CHAPTER 7

Child Protective Services and Substance Use Disorder Treatment Providers: Similarities and Differences

In This Chapter

- Areas of similarity
- Areas of difference

Just as there often is an overlap between the clients who child protective services (CPS) and substance use disorder (SUD) treatment agencies serve, there also is common ground in the structures and the principles that guide these two systems. CPS caseworkers and SUD treatment providers should understand the similarities and the differences between the two systems so that they can offer the most comprehensive services possible to children and families. This chapter traces the areas of similarity and difference between the CPS and SUD treatment systems.

Areas of Similarity

There are many areas in which CPS and SUD treatment agencies overlap, including programmatic goals, the characteristics of the families served, management challenges, and new demands regarding outcomes.

Shared Goals

Though their primary emphases may differ, both CPS and SUD treatment agencies want family members to stop abusing substances and want children to be safe. In addition, they serve many families in common, even though they may be working with different family members. Professionals in each field should recognize that involving and providing appropriate services to the entire family is the most effective way of addressing the family's issues.

Since both systems have common goals, they also should share the responsibility for achieving them. CPS caseworkers need to know whether parents are sufficiently recovered from SUDs before recommending that their children live at home, but CPS caseworkers cannot treat SUDs. SUD treatment providers know that children provide an important incentive for parents to enter and remain in treatment, but SUD treatment providers cannot make decisions regarding where children will live. When each agency only emphasizes its own particular objective, it is unlikely that either will succeed. When both focus on the broader goals of helping the entire family, despite pressures and forces that make that focus difficult, the odds are better that the agencies and the families will succeed.

Shared Characteristics of Families Served

As discussed earlier, individuals with SUDs and parents who maltreat their children often have many other problems (e.g., mental illness, health issues, histories of domestic violence, poverty). They require services that are beyond the scope of either CPS or SUD treatment agencies. Many of these problems overlap, so both CPS and SUD treatment agencies find themselves trying to address problems, such as a serious mental disorder, criminal records, HIV/AIDS, and limited job skills. Too often, each agency tries to tackle these varied problems on its own, overlooking opportunities to share this enormous responsibility with others.

Shared Management and Operational Challenges

CPS and SUD treatment program administrators and staff often face similar challenges in managing their agencies and operating their programs. These challenges may be external, such as locating services that families need, coordinating with agencies that provide those services, navigating complex bureaucracies, and responding to political opinions or media coverage that portray families as unworthy of support. Other challenges are internal, such as difficulties in hiring and training staff, high staff turnover and burnout, low pay, and outdated computer record-keeping systems.

To the extent that administrators and staff can design strategies that build on their common management challenges, they may ease some of these burdens. For example, both CPS and SUD treatment managers spend time locating and coordinating services, such as housing or mental health counseling, frequently for the same families. Time could be saved, and possibly outcomes improved, if managers collaborated in securing these services. In addition, managers could design joint training programs for staff from both agencies and seek continuing education units for staff who participate.

Shared Pressures to Attain Measurable Outcomes

Federal legislation requires both CPS and SUD treatment agencies to achieve measurable results, such as employment for adults and permanency decisions for children. Therefore, managers from both systems are required to design and to monitor their programs to attain those results. This means that managers in both systems have to:

- Establish clear goals for staff
- Create internal monitoring and progress review systems
- Identify problems early and resolve them quickly.

CPS and SUD treatment program managers can share ideas for establishing processes that lead to measurable results. They also can collaborate in designing monitoring and tracking systems in a way that provides useful information between their agencies as well as within them.

Areas of Difference

Notwithstanding these similarities, CPS and SUD treatment agencies may become confused or frustrated when trying to work together, even when they share overarching goals. The two systems differ in some fundamental ways, including how families enter programs, the choices available to families while they are participating, and the consequences for families if they cannot meet the standards required for completion. These different contexts lead to different experiences for families involved with each system. Likewise, staff in each system face disparate experiences and challenges.

Parents can be angry or frightened when CPS caseworkers come to their homes and question their children and neighbors, especially when caseworkers

determine that their children have to be removed. When families come to the attention of CPS agencies, they often become involved with the courts, SUD treatment agencies, and other service providers. If they refuse to comply with the requirements established by these agencies, or if they cannot make adequate progress, they know they risk losing their children permanently.

In contrast, people generally enter SUD treatment voluntarily when they decide they are ready, and they leave when they want, even if they still are using substances. At times, however, courts order treatment as a condition of probation or parole. Coercive treatment has increased over the past several years, in part due to the increase in the use of drug courts, which are special courts designed for arrestees who have SUDs.

CPS and SUD treatment agencies also differ in the following ways:

- The primary focus of CPS is on the safety and well-being of children, and the primary focus of SUD treatment is on adult recovery. Staff of the two systems may see themselves as serving different clients, even if the clients are from the same family.
- The two systems operate under different laws and regulations.
- Funding for the two systems comes from different sources and with different conditions, even while often serving the same family.
- CPS caseworkers and SUD treatment providers may have different training, professional backgrounds and credentials, and disciplines. They also commonly use different terms and have different definitions of certain terms. For example, CPS caseworkers usually do not differentiate between substance use, abuse, or addiction. Caseworkers generally only want to know if the substance use affects an individual's ability to parent.
- Data collection requirements, computer systems, and management reporting requirements are often inconsistent or incompatible between the two systems.

Both systems operate within strict confidentiality guidelines and staff can be uncomfortable sharing information with each other, which can cause frustration. (See Chapter 8, *Putting It Together: Making the Systems Work for Families*, for a more detailed discussion of confidentiality issues.)

CHAPTER 8

Putting It Together: Making the Systems Work for Families

In This Chapter

- Principles to guide collaboration
- Collaboration at all levels
- Techniques for promoting collaboration
- Confidentiality and information sharing

While many child protective services (CPS) and substance use disorder (SUD) treatment agencies find collaboration challenging, it is crucial to achieving positive outcomes for families involved with both systems. This chapter presents principles to guide CPS agencies in forming collaborative relationships with SUD treatment and other agencies. It proposes techniques to improve collaboration at both the policy and the frontline levels. This chapter also discusses confidentiality issues, which often determine what types of information can be shared during the collaborative process.

Setting the Stage: Principles to Guide Collaboration

As discussed earlier, CPS and SUD treatment agencies often have different structures, funding streams, and definitions of success. These differences affect collaboration at the Federal level as well as at the administrative and frontline levels in States and counties.

Families whose members have SUDs and who are involved with the child welfare system have multiple and complex needs as well as strengths. Their needs often span many social service disciplines. No single person, agency, or profession has the capacity to address all of their circumstances. Collaboration builds on the individual strengths of each agency and family member, forging shared approaches that are more effective than an individual response.

Collaboration is grounded in interdependent relationships and is more important when the problems are complex, the needs are varied, and the systems are different. In order to be effective, collaborative relationships should include the following:

- **Trust** that enables individuals to share information, to speak honestly with each other, and to respect other points of view
- **Shared values** that are honored by all participants
- **A focus on common goals** in spite of the fact that participants come from agencies that have different missions, philosophies, or perceptions
- **A common language** that all participants can understand and that is not unnecessarily technical or filled with acronyms

- **Respect** for the knowledge and experience that each participant and each profession brings to the relationship, which includes recognizing the strengths, needs, and limitations of all participants
- **A collective commitment** to working through conflict that encourages participation by all group members
- **A desire to share decision-making, risk taking, and accountability** that supports group members in participating in important decisions and assuming responsibility for the outcome of group decisions.[126]

One of the biggest challenges facing both CPS caseworkers and SUD treatment providers is securing services from other social service agencies with whom relationships may not exist. For example, families involved with either CPS or SUD treatment agencies most likely will need some combination of the following services: mental health, domestic violence, income support, housing, transportation, health care, child care, and early childhood education. While collaboration with all these service providers is important, the need for mental health, domestic violence, and income support services among families receiving child welfare services and affected by substance abuse is especially critical and warrants special attention.

CPS, SUDs, and Court Involvement

The court system is a key partner of both the child welfare and the SUD treatment systems. The courts ultimately decide if a child should be removed from or returned to a home. Therefore, judges and other court staff should have a general knowledge of SUDs and child welfare issues and how those issues are relevant to each case. This requires cross-training as well as ongoing communication and collaboration among the three systems. Along with making decisions to remove from or to return a child to the home, courts also may be involved with these same families through the criminal justice system or the drug courts.

If families also are involved in the criminal justice system, caseworkers may want their case plans to require the completion of all conditions of probation or parole in order for the parents to care for their children. However, the criminal justice system and the juvenile court system may have very different goals with respect to parental SUDs, with one focusing on the prevention of further criminal behavior (an emphasis on public safety) and the other focusing on the welfare of the children in the family.

Many States and communities are utilizing drug courts, which serve as an alternative to a strictly punitive, non-treatment oriented approach. Drug courts integrate public health and public safety and make treatment a priority.[127] They use ongoing, active involvement by judges to provide structure and support, and they hold both families and agencies, such as CPS, accountable for the commitments they make. Drug courts steer individuals with SUDs who commit nonviolent crimes, such as larceny or drug dealing, to treatment instead of jail; follow sentencing guidelines that set standards to ensure equity for jail time based on the crime; and utilize community partnership programs that encourage police, probation and parole officers, treatment providers, and citizens to work together to create healthy and safe environments that benefit everyone. Additionally, drug courts:

- Assess the substance user's needs
- Create an effective, mandated treatment plan
- Provide the necessary follow-up to assist with the treatment process.

Accountability for the participant attending treatment rests with the drug court. In one study, more than two-thirds of participants mandated by drug courts to attend treatment completed it, which is a completion rate six times greater than most previous efforts.[128]

Drug courts are becoming an increasingly popular alternative for responding to methamphetamine use. The ability to respond quickly and consistently to violations of the treatment plan, coupled with the accountability measures and the ever-present threat of going to jail due to a violation, make drug courts one of the most effective mechanisms for dealing with methamphetamine use.[129] For additional information on drug courts and methamphetamine use, visit **http://www.ojp.usdoj.gov/BJA/pdf/MethDrugCourts.pdf**.

Family Treatment Drug Courts (FTDCs) are specialized drug courts designed to work with parents with SUDs who are involved in the child welfare system. A national evaluation found that FTDCs were more successful than traditional child welfare case processing in helping substance-abusing parents enter and complete treatment and reunite with their children.[130]

For more information on drug courts in general, refer to the National Drug Court Institute/National Association of Drug Court Professionals website at **http://www.ndci.org** and the Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project publication, *Juvenile and Family Drug Courts: An Overview*, available at **http://www.ncjrs.org/html/bja/jfdcoview/welcome.html**.

For more information on the courts and CPS, refer to the *User Manual Series* publication, *Working with the Courts in Child Protection*, at **http://www.childwelfare.gov/pubs/usermanuals/courts/**.

In many States, CPS and social welfare are housed within one umbrella social services agency. While this configuration does not guarantee that collaboration will occur, it eliminates some of the structural problems often encountered when agencies do not share a common organizational context.

Collaboration at All Levels

Collaboration among agency officials at the highest levels is a necessary, but not always sufficient, condition for collaboration on the frontline. Suggestions for fostering collaboration are discussed below.

Collaboration at the State Level

There are several steps that State CPS and other officials can take to promote collaboration among their agencies:

- **Establish ongoing interagency task forces and authorize members to make decisions**. The task forces should be charged with addressing issues that make it difficult for staff to coordinate services. Topics might include designing integrated screening or assessment instruments, developing mechanisms to track participants across different agencies, or proposing methods for staff to share information under the rules of confidentiality.
- **Create joint mission statements** with SUD treatment and other agencies and promote the mission statement through notices, memos, or policy directives that are signed by officials from each agency.
- **Prepare integrated funding requests** to support integrated programming activities. Develop and execute shared advocacy strategies for securing those funds.

- **Require cross-training of staff** and schedule staff from other systems to deliver that training. Hold these training sessions at other agencies.

- **Co-locate staff** in each other's agency.

- **Create interagency agreements** such as Memorandums of Understanding (MOUs). For more information about MOUs, see Appendix H, *Memorandums of Understanding*.

Collaboration on the Frontline

There are several steps that frontline staff and supervisors can take to promote collaboration among their agencies:

- **Visit each other's programs**, talk to program participants, and meet each other's staff. CPS caseworkers should visit SUD treatment programs, observe activities, and hear from families who are in recovery. Similarly, SUD treatment professionals should visit CPS offices and accompany caseworkers on some home or field visits.

- **Convene multidisciplinary case staffings**, some of which should include family members. During these meetings, caseworkers and families should develop shared plans for services, allocate tasks, and discuss ways they can share responsibility for activities and outcomes.

- **Discuss differences** in a way that helps everyone understand each other's point of view, the rules, each one's limitations, and the scope of authority.

Techniques for Promoting Collaboration

Collaboration is not likely to occur unless staff from participating agencies have opportunities to understand their partners and to work together to solve shared problems. SUDs and child maltreatment are complicated issues; staff who work in one field generally know little about the other field. In addition, both SUDs and maltreatment are clouded by sensational media stories, shame, and stigma, making it especially important that frontline practitioners have access to accurate information. Information sharing, professional development and training, and co-location are examples of techniques that can promote collaboration.

Information Sharing

The easiest way for CPS caseworkers and SUD treatment providers to collaborate is to share information. Information sharing between colleagues can range from general information about each system (e.g., agency protocols) to case-specific information (e.g., a permanency plan or strategy for handling a parent's possible relapse). CPS caseworkers should be knowledgeable, however, of any confidentiality laws that restrict what information they are allowed to share. Confidentiality issues are discussed later in this chapter.

Professional Development and Cross-training

Professional development provides structured learning experiences that go beyond teaching about new rules or forms. Professional development allows caseworkers to understand their discipline better, to advance their careers, and to feel part of an important human services system. Cross-training means teaching workers from one field, such as CPS, about the fundamental concepts and practices of another field, such as SUD treatment.

CPS agencies can design professional development and cross-training programs in ways that mirror the interagency relationships they want to develop—relationships in which individuals are encouraged to explore and to discuss values, ideas, and policies.

Co-location

Some CPS agencies have SUD treatment providers on site. Co-location demonstrates that agency officials consider cooperation and collaboration to be agency.

Online Tutorials for Knowledge-building and Cross-systems Work

The National Center on Substance Abuse and Child Welfare, an initiative of the Administration for Children and Families and the Substance Abuse and Mental Health Services Administration, has developed four free online self-tutorials to build knowledge about SUDs and child welfare and to support and facilitate cross-systems work. The tutorials are each intended for a specific audience: child welfare professionals, substance abuse treatment professionals, judicial officers and attorneys in the dependency system, and legislators. A certificate for claiming Continuing Education Units is available upon successful completion of each tutorial. The tutorials are available at **http://www.ncsacw.samhsa.gov/tutorials/index.asp**.

For more information on training resources, visit **http://www.childwelfare.gov/systemwide/training/**.

priorities and integral elements of agency culture. If senior officials decide to co-locate staff, they are more likely to realize that collaboration is an expected method of conducting business, not merely an agency buzzword.

Co-location can be highly effective in helping CPS caseworkers and SUD treatment providers develop relationships that are essential to delivering comprehensive and well-organized services. It can change what are often a series of sequential referrals into concurrent discussions (case staffings) that bring greater expertise to case planning. Caseworker stress and burnout can be reduced if several people participate in making difficult and sensitive decisions regarding child placement. Co-location also may make it easier for family members to participate in designing their service plan, to comply with requirements that come from both treatment and CPS agencies, and to understand the roles that different caseworkers perform in helping them succeed.

Co-location, however, is not a perfect solution. It does not automatically create relationships or guarantee collaboration. Co-location can introduce management challenges related to supervision, space, pay differences, performance requirements, or work expectations. Furthermore, it can be administratively complex and, at times, programmatically inappropriate when too many people are involved with one family. When this happens, families may feel overburdened, they may worry that their confidences have been violated, or they may think that decisions are being made without their involvement.

Confidentiality and Information Sharing

As CPS and SUD treatment agencies work more closely, they are faced with deciding how and when to share information about families. Both agencies recognize the importance of allowing families to have privacy to discuss and to address such difficult, sensitive problems as SUDs and child maltreatment. Both also must adhere to a variety of laws and regulations that govern disclosure of information and protect family privacy.

At times, staff within each agency may feel that laws regarding confidentiality make it difficult to share or to receive information, and confidentiality rules may be put forth as a reason for their inability to communicate. For example, a CPS caseworker may become frustrated if an SUD treatment provider cannot share information regarding a parent's progress in treatment; the caseworker may feel that this information might inform child custody decisions. On the other hand, an SUD treatment provider may become frustrated when decisions regarding a child's placement are made without a CPS caseworker discussing how it may affect the parent's progress in treatment. However, a study of seven innovative

CPS agencies and SUD treatment programs noted that while Federal and some State laws are obstacles to information exchange, these laws did not create insurmountable barriers to collaboration.[131] This section discusses confidentiality laws and ways to share information appropriately.

Confidentiality Laws

Laws addressing various aspects of confidentiality involving professional relationships, communications, and situations vary. These laws may focus on:

- SUD treatment privacy requirements
- Mandated reporting of child abuse and neglect
- Privacy of CPS records
- Client-therapist confidentiality statutes
- Research programs and data collection on human subjects.[132]

SUD treatment confidentiality laws are based on the view that individuals with SUDs are more likely to seek treatment if they know that information about them will not be disclosed unnecessarily to others. Without the assurance of privacy, the fear of public disclosure of their problem possibly could prevent some individuals from obtaining needed treatment.

At times, however, there are important reasons for agencies to share information when working with the same families. Federal SUD treatment regulations specify circumstances under which it is appropriate that information be shared, including if the information relates to reports of child abuse or neglect. See Appendix I, *Confidentiality and the Release of Substance Use Disorder Treatment Information*, for a list of circumstances in which patient record information can be released. Additionally, the Child Abuse Prevention and Treatment Act of 1974 (P.L. 93–247) requires that States allow for the public disclosure of information regarding a death, or near death, of a child when it is the result of maltreatment.

SUD treatment providers are subject to mandatory child abuse reporting laws in their States, requiring treatment staff to report incidents of suspected child abuse and neglect. However, this exemption from standard confidentiality requirements applies only to initial reports of child abuse or neglect. It does not apply to requests or even subpoenas for additional information or records, even if the records are sought for use in civil or criminal investigations. Thus, patient files and patient-identifying information protected by the Federal confidentiality law still must be withheld from CPS agencies and the court unless there is some other authorization such as patient consent, an appropriate court order, or in some cases, a Qualified Service Organization Agreement (QSOA). Consent forms and QSOAs are discussed later in this chapter.

Key considerations related to the types of information that can be shared between CPS caseworkers and SUD treatment providers include:

- **CPS case information**. Factors surrounding the case, any previous case history, the family environment, and other factors that are informative to the SUD treatment provider in conducting the assessment and in developing the treatment plan. CPS caseworkers must obtain appropriate consent to share this information.

Subpoenas

A subpoena to testify in court is not sufficient to require the release of confidential information, as specified under Federal regulations related to confidentiality, nor is a police search warrant. If subpoenaed to court to testify, an SUD treatment provider should first refuse, citing Federal regulations related to confidentiality. Only with a judge's subsequent court order that finds a just cause to ignore this law in this particular case may a counselor testify without a client's written consent.

- **SUD screening information**. Federal law and regulations allow CPS caseworkers to share with SUD treatment personnel information gathered during a screening for the purpose of referring an individual for an assessment.

- **SUD diagnosis and treatment information**. An SUD treatment agency may not disclose this information without written consent or court order. This is true even if the CPS agency referred the family member to the treatment program and mandated the assessment. For an example of a consent form, see Appendix J, *Sample Qualified Service Organization Agreement and Consent Form*.

- **Attendance in treatment programs**. SUD treatment programs may report a family member's attendance at treatment, or their failure to attend, as long as the patient has signed a written consent that has not expired or been revoked. Attendance is often a key component of the family's case plan.

- **A treatment participant's relapse**. SUD treatment programs may report information about relapse to CPS caseworkers if that information is covered by a valid written consent signed by the patient. However, for many CPS agencies, the key information may be whether the family member is making satisfactory progress in treatment, even if relapse has occurred.

- **Combined case plan**. Most of the discussion between SUD treatment providers and CPS caseworkers will be permissible as long as the information discussed is covered by a valid written consent form. It is advisable to tell family members that their case will be discussed at periodic meetings or telephone calls and specifically who will participate in the discussions.

If CPS caseworkers release the results of a substance abuse evaluation or any information regarding a client's treatment, they violate Federal regulations related to confidentiality. Everyone, not just SUD treatment providers, is bound by Federal confidentiality statutes, and CPS caseworkers can be prosecuted for violating these laws. Caseworkers should clarify with their supervisor or their agency's attorney any questions they may have about this statute and should document any legal advice given that pertains to this statute.

Ways to Share Information Appropriately

In order for the CPS caseworker and SUD treatment provider to communicate, it is important to obtain the client's consent early, preferably at the time of the referral to treatment. Clients involved with CPS agencies may consent voluntarily to information disclosures in order to aid investigations of child maltreatment because their refusal to cooperate may result in losing custody of their children. However, information that has been disclosed through consent may not be used in criminal investigations or to prosecute the person. A consent form is only valid until the date, event, or condition on which it expires, or at any time when the treatment participant or client revokes consent. Therefore, it is a good idea to set the expiration date far enough into the future to ensure that needed information can be retrieved by the other agency. It is permissible to have the consent form contain an end date that fits circumstances.[133] (See Appendix I, *Confidentiality and the Release of Substance Use Disorder Treatment Information*, for details about what should be included in a voluntary consent form.)

Another way that information can be shared between systems is through a QSOA. SUD treatment providers may disclose information under a QSOA without the patient's consent. A QSOA is an agreement between two service organizations to share information about and to protect the confidentiality of individuals they serve. A QSOA should not be confused with an MOU, which usually is an agreement between two or more organizations to provide services to a common set of clients.

A qualified service organization is one that provides services to the SUD treatment program. CPS agencies meet this definition if they provide services

that help the SUD treatment agency serve the client. The heads of both the SUD treatment agency and the CPS agency must sign this agreement. Once signed, QSOAs permit disclosure of information to enable the organization to provide a service to the alcohol and drug abuse treatment program. QSOAs cannot be used for other purposes, such as obtaining reimbursement. Information obtained as part of a QSOA may not be re-disclosed to any other agency without permission.[134] See Appendix J, *Sample Qualified Service Organization Agreement and Consent Form*, for a sample QSOA form.

Confidentiality is an important part of communication. The parameters and limitations of communication have to be established locally. Furthermore, administrative procedures need to be put in place to encourage communication among staff. When approached with care, confidentiality rules do not automatically limit communication. Rather, they set the context within which staff can share important information, and families can be assured that sensitive aspects of their lives will be protected.

It is important to note, however, that regardless of privacy rules and confidentiality of information under Federal laws, mandatory reporters of child abuse and neglect are required to report suspected cases of child maltreatment, according to an Information Memorandum issued by the U.S. Department of Health and Human Services in September 2005. The memorandum "to affirm the obligation of mandatory reporters to report child abuse and neglect under State and Federal laws" refers specifically to exceptions to the confidentiality and privacy rules in the Health Insurance Portability and Accountability Act (HIPAA), the Public Health Service Act Title X family planning program, and the confidentiality rules relating to patient records in federally funded alcohol and drug abuse treatment services.[135]

Federal Guidelines Regarding Confidentiality

The following are examples of Federal guidelines for patient confidentiality in cases involving SUDs or child maltreatment:

- **The Code of Federal Regulation, Alcohol and Drug Abuse Treatment Confidentiality**, **42 C.F.R., Part II**, provides guidelines for maintaining patient confidentiality, including rules for information sharing, for SUD treatment agencies. They can be viewed at **http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr2_03.html**.
- **The Child Abuse and Neglect Prevention and Treatment Act (CAPTA), 45 C.F.R. 1340.14**, requires States to have guidelines for maintaining confidentiality of child abuse and neglect reports. It can be viewed at **http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr1340_03.html**.
- **HIPAA of 1996 (P.L. 104–191)** provides standards for health plans, health care providers, and health care clearinghouses to ensure the security and privacy of health information, including access to records. HIPAA also upholds mandatory child abuse reporting laws. For more information on HIPAA and its relationship to SUD treatment, visit the Substance Abuse and Mental Health Services Administration website at **http://www.hipaa.samhsa.gov/hipaa.html**.

For more information on child maltreatment legal issues and laws, visit **http://www.childwelfare.gov/systemwide/laws_policies/**.

Conclusion

For staff in any agency, it is easy to lose sight of the other systems and agencies that share a common client base. Families that experience SUDs and child maltreatment have needs, problems, and strengths that are diverse and complex. As a result, they often require the services of multiple agencies. It is critical that CPS caseworkers and SUD treatment providers have an understanding of the other system as well as the skills and desire to work toward a common goal. It is equally important that families are consulted in order to make certain that the collaborative structure helps them to address their SUDs and to ensure the safety and well-being of their children. With all of the parties committed to working jointly toward the same goals and being open to innovative approaches, successful outcomes can be achieved.