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Special Issue

Families in Child Welfare Affected by Substance Use

(Second of two issues)

Guest Editors

Nancy K. Young, PhD, and Julie Collins, LCSW



1726 M Street, NW, Suite 500 • Washington, DC 20036
202-688-4200 • Fax 202-833-1689 • www.cwla.org • E-mail: journal@cwla.org
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- 5 **Acknowledgements**
- 6 **A Note on Substance Use Disorder Terminology**
- 9 **From the Editor: Substance Use and Child Welfare**
- 11 **Special Foreword: Substance Use and Child Welfare**
(Second Issue)
- 21 **Promising Results for Cross-Systems Collaborative Efforts to Meet the Needs of Families Impacted by Substance Use**
Kimberly Dennis, Michael S. Rodi, Gregory Robinson, Kenneth DeCerchio, Nancy K. Young, Sidney L. Gardner, Elaine Stedt and Marianna Corona
- 45 **Predictors of Substance Abuse Assessment and Treatment Completion for Parents Involved with Child Welfare: Child Welfare: One State's Experience in Matching across Systems**
Dorian E. Traube, Amy S. He, Limei Zhu, Christine Scalise and Tyrone Richardson
- 67 **Examining the Relationships between Family Drug Court Program Compliance and Child Welfare Outcomes**
Holly Child and Dara McIntyre

- 89 **Changes in Adult, Child, and Family Functioning among Participants in a Family Treatment Drug Court**
Merith Cosden and Lauren M. Koch
- 107 **Making It Work Without a Family Drug Court: Connecticut’s Approach to Parental Substance Abuse in the Child Welfare System**
Jane Ungemack, Marilou Giovannucci, Samuel Moy, Karen Ohrenberger, Thomas DeMatteo and Staceyann Smith
- 125 **Peer Mentoring in Child Welfare: A Motivational Framework**
Anna Rockhill, Carrie J. Furrer and Thuan M. Duong
- 145 **Enhancing Family Protective Factors in Residential Treatment for Substance Use Disorders**
Joan E. Zweben, Yael Moses, Judith B. Cohen, Genny Price, William Chapman and Joanna Lamb
- 167 **An Integrated Intervention to Address the Comorbid Needs of Families Referred to Child Welfare for Substance Use Disorders and Child Neglect: FAIR Pilot Outcomes**
Lisa Saldana
- 187 **Effects of Intensive Family Preservation Services in Rural Tennessee on Parental Hopefulness with Families Affected by Substance Use**
Edwina Chappell, Kathryn Sielbeck–Mathes, Randall Reiserer, Hannah Wohltjen, Wendy Shuran and Elizabeth McInerney

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Special recognition goes to the select team from the NCSACW and Children and Family Futures staff, who provided their time and expertise conducting the reviews and selection of abstracts. A special acknowledgement goes to Sharon Amatetti, MPH, the NCSACW project officer from SAMHSA, and Elaine Stedt, MSW from Children's Bureau, Office on Child Abuse and Neglect, who provided guidance and oversight to the work of the NCSACW. We also acknowledge the contributions of Amanda Kellerman, MSW, and Kelly Jones from Children and Family Futures, who were instrumental in shepherding the project to fruition. We extend special thanks to the group of peer-review experts that lent their time and expertise conducting reviews of the manuscripts. Without the help of all of these individuals, this two-volume Special Issue could not have been completed.

Finally, special thanks go to the children and families, along with the professionals from the child- and family- serving systems, substance abuse treatment agencies, and community partners who have been so willing to share their journey and experience. It is hoped that this two-volume Special Issue will help increase the knowledge of the fields of child welfare, family courts, and treatment for substance use disorders, and will encourage other communities to take similar actions to improve the outcomes for this important set of families. We are honored and deeply appreciative.

A Note on Substance Use Disorder Terminology

Professionals in the fields of child welfare, treatment for substance use disorders, and the courts that oversee cases of child abuse and neglect may use a range of terminology to refer to concepts related to substance use, physical dependence, and addiction, such as *addiction*, *substance use disorders*, *substance use*, *substance abuse*, and *substance dependence*. Additional terms that might be used are *alcohol and other drug use*, *alcohol and other drug abuse*, and *alcohol and other drug dependence*. While there is variation in use of these terms in the field, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*, released in 2013, provides guidance on this terminology. The DSM-V no longer uses the terms *substance abuse* and *substance dependence*; rather, it refers to *substance use disorders*, which are defined as mild, moderate, or severe, to indicate the level of severity as determined by the number of diagnostic criteria met by an individual. The term addiction was also omitted from the DSM-V diagnostic terminology. Due to this change in terminology used in the DSM-V, the field is shifting toward the use of the term substance use disorders.

According to the DSM-V, substance use disorders occur when the recurrent use of alcohol and or drugs causes clinically and functionally significant impairment, such as health problems; disability; and/or failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Alcohol and other drug use exists on a continuum; however, not everyone who uses substances develops a clinical substance use disorder. Therefore, there are cases in which the term *substance use* is justified. Any pattern of substance use by a parent can present risks of child abuse or neglect for children in the absence of protective factors, whether or not there is a diagnosed *substance use disorder*.

While the DSM-V indicates changes in the classification of substance use disorders, many child welfare, treatment, and court systems still refer to these disorders with the generic term *substance abuse*. There is variation in terminology within the articles in this journal, depending upon the context in which the author is using the term. In some cases, authors use the term *substance abuse* to indicate when an individual's substance use interferes with areas of life functioning, yet there may not be a clinically diagnosed substance use disorder. In other cases, the term addiction is used to refer to individuals who have a substance use disorder. While the authors have attempted to be clear in their delineation of the terms they are using, the reader should be aware of these variations in terminology and the current ubiquitous use of the term substance abuse as the field transitions to the DSM-V classification and terminology.

From the Editor:

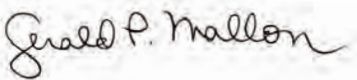
Substance Use and Child Welfare

Child welfare has been consistently dominated by three major social dilemmas that have serious consequences for our children, youth, and families: substance use disorders, domestic violence, and mental health issues. All of these conditions occur under a wide umbrella of poverty. Although each of these areas could fill a special issue of *Child Welfare*, this double issue of the journal focuses on issues related to parents with substance use disorders. Indeed, parental substance use and addiction complicate and interfere with the healthy development of children and youth—and in particular with children, youth, and families known to child welfare.

Volume I features articles on the prevalence of substance use among families involved in child welfare and its impact among specific populations such as infants, children with a serious emotional disturbance, and families in rural communities; it provides specific approaches for the provision of services for these children and their families, as well as for Native Americans living in urban communities. The volume concludes with a description of the federally funded grant program for children affected by methamphetamine that provided family drug courts with funds to augment their services with specific parenting and child development interventions. The focus of the Volume II is on the importance of collaborative efforts to improve outcomes for children and families, such as the regional partnership grants program and family treatment drug courts.

“One day at a time for the rest of my life” is a common adage among persons in recovery. This statement suggests that the work of recovery is ongoing, but parents can and do recover. Our policies and practices in child welfare ought to reflect this reality, and the articles in these issues document the extraordinary efforts underway across the nation to improve the outcomes for this critical set of children and their parents.

We wish to thank the co-editors of this special volume, Nancy K. Young and Julie Collins, who are two of our profession’s finest advocates for understanding and addressing the plethora of issues faced by families affected by parents’ substance use and child abuse or neglect.



Gerald P. Mallon DSW
Senior Editor

Special Foreword:

Substance Use and Child Welfare

(Second Issue)

CWLA's 2001 Special Issue of *Child Welfare* put a spotlight on parental substance use disorders among families in child welfare, including those involved with dependency courts. This topic was of increasing concern because throughout the 1990s, child welfare systems and courts had experienced growing numbers of cases, and many children remained for too long in out-of-home care. The articles in the 2001 Special Issue reflected initial efforts to identify and address these challenges using new case practice and treatment approaches—yet, the editors recognized that this was just the beginning. They suggested that to achieve better outcomes for children and families, five challenges should be addressed by child welfare, the courts, and the systems that provide treatment for substance use disorders and the community resources that support recovery: (1) improved information systems that track these families across systems; (2) expanded resources specific to this population; (3) a better understanding of policies and interventions for infants with prenatal substance exposure; (4) a continuing need to invest in staff development; and (5) ensuring a family focus in child welfare interventions.

Since that time, much work has been conducted and much progress has been made. Many communities across the nation have invested their time and resources to provide enhanced outreach efforts to this group of families through specialized recovery management and motivational enhancement services, developing more than 360 family drug courts, focusing on improving data monitoring across the various systems, instituting comprehensive cross-system training programs, and developing state-wide strategic plans focused on improving outcomes. The federal government fostered grant programs targeting this population, and funds a resource center to provide training and technical assistance to states, tribes, and communities focused on this population. The National Center on Substance Abuse and Child Welfare (NCSACW) (www.ncsacw.samhsa.gov) is jointly funded through the Substance Abuse and Mental Health Services Administration and the Administration on

Children and Families (ACF), providing a wide array of training and technical assistance resources. The Department of Justice's Office of Juvenile Justice and Delinquency Prevention has also provided a targeted training and technical assistance effort to improve dependency court proceedings and to foster the development and improvements of family drug courts (see <http://www.cffutures.org/projects/family-drug-courts-tta>).

Child welfare agencies have worked with treatment agencies and the courts to create new practices and policies that take a collaborative approach toward achieving better outcomes for these children and families. During this 15-year period, states and communities have also seen significant changes in the drug use patterns across the country requiring shifts in resources, approaches, and training to ensure that workers have sufficient knowledge to effectively work with the changing landscape of substance use and co-occurring mental disorders. The production and use of methamphetamine in the first decade of the 21st century required new partnerships by child welfare agencies with law enforcement. The proliferation of opioid-based prescription drugs use and its resultant epidemic of heroin use, combined with the rapid escalation of overdose deaths, has put additional strain on child welfare agencies and courts. The needs of the growing numbers of grandparents and kin who are caring for children involved in child welfare, along with the training needs of staff on medication-assisted treatment for opioid use disorders, are current challenges facing child welfare systems and courts.

Research has also expanded in various fields of practice, including studies that indicate far too many infants in their prenatal period are exposed to alcohol, tobacco, and other drugs, placing them at-risk for neurodevelopmental challenges throughout their lives. Research findings have also driven practice changes to address the needs of each family member in a child's life. Studies such as the Adverse Childhood Experiences,¹ which assessed the association between childhood maltreatment and later-life health and well-being consequences, have brought to light the impact of trauma on two sets of family members: children who are victims of child abuse or neglect

¹Information on the study by Centers for Disease Control and Prevention and Kaiser Permanente can be found at <http://www.cdc.gov/violenceprevention/acestudy/>

and the extraordinarily high rate of parents in child welfare services who have significant trauma histories that must be addressed during treatment for their substance use disorder together with any co-occurring mental disorders. Advancing knowledge of the neuroscience of addictive disorders and evidence-based programs and practices that work with this population have also led to a better understanding of the need for adjustments in practices, treatment approaches, and policies. Even the latest version of the *Diagnostic Services Manual* (DSM-V), which has reclassified the disorders as levels of severity of addiction to alcohol and other drugs, is having an impact on treatment systems and approaches. Research on child abuse and neglect, protective factors, and resiliency has supported the increased use of parent partners and community resources in prevention and intervention with children and their families. Evidence-based practice in parenting programs has supported new ways of addressing the needs of parents as effective prevention among this set of children at high risk of developing their own substance use disorder.

The recent recession has had a significant impact on many communities, with reductions in resources available to families. At the same time, expansion of health insurance coverage across the nation is leading to better health care for family members, while the enforcement of insurance benefit parity rules for treatment for substance use and mental disorders is creating shifts in funding for treatment. There have also been changes in legislation affecting child welfare interventions for this group of families, including amendments to the Child Abuse Prevention and Treatment Act (CAPTA) Title II, that requires infants identified with effects from prenatal substance exposure be provided with a plan of safe care. Federal grant investments, research efforts, as well as other state and local initiatives have led to practices, treatment approaches, and policies that have improved outcomes for the children and families affected by substance use.

Despite these investments, much work still remains in order to implement these practices, treatment approaches, and policies to the scale at which they are needed across the country. In honor of the advancements made to date, CWLA and the NCSACW have compiled the lessons from many of these efforts into this two-volume special issue of *Child Welfare*.

Volume I of this special issue features articles on the prevalence of substance use among families involved in child welfare and its impact among specific populations such as infants, children with a serious emotional disturbance, and families in rural communities. The volume also provides specific approaches for the provision of services for these children and their families, as well as for Native Americans living in urban communities. The volume ends with a description of the federally funded grant program for children affected by methamphetamine (CAM) that provided 12 family drug courts with funds to augment their services with specific parenting and child development interventions.

The focus of the Volume II is on the importance of collaborative efforts to improve outcomes for children and families, such as the regional partnership grants (RPG) program and family treatment drug courts. It also highlights predictors of substance abuse assessment and treatment completion and specific approaches to improve family engagement in services that show much promise. It ends with an article about the unintended outcome from an intensive family preservation service approach that increased families' sense of hopefulness as they participated in child welfare services, which significantly correlated with decreases in the problem severity and mental health symptomology.

The current volume begins with an article about the results of the Children's Bureau' Regional Partnership Grant program, which involved 25,000 children and their families from 2007 to 2012. Authors Dennis, Rodi, Robinson, DeCerchio, Young, Gardner, Stedt, and Corona identify the array of program services implemented by the 53 grantees in their collaborative partnerships: systems collaboration, substance use treatment, services for children and youth, clinical and community supports, and capacity expansion. The outcomes of the performance measures for the children, parents, and families were favorable for children remaining at home, timely reunification, and low rates of repeat maltreatment or return to out-of-home care. Parents accessed treatment quickly, reduced their substance use and treatment completion rates were higher among program participants. Various measures of well-being were implemented by grantees, and highlights of their outcomes are included, indicating an overall improvement in family functioning.

Authors Traube, He, Zhu, Scalise, and Richardson describe the long-standing collaboration in New Jersey between child welfare and treatment agencies, which had a multi-step process to improve parents' access to timely assessment and treatment engagement services. Their study explored variables associated with parents' engagement in each step of the assessment, treatment referral, and treatment completion process. Important differences in completion rates occurred between each step, with minority populations and those who were unemployed being less likely to complete treatment. In addition, the legal status of having an open family court case was the only legal status positively associated with treatment completion.

In the next article, authors Child and McIntyre reported on a different type of collaboration, a Dependency Drug Court, which focused on addressing the substance use of parents involved with child welfare whose children were placed in out-of-home care. The authors analyzed the Sacramento County Dependency Drug Court data on parents' compliance with drug court requirements, examining parent characteristics, compliance data, and family reunification status. The areas of compliance included in the analyses were drug tests, attendance at treatment, meetings with a recovery management specialist, attendance at support groups, and other requirements ordered by the court. After controlling for demographics, each of the individual compliance measures significantly predicted child reunification. All of the compliance measures were added to a single comprehensive model of reunification in which only negative drug tests and attendance at support groups were statistically associated with the likelihood of reunification. While these two factors were significantly related to reunification, the authors suggest that the comprehensive model of services and dependency drug court oversight is critical, as recovery support specialists reinforce access to treatment and provide the support, modeling, and oversight needed for parents to participate in support groups and treatment services.

The next article also focuses on a family treatment drug court that was part of the SAMHSA Children Affected by Methamphetamine grant program. Authors Cosden and Koch examined the changes in adult, child, and family functioning resulting from their participation in

a family treatment drug court that augmented their service array to focus on parenting and child therapeutic services. Parents received residential or intensive outpatient treatment including the Matrix Model, Seeking Safety, and Nurturing Parenting™. Families with infants and toddlers received in-home infant-parenting interventions and older children received individual therapy when indicated. The authors report that a majority of families experienced reunification, and that longer stays in treatment were associated with reunification. They also found that there were significant improvements in measures of adult functioning as well as positive changes in child development, youth behaviors, and family functioning.

The next article, by authors Ungemack, Giovanucci, Moy, Ohrenberger, DeMatteo, and Smith, describes a collaborative effort in Connecticut using a recovery-oriented intervention designed to address the problem of parental substance abuse within the child welfare system without a family drug court. The authors describe the evolution of the Recovery Support Voluntary Program (RSVP), which includes a recovery-oriented system of integrated care, improved collaborative practice among systems, joint training across service sectors to improve parents' timely access to and retention in services, access to case management and recovery supports, timely child permanency decisions, and family reunification. Rather than using traditional family drug court approaches, Connecticut uses court services officers to conduct the reviews of parents' compliance and progress in treatment while the traditional court and judges rule on issues specific to the dependency case. Outcomes of the treatment group were compared to system-wide indicators. Families in RSVP were more likely to complete their first treatment episode, with longer lengths of stay in treatment resulting in higher likelihood of reunification and timely permanency for children. The positive outcomes achieved have helped to shift approaches to these families in child welfare toward a recovery-oriented framework focusing on the impact on children.

The next group of articles describes key aspects of innovative service delivery to improve the involvement and engagement of families with parental substance use in services. Authors Rockhill, Furrer, and Duong focused their efforts on identifying the mechanisms and active ingredients in

parent mentoring programs that are part of treatment programs for families with parental substance use. Interviews with parents who were provided peer mentors were conducted to understand what mentors do and what happens to parents who work with mentors. Qualitative coding of responses generated themes and highlighted key mentoring practices: building caring relationships, providing guidance, and ensuring parents were empowered to set the direction of their goals. The authors offer the theoretical underpinnings supporting these qualitative findings and suggest future program development and research to further delineate the active ingredients in peer mentoring and promotion of motivation among families.

Authors Zweben, Moses, Cohen, Price, Chapman, and Lamb focused their article on the East Bay Community Recovery Project (EBCRP), a residential program for women with co-occurring disorders and their children in northern California, which added services to increase protective factors to reduce child abuse and neglect. The EBCRP augmented the program's trauma-informed treatment model by adding services that focus on enhancing the child and family protective factors: concrete services, parenting and child development knowledge, social and emotional competence of children, parental resilience, and social connections. The program implemented Celebrating Families! and improved their integrated case management system. The comprehensive services available to mothers and their families, including program staff perceptions of the enhancements, are described, along with details on how residential treatment programs can implement program changes to enhance child welfare-focused protective factors.

Author Saldana's article, on the other hand, focuses on an intervention to improve the relationships in families affected by parental substance use referred to child welfare. The Families Actively Improving Relationships (FAIR) pilot intervention integrates evidence-based behavioral interventions that have been shown individually to produce better outcomes among this population. The FAIR team provides interventions in which counselors are available to families around the clock, sessions focus on role play and practice assignments, and interactions reinforce positive gains made by parents. Interventions teach and support parenting skills;

address substance use disorders in the context of parenting; and provide meaningful incentives, ongoing engagement strategies, and clinical supervision. The pilot study described by the author includes a small group for reporting preliminary outcomes in parenting, substance use, and mental health and ancillary needs. In each of these domains, however, the treatment group showed positive results, suggesting the integration of these interventions may serve as important foundations in developing specific evidence-based programs for this population.

This volume ends with the outcomes found in the program evaluation of the Tennessee Regional Partnership Grant, which implemented an intensive family preservation model with trained in-home specialists focused on engaging families in the services they self-identified as important. This was done by focusing on building trusting relationships with families with an emphasis on enhancing parenting skills. Authors Chappell, Sielbeck-Mathes, Reiserer, Wohltjen, Shuran, and McInerney report that one of the battery of instruments used in the program evaluation, the Tennessee Outcomes Measurement System (TOMS), included four items in a hopefulness scale. They report that as the program was implemented, the specialists observed more nurturing interactions between family members, increased use of routines, greater understanding of normal child development, and more effective use of discipline and setting boundaries. The evaluators also saw in early data analyses significant changes in the family's levels of hopefulness. Over time, the researchers found that higher levels of hopefulness and decreased perceptions of problem severity were associated with more success for families in recovery and family stability.

Conclusion

This group of articles highlights the importance of collaborative efforts to improve outcomes for children and families, the key factors that predict treatment completion, and specific approaches to improve family engagement in services that show much promise, especially the increase of a family's sense of hopefulness as they participate in child welfare services. Despite the advancement of our knowledge on how to serve

these families better, there are still concerns and much work to be accomplished. Parents with substance use and mental disorders are given disproportionately inadequate attention in child welfare systems relative to their impact on caseloads, costs, and the lives of the children and their family members. Public child welfare agencies need and deserve help from other child- and family-serving agencies; they cannot accomplish their mission with their own limited resources. Progress has been made at the project level, which is often in just one community, with proven improved outcomes, but little is being done at scale or in moving toward scale. Resources and results can reinforce each other, but the critical ingredient is leadership that builds trusting relationships as the foundation for strategic policy change. As we look forward to the next decade of developing, testing, and scaling up interventions for this significant set of families, prognoses for the future include the need for focused leadership to address these challenges. Strategies for using new and modified funding streams from within and outside child welfare agencies are critical to moving toward scale. We can no longer say that we do not know what to do to obtain better outcomes with this critical set of families. Yet without focused leadership on this issue, there may well be less than optimum results for children involved in child welfare who have parents with a substance use disorder, as well as for those with co-occurring mental disorders.

Nancy K. Young, MSW, PhD

Director, Children and Family Futures

Julie Collins, MSW, LCSW

Director of Standards for Practice Excellence, CWLA

Promising Results for Cross-Systems Collaborative Efforts to Meet the Needs of Families Impacted by Substance Use

Kimberly Dennis

Children and Family Futures

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Gregory Robinson

Children and Family Futures

Kenneth DeCerchio

Children and Family Futures

Nancy K. Young

Children and Family Futures

Sidney L. Gardner

Children and Family Futures

Elaine Stedt

*Children's Bureau, U.S. Department
of Health and Human Services*

Marianna Corona

Children and Family Futures

This study is based on data regarding more than 15,000 families served by 53 federal grantees showing that child safety and permanency, parental recovery, and family well-being improve when agencies work together to address the complex needs of families at the intersection of substance abuse treatment and child welfare. Strategies summarized here offer promising collaborative approaches to mitigate the negative outcomes too often experienced by families impacted by substance use disorders.

Substance use among parents can affect multiple domains of parenting practices and family functioning. Substance use can influence parents' behavior directly because the mind- and mood-altering effects of alcohol and drug use can inhibit their capacity to deliver consistent and sensitive parenting (Dore, 1998). Parents who abuse substances are more likely than parents who do not abuse substances to (1) use inconsistent, irritable, explosive, or inflexible discipline; (2) offer low supervision and have minimal involvement in the family; (3) provide insufficient nurturance and inconsistent emotional responses to children; and (4) tolerate youth substance use (Lam et al., 2007; Staiger, Melville, Hides, Kambouropoulos, & Lubman, 2009; Breshears, Yeh, & Young, 2009). These maladaptive parenting styles may result in disrupted parent-child attachment and family well-being.

Substance use also alters the home environment. Homes with substance-abusing parents are often chaotic and unpredictable. The combination of poor parenting practices and a chaotic home environment puts children at increased risk of physical or emotional abandonment, abuse, and neglect (Dore, 1998; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, & Marks, 1998). If this cycle is uninterrupted by effective interventions, it may lead to multi-generational trauma and abuse (Dube, Felitti, Chapman, Giles, & Anda, 2002).

Parental substance use and child abuse or neglect are strongly associated with trauma, which can add to the burdens on children and families. Research has shown that women with substance use problems have a 30–59% rate of dual diagnosis with post-traumatic stress disorder and substance use that frequently stems from a history of childhood physical and/or sexual assault (Najavitis, Weis, & Shah, 1997). In a treatment-seeking sample of substance users, 60–90% also had a history of victimization (Najavitis, Weis, & Shah, 1997). Failure to understand and address parent trauma may lead to (1) failure of parents to engage in substance use treatment services; (2) increases in symptoms; (3) increases in management problems; (4) re-traumatization; (5) increases in relapse rates; (6) withdrawal from the service relationship; and (7) poor treatment outcomes (Oben, Finkelstein, & Brown, 2011).

This article shows that effective treatment programs address the needs of both parents and children and protect the well-being of all family members, and highlights the results of a federal government initiative designed to increase the well-being, improve the permanency, and enhance the safety of children and families who come to the attention of the child welfare system as a result of parental substance use.

The Child and Family Services Improvement Act of 2006 (Public Law 109-288) helped communities address the parental substance use that underlies the abuse or neglect that many children in the child welfare system have experienced. The law authorized, and Congress appropriated, \$145 million over five years for a new competitive grant program, “Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Use.” Grants funded under this initiative—known as the Regional Partnership Grant (RPG) Program—supported the development of regional partnerships by states, tribes, and communities across the nation to address the broad range of needs among families at the intersection of the substance use treatment and child welfare systems. In September 2007, the Children’s Bureau, Administration for Children and Families (ACF), Department of Health and Human Services (HHS), awarded 53 RPG grants to applicants in 29 states. The grants ranged from \$500,000 to \$1 million per year for three or five years.

The regional partnerships used their multiyear grants to establish or enhance a collaborative infrastructure and build their region’s capacity to serve these families effectively. The RPG Program used a cross-systems performance measurement system that included 23 indicators to assess grantees’ progress in improving safety, permanency, recovery, well-being, and systems collaboration. This article presents selected results that make clear that the time, resources, and effort invested to develop broad-based interagency partnerships and integrated services result in positive child, parent, family, and system outcomes.

Method

The authorizing legislation required HHS to use a consensus process to establish a set of indicators to measure program performance and participant outcomes. The final set of 23 indicators include:

Safety

- Children remain at home
- Occurrence of child maltreatment

Permanency

- Average length of stay in foster care
- Re-entries to foster care placement
- Timeliness of reunification
- Timeliness of adoption or guardianship

Recovery

- Access to treatment
- Retention in substance abuse treatment
- Substance use
- Parents or caregivers connected to supportive services
- Employment
- Criminal behavior

Child, Adult, and Family Well-Being

- Prevention of substance-exposed newborns
- Children connected to supportive services
- Improved child well-being
- Adult mental health status
- Parenting capacity
- Family relationships and functioning
- Risk and protective factors

Systems Collaboration

- Coordinated case management

- Substance abuse education and training for foster care parents and other substitute caregivers
- Collaborative capacity
- Capacity to serve families

Children and Family Futures, as the RPG Program support contractor, facilitated the consensus process and the development of performance measures that balanced reporting consistency with the unique approaches and implementation contexts of the grantees. To minimize data collection burden and enhance interpretability of the results, definitions of many of the RPG performance measures were aligned with existing federal and state child welfare and substance abuse treatment reporting requirements, such as the Adoption and Foster Care Analysis and Reporting System (AFCARS), the National Child Abuse and Neglect Data System (NCANDS), the National Outcomes Measures (NOMs) and the Treatment Episode Data Set (TEDS). Because of the variance and diversity in program-specific strategies and target populations, grantees were not required to report on all 23 measures and only reported on the RPG measures that aligned with their partnership's activities, goals, and intended outcomes. Thus, the number of grantees reporting on each performance measure varied. Grantees submitted their case-level child and adult data to a web-based RPG Data Collection and Reporting System.¹ In general, categorical chi-square analyses or paired *t*-tests were conducted to test for improvements from baseline to discharge. This type of analysis is appropriate and aligns with the overall performance measurement approach HHS used to review grantees' progress insofar as grantees were not required to use experimental designs in their evaluation efforts. For those grantees with a control or comparison group, one-way ANOVA and chi-square analyses were used to determine if baseline differences existed between these grantees' participant

¹ During the first year of the RPG Program, HHS (with the Office of Management and Budget approval) developed an extensive web-based RPG Data Collection and Reporting System to compile indicator data across all 53 grantees. Grantees began submitting their data to the RPG Data System in December 2008 and then uploaded their latest cumulative data files in June and December of each program year. Their final data upload was in December 2012.

and comparison group populations. Statistically significant differences were detected between the groups on several key demographic characteristics for both children and adults. Because of these differences, statistical tests of significance between aggregate RPG participant and control/comparison groups on the performance measures were not conducted. However, when a subgroup of grantees submitted sufficient control/comparison group data (a sample size of 35 or more for both their participant and comparison/control groups) on a given measure, a brief summary of grantees' performance in relation to their own control or comparison groups is included. The following subsections describe the measurement and analysis methods by performance domain.

Safety, Permanency, and Recovery Outcomes

Most of the 12 performance measures in the Safety, Permanency, and Recovery outcome domains align with existing standardized performance measures in federal child welfare and substance abuse treatment outcome reporting systems (e.g., AFCARS, NCANDS, TEDS). Thus, these data are available in state or county automated child welfare and substance abuse treatment data systems. Each grantee submitted standardized case-level client demographic information and the data elements required to calculate these measures in a uniform file format to ensure consistency across grantees.² Two immediate automated quality assurance checks increased data quality and consistency by identifying invalid coding (e.g., a date that had not yet occurred) and potential relational inconsistencies or errors (e.g., a substance abuse assessment that took place after substance abuse treatment entry instead of before treatment admission). For each measure, RPG data were aggregated across grantees and analyzed using International Business Machines (IBM) Statistical Package for the Social Sciences (SPSS) software including basic descriptive statistics on performance measures with select cross tabulation by participant demographic characteristics.

² A few grantees could only collect aggregate rather than case-level data for their comparison groups. The analyses do not include these aggregate data. See the Second Report to Congress (http://www.cffutures.org/files/RPG_Program_Second_Report_to_Congress.pdf) for additional information on the data submission process.

Child, Adult, and Family Well-Being Outcomes

HHS did not require grantees to use specific standardized data collection instruments to measure well-being. Grantees used more than 50 different instruments to measure these outcomes and many grantees used more than one instrument or method to measure a child's, adult's, or family's progress. Further, because the well-being measures are interrelated, grantees often assessed multiple measures with the same instrument (though they may have used a specific subscale or domain for a given well-being measure). Thus, the results of a particular instrument may address multiple well-being measures. This article includes data from nine of the most commonly selected valid and reliable instruments that a minimum of three grantees used, including:

- Addiction Severity Index (ASI);
- Adult-Adolescent Parenting Inventory-2 (AAPI-2);
- Ages and Stages Questionnaires (ASQ);
- ASQ Social-Emotional (ASQ-SE);
- Beck Depression Inventory;
- Child Behavior Checklist (CBCL);
- North Carolina Family Assessment Scales;
- Parenting Stress Index (PSI); and
- Protective Factors Survey.

Thirty-five grantees used one or more of these nine instruments. Grantees submitted case-level data files containing the instrument-specific scores for specified administration time points. While most grantees administered instruments to clients at RPG entry (i.e., baseline) and discharge, some also conducted interim or post-discharge follow-ups. Each of the case-level instrument-specific data files were standardized across grantees (i.e., made consistent in submission of data elements and format) and combined into a uniform database for each of the nine instruments. These data were analyzed using basic, descriptive statistics as well as multivariate analyses to assess the significance of changes from baseline to discharge where appropriate.

Systems Collaboration Outcomes

The Systems Collaboration outcome domain includes performance measures of grantees' efforts to strengthen collaborative practice among the substance abuse treatment, child welfare, court, and other service systems and increase their capacity to serve families. All grantees measured their collaborative capacity using the Collaborative Capacity Instrument (CCI). The CCI is a self-assessment tool that measures 10 key elements of cross-systems linkages. Grantees administered a baseline CCI in RPG Program Year 1, an interim CCI in RPG Program Year 3, and a final CCI in RPG Program Year 5. Data were aggregated across grantees and analyses included basic descriptive statistics and significance tests to assess changes in collaborative capacity from baseline to follow-up.

Results

Program Activities

The breadth of grantees' interagency relationships enabled them to implement a wide array of integrated treatment and support services to meet the needs of the 15,031 families, including 25,541 children and 17,820 adults, they served. Grantees bolstered these direct services with activities to strengthen cross-systems collaboration and service integration. The grant announcement for the RPG Program specified that grant funds could be used in five general program areas, including:

- Systems collaboration and improvements;
- Substance use treatment linkages and services;
- Services for children and youth;
- Clinical and community support services for children, parents, and families; and
- Capacity expansion to provide treatment and other services to families.

All grantees carried out their programs in unique environments that informed the selection of interventions and of strategies for implementing those interventions. Grantees' program activities according to the allowable program included:

Systems Collaboration and Improvements

- 100% of grantees conducted cross-systems training on clinical as well as program and policy issues.
- 98% convened regular regional partnership meetings to discuss programmatic issues and collaborative management and administration.
- 94% held regular joint case staffing meetings to discuss families' case plans or other treatment issues.
- 93% implemented improvements in cross-systems information sharing and data collection.
- 87% developed formalized cross-systems policies and procedures to improve communication, identification, referrals, and service delivery.
- 62% co-located staff to assist with screening, assessment, referral, and/or provision of services.
- 59% used a formal multidisciplinary team decision-making process (e.g., Family Group Decision-Making).

Substance Use and Mental Health Treatment Services and Linkages for Parents and Caregivers

- 96% of grantees provided specialized outreach, engagement, and retention services.
- 93% screened or assessed clients for substance use disorders.
- 87% provided intensive and coordinated case management.
- 87% provided some type of parenting training, education, or other program.
- 81% delivered trauma-informed or trauma-specific services.
- 78% provided family-based substance use treatment services.
- 74% conducted specialized screening or assessments to identify other services that families needed (e.g., trauma services).
- 73% provided outpatient services.
- 72% engaged in at least one substance-use-prevention activity.
- 64% provided mental health services or psychiatric care.

- 57% provided family therapy or counseling.
- 39% provided residential treatment.
- 37% provided supervised, supportive, or therapeutic supervised visitation services.
- 34% conducted targeted outreach to, and engaged, fathers and/or provided specialized programs or services for fathers.
- 34% developed a new Family Drug Court (FDC) or expanded or enhanced an existing FDC.

Services for Children and Youth

- 76% conducted specialized screenings and assessments (e.g., for developmental or behavioral issues).
- 53% provided early intervention and/or developmental services.
- 45% provided therapeutic services and interventions.
- 35% screened or assessed children for trauma issues.
- 34% provided trauma services to children.
- 19% provided remedial or academic supports to school-aged children.
- 6% provided substance use treatment to youth with a substance use disorder.

Expanded Capacity to Provide Treatment and Services to Families

- 81% of grantee services and activities strengthened their region's capacity to serve families. These grantees accomplished this by creating new services or expanding and/or enhancing existing services that increased the number of families served, or improved the quality and delivery of existing services (e.g., provided more intensive or higher levels of service or changed types and levels of staff).
- 33% created new services for the RPG target populations.
- 49% expanded or enhanced existing services.

Participant Characteristics

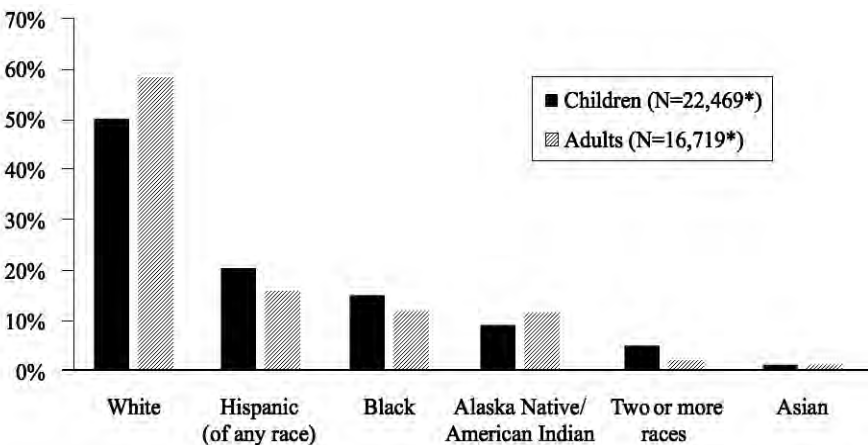
Children

On average, children served were 5.7 years of age at RPG enrollment. Yet well over half (59.7%) were aged 0 to 5 years. One-fifth (20.5%) were infants less than 1 year old; approximately one-fourth (26.1%) were 1 to 3 years old; and 13.1% were 4 to 5 years old. Among school-aged children, 14.9% were 6 to 8 years old, 13.8% were 9 to 12 years old, and the remaining 11.6% were 13 years old or older. Tribal grantees ($n = 6$) served a significantly greater percentage of older children than other grantees. For instance, 46.5% of the children served by the tribal grantees were 9 years old and older, compared to 23.7% for all other grantees ($p < .001$).

As Figure 1 shows, participants in the RPG Program were predominantly White. Approximately one-fifth were Hispanic, approximately 15% were Black, and 10% were Alaska Native/American Indian. Less than 5% of those served were multiracial or Asian.³

Figure 1

Racial and Ethnic Characteristics of Participants



³ All races exclude children of Hispanic origin. Hispanic children are of any race. Asian children include Native Hawaiian/Other Pacific Islanders. These data exclude children with missing race/ethnicity data.

Adults

In general, adult RPG participants tended to be White females in their late 20s or early 30s who had never been married and were the biological mother and primary caregiver of the child(ren) receiving services. Further, adult RPG participants were likely to be unemployed and receiving public assistance at the time of program enrollment. Nearly three-fourths (72.2%) of adult RPG participants were females. Men comprised 27.8% of all adults served, but several grantees targeted their outreach to fathers. Among 13 grantees, at least 35% of the participants served were male.

The mean age among adults at time of RPG enrollment was 31.4 years. Nearly half of all adults were 25 to 34 years old. A small percentage (5.0%) were under 21 years of age, while 17.2% were 21 to 24 years old. The largest proportion of adults was 25 to 29 years (26.4%), followed by 30- to 34-year-olds (21.3%). Those 35 to 39 years old comprised 13.8% of all adults. A roughly equal percentage of adults were 40 to 44 years old (8.2%) or 45 years and older (8.0%).

Most adults were the biological parent of the children receiving services; 75.9% were the biological mother and 16.1% were the biological father. The remaining 8% had some other relationship to the child.⁴ Less than 8% of women (7.4%) were pregnant at the time of RPG program or substance abuse treatment entry. Nearly one-fourth (24.3%) of all adults served were married at time of RPG enrollment. More than one-third (36.5%) of all adults were prior perpetrators of child maltreatment and had a history of child welfare system involvement (not associated with their current RPG program participation). For nearly one-third (32.0%) of adults, involvement with methamphetamine (use or production) was identified as a contributing factor to the risk of child maltreatment.

⁴ Other relationships could include stepmother/father, adoptive mother/father, foster mother/father, presumptive father, grandmother/grandfather, aunt, uncle, significant other, or other relationship not otherwise specified.

Outcomes

Child Safety and Permanency

RPG projects served children in-home and in out-of-home care depending on their program design and community needs. The majority of children (78.6%) were in the physical and legal custody of a parent/caregiver at time of RPG Program enrollment. Of the 11,938 children in-home at time of RPG Program entry, nearly all (92.0% or 10,977) remained at home in their parent’s or caregiver’s custody through RPG case closure. Only 8% (961 children) in home at program entry were removed prior to RPG case closure (see Table 1).

Table 1. Number and Percent of Children who Remained at Home through RPG Program Case Closure⁵

	Number	Percent
Total Number of Children In-Home at Time of RPG Program Enrollment	11,938	100.0%
Remained In-Home through Case Closure	10,977	92.0%
Removed from Home Prior to Case Closure	961	8.0%

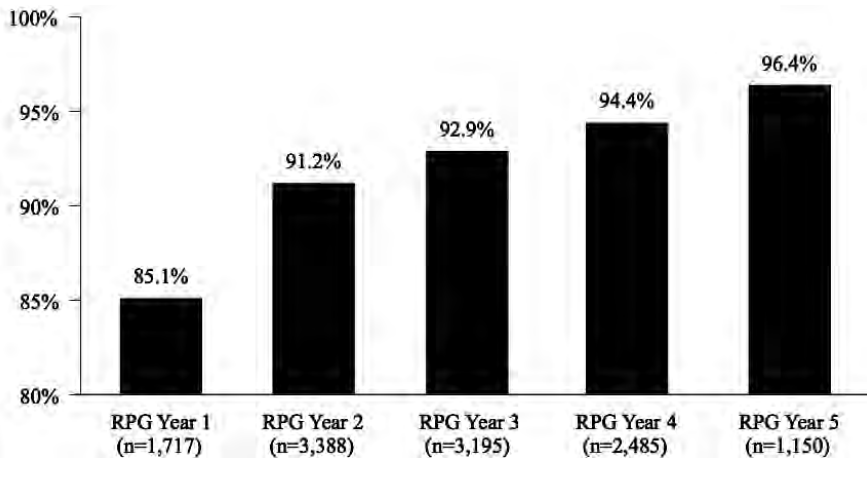
The proportion of children who remained in-home through RPG case closure increased significantly over the course of the RPG Program ($p < .001$). During the early grant period, this proportion increased from 85.1% in Program Year 1 ($n = 1,717$), to 91.2% in Program Year 2 ($n = 3,388$), and to 92.9% in Program Year 3 ($n = 3,195$). Performance continued to improve during the latter part of the grant period, increasing from 94.4% in Program Year 4 ($n = 2,485$) to 96.4% in the final program year ($n = 1,150$), as shown in Figure 2.

⁵ Remained at home includes children who were never removed from the home or removed after the RPG case closure date. Removed from the home includes children removed on or before RPG case closure. Grantees report data on all removals from a parent’s/caregiver’s care regardless of whether the removal was associated with a substantiated/indicated maltreatment incident.

Twenty-one grantees reported comparison group data on this measure. Among 10 of these 21 grantees, higher proportions of children in the grantees' RPG projects remained at home than among children in the comparison condition. Among eight grantees, however, the proportions of children who remained at home through case closure were higher in the comparison condition. For three grantees, 100% of children in both the RPG and comparison conditions remained at home. Of the 5,895 children in these 21 grantees' RPG programs, 93.2% remained at home through case closure compared to 88.6% of the 4,074 children in grantees' comparison conditions.

Figure 2

Percent of Children Who Remained by Program Year



A total of 4.2% of 22,558 children in the RPG Program experienced child maltreatment within six months of program enrollment. The percentage of children who experienced child maltreatment was significantly different across program years ($p < .001$). The rate of maltreatment decreased from 6.6% in RPG Program Year 1 to 4.3% in Year 2, and declined further to 4.2% in Year 3. However, among children who enrolled in Year 4, the

rate of maltreatment within six months of their program enrollment rose to 4.5%, before declining again slightly to 4.4% in Year 5. The overall rate (4.2%) of maltreatment was lower than the rate (5.8%) measured across the 25 states in which grantees implemented their programs.

Grantees reported permanency data on more than 4,000 children discharged from foster care over the course of the grant period. Children discharged from foster care for all reasons combined ($n = 4,078$) had a median length of stay in care of 11.1 months. However, approximately one-fourth (24.7%) of these children were discharged within 6 months of foster care entry. More than three-quarters (81.9%) of the 4,078 children discharged were reunified. Among these children, the median length of stay for the most recent entry into foster care was 9.5 months. Nearly two-thirds (63.6%) of these children were reunified within 12 months and 17.9% were reunified in less than 3 months. Infants and young children younger than 1 year had significantly higher rates of reunification within 12 months (72.7%) than children of all other ages (61.5%). Only 7.3% of all participating children who were reunified re-entered foster care at any point within 24 months following reunification.

Children who remained at home through case closure were significantly older (Mean = 6.0 years) than children who were removed prior to case closure (Mean = 4.6 years; $p < .001$). The proportion of children who remained at home until case closure was significantly associated with child race/ethnicity ($p < .001$). Higher proportions of Asian-Pacific Islander (96.4%) and Hispanic children (94.1%) remained at home, compared to Black (92.1%), multiracial (91.9%), White (90.8%), and Alaskan Native/American Indian children (88.2%).

Furthermore, timeliness of reunification (i.e., within 12 months) increased steadily and significantly throughout the RPG Program ($p < .001$). It increased from 55.4% ($n = 789$) in RPG Program Year 1 to 59.9% ($n = 1,161$) in Year 2, to 66.2% ($n = 937$) in Year 3, and to 72.9% ($n = 656$) in Year 4.⁶

⁶ Program year indicates when a family enrolled in the RPG Program. The trend analysis does not include program year five because of the proportionately smaller number of reunifications ($n = 82$) compared to other program years. Information on the status of all children who enrolled in the last year of the program was not available by the reporting period cutoff date.

Among the 3,340 children reunified with their families, the median length of stay in foster care was 9.5 months. This was two months longer than the state contextual subgroup median of 7.5 months. Children in the RPG Program might have had longer lengths of stay in foster care because their parents were receiving more intensive services to address substance use disorders and other complex needs as part of their permanency plans. It is important to note that the state contextual data are not limited to children removed from the home due to parental substance use.

Most grantees' program models focused on reunification efforts, where appropriate. As a result, only a small number ($n = 464$) of participating children were discharged from foster care to a finalized adoption or legal guardianship.⁷ Of these children, 72.0% exited to a finalized adoption and 28.0% were discharged to relative guardianship. Among the 452 children with data necessary to compute time intervals, 58.6% were discharged to adoption or legal guardianship within 24 months. Specifically, 12.8% were discharged in less than 12 months and 45.8% in 13 to 24 months. The remaining 41.4% exited foster care after 24 months. Among the 418 children discharged to a finalized adoption, the median length of stay in foster care was 24.2 months. This was substantially shorter than the state contextual subgroup median of 29.3 months.

Data from 36 grantees indicated that 3,861 children who were in out-of-home care were reunified with their parent(s).⁸ Only 283 (7.3%) of these children re-entered foster care at any point within 24 months following reunification.⁹ The largest proportion (3.1%) of children who re-entered foster care did so within 6 to 11 months of being reunified. Two percent of children re-entered foster care in less than 6 months of being reunified, while 1.5% re-entered in 12 to 18 months, and 0.8% re-entered in 19 to 24 months. The percentage of children served by RPG projects who re-entered foster care within 12 months (5.1%) was

⁷ As noted previously, only 10.5% of children in the RPG programs exiting foster care were discharged to a finalized adoption and 4.9% to legal guardianship.

⁸ Includes children who were already in foster care at time of RPG enrollment as well as those who entered foster care after RPG enrollment.

⁹ Possible factors that may have contributed to foster care re-entry include a lack of aftercare services to support families after they reunify or no longer having the oversight that these families experience while they participate in the RPG program.

substantially lower than the median rate of 13.1% for the 22 states in which the RPGs are located.

Parental Recovery

Fifty grantees reported on 11,748 adults who received substance abuse treatment during the grant period. Overall, adults participating in the RPG Program accessed substance abuse treatment quickly, on average, within 13 days of entering the RPG Program. Well over one-third (36.4%) entered substance abuse treatment within three days. Once engaged in substance abuse treatment, adult participants remained in treatment a median of 4.8 months and nearly two-thirds (65.2%) stayed in treatment more than 90 days. Treatment completion rates¹⁰ (45.0%) were substantially higher than dropout rates (36.8%).

From substance abuse treatment admission to discharge, 61.1 to 76.2% of adults (depending on the substance they used) in the RPG Program reduced their use of alcohol, marijuana, cocaine, methamphetamine, and heroin. In addition, among adults with recent arrests prior to treatment admission, 80.0% reported decreased criminal behavior.¹¹ Further, the percentage of adults employed (full or part time) increased significantly from 22.8% at treatment admission to 41.3% at discharge, an 81.1% rate of change.¹²

Analysis of key services that support positive treatment outcomes showed that of the adults who needed these services, 87.1% received continuing care, 86.8 received transportation, 85.9 received parenting training and education, and 84.4% received mental health services. In

¹⁰ Includes discharges for treatment completion (all parts of treatment plan or program were completed) and transfers to another facility when the individual was known to report and expected to continue further treatment. Federal treatment outcome reporting also considers such transfers a successful discharge.

¹¹ As measured by the number of subsequent arrests. Nearly all (19.3%) of remaining adults reported no change in criminal behavior, while 0.7% reported an increase in the number of arrests. As noted in the detailed findings, these data represent a small number (n=695) of all adults served by the larger RPG Program. They should be interpreted with caution and cannot be generalized to the entire RPG Program adult population.

¹² % change is calculated by subtracting the admission data from the discharge data, dividing that result by the admission data, and multiplying the subsequent result by 100; for example, $[(41.3-22.8)/22.8] \times 100 = 81.1\%$ change. These data represent a small number (n = 2,701) of all adults served by the larger RPG Program. These results should be interpreted with caution and cannot be generalized to the entire RPG Program adult population.

addition, 78.7% of adults received needed primary medical care, 70.1% received dental care, 69.4% received employment or vocational training/education, 69.2% received housing assistance, and 68.7 received domestic violence services.

Child, Adult, and Family Well-Being

During RPG Program participation, the majority of all children and youth with an identified need received the following supportive services to help strengthen their well-being:¹³

- Substance abuse prevention and education (91.1%)
- Primary pediatric care (85.3%)
- Educational services (82.3%)
- Mental health or counseling services (80.0%)
- Developmental services (75.0%)
- Substance abuse treatment (69.2%)

From RPG Program entry to discharge the percentage of children for whom overall child well-being was a strength significantly increased from 24.8% to 53.0%. Children made the greatest gains in the areas of mental health, behavior, and parent relations.¹⁴

Parents' well-being improved from RPG Program admission to discharge depending on the measurement approach selected by the grantee:

- The percentage of parents experiencing clinical levels of stress significantly decreased from 34.0% to 21.3%.¹⁵
- Participating parents showed significant reductions in severity of unemployment, alcohol and drug use, legal issues, family conflict, medical issues, and psychiatric symptoms.¹⁶

¹³ Percentages are of children assessed and for whom a given service was identified as a need.

¹⁴ Data represent the subset of grantees using the NCFAS (Child Well-Being subscale).

¹⁵ Data represent the subset of grantees using the PSI Short Form (Total Stress scale).

¹⁶ Data represent the subset of grantees using the ASI.

- The percentage of parents for whom overall parental capabilities were a strength significantly increased from 14.9% to 46.5%. Parents showed the most progress in substance use (e.g., no or decreased substance use, or use that does not impair their ability to parent) and age-appropriate supervision of children.¹⁷

From RPG program admission to discharge, families showed statistically significant improvements in their overall family interactions, environment, and family safety.¹⁸ This is illustrated in the proportion of parents rated as showing strengths in the following areas:

- Overall family interactions significantly increased from 21.8% to 47.0%. Parents made the greatest gains in age-appropriate expectations for and bonding with children, as well as mutual emotional and physical support within the family.
- Overall environment (e.g., a family's overall stability and safety in their home and community) significantly increased from 18.4% to 41.5%. Parents showed the greatest progress in the areas of safety in the community, housing stability and habitability, and creating a positive learning environment for their children.
- Overall family safety significantly increased from 17.2% to 41.0%. Parents made the greatest gains in reducing occurrence or risk of child neglect, emotional child abuse, and physical child abuse, as well as reducing or successfully addressing domestic violence between parents or caregivers.

Discussion

This article summarizes information drawn from a significant federal initiative designed to address parental substance use disorders and related needs among families involved with child welfare services. The RPG Program performance measurement effort created one of the largest

¹⁷ Data represent the subset of grantees using the NCFAS (Parental Capabilities subscale).

¹⁸ Data represent the subset of grantees using the NCFAS (Family Interactions, Environment, and Family Safety subscales).

datasets ever assembled about U.S. families involved in the child welfare system who are affected by substance use, including more than 15,000 families representing more than 25,000 children and 17,000 adults. The results and key lessons indicate that through their strengthened cross-systems collaborations, the 53 RPG Program partnerships greatly improved the lives of thousands of children and families in their regions. Collaboration was particularly enhanced through cross-systems training, convening regular meetings across systems, joint case staffing, information sharing and data collection, and establishing cross-systems policies and protocols.

All 53 regional partnerships extended well beyond the required minimum of two partners (one of which had to be the state child welfare agency). Over the grant period, the grantees added partners as families' needs and the environment in which the grantees operated evolved. By the end of the grant period, 75.5% of partnerships consisted of 10 or more member agencies, organizations, and providers representing child welfare, substance abuse treatment, the courts, mental and physical health, criminal justice, education, early childhood development, employment, housing, and other community-based organizations that provide child and family services.

The successes of the RPG grantees' clearly illustrate that the time, resources, and effort they invested in developing broad-based interagency collaboration and integrated services resulted in positive child, parent, and family outcomes. Specifically:

- Most children at risk of removal remained in their parents' custody. Most children in out-of-home placement achieved timely reunification with their parent(s). After returning home, very few children re-entered foster care.
- Parents and caregivers obtained timely access to substance abuse treatment, stayed in treatment for more than 90 days (on average), reduced their substance use, and increased their employment status. They received essential clinical treatment and support services, including continuing care, transportation assistance, parenting

training, mental health services, and housing assistance. These services helped promote and sustain their recovery and supported reunification and family stability.

- Overall child, adult, and family well-being improved between RPG Program admission and discharge (among the subset of grantees that measured well-being). However, grantees experienced challenges in measuring well-being that reflect a field that is still in development and the difficulties associated with assessing changes in such complex constructs.

Limitations

The RPG Program performance measurement process was not designed as a cross-site evaluation. A cross-site evaluation requires all sites in a given project to implement the same model and seeks to determine whether the model is effective in all sites and can be replicated in other sites. The RPG findings in this report represent 53 grantees that had the same major project goals (to improve child, adult, and family outcomes) but did not implement or test the same set of services, interventions, or program models. Furthermore, and for the same reason, the inclusion of contextual information regarding the performance of states in which grantees implemented their programs is not intended to suggest comparability of outcomes.

Implications

Data for this article represent RPG efforts that varied in design, context, and target population. However, findings presented in this study reveal consistencies across grantees in results and strategies used to achieve those results. Outcomes that appear most compelling in the policy context show children remaining at home or reunified with their parent(s), a reduction of further maltreatment, a reduction in re-entry to the child welfare system, and increased levels of parents' recovery. Indeed, these grantees generally outperformed the outcomes experienced by the states in which they were situated even though the population they served may

be assumed to have greater needs. It is also clear that in addition to the results achieved in terms of performance measures, the grantees applied important methods of working across programs and agencies to ensure that parents and children were served through innovative, deep collaboration that had not previously existed.

As in many communities across the country during the implementation period of the projects, most of the agencies associated with the RPG program experienced severe funding reductions due to the economic downturn. This highlights the barriers of bringing these proven projects to scale, and for sustaining the RPG sites' efforts in the years ahead. The sustainability assessments that were performed as part of the overall evaluation suggest that additional cost studies will be needed to justify replication and expansion of such projects.

Further analysis of special populations within the overall parent and child groups would also be useful. For example, the attachment issues among the children of those 893 women who were pregnant during participation in the program may be significant suggesting longer-term tracking of both recovery and recurrence of maltreatment for those families. It may also be important to examine the particular relevance of outcomes for the declining caseloads of children in out-of-home care over the past decade, since during that same time period an increasing number of children who were removed had parents who exhibited drug or alcohol use as a reason for removal, suggesting a more difficult-to-serve caseload. Finally, grantees served a large number of very young children. Given their particular vulnerabilities, further exploration of their outcomes may help advance the child welfare field's ability to more effectively meet the needs of this often overlooked population (Casanueva, Dozier, Jones, Dolan, & Smith, 2012; Lewis, Dozier, & Sepulveda-Kozakowski, 2007).

The federal government's ongoing investment in and refinements of the RPG program shows promise for addressing important evaluation questions. For example, the second cohort of grantees was funded in 2013 and evaluation requirements address issues related to dosage, fidelity, and outcomes to a degree that was not specified for the first cohort.

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Predictors of Substance Abuse Assessment and Treatment Completion for Parents Involved with Child Welfare: One State's Experience in Matching across Systems

Dorian E. Traube

University of Southern California

Amy S. He

University of Southern California

Limei Zhu

*Department of Human Services,
Trenton, New Jersey*

Christine Scalise

*Department of Human Services,
Trenton, New Jersey*

Tyrone Richardson

*Department of Children and Families,
Trenton, New Jersey*

To date, few studies have examined the effect of interagency collaboration on substance abuse assessment and treatment completion for parents who are involved in child welfare. The purpose of this paper is to: (1) describe a statewide, interagency collaborative program aimed at providing targeted substance abuse assessment and treatment to parents engaged in the child welfare system; (2) document the specialized assessment and treatment outcomes for parents engaged through this collaborative program; and (3) determine

factors related to successful treatment completion for parents involved in the child welfare system. This is a retrospective study of an open cohort of 13,829 individuals admitted to the

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New Jersey Child Protection Substance Abuse Initiative (CPSAI) program from October 1, 2009, through September 30, 2010. Data were drawn from two unique administrative data sources. Multivariate Cox regression models were used to explore factors related to successful treatment completion for parents involved in the child welfare system. Trend analysis for the total sample in the CPSAI program revealed that, of the 10,909 individuals who received a CPSAI assessment, 59% were referred to treatment. Of those referred to treatment, 40% enrolled in a treatment program. Once enrolled in a treatment program, 55% completed or were in the process of completing substance abuse treatment. These findings suggest that when adequate screening and treatment is available through a streamlined process, many of the ethnic and gender disparities present among other populations of individuals seeking treatment are minimized. Utilizing inherent child welfare case factors appears to be an important motivating element that aids parents during the assessment and treatment process.

Parents with substance use disorders face persistent and serious difficulties in child welfare systems (CWS). An estimated 50% to 80% of child welfare cases involve parental substance abuse (Young, Boles, & Otero, 2007), and 8.3 million children have at least one parent with a substance use disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009a). Children involved in CWS who have parents with a substance use disorder are more likely to experience lengthier stays in out-of-home placement, recurrent involvement with CWS, and lower rates of reunification (Brook & McDonald, 2007; U.S. Department of Health and Human Services [USDHHS], 1999).

Families in CWS that are also dealing with substance use disorders frequently have multiple needs, exhibiting other stressors that hinder treatment engagement and reunification (Choi & Ryan, 2006; Grella, Hser, & Huang, 2006). These include issues with mental health, domestic violence, and poverty, all of which affect parental participation in and completion of substance abuse treatment (Grella, Needell, Shi, & Hser, 2009). In addition, regulations from the 1997 Adoption and Safe Families Act (ASFA) require permanency hearings to take place within 12 months of a child being placed in foster care, making parents with substance use disorders particularly vulnerable to losing their parental rights (Green, Furrer, Worcel, Burrus, & Finigan, 2007). Due to ASFA guidelines, there is increased pressure on CWS and alcohol and other drug systems (AODS) to provide timely assessments and treatment for parents with substance use disorders.

Emergent models for effective collaboration, especially for complex systems such as CWS and AODS, improve outcomes for families with substance use disorders. Indeed, interagency collaboration between CWS and AODS plays an important role in addressing issues of parental substance use disorders and family reunification (Drabble, 2007; Green, Rockhill, & Burrus, 2008). However, there are unique challenges that act as barriers to effective collaboration between CWS and AODS, including differences in how these systems define clients, case-plan goals, timelines, staff training and education, funding barriers, and shortages of available treatment services (Osterling & Austin, 2008). To date,

few studies have examined the effect of interagency collaboration on substance abuse assessment and treatment completion of parents involved with child welfare. The purpose of this paper is to: (a) describe a statewide, cross-system collaborative program designed to provide targeted substance abuse assessment and treatment to parents engaged in the child welfare system; (b) document the specialized assessment and treatment outcomes for parents engaged through this collaborative program; and (c) determine factors related to successful treatment completion for parents involved with child welfare.

Interorganizational Collaboration Theory

This study was guided by interorganizational collaboration theory (Alter & Hage, 1993) that elucidates the motivation and grounds for interagency collaboration between CWS and AODS. Based on this theory, we identified the core components of implementing cross-system collaboration between CWS and AODS as follows: (a) stationing AODS staff in child welfare offices, (b) creating joint case plans between CWS and AODS, (c) using official committees to guide collaborative efforts, (d) offering training and cross-training, and (e) establishing protocols and policies for sharing confidential information (Osterling & Austin, 2008).

Child Protection Substance Abuse Initiative (CPSAI)

An example of interorganizational collaboration is among New Jersey's Department of Children and Families, Division of Child Protection and Permanency (DCPP), and the Department of Human Services' Division of Addiction Services in their Child Protection Substance Abuse Initiative (CPSAI) program. The goals of the collaboration are child safety; family well-being; increased reunification through identification; assessment, referral, and follow-up with clients in need of substance abuse treatment services; and supporting the recovery of clients involved with child welfare. DCPP contracts for CPSAI services to provide expedited and specialized substance abuse assessment and treatment services to

these clients. Services are delivered by certified drug and alcohol counselors who are located in each DCPP local office and provide a range of services, including (a) assessment of service needs, (b) identification of state-contracted substance abuse treatment programs, (c) referral to these programs, and (d) assistance with the placement of clients into programs with the appropriate level of care.

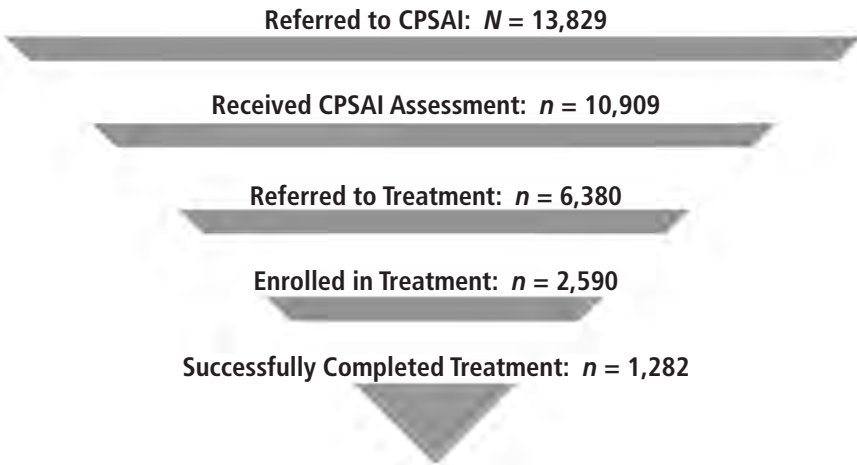
CPSAI Treatment Referral Process

When a family has a case opened with DCPP for potential child maltreatment, the DCPP investigator specifically looks for indicators of parental substance use disorders during the investigation. If substance use issues are detected, the DCPP investigator discusses the case with a supervisor and refers the parent to a certified alcohol and drug counselor for additional assessment. The DCPP local office liaison evaluates the case and assigns a timeline of 24 to 72 hours for referral to a CPSAI provider for in-depth substance abuse assessment. After the referral, the CPSAI provider is required to make three attempts to engage the parent within 30 days. The provider generally contacts the client via phone, mail, or hand-delivered letters or requests that a DCPP worker attempt to contact the client. Once CPSAI contact is achieved, the parent completes a comprehensive substance use evaluation that includes the Addiction Severity Index (Fureman, McLellan, & Alterman, 1994), the American Society of Addiction Medicine's (2001) patient placement criteria, supplemental questions from the New Jersey Substance Abuse Monitoring System (NJSAMS), and drug testing. These assessments lead to one of three outcomes: (a) referring the client for extended assessment to assist in engagement, (b) referring the client to the appropriate level of care for treatment, or (c) discharging the client because services are deemed unnecessary. After a referral for treatment, CPSAI continues case management for up to 30 days or until the client enters a treatment program. Throughout the process, the CPSAI worker or treatment provider delivers case reports to DCPP. Figure 1 illustrates the number of clients successfully transitioning at each step of the

CPSAI process, based on a data tracking process developed by Children and Family Futures under a contract to manage the National Center on Substance Abuse and Child Welfare.

Figure 1

CPSAI Dropoff Analysis (including re-referrals)



*Some clients are still in treatment and may yet successfully complete treatment.

Increasing Treatment Capacity

To support this process, the Department of Children and Families allocates special funding to the Department of Human Services to increase statewide capacity for substance abuse treatment programs designed to address the specific treatment needs of individuals involved with child welfare. This funding allows capacity in all program modalities, including intensive outpatient care with or without housing support, methadone intensive outpatient care, long-term residential care, and halfway-house care. These programs provide gender-specific substance abuse treatment

and other therapeutic interventions for families addressing issues such as parenting, the parent–child relationship, children in the custody of parents in treatment, child developmental needs, and child protection. Additional services include transportation, case management, linkages to health care, and recovery support. This funding ensured the development of a comprehensive set of protocols between DCPD and the Division of Mental Health and Addiction Services to ensure that parents are adequately assessed and referred to treatment programs conducive to child-welfare-focused timelines and case plans.

Methods

This is a retrospective study of an open cohort of 13,829 individuals admitted to the CPSAI program from October 1, 2009, to September 30, 2010. Data are drawn from two administrative data sources: (a) the CPSAI database and (b) NJSAMS. These datasets are linked using a common, state-level identification number or a composite variable that matches name, birth date, and gender. Given the nature of the CPSAI program, these data are limited to parents referred to the CPSAI program after a child maltreatment investigation. Additionally, eligibility for participation in the CPSAI program is limited to parents 18 years old or older. In the instance that an individual is referred to the CPSAI program multiple times during the study period, their most recent referral is selected for tracking.

Variables

Substance Abuse Assessment and Treatment Outcome

Outcomes at each stage of the assessment, referral, and treatment completion process were defined as: (a) completion of substance abuse treatment (including completing or being in treatment during the study period); (b) referral for CPSAI assessment; (c) receipt of CPSAI assessment; (d) referral for substance abuse treatment; (e) receipt of substance abuse treatment; and (f) discharge from substance abuse treatment.

Correlates of Treatment Completion

Demographic predictors of dropout at various stages of substance abuse assessment and treatment in the general population include age (Satre, Chi, Mertens, & Weisner, 2012), gender (Greenfield et al., 2007), employment status (Grella et al., 2006), and race (Milligan, Nich, & Carroll, 2004). Correlates of treatment completion were chosen for analysis *a priori* based on the extant literature and availability of data from CPSAI and NJSAMS. These correlates included:

1. Age at assessment: ≤ 20 years, 21–30 years, 31–40 years, and > 40 years
2. Gender: male or female
3. Race and ethnicity: African American, Hispanic, White, and other or multiethnic
4. Employment status: employed, not in the labor force (student, disabled, homemaker, or retired), and unemployed
5. Legal status: legal case pending, on probation, on parole, current DCPD or family court case, and domestic violence case

Analyses

This study used SAS 9.1 for all analyses and conducted bivariate trend analyses for the assessment and treatment outcomes at each point in the CPSAI program. Multivariate Cox regression models determined the treatment completion outcome. Furthermore, this study used Cox regression for multivariate analyses because of its capacity to model a dichotomous outcome and control for time-to-treatment completion. Time-to-treatment completion refers to the period between the moment a client receives a CPSAI referral to receipt of CPSAI assessment, referral for substance abuse treatment, receipt of substance abuse treatment, and discharge from substance abuse treatment. This study excluded clients at any point if they voluntarily dropped out of the CPSAI program, were discharged due to noncompliance or medical reasons, were incarcerated, died, or if a referral to the next step of the CPSAI assessment or treatment process was not made due to ineligibility. Bivariate survival analyses

Table 1. Demographics of Sample at Each Point of CPSAI Process

Variable	Received CPSAI Assessment (<i>N</i> = 13,829)		Referred to Treatment (<i>n</i> = 10,909)		Entered Treatment		Completed Treatment	
	Yes <i>n</i> (%)	No <i>n</i> (%)	Yes <i>n</i> (%)	No <i>n</i> (%)	Yes <i>n</i> (%)	No <i>n</i> (%)	Yes <i>n</i> (%)	No <i>n</i> (%)
<i>N</i>	10,909	2,920	6,380	4,529	2,590	3,859	1,282	1,065
Gender								
Male	4,350 (75)	1,423 (25)	2,583 (59)	1,767 (41)	894 (34)	1,706 (66)	469 (58)	335 (42)
Female	6,553 (81)	1,488 (19)	3,793 (58)	2,760 (42)	1,694 (44)	2,151 (56)	812 (53)	729 (47)
Race								
White	4,485 (89)	536 (11)	2,812 (63)	1,673 (37)	1,203 (42)	1,644 (58)	603 (56)	473 (44)
African American	2,069 (91)	198 (9)	1,231 (60)	838 (40)	512 (41)	730 (59)	223 (48)	243 (52)
Hispanic	1,830 (84)	340 (16)	913 (50)	917 (50)	347 (38)	574 (62)	189 (59)	133 (41)
Other or multiethnic	2,525 (58)	1,846 (42)	1,424 (56)	1,101 (44)	528 (37)	911 (63)	267 (55)	216 (45)
Age								
<= 20 years	666 (66)	337 (34)	429 (64)	237 (36)	160 (37)	271 (63)	67 (44)	86 (56)
21–30 years	4,028 (79)	1,075 (21)	2,435 (60)	1,593 (40)	1,078 (44)	1,391 (56)	513 (52)	470 (48)
31–40 years	3,298 (80)	818 (20)	1,920 (58)	1,378 (42)	781 (40)	1,159 (60)	394 (56)	306 (44)
> 40 years	2,917 (81)	690 (19)	1,596 (55)	1,321 (45)	571 (34)	1,038 (65)	308 (60)	203 (40)
Employment status								
Employed	--	--	2,313 (53)	2,019 (47)	817 (35)	1,515 (65)	449 (61)	287 (39)
Unemployed	--	--	1,037 (60)	686 (40)	372 (36)	671 (64)	164 (49)	173 (51)
Not in labor force	--	--	3,022 (63)	1,788 (37)	1,395 (46)	1,671 (54)	665 (52)	605 (48)
Pending legal case								
Yes	--	--	1,010 (78)	290 (22)	462 (45)	561 (55)	253 (59)	177 (41)
No	--	--	5,370 (56)	4,239 (44)	2,128 (39)	3,298 (61)	1,029 (54)	888 (46)
Probation								
Yes	--	--	409 (71)	164 (29)	188 (45)	231 (55)	69 (42)	97 (58)
No	--	--	5,971 (58)	4,365 (42)	2,402 (40)	3,628 (60)	1,213 (56)	968 (44)
Parole								
Yes	--	--	35 (58)	25 (42)	12 (34)	23 (66)	5 (42)	7 (58)
No	--	--	6,345 (58)	4,504 (42)	2,578 (40)	3,836 (60)	1,277 (55)	1,058 (45)
DCPP or family court								
Yes	--	--	4,660 (57)	3,447 (43)	1,865 (40)	2,849 (60)	939 (56)	753 (44)
No	--	--	1,720 (61)	1,082 (39)	725 (42)	1,010 (58)	343 (52)	312 (48)
DV history								
Yes	--	--	713 (67)	353 (33)	256 (36)	461 (64)	136 (56)	107 (44)
No	--	--	5,654 (58)	4,106 (42)	2,329 (41)	3,390 (59)	1,144 (54)	957 (46)

Note: CPSAI, Child Protection Substance Abuse Initiative; DCPP, Division of Child Protection and Permanency; DV, domestic violence. Reported *N*s vary slightly across analyses due to missing data.

between each independent variable and dependent variable (not shown) also tested the equality of survivor functions (log-rank test for categorical independent variables and simple Cox model for continuous independent variables). Graphing of the estimated survival functions from the bivariate tests assessed the assumption of proportionality. The Cox regression output included a magnitude of effect called a hazard ratio (exponential parameter coefficient), which is similar to odds ratios in interpretation. A statistically significant hazard ratio (HR) greater than 1 indicates an increased risk, whereas a statistically significant hazard ratio between 0 and 1 reflects decreased risk. For example, a hazard ratio of 2 indicates a doubling of the risk and a hazard ratio of 0.5 indicates a reduction to half of the risk.

Results

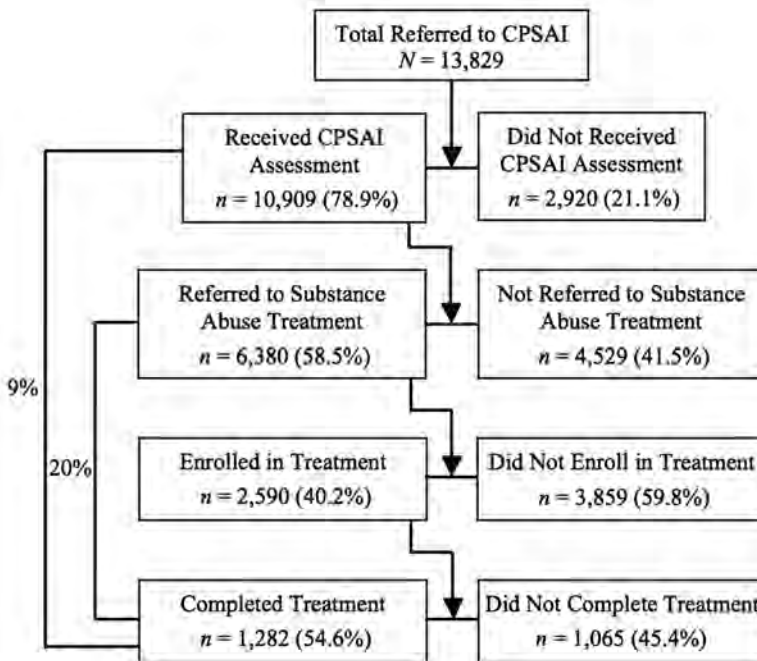
Table 1 shows the key demographics of the sample at each step in the CPSAI process. Women had higher rates of receipt of CPSAI assessment (81% vs. 75% of men) and enrollment in treatment (44% vs. 34% of men). Men had a slightly higher rate of referral to treatment (59% vs. 58% of women) and a higher rate of treatment completion (58% vs. 53% of women). Although African Americans had the highest rate of receipt of CPSAI assessment (91%), they had the lowest rate of treatment completion (48%). In comparison, Whites had the highest rates of referral to treatment (63%) and enrollment in treatment (42%), whereas Hispanics had the highest rate of treatment completion (59%). Although younger parents had higher rates of referral to treatment (≤ 20 years old: 64%; 21–31 years old: 60%), older parents had higher rates of treatment completion (31–40 years old: 56%; > 40 years old: 60%).

Overall, trend analysis for individuals referred to the CPSAI program ($n = 13,829$) revealed that 79% ($n = 10,909$) received a CPSAI assessment, 46% ($n = 6,380$) were referred to substance abuse treatment, 19% ($n = 2,590$) enrolled in a treatment program, and 9% ($n = 1,282$) completed substance abuse treatment (some individuals were still completing their treatment programs at the time of data collection; see Figure 1).

Figure 2 shows the transition patterns at each step of the CPSAI process and reveals that a CPSAI referral for assessment resulted in 79% of parents receiving an assessment. Subsequently, 59% of individuals receiving a CPSAI assessment were referred to treatment. Of those individuals, 40% enrolled in a treatment program. Once they enrolled in a treatment program, 55% completed treatment (some noncompleter cases were in the process of completing substance abuse treatment). Of the individuals referred to substance abuse treatment, 20% completed or were in the process of completing treatment.

Figure 2

Dropoff Points from CPSAI Assessment through Substance Abuse Treatment



Note: Reported *N*s vary slightly due to re-referral.

Table 2 presents the results of the multivariate Cox proportional hazard analysis of completing substance abuse treatment after referral by the CPSAI program. Independent factors of ethnicity, employment status, and legal cases were statistically significantly associated with treatment completion. Specifically, compared to Whites, African American (HR = 1.06, 95% CI [1.01, 1.12]), Hispanic (HR = 1.12, 95% CI [1.06, 1.19]), and other and multiethnic (HR = 1.10, 95% CI [1.04, 1.15]) individuals were more likely to complete treatment. Compared to clients who were unemployed, clients who were working (HR = 1.10, 95% CI [1.05, 1.15]) or holding a status outside the workforce (student, disabled, homemaker, or retired; HR = 1.08, 95% CI [1.02, 1.14]) were more likely to complete treatment. Finally, clients were more likely to complete treatment if they did not have an active criminal legal case (HR = 1.24, 95% CI [1.17, 1.32]) or were not on probation (HR = 1.09, 95% CI [1.01, 1.19]). Conversely, parents without an active family court case (HR = 0.93, 95% CI [0.89, 0.97]) were less likely to complete treatment. Gender, age, and parole status were not statistically significant variables.

Table 2. Cox Regression Models: Hazard Ratios for Predictors of Substance Abuse Treatment Adherence after Single Referral from Child Welfare

Variable	HR	CI
Male	0.95	[0.95, 1.04]
Ethnicity		
African American	1.06*	[1.01, 1.12]
Hispanic	1.12***	[1.06, 1.19]
Other or multiethnic	1.10***	[1.04, 1.15]
Age		
21–30 years	1.00	[0.92, 1.08]
31–40 years	1.00	[0.92, 1.08]
> 40 years	1.03	[0.94, 1.12]
Employment status		
Employed	1.10***	[1.05, 1.15]
Not in workforce	1.08**	[1.02, 1.14]
Legal issues		
No pending legal case	1.24***	[1.17, 1.32]
Not on probation	1.09*	[1.01, 1.19]
Not on parole	1.07	[0.84, 1.38]
No DCPD or family court case	0.93***	[0.89, 0.97]
No history of domestic violence	0.98	[0.95, 1.01]

p* < .05, *p* < .01, ****p* < .001

Note: DCPD, Division of Child Protection and Permanency; HR, hazard ratio. Model fit statistics: Wald $\chi^2 = 127.02$, *df* = 14, *p* < .0001.

Discussion

In this sample of parents receiving a referral for streamlined substance abuse assessment and treatment after incurring a report of child maltreatment, 9% referred for an assessment and 20% referred for treatment successfully completed treatment (see Figure 2). Additionally, 55% of individuals who enrolled in treatment completed the process. The results of this study also show that many individuals did not meet the threshold for treatment referral; 59% of individuals receiving an assessment did not require treatment. However, given the rate of treatment completion for individuals who entered treatment, the wide threshold of referrals for assessment seems to have had a positive effect on client outcomes. Therefore, the success of CPSAI seems to occur at the front end of the treatment process. This success should be considered in tandem with the level of resources expended on assessments, potentially at the cost of ensuring adequate engagement strategies, because the step between treatment referral and enrollment in treatment featured the largest percentage of parents who did not make the transition. This illustrates the gap between treatment need and receipt of treatment (SAMHSA, 2009b).

Although the overall treatment completion rate for individuals receiving a referral to treatment was lower than the national average for the general population (20% in CPSAI vs. 47% nationally; SAMHSA, 2009b), the completion rate for individuals who successfully enrolled in treatment was higher (55% in CPSAI). This is a compelling finding given that families in child welfare have numerous stressors that affect treatment completion not necessarily found in the general population, including a higher representation of women, unemployed individuals, and clients of color (Dolan et al., 2011). By comparison, a similar collaborative effort between the state of Maryland's CWS and AODS resulted in 55% of clients entering into a substance abuse treatment program; however, only 12% completed treatment (Arria & Thoreson, 2007). Evaluations of child welfare and substance abuse treatment collaborations in Delaware in 2005 and Illinois in 2006 reported completion rates similar to New

Jersey (Choi & Ryan, 2006; USDHHS, 2005). Delaware had a 24% treatment completion rate based on individuals assessed for treatment; in Illinois, 22% of referred clients completed treatment. These evaluations also revealed that key demographic variables and case-level factors influence treatment completion, including age, employment status, and legal involvement. Additionally, in these programs, individuals referred to private treatment programs were not tracked, which confounds the treatment completion rate for both studies. Overall treatment completion rates may benefit from increased recovery support to assist families with treatment retention and completion. Prior studies have noted the importance of comprehensive services in ensuring treatment retention and completion. These comprehensive services include: (a) enhancing access to treatment settings by offering child care, transportation, recovery management, and intensive case management; (b) incorporation of interventions designed to bolster parent-child interaction as a step toward promoting recovery from substance use disorders; (c) matched services that address multiple client needs through one service delivery mechanism or intervention (e.g., child welfare case management within a substance abuse treatment program); and (d) bolstering client-provider relationships (Marsh, Smith, & Bruni, 2011). CPSAI program officials have begun to discuss the inclusion of recovery support specialists and 24-hour support hotlines for parents involved with child welfare who are in substance use treatment. Another key issue that must be addressed is that support resources for treatment completion are often targeted to women, and men do not have the opportunity to benefit from additional supportive care.

Correlates of Treatment Completion

Ethnicity, employment status, and legal involvement are key factors that relate to treatment completion. Unique to this study sample is the fact that African Americans were more likely than Whites to complete treatment, followed by Hispanics and other or multiethnic clients. In other studies examining parents involved with child welfare (Choi & Ryan,

2006) and the general population of individuals receiving substance abuse treatment (Marsh, Cao, Guerrero, & Shin, 2009; SAMHSA, 2009b), White clients were more likely to complete treatment than minority clients. Providing tailored or matched services to minority clients illuminates a common barrier to treatment completion for this population (Marsh et al., 2009). The CPSAI program aims to provide assessment, treatment, and case management services that are specific to the presenting needs of parents referred by CWS. The findings from this study reinforce the accumulating evidence that treatment completion rates for minority clients improve when special programs are tailored to the particular needs of these client groups, including streamlined services and knowledge of the stressors, needs, and strengths that distinct client groups bring to treatment (Marsh et al., 2009).

Employment is a widely cited correlate of substance abuse treatment completion in the general population (SAMHSA, 2009b) and child welfare population (Choi & Ryan, 2006). Our findings also confirm that employed individuals in the CPSAI program are more likely to complete treatment, as are individuals who are not in the labor force. There is a paucity of research concerning treatment referrals and completion for individuals not in the labor force because they are students, homemakers, disabled, or retired. Generally, employment is a dichotomous variable in the literature. Individuals who are not in the labor force may have health care and compensation benefits from their schools, Social Security, disability, or retirement programs that are similar to those who have jobs. These benefits may offer individuals more opportunities to seek and complete treatment. Additionally, people who work or are not part of the labor force do not contend with the psychosocial stressors of unemployment that can lead to self-medication and relapse.

Finally, the absence of an open legal case or probationary status facilitated treatment completion. This differs from findings related to a similar program in the state of Illinois (Choi & Ryan, 2006) and possibly affected the statistical power of this study because so few individuals had non-CWS legal issues. The only active legal involvement positively associated with treatment completion was having an active

family court case. We suspect that parents are more motivated to complete their treatment programs when they have a pending family court case because treatment completion likely increases their chances of having their case closed or reuniting with their children. Several studies have indicated that involvement in family dependency treatment courts is more effective at improving treatment compliance and motivation, maintenance of sobriety, completion of court plans, reduction of criminal recidivism, parental reunification with children, and improved outcomes for children, parents, and families when compared with involvement in traditional courts (Grella et al., 2009; Testa & Smith, 2009; Worcel, Furrer, Green, Burrus, & Finigan, 2008). Similarly, parole status was not statistically significant in terms of treatment completion. This speaks to the intrinsic motivation that being the parent of a child confers on the goal of recovery, regardless of involvement with the justice system. This is an important element to address with clients during their substance abuse treatment.

Other factors that were not statistically significantly related to treatment completion included age and gender. The likelihood of completing treatment increases with age for both child welfare-involved populations and the general population (Choi & Ryan, 2006; SAMHSA, 2009b). Given the robust age range among New Jersey CPSAI clients, it is unclear why age did not play a role in treatment completion in this study.

The lack of statistically significant findings regarding gender is also surprising given that most parents with substance use disorders who have active CWS case plans are mothers (USDHHS, 1999). Women in the general population and mothers involved in child welfare often confront greater challenges related to their substance use and abuse (Choi & Ryan, 2006; Greenfield et al., 2007; Osterling & Austin, 2008). Studies have shown that women with substance use disorders have limited social support networks (Grella, 2008) and are more likely to have a partner or spouse who also has a substance use disorder (Dawson, Grant, Chou, & Stinson, 2007). Sociocultural and socioeconomic factors and perceived social stigma also inhibit help-seeking behaviors

among women (Small et al., 2010). This contributes to the underdiagnosis and underdetection of substance use disorders among women, leading to fewer referrals and entry to substance abuse treatment programs (Brady & Ashley, 2005). Lower socioeconomic status and a lack of substance treatment facilities that house women and their children also hinder women's involvement with substance abuse treatment (Grella, 2008). A review of the literature revealed that women with substance use disorders are less likely than men to enter treatment during their lifetime (Greenfield et al., 2007). In addition to these challenges, research has suggested that mothers with substance use disorders who are also involved in CWS are particularly vulnerable and at a higher risk of not reuniting with their children than mothers without substance use disorders (Osterling & Austin, 2008), especially because they tend to be younger, have more children, and have more economic problems (Choi & Ryan, 2006). The high percentage of women involved in the CPSAI project and the lack of gender differences in treatment completion indicates that the CPSAI program is successful in achieving its goal to increase referrals to substance abuse treatment services. CPSAI is also successful in identifying families that tend to be from predominately women-led households that are at increased risk of substance use disorders that affect their child welfare cases. This factor becomes even more important given that there are far more women in this sample than in the general NJSAMS. Hence, CPSAI is capable of identifying and serving the needs of this vulnerable and often overlooked segment of the child welfare population: mothers with substance use disorders.

Limitations

This study contributed to the limited research examining the impact of collaborative efforts between CWS and AODS to meet the needs of families referred to child welfare that have substance use issues. Although this study advanced this often overlooked area of substance abuse treatment, it is not without limitations. As with other studies examining

interagency collaborations between AODS and CWS (Arria & Thoreson, 2007; Choi & Ryan, 2006; USDHHS, 2005), this research did not include any analysis with a comparison group. Given the challenges of using administrative datasets from government agencies, constructing an appropriate comparison group is difficult. Future studies should aim to build comparison samples into their data-sharing agreements to enhance the robustness of this type of research. Furthermore, this study's data analyses used the most recent referral of individuals who received more than one referral to the CPSAI program during the study period. Therefore, this analysis does not reflect outcomes unique to individuals with multiple referrals. Moreover, refinements to CPSAI procedures since the end of the study period may have implications for future analysis. Therefore, these refinements warrant ongoing surveillance.

Because this study was a secondary analysis of administrative data from the CPSAI and NJSAMS databases, we included only select correlates of treatment completion and information about characteristics of the treatment programs, and their fit with specific parents' needs (e.g., level of care, type of substance use) was not explored. NJSAMS captures only the most commonly cited factors of treatment completion. Future research should include explorations of treatment programs and differential outcomes for parents based on type of treatment, level of care, as well as gender- and trauma-specific programming. We also did not explore the numerous child welfare variables that likely play a role in treatment completion, such as mental illness, domestic violence, poverty, whether a child is in out-of-home care, whether the family reunified, whether reunification relates to treatment participation, whether there are multiple open child welfare investigations, and whether or not parental rights are intact. Better merging of AODS data with CWS data will facilitate this level of inquiry. The state of California, in conjunction with the Center for Social Services Research at the University of California, Berkeley, is overseeing the largest data-sharing project between AODS and CWS. We expect that this paper will serve as a platform for more robust investigations using data from the state of California.

Implications and Conclusions

Despite this study's limitations, it contributed to the field of substance abuse treatment in several ways. First, the needs of families involved in child welfare in the realm of substance abuse treatment are often overlooked in policy, practice, and research. This study is one of a few to describe efforts at the state level to better identify and target treatment for parents with open child welfare cases. This study indicates that through collaborative efforts between CWS and AODS, assessment and referral for care is possible for one of the hardest populations to engage in substance abuse treatment. Successful treatment completion seems to hinge on having adequate resources to screen a large number of high-risk individuals through a multi-step assessment process. When adequate screening and treatment is available through a streamlined process, many of the ethnic and gender disparities present among other populations of individuals seeking treatment are less impactful. Furthermore, using benefits afforded through employment, disability, or retirement seems to ease the burdens that often result in unsuccessful treatment completion. Finally, inherent child welfare case factors, including parental desire to reunite with children and resolve their child welfare case, seem to be an important motivating element that aids parents during the assessment and treatment process.

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Examining the Relationships between Family Drug Court Program Compliance and Child Welfare Outcomes

Holly Child

Children and Family

Futures

Dara McIntyre

Children and Family

Futures

Although the evidence is accumulating to substantiate the successes of Family Drug Courts (FDC), there is little research on the relationship between parent compliance and successful reunification of children with their parent(s). This study looked at data from 206 families participating in a FDC in Sacramento County, California. Four compliance measures were examined individually and collectively, after controlling for participant characteristics, using logistic regression models to determine how FDC participation benchmarks impact child reunification. This study found the best predictors of reunification was participation in support group meetings and negative tests for substance use. These findings indicate that initiatives designed to address the needs of families affected by child maltreatment and substance use should take into account and support engagement in informal, community-based activities as well as formal, clinically focused interventions.

More than 300 jurisdictions have developed Family Drug Courts (FDCs) (National Institute of Justice, 2014; Marsh, Smith, & Bruni, 2011) to coordinate services for families in child welfare affected by parents with substance use disorders. Participation in an FDC is associated with reduced substance use and higher employment (Bryan, & Havens, 2008; Powell, Stevens, Dolce, Sinclair, & Swenson-Smith, 2012). Parents in FDCs access substance abuse treatment faster, remain in treatment longer, and complete treatment more often than families solely receiving child welfare services (Green, Rockhill, & Furrer, 2007; Worcel, Furrer, Green, Burrus, & Finigan, 2008). Parents who complete substance abuse treatment are more likely to be reunified with their children, and their children spend considerably fewer days in out-of-home foster care (Boles, Young, Moore, & DiPirro-Beard, 2007; Bruns, Pullmann, Weathers, Wirschem, & Murphy, 2012; Gifford, Eldred, Verneray, and Sloan, 2014; Green, Rockhill, & Furrer, 2007; Worcel, et al., 2008). FDCs also have considerable impact on the child welfare system by reducing costs associated with reoccurrence and re-entry into the system (Burrus, Mackin, & Finigan, 2011; Carey, Sanders, Waller, Burrus, & Aborn, 2010a; Carey, Sanders, Waller, Burrus, & Aborn, 2010b).

Sacramento FDC Program Model

Since 2001, Sacramento County's FDC¹ has developed an innovative court-ordered program for parents with an open child welfare case where parental substance use has been identified as a contributing factor to child maltreatment. There are various reasons that a parent would not be referred to FDC, such as types of substantiated allegations (i.e., sexual abuse), a referral to another type of family court (i.e., the County has an Early Intervention Family Drug Court Program), or parental medical or mental health needs that exceed the scope of services provided by FDC. The Sacramento program is a parallel FDC in which the dependency case proceedings regarding the child abuse or neglect, including

¹ The court under consideration is referred to as a Drug Dependency Court, but the more common term of Family Drug Court is used throughout this article for consistency purposes.

aspects of visitation and permanency, are conducted on a family court docket while the parent is offered specialized court services to address substance use and other factors the court considers having contributed to the maltreatment through the FDC program.

Parents are court-ordered to participate in FDC at an early hearing for their case. A specialized court officer hears the compliance reviews and manages the recovery aspects of the case throughout the parent's participation in FDC. Incentives are given for compliance with treatment and recovery plans, such as certificates of phase completions, recovery stones (stones carved with inspirational words to represent progress and support and provided at key phases in recovery), and fishbowl drawings (opportunities to draw a reward from a "fishbowl" that contains pieces of paper that correspond to prizes). Graduated sanctions are applied for non-compliance such as interviewing a family member, making a photo collage with an assigned topic, and doing community service. A unique feature of the Sacramento FDC program is the use of the Recovery Management Specialists (RMSs), who provide recovery-focused case management services to all parents with substance use disorders and an open child welfare case. RMSs are licensed with the state as California certified addiction counselors and facilitate parents' timely access to substance abuse treatment and related support services. They offer monitoring and accountability for the parent's treatment requirements. In addition, the RMSs communicate drug test results and compliance with treatment requirements to the child welfare agency, attorneys, and the court through a protocol negotiated among all three partners. The Sacramento FDC program is designed to offer parents a supportive environment with an emphasis on honesty and recovery (Bridges STARS Program, 2014).

Program Compliance

The Sacramento FDC includes five compliance measures: (1) drug tests; (2) attendance in substance abuse treatment; (3) attendance in meeting with their RMS; (4) attendance in support groups (e.g., 12-step programs); and (5) compliance with other requirements ordered by the court.

The Sacramento FDC compiles information about compliance twice each month. FDC staff distribute the individual reports to the assigned social worker, attorneys for the children and parents, and the court. At weekly staffing meetings, the treatment team reviews the current status of each parent based on compliance and other related considerations, such as treatment attendance and support group attendance. This study focuses on the first four measures of compliance, as information on other court requirements was not available when the study was completed.

Drug Tests

Drug testing is commonly used as a method to monitor a parent's progress in recovery (Center for Substance Abuse Treatment, 2010). For child welfare workers who are charged with ensuring the safety of children, drug test results assist with the decision-making process regarding whether a parent can retain or resume his or her parental role without jeopardizing the child's well-being. Ideally, in a FDC model all partner agencies, including the court, review the results of drug tests and acknowledge its role in the recovery process (BJA Drug Court Technical Assistance Project, 2013). In the Sacramento FDC, if drug testing indicates abstinence from substance use and the parent is found compliant in other compliance measures, testing frequency is reduced. Although the testing frequency may be reduced, drug tests are still conducted randomly. In addition, other non-compliant behavioral events, such as missed meetings or missed treatment sessions, may also lead to an increase in testing frequency.

Treatment Compliance

At intake, the FDC treatment team assesses participants for substance treatment needs. Typically, the FDC program requires that participants complete six months of treatment. The FDC considers clients non-compliant if they are discharged from treatment prior to completion, fail to follow the guidelines of the treatment provider, have any unexcused absences from treatment, forge or alter treatment attendance slips,

or leave a detox or residential facility without authorization. Although there is a recommended length of treatment, the treatment team determines appropriate treatment length and modality on an individual basis.

Engagement with the RMS

The RMS is responsible for face-to-face contacts with the participants as outlined by the participants' Support Service Plan. These contacts provide a forum for participants to receive support, encouragement, and direction from the RMS and allows for the RMS to document information used in participants' dependency cases. The RMS can perform random substance use screenings, conduct case conferences, and implement interventions. The number of contacts between the participant and the RMS is dependent upon the length of time the client has been with the recovery program and what type of treatment program they are enrolled in. RMSs are required to hold at least half of these contacts in the community at the participant's home, treatment center, or at a neutral location with the remainder at the RMS's office.

Participation in Support Groups

All FDC participants are required to attend support groups that specifically address their recovery from substances. The most common are 12-step support groups such as Alcoholics Anonymous or Narcotics Anonymous, but the FDC considers other groups, including community- or church-based programs, to be acceptable as long as the focus of the group is on recovery from substance abuse. The Sacramento FDC policies and procedures manual states that support group participation is one of the most important factors in succeeding in the FDC program. Participants receive an orientation to available support groups at intake and are required to attend a minimum of six support groups per bi-monthly reporting period unless a special circumstance warrants a reduction of meetings (e.g., young infant in care, multiple children under the age of 5, employment, or school obligations).

Although the evidence is accumulating to substantiate the successes of FDC approaches, very little is known about the connection between

compliance measures and outcomes such as parents' graduation from FDCs and reunification with their children. Nor is there a clear understanding about how to use compliance data to quickly and systematically differentiate between parents who are likely to be successful with the FDC services and those parents who may need additional services or a different service array. Understanding how compliance measures impact reunification in a more efficient and therapeutic manner could assist partners in FDCs to identify parents who are struggling and provide them with additional resources or a change in service array to support their recovery. This article addresses that gap in the literature by examining the relationships between FDC compliance and successful reunification with their parent.

Method

Data Sources

Parent demographic information and child permanency status were extracted from the Child Welfare Parent Identifier Report based on the Child Welfare Services/Case Management System (CWS/CMS) dataset. Child demographic information and parent compliance measures were provided by the case management provider. All information was combined into a single data file using unique parent and family identifiers.

Sample

A total of 673 parents participated in FDC between October 1, 2011, and September 30, 2013. Of these parents, 140 had missing or erroneous data on key variables. Of the 533 parents remaining in the sample, 206 were included in these analyses. These parents had: (1) a child who was removed prior to or during FDC participation; (2) services information on all compliance measures; and (3) their case was closed so determination of the child's permanency outcome was known. For parents who had multiple children reported to FDC, reunification outcomes for the first child reported was used. Parents included in the final

sample were compared to the excluded parents to determine if there were any differences in the characteristics served in the final sample. There were slight differences in sample selected in terms of gender and ethnicity, but the final sample was still representative of parents typically served in Sacramento's FDC.²

Measures

Child Reunification

Child reunification data included date of last removal, date of reunification, and reason for foster care discharge. Foster care discharge categories include reunification, living with relative, adoption, emancipation, relative guardianship, transfer to another agency, runaway, and death. Date of reunification and foster care disposition were combined into a dichotomous variable indicating whether or not a child removed from their home was reunified with their parent (1 = reunified, 0 = not reunified).

Drug Test Results

Date and result of drug test was provided for every test administered to the parent during their participation in FDC. Substance(s) detected were provided for all positive drug tests. Client self-reported substance use was also tracked as a positive drug test. Positive tests due to prescription drugs or residual substances in the participant's system were excluded. When a parent completed a drug test and self-reported any substances used in a single day, these drug tests were consolidated into a single test so each participant had only one drug test in a single day. Total drug tests were calculated as the percent of all drug tests that were negative.

² Parents included in the final sample were significantly different from the excluded parents in terms of gender, $X^2(1, 533) = 42.39, p < 0.001$, and race/ethnicity, $X^2(5, 533) = 11.96, p = 0.035$. Parents included in the sample were significantly more likely to be female (82.0%) compared to parents in the excluded sample (54.4%). Parents included in the sample were also significantly more likely than parents excluded from the sample to be African American (23.3% vs. 17.1%) or Caucasian (53.4% vs. 47.1%). Parents included in the final sample were similar from the excluded parents in terms of age, education, and employment.

Treatment Sessions Attended

Treatment sessions attended included the total number of treatment sessions the parent was required to participate in during FDC and the total number of treatment sessions the parent actually attended. Treatment sessions attended are calculated as a percent of total required sessions the parent has attended.

RMS Meetings Attended

RMS meetings attended included the total number of meetings the parent was required to have with their RMS during their participation in FDC and the total number of meetings the parent actually attended. RMS meetings attended are calculated as a percent of total required meetings the parent has attended.

Support Group Meetings Attended

Support group meetings attended included the total number of support group meetings (e.g., 12-step, AA, NA) the parent was required to attend during FDC and the total number of support group meetings the parent actually attended. Support Group meetings attended are calculated as a percent of total required meetings the parent has attended.

Analysis

A hierarchical logistic regression was used to examine differences in the likelihood of a child being reunified with their parent based on performance on each compliance measure after controlling for age, sex, race/ethnicity, and primary substance of choice.

The impact of individual compliance measures on reunification were first examined separately to explore which, if any, were predictive of child reunification. Compliance measures shown to be significant predictors of child reunification, after controlling for parent demographics, were included in the comprehensive hierarchical multivariate logistic regression model used to specify the relative predictive strength of compliance measures on child reunifications.

Results

Demographics

Most of the parents were female (82.0%), with an average age of 31.4 years. The majority were non-Hispanic White (53.4%), followed by non-Hispanic Black (23.3%) and Hispanic, Any Race (13.1%). Education and employment information was missing for the majority of participants, but when provided, parents were most likely to have completed only some high school (42.4%, $n = 25$), and unemployed (52.8%, $n = 19$). The most common primary substance of use was methamphetamine (39.8%). The least common primary substances of use were hallucinogens/psychedelics, other amphetamines/stimulants, benzodiazepines, other tranquilizers or sedatives, and inhalants. No parents reported these as a primary substance of use.

Table 1 provides a full summary of the demographic characteristics of parents included in the current study.

Table 1. Participant Demographic Profile

	<i>n (%)</i>
Sex	
Male	37 (18.0)
Female	169 (82.0)
Age	
18 to 24 Years Old	37 (18.0)
25 to 29 Years Old	54 (26.2)
30 to 39 Years Old	86 (41.7)
40 to 49 Years Old	26 (12.6)
50 Years Old or Older	3 (1.5)
Race/Ethnicity	
African American, Non-Hispanic	48 (23.3)
American Indian, Non-Hispanic	4 (1.9)
Asian American/Pacific Islander, Non-Hispanic	4 (1.9)
Caucasian, Non-Hispanic	110 (53.4)
Hispanic, Any Race	27 (13.1)
Unknown/Not Reported	13 (6.3)
Highest Level of Education Completed	
Less than High School	25 (12.1)
High School Graduate	23 (11.2)
Some College	11 (5.3)
College Graduate	0 (0.0)
Unknown/Not Reported	147 (71.4)
Employment Status	
Working Full-Time	0 (0.0)
Working Part-Time	4 (1.9)
Unemployed	19 (9.2)
Not in Labor Force	13 (6.3)
Unknown/Not Reported	170 (82.5)
Primary Substance Use	
Alcohol	30 (14.6)
Cocaine/Crack	5 (2.4)
Marijuana/Hashish	45 (21.8)
Heroin/Other Opiates	19 (9.2)
Methamphetamine	82 (39.8)
Unknown/Not Reported	25 (12.1)
Total N	206 (100%)

Compliance and Reunification Summary

Just over half of all parents in the current study (55.3%) were reunified with their child (see Table 2). On average, parents experienced success in program compliance, with parents who reunified reaching at least 70% of their targeted goal in each compliance measure. Compliance success was highest in RMS attendance, with an average compliance rate of 88%. Interestingly, support group attendance was the only compliance measure in which parents exceeded their targeted goal, with some parents more than doubling their required support group sessions.

Table 2. Descriptive Statistics

Variable	N	Percentage	
Reunified with Child			
Yes	114		55.3
No	92		44.7
Variable	N	Range	Mean ± SD
Number of Negative Drug Tests	206	0-100	76.84 ± 27.49
Number of Treatment Groups Attended	206	0-100	71.66 ± 27.94
Number of RMS Sessions Attended	206	0-100	88.20 ± 20.07
Number of Support Group Sessions Attended	206	0-285	83.81 ± 51.90

Relationship between Individual Compliance Measures and Reunification

The relationship between individual compliance measures and reunification was examined using a hierarchical, two-step logistic regression model. The first step (Model 1) included only demographic variables, and the second step (Model 2) included demographics and the compliance measure of interest. Using this two-step hierarchical allows for any impact of demographic variables on reunification to be statistically controlled for prior to investigating each compliance measure. Tables 3 through 6 summarize the results for each compliance

measure; both steps of the logistic regression (Model 1 and Model 2) are provided in each table, but as described above, compliance measures are only examined in the second step (Model 2).

After controlling for demographics, each of the individual compliance measures significantly predicted child reunifications. The percent of negative drug tests had a significant impact of the likelihood of a parent being reunified with their child, $\beta = 0.041$, Wald $z = 28.898$, $p < 0.001$, OR = 1.042, 95% CI [1.026, 1.057]. With each percent increase in negative drug tests, the likelihood of a parent being reunified with their child improved by 4.2%. Similarly, the percent of treatment sessions attended had a significant impact of the likelihood of a parent being reunified with their child, $\beta = 0.036$, Wald $z = 25.238$, $p < 0.001$, OR = 1.037, 95% CI [1.022, 1.051]. With each percent increase in treatment sessions attended, the likelihood of a parent being reunified with their child improved by 3.7%. The percent of RMS meetings attended also had a significant impact of the likelihood of a parent being reunified with their child, $\beta = 0.049$, Wald $z = 17.432$, $p < 0.001$, OR = 1.050, 95% CI [1.026, 1.075]. With each percent increase in RMS meetings attended the likelihood of a parent being reunified with their child improved by 5.0%. Lastly, the percent of support group meetings attended had a significant impact on the likelihood of a parent being reunified with their child, $\beta = 0.022$, Wald $z = 30.517$, $p < 0.001$, OR = 1.022, 95% CI [1.014, 1.030]. With each percent increase in support group meetings attended the likelihood of a parent being reunified with their child improved by 2.2%.

Association between Compliance Measures and Reunification

Next, all compliance measures were added to a single, comprehensive model of reunification to explore which compliance measures were most strongly associated with child reunification. Similar to the individual compliance measure analyses, the comprehensive model of reunification utilized a two-step hierarchical logistic regression. The first step (Model 1) included only demographic variables, and the

Table 3. Drug Test Logistic Regression Model Summaries

Variable	Model 1 Demographics Only			Model 2 Demographics and Compliance		
	β	SE (β)	OR	β	SE (β)	OR
Sex	-0.567	0.402	0.567	-0.491	0.447	0.612
Age	0.024	0.021	1.024	0.018	0.024	1.018
Race/Ethnicity						
African American vs. Unknown	-0.019	0.669	0.982	-0.171	0.712	0.843
American Indian vs. Unknown	-1.733	1.316	0.177	-2.330	1.345	0.097
Asian/Pacific Islander vs. Unknown	1.172	1.370	3.229	1.674	1.820	5.336
Caucasian vs. Unknown	-0.105	0.632	0.900	-0.205	0.677	0.815
Hispanic (any race) vs. Unknown	-0.544	0.716	0.581	-0.806	0.767	0.447
Substance						
Alcohol vs. Unknown	0.407	0.560	1.503	-0.511	0.660	0.600
Cocaine vs. Unknown	0.431	1.050	1.539	-0.773	1.146	0.461
Marijuana vs. Unknown	0.420	0.523	1.522	-0.275	0.624	0.760
Heroin vs. Unknown	-0.216	0.644	0.806	-0.188	0.768	0.828
Meth vs. Unknown	0.657	0.483	1.929	-0.018	0.582	0.982
Number of Negative Drug Tests				0.041	0.008	1.042***
Constant	-0.688			-2.971		
Model Summary	$\chi^2(12, N = 206) = 9.956, p = 0.$					
	$\chi^2(1, N = 206) = 39.176, p < 0.001$					
Comprehensive Model Summary: $\chi^2(13, N = 206) = 49.132, p < 0.001$						

Note: * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

second step (Model 2) included demographics and all compliance measures. Using this two-step hierarchical allows for any impact of demographic variables on reunification to be statistically controlled for prior to investigating each compliance measure. Table 7 summarizes both steps of the logistic regression (Model 1 and Model 2), but

as described above, compliance measures are only examined in the second step (Model 2).

The entire model, including demographics and all compliance measures, was statistically significant, $\chi^2(16, N = 206) = 59.689, p < 0.001$. Further investigation showed that the first block of the model containing only demographics was not statically significant, $\chi^2(12, N = 206) = 9.956$,

Table 4. Treatment Attendance Logistic Regression Model Summaries

Variable	Model 1 Demographics Only			Model 2 Demographics and Compliance		
	β	SE (β)	OR	β	SE (β)	OR
Sex	-0.567	0.402	0.567	-0.695	0.438	0.499
Age	0.024	0.021	1.024	0.015	0.023	1.015
Race/Ethnicity						
African American vs. Unknown	-0.019	0.669	0.982	-0.002	0.709	0.998
American Indian vs. Unknown	-1.733	1.316	0.177	-2.102	1.373	0.112
Asian/Pacific Islander vs. Unknown	1.172	1.370	3.229	1.744	1.774	5.719
Caucasian vs. Unknown	-0.105	0.632	0.900	-0.159	0.674	0.853
Hispanic (any race) vs. Unknown	-0.544	0.716	0.581	-0.716	0.763	0.489
Substance						
Alcohol vs. Unknown	0.407	0.560	1.503	-0.076	0.629	0.927
Cocaine vs. Unknown	0.431	1.050	1.539	-0.031	1.107	0.969
Marijuana vs. Unknown	0.420	0.523	1.522	-0.039	0.587	0.962
Heroin vs. Unknown	-0.216	0.644	0.806	-0.085	0.739	0.919
Meth vs. Unknown	0.657	0.483	1.929	0.362	0.544	1.436
Number of Treatment Groups Attended				0.036	0.007	1.037***
Constant	-0.688			-2.649		
Model Summary	$\chi^2(12, N = 206) = 9.956, p = 0. \chi^2(1, N = 206) = 30.306, p < 0.001$					
620						
Comprehensive Model Summary: $\chi^2(13, N = 206) = 44.262, p < 0.001$						

Note: * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

Table 5. RMS Attendance Logistic Regression Model Summaries

Variable	Model 1 Demographics Only			Model 2 Demographics and Compliance		
	β	SE (β)	OR	β	SE (β)	OR
Sex	-0.567	0.402	0.567	-0.278	0.438	0.758
Age	0.024	0.021	1.024	0.015	0.023	1.015
Race/Ethnicity						
African American vs. Unknown	-0.019	0.669	0.982	-0.146	0.692	0.864
American Indian vs. Unknown	-1.733	1.316	0.177	-2.085	1.328	0.124
Asian/Pacific Islander vs. Unknown	1.172	1.370	3.229	2.339	2.222	10.368
Caucasian vs. Unknown	-0.105	0.632	0.900	-0.139	0.656	0.870
Hispanic (any race) vs. Unknown	-0.544	0.716	0.581	-0.666	0.741	0.514
Substance						
Alcohol vs. Unknown	0.407	0.560	1.503	-0.144	0.631	0.866
Cocaine vs. Unknown	0.431	1.050	1.539	-0.198	1.098	0.820
Marijuana vs. Unknown	0.420	0.523	1.522	-0.072	0.590	0.931
Heroin vs. Unknown	-0.216	0.644	0.806	-0.301	0.732	0.740
Meth vs. Unknown	0.657	0.483	1.929	0.136	0.548	1.146
Number of RMS Sessions Attended				0.049	0.012	1.050***
Constant	-0.688			-4.379		
Model Summary	$\chi^2(12, N = 206) = 9.956, p = 0.620$					
	$\chi^2(1, N = 206) = 26.463, p < 0.001$					
Comprehensive Model Summary: $\chi^2(13, N = 206) = 36.419, p < 0.001$						

Note: * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

$p = 0.620$ (see Table 7). The second model, included all compliance measures and was statistically significant, $\chi^2(4, N = 206) = 49.733, p < 0.001$. After controlling for parent demographics and other compliance measures, the only compliance measures that were statistically associated with the likelihood of a child being reunified were negative drug tests and support group attendance; $\beta = 0.028, \text{Wald } z = 4.473, p = 0.034,$

OR = 1.028, 95% CI [1.002, 1.055] and $\beta = 0.011$, Wald $z = 4.300$, $p = 0.038$, OR = 1.011, 95% CI [1.001, 1.022], respectively. After controlling for parent demographics and the other compliance measures, with each percent increase in negative drug tests, the likelihood of a parent being reunified with their child improved by 2.8%. Similarly, after controlling for parent demographics and the other compliance measures,

Table 6. Support Group Attendance Logistic Regression Model Summaries

Variable	Model 1 Demographics Only			Model 2 Demographics and Compliance		
	β	SE (β)	OR	β	SE (β)	OR
Sex	-0.567	0.402	0.567	-0.408	0.447	0.665
Age	0.024	0.021	1.024	0.012	0.024	1.012
Race/Ethnicity						
African American vs. Unknown	-0.019	0.669	0.982	0.143	0.711	1.154
American Indian vs. Unknown	-1.733	1.316	0.177	-2.354	1.384	0.095
Asian/Pacific Islander vs. Unknown	1.172	1.370	3.229	1.152	1.624	3.163
Caucasian vs. Unknown	-0.105	0.632	0.900	-0.249	0.673	0.780
Hispanic (any race) vs. Unknown	-0.544	0.716	0.581	-0.606	0.764	0.545
Substance						
Alcohol vs. Unknown	0.407	0.560	1.503	0.066	0.640	1.068
Cocaine vs. Unknown	0.431	1.050	1.539	-0.160	1.093	0.852
Marijuana vs. Unknown	0.420	0.523	1.522	0.169	0.596	1.184
Heroin vs. Unknown	-0.216	0.644	0.806	0.136	0.762	1.146
Meth vs. Unknown	0.657	0.483	1.929	0.325	0.559	1.384
Number of Support Group Sessions Attended				0.022	0.004	1.022***
Constant	-0.688			-1.853		
Model Summary	$\chi^2(12, N = 206) = 9.956, p = 0.001$					
	$\chi^2(1, N = 206) = 40.725, p < 0.001$					
Comprehensive Model Summary: $\chi^2(13, N = 206) = 50.681, p < 0.001$						

Note: * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

Table 7. Comprehensive Compliance Measures Logistic Regression Model Summaries

Variable	Model 1 Demographics Only			Model 2 Demographics and Compliance		
	β	SE(β)	OR	β	SE(β)	OR
Sex	-0.567	0.402	0.567	-0.630	0.472	0.532
Age	0.024	0.021	1.024	0.014	0.025	1.014
Race/Ethnicity						
African American vs. Unknown	-0.019	0.669	0.982	0.023	0.728	1.023
American Indian vs. Unknown	-1.733	1.316	0.177	-2.474	1.397	0.084
Asian/Pacific Islander vs. Unknown	1.172	1.370	3.229	1.277	1.771	3.585
Caucasian vs. Unknown	-0.105	0.632	0.900	-0.294	0.690	0.745
Hispanic (any race) vs. Unknown	-0.544	0.716	0.581	-0.811	0.785	0.444
Substance						
Alcohol vs. Unknown	0.407	0.560	1.503	-0.326	0.691	0.722
Cocaine vs. Unknown	0.431	1.050	1.539	-0.595	1.153	0.552
Marijuana vs. Unknown	0.420	0.523	1.522	-0.145	0.646	0.865
Heroin vs. Unknown	-0.216	0.644	0.806	0.150	0.812	1.162
Meth vs. Unknown	0.657	0.483	1.929	0.153	0.606	1.166
Number of Negative Drug Tests				0.028	0.013	1.028*
Number of Treatment Groups Attended				0.015	0.010	1.016
Number of RMS Sessions Attended				0.022	0.019	0.979
Number of Support Group Sessions Attended				0.011	0.005	1.011*
Constant	-0.688			-2.119		
Model Summary	$\chi^2(12, N = 206) = 9.956, p = 0.$ $\chi^2(1, N = 206) = 49.733, p < 0.001$					
Comprehensive Model Summary:	$\chi^2(13, N = 206) = 59.689, p < 0.001$					

Note: * $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

with each percent increase in support group attendance, the likelihood of a parent being reunified with their child improved by 1.1%.

Figure 2 and Figure 3 highlight the observed relationship between negative drug tests and support group attendance on reunification rates. For both negative drug tests and support group attendance, there were small clusters of parents who were reunified with lower levels of compliance in either of these two domains, but for the majority of parents, reunification rates were highest for parents that had 90% to 100% compliance.

Figure 2

Reunification Rate by Percent of Negative Drug Tests

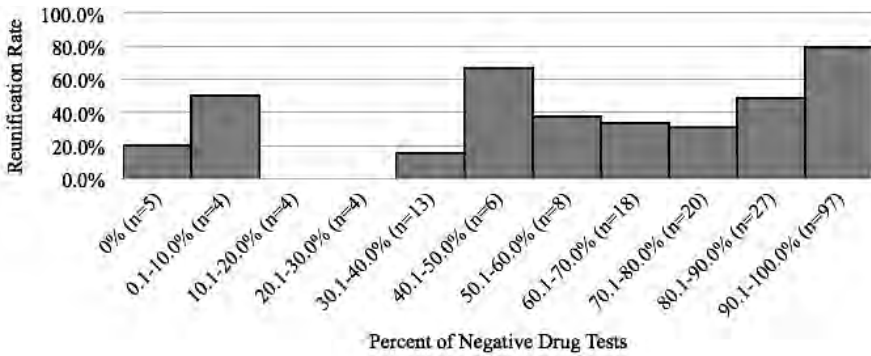
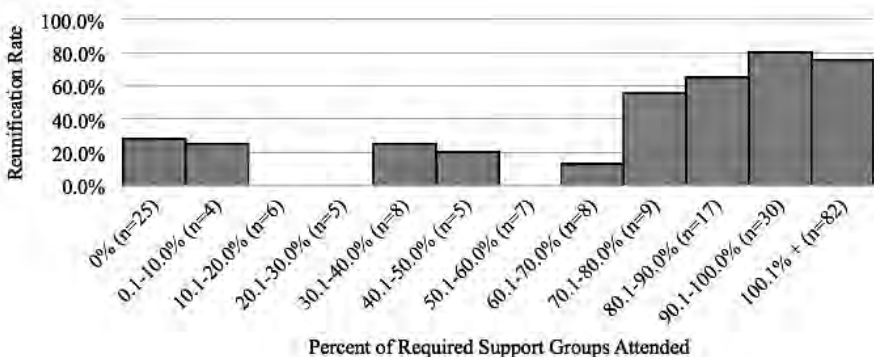


Figure 3

Reunification Rate by Percent of Support Group Attended



Discussion

Considered independently, fulfilling each of the individual treatment requirements was significantly related to reunification. This is not a surprising finding considering that compliance with FDC is considered to be part of the child welfare case as it proceeds, in parallel, through the family court docket. However, when all four compliance measures are considered together and controlling for participant characteristics, the best predictors of reunification were participation in support group meetings and negative tests for substance use. This does not mean that the other compliance components are not important. In fact, it is the combination of all compliance measures that provides the most robust explanation for reunification, suggesting that Sacramento's comprehensive, multi-component approach may be more supportive of reunification than similar programs that focus on fewer measures (such as drug testing alone).

The value of support groups is an especially compelling finding considering that most of these meetings are free or very low-cost (e.g., 12-step programs). Furthermore, though required by the FDC, these activities are not a part of the FDC service array, per se, except that the RMS or other support service providers coordinated through the FDC often identify and link participants to support groups. That said, it is also likely that the logic may be reversed insofar as participation in these meetings and negative drug tests are lagging indicators of participants' recovery status. In other words, it is likely that substance abuse treatment and other support services are yielding improvements that enable clients to better comply with other court requirements—which, in turn, predict reunification. This hypothesis does not necessarily diminish the predictive power of compliance measures, but does beg the question of whether there are more precise, earlier predictors of parental capacity that could enable even earlier reunification.

Limitations

This is an exploratory, descriptive study of four of the five compliance measures used by Sacramento's FDC. Furthermore, other unrelated variables

that are likely to impact reunification, including type of maltreatment and family composition, are not included in this study.

The sample used in the current study was a subset of parents served by Sacramento's FDC. Inclusion criteria resulted in parents that were different from the larger population of parents served in terms of gender and ethnicity. Neither race nor ethnicity were significant predictors of reunification across any model investigated in the current study, so it is not expected that the differences in the subset of parents used had an impact of the results of the study. However, the impact of the sample bias in the current study may have had unanticipated effects on the results.

Conclusions and Future Research

Sacramento County has been implementing one of the largest Family Drug Court Programs in the country for nearly 15 years. During this time, Sacramento's FDC outcomes have shown improvements across measures of substance use as well as child safety, permanency, and family well-being (Boles, Young, Moore, & DiPirro-Beard, 2007). This study is among the first that links those improvements with compliance in substance use treatment.

The results presented here suggest that reunification is significantly predicted by compliance with court requirements. Data from a separate study (Boles, Young, Moore, & DiPirro-Beard, 2007) show that children, once reunified, are safe from repeat maltreatment relative to children who are not served in the FDC (fewer than 6% of children reunified had subsequent substantiated allegation within six months). These findings indicate that initiatives designed to address the needs of families affected by child maltreatment and substance use should take into account and support engagement in informal, community-based activities as well as formal, clinically focused interventions.

While successful reunification was related to high rates of compliance across measures, participants did not have to be completely compliant on any one measure to be reunified. Future studies should apply a more rigorous research design to more accurately specify what patterns of compliance are most strongly related to family well-being. More

research should also explore the relationships between family characteristics, support needs, and outcomes so communities can more efficiently deploy resources. Finally, additional analyses should examine the relationships between treatment compliance and child welfare outcomes outside of the Family Drug Court context, since the vast majority of families struggling with substance use disorders are not being served by Family Drug Courts.

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Changes in Adult, Child, and Family Functioning among Participants in a Family Treatment Drug Court

Merith Cosden
*University of California
Santa Barbara*

Lauren M. Koch
*University of California
Santa Barbara*

Behavioral changes for 76 adults and 115 children from 62 families participating in a Family Treatment Drug Court (FTDC), in either residential or outpatient settings, were studied. Improvements in psychosocial functioning were calculated using a reliable change index (RCI) for family, adult, and child measures. Among outcomes, significant improvements in family functioning were noted and associated with improvements in child development and the likelihood of reunification. Support for FTDCs and implications for future practice and research are discussed.

Parental substance use disorders are a significant factor in many child welfare cases. While prevalence rates vary over studies, it is estimated that over half of children in foster care have parents who abuse alcohol or drugs (Young, Boles, & Otero, 2007). Further, substance abuse typically co-occurs in the context of other concerns, including problems with mental health, housing, and domestic violence (Marsh, Ryan, Choi, & Testa, 2006). Thus, families in which substance abuse occurs have many challenges to overcome before reunification (Maluccio & Ainsworth, 2003).

In the face of these concerns, studies find that providing parents with treatment for substance use disorders can significantly change case dispositions. Parents who complete at least one treatment episode for substance abuse are more likely to be reunified with their children than those who do not engage in such treatment (Green, Rockhill, & Furrer, 2007). While there is a need to provide substance abuse and related treatment services to families within the child welfare system, obstacles to the integration of these services occur for many reasons, including differences in agencies' treatment goals, assessment tools, timeframes for treatment, and definitions and determinations of success and failure (Marsh, Smith, & Bruni, 2011).

One emergent model for integrating substance abuse treatment within the child welfare system is the Family Treatment Drug Court (FTDC).¹ The FTDC is a specialized dependency court designed to increase early reunification by providing and monitoring substance abuse treatment and other interventions while children are in the child welfare system. As described by others (Boles, Young, Moore, & DiPirro-Beard, 2007; Edwards & Ray, 2005; Green, Furrer, Worcel, Burrus, & Finigan, 2009), FTDCs share common ground with drug treatment courts (DTCs) but also differ in some important ways. FTDCs follow the 10 key components that define DTCs, including the integration of drug treatment services within the justice system, a non-adversarial approach to working with clients within that system, frequent drug and alcohol testing, and judicial interactions with participants (Huddleston & Marlowe, 2011). However, there are several areas in which the two

¹ The model labeled a family treatment drug court in this paper has also been referred to as a dependency drug court, family drug treatment court, and family treatment court in the literature.

models differ. FTDCs involve civil proceedings to determine whether or not the child can safely remain at home, whereas drug courts address criminal matters. Further, the primary goal of drug courts is to reduce substance use associated with engagement in criminal activities, while the purpose of FTDCs is to facilitate early child reunification. These programs also have different timelines, with drug courts typically setting longer time in treatment (often 12–18 months) to assure better outcomes in terms of sobriety and FTDCs driven by child welfare mandates to provide reunification within a shorter period of time.

Early studies on FTDCs have had promising findings with regard to parent-child reunification (Chuang, Moore, Barrett, & Young, 2012; Gifford, Eldred, Vernerey, & Sloan, 2014; Worcel, Furrer, Green, Burrus, & Finigan, 2008). These studies report that parents in FTDC programs are more likely to be reunified and to maintain custody of their children than are parents who go through other child welfare programs. Further, studies find that parents in FTDCs enter substance abuse treatment more quickly and are more likely to complete treatment than are parents receiving more standard interventions (Bruns, Pullmann, Weathers, Wirschem, & Murphy, 2012; Green, Furrer, Worcel, Burrus, & Finigan, 2007).

While these outcomes are promising, there is a need to understand more about how FTDCs work. In this study, we look at the impact of a FTDC on adult substance use disorders, infant and child development, child and adolescent behavior problems, family functioning, and reunification.

Purpose

The purpose of this study was to examine changes in adult, child, and family functioning as a function of participation in a FTDC. While prior studies have addressed the impact of FTDCs on reunification and permanency, the impact on parent, child, and family functioning has not been reported. This study examined the impact of participation in a FTDC on psychosocial facets of adult, youth, and family functioning as well as on parent-child reunification.

It was hypothesized that participants in the FTDC would demonstrate significant changes in adult, child, and family outcomes. For adults,

it was hypothesized that there would be a reduction in substance use disorder problems and related concerns. Child measures varied by age; for children who were the youngest (ages 0–5), changes in cognitive and social development were assessed, while for children who were older (ages 6–18), changes in internalizing and externalizing behavior problems were examined. Changes in family functioning examined included parental capabilities, family interactions, child well-being, and readiness for reunification. It was hypothesized that improvements in family functioning would be associated with reductions in adult substance use, enhancements in infant and child development, and enhancements in child and adolescent behavioral functioning. A significant relationship between adult, child, and family functioning and parent–child reunification was also anticipated.

Methods

Participants

Sixty-two families entered the FTDC between December 6, 2010, and October 21, 2013. Child Welfare Services (CWS) referred families to the FTDC. Criteria for participation included having an open case with CWS, parental acknowledgement of a drug or alcohol problem, and willingness to participate in the FTDC program, while severe mental health diagnoses, sexual abuse or serious physical abuse allegations, or parental incarceration disqualified families from enrolling. Data were obtained on all participants (76 adults and 115 children) during this time. Further breakdown of participants by age, gender, and ethnicity is presented in Table 1.

Program

This FTDC was funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). It provided a six-month intensive treatment program for adults and their children ages 0 to 18, which was designed to coincide with the first court status hearing (six months after entry) in which there could be a recommendation for or against reunification. An additional six months in treatment was provided if families were making significant progress toward meeting their goals.

Participants received treatment either within a residential facility ($N = 33$) supported by the grant, or as an outpatient ($N = 43$) if they had a stable living situation in which it appeared they could obtain and maintain sobriety.

Interventions for the adults included the MATRIX (Rawson, Obert, McCann, & Ling, 2005), an evidence-based practice to address substance abuse and relapse prevention; Seeking Safety (Najavits, 2002), to build coping skills for adults who had experienced trauma; and Nurturing Parenting (Bavolek, 2000), to improve parenting knowledge and skills. Each intervention was provided once a week to families in group format; the Matrix was provided to men and women together, as was Nurturing Parenting, while Seeking Safety was provided in same-sex groups. In addition, parents received case management, drug testing, supervised visits with their children, and regular court hearings based on their needs. Services provided to children varied by age. All youth were screened for developmental delays and social/emotional problems. Families with infants and toddlers received in-home infant-parenting interventions, while older children received individual therapy as needed and requested.

Table 1. Parent and Child Demographics

Variable	N (%)
Adult Gender	
Female	56 (74%)
Male	20 (26%)
Adult Age	
18 to 24 Years Old	20 (26%)
25 to 35 Years Old	41 (54%)
36 to 44 Years Old	12 (16%)
45 to 54 Years Old	3 (4%)
Adult Ethnicity	
European	37 (49%)
Hispanic	34 (45%)
Other	5 (6%)
Child Gender	
Female	53 (46%)
Male	62 (54%)
Child Age	
0–5	77 (67%)
6–11	24 (21%)
12–17	14 (12%)
Child Ethnicity	
European	43 (37%)
Hispanic	43 (37%)
Multiracial	22 (19%)
Other	7 (7%)

Measures

Adult Assessment

The Addiction Severity Index (ASI; McLellan et al., 1992) was used to assess adult drug and alcohol use. The ASI is a structured interview with questions on psychosocial functioning over one's lifetime and in the past 30 days in seven domains: drug use, alcohol use, legal problems, medical problems, family/social functioning, employment, and psychiatric problems. Composite scores are derived from critical items in each domain and range from 0 to 1, with higher decimals reflecting greater problems. Severity ratings are provided by the interviewer in each domain and range from 0 to 9, with higher scores reflecting the interviewer's perception that the client had a greater need for further treatment. Overall, the instrument has been shown to have adequate reliability, with Cronbach alpha's for composite scores ranging from 0.65 to 0.89, and good discriminant validity (Leonhard, Mulvey, Gastfriend, & Shwartz, 2000). Scores for parent participants on all domains were analyzed, while the focus of final analyses was on changes in alcohol and drug problems.

Child Assessments

Measures for youth varied by age: the Ages and Stages Questionnaires-3rd Edition (ASQ-3; Squires & Bricker, 2009) was used to assess developmental delays in children from one month to five and a half years of age, while the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) was used to assess problem behaviors for youth ages 6-18. The ASQ-3 screens for developmental delays in communication, gross motor, fine motor, problem solving, and personal-social domains. Each questionnaire includes 30 questions. Scores range from 0 to 60, with lower scores indicating developmental delays. The ASQ-3 has been shown to have good test-retest and inter-rater reliability, as well as fair to good concurrent validity when compared to standardized tests and good internal consistency with alphas ranging from .51 to .87 (Squires, Twombly, Bricker, & Potter, 2009). The CBCL has two primary scales. The internalizing problems scale includes subscales that assess whether the child is

anxious/depressed, withdrawn/depressed, or has somatic complaints. The externalizing problems scale includes subscales on rule-breaking behavior and aggressive behavior. T-scores are provided for both scales. The CBCL has been demonstrated to have good internal consistency (internalizing problems $a = .90$ and externalizing problems $a = .94$) and to be a valid measure of behavioral functioning (Achenbach & Rescorla, 2001).

Family Assessment

The North Carolina Family Assessment Scale for General Services and Reunification (NCFAS; Kirk & Reed-Ashcraft, 1998) is a measure of family functioning in 10 domains: environment (safety in the family's neighborhood), parental capabilities (ability to supervise children), family interactions (mutual familial support), family safety (presence of physical abuse of children), child well-being (child's behavior and discipline problems), caregiver/child ambivalence (caregiver responsiveness to child), readiness for reunification (resolution of child welfare risk factors), social/community life (caregiver relationships with other adults in the child's life), self-sufficiency (caregiver employment), and family health (caregiver's physical health). The NCFAS has good internal consistency, with alphas across domains ranging from 0.71 to 0.94 (Kirk, Griffith, & Martens, 2007), and good concurrent and construct validity (Reed-Ashcraft, Kirk, & Fraser, 2001). One assessment was obtained for each family in the program at each time point.

Procedures

All measures were administered at intake and six months after entry to the program. The ASI was administered by a substance abuse treatment provider who attended yearly trainings with the program evaluation staff for fidelity. The CBCL and ASQ-3 were completed by one of the child's parents in conjunction with the child's treatment provider. The NCFAS was conducted by a staff member who had attended a two-day formal training on the instrument. Responses to questions about the family were based on discussion with and observation of the participating family members.

Analysis Plan

Analyses included paired-sample *t*-tests, and chi-squares analyses based on reliable change indices classifications (RCI; Jacobson, Roberts, Berns, & McGlinchey, 1999). The RCI was used to determine if each participant experienced significant improvements in functioning over the course of treatment. Participants with a RCI higher than 1.96 ($p < .05$) were classified as having made a significant change, while those with a score that did not reach that threshold were classified as not making a significant change. Thus, two different types of change were examined: (1) group changes analyzed through paired *t*-tests; and (2) the number of individuals who made significant improvements as determined by the RCI. The RCI was used to create a dichotomous change variable, which was entered into chi-square analyses to examine the association between improvements in family, adult, and child functioning, and reunification. In addition, differences in outcomes as a function of receiving outpatient or residential treatment, as was the impact of time in treatment, were examined.

Results

Reunification

Of the 62 families in the study, 64% had successful reunifications at the end of the six-month period. There was a higher level of reunification for those in outpatient treatment (77%) than for those in residential treatment (50%), $\chi^2 (N = 134) = 10.66, p < .01$. Time in treatment was also associated with reunification; families with successful reunification averaged more days in treatment ($M = 271.49$), than did those who did not reunify ($M = 219.42$), $F(1, 128) = 6.4, p < .01$. Although participants in residential treatment averaged more time in treatment ($M = 271.94$) than did those in outpatient treatment ($M = 243.66$) this difference was not statistically significant, $F(1, 69) = 1.05, NS$.

RCI Analysis

Changes in adult substance use disorders and related problems, infant and child development, child and adolescent behavioral problems, and family

Table 2. Changes in Adult Measures: Composite Scores on the Addiction Severity Index (ASI)

ASI Domain	Significant RCI	Intake		Discharge		t
	N (%)	Mean	SD	Mean	SD	
Medical	7 (12%)	.13	.24	.09	.23	1.37
Employment	6 (11%)	.70	.31	.65	.32	1.73
Alcohol	8 (15%)	.13	.18	.08	.11	2.12
Drugs	20 (36%)	.15	.09	.07	.07	6.42***
Legal	18 (32%)	.20	.21	.06	.12	4.55***
Family	6 (11%)	.26	.21	.14	.16	4.75***
Psychiatric	10 (18%)	.31	.23	.18	.19	3.85***

* $p < .01$ *** $p < .001$

Note. Significant RCI refers to the number and percent of clients who made significant positive changes on that measure.

functioning, are described in Tables 2 through 4, respectively. In each table, the first column reports the number of participants who were identified as making a significant change through the RCI analysis, while the next columns reflect baseline to follow-up changes for the entire sample as determined by paired t-tests. Given the limited research on FTDCs, analyses were conducted on multiple subscales for each instrument in order to describe changes with as much specificity as possible. To control for Type II error rates, a significance of $p < .01$ was required before the change was considered statistically significant. The RCI was used to determine the number of individuals and families who made significant improvements.

Changes on the ASI are reflected in Table 2. Statistically significant changes were found for alcohol, drug, legal, family, and psychiatric problems. Areas in which the largest number of participants made significant improvements, as determined by the RCI, were drug and legal problems, with approximately one-third of participants showing significant progress in each of these areas.

Changes in child development and youth behaviors are reflected in Table 3. For children ages 0–5, statistically significant changes were

Table 3. Changes in Child Measures: The Ages and Stages Questionnaires-3 (ASQ-3) and the Child Behavior Checklist (CBCL)

Assessment	Significant RCI	Intake		Discharge		t
	N (%)	Mean	SD	Mean	SD	
ASQ-3: Communication	8 (19%)	44.78	15.64	50.36	10.61	2.13
ASQ-3: Gross Motor	6 (14%)	52.26	10.13	54.76	9.17	1.23
ASQ-3: Fine Motor	7 (17%)	47.02	12.98	49.63	13.25	.94
ASQ-3: Problem Solving	14 (34%)	41.34	13.60	51.00	11.28	3.47**
ASQ-3: Personal-Social	10 (24%)	47.32	12.70	50.85	9.35	1.53
CBCL: Internalizing	8 (26%)	48.22	11.64	42.84	7.81	2.76
CBCL: Externalizing	9 (29%)	49.68	12.21	45.48	11.68	2.8

** $p < .01$

Note. Significant RCI refers to the number and percent of clients who made significant positive changes on that measure. Higher scores reflect better development on the ASQ while lower scores reflect fewer problems on the CBCL.

noted on the ASQ-3 on problems solving behaviors. Significant individual improvement was found for approximately one-third of children in that domain, while one-fourth demonstrated significant improvements in personal-social skills, and a lower percentage (from 14% to 19%) showed significant improvements in other areas. For older children, statistically significant group differences were not found at the .01 level for either externalizing or internalizing behaviors; 29% of youth were noted as making significant improvements in externalizing behaviors (i.e., a reduction of problems), while 26% were reported to show a reduction in internalizing concerns.

In terms of family functioning, statistically significant changes were reported on seven of the 10 subscales of the NCFAS (see Table 4). Based on RCI scores, over half of all families made significant improvements in parenting capabilities and readiness for reunification, while close to half had significant improvements in family interactions, family safety, and self-sufficiency.

Table 4. Changes in Family Functioning on the North Carolina Family Assessment Scale (NCFAS)

NCFAS Scale	Significant RCI	Intake		Discharge		t
	N (%)	Mean	SD	Mean	SD	
Environment	24 (41%)	3.05	0.90	3.46	0.82	-3.23**
Parental Capability	34 (58%)	2.95	0.68	3.49	0.90	-4.65***
Family Interaction	29 (49%)	2.98	0.47	3.37	0.81	-3.60**
Family Safety	29 (49%)	3.12	0.74	3.66	0.61	-5.24***
Child Well-Being	16 (27%)	3.56	0.57	3.76	0.50	-2.56
Social Life	24 (41%)	3.10	0.55	3.37	0.64	-2.66
Self-Sufficiency	28 (48%)	2.54	0.70	3.03	0.81	-3.82***
Family Health	19 (32%)	3.32	0.73	3.56	0.70	-2.79**
Ambivalence	15 (31%)	3.59	0.54	3.71	0.50	-1.18
Reunification Readiness	28 (57%)	2.84	0.47	3.35	0.88	-3.56**

** $p < .01$ *** $p < .001$

Note. NCFAS scores originally ranged from -3 to 2 and were transformed to 1 to 6 for ease of analysis. Higher scores indicate better family functioning. Significant RCI refers to the number and percent of clients who made significant positive changes on that measure.

RCI: Setting and Intensity

Differences in behavioral outcomes as a function of residential or outpatient treatment, and time in treatment, were also assessed. There were no differences on intake scores for any of the adult, child, or family scales between participants in residential or outpatient treatment. In terms of the likelihood of demonstrating improvement on the RCI, no differences were noted on any of the child measures as a function of whether the family received treatment in residential or outpatient settings, nor was time in treatment a significant factor. However, there were significant differences in the likelihood of seeing significant change on the ASI for medical problems, as 6% in outpatient treatment changed vs. 24% in residential treatment), $\chi^2 (N = 114) = 8.29, p < .001$; psychiatric problems, with 4% outpatient vs. 29% residential participants showing change, $\chi^2 (N = 113) = 11.86,$

Table 4. Chi Square Analyses of Change in Family Functioning on the North Carolina Family Assessment Scale (NCFAS) in Relation to Adult Changes on the Addiction Severity Index (ASI) and Infant/Toddler/Preschool Child Change on the Ages and Stages Questionnaires-3 (ASQ-3)

NCFAS Scale	ASI		ASQ-3				
	Alcohol	Drug	Communication	Fine Motor	Gross Motor	Problem Solving	Personal Social
Environment	3.79	1.23	5.11	.23	6.06	8.74**	4.89
Parental Capability	6.86**	.19	11.01**	2.52	7.69**	16.83***	10.97**
Family Interaction	2.27	4.46	8.67**	1.46	.87	3.09	4.89
Family Safety	.09	.96	2.14	6.42	.45	3.89	2.64
Child Well-Being	2.89	11.01**	.07	5.02	1.04	2.56	.21
Social Life	.01	1.81	3.06	1.62	5.66	1.51	6.66
Self-Sufficiency	.53	2.75	6.35	.55	7.11**	15.34***	9.95**
Family Health	.22	2.56	12.39***	.01	6.60	15.69***	7.09**
Ambivalence	1.64	.17	.24	1.83	6.08	4.37	10.19***
Reunification Readiness	4.34	3.51	7.70**	.26	.48	6.49	3.88

** $p < .01$ *** $p < .001$

Note. Analyses were conducted on the number of clients who did and did not show significant positive improvements over time based on the RCI for that measure.

$p < .001$; and social problems, with 0 in outpatient and 20% in residential showing significant change, $\chi^2 (N = 113) = 15.34, p < .001$.

Further, time in treatment was associated with improvements on two NCFAS scales, Parental Capability, $F(1, 129) = 11.12, p < .01$, and Family Interactions, $F(1, 129) = 15.19, p < .001$. Families that demonstrated reliable change on these measures spent more time in treatment than did those who did not evidence a reliable change on those measures.

Family Functioning

The association of family changes to reductions in substance use, advances in child development, and reductions in problem behavior for older youth

were examined. As presented in Table 5, there were significant associations between changes in family functioning and adult drug and alcohol use, indicating that adults with a significant reduction of use were also part of families that demonstrated significant improvements in functioning. There were a number of significant associations between improvement in family functioning and 0-to-5-year-old child development. Improvements in parenting capabilities were associated with improvements in communication, gross motor skills, problem solving, and personal-social skills. Because there were no significant associations between youth changes on the CBCL and family changes on the NCFAS, these associations were not tabled.

Finally, areas in which improvements in family functioning on the NCFAS were associated with family reunification were identified. Families who were reunified were also likely to demonstrate changes, based on the RCI, in their environment, $\chi^2 (N = 126) = 13.95, p < .001$; self-sufficiency, $\chi^2 (N = 126) = 9.62, p < .01$; family safety, $\chi^2 (N = 126) = 7.40, p < .01$; parental capabilities, $\chi^2 (N = 126) = 17.72, p < .001$; family interactions, $\chi^2 (N = 126) = 8.20, p < .01$; and readiness for reunification, $\chi^2 (N = 126) = 25.69, p < .001$. In each area, significant improvements in family functioning were associated with court decisions for reunification. There were no significant associations between reunification and changes in substance use, child development, or child and adolescent behavioral functioning at the required $p < .01$ level.

Discussion

This study contributes to the literature on the FTDC as a model for helping families in the child welfare system address their problems with substance use disorders. While this study supports others in finding that a majority of participants in the FTDC were able to reunify (Chuang et al., 2012; Gifford et al., 2014; Worcel et al., 2008), it further identifies significant changes in adult, child, and family functioning that can occur during participation in the FTDC and indicates the association of these changes with reunification.

There are also factors associated with reunification that are independent of changes in family functioning. For example, participants in outpatient treatment were more likely to reunify with their children than were those

in residential treatment. Anecdotal evidence suggests that lack of adequate housing was associated with differences in reunification rates across settings, as adults with less stable housing were admitted to residential treatment and may not have had stable housing even at the end of treatment. Even though behavioral changes had occurred, reunification could not occur until adequate housing was available. Time in treatment was also associated with reunification, with families who successfully reunified averaging more days in treatment than families who did not reunify. Time in treatment was also associated with the development of parenting skills, indicating that time in treatment was important for both behavioral change and reunification.

Improvements in family functioning were significantly associated with 0-to-5-year-old child development as well as court decisions on reunification. This provides evidence for the relationship between family functioning and infant and young child development, and the importance of these changes for reunification. That improvements in family functioning would be associated with improvements in infant and young child development is intuitive, but not previously documented in FTDC studies. However, a study by Dakof and colleagues (2010) comparing a FTDC with intensive parenting training to one with intensive case management found that the one with more focus on parenting was associated with higher levels of reunification. This suggests that future studies focus on both substance use disorders and parenting skills as part of their interventions.

There were no significant associations between changes for older youth and family changes or reunification. Only one instrument, the CBCL, was used to assess older children's behavioral problems; however, no significant behavior reductions were found for the group, with less than one-third identified through the RCI as making a significant personal change in either domain. It appears that older children were less affected than younger children by the parent-focused interventions; it is also likely that many of the older youth had experienced family problems for a prolonged period of time and needed more intensive interventions than were available to them through this program. The importance of providing more treatment to older children and adolescents is supported by studies that show that children in the child welfare system are themselves at risk for substance abuse and

delinquent behavior (Traube, James, Zhang, & Landsverk, 2012). Thus, providing services to older children and adolescents is another area that studies on FTDCs should address in the future.

Methodologically, this study demonstrated the utility of different methods of examining behavior change. Others have discussed the value of using the RCI to define clinically meaningful changes (Jacobson et al., 1999). In this study, the RCI provided clarity with regard to the number of participants for whom reliable improvements in behavior occurred; it also allowed us to examine how changes in family functioning were reflected in child and adult behavior changes and subsequent reunification. Of note, even when *t*-tests were significant, the RCI typically found that fewer than half of participants made significant changes. This reflects the large variation among participants, and the need to further study and understand within group differences in order to provide effective interventions to all participants.

The limitations to this study include the absence of a comparison group. Further, the FTDC in this study served families viewed by the courts as having the possibility for reunification within a relatively short window of time (i.e., six months). Thus, generalization of findings is limited to families with similar concerns. Understanding the impact of this FTDC also is limited by an inability to separate program components (e.g., court supervision, drug testing, and clinical interventions). This is important for future study of FTDCs, for while FTDCs follow guidelines adapted from drug courts, there is still considerable variation in their structure and procedures (Green et al., 2009). Methodologically, the large number of statistical tests opens the possibility for Type II errors in the analyses. Despite this concern, other factors, including baseline levels of psychosocial problems and changes in measures not included in the current study, may also affect reunification and need to be included in future studies.

Finally, the team process, an integral component of the FTDC, may have compromised the independence of data collection. That is, while child, adult, and family assessments were conducted in different ways by various staff members, reducing the threat of mono-method bias, one of the clinical facets of the FTDC was the team meeting for staffing

cases prior to court reviews, during which team members discussed their perceptions with each other and with the courts. These discussions, while intended to provide comprehensive information to the team for decision-making, may also create a bias in how staff collect data and make reunification decisions. Given the importance of the team focus for the FTDC, it is unclear how to further address this concern.

Conclusions

Participants in the FTDC who reunified exhibited improvements in family communication and parenting abilities, which were associated with reductions in substance use disorders and positive 0-to-5-year-old child development. While this study provides evidence to support the FTDC model for families with substance use disorders in the child welfare system, there is still much to learn. Future studies are needed to focus on identifying those aspects of treatment that are associated with behavior change and to determine other methods for obtaining positive changes for older children and adolescents within these families.

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Making It Work Without a Family Drug Court: Connecticut's Approach to Parental Substance Abuse in the Child Welfare System

Jane Ungemack

*University of Connecticut School
of Medicine*

Marilou Giovannucci

Connecticut Judicial Branch

Samuel Moy

Advanced Behavioral Health, Inc.

Karen Ohrenberger

*Connecticut Department of Mental
Health and Addiction Services*

Thomas DeMatteo

*Connecticut Department of Children
and Families*

Staceyann Smith

*University of Connecticut School
of Medicine*

Parental substance abuse presents complex challenges for the child welfare system and courts. This article describes the State of Connecticut's experience implementing the Recovery Specialist Voluntary Program (RSVP), a recovery support program designed to confront the problem of parental substance abuse within the child welfare system without a family drug court. The state-level collaboration efforts, system changes, factors affecting development and implementation of RSVP, program participants, and preliminary outcomes are described.

Substance use disorder is a significant health and social problem affecting many families in this country. Children with caretakers who have a substance use disorder are more likely to face economic deprivation, family instability, poor parenting (Magura & Laudet, 1996), and domestic violence (VanDeMark, Russell, O'Keefe, Finkelstein, Noether, & Gampel, 2005). An estimated 50% to 80% of child welfare cases are related to parental substance abuse (Osterling & Austin, 2008; Young, Boles, & Otero, 2007), and parental substance abuse has been identified as a contributing factor for up to two-thirds of children in out-of-home placements (U.S. Department of Health and Human Services, 1999; Semidei, Radel, & Nolan, 2001).

Yet research shows that the majority of parents' substance abuse treatment needs go unrecognized by child welfare workers (Chuang, Wells, Bellettiere, & Cross, 2013). Further, half of parents involved with child welfare referred to treatment actually receive services, and only 13% in some studies complete treatment (Oliveros & Kaufman, 2011). Barriers to participation and retention in substance abuse treatment programs include parental reluctance to engage in treatment; inadequate access to services; lengthy wait times; and conflicting processes and expectations between child welfare agencies, treatment programs, and judicial systems (Young, Gardner, Whitaker, Yeh, & Otero, 2005; Marsh & Smith, 2012).

The child welfare, substance abuse treatment, and court systems have traditionally struggled independently of each other to address these families' complex needs. Typically, there is little communication across systems because of perceived and real barriers to information exchange between agencies. Coordinated, effective family interventions are hampered as parents are served in one system while their children are served through another, and insufficient mechanisms exist to ensure communication, collaboration, and compliance across the systems (McMahon & Luthar, 1998). Common challenges to collaboration between systems include: insufficient knowledge and understanding of addiction; the complexity of the service needs of parents who abuse substances; lack of a coordinated response to address the

parents' needs; different agency missions and cultures; inadequate understanding of the different agency perspectives and practices; limited access to appropriate treatment options; legal barriers to sharing information; different timeframes and criteria for achieving outcomes; lengthy court proceedings; and children at risk of delayed permanency decision-making and future maltreatment (Marsh & Smith, 2012). The key stakeholders within each system, including agency administrators, social workers, treatment providers, and attorneys, have historically made few efforts at collaboration, and often perceive each other as adversaries.

This article describes Connecticut's experience in confronting the problem of parental substance abuse within the child welfare system through the Recovery Specialist Voluntary Program (RSVP), a joint initiative of the Connecticut Department of Children and Families (DCF), the Judicial Branch, the Department of Mental Health and Addiction Services (DMHAS), and Advanced Behavioral Health (ABH), a non-profit behavioral health administrative services organization. The article describes how a strong leadership and interoperability model has effectuated changes in policy and practice based on a common commitment to children and families, shared data, and evidence-based practice to deliver an outcome-oriented program for parents whose children have been removed by the court.

Background

In Connecticut, as nationally, there has been growing recognition that parental substance abuse is a key factor adversely affecting children's immediate and future health and development, especially for children entering the child welfare system. A study of alcohol and other substance use issues in states' Child and Family Service Reviews found that parental substance use was a reason for a child welfare investigation in 48% of Connecticut's child welfare cases (Young, Gardner, Whitaker, Yeh, & Otero, 2005). A more recent analysis of all court-ordered removals of children from their parents (an Order of Temporary Custody [OTC]) between 2006 and 2009 showed that parental substance

abuse was a factor for removal in 32% of Connecticut's OTC cases (Ungemack, Restrepo-Ruiz, Sienna, & Duan, 2013). These data also confirmed that parental substance abuse was associated with children having longer placements in DCF custody. Children with an OTC for whom parental substance abuse was a factor in removal spent an average of 425 days in DCF placement compared to 377 days for OTCs without substance involvement. Children whose parents were identified as abusers of illicit drugs were less likely to be discharged from DCF within 12 months and less likely to be reunified at discharge than children whose parents did not have substance abuse problems.

In 1995, DCF initiated the Substance Abuse Family Evaluation (Project SAFE) program to provide centralized substance abuse screening and referral for caregivers involved with child protective services. In 1998, DHMAS, the state agency for substance abuse services, collaborated with DCF to administer Project SAFE and to expand access to adult treatment services. Funding for Project SAFE is braided; DCF funds screening and evaluations while DMHAS's funds support treatment costs. Project SAFE improved access to substance abuse treatment services, yet only half of those evaluated as needing treatment actually entered treatment, often after a delay of several weeks. Furthermore, the impact of Project SAFE on child outcomes remained unclear.

In 2008, Connecticut began focusing on the need for recovery support services to improve caregiver engagement and retention in treatment and to reduce time to permanency for their children. Historically, Connecticut has not had Family Drug Courts, so the state agencies and the Judicial Branch collaborated to develop RSVP, a recovery-oriented intervention for parents, or in rare instances non-parental legal guardians, who have lost custody of their children associated with their substance abuse. The partnering agencies began building a coordinated network of support services, policies and practices to help parents with substance use disorders in their recovery, promote the well-being of their families, and achieve more timely permanency. In-depth technical assistance from the National Center on Substance Abuse and Child Welfare helped guide planning and development of RSVP.

RSVP

The objectives of RSVP included: (1) implement a recovery-oriented integrated system of care for families in the child welfare system that addresses multi-system policies, procedures, and practices; (2) improve communication, data-sharing, and problem-solving among child welfare, judicial, and substance abuse treatment systems; (3) develop a system of joint, multidisciplinary training to increase cross-agency understanding of addictions and their consequences for families, evidence-based and culturally appropriate practices, and child development and welfare; (4) improve parents' timely access to, engagement with, and retention in treatment; (5) increase parents' access to case management and recovery support services; (6) improve the timeliness of child placement decisions; and (7) increase family reunification rates. The RSVP program was modeled after the Specialized Treatment and Recovery Services (STARS) program implemented by the Sacramento Drug Dependency Court (Boles, Young, Moore, & DiPirro-Beard, 2007), and adapted for implementation in Connecticut's Superior Court for Juvenile Matters. Connecticut had not adopted family dependency drug courts in large part because of burden to judges and costs, and there were neither financial resources nor political will to support dependency drug courts. The state partners determined, however, that a recovery-oriented intervention was possible within the court by utilizing existing Court Services Officers (CSOs), social workers responsible for case management, facilitation, and mediation of child protection cases. In effect, the CSOs assume some of the functions of the judge/magistrate in dependency drug court, while judges review and approve a parent's entry into RSVP and rule on motions to vacate his/her involvement in the program.

RSVP gives caregivers priority access to substance abuse evaluations and treatment services and support from Recovery Specialists for up to nine months after enrollment in the program. Following the principles of recovery coaching (White, Kurtz, & Sanders, 2006), the Recovery Specialists provide intensive community-based management and coaching to the parents to facilitate treatment engagement and recovery. They also focus on building clients' recovery capital, those internal and

external resources such as social supports, linkage with mutual support groups, self-efficacy, and life skills that can help parents sustain their recovery (Laudet & White, 2008). Importantly, Recovery Specialists are not employees of DCF, DMHAS, or the court, but are ABH staff who act as independent advocates and resources for parents. They must have at least an associate's degree in human services or a related field and two or more years working in behavioral health services. They are carefully selected and trained by ABH in engagement skills and motivational interviewing, and receive additional training in addiction and recovery, co-occurring disorders, the impact of addiction on parenting, child welfare and court processes, culturally and gender-appropriate service delivery, and child development.

The RSVP enrollment process begins when children of parents with substance abuse issues are removed by court order. RSVP eligibility criteria include: parental substance abuse is a reason for removal of her/his child(ren); the parent resides within a court area served by RSVP; there is a potential for reunification; and the parent will not be incarcerated for more than 30 days. There are no other exclusionary criteria. At a case management conference held just prior to the preliminary OTC hearing, the CSO and/or attorney for the parent may suggest that the parent participate in the program. If she/he is interested, the parent and her/his attorney meet with a waiting Recovery Specialist to discuss how RSVP can support the parent. When the parent accepts RSVP services and the OTC is sustained, parent participation in RSVP becomes a court order.

Once RSVP services are accepted, the Recovery Specialist arranges a substance abuse evaluation and connects the parent to a treatment program. The Recovery Specialist monitors the parent's treatment attendance and participation in self-help groups; offers coaching to increase the parent's recovery capital; arranges for transportation as needed; works with the parent to address issues, such as housing and access to benefits, that could impede her/his recovery; and conducts random drug screens based on the client's compliance history and phase in the program. The Recovery Specialist attends court proceedings and DCF

meetings, and prepares compliance reports for DCF and the court. RSVP has three phases, each lasting approximately 90 days, with flexibility to account for the client's recovery status. Treatment attendance and participation in self-help meetings is expected in all phases. The frequency of contact and drug testing, however, varies by program phase, the client's treatment setting, and her/his progress in recovery, as outlined below:

Phase I:

- Two or more meetings per week for clients in outpatient treatment or once per week for clients in inpatient/residential treatment.
- Two or more random alcohol/drug tests per week.

Phase II:

- One or more meetings per week for clients in outpatient treatment or biweekly meetings with clients in residential treatment.
- At least one random alcohol/drug test per week.

Phase III:

- A minimum of biweekly meetings for clients in outpatient treatment or monthly meetings for clients in residential treatment.
- Two random alcohol/drug tests per month.

The Recovery Specialist reassesses the client's recovery plan and progress using input from the client, DCF worker, and treatment provider to identify additional goals and readiness for the next phase and then discharge.

RSVP is unique in that it addresses two competing confidentiality issues. It reduces barriers to information-sharing across systems through a signed Parent's Agreement to permit substance abuse treatment information to be made available to DCF and the court. At the same time,

it protects participant confidentiality by prohibiting the Recovery Specialist, except in very limited circumstances (e.g., when child abuse or neglect is suspected), from testifying in a court proceeding concerning the parent about their communications. Instead, the Recovery Specialist only reports objective information on compliance with treatment and support group attendance, meetings with the Recovery Specialist, and random drug test results.

Case status conferences, facilitated by the CSO, are convened at prescribed intervals at the court. Traditionally, these conferences are held so attorneys and the DCF worker can discuss case settlement options and case management tasks. For RSVP cases, participants include the parent and the Recovery Specialist. This provides an opportunity for the court to directly involve the parent in the direction and outcome of her/his court case. At the conference, all parties review the Recovery Specialist's compliance report and the parent's progress and how that impacts the court case. The CSO guides the discussion, encouraging the parent in her/his recovery efforts, reinforcing the importance of recovery on the court case, allowing the parent to share any barriers or challenges, and identifying practical solutions. For instance, if a client had a positive urine result after being with drug-using peers, there would be discussion of the potential legal consequences, how she/he can handle the situation differently in the future, and a reaffirmation of the client's commitment to the recovery process. This conference reinforces the steps to recovery for the client and also creates greater buy-in from the attorneys for the recovery process.

To foster cross-system communication and coordination of services for clients, RSVP incorporates a DCF-developed collaborative service planning model, the Substance Abuse Managed Service System (SAMSS). SAMSS meetings are conducted by DCF staff with DMHAS representatives, treatment providers, Recovery Specialists, and other relevant providers, such as domestic violence counselors, to jointly discuss each client's needs and develop an action plan for treatment and recovery supports. These meetings facilitate access to and coordination of care for clients, as well as promote collaboration between agencies.

Interoperability among Systems

Successful implementation of RSVP has depended upon building committed, collaborative relationships among DCF, DMHAS and the Judicial Branch. The task, however, was not without challenges. The first major charge was to bridge the culture gaps between agencies. The values, mandates and operations of each of the state systems had to be understood and reconciled in the design of RSVP. The major priority of both DCF and the Judicial Branch is the child's well-being. They are committed to ensuring safety and stability for the child with the goal of achieving permanency as quickly as possible. DMHAS, in contrast, is committed to addressing the adult's behavioral health needs with the perspective that substance abuse is a chronic disease and treatment is a process of recovery. The parties had limited knowledge about each agency's area of concern, and in particular, child welfare and court staff had little understanding of addiction and substance abuse treatment.

In addition to differing cultural views, the partners had to determine how to accommodate varying processes and timetables for court schedules and benchmarks, child permanency decisions, access to and course of treatment, and parental recovery. Federal and state standards dictate relatively short timelines of court processes for custody and control of the child. For instance, the dispositional goal for court performance is 6 months, and a permanency planning hearing must occur within 12 months of the date the child is first placed in out-of-home care. Access to substance abuse treatment, however, is often delayed by the need for evaluation for appropriate treatment placement, waiting for limited slots, and sometimes need for detoxification before entering into treatment. In addition, effective substance abuse treatment typically requires a stay of 90 days or more followed by ongoing recovery supports. Since recovery can be a lengthy process, the parent's treatment process typically lags behind the demands for timely child placement decisions. By sharing information and building consensus about processes for a common goal, the partnering agencies were able to address many of their differences and develop a mutual understanding of their various mandates and operations.

As one of the first steps in building systems collaboration, the RSVP partners implemented cross-systems training. Joint multidisciplinary trainings were provided on substance abuse and recovery; evidence-based and culturally appropriate interventions; children's development and well-being; the impact of substance abuse on parenting, trauma, and child welfare; and judicial processes. The training is offered to key stakeholders in all systems, including agency administrators, social workers, CSOs, judges, attorneys, providers, and RSVP staff to promote a shared understanding of addiction and its consequences for families.

A RSVP Core Management Team was established to provide joint oversight for program implementation and to monitor program performance and outcomes. This team, composed of key representatives of each state agency, the Judicial Branch and ABH, has met monthly since its inception. This is a forum for exchange of information and viewpoints as the members work together to address policy and implementation issues. This management team utilizes a data-driven approach to refine and expand the program, using performance and evaluation reports to monitor program progress and inform decision-making. Since 2009, the partnering agencies have co-contracted with the University of Connecticut to conduct a process and outcome evaluation of RSVP. To foster stakeholder buy-in and feedback, once a year the Core Management Team gathers additional representatives from each of the agencies to meet and share information on RSVP's progress, identify problems, and share ideas about strategies to address challenges. In addition, there is an annual celebration to recognize the accomplishments of successful program graduates.

Implementation Challenges

As with any new program involving system change, RSVP experienced a number of challenges within its first years of operation. A pilot study was designed to ensure that RSVP could be implemented under a variety of different circumstances and settings. Three geographically distinct overlapping court and DCF offices with differing cultures, resources, and demographic profiles—Bridgeport, New Britain, and Willimantic—

were selected to uncover potential challenges in RSVP's implementation and outcomes. The availability and mix of treatment programs within each region varied, as well as their infrastructures for recovery management and in-home services, factors that could potentially affect case-load mixes in each area. Given its more rural nature and wider geographic spread, transportation emerged as an important barrier to program participation and treatment for clients in Willimantic. To reduce distance and transportation as a barrier to random drug testing, local provider testing and in-home testing were permitted as alternatives to on-site urine tests. Diversity in client characteristics, such as ethnicity and type of substance problem, allowed examination of client factors that might affect response to RSVP.

Parent attorneys' buy-in was a key factor to successful implementation of RSVP. Historically, defense attorneys in child welfare cases have distrusted DCF initiatives that they perceived would enhance DCF's chances of succeeding in court at the expense of their clients' ability to effectively defend against the department's allegations. One of the first decisions made by the Core Management Team was to emphasize that the Recovery Specialists, as ABH employees, were independent of both agencies and could be trusted to work for the benefit of the client. In addition, defense attorneys were included early in the design phase of RSVP, particularly for those features that directly affected the legal rights of the parents, such as restrictions on the Recovery Specialists' testimony and the provisions of the client agreement and standing court order. These features of RSVP addressed attorneys' concerns about information sharing with DCF and the courts and potential breaches of confidentiality that could affect their clients' cases. The Core Management Team recognized that if attorneys didn't perceive an advantage for their clients or if they felt that the program wouldn't be helpful, they were unlikely to recommend that their clients enroll in RSVP. Some attorneys expressed concerns about the number and frequency of case status conferences and complained about scheduling difficulties. An increase in defense attorney reimbursements in 2012 helped alleviate concerns about financial compensation. Although the agency partners conceded that RSVP would increase time and effort demands on court

staff and attorneys at the front end of these cases, they felt there would be savings in the long term if cases were resolved more quickly and with less conflict—and would achieve better outcomes for families.

Over time, judges, CSOs and attorneys became comfortable with the RSVP protocol and resistance to RSVP diminished. Attorneys began to recognize the program's benefits for appropriate clients, and in some instances, attorneys reached out to Recovery Specialists about clients they felt would be appropriate for RSVP. Many attorneys, judges, and CSOs from the pilot sites have become advocates for the program as it has been disseminated statewide.

Despite leadership support in each office, DCF staff had concerns about how RSVP worked and how it would change their practice. Social workers needed clarification about what could be included in case records and what could be said at court by the RSVP staff. In response, the Core Management Team, in collaboration with caseworkers, created a "Frequently Asked Questions" document to address specific concerns and confusions faced by case workers (see http://www.abhct.com/Customer Content/WWW/CMS/files/RSVP_FAQ_Final_6-14.pdf).

RSVP participants also presented challenges. Although RSVP was designed as a nine-month program differentiated by phases of decreasing oversight and contact, clients often did not move through the program in the planned structured sequence. Some clients were difficult for the Recovery Specialists to engage and slow to participate. Some moved or were incarcerated. Others needed additional time as they waited for their children's placement decisions to be made.

Application of Knowledge

The RSVP partners realized early on that data-sharing was instrumental for communication and planning to support system change and to monitor the impact of the program. Each organization has its own data management system and reporting mechanisms limited to data relevant to each agency's own mandates and mission. While DCF and the Judicial Branch have child-centered information systems, DMHAS's is limited to adult clients in the treatment system. Each of the agencies has

strict legal restrictions on confidentiality of information that had to be overcome to share client-specific data. As a group, the agency partners, with help from the evaluator, identified administrative data that were relevant to the program objectives and that could be used to evaluate the program's impact. It was critically important that administrators from each agency were at the table to identify and access relevant data for RSVP, as well as to analyze the quality of the data, interpret the findings, and identify their implications for policy and programming.

From the beginning, RSVP has had strong institutional supports. RSVP has been financed by reallocating existing braided funding from DMHAS and DCF; by repurposing existing dollars and allocating them to ABH, RSVP has been a revenue-neutral intervention. A significant portion of the repurposed dollars went from hair testing for drugs to staffing RSVP. In 2008, and again in 2012, the state agencies signed a Memorandum of Understanding to facilitate RSVP's implementation. In 2013, DCF, DMHAS, the Judicial Branch and ABH executed a data-sharing agreement to link individual-level data from each agency to track individual involvement in and outcomes across the various systems and to better assess RSVP's impact.

Participants and Outcomes

To date, 625 clients have enrolled in RSVP since May 2009. For a three-year pilot study, administrative and service data on program participants were available from each agency to describe the participants and provide preliminary information on program outcomes (Ungemack et al., 2013). Of the 208 participants enrolled between May 2009 and May 2012, the majority were mothers, 34 or younger, and unmarried. They were racially and ethnically diverse, reflecting the communities from which they were drawn. They were disproportionately Black (21%) and Hispanic (22%) compared to these racial/ethnic groups' representation in the general population. On average, each RSVP parent had 2.1 children under age 18, with 86% having children aged 5 or younger. Parents had multiple complex problems that required intensive intervention and coordination across service systems. According to DCF data, 78% had

abusive or inadequate parenting skills, 78% had limited or severely impaired coping skills, 50% lacked basic resources, 43% had limited or no social supports, and 29% lived in households with frequent or chronic discord. Income levels of clients were low and unemployment high, and many clients experienced housing instability at enrollment. Half of RSVP enrollees had legal charges pending or were on probation or parole at intake.

Ninety-six percent of RSVP enrollees identified by DCF caseworkers as alcohol- or drug-abusing or -dependent were confirmed as needing substance abuse treatment when evaluated. Eighty-seven percent of those referred to RSVP enrolled in the program, and two-thirds were in treatment within 30 days of RSVP enrollment, most within 14 days. Six in ten had a history of prior substance abuse treatment. At intake into RSVP, 74% of clients reported alcohol use, 76% marijuana use, 60% used cocaine, and 42% were heroin users. The primary problem substances for which RSVP clients received treatment were heroin (29%), alcohol (24%), cocaine/crack (15%), marijuana (15%), other opiates (8%), and PCPs (5%).

Seventy-five percent of RSVP clients successfully completed their initial treatment episode, staying an average of 88 days in treatment. This completion rate exceeded the 43% rate among clients statewide admitted to treatment during the same time period, and it was comparable to rates reported for Family Treatment Drug Courts (Oliveros & Kaufman, 2011). Treatment completion by parents with substance use disorders is significantly associated with the increased likelihood of reunification with their children, and 90 days is optimal for both individual recovery and child welfare outcomes (Smith, 2003; Grella, Needell, Shi, & Hser, 2009).

During the first three years, 167 clients were discharged from RSVP, with 54% successfully discharged; 28% discharged due to non-compliance; and 18% discontinued due to incarceration, death, or moving. Only participant age and gender predicted program completion; adults aged 18 to 29 and men were less likely than older adults and women to successfully complete RSVP. The longer parents participated

and complied with program requirements, the more likely they were to reunite with their children; the reunification rate rose from 27% for clients who did not fully comply with RSVP to 76% for those compliant for at least 180 days. Judicial data comparing RSVP cases with all OTCs occurring within the same time period showed that 74% of children whose parents enrolled in RSVP had a permanent placement within 12 months versus 49% of OTC cases statewide.

These findings, based only on participant data and without a comparison group, only suggest the potential benefits of the RSVP program. In the pilot study, only RSVP intake and service data were available for individual-level analysis; DCF, DMHAS, and judicial analyses relied on aggregate data. With a data-sharing agreement in place, current analyses are focused on individually linked data to determine outcomes across systems with a comparison group of OTC cases that did not receive RSVP, as well as a cost analysis.

Conclusion

For Connecticut, RSVP has become an exemplary model of a recovery-oriented system of care for parents whose substance abuse problems have resulted in an out-of-home placement for their child. The RSVP initiative demonstrates how interoperability, collaboration, information-sharing between systems, and use of data to inform program development and performance monitoring is possible outside of a dependency drug court. Through their efforts, the partners representing child welfare, substance abuse treatment, and the judicial branch have tackled system change and implemented a program that serves some of the most challenging cases in the child welfare system. The positive processes and outcomes of RSVP have helped support a paradigm shift in the state's child welfare system's view of substance abuse as a risk factor in child neglect cases. This recovery-oriented framework has pushed the protective service agency and courts to focus on child impact rather than adult behaviors. Key stakeholders within all three systems have become advocates for the program, and RSVP is being disseminated statewide. The next steps will be to refine RSVP further to incorporate family-centered and

trauma-informed services into the program, to finalize an implementation manual, and to conduct a cost analysis of the program.

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Peer Mentoring in Child Welfare: A Motivational Framework

Anna Rockhill

Portland State University

Carrie J. Furrer

Portland State University

Thuan M. Duong

Portland State University

Peer mentoring interventions for parents with substance use disorders who are involved with the child welfare system are relatively new, complex, individualized interventions and thus need to be understood both in regard to program efficacy and the processes of how they work. This qualitative study of the experiences of parents involved in a parent men-

toring program suggested that certain practices helped motivate parents to think and act in ways that supported their goals and child welfare case plans. The three key mentoring practices that emerged were building caring relationships, providing guidance, and putting parents in charge. These practices promoted parents' positive self-beliefs (e.g., worthy of connection, competence), which helped motivate them to participate in services, cope constructively with difficulties, and more effectively manage behaviors and emotions. Drawing on Self-Determination Theory and Basic Psychological Needs Theory (BPNT) in particular, we propose a motivational framework for understanding how peer mentoring facilitates, or undermines, parents' motivation and results in their making progress on various aspects of their child welfare case. Implications for using the motivational model in future program development and evaluation efforts are discussed.

Peer mentoring is increasingly popular in child welfare as a method of promoting family engagement and helping “ease the pathway through the child welfare system” (Cohen & Canan, 2006; Frame, Conley, & Berrick, 2006). Although a number of studies point to positive outcomes (Berrick, Cohen, & Anthony, 2011; Frame, Conley, & Berrick, 2006; Summer, Wood, Russell, & Macgill, 2012), research that explicates the mechanisms by which peer mentoring promotes participation in services and service planning remains in its early stages. Many of the more rigorous studies evaluating peer services focus on supports offered to parents of children facing serious health and other challenges (Ainbinder, Blanchard, Singer, Sullivan, Powers, Marquis, & Santelli, 1998; Nicholas & Keilty, 2007) and to adults with severe psychiatric disorders (Davidson, Chinman, Sells, & Rowe, 2006). However, significant differences between a medical model and peer mentoring in child welfare suggest that attempts to generalize either underlying mechanisms or efficacy should be done with extreme caution (Nilsen, Affronti, & Coombes, 2009).

An underdeveloped theoretical foundation is a challenge for the field. As Nilsen, Affronti, and Coombes (2009) argued, “without a solid conceptual model and empirical framework, [peer mentoring] will be another expensive program that is without value in reducing the recurrence of maltreatment” (p. 532). Research establishing the link between parent engagement and improved child welfare outcomes (Atkinson & Butler, 1996; Dale, 2004; Littell, 2001) highlights the importance of understanding the underlying mechanisms by which parents’ participation in service planning and services can best be promoted. Preliminary results from studies focused on the outcomes of these types of services are promising (Berrick et al., 2011; Frame et al., 2006; Summer et al., 2012) although more rigorous evaluations are needed. Evaluations focused on the process of peer mentoring have identified a host of supports and services, but only a few have addressed the underlying mechanisms by which these activities might impact parents.

Studies have investigated a range of outputs and outcomes associated with peer mentoring. In a study by Marcenko, Brown, DeVoy, and Conway (2010), parents increased their ability to advocate for themselves

and engaged in services more quickly. Berrick and colleagues (2011) suggested that reunification may be more likely for families involved with peer services. The same authors found that parents who worked with mentors experienced a sense of empowerment that contributed to change, but the mechanisms by which mentors' services facilitated empowerment were not explained. Another evaluation of a parent-to-parent program (Summer et al., 2012) found increased compliance with case plans and attendance at court hearings and visitations. Parents' attitudes and understanding also changed in a positive direction; however, the study was unable to link these changes to the increase in compliance and other activities.

A handful of studies refer to psychological processes in their explorations of how mentoring works. For example, a recent article summarized the existing research as offering tentative support for the idea that family support and mentor programs "help change parents' understanding of their current situation and lead to positive outcomes" (Summer et al., 2012, p. 2037). Another study described mentors as providing coping assistance and speculated that parents identify with a "culture of empowerment" that may result in a "redefinition of identity and subsequent effects on perceptions of self-worth and empowerment" (Berrick, Young, Cohen, & Anthony, 2010, p. 189). Yet another referred to parents' use of peer mentors as a positive source of social comparison (Nilsen et al., 2009). Frame and colleagues (2006) offer one of the fullest explorations of the process of mentoring and link peer support and outcomes via a number of psychological processes. For example, they postulate that peer support facilitated changes in parents' attitudes and behavior, which led to increases in self-esteem, thus creating a foundation for change. They also found that peers offered support and advice in the face of negative events, which often led to parents learning from mistakes and taking proactive measures in the future. The authors called for a closer examination of the developmental stages of parents' attempts to change. Taken together, these findings suggest that psychological processes are at work. However, research to date lacks a cohesive framework for understanding how these mechanisms are facilitated and why they motivate parents to take action.

The current study is part of a larger evaluation of the Parent Mentoring Program (PMP), a recovery-focused, parent-directed program that employs peers as mentors for parents involved in the child welfare system. In an effort to understand how this program works, parents' accounts of their mentoring experiences were examined for descriptions of the processes through which mentoring activities are connected to child welfare outcomes. Building on key themes that emerged from this analysis, an initial theoretical framework was developed that highlights some of the central mechanisms involved in promoting (or undermining) progress in a parent's child welfare case.

Specifying the mechanisms by which various inputs and activities affect results offers advantages for program planning and improvement, and may ultimately lead to the development of different and more effective strategies (Birckmayer & Weiss, 2000). A theoretical framework will allow testing of which connections are and are not supported by evidence, and can highlight the elements of the intervention that merit attention for further evaluation (Birckmayer & Weiss, 2000). Knowledge may also generalize beyond the specific intervention under study and contribute to an understanding of which mechanisms work, and under what conditions. In fact, it is hoped that the emergent framework informs efforts to promote parents' behavior change more broadly; as noted by Frame and colleagues (2006), the field currently lacks sufficient understanding of interventions that help parents address the issues that are of concern to child welfare.

Program Description

The Parent Mentoring Program (PMP) is being implemented as part of a Title IV-E Waiver in a Western state. Parents with an open child welfare case who presented with a substance abuse issue during the protective services assessment are the focus population. Mentors are former clients of the child welfare system with at least 3 years of recovery from substance abuse and closed child welfare cases. Mentors are paid to provide a variety of supports to parents currently involved with child welfare who have a substance use disorder. Services are available for the

duration of the child welfare case; the average length of services is six months, with a range from 1 to 570 days.

PMP mentoring is parent-directed, based on the idea that solutions to problems are most likely to be successful when identified and/or chosen by the parent. The program design was drawn from work by Duncan and Miller on client-directed practice in psychotherapy (Duncan, Miller, & Sparks, 2004; Duncan, 2005). Parents are asked to identify their goals and mentors frequently check in with parents regarding what they are most interested in working on. There is no expectation that parents will direct the work toward, or be limited to, the services outlined in their child welfare case plan. Parents may, for example, focus the mentoring work on acquiring stable housing or obtaining a driver's license rather than on fulfilling service requirements or attending treatment programs. Parents who fail to have regular contact with their mentors are eventually dropped from services; most providers close cases after 90 days of no activity.

Method

The broader Title IV-E Waiver evaluation, of which this study is a part, employs a randomized control design. Parents for whom substance abuse was identified as a problem by child protective services were randomly assigned to either the PMP treatment group or the "services as usual" control group. Participation in services was not mandatory; parents assigned to the treatment group ($n = 501$) were given the option of accepting or declining services. Parents who accepted services ($n = 286$) were invited to consent to be contacted about the interviews; 71% of parents ($n = 203$) did so. Recruitment for the interview component of the evaluation began in year 4 and was limited to parents who had started services within the prior 12 months ($n = 90$). These parents were sent a letter and/or email describing the study. Researchers then contacted the parent by phone, described the evaluation, reviewed the informed consent and, if the parent agreed, scheduled an interview. Researchers read the informed consent and parents were asked to sign it prior to the start of the interview. Recruitment is ongoing, but thus far 26 parents have agreed to an interview, 5 have declined, and 27 either have tacitly refused or had insufficient contact

information. Approval for the study was granted by the researchers' university Institutional Review Board.

These findings draw from 22 in-depth interviews conducted with parents who participated in PMP services. The interview protocol was designed to solicit a richly detailed picture of parents' experiences. Interview guides were semi-structured and focused on respondents' ideas regarding the ways in which services were helpful as well as a description of the services themselves. Interviews lasted an average of 90 minutes and a few exceeded 2 hours. Interviews were conducted face to face unless the parent expressed a preference for communication via telephone (these constituted approximately 25% of the interviews). With parents' permission, interviews were recorded and transcribed. Parents who participated received \$40 in gift cards from a local merchant.

The sample was primarily female, although 4 fathers were interviewed. Race and ethnicity was primarily Caucasian ($n = 18$); 1 parent identified as Native American; 2 identified as African American and/or Hispanic, and 1 identified as Hispanic. All of the parents had worked with the program for at least 3 months; the vast majority had been involved for over a year. Most of the parents were pleased with the PMP program; however, a few were not.

Data Analysis

Both inductive and deductive methods were used to analyze the data. The concepts underlying the parent-directed approach provided a foundation for the deductive analyses and initial coding schema. Researchers actively pursued insights and new ideas as they appeared in the interviews. The first six interviews were open-coded and formed the basis of the initial coding schema. That coding schema was added to and refined on a regular basis, as described below. All of the interviews were reviewed by the Principal Investigator (PI) as both an opportunity to apply new codes and as a final check.

There was a diverse analysis team including a mix of racial and ethnic backgrounds and socio-economic status, along with a variety of disciplinary backgrounds (Social Work, Psychology, and Political Science). Individual

transcripts were coded by dyads that included the interviewer and another member of the research team. Each person coded the interview individually; then, the dyad met to reach alignment on coding. Any issues that were not resolved, along with any new codes that emerged, were presented for review to the full research team. This process was ongoing, alerting reviewers to new and emergent concepts in a timely fashion.

Team meetings served as a process for critiquing and refining the codes themselves, as research team members were required to defend their interpretations. During meetings, each team member was encouraged to ask questions and offer insights and alternative interpretations. This method of analysis drew on the in-depth knowledge the interviewer had with the case while bringing the perspectives of other researchers. This process expanded the range of perspectives “listening to” and “seeing” the data. This investigator triangulation (Patton, 2002) facilitated a more complete view of the parents’ experiences and, coupled with the comparison across cases, decreased the possibility of interpretive bias (Strauss & Corbin, 1998).

As a whole, the interviews provide a richly detailed story of the ways in which mentors facilitated, or did not facilitate, changes in parents’ behavior and parents’ thoughts about themselves and their child welfare cases. As the coding schema evolved, themes and dynamics emerged related to particular categories of supports. These categories were reviewed in the psychology literature to delineate concepts that might further illuminate what parents had described.

Results

What follows is a presentation of the major categories with the goal of explicating the concepts and illustrating the fit between the data and the categories. It begins with a discussion of what mentors do; the second section describes what happened for parents as a result of the mentoring, including how parents felt and what they did.

What do Mentors Do?

Parents’ accounts of what mentors do were reviewed to develop a broad description of the knowledge, activities, and practices that mentors utilize in

the course of their work. Quite commonly, parents portrayed their relationships with their mentors as caring and supportive; in the context of that relationship, mentors acted as parent-directed guides. Instances in which parents did not consistently experience these elements were also described.

Caring relationship. When talking about their relationship with their mentor, numerous parents began by saying, "I felt like [the mentor] cared." In many cases, this created an instant connection for the parent. Care was communicated in a variety of ways such as mentors accompanying parents to meetings and offering support in especially stressful moments. As one parent stated, "It is nice because let's say I wasn't doing good, and I just needed that phone call. When you are doing bad, the phone feels really heavy. Sometimes it is nice just to hear that somebody cares."

Difficulty connecting. A small number of parents described having difficulty connecting with mentors. Shared life experiences, such as substance abuse and child welfare involvement, do not guarantee that parents and mentors will "click" or even like each other, as illustrated by parents who stated, "we never hit it off from the start," or "sometimes you meet people and it is just, I don't like that person." One male parent confided that he would have been able to connect more readily with a female mentor, saying, "I probably would have talked more and be more open. I would have talked about my feelings and how I felt inside and been honest."

Guidance. Parents spent a great deal of time talking about receiving guidance from mentors that was clear, dependable, and predictable, and that reduced uncertainty in their lives. One of the most common ways that mentors were helpful to parents was by providing information. Examples included explaining or translating information given to parents by other professionals, taking the time necessary to put things into words parents could understand, sharing insights and advice, and giving information regarding local treatment resources such as clean and sober activities and 12-step meetings.

Another important aspect of guidance was helping parents link consequences to their actions or creating contingencies. Parents often talked about their mentor celebrating their successes (e.g., achieving 30 days of sobriety), giving them positive feedback, and noticing accomplishments

that others might not notice (e.g., attending a 12-step meeting). Mentors also held parents accountable for their actions and commitments. For example, many mentors worked with parents to set goals and develop a plan for achieving these goals. As described by one parent, “She will ask me ‘How are you doing with building support?’ and I’ll have to write how I am going to do this. The goal isn’t just a goal. They want you to break it down ... They want a date.”

Guidance can also take the form of reality checks, as peer mentors are uniquely suited to speak hard truths to parents. Parents talked about how their mentors have “been there, done that,” and how that gives them a certain credibility. For example, a parent reported that “she [mentor] could give me constructive criticism and I would respect it because I knew that she has worked really hard to get where she is at and overcome a lot of things.” Mentors could insist that a parent face certain truths in a way that other providers could not, and parents often experienced it as supportive rather than controlling. One parent described hearing a hard truth in this way: “I was, ‘I am not an addict. I just use sometimes.’ She was, ‘No, you are an addict.’ She hit me with reality.”

A final example of guidance was forecasting, or helping parents look into the future and imagine the outcomes before they acted. Sometimes this was as simple as telling parents what to expect in a family decision meeting, or giving them tips about how to work with a new caseworker. Other times it was a more complex exercise referred to by some parents as “playing the tape,” walking through likely outcomes of a particular course of action in their head. It was described by one parent in the following way: “...then she told me how to talk myself through things—let the whole tape play, before you make a choice on anything. OK, if I do this, this could happen.”

Lack of follow-through. A few parents described situations in which mentors did not follow through on promises or were unreliable in their communication:

She at the beginning said ‘you can call—whether you are going to use or not, you can call me.’ Well, there were a couple of times when I was so stressed out and not in the right

state of mind, I called her because I thought I was going to use, and she wasn't there. Never called back.

Another parent was confused about why her mentoring case was closed and described a lack of communication on the mentor's part, saying:

I actually found out in the mail. I got a letter in the mail saying that she was closing my case because she couldn't get hold of me, which I thought was funny because I could never get hold of her.

Put parents in charge. Parents consistently reported that mentors gave them the power to choose the direction of the work. Parents also noted that mentors allowed them to see choices that were not otherwise evident. One example was described by a parent as follows:

Sometimes you don't really know, you know what you want to do, but then you don't know. You have to find yourself again, especially after being lost in some world on drugs and stuff. You don't really know [yourself] no more and what you like to do because [using substances] is all you know. When we are setting these goals or whatever, give me some hints. She will give me some ideas. Are you into this and this? Why don't you try this?

The interviews also revealed other, more nuanced ways in which mentors put parents in charge. One example is showing respect by allowing the parent's voice to be heard and valued. Mentors show respect for parents by listening to their opinions, giving them time to think, and validating their needs. As one parent described, "She helped me figure out what to do, instead of just saying, 'Oh my God, I can't believe you did this.'"

One of the most interesting ways by which mentors are parent-directed is by providing a meaningful rationale for why it is important to work with the state agency on behalf of their child. Parents said mentors reframe the situation in such a way that they are able to accept the demands placed on them. Parents can then choose a path forward,

adjust their priorities, and advocate for their own preferences. One parent described how her mentor helped her see the situation differently and move toward action:

I was scared to go to treatment ... I wasn't going to have my kids. I was going to have to be sober and have to deal with these problems. I had to leave this man that I knew was going to cheat on me if I left. I was going to have to fight with my husband about his baby mama and why don't he have to do anything but I do. It was a lot of why, why, why. Then finally she [mentor] said, "Why all these whys? Why not just do it, get it over with, and get your babies back?"

Not parent-directed. In contrast, a small number of parents reported that the mentor pushed an agenda rather than listening to their needs:

She asked me once if I wanted to go to a noon meeting with her, and I told her there was no possibility of that because my daughter at the time was getting out of school right around noon, so it just was not possible ... she was very pushy on going to that meeting and that meeting only. I don't know if it was maybe the only meeting she goes to, the noon meeting, I don't know.

In another case, the parent felt judged by her mentor:

She said, "Your daughter is going to be adopted." She [acted like she] knew what was going on ... I just felt like she had really labeled me ... She knew nothing about my daughter ... She didn't know who I was, didn't know who my daughter was and what was going on.

What Happens to Parents who Work with a Mentor?

Next, the analysis focused on what happened for parents as a result of their work with a mentor, including how parents felt and what they did. Most of the parents reported having more positive self-beliefs and taking action that demonstrated involvement in their child welfare case as

a result of working with their mentors. However, in some cases, work with mentors undermined these processes.

Feeling cared for. Parents talked about developing a relationship with their mentor that was “more intimate and personal” than with other service providers, which in turn made them feel better about themselves. As one parent put it, “It made me feel not alone, like other people go through it too, so I’m not the only person.” Some parents talked about feeling like a number; in contrast, in other service systems, mentors really got to know parents. One parent described her mentor as understanding “what I’m about, what I’m trying to do and about me as a person, me as a mother ...”

Feeling successful. Through positive feedback, noticing successes, and reframing, parents start to believe in themselves, a process described by one parent as follows:

When I first went into treatment, our counselor asked me to say three good things about myself and I couldn’t name one. I started bawling in front of everybody. I can’t, I don’t know, there isn’t anything good about me. Now I can name a lot of things, and it is because I hear it from other people.

Parents described how they felt success was possible for them because their mentor showed them a path forward. One parent said, “...if she [mentor] is able to get up every day and function and live her life and be successful with the things she has been through, I know that I can.”

Feeling in charge. Parents also described feeling that they could make choices and take charge of their situation even when faced with inherently coercive demands from the child welfare system. One parent explained how she discovered that she had choices after accepting her situation:

With me, acceptance is a huge thing. I basically had to just—I didn’t have to, but I chose to accept what was going on and fight for the next move, for the next step, for whatever I had to do, and I did that.

Another parent described how feeling authentic and accepted led to empowerment:

She [mentor] would let me talk and she wouldn't judge me. She would say, "Well, I can give you a suggestion, but I can't tell you what to do"... Because sometimes people will try to fix people instead of letting them walk their own path. ... Nobody can tell us how to change, when to change. And we have our own time and place where we say enough is enough. And the parent mentors have met me where I'm at—to allow me my process and to allow me to grow through the struggles, but with them there.

Feeling neglected or worthless. In contrast, unsupportive interactions with mentors left parents with ambivalent or negative feelings. After a parent did not hear from her mentor for some time, she felt neglected: "...with me, don't tell me you are going to help if you are not." Another parent said her mentor made her feel worthless: "I felt like what she was saying was, 'You are just a piece of crap drug addict and so is her dad and she is going to be adopted.'"

Increased engagement. Many parents articulated improvements in motivational, coping, and self-regulatory processes as a result of working with a parent mentor. For example, parents talked about increased ability to advocate for themselves, to get involved in services, and to take charge of their situation. A parent gave an example of her proactive engagement in services:

When we sat down at the FDM [family decision meeting], for instance, they would say, "OK, let's get this service going for them, or let's get that service going for them"... I already had it going. I already had it. If they said to do this and you do that, I would do that and then call back and say, "What else can I do?"

Parents also described feeling "hope that I hadn't felt in a long time," an indicator of increased emotional engagement, which "gave me that little bit that I needed to take that first step."

Parents gave examples of how they became more independent of their mentors as their ability to engage in child welfare and recovery activities increased. As one parent described, "Now that I can get to meetings, it is my responsibility to get to the meeting and she [mentor] will meet me. She is not an enabler." Another parent gave an example of her gradual progression toward independence:

That means that not only are you trusting that you can make proper decisions and choices for your life, even in spite of what the situation looks like, even if you don't agree with it, that you can walk through stuff, that you can get things done. You can accomplish it and that you trust and believe in yourself enough to say, "I don't need [mentor] to do this. I can do this. Let me get the ball rolling."

Lack of engagement. In response to unsupportive interactions with mentors, which often produced ambivalent or negative feelings, some parents disengaged from the mentoring relationship. For example, after poor communication and a confusing case closing, one parent ceased efforts to contact her mentor:

I didn't care to talk to her, didn't care to see her, I didn't feel that I had gotten much help from her anyway, so I didn't really see a point in trying to find out why the case was closed, why she felt she wasn't getting hold of me.

Another parent, who had not established a strong relationship with his mentor, described what happened as follows:

After our case closed, we were having a hard time. Instead of talking to [mentor] or talking to anybody, I bottled everything up and shut down and I relapsed... I ran into [mentor] and I told I relapsed and he said, 'Give me a call.' I said, 'OK,' and never gave him a call.

Discussion

Interventions such as PMP that are complex, multifaceted, and involve a wide range of individualized services and supports present evaluators

with the challenge of understanding the efficacy of the program as well as how the program has its effects. A theoretical framework that specifies processes of change that are linked to mentors' practices can help to further refine understanding of the mechanisms of a parent-directed model of mentoring, which centers on the notion that parents should drive the work and that mentors should support them in meeting their goals (Duncan et al., 2004; Duncan, 2005). Interviews with parents involved in the PMP suggested that certain practices helped motivate parents to think and act in ways that supported their goals and child welfare case plans. Three key mentoring practices surfaced in these interviews: building caring relationships, providing guidance, and putting parents in charge.

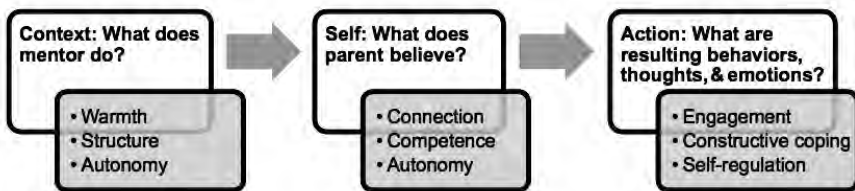
Existing motivational theory literature was explored for an organizing principle that would deepen our understanding of these practices. A particularly good fit for the data was Self-Determination Theory (SDT), a meta-theory that posits that motivation is the product of needs fulfillment in the course of pursuing and attaining desired outcomes (Deci & Ryan, 1985). One of the mini-models within the SDT framework is Basic Psychological Needs Theory (BPNT) (Deci & Ryan, 2000). BPNT assumes that all people have an innate desire to take responsibility for themselves and their families, and the extent to which they do so is dependent upon available personal, social, and contextual resources (Vansteenkiste & Ryan, 2013). Self-beliefs about the degree to which one is competent, autonomous, and connected to others operate as personal resources that can drive a range of motivated actions, thoughts, and emotions. When individuals believe that their needs are met, they are more likely to engage, cope constructively with setbacks, and self-regulate in ways that produce more positive outcomes (Skinner & Zimmer-Gembeck, 2007; Skinner et al., 2009).

In the context of peer mentoring, BPNT suggests that mentors can promote motivation by supporting parents' "fundamental human needs for relatedness, competence and autonomy" (Deci & Ryan, 2000, p. 232). Relatedness is the need for connection and belonging; competence is the need to feel effective in bringing about desired outcomes; autonomy is the need to be authentic and experience oneself as the source of

action. Mentors can meet a parent's psychological need for relatedness by building caring relationships, for competence by providing guidance, and for autonomy by putting parents in charge (see motivational process model in Figure 1).

Figure 1

Parent-Mentor Motivational Process Model



These data suggest that when mentors met their psychological needs, parents felt that someone cared about them, that they could be successful, and that they could take charge of their situation; these findings are consistent with existing mentoring research (Berrick et al., 2006; Berrick et al., 2000; Marcenko et al., 2010; Summer et al., 2012). Positive self-beliefs, in turn, helped motivate parents toward actions that supported their goals by being proactive, meeting responsibilities, advocating for themselves, and gaining independence from their mentors. Motivated action parallels the notion of empowerment as a driver of change discussed in the mentoring literature (e.g., Berrick et al., 2011). Results also point to features of the parent-mentor context that undermine parents' motivation, such as when the parent and mentor fail to connect, lack of consistency or follow-through, and the mentor being overly directive or disrespectful. Unsupportive interactions left parents with ambivalent or negative feelings, such as believing their mentors did not care or thought they were worthless. In such cases, parents disengaged from the mentoring relationship.

Limitations

Whether needs fulfillment for parents involved in the child welfare system, as described above, consistently results in positive child welfare outcomes remains an open question; the findings presented represent the experiences of a small number of parents, and it will be important to employ methodologies that allow these ideas to be tested with a much larger sample. In addition, this sample of interviewees has largely had successful experiences with the PMP; the findings may not represent the full range of ways in which mentors may be perceived as unsupportive and the impact that could have on a parent's self-beliefs and motivation.

It is also the case that peer services are likely not the only vehicle for promoting needs fulfillment among child welfare-involved parents. Furthermore, while BPNT is an especially good fit with these data and persuasively connects mentoring services to parent-level outcomes, it does not explain the totality of the ways in which peer services may be useful to parents.

Implications and Future Directions

Offering BPNT as a relevant theoretical framework may improve peer mentoring services and their evaluation. Such a framework can help guide program development efforts by encouraging mentors to develop the skills necessary to effectively support parents' change processes. SDT is consistent with theory of change processes that underlie motivational interviewing techniques (Markland, Ryan, Tobin, & Rollnick, 2005), pointing to the importance of program designs which foster parents' choices and opportunities for autonomy, especially when they are involved in inherently coercive systems such as child welfare. Moreover, the notion that mentors and other helping professionals can create motivationally rich contexts to support parents in their pursuit of child welfare goals, rather than thinking of motivation as a state trait, should encourage providers to respond to disengagement or disaffection by providing contextual supports.

For further evaluation of mentoring programs, BPNT suggests specific testable hypotheses. For example, a survey method is currently being implemented to measure the degree to which parents perceive relationships with their mentors as warm, structured, and autonomy-supportive, and whether these perceptions are associated with changes in self-perceptions, motivation, and progress toward child welfare and recovery goals. These data collection and analyses processes are in the early stages; it is anticipated that the understanding of the ways in which mentoring services impact parents' change will be refined significantly as the work progresses. This theoretical framework is offered as one way to structure and focus the ongoing conversations between researchers, practitioners, and parents regarding the value of peer mentoring services.

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Enhancing Family Protective Factors in Residential Treatment for Substance Use Disorders

Joan E. Zweben

*East Bay Community Recovery Project (EBCRP)
University of California,
San Francisco*

Yael Moses

East Bay Community Recovery Project (EBCRP)

Judith B. Cohen

East Bay Community Recovery Project (EBCRP)

Genny Price

East Bay Community Recovery Project (EBCRP)

William Chapman

East Bay Community Recovery Project (EBCRP)

Joanna Lamb

East Bay Community Recovery Project (EBCRP)

Substance abuse treatment programs typically focus on reducing attitudes and actions that lead to continued substance dependence and do not always maximize opportunities to strengthen the protective factors that can promote sustained recovery. This article describes a co-occurring disorders residential treatment program for women and their children that enhanced its trauma-informed treatment model by adding supportive treatment components that emphasized protective knowledge and skills and helped build support systems. These protective factors included: (1) concrete support in time of need; (2) knowledge of parenting and child development; (3) social and emotional competence of children; (4) parental resilience; and, (5) social connections. The enhancement included implementing Celebrating Families! (CF!) and an improved integrated case

management system that were well received by staff and clients. Evaluation data confirmed that those who took part in these interventions showed significant improvements in recovery, including reduced mental health symptoms, reduction in risk behaviors, and longer program retention.

Substance abuse has long been recognized to play a major role in the lives of families in the child welfare system (Azzi-Lessing & Olsen, 1996). This involvement has led to a strong focus on integrated, evidence-based practices and coordination between the substance abuse treatment and child welfare systems (Marsh & Smith, 2011). The number and severity of problems of mothers in the child welfare system often qualifies them for participation in highly structured residential care in the substance abuse treatment system. A comparison of mothers involved in the child welfare system with those who are not indicated greater treatment needs related to exposure to physical abuse, economic instability, and criminal justice involvement (Grella, Hser, & Huang, 2006). Substance abuse treatment programs offering comprehensive care often have multiple resources to meet these and other needs, combined with extensive experience in the relevant areas. The substance abuse treatment system also offers a modality that is difficult to find elsewhere: highly structured, intensive, long-term residential treatment where a woman can be admitted with her children.¹ This model offers many opportunities to enhance protective factors, which may not receive enough emphasis in residential settings because of the clinical challenge of addressing the complex needs of these families. This paper describes how activities to enhance protective factors can be integrated into residential treatment as part of the therapeutic process.

The advent of the stimulant epidemic in the 1980s brought many women into the child welfare system and was associated with the placement of large numbers of their children into foster care. Much research on substance abuse treatment has been done to demonstrate the importance of participation in enhanced programs to promote positive outcomes for women with substance use disorders and their children (Zweben, 2014). As studies documented the effectiveness of gender-responsive programming, specific services were developed in both women-only and mixed-gender programs. These included a strong emphasis on working with families and significant others, and providing

¹Treatment Locator: <https://findtreatment.samhsa.gov>.

services related to pregnancy, parenting, and domestic violence (Grella, 2008; Grella & Greenwell, 2004). Such services were much more likely to be found in women-only programs, and were related to greater client satisfaction. These programs improved outcomes for women with substance use disorders and their children.

These enhanced programs also met child welfare goals, especially reunification. Grella, Needell, Shi, and Hser (2009) reported that reunification was more likely if psychiatric and family problems were addressed, and if the mothers completed more than 90 days in treatment. This is consistent with earlier findings that when women entered treatment quickly and spent more time in treatment, their children spent fewer days in foster care and were more likely to be reunified with their parents (Green, Rockhill, & Furrer, 2007).

Protective Factors

The child welfare system and the substance abuse treatment system both emphasize the importance of protective factors in prevention and treatment. Though they have very different histories and distinct cultures, both systems are focused on lowering risk and enhancing protective factors. Risk factors include stressful conditions, events, or circumstances that increase a family's chances for poor outcomes. Examples include maternal psychiatric disorders, family violence, persistent poverty, and substance use. Protective factors are those that mitigate risk and promote healthy development, such as strengths that help buffer and support families at risk. These factors can be enhanced in individuals, families, and the larger community. Increasing the strength of protective factors is an effective prevention and intervention strategy to offset risk exposure and promote enduring gains.

Strengthening Families™, developed by the Center for the Study of Social Policy (CSSP), identifies five protective factors: (1) Concrete Support in Time of Need; (2) Knowledge of Parenting and Child Development; (3) Social and Emotional Competence of Children; (4) Parental Resilience; and (5) Social Connections. Many state child welfare systems have used the CSSP framework to develop major initiatives

focused on building protective factors for the families who come to the attention of or are involved with child welfare. These five protective factors are widely used in child abuse and neglect prevention programming (Browne, 2014; Child Welfare Information Gateway, 2014).

Parenting programs are a major vehicle for strengthening protective factors. Barth and Liggett-Kreel (2014) examined the common components in parenting programs, noting variability in the effectiveness of interventions for various age groups. They reviewed the existing research and its limitations, noting methodological difficulties and many gaps in the research. They stressed the importance of utilizing strategies that include multiple program components that are consistently associated with larger effects, rather than focusing on specific manualized interventions. This more generic approach facilitates wider adoption, allowing for “evidence-informed” parent training programs to become more widely available.

The substance abuse prevention field has also focused on risk and protective factors and has identified the following components: (1) strong and positive family bonds; (2) parental monitoring of children’s activities and peers; (3) clear rules, consistently enforced; (4) involvement of parents in the lives of their children; (5) adoption of conventional norms about drug use; and (6) bonds with community institutions and organizations (National Institute on Drug Abuse, 2002). Similar to child welfare approaches, there is a broad focus on individuals, families, and the micro and macro community. The substance abuse treatment field, focused on severe psychiatric, social, and health problems, has gradually increased emphasis on building resilience by strength-based programming that enhances protective factors.

Long-term residential treatment offers unparalleled opportunities to strengthen protective factors. While many prevention efforts rely heavily on educational efforts, residential treatment offers the opportunity for skill building in an environment that allows for continuous monitoring, coaching, and support. This results in a level of mastery that is less likely to be achieved in outpatient treatment or educational settings. The premise is that these achievements will have a multiplier effect, that

children and other family members will benefit, and that the addiction cycle is more likely to be disrupted. Policy leaders have noted that it is important to move beyond teaching to practice-based skills, but effectiveness trials are lacking (Barth, 2009). Long-term residential treatment offers a promising arena to conduct such studies.

Development of Strength-Based Residential Treatment for Mothers and Their Children

A major barrier to women's participation in substance abuse treatment was identified early in the development of gender-specific programming by recognizing the need to provide child care or a safe setting for her children if residential treatment was appropriate. Beginning in the 1970s, attention to women's issues by the National Institute on Drug Abuse led to increased research on biomedical and psychosocial issues, which in turn led to efforts to identify effective elements of treatment (Moses & Zweben, 2013; Rahdert & National Institute on Drug Abuse, Division of Clinical and Services Research, 1996; Werner, Young, Dennis, & Amatetti, 2007; Zweben, 2014). By the 1990s, the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) funded a federal demonstration grant program for pregnant and parenting women that funded comprehensive culturally and gender-specific residential treatment. These programs made it possible for women to enter treatment with one or more children, and remain in treatment for extended periods of time, often a year or more. Such programs appear to be unique to substance abuse treatment.

Evaluation data indicated reductions in infant mortality and morbidity, and improvement in retention and completion rates (Clark, 2001). Other benefits of treatment included behavioral changes in impulse control, judgment, and the acquisition of parenting skills. Recognition that co-occurring disorders among women was the norm facilitated the integration of treatment for psychiatric disorders, as well. Mood disorders and anxiety disorders, particularly PTSD, were recognized as fairly common among women entering treatment (Kessler et al., 1994; Regier et

al., 1990). Trauma-informed models became more common as research-based treatments emerged (Najavits & Hien, 2013).

All these improvements still operated within a context that emphasized treating what was “broken,” but did not include adding positive or strengthening treatments that might help to prevent relapse once a woman was discharged from treatment. More recently, many areas of health promotion have helped to build positive and protective strengths in co-occurring disorder treatment programs. Clinicians recognized the value of strengthening resiliency factors and many adopted these strategies as well, but there were very few evidence-based interventions to help. One program, Celebrating Families! (CF!), emerged as a useful tool for accomplishing some of these tasks (Tisch & Sibley, 2007).

This article describes a residential treatment program, Project Pride, that had already developed culturally sensitive and trauma-informed care, but wanted to provide a broader emphasis on building protective factors for the young families in the program.

In 2010, Project Pride introduced two major changes into the ongoing treatment program for substance abuse, mental health, and parenting. One was the evidence-based program, CF!. This intervention was selected in response to focus groups held with the mothers (with no staff present), where they were asked to identify changes that they would like to see in Project Pride. A common theme was that it would be easier to stay in the program if family drama on the outside did not pull them away. They also wanted help in dealing with conflicting demands made by various agencies that controlled their futures—e.g., child protective services, parole, probation, and so on. Finally, they were eager to have resources available to them that would help them to do well on the outside when they left Project Pride. Inviting extended family members into the program to participate in CF! provided all family members the opportunity to understand addiction and recovery and improve supportive family communication and actions.

The second program enhancement was building an integrated case management model that included all the agencies and programs involved in each woman’s treatment plan as early as possible after admission. The

goals were twofold: to provide each woman with transparent and coordinated management of her recovery, and to build a community support network while in treatment that increased the chances that after a woman left the program, she would have knowledge and experience in becoming an active participant in her continuing recovery. The intent was to ensure that each woman and her family were no longer subjected to scattered and potentially inconsistent recovery requirements. This model also addressed the needs of the woman's children, who were not in residence in Project Pride to the extent possible.

Description of Project Pride

Project Pride is a residential treatment program for women who are pregnant or have young children within East Bay Community Recovery Project (EBCRP) located in Oakland, California. Most residents are at risk of losing, or have lost custody of, their children following investigation by Child Protective Services. Program participation is their best chance of retaining custody or being reunited with their children. All residents have problems with alcohol, and the majority are also methamphetamine users. Research on the effects of methamphetamine use has shown that women users have very high rates of psychological problems and extensive histories of psychological and physical abuse (Cohen et al., 2003; Zweben et al., 2004). Thus, they require a high level of attention to coexisting psychiatric disorders (Zweben et al., 2004).

Project Pride was launched in Oakland in 1994 as part of the CSAT Demonstration grant program for Pregnant and Parenting Women. Research findings had indicated that children were a major consideration in women's decision-making about whether to enter and remain in treatment. Using evaluation data, the federal demonstration program sought to show that women who could enter residential treatment with their children would remain engaged and have positive outcomes. Indeed, during the CSAT grant period, six California demonstration programs were designed, evaluated, and were found to produce dramatic positive outcomes. In 2009, program completion rates averaged between 60% and 70%. An average of 70% of the women remained drug-free at six

months post-treatment. Criminal justice involvement was reduced by 90%. The majority (65%) of women were employed or in job training at the time of discharge, and 75% were reunified with other children who had been placed in foster or kinship care. All programs reported positive outcomes for the children, as indicated by improved physical, mental, and social functioning. Despite the mothers' high-risk pregnancies, 90% of the children were born full term, free from substances, and without any known medical problems (California Perinatal Treatment Network, 2010).

Strengthening Protective Factors

Project Pride uses the Strengthening Families™ approach developed by CSSP (Child Welfare Information Gateway, 2014). Although not developed for mothers with substance abuse issues, the approach is consistent with those identified in the substance abuse prevention literature and reflected in the CF! intervention. Staff prioritized the five protective factors and activities that they viewed as the most important in strengthening resiliency and identified strategies to implement those strategies in Project Pride (Browne, 2014). Some of the concept labels were adapted so that specific activities could be documented in the treatment program.

Given the primacy of parental influence in children's lives, it is important to support parents in understanding and meeting the child's developmental and emotional needs. Staff members work to help the parents increase their understanding of the child's needs, worries, and coping style. The intent is to promote the child's well-being by strengthening both the parent's understanding of the child and their mutual relationship. Working closely with the parents to help them become the "experts" in their children lives is the first step. This is done through the following:

Concrete Support in Time of Need: Most mothers enter Project Pride in crisis caused by loss of custody of their children, incarceration or other legal involvement, current or impending homelessness, and other challenges. By providing treatment, safe housing, access to health care and public benefits, employment assistance, child care, and other

immediate supports, Project Pride helps address their immediate needs, setting the stage for in-depth services. Since virtually all of the mothers who enter the program arrive with court supervision and other legal involvement, the integrated case-planning and management services are of ongoing help to residents in their recovery.

Knowledge of Parenting and Child Development: Daily parenting education classes are provided by mental health staff at Project Pride. The classes help mothers understand the developmental needs and abilities of their children, how to intervene and set limits to create safety for them, and how to create rituals and structure to more easily manage their children's lives. One weekly class serves as a group problem-solving forum for parenting issues that may arise. In addition, staff monitor parent/child interactions and intervene immediately to provide assistance and identify alternative strategies to help parents cope with frustrations. The CF! program, described in more detail below, involves the extended family to help ensure the continuation of the progress after discharge.

Social and Emotional Competence of Children: All children are screened for developmental and mental health needs, including their social and emotional development. An individualized treatment plan is formulated for each child and for each family. This includes parent/child therapy and referrals to individualized programming in response to identified treatment needs. Since mothers live at Project Pride for an extended period of time, Early Head Start considers it a home and provides home-based services. All children are provided with onsite child care that enables ongoing assessment in a child-friendly environment. Older children can participate in CF! starting at age 8, and are divided into two age groups: 8–11 years old and adolescents. Those who participate can be provided with referrals for assessment and services through local Family Service programs.

Parental Resilience: Project Pride provides individual and group counseling for mothers to help them maintain sobriety and understand the effects of their own attachment issues, trauma, and violent experiences on their relationships with their children. They are helped to recognize that their children have needs that differ from, and may compete

with, their own needs, with the ultimate goal of supporting the mothers to develop healthy strategies to cope with the pressures of parenthood.

Social Connections: Since women do not recover in isolation, but in community, mothers become part of a positive peer group of similarly situated women who can understand their struggles and provide concrete support. Mothers are encouraged to participate in 12-step programs to enhance their community-based supports for recovery. In addition, by engaging their extended families and friends through the CF! program, Project Pride aims to help reduce the familial isolation so many women experience when others in their family and social circle may not understand or be committed to recovery.

Among these protective factors, staff identified improving parental resilience and social connections as the two most critical areas of recovery. This led to the program enhancements described below.

Strengthening the Extended Family

Project Pride implemented Celebrating Families! (CF!), a program designed specifically for families in which one or both parents have a serious problem with alcohol and other drugs and are at high risk for domestic violence, child abuse, and neglect.² It is an evidence-based, cognitive behavioral support group model that aims to increase resiliency and decrease risk factors, integrating addiction recovery concepts with family living skills.

CF! and Strengthening Families™ programs have overlapping goals: providing education and skill building to families who have been impacted by the problems noted above and by substance use disorders. Neither program was developed with a specific focus on families affected by substance use disorders. They are both unique in their emphasis on building strengths rather than identifying weaknesses. The two programs originated in different ways. Strengthening Families™ was developed with a clinical focus, with an initial focus on children. The early articles describing the program provided measures and discussion

² See www.celebratingfamilies.net.

that were clinical in perspective. CF! on the other hand, although also developed by mental health professionals, developed as a program that was more family-focused, with outcome measures that were family ratings of the program. EBCRP chose to implement CF! because it had been developed on family groups that were very similar to the families in our programs: mothers who were women of color with few educational or occupational resources, and who carried the burden of extensive histories of abuse and violence.

Participants in CF! include the mother and child (or children) in residence, grandparents, friends, aunts and uncles, siblings, and other supportive individuals in the mothers' lives. It focuses on family-centered treatment practices and is a multifamily/multigenerational event. CF! is the only evidence-based family program for families involved in substance abuse listed in SAMHSA's National Registry of Evidence Based Programs and Practices (NREPP). Although no controlled trials have been published as yet, NREPP summarizes the available evaluation data used to qualify it for inclusion on its list of evidence-based practices (see <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100>).

CF! sessions are provided weekly over 16 weeks, enabling all residents and their identified extended family members to attend. Each session of CF! is a three and a half hour program which begins with a family meal followed by subgroup programming for adults, children and adolescents, with age-appropriate materials. Following the family dinner, participants attend a 90 minute instructional session on the following themes: (1) healthy living; (2) nutrition; (3) communication; (4) feelings and defenses; (5) anger management; (6) facts about alcohol; tobacco, and other drugs; (7) addiction as a disease; (8) the effects of addiction on the whole family; (9) goal setting; (10) making healthy choices; (11) healthy boundaries; (12) healthy friendships and relationships; and (13) individual uniqueness. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance (see <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100>).

Mothers in Project Pride are carefully assisted in identifying family, friends, partners, and significant others who are, or can become, part of a positive, safe, and supportive community for the women when they leave treatment. CF! sessions generate trust and excitement, enabling staff to expand their intervention efforts. CF! began at Project Pride as a voluntary program, 44 of the 53 residents since it started have participated. A broad definition of “family” is encouraged. To date, of the 44 resident participants, 12 of their mothers and 8 of their fathers have participated, as well as 10 sisters and 3 brothers. Additionally, 10 partners, husbands, or biological fathers of the children have participated, along with 49 children of the mothers who were not in residence at Project Pride. Some families have driven as far as 110 miles round trip to participate. Each of the family members who attended was contacted by the family therapist, interviewed, and offered support, referrals, and information as needed. At six-month follow-up, 96% of residents reported that they had support from family and friends.

Implementing CF! in Project Pride contains elements of a prevention strategy since many family members are at high risk for child abuse, as well as an intervention strategy since the program provides direct treatment to children who are trauma survivors.

Integrated Case Management to Strengthen Protective Factors

The second change made to the program was to build an Integrated Case Management Model that would be unique for each woman in treatment. Previously, the woman received case management services as needs emerged. The transition involved forming a team of internal staff and external providers, starting as early as possible after admission and meeting together as needed to coordinate treatment plans and services.

Two different types of meetings facilitated the goals. Administrative meetings focused on general coordination of services, information, and resources, and provided an opportunity to share perspectives. Meetings with the resident and her family focused on encouraging steps towards specific goals. The overall aim was to provide wraparound services that met the resident’s needs at a given point in time. Working with outside

agencies also gave the resident a better understanding of how to tap community resources and offered practice while she was still in treatment. In some cases, important relationships were initiated with a representative from specific outside service providers. Developing and maintaining these collaborative interactions was no easy task. While all meetings included the County Department of Family Services, other participants included Children's Hospital Oakland Infant Mental Health Program, the Department of Public Health, program specialists from Services to Enhance Early Development (SEED), and Early Head Start.

Meetings can be convened at the request of the mother, a family member, or another member of the team when a court date is scheduled or a new situation arises. It can include the child welfare worker, parent advocate, SEED worker, and family members who are appropriate. This team focused on the woman and child in residence and also on meeting the needs of the mother's other children whenever possible.

Enhancement of protective factors required multiple resources. The Integrated Case Management Model makes it possible to match diverse client needs with appropriate forms of assistance. A tight matching strategy, such as the Integrated Case Management Model, has been documented to improve reunification (Smith & Marsh, 2002). Project Pride teamed up with a number of community and other agencies for core services that we needed, such as health care, mental health, and housing, to provide comprehensive, family-focused assessments and services. These collaborations encompassed mothers, children, and other family members not living in Project Pride who were included in the meetings when appropriate. These meetings occurred with greater frequency at the beginning of treatment, and when the mother was about to graduate from the program, to further help her and her family renegotiate their relationship if needed. Meetings occurred weekly, monthly, and ad hoc to ensure that all the professionals involved had the opportunity to contribute and benefit from the collaboration.

A focus on children's safety necessitated attention to substance abuse and child abuse prevention, education, and treatment for the mother. When past abuse is identified, treatment is offered or arranged. However,

the program went beyond this in building an environment that helped residents to develop their own protective factors.

In addition, Project Pride mental health staff worked with family members who were not in residence (e.g., the mothers' parents, siblings, children that were not in the residential program) to make referrals for needs they identified including mental health and/or substance abuse treatment, housing, and job training. Staff also offered couples and family counseling. These additional counseling services helped ease the transition of the young family into the community maintaining the protective factors developed during their stay in the program.

In implementing these changes, EBCRP observed the following benefits for participants:

a) Children participants in Project Pride, including those in CF!, benefited from being provided with stability, safety, and the opportunity to grow up in a family that was actively supporting their healthy growth and development. Any social, emotional, or health-related deficits were identified and appropriate interventions were recommended, and staff could follow up while the mother was in the program as part of their integrated case management plan. A goal of the project was to end the intergenerational transmission of trauma. Since the children typically spend time being cared for by extended family members, increasing the protective factors in the extended family increased their safety. In addition, an unknown number of children who are part of the extended family (e.g., cousins) similarly benefitted from their caregivers' participation in CF!.

b) Mothers benefitted from participating in treatment with family members of their choice that included partners, parents, siblings, grandparents, friends, and other extended family members. The CF! program aimed to increase the resiliency of all participants, strengthen their family and social connections, and decrease their isolation. They benefitted from increased understanding of substance abuse and its impact on families, trauma and its impact on parenting, and the impact of abuse on their child's development.

c) Family members benefitted from increased understanding of the needs of their children and other relatives. They gained access to family, couples, and

co-parenting counseling to address complex issues and increase their access to other services they may need. They gained an understanding of how treatment can help their family to set and achieve healthy goals, and

Figure 1

Specific Activities to Develop Protective Factors

PROTECTIVE FACTORS					
	Family Functioning/ Resiliency	Social Support	Concrete Support	Child Development/ Knowledge of Parenting	Nuturing and Attachment
Parenting Group	X		X	X	
Child Enrichment	X	X		X	X
Team Meeting			X		
Celebrating Families!		X		X	
Early Head Start/ Head Start	X		X	X	
Library Trips / Zoo Trips/ Other Outings		X	X	X	X
Mommy and Me Group	X			X	X
Bodies in Motion Group	X	X			
Community Awareness	X	X	X	X	
Healthy Connections Group	X	X		X	
Home Groups		X			
NA/AA	X	X	X		
DBT	X	X			
Seeking Safety Group	X		X		
Mom+Child (Dyadic), Co-parenting/Couples Therapy, Family Therapy	X	X	X	X	X
Relapse Prevention Group	X				
Anger Management	X	X		X	
Domestic Violence Group	X	X		X	
Vocational Training	X		X		

increased their capacity to end the intergenerational cycle of trauma. In addition, some deeper family wounds were addressed, which further supports the resiliency of the family. Weekly group activities with other families who share similar difficult experiences reduced stigma and shame.

Figure 1 provides a snapshot of the components of the program and illustrates the activities through which protective factors were enhanced. Project Pride programming is listed in the first column and the protective factors that are part of the activities are shown in the subsequent columns.

The chart documents that residential treatment for mothers and their children offers multiple opportunities to strengthen protective factors in an integrated treatment model. Some of the CSSP protective factor labels were adapted to be more specific to the residential setting.

Outcomes

Highly structured residential treatment for mothers with children are not common, but they share a commitment to improving two outcomes that funders seek: increasing retention in treatment and reunification with children. Funding provided through a SAMHSA grant allowed for providing performance measures; however, a research design with a comparison group was not required by the grant or conducted. The outcomes collected and described here were focused on improvement in retention in treatment and reunification of children with their mother. Specific outcomes, in addition to those mentioned above, include gains in the protective factors of the mothers, gains in communication and support by extended family members, and the engagement of family members in further clinical services.

The SAMHSA grant also provided a staff position to develop the CF!. When CF! began, some women were eager to join, while others were not. That was the only time period when a comparison group of non-equivalent Project Pride residents was available. Project Pride now encourages all residents to participate in CF!. Figure 1 reflects the program activities focused on developing the protective factors. The data on the specific protective factors is now being collected, but since all of the women who are being assessed are still in the program, outcome data is not yet available.

A comparison of outcomes of the 44 women who participated in these two supportive interventions to 51 women who were in Project Pride but did not take part in the interventions showed improvements in several measures of recovery. Data were obtained using the Mental Health sections of the Government Performance and Results Act, or GPRA (see <http://www.samhsa.gov/grants/gpra-measurement-tools>). These included self-reports of mental health symptoms: only 41% ($n = 21$) reported having experienced psychological or emotional problems in the last 30 days, compared to 78% ($n = 40$) who reported such problems when they entered the program. Reductions in self-reported risk behaviors were also apparent at six-month follow-up, compared to intake. These included fewer reports of any drug or alcohol use in the past 30 days (43% at intake vs. 6% six months later). Regarding increased program retention, women who participated in the enhanced program remained in treatment for an average of 206 days, compared to 128 days for women who did not participate. Equally important, reunifications approached 100%, partly because Family Court and Child Protective Services staff learned of both progress toward recovery during the integrated case conferences and family support that would be continuing after discharge. Project Pride staff also reported that the CF! program led some families to realize that other family members also needed mental health and/or substance abuse treatment, and many of these family members have been served by other EBCRP programs.

Figure 2

Comparison of Outcomes

Measures	Intervention Group			Services as Usual
	Baseline	Discharge	6-mo. Follow up	
Self-reported psychological problems	78%	41%		
Drug/Alcohol use in prior 30 days	43%		6%	
Length of Stay	206 days			128 days

Discussion

Concepts from the program spread throughout Project Pride. Staff members reported observing positive language and skills learned in the groups, and even more importantly, supportive behavior and communication being used to help recovery within and between families. Similarly, women are sharing information about their experiences in Integrated Case Management meetings. Focus groups held with consumers indicated that the women and family members were enthusiastic about these additions. Several successful graduates from Project Pride requested to continue attending CF! even after discharge, and their stories provided additional examples of success to current program participants.

This report does not provide sufficiently complete outcome data for readers to assess what may have helped some mothers and families to do so well. The intent of this manuscript is to report a promising change that allows families to work together to build strong protective factors. The field may use this preliminary information, but specifically the testing of the Strengthening Families™ protective factors framework with a group of mothers with substance use and mental health needs is warranted. The program changes are working for the residents who report during the focus groups that they have something positive to look forward to each week and are partnering with family members to build better communication and support one another.

As the enhanced program continues, Project Pride will continue to measure gains made in fostering resilience, social connectedness, and family support. Specific outcomes, in addition to those mentioned above, will include gains in the protective factors of the mothers, gains in communication and support by extended family members, and the engagement of family members in further clinical services. Evaluation will also analyze the “dose” effect of CF! participation to see whether women who participated in more than the median number (10) of sessions had better outcomes than those who attended fewer than the average number of sessions.

Residential treatment is expensive, and there is always pressure from funders to reduce the length of stay to provide more access. Hopefully future research can continue to document the benefits of adequate

treatment, especially with sufficient length of stay, through long-term follow-up of the mothers and their children.

Programs for mothers and their children exist across the country, and it is to be hoped that child welfare workers are aware of those that exist in their communities. It is important to establish or strengthen collaboration, and to encourage the development of a strong program for family members. The enhanced Project Pride program represents a powerful opportunity to work on strengthening the protective factors that support long-term recovery and effective parenting, not only for the residents, but for the family as a whole.

Conclusions

When working with families with multiple challenges, it can be difficult to maintain a strength-based focus. Frequent crises and numerous practical obstacles often consume staff attention. Project Pride staff found that it was useful to work with family members who were not in residence together to identify opportunities for strengthening the family's protective factors and generate strategies and activities to foster their goals. When women and their children are together in a residential treatment setting, this creates unparalleled opportunities for therapeutic intervention, both in specific treatment activities and in the teaching, modeling, mentoring, and reinforcement moments that occur in everyday life. Bringing family members into the recovery process increases these opportunities. This modality, possibly unique to substance abuse treatment, has fulfilled much of its promise. Hopefully, future research will increase understanding of the role these factors play in recovery and ways to strengthen them in residential and other treatment settings.

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An Integrated Intervention to Address the Comorbid Needs of Families Referred to Child Welfare for Substance Use Disorders and Child Neglect: FAIR Pilot Outcomes

Lisa Saldana
Oregon Social Learning Center

Despite repeated calls for evidence-based practice to address the co-occurring needs of families referred to the child welfare system for parental substance use disorders and child neglect, limited attention has been given to the rigorous evaluation of such interventions. This paper describes the initial testing of an intervention developed to meet the complex needs of such families. The Families Actively Improving Relationships (FAIR) program and preliminary outcomes are described. The need for integrated interventions is highlighted.

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In 2012, approximately 3.4 million referrals regarding 6.3 million children were made to the child welfare system (CWS) across the United States (U.S. Department of Health and Human Services [USDHHS], 2013). Of these, 62% were screened in for services, from which 78.3% were indicated for neglect and 10.6% were indicated for other maltreatment, including exposure to parent's drug/alcohol use. Although few states report on substance use, of those that do, some report comorbid substance use in as many as 63% of all cases. As noted in the National Drug Control Strategy, the rate of substance use among women, particularly those with children, has increased steadily over the last decade (Office of the President, 2013), and some states report that their increase in child neglect reports is directly related to an increase in substance use in their regions (USDHHS, 2013).

Both legislators and health professionals recognize the deficits within the current social services systems in meeting the needs of families with comorbid neglect and substance use disorders. Recent recommendations provided in the IOM report *New Directions in Child Abuse and Neglect Research* (2013) suggest "evidence demonstrates that behavior problems in children are addressed most effectively through interventions that target parents as the primary change agents," using "home visiting" models that are focused on "family and parent engagement."

Despite the increased attention toward providing comprehensive treatment for this costly public health problem, currently no evidence-based practice (EBP) exists to address these co-occurring problems (Donohue, Romero, & Hill, 2006; Prinz et al., 2014). Indeed, Dubowitz and colleagues (2012) dubbed this phenomenon as the "neglect of neglect."

Gap in Practice

Of women who enter treatment for their substance use disorder, a disproportionate number are involved in the CWS for child neglect (Office of the President, 2013). As highlighted in a recent review of child welfare services conducted by Pecora and colleagues (2012), several programs have shown promise in addressing the needs of this population, but few have been evaluated rigorously. Many typical programs focus first on parental substance use and do not adequately address the additional risk

factors for neglect. In addition to treatment for substance use disorders, many parents involved in the CWS for neglectful parenting need parent skills training, mental health treatment, and help with ancillary services (e.g., housing, employment). Although commonly recommended in CWS treatment plans, current practice typically refers parents to services to address these needs in a piecemeal manner, with little attention to the interplay between these treatment needs. One notable exception is the recent advance from the Family Drug Court literature. Family Drug Courts have been shown to have improved outcomes when manualized, rigorously tested, family-based treatments are included as part of the Drug Court array of services (Marlowe & Carey, 2012). Multidimensional Family Therapy is one such treatment, and a randomized trial of an adaptation of this EBP, called the Engaging Moms Project, focused on engaging mothers in their substance use treatment by assisting them in developing stronger relationships with their children and families. The Engaging Moms Project has demonstrated high substance use disorder treatment completion rates and positive CWS outcomes compared to usual case management services (Dakof et al., 2010). Nevertheless, this program does not integrate parenting and substance use treatment, but rather provides care in a systematic parallel manner.

Ancillary services have been found to contribute to the success of parents referred for neglect in their treatment for substance use disorders and in their reunification (Smith & Marsh, 2002; Marsh & Cao, 2005). Unfortunately, a recent review of 125 substance use treatment programs across the United States indicated that only 43% reported some form of parent skills training integrated within the treatment and only 3% utilized a curriculum (Arria et al., 2013). This gap in integrated parenting, substance use disorders, and ancillary services may contribute to the number of families who do not achieve reunification, or who experience reentry into the CWS, particularly for those referred for child neglect.

Current Article

The current article describes one attempt to fill the existing gaps in services available for families involved in the CWS for co-occurring parental substance use disorders and child neglect. First, a thorough description

of the Families Actively Improving Relationships (FAIR) program is provided. Although extensive work was conducted to determine the specific program components to include, a description of this process is beyond the scope of the current paper. Second, pilot outcomes are provided demonstrating the initial promise of the FAIR program. Finally, discussion focuses on the importance of future research to continue to address the complex needs of this vulnerable population.

The Families Actively Improving Relationships (FAIR) Program

FAIR is an intensive community-based treatment model that integrates evidence-based components of behavioral interventions shown individually to yield positive outcomes for parenting and substance use (i.e., Parent Management Training [PMTO]; Forgatch & Patterson, 2010; and Reinforcement Based Treatment [RBT]; Jones, Wong, Tuten, & Stitzer, 2005). Both PMTO and RBT rely heavily on observing and tracking behaviors and on providing reinforcement for these behaviors in a strength-based manner within an ecological framework. Both models posit that problem behaviors are sustained when they are more reinforcing than prosocial behaviors. Both models have an emphasis on identifying and acting on the prosocial opposite of problem behaviors (i.e., substituting adaptive behaviors for maladaptive behaviors rather than simply removing maladaptive behaviors). And both models rely on social learning and posit that relationships can provide strong reinforcement. Thus, there is a natural integration of these behavioral components into a single treatment aimed at targeting the problem behavior of substance use and neglectful parenting.

Although both PMTO and RBT have demonstrated successful outcomes across populations relevant to FAIR (e.g., KEEP, a parent management training for families involved with child welfare; Price, Chamberlain, Landsverk, & Reid, 2009; and RBT for women addicted to opiates and/or cocaine who are pregnant; Jones, O'Grady, & Tuten, 2011), it should be noted that neither the PMTO or RBT curriculums are provided in their manualized and tested forms as part of FAIR. Rather, the behavioral components, principles, and key strategies (e.g.,

provision of incentives, use of behavioral monitoring charts) from these two practices were adapted with input from the original developer groups and integrated for the FAIR intervention. The “active” approach emphasizes ongoing engagement strategies throughout the course of treatment to help families maintain focus and stay on track to meet their goals. Treatment lasts approximately 8 months, with an initial intense level of contact that is titrated down over time.

FAIR General Strategies

The FAIR behavioral treatment integrates five major components (described in further detail next). To implement and integrate these components into one model, the FAIR team includes counselors, skills coaches, a resource builder, and a clinical supervisor. Counselors meet parents in their natural home and community environments and reinforce the use of prosocial strategies to accomplish the parents’ goals. As is common in EBPs for serious behavioral problems (e.g., Multidimensional Treatment Foster Care, Multisystemic Therapy), counselors are available 24/7 to provide support during times of high need. Sessions are action-oriented, involving role-plays and hands-on teaching of new skills in the environments in which they will be used, followed by practice assignments. Counselors are trained to find opportunities in every interaction to reinforce parents for positive gains, regardless of how small (Saldana, Chamberlain, Weber, & Rains, 2014). Counselors maintain frequent contact with CWS caseworkers to provide updates on progress and to ensure that treatment includes targeted goals on the CWS treatment plan.

FAIR Program Components

Teaching and Supporting Parenting Skills

Core components from evidence-based parenting interventions (e.g., PMTO, Forgatch & Patterson, 2010; MTFC, Chamberlain, 1998; KEEP, Chamberlain et al., 2008) include reinforcing positive parenting and child behaviors, setting non-harsh limits and following through, problem solving, and stress management. Because of the wide-range of

developmental needs of children from families referred to FAIR, the focus on child needs is topic driven, with an emphasis on reinforcing appropriate developmental expectations.

When children are living out of the home, parents receive parent skills coaching during visitations. In many instances, the caseworker allows the FAIR counselor to serve as the supervisor for supervised community visits. This allows for parenting practice in real-world environments such as the grocery store.

Skills coaching is provided to children who are experiencing either ongoing internalizing or externalizing behaviors. Skills coaching was drawn from the MTFC model for youth in foster care and encourages pro-social coping skills in the home, community, and school environments (Leve & Chamberlain, 2007). In FAIR, skills coaching includes helping children adjust to new routines or expectations from their parent who previously had not provided such expectations.

Addressing Substance Use in the Context of Parenting

The FAIR protocol includes components from the RBT model for the treatment of substance use (Jones et al., 2005), including use of functional assessments, graphing progress, safety contracting, day planning, and modification of physical and peer environments. The FAIR program simultaneously targets parenting and substance use, and addresses the relationship between these two domains. RBT protocols are modified to link achieving sobriety to the steps needed to be an effective parent. Substance use is viewed as a highly potent reinforcer that interferes with the ability to recognize the reinforcing aspects of parenting. In FAIR, parent skills training and hands-on in vivo parent coaching are provided and parental reactions in relation to drug cravings are addressed (e.g., coping with the stress of tough parenting moments in the absence of substances). Parents are able to feel successful, experience less parenting stress, and parenting moments can become reinforcing.

Behavioral treatment strategies are supported with frequent urinalysis (UAs). Because the majority of referred parents have a preference for substances that have a rapid time period for detection (e.g., methamphetamine

can leave the system within 72 hours; redwoodtoxicology.com), frequent urinalysis allows for both use detection and, when screens are negative, the opportunity for frequent positive reinforcement. It also allows for immediate intervention and use of a functional assessment to help address and modify the environments and behaviors contributing to substance use.

As will be described, negative screens are incentivized with FAIR bucks. When screens are positive, the counselor assists the parent in notifying the CWS caseworker of the parents' use. During the first 3 weeks of treatment, caseworkers are pre-taught that parents will likely have some positive screens as they work to achieve sobriety. However, ongoing knowledge of parental use is viewed as key information for caseworkers in making decisions regarding ongoing child safety.

Resource Building

To help maximize the potential for a reinforcement system that can offer meaningful incentives for parents and yet be sustainable for programs operating in real-world community mental health settings, a FAIR store was created as a key component of the intervention. A Resource Builder solicits donated goods allowing the program to provide parents with a range of high (e.g., voucher for free summer camp, membership to local children's museum, snow boots) to low (e.g., toothpaste, calendars, story books, nail clippers) value reinforcers. The reinforcers stocked in the FAIR store are deliberately linked toward a safer and healthier home/family environment.

The Resource Builder also identifies free or low-cost family events occurring locally each week (e.g., puppet shows, concert in the park) to provide suggestions for safe alternatives for family activities. These resources are provided to counselors to be utilized in creating day plans with parents and to help find activities to enjoy with their child.

Use of Incentives with FAIR Bucks

Positive parenting moments, negative UAs, progress made toward goals (e.g., completing job application), and other small successes are reinforced

with “FAIR bucks” that can be traded in for a range of items in the FAIR store. Parents “buy” items to address their costly ongoing needs such as child and parent clothing, hygiene items, school supplies, alarm clocks, and diapers. One goal of having parents earn the FAIR bucks used as currency in the FAIR store is to develop a sense of ownership and responsibility for obtaining items necessary for their children’s care.

Ongoing Engagement

FAIR team members utilize engagement strategies throughout treatment. This includes providing small incentives such as bringing the parent coffee for an early morning appointment focused on morning routines, or offering to provide a ride to an appointment (an opportunity to conduct a session in the car with the parent’s undivided attention). Text messaging is utilized as a time- and cost-efficient means of maintaining contact with parents, while providing a forum for ongoing encouragement, support, and reminders between in-person contacts (e.g., “Good luck on your job interview today! Can’t wait to hear how it goes!”).

Clinical Supervision

A supervisor is available to clinical team members to help problem-solve intervention needs throughout the week and assist with crisis management. The supervisor conducts a weekly team supervision meeting, which includes case coordination. Half-time counselors carry a caseload of approximately five mothers at a time, ideally with a diverse caseload (i.e., some mothers at the beginning of treatment with daily contact and others near the end of treatment with once-weekly sessions).

Methods

Recruitment and Randomization

Presentations were made by the first author to state and local CWS workers. Eligibility criteria were described, including: (1) referral to CWS for substance use and child neglect; (2) substances reported other

than/in addition to alcohol and marijuana; (3) child either remaining in the home or a reunification plan in place; (4) not already enrolled in substance use or parenting treatment; (5) mother was English speaking; and (6) living in the local county.

Mothers referred to the FAIR program were contacted within 48 hours of referral and screened by study staff over the phone. Of those referred, 21 were deemed to be ineligible, primarily due to already being enrolled in treatment. Eligible participants were met in person and IRB-approved consent forms and project descriptions were explained. Due to IRB requirements and the vulnerable nature of the population, all participants were informed that urinalyses that were positive for non-prescribed substances would be reported to their caseworker as part of mandated reporting for child safety. Three potential participants declined to participate. For those who consented ($n = 34$), a baseline assessment was scheduled to occur within 72 hours and of those, contact was lost with three mothers prior to conducting the assessment.

Randomization

As part of the developmental process of this study, the first five “feasibility” referrals were automatically assigned to the experimental FAIR condition. All additional referrals were randomized to either FAIR or to caseworker referred treatment as usual (TAU). Because of the vulnerable nature of this sample, randomization occurred at the time of consent rather than following the baseline assessment so that those randomized to TAU could be immediately referred to services as usual by their caseworkers. These services included traditional substance use treatment and 12-step programs, group (non-EBP) parenting classes, and individual and/or family mental health counseling from an array of mental health providers.

Participants

Thirty-one mothers involved with the CWS for child neglect and severe substance use (94% methamphetamine; 6% opiates; 100% polysubstance;

45% IV users; 6% HIV positive) were referred. Of the 31, 13 mothers were randomized to TAU and 18 mothers received the FAIR experimental treatment ($n = 5$ feasibility; 13 randomized). Ethnicity reflected regional demographics: 27 Caucasian (87.1%), 2 African American (6.5%), 1 Native American (3.2%) and 1 Pacific Islander (3.2%). Three of the 31 mothers (9%) endorsed a second ethnicity (1 Caucasian, 2 Native American).

At baseline, 24 of the mothers (77%) reported that their children had currently been removed from the home and most reported having more than one child ($M = 1.77$; $SD = 2.15$; Range = 1–11). The mothers had a history of repeated difficulties with the CWS; 51.6% reported having had one prior removal and 22.6% reported 2 prior removals. On average, mothers reported over 5 previous treatment attempts for their substance use. Table 1 provides baseline characteristics between both conditions. Randomization was successful, with no statistically significant differences between groups.

Assessment Procedures

Assessments were conducted at baseline, 6 months, and 12 months. Participants were met at places and times that were convenient for them to complete assessments and compensated for their time (approximately 3 hours) with \$100 gift cards to a retail store that provided goods ranging from groceries to gas to household items and clothing. Monthly check-in calls were made by the assessor to collect a brief monthly service utilization.

Measures

The Parent Daily Report (PDR: Chamberlain & Reid, 1987) is a 31-item ordinal questionnaire that records child behaviors in the previous 24-hour period. The PDR has been significantly related to the Becker Adjective Checklist and to home observation of the youth's aversive behavior. Test-retest and inter-observer reliability ranges suggest stable psychometric properties.

The Child Behavior Checklist (CBCL; Achenbach, 2001) consists of social competence and behavior problem items applicable to children ages 4–18. The CBCL has strong psychometric properties and has been utilized in a multitude of randomized trials evaluating child behavior.

The Parenting Stress Inventory (PSI; Abidin, 1995) was developed from the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent. Psychometrics are adequate.

The Brief Child Abuse Potential Inventory (BCAP; Ondersma, Chaffin, Mullins, & LeBreton, 2005) is a validated 33-item self-report questionnaire. The BCAP includes six subscales and has shown greater success at predicting neglectful parenting behaviors than other forms of maltreatment.

The Addiction Severity Index (ASI; McLellan, Luborsky, O'Brien, & Woody, 1980) is a standardized tool for evaluating days, amount, and kind of substance use, as well as psychosocial correlates of use (e.g., employment). This self-report assessment includes reports across the lifespan as well as in the last 30 days. Psychometric properties have been demonstrated in a number of studies.

Drug Cravings. Four questions regarding the parent's craving for substances were assessed. On a 7-point Likert Scale, mothers reported "in the last 24 hours" how often they had thought about using drugs, how strong their cravings were at their most severe point, how difficult it would have been to resist using drugs if available, and their overall rating of cravings. Cronbach's alpha for the scale was acceptable ($\alpha = .88$)

The Trauma Symptom Inventory (TSI; Briere, 1995) is a 100-item questionnaire that assesses posttraumatic symptomatology and psychological functioning. The TSI has demonstrated strong psychometric properties with a range of populations (Briere, 1995).

The Beck Depression Inventory (BDI; Beck & Steer, 1993) is a self-report, well-established, and widely used measure of depressive symptoms with acceptable reliability and validity.

Service utilization Survey (SUS). Monthly, participants were asked about participation in substance use, mental health, and child welfare services. This allowed for a strong assessment of what TAU services included. Rather than relying on what services clients were referred to from case notes, this allowed for an assessment of what clients reported they actually attended.

Results

Engagement

Of the 18 mothers in the FAIR condition, 94% ($n = 17$) engaged in treatment and 87% ($n = 16$) completed treatment. Of those randomized to TAU, 38% of mothers engaged in some substance use treatment (inpatient/outpatient), 69% received some mental health treatment, and 38% received some family/parenting therapy. However, only 3 TAU participants (23%) engaged in all three at some point in the study period. Because service utilization was obtained by self-report, completion of TAU treatment plans are unknown.

Clinical Outcomes

Given the pilot sample size and the range in presentation of participants, paired t-tests were used to evaluate the within participant change over time in parenting and substance use. It should be noted that only 13 mothers randomized to FAIR participated in the 12-month assessment (72%) as did only 9 of those randomized to TAU (69%). To assess for differences between those who did and did not complete their follow-up assessment, means and chi-square difference analyses were conducted on all baseline characteristics shown in Table 1. Of those randomized to FAIR, mothers who completed their follow-up assessment were more educated [$F(1, 17) = 13.74, p = .002$; completed = 13.5 ($SD = 1.21$); not completed = 11.43 ($SD = .98$)] experienced a marginally greater number of previous treatment attempts [$F(1, 17) = 4.05, p = .06$; completed = 5.5 ($SD = 4.72$); not completed = 1.71 ($SD = 2.06$)] and child removals [$F(1, 17) = 4.30, p = .06$; completed = 1.10 ($SD = .57$); not completed = 0.5 ($SD = .55$)]. Of mothers randomized to TAU, the longest period of

Table 1. Descriptive Characteristics of Mothers Referred to the FAIR Randomized Pilot

Characteristic	FAIR Group		TAU Group	
	Mean (SD)	range	Mean (SD)	range
Maternal Age	31.5 (7.69)	24–49	29.46 (5.19)	22–37
Years Education	12.67 (1.50)	10–16	12.08 (2.07)	8–16
Household Income	\$27,517 (21,870)	3–80K	\$18,309 (11,784)	2–40K
Age of First Substance Use	17.11 (5.70)	8–34	16.92 (3.84)	9–22
Number of Previous Treatment Attempts	4.06 (4.23)	0–15	5.85 (4.76)	0–12
Longest Period of Abstinence (months)	8.47 (8.49)	1–24	14.31 (15.18)	1–48
Number of Children	2.11 (2.56)	0–11	1.31 (1.38)	0–4
Number of Previous Child Removals	0.88 (0.62)	0–2	1.23 (0.73)	0–2
	Percentage		Percentage	
Target Child Currently Removed	54%		46%	
Any Child Removed	72%		85%	
Unemployed	61%		62%	
Full Time Employed	11%		15%	

Note: No significant differences were found between groups on any baseline characteristics.

abstinence was significantly different between those who completed their follow-up assessment and those who did not [$F(1, 12) = 6.09$, $p = .03$; completed = 20.11 mon ($SD = 14.91$); not completed = 1.25 ($SD = .50$)]. These baseline differences between those who did and did not complete assessments suggest a rigorous evaluation of the FAIR intervention. The following primary outcomes are shown in Table 2.

Parenting. At 6 months post-baseline, mothers receiving FAIR showed significant improvements in parenting and subsequent child functioning, as rated by the PDR and CBCL. By 12 months post-baseline, these positive parenting outcomes extended to include decreased parental stress and child neglect potential.

Table 2 Means (SD) and Within Participant Change Evaluated Using Paired *t*-tests, Within Condition for Mothers Referred to Treatment for Severe Substance Use and Child Neglect.

Outcome	Baseline		6 Months	
	FAIR	TAU	FAIR	TAU
Parenting				
Parent Daily Report	23.16 (11.18)	17.50 (12.02)	11.67 (5.68)	18.50 (10.61)
Child Behavior Checklist	53.30 (20.97)	42.71(20.77)	41.80 (19.74)	44.86 (22.05)
Parenting Stress Inv.	236.85 (39.81)	249.89 (46.53)	219.71(73.24)	250.78 (45.54)
Brief Child Abuse Potential	9.46 (5.12)	9.10 (6.81)	8.30 (5.59)	7.40 (6.88)
Substance Use				
Addiction Severity Index (ASI) – Drug Composite	.17 (.12)	.12 (.08)	.12 (.07)	.08 (.08)
ASI – Amphetamine Use (Days)	3.57 (8.84)	.70 (1.57)	0.42 (1.16)	1.30 (2.83)
Cravings Scale	3.07 (2.24)	3.91 (3.59)	2.64 (1.28)	2.27 (2.37)
Drug Problems Scale	5.42 (5.72)	5.64 (6.31)	4.50 (3.30)	3.18 (5.84)
Mental Health				
Trauma Symptoms Inv.	114.85 (42.72)	105.50 (50.34)	76.78 (33.46)	82.80 (41.23)
Beck Depression Inv.	20.57 (12.75)	22.20 (12.40)	16.14 (12.18)	17.10 (14.93)
Psychosocial				
ASI - Employment	1.92 (3.54)	3.50 (5.72)	6.50 (8.80)	5.10 (6.71)

Note: Not all participants completed every measure at every time point; these results represent maximum possible number of participants for a measure at a specific time point when paired with a subsequent time point. $p < .05$, change from T1 to T2 or T1 to T3. $p < .05$, change from T2 to T3.

Substance Use. Mothers randomized to FAIR reported significant improvements as rated by the ASI by 6 months post-baseline. By 12 months, mothers randomized to FAIR were not only more likely to have achieved and maintained sobriety, but reported significant decreases in cravings and problems related to substance use.

Mental Health and Ancillary Needs. Mothers randomized to FAIR showed significant improvements in mental health symptoms over time. FAIR mothers also showed increases in days of employment by 6 months.

Discussion

The promising pilot outcomes suggest the potential for the FAIR program to fill a substantial treatment gap for families involved in the CWS referred for substance use and child neglect. Results indicated that mothers who received FAIR were likely to engage in and complete their comprehensive treatment program. This finding is important given that mothers involved with the CWS who use substances typically demonstrate low rates (10–22%) of substance use treatment completion (Choi & Ryan, 2006). Moreover, only 46–62% of women in general (Brady & Ashley, 2005) typically complete treatment for their substance use, suggesting that mothers receiving FAIR engaged at higher rates than even the general population that use substances. When caregivers enter substance use treatment more quickly and complete at least one treatment episode, children who have been removed spend fewer days in out-of-home care and are more likely to be reunified (Green, Rockhill, & Fur-

rer, 2007; Smith, 2003). Thus, a treatment that successfully retains parents involved with CWS and addresses co-occurring parenting and substance use needs, might result in a significant reduction in the number of children who reenter the CWS as well as an increased rate of reunification.

Similarly, findings suggested that only 23% of mothers randomized to TAU received services related to substance use, parenting, and mental health needs. Although more mothers received at least one of these treatment components, the multifaceted needs of these mothers might have been overlooked. Theory suggests that the interplay between these treatment components might contribute to the intractable nature of

12 Months	
FAIR	TAU
6.60 (6.47)	9.50 (13.44)
35.63 (21.92)	34.00 (22.27)
216.54 (53.85)	236.75 (61.10)
6.81 (4.89)	6.11 (4.17)
.10 (.09)	.08 (.06)
0.00 (0.00)	3.33 (10.00)
1.75 (1.13)	2.11 (1.76)
2.67 (3.82)	2.00 (2.45)
77.5 (39.10)	67.44 (39.91)
12.0 (11.69)	14.78 (12.96)
6.46 (8.41)	3.33 (6.56)

parental substance use and child neglect. Indeed, secondary analyses across the entire sample (not shown) indicated significant correlations suggesting that as substance use decreased, so did problematic parenting and mental health symptoms.

Further evaluation is necessary, however, to determine the efficacy of FAIR. Indeed, although most indicators were not statistically significant, those randomized to the TAU condition also showed improvements related to parenting and mental health. It is possible that those who were exposed to higher dosages of TAU services were more likely to be retained in the study. There was a relatively large number of participants who were lost between the 6- and 12-month assessment periods for both conditions. It is unknown if those participants were more likely to have experienced negative outcomes. A secondary analysis indicated that those in the TAU condition who were lost between those time periods had yet to report engaging in any services. Thus, outcomes should be considered very preliminary yet rigorous, with the recognition that although the TAU condition is smaller, it also is made up of the portion of the sample that received some form of treatment throughout the study period. Moreover, difference testing between those who completed assessments and those who did not, suggested the possibility that more challenging cases were included in the FAIR than TAU follow-up analyses.

Study Limitations

In addition to sample size considerations, several other limitations should be noted. First, because of the developmental nature of this pilot, FAIR components evolved over the course of the study period. Second, because of the limited grant resources that were available with the K-award mechanism, more advanced methods for tracking participants through the 12-month study period were not possible. Third, although state archival data was requested in order to determine the system level outcomes that were achieved by participants, the state experienced a change in reporting procedures partway through the study period resulting in subsequent record keeping difficulties and unreliable data. Fourth, as is common with pilot projects, this sample was limited geo-

graphically and had limited racial and ethnic diversity. Finally, the FAIR intervention has not been evaluated for fathers. Despite these study limitations, results from the pilot suggest the potential for the FAIR program to fill a service gap worthy of further investigation. A recently federally funded evaluation of these services is underway which will allow for the necessary rigorous evaluation to determine the effectiveness of the FAIR program.

Conclusions

Despite repeated calls for the development of EBPs to address the needs of families referred for substance use disorders and child neglect, to date no such EBP exists. Efforts by Donohue and colleagues have demonstrated some success in treating different aspects of families that meet this profile such as reductions in substance use by adapting Family Behavior Therapy (2011). Other comprehensive models such as Multisystemic Therapy have undergone adaptations to address the needs of families involved in the CWS for substance use (Swenson et al., 2009). Models such as the MST-Building Stronger Families (MST-BSF; Schaffer, Swenson, Tuerk, & Henggeler, 2013) program have evolved from these practices, and have demonstrated promise in yielding reductions in drug and alcohol use and negative discipline, but do not focus on severe substance use such as methamphetamine or neglectful parenting behaviors. Importantly, however, the MST-BSF model has demonstrated success 24-months post baseline in achieving significant CWS outcomes including reduced odds of additional substantiated child maltreatment reports and reduced time for youth in out-of-home care.

The FAIR program was designed specifically to address the needs of families referred to the CWS for severe substance use (e.g., methamphetamine, heroin) and child neglect. Initial outcomes suggest that mothers who are referred to FAIR are likely to engage in and complete treatment, and to demonstrate positive outcomes related to substance use, parenting, and ancillary needs. Future research is necessary to determine if positive clinical outcomes are achieved, resulting in more distal system level positive gains. Given the intensity and resulting expense of integrated pro-

grams such as FAIR, economic analyses will be essential to determine if outcomes result in long-term cost savings. Nevertheless, this pilot demonstrated that it is indeed feasible to engage and retain a highly vulnerable and difficult-to-treat population that makes up a significant portion of the families that are most challenging who are referred to the CWS.

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Effects of Intensive Family Preservation Services in Rural Tennessee on Parental Hopefulness with Families Affected by Substance Use

Edwina Chappell

*Building Strong Families in
Rural Tennessee
Tennessee Department of
Mental Health and Substance
Abuse Services*

Kathryn Sielbeck-Mathes

Centerstone Research Institute

Randall Reiserer

Centerstone Research Institute

Hannah Wohltjen

Centerstone Research Institute

Wendy Shuran

Centerstone Research Institute

Elizabeth McNerney

Vanderbilt University

This article describes how Building Strong Families in Rural Tennessee (BS-FinRT) increased hopefulness and helped to promote the policy goal of developing a recovery focus among families with vulnerabilities. These outcomes were achieved by implementing collaborative strategies for addressing issues of child safety, substance use, and family stability. Early analyses of the program's outcomes indicated an unexpected positive influence on parent and child hopefulness. Further analyses found that changes in hope between baseline and discharge correlated positively with changes over the same time period in problem severity, general functioning, and mental health symptomology.

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The Child and Family Services Improvement Act (Public Law 109-288) supported 53 regional partnerships to improve the well-being, safety, and family permanency of children affected by methamphetamine and other substance use through interagency collaboration and integration of programs and services. In 2007, the Building Strong Families in Rural Tennessee (BSFinRT) project, a partnership of state- and community-based agencies, received a Regional Partnership Grant (RPG) award to create infrastructure and pilot a service model to address the complex needs of children ages 0–17 who were in or at risk of out-of-home placement due to parent/caregiver substance use. At the time, Tennessee was experiencing a methamphetamine epidemic that was taking a heavy toll on the health of children, exposing them to drug paraphernalia; toxic fumes; chemicals; adult violence; polysubstance use; criminal behavior; neglect; and physical, sexual, and emotional abuse. Research indicated that use of methamphetamine and/or other substances negatively influenced parenting (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). The state was further plagued by increases in prescription drug abuse. Child welfare workers had long recognized the impact of substance use on children and families and acknowledged that parents/caregivers with these problems were more likely to neglect and/or abuse their children (Fanshel, 1975; Jaudes, Ekwo, & Voorhis, 1995). In addition, the Tennessee Department of Children's Services (TDCS) had begun to report larger numbers of investigations and custody placements due to parent/caregiver substance use (BSFinRT proposal, personal communication, July 3, 2007).

Legal and State Contexts

Though Tennessee legislation resulted in action by law enforcement to stop the manufacturing and trafficking of methamphetamine in the state, methamphetamine abuse rates continued to rise, particularly in rural areas. Hence, Building Strong Families in Rural Tennessee (BSFinRT) was formulated as one effort to help strengthen families and move them toward recovery. Rural areas in the state, especially those served by BSFinRT, were experiencing high numbers of reports to child protective services and children entering state custody due to parental substance use (TDCS,

2006). Building Strong Families in Rural Tennessee (BSFinRT) was envisioned to bridge a significant gap in services. It would employ an evidence-based Intensive Family Preservation Services (IFPS) model with families. These service models were designed to address the multiple and multi-faceted issues facing families with children at risk of out-of-home placement and to both reduce such placement as well as enhance reunification efforts (Kirk, 2000; Kirk & Griffith, 2007).

The ultimate goal of BSFinRT was to decrease out-of-home placement, reduce parent/caregiver substance use, and improve parenting knowledge and skills. However, early analyses of the program's outcomes indicated an unexpected positive influence on parent and child hopefulness. This article will describe an evidence-based, family-centered intervention and elements of human interrelationships that helped instill greater hope among families who entered the program with very little.

Description of BSFinRT

Using an evidence-based Intensive Family Preservation Services (IFPS) model, Building Strong Families in Rural Tennessee (BSFinRT) focused primarily upon strengthening families by providing supports and services to the family as a unit. Eligible families from eight rural counties in the south central area of Tennessee—Bedford, Cannon, Coffee, Grundy, Franklin, Lincoln, Moore, and Warren—were enrolled into the program whenever there were slots available.

Implementation of BSFinRT was carried out by well-trained, compassionate, and respectful In-Home Specialists (IHS) dedicated to developing trusting relationships with program families, which proved to be a critical component of the intervention. Trusting relationships were established and maintained for approximately five weeks, with a maximum of 53 hours of face-to-face contacts per family, on average, over the course of the intervention. Services and educational strategies were tailored to the family's self-identified needs, goals, and values, with safety, child well-being, and permanency being the primary focus.

The IHS maintained flexibility throughout implementation, always taking into account the family's needs/desires, schedule, and circumstances. Safety was the first priority, so the initial task for the IHS was to create a safety plan for the families. Rapport-building was accomplished through

active listening. A variety of teaching methods including role-playing, coaching, direct teaching, audio/visual materials, and homework were used. These techniques helped family members learn new concepts and ways of relating to their children while providing multiple opportunities to practice and apply the information shared in a real-world context. For example, one parent reported, "I was taught skills to communicate with my boys properly and positively. We were given the proper tools and encouragement to build structure. We have learned about boundaries and have incorporated them into our lives as well. Not only has [the IHS] helped our family become more functional as a family, but [the IHS] has given us a pride in ourselves that every family should feel." This intensive and holistic approach took into account the individual, the relationship between individuals and the family, and was intended to help strengthen the family by building their knowledge, confidence, and skill.

In-home specialists provided a comprehensive range of services prescribed by the IFPS service model. These comprised professional services, from helping clients meet the basic needs of food, clothing, and shelter to the most sophisticated therapeutic techniques, including strategies for addressing issues facing families affected by substance use. Among the therapeutic processes used were skill-building, behavioral interventions, motivational interviewing, relapse prevention, rational emotive therapy, and other cognitive strategies. Almost all services took place in the home and/or in the community in which the problems were occurring. Based on the IFPS model, the IHSs taught families basic skills such as how to use public transportation, manage a budget, and, where necessary, obtain and/or navigate social services. They also worked with families to develop their knowledge and skills on child development, parenting, anger management, other mood management, communication, and assertiveness. The IHS linked families to, and helped ensure participation in, substance use treatment services, primary and behavioral healthcare, and support services (e.g., 12-step programs, children's community activities, or job/vocational training.).

With a caseload of two to three families, the IHS provided assessments (including developmental and psychosocial), counseling, and crisis intervention, and developed community support. On average, the IHS spent 8–10 hours per week in direct contact with the family for five to five

and a half weeks per family. (See Martens [2009] for information on typical model duration and dosage with families.) Low caseloads allowed for more access and higher therapeutic service intensity. BSFinRT services incorporated a single practitioner model, with a team backup for co-therapy and consultation. The IHS also taught strategies that involve modeling and descriptions of skills and behaviors, as well as role-plays and rehearsals of newly acquired skills. Teaching tools included skills-based video and audiotapes, workbooks, handouts, articles, and exercises. Families were seen as the expert on the child/family while the IHS was the expert on methods and skills that fit family needs. Services were flexible and available at times convenient to the families (24/7/365 for families in crisis). In-home specialists reached families within 24 hours of referral.

Families appreciated the respect, skills, and support of BSFinRT staff and credited the program in assisting them in maintaining care and custody of their children. A sample of comments collected at case closure or during evaluation activities confirms parental perceptions of the program's benefits:

- *“Me and my husband wouldn't be together; we'd probably be fighting over the kids or lost them by now over domestic violence.”*
- *“We probably wouldn't be together kids would be split apart. I think it would have turned out terrible.”*
- *“Without BSF, I don't know what we would have done. We didn't have money or insurance to go to a parenting class or anger management class. It was a blessing because I don't know if they would have let them keep up without this program.”*
- *“I probably would have lost my child, ended back locked up if I lost my child. That's what helped me get through”.*
- *(What helped was) “Having to go through all this and being scared that I'm that close to losing everything”.*
- *“I don't see it (BSF) getting any better as far as helpfulness. It was easy for all of us to be ourselves and talk. Programs like these should be like that”.*

Primary caregivers for BSFinRT were predominantly female (68%). Approximately 20% of the primary caregivers had more than 12 years of education and nearly 30% had less than a high school education. Further, the parents/caregivers were primarily white (94.8%). Forty three percent (43.3%) of the children in families served by the project were under the age of 6, with 23.3% categorized as adolescents (ages 13–17). After six years, BSFinRT had enrolled 276 unique families, of which 233 (84.4%) consented to participate in evaluation activities.

Measuring BSFinRT Outcomes

Local Program Theory was used in the development of a logic model that served to underpin a naturalistic longitudinal evaluation design for BSFinRT in which outcomes were measured on the children, parents/caregivers, and families at four time periods over a six-year period.

The BSFinRT evaluation included a number of assessment instruments as well as administrative data collection tools. The project wanted to measure the extent to which outcomes for families were improved, especially in relation to entry to custody, recurring maltreatment, family functioning, and well-being. Administrative data was used to examine entry to custody and recurring maltreatment. Family functioning was initially measured by the Family Assessment Device (FAD). The FAD uses a 4-point scale with 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. However, there have been some concerns about the sensitivity of the instrument for repetitive use. Another tool, the OQ-45.2, was employed as a measure of parent/caregiver well-being.

The OQ-45.2 (Lambert et al., 1996) is a 45-item questionnaire that measures overall mental health functioning and three subdomains—symptom distress (anxiety and depression), interpersonal relations, and social role. This instrument is an outcome-tracking and clinical support tool that allows clinicians to assess progress during behavioral health treatment. Response categories are 0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *frequently*, and 4 = *almost always*. A higher score indicates poorer functioning, and cutoff scores have been established for the total scale and each subscale that differentiate clinical and community normative populations. The possible score ranges and cutoff scores for the total scale and each subscale are as follows:

Total Score = 0-180, cutoff = 64; Symptom Distress = 0-100, cutoff = 36; Interpersonal Relations = 0-44, cutoff = 15; and Social Role = 0-36, cutoff = 12. Acceptable psychometric properties for validity and reliability of the questionnaire have been established (Lambert et al., 1996). Many parents/caregivers enrolled in BSFinRT did not meet the clinical cutoffs of the OQ-45.2, so another outcome instrument was piloted with families: the Tennessee Outcomes Measurement System (TOMS).

The TOMS is a reliable, valid, and sensitive repeated measure instrument that has been used to track the effectiveness of mental health interventions for youth with serious emotional disorders in the state of Tennessee since 2006. It was developed as a practical yet rigorous means of tracking the progress of children and adolescents receiving mental health services. The scales provide a parallel form for both parents/caregivers and youth measuring problems (e.g., depression, anxiety, risky behavior, etc.) and functioning (e.g., social, school, resiliency, etc.), hopefulness, and perceived problem severity. Hopefulness on the TOMS is measured using Likert-style questions on a six-point scale. A total score for the level of hopefulness is a simple sum of the four items for that scale with a range of 0 to 24. TOM's analysis was performed on primary parents/caregivers separated by gender. ANOVA was the analysis technique used with time as the repeated measure at baseline, discharge, 6 months, and 12 months. Initial analyses of TOMS data led to interesting findings related to hope and hopefulness.

Hopefulness

Hope has been defined in a variety of ways in the literature. Combining the multiple definitions found in their systematic review, Schrank, Bird, Rudnick, and Slade (2012) defined hope as "a primarily future-oriented expectation (potentially informed by negative experiences such as having a child removed from the home and placed into state custody) of attaining personally valued goals which give meaning and are subjectively considered possible and depend on personal activity or characteristics (e.g., resilience and courage) and/or external factors (e.g., resource availability, support and encouragement from the in-home therapist)" (p. 555). The researchers demonstrated that hope was positively correlated with self-efficacy, self-

esteem, empowerment, perceived recovery, spirituality, social support, and quality of life. Schrank and colleagues (2012) found that hope was negatively correlated with family problems, anxiety, depression, and barriers to employment. The authors indicate that hope is a central component of recovery; however, they caution that the determinants of hope are not well understood, particularly as hope relates to a family's perspective and potential for long-term recovery and overall well-being and stability (Schrank et al., 2012).

Further research has shown that hope is closely related to optimism, feelings of control, and motivation toward achieving one's goals (Snyder, 2002; Kashdan et al., 2002). Kashdan and colleagues (2002) found significant association among "hope and parental and familial functioning indices such as warm and nurturing parenting styles, cohesive and active family environment, adaptive coping strategies" (p. 441). Furthermore, hope significantly predicted psychological functioning beyond what was accounted for by social desirability, the severity of child symptoms, and optimistic attributions. Lloyd and Hasting (2009) identified hope as an aspect of positive psychology that correlates highly with well-being and resilience among parents of children with intellectual disability.

Snyder, Feldman, Taylor, Schroeder, and Adams (2000) emphasized the role of hopeful thinking in preventing problems and enhancing strengths. Snyder first conceptualized Hope Theory and defined hope as the overall perception that one's goals can be achieved. He hypothesized that goals needed to be of sufficient value to the individual so as to occupy conscious thought and that they need to be attainable yet challenging in nature—goals that are 100% likely to be achieved do not give people hope. Interestingly, individuals with the highest levels of hope tend to generate multiple pathways to goal achievement. Further, positive emotions correlate with perceived success in achieving goals and negative emotions correlate with perceived failure in achieving goals (Snyder et al., 2000).

The level of hope people have is related to their perceptions about themselves and their goals. People with higher levels of hope remember more positive comments and events about themselves, whereas people with lower levels remember more negative comments and events. Higher levels of hope are correlated with better coping skills, less depression, fewer harmful-to-recovery behaviors, and better interactions with caregivers (Hobbs & Baker, 2000).

Unintentional Look at Hopefulness

During the evaluation process it was observed that in-home specialists particularly emphasized the enhancement of parenting skills. As a result, parents enrolled in BSFinRT were consistently observed to interact in a more nurturing way with their child(ren), create routines where they never existed before, gain understanding in normal child development, set boundaries, and discipline more competently and appropriately. This enhanced parental self-confidence/efficacy was a key determinant of success within the Building Strong Families program, as it was explicitly designed to help families keep their children safely at home and out of state custody. Results from early analyses of data suggested that hopefulness among family members improved significantly over the course of their participation in the BSFinRT program (parent/caregiver, *rmANOVA* $p < 0.001$; child, *rmANOVA* $p = 0.024$) and that changes in hopefulness mirrored significant changes in other variables. Based on these initial results, the evaluation team undertook an analysis focused specifically on the relationships between hopefulness and the other variables of interest (Problem Severity, Functioning, and mental health symptomology).

Design and Analysis

Data from the two outcomes instruments (TOMS and OQ-45) were transformed into progress scores by computing the magnitude of change from baseline to 12-month follow-up. Measures for which positive change was represented by decreasing values (e.g., OQ-45) were calculated by subtracting baseline values from 12-month follow-up values, while measures for which positive change was represented by increasing values were calculated by subtracting 12-month values from baseline values. The effect in both cases was to compute the change (Δ) between baseline and follow-up, with positive progress scores representing positive change and negative progress scores representing negative change.

Progress score data sets were tested for normality and examined for distributional anomalies using IBM SPSS Advanced Statistics, Version 20.0 (IBM Corporation, 2011). Various plots were used (e.g., Q-Q, stem-and-leaf) to identify outliers, which were removed from the datasets to improve fit to a linear model. Assumptions of linearity were confirmed before applying Pearson's correlation test.

Our main objective was to evaluate how changes in hopefulness predict changes in other important indicators of mental health, such as personal and family functioning, problem severity, and mental health symptomology. Therefore, TOMS Hopefulness was selected as the reference variable (independent variable) for analysis of relationships among the other measures. Progress scores for hopefulness (Δ Hope) were computed, as well as those for Problem Severity (Δ ProbSev) and Functioning (Δ Func).

The OQ-45 scale scoring involved summing the participant's ratings on the Likert scale for items comprising each of the subdomain scores: Symptom Distress (SD), Interpersonal Relationships (IR), and Social Role (SR). The Total Score was calculated by summing across all 45 items. The higher the score on the scales, the more mental health symptomatology and the more debilitated the participant. Progress scores were calculated for OQ-45 (Δ OQ-45) and its subdomains (Δ SD, Δ IR, and Δ SR) and each was evaluated against Δ Hope.

Children age 12 or older ($N = 23$, 11 boys and 12 girls) who had provided TOMS data were matched with their parent/caregiver for analysis of hopefulness. Δ Hope was calculated for children in the same way as for adults. Δ Hope for children was evaluated against Δ Hope for adult caregivers.

Results

Repeated measures ANOVA of BSFinRT data collected at baseline, program discharge, 6 month, and 12-month follow-up revealed enhanced family functioning, improved mental health symptomology, less perceived problem severity, and more hope. The analysis reflected sustained higher levels of hopefulness and decreased perceptions of problem severity among parents and youth from the most successful families in terms of sustained recovery, permanency, and overall stability.

Changes in hope between baseline and discharge correlated positively with changes over the same time period in problem severity, general functioning, and mental health symptomology (see Table 1). Participants who made the most progress in terms of hopefulness improved most in these other measures. Progress in hopefulness in children correlated with that in parents ($r = 0.436$, $n = 23$, $p = 0.037$), suggesting that children get cues about how hopeful to be from their primary caregiver(s). To further

Table 1 Pearson's test statistics for correlations between progress scores calculated for hopefulness and those calculated for the scales and subscales listed. The subscales of the OQ-45 instrument appear in italics.

Progress Score	Pearson's rho (<i>r</i>)	Sample size (<i>n</i>)	Significance (<i>p</i>)
Δ Problem Severity	0.356	69	0.003
Δ Functioning	0.538	66	< 0.001
Δ OQ-45	0.491	71	< 0.001
Δ <i>Symptom Distress</i>	0.459	69	< 0.001
Δ <i>Interpersonal Relationships</i>	0.334	69	0.005
Δ <i>Social Role</i>	0.427	71	< 0.001

examine how parental hope affected child hope before and after the intervention, we compared parent/caregiver raw baseline data with child raw baseline data and parent/caregiver 12-month follow-up data with child 12-month follow-up data. We found no correlation between parent/caregiver and child baseline data ($r = 0.190$, $n = 23$, $p = 0.368$), but the 12-month follow-up data showed a strong correlation ($r = 0.601$, $n = 23$, $p = 0.002$) further indicating that the program aligned the feelings of adults and their children in a positive way.

A qualitative content analysis was also conducted on statements collected from family members at program discharge and follow-ups. Themes identified from statements concerning the key impacts were summarized in the following ways: improved communication, improved parenting skills, set common family goals, and gained a sense of hope. Many respondents perceived that they had improved their skills, or gained new ones, in parenting, decision-making, coping, and communication. As one participant noted, "I have really enjoyed working and learning new skills and tools from [the in-home therapist]. My children (especially my 8 year old) have responded to my new parenting skills which makes my life easier, leaving me more time to spend with my kids." Families felt they were now equipped with resources to help them and valued the opportunity to set goals and learn new things together. Some participants also perceived that their lives were better following the program and that a

beneficial change had occurred. One participant responded, “I love it. I wish they could stay longer. My family was being torn apart before BSF had come. Now, since they came out, my family is getting close again.”

Importantly, BSFinRT participants also emphasized their positive views of the future following their participation in the program. Responses indicated optimistic and confident forward thinking, both in terms of respondents’ attitudes about their family interactions, as well as their intentions to continue developing the skills they had gained during their time in the BSFinRT program. One respondent commented, “I’m glad me and my family had this opportunity to work with [the in-home therapist] and the BSF program. It’s helped me understand things and I know my future and the future of my child is bright!”

Conclusions

The positive impact on hope directly was unanticipated; however, upon closer consideration of the intervention strategy, this finding made logical sense. The BSFinRT in-home specialist created an environment that helped empower families to set relevant goals, then nurtured and supported them in being successful in achieving the goals they had set. This success enhanced their hopefulness particularly as it related to their ability to be effective parents.

Implications for Child Welfare

This article describes how BSFinRT increased hopefulness and helped to promote the policy goal of developing a recovery focus among families with vulnerabilities. These outcomes were achieved by implementing collaborative strategies for addressing issues of child safety, substance use, and family stability. This was accomplished primarily through intensive and intentional time spent by IHS fostering positive relationships, helping families to assume control and to formulate and pursue realistic goals, implementing a myriad of intervention strategies to support self-efficacy, empowerment, and well-being all while consciously maintaining unconditional positive regard throughout the process.

To address complex problems like family instability, addiction, unemployment, unhealthy relationships, poverty, and child welfare involvement,

BSFinRT had to be a comprehensive, multifaceted intervention aimed at changing a variety of outcomes. In response, the evaluation had to employ multiple methods and perspectives to identify and measure impact of these interventions that were often not easy to see or describe. While the IFPS Model does not expressly claim to impact hope among families at risk, the core principles, philosophy, and overall approach positively impacted hope among some of our BSFinRT families. Hope, in this circumstance, linked to goal-directed energy and the capacity to establish strategies to achieve self-set goals focused upon strengthening the family so that children ultimately experienced greater safety, well-being, and permanency.

The process of supporting families as they established their own goals—helping them to set timeframes for achievement and concrete evidence of success, then celebrating that success—helped families to see a light at the end of the child welfare tunnel. We believe that hope was connected to the family's sense of possibility: the greater their perception of possibilities, the greater their hope. Families coming into BSFinRT with a greater propensity for hope naturally gained the most. Unfortunately, families with the most constricted view of possibility experienced lower levels of hope during their enrollment in BSFinRT.

Positively impacting hope was a significant accomplishment among some of the families served. When hope is damaged, it affects more than one person. When real hope is denied, it is hard to replace. When a family has lost hope, it is difficult to find motivation to seek mental health care, remain sober, parent competently, and/or maintain employment. Hope among families at risk of child welfare involvement is not an option; it is a requirement. Programming to help strengthen families must actively work with families in order to find ways to build hope for a better life for themselves and their children, always remembering that hope breeds hope.

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