Module 7:
Collaborating to Serve Parents with Substance Use Disorders

Child Welfare Training Toolkit

National Center on Substance Abuse and Child Welfare

Acknowledgment

National Center on Substance Abuse and Child Welfare

A program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF), Children's Bureau

SAMHSA
Substance Abuse and Mental Health Services Administration

Children's Bureau

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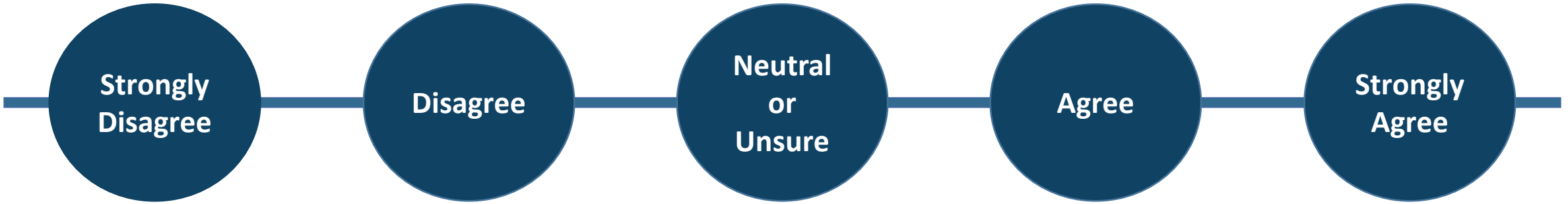
Learning Objectives

After completing this training, child welfare workers will:

- Identify the importance of collaboration with other service providers
- Recognize key steps in building effective cross-systems collaboration
- Discuss 42 CFR, HIPPA, and Releases of Information
- Determine what information to gather from service providers
- Determine what information to share with service providers
- Demonstrate collaborative case planning
- Adhere to information and communication protocols
- Consider shared outcomes

Collaborative Values Inventory



- The need to protect client confidentiality will always be a significant barrier to case planning between our partner agencies
- Substance use disorder treatment professionals involved with parents should have a voice in decisions about child safety, custody, and living arrangements
- Child welfare workers should have a voice in decisions about treatment needs of parents with a substance use disorder

(Children and Family Futures, 2017)

The Need To Do Better for Families

Substance use disorders can negatively affect a parent's ability to provide a stable, nurturing home and environment. Of children in care, an estimated **61% of infants and 41% of older children** have at least one parent who **is using drugs or alcohol** (Wulczyn, Ernst, & Fisher, 2011)

Families affected by parental substance use disorders have a **lower likelihood of successful reunification** with their children, and their children tend to **stay in the foster care system longer** than children of parents without substance use disorders (Brook & McDonald, 2010)

The **lack of coordination and collaboration** between child welfare agencies, community partners, and substance use disorder treatment providers **undermines the effectiveness of agencies' response to families** (Radel et al., 2018)

The Necessity of Collaboration

Substance use and child maltreatment are often **multi-generational problems** that can only be addressed through a coordinated approach across multiple systems to address the needs of both parents and children.

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2010)

Benefits of Collaboration

- Collaboration contributes to better outcomes and efficiencies in the service delivery systems
- The investment of time leads to better shared understanding, improved planning efficiency, and more effective monitoring of parental progress
- Collaboration in case planning and information sharing can include child welfare workers, substance use treatment providers, mental health treatment providers, court professionals, and other related service professionals

Improving Communication: No Single Agency Can Do This Alone

Improving the outcomes of children and families affected by parental substance use requires a coordinated response that draws from the talents and resources of **at least** three systems:

- Child welfare
- Substance use disorder treatment
- Courts

(Children and Family Futures, 2011)

Systems Change

A permanent shift in doing business that relies on **relationships** across systems and within the community to secure needed **resources** to achieve better **results** and outcomes for all children and families.

Seven Collaborative Practice Strategies

1. **Identification:** A system of identifying families in need of substance use disorder treatment
2. **Timely Access:** Timely access to substance use disorder assessment and treatment services
3. **Recovery Support Services:** Increased management of recovery services and monitoring compliance with treatment
4. **Comprehensive Family Services:** Two-generation family-centered services that improve parent-child relationships
5. **Increased Judicial and Administrative Oversight:** More frequent contact with parents with a family focus to interventions
6. **Cross-Systems Response:** Systematic response for participants based on contingency contracting methods
7. **Collaborative Structures:** Collaborative non-adversarial approach grounded in efficient communication across service systems and the courts

(National Center on Substance Abuse and Child Welfare, 2014; U.S. Department of Health and Human Services, 2013; National Center on Substance Abuse and Child Welfare, 2016)

The Five R's: Core Outcomes for Families

1. **Recovery:** Parents access treatment for substance use disorders more quickly
2. **Remain at Home:** More children remain in the care of their parents
3. **Reunification:** Children stay less days in foster care and reunify at a higher rate
4. **Reoccurrence:** Decreased incidence of repeat maltreatment
5. **Re-entry:** Decreased number of children re-entering foster care

(National Center on Substance Abuse and Child Welfare, 2014; U.S. Department of Health and Human Services, 2013; National Center on Substance Abuse and Child Welfare, 2016)

A Collaborative Approach Across Systems

- Agreement on common values
- Enhanced communication and information sharing
- Blended funding and data collection for shared outcomes

Results in improved outcomes for families:

- Increased engagement and retention of parents in substance use treatment
- Fewer children removed from parental custody
- Increased family reunification post-removal
- Fewer children re-entering the child welfare system and foster care

(Boles et al., 2012; Dennis et al., 2015; Drabble, 2010)

Levels of Collaboration

Systemic Collaboration

At the systems level, collaboration can occur between organizations to exchange information, develop joint policies, and develop joint outcomes

Individual Case Collaboration

At the practice level, collaboration can occur between child welfare workers, treatment counselors, and other providers to coordinate client resources and case planning

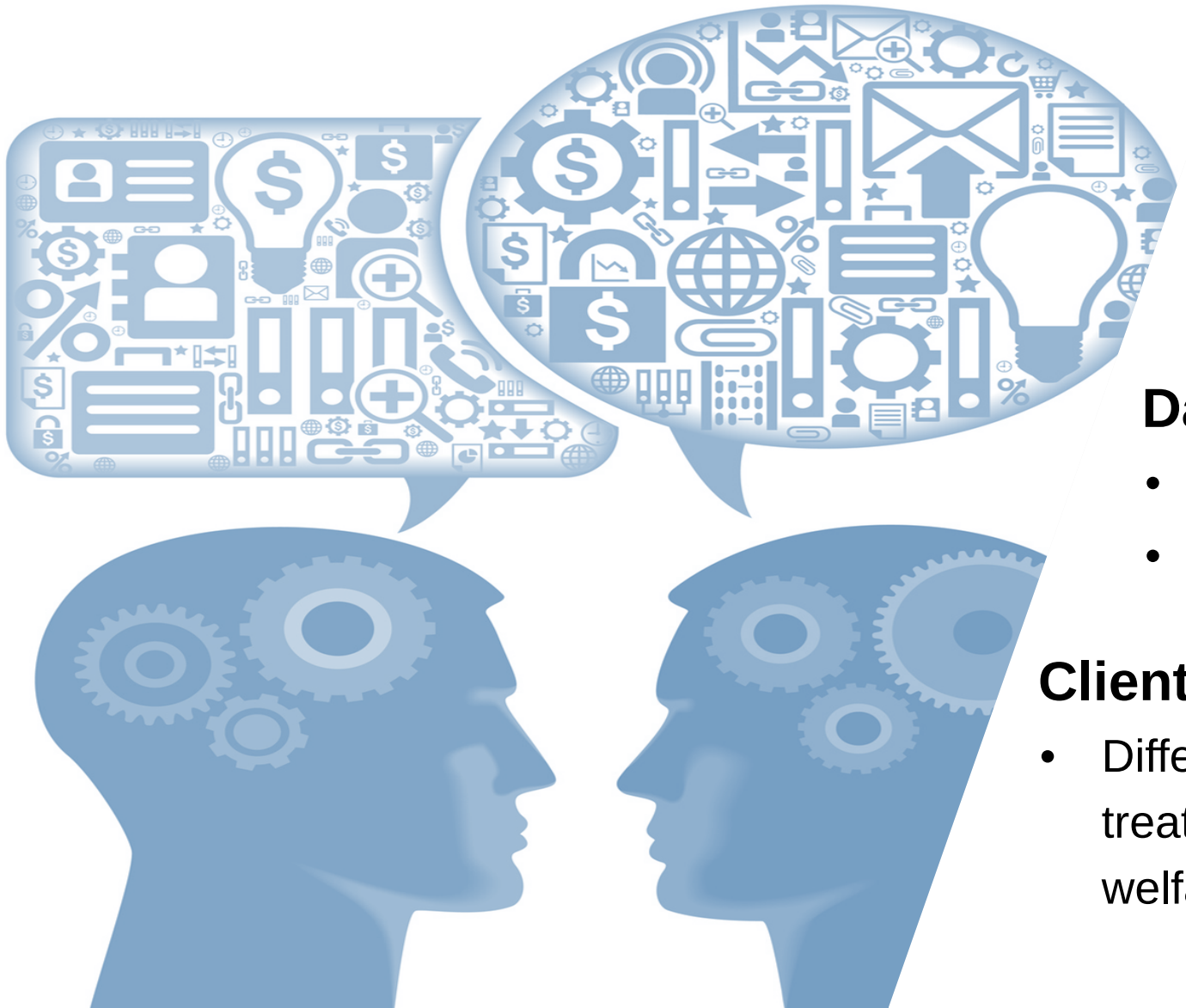
(Children and Family Futures, 2011)

Examples of Collaborative Activities

- Developing a common understanding with a treatment counselor about his or her specific expectations, requirements, and practices
- Identifying and working out joint strategies to address specific, identified issues that have affected parenting capacities, such as safety plans for children when parents relapse, difficulties in accessing needed support or treatment services, difficulties arising from placement of children in foster or relative care, or inconsistent visitation practices
- Jointly identifying effective parenting programs for parents who use substances
- Working collaboratively to avoid duplication of services, including coordinating drug testing
- Working out collaborative interventions to re-engage parents in treatment and to reassess the safety of children

(Children and Family Futures, 2011)

Barriers to Collaboration



Clashes With Mission and Vision

- Differences of opinion with overall mission and agency priorities and regulations

Data Sharing and Communication

- Regulations related to confidentiality
- Trust between systems

Client Engagement

- Differences in efforts to engage clients in treatment, and client mistrust of the child welfare system

(Drabble, 2010)

Key Steps to Building an Effective Collaboration

1. Identify differences in values and perceptions
2. Establish individual and cross-system roles and responsibilities
3. Establish joint policies for information sharing
4. Develop integrated case plans
5. Develop shared indicators to monitor progress and evaluate outcomes

(Children and Family Futures, 2011)

Step 1: Identify Differences in Values and Perceptions

Values

Child Welfare

- Safety
- Protection

Treatment

- Hope
- Recovery

Courts

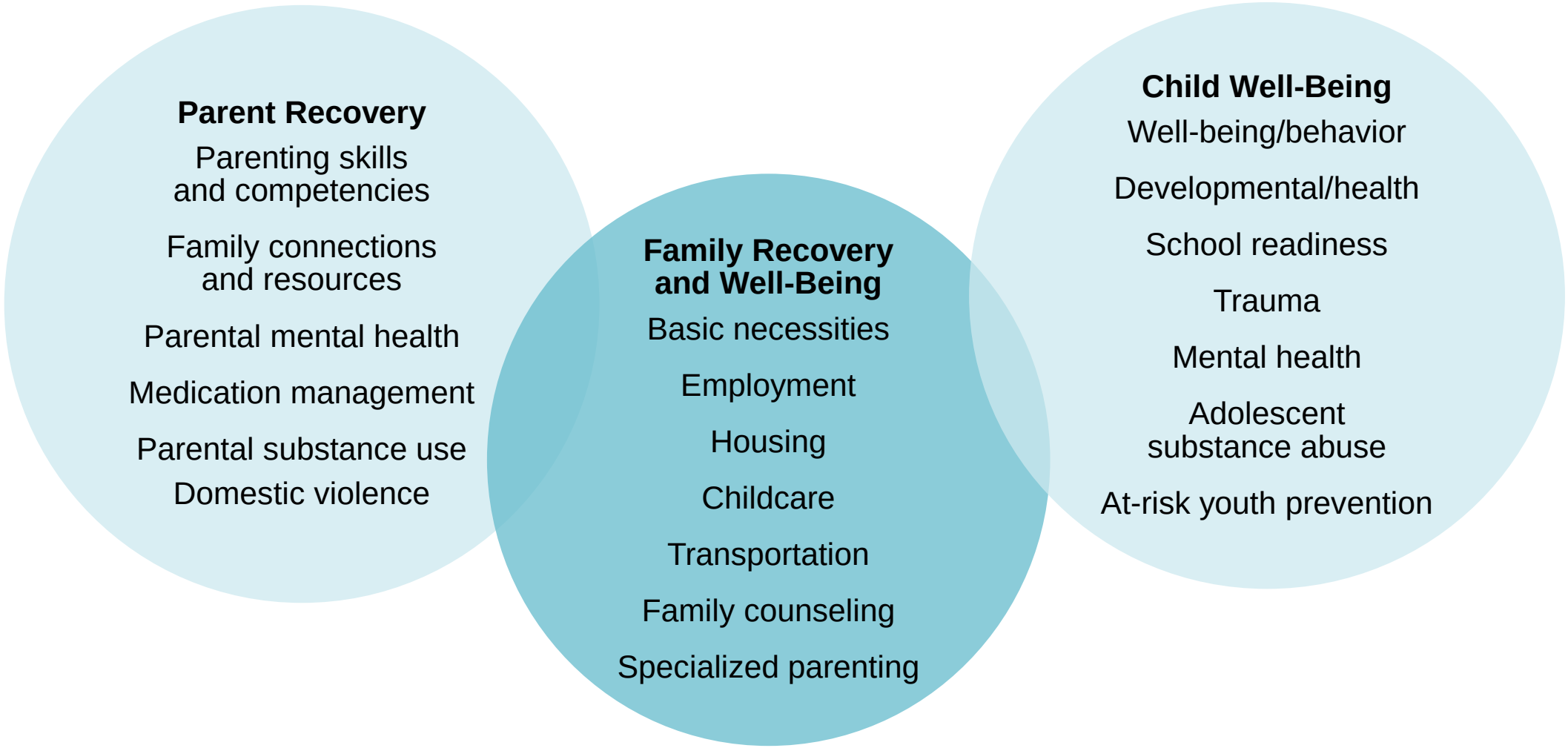
- Justice
- Equal Protection

(Children and Family Futures, 2011)

Stigma & Perceptions of Parents with Substance Use Disorders

- “Once an addict, always an addict.”
- “They don’t really want to change.”
- “They lie.”
- “They must love their drug more than their child.”
- “They need to get to rock bottom, before…”

A Family Focus



(Werner, Young, Dennis, & Amatetti, 2007)

Step 2: Establish Individual and Cross-System Roles and Responsibilities

Understanding Other Systems

Partners need an in-depth understanding of each other's systems and how they affect each other:

- Who does what? When? Why? And How?
- How does that affect the families you serve?

In developing this understanding, partners:

- Raise awareness about unknown processes
- Clarify misunderstood processes
- Develop a shared, common language
- Identify opportunities for improvements

(Children and Family Futures, 2011)

Benefits of Building Trust Between Systems

- Improved quality of services
- Increased commitment to the organization or team
- Better relationships with families
- More effective, cohesive teams
- Decreased frustrations caused by strained relationships
- Formal systems model partnership

(Green, Rockhill, & Burrus, 2008; Children and Family Futures, 2011)

Step 3: Establish Joint Policies for Information Sharing

Two Levels of Information Sharing

Front-Line Level (Micro)

- Case management
- Reporting
- Tracking

Administrative Level (Macro)

- Baselines and dashboards
- Outcomes
- Sustainability

Information sharing can support more effective communication between systems to meet the needs of families and strengthen collaborative capacity.

(Children and Family Futures, 2011)

Confidentiality

HIPAA: “A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while **allowing the flow of health information needed to provide and promote high quality health care**, and to **protect the public's health and well being**.”

42 CFR Part 2: More stringent than HIPAA, 42 CFR outlines under what limited **circumstances where information about the client’s treatment may be disclosed** with and without the client’s consent. Recent changes enacted in March 2017.

(Substance Abuse and Mental Health Services Administration, 2018; U.S. Department of Health and Human Services, 2003)

Consent Forms

Typical consent forms include the following:

- Name or general description of programs making disclosure
- Name or title of individual or organization that will receive disclosure
- Name of the person who is the subject of disclosure
- Purpose or need for disclosure
- Details on how much and what kind of information will be disclosed
- Statement that the person giving consent may revoke (take back) consent at any time, except to the extent that the program has already acted on it
- Date, event, or condition upon which consent will expire, if not previously revoked
- Signature (and, in some states, that of the individual’s parent)
- Date on which consent is signed

WHO
needs to
know
WHAT,
WHEN?

Information Needed by Substance Use Treatment Providers

- Reason for referral and current drug and alcohol concerns
- Screening and assessment results and case plan
- Confirmation of release of information signed
- Drug and alcohol history, if known
- History of child welfare involvement
- Family strengths and protective factors
- Household composition and any children previously removed
- Status of children and visitation plan (including any changes in child placement or visitation) and permanency goal
- Name and contact information of the child welfare worker

Information Needed by Child Welfare and Court Professionals

- Whether the parents are participating in a treatment program, including:
  - The degree of parental participation
  - Treatment recommendations
  - Whether they are regularly attending or failing to attend appointments
  - Drug testing results
  - Treatment plan
  - The quality of their engagement and progress in treatment
  - If parents relapse or have left treatment
  - Relapse prevention plans
  - The timeframe for anticipated successful completion of treatment measured against the timelines of the Adoption and Safe Families Act (ASFA)
  - Discharge plan and aftercare recommendations

Barriers to Effective Cross-Systems Communication

- Legal mandates
- Lack of trust between the systems
- Competing timelines
- Caseload volume
- Confidentiality provisions
- Lack of a proper signed release of information in place

Step 4: Develop Integrated Case Plans

Joint Case Plans

Effective Case Plans

- Assess safety and well-being of children throughout the case
- Motivate parents to enter and continue treatment

Using Social Work Skills

- Initial relationship that demonstrates concern about parents' well-being
- Collaboration with service providers

Joint Case Planning Activities

- Incorporate objectives related to parents' treatment and recovery
- Ensure that child welfare case plans and treatment plans do not conflict
- Include joint reviews of the case plans with treatment professionals and family
- Share case plans with treatment providers
- Regularly review parents' progress to meet the qualitative and quantitative goals of the case plan, especially when critical events occur
- Include indicators of parents' capacities to meet the needs of their children and outcome data pertaining to the case plans
- Regularly monitor and share progress with treatment counselors

Joint Case Planning Activities

- Share new information with treatment professionals when there are changes that might create stresses for the parents or affect the parents' participation in treatment
- Some examples of these changes could be:
  - Visitation with children is being increased or unmonitored visits with children are being instituted
  - Family group conferencing or team meetings occur
  - The family's case is being transferred to a new child welfare worker or to a different unit
  - Unanticipated changes occur in any additional services that are part of the case plan
  - The schedule of court hearings changes

Joint Case Reviews: Considerations

- Parents have improved their capacity to meet the needs of their children
- Parents have completed the recommended treatment program at an acceptable level, or are proceeding well enough to know that children are not at risk
- There are no remaining unsafe conditions or other conditions that pose a risk to children, based on a safety assessment

Joint Case Reviews: Considerations

- There are no additional reports of child abuse or neglect
- Positive family supports and community links are available when needed
- A safety plan is in place
- Parent demonstrates the ability and willingness to use community supports
- Children have a safe, stable, and appropriate permanency goal of reunification, adoption, or another planned permanent living arrangement

Step 5: Develop Shared Indicators to Monitor Progress and Evaluate Outcomes

Measuring Progress

- What indicators are you trying to move?
- What outcomes are the most important?
- Is there shared accountability for “moving the needle” in a measurable way?
- Whom are we comparing the clients to?

(Children and Family Futures, 2011)

Joint Outcomes

Substance Use Outcomes

- Access to treatment
- Retention in treatment
- Positive discharge from treatment
- Reduction in substance use

Child Welfare Outcomes

- Children remaining at home
- Occurrence of maltreatment
- Reduced length of stay in foster care
- Timeliness of reunification or permanency

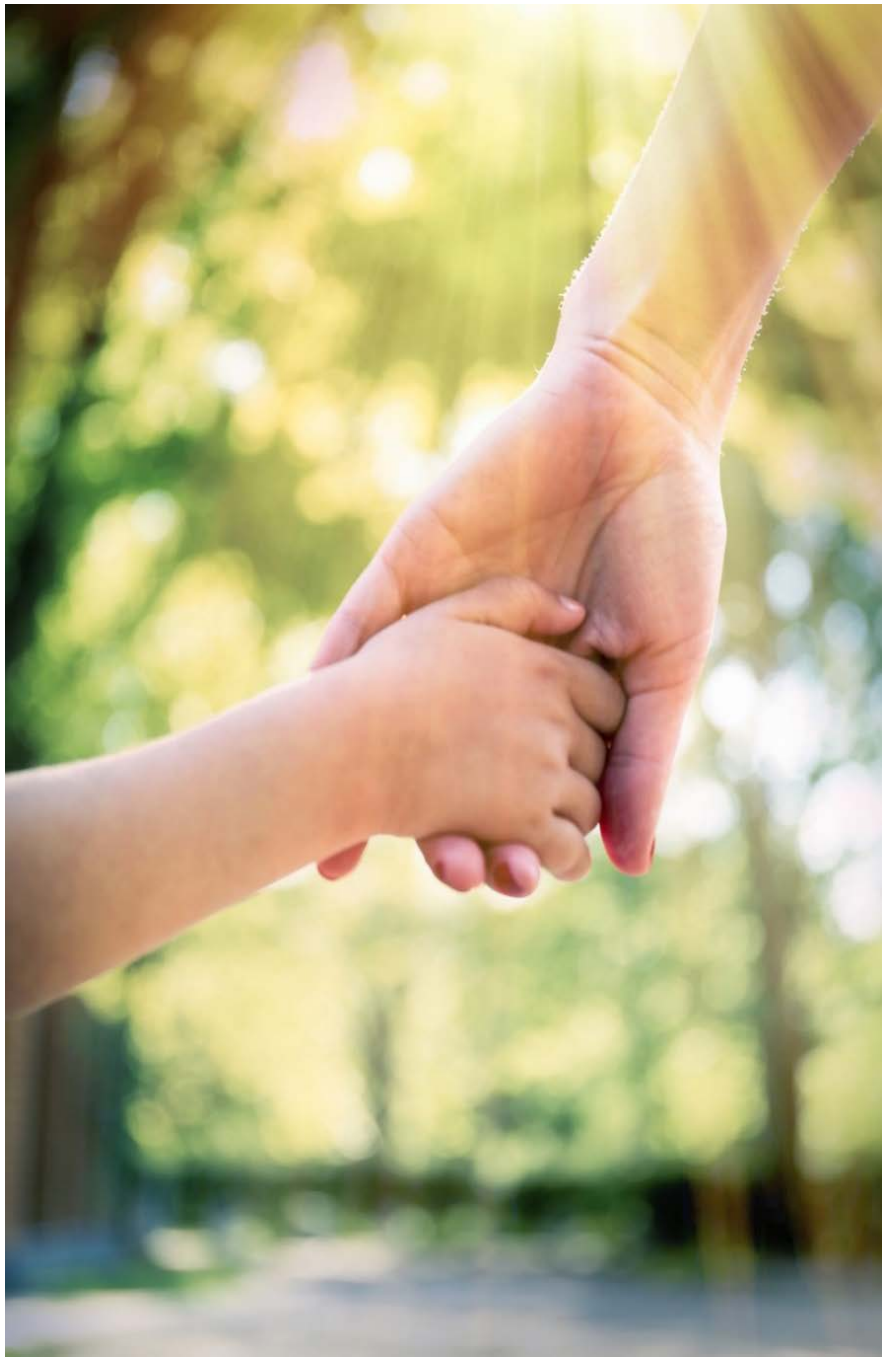
Other Important Outcomes

- Child well-being
- Adult mental health status and reduction in trauma symptoms
- School attendance
- Parenting skills
- Family functioning
- Risk or protective factors

(Children and Family Futures, 2011)

Creating a Collaborative Environment

- Mutual respect, understanding, and trust
- Honest and frequent communication
- Collaboration in the interest of all participants
- Understanding of values and, when they are different, adoption of principles for working together
- Mutual sense of ownership on specific plans
- Jointly developed objectives for specific parents



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Resources

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