

Access to Substance Abuse Treatment in Child Welfare

Sam Choi¹, MSW, Ph.D.

Abstract

This article presents the results of a study that evaluated the efficacy of Recovery Coaches in increasing substance abuse treatment access in timely manner, using a randomized experimental design with 200 custodial parents in the child welfare system. The primary goal of Recovery Coaches is to engage parents in treatment for recovery through a proactive case management strategy. Recovery Coaches were associated with (1) higher rates of service access and (2) more timely access.

Keywords: substance abuse, child welfare, service access, case management

1. Introduction

The core mission of child welfare is to protect children from the risk of maltreatment and increase family capacity (Pecora, Whittaker, Maluccio, & Barth, 2000). Yet this mission is often obstructed by parental substance abuse. Addiction to alcohol and drugs interferes with appropriate parenting practices and increases the risk of child maltreatment (Famularo, Kincherff, & Fenton, 1992; Jaudes, Ekwo, & Van Voorhis, 1995). Moreover, parents who are unable to engage or complete substance abuse treatment programs experience significant delays in family reunification. The children in substance abusing families remain in substitute care placement for significantly longer periods of time (Lewis, Giovannoni, & Leake, 1997). Thus, as many as two-thirds of children in out-of-home care are from families with substance abuse problems (Besigner, Garland, Litrownik, & Landsverk, 1999). For these reasons, it's important to identify intervention strategies that facilitate the recovery process for parents involved with the child welfare system.

Although there is a clear linkage between parental substance abuse and negative impacts on the well-being of children, current knowledge on successful intervention strategies for substance abusing families in child welfare is limited. Four major challenges in working with substance abusing parents have been noted in past research. First, treatment utilization is often low and engagement in substance abuse treatment is often difficult (Simpton, Joe, Rowna-Szal, & Greener, 1997; Hser, Anglin, Grella, Longshore, & Predergast, 1997). For example, according to 1998 GAO report, among custodial mothers with substance abuse problems, approximately one-third had never been in treatment. Within this same group, only 20 % had either completed or were enrolled in AODA treatment. A more recent report of Substance Abuse and Mental Health Administration (SAMHSA)'s National Survey on Drug Use and Health highlights that 26.3 million people needed treatment for an AODA problem. Yet 94 % of people with substance use disorders did not receive treatment.

Second, although studies revealed that the length of treatment is positively related to treatment outcome, dropouts and relapse are prevalent among substance abusers (Hser et al., 1997). The Drug Service Research Survey revealed that about 40% of a nationally representative sample of admissions to drug treatment did not complete their treatment (NIDA, Office of Technology Assessment, 1992).

Third, there is a national shortage of accessible services for substance abusers, especially for women with children (Marsh, D'Aunno, & Smith, 2002). The lack of child care, housing, and transportation issues are often identified as likely barriers to available services for women with children.

¹ Department of Social Work, Psychology and Counseling, Alabama A & M University (e-mail: sam.choi@aamu.edu)

A 1997 Child Welfare League of American study of state child welfare agencies estimated that almost two-third of parents in the child welfare system required substance abuse treatment services, but child welfare agencies were able to provide treatment for only one-third of the families who needed it (Young, Gardner, & Dennis, 1998). Moreover, the waiting period for parents to get into available treatment was up to 12 months in most states.

Finally, prior research indicates that working with substance abusing families is the most complex task because the existence of co-occurring problems such as poverty, domestic violence, health, mental health, social, or legal problems (Maluccio & Ainsworth, 2003). Such co-occurring problems are negatively associated with treatment outcome if those need are not addressed in treatment (Campbell & Alexander, 2002).

Policy Context. Given the difficulties associated with treatment engagement and completion, the Adoption and Safe Families Act (ASFA) presents a unique problem for those attempting to achieve family reunification in a shorter period of time, and emphasizes the need for effective treatment strategies. ASFA reduces the maximum allowable time for making permanency decisions to 12 months rather than 18 months under the previous law. Child welfare professionals face the greater challenges of identifying indicators for safe reunification or termination of parental rights within this 12 months time frame. This shortened time frame, in combination with poor treatment outcomes, makes family reunification difficult for substance abusing families.

To address these challenges, a variety of collaborations among multiple systems have emerged. The intent of these collaborations is to provide an integrated service response. In part, integrated service systems attempt to eliminate barriers that obstruct access to adequate care. These collaborative efforts often utilize innovative practice strategies. One such strategy is the use of a Recovery Coach. Recovery Coaches were implemented in Illinois through close collaboration between the child welfare system and AODA treatment systems. Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts via working with parents, child welfare caseworkers, and AODA treatment agency. The goal is to engage and retain parents in treatment and other services needed for recovery. The primary responsibility of the Recovery Coach is to facilitate access to services and re-engage parents in treatment when necessary. Illinois is currently in the midst of a five year waiver demonstration to better understand the efficacy of Recovery Coaches in child welfare.

Why Recovery Coaches? The potential usefulness of Recovery Coaches is supported by the literature, where there are indications that aggressive case management can increase engagement and retention among families with substance abuse problems (Maluccio & Ainsworth, 2003). Clients that receive support and services responding to identified needs through aggressive case management tend to stay in services longer (Hser et al., 1997), reduce their substance use (Smith & March, 2002), reduce their criminal activities, and improve their functioning in areas where they have received targeted services (McLellan, Frisson, Zanic, Randall, Brill, & O'Brien, 1997). A Title IV-E Waiver demonstration in Delaware focused on a multi-disciplinary treatment team to link clients with substance abuse treatment and on-going assessment, and removes the engagement barriers (Delaware Division of Family Services, 2002). The evaluation found that this approach was effective at decreasing resistance and improving treatment access. Marsh, D'Aunno and Smith (2000) studied the relationship between treatment access and treatment outcome. The authors conclude that those who receive the transportation, outreach, and child-care services were more likely to use the service that, in turn, reduces the substance use. Brindis and colleagues (1997) found that connecting substance abuse treatment with intensive case management services improved treatment engagement and other desirable outcomes.

Prior studies in this area have made a valuable contribution to the field. Yet there is still little understanding of the factors related to treatment access. The vast majority of evaluations of substance abuse in child welfare focus on the duration and frequency of treatment participation. Far less attention has been paid to ensuring timely access to initial treatment. Given the conflicting time frames among between ASFA, recovery from substance abuse, and child development, successful interventions highly depend upon a timely access to treatment. The purpose of the current study is to investigate the efficacy of Recovery Coaches in increasing treatment access in timely manner.

The current study also focuses on the comprehensive nature of services (or access to a wide range of services). Specifically, this study addresses the following research questions:

1. Does the use of a Recovery Coach shorten the amount of time it takes substance abusing parents to access treatment?
2. Does the use of a Recovery Coach increase the percentage of families accessing treatment?

3. Does the use of a Recovery Coach shorten the amount of time it takes to access a variety of treatment services? We focus specifically on detoxification, outpatient, intensive outpatient, and residential services.

2. Methodology

This study is part of a larger research effort funded by the provisions of Title IV-E waiver with the Children's Bureau of the Administration of Children and Families. This research effort is to evaluate the five year Illinois Alcohol and Other Drug Abuse (AODA) waiver demonstration project. The general goal of the AODA waiver project was to improve permanency outcomes with substance abusing families by the use of a Recovery Coach.

2.1. Procedures

A classic experiment was conducted. Research participants are custodial parents with cases opened on or after April 28, 2000 in Chicago and suburban Cook County. To qualify for the project, substance abusing parents were referred to the Juvenile Court Assessment Project (JCAP) at the time of their temporary custody hearing or at any time within 90 days subsequent to the hearing. JCAP staff assessed the parents referred by the Court or child welfare workers and made an initial treatment recommendation and referral for services. Once it had been determined that substance abuse was an issue, families were randomly assigned to either the control or experimental group. Members of the experimental group were referred to a Recovery Coach. Recovery Coaches were expected to meet the substance abusing parents within 48 hours. The control group received the existing package of substance abuse treatment services without a Recovery Coach. As of March 31, 2003, 532 parents were participating in this five-year waiver project: 164 parents in the control group and 368 parents in the experimental group. Informed consent was necessary to access the substance abuse treatment records of these parents. Of the 534 cases, 200 signed the letter of informed consent (148 experimental group, 52 control group).

2.2. Sources of Data and Measures

JCAP assessment data provided a variety of demographic information, substance abuse histories and other problem areas. Time to first service was measured by the number of days between JCAP and the date of first service episode. Department's Automated Reported and Tracking System (DARTS) data allowed having information such as intake date and service setting. The specific types of services also come from the DARTS system. In the current study we limit our analyses to the most common types of substance abuse treatment - detoxification, outpatient, intensive outpatient, and residential.

2.3. Data Analysis

Bivariate analyses were conducted to describe and compare the experimental and control groups. We then developed life tables to understand the impact of recovery coaches on the time it takes parents to access substance abuse treatment. Life tables censor observations. That is, cases are dropped from subsequent risk sets if they have yet to experience the event of interest (service access) prior to the end of data collection. As families were randomly assigned at different points in time, this analytic technique is appropriate.

3. Results

Table 1 displays basic demographic and drug use characteristics of the sample. There are no significant differences between the experimental and control groups. Thus, the random assignment worked and the issue of informed consent (i.e., not everyone granting such consent) did not compromise the equivalency of the two groups. The subjects averaged 33 years of age. Women accounted for over 75 % of the total sample. Most study participants were African American. Ten percent of parents were married and the majority of parents (73 %) were never married. Almost half of study participants reported that they live with family while 22 % of parents reported that they live alone. Over 50 % of the sample had less than a high school education.

Nearly 75 % of the subjects were unemployed and 35 % of all population were receiving public aid. The average number of children per a parent was five and the average number of SEI (Substance-Exposed Infant) per a parent was four. Almost 60 % of the subjects reported to having previous substance abuse treatment history and 18 % of all participants had a treatment history due to emotional or mental disorder. Over 90 % of the sample experienced social problem due to substance use and 33 % of participants experienced of legal problem due to substance use. Almost one fifth of study participants reported to experiencing physical abuse. Their primary choice of substance was cocaine (40 %), opioids (27 %), alcohol (25 %) and marijuana (8 %), respectively.

Table 1. Demographic Statistics: The Characteristics of Parent

		Control Group	Experimental Group
		N (% within group)	N (% within group)
Overall		52 (100)	148 (100)
Gender	Male	14 (26.9)	39 (26.4)
	Female	38 (73.1)	109 (73.6)
Race	African American	43 (82.7)	120 (81.1)
	Caucasian	5 (9.6)	19 (12.8)
	Others	4 (7.7)	9 (6.1)
Marital Status	Married	8 (15.4)	11 (7.4)
	Never Married	36 (69.2)	110 (74.3)
	Others	8 (15.4)	24 (18.3)
Employment	Unemployed	32 (80)	98 (83.1)
Education	Less High School	31 (59.6)	84 (56.7)
Living Situation	Family	26 (50)	72 (49.3)
	Friends	9 (17.3)	27 (18.2)
	Alone	13 (25)	30 (20.3)
	Homeless	2 (3.8)	10 (6.8)
# of Children	1	7 (14.3)	11 (8.1)
	2-3	18 (36.8)	37 (17.5)
	More than 4	24 (48.9)	87 (64.4)
# of SEI	0	14 (26.9)	34 (23)
	1-2	18 (34.6)	42 (28.4)
	More than 3	20 (38.4)	72 (48.6)
TANF		23 (44.2)	55 (37.2)
Medical Problem		17 (33.3)	52 (37.7)
Mental Health Problems		52 (100)	147 (99.3)
Previous Treatment History			
	Substance Abuse	25 (48.1)	95 (65.1)
	Mental Disorder	10 (19.2)	25 (16.9)
Type of Substance Abuse			
	Alcohol	15 (28.8)	34 (23)
	Cocaine	21 (40.4)	58 (39.2)
	Marijuana	4 (7.7)	12 (8.1)
	Opioids	12 (23.1)	41 (27.7)
Age			
	Mean	32.69	33.80
	Median	31.66	33.37

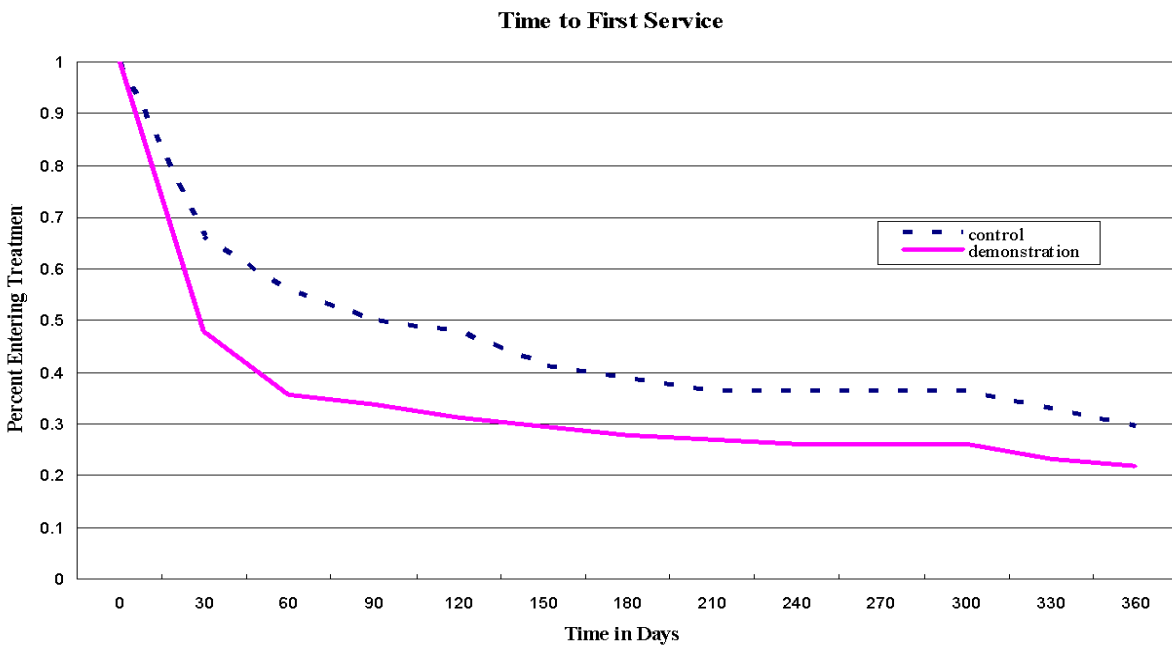
Table 2 describes the referred types of services by group memberships. At the JCAP assessment, 32.4 % of parents in the experimental group and 23.1 % of parents in the control group were referred to detoxification service (total n=60). In terms of referral to outpatient services, there were 25.7 % of parents in the experimental group and 19.2 % of parents in the control group (total n=48). While 24 % of parents in the experimental group were assigned to intensive outpatient services (total n=76), 19.2 % of parents in the control group were assigned to the same type of service. Among study participants, 38.5 % of parents in the experimental group and 40.4 % of parents in the control group were referred to residential services (total n=78).

Table 2 Descriptive Statistics: Types of Referrals

Types of Referrals	Control Group N (% within group)	Experimental Group N (% within group)
Detoxification	12 (23.1)	48 (32.4)
Intensive Outpatient	10 (19.2)	38 (25.7)
Outpatient	17 (32.7)	59 (39.9)
Residential	21 (40.4)	57 (38.5)

Figure 1 illustrates the survival lines indicating time to first treatment between the experimental group and control group. Observation of Figure 1 reveals that the survival lines split into different trajectories after 30 days. At 60 days, 56 % of parents in control group were not involved in their first treatment in contrast to 36 % of parents in the experimental group. The estimated risk of not accessing substance abuse treatment for the two groups within the 1 year time period was 23 % for the experimental group and 33 % for the control group. Comparison of the survival lines was performed using the Wilcoxon (Gehan) statistic (5.627, df=1. $p = .0177, p < .05$). The result highlights that the trajectories of these lines are significantly different.

Figure 1: Life Table. Time to First Service



The survival lines in Figure 2 illustrate the time to detoxification services between the two groups over time. The survival lines split at 30 days. At 60 days, 92 % of the parents in the control group were not involved in detoxification service (8 % of involvement) compared to 76 % of parents in the experimental group (24 % of involvement). The estimated risk of not accessing substance abuse treatment for the two groups within the 1 year time period was 66 % for the experimental group and 76 % for the control group. An average 68 % of participants with detoxification referrals did not receive their service within a year. The Wilcoxon (Gehan) statistic (4.610, df=1. $p = .031, p < .05$) reveals that the trajectories of two lines are significantly different.

Figure 2: Life Table. Time to Detoxification

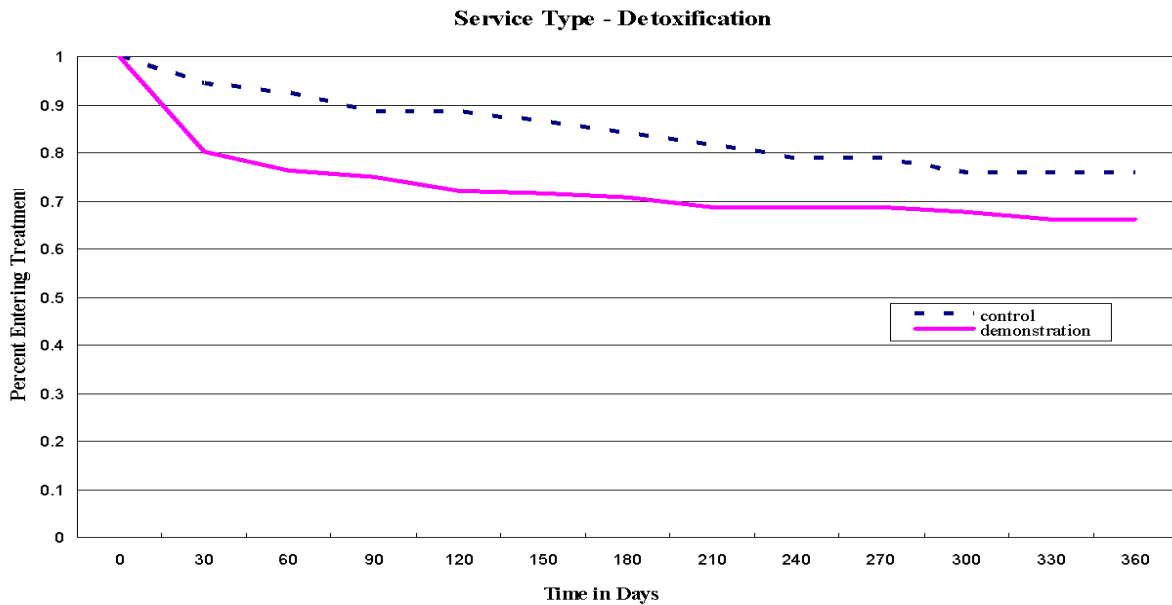
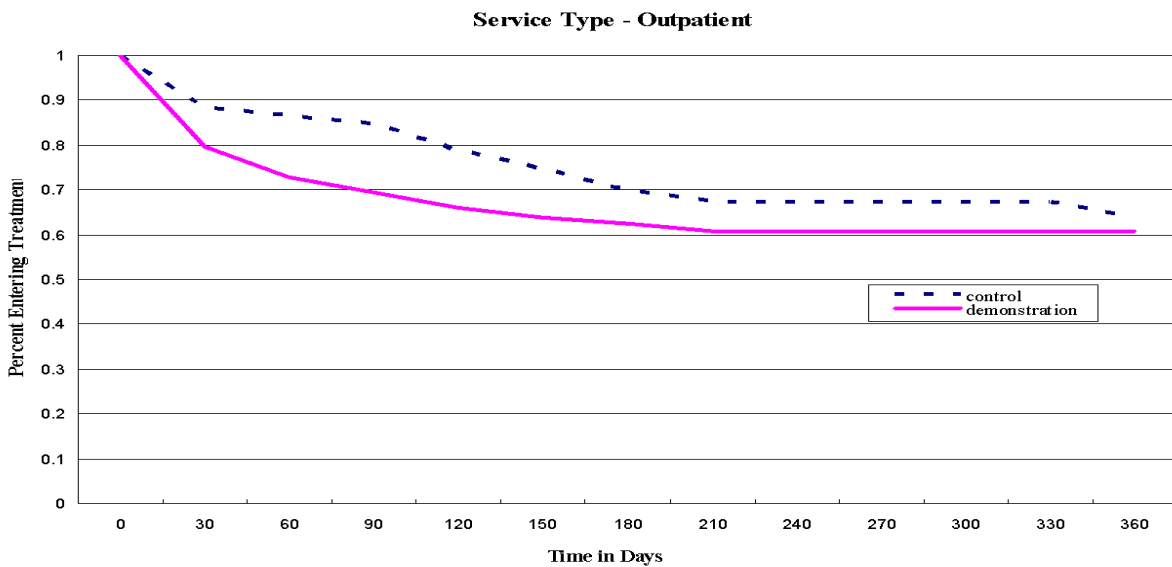


Figure 3 illustrates the time to outpatient service between two groups over time. The two lines diverged 30 days after the referral was made. At 60 days, 87 % of parents in the control group were not involved in outpatient service (13 % of involvement) while 73 % of parents in the experimental group were not involved in outpatient service (27 % of involvement). One year after the initial referral was made, 60 % of the experimental group and 63 % of the control group did not attend their first outpatient treatment (an average of 61 % with no enrollment). Comparison of the survival lines was performed using the Wilcoxon (Gehan) statistic (2.227, df=1. $p=.135$, $p >.05$) and indicates that the trajectories of two lines are not significantly different.

Figure 3: Life Table. Time to Outpatient Service



The survival lines illustrate the time to intensive outpatient service between the two groups over time. Observation of Figure 4 reveals that the survival lines have equivalent trajectories up to the 12 months. At 60 days, 88 % of the parents in the control group were not involved in intensive outpatient service (12 % of involvement) while 86% of the parents in the experimental group were not involved in intensive outpatient service (14% of involvement). The estimated risk of not accessing substance abuse treatment for the two groups within the 1 year time period was 76 % for the experimental group and 80 % for the control group.

An average, seventy-seven percent of all participants did not enroll in their intensive outpatient. The Wilcoxon (Gehan) statistic (.160, df=1. $p=.689$, $p >.05$) indicates that the trajectories of two lines are not significantly different.

Figure 4: Life Table. Time to Intensive Outpatient Service

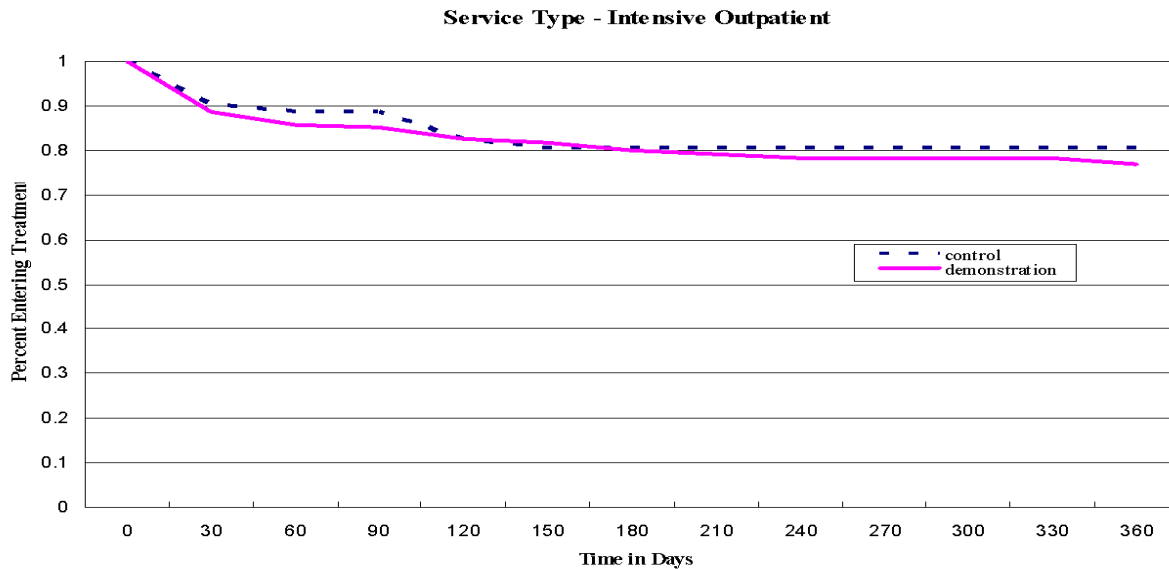
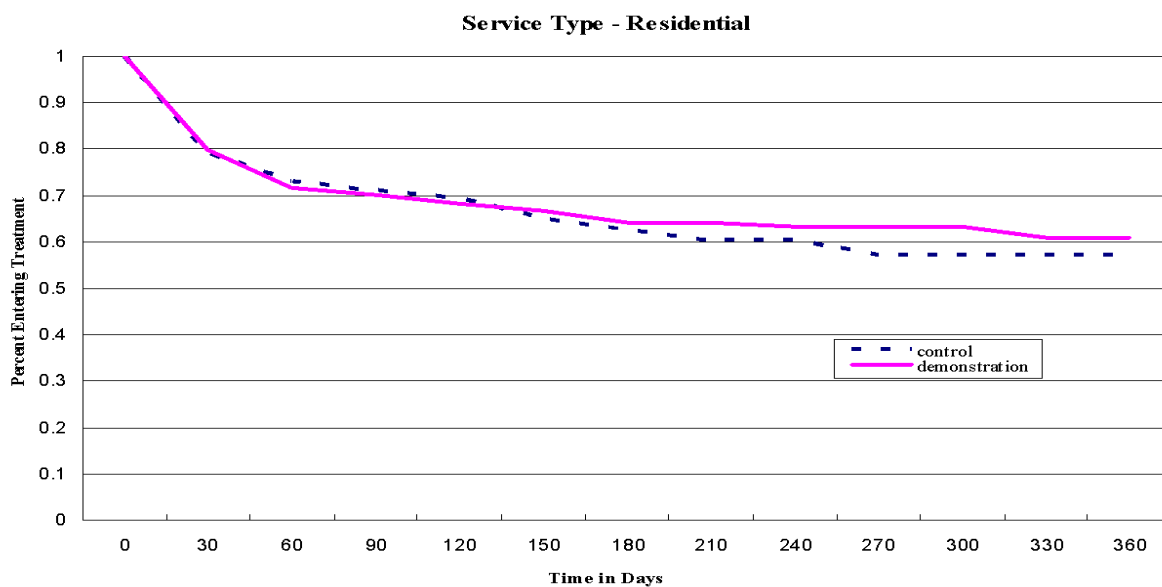


Figure 5 illustrates the time to intensive outpatient service between two groups over time. Survival lines have equivalent trajectories up to the first 6 months with the lines splitting after this point with survival rates of approximately 62 % for the experimental group and 57 % for the control group. When survival lines were compared over the time period, the Wilcoxon (Gehan) statistic (.120, df=1. $p=.729$, $p >.05$) did not reach significance.

Figure 5: Life Table. Time to Residential Service



4. Discussion

The goal of the current study was to evaluate the efficacy of the use of Recovery Coaches in increasing treatment access with a timely manner. The primary goal of Recovery Coaches is to increase a parent’s limited opportunities for recovering from addiction by facilitating service access. The participants in this research were randomly assigned to either an experimental or control condition. The control group received services as usual. The experimental group received services as usual plus the services of a recovery coach.

We hypothesized that the use of Recovery Coaches would improve treatment access. This hypothesis was based on prior research which indicates that aggressive case management case management is associated with positive outcomes of treatment access (Hser et al., 1997).

The findings indicate that the use of a Recovery Coach is associated with higher rates of initial service access. Specifically, 50 % of the parents in the experimental group accessed services within the first 30 days. In contrast, parents in the control group reached 50 % of access to substance abuse services at nearly 90 days. Given the importance of early enrollment to treatment, successful intervention should reflect treatment access in a timely manner. As such, the use of Recovery Coaches is an important component of successful intervention for substance abusing parents in the child welfare system.

This study also focused on the time it takes parents to access specific types of services. No previous studies have investigated the issue of access time for particular types of services. We hypothesized that the use of Recovery Coaches would also improve access time to a wide range of service types. The findings indicate that although the experimental group generally appeared to access services more often, the use of Recovery Coaches only improved the timely access to detoxification services. At 30 days, 20 % of the experimental group with Recovery Coaches entered detoxification services while only 6 % of the control group did so. At 90 days, only 12 % of the control group accessed detoxification service. In contrast, 25 % of experimental group accessed the detoxification services.

The most striking finding of this study is that more than half of parents failed to access to their referred services within the 1 year time period. Specifically, sixty parents were referred to detoxification service at the initial assessment. However, thirty-six parents (68 %) remained without the service within the 1 year time period. Thirty parents (61 %) in outpatient service, fifty-nine parents (77 %) in intensive outpatient service, and forty-seven (60 %) in residential services failed to enter their recommended services. These rates must be improved. Special assistance is needed for substance abusing parents in accessing to those services.

The present study points to the need for future research to fully evaluate the efficacy of Recovery Coaches in service access. Perhaps the most basic issue to be addressed is the further investigation of the mechanism between the Recovery Coach and service access. What aspects of Recovery Coaches work in increasing service access? Some studies found that the program characteristics such as program policies, quality of staff or variety of service provided, or interaction of those were related to client engagement (Campbell, & Alexander, 2002; McLellan et al., 1997). However, the validity of these studies varies, and the studies are limited by design flaws, including a lack of comparison groups, low response rate, and small number of homogenous samples. Incorporated with Recovery Coach variables, this unique experimental design would allow advanced investigation and permit causal inference to understand the mechanisms of access. As such, we will determine what component of Recovery Coach makes access better and why some parents are more likely to access treatment. Second, future work could also look at the effects of early service access on service retention and completion, and in turn, the permanency outcome. This would address the question of whether those who accessed services earlier stay longer in treatment or complete treatment more frequently than those who did not. Finally, future research should determine the causes of this low utilization of particular types of services. What are the factors that prevent clients from entering particular types of services? Is this result related to the shortage of available substance abuse services? Were all services available at the time services were needed in their community? Many reports clearly indicate that there is a national shortage of substance abuse treatment for women (Marsh, D'Aunno, & Smith). Considering the majority of subjects of this study are women, it is possible that service unavailability or long waiting lists contribute to this low utilization rate regardless of whether they receive Recovery Coaches.

5. Conclusion

The abuse of alcohol and drugs compromises parenting practices and thus decreases the likelihood of family reunification. Consequently, children in substance abusing families experience significantly longer stays in substitute care settings. Given the conflicting time frames among ASFA, recovery from substance abuse, and child development, successful interventions must facilitate a timely access to treatment. The purpose of this study was to investigate the efficacy of the use of Recovery Coaches in increasing treatment access. The results of this study suggest that the use of Recovery Coaches is associated with (1) higher rates of initial service access and (2) a more timely access to their first services. With regards to specific services, Recovery Coaches significantly improved accessed to detoxification. If child welfare practitioners and policy makers are interested in developing treatment strategies grounded in empirical evidence, the findings from the current study cannot be ignored.

Substance abusing parents in the child welfare system experience a host of negative outcomes - identifying and rigorously testing interventions to improve these outcomes is critical.

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