

SCREENING AND ASSESSMENT FOR FAMILY ENGAGEMENT, RETENTION, AND RECOVERY (SAFERR)



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SECTION II: COLLABORATIVE ROLES AND RESPONSIBILITIES

Section I of this guidebook establishes the importance of collaboration and presents a structure within which collaboration among child welfare, alcohol and drug, and court systems can take place. It is beyond the scope of this guidebook to address other systems such as mental health and welfare that serve the same families, but SAFERR's premises and processes should also be useful in collaborating with those systems.

The current section identifies and discusses individual and shared responsibilities of people working in the child welfare, alcohol and drug, and court systems. It begins with a summary of essential roles within each system and concludes with a description of cross-system roles.

2.1 Responsibilities of the Child Welfare Service System

Child welfare officials have a responsibility to ensure that their employees and employees of contract agencies have adequate and accurate knowledge about the alcohol and drug service and the court systems. Specific responsibilities along these lines include:

- **Ensuring that personnel with decisionmaking roles involving families understand the fundamentals of substance use disorders, the implications of those disorders on child safety and well-being, and the potential for effective treatment.**

Although there is general consensus among child welfare staff that substance use can contribute to child maltreatment, many do not understand substance use, treatment and recovery, and how use and recovery are related to child safety and well-being. These relationships are often complex. Although a substance use disorder can have a causative relationship to child maltreatment, it also is possible that the underlying causes of child maltreatment are not related to substance use disorders. In the latter situations, treating parental substance use disorders may not resolve child maltreatment problems. In other situations, especially when maltreatment involves child neglect rather than abuse, successfully treating parental substance use disorders is more likely to resolve the parent's neglectful behavior.

It should be required that child welfare training curricula include attention to fundamentals of substance use disorders, treatment engagement, treatment services, recovery, and the impact of disorders, treatment, and recovery on child safety and well-being. Appendix A provides fact sheets that address the impact of parental substance use disorders on children's development and well-being.

At a minimum, child welfare staff should understand—

- How and why people develop substance use disorders;
- Types of substance use disorders;
- How addiction affects a person's ability to function (particularly as a parent);
- How people are screened and assessed for substance use disorders;
- Types of treatment available to families;
- The role of relapse in the recovery process; and
- How treatment improves family stability, employment, and other outcomes.

Child welfare staff also require training to give them the skills to screen families for potential substance use disorders, including skills needed to interact with families in ways that encourage them to disclose and address their substance use disorders. Training may be enhanced if child welfare staff visit a substance abuse treatment program and hear stories of families who have recovered from addiction, including parents involved with the child welfare system.

Finally, child welfare workers need opportunities that allow them to explore their attitudes and values about addiction. Few people in our society are immune from the effects of substance use disorders, and staff experiences with these disorders affect how they address those disorders with families. Therefore, staff need training that helps them recognize how their personal beliefs and attitudes may affect how they relate to families.

Resources and training curricula are available to assist the Steering Committee in creating training standards and expectations and to assist local jurisdictions in delivering training to staff. For example, *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers* can be used to train child welfare workers in (1) recognizing the relationship between substance use disorders and child welfare; (2) understanding addiction and how to support families during the treatment and recovery process; (3) enhancing collaboration with substance abuse treatment partners; and, (4) improving outcomes for children of parents with substance use disorders. This guide is available online at www.ncsacw.samhsa.gov.

- **Ensuring that children from families with substance use disorders receive developmentally appropriate services that address the effects of substance use disorders on their lives.**

Children whose parents have substance use disorders and who come in contact with the child welfare system often lack the environment, support, and structure required to move through childhood in appropriate developmental stages. Child welfare staff should ensure that these children are assessed to determine whether they are functioning at the stage of development appropriate for their chronological age. Knowing the developmental skills that are expected for each chronological age will help staff determine whether or not children are exhibiting deficits or delays and should be referred for further assessment or intervention. Attending to developmental stages is important because behavior that is appropriate at one stage may be considered maladaptive at another developmental stage. Good resources that succinctly present characteristics of children across developmental stages are available online and can be found at www.childdevelopmentinfo.com/development/normaldevelopment.shtml.

After children are assessed, child welfare staff should assure that they receive developmentally appropriate services that allow them to grow and mature, and they should share information about children with alcohol and drug treatment staff working with parents. Appendix C provides information about prenatal and postnatal substance exposure and the consequences of exposure to both, issues related to substance use among youth, and a description of resources for children who have been identified as affected by parental substance use disorders.

- **Ensuring that there are protocols for screening family members for possible substance use disorders, and that results of screens are entered into case files and shared with alcohol and drug and court staff, if relevant.**

Many, if not most, children under the jurisdiction of child welfare agencies and the courts come from families with substance use disorders. The *SAFERR model* therefore holds that child welfare staff should screen for substance use disorders as a routine procedure. Screening for substance use disorders

determines the likelihood that a problem exists (or, the presence of a problem) and is most often conducted in places outside of the alcohol and drug service system: places such as criminal justice agencies, mental health agencies, maternal and child health care providers, hospitals, or child welfare agencies.

There are many screening tools for substance use disorders. Because child welfare workers often have large and complex caseloads, screening tools should be brief, easy to learn, and able to be administered as part of an interview or imbedded in a standard questionnaire. At the same time, screening tools should be sufficient to achieve a reasonable balance between sensitivity (ability to detect problems when they do exist) and specificity (ability to rule out problems when they do not exist). Decisions regarding which tool to use must be made in conjunction with and supported by the alcohol and drug treatment system and others who conduct screenings for substance use disorders. A Subcommittee of the Steering Committee, comprising representatives from relevant systems, can be charged with recommending screening tools. Because the results of screenings conducted by child welfare staff become the baseline used by alcohol and drug services staff, information derived from screenings should meet the needs of staff and should be consistent with information provided by other systems.

Section III of this guidebook presents detailed information about substance abuse screening and assessment tools and strategies, and Appendix D, “Alcohol and Other Drug (AOD) Preliminary Assessment,” provides information about several screening tools that include only six to eight questions and are sufficient to meet the needs of child welfare staff. Regardless of which tool is selected, however, as noted in the Introduction, the premise of SAFERR is that collaboration and communication—not the tool—will ultimately make the difference in whether staff can meet the needs of children and families.

Screenings may be able to detect whether substance use disorders are a factor in the overall family situation, but they do not provide information on which to make decisions about the nature and extent of substance use disorders. These decisions require complete information derived from in-depth assessments conducted by trained and qualified personnel.

Activities regarding screenings for substance use disorders and referrals for assessments should be documented in child welfare case records and made available for monitoring purposes, reviews for court hearings if appropriate, and use by alcohol and drug services staff if requested. These records are particularly important given the frequent turnover of staff in many local child welfare agencies.

Although it is generally not feasible for alcohol and drug treatment staff to screen all families involved with child welfare, some jurisdictions have co-located substance abuse counselors at child welfare offices to help in specific situations, provide consultation, and conduct comprehensive substance abuse assessments. Colocation is described more thoroughly at the end of this section, and exploring colocation may be a task charged to either the Steering Committee or one of its Subcommittees.

- **Ensuring that families have the opportunity to be successful in treatment by—**
 - Understanding treatment plan requirements, schedules, and activities;
 - Communicating with alcohol and drug treatment staff to coordinate schedules so that families do not have conflicting demands that force them to choose between meeting their child welfare case plan and their substance abuse treatment plan goals and expectations;
 - Ensuring that the array of child welfare services provided to families support the goals of treatment; and

- Sharing information with alcohol and drug treatment staff regarding how children are doing, how parent and child visits are working out, and how parents are progressing in developing parenting capacities.
- **Ensuring that all personnel working with children and families or making decisions regarding families understand how their local alcohol and drug service system works and the nature of local assessment and treatment services.**

It is not reasonable or appropriate to expect child welfare staff to have the skills to conduct the in-depth substance use diagnoses and assessments that follow screenings. These diagnoses and assessments must be conducted by substance abuse clinicians with relevant training and expertise. The key purpose of the diagnostic and assessment process is to determine whether treatment is needed, and if it is, to identify the level of treatment and types of services necessary to maximize the potential for recovery.

Child welfare staff should know the following about their local alcohol and drug service systems:

- What are the procedures for making referrals for assessments regarding the nature and extent of substance use? Who has to “sign off” on referrals? Who pays for assessments? Where are substance use disorder assessments conducted and how accessible are these locations to families?
- What assessment instruments are used? How long do assessments take? Are they always the same, and if not, why are different ones used?
- Is there a waiting list for an assessment, and if so, how long is it?
- What do the “results” look like? What releases of information are necessary to receive results? How long does it take to receive them? How are the results used to decide what type of treatment, particularly residential treatment, is needed?
- What treatment resources are available in the community? Are there waiting lists, and if so, how long are they and for what type of treatment? Are there interim programs for parents while they wait for an opening in a treatment facility?
- What are the implications of substance use disorder assessments and type of treatment selected for child welfare planning?

To ensure that child welfare staff have this level of knowledge, the Steering Committee should establish guidelines to ensure that the information is understood by managers throughout the child welfare system and that basic information about local alcohol and drug service systems is incorporated into training for child welfare staff. If training is provided by staff from the local alcohol and drug service system, its structure and format can be incorporated into collaborative agreements established by child welfare, alcohol and drug, and court systems.

- **Ensuring that staff understand the substance use disorder treatment process and its relationship to ASFA requirements and timeframes.**

Treating substance use disorders involves ongoing management of a lifelong disease such as diabetes or high blood pressure, as opposed to short-term interventions for acute crises such as broken arms. Recovery from substance use disorders is not a straight line from use to sobriety, but it involves periods in which people may return to use and then stop again. Appendix E, “Substance Use, Abuse,

Dependence Continuum, and Principles of Effective Treatment,” provides information about substance use disorders and summarizes substance abuse treatment principles developed by the Federal Government.

Understanding the substance use disorder treatment process is essential in case planning and decisionmaking regarding permanency for children in foster care, particularly decisions pertaining to reunification, termination of parental rights, and continuing and aftercare services when children have been reunified with their families. Staff from the alcohol and drug service system frequently voice concerns that the timeframes for reunification and termination of parental rights are not consistent with the substance use disorder treatment and recovery process.

ASFA requires States to file a petition for termination of parental rights for children who have been in foster care for 15 of the most recent 22 months, unless any of the following conditions are met:

- At the option of the State, the child is under the care of a relative;
- A State agency has documented in the case plan a compelling reason for determining that filing such a petition would not be in the best interests of the child; or
- The State has not provided to the family, consistent with the time in the State case plan, such services as the State deems necessary for the safe return of the child to the child’s home.

Because child welfare staff must make decisions that conform to ASFA rules, it is urgent that they screen, assess, and engage families in treatment at the earliest possible moment. The process of recovery from substance use disorders can easily take more time than ASFA rules permit, so it is imperative that families be given the best opportunity and the longest possible time to make satisfactory progress.

- **Ensuring that staff understand the State or District Family Court System, including the roles of judges or magistrates, mediators, CASAs, and attorneys.**

Although many court decisions are driven by the requirements of ASFA, there are other legal protocols and procedures that child welfare staff must understand and follow. It is not uncommon for child welfare cases to involve three attorneys (one representing the parent, one representing the children, and one representing the child welfare agency) and a Court Appointed Special Advocate (CASA). Child welfare officials should work with court staff to obtain training regarding the roles of various legal representatives in child welfare cases, how court staff make decisions, and what information attorneys require to best represent their clients.

2.2 Responsibilities of the Alcohol and Drug Service System

People working in the alcohol and drug service system share responsibilities with colleagues from the court and child welfare systems in ensuring that collaborative structures and relationships result in better services to families. In recent years, treatment providers and the public alcohol and drug service system have come to understand that family members are important in the recovery process for individuals in treatment. As a result, they have assumed greater responsibility for determining the parenting status, capacities, and needs of people in treatment.

Responsibilities of staff in the alcohol and drug service system differ somewhat depending on whether parents have an open child welfare case and whether the child is in the custody of the court or the parent. Specific responsibilities include—

- **Understanding the ways that substance use disorders put children at risk and the ways that the child welfare system must respond to those risks, including ASFA requirements.**

Traditional assessments for substance use disorders have focused on the effects of substance use on the person entering treatment, including effects on employment, housing, and mental and physical health. Workers in the alcohol and drug treatment system were less likely to explore the effects of substance use on other people in the person’s life, including children. Moreover, treatment counselors are not generally trained in the area of child development and may overlook important signals suggesting that children of parents in treatment are not developing appropriately, may need help, or may need to be removed from their homes at least temporarily. Alcohol and drug treatment staff may feel that reporting suspicions of child abuse or neglect will undermine their therapeutic relationship with parents and may be hesitant to or uncertain about taking action.

Reporting requirements for child maltreatment are discussed below. It is, however, essential that alcohol and drug treatment staff receive training about basic principles of child safety, theories of child development, stages of child development, and ways that parental substance use disorders affect children at all developmental stages, including prenatal substance exposure. In addition, they should receive training regarding the range of possible responses from the child welfare system, including responses such as preventive services that may allow parents to retain custody of their children while they participate in treatment.

Staff working in the alcohol and drug service system need specialized training that addresses at least the following:

- State definitions of child maltreatment;
- The role of the treatment provider in reporting suspected abuse or neglect;
- Benefits from addressing family dynamics and potential child maltreatment when working with a parent who has a substance use disorder;
- Consequences for children whose parents have substance use disorders;
- Other family issues that arise when parents are involved with child welfare;
- Ways treatment staff help parents prepare for child welfare and court reviews; and
- How ASFA requirements influence decisions regarding treatment.

Just as child welfare staff need to explore their beliefs about addiction, alcohol and drug services staff need opportunities that will allow them to address their experiences with and exposures to the child welfare and court systems, and to identify the attitudes that have come from these experiences. Training for alcohol and drug services staff must also help them recognize how their personal beliefs and attitudes regarding child maltreatment may affect their ability to work with families.

The NCSACW developed an online training curriculum for substance abuse professionals, entitled “Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals” available at www.ncsacw.samhsa.gov.

- **Ensuring that alcohol and drug services staff understand and comply with State laws regarding the reporting of child abuse and neglect.**

In order to avoid confusion about reporting child abuse and neglect, alcohol and drug services staff must be trained about State rules regarding mandatory reporting of abuse or neglect. As noted above, treatment workers may hesitate to report suspicions of child abuse or neglect. Decisions regarding responsibility to report maltreatment, however, are dictated by law, making reporting less a personal decision than a professional responsibility. Staff also need to understand that privacy rules pertaining to reporting limit their responsibility and authority to making only an initial report. These rules do not allow people making reports to respond to followup requests for information or subpoenas unless the parent has signed a consent form or a court has issued an order that complies with relevant rules.

In order to make appropriate reports or provide child welfare staff with information that will help them secure services for families and monitor family progress, alcohol and drug services staff must understand how their local child welfare system works. Child welfare operations and regulations vary greatly across States and localities. Variation is found in statutory definitions of child maltreatment, how reports of maltreatment are handled when first received, the kinds of evidence necessary to substantiate reports of maltreatment, and the use of police and/or child welfare personnel to investigate reports and conduct initial safety assessments. Ideally, staff from the local child welfare agency should provide this training to workers in the alcohol and drug service system, and at a minimum, child welfare staff should provide input into the training curriculum.

The following additional examples of variations among child welfare systems underscore the importance of training workers in the alcohol and drug service system about child welfare operations in their particular community.

Variations among child welfare systems:

- In some localities, reports of domestic violence are considered “eligible” child maltreatment reports, while in other localities, domestic violence is not included in the statutory definition of child maltreatment and such reports are “screened out” (i.e., they are not referred to the child welfare for further action).
 - In some localities, child welfare responses include an “alternative response track.” This option permits child welfare agencies to respond to families on whom reports have been made with an assessment and an offer of voluntary services rather than with an investigation to determine whether child maltreatment actually occurred.
 - In some localities, any one of these methods of contacting families may occur: first contacts after a maltreatment report has been accepted are generally made by the police; these contacts are generally made by child welfare staff; the police respond to some types of maltreatment reports (such as sexual abuse and severe physical abuse), and child welfare staff respond to others; the police make initial contact if it is “afterhours,” while child welfare workers make contact during regular working hours; and police and child welfare staff make the first contact as a team.
- **When there is not an open child welfare case, determining whether children are present in the home, whether the parent has caretaking responsibilities for children in the home, and whether the nature of the substance use disorder (whether or not the person is a caretaker) creates a risk of child maltreatment.**

Just as child welfare staff should seek advice from colleagues in the alcohol and drug treatment system in selecting substance abuse screening tools, so should alcohol and drug service system staff seek

advice from colleagues working in child welfare in selecting tools to screen for child safety. Because the Subcommittee charged with recommending substance use disorder screening tools includes representatives from multiple systems, that Subcommittee would be well positioned to recommend a child safety screening tool as well.

When screenings conducted by workers in the alcohol and drug service system suggest that children are at risk or have been maltreated, those workers should consult with child welfare staff regarding next steps. Therefore, alcohol and drug service staff must understand how to make reports of child maltreatment, and they must be aware of preventive services in the community if the information obtained from the screening process is a concern but does not warrant a child maltreatment report.

Determining child safety and child risk is not a precise science, and although many strategies have been developed to evaluate safety and risk, none can guarantee that maltreatment will or will not recur. Training for alcohol and drug services staff should focus on the general assessment tools used by the local child welfare services agency, the limitations of those assessment tools, and how those tools incorporate substance use disorders into the safety and risk assessment process. Appendix F, “Examples of Safety and Risk Assessments for Use by Child Welfare Staff,” provides information regarding safety and risk assessment tools used by child welfare staff.

- **When there is an open child welfare case, participating in creating case plans, sharing information about parents and children with child welfare staff, and guiding their patients in taking steps to comply with plans. Alcohol and drug treatment staff should also understand the continuum of child welfare activities, processes, and timetables and that a parent can have an open child welfare case and still have custody of children (these are often referred to as “in home” services).**

Most staff in local child welfare agencies complete standard required case plan forms. Alcohol and drug treatment staff should understand these forms and participate in developing child welfare case plans recorded on them. They should conduct multidimensional assessments and share assessment results with child welfare staff as quickly as possible, generally within 7 days.

Although child welfare staff interact regularly with court staff, alcohol and drug treatment personnel do so less frequently and need to understand the role of courts when children of their clients are in foster care. It is important for them to understand the Federal, and sometimes State, statutory requirements that govern child welfare case plans and decisions about families. In particular, they need to understand the Federal ASFA requirement that permanency hearings be held after children have been in foster care for 12 months, with the expectation that decisions and next steps regarding permanent placement of children will result from permanency hearings.

The child welfare and court timeframes put added pressure on parents to progress quickly through treatment. One way that the alcohol and drug service treatment system can respond to this urgency and increase collaborative relationships with child welfare and courts is to give treatment priority to people with open child welfare cases involving children in foster care, where possible and within Federal rules regarding access to treatment.

Treatment providers can support family members by—

- Encouraging them to sign consent forms allowing for disclosure of treatment progress to child welfare workers and court professionals;

- Understanding their child welfare case plan requirements, meetings, appointments, and expectations for visits or involvement with children;
- Communicating with child welfare caseworkers to coordinate schedules so that family members do not have conflicting demands that force them to choose between meeting their child welfare case plan goals and expectations and those of their substance abuse treatment plan; and
- Ensuring that child welfare workers understand the difference between treatment lapses and treatment relapses, and communicating clearly how both lapses and relapses are being addressed in treatment.

Alcohol and drug treatment staff should have the following knowledge about the operations of their local child welfare systems:

- What are the indicators of child maltreatment, and how are reports made?
- How does child welfare staff respond to reports of maltreatment, and how are initial and subsequent investigations and assessments made? What assessment forms are used, and how long does it take to conduct an investigation or assessment?
- What happens when a child abuse report to a hot line turns into allegations of child abuse or neglect? What happens when the allegations are not substantiated, and what happens when they are substantiated? How long does it take to determine whether reports are substantiated?
- How does child welfare make determinations about removing a child from a parent's custody and how do they determine when to return a child? What services are available to children and families, and how are those services delivered?
- What are the implications of child welfare findings for treating substance use disorders?

2.3 Responsibilities of the Court System

Court officials have a responsibility to ensure that employees, attorneys, and volunteers receive adequate and accurate training about the alcohol and drug service and child welfare systems. These responsibilities include—

- **Understanding the fundamentals of substance use disorders, the implications of those disorders on child safety and well-being, and the potential for effective treatment.**

As noted earlier, the relationship between substance use disorders and child maltreatment is often complex. Court and legal staff and volunteers should be required to receive training in topics such as the nature of substance use disorders, treatment engagement and services, recovery, and the impact of substance use disorders and treatment on children including aspects related to prenatal substance exposure. Continuing legal education credits can often be provided for this kind of training.

Ideally, staff from the alcohol and drug service system or a local treatment provider should develop curricula and provide training to court and legal staff. NCSACW developed an online curriculum aimed at court and legal staff that is available at www.ncsacw.samhsa.gov. Alcohol and drug treatment staff can adapt the curricula for their jurisdiction.

- **Understanding the fundamentals of child development and how substance use disorders affect children's capacity to grow.**

Child welfare staff are often well versed in the developmental stages of children and attempt to address those stages in the decisions they make regarding placement of and services to children whose parents have substance use disorders. Court and legal staff are much less likely to have this knowledge and therefore may make decisions regarding services and custody without understanding how those decisions affect the ability of children to progress developmentally.

Staff from the child welfare service system can adapt curricula used to train their own staff for use in training court staff, and they can provide training in this area.

- **Requiring that all families coming before the court be screened, and if appropriate, assessed for substance use disorders; that developmental assessments of children have been completed; and that prenatal substance exposure, if it exists, be addressed.**

Despite the correlation between substance use disorders and child maltreatment and the importance of screening for substance use disorders upon first contact with a family reported for maltreatment, such screenings may not occur. Judges and magistrates can greatly increase the likelihood that screenings will be completed if they routinely ask whether they have been done and for information about their outcome.

Ideally, court or legal staff should participate in the Subcommittee of the Steering Committee charged with recommending a particular screening tool for substance use disorders.

If screening results suggest that family members have substance use disorders, judges and attorneys should ask for information regarding followup assessments, referrals to services, and protocols for supporting and monitoring family members through treatment.

- **Using court authority to prompt collaboration required to ensure compliance with ASFA.**

Because ASFA imposes strict timelines for terminating parental rights, it puts added pressure on child welfare and alcohol and drug treatment agencies to collaborate.

Judges and magistrates should use the authority of the court to hold families, child welfare staff, and alcohol and drug treatment staff accountable for complying with ASFA requirements or developing compelling reasons why ASFA rules should not apply in a particular case. Judges also can issue findings that the State has not made reasonable efforts (or active efforts for families covered by the Indian Child Welfare Act) to provide services to families. These findings generally require immediate remedial actions by agencies to make those efforts.

2.4 Collaborative Responsibilities of the Child Welfare, Court, and Alcohol and Drug Service Systems

Although each system has certain individual responsibilities to the other systems, as described above, there are also critical collaborative activities whose responsibilities must be shared across the three systems. The Steering Committee should specify those areas of shared responsibility, create communication structures that promote and enforce them, and develop mechanisms to guide and evaluate local jurisdictions in adapting and implementing shared responsibility across the three systems. Section I suggests that the Steering Committee develop a plan of action to oversee progress toward collaborative goals and objectives, and these collaborative activities should be incorporated into the plan

of action. Appendix B of this guidebook provides a template for creating the plan of action. Some of the basic shared collaborative responsibilities of the child welfare, court, and alcohol and drug systems are described below:

- **Child welfare, court, and alcohol and drug service systems share responsibility for facilitating engagement of families by establishing joint policies and procedures for sharing information regarding screening, assessment, treatment, and case planning.**

Child welfare, court, and alcohol and drug treatment staff share responsibility for helping families engage in child welfare and treatment services. An important factor in influencing whether families are engaged is the extent to which staff from all systems have accurate and timely information about families they serve, information that is gathered and shared at critical points across the span of a family's involvement with any system. Having formal structures in place to make it easier for staff to communicate information increases the likelihood that they will in fact communicate appropriately, which in turn increases the likelihood that they will be able to engage and retain families in services.

One important element of effective communication involves protecting people's rights to privacy, rights that are specified and guaranteed by Federal and State laws. Appendix H, "Sharing Confidential Information," includes a detailed discussion of confidentiality concerns and informed consent procedures. Staff from all three systems should develop uniform protocols that provide guidance to workers in sharing information. The Steering Committee should charge a Subcommittee with researching existing protocols, locating promising practices from other jurisdictions, and developing recommendations for improvements to protocols.

- **The child welfare, court, and alcohol and drug systems share responsibility for ensuring that case plans and court orders (when relevant) for children and families are developed collaboratively and create a context within which staff from each system can actively help families engage and succeed in services.**

Although each system has its own requirements for case plans, plans generated by each system should incorporate information about families obtained from the other systems and all plans should be constructed so as to support the capacity of families to engage in required services. When case plans do not include the array of activities required by all systems, the plans duplicate one another, contradict one another, or pose barriers for the family due to excessive or conflicting demands on family members' time. For example, it is extremely difficult for families to participate in daily outpatient substance use disorder treatment programs as required by the alcohol and drug treatment plan, hold a full-time job or participate in daily employment training programs as required by the child welfare case plan or court order, attend two parenting education or anger management classes per week as required in the child welfare case plan, and visit with their children twice per week, also as required by the child welfare case plan.

Alcohol and drug treatment and child welfare case plans should be developed through joint efforts of staff from both systems and the court, and must accommodate the timetables under which all systems operate. Information regarding the following responsibilities should be shared.

In developing case plans, alcohol and drug treatment and child welfare staff should share the following:

- Treatment plans and requirements, including drug testing requirements;
- Child welfare case plan activities and objectives;
- Family service interventions;
- Plans for ensuring child safety;
- Parent and child visitation plans; and
- Permanency goals and plans.

Ideally, sharing these responsibilities should result in a unified plan that emphasizes engaging and retaining families in services, ensuring child safety and family stability, promoting recovery, and continuing services even after families complete case plan requirements (sometimes called aftercare).

- **The child welfare, court, and alcohol and drug service systems share responsibility for developing indicators of progress that meet the needs, requirements, and missions of each system and that focus on the entire family.**

“Progress” has different meanings to people working in different systems, although in all three systems, progress frequently is not characterized by an unbroken straight line to success. In fact, staff in child welfare, court, and alcohol and drug systems routinely report that families make progress, stumble, resume progress, stumble again, and so on. The “Stages of Change” theory described in Section III arose out of research involving people with substance use disorders, but it applies as well to other situations in which people attempt to change longstanding behaviors. Movement from one state of change to another is an important marker of progress.

The tensions surrounding what constitutes progress have often been expressed in discussions about substance use relapse. When people who have abstained from using substances have an episode of using again, child welfare and court staff may view the substance use as equivalent to “backsliding” into substance abuse. However, staff in the alcohol and drug service system distinguish between “lapse” (a period of substance use) and “relapse” (the return to problem behaviors associated with substance use). It is important for child welfare and court staff to understand that distinction and avoid concluding that relapse is the same as treatment failure.

Relapse may occur because the treatment plan has not adequately addressed issues relevant to the substance use disorder. At the same time, alcohol and drug treatment staff should understand that relapse does have implications for child safety.

While relapse is most frequently associated with substance use disorders, it is important for staff from all systems to have a shared understanding that families may also experience periods of return to child maltreatment or criminal involvement. In general, progress can be considered as the degree to which people have increasing periods of sobriety, decreasing incidences of relapse and improved ability to take care of responsibilities, including parenting. Staff should develop shared responses to relapses and setbacks when they occur.

As noted in Section I, one important task for the Steering Committee is to develop broad indicators or benchmarks for measuring families’ progress in both recovering from substance use disorders and attaining appropriate parenting capacities. Indicators and benchmarks should be based on requirements

included in the treatment and case plans. These indicators and benchmarks help alcohol and drug treatment staff determine the appropriateness or effectiveness of the treatment services provided to families. These tools also guide child welfare and court decisions regarding permanency arrangements for children (particularly with respect to seeking termination of parental rights or providing aftercare services to families when children are reunified) and services to ensure child safety and well-being. The Steering Committee uses indicators and benchmarks to assess how well their systems are sharing information, engaging and retaining families, and making appropriate and timely decisions.

Joint indicators and benchmarks require that staff have protocols for obtaining information from families and for sharing information with colleagues. The following strategies can be useful in securing and sharing important information:

- Developing joint disclosure forms that meet the needs of all relevant systems;
 - Convening meetings of staff from all systems to address pertinent issues;
 - Conducting meetings involving all involved staff and family members, to discuss progress, problems, and next steps; and
 - Working with the parent's legal advocate to ensure that the court is responsive to the parent's treatment needs and progress.
- **The child welfare, court, and alcohol and drug service systems share responsibility for monitoring and evaluating the results of collaborative screening, assessment, engagement, and retention efforts. Evaluations should include determinations regarding whether individual system and collaborative responsibilities are being met, determinations about whether expected outcomes are being achieved, and procedures for making revisions based on evaluation information.**

If families are not engaged and retained in services, collaborative efforts have failed. The primary objective of the collaborative endeavor presented in this guidebook, and the most important goal for the Steering Committee, is to ensure that families receive timely, appropriate, and well-coordinated services.

As described in Section I, at the onset of working together, members of the Steering Committee should gather and understand the data from their own systems and then create a baseline of information that the Steering Committee and local Subcommittees can use to establish priorities. Appendix B provides information regarding the *Collaborative Capacity Instrument* and other tools to help the Steering Committee members assess the strengths and weaknesses of their systems. This assessment should be conducted at one of the early Steering Committee meetings and periodically thereafter. Results from these tools frequently prompt discussions among Steering Committee members about the ways systems are perceived, reasons why they conflict, and areas in which strong collaborations already exist. Information from assessments should be shared with Steering Committee and Subcommittee members and with others who have a stake in improving collaborative capacities among agencies.

When the baseline has been established, all three systems share responsibility for establishing outcomes they feel equally responsible to achieve. Outcomes should not be merely a compilation of outcome measures specific to each system, and each system should feel responsible for the outcomes of the three systems as a whole. Each system's performance should be measured at least in part against those overarching outcomes.

2.5 Models for Cross-System Collaboration

Successful collaborations usually involve the creation of a “teaming” approach. These teams can be formal or informal and can function within a variety of structures. Team approaches that have been used in some localities are described below.

Colocation of Staff

One team model involves colocating staff from different systems in the same office. For example, some localities “outstation” staff from the alcohol and drug service system in a child welfare office or court environment. Although colocating staff does not in itself ensure effective collaboration, reports from localities that have implemented this model suggest that workers are generally satisfied with the arrangement and believe that everyone, including the families, benefits from it. Colocation is usually the model that many tribes have developed to deliver services to families.

Colocation has considerable potential for enhancing cross-system collaboration. It provides opportunities for people to learn about other professions and to develop more complete understandings about family strengths and problems. In many localities that have implemented the colocation model, staff from the alcohol and drug service system not only conduct assessments of families, but also participate in staff meetings and conduct trainings for staff and sometimes families.

The following factors are to be considered in deciding whether and how to colocate staff from different agencies:

- Program
 - Are the goals for colocation clear, and do all staff share these goals?
 - How will information be shared and privacy protected?
 - Have staff that will be colocated received basic cross-training to work together effectively?
 - What functions will the colocated staff perform? (For example, will alcohol and drug services colocated staff conduct screenings and/or assessments, provide ad hoc advice, conduct home visits, or participate in child welfare staff meetings, or perform any combination of these functions?)
- Logistics
 - Where will staff sit, what access will they have to computers, photocopiers, and similar equipment?
 - How will supervision be handled?
 - How will differences in work rules such as dress codes, signing-in, coming and going into the field, pay, and reward structures be resolved?
- Lessons learned
 - Staff who are colocated in another agency must be part of the agency where they sit and maintain their own identity.
 - Alcohol and drug training provided by alcohol and drug treatment staff that are outstationed with child welfare staff is often better received than training provided by child welfare staff.

Creating Specialized Staff Positions

Another team approach is to create specialized workers who work only with particular types of families and who are responsible for interacting with other staff from systems that work with those families. For example, some child welfare agencies have created specialized units or specialized worker positions to focus on cases in which problems such as sexual abuse, domestic violence, or parental substance use disorders are prominent.

When families struggle with both substance use disorders and child maltreatment, this approach permits designated child welfare workers to develop expertise in the area of substance use disorders and familiarity with the local alcohol and drug treatment providers. This expertise and familiarity between child welfare and alcohol and drug treatment staff increases the likelihood that staff will communicate consistently, and it promotes a sense of teamwork and camaraderie. Specialized child welfare workers may spend part of their week at treatment sites to meet with families or resolve problems. Because they learn how treatment programs operate, these specialized workers can collaborate with treatment staff to ensure that families are not confused or frustrated in their efforts to meet potential conflicting requirements of the alcohol and drug service, court, and child welfare systems.

Multidisciplinary Teams

Another collaborative team model involves developing multidisciplinary teams to participate in child welfare case staffing meetings or case conferences. Multidisciplinary teams can be combined with the colocated or specialized staff strategies described above, or they can be used independently. Multidisciplinary teams that include representatives from the alcohol and drug service and court systems create a context that makes collaboration more feasible because team meetings afford structured time for workers to get and provide information about families, seek suggestions on resolving problems, and share resources.

Establishing and implementing multidisciplinary teams often brings to the fore the underlying tensions and inconsistencies that have existed among the systems. Therefore, it is essential that people from all systems expected to participate in multidisciplinary teams share in establishing the framework and protocols for how the teams will operate. In particular, attention should be paid to establishing clear roles for each team member, defining ways that information will be shared among team members, reaching consensus regarding the role of family members on teams, and clarifying how decisions will be made and enforced. The Steering Committee could charge a Subcommittee with exploring these and other options and recommending one or more for use in the State.

Creating multidisciplinary teams requires significant upfront investments in identifying staff who are comfortable working in groups, creating and delivering training regarding effective group processes and teamwork, and determining who has authority to make which kinds of decisions. Some jurisdictions have limited the number of families or assigned only those with the most intense service needs to the multidisciplinary team, because they can be time and resource intensive.

However difficult, teams can be very productive, and their work can result in several benefits:

- Multidisciplinary teams ensure that a broad range of knowledge and expertise is available to address problems, thereby increasing the likelihood that services will be comprehensive and that families will engage and remain in them.

- Because team members learn about one another's services and procedures, each is less likely to provide incorrect information to families and more likely to communicate and coordinate services.
- The multidisciplinary approach allows child welfare workers to develop a broader understanding of the needs of the children and parents and enhances their ability to match services to family needs.

