

Commonwealth of Massachusetts

The Massachusetts Family Recovery Collaborative

Memorandum of Understanding

**A Collaborative Agreement among the Massachusetts
Departments of Social Services and Public Health, Bureau of Substance Abuse
Services, Massachusetts Juvenile Court, and the Wampanoag Tribe of Gay Head
(Aquinnah)**

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I. Declaration

The Department of Social Services (DSS), Department of Public Health/Bureau of Substance Abuse Services (DPH/BSAS), the Administrative Office of the Trial Court – Juvenile Department (Court), and the Wampanoag Tribe of Gay Head Aquinnah (Tribe) do hereby enter into this Memorandum of Understanding (MOU) for the purpose of developing an integrated, coordinated system of care for families where parental substance use disorders result in the maltreatment and/or neglect of children or increase the risk of such maltreatment or neglect, with the goal of improved well-being of children and strengthened families. These entities, hereinafter referred to as the “parties,” constitute the Family Recovery Collaborative (Collaborative).

II. Background and Purpose

The parties enumerated above recognize that a majority of families brought before the Juvenile Court pursuant to Mass. G.L. c. 119 present with substance use disorders (SUDs) that impair parents’ ability to safely and adequately meet their children’s basic needs and that only a minority of these parents are able to enter into and complete substance abuse treatment within the time frame established by Massachusetts’ law and regulation and federal law pursuant to the Adoption and Safe Families Act. Unavailability of appropriate services that can be accessed by parents within a reasonable period of time is a substantial roadblock to strengthening and/or reuniting families. The parties further recognize that children are negatively affected by their parents’ substance abuse and experience greater risk of emotional, behavioral and social difficulties as a result. Individuals dealing with substance abuse are similarly faced with its negative impact on their parenting and the risk of government intervention and possible loss of custody of their children. Finally, the parties also recognize that many families within the target population participate in services from multiple agencies and providers but service delivery is often fragmented. Many of these families also experience mental health issues, trauma, and domestic violence, requiring multiple services and systems to provide a seamless system of care.

Building upon their history of cross-system planning efforts, the parties sought and were awarded a Technical Assistance grant from the National Center for Substance Abuse and Child Welfare (NCSACW) in 2005. This MOU is one of the products of the collaboration

among the parties conducted under the auspices of the NCSACW grant, and represents the agreement of the parties to put into effect the recommendations of the Family Recovery Collaborative team.

The purpose of this Memorandum of Understanding is two-fold:

1. To serve as the template for developing and implementing collaborative policy and practice among participating systems; and
2. To delineate the roles and responsibilities of the parties, as well as the parameters of information sharing, communication, problem resolution, and resource allocation.

III. Priorities and Goals of Collaborative Efforts

The priorities of the Family Recovery Collaborative are to address the issues confronting the children and families who are affected by substance use disorders. This population includes:

1. Families involved with DSS and the Juvenile Court where parents or caregivers have substance use disorders;
2. Children, youth, and families identified by DSS who are not court-involved but where parents or caregivers have substance use disorders;
3. Children, youth, and families in substance use treatment who are not involved with DSS but whose substance use disorder places them at risk for DSS involvement.

The goals of Family Recovery Collaborative are to:

1. Develop and implement an integrated system of care for families where substance use disorders are present such that these families, when identified by a system participant, receive immediate access to substance abuse service providers and collateral support services to engage parents and maintain children's safety and welfare. Services will also be sought to address a parent's mental health, trauma, and domestic violence treatment needs if identified.
2. Increase the systems' capacity to better serve families impacted by substance use disorders by (a) having DSS workers screen for substance use disorders and Indian Child Welfare Act (ICWA) eligibility at intake/assessment; (b) having contracted substance abuse service providers screen for child well-being and impact of parental substance use on child functioning; and (c) encouraging judges, probation officers, attorneys, and court clinicians to collaborate with and support parents in their treatment efforts;
3. Improve communication and information exchange among systems, practitioners, communities, consumers and families by developing and implementing standardized releases of information and informed consent forms;
4. Develop and implement a system of multidisciplinary training in SUDs, screening protocols, evidence-based interventions, children's mental health, child development and well-being, the impact of substance use on parenting, and culturally and gender-appropriate service delivery;

5. Improve access to culturally and gender appropriate services; and
6. Develop ongoing mechanisms of program evaluation to improve service quality, effectiveness, and sustainability to meet the needs of families across systems.

IV. Statement of Shared Values

The Family Recovery Collaborative establishes the following shared values and guiding principles:

- No one organization or system can address all of the substance use problems facing families and communities. Ensuring child safety and family health requires collaboration and partnership among families, professionals, agencies, organizations, and communities.
- Effective collaboration requires that individuals, families, systems, and communities value differences and diverse perspectives but seek to establish a common purpose that creates a shared vision for their community.
- Families experiencing alcohol and other drug problems often share histories of violence and trauma. Our systems should seek to work together in an integrated approach to minimize the possibility of further trauma and abuse.
- Every parent who has an alcohol or other drug problem should have a fair shot at recovery with timely and comprehensive treatment within their community. Every child who is experiencing his/her own alcohol and/or other drug problems, either directly or indirectly, should also have fair access to treatment and recovery.
- Services should be family-focused and needs-driven, utilizing best practices. Services should respect culture and language at all levels. Service standards must be quality-driven and maintained through a commitment to life-long learning.
- The needs of the children, youth, and families of the Wampanoag Tribe and other Native American families of federally recognized tribes residing in the Commonwealth are understood to be unique and complex because of their sovereign status and the historic failure by the American government to address these needs. Service delivery to this population should not only conform to the requirements of the Indian Child Welfare Act but also be culturally competent and delivered by well-trained providers.
- Every child has a right to be free of abuse and neglect, and a child's developmental needs take precedence over the timing of parental recovery.
- Safety and permanency are the birthright of every child in our community. The goals of the child welfare system and its partners are to support safe, nurturing, and permanent families for children within their community – where possible within the biological family and where not possible with another permanent family. In all

circumstances, compliance with the requirements of the Adoption and Safe Families Act of 1997 is paramount.

V. Initial Priorities and On-going Planning Efforts

The parties agree to develop an integrated system of care based upon the following priorities and plans, and acknowledge that these priorities represent the minimal level of service delivery and infrastructure development.

A. Initial Priorities for Practice

Initial priorities established in the approved Scope of Work include the following products:

1. Screening and Assessment

- (a) The parties shall choose screening questions/ protocols and integrate them into the intake/assessment policies and practices of both DSS workers and substance abuse providers. DSS social workers shall be trained to screen for substance use disorders, their impact on the child/ren in the family, and Indian Child Welfare Act eligibility during the intake/assessment phase for all new cases, document the outcome of these screenings, and make referrals according to interagency protocols to be devised by the parties. In addition, substance abuse practitioners shall include child and parenting focused questions in substance abuse assessment procedures and shall document the results of such screening in all case records. Policies to support consistent family-centered practice and data collection mechanisms shall be included in both substance abuse and child well-being screening procedures. The Juvenile Court should be consistently aware of substance abuse dynamics and the effects of SUDs on children and parents. The Court should support and encourage recovery efforts of parents and collaboration among systems.
- (b) The parties agree to develop and implement procedures for the sharing of information across agencies, including the judicial system to the extent permissible by due process and other legal considerations, that are consistent with applicable state and federal law. Such procedures shall include an informed consent process for participating parents that addresses the purpose of the screening and/or intervention, confidentiality of DSS, mental health, and substance abuse information and exceptions thereto, the purpose of sharing information across agencies, the use of such information in pending or future court proceedings, the right to revoke consent at any time, the right to ask and have questions answered prior to giving consent, and the expiration date of the consent. Children age 12 or older can consent to their own drug dependence treatment and therefore informed consent about the release of confidential treatment information must be obtained in the same manner from these children/adolescents. See G.L. c. 112, § 12E.

2. Client Engagement and Retention in Care

The chief priority for Client Engagement and Retention is the procurement of immediate access to substance abuse services for parents and children who are identified by DSS through a mandated report or by a voluntary request for services and substance abuse is determined, after screening, to be an issue affecting the parent's capacity to safely and adequately care for his/her child/ren. Formal collaboration between DSS and DPH/BSAS to develop a system of funded pre-treatment (engagement) and treatment options for identified parents shall be explored and each agency shall seek resources to underwrite these services. The goal of these services is for parents to engage and remain in community substance abuse treatment services to achieve recovery. One strategy to achieve this goal is for a parent to receive contact from a Child Welfare/Substance Abuse Specialist (e.g., a trained peer support person who is well-established in his/her recovery) at the time of entry into the system, that is, when the family engages with DSS to determine the family's strengths and needs. This Specialist shall refer and, if necessary, bring the parent to an appropriate substance abuse treatment program that has agreed to give first priority to parents involved in the DSS and Juvenile Court systems. If the parent must wait to enter a program, the Specialist shall serve as the maintenance resource for the parent until the parent is admitted.

Family engagement and retention practices shall be based upon best practice and/or evidence-based models for intervention with parents whose use of substances is impairing their ability to adequately parent their children and with children whose lives are negatively impacted by their parents' substance use. Where possible, the parties will strive to ensure that parents and children have access to necessary services in their communities. All best practice and evidence-based models must have demonstrated capacity for use with varying cultural groups as well as demonstrated sensitivity to gender issues in SUD treatment. The parties shall strive to engage practitioners with demonstrated cultural competence with the goal of developing a workforce that is reflective of the cultural diversity of the communities that they serve.

The parties shall develop systems of data collection to track important variables such as time from referral to service delivery, length of treatment, and treatment outcomes. The overall purpose of data collection is to assist in ongoing program assessment and monitoring of the efficacy of screening and intervention strategies. The parties agree to review and integrate the results of such assessment and monitoring into their ongoing planning and cross-systems collaborations.

3. Training and Staff Development

The parties shall establish a collaborative system of ongoing training to address the training and professional development needs of practitioners in the child welfare, substance abuse, tribal, and juvenile court systems as well as those who care for children affected by parental substance abuse. Input from consumers and the recovery community shall be sought in the development and implementation of this training.

B. On-going Planning

The parties agree to extend their collaboration beyond the expiration of the NCSACW Technical Assistance Grant on March 31, 2006, and develop a multiyear plan to implement and support the products of the grant. The parties recognize that it will take time to bring about the systemic change and collaboration envisioned by this project. The multiyear plan shall address the Ten Elements of System Linkage developed by NCSACW. The ten elements are:

- Underlying Values and Principles of Collaborative Relationships
- Daily Practice – Client Screening and Assessment
- Daily Practice – Client Engagement and Retention in Care
- Daily Practice – Services to Children of Substance Abusers
- Joint Accountability and Shared Outcomes
- Information Sharing and Data Systems
- Training and Staff Development
- Budgeting and Program Sustainability
- Working with Related Agencies
- Working with the Community and Supporting Families

The Massachusetts State Application for the In-Depth Technical Assistance Program was developed utilizing the Ten Elements of System Linkage provided by NCSACW, and it is on file for reference. The multiyear plan will also address relevant cross-system issues raised by the State Team.

Each party shall identify a staff person as the agency liaison who will be the point person for oversight of implementation, sustainability, and further development of the Multiyear Plan. This point person shall serve as the party's liaison, and will actively participate in meetings and subcommittee work of the Family Recovery Collaborative. Further, the parties agree to share equally in the administrative support of the project, including but not limited to hosting a quarterly meeting, providing administrative support for the distribution of meeting notices, taking and distributing meeting minutes, providing meeting space and refreshments, sharing costs of product development and dissemination, and any other similar support activity mutually agreed to by the parties. In recognition that the resources available to the parties are not equally distributed, a party may seek to offer a substitute in-kind service in lieu of, for example, hosting a meeting.

VI. Roles and Responsibilities for Implementing Collaborative Practice

A. Lead Agency Designation and Committees

The parties agree to participate and be mutually responsible for the implementation of the provisions of this agreement. In addition, there are specific roles and responsibilities as delineated in the approved work plan.

1. Lead Agency

For the purposes of the NCSACW In-depth Technical Assistance Program, DSS shall serve as lead agency. In this capacity, DSS shall be responsible for coordinating the Core and State Team meetings, in addition to coordinating all information and reporting requirements of the project with NCSACW. All parties agree to provide DSS with appropriate materials and a timely response to meet deadlines for meetings and other requirements and DSS agrees to meet its obligations and deadlines in a timely manner.

2. Oversight Committee

Oversight accountability for the project rests with the Commissioners of Social Services and Public Health, Chief Justice of the Juvenile Court, and Wampanoag Tribal Council Chairman as signatories to this agreement.

3. Core Team

System representatives from DSS, DPH/BSAS, the Court, and the Tribe comprise the Core Team and shall act in an executive capacity for the State Team.

4. State Team

The State Team is the main body of the Massachusetts Family Recovery Collaborative. It is comprised of state, tribal, and local system representatives, and includes providers, consumers, community agencies, and advocacy groups.

5. Work Groups

Work groups are composed of State Team members and other individuals as required to develop and implement specific products outlined in the work plan or as may otherwise be identified. Each work group will be Co-chaired by a member of the Core Team and a member selected by the work group.

B. Joint and/or mutual roles and responsibilities among the parties of this agreement include:

1. Information Exchange and Confidentiality

- a. DSS and DPH/BSAS, in collaboration with the Juvenile Court and the tribe, will develop a mutually agreed upon Release of Information and Informed Consent Form that will comply with the Federal and State Confidentiality laws.

- b. DSS and DPH/BSAS programs will obtain releases of information in accordance with Federal, State, and tribal regulations to allow exchange of information beyond accessing services or responding to child or family emergencies. The requirements regarding confidentiality of records in DSS and DPH/BSAS will be summarized and communicated to providers in each agency.
- c. Service agreements will be developed between participating agencies to allow the transfer of initial referral information, particularly to facilitate access to the appropriate service or respond to child or family emergencies.

2. Resource Allocation

Except as otherwise noted, nothing in this agreement shall be construed as obligating agencies to expend funds or be involved in any obligation for future payment of money or provision of resources. This instrument is neither a fiscal nor a funds-obligation document. Any endeavor involving reimbursement or contribution of funds between the parties to this instrument will be handled in accordance with applicable laws, regulations, and procedures including those for federal procurement, assistance, and printing. Such endeavors shall be outlined in separate agreements that shall be made in writing by representatives of the parties and shall be independently authorized by appropriate statutory authority.

The foregoing paragraph notwithstanding, and subject to other federal and/or state provisions, the parties do agree to seek and/or commit resources that enhance priority access to substance use services by families engaged in the child welfare system, maximize cross system funding opportunities and fund leveraging between the parties, and ensure a commitment to resource sustainability.

3. Conflict Resolution

The parties shall develop and disseminate protocols for resolving conflict between the parties. In general, disputes should be resolved at the level closest to the conflict. In addition to consumer rights and grievance procedures, these protocols shall delineate the process for resolving conflict among the system partners, based upon resolution at the lowest possible level and containing provisions or procedures for conflict resolution in the event such efforts are unsuccessful.

VII. General Terms and Conditions of Agreement

A. Term of Agreement

The term of this agreement shall commence on the date on which all parties sign this agreement and remain in full force and effect unless terminated in writing by agreement of all parties. Any party may terminate its participation in this agreement by giving forty-five (45) days written notice to the other parties. This agreement may be renewed or renegotiated upon written mutual consent of the parties.

B. Amendments

This agreement may be amended by mutual consent of the parties. Amendment within the scope of this Memorandum shall be made by formal consent of all parties, by the issuance of a written amendment, signed and dated by the parties.

C. Meetings and Communications

Meetings and communications among the parties of this agreement shall be conducted in the following manner:

1. The State Team shall meet, at a minimum, on a semi-annual basis or more frequently as required. The purpose for State Team meetings is to facilitate ongoing inter-agency planning and collaboration, and will be used to identify needs, seek input, and develop strategies for improved policy and practice. The agenda and format for State Team meetings shall be developed by the Core Team and shall be sent to the State Team in advance of the State Team meeting. Responsibility for the logistical requirements of these meetings shall rotate among the parties.
2. The Core Team shall meet at least monthly or more frequently as required to review the provisions and operations set forth in this agreement. These meetings shall be held either in person or through teleconference, and minutes will be distributed and kept on file by DSS.
3. Work Groups shall meet as needed. Agendas for the work groups shall be developed by the Co-chairs and sent to work group members in advance of the meeting. Minutes of the work group meetings shall be sent to the Core Team and kept on file by the Co-chairs and DSS.
4. The Commissioners of the Departments of Social Services and Health, Chief Justice of the Juvenile Court, and the Chair of the Wampanoag Tribal Council shall convene at least once prior to the termination of this agreement to receive a report from the Departments and to determine what future actions, if any, need to be taken.

D. Approvals

This document has been reviewed and approved as to form and content.

E. Notice

Notice to the parties in connection with this agreement shall be given by service in person or by first class mail addressed as follows:

Commissioner Harry Spence
Department of Social Services
24 Farnsworth Street
Boston, MA 02210

Commissioner Paul Cote
Department of Public Health
250 Washington Avenue
Boston, MA 02108

Chief Justice Martha P. Grace
Administrative Office of the Trial Court – Juvenile Department
3 Center Plaza, Suite 520
Boston, MA 02108

Donald Widdiss, Tribal Chairman
20 Black Brook
Aquinnah, MA 02535

IX. Signatures

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the day and year first written below.

BY: _____ Date
Commissioner Harry Spence
Department of Social Services

BY: _____ Date
Commissioner Paul Cote
Department of Public Health

BY: _____ Date
Chief Justice Martha P Grace
Juvenile Court

BY: _____ Date
Donald Widdiss, Chairman of the Tribal Council
Wampanoag Tribe of Gay Head (Aquinnah)