BUILDING COLLABORATIVE CAPACITY SERIES

HOW TO DEVELOP CROSS-SYSTEMS TEAMS AND IMPLEMENT COLLABORATIVE PRACTICE

National Center on Substance Abuse and Child Welfare

Children's Bureau
An Office of the Administration for Children & Families

SAMHSA
Substance Abuse and Mental Health Services Administration

BUILDING COLLABORATIVE CAPACITY SERIES OVERVIEW

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the *Building Collaborative Capacity Series* to provide states and communities with strategies to create cross-systems collaborative teams, communication protocols, and practice innovations. These strategies aim to improve screening, assessment, and engagement of parents in services to best serve families affected by substance use disorders (SUDs) and child welfare service involvement.

Setting the Collaborative Foundation: Modules 1-4, the first cluster of modules in the series, provides a framework for establishing a collaborative team. This framework includes developing a governance structure and offers ideas to establish the team's principles and mission. It highlights two critical elements of successful collaboration: cross-system communication and a commitment to shared outcomes.

THE MODULES ARE:

- *Module 1: Developing the Structure of Collaborative Teams to Serve Families Affected by Substance Use Disorders (SUDs)*
- *Module 2: Addressing Values and Developing Shared Principles and Trust in Collaborative Teams*
- *Module 3: Establishing Practice-Level Communication Pathways and Information Sharing Protocols*
- *Module 4: Establishing Administrative-Level Data Sharing to Monitor and Evaluate Program Success*

Frontline Collaborative Efforts: Modules 5-7, the second cluster of modules in this series, highlight strategies to improve identification of SUDs and provide timely access to assessment and treatment to support child and family safety, permanency, well-being, and parents' recovery.

THE MODULES ARE:

- *Module 5: Developing Screening Protocols to Identify Parental Substance Use Disorders and Related Child and Family Needs*
- *Module 6: Establishing Comprehensive Assessment Procedures and Promoting Family Engagement into Services*
- **Module 7: Developing and Monitoring Joint Case Plans and Promoting Treatment Retention and Positive Family Outcomes**

While each of the modules can stand alone, they build on each other; thus, professionals should review the entire series to gain a holistic understanding of building a cross-systems initiative.

NCSACW is a technical assistance resource center jointly funded by the Children's Bureau (CB), Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Points of view or opinions expressed in this series are those of the authors and do not necessarily represent the official position or policies of ACF or SAMHSA.

FRONTLINE COLLABORATIVE EFFORTS:
Developing and Monitoring Joint Case Plans and Promoting Treatment Retention and Positive Family Outcomes

The first cluster of modules in this series *(Setting the Collaborative Foundation: Modules 1-4)* provides a framework for establishing a collaborative team to improve policy and practice on behalf of families affected by substance use disorders (SUDs) and involved with child welfare services. Collaborative teams must first create a governance structure to oversee the initiative, clarify their values and develop a shared mission, and formalize their information sharing agreements and protocols for evaluating the success of the initiative prior to making frontline practice changes.

The next cluster of modules in this series *(Frontline Collaborative Efforts: Modules 5-7)* highlights frontline collaborative efforts to improve identification of parental SUDs and related family member needs, while providing timely access to SUD assessment and treatment services to support child and family safety, permanency, and well-being. The steering committee and relevant subcommittees, described in *Module 1*, should guide, oversee, and evaluate the activities described in these next modules, while leveraging local experiences to revise state policies and procedures when required.

Module 7 describes how cross-systems collaboratives can jointly develop and monitor family case plans both mutually supportive and considerate of the needs and requirements placed on the family by each involved system. It also offers engagement strategies to empower parents to build upon their strengths, promote family retention in treatment, and foster positive family outcomes.

Once the collaborative team has established a comprehensive screening and assessment protocol for families affected by SUDs, members must ensure the parents' and family members' identified treatment and service needs are directly linked to their case plans, while collaboratively monitoring family outcomes. Parents with SUDs and who are involved with child welfare services often have multiple case plans for each of the services they receive from various agencies. Thus, it is critical that collaborative partners representing child welfare, SUD treatment, mental health treatment, courts, healthcare, and other community-based providers work together to ensure their case plans are comprehensive and coordinated, lead to desired outcomes, and that a method exists to jointly monitor parent and family progress. These guidelines, described in previous modules, set the stage for continued collaborative efforts in developing and monitoring joint case plans for these families.

Collaborative teams can take the following key steps to develop coordinated joint case plans that ensure appropriate service provision and collaborative monitoring of family progress.

KEY STEPS TO DEVELOP JOINT CASE PLANS AND MONITOR FAMILY PROGRESS

COORDINATE CASE PLANS ACROSS AGENCIES

Whether through child welfare, SUD treatment, mental health treatment, healthcare, or other community-based agencies, family case plans should directly link to prior screening and assessment results. They should reflect the strengths, needs, and culture of an individual or family. They should be outcome-driven and structured. Case plans generally include the following information:

- Family strengths and resources
- Family needs
- Goals and objectives in each need area
- Services and supports to address needs and build on strengths
- Target dates for reaching goals and objectives through services and supports
- People responsible for all listed actions
- Indicators that demonstrate if specific goals are being met or progress is being made

Each agency has its own specific requirements for information to be included in the family case plan; they are typically aligned with the goals and outcomes of that system. The table below displays the items typically included in child welfare case plans and SUD treatment plans.

CHILD WELFARE CASE PLANS	SUD TREATMENT PLANS
Typically include: • Services to be provided for adults and children to ensure child safety, permanency, and family well-being • Placement of children • Safety plans that include identification of risks, along with strategies to decrease/eliminate them, and steps the family and others will take to ensure safety • Permanency plans that state the permanency goal and specify steps to achieve that goal within ASFA timelines • Visitation schedules • Required activities and objectives, such as successful completion of parenting classes, abstaining from substance use, and providing a safe home environment for reunification in cases where children have been removed • Concurrent planning activities and objectives as applicable	Typically include: • History of substance use • Drug testing requirements • Problems to be addressed (substance use, family relationships, medical care, and educational and employment needs) • Goals of the treatment process • Objectives and strategies to reach the treatment goals • Requirements for attending group and individual treatment sessions, as well as self-help groups (when appropriate) • People responsible for actions such as making referrals, attending treatment sessions, and preparing follow-up reports • Timeframe when certain activities should occur Expected benefits for the individual participating in treatment

In addition to the child welfare and treatment plans, the dependency court has a court-ordered case plan that includes the federally- and state-mandated findings regarding court review. The court order can also incorporate both the child welfare and SUD treatment plans, while overseeing the provision of services and parental compliance with the plans.

JOINT CASE PLANS: Although agencies have their own requirements for case plans, each agency-specific plan should incorporate information about family members obtained from the collaborative partners. All plans should be constructed to support the capacity of family members to engage in required services.

Ideally, collaborative teams should aim to develop a unified, comprehensive case plan that includes the services, overall goals, and mandates across systems for family members. Without unified collaborative case planning, individual agency case plans risk duplicating or even contradicting each other, which can create barriers for family members trying to meet the conflicting requirements.

For example, it would be extremely difficult for parents to participate in daily outpatient SUD treatment programs as required by the SUD treatment plan, hold a full-time job (or participate in daily employment training programs) as required by the child welfare case plan or court order, attend two parenting education (or anger management classes) per week as required in the child welfare case plan, and visit with their children twice per week—also required by the child welfare case plan. To avoid this conflict, all agencies providing services for the family members must coordinate, share information, and jointly develop their case plans.

In developing and monitoring treatment and case plans, child welfare, SUD treatment, mental health treatment, court staff, healthcare, and other community-based agency providers should share information regarding:

- Treatment and case plan activities and objectives
- Family service interventions
- Treatment requirements—including type of treatment recommended and number of required sessions
- Required drug testing
- Safety plans
- Visitation plans
- Requirements for reunification
- Permanency plan

Consistently sharing this information across systems requires an information sharing agreement and established pathways of communication, as described in *Module 3*.

The following table provides examples of factors that can be added to child welfare case plans and SUD treatment plans to ensure they are mutually supportive and inclusive of family members' holistic needs.

CHILD WELFARE CASE PLAN COMPONENTS INCLUSIVE OF SUD TREATMENT GOALS	SUD TREATMENT PLAN COMPONENTS INCLUSIVE OF CHILD WELFARE GOALS
• Assess parental substance use and related risks to children throughout the case • Incorporate objectives related to parents' treatment and recovery • Establish a plan that will encourage parents to identify and engage in appropriate SUD treatment • Address other identified needs of the child or parent	• Assess safety and well-being of children throughout the case • Incorporate objectives related to children's safety, permanency, and well-being • Identify therapeutic needs of the children and other family members • Establish a plan that will help children and family members access and engage in needed therapeutic services

Ideally, families would receive a unified case plan that emphasizes engagement and retention in services, ensures child safety and family stability, promotes recovery, and continues services even after family members complete their case plan requirements.

CONDUCT JOINT CASE REVIEWS TO MONITOR PROGRESS

Once the collaborative partners have established joint case plans for families, they must regularly review the plans to ensure they are responsive to any new family needs or new information gleaned through ongoing assessments. Monitoring change is an ongoing component of working with families—beginning as soon as the case plan is implemented—and continuing throughout the time the family is involved with child welfare, SUD treatment, and the court. Evaluating whether risk behaviors and conditions have changed drives decisions regarding service needs and adjustments to treatment, recommendations to courts, and ultimately, whether children remain with their parents.

Each agency has its own requirements and process for monitoring and reviewing case/treatment plans. However, to best serve families affected by SUDs, the frequency of these reviews may need to be more frequent than standard practices. It is also helpful to conduct joint family case reviews, ideally including all partners from child welfare, SUD treatment, courts, mental health treatment, healthcare, and other community-based services providers. These meetings should allow collaborative partners to regularly review parents' progress to meet the qualitative and quantitative goals of the case plan, especially when critical events occur. The following graphic highlights the general purposes of case reviews conducted by child welfare, SUD treatment, and dependency courts:

CHILD WELFARE CASE MONITORING	SUD TREATMENT MONITORING	COURT REVIEW HEARINGS
Review the family case plan and report to the court (when applicable) on parents' progress toward alleviating the circumstances that led to the placement, compliance with the case plan, participation in visitation, engagement in services and activities, and children's safety and well-being	Conduct oversight and tracking of participants' progress in treatment and recovery, such as attendance of individual and group treatment sessions, drug testing results, and progress toward treatment goals and objectives	Conduct a review hearing within six months of foster care entry (as required by the Adoption and Safe Families Act)—and every six months thereafter—in which judges and attorneys assess how families are progressing in their case plans, whether agencies are complying with ASFA requirements, the child's safety and well-being, the continuing necessity for out-of-home placement, and a projected date the family may be reunited

Child welfare professionals, with appropriate consent (see *Module 3* for more information on information sharing agreements and consent forms), should share any new information with SUD treatment professionals that might place stress on parents or affect the parents' participation in treatment. Some examples of stresses and changes may include:

- An increase in visitation with children
- Starting unmonitored visits
- A different unit, or child welfare worker overseeing the family's case
- Unanticipated changes in any additional services that are part of the case plan
- A change to the schedule of court hearings

SUD treatment professionals and other collaborative partners working with the family can provide valuable insight into parents' progress in treatment and recovery, along with the families' current needs and strengths. During case review meetings, SUD treatment professionals should share any new information with child welfare and the courts—especially if it could affect the children's safety and well-being—such as drug testing results, relapse or lapses in use, and overall treatment progress.

ADDRESSING RELAPSE: Substance use relapse can happen at any time in the recovery process, but parents involved with child welfare may be more at risk at certain points: before court hearings, after visitations with their children, shortly before regaining custody of their children, and shortly before exiting from the child welfare system. Parents may experience a "lapse" (a period of substance use) or a "relapse" (the return to problem behaviors associated with substance use).

Because addiction is a brain disease, lapses and relapses can happen and can be understood as a part of the overall recovery process. Treatment professionals can help child welfare and court staff, as well as parents and family members, avoid classifying either as a treatment failure; instead, they can help parents restart treatment as soon as possible. Child welfare workers, together with SUD treatment professionals, can also help parents use relapse episodes to recognize factors that trigger cravings, while anticipating the possibility of relapse by creating safety plans for their children.

Parents who learn their triggers are more empowered to plan for the safety of their children and seek healthy ways to neutralize these triggers. Through joint case monitoring, the collaborative team can work together following a lapse or relapse to adjust the case plans to meet the parent's needs, address any implications for child safety, and foster treatment success.

ENGAGING FAMILIES IN CASE REVIEWS: Collaborative teams must also actively engage parents and family members in creating and monitoring their case plans. Families often have resources in the form of relatives, friends, churches, or other support networks that participate in creating plans while ensuring parents and family members can comply with them. Teams should welcome family members as full participants in multidisciplinary meetings where decisions about case plans will be made. Collaborative teams can use family group conferencing strategies such as Team Decision Making to ensure all key family participants understand the treatment and child welfare goals for the parent—and are working on ways to support them. The Annie E. Casey Foundation developed an infographic displaying the elements of Team Decision Making as well as a resource that compares and contrasts the different approaches to family group conferencing, titled Four Approaches to Family Team Meetings.

ESTABLISH BENCHMARKS TO MEASURE FAMILIES' PROGRESS AND DETERMINE READINESS FOR CASE CLOSURE

As described in *Module 4*, developing collaborative outcome measures or benchmarks to measure parents' progress in recovering from SUDs, and assessing parenting capacities are important tasks. Outcome benchmarks should be based on requirements included in the treatment and case plans. Benchmarks help SUD treatment staff determine the appropriateness or effectiveness of the treatment services provided to family members. Benchmarks also guide child welfare and court decisions regarding permanency arrangements for children (particularly with respect to seeking termination of parental rights or providing aftercare services to families when children are reunified) and services to ensure child safety and well-being. The team uses these measures to assess how well their systems are sharing information, engaging and retaining families, and making appropriate, timely decisions.

Collaborative outcome measures and benchmarks require staff to have protocols for obtaining information from families and for sharing information with colleagues. See *Module 3* to learn more about information sharing protocols. Teams can use the following strategies to secure and share important information related to family progress:

- Develop joint disclosure forms that meet the needs of all relevant systems
- Conduct cross-system staff meetings to address pertinent issues
- Invite staff and family members to discuss progress, problems, and next steps during meetings
- Work with the parent's legal advocate to ensure the court is responding to the parent's treatment needs and progress

The question of whether demonstrable changes are sufficient to warrant family reunification or closing the case can be answered only if all staff work closely with families to monitor their progress and adjust plans as needed. Effective communication between the child welfare, SUD treatment, and court systems also play a role.

SUD TREATMENT TRANSITION PLANNING: When a parent has demonstrated progress meeting SUD treatment objectives, SUD treatment professionals must decide whether the parent is ready to transition out of formal treatment. This determination involves developing the parent's ongoing recovery plan and putting support systems in place.

Continuing care (or aftercare) services are essential to sustaining treatment success, child safety, and family well-being because they give parents a chance to solidify new behaviors that promote health and wellness. Without such services and community supports, relapse can occur, even if parents have achieved long periods of sobriety while in treatment.

Continuing care also includes clinical treatment and community support addressing needs identified in the relapse prevention plan and creating a supportive net around the parent and family members to encourage recovery. For families involved with the child welfare system, continuing services should offer help to parents in recovery who may be under new stress related to their children returning home. Other supports frequently needed include housing, job training, mental health services, or educational services. Staff and family members should work together to establish a system of support for families, and a process by which family members can both assess their own progress over time and receive assessments from professional counselors as needed.

CHILD WELFARE PERMANENCY DETERMINATION: Monitoring change is an ongoing component of child welfare work and continues throughout family involvement. Evaluating whether risk behaviors and conditions for families have changed drives decisions regarding service needs and adjustments, recommendations to courts, and ultimately, whether children remain with their parents. As discussed previously, formal reviews regarding the status of each child in foster care are required at least once every six months. In some states, child welfare staff conduct these reviews, which go to the court only if circumstances warrant. In most states the court conducts the reviews.

The Adoption and Safe Families Act (ASFA) requires each child to have a permanency hearing no later than 12 months after entering foster care. When a child has been in foster care for 15 of the most recent 22 months, the state must file a petition to terminate parental rights unless a relative is caring for the child, there is a compelling reason that termination is not in the best interests of the child, or the state has not provided the needed services within the required deadlines. When appropriate treatment services are not available to a parent within ASFA timeframes, the third reason may provide a justification for extending family reunification efforts. In these cases, it is essential that staff from child welfare, treatment, and the courts determine whether an extension is appropriate.

The following are examples of demonstrable changes that might indicate families are ready for reunification:

- Parents have improved their capacity to meet the needs of their children.
- Parents have completed the recommended treatment program at an acceptable level or are proceeding well enough to know that children are not at risk.
- There are no remaining unsafe conditions posing a risk to children, based on a safety assessment.
- There are no additional reports of child abuse or neglect.
- Positive family supports and community links are available when needed.
- A safety plan is in place.
- Parent demonstrates the ability and willingness to use community supports.
- Children have a safe, stable, and appropriate permanency goal of reunification, adoption, or another planned permanent living arrangement.

KEY STRATEGIES TO PROMOTE RETENTION IN TREATMENT AND POSITIVE FAMILY OUTCOMES

As child welfare, SUD treatment, mental health treatment, courts, and other collaborative partners jointly monitor the family's progress in the case and treatment plans, they must collectively ensure services provided are meeting the family members' needs and the systems are actively engaging family members in the treatment and recovery process. Collaborative partners can use the following key strategies to promote parent retention in treatment and foster positive family outcomes:

PROVIDE FAMILY-CENTERED TREATMENT

Traditional SUD treatment often focuses mainly on the effects of substance use on the individual entering treatment and less on the effect SUDs have on the entire family unit; thus, the children and extended family members may be left out of the treatment process. When a parent has an SUD, it can affect the entire family's functioning and well-being. Many parents involved with child welfare are dealing with multiple challenges and risks that can negatively affect safety, permanency, well-being, and recovery outcomes.[1]

Parental recovery occurs within the context of family relationships.

A family-centered approach to treatment provides a comprehensive array of clinical treatment and related support services that meet the needs of the children and each member of the family, not only the parent with the SUD. Service length, setting type (e.g., residential, outpatient), and program size can vary. All family-centered treatment programs share common objectives: making sure parents are fully supported in their parenting roles and children receive the necessary services and supports to remain with their parent(s) during the treatment and recovery process. Treatment provider approaches may differ along a continuum, from family involvement (a minimum standard of service) to family-centered services (in which children or other family members may receive their own services)—to full comprehensive family-based treatment (in which all members of the family have individualized case plans and share an integrated family plan).[2]

CONTINUUM OF FAMILY-BASED TREATMENT SERVICES

PARENT'S TREATMENT WITH FAMILY INVOLVEMENT	PARENT'S TREATMENT WITH CHILDREN PRESENT	PARENT'S AND CHILDREN'S SERVICES	FAMILY SERVICES	FAMILY-CENTERED TREATMENT
Services for parent(s) with substance use disorders. Treatment plan includes family issues, family involvement	Children accompany parent(s) to treatment. Children participate in child care, but receive no therapeutic services. Only parent(s) have treatment plans	Children accompany parent(s) to treatment. Parent(s) and attending children have treatment plans and receive appropriate services.	Children accompany parent(s) to treatment; parent(s) and children have treatment plans. Some services provided to other family members.	Each family member has a treatment plan and receives individual and family services.
Goal: improved outcomes for parent(s)	**Goal:** improved outcomes for parent(s)	**Goal:** improved outcomes for parent(s) & children, better parenting	**Goal:** improved outcomes for parent(s) & children, better parenting	**Goal:** improved outcomes for parent(s), children, & other family members; better parenting and family functioning

(Werner et al., 2007; Substance Abuse and Mental Health Services Administration, 2009)

A key element to providing family-centered child welfare practices for families affected by SUDs is to prioritize visitation/quality family time without tying it to drug testing results. Withholding visitation should not be used as a punishment for relapse. Although safety is always the priority, using visitation to encourage recovery is not helpful and can harm both the child and parent. Visitation is vital for all involved, and all efforts should both encourage and support quality time between children and parents.

The following are some other key considerations for parenting time:

- Visitation should occur consistently and frequently, for an appropriate amount of time, and in a comfortable and safe setting.
- Visitation should include therapeutic supervision when appropriate.
- Parents should have the opportunity to be present during typical parenting situations such as doctor visits and appointments with therapists when appropriate.
- Parents may need help designing appropriate activities to do with their children during visitation.
- Keeping parents connected to their children in meaningful ways can help parents gain the necessary skills to meet the needs of their children.
- Visitation is an opportunity to gather information about parent and child service needs.

For more information on family-centered treatment, see the NCSACW Training Modules: *Implementing a Family-Centered Approach for Families Affected by Substance Use Disorders and Involvement with Child Welfare Services*.

IMPLEMENT A FAMILY TREATMENT COURT

A family treatment court (FTC) is a collaborative model that improves parent and family member engagement in treatment and other services. FTCs are juvenile or family court dockets for cases of child abuse or neglect in which parental substance use, and often co-occurring mental health disorders, are contributing factors. This collaborative model brings together judges, court personnel, attorneys, child welfare services, SUD treatment professionals, mental health treatment professionals, and other community partners to coordinate services for families. The model strives to ensure children have safe, nurturing, and permanent homes within mandatory permanency time frames, parents achieve stable recovery, and each family member receives needed services and supports.[3] FTCs have been shown to promote higher rates of parent participation and longer stays in SUD treatment, increased family reunification, and less time for children in foster care.[4,5,6,7]

For more information on FTCs see *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* and *Family Treatment Court Best Practice Standards*.

ADDRESS RACIAL DISPROPORTIONALITY AND ENSURE SERVICES ARE CULTURALLY RESPONSIVE

Significant research has documented the overrepresentation of certain racial and ethnic populations in the child welfare system as compared to the general population.[8,9,10] Adoption and Foster Care Analysis and Reporting System data from Fiscal Year 2019 indicate that American Indian/Alaskan Native children make up 2% of the children in foster care and African American children make up 23% of the children in care, despite the fact that they represent 1% and 14% of U.S. child population, respectively.[11] African American children are more likely to experience longer stays in out-of-home care, less likely to be reunified with their families and find permanency; and more likely to have poor educational, social, behavioral, and other outcomes.[12] African American children may be less likely to be reunified due to barriers related to service disparities.[13] Research indicates African Americans experience lower rates of referral to—and engagement in—SUD and mental health services.[14] It is important for child welfare and SUD treatment providers to acknowledge systemic racism and the impact of racial disproportionality on families, address implicit bias, and change policies and practices that further the disproportionality and create barriers to care. The Center for the Study of Social Policy (CSSP) resource, *Using an Anti-Racist Intersectional Frame at CSSP*, is a conceptual tool to examine systemic power and the oppression that Black, Indigenous, and people of color (BIPOC) face. A 2021 resource from the Child Welfare Information Gateway, *Child Welfare Practice to Address Racial Disproportionality and Disparity*, offers child welfare caseworkers, administrators, program managers, and policymakers strategies to address racial disproportionality and disparity along the child welfare continuum. The Kirwan Institute for the Study of Race and Ethnicity and CSSP provide an online course for child welfare professionals, *inSIGHT: Exploring Implicit Bias in Child Protections*.

Ensuring services respect and respond to the cultural identities and needs of families is an important way to improve engagement and provide access to high-quality care. Effective SUD treatment and other services must be tailored according to the individual's race, gender, cultural identity, and sexual orientation. By providing culturally-responsive services, providers can improve relationships with their clients, encourage engagement in services, improve retention in and completion of treatment, and decrease disparities in behavioral health.[15] Services must be responsive to the family's experience of racial injustice, historical trauma, and cultural and linguistic needs. Organizations need to infuse cultural awareness, responsiveness, and understanding throughout every level to be most effective. SAMHSA's *Treatment Improvement Protocol 59: Improving Cultural Competence* provides counselors and other health care providers with specific racial, ethnic, and cultural considerations along with information about the core elements of cultural competence.

In serving Native American families, treatment must recognize the impact of historical trauma; identify the role of culture and cultural identity; take a holistic approach that incorporates the spiritual, emotional, physical, social, behavioral, and cognitive aspects of life; recognize tribal sovereignty; promote cultural awareness and culturally responsible services; and respect the many paths to healing.[16] For more information see SAMHSA's *TIP 61: Behavioral Health Services for American Indians and Alaska Natives*.

The National Survey on Drug Use and Health found that individuals who identify as lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) were more likely than their heterosexual and cisgender counterparts to have substance use and mental health issues, including a higher risk of using illicit drugs in the past year and increased likelihood of current cigarette and alcohol use.[17] Professionals working with families affected by SUDs and involved with child welfare must ensure they are responsive to the needs of this population. SAMHSA's Addiction Technology Transfer Program offers the *Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals (2nd Edition)*. This training curriculum helps administrators and clinicians skillfully deliver culturally responsive prevention and treatment services for the LGBTQ population, especially those dealing with co-occurring substance use, mental health disorders, and/or physical health issues. The Child Welfare Information Gateway offers a resource bulletin, *Working With Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Families in Foster Care and Adoption*.

PROVIDE TRAUMA-INFORMED CARE FOR FAMILIES

As discussed in *Module 5*, many parents with SUDs and child welfare involvement, as well as their families, have experienced traumatic events. Parents, children, and other family members need a system of care that recognizes the effect of trauma on their recovery. Professionals must provide evidence-based trauma services within the context of a trauma-informed organizational culture that avoids triggering the unintentional retraumatization of parents, children, and other family members. Being a trauma-informed organization means that every part of the organization—from management to service delivery—understands how trauma affects the life of an individual seeking services.[18] Staff in trauma-informed programs understand the vulnerabilities or triggers of trauma survivors, as opposed to traditional service delivery approaches which may exacerbate those issues. Trauma-informed care must be weaved through each service system, including child welfare services, SUD treatment, courts, healthcare, and other community-based agencies.

SAMHSA describes the Six Principles of a Trauma-Informed Approach:[19]

SAFETY	Ensure the physical and emotional safety of clients and staff
TRUSTWORTHINESS AND TRANSPARENCY	Provide clear information about what the client may expect in the program, ensure consistency in practice and maintain boundaries
PEER SUPPORT	Provide peer support from persons with lived experiences of trauma to establish safety and hope and build trust
COLLABORATION AND MUTUALITY	Maximize collaboration and the sharing of power with consumers to level the differences between staff and clients and maximize collaboration with other providers
EMPOWERMENT, VOICE AND CONTROL	Empower clients and staff to have a voice, share in decision making and goal setting to cultivate self-advocacy
CULTURAL, HISTORICAL AND GENDER ISSUES	Move past cultural stereotypes and biases, offer gender and culturally responsive services, and recognize and address historical trauma

Child welfare and SUD treatment providers must screen children and parents for traumatic experiences. When warranted, they must ensure a clinical assessment and links to appropriate trauma services. Some examples of trauma-specific services for adults, children, and adolescents include:

- *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*—TF-CBT is an evidence-based treatment for parents and their children (ages 3-18) who have experienced trauma and have significant emotional problems, such as post-traumatic stress disorder (PTSD), fear, anxiety, or depression.
- *Seeking Safety*—Seeking Safety is an evidence-based counseling model to support adults and adolescents with a history of trauma and/or substance use. It may be conducted in a group or individual format. The model consists of 25 topics that can be conducted in any order and in as many sessions as needed.
- *Child-Parent Psychotherapy (CPP)*—CPP is an intervention model for parents and children (aged 0-5) who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including PTSD. CPP aims to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health.

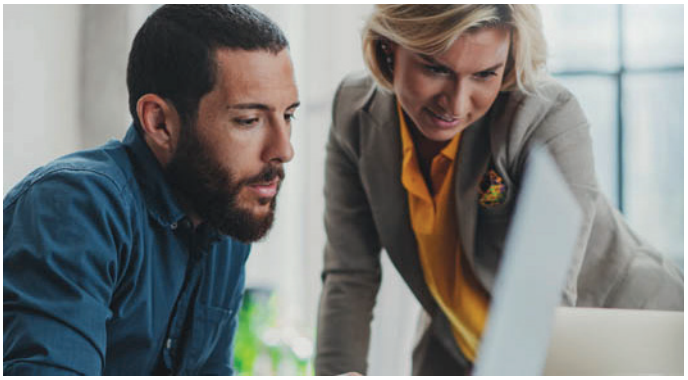
For more information on trauma-informed care within child welfare, see the Child Welfare Information Gateway *Issue Brief: The Importance of a Trauma-Informed Child Welfare System*. This brief describes the essential components of a trauma-informed child welfare system and features examples from state and local programs that are incorporating trauma-informed practice.[20] The National Child Traumatic Stress Network offers the *Child Welfare Trauma Training Toolkit*, a training series designed to support the infusion of trauma-informed knowledge and skills into child welfare organizational cultures.

THE ROLE OF TRAINING

While staff in child welfare, SUD treatment, healthcare, and other community-based agencies are generally quite familiar with the case plans required by their respective agencies, those lacking extensive experience in partnering across systems will likely need training on developing joint case plans. The collaborative team must ensure that orientation and ongoing training programs provide these professionals the practical skills necessary for joint case planning and collaboratively monitoring families' progress. In addition, cross-training must also educate partners on case plan requirements and expectations placed upon families by the collaborating agencies. They must also ensure that partners weigh in on, and understand, the protocols and practices for joint case planning.

Each collaborative partner must receive training on the engagement practices previously described to best serve these families. The collaborative team can design cross-system training programs to help partners understand how to implement family-centered, culturally responsive, and trauma-informed practices.

Court and legal professionals who make decisions regarding child placements and services must also receive training on the effect of parental SUDs on children and family members, as well as child social-emotional and developmental stages. NCSACW offers a free online tutorial geared toward legal professionals working with children and families affected by SUDs and involved with child welfare services.



Child welfare and SUD treatment providers must screen children and parents for trauma.

NEXT STEPS

Module 7 is the final module in the *Building Collaborative Capacity Series*. The first cluster of modules in the series offers strategies for building an effective cross-systems collaborative team to improve policy and practice on behalf of families affected by SUDs and involved with child welfare services. The second and final cluster of modules focuses on frontline collaborative efforts to improve identification of SUDs, while providing timely access to assessment and treatment services to prevent child removal—in favor of permanency and family well-being.

The NCSACW provides a variety of resources and technical assistance opportunities for states and communities to improve policy and practice on behalf of these families. Please visit the website to learn more.

ABOUT US

The National Center on Substance Abuse and Child Welfare (NCSACW) is a technical assistance resource center jointly funded by the Children's Bureau (CB), Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. NCSACW provides no-cost consultation, training, and technical assistance to child welfare agencies, SUDs treatment agencies, mental health treatment agencies, courts, healthcare, early childhood providers, and other related entities. NCSACW supports these agencies' efforts to make policy and practice changes to improve outcomes for families affected by SUDs.

Email NCSACW at *ncsacw@cffutures.org*

Visit the website at *https://ncsacw.acf.hhs.gov/*

Call toll-free at ***866.493.2758***

REFERENCES

[1] Brook, J. M., & McDonald, T. (2009). The impact of parental substance abuse on the stability of family reunifications from foster care. *Children & Youth Services Review, 31*(2), 193-198. doi:10.1016/j.childyouth.2008.07.010

[2] Werner, D., Young, N.K., Dennis, K, & Amatetti, S. (2007). *Family-centered treatment for women with substance use disorders: History, key elements and challenges.* Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

[3] Children and Family Futures. (2015). *Guidance to states: recommendations for developing family drug court guidelines*. Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs. http://www.cffutures.org/files/publications/FDC-Guidelines.pdf

[4] Boles, S. M., Young, N. K., Moore, T., & DiPirro-Beard, S. (2007). The Sacramento dependency drug court: Development and outcomes. *Child Maltreatment, 12*, 161-171. doi: 10.1177/1077559507300643

[5] Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review, 29*, 460-473. doi: 10.1016/j.childyouth.2006.08.006

[6] Worcel, S. D., Green, B. L., Furrer, C. J., Burrus, S. W. M., & Finigan, M. W. (2007). *Family treatment drug court evaluation: Executive summary*. Substance Abuse and Mental Health Services Administration. https://npcresearch.com/wp-content/uploads/FTDC_Evaluation_Executive_Summary.pdf

[7] Worcel, S. D., Green, B. L., Furrer, C. J., Burrus, S. W. M., & Finigan, M. W. (2007). *Family treatment drug court evaluation: Executive summary*. Substance Abuse and Mental Health Services Administration. https://npcresearch.com/wp-content/uploads/FTDC_Evaluation_Executive_Summary.pdf

[8] Magruder, J., & Shaw, T. V. (2008). Children ever in care: An examination of cumulative disproportionality. *Child Welfare, 87*(2), 169–188. https://pubmed.ncbi.nlm.nih.gov/18972937/

[9] Ganasarajah, S., Siegel, G., & Sickmund, M. (2017). *Disproportionality rates for children of color in foster care (fiscal year 2015)*. National Council of Juvenile and Family Court Judges. https://www.ncjfcj.org/wp-content/uploads/2017/09/NCJFCJ-Disproportionality-TAB-2015_0.pdf

[10] Wells, S. J. (2011). Disproportionality and disparity in child welfare: An overview of definitions and methods of measurement. In D. K. Green, K. Belanger, R. G. McRoy, & L. Bullard (Eds.), *Challenging racial disproportionality in child welfare: Research, policy, and practice* (pp. 3–12). CWLA Press.

[11] Adoption and Foster Care Analysis and Reporting System (AFCARS). (2020). *The AFCARS report*. Administration for Children, Youth and Families, Children's Bureau. https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf

[12] Center for the Study of Social Policy & Annie E. Casey Foundation. (2011). *Disparities and disproportionality in child welfare: Analysis of the research*. https://casala.org/wp-content/uploads/2015/12/Disparities-and-Disproportionality-in-Child-Welfare_An-Analysis-of-the-Research-December-2011-1.pdf

[13] Child Welfare League of America. (2008). Statement submitted to hearing on racial disproportionality in foster care before the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, U.S. House of Representatives, 110th Congress, second session, July 31, 2008. Government Printing Office.

[14] National Institute on Drug Abuse. (2003). Drug use among racial ethnic minorities (NIH Publication No. 03-3888). Bethesda, MD: Author. https://archives.drugabuse.gov/sites/default/files/minorities03_1.pdf

[15] Substance Abuse and Mental Health Services Administration. (2014). TIP 59: *Improving cultural competence.* https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

[16] Substance Abuse and Mental Health Services Administration.(2018). *TIP 61: Behavioral health services for American Indians and Alaska Natives*. https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf

[17] National Survey on Drug Use and Health. (2016). *Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 National Survey on Drug Use and Health*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/ NSDUH-SexualOrientation-2015.htm

[18] Substance Abuse and Mental Health Services Administration. (2014). *Concept of trauma and guidance for a trauma-informed approach*. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

[19] Substance Abuse and Mental Health Services Administration. (2014). *Concept of trauma and guidance for a trauma-informed approach*. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

[20] Child Welfare Information Gateway. (2020). *Issue brief: The importance of a trauma-informed child welfare system*. Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubPDFs/trauma_informed.pdf