California Social Work Education Center

C A L S W E C

Pathways to Collaboration

Understanding the Role of Values and System-Related Factors in Collaboration Between Child Welfare and Substance Abuse Treatment Fields

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ABSTRACT

A growing body of research and policy analysis focused on addressing the needs of substance-abusing families in child welfare call for "bridging the gap" in values and attitudes between systems and developing collaborative models for intervention and case planning (DHHS, 1999; Young & Gardner, 2002). Changes in national and state laws that limit timelines for potential reunification, combined with the high prevalence of children of substance-abusing families in out-of-home placements, underscore the importance of addressing these differences effectively. To this end, there is a need for greater understanding how values and practices within and between these two fields may be better aligned to facilitate successful collaboration in programs and cooperation in case planning.

This study examined similarities and differences in values and perceived capacity for collaboration between substance abuse and child welfare fields based on survey data using a "Collaborative Values Inventory" and "Collaborative Capacity Instrument" from 350 respondents in 12 counties in California. This curriculum, which is grounded in the findings from the study, provides highlights of research and experiential activities in four primary areas that may be used independently or in combination: a) relationships between child welfare and substance abuse; b) impact of values, beliefs, and expectations on practice; c) differences and similarities in attitudes and values between child welfare and substance abuse treatment professionals; and d) building systemic collaboration.

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state collation of social work educators and practitioners. It is a consortium of the state's 16 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child

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welfare field, CalSWEC funds a series of curriculum sections that employ varied research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, curriculum sections are made available through the CalSWEC Child Welfare Resource Library to all participating school and collaborating agencies.

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

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ABOUT THE AUTHORS

Laurie Drabble, PhD, MSW, MPH is an Assistant Professor at the San José State University College of Social Work. Dr. Drabble was Principal Investigator for the research project on *Pathways to Collaboration: Understanding the Role of Values and System-Related Factors that Contribute to the Adoption of Promising Practices between Child Welfare and Alcohol and Drug Systems*. Dr. Drabble has been involved in a number of research projects related to alcohol and drug problems among marginalized populations of women and improvement of service delivery systems. She is an Affiliate Associate Scientist with the Alcohol Research Group in Berkeley, California and she was Co-Investigator for the San José State University College of Social Work study on *Factors Related to the Over-Representation of Children of Color in the Santa Clara County Child Welfare System*. She also conducted a study for the University of California at Davis Center for Human Services/Northern California Children & Family Services Training Academy examining the substance abuse training needs of child welfare and allied professionals in 14 Northern California counties. In her earlier career, Dr. Drabble was Executive Director of the California Women's Commission on Alcohol and Drug Dependencies (CWCADD). She has a long history of working statewide on a wide range of projects related to collaboration between child welfare and substance abuse fields, including developing training curricula, conducting training needs assessments, and organizing trainings/conferences.

Marty Tweed, MSW, LCSW**,** was a full-time member of the faculty at San José

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State University from 1993-2004, serving in various capacities (Title IV-E Faculty Field Liaison, Lecturer, and MSW Admissions Director). She was employed in public child welfare services from 1984-1993 and held positions including that of social worker and supervisor. Ms. Tweed is currently working as the Field Program Coordinator and Lecturer at the Department of Health, Human Services and Public Policy of California State University Monterey Bay (CSUMB). Ms. Tweed's practice interests include public child welfare, permanency planning mediation and adoptions, graduate admissions, and outcomes-based education. She is responsible for assisting with adaptation of the CalSWEC-funded *Pathways to Collaboration* research report into this curriculum.

Kathy L. Osterling, MSW, PhD Candidate, is completing her doctorate at the School of Social Welfare at U.C. Berkeley. Ms. Osterling has had experience on several research projects in the School of Social Work at San José State University, including as a research assistant on an examination of the factors related to the disproportionate representation of children of color in Santa Clara County's child welfare system; factors related to college-attendance among former foster youth; and the current study on collaboration between the child welfare and substance abuse treatment fields. Ms. Osterling has also served as a research assistant for the Bay Area Social Services Consortium at the School of Social Welfare, U.C. Berkeley, where she worked on reports reviewing evidence-based practice on promising programs for low-income families, interventions to reduce racial/ethnic disproportionality in the child welfare system, substance abuse interventions for parents involved in the child welfare system,

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and research on child welfare outcomes. Ms. Osterling's dissertation is focused on examining the impact of poverty on immigrant children's mental health. Fall 2006, she will begin as an Assistant Professor in the School of Social Work at San José State University.

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Contra Costa County
Amalia Gonzalez del Valle, Contra Costa County Alcohol and Other Drug Services Administration
Gloria Halverson, Contra Costa County Children and Family Services
Brenda Underhill, Alcohol and Other Drug Services Administration

Glenn County
Cindy Biddle, Glenn County Health Services
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Chellie Gates, Glenn County Human Resource Agency
Cheryl Harrison, Glenn County Human Resource Agency

Humboldt County
Larry Dorfman, Humboldt County Department of Health and Human Services

Merced County
Ana Pagan, Merced County Human Services Agency
David Schilling, Merced County Human Services Agency
Thomas Skinner, Merced County Department of Mental Health, Alcohol and Drug Services

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Sacramento County
Elizabeth English, Sacramento County Department of Health and Human Services, Alcohol and Drug Services Division

San Diego County
Rhonda Sarmiento, San Diego County Health and Human Services Agency, Child Welfare Services

San Joaquin County
Kristine Maxwell, San Joaquin County Human Services Agency
Francis Hutchins, San Joaquin County Office of Substance Abuse

San Luis Obispo County
Nita Kenyon, San Luis Obispo County Department of Social Services
Star Graber, San Luis Obispo County Behavioral Health Services, Drug & Alcohol Services

Shasta County
Susan Hacking, Shasta County Alcohol and Drug Programs
Lynne Jones, Shasta County Social Services, Children & Family Services

Stanislaus County
Carlos de la Cerda, Stanislaus County Behavioral Health & Recovery Services
Cheryl Smith Carroll, Stanislaus County Child Welfare Services, Families in Partnership

Tehema County
Randi Gottlieb-Robinson, Tehema County Department of Social Services, Child Welfare Services
Patrice Tamp, Tehema County Health Services Agency, Drug & Alcohol Division

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curriculum for this project.

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Alice Hines and Joan Merdinger, San José State University, provided inspiration and practical advice during the development of the research proposal. Emily Bruce, Blanca Tavera, and Anna-Maria Karnes, provided valuable feedback on curriculum drafts.

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In any endeavor that involves multiple counties and hundreds of respondents, it is impossible to publicly thank every contributor. To all the respondents who filled out surveys, individuals who encouraged participation in the study, and colleagues who extended practical and moral support to the evolution of the projects, our research team extends our heartfelt appreciation.

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INTRODUCTION

Research over the last 20 years has documented a strong correlation between substance abuse and risk of involvement in the child welfare system. More recently, a growing body of research and policy analysis focused on addressing the needs of substance-abusing families in child welfare calls for "bridging the gap" in values and attitudes between child welfare and substance abuse treatment service delivery systems and developing collaborative models for intervention and case planning (Department of Health and Human Services [DHHS], 1999; Legal Action Center, 2003; McDonald & Associates, 2001; Young, Gardner, & Dennis, 1998; Young & Gardner, 2002).

The purpose of this research-based curriculum is to increase awareness about how individual and professional values may impact interdisciplinary practice and to develop skills for improved collaborative practice among child welfare workers, substance abuse treatment professionals, and other professionals working with substance-abusing families involved in the child welfare system.

The primary focus of the study used in the development of this curriculum was to investigate the role of values and other system-level factors in the development of collaborative models for improved intervention and shared case planning with substance-abusing families involved in the child welfare system. Specifically, this study examined similarities and differences in values and perceived capacity for collaboration between substance abuse and child welfare fields based on survey data from 350

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respondents in 12 counties in California. Respondents included managers, supervisors, and line staff in child welfare, substance abuse treatment, and other fields (such as dependency courts, health, and mental health). The instruments used in this study, the Collaborative Values Inventory (CVI) and Collaborative Capacity Instrument (CCI), were developed by Children and Family Futures/National Center for Substance Abuse and Child Welfare.

This curriculum provides a review of key research literature reports on findings of the research conducted for this project in two primary areas. First, findings highlight key similarities and differences in values and beliefs between substance abuse and child welfare respondents in several domains (defined through factor analysis) such as attitudes about substance-abusing parents and perceived barriers to collaboration. Second, findings document some of the key collaborative practices more commonly reported by counties with a strong history of collaboration compared to counties earlier in the collaborative process, particularly in the areas of screening, assessment, and training. The findings underscore the importance of a) addressing differences in personal and professional values in professional and educational settings, and b) learning about innovative processes, programs, and policies from counties and states that have forged successful collaborative models.

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CURRICULUM OVERVIEW

This curriculum will provide users with research highlights, conceptual frameworks, tools, and experiential opportunities to strengthen their understanding of the relationship between substance abuse and child welfare and increase their capacity to work collaboratively across fields. This curriculum is based on the following assumptions:

- ❖ Individual and systemic capacity for collaboration is critical given the prevalence of substance-abusing families in child welfare and the urgency for developing collaborative case planning in the context of new timelines.
- ❖ The ability of child welfare and other helping professionals to provide appropriate assessment and intervention is informed by their own values, affected by value differences between systems, and supported or constrained by the ability to communicate between systems to resolve differences in case planning.

Objectives

The curriculum objectives for each section are described below.

Section I - Relationships Between Child Welfare and Substance Abuse

By the end of this section, participants will:

- ❖ Recognize relationships between substance abuse and child welfare issues, including prevalence of alcohol and drug abuse among parents, and correlations between substance abuse and child welfare involvement.
- ❖ Name at least three policy changes that underlie the urgency for addressing substance abuse problems among families involved in the child welfare system.
- ❖ Discuss some of the dilemmas and concerns faced by professionals seeking to address intersecting substance abuse and child welfare issues.

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Section II - Impact of Values, Beliefs, and Expectations in Practice

By the end of this section, participants will be able to:

- ❖ Describe how personal beliefs, expectations, and values may impact practice.
- ❖ Recognize some of the values and beliefs that are compatible with effective practice with families impacted by substance abuse.
- ❖ Identify at least three strategies to minimize the potential for bias based on personal values that may influence practice.

Section III - Attitudes and Values of Child Welfare and Substance Abuse Treatment Professionals in California: Findings from the Collaborative Values inventory

By the end of this section, participants will:

- ❖ Discuss the importance of identifying differences in values and developing shared values in the process of building collaborative relationships.
- ❖ Understand how the Collaborative Values Inventory may be used as a tool for clarifying differences in values and creating common values between systems.
- ❖ Recognize similarities and differences in values, attitudes, and beliefs between substance abuse and child welfare professionals who participated in the study.
- ❖ Practice skills in reflecting on their own values and discussing values and potential bias with colleagues.

Section IV - Building Systemic Collaboration: Findings from the Collaborative Capacity Instrument

By the end of this section, participants will be able to:

- ❖ Identify at least 3 of 10 domains for collaborative practice measured by the Collaborative Capacity Instrument.
- ❖ Understand how tools such as the Collaborative Capacity Instrument may be used to assess and facilitate collaborative relationships between systems.
- ❖ Engage in problem solving and identification of macro level strategies for building cross-systems collaboration.

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Section V - Building Bridges Between Systems: Resources and Next-Steps

By the end of this section, participants will be able to:

- ❖ Discuss implications of the literature and the current research study on social work practice.
- ❖ Identify key resources for obtaining additional information about practice issues related to the intersection of substance abuse and child welfare.
- ❖ Articulate "next-steps" for their own application of information and ideas from the curriculum.

Intended Audience

The primary audiences for this curriculum are IV-E students and entry-level child welfare professionals. Although some of the materials emphasize the child welfare field, many of the sections may be used or adopted for students and professionals in a variety of disciplines who may work in any way with issues of substance abuse and child maltreatment.

The sections in this training may be adapted for use with students or other participants with varied levels of knowledge in working with substance-abusing parents in the child welfare system. However, instructors or trainers working with students or professionals who have little knowledge of the subject will need to cover essential information related to correlations between substance abuse and child welfare involvement (Section I) as well as information and activities that underscore how underlying personal and professional values may impact practice and, consequently, must be identified clearly and examined critically (Section II and Section III). These sections may also be particularly relevant to MSW practice classes.

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Instructors working with advanced practitioners may elect to highlight information and activities that emphasize systems-level issues and problem solving (Parts of Sections II, III, and IV). These segments of the curriculum could also be used in MSW courses related to policy, organizational development, or agency management.

Organization of Curriculum

The curriculum sections are intended to build upon one another. However, it is possible for instructors to use each of the sections independently or in combination. A brief description of each section follows:

Section I – Relationships Between Child Welfare and Substance Abuse. This section provides foundation knowledge and an introduction to the topic of the correlation between substance abuse and child welfare involvement. Specifically, this section provides a brief overview of the relationship between substance abuse and child welfare based on research literature and an opportunity to discuss efforts to address these intersecting topics. This section begins with an introductory activity designed to raise awareness about the impact of values and attitudes in professional work. It then provides an overview of the literature focused on correlations between substance abuse and child maltreatment, a discussion of policies relevant to child welfare practice, and an opportunity for participants to reflect on the content through discussion questions.

Section II – Impact of Values, Beliefs, and Expectations in Practice. This section provides a foundation for understanding how personal and professional values and attitudes can affect practice, with a special focus on issues related to case planning

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with children of substance-abusing parents. Specifically, this section provides a brief overview of key literature related to personal bias and practice, presents guides to practice with substance-abusing families, and offers an experiential activity that illustrates how personal values may impact case planning.

Section III – Attitudes and Values of Child Welfare and Substance Abuse Treatment Professionals in California: Findings from the Collaborative Values Inventory. This section provides an overview of findings based on data collected from the Collaborative Values Inventory, which explores attitudes and values of professionals in both child welfare and substance abuse fields. Specifically, this section provides a brief overview of key domains of the Collaborative Values Inventory (as identified through factor analysis) and a discussion of findings about areas of agreement and disagreement among professionals from child welfare and substance abuse fields in 12 California counties. It also includes two experiential activities designed to facilitate students' critical thinking about their own values and attitudes and their responses to possible bias among colleagues in work settings. Both of the activities include guidelines and suggested discussion questions for the instructor.

Section IV – Building Systemic Collaboration: Findings from the Collaborative Capacity Instrument. While Section III emphasizes critical thinking and reflection about individual level values, attitudes, and practices, Section IV places more focus on macro practice and problem solving related to collaboration between substance abuse, child welfare, and court systems. An overview of findings is presented

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based on data collected from the Collaborative Capacity Instrument, which measures perception of collaborative practices between substance abuse treatment, child welfare, and court systems. An experiential activity is used to provide participants with an opportunity to assess problems and develop recommendations in relation to collaborative practice using case scenarios.

Section V – Building Bridges Between Systems: Resources and Next-Steps. This last section provides a brief overview of highlights from the research study and affords participants an opportunity to identify implications and possible next-steps that training participants can take in their own practice or work settings. Reference materials and organizational resources are reviewed and included in a handout so participants can continue to acquire new knowledge and skills.

Appendixes. The appendixes (located in a separate document) include a complete overview of findings from the study on which this curriculum is based as well as copies of the Collaborative Values Inventory and Collaborative Capacity Instrument used in the research. A PowerPoint presentation for classroom or training use is also provided in a separate document.

Time Estimates and Tips for Training

Addressing issues related to individual and systemic values is an important component of any training related to working effectively with substance-abusing families in child welfare. As such, the sections in this curriculum may be used in conjunction with other training materials that focus on other facets of direct service with substance-

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abusing families or models of collaborative practice between substance abuse and child welfare systems. The time required to complete the training is estimated based on conducting a 1-day, 6½-hour training. However, instructors may elect to condense the background information (based on assessment of participant knowledge, skill, and experience) or to integrate components of this training into other training or class sessions on direct or collaborative practice. Estimated time for completing the sections are as follows:

Section	Description	Estimated Time
Section I	Content: Overview of correlation between substance abuse and child welfare. Activity: Introductory activity.	1 hour
Section II	Content: Literature review related to the impact of values and attitudes on collaborative practice with substance-abusing parents in child welfare. Activity: Simulated case planning session (2 cases examined though different value perspectives).	1 hour, 30 minutes
Section III	Content: Values and attitudes of child welfare and substance abuse professionals in California (based on findings from research using a CVI). Activity: Exploration of participant values using a "mini" CVI. Optional Activity: Identifying and addressing potential bias in case planning/values differences with colleagues.	1 hour, 45 minutes
Section IV	Content: Systems-level capacity for collaboration (based on findings from a study using the CCI). Activity: Small group discussion and brainstorming of strategies to address systems-level barriers to collaboration based on organizational case studies.	1 hour, 45 minutes
Section V	Content: Brief review of themes from research related to effective collaboration and implications for practice. Activity: Identification of next-steps for participants to apply key ideas from the curriculum in their practice or work settings.	30 minutes

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Other Suggested Tools and Materials

Courses or trainings with graduate students or new workers will need to provide content on basic knowledge and skills in direct practice with substance-abusing families in addition to the material in this curriculum that examines how personal and professional values inform practice. It is recommended that instructors working with graduate students or new workers also review the CalSWEC curriculum on building skills related to assessment and recovery support with parents involved in the child welfare system prepared by Melinda Hohman of San Diego State University (1998).

The following provides detailed information about this particular curriculum:

Title:	Assessment, Intervention, and Recovery Support for Substance-Abusing Parents in the Child Welfare System
Author:	Melinda Hohman, San Diego State University
Description:	This curriculum covers a combination of the following public child welfare competencies: ethnic sensitive and multicultural practice; core child welfare skills; social work skills and methods; and human development and the social environment. Sections on assessment and intervention, treatment models, principles, programs and self-help groups, the recovery process, and relapse prevention are included, as are models of the recovery process, references, transparencies, self-help brochures, website resources, and pre- and posttests.
Order Information:	Cheryl Fujii, Resource Specialist Department of Social Work California State University, Long Beach 1250 Bellflower Boulevard Long Beach, CA 90840-4602 (562) 985-4570 (phone), cfujii@csulb.edu (email)
Cost:	$57.00 – 123 pages with transparencies $37.00 – 123 pages without transparencies (Price includes shipping; checks payable to CSULB Foundation; call for credit card orders)

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CALSWEC CURRICULUM COMPETENCIES

The CalSWEC Curriculum Competencies for Public Child Welfare were created for graduate schools of social work to use to prepare their child welfare students. These competencies reflect the common priorities of schools and agencies; yet allow each institution suitable autonomy. This curriculum addresses the competencies listed below. The introduction to each section in the curriculum provides a list of competencies specifically addressed in that section.

Section II: Core Child Welfare Practice

2.2 Student demonstrates the ability to assess the interaction of factors underlying abuse and neglect and the capacity to identify strengths that act to preserve the family and protect the child.

2.5 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income and single-parent families and uses this knowledge in providing appropriate child welfare services.

2.9 Student recognizes the need to monitor the safety of the child by initial and ongoing assessment of risk.

2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

2.15 Student understands the value base of the profession and its ethical standards and principles, and practices accordingly.

2.17 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations in which the worker's values are challenged.

2.19 Student is able to engage and assess families from a strengths-based "person in environment" perspective and to develop and implement a case plan based on this assessment.

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2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

Section III: Human Behavior in the Social Environment

3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

3.5 Student demonstrates understanding of how the strengths perspective and empowerment approaches can influence growth, development, and behavior change.

Section IV: Workplace Management

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effects on services for children and families.

4.6 Student is able to seek client, organization, and community feedback for evaluation of practice, process, and outcomes.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

Section IV: Culturally Competent Child Welfare Practice

5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethic and cultural populations.

Section VII: Human Behavior and the Child Welfare Environment

7.1 Student demonstrates the ability to assess the effects of family transitions and the impact of becoming a client of the child welfare system.

7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families.

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Section VIII: Child Welfare Policy, Planning and Administration

8.2 Student understands how political activities and regulatory, legislative, and judicial processes at local, state, and national levels influence agency policies, procedures, and programs.

8.3 Student understands how leaders/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

8.4 Student understands how to use information, research, and technology to evaluate practice and program effectiveness, to measure outcomes, and to determine accountability of services.

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

8.9 Student demonstrates the ability to negotiate and advocate for the development of resources that children and families need to meet their goals.

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SECTION I

RELATIONSHIPS BETWEEN CHILD WELFARE AND SUBSTANCE ABUSE

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SECTION I
RELATIONSHIPS BETWEEN
CHILD WELFARE AND SUBSTANCE ABUSE

Instructional Guide

Learning Objectives

This section provides foundation knowledge about the positive correlation between parental substance abuse and child welfare involvement. Specifically, this section provides a brief overview about the relationship between substance abuse and child welfare based on research literature and an opportunity for participants to discuss issues associated with efforts to address these intersecting problems.

By the end of this section, participants will be able to:

- ❖ Recognize relationships between substance abuse and child welfare issues including prevalence of alcohol and drug abuse among parents and correlations between substance abuse and child welfare involvement,
- ❖ Name at least three policy changes that make urgent the need for developing effective strategies for addressing substance abuse issue problems among families involved in the child welfare system, and
- ❖ Discuss some of the dilemmas and concerns faced by professionals seeking to address intersecting substance abuse and child welfare issues.

Public Child Welfare Competencies

Section II: Core Child Welfare Practice

2.2 Student demonstrates the ability to assess the interaction of factors underlying abuse and neglect and the capacity to identify strengths that act to preserve the family and protect the child.

2.10 Student understands policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

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Section VII: Human Behavior and the Child Welfare Environment

7.4 Student is able to identify agency and legislative policies and procedures that create barriers to the growth and development of children and families**.**

Section VIII: Child Welfare Policy, Planning, and Administration

8.2 Student understands how political activities and regulatory, legislative, and judicial processes at local, state, and national levels influence agency policies, procedures, and programs.

8.3 Student understands how leaders/managers use the collaborative process for the purpose of planning, formulating policy, and implementing services.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice**.**

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour

- Introduction
  - Introduction of trainer(s)
  - Introduction to section content
  - Introduction of participants (if not part of ongoing course)
  - Activity: Introductory activity using "Find someone who…"
- Overview of relationship between substance abuse and child welfare
  - Prevalence of substance use, abuse, and dependence among parents
  - Relationship of substance abuse to involvement in the child welfare system
- Policy changes and trends
- Activity: Participant discussion (based on questions for class discussion).

Instructors are encouraged to use this chapter in a range of ways that meet their

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needs. For example, instructors may elect to provide a very brief overview of the relationship between substance abuse and child welfare using only two or three of the PowerPoint slides provided in this section. The introductory activity may also be omitted or easily adapted for use with other Sections of this curriculum.

Materials Needed

- ❑ Overhead projector
- ❑ PowerPoint slides
- ❑ Handout 1-1 (Find someone who…)
- ❑ Markers and flip chart or white board (optional – for writing key points in response to questions for class discussion)

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Relationships Between Child Welfare and Substance Abuse

Activity I-1: Introductory Activity

Purpose: This exercise gives participants an opportunity to interact, raise an awareness of the impact of values and attitudes in professional work, and identify common experiences and assumptions related to the area of substance abuse services.

Audience: This activity may be most appropriate for participants who are not working primarily in the field of substance abuse.

Instructions: Invite participants to collect as many signatures as they are able (or willing) on the "Find Someone Who…" handout (Handout I-1). Instruct them to find an individual in the room for whom a given statement is true, then have that person sign or initial the line next to that statement. Encourage participants to get just one signature from each person and to collect as many signatures as possible to allow them to interact with more people.

After the exercise, debrief with participants.

- ❖ Ask participants to observe if some of the statements were more difficult to approach people about than others. Use responses to highlight potential challenges in addressing alcohol and drug issues with clients (or in collaboration with colleagues).

- ❖ Invite other comments (e.g., about common experiences or observations that may have emerged in the process of completing the activity).

Prevalence of Parental Substance Use, Abuse, and Dependence

Children of substance-abusing parents. While not all parents with alcohol or drug problems have difficulties taking care of their children, among substance-abusing parents, research points to an "increased likelihood of impaired parenting capacity and poor child outcomes" (Barnard & McKeganey, 2004, p. 552). Although parents are less likely to abuse alcohol and other drugs than individuals without children, findings from

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the 2001 National Household Survey on Drug Abuse suggest that over 6 million (approximately 9%) children younger than 18 years of age in the U.S. lived with at least one parent who abused or was dependent on alcohol or illicit drugs in the past year (Office of Applied Studies, 2003). Although fathers (8%) are more likely than mothers (4%) to be classified as having problems with alcohol or illicit drug abuse or dependence, (Office of Applied Studies), mothers are more likely to be referred into the child protective system (DHHS, 1999).

Substance abuse and dependence in the National Household Survey on Drug Use and Health (NSDUH) was defined based on the DSM-IV and includes symptoms such as “physical danger, trouble with the law due to substance use, increased tolerance, and interference in everyday life during the past year” (Office of Applied Studies, 2003, p. 1). Figure I-1 below depicts the drugs of abuse reported by substance-abusing or dependent parents with children under the age of 18 (Office of Applied Studies). Alcohol abuse or dependence was substantially more common among parents than problems with illicit drugs. Illicit drugs include marijuana/hashish, cocaine/crack, inhalants, hallucinogens, heroin, and nonmedical use of prescription drugs.

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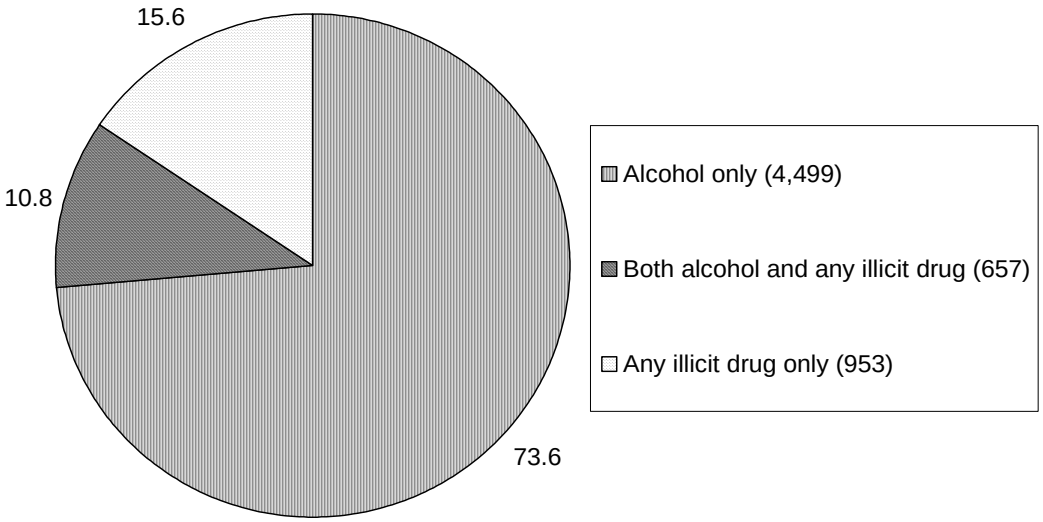
Figure I-1: Drugs of Choice Among Parents with Past Year Substance Abuse or Dependence (and Number in Thousands of Children Living with One or More Parent with Substance Abuse or Dependence).



Source: Office of Applied Studies (2003)

It is interesting to note that the distribution of substances reported among parents involved in the child welfare system is very different than that of the general population. Although alcohol abuse and dependence is more common than drug abuse and dependence, children of illicit drug users are disproportionately represented in child welfare. For example, the following graph (Figure I-2) depicts drugs of abuse among mothers with children in foster care in California in the mid 1990s (General Accounting Office [GAO], 1998).

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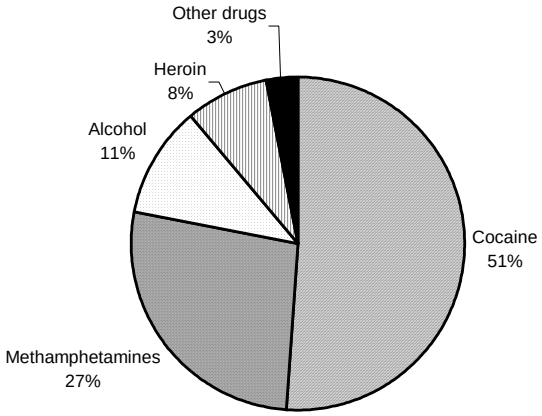
Figure I-2: Primary Drug of Abuse for Mothers of Children in Foster Care in California



Source: U.S. General Accounting Office (1998)

Differences between the distribution of drug use reported by a general population sample and a sample of parents with children in foster placement might be accounted for by differences in risk associated with different substances. Illicit drug use is associated with a number of other risks that may impact infant or child outcomes including involvement with criminal activity, parental incarcerations, and instability in housing (Barth, 2001). For example, methamphetamine abuse appears to be increasing in California and nationally, including among women of childbearing age. Child welfare and law enforcement professionals are becoming increasingly concerned about the increase of methamphetamine use and manufacturing as a risk factor in child abuse and neglect (Hohman, Oliver, & Wright, 2004).

In addition to the possible increased risk associated with certain substances, it is

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also possible that perceptions about different drugs may influence case disposition. For example, a study of child abuse and neglect cases found that 90% of drug-using parents eventually had their children removed compared to 60% of alcohol-abusing parents, in spite of the fact that the alcohol-abusing parents had more previous referrals to child protective services than the drug abusers (Murphy et al., 1991). Another study found an interaction between race, drug use, and the disposition of cases referred into child welfare: “A high proportion of cocaine cases (the drug of choice for African-Americans) continued through the court hearings, while amphetamine cases (mostly a drug used by Caucasians), were much less likely to be referred to court” (Sagatun-Edwards, Saylor, & Shifflett, 1995, p. 90).

Substance use during pregnancy. Another way children are impacted by parental alcohol and drug use is through prenatal substance exposure. A study based on data from the 2002 National Survey of Drug Use and Health examined past 30 day use of alcohol and drugs among pregnant women and reported the following rates of use (Office of Applied Studies, 2004):

- 9% reported drinking any alcohol.
- 3% reported “binge” alcohol use (5 or more drinks on at least one occasion).
- 3% reported use of illicit drugs (with higher rates of 6.8% among women 15-25 compared to .5 among women 26-44 years of age).
- Although rates of past 30 day alcohol and drug use were lower among pregnant women than nonpregnant women, rates of alcohol and drug use among women in the first year after giving birth were not significantly different from nonpregnant women. For example, the rates of illicit drug use among recent mothers (9%) were similar to that of nonpregnant women (10%).

Studies reporting rates of substance exposure during pregnancy may underestimate potential exposure depending on the timeframe used in the study. For example, use of the past-30-day timeframe in the National Survey of Drug Use and Health may miss drug use among pregnant women who may have used substances earlier than the month before participating in the survey.

Prenatal alcohol consumption is considered one of the leading preventable causes of birth defects. Of all drugs, alcohol is most strongly associated with risk of irreversible negative effects generally known as fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE). These negative effects include mental retardation, growth retardation, neurological deficits, and facial malformation (Ondersma, Simpson, Brestan, & Ward, 2000). Consequently, one of the national health objectives defined in Healthy People 2010 was to increase abstention from any alcohol consumption among pregnant women to 94% and to increase abstention from heavier drinking (five or more drinks on one or more occasions) to 100% (Center for Disease Control, 2002).

Some of the earlier predictions that children exposed to illicit drugs, particularly cocaine, would suffer from irreversible cognitive and behavioral problems have been mediated by recent research. Although more recent research has discovered “specific and subtle deficits in some affected infants,” it appears that these are mediated considerably by postnatal environments (Ondersma et al., 2000, p. 93). Drug exposure alone may be less significant than other factors such as abuse or neglect, problems with attachment, and response to potential developmental delays (Franck, 1996; Ondersma

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et al., 2000). One study of drug-exposed children in out-of-home care found an equally high rate of developmental delays among children of parents both with and without a drug use history. Consequently, the authors stress the importance of considering the complexity of factors that may impact child development (Franck, 1996).

Prevalence of Substance Abuse in Child Welfare Involved Families

Research over the past decade has documented a strong relationship between substance abuse and problems of child abuse and neglect (Curtis & McCullough, 1993; Karoll & Poertner, 2002; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Magura & Laudet, 1996; Maluccio & Ainsworth, 2003; McAlpine, Marshall, & Doran, 2001; Peterson, Gable, & Saldana, 1996; Smith, 2003; Sun, Shillington, Hohman, & Jones, 2001; Tracy & Farkas, 1994; Widom & Hiller-Sturmhofel, 2001). Although many data collection systems do not gather accurate data on substance abuse and child welfare, most studies suggest parental substance abuse is a factor in one third to two thirds of children involved in the child welfare system (DHHS, 1999). Lower estimates tend to be associated with initial reports of child abuse and higher estimates are generally associated with out-of-home placements (DHHS, 1999).

Although many of the studies to date have methodological weaknesses (e.g., based on regional samples, non-randomly sampled cases, or estimates from state directors), they contribute to an emerging picture of the relationship between substance abuse and child welfare cases. In general, national surveys of child welfare directors and of professionals in child welfare and dependency courts suggest that well over half

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of substantiated child abuse cases are related to substance abuse problems among parents (Child Welfare League of America [CWLA], 1998; DHHS, 1999). Studies with more rigorous methodologies confirm the strong association between substance abuse and child welfare involvement in several areas including the following:

- ❖ Higher incidence of child abuse and neglect among substance abusers in the community.
    - One of the strongest studies to date examined the relationship of alcohol and drug disorders with physical abuse and neglect using a large probability sample from a community population rather than referred cases, a matched control group, and data-analytic procedures to better control for confounding variables (Kelleher et al., 1994). This study found that respondents reporting either neglect or physical abuse of children were significantly more likely than matched control subjects to have substance abuse or dependence. Findings from this study indicated the following:
        - Adults with an alcohol or drug problem were 2.7 times more likely to have reported abusive behavior toward their children and 4.2 times more likely to have reported neglectful behavior than the control subjects.
        - Forty percent of the adults reporting physically abusive behavior and 56% of those reporting neglectful behavior met criteria for having had an alcohol or drug disorder at some point in their lifetime.
        - Substance abuse was a predictor of child abuse and neglect even when controlling for other variables including depression, number in household, antisocial personality disorder, and social support.
        - A study of the second wave of data from the community-based sample revealed 63 new abuse cases and 84 new neglect cases (Chaffin, Kelleher, & Hollenberg, 1996). Substance abuse disorders were strongly associated with the onset of both abuse and neglect and depression was associated with physical abuse.
- ❖ Higher rates of substantiated child maltreatment among substance-abusing parents referred into child welfare.

- For example, a regional study based on a large scale dataset in Nevada found case substantiation was greater among caregivers with indication of alcohol and drug use present (53.5%) compared to those without (33.4%; Sun et al., 2001).

❖ Higher rates of out-of-home placements (Barth, 1994; Maluccio & Ainsworth, 2003; Zuravin & DePanfilis, 1997), re-reports of abuse, and reentry into foster care (Berrick, Brodowski, Frame, & Goldberg, 1997; GAO, 1998; Wolock & Magura, 1996).

- Substance abuse is a factor for one third to two thirds of children in out-of-home placement (Maluccio & Ainsworth, 2003).

- Zuravin and DePanfilis (1997) examined factors predicting out-of-home placement in foster care in 1,035 maltreating families. Even when accounting for family demographics, maltreatment characteristics, and other maternal problems, mothers with drug problems or both alcohol and drug problems were 2.29 times as likely to experience child out-of-home placement as women without such problems. In their discussion, the authors point out that "congruent with the rise in drug use and professionals' concern about families with substance abuse problems overwhelming the CPS and foster care systems, substance abuse problems had more influence on decision making than any other characteristic" (p. 41).

- Substance abuse also appears to be linked to re-reports of maltreatment and to re-entry of children into foster care. A study of factors associated with family reunification outcomes found that a mother's history of substance abuse, drug treatment, criminal activity, and being a victim of domestic violence or childhood abuse were each associated with children's reentry into foster care (Berrick et al., 1997). A different longitudinal study of child abuse and neglect cases closed after investigation found that, as hypothesized, substance abuse was associated with re-reports of maltreatment both directly and as mediated by family functioning (Wolock & Magura, 1996).

Children from families with substance abuse problems, once they are involved in the child welfare system, appear to differ from other children in several regards (Semidei, Feig-Radel, & Nolan, 2001). The children are:

- Generally younger,
- More likely to be placed in care and to remain in care longer,
- More likely to have experienced severe abuse or chronic neglect, and
- More likely to exit through adoption (although most return to their parent or are placed with relatives).

Two research studies based in California suggested that mothers in substance abuse treatment who are also involved in child welfare also appear to have characteristics that differ compared to mothers in treatment who are not child welfare involved (Grella, Hser, & Huang, 2006; Shillington, Hohman, & Jones, 2001). These child welfare involved women:

- Were generally younger,
- Had more children,
- Had more economic problems,
- Were more likely to be referred by the criminal justice system or other providers,
- Were more likely to be in outpatient programs, and
- Were more likely to be transferred to another treatment program at discharge.

Although the demographics of parents with and without substance abuse problems are similar, national data suggests that African American women with substance abuse or dependence may be disproportionately more likely to come to the attention of child protective systems compared to White or Hispanic women (DHHS, 1999). For example, there is some indication that women of color who deliver drug-

exposed infants are more likely to be referred into child welfare than White women (Chasnoff, Landress, & Barrett, 1990; Sagutun-Edwards et al., 1995). By contrast, another study found some indication of overrepresentation of African American and Latino children in substantiated cases (not limited to drug-exposed infants) among families without alcohol and drug problems—but not when alcohol or drug use is indicated—which "may imply that the impact of caregiver AOD use on referral substantiation is stronger than that of racial bias" (Sun et al., 2001, p. 172).

Intervention and Treatment

The high rates of substance abuse among parents and the strong correlation between substance abuse and child maltreatment are cause for concern. At the same time, not all parents with substance use or abuse problems maltreat their children. Other important factors may mediate the potential negative effect of parental substance abuse, including availability of other caregivers, parenting skills, parent-child relationship, and family resources (Azzi-Lessing & Olsen, 1996; Smith & Testa, 2002). Research also suggests that many mothers with substance abuse problems have strong attachments to their children and may employ a variety of strategies to provide good care and protect their children from problems associated with substance use or abuse (Baker & Carson, 1999; Kearney, Murphy, & Rosenbaum, 1994; Klein & Zahnd, 1997). Researchers argue for interventions at different levels from prevention to treatment. In particular, interventions should include the following:

- Targeted prevention for substance abusers and their children (Dore & Doris, 1998; Price & Emshoff, 1997).

- ❖ Initial and ongoing assessment that considers multiple factors related to child well-being, rather than solely abstinence status or compliance with court order, for families involved in the child welfare system (Dore, Doris, & Wright, 1995; Ritter & Dozier, 2000).

- ❖ Implementation of treatment models that have evidenced positive outcomes for children and families affected by both substance abuse and child maltreatment (Young & Gardner, 2002).

Reviews of substance abuse treatment effectiveness suggest that addiction treatment has positive effects on reduction of substance use, prevention of relapse, physical health, psychosocial functioning, employment stability, and family functioning (Center for Substance Abuse Treatment [CSAT], 1998; Osterling & Austin, 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 1997). Treatment services designed specifically for women often have unique program characteristics, such as services associated with pregnancy and parenting, that may be more effective for some women (Grella, Polinsky, Hser, & Perry, 1999). Substance abuse treatment may help prevent out-of-home placements (Dore & Doris, 1998). Furthermore, research that examines outcomes for women in substance abuse treatment also suggests that treatment may help decrease involvement in child welfare and contribute to opportunities for family reunification. Examples of these findings are provided below:

- ❖ A review of 24 federally funded programs for pregnant and parenting women found positive outcomes including increased abstinence among parents, better birth outcomes, and increased completion rates among women whose children were in residence (Clark, 2001).

- ❖ A study of the Options for Recovery pilot programs in California for pregnant and parenting women found that 73% of infants delivered to mothers involved in the program were not affected by substance exposure, parent involvement with child

welfare declined by 27% between program admission and discharge, 42% of the children that were in foster care were reunited with their biological families, and children of parents in the program spent approximately 150 fewer days in foster care compared to other children (Brindis, Clayson, & Berkowitz, 1997).

- An intriguing study by Smith (2003) found that compliance with drug treatment was associated with reunification, independent of changes in drug use among parents or scores on measures of high risk parenting. The author suggests that "the organizationally promoted expectations of child welfare agents, in combination with agents' classifications of client actions, may independently influence the likelihood of reunification" (p. 359).

- Another study of intensive services for mothers of drug-exposed infants found that amount of participation in different aspects of the program and progress toward treatment goals was related significantly to lower CPS reports over a period of approximately 1 year after treatment, although other treatment measures (such as time spent in individual contact and groups) were not significant (Mullins, Bard, & Ondersma, 2005)

Although comprehensive treatment is pivotal in efforts to prevent and address child maltreatment among substance-abusing families, the availability of treatment falls far short of the demand (Center on Addiction and Substance Abuse [CASA], 1999). There is a need for more programs designed specifically for women with children, and the shortage of publicly funded treatment is perceived by child welfare professionals, courts, and substance abuse professionals to be a critical barrier to reducing the intersecting problems of substance abuse and child maltreatment (CASA).

Timing Issues and the Evolving Policy Landscape

The child welfare system is engaged in a process of reform that generates new challenges as well as new opportunities for collaboration between multiple systems (Webb & Harden, 2003). The high prevalence of children of substance-abusing families in out-of-home placements, coupled with recent changes in national and state law that

limit timelines for potential reunification, underscore the importance of addressing these differences effectively (Young & Gardner, 2002). Key policy changes that make the need for stronger collaboration urgent are outlined below.

The Adoption and Safe Families Act (ASFA). The Adoption and Safe Families Act (ASFA), which was enacted in 1997 and reauthorized in 2003, accelerates permanent placements of children in foster care. Specifically, ASFA requires permanency plans to be in place within a 12-month timeframe and requires termination of parental rights if a child is in out-of-home placement for 15 of the recent past 22 months. Policy related to permanency planning varies in different states. For example, California has also enacted legislation that allows for expedited permanency planning for children who meet specific criteria. As a result of the 1997 passage of AB 1524, children under the age of 3 years may be exempted from an 18-month reunification timeframe. Practices related to reunification and permanency planning may vary between counties.

Temporary Assistance to Needy Families (TANF). Time limits for eligibility for Temporary Assistance to Needy Families (TANF) represent another timetable that impacts many low-income families who may be involved in child welfare and substance abuse treatment systems. With rare exceptions, federal guidelines require that adults obtain work within a maximum of 24 months after obtaining assistance and that adults participate in work activities to receive benefits (Kelch, 2002). CalWORKS, which combined California's former Aid to Families with Dependent Children program and

welfare-to-work program, has two time limits: a lifetime limit of 60 months for case assistance and a limit on welfare-to-work services. There is notable overlap between clients in child welfare and CalWORKS. For example, 22% of children entering AFDC in 10 California counties between 1990 and 1995 had child abuse allegations and 8% had child abuse cases opened (Needell, 1999). Clients in CalWORKS and child welfare, who also have alcohol and drug problems, will be affected by these timelines but may also benefit from some provisions of CalWORKS. For example, CalWORKS may provide support for some treatment services and participation in services, such as substance abuse treatment, may be counted toward welfare to work requirements under CalWORKS.

Laws and Reporting Practices Regarding Substance-Exposed Infants. Although there is significant variation between counties, research suggests that at least 11.3% of infants born in California are substance exposed (Noble et al., 1997). Current law (based on SB 2669 passed in 1991) in California specifies that a positive toxicology screen at the time of delivery of an infant is not, in and of itself, a sufficient basis for reporting child abuse or neglect. However, indications of maternal substance abuse should lead to an assessment of the mother and child and each county is required to have protocols in place for assessment, referral to services, and, if indicated, referral to child protective services. A majority of counties in California created protocols in the spirit of the law and several reported a reduction in removal of infants and an increase in voluntary family maintenance planning (Noble, 1994). However, approximately one

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fourth of the counties created protocols that require (contrary to the intent of the law) reporting to child welfare or law enforcement in the case of a positive toxicology screen (Noble, 1994). In the absence of enforcement or training related to SB2669, implementation of the law varies considerably between counties and between hospitals within counties (Klein, Noble, Zahnd, & Holtby, 2000). In addition, reports of maltreatment appear to have decreased in at least two California counties. The authors note that this apparent decrease in reports may not necessarily be the most desirable outcome in the context of information about the association between substance abuse and child welfare. If the parents are receiving treatment without a child welfare referral, then the legislation is benefiting the entire family as intended. If, by contrast, substance-abusing mothers who are not reported are also not accessing treatment, the failure to report might be a lost opportunity for early intervention that would benefit children (Klein et al., 2000).

More recently, the federal Child Abuse Prevention and Treatment Act was reauthorized with provisions that require that infants identified as affected by illegal substances be reported to child protective services (not to be construed as establishing a definition of child abuse; Otero, Gardner, & Brodowski, 2004). These CAPTA provisions may facilitate early intervention with families at risk, although some service providers are concerned that implementation could pave the way for punitive measures and, as a consequence, deter women from prenatal care.

Competing Timelines: The "Four Clocks." Young and Gardner (2002)

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describe the “four clocks” that represent different timetables that impact both clients and front-line workers:

- The first clock is that of the federal, state, and local child welfare system policies, such as ASFA provisions (described above) that requires a permanency hearing within 12 months and pursuit of termination of parental rights if a child has been in out-of-home placement during 15 out of 22 of the most recent months.

- The second clock involves state and federal time limits for CalWORKS eligibility and welfare-to-work requirements.

- The third clock marks the time required for parents to recover from alcohol and drug dependence. Evidence suggests that length of time in treatment is one of the strongest predictors of success. For example, a study of federally funded treatment programs for pregnant and parenting women found high treatment success rates among women who spent 6 months or more in treatment (Greenfield et al., 2004). However, that treatment time and possible barriers or delays to accessing treatment may conflict with other “clocks” (DHHS, 1999).

- Finally,

> the fourth, and perhaps most important, clock is the developmental timetable that affects children, especially younger children, as they achieve – or fail to achieve – bonding and attachment during their first 18 months. This is critical, according to new research on brain development (Young & Gardner, 2002, p. 6).

A “fifth clock” measures the degree to which service delivery systems and services providers mobilize to respond to the deadlines and demands reflected by the four clocks described above (Young & Gardner, 2002). The authors note that this analogy has been helpful for staff from diverse service delivery systems to better understand the important but often conflicting requirements that impact families and children at risk. This framework also stresses the urgency for creating collaborative

practices and policy agendas that will address these issues while these clocks are still "ticking."

Implications for Practice: Strengthening Collaboration. The Adoption and Safe Families Act required that the Administration for Children and Families (ACF) submit a report to Congress about the prevalence of substance abuse among families in child welfare, availability and effectiveness of services, and recommendations for improving efforts to address joint substance abuse and child maltreatment problems. Recommendations from the report included assuring access to comprehensive substance abuse treatment services, improving timelines and decision making for children, improving engagement and retention of clients in care, enhancing services for children, and addressing gaps in information gathering and research. Realizing these goals will require interdisciplinary partnerships, the report calls for building collaborative working relationships between systems, noting that:

> The first step toward improved services and ultimately better outcomes for these families is to begin working together more effectively….Until agencies work together to assist families move toward healthy lifestyles, they risk an expensive and futile tug of war in which families are torn apart between conflicting imperatives as staff argue over whose problem it is (DHHS, 1999, p. 124).

A more recent local call for improved collaboration between systems emerged from the Final Report of the California Child Welfare Services Stakeholder Group (CWS

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Stakeholders Group, 2003). This 3-year redesign effort, initiated in 2000, resulted in a strategic plan to improve child welfare outcomes that "blends effective practices grounded in principles of fairness and equity with system reforms to ensure sufficient resources, stronger partnerships, workforce excellence and greater accountability to sustain results over time" (CWS Stakeholders Group, p. 5). Specific goals include strengthening interagency partnerships at both the state and local levels and enhancing service integration between CWS, alcohol and drug programs, the courts, and other agencies.

A number of counties in California and other states have begun to pilot collaborative efforts between child welfare and substance abuse. Early efforts to coordinate services between substance abuse and foster care and other children's services occurred in the context of treatment for women with children through the California Options for Recovery pilot projects and federally funded residential treatment programs for women and children. Evaluation of these programs found improved outcomes for women and children, including increased reunification with children and reduced out-of-home placement (Brindis et al., 1997; Clark, 2001). More recently, a number of states and counties in California have developed collaborative models that show promise in addressing the needs of substance-abusing families in child welfare systems. These models include family dependency drug courts, outstationed alcohol and drug workers at CPS offices or courts, use of family advocates (women in recovery) working collaboratively with social workers, and extensive training and cross training to

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institutionalize effective screening, assessment, and interventions (Young & Gardner, 2002).

Despite this progress, the need for successful collaboration between systems remains urgent. Although development and documentation of collaborative efforts in recent years is substantial in comparison to past inattention to these issues, a more important measure is "what we are doing now against the needs of thousands of children who are still affected by their double jeopardy in the arenas of child abuse and substance abuse" (Young, Wingfield, & Gardner, 2001, p. 302).

Activity I-2: Focus Questions for Section I

This activity may be used immediately after review of the literature in Section I. It may be most appropriate in a classroom setting.

Purpose: The purpose of the exercise is to give participants an opportunity to reflect on and discuss the information and issues described in the literature.

Instructions: Invite participants to form 3-5 groups and instruct them to discuss one of the questions listed in the handout for Activity I-2. This handout should be distributed along with the instructor's verbal instructions.

The small groups should be given at least 15-20 minutes to discuss their questions. Then, each group should summarize highlights of their discussion and then share the information briefly with the larger group (approximately 10 minutes). The instructor may elect to write key points on a board in order to summarize or elaborate on important ideas after the small groups report back.

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SECTION I

RELATIONSHIPS BETWEEN CHILD WELFARE AND SUBSTANCE ABUSE

HANDOUTS

Drabble, L., & Tweed, M., & Osterling, K. L. (with Navarrette, L., Pearce, C., Ribeiro, P., & Twomey, E.). (2006). P*athways to collaboration: The role of values and system-related factors in advancing collaborative practice between child welfare and substance abuse treatment fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Find Someone Who…

_____ Currently has a client in alcohol/drug treatment.

_____ Is wondering how to do concurrent planning with substance-abusing families.

_____ Knows someone who no longer drinks.

_____ Has been personally affected by alcohol, tobacco, or other drugs.

_____ Has trouble seeing alcoholism and drug dependence as diseases in and of themselves.

_____ Knows about the neurobiology of addiction.

_____ Has ordered information from the National Clearinghouse on Alcohol and Drug Information (NCADI).

_____ Personally knows a staff person at a local treatment agency.

_____ Has ever been frustrated by someone's (e.g., client, colleague, friend) alcohol or drug use.

_____ Has ever been dependent on a substance (including cigarettes or coffee).

_____ Received adequate training on substance abuse issues, addiction, and recovery in their social work (or other) education.

_____ Worked in a setting where workers known to have alcohol or drug problems were not confronted or referred to treatment by their supervisors.

_____ Sometimes feels discouraged before even starting with a new client who has a history of alcohol/drug abuse.

_____ Feels naïve about working with clients who have alcohol and other drug problems. (e.g., uncertain what to ask and not sure of understanding the answers).

_____ Feels hopeful that clients with alcohol and other drug problems will recover.

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Discussion Questions: Activity I – 2

Review Section I and address the following questions in small groups. Present your responses to the rest of the class.

1. The National Household Survey on Drug Abuse found that over 6 million (about 9%) children under the age of 18 lived with at least one parent who abused or was addicted to alcohol and/or other drugs. The number of children whose parents used alcohol or drugs (but did not report symptoms of abuse) was much higher. Discuss the following questions in your group:
    - ❖ Should CPS always be involved with all families in which a parent uses drugs, abuses drugs, or is addicted to drugs? Why or why not?
    - ❖ Is it more important to intervene when the parent is using illicit drugs? If so, why?
    - ❖ If not, under what circumstances should involvement occur? What should be considered "good enough" parenting?

2. There is a strong correlation between substance use and abuse and child maltreatment; yet, not all families where alcohol or drugs are a problem will abuse children. Discuss the following questions in your group:
    - ❖ What practices or policies make sense for ensuring child safety while still respecting the integrity of families?
    - ❖ What are some of the possible benefits and limitations of requiring complete abstention from drugs or alcohol among parents when drug or alcohol abuse has contributed to child neglect or abuse? What practices might make sense in this area?
    - ❖ What are some of the benefits and possible problems related to reporting women who deliver drug-exposed infants to child welfare? What practices might make sense in this area?

3. Identify and describe the various "clocks" that represent timetables impacting clients and child welfare professionals. Discuss some the following questions in your group:
    - ❖ Which "clock" do you feel most significantly impacts decision making in child welfare practice, and more specifically in your own cases? Why is this so?
    - ❖ What are some of the ideas for working collaboratively that may be effective in addressing the needs of substance-abusing families in the context of these conflicting "clocks"?

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SECTION II

IMPACT OF VALUES, BELIEFS, AND EXPECTATIONS IN PRACTICE

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SECTION II
IMPACT OF VALUES, BELIEFS, AND EXPECTATIONS IN PRACTICE

Instructional Guide

Learning Objectives

This section provides a foundation for understanding how personal and professional values can impact practice, with a special focus on issues that may influence case planning with substance-abusing parents. It provides a brief literature overview, and offers participants an opportunity to participate in an experiential activity that illustrates how personal values might affect case planning.

By the end of this section, participants will be able to:

- ❖ Describe how personal beliefs, expectations, and values may impact practice.
- ❖ Recognize some of the values that are compatible with effective practice with families impacted by substance abuse.
- ❖ Identify at least three strategies for minimizing the potential for bias based on personal values and beliefs.

Public Child Welfare Competencies

Section II: Core Child Welfare Practice

2.5 Student is aware of forms and mechanisms of oppression and discrimination pertaining to low-income and single-parent families and uses this knowledge in providing appropriate child welfare services.

2.15 Student understands the value base of the profession and its ethical standards and principles, and practices accordingly.

2.17 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations in which the worker's values are challenged.

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2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

Section III: Human Behavior and the Social Environment

3.5 Student demonstrates understanding of how the strengths perspective and empowerment approaches can influence growth, development, and behavior change.

Section V: Culturally Competent Child Welfare Practice

5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse and ethnic and cultural populations.

Section VIII: Child Welfare Policy, Planning and Administration

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour and 30 minutes

Agenda:

- Review of literature highlights
  - Highlights about how beliefs, attitudes, and values may impact practice.
  - Highlights specific to child welfare practice with substance-abusing families.
- Reducing potential bias based on personal values
  - Activity II-1: Small group case planning (guided by assigned attitudes and beliefs).
  - Brainstorming and review of strategies for reducing the impact of bias based on personal values including use of critical thinking and adoption of collaborative case planning models.

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Instructors are encouraged to use this chapter to review existing research on the influence of values and attitudes on the case planning and service delivery process and to highlight implications for practice. Instructors may elect to emphasize the following:

- ❖ The individual attitudes, expectations, and values we hold can be linked to practice and may, therefore, impact client outcomes.
- ❖ Use of critical thinking is vital to becoming aware of potential personal biases.
- ❖ Intuition, on its own, is not an adequate assessment tool in child welfare practice.

Highlights from the literature are covered briefly with a few PowerPoint slides. Specific illustrations for each bullet, based on the literature, may be found in the text. Instructors are invited to provide other evidence-based examples.

The focal point of this section is in the experiential activity using case studies that amplify how personal values may impact practice (Activity II-1). This activity is framed by highlights from research literature and followed by brainstorming and discussion of strategies for minimizing potential bias. This activity can be used with other Sections in this curriculum or can be adapted for use in classes or trainings that are not specific to child welfare and substance abuse issues (e.g., class segments related to critical thinking or exploration of how personal values may impact practice).

Materials Needed

- ❑ Overhead projector
- ❑ PowerPoint slides
- ❑ Handout II-1 (case studies) and Handout II-2 (assigned attitudes/beliefs)
- ❑ Markers and flip chart or white board (optional – for writing key points in response to questions for class discussion)

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Impact of Values, Beliefs, and Expectations in Practice

Social Worker Expectations, Beliefs, and Values: Avoiding Bias in Practice

Although little research has been conducted that specifically explores the impact of social worker attitudes and values about substance-abusing parents on practice in child welfare settings, there is evidence that personal attitudes, beliefs, and values may affect practice in social service settings including child welfare (Drury-Hudson, 1999; Rossi, Schuerman, & Budde, 1999).

Gambrill (1997) defines values as "the social principles, goals, or standards held by an individual, group, or society" (p. 44). Values are used to guide decision-making on multiple levels (e.g., policy, agency practice, and individual social worker). Ethical dilemmas "are those in which two or more principles or values conflict or when it is difficult or impossible to be faithful to an ethical principle" (p. 44). An example might be perceived conflict between the parental rights of a mother with a substance abuse problem who is involved in the child welfare system as a result of child neglect and the need of a child for a safe and stable home environment. Gambrill (p. 44) outlines factors that social workers take into consideration when making challenging decisions:

1. The client's interests.
2. The interests and rights of other involved parties such as family members or victims.
3. The professional code of ethics.
4. The social worker's personal values.
5. The agency's policy.

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6. Legal regulation.

The focus of this section is on the fourth factor, the social worker's personal values. Personal values and beliefs may have a significant impact on decision-making, particularly if they remain unexamined by the social worker who possesses them. A few highlights from the literature underscore the importance of understanding how individual beliefs and attitudes may impact practice and, therefore, outcomes with clients.

- ❖ Recognizing and overcoming possible biases is an important part of effective social work practice. Gambrill (1997) defines bias as "an emotional leaning to one side in regard to a person, group or issue" (p. 34). Individuals may or may not be aware of their own biases and how they influence decision-making in practice.

    - One illustration of bias involves a social worker who is inclined to minimize the potential negative impact of parental abuse of drugs or alcohol on a child referred to child welfare because of his or her own heavy alcohol or drug use. Richmond and Foster (2003) found that helping professionals who were regular cannabis users, occasional users of other drugs, and smokers had lower scores related to having a treatment/intervention orientation.

    - Another example might be a caseworker who is disinclined to consider reunification of a child with a substance-abusing parent even before conducting a full assessment. Martin, Peters, and Glisson (1998) surveyed 100 child welfare workers in five states and found that workers did not make service and placement recommendations for children based on a uniform psychosocial assessment. Instead, decisions were influenced more by the labels attached to children upon entry to care and judicial decisions. Children whose files contained language such as "substance abuser, child of substance abuser, sex offender, victim of sexual abuse and victim of physical abuse" (Martin et al., p. 3) were more likely to be recommended mental health services and more restrictive placements, regardless of their needs as indicated in a psychosocial assessment.

    - A third illustration would be unintended bias related to race and ethnicity. For example, individual and institutional biases and norms may be one of many factors that contribute to the overrepresentation of children of color in the child welfare system (Hines, Lee, Drabble, Snowden, & Lemon, 2002). Specifically, individual values and institutional biases that favor

European cultural norms and White, middle class values as standards by which ethnically diverse families are assessed, may contribute to ineffective child welfare practices with families of color (Cohen, 2003; Miller & Gatson, 2003). Cohen observes that:

> The cultural and racial background of families influences the specific factors that workers consider in assessing the severity of risk and level of intervention. Decisions are more likely to be made on the basis of deficits in available resources, accepted agency practice, personal values and biases, and notions of an ideal family, than by applications of consistent case rules (p. 145).

As a case in point, one study found that African American women were more likely to be reported to authorities for illicit drug use during pregnancy than women of European descent, even though the rates of drug exposure among infants of these two groups were not significantly different (Chasnoff et al., 1990).

Similarly, a study that followed drug-exposed infants through the social service and Juvenile Court system found an overrepresentation of African American and Hispanic cases referred into the system (Sagutun-Edwards et al., 1995). In this study, a majority of Caucasian women were referred to informal supervision (52%) while African American and Hispanic women were more likely to be referred to court.

❖ Effective social work practice requires that social workers develop a capacity to critically evaluate their own expectations and beliefs.

- Social worker beliefs may impact their evaluation of clients (Gambrill, 1997). Specifically, social worker actions with clients may be impacted by "beliefs about what behaviors are appropriate, what causes a particular behavior, whether and how that behavior can be changed, and how much responsibility their clients have" (Gambrill, p. 25). Beliefs and expectations may be based on our own feelings or on influences from the larger society. For example, a social worker's personal beliefs about the etiology of addiction and the effectiveness of substance abuse treatment might impact the evaluation of a client's prospects for success.

- Gambrill (1997) points out that it is important for social workers to examine their own expectations because expectations "alter what we do or do not attend to" (p. 114). There is also evidence that expectations can influence client outcomes.

❖ Social workers must be cautious about use of "intuition" or personal values in decision-making.

- Daniel (2003) examined how individuals in child welfare evaluate evidence in the process of case planning and found that child welfare professionals rely on both intuitive and analytic decision-making. The author acknowledges that the intuitive process is influenced at least in part by personal experience and beliefs and may produce errors. At the same time, the author suggests that intuition may be both inevitable and valuable in decision-making. The author points to the importance of "knowing the sources of error and bias, as well as techniques for countering them" (p. 214).

- Intuition is "the direct knowing or learning of something without the conscious use of reasoning" (Webster's New Collegiate Dictionary as cited in Gambrill, 1997). The "unconscious" reasoning that underlies what an experienced practitioner calls "intuition" might be sound. However, decision-making without critical analysis of beliefs and assumptions associated with a given intuition may result in harm to clients. Gambrill points out the following:

> Relying on intuition often means that we use only some of the information relevant to a decision. Moreover, decisions based on intuition are likely to be inconsistent. But this inconsistency may not be evident because no one keeps track of the decisions made, the grounds for making them, and their outcomes. We may not be aware of our inconsistent reliance on values and rules that we think are important. The greater the number of factors that must be considered in arriving at a well-reasoned decision and the more that is known about the relevance of considering them, the less likely is intuition to offer the best guide for decisions (p. 82).

- New workers in child welfare may be particularly vulnerable to rely on personal values when making assessments. For example, one study found that newer workers had less knowledge of theory, research, and legislation in the child welfare field compared to practitioners with at least 10 years of experience, were less likely to be able to apply such knowledge to identify risk in a hypothetical scenarios, and, consequently, may be more likely to rely on their "own values about children and families when making decisions about the removal of children from the home" (Drury-Hudson, 1999, p. 154).

Social Worker Attitudes and Values in Practice with Individuals with Substance Abuse Problems

One of the themes in an emerging literature on working with substance-abusing families involved in the child welfare system asserts that collaborating agencies should move toward a family-centered approach (Lewandowski & GlenMaye, 2002). Both child welfare professionals and alcohol and drug treatment providers may improve services through a stronger focus on the family as the client rather than addressing the concerns of addicted parents and their children separately (Scott & Campbell, 1994). Adoption of family-centered values and empowerment principles would "require not only a fundamental change of the child protection system, but all other traditional service providers that work with these families, thus making all service providers partners in the child and family protection system" (Sandau-Beckler, Salcido, Beckler, Mannes, & Beck, 2002, p. 727).

Adams (1999) conducted one of the only studies that examined social worker attitudes about drug-using parents and how these attitudes might support or hinder a family support approach in working with substance-abusing parents whose children are involved in the child welfare system. An "Attitudes to Drug Use and Parenting Survey" (ADUPS) was administered to social work line staff and managers in a large, racially diverse region in London, England. The survey used a Likert-type scale to measure responses to 40 statements about drug use and parenting. The 75 responses represented approximately half of the 141 social workers, managers, and family workers that received the survey. Several interviews with respondents were conducted to

complement quantitative data gathered in the study. Some of the highlights of the study are summarized below.

- ❖ Eighty-eight percent of social workers believed that trying to help drug-using parents is a worthwhile task.

- ❖ A majority felt that drug-using parents are capable of changing their drug-using behavior (82%), even in the context of prior relapses (72%).

- ❖ Nearly all respondents (99%) asserted that drug-using parents are entitled to the same respect as anyone else and approximately two thirds rejected negative stereotyping of drug-using parents. Only 16% of respondents perceived drug-using parents as deceitful, unreliable, and uncooperative or as holding views on child care that are notably different from the larger population (8%).

- ❖ Most respondents agreed with the statement that a large number of drug users are good enough parents (68%) and disagreed that drug-using parents, by definition, cannot provide good enough parenting (70%).

- ❖ At the same time, a majority of respondents believed that parents living with children should not use drugs (63%) and that even if parental drug use is not significantly affecting the child, professionals should not give the message that it is acceptable (73%).

- ❖ A minority of social workers appeared to have attitudes and values that were incompatible with a family support approach with drug-using parents. This group held negative stereotyped beliefs about drug-using parents (8-16%) and believed that all children of drug-using parents are at risk and should have their names placed on a child protection register (9% agreed, 9% refused to express a view).

- ❖ When asked about treatment of drug-using parents by other social workers and the system as a whole, respondents appeared to be less optimistic. Only 18% of respondents felt that drug-using parents are treated as fairly as non-drug-using parents in the child protection system while nearly half (47%) felt they are not, and approximately one third (35%) were uncertain. Approximately one third of respondents (32%) agreed or were uncertain (39%) in response to a statement that social workers discriminate unfairly against drug-using parents.

The author notes that a majority of social workers perceive their own values to be compatible with a family-centered practice model, but view discrimination against drug-

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using parents to be fairly prevalent. The author notes “respondents appear to be suggesting that while discrimination is widespread, they themselves are not implicated” (Adams, 1999, p. 24). In sum, the study found that a majority of social workers support a family-centered approach to working with parents who use drugs. At the same time, the study suggests that many social workers who embrace a family-focused approach may still feel ambivalent about working with substance-using parents, that a minority of social workers appear to have attitudes that would support discriminatory rather than supportive practices, and that social workers often perceive discrimination against drug-using parents in their workplaces but not in their own practice.

Social workers may be influenced by values and attitudes about substance use and dependence that are common in the general public and social workers are often prepared inadequately to work with substance abuse issues in practice (Billingham, 1999). Practice with individuals with substance abuse problems appears to be impacted by different values and attitudes including the degree to which helping professionals hold stereotyped beliefs about substance abuse, moralistic attitudes about substance use, and optimism about treatment (Howard & Chung, 2000; Richmond & Foster, 2003; Tracy & Farkas, 1994). Moralistic attitudes about self-destructive behaviors, such as substance abuse, and feelings of frustration or inadequacy among helping professionals may result in “interactions that are characterized by suspicion, mistrust and avoidance on both sides” (Richmond & Foster, p. 394). By contrast, attitudes that may offer a more constructive foundation for working with substance-abusing adults include the

following: optimism about treatment and the possibility of success, avoidance of stereotyping, non-moralism (or “avoidance of moralistic perspective when considering substance use and substance users”; Richmond & Foster, p. 395).

The idea that cultivating attitudes among social workers that are conducive to practice with substance-abusing families is echoed in a study of the impact of addiction training for public child welfare professionals. Changes in attitudes about working with substance-abusing parents may be a precursor to changes in practice. The study found that training was associated with reduced aversion to working with individuals with alcohol or other drug problems and increased belief that social workers can be helpful to individuals with addiction (Gregorie, 1994). This study also found that support from management and supervisors, as well as clarity about policies and performance expectations, related to working with addiction were important to implementation of knowledge and skills acquired through training.

The influence of implicit assumptions and the complexity inherent in child welfare decisions has prompted many practitioners and researchers to call for more objective or collaborative decision-making practices. Some of the strategies considered by many to offer more objective, balanced, and inclusive methods of decision-making include:

- Structured risk assessment tools,
- Multidisciplinary teams, and
- Family group conferencing (Osterling & Austin, 2006).

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Activity II – 1: Impact of Values on Practice

Purpose: This experiential activity underscores the impact of individual and group values on case planning. The instructor may substitute other case studies as appropriate for the class.

Instructions: First, invite the trainees to divide into at least four small groups. Half the groups are given one case scenario (Maria) and the other half is given the other case scenario (Sarah). Both of the cases involve substance-abusing parents whose children have been referred to child welfare.

Second, each group should be instructed to consider the case through the lens of very different sets of values. Groups with the same case are given different instructions (i.e., one group discussing Maria's case is given written instructions that suggest they view the case through a permissive lens and the second group discussing Maria's case is given written instructions that suggest a more punitive perspective). Finally, groups should be instructed to develop initial case plans based on the written assumptions that they have been given. The instructor should encourage students to do their best to conduct their case planning session from the perspective they have been given (without revealing the information that instructions are different).

Following development of case plans, each small group should report back to the larger group. The instructor/trainer should invite participants to discuss differences in case plans that were informed by different values. The instructor may acknowledge that the value sets provided for group A and group B for each case planning group are presented in a dichotomous manner, but that elements of these values may influence case planning.

Discuss the case plans developed for Maria and Sarah by both groups A & B. The instructor/trainer may use the questions below to process the activity.

- How were the case plans similar? How were they different? Were the clients well-served by the case plans?
- What should good interdisciplinary case planning look like? (Identify the core elements.)
- To what degree were you comfortable or uncomfortable "trying on" the assumptions and values in your group? What other observations might you have had about your own reactions?

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SECTION II

IMPACT OF VALUES, BELIEFS AND EXPECTATIONS IN PRACTICE

HANDOUTS

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Small Group Instructions

Maria (Group A)
Sarah (Group A)

Members of your group have the following attitudes and beliefs.

- Addiction is a choice and a character problem rather than a "disease."
- Addicts and alcoholics rarely fully recover. Few ever "make it," and those that do are usually damaged people. The concept of "relapse" reinforces your belief that these people rarely truly get better.
- No child could really be safe with alcohol/drug-using parents unless they were completely clean and sober for a significant period of time.
- Punishment is the only effective way to get the attention of people with substance abuse problems – and to ensure the safety of children and communities.
- The immediate family members of substance abusers are probably addicted themselves or, in other ways, just as "sick" as the alcoholics/addicts.

Review your case study from this perspective. Discuss this case and develop an initial case plan based on these assumptions. Identify one member of the group who will briefly report your plan to the larger group.

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Small Group Instructions

Maria (Group B)
Sarah (Group B)

Members of your group have the following attitudes and beliefs.

- People should be allowed to use drugs for their own recreation if they chose to.
- Recent changes in social circumstances and increased economic pressures on families contribute significantly to both substance abuse problems and child neglect.
- Substance abusers are unlikely to cause harm to children except in rare and extreme circumstances.
- People who use substances should receive support rather than punishment.
- Keeping children in the home is a good motivation for recovery.

Review your case study from this perspective. Discuss this case and develop an initial case plan based on these assumptions. Identify one member of the group who will briefly report your plan to the larger group.

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Maria's Case

Maria is a 24-year-old Mexican American mother of two children, John (age 4) and Joseph (8 months). She has an 8-year history of poly substance use with methamphetamine as her current and primary drug of choice. Maria entered a treatment program for pregnant and parenting women 3 months ago with her newborn. The other child remains in foster care. Maria was enrolled in an outpatient program for two weeks while waiting for a residential bed. This is Maria's third treatment episode. During her prior episodes, Maria left before completion and relapsed.

Since Maria entered treatment, she has demonstrated resistance to the program's rules and lacks motivation to work on her recovery. Maria has difficulty accepting advice from the parenting counselor about what to expect from Joseph in his current stage of development. Maria takes pride in keeping her baby clean and well dressed, but several times, she has walked away and left her baby unattended without asking for support from staff or other mothers in the program. Maria has attended all of her Alcohol and Drug groups since intake, but she often arrives late, which is against program rules. Her lack of punctuality has caused Maria to miss key group activities.

Maria has also missed 4 of 8 parenting classes this month due to court and medical appointments. Staff members have been working with Maria individually in an effort to help her catch up on missed assignments and to encourage her to improve her overall participation in groups. Maria responds well to individualized counseling and

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she has begun to identify her relapse trigger and develop relapse prevention plans.

In recent weeks, Maria has become more open to feedback and has been working on managing her anger. Maria has admitted that she feels overwhelmed and that she is not ready to parent both of her children at this time.

Case study adapted with permission from Contra Costa County Community Substance Abuse Services. Handout from year 2000 training – Memorandum of Understanding Between Community Substance Abuse Services and Children and Family Services Bureau.

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Sarah's Case

Sarah is a 36-year-old Anglo mother of three children: Jessica (age 10), Sam (age 7), and Amanda (9 months). Sarah's two oldest children were relinquished for adoption several years ago due to her long history of substance abuse and instability. Amanda was born prenatally exposed to cocaine and tested HIV positive. Sarah tested positive for HIV one year ago. Sarah, who had a prior CPS case, was mandated into treatment as a condition of reunification and Amanda was placed in foster care.

Sarah had a prior case with CPS that was closed 3 years ago. The past case opened with a report of domestic violence and substance abuse that resulted in injury to the two older children. The children were beaten by the mother's boyfriend (Jessica and Sam's father) and Sarah was unable to protect herself or them, in part, due to her alcohol and cocaine addiction. The children were removed and placed in foster care. Despite strong interventions to help the mother gain sobriety and to protect her, she declined services. She continued to appear high during visits with her children. Sarah eventually surrendered the children for adoption. Jessica and Sam's father is absent and his whereabouts are unknown.

Sarah is presently residing with her boyfriend, Tony, who is Amanda's father. Tony denies any drug use despite the fact that he has had many arrests for trafficking, the last one about a year ago. Sarah states that Tony has not hit her in about a year. Today Sarah is seven months into sobriety with one relapse four weeks ago. She reported using alcohol three times during one week. She continues to deny any violence between Tony and herself. She dislikes meeting with social workers, "who I never could trust." Sarah has visited Amanda regularly in the past 8 months, demonstrating affection and sensitivity to the child's needs.

Sarah is seeking reunification with Amanda. She is attending parenting classes two times a week, a weekly outpatient support group for her alcohol/drug recovery, and a weekly self-help meeting. She and Tony moved into a one-room apartment in a high-

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risk drug involved neighborhood. The police get called to the neighborhood regularly. Sarah denies risk to her sobriety.

Sarah's attorney is pushing heavily for return of Amanda within the next 6 months. Sarah's counselor says, "She's getting her act together. She's going to make it despite her recent relapse."

Case study adapted from Center for Substance Abuse Prevention. (1992). *Social workers training course: Prevention and early identification of alcohol and other drug abuse.* Rockville, MD: Substance Abuse and Mental Health Services Administration. (Developed with the co-sponsorship of the National Association of Social Workers. Formerly available through the National Clearinghouse on Alcohol and Drug Information, 1-800-729-6686.

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SECTION III

ATTITUDES AND VALUES OF CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT PROFESSIONALS IN CALIFORNIA: FINDINGS FROM THE COLLABORATIVE VALUES INVENTORY

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SECTION III
ATTITUDES AND VALUES OF CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT PROFESSIONALS IN CALIFORNIA: FINDINGS FROM THE COLLABORATIVE VALUES INVENTORY

Instructional Guide

Learning Objectives

This chapter provides an overview of findings based on data collected from the "Collaborative Values Inventory," which explores attitudes and values of professionals in both child welfare and substance abuse fields. It provides a brief overview of key domains of the Collaborative Values Inventory (as identified through factor analysis) and a discussion of findings about areas of agreement and disagreement among professionals from child welfare and substance abuse fields. There are two experiential activities in this module that are designed to facilitate student critical thinking about their own values and attitudes and those of colleagues in work settings. Both of the activities include guidelines and suggested discussion questions for the instructor.

- Activity III–1, the Values Clarification Tool, offers the students an opportunity to take a brief inventory of their own values. The "Mini" Collaborative Values Inventory is comprised primarily of items that appeared to perform well based on the factor analysis or that were of interest in the comparative analysis between substance abuse and child welfare fields.

- Activity III–2 provides students or trainees with an opportunity to discuss issues and possible responses associated with four case scenarios that illustrate possible value bias in decision making and case planning. The scenarios are designed to highlight domains of values, such as values related to drug-using parents and parental accountability that were particularly salient in the research findings.

By the end of this section, participants will be able to:

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- ❖ Discuss the importance of identifying differences in values and developing shared values in the process of building collaborative relationships.

- ❖ Understand how the Collaborative Values Inventory may be used as a tool for clarifying differences in values and creating common values between systems.

- ❖ Recognize similarities and differences in values, attitudes, and beliefs between substance abuse and child welfare professionals who participated in the study.

- ❖ Practice skills in reflecting on their own values and discussing values and potential bias with colleagues.

Public Child Welfare Competencies

Section II: Core Child Welfare Practice

2.2 Student demonstrates the ability to assess the interaction of factors underlying abuse and neglect and the capacity to identify strengths that act to preserve the family and protect the child.

2.9 Student recognizes the need to monitor the safety of the child by initial and ongoing assessment of risk.

2.15 Student understands the values base of the profession and its ethical standards and principles, and practices accordingly.

2.17 Student demonstrates the ability to assess his or her own emotional responses to clients, co-workers, and situations in which the worker's own values are challenged.

Section III: Human Behavior and the Social Environment

3.3 Student demonstrates understanding of the potential effects of poverty, racism, sexism, homophobia, violence, and other forms of oppression on human behavior.

Section VII: Human Behavior and the Child Welfare Environment

7.1 Student demonstrates the ability to assess the effects of family transitions and the impact of becoming a client of the child welfare system.

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Section VIII: Child Welfare Policy, Planning, and Administration

8.4 Student understands how to use information, research, and technology to evaluate practice and program effectiveness, to measure outcomes, and to determine accountability of services.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

8.9 Student demonstrates the ability to negotiate and advocate for the development of resources that children and families need to meet their goals.

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour and 45 minutes

Agenda:

- Introduction of topic and Collaborative Values Inventory (CVI)
  - The importance of understanding differences in professional values
  - Development of shared values and principles between fields
  - Introduction of the Collaborative Values Inventory as a tool
  - Brief introduction of research aims and methods
  - Highlights of domains from the Collaborative Values Inventory (as identified through factor analysis)
  - Activity III-1: "Mini" Collaborative Values Inventory
- Differences between professional fields: Findings from the respondents in California based on the Collaborative Values Inventory
  - Commonalities in perceptions of problems that most impact families
  - Commonalities and differences in other key domains of the CVI
- Activity: Participant discussion (based on questions for class discussion).
- Activity III-2: Responding to biases/modeling critical thinking in response to unexamined beliefs, attitudes, and values.

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The activities in this module are designed to create active learning opportunities that are linked to the content of the research findings. Instructors may elect to briefly review findings before introducing and facilitating the experiential activity. It is also possible that instructors may elect to use one or both of these activities independently in a training or course related to social work theory, research, or practice. In this event, instructors are encouraged to provide a context for the activity by briefly acknowledging that the activity is based on research supported by CalSWEC that explored similarities and differences in values between substance abuse and child welfare fields. Instructors are encouraged to use the activities and content of this chapter in any combination that meets the needs of their course or training objectives. For example, instructors may elect to use the Mini Collaborative Values Inventory from the first section of this module with an overview of findings from the California-based research on the CVI as presented in the second section of this module.

This module highlights similarities and differences among respondents by field of practice: child welfare, substance abuse, and other (e.g., dependency court, health, and probation). Some findings in relation to other analyses conducted in this study that focused on difference by staff level (line staff, supervisor, manager/administrator) or level of county collaboration (advanced vs. earlier collaboration) are available in Appendix A and may be included by the instructor based on time and interest.

Materials Needed

- ❑ Overhead projector
- ❑ PowerPoint slides
- ❑ Handout III-1 Mini Collaborative Values Inventory

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- ❑ Handout III-2 Challenging biases in the workplace
- ❑ Markers and flip chart or white board (optional – for writing key points in response to questions for class discussion)

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Attitudes and Values of Child Welfare and Substance Abuse Treatment Professionals in California: Findings from the Collaborative Values Inventory

Impact of Values and Attitudes on Systems Level Practice

One consistent theme in the literature in relation to solutions to addressing alcohol and drug-related child abuse and neglect is a call for greater collaboration and coordination between systems (CSAT, 1993, 1994; DHHS, 1999; Fieg & McCullough, 1997; Gustavsson & Rycraft, 1993; Kropenske & Howard, 1994; Semidei et al., 2001; Tracy, 1994; Young et al., 1998; Young & Gardner, 2002; Young et al., 2001). Significant barriers to communication and collaboration between systems include the following (Fieg & McCullough; Young et al., 1998; Young & Gardner):

- Differences in who is defined as a client (the perception of the child as the primary client in child welfare services and the focus on the substance-abusing parent in substance abuse treatment),
- Conflicting attitudes and values about parents with alcohol or drug addiction,
- Differing perceptions about the prognosis for substance-abusing parents and effectiveness of treatment,
- Significant differences in focus, policy, and practice related to expected timing for reunification efforts where child welfare professionals focus primarily on the safety and developmental needs of the child and treatment staff are concerned primarily with the parental process of recovery and relapse, and
- Differing laws and regulations related to client confidentiality between the two fields.

As noted in the previous section, values may be defined "as the social principles, goals or standards held by an individual, group or society" (Gambrill, 1997, p. 44). The

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process of making decisions on both policy levels and with individual clients should be guided by professional values and principles. Because of this, the National Association of Social Workers, like other professional organizations, had adopted explicit statements about values and ethics that should guide practice on micro, mezzo, and macro levels. The articulation of values or guiding principles can be a crucial first step in developing and implementing strategies for addressing complex social problems such as the intersecting problems of substance abuse and child maltreatment.

A seminal research study and policy analysis entitled *No Safe Haven: Children of Substance Abusing Parents* from the National Center of Addiction and Substance Abuse at Columbia University (CASA) encapsulates the problems facing social services and proposes guiding principles for practice:

> The problem facing the child welfare system is primarily one of practice: how to identify the problems facing families; how to assess the need for services; what services to provide; how to pay for them; and what constitutes "reasonable efforts" to treat parents and hold families together. In this challenging environment, it makes sense to focus on crafting practice guidelines that can be tested, replicated and adopted as they demonstrate their effectiveness and command confidence….To respond to the reality and consequences of a caseload not dominated by substance-abusing parents, CASA suggests the following guiding principles:
>
> 1. Every child has a right to have his or her substance-abusing

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parents get a fair shot at recovery with timely and comprehensive treatment.

2. Every child has a right to be free of drug- and alcohol-abusing parents who are abusing or neglecting their children and who refuse to enter treatment or despite treatment are unable to conquer their abuse and addiction.

3. Every child has a right to have precious and urgent developmental needs take precedence over the timing of parental recovery.

4. The goal of the child welfare systems is to form and support safe, nurturing families for children—where possible within the biological family and where not possible with an adoptive family (CASA, 1999, p. 77-78)

An examination of case studies illustrating emerging best practices in collaboration between substance abuse and child welfare fields revealed that the process of values clarification was crucial to the formation and evolution of collaborative efforts (Young & Gardner, 2002). Findings from the case studies "make clear that the difference underlying values in the child welfare and substance abuse treatment partners can lead to problems that impede collaborative relationships, unless these differences are addressed" (Young & Gardner, p. 91). Some of counties and states that were selected as sites had developed formal statements of principles to guide their efforts, while others worked to clarify their values in the process of developing their innovative programs. Some key issues addressed through values clarification included the following: treatment priorities in the context of limited resources, responsibility for compliance with substance abuse treatment when mandated by child welfare, approaches to dealing with relapse, beliefs about treatment (e.g., abstinence and harm reduction), and evaluation criteria and values that underlie permanency decisions.

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The Sacramento County Alcohol and Other Drug Treatment Initiative illustrates the importance of values clarification across systems. Sacramento County, in recognition that treatment resources were insufficient to assess and respond adequately to the large percentage of child welfare involved clients with substance abuse problems, embarked on an ambitious effort to train all social workers to conduct alcohol and drug screening and assessment and to train alcohol and drug providers to work more effectively in collaboration with child welfare (Young & Gardner, 2002). A formal statement of philosophy developed during the early years of the project asserted that "service priority should be given to those clients at greatest risk, which strongly argues that clients with children…should be among those at greatest risk because their children are also at risk" (Young & Gardner, p. 48). The written values and principles statement included the following:

- Prioritizing high-risk clients,
- Expanding treatment and support service capacity within existing resources, primarily by expanding group services with different foci (e.g., education and support, treatment readiness, brief intervention, traditional treatment groups),
- Viewing the client as an integral partner in a successful intervention,
- Increasing the staff's level of knowledge and understanding of, and sensitivity to addiction, recovery, and relapse, and
- Increasing the staff's ability to respond appropriately to problems associated with alcohol and drug use.

Using these values to guide the development of new collaborative models and daily practice has impacted services in Sacramento. An evaluation of the impact of systemic changes using treatment access data found that 52% of clients receiving

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treatment in Sacramento were women, in contrast with the state as a whole where only 35% of clients receiving treatment were women (Young & Gardner, 2002).

The Collaborative Values Inventory: A Tool for Values Clarification Between Systems

Children and Family Futures (CFF), an organization in California with a strong history of facilitating collaboration between substance abuse, child welfare, and other related professional fields, developed a Collaborative Values Inventory (CVI). CFF now operates a National Center for Substance Abuse and Child Welfare and continues to advance collaboration and research in California and other states. The CVI was designed by Children and Family Futures as a neutral tool for assessing group commonality or differences in beliefs and values between systems. This instrument has been used widely by many counties and states to help illuminate value differences that might interfere with collaboration and to facilitate productive discussion about underlying values that might be adopted to create a foundation for effective collaboration. CFF also created an instrument to measure collaborative practice across counties or states: the Collaborative Capacity Instrument (CCI; see Section IV and Appendix C for additional information about the CCI).

Although these instruments were used in work with California counties and with several state agencies in the United States as tools for establishing or enhancing collaboration, studies had not yet been conducted to examine the strength of these instruments. Therefore, one of the aims of the study described in this training curriculum was to examine the strength (or internal consistency) of the instruments and to identify

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some of the underlying dimensions (or factors) that make up the Collaborative Values Inventory. To this end, factor analysis and reliability testing were conducted on data from approximately 350 CVIs. The first 47 items on the inventory measure responses to a variety of statements about values and beliefs related to collaboration on a scale from 1-4 (strongly disagree to strongly agree). In general, the factor analysis suggested that the measures in the CVI were reasonably strong. (Additional detail about this analysis is available in Appendix A.)

Factor analysis of the first 47 items suggested seven underlying factors or dimensions of the Collaborative Values Inventory. An eighth factor (based on a different scale from 1 to 5) was analyzed separately. The factor analysis basically helps identify items on a survey that correlate strongly with one and, therefore, describe an important dimension of the survey. These factors or dimensions are generally named based on several high loading items (Pett, Lackey, & Sullivan, 2003) and the factors identified through this analysis reflect the dominant *theme* of the items that strongly correlate with one another. The table below describes the eight dimensions that are captured in the Collaborative Values Inventory.

Table III-1: Factors for the Collaborative Values Inventory

Factor or Dimension	**No of items**
Factor 1: Values and beliefs about planning and outcomes	8
Factor 2: Values and beliefs about drugs and drug-using parents	7
Factor 3: Values and beliefs about parental accountability	5
Factor 4: Beliefs about improving service and community systems	7
Factor 5: Values about funding	4
Factor 6: Beliefs about dependency courts related to substance abuse and child welfare	6
Factor 7: Values about community priorities	3
Factor 8: Beliefs about parental success in services	2

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A Mini Collaborative Values Inventory was developed for use in this training and contains 15 out of 47 of the items from the full Collaborative Values Inventory that were the stronger items in each of the first seven categories or that were particularly interesting in follow-up analyses of individual items.

The experiential activity below provides students or trainees with an opportunity to engage in an abbreviated version of the type of values clarification activity that is often helpful in creating or maintaining collaboration between systems.

Activity III-1:

Purpose: Selected questions from the Collaborative Values Inventory will be completed by participants to increase familiarity with the instrument (used in the research) and also to facilitate critical thinking about the student's/trainee's own values.

Instructions: Participants fill out a mini survey with selected items from the Collaborative Values Inventory (See Handout III-1). Participants should be reminded that there are no correct answers and encouraged to select the answer that best describes their beliefs. After participants have completed the tool on their own, the facilitator or instructor may lead the group in an exploration of their responses using the following activity:

- The instructor will read a statement and then invite participants to physically place themselves in a line that is ordered from "strongly disagree" to "strongly agree." This approach may also be used in relation to participant estimates of the proportion of clients that will succeed in child welfare services and in substance abuse treatment. (If the classroom or training space is not conducive to creating a line or if mobility would be a barrier to inclusion for any participants, the instructor or trainer may invite a show of hands for levels of agreement or disagreement.)
- Invite volunteers to identify why they selected their position. (Remind participants that this activity is not intended to be a debate and that listening to different views is an important part of the collaborative process.) Repeat using a variety of statements. The instructor should summarize commonalities and differences as appropriate.
- Other debriefing questions may include the following:

  1. Which questions were most challenging or troubling to complete and why?

  2. If this group were to begin to develop a collaborative program together, what are some of the differences that might need to be addressed further?

  3. What, if any, were some of the areas where there appeared to be strong agreement and what implications might these have for working together?

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Table III-2: Sample Items from the Collaborative Values Inventory by Factor

Item on the Mini Collaborative Values Inventory (Question Number)	Factor or Dimension
• Child welfare service outcome measures should include indicators regarding the substance abuse recovery status of parents of the children they seek to protect. (Q-11) • Persons who are in recovery and have successfully transitioned out of the child welfare system should play a more significant role in staffing roles which support and advocate for parents in the child welfare and family court systems. (Q-7)	Factor 1: Values and beliefs about planning and outcomes
• There is no way that a parent who *uses* alcohol or other drugs can be an effective parent. (Q-2) • There is no way that a parent who is *chemically dependent* on alcohol or other drugs can be an effective parent. (Q-3) • In assessing the effects of the use of alcohol and other drugs, the standard we should use for deciding when to remove or reunify children with their parents is whether the parents are fully abstaining from use of alcohol or other drugs. (Q-4)	Factor 2: Values and beliefs about drugs and drug-using parents.
• Parents who have been ordered to remain clean and sober should face consequences for non-compliance with those orders. (Q-5) • Parents who are noncompliant with dependency court orders should face jail time as a consequence. (Q-6)	Factor 3: Values and beliefs about parental accountability
• Services would be improved if agencies were more responsive to the cultural differences between client groups. (Q-12) • I believe that publicly-funded alcohol and drug treatment providers should give higher priority in allocating treatment slots than they do at present to women referred from child protective services. (Q-15) • I believe that the significant barriers to interagency cooperation would be resolved if children's services, substance abuse and dependency court staff were involved in a comprehensive training program for child welfare staff. (Q-13) • I believe that confidentiality of client records is a significant barrier to allowing greater cooperation among alcohol and drug treatment, children's services agencies, and the courts. (Q-14)	Factor 4: Beliefs about improving service and community systems
• We should fund programs that serve children and families based on their results, not based on the number of people they serve, as we often do at present. (Q-8) • We should fund programs that treat parents for their abuse of alcohol and other drugs based on their results, not based on the number of people they serve, as we often do at present. (Q-9)	Factor 5: Values about funding
• Our judges' and attorneys' response to parents with problems of addiction is generally appropriate and effective. (Q-10)	Factor 6: Beliefs about courts
• Dealing with the problems caused by alcohol and other drugs would improve the lives of a significant number of children, families, and others in need in our community (Q-1)	Factor 7: Values about community priorities

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Training participants may be interested in knowing about the relationship between specific items on the Mini CVI and the factors from which they are drawn. Table III-2 above identifies the items on the inventory and the associated factors.

Findings from the Collaborative Values Inventory: Similarities and Differences Between Substance Abuse and Child Welfare Fields

One of the aims of the study described in this curriculum was to answer the following question: What is the relationship between values and field of practice (e.g., what are the similarities and differences in values between child welfare and substance abuse professionals)? To examine this question, data using the full Collaborative Values Inventory were gathered from 350 managers, supervisors, and line staff who work with families impacted by substance abuse and also involved in the child welfare system. Respondents included professionals in child welfare, substance abuse treatment, and other allied fields (such as dependency courts, probation, domestic violence, and mental health) in 12 counties in California.

Most important problems. Individuals responding to the Collaborative Values Inventory were invited to identify the three "most important causes of problems affecting children, families, and others in need in our community" from a menu of 25 options (see Appendix B for full text of the CVI). Although there was some variation in the proportion assigned to specific problem areas, those listed in Figure III-1 consistently emerged as the top issues across disciplines. Drug abuse and mental illness were consistently identified as compelling causes of problems that impact children and families. Other critical problems areas included poverty, domestic violence, and alcoholism.

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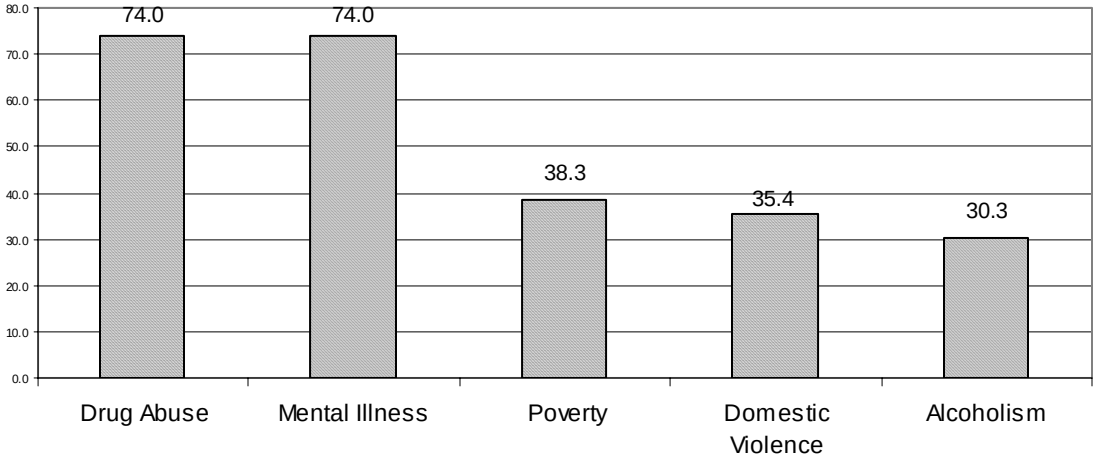
Figure III-1: Most Important Causes of Problems Affecting Children, Families, and Others (Frequencies, Full Sample, N = 350)



Commonalities and Differences by Field of Practice. As described above, responses to similar questions on the Collaborative Values Inventory were combined to create *scores* in seven general areas. These scores were used to compare differences between groups of respondents based on their professional discipline (child welfare, substance abuse, or other fields). Figure III-2 compares these scores for the first seven areas (or factors) of the CVI between respondents from child welfare, substance abuse treatment, and other fields (e.g., courts, health, mental health, domestic violence). In general, higher scores suggest greater levels of agreement to statements that comprise each of the areas (or factors).

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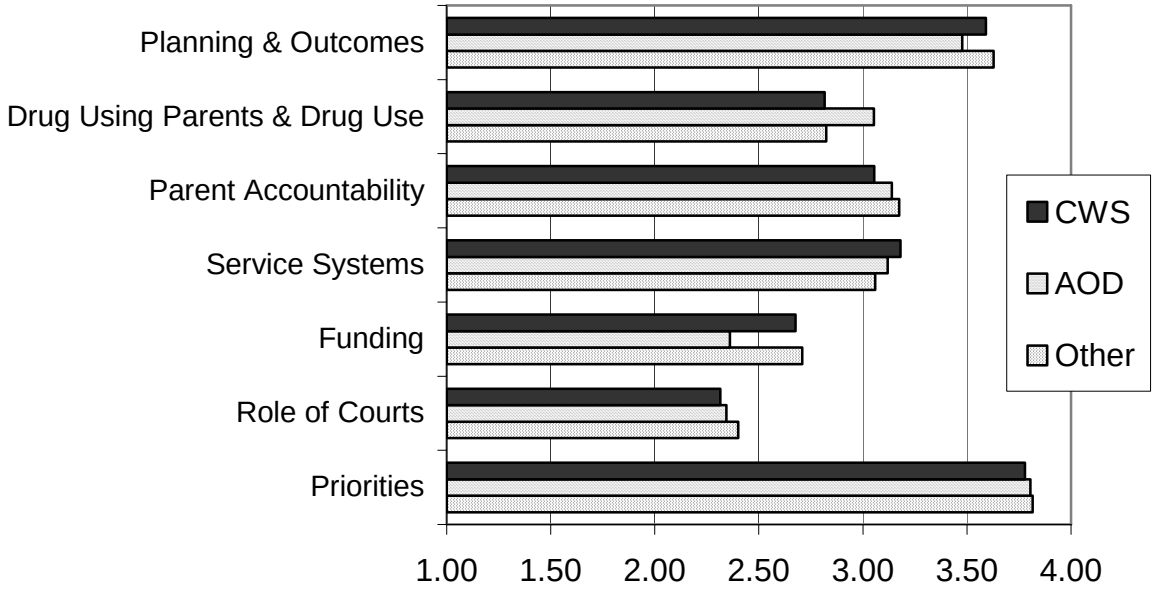
Figure III-2: Mean Scores for CVI Factors by Field of Practice: Child Welfare, Substance Abuse Treatment and Other Disciplines (1 = disagree and 4 = strongly agree)



Some of the *highlights of scores for factors that were similar* between different fields include the following:

- Strong *agreement with statements about priorities*, such as the importance of addressing substance abuse issues and child welfare, was consistent across fields (*M* = 3.8 on a scale in which 4 represents "strongly agree").

- Respondents across fields also tended to *disagree* with statements corresponding to *beliefs about dependency court* (*M* = 2.3, with the value of 2 representing "disagree"), including statements asserting that judges and attorney responses to parents with alcohol and drug problems are appropriate and effective and that dependency courts do a good job involving communities in planning and evaluating court services.

- Respondents had similar levels of agreement (*M* = 3.1) related to beliefs *about improving service delivery systems and community systems*. However, a separate analysis of individual items in this area revealed important differences:

    - Child welfare respondents were more likely than respondents from the alcohol and drug field to perceive confidentiality of client records as a barrier to collaboration.

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- Child welfare respondents were also more likely to believe that publicly-funding substance abuse treatment providers should give higher priority to women referred from child protective services.

DISCUSSION QUESTIONS:

- How might common priorities and beliefs about improving systems help in the early stages of collaboration?
- Why might respondents have disagreed with statements suggesting that court/ attorney responses to parents with alcohol and drug problems are appropriate and effective? What might contribute to this?
- How might differences in perceptions about confidentiality as a barrier to collaboration be addressed?

Areas of commonality between fields provide a rich opportunity for building on a sense of shared purpose and identifying problems to be overcome in the process of collaboration. For example, the near consensus about the importance of addressing both substance abuse and child welfare issues may be a pivotal starting point for growing collaborative efforts, particularly if collaborating partners translate these values into formal policies and programs. Establishing clear priorities-related treatment services may represent one opportunity for translating stated priorities into practice, as evidenced by the finding that child welfare respondents were significantly more likely than respondents from the alcohol and drug field to suggest that publicly-funded alcohol and drug treatment programs should place greater priority on allocating treatment to women referred from CPS.

Other findings similarly point to opportunities for improved planning and practice

between fields. The fact that child welfare professionals were significantly more likely to agree that confidentiality of client records represented a substantial barrier to cooperation between systems underscores the importance of developing mechanisms for better communication and collaboration across fields in relation to shared case planning. The relatively low scores across fields for the factor associated with courts may indicate a need to improve existing services. High concurrence about the importance of targeting children from substance-abusing families in child welfare for services (in the CVI), in conjunction with the overall low score for services to children (on the CCI discussed in greater detail in Section IV), might also point to the need to pursue new collaborative funding or programming in this area.

Significant *differences were found in three of the seven factor scores:* values and beliefs about planning and outcomes, values and beliefs about drugs and drug-using parents, and values about funding. A separate analysis of individual items from the Collaborative Values Inventory that were significantly different between fields provides some interesting insight into these differences.

- The mean score related to beliefs about drugs and drug-using parents was higher among respondents who stated that they worked in the alcohol and drug field (*M* = 3.1) compared to child welfare professionals (*M* = 2.8) and other professionals (*M* = 2.8).
- By contrast, mean scores in the area of planning and outcomes were lower among respondents from the alcohol and drug treatment field (*M* = 3.5) compared to those from child welfare (*M* = 3.6) and other disciplines (*M* = 3.6).
- The mean score for the scale related to funding was also lower among respondents from the alcohol and drug field (*M* = 2.4) compared to child welfare (*M* = 2.7) and other fields (*M* = 2.7).

In relation to the factor related to beliefs about drug-using parents, alcohol and drug treatment professionals were more likely to assert that people who were chemically dependent have a disease for which they need treatment. Although a majority of respondents (69%; analysis not shown) disagreed or strongly disagreed with the statement that there is no way that a parent who uses drugs can be an effective parent, respondents from the AOD field were more likely to express doubt that parents who use, abuse, or are dependent on drugs can be effective as parents. It is important to note that there is no method in this study to measure whether respondents from alcohol and drug fields and child welfare conceptualize *effective* differently in these kinds of items. At the same time, respondents from child welfare were significantly more likely to agree with the statement, "Some parents with problems with alcohol and other drugs will never succeed in treatment." This finding suggests that development of policies and protocols for practice will likely require addressing fundamental exploration about how different stakeholders conceptualize the process of addiction as well as *effective* or *ineffective* parenting.

Two items (out of eight) that comprised the factor related to *planning and outcomes* were significantly different by field of practice. Child welfare and professionals in other fields were more likely to agree or strongly agree that agencies should involve communities in planning for both child welfare and substance abuse services. There are at least two implications of this finding for initiating collaborations. First, it would be important for collaborating professionals to articulate the degree to which community

representatives are already involved in planning. For example, the alcohol and drug field in many counties places a strong emphasis on peer-oriented services and community-oriented prevention. In this case, the lower scores for the alcohol and drug field may reflect the degree to which respondents believe they are already engaged in participatory planning. Second, it is also possible that there are differences between how participants conceptualize the idea of community involvement. Either way, the findings point to the importance of discussing explicitly their current practices, possible differences, and ideal practices in relation to planning services in a manner that is informed by communities.

Although 80.9% of respondents *disagreed or strongly disagreed* with the statement that there is enough money in the systems to respond to alcohol and drug problems (analysis not shown), disagreement was particularly pronounced among respondents from the alcohol and drug field. These differences may reflect differences in funding levels or differences in the perceived *gap* between needed and existing services. Respondents from the alcohol and drug field were also less likely to agree that programs should be funded based on results. This finding is of interest in the context of increasing pressure to measure client outcomes; however, it is not possible from the study design to determine whether this later finding reflects a difference in value placed on such measure or a difference in funding and capacity for evaluation.

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DISCUSSION QUESTIONS:

- What might account for differences in beliefs about drugs and drug-using parents? How might that impact collaboration?
- How might respondents from child welfare and alcohol and drug fields define *effective* or *ineffective* parenting differently?
- Why might people from different fields have different perceptions of systems level issues (such as need for funding or need for including communities in planning)?

Activity III- 2: Challenging Bias in the Workplace

Purpose: Research suggests that values, beliefs, and attitudes may impact professional practice. In addition to developing the capacity to critically analyze one's own values and assumptions, identifying and employing skills to address possible values conflict or biases in decision-making in groups or among colleagues is an important skill in successful collaboration.

Audience: Most appropriate for IV-E students or entry level professionals in child welfare.

Instructions: Break participants into four groups and assign one scenario to each group. Discuss the scenario in the group and address the following questions:

1. Have you encountered this situation, or a similar situation in your work setting?
2. What values and attitudes appear to be in conflict?
3. What specific steps or strategies might be employed to address the conflict?

This section provided a description of the Collaborative Values Inventory as well as an opportunity for participants to understand how this tool might be used in a practice setting to begin to clarify and create common values. This section also provided an overview of key similarities and differences between California respondents in the fields of substance abuse and child welfare based on their responses to the Collaborative Values Inventory.

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SECTION III

ATTITUDES AND VALUES OF CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT PROFESSIONALS IN CALIFORNIA: FINDINGS FROM THE COLLABORATIVE VALUES INVENTORY

HANDOUTS

Drabble, L., & Tweed, M., & Osterling, K. L. (with Navarrette, L., Pearce, C., Ribeiro, P., & Twomey, E.). (2006). *Pathways to collaboration: The role of values and system-related factors in advancing collaborative practice between child welfare and substance abuse treatment fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

"Mini" Collaborative Values Inventory: What Do We Believe About Alcohol and Other Drugs, Services to Children and Families, and Dependency Courts?

The Collaborative Values Inventory (CVI) was developed by Children and Family Futures (CFF) as a neutral tool for assessing group commonality or differences in beliefs and values between systems. The box below contains the language at the beginning of the CVI that explains how the instrument is typically used to surface and facilitate discussion of underlying values among professionals in different fields including child welfare, substance abuse treatment, and dependency courts.

Introduction to the Collaborative Values Inventory
Many collaboratives begin their work without much discussion of what their members agree or disagree about in terms of underlying values. This questionnaire is a neutral way of assessing how much a group shares ideas about the values that underlie its work. It can surface issues that may not be raised if the collaborative begins its work with an emphasis on programs and operational issues, without addressing the important values issues affecting their work. Learning that a group may have strong disagreements about basic assumptions that affect its community's needs and resources may help the group clarify later disagreements about less important issues which are really about these more important underlying values. After reviewing the results from a collaborative's scoring of the Inventory, it is important to discuss the areas of common agreement and divergent views. That discussion should lead to a consensus on principles that the collaborative members agree can form the basis of state or local priorities for implementing practice and policies changes, leading to improved services and outcomes for families.

The questions below are selected from the Collaborative Values Inventory. (See Appendix B in this curriculum or visit http://www.cffutures.org to obtain a copy of the full instrument.) Please review the statements below and select that answer that best reflects your own beliefs (on a scale from strongly disagree to strongly agree). There are no *correct* answers. This activity provides an opportunity to engage in the type of process for exploring and discussing values that has proven valuable in the development of cross-systems collaboration.

Circle the response category that most closely represents your extent of agreement with each of the following statements:

1. Dealing with the problems caused by alcohol and other drugs would improve the lives of a significant number of children, families, and others in need in our community.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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2. There is no way that a parent who *uses* alcohol or other drugs can be an effective parent.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

3. There is no way that a parent who is *chemically dependent* on alcohol or other drugs can be an effective parent.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

4. In assessing the effects of the use of alcohol and other drugs, the standard we should use for deciding when to remove or reunify children with their parents is whether the parents are fully abstaining from use of alcohol or other drugs.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

5. Parents who have been ordered to remain clean and sober should face consequences for non-compliance with those orders.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

6. Parents who are noncompliant with dependency court orders should face jail time as a consequence.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

7. Persons who are in recovery and have successfully transitioned out of the child welfare system should play a more significant role in staffing roles which support and advocate for parents in the child welfare and family court systems.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

8. We should fund programs that serve children and families based on their results, not based on the number of people they serve, as we often do at present.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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9. We should fund programs that treat parents for their abuse of alcohol and other drugs based on their results, not based on the number of people they serve, as we often do at present.

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

10. Our judges' and attorneys' response to parents with problems of addiction is generally appropriate and effective.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

11. Child welfare service outcome measures should include indicators regarding the substance abuse recovery status of parents of the children they seek to protect.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

12. Services would be improved if agencies were more responsive to the cultural differences between client groups.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

13. I believe that the significant barriers to interagency cooperation would be resolved if children's services, substance abuse and dependency court staff were involved in a comprehensive training program for child welfare staff.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

14. I believe that confidentiality of client records is a significant barrier to allowing greater cooperation among alcohol and drug treatment, children's services agencies, and the courts.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

15. I believe that publicly-funded alcohol and drug treatment providers should give higher priority in allocating treatment slots than they do at present to women referred from child protective services.

    Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

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Activity III-2: Challenging Biases in the Workplace

Purpose: Research suggests that values, beliefs, and attitudes may impact professional practice. In addition to developing the capacity to critically analyze one's own values and assumptions, identifying and employing skills to address possible values conflict or biases in decision-making in groups or among colleagues is an important skill in successful collaboration.

Instructions: After breaking into small groups, you will be assigned to review one of the four case scenarios outlined below. In your group, discuss your assigned scenario and address the following questions:

1. Have you encountered this situation or a similar situation in your work setting?
2. What values and attitudes appear to be in conflict?
3. What specific steps or strategies might be employed to address the conflict?

Case Scenarios:

1. During a family reunification unit meeting, you and your colleagues are talking about substance abuse services offered to your clients. One of your colleagues makes a statement about how substance abuse services will not help any parent who is addicted to drugs, especially if the parent doesn't want the help. Your colleague goes on to state that the Department is wasting money on families who will eventually return to the system in a few years.

2. As an FR worker, you are currently working with a young African American mother who recently gave birth to child who tested positive for exposure to an illicit drug. The mother had one prior failed attempt at treatment. This is her first child and she is currently enrolled in an outpatient drug treatment program for pregnant and parenting women. The newborn is placed in the care of a foster/adoptive family who is willing to adopt the baby if family reunification services are terminated. You are informed by the adoptive family that the adoptions social worker has told them not to worry about not having the baby permanently. When you inquire about the statement made by the adoptions social worker, the family tells you that the adoptions social worker has told them that the birth mother is a heavy drug user and it is most likely that she will not pass family reunification. According to the family, they were told by the adoptions social worker to start making plans to sever ties to the birth mother. The adoptive family is confused by your role as a FR worker since it seemed clear by the remarks made by the adoptions worker that the mother was not getting the baby back.

3. You often hear colleagues talk about how it is so important for families participating in child welfare services to attain beneficial and effective substance abuse treatment. However, many of the services offered in your county have not been

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evaluated and are limited, especially for undocumented clients or clients whose primary language is not English. In your county, Latino children and families are overrepresented in the child welfare system in comparison to Anglo populations and are equally likely to be considered affected by substance abuse problems. You have a few colleagues who believe that any of the families who are referred to substance abuse services should be able to overcome their addiction within a 12-month timeframe (or less if a child is under 3 years of age) and "it should not matter whether or not services are available or effective because it is dependent on the parent to want to live a sober and clean lifestyle."

4. As a Permanent Placement (Long Term Foster Care) worker, you are in the process of looking for a permanent and stable placement for a 14-year-old boy on your caseload. The 14-year-old has been in the child welfare system for 6 years. He was removed from his mother's care due to her inability to parent because of her drug use. At the time of reunification services, the mother was unable to reunify with her son because she continued to use drugs. The teenager has been placed in several foster homes throughout the 6 years and has recently started to have visits with his mother, who has been clean and sober for 2 years. The birth mother has spoken to you about the possibility of having her son returned to her if things continue to go well in regard to visits and the rebuilding of their relationship. You bring this case to the attention of your supervisor and some colleagues to ask for input. One colleague states that this placement could work and the teen could return to his mother's care with supervision. This would involve a permanent placement of the child to his birth family. However, the senior social worker offered strongest comment, asserting that you should not even consider the birth mother because of her heavy and extensive use of drugs in the past. This colleague went on to state that if the teen went back home with his mother, the department would not be serving the child's best interest since it was evident that the mother has only been clean and sober for a short amount of time. The senior social worker's last comment to you is to have the teen remain in long term foster care or find a better family.

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SECTION IV

BUILDING SYSTEMIC COLLABORATION: FINDINGS FROM THE COLLABORATIVE CAPACITY INSTRUMENT

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SECTION IV
BUILDING SYSTEMIC COLLABORATION: FINDINGS FROM THE COLLABORATIVE CAPACITY INSTRUMENT

Instructional Guide

Learning Objectives

This chapter presents an overview of findings based on data collected from the "Collaborative Capacity Instrument," which measures perception of collaborative practices between substance abuse treatment, child welfare, and court systems. Section III of this curriculum emphasizes critical thinking and reflection about individual level values, attitudes, and practices. By contrast, this module places more focus on macro practice and problem solving related to collaboration between substance abuse, child welfare, and court systems.

By the end of this section, participants will be able to:

- ❖ Recognize the 10 areas for collaborative practice measured by the Collaborative Capacity Instrument.
- ❖ Understand how the Collaborative Capacity Instrument is used as a tool for assessment of macro level collaborative relationships between systems.
- ❖ Engage in problem solving and identification of macro level strategies for building cross-systems collaboration.

Public Child Welfare Competencies

The following competencies are addressed in this chapter:

Section II: Core Child Welfare Practice

2.20 Student understands and utilizes the case manager's role to create and sustain a helping system for clients, a system that includes collaborative child welfare work with members of other disciplines.

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Section IV: Workplace Management

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.

4.4 Student is able to identify an organization's strengths and limitations and is able to assess its effects on services for children and families.

4.6 Student is able to seek client, organization, and community feedback for evaluation of practice, process, and outcomes.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

Section V: Culturally Competent Child Welfare Practice

5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethnic and cultural populations.

Section VIII: Child Welfare Policy, Planning and Administration

8.5 Student demonstrates knowledge of how organizational structure and culture affect service delivery, worker productivity, and morale.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare practice.

Agenda and Suggestions for Instructors

Time allocation: Approximately 1 hour and 45 minutes

Agenda:

- Introduction to the Collaborative Capacity Inventory (CCI) and research
    - Review of background information about the CCI
    - Definition and description of 10 areas of the CCI
    - Brief explanation of research aims and methods
- Research findings related to the CCI in California sample
    - Review of overall scores and differences between scores on aggregated items

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- Review of specific practices (related to specific items) that were significantly higher in counties with a strong history of collaboration

❖ Active learning activity in addressing systems issues and barriers to collaboration.

- Small group review and discussion of case scenarios
- Full group report of key issues and recommendations

The three components listed above build upon one another. However, if time constraints preclude use of all three parts, the instructor may elect to present the overview of the Collaborative Capacity Instrument followed by either of the two following sections: the highlights of findings from the study, or the small group activity using organizational case studies. The findings presented in this section, which examine county level of collaboration, are particularly interesting and salient for reflecting on systems-level collaborative practice. However, the study also examined the Collaborative Values Inventory by staff level (manager, supervisor, and line staff) and field of practice (child welfare, alcohol and drug treatment, or other fields). These findings are available in Appendix A and may be used as appropriate.

Materials Needed

❑ Overhead projector
❑ PowerPoint slides
❑ Handout IV-1 (10-Element Framework for Collaborative Practice)
❑ Handouts IV-2 a-d (Four Organizational Case Studies)
❑ Markers and flip chart or white board (optional – for writing key points in response to questions for class discussion)

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Building Systemic Collaboration:
Findings from the Collaborative Capacity Instrument

Elements of Collaboration: Background and Description of the Collaborative Capacity Instrument

In the late 1990s, several important national reports were released that documented the strong correlation between substance abuse and child welfare, identified barriers to collaboration between multiple systems serving families with substance abuse problems in the child welfare system, and called for innovations in practice and policy to pave the way for more effective collaboration (CASA, 1999; DHHS, 1999; GAO, 1998; Young et al., 1998). In an effort to create a framework for effective collaboration, a study was conducted by Children and Family Futures (CFF) to examine "lessons learned" from innovative programs forged through partnerships between alcohol and other drug (AOD) services, child welfare services (CWS), and the courts (Young & Gardner, 2002). The frameworks used to conduct this study include the 10 elements listed below:

1) Underlying values and principles,
2) Daily practice related to screening, and assessment,
3) Daily practice related to client engagement and retention in care,
4) Services to children,
5) Joint accountability and shared outcomes,
6) Information sharing and data systems,
7) Training and staff development,

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8) Budgeting and program sustainability,

9) Working with related agencies, and

10) Working with communities and supporting families.

NOTE TO INSTRUCTOR: Distribute Handout IV-1: 10 Elements for Collaborative Practice.

Use the handout to describe elements of collaborative practice.

The instructor may also note that this handout will be used as a reference for an experiential activity that will allow participants to assess macro level problems and possible solutions to issues described in several organizational case studies.

The instructor may also point out that the document describing best practices in each of these 10 areas is available at no cost through the National Clearinghouse on Alcohol and Drug Information. (Contact information is included on the handout).

The Collaborative Capacity Instrument: A Tool for Assessment of Collaboration Between Systems:

The Collaborative Capacity Instrument (CCI) was developed by Children and Family Futures and is used to assess collaborative process in the 10 areas outlined above. The CCI measures agreement or disagreement to statements in each of these 10 areas using a four-category response scale (agree, somewhat agree, disagree, and not sure). Children and Family Futures also developed a Collaborative Values Inventory (CVI) as a neutral tool for assessing group commonality or differences in beliefs and values between systems. (The Collaborative Values Inventory is described in greater detail in Section III and Appendix B.)

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Instructor note:

The instructor may elect to use some of the examples below to illustrate the type of items included on the Collaborative Capacity Instrument or, as an alternative, select items from the full CCI provided in Appendix C.

Examples of items from the values and principles area of the inventory are provided below.

- Our county CWS and AOD agencies have begun discussions about their differences in underlying values and principles.
- Our county AOD and CWS agencies have used a formal values assessment process to determine how much consensus or disagreement we have about issues related to AOD use, parenting, and child safety.
- Our county AOD and CWS agencies have negotiated a shared principles or goal statement that reflects a consensus of the two agencies.
- Our county has prioritized parents in the CWS system for AOD treatment services.
- Our county has developed strategies to recruit broad community participation in addressing the needs of AOD-CWS-involved families.
- Our county's dependency court system has realistic expectations for CWS parents with AOD problems (e.g., approach to relapse and zero tolerance issues).
- In our county, CWS staff and the courts view alcohol abuse as much as a major risk factor as they do other drugs for child abuse and/or neglect.
- Our county has discussed and developed responses to the conflicting timeframes associated with CWS, CalWORKs, AOD treatment, and child development.

Although these instruments have been used in work with California counties and with several state agencies in the United States as tools for establishing or enhancing collaboration, studies had not yet been conducted to examine the strength of these

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instruments. Therefore, one of the aims of the study described in this training curriculum was to examine the strength (or internal consistency) of the instruments. To this end, factor analysis and reliability testing were conducted on data from approximately 346 Collaborative Capacity Instruments. In general, the factor analysis suggested that the measures in the Collaborative Capacity Instrument were strong. (Additional detail about this analysis is available in Appendix A.)

Findings from the Collaborative Capacity Instrument: Similarities and Differences Between Counties by History of Collaboration

Another aim of the study described in this curriculum was to answer the following question: How do measures of perceived collaboration differ in counties that are developmentally in different stages of collaboration (e.g., counties with a strong history of collaboration compared to counties earlier in the collaborative process)? To answer this question, data from 346 Collaborative Capacity Instruments were analyzed from respondents in 12 counties in California. Several of these counties had a very strong history of collaboration and other counties were in the early stages of establishing collaborative relationships between the child welfare field, substance abuse treatment, the courts, and other allied fields.

Capacity for collaboration was measured by creating and then comparing scores based on responses to questions in each of the 10 areas of the Collaborative Capacity Instrument (as described above). There are between 7-16 questions grouped under each of these 10 areas, which were used to create a single score for each of the 10 areas. These scores were used for the comparison between counties with a strong

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history of collaboration and counties earlier in the process of developing collaborative practice. Scores were created and compared for two additional questions on the CCI that allowed respondents to rate their county substance abuse treatment and child welfare services on a scale of 1 to 5 (poor to excellent) in six areas: gender specific, culturally relevant, geographically accessible, family focused, age-specific responses to children's needs, and adequacy of adolescent treatment. (See Appendix C for full text of the Collaborative Capacity Instrument.)

Building Systemic Capacity for Collaboration: Findings from the Collaborative Capacity Instrument

Scores from the Collaborative Capacity Instrument were compared between respondents from counties that were more advanced in the collaboration process and counties that were earlier in the process of developing collaboration (Figure 4-1). Scores were slightly higher for those counties with a strong history of collaboration. However, differences were significant in only two areas: screening and assessment (M = 2.3 vs. 2.0), and training (M = 2.0 vs. 1.8). While the mean score in the area of budget and sustainability of funding was higher in collaborating counties, this score approached but did not reach significance.

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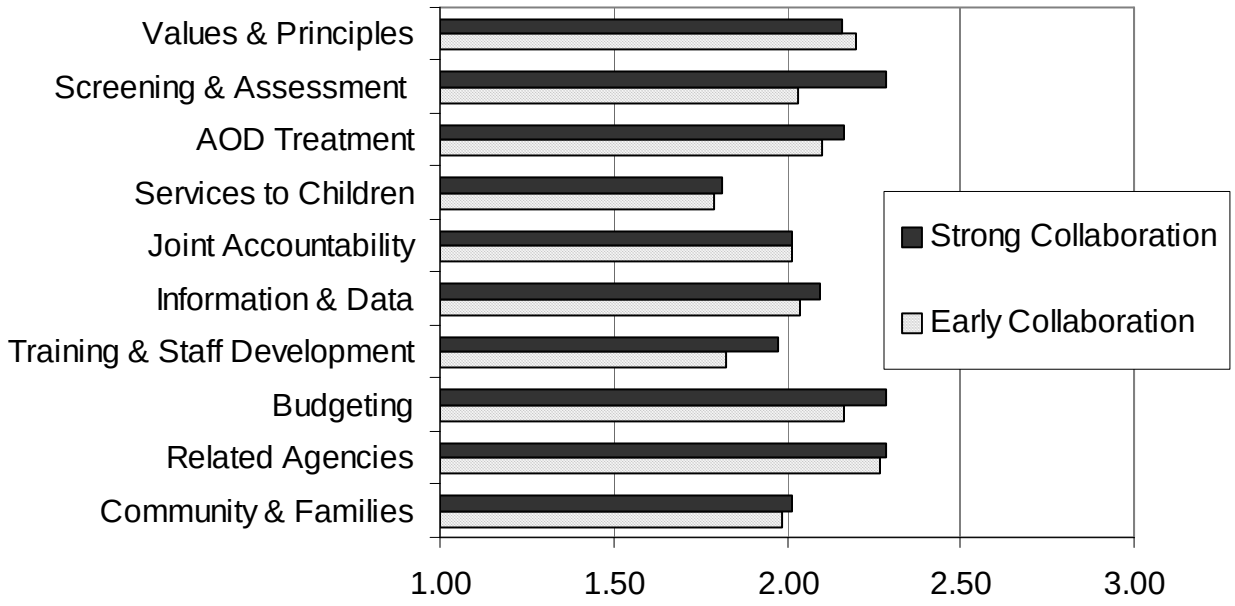
Figure IV-1: Summary of Scores by Collaboration in County from the Collaborative Capacity Instrument: Disagree (1) to Agree (3).



Scores related to perceived collaborative capacity were generally higher in counties with a strong history of collaboration compared to counties in earlier stages of collaboration, but only reached significance in relation to screening and assessment and in the area of training and staff development.

The finding of few differences might be related to the limitation of using a scale that has such a small range (1 to 3 points representing “disagree”, “somewhat agree,” and “agree”). A web version of this instrument (not used for this study) allowed respondents to rate each statement on a 10-point scale from “agree” to “disagree.” A more nuanced scale might have been more effective in relation to detecting differences that were only slight using this more limited scale. The possibility also exists that the

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finding of few differences was related to characteristics of the sample. Counties that elected to participate in this study were motivated to participate in this study, at least in part, because of a strong commitment to the evolution of cross-systems collaboration. This strong level of commitment may have influenced scores of counties early in the process of collaboration.

A more detailed follow-up examination of individual items in all 10 of the primary areas of the Collaborative Capacity Instrument was conducted. (This follow-up was done using the Mann-Whitney *U* test, which is appropriate to use when responses may be grouped in one direction or another rather than normally distributed.) This follow-up analysis found that counties with a stronger history of collaboration were more likely to report institutionalized collaborative practices in a number of different areas.

- Counties with a stronger history of collaboration were more likely to report use of promising practices in multiple areas of *screening and assessment* including:
    - Development of a joint AOD-CWS-Dependency Court policy on standardized screening and assessment of substance-abusing families in CWS,
    - Use of outstationed AOD workers at CWS offices and courts,
    - Multidisciplinary teams for services and case planning
    - Intake processes that allow the child welfare system to identify clients with prior AOD treatment episodes and the AOD system to have adequate information about child welfare cases to conduct assessments.
- In the area of *training and staff development*, counties with a strong history of collaboration were more likely to report having:
    - A multi-year staff development plan that includes updates to training provided to CWS and AOD agencies on working together,

- Training programs that include staff's cultural competency in working with diverse AOD-CWS clients groups,

- Multidisciplinary training, and

- Basic training on substance abuse in addition to attorneys who work in dependency court.

❖ Counties with a strong history of collaboration are also more likely to report collaborative practices in several other areas such as:

- Use of a multi-year budget plan to support integrated CWS-AOD systems.

- Implementation of case plans that include a substance abuse recovery plan integrated or linked with the child welfare plan and adoption of agreements about the level of information about clients' progress in treatment to be communicated to CWS and the courts.

- Development of shared outcomes for CWS-AOD outcomes that are shared with policy leaders and integrated into contracts with community-based providers serving CWS/AOD clients.

- Not relying on drug testing as the most important indicator of clients' compliance with substance abuse treatment and their recovery.

Respondents from counties earlier in the process of collaboration ranked higher on two items related to providing referrals in comparison to respondents from counties with advanced collaboration. The first item is a statement that parents involved in both child welfare and substance abuse systems are referred to parenting programs that have demonstrated positive results with this population (Mann-Whitney *U,* $p<.05$). The second item is a statement that child welfare staff know how to identify and link families with the support services that are frequently needed by clients involved in both systems (such as transportation, child care, employment, housing) and makes effective referrals to those agencies (Mann-Whitney *U,* $p<.05$). There is a possibility that respondents from

counties with a stronger history of collaboration are more informed and realistic about limitations of services in their regions. The possibility also exists that counties with fewer formal collaborative practices and collaborative programs rely heavily on referral to specific services that are perceived to be effective.

Despite some of the limitations of this study, the findings document some of the collaborative practices that appear to be more common among counties with a stronger history of collaboration. Counties in earlier stages of collaboration might benefit from formal opportunities to learn about collaborative processes, programs, and policies from counties that have developed successful models in areas such as training, screening, and assessment.

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Activity IV-1: Overcoming Barriers to Collaboration

Purpose: This activity allows participants to identify problems and potential solutions related to collaboration on a macro systems level through analysis of case studies.

Instructions: Break the participants into four groups. Assign one case to each group. Give participants instructions (Handout IV-2a) and one case study (Handout IV-2b, c, d, or e). Explain to participants that each of the four different case studies focuses on a different issue that might be mediated by addressing differences between systems and the development of collaborative practices, programs, or policies. Participants should imagine that they have been asked to be part of an interdisciplinary team to make recommendations on a systems level. They should a) review the case study, b) respond to the suggested question in order to assess the systemic issues and develop ideas for interventions or changes they would recommend, and c) prepare to report back to the full group. Participants should be invited to refer to the description of the 10-Element Framework of Collaborative Practice to inform their assessment and recommendations (Handout IV-1).

The small groups should summarize their responses to the following questions:

1) Who are the stakeholders in this scenario? Who should be included in problem solving?
2) What are the primary issues in the case study?
3) Based on your experience and training, what is likely to happen to future clients in the absence of change?
4) What are some specific strategies that might be employed to increase interagency collaboration? What specific steps would you take to implement these strategies?
5) What values and attitudes (individual workers or systemic) might present either as driving forces or barriers to change?
6) Are there other systemic issues that should be acknowledged related to client time lines in respective systems? (e.g., judicial proceedings, culturally relevant services etc.)? Could these be addressed? If so, how?
7) If your team were to consider training or cross training in your plan, what are some of the key areas to be covered?

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SECTION IV

BUILDING SYSTEMIC COLLABORATION: FINDINGS FROM THE COLLABORATIVE CAPACITY INSTRUMENT

HANDOUTS

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10-Element Framework for Collaborative Practice

1. *Underlying values and principles of collaborative relationships.* Agencies seeking a partnership often have different perspectives on whether substance abusers can be effective parents; whether the client is the parent, child, or family; and whether the goal is child safety, family preservation, or economic self-sufficiency. Agencies will not reach agreement until these underlying issues are discussed.

2. *Daily practice: Client intake, screening, and assessment.* Partners typically screen clients for different categories of problems. Child welfare agencies investigate child abuse and neglect, while ADS treatment agencies look for substance abuse. For a successful collaboration, CWS agencies must ask clients about alcohol and drugs to refer users for treatment when appropriate, and substance abuse treatment providers must document the status of clients' children.

3. *Daily practice: Client engagement and retention in care*. ASFA demands that clients meet their treatment goals in order to regain custody of their children before family reunification plans are abandoned.

4. *Daily practice: Services to children*. Treating parents alone ignores the effects of substance abuse on the children and places the children at risk for developing addiction, as well as other maladaptive behaviors.

5. *Joint accountability and shared outcomes.* Jointly developed outcomes are the best indicators that both agencies agree on the goals of their partnership and how to measure their progress toward achieving those goals. Without agreement on accountability and outcomes, the partners may continue measuring their progress using their own, different measures of effectiveness.

6. *Information sharing and data systems.* These are the prerequisites for joint accountability; otherwise, the partnership will have no guideposts to determine whether its programs are effective.

7. *Budgeting and program sustainability.* Maximizing the full range of funding resources available to a state or community is the only way to develop financial stability for innovative approaches.

8. *Training and staff development.* In order for child welfare and substance abuse treatment workers to address the complex problems of their shared clients, they need ongoing interdisciplinary training. Conventional training will only deepen the divisions between agency staff.

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9. *Working with the courts.* The courts establish and enforce time limits for family reunification and make judgments about parents' progress in substance abuse treatment. When the two agencies coordinate their decisions about a family, their shared perspectives generate a better ruling.

10. *Working with related agencies and the community.* Many clients need help with parenting, education, and vocational guidance; medical and dental care; mental health care; housing; transportation; childcare; and domestic violence.

The framework described above is reprinted directly from pp. 11-12 of the following document:

Young, N. K., & Gardner, S. L. (2002). *Navigating the pathways: Lessons learned and promising practices in linking alcohol and drug services with child welfare* (SAHMSA Pub. No. SMA-02-3639). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

This document is available at no cost through the National Clearinghouse on Alcohol and Drug Information (NCADI). Contact them at 1-800-729-6686 or www.ncadi.samhsa.gov and request inventory number BKD436.

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Participant Instruction Sheet: Activity for Assessment and Recommendations for Collaborative Practice, Programs, and Policies

This activity allows participants to identify problems and potential solutions related to collaboration on a macro systems level through analysis of case studies.

Participants should imagine that they have been asked to be part of an interdisciplinary team to make recommendations on a systems level. Each small group will a) review the case study, b) respond to the suggested questions in order to assess the systemic issues and develop recommendations, and c) prepare to report back to the full group. Please feel free to refer to the description of the 10-Element Framework of Collaborative Practice to inform your assessment and recommendations.

Please consider the following questions:

1. Who are the stakeholders in this scenario? Who should be included in problem solving?

2. What are the primary issues in the case study?

3. Based on your experience and training, what is likely to happen to future clients in the absence of change?

4. What are some specific strategies that might be employed to increase interagency collaboration? What specific steps would you take to implement these strategies?

5. What values and attitudes (individual workers or systemic) might present either as driving forces or barriers to change?

6. Are there other systemic issues that should be acknowledged related to client timelines in respective systems (e.g., judicial proceedings, culturally relevant services, etc.)? Could these be addressed? If so, how?

7. If your team were to consider training or cross training in your plan, what are some of the key areas to be covered?

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Organizational Case Study # 1

The local Women's Alcohol and Drug Treatment Center is providing services to pregnant and parenting women, many of whom have children in the child welfare system. You have become aware of tensions between staff of the respective organizations and it has come to your attention that many clients are complaining about "going crazy" trying to do what they are being told by their alcohol/drug counselors and their child welfare social workers. In addition, many of the foster parents caring for children of parents in the program are resistant to "having anything to do with those addicts."

Providers in the alcohol and drug treatment program complain about social worker hostility to their clients. They claim that child welfare professionals do not understand recovery and are obstructive in their efforts to plan for reunification in the recovery process. They state that child welfare staff either dislike the mothers or have unrealistic expectations about the time required for a woman to recover and become ready for full care of her child. At the same time, child welfare professionals have expressed concern over the parenting capacity of women in recovery and frustration about the mothers and the staff of the agency "getting serious" about what steps they need to take for reunification or to participate in decisions regarding the welfare of the children. Child welfare staff also considers the programs to be uncooperative; one worker suggested the programs were "paranoid" and excessive in their refusal to even acknowledge that a client was still in the program let alone release substantive useful

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information.

Disposition of cases depends largely on the individual perspective of the particular judges that hear these cases. There have been recent newspaper stories dramatizing problems—both in relation to a death of a child of drug-using parents and in relation to several stories of families that were kept separated in spite of “cleaning up their acts.” You are part of a small group of professionals who are meeting to determine how to address these issues.

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Organizational Case Study # 2

A multidisciplinary team is convening initial meetings to discuss the creation of a Dependency Drug Court (DDC). The DDC would be established to respond to the legal need to comply with the time limits enforced by the Adoption and Safe Families Act (ASFA). The goal of the DDC will be to achieve reunification or permanency plans in a timely manner when drugs and alcohol are the predominant problem or the trigger of the problem. Different stakeholders in the community will have to be brought together in order to create “buy in” for this initiative and to compete for a grant that will fund this project. The request for proposals will be released in three months. A local judge initiated the process of calling together the multidisciplinary team. Two preliminary meetings have surfaced a number of issues.

The local alcohol and drug (AOD) treatment programs have a history of long waiting lists. It is common that parent(s) of children in the child welfare system have not received treatment by the 6-month review. The judge who has been instrumental in establishing this multidisciplinary team believes that parent(s) benefit from immediate consequences for noncompliance with court orders. Compliance with the DDC would require active participation in treatment, weekly court appearances during initial treatment phases, and compliance with court orders. This includes a requirement for parent(s) to completely abstain from all drugs and alcohol. The consequences for noncompliance can include jail time, a monetary fine, or both.

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The first goal of the multidisciplinary team, that will include child welfare (CWS) agencies, alcohol and other drug (AOD) treatment agencies, and the court, will be to discuss the values and principles of the proposed DDC. Everyone agrees that it is essential to spend time discussing the values and principles for the DDC due to the differing perspectives of each agency. The invited participants will include program managers, supervisors, and line staff from both the CWS agencies and the AOD agencies. The court representatives include judges and attorneys.

Several questions were raised during preliminary interviews with key stakeholders in preparation for the first meetings. Some participants from CWS were concerned that too much emphasis was being placed on becoming clean and sober as opposed to whether the parent(s) can parent their children appropriately. Other CWS participants were concerned about whether they could count on AOD programs to give them accurate information about the clients' progress in treatment. The participants from the AOD agencies had concerns regarding the punitive actions imposed on the parent(s) for noncompliance. They feel strongly that relapse is part of recovery, and that punitive measures would be imposed on the parent(s) too quickly. The AOD agencies also believe that there is too much emphasis put on drug tests as the most important indicator of parental compliance and treatment progress. The court representatives were concerned about ensuring that reasonable efforts to reunify are met and, if not, for expedient permanency placement for children. The parents' attorneys were concerned that parent's legal rights were not being sufficiently protected while the children's

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attorneys were concerned that the needs of children might not be adequately attended to under the proposed program.

You are a member of the planning team that will be charged with developing both short-term and long-term recommendations for moving forward with development of the Dependency Drug Court.

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Organizational Case Study # 3

An advocacy group in your county is calling for creation of a community coalition to develop policies and guidelines in reaction to concerns about county practices related to responding to drug-exposed infants. The advocates calling for the meeting include a small group of leaders in public health and local representatives of a statewide group concerned with women's alcohol and other drug treatment issues. Advocates state that child welfare agencies routinely remove drug-exposed infants from their mothers at the local public hospital. Specifically, advocates state that these mothers who have given birth to substance-exposed infants are being profiled as neglectful parents without a thorough assessment to determine the risk of child maltreatment or the risk of continued parental substance abuse. The advocates suggest that despite the law that specifies that drug exposure should not be considered evidence of child abuse, it appears that in practice, some child welfare workers are treating drug exposure of an infant as child abuse when they make the decision to remove. In addition, advocates point out that the mothers referred to child welfare from the public hospital are disproportionately poor women of color. Although state studies suggest that mothers in private hospitals are also giving birth to drug-exposed infants, few referrals are ever made from local private hospitals.

The publicly funded hospital that is the focal point for these concerns has a written protocol to notify child protective services when a pregnant mother or newborn child tests positive for drugs. The hospital representatives point out that they do not

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have the resources to hire public health nurses to conduct assessments of mothers who deliver drug-exposed infants and, consequently, they must rely on child welfare to conduct assessments.

The child welfare agencies have stated that they do not have a policy of removing children from mothers solely on the grounds of drug exposure. However, the child welfare agency has a long-standing practice of developing scan lists of pregnant mothers who have a history with child welfare agencies or who have been identified as high risk for delivering a drug-exposed infant. The directors of child welfare agencies in question believe that their line workers are responding appropriately to births that are on the scan list and performing appropriate assessments. Other stakeholders, and even some child welfare workers, are concerned that decision making is inconsistent, possibly biased, and that opportunities for intervention with families at risk are frequently missed.

Alcohol and other drug (AOD) treatment providers expressed concerns that parents are classified as having addiction problems without adequate assessment performed by an AOD specialist. Some representatives from AOD agencies believe that often child welfare agencies are not doing a thorough assessment, but relying on the drug exposure or past child welfare history as cause for detentions. There is a local women's treatment program that is funded to work with pregnant and parenting women, yet there has been a consistent lack of cross-agency communication between the hospital, the treatment program, and child welfare agencies.

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These concerns were recently aired at a County Board of Supervisors meeting and some board members have asked the County Department of Social Services and Alcohol and Drug Program Administration to convene a workgroup to explore these concerns and develop recommendations for improving collaborative responses for evaluating child maltreatment risks among drug-exposed infants.

You are a member of the workgroup that will be charged with developing both short-term and long-term recommendations for addressing these concerns.

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Complete List of Statements Ranked Higher by Counties with a Strong History of Collaboration (Collaborative Capacity Instrument) Compared to Counties in Earlier Collaboration (N = 346), Mann-Whitney *U* test

Daily Practice: Screening and Assessment	***p***
Our county has developed a joint AOD-CWS-Dependency Court policy on its approach to standardized screening and assessment of substance abuse issues among families in child welfare.	<.01
Our county has successfully out-stationed AOD workers at CPS offices and/or the dependency court to help with screening and assessment of clients.	<.001
Our county has multi-disciplinary service teams that include both AOD and CWS workers.	<.001
Our county has developed coordinated AOD treatment and CPS case plans.	<.001
Our county's child welfare intake process is able to identify prior AOD treatment episodes based on previously negotiated information sharing protocols.	<.05
Our county's AOD providers have sufficient information about the child welfare case to conduct quality assessments among families referred by child welfare to treatment.	<.01
Our county routinely monitors the implementation and the quality of its screening and assessment protocols.	<.001
Daily Practice: Client Engagement and Retention in Care	
Our county has trained attorneys who practice in the dependency court regarding effective advocacy and basic education regarding substance abuse and addiction.	<.05
Our county has a multi-year staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies on working together.	<.05
Our county has training programs that include cultural issues to improve staff's cultural relevance and competency in working with diverse AOD-CWS client groups.	<.05
Training programs regarding substance abuse, child welfare, and dependency court issues that are offered in our county are multidisciplinary in their approach and in their delivery.	<.01
Training and Staff Development	
Our systems have implemented integrated case plans that include the substance abuse recovery plan integrated or linked with the child welfare case plan.	<.05
Our county has developed and trained our staff in approaches with clients that improve rates of retention in treatment once they enter it.	<.05
In our county, CWS and AOD agencies have agreed on the level of information about clients' progress in treatment that will be communicated from treatment agencies to CWS workers and the courts.	<.01
Joint Accountability and Shared Outcomes	
Our county's AOD and CWS agencies and the courts have developed shared outcomes for CWS-AOD involved families and have agreed on how to use this information to inform policy leaders.	<.01
Our county has developed outcome criteria in their contracts with community-based providers (who serve CWS-AOD clients) to measure their effectiveness in achieving shared outcomes.	<.05
In our county, drug testing is not used in the court system as the most important indicator of clients' compliance with substance abuse treatment and their recovery.	<.05
Budgeting and Program Sustainability	
Our county has a multi-year budget plan to support integrated CWS-AOD services.	<.05
Working with Related Agencies	
Our county has AOD support/recovery groups that include a special focus on CWS and child safety issues.	<.01
Working with Community and Supporting Families	
Our county assists in supporting sober living communities and housing for parents in recovery.	<.05

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MODULE V

BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND NEXT-STEPS

Drabble, L., Tweed, M., & Osterling, K. L. (with Navarrette, L., Pearce, C., Ribeiro, P., & Twomey, E.). (2006). *Pathways to collaboration: The role of values and system-related factors in advancing collaborative practice between child welfare and substance abuse treatment fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

MODULE V
BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND NEXT-STEPS

Instructional Guide

Learning Objectives

This section provides an opportunity for participants to reflect on implications for practice based on the literature review and research findings and to identify resources for continued learning related to the intersections between substance abuse and child welfare fields.

By the end of this section, participants will be able to:

- Discuss implications of the literature and the current research study on social work practice.
- Identify key resources for obtaining additional information about practice issues related to the intersection of substance abuse and child welfare.
- Articulate "next-steps" for applying information from the training to their practice or work settings.

This section may be used as review and closure after use of any combination of Sections I through IV of this curriculum.

Public Child Welfare Competencies

The following competencies are addressed in this chapter:

Section I: Ethnic Sensitive and Multicultural Practice

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

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Section IV: Workload Management

4.3 Student understands client and system problems and strengths from the perspectives of all participants in a multidisciplinary team and effectively maximizes the positive contributions of each member.

4.7 Student understands and is able to utilize collaborative skills and techniques in organizational settings to enhance service quality.

Section VIII: Child Welfare Policy, Planning and Administration

8.3 Student understands how leaders/managers use the collaborative process for the purpose of formulating policy and implementing services.

8.8 Student understands how professional values, ethics, and standards influence decision-making processes in public child welfare services.

Agenda and Suggestions for Instructors

Time allocation: Approximately 30 minutes

Agenda:

- ❖ Review of implications for practice
    - Brief review
    - Additional brainstorming and discussion from participants
- ❖ Review of resources
- ❖ Activity V-1: Participant identification of next-steps.

Materials Needed

- ❑ Overhead projector
- ❑ PowerPoint slides
- ❑ Handout V-1 (Resources)
- ❑ Optional: Handout V-2 (Discussion questions)
- ❑ Markers and flip chart or white board (optional – for writing key points in response to questions for class discussion)

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BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND NEXT-STEPS

Review of Implications for Practice

Some of the highlights and implications for practice associated with the literature reviews (Sections I and II) and the research study (Sections III and IV) include the following:

Highlights from the literature review and research study:

- There exits a strong relationship between substance abuse and child abuse and neglect, including a correlation with out-of-home placements.
- There is an urgency to overcome systemic differences and build collaborative capacity due in part to the passage of the Adoption and Safe Families Act of 1997 (which requires permanency planning within 12 months).
- Personal and professional values often underlie practice decisions.
- Professionals in child welfare and substance abuse treatment fields may hold differing beliefs and values in a number of areas, including beliefs related to substance-abusing parents.
- Counties with a strong history of collaboration report engaging in specific collaborative practices in screening and assessment, training and staff development, and other areas.

Implications for practice include the following:

- The strong correlation between substance abuse and child welfare coupled with recent policy changes make urgent the need to improve practices, program design, and policies for addressing these intersecting issues.
- Social workers need to use skills in critical thinking and evaluation of personal and professional values in order to minimize potential bias.
- It is equally important that social workers specializing in child welfare, substance abuse, and related fields develop skills in identifying systemic value differences and other barriers to collaboration.

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- ❖ Social workers can employ specific tools (such as the Collaborative Values Inventory and the Collaborative Capacity Instrument) to clarify and build shared values processes and to assess systems-level progress toward collaborative practice.

Brainstorming: Invite class/training participants to brainstorm or discuss additional implications for practice.

Resources/Websites

There are several valuable resources for obtaining information to strengthen practice, program development, and policy development related to working with substance-abusing families in the child welfare system. Resources include web-based information and documents that are available to helping professionals free of charge. Some examples of useful resources include the following:

- ❖ Children and Family Futures/National Center on Substance Abuse and Child Welfare (www.cffutures.org), and
- ❖ National Clearinghouse on Alcohol and Drug Information [including Young, N. K., & Gardner, S. (2002). *Navigating the pathways: Lessons and promising practices in linking alcohol and other drug treatment with child welfare services.*].

Training Tip: In addition to distributing handout V-1, the instructor may elect to share additional local, state, or national resources that may be of interest to the specific class/training audience.

Activity V-1: Identification of Next-Steps in Practice or Work Setting

Purpose: To afford participants an opportunity to translate information and ideas obtained from the curriculum into specific action steps that they may take in their own practice and/or in their work settings.

Instructions: Review the purpose of this activity. Invite participants to take a few minutes to reflect on the questions outlined in Handout V-2 and to make notes about their responses. Let participants know that they will not be asked to show their written responses to anyone.

Have participants form groups of three. Ask participants to verbally share some of the next-steps they could take in relation to their own practice or in relation to their own county or agency systems (related to working with children and families in the child welfare system that are impacted by substance abuse).

Close the training with group discussion about next-steps for program participants. Identify any themes that seem to be prevalent. Optional: Ask if participants would like their written reflection on next-steps mailed to them in 2-3 weeks time. This could serve as a reminder of knowledge acquisition and commitments to improved services for children and families. If so, obtain mailing addresses of participants and thank them for their contributions during the class/training.

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SECTION V

BUILDING BRIDGES BETWEEN SYSTEMS: RESOURCES AND NEXT-STEPS

HANDOUTS

Drabble, L., Tweed, M., & Osterling, K. L. (with Navarrette, L., Pearce, C., Ribeiro, P., & Twomey, E.). (2006). *Pathways to collaboration: The role of values and system-related factors in advancing collaborative practice between child welfare and substance abuse treatment fields.* Berkeley: University of California at Berkeley, California Social Work Education Center.

References & Resources: Training Child Welfare Staff and Substance Abuse Treatment Providers

Compiled by Laurie Drabble, PhD, MSW, MPH

Reference Materials

Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Other Drug Treatment with Child Welfare Services (2002) by Nancy K. Young and Sid Gardner offers case studies and tools for successful collaboration between systems. This document is published by the Substance Abuse and Mental Health Services Administration (SAMHSA; Publication No. SMA-02-3639) and can be accessed electronically through www.samhsa.gov. Free copies are also available from the National Clearinghouse on Alcohol and Drug Information at www.ncadi.samhsa.gov (inventory number BKD436) or 1-800-729-6686.

The Child Welfare-Substance Abuse Connection: A Compendium of Training provides abstracts of training curricula developed between 1993 and 2003 for child welfare and substance abuse workers about addiction, child welfare, interagency collaboration, assessment, service provision, and treatment. Other topics include working with children and adolescents, legal processes, and the implications of substance abuse for foster care and adoption. Each profile identifies the intended audience of the curricula, the year of production, cost information, trainer availability, and technical assistance. The Compendium is an outstanding resource for identifying training curricula that can be used or adapted in local communities. To order, go to http://nccanch.acf.hhs.gov and search under *Clearinghouse Publications*.

Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues (2000) examines treatment issues for both adult survivors of child abuse or neglect and adults in treatment who may be abusing or neglecting their children. Content includes chapters on how alcohol and drug counselors can identify whether clients are at risk or are currently abusing or neglecting their children, what can be done to break the cycle of abuse and neglect, and how to work with child protective service agencies. Other TIPs of interest: *Enhancing Motivation for Change in Substance Abuse Treatment; Improving Treatment for Drug Exposed Infants; Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases; Pregnant, Substance Abusing Women; Brief Interventions and Brief Therapies for Substance Abuse; and Substance Abuse Treatment for Stimulant Use Disorders.* The Technical Assistance Publication (TAP) series (e.g. *Relapse Prevention and the Substance Abusing Criminal Offender)* is also a valuable resource. Available free from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.

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The Anne E. Casey Foundation offers a series of ***Family to Family Tools*** that are outstanding resources, particularly for the child welfare field. Three of the publications specifically address the challenge of drug abuse in child welfare. To order any of the publications in this series, go to http://www.aecf.org/initiatives/familytofamily/tools.htm

Organizational Resources

The California Social Work Education Center (CalSWEC) is a partnership between the schools of social work, public child welfare agencies, and other related professional organizations that facilitates the integration of education and practice to assure effective, culturally competent service delivery to the people of California. Among many activities, CalSWEC offers a wide range of curriculum resources (including content related to working with families impacted by substance abuse and cross-systems collaboration). Contact: CalSWEC (510) 643-9272, http://calswec.berkeley.edu/

Children and Family Futures (CFF) is a nonprofit organization which brings together several vital areas affecting the future of children and families including: policy research on conditions of children, development of accountability measures at both community and program levels, and effective responses to reducing the impact of alcohol and other drugs on children and families. CFF also runs the National Center on Substance Abuse and Child Welfare. Contact: (714) 505-3525, http://www.cffutures.com

Legal Action Center is the only law and policy organization in the United States that fights discrimination against people with histories of addiction, AIDS, and criminal records, and advocates for sound public policies in these areas. Publications include *Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work*, publications related to federal requirements for maintaining confidentiality of alcohol and drug patient records, and other practical resources related to policy and practice across systems. Contact: (202) 544-5478, 236 Massachusetts Avenue NE, Suite 505, Washington, DC 20002, http://www.lac.org

National Clearinghouse on Alcohol and Drug Information (NCADI) is a “one-stop resource” for Federal alcohol, tobacco, and drug information. Free publications available through NCADI include a wide range of practical written publications and videos about the prevention, identification, and treatment of alcohol and other drug problems among diverse populations. For a catalog, call 1-800-729-6686, or go to: http://www.health.org

The National Clearinghouse on Child Abuse and Neglect Information connects professionals and concerned citizens to timely, well-balanced information on programs, research, legislation, and statistics regarding the safety, permanency, and well being of children and families. The Clearinghouse distributes both print and electronic documents created by the Administration for Children and Families, their grantees and the Clearinghouse. Contact: 1-800-FYI-3366 or visit http://nccanch.acf.hhs.gov/

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Questions for Identification of Next-Steps in Practice or Work Setting

- As you reflect on highlights from the curriculum, what areas stand out to you and why?

- What specific information or ideas might be relevant to *your own* social work practice? What next-steps would be useful to you as a practitioner? (These might include action steps with clients, colleagues, obtaining additional training, or written resources, etc.)

- What "promising practices" in cross-systems collaboration might be adopted or adapted in your county system? What are the next-steps you would recommend to your county administrators and staff?

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