

Parenting in Recovery Program: Participant Responses and Case Examples

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Approximately 80% of children served by child welfare agencies have parents who abuse or are dependent on alcohol or illicit drugs. Despite the devastating effects on children from living in substance abusing families, child protective service practitioners have limited options available to assist these families. The Parenting in Recovery program was created to address the needs of substance-abusing mothers involved in child welfare. This manuscript describes this program and perceptions of participants concerning its effectiveness.

Many communities across the United States are struggling to meet the needs of children whose families are dealing with substance abuse. It is estimated that 11% of U.S. children (8.3 million) reside with a substance-abusing parent (Child Welfare Information Gateway [CWIG], 2003). Children of alcohol and drug abusers are often subjected to extreme household disorganization, neglectful/abusive parenting, and economic hardship (Grant, 2000). Parents impaired by addiction are less likely to appropriately nurture, supervise, and care for their children (O'Connor, 2005) and substance abuse is a contributory factor for 30%–66% of children involved with child protective services (CSIG, 2003). Child welfare cases with parents who abuse substances generally include younger children who are more likely to be severely abused and neglected.

Parental substance abuse affects the child in many significant ways, including multiple incidents of child maltreatment, removal to foster care with a potential for multiple moves within the foster care system, delayed permanency, failed reunification, maladaptive behaviors, and potentially the loss of the parent due to termination of parental rights. Living with a substance abusing parent places children at risk for poorer developmental outcomes (physical, intellectual, social, and emotional) than other children (Berger, Slack, Waldfogel, & Bruch, 2010). Children exposed to drugs or alcohol in utero may experience fetal anomalies, delays in infants' gross and fine motor skill development, and neonatal withdrawal symptoms (Clark, 2001; Singer, Minnes, Short et al., 2004). The result is a greater likelihood of placement of these young children in out-of-home care and longer lengths of stay in foster care than other children in the child welfare system (Carlson, 2006).

The complexities of serving families with parental substance abuse and child maltreatment require interventions that are comprehensive, holistic, and coordinated across multiple agencies (Clark, 2001; Kinard, 2002). Comprehensive services that include education and employment; housing security; parenting classes; ongoing substance abuse treatment and recovery for mothers; and targeted services for children's educational, behavioral, and emotional needs appear most appropriate (McApline, Marshall, & Doran, 2001; Smith, 2003).

Services must be linguistically or culturally appropriate (McAlpine et al., 2001) and address the long-term needs associated with the multiple challenges faced by these families (Berger et al., 2010). Residential or intensive outpatient substance abuse treatment that allows mothers to retain parental interaction with their children while providing the child(ren) with additional supports has been shown an optimal choice (Einbinder, 2010).

One major challenge in assisting women with substance abuse and their children is the divergent priorities and perceptions of substance abuse treatment providers and child welfare workers. Child welfare workers rarely have the clinical background to diagnose or treat substance abuse; substance abuse providers may not understand the time pressures or legal mandates under which child welfare case-workers operate (Semidei, Radel, & Nolan, 2001; McAlpine et al., 2001). Other potential conflicts include identification of the client (child versus adult) and defining outcomes and successes. For example, in the substance abuse treatment field, success is typically defined by reductions in drug use with the optimal outcome of abstinence. From the child welfare perspective, a parent could be abstinent but remain incapable of providing a safe and adequate environment for the child's development and well-being.

Women who are dependent on alcohol/drugs and who are involved with child welfare often lack effective collaborative treatment planning between child welfare and substance abuse treatment providers. Even among those who receive residential substance abuse treatment, upon discharge many have difficulty locating safe, affordable housing; those with few financial resources have limited options and often must return to environments that contributed to their instability and substance abuse. Women in this situation generally have limited employment skills, a history of domestic violence, trauma experiences, and strained family relationships (Kovalesky, 2001). They also may have a criminal history, which further complicates their ability to locate housing as landlords are reticent or refuse to rent to individuals with a criminal record. Additionally, affordable child care is difficult to locate (Semidei, et al., 2001). The combination of these

factors contributes to heightened stress at discharge from substance abuse treatment and increases the risk of relapse and losing parental rights if CPS determines the child is not assured of safety in their parent's home. Thus, it is clear that drug-affected families in the child welfare system are often more complex and challenging for case workers due to the wide range of problems and challenges.

In an attempt to address the issues of parental substance abuse and child welfare involvement, a collaborative intervention project, funded by the Administration for Children, Youth, and Families, was developed. The Parenting in Recovery (PIR) program aimed to address parental substance abuse and child well-being among families involved in the child welfare system. This project brought together a coalition of community service providers to deliver a flexible, comprehensive continuum of services to drug/alcohol dependent women with children under the age of five who were involved in the state child welfare system. The core objectives of the PIR program were to assist mothers of young children in recovering from substance dependence, maintaining/regaining custody of their children, and establishing safe and healthy homes for their children.

This study aimed to delineate preliminary qualitative findings of the program from the perspective of participants. Focus groups with mothers engaged in the program were conducted to understand their perceptions of the program, provide information about the various challenges they faced in their lives, discuss what services and supports assisted their recovery and parenting, and gain insight as how the program might need to be modified in the future. Individual case descriptions are also provided as exemplars of the challenges faced by participants of the program and the successful and unsuccessful outcomes of four PIR participants.

Methods

Participants and Procedures

The target population was women with child(ren) who had been identified as substance-dependent by a CPS investigator. As a

component of this program, CPS investigators were trained in conducting standardized assessments for substance dependency. Identification and entry into PIR required the mother's substance abuse to be a major contributing factor to her child's maltreatment and the child(ren) had to be newborn to 5 years of age. The mother was immediately eligible if she gave birth to a drug-positive infant. Caseworkers responded to referrals within 24–72 hours; the mother's eligibility for enrollment into PIR and placement of the child(ren) was determined at that time. PIR participant children either remained in the care of their mother or were placed in out-of-home care with a relative.

Once a family's eligibility requirements were confirmed, CPS caseworkers described the PIR program to the mother during a family team meeting. Consent procedures, as authorized by the affiliated university's Institutional Review Board for the protection of human subjects, were described and recruitment sought. A comprehensive collection of services was available to participants over the course of approximately 18 months of program participation, including:

1. Admission to comprehensive residential substance abuse treatment in a timely fashion (typically within 7 days of CPS involvement) and for up to 90 days in-patient care. A specialized unit at the treatment facility was designed for mothers to have up to two children under 5 years or age remain with them in treatment.
2. Participation in Family Drug Treatment Court was required. Mothers attended weekly sessions and interacted with case managers and a judge with substance use treatment experience. They also interacted with other PIR program participants and listened during court while the judge and other team members commented on each participant's successes and challenges.
3. Parenting classes and in-home visitation once mothers moved from residential substance abuse treatment.
4. Individual counseling and psychiatric services to address mental health issues.

5. Employment, workforce and educational support services were available and encouraged to increase employment skills or complete the General Equivalency Diploma (GED).
6. Health care was provided and mothers were assisted in registering for Community Health Center services.
7. Dental care was provided for mothers as they frequently had not had dental care for years and included needed extractions or full-mouth dentures.
8. Intensive outpatient substance abuse treatment and referral to 12-step programs was provided following discharge from residential substance abuse treatment services.
9. Rental assistance with a case manager was provided when the mother and her children transitioned from substance treatment into community housing.
10. Assistance with daycare costs and transportation needs were provided.

The children also received wraparound services based on an initial assessment to identify unmet needs and recommend service supports; they received ongoing medical and dental care, educational/developmental support, access to licensed child-care, therapeutic interventions associated with behavioral and emotional difficulties, and activities aimed at enrichment and general well-being. Supporting the mother in efforts to retain custody of her child(ren) was a fundamental effort of the program; when this was not possible, children were placed with appropriate family members/kin.

Data Collection Procedures

Three focus groups were held with mothers who were participating in the Parenting in Recovery Program. As effective focus groups cover a maximum range of relevant topics and foster interactions between group members, focus group participants ($n = 27$) were asked a set of questions by two facilitators (one was a PIR staff member, the other was not). Questions had been developed for other focus groups held nationally that sought perceptions of participants concerning program strengths and challenges; however, facilitators were encouraged

to allow participants to discuss topics and issues they felt were important to them. Core questions for the focus groups included: (1) Why did you decide to join PIR?; (2) What services or supports did you utilize and how much did they help or did not help you?; (3) What has been your biggest support/challenge while in the program?; and (4) What are your thoughts about the program?

Data from the focus groups were collected through taking notes and recording specific quotes of participants during the discussions. This qualitative information was transcribed and text was analyzed by two coders using an iterative process to develop themes, as suggested by Morgan (1997). A high-inference coding process (axial coding) focused on reading through each report multiple times to develop a list of major themes, which included: (1) reasons for participating in PIR; (2) services and supports, including substance abuse services, employment and financial resources; (3) challenges with program requirements; and (4) overall perceptions about PIR. Coders then examined individual coding units (i.e. word, phrase, sentence that pertained to a single concept stated by an individual) and coded each statement into one theme by discussing and reaching consensus. In addition to these focus groups, 4 individual case studies were developed as examples of the challenges and outcomes of participants.

Results

The PIR program has served 97 women and 157 children to date; nearly half tested positive for drugs at the time of the birth of a child. Approximately 37% are of Hispanic origin and completed an average of 11 years of education. Seventy-one percent were never married and 86% were unemployed at program admission. Mothers had 1–2 children on average and 86% of these children were under the age of 5; most of children were confirmed victims of physical abuse (67%) or neglect (21%). Fifty-seven percent of the children were placed into kinship care when the mother was admitted to substance abuse treatment; however, 37% remained with their

mothers in the specialized program for substance abusing mothers and their children. PIR programs participants completed an average of 70 days residential substance abuse treatment. Focus group participants represented a cross-section of these mothers.

Focus Group Themes

Reasons for Participating in PIR

Participants noted that they agreed to engage in the Parenting in Recovery program not necessarily to help themselves, but because they believed it would allow them to keep their children or be reunited with their children more quickly, for example: "It was the only way to keep my kids." Another mother described being in the hospital after the birth of her child: "I was told right up front that I had the option to keep my baby. I was still in the hospital and it made me feel good because I wasn't going to give my third baby to CPS or to a family member." Several participants noted that their original motivation for PIR participation and substance abuse treatment admission had little to do with a desire to become clean and sober. Rather, they were willing to do anything to keep their children, even if that included admission to 90 days of intensive residential substance abuse treatment. Some noted that they agreed to become involved to avoid a criminal investigation, arrest or jail. One mother said, "going to inpatient treatment was better than going to jail."

Services and Supports

Substance abuse services. Mothers discussed at length the issues of inpatient substance abuse treatment, agreeing that it was only after they were discharged that they recognized the value of what they had learned during residential treatment. One participant noted that "going to treatment is a lot of hard work. It's a lot of structure and rules, but there are lots of benefits at the end of it. You will get out of it what you put into it." Mothers who completed residential inpatient substance abuse treatment overwhelmingly voiced a genuine desire to remain clean and sober and work a program of recovery in order to be a good parent to their children. These revelations strengthened

understanding of the importance of promoting reunification if participants made progress in treatment.

Participants were required to attend 12-step program meetings throughout their enrollment in PIR. Some used the requirement to become strongly connected with Alcoholics Anonymous/Narcotics Anonymous "home groups" and the recovery community in general. Others resisted attending 12-step meetings as they did not agree with the principles expressed in the meetings. However, virtually all participants, regardless of their attitudes toward the 12-step process, spoke about the difficulty they had complying with the requirement to attend "90 meetings in 90 days" following completion of intensive outpatient substance abuse treatment.

Employment services. Most participants came into the program with very limited education and few had ever been employed. Few participants did obtain jobs or were successful in moving toward self-sufficiency during their time in the program; however, a few participants took advantage of PIR service options to obtain job training and certifications. Two participants obtained certification as nurses' aides and were registered with local home health care agencies. Focus group members described how not having a job made it even more difficult to remain clean and sober; they desired employment that would allow them to be self-sufficient and care for their children independent of others. Participants suggested that finding adequate employment was one of the most significant barriers to being independent, especially due to their lack of well-developed educational skills.

Financial resources. Those who qualified for entitlement programs appeared to have a small advantage financially, but many PIR participants reported that they did not qualify for these benefits. The overwhelming majority of participants felt that if they were able to maintain or regain strong family relationships, they could rely on family to help. One participant noted how financial support from her partner had helped the family and her own recovery. Other participants agreed that those who had an employed partner that contributed financially to the family allowed them to fully invest in their recovery. One participant reported that because her husband worked

full-time, she was able to attend to her own career training. She had previously completed about one-third of a beauty college curriculum; PIR helped her complete that curriculum. On the other hand, many participants voiced a lack of reliable and supportive family connections; they continued to work toward regaining the trust of their family members and receiving tangible or emotional support from them. Few families could be called upon for financial supports.

Challenges with PIR Program

Participants of focus groups discussed at length their frustrations with the uniformly high, and often unreasonable, expectations of the PIR program. Participants described spending their first three months in residential treatment, then moving into sober housing for three months and beginning six weeks of intensive outpatient (IOP) treatment, which required attendance four mornings per week. Few participants had private transportation; reliable, accessible, affordable public transportation was scarce and contributed to difficulties in attending program meetings and taking children to daycare. By the time they completed residential and IOP treatment, they are essentially five months into the program and were expected to begin contributing financially to rent and other living expenses within six months of entering the program. While engaged in these activities, they were learning to parent their children; attending drug court and CPS hearings; participating in parent training sessions, peer recovery coaching meetings, and individual therapy; and receiving home visits from a variety of service providers, including CPS. For many of the participants, they wondered, "When do I have time to train for a job, look for a job, and work at a job if I find one?" One woman stated, "You may think you're pushing me forward, but you're really pushing me toward the edge."

They also had difficulty with their CPS caseworkers. They felt these relationships were superficial and overwhelmingly negative. For example, one mother said, "Even though I've been clean since I went into treatment, it seems like it's never good enough. She's always coming up with things that she thinks are not good

enough...She focuses on the small stuff and seems like she is requesting perfection." Another noted, "They need to focus more on what we are doing right instead of what we're doing wrong...She never focuses on what I have accomplished."

Overall Perceptions about PIR

Many participants described their feelings when they first entered the program as being overwhelming. For example, one young woman said: "I just wanted to turn around and run;" another said, "people just need to know it's not a walk in the park." Even though they felt uncertain about successfully completing the program, most participants indicated they had achieved a great deal. Expectations of the program requirements were often difficult to achieve. As one woman suggested, she especially appreciated that the program did not require her to find a job right away; it helped her feel less overwhelmed with the need to be totally self-sufficient while also trying to parent her child and work on her recovery from substance abuse. Many participants discussed their gratitude for having the opportunity to be involved in PIR. They felt it gave them a chance to "make a new start" and make better decisions. As one of the greatest fears was the unknown associated with living on their own after being discharged from substance abuse treatment, they found that PIR was helpful in "every aspect of getting back on my feet." It seemed less overwhelming when there was a system in place to provide ongoing support.

Individual Case Examples (False Names)

Judy faced significant challenges when she entered the PIR Drug Court program. She had Axis I diagnoses that included methamphetamine dependence, major depression, and post-traumatic stress disorder, the latter resulting from severe physical and sexual abuse as a child and domestic violence as an adult. She had numerous physical health issues, including serious dental problems that discouraged her from smiling or speaking in public. She also was the primary caregiver for her young child, who had medical challenges of his own. This participant remained isolated and remote throughout much of

the program; she seldom interacted or connected with other program participants. She described being discouraged and hopeless, leading her to seek discharge from the program on several occasions. She stated that she could not cope with the demands and expectations of the program. However, with intense support and assistance from program team members, she eventually developed confidence and optimism for the future. PIR helped her access resources and provided her with needed services she had not had access to previously. In addition to residential and outpatient substance abuse treatment, she obtained safe permanent housing, worked one-on-one with a parenting coach, participated in trauma-informed individual psychotherapy, and received significant dental reconstruction. Once becoming motivated, she complied with court orders, progressed through program phases at a steady pace, and successfully completed and graduated from PIR in 14 months. Although she declined to be photographed, she smiled and spoke in front of a group of her peers at her graduation. She voluntarily joined a group of alumni who had participated in the program and has successfully maintained her sobriety and parenting of her child.

Nancy was a 27-year-old participant with an infant son. Both mother and son tested positive for cocaine at the time of his birth. Nancy scored below 70 on IQ testing, had never held legitimate employment, and had never obtained housing in her own name. She read at a first-grade level and had been in self-contained special education classrooms throughout her childhood. She had a lengthy history with both the juvenile and adult criminal courts. Nancy was a victim of childhood abuse by a mother who also suffered from drug addiction; Nancy also experienced domestic violence at the hands of her son's father. She had lost three previous children to the child welfare system and reported continuing grief over their loss and her mother's death a few years prior. Nancy had a strong dedication to parenting her newborn son and a very deep love and affection for him. Although she started parenting training with one of the lowest scores on standardized parenting measures that the team had ever seen, she listened intently to her parenting trainer, responded to feedback, and

followed through with suggestions. By the time she successfully completed parenting training, Nancy had a very high score on the same standardized test and was very proud of her progress. Nancy's other strengths included her ongoing willingness to seek support, her continued affection and support for other women in the program, and her resiliency despite adversity. Nancy was also fortunate to have the support of her sister, who cared for Nancy's son when she attended services and 12-step meetings. While in the program, Nancy had six separate admissions for substance abuse treatment—three in residential and three in intensive out-patient programs. PIR staff identified her for unsuccessful discharge from the program on three different occasions due to relapses on cocaine and alcohol; however, because she continued to sincerely seek help, staff felt committed to continue working with her. Program staff helped Nancy pursue Social Security Disability, which she obtained on her first try. About six months prior to completing the program, she reunited with a previous significant other (not her son's father) who was stable and sober and moved into his home. At her program graduation, Nancy reported gleefully to the PIR team and her peers that she had been asked to speak to young mothers at a local high school about her struggles and successes. She loved this experience and felt that being in the role of educator and mentor was a truly unique and rewarding experience for her. She continues to be clean and sober, happy, and grateful to be a full-time mother who is successfully caring for her child.

Trisha was a 36-year-old mother of two. She successfully completed 90 days of residential treatment one week before her mother unexpectedly passed away. Because her father was an active alcoholic, she handled all of the funeral arrangements and provided comfort to her family, including her children. One month after her mother's death, her husband died in an automobile accident. Again, she took charge and managed all the arrangements, despite the fact that her husband had two grown sons who were his business partners. After the funeral, these men promptly broke all ties with Trisha and refused to allow her access to anything associated with the business. PIR staff gave her intensive support during and following these crises. She

spoke with one staff member almost every day, and other program participants visited her at home at least once per week. These tragic events and their aftermath interrupted what would have been Trish's normal participation in PIR services and activities. She bypassed a step-down to intensive outpatient treatment and relied instead on a weekly aftercare groups and community-based recovery support meetings. She obtained a strong AA sponsor and attended a minimum of three AA meetings per week, which in itself was challenging as she lived about 40 miles outside of the metropolitan area. She stayed clean and sober throughout the process and continued to care for her two children, both of whom received therapeutic services provided through PIR. About three months prior to successfully completing PIR, Trish opened her own small landscaping business and hired one of her peers from the program to work with her. She often-times arrived at morning program meetings having worked since sunrise. Since graduation, she has maintained contact with program staff; her children are thriving, and her business is successful to the extent that she is fully self-sufficient and employs two assistants.

Helen was a 24-year-old mother of three children—ages five, three, and one—who was referred to PIR at the beginning of two different child welfare cases. She declined participation the first time but agreed to enroll the second time when she tested positive for heroin at the birth of her third child. At the beginning of the case, all three children were voluntarily placed with their great grandmother while the client entered residential treatment. After one week in treatment, she transferred into a short-term residential psychiatric hospital where she was stabilized and released back to the substance abuse treatment program. She participated for a short time but was discharged for creating disturbances and repeated rule violations. She then entered another treatment facility outside of the metropolitan area that focuses services more narrowly on clients with co-occurring psychiatric and substance abuse disorders. She left that treatment center three weeks later, against medical advice, with a male resident whom she met at the facility. She did not contact PIR staff and could not be located for two months, at which time she was unsuccessfully

discharged from the program. She eventually reconnected with PIR program staff and moved in with her mother, who was also a heroin addict. She died of a heroin overdose a short time later. Her children remain with their great-grandmother.

Discussion

The goals of the PIR program aimed to serve mothers by removing barriers associated with multiple physical, mental, emotional, and life skills needs in order to achieve sobriety and retain custody of their children, despite child protective service involvement. Core elements of the program included residential substance abuse treatment, safe and stable housing, training in appropriate parenting, and encouraging mothers to move quickly toward self-sufficiency.

Most PIR participants, like most individuals who abuse substances generally, entered the program with limited understanding of the extent of their addiction and its effect on their families (Einbinder, 2010). They experienced a variety of challenges, including severe addiction, limited work skills, poor employment histories, limited access to transportation, low educational levels, and felony/misdemeanor convictions that disqualified them from many forms of employment and housing options. With multiple personal and environmental barriers to achieving sobriety, self-sufficiency, and appropriate parenting (Kovalesky, 2001), these mothers represent one of the most challenging segments of the substance-using population.

During the course of PIR program delivery, it became clear that the process of personal growth and change takes a great deal of time, especially among those who had limited experiences with independence and self-reliance. Significant and meaningful change developed slowly as they moved through denial of the addiction, began the process of recovery, and learned basic living and parenting skills. They gained access and utilized a wide variety of essential services that they may not have had without being involved in the program. As significant internal and external personal challenges require much more time and effort to overcome (Kovalesky, 2001), the changes in attitudes,

beliefs and lifestyle were profound. With encouragement, patience, and flexibility of PIR service providers, participants confronted barriers that had previously appeared insurmountable.

Intensive service provision within a collaborative continuum of care providers who are flexible and committed to the success of participants appears to be the core process needed by this population of mothers. Staff encouraged active participation of the women in developing their goals and provided encouragement and support without threatening their independence. Although some women felt frustration with the program's high, possibly unreasonable, expectations of participants to address their substance dependency while becoming self-sufficient and a good parent, many rose to the challenge.

Limitations and Recommendations for Future Research

The findings from the qualitative focus groups present various limitations that must be noted. The sample included a group of participants engaged in PIR, which may be very different in terms of service access among other populations of substance dependent mothers who are involved with child welfare services. Even though several programs have been developed in the past few years that provide drug treatment to parenting women (e.g. Metsch, et al., 2001; McApline, et al., 2001), further research is needed to corroborate these results among other similarly situated women in other locations across the country. In addition, the sample size is small and likely reflects those most willing to participate in the focus groups. Focus group methodology was chosen because of the efficiency of data collection and capacity to incorporate group interactions (Krueger, 1994); however, these strengths also create concerns as groups have a tendency to create conformity among some members. This results in some members not discussing issues that they might in one-on-one interviews. "Polarization" may also occur where some participants express more extreme views in a group situation than they would in individual settings (Sussman, Burton, Dent, Stacy, & Flay, 1991).

Recognizing these limitations of this study, it does add to existing understanding of the profound challenges faced by women who

are involved in child protective services and who are substance dependent. Although child welfare professionals are charged with protecting the welfare and safety of children, it is important for workers to recognize issues associated with addictions and have more information concerning effective and efficient methods of service provision to these multi-problem families. Effective evidence-based practices are needed that focus on the child's well-being while providing assistance to parents struggling with addiction. Recognizing how issues of substance abuse, economic hardship, and mental illness impact these families are areas of training for child welfare workers (Semidei et al., 2001; McAlpine et al., 2001). On the other hand, substance abuse treatment providers require training and understanding of the issues associated with addiction recovery among parents who have children in the child welfare system. Extant research suggests that appropriate training improves worker's ability to identify, refer, and provide more effective treatment (Meyers, Apodaca, Flicher, & Slesnick, 2002).

In sum, these families require services that address the challenging and multi-problem areas of substance abuse, poverty, poor education, inadequate housing, unemployment/ underemployment, and difficulties with transportation and child care. If these concrete problems are not attended to, the likelihood that the child is removed from his/her home increases. Through collaboration between child welfare and substance abuse treatment systems, the needs of these highly vulnerable families may be addressed.

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