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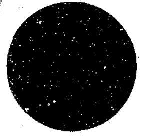

# FINDING COMMON GROUND

## A Call for Collaboration

PROMOTING STATE INTERAGENCY EFFORTS TO REDUCE THE IMPACT OF PERINATAL ALCOHOL AND OTHER DRUG USE ON FAMILIES

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## PROMOTING STATE INTERAGENCY EFFORTS TO REDUCE THE IMPACT OF PERINATAL ALCOHOL AND OTHER DRUG USE ON FAMILIES

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# INTRODUCTION

The use of alcohol and other drugs by women during pregnancy is perceived by many to be a growing problem in the United States. Maternal use of alcohol and other drugs increases the risk of developmental disability for infants and children.[1] It profoundly affects not only the mother and child but also other family members and the community. Successful response to alcohol and other drug use demands coordination among the multiple service providers who interact with afflicted and at-risk individuals. The sheer number of families struggling with addiction coupled with the need for a communitywide response has impacted professionals in different agencies in their attempts to achieve consensus on effective prevention and intervention strategies.

This manual is offered as a resource for staff of State agencies for use in developing public policy and programs to address prevention and treatment. Because success in this arena requires attention to all aspects of well-being and self-sufficiency, we stress cooperation among agencies at a minimum and encourage truly collaborative action rather than fragmented services. The myriad of agencies responsible for services includes maternal and child health, alcohol and other drug prevention and treatment services, child welfare, education, mental health, housing, and corrections. Each plays an integral role in addressing the problem of substance abuse and dependency as it influences families. Consumer advocacy groups, businesses, professionals, elected officials, foundations, local leadership, and consumers should work with these agencies to jointly define the problem and appropriate responses.

State agency staff can play a vital role in formulating public policy around issues related to the use of harmful substances by women of childbearing age. The exact nature and extent of alcohol and other drug use varies from community to community as do the resources available to meet the needs of affected individuals. Clearly, local communities must be responsible for designing and providing services which are accessible and acceptable in their particular environment. Yet State agencies are frequently sources of the monetary and informational base and leadership which enable or limit local groups. It is critical, therefore, that State agencies model a collaborative approach to the prevention, treatment, and rehabilitation of women, children, and families involved with alcohol and other drugs.

CHAPTER 1

# THE CALL FOR COLLABORATION

No single agency or system of services can respond effectively to the complex needs presented by those involved in or at risk for alcohol and other drug dependency.[2] The categorical nature of service programs demands parallel interagency cooperation at the Federal, State, and local levels if coherent approaches to alcohol and other drug use prevention and intervention are to be planned, implemented, and evaluated.

Notable among the recommendations of several recent national commissions has been the call for interagency cooperation around the issues of perinatal alcohol and other drug use prevention. The North American Commission on Chemical Dependency and Child Welfare, convened by the Child Welfare League of America, the National Commission on Children, and the National Commission to Prevent Infant Mortality, have all recognized the need for united efforts to effectively reduce the impact of perinatal alcohol and other drug use.[3,4,5] Such acknowledgment is drawn from the experiences of those working directly with affected women, children, and families who struggle against fragmented, inadequate, and prejudicial service systems.

Fortunately, interagency collaboration is not a new concept. Federal legislation over the past decade has mandated multi-agency planning and programming in a number of overlapping arenas. The Medicaid (Title XIX) and Maternal and Child Health (Title V) Programs have been directed to establish formal agreements, to share outreach responsibilities, and to coordinate resources for the purpose of reducing infant mortality and morbidity.[6] In deliberating the most recent amendments to part H of the Individuals with Disabilities Act, Congress hailed interagency collaboration around early intervention for children with developmental disabilities as a new paradigm for systems operation.[7]

One example of interagency cooperation at the Federal level is the relationship between the Maternal and Child Health Bureau (MCHB) of the

Health Resources and Services Administration (HRSA) and the Center for Substance Abuse Prevention (CSAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA).* Integrated programming has been pursued by the two agencies through cooperative policy development, the sharing of staff and other resources, and the mutual funding of substance abuse prevention activities that relate to pregnant women and children. The CSAP and MCHB together have guided the development and implementation of the Pregnant, Postpartum Women and Their Infants demonstration grants as well as the National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs.

Also pertinent to collaboration within the field of perinatal alcohol and other drug use prevention is the Federal Healthy Start program launched in 1991. Fifteen communities across the Nation have been funded to develop a consortia of agencies, both public and private, and including the business community to focus on infant mortality reduction. Many Healthy Start projects focus on reducing perinatal alcohol and other drug use. Healthy Start communities will also test the effectiveness of community coalitions as agents of change, provide models of collaboration, and delineate the breadth of agencies addressing infant mortality reduction.

The Head Start Program, the CSAP Community Partnership Grants, several individual grants awarded through the Office of Special Education Programs within the U.S. Department of Education, and the special projects of regional and national significance (SPRANS) awarded through the MCHB are other examples of collaborative Federal efforts that address reduction of perinatal alcohol and other drug use among their goals.

Staff in many State agencies already work collaboratively to prevent maternal alcohol and other drug use, primarily by establishing task forces or commissions. The valuable experiences gained by these groups can contribute richly to ongoing collaborative interagency work. The following chapters describe the process of interagency collaboration, highlighting frequent barriers and tools for overcoming those barriers. Awareness of and attention to the process of establishing collaboration will increase the likelihood that interagency efforts will have a positive effect on the reduction of alcohol and other drug use on women, children, and families.

** As of October 1, 1992, the Office for Substance Abuse Prevention (OSAP) became CSAP within SAMHSA.*

CHAPTER 2

# RELEVANT STATE AGENCIES

Leadership in addressing the problem of perinatal alcohol and other drug use has come from officials in executive, legislative, judicial, and administrative branches of State governments. As State agency staff come together to establish a mutual agenda, they realize that they each represent strong organizational, professional, and personal identities. The consequences of inadequate knowledge about the various agencies working with families who are affected by drugs include duplication of services, underuse of valuable expertise, and mistrust. Not coincidentally, these are also organizational motives for seeking interagency action. An appreciation for differences in agency histories, missions, legislative mandates, funding requirements, and operating mechanisms can ease developing common ground for action.

This chapter will focus on the background and activities of the State service systems most prominently involved in reducing the impact of alcohol and other drug use on families. Several types of agencies will be mentioned, since many resources must be assembled to implement effective prevention and intervention strategies.

# THREE STATE SERVICE SYSTEMS: THEIR MISSIONS, MANDATES, AND EXPERIENCES

## Maternal and Child Health Bureau
## The Mission

Established in 1935 as part of the Social Security Act, Title V (Maternal and Child Health Bureau) remains the only national Federal program devoted exclusively to maternal and child health services. Title V provides not only a Federal statutory basis for maternal and child health services in each State and territory, but also important resources to support the infrastructure for those services.[8] The Title V mandate is extremely broad, i.e., to improve the health of all mothers and children. Special attention, however, is directed to low-income families, families with limited access to care, and families with children who have special health needs due to chronic or disabling conditions. Strategies often used to promote maternal and child health—such as outreach to isolated and otherwise hard-to-reach populations, home visiting, identification of high-risk health conditions, and assurance of access to risk appropriate care—are highly relevant to the needs of women and children involved with alcohol and other drug use.

## The Federal Mandate

The current framework of maternal and child health was created in 1981 when the Maternal and Child Health Services Program, the Children with Special Health Care Needs Program,* and additional categorical programs targeting mothers, children, and/or youth were consolidated into the Maternal and Child Health (MCH) Services Block Grant. Each State receives block grant funds distributed through the Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service (PHS), U.S. Department of Health and Human Services (DHHS), according to a set formula.

In amending the Title V legislation through the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress established specific guidelines for the use of MCH Block Grant funds, and for planning and reporting by the States.† Through the support of statewide system

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* *The title* Children With Special Health Care Needs *replaced that of the Crippled Children's Program in 1986.*
† *Sec. 501. (a) of the Social Security Act.*

development and direct support of community services, State Title V agencies are required to:

1. Assure access to quality, community-based preventive and primary care for pregnant women, infants, children, and youth, as well as specialized health care and family support services for children with special health needs;
2. Conduct comprehensive needs assessment and planning;
3. Develop family-centered, coordinated, community-based systems;
4. Enhance interagency coordination; and
5. Submit an annual report.

Perinatal alcohol and other drug use are pertinent to each of these categories of activities.

The discretionary portion of MCH Block Grant funding supports a variety of demonstration, research, training, and services grant programs known as special projects of regional and national significance (SPRANS grants). One particular category, initiated in 1992, is the Community Integrated Service System (CISS) grants which support demonstration projects related to home visiting, provider participation, integrated service delivery, nonprofit hospital MCH centers, rural programs, and community projects for children with special health needs. While not solely focused on the needs of families affected by alcohol and other drugs, these grants do foster advances in service delivery which are critical in meeting the needs of such families.

## State Structure and Responsibilities

At the State level, Title V MCH programs must be administered by the State health agency. Because of historical arrangements, however, Children with Special Health Care Needs (CSHCN) programs in 10 States are located in another agency or university. As is true for other State systems, the structural relationships of the maternal and child health program to the Governor's office, to other State agencies, and to local health agencies varies from State to State. OBRA '89 requires each State to maintain its contribution to MCH funding at or above fiscal year 1989 levels. Beyond requirements to spend at least 30 percent of program funds on preventive and primary care for children, at least 30 percent on children with special health

needs, and no more than 10 percent on administrative needs, States have significant discretion in determining the nature of their programs consistent with documented need assessment.

The responsibilities of State Title V MCH agencies in systems development and direct service provision are germane to perinatal alcohol and other drug issues. Activities aimed at building the capacity of the health care system may include the following: the recruitment of providers willing to serve pregnant women, infants, and children who are affected by alcohol and other drug use; instructing providers about alcohol and drug assessment; developing models of early intervention that incorporate home visiting and case management; and strengthening linkages with other State and local agencies serving women and children.

Direct services provided or funded by State MCH agencies emphasize primary and preventive care, such as the reproductive health needs of women, risk-appropriate prenatal care, and health supervision for children and youth. Those children with special health needs are served with a focus on comprehensive care that is family centered and community based.

As part of their annual reporting, States are required to document the number of newborns with fetal alcohol syndrome and drug dependency. Related information also collected includes infant mortality rates, low birthweight rates, the availability of services, and the number of women and infants covered by Medicaid or insurance.[9]

Hotlines for parents to learn about Medicaid and MCH providers are another requirement of MCH programs. MCH programs must establish written agreements with the State Medicaid agency that defines how both agencies will identify pregnant women and children who are eligible for Medicaid and assist them in application procedures. The substance of these existing agreements, the process of interagency communication used to negotiate the agreements, and the resulting interagency relationships offer successful efforts on which to build coordination around substance abuse issues. For example, staff of other State agencies can benefit by contacting their Title V Director and learning what specific MCH support exists in their State for outreach, education, data collection, service provision, and community coordination on behalf of women of childbearing age, their children, and their families. (*See* appendix A on page 37 for a current listing of State Title V Directors.)

## Substance Abuse Services
## The Mission

In the Alcohol, Drug Abuse, and Mental Health Services Administration (ADAMHA) Reorganization Act of 1992, the Congress reconstituted the Substance Abuse and Mental Health Services Administration (SAMHSA) with a series of new responsibilities. First among them is to "establish and implement a comprehensive program to improve prevention and treatment related services to individuals with substance abuse and mental illness; improve prevention services; promote mental health and protect the legal rights of both substance abusers and the mentally ill."[10] The needs of women and high-risk youth are particularly emphasized. The importance of coordination with other systems is underscored as the Act directs SAMHSA to "collaborate with the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA) to promote integration of substance abuse into mainstream health care."[11]

## The Federal Structure

In the early 1980s, seven Federal programs for alcohol, drug abuse and mental health services were consolidated into the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant to be administered by the ADAMHA. This major Federal funding initiative for alcohol and other drug services at the State level has supported "planning, establishment and evaluation of prevention, treatment and rehabilitation services."[11] The Anti-Drug Abuse Acts of 1986 (P.L. 99-570) and 1988 (P.L. 100-690) focused activity on the prevention of substance abuse, the latter by establishing the Office for Substance Abuse Prevention (OSAP) within the ADAMHA.[12] The need to support the development of State and community infrastructures around substance abuse services resulted in the creation of the Office for Treatment Improvement (OTI) in 1990. It is this entity which has administered the ADMS Block Grant to the States in recent years, providing technical assistance for improving treatment services and centralizing information on State operations.

With the creation of SAMHSA, various responsibilities have been redistributed among three Centers: the Center for Substance Abuse Prevention (CSAP), formerly OSAP; the Center for Substance Abuse Treatment (CSAT), formerly OTI; and the Center for Mental Health Services

(CMHS), a new agency. Women, children, and families, community systems and coordination are given high priorities by the CMHS, with the aim of strengthening prevention and treatment efforts.

Under the Act, the research programs of the National Institute on Drug Abuse (NIDA), the National Institute on Alcoholism and Alcohol Abuse (NIAAA), and the National Institute of Mental Health (NIMH) are now part of the National Institutes of Health (NIH). A large part of SAMHSA's role is administering the categorical demonstration projects; these include client-oriented grant programs, systems development grant programs, substance abuse treatment capacity building grants, and training grants. Requirements for multi-agency coordination and treatment expansion for special populations are a feature of each grant program. Grantees within each State have the potential to contribute significantly to the increased availability of services and advancement of the state of the art.

## State Structure and Responsibilities

It is important for members of a State agency consortium to understand not only current structure but also agency histories. Today, all State alcohol and other drug programs are combined under common State statutes. Alcohol and other drug programs, however, may have been originally established in separate agencies with differing missions and later merged by State legislation. Such legislation may dictate structural organization, but it does not always assure the development of a common mission and cohesive programming. Likewise, the creation of SAMHSA sets into motion State program adjustments that may take several years to mature.

Title II of the ADAMHA Reorganization Act of 1992 realigned the ADMS Block Grant into two block grants: one for substance abuse and the other for mental health. Many States will relate to the two block grants through separate substance abuse and mental health agencies. As under the ADMS Block Grant prior to the Act, States must maintain funding for alcohol and drug abuse services and for primary prevention activities. They also must address tobacco products and tobacco use, particularly among minority populations. The Women's Set-Aside has been restructured exclusively for pregnant women. States must show a 5 percent increase in their capacity to serve pregnant women and women with dependent children during each of the next 2 years.

Several provisions of the Act will lead State alcohol and drug agencies into coordination with other State agencies. For example, each treatment program receiving funds under the block grant must directly—or through arrangements with other providers—make prenatal and child health care available for all participants. Tuberculosis and HIV screening, testing, counseling, and access to treatment services must be available in States with AIDS case rates of 10 per 100,000 or greater. Pregnant women seeking alcohol and other drug treatment must be given preference; this policy must be publicized.

State agencies receiving block grants have a specific responsibility to "coordinate various services and activities . . . with other appropriate services including health, social [services], corrections and criminal justice, education, vocational rehabilitation and employment." Whether in regard to training of professionals, public awareness campaigns, developing interagency agreements, or conducting needs assessment, other State agencies have overlapping Federal mandates and, more importantly, experience that is valuable to State alcohol and drug agencies as they respond to new block grant provisions. (*See* appendix B on page 55 for a current listing of State Alcohol and Drug Agency Directors.)

## Child Welfare

The child welfare system is less uniform in its structure from State to State than those presented above. In contrast to the definition of a system as "units which function interdependently and harmoniously," the Child Welfare League of America (CWLA) points out that the child welfare system is loosely composed of hundreds of State and county child welfare and family service agencies and thousands of independent, private agencies.[13] Services provided by this array of public and private sources strengthen and support families, prevent child abuse and neglect, and mitigate stressful environmental conditions, such as violence and poverty, which ultimately threaten children and families. The increased involvement of families with alcohol and other drug use has made it more difficult for agency staff to meet these goals.

## The Mission

Briefly stated, the mission of the child welfare system is to promote and protect the well-being of children, doing so to the greatest extent possible within the context of the family. In the report entitled *Children at the Front—A Different View of the War on Alcohol and Drugs*, the CWLA lists eight major areas of responsibility for agencies serving the child welfare system: (1) protecting and promoting the well-being of all children; (2) supporting families and preventing abuse, neglect, exploitation, and delinquency; (3) promoting family stability; (4) placing children in appropriate out-of-home care when they are jeopardized by remaining with the family; (5) assuring adequate services to children in out-of-home placement; (6) providing services toward family reunification; (7) providing adoption services when reunification is not possible; and (8) proactively identifying and ameliorating social conditions that negatively impact on children.[13]

## Federal Funding Sources

Funding for aspects of child welfare come from several Federal sources. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services distributes monies under Title IV-B of the Social Security Act to specific State agencies to subsidize State child welfare service costs. Title IV-E is allocated for State costs related to Aid to Families with Dependent Children (AFDC) eligible children in need of foster care. Although Title XX of the Social Security Act can theoretically provide funds for crisis intervention with children, in practice the funds are too limited to meet this demand. The ACF also makes funding available to States through the National Child Abuse and Neglect grants and the Abandoned Infants Assistance grants (for children at risk of abandonment because of substance abuse exposure or HIV status).

## Community Implementation of Child Welfare

The Adoption Assistance Act of 1980, P.L. 96-272, established the mandate that determines child welfare practice today. At the time of its passage, the Act presented a bold, new concept to child welfare: that the well-being of children was best protected and promoted when their needs were

considered within the context of the family. The law instructs agencies to make "reasonable efforts" to maintain family unity and work for reunification when temporary foster placement is necessary.

Progress towards these goals has been hampered by a number of interrelated factors which have strained the child welfare system during the past decade. There has been a dramatic upswing in reported cases of child abuse and neglect. Increasing numbers of children and families live in poverty with limited access to essential health and human services. Neither the human nor the financial resources necessary to protect these vulnerable children or strengthen their families has been available. Further, the recent surge of crack cocaine use among women of childbearing age and its impact on families has resulted in more children requiring out-of-home care.

There is uneven interpretation and implementation of P.L. 96-272 at the State and local levels, hampering its effectiveness. Vaguely defined terms, such as "reasonable efforts," have been subject to differing interpretations by juvenile courts, State legislatures, and child welfare administrators. New protocols for protecting and promoting child well-being and family stability need to be developed and integrated into the efforts of the entire community.[13] For children who cannot remain at home, the array of options should include temporary and permanent placement, kinship care, foster care, residential out-of-home care, and adoption. Indeed, the provision of all services to children and families should be based on need and not on availability.

## Issues for Cross-Agency Coordination

The Twelve Step National Policy Agenda proposed by the CWLA's North American Commission on Chemical Dependency and Child Welfare is replete with recommendations requiring interagency coordination for effective implementation, such as:

1. A system of comprehensive health care for all children and families which includes alcohol and drug treatment;
2. The establishment of culturally appropriate, neighborhood-based family resource centers that offer a variety of child and adult services;
3. Increased support of interagency research into child abuse prevention;

4. The availability of family planning services, human immunodeficiency virus (HIV) services, child care, outreach to the homeless, housing, employment services, and recreational services through coordination of existing resources; and
5. Cross-training of agency staff, professionals, and caregivers.[13]

Also proposed are activities to strengthen the ability of communities to meet the eight areas of responsibility listed earlier (*see* appendix C on page 63 for the current listing of State Child Welfare Commissioners/Directors).

## Other State Agencies and Groups

Maternal and child health, alcohol and other drug prevention and treatment, and child welfare agencies are by no means the only agencies working to reduce the impact of drug and alcohol dependency on women of childbearing age, their children, and their families. Virtually any agency that serves families can contribute to collaborative efforts which address the problem of perinatal alcohol and other drug use. Since no single agency can meet the complex, interrelated needs of addicted individuals, collaboration among agencies is imperative. Prevention efforts will not be as effective if they are scattered and narrowly focused. Following is a portrayal of other agencies having significant impact on perinatal alcohol and other drug use. Each should participate as challenges are discussed and responses considered.

## Medicaid

Initially passed in 1965 as Title XIX of the Social Security Act, Medicaid was intended to provide the poor with access to health care. The Health Care Financing Administration within the DHHS is responsible for oversight of this program which is administered by each State. States have been allowed varying degrees of freedom in defining the parameters of their own Medicaid programs within broad Federal guidelines. Again, interagency participants should be aware of their own State Medicaid plan and the State legislation that guides it.

Since 1984, Congress has taken Medicaid through a series of changes which has decoupled Medicaid from the Aid for Families with Dependent Children program, broadened the array of available services, and lowered income thresholds for eligibility for pregnant and postpartum women and their children. As a result of these amendments and increases in the number

of women and children in poverty, some States are already reporting that 50 percent of their births are being covered by Medicaid.[14] This percentage could continue to climb as incremental eligibility admits older children to coverage through the year 2001.

Underlying the eligibility and service package changes for mothers and children has been a major change in philosophy. Medicaid is now seen as an opportunity to prevent infant mortality and morbidity by improving access to prenatal, postpartum, and child health care. Rather than enforcing eligibility criteria which limit the number of individuals likely to qualify for Medicaid, officials have engaged in outreach, case management, and mandated coordination with other agencies and programs in efforts to find, enroll, and serve eligible women and children.

As of July 1992, 40 States have expanded the range of services available to Medicaid-eligible pregnant women.[15] Such services include risk assessment in which drug and/or alcohol dependency figure prominently. A determination of high-risk status triggers intensified prenatal, obstetric, and postpartum services. Medicaid may even cover inpatient detoxification for a limited number of days.

Through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid, infants and children have access to health care services for the purpose of detecting and treating conditions which negatively impact a child's physical, developmental and emotional well-being. There is great potential in this program to serve children known to have been prenatally exposed to drugs or those who carry no such diagnosis but manifest related difficulties.

Efforts are under way in a number of States and at the national level to use Medicaid as a vehicle to supplement the funding of drug and alcohol treatment for those who are eligible, with special emphasis being given to women and children. In one study, the General Accounting Office (GAO) found that "Despite the variety of services covered, multiple barriers exist that limit the States' ability to expand the use of Medicaid as a treatment resource. Federal law, policies, insufficient State funds and provider reluctance to accept some clients are all barriers to expansion."[16] Even with present limits on coverage of alcohol and other drug-dependency related conditions, Medicaid stands as a powerful tool in securing health care, transportation, case management, and mental health services for pregnant women and children affected by alcohol and other drug use.

## Mental Health

The role of mental illness as a condition frequently co-existing with alcohol and other drug dependency has been increasingly recognized. Within the SAMHSA, the new Center for Mental Health Services (CMHS) was created on an administrative level equivalent to substance abuse prevention and substance abuse treatment.[11] The ADMS Block Grant has now been clearly split into two distinct block grants, one for substance abuse and one for mental health. The latter will now be administered by the Center for Mental Health Services.

Although both Substance Abuse Services and Mental Health Services fall under the same agency at the Federal level, this is not necessarily true at the State level. Yet the role of the State Mental Health Agency in statewide planning and activities for families affected by alcohol and other drugs is important in regard to women who may have dual diagnoses. It is also applicable in providing early intervention for children either prenatally exposed to alcohol or other drugs or growing up in a family struggling with addiction.

## Mental Retardation/Developmental Disabilities

Fetal alcohol syndrome is considered to be the leading preventable cause of mental retardation in this country.[17] Increasing knowledge about the relationship between prenatal consumption of alcohol and birth defects highlights interagency opportunities for prevention and early intervention. In regard to alcohol, tobacco, illicit substances, or other medications and products, both professionals and the general public require continuing education about the risks of abuse, prevention strategies, and the need for prompt identification of and intervention with those affected.

Whether from direct toxic exposure prenatally, environmentally imposed risk, or a combination of those factors, developmental delay is a significant problem for children who are affected by alcohol and other drugs.[18] Through State-sponsored programs and local boards, adults and children can receive diagnostic services and some treatment services. Staff in agencies that serve those with developmental disabilities are important in the identification and referral of at-risk individuals and family members. The services they provide will be most effective when offered within the context of the comprehensive services needed by families affected by alcohol and other drug use.

## Education

Prevention programs have been a focal point for school systems across the country. In regard to women of childbearing age and young children, the educational system plays an equally important role in identification, early intervention, and supportive services.

The Individuals with Disabilities Education Act (P.L. 99-457) and its recent amendments (P.L. 102-119) support the educational readiness of young children by establishing a system of early intervention services from birth through entry into school. The paradigm of systems coordination that has developed through early intervention services is tailor-made for the child at risk for developmental delay because of prenatal or environmental exposure to drugs or alcohol. Both Part H of the Act (children ages birth through 2 years) and Part B (children ages 3 to 5 years) call for the integration of health, social, and educational services as part of individualized planned response and demand that such plans be family centered. The best opportunities for assuring appropriate coordinated services for affected children are instituting early intervention services and making children at risk for developmental delay eligible.

Head Start programs offer another opportunity for identifying the drug-affected child and family intervention. Based on the successful involvement of parents in Head Start, vigorous efforts are under way to support those parents who may be struggling with addiction.[19]

As drug and alcohol dependent parents are rehabilitated, attainment of educational skills which allow meaningful employment are a must. Adolescent parenting programs, G.E.D. certificate programs, job training, and job development are being increasingly incorporated into community demonstration models to encourage and sustain self-sufficiency; these provide excellent opportunities for collaboration among agencies.

## Corrections

Significant numbers of incarcerated pregnant and parenting mothers and fathers are dependent on alcohol and other drugs. Unfortunately, incarceration often means lack of basic health care, risk-appropriate prenatal care, and drug and alcohol treatment.[20] Agency staff note that incarcerated parents often lack information about the harmful side effects of substance abuse, personal health care, and parenting. At the same time, they have found

parents to be receptive to education and other services—even without coercion. The high-risk populations of men and women residing in prison are in need of the attention of maternal and child health providers, child welfare workers, alcohol and other drug treatment providers, and others in obtaining services necessary for health, recovery, and family reunification.

## Juvenile Services

There appear to be strong associations among adolescent pregnancy, dropping out of school, chronic legal entanglements, and alcohol and drug abuse. Youth involved with juvenile justice systems are at high risk for each of these situations. Juvenile justice officials and institutional staff may be eager to coordinate with State agency staff members around the health, treatment, and educational needs of youth in the system. Ideally, a State interagency consortium will involve juvenile justice authorities not only in designing treatment programs for incarcerated youth, but also in prevention and early intervention efforts. Such collaboration offers the hope of reducing the number of first-time offenders and recidivism rates. It also enhances an understanding of the complex needs of adolescents by staff from each of the State agencies who interact with adolescents.

## Elected Officials

Depending on their ownership of the problem, the legislative and executive branches of State government will be either partners or adversaries in accomplishing the goals of a State coalition. Ultimately, they dictate final goals. It is wise, therefore, to include them as active members of the consortia. Staff members from the Governor's office and the Attorney General's office, as well as members of the State legislature, their aides, and others, should participate in cross-training opportunities, in studies of the problems, in constructing recommendations, and in implementing responses.

## Other Groups

The above discussion centers on those State agencies in which staff are most likely to encounter families involved with substance abuse. In developing statewide plans and programs, representation from or liaison with other agencies and organizations may be productive. State agencies dealing

with economic development influence community policies regarding the advertisement of tobacco and alcohol products, and can target employment programs toward particularly disadvantaged groups. The input and involvement of professional organizations, the business community, and grass-roots organizations should be incorporated at all levels of activity.

When asked about barriers to early success, consortia members with experience in addressing the needs of families affected by alcohol and other drug use have stated that not identifying and bringing all involved agencies to the table at the onset of the process had been their greatest stumbling block.[21] State officials are urged to heed this lesson and to draw together the participants for creating a service system that truly responds to the needs of such families. As the consortia matures, there will be opportunities to broaden membership even further. Diversity in consortia membership will enhance ownership of the problems and solutions and will lend greater creativity to the programs devised. The benefits are worth the energy required to blend the concerns and styles of additional agency representatives.

CHAPTER 3

# ESTABLISHING COLLABORATIVE EFFORTS

Several aspects of alcohol and other drug use among women of childbearing age and their families thwart attempts by single providers or even single agencies to effectively serve them.

First, rehabilitation of a mother or intervention with a drug-affected child demands the attention of the multiple service systems that serve them in our society. Experience in community-based projects is showing that the entire family unit plays a role in either motivating its members toward recovery or propelling them further into addiction and dependency. A second common observation is that addiction gradually shreds any organization in the lives of those who are alcohol or drug dependent, presenting them with seemingly insurmountable legal, financial, and social problems. The current inadequacy of resources and the opportunity to lessen the impact of harmful substances on families now demand that agencies combine their energies.

Thoughtful planning and implementation are often viewed as a hindrance to urgent action. Lessons learned through other collaborative efforts have shown that guiding the process of collaboration actually conserves time spent across multiple organizations and provides a road map for constant adaptation of activities to changing environments.

In establishing an interagency approach, four stages of development can be described: formation, conceptualization, development, and implementation.[22] Each stage is characterized by a specific set of tasks which can be illustrated using the experiences of communities and organizations active in serving families affected by alcohol and other drug use.

## Formation
### Membership

The message from long-standing consortia bears repeating: Not identifying and bringing all potential agencies to the table at the onset of the process had been their greatest stumbling block.[21] Assembling a large membership may seem unwieldy, but early involvement in a group is critical to full participation in problem identification and resolution. Those agencies left out may actually be a hindrance to achieving consortia goals.

Broad membership will also allow balanced policy and program development. Any one agency or profession is likely to view substance abuse within the context of their own training and experience. For example, health professionals may focus heavily on the content of prenatal or child health care, while failing to ensure appropriate maternal alcohol or other drug treatment. Those concerned with the provision of alcohol and other drug treatment for the mother may fail to recognize the significance of co-existing mental illness. Without specific training on the cause and consequences of addiction and dependency, child welfare workers may be critical of a mother's needs. Blending agency and professional perspectives begins in mutual examination of the problem and continues with planning, implementation, and evaluation.

As the interagency group assembles, it should be aware of the potential for overlap in purpose and authority. Maternal substance abuse may be seen as part of the responsibility of alcohol and drug agency services, as an issue for health planning, or as a concern of child welfare. Each agency is likely to have initiatives addressing more global concerns. The interagency group will need to clarify its sphere of concern as related to individual agency activities.

### Group Structure

Answering questions about the organizational structure of the interagency group may guide invitations to participate. How long is the group to function? If the intent is to institutionalize the group, can organizations and businesses outside State government be included as equal partners? Is participation in highly structured meetings the only way for consumers of services to contribute to the partnership?

Existing interagency collaborative efforts, such as Healthy Mothers, Healthy Babies coalition, have been used successfully to launch State and

community efforts. Through already existing organizations, administrative resources can be conserved and community acceptance of new activities around perinatal addiction facilitated.

## State and Local Community Relationships

The relationship between the State interagency group and local communities will be determined in part by the existing State agency structure. For example, in some States, local health departments are units of the State agency with budget, policy, and programming emanating from the State agency. In other States, local health departments are largely autonomous and directed by local elected or appointed boards. The independence of such local agencies means that their participation will depend upon their perception of mutual benefit coming out of the interagency group.

Regardless of the State-local relationship, the community should be the focal point of planning and support since it is at the neighborhood level that programming can best respond to local alcohol and other drug usage patterns, service availability, and cultural differences. During the past decade, work around early intervention for children has shown that State interagency groups can learn and benefit from innovation at the local level. In Missouri, the State-level interagency group participants believe they are able to better monitor and adapt the effectiveness of their policies because they maintain close contact with local agencies providing direct services to their target population.[23]

## Leadership

Leadership for the interagency group will also depend on membership and will influence group structure. Membership, leadership, and structure of an interagency group may already be established by State law. It is common for a single lead agency to be selected so that responsibility for group process can be clearly assigned.[24] Not all believe this is desirable, however, with some preferring a shared authority.[25] Sharing or rotating leadership allows each agency to provide direction to the group and brings recognition to their particular area of expertise and responsibility.

## Conceptualization
## Establishing a Mission and Philosophy

Definition of a unified mission statement and philosophy is the first task of a newly assembled interagency group. The relative importance of supportive vs. punitive approaches, designation of special populations to be served, and beliefs about various modes of prevention and treatment are but a few of the issues which may stir debate among members. Since early commitment to the group will be fostered by early success, it is important to adopt principles on which there seems to be a high level of agreement. Divisive issues can be negotiated more easily after some group identity and trust has been established.

In Ohio, the Task Force on Drug-Exposed Infants immediately adopted a preliminary set of guiding philosophical statements to set itself apart from the myriad of other legislative, judicial, and criminal justice commissions already in existence.[26] Task force members acknowledged that further investigation and potential solutions might result in a change of direction for the group. Still, the philosophy statements established an identity that attracted debate, and generated information and invitations to publicly explore perinatal substance abuse issues.

## Building Consensus

Several barriers to consensus building need to be identified and overcome. The interface between agencies is similar to that of different cultures. Specific "language" or jargon exists in each agency culture, along with unique perspectives on the problem, specific Federal or State mandates, etc. Just as effective translation of language must be literal and conceptual, so too translation across agencies and between staff of different professional backgrounds must account for terminology, definitions, and perspectives. For example, the definition of "prevention" in one system may refer only to activities that prevent first use, while other systems may apply prevention to aspects of early intervention and rehabilitation as well.

Another significant barrier to consensus is resistance to change. Agency staff should be wary of such resistance in themselves, from their own agencies as the group moves ahead in its understanding of the issues, and from the outside as recommendations for change are made and pursued. Moderating the threats inherent in change is often possible. Some interagency groups

have approached this by scheduling quarterly updates for their agency directors or through ongoing training sessions for agency staff not participating directly in group activities.

A method increasingly used to improve understanding among agencies is cross-training of staff. Federal agencies, several communities, and some States have "loaned" agency staff to each other either for a period of time or to work on a specific interagency project. The result has been increased appreciation for the resources, constraints, and policies among the agencies involved in exchange and improved program coordination. If exchanging staff is not possible, interagency group meetings can be rotated among the physical settings of member agencies or group members can participate in site visits to agency projects in the field.[27,28]

## Needs Assessment

Each agency joins the partnership with different understandings of the problem, its own information sources and data, which may or may not be comparable to the data of other agencies. After an initial listing of questions to be answered and while early consensus is being gained on group goals and objectives, agencies can identify information available to each. Definitions of data elements, the cost and personnel resources required to access data, and the compatibility of information management systems must be clear in order to judge its availability.

The usefulness of data lies in understanding its limitations. Both data elements and the systems which manipulate the data contribute to the accuracy of information obtained. All members of the State interagency group should strive to reach a common level of understanding of these limitations so that they speak the same language in analyzing and responding to the data.

Data inform all steps of the coordination process. They are needed to define the common problem(s) uniting the State interagency group, to formulate goals and objectives, to quantify and qualify results, and to support evaluation. Once the interagency group has acquired a preliminary understanding of the extent of perinatal substance use-related problems—such as the number of women who use alcohol or other drugs during pregnancy, and what the ideal situation might be—they can formulate measurable goals and objectives. The specificity of the goals and objectives

may be driven by existing State plans, by legislative or regulatory mandate, or by community expectations for information. Evaluation of group success in meeting their objectives may lead to refinement or adjustment of objectives and a gradual maturation of the needs assessment process.

## Evaluation

The foundation for evaluation of group efforts should be established early in the group's organizational development. Records of the process and progress should be kept from the group's first formation. Consortia functioning over several years report the importance of being able to reflect back on group successes, even those that seemed minor at the time.[26] Evaluation of outcomes depends on knowledge of the conditions at the outset of group efforts and the degree to which goals and objectives are met. After choosing indicators and tools to measure progress, the group members must constantly examine the data they have collected and reassess whether they are measuring what they initially intended.

## Development

During the third stage of interagency consortia growth, working groups and communication networks are established. Certain committees and communication patterns will have developed earlier, during the stages of formation and conceptualization. Upon completion of the needs assessment, however, the consortia moves into a period of intense activity as it determines potential activities and prioritizes them.

## Communications

Committees may focus their work on individuals within the family, on various service needs, or on functional issues, such as legislative concerns, confidentiality, or mechanisms of interagency coordination. Regardless of how the work is divided, committee issues will overlap. A clear pattern of information sharing and planning should be established among group members. Arrangements for necessary sign-off from agency directors and other authorities should be thought through ahead of time.

Given the public visibility of the issue and of most State agency groups, communication with advocates, the news media, and other interested parties should be well-planned. Regular media contact can avert premature criticism

of the group's efforts and actually build community support. Sunshine laws* applying to public agencies may allow media representatives more knowledge of consortia activities than the group desires; however, the consortia should be prepared for their presence.

Even while the consortia is in developmental stages, the support of advocacy groups should be nurtured. Local consortia and consumers are especially important in this regard. In two-way exchange, the public can be both informed and their input sought through public hearings—a rich source of information about community attitudes and services.

There are several vehicles for communication throughout the life of the consortium. Newsletters can relay brief updates on consortia membership, requests for information or contacts. Consortia members may serve as presenters at conferences or training seminars where they have an opportunity to advance the agenda of the consortium. Provision of testimony on related legislation even before recommendations are finalized may be critical, given the somewhat unpredictable timetable for bill passage. Support gained as the consortium proceeds with its work will serve to strengthen its ability to accomplish system changes in a timely manner.

## Cooperation vs. Collaboration

At this point in its life, the consortium will also be facing decisions about the extent to which members are willing to integrate services. Terminology describing the stages of interagency relations is evolving. In this document, coordination refers to any stage of interagency effort across the full range of possibilities. The Education and Human Services Consortium, Washington, D.C., draws a clear distinction between cooperation and collaboration.[29] Cooperation allows multiple agencies to meet their respective organizational goals, to assess the need for more comprehensive services, and coordinate existing services without changes in the basic services or in agency policies and regulations. Budgets remain under the control of the parent agencies.

The interagency group functioning at a cooperative level should not consider themselves at an inferior starting point. Participating agencies may not be ready philosophically to move beyond cooperation, or they may not have the authority and resources to enter a collaborative effort. Better

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* *The term* sunshine law *often refers to laws which require government agencies or other publicly-subsidized entities to open to public scrutiny the information they gather, the documents they produce and all their operations. Exceptions are stipulated in law.*

understanding of the issues surrounding perinatal substance abuse, improvement in the quality of services, minimal duplication of services, and increased interagency referral of clients are a few of the benefits of cooperative activities.

Collaboration requires partners to relinquish total control of resources in favor of the group process. Resources are pooled while consortia members jointly plan, implement, and evaluate new services and procedures. Budgetary resource commitment is usually the acid test of agency buy-in to consortia activities. In order for this to occur, agency directors must be supportive of the consortium, and representatives to the consortium must be able to influence the redirection of policies, resources, and facilities in their own agencies. Cooperative activities which are successful will build tension towards increasingly collaborative efforts.

An example of collaboration can be seen in States which establish a single pooled fund drawn from the monies available to member agencies. The mechanism for disbursing funds, the activities to be funded, and the requirements for reporting are determined by group consensus.

## Implementation

Written agreements and adapted policies become the concrete evidence that the consortium is ready to implement its plans. As legally binding commitments, memorandums of agreement among agencies test the willingness of the participants to move forward with plans. Because of existing Federal requirements, several member agencies may already have written agreements which address at least a portion of the services needed for prevention and intervention on behalf of families affected by alcohol and other drug use. Their experience in negotiating and executing those agreements are of benefit to the group. Indeed, existing agreements may require only an addendum to accomplish certain consortia goals.

The interagency consortium will realize success as policies, rules, and regulations of the parent agencies become consistent with the philosophy of the consortium. Unfortunately, the short life of task forces, lack of parent agency investment in consortia activities, and the instability of political environments often jeopardize even the best conceived plans. Community groups working under demonstration grants have found that it may take as long as 1 to 3 years after the development of goals, objectives, and an implementation plan to overcome unforeseen administrative, community,

and conceptual barriers. With frequent turnover in key cabinet posts, elected officials and other leaders whose support is critical to sustained consortia activity, interagency groups can easily loose momentum and disband. Therefore, the interagency group should identify mechanisms, such as legislation, for assuring continuity of successful collaborative activities.

## Evaluation

Evaluation of movement toward consortia goals is a process that continually refines the mission, philosophy, and goals of the interagency group. It may result in consortia membership changes or adaptation of the organizational structure and leadership. The ultimate client outcomes related to decreased impact of drug and alcohol abuse on women, their children, and their families should dictate the necessity for consortia realignment.

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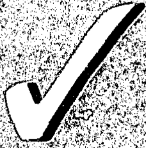


# GUIDELINES FOR ESTABLISHING COLLABORATION

Although details of the collaborative process in each State will be as diverse as the families and communities being served, the organizational structures of involved agencies and the resources available, recommendations for successful group process are emerging from the work of Federal, State, and community agency staff who together have grappled with the issue of perinatal alcohol and other drug use. Lessons learned through trial and error are discussed in previous chapters but are summarized here as guidelines. They are offered as a springboard to policy and program development to more effectively and efficiently reduce the impact of alcohol and drug use on women, their children, and their families.

## GUIDELINES

1 Successful response to perinatal alcohol and other drug use demands the coordination of services among multiple agencies and the professionals who interact with families affected by alcohol and other drug use.

2 Mutual appreciation for the differences in agency histories, missions, legislative mandates, funding requirements, and operating mechanisms can greatly ease developing common ground for action.

3 Deliberate guidance of the process of collaboration conserves the staff effort that is often invested in tasks that cross multiple agencies. It provides a road map for constant adaptation of activities to changing environments.

4 Early involvement of a broad membership is critical to full participation in problem identification and resolution. Failure to involve key agencies may hinder implementation of consortia goals.

5 The local community should be the focal point of State interagency planning and support, with community members informing the interagency process and providing evidence of its success.

6 Development of a unified mission statement and philosophy is the defining task of a newly established group.

7 Agency staff members serving on a consortium must be aware of interorganizational differences in language, terminology, and perspectives, and of both personal and organizational resistance to change.

8 Members of a consortium must allocate time for agency and discipline cross-training. The education process is continuous and will keep consortia members abreast of changes, trends, and emerging issues in all related fields.

9 An ongoing record of progress and a review of group successes will provide important motivation for the group as members struggle through the stages of development and implementation of coordinated service systems.

10 Existing interagency consortia dedicated to human service system change can provide templates on which to build interagency efforts to reduce the impact of alcohol and other drugs on families and communities.

11 Individual agency support of consortia efforts through funding and other resource sharing gives evidence of the level of commitment to consortia goals. It frequently parallels the maturing of agency relationships: The financing of early cooperative activities are controlled by individual agencies, while collaborative strategies are usually accomplished through pooled funds under the group's control.

12 Evaluation of movement towards consortia goals will allow continual refinement of mission, philosophy, goals, membership, structure, and leadership.

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