

## OVERVIEW

Goal—The goal of Module 5 is to provide child welfare professionals with an in-depth understanding and recommended techniques for incorporating information about an individual or families' substance use, mental disorder, or co-occurring disorders and treatment into the child welfare case plan, and to assure the delivery of culturally competent services, as well as how to monitor progress. In addition, this module will provide child welfare professionals with an understanding of the importance of collaborating with other service providers in developing and monitoring a family's case plan.

Methods: PowerPoint presentations (or overhead/transparencies); large group and small group discussions.

Training Aids: Projector and computer, disk with PowerPoint file (or overhead and transparencies); flip chart with markers; participant notebook.

Time: 2 hours, 50 minutes

Learning Objectives—After completing Module 5, child welfare professionals will have an understanding of the following topics:

- Child and family service delivery system and competencies.
- Integrated helping systems (e.g., systems of care)
- Developing culturally relevant comprehensive case plans and monitoring progress
  - Incorporating substance abuse treatment components
  - Incorporating mental health treatment components
  - Incorporating co-occurring issue treatment components
  - Critical role of collaboration with other service providers
- Monitoring comprehensive case plans
  - Importance of on-going assessment and reevaluation
  - Critical role of collaboration with other service providers
- Transition and permanency planning
  - Importance of early planning for transition and permanency
  - Relapse and relapse prevention
  - Establishing/ensuring community support systems
  - Critical role of collaboration with other service providers
- Ways to encourage/support collaboration with other service providers

**Prior to start**                    **Meet and greet, registration**

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***Purpose is to give participants access to the space. Each will prepare differently, arrive at different times. Conduct registration and distribute materials. Trainers get ready.***

**0 – 15 minutes**                    **Introductions; Purpose; Ground Rules**                    **15 min.**

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***Trainer introduces him- or herself. Invite participants to briefly introduce themselves (e.g., name, unit, office location, years in the system, etc.). If this same group has been together for other modules in this series, you might substitute by asking them how they used information learned in previous sessions in place of introductions. If group is smaller than 12-15 people, trainer can invite them also to briefly describe their interest in this training. If group is larger than 40-50 people, individual introductions are likely to take too much time.***

***Describe the purpose of Module 5. Language for this overview is provided below, at the beginning of the presentation scripts, right before Presentation 15. Emphasize that child welfare professionals often work with families where one or more adults are experiencing substance use and/or mental disorders and this training is intended to prepare them to better help such adults recover from the effects of their disorder and function appropriately as parent or caregiver. The bottom line goal is safe care of children. The following paragraphs also describe four simple ground rules for the training session. After presenting them, the trainer may ask the group if there are any other ground rules important to them.***

**[Slide V-1] Module 5: Developing a Comprehensive Response for Families Affected by Substance Use Disorders, Mental Disorders, and Co-Occurring Disorders**

Good morning! (afternoon/evening) Thank you for being here today and welcome to this training. This curriculum has been designed specifically for you, for child welfare professionals, and will give you relevant information and opportunities to practice skills useful to your work. In particular, this Module is designed to educate you about helping parents or primary caregivers who may experience substance use or mental disorders – how to support their planned treatment; how to find and use assistance in the community; how to understand change and recovery; and how to ensure that parents feel hopeful about the prospect of positive change.

We all know that many of the families whose children come into state custody and for whom you provide help are experiencing some effects from substance use and/or mental disorders and we know that those disorders are treatable. This curriculum is designed to help you better help them succeed in treatment.

The information in this module assumes that you already have a basic understanding of substance use and of mental and co-occurring disorders. In addition, this module assumes you have a basic understanding of screening and assessment for substance use, mental and co-occurring disorders. In this module, we are going to examine the process for developing case plans that incorporate substance abuse, mental health and co-occurring treatment components. In particular, this module is going to focus on the need for collaboration with treatment professionals, and strategies to support that collaboration.

Today's session is going to include several informational presentations as well as several opportunities to talk about this information and its relevance to your work with each other in small groups and as a whole group. In our time together, I ask that we: 1) treat each other with respect; 2) talk only one at a time; 3) give each person the opportunity to participate; and 4) think about how to take new learning back to your job responsibilities.

## PRESENTATION 15

15 – 35 minutes      ***Presentation 15: Community service systems;  
collaborative work with integrated systems***      **20 min.**

***Deliver scripted presentation about community services and integrated care systems. Slides V-2 through V-10. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief. Only answer questions to which you know the answer.***

In this presentation we'll begin with a general discussion of the child and family service delivery system, competencies within that system and integrated systems work.

### **[Slide V-2] Family Services delivery system and competencies within that system**

Child welfare is one of many government agencies that organize, fund and monitor services in the community. Each State organizes service agencies differently, and for most types of services there are also Federal requirements and funding, which are again organized uniquely. Refer to Handout *Components of Family-Centered Treatment*.

### **[Slide V-3] All States Offer:**

But beyond the differences, all States use State and Federal resources to offer services that can impact parents you come in contact with:

- All States offer *health* programming of various types, some with low or no cost to the recipient.
- All States offer *child welfare* services, including protection, placement and permanency, although the assignment of delivery and management responsibilities are unique within each State. For example, some are supervised and run by the state; others are supervised by the state and run by the county; and still others are supervised and run by the county.
- All States offer some types of *substance abuse and mental health treatment*, ranging from institutions to a wide menu of community-based treatment options.
- All States maintain services through a *criminal justice* system, but the organization and administration of courts and institutions that will potentially serve families are unique to almost every community.
- Services for persons with severe *developmental disabilities* are offered in all States, with varying eligibility requirements governing who is included.
- All States offer organized *public education* systems, but in most States the decision-making control over schools resides at the community level.
- *Job training and support*, usually with substantial Federal support, is offered in all States, but eligibility varies by State.
- *Public assistance* – this is financial and living support for people with high needs – also includes substantial Federal support and is available in all States in varying formats.

- Additionally, there are publicly funded *housing* options in most states, publicly funded *transportation* (many offering specialized assistance to persons with physical disabilities), economic and *small business support* programs, and many other types of programs that might be of assistance to families served by the child welfare system.

It is important to remember that all of these organizations operate differently. To help your families you must learn all you can about those different organizations, finding out the realities of how they operate within your community, in service to your families.

#### **[Slide V-4] Family Service Competencies**

There are some very specific competencies that are necessary if you are going to successfully serve children and their families within those public service systems. In this curriculum, we use the term “competencies” to refer to the *attitudes*, *knowledge*, and *skills* that helpers must develop and use, with system support. *Attitudes* are the reflection of inner feelings and beliefs. *Knowledge* is specific, factual information relevant to the helper’s role. *Skills* develop as the consequence of applying the knowledge to day-to-day experience, always tempered through the lens of attitude, and guided through supervision (Pennsylvania CASSP Training and Technical Assistance Institute, 1995).

Successful service to children and their families requires the development and support of competencies in three distinct work areas: *children and adolescents*; *families*; and *community collaboration*. One role of the child welfare professional is to give every child the best possible chance to grow up to become a satisfied and contributing adult. That role requires competencies in communicating with children and adolescents and in understanding child and adolescent development. A second role is to understand problems that parents and caregivers (adults) might be facing, with some empathy for the stressors parents may face as they struggle to raise their family. Finally, you will not be able to solve everything that confronts families as they try to raise their children. Understanding and developing alliances with other helpers forms a more effective network around each child and family.

#### **[Slide V-5] Adoption and Safe Families Act Timetables**

Refer to Handout *Adoption and Safe Families Act Timeline*. Key timeframes in the Adoption and Safe Families Act (or AFSA) make it necessary to quickly develop collaborative relationships with others who might be providing support to families, particularly if those families are affected by substance use, mental or co-occurring disorders. Let’s briefly go over those timetables.

Time-limited family reunification services are those provided to a child and family where the child has been removed and placed in foster care. Family reunification services must be provided in the first 15 months from the date the child enters foster care. Each child must have a case plan that places the child in a safe environment using the setting that is most like that of a family (also called “least restrictive”) that is available and in proximity to the parents’ home, consistent with the best interests of the child.

A case review is conducted on the status of each child in foster care no less than once every 6 months, either by a court or by the child welfare agency. Case review determines safety of the child, continuing necessity for placement, extent to which the parents have complied with the case plan, progress toward alleviating the circumstances that required placement, and projection of a date by which reunification is likely to take place.

Each child must also have a permanency hearing, usually held in a family or juvenile court, no later than 12 months after the child enters foster care and not less than every 12 months

thereafter while they are in foster care, depending on the State statute. This hearing determines the permanency plan for the child.

***[Note to Trainer: As an optional activity, this section can be formulated into a quiz that the group completes together rather than as a didactic presentation.]***

**[Slide V-6] Adoption and Safe Families Act Timetables (cont.)**

When a child has been in foster care for 15 of the most recent 22 months, the State must request a petition to terminate parental rights, unless one of these three conditions applies: (1) a relative is caring for the child, (2) there is a compelling reason that termination would not be in the best interests of the child, or (3) the State has not provided the family the needed services within the required deadlines. A State agency can document in the case plan a *compelling reason* for determining that filing such a petition would not be in the best interest of the child.

One situation that might suggest that termination of parental rights and adoption are not appropriate goals for the child is if a parent is attending a substance abuse treatment program. A compelling reason might be a good prognosis for completing treatment based on clear evidence of substantial progress in abstinence and parenting, such that the child is likely to be able to return home safely within the next six months. The Center for the Study of Social Policy recommends, unless there are extenuating circumstances, this factor should not be invoked more than once (Center for the Study of Social Policy, 2005).

- To learn more, review *Criteria and Procedures for Determining a “Compelling Reason” Not to File a TPR* written by the Center for the Study of Social Policy. The link is provided on your resource list.

To illustrate this concept, we are going to read the case vignette for Module 5—and we will use this case study for further discussion of these concepts.

**[Slide V-7] Developing a Comprehensive Response**

To help families achieve their goals, particularly under the faster timelines set by ASFA, you will need to work with professionals from all the other systems the families are involved with. Refer to Handout *Dimensions of Trust*. These are some guidelines for working with substance abuse and mental health treatment professionals:

- Recognize differing perspectives. Child welfare workers, substance abuse treatment professionals and mental health treatment professionals have different types of knowledge about the parents they serve and different experiences and relationships with them. Likewise, each system has its own requirements and strategies for working with families.
- Share knowledge. To maximize the ability of each system to help parents, it is important that key professionals share knowledge about the resources and practices of the systems, and about the needs and experiences of the parents and children. At the same time, we must respect each other's professional concerns and statutory mandates. Consistent sharing of this kind of information will allow professionals to support each other's requirements and the desired outcomes for the parents

**[Note to Trainer: As an additional discussion, you can ask participants “Which systems are involved with Irene and Daniel’s family? What are the time constraints imposed by each?”]**

### **[Slide V-8] Community Care Systems**

Each individual is a complex, unique human being and helpers must recognize this reality if they are going to be effective. Help for complex and unique needs is likely to require more than one helper. But the collective work of many helpers can only be effective if it is coordinated and aligned. Expecting a person or a family that is already struggling with the challenges that bring them to the helping systems to coordinate their own care among multiple helpers is unrealistic and ineffective for most people.

Therefore, effective care within any community takes place when helpers have opportunities and mechanisms to help them coordinate the collective care provided by the community. Leaders in many systems and agencies must come together and organize those opportunities and mechanisms, for both helpers and receivers of help, and create a true community *system*. Persons who need and/or receive community services must be included in every step of system-building.

### **[Slide V-9] System of Care Approach**

A current model describing integrated community helping systems is the called a “System of Care.” Refer to Handout *An Overview of Systems of Care in Child Welfare*. This approach, developed in systems that serve children and their families, involves many helping agents and is designed to serve many populations of need, whether publicly funded or not. In this model, all helping systems (*public health, child protection, community protection, day care and education, mental health treatment, substance abuse treatment, domestic violence, and developmental disability treatment*), including all formal and informal resources, align their strategies to keep children safe in their homes and in their community. They also create appropriate developmental opportunities. The goal of everyone in a care system like this is for children to grow up successfully to adulthood with the support of their families (Stroul and Friedman, 1994).

On this slide are listed the elements you will find in effective care systems (Stroul and Friedman, 1994):

- They build on a foundation of shared values and principles that community members hold about the care of children and families with needs. Those principles guide all decision-making.
- They develop differently in each community, but they hold certain principles, functions, and outcomes in common. It is possible to learn from each other, and it is necessary to adapt almost every process to succeed in each specific community.
- They create a shared community system infrastructure, establishing ways to manage interagency decision-making, leadership, funding, resource allocation, service planning, coordination of care, research and evaluation, quality improvement, and other key functions.
- They ensure, encourage and even seek out continuous feedback from and participation by the children and family members receiving services. “Nothing about me without me,” is a current and poignant expression about how important it is to include recipients in decisions that affect them. The input of children, youth, parents and other family members can really help us understand the best way to address the needs they bring to the care system.
- They employ comprehensive quality improvement strategies, both within and across systems and agencies, which is another way of saying that they attempt to do better tomorrow than today. Communities as a whole have to examine the impact of publicly funded services on community members. Data from a single agency or system cannot represent the experience of a whole community, and –if you want to paint a meaningful

picture of community service success or failure—you need to collect, analyze, and report data across all of a community’s helping agencies and systems.

***[Note to Trainer: As an additional discussion, you can ask participants, “How do the systems involved with Daniel and Irene provide services and evaluate quality?”]***

**[Slide V-10] Integrated System Approach: Considerations**

The information I just presented is not an in-depth study of integrated systems. But I hope it does give you an understanding of the concepts that lie under the system of care model, as one example of an integrated system approach. As we think about these concepts, there are three things we need to consider:

- First, how much does the system in your community function following these concepts? Find out how the systems in your community function. Is your community or State moving toward an integrated system approach, and if so, in what ways?
- How well does your agency work in these kinds of partnerships? How often does your agency partner with other agencies, with what organizations does your agency partner, and how do those partnerships play out?
- And finally, consider your own ways of practicing. Think about the extent to which you reach out to other partners, and how do you respond to partners who may reach out to you?

***[Note to Trainer: As an additional discussion, you can use these questions as a facilitated discussion or as small group discussion with a report back. This can be done either in conjunction with or separate from the following facilitated discussion.]***

**35 – 55 minutes      Facilitated Group Discussion      20 min.**

***Once questions have been addressed, move the whole group into a discussion about the differences between ideal service systems, where everyone works together, and the realities of the systems in which these workers work. Begin the discussion by asking:***

***You have heard about a lot of principles and practices in communities that collaborate actively in their services for families, but—in your experience—how real do these practices seem? What kinds of collaborative practices take place in the real world where you work?***

***To stimulate discussion, you might ask any of the following questions:***

- ***What collaborative practices do you personally participate in?***
- ***What collaborative practices do you wish would happen in your community, but in reality don’t?***

***The GOAL of this discussion is to help participants recognize that there are collaborative practices operating in their system and that there are better ways to help families than are employed in many communities. Try not to let one participant dominate the discussion; draw in others to the discussion.***

***To bring closure to this discussion, emphasize that no community service system is perfect and that the strategies and characteristics that have been presented represent ideal practices we all want the system to move toward. Furthermore, we each have to be a good partner in order to have good partners.***

## PRESENTATION 16

55 – 80 minutes

**Presentation 16: Culturally relevant case plans;  
measuring progress**

**25 min.**

***Deliver scripted presentation on helping parents through appropriate case planning strategies and measuring their progress towards case plan goals. Slides V-11 through V-31. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on. Keep answers brief. Trainer should only answer questions to which you know the answer.***

### **[Slide V-11] Information Provided by Substance Use and Mental Health Assessments**

#### **Developing culturally relevant comprehensive case plans and how to monitor progress**

Once an individual has been assessed for substance use, mental or co-occurring disorders, there are several pieces of information you can expect from the treatment provider, which will be helpful to you in developing case plans:

- An assessment will provide a diagnostic label and a number code that coincides with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) system for coding diagnoses. A substance abuse treatment professional will make a diagnosis of a substance use disorder and a mental health treatment professional will make a diagnosis of a mental disorder. A person might receive multiple mental disorder diagnostic labels if he or she meets the criteria for more than one mental illness. If there is a diagnosis of a substance use disorder and a diagnosis of a mental disorder, then the individual is considered to have co-occurring disorders.
  - There are often questions about whether a biological basis for a mental disorder can be identified, and that might require further testing and/or assessment by a professional with more specialized skills and tools (such as a neurologist). Certain professionals have expertise in particular diagnoses and obtaining a specialized assessment may help focus a more effective course of treatment.
- An assessment of a substance use and/or mental disorder will also include recommendations about treatment and level of care, based on the severity and type of disorder, whether there are co-occurring disorders, and any other factors that are identified during the assessment
- A treatment plan for comprehensive services will generally be recommended.
- Recommendations for how other service agencies (such as child protection or justice systems) can respond most effectively to the person's mental disorder may or may not be included in this type of assessment.

***[Note to Trainer: Child welfare professionals should be sure that the questions they need answered are included in the referral made to the treatment agency. Otherwise, the assessment may not yield the kind of information that will be helpful to case planning. Find out the process for asking questions during the referral process to provide suggestions to participants.]***

### **[Slide V-12] Developing Case Plans**

Effective case plans that address underlying problems of substance use and mental disorders can help child welfare professionals assess the safety and well-being of children throughout the life of the case. It can also help motivate parents to enter and continue treatment.

Child welfare professionals already know the importance of establishing an initial relationship with parents that demonstrates an interest in and concern about their well-being. You also know how to use social work competencies, such as documentation, observation, and interviews, to determine what has happened to the parents and children and to establish a case plan.

You can use these same techniques with parents and children to explore issues relevant to substance use or mental disorders, focusing especially on the parents' feelings about safety and their experiences with trauma. Some child welfare agencies may already have specific protocols and procedures in place, which can be expanded to incorporate some of these issues.

***[Note to Trainer: A review of motivational interviewing techniques would help to reinforce these skills, if they have been practiced, and their applicability.]***

### **[Slide V-13] Child Welfare Case Planning: What You Can Do**

When an assessment leads to a diagnosis (or multiple diagnoses) and recommendations for treatment, a child welfare case plan should include whatever actions might be needed to help that individual obtain the recommended treatment, hopefully within their community and provided in a timely manner by a professional qualified to respond to their needs. This might include a wide menu of supportive actions.

A child welfare professional's role may be to address social, economic, motivational, or other needs that enable the person to accept and receive the recommended treatment, while child safety is monitored. If parents show motivation to address their own needs in order to become better able to care for their children, try to take advantage of that motivation – it can be very powerful.

**[Note to Trainer: As an additional discussion, you can ask participants “ We know of some of Daniel and Irene’s diagnoses—how would we go to work on planning and providing services for them?”]**

### **[Slide V-14] Culturally Competent Case Planning**

To develop culturally relevant case plans, child welfare professionals need to understand that culture plays out primarily within the family. Therefore, in your work to help a family safely raise their children, you need to learn about that family's culture, which in this curriculum is defined as their *beliefs, traditions* and *values*.

Organizational cultures, such as those of community service organizations, will also impact how an individual worker perceives the needs of families they are trying to serve. You need to think about and understand your own agency's culture, as well as the influence of your personal culture. Successful work with families takes place in agencies where the organizational culture strongly supports effective practices by staff.

After learning about a family's culture as well as the culture of your organization, you can use the beliefs, traditions and values important to that family as starting points or building blocks for interventions. Likewise, as long as safety is maintained, be careful not to devise strategies or interventions that are in conflict with the family culture— that conflict will greatly decrease your effectiveness.

### **[Slide V-15] What Goes Into a Case Plan**

Every case plan should be unique, expressly designed to reflect the strengths, needs and culture of a particular individual and family. Case plans are generally not brief, especially when needs are multiple, complex, and/or long-standing. In general, a good case plan will include a listing of these things: a) strengths and resources, b) needs, c) goals and objectives in each need area, d) services and supports directly designed to build on the strengths to address needs, e) target dates for reaching goals and objectives using services and supports, f) persons responsible for all listed actions, and g) indicators that will demonstrate success or lack of success in meeting specific goals and objectives. In developing case plans, you want to always consider how to make use of the family's culture and natural supports.

Social workers will want to seek information from the family and other helpers about progress towards goals and objectives identified in the case plan. Progress, or lack of progress, should always be noted. Lack of progress means something is not right about the plan – if it is not working, change it. Do not automatically assume lack of progress means the person is not doing enough or is not capable of changing.

### **[Slide V-16] Help Parents Prepare: Know Resources**

How can child welfare workers partner with treatment programs to prepare parents for their treatment? You need to know about treatment resources, organizations, and practices in their communities. With this information, the parent can establish successful partnering relationships with treatment professionals regarding their jointly shared consumers. You need to:

- Know the extent and range of treatment resources available to parents in their communities;
- Understand the characteristics of the various treatment programs;
- Understand the services that the programs provide; and
- Understand the requirements, expectations, and conditions for participating in treatment.

***[Note to Trainer: As an additional discussion, you can ask participants “How would knowing this information be critical to helping Irene and Daniel?”]***

### **[Slide V 17] Partnerships With Treatment Professionals**

Establish partnering relationships with treatment professionals where you learn about each other's agency, and then, when appropriate, share information regarding children, adults, and families being jointly served. This includes understanding how Section 42 of the Code of Federal Regulations (C.F.R.), part 2 (for substance abuse treatment), and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Requirements (for all health-related information, including substance abuse and mental health treatment) impact how information can be shared. Most important, each child welfare professional must understand the meaning and use of *informed consent*, which is the foundational concept that drives these important Federal protections. Informed consent will be discussed later in this module

### **[Slide V-18] Help Parents Prepare – Gather Information 1**

Child welfare professionals need to develop a knowledge base about the treatment programs they refer parents to. These are some of the areas where you want to gather information from treatment programs that are collaborating regarding specific parents:

- Mission of the programs;
- Policies, rules, procedures, and statutes that must be followed to deliver services; (especially confidentiality requirements and procedures);

- The amount of time participants are expected to commit to the program;
- Funding sources and limitations on spending; and
- How the program defines and measures success.

**[Slide V-19] Help Parents Prepare – Gather Information 2**

And here are a few more things you want to know about the programs:

- Language, terms, and acronyms (develop a common understanding of each other's language and meanings of words);
- Staffing structure of organizations and who makes decisions about which issues;
- Formal and informal communication within the programs; and
- What programs can offer each other in a collaborative relationship.

**[Slide V-20] Referrals and Expectations**

Child welfare professionals can help parents with the treatment program referral process. You can provide parents with contact information and recommendations, and assist them in following through with the referrals. Refer to Handout *Use the Treatment Facility Locator*. The SAMHSA Substance Abuse Treatment Facility Locator is a searchable directory of substance abuse treatment programs throughout the country. This easy-to-use online resource includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism.

***[Note to Trainer: Refer to Module 2, Presentation 6 for more information on the SAMHSA Treatment Facility Locator.]***

You can also learn about treatment programs' services, expectations, and requirements. Convey this information to parents to help them know what to expect and what to do.

Child welfare professionals are not expected to be treatment specialists. Once a parent has received an initial referral to treatment, the treatment program will conduct additional assessments and determine if it is the best available choice or whether the parent needs to be referred to a more appropriate treatment resource. Child welfare workers can also develop an understanding of why a particular treatment setting is or is not appropriate for a parent.

**[Slide V-21] Help Parents Prepare: Suggestions - 1**

When helping parents with in-home services, provide them with opportunities to improve parenting skills and interactions with their children, just as you would with any family on your caseload. Help parents set up a household that offers stability and continuity for their children. Develop safe arrangements for children when parents are having difficulty being available to children because of substance use or mental disorders.

When helping parents whose children are in foster care, support parents' participation in treatment so that they can meet dependency court requirements and participate fully in visitation rights. Some parents may need very concrete instructions and suggestions regarding visitation with their children (e.g. appropriate clothing, behavior, words). Help parents get help to set up a household once treatment is well underway and dependency court requirements are being met. Collaboratively work with treatment providers to address relapse

**[Slide V-22] Help Parents Prepare: Suggestions - 2**

Here are some other suggestions. You'll want to keep treatment providers informed about the dependency court schedule of hearings and their outcomes and keep the court informed about parental progress in treatment and problems that the judge is addressing throughout this

process. When it is possible and appropriate, invite treatment professionals to hearings and to offer testimony. In addition, treatment providers need to know the point in the case when a parent seeks treatment. For example, parents presenting for treatment immediately after their children are removed will express different motivations and behavior than parents whose Termination of Parental Rights hearing is approaching.

### **[Slide V-23] Measuring Progress – 1**

Even through treatment counselors and child welfare workers may share the same recipients of services, they do not always measure and define progress the same way:

- For many substance abuse treatment professionals, progress is measured in two ways:
  - First is whether the person's treatment is resulting in increased periods of sobriety and decreased periods of lapse or relapse.
  - Second are the scope and durability of changes people are able to make in other areas of their lives so that sobriety will be maintained (things like satisfying employment; building a support system; or attending self-help groups).
- For many mental health treatment professionals, progress in the Recovery Model is measured by the quality of life experienced by the individual, which would be reflected in a decrease in problematic effects from the disorder and an increase in positive, supportive life experiences. Progress may also be demonstrated by the person's increasing understanding of the disorder he or she experiences and self-management of the symptoms, in ways that benefit both themselves and society.

Publically funded treatment providers and child welfare agencies also measure progress according to the National Outcome Measures and the Child and Family Services Reviews measures. Refer to Handout *Child and Family Services Review* and Handout *National Outcome Measures*.

### **[Slide V-24] Measuring Progress - 2**

- Child welfare professionals and dependency court judges can measure progress in similar ways. They will both look at whether the parent is fully participating in treatment and all the services that are being offered and whether improvements are being made, especially in relation to the safety and care of children. However, the parent also must accomplish these outcomes within the strict statutory deadline established by the court to provide a safe and nurturing home for the children.
- There are also many shared views among all professionals working with the parent and family. Child welfare professionals and treatment professionals depend on a parent's participation in treatment to accomplish the basic goals required by each system. All depend on a parent's motivation to achieve the conditions that will result in retaining or reuniting with children. As they work on their respective system goals for parents, each professional is also working toward a larger, common goal of restoring health to the parents and their families.

***[Note to Trainer: As an additional discussion, you can ask participants "How can you tell whether or not Irene is making sufficient progress toward her treatment goals?"]***

### **[Slide V-25] Collaborative Case Planning**

I'd like to talk a little about how to work as part of a care planning and/or service delivery team. As we discussed earlier, child welfare professionals must coordinate closely with treatment professionals when working with parents who need or are receiving treatment for substance use or mental disorders. How do you do this? You will want to prepare case plans with families that

include activities, objectives, and service strategies that will help parents meet child welfare and dependency court requirements for the safety and well-being of their children. When workers are collaborating with other professionals, case plans need to incorporate joint goals and activities that are mutually supportive and informative. These are a few ways that workers and counselors collaborate in 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 staff and family.
- Discuss confidentiality protections fully with parents and seek their consent to share appropriate and helpful information.
- 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.
- Identify indicators of parents' capacities to meet the needs of their children and outcome data pertaining to the case plans.
- Regularly monitor progress and share with treatment professionals.

#### **[Slide V-26] Sharing Information in a Service Delivery Team**

When collaborating with treatment professionals, you should also share new information with treatment staff when there are changes that might create stresses for the parents or that might affect the parents' participation in treatment. These might include:

- When visitation with children is being increased or unmonitored visits with children are being instituted.
- Meetings are scheduled with the social workers.
- 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 plans.
- The schedule of court hearings and any changes that occur in the court calendar.

#### **[Slide V-27] Co-Occurring Necessities**

The most important variables in providing treatment for co-occurring disorders, assuming more than one provider is involved, are *communication*, *coordination*, and *consultation* between all involved providers (CSAT, 2005). Most people with co-occurring disorders need to receive consistent information and care if we expect them to make progress. The child welfare professional may be the key person who assures that the communication and coordination take place as the case plan is implemented and monitored for a particular family.

If there are differences in how the respective professionals are viewing or attempting to treat the individual, the person receiving care is best served by getting the professionals together to find agreement about care of the person. One of the most effective ways to bring everyone on to the same page is to form an individualized family team, including everyone working with that family.

#### **[Slide V-28] The Role of the Team**

Once professionals are gathered together, teams must find an "individualized course of action" (Child Welfare Policy and Practice Group, 1999) for each child and family, that has these characteristics:

- It must be "strengths-based."
- It needs to be inclusive of and responsive to family needs.
- It should be highly individualized.
- It should be heavily reliant on assistance from the family, the family's natural helping system, and formal and informal community stakeholders.

Teams need to be structured so that they can do these things (Child Welfare Policy and Practice Group, 1999):

- Engage with the child and family;
- Ensure appropriate and adequate assessment(s) to determine the child's needs and information necessary to choose appropriate interventions;
- Develop and implement a course of action, as articulated in a service plan;
- Track progress and implement mechanisms to address emerging concerns; and
- Sustain and support child and family change over time, as needed.

***[Note to Trainer: As an additional discussion, you can ask participants “How can Daniel’s caseworker, Irene’s counselors, Irene, Daniel and Daniel’s foster parents work together as a team?” If time permits, use this opportunity to engage in an optional discussion. Ask the group: “How many of you have been involved in some type of team family decision making?” “What was your experience?” “What were the advantages or disadvantages for the family you were serving together?”]***

***[Note to Trainer: Depending on the structure of the child welfare office in your locality, the following section may refer to policies and procedures that are set by management. They may not be the audience and line workers might feel powerless to effect these changes in practice.]***

#### **[Slide V-29] Team Conference Process - 1**

There are many examples of structured processes that bring together families and the professionals involved in their case. These can be called Family Group (or Team) Decision Making Meetings. I’m going to walk you through a Team Conference Process (with permission from Child Welfare Policy and Practice Group)—this is an excellent example of the structured processes that are being implemented at the community level across the country. Many other models in operation share components with this particular example.

The first component of this Team Conference Process is information gathering and assessment. This includes discussing, with the family, the family’s and the child’s strengths and needs; reviewing all available information, assessments, social histories, court reports, etc.; and signing informed consent release authorizations. This is the time to obtain additional assessments, as may be needed.

The second component is preparation for the Family Team Conference. A Family Advocate helps identify outcomes the family desires and prepares the family for the meeting. This Family Advocate is either someone the family identifies or someone child welfare appoints. This Meeting should identify and include all persons who could contribute to family’s success. So, in addition to scheduling the meeting, you need to be sure to invite these participants to the conference process. If the parent needs or is involved in substance abuse treatment, a substance abuse treatment professional should be invited to participate in the conference process to the extent that is appropriate. Likewise, if the parent needs or is involved with mental health treatment, a mental health treatment professional should be invited to participate in the conference process to the extent that is appropriate.

In the actual Family Team Conference, begin with introductions and describe the purpose, process, and confidentiality expectations. Establish “ground rules,” as simply as possible, and support participation by everyone. Begin the planning process by providing a summary of the child and family’s strengths and needs. Identify and agree on strengths and needs before suggesting services or supports. For children in substitute care, identify needs for family contact

necessary to maintain attachment with child. Develop goals that address needs and risk factors. Should needs or risk factors be related to substance use or mental disorders, ensure that treatment professionals are engaged in developing realistic goals. Setting goals includes describing how progress can be tracked. Blend short- and long-term goals, and prepare for goals to change over time.

**[Slide V-30] Team Conference Process – 2**

During a Family Team Conference, brainstorm strategies for meeting goals. Raise and consider many possibilities, without regard to what already exists. Include consideration of all persons who might be in the child and family’s life. This is the time to be creative. When goals need to be developed for substance abuse or mental health treatment, ensure that treatment professionals are engaged in identifying strategies to meet goals.

After considering a wide range of possibilities, select actions, services, and supports. Match actions to needs, and set reasonable, feasible, time-limited goals. Always identify what, by whom and by when. Mix “services” and “supports” in response to family preferences. And always discuss potential crises and steps to take if/when those crises occur, including substance abuse relapse or recurrence of the symptoms of the mental disorder. At the end of the meeting, no matter the process or the outcome, thank everyone for their time and efforts, set a date for the next meeting or when a regular review will take place, and ensure that members will get written copies of the resulting plan, and get signatures from everyone involved.

Finally, you need to be sure that follow-up happens in a timely manner. Prepare and distribute written copies of the plan as soon as possible. Check after about two weeks to ensure that interventions have begun as planned. Assess progress with child, family, and relevant others, and reconvene as needed.

**[Slide V-31] Managing the Team Process**

This is just one formalized way in which to operate a team planning and care process. The creators of this approach would say that their approach is not the only one likely to be effective and that, in fact, teams tend to be most successful when following a process they have helped to design and/or designed collectively at the community level. Regardless of the structure used in your community it is important to involve treatment professionals as appropriate and indicated by the risk and needs assessments. In the process it is also important to learn about each other’s systems. Share information relevant to the needs of the child and the treatment progress of the parent, while abiding by confidentiality requirements. As with any group process, it is important to monitor the impact of team process and adjust the plan as needed.

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**80 – 95 minutes      *Break*      **15 min.****

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**95 – 115 minutes      *Facilitated Discussion of Case Vignette*      **20 min.****

***On their return from the break, ask participants to organize themselves into smaller discussion groups with 5-7 people in each group. Ask them to each quietly read Module 5 Vignette, at the end of this guide, which describes a real family involved with the child welfare system.***

***Then ask the small groups to discuss the Vignette for a few minutes, specifically:***

- 1) *What progress has been made?*
- 2) *What progress needs to be made to support family reunification?*
- 3) *How might the case plan goals and objectives be changed to better reflect the needs of the family and to be more likely to lead to success, including any adjustments for cultural reasons?*

*After just 9-10 minutes, ask them to bring their attention back to the larger group (no need to move seats again) and ask them to share a bit from their small discussion groups. In particular, ask,*

*“What kind of changes did you talk about making in the case plan?”*

*The GOAL of this discussion is to help participants apply the content of the session to a real family situation. Try not to let one participant dominate the discussion; draw in others whenever possible.*

*To bring closure to this discussion, emphasize that progress on personal life needs is not always clear-cut, nor does it always follow a straight line forward. Encourage them to talk with supervisors and co-workers to find out what they think about how to measure progress and what is adequate progress.*

<b>PRESENTATION 17</b>
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<b>115 – 140 minutes</b>	<b><i>Presentation 17: Coordination of treatment and services; permanency planning; collaboration</i></b>	<b>25 min.</b>
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*Deliver scripted presentation describing ongoing issues that arise during recovery from substance use and/or mental disorders. Slides V-32 through V-54. At the conclusion of the presentation, ask first if there are any brief questions that can be answered before moving on to the following discussion. Keep answers brief. Trainer should only answer questions to which you know the answer.*

**[Slide V-32] Working Together: Tasks for Counselors, Workers, and Judges - 1**

Welcome back! We are now going to talk a little bit about how you monitor case plans. Monitoring includes on-going assessment and reevaluation, and collaboration.

Working together requires that there be certain tasks for treatment professionals, child welfare workers, and dependency court judges and their staff. Each professional should explain to the parents the requirements of the dependency court that must be met for parents to retain their children or have their children returned to them. This process is led by the child welfare worker and/or the responsible court. The following lists describe the responsibilities that treatment professionals, child welfare workers, and dependency court judges have when working with child welfare parents who are in treatment. I'd like you to refer to *Handout Tasks for Counselors, Workers, and Judges* as we go through these lists.

First, helping tasks for the treatment counselor include:

- Helping parents end their denial—and envision a positive life without substance use or symptoms of a mental disorder.
- Helping parents understand how their substance use disorder has affected their lives and the lives of their families and friends and
- Helping parents understand how their mental disorder has affected their lives and the lives of their families and friends.

**[Slide V-33] Working Together: Tasks for Counselors, Workers, and Judges - 2**

Helping tasks for the child welfare professional include:

- Conducting investigations to assess the safety of children and
- Conducting casework and case management to provide a nurturing environment for children while helping parents heal and develop needed capacities to care for their children.

**[Slide V-34] Working Together: Tasks for Counselors, Workers, and Judges - 3**

Helping tasks for the dependency court judge and staff include:

- Assessing information to make judicial decisions that lead to permanency for children in the child welfare system.
- Following the procedures and timetables specified in the State statute and the Federal law (such as the Adoption and Safe Families Act) and
- Presiding over a series of hearings that examine whether reasonable efforts have been made by the child welfare agency to provide needed services to prevent removal and/or to achieve reunification.

***[Note to Trainer: As an optional facilitated discussion, these helping tasks could be drawn out of the group through the use of questioning rather than presented as a lecture.]***

**[Slide V-35] Benefits of Information Sharing**

Sharing critical information will help ensure that children are safe, determine whether parents are meeting the dependency court requirements, and provide appropriate support for the parents throughout the treatment process. However, this information sharing must always follow the prescribed procedures to protect the privacy of the parents.

**[Slide V-36] Confidentiality Procedures for Sharing Information**

In general, substance abuse and mental health professionals, as well as child welfare professionals, have confidentiality procedures that require permission from the parent before any specific information can be shared across agencies or with other services.

Typically, the consent forms used in the treatment agency need to be used, rather than the child welfare forms, because they are designed to conform to Federal regulations (42 CFR, Part 2 and HIPAA Privacy Act), which address the key treatment confidentiality requirements for sharing information.

Generally, treatment professionals will be cautious about sharing information. Ideally, leaders in each community's child welfare and treatment agencies will work together to make forms and information sharing as simple as possible.

**[Slide V-37] Treatment Confidentiality Requirements**

Treatment confidentiality requirements are strict so that persons will be encouraged to enter treatment without fear of public judgment that could bring about harmful results. Such results

might include being fired, losing housing, being denied benefits or services, or losing parental rights, all serious consequences.

This is why Federal substance abuse treatment confidentiality requirements is a core responsibility of a substance abuse treatment professional. Likewise, mental health treatment professionals must adhere to professional standards and Federal regulations built on the concept of “informed consent” for information sharing. The requirements for these professionals are comparable to a child welfare professional’s responsibility to ensure that information about a person who has filed a child abuse report is held to the highest standard of confidentiality.

Because confidentiality requirements for addiction treatment are very stringent, the worker/counselor team must work with parents to obtain permission to share information about the type and progress of treatment for a substance use disorder. How do child welfare workers ensure that treatment confidentiality requirements are met?

Informed consent means that a professional has talked with the person about confidentiality protections, ensuring that they understand the protections and choices legally available to them. Then discussion must take place about the specific information to be shared, the people or agencies with whom it will be shared, the purpose for sharing, how that information will be used by the receiving person or agency, how long the permission is good for, and how the individual may revoke their permission at a later time. If, after all that has taken place and been put in writing, the individual gives their consent, the relevant information may then be shared to their benefit.

Finally, not all information learned by any professional needs to be shared, and in many cases, not all information should be shared between treatment and child welfare professionals. However, there are specific pieces of information that are needed by each professional from the other. These pieces of information can be identified early so that treatment providers and child welfare professionals know what is expected of each other.

It is important for child welfare workers to understand that not only is the original information protected, but the information may not be re-disclosed to any other person without the parent’s consent. Child welfare workers can check with their agency attorneys to get a legal opinion regarding how to share confidential information, or the agency may have a policy regarding this.

***[Note to Trainer: As an additional discussion, you can ask participants “Why might the protection of 42 CFR Part 2 be important to Irene?” If time permits, use this opportunity to engage in an optional discussion. Ask the group: “What kind of information do you feel you need about a parent’s treatment for a substance use or mental disorder?” “What has been your experience in trying to obtain and use that kind of information?”]***

#### **[Slide V-38] Information Needed by Child Welfare Workers**

Information needed by the child welfare professional from the treatment professional includes:

- Whether the parents are actually involved in a treatment program;
- The degree of parental participation: whether they are regularly attending, not missing appointments, and demonstrating a willingness to engage in treatment;
- Barriers that might exist to active participation, particularly when the child welfare professional may be able to help address such barriers;
- Support systems being developed around the parent and family;
- When parents are experiencing relapse or have left treatment;

- The continuing care plan of the parents if they are in residential or institutional treatment.

**[Slide V-39] Information Needed by Substance Abuse & Mental Health Treatment Professionals**

Information needed by the treatment professional from the child welfare professional includes:

- If the child is in the home or has been removed;
- If some children have been removed while others remain at home;
- If it is a voluntary case or is court ordered;
- The permanency goal for the child, including whether reunification is a goal and if there are concurrent plans for both foster care and adoption;
- Case plan goals in which the treatment professional is expected to participate and the specific outcomes desired;
- The court requirements and deadlines for specific hearings and achieving necessary outcomes.

**[Slide V-40] Procedures for Obtaining Confidential Information**

You will find a good summary of Federal confidentiality issues for treatment in the CSAT Technical Assistance Publication (TAP 24) called *Welfare Reform and Substance Abuse Confidentiality*.

We recommend that you read Section Three. This section reviews disclosure between the treatment and welfare systems, client revocation of consent, reporting relapse, combined case planning, and qualified service organization agreements.

You will also find included with this training a *Confidentiality Packet* that describes rules for obtaining patient consent to disclose treatment information, patient consent for the release of confidential information, a multiparty consent form, and the prohibition on re-disclosure of information concerning clients in alcohol or drug abuse treatment. Generally speaking, the process of information sharing about mental disorder treatment is very similar to the process described in this CSAT publication.

- To learn more, read Section Three of the attached Center for Substance Abuse Treatment (CSAT) Technical Assistance Publication (TAP 24) called *Welfare Reform and Substance Abuse Confidentiality*.
- To learn more, read the attached *Confidentiality Packet*.
- To learn more, read the Legal Action Center

**[Slide V-41] Closing a Child Welfare Case**

How do you decide when to close a child welfare case? Treatment completion is not the only condition that is considered when closing a case. Dependency courts and child welfare agencies are also concerned that parents have established the capacities they will need to provide safety and well-being for their children on an ongoing basis.

- A parent's progress in the child welfare and the treatment systems may not proceed on the same clock—a parent's 12-month permanency hearing might occur before the parent has completed treatment. This is typically a compelling reason not to terminate parental rights. In instances like this, if a judge decides to return children while parents are still in treatment, reunification does not necessarily mean that court jurisdiction over the parent ends. It is especially important to work out relapse prevention strategies, child safety plans in case relapse occurs, and plans to re-engage treatment if it is needed.

- When considering whether a child welfare case involving parental substance use or mental disorders is ready to be closed, child welfare workers should conduct or participate in a joint case review with the treatment professional that ensures child safety and well-being at a sufficient level for each particular child. They should consult with agency attorneys to ensure that State statutes and agency protocol are followed.

***[Note to Trainer: As an additional discussion, ask participants “How can you involve parents in this process? How could you facilitate these transitions to prevent parents from feeling intimidated or confused?”]***

**[Slide V-42] Joint Case Reviews: Considerations**

What are some of the things that should be addressed in a Joint Case Review: Here are just a few:

- Do the parents demonstrate the capacity to meet the needs of their children?
- Do children show evidence of improved care and development?
- Have parents completed the recommended treatment program at an acceptable level, or it is proceeding well enough to know that children are not at risk?
- Does a safety assessment of the children ensure there are no remaining unsafe conditions or other conditions that pose a risk to them?

**[Slide V-43] Joint Case Reviews – More Considerations**

And here are a few more:

- Have any additional reports of child abuse or neglect been indicated?
- Has the family established positive family supports and community links that are available when needed?
- Likewise, has the parent demonstrated the ability and willingness to use community supports when needed?
- And finally, do the children have a safe, stable, and appropriate permanency goal of reunification, adoption, or another planned permanent living arrangement?

**[Slide V-44] Helping Parents Prepare for Recovery**

How can child welfare workers assist parents to prepare for and sustain life-long recovery after their child welfare cases are closed? Recovery from substance use or mental disorders may be an ongoing, life-long process. During the early months of recovery, addicted persons are especially vulnerable to relapse and persons with mental disorders may resist the need for treatment. Many persons may need to return to a more intensive level of treatment. The parents you meet with are likely to need help and support for these activities:

- Maintaining sobriety.
- Maintaining a psychological medication regimen.
- Adjusting their lifestyles to avoid situations that contributed to the substance abuse.
- Finding basic services that will help them re-establish their lives, jobs, and families (such as information about Earned Income Tax Credit for which they might be eligible).
- Acknowledging the loss of relationships with the child welfare, substance abuse and/or mental health treatment worker.
- Finding and connecting with new support systems and resources in the community that will continue after termination of the relationships with the child welfare and treatment professionals.

**[Slide V-45] Helping Families Leave the Child Welfare System**

When working with parents during the case closure phases and helping them develop life-long recovery strategies, consider developing and using resources like these:

- 12-Step participation. For those parents with a substance use disorder, use motivational enhancement interventions to encourage their ongoing participation in the 12-Step programs and to obtain a 12-Step sponsor.
- Identify individualized services. Work with the treatment professional to determine the specific services that parents will need for themselves and their families during the recovery period.

Likewise, try to maintain a directory of local community- and faith-based organizations and social support services. Collect relevant contact information like phone numbers, addresses, hours of service, and referral requirements. And finally, be sure to establish relationships with organization representatives to make ongoing, informed referrals for parents, as needs arise. You can also arrange for an in-person referral between caseworker, community services provider and the parent to facilitate the transition.

**[Slide V-46] Helping Families Leave: Support and Safety Planning**

Another critical role you play at this juncture is in helping families establish a community network of support and safety planning that they can rely on when the case is closed. This network needs to provide linkages, relationships, and benefits.

- Help promote linkages with community-based organizations and resources that can provide ongoing support and assistance to families about issues for which they need help. Reinforce the linkages with contacts, arrangements for initial visits while the family is still in the child welfare system, and follow-up discussions to determine how effectively the linkages met family needs.
- Help families establish relationships with family members, friends, churches or temples, or other social support groups that can support the parent as they make their way through recovery.
- Ensure that parents are receiving the full income and other benefits from the State's Temporary Assistance for Needy Families (TANF) Program and are participating in the Earned Income Tax Credit. You can find more on this on the IRS page on Earned Income Tax Credit.

***[Note to Trainer: As an additional discussion, you can ask participants “How might this help Irene?]***

**[Slide V-47] Collaboration: A Continuum**

What are the characteristics of successful collaboration between professionals? There is a continuum of possibilities to engage in collaboration, ranging from full system collaboration, to agency collaborations, to collaborations between two professionals. Full system collaboration takes considerable time and effort and requires the support of organizations as well as individuals. For example, organizations can collaborate to exchange information on a regular basis, develop joint projects, and consider joint plans to change rules.

**[Slide V-48] Collaboration: Workers and Treatment Professionals**

Even though full collaboration between systems or agencies is not always possible, there are still opportunities for networking, coordination, and cooperation between individual child welfare and treatment professionals who are working with the same parents. Collaboration can involve simple or more comprehensive types of interaction between child welfare workers and treatment professionals. Here are a few examples:

- Professionals can network together to exchange information about resources, systems, requirements, and service recipients;

- Professionals can coordinate the scheduling of activities with each other's requirements in mind;
- Professionals can cooperate to work toward common outcomes for specific clients by developing a common or joint plan; and
- Professionals can collaborate to carry out a commonly defined and supported set of agency or system outcomes.

Finally, many Federally recognized Tribal Governments and States have agreed to provide child welfare services through intergovernmental agreements. If you work in an area where this might apply, the knowledge and use of these agreements can help with communication and collaboration of functions in a way that will assist both systems.

Communities across the country use a wide array of strategies to ensure collaboration between and among service providers, especially when multiple helpers are involved with the same family or individual.

#### **[Slide V-49] Collaboration Strategies – 1**

Next, I am going to talk about nine strategies that are common in communities with high levels of collaboration among helpers and helping systems. I'll describe each of these briefly to give you ideas and to help you put your own community's system into perspective, perhaps opening possibilities for ways you can contribute to your own system's collaboration (Davis, 2002; Ira and Lourie, 1994):

1. Individualized planning teams – In these teams, helpers with different types of expertise come together around a common table, once or many times, to plan and coordinate care of individual persons or families with complex needs.
2. Integrated planning and management of crisis interventions – Many systems in the community offer some form of crisis management (such as child welfare workers who can be called at any hour to a home where abuse or neglect of a child is suspected). Some communities establish systems that link many types of crisis intervention together in a single team or process.
3. Centralized intake, assessment, and/or case planning processes – Virtually all helping systems perform intake, assessment and case planning functions. Some communities have organized those functions into centralized or coordinated systems, managed jointly by multiple systems.
4. Interagency clinical or supervisory resource teams – In these teams, experienced and/or supervisory staff from multiple systems meet together regularly to review complex care situations and make recommendations for direct care staff. In many systems, direct care staff are also invited to bring forward families they need help with or additional resources for. In some communities such teams also provide gate-keeping functions for intensive or expensive types of services (such as placement out of the community).

#### **[Slide V-50] Collaboration Strategies – 2**

Here are a few more:

5. Opportunities for helpers in all agencies to learn about each other – Special events, such as resource fairs or regular meetings, can bring together all levels of staff from many helping agencies to learn about each other and build networks of relationships among the community's helpers.
6. Blended or flexible resources – These are funds made available to individualized planning teams that can be used to fill in gaps between funded services. Generally these are relatively small amounts of monies used to pay for unusual needs or services that will make the rest of a care plan more likely to succeed.

7. Written interagency agreements – Contracts, memoranda of understanding (or “MOUs”), or memoranda of agreement (or “MOAs”) can clearly articulate how different community helping agencies will work together around specific actions, functions, or groups of consumers. When system/agency leaders establish written agreements about common or connected functions, they are providing direct care staff with better guidance about how to effectively collaborate with other helpers.
8. Community helping system management or leadership groups – In these groups, executive decision makers in many helping systems or agencies come together regularly around a common table to discuss and manage issues shared by systems. This type of group is a necessity for most of the other strategies in this listing.
9. Community quality improvement practices – Finally, most helping systems use different types of quality assurance or quality improvement practices. Some communities have linked those practices together across service systems so that they can regularly examine how well the entire community helping system is functioning.

### **[Slide V-51] Creating a Collaborative Environment**

How do you go about creating a collaborative environment? First of all, to work together, child welfare and treatment professionals need to establish an environment where they can effectively solve problems. This environment needs to support different types of rapport and interactions, like these:

- You need to develop mutual respect, understanding, and trust;
- Communication, both formal and informal, must be frequent and honest;
- Everyone needs to recognize that collaboration is in the self-interests of both workers and treatment professionals;
- Likewise, everyone needs to understand each others’ values and, when values differ; common principles for working together need to be adopted;
- A mutual sense of ownership in planning for the success of specific parents is needed; and finally,
- Jointly developed concrete and attainable objectives for specific parents need to be established.

### **[Slide V-52] Collaborative Values Inventory**

Many collaborative relationships begin without much discussion of the underlying values on which members agree or disagree. The Collaborative Values Inventory Survey is a neutral way to assess how much a group shares ideas about the values that underlie its work. It can be used to identify and discuss values between entire child welfare and treatment staffs. It can also be used by an individual child welfare worker and a treatment professional working together with a particular family. After reviewing the results from a collaborative group's scoring of the Inventory, it is important to discuss the areas of common agreement and divergent views. When the Inventory identifies differing values, it is important to discuss the divergent views and develop common principles that workers can share.

- To learn more, visit the Children and Family Futures Website and select "Collaborative Values Inventory Survey." The link is provided in your resource list.

### **[Slide V-53] Collaboration Strategies**

There are a number of ways that child welfare professionals can collaborate to help parents reach a good outcome. Sometimes front-line social workers can use these strategies. Sometimes supervisors or agency administrators are needed to support these strategies--sometimes, discussing these issues with supervisors or administrators can lead to positive



***Briefly review the areas that have been covered in this training session, focused on case planning and service strategies, including collaboration with others. Ask the group:***

- ***What new things have you learned in this session that you can take with you and apply to your work with families?***
- ***Have you changed any personal attitudes as a result of this session?***

***The GOAL of this brief discussion is to help participants think about what they will take away from the session. At the end, thank them all for participating. If they will be receiving more modules in this series, you might remind them of what comes next, and when.***