Journal of Social Work Practice in the Addictions
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t792306973

Collocation: Integrating Child Welfare and Substance Abuse Services

Eunju Lee [a]; Nina Esaki [b]; Rose Greene [c]
[a] Senior Research Scientist, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA [b] Research Scientist, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA [c] Associate Director, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA

Online Publication Date: 01 January 2009

To cite this Article Lee, Eunju, Esaki, Nina and Greene, Rose(2009)'Collocation: Integrating Child Welfare and Substance Abuse Services',Journal of Social Work Practice in the Addictions,9:1,55 — 70
To link to this Article: DOI: 10.1080/15332560802533612
URL: http://dx.doi.org/10.1080/15332560802533612

Journal of Social Work Practice in the Addictions, 9:55–70, 2009

ISSN: 1533-256X print/1533-2578 online
DOI: 10.1080/15332560802533612

Routledge
Taylor & Francis Group

Collocation: Integrating Child Welfare and Substance Abuse Services

EUNJU LEE, PHD
Senior Research Scientist, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA

NINA ESAKI, PHD
Research Scientist, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA

ROSE GREENE, MA
Associate Director, Center for Human Services Research, School of Social Welfare, University at Albany, New York, USA

This article presents findings from a process evaluation of a pilot program to address parental substance abuse in the child welfare system. By placing substance abuse counselors in a local child welfare office, the collocation program was designed to facilitate early identification, timely referral to treatment, and improved treatment engagement of substance-abusing parents. Frontline child welfare workers in 6 of the 7 pilot sites endorsed the program as they found that the collocated substance abuse counselors provided additional resources and facilitated case processing. Findings suggest that clearly defined procedures and sufficient staffing of qualified substance abuse counselors could lead to better programs.

KEYWORDS child welfare, parental substance abuse, service integration

Received May 16, 2007; accepted February 8, 2008.

This research was funded by the Children's Bureau (#90CW-1111), Administration of Children and Family, U.S. Department of Health and Human Services.

Address correspondence to Eunju Lee, Center for Human Services Research, School of Social Welfare, University at Albany, 135 Western Ave., Albany, NY 12222, USA. E-mail: Elee@uamail.albany.edu

Parental substance abuse is a well-known risk factor affecting families in the child welfare system. However, both the child welfare and substance abuse service systems have faced challenges in identifying, engaging, and providing effective treatment to substance-abusing parents investigated for child maltreatment.

Challenges include the different goals, legal mandates, and practices between the child welfare and substance abuse fields. As a result of the Adoption and Safe Families Act of 1997, the timelines for placement decisions and family reunification were shortened, placing unrealistic demands on substance-abusing parents to make significant life changes. Additionally, the child welfare system seeks to protect children and, whenever possible, to keep families together. Substance abuse treatment providers view addiction as a chronic, relapsing condition and traditionally place primary focus on the individual client.

In response to these challenges, policymakers and administrators have invested in service integration models. Promising results from the Illinois Title IV demonstration program will further generate interest in service integration (Marsh, Ryan, Choi, & Testa, 2006; Ryan, Marsh, Testa, & Louderman, 2006). Despite this recent advance, empirical research on service integration models is still limited and few studies have rigorously examined the implementation issues of these models.

A collocation program piloted in a northeastern state is a service integration model designed to address parental substance abuse in the child welfare system. The program consists of placing credentialed alcoholism and substance abuse counselors (CASACs) in local child welfare offices to work with frontline child welfare workers to increase the level of substance abuse identification, treatment referral, and treatment engagement. This article presents the results of a process evaluation of the collocation model using data from interviews, focus groups, and administrative records. The program model, implementation process, implementation challenges, perceived effects, and suggestions for future service integration models are examined.

LITERATURE REVIEW

Prevalence and Risk of Substance Abuse in the Child Welfare System

Although substance abuse is considered a serious risk factor for child maltreatment, current prevalence rates of parental substance abuse in child welfare cases vary widely due to differences in definitions and methodology (Besinger, Garland, Litrownik, & Landsverk, 1999; Semidei, Radel, & Nolan, 2001; Young, Boles, & Otero, 2007). For example, the Child Welfare League of America (1998) estimated that at least 50% of confirmed cases of child maltreatment involve parents with substance abuse problems. Semidei et al.

(2001) found substance abuse contributed to child maltreatment for one third to two thirds of the families involved with child welfare agencies. Parental alcohol or drug use has been also strongly associated with the substantiation of abuse or neglect allegations (Sun, Shillington, Hohman, & Jones, 2001; Wolock, Sherman, Feldman, & Metzger, 2001). Estimates of parental substance abuse for children entering foster care have been even more staggering: About 80% of children placed out of home due to maltreatment have parents with substance abuse issues (Besinger et al., 1999; U.S. Department of Health and Human Services [USDHHS], 1999). The prognosis for families with substance abuse problems in the child welfare system is dismal. Child maltreatment cases involving parental substance abuse often result in recurring maltreatment allegations, longer stays in foster care, and reduced likelihood of family reunification (Ryan et al., 2006; Smith & Testa, 2002; USDHHS, 1999; U.S. Government Accounting Office, 1998; Wolock & Magura, 1996).

Barriers to Service and Treatment

Unfortunately, less than half of all parents with substance abuse issues in the child welfare system enter and complete necessary alcohol and drug services (Young, Gardner, & Dennis, 1998). Gregoire and Schultz (2001) found that few parents complete assessment or treatment. Engaging and retaining these clients in treatment has been a critical problem (Choi & Ryan, 2006; USDHHS, 1999). There have been clinical and systemic barriers for engagement and retention of parents in treatment (McAlpine, Marshall, & Doran, 2001). These issues revolve around the nature of the child welfare job, the types of substance abuse treatment services readily available in communities, federal and state policies, and the differing perspectives of the child welfare and substance abuse fields.

First, child welfare staff lacks the training and experience to accurately assess the extent of substance abuse problems of parents investigated for child maltreatment (Semidei et al., 2001; Tracy, 1994; Young et al., 1998). Parents in the child welfare system are likely to deny their alcohol and other drug problems as well as their need for help, in part, because they fear removal of their children (Dore, Doris, & Wright, 1995; Jessup, Humphreys, Brindis, & Lee, 2003). Child welfare workers whose primary focus is the safety of children are also not experienced in helping parents with substance problems (Marsh & Cao, 2005; Tracy & Farkas, 1994) and view substance-abusing parents as difficult to treat (Semidei et al., 2001).

Effective treatment designed for parents, especially women with young children, is not easily available in many communities. Many providers are not prepared or equipped to address the complex physical, mental, social, and economic issues facing these women and their children (USDHHS, 1999). In addition, these parents, particularly mothers, often lack critical concrete supports (e.g., child care, transportation) necessary to begin and complete treatment (Azzi-Lessing & Olsen, 1996; Carlson, 2006).

Despite a lengthy recovery process and the need for concrete services to enter and complete treatment, federal and state policies place demanding timelines on such families. Under the Adoption and Safe Families Act (ASFA) of 1997, parents must resolve their problem within a 12-month period or risk permanent loss of their children (Green, Rockhill, & Furrer, 2006; Smith, 2001). These policies not only place demands on substance-abusing parents to make significant life changes in relatively brief periods of time, but also place undue burdens on child welfare services to accelerate accurate assessment, referral, and case management services (McAlpine et al., 2001).

Finally, the child welfare and substance abuse treatment systems have different perspectives (Feig, 1998; Young & Gardner, 1998). Substance abuse treatment staff members who are knowledgeable about addiction focus almost exclusively on the drug abuser. In contrast, child welfare workers who are more knowledgeable about the consequences of addiction on the other family members might have a punitive attitude toward substance abusers and focus on the maltreated child. In addition, given the often different background and training experiences of workers in these two fields, child welfare workers and substance abuse treatment providers typically know very little about the other area (Carlson, 2006).

Need for Collaboration Between the Two Systems

To address the challenges associated with substance abuse in child welfare, strategies for integrating substance abuse treatment and child welfare services have gained increased popularity (Horwath & Morrison, 2007; Ryan et al., 2006). Historically, the implicit model in child welfare depended on the child welfare worker acting in isolation to motivate the substance-abusing client to seek treatment. However, more recently, policymakers, practitioners, and scholars have come to believe that collaboration between substance abuse and child welfare systems can be more effective in engaging the parents in treatment (Colby and Murrell, 1998; Cornerstone Consulting Group, 2002; McAlpine et al., 2001; Peterson, Gable, & Saldana, 1996; Ryan et al., 2006; Semidei et al., 2001; Young & Gardner, 2002).

Some research suggests collaboration between substance abuse treatment and other social service systems improves treatment outcomes, especially for women (Dore & Doris, 1998; Kraft & Dickinson, 1997; Marsh, D'Aunno, & Smith, 2000; Randolph & Sherman, 1993; Walsh & Young, 1998; Young & Gardner, 1998). Dore and Doris (1998) found that nearly half of the women in their study were able to complete treatment through a placement prevention initiative staffed by both child welfare workers and substance abuse specialists. For women with children, improved access to treatment, specifically the provision of transportation, outreach, and child-care services, showed a negative relationship with continued substance abuse (Marsh et al., 2000).

A number of states have initiated collaborative efforts between the child welfare and substance abuse systems to build effective new partnerships. Although some show promising results (Cornerstone Consulting Group, 2002; Maluccio & Ainsworth, 2003; Young & Gardner, 2002), there has been limited empirical evidence to demonstrate the impact of these collaborative efforts on child welfare outcomes (Barth, Gibbons, & Guo, 2006; Marsh et al., 2006). One exception has been a recent study (Ryan et al., 2006) that demonstrated positive results after provision of intensive case management to link substance abuse services and child welfare services in Illinois.

Collocation: A Service Integration Model

Collocation refers to strategies that place multiple services in the same physical space (Ginsburg, 2008). It has been suggested as a strategy for integrating different service systems for clients with multiple service needs (Agranoff, 1991; Austin, 1997). Clients with multiple needs face difficulties in navigating fractured systems with different sets of rules and expectations. As a result, they are less likely to receive needed services and more likely to experience poor outcomes (Marsh et al., 2006). A recent study indicated that child welfare outcomes are substantially enhanced when families receive appropriate substance abuse services (Green, Rockhill, & Furrer, 2007).

A collocation model, which places substance abuse counselors at local child welfare agencies, serves as a simple, concrete, and straightforward mechanism for facilitating collaboration between the two systems. The model has the potential to increase early identification of substance-abusing parents in the child welfare system. It could also address some of the barriers to treatment, thereby engaging and retaining substance-abusing parents in treatment that might, in turn, lead to improved child welfare outcomes. Substance abuse specialists are trained to utilize empirically based techniques, such as the transtheoretical model of change (Prochaska & DiClemente, 1984; Prochaska & Norcross, 1999) and motivational interviewing (Miller & Rollnick, 2002), a process of engagement that is designed to overcome child welfare clients' denial of abuse and to motivate them to enter treatment. These specialists, working in concert with child welfare workers, can address the logistical and psychosocial barriers to treatment, can build a trusting relationship during the "window of opportunity" when parents feel highly vulnerable, and can successfully obtain the parents' acceptance of care plan goals within federal and state time constraints.

Unfortunately, literature specific to the topic of collocation is limited. Several descriptive studies regarding collocation have been conducted in such venues as human services in schools (Briar-Lawson, Lawson, Collier, & Joseph, 1997; Tapper, Kleinman, & Nakashian, 1997), mental health service

providers in buildings of primary care physicians for the treatment of depressed patients (Valenstein et al., 1999), and substance abuse providers in departments of social services for the assessment of Temporary Assistance to Needy Families (TANF) recipients (Center on Addiction and Substance Abuse, 1999). Similarly, research regarding the collocation of substance abuse specialists in child protective services (CPS) is sparse, and although encouraging regarding intermediate outcomes (McAlpine et al., 2001), remains inconclusive regarding longer term child welfare outcomes (Marsh et al., 2006). McAlpine and colleagues (2001) examined a program that included collocating substance abuse specialists in child welfare offices. They found substantial increased use of the substance abuse specialist by the child welfare office in less than 1 year—from an initial rate of 10 staff members making requests for 169 investigations to 32 staff members making requests for 282 investigations. A recent evaluation of the Illinois Title IV-E demonstration program showed promise of service integration for substance-abusing parents whose children were removed from their care (Ryan et al., 2006).

Despite encouraging outcomes, additional research is needed regarding service integration models for child welfare clients. Particularly useful would be studies examining implementation issues. The Maryland Title IV-E demonstration was terminated due to several factors, but some were related to program implementation (USDHHS, 2005), indicating difficulties of service integration regardless of its promise.

METHODOLOGY

To address the issue of substance abuse in families involved in the child welfare system, the child welfare and substance abuse state agencies in a northeastern state issued a request for proposals (RFP). Collocation was one of the suggested models funded under this RFP, using TANF prevention funds. For this model, CASACs were to be collocated in child welfare offices to identify and assist parents with substance abuse problems. Treatment agencies were eligible to apply for the funding in partnership with child welfare offices in their region. In 2001, nine programs began to serve child welfare clients and the pilot programs ended in most sites by 2004.

Study Design

From 2004 to 2005, the authors conducted a process study as part of an evaluation of the pilot collocation program. The study included seven sites; four programs in primarily rural locations and three programs in primarily metropolitan areas. Two of the original sites were eliminated from the study. One site was defunded in the first year due to the inability of the

substance abuse treatment agency to establish a working relationship with the local child welfare office. The second site adopted a blended intervention model of the collocation and family drug court programs, which was unfavorable to an evaluation of the collocation model.

The study's goal was to examine the implementation processes and to assess whether program sites varied in implementation success. Specifically, the authors were interested in examining the following questions: 1) Were the target populations served? 2) Did collocation increase collaboration and understanding between the child welfare and substance abuse agencies? 3) Was the program implemented as intended? and 4) What were the barriers to successful implementation?

Data and Analysis

Data were collected from focus groups and individual interviews at each of the seven collocation sites, as well as from interviews with stakeholders at the state agencies. Information gathered from stakeholders included the planning and startup of the program, the operations, processes for case identification and referrals, the relationship between the child welfare and substance abuse fields, and administrative procedures and protocols. In each collocation site, a focus group consisting of 10 to 15 child welfare workers and a separate focus group for 6 to 12 child welfare supervisors were conducted. Interviews were also held with at least one key child welfare administrator, often the individual with responsibility for overseeing the program at each program site. Separate interviews were conducted with each CASAC and his or her supervisor from the treatment agency. To eliminate bias, two investigators were present at each of the focus groups and interviews, and sessions were tape-recorded. In total, 14 focus groups and 18 interviews were conducted. Additionally, progress reports and other administrative records, such as the original contracts, were reviewed.

After each site visit, the tapes from the interviews and focus groups were transcribed and categorized. To ensure accuracy and to eliminate bias, the transcribed notes were compared with the notes taken by the two authors. Data were then analyzed using the constant comparison method (Glaser, 1978) by writing down emerging themes and by comparing similarities and differences within and across sites (Miles & Huberman, 1994; Patton, 2002).

RESULTS

Despite initial start-up difficulties, all but one of the seven sites succeeded in implementing the collocation model. At the one site where implementation did not occur, staff at the child welfare office and at the treatment

agency disagreed on program goals and operating procedures and could not establish a strong working relationship.

In general, child welfare workers who admitted to being initially skeptical about yet another new initiative ended up embracing the program. Similarly, substance abuse counselors who typically provide services within their clinics grew to realize the benefits of home visits as a way to identify and assess substance abuse issues and to elicit greater awareness of client needs. Both agreed that the collocation program improved their understanding of each other's system and perceived that the program improved early identification, timely referral to treatment, and treatment outcomes of substance-abusing parents in the child welfare system.

Challenges

Acceptance by child welfare staff

Although frontline child welfare workers were advised of the new initiative, specific mechanisms were not established about how to work with the collocated substance abuse worker. In addition, many of the child welfare workers were skeptical about the introduction of yet another new program in their offices. As a result, the burden of implementation fell heavily on the CASACs and their supervisors.

The lack of established procedures made implementation difficult, especially in the first year. All of the collocated counselors encountered a number of startup difficulties, particularly in obtaining acceptance from the child welfare workers and in achieving an adequate number of case referrals. Although the concept of collocation implies an egalitarian partnership, it was the CASACs who had to make an extra effort to ingratiate themselves to the child welfare staff and to make personal appeals for case referrals. Two CASACs were replaced early on because they were unable to develop close working relationships with child welfare workers.

Model variations

Although the program framework was identified in the RFP, the design of the program mechanisms was determined by the localities. At six out of the seven sites, the collocated counselors consistently provided two core services: assessment of substance abuse and referral to treatment services. However, the programs varied on how the counselors provided these services and whether they provided additional services beyond these two core activities.

Two basic variations of the program emerged: one in the metropolitan sites and one in the rural sites. In the metropolitan programs, the client interviews, assessments, and referrals were conducted in the child welfare

office. In the rural programs, the counselors conducted home visits and their services were not physically limited to the child welfare offices. Additionally, in the rural sites, the CASACs continued to work with the client over a longer period of time than in the metropolitan programs by providing case management services, such as transportation, for the duration of their treatment.

Similarly, there were two different processes for how the case was referred to the collocated counselors. Identification of substance abuse cases occurred either through a call to the child abuse hotline or after the initial investigation. In some sites, the hotline call that identified parental substance abuse was forwarded directly to the substance abuse counselor, although this represented a minority of referrals to the program. Most often, cases were referred to the collocated counselor after the investigation was initiated by the child welfare worker. Child welfare workers were generally willing to involve the CASACs in such cases to obtain additional assistance and counsel. However, they were inconsistent regarding the types of cases that were referred and when the referrals were made. No consistent rules were established, resulting in individual child welfare workers using their own discretion.

Target populations and capacity

Overall, the collocation programs served the intended populations, TANF parents affected by substance abuse. In most cases, the CASACs served mothers who were being investigated for child maltreatment. However, on occasion, the counselors would provide services to other family members. In some of the smaller rural counties, the collocated counselors worked with a significant number of adolescents with substance abuse issues involved in persons in need of supervision (PINS) cases, who were neither the perpetrators nor victims of the CPS reports.

As for capacity, even in the smallest county, a single CASAC could not serve all eligible clients, especially when the CASAC was conducting both home visits and providing case management services. Due to the level of funding, the sites were limited to hiring one or two CASACs. Although child welfare workers generally respected the collocated counselors for their ability to engage the clients as well as for their knowledge of appropriate treatment services, they expressed frustration about the limited service capacity that could be offered by one or two CASACs. Child welfare workers in one focus group expressed a desire for 10 substance abuse counselors to be assigned to their local program.

Confidentiality

At a number of sites, there was confusion and apprehension among the child welfare workers about sharing information. Child welfare workers felt that they had to obtain consent forms from their clients to share information with

the CASACs. This process slowed down the CASACs' effort to quickly engage clients and provide them with appropriate assessments and treatment referrals during the short investigation period. Eventually, some sites developed memoranda of understanding (MOUs) between the two agencies that addressed this issue. In compliance with the Health Insurance Portability and Accountability Act (HIPAA) laws, CASACs obtained a signed consent form from clients to share client information with child welfare workers. Addressing the issues of information sharing and confidentiality prior to implementation is important to reduce confusion and difficulties for workers on both sides.

Benefits

Improved coordination of services

At the programmatic level, there was an improved relationship between the child welfare and substance abuse fields as demonstrated by the enhanced coordination of service delivery. This could be partly attributed to an increased awareness on both sides of the goals, objectives, and challenges of each other's field. Similarly, the physical proximity of the CASAC made a difference for child welfare workers and their clients. Child welfare workers were able to contact the CASAC immediately and have the client meet with the substance abuse specialist in a timely fashion, which was extremely important due to policies imposing time limitations in case determination.

The child welfare workers believed the program led to less recurrence of child maltreatment and consequently fewer subsequent CPS reports. However, this impression has yet to be verified by a comprehensive review of the administrative data.

Increased substance abuse identification and better referral

The child welfare workers agreed that the substance abuse counselors were better equipped to persuade child welfare clients to admit to substance abuse problems. Two possible explanations can be offered. First, unlike the child welfare workers, the counselors were trained specifically in techniques for engaging clients with substance abuse problems. Second, the clients were not as threatened by the counselors as they were by the child welfare workers, who could ultimately remove their children from the home. Therefore, they were more willing to be honest about their substance abuse issues and were more motivated to resolve their problems with assistance from an experienced substance abuse counselor.

Some counselors helped clients access treatment services and worked with them to remain in treatment. In the rural sites, the counselors followed the clients beyond the referral stage by providing additional case management services, such as arranging transportation and removing other barriers that

might impede clients from obtaining treatment. In all of the sites, the counselors had discretionary funds to assist clients in this capacity.

DISCUSSION

Findings from this study offer insight into the challenges and potential benefits of implementing a program to collocate substance abuse counselors in child welfare offices. The collocation programs faced issues similar to those that plague many new initiatives. Suggestions for successful implementation of a collocation program include careful planning, engaging child welfare workers, standardizing procedures, and providing strong leadership.

Planning

To facilitate communication and processing of cases between child welfare workers and counselors, child welfare offices and collaborating treatment agencies would benefit from detailing policies on confidentiality in MOUs. Similarly, providing adequate physical facilities for collocated counselors should be planned to enhance their integration into the child welfare offices.

In the planning phase, administrators might want to consider the specific qualities that would maximize the acceptance of the collocated counselor by the child welfare office. Early on, it needs to be recognized that the collocated substance abuse counselors are entering a potentially unwelcoming culture. Although good clinical skills are important, the collocated substance abuse counselor also needs a flexible personality, as demonstrated by a willingness to work with child welfare workers, an aptitude for learning new rules, and an open-mindedness toward the culture of child welfare offices.

Engaging Child Welfare Workers

Programs that engage both child welfare workers and substance abuse counselors in advance of program implementation are likely to experience greater success. Informing workers of the program and soliciting their feedback beforehand will lead to easier program implementation when formally introduced. Providing the workers with information regarding the program, especially the benefits to both them and their clients, is essential. Child welfare workers are often wary of new initiatives that tend to add more work to their already heavy caseloads. The successful implementation of the collocation program was partly due to the fact that the CASACs provided additional resources to child welfare workers, thus lessening some of their burden.

Similarly, substance abuse counselors need to understand that their role is to be complementary to that of the child welfare workers. They need to be trained on the policies and practices of the child welfare system from the

beginning, especially the laws, requirements, and timelines pertinent to the child welfare system. To be accepted and effective, they need to overcome preconceived notions about the child welfare system and adapt to the agency's culture.

Standardizing Procedures

Collocation programs would benefit from clearly stated procedures outlining the program model, program eligibility, and the process for identification, referral, and follow-up of clients. The lack of such procedures is not conducive to collaboration, as workers from the two systems could be left with differing expectations.

Standardization may include the identification and referral of all child welfare cases with parental substance abuse issues directly to the collocated substance abuse counselors as soon as possible. Specifically, cases with substance abuse issues identified in the initial hotline call may be automatically referred to the counselors. Similarly, all other cases that are investigated by child welfare workers should be screened, if possible, using a brief standardized tool. The earlier the intervention, the better the potential outcomes for the families. The CPS investigation provides a window of opportunity to engage child welfare clients when they are feeling vulnerable and perhaps more receptive to treatment services.

In addition, it might be advantageous to implement an automated information system to track cases that are referred to the CASAC. By so doing, both the child welfare workers and the CASAC can identify trends, such as tracking the duration between case intake and referral to the CASAC, and to make informed program adjustments.

Leadership

Although the collocation program depends primarily on collaboration among frontline workers from two service agencies, leadership at each agency plays a critical role in successful implementation. The collocation of frontline staff is not just a new initiative, but a sign of a burgeoning relationship between workers in two systems that have long held different views and have operated on different sets of mandates.

For better outcomes, substance abuse treatment agencies must continue to provide support to the collocated counselors and maintain collaborative relationships with the child welfare agencies at higher levels of management. The senior management teams in both organizations should be in regular communication and should address any programmatic issues in a collaborative, expeditious fashion to keep the program running smoothly. The implementation of the pilot program was successful partly due to the leaders from both agencies being willing to listen to and work with each other, including replacing ineffective project members when necessary.

Limitations of the Study

There are several limitations to this study. The primary data for this study were gathered through focus groups and interviews. Focus groups include the tendency for certain types of socially acceptable opinions to emerge and for certain types of participants to dominate the research process (Smithson, 2000). Steps were taken at the beginning of each focus group to emphasize the confidential nature of the information that was being collected as well as to encourage participants to "speak up, even if you disagree with everyone else in the group." Although steps were taken to reduce these biases, these elements could not be completely avoided.

In addition, although there were a minimum of two researchers who participated in each of the focus group and interview sessions, there is the possibility that key conclusions might have been biased by the perspectives of the researchers. Although information gathered from the program participants suggests some positive outcomes of the program, it will only be through a quantitative outcome study that actual impact can be determined.

CONCLUSION

The findings of this process study are encouraging in regard to the possible impact of the collocation model on coordination of services between the child welfare and substance abuse systems. Given the prevalence of substance abuse in the child welfare population, it is important that new and innovative interventions are developed and tested to improve child welfare outcomes for vulnerable families who are in need of services. Although this study was limited to a small-scale pilot program, the initial findings provide a strong foundation on which a quantitative outcome study can be conducted to determine what impact, if any, the program might actually have. It is through the pilot testing of new programs and process studies such as this one that program developers can learn about various factors that facilitate or hinder successful implementation of any program. The successful implementation of a program is the first step toward assessing its efficacy.

REFERENCES

Agranoff, R. (1991). Human services integration: Past and present challenges in public administration. *Public Administration Review*, *51*, 533–542.

Austin, M. J. (1997). Service integration: Introduction. *Administration in Social Work*, *21*(3–4), 1–7.

Azzi-Lessing, L., & Olsen, L. (1996). Substance abuse-affected families in the child welfare system: New challenges, new alliances. *Social Work*, *41*(1), 15–23.

Barth, R. P., Gibbons, C., & Guo, S. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment*, *30*, 93–104.

Besinger, B. A., Garland, A. F., Litrownik, A. J., & Landsverk, J. (1999). Caregiver substance abuse among maltreated children placed in out-of-home care. *Child Welfare*, *78*, 221–239.

Briar-Lawson, K., Lawson, H. A., Collier, C., & Joseph, A. (1997). School-linked comprehensive services: Promising beginnings, lessons learned, and future challenges. *Social Work in Education*, *19*, 136–148.

Carlson, B. E. (2006). Best practices in the treatment of substance-abusing women in the child welfare system. *Journal of Social Work Practice in the Addictions*, *6*, 97–115.

Center on Addiction and Substance Abuse. (1999). *Building bridges: States respond to substance abuse and welfare reform*. New York: Author.

Child Welfare League of America. (1998). *Alcohol and other drug survey of state child welfare agencies*. Washington, DC: Author.

Choi, S., & Ryan, J. P. (2006). Completing substance abuse treatment in child welfare: The role of co-occurring problems and primary drug of choice. *Child Maltreatment*, *11*, 313–325.

Colby, S. M., & Murrell, W. (1998). Child welfare and substance abuse services: From barriers to collaboration. In R. L. Hampton, V. Senatore, & T. P. Gullotta (Eds.), *Substance abuse, family violence, and child welfare: Bridging perspectives* (pp. 188–219). Thousand Oaks, CA: Sage.

Cornerstone Consulting Group. (2002). *A review of the four child welfare IV-E waivers related to substance abuse services in Delaware, Maryland, New Hampshire, and Illinois*. Houston, TX: Author.

Dore, M. M., & Doris, J. M. (1998). Preventing child placement in substance-abusing families: Research-informed practice. *Child Welfare*, *77*, 407–426.

Dore, M. M., Doris, J. M., & Wright, P. (1995). Identifying substance abuse in maltreating families: A child welfare challenge. *Child Abuse & Neglect*, *19*, 531–543.

Feig, L. (1998). Understanding the problem: The gap between substance abuse programs and child welfare services. In R. L. Hampton, V. Senatore, & T. P. Gullotta (Eds.), *Substance abuse, family violence, and child welfare: Bridging perspectives* (pp. 62–95). Thousand Oaks, CA: Sage.

Ginsburg, S. (2008). *Colocating health services: A way to improve coordination of children's health care?* New York: The Commonwealth Fund.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Green, B. L., Rockhill, A., & Furrer, C. (2006). Understanding patterns of substance abuse treatment for women involved with child welfare: The influence of the Adoption and Safe Families Act (ASFA). *American Journal of Drug and Alcohol Abuse*, *32*, 149–176.

Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children & Youth Services Review*, *29*, 460–473.

Gregoire, K. A., & Schultz, D. J. (2001). Substance-abusing child welfare parents: Treatment and child placement outcomes. *Child Welfare*, *80*, 433–452.

Horwath, J., & Morrison, T. (2007). Collaboration, integration and change in children's services: Critical issues and key ingredients. *Child Abuse & Neglect*, *31*(1), 55–69.

Jessup, M. A., Humphreys, J. C., Brindis, C. D., & Lee, K. A. (2003). Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *Journal of Drug Issues*, *33*, 285–304.

Kraft, M. K., & Dickinson, J. E. (1997). Partnerships for improved service delivery: The Newark target cities project. *Health & Social Work*, *22*, 143–148.

Maluccio, A. N., & Ainsworth, F. (2003). Drug use among parents: A challenge for family reunification practice. *Children and Youth Services Review*, *25*, 511–533.

Marsh, J. C., & Cao, D. (2005). Parents in substance abuse treatment: Implications for child welfare practice. *Children and Youth Services Review*, *27*, 1259–1278.

Marsh, J. C., D'Aunno, T. A., & Smith, B. D. (2000). Increasing access and providing social services to improve drug treatment for women with children. *Addiction*, *95*, 1237–1247.

Marsh, J. C., Ryan, J. P., Choi, S., & Testa, M. F. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review*, *28*, 1074–1087.

McAlpine, C., Marshall, C. C., & Doran, N. H. (2001). Combining child welfare and substance abuse services: A blended model of intervention. *Child Welfare*, *80*, 129–149.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change* (2nd ed.). New York: Guilford.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Peterson, L., Gable, S., & Saldana, L. (1996). Treatment of maternal addiction to prevent child abuse and neglect. *Addictive Behaviors*, *21*, 789–801.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of change*. Homewood, IL: Dorsey.

Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical approach* (4th ed.). New York: Brooks/Cole.

Randolph, L. A., & Sherman, B. R. (1993). Project CONNECT: An interagency partnership to confront new challenges facing at-risk women and children in New York City. *Journal of Community Health*, *18*, 73–81.

Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services: Findings from the Illinois alcohol and other drug abuse waiver demonstration. *Social Work Research*, *30*, 95–107.

Semidei, J., Radel, L. F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare*, *80*, 109–128.

Smith, B. D. (2001). Child welfare and substance abuse: Toward partnerships with parents and communities. In A. L. Sallee, H. A. Lawson, & K. Briar-Lawson (Eds.), *Innovative practices with vulnerable children and families* (pp. 121–143). Dubuque, IA: Eddie Bowers.

Smith, B. D., & Testa, M. F. (2002). The risk of subsequent maltreatment allegations in families with substance exposed infants. *Child Abuse & Neglect*, *26*(1), 97–114.

Smithson, J. (2000). Using and analysing focus groups: Limitations and possibilities. *International Journal of Social Research Methodology*, *3*, 103–119.

Sun, A., Shillington, A. M., Hohman, M., & Jones, L. (2001). Caregiver AOD use, case substantiation, and AOD treatment: Studies based on two southwestern counties. *Child Welfare*, *80*, 151–177.

Tapper, D., Kleinman, P., & Nakashian, M. (1997). An interagency collaboration strategy for linking schools with social and criminal justice services. *Social Work in Education*, *19*, 176–188.

Tracy, E. M. (1994). Maternal substance abuse: Protecting the child, preserving the family. *Social Work*, *39*, 534–540.

Tracy, E. M., & Farkas, K. J. (1994). Preparing practitioners for child welfare practice with substance-abusing families. *Child Welfare*, *73*, 57–68.

U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2005, September). Child welfare demonstration projects: Evaluation methodologies. Retrieved January 14, 2007, from http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/substanceabuse/evaluation.htm#t5

U.S. Government Accounting Office. (1998). *Foster care: Agencies face challenges securing stable homes for children of substance abusers* (GAO/HEHS-98–182). Washington, DC: Author.

Valenstein, M., Klinkman, M., Becker, S., Blow, F. C., Barry, K. L., Sattar, A., et al. (1999). Concurrent treatment of patients with depression in the community: Provider practices, attitudes, and barriers to collaboration. *Journal of Family Practice*, *48*, 180–187.

Walsh, M. A., & Young, J. J. (1998). Innovative strategies for strengthening systemic links between child welfare services and services for alcohol and other drug problems: The DHS IMPACT program. *The Source*, *8*(2), 12–13.

Wolock, I., & Magura, S. (1996). Parental substance abuse as a predictor of child maltreatment re-reports. *Child Abuse and Neglect*, *20*, 1183–1193.

Wolock, I., Sherman, P., Feldman, L. H., & Metzger, B. (2001). Child abuse and neglect referral patterns: A longitudinal study. *Children and Youth Services Review*, *23*(1), 21–47.

Young, N. K., Boles, S. M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment*, *12*, 137–149.

Young, N. K., & Gardner, S. L. (1998). Children at the crossroads. *Public Welfare*, *56*(1), 3–11.

Young, N. K., & Gardner, S. L. (2002). *Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together policy and practice*. Washington, DC: CWLA Press.