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# Substance Abuse Interventions for Parents Involved in the Child Welfare System: Evidence and Implications

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**SUMMARY.** As child welfare systems across the country face the problem of parental substance abuse, there is an increasing need to understand the types of treatment approaches that are most effective for substance-abusing parents in the child welfare system—the majority of whom are mothers. This structured review of the literature focuses on evidence related to two areas: (1) individual-level interventions designed to assist mothers and women in addressing their substance abuse problems, and (2) system-level interventions designed to improve collaboration and coordination between the child welfare system and the alcohol and other drug system. Overall, research suggests the following program components may be effective with substance-abusing women with children: (1) Women-centered treatment that involves children, (2) Specialized health and mental health services, (3) Home visitation services, (4) Concrete assistance, (5) Short-term targeted interventions, and (6) Comprehensive programs that integrate many of these components.

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Research also suggests that promising collaborative models between the child welfare system (CWS) and the alcohol and other drug (AOD) system typically include the following core elements: (1) Out-stationing AOD workers in child welfare offices, (2) Joint case planning, (3) Using official committees to guide collaborative efforts, (4) Training and cross-training, (5) Using protocols for sharing confidential information, and (6) Using dependency drug courts. Although more rigorous research is needed on both individual-level and system-level substance abuse interventions for parents involved in the child welfare system, the integration of individual-level interventions and system-level approaches is a potentially useful practice approach with this vulnerable population. doi:10.1300/J394v05n01\_07 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2008 by The Haworth Press. All rights reserved.]

**KEYWORDS.** Parental substance abuse, intervention, child welfare, alcohol and other drug

### INTRODUCTION

Parental substance abuse is a serious problem for the child welfare system. Estimates suggest that between 50 percent to 80 percent of child welfare cases involve a parent with a substance abuse problem (Bellis, Broussard, Herring, Wexler, Moritz, & Benitez, 2001; Famularo, Kinscherff, & Fenton, 1992; Murphy, Jellinek, Quinn, Smith, Poitras, & Goshko, 1991, U.S. General Accounting Office [USGAO], 1998). Nationally, it is estimated that 8.3 million children live with at least one parent who has a substance abuse problem (Substance Abuse and Mental Health Services Administration, ([SAMHSA] 1996). Estimates also indicate that 4.3 percent of pregnant women use illegal drugs during pregnancy and 9.8 percent of pregnant women use alcohol during pregnancy, with 4.1 percent being binge drinkers (SAMHSA, 2003). Research suggests that children in the child welfare system who have parents with substance abuse problems are at risk for a variety of poor outcomes; they are more likely to experience an out-of-home placement, they have lengthier stays in out-of-home placement, and they are more likely to have adoption as a case plan (U.S. Department of Health and Human Services [USDHHS], 1997).

As child welfare systems across the country face the problem of parental substance abuse, there is an increasing need to understand the

types of treatment approaches that have been found to be effective for parents with substance abuse problems. Research suggests that compliance with substance abuse treatment is related to faster reunification (Smith, 2003), however less is known about the actual effectiveness of substance abuse interventions for parents in the child welfare system, and the types of outcomes associated with differing treatment approaches. In addition, strong collaboration between the child welfare system (CWS) and the alcohol and other drug (AOD) system can play an important role in ensuring access to substance abuse treatment for parents involved in the child welfare system, as well as treatment coordination between systems. As such, this review of the literature focuses on evidence related to both individual level substance abuse interventions, as well as system-level collaborative approaches that may be effective with this population.

### *Impact of Parental Substance Abuse on Child and Family Functioning*

Research suggests that parental substance abuse is associated with a variety of problems related to child and family functioning. Studies indicate that parental substance abuse increases the risk of poor child developmental outcomes in several domains, including complications at birth, lower cognitive functioning, physical and mental health problems, and problems with social adaptation (Bauman & Levine, 1986; Conners, Bradley, Whiteside Mansell, Liu, Roberts, Burgdorf et al., 2004; McMahan & Luthar, 1998; McNichol & Tash, 2001; Werner, 1986). There is also evidence that children with a family history of substance abuse have an increased risk for substance abuse themselves (Merikangas, Stolar, Stevens, Goulet, Preisig, Fenton et al., 1998).

Problems in family functioning are also associated with parental substance abuse. Maternal substance abuse has been linked with increased punitiveness toward children (Hien & Honeyman, 2000; Miller, Smyth, & Mudar, 1997), increased rigidity and overcontrol in parenting (Burns, Chethik, Burns, & Clark, 1991), authoritarian parenting attitudes (Bauman & Levine, 1986), and parenting stress (Kelley, 1998). Some research indicates that parents with substance abuse problems have a greater likelihood of neglectful or abusive behaviors toward their children (Chaffin, Kelleher, & Hollenberg, 1996; Kelleher, Chaffin, Hollenberg, & Fisher, 1994; Wasserman & Leventhal, 1993; Williams-Petersen, Myers, McFarland Degen, Knisely, Elswick, Schnoll, 1994). However, although there is evidence suggesting that parental substance abuse is associated with problems in parenting and family

functioning, other research indicates that mothers who use drugs may also be strongly attached and committed to their children (Baker & Carson, 1999; Kearney, Murphy, & Rosenbaum, 1994).

### ***INDIVIDUAL-LEVEL FACTORS AFFECTING TREATMENT***

#### ***Unique Needs of Women in Substance Abuse Treatment***

Although both mothers and fathers are equally likely to abuse drugs or alcohol, mothers make up the majority of substance-abusing parents in the child welfare system (U.S. Department of Health and Human Services [USDHHS], 1999). Research suggests that women who abuse alcohol or other drugs typically experience different circumstances than men and have unique needs that should be considered in the design of substance abuse interventions (Abbott, 1994, Reed, 1987). Overall, studies indicate that women with substance abuse problems experience a high incidence of socioeconomic problems, criminal justice system involvement, histories of victimization, and mental and physical health problems (Conners, Bradley, Whiteside Mansell, Liu, Roberts, Burgdorf, et al., 2004).

#### ***Socioeconomic Problems***

Studies have found unemployment rates among women entering substance abuse treatment to range from 89 percent to 92 percent (Clark 2001; Conners, et al., 2004). Other studies have found homelessness rates to range from 25 percent to 58 percent (Chavkin, Paone, Friedman, & Wilets, 1993; Clark, 2001; El-Bassel, Gilbert, Schilling, & Wada, 2000; Grella, 1999; Saunders, 1993). Public assistance use ranges from 48 percent to 96 percent (Clark, 2001; Dore & Doris, 1998; Knight, Hood, Logan, & Chatham, 1999). And one study found that among woman in residential substance abuse treatment, 88 percent had incomes below the poverty line (Knight et al., 1999).

#### ***Criminal Justice System Involvement***

Women in substance abuse treatment also tend to have a history of arrest, incarceration, or other involvement in the criminal justice system. Studies suggest that the majority of women in substance abuse treatment have been arrested at least once; arrest rates range from 66 percent to 90 percent (Clark, 2001; Conners et al., 2004; Knight et al., 1999; Whitesdale-Mansell, Crone & Conners, 1998). Incarceration rates

range from 22 percent to 46 percent (Chavkin et al., 1993; El-Bassel et al., 2000). Moreover, current or past criminal justice system involvement (e.g. convictions, parole, probation, incarceration) ranges from 52 percent to 80 percent (Clark, 2001; Conners et al., 2004; Porowski, Burgdorf, & Herrell, 2004; Stevens & Arbiter, 1995).

### ***Current and Past Histories of Abuse and Victimization***

One of the most consistent findings from studies on women in substance abuse treatment is the high prevalence of abuse and victimization. Studies have found high rates of childhood abuse among women in substance abuse treatment. Overall childhood abuse rates range from 30 percent to 57 percent (Conners et al., 2004; Dore & Doris, 1998; El-Bassel et al., 2000; Saunder, 1993; Whitesdale-Mansell et al., 1998). Rates of ever-having-been sexually abused (e.g., rape, incest) range from 20 percent to 95 percent (Chavkin, et al., 1993; Dore & Doris, 1998; Ladwig & Andersen, 1989; Knight et al., 1999; Stevens & Arbiter, 1995). Rates of ever-having-been physically abused (including spousal abuse) range from 40 percent to 90 percent (Clark, 2001; Dore & Doris, 1998; Knight et al., 1999; Saunders, 1993; Stevens & Arbiter, 1995; Whitesdale-Mansell et al., 1998). Rates of emotional abuse range from 73 percent to 93 percent (Knight et al., 1999; Whitesdale-Mansell et al., 1998).

### ***Physical and Mental Health Problems***

Rates of physical health problems among women in substance abuse treatment range from 60 percent to 67 percent (Conners et al., 2004; Porowski et al., 2004). Rates of mental health problems range from 49 percent to 58 percent (Chavkin et al., 1993; Porowski et al., 2004). Additionally, one study found that nearly 30 percent of the mothers in a substance abuse program had attempted suicide (Conners et al., 2004). Other research has found that substance-abusing women are more likely than their male counterparts to have a psychiatric diagnosis (Grella, 1997; SAMHSA, 1997).

### ***Special Vulnerability of Substance-Abusing Mothers in the Child Welfare System***

Research suggests that substance-abusing mothers involved in the child welfare system may be especially vulnerable. Compared to sub-

stance-abusing mothers not involved in the child welfare system, child welfare system-involved mothers tend to be younger, unemployed, have less education, are less likely to be married, are more likely to have a chronic mental illness, are more likely to have more children, are more likely to use methamphetamines, and are more likely to have unsatisfactory exits from treatment (Shillington, Hohman, & Jones, 2001). Other research also suggests that substance-abusing mothers in the child welfare system are more likely than their non-child welfare system involved counterparts to have unsatisfactory exits from treatment (Hohman, Shillington, & Grigg Baxter, 2003).

### ***SYSTEM-LEVEL FACTORS AFFECTING TREATMENT***

#### ***Collaboration Between the Child Welfare and Alcohol and Other Drug Systems***

In addition to individual-level interventions, researchers, practitioners and policy makers have begun to identify the issue of collaboration between alcohol and other drug (AOD) systems and the child welfare system (CWS) as a key factor in substance abuse treatment for parents in the CWS. Poor collaboration between systems can lead to fragmented service delivery. Several scholars have described numerous barriers to collaboration between AOD systems and the CWS (Hunter, 2003; McAlpine, Marshall, Harper Doran, 2001; USDHHS, 1999, Young, Garnder, & Dennis, 1998). These barriers include: (1) differences in how the two systems define the client, (2) differing time line constraints, (3) different training and education of practitioners, (4) funding barriers and shortages of available treatment, (5) problems related to confidentiality mandates, and (6) differences in defining successful outcomes.

#### ***Differences in Defining the Client***

AOD systems and the CWS have historically defined the client in different ways. Child welfare systems typically consider the client to be first and foremost the child and then secondarily the family; whereas AOD systems typically define the client as the individual who is abusing drugs or alcohol (Hunter, 2003). As a result, the child welfare system is primarily concerned with the safety and well-being of the child within the family. In contrast, AOD systems typically do not consider



children or the adults' status as a parent as necessarily relevant to addressing their problems with drugs or alcohol (Young et al., 1998). Instead, the individual's use of drugs or alcohol is the primary focus of intervention. These differing definitions of the client can act as a barrier to collaboration; both systems may see themselves as the primary service provider and the two systems may struggle with different treatment goals depending on who is viewed as the client (USDHSS, 1999).

### *Differences in Case Goals*

The potentially conflicting value and treatment orientations of the AOD system and the CWS may also be reflected in different case goals for parents and children. In general, substance abuse treatment programs are concerned with assuring that clients decrease or eliminate their drug use and the negative consequences of drug use related to criminal behavior or health problems (Feig, 1998; USDHHS, 1999). The well-being of the family or child of the client is generally not a primary goal of treatment. However, the CWS is primarily concerned with the safety and well-being of the child and ensuring a timely permanent placement, with birth parents or in an alternate setting (USDHHS, 1999). While the goals of each system may compliment one another, they may also conflict. For instance, Feig (1998) notes that removing a child from the home may help ensure the child's safety and well-being and help create a permanent living situation, but may also cause a parent to drop out of substance abuse treatment.

### *Time Line Constraints*

Young et al. (1998) note that substance-abusing parents involved with the child welfare system typically face "four clocks" that can act as a barrier to collaboration between the AOD system and the CWS. These four clocks include: (1) *Child welfare time limits* mandated by the Adoption and Safe Families Act (ASFA) which stipulate that a permanency hearing must be held after 12 months of out-of-home care, (2) *Treatment time lines* also affect substance-abusing parents in the child welfare system. The long-term nature of substance abuse treatment and the occurrence of relapses may conflict with child welfare time limits requiring substance-abusing parents to be drug-free for a certain amount of time prior to reunification (USDHHS, 1999), (3) *Welfare time limits* mandated by the Temporary Assistance to Needy Families (TANF) polices mandate a 24 month TANF time limit requiring parents



to be engaged in work activities. For parents involved in TANF and the CWS, this may interfere with their treatment needs, as well as their ability to provide for their children if their welfare benefits are cut, and 4) The *developmental time trajectory* of children can also serve as a time constraint. It may be detrimental to children's development to be separated from their parents for long periods of time, yet, the AOD system typically views substance abuse treatment as a long-term process.

These four time-line constraints can cause conflicts between the AOD system and the CWS. While the AOD system may view long-term treatment as typical, the relatively short time lines imposed by ASFA and TANF policies, as well as the developmental needs of children, may create a number of challenges to effective collaboration.

### ***Differences in Training and Education***

The differences in training and education between the AOD system and the CWS may also act as a barrier to collaboration. Young et al. (1998) note that education on substance abuse interventions is generally lacking in CWS training, and that those working in the AOD system may not be aware of CWS practices. In addition, training within the two systems does not generally include information on cross-system collaboration.

### ***Funding Barriers and Shortages of Available Treatment***

Funding barriers between the two systems can also create problems with collaboration; Young et al. (1998) suggest that both systems may seek to safeguard their own funding sources by seeking reimbursements from the other. Moreover, court mandates and the restrictions set forth by the managed care system may cause both systems to be faced with difficulties in controlling their own resources. These external restrictions may make collaboration more difficult because ensuring treatment for some clients may not be in the control of either system. In addition, there is also an overall shortage of resources in both fields. SAMHSA (1997, as cited in USDHHS, 1999) reports that only 37 percent of substance-abusing mothers with children received some form of substance abuse treatment in 1994-1995, compared with 48 percent of substance-abusing fathers.

### ***Problems Surrounding Confidentiality Mandates***

Both AOD systems and the CWS are bound by federal and state regulations governing the types of client information that can be shared or

released. Although these regulations are intended to protect the privacy and rights of clients and children, they can also create a barrier to collaboration between the two systems. Typically, substance abuse treatment programs are not allowed to discuss information about a client with other service systems, and child welfare agencies are generally not allowed to release information about children or families (Feig, 1998, USDHHS, 1999). However, collaboration between the two fields could be improved by sharing information on children and families. For instance, the USDHHS (1999) suggests that sharing information between AOD systems and the CWS can help to ensure that: (1) clients are fully assessed and their needs are understood, (2) desired case outcomes are consistent between the two systems so that agencies are not working toward conflicting goals, and (3) resources are used efficiently to prevent duplication of services.

Overall, both individual-level interventions and system-level collaborative approaches are important for successful treatment of parents with substance abuse problems in the CWS. Effective individual-level interventions can assist parents in the child welfare system to address their substance abuse problems, while effective system-level collaborative interventions can help streamline access to services and ensure treatment coordination between service providers. This review of the literature describes evidence related to core program components within both individual-level interventions and system-level collaborative approaches.

## ***METHODS***

The methods for this review involved the selection of studies based on an explicit search protocol that included identification of the population, interventions, and outcomes of interest, as well as the use of pre-determined search terms, databases to be searched, and an inclusion and exclusion criteria. This review focused on two overall areas: (1) individual-level substance abuse interventions, and (2) system-level collaborative approaches between the child welfare and alcohol and other drug systems.

### ***Search Protocol for Individual-Level Substance Abuse Interventions***

The population of interest for the individual-level substance abuse intervention review included parents with substance abuse problems

who are involved in the child welfare system and women with and without children who are experiencing substance abuse problems. Information on outcomes related to the child welfare system were specifically targeted, including outcomes related to family reunification and permanency, however all outcomes included in the research are described. All substance abuse interventions targeted to parents involved in the child welfare system and women with substance abuse problems were eligible for review.

Inclusion criteria for individual-level interventions included studies using experimental or quasi-experimental methods. The experimental studies used a randomized controlled trial research design in which participants were randomly assigned to an intervention condition or a control condition. Randomized controlled trials are typically considered to represent the highest level of evidence because the randomization process generally eliminates possible differences between the two groups. Quasi-experimental studies included in this study either used a pre and post outcome design or a non-equivalent control group design. In the pre and post outcome design, outcome measures taken prior to the intervention are compared to those after the completion of the intervention. This is considered a less rigorous design than a randomized control trial because it is impossible to say definitively whether the intervention caused changes between pre and post or whether changes are due to some other unmeasured factor. A non-equivalent control group design compares an intervention group to some other group who either did not receive the intervention or received less of the intervention. Because the groups are not randomly assigned the possible differences between measures may be related to pre-existing differences between the two groups.

For individual-level interventions, the studies that were excluded from review included those that described interventions or program approaches that included no data on outcomes, studies that provided only descriptive data with no outcome data, studies that did not have an exclusive focus on women, women with children, or parents in the child welfare system, studies that provided no description of the intervention, studies that focused on adolescent mothers, and studies that reported preliminary results for which a subsequent evaluation provided full results.

### ***Search Protocol for System-Level Collaborative Approaches Between the CWS and AOD System***

The population of interest for the system-level collaborative review included all workers and clients involved in the child welfare and alcohol and other drug systems. Because empirical information on sys-

tem-level collaborative practice approaches between the child welfare and alcohol and other drug systems is extremely limited, explicit inclusion and exclusion criteria for literature generated from the collaborative models search was not possible. Similarly, although outcomes of interest related to improved treatment access and effectiveness were included in the search protocol, the lack of any empirical information related to collaborative practice approaches between the CWS and AOD system made it impossible to assess outcomes. As a result, a broad search protocol was used in which all materials relevant to the topic area were reviewed. This broad approach was chosen in an effort to identify potentially effective collaborative practice approaches that could be implemented and further evaluated in local agencies.

### ***SEARCH STRATEGY***

Twelve academic databases available from the University of California were searched including those related to psychology, sociology, social work, and social services. Systematic review websites (e.g., Cochrane and Campbell Collaborations) were also searched, as were research institute databases, conference proceedings, dissertation abstracts, professional evaluation listservs and overall internet searches. In addition, a snowball method was also used in which additional materials were identified from primary reference lists of other studies. For instance a systematic review of the effectiveness of substance abuse treatment for women by Ashley, Marsden and Brady (2003) was used to identify several studies focusing on women and women with children.

### ***RESULTS***

#### ***Individual-Level Substance Abuse Interventions***

Forty-seven studies focused on micro-level substance abuse interventions were identified through the structured review process. Table 1 presents an overview of all studies included in this review. A synthesis of this research suggests that outcomes for women with children in substance abuse treatment are enhanced by the inclusion of the following program components: (1) woman-centered treatment that involves children, (2) specialized health and mental health services, (3) home visitation, (4) concrete assistance (e.g., transportation, child care, assistance

linking with substance abuse treatment), (5) short-term targeted interventions, and (6) comprehensive programs that integrate many of these components. Figure 1 summarizes these interventions and their outcomes.

### *Woman-Centered Treatment Involving Children*

Fifteen studies were identified that investigated outcomes related to the effectiveness of woman-centered treatment and treatment that involved children. Overall, research suggests that women in woman-only treatment centers tend to have greater treatment retention and completion than those in mixed-gender programs (Egelko, Galanter, Dermatis, & DeMaio, 1998; Grella, 1999; Stevens, Arbiter, & Glider, 1989; Stranz & Welch, 1995). Women-only treatment is also associated with greater sobriety (Dahlgren & Willander, 1989; deZwart, 1991; Egelko et al., 1998; Rosett, Weiner, Zuckerman, McKinlay & Edelin, 1980; Stevens & Arbiter, 1995), greater likelihood of employment (Dahlgren & Willander, 1989; Stevens & Arbiter, 1995), decreased arrest rates, decreased use of government assistance and increased likelihood of having custody of children (Stevens & Arbiter, 1995). Although most identified studies suggest that woman-centered treatment may be more effective than mixed gender or traditional treatment, one quasi-experimental study that compared outcomes for women in a 6-week woman-centered residential program to outcomes for women in one of two traditional mixed gender residential programs (one that lasted 3 weeks and one that lasted 1 week) found no differences in drug use, employment status, social support or mental health status (Copeland, Hall, Didcott, & Biggs, 1993).

Other research suggests that better outcomes result when children are living with their mothers while they are in treatment. Studies suggest that women who are allowed to reside in residential treatment with their children experience greater treatment retention and completion than those not residing with their children (Clark, 2001; Hughes, Coletti, Neri, Urmann, Stahl, Sicilian, & Anthony, 1995; Wobie, Eyler, Conlon, Clarke & Behnke, 1997) and also exhibit greater abstinence (Metsch, Wolfe, Fewell, McCoy, Elwood, Wohler-Torres et al., 2001), fewer problems with depression and higher self-esteem (Wobie et al., 1997). Although most identified studies suggest better outcomes when children live with their mothers in treatment, two studies found no differences between women residing with children compared to those

FIGURE 1. Intervention Components and Outcomes

Component	Description	Outcomes
Woman-centered treatment involving children	Treatment programs that involve only women and are targeted toward the unique needs of women, as well as programs that involve children in treatment.	<ul style="list-style-type: none"> <li>• Increased treatment retention and completion</li> <li>• Greater abstinence</li> <li>• Decreased likelihood of criminal justice system involvement</li> <li>• Increased likelihood of employment</li> <li>• Decreased likelihood of public assistance use</li> <li>• Increased likelihood of child custody</li> <li>• Decreased depression</li> <li>• Higher self-esteem</li> </ul>
Health and Mental Health Care	Health care services, particularly prenatal care for pregnant women and mental health interventions such as individual therapy and specialized group therapy.	<ul style="list-style-type: none"> <li>• Longer gestational periods</li> <li>• Better birth outcomes</li> <li>• Increased treatment retention</li> <li>• Greater abstinence</li> <li>• Greater likelihood of employment</li> <li>• Reduction in high-risk injecting drug use behavior</li> </ul>
Home Visitation	Home visits by a nurse or a paraprofessional that focus on providing maternal support, promoting healthy parent-child interaction, and providing linkages to concrete resources.	<ul style="list-style-type: none"> <li>• Greater abstinence</li> <li>• Greater attendance at medical appointments</li> <li>• More emotional responsiveness to children</li> <li>• More stimulating home environment</li> <li>• Increased likelihood of using reliable form of birth control</li> <li>• Higher rates of having children live with mother</li> <li>• Decreased subsequent pregnancy or birth</li> <li>• Increase in permanent housing</li> <li>• Decrease in incarceration</li> <li>• Decreased likelihood of involvement in the CWS</li> </ul>
Concrete Support and Assistance	Services such as child care, transportation, or the provision of counseling workers to facilitate entry into treatment.	<ul style="list-style-type: none"> <li>• Increased attendance and completion of treatment</li> <li>• Greater abstinence</li> <li>• Increased likelihood of accessing treatment quickly</li> <li>• Fewer days in out-of-home placement among children with substance-abusing parents in the CWS</li> </ul>
Short-term and Targeted Interventions	Psychoeducational groups, support groups, contingency management.	<ul style="list-style-type: none"> <li>• Higher self-esteem</li> <li>• Greater treatment retention</li> <li>• Greater improvements in knowledge concerning assertiveness, communication skills and sexual health</li> <li>• More positive attitudes toward safe sex and being assertive</li> <li>• Greater attendance at prenatal health visits</li> <li>• Better birth outcomes</li> <li>• Lower health care costs</li> </ul>
Comprehensive and Holistic Interventions	Combine several program elements into a comprehensive intervention.	<ul style="list-style-type: none"> <li>• Decreased criminal activity</li> <li>• Decreased neglect of self or children</li> <li>• Decreased socioeconomic problems</li> <li>• Decreased likelihood of being taken advantage of</li> <li>• Decreased suicidality and psychological distress</li> <li>• Decreased out-of-home placements for children</li> <li>• High compliance rates with prenatal care</li> <li>• Good birth outcomes</li> <li>• High treatment retention rates</li> <li>• Greater abstinence</li> <li>• Greater family cohesion</li> <li>• Improved parenting skills</li> <li>• Increased likelihood of enrollment in vocational/education training</li> <li>• Reductions in physical health problems</li> </ul>

without their children (Schinka, Hughes, Coletti, Hamilton, Renard, Urmann et al., 1999; Wexler, Cuadrado, & Stevens, 1998).

**Health and Mental Health Care**

There is some evidence to suggest that substance abuse treatment services that include health care services, especially prenatal care, as well

TABLE 1. Summary of Studies on Interventions for Parents in the Child Welfare System or Mothers and Women in General

Author	Type of Intervention	Location and Time Period	Type of Study	Sample Characteristics	CWS Involvement	Outcomes
Bander et al. (1983)	Outpatient program focusing on individual and group counseling	Hartford, CT, 1977-1979	Quasi-experimental (N=167)	Average age 40 yrs, 56% African American, 31% white, 7% Mexican Indian, 6% Hispanic, 86% unmarried	Not reported	Increased abstinence & increased employment
Bartholomew et al. (1994)	A 6-week sexuality and assertiveness workshop for women	Corpus Christi, Dallas and Houston Texas 1991-1993	Quasi-experimental (N=81)	Average age 35 yrs, 26% Mexican-American, 50% White, 24% African American, 55% not married	Not reported	Higher self-esteem, greater retention in drug treatment
Berkowitz et al. (1998)	Outpatient treatment included comprehensive and holistic services	California 1993-1995	Quasi-experimental (N=460)	Average age 30.4 yrs, 53% White, 29% African American, 14% Hispanic, 2% Native American, 1% Asian	18% referred by CWS or criminal justice system	Decreases in: drug use, criminal activity, fights, neglect to self or children, homelessness, suicidal ideation, and OHP for children
Black et al. (1994)	An 18 month home visiting program	Not reported	Experimental (N=60)	Average age 26.4 yrs, 100% single, specific race/ethnicity information not provided. Sample described as "primarily African American."	Not reported	Increased abstinence and emotional responsiveness to children, higher compliance with medical appointments, and mothers provided more opportunities for stimulation
Carroll et al. (1995)	Targeted to methadone-maintained pregnant women, focused on health and mental health services	New Haven, CT, 1990-1992	Experimental (N=14)	Average age 27.6 yrs., 79% "non-minority," average number of children 1.4	Not reported	Greater number of prenatal visits, longer gestational periods, greater birth weights, no differences in drug use
Chang et al. (1992)	Targeted to methadone-maintained pregnant women, focused on health and mental health services	New Haven, Ct, time period not reported	Quasi-experimental (N=12)	Intervention group: average age 25.8yrs, 16% minority, 83% not married, average number of children 2.2	Not reported	Fewer positive urine toxicology screens, increased prenatal care, longer gestational periods, greater birth weights
Clark (2001)	Residential treatment for women and their children	Multiple sites across the nation, 24 sites participated in evaluation	Quasi-experimental (N=1,847)	Median age 29 years, 49% African American, 35% white, 9% Hispanic, 4% Asian, 4% American Indian/Alaska Native. At admission, 18% did not have custody of child	21% of sample referred by CWS	Better birth outcomes, increased abstinence and employment, women with children living with them had the highest completion rates and the longest stays in treatment
Comners et al. (2001)	Comprehensive and holistic residential treatment	Little Rock, Arkansas, time period not reported	Quasi-experimental (N=62)	Specific demographics not reported	Not reported	Increased abstinence, employment, improvement in parenting skills, poverty status, decreased arrests, improvements in family cohesion



Author	Type of Intervention	Location and Time Period	Type of Study	Sample Characteristics	CWS Involvement	Outcomes
Copeland et al. (1993)	Residential woman-centered treatment	Australia, 1989-1991	Quasi-experimental (N=160)	Intervention group: average age 30.3 yrs., race/ethnicity not reported, 61.3% not married, 53.8% with dependent children Not reported	Not reported	No effects found
Dahlgren & Willander (1989)	Woman-only outpatient alcohol treatment	Sweden, 1983-1986	Experimental (N=200)	Not reported	Not reported	Increased abstinence and employment
deZwart (1991)	Alcohol clinic for women only	The Netherlands, 1985	Quasi-experimental (N=44)	Mean age 37.7 yrs., 63% not married, 64% of women had children	Not reported	Increased abstinence
Dore & Doris (1998)	Targeted to CW involved parents, provided concrete support and assistance	Major metropolitan area in the Northeast	Quasi-experimental (N=119)	Average age 31.5 yrs. average of 3 children per home, 100% African American, 98% female, 77% single, never married	100% involved in CWS	Use of child care related to treatment completion. No relationship between treatment completion and child placement
Egelko et al. (1998)	A multisystems gender specific perinatal program	New York City, 1992-1995	Quasi-experimental (N=48)	Intervention group: average age 28.8 yrs, 78% African American, 22% Hispanic, 77% unmarried	Intervention group: 66% had an open CWS case.	Greater abstinence and greater treatment retention
Elk et al. (1998)	Contingency management intervention (CMI) that provided financial incentives for clean drug tests	Location not reported, 1994-1996	Experimental (N=12)	Intervention group: 50% African American, 85% not married	Not reported	Higher compliance with prenatal visits
Elk et al. (1997)	Multidisciplinary, comprehensive and holistic treatment	Houston TX, time period not reported	Quasi-experimental (N=70)	Average age 29 yrs., 54% African American, 37% White, 9% Hispanic, 77% not married	Not reported	High treatment retention rate, compliance with prenatal care and abstinence
Ernst et al. (1999)	Home visitation program	Seattle Washington, 1991-1995	Experimental (N=90)	Intervention group: average age 27.6 yrs, 77% single/separated/ divorced, 45% African American, 30% White, 17% Native American, 8% Other	Not reported	Increased abstinence, use of regular birth control, likelihood of living with child, decreased likelihood of pregnancy
Grant et al. (2003)	Home visitation program	Seattle WA, 1991-1995	Quasi-experimental (N=45)	Not reported	Not reported	Increased abstinence, regular use of family planning, employment, permanent housing, decrease in public assistance, incarceration and subsequent pregnancy
Grella (1999)	Woman-only residential treatment	Los Angeles CA, 1987-1994	Quasi-experimental (N=4,117)	Average age 29.7 yrs., 49.5% African American, 29.3% White, 16.9% Latino, 4.5% Other	Not reported	Greater treatment retention and completion
<b>Author</b>	<b>Type of Intervention</b>	<b>Location and</b>	<b>Type of Study</b>	<b>Sample Characteristics</b>	<b>CWS</b>	<b>Outcomes</b>

TABLE 1 (continued)

	Time Period			Involvement		
Hiller et al. (1996)	Houston Texas, 1994	A 6-week sexuality and assertiveness workshop for women	Experimental (N=21)	Intervention group: average age 33 yrs., 73% African American, 18% white, 9% Hispanic	Not reported	Improvements in assertiveness knowledge, communication skills, & sexual health, more positive attitudes toward safer sex
Hughes et al. (1995)	Southeastern U.S., time period not reported	Residential treatment for women	Experimental (N=53)	Intervention group: average age 27.8 yrs., 81% African American, 80% not married, average number of children 3.3	Intervention referred by CWS 58%	Increased treatment retention
Killeen & Brady (2000)	Rural South Carolina. Time period not reported	Residential program for women and their children	Quasi-experimental (N=63)	Average age 31.5 yrs., 70% African American, 29% white, 1% Hispanic, 75% unmarried	Not reported	Improved parenting skills, child behaviors, & improved scores on an Addiction Severity Index
Knight et al. (1999)	Fort Worth, TX, 1996-2000	Residential program for women and their children	Quasi-experimental (N=41)	54% between 25-34 yrs., 51% African American, 42% white, 7% Hispanic, 71% not married, 88% had at least one child in treatment	20% had an open CWS case	73% of women stayed in treatment 90 days or longer
Laken & Ager (1996)	Detroit Michigan, 1990-1992	Concrete support and assistance within an outpatient program	Quasi-experimental (N=225)	Average age 29.6 yrs., 88.4% African American	Not reported	Retention in the outpatient program was related to receiving transportation to services
Marsh et al. (2000)	Chicago and Rockford, Illinois, 1995-1996	Concrete support and assistance for women involved in CWS	Quasi-experimental (N=148)	Average age 33 yrs., approximately 82% African American, average number of children 3.6	100% involved in CWS	Increased abstinence
McComish et al. (1999)	Flint Michigan, 1994-1996	Weekly grief counseling group included as part of a residential program	Quasi-experimental (N=55)	Intervention group: average age 31 yrs., 83% African American, 97% single, average number of children in program with mother 2	Not reported	Increased treatment retention and self-esteem
Meisch et al. (2001)	Key West Florida, 1996-1998	Residential program for women with children	Quasi-experimental (N=36)	Average age 34 yrs., 22.5% were married, 65% Caucasian, 27.5% African American, 7.5% Hispanic	22.5% referred by CWS	Women in program with children had higher abstinence rates than those in program without children
Mullins et al. (2004)	Midwestern city, time period not reported	Motivational interviewing	Experimental (N=71)	Average age 27.1 yrs., 73.2% single, never married, 47.9% Caucasian, 32.4% African American, 12.7% Native American, and 7.0% Hispanic	97% had open CWS case	No impact on treatment engagement and retention
O'Neill et al. (1996)	Sydney, Australia, 1992-1993	Six-session cognitive behavioral intervention for methadone-maintained pregnant women	Experimental (N=80)	Average age 26.2 yrs., all currently pregnant, 36% had one other child	Not reported	Reduction in high-risk injecting drug use behavior

Author	Type of Intervention	Location and Time Period	Type of Study	Sample Characteristics	CWS Involvement	Outcomes
Porowski et al. (2004)	Residential program for women and their children	32 sites across the nation, 1996-2001	Quasi-experimental (N=1,181)	Average age 30.3 yrs, 40% African American, 32% white, 14% Hispanic, 88% not married/not living with spouse, 54% had three or more children	47% had child in OHP at some time	Increased abstinence, employment, and likelihood of living with children, decreased criminal activity, physical health problems, and likelihood of living with an AOD partner
Potocky & McDonald (1996)	Home visitation program	Midwestern metropolitan area, 1991-1993	Quasi-experimental (N=27)	Average age 26.8 yrs, 75% minority, 70% unmarried, average number of children 3.1	100% referred by CWS	The more services mothers used, the greater the improvement in their child's well-being, 70% of children remained with parents
Roberts & Nishimoto (1996)	An intensive day treatment that was women focused and included concrete support and assistance	Location not reported, 1995	Quasi-experimental (N=369)	33.3% between 31-35 yrs, 94% African American, 3.5% Hispanic, 87% not married	Not reported	Increased treatment retention and completion
Rosett et al. (1980)	Woman-only outpatient treatment program for pregnant women	Boston, MA, 1974-1977	Quasi-experimental (N=138)	Average age 26.2 yrs., 57% African American, 39% White, 4% American Indian, 49.5% living alone	Not reported	Better birth outcomes among women who stopped using alcohol in the third trimester
Saunders (1993)	Residential program for women and their children	Des Moines, Iowa, 1990-1992	Quasi-experimental (N=70)	Average age 28.5 yrs, 73% white, 18% African American, 6.3% Native American, 1% Hispanic. Marital status not reported	32% involved with CWS	Increased abstinence, decreased psychological distress, improved parenting skills
Schinka et al. (1999)	Residential program for women and their children	Florida, 1990-1992	Experimental (N=46)	Average age 27.3 yrs, 81% African American, 69.8% had never been married, average number of children 3.2	57% referred by CWS	Improvements in psychopathology
Schuler et al. (2000)	Home visitation program	Not reported	Experimental (N=171)	Not reported	Not reported	Decreased likelihood of CWS involvement
Smith & Marsh (2002)	Matching substance-abusing women with specific treatment services	Illinois, time period not reported	Quasi-experimental (N=183)	Average age 33 yrs, 83% African American, 11% white, 2% Hispanic	100% had some contact with the CWS	The more services women received, the better the outcomes
Sowers et al. (2002)	A transitional housing program providing comprehensive and holistic interventions	Broward County, Florida, time period not reported.	Quasi-experimental (N=41)	Intervention group: average age 29.5 yrs, 65.4% white, 15.4% African American, 7.7% Hispanic, 3.8% American Indian	Not reported	Decreased likelihood of arrest, increased employment, improvements in overall functioning
Stevens & Arbitr (1995)	Residential treatment for women with children	Tucson, AZ, 1994	Quasi-experimental (N=114)	Average age 28 yrs, 44% white, 25% African American, 22% Hispanic, 9% Native American, 82% not married	33% involved with CWS	At follow-up, the majority of women were employed and had custody of children

TABLE 1 (continued)

Author	Type of Intervention	Location and Time Period	Type of Study	Sample Characteristics	CWS Involvement	Outcomes
Stevens et al. (1989)	Residential treatment for women with children	Tucson AZ, 1981-1985	Quasi-experimental, sample size not reported	Not reported	Not reported	Increased length of stay
Strantz & Welch (1995)	Woman-centered day treatment program	Location not reported, Discharge date 1995	Experimental (N=292)	Average age 30.5 years, specific race/ethnicity not reported, sample described as "large majority" African American, 69.9% never married, median number of children was 3	82.7% referred by CWS	Increased treatment retention, having custody of child predicted treatment retention
Sviks et al. (1998)	Weekly substance abuse support group	Baltimore, MD, 1989-1990	Quasi-experimental (N=121)	Intervention group: average age 24.9 yrs., 84% African American, 79% not married	Not reported	Increased attendance at prenatal visits, greater birth weights, higher Apgar scores, lower health care costs
Sweeney et al. (2000)	Outpatient program that included maternal and child health care	Providence RI, time period not reported	Quasi-experimental (N=174)	Average age 26.9 yrs., 54% white, 33% African American, 68% had other children. Postpartum group: Mean age 27.6 yrs., 51% white, 39% African American, 87% had other children	Not reported	Women who enrolled during pregnancy had better birth outcomes
Testa et al. (2003)	"Recovery Coaches" to assist CWS-involved parents in participating in substance abuse treatment	Cook County Illinois, 2000-2002	Experimental (N=532)	Intervention group: average age 33 yrs, 73% women, 80% African American, 4% Hispanic, 90% not married. Control group: average age 33 yrs, 73% women, 84% African American, 6% Hispanic	100% involved in the CWS	Increased likelihood of accessing treatment and obtaining treatment more quickly, children in intervention group experienced less time in placement
Volpicelli et al. (2000)	A psychosocially enhanced treatment program	Not reported	Experimental (N=84)	Intervention group: average age 31.6 yrs, 97.6% African American, 2.4% Hispanic, average number of children 3.83	Not reported	Increased abstinence and treatment retention
Wexler et al. (1998)	Residential program for women and their children	Tucson AZ, 1992-1993	Quasi-experimental (N=83)	Average age 28.3 yrs, 59% white, 22% African American, 13% Hispanic, 6% Native American, 76% not married	Not reported	Increased employment and abstinence, decreased criminality, depression, and psychopathology
Whiteside-Mansell et al. (1998)	Residential program that included comprehensive and holistic interventions	Little Rock, Arkansas, time period not reported	Quasi-experimental (N=95)	Average age 28.8 yrs, 75% African American, 60.9% never married	31.4% involved in CWS	Increased abstinence, decreased likelihood of premature labor and maternal infection
Wobie et al. (1997)	Residential treatment center for women and their children	Orlando, FL, 1993-1996	Quasi-experimental (N=172)	Average age 27.3 yrs., 62% African American, 25% White, 13% Hispanic	Not reported	Women with children residing with them had greater treatment completion, less depression and higher self-esteem

as mental health services may improve outcomes for women and their children. Six studies were identified that examined specific health or mental health substance abuse treatment services. Overall, the research suggests that health interventions, particularly those aimed at prenatal care for pregnant substance-abusing women are associated with longer gestational periods and better birth outcomes (Carroll, Chang, Behr, Clinton & Kosten, 1995; Chang, Carroll, Behr & Kosten, 1992; Sweeney, Schwartz, & Mattis, 2000).

Mental health interventions may also improve outcomes. Research suggests that substance abuse treatment that includes specialized mental health interventions such as individual therapy or specialized group therapy is associated with increased treatment retention (Volpicelli, Markman, Monterosso, Filing, & O'Brien, 2000), greater sobriety (Bander, Stilwell, Fein, & Bishop, 1983; Volpicelli et al., 2000), greater likelihood of employment (Bander et al., 1983), and a reduction in high-risk injecting drug use behavior (O'Neill, Baker, Cooke, Collins, Heather, & Wodak, 1996).

### *Home Visitation*

Other studies suggest that home visitation programs may improve outcomes for substance-abusing mothers. Five studies were identified that evaluated home visitation services for substance-abusing mothers. These interventions typically include home visits by a nurse or a paraprofessional that focus on providing maternal support, promoting healthy parent-child interactions, and providing information and linkages to concrete resources. Overall, research suggests that home visitation programs are associated with greater sobriety (Black, Nair, Kight, Wachtel, Roby, & Schuler, 1994; Ernst, Grant, Streissguth, & Sampson, 1999; Grant, Ernst, Pagalilauan, & Streissguth, 2003), greater attendance at medical appointments, more emotional responsiveness to children, a more stimulating home environment (Blair et al., 1994), increased likelihood of using a reliable method of birth control (Ernst et al., 1999), higher rates of having children living with their mother (Ernst et al., 1999; Potocky & McDonald, 1996), decreased subsequent pregnancy or birth, increase in permanent housing, decrease in incarceration (Grant et al., 2003) and a decreased likelihood of involvement in the child welfare system (Schuler, Nair, Black, & Kettinger, 2000).

### *Concrete Support and Assistance*

Some studies have evaluated the effectiveness of interventions that provide concrete support and assistance, such as transportation, child

care or the provision of counselors to facilitate entry into treatment. Five studies were identified that evaluated the use of concrete supports and assistance in substance abuse treatment for women. Overall, research suggests that certain supports are associated with improved outcomes, specifically transportation to services is associated with increased treatment attendance (Laken & Ager, 1996) and child care is associated with increased treatment retention and completion (Dore & Doris, 1998; Roberts & Nishimoto, 1996). A combination of supports including transportation, outreach, and child care services has been linked to greater abstinence (Marsh, D'Aunno & Smith, 2000). The use of "Recovery Coaches" to assist parents in the child welfare system in obtaining and participating in substance abuse treatment as well as providing assistance in understanding and negotiating child welfare and court requirements is linked with increased access to treatment, quicker entry into treatment and fewer days in out-of-home placement among children (Testa, Ryan, Louderman, Sullivan, Gillespie, Gianforte et al., 2003).

### *Short-Term and Targeted Interventions*

Some research has focused on the use of short-term and targeted interventions, such as psychoeducational groups, motivational interviewing and contingency management interventions, on outcomes for women in substance abuse treatment. Six studies were identified that investigated short-term and targeted interventions. Research suggests that the use of psychoeducational groups is associated with higher self-esteem (Bartholomew, Rowan-Szal, Chatham, & Simpson, 1994; Hiller, Rowan-Szal, Bartholomew, & Simpson, 1996), greater treatment retention (Bartholomew et al., 1994), greater improvements in knowledge concerning assertiveness, communication skills and sexual health, and more positive attitudes toward safe sex and being assertive (Hiller et al., 1996). Another study on the effects of a grief counseling group found that participation in the group was associated with increased treatment retention and self-esteem (McComish, Greenberg, Kent-Bryant, Chruscial, Ager, Hines et al., 1999). The use of support groups is linked to greater attendance at prenatal visits, better birth outcomes and lower health care costs (Svikis, McCaul, Feng, Stuart, Fox, & Stokes 1998). The use of contingency management interventions (in which incentives are provided for abstinence) is associated with higher compliance with prenatal medical visits. The use of motivational interviewing, a short-term intervention described as client-centered and directed toward decreasing clients' ambiv-

alence about stopping their substance abuse and increasing their motivation for change has been found to be unrelated to treatment retention or completion among substance-abusing women in the child welfare system (Mullins, Suarez, Ondersma, & Page, 2004).

### ***Comprehensive and Holistic Interventions***

In addition to the program components noted above, there is also evidence that comprehensive and holistic interventions that combine several of these program elements may be effective with substance-abusing mothers. Ten studies were identified that focus on comprehensive and holistic interventions. Overall, research suggests that the more services substance-abusing women receive, the better the outcomes (Smith & Marsh, 2002). Comprehensive and holistic interventions that combine a variety of services have been linked to decreased criminal activity (Berkowitz, Brindis, & Peterson, 1998; Conners, Bradley, Whiteside-Mansell, & Crone, 2001; Porowski, Burgdorf, & Herrell, 2004; Sowers, Ellis, Washington & Currant, 2002), decreased neglect of self or children, decreased homelessness, decreased likelihood of being taken advantage of, decreased suicidality, decreased out-of-home placement of children (Berkowitz et al., 1998), high compliance rates with prenatal care (Elk, Mangus, LaSoya, Rhoades, Andres, & Grabowski, 1997), good birth outcomes (Elk et al., 1997; Whiteside-Mansell et al., 1998), high treatment retention rates (Elk et al., 1997; Knight et al., 1999), greater abstinence (Conners, Bradley, Saunders, 1993; Whiteside-Mansell, & Crone, 2001; Whiteside et al., 1998), decreased poverty, greater family cohesion (Conners et al., 2001), improved parenting skills (Conners et al., 2001; Killeen & Brady, 2000; Saunders, 1993), increased likelihood of employment (Porowski et al., 2004; Sowers et al., 2002), increased likelihood of enrollment in vocational/educational training, reductions in physical health problems, increased likelihood of living with at least one child (Porowski et al., 2004), and decreases in psychological distress (Saunders, 1993).

### ***Studies Addressing Child Welfare Outcomes***

Very few studies identified in this review reported on outcomes related to child welfare system involvement. It is therefore not possible to draw conclusions about which interventions are most effective with substance-abusing parents in the child welfare system. Overall, nine



studies were identified that either contained samples exclusively of child welfare parents or included some outcome data related to child welfare outcomes (such as whether children resided with parents after treatment). Figure 2 provides a summary of these program components and the related child welfare outcomes. Three studies assessed home visitation services, three studies assessed concrete support and assistance, two studies assessed comprehensive programs and one study assessed woman-centered treatment. It should be noted that it is possible that other interventions are equally or more effective with substance-abusing parents in the child welfare system, but outcomes related to involvement in the child welfare system have not been assessed.

### ***System-Level Collaborative Approaches Between the CWS and the AOD System***

Literature related to system-level collaborative approaches between the child welfare system (CWS) and alcohol and other drug system (AOD) was synthesized to identify core components of promising collaborative models. These core components include: (1) Outstationing AOD workers in child welfare offices, (2) Creating joint case plans between AOD and CWS, (3) Using official committees to guide collaborative efforts, (4) Training and cross-training, (5) Establishing protocols for sharing confidential information, and (6) Using dependency drug courts. Figure 3 provides a summary of the core components of promising collaborative models between the CWS and the AOD system.

### ***Outstationing AOD Workers in Child Welfare Offices***

Several collaborative models have placed AOD specialists within child welfare offices to ensure that parents are assessed as quickly as possible, to improve client engagement and retention in treatment, to streamline entry into treatment and to provide consultation to child welfare workers. In general, outstationed AOD workers typically assist child welfare workers in assessing parents, provide treatment referral, engage parents in substance abuse treatment and provide consultation to child welfare workers. The general goal behind outstationing AOD workers in child welfare offices is to provide parents with a smooth entry into the AOD system (McAlpine, Marshall & Doran, 2001; Semidei, Radel, & Nolan, 2001; Young & Gardner, 2002).

FIGURE 2. Summary of Interventions with Child Welfare Outcome Data

Component	Child Welfare Related Outcomes
Home Visitation	<ul style="list-style-type: none"> <li>• Increased likelihood of maintaining custody of child</li> <li>• Decreased involvement in the child welfare system</li> </ul>
Concrete Support and Assistance	<ul style="list-style-type: none"> <li>• Increased likelihood of accessing treatment</li> <li>• Increased likelihood of timely access to treatment</li> <li>• Children experience fewer days in out-of-home placement</li> </ul>
Comprehensive and Holistic Interventions	<ul style="list-style-type: none"> <li>• Reductions in out-of-home placement</li> </ul>
Woman-Centered Treatment	<ul style="list-style-type: none"> <li>• Increased likelihood of maintaining custody of child</li> </ul>

FIGURE 3. Collaborative Model Components

Component	Description and Rationale
Outstationing Alcohol and other Drug Workers in Child Welfare Offices	Placing AOD workers in child welfare offices may help ensure that parents are assessed quickly, improve client engagement and retention in treatment, streamline entry into treatment, and provide CWS workers with consultation on cases involving parental substance abuse.
Joint Case Planning	Joint case plans that are created and monitored by workers in both systems may help reduce conflicting case goals and improve treatment planning.
Official Committees to Guide Collaborative Efforts	Specially appointed committees or task forces that guide collaborative efforts can provide structure and oversight to collaboration and ensure input from both systems.
Training and Cross-Training	Training for CWS workers on substance abuse issues and training AOD workers on child welfare issues can improve understanding of the issues facing both systems.
Protocols for Sharing Confidential Information	Protocols include release of information forms that specify the types of information that can be shared. These protocols can help ensure that clients are fully assessed, that desired outcomes are consistent between the two systems and that resources are used efficiently to prevent duplication of services.
Dependency Drug Courts	Dependency drug courts usually provide judges with the primary role of monitoring the behaviors of parents and implementing rewards and sanctions based on treatment progress. Dependency drug courts may help ensure effective coordination between the CWS, AOD system and the courts so that parents have timely access to treatment, as well as the timely completion of reunification or permanency plans.

### ***Joint Case Planning***

The collaboration between the CWS and the AOD system can also be structured through the use of case plans that are jointly created and monitored by both systems (and other systems when appropriate). In general, joint case planning includes the creation of a family-focused case plan that includes input from all involved agencies, including AOD, CWS, the court, and others when appropriate. The case plan is then jointly implemented by the systems involved (Harrell & Goodman, 1999; Young & Gardner, 2002). The process of including input from representatives of the AOD system in case planning is described by Young and Gardner (2002) as a major breakthrough in enhancing effective relations between AOD and CWS services.

### ***Official Committees to Guide Collaborative Efforts***

Most collaborative models use specially appointed committees or task forces to guide collaborative efforts. These committees help to establish a closer relationship between AOD and CWS representatives, they ensure input from both systems, and can provide structure and oversight to the collaboration efforts (Young & Gardner, 2002; Semidei et al., 2001).

### ***Training and Cross-Training***

Training and cross-training between systems are core elements of most promising collaborative models. Elements involved in training include substance abuse training for all new child welfare workers and in-service training for current workers, as well as the creation of training curriculums developed by both CWS and AOD workers. Trainings often include AOD information for child welfare workers that focuses on basic information related to substance abuse and use, assessment tools, methods to engage clients and how to access treatment, as well as CWS information for AOD workers including an overview of child welfare policies and mandates and the types of services offered to families (McAlpine et al., 2001; Young & Gardner, 2002).

### ***Protocols for Sharing Confidential Information***

Most collaborative models identified in this search have established protocols for sharing confidential information between the CWS and

AOD systems. These protocols include release of information forms that specify the types of information that can be shared; clients then must give their written consent on the release of information forms in order for the two systems to share information. Many collaborative models have integrated these protocols into daily practice in order to streamline the sharing of information about client progress (Young & Gardner, 2002).

### ***Dependency Drug Courts***

The use of dependency drug courts also represents a collaborative model that is being used in a number of localities. In general, the use of dependency drug courts by the child welfare system is aimed at ensuring effective coordination between the CWS, AOD systems and the courts so that parents have timely access to treatment, as well as the timely completion of reunification or permanency plans (Harrell & Goodman, 1999; Young & Gardner, 2002). Dependency drug courts usually provide judges with the primary role of monitoring the behavior of parents and implementing rewards and sanctions based on treatment progress (Harrell & Goodman, 1999; Young & Gardner, 2002).

## ***CONCLUSION AND IMPLICATIONS***

The growing number of substance-abusing parents who come to the attention of the child welfare system has created an urgent need to understand the types of interventions that are most effective with this population. This review of the literature focused on evidence related to individual-level interventions for parents involved in the CWS and mothers and women in general, as well as descriptive information on system-level collaborative approaches between the CWS and the AOD system. At the individual level, experimental and quasi-experimental research suggests the following program components are associated with a variety of positive outcomes: (1) Women-centered treatment that involves children, (2) Specialized health and mental health services, (3) Home visitation services, (4) Concrete assistance (e.g., transportation, child care, assistance linking with substance abuse treatment), (5) Short-term targeted interventions, and (6) Comprehensive programs that integrate many of these components. Although the research on individual-level interventions identified in this review points to the potential effectiveness of these program components, more research using

experimental designs is needed to establish effectiveness. In addition, more research is needed to test the effectiveness of individual-level interventions specifically for parents in the child welfare system. Most studies identified in this review did not report on child welfare system involvement, and only nine of the studies in this review reported on outcomes related to the child welfare system.

In addition to individual-level interventions, this review identified key components of promising system-level collaborative approaches between the CWS and the AOD system. Descriptive information suggests that many collaborative models between the CWS and the AOD system contain the following core elements: (1) Outstationing AOD workers in child welfare offices, (2) Joint case planning, (3) Using official committees to guide collaborative efforts, (4) Training and cross-training, (5) Using protocols for sharing confidential information, and (6) Using dependency drug courts. These components may improve communication, coordination and collaboration between the CWS and AOD systems, however, empirical information on the association between these collaborative components and treatment outcomes for parents involved in the CWS is lacking. More information is needed to link the use of collaborative practice approaches between the CWS and the AOD system to certain critical outcomes for substance abusing parents in the CWS, such as access to treatment, treatment participation and retention, and overall treatment success.

Although more empirical research is needed on the interventions identified in this review, it is clear that addressing the problem of substance abuse among parents involved in the child welfare system will likely require a multifaceted approach that integrates the best available individual-level interventions with system-level collaborative approaches. This review has synthesized the available evidence on a number of potentially useful interventions. County agencies may benefit from identifying areas of need in their own localities and choosing from among the various interventions identified in this review. In light of such a limited amount of research, evaluations of these local efforts would help to assess their effectiveness. Ultimately, an approach that integrates individual-level interventions and system-level approaches, along with careful follow-up evaluations, may shed even more light on the types of interventions that are most effective with this vulnerable population.

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