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Child welfare agency ties to providers and schools and substance abuse treatment use by adolescents

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Abstract

Policy makers and advocates are increasingly encouraging child-serving organizations to work together. This study examined how child welfare agency ties with substance abuse treatment providers and schools correlated with substance abuse treatment for adolescents receiving child protective services. A sample of adolescents with substance use risk was extracted from a national survey of families engaged with child welfare. Logistic regressions with adjustments for complex survey design used child welfare agency ties to substance abuse treatment providers and schools to predict treatment. As expected, adolescents were more likely to report treatment when child protective services and substance abuse treatment were in the same agency and when child welfare agency directors reported joint planning with schools. However, child welfare agency agreements with substance abuse treatment providers were negatively associated with treatment. This unexpected finding implies that agencies may sometimes cooperate to address problems and to improve service utilization.

Keywords: Interorganizational relationships; Interagency cooperation; Substance abuse treatment; Adolescents; Child welfare; Schools

1. Introduction

Adolescents involved with the child welfare system are disproportionately affected by substance use (Aarons, Brown, Hough, Garland, & Wood, 2001; SAMHSA, 2008b). A San Diego study found almost one in five adolescents ages 13–18 engaged with child welfare to have had a substance use disorder at some point in their lives (Aarons et al., 2001). In addition to a pressing need for prevention, the organizations serving these young people must also help those with substance use disorders to achieve and sustain sobriety.

Substance abuse treatment can help adolescents overcome addiction (Deas & Thomas, 2001; Vaughn & Howard, 2004; Williams & Chang, 2000; Winters & Leitten, 2007), especially if tailored to their age group (Brown, Gleghorn, Schuckit, Myers, & Mott, 1996; Catalano, Hawkins, Wells, Miller, & Brewer, 1991; Wagner, Tubman, & Gil, 2004; Williams & Chang, 2000). Unfortunately, treatment rates remain very low. In 2007, fewer than 10% of adolescents who met *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria received substance abuse treatment (SAMHSA, 2008b). Although parent and adolescent perceptions strongly affect engagement in substance abuse treatment (Dakof, Tejeda, & Liddle, 2001), system factors also affect use. Limiting factors include scarcity of treatment providers, inadequate system financing, limited transportation, inaccessible treatment locations and appointment times, and a lack of variety among treatment models (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007).

Engagement with the child welfare system may help adolescents secure substance abuse treatment. Often, child welfare agencies identify behavioral problems during

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investigations of maltreatment and subsequent interactions with families. Thus, child protective services may serve as a gateway to behavioral health services (Burns et al., 1995; Leslie et al., 2005; Lyons & Rogers, 2004). Most child welfare agencies do not provide behavioral treatment themselves but instead refer to providers for these services (Burns et al., 1995). The disruptions associated with families' involvement with child protective services, such as strained relationships with caregivers and in some cases removal from home, may make professional facilitation of service use particularly important. Such facilitation may in turn depend on how staff across agencies work together.

1.1. How child welfare ties to providers may affect entry into substance abuse treatment

The connection between child welfare and substance abuse treatment staff is often challenging for both parties. Limited capacity, especially for adolescent services (Stephan et al., 2007), can slow entry into treatment. Child welfare workers sometimes have different beliefs about drug use than those of substance abuse treatment counselors (Drabble, 2007), which may impede coordination. Adolescents may not share relevant information for fear of getting themselves and their families into trouble. Finally, restrictive federal privacy guidelines may impede communication across agencies about substance use and treatment (Legal Action Center, 2006).

One way child welfare agencies and substance abuse treatment providers can improve communication and service use is to colocate. Face-to-face contact between child welfare and substance abuse treatment staff may be particularly important because e-mail is generally not considered secure enough to protect privacy. An integration model entailing colocation of substance abuse treatment with child welfare as well as provision of enabling services was associated with reduced substance use for women with children (Marsh, D'Aunno, & Smith, 2000). Another program for parents engaged with child welfare, including joint visits by child welfare workers and substance abuse treatment staff, had higher rates of substance abuse treatment use for parents and higher rates of reunification with children who had been removed from their custody (Ryan, Marsh, Testa, & Louderman, 2006). One reason for this model's success may have been direct and frequent communication between child welfare and substance abuse treatment staff.

In general, previous research suggests that integration between child welfare and substance abuse treatment improves utilization. However, previous studies have not examined the potentially differential effects of specific types of coordination. For instance, memoranda of understanding and other formal agreements explicate the intentions and obligations of each party (Imperial, 2005). These may lay the foundation for or follow other cooperative strategies such as joint strategic or operational planning between agency leadership, training staff together, or pooling funds for shared efforts. In this study, we hypothesized that child welfare-involved adolescents who used substances would be more likely to receive treatment when child protective services and substance abuse treatment were provided by the same agency and/or child welfare agencies used interagency agreements, joint planning, joint training, or joint budgeting to coordinate with substance abuse treatment providers. To reveal the potentially distinct effects of different types of ties, these were framed in this study as five separate predictions.

1.2. How child welfare ties to schools may affect entry into substance abuse treatment

A second potentially key partner for improving substance abuse treatment use for adolescents engaged with child welfare is the school system. As the organizations in which adolescents spend the most time, schools are centrally positioned to identify those with behavioral problems (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). Schools are also the primary provider of mental health treatment for children (Burns et al., 1995) and thus a major portal into related services (Brener et al., 2007). In a national survey, middle school counselors reported that they were generally students' first point of contact for their substance use problems (Burrow-Sanchez, Lopez, & Slagle, 2008).

Despite the important role schools play in identifying child maltreatment and facilitating service use, the different foci of child protective services and education often make it difficult for them to collaborate effectively (Altshuler, 1997; Goren, 1996). Educators may not understand the confidentiality constraints that apply to child welfare caseworkers, and caseworkers may not always fully appreciate how adolescents' living situations affect their classroom functioning (Altshuler, 2003). Interagency agreements can make it easier for child welfare caseworkers and school personnel to share information. Joint policy planning can include developing mechanisms to improve adolescents' behavioral health services. Cross-training staff can foster personal contacts that facilitate referrals into treatment, as well as better mutual understanding about each organization's goals and constraints (Hodges, Nesman, & Hernandez, 1999). Finally, joint budgeting may enable child welfare agencies and schools to use resources more effectively. Previous school-based interventions addressing child maltreatment have been traced to improved academic and behavioral outcomes for children (Children's Bureau, 2003). No previous research has examined how child welfare ties to schools affect substance abuse treatment for adolescents.

Cumulatively, findings from previous research suggest that ties between child welfare agencies and schools may improve use of a variety of services for child welfare-engaged adolescents. In this study, we hypothesized that such adolescents would be more likely to receive needed