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Integrated services for families with multiple problems: Obstacles to family reunification

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Abstract

Child welfare clients with co-occurring problems are recognized as clients who have difficulty achieving positive child welfare outcomes. The current study focuses on families in the child welfare system with co-occurring problems and the impact of such problems on the likelihood of reunification. The current study contributes to the literature on service integration by examining whether it is necessary to go beyond assessment and service access to insure families make progress in each co-occurring problem area to achieve reunification. The sample is comprised of 724 substance-abusing families enrolled in the Illinois Title IV-E Alcohol and Other Drug Abuse (AODA) Waiver Demonstration. Data on client progress consisted of provider ratings completed quarterly to track progress related to problems of substance abuse, domestic violence, housing and mental health. The findings indicate that progress in resolving co-occurring problem areas does increase the likelihood of achieving family reunification. Thus, the provision of the child welfare service model alone is insufficient. In order for child welfare systems to increase reunification rates, services must target the specific needs of individual families and assist them in achieving progress within co-occurring problem areas. Successful integrated service programs must identify the range of specific problems that clients are dealing with and insure that they address and resolve these problems in order to increase the likelihood of family reunification.

Keywords: Family reunification; Integrated services; Child welfare system; Multiple problem families

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1. Introduction

Child welfare clients with co-occurring problems–such as substance abuse, mental health, domestic violence and housing problems–are recognized as clients who have difficulty achieving positive outcomes in the child welfare system. Several integrated service models have been developed specifically for multiple-problem families in the child welfare system. Yet, little is known about the effectiveness of such models (Ryan, Marsh, Testa & Louderman, in press; for a review, see Maluccio & Ainsworth, 2003). Relatively few evaluations of integrated service models focus on child welfare outcomes, such as reunification. These studies indicate that even the most intensive efforts result in low rates of reunification (Ryan et al., in press). To better understand why low rates of reunification persist even after the receipt of integrated services, the current study focuses on families in the child welfare system who experience multiple problems. Specifically, we examine child welfare in relation to domestic violence, housing and mental health. This study builds on prior research on comprehensive services by examining whether families who have access to services must also demonstrate progress in child welfare, substance abuse and other co-occurring problems before reunification can be achieved.

Integrated service models refer to interventions for co-occurring problems combined within the context of a primary treatment relationship or service setting (Center for Substance Abuse Treatment, 2005). In part, integrated models emerged in response to the many barriers (e.g., fragmented treatment plans, specialized clinicians, limited funding) that limit the capacity of single-service providers to meet the complex needs of persons with co-occurring problems (SAMSHA, 2002). The development and use of such integrated models are increasingly advocated for child welfare clients who also are dealing with problems of substance abuse, domestic violence, housing and mental health.

The growing number of child welfare families who also are dealing with substance abuse has led to the development of integrated service models designed to improve reunification rates (Maluccio & Ainsworth, 2003; Young, Gardner, & Dennis, 1998). One of the only models to be systematically evaluated so far, the Illinois AODA Title IV-E Waiver Demonstration, resulted in low reunification rates. The Title IV-E Waiver Demonstration evaluation used an experimental design to evaluate a service integration model relying on a recovery coach (one who systematically links child welfare clients with substance abuse and other services) with a model relying only on the child welfare worker to make these connections. The recovery coach model is an intensive case management model designed to increase clients' access to substance abuse services, to improve substance abuse treatment outcomes, to shorten the length of time in substitute care placements and to increase rates of family reunification. To achieve these goals, recovery coaches engage in a variety of activities, including comprehensive clinical assessments, advocacy, service planning, outreach and case management. Thus, the Title IV-E Waiver Demonstration evaluated whether increased assessment, along with intensive case management designed to increase access, would result in increased reunification rates. The findings of the study showed that, although the experimental group had significantly greater reunification rates than the control group, reunification rates for this group of substance-involved families was low overall (10%) (Ryan et al., in press). This was especially true for clients dealing with multiple problems—clients who, in addition to substance abuse, were dealing with mental health, domestic violence and housing problems.

1.1. Model assumptions

Clients with co-occurring problems often fail to receive services they need because the range of problems with which they struggle goes unrecognized. Further, disjointed service models often result in limited access to needed services. The program theory underlying the Illinois AODA Waiver Demonstration is a basic access-linkage model that posits that programmatic outcomes improve when the program elements include (a) careful assessment of client problems; (b) tailored treatment plans so that specific services are matched with or designed to address specific problems; and (c) specific linkage mechanisms (e.g., referral, on-site services or intensive case management) that increase access to these services. This model emerges from the empirical literature which examines the impact of comprehensive and tailored services in substance abuse treatment (D'Aunno, 1997; McLellan, Arndt, Metzger, Woody & O'Brien, 1993; McLellan et al., 1997; McLellan et al., 1998) as well as in child welfare (Marsh, D'Aunno, & Smith, 2000; Smith & Marsh, 2002; Ryan & Schuerman, 2004).

The initial evaluation of the Illinois AODA Waiver Demonstration found that increased assessment and access were related to increases in the rates at which children are reunified with their families (Ryan et al., in press). This research focused on four outcomes: (1) access to substance abuse treatment services, (2) substance abuse use, (3) length of time to substitute care placement and (4) family reunification. The findings from this evaluation indicate a significant difference between the control and experimental groups on all four outcomes (Ryan et al., in press). In the experimental group (where services were received from a recovery coach), caregivers accessed substance abuse services more quickly and experienced a greater reduction in substance use. The children of these caregivers spent significantly less time in substitute care placement and were more likely to achieve family reunification, compared with the children in the control group. However, although there were significant differences between the experimental and control groups, the initial findings of the AODA Waiver Demonstration indicated that the probability of family reunification was very low for both groups (7% control vs. 12% experimental).

The conceptualization of the current study emerged from the question of why reunification rates remained low despite documented implementation of the program model (e.g., careful assessment and timely access to substance abuse treatment). What else might obstruct reunification? These questions led us to investigate the role of multiple problems and, in particular, the role of domestic violence, housing and mental health, in combination with substance abuse problems.

1.2. Domestic violence and child welfare

Domestic violence is a major challenge confronting child welfare systems. Recent estimates indicate that between 30% and 60% of families involved with public child welfare also experience domestic violence (Edleson & Eisikovits, 1996; Findlater & Kelly, 1999). Such violence in the family home increases the risk of child maltreatment and the risk of substitute care placement (Straus & Gelles, 1990). With regard to reunification, the presence of violence in the home is a major contributor to the disruption of the family reunification process. Hess, Folaron, and Jefferson (1992) report that domestic violence is responsible for the disruption of approximately 56% of failed attempts of reunification. Often times these problems emerge when initial treatment plans fail to identify domestic violence as a co-

occurring problem (Aron & Olson, 1997). Only in recent years are child welfare systems and domestic violence initiatives collaborating in the pursuit of child and partner safety (Findlater & Kelly, 1999).

1.3. Housing and child welfare

The problem of housing is well documented throughout the literature and impacts both family and child outcomes (Courtney, McMurtry, & Zinn, 2004; Jones, 1998). Children living in families who are unable to secure safe, affordable and stable housing are at an increased risk for a variety of negative outcomes including serious injury (Jones, 1998). Thus, these children and families are also at an increased risk of involvement with public child welfare systems (Park, Metraux, Brodbar, & Culhane, 2004; Steinbock, 1995). Once in the system, families with housing problems are significantly less likely to achieve reunification (Jones, 1998). With regard to housing services, caregivers often report that housing assistance is one of the most important components of treatment planning. Similarly, the receipt of housing assistance has been found to increase the likelihood of reunification (Hoffman & Rosenheck, 2001) and decrease the future risk of maltreatment (Ryan & Schuerman, 2004).

1.4. Mental health and child welfare

There is a broad array of literature describing the mental health needs of families involved with public child welfare. Dependent children with mental health and substance problems spend more time in foster care, are more likely to bounce between multiple foster homes and are less likely to experience reunification relative to dependent children without such problems (Horwitz, Simms, & Farrington, 1994; Landsverk, Davis, Ganger, Newton, & Johnson, 1996; Newton, Litrownik, & Landsverk, 2000). At the caregiver level, researchers estimate that up to 70% of parents involved with child welfare services have at least one mental health problem (Faller & Bellamy, 2000). Such problems routinely interfere with appropriate parenting practices and may even exacerbate the circumstances that bring parents to the attention of child welfare systems (D&S Associates, 1997).

The review of the literature reveals that the study of co-occurring problems is not a recent phenomenon. Yet, the vast majority of this literature focuses on only two simultaneous problems (e.g., domestic violence and child maltreatment). Moreover, we could not find any studies that focus on how the progress within these problem areas impacts outcomes in the child welfare system. A primary objective of the current study is to advance this body of knowledge by investigating the role of multiple problems for caregivers involved with public child welfare. We focus not only on the presence of co-occurring problems, but also how the existence of co-occurring problems may interfere with the reunification process. Finally, we examine how progress is achieved within each problem area. The following three questions guide the analyses:

1. What percent of substance-abusing families in the child welfare system are also dealing with issues of domestic violence, housing and mental health?
2. Are substance-abusing families in the child welfare system making progress in terms of dealing with these co-occurring problems?
3. To what extent do co-occurring problems interfere with family reunification?

2. Methods

2.1. Sample

The sample represents a subset of families enrolled in the Illinois AODA Title IV-E Demonstration Waiver as of March 31, 2004. Title IV-E waivers permit states to bypass federal regulations related to the financing of foster care services in order to develop and test improved strategies for serving children and families. The AODA demonstration project in Illinois utilizes an existing service relationship between the Office of Alcoholism and Substance Abuse (OASA) and the Illinois Department of Children and Family Services (IDCFS). The purpose of the AODA Waiver Demonstration is to test a model of intensive case management in the form of a recovery coach designed to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten the length of time in substitute care placements and increase rates of family reunification. Eligible families for this demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. To qualify for the project, parents in substance-involved families were referred to the Juvenile Court Assessment Program (JCAP) at the time of their temporary custody hearing or at any time within 90 days subsequent to the hearing. The JCAP staff conducted substance abuse screenings and referred families for substance abuse treatment. Child welfare caseworkers completed service plan forms throughout the treatment process. These forms were completed quarterly and captured a wide variety of information, including the presence of co-occurring problems and the progress made in addressing such problems.

As of March 31, 2004, a total of 996 families were enrolled in the experimental group of the Illinois AODA Waiver Demonstration. The sample used in the current study is limited to the families in the experimental group, i.e., those receiving the integrated service model, who had at least two completed service plan forms. We selected families with at least two forms (as opposed to families with only one completed form) so that we could investigate progress within each problem area. Although progress could be achieved within one quarter, a minimum of two quarters of service plan data provided a more accurate description of (1) the problems experienced within each family system, and (2) the amount of progress achieved within each problem area. Of the original 996 families, 724 (73%) had at least two completed forms and thus comprise the sample used in the current study.

2.2. Missing data analysis

We conducted a missing data analysis to determine if there were any significant differences between the families with at least two forms compared to the families with *no* service plan forms. The analyses reveal that only one family characteristic was different between the two groups. The families with completed forms were more likely to have at least one member of the family employed at least part-time. There were no differences with regard to age of caregivers, race, education, primary substance use, number of children in the family, group assignment, involvement with the adult correctional system or reunification.

2.3. Data sources

The current study utilizes multiple sources of data. Data pertaining to placement, permanency and child safety come from the Illinois Department of Children and Family Services' (IDCFS)

integrated database. The IDCFS database includes placement events through June 30, 2004. Substance abuse assessment data come from the Juvenile Court Assessment Program (JCAP). JCAP data include a variety of demographic information (e.g., employment status, living situation), substance abuse histories and indications of prior substance-exposed infants.

In addition to administrative and assessment data, the current study analyzes data captured on service plan forms. The Department of Children and Family Services contracted with a local organization to provide assessments and referrals at the JCAP site. An additional contract exists with this organization to coordinate the computer-based data collection integrated system called the Treatment Record and Continuing Care System (TRACCS). The TRACCS forms are sent quarterly to the child welfare caseworkers in the field. The forms capture a wide range of demographic and treatment-related information. One component of the TRACCS form focuses specifically on the problems families are experiencing and their progress. We focus on three problem areas: domestic violence, housing and mental health. We then review the progress that families are achieving in these areas.

Each quarter, child welfare caseworkers complete TRACCS forms and indicate whether or not a family is experiencing problems with domestic violence, housing or mental health. The caseworker assessment is simply a "yes" or "no" response to the question "Does the problem exist?" Next to each problem area is a space for the caseworker to record a progress code. The progress codes are: 1 = unsatisfactory progress, 2 = reasonable effort/commitment, 3 = substantial progress and 4 = complete progress. In the current study we aggregate from the record (i.e., individual TRACCS forms) to the family level. We use the highest progress code achieved in the current analyses. That is, at the aggregate level families are assigned a code of "4" if in any quarter the child welfare caseworker reported "complete progress" in addressing the specified problem.

2.4. Analytic techniques

We used cross-tabulation and chi-square to explore the relationship between problem areas, progress achieved and family reunification. We use survival analysis (SPSS Cox Regression) to examine the influence of individual variables on survival rates. This analytic technique is similar to logistic regression in that it enables one to calculate the odds of a particular event occurring. However, survival analysis considers the differential impact between groups on the timing of this event (Land, McCall, & Parker, 1994). In the current study, families enter the waiver demonstration at different points in time. Thus, they are exposed to the risk of reunification for varying lengths of time. The time period used in the current study is the number of days between the JCAP assessment and June 30, 2004 (the date we pulled reunification data from the IDCFS database). The average time at risk for this sample was 815 days (2.23 years), ranging from 98 days to 1525 days (4.2 years). Survival models adjust for these variations by censoring observations. Observations are censored if the target event (family reunification) was not observed during the period of data collection. The resultant coefficients are interpreted similarly to those from logistic regression.

3. Results

3.1. Sample description

As shown in Table 1, 83% ($n = 599$) of the sample is African American; 8% ($n = 55$) is Hispanic; and 9% ($n = 70$) is White. Seventy-eight percent of these families report no one

Table 1
Crosstabs and *t*-tests: families with service plan forms ($n = 724$)

Categorical variables	Percentage
Race	
African American	83%
Hispanic	8%
White	9%
Level of education	
Less than high school	56%
High school graduate	4%
Primary substance	
Alcohol	25%
Cocaine	43%
Heroin	20%
Employment status	
Unemployed	78%
At least part time employment	22%
Involvement with law enforcement	
No involvement	98%
Pending/probation	2%
Reunification	
Not reunified	80%
Reunified	20%
Continuous variables	
Age of youngest caregiver	32.3
Number of children	1.9
Age of youngest child	2.0

working at least part time in the home, and 56% report no one with at least a high school diploma living in the home. The average age of the youngest caregiver was 32 years old. On average, 1.9 children were associated with each family. Fifty-five percent of the families had only one child. Fifty-nine percent of the families were associated with the birth of at least one prior substance-exposed infant. Regarding multiple problems from the caseworker perspective, 60% of the families have mental health problems, 81% of the families have housing problems and 42% of the families have domestic violence problems.

3.2. Bivariate relationships

To assess the relation between reunification outcomes and having specific problems and progress on problems, Tables 2–4 display the likelihood of achieving reunification by total problems, by each problem subgroup and by progress made within each subgroup. The "substance abuse only" row in Table 2 represents the group of families with AODA problems only. That is, the child welfare caseworker indicated no problems with domestic violence, housing or mental health. There are at least two important items to note. First, very few families (8%) are dealing with the problem of substance abuse *only*. The majority of substance-abusing families in this sample are dealing with at least three problems simultaneously (35%). It is also

Table 2
Number of family problems by the likelihood of reunification ($n=724$)

Problems indicated by caseworker	Not reunified	Reunified	Totals
Substance abuse only	44 (79%)	12 (21%)	56 (8%)
One additional problem	191 (89%)	23 (11%)	214 (30%)
Two additional problems	222 (88%)	30 (12%)	252 (35%)
Three additional problems	180 (89%)	22 (11%)	202 (27%)
Totals	637 (88%)	87 (12%)	724 (100%)

important to note that families are more likely to achieve reunification when they are not experiencing co-occurring problems. Overall, 12% of the families achieved reunification. However, as shown in Table 2, 21% of the families dealing only with substance abuse achieved reunification. The difference between the probability of reunification for the substance abuse only group compared to the group of families with additional co-occurring problems is statistically significant ($\chi^2=5.08$, $df=1$, $p<.05$).

Table 3 displays the relative probability of achieving reunification by each problem area. There are no statistically significant differences in reunification rates between the families with mental health, domestic violence and housing problems and those without such problems. That is, the mere presence of the problem does not seem to be associated with the likelihood of reunification.

Table 4 displays the likelihood of achieving reunification by the progress made within each problem area. The first column of Table 4 displays the percentage of families (with each particular problem) in each progress category. Two pieces of information are important to note with regard to progress and reunification. First, very few families are making complete or even substantial progress in terms of addressing the substance abuse, mental health, domestic violence and housing problem areas. For example, of the 724 families, only 18% have achieved complete progress in substance abuse treatment. On average, these families have been enrolled in the waiver demonstration for over 2 years. So one could certainly argue that families have had sufficient time to address substance abuse issues and achieve "complete progress." According to the child welfare caseworker, 43% of families are making unsatisfactory progress with regard to substance abuse treatment. The distribution of progress achieved is similar for domestic violence, housing and mental health. The second item worth noting is that progress ratings are

Table 3
Specific problem area by likelihood of reunification ($n=724$)

Problem area	Not reunified	Reunified
Domestic violence		
No problem	87%	13%
Yes—has problem	90%	10%
Housing		
No problem	87%	13%
Yes—has problem	88%	12%
Mental health		
No problem	87%	13%
Yes—has problem	89%	11%

Table 4
Progress as reported by child welfare caseworker by likelihood of reunification ($n = 724$)

Problem area	% Progress	Not reunified	Reunified
*Substance abuse***			
Complete	18%	74%	26%
Substantial	24%	87%	13%
Reasonable effort	15%	91%	9%
Unsatisfactory	43%	93%	7%
*Domestic violence***			
Complete	15%	75%	25%
Substantial	9%	76%	24%
Reasonable effort	18%	90%	10%
Unsatisfactory	58%	95%	5%
*Housing***			
Complete	10%	69%	31%
Substantial	13%	83%	17%
Reasonable effort	22%	88%	12%
Unsatisfactory	55%	93%	7%
*Mental health***			
Complete	5%	58%	42%
Substantial	18%	88%	13%
Reasonable effort	20%	92%	8%
Unsatisfactory	57%	93%	7%

*$p < .05$., **$p < .01$.

significantly associated with family reunification. This is true for all problem areas. Families in the top two progress categories (substantial progress or complete progress) are more likely to achieve reunification, as compared to the families in the bottom two progress categories (reasonable efforts or unsatisfactory progress). Finally, it is important to note that progress is not the sole determinant of reunification: There are a small percentage of families who achieved reunification without making any progress.

In summary, the bivariate analyses indicate that it is not the problem itself that decreases the likelihood of reunification, but rather the lack of demonstrated progress made within these problem areas. In relation to the underlying program theory, these results indicate that having access to and receiving services is–without some progress in resolving the problem–insufficient to affect the child welfare outcome of family reunification. We use this information in the development of our multivariate model. That is, we use the progress measures as independent variables.

3.3. Survival analysis

The important relation between progress on co-occurring problems and reunification is reinforced by a survival analysis. The results from the Cox regression are displayed in Table 5. The table includes the coefficient and standard error for each independent variable, as well as the hazard ratio. A hazard ratio greater than 1 indicates a higher likelihood of reunification. A hazard ratio less than 1 indicates a lower likelihood of reunification. If 1 is subtracted from the hazard ratio and the remainder is multiplied by 100, the result is equal to the percentage change in the hazard of achieving family reunification. Of the 724 families, 87 (12%) achieved reunification.

Table 5
Cox regression: multiple problems and family reunification ($n=724$)

Independent variables	*B*	S.E.	Hazard ratio
Demographic characteristics			
Age of youngest caregiver	.04*	.02	1.04
African American	−.20	.35	.82
Hispanic	.32	.47	1.38
Parents living together (1=yes)	.15	.27	1.16
High school education	.15	.23	1.16
Unemployed	−.03	.27	.97
One child in the family	−.61**	.23	.54
Prior SEI	.07	.24	1.07
Adult corrections	−.25	.27	.78
Group assignment (1=demonstration)	.01	.24	1.00
Progress in problem areas			
Substance abuse	−.54*	.24	.58
Domestic violence	−.75**	.28	.47
Mental health	−.49	.25	.61

* $p<.05$.
** $p<.01$.

The Cox regression model was developed in two separate steps. We entered a variety of demographic information in the first step. We then entered four variables indicating progress (or lack thereof) in each of the four problem areas: Substance abuse, domestic violence, housing and mental health. The progress variables are dummy coded. A value of "0" indicates that families either do not have the specific problem[1] or that families are making complete or satisfactory progress. A value of "1" indicates that families are either making only reasonable efforts or unsatisfactory progress. The housing variable was dropped from the final model because it was constant once we controlled for progress in the other three problem areas.

We find that four variables help explain reunification for substance-abusing families in the child welfare system. Not surprisingly, the hazard ratio associated with progress in substance abuse treatment indicates that, in an intervention focusing on reducing substance use, families unable to make sufficient progress were $[(0.58-1.0)\times 100\%=]$ 42% less likely to achieve reunification. Regarding multiple problems, families unable to make sufficient progress in the area of domestic violence are significantly less likely to achieve reunification. Families unable to make sufficient progress in the area of domestic violence were $[(0.47-1.0)\times 100\%=]$ 53% less likely to achieve reunification. This is true even after controlling for a variety of demographic characteristics and controlling for the progress made in the area of substance abuse. The coefficient associated with mental health progress was marginally significant ($p=.052$). The direction and size of this coefficient also suggests that families unable to make progress in the area of mental health were $[(0.61-1.0)\times 100\%=]$ 39% less likely to achieve reunification. Finally, the age of the caregiver and family size are related to reunification. Each additional year of age increases the hazard of reunification by 4%. Having more than one child in the family decreases the likelihood of reunification by $[(0.54-1.0)\times 100\%=]$ 46%.

[1] This is true for domestic violence, housing and mental health. This is not true for substance abuse—as all families have substance abuse issues.

4. Discussion

This analysis shows that child welfare families with co-occurring problems have difficulty achieving reunification. Overall, a large proportion of the sample families participating in the experimental group of the Illinois AODA Waiver Demonstration had *numerous problems* and *few resources*. Although families were recruited into this project by virtue of their substance abuse problem (i.e., all families had child welfare and substance abuse problems), only 8% had only a substance abuse and a child welfare problem. Ninety-two percent had a substance abuse problem plus at least one other. Resources in these families were scarce: No adult was employed in three quarters of the households, and no adult had a high school diploma in half the households. Further, more than half of the households had previously had at least one substance-exposed infant.

In this group of families with many problems and few resources, progress is slow and rates of reunification are low. Few families are making complete or substantial progress in terms of addressing substance abuse, mental health, domestic violence or housing problems. Even in a service model designed to increase access to services through intensive case management by a recovery coach, only 18% had achieved complete progress in substance abuse treatment even after 2 years in the waiver demonstration. Progress achieved in areas of mental health, domestic violence and housing was similarly slow.

This research shows, however, a relation between progress on problems of domestic violence, housing and mental health and reunification: To the extent that families are able to make progress in specific problem areas, they are more likely to achieve reunification. The overall rate of reunification for families dealing with multiple problems is 12%, but for the families dealing only with a substance abuse problem, the rate increases to 21%. Further, the progress in each problem area is significantly related to reunification. What we learn from these findings, then, is that it is not necessarily the existence of co-occurring problems, but rather the ability to make progress within these problem areas that is associated with reunification. In other words, those families showing substantial progress in each of the problem areas are more likely to be reunified.

Overall, we see that in a child welfare intervention designed to increase assessment and access to substance abuse services, few families make progress on substance abuse. Even fewer make progress on problems that are not the focus of the intervention. A limitation of the study is that we do not know whether clients received or perceived that they received services addressing the co-occurring problems. This limitation of the study derives from the fact that the information about the existence of problems and progress made is derived completely from the perspectives of service providers. Previous research has shown little agreement between service providers and service recipients about services delivered and received. In national studies of substance abuse treatment organizations, service provider estimates about services administered consistently exceeded client estimates of services received (Allison, Hubbard, & Rachal, 1995; Gerstein et al., 1997). We know that when child welfare clients specify the nature of their problems and then receive services for their problems, they are much more satisfied with the services received (Smith & Marsh, 2002). A fundamental principle of social work holds that interventions will be more effective when they are responsive to the client's definition of the problem. In this study, we have no information about the client's perspective on the problem, on whether they received services for the problem or whether they were making progress. It is possible that providers may mis-specify the problems and underestimate progress being made.

The courts also may provide some explanation for the direction of these findings. Courts play a central role in determining whether families will be reunited. It is the responsibility of the child

welfare worker to provide concrete evidence that the client has made progress on the problems that brought them into the system. For clients in this sample, progress needed to be demonstrated on both parenting and substance abuse. Early results from the evaluation indicated that progress in these two areas was insufficient. The AODA waiver evaluation showed that clients who addressed parenting problems, completed substance abuse treatment and consistently provided evidence to the courts of being substance free frequently did not achieve reunification (Ryan et al., in press).

In addition to the limitations discussed, the study has a number of important strengths. One strength is the access-service linkage model from which the important elements of the service model derive, including (a) careful assessment, (b) tailored and targeted services and (c) the use of an intensive case management linkage mechanism. All elements of this model have been identified as relevant to the delivery of comprehensive services for substance-involved clients in the child welfare system (Young et al., 1998; Maluccio & Ainsworth, 2003). This study reinforces the value of these elements and goes beyond to examine the relation of worker perceptions of progress on reunification. A second important strength is the focus on family reunification. Few, if any, other studies have examined important child welfare outcomes like family reunification and the relation between the existence of problems, availability of services, progress on particular problems and reunification. This study is one of a very small number that examines the impact of integrated services on child welfare outcomes.

What are the lessons learned for child welfare practice from these findings? The research shows a sample of substance-using child welfare clients that is largely uneducated and unemployed and has multiple additional problems in the areas of domestic violence, mental health and housing. Reunification rates are low, especially for those with multiple problems, i.e., with more than substance use and child welfare problems. The data show that, despite the fact that progress is slow in each area, making progress is related to increases in reunification rates. Thus, integrated-service programs such as this one, designed to increase access to substance abuse treatment and a range of other services, will not be successful unless services are targeted to a specific problem area and effective enough to insure client progress. Overall, results indicate that such child welfare programs as the Illinois Title IV-E Waiver Demonstration which seek to provide services for substance-abusing clients must recognize these clients often have a range of co-occurring problems that must be addressed if positive child welfare outcomes are to be achieved. Findings further indicate that child welfare programs using integrated-service models to improve child welfare outcomes must focus on problem assessment and insure clients get the specific services they need to make progress in each specific problem area.

The results of the research have implications for the AODA Title IV-E Waiver Demonstration, as well as for its underlying program theory. The underlying program theory, based on an access linkage model, posited that important child welfare outcomes, such as reunification of the child with the family, would be improved with a program model that included (a) careful assessment of client problems; (b) tailored treatment plans that specific services could be matched with or designed to address specific problems; and (c) specific linkage mechanisms (in this program, through intensive case management in the form of a recovery coach). An implementation analysis documented that the program was, in fact, implemented as planned–clients were receiving careful assessment as well as the intensive case management–and clients receiving these services did have a high rate of reunification. However, the rate of reunification overall was quite low. This study builds on program theory used in this by going beyond a focus on service delivery to determine whether services must have a demonstrable impact in terms of worker perception of progress in order to influence outcome. Results show that families who make

progress in ancillary problems (domestic violence, housing and mental health) are more likely to have positive child welfare outcomes. The implications for our model of service delivery, one that focuses on integrated services, is that while careful assessment and increased service access are important elements, so is demonstrable progress in specific problem areas. The implications for Title IV-E Waiver Demonstration is to recognize that program participants face numerous problems in addition to their child welfare and substance abuse problems. Substance-involved families in the child welfare system are likely to be families confronting a number of problems with very few resources. Furthermore, receiving the targeted services to enable them to make progress in these areas–in addition to making progress on their substance abuse problems–is an important part of resolving or addressing their child welfare problems. Successful integrated-service programs must identify the range of specific problems that clients are dealing with and insure that they can address and resolve these problems in order to increase the likelihood of family reunification. It is clear that model provision alone is insufficient. Providers must insure that clients receive the comprehensive services they need and that they participate in these services to make progress in resolving the range of specific problems they are designed to address.

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