Capacity Building

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Creating and Sustaining Cross-System Collaboration to Support Families in Child Welfare With Co-Occurring Issues: An Administrator's Handbook

Handbook Introduction:

The *Creating and Sustaining Cross-System Collaboration to Support Families in Child Welfare With Co-Occurring Issues: An Administrator's Handbook* is designed to help states collaborate across human service systems to meet the needs of families with co-occurring disorders.

The following pages include:

Overview

of the need for collaboration across systems to support families dealing with co-occurring disorders ▷ **Chapter 1**

Definitions

of co-occurring disorders and their impact on children and families ▷ **Chapter 2**

Description

of cross-system collaboration and information on effective collaboration models and practices ▷ **Chapter 3**

Guidelines

for conducting a Readiness Assessment ▷ **Chapter 4**

Strategies

for child welfare agencies to build capacity to collaborate across systems ▷ **Chapter 5**

Additional Resources

for further exploration on this topic

Chapter 1. Overview

The average human services client has many complex needs. The first system an individual comes into contact with may be the one best equipped to address the issue that appears to be the most urgent or immediate, but it might not be equipped to handle deeper issues the individual is dealing with and their root causes. Parents in need of serious mental health and substance use disorder services frequently enter the human services system through child welfare due to a referral for child neglect. Therefore, many families involved with the child welfare system have multiple and complex needs, including mental health and substance abuse issues as well as related issues such as domestic violence and juvenile justice involvement. Child welfare agencies acting alone face difficulties in treating families with co-occurring issues because these families become involved in multiple systems.

The provision of effective services and treatment for children and families dealing with co-occurring issues relies on collaboration across systems so that the needs of children and families can be better understood and services can become more streamlined and cohesive.

Forming collaborative partnerships is not an easy task across the human services field because the field is built with inherent divisions. Each individual system operates with separate funding mechanisms, policies, programs, purchasing strategies, technology, and other operating mechanisms. However, child welfare agencies need to focus on how families are being supported through cross-system collaboration because the services and treatment provided by other systems may directly impact child welfare outcomes for the families and children involved in them.

Effective collaboration across human service systems requires strategies that build organizational capacity to engage with internal and external, as well as traditional and nontraditional, partners in order to overcome the fragmented nature of the human service field. This Handbook is designed to increase awareness of co-occurring issues broadly and build agency capacity to collaborate across systems to support families with co-occurring disorders.

Chapter 2. Co-Occurring Disorders and Their Impact on Children and Families in the Child Welfare System

The Substance Abuse and Mental Health Services Administration (SAMHSA , 2016) and the National Alliance on Mental Illness broadly define co-occurring disorders as the simultaneous presence of one or more mental health issues and substance use disorder (National Alliance on Mental Illness, n.d.). Although co-occurring disorders can consist of various combinations of substance abuse and mental health issues, some common examples of co-occurring disorders, according to Psychology Today (2017), include:

- Depression with cocaine addiction
- Panic disorder with alcohol addiction
- Schizophrenia with alcoholism and polydrug addiction
- Borderline personality disorder with episodic polydrug abuse

The 2014 National Survey on Drug Use and Health estimated that approximately 7.9 million adults in the United States had co-occurring disorders (SAMHSA, 2016). In 2014, 3.3 percent of all adults had a mental illness combined with a substance use disorder within the past year, and 1.0 percent had both severe mental illness and a substance use disorder (SAMHSA, 2015). Slightly more than one-third of adults with substance use disorders have a co-occurring mental illness (Child Welfare Information Gateway, 2014).

What Does This Mean for Families?

There is significant representation of parents with co-occurring disorders involved with the child welfare system (Ward, Barry, Laliberte, & Meyer-Kalos, 2016). According to the Adoption and Foster Care Analysis and Reporting System, during fiscal year 2015, 32 percent of children who entered foster care were removed from home due to parental drug abuse, 14 percent were removed due to the inability of caretakers to cope, and 6 percent were removed due to parental alcohol abuse (Children's Bureau, 2016).

According to some research, parental capacity is a major challenge for parents with complex needs, and many parents believe that their personal trauma impacts their ability to respond to the needs of their children (Romfield, Sutherland, and Parker, 2012). With increased risk factors and safety concerns, as well as stigma around mental illness, parents with mental health issues are especially vulnerable when it comes to child custody issues. If the human service system fails to address parent trauma, the result may lead to (Oben, Finkelstein, & Brown, 2011):

- Failure of parents to engage in treatment services or withdrawal from the service relationship
- Increases in symptoms
- Increases in difficulty managing problems and increases in relapse rates
- Retraumatization
- Poor treatment outcomes

Research has found that children and youth in families in which parents have co-occurring disorders experience difficulties that include increased risk of exposure to violence and trauma, poverty, neglect, unstable living environments, and custodial instability. These adverse experiences contribute to family vulnerabilities that often lead to involvement with the child welfare system. Furthermore, children and youth in these situations face heightened risk of mental health issues and substance use disorders themselves (Hopping-Winn, 2012).

Today's Drug Epidemic and Opioid Crisis

The widespread and growing abuse of opioids and methamphetamines has played a significant role in reversing a positive trend of fewer children needing foster homes (Dennis et al., 2015). In 2012, 397,000 children were in foster care according to data from the U.S. Department of Health and Human Services—a low point following a steady decline (Children's Bureau, 2013). By 2015, that number had risen eight percent to 428,000. The height of the opioid epidemic over the past two years has corresponded with the dramatic increase in children living in foster care, although concrete data linking the two is not yet available.

From the Washington Post: Foster care experts suggest that as the drug epidemic has intensified during the past two years, it has led to a rush of children entering the system. To compound the problem, state budgets are stretched, social workers are overloaded, and not enough families are willing to provide children with temporary homes (Stein & Bever, 2017).

Children who have been exposed to parental opioid abuse are exposed to psychological stress, beginning with the immediate trauma of living with an unstable parent or being taken from family and sometimes from school and friends (Dennis et al., 2015). There are also significant long-term implications. Research indicates that children who undergo traumatic events early in life are more likely to experience mental and physical difficulties later on, in the form of substance abuse, depression, heart disease, or cancer (Dennis et al., 2015).

Challenges in Service Delivery to Children, Youth, and Families Affected by Parental Substance Use Disorder (Child Welfare Information Gateway, 2014)

- ☐ Insufficient service availability or scope of services to meet existing needs
- ☐ Inadequate funds for services or dependence on client insurance coverage
- ☐ Difficulties in engaging and retaining parents in treatment
- ☐ Knowledge gaps among child welfare workers to meet the comprehensive needs of families with substance use issues
- ☐ Lack of coordination between the child welfare system and other systems, including hospitals that may screen for drug exposure, treatment agencies, mental health services, criminal justice system, and family/dependency courts
- ☐ Differences in perspectives, timeframes, policies, philosophies, and goals in child welfare and substance abuse treatment systems

Approaches to Meet These Challenges

- ✔ Promotion of protective factors, such as social connections, concrete supports, and parenting knowledge, to support families and buffer risks
- ✔ Early identification of at-risk families – for example, expanded prenatal screening initiatives
- ✔ Gender-sensitive treatment and supportservices that respond to the specific needs, characteristics, and co-occurring issues of women who have substance use disorders
- ✔ Family-centered treatment services, including inpatient treatment for mothers combined with services for their children with provision of services to family members
- ✔ Recovery coaches or mentors for parents to support treatment, recovery, and parenting
- ✔ Shared family care in which a family experiencing parental substance use and child maltreatment is placed with a host family for support and mentoring
- ✔ Collocation of substance abuse and mental health specialists in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation to child welfare workers
- ✔ Cross-systems information sharing related to screening, assessments, and case and treatment plans and progress
- ✔ Joint planning and case management so as not to overwhelm families with different systems
- ✔ Flexible financing strategies that leverage or combine various funding streams to address the needs of substance abuse treatment for those involved in child welfare
- ✔ Linked data systems that track progress on shared system objectives and achievement of desired outcomes while also promoting shared accountability

What Next?

The complex nature of co-occurring disorders in child welfare calls for a collaborative approach to address the needs of children, youth, and families. By increasing agency capacity to recognize and understand co-occurring disorders and deliver appropriate services to meet individualized family needs through effective cross-system collaboration, agencies will achieve better outcomes related to safety, permanency, and family preservation and reunification.

Chapter 3. What is Cross-System Collaboration?

Collaborative relationships focus on common goals, mutual benefit, and cooperation. Effective collaboration requires that all parties involved share their knowledge and resources (Hogue, Iyechad, Bergstrom, & Clark, 1995). Working with families with co-occurring disorders requires a cohesive and unified approach from all parties to address the range of complex needs, including access to proper services and supports (Romfield et al., 2012; Friesen, Katz-Leavy, & Nicholson, 2011). Therefore, cross-system collaboration requires mutually beneficial partnerships with common goals that engage child welfare and other human services systems in order to improve the assessment and delivery of individualized services for children and families.

> Collaboration is "a mutually beneficial relationship between two or more parties who work toward common goals by sharing responsibility, authority, and accountability for achieving results" (Chrislip & Larson, 1994, p.19).

Effectively Building and Sustaining Collaborative Partnerships Relies on Laying a Foundation That Encompasses:

- Trust
- Shared interest and relevance
- Leadership
- Collaborative infrastructure
- Time and patience
- Buy-in at all levels

(National Technical Assistance and Evaluation Center for Systems of Care [NTAECSC], 2011)

Reasons for Collaboration

Child welfare experts have increasingly recognized the importance of cross-system collaborative partnerships to achieve safety, permanency, and well-being goals for children, youth, and families (Children and Family Futures, 2011). Collaboration can be a mechanism to improve efficiencies and increase resources and opportunities. However, it involves more than time and a financial commitment—it is an agreement to change the existing institutional culture, so it is important to know the underlying reasons for collaboration and be aware of potential challenges.

> Collaboration for the sake of collaboration can be just as destructive to system building as no collaboration. Effective collaboration has a purpose and concrete objectives, which change over time (Pires, 2002).

A system may be interested in pursuing collaboration because money and resources may be acquired through collaboration. Both government and private funding opportunities increasingly require collaboratives to be in place before an agency can receive funding. If requirements for the funding are not fulfilled, there may be consequences, including federal penalties through payback clauses.

A system may also pursue collaboration because it is the latest trend. It is important to think strategically about collaboration, work through the pros and cons, and be sure your system is ready (see Chapter 4, "Conducting a Readiness Assessment").

Challenges of Collaboration

- ☐ Less time and attention devoted to one effort due to involvement in multiple initiatives (National Technical Assistance and Evaluation Center for Systems of Care [NTAECSC, 2011])
- ☐ Inconsistent messages according to diverse partners' needs (NTAECSC, 2011)
- ☐ Difficulties in developing trust due to negative preconceptions about the child welfare system (NTAECSC, 2011)
- ☐ Ineffective communication—e.g., differences in jargon and acronyms used in certain fields (NTAECSC, 2011)
- ☐ Difficulty fitting individual priorities and agendas into the collective goals (NTAECSC, 2011)
- ☐ Required time and effort to establish, nurture, and sustain relationships (NTAECSC, 2011)
- ☐ Different operating systems and capacity to serve the child welfare population (Center for States, 2017)
- ☐ Competing funding interests for clients across systems (Center for States, 2017)

Benefits of Collaboration

- ✔ Having the "right people" at the table, who make meaningful and ongoing contributions (National Technical Assistance and Evaluation Center for Systems of Care [NTAECSC], 2011)
- ✔ Greater diversity of perspectives heard (NTAECSC, 2011)
- ✔ Increased access to outcome data (NTAECSC, 2011)
- ✔ Increased understanding of strengths, accomplishments, and areas of need across systems (NTAECSC, 2011)
- ✔ More knowledge of and access to available services for children and families (Center for States, 2017)
- ✔ A more integrated approach to services that meet individualized needs (Center for States, 2017)
- ✔ Increased ability to share information and track families across agencies and providers (Center for States, 2017)
- ✔ Better coordination between service providers dealing with co-occurring issues (Center for States, 2017)

Role of Leadership

Leadership during collaboration building must focus on how the individual systems in the collaborative define organizational leadership as well as on how people influence and inspire wide-scale impact, regardless of job title or role.

Effective systems reform requires leaders to build a strong constituency that will last long beyond initial implementation and the tenures of the original leaders. Leaders involved in a collaborative effort must take a strategic approach and develop a shared vision from the onset to avoid unnecessary starts and stops that can impede momentum and expend unnecessary time, energy, and resources. Different leadership styles may emerge over time, but the leadership role should be supported by a clear, concise set of expectations leading to a common goal.

Who are Collaborative Leaders? No miracle worker exists who can build a collaboration alone, so it is important to be inclusive when thinking of leadership.

Although buy-in from top leadership from the start is optimal, the actual leaders may change throughout the collaborative development process depending on the stage or focus of the task at hand. Leadership responsibilities often fall to middle managers during system reform due to their strong content knowledge of the system and their ability to work through bureaucratic deficiencies.

Leadership can come from external partners, or even critics, who are involved early in the collaboration process and raise their concerns along the way. For example, family advocates are some of the greatest champions of collaboration and systems reform because they see firsthand areas in which change is needed. They can carry a powerful message to multiple systems as the efforts progress.

Leadership benefits from a core team that involves all essential stakeholders, including information technology (IT) and Medicaid. Failing to bring IT and Medicaid into various collaborations early on may cause significant implementation delays and cost overruns.

Medicaid, which is one of the most important vehicles to drive health and human services reform, can be difficult to corral. In state-administered systems, high-level Medicaid representatives have limited availability due to being pulled in multiple directions. Although there are specific regulations guiding the use of Medicaid, it can be difficult to determine who can provide the knowledge, has the same vision, and has the authority to influence others and get things done when seeking a partner for a collaborative. With county-based systems, Medicaid representatives can vary from county to county and have several different leaders, so it is even more difficult to determine who should be involved. In spite of these challenges, it is important to concentrate on assembling a strong leadership team including Medicaid representatives that works well together and can successfully produce outcomes.

Approaches to Collaboration

Collaboration can be formal or informal. Informal collaboration can be as simple as inviting key people from other systems to meetings to begin to cultivate an environment of information sharing. Formal collaboration is more involved.

Two formal methods that have been used to develop collaborative cultures leading to systems change are the **Learning Collaborative** and the **Breakthrough Series Collaborative**. Although these models are not specifically related to cross-system collaboration, they are useful frameworks for developing collaborative learning processes.

Learning Collaborative: According to the National Child Trauma Stress Network (NCTSN), the Learning Collaborative approach "focuses on spreading, adopting, and adapting best practices across diverse service settings and creating changes in organizations that promote the delivery of effective interventions and services" (NCTSN, 2007). It emphasizes adult learning principles, interactive training methods and coaching, and skill-focused learning. The model includes approximately three in-person training sessions over a 9- to 12-month period, follow-up consultation activities, feedback loops, and resources to support sustained learning. It also provides opportunities to practice new skills and share progress through the collaborative.

Learning Collaboratives are labor intensive and require strong commitment from an array of stakeholders. The overall activity of bringing people together around a common goal to discuss, brainstorm, and come to consensus or develop a solution is very powerful and lends itself to relationship building.

Breakthrough Series Collaborative: The Breakthrough Series Collaborative model is designed to help organizations close the gap between what they know and what they do. The Breakthrough Series creates a structure in which organizations can learn from each other and from experts in specific areas and collaborate on where they want to make improvements.

A Breakthrough Series Collaborative lasts 6- to 15-months and can range in size from 12 to 160 organizational teams. Each team typically sends three of its members to attend three face-to-face learning sessions over the course of the collaborative, while additional members work on improvements in the local agency or community.

Both of these collaborative approaches involve an inclusive process, with staff feedback and data collection built into the methodologies. Although labor intensive and expensive, these models provide several benefits, including increased relationships and identified champions who are key collaborators essential for strategic implementation.

Cross-system coordinated delivery systems are the most formal type of collaboration. Two well-known models that provide good practices for the child welfare field include No Wrong Door and Systems of Care.

No Wrong Door: The No Wrong Door approach provides clients with a universal gateway to services and government programs. Although the individual systems remain intact, the overall mission is blended together with a strong focus on patient- or client-centered intervention.
It is a need-centered rather than service-centered approach, allowing the individual or family to identify the need and seek assistance from the provider they choose. If the agency first contacted is unable to provide assistance, the client is navigated to a better matched service provider. This is a hands-off approach, which requires coordination and a strong communication plan, and ideally provides the consumer with coordinated service delivery through a streamlined, seamless mechanism (Bowen & Fox-Grange, 2017).

Systems of Care: The Systems of Care (SOC) model, which was initially developed to provide support for children and youth emotionally at risk or with mental health challenges and their families, is generally implemented at the community level. Systems stay separate, but they adopt a common philosophy across all components and are organized into a coordinated network.

This highly collaborative model incorporates seven core principles that must be followed across all systems to maintain continuity. SOC models adopt comprehensive, coordinated, collaborative approaches across organizations and systems and work in full partnership with families and youth. They are culturally and linguistically competent, flexible to fit each child and family, and strength based (Stroul, 1996).

Chapter 4. Conducting a Readiness Assessment

Cross-systems collaboration must be approached from a thoughtful, well-informed perspective. The better prepared the stakeholders are, the more efficient the process. To evaluate the cultural and political landscape and determine if the environment is ripe for collaboration, it is helpful to develop a readiness assessment that can be administered to a representative group of stakeholders.

A. Consider how each system in the collaboration is structured. Some questions to ask:

- Are there state regulations or federal policies that may impact successful systems integration?
- Are the qualified executive leaders or political appointees term limited—how long will leadership be able to lead the collaborative?
- What are the payment structures of each system?
- Are the system partners state supervised, county based, or regionalized?

Additional questions—such as whether private service providers make up parts of the systems or whether unions play a role—may be added to this list; the assessment needs to be tailored so that all of the nuances of the systems are revealed to avoid unexpected delays further into the planning. The structure and operations of each system must be explored because not all systems within a state or county are similarly administered (Child Welfare Information Gateway, 2012).

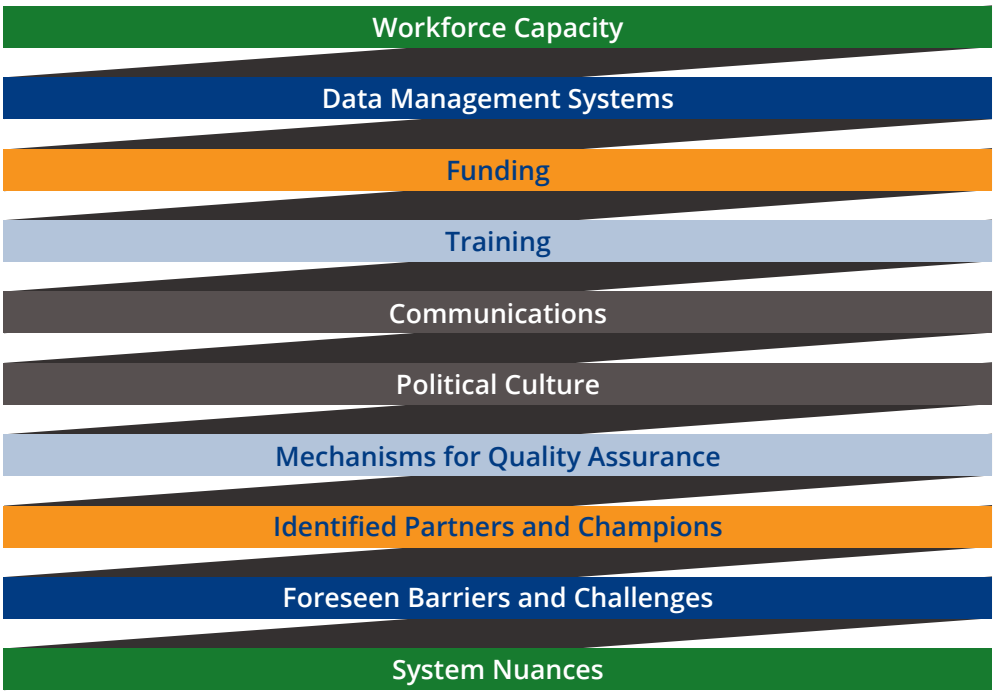
B. Consider the political landscape. Depending on how state and local control is assigned, there may be different political and social cultures, as well as service delivery models and priorities.

C. Consider whether any of the systems are in the midst of financial reform (i.e., a change from fee for service to managed care). Potential partners may find themselves unable to follow through on commitments or plans simply because they have competing interests in their own systems.

D. Consider core values and competencies of the systems involved in the collaboration. Some coordinated service models are predicated on a core set of values, such as the Systems of Care model. Some questions to ask:

- Are partners willing to make their systems person centered and culturally and linguistically competent?
- Is ensuring that services will be evidence based and timely delivered a priority?
- Will the values be reflected in the collaborative's policies?
- Do middle management and top leadership support the core values, and are they willing to create a body of principles reflecting a shared value system?
- Is there a joint framework within which to accomplish the work? Evaluation of a joint framework should begin on day one. A joint framework should include both long- and short-term goals.
- Is there a commitment to jointly identify and address barriers involving core values and competencies?

Readiness assessments are available in the public domain and can be modified or developed to suit the systems' needs. To adequately address cross-system work, a comprehensive readiness assessment that covers the following areas should be administered:



Readiness assessments should be user friendly, employing simple language that is tailored for the specific audience. System-specific language and acronyms should be defined. Common definitions across existing systems, such as workforce development or training, may need to be established so that respondents are answering from the same framework.

Readiness assessment questions must fully explore the uniqueness of each system. They should be short but comprehensive. A good example includes a series of yes or no responses to questions:

Sample Readiness Assessment Questions for Child Welfare System and Mental Health System Stakeholders

Is the child welfare system/mental health system state supervised? ..... Y N

Is the child welfare system/mental health system county administered? ..... Y N

Is the child welfare system/mental health system made up of over 35 percent private providers? ..... Y N

Is the state in the midst of financial reform, such as a change from fee for service to managed care? ..... Y N

Is it difficult to retain staff, from the executive leadership level to the front line? ..... Y N

If yes, what is this attributable to?

❑ Turnovers in political administrations
❑ Changing priorities
❑ Secondary stress
❑ All of the above
❑ Other _____

Are workers unionized? ..... Y N

If yes, approximate number of unions ___

Are there other competing interests or multiple child-related initiatives in the state or community? ..... Y N

If yes, identify which apply:

❑ Federal consent decrees
❑ Title IV-E waiver
❑ System of Care grant
❑ Other _____

It is important that stakeholders understand all of the systems involved in a collaborative in order to complete the readiness assessment and be able to go forward with a strong collaboration.

Additional Resources:

- Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2006). *Screening and Assessment for Family Engagement, Retention, and Recovery* (SAFERR). DHHS Pub. No. 0000. Rockville, MD: Substance Abuse and Mental Health Services Administration.

  This guidebook helps professionals respond to families affected by substance use disorders using the Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) model, which was developed by the National Center on Substance Abuse and Child Welfare (NC-SACW). The SAFERR model emphasizes connection, communication, and collaboration among the systems of child welfare, alcohol and drug services, and the courts to promote child safety and family well-being. It includes screening and assessment tools, as well as strategies relevant for coordinating services across systems. The guidebook includes sections on (1) building cross-systems collaboration, (2) collaborative roles and responsibilities, and (3) collaborative practice at the frontline.

- Children and Family Futures. (2011). *The Collaborative Practice Model for Family Recovery, Safety and Stability*. Irvine, CA: Author. Retrieved from http://www.cffutures.org/files/PracticeModel.pdf

  The Collaborative Practice Model for Family Recovery, Safety and Stability highlights the need for collaboration among child welfare, family treatment, and dependency courts, agencies, and providers. Drawing from the experiences of communities that have implemented practice and policy changes to address the needs of families, the model emphasizes a call for collaboration beyond the child welfare arena, including the court system, mental health providers, and other agencies whose resources can help achieve child welfare outcomes. Important among those other agencies are primary health, education, child development, domestic violence, and housing. This document discusses ten system linkage elements that child welfare, substance abuse treatment, and juvenile court dependency systems, as well as other agencies and providers working with these systems, should use to collaborate with one another. The purpose of the document is to define and provide examples of collaborative practice in each of the ten system linkage elements. State and community collaborative groups can use this information to guide their own efforts to implement collaborative practice in their own communities.

Chapter 5. How to Build Capacity for Cross-Systems Collaborations

The Child Welfare Capacity Building Collaborative supports child welfare organizations in assessing and enhancing capacity in five key areas:

1. **Resources:** Concrete materials and assets (e.g., staff, information, and equipment)
2. **Infrastructure:** Organization structure and processes (e.g., policies and procedures, lines of authority, functional departments, programs, and service structure)
3. **Knowledge and skills:** Expertise and competencies of staff (e.g., technical and analytic skills, cultural competency, and leadership)
4. **Culture and climate:** Organizational norms, beliefs, values, and attitudes (e.g., perceptions of agency effectiveness, institutional expectations of behavior, feelings about one's role and value in the workplace)
5. **Engagement and partnership:** Intraorganizational and interorganizational relationships (e.g., internal teaming, community participation, interagency agreements, and shared authority with key stakeholders)

Strategies child welfare organizations can use to build cross-system collaborations are organized under each capacity building area—or domain. These are outlined below.

Capacity Building Domain 1: Assessing Resources to Improve Services to Children, Youth, and Families With Co-Occurring Issues

- Examine your organization's child welfare data. Consider what your data indicate about:
  - Number of children entering and re-entering care
  - Reasons for entry
  - How and where children are placed
  - Identification of complex clinical needs of children and youth
- Link data systems that track progress with the collaborative's objectives.
- Identify funding streams (e.g., child welfare streams, Medicaid, CHIP, Temporary Assistance for Needy Families, housing, juvenile justice, education, etc.).
- Consider flexible financing strategies that leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare.
- Engage in financial mapping to better understand and align the different funding streams for services and supports.
- Develop an evaluation process and outcome goals.
- Coordinate with the existing quality assurance department.

Capacity Building Domain 2: Building Agency Infrastructure for Serving Children, Youth, and Families With Co-Occurring Issues

Policies, practice protocols, and quality improvement approaches to consider:

- Ensure there is cross-system information sharing related to screening and assessment results, case plans, treatment plans, and progress toward goals, which can support professionals in each system to make informed decisions while still adhering to confidentiality parameters.
- Engage in joint planning and case management to help safeguard against parents' becom-

ing overwhelmed by multiple and potentially conflicting requirements of different systems.

- Identify types of assessments and practice protocols, such as trauma-informed care or screening and functional assessments.
- Develop a shared goals plan with all system partners.
- Develop communication protocols with partners.
- Define commonly used terminology and provide definitions.
- Provide clear role definitions across systems.
- Develop Memoranda of Understanding pertaining to what information can be shared and how, including any privacy concerns or consents needed.

Capacity Building Domain 3: Building Staff Knowledge and Skills to Improve Child Welfare Practice for Children, Youth, and Families With Co-Occurring Issues

- Build workforce capacity through training and professional development opportunities.
- Develop cross-system competencies by engaging staff and leaders from partner systems in cross-training opportunities and inviting partners to participate in group meetings with clients.
- Conduct cross-training of child welfare, substance abuse treatment, and mental health professionals to build an understanding of each other's systems, legal requirements, goals, approaches, and shared interests.
- Promote colocation of substance abuse specialists and mental health professionals in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation services to child welfare workers.
- Provide ongoing opportunities for professional learning through developing online communities of practice.
- Provide job shadowing opportunities across agency roles to promote better understanding of the big picture for frontline workers as well as to reveal challenges for managers and leadership.

Capacity Building Domain 4: Fostering a Culture and Climate of Collaborative Practice to Serve Children, Youth, and Families With Co-Occurring Issues

- Develop an advisory committee made up of core members with well-defined roles.
- Target nontraditional members who can bring unique perspectives and resources to the table, such as faith-based groups and unions.
- Identify champions—trainers, community leaders, members of the community with lived experience—from different parts of the system who can promote and support collaboration efforts.
- Create common values across systems to establish a culture of cross-collaboration.

Capacity Building Domain 5: Engaging and Partnering to Support Organizational Changes Necessary to Improve Child Welfare Practice for Children, Youth, and Families With Co-Occurring Issues

- Develop cross-system partnerships based on shared principles that ensure coordinated services through formal linkages such as interagency agreements.
- Consider the following partners for dealing with co-occurring disorders: child welfare agencies, mental health treatment providers, substance use disorder treatment providers, juvenile justice systems, education agencies, Medicaid offices, public health agencies, governments, academia, courts and legal systems, parents, family, youth, IT, law enforcement, unions, and faith-based organizations.
    - Medicaid is an essential partner for collaboration around co-occurring issues and child welfare.
    - Partners that provide wraparound and comprehensive community services that address multiple service needs of parents and children—including those related to parenting skills, mental health, physical health, domestic violence, housing, employment, income support, education, and child care—are essential.
- Develop an advisory board to engage diverse stakeholder involvement and develop mechanisms to sustain partnership.
- Create incentives for people to collaborate, including practices that recognize accomplishments and strengths.
- Develop feedback mechanisms to share information across systems.
- Discuss advantages and disadvantages of ongoing communication using informal means (e.g., emails, phone calls, unofficial records) versus formal channels (e.g., formal meetings, published or formally recorded documentation).
- Identify who is authorized to communicate for each system partner.
- Discuss communication methods (e.g., face to face, Skype, publications, newsletters, blogs, etc.).
- Minimize the use of acronyms, especially in cross-system meetings and communications.
- Create an acronym and terminology directory.

Additional Resources and References

Additional Resources

- For additional strategies to build effective community partnerships see "Building and Sustaining Collaborative Relationships." The Capacity Building Center for States, located at http://capacity.childwelfare.gov/states/focus-areas/family-preservation/

- Additional ideas on community stakeholders to partner with may be found in Appendix H of *Community Partnerships: Improving the Response to Child Maltreatment*, located at http://www.childwelfare.gov/pubs/usermanuals/partners/

- For another useful checklist for collaboration planning, see Appendix G of *Community Partnerships: Improving the Response to Child Maltreatment*, located at http://www.childwelfare.gov/pubs/usermanuals/partners/

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