PRACTICE GUIDELINES

BETWEEN

TORONTO SUBSTANCE ABUSE TREATMENT AGENCIES

AND

CHILDREN'S AID SOCIETIES

Revised Sept. 2005

This document was developed by a working group in consultation with a broad group of stakeholders in both the substance use and child welfare sectors.

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Women's Own Withdrawal Management Centre

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Between
Toronto Substance Abuse Treatment Agencies
And
Children's Aid Societies

RATIONALE

Since substance use is common amongst individuals who are involved with the child welfare system and is often a reason for child welfare involvement in the lives of children, it is important that those involved in decision making regarding both child welfare and substance abuse treatment issues have a good understanding of the continuum of substance use (from no use or experimental use to abuse and dependence) and its impact on caregivers, parents, parenting and children. Roles, responsibilities and expertise of both substance abuse treatment services and child welfare services need to be mutually understood and respected. It is important that both systems develop a shared understanding that the welfare of children is of paramount importance. Collaboration and communication are essential to effectively meet the complex needs of our clients.

Clear communication between child welfare and substance abuse service providers is essential so that relevant and appropriate information can be shared in a timely manner. It is important that child welfare workers have a fundamental understanding of addictions and know when and who to consult on a case by case basis should they have questions about the implications and possible impact of specific episodes or pattern of use. Similarly, substance abuse workers need to understand the impact of substance use on children and need to clearly understand their reporting obligations. The context and consequences for the family would likely determine whether use is a concern with regard to the safety of children. Workers in both systems need to be clear about who would make the determination regarding whether a report needs to be made, what the criteria would be and what actions would be taken.

Open communication and trust would allow all the relevant parties to have the information they need to bring together their knowledge and expertise so that the best possible plan can be made for the clients and so that we can ensure as much as possible that no one "falls through the cracks". Misconceptions of substance use issues and/or child welfare practices may result in service providers in both sectors avoiding consultation from each other or making referrals. Similarly caregivers with substance use concerns may avoid seeking help or downplay their concerns, out of fear of penalties. (See Core Dilemmas, Appendix E)

This guideline attempts to build on practice principles that are already the basis of good counselling practice regarding collaboration amongst service sectors and agencies. It is an attempt to avoid a prescriptive approach and to promote collaboration, consultation, communication and joint planning when child welfare and substance abuse treatment resources have clients in common.

PURPOSE OF THE GUIDELINES

- To promote the safety of children and families
- To facilitate optimal outcomes for children, parents and other caregivers
- To promote a co-operative and positive working relationship between substance abuse treatment agency staff and child welfare staff
- To facilitate open communication, collaboration and effective problem-solving at both the case management and system levels
- To clarify roles and responsibilities
- To facilitate inter-sectoral training
- To promote familiarity and relationship-building between local substance abuse treatment agencies and child welfare agencies
- To promote effective treatment planning and case management

STAKEHOLDERS

Catholic Children's Aid Society of Toronto
Children's Aid Society of Toronto
Jewish Family and Child Service
Native Child and Family Services Toronto
Substance Abuse Treatment Agencies (See Appendix A)

VALUES AND PRINCIPLES

- The safety and well-being of the child is paramount
- Child welfare and substance abuse treatment agencies are committed to working collaboratively to assist parents to make choices that will promote the safety and well being of their children
- Early intervention is essential as substance abuse can impair parenting and the younger the child, the greater the risk to safety and for long term neglect
- An environment of encouragement and motivation is important for the development of a therapeutic relationship based on trust and a non-judgmental outlook. This needs to be balanced against the primary mandate of child protection.
- Parents, youth, and other caregivers need to be able to access substance abuse treatment and allied support services in a timely manner
- Pregnant women who are not yet parents benefit from early intervention support and service coordination from substance abuse treatment and child welfare service providers
- Staff of each sector will assist clients to recognize the potential benefits of involvement with the other sector and will strive to keep the clients engaged.
- Information sharing, with client knowledge, informed consent and participation between professionals, is critical to good case co-ordination
- Staff of both sectors will acknowledge each other's professionalism and expertise when sharing concerns, information and treatment planning.

ROLES AND RESPONSIBILITIES

- All professionals, under the "duty to report", have the on-going responsibility to refer to child welfare when they have reason to believe that children are being adversely affected by their caregivers' behaviours and/or if they have learned that the child is at risk of harm or has been harmed
- Child welfare workers have responsibility for investigations and case management in child protection matters and that responsibility cannot be delegated along with responsibility for advocacy and support. (See Appendix B)
- Substance abuse service providers have responsibilities for a wide range of services, which may include providing community outreach, case management, and consultation, counseling and psychoeducational activities to people with substance use concerns and related issues and/or to those who may be impacted by substance use, depending on agency mandate.

1. Service Co-ordination

- The children's aid society worker, substance abuse treatment counselor and the caregiver will work together to establish a plan that outlines expectations and goals
- As case manager, the child welfare worker has the primary responsibility to ensure the plan is clear, role assignment is understood and the plan is supervised
- Wherever possible, consent for release of information will be obtained to allow for on going collaboration and sharing of relevant information in a timely fashion between child welfare, the service providers involved and the client
- The plan should include:
    a. Specific and clear outline of tasks and timelines
    b. Clear identification of responsibilities for tasks
    c. Clear identification of responsibility for verification of tasks and follow-up
    d. Clear understanding between child welfare and substance abuse treatment staff of the circumstances under which child welfare would have to be notified
- Child welfare and substance abuse treatment staff should strive for a case conference with the client at the beginning of treatment and every three months or at termination of treatment, whichever comes first
- For cases involving residential or brief treatment interventions, everyone will strive for a minimum of one case conference between substance abuse treatment staff and child welfare staff, timing to be determined on a case by case basis
- Child welfare staff are available to substance abuse treatment staff as a resource regarding consultation around a specific case or to answer questions around general protection concerns
- Consultation with child welfare does not require disclosing identifying information about the client
- If consultation demonstrates the need for a protection referral – the substance abuse treatment staff will be advised to make a referral

2. Communication

- Child welfare staff will respond to referrals made by treatment staff according to Ministry Standards. In cases of an allegation of physical/sexual abuse or serious neglect, the response time is usually 12 hours and a maximum of 7 days in all other cases
- Treatment agencies can expect a call back regarding the child welfare agency's response to the allegation and every effort will be made to ensure that the client remains engaged with the relevant services. Type of information shared will be dependent on whether consent for release of information has been signed by the client.
- The sharing of information between child welfare staff and treatment staff is pivotal to effective teamwork and the provision of co-ordinated service
- The importance of sharing information will be explained to caregivers ideally by the child welfare worker and treatment counselor together and information disclosed will be done so with the signed consent of the caregiver
- Any concerns regarding the immediate safety of children supercedes the existence of a signed consent to share information
- Any concern about decisions made by either sector should be resolved whenever possible between the staff involved
- If not successful, matters should involve respective supervisory or management staff
- Consultation can be sought about substance abuse and child welfare issues through resources listed in Appendices A and B

3. Training

- Opportunities for inter-sectoral networking, consultation and on-going dialogue will be established
- Each sector operates from a set of philosophical beliefs and principles that need to be identified and discussed in training in order to effectively work together to serve children and families (See Appendix E)
- Child welfare sector will identify areas of training and information needs regarding substance abuse
- Treatment sector staff will identify training and information needs regarding child welfare
- Whenever possible training will be co-facilitated by staff from both sectors who already have expertise working cross- sectorally

4. Review

- A process will be established to review and evaluate the effectiveness of these guidelines

Appendix A

OVERVIEW OF SUBSTANCE ABUSE TREATMENT RESOURCES

Ontario Drug and Alcohol Registry of Treatment (DART)

Provides information about local assessment and referral, withdrawal management, and other treatment resources (including wait lists and availability) across Ontario to professionals and members of the public. This service is easy to use and staff are knowledgeable and accessible.

Information and Referral Phone	1.800.565.8603
Information and Referral Email	info_ref_services@dart.on.ca
Data and Information Services Email	data_info_services@dart.on.ca
Website	www.dart.on.ca

Addiction Clinical Consultation Service (ACCS)

Provides advice to professionals on:

- Medical complications of drug and alcohol use
- Management of clients with addiction problems
- Counselling for individuals, couples and families
- Alcohol, tobacco and illicit drugs, prescription and over-the-counter drugs
- Drug interactions
- Concurrent disorders

Toll Free Phone	1.888.720.2227
Toronto Area Phone	416.595.6968
Website	www.camh.net/about_camh/Guide_AddctnClinConsultSvc.html

Please Note: Staff will assess your query, contact the appropriate consultant team (medical, psycho-social or pharmacy), and provide relevant information and materials. A consultant will return your call within four hours.

Metropolitan Toronto Addiction Assessment and Referral Service (MAARS)

Offers:

- An assessment and referral service which serves the public directly, providing in-person assessment, treatment service matching and referral for individuals
- Some case management is provided pending an individual's beginning with a treatment program
- Consultations are provided for social service professionals and family members. This service is provided for anyone living in the GTA and is available in English, Spanish, Cantonese, Serbian, Hungarian and Slovenian.
- No referral is required.

Phone	416.599.1448
Website	www.camh.net/about_camh/Guide_AGT_MAARS.html

Pathways to Healthy Families

A partnership program with six locations throughout Toronto focusing on pregnant and/or parenting women with substance use concerns and their children ages 0-6 years and providing:

- Consultation, liaison, information and linkages to professionals
- Outreach, information, support, counselling and referrals for clients

Locations

Rosalie Hall, Scarborough	416.438.6880, ext. 333
Robertson House, Shelter System and Downtown	416.392.0190
Massey Centre for Women, East Toronto	416.425.6348, ext. 239
Native Child and Family Services of Toronto, Aboriginal Community	416.969.8510, ext. 233
Lawrence Heights Community Health Centre, North York	416.787.1676, ext. 224
Rexdale Community Health Centre, North/Central Etobicoke	416.744.6312, ext. 225
Jean Tweed Centre, Central Office	416.255.7359, ext. 242

Website www.jeantweed.com/Pathways.htm

Appendix B

OVERVIEW OF CHILD WELFARE AGENCIES

There are three mandated child welfare agencies in Toronto. They include Catholic Children's Aid Society of Toronto (CCAS), Toronto Children's Aid Society (CAST) and Jewish Family and Child Service (JF&CS). CAST and CCAS have existing protocols in place with Native Child and Family Services. In cases involving aboriginal families, the child welfare agency will contact Native Child and Family Services to assist with the provision of service. NCFST has been mandated as a child welfare agency as of July 5, 2004.

Child welfare agencies are mandated to protect children from neglect, physical, sexual and emotional abuse (see Appendix C for definition of a "child in need of protection). Child welfare agencies must investigate reports they receive that a child may be abused or neglected, and assess the risk to the child and, if needed, develop and activate services and supports to keep the child safe.

The legal mandate for child welfare agencies is described in the Child and Family Services Act of Ontario, revised in 2000. The provincial government funds child welfare agencies to carry out these protection responsibilities. The availability of services for children and families, such as prevention and early intervention services vary across the child welfare sector.

Child welfare agencies employ a variety of professional staff to support a range of supportive and prevention activities. These may include Child Protection Workers and Supervisors, Child and Youth Workers, Social Service Workers, Health Specialists, Court Process Assistants, Lawyers, and other administrative and professional staff. Child protection workers provide services, support and guidance directly to families and may also refer to specialized internal services. These include parent support workers, child access programs, educational consultants, and others. Families are also helped to make connections with community programs and other groups, which can provide support and solutions.

In addition to substance abuse professionals, child welfare agencies collaborate regularly with a number of community professionals such as teachers, public health nurses, police officers, doctors and community workers.

What Happens when a Report is made to a Child Welfare Agency?

When an initial report is made to a child welfare agency, it goes to an intake team and is assigned to a child protection worker according to where a family lives. The worker checks to see if the family has a previous history with a child welfare agency and if there are any patterns of concern. The child protection worker may speak to the person who made the report to get more information, and will visit the family and speak to the parents, the children and any other caregivers that may be involved. The investigation may involve an examination of the child by the health specialist or a doctor and gathering information from other professionals working with the child and family. When the report suggests an offence has been committed against a child, the police will be involved in the investigation and criminal charges may be laid against the abuser.

The information gathered is used to decide if the child is at risk of future harm, based on the Ontario Risk Assessment Model, which is used by all child protection agencies in Ontario. The Risk Assessment Model is a clinical tool to assist protection workers in their decision-making. The tool is

comprised of three components: An Eligibility Spectrum (to assist in determining if the client is eligible for child welfare services), a Safety Assessment (to help the worker determine is the child safe right now) and a Risk Assessment (to help predict the risk of future harm to the child).

Once a report is received several outcomes are possible after the investigation: the case may be closed and/or the family may be referred to the community for service, the Society may work voluntarily with the family, court involvement may be required to allow the Society to supervise the family or, the court may order the child be placed in the Society's care. The level of risk to the child will determine the case direction. If ongoing service is required, a worker will be assigned to work with the family to try and resolve the protection concerns. Children in care will be returned to their natural families or substitute caregivers if a safe plan can be put in place. If that is not possible the Society may plan to care for the child long term or may seek alternatives such as an adoptive or family placement. Anytime a child is apprehended, a court hearing will be held within 5 days. Children under six can only be in temporary care for a total of 12 months; for children over six the total time in temporary care can be 24 months.

Emergency Duty Service – After-Hours

Each Children's Aid Society has an emergency duty service covering evenings, weekends and statutory holidays. This service will respond to emergency calls only. All calls are answered by a call centre and referred to a child protection worker that can consult with a supervisor about high-risk situations. The worker may respond to the matter by interviewing the child/family immediately, referring the matter to the daytime staff (who may respond the next business day or within 7 days) or complete a written record of the situation deeming that no immediate child protection investigation is needed.

The telephone numbers for daytime and after hours service include:

Children's Aid Society of Toronto	416-924-4646
Catholic Children's Aid Society of Toronto	416-395-1500
Jewish Family and Child Service	416-638-7800
Native Child and Family Services Toronto	416-969-8510

For more information on Child Welfare Substance Abuse Guidelines, visit www.torontocas.ca/Rep_mainframe.htm and click on "Publications" then "Substance Abuse Guide".

Appendix C – Excerpts from the Child and Family Services Act

INTRODUCTION TO THE CHILD AND FAMILY SERVICES ACT

Ontario's *Child and Family Services Act* (CFSA) provides for a broad range of services for families and children, including children who are or may be victims of child abuse or neglect.

The paramount purpose of the Act is to promote the best interests, protection and well being of children.

The Act recognizes that each of us has a responsibility for the welfare of children. It states clearly that members of the public, including professionals who work with children, have an obligation to report promptly to a children's aid society if they suspect that a child is or may be in need of protection.

The Act defines the term "child in need of protection" and sets out what must be reported to a children's aid society. This definition (CFSA s.72(1)) is set out in detail on the following pages. It includes physical, sexual and emotional abuse, neglect and risk of harm.

DUTY TO REPORT

Under the Child and Family Services Act,

1. "Child" means a person under the age of 16 years old
2. "Child in need of protection" means the definition assigned by section 37(2) of the CFSA

Responsibility to report a child in need of protection CFSA s.72(1)

If a person has reasonable grounds to suspect that a child is or may be in need of protection, the person must promptly report the suspicion and the information upon which it is based to a children's aid society.

The situations that must be reported are listed in detail below.

A child is in need of protection where:

1. the child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's
    a. failure to adequately care for, provide for, supervise or protect the child, or
    b. pattern of neglect in caring for, providing for, supervising or protecting the child;

2. there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
    a. failure to adequately care for, provide for, supervise or protect the child, or
    b. pattern of neglect in caring for, providing for, supervising or protecting the child;

3. the child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child;

4. there is a risk that the child is likely to be sexually molested or sexually exploited as described in clause (3)

5. the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment;

6. the child has suffered emotional harm, demonstrated by serious
    a. anxiety
    b. depression,
    c. withdrawal,
    d. self-destructive or aggressive behaviour, or
    e. delayed development

    and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child;

        i. the child has suffered emotional harm of the kind described in sub clause (6) (a, b, c, d or e) and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm;

7. there is a risk that the child is likely to suffer emotional harm of the kind described in sub clause (6) (a, b, c, d or e) resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child;

        i. there is a risk that the child is likely to suffer emotional harm of the kind described in sub clause (6) (a, b, c, d or e) and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm;

8. the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition;

9. the child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody;

10. the child is less than twelve years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child

does not provide, or refuses or is unavailable or unable to consent to, those services or treatment;

11. the child is less than twelve years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately; or

    a. the child's parent is unable to care for the child and the child is brought before the court with the parent's consent and, where the child is twelve years of age or older, with the child's consent, to be dealt with under this Part.

Ongoing duty to report CFSA s.72(2)
The duty to report is an ongoing obligation. If a person has made a previous report about a child, and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make a further report to a children's aid society.

Persons must report directly CFSA s.72(3)
The person who has the reasonable grounds to suspect that a child is or may be in need of protection must make the report directly to a children's aid society. The person must not rely on anyone else to report on his or her behalf.

What are "reasonable grounds to suspect"?
You do not need to be sure that a child is or may be in need of protection to make a report to a children's aid society. "Reasonable grounds" are what an average person, given his or her training, background and experience, exercising normal and honest judgment, would suspect.

Special responsibilities of professionals and officials, and penalty for failure to report CFSA s.72(4), (6.2)
Professional persons and officials have the same duty as any member of the public to report a suspicion that a child is in need of protection. The Act recognizes, however, that persons working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to report their suspicions, and so makes it an offence to fail to report.

Any professional or official who fails to report a suspicion that a child is or may be in need of protection, where the information on which that suspicion is based was obtained in the course of his or her professional or official duties, is liable on conviction to a fine of up to $1,000.

Professionals affected CFSA s.72(5)
Persons who perform professional or official duties with respect to children include the following:

- Health care professionals, including physicians, nurses, dentists, pharmacists and psychologists;
- Teachers, and school principals;
- Social workers and family counsellors;
- Priests, rabbis and other members of the clergy;
- Operators or employees of day nurseries;
- Youth and recreation workers (not volunteers);
- Peace officers and coroners;
- Solicitors;
- Service providers and employees of service providers; and
- Any other person who performs professional or official duties with respect to a child.

This list sets out examples only. If your work involves children but is not listed above, you may still be considered to be a professional for purposes of the duty to report. If you are not sure whether you may be considered to be a professional for purposes of the duty to report, you should contact your local children's aid society, professional association or regulatory body.

Professional confidentiality CFSA s.72(7),(8)
The professional's duty to report overrides the provisions of any other provincial statute, specifically, those provisions that would otherwise prohibit disclosure by the professional or official.

That is, the professional must report that a child is or may be in need of protection even when the information is supposed to be confidential or privileged. (The only exception for "privileged" information is in the relationship between a solicitor and a client.)

Protection from liability CFSA s. 72(7)
If a civil action is brought against a person who made a report, that person will be protected unless he or she acted maliciously or without reasonable grounds for his or her suspicion.

What will the children's aid society do?
Children's aid society workers have the responsibility and the authority to investigate allegations and to provide services to protect children. A children's aid society worker may, as part of the investigation and plan to protect the child, involve the police and other community agencies.

How to contact a children's aid society
Check the telephone directory for the office closest to you. In some communities, the children's aid society is known as "family and children's services". The emergency pages in most Ontario telephone directories have the number to call to report to a children's aid society. All the children's aid societies/family and children's services have emergency service 24 hours a day, so that you can call anytime.

Appendix D

CHILD WELFARE CONTACT INFORMATION

Catholic Children's Aid Society of Toronto

Branch/Office	Street Address	Telephone	Fax
Head Office	26 Maitland St. Toronto, ON M4Y 1C6	416-395-1500	416-395-1581
Etobicoke/York Branch	Six Points Plaza 5320 Dundas St. W, Ste. 1 Islington, ON M9B 1A8	416-395-1698	416-395-1425
North York Branch	30 Drewry Ave. North York, ON M2M 4C4	416-395-1700	416-395-1867/1868
Scarborough Branch	1880 Birchmount Rd. Scarborough, ON M1P 2J7	416-395-1966	416-395-1950
East Toronto Branch	2494 Danforth Ave. Ste A Toronto, ON M4C 1K9	416-395-1600	416-395-1539
Toronto Branch	Dufferin Mall 900 Dufferin St. Ste. 219 Toronto, ON M6H 4B1	416-395-1690	416-395-1704

Children's Aid Society of Toronto

Branch/Office	Street Address	Telephone	Fax
Head Office	789 Don Mills Road, 3rd floor Toronto, ON M3C 1T5	416-924-4646	416-324-2485
Intake Services	789 Don Mills Road, 11th floor Toronto, ON M3C 1T5	416-924-4646	416-324-2507
Etobicoke Branch	70 Chartwell Rd. Etobicoke, ON M8Z 4G6	416-924-4646	416-324-2556
North York Branch	4211 Yonge St., Ste. 400 North York, ON M2P 2A9	416-924-4646	416-324-2554
Pape Adolescent Centre	469 Pape Ave. Toronto, ON M4K 3P9	416-462-1010	416-462-0161
Scarborough Branch	843 Kennedy Rd. Scarborough, ON M1K 2E3	416-924-4646	416-324-2553
Toronto East Branch	15 Huntley St. Toronto, ON M4Y 2K9	416-924-4646	416-324-2552
Toronto West Branch	Dufferin Mall 900 Dufferin, Ste. 201 Toronto, ON M6H 4B1	416-942-4646	416-324-2555

Jewish Family and Child Service of Greater Toronto

Branch/Office	Street Address	Telephone	Fax
Head Office	4600 Bathurst St, 6th Floor Toronto, ON M2R 3V3	416-638-7800	416-638-7943
Downtown Branch	750 Spadina Ave, 1st Floor Toronto, ON M5S 2J2	416-961-9344	416-961-9351
Thornhill Branch	1 Promenade Circle, Ste 313 Thornhill, ON L4J 4P8	905-882-2331	

Native Family and Child Services of Toronto

Branch/Office	Street Address	Telephone	Fax
Head Office	295 College St. Toronto, ON M5J 1S2	416-969-8510	416-928-2109

Appendix E

CORE DILEMMAS

The primary goal of Children's Aid Societies is to protect children from maltreatment and neglect by strengthening and empowering the child's own family to ensure that children receive safe and nurturing care at home. This obligation accepts the fact that the family-centered model of practice does not always result in the preservation of the child's own family. When services to support and empower families cannot protect children at home, other placement alternatives must be considered.

Substance abuse service agencies, which are also client centered, are focused on the needs of the parent with a substance abuse or substance dependence problem. The various substance abuse service models do not impose compliance with treatment goals by relying on an ultimate enforcement process but rather attempt to encourage and motivate the individual to return to a treatment plan in which his/her participation is essential to success. Substance abuse staff accept the fact that a variety of more intensive treatment approaches (stepped care) might be required before the client can begin to understand the cycles caused by the dependence.

Experts canvassed during the preparation of the Health Canada "Best Practice" project found that there was a significant level of key expert consensus around several barriers affecting access to treatment.

Fear of losing children	Most key experts identified caregivers' fears of losing their children to their partners or child welfare as a central reason for not accessing treatment. Key experts described this fear as "immense." Many caregivers have total responsibility for their children. They fear having to give their children to child welfare (in order to enter residential treatment) and "never getting them back."
Inadequate diagnostic services/poor or incomplete diagnoses.	A large number of key experts noted that caregivers with mental health disorders are poorly diagnosed at intake by both the mental health and alcohol/drug treatment systems. Substance abuse programs may not have the staff expertise to provide comprehensive mental health assessments. Mental health staff may overlook addictions problems
Isolation	Caregivers with concurrent problems are highly isolated. They often lack personal and family support and may fear entering treatment which involves outreach to others
Lack of confidentiality and privacy	Acknowledgment of alcohol/drug problems is particularly difficult in small communities where social networks are small and interconnected, and where there is a lack of privacy and confidentiality. By acknowledging problems with alcohol or drugs, caregivers risk not only their own reputations but also those of their families and children.
Inflexibility	Rigid abstinence requirements are too inflexible for many caregivers.

Consequently, in many cases the legislative and policy requirements imposed on both service groups, the philosophical approach of employees and entrenched informal practices lead to approaches to intervention that may yield to conflict:

- Agencies have different mandates (Substance abuse treatment may consider the caregiver to be the primary client while children are the statutory clients of Societies but they don't exclude other family members).
- The harm reduction approach in clinical interventions adopted by substance abuse treatment services may conflict with the risk assessment model used by Societies that may require abstinence.
- Preferred treatment modalities dictated by the stepped care policy might encourage a treatment plan for the caregiver that could be in conflict with the outcomes expected from the Plan of Service implemented by a Society protection worker as a result of the risk assessment performed on the child.
- The substance abuse treatment system (Setting the Course) accepts client choice in the development of treatment plans consistent with the agencies' program policies. The Societies might be required to enforce certain conduct or conditions regardless of a client's wish since the welfare of the child is paramount.
- Substance abuse treatment agencies may approach relapse as a component of a long-term recovery process and Societies are mandated to reassess conduct to ensure that the child will not be put at risk.
- Substance abuse treatment agencies respect the privacy of the therapeutic alliance with the caregiver by informing the caregiver at the onset the nature of limitation of the confidentiality and the duty to report on section 72 of the CFSA. Societies attempt to provide guidance, counselling and other services to families as per section 15(c) of the CFSA.

Substance abuse treatment agencies recognize that client retention in treatment programs is dependent upon:

- Treatment that is flexible—allows caregivers to move in and out as required.
- Treatment that is client-centred and individualized.
- Treatment that is provided in the context of relationships with family and others.
- A clinical relationship where relapse is not a defining point in recovery.
- Treatment offers a menu of services.
- Treatment looks at small goals and short-term success.
- Treatment is matched specifically to client need.
- Treatment discharge is planned in advance.
- Staff have respectful and collaborative relationships with clients.

Please Note: The above information has been adopted from the *Champlain Health District Children's Aid Society and Addiction Services Agencies Protocol*.