Evaluating the Effects of Comprehensive Substance Abuse Intervention on Successful Reunification

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Objective: This study examines permanency outcomes of families with children in foster care who participated in a comprehensive service-delivery program designed to assist families and communities in dealing with alcohol and other drug (AOD) problems. Method: Survival analysis is used to measure the impact of program participation on family reunification and re-entry of children into foster care. Results: The results of this study are that, contrary to initial expectations, participants move more slowly to reunification, although the group differences are not statistically significantly different, and re-entry rates are significantly higher among those children whose parents participate in this service. Conclusions: AOD abuse recovery is a long-term process. More intensive service interventions may not automatically produce better permanency outcomes.

Keywords: *child welfare; substance abuse; reunification; child abuse and neglect*

Although the precise role alcohol and other drug (AOD) abuse plays in affecting permanency outcomes is difficult to quantify, the presence of parental AOD abuse has been consistently documented in the literature as a predictor of poor child welfare outcomes (Young, Gardner, & Dennis, 1998). It is estimated that 60% of all families within the child welfare system have AOD problems that are related to the abuse or neglect their children experience and that in 75% of all out-of-home placements, AOD abuse is a contributing factor (Young et al., 1998).

The difficulties in addressing issues related to AOD abuse from a child welfare perspective have informed policy development in the areas of family preservation and birth family reunification. The Adoption and Safe Families Act of 1997 (ASFA) mandates time frames in which child welfare workers must evaluate reunification goals and parental compliance to family reunification plans, which may include AOD abuse recovery progress (Child Welfare League of America [CWLA], 2002; Smith, 2003). It has been noted throughout the literature that the time frames of AOD recovery and ASFA are incompatible, and family reunification efforts have been negatively affected as a result (CWLA, 2002; Hohman & Butt, 2001; U.S. Department of Health and Human Services [DHHS], 1999; Young et al., 1998).

Although the presence of substance abuse as a precipitating reason for entry into the child welfare system is well documented, its role from the entry point forward is not. This is to say that although many studies have documented the presence of substance abuse in cases referred to child abuse and neglect authorities, few studies have followed these same referrals to ascertain how AOD abuse (or treatment) affects permanency outcomes (such as reunification rates, maltreatment recurrence, reunification stability, termination of parental rights, adoption, and guardianship).

In an effort to begin developing population-specific services to these families in the child welfare system, programs are being developed at state, county, and local levels throughout the country (e.g., see Children and Family Futures, 2004, 2006; Drescher-Burke & Price, 2005; Maluccio & Ainsworth, 2003; Marsh, D'Aunno, & Smith, 2000; Ryan, Marsh, Testa, & Louderman, 2006). Although there are many variations in these programs, the services they provide, and the interventions used, many of these programs focus on the need for integration between service systems and increased access and engagement of clients in substance abuse treatment services. The program evaluated in this work represents an attempt by one rural county to meet these needs. This program sought to provide collaborative, multidisciplinary,

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community-based intensive services to families struggling with addiction that have child welfare involvement. This evaluation represents an attempt to assess the impact of participation in this intensive service program on time to reunification and reentry of children into foster care following reunification.

LITERATURE REVIEW

Research indicates that there are familial, parental, child, system, and community variables that are likely to influence permanency outcomes. Although a complete review of each of these factors is outside the scope of this work, there are several areas that these authors believe represent issues germane to the discussion of this program evaluation.

Reunification

According to DHHS (2003), 72% (median) of the children who reunify with birth families do so within 12 months following their entry into care. However, this percentage ranged widely, from 40.6 to 92.3 among the reporting states. The likelihood of eventual reunification declines after the first year in out-of-home care, and by the third year in foster care, the likelihood of adoption as an exit from foster care exceeds the likelihood of family reunification (Wulczyn, 2004). Wulczyn (2004) reports that reunification with birth families is the most common form of exit from foster care. However, the number of children reunifying with birth families has declined since 1990, and adoption rates for children in foster care are increasing (Wulczyn, 2004).

There are many factors that have been demonstrated to affect the likelihood of reunification, and these factors may be influenced by the presence of AOD abuse. For example, family composition is a predictor of reunification rates, and children removed from single-parent homes have less likelihood of reunification than those from two-parent households (Fein, 1993; Harris, 1999). The majority of women who present for AOD treatment with child welfare involvement are single mothers (DHHS, 1999).

Socioeconomic status is also predictive of reunification success, and the presence of poverty is one of the most established, consistently validated predictors of placement in foster care and lack of reunification success (Courtney, 1994, 1995; Courtney, Piliavin, & Enter-Wright 1997; Fernandez, 1999; Festinger, 1996; Jones, 1998; Thomlison, Maluccio, & Abramczyk, 1996). The relationship between poverty and AOD abuse and recovery has been documented. Weiner, Wallen, and Zankowski (1990) found that the more impoverished a woman is, the less likely she is to recover (DHHS, 1999; Hohman & Butt, 2001). Young and Gardner (1998) report that persons with substance abuse issues are more likely than any other group of service recipient to experience failure within both the child welfare and Temporary Assistance for Needy Families populations.

Maltreatment Recurrence

Although many children are reunifying with their families within 1 year of entering care, reentry rates into foster care remain high. Wulczyn (2004) reports that, of those children entering in 1990, 28% reentered care within 10 years. The Child Welfare Outcomes Report (DHHS, 2003) shows a decline in the past 4 reporting years (2000-2003) for reentry into foster care within 12 months of the prior foster care episode, with rates going from 10.6% to 9.8% of children. However, reentry rates vary depending on the length of time (i.e., observation period) following reunification being studied.

The duration of placement has been demonstrated to affect the success of reunification. Overall, research has tended to indicate that shorter placements result in higher reentry rates (Barth, 1997; Courtney, 1994; Davis & Ellis-MacLeod, 1994; Davis, Landsverk, & Newton, 1997; Rzepnicki, Schuerman, & Johnson, 1997; Westat, 2001; Wulczyn, 2004). However, a recent work by McDonald, Bryson, and Poertner (2006) did not find this to be true of cases reunified following very short stays (fewer than 30 days) in foster care.

Substance abuse in families results in an increased incidence of recurrent reports to child welfare authorities on behalf of the same children (Jaudes, Ekwo, & Voorhis, 1995; Wolock & Magura, 1996). Multiple recurrent reports to child welfare authorities, as well as lack of progress in reunification goals, are often attributed to the variable, long-term nature of recovery from AOD abuse and the fact that AOD abuse is intertwined with other issues that have been demonstrated to affect reunification, such as poverty, homelessness, lack of vocational training, intimate partner violence, and single parenting (Carten, 1996; CWLA, 2002; Strantz & Welch, 1995).

Child Characteristics

Certain child characteristics are associated with poorer permanency outcomes as well. Behavioral problems and physical disabilities in particular are associated with poorer outcomes (Teare, Becker-Wilson, & Larzelere, 2001; Wells & Guo, 1999). Although the precise role that

substance abuse plays in determining behavioral problems and physical disabilities is not well understood, it is likely that the combined impact of prenatal and postnatal substance abuse and the caregiving environment in which children from AOD-affected families are raised contributes to behavioral problems and physical disabilities in some children (Kim & Krall, 2006). Although research on the behavioral impact of parental substance abuse on children is mixed, several recent studies have shown that girls exposed to cocaine prenatally exhibit more aggression than girls not exposed (Kim & Krall, 2006; Nordstrom Bailey et al., 2005; Sood et al., 2005). Additionally, Delaney-Black et al. (2004) found more behavioral problems (including hyperactivity and acting out) among boys exposed to cocaine prenatally.

Certain parenting characteristics of AOD abusers affect their ability to provide age- and development-appropriate parenting techniques and contribute to the social and behavioral difficulties their children experience. AOD-abusing parents are more likely to provide inconsistent discipline and less likely to respond to cues from their children regarding social and emotional needs (Tartner, Blackson, Martin, Loeber, & Moss, 1993).

Service Delivery

According to Wulczyn (2004), "The evidence base for successful reunification programs and practices is especially thin, even by child welfare standards" (p. 108). Within the foster care population, the subgroup of AOD-affected families has received even less attention. Lack of information about service delivery may contribute to reunification success in families with AOD abuse issues (CWLA, 2002; Ryan et al., 2006; Smith, 2003). The lack of collaboration between the AOD treatment community and the child welfare system has played an important role. One recent work (Ryan et al., 2006) reported higher rates of reunification and greater access to treatment for AOD-involved families in the child welfare system when the services of nonchild welfare–, nontreatment center–affiliated recovery coaches were used.

The workers within these service delivery systems are placed in a difficult dilemma: Client outcomes are directly affected by services received in agencies other than their own (Young et al., 1998). Child welfare workers historically have received little training in assessment or treatment of substance abuse, yet they are required to evaluate client progress in recovery as part of reunification plans. Workers within these agencies often have differing philosophies and values about addiction, the role of the helping professional, appropriate treatment approaches, and desired outcomes in treatment (Besharov, 1992; Cole, Barth, Crocker, & Moss, 1996; Young & Gardner, 1998; Young et al., 1998).

METHOD

Program Description

In response to difficulties in working with families affected by AOD abuse, the county agency decided to implement a program for working with this population that was conceived from the existing literature (as of 2000) and took into account their local practices and resources (e.g., see Children of Alcoholics Foundation, 1996; CWLA, 1997, 1998; DHHS, 1999; Dore & Alexander, 1996; Hohman, 1998; Jaudes et al., 1995; National Center on Addiction and Substance Abuse at Columbia University [CASA], 1998, 1999; Young et al., 1998). Through their work with a national agency whose focus is on substance abuse prevention, treatment, and education, county-level stakeholders were able to formulate a program that was multidisciplinary, community based, and collaborative in nature and addressed the intertwined issues of substance abuse with child welfare, poverty, domestic violence, single parenting, mental illness, homelessness, and other social problems. They identified that, to be effective in the long term, their intervention needed to take place at three levels. The first level identified was the direct service to families level. At this level, the county developed an intensive service program to serve the needs of substance-affected families with children in the state's custody. The second level focused on the county agencies and was centered on providing assistance services to agencies designed to serve these families (both public and private agencies, such as child welfare agencies and substance abuse treatment centers). The third level of intervention was targeted at the development of policy, which was responsive to and inclusive of the needs of AOD-affected families. The first level of intervention (intensive services to families) is the subject of this evaluation.

The program operated through the identification and designation of a "lead agency" that provided a single point of coordination for intensive services offered by the following community service agencies: child welfare assessment and intake, parenting training, mental health, substance abuse treatment, permanency workers for the child welfare system, temporary assistance to needy families, domestic violence shelters, family court, and the local housing authority. In addition to providing a single point of coordination, this lead agency also collected the necessary data for the evaluation of their intervention

TABLE 1: Overview of Services and Time Allotment for Program Participants

Service Description	Typical Time Allotment
Substance abuse treatment services	9 hours per week for minimum of 6 months
Employment counseling or services	5 hours per week for minimum of 6 months
Case management	5 hours per week
Parenting classes or training	2 hours per week
Other services such as family therapy, trauma counseling, and domestic violence counseling	1-4 hours per week

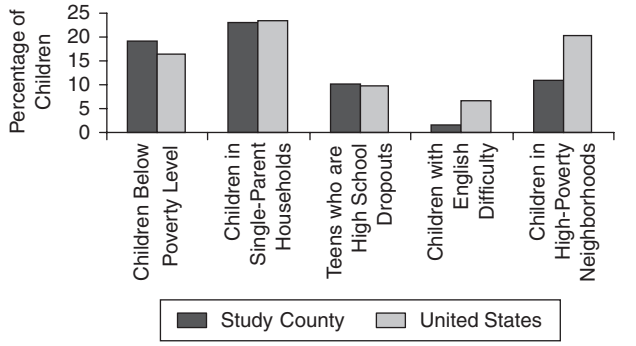

Figure 1: Key Indicators of Child Well-Being for Study County Compared to Key Indicators of Child Well-Being for U.S. Children Overall (Population Reference Bureau for the Annie E. Casey Foundation, 2004)

and provided these researchers with de-identified data for the analysis. This lead agency used the authors for the evaluation of this demonstration project. This evaluation was submitted to the University of Kansas Human Subject's Committee (Lawrence) in July 2003 and was given approval at that time. Table 1 provides the reader with an overview of program services offered and the recommended time allotment for service provision within selected agencies.

Families used the services offered in the program based on their individual needs. In addition to the provision of services, the program participants also attended monthly court hearings in a specialized docket devoted to AOD-affected families in the child welfare system and attended monthly family conferences, where all stakeholders involved in the case were represented. A typical monthly case meeting included the client, child welfare workers, AOD abuse treatment providers, mental health workers, a representative from the court, and any other key stakeholders in the case.

A relationship was established with one substance abuse treatment center, which provided all of the primary treatment for substance abuse. This center (the only one located in this rural area's immediate region) provided services to families based on patient placement criteria established by the American Society of Addiction Medicine (2001). The majority of this program's clients were provided with intensive outpatient treatment.

Site Description

According to the U.S. Census Bureau (2000), the county has an estimated population of 66,000; 80% are Caucasian, and 11% are American Indian or Alaskan Native. Of the county residents older than 18, 80% are high school graduates, and 16% have bachelor's degrees or higher. The median family income (1999 dollars) was $38,162. Approximately 12% of the families fall below the poverty level, compared to 9% of families nationally (U.S. Census Bureau, 2000). Figure 1 provides the reader with an overview of key child well-being indicators for the county in which the study was conducted and compares these indicators to national levels.

Sample Description

Participants were referred to the program worker through the intake process at the local child welfare office following a child abuse or neglect referral that included reasons associated with AOD abuse as part of the intake. The criterion for referral was singular: That there was a removal of children from the home based on parental substance abuse. During intake, the program worker met with the family and provided them with information about the program. The worker described the program and its requirements and assessed willingness to participate. Families were given a written description of the program, as well as a written description of what participation in the program would require in terms of time commitments. Participation in the program was offered as voluntary in nature, and those choosing to participate were then referred to an assessment counselor for a substance abuse assessment. If the individual (or couple) was assessed as having a substance abuse problem that required treatment, they were referred back to the program, at which time they could continue making a decision about participation.

Participants were given the opportunity to ask questions about the program, learn of the time requirements, and review the program once again. If the individual or couple chose to participate, at this time, they were asked to sign statements indicating their willingness to participate, including a statement of informed consent. Clients who chose not to participate in the program (or who did not present with substance abuse that rose to the level of

needing treatment) were referred back to intake for assignment to a nonprogram worker. There were no program eligibility requirements such as an assessment of motivation for change or use of specific drugs of abuse.

When the program began, the child welfare agency supervisor instructed intake workers to refer all families (receiving intake services) with child removals because of substance abuse to the program's coordinator for an assessment. However, this practice was slow to be implemented by the workers, and it was discovered that some individual workers would learn of AOD involvement after the initial referral and then not refer the case to the program office. Follow-up with these workers indicated that they were not entirely trusting the program or they simply did not want to "let go" of their cases to other workers.

From January 2000 to October 2004, 60 families received program services as part of their child welfare involvement. Data were collected on the participant families from the state's administrative database, using the time period from January 2000 to October 2004. In those cases where children had multiple removal episodes during the time period from January 2000 to October 2004, researchers selected the specific episode/entry into foster care that matched the parents' involvement dates in the program. As the focus of this evaluation was on the reunification and reentry experience of these children, data collected for this study were at the child level.

A comparison cohort was created from this same database, which consists of other children residing in the same county who were placed in foster care for reasons of parental AOD abuse during the same period of time but who did not receive program services as part of their child welfare experience.

The initial sample for this study contained 220 cases (60 participant cases and 160 comparison cases). However, prior to data analysis of reunification and reentry outcomes, cross-tabulations with chi-square statistics and *t* tests were computed to test for statistically significant demographic differences between the program participants and comparison group. Based on prior research of predictors of permanency outcomes, demographic characteristics including ethnicity, family structure, reason for removal, presence of child medical or behavioral diagnosis, and age of the child were compared across the two groups. Significant differences were found between the two groups in the areas of age at removal, ethnicity, and year of entry into foster care. Program participant children were much more likely to be Caucasian and to have entered foster care at a younger age. The racial and age differences between the program participant and comparison groups suggested that the participant selection process might be biased in a way that would lead to more favorable permanency outcomes for program participants.

Before comparing the two groups on permanency outcomes, the researchers adjusted for this variation between the groups by first evaluating the range of ages in the two groups. There were no children older than 12 in the program participant group, so children older than 12 were eliminated from the comparison cohort. Next, some of the children belonging to non-Caucasian ethnic groups were randomly removed from the comparison cohort, thereby eliminating any statistical differences between the two groups with respect to ethnicity. The dispersion of cases relative to year of entry was also significantly different for the two groups, with program participants having a majority of its cohort members entering in 2002 and 2003, although the comparison group had a substantial number of entries in 2001 and 2004. The rationale for evaluating this aspect of group differences is that cases entering foster care at a significantly earlier date than others would have a greater opportunity to achieve reunification and experience reentry. Cases were randomly eliminated from the larger comparison group to obtain the same proportional distribution across entry years for both the comparison and participant groups.

Following these adjustments, it was also noted that there were four children in the initial comparison group who were removed for parental death concurrent with AOD abuse and no comparable cases in the program participant group. These cases were excluded with the rationale being that the reunification experience of these children would likely be different from others. The resulting sample (following these adjustments) contains 60 program participant children and 79 comparison children (n = 139). From a demographic perspective, there are no statistically significant differences between the two groups (see Table 2).

Of the program participant children, 48% (29) are female, compared with 53% (42) of the comparison group. In both groups, Caucasian ethnicity represents the majority of cases. In the program participants group, 80% (48) are Caucasian, followed by American Indian (8), then African American (4). The comparison cohort contains 63% (50) Caucasian children, followed by 29% (23) American Indian children, then African American (6). Of cases in both cohorts, 42% represent children from single female-headed households. Of the children from the program participants cohort, 13% (8) were removed for reasons of abandonment, and 6% (5) of the children from the comparison cohort were removed for this same reason. The presence of a medical diagnosis for children entering foster care has been demonstrated to affect the placement experience, so between-group

TABLE 2: Demographic Characteristics of Program Participants and Comparison Cohorts

Characteristic	Program Cohort (n = 60)	Comparison Cohort (n = 79)	Test Statistic
Gender—female	48% (29)	53% (42)	χ^2 = .319, p = .572
Ethnicity—Caucasian	80% (48)	63% (50)	χ^2 = 5.81, p = .121
Family structure—single, female-headed household	42% (25)	42% (33)	χ^2 = 9.15, p = .103
Removal reason—abandonment	13% (8)	6% (5)	χ^2 = 1.97, p = .160
Child medical diagnosis	7% (4)	4% (3)	χ^2 = .587, p = .444
Mean age of child at removal	3.91 years	4.51 years	F = .986, p = .323

comparisons were made for this variable. Of the program participant children, 7% (4) met this criterion, and 4% (3) of the children from the comparison cohort did as well. The mean age of the children at the time of removal from the home was also not significantly different between the two groups, with the mean age of program participant children being 3.9 years compared to comparison children at 4.5 years.

The average time in placement was 512 days (median = 537) for cases not experiencing a reunification and 187 (median = 125) for those cases reunified. The average time to at home for those reunified who experienced a reentry was 213 days (median = 175) and 558 days (median = 502) for those who remained in their home at the end of the follow-up period.

Analysis

The analysis was designed to test the group effects of the intervention on permanency outcomes for children of parents receiving program services. Permanency outcomes like reunification of children in foster care have two components: A status change marked by a specific event (move from foster care to home of parents) and the time required to achieve the event. Thus the program was judged to be successful with regard to permanency outcomes for these children if the children of program participants moved more quickly out of foster care and into permanent homes. The use of a constructed comparison group allowed the examination of children residing in the same geographic area who were placed in custody for similar reasons but with no program participation.

Event history analysis (also known as survival analysis) was used to test program effects. Event history analysis is the appropriate statistical procedure when one is interested in the time between two events—in this case, removal of the child from the home and achievement of permanency (primarily through reunification). In this situation, the dependent variable has two components: one indicating the event (dummy variable indicating reunification) and the other indicating the time to the event (days from removal to reunification).

A problem that usually arises in these situations is how to treat the cases that have not reached the second event; that is, what is the time value for children who have not yet been reunified? Such cases are known as *censored cases*, and they make this kind of study inappropriate for traditional techniques such as *t* tests or linear regression. Event history analysis deals with these situations by including censored cases for the time period that they are observed, calculating the time from the first event (i.e., removal) to the end of the observation period. These censored cases are then included through the time they were observed to estimate the probability of a terminal event occurring at specified points or intervals. These individual probability estimates are then included to estimate the overall probability of the event occurring at different time points (Allison, 1984).

The analyses were conducted using SPSS version 14.0 for Windows. Initial analyses involved plots and statistical tests of the survival and hazard plots for children of program participants and the comparison group. Cox regression was used to introduce covariates for greater precision when testing the impact of the program participation, which was represented in the regression analyses as a dummy coded variable. The covariates included the variables listed in Table 2.

RESULTS

The primary goal of the child welfare foster care system is to achieve permanency for children as quickly as possible. For most children who enter foster care, this is achieved through reunification of the family. However, if the reunification does not remain stable, it would not be judged to be successful. Our analysis of this program was designed to evaluate the success of this program from this perspective.

Time to Reunification

Analysis of participation in program services from a reunification standpoint was measured through the use

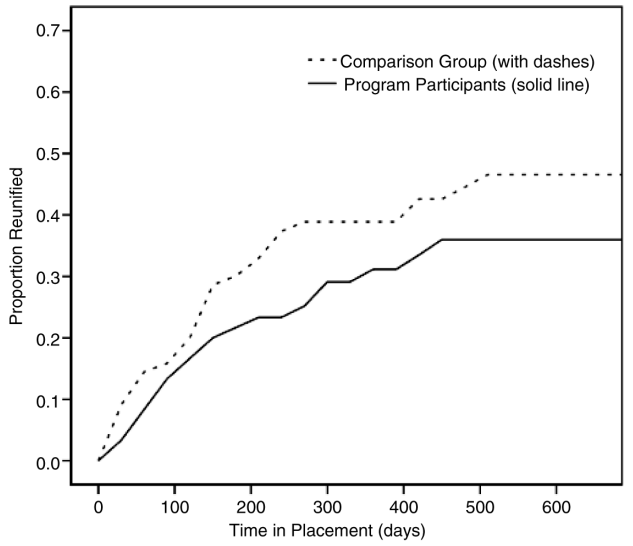

Figure 2: Proportion of Children Reunified by Time to Reunification

of event history analysis. Through the use of this technique, researchers can estimate time to reunification for both the program participant and comparison cohorts. Figure 2 provides a survival chart for time to reunification for these two groups.

For Figure 2, faster reunifications are reflected in steeper sloping lines. By looking at this figure, the reader can see that the top line (with dashes), which represents the comparison group, is moving more quickly to reunification than the program participants group, which is represented by the bottom solid line. By comparing the lines in the above figure, one can see that at 200 days, approximately 32% of the comparison group had reunified, whereas the program participant cohort had approximately a 22% reunification rate. At 400 days, approximately 40% of the comparison group had reunified, whereas the program participants' rate for the same time frame was a little more than 30%. Although we would judge this 10% difference in reunification rates to be substantively significant, using Cohen's (1988) conventions, it would be considered "small," and it is not statistically significant (Wilcoxon [Gehan] statistic = 1.763, $p = .1842$). The power for this test is only 26% because of the relatively small sample size. Differences in reunification rates would need to be roughly 18% (medium to large) for there to be statistical significance with the given sample size.

Reentry

Of those program participant cases that had experienced reunification at the time of this analysis ($n = 40$), 9 cases (23%) had reunified and then subsequently reentered foster care. Of those comparison group cases that had experienced reunification ($n = 59$), 4 cases (7%) had reentered care at the time of this analysis. The differences in the two groups are statistically significant with respect to the proportions experiencing reentry. Program participant children are more likely to reenter foster care than the comparison cohort ($\chi^2 = 5.17$, $p = .023$).

Figure 3 demonstrates that program participant children (the top, solid line) are moving more quickly to reentry than are the children in the comparison group (the bottom line with dashes). Analysis of this difference indicates that there are statistically significant differences between the groups with respect to reentry rates (Wilcoxen Gehan = 3.98, $p = .046$). This figure also allows the reader to get an estimate of what percentage of the children in each group have reentered at the points in time represented on the horizontal axis of this chart. For example, one can look at the figure and see that at Day 200, about 12% of the kids in the program participant cohort had reentered care, compared to approximately 8% of the comparison cohort. It is also noteworthy that reentries appear to stop after 180 days for the comparison group but continue to occur for program participant kids.

DISCUSSION AND APPLICATIONS TO SOCIAL WORK

Although it has been suggested that interventions that are aimed at providing comprehensive, integrated services to the AOD/child welfare population result in increased likelihood of favorable permanency outcomes, this has not been demonstrated in the areas of time to reunification and reentry through our evaluation of this program. Although this evaluation is representative of only a single effort, these researchers believe that these outcomes should prompt workers in child welfare, family drug courts, and substance abuse to question the assumption that more intensive service will result in better outcomes in regard to permanency.

When these authors began evaluating these permanency outcomes, we initiated discussions with program personnel. These discussions were aimed at shedding some light on these findings. What these providers told us is that there is no underlying rationale for the expectation that involvement in this program should result in shorter durations in out-of-home care, because recovery from AOD abuse is a long-term process and the problems of these families are multiple and intertwined and thus not likely to respond to quick intervention. In addition to this information, the workers also discussed three

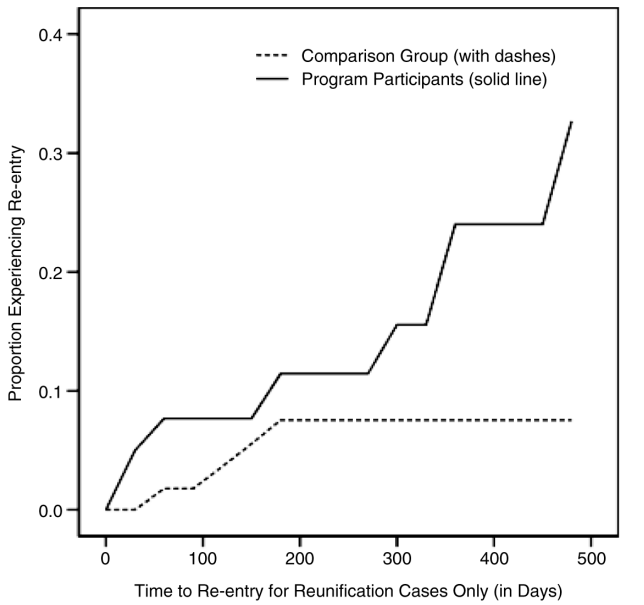

Figure 3: Time to Re-entry for Reunification Cases

specific aspects of program participation that provide a contribution to increased understanding of the findings. First, workers stated that because there were multiple providers all assisting in decision making related to the optimal time to reunify, reaching a consensus about when to reunify was often a difficult task. Typically, one provider (e.g., substance abuse aftercare worker) would believe that it was time for the children to be returned to the home, although another provider (e.g., employment counselor) thought that it was not the best time. Typically, the group decided to take the more conservative route and wait until everyone agreed.

Second, the providers noted repeatedly that when there are multiple, varied interests represented (such as child welfare, employment, substance abuse counseling, trauma counseling, and case management professionals) the expectations of the client often became higher. In one provider's words, "The bar gets raised for what it means to be a good enough parent."

Finally, especially with respect to reentry, it is possible that there were some factors that were present in this agency that are not explicitly part of the program design that influenced reentry rates. Researchers reviewed each reentry case individually. Many of the providers attributed the higher reentry rates to the fact that program participation meant that these clients were watched much more closely than other child welfare clients—especially as it relates to the use of urine testing to identify relapse episodes. What was discovered through this process is that, in many of these cases, the reentry occurred as a result of local family drug court policy to always remove a child in the event of a positive urine screen for the parent, regardless of whether the child was placed at risk during this parental relapse. In other words, the use of urine screens as the single measure of parental fitness occurred. It is likely that this practice and other aspects of a more intensive and longer follow-up of the cases of program participants led to this higher incidence of reentry. It is impossible to say whether these reentries represent improved safety and well-being for the children or an unnecessary intervention into the lives of the families involved.

Longer duration of out-of-home placement and even lower overall reunification rates could be justified if the ultimate outcome of these cases proved to be safer and more permanent homes. In that sense, reunification is a somewhat incomplete outcome measure in that reunification alone cannot be judged to be positive unless the resulting placement in the home proves to be both safe and secure. Reentry to foster care can be thought of as a measure of the stability of the reunification. For this sample, the children of participants in the program were significantly more likely to reenter foster care after reunification. Does this mean that the reunifications were less successful or more injurious to the child?

What is most striking about the demonstration project described here was the lack of a clear expectation concerning the relationship between improving access to both community services and treatment of parents with substance abuse problems and permanency outcomes for their children in foster care. Parental substance abuse is clearly a major contributor to children entering and remaining in foster care. Others have raised issues regarding the possible conflicting goals and timelines of the child welfare and drug treatment systems (Young et al., 1998).

The results from this study represent a small sample in a single county agency and should therefore be viewed with caution. Additionally, because the intensive service intervention involved many components of service, which the clients accessed at individualized levels, it is impossible for the researchers to know what aspects of the program contributed to these findings and in what way. Furthermore, research is needed to disentangle the contributors of reunification and reentry within this population.

However, the possible unintended consequences suggested in this exploratory study—longer time to reunification and greater risk of reentry—highlight the need for more discussion and greater clarity with regard to program goals and rigorous evaluation of both AOD

treatment and permanency outcomes for the children and parents served.

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