Promising Practice and Collaboration for Families with Substance Abuse and Child Welfare Issues

In the Best Interests of the Systems?

American Humane Association
Organized by the
Rocky Mountain Quality Improvement Center,
funded by
US DHHS Administration of Children and Families,
Office on Child Abuse and Neglect

Sid Gardner
Children and Family Futures
May 16, 2006

Q: What is most often left out of multi-systems planning and service delivery?

A: Children affected by family violence, child abuse and neglect, mental illness, and substance use disorders

A Simple Narrative:

1. More and more children and families need help from more than one system
2. Our screening and assessment—and the lessons of brain science—are increasingly documenting the need for multiple services from multiple agencies, and for earlier identification and intervention
3. So agencies should collaborate more

So why don't they??

- The list of the barriers is well-known: values, turf, categorical funding, limited budgets, data gaps, training gaps, etc.
- But we also need to factor in *pace* and *the lack of urgency:* we are getting better at connecting, but not as fast as the need to connect is growing
- How can collaboration create a sense of urgency—or how can an external source of new urgency strengthen collaboration?

Where could a sense of urgency come from?

- Legal pressures—states and localities are out of compliance in many areas
- Political pressures: LNCB, CFSR, NOMS—states are failing or may fail on new federal report cards; some have sanctions and negative visibility
- Fiscal pressures—doing it wrong costs more
- Leadership: Governors and legislators can mandate and monitor serious collaboration

Six Policy Challenges:

- Substance-exposed births: 90-95% undetected
- School readiness and preschool expansion that leaves special needs kids out
- Failure to implement Part C referrals required for all substantiated abuse and neglect cases
- Child and family service reviews that do not adequately assess drug or mental health treatment gaps
- Mental health silos [adults vs children] as a barrier to family-centered treatment
- Most drug and alcohol treatment providers are not linked with COSA services; most do not track children of clients

The Missing Numbers Show Where The Policy Gaps Are

- Number of substance-exposed births
- Number of SEBs reported to child protective services
- Number of admissions to treatment resulting from SEBs
- Number of 0-2 year-olds referred for developmental assessment due to an SEB, a substantiated abuse case, or a DV case
- Number of admissions to treatment of parents with co-occurring disorders and number of children affected

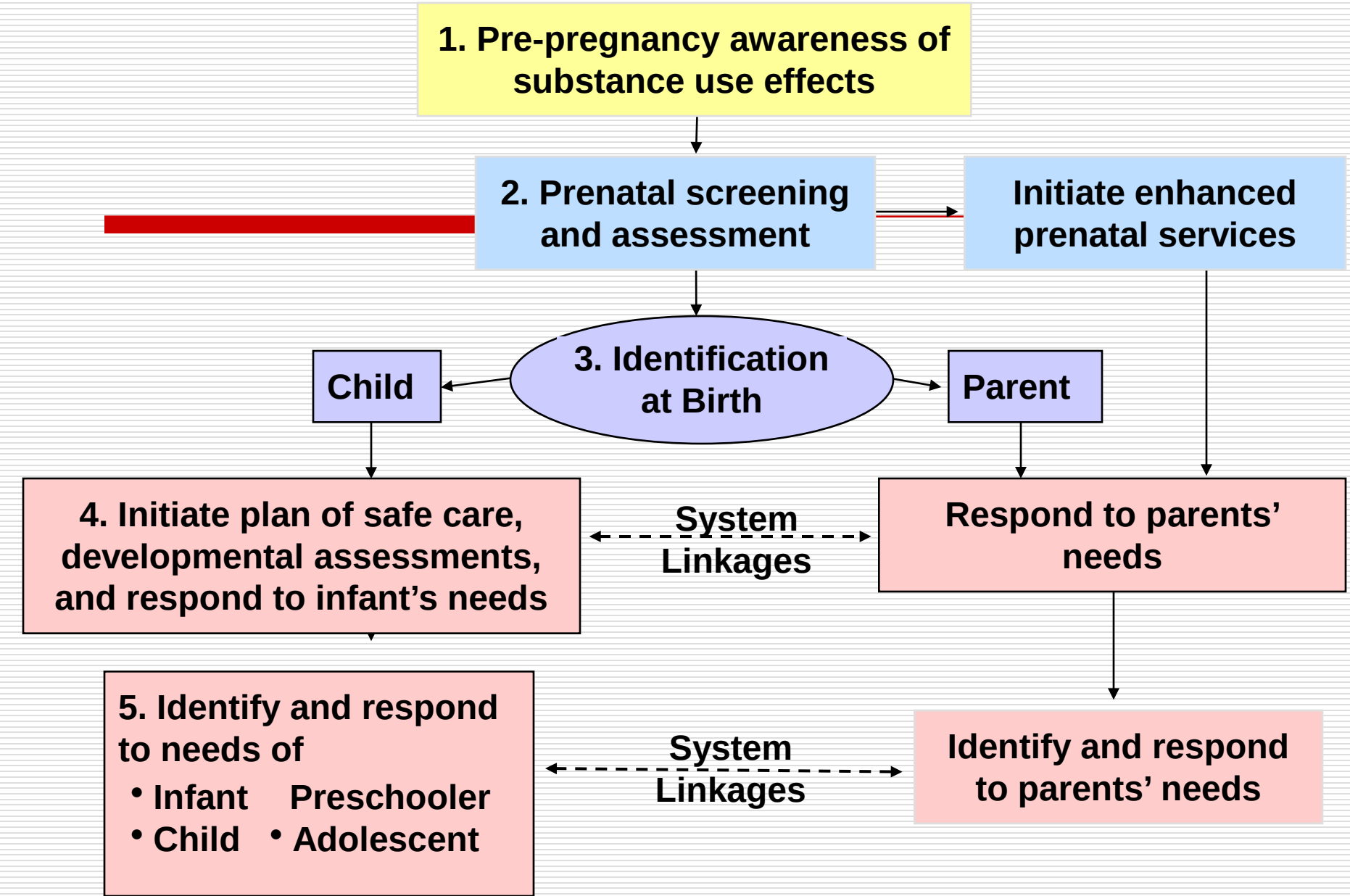
What are the Lessons of 40 Years of Service Integration and Collaboration?

- Integration *in time* matters more than integration at the same place
  - aftercare in AOD and MH treatment
  - 5 levels of intervention with prenatally exposed children [see chart]
- *Shared outcomes* is the final test of serious SI/collaboration—can all three systems agree on some shared measures? eg CFSR uses CW outcomes only
- Family treatment requires *changing the rules*, e.g. MH silo planning—adults, children—where are families? e.g. information systems—where are the missing boxes

Services Integration in Time: The Five Levels of Intervention

1. Pre-pregnancy public education
2. Prenatal screening and referral
3. Testing at birth and referral
4. Services to parents
5. Services to infants and children

Policy and Practice Framework: Five Points of Intervention



What models exist?

- Prenatal screening models in states and California counties: 4PsPlus MCH-AOD-DD
- Massachusetts MECLI model: referrals from SEBs to Part C IDEA agency; Arizona 20% increase in referrals to Part C from CPS
- Family-based treatment models
- Home visiting programs that address developmental screening, mental health, and substance use disorders
- Recovery coaches, peer mentors, and *promotoras* to improve outreach and client engagement and retention: the human dimension of SI

How can agencies self-assess their collaborative tools and skills?

- How “trilingual” are we—do we work equally with DV, MH, and SA agencies?
- Whom do we make referrals to; whom do we get referrals from?
- Whose resources do we share?
- Whose outcomes do we track—how do we keep score? Do we have data on #s of children at each level of intervention?

Additional self-assessment questions on collaboration

- Joint training?
- Linked data systems?
- Shared outcomes?
- Out-stationed staff?
- Shared client engagement staffing and outreach?
- Discussion across agencies of underlying values?

So—are we operating in the best interests of the child?

- Or in the best interests of the systems…?

“We’re getting better at it…”

…**is not the same as *making things better* for children and families**

Tension: Process of collaboration vs its results

Are we going to be satisfied with meetings—or should we negotiate shared results and agree on the best way to measure them annually?

Collaboration quotes:

I found that the entrepreneurial spirit producing innovation is associated with a particular way of approaching problems that I call "integrative": the willingness to move beyond received wisdom, to combine ideas from unconnected sources, to embrace change as an opportunity to test limits. To see problems integratively is to see them as wholes, related to larger wholes, and thus challenging established practices.

Rosabeth Moss Kanter, *The Change Masters*

Interagency collaborative capacity has an objective and a subjective component: formal agreements, budgets, personnel, accountability, but also *expectations, legitimacy, and trust.*

Eugene Bardach, *Getting Agencies to Work Together*