare (www.cffutures.org)
- National Clearinghouse on Alcohol and Drug Information (including Young & Gardner, [2002]). *Navigating the pathways: Lessons and promising practices in linking alcohol and other drug treatment with child welfare services.).*

Training Tip: In addition to distributing Handout V-1, the instructor may elect to share additional local, state or national resources that may be of interest to the specific class/training audience.

Activity V-1: Website Exercise

Purpose:
To give participants an opportunity to explore resources that may be useful for advancing collaboration in their own daily practice and/or the systems in which they practice.

Note:
This activity may be most effective if the students/trainees have access to computers or are part of a class that will meet again and allow participants to explore resources as "homework" and report back at a future meeting.

Instructions:
Instructor provides participants with a handout that offers resources for advancing cross-systems collaborative programs. The handout includes information about free written materials that provide practical information for effective collaborative practice as well as several key organizational resources and resources for further training (Handout V-1).

Participants will then select one website of interest to review and share with the class.

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Activity V-2: Take-Home Ideas

Purpose:
To afford participants an opportunity to translate information and ideas obtained from the curriculum into specific action steps that they may take in their own practice and/or in their work settings.

Instructions:
Review the purpose of this activity. Invite participants to take a few minutes to reflect on the questions outlined in Handout V-2 and to make notes about their responses. Let participants know that they will not be asked to show their written responses to anyone.

Have participants form groups of three. Ask participants to verbally share some of the next steps they could take in relation to their own practice or in relation to their own county or agency systems (related to working with children and families in the child welfare system that are impacted by substance abuse).

Close the training with group discussion about next steps for program participants. Identify any themes that seem to be prevalent.

Optional:
Small groups may share their reflections with the larger group so the list can be consolidated. The instructor may emphasize the role of advocacy as well as training in order to advance practice that is grounded in a commitment to collaborative case planning.

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APPENDIXES

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RESEARCH METHODS

Research Design

In-depth interviews were conducted with a sample of 8-12 managers and line staff from both child welfare and substance abuse fields in each of five counties that have adopted formal collaborative policies, programs, and practices. Qualitative methods, such as interviews, are ideally suited for capturing and documenting common experiences about what has "worked" and what might have been problematic from the perspective of individuals involved in different parts of a given system, such as child welfare or substance abuse. These methods may also help to illuminate quantitative findings, offer information about formal and informal local daily practices, and provide a context for understanding a variety of factors that might influence collaboration. The use of in-depth interviews for this study is grounded in the recognition that child welfare social work managers, supervisors, and line staff have a crucial role in the development of evidence-based collaborative models appropriate to their specific counties. In addition, child welfare line staff and supervisors operate in contexts that vary considerably in level of formal collaboration between systems. Consequently, the interviews were designed to explore with experts the facets of collaboration that may be relevant to systems-level collaboration as well as individual practice in relation to work with substance-abusing families.

Sampling Procedures

Recruitment of subjects took place in two phases. First, counties were identified and recruited for participation in this study. Only counties that participated in Phase I of

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the study were invited to participate in the Phase II study. Furthermore, eligibility for recruitment into the Phase II study was reserved for counties that had formal collaborative policies, programs, and practices designed to provide services and improve outcomes for substance-abusing families in the child welfare system. Collaborative practices used to evaluate eligibility for participation in the study include initiatives such as the use of outstationed substance abuse staff in child welfare agencies, early intervention/outreach specialists in child welfare court disposition hearings, family drug court, and other formal collaborative programs and agreements between systems. Qualified counties were prioritized in consultation between the Principal Investigator and Children and Family Futures (collaborating agency for this research project) based on several criteria: (a) current collaborative status, (b) length of collaboration, and (c) representation of different regions of California. Through this process, the following counties were invited to participate in the study: Contra Costa, Merced, Sacramento, San Diego, and Shasta. Counties were invited to participate in the study through contacting child welfare administrators and/or alcohol and drug program administrators. All of the invited counties agreed to participate in the study.

For the second phase of recruitment, purposive sampling was used to identify prospective interviewees from child welfare, alcohol and drug fields, or other systems in each county. Key contacts in each county, recommended by county administrators, assisted the Principal Investigator to compile lists of key managers, supervisors, and line staff members who had been or were currently involved in collaborative activities (including collaborative planning, policy development, and/or program implementation).

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Prospective interviewees were then contacted by email and/or phone to inform them of the purpose of the study and to invite their participation. Prospective interviewees who did not respond to initial contacts were given follow-up emails and phone calls to reaffirm the invitation to participate in the study. Prospective study participants were informed of the purpose of the study, the voluntary nature of their participation, and were invited to ask questions about the study.

Sample Description

A total of 49 professionals from five California counties participated in this study. The respondents were from the following counties: Contra Costa (n = 9, 18.4%), Merced (n = 9, 18.4%), Sacramento (n = 8, 16.3%), San Diego (n = 12, 24.5%), and Shasta (n = 11, 22.4%).

Overall, respondents had substantial history in the helping professions and collaborative work. Close to half of the interviewees were primarily in the alcohol and drug field, over one third were primarily from child welfare, and approximately 16% were from other fields, including the courts, or liaison positions between substance abuse, child welfare, and court systems. Approximately 34.8% of all respondents worked in positions that specifically entailed collaborative work or outstationed work in other fields (analysis not shown). A majority of respondents had advanced educational degrees and a majority described their ethnicity as Caucasian. Table 1 provides a description of the professionals who participated in the study.

Table 1: Description of Sample (N = 49)

Demographic Variables	Mean (SE)
Mean years in profession (SE)	16.0 (3.74)
Mean years in current position (SE)	5.8 (3.70)
Mean years of collaborative practice (SE)	7.7 (5.10)
	% (n)
Professional field	
Child welfare	34.7 (17)
Alcohol and drug	49.0 (24)
Other	16.3 (8)
Education	
None	2.3 (1)
Undergraduate/Certificate	27.9 (12)
Graduate	60.5 (26)
Postgraduate/JD	9.3 (4)
Race/Ethnicity	
African American	15.6 (7)
Caucasian	80.0 (36)
Hispanic/Latino/a	2.2 (1)
Asian/East Indian/Other	2.2 (1)

Interview Guide and Data Collection Procedures

The interviews were typically conducted over the phone and took between 45-90 minutes. All prospective interviewees were given information about the study and were sent a written consent form to review, sign, and return prior to their interview. Care was taken to minimize any inconvenience associated with participating in the study and interviews were scheduled and, in some cases rescheduled, to accommodate the

interviewees. In two instances, prospective interviewees affiliated with the same agency requested group interviews. These requests were accommodated by the researcher and, in these cases, group interviews were conducted in person and individual follow-up interviews were arranged as needed.

The interviews were structured using an interview guide with seven questions and several probe questions (see Appendix B: Interview Guide). The Principal Investigator conducted all of the interviews. Notes were taken during individual interviews and audiotape recordings were made, with the permission of the interviewee, to ensure accuracy of the transcribed notes. The qualitative interviews were transcribed by a graduate research assistant using both notes and audiotapes. Interviewees were invited to discuss their own experiences and perceptions about what factors have helped or hindered collaboration in their local county. Examples of questions that were included in the interview included the following:

- What are some of the collaborative practices between child welfare and substance abuse systems in this county that are in place, in process, or under development?
- How did these collaborative efforts begin?
- Did clarification of values play a role in this process, and if so, how did this occur?
- Based on your own experience and what you hear from colleagues, what were the most important factors that allowed this collaboration to develop?
- What have been the barriers to collaboration or factors that "got in the way" of collaboration? How were these overcome?
- From your perspective, what are the most important "lessons learned" from your experience that would be important for other interested counties to know about?

Analysis

A content analysis of the interviews was conducted to identify key themes between counties and to provide a more complete, detailed picture of specific factors that have helped or hindered progress toward development of collaborative partnerships between child welfare and substance abuse. In addition, interview data were examined for themes that have implications for individual practice in county settings or positions where formal systemic collaboration is not yet fully developed.

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INTERVIEW GUIDE

I. Introduction

(Purpose):

We are trying to learn in detail what factors help and hinder collaboration between child welfare and substance abuse fields. If services are to be effective with substance-abusing families in the child welfare system, we need to know exactly how collaborative projects are developed, what it takes to develop and institutionalize lines of communication between systems, and which strategies work best to get professionals in both systems "on the same page" in case planning with substance-abusing families. To this end, we are conducting a series of interviews with staff from both the child welfare and substance abuse fields in several counties that have managed to develop formal collaborative models. Professionals in each of these fields, such as you, are in an unusually good position to observe the specific processes, practices, policies, and programs that are involved in collaboration.

(Logistics):

- Explain confidentiality and collect consent form
- Stress that results will be summarized and reported in aggregate form; no interviewee identifying information will be included
- Explain purpose of taping and that tape will be erased after transcription

II. Questions

1. What are some of the collaborative practices between child welfare and substance abuse systems in this county that are in place?
   Probes:
   - How did these collaborative efforts begin?
   - What were the first steps that were taken to develop collaboration?
   - Who was involved, what events–if any–facilitated the initiation of this/these effort/s, how did the idea/s for collaboration begin?
   - Did clarification of values play a role in this process, and if so, how did this occur?
   - How does the process of values clarification continue as you work together?
   - What would you say were the three most important factors that facilitated *the beginning* of your collaboration?
   - Describe the status of each of these efforts today.

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2. Based on your own experience and what you hear from colleagues, what were the most important factors that helped this collaboration to develop?
   Probes:
   - These factors can include anything that helped your collaboration (people/leaders, policy changes, values clarification, shared projects, cross-training, etc).
   - What are some of the factors that are currently most helpful to advancing your collaborative efforts?
   - General probe: You mentioned _____ as an important factor. Can you explain exactly how that facilitated your collaborative efforts?

3. What have been the factors that "got in the way" of collaboration? How were these overcome? (If they were not entirely overcome, how have these factors impacted collaboration?)
   - These factors can include anything that hindered your collaboration (people/leaders, policy changes, values conflict, problems in shared projects, gaps in training, etc).
   - What are some of the factors that you consider to be significant barriers or problems in building or sustaining your collaborative efforts?
   - You mentioned _____ as an important factor. Can you explain exactly how that impeded your collaborative efforts?

4. What formal and informal mechanisms are in place to facilitate collaboration between substance abuse and child welfare fields in your county?
   - Probe questions for each specific mechanism: How does it work? Who is involved?
   - What ways—if any—might it be improved? What is being done to ensure that these practices continue or are used by different staff? (For formal agreement, ask if it would be possible to obtain a copy of written agreements and who would need to be approached to obtain the document).
   - How is the adoption of these practices encouraged? How are they institutionalized?
   - Describe differences you perceive, if any, in the adoption and use of formal communication protocols among helping professionals that are closely involved in your collaboration and those that are working in other programs/divisions/areas.

Preface: One of the best ways to define effective practices is to explore the details of specific incidents that were particularly successful. Also, as you know, some

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of the best "lessons" emerge out of mistakes, so it is important to gather information about incidents that were less successful. I have a few questions in each of these areas.

5. Think back to when you had a specific success in relation to communication between child welfare and substance abuse systems. What *specifically* made it "work?"
    - What strategies or approaches "worked" in this case?
    - Exactly what practices did you (or another professional) employ in this case?
    - Describe what (if any) policy, procedure, or tool was used to facilitate communication?
    - What was the outcome in relation to collaborative case planning between child welfare and substance abuse systems?
    - What was the outcome for the child/family involved?

6. Now I would like to ask you to think of an incident in which communication between systems were problematic. What *specifically* was problematic?
    - What were the barriers to communication in this incident?
    - Exactly what practices did you (or another professional) employ in this case?
    - Describe what (if any) policy, procedure, or tool was used to facilitate communication?
    - What was the outcome in relation to collaborative case planning between systems?
    - What was the outcome for the child/family involved?
    - What practices, resources, or conditions, in your opinion, might have lead to a better outcome?

7. From your experience, what are the most important practices for communicating between systems that might be helpful in daily practice when working with substance-abusing families in the child welfare system, even for helping professional working in counties that may not yet have *formal* collaborative programs?
    - How would you describe these practices?
    - What tools, skills, and information are required to implement this practice?
    - In what ways, if any, might this lead to improved shared case planning?

8. This interview today was intended to help us understand what factors facilitate or impede collaboration between substance abuse and child welfare systems. Have we missed anything?

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III. Demographics

1. What is your current position (in Alcohol/Other Drug Programs or Children and Family Services)? Would you categorize this as a management, supervisor, or direct services position?

2. How long have you been in this position?

3. How long have you been involved in collaboration between child welfare, substance abuse fields, and the courts in your county?

4. What is your role in the collaboration?

5. What is the highest degree that you hold?

6. How would you describe your ethnic background?

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HANDOUTS

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ACTIVITY 1
INTRODUCTORY ACTIVITY

Small Group Instructions

In your small groups, please spend a few minutes each on the following activities. Keep track of the highlights of your discussion and be prepared to report back briefly to the large group. You may want to have different group members take responsibility for reporting back your highlights in each of the areas described below. Remember that the report back will be brief and should reflect just a few main points.

In your small groups, please do the following:

1. ***Define collaboration*** in your own words.

2. Brainstorm the ***benefits of collaboration*** at different levels: micro (i.e., "What's in it for me?"), mezzo (groups, community), and macro (organizations, systems). Be sure to include specific examples to illustrate.

3. Despite potential benefits, there are often ***barriers to collaboration*** on micro, mezzo, and macro levels. Discuss what a few of these barriers might be.

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ACTIVITY 2
MODELS OF COLLABORATION

A Systems Perspective of Collaboration	
Whittington (2003)	1) *Micro-level personal factors*: individual characteristics and experiences that shape social identity and influence the establishment of trust within a collaboration. 2) *Mezzo-level professional factors*: practitioners from various disciplines need to understand the commonalities between professions, the unique contributions of each profession, how professions can complement one another, and areas of potential conflict. 3) *Macro-level organizational factors*: support provided by senior-level administrators and managers is a key factor in effective collaboration. The use of strategic plans or other planning documents may also facilitate inter-organizational collaboration.
A Developmental Perspective of Collaboration	
Robertson (1998)	1) *Incentive to collaborate*: collaboration is often motivated by a need to share resources, use existing resources more efficiently, gain access to information, address problems, or gain legitimacy and political advantage. 2) *Willingness to collaborate*: based primarily on the level of interpersonal and interorganizational trust, respect, commitment, and shared values and norms between collaborating parties. 3) *Ability to collaborate*: being able to work together on a shared task, as well as the ability of participants to add the work of collaboration on top of their regular work duties. 4) *Capacity to collaborate*: establishing systems, guidelines, and structures to facilitate the collaboration.
A Process Perspective of Collaboration	
Bronstein (2003)	1) *Interdependence*: circumstances that make professionals dependent upon one another to accomplish a shared goal. 2) *Newly-created professional identities*: collaborations between professionals can create widespread changes to existing service delivery, thereby creating new professional activities. 3) *Flexibility*: the ability to blur professional roles, a willingness to compromise during disagreements, and adaptability within the face of changing circumstances. Egalitarian and non-hierarchical collaborations foster flexibility. 4) *Collective ownership of goals*: shared goals that are clearly defined and widespread involvement in decision-making processes contribute to effective collaboration. 5) *Reflection on process*: attention to and communication about the collaborative process, followed by incorporation of these reflections can improve collaborations.

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ACTIVITY 3
DEVELOPING AN INTEGRATED SERVICE PLAN

Case Scenario

Ms. B. is age 27, of biracial descent (Caucasian and African American), and has a documented drug abuse history of over 8 years. Ms. B. has two children, Jack, age 3, and Jasmine, age 7. Both are currently in foster care for neglect related to substance abuse. Reports to child welfare services have included recent allegations of leaving the children home unattended, dirty home with little food, and minimal attachment and interaction with the children. There were also reports of lots of screaming and yelling in the home, and Ms. B. was described as having "quite a temper." Jasmine attends second grade, but missed school frequently when in her mother's care and appears to have marginal social skills with other children.

Ms. B. was first diagnosed as a poly-substance abuser (although methamphetamine is the current primary drug issue) approximately 3 years ago. Voluntary services were offered when her youngest child, Jack, was born, but Ms. B. did not successfully complete the treatment program she was enrolled in at that time and the case was closed as the children appeared safe at that time.

Jasmine's father has not had any contact with the family since Jasmine was age 2, and his current whereabouts are unknown. However, Jack's father has sporadic contact with both Jack and his mother. He allegedly sells drugs, but has no history of arrests or convictions. Ms. B. also has extended family in the local area, but most are well known to have chronic drug histories.

Ms. B. has lived with various friends since the children were placed into care. She has not been able to maintain stable housing due to lack of employment. However, Ms. B. does have some employment skills in retail services. The friend Ms. B. is now staying with is an individual in recovery, with 5 years sobriety. This has been very inspirational for Ms. B., who appears very motivated to now participate in treatment.

The CWS social worker has referred Ms. B. to a residential treatment program for women. Other services planned for Ms B. include parenting education and employment training so that she can work towards self-sufficiency.

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM[2]			
	Fundamentals for Improved Practice	**Good Practice**	**Best Practice***
Underlying Values and Principles of Collaborative Relationships	Values clarification efforts have begun among the three systems There is an understanding and articulation of the value of family strengths and how family systems, issues of culture, and gender are related to addiction, recovery, relapse and its effect on families Discussions have begun concerning the priority/political will to address the overlapping AOD/CW populations Different time limits and developmental needs of children have been identified as critical issues	A formal joint statement of principles has been negotiated and drafted among the three systems covering responses to CWS children and parents with substance abuse problems Cross-system discussions and problem solving among policy makers, administrators, and practitioners are instituted	Formal values clarification efforts have included all staff of the three systems. The systems have agreed upon individual and joint goals to serve the whole family as their primary client
Daily Practice: Client Screening and Assessment	The three systems have a joint policy on decision-making regarding screening and assessment and impact of results on removal/placement decisions There is a jointly developed and implemented risk assessment protocol that includes a formal review of parents' and children's AOD needs and is recorded for all clients Issues of culture and gender are included and appropriately addressed in the assessment process	Roles for screening and assessment have been clarified; AOD workers have been out-stationed at CWS offices and dependency courts for screening and assessment of contracted staff have been assigned screening and assessment roles for CWS parents Culture- and gender-appropriate joint case assessments and plans have been developed with CWS parents with substance abuse problems	Screening and assessment roles have been negotiated with clarity among all three systems about which system will perform each, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems. Jointly developed quality assurance mechanisms have been implemented for interpretation of assessment information

[2] Reprinted with permission of Children and Family Futures/National Center on Substance Abuse and Child Welfare. Availability: http://www.cffutures.org/docs/Matrix_of_Best_Practices.pdf

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM (cont'd)

	Fundamentals for Improved Practice	Good Practice	Best Practice
Daily Practice: Client Engagement and Retention in Care	Systems have begun "drop-off mapping" of the points at which parents are not responding to referrals and not complying with treatment requirements Systems have agreed on procedures for culture- and gender-specific approaches to outreach for parents who miss appointments The issue of relapse has been identified as a major area needing clarification between the two agencies and the courts, and discussions are under way to negotiate a consensus on shared outcomes that reflect both child safety and recovery goals Dependency courts understand that they have a role in monitoring compliance with court orders for treatment and case plans	Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment Programmatic responses have been put in place to improve family participation/completion rates Systems understand and are responding to how AOD issues and treatment requirements of families interplay with CWS and court requirements	Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety Systems are monitoring and responding to how compliance with case plans and requirements is resulting in changes in behavior The three systems have agreed upon how aftercare will be monitored and the desired long-term outcomes of treatment as it affects children and families Efficient case management and outcomes monitoring tools that enable tracking progress of individual clients as well as the effectiveness of the whole system are in place
Daily Practice: Services to Children of Substance Abusers	Systems are taking a developmental perspective to addressing needs of children of substance abusers in their own system Each system has a focus on child safety as well as family recovery Each system is ensuring that children and youth are being assessed for the effects of parental substance use on children as well as children's AOD use Issues of culture and gender are incorporated in service delivery and programs for all children	Each system ensures that children and families are linked to specific programming for family treatment, and children of substance abusers prevention and intervention services Each system understands and implements its role in ensuring child safety Independent Living Programs include AOD prevention and intervention programs for youth	All children involved with CWS receive developmentally appropriate interventions to address their status as a child of a substance abuser

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM (cont'd)			
	Fundamentals for Improved Practice	**Good Practice**	**Best Practice**
Joint Accountability and Shared Outcomes	Each system has their own outcome measures with beginning recognition of the overlapping issues in cross-system outcomes Some shared outcomes have been agreed upon but each system feels primarily accountable for their own measures of success	Systems use outcome criteria in their contracts with community-based providers (who serve CW-AOD parents) to measure their effectiveness in achieving shared outcomes	The child welfare agency has accepted shared accountability for recovery outcomes for its clients and the treatment agency has accepted shared accountability for child safety for the children of its clients and the court has accepted responsibility for monitoring the outcomes for children and families in the court system All three systems have accountability for safety, permanency, and well-being outcomes for children and families Systems use summaries of outcome data from across three systems to inform policy leaders and community
Training and Staff Development	Commitment has been made to staff development in each system to address substance abuse and child welfare issues Training for all stakeholders has begun with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues Training for parents, guardians, and foster parents has begun to address substance abuse issues	Training in each system has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse and child welfare issues Multi-disciplinary training has been implemented Training for parents and foster parents addresses substance abuse issues by drawing upon parents' experience and the lessons of services and prevention efforts with children of substance abusers	The three systems have engaged local colleges, universities, and law schools to develop pre-service education that addresses the cross-system issues Systems are monitoring the outcomes of the training Training for parents and foster parents is treated as an equal priority to professional training

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM (cont'd)			
	Fundamentals for Improved Practice	**Good Practice**	**Best Practice**
Information Sharing and Data Systems	The three systems have documented the gaps in their current client information systems and are addressing them AOD assessment at intake captures data about child needs among child welfare families CWS assessment at intake captures data about AOD issues Data on the overlap between child welfare families and the caseloads of other systems has begun to be available to AOD, CW, and court systems An interagency process has identified the confidentiality provisions that affect AOD-CW, and court connections and has devised means of sharing information while observing these regulations	The three systems have agreed upon information systems that track parent's referral, prior episodes in each system, progress in treatment, and family outcomes for those parents who the agencies can regularly identify as shared clients Data on the overlap between child welfare families and the caseloads of other systems is consistently available to AOD, CW, and court systems Interagency communication protocols have been developed and are being utilized for information sharing between the three systems	The systems have developed and are fully utilizing information systems that can be linked to track parents through all three systems and monitor family and treatment outcomes, using data to re-allocate resources toward client and community needs and toward the most effective programs Overlap data is being used to redirect resources The systems are monitoring the outcomes of information sharing
Budgeting and Program Sustainability	Systems have begun to develop an inventory of all funds available for treatment and children's services in the state/community Systems have begun to identify the outcomes of innovative practices that merit sustained funding	TANF, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents	A multi-year funding plan has been developed with input from all three systems, which includes negotiated commitments from multiple funding sources, including those beyond the direct control of substance abuse and child welfare agencies

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM (cont'd)			
	Fundamentals for Improved Practice	**Good Practice**	**Best Practice**
Working with the Community and Supporting Families	Community members are included in the planning and development process There are beginning stages of implementing proactive responses to prevention of substance abuse and child abuse/neglect and support for families through partnerships with community members and family support systems There is a system for community education about substance abuse, child abuse/neglect protection and reporting which includes civic groups in the collaborative efforts Efforts have begun to engage faith-based communities in supporting families There are a variety of supports to provide mutual aid and recovery networks to families	Environmental data collection supports community education (e.g., mapping liquor stores and DUI arrests) Geo-mapping of family resource centers and other community assets has been implemented Program using consumer/families/ graduates as active members of service implementation have been instituted A formal mechanism exists to solicit the support of a community advisory group including consumers in its membership There are community supports for sustaining sober living communities and environments	Sober living and transitional housing programs are linked to institutionalized funding sources Community-wide accountability (report cards) systems are in place and information is used to redirect resources toward highest-priority areas and most effective programs Community partnerships in child welfare recognize the central role of substance abuse and have shown their willingness to accept direct family support roles for substance-abusing parents

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MATRIX OF PROGRESS IN LINKAGES AMONG ALCOHOL AND DRUG AND CHILD WELFARE SERVICES AND THE DEPENDENCY COURT SYSTEM (cont'd)			
	Fundamentals for Improved Practice	**Good Practice**	**Best Practice**
Working with Related Agencies	A partnership with law enforcement is in place to appropriately address the needs of children during any needed police action Recognition by all three systems that each member of a family may have a variety of co-occurring needs Core clinical issues – mental health, family violence, and trauma Concrete support services – income support, employment training, transportation, housing, and child care Other needed supports – primary health care, HIV/AIDS, education, dental services Staff are aware of how to identify and link families with the other services that are frequently needed by AOD/CW-involved parents and make referrals to those agencies Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues	Staff are assessing and addressing children and parents' needs as barriers to family recovery The three systems monitor receipt of services Parent education courses are formally evaluated for their impact on parenting practices The three systems have developed a case management role of mentoring and facilitating engagement in and delivery of services The three systems coordinate with law enforcement, corrections agencies, and criminal courts to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)	All three systems are evaluating outcomes of services provided to families and are routinely monitoring the effectiveness of services A fully collaborative process exists across systems with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children

***** Best practice refers to the most fully developed system envisioned by a collaborative of the substance abuse, child welfare, and dependency courts working together. It does not imply "evidence-based practice" and there is a desire to continue to assess best practice. Revisions of this document will continue to evolve as systems across the nation improve their efforts and programs.

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CORE ELEMENTS OF CW AND AOD SYSTEMS

Elements of Successful Collaboration *(Matrix of Progress)*	**Description**
Development of a shared vision through regular communication *(Underlying values and principles of collaborative relationships)*	Often the development of a shared vision involves representatives from both systems gaining a greater understanding of one another's roles. Regular communication through the use of task forces or other advisory groups facilitates the development of a shared vision.
Establishment of guidelines, memorandums of understanding, and protocols for sharing confidential information *(Information sharing and data systems)*	Many promising collaborative models establish guidelines, strategic plans, MOUs, and protocols for sharing confidential information to help guide their activities.
Development of concrete programs such as outstationed AOD workers, the use of liaisons. *(Daily practice re: client screening and assessment, engagement and retention in care, and services to children. Budgeting and program sustainability)*	Examples of concrete programs include dependency drug courts, AOD workers placed in CW offices to provide consultation to CW staff, and assessment of parents and referral to substance abuse services. Liaisons monitor client progress and improve client engagement and retention in treatment.
Training and cross-training *(Training and staff development)*	Providing workers with training and education on substance abuse assessment and treatment, as well as issues involved in the CWS.
Joint case planning *(Joint accountability and shared outcomes, working with related agencies, working with the community, and supporting families)*	Bringing together workers from the CW and AOD systems (as well as other systems as appropriate) to develop a joint case plan that coordinates treatment goals between the systems.

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COLLABORATIVE PRACTICE ILLUSTRATION 1
Sacramento County*

Development of Shared Vision.

Sacramento County developed an Alcohol, Other Drug Treatment Initiative (AODTI) in 1994. With leadership from County Health and Human Services, which includes Alcohol and Drug Services and Child Protective Services, the Initiative began with development of a core training on alcohol and drug issues and intervention that was required for all employees. Additional collaborative projects emerged from this foundation, including the creation of the drug dependency court (DDC).

Overall, Sacramento's Alcohol and Other Drug Treatment Initiative is a multifaceted collaborative model that focuses on training the health and human service system (Child Protective Services, Mental Health, Public Health, Primary Health Services, and Adult Protective Services. Provision of training for professionals in all systems in the Department of Health and Human Services (DHHS) helps to ensure that every substance-abusing parent in need of treatment has access to services. The underlying values and principles of this collaboration center around a recognition that both the CW and AOD systems need to learn from one another in order to effectively serve clients within both systems. The initiative explicitly focuses on prioritizing services for high-risk clients, expanding service capacity, viewing parents as partners, increasing staff understanding of AOD issues, and increasing staff capacity to address AOD use among parents (Young & Gardner, 2002).

A DDC Committee helps to oversee implementation of the DDC and is comprised of representatives from the county's CW and AOD systems, and the case management provider. There is a policy committee that meets quarterly and a work group that meets monthly. In order to assess levels of interagency collaboration, the Collaborative Capacity Instrument was administered to Committee participants. This tool assesses progress in establishing collaborations between the CW and AOD systems. Results revealed that 63% of participants reported that there was agreement among the collaborating parties on the underlying values driving the collaboration, 61% of respondents agreed that there was adequate collaboration with the courts, 55% felt that collaboration was strong in the area of screening and assessment, and 54% reported good collaboration in the area of treatment engagement and retention. Areas where less than 50% of participants reported strong collaboration included budgeting and program sustainability, working with related agencies and joint accountability, information sharing, training and staff development, and services to children (Children and Family Futures, 2002).

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Development of Concrete Programs

In addition to the training initiative described above, a major focus of the Alcohol and Other Drug Services division in Sacramento County is coordinating a system of care (SOC) that (a) gives parents in child welfare priority access to treatment and (b) provides immediate access to pre-treatment groups. In addition, emphasis is placed on accurate assessment of the client's needs and matching client needs with an appropriate level of care. Three levels of service intensity are used: (a) intensive residential and detoxification services, (b) intensive outpatient and day treatment services, and (c) community-based self-help groups. Matching client needs with services is considered to improve treatment retention and engagement (Young & Gardner, 2002). There is some evidence suggesting that the AODTI has been successful in improving access to substance abuse treatment. For instance, in the state of California, women receive 35% of treatment resources, while in Sacramento women receive 52% of treatment resources (Young & Gardner).

Early Intervention Specialists with experience in both the CW and AOD systems provide outreach, support, assessment, and education for parents during their initial detention hearing. These workers also serve as liaisons between CW and AOD service providers and provide parents with assistance in accessing and participating in treatment and meeting court requirements.

Other aspects of the AODTI include the use of a dependency drug court (DDC). The DDC provides rewards and sanctions for compliance with treatment and abstinence from drugs and alcohol. The goals of the DDC are to increase family reunification rates; increase parents' substance abuse treatment compliance rates; decrease children's time in out-of-home care; decrease out-of-home care costs; increase the number of substance-abusing parents who are evaluated and placed in appropriate treatment; and increase collaboration between the court, the CWS, and AOD service providers. Parents with substance abuse problems are identified at the detention hearing by an Early Intervention Specialist (EIS) who conducts an initial AOD evaluation and refers families to services and to the Specialized Treatment and Recovery Services (STARS) program.

Recovery management specialists from the STARS program focus on providing support to the parent in order to increase engagement and retention in services. They also monitor compliance with treatment and random drug testing. Participating parents receive sanctions for noncompliance (e.g., failure to enroll in treatment, positive drug tests, missed drug tests, not participating in treatment, etc.). Sanctions can include a reprimand or jail time (Children and Family Futures, 2002; 2005).

A recent evaluation on the effectiveness of Sacramento County's DDC found positive outcomes. Results indicated that parents participating in the DDC had significantly

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higher rates of entering AOD treatment than parents in a comparison group that did not participate in the DDC. Eighty five percent of DDC participating parents in Years One and Two of implementation and 88.5% in Year Three entered treatment, compared to 50.5% in the comparison group. The DDC also appears to have beneficial effects on reunification rates. At 12 months, 33.3% of Year One DDC-participating children were reunified, and 28.9% of Year Two children were reunified, compared with 18.7% of the comparison children. At 18 months, 43% of the Year One DDC children reunified compared with 24.9% of the comparison children. Similar reunification rates were noted at 24 months. In addition, DDC children were less likely than the comparison group to be in adoption, guardianship, or long-term placement. Overall, the DDC resulted in cost savings as a result of increased reunification rates (Children and Family Futures, 2005).

Establishment of MOU/Protocols for Sharing Information

The DDC has developed clear agreements and protocols for communication between systems. For example, parents who are child welfare involved and who are assessed through the alcohol and drug system of care all sign releases to allow for the exchange of information among agencies named in the consent agreement.

Training and Cross Training

The AODTI continues to ensure that professionals in both CW and AOD systems receive training and cross-training that support collaborative practice. CPS, Mental Health, and the Department of Human Assistance all pay for training slots for their respective employees. A 4-day training is offered for all staff. The training provides an overview of chemical dependency as well as assessment and interventions skills. The course provides participants with knowledge and skills related to assessment, treatment, relapse prevention, and accessing services through Sacramento County's System of Care. Additional specialized trainings are also offered through the AODTI including group co-facilitation skills, motivational engagement, strategies for family change, and adolescent alcohol and other drug and mental health treatment.

Joint Case Planning

The STARS program serves as a hub for coordinating case conferences that may include substance abuse treatment, child welfare, courts, and other related systems involved in a given case.

* This case study is based on interview data and information from a SAMHSA publication (Young & Gardner, 2002). This case study in this curriculum is intended to provide a few illustrative highlights from this county for educational and training purposes. The collaborative elements described in this case study are not exhaustive and should not be presumed to reflect the full history and collaborative policy, programming, or practices of the county.

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COLLABORATIVE PRACTICE ILLUSTRATION 2
San Diego County*

Development of Shared Vision.

The San Diego County Dependency Court Recovery Project (DCRP) started in 1998. The DCRP Policy group invested substantial time in convening and working out differences in perspectives as well as roles and responsibilities among representatives of department leaders from participating agencies. The DCRP policy group met weekly during the formation of the project and currently continues to meet on a regular basis to maintain and improve the project.

Development of Concrete Programs

The overall goals of San Diego County's Dependency Court Recovery Project (DCRP) are to comply with the ASFA and ensure that a reunification or permanency plan is achieved on time. This collaborative model gives parents in the dependency court top priority for substance abuse treatment slots. The underlying values and principles of the DCRP include the perspective that ASFA timelines need to be enforced and that substance-abusing parents need to maintain their sobriety in order to address parenting issues.

The DCRP incorporates several program elements. Parents are assessed initially by a CWS worker and if a substance abuse problem appears to be present, they are referred to the Substance Abuse Recovery Management Systems (SARMS). SARMS then provides an AOD worker who assesses the parent, provides case management, random drug testing, and regular reports to the CWS and the court on client progress. Parents who refuse treatment, have a positive drug test, refuse a drug test or do not appear for a court hearing are subject to court sanctions. Parents who are repeatedly noncompliant may be referred to the dependency drug court (DDC), where they receive more intense monitoring and sanctions for noncompliance that include jail time or paying a fine (Young & Gardner, 2002). Information on outcomes of the DCRP indicate that 79% of SARMS clients were compliant with their case plans and the time from removal of the child to achievement of a permanent placement or reunification has decreased from an average of 34 months to 12-13 months (Young & Gardner).

Establishment of MOU/Protocols for Sharing Information

The DCRP policy group has worked out roles and responsibilities for all participants in the project, including protocols and forms to facilitate communication.

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Training and Cross-Training

Social workers received training on alcohol and drug issues, as well as mental health issues, as part of basic worker orientation.

Joint Case Planning

Case conferences are coordinated through the SARMS project. In addition, settlement conferences were instituted so that issues that might have been litigated in the past are settled outside of courts. The county also has implemented family group decision making conferences that include the family as stakeholders in decisions about family reunification plans.

* This case study is based on interview data and information from a SAMHSA publication (Young & Gardner, 2002). This case study in this curriculum is intended to provide a few illustrative highlights from this county for educational and training purposes. The collaborative elements described in this case study are not exhaustive and should not be presumed to reflect the full history and collaborative policy, programming, or practices of the county.

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COLLABORATIVE PRACTICE ILLUSTRATION 3
Contra Costa County*

Development of Shared Vision

The Contra Costa County Alcohol and Other Drugs (AODS) and Children and Family Services (CFS) Collaborative, which began in 1998, had roots in earlier collaborative efforts related to substance abuse treatment for pregnant and parenting women and an AODS/CFS cross training ("Breaking the Barriers). The collaborative worked together to identify and address gaps in the system and, through this process, initiated concrete programs described below. The collaborative includes leaders and direct service providers from both AODS and CFS and meets on a regular basis for both planning and problem solving.

Development of Concrete Programs

In 1998, an "Early Intervention Outreach Specialist" (EIOS) position was funded through CFS. The EIOS worker has experience in both the CW and AOD systems and provides outreach, support, assessment, and education for parents during their initial detention hearing. In addition, the EIOS helps to facilitate access to treatment and has both formal and informal roles in facilitating communication and addressing problems in collaboration between systems. Because of the improved success in reunification and permanent placement associated with this early pilot, EIOS positions were established and are still maintained in several regions of the county.

Through an agreement outlined in a Memoradum of Understanding (MOU), CFS and AODS work together to provide coordinated services from initial screening and assessment through entry and compliance with treatment. Families receiving CFS services with substance abuse problems are referred to EIOS and then are screened by an AODS treatment provider. The AODS treatment plan identifies the involvement of AODS. CFS visits and activities are scheduled to avoid conflict with the schedule of the treatment program and the AODS treatment provider notifies CFS of key information, such as passes to leave the treatment program. Supervisors in CFS may grant exceptions to MOU practices if clients, parents, or children are endangered.

In addition to the integrated model for coordinated services described above, AODS and CFS applied successfully for a grant to fund a special residential program for substance-abusing women and children who are involved in CFS.

Establishment of MOU/Protocols for Sharing Information

The Memorandum of Understanding outlines protocols for obtaining releases, facilitating appropriate placement into treatment, coordinating CFS visits to clients in treatment,

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communicating between systems about progress and compliance in treatment, coordinating Multidisciplinary Case Conferences (MDCC), and facilitating problem resolution when concerns arise.

AODS provides a monthly progress report to CFS. Specific forms and protocols have been developed for routine reporting about compliance as well as use of a "Hot Sheet Notice" and calls in the event of non-compliance. AODS and CFS share responsibility for getting signed releases from shared clients.

Training and Cross-Training

The CFS/AODS Collaborative has continued to plan and implement an annual cross-training conference (originally the "Breaking the Barriers" annual conference). In addition, special presentations to AODS providers are arranged as needed, such as training about the child welfare system or provisions of the MOU. Presentations about provisions of the MOU are also provided to CFS.

Joint Case Planning

EIOS staff often help arrange a Multidisciplinary Case Conference (MDCC) to ensure coordination of the proposed case treatment plans. When a case is transferred from the court unit, the CFS case work initiates a case transfer staffing that includes the client/parent, AODS staff, CFS worker, and other providers as needed to clarify the CFS and AODS treatment plan. AODS staff and treatment providers are part of regular or special MDCC convened by child welfare. Problems that arise in specific cases are addressed through the MDCC process and, if not resolved through the MDCC process or with the support of supervisors, are addressed in the collaborative AODS/CFS Steering Committee.

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COLLABORATIVE PRACTICE ILLUSTRATION 4
Merced County

Development of Shared Vision

Merced County has developed collaborative planning both through the strong working relationships between leaders of different County agencies and through the development of a number of collaborative planning bodies, many with overlapping membership, that help guide collaborative planning and programming. One of the earliest formal collaborative endeavors involved inclusion of a Child Welfare representative on the AOD Advisory Board, which helped to fuel the development of ideas for specific collaborative practice and programming. In more recent years, a Children's System of Care policy and planning group was formed to include representatives from the alcohol and drug field, child welfare, education, and other key stakeholders concerned with children's issues.

Over the years, county leaders have formed other working groups to establish and then maintain collaborative programs that involved partners from social services, alcohol and drug services, and the court. Initial collaborative efforts began with the establishment of an adult drug court. In due course, a juvenile drug court program was instituted. The success of these earlier programs helped to fuel an ultimately successful effort to establish a drug dependency court, with participation of representatives from Alcohol and Drug Services, Social Services, the District Attorney's Office, Public Defenders, and the courts. Regular meetings take place with partners who continue coordination of these various collaborative programs.

Development of Concrete Programs

Supportive Ongoing Services (SOS) is a multi-agency effort at joint case planning. It is a weekly meeting to discuss child placement issues. The SOS team, which includes Alcohol and Drug Programs, Child Welfare, Mental Health, and school personnel, meets regularly to address the placement issues and other needs of "the very difficult cases." The clients' case information is presented and reviewed by members of the collaborative, allowing for coordination of services to address multiple issues and to identify "wraparound services to shore up the family."

Experts in alcohol and drug assessment, intervention, and treatment are outstationed in Social Services and other key agencies in the community. Outstationed AOD experts in social services provide assessments and assist in case planning for clients in child welfare as well as clients with alcohol and drug problems who are referred from TANF or the welfare-to-work program. Social workers are stationed at schools, providing an opportunity for early intervention. Both a social worker and a probation worker are co-located at Mental Health offices. The co-location at Child Welfare of Probation, Mental

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Health, A Women's Place (domestic violence provider), Alcohol and Drug (AOD) services, Sheriff's Department, and Public Health ensures quick action and access to information.

Establishment of Guidelines, Memorandum of Understanding, and Protocols for Sharing Confidential Information

A universal release form exists for most service agencies within Merced County with the exception of Mental Health and AOD. Release of information forms for clients who are involved in AOD treatment adhere to federal regulations governing protection of confidentiality for this population. The Merced County Alcohol and Drug Services Division is located in the Department of Mental Health. The Merced County Mental Health director and Child Protective Services signed a Memorandum of Understanding (MOU) delineating funding, as well as terms of information exchange regarding clients shared by each agency.

Training and Cross Training

Child Protective Services offer its staff periodic training on confidentiality and confidentiality issues, including confidentiality regulations for clients in substance abuse treatment. Participants from multiple systems are invited to participate in trainings that are sponsored by county agencies. For example, training funded by the Human Services Agency are made available to staff from Mental Health/AOD.

Joint Case Planning

Regular joint case planning meetings are conducted in relation to specific collaborative programs described above, such as the drug dependency court and the SOS program.

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COLLABORATIVE PRACTICE ILLUSTRATION 5
Shasta County

Development of Shared Vision and Development of Concrete Programs

Shasta County Children and Family Service (CFS) developed collaborative groups to work with different levels of service: intake, court, and family preservation and Local Interagency Network for Children (LINCS), which includes treatment and high-end treatment units.

The focus of this collaboration was to provide integrated services for children and families involved with CFS. The collaborative partners include children's mental health, alcohol/drug services, public health, education, probation, eligibility, and domestic violence. While all of these partners are not stationed at each of the service level offices, staff has direct access to the partners who are co-located in the building, and indirect access to the other partners.

The teams develop treatment plans to meet the needs of the child and family, pulling together appropriate services for each child and his or her family. The social services teamwork approach has facilitated ongoing conversations between the different disciplines, improving relationships, as well as increasing respect.

Co-location has increased effectiveness of services, communication, and collaborative service planning and benefited both children and parents in Shasta County. The staff "sit at the same table reviewing the same client case file, sharing expertise, determining the services needed together, and working with clients." These collaborative efforts have worked so effectively that efforts have continued to negotiate and fund additional program representation.

In addition, Shasta County has several other collaborative efforts and processes which have been developed. For example, another collaborative, the Perinatal Substance Abuse committee has representatives from Alcohol and Drug, Public Health, Child and Family Services, and local doctors and providers. Using the strength in diversity of perspective and experience of the participating staff, pregnant women are screened for drug use and referred to the appropriate services if the test is positive for drug use.

Shasta County also has the Behavioral Health Team (BHT) stationed at Social Services eligibility and at CalWORKS. The BHT work with clients with mental health, alcohol and drug, and domestic violence problems when these issues are identified as a barrier to employment.

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Establishment of Guidelines, Memorandum of Understanding, and Protocols for Sharing Confidential Information

There is a memorandum of understanding (MOU) that details how the agencies will work together, share information, and report results to the associated agencies. The release of information form includes all the representative agencies that work in these partnerships. In addition there are currently separate release forms used by some of the programs to ensure confidentiality as required by HIPAA and federal confidentiality laws for alcohol and drug (42 CFR), domestic violence, and mental health.

Training and Cross Training

Recognizing that joint training builds relationships and strengthens collaboration, a Training Officer was appointed. The Training Officer communicates to staff about training programs available at University of California, Davis and other educational venues.

Joint Case Planning

Collaborative interagency family meetings are part of the day-to-day business. These are short meetings facilitated by a staff member that generally take 1-1½ hours to develop concrete plans and problem solve with the client and family to discuss concerns, strengths, and plans.

On a systems level, a state-mandated Multidisciplinary team (MDT) makes decisions about Family Maintenance, Family Reunification, or bypass and then forward recommendations to the judge. The MDT includes representatives from Alcohol and Drug, Mental Health, Public Health, Probation, CFS (supervisors from all the units), Women's Refuge, and the parenting program.

A pre-placement review team that includes Child Welfare, Mental Health, Education, and Juvenile (probation) determines the level of treatment that the child will enter (e.g., high-end placement for substance-abusing youth). A Concurrent Review team interfaces with Social Work on concurrent planning of treatment and services, ensuring all caseworkers are using concurrent planning methods as well as reviewing the content of those plans.

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MEDIATION EXERCISE: ADDRESSING FACTORS THAT HINDER COLLABORATION

Instructions for Small Group Discussion:

Read the following case scenario in small groups and address the questions that follow.

You have just completed training on the benefits of collaboration across systems and are excited about opportunities to put your new knowledge to practice. The issue of inter-agency collaboration has recently been a hot topic in the county you work in, and there is much support and interest by various agency leaders (both public and private sectors) to bring about positive changes in this area. Unfortunately, it appears some staff in the agency are resistant to change, believing the "old model" of practice is just fine. Because you are energetic, and a hard worker, your agency has asked that you be part of an inter-agency team to help move these changes forward.

1. How might you specifically approach this situation to help motivate both staff and agency systems to adopt more of a collaborative approach in the work?
2. What immediate changes in practice might the CWS units adopt?
3. What immediate changes in the treatment agencies might be adopted?
4. How might inter-agency collaboration on a systems level be improved?
5. How might you employ the assistance of co-workers, supervisors, or others to facilitate acceptance and interest in these ideas?

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MOCK COLLABORATIVE: ROLES OF COLLABORATIVE MEMBERS

NOTE TO INSTRUCTOR:

The roles below are intended for distribution for the "mock collaborative" activity. For smaller groups, select the first few roles in each category to ensure representation from each group.

The roles with the asterisk should be assigned to just one individual. Other roles may be distributed to more than one participant for larger groups. The instructor may also elect to add new roles as they deem appropriate for their group.

***CWS Roles*:**

***Program Analyst/Manager:** You are in a leadership role in CWS and are highly committed to developing successful collaborative practices and programs. The Director of the County Child Welfare Department, who is also committed to advancing more collaborative practice in the County, has given you the authority to commit the Department to consider changes that the collaborative might propose.

***Unit Supervisor 1:** You are supervisor of the FR unit and you really dislike moving towards termination of parental rights. You would much rather provide the benefit of the doubt to parents.

***Unit Supervisor 2:** You are supervisor of adoptions and you are personally skeptical about whether substance-abusing parents can recovery enough to provide adequate parenting to children. There are a number of children in foster care with parents who are interested in adoption and you would like to see the time shortened for permanency planning for those children.

Family Reunification Worker: You are fairly new to FR work, and are overwhelmed with the number of cases you currently have. You are frustrated that you cannot seem to get much information from the treatment programs that your clients are attending.

Adoptions Worker: You have worked very hard to provide post-adoption services to families in which the children have had chemically-dependent parents.

ER Worker 1: This individual has been in ER for over 10 years and presents like a "know-it-all."

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AOD Roles:

***Program Analyst/Manager:** You are in a leadership role in the AOD system and are highly committed to developing successful collaborative practices and programs. The Director of the Alcohol and Drug Program Division and the Director of the Child Welfare Department are both committed to advancing more collaborative practice in the County. You have been selected to represent the County AOD Division on the Collaborative. At the same time, you have the authority only to bring recommendations back to the Director and may not commit to changes or use of AOD resources without approval.

***Substance Abuse Treatment Program Director 1:** You are Director of a treatment program for pregnant and parenting women. You are well aware of conflicts that frequently arise between your substance abuse treatment staff and child welfare workers providing oversight to clients in treatment (some of whom have their children in the program and others have children in foster care or placed with family members). The degree to which CW cooperates well with AOD treatment staff seems to vary considerably between individual CW workers. You are interested in creating consistency and clarity about standards and expectations.

***Substance Abuse Treatment Program Director 2:** You are Director of a co-gender treatment program. A number of your female clients have had open cases with child welfare while they were in treatment. You tend to believe that treatment should come first and that CW should let the program "do their job" before making demands on clients and AOD treatment staff. You are also concerned that cooperation with CW will expedite permanent removal of children rather than reunification. You have been in the alcohol and drug field a long time and have had a number of experiences of observing bias against clients in recovery from professionals in health, welfare, and legal professions. You are concerned that collaboration will result in breeches in client confidentiality and may ultimately be harmful to clients.

Paraprofessional (recovering user): You do not have children of your own, but had a 10-year history of substance abuse involving legal problems. You have many years of recovery and have a reputation as a good counselor. You have had both positive and negative experiences with different child welfare workers assigned to your clients. Most recently, a CW worker with a Master's in Social Work stated that she did not feel that you were qualified to assess the progress of your own client because you did not have a degree.

Treatment counselor: You have an MSW and substantial training in treatment of substance abuse, but no personal experience with substance abuse. You respect your colleagues, who generally have life experience and certification as counselors but not degrees. Many of your clients have successfully reunified with their children and families. However, you have occasionally had clients who you believed should relinquish their children or otherwise not serve as primary caretakers.

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Court Roles:

***Judge or referee:** You are frustrated with the way that things currently function. You are required to ensure that reasonable efforts are made for reunification; however, delays in getting parents into treatment and failures in coordination between child welfare and substance abuse systems has created parallel delays in closing cases. You believe that this is harmful to families that might be able to reunify and even more harmful for children who are delayed in achieving permanent placement (through reunification, placement with other family members, or adoption). You are aware that collaborative models have helped to reduce these problems in other counties and are interested in changes. At the same time, you know that at least one of your colleagues is skeptical of such efforts and is harsh in adjudicating cases with substance-abusing parents.

***County Counsel:** You are an excellent attorney who provides helpful, sound advice for social services. You are not likely to be an ongoing participant in the collaborative, but you have been invited to attend the first meeting. You are interested in identifying issues that may pertain to policy concerns and legal issues (e.g., protection of confidentiality) that may need to be addressed in order for the collaborative to succeed. You are aware of the fact that both the Child Welfare Services Director and the Director of the Alcohol and Drug Services Division are supportive of advancing collaborative efforts.

***Attorney for parents:** You generally have a very collaborative approach with DSS and the court; however, you are also concerned that collaboration may make it more difficult to advocate for parent's rights.

***Attorney for children:** You are a strong advocate for children's rights and safety. You have a good relationship with the courts and child welfare. However, you are very concerned that these discussions of collaboration may interfere with what you consider your primary professional (and even personal) mission: to fight for the rights and safety of children.

Probation officer: You are experienced, and very much focused on "taking responsibility." Some of your clients are involved in both the substance abuse and child welfare systems because of arrests on drug-related charges.

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ACTIVITY IV-2
QUIZ ON CONFIDENTIALITY OF PATIENT RECORDS FOR ALCOHOL AND OTHER DRUG TREATMENT

1. The purpose of the federal regulations governing confidentiality of alcohol and drug abuse patient records (45 CFR, Part 2) include all of the following ***except:***

    a. Decrease the risk that information about individuals in recovery will be disseminated
    b. Decrease the risk that recovering individuals will be discriminated against
    c. Encourage people to seek treatment for substance abuse disorders
    d. Protect parents from accountability when they are concurrently involved in the child welfare system.

2. The federal confidentiality regulations apply to any program that specializes in whole or in part, in provision of treatment, counseling and/or assessment, and referral services for clients with substance abuse disorders and that receives any federal assistance including:

    a. Any program receiving federal funding, including federal funding that is administered through the state or local counties
    b. Any program that has tax-exempt status
    c. Prevention programs for individuals and families at risk.
    d. All of the above
    e. Only a and b

3. Federal confidentiality regulations require that records of the identity, diagnosis, prognosis, or treatment of any client be protected. Protected information includes:

    a. Name
    b. Address or phone number
    c. Social security number
    d. Photograph
    e. All of the above

4. The scope of the federal confidentiality regulations apply to the patient-identifying information of a person who **(Circle all that apply):**

    a. Is currently receiving treatment
    b. Has received treatment in the past
    c. Does not show up for an appointment arranged for by a third party
    d. Has had an assessment but has not yet attended treatment

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5. Which of the following communications would be acceptable in relation to disclosing patient records? **(Circle all that apply)**

    a. Giving written records with a patient's name on it
    b. Testifying in court about a patient's treatment
    c. Reporting to a government agency that the person has sought treatment or a referral for treatment
    d. Answering a telephone and informing the caller that the person to whom the caller wishes to speak is present
    e. Reviewing a list of individuals and indicating which individuals are not patients
    f. Sending a letter to someone with a return address like "XYZ Treatment Center"

6. Confidential information may be shared under all of the following conditions ***except*:**

    a. When the client signs a proper consent
    b. When a law enforcement officer comes to the program without a court order, but with a subpoena, search warrant, or arrest warrant
    c. Medical emergency
    d. Internal program communications
    e. Mandated reports of child abuse or neglect

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PROTECTING CLIENTS' PRIVACY[3]

by Margaret K. Brooks, Esq.

THE FEDERAL CONFIDENTIALITY LAW AND REGULATIONS

Among Americans, there is a widespread perception that people with substance abuse disorders are weak or morally impaired. The Federal confidentiality law and regulations grew out of a concern that this social stigma and discrimination against recovering substance users might deter people from entering treatment. The law is codified as 42 U.S.C. §290dd-2. The implementing Federal regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," are contained in 42 Code of Federal Regulations (CFR), Part 2.

The Federal law and regulations severely restrict communications about identifiable individuals by "programs" that provide substance use diagnosis, treatment, or referral for treatment (§2.11) (citations in the form "§2..." refer to specific sections of 42 CFR Part 2). The purpose of the law and regulations is to decrease the risk that information about individuals in recovery will be disseminated and that they will be subjected to discrimination, and to encourage people to seek treatment for substance abuse disorders.

The regulations restrict communications more tightly in many instances than, for example, the laws governing either doctor-patient or attorney-client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4). Some may view these Federal regulations governing communication about the client and protecting privacy rights as an irritation or a barrier to achieving program goals. However, most of the problems that may crop up under the regulations can be easily avoided through planning ahead. Familiarity with the regulations' requirements will assist communication. It also can reduce confidentiality-related conflicts among the program, client, and outside agencies so that these conflicts rarely occur.

What Types of Programs Are Governed by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for clients with substance abuse disorders must comply with the Federal confidentiality regulations (§2.12(e). Although the Federal regulations apply only to programs that receive Federal assistance, this assistance

[3] Reprinted from the following public domain document: Howard, J. (2000). *Substance abuse treatment for persons with child abuse and neglect issues.* (DHHS Publication No. SMA 00-3357; pp. 151-163). Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

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includes indirect forms of Federal aid such as tax-exempt status or State or local government funding (in whole or in part) from the Federal government.

Coverage under the Federal regulations is not contingent upon how a program labels its services. A "prevention" program is not excused from adhering to the confidentiality rules. The kind of services, not the label, determines whether the program must comply with the Federal law.

Overview of Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about a client who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program covered under the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment. The restrictions on disclosure (the act of making information known to another) apply to any information that would identify the client as a substance user either directly or by implication. The general rule applies from the time the client makes an appointment, applies for services, is assessed, or begins treatment. It also applies to former clients. Furthermore, the rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When May Confidential Information Be Shared With Others?

Information protected by the Federal confidentiality regulations may always be disclosed after the client signs a proper consent form. (For minors, however, parental consent must also be obtained in some States.) The regulations also permit disclosure without the client's consent in several situations, including during medical emergencies, in communications among program staff, when reporting is mandated as in instances of child abuse or neglect, or when there is a danger to self or others. Nevertheless, obtaining the client's consent is the most common exception to the general rule prohibiting disclosure. The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

RULES FOR OBTAINING CLIENT CONSENT TO DISCLOSE TREATMENT INFORMATION

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). However, no information obtained from a provider--even with the client's consent--may be used in a criminal investigation or prosecution of a client unless a court order also has been issued in accordance with §2.65 (see §2.12(a) and (d)).

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A proper consent form must be in writing and must contain *each* of the items specified in §2.31, as follows:

- The name or general description of the program(s) making the disclosure,
- The name or title of the individual or organization that will receive the disclosure,
- The name of the client who is the subject of the disclosure,
- The purpose or need for the disclosure,
- How much and what kind of information will be disclosed,
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it,
- The date, event, or condition upon which the consent will expire if not previously revoked,
- The signature of the client (and, in some States, that of the parent), and
- The date on which the consent is signed.

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See sample consent form in Figure B-1.) Several items on this list deserve further explanation and are discussed below: the purpose of the disclosure and how much and what kind of information will be disclosed, the client's right to revoke consent, expiration of the consent form, and the required notice against re-releasing information. A note about agency use of the consent forms follows.

The Purpose of the Disclosure and the Information That Will Be Disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

The purpose or need for the communication of information must be specified on the consent form. Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed and to tailor it to what is essential to the specified need or purpose. Thus, the amount and type of information required must be written into the consent form. (The release of any HIV-related information may require a separate consent form, depending on the requirements of State law. For a discussion of the confidentiality of HIV-related information, see the forthcoming TIP, *Substance Abuse Treatment for Persons with HIV/AIDS,* in press [b].)

As an illustration, if a client must have participation in treatment verified to continue receiving public assistance, the purpose of the disclosure would be to "verify

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treatment status to the welfare authorities," and the amount and kind of information to be disclosed would be "time and dates of appointments" or "attendance." The disclosure would then be limited to a statement that "Jane Doe (the client) is receiving counseling at the XYZ Drug Treatment Program on Tuesday afternoons at 2 p.m."

The Client's Right to Revoke Consent

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client's signed consent, it is not required to retrieve the information it has already disclosed.

The regulations also provide that "acting in reliance" includes provision of services while relying on a consent form permitting disclosures to a third-party payor. (Third-party payors are health insurance companies, Medicaid, or any party that pays the bills other than the client's family.) Thus, a program can bill the third-party payor for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payor does so at its own financial risk.

Expiration of Consent Form

The consent form must contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). Depending on the purpose of the consented disclosure, the consent form may expire in 5 days, 6 months, or longer. Sound practice calls for adjusting the expiration date in this way, rather than imposing a set time period, say 60-90 days. For example, providers sometimes find themselves in a situation requiring disclosure when the client's consent form has expired. This means at the least that the client must return to the agency to sign a new consent form. At worst, the client has left or is unavailable, and the agency will not be able to make the disclosure.

The consent form need not contain a specific expiration date but may instead specify an event or condition. For example, if a client is in treatment as part of a service plan drawn up by the child protective services (CPS) agency, the consent form can be drafted to expire at the completion of the case with the CPS agency. Or if a client is being referred to a specialist for a single appointment, the consent form should stipulate that consent will expire after this appointment.

Required Notice Against Redisclosing Information

Once the consent form is properly completed, one formal requirement remains. Any disclosure made with the client's consent must be accompanied by a written

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statement that the information disclosed is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing redisclosure.)

Note on Agency Use of Consent Forms

The fact that a client has signed a proper consent form authorizing release of information does not compel a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1), 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure even if consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: disclose only what is necessary and only as long as necessary, keeping in mind the purpose of disclosing the information.

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Figure B-1: Sample Consent Form

Consent for the Release of Confidential Information

I, _____, authorize XYZ Clinic to receive
(name of client or participant)

from/disclose to _____
(name of person and organization)

For the purpose of _____
(need for disclosure)

for the following information _____

_____

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____ unless otherwise specified below. (date, condition, or event)

Other expiration specifications: _____

_____

_____
Date executed

_____
Signature of client

_____
Signature of parent or guardian, where required

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RULES FOR COMMUNICATING WITH CPS AGENCIES AND OTHERS ABOUT CLIENTS

Communicating With CPS Agencies, Coordinating Care, and Making Referrals

Programs treating parents involved with CPS agencies may be called on to provide information to CPS or to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. The best way to proceed is to obtain the client's consent. Care should be taken in wording the consent form to permit the kinds of communications necessary.

For example, if the program is treating a client who has been referred to treatment and whose parental rights are at risk, the purpose of disclosure might be to "assist the client to comply with the CPS system's requirements, goals, and timetables," or to "supply periodic reports about attendance," and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment."

On the other hand, if the program needs ongoing communications with a mental health provider, the purpose of the disclosure would be "coordination of care for John Doe," and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

Note that the kinds of information disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if sharing would assist in coordinating care. Disclosure to CPS agencies should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to CPS agencies could, in many circumstances, be inappropriate.

The program should also give considerable thought to the date or event that will end the period of consent. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to CPS agencies might expire when the client's CPS case is closed.

Making Referrals

Programs treating clients often refer them to other health care or social service agencies. Giving a client the name and telephone number of an outside gynecologist, tutoring service, or training program might not be effective unless the client's treatment counselor calls to set up the appointment for the client. However, such a call is a disclosure of confidential information that the client has a substance abuse problem, and thus the counselor is required to obtain the client's consent in writing (as well as parental consent in States requiring it).

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Special Consent Rules for Clients Involved in the Justice System

Programs assessing or treating clients who are involved in the criminal justice system (CJS) must still follow the Federal confidentiality rules. However, special rules apply when a client comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of a criminal justice proceeding. (Note that these rules do *not* apply to clients referred by the CPS system or "mandated" into treatment by CPS. They apply only to clients mandated into treatment as a condition of the disposition of a criminal case.)

A consent form (or court order) is required before a program can disclose information about a client who is the subject of CJS referral. However, the rules are different concerning the length of time a consent is valid and the process for revoking it (§2.35). Specifically, the regulations require that the following factors be considered in determining how long a criminal justice consent will remain in effect:

- Anticipated duration of treatment,
- Type of criminal proceeding,
- Need for treatment information in dealing with the proceeding,
- Time of the final disposition, and
- Anything else the client, program, or justice agency believes is relevant.

These rules allow programs to draft the consent form to expire "when there is a substantial change in the client's justice system status." A substantial change in justice system status occurs whenever the client moves from one phase of the CJS to the next. For example, for a client on probation, a change in CJS status would occur when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment and periodic reports to the client's probation officer and could even testify at a probation revocation hearing if it so desired, because no change in status would occur until after that hearing.

An important difference between the regular consent form and the CJS consent form is that the Federal regulations permit the program to draft the CJS consent form so that it cannot be revoked until a specified date or condition occurs. The regulations permit the CJS consent form to be irrevocable so that a client who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring his or her progress. Note that although a CJS consent may be made irrevocable for a specified period of time, that period must end no later than the time of the final disposition of the juvenile or criminal justice proceeding. Thereafter, the client may freely revoke consent. A sample CJS consent form appears in Figure B-2.

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Figure B-2:
Consent Form: Criminal Justice System Referral

Consent for the Release of Information

I, _____, hereby consent to
(name of defendant)

communication between _____and
(treatment program)

_____
(court, probation, parole, and/or other referring agency)

the following information_____
(nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

____ _____
(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

_____ _____
(date) (Signature of defendant/patient)

_____
(Signature of parent, guardian, or authorized representative if required)

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OTHER EXCEPTIONS TO THE GENERAL RULE

Chapter 6 [of Howard/SAMHSA, 2000] made reference to other exceptions to the general rule prohibiting disclosure of information about a client who seeks or receives substance use treatment services. These include:

- Disclosures that do not reveal "client-identifying" information,
- Disclosures authorized by court order,
- Disclosures to an outside agency that provides a service to the program,
- Mandated reporting of child abuse or neglect, and
- Imminent danger to self or others.

Disclosures That Do Not Reveal "Client-Identifying" Information

Federal regulations permit treatment programs to disclose information about a client if the program reveals no client-identifying information. "Client-identifying" information is information that identifies an individual as a substance user. Thus, a program may disclose information about a client if that information does not identify him as a substance user or support anyone else's identification of the client as a substance user. For example, a counselor in a program that provides services to clients with other problems or illnesses as well as substance abuse disorders may disclose information about an identified client to a peer in another treatment program or to a lawyer at a legal services program (to obtain advice, for example) as long as the counselor does not reveal the fact that the client has a substance abuse disorder or is receiving treatment (§2.12(a)(i)). Similarly, a counselor employed by a program that is part of a general hospital could make such a disclosure, if no mention is made of the client's substance abuse or participation in a treatment program. Of course, if information the counselor must discuss with the colleague or lawyer involves substance abuse, this exception will not work.

Programs that provide only substance abuse services cannot disclose information that identifies a client under this exception, because telling a colleague or a lawyer that the call is being made from the "XYZ Drug Treatment Program" automatically identifies the client as a participant in the program. However, a freestanding program can sometimes make "anonymous" disclosures; that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as a substance user. In other words, a counselor could call a colleague or a lawyer and ask for advice, yet not be obliged to identify the program by name.

Court-Ordered Disclosures

A State or Federal court may issue an order permitting a program to make a disclosure about a client that would otherwise be forbidden. However, a court may issue

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one of these authorizing orders only after it follows special procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information* (§2.61). Additional information about dealing with subpoenas appears in *Confidentiality: A Guide to the Federal Laws and Regulations* (Legal Action Center, 1995). Before a court can issue an order authorizing a disclosure about a client that is otherwise forbidden, the program and the client whose records are sought must be given notice of the application for the order, as well as an opportunity to make an oral or written statement to the court. (If the information is being sought to investigate or prosecute a client for a crime, however, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).)

Generally, the application and any court order must use a fictitious (made-up) name for any known client, *not* the real name. All court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect the disclosure will have on the client or the doctor-patient or counselor-client relationship and on the effectiveness of the program's treatment services. Before it may issue an order, the court also must find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c).

The scope of the disclosure a court may authorize is limited as well, even when the court finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court also should take any other steps necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§2.64(e)). The court may order disclosure of "confidential communications" by a client to the program only if the disclosure is:

- Necessary to protect against a threat to life or of serious bodily injury,
- Necessary to investigate or prosecute an extremely serious crime (including child abuse), or
- Connected with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor...") (§2.63).

These standards govern any effort by CPS agencies to obtain information from a program. However, if the information is sought not by CPS, but by law enforcement

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authorities to investigate or prosecute a client for a crime, the court must make these additional findings:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury (including child abuse and neglect),
- The records sought are likely to contain information of significance to the investigation or prosecution,
- There is no other practical way to obtain the information, or
- The public interest in disclosure outweighs any actual or potential harm to the client, the doctor-patient relationship, and the ability of the program to provide services to other clients.

When law enforcement personnel seek the order, the court also must find that the program had an opportunity to be represented by independent counsel. If the program is a government entity, it *must* be represented by counsel (§2.65(d)).

Sharing Information With an Outside Service Agency

If a program routinely must share certain information with an outside agency that provides services to the program, a qualified service organization agreement (QSOA) can be made. A QSOA is a written agreement between a program and a person (or agency) providing services to the program, in which that person (or agency):

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, he is fully bound by Federal confidentiality regulations, and
- Promises that, if necessary, he will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§§2.11, 2.12(c)(4)).

A sample QSOA is provided in Figure B-3.

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. One example of a QSOA is an agreement with an attorney who advises and represents the program. This kind of agreement is helpful if a program has a question about making a report to the CPS system, or receives a subpoena or a notice that someone is seeking a court order authorizing the program to disclose records. The attorney is providing a service to the program by advising on whether a child abuse report must be made or how to handle a subpoena. If a QSOA is made with an attorney, the program can disclose the information the attorney needs to provide the advice. In return, the attorney guarantees that he is bound by the Federal regulations and will not disclose information learned from the program unless the disclosure is permitted by the Federal regulations. Without a QSOA, the program might not be able to communicate with an attorney in order to get assistance--unless the

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client(s) whose records are sought consents. It is not always possible to obtain a client's consent; for example, she might be incarcerated. Of course, the attorney cannot redisclose the information when redisclosure would violate the regulations.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information needed by others so that the program can function effectively. A QSOA may not be used between different programs providing substance abuse treatment and other services.

Other Exceptions

Several other exceptions deserve brief mention:

- Communications among program staff,
- Medical emergency, and
- Research, audit, and evaluation.

Internal program communications

The Federal regulations permit some information to be disclosed to staff within the same program:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of substance abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)».

In other words, staff members who have access to client records because they work for or administratively direct the program--including full- or part-time employees and unpaid volunteers--may consult among themselves or otherwise share information if their substance abuse work so requires (§2.12(c)(3)).

Medical Emergency

A program may make disclosures to public or private medical personnel "who have a need for information about [a client] for the purpose of treating a condition which poses an immediate threat to the health" of the client or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that the exception cannot be used as the basis for a disclosure to the police

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or other non-medical personnel.

Whenever a disclosure is made to cope with a medical emergency, the program must document the following information in the client's records:

- Name and affiliation of the recipient of the information,
- Name of the individual making the disclosure,
- Date and time of the disclosure, and
- Nature of the emergency.

Research, Audit, and Evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (§§2.52, 2.53).

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Figure B-3: Qualified Service Organization Agreement

XYX Service Center ("the Center") and the _____,
(name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide_____

_____
(nature of services to be provided)

Furthermore, the Center:

1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2; and

2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 CFR Part 2

I understand that my records are protected under the Federal and State Confidentiality Regulations.

Executed this _____ day of _____, 20____

_____	_____
President	Program Director
XYZ Service Center	(name of the program)
(address)	(address)

OTHER RULES ABOUT CLIENTS' RIGHT TO CONFIDENTIALITY

Client Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to clients when they begin participating in the program or soon thereafter (§22(a)). The regulations contain a sample notice. Programs can use their own judgment about when to permit clients to view or obtain copies of their records, unless State law allows clients the right of access

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to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, locked file cabinet, safe, or other similar container. Programs should establish written procedures that regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16). Computerization of records greatly complicates efforts to ensure security. (For a brief discussion of some of the issues computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* [CSAT, 1996].)

State Confidentiality Laws

States also have laws limiting what information about clients may be disclosed and how disclosure must be handled. For example, most States have laws that offer some protection to patients' medical information. Clients think of these laws as the "doctor-patient privilege."

Strictly speaking, the doctor-patient privilege is a rule of evidence that governs whether a clinician can be asked or compelled to testify in a court case about a client. In many States, however, laws offer wider protection. Some States have special confidentiality laws that explicitly prohibit certain types of providers from divulging information about clients without consent. States often include such prohibitions in professional licensing laws, which generally prohibit licensed professionals from divulging information about clients and make unauthorized disclosures grounds for disciplinary action, including license revocation.

Each State has its own set of rules, which means that the scope of protection offered by State law varies widely. Whether a communication (or laboratory test result) is "privileged" or "protected" may depend on a number of factors:

- The type of professional holding the information and whether he is licensed or certified by the State,
- The context in which the information was communicated to or obtained by the professional,
- The context in which the information will be or was disclosed,
- Exceptions to any general rule protecting information, and
- How the protection is enforced.

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CONCLUSION

To be effective in treating clients with substance abuse disorders, counselors must respect their clients' right to confidentiality. With the complex layering of Federal and State rules concerning confidentiality, how does a counselor avoid violating the rules--short of hiring a lawyer? When in doubt, counselors usually can follow these simple rules: (a) consult the client--making clear the options, as well as the counselor's legal obligations, (b) be sensitive to what information is disclosed and how, and c) review the case with a clinical supervisor. Only as a last resort should the counselor have to consult State law or a lawyer.

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CONFIDENTIALITY OF PATIENT RECORDS FOR ALCOHOL AND OTHER DRUG TREATMENT

Where are the federal regulations related to confidentiality located?
Regulations are set out in Title 42, part 2, Code of Federal Regulations

What is the primary purpose of the law?
The Federal drug and alcohol confidentiality laws are predicated on the public health view that people with alcohol or other drug problems are likelier to seek (and succeed at) treatment if they are assured that their need for treatment will not be disclosed unnecessarily to others. The confidentiality regulations grew out of a concern that that the social stigma and potential discrimination would deter people with alcohol and other drug problems from entering treatment. Every patient and former patient must be assured that his or her right to privacy will be protected.

What is the scope of the law?
The Federal alcohol and drug confidentiality regulations restrict the disclosure and use of "patient identifying" information about individuals in alcohol and other drug treatment. Patient-identifying information is defined as information that reveals a person is receiving, has received, or has applied for alcohol and other drug treatment. Applicants are protected, even if they are not admitted to the program. However, someone who does not show up for an appointment arranged for by a third party would not be considered a client.

To whom does the law apply?
The law applies to any type of program that specializes in whole, or in part, in any type of treatment, assessment, referral, or counseling for clients with alcohol and other drug problems. A "prevention" program is not excused from adhering to the confidentiality rule because it is the type of services, rather than the label, that determines whether the program must comply. The law applies to programs that receive any federal assistance including federal funds (such as federal funds that are administered through local counties) or tax-exempt status. The regulations apply to holders, recipients, and seekers of patient-identifying information. An individual or program in possession of such information, may not release it except as authorized by the patient concerned.

What about conflicts with state laws?
State confidentiality law may be more restrictive than but may not override the Federal regulations. Where state law is less restrictive or in conflict with Federal regulations, State law must yield.

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What is the general rule?
The general rule is that a federally-assisted drug or alcohol treatment program may not disclose, directly or indirectly, the identity of its former, current, or would-be patients. For example, programs may not permit an employee to testify about a patient's treatment, allow a receptionist to confirm that a particular person is a patient of the program, or use stationery that suggests that the addressee may be one of its patients.

What are the exceptions to the general rule?
Exceptions to the rule prohibiting disclosure about a client who seeks or receives alcohol and other drug treatment are described briefly below.

Internal Program Communications: Patient-identifying information may be disclosed within a program or to an entity having direct administrative control over a program, if the recipient of the disclosure needs the information to provide substance abuse services to the patient. For example, the staff of a detox unit within a hospital may share information with one another--where such sharing of information is needed to provide the services to the patient. The program may also share information with the hospital's record-keeping or billing departments, since these units are integral to the program's functioning. These individuals must also adhere to the confidentiality regulations regarding redisclosure.

Consent: A program may disclose information about a patient if the patient authorizes it by signing a valid consent form. To be valid, a consent form must specify the following:

- Name of the program or person permitted to make the disclosure,
- Name or title of the individual or organization to receive disclosure,
- Name of patient/client,
- Purpose or need for the disclosure,
- The information to be released (described as exactly as possible),
- Statement that the patient may revoke the consent at any time,
- Date or condition upon which the consent expires, and
- Signature of patient and date signed.

Disclosures That Do Not Reveal Client-Identifying Information
Programs may disclose information about a client if the program reveals no client-identifying information, which identifies the client as a treatment recipient or as having an alcohol or drug problem. A program that provides only alcohol or other drug treatment services cannot disclose under this exception, because stating that a contact is from a treatment program by default would identify a client as a substance abuse treatment client.

Research, Audit, and Evaluation
Programs can disclose client-identifying information for research, audit, or evaluation purposes as long as certain safeguards are met.

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Qualified Service Organization
Programs may disclose information to a person or agency that provides professional services (dosage preparation, lab analyses, medical etc.) that the program does not provide for itself. To become qualified, the service organization must enter into a written agreement with the program in which it acknowledges it is also bound by Federal confidentiality regulations.

Crimes on Program Premises
Programs may release information to the police where a patient commits or threatens to commit a crime on the premises or against program staff.

Medical Emergencies
Information may be disclosed to certain persons in a medical emergency that poses an immediate threat to the health of an individual (need not be the patient) and requires immediate medical intervention.

Mandated Reports of Child Abuse or Neglect
Programs are required to report suspected child abuse, but it must still protect patient records from subsequent disclosures absent patient consent or court order to release the information.

Disclosures Authorized by Court Order
A court may authorize disclosure of "confidential communications" by a patient to the program only if the disclosure is (a) necessary to protect against a threat to life or of serious bodily injury, (b) is necessary to investigate or prosecute an extremely serious crime, (including child abuse), or (c) is in connection with a proceeding in which the patient has already presented evidence concerning confidential communications.

A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information.

Source: Adapted from *Confidentiality of patient records for alcohol and other drug treatment* (Technical Assistance Publication #13; DHHS Publication No SMA 95-3018), US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (1994) and "Protecting clients privacy" in *Substance abuse treatment for persons with child abuse and neglect issues* (Treatment Improvement Protocol #36; DHHS Publication No SMA 00-3357, 2000).

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[FOR USE IN ACTIVITY ONLY – INCOMPLETE RELEASE FORM]

RELEASE OF INFORMATION

I, _____ do hereby grant permission for Genesis House to release information about my substance abuse treatment to the Yolo County Department of Social Services.

_____
Name

_____
Date

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TIPS FOR DEVELOPING AND OBTAINING CONSENT FORMS

Some recommendations for crafting and using consent forms in a way that maximize collaboration are outlined by the Legal Action Center (2003, p. 118-120).

- *Identify all necessary parties*. It may be helpful to be sure that the consent form authorizes communication between all parties who need to communicate about the client and case, providing that the purpose of the disclosure and information to be disclosed are the same. Appropriate parties to list may include the child welfare agency, court, treatment program, client's attorney, and child's attorney.

- *Define the information to be shared.* Confidentiality regulations require that information disclosed through the use of a consent form be limited to information needed to achieve the specific purpose(s) of the disclosure. Consequently, stating "all my records" would not be specific enough.

- *Define appropriate duration of consent.* The regulations do not require that consents be limited to a specific time period, such as 6 months. The consent can, instead, specify a condition upon which the consent should expire such as "upon termination of the child abuse/neglect case against me" (Legal Action Center, p. 119).

- *Obtain consent at the earliest possible point.* Ideally, a consent form should be collected at the earliest point possible, whether that initial contact is with the court, a child welfare worker, or the treatment program. This ensures that communications can occur if, for example, the client makes an appointment for treatment but does not appear. As long as the consent has all of the elements required by federal confidentiality regulations, it does not matter who collects the form.

- *Remember potential limits of consent.* It is important to remember that there are limitations to consent. For example, a client may revoke consent at any time. (This revocation does not cover information that was already shared when the consent was in effect). A client who is not doing well in treatment could revoke consent, although clients are often reluctant to do so because of potential negative consequences. Substance abuse treatment programs and child welfare agencies should ensure that parents understand the consequences of revoking consent and the potential benefits of allowing the consent to remain in place.

As described above, consent forms must specify the purpose and type of information that may be disclosed. Specific ideas for such language are summarized below:

Drabble, L., Osterling, K. L., Tweed, M., & Pearce, C. A. (2008). *Pathways to collaboration: Factors that help and hinder collaboration between substance abuse and child welfare fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

- A *statement of purpose* might authorize communication to "provide the [Child Welfare Agency], [Family Court], [children's attorney (law guardian(s)] and [my attorney] with the information they need to determine whether I have made sufficient progress in my treatment so as to [retain] [regain] custody of my child(ren)" (Legal Action Center, p. 232).

- A consent form may allow the listed parties to

  communicate with and disclose to one another the following information: (Nature and amount of information to be as limited as possible). Initial each category that applies:
  _____ my name and other personal identifying information;
  _____ my status as a patient in [alcohol and/or drug] treatment;
  _____ initial evaluation;
  _____ date of admission;
  _____ assessment results and history;
  _____ summary of treatment plan, progress, and compliance;
  _____ attendance;
  _____ urinalysis results;
  _____ changes in address, household composition, or personal relationships that could result in child neglect/abuse or domestic violence;
  _____ observations of visitation of children;
  _____ discharge plan;
  _____ date of discharge and discharge status; and
  _____ other"

  (Legal Action Center, p. 231-232).

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REFERENCES AND RESOURCES: COLLABORATIVE PRACTICE BETWEEN CHILD WELFARE AND SUBSTANCE ABUSE FIELDS

Compiled by Laurie Drabble, PhD, MSW, MPH

(This information is also used in Activity V-1)

ORGANIZATIONAL RESOURCES

The National Center on Substance Abuse and Child Welfare (NCSACW), an initiative of the Department of Health and Human Services, is jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN). NCSACW provides a comprehensive program of information gathering and dissemination, technical assistance, as well as offers free specialized online training for child welfare professionals, substance abuse treatment professionals, policy makers, and legislators. NCSACW is coordinated by the staff of Children and Family Futures (described below). Contact: www.ncsacw.samhsa.gov

Children and Family Futures (CFF) is a nonprofit organization which brings together several vital areas affecting the future of children and families including: policy research on conditions of children, development of accountability measures at both community and program levels, and effective responses to reducing the impact of alcohol and other drugs on children and families. Contact: Children and Family Futures, (714) 505-3525, www.cffutures.com

Legal Action Center is the only law and policy organization in the United States that fights discrimination against people with histories of addiction, AIDS, and criminal records, and advocates for sound public policies in these areas. Publications include *Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA* as well as other documents and practical resources related to collaborative practice and policy across systems. Contact: The Legal Action Center, (202) 544-5478, 236 Massachusetts Avenue NE, Suite 505, Washington, DC 20002. Contact: www.lac.org

National Clearinghouse on Alcohol and Drug Information (NCADI) is a “one-stop resource” for Federal alcohol, tobacco, and drug information. Free publications available through NCADI include a wide range of practical written publications and videos about the prevention, identification, and treatment of alcohol and other drug problems among

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diverse populations. For a catalog of materials, call 1-800-729-6686 or visit http://ncadi.samhsa.gov

The National Clearinghouse on Child Abuse and Neglect Information provides information on programs, research, legislation, and statistics regarding the safety, permanency, and well being of children and families. The Clearinghouse distributes both print and electronic documents that have been created by the Administration for Children and Families, their grantees, and the Clearinghouse. Contact 1-800-FYI-3366 or visit http://nccanch.acf.hhs.gov/

The California Social Work Education Center (CalSWEC) is a partnership between the schools of social work, public child welfare agencies, and other related professional organizations that facilitates the integration of education and practice to assure effective, culturally competent service delivery to the people of California. Among many activities, CalSWEC offers a wide range of curriculum resources (including content related to working with families impacted by substance abuse and cross-systems collaboration). Contact: CalSWEC (510) 643-9272, http://calswec.berkeley.edu/

RESOURCES FOR ADDITIONAL TRAINING

The National Center for Substance Abuse and Child Welfare offers several online tutorials at no cost for professionals. ***Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals*** provides a primer on alcohol and drug addiction, substance abuse treatment and recovery, enhancing treatment readiness and treatment effectiveness, cross-system communication and collaboration, as well as contact information for other national resources. ***Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals*** is designed to provide comprehensive information regarding child welfare issues for the substance abuse treatment professional. Online trainings are also available for other professionals including judicial officers and legislators. Source: http://www.ncsacw.samhsa.gov/tutorials/index.asp

The Child Welfare-Substance Abuse Connection: A Compendium of Training provides abstracts of training curricula developed between 1993 and 2003 for child welfare and substance abuse workers about addiction, child welfare, interagency collaboration, assessment, service provision, and treatment. Other topics include working with children and adolescents, legal processes, and the implications of substance abuse for foster care and adoption. Each profile identifies the intended audience of the curricula, the year of production, cost information, trainer availability, and technical assistance. The Compendium is an outstanding resource for identifying training curricula that can be used or adapted in local communities. To order the compendium, go to http://nccanch.acf.hhs.gov/ and search under *Clearinghouse Publications*:

Drabble, L., Osterling, K. L., Tweed, M., & Pearce, C. A. (2008). *Pathways to collaboration: Factors that help and hinder collaboration between substance abuse and child welfare fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

REFERENCE MATERIALS

Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Other Drug Treatment with Child Welfare Services (2002) by Young and Gardner offers case studies and tools for successful collaboration between systems. This document is published by the Substance Abuse and Mental Health Services Administration (SAMHSA Publication No. SMA-02-3639). This document can be accessed electronically through www.samhsa.gov or free copies are available from the National Clearinghouse on Alcohol and Drug Information at www.ncadi.samhsa.gov inventory number BKD436 or 1-800-729-6686.

A number of other publications are available at no cost from the National Clearinghouse on Alcohol and Drug Information (described above). These publications are designed to serve as "hands on" resources for line staff, managers, and policymakers in many professional settings. The **Treatment Improvement Protocol (TIP) series** are the products of a systematic and innovative process bringing together clinicians, researchers, program managers, policymakers, and non-Federal experts to reach a consensus on various state-of-the-art treatment practices. Publications related to children and families include:

- ***TIP 39*** Substance Abuse Treatment and Family Therapy
- ***TIP 36*** Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues
- ***TIP 32*** Treatment of Adolescents With Substance Use Disorders
- ***TIP 31*** Screening and Assessing Adolescents With Substance Use Disorders
- ***TIP 25*** Substance Abuse Treatment and Domestic Violence
- **TIP 24** A Guide to Substance Abuse Services for Primary Care Clinicians
- ***TIP 5*** Improving Treatment for Drug-Exposed Infants
- ***TIP 4*** Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents (Revised--see also TIP 32)
- ***TIP 3*** Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents
- ***TIP 2*** Pregnant, Substance-Using Women

Other documents of interest are available in the Technical Assistant Publication (TAP) series, including a document on **Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy** (TAP# 24; Availability: http://www.treatment.org/Taps/Tap24.pdf). Free from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686, http://ncadi.samhsa.gov

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ACTIVITY V-2
QUESTIONS FOR IDENTIFICATION OF NEXT STEPS IN PRACTICE OR WORK SETTING

- As you reflect on highlights about some of the factors that help and hinder collaboration, what areas stand out to you and why?

- What specific information or ideas might be relevant to *your own* social work practice? What next steps would be useful to you as a practitioner? (These might include action steps with clients, colleagues, obtaining additional training, or written resources, etc.)

- What practices related to communication or other "promising practices" in cross-systems collaboration might be adopted or adapted in your county system? What are the next steps you would recommend to your county administrators and staff?

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