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Services for Substance Abuse-Affected Families: The Project Connect Experience

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ABSTRACT: With more families entering the child welfare system with problems of substance abuse, there is an increasing need for programs that can respond effectively to these families' needs. This article describes one community-based program designed to support and strengthen families with an identified problem of substance abuse. Parents' progress in addressing their problems with substance abuse, reduction of risk in Project families, children's placement experiences, and client satisfaction are discussed. The article concludes with implications for practice with substance abuse-affected families.

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With the large number of families entering the child welfare system with problems of substance abuse, there is an increasing need for services targeted to this population. A recent survey by the Child Welfare League of America (CWLA) reported state-wide rates of alcohol and other drug use that were as high as 60% (Curtis & McCullough, 1993). Local estimates of child protective services cases involving substance abuse range up to 80% (Feig, 1990). The complexities of these cases demand our best. The CWLA North American Commission on Chemical Dependency and Child Welfare (1992) has issued a call to

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action that would guide our response to this growing problem. Among their recommendations was the development and expansion of community-based programs to support and strengthen chemically involved families. To respond to the need for program models that could guide such intervention, the National Center on Child Abuse and Neglect (1993) recently funded a number of demonstration projects designed to improve and expand the services available to these families.

Program Description

Project Connect is one such project. It represents a collaborative effort between a state department of child welfare, a private non-profit agency, a school of social work, and a number of substance abuse treatment and health care agencies. The goals of Project Connect are two-fold: 1) to reduce the risk of child maltreatment and keep families affected by substance abuse together and 2) to increase the capacity of the local service system to respond effectively to the needs of these families.

To be eligible for services, families must have been indicated for abuse or neglect by the state child welfare system and have an identified problem of parental substance abuse. Most of the families served by the Project are headed by young single mothers. Most parents are poly-drug abusers, often using a combination of cocaine, alcohol, and marijuana. Many come from families where there is an extensive history of substance abuse. In addition to their own addiction, these parents are often struggling with the effects of physical and sexual trauma suffered in childhood as well as in their adult years. Moreover, they must cope with the effects of poverty and oppression on a daily basis. Unsafe, inadequate housing is a major problem. For many of the families served by Project Connect, the greatest needs are the most basic ones—shelter, transportation, adequate food, and health care (Azzi-Lessing & Olsen, 1994).

The Project's work with these families is guided by the philosophy so well articulated by the CWLA North American Commission on Chemical Dependency and Child Welfare (1992):

> Chemical dependency in the family may be the child's worst enemy, but the parent usually is not. Therefore, child welfare services must attempt to help chemically dependent parents address AOD problems and begin the recovery process (p.16).

Project Connect provides its families with therapeutic home-based and case management services. Following a referral from the state department of child welfare, Project staff complete an in-depth assessment of the family and work with the parent to develop a service plan. Services include home-based substance abuse assessment and counseling, individual and family counseling, parent education, pediatric nursing services, and linkage with formal substance abuse treatment programs and other community resources (Azzi-Lessing & Olsen, 1994).

Staff work with families for an average of 10 months, although cases may remain open longer if the family requires longer-term involvement. The Project is staffed by five clinicians with Master's degrees in social work and a pediatric nurse. One clinician is bi-lingual. Staff carry a caseload of between eight and ten cases. The theme that runs through the Project's work is flexibility—services are tailored to the individual needs of particular families. Staff see themselves as advocates for the parent, working through the barriers parents face in getting services.

The Project is working to improve the responsiveness of various agencies to these families. A Coordinating Committee meets monthly to address problems of inter-agency collaboration and to initiate improvements in the response of service providers to families struggling with problems of chemical dependence. The Committee consists of representatives from the state child welfare system, substance abuse treatment providers, and health care providers. Changes thus far include the development of state child welfare policy on collaboration with substance abuse treatment providers and changes in the state's funding mechanisms to decrease delays in initiating substance abuse treatment (Azzi-Lessing & Olsen, 1994).

Program Evaluation

Evaluation was built into the design of Project Connect at the outset. The evaluator provided feedback on the development of project goals and together with staff designed a data collection system that would monitor progress toward those goals. Data used in the evaluation were drawn from the Client Intake Form, the Family Risk Scales (Magura, Moses, & Jones, 1987), a Substance Abuse Assessment Form, a Substance Abuse Tracking Form which is used to monitor program referrals, service logs, case plans, and termination summaries.

Additional data were collected from the state child welfare management information system. These data allowed us to compare children's living arrangements with a similar group of substance abuse-affected families who were not receiving the Project's services. Families were matched on AFDC status, age of the children, geographic area, ethnicity, and length of case involvement. Cases were tracked for up to 18 months.

Using these data sources, the evaluation of Project Connect tested the following hypotheses: 1) parents will make steady progress on the goals set out in their service plans; 2) parents receiving project services will increase their rate of participation in substance abuse treatment programs; 3) the risk of child abuse and neglect will be reduced in families receiving project services; and 4) children receiving project services will experience fewer and shorter out-of-home placements than children not in the Project whose parents are similarly affected by problems of chemical dependence.

Sample

To date the Project has worked with 66 parents and 176 children. Families were primarily headed by single parents whose ages ranged from 19 to 38 years. Parents typically had an infant or several young children, often including an infant. At the time of intake, children ranged in age from under one year to 12 years. An additional 10 children were born while their mother was in the Project. Families were primarily white, non-Hispanic (26), African American (20), or Hispanic (13). Family income was typically very low, with all but four receiving AFDC. Parents' struggle with addiction was compounded by long years of use. On average, they had been using both alcohol and marijuana for 11 years and cocaine for six years.

Results

The majority of parents made steady progress on service plan goals related to substance abuse and in the substance abuse treatment programs to which they had been referred. With an average progress score of 3.4 on a five point scale at their third service plan review, parents had, on average, made moderate progress in addressing their substance abuse problems. All but one parent followed up with referral for treatment.

Parents were referred to outpatient treatment, day treatment, and residential treatment, depending on their treatment needs. Referrals

were often made to more than one treatment program before the right match was found. This match consists of finding the right program structure, counselor attitudes and skills, and the client's motivation to engage in treatment (Washton & Stone-Washton, 1990). Project Connect assists with eliminating such concrete barriers to treatment as transportation and child care, so that the remaining barriers were primarily those related to the client's own readiness and finding the right fit between the program and her treatment needs. As parents pursued treatment, their average progress scores increased from 2.2, indicating slight progress, to 3.6 on a five point scale, suggesting that as parents continued in treatment, they were making good progress. This is consistent with the findings of other research which have shown that clients do better the longer they stay in treatment (Cooper et al., 1983).

Risk Reduction. To assess whether the risk of abuse and neglect was subsequently reduced in these families, the Family Risk Scales (Magura et al., 1987) were given at the point of intake and again when the families' case was closed. Developed by the Child Welfare League of America to help child protective service workers assess a child's risk of placement, these scales measure those factors thought to contribute to a child's need for placement. There are 26 individual scales, three of which are not reported here as there were too few responses. Scores are presented in Table 1 for the 47 families whose cases had been closed.

Pronounced improvements occurred in the risks associated with the habitability of the family's housing, the parent's mental health, her knowledge of child care, and her substance abuse. In each of these areas, risk scores declined significantly. Although not statistically significant, there were higher risk scores at posttest in both adult conflict and the clients' cooperation. The findings regarding adult conflict are particularly important to note. For many women, conflict with significant others can be expected to increase as they attempt to break out of relationships that may have kept them dependent and have contributed to their addiction. This does raise the potential for domestic violence in the family and staff should be prepared to deal with this possibility (McKay, 1994).

It is also possible to look at the number of families whose situations improved. Two scales most central to the Project's goals provide useful information for answering this question. The first, rating the parent's substance abuse, showed that 29 of the 47 parents (62%) made

TABLE 1

Mean Family Risk Scores: Pretest and Posttest Scores

	Family (N=47)	
	Pretest	*Posttest*
Habitability of residence	1.9	1.4*
Suitability of living conditions	1.8	1.6
Financial problems	2.5	2.5
Adult relationships	2.1	2.4
Social support	2.3	2.1
	Primary Caretaker (N=47)	
Physical health	2.0	1.8
Mental health	2.6	2.2*
Knowledge of child care	2.5	2.2*
Substance abuse	3.7	2.3*
Motivation	2.4	2.4
Attitude toward placement	1.1	1.2
Cooperation	2.0	2.3
	Children (N=123)	
Supervision under age 10	1.8	1.8
Physical punishment	1.7	1.7
Verbal discipline	2.2	2.0
Emotional care under age 2	1.6	1.6
Emotional care age 2 and up	2.4	2.2
Child's physical needs	1.5	1.6
Sexual abuse	1.2	1.2
Child's physical health	1.6	1.5
Child's mental health	1.4	1.4
School adjustment	1.9	1.8
Home-related behavior	1.4	1.4

Mean values range from (1) Low Risk to (6) High Risk.
*Posttest differences are statistically significant at $p \leq .05$.
Differences were tested using paired sample t-tests.

gains in addressing their problems with substance abuse and that 8 (17%) had essentially the same problem as when they entered the Project. In ten families (21%), problems of substance abuse worsened. Ratings on the parent's motivation revealed similar patterns. Thirty-two (68%) either became more motivated over the course of services (15) or retained the same level of motivation they had when they started with the Project (17). Fifteen (32%) decreased in their level of motivation for addressing the problems that had brought them into care. Clearly, this finding suggests that client readiness must be factored into the evaluation of project outcomes (Brownell et al., 1986; Washton & Stone-Washton, 1990).

It is not surprising that the risk scores remaining highest at the time of case closure involved the parent's substance abuse and motivation, her mental health, financial difficulties, conflict in adult relations, social support, and her knowledge of child care and ability to provide emotionally for her children. Despite the reduction in risks associated with the parent's mental health and her substance abuse, the posttest scores suggest that parents will continue to need supports to sustain their progress in these areas. Recovery is a long and slow process, and for these parents, it is accompanied by many other limitations in their lives. These data underscore the importance of having long-term supports available to families once they leave the Project.

Placement Experiences. Caution should be exercised when using placement rates to examine family preservation initiatives such as Project Connect (Child Welfare League of America, 1990; Cole & Duva, 1990). With the dearth of residential treatment facilities that allow children to remain with their mother when she enters treatment, it is often necessary to place children. The Project has also recommended placement in situations where there were unacceptably high levels of risk in the home.

To determine whether the placement experiences of Project children differed for children not receiving Project services, a comparison was made between 76 Project children and 80 state-involved children whose parents had similar problems of substance abuse. Cases opened after January, 1992 were tracked for an 18 month period. Fourteen of the Project children, and 13 non-Project children, dropped out of the sample prior to the end of the 18 month tracking period when their cases were closed to the state child welfare system. The

remaining children were in families requiring continued state involvement; we can assume that these were the most problematic cases.

The data reveal interesting patterns with regard to children's living arrangements (see Table 2). Children in both groups were placed at about the same rate. Sixty-three percent of the Project children and 66% of the non-Project children were placed at some point during the period of time their cases were tracked. However, more Project children were reunified and they were reunified within much shorter periods of time. Forty-five percent of the Project's children were returned to their parents, as compared with 18% of the non-Project children. Project children, on average, were returned after 5 months in placement, while non-Project children were returned after 10 months.

It should be noted that a large percentage (74%) of the Project's children returning home did go on to experience a subsequent change in their living situation, almost always because of the mother's decision to enter residential treatment. Kinship care was available for most children in this situation, however, thus minimizing the disruption of family ties. In one case, the children's grandmother moved into the children's home and was subsequently approved as a foster parent while the mother pursued treatment. The mother has since completed residential treatment and is working to regain custody of her children. The shortage of facilities allowing children to remain with their parents while they pursue treatment clearly plays a significant role in determining whether families can remain together.

In addition, we looked at the question of where children were living when the Project terminated its work with families. These data were compared with the living situation of non-Project children at the end

TABLE 2

Children's Placement Experiences

	Project Children	Comparison Group
Percent placed in foster care	63%	66%
Percent returned home	45%	18%
Time to reunification	5 months	10 months

of the tracking period. Of those children whose cases remained open to the state and thus could be followed, 31% of the Project children, in contrast with 53% of those not involved with the Project, remained in foster placement.

It was also possible to look at whether Project children remained at home once the Project was no longer involved with the family. In reviewing these data, we found that it was very important to factor in the parent's level of participation in the Project and overall success in addressing her substance abuse problems (Koeske, 1993; National Resource Center on Child Abuse and Neglect, 1993). When parents had been successfully involved with Project services, 83% percent of their children remained at home. In contrast, only 17% of those whose parents had not been successfully engaged in service remained at home at the end of the tracking period. Thus, these data tell us that a project designed to offer supportive services to families struggling with problems of addiction can be successful in helping to maintain family ties and reducing the risk of child maltreatment in those cases where the parent is able to successfully engage in the recovery process.

Client Satisfaction. A pilot study was carried out during the first year of the Project with 11 families who had been involved with the Project for six months or longer (Valletta, 1993). Questions were patterned after the Homebuilders Client Feedback Survey (Whittaker et al., 1990) and Magura and Moses' (1986) Parent Outcome Interview. Parents were asked about their expectations for service, satisfaction with services and their worker, and their assessment of their substance abuse problem.

Participants had a variety of expectations when they began services. Most of these expectations were negative. Although services were voluntary, parents indicated that they had no choice in being involved with the Project. One woman stated "In the beginning I was afraid of Project Connect. I thought they would take my kids and that with Project Connect I wouldn't have power to make decisions anymore." Another said that she thought that "Project Connect would just be meddling in my life and I was very resentful." Several other women indicated that they were still using drugs when they became involved in the Project and expected the worker to be "nosey; come to my house and tell me what was wrong." Another woman stated that she "was still using and was trying to get rid of the worker. I was blowing off appointments but I was glad that the worker stood by me."

Once they became more involved with the Project, however, their attitudes changed. All participants indicated that they were very satisfied with the services they received and that they would recommend Project Connect to other families in a situation similar to theirs. Several spoke of specific services they found helpful such as assistance with parenting, transportation, budgeting, assistance with DCYF, and help in staying clean. More than specific services, though, they spoke of the support, attitude, caring, and friendliness of the Project Connect worker, saying that this was the most helpful aspect of the program.

In fact, all indicated that they were very satisfied with their worker. One woman said "I can talk about anything with her. She's not just a counselor, but a friend. She listens to me; she makes me feel good." These women discussed the comfort they felt with the worker and how this helped them to be open with her. Several of the women believed that the social worker was doing more than her job. As one woman stated, "It's not just a job for her. She really cares about people. I tell her everything, more than my (drug treatment) counselor."

Participants spoke mostly of the worker's caring. One participant said, "I liked how she was always there for me. That feels good when you need someone and they're there for you." Other participants spoke of the worker's understanding, her "ability to see both sides, not just the fact that I was an addict like other programs," her concern, and her ability to be sympathetic.

A few women indicated some dissatisfaction with Project Connect. Two were concerned about confidentiality and did not appreciate the contact that the Project Connect worker had with the state child welfare system. Another participant felt that the worker's questions were sometimes too personal, especially those questions around sexual activity. One woman speaking of an early dissatisfaction said that, "In the beginning she (the worker) was very strong the way she said things. She told me exactly how it was and I didn't like it, but I needed that. She made me worry (about the possibility of my children being removed)."

Denial of a substance abuse problem was remarkably absent from participants' responses. All acknowledged that they had a problem. Eight of the participants believed that their substance abuse problem was a lot better now and three felt that it was a little better. The majority stated that they are no longer using drugs or alcohol. However, one participant spoke about the difficulty of not using and how she missed it.

Overall, participants felt that the Project Connect worker helped them to deal with their substance abuse problems by being there to talk with, to listen, and by being supportive and caring. They spoke about how their worker had helped them to get into an appropriate drug treatment program. They talked about how the Project Connect worker had helped them to see the pros and cons of substance abuse and had assisted them in becoming more aware of the problems associated with substance abuse. They also discussed feelings of well-being. As one woman said, "She brings my spirit up. She helps me to feel good about myself." Another commented that "when you're coming off drugs, it really helps to have that person push for you."

As positive as this feedback is, it is important to keep in mind that not all families are represented and that others, especially those who dropped out, may have had very different experiences. The feedback that we do have, however, is consistent with other studies (Pharis & Levin, 1991) which have found that high-risk mothers are likely to respond very enthusiastically when they are offered the right kind of help.

Conclusions

Parents struggling with substance abuse are among the most challenging to serve. Those who come to the attention of the child welfare system are often very poor, with few work skills and lower levels of educational attainment. They are often living in high crime areas saturated with drugs. Moreover, they often bring family histories of abuse which have not prepared them well for the demands of parenting (Wallace, 1992; Weiner et al., 1990). Yet our work has shown that these parents have many strengths, including a strong attachment to their children and often a motivation to address their chemical dependence.

The challenge for us is to find a way to build on these strengths and to work with these families to help them address their substance abuse and reduce the sources of stress that are associated with relapse. Although parents may initially be skeptical about services, as were many of the Project Connect parents, this reluctance to engage in treatment is characteristic of addiction (Straussner, 1989; Tatarsky & Washton, 1992). Parents with a long history of substance abuse are quite likely to be in denial. To break through this denial, staff need to be able to establish a relationship in which parents feel supported and which will help them take those first hard steps toward recovery.

The findings of this evaluation suggest that the relationship between the clinician and client, more than any one specific service, is critical to the parent's success. Clinicians must be able to help parents deal with the "motivational conflicts about initial abstinence" that are inherent in the recovery process (Tatarsky & Washton, 1992, p. 31). Working in a non-judgmental manner, clinicians need to align themselves with the parent against the addiction (Straussner, 1989). If they are able to do this, they will then be in a position to encourage and support the parent's commitment to recovery.

Staff must also be able to work through the systems barriers that hinder our response to families. Part of Project Connect's work involved the elimination of concrete barriers to service, such as the lack of child care and transportation. Through inter-agency collaboration, staff were able to change the state's reimbursement policies so that clients would not have to wait as long to begin treatment. Staff served as advocates and brokers, linking clients with services and working with clients to negotiate the many systems they needed to access.

Parents with substance abuse problems are likely to need long-term support. Families' risk scores at the point they completed the Project tell us that parents were still struggling with recovery, as well as the financial limitations of their lives, parenting skills, conflict with significant others, and finding positive supports in their lives. To maintain the successes these parents made in treatment, we must have in place such transitional services as safe housing and make follow-up support available to the family (Child Welfare League of America North American Commission on Chemical Dependency and Child Welfare, 1992; Woodruff & Sterzin, 1993).

The Project plans to initiate support groups which will be open to parents who have completed the more intensive phase of services as well as those in the earlier stages of treatment. Parents who are further along in their recovery will be able to support one another and also serve as role models for those just beginning to address their addiction. Parents will also be able to use the agency's new drop-in center as needs arise. In these ways, the Project will expand its capacity to serve families with a history of substance abuse.

Through a community-based approach, Project Connect has worked to build on parents' strengths and to put in place the supports needed by parents struggling with problems of chemical dependence. Relationships between clinicians and families have been a key part of the Project's success, as have the steps taken to eliminate barriers to service. Efforts such as this demonstrate that we can respond effectively to the many needs of these families and work with parents to create

the safe and nurturing environment their children require for healthy growth and development.

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