Illinois Intact Family Recovery Program Evaluation

Final Report

October 2023

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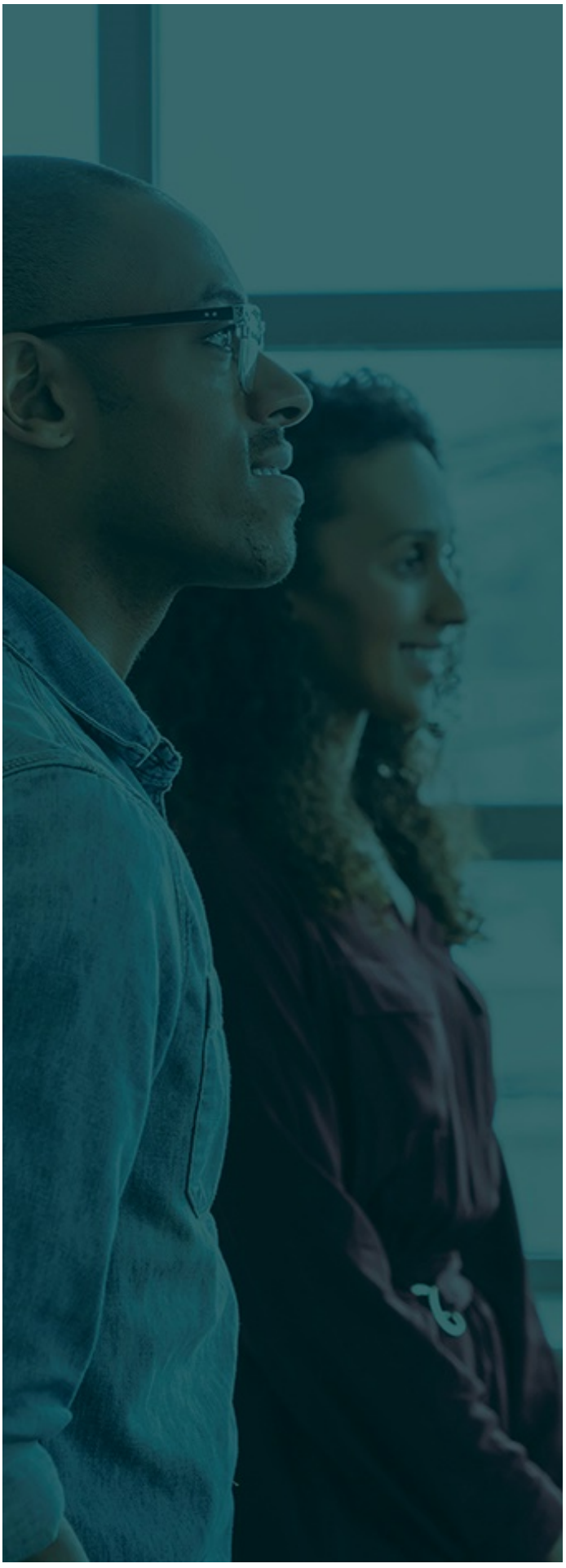

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ILLINOIS INTACT FAMILY RECOVERY (IFR) PROGRAM: OVERVIEW

What is the IL IFR Program?

Substance misuse is a long-standing challenge for child welfare systems. Parental substance misuse disrupts family stability and cohesion and endangers the safety and well-being of children (Ryan et al., 2016). Studies suggest that the use of recovery coordinators—specialized case managers whose primary focus is getting parents into substance use treatment and staying in treatment—can result in improved family outcomes, including higher parental substance use treatment completion rates, decreased time in foster care, increased reunification rates and decreased risk of subsequent child maltreatment (McLellan & McKay, 1998; Young et al., 1998; Ryan et al., 2016).

The Illinois Intact Family Recovery (IL IFR) program was a five-year project funded in 2017 by the U.S. Department of Health & Human Services, Administration for Children and Families (ACF) under its Regional Planning Grant (RPG) initiative (Grant #90CU0094). RPG grantees were required to: 1) provide services that increase the well-being, permanency and safety of children who are at risk for abuse and neglect due to a parent's substance use disorder (SUD); 2) form partnerships across systems to increase treatment capacity; 3) evaluate program outcomes; and 4) participate in a national cross-site evaluation of RPG programs led by Mathematica Policy Research (MPR). The IL IFR program met each of these requirements by: 1) expanding use of recovery coordinators in the Illinois Department of Children & Family Services' (DCFS) Intact Family Services (IFS) program in two regions in northern Illinois; 2) establishing the Illinois Regional Partnership (members include the Illinois Collaboration on Youth (ICOY), DCFS, child welfare agencies, and substance use treatment providers) to implement the program and provide services; 3) conducting an independent evaluation to assess program process and participant outcomes; and 4) participating in the national cross-site evaluation. ICOY chaired the Illinois Regional Partnership and oversaw the project. Dr. Susan Pickett of Advocates for Human Potential, Inc. (AHP) led the IL IFR program evaluation.

This report summarizes evaluation activities conducted across the five years of the IL IFR project. We begin by describing the IL IFR program and the services that were delivered to participants. Next, we provide an overview of the IL IFR program evaluation. Our evaluation included an outcome evaluation that assessed the impact of IL IFR services on family and child well-being and a process evaluation that assessed project process and collaboration. We conclude by discussing the implication of evaluation results for long-term sustainability of the IL IFR program.

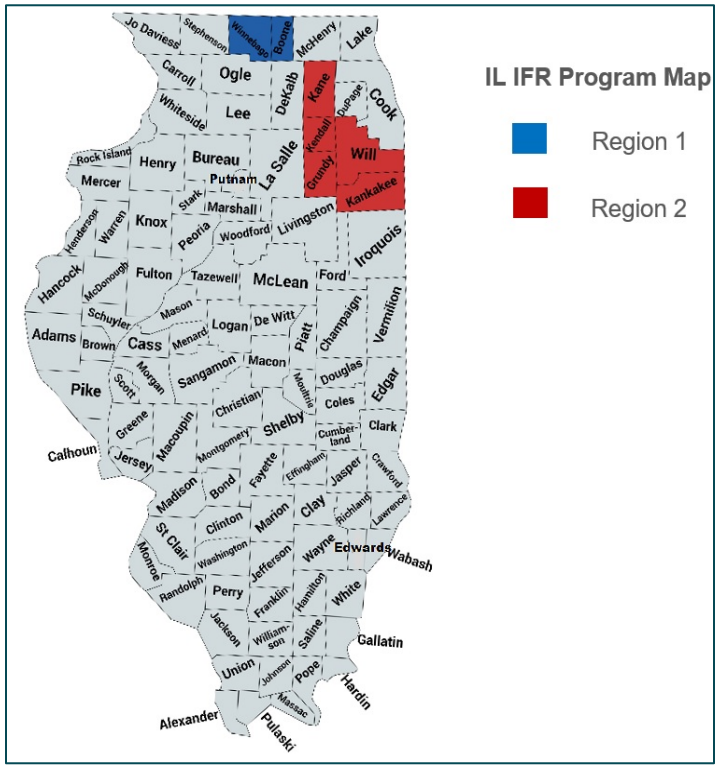
IL IFR Model and Services

DCFS' IFS program is an in-home, community-based program that works with families that DCFS has identified as at-risk for foster care placement. The program helps families identify strengths, set goals, and modify behaviors that put their children at risk, with the goal of safely maintaining the children in the home. Intact Family case managers—referred to throughout this report as Intact workers—closely monitor families, and provide and link families to counseling, parenting training, home-based services, substance use treatment, housing, employment, and other supportive services. In the IFR program, families receive integrated Intact Family services and specialized substance use treatment case

management from Intact workers and recovery coordinators who are co-located at the IFS program and are part of the Intact team.

The IL IFR program is built on results of an ongoing project in Cook County (Chicago) that provides recovery coordinator services to families with children in foster care due to a substance-exposed infant (i.e., an infant born with drugs in their system). Studies of this project show parents with SUD who received IFR were more likely to complete substance use treatment and achieve stable reunification with their children. In our project, we expanded this model to provide IFR services to any family with a parent who has SUD, not just those who had a substance-exposed infant. We also tested the model in a wide range of urban and rural communities in seven northern Illinois counties.

Figure 1. IL IFR Program Map



Our project sought to enroll 480 families in IL IFR services in two regions in northern Illinois. IL IFR Region 1 included Winnebago and Boone counties, and Region 2 included Kane, Kankakee, Kendall, Grundy, and Will counties (see Figure 1). In each region, two child welfare program partners were randomly selected to serve as intervention or comparison group sites. Intervention group sites provided Intact + recovery coordinator services. Comparison group sites provided Intact only, i.e., "treatment as usual." In Region 1, Children's Home + Aid – Rockford (CHA-R) was randomly selected to be the intervention group agency and Lutheran Social Services of Illinois (LSSI) was randomly selected to be the comparison group agency. In Region 2, Aunt Martha's Health and Wellness (AMHW) was randomly selected to be the intervention group agency and Children's Home + Aid – Joliet (CHA-J) was randomly selected to be the comparison group agency.[1] Each site was to serve 120 families. Remedies Renewing Lives, Stepping Stones and Treatment Alternatives for Safer Communities (TASC) were the project's substance use treatment partners and were responsible for hiring and supervising the recovery coordinators.

[1] In July 2021, AMHW ended its DCFS contract to provide Intact services and stopped participating in the study. From November 2021 to March 2022, CHA-J served as the intervention group site in Region 2, and Lydia Home, a DCFS-licensed Intact provider, served as the comparison group site in Region 2. Lydia Home dropped out of the project in February 2022. No Lydia Home clients enrolled in the evaluation.

Standard IFS case assignment procedures were used to assign families to our child welfare provider partners. DCFS determines whether a family is eligible for IFS and assigns families to a licensed Intact Family provider. DCFS staff responsible for assigning families to our sites were "blinded" to agency randomization and did not know whether they were assigning families to an agency providing intervention or comparison group services. To be eligible to participate in the IL IFR project, participants had to be case assigned by DCFS to one of our child welfare provider partners' Intact programs, have an SUD confirmed by the CFS 440-5 or the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), be 18 years or older, and agree to participate in the program. All families that participated in the IL IFR project, regardless of whether they were case assigned to an intervention or comparison group site, were eligible to receive services for six months, with the option to receive services for an additional 6-12 months if they chose to do so and/or if the site recommended that they continue to receive services.

All families, regardless of assignment to the treatment or comparison groups, received the complete range of Intact services. Families assigned to intervention group sites received Intact services plus recovery coordinator services. Recovery coordinator services included substance use screening, comprehensive SUD assessments, and relapse prevention. Intact workers and recovery coordinators worked together to develop and implement joint case planning and deliver services to families. This included routine joint visits with families at varying intervals depending on parents' phase of SUD treatment. Parents in initial phase of SUD treatment (i.e., initial referral and receipt of SUD treatment) received weekly joint visits; parents who completed SUD treatment received monthly joint visits.

Partner sites enrolled participants in the IL IFR program from April 1, 2018 – March 31, 2022. IL IFR services were provided through September 30, 2022. A total of 354 participants enrolled in the program: 180 were intervention group participants and 174 were comparison group participants. AMHW served 85 participants; Children's Home + Aid-R served 92 participants; LSSI served 96 participants; Children's Home + Aid-J served 78 participants[2] and Lydia Home served 3 participants.

Evaluation Overview

AHP implemented a comprehensive mixed-methods study design that featured a qualitative process evaluation and a quantitative outcome evaluation. The outcome evaluation included longitudinal interviews with participants and service use data collection. The process evaluation described development and implementation of the project over time and documented information on barriers encountered, effective strategies to overcome barriers, and lessons learned about implementing collaborative, cross-systems projects and integrating services.

[2] 75 Children's Home + Aid-J participants were comparison group participants and 3 were intervention group participants.

OUTCOME EVALUATION

Outcome Evaluation: Goals and Hypotheses

The goal of the outcome evaluation was to test the effectiveness of integrated child welfare and recovery coordinator services in improving family and child outcomes.

Our hypotheses included:

- Intervention group parents will show greater improvements in recovery compared to comparison group parents, specifically: a) decreased substance use and b) decreased mental health symptoms.
- Intervention group parents will show greater improvements in family stability compared to comparison group parents, specifically: a) decreased parenting stress and b) improved family relationships.
- Intervention group children will show greater improvements in well-being, safety and permanency compared to comparison group children, specifically: a) improved adaptive functioning and social/emotional well-being; b) decreased problem behaviors; c) decreased trauma and mental health symptoms; d) fewer substantiated maltreatment recurrences; and e) fewer out-of-home placements.

We used a quasi-experimental, mixed methods design to test these hypotheses and determine the impact of the IL IFR program on family and child outcomes.

Methods

This section describes evaluation methods and procedures used to conduct the outcome evaluation. All evaluation and data collection procedures were approved by the AHP, DCFS, and child welfare provider partners' Institutional Review Boards (IRBs).

Participant Eligibility Criteria and Recruitment

ELIGIBILITY CRITERIA

Similar to IL IFR program eligibility, to participate in the evaluation, parents had to: 1) be 18 years or older; 2) be case assigned by DCFS to one of our sites' Intact programs; 3) have a SUD assessed by the CFS 440-5; and 4) agree to receive IFR services (intervention group sites) or IFS services (comparison group sites). For cases where SUD was not clear, IL IFR program staff administered the ASSIST, a short tool developed by the World Health Organization (WHO) that screens for substance use and related problems in adults. Participants who scored a 4 or higher on the ASSIST were determined to have a SUD and be eligible for the project and evaluation.

RECRUITMENT AND ENROLLMENT

Within the first few weeks of program enrollment, IL IFR program staff (recovery coordinators or Intact workers) met with participants and told them about the evaluation. Program staff gave participants a copy of a short, one-page evaluation fact sheet. Staff reviewed the fact sheet with participants and explained that: 1) AHP is conducting the evaluation to learn how programs like Intact help families; 2) participation in the evaluation is voluntary and confidential; 3) participation involves three in-person interviews that ask about substance use, mental health, children and parenting, and collecting

information from IFS case records and DCFS; and 4) participants will receive a gift card for each interview that they complete.

IL IFR program staff gave an evaluation referral form to clients who expressed interest in participating in the study. Clients filled in their contact information on this form and gave permission for AHP to call them to tell them more about the evaluation. IL IFR staff submitted completed and signed referral forms to AHP. We contacted interested individuals to explain evaluation procedures and goals, answer questions, and invite them to participate in the study. AHP researchers obtained informed consent from clients to participate in the evaluation and releases of information to obtain DCFS and service use data prior to the baseline interview. Clients were formally enrolled in the evaluation after completing the baseline interview.

Interviews

Prior to March 2020 and the COVID-19 pandemic, AHP researchers conducted in-person interviews at participants' homes or other locations of their choosing. Following the onset of the pandemic and stay at-home orders, all interviews were conducted by phone to promote social distancing. After stay-at-home orders were lifted, we continued to conduct interviews by phone as participants shared that it was more convenient and easier for them to do interviews by phone than in person. In the first year of the project, interviews were conducted via the Snap Survey platform. AHP began using Research Electronic Data Capture (REDCap) in 2019 to collect and manage data. REDCap is a secure, HIPAA-compliant web application for collecting and managing data. AHP researchers used REDCap for all interviews conducted after August 2019.

As described above, AHP researchers conducted participant interviews at baseline (IL IFR program enrollment), 9 months post-baseline, and 18 months post-baseline. Participants initially received a $30 gift card for each interview they completed. Additional funding in 2020 allowed us to increase incentives to $60/interview. We also asked for permission to reach out to secondary contacts and IL IFR program staff to help find participants for their interviews.

National Cross-Site Evaluation

All ACF RPG grantees were required to participate in the national cross-site evaluation led by MPR. The cross-site evaluation required RPG grantees to use standardized measures to assess parent and child outcomes and service use and to submit those data to MPR. While AHP began data collection in May 2018, cross-site evaluation measures were not finalized until mid-2019. Thus, only individuals who enrolled in the IL IFR program evaluation after 1) the cross-site evaluation was implemented and 2) we received approval from the AHP, DCFS and sites' IRBs to administer cross-site measures, were enrolled in the cross-site evaluation. Individuals who enrolled in the evaluation prior to September 2019 were not included in the cross-site evaluation. In accordance with MPR's data sharing agreement, no cross-site measures that were not publicly available were administered to participants who completed interviews after the cross-site evaluation data collection ended in March 2022.

Measures: Interview Protocol and Assessments

The interview protocol assessed parental substance use and mental health, parenting stress, family relationships, child functioning/well-being, parent and child demographic characteristics, parents' perceived strengths, and experiences with DCFS-related stigma and Intact services. Evaluation data collection began in May 2018, prior to finalization of cross-site measures. When the cross-site evaluation was implemented in September 2019, the interview protocol was updated to include only

cross-site measures. Participants who enrolled in the evaluation prior to September 2019 completed all "pre-cross-site" measures at their baseline, 9-month, and 18-month follow-up interviews. Participants who enrolled in the cross-site evaluation completed cross-site evaluation measures only. Pre-cross-site and cross-site measures are identified in the table below. Measures were administered at all interview timepoints unless otherwise indicated.

PARENT OUTCOME MEASURES

Addiction Severity Index (ASI) Lite. (Pre-cross site). The ASI Lite is a 41-item instrument that assesses participants' drug and alcohol use and psychiatric status. Drug/alcohol questions assessed the types of drugs participants have used during the past 30 days and in their lifetime. Psychiatric status questions assess participants' mental health problems (e.g., depression, anxiety, suicidality, etc.) during the past 30 days and in their lifetime, and mental health treatment. Psychiatric status questions were administered to both pre-cross-site and cross-site evaluation participants. However, MPR did not require collection of psychiatric status data, so these data were not shared with MPR.

Addiction Severity Index Self Report (ASI-SR) (Cross-site measure). The ASI-SR is a 19-item instrument that uses items included in the ASI Lite to assess substance use and treatment. Participants are asked to report use of alcohol and nine illicit drugs (e.g., heroin, other opioids, sedatives, cannabis, methamphetamine) during the past 30 days, the extent to which they have been bothered by their alcohol and drug use, and their interest in receiving treatment for substance use.

Center for Epidemiological Studies Depression Scale (CES-D). (Pre-cross-site and cross-site measure). The CES-D assesses the presence and severity of depressive symptoms during the past week. Participants rate how often they experienced each symptom along a four-point scale ranging from 0 (rarely or never) to 3 (most or all of the time). The CES-D 20 (20-item version) was used in the pre-cross-site evaluation and the CES-D 12 (12-item version) was used in the cross-site evaluation. Items are summed for a total CES-D score. Higher scores indicate a greater number of depressive symptoms and greater depressive symptom severity.

Trauma Symptoms Checklist 40 (TSC-40). (Pre-cross-site and cross-site measure). The TSC-40 is a 40-item measure that assesses post-traumatic stress and other symptom clusters in adults who have had childhood or adult traumatic experiences. This instrument includes six subscales (anxiety, depression, dissociation, Sexual Abuse Trauma Index (SATI), sexual problems, and sleep disturbance) as well as a total score. Participants rate how often they have experienced a symptom during the past two months along a four-point scale ranging from 0 (never) to 3 (often). Items are summed for each subscale and total scale scores, respectively. Higher scores indicate greater levels of trauma symptoms and trauma severity.

Child Rearing Practices Report – Modified (CRPR) (Pre-cross-site measure). The CRPR is an 18-item instrument that assesses positive parenting practices. Participants rate their parenting practices along a six-point scale ranging from 1 ("not at all true") to 6 ("highly true"). Items are summed for a total CRPR score; higher scores indicate greater positive, nurturing parenting.

Parental Stress Scale (PSS). (Pre-cross-site measure) The PSS is an 18-item scale that assesses how participants feel about their parenting role, including both positive aspects (e.g., emotional benefits, personal development) and negative aspects (e.g., demands on resources, feelings of stress) of parenthood. Participants rate their agreement with each item along a five-point scale ranging from 1 ("strongly disagree") to 5 ("strongly agree"). Items that asked about positive parenting behaviors were first reversed scored before being summed into the total score. Items are summed for a total parental

stress score, with higher scores indicating greater levels of parenting stress. The PSS was administered to both pre-cross-site and cross-site evaluation participants. However, MPR did not require use of the PSS, so PSS data was not shared with MPR.

Adult Adolescent Parenting Inventory 2 (AAPI-2) (Cross-site measure). The AAPI-2 is a 40-item instrument that assesses parenting and child-rearing attitudes. This instrument includes five subscales that measure expectations of children, parental empathy toward children's needs, use of corporal punishment, parent–child family roles, and children's power and independence. Higher scores indicate lower risk of child-rearing behaviors associated with abusive parents. The AAPI-2 comes in two forms to reduce bias due to a practice effect when repeating the form within a short period. Form A was administered to participants at baseline. Form B was administered at follow-up.

Stigma, Intact Family Services and Strengths (Pre-cross-site measure). The interview protocol included three open-ended questions that ask participants about the negative reactions and perceptions they have experienced because of their involvement with DCFS, the Intact services they received, and their personal strengths. AHP researchers created these stigma items in collaboration with project leadership. We used qualitative analyses, (see Analyses section) to categorize participants' responses to these questions. These three questions were administered to pre-cross-site and cross-site evaluation participants. However, these data were not required for the cross-site evaluation and were not shared with MPR.

CHILD OUTCOME MEASURES

During the baseline interview, we asked participants to identify their focal child—their child who was between the ages of 3-7 years. If the participant had more than one child between the age of 3-7 years, the focal child was the child whose age was closest to 5 years. If the participant's children were older than 7 years, the focal child was the child whose age was closest to 7 years. If the participant's children were younger than 3 years, the focal child was the child whose age was closest to 3 years. All child outcome measures assessed the participant's focal child. Child outcome measures were administered based on the age of the participant's focal child. We didn't administer every child well-being assessment to every participant, we only administered those that "matched" the age of the focal child.

Child and Adolescent Disruptive Behavior Inventory (CADBI) (Pre-cross-site measure). The CADBI is a 25-item instrument that measures a range of problem behaviors that often occur in childhood and adolescence. The CADBI include three subscales that assess oppositional defiant behavior, inattention, and hyperactivity/impulsivity. Participants rate how often a behavior occurred in the past month using an eight-point scale ranging from 0 ("never in the past month") to 7 ("10 or more times per day"). Higher scores indicate greater levels of problem behaviors.

Pediatric Symptom Checklist-35 (PSC-35). (Pre-cross-site measure). The PSC-35 is a 35-item psychosocial screen that identifies cognitive, emotional, and behavioral problems in children. Participants rate how often a behavior occurred using a three-point scale ranging from 1 ("never") to 3 ("often"). Items are summed for a total PSC score, with higher scores indicating greater problem behaviors.

Strengths and Difficulties Questionnaire (SDQ). (Pre-cross-site measure). The SDQ is a 25-item scale that assesses behavioral and emotional problems in children aged 4-17 years. The SDQ has five subscales that measure emotional problems, conduct problems, hyperactivity/inattention, peer problems, and prosocial problems. A total score sums all subscale scores except for the prosocial subscale score. Higher scores indicate a greater number and severity of problems.

Traumatic Events Screening Inventory - Parent Report Revised (TESI-PRR) (Pre-cross-site measure). The TESI-PRR is a 24-item measure that assesses exposure to potentially traumatic events, including non-interpersonal (accident, illness, disaster), interpersonal (physical, sexual, emotional abuse; physical, emotional neglect; witnessing family or community violence; peer/sibling victimization; kidnapping; war; parental impairment), and loss (primary caregiver, family members). Higher scores indicate exposure to more potentially traumatic events. The TESI-PRR was administered at baseline only.

Child Behavior Checklist (CBCL) (Cross-site measure). The CBCL assesses children's behavior and emotional and social functioning. The CBCL-Preschool Form (CBCL/1.5–5) is used to assess children aged 1.5-5 years and the CBCL-School-Age Form (CBCL/6–18) is used to assess children aged 6-18 years. Parents rate their child's behavior along a four-point scale ranging from "not true" to "very true." The CBCL also uses a normative sample to create standard scores. Scores are normed based on age and sex. These compare the raw score to what would be typical compared to responses for children of the same gender and similar age. Higher scores indicate greater behavioral problems and lower emotional and social functioning.

Infant Toddler Sensory Profile (ITSP) (Cross-site measure). The ITSP is a standardized instrument that measures a child's sensory processing abilities and profiles the effect of sensory processing on functional performance in their daily life. The profile is designed for children from birth to 36 months old. The ITSP includes two versions depending on the child's age: one for children aged birth to 6 months old (36 items) and one for children aged 7 to 36 months (48 items). Items describe children's responses to various sensory experiences. Together, the items assess six types of processing: general, auditory, visual, tactile, vestibular, and oral sensory. Each item response is assigned a score on a five-point scale that reports how frequently infants respond to sensory experiences; a score of one is assigned to "almost always", and a score of five to "almost never". Lower scale scores indicate high levels of responsiveness to stimuli; higher scores indicate low responsiveness to stimuli.

Table 1. Pre-Cross-Site and Cross-Site Measures

Measure	Pre-Cross-Site Evaluation	Cross-Site Evaluation
Parent Outcome Measures		
ASI Lite	•	
ASI SR		•
CES-D	•	•
TSC-40	•	•
CRPR	•	
PSS	•	
AAPI-2		•
Stigma, Intact Family Services and Strengths	•	
Child Outcome Measures		
SDQ	•	
CADBI	•	
PSC-35	•	
TESI-PRR	•	
ITSP		•
CBCL		•

Participant Service Use Data

The national cross-site evaluation required that service use data be collected for all participants enrolled in the evaluation. Service use data were collected throughout participants' tenure in the IL IFR program, defined as evaluation enrollment through program closure or termination. Standardized forms, (i.e., service logs), created by MPR for the cross-site evaluation were used to collect data on services provided to participants by Intact workers and recovery coordinators. MPR required that a service log be completed and submitted for every service provided to participants. This information included: date, duration and location of service, types of services provided, and referrals to external services. The logs also documented who provided the service (i.e., Intact worker, recovery coordinator) and the individuals receiving services (i.e., participant, participant's children, other family members).

The evaluation team trained recovery coordinators and Intact supervisors how to complete and submit service logs. Service logs were submitted for every Intact worker and recovery coordinator visit with participants enrolled in the cross-site evaluation. Visits included in-person home visits, meetings in other locations (e.g., residential treatment facilities, court, office visits), and video conferences/phone calls with families to discuss and coordinate services. Recovery coordinators completed service logs for all joint Intact worker-recovery coordinator visits. Intact supervisors completed service logs for Intact workers' individual visits with families. AHP researchers tracked visit dates reported during bi/weekly phone calls with recovery coordinators and Intact supervisors and compared these dates against submitted service logs. All service logs were reviewed and verified by AHP prior to submission to MPR. AHP researchers coded for common services using MPR's specified service categories and discussed and resolved coding issues to accurately document all reported services.

Parent Substance Use Treatment

One of the goals of the IL IFR program and evaluation was to assess parents' access to and receipt of substance use treatment services. AHP tracked parents' "movement" through the substance use treatment system from initial referral for assessments to post-treatment abstinence. We tracked parents' progression through treatment during biweekly check-in calls with Intact supervisors and recovery coordinators. This progression was tracked for parents' initial treatment episode after enrolling in the IL IFR program as well as for parents who were receiving substance use treatment when they enrolled in the IL IFR program.

Figure 2. Substance use treatment progression

The evaluation team also tracked 30-day post-treatment outcomes for participants who completed substance use treatment. These outcomes, listed below, were reported to AHP by recovery coordinators and/or Intact supervisors during check-in calls. Post-treatment outcomes included:

- **Maintained abstinence:** No alcohol or drug use during the first 30 days following initial SUD treatment.
- **Relapsed – returned to treatment:** Relapse occurred (i.e., participant used alcohol or drugs) but participant returned to SUD treatment.

- **Relapsed – engaged in IL IFR services:** Relapse occurred but participants remained engaged in IL IFR services and continued to work with their recovery coordinator and/or Intact worker.
- **Relapsed – disengaged from IL IFR services:** Relapse occurred, and participants left/chose to stop receiving IL IFR services.

IL IFR Program Discharge/Closure Outcomes

IL IFR program discharge or closure was coded as successful program completion or unsuccessful program discharge/completion.

- **Successful closure:** Participant completed substance use treatment and all Intact service requirements and their children remained in the home and did not enter foster care placement.
- **Unsuccessful closure – placement:** Participant's children were removed from the home and placed into foster care.
- **Unsuccessful closure – dropped:** Participant withdrew or dropped out of IL IFR services and/or did not complete all required program components or substance use treatment, was incarcerated, or sites closed the participant for program non-compliance.

We examined participants' **SUD treatment status at closure**. These data were taken from Intact supervisor and/or recovery coordinator reports on participants' involvement in SUD treatment at IL IFR program discharge.

- **SUD treatment completed:** Participant completed initial SUD treatment or was actively engaged with treatment at the time their case was closed.
- **SUD treatment not completed:** Participant did not complete initial or any SUD treatment and was not actively engaged with treatment at the time their case was closed.

We also coded participants' **SUD stability at closure**. Data for SUD stability were collected was from Intact supervisors' and recovery coordinators' reports of participants' substance use at IL IFR program discharge. IL IFR SUD stability at closing was coded as follows:

- **Stable/abstinent:** Participant was not using substances at the time the case was closed.
- **Actively using:** Participant was using substances at the time the case was closed.

Analyses

We analyzed baseline interview demographic data for normal distributions and to identify any differences in baseline characteristics between intervention and treatment groups. Bivariate analyses were used to investigate any potential differences between the groups using $p < 0.05$ as the indication of significant differences.

We conducted multilevel modeling to examine changes in parent and child outcomes for families included in the evaluation. For all models that examined change over time, multilevel models with maximum likelihood estimation were used. Multilevel models account for the nested nature of the data given the repeated measurements for each family. These models account for the nested nature of the data and allow for the operationalization of both within-group and between-group comparisons (e.g., intervention versus control-group comparisons across time). Additionally, multilevel modeling allowed us to account for any baseline differences that may have been present between intervention and control groups. The effects of the following covariates were included in each model: follow-up interview

timepoint, group assignment, total number of Intact worker contacts, SUD treatment status at closure, SUD treatment stability at closure, closure status, program tenure, family size, and parent age.

Non-dichotomous measures models were conducted with the assumption of normality using multilevel linear regressions. Given there were only three time points, all models of change examined linear change only. Two-tailed tests were used to determine whether any changes over time in scores were statistically significant. P-values of less than 0.05 were used to determine significance for all models. For dichotomous measures, multilevel logistic regression with binomial distributions was used. Two-tailed tests were used to determine whether follow-up and baseline scores were statistically different. P-values of less than 0.05 were used to determine significance for all models.

To be included in these analyses, participants must have completed at least a baseline interview. The analytic sample included 131 families who completed a baseline interview for the evaluation.

Qualitative data—participants' experiences of stigma and perceived strengths—were analyzed via content analysis. Coding categories were developed using a joint iterative process to identify common themes. We used Dedoose software to conduct all qualitative analyses.

Results

EVALUATION ENROLLMENT AND INTERVIEWS COMPLETED

Of the 354 individuals who enrolled in IL IFR services, 331 were eligible for the evaluation. Table 2 below documents evaluation enrollment progression by site and for the total sample.

Table 2. Evaluation Enrollment by Site

	CHA-R	CHA-J	LSSI	AMHW	CHA-J-intervention	Lydia Home	Total
Eligible for the evaluation	83	70	90	82	3	3	331
Informed about the evaluation	72	70	89	82	3	2	318
Declined – no referral form signed	17	38	52	15	0	2	124
Completed referral form	55	32	37	67	3	0	194
Declined after signing referral form	17	15	8	23	0	0	63
Enrolled in evaluation	38	17	29	44	3	0	131

A total of 131 participants enrolled in the evaluation and completed baseline interviews. Of this group, 101 (77%) completed 9-month follow-up interviews and 79 (60%) completed 18-month follow-up interviews.[3] As shown in Table 3, the majority of evaluation participants were intervention group participants (N=85, 65%). Thirty-four percent of evaluation participants were AMHW clients; 29% were CHA-R clients; 22% were LSSI clients; 13% were CHA-J clients; and 2% were CHA-J intervention site clients.

[3] The project ended before 11 participants were eligible to complete their 18-month follow-up interview. When these individuals are removed from the total interview count, the 18-month follow-up interview completion rate is 66%.

Table 3. Number of Interviews Completed by Timepoint by Group

	Intervention Group N (%)	Comparison Group N (%)	Total
Baseline	85 (65%)	46 (35%)	131
9-month follow-up	62 (61%)	39 (39%)	101
18-month follow-up	50 (63%)	29 (37%)	79

Table 4. Number of Interviews Completed by Site

Program Site	Baseline (N=131) N (%)	9-Month Follow-Up (N=101) N (%)	18-Month Follow-Up (N=79) N (%)
CHA – R	38 (29%)	28 (28%)	23 (29%)
CHA - J	17 (13%)	15 (15%)	13 (16%)
LSSI	29 (22%)	24 (24%)	16 (20%)
AMHW	44 (34%)	32 (32%)	25 (32%)
CHA – J – Intervention	3 (2%)	2 (2%)	2 (3%)

Participant Demographic Characteristics

Table 5 lists evaluation participants' demographic characteristics at baseline. Most participants were White (78%) and female (85%). Participants ranged in age from 18-65 years, with an average age of 32 years. Slightly more than half (53%) were aged 31 years or younger. Most participants were unemployed (60%) and had an annual income of $19,000 or less (68%). More than half (57%) lived in their own home or apartment. Forty-five percent were single/unmarried. Participants' children ranged in age from birth to 47 years with average age of 8 years; 81% of participants had at least one child under the age of eight. Participants had an average of three children. Eleven percent of participants were not living with any of their children. Intervention group participants were more likely to be White than comparison group participants ($z = 2.40$, $p = 0.02$). Other than race, there were no other significant demographic characteristics differences between the groups.

Table 5. Participant Demographic Characteristics

	Intervention Group (N=85) N (%)	Control Group (N=46) N (%)	Total Sample (N=131) N (%)
Race			
African American	6 (7%)	10 (22%)	16 (12%)
Asian	0 (0%)	1 (2%)	1 (1%)
White	71 (83%)	31 (67%)	102 (78%)
Multi-Racial	4 (4%)	4 (8%)	8 (6%)
Unknown	4 (4%)	0 (0%)	4 (3%)
Hispanic	13 (15%)	6 (13%)	19 (15%)
Parent Gender			
Female	71 (84%)	41 (89%)	112 (85%)
Male	14 (16%)	5 (11%)	19 (15%)
Parent Age	18 to 65 years; average age=32 years	18 to 59 years; average age=32 years	18 to 65 years, average age= 32 years
Education			
Some high school	21 (25%)	14 (30%)	35 (27%)
High school diploma/GED	24 (28%)	12 (26%)	36 (27%)
Some vocational/technical school	4 (5%)	0 (0%)	4 (3%)

	Intervention Group (N=85) N (%)	Control Group (N=46) N (%)	Total Sample (N=131) N (%)
Vocational/technical diploma	3 (4%)	2 (4%)	5 (4%)
Some college	27 (32%)	13 (28%)	40 (31%)
Associate's degree	3 (4%)	3 (7%)	6 (5%)
Bachelor's degree	0 (0%)	2 (4%)	2 (2%)
Employment Status			
No	46 (54%)	33 (72%)	79 (60%)
Yes	39 (46%)	13 (28%)	52 (40%)
Annual Income			
$0 - 9,999	36 (42%)	23 (50%)	59 (45%)
$10,000 - 19,000	18 (21%)	12 (26%)	30 (23%)
$19,001 - 24,999	9 (11%)	3 (7%)	12 (9%)
$25,000 - 34,999	9 (11%)	2 (4%)	11 (8%)
$35,000 - 49,999	8 (9%)	2 (4%)	10 (8%)
$50,000 or higher	0 (0%)	4 (9%)	4 (3%)
Unknown	5 (6%)	0 (0%)	5 (4%)
Marital Status			
Single (unmarried & not cohabitating)	38 (45%)	21 (46%)	59 (45%)
Married	10 (12%)	6 (13%)	16 (12%)
Cohabitating	26 (31%)	5 (11%)	31 (24%)
Divorced	5 (6%)	8 (17%)	13 (10%)
Separated	0 (0%)	3 (7%)	3 (2%)
Widowed	4 (5%)	0 (0%)	4 (3%)
Other	4 (5%)	3 (7%)	7 (5%)
Living Situation			
Own home/apartment	48 (56%)	27 (59%)	75 (57%)
Someone else's home/apartment	33 (39%)	15 (33%)	48 (37%)
Homeless/shelter	0 (0%)	1 (2%)	1 (0%)
Other	4 (5%)	3 (7%)	7 (5%)
Average Child Age	7.42 years (birth – 47 years)	8.81 years (birth – 34 years)	7.93 years (birth – 47 years)
Average Family Size - Children (Range)	3 (1-8 children)	3 (1-8 children)	3 (1-8 children)
Average Number of Children Under 6 Per Participant (Range)	1 (0-4 children)	1 (0-4 children)	1 (0-4 children)
Average Number of Children Living with Participant	2 (0 -5 children)	2 (0-4 children)	2 (0-5 children)
Participants Not Living with Any Children	5 (6%)	10 (21%)	15 (11%)

Parent Outcomes

We examined the following parent outcomes: substance use, mental health, and parenting/family stability. Notable results, documented in detail in the tables and charts in this section include:

- The percentage of participants reporting substance use in the past 30 days decreased over time. Participants in the intervention group were consistently troubled by their substance use. On the other hand, the comparison group showed an initial decline in their substance use with a corresponding decline in being troubled by their substance use at 9-month follow-up. At 18-month follow-up, a greater percentage of comparison group participants were less concerned about their substance use at 18 months than at baseline. Participants who had stable SUD at program closure (i.e., were abstinent) were less likely to report any substance use over time.
- Overall, parental mental health outcomes improved over time. At the 9-month follow-up, both intervention and control group participants experienced less depression, fewer trauma symptoms and were less troubled by their mental health problems. The intervention group continued to show improvements in mental health outcomes at 18-month follow-up, showing further decreases in depression and trauma, and were less troubled by their mental health problems.
- Both intervention and comparison group participants reported engaging in more warm and nurturing parenting behaviors over time. They also experienced a significant increase in appraisal of parent-child family roles, viewing their children as a child rather than a peer or caregiver.

PARENTAL SUBSTANCE USE

Any Substance Use Past 30 Days

At each interview timepoint, most participants reported that they did not use any substances (illicit drugs) in the past 30 days. However, the percentage of participants who did report substance use significantly decreased over time (9-months: z = -2.82, p = 0.005 and 18-months: z = -0.99, p = 0.32). There were no significant differences between the intervention and control groups' use of substances over time (z = -1.27, p = 0.20). We did find that among those who had stable SUD at program closure (i.e., were abstinent at program discharge), a lower percentage reported any substance use over time compared to those who were actively using at program closure (z = 2.22, p =0.03). In other words, participants with stable SUD at program discharge were less likely to report substance use at follow-up compared to participants who were actively using at program discharge.

Figure 3. Substance Use Past 30 Days: Total Sample

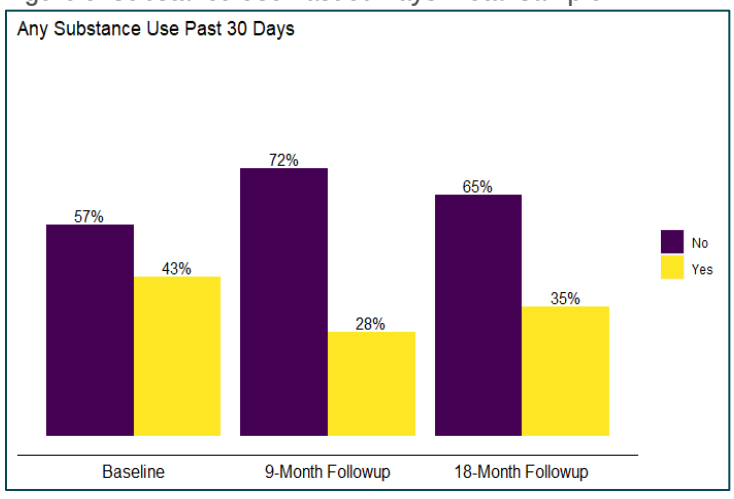


Figure 4. Substance Use Past 30 Days by Group

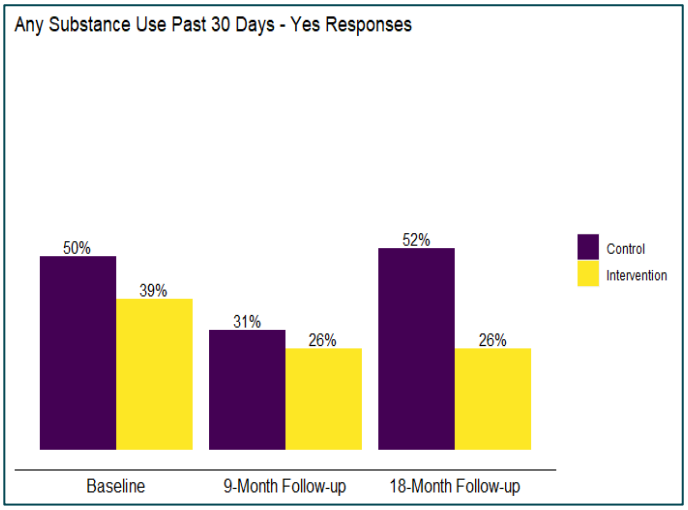
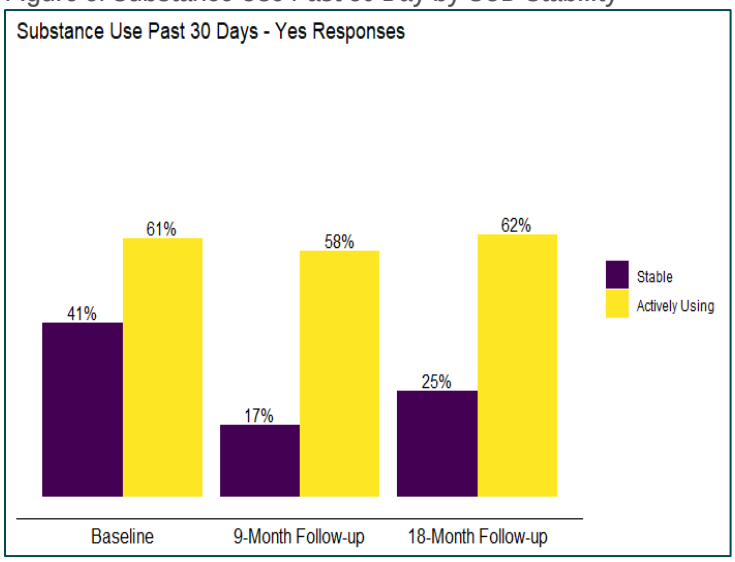


Figure 5. Substance Use Past 30 Day by SUD Stability



In addition to change over time, there were trending differences in substance use in the past 30 days by closure status; those who used substances in the past 30 days were more likely to have their case closed due to placement compared to closed successfully.

We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, program tenure, family size, or parent age and substance use.

Table 6. Effects of Covariates on Substance Use

Covariate	Estimate	Standard Error	z-value	p-value
9-month follow-up interview	-1.37	0.61	-2.82	0.005
18-month follow-up interview	0.23	0.63	0.99	0.32
Intervention group	-0.77	0.6	-1.27	0.20
Total # of Intact worker contacts	0.01	0.01	0.44	0.66
SUD treatment status	0.53	1.56	0.34	0.73
SUD stability	3.65	1.64	2.22	0.03
Unsuccessful closure – placement	1.62	0.89	1.83	0.07
Unsuccessful closure – dropped	0.97	0.77	1.26	0.21
Program tenure	0.00	0.00	1.03	0.30
Family size	0.05	0.20	0.26	0.80
Parent age	-0.07	0.04	-1.69	0.09

Cannabis Use in the Past 30 Days

While we didn't find any significant changes over time in cannabis use (although there was a trending level decrease at 9-months; $t = -1.84$, $p = 0.06$), we did find that a greater percentage of control group participants used cannabis at baseline than the intervention group at baseline ($t = -2.17$, $p = 0.03$). Additionally, a lower percentage of those who were SUD stable at program closure reported cannabis use over time compared to those who were actively using at closing ($z = 2.09$, $p = 0.04$). Younger parents also tended to use more cannabis ($t = -2.20$, $p = 0.03$).

Figure 6. Cannabis Use by Group at Baseline

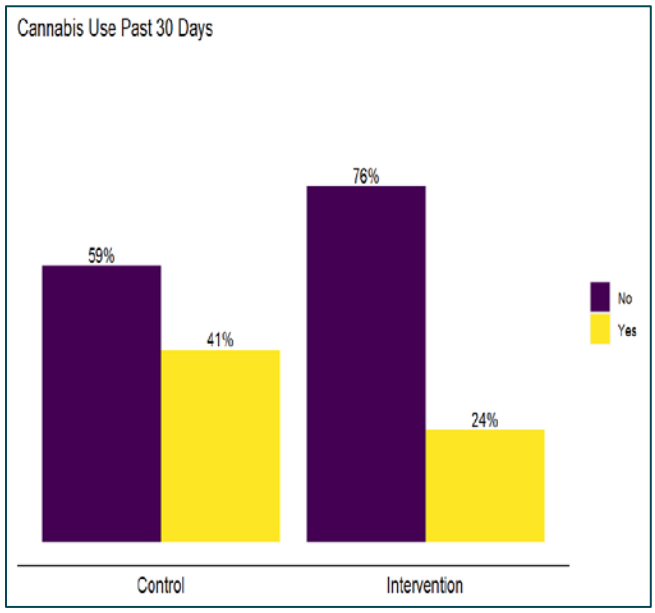


Figure 7. Cannabis Use by Group: All Timepoints

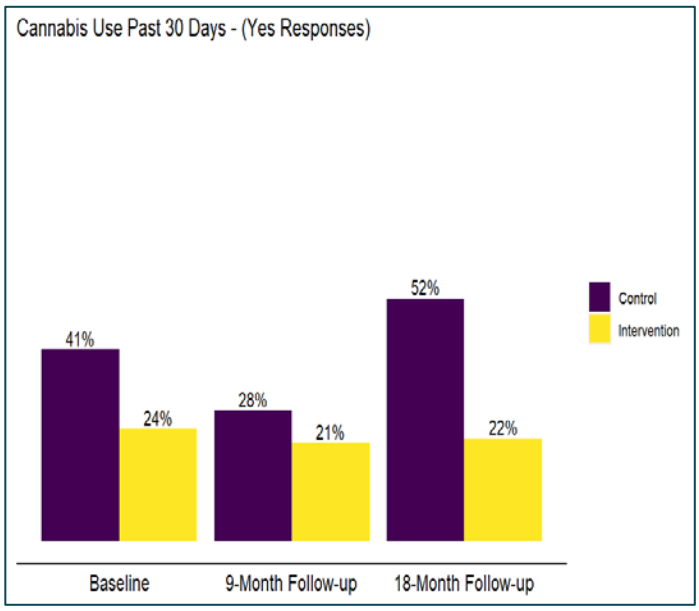


Figure 8. Cannabis Use: SUD Stability

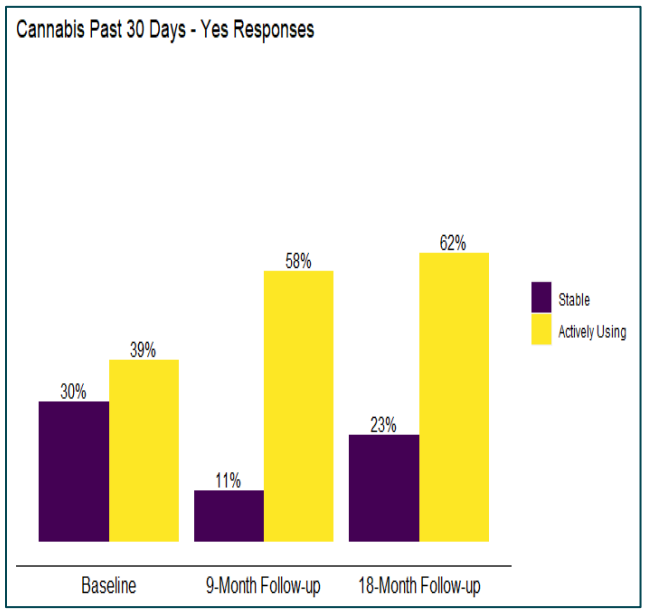
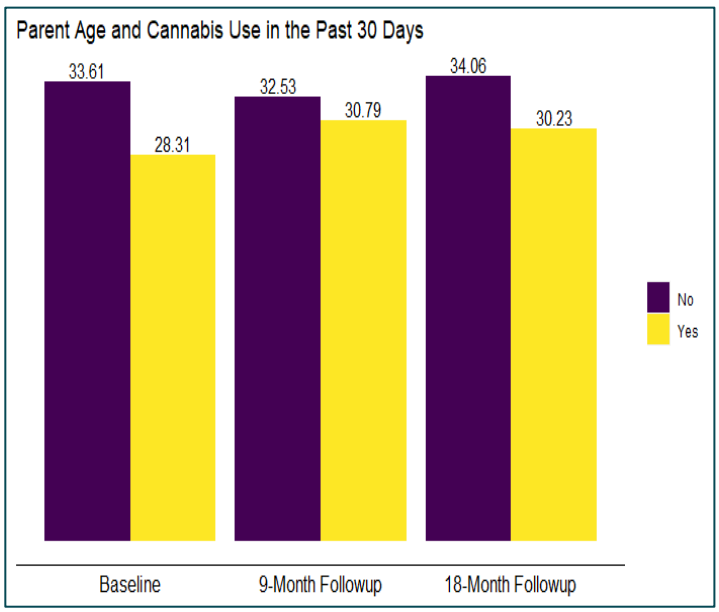


Figure 9. Cannabis Use: Parent Age



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, closure status, program tenure, or family size and cannabis use.

Table 7. Effects of Covariates on Cannabis Use

Covariate	Estimate	Standard Error	Z-value	p-value
9-month follow-up interview	-0.14	0.07	-1.84	0.06
18-month follow-up interview	0.13	0.08	1.62	0.10
Intervention group	-1.38	1.35	-2.17	0.03
Total # Intact worker contacts	-0.02	0.02	-0.93	0.35
SUD treatment status	0.75	1.72	0.44	0.66
SUD stability	3.98	1.91	2.09	0.04
Unsuccessful closure – placement	1.80	1.09	1.65	0.10
Unsuccessful closure – dropped	0.87	0.94	0.93	0.35
Program tenure	0.00	0.00	1.15	0.25

Covariate	Estimate	Standard Error	Z-value	p-value
Family size	0.03	0.29	0.10	0.92
Parent age	-0.17	0.08	-2.20	0.03

Alcohol Use in the Past 30 days

Although a slightly greater percentage of intervention group participants than control group participants self-reported alcohol use in the past 30 days at each interview timepoint, these differences between the groups were not significant. There also were no significant changes over time for alcohol use. However, there was an effect for closure status such that those who responded as using alcohol in the past 30 days were more likely to be closed due to placement (z = 2.94, p <0.001) or withdrawn or dropped for IL IFR services (z = 3.04, p < 0.001) compared to participants whose cases were closed successfully.

Figure 10. Alcohol Use by Group

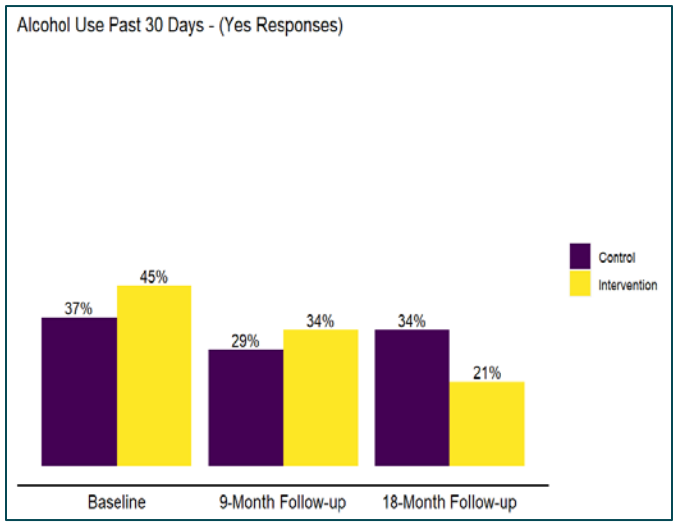
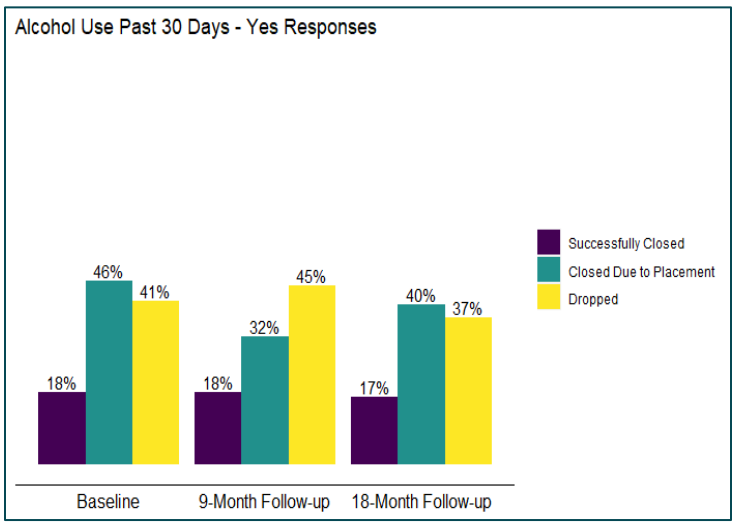


Figure 11. Alcohol Use by Closure Status



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability, program tenure, family size, or parent age and alcohol use.

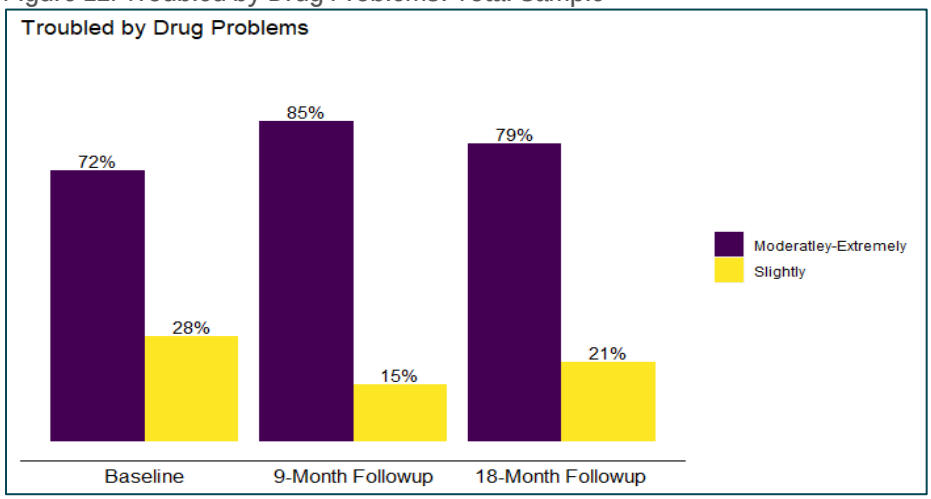
Table 8. Effects of Covariates on Alcohol Use

Covariate	Estimate	Standard Error	Z-value	p-value
9-month follow-up	-0.38	0.70	-0.54	0.59
18-month follow-up	1.29	0.76	1.69	0.09
Intervention group	0.15	0.75	0.21	0.84
Total # Intact worker contacts	0.01	0.01	0.67	0.51
SUD treatment status	-0.01	1.4	-0.01	0.99
SUD stability	2.14	1.47	1.46	0.15
Unsuccessful closure – placement	2.50	1.50	2.94	< 0.001
Unsuccessful closure – dropped	3.00	1.35	3.04	<0.001
Program tenure	0.00	0.00	0.31	0.76
Family size	-0.03	0.23	-0.13	0.90
Parent age	-0.02	0.05	-0.36	0.72

Troubled by Drug Problems – Past 30 Days

Overall, most participants reported at each interview timepoint that they were moderately to extremely troubled by drug problems in the past 30 days. We found that the percentage of participants who reported being slightly troubled by drug problems in the past 30 days decreased significantly at 9-month follow-up (t = -2.28, p = 0.03) but not at 18-month follow-up (t = -1.34, p = 0.19).

Figure 12. Troubled by Drug Problems: Total Sample



We found significant differences between the intervention and comparison group (t = -2.09, p = 0.03). Specifically, the percentage of intervention group participants who reported being moderately to extremely troubled by drug problems in the last 30 days remained consistent over time. For the comparison group, we saw an increase in the percentage of participants who were moderately to extremely troubled by drug problems from baseline to 9-month follow-up, and then a slight decrease at 18-month follow-up.

Figure 13. Troubled by Drug Problems: Control Group

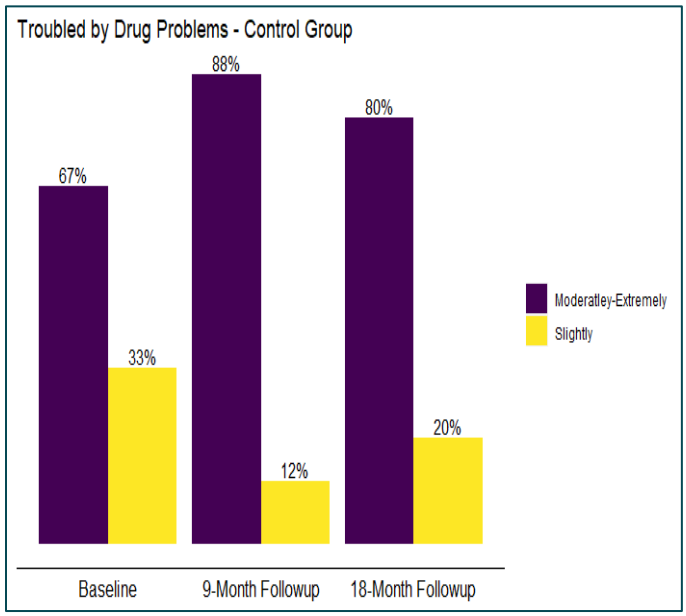
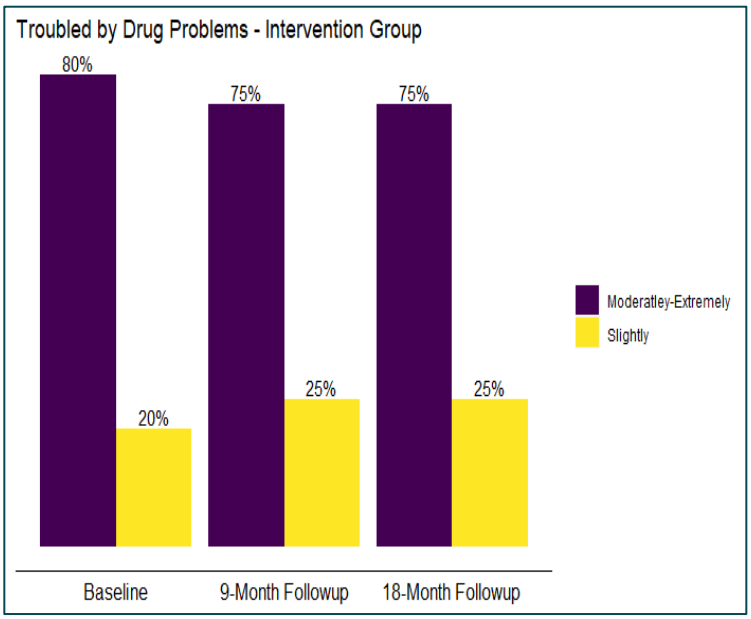


Figure 14. Troubled by Drug Problems: Intervention Group



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability at closing, closure status, program tenure, family size, or parent age and participants' self-report of being troubled by drug problems.

Table 9. Effects of Covariates on Troubled by Drug Problems

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.67	0.2	-2.28	0.03
18-month follow-up interview	-0.07	0.2	-1.34	0.19
Intervention group	-0.23	0.19	-2.09	0.03
Total # of Intact worker contacts	-0.14	0.14	-0.99	0.33
SUD treatment status	0.02	0.25	0.07	0.94
SUD stability	0.24	0.25	0.94	0.36
Unsuccessful closure – placement	0.00	0.00	0.81	0.43
Unsuccessful closure – dropped	-0.27	0.14	-1.86	0.07
Program tenure	0.07	0.16	0.43	0.67
Family size	-0.13	0.14	-0.97	0.34
Parent age	0.00	0.00	0.05	0.96

Importance of Receiving Treatment for Drug Problems

At each interview, participants were asked to rate the importance of receiving treatment for their drug problems. There were no significant differences between groups for this outcome.

Table 10. Importance of Receiving Treatment for Drug Problems

	Baseline			9-Month Follow-Up			18-Month Follow-Up		
Importance of Receiving Drug Treatment	Not at All	Slightly	Moderately to Extremely	Not at All	Slightly	Moderately to Extremely	Not at All	Slightly	Moderately to Extremely
Intervention Group	27%	13%	60%	71%	14%	14%	64%	9%	27%
Control Group	40%	0%	60%	73%	0%	27%	64%	0%	36%
Total Sample	31%	9%	60%	72%	8%	20%	64%	5%	32%

We did not find any changes over time or significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability, closure status, program tenure, family size, or parent age and participants' ratings of the importance of receiving treatment for drug problems.

Table 11. Effects of Covariates on Importance of Receiving Treatment for Drug Problems

Covariate	Estimate	Standard Error	Z-value	p-value
9-month follow-up	-0.26	0.18	-1.48	0.18
18-month follow-up	-0.36	0.20	-1.82	0.11
Intervention group	-0.12	0.09	-1.33	0.19
Total # Intact worker contacts	-0.02	0.01	-1.84	0.08
SUD treatment status	-0.57	1.08	-0.53	0.6
SUD stability	-0.22	1.11	-0.2	0.84
Unsuccessful closure – placement	0.18	0.31	0.57	0.58
Unsuccessful closure – dropped	0.18	0.29	0.63	0.54
Program tenure	0.00	0.00	2.00	0.06
Family size	-0.16	0.09	-1.78	0.12
Parent age	-0.02	0.02	-0.93	0.37

PARENT MENTAL HEALTH

Serious Depression Past 30 Days

As shown in Figure 15, most participants reported experiencing serious depression in the past 30 days at each interview timepoint. We found that the percentage of participants who self-reported experiencing serious depression in the past 30 days decreased at the 9-month follow-up (z = -2.50, p =

0.01), though this was driven by the control group who showed a greater decrease than the intervention group (z = 2.23, p = 0.03). Additionally, we found that a greater percentage of the control group reported experiencing serious depression over time than the intervention group (z = -3.13, p = 0.002).

Figure 15. Serious Depression Past 30 Days

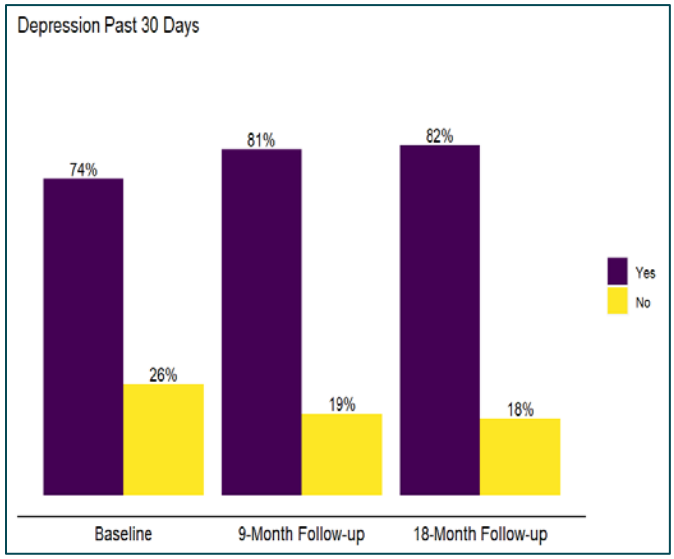


Figure 16. Serious Depression by Group

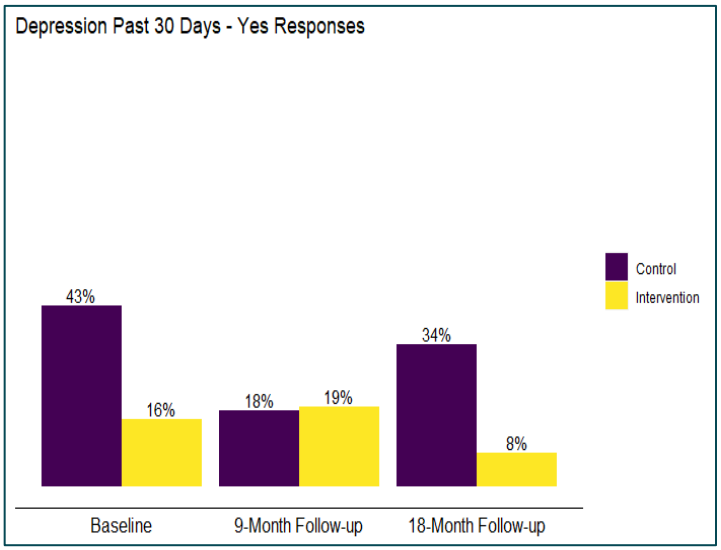
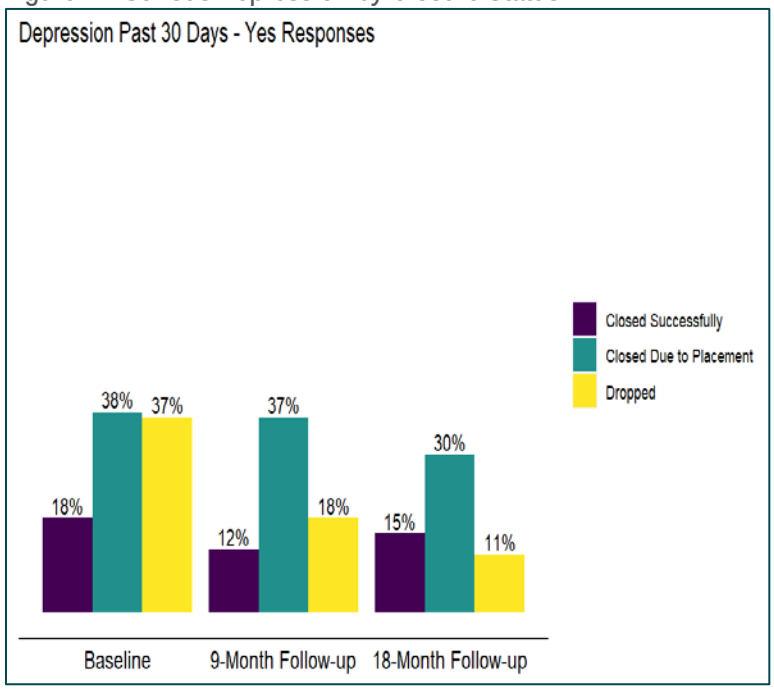


Figure 17. Serious Depression by Closure Status



In addition to change over time, we also saw differences in depression by closure status (e.g., closed successfully). Participants who reported experiencing depressive symptoms were more likely to have their case closed due to placement. Participants with longer program tenures were less likely to report depressive symptoms (t = 2.44, p = 0.01). We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability, family size, or parent age and participants' self-reports of serious depression.

Table 12. Effects of Covariates on Serious Depression

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-1.41	0.57	-2.50	0.01
18-month follow-up interview	-0.91	0.59	-1.55	0.12
Intervention group	-1.67	0.51	-3.13	0.002
Total # of Intact worker contacts	-0.01	0.01	-1.00	0.32
SUD treatment status	0.32	0.79	0.4	0.69
SUD stability	1.21	0.9	1.34	0.18

Covariate	Estimate	Standard Error	t-value	p-value
Unsuccessful closure – placement	0.42	1.06	2.44	0.01
Closure status – dropped	0.38	0.51	0.73	0.46
Program tenure	0.005	0.003	2.44	0.01
Family size	-0.12	0.16	-0.77	0.44
Parent age	0.05	0.03	1.70	0.09

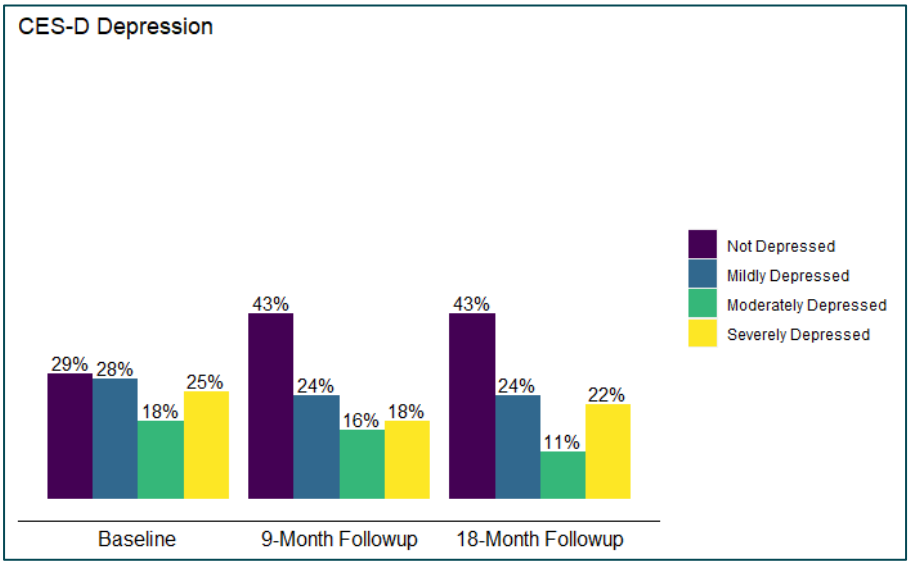
CES-D

As shown in Table 13, CES-D scores indicate that, on average, participants reported mild levels of depression. We found that CES-D scores and the percentage of participants who reported depressive symptoms decreased significantly from baseline to 18-month follow-up for all participants (9-months: t = -2.47, p = 0.01; 18-months: t = -2.07, p = 0.04).

Table 13. CES-D Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	85	8.19 (0-30)	62	7.90 (0-29)	50	6.02 (0-25)
Control Group	46	12.62 (0-31)	39	7.97 (0-24)	29	11.66 (0-32)
Total Sample	131	9.75 (0-31)	101	7.93 (0-29)	79	8.09 (0-32)

Figure 18. CES-D Scores: % Depressed Total Sample



We also found significant differences between intervention and control group participants, with intervention group participants reporting greater decreases in depressive symptoms and symptom severity (t = -3.60, p < 0.001). While both groups showed a decrease in the percentage of those who were severely depressed at 9-months, at 18 months, a greater percentage of control group participants were severely depressed, while the percentage of intervention group participants who were severely depressed continued to decrease over time.

Figure 19. CES-D: Control Group

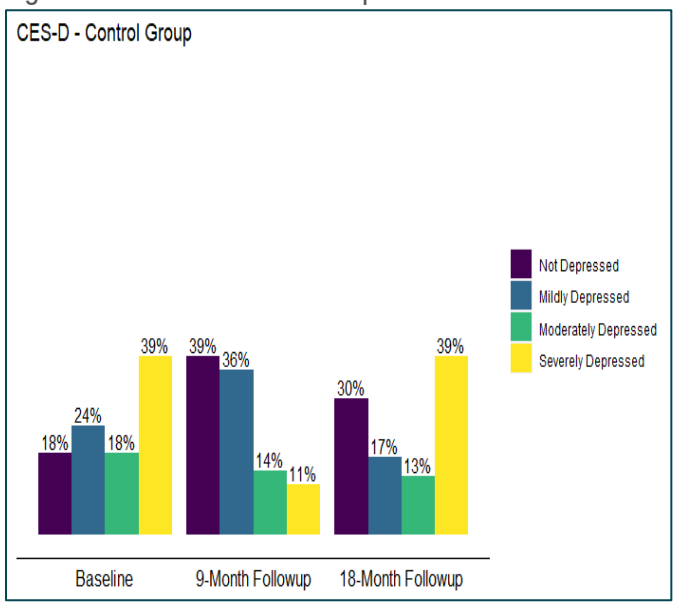
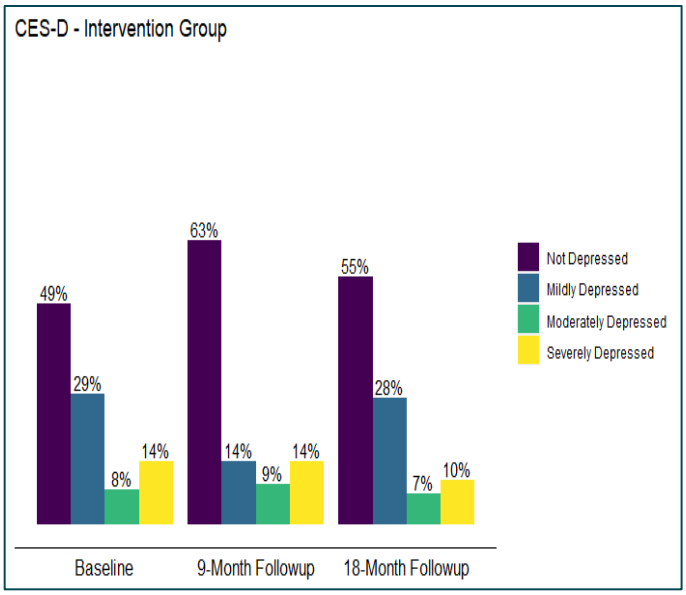


Figure 20. CES-D: Intervention Group



In addition to change over time, we also saw differences in CES-D scores by closure status. Participants with higher CES-D scores (i.e., those who were more depressed) were more like to have their case closed due to placement than participants who were closed successfully.

Figure 21. CES-D: Unsuccessful Closure -Placement

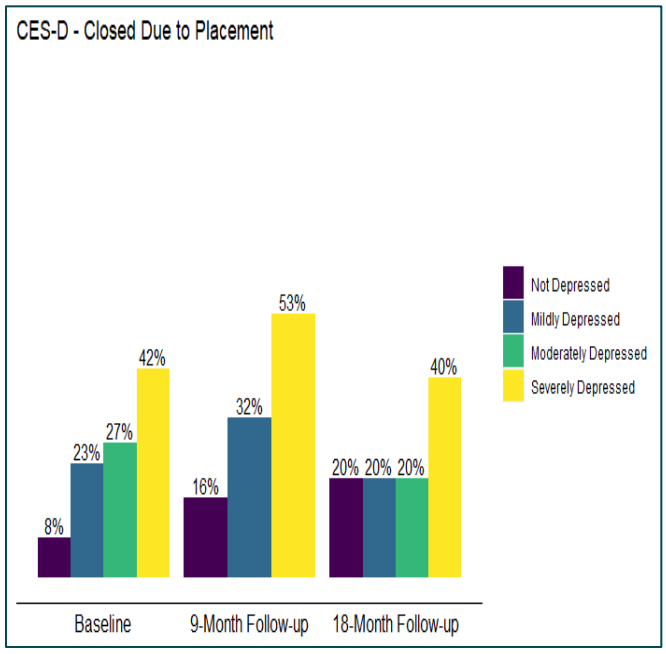


Figure 22. CES-D: Successful Closure

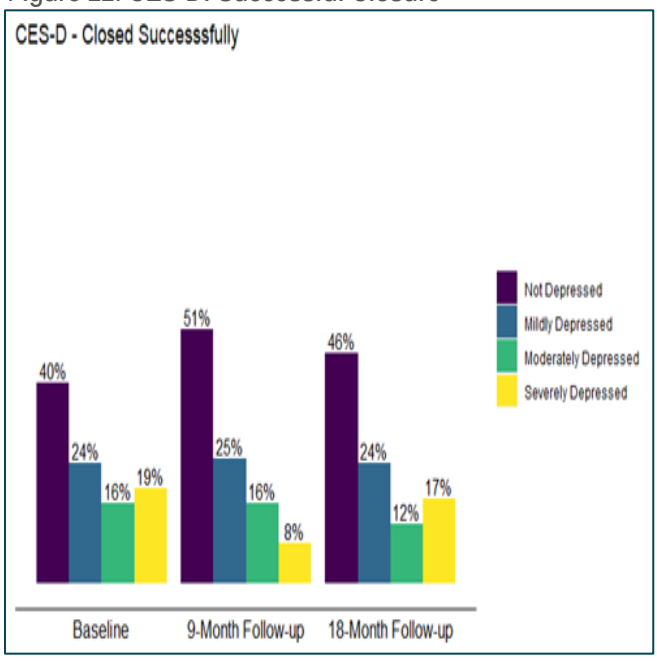
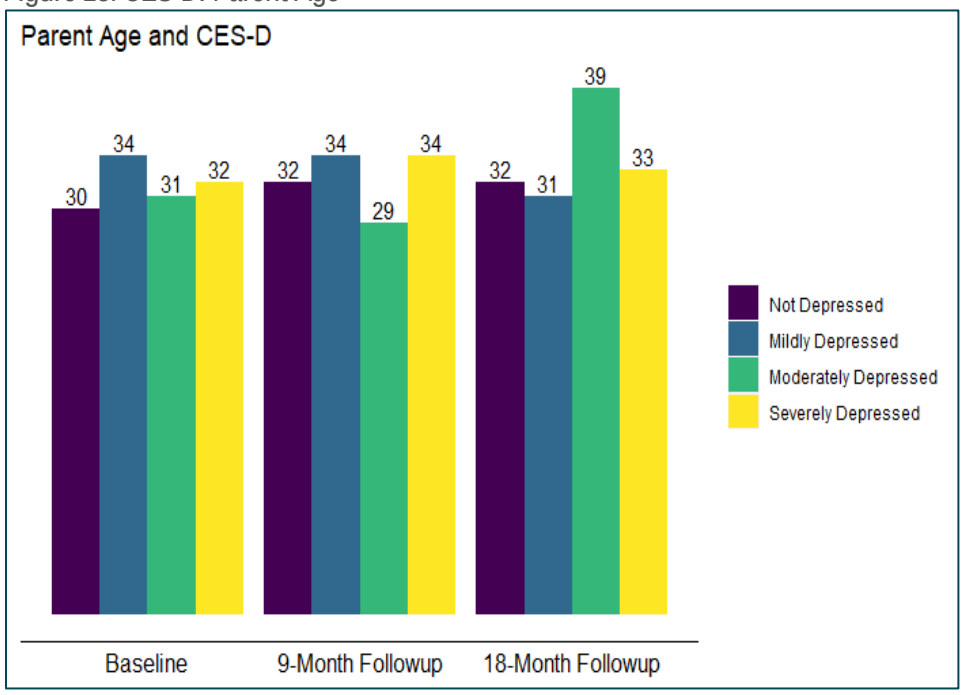


Figure 23. CES-D: Parent Age



Younger parents also had fewer depressive symptoms and were less depressed than older parents (t = 2.44, p = 0.02). We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, or SUD stability and CES-D scores.

Table 14. Effects of Covariates on CES-D Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.74	0.18	-2.47	0.01
18-month follow-up interview	-0.24	0.2	-2.07	0.04
Intervention group	-0.74	0.21	-3.60	<0.001
Total # of Intact worker contacts	0.00	0.00	-0.23	0.82
SUD treatment status	0.3	0.34	0.88	0.38
SUD stability	-0.39	0.31	-1.25	0.22
Unsuccessful closure – placement	0.78	0.35	2.20	0.03
Unsuccessful closure – dropped	0.10	0.25	0.41	0.68
Program tenure	0.00	0.00	0.84	0.40
Family size	-0.10	0.07	-1.41	0.16
Parent age	0.02	0.23	2.44	0.02

Serious Anxiety Past 30 Days

Participants were asked at each interview whether they experienced any serious anxiety symptoms in the past 30 days. While a greater percentage of comparison group participants than intervention group participants reported experiencing serious anxiety in the month prior to each interview, this difference was not significant.

Table 15. Serious Anxiety

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	Yes	No	Yes	No	Yes	No
Intervention Group	41%	59%	48%	52%	26%	74%
Control Group	61%	39%	51%	49%	69%	31%
Total Sample	48%	52%	50%	50%	26%	74%

We did not find any significant changes over time, or significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability, closure status, program tenure, family size, or parent age and serious anxiety.

Table 16. Effects of Covariates on Serious Anxiety

Covariate	Estimate	Standard Error	Z-value	p-value
9-month follow-up interview	-0.55	0.55	-0.99	0.32
18-month follow-up interview	0.46	0.62	0.74	0.46
Intervention group	-1.26	0.58	-2.16	0.06
Total # of Intact worker contacts	0.00	0.01	-0.31	0.75
SUD treatment status	0.12	0.8	0.15	0.88
SUD stability	-0.73	0.78	-0.93	0.35
Unsuccessful closure - placement	0.97	0.60	1.62	0.10
Unsuccessful closure – dropped	-0.29	0.52	-0.56	0.58
Program tenure	0.00	0.00	1.68	0.09
Family size	-0.16	0.15	-1.01	0.31
Parent age	0.01	0.03	0.22	0.83

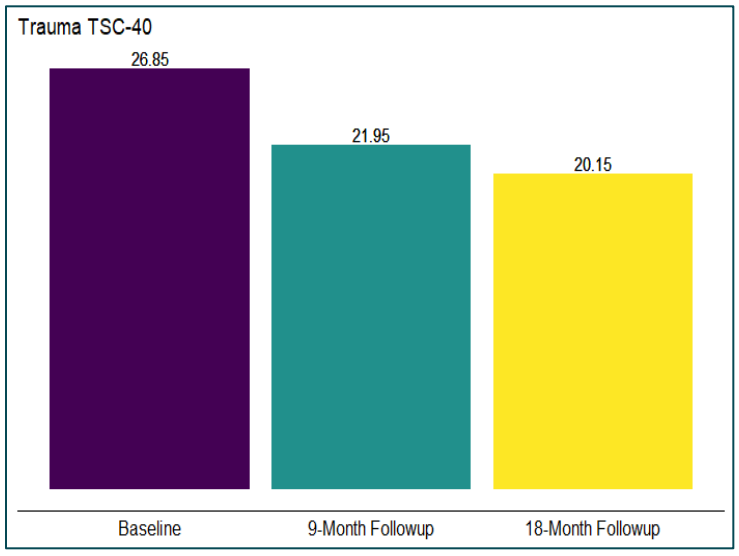
Trauma Symptom Checklist (TSC)-40

Overall, participants reported low levels of trauma, as assessed by the TSC-40. We found that trauma scores decreased significantly over time (9-months: t = -3.03, p = 0.002 and 18-months: t = -3.30, p = 0.001).

Table 17. TSC-40 Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	85	23.48 (0-70)	62	20.23 (0-60)	50	15.72 (0-69)
Control Group	46	33.09 (0-78)	39	24.69 (0-68)	29	27.79 (0-64)
Total Sample	131	26.85 (0-78)	101	21.95 (0-68)	79	20.15 (0-69)

Figure 24. Trauma TSC-40 Score Total Sample



We also found significant differences between the intervention and control groups. Intervention group participants had a steady decrease in trauma scores over time while comparison group participants had an initial decrease in trauma scores, followed by an increase at 18-month follow-up (t = -2.96, p = 0.004).

Figure 25. TSC-40: Control Group

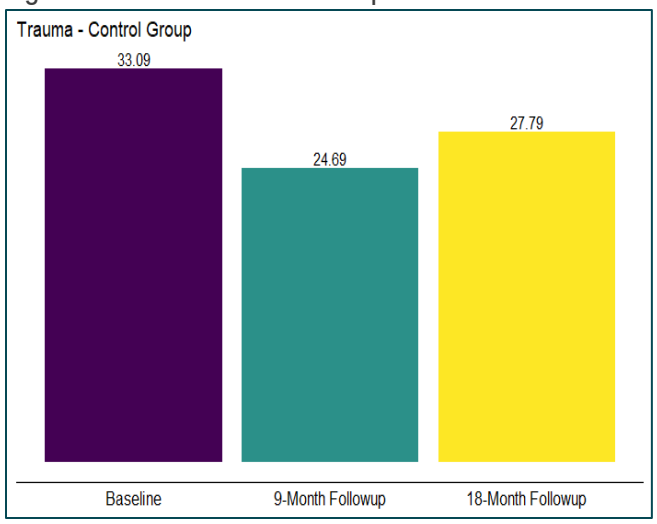


Figure 26. TSC-40: Intervention Group

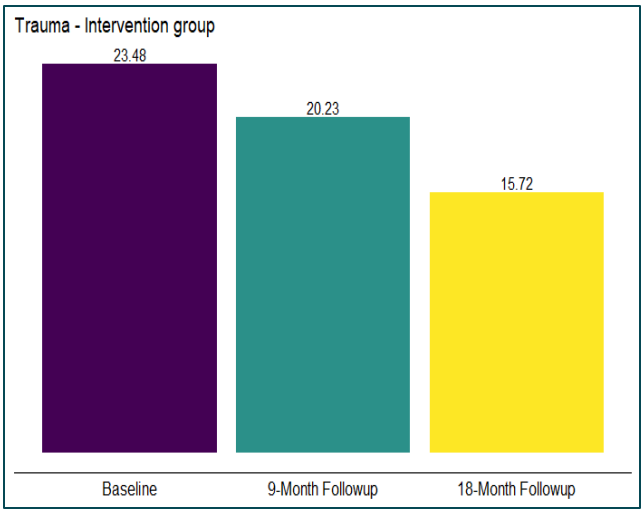
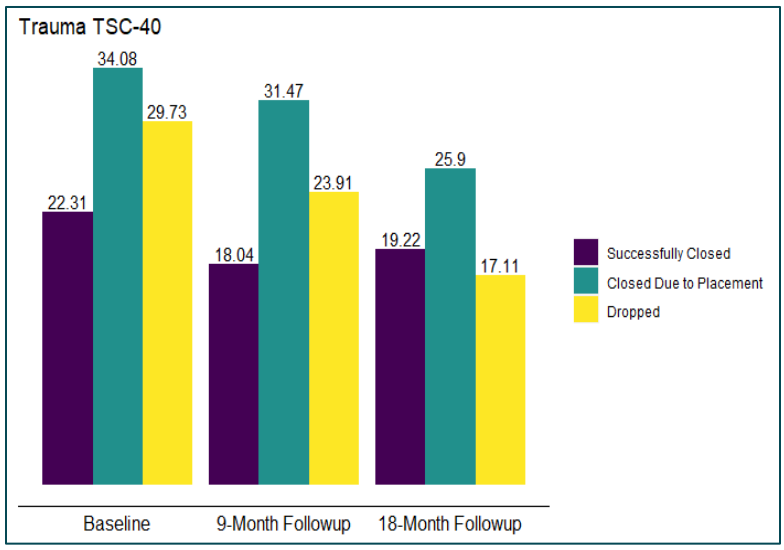


Figure 27. TSC-40 by Closure Status



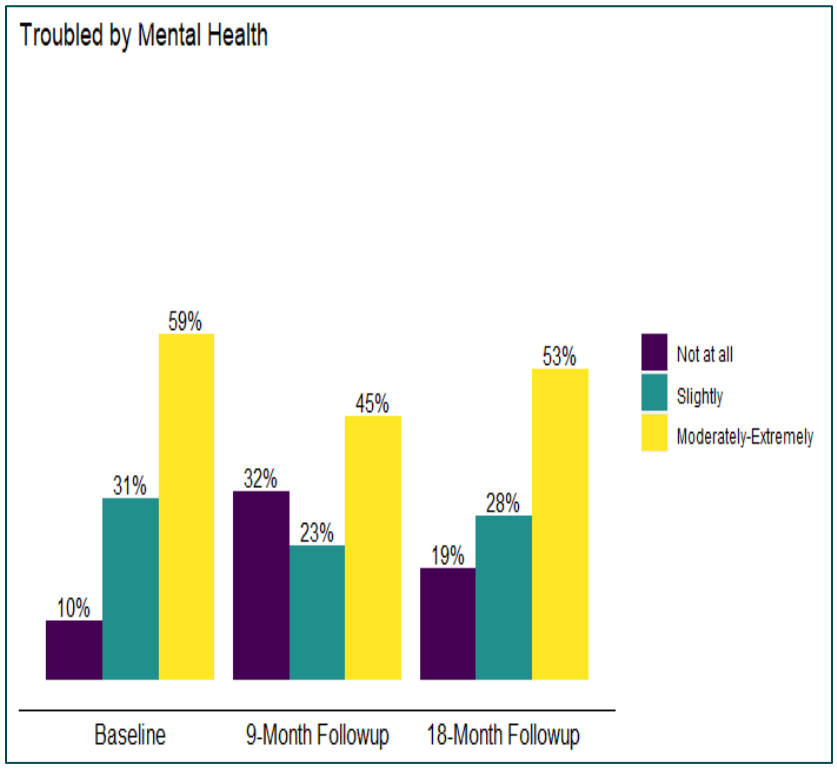
In addition to change over time, we also saw differences in trauma scores by closure status. Participants who had higher trauma scores were more like to have their case closed due to placement ($z = 2.34$, $p = 0.02$). Also, those who had smaller families ($t = -2.14$, $p = 0.03$) had fewer trauma symptoms. We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, program tenure or parent age and TSC-40 scores.

Table 18. Effects of Covariates on TSC-40

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-6.9	2.4	-3.03	0.002
18-month follow-up interview	-2.78	2.68	-3.30	0.001
Intervention group	-9.6	3.25	-2.96	0.004
Total # of Intact worker contacts	-0.06	0.07	-0.85	0.40
SUD treatment status	5.46	6.14	0.89	0.38
SUD stability	-7.6	5.78	-1.32	0.19
Unsuccessful closure – placement	10.36	6.55	2.34	0.02
Unsuccessful closure – dropped	3.47	4.15	0.83	0.41
Program tenure	0.03	0.02	1.85	0.07
Family size	1.22	0.95	-2.14	0.03
Parent age	0.27	0.24	1.15	0.26

Troubled by Mental Health Problems

Figure 28. Troubled by Mental Health Problems



At each interview timepoint, approximately one-third of participants reported that they were slightly troubled by their mental health problems in the past 30 days, and approximately 50% were moderately to extremely troubled by their mental health problems. We found that the percentage of participants who reported being troubled by mental health problems decreased significantly at 9-month follow-up ($t = -3.33$, $p = 0.001$). The control group saw a large decrease in the percentage of participants who were moderately to extremely troubled by mental health problems at 9 months ($t = 2.13$, $p = 0.04$) compared to intervention group participants. The intervention group continued to show a decrease in the percentage of participants who were moderately to extremely troubled by their mental health problems at 18-month follow-up, while the percentage of comparison group participants who were more troubled by their mental health problems increased.

Figure 29. Troubled by MH Problems: Control Group

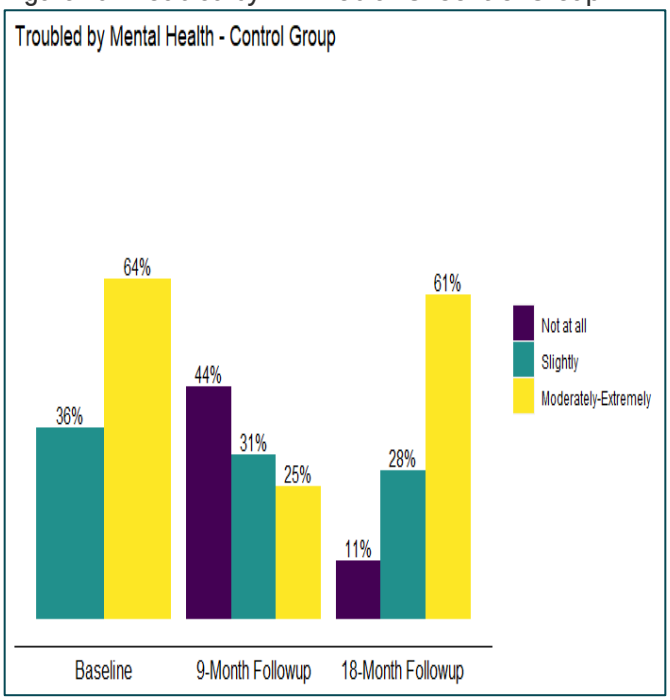


Figure 30. Troubled by MH Problems: Intervention Group

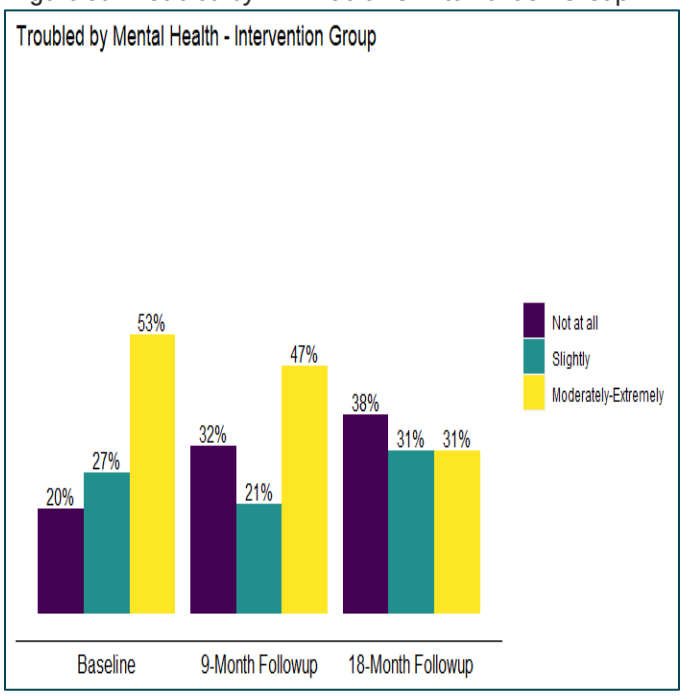
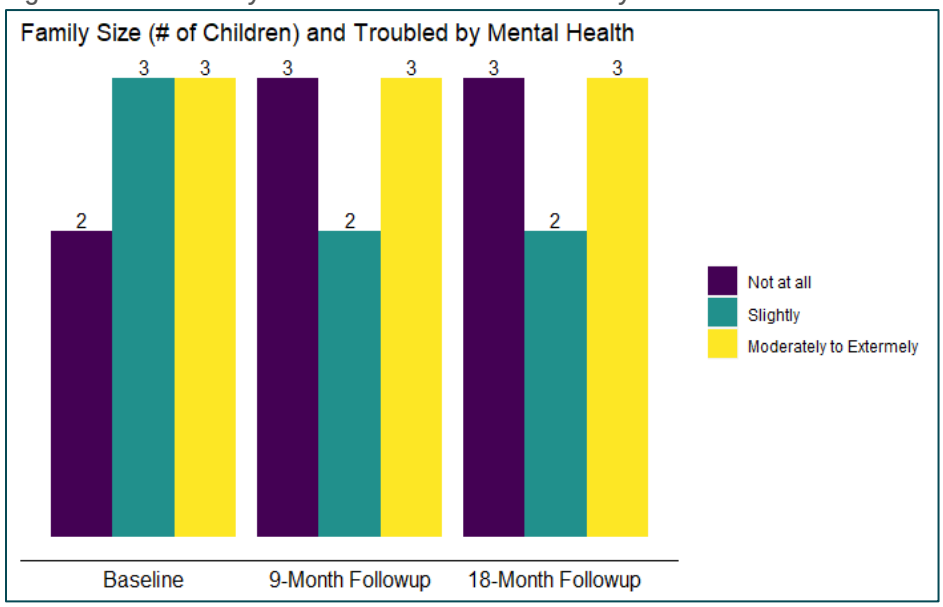


Figure 31. Troubled by Mental Health Problems: Family Size



In addition to change over time, those with fewer children tended to be less bothered by mental health problems (t = -2.16, p =0.04). We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure or parent age and troubled by mental health problems.

Table 19. Effects of Covariates on Troubled by Mental Health Problems

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up	-0.67	0.2	-3.33	0.001
18-month follow-up	-0.07	0.2	-0.35	0.73
Intervention group	0.56	0.26	2.13	0.04
Total # of Intact worker contacts	0.00	0.00	-0.31	0.76
SUD treatment status	0.53	0.4	1.32	0.19
SUD stability	-0.79	0.44	-1.79	0.08
Unsuccessful closure - placement	0.18	0.21	0.86	0.39
Unsuccessful closure – dropped	-0.10	0.21	-0.49	0.63
Program tenure	0.00	0.00	0.69	0.50
Family size	-0.07	0.10	-2.16	0.04
Parent age	0.02	0.01	1.50	0.14

Importance of Receiving Treatment for Mental Health Problems

Participants were asked to rate how important it was for them to receive treatment for their mental health problems. At each interview timepoint, most participants reported that it was moderately to extremely important that they receive mental health treatment. At baseline and 9-month follow-up, a slightly greater percentage of intervention group participants compared to control group participants reported that it was moderately to extremely important that they receive mental health treatment. At 18 months, a slightly greater percentage of comparison group participants than intervention group participants stated that it was moderately to extremely important to receive mental health treatment. These differences between the groups, however, were not significant.

Table 20. Importance of Receiving Treatment for Mental Health Problems.

	Baseline			9-Month Follow-Up			18-Month Follow-Up		
Importance of Receiving Mental Health Treatment	Not at All	Slightly	Moderately to Extremely	Not at All	Slightly	Moderately to Extremely	Not at All	Slightly	Moderately to Extremely
Intervention Group	8%	15%	77%	23%	12%	65%	31%	12%	56%
Control Group	12%	15%	73%	26%	16%	58%	20%	0%	80%
Total Sample	9%	15%	75%	24%	13%	62%	25%	6%	69%

We did not find any significant changes over time, or significant relationships between the number of Intact workers contacts, SUD treatment status at closing, SUD stability, closure status, program tenure, family size, or parent age and participants' ratings of the importance of receiving mental health treatment.

Table 21. Effects of Covariates on Importance of Receiving Mental Health Treatment

Covariate	Estimate	Standard Error	Z-value	p-value
9-month follow-up	-0.15	0.29	-0.51	0.62
18-month follow-up	-0.35	0.33	-1.07	0.30
Intervention group	-0.04	1.14	-0.26	0.79
Total # of Intact worker contacts	0.01	0.01	0.66	0.52
SUD treatment status	0.07	0.39	0.19	0.85
SUD stability	0.03	0.43	0.08	0.94
Unsuccessful closure – placement	0.57	0.55	1.04	0.32
Unsuccess closure – dropped	0.23	0.42	0.56	0.59
Program tenure	0.00	0.00	0.31	0.76
Family size	0.06	0.14	0.45	0.66
Parent age	0.00	0.02	0.24	0.82

PARENTING

Child Rearing Practices Report-Modified (CRPR)

On average, CRPR scores show that participants reported high levels of positive parenting practices at each interview timepoint.

Table 22. CRPR Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	32	94.19 (56-108)	25	96.52 (71-107)	20	99.40 (81-107)
Control Group	13	91.15 (43-108)	11	95.09 (68-108)	6	100.50 (90-108)
Total Sample	45	93.31 (43-108)	36	96.08 (68-108)	26	99.65 (81-108)

We found that CRPR scores increased significantly at 18-months compared to baseline (9-months: z = -1.61, p = 0.11; 18-months: z = -2.67, p = 0.008). However, as noted above, overall CRPR scores were high across time. There were no differences between the intervention group and control group.

Figure 32. CRPR Scores Total Sample

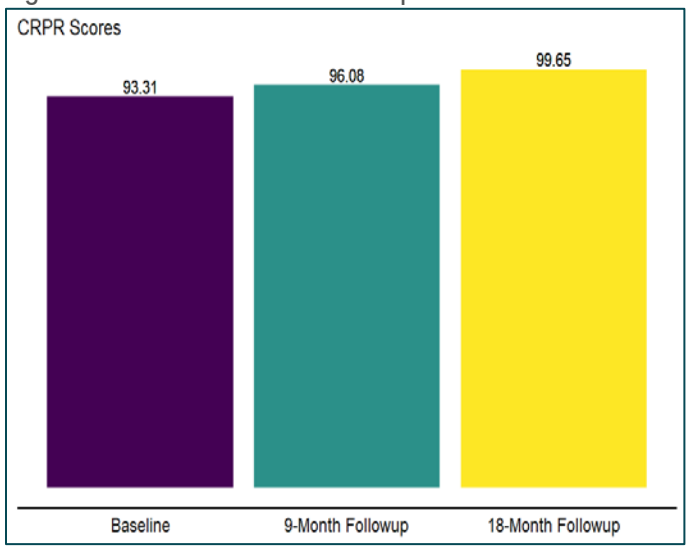
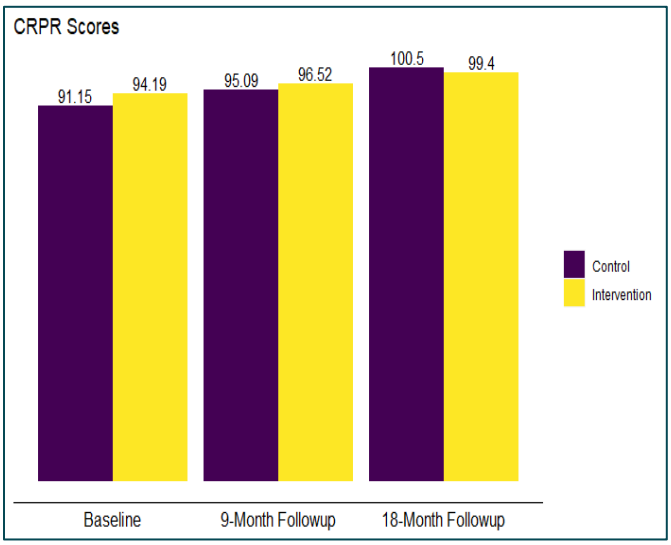


Figure 33. CRPR Scores by Group



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability at closing, closure status, program tenure, family size, or parent age and CRPR scores.

Table 23. Effects of Covariates on CRPR Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.86	0.53	-1.61	0.11
18-month follow-up interview	-2.24	0.84	-2.67	0.008
Intervention group	3.03	3.91	0.78	0.44
Total # Intact worker contacts	0.04	0.08	0.46	0.65
SUD treatment status	-3.99	8.55	-0.47	0.65
SUD stability	1.14	5.72	0.2	0.84
Unsuccessful closure – placement	-2.99	4.24	-0.71	0.49
Unsuccessful closure – dropped	4.53	3.39	1.34	0.19
Program tenure	0.01	0.02	0.32	0.75
Family size	1.50	1.28	1.17	0.25
Parent age	0.03	0.26	0.10	0.92

Parental Stress Scale (PSS)

Participants reported low levels of parenting stress at each interview timepoint. There were no significant differences in PSS scores between intervention group and control group participants.

Table 24. Parental Stress Scale Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	85	33.4 (18-64)	62	34.2 (18-51)	50	34.0 (18-52)
Control Group	46	34.7 (20-54)	39	34.7 (23-51)	29	35.2 (21-53)
Total Sample	131	33.9 (18-64)	101	34.8 (18-51)	79	34.4 (18-53)

We did not find any significant changes over time, or significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability, closure status, program tenure, family size, or parent age and PSS scores.

Table 25. Effects of Covariates on Parental Stress Scale Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	1.21	1.23	0.99	0.32
18-month follow-up interview	0.74	1.37	0.54	0.59
Intervention group	-1.29	1.46	-0.88	0.38
Total # of Intact worker contacts	0.02	0.03	0.49	0.63
SUD treatment status	-1.33	3.29	-0.4	0.69
SUD stability	1.63	3.11	0.52	0.60
Unsuccessful closure – placement	3.86	1.97	1.96	0.06
Unsuccessful closure – dropped	0.44	1.79	0.25	0.81
Program tenure	0.01	0.01	0.71	0.48
Family size	-0.49	0.50	-0.97	0.33
Parent age	0.06	0.11	0.55	0.58

Adult Adolescent Parenting Inventory 2 (AAPI-2)

The AAPI-2 contains five subscales, referred to as constructs: expectations of children (Construct A), parental empathy towards children's needs (Construct B), use of corporal punishment (Construct C), parent-child roles (Construct D), and children's power and independence (Construct E). We found significant results for all AAPI-2 subscales except Construct C.

AAPI Construct A: Expectations of Children

Construct A assesses parental expectations of children, with higher scores indicating appropriate expectations of children (i.e., understands what, in terms of development, a 3-year-old can and cannot do) and lower scores indicating inappropriate or unrealistic expectations of children. On average, participants had somewhat realistic expectations of their children. Intervention group participants had slightly more appropriate expectations of their children than control group participants, however, this difference was not significant.

Table 26. AAPI Construct A Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	52	5.62 (1-22)	32	6.02 (1-25)	20	5.20 (1-10)
Control Group	33	5.21 (1-8)	28	5.00 (1-10)	15	4.80 (1-8)
Total Sample	85	5.46 (1-22)	60	5.54 (1-25)	35	5.03 (1-10)

Figure 34. AAPI Construct A Scores

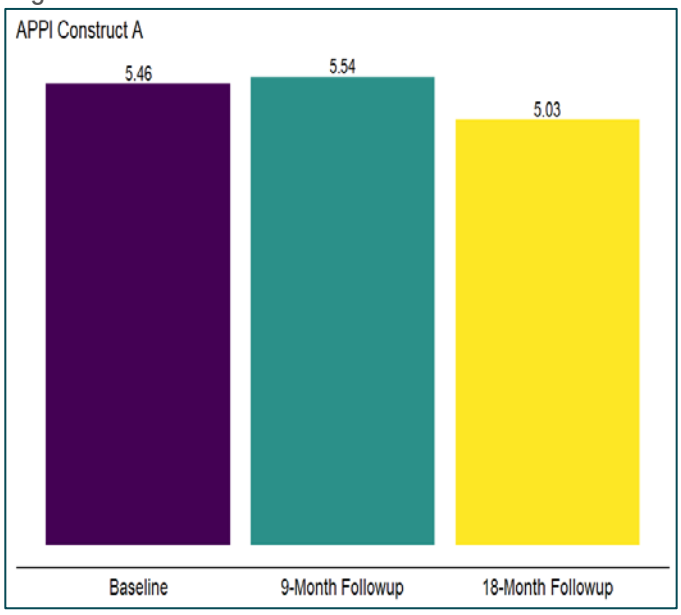


Figure 35. AAPI Construct A Scores by Group

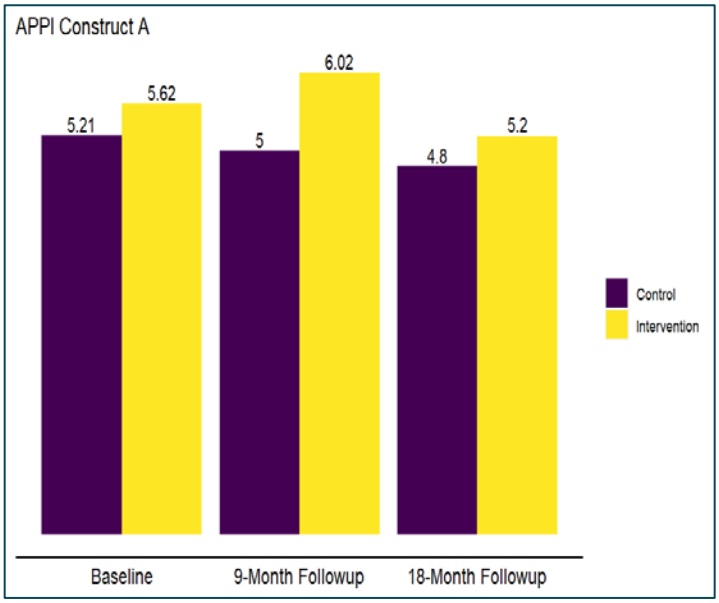
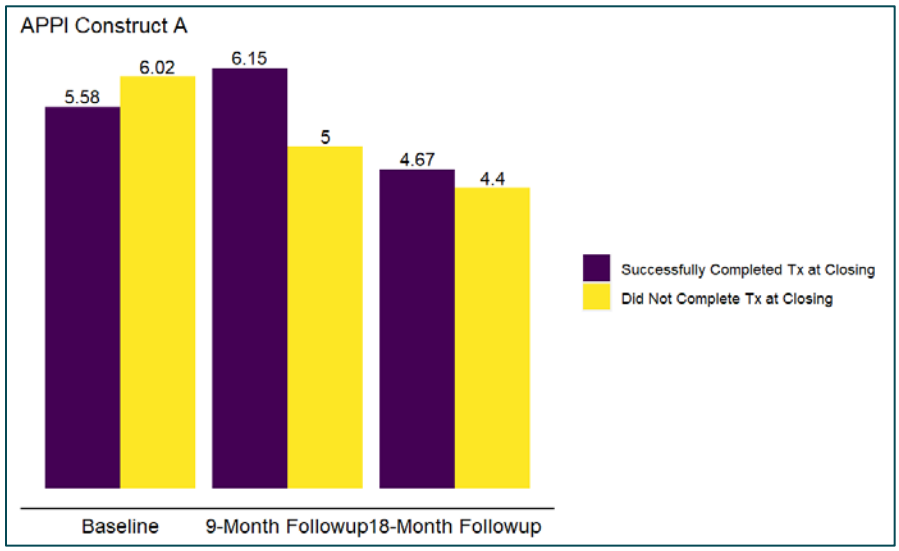


Figure 36. AAPI Construct A Scores by SUD Treatment Completion



While we did not find any significant changes over time or differences between the intervention and control groups, we did find differences between those who did and did not complete SUD treatment. At baseline, those who completed SUD treatment at program closure had more inappropriate expectations of children than parents who did not complete SUD treatment. However, at 9-month and 18-month follow-up, participants who complete SUD treatment had higher scores, i.e., more appropriate expectations of their children than those who did not complete treatment ($t = -2.01$, $p = 0.05$).

We did not find any significant relationships between the number of Intact worker contacts, SUD stability at closing, closure status, program tenure, family size, or parent age and Construct A scores.

Table 27. Effects of Covariates on AAPI Construct A

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.25	0.61	-0.41	0.68
18-month follow-up interview	-0.27	0.76	-0.35	0.73
Intervention group	0.41	0.63	0.65	0.52
Total # of Intact worker contacts	0.01	0.02	0.58	0.57
SUD treatment status	-4.41	2.20	-2.01	0.05
SUD stability	4.96	2.84	1.75	0.09

Covariate	Estimate	Standard Error	t-value	p-value
Unsuccessful closure – placement	2.18	1.30	1.68	0.10
Unsuccessful closure – dropped	-0.42	1.39	-0.30	0.76
Program tenure	0.00	0.00	-1.00	0.33
Family size	0.39	0.29	1.36	0.18
Parent age	-0.18	0.07	-2.48	0.06

AAPI Construct B: Parental Empathy Towards Children's Needs

Construct B assesses low levels of parental empathy towards children's needs (i.e., parent lacks nurturing skills) and high levels of empathy (i.e., parent understands and values children's needs, nurtures children). Higher Construct B scores indicate higher levels of empathy. Participants had, on average, moderate levels of parental empathy.

Table 28. AAPI Construct B Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	52	5.05 (1-37)	32	5.00 (2-8)	20	4.95 (1-10)
Control Group	33	5.12 (1-9)	28	4.61 (1-10)	15	6.94 (1-41)
Total Sample	85	5.08 (1-37)	60	4.82 (1-10)	35	5.80 (1-41)

There were no significant changes in Construct B scores over time and no differences between the intervention and control groups.

Figure 37. AAPI Construct B Scores

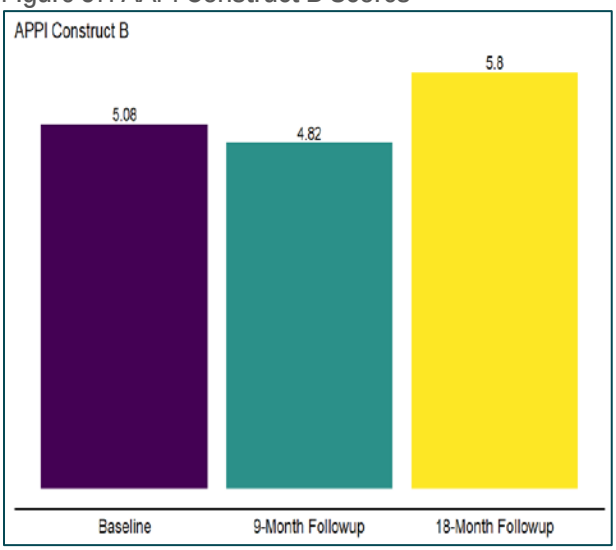


Figure 38. AAPI Construct B Scores by Group

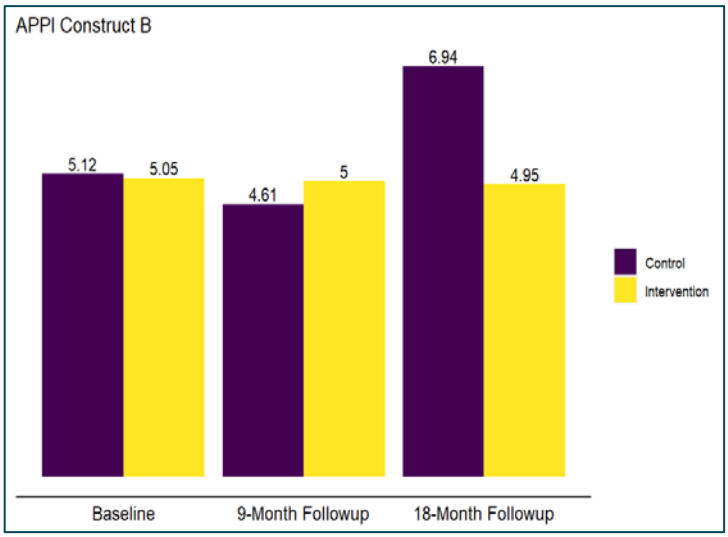
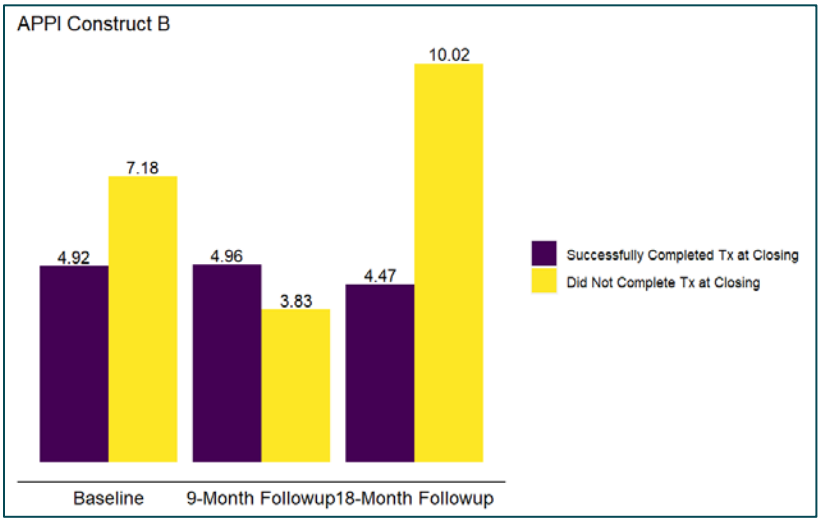


Figure 39. AAPI Construct B by SUD Treatment Completion



We found significant differences in empathy scores for those who did and did not complete SUD treatment. Specifically, those who did not complete SUD treatment had higher scores at baseline and 18-month follow-up, indicating more parental empathy towards children than those who did complete treatment (t = 2.36, p = 0.02).

We did not find any significant relationships between the number of Intact worker contacts, SUD stability, closure status, program tenure, or family size and Construct B scores. There was a trend for younger parents have to higher levels of empathy, but this result was not significant.

Table 29. Effect of Covariates on AAPI Construct B

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.52	1.06	-0.49	0.63
18-month follow-up interview	1.84	1.29	1.43	0.16
Intervention group	-0.07	0.94	-0.08	0.94
Total # of Intact worker contacts	-0.01	0.01	-1.04	0.30
SUD treatment status	5.22	2.21	2.36	0.02
SUD stability	-4.78	2.87	-1.67	0.11
Unsuccessful closure – placement	0.43	0.78	0.55	0.59
Unsuccessful closure – dropped	-0.42	0.83	-0.50	0.62
Program tenure	0.00	0.00	0.01	0.99
Family size	0.20	0.18	1.08	0.29
Parent age	-0.10	0.04	-2.28	0.06

AAPI Construct C: Corporal Punishment

Construct C measures the extent to which a parent values alternatives to corporal punishment. Lower scores indicate that participants believe in the use of corporal punishment; higher scores indicate that participants support alternatives to corporal punishment. On average, Construct C scores suggest that parents somewhat believed in the use of corporal punishment.

Table 30. AAPI Construct C Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	52	6.11 (1-29)	32	5.81 (3-10)	20	5.60 (3-8)
Control Group	33	6.24 (3-10)	28	6.07 (2-9)	15	6.07 (3-10)
Total Sample	85	6.16 (1-29)	60	5.93 (2-10)	35	5.80 (3-10)

There were no significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and Construct C scores.

Table 31. Effects of Covariates on AAPI Construct C

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.16	0.61	-0.26	0.80
18-month follow-up interview	-0.18	0.75	-0.24	0.81
Intervention group	-0.13	0.56	-0.24	0.81
Total # Intact worker contacts	-0.01	0.01	-0.87	0.39
SUD treatment status	0.51	1.13	0.45	0.65
SUD stability	-0.96	1.46	-0.66	0.52
Unsuccessful closure – placement	0.28	0.59	0.48	0.64
Unsuccessful closure – dropped	-1.13	0.63	-1.78	0.08
Program tenure	0.00	0.00	-0.85	0.40
Family size	-0.03	0.14	-0.24	0.81
Parent age	0.00	0.03	-0.04	0.97

AAPI Construct D: Parent-Child Family Roles

Construct D measures the degree to which a parent appropriately views a child as a child, not a caregiver or peer. Higher scores indicate more appropriate views of parent-child roles.

Table 32. AAPI Construct D Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	52	6.50 (1-10)	32	6.00 (3-10)	20	6.50 (1-10)
Control Group	33	5.93 (1-8)	28	5.89 (2-10)	15	5.93 (1-8)
Total Sample	85	5.44 (1-10)	60	5.95 (2-10)	35	6.26 (1-10)

We found that Construct D increased significantly over time (9-months: $t = 2.74$, $p = 0.007$; 18-months: $t = 4.43$, $p < 0.001$), indicating more appropriate views of parent-child roles. There were no significant differences between the intervention and control groups.

Figure 40. AAPI Construct D Scores

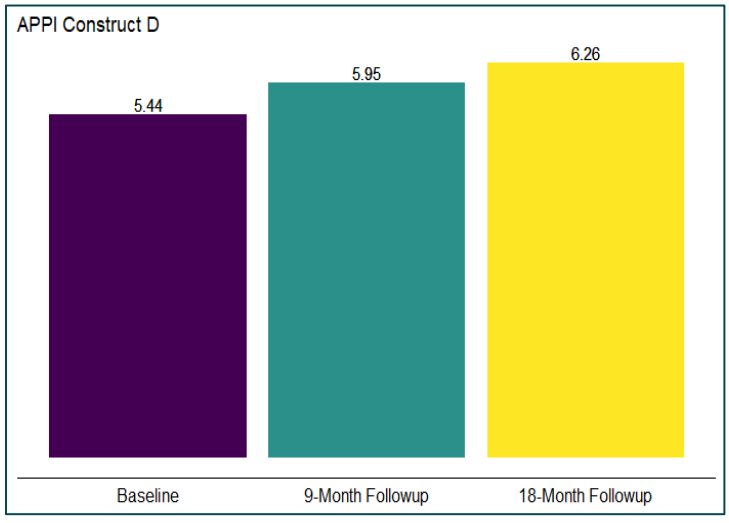
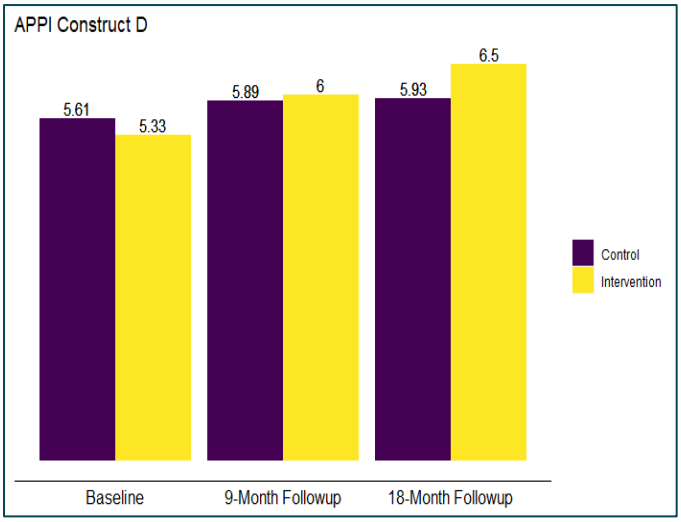


Figure 41. AAPI Construct D Scores by Group



We did not find any significant relationships between the number of Intact workers contacts, SUD treatment status at program closure, SUD stability, closure status, program tenure, family size, or parent age and Construct D scores.

Table 33. Effects of Covariates on AAPI Construct D

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	0.61	0.28	2.74	0.007
18-month follow-up interview	0.78	0.38	4.43	0.001
Intervention group	-1.71	0.94	-1.83	0.08
Total # of Intact worker contacts	-0.02	0.01	-1.48	0.15
SUD treatment status	-0.22	1.25	-0.18	0.86
SUD stability	-0.95	1.62	-0.58	0.56
Unsuccessful closure – placement	0.67	0.76	0.88	0.38
Unsuccessful closure – dropped	0.42	0.81	0.52	0.61
Program tenure	0.00	0.00	-1.22	0.23
Family size	0.14	0.15	0.96	0.34
Parent age	-0.08	0.04	-1.91	0.06

AAPI Construct E: Children's Power and Independence

Construct E assesses the extent to which parents support a child's power and independence (i.e., valuing a child's ability to problem solve, encouraging a child to express their views). Higher scores indicate greater support for children's power and independence. On average, participants somewhat supported their children's power and independence.

Table 34. AAPI Construct E Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	52	5.69 (1-9)	32	4.78 (1-8)	20	5.15 (2-9)
Control Group	33	5.94 (2-9)	28	5.14 (1-9)	15	4.33 (1-10)
Total Sample	85	5.79 (1-9)	60	4.95 (1-9)	35	4.80 (1-10)

We found that Construct E scores decreased significantly over time (9-months: t = -2.87, p = 0.006;18-months: t = -2.72, p = 0.009). There were no significant differences between the intervention and control groups.

Figure 42. AAPI Construct E Scores

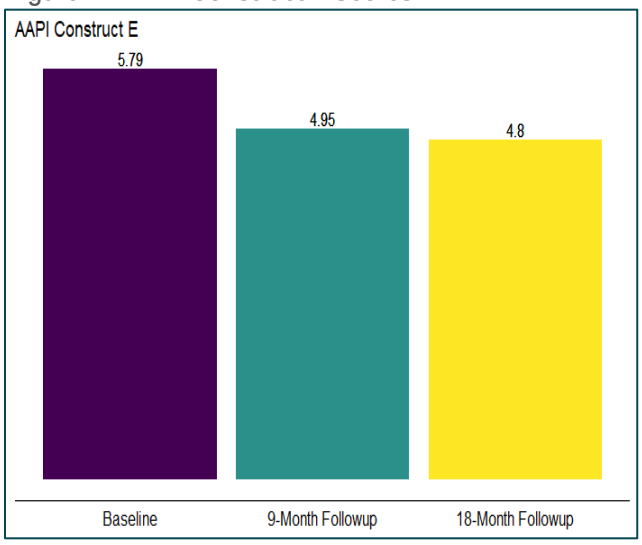
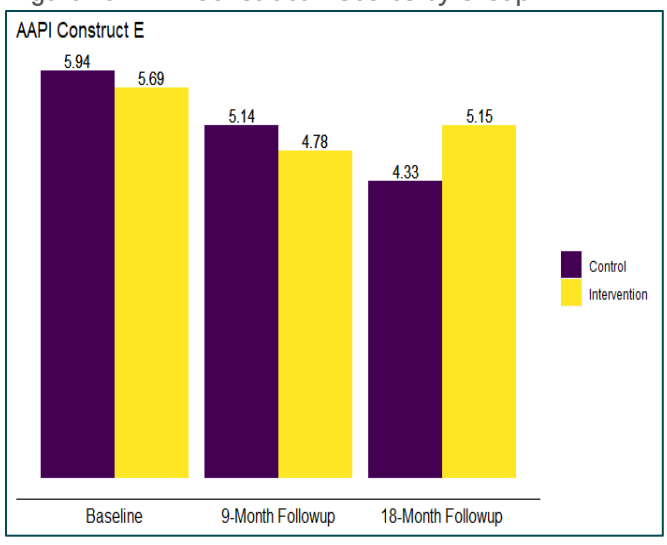


Figure 43. AAPI Construct E Scores by Group



We did not find any significant relationships between number of Intact worker contacts, SUD treatment status at program closure, SUD stability, closure status, program tenure, family size, or parent age and Construct E scores.

Table 35. Effects of Covariates on AAPI Construct E Scores

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.75	0.41	-2.87	0.006
18-month follow-up interview	-1.39	0.52	-2.72	0.009
Intervention group	-0.25	0.45	-0.55	0.58
Total # of Intact worker contacts	0.00	0.01	0.16	0.87
SUD treatment status	-0.58	1.21	-0.48	0.64
SUD stability	-0.95	1.56	-0.61	0.55
Unsuccessful closure – placement	-0.95	0.75	-1.27	0.21
Unsuccessful closure – dropped	-0.85	0.80	-1.07	0.29
Program tenure	0.00	0.00	-0.08	0.93
Family size	-0.17	0.19	-0.93	0.36
Parent age	-0.02	0.04	-0.42	0.67

STIGMA

Participants reported experiencing the following types of stigma related to their involvement with DCFS:

Social/public stigma: Fifty percent of participants reported experiencing negative comments and attitudes from family members, friends, neighbors, intimate partners, employers, colleagues, housemates, professionals (e.g., Intact workers, nurses, court staff), acquaintances (e.g., community members, foster parent, ex-partner's child's mother), the media (e.g., television), people on social media, and the general public. This stigma included negative comments (e.g., "someone told me that I don't deserve my child"), negative assumptions about their parenting (e.g., "they assume that I am a bad parent and not someone who just needs help"), distrust (e.g., "they won't let me watch their kids anymore"), avoidance (e.g., "my friends don't want to hang out with me anymore"), and gossip (e.g., "people talk about it behind my back").

Perceived stigma. Perceived stigma refers to an individual's beliefs about the negative attitudes that others may hold about families involved with DCFS and can lead to fear of stigmatization and anxiety about disclosing their DCFS status (Latalova, Kamaradova, & Prasko, 2014). Nineteen percent of participants reported perceived stigma and told AHP interviewers that they chose not to disclose that they were involved with DCFS out of fear of being judged by others (e.g., "I'm afraid to tell anyone because they will judge me"). Commonly reported fears included being judged by others as a bad, neglectful, or abusive parent.

Self-stigma. Self-stigma occurs when parents believe or internalize negative stereotypes about families involved with child welfare. Seven percent of participants reported feelings of shame or embarrassment because of their DCFS involvement. Others reported that they felt like a criminal because of their involvement with DCFS.

"Non-stigma": Positive social support. Some participants (8%) shared that they did not experience stigma but rather received positive social support from others because of their involvement with DCFS. These participants told us that their lives have significantly improved as a result of their involvement with DCFS.

PARTICIPANT STRENGTHS

We concluded each interview by asking participants to identify three personal strengths. Across all interview timepoints, the most frequently listed strengths included “good parent” and “hard worker.” At follow-up, participants also reported “resilience” and “optimism” as personal strengths. The word cloud below illustrates participants’ self-identified personal strengths. Phrases in larger text represent strengths more frequently shared by participants (e.g., “good parent”). Phrases in smaller text represent strengths shared by fewer participants (e.g., “adaptable”).

Child Outcomes

Participants' children also experienced improved outcomes. Notable outcomes, shown in the tables and charts in this section include the following:

- Child and adolescent behavior problems decreased over time for both the intervention and control groups. Although the control group's children experienced a greater decrease in behavior problems, at control group children had more behavior problems at baseline than intervention group children. .
- Due to insufficient sample size, results for the Traumatic Events Screening Inventory - Parent Report Revised (TESI-PRR) and the Infant Toddler Sensory Profile (ITSP) 0-6 months are not reported.

Child and Adolescent Disruptive Behavior Inventory (CADBI)

The CADBI assesses focal child problem behaviors that occurred in the past month. On average, participants reported low to moderate focal child problem behaviors.

Table 36. CADBI Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	29	45.69 (1-125)	25	41.88 (0-111)	19	32.68 (0-101)
Control Group	11	60.18 (21-104)	10	31.40 (2-89)	6	24.83 (1-43)
Total Sample	40	49.67 (1-125)	35	38.89 (0-111)	25	30.80 (0-101)

We found that child problem behaviors decreased significantly over time (9-months: t = -2.87, p = 0.006; 18-months: t = -2.72, p = 0.009). While CADBI scores decreased for both groups, control group scores had a greater decrease over time compared to the intervention group (t = 2.03, p = 0.05).

Figure 44. CADBI Scores

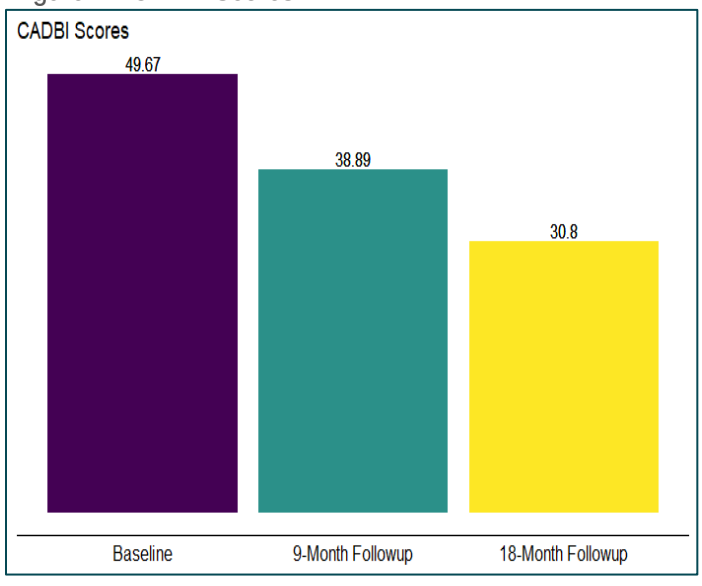
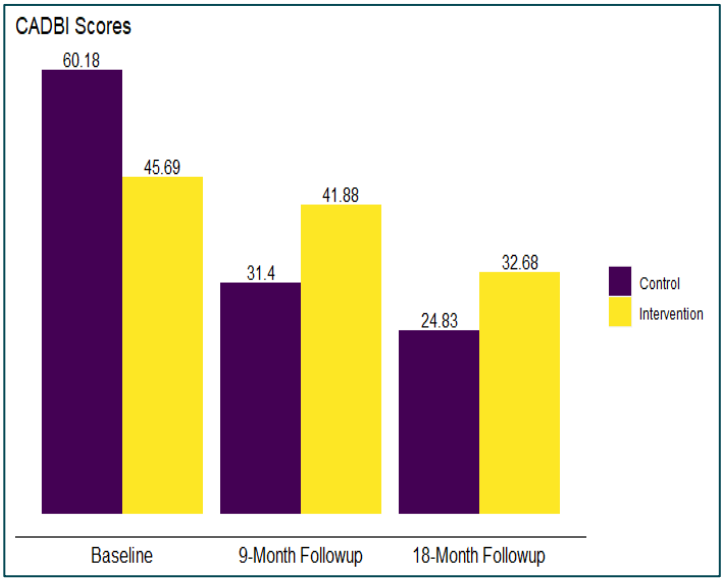


Figure 45. CADBI Scores by Group



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closing, SUD stability at closing, closure status, program tenure, family size, or parent age and CADBI scores.

Table 37. Effects of Covariates on CADBI Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-17.00	6.15	-2.87	0.006
18-month follow-up interview	-23.76	6.49	-2.72	0.009
Intervention group	23.21	11.46	2.03	0.05
Total # of Intact worker contacts	-0.15	0.25	-0.61	0.55
SUD treatment status	15.19	25.16	0.6	0.55
SUD stability	-7.94	16.94	-0.47	0.64
Unsuccessful closure- placement	22.72	13.47	1.69	0.10
Unsuccessful closure - dropped	11.34	10.86	1.04	0.31
Program tenure	0.02	0.08	0.21	0.84
Family size	4.04	3.94	1.02	0.31
Parent age	-0.07	0.83	-0.09	0.93

Pediatric Symptom Checklist-35 (PSC-35)

The PSC-35 assesses child cognitive, emotional, and behavioral problems. On average, participants reported that their focal child had few to moderate problem behaviors.

Table 38. PSC-35 Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	31	13.32 (1-41)	10	11.70 (0-21)	6	13.50 (0-21)
Control Group	12	16.83 (1-33)	25	13.04 (0-34)	20	12.20 (0-31)
Total Sample	43	14.3 (1-41)	35	12.66 (0-34)	26	12.50 (0-31)

We found that focal children experienced fewer behavioral and emotional problems at 9-month follow-up than at baseline (t = -2.57, p = 0.01). There were no significant differences between the intervention and control groups.

Figure 46. PSC-35 Scores

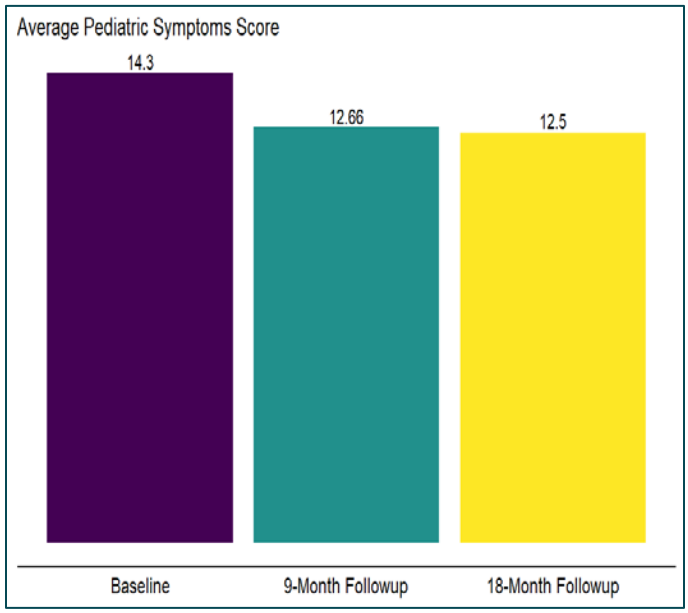
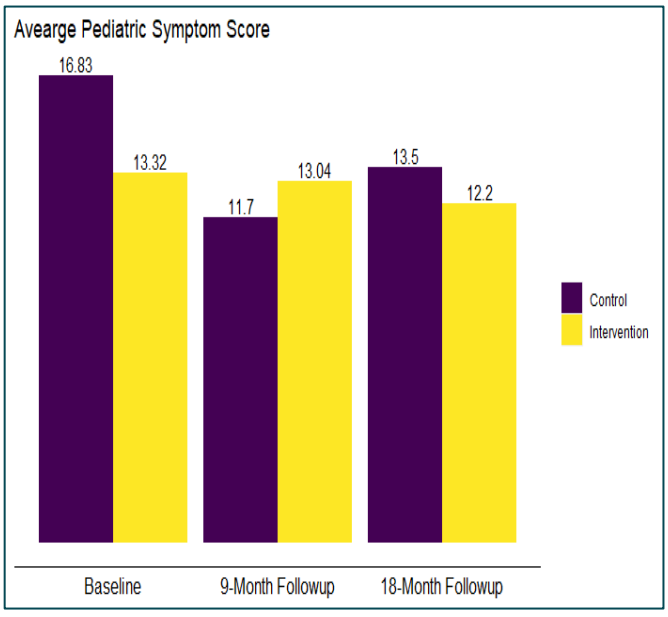


Figure 47. PSC-35 Scores by Group



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and PSC-35 scores.

Table 39. Effects of Covariates on PSC-35 Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-4.04	1.68	-2.57	0.01
18-month follow-up interview	-2.90	2.90	-1.00	0.32
Intervention group	-3.30	3.39	-0.97	0.34
Total # of Intact worker contacts	-0.03	0.08	-0.34	0.74
SUD treatment status	8.92	8.56	1.04	0.31
SUD stability	-0.49	5.79	-0.08	0.93
Unsuccessful closure – placement	8.23	4.46	1.85	0.08
Unsuccessful closure – dropped	5.36	3.60	1.49	0.15
Program tenure	0.01	0.03	0.47	0.64
Family size	0.55	1.22	0.45	0.65
Parent age	0.03	0.28	0.12	0.90

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire includes five subscales that assess child behavioral and emotional problems. Significant results emerged only for the prosocial behavior subscale.

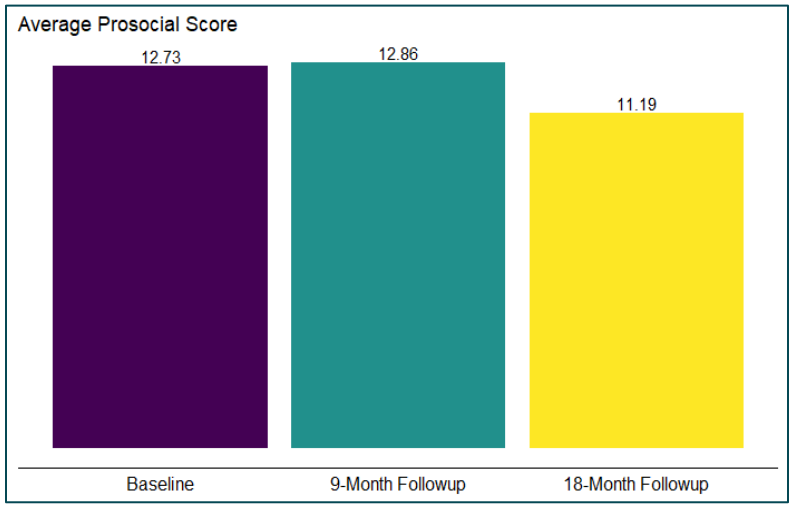
SDQ: Prosocial Behaviors

On average, participants rated their focal child high on prosocial behaviors, i.e., are kind to younger children, are helpful and considerate of others.

Table 40. SDQ Prosocial Behavior Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	13	12.46 (6-24)	11	14.27 (8-24)	6	12.17 (8-17)
Control Group	32	12.84 (7-24)	25	12.24 (9-24)	20	10.90 (7-12)
Total Sample	45	12.73 (6-24)	36	12.86 (8-24)	26	11.19 (7-17)

Figure 48. SDQ Prosocial Behavior Scores



While we didn't find any significant changes over time or differences between the intervention and control groups, we did find that participants who had successful closures were more likely to have children with higher baseline prosocial behavior scores than participants with unsuccessful closures due to child placement into foster care (t = -2.31, p = 0.03) or those who dropped out or withdrew from the program (t = -2.33, p = 0.03).

Figure 49. SDQ Prosocial Behavior Scores by Closure Status

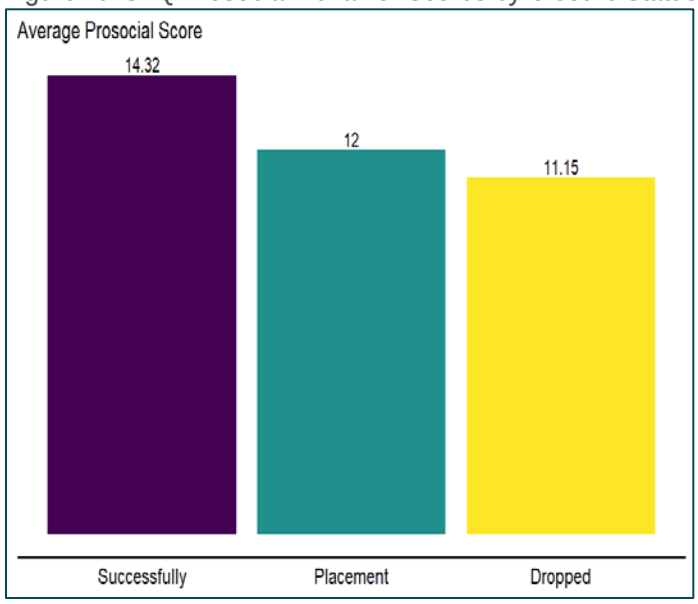
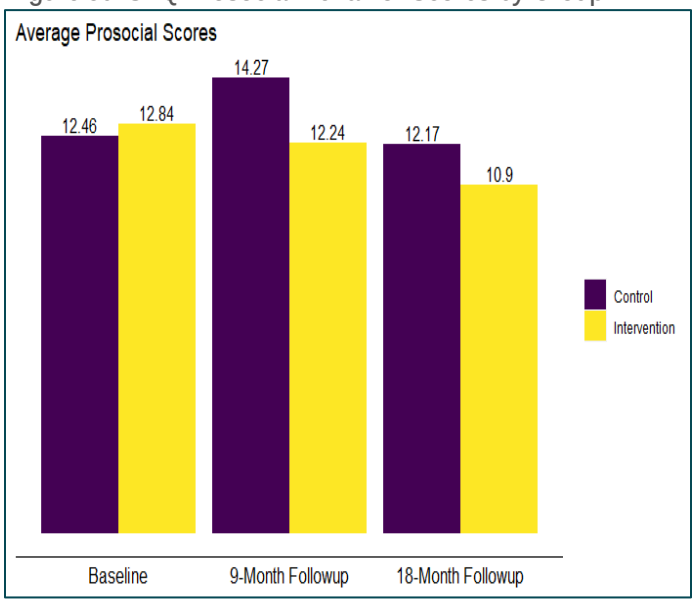


Figure 50. SDQ Prosocial Behavior Scores by Group



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, program tenure, family size, or parent age and SDQ Prosocial Behavior scores.

Table 41. Effects of Covariates on SDQ Prosocial Behavior Scores

Covariate	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	1.72	1.20	1.43	0.16
18-month follow-up interview	-0.48	1.51	-0.32	0.75
Intervention group	0.38	1.40	0.27	0.79
Total # of Intact worker contacts	-0.03	0.03	-1.06	0.30
SUD treatment status	-0.29	3.62	-0.08	0.94
SUD stability	-0.08	2.45	-0.03	0.97
Unsuccessful closure – placement	-2.87	3.91	-2.31	0.03
Unsuccessful closure – dropped	-2.85	2.63	-2.33	0.03
Program tenure	-0.01	0.01	-0.78	0.44
Family size	0.80	0.45	0.18	0.85
Parent age	-0.16	0.09	-1.71	0.10

SDQ Emotional Problems

The SDQ Emotional Problems subscale assesses children's emotional problems (i.e., feeling depressed or anxious). On average, focal children had moderate levels of emotional problems.

Table 42. SDQ Emotional Problems

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	13	9.53 (5-30)	11	9.36 (5-30)	6	7.53 (5-20)
Control Group	32	10.62 (5-30)	25	12.73 (5-30)	20	8.50 (5-13)
Total Sample	45	9.84 (5-30)	36	10.39 (5-30)	26	7.62 (5-20)

While emotional problems scores for intervention group focal children decreased from 9-month to 18-month follow-up, this change was not significant. We did not find any significant relationships between change over time, group assignment (intervention vs. control), number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and SDQ Emotional Problems scores.

Table 43. Effects of Covariates on SDQ Emotional Problems

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	1.66	1.61	1.03	0.30
18-month follow-up interview	-1.28	2.04	-0.63	0.53
Intervention group	-1.08	2.25	-0.48	0.63
Total # of Intact worker contacts	-0.02	0.05	-0.37	0.71
SUD treatment status	1.54	6.23	0.25	0.81
SUD stability	-0.23	4.22	-0.05	0.96
Unsuccessful closure - placement	-3.57	2.92	-1.22	0.23
Unsuccessful closure - dropped	-4.20	2.36	-1.78	0.09
Program tenure	-0.01	0.02	-0.70	0.49
Family size	-0.26	0.75	-0.34	0.73
Parent age	-0.21	0.17	-1.23	0.23

SDQ Conduct Problems

The SDQ Conduct Problems subscale assesses children's problem behaviors that include lying, stealing, and fighting. On average, participants' focal children had moderate levels of conduct problems.

Table 44. SDQ Conduct Problems Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	13	11.91 (6-30)	11	10.76 (5-26)	6	9.05 (6-19)
Control Group	32	12.08 (7-30)	25	14.18 (7-30)	20	10.17 (6-22)
Total Sample	45	11.96 (6-30)	36	11.81 (5-30)	26	9.31 (6-22)

Intervention group's focal children's conduct problems scores decreased over time. However, these changes were not significant. There was a trend for younger parents' focal children to have higher conduct problems scores, but these trends were not significant. We did not find any significant changes over time, or relationships between group assignment, the number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and SDQ Conduct Problems scores.

Table 45. Effects of Covariates on SDQ Conduct Problems

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	1.49	1.36	1.10	0.28
18-month follow-up interview	-1.35	1.73	-0.78	0.44
Intervention group	-0.17	2.06	-0.08	0.93
Total # of Intact worker contacts	-0.02	0.05	-0.40	0.69
SUD treatment status	1.38	5.77	0.24	0.81
SUD stability	0.8	3.91	0.21	0.84
Unsuccessful closure- placement	-4.19	2.75	-1.53	0.14

	Estimate	Standard Error	t-value	p-value
Unsuccessful closure – dropped	-4.78	2.22	-2.16	0.06
Program tenure	0.00	0.01	-0.27	0.79
Family size	0.32	0.70	0.46	0.65
Parent age	-0.39	0.16	-2.48	0.06

SDQ Hyperactivity

The SDQ Hyperactivity subscale assesses children's hyperactive behaviors (e.g., restless, constantly fidgeting, easily distracted). Focal children had, on average, moderate levels of hyperactivity.

Table 46. SDQ Hyperactivity Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	13	12.53 (8-30)	11	11.60 (8-18)	6	9.95 (7-13)
Control Group	32	13.31 (9-30)	25	14.36 (8-30)	20	10.00 (7-13)
Total Sample	45	12.76 (8-30)	36	12.44 (8-30)	26	9.96 (7-13)

Focal children's hyperactivity scores decreased over time; however, this change was not significant. We did not find any significant change over time, or significant relationships between group assignment, number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age on SDQ Hyperactivity scores.

Table 47. Effects of Covariates on SDQ Hyperactivity

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	0.84	1.45	0.58	0.56
18-month follow-up interview	-2.98	1.82	-1.64	0.12
Intervention group	-0.78	1.50	-0.52	0.61
Total # of Intact worker contacts	0.05	0.07	0.66	0.52
SUD treatment status	-0.04	3.77	-0.01	0.99
SUD stability	-0.9	2.53	-0.36	0.72
Unsuccessful closure - placement	-3.49	2.10	-1.66	0.12
Unsuccessful closure - dropped	-1.90	2.20	-0.86	0.40
Program tenure	-0.01	0.01	-0.95	0.35
Family size	-0.52	0.53	-0.99	0.33
Parent age	-0.13	0.10	-1.23	0.23

SDQ Peer Problems

The SDQ Peer Problems subscale measures children's problems getting along with their peers (e.g., is bullied by other children, tends to play alone). On average, focal children had moderate levels of peer problems.

Table 48. SDQ Peer Problems

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	13	12.94 (8-30)	11	12.48 (7-27)	6	10.25 (6-21)
Control Group	32	12.94 (8-30)	25	15.36 (9-30)	20	9.67 (7-21)
Total Sample	45	12.93 (8-30)	36	13.36 (7-30)	26	10.12 (6-21)

Control group focal children had a significant increase in peer problem behaviors from baseline to 9-month follow-up, and a significant decrease from 9-month follow-up to 18-month follow-up. These changes, however, were not significant. We did not find any significant change over time, or significant relationships between group assignment, number of Intact worker contacts. SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and SDQ Peer Problems scores.

Table 49. Effects of Covariates on SDQ Peer Problems

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	2.15	1.66	1.30	0.20
18-month follow-up interview	-2.84	2.09	-1.36	0.18
Intervention group	0.01	1.95	0.01	0.99
Total IW Contacts	-0.04	0.04	-0.92	0.37
SUD treatment status	-1.42	4.75	-0.3	0.77
SUD stability	0.04	3.19	0.01	0.99
Unsuccessful closure - placement	-4.00	2.19	-1.83	0.08
Unsuccessful closure – dropped	-4.61	1.75	-2.63	0.06
Program tenure	-0.01	0.01	-0.45	0.66
Family size	-0.44	0.65	-0.67	0.51
Parent age	-0.12	0.13	-0.92	0.37

Child Behavior Checklist (CBCL)

The CBCL assesses emotional, behavioral, and social problems in children ages 4 and older. We present results for three risk indicators: internalizing (emotional) problems, externalizing (behavioral) problems and total emotional, behavioral, and social problems.

CBCL Internalizing Scale Scores

The CBCL Internalizing Scale assesses children's emotional problems. Higher scores indicate a greater number and frequency of emotional problems. On average, focal children had few emotional problems.

Table 50. CBCL Internalizing Scale Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	24	8.29 (0-28)	12	9.50 (0-49)	11	6.18 (1-22)
Control Group	14	10.07 (0-26)	13	8.92 (1-23)	5	14.60 (3-42)
Total Sample	38	8.95 (0-28)	25	9.20 (0-49)	16	8.81 (1-42)

There were no significant changes in CBCL Internalizing Scale scores over time, and no differences between the intervention and control groups.

Figure 51. CBCL Internalizing Scale Scores

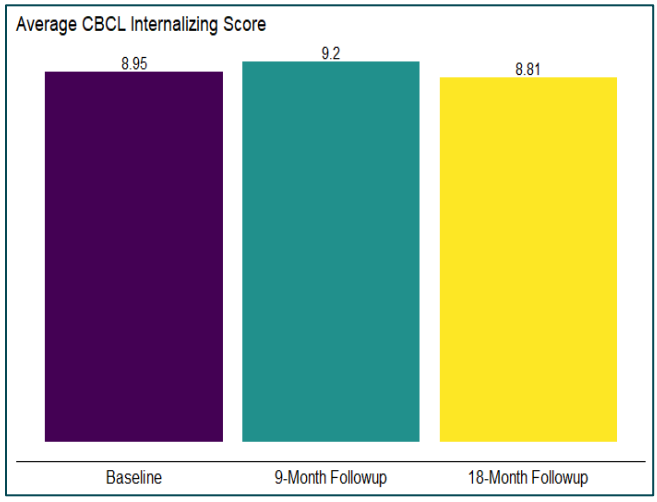
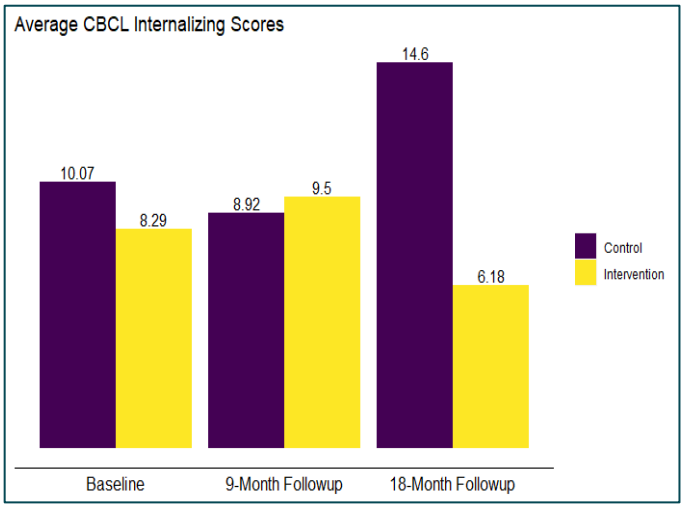
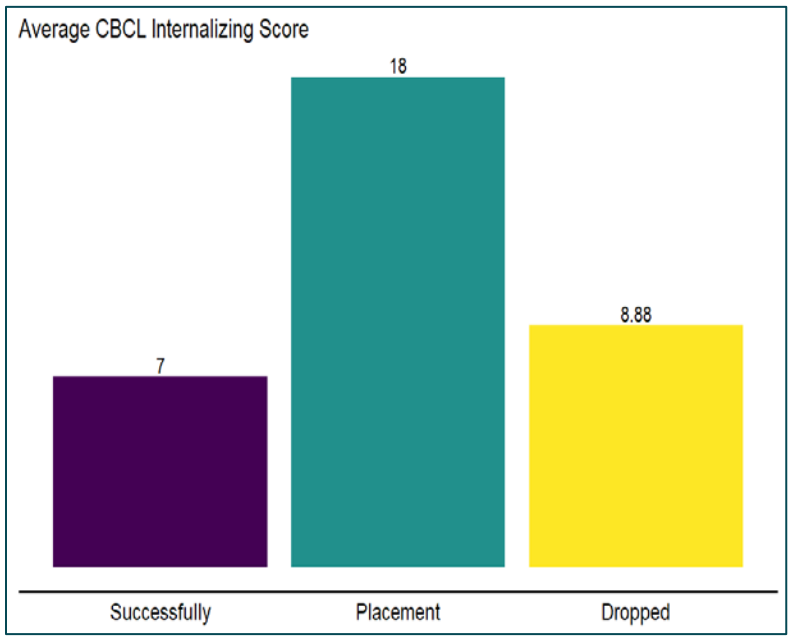


Figure 52. CBCL Internalizing Scale Scores by Group



However, participants who were closed due to placement were more likely to have focal children who had higher baseline internalizing scores at baseline than participants who had successful program closures (t = 2.23, p = 0.04).

Figure 53. CBCL Internalizing Scale Scores by Closure Status



We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at program closure, SUD stability, program tenure, family size, or parent age and CBCL Internalizing Scale scores.

Table 51. Effects of Covariates on CBCL Internalizing Scale Scores

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.73	2.57	-0.29	0.78
18-month follow-up interview	6.61	3.83	1.73	0.10
Intervention group	-1.80	3.01	-0.60	0.55
Total # of Intact worker contacts	0.02	0.10	0.22	0.83
SUD treatment status	15.66	11.73	1.34	0.21

	Estimate	Standard Error	t-value	p-value
SUD stability	7.04	18.78	0.37	0.72
Unsuccessful closure – placement	11.68	5.90	2.23	0.04
Unsuccessful closure – dropped	5.17	3.97	1.30	0.21
Program tenure	0.03	0.02	1.52	0.15
Family size	-0.95	1.41	-0.67	0.51
Parent age	0.68	0.45	1.50	0.15

CBCL Externalizing Scale Scores

Higher scores on this CBCL scale indicate a greater number and frequency of child behavioral problems. On average, focal children had low to moderate levels of behavioral problems.

Table 52. CBCL Externalizing Scale Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	24	15.62 (0-34)	12	17.42 (3-40)	11	13.91 (2-35)
Control Group	14	14.79 (0-29)	13	13.77 (1-29)	5	15.76 (2-42)
Total Sample	38	15.32 (0-34)	25	15.52 (1-40)	16	14.69 (2-42)

We did not find any significant changes over time in CBCL Externalizing Scale scores or differences between the intervention and control groups.

Figure 54. CBCL Externalizing Scale Scores

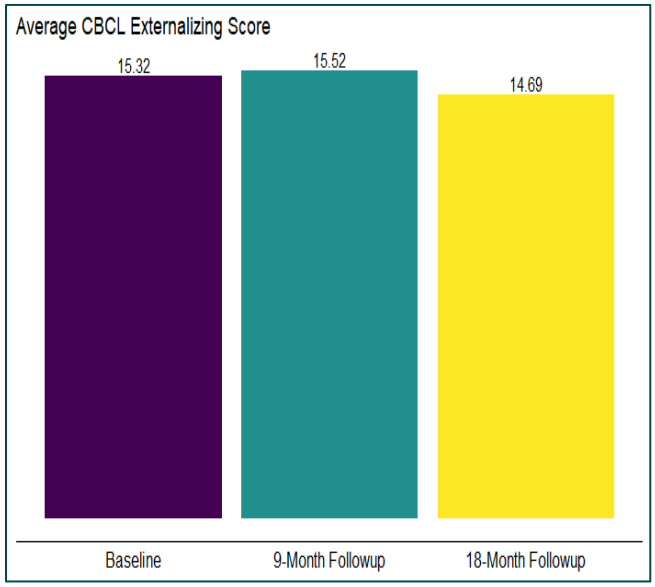


Figure 55. CBCL Externalizing Scale Scores by Group

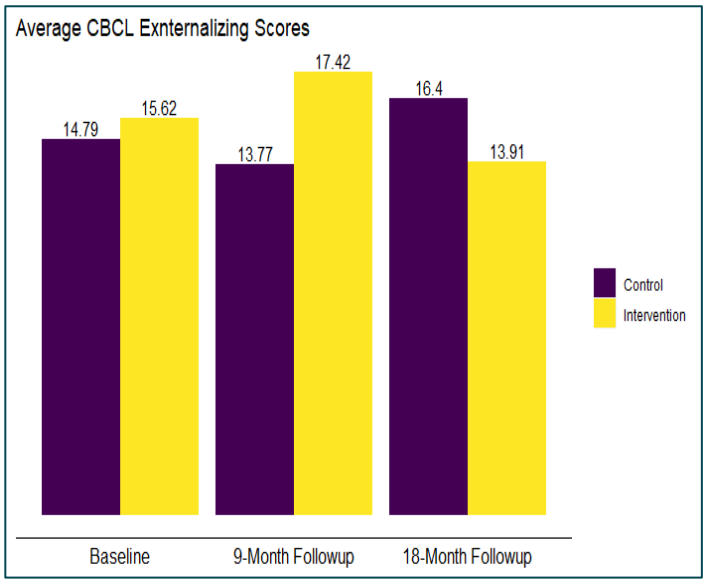
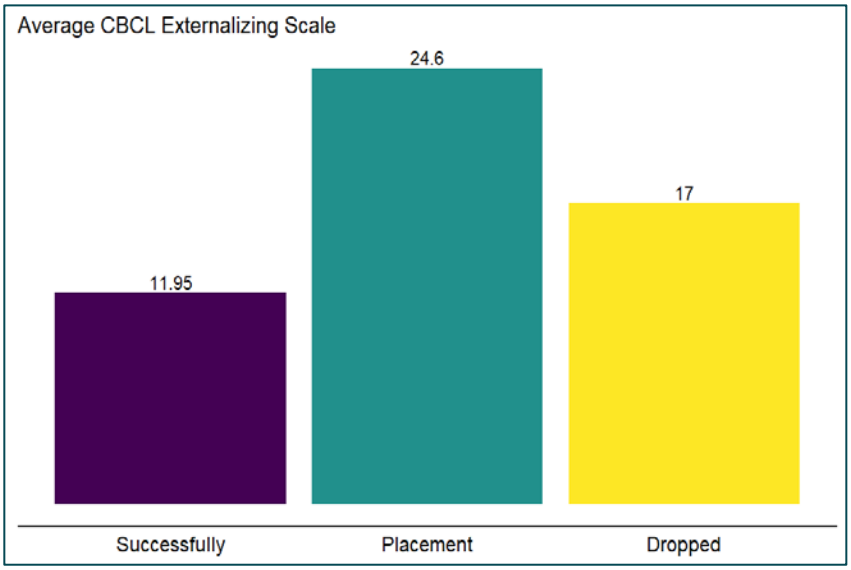


Figure 56. CBCL Externalizing Scores by Closure Status



We found that the focal children of participants who had unsuccessful closures due to placement and the focal children of participants who dropped out of the program had higher externalizing scores at baseline (t = 2.31, p = 0.03; t = 2.46, = 0.02) compared to the focal children of participants who had successful program closures.

We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status, SUD stability, program tenure, family size, or parent age on CBCL Externalizing Scale scores.

Table 53. Effects of Covariates on CBCL Externalizing Scale Scores

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-0.43	2.66	-0.16	0.87
18-month follow-up interview	3.26	4.02	0.81	0.43
Intervention group	0.74	3.40	0.22	0.83
Total # of Intact worker contacts	0.15	0.12	1.28	0.22
SUD treatment status	3.74	10.84	0.34	0.74
SUD stability	5.11	17.84	0.29	0.78
Unsuccessful closure – placement	8.82	15.89	2.31	0.03
Unsuccessful closure – dropped	9.37	17.12	2.46	0.02
Program tenure	0.03	0.03	0.99	0.33
Family size	-1.18	1.95	-0.60	0.56
Parent age	0.12	0.62	0.19	0.85

CBCL Total Problems Scores

Higher CBCL Total Problems scores indicate a greater number and frequency of child emotional, behavioral, and social problems. On average, participants' focal children had low CBCL Total Problems scores.

Table 54. CBCL Total Problems Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range)	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	24	36.58 (4-85)	12	42.58 (5-134)	11	30.73 (6-70)
Control Group	14	39.21 (3-79)	13	33.15 (4-82)	5	49.4 (8-128)
Total Sample	38	37.55 (3-85)	25	37.68 (4-134)	16	36.56 (6-128)

There were no significant changes over time in CBCL Total Problems scores. Control group participants' focal children had higher CBCL Total Problems scores at baseline and 18-month follow-up; however, these differences were not significant.

Figure 57. CBCL Total Problems Scores

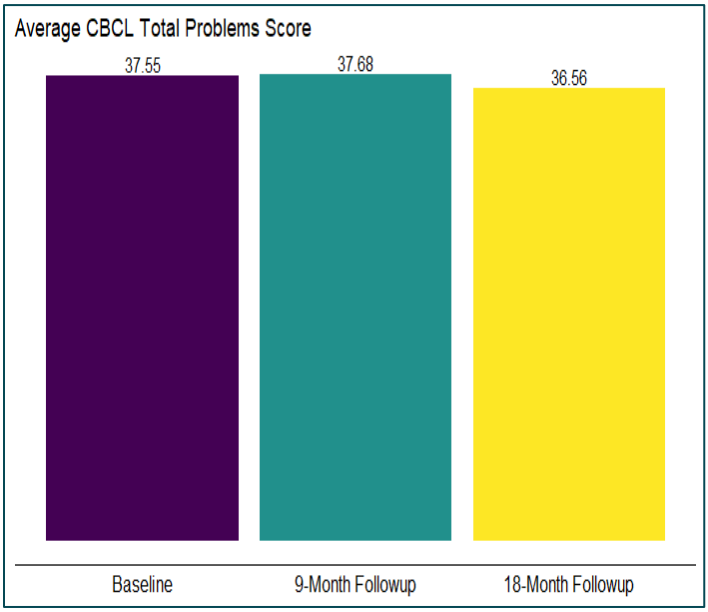


Figure 58. CBCL Total Problems Scores by Group

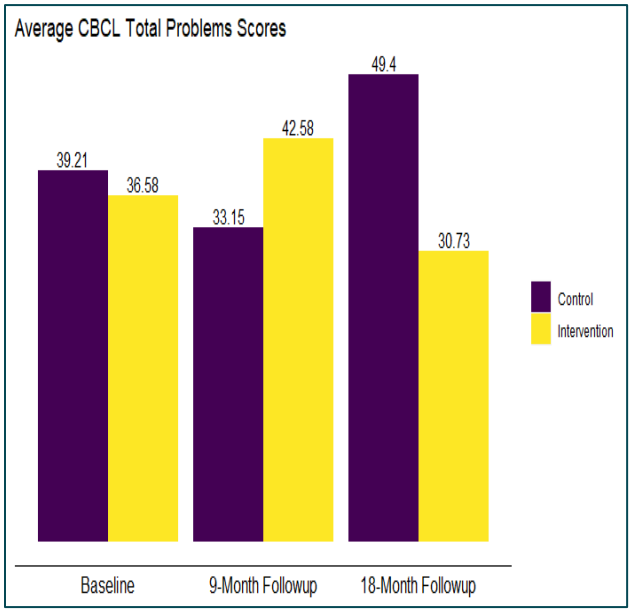
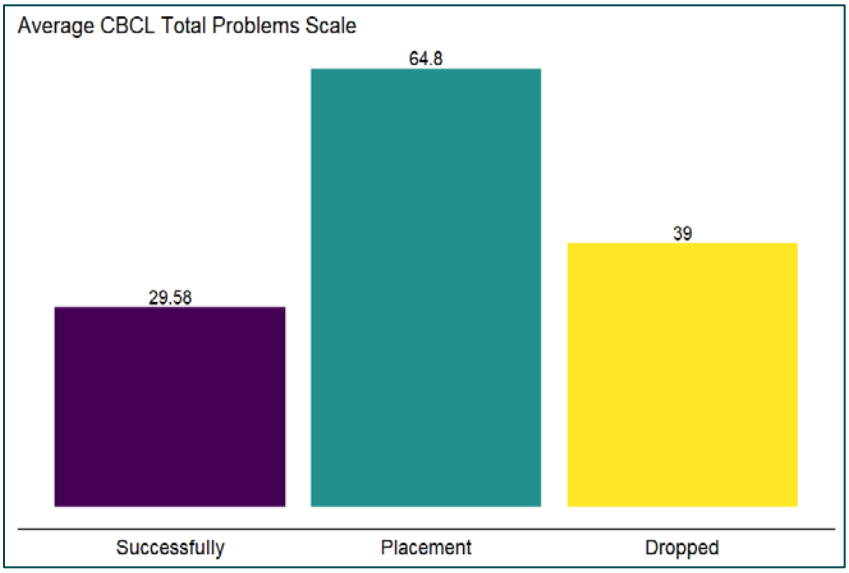


Figure 59. CBCL Total Problems Scores by Closure Status



Focal children of participants who were closed due to placement had higher baseline CBCL Total Problem scores (t = 2.33, p = 0.03) compared to focal children of participants who had successful program closures.

We did not find any significant relationships between the number of Intact worker contacts, SUD treatment status at closure, SUD stability, program tenure, family size, or parent age and CBCL Total Problems scores.

Table 55. Effects of Covariates on CBLC Total Problems

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	-3.88	6.83	-0.57	0.57
18-month follow-up interview	16.91	10.34	1.63	0.11
Intervention group	-2.41	8.87	-0.27	0.79

	Estimate	Standard Error	t-value	p-value
Total # of Intact worker contacts	0.22	0.31	0.71	0.48
SUD treatment status	36.89	30.28	1.22	0.25
SUD stability	12.2	49.05	0.25	0.81
Unsuccessful closure – placement	15.12	43.64	2.33	0.03
Unsuccessful closure – dropped	5.91	51.84	0.11	0.91
Program tenure	0.09	0.07	1.33	0.20
Family size	-3.73	4.89	-0.76	0.46
Parent age	1.18	1.56	0.75	0.46

Infant Toddler Sensory Profile (ITSP) 7 to 36 Months

This assessment measures sensory processing for focal children ages 7 to 36 months. Low scores represent high levels of responsiveness to stimuli, and high scores represent low levels of responsiveness to stimuli. There were no significant results for any of the five ITSP subscales.

ITSP Low Registration

The ITSP Low Registration scale measures children's awareness of all types of sensation (e.g., "My child seems to be unaware of wet or dirty diapers"). On average, participants' focal children who were aged 7 to 36 months had moderate to low awareness of sensations.

Table 56. ITSP Low Registration Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	12	49.31 (44-55)	10	50.00 (38-55)	6	53.33 (51-55)
Control Group	5	45.25 (40-55)	6	49.17 (45-55)	5	44.00 (41-48)
Total Sample	17	48.35 (40-55)	16	49.69 (38-55)	11	48.67 (41-55)

We did not find any significant changes over time, or significant relationships between group assignment (intervention vs. control), the number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and ITSP Low Registration scores.

Table 57. Effects of Covariates on ITSP Low Registration Scores

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	3.91	2.48	1.57	0.15
18-month follow-up interview	-1.02	2.93	-0.35	0.74
Intervention group	4.23	2.47	1.71	0.10
Total # of Intact worker contacts	-0.08	0.11	-0.73	0.50
SUD treatment status	0.97	3.14	0.31	0.76
SUD stability	-0.11	4.22	-0.03	0.97
Unsuccessful closure – placement	3.68	4.94	0.74	0.49
Unsuccessful closure – dropped	6.59	3.23	2.04	0.10
Program tenure	-0.03	0.02	-1.71	0.23
Family size	-0.23	2.20	-0.10	0.93
Parent age	-0.16	0.29	-0.55	0.64

ITSP Sensation Seeking

The ITSP Sensation Seeking scale measures children's interest in, and the pleasure they get, from all types of sensation (e.g., "My child enjoys looking at their own reflection in the mirror"). On average, participants' focal children who were aged 7 to 36 months had moderate to high sensation seeking scores.

Table 58. ITSP Sensation Seeking Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	12	30.77 (22-48)	10	30.77 (22-48)	6	42.00 (26-52)
Control Group	5	20.5 (14-28)	6	23.17 (14-34)	5	32.00 (24-42)
Total Sample	17	28.35 (14-48)	16	28.38 (14-51)	11	37.00 (14-51)

We did not find any significant changes over time, or significant relationships with group assignment (intervention vs. control), number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age on ITSP Sensation Seeking scores.

Table 59. Effects of Covariates on ITSP Sensation Seeking

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	6.42	1.49	4.32	0.14
18-month follow-up interview	-0.84	2.10	-0.40	0.76
Intervention group	15.44	8.93	1.73	0.14
Total # of Intact worker contacts	-0.36	0.28	-1.29	0.25
SUD treatment status*	-	-	-	-
SUD stability	-9.42	12.36	-0.76	0.48
Unsuccessful closure – placement	33.09	10.46	3.16	0.06
Unsuccessful closure – dropped	0.04	9.90	0.00	1.00
Program tenure	0.06	0.04	1.51	0.19
Family size	3.40	1.64	2.07	0.09
Parent age	0.12	0.69	0.18	0.87

*Cell/sample size insufficient to generate results.

ITSP Sensation Sensitivity

The ITSP Sensation Sensitivity scale measures children's ability to notice all types of sensation (e.g., "My child is distracted and/or has difficulty eating in noisy environments"). On average, participants' focal children who were aged 7 to 36 months had moderate ability to notice all types of sensation.

Table 60. ITSP Sensation Sensitivity Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	12	48.77 (42-53)	10	50.30 (44-55)	6	48.00 (45-51)
Control Group	5	46.25 (32-55)	6	47.17 (42-52)	5	41.33 (40-43)
Total Sample	17	48.18 (32-55)	16	49.13 (42-55)	11	44.67 (40-51)

We did not find any significant changes over time, or significant relationships with group assignment (intervention vs. control), the number of Intact worker contacts, SUD treatment status at closing, SUD stability at closing, closure status, program tenure, family size, or parent age and ITSP Sensation Sensitivity scores.

Table 61. Effects of Covariates on ITSP Sensation Sensitivity

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	0.90	2.64	0.34	0.74
18-month follow-up interview	-4.50	3.12	-1.44	0.18
Intervention group	2.27	2.48	0.91	0.37
Total # of Intact worker contacts	-0.14	0.12	-1.19	0.29
SUD treatment status	1.10	1.86	0.59	0.57
SUD stability	3.50	3.75	0.93	0.37
Unsuccessful closure – placement	1.76	5.07	0.35	0.74
Unsuccessful closure – dropped	1.83	3.33	0.55	0.61
Program tenure	0.01	0.02	0.58	0.62
Family size	1.29	2.41	0.54	0.65
Parent age	-0.72	0.31	-2.30	0.15

ITSP Sensation Avoiding

The ITSP Sensation Avoiding scale measures children's need to control the amount and types of sensations in their environment at any time (e.g., "My child avoids getting their face/nose wiped"). On average, participants' focal children who were aged 7 to 36 months had moderate to high levels of sensation avoiding.

Table 62. ITSP Sensation Avoiding Score

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	12	51.77 (38-60)	10	55.60 (51-59)	6	54.33 (49-58)
Control Group	5	49.75 (42-58)	6	51.00 (41-57)	5	42.67 (38-48)
Total Sample	17	51.29 (38-60)	16	53.88 (41-59)	11	48.50 (38-58)

We did not find any significant changes over time, or significant relationships between group assignment (intervention vs. control), number of Intact worker contacts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age and ITSP Sensation Avoiding scores.

Table 63. Effects of Covariates on ITSP Sensation Avoiding

	Estimate	Standard Error	t-value	p-value
9-month follow-up	1.79	3.19	0.56	0.59
18-month follow-up	-6.73	3.77	-1.78	0.10
Intervention group	2.18	3.06	0.71	0.48
Total # of Intact worker contacts	-0.18	0.18	-1.03	0.35
SUD treatment status	1.70	3.20	0.53	0.61
SUD stability	1.50	5.15	0.29	0.79
Unsuccessful closure – placement	-3.99	7.79	-0.51	0.63
Unsuccessful closure – dropped	1.44	5.20	0.28	0.79
Program tenure	-0.03	0.03	-0.88	0.47
Family size	4.97	5.00	0.99	0.42
Parent age	-0.22	0.64	-0.34	0.76

ITSP Low Threshold

The ITSP Low Threshold score is an aggregate of the Sensory Sensitivity and the Sensation Avoiding scales and represents low neurological thresholds in children who use both active and passive self-regulation strategies. Children who have low threshold conditions tend to be fussy and require a great deal of structure. On average, participants' focal children who were aged 7 to 36 months had high low threshold conditions.

Table 64. ITSP Low Threshold Scores

	Baseline		9-Month Follow-Up		18-Month Follow-Up	
	N	Mean Score (Range	N	Mean Score (Range)	N	Mean Score (Range)
Intervention Group	12	100.54 (80-113)	10	105.90 (96-112)	6	102.33 (94-109)
Control Group	5	96.00 (74-112)	6	98.17 (83-106)	5	84.00(79-91)
Total Sample	17	99.47 (74-113)	16	103.00 (83-113)	11	93.17 (79-109)

We did not find any significant changes over time, or significant relationships between group assignment, number of Intact worker contracts, SUD treatment status, SUD stability, closure status, program tenure, family size, or parent age on ITSP Low Threshold scores.

Table 65. Effects of Covariates on ITSP Low Thresholds

	Estimate	Standard Error	t-value	p-value
9-month follow-up interview	2.72	5.25	0.52	0.62
18-month follow-up interview	-11.05	6.21	-1.78	0.11
Intervention group	4.39	5.09	0.86	0.40
Total # of Intact worker contacts	-0.32	0.27	-1.20	0.28
SUD treatment status	2.45	4.35	0.56	0.59
SUD stability	5.00	7.97	0.62	0.54
Unsuccessful closure – placement	-2.18	11.75	-0.19	0.86
Unsuccessful closure – dropped	3.37	7.72	0.44	0.68
Program tenure	-0.02	0.05	-0.47	0.68
Family size	6.25	6.73	0.93	0.45
Parent age	-0.95	0.87	-1.09	0.39

IL IFR Program Participation, Program Closure, SUD Treatment and Services

The following section describes IL IFR program participation, program closure, SUD treatment outcomes, and the services IL IFR participants received. Key findings include the following:

- Overall, most cases closed successfully, with longer program tenures associated with successful program closures. Intervention group participants who had successful closures had longer program tenures and a greater number of Intact worker contacts than comparison group participants who had successful closures.
- There were no significant differences between the intervention and control group in SUD treatment completion or SUD stability at program closure.
- The intervention group had a greater number of contacts with Intact workers, received more services including SUD specific services, and had longer Intact worker visits. The control group received more mental health services.

IL IFR PROGRAM PARTICIPATION

As shown in Table 66, a total of 2,324 service logs documenting Intact worker and recovery coordinator visits with evaluation participants were submitted. The majority of these service logs (68%) documented visits with intervention group participants. Slightly more than half (51%) of intervention group visits were joint visits with the Intact worker and recovery coordinator. Case management services were provided at 95% of visits; for recovery coordinators, this included substance use treatment case management services. Participants' program tenure ranged from 24-764 days.

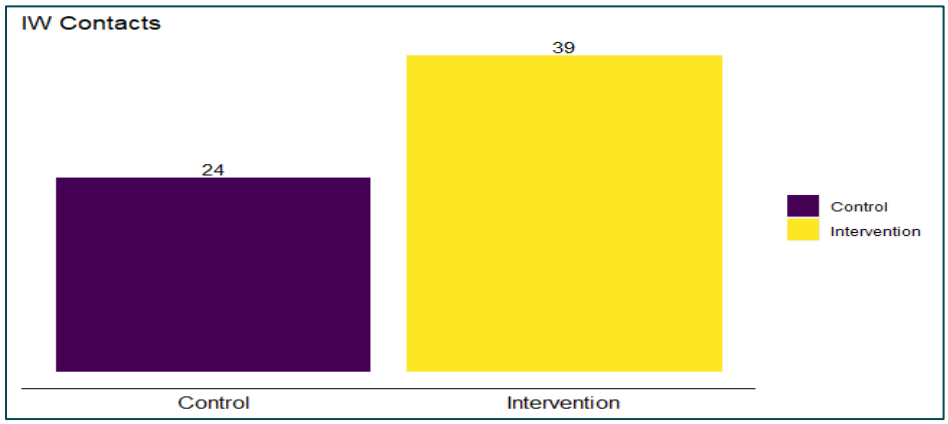
Table 66. IL IFR Services and Program Tenure

	Intervention Group	Comparison Group	Total Sample
Total service logs submitted	1,581	743	2,324
Number of Intact worker visits	510	743	1,253
Number of recovery coordinator visits (intervention group only)	271	--	271
Number of joint visits with recovery coordinator and Intact worker (intervention group only)	800	--	800
Total number of service logs by service type			
Case management	1,510	710	2,220
Court/legal	38	18	56
Screening/assessment	14	15	29
Transportation	19	0	19
Referrals	149	33	182
Average program tenure - Days (range)	271 (24-704) days	267 (42 -764) days	269 (24-764) days
Average # service contacts with Intact workers and/or recovery coordinators per participant (range)	31 (2-95)	23 (3-62)	28 (2-95)
Average # of services received (range)	129 (6-483)	62 (12-183)	104 (6-483)
SUD treatment services	26 (0-85)	15 (0-47)	22 (0-85)
Mental health services	5 (0-28)	8 (0-41)	7 (0-41)

*Service logs document all services provided during a visit; therefore, the number of services documented in this table exceed the total number of logs submitted.

We found that the intervention group experienced significantly more contacts with Intact workers than the control group ($t = 5.04$, $p < 0.001$). Intervention group participants received, on average, 39 contacts or visits from Intact workers; comparison group participants received an average of 24 visits.

Figure 60. Average Number of Intact Worker Contacts by Group



We found that the intervention group was more likely to have received, on average, a greater number of services than the comparison group (t = 2.42, p = 0.02). The intervention group was more likely to have received a greater number of SUD treatment services than the control group (t = 2.79, p = 0.006). We did not find any significant differences between the intervention and comparison group in receipt of mental health services (t = -1.88, p = 0.06).

Figure 61. Total Services Received

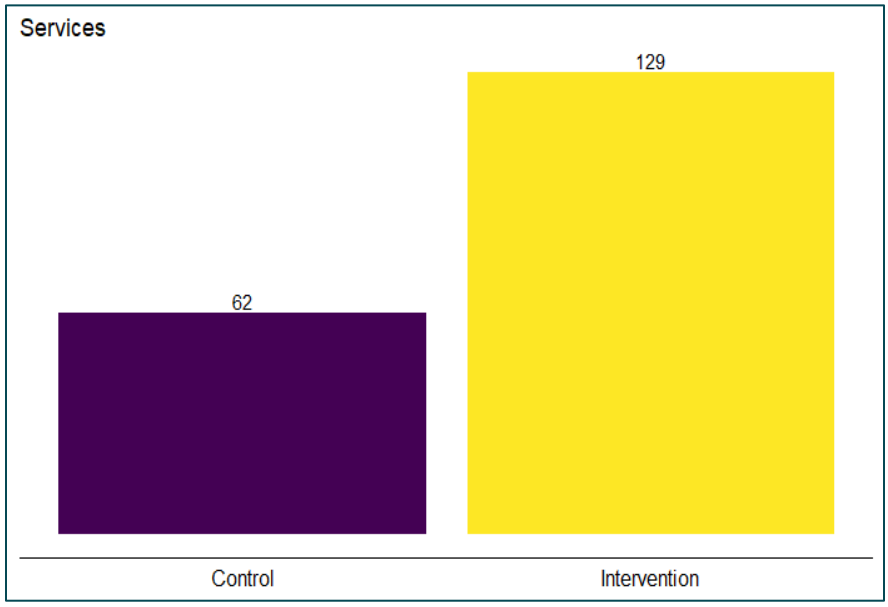


Figure 62. SUD Treatment Services Received

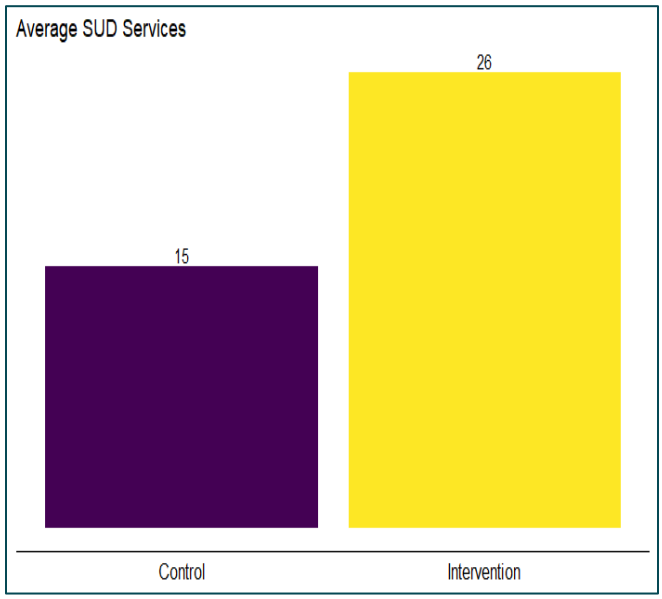


Figure 63. Mental Health Services Received

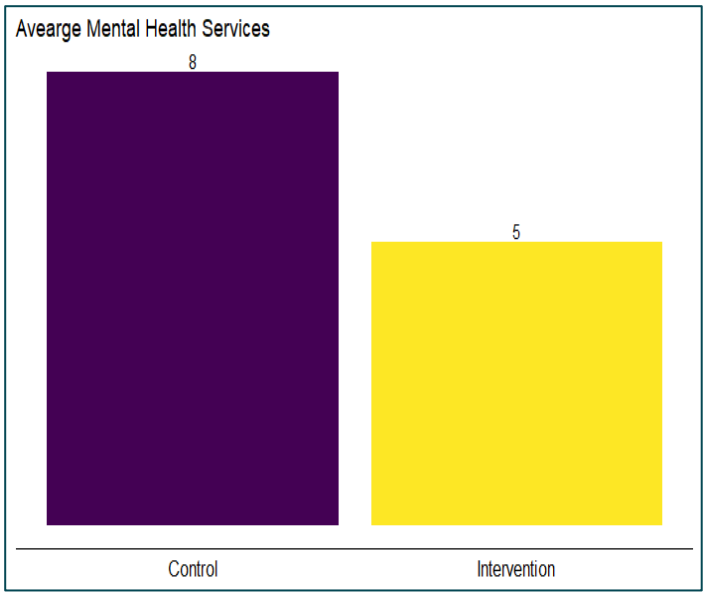
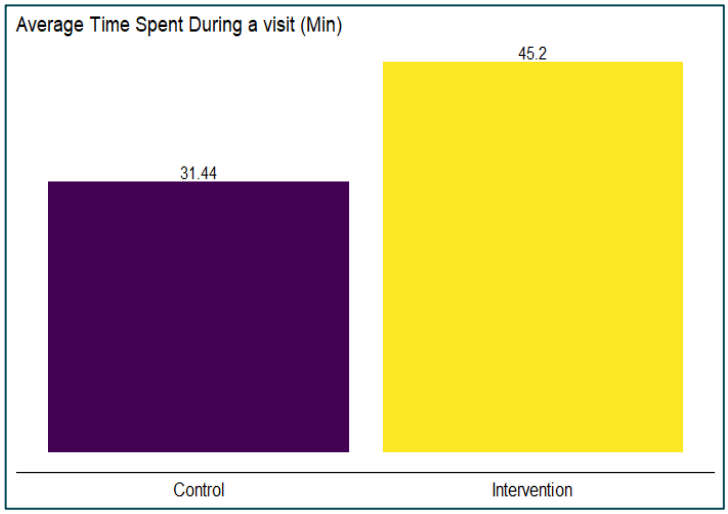


Figure 64. Average Intact Worker Visit (Minutes)



The intervention group had longer Intact worker visits compared to control group participants ($t = 5.16$, $p < 0.001$). Visits with intervention group participants averaged 45 minutes per visit; visits with comparison group participants averaged 31 minutes per visit. Overall, the intervention group had more contact with their Intact workers, received more services, more SUD treatment services, and longer visits. Comparison group participants received more mental health services.

IL IFR PROGRAM CLOSURES

More than half of all IL IFR program participants (54%) had successful program closures. A greater percentage of control group participants (67%) than intervention group participants (40%) had successful closures.

Table 67. IFR Program Closure

	Intervention Group N (%)	Comparison Group N (%)	Total Sample N (%)
Closure Status			
Successful closure	70 (40%)	113 (67%)	183 (54%)
Unsuccessful - placement	40 (23%)	33 (20%)	73 (21%)
Unsuccessful - dropped	63 (36%)	22 (13%)	85 (25%)

Figure 65. Closure Status by Group

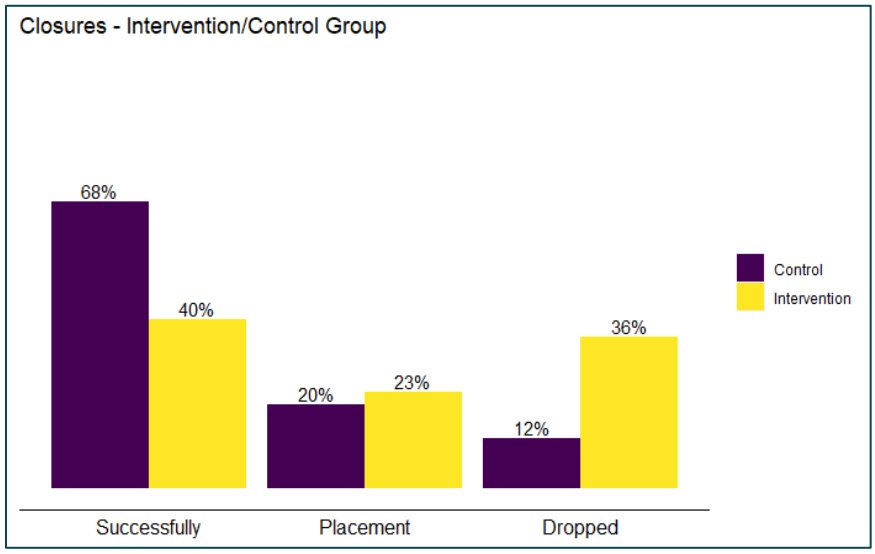
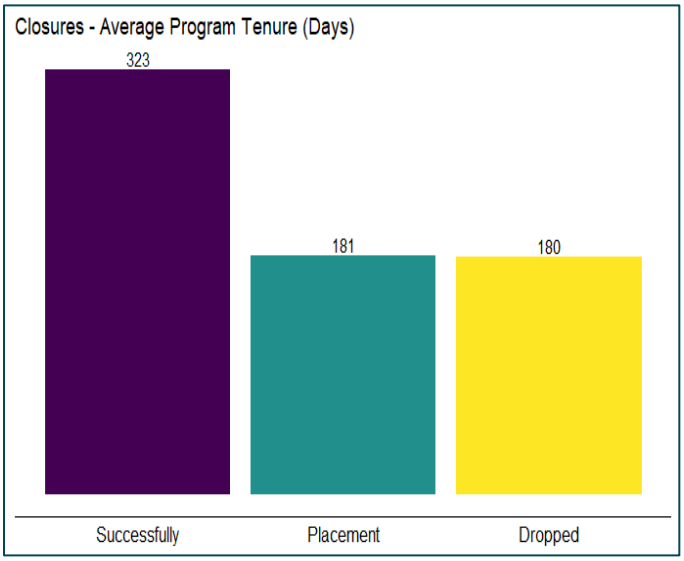


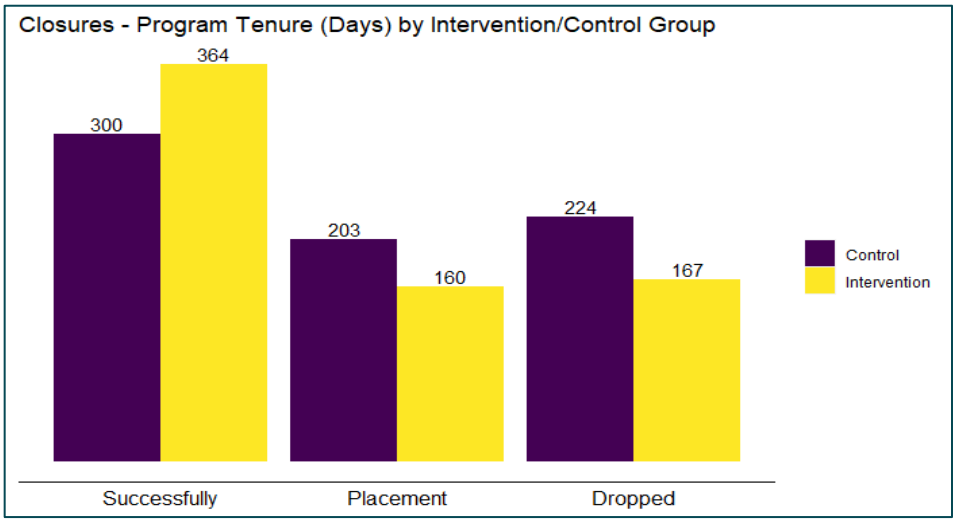
Figure 66. Closure Status by Program Tenure



For both groups, participants with longer program tenures were more likely to have successful closures compared to unsuccessful closure due to placement ($t = -3.93$, $p < 0.001$) or being dropped or withdrawn from the program ($t = -3.22$, $p < 0.001$).

While the control group had more successful case closures compared to cases closed due to placement ($z = 2.35$, $p = 0.02$) or being dropped ($z = 5.33$, $p < 0.001$), factors such as length of stay in the program and Intact worker visits played a key role in the differences between the intervention and control groups. Intervention group participants had longer program tenures, and those with longer program tenures were more likely to have successful closures.

Figure 67. Closure Status by Program Tenure by Group



Intervention group participants who had a greater number of Intact worker contacts were more likely to have closed successfully ($t = 3.74$, $p < 0.001$). There were no significant relationships with family size or parent age on closure status.

Table 68. Effect of Covariates on IL IFR Program Closure Status

Covariate	Estimate	Standard Error	t-value	p-value
Effect of program tenure on unsuccessful closure – placement	-134.95	34.36	-3.92	<0.001
Effect of program tenure on unsuccessful closure – dropped	-104.82	35.57	-3.22	< 0.001
Effect of intervention group on unsuccessful closure – placement	-0.32	2.24	-2.35	0.02
Effect of intervention group on unsuccessful closure – dropped	0.86	2.56	5.33	< 0.001
Total # Intact worker contacts	0.85	0.23	3.74	<0.001
Family size	-1.14	6.55	-1.73	0.08
Parent age	6.38	3.44	1.53	0.09

SUD TREATMENT AND STABILITY AT IL IFR PROGRAM CLOSURE

As below in Table 69, most IL IFR program participants successfully completed their initial episode of SUD treatment and were abstinent at program closure.

Table 69. SUD Treatment Status and Stability at IL IFR Program Closure

	Intervention Group N (%)	Comparison Group N (%)	Total Sample N (%)
SUD Treatment Status at Closure			
SUD treatment completed	77 (79%)	93 (84%)	170 (82%)
SUD treatment not completed	20 (21%)	18 (16%)	38 (18%)
SUD Stability at Closure			
Stable SUD/Abstinent	102 (72%)	70 (70%)	172 (71%)
Actively using	39 (28%)	30 (30%)	69 (29%)

We did find a significant difference between the intervention and control groups on SUD treatment completion compared to not completing treatment (z = -2.21, p = 0.02), such that a greater percentage of intervention group participants completed treatment successfully than the control group. There were no significant differences in SUD stability compared to actively using at closure between the intervention and control group (z = -0.78, p = 0.43).

Figure 68. SUD Treatment Status by Group

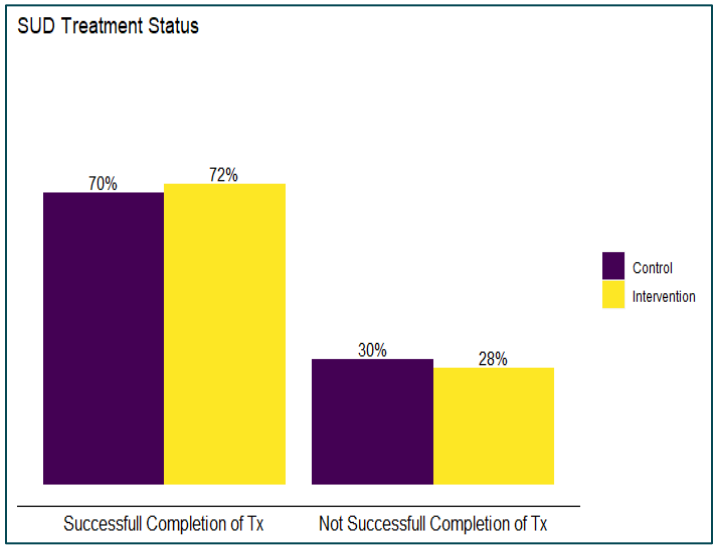
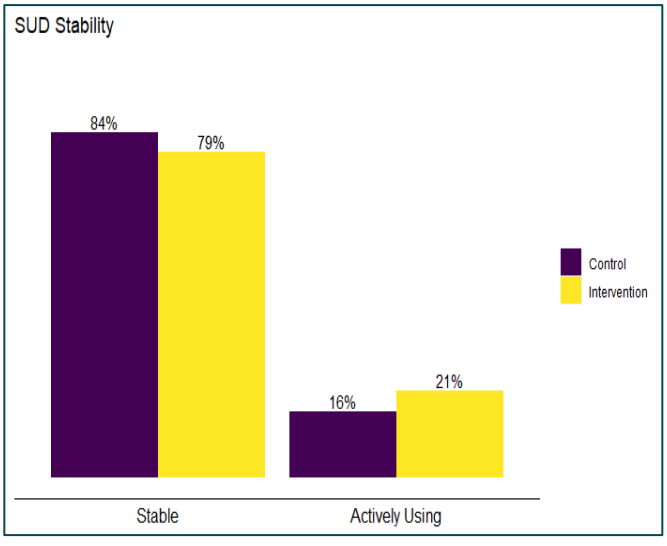


Figure 69. SUD Stability at Closure by Group



Participants who received a greater number of Intact worker contacts were more likely to have completed SUD treatment successfully (t = 2.67, p = 0.008) and be stable at closing (t = 195.76, p < 0.001).

Table 70. Effects of Covariates on SUD Treatment Status at IL IFR Program Closure

Covariate	Estimate	Standard Error	t-value	p-value
Intervention group	-1.15	0.52	-2.21	0.02
Total # of Intact worker contacts	0.25	0.09	2.67	0.008
Family size	0.04	0.74	0.06	0.96
Parent age	-0.02	0.15	-0.16	0.87

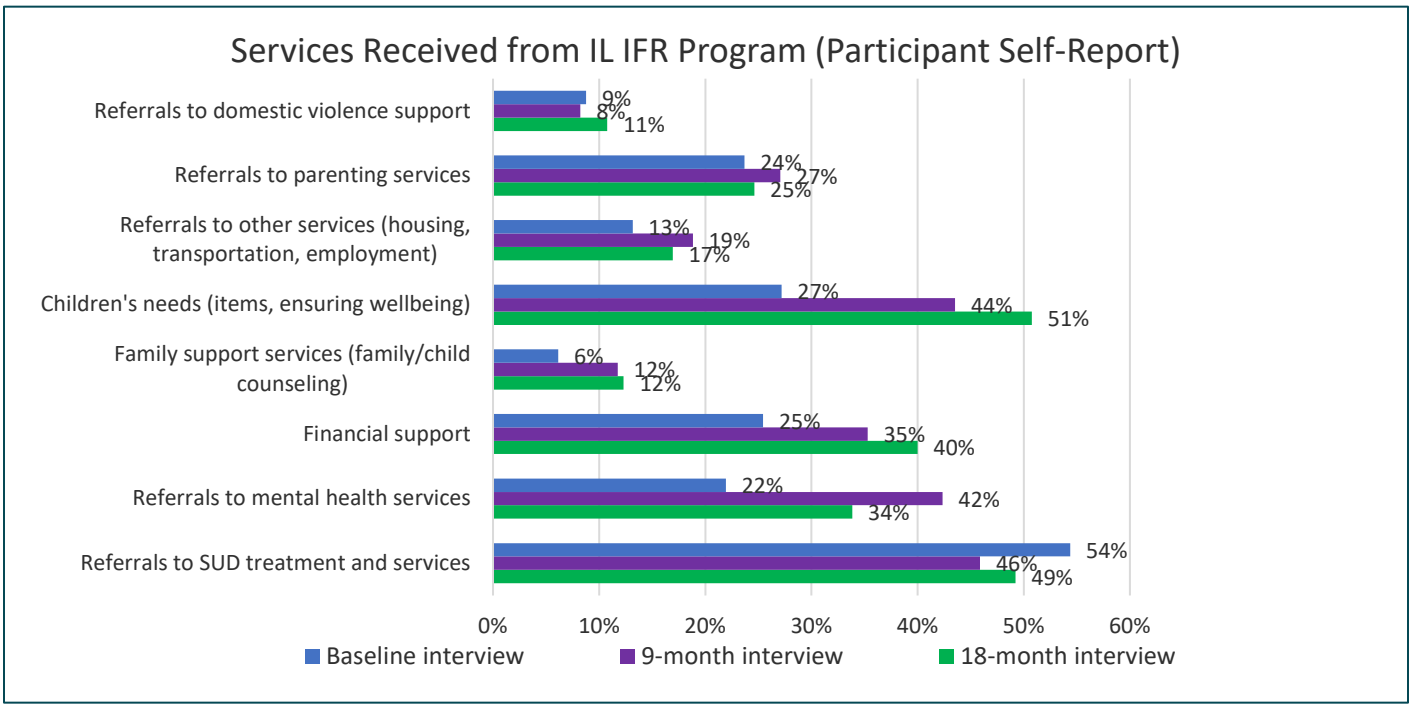
Table 71. Effects of Covariates on SUD Stability Status at IL IFR Program Closure

Covariate	Estimate	Standard Error	t-value	p-value
Intervention group	-0.43	0.25	-0.78	0.43
Total # of Intact worker contacts	0.31	0.001	195.76	<0.001
Family size	0.21	0.001	1.45	0.73
Parent age	0.09	0.001	1.16	0.54

IL IFR SERVICES RECEIVED: PARTICIPANT SELF-REPORT

The interview protocol asked participants to list the services they received from the IL IFR program. As shown in Figure 70, participants reported being referred or connected to a variety of services and supports. Across all three interview timepoints, 50% of participants reported that the IL IFR program referred them to substance use treatment and services. More than one-third reported that they received financial support and were referred to mental health services. At 18-month follow-up, 51% of participants reported receiving help meeting their children's material and physical well-being needs. There were few differences between services reported by intervention and comparison group participants. At 9-month follow-up, 49% of intervention group participants and 35% of comparison group participants reported receiving material supports and services for their children; 14% of intervention group participants compared to 9% of control group participants reported receiving referrals to family support services. A slightly greater percentage of intervention group participants (49%) reported that their IL IFR program referred them to substance use treatment compared to control group participants (41%).

Figure 70. Receipt of IL IFR Services (Participant Self-Report)



INTACT WORKER AND RECOVERY COORDINATOR CONTACTS AND PARTICIPANT AND CHILD OUTCOMES

We conducted a series of correlation analyses to explore the relationship between Intact worker contacts, recovery coordinator contacts, and parent and child outcomes.

Outcomes associated with a greater number of Intact worker visits include:

- Increased serious anxiety in the past 30 days ($r = 0.16$, $p = 0.02$)
- Increased CBCL Externalizing scores ($r = 0.23$, $p = 0.05$)

The following outcomes were associated with a greater number of recovery coordinator visits:

- Decreased cannabis use ($r = -0.15$, $p = 0.05$).
- Two measures of focal children aged 7-36 months' abnormal sensory processing were related to total recovery coordinator visits. As the number of recovery coordinator visits increased, sensation avoidance ($r = -0.48$, $p = 0.04$) and low threshold decreased ($r = -0.46$, $p = 0.05$). In other words, recovery coordinators visits were related to improved sensory processing for focal children aged 7-36 months.

A greater number of joint Intact worker and recovery coordinator visits were associated with improvements in the following outcomes for intervention group participants:

- Decreased substance use in the past 30 days ($r = -0.16$, $p = 0.03$).
- Decreased cannabis use in the past 30 days ($r = -0.22$, $p = 0.002$).
- Decreased depression in the past 30 days ($r = -0.14$, $p = 0.05$) as well as decreased depressive symptoms and severity (decreased CES-D scores) ($r = -0.14$, $p = .05$).

- Decreased trauma (decreased TSC-40 scores) (r = -0.16, p = 0.02)

Table 72. Correlations between Outcomes and Intact Worker, Recovery Coordinator, and Joint Visits*

	Total # of Intact Worker Visits	Total # of Recovery Coordinator Visits	Total # of Joint Visits
Interview timepoint	0.03	0.02	-0.02
Substance use past 30 days	0.05	-0.03	-0.16*
Cannabis use past 30 day	-0.03	-0.15*	-0.22*
Alcohol use past 30 days	-0.05	0.06	-0.02
Troubled by drug problems	0.02	0.25	0.09
Importance of receiving treatment for drug problems	0.02	0.22	0.09
Serious depression past 30 days	0.005	-0.12	-0.14*
CES-D	0.04	0.02	-0.14*
Serious anxiety past 30 days	0.16*	0.02	-0.07
TSC-40	0.03	0.02	-0.16*
Troubled by mental health problems	-0.08	0.01	-0.06
Importance of receiving treatment for mental health problems	0.01	0.03	0.05
CRPR	Cell Size Insufficient	0.18	Cell Size Insufficient
Parent Stress Scale	0.12	-0.11	-0.04
AAPI Construct A	0.13	0.15	0.15
AAPI Construct B	0.07	0.01	0.02
AAPI Construct C	0.07	0.14	0.07
AAPI Construct D	-0.13	-0.03	-0.05
AAPI Construct E	-0.11	0.01	-0.06
CADBI	Cell Size Insufficient	-0.28	Cell Size Insufficient
PSC-35	Cell Size Insufficient	-0.19	Cell Size Insufficient
SDQ Prosocial Behavior	-0.1	-0.11	Cell Size Insufficient
SDQ Emotional Problems	-0.09	-0.07	Cell Size Insufficient
SDQ Conduct Problems	-0.09	-0.11	Cell Size Insufficient
SDQ Hyperactivity	-0.19	-0.19	Cell Size Insufficient
SDQ Peer Problems	-0.06	-0.07	Cell Size Insufficient
CBCL Internalizing	0.11	0.32	0.07
CBCL Externalizing	0.23*	0.15	0.14
CBCL Total Problems	0.16	0.22	0.09
ITSP Low Registration	-0.1	-0.15	0
ITSP Sensation Seeking	-0.22	-0.21	0.18
ITSP Sensory Sensitivity	0.03	-0.36	0.12
ITSP Sensation Avoidance	-0.1	-0.48*	0.07
ITSP Low Threshold	-0.04	-0.46*	0.09

*Asterisks denote p-value $\leq$ .05.

IL IFR PROGRAM PARTICIPATION BENEFITS

We asked participants how the services they received from their IL IFR program helped them and their families. Participants reported the following benefits:

- **Increased personal and family stability:** Participating in the IL IFR program helped parents "get their lives together." Thirty-two percent of participants reported that the program helped them finish school, get a job, and secure stable housing. Participants also shared that the program helped them achieve greater personal responsibility and accountability for themselves and their children.
- **Improved parenting:** Twenty-two percent of participants reported that the program helped them become better parents and that they felt closer to their children.
- **Improved behavioral health:** Nineteen percent of participants reported that the program helped them understand and cope with their mental health and substance use problems.
- **Increased connections to community resources:** Ten percent of participants reported that IL IFR program staff helped connect participants to a wide range of community services that they did not know about and/or had not been able to access in the past.
- **Increased abstinence**: Nine percent of participants reported that the program helped them attain and maintain abstinence.
- **Increased confidence to leave domestic violence situation:** Two percent of participants reported that the program increased their confidence in their ability to leave domestic violence situations.

The statements below are comments participants shared with us about how the IL IFR program helped them and their families. Comments have been edited to protect participant confidentiality.

"The program helped me get treatment, go to groups and helped me understand relapse prevention planning. That was huge for me. Having them show up to visit me, that has been very therapeutic for me. That support, it's made a big difference."

"It (IL IFR program) helped me stay clean; it was the push that I needed to stop using."

"Without that program I don't think I would have gone back to school. Now I feel like I have a brighter future. I don't get angry or fearful like I used to. I deal with things better."

"The program helped connect me to parenting classes, which has helped my family. Taking part in domestic violence classes helped me realize different things, like how to notice and avoid red flags."

"The program gave me the tools and structure to figure things out. I didn't know what schools to call, or which type of therapist could help my child. They pointed me in the right direction."

Outcome Evaluation Limitations

We encountered several outcome evaluation challenges that resulted in an unanticipated small sample. This in turn limited our ability to explore differences across sites, as well as conduct analyses of some outcome measures. It may also have contributed to few significant differences in outcomes between intervention and control group participants.

LOWER THAN ANTICIPATED DCFS REFERRALS TO IL IFR PROGRAMS

As described in detail in the Process Evaluation section, our IL IFR program partners received fewer referrals of eligible parents from DCFS than originally anticipated. Fewer referrals to IL IFR programs resulted in lower program enrollment; lower program enrollment resulted in fewer eligible participants to recruit and enroll in the evaluation. Strategies to increase DCFS referrals to IL IFR programs are discussed in the Process Evaluation section.

ATTRITION

We achieved a 78% completion rate for 9-month follow-up interviews and a 66% completion rate for 18-month follow-up interviews. Strategies to minimize attrition included identifying and contacting secondary contacts to help locate participants for follow-up interviews, calling participants every two months to verify contact information, conducting Google web searches to obtain updated contact information, and working with IL IFR program staff to update participant contact information and help locate participants. We also increased interview incentives from $20/interview to $60/interview.

GREATER ENROLLMENT OF INTERVENTION GROUP PARTICIPANTS IN THE EVALUATION

Several factors contributed to a greater number of intervention group participants than comparison group participants enrolling in the evaluation. 1) In the first two years of enrollment, comparison group sites received fewer referrals of eligible parents than intervention group sites. We addressed this challenge by expanding the project to include adjacent counties where sites provided Intact services and working with our DCFS liaison to identify and resolve low referrals to comparison group sites. 2) Recovery coordinators were responsible for recruiting participants at intervention group sites. They also had weekly check-in calls with the AHP evaluation team. These weekly check-ins helped address and resolve recruitment challenges in 'real time.' Comparison group sites relied on Intact workers to recruit participants for the evaluation. We had little or no regular contact with Intact workers and relied on Intact supervisors to encourage their staff to tell participants about the evaluation. Some Intact supervisors had poor buy-in for the evaluation; as a result, enrollment lagged. In the last two years of the project, we gave Intact workers and supervisors gift cards for each participant referral they submitted to the evaluation; this helped increase enrollment. 3) In the final year of enrollment, one of our intervention group sites stopped providing Intact services and dropped out of the project. The comparison group site became the intervention group site, and a new Intact program joined the program as the comparison group site. However, the new program dropped out of the project after four months and never recruited or enrolled eligible participants in the evaluation.

DELAYED NATIONAL CROSS-SITE EVALUATION IMPLEMENTATION

As described above, we began data collection in May 2018 and the national cross-site evaluation did not begin until late 2019. Given cross-site requirements, we modified our evaluation plan to only use cross-site measures after September 2019. As a result, participants who enrolled prior to September 2019 did not complete all cross-site measures and participants enrolled after September 2019 did not complete all pre-site measures. This resulted in an insufficient sample to conduct analyses of the TESI and ITSP 0-6 Months.

LACK OF SAMPLE DIVERSITY

As shown in Table 5, most evaluation participants were white and female. Results were therefore not generalizable to males or people of color.

PROCESS EVALUATION

The IL IFR qualitative process evaluation documented the program's development and implementation over time, including barriers encountered, strategies used to overcome those barriers, and other lessons learned about implementing this collaborative, cross-systems project and integrating services.

Methods

Process evaluation data were collected via project meeting minutes. Minutes from meetings convened through IL IFR program planning period and implementation were reviewed. These include:

- **Steering committee meetings.** Steering committee meetings were held monthly during the IL IFR project planning phase (November 2017 – 2018), and quarterly between the implementation phase (November 2018 – September 2022). Participants included executive-level representatives from each of the eight partner agencies—AMHW, CHA-R, CHA-J, LSSI, Lydia Home, Remedies, Stepping Stones, and TASC; the AHP evaluation team; ICOY; and key state agencies—DCFS and the Illinois Department of Human Services/Substance Use Prevention and Recovery (IDHS/SUPR). Steering committee meetings' topics focused on IL IFR program roles and responsibilities, training/technical support needs, and implementation barriers and solutions.
- **Regional meetings.** Meetings were convened monthly in each project region from February 2018 through September 2022. Regional meetings included representatives from ICOY, AHP, and supervisors from each IL IFR partner agency. Participants used these meetings to network, monitor program implementation, review service delivery challenges, and develop strategies to overcome these challenges.
- **Recovery coordinator meetings.** Recovery coordinator meetings occurred quarterly from October 2019 to October 2022. Participants included recovery coordinators and representatives from ICOY and AHP. These meetings provided opportunities for the recovery coordinators to network, share service delivery challenges and successes, and identify strategies to address challenges related to working with the Intact teams.

Analyses

We used Dedoose software to analyze qualitative process evaluation data. The evaluation team uploaded meeting minutes to Dedoose's web platform to conduct content analysis. Content analysis is a systematic, replicable technique that reduces textual data to categories based on explicit rules of coding. Following a preliminary examination of meeting minutes, the evaluation team established coding categories. The codes were developed iteratively and updated throughout the project to capture emergent themes. We then identified patterns in the qualitative data by informant, theme/topic, and timepoint.

Results

This section presents results of our qualitative analyses of meeting minutes. Results are presented for the following domains:

- Project implementation
- Recovery coordinators
- DCFS referrals
- Staffing
- Training and resources
- Evaluation recruitment and enrollment challenges and strategies
- Project sustainability

Project Implementation

PROGRAM PLANNING PHASE ACTIVITIES

The IL IFR program had an initial 6-month planning period from November 2017 through April 2018. During this time, ICOY and AHP worked to develop relationships between partners and prepared for program implementation by conducting site visits and holding regular Steering Committee meetings. Monthly regional meetings began in February 2018 to allow for deeper dives into the formalization of relationships and to set expectations for each partner agency in their respective geographic services areas. Regional meetings included Intact supervisors who assumed local IL IFR management roles following program implementation in April 2018. The following project components were developed in Steering Committee and regional meetings during the planning period:

IL IFR program governance structure. The program governance structure was created during the planning phase to help the partners prioritize, oversee, and sustain project activities. The Steering Committee served as the oversight board of the project and partners with decision-making authority, each of whom provided status updates, collaborated in universal decisions for project processes, and addressed sustainability issues. Day-to-day project implementation issues were discussed and resolved at regional meetings by Intact and substance use provider partner supervisors, ICOY, and AHP.

Development of the IL IFR program plan. The IL IFR program plan developed by the Steering Committee provided definitions of services, target populations, employee qualifications, and a detailed description of the recovery coordinators' and Intact workers' roles and responsibilities. Regional meeting participants developed detailed processes for recovery coordinator and Intact worker communication, training, supervision, and service delivery.

IL IFR PARTNER ENGAGEMENT

IL IFR program partner engagement was essential to successful program and evaluation implementation. ICOY and the evaluation team convened ongoing meetings and trainings and employed a variety of strategies to foster and maintain program partner engagement. These strategies, described below, provided opportunities for partners to discuss local implementation processes, service delivery and staffing issues, and enhance partners' buy-in and support.

Planning phase site visits. ICOY and AHP conducted site visits with each program partner to share IL IFR program and evaluation plans and obtain partner feedback.

Regional meetings. Monthly regional meetings provided opportunities for partners to review and provide input on program and evaluation materials and processes. These meetings also provided opportunities for partners to discuss and develop strategies to resolve service delivery challenges.

Ongoing IL IFR program and evaluation trainings. ICOY and AHP held ongoing trainings on program service delivery and evaluation processes throughout the project. These trainings ensured that supervisors and frontline staff understood program and evaluation goals and how to implement the IL IFR model.

Evaluation check-in calls. AHP convened weekly and bi-weekly evaluation check-in calls with recovery coordinators and Intact supervisors, respectively, to discuss participant eligibility and enrollment in IL IFR services and the evaluation, IFR service receipt, and case closures. These calls built rapport with staff and helped to identify and resolve service delivery and evaluation challenges in real-time.

Evaluation newsletters. AHP created an online monthly newsletter that gave an overview of the projects, shared updated information on evaluation progress (i.e., # of participants enrolled at each site, # of interviews completed), and shared tips for IL IFR service delivery, engaging participants in the evaluation, and self-care. The newsletter was shared with all recovery coordinators, Intact workers, and supervisors.

CROSS-SYSTEMS COLLABORATION AND RESOURCE SHARING

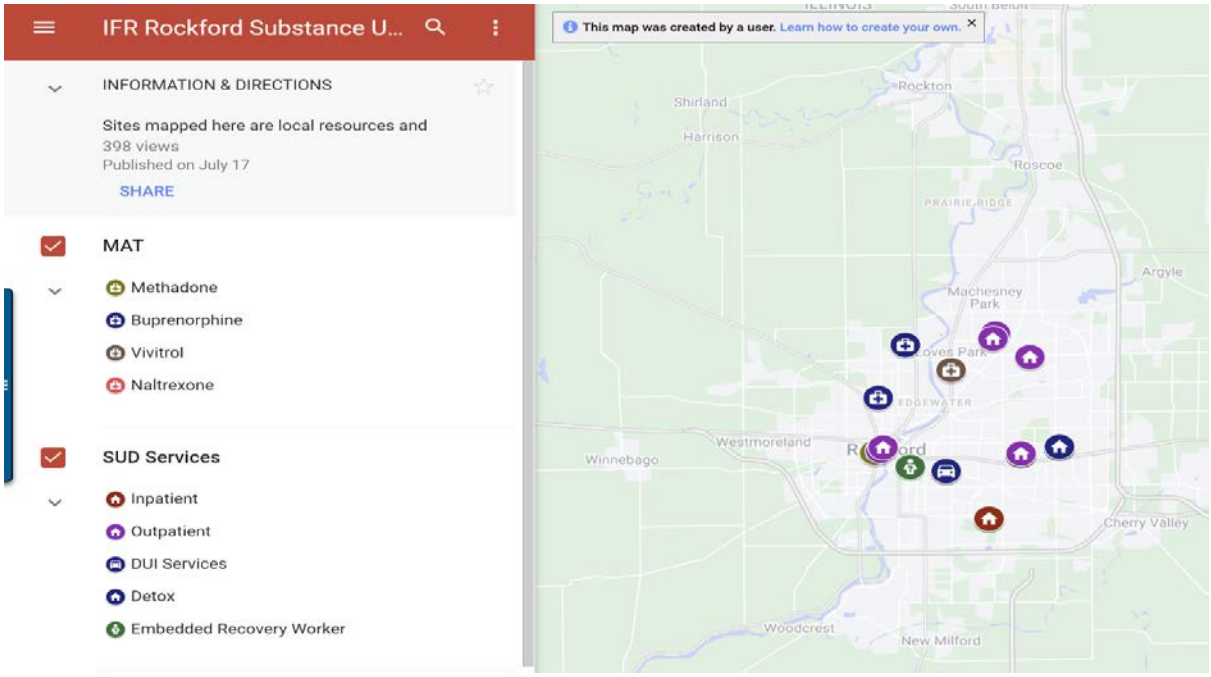
IL IFR program partners developed and implemented the following strategies to strengthen coordination and collaboration between child welfare and substance use treatment partners and systems.

Participant information sharing. IL IFR program partners created systems to share information about participants across organizations. Substance use treatment partners created a substance use assessment summary early in project implementation that shared information with Intact workers on participants' treatment progress. Substance use treatment partners also provided relapse prevention forms that teams could use to connect participants to recovery support resources in their communities.

Cross-systems trainings. Intact teams offered opportunities for recovery coordinators to participate in trainings on a variety of child welfare topics offered by their organizations and DCFS. Substance use treatment provider partners linked Intact teams to trainings on naloxone and relapse prevention. At intervention sites, cross-training occurred organically during joint Intact worker and recovery coordinator visits with participants. Intact workers reported that recovery coordinators taught them how to recognize signs of substance misuse. Recovery coordinators shared that Intact workers taught them how to identify child safety risks.

Community resource map. Early in program implementation, partners discussed ongoing struggles to locate housing, healthcare, and other resources IL IFR participants and their children needed. AHP worked with IL IFR program partners to create an interactive, web-based community resource map. The map uses geospatial technology (e.g., Google Maps) to identify or "pinpoint" a service location. Service-specific information, such as eligibility criteria, hours of services, type of insurance accepted, etc., is also included in the map. An example of a community map appears below. Program partners identified resources in their respective regions, including medication-assisted recovery (MAR) and substance use treatment, housing, healthcare, employment, and legal services. AHP compiled these resources into an interactive online map that can be filtered by type of service, as shown in the exhibit below. Each resource in the map includes organization names, addresses and contact information, and types of services provided. Two maps were created: one for the Rockford region (IFR Rockford Community Resource Map) and one for the Joliet region (IFR Joliet Community Resource Map). Program partners were trained to use and update the map. The map is publicly available and has been used by IL IFR program partners, clients and their families, and other individuals to find services in their communities. As of August 4, 2023, the maps had a total of 636 unique views.

Figure 71: IFR Rockford Substance Use Community Resource Map



SUBSTANCE USE TREATMENT CHALLENGES

Substance use treatment access and availability. Throughout the project, IL IFR program partners reported various challenges in helping participants access substance use treatment services. These challenges included long wait lists for assessments and treatment at all substance use treatment providers in the IL IFR project regions. For example, a substance use provider only conducted a specific number of walk-in assessments per day, and IL IFR clients often had to wait a month or more to be assessed for treatment. Program partners worked with this treatment provider to implement a system where the provider gave a letter to clients who arrived for an assessment but were not seen; clients who had two letters indicating that they had arrived for assessment but had not been seen could bypass the walk-in and schedule an assessment appointment. Long waitlists were in effect prior to the COVID-19 pandemic; wait times became even longer during and after the pandemic due to staff shortages, with some clients waiting three months or more for an assessment.

Drug screening. Recovery Coordinators believed that, as part of their role, they needed to be able to use their organizations' procedures to conduct random drug tests with IL IFR participants. However, standard Intact procedures placed responsibility for scheduling participant drug testing on Intact workers. Additionally, Intact procedures required that Intact workers upload drug testing results to the Statewide Automated Child Welfare Information System (SACWIS) a DCFS database that recovery coordinators could not access. Partners worked together to advocate and implement ready-cups (i.e., at-home drug test kits) that recovery coordinators could administer to participants during home visits. The IL IFR Steering committee developed policies and procedures for the proper use of ready-cups. At intervention group sites, recovery coordinators administered ready cups to participants and shared results with Intact workers. At comparison group sites, Intact workers administered ready-cups to participants.

IMPACT OF COVID-19 ON IL IFR SERVICES

The COVID-19 pandemic impacted the IL IFR program and service delivery in the following ways:

Client engagement. IL IFR program partners reported that client engagement was one of the biggest challenges they faced during the pandemic. Intact workers and recovery coordinators moved from in-person to virtual (phone, Zoom) visits with families. It was difficult and at times impossible to meet with participants with poor or no phone and/or Internet access. Participants who did not want to meet with the team would not answer the phone or refuse DCFS-required "porch" visits. Others hung up in the middle of virtual sessions.

Decreased DCFS referrals. Due to DCFS staff shortages and social distancing requirements, only high-risk domestic violence and neglect cases were actively screened and referred to Intact services. Sites reported a decrease in the number of referrals of families with substance misuse to their Intact programs.

Decreased staff capacity. All IL IFR program partners reported decreased staff capacity during the pandemic due to high rates of COVID-19 among staff at their organizations and staff attrition. Staff often became frustrated with social distancing protocols and virtual home visits, reporting that they were unable to keep children safe. Project partners also reported that virtual staff meetings hindered team communication and collaboration.

Limited access to substance use treatment and other services. Social distancing protocols and statewide behavioral health workforce shortages results in increased wait times and decreased availability of substance use and mental health treatment services.

SITE CHANGES

In July 2021, AMHW ended its DCFS contract to provide Intact services and stopped participating in the study. From November 2021 to March 2022, CHA-J served as the intervention group agency in Region 2, and Lydia Home, a DCFS-licensed Intact provider in Region 2, served as the comparison group site. The recovery coordinators at AMHW were transferred to CHA-J. AMHW IFR cases were closed and/or transferred to other services at AMHW or CHA-J. AMHW participants who were enrolled in the evaluation continued their evaluation participation. Lydia Home chose to withdraw from the project in February 2022. The site enrolled three clients in IL IFR services. No Lydia Home clients enrolled in the evaluation.

Recovery Coordinators

Recovery coordinators were co-located at the child welfare partner sites. In the IL IFR model, recovery coordinators were embedded in Intact teams and worked with Intact providers to deliver services to IL IFR clients. This included doing joint client visits with the Intact worker on a weekly, bi-weekly, or monthly basis, and attending meetings where DCFS did a warm hand-off of clients to Intact teams. Recovery coordinators' primary role was to connect participants to substance use treatment and support them throughout the treatment and recovery process. Recovery coordinators scheduled and conducted assessments, accompanied participants to treatment, provided relapse prevention, did drug testing, and connected participants to community-based recovery support services.

RECOVERY COORDINATOR BENEFITS

Intervention sites reported that working with the recovery coordinators provided several benefits to their Intact teams:

Improved client engagement and access to substance use treatment. IL IFR supervisors reported that recovery coordinators facilitated client entry into substance use treatment and used their specialized clinical knowledge to connect clients to a wealth of substance use treatment and recovery support resources. Supervisors reported that clients appeared to be more responsive and open to treatment after working with recovery coordinators.

Additional staff support. IL IFR supervisors noted that recovery coordinators were an "extra set of eyes" on a family, helping to reduce the workload for Intact workers. Intact workers reported that it was easier to get substance use treatment updates for clients because they could get it directly from recovery coordinators. The recovery coordinators' clinical expertise also provided access to a wide variety of recovery support resources. Intervention sites reported that their Intact teams struggled to fill the void left by recovery coordinators after funding ended.

Increased Intact worker knowledge of substance misuse and substance use treatment. Partners reported that recovery coordinators shared their expertise with Intact workers and taught them how to recognize signs of substance misuse and relapse, and strategies for engaging clients in discussions about substance use and treatment.

RECOVERY COORDINATOR CO-LOCATION CHALLENGES AND SOLUTIONS

Several challenges arose related to co-location of recovery coordinators on Intact teams. These challenges were addressed in Steering Committee, regional and recovery coordinator meetings. Challenges and solutions are summarized below.

DCFS warm handoffs. After DCFS refers a family to an Intact program, DCFS and members of the Intact team meet and do a warm handoff, i.e., a meeting attended by DCFS, the IFS provider, and the family where the family is formally transferred or "handed off" to the IFS provider. Recovery coordinators attended these meetings to explain the IL IFR program to participants and help enroll them in the program. Local DCFS staff, however, were resistant to recovery coordinators attending these meetings. To resolve this, the Project Director, Intact and substance use treatment partner supervisors met with staff at local DCFS office to share information about the IL IFR program, the role of the recovery coordinator, and client enrollment procedures. The meeting had a positive impact and resulted in less resistance from local DCFS staff regarding recovery coordinators' attendance of warm hand-off meetings.

Communication and collaboration with Intact workers. Recovery coordinators and Intact teams experienced several communication and collaboration challenges in the initial months of program implementation. Recovery coordinators felt alienated from Intact workers due to a lack of regular in-person contact, Intact staff turnover, and lack of inclusion in team activities. Recovery coordinators and Intact workers had problems coordinating required joint home visits with IL IFR cases. Intact workers did not always notify recovery coordinators when warm handoff and home visits were scheduled, resulting in missed warm hand-offs and joint visits. It was often difficult to share information about clients; some Intact workers were reluctant to share information; technology challenges (i.e., lack of access to SACWIS, systems not "talking" to each other) also made it difficult to share information. Strategies to resolve communication and collaboration challenges included:

- Weekly joint supervision sessions that included the Intact supervisor, recovery coordinator supervisor, Intact worker and recovery coordinator.
- Pairing the recovery coordinator with one or two Intact workers and assigning all IL IFR cases to the recovery coordinator-Intact worker team rather than an entire Intact team.
- Including recovery coordinators at all Intact team meetings, including weekly case staffing meetings.

These strategies increased communication between recovery coordinators and Intact workers, enhanced information sharing, and helped create a greater sense of "one IFR team".

SUBSTANCE USE TREATMENT APPROACH DISPARITIES

IL IFR program partners reported that recovery coordinators and Intact workers did not always share the same views on substance use treatment. Recovery coordinators sometimes felt that Intact teams did not understand the important of relapse prevention and closed cases too soon after parents completed substance use treatment. Intact teams often disagreed with some recovery coordinators' "abstinence only" approach. For example, after Illinois legalized recreational cannabis, Intact protocols did not consider clients' cannabis use to be problematic if it did not impact child safety. Recovery coordinators, however, endorsed abstinence and felt that any substance use was cause for concern. To

address these differences in substance use treatment approaches, ICOY offered several online cross-systems learning collaboratives to all IL IFR team. Child welfare training topics included how to identify child safety and well-being issues during home visits, DCFS minimum parent standards, and guidelines for calling the DCFS hotline. Substance use treatment topics included stages of recovery, how to identify signs that a person has relapsed, and how to talk with clients about substance use. IDHS/SUPR hosted a webinar on harm reduction. After the webinar, the Steering Committee agreed that 1) cases should not be closed at intervention sites without the recovery coordinators' input; and 2) parents' use of recreational cannabis should be discussed on a case-by-case basis and take child safety into consideration before addressing the issue with parents.

DCFS Referrals

The IL IFR project's successful enrollment of families was dependent on DCFS referrals to our child welfare provider partners' Intact services programs. DCFS referrals of eligible parents were lower than anticipated throughout the project. This included:

LOWER THAN ANTICIPATED REFERRALS OF FAMILIES WITH SUBSTANCE MISUSE

IL IFR program partner sites reported ongoing challenges with the low number of DCFS referrals of parents with substance misuse to their Intact programs. For example, from October 2019 to March 2020, CHA-J received only two referrals that met IL IFR program eligibility criteria. Program partners reported that DCFS referrals to their Intact programs were primarily families experiencing domestic violence, mental health problems, child truancy, or were complex and high-risk cases with multiple challenges. Additionally, during early implementation, IL IFR program sites reported that DCFS did not always correctly assess parent substance use: some parents that were referred by DCFS were later determined by IFR staff to not have SUD, and some parents who DCFS reported did not have SUD were later determined by IFR staff to have substance use problems. We addressed these issues in Steering Committee meetings. Project leadership agreed to expand the program in Region 2 to adjacent counties that CHA-J and AMHW served. They also agreed that IFR staff should use a standardized SUD screening tool with all parents who enrolled in Intact services at each site. The Steering Committee selected the ASSIST, described above. The number of eligible referrals increased after implementing these strategies.

REFERRAL HOLDS

IL IFR program partners reported DCFS referral holds at various timepoints throughout the project. Referral holds occurred when DCFS determined that a child welfare partner's Intact program was at capacity; DCFS would put the site on "hold" and not send additional referrals until cases closed and/or the site hired additional Intact workers. All IL IFR program sites reported referral holds during COVID-19.

Staffing

The IL IFR program experienced several staffing challenges over the course of the project's implementation.

STAFFING SHORTAGES AND TURNOVER

All program partner sites reported staffing shortages over the course of the project; these were most pronounced during the pandemic, as many staff tested positive for COVID-19 and were unable to work. One site had only one IL IFR supervisor managing cases for much of 2018. A shortage of Intact workers and IL IFR supervisors resulted in referral holds at two sites in 2019. All sites experienced staff turnover in all roles (i.e., supervisors, Intact workers, recovery coordinators); by the end of the project, only a handful of staff—including supervisors and project leadership—had been with the program for its entire tenure.

IL IFR program partners reported during meetings that recruiting and retaining qualified staff and supervisors were ongoing issues, citing high turnover rates, lack of a competitive salary, job stress, and challenges recruiting qualified staff as limiting factors. ICOY provided retention bonuses in 2021 to all IL IFR frontline and supervisory staff to support retention efforts. DCFS also provided bonuses to Intact staff during this period.

Training

Training needs were identified at Steering committee, regional, and recovery coordinator meetings. ICOY and AHP provided trainings and resources throughout the project to address these training needs. These trainings included:

LSSI LEARNING COLLABORATIVES

ICOY contracted with the LSSI Cook County IFR program to provide training for IL IFR direct service staff and supervisors on program implementation. The learning collaboratives focused on helping staff and supervisors understand how a co-location program functions, recovery coordinators' and Intact workers' roles and responsibilities, and IFR program implementation challenges. Recovery coordinators, Intact workers, and supervisors participated in these learning collaboratives.

CROSS-TRAINING WEBINARS

In May 2019, IL IFR program partners recommended that the project offer cross-training opportunities to support IL IFR recovery coordinators and Intact workers' knowledge and skills. ICOY hosted, recorded, and posted a variety of webinars for recovery coordinators, Intact workers, and supervisors. Some trainings included Continuing Education Unit (CEU) options for licensed practitioners. Training topics included trauma training; child safety, permanency, and well-being training; motivational interviewing; family dynamics in a substance use home; working with dual diagnosis clients; client-centered treatment; the impact of substance abuse on children and families; working with resistant clients; and communicating the implications of substance use to clients. Webinars offered by the Association for Addiction Professionals also were provided. Program partners reported that this cross-training resource provided important learning opportunities and fostered cohesive partnership among staff.

IL IFR PROGRAM AND EVALUATION TRAININGS

IL IFR program partner sites reported challenges understanding staff roles and expectations within the program, and issues with collaboration and communication between recovery coordinators and Intact workers. Staff turnover compounded these challenges. ICOY and AHP conducted IL IFR program and evaluation trainings for all new staff and annual "refresher" trainings for all sites. These trainings gave an overview of the IL IFR program and evaluation, and staff roles and responsibilities. Training materials (i.e., program flow chart, program communication chart, evaluation goals) were shared at each training and emailed to all training participants.

HARM REDUCTION TRAINING

As noted above, in December 2021, IL IFR SUD partner agencies expressed concerns about clients' cannabis use and suggested a zero-tolerance approach to cannabis use for IL IFR clients. In contrast, the IL IFR child welfare partner agencies practiced a harm reduction approach with families and did not stigmatize or take punitive action against parents using marijuana when it did not appear to impact their parenting or pose a safety risk to the child. IL IFR child welfare partner agencies felt this approach should continue to apply to clients participating in the IL IFR program. To mitigate this difference in approach between agency partners, AHP organized a harm reduction presentation with Illinois Department of Human Services/Division of Substance Use Prevention and Recovery Medical Director Dr. Nicole Gastala in January 2022. Program partners reported that they enjoyed the presentation and found subsequent discussion useful. SUD treatment providers found that clients should be evaluated on a case-by-case basis, while those with severe SUD should maintain abstinence from all substances, where possible.

Evaluation Recruitment and Enrollment Challenges and Solutions

We experienced several evaluation participant recruitment and enrollment challenges. These challenges were shared during Steering Committee, regional, and recovery coordinator meetings. Challenges and solutions discussed at these meetings are summarized below.

COMPARISON SITE RECRUITMENT

As described in the Outcome Evaluation Limitations section, comparison group sites recruited and enrolled fewer IL IFR clients in the evaluation than intervention group sites. While some of this was due to comparison sites receiving fewer referrals of eligible parents, staff turnover at comparison sites and lack of support or buy-in for the evaluation also contributed to recruitment challenges. For example, comparison group Intact supervisors reported that they forgot to tell their Intact workers to ask clients about the evaluation; others reported that the evaluation was an extra burden for their Intact workers. Strategies to address these issues included:

- Evaluation training for all new Intact workers and supervisors; annual evaluation refresher training for all IL IFR staff.
- "Thank you" gift cards sent to comparison site Intact workers for each evaluation referral form to AHP.
- Discussing evaluation goals at regional meetings and working with Intact supervisors to ensure that Intact workers told eligible clients about this evaluation. This included reminders to supervisors during bi-weekly evaluation check-in calls.

- Ongoing reminders from Steering Committee members that comparison site data are needed to help document the effectiveness of recovery coordinators and ensure that all Intact programs in Illinois include recovery coordinators.

LOWER THAN ANTICIPATED PARTICIPANT ENROLLMENT IN THE EVALUATION

While a lower than anticipated number of DCFS referrals to the program contributed to lower than anticipated enrollment in the evaluation, we also experienced higher than expected evaluation decline rates in the initial months of the project. At project implementation, the Steering Committee had agreed that parents should be asked to participate in the evaluation at the transition or warm handoff meeting. However, very few clients who were asked during the transition meeting to take part in the evaluation agreed to do so. Sites reported that clients may have declined the evaluation because they were presented with a great deal of information about Intact program requirements and were feeling overwhelmed. AHP discussed this issue with project partners, and we agreed to wait to tell clients about the evaluation until 2-3 weeks post-enrollment. This allowed recovery coordinators and Intact workers to develop relationships with clients, as well as gave clients time to adjust to program requirements. Evaluation enrollment increased after making this change. Other strategies identified during partner meetings that we implemented to increase client enrollment in the evaluation included:

- We worked with recovery coordinators and Intact workers to identify reasons why clients declined the evaluation and created a fact sheet that these IFR staff could use when encouraging clients to enroll in the evaluation. Example: Client says, “I’m too busy”, IFR staff respond “AHP will do the interview on a day and time that works for you. And you don’t have to do the interview all at once, you can do the interview over a few days.”
- Project partners shared that IL IFR clients told them that the initial $20/interview was not enough money to compensate them for doing an hour-long interview. We were able to use carry-forward funds to increase the interview incentive to $60/interview.
- During the pandemic, we stopped doing in-person interviews and began doing phone interviews with participants. Project partners reported that clients had shared with them that phone interviews made it easier for them to participate in the evaluation. We agreed that we would honor clients’ preferences for phone interviews and would not resume in-person interviews once social distancing requirements were lifted.

Project Sustainability

ICOY convened meetings with Steering Committee members throughout the project to address sustainability and establish IFR as an evidence-based model that could be implemented in all Illinois Intact programs. IL IFR program sustainability activities included: 1) ongoing meetings with DCFS to ensure sustained support for the IL IFR program once the grant period ended; 2) participating in DCFS Family First Prevention Services Act workgroups to raise awareness about the IL IFR program; 3) providing DCFS and the DCFS FFPSA workgroups preliminary IL IFR results to support inclusion of the program in future FFPSA implementation. ICOY applied for DCFS funding to expand the IL IFR program to twelve organizations across Illinois and prioritized current IFR grantees. DCFS reviewed this proposal and supports the IL IFR model but was unable to fund the program when services ended in September 2022.

CONCLUSIONS

The IL IFR program served 354 participants with SUD in four sites in northern Illinois. Participants received IL IFR services for approximately nine months, and most were closed from the program successfully, completing program requirements and retaining custody of their children. The majority of IL IFR participants completed SUD treatment and were abstinent at program discharge.

Significant outcome evaluation results include:

- The ***typical IL IFR client*** was a 32-year-old single White female with three children under the age of ten. She was unemployed and earned less than $19,000 a year.
- The percentage of IL IFR participants who reported ***use of any illicit drugs or alcohol significantly decreased over time***.
- ***Intervention group participants*** had ***greater decreases in depressive and trauma symptoms*** and were ***less troubled by their mental health problems*** than comparison group participants.
- Participants who had ***successful closures*** had ***fewer depressive and trauma symptoms*** and their ***children had fewer emotional and behavioral problems*** than participants who were closed due to placement.
- ***Positive parenting practices increased*** for all IL IFR program participants.
- Participants who ***successfully completed SUD treatment had more appropriate expectations for their children***.
- ***Child problem behaviors decreased*** for both intervention and comparison group focal children. ***Comparison group focal children had greater decreases in problem behaviors***; however, they enrolled in the program with more problem behaviors than intervention group children.
- A ***greater percentage of intervention group participants successfully completed SUD treatment*** than comparison group participants. This suggests that recovery coordinators helped participants access, receive, and stay in SUD treatment.
- Success takes time. ***Participants with successful closures had longer program tenures*** than participants whose children went into placement. ***Intervention group participants had longer program tenures, and those with longer program tenures had more successful closures.***
- ***IL IFR is "labor intensive***": Intervention group participants received a greater number and longer visits from Intact workers and a greater number of services than comparison group participants.
- Intervention group participants received a greater number of SUD treatment services. This suggests that ***recovery coordinators successfully connected IL IFR participants to SUD treatment*** and recovery support services.
- Intervention group participants who received a greater number of joint visits from Intact workers and recovery coordinators had decreased substance use, decreased cannabis use, and decreased depressive and trauma symptoms. This suggests that ***greater receipt of IL IFR services may be related to improved substance use and mental health outcomes***.

Our process evaluation results show that ***successful IL IFR program implementation requires ongoing commitment, collaboration, and communication among and across program leadership, partners, and systems***. One of the biggest obstacles during initial implementation was the addition of recovery coordinators to child welfare partners' Intact teams. Some Intact supervisors and Intact workers were reluctant—and at times resistant—to include recovery coordinators in team meetings and home visits. Joint supervision, cross-training, and discussions at monthly supervisors' meetings helped identify and resolve these challenges.

Staff turnover was another critical implementation challenge. While we found that regular initial and refresher trainings helped bring new staff up to speed, our greatest success in achieving buy-in for the IL IFR program and evaluation was support from existing staff. ***Intact supervisors and Intact workers who believed in the benefits of the program were our IL IFR "champions"*** who encouraged new staff to work with recovery coordinators and participate in program activities, including the evaluation. As a result, IL IFR services were provided without interruption throughout the project.

The lower than anticipated number of DCFS referrals of families with parental substance misuse to our child welfare partners' IFS programs was our greatest, and most persistent challenge. ***"Where are the families with substance use problems?"*** was a question that we asked throughout the project. Anecdotal evidence suggests staff turnover at DCFS may have resulted in a backlog of cases, with the most serious cases of abuse and neglect receiving immediate attention. Parents with SUD with more serious abuse and neglect charges may not be referred to Intact; conversely, parents with SUD who are not considered at risk or have less serious charges may be in the backlog of cases, i.e., may not be in the system. Anecdotal evidence also suggests that families referred to IFS for domestic violence or other charges are not always screened for SUD. In the future, requiring SUD screening of all IFS families may increase referrals to IL IFR services. We did discuss this option with our partners in the last two years of the project, but given staff shortages, our partners felt that screening all parents referred to IL IFR would be burdensome.

Despite our challenges, we successfully implemented the IL IFR program and served hundreds of families. Our results suggest that receipt of IL IFR services improve parental substance use and mental health outcomes. Recovery coordinators connected IL IFR participants to SUD treatment and helped them complete treatment. ***Participants reported several IL IFR benefits***: it helped them decrease their substance use, improve their well-being and get their lives back. Perhaps most of all, ***participants told us that IL IFR helped them be better parents***. The IL IFR program's success is documented in families' success. We will continue to explore these successes in our ongoing IL IFR studies in the east-central and the east St. Louis regions of Illinois. Through a future large, combined dataset, we will learn more about how IL IFR services improve parent and child outcomes and achieve long-term program sustainability.

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