Journal of Substance Abuse Treatment 79 (2017) 20–28

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

Interagency collaboration and receipt of substance abuse treatment services for child welfare-involved caregivers☆

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ARTICLE INFO

Article history:
Received 10 January 2017
Received in revised form 5 May 2017
Accepted 9 May 2017

Keywords:
Caregiver
Child welfare
Collaboration
Service delivery

ABSTRACT

Caregivers dealing with problematic substance use pose persistent challenges for families involved with the child welfare (CW) system. Research has indicated that receipt of substance use disorder (SUD) services help improve family outcomes. However, there are many challenging stages of intervention in the SUD treatment process, including detection, assessment, referral, entry, and completion. Considerable work is needed to illuminate factors that strengthen the delivery of SUD-related services at various points in the treatment services continuum. Although a growing body of work has focused on individual-level correlates, few studies have examined organizational factors that potentially affect the delivery of SUD-related services. This study sought to further understanding of the relationship between CW organizational factors (interagency collaboration and organizational resources) and delivery of SUD-related services in a nationally representative sample of CW-involved caregivers. In this study sample, engagement in collaboration through a memorandum of understanding (MOU) and co-location supported caregiver receipt of a referral to SUD services. Caregivers were more likely to receive a formal assessment for SUD problems when their CW agencies reported the availability of a standardized SUD assessment tool. Also, having arrangements with SUD agencies so that CW-involved families had priority status to enter treatment was pertinent to caregiver receipt of SUD treatment services. These results provide evidence that engagement in collaboration activities and greater organizational resources can increase an organization's capacity to deliver services to clients.

1. Introduction

Caregivers dealing with problematic substance use pose persistent challenges for families involved with the child welfare (CW) system (U.S. Government Accountability Office, 1998; Wulczyn, Ernst, & Fisher, 2011; Young, Boles, & Otero, 2007). This includes associations with negative outcomes such as lower rates of reunification, higher rates of out-of-home placement, and reentry to CW (Barth, Gibbons, & Guo, 2006; Brook & McDonald, 2007; Choi & Ryan, 2006; Grella, Hser, & Huang, 2006; U.S. Department of Health and Human Services, 1999; Vanderploeg et al., 2007). Additionally, stipulations from the 1997 Adoption and Safe Families Act (ASFA), which require permanency hearings to take place within 12 months of a child being placed in foster care, place parents with substance use disorders (SUD) at greater risk for losing their parental rights (Green, Furrer, Worcel, Burrus, & Finigan, 2007). An estimated of up to two thirds CW-involved caregivers are affected by SUDs (U.S. Government Accountability Office, 1998; Wulczyn et al., 2011; Young et al., 2007), making delivery of SUD-related services crucial to improving child and family well-being outcomes. Moreover, research has indicated that receipt of SUD services such as treatment services help improve family outcomes, including children spending fewer days in foster care and a greater likelihood of family reunification (Green, Furrer, et al., 2007; Green, Rockhill, & Furrer, 2007; Ryan, Marsh, Testa, & Louderman, 2006).

However, research has found many challenging stages of intervention in the SUD treatment process, including detection, assessment, referral, entry, and completion (Arria & Thoreson, 2007; Belenko et al., 2017; Brady & Ashley, 2005; Redko, Rapp, & Carlson, 2006; Xu, Rapp, Wang, & Carlson, 2008). Indeed, many different behaviors, actions, and circumstances at various levels (e.g., individual, staff, and agency characteristics) influence both the delivery of and engagement in these services for CW-involved families. Considerable work is needed to illuminate factors that strengthen the delivery of SUD-related services at various points in the treatment services continuum, especially for families receiving services across service systems (Belenko et al., 2017). Although a growing body of work has focused on individual-level correlates (e.g., child, family, and caseworker; Choi & Ryan, 2006; Chuang, Wells, Bellettiere, & Cross, 2013; Grella, Needell, Shi, & Hser,

☆ All contributing authors have no relevant financial interests pertaining to this manuscript and certify that there are no conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject matter or materials discussed in the manuscript.

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http://dx.doi.org/10.1016/j.jsat.2017.05.006
0740-5472/

2009; Ryan, Choi, Hong, Hernandez, & Larrison, 2008), few studies have examined organizational factors that potentially affect the delivery of SUD-related services. This work sought to further understanding of the relationship between CW organizational contextual factors and delivery of SUD-related services in a nationally representative sample of CW-involved caregivers. In particular, drawing from interorganizational theories of collaboration, this study examined the role of interagency collaboration between CW and drug and alcohol service [DAS] agencies and the availability of SUD resources in CW agencies in influencing the delivery of SUD-related services to this population.

1.1. Interorganizational theories of collaboration

Alter and Hage's (1993) interorganizational collaboration theory expanded on several theories that provide context for the connection between engagement in collaboration activities and organizational environmental factors in the delivery of services to high-risk populations. One of the theories they used was rational choice theory (Alter & Hage, 1993; Postmus & Hahn, 2007), which posits that organizations that provide services to the same clientele (particularly those with high needs) collaborate to increase service capacity and meet client needs. Additionally, according to resource-based theories (Dyer & Singh, 1998; Pfeffer & Salancik, 1978), organizations also collaborate with partners when that partner can provide or contribute to resources or capacities that the organization does not possess. Therefore, CW agencies may be engaging in collaborative efforts with DAS providers to improve delivery and connection to SUD-related services for caregivers dealing with SUD problems (He, 2015; Pfeffer & Salancik, 1978). Moreover, because CW agencies traditionally provide nonspecialized services, collaborating with specialized services providers is vital to providing expedited services (e.g., SUD-related treatment services) to vulnerable families.

The few studies that have examined organizational factors such as collaboration in delivering SUD-related services to caregivers have been mostly atheoretical. However, these studies indicated that collaboration between CW agencies and DAS providers was especially effective in increasing caregiver receipt of formal assessment by DAS specialists, referrals to SUD services, and access to SUD treatment services (Aarons, Hurlburt, & Horwitz, 2011; Green, Furrer, et al., 2007; Ryan et al., 2008; Traube, He, Zhu, Scalise, & Richardson, 2015; Wells & Chuang, 2012). Although collaboration with DAS providers has been found to promote access and referral to SUD treatment services, there is a lack of understanding regarding which aspects of collaboration or what collaboration strategy contributes to strengthening delivery of SUD-related services.

1.2. Organizational resources and SUD services

Emergent research has indicated that availability of organizational resources, such as the use of a standardized SUD assessment instrument, may reduce subjectivity and better equip CW caseworkers with the tools necessary for accurate identification and assessment of SUD problems (Chuang et al., 2013; Feit, Fisher, Cummings, & Peery, 2015). In turn, having adequate resources to screen for SUD needs can support assessment of and referral to SUD services and facilitate entry into SUD treatment for CW-involved caregivers at high risk of SUD problems (Traube et al., 2015). On the other hand, even if SUD needs have been identified, additional organizational resource constraints such as limited availability of SUD service agencies and long wait lists have posed challenges in delivering SUD-related services to a wide range of individuals, including CW-involved caregivers (Arria & Thoreson, 2007; Brucker, 2010; Small, Curran, & Booth, 2010). Additionally, organizational resource constrictions including worker burden related to high caseloads can also affect caseworker service delivery (Burton, 2010; Ford, Cerasoli, Higgins, & Decesare, 2011).

1.3. Caregiver characteristics and SUD services

Extensive research has explored individual-level caregiver factors associated with the use of various health services, primarily demographic characteristics such as age, gender, race and ethnicity, and education (Andersen, 1995; Kimerling & Baumrind, 2005; Small, 2015; Stein, Andersen, & Gelberg, 2007). For example, a review of the literature found that women with SUDs were less likely than men to enter treatment (Greenfield et al., 2007). Associations have also been found between caregivers' age, race and ethnicity, education, and poverty and receipt of SUD treatment (Grella et al., 2006; Small, 2015). Moreover, CW-involved caregivers dealing with SUD-related problems participate in treatment services at a lower rate than those without such involvement (Choi & Ryan, 2006; Ryan et al., 2008).

Hence, accounting for caregivers' individual characteristics, the goal of this paper was to examine the relationship between organizational factors of interagency collaboration and organizational resources and the delivery of SUD-related services (assessment, referral, and treatment) to CW-involved caregivers at high risk of SUD problems.

2. Methods

2.1. Study design

The current study used data from the second cohort of families from the National Survey of Child and Adolescent Well-Being (NSCAW II). NSCAW II is the only national longitudinal study of families investigated by U.S. child protective services agencies. Researchers employed a complex sampling approach involving two stages of stratification. The primary sampling units were county CW agencies (81 located in 30 states) and the secondary sampling units were children (and their families) randomly chosen from a list of all children investigated by sampled CW agencies between February 2008 and April 2009. Children were given a unique identification number which was used to connect them to corresponding data collected from: (a) the CW agency in which they were involved with; (b) the investigative caseworkers who were assigned to the children's cases; and (c) the children's primary caregivers. The NSCAW II dataset contained analysis weights that accounted for the complex sampling design (e.g., issues of nested data, missingness) and the estimation of differential probabilities of inclusion in the sample. Additionally, the NSCAW study used two-level probability weights (adjusted for stratification by state), with person-level weights at level 1 and agency weights at level 2. More comprehensive information about NSCAW II's study design can be found elsewhere (Dowd et al., 2012).

For this current study, NSCAW II baseline data were provided by local agency directors, investigative caseworkers, and primary caregivers. Local CW agency directors provided information on CW organizational contexts and represented counties participating in the NSCAW II. When an agency director had oversight over multiple participating counties, he/she completed separate interviews for each county. Investigative caseworkers were required to access written case records for the families (Dowd et al., 2010) and asked to provide information on the services received by families. Data were also collected from interviews with primary caregivers identified as the person most involved with the child on a day-to-day basis.

2.2. Analytic sample

The initial NSCAW II sample consisted of 5873 families, of which 5091 cases included investigative caseworker interviews; data were collected for one unique child and one unique primary caregiver for each family. The study sample was restricted to primary caregivers who met criteria for harmful use of or dependence on alcohol or drugs on two validated instruments (caregiver self-report, as described in the variables section) and those reported by CW caseworkers as