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The Role of Interagency Collaboration for Substance-Abusing Families Involved with Child Welfare

Beth L. Green, Anna Rockhill, and Scott Burrus

Meeting the needs of families involved with the child welfare system because of a substance abuse issue remains a challenge for child welfare practitioners. In order to improve services to these families, there has been an increasing focus on improving collaboration between child welfare, treatment providers, and the court systems. This paper presents the results from qualitative interviews with 104 representatives of these three systems that explore how the collaborative process works to benefit families, as well as the barriers and supports for building successful collaborations. Results indicate that collaboration has at least three major functions: building shared value systems, improving communication, and providing a "team" of support. Each of these leads to different kinds of benefits for families as well as providers and has different implications for building successful collaborative interventions. Despite these putative benefits, providers within each system, however, continue to struggle to build effective collaborations, and they face such issues as deeply ingrained mistrust and continued lack of understanding of other systems' values, goals, and perspectives. Challenges that remain for successful collaborations are discussed.

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There is little question that substance abuse is a major issue confronting families involved with child welfare services. Studies indicate that problems with alcohol and drug use are present in between 40% and 80% of the families known to child welfare agencies (Tracy, 1994; see also National Center on Addiction and Substance Abuse, 1999; Department of Health and Human Services [DHHS], 1999). According to a 1988 study by the National Committee for the Prevention of Child Abuse, substance abuse was the dominant characteristic in the child abuse caseloads of 22 states and Washington, DC (Besharov, 1989). Further, alcohol and drug abuse is associated with more severe child abuse and neglect and is indicated in a large percentage of neglect-related child fatalities (Tracy, 1994).

With the passage of the federal Adoption and Safe Families Act (ASFA; 1997), the complex issues involved in dealing with substance-abusing parents involved with the child welfare system have become the focus of increased attention. Under ASFA, substance-abusing parents have as little as one year in which to comply with reunification requirements, including attaining and demonstrating recovery from their addiction, or they face permanent termination of their parental rights. Given the historically low rates of reunification and extended duration of foster care placements for families with substance abuse issues, these families are likely to comprise the bulk of families affected by this legislation (Lewis, Giovannoni, & Leake, 1997; Walker, Zangrillo, & Smith, 1991).

In April 1999, the DHHS, in accordance with ASFA requirements, published a report to Congress that highlighted the difficult and complex issues facing child welfare and treatment systems agencies that work with these families. In this report, the tensions

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between these two service systems were highlighted:

> While both the substance abuse treatment and the child welfare fields have the vision of healthy, functional families resulting from their interventions, in moving from the family's immediate situation to that end result, different perspectives and philosophies sometimes impede cooperation, engender mistrust, and can cause agencies to hamper one another's efforts and stymie progress. . . . It becomes obvious to observers of interactions between service providers in the child welfare and substance abuse treatment fields that in most instances, agencies do not work well together and that truly collaborative relationships are rare (DHHS, 1999).

In the past, a lack of coordination and collaboration has hindered the ability of these systems to support these families (Arthur Liman Policy Institute, 2003; DHHS, 1999; Young, Gardner, & Dennis, 1998). The systems operate under different—even conflicting—mandates, priorities, timelines, and definitions of the primary client. Further, each system has different goals and definitions of success (Feig, 1998). Another significant barrier to coordinated services is confidentiality and concerns about information sharing more generally. Treatment providers are often asked to provide information regarding parents' treatment progress, but they know that negative reports may be used to justify termination of parental rights. From a treatment perspective, the hope of being reunited with their children is an important motivational factor for many parents, and removing this hope may significantly impact parents' recovery (Tracy, 1994).

One of the primary emphases in discussions of how to best meet the needs of substance-abusing families under ASFA has been on increasing the degree of collaboration between the child welfare

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system (including the juvenile and family courts that oversee child welfare cases) and the substance abuse treatment system. Coordinated efforts on the parts of child welfare caseworkers, treatment providers, and judiciary workers are thought to be the key to timely access to appropriate treatment services, client participation in treatment services, and quality follow-up support (DHHS, 1999; Semidei, Radel, & Nolan, 2001). Further, interagency collaboration can help agencies communicate more effectively, so that families are not overwhelmed with requirements and demands (Young et al., 1998).

This emphasis on collaboration is reflected in the growing number of systems changes and service demonstration programs aimed specifically at enhancing collaboration between these systems (Young et al., 1998). Further, reports by DHHS (1999), the National Center on Addiction and Substance Abuse (1999), the National Association of Public Child Welfare Administrators (NAPCWA, 2002), and the Arthur Liman Policy Institute (2003), all highlighted the importance of strengthening the extent and quality of collaboration between substance-abuse treatment and child welfare agencies as one of their key recommendations for improved service to these families. Models of collaborative intervention vary widely in emphasis, and they include such innovations as colocation of alcohol and drug specialists in child welfare offices, court-located alcohol and other drug (AOD) screening and assessment, family drug courts, joint case management and wraparound services, cross-agency training, and others.

Although one of the primary goals of such programs is to

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"increase collaboration," however, the specific mechanisms through which such collaboration will be developed and maintained and the expected role and function of the collaborations are often not clearly specified. There is a growing literature on service integration and collaborative service delivery that suggests that in order to be most effective, collaborative programs should be clear about *how* collaboration is going to be accomplished, and *what outcomes* collaboration is expected to have (Ingram, Bloomberg, & Seppanen, 1996; Kusserow, 1991). To develop the most effective models of collaboration between child welfare and treatment, it is thus important to have a more in-depth understanding of the collaborative process. The current study will attempt to deepen our understanding of collaboration and the implications for developing effective systems by answering the following research questions:

1. What are the mechanisms and functions of cross-system collaboration? That is, *what* does collaboration *do* and what are its *benefits* to families, especially given ASFA timelines?
2. What are the barriers to effective collaboration?
3. What are the practices and policies that support and maintain effective collaboration?

Methodology

Sample and Study Context

The study sample was comprised of 106 key informants from the child welfare, substance-abuse treatment, and family court systems in a medium-sized, northwest city. Data were collected in early 2001, approximately two years after local implementation of ASFA. At the time of data collection, two special programs were being implemented that were designed to improve the linkages between child welfare, treatment, and the courts. The first, known as the Family Involvement Team (FIT), was designed primarily to facilitate access to treatment for substance-abusing parents. This model

included colocation of substance abuse assessment staff at the family court, as well as case managers hired by partnering treatment agencies who were charged with supporting child welfare-involved clients. The second model, the Family Support Teams (FSTs), involved providing families with a team of providers to work with, including a child welfare case manager with specialized training in alcohol and drug issues, public health nurses, treatment providers, and others. These providers met as a team to do case planning and worked jointly with the parents. Finally, Oregon's state child welfare system requires that each family have a "family decision meeting" (FDM), which is a case planning meeting that, ideally, involves all providers working with a family (e.g., treatment providers, attorneys, etc.) as well as extended family members. In practice, these meetings vary considerably in terms of who is represented. In the context of this study, these three service innovations were repeatedly referred to by respondents as examples of the ways in which collaboration was (or was not) working. However, it should be noted that while interview questions included probes related to these services, they did not focus exclusively on these models, but rather on overall cross-system issues.

Purposive sampling was used to ensure an adequate representation of different kinds of providers within each system, including substance abuse counselors, child welfare caseworkers, supervisors, local and state agency administrators and managers, judges, lawyers, and other key judicial staff. Treatment providers were selected from a list of agencies provided by the local child welfare agency, as we were interested in focusing on treatment providers who were involved in serving child welfare clients. Respondents were contacted by telephone and asked to participate in a one-hour, face-to-face interview. We successfully contacted 104 individuals (98%) who agreed to participate in the study and were interviewed.

The final sample was comprised of 46 Child Welfare System (CWS) representatives (44%), 44 treatment system representatives

(42%), and 14 people from the family court system (14%). Of the CWS and treatment participants, 64% were direct service staff (e.g., counselors, caseworkers, n = 56); 36 were in administrative/managerial roles, including state and county level administrators and supervisors, treatment program directors, etc. (n = 32). Of all participants, 42% had been in their same job or position for more than 5 years, and 70% had worked in their system for over 10 years. Reflecting local demographics, 78% of respondents were white, 10% were African American, 6% were American Indian, and 4% were Hispanic. More than three-fourths (77%) of the respondents were female.

Interview Instrument

The interview was a semistructured, open-ended interview that included a number of questions related to the intersection of child welfare, treatment, and the judicial system. Interview questions were developed in consultation with an interdisciplinary research advisory group consisting of representatives from each of the three key systems. The interview was a part of a larger study of the effects of ASFA on substance-abusing families and, therefore, included questions that did not directly ask about collaboration. For each question, respondents were probed about their knowledge of, or experience with, the three collaborative interventions described previously (FIT, FST, and FDM services). Providers were asked to respond to each question about each system (CWS, treatment, judicial) in turn. For the current analysis, relevant questions were as follows:

1. Thinking about families in which the parent(s) have substance abuse issues and the child is removed from the home, in what ways does the [child welfare agency/substance abuse treatment system/judicial system] help the family make progress, given the ASFA timelines?
2. Thinking about families in which the parent(s) have substance abuse issues and the child is removed from the home,

in what ways does the [child welfare agency/substance abuse treatment system/judicial system] hinder the family from making progress, given the ASFA timelines?

3. Now that ASFA timelines are in place, what, if anything, are you personally doing differently that helps families make timely progress?
4. Given ASFA timelines, to what extent do you think that CWS, treatment providers, and the legal system are doing a good job to coordinate their efforts to support CWS families with substance abuse issues? (a) In what ways is coordination working? (b) What are the biggest barriers to coordination?

Responses were entered into a qualitative software package (NUD*IST) for storage and analysis.

Results

Coding

To develop an initial coding scheme, the Principal Investigator read a sample of 15 interviews. Answers to each question were content-coded to provide an exhaustive listing of relevant participant responses. Four other members of the research team were then trained on the coding scheme, and the same three interviews were coded independently. The team met to discuss agreement in coding and to clarify categories when needed. The team then coded an additional set of three interviews, and an average of 85% interrater agreement on coding was achieved. Weekly meetings were held to review coding and refine the coding scheme. Codes that were related to the topic of collaboration included

- communication (positive/negative),
- system collaboration (positive/negative),
- relationships with parents (positive/negative),
- training,
- case management/case work (positive/negative),
- parent involvement in planning,

- provider (caseworker, treatment provider, attorney),
- quality (positive/negative),
- confidentiality issues,
- agency relationships (positive/negative), and
- workload issues.

Responses for these categories were used for subsequent analyses.

Analysis

The principal investigator reviewed all coded responses relevant to the topic of collaboration (listed previously). Analyses focused on the primary research questions: *How* does collaboration help families? What *supports* collaboration? What are *barriers* to collaboration? Responses were then organized into specific categories based on themes and issues that emerged from the interviews. Quotes were used to support the development of a specific topic. These topics, and the data elements that defined them, were then reviewed by two other members of the research team, who examined the extent of fit between the quotes and the proposed theme or category and, in some cases, suggested changes. These analyses led us to develop the conceptual model presented in Figure 1, which we use to organize the findings presented now.

Research Question 1: How does collaboration help families make timely progress?

The first part of our analysis focused on trying to understand the primary mechanisms through which collaboration has its effects. That is, to answer the question, "What does collaboration *do* that helps families?" As shown in Figure 1, analyses suggested that collaboration works through three primary mechanisms: (1) through increasing communication and information sharing among and

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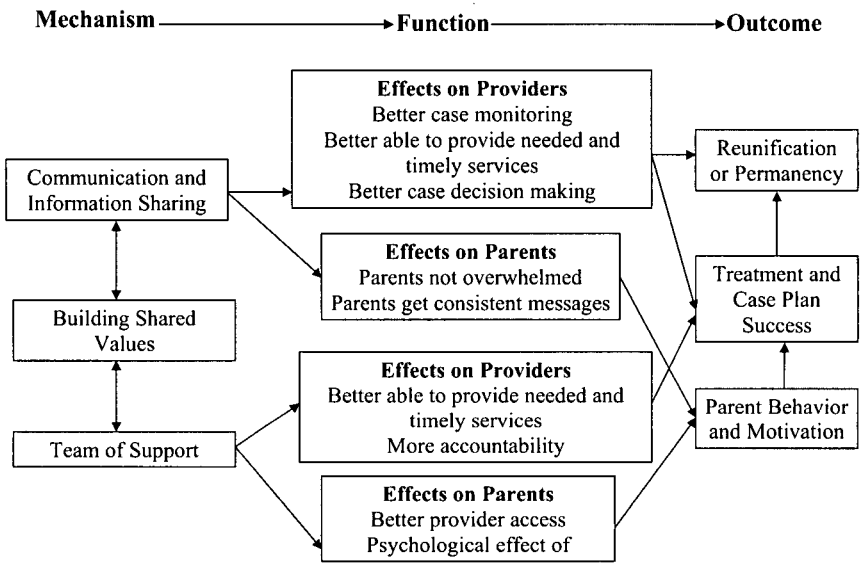
1 A fourth mechanism, creating an immediate response to family needs, was also identified as important and was a key part of one of the service innovations (the colocation model, or FITs). However, this mechanism appeared to be related more to the location of services within the family court setting and the ability to send parents to meet with FIT members immediately at the time of the detention hearing rather than to the collaborative process per se.

FIGURE 1

Understanding the Collaborative Process



between agencies and parents, (2) by creating a "team" of supportive individuals, and (3) by helping to support the development of a shared value system and cross-agency understanding.[1] None of these are particularly surprising, as communication and teamwork are key elements of good collaborative work, and the importance of building better cross-agency understanding has been acknowledged as a key issue for child welfare and treatment (e.g., DHHS, 1999; Young & Gardner, 2002).

The next step of the analysis was to understand more deeply the function of the mechanism, asking the question, "Why is the mechanism important?" By doing this we were able to identify the specific function of each of the three main collaborative processes (communication, team approaches, and development of shared values). This process suggested that these collaborative processes could be broadly construed as primarily effecting either providers

and provider functioning or parents and parental behavior. Each of the three primary mechanisms, and their corresponding functions, are described in more detail now.

Collaboration Acts by Improving Communication and Information Sharing

Not surprisingly, communication and information sharing emerged as key themes in terms of understanding how collaboration works. Improving communication between child welfare workers, treatment providers, and judicial representatives, as well as communication with parents, was seen as a key component of collaboration and as one of the most important factors in helping to improve case outcomes.

Functions of communication and information sharing. Responses related to the importance of collaboration went well beyond the more obvious issues of confidentiality and interagency agreements, and respondents described a number of reasons why collaboration that involves facilitating good communication is critical to helping parents. Responses suggested that good interagency communication was as important because it helped *providers* to

- improve the quality of case monitoring and relapse support,
- improve their ability to provide needed and timely resources to parents, and
- support better decision making about the case.

Interagency communication was also described as helping parents more directly by

- ensuring that agency demands on parents are not competing or overwhelming, and
- ensuring that parents hear consistent messages from all involved professionals.

Data supporting these functions is described now.

Reason 1: Good interagency communication improves the quality of case monitoring and relapse support.

Respondents described the role of good communication in helping

to keep the cases "on track" and providing better relapse support. In particular, collaborative models that included such things as frequent team meetings, collaborative case planning, and intensive, ongoing support to families were seen as important in helping with case monitoring. Although this ongoing support is likely to be helpful in other ways, timely communication about what is happening with families was seen as especially important in terms of providing adequate relapse support.

> When there's close coordination there is better tracking of the case. In cases I'm reviewing there was close monitoring by [CWS] and integration with legal and treatment. In some cases that coordination brought the drug use more to the surface, made it easier to identify. So levels of treatment were increased as a consequence of knowing about relapse. (Treatment)

Reason 2: Better communication helps providers to better meet families' service needs.

Many respondents commented on the multiple service needs that these families have beyond substance-abuse treatment. Communication was seen as critical to ensuring that these service needs were identified and met in the most efficient way.

> Since the ASFA law, it's absolutely imperative that we communicate with everyone in the system to be able to provide the clients with what they need. The old "us vs. them" attitude is extremely detrimental. They [CWS] definitely have resources that we don't have and that the client can't access on their own. So, in order to access those resources and bridge that gap, we have to be better at communicating. (Treatment)

Reason 3: Good communication improves the quality of decision making about the case.

These responses spoke largely to the barriers to communication resulting from the historical "rift" between treatment and child welfare services. Treatment providers have been seen as the parents'

advocate, even to the extent that child welfare workers and judges have come to doubt their testimony about parents' progress. Treatment providers have also felt their therapeutic relationship with the parent might be jeopardized by openly communicating with child welfare, which has led some of them to be less than forthcoming with information. Not surprisingly, some respondents also felt that child welfare does not always share important information with treatment providers. As evidenced by the statements following, however, providers are beginning to understand how honest and open communication can facilitate good decision making, sometimes even in cases where parents have not made significant progress toward recovery.

> Sharing of confidential information or sharing of treatment updates doesn't always happen as it should. We need to have information regarding relapse so we can make the best decision for the child based on good, accurate information, but a lot of times they don't want to share that with us for fear we will use it against the parent. (Child Welfare)

> Treatment providers are starting to be more willing to talk to caseworkers about what is happening with their clients. They are starting to realize that with that information we [CWS] can help the clients better. We will focus on the plan of returning the child if we know more about what is going on and feel confident that we have accurate information. (Child Welfare)

Reason 4: Communication helps ensure that agency demands on parents are not conflicting or overwhelming.

Because of the multiple service needs of families, it is easy for them to be overwhelmed, and to "not know where to start." Agencies may differ in terms of what they see as the family's priorities, or how these needs should be met. Communication can help to ensure that providers do not overwhelm parents with too much to do. This communication is supported by having an understanding of the other agencies' perspectives and philosophies, as noted now.

> Women get overwhelmed when they don't understand the system. (They) don't have good information, and don't have the support to help them make good choices, especially when there is a disconnect between systems. They might have different things that the PO wants them to do, things that the [CWS] worker wants them to do and then things that the treatment system wants them to do. So people can really get lost . . . it becomes overwhelming. (Treatment)
>
> When three different philosophies are brought together, each system can think of themselves as number one, and forget the other perspectives. They aren't aware of the pressing concerns of the other agencies, and then the client gets confused about who it is they need to be following. (Treatment)

Reason 5: Good interagency communication ensures that parents receive consistent messages and expectations about what they need to do to be reunified with their children.

In other words, good agency communication can help improve the quality of communication with parents. This is related to Reason 4, but responses were less focused on the overload issue, and more concerned that communication with parents was clear and consistent across agencies so that both parents and agencies would know what they needed to do to support the case.

> There needs to be more communication about the meaning of things. Everyone is speaking different languages and they can't make sense of it when services are being delivered. When [Treatment] has an antagonistic relationship with the [CWS] agency, the parent gets caught in the middle because no one trusts each other and the parent doesn't know what to do because they are getting mixed messages from both sides. (Judicial)

Collaboration Acts by Providing a "Team" of Support for Families

The second major collaborative mechanism that we identified was related to the concept of building "collaborative teams." Although

clearly related to the issue of communication, they are not synonymous. For example, it would be possible to have good communication without "teams" actively working with parents; conversely, it is possible to have "teams" that meet but that are not characterized by good communication. All three of the innovations taking place during the time of this interview involved some element of teamwork, and respondents described several reasons why such teamwork helps providers work more effectively, including

- helping to ensure cross-agency accountability, and
- helping providers to be better able to provide the range of needed services.

And, for parents, teams

- support better access to providers, in that there are "back-up" providers so parents always have someone to call for support, and
- provide strong emotional and psychological support to families.

Reason 1: Teams lead to better agency accountability for meeting parents' needs.

Having a team of providers who are working together was seen as helping to ensure that everyone involved with the case was held responsible for doing what he or she agreed to do. Despite their best intentions, busy treatment or child welfare workers can become overwhelmed with tasks and, as a result, families "slip through the cracks." The public commitment element of the collaborative team can help to safeguard against this.

> In family decision meetings it levels the playing field. Everyone hears the same stuff and everyone is accountable from the grandma to the attorney. Everyone gets a clear expectation of what's written. That can lead to sooner reunification. People meeting those expectations. Gives those check points and in this way clients get support and people work as a team. And the team approach really works. (Treatment)

Reason 2: Teamwork helps improve the quality of service provision to families.

Respondents described the ways in which the team approach insures that families not only get access to more services, but that those services are offered in a more timely fashion. In addition, teamwork helps providers organize themselves so as not to confuse or overwhelm families.

> If the FST is involved they do everything to help them. They get them to evaluations, provide transportation, do the family meetings to get extended family in the loop, make backup plans, and the same goes for the FIT. When you don't have all that there is much more of a delay in putting those things in place because one worker can't do in the same amount of time what a whole team of people can do. Most workers try to make the referrals and get the parent engaged. (Judicial)

Reason 3: Having a team of providers means that parents have someone to fall back on.

Responses hinted of the importance of timely intervention at the point when parents are ready for help. It was also suggested that having a team of providers could help ensure that parents would have at least one person that they could contact at that particularly vulnerable moment. Some teams also have individuals who are assigned to provide more intensive ongoing support than caseworkers alone are able to provide.

> "If there is a team effort in place, if there are other members of the team, they have someone to go to, but if the caseworker is the only one, that leaves them out in the cold sometimes at critical times. With these parents you have to be ready to move as soon as they show signs of being ready. It's a small window sometimes, and if you lose the chance, you may have to wait a while before it comes again, and sometimes it doesn't come again. If a caseworker isn't there when

> the parent needs them, that wastes precious time. (Judicial)
>
> When we started the FST I thought that was a great idea in providing a more holistic approach to the whole problem and it's been a real good thing. You have more people approaching the family and more voices and support. You have the better chance to connect with the family in a positive way. (Child Welfare)

Reason 4: Having a team of supporters has a powerful psychological effect on parents.

These responses referred to the fact that clients, many of whom come from abusive and/or neglecting households themselves, benefit from someone (or a team) showing them positive regard and consistent support.

> The fact that we have the FIT and FST teams I think sends the message that we value these people and want to work with them to help them get their lives straightened out. (Child Welfare)
>
> You're taking several systems and they all have to do a good job in their own aspects, and then we can do a good job together. You want everyone to be on the same page and be motivated by that synergy. It helps the parents to see that too, and it gives them good self-esteem for themselves, to see that they can make positive changes. They see that they are not bad people and there is someone who is backing them. It breaks the chain of negativity they have grown up with and they can see the light at the end of the tunnel. (Child Welfare)

Building Shared Value Systems

The third primary function of collaboration that was identified by respondents was related to overcoming one of the key problems facing these systems: striking differences in value systems and

service mandates, and a concomitant lack of understanding of each other's roles and responsibilities. In essence, respondents suggested that collaboration functions by helping to overcome this mistrust and increase cross-systems understanding. Rather than having specific, direct effects on parents or providers, this mechanism influenced the collaborative process itself. That is, the act of collaborating itself improved the nature of future collaboration by building better cross-agency understanding and a better sense of shared values. Interestingly, a number of individuals credited the increased time pressures under ASFA legislation as providing the impetus for engaging in this collaborative work.

> Given the history of the alcohol and drug treatment providers and their attitudes about confidentiality, we've come a long way in terms of working together in the short time we have been trying. As we learn to trust each other more and develop the relationships between the different people it will get better. It could really benefit the clients and make our jobs easier. (Treatment)

Outcomes of Collaboration

The previous discussion provides a number of implicit and explicit links between these collaborative processes and more distal case outcomes: parent participation and engagement in services, success in meeting the requirements of the case plans, and reunification or other timely permanency. To summarize, successful collaborative processes such as improved service delivery, enhanced communication, and the psychological effects of team support helped to support positive outcomes for parents.

> The women are most successful when the key players consistently communicate, meet on a regular basis, and give the client consistent messages and information. That is everything from the PO needing to be involved in all aspects of the women's life, the judge needing to be kept informed. When those supports are in place then these women are the most successful. There have been several situations where

> that was happening, where everyone came to the table and those had the most successful outcomes. (Treatment)
>
> The legal system has a lot of resources too. Instead of just saying this is what you have to do, now go do it, they will say here is the FIT team who is about helping you do these things. The client is already working with a drug-affected mind, they are under stress and duress, and they are not able to make clear decisions and understand what it is they need to do. We have to step in and give them that help so we can ultimately keep the children with them. (Judicial)

Provider-related collaborative processes also were linked to positive case outcomes primarily because of their effects on improved service delivery, and better case monitoring and decision making.

> Communication is much better between [CWS and Treatment], and that benefits the parents because we [caseworkers] get the clear message about what parents need to do and we can help provide information to the therapist and make sure that they get the services that the court is going to want and what they need to do is understood, and we can ensure that it will occur. (Child Welfare)

Barriers to Collaboration: What Prevents Good Collaboration From Happening?

The next phase of analysis focused on identifying barriers to collaboration described by these providers. These barriers, described more fully below, included

- providers' mistrust and lack of understanding of other agencies' perspectives,
- confidentiality concerns,
- logistical and resource concerns, such as the number of agencies involved with the case and time needed for good collaborative work,
- time pressure imposed by ASFA timelines, and

- turnover among AOD treatment providers.

Barrier 1: Providers' mistrust and lack of understanding of other agencies' perspectives

Agencies differ in terms of their approach to services, including whether the parent, child, or family is the primary client. Differences in language, training, and experience add to the distance that can exist between providers. The difficulty in overcoming these differences has been noted as a key problem in providing effective services to substance-abusing families involved with child welfare and was highlighted in a 1999 report by the federal DHHS. Respondents in this study also emphasized this problem: Overall, the general lack of understanding between members of the two systems was the most frequently mentioned barrier to successful collaboration. Specifically, issues related to mistrust can be categorized as reflecting

- negative perceptions and biases about each other's systems,
- differences in primary client alliance or focus, and
- basic lack of understanding of each system's service mandates, approaches, and goals.

Both AOD treatment providers and CWS workers described biases within and across the two systems. For example, one treatment provider commented,

> Our [Treatment] own prejudice that we might have against [CWS] caseworkers and how we perceive their treatment of A&D clients can be a hindrance. It causes us to misinterpret how they are rushing people into recovery because of the timelines. We get frustrated and that hinders how we help them because we are not the best consultants to the [CWS] workers. They need education and we don't always do a good job of that because of our biases. (Treatment)

At the same time, child welfare workers noted that they may con-

tribute to these negative perceptions:

> I don't think we as caseworkers overall have an empathetic understanding of addiction, and that adds to their [Treatment] mistrust of our motives. They recognize the inconsistencies in casework from case to case and so any caseworker is suspect. They get very protective of their clients. (Child Welfare)

Child welfare workers also noted that some treatment providers bring a personal history of involvement with child welfare services, which contributes to these negative attitudes:

> A mix of recovering people [as treatment providers] makes it both good and bad. They come from the background and bring a lot of baggage about Child Welfare that hurts the relationships with us [CWS] sometimes. (Child Welfare)

Respondents also commented on how different emphases across the systems in terms of who the primary client is can create barriers to successful collaboration. For example:

> They [Treatment] don't really have the time or the belief that they can educate us because they see us [CWS] in the protection-of-the-child mode, as an adversary instead of a partner. (Child Welfare)

> [Treatment and CWS] workers look at their client's needs and not at the whole family's needs. Their conception of what needs to be done and how they fit into the picture stops at the client level and doesn't encompass the family level and that doesn't foster coordination. The family's needs are many, and there are lots of opportunities for collaboration to help these families that get missed. (Judicial)

Other providers commented about a more general need for better understanding between the two systems:

> Everyone comes from different disciplines and has a differ-

> ent understanding about legal issues, recovery, treatment, and addiction. When you have a multidisciplinary team everyone comes with their own language specific to their field and you tend to talk at each other. . . . We assume too much knowledge on the part of others. A & D and Child Welfare people don't know things that others think they should know. (Child Welfare)
>
> We [CWS] all could use a better understanding of other disciplines, even when you train staff you have new staff coming in, you have many people with personal bias about substance abuse issues that can get in their way of understanding the issues. (Child Welfare)

Confidentiality

Although a surprising number of the providers we interviewed mentioned that confidentiality problems had been decreasing in recent years, many still perceived it to be a barrier, especially in terms of treatment providers not sharing information.[2]

> Treatment providers are still resistant to the confidentiality stuff. We [caseworkers] still don't get enough information. They don't understand that when we feel like we don't know what is going on, we are more likely to move towards termination. (Child Welfare)
>
> The whole issue of confidentiality with A & D, and what they view as their responsibility. When they have a release they can turn over whatever they want, but they don't. There are some A & D providers that are incredible and are very open and good about telling us things. Others are not that way. They make us subpoena the information. (Child Welfare)
>
> Under ASFA, the failure to receive needed information from

2 We should note that these interviews took place before Oregon's implementation of federal Health Insurance Portability and Accountability Act (HIPAA).

treatment providers in a timely fashion was also a significant concern:

> [Treatment providers] make disclosure of pertinent information difficult by not responding in a timely manner to court requests and DA subpoenas, and are notorious for poor record keeping just to prevent the system from having information. (Judicial)

> There is still a lack of communication about what the person's progress is or it is too late to the court or the attorney, and so no one receives the documentation they need about how a person is doing so they can be prepared for court, and so hearings will have to be rescheduled. (Judicial)

A number of respondents acknowledged, however, the difficult situation that treatment providers are in, in terms of having to simultaneously develop rapport with parents and, at the same time, be an active partner with CWS.

> Confidentiality is a problem because they [Treatment] want to support their client but at some point they are counterproductive if they aren't being up front with the court . . . if we're not able to fine tune what the parent needs. (Judicial)

Logistical and Resource Concerns

Respondents also commented on the lack of resources available to support collaborative efforts, especially given the complexity of the systems and sheer number of people involved in a single case. For example, treatment providers are often unable to attend case planning meetings given that this time is not "billable." Workload is another issue for caseworkers, treatment counselors, and attorneys alike.

> I think there needs to be a lot more partnering. We [CWS] need to go there, but they [Treatment] need to come here too. They need to be better staffed to do that. They can't get away to see us because they lose billable hours and that is

> the death knell of the agency when that declines. More money is needed. (Child Welfare)
>
> Volume, the numbers that have to be dealt with. A lot of people to track, there are a lot of people that need the information. There are a lot of cases and a lot of treatment centers trying to get hold of those caseworkers. There are communication obstacles everywhere you turn. (Child Welfare)
>
> Not having time to address all the coordination. Heavy caseloads may cause them [Child Welfare caseworkers] to not be able to follow through with things they need. A & D counselors don't go to family unity meetings or to court because they don't have the time. I try to go but it is rare because I just don't have time. CWS and criminal justice involvement becomes an extra burden on the counselor in terms of the amount of paperwork. (Child Welfare)

ASFA Itself Is a Barrier

A few respondents expressed concern that ASFA itself serves as a barrier to collaboration. Some treatment agencies' belief that the timelines are too short reinforces their sense that child welfare is simply "out to get the parents," and that therefore, there is no reason to collaborate. In addition, increased pressure on treatment agencies to share more information faster was seen as doing little to improve relations between the providers and child welfare. Finally, several noted that the timelines themselves serve to restrict the time available for the relationship building necessary to successful collaboration.

> It [ASFA] increased the friction between Child Welfare and A & D programs. They [CWS] want information more often and sooner and the A & D programs didn't want to give it up and with good reason. It has created a crisis point in information exchange. (Child Welfare)
>
> There doesn't seem to be enough time in the timeline for

agencies to really coordinate with one another. (Treatment)

AOD Turnover Is a Barrier

One final barrier to collaboration that was mentioned was the high staff turnover rate in the A & D system. Meaningful collaboration requires sustained, positive working relationships and turnover prevents staff from having the opportunity to work together across cases and over time. Limited treatment dollars no doubt influence pay rates among AOD providers, which may be linked to turnover.

> There is high turnover of counselors, the counselor with the longest time here has been here five years, the next longest time is one year. High burnout field. They work intensely. There is high burnout and so not the time to build sustained relationships with people in the other systems. (Treatment)

What Supports Collaboration?

Finally, we analyzed responses to better understand the features of providers and service systems identified as being particularly important in helping to build strong collaborations. Because of our focus on systems issues, the majority of the supports that respondents discussed were related to ongoing systems efforts to build successful collaborations. We describe these in the following. In addition, however, the general issue of having a "collaboration mind-set" was mentioned by a number of providers, and so we present a few examples of how and why this is important for supporting successful collaboration.

Trainings. In the year prior to the interviews, a number of cross-system trainings and forums had been held in an attempt to bring together members of the treatment and child welfare systems and to build greater understanding among each type of provider about the priorities, values, and experiences about the other. A number of individuals mentioned that these trainings were particularly important to helping build successful collaboration.

> We have more trainings happening and more efforts at try-

> ing to understand each other. The systems need to learn to cooperate and we all have different agendas and we need to start working together more to achieve the best possible outcome for everyone. So we are seeing more training on things, which really highlight the fact that we don't really understand others. (Treatment)

Family Decision Meetings

FDMs, in addition to their primary function of involving the parent in case planning and decision making, were also seen as an important mechanism through which providers in the different systems learned about each other, and as providing a forum for sharing information between providers and between providers and parents. FDMs were also seen as an important arena in which all of the different players, including parents, could "get on the same page" in terms of goals, services needed, and expectations:

> In their purest form, the family decision meetings are the most collaborative piece of all. It gives us a reason to say hey, let's get on the same page, and it gives us the opportunity to do the education with all the other people and that can go well. It helps to get everyone on board with the parents. (Child Welfare)

Court's Authority

Respondents felt that the court played an extremely important role in helping to facilitate successful collaboration. First, courts were seen as supporting collaboration by providing a kind of "positive coercion" for treatment and child welfare to work effectively together. Respondents also commented on the effectiveness of having the courts involved in developing service plans and finding resources for families.

> The judicial system has been very assertive and active and they've made a difference in making services happen. When FIT was first being talked about and developed I had my

> reservations about whether the systems could work together cooperatively. It's an effort from all systems but from the courts system as well. They help increase motivation, by positive coercion and by the reinforcement of positive things that are occurring. (Treatment)

Meetings in General

A variety of other meetings were mentioned which provided additional ways for providers to come together on behalf of families. All of these were seen as important for supporting collaboration:

> We have a dependency committee meeting every month and all the branch managers, judges, the CRB [Citizen's Review Board], and the CASA supervisor get together to talk about issues that are affecting all of us. That is helpful, so at least there is a way to address them. We have a CRB roundtable to discuss those specific issues, and we try to have communication and not be defensive about things, and just keep pluggin' away. (Child Welfare)

> There are these big CRB meetings and big staffing meetings that they invite POs to them and they [Treatment] have become more open to networking and sharing information with the other involved agencies. They have more goal-oriented treatment plans, and they have tightened up their requirements so that if someone is not working on the program, they don't get to stay in the program. They have tightened up their communications with everyone. (Judicial)

Positive Attitudes Toward Collaboration

In addition to the more systems-level supports mentioned previously, respondents talked about the importance of individual providers having a positive attitude toward collaboration, and a willingness to work together with other providers on behalf of the parent and child.

> Our collaboration and relationship with the A&D network

> and the judicial network has gotten better. We've come together around ASFA and we've formed a tighter bond with each other, and all of the players within the system really internalized that this type of consequence is out there for the families. (Child Welfare)

Respondents noted that perhaps the biggest changes in terms of having a collaborative mindset were taking place among courts and attorneys, in an increasing tendency for judges and other representatives of the legal system to work nonadversarially with case workers, treatment providers, and families.

> I think the attorneys and the judiciary folks to some degree are trying to be helpful to new workers and are trying to help them see how they can take care of things. That isn't universal certainly, but for the most part they try to work with the strengths of the worker and try to get the job done for the child. They are trained to tear people up verbally, and sometimes it is hard for us to go in and do battle with attorneys successfully, and they have made real efforts to be aware of that and work with us compatibly instead of in an adversarial way. (CWS)

> The changes we've seen in the way the attorneys see this program and the way they see working with CWS and A & D programs are really positive. They were reluctant to do that before because we ask a lot of questions that they don't want us to ask. They would rather the client admit nothing. They are getting much better at it. Sometimes but not often they will say, my client will accept but don't ask any questions.

Finally, some respondents noted that building successful collaboration may not come as much from systems-level policy changes as mandates, but rather from ongoing success in developing smaller collaborative teams and case-by-case teamwork:

> I think there is still a big disconnect between value in drug treatment and child welfare and I don't see it changing

with big systemic reform. I think it will come from small group discussion. It happens in little pods of people who figure out how to work with each other. (Judicial)

Discussion

These results suggest that the collaborative process functions to provide a variety of supports to parents and has an important impact on systems as well. For example, parents benefit directly in terms of increased psychological and emotional support. Successful collaboration, and in particular, consistent, coordinated communication from providers to parents, helps to ensure that parents are not overwhelmed by the multiple demands and requirements of their case plans. Having a "team of support" also helps parents by increasing the likelihood that at least one member of the team is available to the parent, by improving the chances that at least one of the team members will build a positive relationship with the parent, and, perhaps most importantly, by sending a message that the systems really are working together to help the parent succeed in making progress.

Collaboration also supports parents indirectly by improving the ability of providers to work together on the parents' behalf. This includes such functions as providing a bigger resource base from which to offer needed services, helping providers to better monitor case progress and to provide additional services and supports when parents are struggling, improving the coordination and timing of services, and holding providers accountable to each other for doing what they are supposed to do.

It should be added that collaboration, and in particular, communication, can influence case outcomes by improving the ability of key stakeholders to make good decisions due to the availability of timely, comprehensive, and accurate information. Sometimes this means moving more quickly to an alternative to reunification if parents are not doing well; this might also mean allowing parents more time to successfully complete case plans if their progress has been hindered by situations outside the parents'

control.

Together, this suggests that successful collaboration can improve the efficiency with which the systems are able to meet the needs of families, a critical issue given the complexity of child welfare cases involving substance abuse and the relatively short time frame allowed under ASFA. Collaboration can also improve the overall effectiveness of services, for example, by moving parents toward a greater state of "readiness to change" through provision of ample emotional, psychological, and tangible support. In short, collaboration makes systems work better.

Our findings also suggest, however, that there remain some concrete barriers to collaboration that need to be addressed before such benefits can be fully attained. The issue of resources, of course, is a perennial problem. Collaboration requires that multiple people attend multiple meetings and that communication among partners be frequent. In addition, this type of effort takes time; time to make phone calls and attend meetings. Furthermore, to actually realize many of the benefits of collaboration discussed in this paper, team members need to have resources at their disposal which can then be provided to the families.

At the same time, though, collaboration seems to have the potential to actually increase the efficiency of service delivery and should therefore be seen as a means of using scarce resources more wisely. Moreover, to the extent which service delivery is more effective, that is, more well-coordinated and organized, parents are able to make better use of existing resources, and as a result, remain in the system for shorter periods of time.

It should also be pointed out that the energies needed to facilitate the minimal levels of required communication within an *uncoordinated* system are likely considerable. That is, at some point caseworkers, treatment providers, attorneys, and judges have to communicate; this communication may take less time in the context of a collaborative system, and it is likely to be of higher quality than it is in a system that is not making the effort to collaborate.

Interestingly, the biggest barriers to successful collaboration

for people in this study were the negative cross-system attitudes, mistrust, and a lack of understanding of each others' activities, perspectives, and priorities. Related to this, of course, is the issue of confidentiality and the tension between treatment providers' need to build a trusting relationship with the parent and the need to share information about client progress with child welfare and the courts. There is no easy answer to this, although it appears that for many that we spoke with, the process of trying to collaborate and work things out in and of itself may help to overcome this barrier. Not surprisingly, building relationships among providers was seen as critical for successful collaboration; at the same time, the difficult reality of high turnover rates among both treatment providers and caseworkers was mentioned as an impediment to developing successful collaborations.

Respondents differed in terms of what they saw as the right way to grow collaboration. Some respondents suggested that mandating collaboration is the only way to ensure that all relevant parties would make the effort to collaborate. On the other hand, some felt that mandating collaboration was not effective. Rather, they felt that the needed change will come about as a result of small groups of people working together, experiencing success, and presumably, others learning from their experiences. Which of these approaches is ultimately most effective remains to be seen; however, there is evidence that larger systems need to support and model effective communication and collaboration in order for these changes in practice to occur "in the field" (Young & Gardner, 2000). Our results suggest that formal trainings and meetings, such as family group decision meetings or citizens review board hearings are effective and relatively low-cost venues for advancing the collaborative agenda by facilitating cross-systems understandings. Furthermore, given the current combination of scarce resources and ASFA timelines, it seems imperative to develop creative ways to facilitate teamwork and communication, such as holding meetings at court or at treatment centers, allowing individuals to participate by phone, and developing secure e-mail or Web-based

data systems for information sharing. Whatever the mechanism, unless change occurs systemically, it will remain the case that families who end up with an attorney, judge, treatment provider, or caseworker who is not willing to work collaboratively will be less likely to succeed than parents who do have collaborative support.

It should be noted that the results of this study are based on the perceptions of service providers; no data were collected directly from clients themselves. Parents' experiences of the collaborative process (or lack thereof) are critical for a full understanding of how collaboration works, what its effects on parents truly are, and how collaboration leads to improved client outcomes. Future research to address this question is clearly needed. Further, these data reflect the attitudes and beliefs of a single jurisdiction, located in a state that is widely acknowledged as having an innovative stance towards child welfare services (Oregon). Other barriers might be encountered in areas with different child welfare, treatment, or court systems; similarly, the approaches to enhancing collaboration are likely to need to be tailored to local regions.

Clearly, more research is needed to determine the most effective and efficient forms of collaboration. The current research helps guide this discussion by furthering our understanding of exactly how collaboration functions, and what its putative benefits are for families. By better understanding the nature of the "intervention," more focused efforts may be developed that can maximize the critical "active ingredients" of collaboration and help practitioners who are striving to improve services for these families better understand what collaboration needs to do in order to be effective. Furthermore, collaboration must be recognized as a means to more clearly defined ends; by better understanding what the ends are that we are trying to accomplish, we can be more efficient and effective in implementing the means.

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