California Social Work Education Center

CALSWEC

COLLABORATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SERVICES

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2010
Disseminated by Loma Linda University on behalf of the California Social Work Education Center (CalSWEC)

This Curriculum Module was supported by a grant from the Zellerbach Family Foundation

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CalSWEC PREFACE

“Created in 1990, CalSWEC [The California Social Work Education Center] is a consortium of the state’s 20 accredited social work graduate schools, the 58 county departments of social services and mental health, the California Department of Social Services (CDSS) and Mental Health (CDMH), the California Chapter of the National Association of Social Workers, professional associations, and foundations. It is the nation’s largest coalition of its kind working together to provide professional education, student financial aid, in-service training, and workforce research—all directed toward developing effective, culturally competent public service delivery to the people of California.”¹

CalSWEC, a unit of the School of Social Welfare at the University of California, Berkeley, currently sponsors three major focus areas - Child Welfare, Mental Health and Aging - and also oversees the Title IV-E Child Welfare Stipend Program, Regional Training Academy (RTA) Coordination Project, and the Mental Health Educational Stipend Program (MHESP). “In collaboration with its partners, it works to develop a diverse and qualified new workforce for the fields of child welfare, mental health, and gerontology; enhance skills among public and contract agency staff to serve diverse populations in California; and contribute to knowledge in these systems. CalSWEC provides stipends to schools of social work for Bachelor’s- and Master’s-level students; develops curricular tools for faculty and in-service trainers; coordinates statewide in-service training activities, and studies the effectiveness of its programs.”

¹ This Preface is based on the information provided on the CalSWEC website. All direct quotes are taken verbatim from the website (calswec.berkeley.edu).
Among its varied activities, CalSWEC has been involved in developing and revising Curriculum Competencies for Public Child Welfare and Mental Health. These competencies have been created to assist graduate schools of social work in preparing child welfare and mental health MSW students for future careers in either service system. The California Public Child Welfare Competencies “serve as a model for collaborative curriculum development across the nation and are revised periodically to reflect current practice” (also see http://calswec.berkeley.edu/CalSWEC/Curric_Comps.html). The Mental Health Competencies guide the development of recovery-oriented curricula, which each school addresses in the foundation and advanced years through academic coursework and field placements (http://calswec.berkeley.edu/MHInitiative_Competencies.html).

CalSWEC is involved in multiple training activities with both Child Welfare and Mental Health. The Regional Training Academy (RTA) Coordination Program and the Child Welfare Resource Library (http://www.csulb.edu/projects/ccwrl/) are important resources for training and education of public child welfare professionals. To foster continuing learning and evidence-based practice within the mental health field, CalSWEC, with supplemental funding from The Zellerbach Family Foundation Curriculum Implementation Grants, has developed a series of curriculum modules. To increase distribution and learning throughout the state, curriculum modules are made available through the CalSWEC Mental Health Curriculum Resources Website (http://calswec.berkeley.edu/calswec/MHInitiative_SWSyllabi.html).
ABOUT THE AUTHORS

**Sigrid James, PhD, MSW, LCSW** is an Associate Professor in the Department of Social Work and Social Ecology at Loma Linda University and continues to be affiliated as a research scientist with the Child and Adolescent Services Research Center, Rady Children’s Hospital, San Diego. She is also a 2010/11 Fellow at the Dissemination and Implementation Research Institute, Center for Mental Health Services Research, Washington University, St. Louis, Missouri. She completed her graduate studies at UCLA (MSW 1990) and the University of Southern California (PhD 2003). She has more than twenty years of experience in social work as a licensed clinician, administrator, and researcher. Her work as a clinician and researcher has focused on the intersection between child welfare and mental health, specifically the needs of children in the child welfare system who present with the most severe emotional and behavioral problems. She is the recipient of several grants, which have investigated aspects of children’s placement experiences, including placement disruptions and psychiatric hospitalization. Currently, she is studying the role of group homes in the treatment of foster youth with emotional and behavioral disorders as part of a 5-year NIMH training grant. Dr. James sits on several community child welfare and mental health committees to improve the quality of services for children in the child welfare system. She also serves as a topical expert to the California Clearinghouse on Evidence-Based Practice in Child Welfare in the area of ‘higher level placement.’

**Lynne Marsenich, MSW, LCSW** is a senior associate at the California Institute for Mental Health. Her work in California focuses on bridging the gap between science and practice through the successful implementation of empirically informed programs, treatments
and practices. She and her colleagues at the California Institute for Mental Health have
developed a multi-level intervention to help transport evidence-based practices into publicly
funded behavioral health, child welfare and juvenile justice service systems. The
intervention referred to as a Community Development Team has been used to help 32
California counties and 30 community-based organizations successfully adopt, implement
and sustain seven separate evidence-based practices and programs.

Lynne Marsenich is the Co-Principal investigator on two NIMH-funded
implementation grants. The first, “Community Development Teams to Scale-Up MTFC in
California,” is a collaboration with Patricia Chamberlain from the Center for Research to
Practice in Oregon, and is a test of effectiveness of the Community Development Team.
The second, “Improving Therapist Fidelity during EBP Implementation,” is a collaboration
with Dr. Carolyn Webster-Stratton from the University of Washington. The goal of the study
is to examine the relationship between two different methods of implementing the Incredible
Years parenting program and of promoting fidelity to the model.

Prior to joining the California Institute for Mental Health, Lynne Marsenich spent ten
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ACKNOWLEDGMENTS

Special thanks go to Phillip Crandall, Director, Alane Price, Executive Secretary, and Shelley Nilsen, Deputy Director, Children and Family Services from the Humboldt County Department of Health and Human Services and Richard Knecht and Michael Lombardo, from the Placer County system of care leadership team in the Placer County Health and Human Services Department, who shared their insights and documents for this project.

We are particularly indebted to Jan Black, John Ryan, Bev Abbott, Pat Jordan and Bev Buckles for providing valuable feedback throughout the development of this module.

This project benefited greatly from the active participation and constructive feedback of our workshop participants in Los Angeles and Oakland. Their ideas and comments were integrated as much as possible as we designed the final draft of this module. We thank you for your contribution and honest feedback!

Finally, special thanks go to our student assistant Alyssa James for aiding in the formatting, editing and ‘putting-together’ of this module.
INTRODUCTION AND OVERVIEW

Introduction

Children and adolescents in public child welfare and mental health systems share many characteristics and are considered at risk for adverse outcomes in multiple domains (Garland, Hough, Landsverk & Brown, 2001). Research during the last three decades has consistently established that maltreated children, in particular those placed into out-of-home care, exhibit significantly higher rates of mental health problems than children in community samples (e.g., Burns et al., 2004; Landsverk, Garland & Leslie, 2002). Rates of moderate to severe mental health problems have ranged from 35 to 80 percent across various studies (e.g., Burns et al., 2004; Dierker, Solomon, Smith, Johnson & Farrell, 2004; Halfon, Zepeda & Inkelas, 2002). The exact causes of these higher rates are not well understood. However, histories of abuse and neglect, backgrounds of general family dysfunction, parental substance abuse and poverty coupled with the potential trauma associated with removal from home are all believed to be contributing factors (Landsverk et al., 2002).

Children and families with both protective and mental health needs rely on both systems to work together to provide optimal care. How to accomplish this continues to be a matter of debate. The child welfare system has traditionally relied on the curative powers of the foster home and on the abilities of foster parents to provide a therapeutic experience for children in their care while focusing on its primary charges of protecting children, preserving families and providing permanent placements. During the past ten to fifteen years, however, there has been growing recognition that most foster placements are not equipped to deal with the severe emotional and behavioral problems present in many abused children today.
and that additional mental health services are needed to assess and ameliorate their problems. This has resulted in explicit mandates to support the well-being of children in the care of the child welfare system.²

Services to address the emotional and behavioral problems of children in the child welfare system have for the most part been provided through linkages to mental health and other agencies outside of the child welfare system (Landsverk et al., 2002). Since the early 1980s, these linkages have been described as inadequate, fragmented and uncoordinated (Knitzer, 1982; Knitzer & Yelton, 1990; Saxe, Cross & Silverman, 1988; Tuma, 1989). Publications such as Knitzer’s book “Unclaimed Children” (1982) provided the impetus for federal initiatives that aimed to develop a comprehensive, coordinated system of care for severely emotionally disturbed children and adolescents (National Institute of Mental Health, 1983; Stroul & Friedman, 1986). Guiding principles for the delivery of services within the system of care included the provision of developmentally-appropriate, culturally-sensitive, child-centered and community-based services across service systems that should be provided within the least restrictive environment possible. The model further emphasized that service delivery should be driven by the needs of the child and the child’s family (Duchnowski, Kutash & Friedman, 2002; Kutash & Duchnowski, 1997; Stroul & Friedman, 1986). Despite the formulation of guiding systems of care principles, the organization and delivery of mental health services to children in the child welfare system has remained largely atheoretical. In fact, efforts toward collaboration and integration of services have

² In March of 2000 the Department of Health and Human Services established a review process for ensuring that state child welfare programs meet certain standards, among them child well-being. In order to meet this standard, states must demonstrate: 1) families have enhanced capacity to provide for their children’s needs; 2) children receive appropriate services to meet their educational needs, and 3) children receive adequate services to meet their physical and mental health needs (e.g., http://www.dss.iahwnet.gov/cfsweb/P1520.htm).

been primarily driven by ideology, policy and descriptive findings from various demonstration projects; research findings in this area remain sparse. 

The establishment of mental health systems of care for children was accompanied by efforts, beginning in the late 1980s, to empirically investigate mental health services to vulnerable child populations. Studies in this area have somewhat unexpectedly demonstrated that children in the child welfare system – in particular children placed in out-of-home care – are among the highest users of mental health services. Such findings have suggested that the child welfare system and the mental health system are more strongly linked than commonly thought (Halfon, Berkowitz & Klee, 1992; Landsverk et al., 2002; Takayama, Berman & Connell, 1994). Nonetheless, significant levels of unmet need continue to be documented.

Curriculum Overview

Collaboration is not a new topic of interest for CalSWEC. Several previous modules have addressed various aspects of collaboration that are relevant to the field of child welfare (e.g., Drabble, Osterling, Tweed & Pearce, 2008; Drabble, Tweed & Osterling, 2006; Rector, Garcia & Foster, 1997). Why another module? This Curriculum Module focuses specifically on collaboration between the child welfare and mental health system. This has multiple implications for the organization and content of this module.

First, one of our aims was to present base content on collaboration. Here we had two concerns. We did not want to duplicate the content of previous modules. Instead, we see these prior efforts as important resources for instructors interested in the topic of collaboration. All prior modules contain relevant literature and valuable activities that may
also be used.\textsuperscript{3} We also did not want to delve too deeply into the much more developed research literature on collaboration in other fields, such as organizational development or management. While we included some references and touched on a few conceptual frameworks in other fields, we have made every effort to add content that is specific and relevant to the intersection of child welfare and mental health.

Second, we wanted to facilitate knowledge building about both systems – child welfare and mental health. It is our experience that many times professionals from either field have limited knowledge and understanding about the role of the social worker in other systems. In fact, collaborative efforts are often hindered by misconceptions and biases about the “other” system.

Third, we wanted to introduce collaborative models between child welfare and mental health “that are working.” While findings from “model” collaborations may not be easily generalizable to all systems, they do teach about core ingredients of successful collaborations.

Finally, we would like to note that this is a teaching, not a research module. This means that we have been less concerned about presenting a comprehensive review of the growing literature at the intersection between child welfare and mental health than with presenting contents that will facilitate collaborative relationships between workers from the two service systems.

\textsuperscript{3} For instance, the module developed by Rector and colleagues contains a section, which offers useful exercises to strengthen interpersonal skills necessary for successful collaborations; see Rector et al., 1997, Module III. Beyond CalSWEC resources, we would like to refer readers to The British Columbia Competency Framework for Interprofessional Collaboration, which effectively summarizes some of the core skills necessary for effective collaboration (www.chd.ubc.ca/node/57).
**Curriculum Structure**

The Curriculum Module contains five primary sections:

Section I: A Primer on Collaboration
Section II: Understanding the Child Welfare and Mental Health System
Section III: Theories and Explanatory Models of Collaboration or What Makes Collaborations Work or Not?
Section IV: How Does Collaboration at the Intersect of Child Welfare and Mental Health Work?
Section V: Another Word on Results-Based, Outcome-Oriented Collaboration

Each section includes Powerpoint slides with commentary along with relevant activities and proposed questions for discussion. The right column called “Instructor’s Notes” sometimes offers suggestions or ideas for the development of a class or session. It can also be utilized as a space for instructors to add their own ideas and comments. The five main sections are followed by appendices, which include references, Powerpoint slides, handouts, and case studies. Links are provided to key articles for which copyright clearance was obtained.

**Intended Audience**

The primary audience for this curriculum consists of MSW students entering the fields of public child welfare and public mental health, with a specific focus on MSW Title IV-E students and MSW Mental Health Stipend students, as well as entry-level child welfare and mental health professionals. However, some of the material may be used or adapted for
students or professionals in other social service fields. Materials in this curriculum may also be adapted for use with BSW students.

Sections of this curriculum may be used together or independently. Instructors may elect to delve deeper into a section or just introduce it briefly. The length of time required to implement each section is therefore flexible and dependent on how many activities and questions an instructor introduces in his/her classroom. Each section offers suggestions how the content can be structured and introduced or combined with other sections. The curriculum may be used in courses or training focused on practice, policy or human behavior.

**Learning How to Collaborate**

There is ample evidence from the research literature that organizational norms influence the adoption of new ways of practicing (Aarons, 2004; Glisson, 2002; Rogers, 1995; Sandfort, 1999). This is also true for collaboration. If we want our students and professionals entering the fields of child welfare and mental health to possess skill sets that make them good collaborative partners, there needs to be an expectation of team-work and an environment that supports this expectation. Completing a single module on collaboration will not automatically produce a great collaborative partner. We believe that collaboration requires skills that can and need to be fostered throughout the social work curriculum, even when the content area has nothing to do with collaboration. What do we mean by that?

Many times throughout their undergraduate or graduate education, students are expected to complete assignments in groups. Sometimes this is expected to make the life of the instructor easier (it takes less time to grade 10 than 30 papers!); other times, the scope
of a project would be too big for a single student. Very seldom, however, are group projects assigned because they are purposefully designed to teach students about “collaboration.” In fact, quite the opposite! From our own experience as instructors, students are often simply expected to know how to work together effectively. Not surprisingly, group projects are frequently dreaded by many students. Each time, I (S. James) assign a group project, I can guarantee having to deal with at least two or three groups who do not work well together, complain about uneven contribution to the project, and wish they could have completed the project on their own. Most are convinced that they could have done a better job if the project had been solely theirs. And they may be right! The problem is that we (and we are including ourselves in this criticism) do not teach students HOW to work together.

Each group assignment should include reflection on the process of collaborating. What worked? What went wrong? Who did you find difficult to work with? Why? Who complemented your skills? What could have been done to problem-solve disagreements? Without reflection on the process, students’ attention is not drawn to the collaborative process. Similarly, taking the time to reflect on the process and perhaps evaluating students’ willingness and ability to be a collaborative partner can facilitate the teaching of collaborative skills beyond classes focused specifically on collaboration. The British Columbia Competency Framework for Interprofessional Collaboration provides a framework, which could also aid in the evaluation of students’ ability and willingness to collaborate (www.chd.ubc.ca/node/57).

The module has been commissioned with your learning in mind. We sincerely hope that you find it useful.
SECTION I

A PRIMER ON COLLABORATION
I. A PRIMER ON COLLABORATION

Introduction: The first section in this curriculum provides basic background information on collaboration. It introduces students to the topic by eliciting reactions to experiences with collaborations, discussing the rationale for collaboration and clarifying terminology.

I.1 Free Association Exercise

SLIDE I.1-1

Everybody has had experiences with collaborative projects – from small group projects to large-scale efforts that involve multiple partners and stakeholders from different agencies and professional groups. While collaboration is generally viewed as something that is beneficial and that “we ought to do,” many professionals and students have a mix of responses related to “collaboration.”

Please put yourself on Dr. Freud’s proverbial couch, and report your immediate reactions to the term “collaboration.”
I.2 Why Collaborate?

SLIDE I.2-1

Why Collaborate???

- Interagency collaboration is mandated by many policies regulating services for children and families.
- Many experts view collaboration as a key solution to addressing the complex needs of children in the child welfare system.
- Collaboration is believed to have many benefits.

In today’s work environment, collaboration is frequently a preferred and expected mode of working. Collaboration may occur between agencies and organizations or between disciplines. It may be part of the organizational structure or it may be initiated and maintained by individual workers who aim to achieve the best outcome for a particular client. Many experts view collaboration as a key to addressing the complex needs of children in the child welfare system and children with severe emotional disorders. Collaboration is supported by policies at the federal, state and local level, and it is generally viewed as an approach that is beneficial.

There are numerous articles in the literature that argue for the value of collaborative practice in Human Services (e.g., Altshuler, 2005; Bronstein, 2003; Sandfort, 1999).
There are three primary reasons for collaboration specifically between CW and MH, involving (1) policy mandates, (2) common goals, and (3) shared client characteristics.

Questions for Discussion / Proposed Activities:

1. Review CW and MH competencies and identify competencies that either implicitly or explicitly address collaboration (see cited websites in the Reference Section).

   Child Welfare Competencies:

   Mental Health Competencies:
   http://calswec.berkeley.edu/CalSWEC/MH_Competencies_Fdn_06.pdf
   http://calswec.berkeley.edu/CalSWEC/MH_Competencies_Adv_Specializn_06.pdf

2. Identify common and divergent goals between child welfare and mental health.

3. Identify similarities between children and families involved with the CW system and those involved with the MH system.

INSTRUCTOR’S NOTES

Instructors may find it helpful to begin examination of this topic by having students review California’s CW and MH competencies (this could also occur later in Section II when discussing the policy context of collaboration between CW and MH). In groups of 3-4, students could identify implicit and explicit mandates for collaboration in all sets of competencies.

Suggested discussion questions are aimed at exploring students’ thinking about the two systems. Both, overlapping and divergent goals for CW and MH as well as similarities in characteristics will be addressed in depth in Section II.

We suggest that the discussion remain brief at this point of overview.

Soo...if most professionals agree that we should work collaboratively what makes collaborating so difficult?

Many articles in the literature address the challenges of successful collaborations (e.g., Darlington, Feeney & Rixon, 2005; Hodges, Hernandez & Nesman, 2003; Prince & Austin, 2005). This module will address barriers and challenges to collaboration throughout, but particularly in Section III.

INSTRUCTOR’S NOTES

Section III will be devoted to understanding barriers and facilitators of collaboration. At this point, it would be sufficient to acknowledge that collaborating is not an easy task but requires commitment, time, resources and leadership.
I.3 The Messiness of Terminology

Introduction: This section is intended to introduce students to some of the definitional challenges in the area of collaboration.

SLIDE I.3-1

The Messiness of Terminology

- Inter-organizational relationships
- Boundary spanning
- Co-operation
- Co-ordination
- Coalition
- Alliance
- Integration
- Coupling mechanism
- Symbiotic arrangement
- Partnership
- Team approach
- Multidisciplinary...
- Interdisciplinary...
- Cross-disciplinary...
- Co-production interventions
- Cross-system...

Many different terms are used in the literature for collaborative alliances. They all have slightly different meanings but are often used interchangeably.

INSTRUCTOR’S NOTES

Suggested Time: 15-30 min

Instructors may decide how much time they want to spend on this section. Definitional issues are important to facilitate theoretical thinking about collaboration, but it may not be necessary to spend more than 15-30 minutes on this section.
Collaboration also carries different meanings. This slide captures some of these meanings.

**Meanings**
- Joint ‘decision making,’ etc.
- Shared ‘commitment,’ etc.
- Interchangeability of some function
- Co-accountability for outcome
- Active participatory process
- Functional mutuality
- Multi-party problem solving

Colleagues Gray and Wood contributed to theory development in the area of collaboration in the early 1990s (Gray & Wood, 1991; Wood & Gray, 1991). This citation points out that there is no agreement even at a basic definitional level.

"Definitions are crucial to theory building. A general theory of collaboration must begin with a definition of the phenomena that encompasses all observable forms and excludes irrelevant issues. We began our work on these special issues assuming a commonly accepted definition of collaboration existed and that we could move quickly beyond this primal task. Instead, we found a welter of definitions, each having something to offer and none being entirely satisfactory by itself” (Wood & Gray, 1991, p.143).

It might be useful to ask students to formulate their own definition.

We recommend reading Gray and Wood’s articles on collaboration for a greater understanding of some of the conceptual challenges in this area.
The next two slides present examples of definitions that have appeared in the literature.

**SLIDE I.3-5**

**Defining Collaboration (3)**

- “A fluid process through which a group of diverse, autonomous actors (organizations and individuals) undertakes a joint initiative, solves shared problems, or otherwise achieves common goals” (Abramson & Rosenthal, 1995)
- “A process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible” (Gray, 1989, p.5)
It is our position that collaboration is not meaningful unless it is tied to improved client outcomes. This is a stance that is frequently reflected in the literature. As such, collaboration would describe ‘the process’; it would be viewed as a means to an end.

Questions for Discussion / Proposed Activities:

1. What does it mean viewing collaboration as a process rather than an end?

2. Is there any benefit to viewing collaboration as ‘the goal’ itself?

A Few More Notes…

- In the literature, collaboration generally refers to a process
- It is viewed as a means to an end, not an end in and of itself
- Collaborative alliances are the forms that are taken to promote collaboration

INSTRUCTOR’S NOTES

This slide generated a lot of discussion in our workshops. It is our position that collaboration is not meaningful unless it is tied to improved client outcomes. This is a stance that is frequently reflected in the literature. As such, collaboration would describe ‘the process.’ It would be viewed as a means to an end. However, several participants in our workshops pointed out that a collaborative working style creates an improved work environment regardless of the ultimate outcome. Therefore, collaboration might be worthwhile in and of itself even if it doesn’t always produce desired outcomes and may cost more time and resources. This is an important point of discussion that instructors may want to pursue.
Sounds great, but...

Although there is general agreement of the need of and benefits for collaboration, knowledge is limited about

- “how collaboration functions,
- its goals,
- the types of structural criteria essential to its function,
- and whether collaboration actually contributes to better decision-making, legitimate decisions and just distribution of welfare”

(Willumsen & Skivenes, 2005)

INSTRUCTOR’S NOTES

This slide ends the section on terminology. It points to the lack of a knowledge base in the area, and to the fact that our assumptions about collaboration deserve critical examination.
SECTION II

UNDERSTANDING THE CHILD WELFARE AND MENTAL HEALTH SYSTEM
II. UNDERSTANDING THE CHILD WELFARE AND MENTAL HEALTH SYSTEM

**Introduction:** Beyond a basic understanding of the construct of collaboration, students will need to have base knowledge about the child welfare and mental health system. It is our experience that many times professionals working in one system know little about other service systems.

There are four sections in this module. All are aimed at (1) revealing and dispelling misconceptions and myths, and (2) imparting knowledge about the two systems.

1. Imagine Exchange Activity
2. CW/MH Jeopardy Table
3. The Policy Context
4. The Intersection of Child Welfare and Mental Health

**INSTRUCTOR’S NOTES**

There are multiple ways that this section could be used. Some instructors prefer providing a context first before launching into structured activities and discussion. In that case, instructors should first go to section II.3-The Policy Context and II.4-The Intersection of Child Welfare and Mental Health before using the II.1-Imagine Exchange Activity and/or the II.2-CW/MH Jeopardy Table.

Other instructors may prefer having students share their knowledge and mis/conceptions before providing “the facts.” In that case, one or both activities could be used before launching into a presentation on the policy context and the intersection of child welfare and mental health.
II.1 Image Exchange Activity

**Introduction:** Much of the literature on collaboration has focused on identifying barriers to successful collaboration. The *Imagine Exchange Activity* is an experiential way of identifying biases and misconceptions that may stand in the way of working together. The *Image Exchange Activity* is a team building technique from the field of organizational development (Pfeiffer & Jones, 1974) that aims to address such biases and misconceptions. This activity is also known as intergroup team building (Harvey & Brown, 1992). Colleagues from San Diego State University (Packard, Jones & Nahrstedt, 2006) used the *Image Exchange Activity* with professionals from child welfare, domestic violence, mental health, and substance abuse for team development and role clarification. Their 2006 publication is a report about this experience.

**Reference:**


**Questions for Discussion / Proposed Activity:**

You will be identified as either a CW or MH student / professional. Join small groups of 3-5 fellow CW or MH students / professionals and take 30 minutes to discuss the questions on the next page in your group.

Once you’re done, be prepared to share your thoughts with the larger group.

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**INSTRUCTOR’S NOTES**

**Suggested Time:** 45 min +

This activity is most effective if students / professionals from both systems are present.

If the class consists of students who have little experience in either system, this activity may not be as helpful. We believe that students should have had a minimum of one quarter or semester experience in a CW or MH field practicum before being able to benefit from this activity.

Instructors should divide the class into two groups: CW students / professionals and MH students / professionals. Instructors should create smaller sub-groups of 3-5 students and have them discuss the questions pasted on the next page. About 30 minutes are adequate for small group discussion.

Ample time should be left for processing following the activity.
For CW Professionals:

(1) How do you see yourself as a CW professional?
(2) How do you see / What are your perceptions of MH professionals?
(3) How do you think MH professionals see you?
(4) What do you want a MH professional to understand about your job?

For MH Professionals:

(1) How do you see yourself as a MH professional?
(2) How do you see / What are your perceptions of CW professionals?
(3) How do you think CW professionals see you?
(4) What do you want a CW professional to understand about your job?
II.2 Activity: Playing “CW / MH Jeopardy”

Introduction: This activity is intended to provide information about various aspects of the child welfare and mental health system. It is a tool for learning about each system, dispelling misconceptions and identifying areas for collaboration. We have found this activity to be very helpful in generating discussion and imparting information about the child welfare and mental health system.

We have also found that experts do not necessarily agree on all the answers. For instance, in one workshop child welfare professionals emphasized the hierarchical and bureaucratic structure of the child welfare system. Mental health professionals countered that the mental health system is even more hierarchical with roles along professional disciplines clearly delineated and hierarchically structured. As such, lively discussion and divergent views should be expected. A handout of *The Table* is available in the Handout Section.

SLIDE II.2-1

<table>
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<tr>
<th>#1 CW</th>
<th>#2 MH</th>
<th>#3 Areas of Overlap</th>
<th>#4 Areas of Divergence</th>
<th>#5 Implications for Collaboration</th>
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<td>Organizational culture</td>
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INSTRUCTOR’S NOTES

Suggested Time: 90 min +

Needed: Flipchart; markers; copies of the CW/MH Jeopardy Table for each student (see Handout section. This is optional - *The Table* could also be shown through the projector)

How to Use *The Table*: *The Table* can be used in multiple ways. The instructor can choose to only focus on the first two columns; others may want to address all five in their discussions. Discussions generated by this activity can easily take up to 90 minutes, and could be extended over an entire 3-hour seminar period. Time can be shortened if the focus is only on a few domains (left column) and columns #1 and #2. We recommend allocating a minimum of 90 minutes to this activity.

Example: With regard to the domain ‘Legal Obligations,’ students may list CW’s obligation to meet mandated timelines in processing cases. For instance, there is a 6-month review hearing during the Juvenile Dependency Process, during which a decision is made whether the child can be returned home or should remain in foster care. A primary legal obligation of a MH professional is the protection of the therapeutic relationship (through confidentiality, for instance). While there are exceptions to confidentiality, MH professionals are focused on building and maintaining a therapeutic relationship with their client. (cont’d)
Columns #1 and #2:

For columns “CW System” and “MH System” students are meant to simply gather descriptive information about each system. What is the mission of the CW System and the MH System, respectively? What are the predominant values of each system? How would you describe the organizational structure of each system? etc. In classes with little background knowledge about each system, it may be helpful to ask students prior to coming to class to complete The Table collaboratively with a few other students as an assignment. Due to the nature of this activity, we have abstained from providing answers for each dimension captured on the left. We provide examples for three domains to show what type of information may be gathered.

Columns #3, #4, and #5:

These columns can be included to explicitly address areas of overlap and divergence between each system across the multiple domains. Areas of significant divergence may serve as important demarcations and may not lend themselves to collaborative projects. As such, implications for collaboration should be part of the discussion.

Questions for Discussion / Proposed Activities:

I. In-class Tool:

1. Gather information about each system in class through discussion.

2. Divide by specialization – CW or MH; gather information about the respective other system through small group discussion.

3. Divide into small groups (groups may be a mix of CW and MH students). You will be assigned several different dimensions (e.g., values, mission, knowledge base). Gather information about each system along the assigned dimensions. Once you have completed this task, reflect on the collaborative aspects of the exercise. For instance: What was it like to be part of your group? What worked well? Who were the leaders in the group? How were roles divided? What annoyed you?

INSTRUCTOR’S NOTES

(also see Gushwa & Chance, 2008 article listed in the resource section on the next page).

How do these different legal and professional obligations clash? Are there areas of overlap?

Both professional groups are expected to work toward the best interest of the child. However, whereas CW has timelines set by legal mandates and the courts, MH professionals may feel that these timelines do not coincide with the evolution of the therapeutic process. What implications does this have for collaboration?

MH professionals will have to develop an understanding and appreciation for the legal mandates under which a CW professional is working. Rather than dismissing these timelines as counter-therapeutic, it would be important to know why these timelines were set, what they intend to achieve, etc. By the same token, CW professionals will have to understand that treatment is a process that cannot necessarily be accelerated just because a court report comes due. Understanding each other’s obligations and roles will hopefully lead to mutual appreciation and support on behalf of the best interest of the child.

II. Homework Assignments

1. Divide into small groups (3-4); gather information about each or both systems along several or all dimensions prior to coming to class (as indicated by your instructor). Reflect on the collaborative aspects of the exercise (see I.3)

2. Divide into small groups (3-4); you will be asked to write a paper using this activity. Such a paper could be descriptive, focusing primarily on columns #1 and #2, or analytic and integrative, focusing on columns #3 - #5. The paper should be a group project and should include reflection on the collaborative process of writing the paper together. Details will be provided by your instructor.

Resources:


INSTRUCTOR’S NOTES

How To Use The Table (cont’d):
The Table can be used as an ‘In-Class’ Tool or as part of a Homework Assignment. There are potentially other uses, and we are interested in learning how instructors are utilizing this tool in their classes in other ways than described here.

We only provided ideas here, and instructors are asked to further specify their expectations for their class.

For additional background information, instructors and students are referred to the resources listed to the left. Instructors may use this as a reading list if this activity is assigned as a larger paper or homework assignment. It may also be useful to refer to textbooks and other literature on the child welfare and mental health system.
II.3 The Policy Context of Child Welfare and Mental Health

Introduction: In this section, students are familiarized with the policy context in which collaboration between child welfare and mental health occurs. Mental health and child welfare policy initiatives are considered separately because they were developed and in some cases, implemented independently of each other. It is only in the last few years that there has been a focus on ensuring that these two service systems work together to improve outcomes for children, youth and families.

SLIDE II.3-1

Policy Context – Mental Health

- 1983 - Child and Adolescent Service System Program (CASSP) encouraged collaborations with other child-serving systems (Systems of Care)
- 1992 – Expansion of CASSP; Comprehensive Community MH Services for Children and Their Families Program, established by CMHS/SAMHSA
- 2003 - New Freedom Commission on Mental Health; identified transformation of children’s MH services as a national priority

The federal Child and Adolescent Service System Program (CASSP) and funding were initiated by the National Institute for Mental Health in 1984 (and later administered by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration) to help states and communities begin to plan for and implement children systems of care.

Historically, Systems of Care have focused on improving access to and availability of services and on reducing service funding and fragmentation. Systems of Care approaches explicitly target interagency collaboration to help ensure that service providers work together.

INSTRUCTOR’S NOTES

Suggested Time: 30-60 min

As already mentioned earlier, some instructors may prefer to introduce this section earlier, prior to the proposed activities. We have received varying feedback on the sequencing of the material, and believe that this should be decided by the instructor based on their teaching style and their students’ learning style.

Instructors may want to refer to the following websites and documents which are helpful in understanding how Systems of Care approaches have significantly influenced mental health service provision (These documents are also listed with the entire reference in the Reference section at the end of this document).

http://gucchd.georgetown.edu/products/SOCIssueBrief.pdf

http://gucchd.georgetown.edu/67211.html

http://www.dmh.ca.gov/pro p_63/mhsa/default.asp
The recommendations in the President’s New Freedom Commission on mental health are reinforcing the principles of Systems of Care and support service systems collaborating to decrease fragmentation and improve outcomes. It should be noted that the recommendations from this report form the foundation of the 2004 Mental Health Services Act in California.

**SLIDE II.3-2**

**Policy Context – Mental Health (2)**

- 1997 - SB 163 Establishment of Wraparound
- 2004 - Mental Health Services Act

SB 163 and the Mental Health Services Act are both California policy initiatives codified in legislation which have had profound impact on developing collaborative services and organizational structures.

The Wraparound service model requires team-based service planning which involves at the very least the child welfare worker and the mental health provider (see Section IV.3 for more detail).

The Mental Health Services Act specifically requires Wraparound programs for all counties (with populations greater than 200,000) and further provides funding for collaboration between child welfare and mental health services systems to develop services that meet the mental health needs of children and youth in the child welfare system.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004 provides the first opportunity in many years for the California Department of
Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

The MHSA directs the state Department of Mental Health to dedicate resources to create a culturally competent system that promotes recovery/wellness for adults with severe mental illness and resiliency for children with serious emotional disorders and their families. The overall goals are to build a mental health system where access will be easier, services are more effective and out-of-home care and institutional care are reduced.

Those interested in a comprehensive description of the MHSA including specific components are referred to the following website:

http://www.dmh.ca.gov/prop_63/mhsa/default.asp
Federal child welfare legislation has focused on encouraging permanency through family preservation and adoption. While not explicitly acknowledging collaboration as a means to ensuring permanency, funding mechanisms allow for working with other service systems to procure services that enhance the likelihood of permanency.

The California Child Welfare Redesign policy initiative represents a major shift in direction for child welfare emphasizing prevention and collaboration with families, communities and other child serving systems as the means to ensuring child safety, permanency and well-being.

The Child Welfare Primer provides a good synopsis of legislation.

In order to better understand the impact of the Child Welfare Redesign on service systems refer to the web site below.
http://www.childsworld.ca.gov/PG1519.htm

Questions for Discussion / Suggested Activities:

1. Given this additional information on child welfare and mental health policy, where do you see areas of overlap and divergence? What are possible implications for collaboration?
II.4 The Intersection of Child Welfare and Mental Health

**Introduction:** This section is intended to help students examine how closer collaboration between the child welfare and mental health systems potentially impact access, utilization and outcome for children, youth and families. We argue that collaborative efforts focused on providing mental health interventions that support child welfare goals have benefits not only to clients but to improving outcomes in both service systems.

Opportunities for joint service planning and provision exist at several points along each of the systems service sequences. We will consider five points of intersection where collaboration might be especially beneficial for children and families:

1. Assessment of mental health needs
2. Mental health role in differential response in child welfare
3. Reducing the impact of trauma
4. Supporting permanency and mental health outcomes
5. Racial and ethnic disproportionality in child welfare and disparities in mental health care access and utilization

**INSTRUCTOR’S NOTES**

**Suggested Time:**
Each of the five sub-topics in this section will take a minimum of 30 minutes to present and discuss. If the case discussions are utilized, each section could last up to 90 minutes.

Instructors may choose to only focus on one topic rather than all and deepen the discussion in one area.
II.4.1 Assessment of Mental Health Need

Since the early 1980s a growing number of studies have investigated the mental health needs and services to children in the child welfare system. These studies have found high rates of mental health problems among children involved with the child welfare system, including children who are not placed out-of-home but receive home-based services.

### Potential for Reducing Out-of-Home Care

- Children who receive timely mental health assessments and access to mental health care are less likely to need out of home placement.
- This is especially important because a high number of children referred to child welfare are receiving services at home (Glisson & Green, 2006).
Benefits of Collaboration on Receipt of Mental Health Services

- Some research suggests that interagency coordination increases the likelihood that child welfare youth in need of mental health services actually receive services.
- In addition decreases in mental health disparities for African American youth have been observed (Hurlburt et al., 2004).

Slides II.4.1-1 through II.4.1-4 are intended to help students understand that: a) children who are referred to the child welfare system are very likely to have emotional and behavioral problems necessitating mental health treatment; b) timely mental health services may prevent out-of-home placement, and c) collaboration increases the probability of children receiving needed services. This seems to be particularly true for African American children.

Collaboration also has benefits for the mental health service system. Ensuring mental health assessment for children and youth increases the likelihood that they will gain timely access to services and receive the most effective interventions in the least restrictive environments. Too often a mental health assessment is requested only after numerous placement disruptions and/or psychiatric hospitalizations.
Questions for Discussion / Proposed Activities:

1. Discuss Case Study #1, questions 1-4 (see Case Study Section).

INSTRUCTOR’S NOTES

In the Case Study Section, we present four cases, which can be used as a starting point for discussion. They are presented with limited background information. Instructors should feel free to 'flesh out' the cases or introduce cases from their own experience.

It is up to the instructor to decide which questions they want to focus on. Additional questions may be added. We would, however, encourage instructors to always leave sufficient time for those questions that concern the role of the child welfare and mental health worker and which focus attention on the potential benefits of a collaborative approach to the case.

We would like to learn from instructors, which case studies and questions were helpful in fostering thinking about collaboration.

Challenges

- Despite increased recognition of the mental health needs of youth in the child welfare system, accessing mental health assessments and services continue to be problematic in most counties.
- Collaborative arrangements between child welfare and mental health service providers have the potential to contribute to a solution to this problem.
II.4.2 Differential Response

Differential response is a front-end child protective service practice that allows for more than one method of initial response to reports of child abuse and neglect. This approach recognizes that there is a great deal of variability in the nature of referrals and allows flexibility in responding differentially to different types of cases.

Differential Response Necessitates Collaboration

- Successful implementation of differential response requires that child welfare agencies develop extensive collaborative relationships with other agencies and organizations including work processes and protocols.
- Collaboration with mental health providers has the potential to ensure that timely and effective services are provided for children and families.
Differential response systems focus on assessing family strengths and needs. Families are then referred to services that fit their needs. This requires availability and coordination of appropriate and timely community services including mental health services.

SLIDE II.4.2-3

Benefits for Children and Families

- Collaboration should focus on the provision of mental health services which target the specific emotional and behavioral problems of children and families referred to child welfare – trauma, substance abuse, parental mental illness and disruptive behavior problems.
- This may result in more families receiving help to stabilize and ameliorate the circumstances that are potentially harmful to children, avoiding the need for longer term child welfare involvement.

Reference:

Questions for Discussion / Proposed Activities:

1. Using Case Study #2, discuss whether Differential Response may have been a promising way of intervening with this family. Are there arguments against using Differential Response in this case?

2. What systems would have to collaborate to address the needs of Susan and James? What challenges would you anticipate in coordinating services?
II.4.3 Trauma

By definition children entering the child welfare system are among the most vulnerable and are at risk of developing trauma-related mental health problems. Children who have been removed from their homes due to abuse and neglect and placed in substitute care have an extremely high risk of mental health problems, especially traumatic stress.

Trauma exposure among children and youth is associated with lifelong health, mental health, and substance abuse problems and with related increased costs. The impact of trauma can be mitigated by developing a care delivery and support system that is trauma-informed and focused on improving mental health functioning for children, youth and their families.

Evaluating the extent of a child’s traumatic experiences including number and frequency of placements and ensuring that the information is shared can have a direct impact on the quality of care given to the child and on the child’s well-being. In addition there are scientifically sound treatments that have proven to be effective in ameliorating the effects of trauma on children. Ensuring that children and their caregivers receive effective treatment should be a primary focus of child welfare and mental health collaboration.

The National Center for Child Traumatic Stress – funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is an excellent resource for anyone interested in learning more about the impact of trauma and effective intervention and policy responses.

http://www.nctsnet.org/nccts/nav.do?pid=hom_main
Collaboration may help to ensure early mental health intervention which is one of the goals of the Prevention and Early Intervention component of the Mental Health Services Act. Early identification and treatment holds promise for decreasing the most negative impacts of trauma exposure.

By the same token, children with trauma-related symptoms may be referred for mental health services but may never have had involvement with the child welfare system. A mental health professional/therapist may suspect child abuse, but may feel there is not sufficient evidence for a referral. Case Study #4 addresses this issue.

Questions for Discussion / Proposed Activities:

1. Discuss Case Study #3, and address questions 1 - 3.
2. Discuss Case Study #4, and address questions 1 - 3.

How Might Collaboration Help?

- Ensure that all children removed from home receive a screening for trauma symptoms
- Joint training to better understand the impact of trauma on the child and strategies for decreasing traumatic stress
- Immediate support to substitute caregivers to help children manage and cope with overwhelming emotions
- Short-term supportive intervention (at the time of removal) to help children make sense of their experiences.
II.4.4 Promoting Child Welfare and Mental Health Goals

The authors admit to a bias in favor of mental health practices and programs for children, youth and families in child welfare that are evidence-based. As previous sections of the module demonstrate, youth in child welfare, whether remaining at home or placed in out-of-home care, have high unmet mental health need. It seems reasonable to assert that they should receive services with demonstrated effectiveness. This would ensure that limited resources are invested wisely, and that the expected gains from service delivery are realized.

Furthermore, there is a growing and robust body of literature demonstrating positive effects of culturally adapted evidence-based practices for diverse racial and ethnic groups, which has the potential to reduce disparities in access and utilization. Finally, there are adaptations for youth in the child welfare system. The California Evidence-Based Clearinghouse for Child Welfare Practice has developed the Relevance to Child Welfare Scale. This scale measures the extent to which a program is deemed effective at serving the children, youth and families in child welfare versus other populations who vary in similarity to the child welfare population.
Mental health goals include providing adequate and timely access to services, delivering effective services to children and their families, and preventing need for more intensive and restrictive interventions, such as a group home or inpatient psychiatric placement.

Collaboration to Promote Mental Health Goals

- Collaboration between mental health and child welfare increases the likelihood that problems will be identified at onset when opportunities for preventing maladaptive behaviors are greatest
  - Prevents greater suffering for children
  - Decreases need for more intense and costly services

Collaboration to Promote Mental Health Goals (2)

- Collaboration may increase continuity of care for children and adolescents receiving mental health services
  - Continuity of care is critical to achieving positive mental health outcomes but is often compromised when youth are moved to a new placement without input from the mental health provider
Collaboration has the potential to help both service systems achieve better outcomes. For example, placement stability (a child welfare goal) and treatment continuity (a mental health goal) can be achieved by providing coordinated services which results in greater benefits for youth and lower economic costs to service systems.

**The Need for Collaboration**

- Ensuring that mental health services target child welfare goals and vice versa requires cross system collaboration.
- Service providers should develop frameworks for documenting how both systems support each other’s goals. This includes:
  - Exchanging information
  - Coordinating assessments
  - Planning and delivering care
- Collaboration enables all helping professionals to see the child and family in context and may prevent potentially competing priorities.

Interested students may want to explore which mental health practices demonstrate good outcomes for child welfare populations. The California Evidence-Based Clearinghouse for Child Welfare provides a wealth of information on the topic: [www.cebc4cw.org](http://www.cebc4cw.org)
Questions for Discussion / Proposed Activities:

In the preceding section we have argued that closer collaboration at the intersections of child welfare and mental health holds promise for improving the lives of children placed at risk. However, collaboration between the two service systems remains a challenge.

Now that students have some understanding of the mandates, goals, and funding structures for each of the service systems, the instructor may want to facilitate a discussion regarding barriers to collaboration at each of the intersections described in this module. Suggestions include:

1. What kinds of resource problems may prove a barrier to collaboration? Discuss each of the following:
   a. Mental Health funding
   b. Workload
   c. Eligibility requirements for mental health services

2. Do differences in system goals, policies and or mandates create barriers?
   a. Timelines (for example, child welfare workers operate under legally sanctioned time lines for making safety decisions)
   b. Consent for treatment for minor children

Conversely, students should be asked to think about what factors may facilitate collaboration. Referring back to The Jeopardy Table exercise (II.2) and reviewing areas of system overlap may be helpful.

Additionally, implications for collaboration contained within the Mental Health Services Act (Prop 63), particularly the prevention and early intervention guidelines, may be discussed. Information may be accessed from the web site listed below:

http://www.preventionearlyintervention.org/go/
II.4.5 Cultural Competency: Disproportionality in Child Welfare and Disparities in Mental Health

Introduction: This section deals with the important topic of disproportionality in the child welfare system. It draws a connection for students between disproportionality in child welfare and disparities in mental health and addresses how collaboration may be helpful in bridging the gaps.

INSTRUCTOR’S NOTES

Case Studies #1-3 (see Case Study section) can be used to discuss disproportionality.

There are multiple studies that deal with the important topics of disproportionality and disparity. We cite a few of them, but an exhaustive listing goes beyond the scope of this module.

SLIDE II.4.5.-1

Racial and Ethnic Disproportionality in Child Welfare

- Children and youth from some racial and ethnic groups are overrepresented in the child welfare system.
- The U.S. Department of Health and Human Services reported in 2003 that although African American children accounted for 15% of the population, they made up 25% of victims in substantiated maltreatment cases and 45% of children in foster care (Chibnall et al., 2003)

SLIDE II.4.5-2

Disproportionality in Child Welfare

- Disproportionality is best described as overrepresentation.
- The racial and ethnic make-up of the child welfare population is usually compared with the racial and ethnic make-up of the general population.
- So disproportionality refers to the fact that some racial or ethnic groups of children and families are represented in child welfare populations at levels that are disproportionate to their numbers in the overall family or child population (Courtney & Skyles, 2003)
Overrepresentation may be the best term to use when thinking about the race-related differences of children that have contact with the child welfare system. The term speaks directly to this fundamental concern.

**SLIDE II.4.5-3**

**Mechanisms Through Which Disproportionality Occurs**

- Entry into the child welfare system occurs at higher rates for some racial and ethnic groups
  - For example, substantiated child protective service referrals are higher for African American and Native American children
- Exits from the child welfare system (through reunification, guardianship or adoption) occur at slower rates
  - African American children have greater lengths of stay than any other group in the child welfare system

Both differences in admission and exit rates are critical to our understanding as they are both contributors to disproportionality. For example, if Native American children are overrepresented in a county child welfare system, one must look both at the proportion of substantiated maltreatment referrals and at exit rates from foster care to better understand the reasons for overrepresentation.
Students may be wondering about NSCAW. What is it?

In the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, Congress directed the Secretary of the Department of Health and Human Services to conduct a national study of children who are at risk of abuse or neglect or are in the child welfare system. In response, the Administration for Children and Families has undertaken the National Survey of Child and Adolescent Well-Being (NSCAW). The NSCAW makes available **nationally representative data** drawn from first hand reports from children, parents, and other caregivers, as well as reports from caseworkers, teachers and data from administrative records. These data have proved to be a rich resource for contributing to our understanding of the processes and outcomes for children in the child welfare system.

The NSCAW studies lend insight about the relationship between early childhood developmental needs and the receipt of services. Specifically, the findings show that race and ethnicity are strongly associated with the overall level of child welfare involvement and the receipt of services. White children are more likely to remain at home, and African American children, whether at home or in foster care, are less likely to receive developmental services than white children. Furthermore, even when white and African American children had equal need for services, African American children were less likely to receive services.
These studies of mental health need, use, and access strengthen previous findings that children in foster care have high need and that race/ethnicity is associated with less access to mental health intervention. Although African American children did not display elevated need as a group, African American children ages 6-10 did have high need for mental health services but were found to have a significantly reduced likelihood of receiving mental health care when compared to children of other ethnicities in the same age group (Burns et al., 2004).

Mental Health Disparities

- Disparity is used to describe differences in access to care, utilization of care or quality of care.
- Disparity implies an underlying connection to need.
  - Given comparable levels of need, one would expect equal utilization of services.
  - The term “unmet need” is also used in research to describe the differences between racial and ethnic groups and use of mental health services.
Access to mental health care is defined as the “timely use of personal health services to achieve the best possible outcome” (Snowden & Yamada, 2005). Although few people in need of mental health care receive it, members of racial and ethnic groups are among those least likely to receive care appropriate to their needs.
Several factors appear to explain racial and ethnic disparities in access to care. These include differences in help seeking which may favor non-mental health sources of assistance such as spiritual leaders; trust and receptiveness to treatment intervention; stigma and culturally distinctive styles of expressing mental health symptoms.

**SLIDE II.4.5-9**

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<tr>
<td>- Parental cultural factors</td>
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<td>- Values, beliefs and/or behaviors</td>
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<tr>
<td>- Level of parental acculturation found to be related to disparities in mental health service use (Ho, Yeh, McCabe &amp; Hough, 2007)</td>
</tr>
<tr>
<td>- Among children found to be at high risk for Attention-Deficit Disorder with Hyperactivity (ADHD) girls and African American children were the least likely to get an evaluation or if diagnosed to get treatment</td>
</tr>
<tr>
<td>- African American parents reported more stigma related barriers to care and expressed more negative expectations from treatment (Bussing, Zima, Gary &amp; Garvan, 2003)</td>
</tr>
</tbody>
</table>

The findings regarding acculturation need to be interpreted with caution as there is significant within group variability (see Snowden & Yamada, 2005). However, less acculturated parents who do not see their children’s emotional and behavioral problems as mental health issues are unlikely to seek treatment for their children.

Zima and her colleagues reported that 50% of children meeting the diagnostic criteria for ADHD did not receive services. In general, African American parent expressed more negative expectations from service receipt than did their Caucasian counterparts.
In a study investigating the relationship between interagency coordination and access to mental health services, Hurlburt and colleagues (2004) found that increased coordination seemed to decrease disparities for African American children. The findings from this study give reason for optimism that increased collaboration may be able to prevent disparities in mental health use for African American children who are heavily overrepresented in the child welfare system.

**Implications for Collaboration (2)**

- Collaborative practices may increase the likelihood of culturally competent service delivery.
- Options include:
  - Referral to ethnic specific service agencies
  - Home based mental health service delivery to decrease barriers in access
  - Wraparound services to increase neighborhood and faith based service mental health service delivery
Questions for Discussion / Proposed Activities:

Choose one of the Case Studies and address the question related to the racial/ethnic background of the case.

1. Discuss Case Study #1, and address Question #5.
2. Discuss Case Study #2, and address Question #4.
3. Discuss Case Study #3, and address Question #5.

INSTRUCTOR’S NOTES

Instructors may want to focus this discussion on the case students are most familiar with.
SECTION III

THEORIES AND EXPLANATORY MODELS OF COLLABORATION

or

What Makes Collaborations Work or Not?
III. Theories and Explanatory Models of Collaboration or

What Makes Collaborations Work or Not?

Introduction: In this section, students are introduced to potentially useful explanatory models of collaboration. To date, there are no ‘grand theories’ of collaboration, but there are theories and explanatory or conceptual models, which aid in understanding factors that facilitate and hinder collaborative efforts.

Existing theories or models have tended to focus on the organization itself and in some cases on individuals in organizations, but not generally on the actual interorganizational domain. Many of the current theories apply to business and industrial organizations and have limited relevance to human service organizations.

Given the focus of this Curriculum Module, we have chosen conceptual models which capture dimensions that are useful to a better understanding of collaboration between child serving systems. In addition, we introduce a few theories that have come out of social psychology and sociology and address barriers as well as facilitative factors at the individual level (rather than the organizational level).

It is our belief that graduate students need to be able to think and argue theoretically. This section will provide basic tools for this process. We have made great efforts to keep this section applied and believe that the guided questions and activities will be useful.

This section has three parts:

1. Introduction

2. Conceptualizations of Collaboration
   • The continuum of collaboration
   • Key ingredients of collaboration
   • A developmental model of collaboration

3. Other Relevant Explanatory Models
   • Social Identity Theory
   • Social Exchange Theory
   • Role Theory
   • Street-Level Bureaucracy

INSTRUCTOR’S NOTES

Suggested Time: 90 min – 3 hours

It will be up to the individual instructor to decide how much s/he wants to delve into this section. In-depth discussion of this section is likely best suited for graduate students, but sections could also be used for students at the undergraduate level. We particularly recommend the section ‘Key Ingredients of Collaboration’ (Part 2 – Conceptualizations of Collaboration) as it covers barriers and facilitators of collaboration within the framework of a conceptual model.

Instructors may want to provide a broad overview of the models, using some of the questions and activities to go into depth.

Other instructors may just want to focus on one model and spent significant time on that model. Addressing all models in depth will likely be too much.
III.1 Introduction

SLIDE III.1-1

Explanatory Theories of Collaboration

“Collaboration is a promising mode of human engagement but in order to become more than a passing fad, a theoretical structure and framework are needed to guide individuals and groups toward successful collaboration.”

(John-Steiner, 1992)

This slide simply accentuates the need for theoretical frameworks.

SLIDE III.1-2

Explanatory Theories of Collaboration (2)

- No grand or general theory of collaboration
- “No consensus ...on either an operational definition or theoretical foundation of collaboration” (Welch, 1998, p.2)
- Organizational theory development has been lagging behind practice

The next two slides summarize what was stated in the Introduction to Section III (p.43).
This slide addresses the complexity of collaborative alliances. Few studies and theories have captured this complexity.

Explanatory Theories of Collaboration (3)

- Theories have tended to focus on the organization itself and in some cases on individuals in organizations but not generally on the actual interorganizational domain
- Many of the theories apply to business and industrial organizations and have limited relevance to human service organizations (Gray & Wood, 1991; Wood & Gray, 1991).

Explanatory Theories of Collaboration (4)

- Conceptual models and studies ought to consider the multi-level context of collaboration including
  - The demographics of the larger community
  - The characteristics of a service network
  - The characteristics of specific interorganizational linkages
  - The characteristics of the interpersonal linkages

(Whetten, 1982)
What is the purpose of theory? Theories are tools for understanding, explaining and making predictions about a given phenomenon. To be useful what should a theory explain about collaboration? The slide presents examples of questions that would need to be answered in order to advance the knowledge base on collaboration.

Questions for Discussion / Proposed Activities:

1. Formulate questions of interest specific to the relationship between the child welfare and mental health system. For instance: What would we need to know about collaborations between child welfare and mental health? What questions need to be asked to increase the chances of success for collaborations between the two systems?
III.2 Conceptualizations of Collaboration

Introduction: This section introduces students to a variety of ways that collaboration has been conceptualized in the literature: the continuum of collaboration, key ingredients for collaboration and a developmental model of collaboration.

Section III.2.1 will be based on a 2007 publication by Horwath and Morrison entitled Collaboration, integration, and change in children’s services: Critical issues and key ingredients, published in the journal Child Abuse and Neglect. We found the concepts introduced in this article to be relevant and helpful.

A developmental framework for collaboration was introduced by Hodges, Hernandez and Nesman in 2003. It may be helpful for assessing the current stage of a collaborative effort and taking steps to strengthen the process (see Section III.2.3).

References:

III.2.1 The Continuum of Collaboration

Introduction: This section is based on the Horwath and Morrison article referenced above.

SLIDE III.2.1-1

Levels of Collaboration

- Collaboration around individual service users
- Collaboration around delivering local services
- Whole service system integration

(Miller & McNicholl, 2003; Waldfogel, 1997)

Some authors approach collaboration in terms of level or degree of service integration. “At the simplest level, the focus is on collaboration around individual service users. The next level refers to staff working together to deliver local services. The highest degree of integration occurs when whole systems collaborate with regard to the planning, commissioning and management of services” (Horwath & Morrison, 2007, p.56).
Other authors have thought of collaboration as occurring along four dimensions: formalization, intensity, reciprocity and standardization. The slide provides definitions of each of these terms.

**Dimensions of Collaboration**

- **Formalization**: agreements/contracts that delineate the degree to which agency autonomy is to be ceded in the partnership
- **Intensity**: range of activities and resources
- **Reciprocity**: equality or power imbalance between partners
- **Standardization**: clarity of delineation as to the 'units exchanged'

(Marrett, 1971; Ovretveit, 1996)

Pass out the handout and have students discuss their first impressions of the model. It is important to emphasize that the terms low-level collaboration and high-level collaboration are not value judgments. There are many situations in which low-level collaboration may be the most appropriate and most efficient form of collaboration.
As shown in the previous section, the terminology used to capture collaboration is not very precise. The term is used to describe a range of ‘working-together’ arrangements. In their review of the literature, Horwath and Morrison (2007) identified five arrangements: communication, co-operation, co-ordination, coalition, integration. The definitions of these terms are presented in the next slide (Slide III.2.1-4).

These working arrangements can be arranged along a continuum from low-level collaboration to high-level collaboration. The slide depicts the two ends of this continuum. It is important to emphasize that the terms low-level collaboration and high-level collaboration are not value judgments. There are many situations in which low-level collaboration may be the most appropriate and most efficient form of collaboration.

**SLIDE III.2.1-4**

The Continuum of Collaboration

- **Communication**: individual from different disciplines talking together
- **Co-operation**: low key joint working on a case-by-case basis
- **Co-ordination**: more formalized joint working, but no sanctions for non-compliance
- **Coalition**: joint structures sacrificing some autonomy
- **Integration**: organizations merge to create new joint identity

(Source: Horwath & Morrison, 2007)

These are the definitions of the five collaborative arrangements.
This slide presents the points made earlier (see Slide III.2.1-3) that high- and low-level collaboration may be appropriate in different situations. It is also important to emphasize that high-level collaboration, e.g., full service integration can “have a price.” For instance, individual agencies may have to give up a certain degree of autonomy, and the unique identity of an agency can be challenged. In addition, full service integration may require focus on systems, structure and funding, and as such may avert focus from client-oriented goals.

Questions for Discussion / Proposed Activities:

1. What are the dis/advantages of each of the five collaborative working arrangements? Provide examples of situations in which each of these arrangements might be appropriate or inappropriate.

2. Based on your own experience, provide examples of different types of collaborative arrangements between child welfare and mental health systems.
The conceptual model in this slide addresses key ingredients for collaboration. As such it captures both barriers and facilitating factors for collaborative working arrangements. While the model does not specify the relationship between specific variables, it presents essential dimensions to consider in collaboration.

The model is based on Challis et al. work (1988), which developed a model of collaboration based on three key components: machinery, process and outputs. The model was subsequently expanded by Horwath and Morrison. Slides III.2.2-2 through III.2.2-10 describe each of the dimensions and ingredients.
The first dimension in the model is called ‘predisposing factors.’ According to the model, a history of agency relations, existing informal networks and individual agency cohesion are factors that “predispose” agencies for successful or unsuccessful collaborative partnerships.

Few studies have examined the relationship between intra- and interagency working, but the limited research suggests “that the quality of inter-agency collaboration is highly influenced by the intra-agency environment of each constituent agency” (Horwath & Morrison, 2007, p.59). Not surprisingly, agencies that lack resources, have poor morale and weak leadership make less effective collaborative partners. Similarly, an agency's history of formal and informal networking – whether positive or negative – shapes subsequent collaborative efforts.

The importance of the intra-agency environment has been confirmed by Charles Glisson and his colleagues’ research. They found that collaborative practices are more common when organizational climates are conducive to such practices. Facilitative factors for collaborative practices included shared perceptions about the work environment and role clarity. Role overload and emotional exhaustion, on the other hand, constituted barriers to collaboration (Glisson, 2002; Glisson & Hemmelgarn, 1998).
Horwath and Morrison also mention class, gender and racial identities as important factors that may hinder or facilitate collaborative relationships. These are factors that will be considered later in this module (see Section III.3) within the context of interpersonal or process-related barriers to collaboration.

To ensure successful collaboration, there is a need to assess the capacity of member agencies to collaborate. This may include an assessment of resources to sustain joint working as well as an assessment of the “level or degree of activity or degree of change a collaborative relationship can sustain without any partner losing security in the relationship” (Hudson et al., 2007, p.60). “An underestimation of capacity can mean that collaboration is restricted to marginal tasks, while overestimation will result in unrealistic expectations” (Horwath & Morrison, 2007, p.60).

Questions for Discussion / Proposed Activities:

1. Think of a collaborative effort that you have been part of, either in your classes or in an agency. Identify predisposing factors that may have presented barriers to this effort or may have facilitated it.

2. Identify predisposing factors in the child welfare and mental health system that may present barriers to collaboration or may support such efforts.

INSTRUCTOR’S NOTES

Instructors may first want to focus this discussion on child welfare and mental health systems in general. The discussion may then become more specific and focus on the child welfare and mental health systems students are familiar with.
The second dimension in the model is called “Mandate.” It refers to the “need, authority or requirement for collaboration” (Horwarth & Morrison, 2007). Mandates include legislative directives and funding specifications. At times, collaborative alliances have been prompted by class-action lawsuits.

It needs to be noted that collaborative efforts are often undermined by conflicting government initiatives and directives, changing performance targets and funding priorities.

Even within the context of existing mandates, collaborative efforts are helped when there is a “shared recognition of the need for collaboration” (p.60). What are the potential gains that each agency expects from this partnership?

Others have suggested that anxiety can be a strong motivating factor for or against collaboration, especially in high risk fields, such as child protection. A shared burden may mean shared accountability and thus dispel external pressure. On the other hand, sharing responsibility for decisions that carry great weight may also increase liability; this may make an agency less inclined to collaborate.
While mandates and incentives for collaborative activity are necessary for collaboration to occur, they are not sufficient to guarantee effective implementation. Shared values, perceived gains for all involved parties, political consensus and systematic reinforcement are viewed as necessary to build effective alliances and maintain them.

**SLIDE III.2.2-4**

<table>
<thead>
<tr>
<th>Mandate (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a difference between agreed upon mandates and actual interpretation</td>
</tr>
<tr>
<td>Mandates need to be translated into shared goals</td>
</tr>
<tr>
<td>Meta-goals</td>
</tr>
<tr>
<td>Individual agency goals</td>
</tr>
<tr>
<td>Individual agency representative goals</td>
</tr>
<tr>
<td>Strategic planning and commissioning is crucial in translating shared goals into achievable outcomes.</td>
</tr>
</tbody>
</table>

Beyond the problems mentioned above, research has also found differences between agreed upon mandates and actual interpretation of these mandates by each collaborative partner.

An important step toward successful collaborations is to translate mandates into meaningful and shared goals. These should be part of an overall strategic plan.

Establishing goals may be more complex than first thought because of differences in the use of language, organizational cultures and procedures. Lipsky (1980) in his model of street level bureaucracy (also see Section III.3.4; p.77) noted that goals set by senior managers, for instance, may be differently interpreted by front-line practitioners.

It may be helpful to distinguish between three different types of goals (Huxham & Vangen, 1996, p.9).
• **Meta goals**: Overarching aims of the collaboration

• **Individual agency goals**: May not be directly related to the meta goals, but will influence the contribution of individual agencies

• **Individual agency representative goals**: These goals usually remain hidden, but can influence a collaborative effort.

The explication of goals is viewed as a critical ingredient to successful collaborations (Knitzer, 1982). External directives to collaborate do not necessarily translate into compliance or clearly delineated goals.

**Questions for Discussion / Proposed Activities:**

1. What can lead to different interpretations of goals?

2. How would you go about clarifying goals? Be specific and draw on your experience with collaborations.

3. Identify a collaboration that you are familiar with. Identify meta, individual agency and individual agency representative goals. Discuss potential barriers for the collaborative effort and resultant effects. How could such barriers be overcome? How can different goal sets be aligned to lead to a successful collaboration?

Question 3 lends itself to both discussion as well as a written assignment.
Membership and Leadership make up the third domain in this model. An important step to successful collaborations is the identification of appropriate members.

1. Who sits at the table?
2. Do they all have the same stake?
3. Who determines the agenda? (issues of status and power)
4. Difficulties of changing membership
5. Should service users be involved in the collaborative?
6. Importance of leadership – “collaborative champion”

These are crucial questions that may reveal power differentials that can lead to tension and hidden agendas among collaborative partners.

Another factor that can destabilize the building and maintaining of a collaborative alliance is changing membership.

1. What consequences could a change in membership have on a collaborative effort?
2. How could a negative impact of changing membership be counteracted?

INSTRUCTOR’S NOTES

Small group dynamics play an important role in understanding collaboration. Instructors may want to reference concepts and ideas from classes that students have taken in group work. Students could be referred to readings on task groups and group dynamics. Some of these issues are addressed in Section III.3, p.67ff.

In this section, discussion questions are introduced throughout the text rather than at the end. Instructors may want to use these questions to deepen the discussion.
The involvement of service users in collaborative efforts has become a critical issue in child-serving systems and is sometimes an issue of contention. “The meaning of ‘user participation’ varies widely between agencies” (Howarth & Morrison, 2007).

1. How are service users or consumers viewed by the child welfare system / mental health system, respectively?

2. At this point, the Image Exchange Activity (Module II.1) could be adapted to have students from each service system describe their view of “their” and “the other system’s” client population.

3. Discuss where different perceptions about child welfare and mental health clientele may stem from?

Leadership style is another crucial factor in successful collaborations that was already mentioned by Knitzer in 1982 when she criticized the fragmentation of services to children and families. Being able to engage collaborative partners and to guide them through challenging issues is an important ability or gift. The term “collaborative champion” has been used for such individuals (Hallet & Birchall, 1992; Hudson et al., 2003). The characteristics of such leaders are mentioned on the next slide.
The importance of leadership will later be illustrated through real-world examples of successful collaborative models (see Integrated Services Systems, Humboldt County, Section IV).

1. Provide examples from your own experience as student of worker in the child welfare or mental health system where effective or ineffective leadership made the difference in the success of a collaborative effort.

On Leaders…

“These are committed, energized individuals who have high levels of credibility, influence, charisma and integrity, acknowledged both internally and externally by other agencies. They possess high quality interpersonal and networking skills, which enable them to negotiate the interfaces, ambiguities, tensions and turf issues, which exist between and within agencies. They provide the confidence and reassurance that is required for the kinds of innovation and risk-taking without which collaboration may add little or no value.” (Horwath & Morrison, 2007, p.61)

The importance of leadership will later be illustrated through real-world examples of successful collaborative models (see Integrated Services Systems, Humboldt County, Section IV).

1. Provide examples from your own experience as student of worker in the child welfare or mental health system where effective or ineffective leadership made the difference in the success of a collaborative effort.

Machinery

“If members are unclear about the structures of the collaboration, they cannot be clear where the accountabilities lie” (Huxham & Vaugen, 2000, p.800).

- **Governance** refers to the need to define the nature and extent of collective responsibility for which the partners will be held accountable.
- **Systems and structures** are a vehicle for formal control between organizations to ensure desirable behavior between members.
- **Practical issues** include physical location, access to equipment and resources, information exchange, issues of boundaries, etc.
Machinery generally refers to the structure and form of the collaborative alliance. In the model, three items are addressed: governance, systems and structures, and practical issues:

- **Governance**: Clear policies and lines of accountability are necessary for effective collaborative alliances
- **Systems and structures**: Provide consistency across different systems
- **Practical issues**: Each collaborative alliance needs to decide on pragmatic issues, such as where to meet, who provides resources, etc. If not addressed explicitly these issues can lead to frustration and tension.

**SLIDE III.2.2-8**

Process refers to the interactional and relational component of collaboration
- Values
- Trust
- Role clarity
- Communication
- Managing change

Process refers to the inter-relational aspects of collaborative alliances. Different values, lack of trust and clarity about roles, miscommunication and difficulties in managing change can be barriers to effective collaboration.

These process-related barriers can be significant stumbling blocks in collaborative efforts and deserve a more in-depth discussion. The next section ‘Other Relevant Explanatory Models’ will address these issues further and will provide questions and activities for additional discussion.
Horwath and Morrison’s model does include a focus on outcomes, thereby emphasizing that collaboration is ultimately aimed at improving outcomes for clients. This has also been called “results-based” collaboration (Page, 2002).

In many human service systems, outcomes were for a long time narrowly defined in terms of ‘outputs.’ How many clients were served? How many clients accessed a service? etc. While such information may provide important information about service disparities, a more refined, and likely useful way is to conceptualize outcomes in terms of the quality and effectiveness of services on targeted client outcomes.

Questions for Discussion / Proposed Activities:

1. Identify expected outcomes for child welfare and child mental health.

2. Where is overlap?

3. Where is divergence?

4. What other outcomes should be considered?
Questions for Discussion / Proposed Activities:

1. Please critique Horwath and Morrison’s model in its usefulness to understanding collaboration.

2. How has the model helped you think about collaboration?

3. Where do you see need to modify/expand the model?
III.2.3 A Developmental Model of Collaboration

Introduction: This developmental framework for collaboration is based on findings from a study on promising practices in children's mental health (Hodges, Nesman & Hernandez, 1999). The framework can be used by child-serving systems "to assess their current stage of collaboration" and "to consider opportunities for building collaborative processes across child-serving agencies" (Hodges et al., 2003, p.292). (For more information about the project and the study, students are referred to the Hodges et al. article).

There have been other efforts to delineate stages of collaboration (Elmer & Lein, 1994; Kagan, 1991; National Network for Collaboration, n.d.). The stages in Hodges et al.'s developmental model for collaboration are derived from qualitative data collected as part of semi-structured interviews with a range of social service administrators and staff. This means that the conceptualization of the stages and their characteristics emerged from interviews with service providers.

The two next slides show the defining characteristics and collaborative activities for the stages and are based on the table created by Hodges et al. (p.299).

Reference:

INSTRUCTOR'S NOTES

Suggested Time: 20-45 minutes

Handouts of the model are available in the Handout Section.

We recommend instructors read the Hodges et al. article before presenting this section of the module. It is available in the Articles Section.
### A Developmental Framework For Collaboration (cont’d)

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Defining Characteristic</th>
<th>Collaborative Activities</th>
</tr>
</thead>
</table>
| #4: Professional Collaboration | *Collaboration effective at agency level, program level, and practice level*  
*Agreed upon guidelines and procedures for collaboration*  
*Shared responsibility*  
*Group decision-making*  
*Pool of collaborative funds*  
*Established collaborative culture (shared vision, goals, language)* | *Regular meetings of collaborative bodies for purpose of guiding collaborative service delivery and reviewing effectiveness of collaborative processes*  
*Training to reinforce collaborative efforts at all levels of child-serving organizations*  
*Formal interagency agreements* |
| #5: True Collaboration | *Families as full partners in service delivery*  
*Role clarity for families and service providers*  
*Broader community involvement in collaboration (extending beyond mental health, child welfare, juvenile justice and education)*  
*Interdependence and shared responsibility among stakeholders*  
*Vision-driven solutions* | *Include activities of professional stage of collaborative development, but are qualitatively different because of the full partnership of family members* |
Questions for Discussion / Proposed Activities:

1. Choose a collaborative effort that you have been involved in and use this framework to describe the development of the collaboration. Reflect on challenges and processes that may have furthered the development of the collaborative effort.

2. Interview one or two service providers from child welfare and/or mental health about a collaboration they have been involved in. Ask them to discuss the development of this collaboration.
III.3 Other Relevant Explanatory Models

**Introduction:** In this section we go back to some of the 'process' issues addressed in Horwath and Morrison’s model. These were referred to as the interactional and relational aspects of collaboration. Students already discussed some of the potential process-related barriers, such as lack of trust, poor communication, etc.

Here we introduce a few theories and concepts that offer explanations as to the difficulties of working together effectively. The theories/models are:

- Social Identity Theory
- Social Exchange Theory
- Role Theory
- Street Bureaucracy

**SLIDE III.3-1**

**Summary:**

**Process-Related Barriers**

- Negative beliefs and attitudes about collaboration (e.g., lack of commitment, lack of motivation)
- Negative appraisals of collaboration partners (e.g., power differentials)
- ‘Us vs Them’ professional identity
- Biases
- Unrealistic expectations
- Problem-solving skills/styles (e.g., coping strategies, conflict resolution skills)
- Interpersonal skills/styles (e.g., empathy, communication skills, self-awareness)
- Sociodemographic characteristics (race/ethnicity, age, gender)

To get started, students may want to recall some of the process-related barriers to collaboration.
A number of studies have investigated personal characteristics and process-related barriers in relation to various practices, including inter-professional collaboration, knowledge sharing, innovation diffusion and adoption of evidence-based practices. Findings about the effect of personal characteristics (e.g., age, gender, race/ethnicity) on such practices have been mixed, meaning in some studies they have been found to have an effect, in others they have not. However, higher education of workers seems to be associated with greater openness toward new practices and a higher likelihood that new practices are indeed adopted.

Findings from other studies have found that individuals are more open to new ways of “doing their job” when they (1) believe that it is easy to implement; (2) have an openness toward knowledge sharing; (3) when the new way of practicing fits with their ‘usual way’ of practicing; and (4) when they have a commitment to the purpose of an agency and this commitment and belief are shared with their colleagues (e.g., Aarons, 2004; Glisson, 2002; Sandfort, 1999). Shared beliefs and a common commitment seem to be particularly relevant as they influence how staff interprets interactions with other agencies. One way that a climate of commitment and shared beliefs can be promoted is through the daily interactions and routines in an agency (Sandfort, 1999).
In addition, service provider knowledge and skills and normative pressures can either hinder or facilitate collaborations. With regard to knowledge, service providers’ appraisal of needs and problems tends to be shaped by their training. This means that professionals who are trained to think and work collaboratively are more likely to apply a team-working approach. Conversely, without such training, professionals are more likely to fall back on practices that were part of their professional socialization. It needs to be emphasized that not every client situation asks for a collaborative approach, and in some cases such an approach may in fact be counterproductive. As such, it is always important to choose the method that is most likely to produce the best outcome for the client.

Normative pressures relate to the organizational culture and its expectations. Are staff expected to work together? Is collaborative work viewed as a “waste of time?” What are the incentives or disincentives for working collaboratively on cases? What are the implicit and explicit norms and directives about collaboration?
III.3.1 Social Identity Theory

The first theory we introduce is **Social Identity Theory**. This theory offers a useful model to understanding barriers to collaboration. Developed by Tajfel and colleagues in the late 1970s, the theory explains how people develop a sense of membership and belonging in particular groups, and how intergroup discrimination develops.

Tajfel proposed that each individual holds several identities. Which of these identities is most salient and may determine behavior will vary based on the social context. Perceived group membership is believed to exert great influence on people’s behavior. The theory further suggests that individuals tend to distinguish between in-groups and out-groups, assigning positive value to their own group. Identifying with a group lends positive esteem and a sense of belonging.

The theory also addresses issues of differential status (high vs low status groups). This is of particular relevance to collaborations between Child Welfare and Mental Health as the individuals from the two different groups may perceive themselves at different “levels” (e.g., a mental health clinician with a master degree might view him/herself as better trained than a child welfare worker, which might lead to barriers in collaboration).
Social identity theory proposes several mechanisms through which low-status groups may want to “improve” their position: (1) moving to another group (e.g., obtaining a graduate degree; switching service systems – this may not always be desired or viable); (2) direct competition (e.g., proving to oneself and members of the other group that the ‘low-status’ assignment was unjustified); (3) redefining negative elements of group identity along different dimensions where members of a low-status group may compare more favorably.

Questions for Discussion / Proposed Activities:

1. Choose a collaborative effort that you have been involved in and use this theory and its concepts to explain why the collaboration worked or did not work.

2. What relevance does this theory have to understanding collaboration between Child Welfare and Mental Health?
III.3.2 Social Exchange Theory

Social Exchange Theory has roots in economics, psychology and sociology. It posits that all human relationships are the result of an exchange process, and boil down to a subjective cost-benefit analysis. When the risks outweigh the rewards, individuals will terminate or abandon a relationship. If the benefits are perceived to be greater than the risks, individuals stay engaged.

Four factors determine the level of engagement:

1. anticipated reciprocity
2. expected gain in reputation and influence on others
3. altruism and perception of efficacy
4. direct reward

INSTRUCTOR’S NOTES

Social Exchange Theory

- Important contributors: Hoekstra, Homan, Blau, Thibaut, Kelley
- Proposes that social behavior is the result of an exchange process. The purpose of this exchange is to maximize benefits and minimize costs.
- People weigh the potential benefits and risks of social relationships. When the risks outweigh the rewards, people will terminate or abandon that relationship.
- Factors that determine engagement in social exchange: (1) anticipated reciprocity; (2) expected gain in reputation and influence on others; (3) altruism and perception of efficacy; (4) direct reward
Questions for Discussion / Proposed Activities:

1. Choose a collaborative effort that you have been involved in and use this theory and its concepts to explain why the collaboration worked or did not work.

2. What role did the 4 factors play in maintaining or undermining the collaboration?

3. What relevance does this theory have to understanding collaboration between Child Welfare and Mental Health?
III.3.3 Role Theory

Role theory uses the metaphor of the ‘acting stage’ to understand behaviors. It views individuals' behavior as an acting out of socially defined categories (e.g., mother, child welfare worker, therapist). Roles are occupied by individuals who are considered the “actors.” Each role carries with it expectations, rights and duties. The theory posits that individuals tend to behave in predictable ways, and this behavior is context-specific and determined by social position and other factors.
Role theory posits several propositions about social behavior. Here are a few that have particular relevance to understanding collaboration:

1. Social roles are guided by social norms, which are commonly accepted and define appropriate and permitted forms of behavior;

2. When individuals approve of a social role, they will incur costs to conform to role norms, and will also incur costs to punish those who violate role norms;

3. Changed conditions can render a social role outdated or illegitimate, in which case social pressures are likely to lead to role change;

4. The anticipation of reward and punishments, as well as the satisfaction of behaving in a pro-social way account for why individuals conform to role requirements;

5. Role conflict occurs when a person is expected to simultaneously act out multiple roles that carry contradictory expectations.
Questions for Discussion / Proposed Activities:

1. Choose a collaborative effort that you have been involved in and use this theory and its concepts to explain why the collaboration worked or did not work.

2. What relevance does this theory have to understanding collaboration between child welfare and mental health? Apply the propositions to make your case.
The concept of **street-level bureaucracy** was first coined by Michael Lipsky in 1980. Street-level bureaucrats include police officers, fire fighters and other professionals (including social workers) who provide services to ordinary citizens and implement public policy. He asserted that "policy implementation in the end comes down to the people who actually implement it." As such, street-level bureaucrats are viewed as part of the “policy-making community.”

Given limited resources and other challenges encountered in the provision of services (e.g., involuntary clients), street-level bureaucrats frequently use their discretion in implementing laws and policies. This has been viewed as both positive and negative. A researcher from the University of Kansas actually showed that “workers' beliefs about the people they interact with continually rub against policies and rules" and that the treatment of clients by street-level bureaucrats is shaped by their prejudices. This means that the values and beliefs of individual service providers may ultimately be more instrumental than a stated policy.
Questions for Discussion / Proposed Activities:

1. What relevance does this theory have to understanding collaboration between Child Welfare and Mental Health?

2. Going back to the Image Exchange Activity, what beliefs and prejudices about Child Welfare or Mental Health professionals may stand in the way of effective collaboration?

3. How do such prejudices develop? How are they maintained? How can they be overcome?

4. Provide an example of a collaborative effort that was hindered by “prejudices” you held about your “team-mates.” How could this situation have been addressed differently?
To finish the discussion on facilitators and barriers to collaboration, we want to look at a study that tested the effects of organizational-level as well as process-related or individual-level influences simultaneously. The study was conducted by Brenda Wilson and Cristina Mogro-Wilson. It addressed inter-agency collaboration between child welfare and substance abuse treatment. It specifically examined which organizational conditions and staff characteristics would promote or hinder collaborative practices between the two service systems. The researchers interviewed 216 frontline staff and 20 administrators and asked them about specific collaborative practices. Organizational-level influences were measured in terms of organizational policies and climate. Individual-level influences included staff beliefs and attitudes toward collaboration, knowledge and skills and normative pressures (for more detail on how each variable was operationalized and measured, students are referred to the original article).

The study found that most of the variation in collaboration was explained by individual-level variables. Staff members’ attitudes and beliefs about collaboration, their knowledge and skill sets along with their perceptions about organizational norms toward collaboration promoted collaborative practice.
Instead, the number of pro-collaboration policies (an organizational-level variable) were not related to "more" collaboration.

The study suggests that policies alone will not be sufficient in promoting collaborative practices. Mandates for collaboration do not necessarily translate into effective implementation of such mandates. Individual staff members implement policies based on their own perceptions, attitudes and knowledge. While a supportive organizational structure is important to develop and sustain collaborative partnerships, the ultimate gatekeepers are the individual workers and staff that engage in these partnerships.

A 2010 article by Janssens and colleagues entitled “Conceptualizing collaboration between children’s services and child and adolescent psychiatry: A bottom-up process based on a qualitative needs assessment among the professionals” supports this view. It showed that many professionals resist top-down efforts at collaboration because they fear to lose their professional autonomy and identity and do not feel valued in their expertise. This means that much effort needs to be placed into teaching staff about the value of collaboration and exposing them to positive collaborative experiences.

References:

SECTION IV

HOW DOES COLLABORATION WORK AT THE INTERSECTION OF CHILD WELFARE AND MENTAL HEALTH?

OR

LEARNING FROM MODEL PROGRAMS
IV. HOW DOES COLLABORATION WORK? OR LEARNING FROM MODEL PROGRAMS

Introduction: Earlier sections of the module provided models of collaboration derived from the research literature. In this section we provide examples of collaborative structures developed and implemented in real-world service systems in California. The specific counties and programs were chosen because each demonstrates the characteristic features of different levels of interagency collaboration.

SLIDE IV.1

Models for Collaboration

1. Integrated Service Systems: Example Humboldt County
2. System of Care: Example Placer County
3. Coordinated Service Delivery: Example Wraparound
4. Evidence-Based Practices: Examples ‘Incredible Years’ and ‘Multidimensional Treatment Foster Care’

Four models for collaboration will be examined within the context of specific examples:

1. Integrated Service Systems
2. System of Care
3. Coordinated Service Delivery
4. Evidence-Based Practices

INSTRUCTOR’S NOTES

We understand that instructors may have limited familiarity with the models presented here. The slides are relatively self-explanatory, but without knowledge of the specific models, it will be challenging to provide a lot of background information. Instructors may want to visit the websites for Humboldt and Placer County, or may want to limit their presentation to the models they are most familiar with.

We have chosen some of the best examples in CA; however, instructors may also be familiar with other successful collaborative efforts and may prefer to present those examples.

It may also be advisable to invite a guest speaker from a county child welfare or mental health agency who could talk about model collaborations between their agencies.
There are few service systems, which are truly integrated. Characteristics of such systems include (1) unified management systems; (2) pooled funds; (3) common governance; (4) whole systems approach to training, information and finance; and (5) a single assessment and shared targets.
We begin with Humboldt County as it provides the only example in California of a completely integrated service system. Shared administrative structures and funding have helped to create an evidence-based, outcome-driven service system and one in which effective services for child welfare families have been a focus of attention.

The next slides will discuss some of the key features of this system. Most of them are relatively self-explanatory, and no additional text may be provided.
This chart shows the organizational structure of Humboldt County’s integrated Health and Human Services Agency.

Questions for Discussion / Proposed Activities:

1. Obtain organizational charts from your county child welfare and mental health systems and compare them with this one.

2. Discuss how this organizational structure demonstrates collaboration.

3. Discuss what implications this organizational structure may have for service delivery.
Humboldt Mental Health-Foster Care Goals

To stabilize and maintain youth in the least restrictive placement setting...

- Every youth in foster care is assessed for behavioral and physical health services.
  - Emergency requests are referred the same day for immediate intervention.
  - Urgent requests are scheduled within two working days.
  - Intermediate and lower level requests are scheduled within 5 days.

Humboldt Mental Health-Foster Care Goals (2)

- If assessed to need behavioral health services, a treatment plan is developed by a mental health clinician which may include:
  - Individual, group and/or family counseling
  - Case management services
  - Referral to an Evidence-Based Practice
  - Medication evaluation and support services
  - Wraparound services
  - Therapeutic Behavioral Services

- Permanent connections for all youth transitioning out of foster care.
"How did we do it?"

**DATA TRACKING**
- Youth in the Permanency Planning (PP) Units were cross-referenced in both the CYFS and CWS/CMS electronic data management systems and a single data tracking tool was developed.
- Program Managers and Supervisors from all three branches continue to meet weekly to review the PP unit caseload and to identify youth in need of either a MHST and/or assessment. Public health needs were also reviewed to insure that youth are receiving medical and dental care.

**INTEGRATION**
- The Program Managers from CYFS and CWS met to identify youth in the PP units who were in need of an assessment.
- Processes were reviewed to streamline referrals and the data tracking tool was expanded to include public health information.

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"How did we do it?" (2)

**POLICY and PROCEDURES**
- Policy and Procedures for referring youth from CWS to CYFS were reviewed and distributed to all integrated staff cross discipline.
- Training on the need for mental health services, for youth in foster care, was provided across disciplines to insure that coordinated support was provided to every youth in care.

**STAFFING (Initial)**
- 10 Case Managers, 2 Mental Health Clinicians and a Supervising Clinician were assigned to the project.
**Next Steps**

- Comprehensive mental health assessments for all youth in the Family Reunification Unit are also being provided to ensure that all youth needing behavioral health services are receiving them. Children new to care are being screened and referred for mental health assessments as an “urgent” referral with assessments provided within two working days of the referral whenever possible.

**Next Steps (2)**

- Data collection of outcomes: clinical scales, placement stability, frequency of placement changes, successful completion of high school, transition to independence.

- Develop specialized services for those who are not in a natural home setting.

- Assess and expand effective behavioral health approaches (e.g. Trauma-Focused Cognitive-Behavioral Therapy).
Differential Response

- Differential Response is an alternative way of responding to the reports of child abuse and neglect that child welfare agencies receive.
- Differential Response offers three paths for ensuring child safety that include engaging families whenever possible.
- All Differential Response data are in an early developmental stage and numbers may be subject to adjustment over time.

Differential Response is Built Around 3 Guiding Principles:

1. Children are safer and families are stronger when communities work together.
2. The earlier family issues are identified and addressed, the better children and families do.
3. Families can resolve issues more successfully when they voluntarily engage in services, supports, and solutions.
Humboldt County
Three Differential Response Paths:

**Path 1: Community Response** – Allegations do not meet statutory definitions of abuse/neglect; indications that a family could benefit from community services. Currently, Family Resource Centers or Alternative Response Team.

**Path 2: CWS and Community Response** – Allegations meet statutory definitions of abuse/neglect. Usually chosen when no immediate safety risks exist. CWS social workers team with staff from other county agencies, either Public Health, Mental Health or both.

**Path 3: CWS Response** – Allegations meet statutory definitions of abuse/neglect. Usually chosen when an “immediate” response is necessary. Some Path 3 responses are partnered with Mental Health or Public Health if time allows.

Integrated Services – Humboldt Country

- A system 10 years in the making
- Enabling legislation
- Visionary leadership with long term commitment to the community
- Long range planning beginning with an infrastructure
- Centralized administration with decentralized service units
- Face to face meetings with stakeholders
Questions for Discussion / Proposed Activities:

1. The Humboldt County integrated services model generated lively discussion in our workshops. Most participants did not think it could be replicated in other counties and that its success is due in large part to the size of the county. What other factors contributed to the creation of their integrated services model?

2. Could part of the model be replicated? For example the Mental Health/Child Welfare differential response collaboration?

3. Using Horwath & Morrison’s ‘Ingredients for Collaboration’ slide (III.2.2-10ff.), examine this model and assess which of the ingredients are present and might help to explain the “success” of the collaboration.
IV.2 System of Care

**Introduction:** The second model we describe, System of Care, has many but not all of the characteristics of an integrated service system. In California, as elsewhere in the nation, System of Care has been driven largely by the mental health service system and does not always include shared governance and funding for children’s services. Placer County’s System of Care has flourished, in part because, other child serving systems (juvenile justice and education) have shared funding and leadership which has helped to close service gaps.

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**SLIDE IV.2-1**

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**System of Care**

- The original intent was to provide a framework and philosophy to guide service systems and service delivery to improve the lives of children and youth with mental health problems
- Created as a response to a fragmented mental health system
- In many jurisdictions systems of care included youth in the child welfare system
The evolution of the Placer County System of Care demonstrates how the community was engaged to plan, implement and evaluate a system of care service delivery framework which is responsive to the unique needs, goals, priorities and populations served in their county.

**SLIDE IV.2-2**

**Example:**

**Placer County System of Care**

- The SOC has become institutionalized despite no ongoing funding to support the infrastructure
- Single administrative unit which encompasses three service systems
  - Child welfare
  - Mental Health
  - Juvenile Justice

**SLIDE IV.2-3**

**Brief CSOC Timeline - 1988**

- Leaders from Juvenile Court, Probation, Mental Health, and Child Welfare Services committed to serve OUR Children and Families, regardless of the agency door by which families enter 'the system' (Education signed on shortly thereafter)
- Leaders developed a Memorandum of Understanding (MOU) accepting joint responsibility for Placer County's most at-risk children and families and created Placer County's Policy Board, now known as the Systems, Management, Advocacy and resource Team (S.M.A.R.T.)
BRIEF CSOC TIMELINE – 1988 (2)

- Established Interagency Case Management Team with key managers/supervisors from each partner agency who were authorized to:
  - Collaboratively assess the full range of needs of seriously troubled children and families.
  - Approve all services and resources to address holistic needs.

BRIEF CSOC TIMELINE – Early 1990s

- The Welfare Department and the Health Department were reorganized into the Department of Health and Human Services which includes Children’s System of Care, ACCESS (an Emergency Response System), and Adult System of Care.

- SMART Policy Board established a full-scale countywide comprehensive integrated services system.

- SMART Policy Board gave “SMT” collaborative authority over all county staff providing services to children and their families.
**Brief CSOC Timeline - 1999**

- Parent Partner Coordinator hired; participated in all phases of services plan, Quality Improvement Committee work and was member of SMART Management Team (SMT) and Placement Review Team (PRT).

- Placer’s Parent Coordinator had direct access to the Director of SMART-CSOC and its management team.

**SMART POLICY BOARD**

- The SMART Policy Board consists of the Chief Probation Officer, Director of Health and Human Services, Deputy Superintendent of Schools, and the designated Superior Court Judge, who is the Chair of the collaborative.

- The SMART Policy Board meets semi-monthly.
Funding for children's System of Care arrangements was cut from the Department of Mental Health budget in fiscal year 2004-2005, and as a consequence, most counties in California have not been able to sustain their organizational structures. However, in Placer County, System of Care has not only been sustained but continues to be the primary service delivery mechanism for children's programs. Their success has been sustained through:

- On-going collaboration and partnerships
- Multiple blended funding streams
- On-going MOU's/Interagency Agreements
- Supporting Family and Youth voice
- Authentic Community Involvement
- Awareness and Education of Issues impacting our community

Placer County Systems of Care is sustained through:
built upon a genuine interagency collaboration. The development of these true collaborative partnerships has created the means to redirect resources away from institutional settings (such as group homes and probation camps) to community based programs.

SLIDE IV.2-12

Notable Child Welfare Outcomes

- Total Dependency cases reduced by more than 25%
- Foster Placements reduced 22%
- Group Home use reduced 25%
- Placer has 12 dependency youth, and 6362 funded youth in Group Homes as of June 30, 2010.

SLIDE IV.2-13

Systemic Barriers Addressed by Placer County System of Care

- Practices, service procedures and intervention priorities are aligned
- Improved information flow
- Organizational cultures (child welfare, mental health and juvenile probation) are aligned and focused on client outcome
- Interaction is increased and focused on common goals
Questions for Discussion / Proposed Activities:

1. Using Horwath & Morrison’s ‘Ingredients for Collaboration’ slide (III.2.2-10ff.), examine this model and assess which of the ingredients are present and might help to explain the “success” of the collaboration.

2. Horwath and Morrison note that one of the predisposing factors for collaboration is the history of agency relationships. How might the history of agency relationships have contributed to the Placer County system of care model?
IV.3 Coordinated Service Delivery

**Introduction:** We next look at Wraparound as an example of coordinated services. In California, Wraparound has been widely adopted as a strategy for ensuring service coordination for children and youth with severe emotional and behavioral disorders, many of whom are also served by the child welfare system. Wraparound’s team-based approach encourages coordination among service providers and families that can help identify gaps in treatment and barriers to follow-through while avoiding redundancies. The widespread use of Wraparound has been supported through policy and funding mechanisms in the state.

**SLIDE IV.3-1**

**Wraparound: Los Angeles County Department of Child and Family Services**

- Los Angeles County DCFS has made a significant investment in Wraparound
- It is one of the primary strategies being used to improve outcomes for child welfare youth with complex emotional and behavioral needs
- The targeted outcomes are permanency, safety and well-being
It should be noted that the outcomes for Wraparound have been equivocal at best. Studies show generally positive outcomes for youth receiving Wraparound, but most do not show positive effects on some outcomes, and there continues to be serious concern about the methodology employed in research on Wraparound.

In general, research on Wraparound shows positive effects on youth living situation but little to no effect on measures of mental health outcome and youth functioning (including school outcomes) (Suter & Bruns, 2009). These findings suggest that Wraparound by itself is not sufficient for improving child well-being.
As was noted earlier, Wraparound has been widely adopted in the state of California (in fact, mandated by the MHSA), in large part because the process produces a single, comprehensive plan of care that integrates the efforts of multiple agencies.

Questions for Discussion / Proposed Activities:

1. Find out about the Wraparound program in your area. Interview an administrator or worker involved with the Wraparound program. How does Wraparound rely on collaborative practices?

Wraparound as a Collaborative Process

- Wraparound services necessitate a collaborative process
- In order to develop a comprehensive service plan all of the individuals involved in a child’s life, including service providers come together, to collaboratively develop an individualized plan of care.
IV.4 Evidence-Based Practices

Introduction: In the final section, we give examples of the provision of evidence-based practices to illustrate cooperation and service coordination between child welfare and mental health agencies. Many evidence-based practices relevant to child welfare offer strategies for collaboration. These include: (1) clearly identifying goals from the outset; (2) identifying issues of confidentiality and reaching agreements prior to service provision; and (3) clear articulation of professional roles and responsibilities.

Successful implementation of evidence-based practices with child welfare clients has a dual purpose: (1) ensuring that children and youth receive treatment to improve developmental outcomes, and (2) supporting child welfare goals such as placement stability, safety and permanency.

In this section, we introduce two evidence-based practices, which rely on collaborative arrangements between child-serving systems.

1. The Incredible Years Parenting Program as implemented in Riverside County

2. Multidimensional Treatment Foster Care as implemented in Orange County.
IV.4.1 The Incredible Years Parenting Program

Example: Incredible Years Parenting Program

- The Incredible Years is a parenting program for parents of children ages 2-12
- The program has been studied with child welfare populations
- The program achieves outcomes of interest to child welfare
  - Prevention of child abuse and neglect
  - Families have enhanced capacity to provide for their children’s needs

To learn more about the Incredible Years Parenting Program, you can access web resources or the scientific literature, which contains multiple studies on this intervention.

References:

The Incredible Years. [www.incredibleyears.com/program/parent.asp](http://www.incredibleyears.com/program/parent.asp)
The child welfare-mental health Incredible Years collaboration in Riverside County grew out of a long history of collaboration between the two service systems and, the funding opportunities available through the Mental Health Services Act (MHSA). Riverside was one of the first Federal System of Care sites, which helped to create an organizational infrastructure to support collaboration – including having mental health staff co-located in child welfare offices. Riverside was uniquely positioned to take advantage of training funds provided by the MHSA – funds specifically intended to reduce negative outcomes for children in the child welfare system.

**SLIDE IV.4.1-2**

Riverside County Child Welfare-Mental Health Incredible Years Collaboration

- Management Level Committee to develop contracts for agencies interested in delivering IY as part of a family preservation or family reunification service
- Mental Health funded the clinical training, consultation and evaluation components of the project
- Child welfare funded purchase of materials, food for parent meetings and child care
Incredible Years Collaboration

- MOU’s developed between contract agencies and child welfare and mental health
- Single point of referral agreed upon
- Confidentiality issues articulated in a joint agreement
- Monthly meetings with child welfare, mental health and contract agency administrators

Incredible Years Collaboration (2)

- CWS workers given information about the Incredible Years parenting strategies
- CWS workers incorporated IY strategies into supervised visits between parents and children
- CWS workers and IY group leaders agreed about what information would be communicated and with what frequency.
  - Parents were clear about what was communicated
- IY group leaders provided CWS workers with detailed information for court reports including what skills were taught and what outcomes were achieved

Collaboration occurred in several ways: (1) Child welfare workers were given information about the Incredible Years parenting strategies; (2) Child welfare workers incorporated IY strategies into supervised visits between parents and children; (3) agreements were made between child welfare workers and IY group leaders about what information would be communicated to parents and with what frequency; and (4) IY group leaders provided child welfare workers with detailed information for court reports including what skills were taught and what outcomes were achieved.
IV.4.2 Multidimensional Treatment Foster Care

SLIDE IV.4.2-1

Orange County Mental Health – Child Welfare
Multidimensional Treatment Foster Care (MTFC)
Collaboration

- MTFC is a treatment foster care intervention for youth 12-18 with severe emotional and behavioral problems
- Alternative to group care
- Child welfare outcomes
  - Placement stability
  - Permanency
  - Child and family well-being

INSTRUCTOR’S NOTES
Background information on Multidimensional Treatment Foster Care is available through web resources as well as numerous scientific articles.

www.mtfc.com

Students may want to do some background reading on MTFC through web resources.

www.mtfc.com

The child welfare-mental health MTFC collaboration in Orange County demonstrates a successful implementation of an evidence-based practice. MTFC has been well received by front line staff in both service systems and by foster parents. As in Riverside County, mental health staff is co-located in child welfare offices which contribute to trusting relationships and shared goals.
MTFC Collaboration

- Administrative oversight includes managers from both the child welfare and the mental health service agencies
  - Ensures funding
  - Is responsible for monitoring process and outcome evaluation
  - Ensures referrals
  - Markets the program
  - System for managing conflict

MTFC Collaboration (2)

- MTFC “treatment” team
  - Foster parent recruiter works for child welfare
  - Other members of the intervention team work for mental health
  - CWS worker is a member of the team
  - Parent partner is a member of the team
MTFC Collaboration (3)

- Goal is for the youth to be in a permanent placement 9 to 12 months after entering the program
- Program depends upon role stratification with the MTFC program supervisor responsible for program decisions including at least weekly contact with the CWS worker
  - Results in fewer role conflicts
- Confidentiality issues are discussed prior to youth placement
  - CWS worker seen as the legally responsible party so information regarding safety is critically important

MTFC Collaboration (4)

- Information from Parent Daily Report is aggregated and included in quarterly reports to CWS workers
  - Reports include school attendance and homework completion information for every school day of the quarter
Questions for Discussion / Proposed Activities:

1. Both Riverside and Orange counties have mental health staff co-located with child welfare staff and Riverside was a federally funded system of care site for ten years. Do previous experiences with collaboration make it more likely that agencies will implement an evidence-based mental health practice for youth in child welfare? Discuss.

2. Interview a child welfare and/or mental health administrator in your county and find out about the history of evidence-based practices in your county. What evidence-based practices are provided? How were they introduced and implemented? What have been challenges?

MTFC Collaboration (5)

- Outcomes
  - Eighty percent of youth are achieving permanency
  - Return to biological parents
  - Return to kin
  - Return to former foster parents who seek guardianship
  - 100 percent of youth leave on one or no psychotropic medications
IV.4.3 Conclusion

Evidence-Based Practices: Strategies for Improving Child Well-Being

- Children and youth in the child welfare system, including those receiving home-based services, are at high risk for emotional and behavioral disorders
- These problems create significant challenges for their biological parent and/or substitute caregivers
  - Increased probability of placement disruption
  - Risk for increases in mental health problems and school failure

Conclusion: Evidence-Based Practices

- Evidence-Based parenting interventions such as IY and MTFC demonstrate positive outcomes for children, youth and families in the child welfare system
- However implementation is challenging
  - Collaboration facilitates effective implementation
  - Focus is upon shared goals and outcomes and a sharing of resources including management oversight and support

Child welfare systems are mandated to deliver or facilitate the delivery of services designed to help children safely remain at home, prevent further abuse and neglect, reduce restrictive placements and placement disruptions. Failure to use evidence-based programs is a missed opportunity to improve the lives of hundreds of children.
Questions for Discussion / Proposed Activities:

1. Using Horwath & Morrison’s ‘Ingredients for Collaboration’ slide (III.2.2-10ff.), compare each of the models in this module and assess which of the ingredients are present and might help to explain the “success” of the collaboration.

2. Students are asked to interview administrators and/or line staff in their field placement agencies to identify collaborations between mental health and child welfare. What are the key ingredients that make the collaboration successful? If it is not successful what are the barriers experienced by the staff being interviewed? Are there common themes among agencies?

INSTRUCTOR’S NOTES

It may be helpful to use the Horwath and Morrison Ingredients for Collaboration slide (III.2.2-1ff.) to help inform a discussion on the real world models just presented. Students could examine each of the models presented to see which of the ingredients are present and might help to explain the “success” of the collaboration.

CONCLUSION

The collaborative systems and programs described in this section of the module demonstrate clear mental health benefits to children, youth and families served by the child welfare system. While the focus is on the child welfare system, there are similar benefits to the mental health service system. In the examples provided for both Humboldt and Placer counties, group home and other institutional placements have been drastically reduced, which is a mental health service system goal. In addition, Multidimensional Treatment Foster Care and Incredible Years – by helping youth and parents develop the skills and competencies to manage on their own – prevent the need for more costly and intensive services mental health services.
IV.5 When Collaboration Does Not Work or When To Cut and Run!

**Introduction:** Including information on a failed collaboration was prompted by discussion in our workshops. Participants generated several examples of collaborations that resulted in frustration and acrimony between and among staff members. The question was asked whether there was ever a point when terminating a collaborative effort was indicated. How do we know whether to stay or leave?

Many of us have been involved in a stalled collaboration or one that simply crashed and burnt. Therefore it would be nice to know early in the process if we are simply wasting our time. Although there is no fool-proof way to predict the outcome of any undertaking that involves people and organizations working together, a few basic checkpoints can be quite revealing.

- **The purpose for the collaboration must be clear at the outset.** One of the most important factors that help collaborative alliances stay together is the commitment all partners have in serving a specific population. Once the purpose is defined, concrete and attainable goals must be identified.

- **Successful collaboration requires representation from all community stakeholder groups who will be affected by its activities.** This means key representatives to the collaborative should include individuals to have important influence on the issues being addressed by the group.

- **Successful collaborations utilize frequent and open communication and keep all partners informed of decisions.** Establishing agreed upon communication processes is critical.

- **Successful collaborations rely on partners having joint decision-making authority.** Membership in the collaboration should come from all layers of an organization. Some members must have both the responsibility and authority for making decisions and committing organizational resources. There must also be membership from direct service staff and service recipients who understand how decisions made will impact day-to-day service delivery.
In order to survive, collaborations must have some success in reaching goals.


Case Study: A Failed Collaboration

- In an effort to improve child safety, a child welfare department decided to work collaboratively with the mental health department.
- Children and youth identified as having serious emotional and behavioral difficulties were referred to the public mental health department for assessment and treatment.
- The mental health department provided the screening and then referred cases to its network of community-based providers for assessment and treatment.

Organizational Factors

- The mental health director retired three months after the collaborative effort was initiated.
- The child welfare department was experiencing unusually high turnover at the management level as the result of a child death in foster care.
- Neither department had a history of effective collaboration which was magnified during the investigation of the child fatality as both departments were providing services.
- The collaboration was designed to respond to the negative publicity generated by what had gone wrong in this case.
Organizational Factors (2)
- At the end of the first year there was still no memorandum of understanding signed
- Mid-level managers in the child welfare department were inundated with new requirements as a result of the investigation and subsequent findings
- There were no designated managers with responsibility or authority to ensure the effectiveness of the collaborative efforts
- Community-based mental health providers were not given an increase in funding for the additional work required by the collaboration.

Outcomes
- Community based mental health organizations complained that families were frequently unaware that a referral for mental health services had been made on their behalf
- Families complained that they had to meet too many demands: those imposed by child welfare and the requirements of participation in the mental health treatment program. Families felt “punished” because the two service systems were unable to work together.
- Joint meetings to resolve problems were either not attended by one or the other of the service systems the “representative” did not have authority to make decisions.
Questions for Discussion / Proposed Activities:

1. This collaboration was designed as a response to negative publicity. Did the effort put children at risk?

2. Should the collaboration have been abandoned in this case?

3. What steps could have been taken prior to the organizations implementing a collaborative strategy?

4. Design a "correction" for this failed collaboration.
SECTION V

ANOTHER WORD ON RESULTS-BASED, OUTCOME-ORIENTED COLLABORATION
V. ANOTHER WORD ON RESULTS-BASED, OUTCOME-ORIENTED COLLABORATION

Introduction: As we discussed in Section I, collaborative practice is often an expected and even mandated approach, and it is believed to have multiple benefits for service delivery and client outcome.

“Factors supporting the call for joint working...include the bringing together of knowledge, skills and values of different professions and agencies to generate creative solutions for these families, who would otherwise be beyond the scope of any person or agency (Costongs & Springett, 1997; Mattessich, Murray-Close & Monsey, 2001), improved cost effectiveness (Johnson, Wistow, Schulz & Hardy, 2003), faster access to services (Cottrell, Lucey, Porter & Walker, 2000), reduced anxiety for workers (Hetherington, Baistow, Katz, Mesie & Trowell, 2002), greater continuity of care and most holistic services (Williamson, 2001)” (Janssens, Peremans & Deboutte, 2010, p.252).

While many authors extol the benefits of collaboration from a theoretical or conceptual standpoint, research lags behind in actually providing evidence for improved outcomes, in particular client-level outcomes. Most studies find that collaboration does improve service delivery through greater access to more appropriate services. However, not all studies have been able to link collaborative practices with improvements in client outcomes.

“There is little evidence that supports the effectiveness of these multiagency collaborations in meeting the needs of these children, and the few evaluations that have been carried out were methodologically poor (Cameron & Lart; Sloper, 2004)” (Janssens et al., 2010, p.252).

Research studies examining collaborations between child welfare and mental health are particularly sparse. In this section we highlight three studies that are relevant to collaborations aimed at improving children’s mental health outcomes:

1. The Fort Bragg Evaluation Project
2. Glisson & Hemmelgarn, 1998
3. Foster et al., 2007
From a methodological standpoint, these studies probably represent the most rigorously conducted research in the area of collaboration and integrated systems. The Fort Bragg Evaluation Project is considered a landmark study. All three studies evaluate the effect of collaborative practices on child level outcomes. Results are, as we already stated above, mixed. These findings require careful consideration and debate.

But before we begin reviewing these studies, let’s look again at the reported benefits of collaboration:

SLIDE V-1

<table>
<thead>
<tr>
<th>Reported Benefits of Collaboration</th>
</tr>
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<tbody>
<tr>
<td>Improved cost effectiveness</td>
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<tr>
<td>Easier, faster and more cohesive services</td>
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<tr>
<td>Greater continuity of care</td>
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<tr>
<td>Reduced anxiety for workers</td>
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<tr>
<td>Enhanced creativity and problem-solving</td>
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<tr>
<td>Improved awareness of one’s own organizational culture</td>
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<tr>
<td>Sharing of knowledge and skill base</td>
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<tr>
<td>Greater advocacy and emotional support for clients</td>
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<tr>
<td>Improved ability to influence public policy</td>
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<tr>
<td>Debunking of professional stereotypes</td>
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Costongs & Springett, 1997; Hallett, 1995; Hetherington et al., 2002; Johnson et al., 2003; Mattessich & Monsey, 1992

This slide summarizes some of the reported benefits of collaboration.
Limits of Current Models/Research

- Much of research is descriptive, not evaluative
- Focuses on front-line practice rather than system management
- Strong conceptual assumptions about the benefits of collaboration
- Collaboration is usually described from the organizational perspective, not the perspective of stakeholders
- Few studies address irrational, unconscious aspects that might hinder collaboration

As stated in the Introduction to this section, the current body of knowledge on collaboration has many limitations. Most studies are descriptive and not evaluative. Studies might even link collaborative practices to a higher number of inter-disciplinary meetings and other service delivery outcomes that are believed to be linked to improved quality of care. What is consistent across studies from different fields is the pervasive belief that collaboration is “always better.” As such, much of the current research is based on strong conceptual assumptions about the benefits of collaboration, even though these assumptions still remain to be proven for the most part.
V.1 Fort Bragg Evaluation Project

Introduction: The Fort Bragg Evaluation Project was an ambitious evaluation study. It tested the effect of a well implemented continuum of services aimed at addressing mental health service delivery and improving mental health outcomes for children and adolescents. The notion of a continuum of services was the basis for government policies in the 1990s for reforming mental health services for children and adolescents in the United States.

“The term continuum of services provided to treat severely disturbed children and adolescents that include both nonresidential and residential services (Stroul & Friedman, 1986). The continuum emphasizes mid-range or intermediate level services as an alternative to more restrictive care. This approach attempts to deliver needed services on an individualized basis and in a coordinated manner, to integrate treatment programs and facilitate transitions between services. The ideal continuum is community-based, involving various agencies pertinent to children’s developmental, social, medical, and mental health needs” (Bickman, Heflinger, Lambert & Summerfelt, 1996).

The Fort Bragg Evaluation was theory-driven and involved a longitudinal quasi-experimental study design. Baseline data on behavioral and mental health outcomes were collected within about 30 days of entry into services, followed by three additional waves of data collection approximately six months apart. Data were collected at three sites: The experimental site at Fort Bragg, which involved the integrated continuum of services, and two comparison sites at other Army posts (Fort Campbell, KY, and Fort Stewart, GA) where services were covered by CHAMPUS. The three sites were comparable along a range of salient variables.

A total of 984 families (Demonstration Site N=574; Comparison Sites N=410) participated in the first Wave of data collection. Findings indicated that despite improvements in access to services, the integrated continuum of services did not produce better mental health outcomes in either the short-or long-term (12 months, 18 months, 5 years) than the comparison sites.

Findings and implications of this project have been the subject of much debate and the basis for many publications. Multiple possible explanations have been put forth. Similar findings
were subsequently determined in a similar study conducted with poor civilian children in Stark County, OH, again casting doubt about the effectiveness of an integrated system to improve outcome at the child level.

References for further reading on this study:


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**SLIDE V.1-1**

**Fort Bragg Evaluation Project**

- **Purpose:** To test the effect of a well implemented continuum of services on mental health outcomes for children
- **Method:** Quasi-experimental design (one demonstration site, two comparable Army posts)
- **Results:** Access to services was improved at demonstration site; however, there were no differences in child mental health outcomes at 12 months, 18 months, and at 5 years.
V.2 Glisson & Hemmelgarn Study

**Introduction:** Charles Glisson and his research team have conducted multiple studies that have focused on understanding the role of organizational variables in affecting outcomes for children in the child welfare system.

**Reference:**

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**SLIDE V.2-1**

**Glisson & Hemmelgarn (1998)**
- **Purpose:** Examined the effects of organizational characteristics (organizational climate and interorganizational coordination) on the outcomes of children's service systems
- **Method:** Quasi-experimental longitudinal design; mixed methods; collected data on 250 children in 32 child welfare offices in 24 counties in Tennessee

One study in particular (Glisson & Hemmelgarn, 1998) produced interesting findings that are relevant to understanding inter-agency collaboration. The study, which was conducted in 32 child welfare offices in 24 counties in Tennessee, examined the effects of a range of organizational characteristics (including organizational climate and inter-organizational coordination) on the outcomes of children in the child welfare system.
The study had four main findings:

1. Improvements in psychosocial functioning were significantly greater for children served by offices with more positive climates.

2. Improved service quality (comprehensiveness, continuity) were not associated with improved child-level outcomes.

3. Organizational climate (low conflict, cooperation, role clarity, and personalization) is a primary predictor of positive child-level outcomes.

4. Increased service coordination decreased services quality.

Results:

1. Improvements in psychosocial functioning were significantly greater for children served by offices with more positive climates.

2. Improved service quality (comprehensiveness, continuity) were not associated with improved child-level outcomes.

3. Organizational climate (low conflict, cooperation, role clarity, and personalization) is a primary predictor of positive child-level outcomes.

4. Increased service coordination decreased services quality.
The last finding was the cause of much debate. Glisson and Hemmelgarn put forth the following explanations for this curious finding:

1. Increases in service coordination deflected caseworkers’ behaviors from activities associated with improved care for children

2. In areas where coordination increased, caseworkers relinquished responsibility across the board for those activities

3. Centralization of services can diffuse rather than focus responsibility for casework activities
V.3 Foster et al. Study

Introduction: Foster and colleagues conducted an evaluation of two systems of care communities. The development of these systems had been funded by The Center for Mental Health Services (CMHS) located in the Substance Abuse and Mental Health Services Administration. The CMHS has provided over $1 billion to 126 communities since the early 1990s to develop local systems of care. Beyond providing community-based, culturally sensitive services in the least restrictive setting, systems of care are built on interagency cooperation and coordination. Within the framework of systems of care, local sites are permitted to tailor their systems according to the needs, strengths and resources of their community.

This evaluation compared outcomes in two SOC communities: Alabama and Nebraska. To facilitate comparison, these SOC communities were paired with non-CMHS-funded communities that used a different approach to serving children with mental health problems. Outcomes for children served through these different systems were compared along a range of mental health dimensions. Findings indicated that children in Alabama showed substantially greater improvement than did their matched counterparts. Such differences were not found in Nebraska. The authors suggested that the differences in the effectiveness of the SOC model between the two pairs of sites may reflect differences in how the SOC model was actually implemented at each site.

Reference:
Foster et al. (2007)

**Purpose:** Compared MH outcomes (CBCL, CAFAS) for 573 children receiving services in two federally funded system-of-care communities (AL, NE) to those of children in similar communities

- **Method:** Comparison of children’s clinical and functional outcomes over 3 waves of data collection for 573 children and youth (analyzed through propensity score matching)
- **Results:** Children in AL system of care showed substantially greater improvement than did their matched counterparts; such differences were not found in NE
- **Conclusion:** The differences in the effectiveness of the system of care between the two pairs of sites may reflect differences in system implementation, especially as affecting service use
V.4 Conclusion

How are we expected to understand the findings of these studies?

The most rigorously conducted studies tested outcomes related to different forms of collaboration (continuum of services, coordination, system of care). Each of the studies produced (some) unanticipated findings, which warrant discussion and further studies.

**What Does It All Mean?**

- Greater service integration improved access to care in the Fort Bragg Evaluation, but did not improve targeted mental health outcomes.
- Collaboration can have unintended consequences – greater service coordination decreased the quality of services in Glisson and Hemmelgarn’s study, presumably because individual workers felt less responsible for following through with necessary tasks.
- Variability in the implementation of collaborative efforts may effect targeted outcomes, as suggested by Foster et al.
These studies caution us to not simply assume that collaboration is always the panacea. Collaboration alone may not be sufficient to actually improve client-level outcomes. In the Fort Bragg Evaluation Project, for instance, it was subsequently argued that greater coordination of services which lack an evidence base will not lead to better client-level outcome.

Given the time and cost involved in building and maintaining collaborative partnerships, it is also important that expected outcomes are clearly defined in the planning stage. If improved client-level outcomes are the ultimate goal, evaluations of collaborations are necessary to ascertain that such outcomes are indeed attained. Role clarification is also a necessary process as greater service coordination may lead to the relinquishing of important tasks by individual workers. Finally, how a collaborative effort gets implemented may make all the difference. Section III provided information on some of the necessary key ingredients for successful collaborations.