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5 Effective Referrals and Collaborations

Adopting a holistic view of clients in substance abuse treatment is especially important for any service provider making referrals to other providers or agencies. At the point of referral, there is both an opportunity to address a client's unmet needs and a potential danger of losing the client. Collaboration is crucial for preventing clients from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

This chapter explores the elements of integrated services using a community–collaborative model. This model is based on an agency's ability to make effective referrals within a network of numerous agencies, including vocational services, serving common clients. Only when these service providers are truly interconnected can they work together toward the common goal of successful client outcomes. The phrase *authentically connected* has been coined to describe an integrated network in which agencies function as equal players with each other and with the client to identify and address the complex interplay of needs that is typical of clients with substance abuse disorders.

Collaboration as the Cornerstone of Effective Referral

When the many agencies that work with clients who have substance abuse disorders work independently of each other, the result is that the client is subject to fragmented services, none of which might address the client as a whole person. One of the biggest challenges to any collaborative or network-based model occurs when each of numerous agencies wants to use a different assessment tool to gather the same information. At best, this produces a fragmented portrait of the client; at worst, it creates frustration and confusion for the client, who may drop out of treatment as a result.

A shared vision among potential collaborators facilitates strategies to achieve common goals (Nelson et al., 1999). The biggest benefit of collaboration among health agencies is the improved health of clients and therefore of the community. One study found that health is dependent on how people perceive the quality of their community. Leadership and vision among collaborative agencies can make a difference in the quality of a community health care system and in the cost-effectiveness of the care provided (Molinari et al., 1998).

Collaboration among agencies is the key to preventing fragmentation. In addition to reducing the likelihood of clients falling through the cracks between disparate and unconnected agencies, collaboration can foster a more holistic view of the client. Sometimes just a simple change of perspective can make the difference between circumstances being viewed as "needs" and being viewed as assets. For example, a single parent who cannot find a babysitter on a particular evening misses a treatment session. This client is then labeled "noncompliant" by one treatment provider, but another provider who focuses on child care and parenting skills recognizes the client's adherence to her parental responsibility as a positive asset. With effective collaboration, service providers will learn to recognize these differing viewpoints through their contact with professionals with expertise in different areas.

Another approach to prevent fragmentation is to designate one agency as the primary contact both for the client and for the other agencies. The primary agency provides a holistic assessment that accompanies the client throughout the referral process. The assessment must be comprehensive enough to satisfy all the agencies and organizations participating in the client's care and might include medical/psychiatric history and conditions, substance use patterns, work history, housing situation, physical/sexual abuse history, involvement in family violence and the criminal justice system, and other data about the client. In addition to decreasing paperwork and minimizing fragmentation, this process could help to strengthen linkages and communication among various agencies providing different services.

Barriers to Collaboration

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration. Examples of obstacles are designation of which agency has major responsibility for a client, structural barriers driven by funding sources (e.g., payment to only one treatment agency), difficult-to-treat clients, and differing staff credentials.

The issue of which agency "takes credit" for a client is a difficult question arising from competition among different agencies, each of which has an interest in maintaining a certain "head count" to ensure continued funding. This barrier highlights the need to change the way that agencies are credited for their participation in a client's recovery. In many treatment systems, only one agency can receive credit for clients who are served by several service providers. It would be preferable to allow all participating agencies to take credit for these clients. For example, this happens in communities that have collaborative relationships based on shared outcomes negotiated across agencies. These cross-agency outcomes can occur across service systems (e.g., substance abuse treatment and social services) or across provider networks (e.g., residential and outpatient providers). Outcomes are negotiated both across agencies and with funders of services. Funders play a critical role because they must "change the rules" that allow only one agency to receive credit for a client. This change from a rules-driven system to a results-based system encourages all participating agencies to be recognized for their contribution to client outcomes. Also, it is important that each provider understand the role of the other providers so that it does not seem as if they are competing. Each provider must create an appropriate working relationship with the other providers so the client can benefit from all.

Structural barriers may also be posed by program policies that are determined by the program's primary funding source. Such policies may dictate, for example, that clients

cannot engage in concurrent activities, such as vocational training and treatment of substance abuse disorders. If the State or a managed care system does not allow clients to participate in concurrent services, then collaboration efforts will be difficult, or even impossible. However, in some cases, this is simply a program philosophy and not a formal policy, and efforts should be made to change this mode of operation. Another major barrier in the past has been confidentiality requirements. One answer to addressing this problem is joint training.

In the present system, there are no rewards for serving difficult-to-treat clients, and sometimes agencies set criteria under which only the clients with the greatest potential for success are accepted. Incentives are needed for programs to accept those clients who have the greatest problem severity or multiple needs. This is known as "case mix adjustment." The incentives should be based on three factors: (1) identification of difficult-to-treat clients based on analysis of differential outcomes and clients' characteristics, (2) analysis of the additional average costs of serving these clients, and (3) provision of either explicit incentives for serving these clients or a more equitable approach. A key element in a more equitable approach is for funders to recognize that serving difficult-to-treat clients is as valuable as serving clients with fewer risk factors, even though success rates will be lower as a result. Referring difficult-to-treat clients should be viewed not as a matter of "handing off" problematic clients, but rather as securing additional services to meet these clients' needs.

Staff licensing can sometimes be a barrier to collaboration because it is defined categorically. For example, sometimes the referring agency has a policy requiring that the staff members of the receiving agency have the same licenses and credentials as the referring agency's staff. In addition to requiring specific types of expertise, a referring agency sometimes requires the staff members of the other agency to be "professionals" with advanced degrees. The unfortunate consequence is that credentialing standards, rather than transdisciplinary collaboration, often dictate the services clients receive.

Finding Potential Collaborators

Programs must look at their clients with the assumption that it is not feasible or effective to provide everything that clients need "under one roof." A more fruitful approach is to collaborate with other agencies on the basis of client needs and overlapping client caseloads. This procedure is called data matching. Figure 5-1 provides an example of this process.

Agencies and organizations that provide vocational training in collaboration with substance abuse treatment programs can be divided into two levels—agencies providing specific training for employment (Level 1), and agencies with resources and services needed by clients at the same time they are receiving substance abuse treatment and employment rehabilitation services (Level 2). Examples of Level 1 resources include

- City-, county-, and State-operated vocational rehabilitation (VR) services
- Public and private employment and job placement services
- Public and private employers in the community
- Vocational–technical colleges
- Community colleges
- Privately owned VR facilities
- Criminal justice vocational training programs

Examples of Level 2 resources include

- Economic Development Centers (One-Stop or Workforce Development Centers)
- Shelters for survivors of domestic violence
- Mental health agencies
- Homeless shelters
- Child welfare agencies

Figure 5-1
Data-Matching Software

The use of data-matching tools such as unique client identifiers (e.g., the client's first and last name and middle initial and the last four digits of the client's Social Security number) can help agencies determine overlapping client caseloads. The software ArcView (Environmental Systems Research Institute, Inc., 380 New York Street, Redlands, CA 92373-8100) can aid in assessing the effectiveness of collaborative relationships among service providers by providing data on the numbers of clients being served by multiple agencies. Some of the locations in which data matching has been implemented include Chicago, San Diego, Los Angeles, and Alameda County, California. This software compares data from specific client populations with those from other populations. The user can then determine the proportions of clients receiving substance abuse treatment services who are counted in the caseloads of other agencies. This makes it possible to determine, for example, what percentage of clients who are receiving substance abuse treatment have children in remedial education. By identifying areas of overlap such as this, data-matching tools can influence decisions about the makeup of a multidisciplinary team, the coincidental needs of clients, and what types of collaborative relationships with other agencies are most likely to benefit a program's client population.

- Child care services
- Family services
- Housing authorities
- Evening adult education programs
- Alternative education programs
- Literacy programs
- Adult basic education programs and general equivalency diploma (GED) programs
- Young Men's Christian Associations (YMCAs), Young Women's Christian Associations (YWCAs), Young Men's Hebrew Associations (YMHAs), and Young Women's Hebrew Associations (YWHAs)
- Social service organizations
- HIV/AIDS programs
- Health and disability organizations
- Independent living centers
- Religious groups
- Self-help meetings
- Accessible meetings

Often, collaborating agencies must be educated about the nature of substance abuse disorders, including the cycles of relapse and recovery. Alcohol and drug counselors may also benefit from applying the relapsing and remitting model in areas other than substance abuse disorders. For example, clients may also "relapse" into and out of employment, medication management, or violent situations. The failure of any one of these supports can then be a trigger for failure of any of the others. All collaborators, including those providing treatment for substance abuse disorders, should be aware that their efforts are likely to be ineffective unless all the client's life areas are addressed. To that end, agencies must recognize the existence, roles, and importance of each other in achieving their goals. It is preferable to have formal written agreements that outline the responsibilities of each agency.

Although the prison population has grown substantially in the last several years, vocational training programs for inmates are limited. The vocational training programs that are available to incarcerated individuals will vary according to the setting of the incarceration, and treatment programs will need to be in contact with penal institutions in order to find out what particular types of substance abuse treatment and vocational training are available (see Chapter 8 for more information about working with ex-offenders). Providers interested in more information concerning the particular

procedures and problems involved in establishing service agreements with criminal justice agencies (including prisons, detention centers, and community supervision agencies for ex-offenders) should consult Chapters 1 to 4 in TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT, 1998d).

Figure 5-2 summarizes the steps that substance abuse treatment providers can take to establish an authentically connected network with other agencies or to screen potential collaborators. The next section provides more detailed information about this process.

Multidisciplinary Teams

In its conventional sense, a multidisciplinary team is composed of members from different service areas (e.g., substance abuse treatment, vocational rehabilitation, mental health). This method of service, which is more common in programs that provide multiple services in-house, is just one way of functioning in a multidisciplinary manner. In an authentically connected referral network, however, members of the multidisciplinary team provide their services in different locations. Still, in an authentically connected network, a multidisciplinary team approach can be fostered by regularly scheduled case conferences.

In the authentically connected model, the agencies are interdependent. They cross-train their staffs in concepts and methodologies from different disciplines and promote awareness of resources that each agency might provide. Instead of being dependent on certification, learning about other disciplines, and becoming recertified every few years, service providers are taught how to learn on their own.

Careful consideration must be given to the formation of a multifocal treatment team. One approach is to view the team as a pie divided into sections, with the team members proportionally reflecting the needs of clients in areas such as coexisting mental disorders, job skills and employment, and child custody and care. The community must be considered as a whole throughout the treatment and referral process, and all available resources in the local geographic area should be considered to meet

Figure 5-2
Steps for Establishing an Authentically Connected Network

The Consensus Panel developed the concept of authentically connected networks, which include the following steps to their establishment:

1. Determine the services that are available in the local area by developing an updated inventory and by resource mapping.
2. Hold discussions with agencies identified as potential collaborators. Discussions can include topics such as the following:
   - Emphasis on the benefits of collaboration
   - Cross-training of staff
   - How the other agency conducts business (e.g., "turf" issues)
3. Develop working agreements or memorandums of understanding between collaborators to organize information sharing and communicate respective roles.
4. Determine the agency's criteria for accepting clients (e.g., what types of clients and levels of severity do they accept?).
5. If warranted, establish a partnership with the agency, as well as agreements regarding the flow of information and feedback between the agencies to ensure provider accountability.

client needs. Multidisciplinary teams can be composed of credentialed specialists as well as self-help and grassroots organizations. The more diverse the team, the more likely that the client will be viewed holistically.

True collaboration is a higher order of referral than either cooperation or coordination. *Referral* is a term that is used to mean many different things. Whereas a traditional referral is unidirectional (e.g., the client is sent for services to an outside agency), an authentically connected referral network is multidirectional and incorporates the ideals of collaborative relationships, accountability, cultural competence, client-centered services, and holistic assessment.

Authentically Connected Referral Networks

Integrating Cultural Competence Into Treatment and Referral

People live in different environments, and service providers have a responsibility to understand the contexts in which their clients operate. Client-focused treatment and referral must be based on an understanding of the family relationships, cultures, and communities of the clients. Culture can be broadly defined as incorporating demographic variables (e.g., age, sex, family), status variables (e.g., socioeconomic, educational, vocational, disability), affiliations (formal and informal), and ethnographic variables (e.g., nationality, religion, language, ethnicity). In many cases the client's belief system is intricately woven with culture, and providers must start where the client is and acknowledge the spiritual part of the work. Substance abuse treatment programs should be open to faith-based organizations in their communities, which can be valuable collaborative partners.

Throughout this chapter, the expression *cultural competence* refers to the capacity to view and understand individual clients within these contexts (Center for Substance Abuse Treatment [CSAT], 1999a). It is a core philosophy that must be integrated into and must guide the entire treatment and referral process. Too often, cultural competence is equated with the completion of a workshop, a multicultural staff, or proficiency in the language(s) spoken among the client population served. However, diversity of staffing does not ensure the cultural competence of the treatment program. Cultural competence is not achieved solely by attending workshops or by having a diverse, multilingual staff. When taken seriously, cultural competency is a continual learning process that is dynamic and is constantly expanded, refined, and defined by the community being served.

Building an integrated service model based on community partners must begin from the clients' base, taking into account their values and building on the strengths of their culture to create referrals that are appropriate and effective for their particular needs. Issues of culture can begin during the intake and assessment process, when clients are asked about their ethnic identification, their religion, and their participation in culturally based activities. Providers should feel comfortable discussing these issues with their clients and not make assumptions based on outward appearances, whether they are related to attire, complexion, or language. In programs working with highly diverse, multicultural populations, it may not be possible to be intimately familiar with all the details of each group's customs and culture. In any case, it is probably more important for providers to be aware of what they do not know and to have access to resources that can help, such as local community centers working in collaboration with their program.

Moreover, a delicate balance is needed between a client's current circumstances and the

historical and cultural issues that come into play. Some cultures may be relatively "closed" to nonparticipants. One must sometimes maintain a presence for years until he is accepted as a participant or observer. Although outwardly some groups may seem more approachable, gaining the trust of any client takes time.

Client-Centered Versus Agency-Centered Treatment and Referral

Substance abuse treatment that is both client-centered and client-focused is more likely to improve the lives of clients. Collaboration among agencies providing requisite services is an initial step toward client-centered care. Referral can be a way for agencies to hold each other accountable for getting results for clients. Referrals are necessary and appropriate when the substance abuse treatment program cannot provide special services needed by their clients. Some of the areas for which referrals may be needed include job readiness, job training, medical care, and ethnic/cultural expertise.

If the rationale for integrated treatment is a successful outcome for the client, there must be some way of measuring whether the referral is successful. From the referring provider's perspective, referral represents an act of faith, hope, and trust that the agency to which the client is referred will be accountable and will share the goal of client success along with the referring agency. Referrals also represent an opportunity for change, growth, and development. Far too often, however, a referral consists merely of handing a client a list of names and telephone numbers and assuming or hoping that the client will take the initiative to make the necessary contacts.

Distinct from this traditional model is one in which collaborations are fostered and maintained among agencies providing services to clients with overlapping needs, such as substance abuse treatment, employment, housing, education, and child care. In this context, the multidisciplinary team approach comes into play, but rather than coexisting under one roof, team members work within the various agencies engaged in collaboration. Referrals are negotiated among interlinked and interdependent agencies that share mutual goals and outcomes. These authentic connections and shared outcomes can then serve as an agreed-upon basis for the involved agencies to measure their results instead of merely going through the motions of collaboration. Figure 5-3 lists the characteristics of authentically connected referral networks.

Elements of Effective Referrals

In general, an authentically connected referral network is composed of a set of defined relationships formed as clients' needs dictate, using sound principles of case management and building in flexibility and adaptability to meet the needs of individual clients (see also TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* [CSAT, 1998a]).

Although authentically connected referral networks share several features such as those listed in Figure 5-3, this similarity does not constitute a mandate for all treatment programs to form identical referral networks. Rather, in order for such an authentically connected network to be effective, each program must understand its own mission as well as those of the other agencies.

Mechanism for information dissemination

The authentically connected model calls for a communication mechanism that allows the timely dissemination of information to all agencies and stakeholders. An authentically connected network also includes continually updated information about available resources. For example, a network might use a Web site to post referral information, which can readily be updated (see the "Inventory" section later in this

Figure 5-3
Characteristics of Authentically Connected Referral Networks

- Multiple agencies work as equal partners with each other and with the client; referring agencies make the initial contact to the referral source and keep abreast of client progress.
- Clients and agencies have mutual responsibility and trust; interagency accountability and data sharing exists.
- Communication mechanisms for timely information dissemination are accessible to all agencies and stakeholders.
- The full range of stakeholders is identified, including local community services, and feedback is elicited from all of them.
- Relationships among providers are collaborative and flexible in the assumption of multiple job tasks related to client needs.
- The network is client-, vision-, and mission-driven.
- Change and growth of the referring organization are demonstrated as a result of the referral process; dynamic network.
- The network is open to new paradigms, approaches, use of technology on behalf of clients (e.g., electronic portfolios), and individualization of client treatment plans and services.
- There is ongoing provider training and involvement in continuing education and staff development.
- Shared assessment of network effectiveness is ongoing.
- Cross-training of staff among collaborating agencies is ongoing.
- Accountability is results- and progress-based, with interagency negotiation of shared outcomes.
- The referral process is concurrent.

chapter for more information about electronic communication).

Focus on communitywide outcomes

Focusing on communitywide outcomes allows community leaders and agencies, as well as clients, to set priorities based on client populations in individual communities. Authentically connected referral networks also educate the larger community about substance abuse in general. In so doing, they encourage responsiveness on the part of the community and the network as a whole, rather than from the agency only. The use of a community scorecard is one method to rate a community's responsiveness to treatment issues.

Vision-driven service provision

Authentically connected referral networks are vision driven and have client needs as the primary focus of the agencies' existence. The emphasis is on shared purpose while acknowledging the organizational "cultures" among collaborating agencies. In contrast, "rule-driven" systems are agency centered and tend to be focused on agency policies.

Provider credibility and consistency

Mutual provider credibility and trust are at the core of the referral relationship. In the absence of trust, even the most sophisticated system will fail. Clients' trust must be built on the reliability of the provider and the provider's ability to be a consistent, accessible presence for the client. To be otherwise is to risk reinforcing a history of repeated abandonment and disappointment. The need for trust speaks to the credibility of providers and whether they are truly client oriented or are merely protecting the status quo of the program.

A sense of uniformity and cooperation is fostered by effective referrals. In a well-coordinated referral system, providers have

some sense of being part of a systematic network rather than one of many disparate and independent agencies. Clients and providers alike find it easier to work through a collaborative, uniform system.

Building an Authentically Connected Referral Network

Fostering collaborative interagency relationships in the community is only one step in the development of an authentically connected network. Once the participants in the network are identified and information about them gathered, the collaborating agencies can then begin to develop an interconnected service system that reflects the needs of the local community. The next step is to form a focus group involving all the agencies. This group will develop a shared vision of the services the community needs in regard to substance abuse treatment. Lastly, the collaborators can then determine which provider is best equipped to offer which services; this step takes the form of resource mapping, which is discussed below.

Resource Mapping and Inventory

Resource mapping

Resource mapping consists of gathering information about agencies and programs in the community with which linkages can be made to provide collaborative services to clients. This mapping of available resources should include the funding sources of these programs. In a collaborative effort, money can be pooled from the various funding streams and then "decategorized" so that it no longer drives the roles of service providers. A proposal can be sent to Federal, State, and local funding sources for approval of small demonstration projects or experimental initiatives. If these efforts are successful, this model might be accepted on a more global level.

Inventory

Many agencies that are willing to make referrals find that they may not know of all the resources and services available to meet their clients' needs. To fill in knowledge gaps, some communities maintain a database or inventory of available resources and geographically map them with computer software to facilitate the logistics of referrals. Such an inventory needs to include not only programs and agencies but also collaboratives. One way to make this information useful is to create a directory that is updated periodically. This directory could be posted on the Internet and also include information on eligibility criteria and available slots. For substance abuse treatment providers, an inventory of the full range of vocational opportunities available in the surrounding area can be a useful resource. Another important source of information is the State Occupational Information Coordinating Committees (SOICCs), which can provide labor market information. Computer technology can be a valuable resource for managing and updating information and matching data across systems and agencies, within the limits of confidentiality (see Chapter 7 for discussion of confidentiality issues).

Organizational Alignment and Capacity Building

Organizational alignment means that a service provider's vision, structure, mission, and policies are all based on the same underlying philosophy. All the activities and services the organization provides must be evaluated to determine the degree to which they contribute to client success. Having a mechanism for measuring client outcomes is important; information systems that track referrals and fiscal responsibility play key roles in identifying successful referrals as well as troubleshooting for cases in which needs were not adequately met.

Capacity building is the process by which organizational alignment is achieved; it involves elements such as program assessment and staff development.

Program assessment

For substance abuse treatment programs, capacity building includes changing the way in which assessment is viewed. At the client level, assessment involves determining a client's needs and assets and viewing the individual within the concentric contexts of family, culture, and community. At the agency level, assessment means evaluating the collaborative network of service providers and determining how well they are serving clients. This allows the collaborating agencies to better understand their missions and how they overlap and support each other. There is a potential pitfall, however, that must be monitored. As an organization begins to engage in capacity building, it will find that its initial costs may be higher than under the old method. Programs and funders will need to be educated that in the short run, the new authentically connected referral model will be more expensive, and capacity building initially will incur more overhead costs. However, once the network is in place, it will maximize the use of funds by avoiding duplication of services and, most important, it will result in higher client rehabilitation success rates.

Staff development

Cross-training initiatives are key to building the capacity to serve clients more directly and efficiently. Communication mechanisms must be established among collaborative agencies to provide and receive feedback that can be used to improve services. For example, in the Substance Abuse Treatment Initiative in Sacramento County, California, the entire staff of the County Health and Human Services Department (about 1,500 people) completed training in addiction and recovery. In addition, it should be noted that alcohol and drug counselors should be cross-trained in VR issues. The initiative was intended to ensure that staff members conducting intake interviews in county health and human services agencies understood concepts related to substance abuse and were able to identify individuals and intervene when appropriate. The Child Welfare League of America has published a book (Young et al., 1998) reviewing the lessons learned from this and other projects across the fields of substance abuse treatment and child welfare services. Several other California counties and the State of Oklahoma have implemented cross-training based on the curriculum developed by Sacramento County.

Capacity building also affects staff hiring, promotion, and compensation practices, which must be geared toward enhancing client outcomes rather than based solely on an individual's credentials. Newly hired staff members should be informed that their responsibilities include becoming proficient in a sophisticated network of referral to and from other agencies with which collaborations have been formed.