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

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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 who abuses alcohol or other drugs (Bellis, Broussard, Herring, Wexler, Moritz, & Benitez, 2001; Famularo, Kinscherff, & Fenton, 1992; Murphy, Jellinek, Quinn, Smith, Poitrast, & 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 abuses alcohol or other drugs (Substance Abuse and Mental Health Services Administration, ([SAMHSA] 1996). Estimates also indicate that 4.3 percent of pregnant women use illicit 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 with parents who abuse alcohol or other drugs are at an increased risk of a variety of poor outcomes; they have an increased likelihood of being placed in out-of-home care, they spend longer periods of time in out-of-home care, they are more likely to have a case plan of adoption, and tend to be approximately two years younger than children with parents who do not abuse alcohol or other drugs (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 substance-abusing parents. 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. 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). As such, this structured review focuses on substance abuse interventions with substance-abusing parents in the child welfare system, as well as interventions for mothers and women in general. Additionally, a review of collaborative models between the child welfare system (CWS) and the alcohol and other drug (AOD) systems will also be presented. In order to provide a context for this review, a brief overview of the impact of parental substance abuse on child and family functioning will be presented, as well as an overview of factors affecting treatment, including individual-level factors such as the unique needs of women in substance abuse treatment, women’s histories of victimization, socioeconomic problems, and mental and physical health problems, as well as system-related factors including poor collaboration between the CWS and AOD systems.

**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. For children, the effects of parental drug use can occur as a result of exposure to drugs in utero, as well as a result of the effects of drug use on parenting. In general, research suggests that parental substance abuse increases the risk of poor developmental outcomes in a variety of domains (McMahon & Luthar, 1998). For instance, children of methadone-maintained mothers have been found to score lower on intelligence tests and measures of socially adaptive behavior and that those children exposed prenatally to drugs tend to have more developmental delays, perform more poorly on intelligence tests and have lower heights and weights in comparison to children of methadone-maintained mothers not exposed to drugs prenatally (Bauman & Levine, 1986). Other research has found that children in foster care with prenatal exposure to drugs score in the low average range on intelligence tests,
and perform more poorly on intelligence tests than foster children with a family history of drug use (McNichol & Tash, 2001).

Other research using a large sample of children whose mothers were participating in federally funded substance abuse programs found that compared to national estimates, children in the sample experienced a disproportionately high number of risk factors such as experiencing complications at birth, living in single parent homes, maternal mental illness, low maternal education, and low-income status. Children also had an increased likelihood of experiencing asthma, and hearing and vision problems (Conners, Bradley, Whiteside Mansell, Liu, Roberts, Burgdorf, et al., 2004). Additionally, a longitudinal study on coping problems among children of alcoholics found that at age 18, 30 percent of the sample had criminal justice system records, and 25 percent had serious mental health problems (vs. 9 percent of children from non-alcoholic homes) (Werner, 1986). There is also evidence to suggest that children with a family history of substance abuse have a significantly increased risk for substance abuse themselves (Merikangas, Stolar, Stevens, Goulet, Preisig, Fenton et al., 1998).

Problems in family functioning have also been associated with parental substance abuse. There is evidence to suggest that maternal substance abuse is associated with increased punitiveness toward children (Hien & Honeyman, 2000; Miller, Smyth, & Mudar, 1997), as well as increased rigidity and overcontrol in parenting (Burns, Chethik, Burns, & Clark, 1991), and authoritarian attitudes toward parenting (Bauman & Levine, 1986). Other research suggests that parental substance abuse is associated with increased parenting stress (Kelley, 1998).

There is also some research indicating that parents who abuse drugs or alcohol have a greater likelihood of neglectful or abusive behaviors toward their children. One study comparing pregnant women currently using alcohol or drugs to non-using pregnant women found that those
using drugs had higher scores on a measure of child abuse potential and that over 50 percent of
the drug-using mothers scored in the “extreme risk” range (Williams-Petersen, Myers,
Mcfarland Degen, Knisely, Elswick, Schnoll, 1994). In addition, Wasserman and Leventhal
(1993) investigated the relationship between maternal use of cocaine during pregnancy and
subsequent child maltreatment during the first two years of the child’s life and found that 23
percent of mothers who used cocaine during pregnancy had a substantiated incident of child
maltreatment during the first 24 months of the child’s life compared to 4 percent in a matched
comparison group.

Additionally, Kelleher, Chaffin, Hollenberg, and Fisher (1994) used data from Wave I of
the Epidemiological Catchment Area (ECA) Survey—a large community survey—and found
that 40 percent of parents who reported committing physical child abuse and 56 percent of
parents who reported committing child neglect also had an alcohol or drug disorder during their
lifetime. The authors found that the presence of a substance abuse disorder predicted child
maltreatment even after the effects of depression, household size, antisocial personality disorder,
and social support were statistically controlled. In a follow-up study, using Wave II ECA data,
results indicated that the presence of substance abuse disorders at Wave I strongly predicted the
occurrence of child maltreatment at Wave II—suggesting that substance abuse may be a causal
factor in the occurrence of child maltreatment (Chaffin, Kelleher, & Hollenberg, 1996).

Although there is evidence suggesting that parental substance abuse is associated with
problems in parenting and family functioning, other research indicates that mothers who abuse
drugs may also be strongly committed to their children. Baker and Carson (1999) conducted a
qualitative study of the mothering practices of substance abusing women, and while the mothers
in the study openly discussed some of their problems in parenting, they also discussed their
strong attachments to their children and perceived themselves as good mothers who met their children’s practical needs, protected their children from harm, and coped with stress. Similarly, Kearney, Murphy and Rosenbaum (1994) interviewed crack cocaine using mothers and found that the women felt a strong responsibility to their children, and described feelings of pride for their children. The mothers also described a number of strategies they employed to protect their children from the effects of their drug use, including physically separating children from drugs, budgeting scarce resources, isolating from poor influences and ultimately some of the mothers relinquished custody of their children in order to protect them. These findings suggest that although substance-abusing mothers may exhibit problems in parenting, they may also be strongly attached to their children.

**Individual-Level Factors Affecting Treatment:**

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

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, research suggests that women with substance abuse problems typically 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**

Information on characteristics of women in substance abuse treatment suggests a variety of socioeconomic problems including unemployment, homelessness, public assistance use and poverty. 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 has been found to range 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 have been found to 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) has been found to range 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/Victimization**

One of the most consistent findings from studies on women in substance abuse treatment is the high prevalence of abuse/victimization. Studies have found high rates of childhood abuse among women in substance abuse treatment. Overall childhood abuse rates have been found to range from 30 percent to 57 percent (Conners et al., 2004; El-Bassel et al., 2000; Whitesdale-Mansell et al., 1998). Rates of physical childhood abuse have been found to range from 46
percent to 50 percent (Dore & Doris, 1998; Saunders, 1993), and rates of childhood sexual abuse have been found to range from 30 percent to 45 percent (Dore & Doris, 1998; Saunders, 1993). Additionally, one study reports that among pregnant and postpartum women in residential substance abuse treatment, 45 percent had been abandoned by a parent or removed from the custody of their parent (Clark, 2001).

Other studies have reported on rates of ever-having-been-abused among women in substance abuse treatment. Rates of ever having been sexually abused (e.g. rape, incest) have been found to range from 20 percent to 95 percent (Chavkin, et al., 1993; Dore & Doris, 1998; Ladwig & Andersen, 1989; Knight et al., 1999; Stevens & Arbiter, 1995). Other research suggests that women who abuse alcohol are more likely than those who do not abuse alcohol to have experienced sexual abuse (Miller, Downs, Gondoli, & Keil, 1987). A separate study using the same sample found that women who abused alcohol also had significantly higher rates of spousal abuse, even after statistically controlling for the effects of income, alcohol problems in the husband, experiences of childhood abuse, and changes in the parental family (Miller, Downs, & Gondoli, 1989). Moreover, in a study of women currently receiving methadone treatment approximately 75 percent of women had ever experienced physical abuse, life threatening abuse or sexual abuse; 32 percent had experienced physical abuse, life threatening abuse or sexual abuse during the previous year (El-Bassel et al., 2000). Rates of ever having been physically abused (including spousal abuse) have been found to 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 have been found to range from 73 percent to 93 percent (Knight et al., 1999; Whitesdale-Mansell et al., 1998).
Physical and Mental Health Problems

High rates of physical and mental health problems have also been found among women in substance abuse treatment. In one study of women in residential substance abuse treatment, nearly 67 percent of mothers reported physical health problems, including respiratory problems (24.1%), sexually transmitted diseases (13.4%), and other gynecological problems (11.9%) (Conners et al., 2004). Approximately 58 percent reported mental health problems, including depression (40.1%), psychological trauma (10.7%), and bipolar disorder (6.7%). Additionally, nearly 30 percent of the mothers 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). Additionally, Chavkin et al. (1993) found that 58 percent of a sample of crack cocaine using mothers had ever had “bad nerves” and 27 percent had been hospitalized for “nerves.” Among pregnant and postpartum women in residential substance abuse treatment, 49 percent have been found to have significant mental health problems, and 37 percent have been found to have a history of mental health treatment (Clark, 2001). Moreover, Porowski et al. (2004) report that 60 percent of women entering residential substance abuse treatment reported physical health problems and 49 percent reported having experienced serious mental health problems in the recent past.

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

Clearly, research suggests that women who abuse alcohol or other drugs experience multiple problems, yet research also suggests that substance-abusing mothers involved in the child welfare system may be especially vulnerable. For instance, among a sample of women in methadone treatment, women who experienced physical abuse, life threatening abuse or sexual abuse in the previous year were less likely to live with their children than those not experiencing
abuse (El-Bassel et al., 2000). Other research has found that substance-abusing mothers involved with the child welfare system differ from substance-abusing mothers not involved in the child welfare system in a number of ways: 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, 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).

**The Methodology of a Structured Review**

This review uses pre-determined search terms and search sources to identify research literature within a given topic. This method of searching can reduce the potential for bias in the selection of materials. Using specified search terms, we searched numerous social science and academic databases available through the University of California library. In addition, we searched websites specializing in systematic reviews, as well as research institutes, conference proceedings databases, dissertation databases, and conducted overall internet searches. In order to gather information on research that has not been published, inquiries were sent to professional email lists serving professional evaluators and child maltreatment researchers (please see Appendix for a description of the search strategy). 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.
The studies included in this review used 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 possible differences between the two groups are generally eliminated by the randomization process.

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.

The studies that were excluded from this 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.
Evidence on Micro-Level Substance Abuse Interventions

Overall, 47 studies were identified according to the inclusion and exclusion criteria. Table 1 provides information on all of the studies included in this structured review, type of intervention is described, study location and time period, type of study (e.g. experimental or quasi-experimental, if quasi-experimental the type of quasi-experimental design and sample size), sample characteristics (age, race/ethnicity, marital status and number of children when reported), whether the sample was involved in the child welfare system and outcomes of the
Table 1. Summary of Studies on Interventions for Parents in the Child Welfare System or Mothers and Women in General

<table>
<thead>
<tr>
<th>Author</th>
<th>Type of Intervention</th>
<th>Location and Time Period</th>
<th>Type of Study</th>
<th>Sample Characteristics</th>
<th>CWS Involvement</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Bander et al. (1983)</td>
<td>An outpatient program designed for inner-city women alcoholics. Included individual and group counseling, outreach to home and hospital, vocational training, recreational activities, access to health and legal services.</td>
<td>Hartford, CT, 1977-1979.</td>
<td>Quasi-experimental, pre and post outcomes (N=167).</td>
<td>Average age 40 yrs, 56% African American, 31% white, 7% American Indian, 6% Hispanic, 86% unmarried.</td>
<td>Not reported.</td>
<td>At 21 month follow-up, increased abstinence, and increased employment 19 (statistical tests not reported).</td>
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<td>Bartholomew et al. (1994)</td>
<td>A 6-week sexuality and assertiveness workshop for women participating in three community based methadone maintenance programs. Workshops included educational topics such as reproductive health, and HIV prevention, as well as information on women’s socialization.</td>
<td>Three sites: Corpus Christi, Dallas and Houston Texas 1991-1993.</td>
<td>Quasi-experimental: Compared women who attended 1-3 sessions (N=46) to those attending 4-6 sessions (N=35), and compared pre-post outcomes for both groups.</td>
<td>Average age 35 yrs, 26% Mexican-American, 50% White, 24% African American, 55% not married.</td>
<td>Not reported.</td>
<td>Higher self-esteem, greater retention in drug treatment.</td>
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<td>Berkowitz et al. (1998)</td>
<td>The California Perinatal Services Network (PSN), services included outpatient treatment, counseling, case management, child care, transportation, health services, substance use education, home visitation, and aftercare services.</td>
<td>California 1993-1995.</td>
<td>Quasi-experimental: Interviews conducted with women shortly before leaving treatment and then 6 months later (N=460).</td>
<td>Average age 30.4 yrs, 53% White, 29% African American, 14% Hispanic, 2% Native American, 1% Asian.</td>
<td>18% referred by CWS or criminal justice system.</td>
<td>Decreased drug use, decreased involvement in criminal activity, fights, decreased likelihood of neglect to self or children, decreased homelessness, decreased likelihood of being taken advantage of, decreased suicidal ideation, reduction in number of children required by the CWS or criminal justice system be placed out of the home.</td>
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<td>Black et al. (1994)</td>
<td>An 18 month home visiting program delivered by nurses. Visits focused on providing support to mother, promoting healthy parent-child interactions, providing information about child care, child development and community resources. Visits occurred biweekly.</td>
<td>Not reported.</td>
<td>Experimental: Randomized control trial, intervention group (N=31), control group (N=29).</td>
<td>Average age 26.4 yrs, 100% single, specific race/ethnicity information not provided. Sample described as “primarily African American.”</td>
<td>Not reported.</td>
<td>Marginal improvements in being drug-free, marginally higher compliance with medical appointments, increased emotional responsiveness to children, and provided marginally more opportunities for stimulation, children had marginally higher cognitive scores at 6 months, however differences between the two groups were not detected at 12 and 18 months. More home visits related to better outcomes.</td>
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<td>Carroll et al. (1995)</td>
<td>Intervention was targeted to methadone-maintained pregnant women and included weekly prenatal care, weekly relapse-prevention groups, contingency management, and therapeutic child care.</td>
<td>New Haven, CT, 1990-1992.</td>
<td>Experimental: Women were randomly assigned to the intervention group (N=7) or the control group (N=7) who received treatment-as-usual.</td>
<td>Overall sample: average age 27.6 yrs., 79% “non-minority,” average number of children 1.4.</td>
<td>Not reported.</td>
<td>Intervention group had greater number of prenatal visits, longer gestational periods, greater birth weights, no differences in drug use.</td>
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<td>Chang et al. (1992)</td>
<td>An enhanced methadone maintenance intervention that included prenatal care, relapse prevention groups, financial incentives for remaining abstinent, and therapeutic child care.</td>
<td>New Haven, Ct, time period not reported.</td>
<td>Quasi-experimental: Compared those in enhanced methadone maintenance (N=6) to those in treatment as usual (N=6), nonrandom assignment.</td>
<td>Intervention group: average age 25.8yrs, 16% minority, 83% not married, average number of children 2.2.</td>
<td>Not reported.</td>
<td>Significance tests not performed, intervention group had fewer positive urine toxicology screens, had more prenatal care, had longer gestational periods, and delivered babies with greater birth weights.</td>
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<td>Clark (2001)</td>
<td>The Pregnant and Postpartum Women (PPW) program, a multi-site intervention targeted to substance-abusing pregnant or postpartum women. Intervention was residential and “child focused” and included counseling, relapse prevention, and self-help services. Also included maternal medical care, psychotherapy, parenting education, life skills training, counseling about HIV/AIDS prevention, domestic violence, sexual abuse, and employment training. Treatment lasted up to 12 months (PPW program funded by Center for Substance Abuse Treatment (CSAT)).</td>
<td>Multiple sites across the nation, 24 sites participate in evaluation.</td>
<td>Quasi-experimental: pre-post, also compared outcomes for women who completed treatment vs. those who left early (N=1,847), and women living with children compared to those without children (individual sample sizes not reported).</td>
<td>Median age was 29 years, 49% African American, 32% white, 9% Hispanic, 4% Asian, 4% American Indian/Alaska Native. At admission, and 18% did not have custody of child at entry.</td>
<td>21% of sample referred by CWS. 80% had history of being investigated for suspected child maltreatment by CWS, 57% had at least one child removed from their custody and of the children living in the residential centers, 39% had been under CWS custody at some point.</td>
<td>Better birth outcomes; women with children living with them in treatment had the highest completion rates and the longest stays in treatment. At a 6-month follow-up, decreased drug use and increased employment.</td>
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<td>Connors et al. (2001)</td>
<td>The residential component of the Arkansas Center for Addictions Research, Education and Services (AR-CARES). Program included AOD education, 12-step, relapse prevention, counseling, life skills training, health education, parenting education, linkage to other support services, children received educational and mental health services (a PPW program funded by Center for Substance Abuse Treatment (CSAT)).</td>
<td>Little Rock, Arkansas, time period not specified.</td>
<td>Quasi-experimental: Compared three groups: early drop-outs (less than 30 days) (N=10), late drop-outs (more than 30 days, but no completion) (N=26) and graduates (N=26).</td>
<td>Specific demographics not reported. Most women in sample described as single with an average of 3 children. More white women were in the late drop-out group (42.9%) than in the early drop-out (21.4%) or graduate (13.3%) groups.</td>
<td>Not reported.</td>
<td>Decreased drug use, increased employment, marginal improvement in poverty status and likelihood of arrest, improvements in parenting, and marginal improvements in family cohesion.</td>
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<td>Copeland et al. (1993)</td>
<td>The specialist women’s service, a residential program that was woman-only, and offered child care. Duration was 6 weeks.</td>
<td>Australia, 1989-1991</td>
<td>Quasi-experimental: Compared outcomes for women in the woman-centered intervention (N=80), to those in traditional services (N=80).</td>
<td>Intervention group: Average age 30.3 yrs., race/ethnicity not reported, 61.3% not married, 53.8% with dependent children.</td>
<td>Not reported.</td>
<td>At 6-month follow-up no differences in use of alcohol or other drugs, social support, employment status, or maternal satisfaction.</td>
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<td>Dahlgren &amp; Willander (1989)</td>
<td>Woman-only outpatient alcohol treatment program designed for women with early alcohol problems.</td>
<td>Sweden, 1983-1986</td>
<td>Experimental: Random assignment to intervention group (N=100) or a control group (N=100) that received treatment-as-usual.</td>
<td>Not reported.</td>
<td>Not reported.</td>
<td>At 2-year follow-up, intervention group less likely to be using alcohol and more likely to be employed.</td>
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<td>deZwart (1991)</td>
<td>Alcohol clinic for women only.</td>
<td>The Netherlands, 1985</td>
<td>Quasi-experimental: Pre and post outcomes (N=44).</td>
<td>Mean age 37.7 yrs., 63% not married, 64% of women had children.</td>
<td>Not reported.</td>
<td>At 3 month follow-up, increased abstinence from alcohol, tranquilizers and sleeping pills.</td>
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<td>Dore &amp; Doris (1998)</td>
<td>Intervention delivered by a voluntary child welfare agency, included in-home supportive counseling, linkages to substance abuse treatment programs, mentoring, day care, respite care, parenting education, transportation, concrete support. Average length of treatment was 8 months.</td>
<td>Major metropolitan area in the Northeast.</td>
<td>Quasi-experimental: Pre and post outcomes (N=119).</td>
<td>Average age 31.5 yrs, average of 3 children per home, 100% African American, 98% female, 77% single, never married.</td>
<td>All were involved with the CWS, average length of CWS involvement was 18 months, 39.2% of sample had at least one child placed out of the home.</td>
<td>At 12 month follow-up: 41% had completed treatment and stayed sober the entire 12 month period, 41% did not complete treatment. Clinician ratings indicated that 73% of clients had made “significant progress.” No relationship between level of participation in treatment and substance abuse treatment status. Clients who had a child in the day care program were more likely to complete treatment. No relationship between treatment completion and child placement was found.</td>
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<td>Egelko et al. (1998)</td>
<td>A multisystems gender specific perinatal program that focused on establishing a strong mother-infant bond, providing outreach to family and friends in order to include them in the treatment process.</td>
<td>New York City, 1992-1995.</td>
<td>Quasi-experimental, compared those in multisystems intervention (N=27) to treatment as usual group (N=21), no randomization.</td>
<td>Intervention group: average age 28.8 yrs, 78% African American, 22% Hispanic, 77% unmarried.</td>
<td>Intervention group: 66% had an open CWS case, 19% had a past CWS case.</td>
<td>Intervention group had greater abstinence and greater treatment retention than the comparison group.</td>
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<td>Elk et al. (1998)</td>
<td>An adjunctive Contingency management intervention (CMI) that was added to an outpatient program The CMI included financial incentives for clean drug tests.</td>
<td>Location not reported, 1994-1996.</td>
<td>Experimental: Random assignment to CMI (N=6) (intervention group) or treatment as usual (N=6) (control group).</td>
<td>Intervention group: 50% African American, 83% not married.</td>
<td>Not reported.</td>
<td>Intervention group had higher compliance with prenatal visits, no significant differences between groups in rates of retention, drug use, or perinatal outcomes.</td>
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<tr>
<td>Elk et al. (1997)</td>
<td>The “Pregnancy Project,” included multidisciplinary treatment including child care, prenatal care, HIV counseling, parenting education, prenatal and nutrition classes, post-partum counseling, health care, counseling, substance abuse treatment, and transportation.</td>
<td>Houston TX, time period not reported.</td>
<td>Quasi-experimental: Examined outcomes after treatment for entire sample (N=35), as well as comparing outcomes for a group who used cocaine prior one month prior to entry (N=24) and a group that stopped use prior to entry (N=11).</td>
<td>Overall sample: Average age 29 yrs., 54% African American, 37% White, 9% Hispanic, 77% not married.</td>
<td>Not reported.</td>
<td>Overall retention rate was 69%, 82% of women were compliant with prenatal care, 60% remained abstinent from cocaine for at least 60 days after treatment, good birth outcomes. Outcomes were generally better for the group that stopped using cocaine prior to entry.</td>
</tr>
<tr>
<td>Ernst et al. (1999)</td>
<td>The Seattle Birth to 3 program (AKA the Parent-Child Assistance Program): A 3-year home visitation program using paraprofessional advocates who visit mothers’ home weekly or bi-weekly, link mothers to other services, provide transportation to medical appointments and general support. Program directed toward high risk substance abusing women pregnant women.</td>
<td>Seattle Washington, 1991-1995.</td>
<td>Experimental: Randomized controlled trial: Compared women receiving intervention (N=60) to women not receiving the intervention (N=30).</td>
<td>Intervention group: At completion of program, average age 27.6 yrs, 77% single/separated/divorced, 45% African American, 30% White, 17% Native American, 8% Other</td>
<td>Not reported.</td>
<td>Increased sobriety, increased use of regular birth control, decreased likelihood of pregnancy, increased likelihood of mother living with child.</td>
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<td>Grant et al. (2003)</td>
<td>Intervention was the Parent Child Assistance Program (see Ernst et al. (1999)).</td>
<td>Seattle WA, 1991-1995.</td>
<td>Quasi-experimental: Comparison of pre and post outcomes, 2.5 years after treatment completed (N=45).</td>
<td>Not reported.</td>
<td>Not reported.</td>
<td>Increased abstinence, increase in regular use of family planning, decrease in public assistance, decrease in incarceration, decrease in subsequent pregnancy, increase in employment as primary source of income and having permanent housing.</td>
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<tr>
<td>Grella (1999)</td>
<td>Intervention included woman-only residential substance abuse treatment.</td>
<td>Los Angeles CA, 1987-1994.</td>
<td>Quasi-experimental: Compared outcomes for women in woman only treatment (N=800), to those in mixed-gender programs (N=3,317).</td>
<td>Sample in woman-only programs: average age 29.7 yrs., 49.5% African American, 29.3% White, 16.9% Latino, 4.5% Other.</td>
<td>Not reported.</td>
<td>Women in woman-only programs had longer stays in treatment, and were more likely to complete treatment than those in mixed-gender programs.</td>
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<td>Hughes et al. (1995)</td>
<td>Intervention included a therapeutic community, residential treatment for women, services included parenting education, women’s issues groups.</td>
<td>Southeastern U.S., time period not reported.</td>
<td>Experimental: Randomized controlled trial. Intervention group included women who were allowed to have their children reside with them in treatment (N=31) compared to those without children living with them (N=22).</td>
<td>Intervention group: average age 27.8 yrs, 81% African American, 80% not married, average number of children 3.3.</td>
<td>Intervention group 58% referred by CWS.</td>
<td>Women in intervention group remained in treatment longer than those in control group,</td>
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<td>Knight et al. (1999)</td>
<td>Salvation Army First Choice Program, residential substance abuse treatment program for women with children. Services included individual counseling, group counseling, educational and vocational training. Child care is provided, transportation to other needed services, children receive therapy and educational groups. 12-month program.</td>
<td>Fort Worth, TX, 1996-2000.</td>
<td>Quasi-experimental: Compared pre and post outcomes (N=41).</td>
<td>54% between 25-34 yrs, 51% African American, 42% white, 7% Hispanic, 71% not married, 88% had at least one child in treatment.</td>
<td>20% had a case currently open with CWS, and 51% had a history of formal action taken by the CWS.</td>
<td>73% of women stayed in treatment 90 days or longer.</td>
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<td>Laken &amp; Ager (1996)</td>
<td>Intervention included services provided by a case management team, provided transportation to a woman-only outpatient treatment center and prenatal care, case management team coordinated care, provided monitoring of clients.</td>
<td>Detroit Michigan, 1990-1992.</td>
<td>Quasi-experimental: Examined post-intervention outcomes (N=225).</td>
<td>Average age 29.6 yrs, 88.4% African American.</td>
<td>Not reported.</td>
<td>Retention in the outpatient program was related to receiving transportation to services.</td>
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<td>Marsh et al. (2000)</td>
<td>Service enhancements intended to reduce barriers to substance abuse treatment for women involved in the CWS, service enhancements included transportation, outreach and child care services.</td>
<td>Chicago and Rockford, Illinois, 1995-1996.</td>
<td>Quasi-experimental: Compared clients in program offering enhanced services (N=73) to those in treatment as usual (N=75).</td>
<td>Total sample: average age 33 yrs, approximately 82% African American, 44% of intervention group did not have a spouse/partner, 41% of comparison group did not have a partner, average number of children 3.6.</td>
<td>All women included in the study were clients of the CWS.</td>
<td>Intervention group received more services including assistance with child care arrangements, parenting classes, transportation and use of an outreach worker, intervention group also related to decreased drug use.</td>
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<tr>
<td>McComish et al. (1999)</td>
<td>Weekly grief counseling group included as part of a residential program for substance-abusing women. Group included didactic format, as well as psychotherapeutic approaches; experiences of loss and grief were linked to substance abuse. Group was open-ended, women entered and exited at their own discretion. Average number of groups attended 5.</td>
<td>Flint Michigan, 1994-1996.</td>
<td>Quasi-experimental: Compared women (N=24) in the intervention group to women who did not participate in the intervention (N=31).</td>
<td>Intervention group: average age 31 yrs., 83% African American, 97% single, average number of children in program with mother 2. Comparison group: average age 29 yrs., 87% African American, 100% single, average number of children in program with mother 2.</td>
<td>Not reported.</td>
<td>Participation in intervention was associated with increased treatment retention and self-esteem, no differences between the groups on measures of overall mood, depression, and parenting skills.</td>
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<td>Metsch et al. (2001)</td>
<td>A 12-month residential substance abuse treatment program for women within public housing. Included life skills training, individual, group and family counseling, employability skills training, relapse prevention, on-site childcare and developmental services (PPW program funded by CSAT).</td>
<td>Key West Florida, 1996-1998.</td>
<td>Quasi-experimental: Compared outcomes of women who resided with their children in treatment (N=22) to those who did not reside with their children (N=14).</td>
<td>Average age 34yrs, 22.5% were married, 65% Caucasian, 27.5% African American, 7.5% Hispanic.</td>
<td>22.5% referred by Children and Family Services.</td>
<td>Women in program with children had higher abstinence rates than those in program without children.</td>
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<td>Mullins et al.</td>
<td>Motivational interviewing, a brief intervention designed to decrease client ambivalence and increase motivation for change.</td>
<td>Time period not specified. Took place in a university medical school in a Midwestern city.</td>
<td>Experimental: Randomized control trial. Compared motivational interviewing intervention (N=35) to an education control condition (N=36).</td>
<td>Total sample: Average age 27.1yrs, 73.2% were single, never married, 47.9% Caucasian, 32.4% African American, 12.7% Native American, and 7.0% Hispanic.</td>
<td>97% of sample had active child welfare case; 83% had lost custody of their child.</td>
<td>At 8-week follow-up: No differences were found between the MI group and the EC group on outcomes related to treatment engagement and retention.</td>
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<tr>
<td>O’Neill et al.</td>
<td>A six-session cognitive behavioral intervention that augmented usual methadone maintenance treatment targeted to pregnant women. Cognitive behavioral intervention focused on identifying high-risk situations and developing skills to identify trigger to relapse.</td>
<td>Sydney, Australia, 1992-1993.</td>
<td>Experimental. Randomized control trial. Compared outcomes for intervention group (N=40) versus control group (N=40) who received usual methadone maintenance.</td>
<td>Total sample average age 26.2 yrs, all currently pregnant, 36% had one other child.</td>
<td>Not reported.</td>
<td>At 9 month follow-up: intervention group reducing high-risk injecting drug use behavior (e.g. sharing needles). No differences between groups in drug use or high-risk sexual behavior.</td>
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<tr>
<td>Porowski et al.</td>
<td>Follow-up evaluation of the PPW programs. Intervention included 6 or 12 month residential substance abuse treatment for pregnant or postpartum women. Women could reside with their children in treatment, services included substance abuse treatment, health care, mental health services, vocational parenting, legal services, day care and transportation.</td>
<td>32 sites across the nation. 1996-2001.</td>
<td>Quasi-experimental: Compared pre and post outcomes (N=1,181) and comparison of those who relapsed to those who abstained during the 6 month follow-up.</td>
<td>Average age 30.3yrs, 40% African American, 32% white, 14% Hispanic. 88% not married/not living with spouse, 54% had three or more children.</td>
<td>47 percent had one or more children placed in out-of-home care at some time.</td>
<td>Increased abstinence, decreased criminal activity, increases in employment or enrollment in educational/vocational training, reductions in physical health problems, decreased likelihood of living with an AOD partner, increased likelihood of living with at least one child. Those who remained sober during follow-up were less likely to have mental health problems and less likely to have at least one child in foster care (not true of relapsers).</td>
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<td>Potocky &amp; McDonald</td>
<td>A 6-month home visitation program, that included visits by a social worker focusing on parenting issues, basic survival skills, and substance abuse recovery; early childhood education services, nursing services, parent education/support group, a parent/child group, transportation assistance, respite child care. Average of 0.6 hours of home visits/week.</td>
<td>Midwestern metropolitan area, 1991-1993.</td>
<td>Quasi-experimental: Assessed outcomes after treatment completion (N=27).</td>
<td>Average age 26.8 yrs, 75% minority, 70% unmarried, average number of children 3.1.</td>
<td>All mothers had drug-exposed infants and were referred by CWS or local hospital.</td>
<td>At program completion, 70% of children remained with parents, families who remained intact used the parent education/support groups and the parent/child interaction groups more frequently than those who had children placed in foster care. The more services mothers used, the greater the improvement in their child’s well-being.</td>
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<tr>
<td>Roberts &amp; Nishimoto</td>
<td>An intensive day treatment that was women focused, and included counseling, support groups, educational groups, vocational assessment and referral, relapse prevention, health assessments and referrals, case management, family therapy, parenting education, specialized education, child care and transportation.</td>
<td>Location not reported, 1995.</td>
<td>Quasi-experimental: Compared three groups: intervention group (N=151), an outpatient group that included everything in the intervention except family therapy, parenting education, specialized education, child care and transportation (N=141) and a residential group that was male based (N=77).</td>
<td>Full sample: 33.3% between 31-35 yrs, 94% African American, 3.5% Hispanic, 87% not married.</td>
<td>Not reported.</td>
<td>Women in intervention group more likely to stay in treatment longer and complete treatment than those in other two groups.</td>
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<td>Rosett et al. (1980)</td>
<td>Woman-only outpatient treatment program for pregnant women using alcohol.</td>
<td>Boston, MA, 1974-1977.</td>
<td>Quasi-experimental: examined outcomes among women participating in the program (N=69), also compared women who stopped/reduced alcohol use in the third trimester (N=25) to those who did not (N=44).</td>
<td>Average age 26.2 yrs., 57% African American, 39% White, 4% American Indian, 49.5% living alone.</td>
<td>Not reported.</td>
<td>36% of women stopped using alcohol or significantly reduced alcohol consumption in the third trimester. Those who stopped or significantly reduced their use of alcohol in the third trimester has better birth outcomes.</td>
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<td>Saunders (1993)</td>
<td>The Project Together Program: a residential substance abuse treatment program for women and their children. Provides child care, health care, educational or vocational training, life skills training, counseling, parenting education, and group support. Program lasts up to 2 years.</td>
<td>Des Moines, Iowa, 1990-1992.</td>
<td>Quasi-experimental: Compared pre and post outcomes (N=70).</td>
<td>At entry into program, average age was 28.5 yrs, 73% white, 18% African American, 6.3% Native American, 1% Hispanic. Marital status not reported.</td>
<td>32% of sample at entry were involved with the child welfare system</td>
<td>At completion of program, increased sobriety, decreased psychological distress, improved parenting skills.</td>
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<tr>
<td>Schinka et al. (1999)</td>
<td>Intervention included a therapeutic community, residential treatment program for women, women allowed to have children with them in treatment (PAR Village program).</td>
<td>Florida, 1990-1992.</td>
<td>Experimental: Randomized control trial. Compared women who resided in treatment with children (N=28), to those who did not reside with children (N=18). Also compared pre and post outcomes for overall sample.</td>
<td>Full sample: 27.3 yrs, 81% African American, 69.8% had never been married, average number of children 3.2.</td>
<td>57% referred by CWS.</td>
<td>No differences between intervention and control groups on measures of psychopathology. Pre-post differences for entire sample indicated that at 12-month follow-up improvements in psychopathology were detected.</td>
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<tr>
<td>Schuler et al. (2000)</td>
<td>A 6 month home visiting intervention program delivered by lay visitors. Contained an infant and a parent component. Topics in parent component included linking mother to needed supports and education on drug use and drug treatment. Infant component included a curriculum to promote infant development. Average number of visits over the 6 months was 8.9.</td>
<td>Not reported.</td>
<td>Experimental: Randomized control trial. Compared intervention group (N=87) to a control group (N=84) that received brief monthly home visits to reduce attrition.</td>
<td>Not reported.</td>
<td>Not reported.</td>
<td>At completion of program: No differences on measures of maternal responsiveness or infant warmth, use of existing services, use of cocaine, heroin, marijuana, or alcohol Control mothers were more likely than intervention mothers to be currently involved with the child welfare system. Control mothers who continued to use drugs or alcohol were less responsive to their infants than intervention mothers who continued to use drugs.</td>
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<td>Smith &amp; Marsh (2002)</td>
<td>Intervention included matching substance-abusing women with specific treatment services based on an assessment of their need. One group included matched counseling services that focused on domestic violence services and family counseling and a second group included matched ancillary services including housing, job training, and legal services.</td>
<td>Illinois, time period not reported.</td>
<td>Quasi-experimental: Compared three groups: those who had enhanced (matched) treatment—the intervention group, those who had regular treatment, and a control group who may or may not have attended treatment. Total sample size = 183, specific samples for each group not reported.</td>
<td>Average age 33 yrs, 83% African American, 11% white, 2% Hispanic. Sample was selected from women with children who had contact with the CWS.</td>
<td>CWS involvement was a stronger predictor treatment outcome.</td>
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<td>Sowers et al. (2002)</td>
<td>A transitional housing substance abuse treatment center (The Susan B. Anthony Center) for women and their children. Services included counseling, social skills training, substance abuse education, parent training, and employment counseling.</td>
<td>Broward County, Florida, time period not reported.</td>
<td>Quasi-experimental: Women in intervention (N=26) were compared to women in traditional day treatment that included only counseling and social skills training (N=15). Pre and post outcomes also assessed for intervention group.</td>
<td>Intervention group: average age 29.5 yrs, 65.4% white, 15.4% African American, 7.7% Hispanic, 3.8% American Indian. Not reported.</td>
<td>Decreased likelihood of arrest, increased employment, improvements in overall functioning.</td>
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<td>Stevens &amp; Arbiter (1995)</td>
<td>A Therapeutic Community (“Amity”), a residential treatment center for women with children. Goal of treatment is overall changes in lifestyle. Intervention included groups, seminars and retreats focused on women’s issues such as emotional bonding, female friendships, sexual abuse issues, and parenting.</td>
<td>Tucson, AZ, 1994.</td>
<td>Quasi-experimental: Pre-post outcomes (N=57) and comparison of women who dropped out of treatment (N=44) to those who completed treatment (N=13).</td>
<td>Average age 28 yrs, 44% white, 25% African American, 22% Hispanic, 9% Native American, 82% not married.</td>
<td>33% involved with CWS at time of entry to treatment. At 6 or 12 month follow-up: 44% reported not using drugs or alcohol in the 6 months since leaving treatment, 40% were re-arrested, 54% had worked part-time or full-time, 58% had custody of at least one child.</td>
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<td>Strantz &amp; Welch (1995)</td>
<td>An intensive 7-day a week day treatment program designed for women that focused on education, individual and group counseling, parenting training, and personal development activities; transportation was provided.</td>
<td>Location not reported, Discharge date 1995.</td>
<td>Experimental: Randomized control trial. Compared women in the day treatment intervention group to those in the outpatient group. Total sample size=292. Samples sizes for each group not reported.</td>
<td>Average age 30.5 years, specific race/ethnicity not reported, sample described as a “large majority” African American, 69.9% never married, median number of children was 3.</td>
<td>82.7% of sample was referred by the child welfare system, 64% of those referred by the CWS were court-mandated to treatment.</td>
<td>Higher completion rates in intervention group, voluntary clients stayed longer than court-ordered clients; having custody of a child strongly predicted retention in the intervention.</td>
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<td>Svikis et al. (1998)</td>
<td>Weekly substance abuse support group within an obstetric clinic. Group included discussion of relapse, effects of drugs on fetus, use of social support, and behavioral contracting.</td>
<td>Baltimore, MD, 1989-1990.</td>
<td>Quasi-experimental: Women who attended at least 2 groups (N=54) constituted the intervention group; women who attended one or no groups constituted the comparison group (N=67).</td>
<td>Intervention group: average age 24.9 yrs., 84% African American, 79% not married.</td>
<td>Not reported.</td>
<td>Intervention group attended more prenatal visits, had babies with greater birth weights, and higher Apgar scores and lower health care costs.</td>
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<tr>
<td>Sweeney et al. (2000)</td>
<td>“Project Link:” provided an intensive outpatient program that included combined substance abuse treatment with maternal and child health care.</td>
<td>Providence RI.</td>
<td>Quasi-experimental: Compared outcomes for women in Project Link who enrolled in program while pregnant (N=87) to those who enrolled in program after delivery (N=87).</td>
<td>Pregnant group: Mean age 26.9 yrs., 54% white, 33% African American, 68% had other children.</td>
<td>Not reported.</td>
<td>Women who enrolled during pregnancy had longer gestational periods, babies with greater birth weights, higher newborn Apgar scores, shorter stays in hospital for newborns, infants less likely to be admitted to intensive care, and were less likely to have a positive toxicology screen at birth.</td>
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<td>Testa et al. (2003)</td>
<td>Redirected Title IV-E funds to implement demonstration project for substance abusing parents in the child welfare system. Intervention included the use of “Recovery Coaches” to assist parents in participating in substance abuse treatment, and negotiating system requirements.</td>
<td>Cook County Illinois, 2000-2002.</td>
<td>Experimental: Sites were randomly chosen for the demonstration project, interim evaluation compared parents in the demonstration sites (N=368) to those in the control group who received treatment as usual (N=164).</td>
<td>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.</td>
<td>All involved in the CWS.</td>
<td>Intervention group more likely to access substance abuse treatment, more likely to access treatment more quickly, children in intervention group experienced less time in placement. No differences in reunification rates, average number of placements, or rates of subsequent maltreatment.</td>
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<td>Volpicelli et al. (2000)</td>
<td>A psychosocially enhanced treatment program that included child care and group counseling, but was enhanced with additional onsite services included parenting education, access to a psychiatrist, individual therapy, and GED classes.</td>
<td>Not reported.</td>
<td>Experimental: Randomized control trial: Intervention group included the psychosocially enhanced treatment (N=42) and control group included a case management-oriented outpatient program that did not include additional onsite services (N=42).</td>
<td>Intervention group: average age 31.6 yrs, 97.6% African American, 2.4% Hispanic, average number of children 3.83.</td>
<td>Not reported.</td>
<td>Longer attendance at treatment, less use of cocaine over a 12-month period, no differences on psychosocial outcomes including depression and overall functioning.</td>
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<tr>
<td>Wexler et al. (1998)</td>
<td>The “Desert Willow” program, a therapeutic community residential program including case management and referral, counseling, education, support groups, parenting education, GED classes, vocational training and services for family and significant others. Children were allowed to be in treatment with women.</td>
<td>Tucson AZ, 1992-1993.</td>
<td>Quasi-experimental: Compared pre and post outcomes and outcomes between women who had children with them in treatment (N=44) versus those without children in treatment with them (N=39).</td>
<td>Total sample: average age 28.3 yrs, 59% white, 22% African American, 13% Hispanic, 6% Native American, 76% not married.</td>
<td>Not reported.</td>
<td>For total sample at 6 month follow-up increases in employment, and decreases in the use of alcohol and drugs, committing illegal acts, depression, and psychopathology, women who remained in program longer had better outcomes, few differences between women with children in treatment vs. those without children in treatment.</td>
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<td>Whiteside-Mansell et al. (1998)</td>
<td>Intervention was part of the Arkansas Center for Addictions Research, Education and Services (AR-CARES). Included residential treatment and outpatient treatment, child care, transportation, treatment focused on family outcomes rather than individual outcomes, child health services provided, counseling, parenting education, life skills, and education.</td>
<td>Little Rock, Arkansas, time period not specified.</td>
<td>Quasi-experimental: Compared women who participated in program (N=72) to those who did not participate in program (N=23), also compared pre-post outcomes for participating women.</td>
<td>Participating women: average age 28.8 yrs, 75% African American, 60.9% never married.</td>
<td>31.4% of participating women had an open CWS case.</td>
<td>Decreased AOD use, decreased likelihood of premature labor and maternal infection. Longer participation in treatment was associated with larger birth-weight.</td>
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<td>Wobie et al. (1997)</td>
<td>Residential treatment center for women and their infants, services include addiction and parenting groups, educational and vocational services, health care, and child care.</td>
<td>Orlando, FL, 1993-1996.</td>
<td>Quasi-experimental: Evaluated outcomes at completion of program (N=86), also compared women who had children with them in treatment (N=53), to those without children in treatment (N=33).</td>
<td>Overall sample: average age 27.3 yrs., 62% African American, 25% White, 13% Hispanic.</td>
<td>Not reported.</td>
<td>Women who had children residing with them in treatment were significantly more likely to complete treatment, had fewer problems with depression, and higher self-esteem than those without children living with them.</td>
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study. A synthesis of the research compiled in Table 1 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 provides an overview of these six program components and associated outcomes found in the research literature.

*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. One quasi-experimental study compared outcomes for women in woman-only residential substance abuse treatment to women in mixed gender residential programs and found that women in the woman-only programs had longer stays in treatment and were more likely to complete treatment than those in mixed gender programs (Grella, 1999). Similarly, one quasi-experimental study compared correlates of treatment retention and completion between an intensive women-centered day treatment program and a traditional mixed gender outpatient program and found the completion rate was higher in the women centered day treatment condition (Stranz & Welch, 1995). In addition, deZwart (1991) used a quasi-experimental design to test pre- and post-outcomes among women in a woman-centered alcohol clinic. At a three-month follow-up, women who participated in treatment reported greater abstinence from alcohol, tranquilizers and sleeping pills. Moreover, Dahlgren and Willander (1989) conducted an experimental randomized controlled trial comparing women in an outpatient woman-only alcohol treatment program to those in a control
### Figure 1. Intervention Components and Outcomes

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Outcomes</th>
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| 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. | • Increased treatment retention and completion  
• Greater abstinence  
• Decreased likelihood of criminal justice system involvement  
• Increased likelihood of employment  
• Decreased likelihood of public assistance use  
• Increased likelihood of child custody  
• Decreased depression  
• Higher self-esteem |
| 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. | • Longer gestational periods  
• Better birth outcomes  
• Increased treatment retention  
• Greater abstinence  
• Greater likelihood of employment  
• Reduction in high-risk injecting drug use behavior |
| 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. | • Greater abstinence  
• Greater attendance at medical appointments  
• More emotional responsivity to children  
• More stimulating home environment  
• Increased likelihood of using reliable form of birth control  
• Higher rates of having children live with mother  
• Decreased subsequent pregnancy or birth  
• Increase in permanent housing  
• Decrease in incarceration  
• Decreased likelihood of involvement in the CWS |
| Concrete Support and Assistance          | Services such as child care, transportation, or the provision of counseling workers to facilitate entry into treatment. | • Increased attendance and completion of treatment  
• Greater abstinence  
• Increased likelihood of accessing treatment quickly  
• Fewer days in out-of-home placement among children with substance-abusing parents in the CWS |
| Short-term and Targeted Interventions    | Psychoeducational groups, support groups, contingency management.                                      | • Higher self-esteem  
• Greater treatment retention  
• Greater improvements in knowledge concerning assertiveness, communication skills and sexual health  
• More positive attitudes toward safe sex and being assertive  
• Greater attendance at prenatal health visits  
• Better birth outcomes  
• Lower health care costs |
| Comprehensive and Holistic Interventions | Combine several program elements into a comprehensive intervention.                                     | • Decreased criminal activity  
• Decreased neglect of self or children  
• Decreased socioeconomic problems  
• Decreased likelihood of being taken advantage of  
• Decreased suicidality and psychological distress  
• Decreased out-of-home placements for children  
• High compliance rates with prenatal care  
• Good birth outcomes  
• High treatment retention rates  
• Greater abstinence  
• Greater family cohesion  
• Improved parenting skills  
• Increased likelihood of enrollment in vocational/education training  
• Reductions in physical health problems |
group that received treatment-as-usual (e.g. not gender-specific) and found that those in the woman-only treatment condition experienced greater abstinence and were more likely to be employed than those in the control group. In addition, Rosett, Weiner, Zuckerman, McKinlay, and Edelin (1980) examined outcomes for a group of pregnant women participating in a woman-only outpatient treatment program and found that 36 percent of women stopped using alcohol or significantly reduced alcohol consumption in the third trimester. Women who stopped or reduced alcohol consumption in their third trimester had better birth outcomes than those who continued using alcohol.

Another quasi-experimental study on a gender-specific substance abuse intervention found that the use of a multisystems model for family reintegration may improve treatment outcomes. Specifically, nonrandom assignment was used to compare an intervention group who received a multisystems gender-specific perinatal intervention that focused on establishing a strong mother-child bond (by providing outreach to family and friends in order to include them in the treatment process), to a comparison group who received a standard gender-specific perinatal program that did not include a multisystems model. The results indicated that those in the intervention group experienced greater abstinence and greater treatment retention (Egelko, Galanter, Dermatis, & DeMaio, 1998).

Moreover, Stevens, Arbiter, and Glider (1989) conducted a quasi-experimental study that compared outcomes for women before and after implementation of woman-centered services within a residential treatment center using a therapeutic community model and found that after implementation of woman-centered services (that included involving children and focused on issues such as sexual abuse, and parenting) the length of stay for women in the program increased. Similarly, Stevens and Arbiter (1995) conducted a quasi-experimental study of the
same program and found that outcomes for those who completed treatment were better than for those who dropped out of treatment. Although tests of statistical significance were not conducted in this study, the results suggest that women who completed treatment were less likely to report using drugs or alcohol in the 6 months since leaving the program, less likely to be re-arrested, more likely to be employed, less likely to receive government assistance, and more likely to have custody of at least one of their children. Most identified studies suggest that woman-centered treatment may be more effective than mixed gender or traditional treatment, however 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). These conflicting findings may possibly be due to the relatively short length of treatment in the Copeland et al. study.

Other research suggests that better outcomes result when children are living with their mothers while they are in treatment. For instance, the federally-funded Pregnant and Postpartum Women (PPW) program is a national multi-site residential program that is targeted to substance-abusing pregnant and postpartum women. Children are allowed to reside at the treatment center with their mothers and the intervention is described as “child focused.” A quasi-experimental evaluation of 24 PPW sites found that women with children living with them in treatment had higher completion rates than those not living with their children, as well as longer stays in treatment (Clark, 2001). Similarly, a separate experimental evaluation of a therapeutic community residential treatment center used a randomized control trial and compared women residing with children in treatment to those residing without children and found that women
residing with their children remained in treatment significantly longer than those without their children (Hughes, Coletti, Neri, Urmann, Stahl, Sicilian, & Anthony, 1995). There is also evidence to suggest that greater abstinence from drug use occurs in treatment centers where children reside with their mothers; a quasi-experimental evaluation of one PPW site found that at a 6-month follow-up, 18 percent of women who entered the program with their children reported using drugs, compared to 79 percent of women who entered the program without their children (Metsch, Wolfe, Fewell, McCoy, Elwood, Wohler-Torres, et al., 2001). Additionally, one study examining outpatient programs found that women who retained custody of their children while they attended an intensive woman-centered day treatment program had higher retention rates than those who did not have custody of their children (Stranz & Welch, 1995). Similarly, Wobie, Eyler, Conlon, Clarke and Behnke (1997) found that women who resided with their children in treatment were more likely than those whose children were living elsewhere to complete treatment, have fewer problems with depression and have higher self-esteem.

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 without their children. One experimental study compared women randomly assigned to residential treatment in which they were allowed to live with their children to women assigned to residential treatment without their children found no differences between the groups on measures of psychopathology (Schinka, Hughes, Coletti, Hamilton, Renard, Urmann et al., 1999). Another quasi-experimental study found few differences between women with children versus those without on outcomes related to employment, substance use, criminality, and psychopathology (Wexler, Cuadrado, & Stevesm 1998). Taken together, these findings may suggest that residing with children in treatment is related to longer stays in treatment, higher
completion rates, and possibly greater abstinence from drugs or alcohol, yet it may not affect other outcomes such as psychopathology, criminality or employment.

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 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. Carroll, Chang, Behr, Clinton, and Kosten (1995) conducted an experimental randomized controlled trial comparing birth outcomes among pregnant methadone-maintained women participating in an enhanced treatment condition (weekly prenatal care, relapse-prevention groups, contingency management, and therapeutic child care) to those participating in treatment-as-usual (daily methadone medication, weekly group counseling and drug screening). Although the results indicated no differences between the groups in actual drug use, women participating in the enhanced treatment condition had a greater number of prenatal visits, longer gestational periods, and greater birth weights. In addition, Chang, Carroll, Behr and Kosten (1992) used a quasi-experimental design to assess differences in outcomes between pregnant women who participated in an enhanced methadone maintenance program that included prenatal care, as well as relapse prevention and financial incentives for remaining sober, to women who participated in methadone maintenance without the enhanced intervention. Although tests of statistical significance were not reported in the study, results did indicate that those women in the enhanced treatment condition had fewer positive urine toxicology screens, participated in more prenatal visits, had longer gestational periods and delivered babies with greater birth weight. Additionally, Sweeney, Schwartz, and Mattis (2000) used a quasi-experimental design to evaluate “Project Link” which is an intensive outpatient
program for substance abusing pregnant and postpartum women. The intervention focused on combining substance abuse treatment with maternal and child health care. The results of the study indicated that, compared to women who enrolled in the program after delivery, those who enrolled during pregnancy had infants with greater birth weights, higher Apgar scores, shorter stays in the hospital, a decreased likelihood of being admitted to intensive care, and a decreased likelihood of testing positive for drugs or alcohol at birth. Pregnant women in the program also had longer gestational periods than those who enrolled after delivery.

There is also some evidence to suggest that mental health services may improve outcomes for women in substance abuse treatment. Volpicelli, Markman, Monterosso, Filing, and O’Brien (2000), conducted an experimental study that randomly assigned women to a psychosocially enhanced outpatient substance abuse treatment program that included parenting education, access to a psychiatrist, individual therapy and GED classes or to a case management-oriented outpatient program that did not include these additional services. Results indicated that women receiving the psychosocially enhanced program attended treatment for a longer period of time and reported less use of cocaine over a 12-month follow-up period, however no differences were found in depression and overall functioning. The authors note that the most frequently used service within the enhanced treatment condition was individual therapy and that this mental health treatment may have been responsible for the differences in outcomes. Additionally, another study used a quasi-experimental design to investigate outcomes for women participating in an outpatient program for women who abused alcohol. The intervention included individual and group counseling, as well as other services such as vocational training, recreational activities, outreach to home and hospital, and access to health and legal services. Outcome data indicated that at a 21-month follow-up, 19 percent of women were rated by their counselors as
abstinent, and although statistical tests were not reported, employment rose from 11 percent prior to treatment to 26 percent while women were in treatment (Bander, Stilwell, Fein, & Bishop, 1983). Moreover, O’Neill, Baker, Cooke, Collins, Heather, and Wodak (1996) used an experimental design and randomly assigned women to an enhanced methadone maintenance program that included a six-session cognitive behavioral intervention or to methadone maintenance treatment as usual. At a 9-month follow-up, the group receiving the cognitive behavioral enhancement reduced the high-risk injecting drug use behavior, however no differences were found between the groups on actual drug use or high-risk sexual behavior.

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. Black, Nair, Kight, Wachtel, Roby, and Schuler (1994) conducted an experimental study using a randomized control trial to assess the impact of an 18-month home visiting program targeted to pregnant substance-abusing women. The program was delivered by nurses and biweekly home visits focused on providing maternal support, promoting healthy parent-child interactions, and providing information on child care, child development and community resources. Women in the intervention home visiting group were compared to women who received no intervention. Results indicated that over the 18 month period women in the intervention group were marginally more likely than control mothers to be sober, to attend medical appointments, to be emotionally responsive to their children and to provide a marginally more stimulating home environment. At 6 months, children in the intervention group had marginally higher cognitive scores, however differences were not detected at 12 and 18 months. Additionally, the greater the number of home visits, the more likely the intervention mothers
were to be sober, to be compliant with health care protocols and to provide a more stimulating
home environment.

Another experimental evaluation of a home visitation program for substance-abusing
mothers randomly assigned women to either the intervention condition or a control condition
(Schuler, Nair, Black, & Kettinger, 2000). The intervention group received 6 months of home
visiting delivered by lay visitors that included services such as linking the mother to needed
supports and providing education on drug use and drug treatment, as well as a curriculum to
promote infant development. The control group received brief monthly home visits to reduce
attrition. Women in the intervention group received an average of 8.9 visits over the 6-month
period. At completion of the program, control mothers were more likely than intervention
mothers to be currently involved with the child welfare system, and control mothers who
continued to use drugs or alcohol were less responsive to their infants than control mothers who
continued to use drugs or alcohol, however no differences between the groups were found on
overall measures of maternal responsiveness or infant warmth, use of existing services, or drug
use (Schuler et al., 2000).

Additionally, Ernst, Grant, Streissguth, and Sampson (1999) used an experimental design
and randomly assigned women to an intervention group that received services through “The
Seattle Birth to 3 Program,” (later known as the “Parent-Child Assistance Program”) or to a
control condition that received no services. The intervention is a three-year home visitation
program, delivered by paraprofessional advocates in which women receive weekly or biweekly
visits focused on linking mothers to other needed services, providing transportation to medical
appointments, assisting mothers to identify personal goals and providing general support and
guidance. The results indicated that, at the completion of the program, 85 percent of intervention
mothers had completed some form of substance abuse treatment. Although tests of statistical significance were not provided, sobriety rates were higher for women who were most involved in the intervention (53%) than those who were least involved (27%) and those in the control condition (24%). Mothers most involved in the program were also more likely to be using a reliable method of birth control (60%) than those least involved (33%) or those in the control group (32%). And mothers most involved had higher rates of having the target child live with them (92%) than those least involved (31%) or those in the control group (67%). Additionally, in a follow-up quasi-experimental evaluation, Grant, Ernst, Pagalilauan, & Streissguth (2003) examined outcomes for the intervention group approximately 2.5 years after completion of the program and reported that between program exit and follow-up, mothers experienced an increase in abstinence from alcohol or other drugs. There was also a decrease in the number of mothers with a subsequent pregnancy or birth, an increase in permanent housing, and a decrease in incarceration.

Other research suggests that home visitation programs may have unique benefits for mothers involved with the child welfare system. Potocky and McDonald (1996) conducted a quasi-experimental study that assessed outcomes in a home visitation program targeted to mothers who had given birth to drug-exposed infants. The six-month intervention included home visits by a social worker that focused on parenting issues, basic survival skills and substance abuse treatment, other program components included early childhood education services, nursing services, parent education/support groups, transportation and respite child care. At the completion of the program, 70 percent of children remained with their parents; the more services the mothers used, the greater the improvement in their child’s well-being.

_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 counseling workers to facilitate entry into treatment. Five studies were identified that evaluated the use of concrete supports and assistance in substance abuse treatment for women. Laken and Ager (1996) conducted a quasi-experimental study that examined outcomes for women participating in a case management intervention designed to improve retention in prenatal substance abuse treatment. The case management intervention included transportation to a woman-centered outpatient treatment center, prenatal care, monitoring of clients and case coordination by a case management team. The results indicated that transportation to the treatment center was one of the most significant factors related to attendance at treatment. Child care may also increase program effectiveness. Roberts and Nishimoto (1996) used a quasi-experimental design to evaluate the impact of a day treatment program that was enhanced by providing family therapy, parenting education, educational classes and child care. The outcomes for women in the day treatment program were compared to outcomes for women in a traditional outpatient program and a residential program. The results indicated that women in the day treatment program that offered child care were more likely to stay in treatment longer and to complete treatment than women in the other two conditions.

There is also some evidence to suggest that the use of concrete support and assistance may be especially beneficial for mothers involved in the child welfare system. Marsh, D’Aunno and Smith (2000) used a quasi-experimental design that compared mothers in an enhanced treatment condition (designed to remove barriers to substance abuse treatment for women involved in the child welfare system) to mothers in a treatment-as-usual condition. The enhanced treatment condition included transportation, outreach, and child care services. The results
indicated that women receiving the enhanced treatment did receive more services including assistance with child care, parenting classes, transportation, and the use of outreach workers; participation in the program was also related to decreased substance abuse. Dore and Doris (1998) conducted a quasi-experimental study of an intervention for substance-abusing parents in the child welfare system (98% were mothers) that included in-home supportive services, linkages to substance abuse treatment, mentoring, parenting education, transportation, child care and other concrete support (such as emergency funds, food, and clothing). The results indicated that parents who utilized the child care portion of the program were more likely than those not using child care to complete substance abuse treatment.

And finally, the Illinois AODA IV-E Waiver Demonstration Project redirected Title IV-E funds to provide substance-abusing parents in the child welfare system with “Recovery Coaches” who assisted parents in obtaining and participating in substance abuse treatment as well as providing assistance in understanding and negotiating child welfare and court requirements. Although full evaluation results are not yet completed, a two-year interim experimental evaluation that used random assignment has found some promising results. The results indicate that those in the demonstration groups are more likely to access substance abuse treatment than those in the control groups (69% vs. 60%), they are also more likely to access this treatment more quickly (median days to treatment in demonstration groups 14 vs. 28 days in control groups). Children in the demonstration groups also experienced fewer days in out-of-home placement than those in control groups (mean 282.9 days vs. mean 308.9 days). However, no differences were found on reunification rates, number of out-of-home placement, or rates of subsequent maltreatment between the two groups (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. The use of a psychoeducational groups as an enhancement to substance abuse treatment was evaluated in a quasi-experimental study that examined the impact of a six-week sexuality and assertiveness workshop for women participating in methadone maintenance entitled “Time Out! For Me.” Workshops included topics such as reproductive health, HIV prevention and women’s socialization. The results indicated that women who completed 4-6 sessions had higher self-esteem and remained in drug treatment longer than those who completed 1-3 sessions and both groups experienced reductions in anxiety, although no differences in depression were found (Bartholomew, Rowan-Szal, Chatham, & Simpson, 1994). Moreover, a separate study used an experimental design to test the same intervention in a residential substance abuse treatment center for women where women were randomly assigned to the intervention or control condition (Hiller, Rowan-Szal, Bartholomew, & Simpson, 1996). The intervention group receiving the short-term psychoeducational group experienced greater improvements in knowledge concerning assertiveness, communication skills, and sexual health, more positive attitudes toward safe sex and being assertive, and increased self-esteem than the control group (Hiller et al., 1996).

Moreover, McComish, Greenberg, Kent-Bryant, Chrucial, Ager, Hines, et al. (1999) conducted a quasi-experimental study on a weekly grief counseling group for women enrolled in residential substance abuse treatment. The group was both didactic and psychotherapeutic and focused on providing information on the grief process as well as linking past experiences of loss
and grief to substance abuse. Women attended an average of five sessions. Comparisons between the intervention and comparison group indicated that participation in the intervention was associated with increased treatment retention and self-esteem, no differences were found between the two groups on measures of overall mood, depression, and parenting skills.

There is also evidence that targeted interventions may help improve birth outcomes among pregnant substance-abusing women. Svikis, McCaul, Feng, Stuart, Fox and Stokes (1998) conducted a quasi-experimental study comparing women who attended at least two sessions of a support group to those who attended one or no sessions. The support group included discussion of topics related to substance abuse including relapse and the effects of drugs on the fetus, ways to establish support systems and behavioral contracting to increase attendance. The results indicated that the intervention group attended more prenatal visits, had babies with greater birth weights and higher Apgar scores and experienced lower overall health care costs.

In addition, Elk, Mangus, Rhoades, Andres and Grabowski (1998) used an experimental design to test the effects of a contingency management intervention for pregnant women using cocaine. The intervention took place within an outpatient substance abuse program where women were randomly assigned to the intervention condition (including financial incentives for clean drug tests) or the control condition (no incentives). The results indicated that the intervention group had higher compliance with prenatal medical visits, however there were no differences between the groups in rates of retention, drug use or perinatal outcomes.

The use of motivational interviewing to increase retention in treatment has also been investigated as a potentially useful short-term intervention for substance-abusing mothers. Mullins, Suarez, Ondersma, and Page (2004) used an experimental design and randomly assigned substance-abusing women in the child welfare system to an intervention condition
receiving motivational interviewing or a control condition that watched educational videos on substance abuse. The majority of women in both groups had lost custody of their child. The motivational interviewing intervention included three sessions with a mental health provider trained in motivational interviewing. This technique is described as client-centered and directed toward decreasing clients’ ambivalence about stopping their substance abuse and increasing their motivation for change. At an eight-week follow-up, no differences on outcomes related to treatment engagement and retention were found between the intervention and the control group. The authors speculate that motivational interviewing may not be effective with an involuntary population who may be worried about information being shared with the court or child welfare system; or that these clients already had a high level of readiness for change and thus the intervention had no effect; or that the control condition involving educational videos had a strong impact on the participants.

*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. For instance, Smith & Marsh (2002) used a quasi-experimental design to investigate the role of client-service matching for mothers in substance abuse treatment. The results revealed that the matching of services to client needs had little effect on outcomes; however, the more services in general the women received the better the outcomes. Berkowitz, Brindis, and Peterson (1998) conducted a quasi-experimental study that assessed outcomes for women participating in the California Perinatal Services Network, a comprehensive intervention that included outpatient treatment, counseling, case management, child care,
transportation, health services, substance use education, home visitation and aftercare services. The study compared outcomes prior to treatment to those during a six-month follow-up period after completing treatment. The results indicated that women were less likely to be involved in criminal activity (or fights), less likely to neglect themselves or their children, and less likely to be homeless, to be taken advantage of, or to feel suicidal. At the six-month follow-up, there was also a reduction in the number of children required by the child welfare system or the criminal justice system to be placed out of the home. In addition, Elk, Mangus, LaSoya, Rhoades, Andres, and Grabowski (1997) used a quasi-experimental design to evaluate outcomes for pregnant women participating in a multidisciplinary treatment program that included child care, prenatal care, HIV counseling, parenting education, prenatal and nutrition classes, post-partum counseling, health care, psychological counseling, substance abuse treatment and transportation. The results indicated a high overall retention rate (69%), high compliance rate with prenatal care (82%), good birth outcomes and a high rate of abstinence after treatment (60%).

Other studies have evaluated comprehensive residential programs and found positive outcomes. Knight et al. (1999) used a quasi-experimental design to study the Salvation Army “First Choice Program,” a residential program for women with children that included individual and group counseling, educational and vocational training, relapse prevention, life skills, psychoeducational groups, parenting skills training, child care, transportation, and therapy and educational groups for children. The results indicated that 73 percent of women remained in treatment 90 days or longer.

Two studies evaluated outcomes of the “Arkansas Center for Addictions Research, Education and Services” (AR-CARES), a substance abuse program for women and their children. The program initially began as an outpatient program that evolved to include residential
services. The program components include AOD education, 12-step, relapse prevention, life skills training, vocational training, health education, parenting education, transportation, linkage to other services, child care and educational and mental health services for children. Whiteside-Mansell et al. (1998) conducted a quasi-experimental evaluation of the program that compared outcomes for women participating in the program to those not participating (no randomization) as well as pre- and post-outcomes for participating women. The results indicated that participating pregnant women experienced significantly greater declines in alcohol and other drug use than non-participating women, and their use of drugs or alcohol also declined significantly between intake and delivery of their child. Participating women were also less likely than non-participating women to experience premature labor and infection. Overall, longer participation in treatment was associated with larger birth weights.

A second quasi-experimental evaluation of only the residential portion of the program found that graduates of the program were less likely to be using drugs at a 3, 6, or 12 month follow-up than women who dropped out of treatment early (less than 30 days) and women who dropped out of treatment late (more than 30 days, but no completion). The graduates were also marginally less likely to experience poverty, marginally less likely to have been arrested, and marginally more likely to experience greater family cohesion than the other two groups. Additionally, the graduates significantly improved their parenting skills in comparison to the late drop-outs (Conners, Bradley, Whiteside-Mansell, & Crone, 2001).

In addition, Sowers, Ellis, Washington and Currant (2002) also reported positive outcomes in a quasi-experimental study of “The Susan B. Anthony Center,” a transitional housing substance abuse treatment center for women and children that included counseling, social skills training, substance abuse education, parent training, and employment counseling.
The outcome data that compared women in this intervention to those in traditional day treatment services indicated that women in the intervention group experienced fewer arrests and were more likely to be employed; however, no differences in substance abuse were found. The pre- and post-outcome data for the intervention group also indicated that women experienced improvements in overall functioning, although tests of statistical significance were not reported. Similarly, a quasi-experimental evaluation of 32 Pregnant and Postpartum Women (PPW) programs reported improved outcomes in a number of domains. The residential program included substance abuse treatment, health care, mental health services, vocational training, parenting education, legal services, child care and transportation. The pre- and post-outcome data indicated significant reductions in alcohol or other drug (AOD) use; further analysis compared women who remained sober during a six-month follow-up (abstainers) to those who relapsed (relapsers). The results indicated that both abstainers and relapsers reduced criminal activity, were less likely to live with an AOD-involved partner, were more likely to be employed for at least 30 days, were more likely to be in vocational/educational training, experienced reductions in physical health problems, and lived with at least one child. These changes were greater in magnitude for the abstainers than for the relapsers. The abstainers were also less likely than relapsers to have mental health problems and were less likely to have at least one child in foster care (Porowski, Burgdorf, & Herrell, 2004).

Likewise, Killeen and Brady (2000) conducted a quasi-experimental study of a residential program for women and children that included 12-step, substance abuse education, parenting classes, relapse prevention, involvement in community programs, child care and services for children including counseling, substance abuse education, structured mother-child interaction groups, and health services. The outcome data indicated that parenting skills were improved at a
twelve-month follow-up. A further comparison of those who completed the program with those who dropped out early found that graduates scored better on parenting assessments at both a six and a twelve-month follow-up, child behaviors of graduates improved at six-month follow-up (compared to no improvement for non-graduates) and graduates displayed greater improvement on scores on an Addiction Severity Index scores than non-graduates.

Similarly positive outcomes were also noted by Saunders (1993) in a quasi-experimental study of the “Project Together Program,” a residential substance abuse treatment program for women and their children that included counseling and therapy, parenting education, 12-step, health care, educational or vocational training, child care and support groups. The results revealed that women who completed the program had longer periods of sobriety and more improved parenting skills than those who dropped out early. And pre- and post-outcome data indicated that scores on measures of psychological distress decreased, indicating less depression, anxiety and somatic complaints at the completion of the program.

Summary of Studies Addressing Child Welfare Outcomes

Table 2 provides a summary of interventions included in this review that assess outcomes specifically related to the child welfare system. Since very few studies reported on outcomes related to child welfare system involvement, it is impossible to draw conclusions about which interventions are most effective with substance-abusing parents in the child welfare system. Instead Table 2 simply summarizes those studies 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). It is possible that other interventions are equally or more effective with substance-abusing parents in the child welfare system, but the child welfare outcome data is not reported. There were nine studies that either used samples
<table>
<thead>
<tr>
<th>Authors</th>
<th>Intervention</th>
<th>Type of Study</th>
<th>CWS Involvement of Sample</th>
<th>Child Welfare Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkowitz et al.</td>
<td>California Perinatal Services Network. Services included outpatient treatment, counseling, case management, child care, transportation, health services, substance use education, home visitation, and aftercare services.</td>
<td>Quasi-experimental: Interviews conducted with women shortly before leaving treatment and then 6 months later (N=460).</td>
<td>18% referred by CWS or criminal justice system.</td>
<td>At 6 month follow-up there was a reduction in number of children required by the CWS or criminal justice system be placed out of the home.</td>
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<td>(1998)</td>
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<td>Dore &amp; Doris</td>
<td>Intervention delivered by a voluntary child welfare agency, included in-home supportive counseling, linkages to substance abuse treatment programs, mentoring, day care, respite care, parenting education, transportation, concrete support. Average length of treatment was 8 months.</td>
<td>Quasi-experimental: Pre and post outcomes (N=119).</td>
<td>All were involved with the CWS, average length of CWS involvement was 18 months, 39.2% of sample had at least one child placed out of the home.</td>
<td>At 12 month follow-up: 41% had completed treatment and stayed sober the entire 12 month period, 41% did not complete treatment. Clinician ratings indicated that 73% of clients had made “significant progress.” No relationship between level of participation in treatment and substance abuse treatment status. Clients who had a child in the day care program were more likely to complete treatment. No relationship between treatment completion and child placement.</td>
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<td>(1998)</td>
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<tr>
<td>Ernst et al.</td>
<td>The Seattle Birth to 3 program (AKA the Parent-Child Assistance Program): A 3-year home visitation program that uses paraprofessional advocates that work with women from the birth of their child to age 3. Advocates visit mothers’ home weekly or bi-weekly, link mothers to other services, provide transportation to medical appointments and provide general support as needed. Program directed toward high risk substance abusing women pregnant women.</td>
<td>Experimental: Randomized control trial: Compared women receiving intervention (N=60) to women not receiving the intervention (N=30).</td>
<td>Not reported.</td>
<td>Mothers most involved in the program had higher rates of having the target child live with them (92%), than those least involved (31%), or the control group (67%).</td>
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<td>(1999)</td>
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<td>Marsh et al.</td>
<td>Intervention included service enhancements intended to reduce barriers to substance abuse treatment for women involved in the CWS; service enhancements included transportation, outreach and child care services.</td>
<td>Quasi-experimental: Compared clients in program offering enhanced services (N=73) to those in treatment as usual (N=75).</td>
<td>All women included in the study were clients of the CWS.</td>
<td>Intervention group received more services including assistance with child care arrangements, parenting classes, transportation and use of an outreach worker, intervention group also related to decreased drug use.</td>
</tr>
<tr>
<td>Authors</td>
<td>Intervention</td>
<td>Type of Study</td>
<td>CWS Involvement of Sample</td>
<td>Child Welfare Outcomes</td>
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<td>Porowski et al. (2004)</td>
<td>Follow-up evaluation of the PPW programs. Intervention included 6 or 12 month residential substance abuse treatment for pregnant or postpartum women. Women could reside with their children in treatment, services include substance abuse treatment, health care, mental health services, vocational parenting, legal services, day care and transportation.</td>
<td>Quasi-experimental: Compared pre and post outcomes (N=1,181) and comparison of those who relapsed to those who abstained during the 6 month follow-up.</td>
<td>47 percent had one or more children placed in out-of-home care at some time.</td>
<td>At 6-month follow-up, women who remained sober were less likely to have at least one child in foster care then at entry into the program.</td>
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<td>Potocky &amp; McDonald (1996)</td>
<td>A 6-month home visitation program, visits by a social worker focusing on parenting issues, basic survival skills, and substance abuse recovery; early childhood education services, nursing services, parent education/support group, a parent/child group, transportation assistance, respite child care. Average of 0.6 hours of home visits/week.</td>
<td>Quasi-experimental: Assessed outcomes after treatment completion (N=27).</td>
<td>All mothers had drug-exposed infants and were referred by CWS or local hospital.</td>
<td>At program completion, 70% of children remained with parents, families who remained intact used the parent education/support groups and the parent/child interaction groups more frequently than those who had children placed in foster care. The more services mothers used, the greater the improvement in their child’s well-being.</td>
</tr>
<tr>
<td>Schuler et al. (2000)</td>
<td>A 6-month home visiting intervention program delivered by lay visitors. Contained an infant and a parent component. Topics in parent component included linking mother to needed supports and education on drug use and drug treatment. Infant component included a curriculum to promote infant development. Average number of visits over the 6 months was 8.9.</td>
<td>Experimental: Randomized control trial. Compared intervention group (N=87) to a control group (N=84) that received brief monthly home visits to reduce attrition.</td>
<td>Not reported.</td>
<td>At completion of program, control mothers were more likely than intervention mothers to be currently involved with the child welfare system.</td>
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<tr>
<td>Stevens &amp; Arbiter (1995)</td>
<td>Intervention is a Therapeutic Community (“Amity”), a residential treatment center for women with children. Goal of treatment is overall changes in lifestyle, not just reduction of substance use. Intervention included groups, seminars and retreats focused on women’s issues such as emotional bonding, female friendships, sexual abuse issues, and parenting.</td>
<td>Quasi-experimental: Pre-post outcomes (N=57) and comparison of women who dropped out of treatment (N=44) to those who completed treatment (N=13).</td>
<td>33% involved with CWS at time of entry to treatment.</td>
<td>At 6 or 12 month follow-up 58% had custody of at least one child.</td>
</tr>
<tr>
<td>Authors</td>
<td>Intervention</td>
<td>Type of Study</td>
<td>CWS Involvement of Sample</td>
<td>Child Welfare Outcomes</td>
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<td>Testa et al. (2003)</td>
<td>Redirected Title IV-E funds to implement demonstration project for substance abusing parents in the child welfare system. Intervention included the use of “Recovery Coaches” to assist parents in participating in substance abuse treatment, and negotiating system requirements.</td>
<td>Experimental: Sites were randomly chosen for the demonstration project, interim evaluation compared parents in the demonstration sites (N=368) to those in the control group who received treatment as usual (N=164).</td>
<td>All involved in the CWS.</td>
<td>24 months after demonstration project began: Intervention group more likely to access substance abuse treatment, more likely to access treatment more quickly, children in intervention group experienced less time in placement. No differences between in reunification rates, average number of placements, or rates of subsequent maltreatment.</td>
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</table>
exclusively of parents involved in the child welfare system or reported on child welfare system 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. Figure 2 provides a summary of these program components and associated child welfare outcomes.

Figure 2. Summary of Interventions With Child Welfare Outcome Data

<table>
<thead>
<tr>
<th>Component</th>
<th>Child Welfare Related Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visitation</td>
<td>• Increased likelihood of maintaining custody of child • Decreased involvement in the child welfare system</td>
</tr>
<tr>
<td>Concrete Support and Assistance</td>
<td>• Increased likelihood of accessing treatment • Increased likelihood of timely access to treatment • Children experience fewer days in out-of-home placement</td>
</tr>
<tr>
<td>Comprehensive and Holistic Interventions</td>
<td>• Reductions in out-of-home placement</td>
</tr>
<tr>
<td>Woman-Centered Treatment</td>
<td>• Increased likelihood of maintaining custody of child</td>
</tr>
</tbody>
</table>

**System-Level Factors Affecting Treatment**

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. Several scholars have noted that there are 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 differences in how the two systems define the client, operate with different time line constraints, receive different training and education, experience different funding barriers and shortages of available treatment, operate with different confidentiality mandates, and define successful outcomes in different ways.
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. However, for substance-abusing women involved in the child welfare system, issues surrounding their children are often very important to them, and treatment approaches that do not address the relationship of women with their children may not be effective for parents involved in the child welfare system (U.S. DHHS, 1999). 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) noted 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) stipulate that a permanency hearing must be held after 12 months of out-of-home care and a petition for termination of parental rights must be filed for children who are placed in out-of-home care for 15 out of 22 months, unless special circumstances apply.

2) Treatment time lines also affect substance-abusing parents in the child welfare system. It has been noted that substance abuse problems are complex and that relapse is often a common occurrence within substance abuse treatment (USDHHS, 1999). 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.

3) Welfare time limits mandated by the Temporary Assistance to Needy Families (TANF) polices may also impact substance-abusing parents in the child welfare system. As parents are often involved in both the child welfare system and the
welfare system, the 24 month TANF time limit requiring parents to be engaged in work activities may interfere with their treatment needs, as well as their ability to provide for their children if their welfare benefits are cut.

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—a fact that was a major impetus behind the passage of ASFA. 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 have been trained in a variety of disciplines or have limited formal training. 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.

Models to Improve Collaboration

The models of collaboration between AOD systems and the CWS have been developed to address many of the barriers that exist between the two systems. In addition to specific
interventions for substance-abusing mothers and parents in the child welfare system, this review also identified models that may improve collaboration between the two systems. While there are very few studies that have assessed the outcomes of collaborative models, this review included all identified empirical or descriptive studies or reports related to collaboration between the two systems. Methods used to identify information on collaborations between AOD systems and the CWS were similar to those used to identify interventions for substance-abusing parents in the child welfare system (see Appendix A).

Table 3 provides a summary of the collaborative models found in the literature, but it is not exhaustive or necessarily representative of the best collaborative models currently in use. Instead, it represents those collaborative models that have been described in the literature as promising examples. An analysis of the information provided in Table 3 suggests that the following elements may be important characteristics of collaborative models: 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 these core elements and their rationale.

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. Connecticut’s Project SAFE (Substance Abuse Family Evaluation) gives priority to timely assessment of substance abuse problems and immediate access to services for those in need of treatment. One aspect of their approach is to assign a substance abuse specialist
<table>
<thead>
<tr>
<th>Model Name</th>
<th>Core Elements</th>
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| Connecticut’s Project SAFE                    | • Began in 1995  
• Goal is to ensure timely access to substance abuse assessment and services for CW parents  
• Provides screening for barriers to engagement and retention in treatment, such as transportation, child care or health care  
• Developed of 15 guideposts for collaboration between CWS and AOD system  
• Formed a working group that developed a strategic plan, and a client-based treatment model to substance-abusing parents in the CWS  
• AOD specialist is assigned to every regional CW office  
• Development of a shared database for AOD and CWS to access in order to track outcomes for substance-abusing parents in the CWS  
• Commitment to cross-training  
• Funding comes from variety of sources: state funding, AOD system grants, and Medicaid |
| New Jersey’s Child Protection Substance Abuse Initiative | • Began in 1995  
• Provides assessment, referral and case management to parents  
• The CW caseworker can request that a substance abuse counselor assess a parent with a substance abuse problem, the CW caseworker and substance abuse counselor then create a joint service plan for treatment.  
• Home visitors are also used to monitor parent’s progress and compliance, and provide concrete assistance such as transportation, and referrals to other support services  
• Initial assessments are to occur within 24-72 hours of the intake process  
• CWS contracts with substance abuse treatment services that provide comprehensive services and work closely with the CWS.  
• Confidentiality protocols and releases have been established in order to share information between systems.  
• New CW workers participate in 3 days of substance abuse trainings, in-service training provided to current CW workers.  
• Funding comes from both the CWS and the AOD system, as well as State family preservation funding, Medicaid and the federal Center for Substance Abuse Treatment |
<table>
<thead>
<tr>
<th>Model Name</th>
<th>Core Elements</th>
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</table>
| Sacramento County’s Alcohol and Other Drug Treatment Initiative            | • Began in 1993  
• CW workers initially screen parents and then make an appointment with an AOD worker for assessment  
• CW workers who have completed a certain level of substance abuse training can complete a preliminary assessment, and obtain telephone authorization from the AOD system for treatment  
• The AOD and CWS have implemented programs such as Options for Recovery, which assigns an AOD case manager to child welfare cases involving substance-abusing mothers to ensure timely linkages to treatment.  
• Implemented the Early Intervention Specialists Program which targets services to substance-abusing pregnant women or those with young children. An intervention specialist is stationed at the dependency court and provides outreach, assessment and intervention, and education about court processes and timelines.  
• In 2001 a Dependency Drug Court was established that ensured that Early Intervention Specialists assess all parents in need of an AOD assessment when they come into the court. If reunification services are ordered, parents are ordered to participate in the Specialized Treatment and Recovery Services (STARS) program which assigns a worker to the case who provides support and monitors parents to ensure engagement and retention in services, the worker also services as a liaison to the court, the CWS and AOD treatment  
• Clients sign a release of information statement so that the systems can share information  
• CW staff participates in training that classifies them as a Level I, II or III in AOD knowledge and skills  
• Court staff also participate in training  
• Funding initially provided by the Annie E. Casey Foundation and is now funded by county funds and through marketing of the initiative to other localities |
| Cuyahoga County’s Sobriety Treatment and Recovery Teams                    | • Began in 1997  
• The Sobriety Treatment and Recovery Teams (START) program focuses on pregnant substance-abusing women or mothers who deliver a drug-exposed infant  
• Services are provided by social workers and family advocates who are women in recovery  
• Cases are assigned to START by hospital staff after a pregnant women or mother tests positive for drugs  
• START workers assess and refer women to treatment within 3-4 days of the initial report  
• START works closely with substance abuse treatment providers, there are monthly meetings between providers and supervisors and weekly contact between the START team and the provider while the mother is in treatment.  
• Communication protocols have been established so that confidential information may be released between systems  
• START staff undergo extensive AOD training  
• Funding is provided by state and county funds as well as the Annie E. Casey Foundation |
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<tr>
<th>Model Name</th>
<th>Core Elements</th>
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| Jacksonville’s Treatment Agency Initiated Program | • Began in 2000.  
• Outstations AOD counselors in specific child welfare investigation units, AOD workers assist CW workers in assessing parents, providing treatment referral and engaging parents in substance abuse treatment  
• CW workers consult with AOD workers on cases involving substance-abusing parents  
• An Individualized Course of Action (ICA) plan is created with input from all relevant agencies  
• A 3-day training is provided for both CWS and AOD workers  
• Strong collaboration between AOD and CWS, task force has been established  
• Funding for treatment is provided by State, TANF funds are used to fund the outstationed workers, and treatment services, Medicaid is also used to fund treatment services |
| San Diego County’s Dependency Court Recovery Project | • Began in 1998  
• Overall goal is to ensure that a reunification or permanency plan is achieved on time  
• System was developed to give parents in the dependency court top priority for substance abuse treatment slots.  
• Parents initially assessed by CW workers using a risk assessment tool as having an observable substance abuse problem are enrolled in the Substance Abuse Recovery Management System (SARMS)  
• Once in SARMS, a substance abuse counselor assesses the parent(s) and intensive case management, random drug testing and bimonthly reporting the CWS worker and the court are required  
• Goal is to place SARMS clients in treatment within two days of the assessment  
• 25-30 different treatment service providers are under contract  
• Recovery specialists with experience and education in AOD monitor parents and are responsible for engaging them in treatment  
• Parents who do not comply with SARMS are referred to the Dependency Drug Court (DDC), which requires participation in treatment, abstinence from drugs and alcohol, compliance with court orders and weekly court appearances during the initial phases of treatment  
• Noncompliance with court orders results in sanctions such as short term incarceration, paying a fine, or both.  
• Substance abuse training is provided to all new CW workers, and cross-training between systems is also provided  
• Funding comes from the county’s share of the substance abuse prevention and treatment block grant, family preservation funding, Medicaid, State tobacco settlement funds, TANF, and state general funds |
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<th>Model Name</th>
<th>Core Elements</th>
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| Miami/Dade County’s Dependency Drug Court     | • Began in 1999  
• CW workers and AOD specialists are assigned to the Dependency Drug Court (DDC).  
• Judges initially refer parents to the DDC  
• The DDC is a 15-month program and throughout participation parents must be drug tested, maintain daily contact with a DDC specialist, and participate in a 12-step program  
• DDC addiction specialists work with CW workers to develop a case plan that is implemented by both the substance abuse treatment providers and the CWS  
• To graduate from the DDC, parents must have completed their case plan, have housing and employment, completed a parenting class specifically for substance-abusing parents, completed four motivational workshops, and regained custody of their child(ren)  
• DDC addiction specialists are supervised by psychologists and are trained in using an empirically-validated engagement intervention  
• Parents sign consent forms to release information across systems  
• Educational seminars are provided to court and CW personnel  
• Funding comes from TANF and legislative funds |
| Delaware’s Title IV-E Waiver Demonstration   | • Began in 1996  
• Uses Title IV-E funds to place AOD specialists in child welfare offices  
• AOD specialists conduct assessments of parents, identify treatment services, serve as a liaison between the CWS and service providers, and provide consultation to CW workers  
• CWS has worked to establish close ties with service providers to ensure that parents have access to services and that service providers are aware of the needs of parents in the child welfare system |
| Manhattan Family Treatment Court              | • Goals are early intervention and timely participation in treatment, monitoring of parent progress and compliance, basing child placement decisions on information about parents’ progress, and improving coordination of service delivery and monitoring among all systems involved in the case  
• Coordination of systems is conducted through a series of committees  
• Assessments are conducted by a treatment court case manager, who develops an initial treatment plan.  
• When in treatment, parents are required to meet regularly with court case managers, participate in drug testing, and complete other elements of their case plan  
• Court case managers work collaboratively with CW workers to ensure that treatment is delivered  
• Rewards and sanctions are used including rewards such as increased visitation, or certificates of achievement; sanctions can include jail time |
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<th>Model Name</th>
<th>Core Elements</th>
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</table>
| **Suffolk County Family Drug Treatment Court** | • Goals include timely fact-finding hearings, coordinated case management, speedy dispositional hearing and regular oversight of cases  
• A multidisciplinary, multi-agency Case Management Team (CMT) creates service plans and monitors parent participation. The team includes court staff, staff from a non-profit agency that provides support services to the court, case manager, a facilitator, a Court-Appointed Special Advocate (CASA), and AOD specialists  
• The CMT create a joint case plan, AOD specialists initially assess the parent and identify treatment options,  
• An interagency policy committee that includes service providers, and representatives from county departments meets regularly to support the project, identify needs and provide recommendations  
• Sanctions, such as more frequent testing, or jail time and rewards such as special outings for parents and children or books to read with children are provided |
| **Escambia County Family Treatment Court (Pensacola FL)** | • Parents enter the family drug court when they fail to comply with a family court dispositional order  
• Once admitted to the family drug court, parents are referred to a substance abuse treatment provider for assessment, after assessment a treatment plan is created that is parallel to the child welfare case plan  
• Representatives from agencies collaborate in the treatment process for parents, including CW workers and AOD staff  
• A certain number of slots are reserved within substance abuse treatment center for drug court parents  
• Once in treatment, the service provider works collaboratively with other service providers  
• The judge meets regularly with a team involving representatives from the CWS, the probation department, a drug-court nurse from the Department of Health and AOD specialists  
• Sanctions can include increased monitoring or more intense treatment |
| **Montgomery County’s Blended Model of Intervention** | • Began in 1997  
• An interagency task force was created to guide collaborative efforts  
• A training curriculum for both AOD and CW workers was created and utilized  
• Created a “Structured Response” system, which provides a planned and coordinated approach to parental substance abuse, including the use of three levels of action depending on parents’ level of substance abuse problem and their compliance with the CWS  
• Outstationed a substance abuse specialist at the central CW office  
• Emphasis on using existing strong relationships between AOD and CW staff to improve collaboration |
to every regional child welfare office. This specialist, who is a child welfare system employee, provides consultation and training to child welfare workers, as well as intervention with parents. The child welfare workers perceive the locating of this specialist at their office as extremely beneficial to their work (Young & Gardner, 2002). Similarly, Jacksonville’s Treatment Agency Initiated Program has outstationed AOD workers in specific child welfare investigation units. These workers assist child welfare workers in assessing parents, providing treatment referral, engaging parents in substance abuse treatment and providing consultation to child welfare workers. The goal behind outstationing these substance abuse specialists (who are supported with outside funding) with child welfare investigation units is to provide parents with a smooth entry into the AOD system by reducing the need to travel to additional appointments for assessment and referral (Young & Gardner, 2002). Delaware’s Title IV-E Waiver Demonstration has used Title IV-E funds to hire substance abuse specialists for every child welfare office. Similar to other collaborative models, these specialists assess parents, identify treatment options, monitor client entry into treatment in order to improve retention, and provide consultation to child welfare workers (Semidei, Radel, & Nolan, 2001). Montgomery County, Maryland has also used an outstationed AOD worker to improve services for substance-abusing parents. This worker is housed at the central child welfare office and is responsible for consulting with child welfare workers on specific substance abuse cases, modeling intervention with substance abusing parents, and facilitating referrals for assessment and evaluation. The substance abuse specialist also may accompany child welfare workers on home visits (McAlpine, Marshall & Doran, 2001).

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
**Figure 3. Collaborative Model Components**

<table>
<thead>
<tr>
<th>Component</th>
<th>Description and Rationale</th>
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<tbody>
<tr>
<td>Outstationing Alcohol and other Drug Workers in Child Welfare Offices</td>
<td>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 AOD workers can provide consultation to CWS workers on substance abuse cases.</td>
</tr>
<tr>
<td>Joint Case Planning</td>
<td>Case plans that are jointly created and monitored by both systems. Joint case plans may help reduce conflicting case goals and improve treatment planning.</td>
</tr>
<tr>
<td>Official Committees to Guide Collaborative Efforts</td>
<td>Specially appointed committees or task forces that guide collaborative efforts. Committees can provide structure and oversight to collaboration and ensure input from both systems.</td>
</tr>
<tr>
<td>Training and Cross-Training</td>
<td>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.</td>
</tr>
<tr>
<td>Protocols for Sharing Confidential Information</td>
<td>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.</td>
</tr>
<tr>
<td>Dependency Drug Courts</td>
<td>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. The goals are to 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.</td>
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</tbody>
</table>

when appropriate). Jacksonville’s Treatment Agency Initiated Program uses an Individualized Course of Action (ICA), a family-focused case plan that includes input from all involved agencies. Child welfare workers have described the use of ICAs as helping to ensure that all agencies and resources are brought together with the family; the process of including input from representatives from the AOD system is described by Young and Gardner (2002) as a major breakthrough in enhancing effective relations between AOD and CWS services.

The Dependency Drug Court in Miami/Dade County also uses joint case planning to facilitate collaboration and improve treatment planning for clients. The addiction specialists in the Drug Dependency Court work with child welfare workers to create a case plan that is jointly
implemented by substance abuse treatment providers and the Drug Dependency Court. The plans are family-focused and include a variety of services in addition to substance abuse treatment (Young & Gardner, 2002). Similarly, the Suffolk County Family Drug Treatment Court uses a multidisciplinary, multi-agency Case Management Team that creates service plans and monitors parent participation and compliance with the plan. The team includes court staff, support services, case managers, a facilitator, a Court Appointed Special Advocate and AOD specialists (Harrell & Goodman, 1999).

The Use of Official Committees to Guide Collaborative Efforts

Most collaborative models use specially appointed committees or task forces to guide collaborative efforts. Connecticut’s Project SAFE recognized the need for the CWS and the AOD system to establish a closer relationship if collaborative efforts were to be successful. A working group of representatives from both systems developed fifteen guideposts for collaboration between the two systems. The guideposts included shared principles related to explicit agreements between the systems on the areas that needed to be improved (e.g. more timely assessments, increased case management, exploring alternative funding options etc…), a strategic plan to guide their collaboration, and a client-based treatment model (Young & Gardner, 2002).

Delaware’s Title IV-E Waiver Demonstration initially began without sufficient input from the AOD system and substance abuse providers. However when a need for additional treatment options for parents became a challenge in the implementation of the project, the child welfare system worked to establish closer working relationships with both the state substance abuse agency and local substance abuse treatment providers. The building of closer ties between the CWS and AOD systems was critical for parents to have access to a limited number of
treatment services. Such collaboration has also helped to inform AOD systems of the needs of parents in the child welfare system, especially the need for timely access to treatment due to ASFA timelines (Semidei et al., 2001).

**Training and Cross-Training**

Training and cross-training between systems are core elements of most successful collaborative models. For example, New Jersey’s Child Protection Substance Abuse Initiative provides three days of substance abuse training for all new child welfare workers and in-service training for current workers on a state-wide basis. Similarly, Cuyahoga’s Sobriety Treatment Recovery Teams (START), comprised of child welfare workers and family advocates who are women in recovery engage in extensive substance abuse training on a wide range of issues along with technical assistance from the Annie E. Casey Foundation (Young & Gardner, 2002). Other efforts have focused specifically on cross-training between both fields. Montgomery County’s Blended Model of Intervention uses a training curriculum that was developed by both CWS and AOD workers and is aimed at providing both systems with information on how each system operates. The training includes 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. In addition, CWS information for AOD workers includes an overview of child welfare policies and mandates and the types of services offered to families (McAlpine et al., 2001).

**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.

**Dependency Drug Courts**

The use of dependency drug courts (DDC) 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). San Diego County’s Dependency Court Recovery Project was developed in order to give parents top priority for substance abuse treatment slots. Parents are initially assessed by a child welfare worker and if a substance abuse problem is suspected they are referred to the Substance Abuse Recovery Management System (SARMS). Once in SARMS, a substance abuse specialist provides assessment and case management services, as well as random drug testing along with bimonthly reporting to the child welfare worker and the court. The goal is to ensure that SARMS clients are in treatment within two days of their assessment. Once in treatment, recovery specialists (with experience and education in substance abuse treatment) monitor treatment progress and work to engage clients in treatment. Parents who fail to comply with SARMS are then referred to the DDC, which requires participation in treatment, abstinence from drugs and alcohol, and compliance with court orders. Clients in SARMS and those in the
DDC are sanctioned for noncompliance, including short-term incarceration, paying a fine, or both (Young & Gardner, 2002).

Miami/Dade County’s Dependency Drug Court has both CW and AOD workers assigned to the court. The judge initially refers parents to the DDC, which consists of a 15-month program throughout which parents must be drug tested, maintain daily contact with a DDC specialist and participate in a 12-step program. A joint case plan is created and implemented by the child welfare system and substance abuse treatment providers. To graduate from the DDC, parents must have completed their case plan, secured housing and employment, completed a parenting class specifically for substance-abusing parents, completed four motivational workshops, and regained custody of their child(ren) (Young & Gardner, 2002).

The goals of the Manhattan Family Treatment Court are early intervention and timely participation in treatment, monitoring parent progress and compliance, making child placement decisions based on information about the treatment progress made by parents and improving service delivery coordination and monitoring among all systems involved in the case. Various committees are used to ensure coordination of systems. Substance abuse assessments are conducted by a treatment court case manager who develops an initial treatment plan and works collaboratively with child welfare workers to ensure that treatment is delivered. The rewards and sanctions are issued by judges for compliance and noncompliance including such rewards as increased visitation or certificates of achievement and sanctions such as jail time (Harrell & Goodman, 1999).

The Suffolk County Family Drug Treatment Court is aimed at ensuring timely fact-finding hearings, coordinated case management, speedy dispositional hearings and regular oversight of cases. The substance abuse specialists initially assess the parent and identify
treatment options and a multidisciplinary team creates a joint case plan. In addition, an interagency policy committee that includes service providers and representatives from county departments meets regularly to support the project, identify needs and provide recommendations. Sanctions and rewards are also used for noncompliance and compliance with court orders (Harrell & Goodman, 1999).

The Escambia County Family Treatment Court in Pensacola Florida uses many of the same elements as other DDCs. Parents enter the DDC when they fail to comply with a family court dispositional order. Once admitted to the DDC, parents are referred to a substance abuse treatment provider for assessment and creation of a treatment plan that is coordinated with the child welfare case plan. Agency representatives collaborate in the treatment process and a certain number of treatment slots are reserved for drug court parents. The judge also meets regularly with a team involving representatives from the CWS, the probation department, a drug-court nurse and AOD specialists. The sanctions for noncompliance can include increased monitoring or more intense treatment (Harrell & Goodman, 1999).

Summary and Implications

The high prevalence of parental substance abuse in the child welfare system has widespread implications for practitioners, researchers, policy makers and families. Overall, research suggests that parental substance abuse is associated with problems in child and family functioning and may increase the risk of child maltreatment (Bauman & Levine, 1986; Burns et al., 1991; Chaffin et al., 1996; Hien & Honeyman, 2000; McNichol & Tash, 2001; Wasserman & Leventhal, 1993; Williams-Petersen et al., 1994). There is also evidence to suggest that children in the child welfare system with substance-abusing parents are at risk for a variety of poor outcomes (USDHHS, 1997).
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 structured review on the effectiveness of interventions for parents in the child welfare system has focused on both the micro level of the individual and the macro level of organizational systems. At the micro level, this review identified experimental and quasi-experimental studies that tested the effectiveness of interventions for parents in the child welfare system and for mothers and women in general. Research suggests that women in substance abuse treatment have unique needs and are affected by a number of risk factors including socioeconomic problems, criminal justice system involvement, current and past histories of abuse/victimization, and physical and mental health problems. Overall, more research is needed to test the effectiveness of micro level interventions specifically for parents in the child welfare system. Many identified studies did not report on the involvement of the child welfare system in their sample, and only nine of the studies in this review reported on outcomes related to the child welfare system. However, from the identified studies, a number of program components emerged as potentially effective with parents in the child welfare system, mothers or women in general. Many of the following program components appear to address the unique needs of this population: 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.

In addition to the micro-level of interventions for parents, the professionals involved with the CWS and AOD systems are becoming increasingly aware of the importance of collaboration between the two systems in order to ensure accurate assessment of parents, access to treatment,
and monitoring of clients. Many researchers have noted the numerous barriers to effective collaborative between the CWS and the AOD system, including differences in how the two systems define the client, time line constraints, differences in training and education, funding barriers and shortages of available treatment, problems surrounding confidentiality mandates, and differences in defining a successful outcome. Empirical studies on the effectiveness of collaborative models are lacking, however descriptive information suggests that many collaborative models contain the following core elements that seek to address these barriers to collaboration: 1) Oustationing 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.

Addressing the problem of substance abuse among parents involved in the child welfare system may require a multifaceted approach that integrates the best available micro-level interventions with macro-level interventions that include concerted efforts to implement models to improve collaboration between the CWS and AOD system. Although more research is needed to make definitive conclusions about effective micro and macro-level interventions for this population, 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, the evaluations of these county efforts would help to assess their effectiveness. Ultimately, an approach that integrates micro-level and macro-level interventions, along with careful follow-up evaluations, may shed even more light on the types of interventions that are most effective with this vulnerable population.
References


Substance Abuse and Mental Health Administration (2003). *Results from the 2003 National Survey on Drug Use and Health: National Findings.* Online, retrieved July 8, 2005 from: [http://www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm#ch3](http://www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm#ch3)


Appendix A
BASSC Search Protocol

Search Terms

1. substance abuse interventions OR drug interventions OR alcohol interventions AND child welfare
2. substance abuse treatment OR drug treatment OR alcohol treatment AND child welfare
3. substance abuse interventions OR drug interventions OR alcohol interventions AND parents
4. substance abuse treatment OR drug treatment OR alcohol treatment AND parents
5. substance abuse interventions OR drug interventions OR alcohol interventions AND mothers
6. substance abuse treatment OR drug treatment OR alcohol treatment AND mothers
7. substance abuse interventions OR drug interventions OR alcohol interventions AND fathers
8. substance abuse treatment OR drug treatment OR alcohol treatment AND fathers
9. substance abuse interventions OR drug interventions OR alcohol interventions AND effectiveness
10. substance abuse treatment OR drug treatment OR alcohol treatment AND effectiveness

Databases

Academic databases for books and articles

Pathfinder or Melvyl
ArticleFirst
Current Contents Database
ERIC
Expanded Academic ASAP
Family and Society Studies Worldwide
PAIS International
PsychInfo
Social Science Citation Index
Social Services Abstracts
Social Work Abstracts
Sociological Abstracts

Systematic Reviews

Cochrane Collaboration
Campbell Collaboration
Reference lists from primary & review articles

Research Institutes

Mathematica
Urban Institute
RAND
GAO
National Academy of Sciences
Chapin Hall
CASRC (San Diego)
Brookings Institute
Manpower Demonstration Research Corporation
Annie E. Casey Foundation

Conference proceedings

PapersFirst (UCB Database)
Proceedings (UCB Database)

Dissertation Abstracts

DigitalDissertations (UCB database)

Professional Evaluation Listserves

EVALTALK
GOVTEVAL
ChildMaltreatmentListserve

Internet

Google
Dogpile

Experts / personal contacts

Exclusion/Inclusion Criteria

Excluded:
Articles describing interventions or program approaches with no data
Studies that provided only descriptive data with no outcome data
Studies that did not focus on women or women with children or parents in the CWS
Studies that reported preliminary results for which a subsequent evaluation provided full results.
Studies that provided no description of the intervention.
Studies that focused on adolescent mothers.
Included:
Experimental Randomized controlled trials
Quasi-experimental: pre and post tests/ no control group, control group that is not randomized, comparing groups that differed in the dosage of treatment they received.
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