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Facilitators and barriers to interagency collaboration in mother–child residential substance abuse treatment programs

A.L. Iachini *, D.D. DeHart, J. McLeer, R. Hock, T. Browne, S. Clone

College of Social Work, University of South Carolina, Columbia, SC 29208, United States

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ABSTRACT

Interagency collaboration is imperative to address the multiple and co-occurring needs of youth and families impacted by substance abuse. Mother–child residential treatment programs represent a unique program model where success often hinges on collaboration between substance abuse agencies and a range of other service providers. Little is known, however, about the facilitators and barriers to implementing these service programs. The purpose of this qualitative study was to uncover these program influences within six mother–child residential treatment programs in one southeastern state and identify whether there were differences in these influences based on the developmental stage of the collaborative. Interviews were conducted with 26 stakeholders from substance abuse agencies and their community partners. Field notes also were captured at each site. All qualitative data were analyzed using open, axial, and selective coding methods. Three overarching themes represented by both facilitators and barriers emerged, including 1) Clarity, Credibility, & Support for the Model (e.g., success stories, stakeholder support), 2) Continuity of Care across Agencies (e.g., interagency communication, disciplinary service silos), and 3) Knowledge and Processes for Collaborative Work (e.g., commitment to client population, need for training, sustainable practices). These influences on interagency collaboration were found to vary based on developmental stage of the collaborative. Implications and recommendations for child and family service practitioners, policymakers, and researchers are discussed relative to maximizing the positive impact of mother–child residential treatment programs for children and families.

1. Introduction

Parental substance abuse is noted as a contributing factor in approximately one to two-thirds of cases in the child welfare system (Besinger, Garland, Litrownik, & Landsverk, 1999; Semidei, Radel, & Nolan, 2001; United States Department of Health and Human Services (USDHHS), 1999). Children living with parents that have substance use problems are at higher risk for maltreatment and abuse, and severity of child abuse and neglect tends to be worse when parents have substance abuse problems (Semidei et al., 2001). In addition, when children living in such situations enter the child welfare system, they often remain in the system longer with less chance of reunification with their family (Ryan, Marsh, Testa, & Louderman, 2006; USDHHS, 1999; United States Government Accounting Office, 1998). Thus, when parental substance abuse is unaddressed, detrimental consequences extend beyond the parents to affect children and families.

Given the intersection of parental substance abuse with child maltreatment and child welfare involvement, as well as the broad-ranging impacts on the family, comprehensive and coordinated services are needed to span across substance abuse treatment, child welfare, and other human service systems (Lee, Esaki, & Greene, 2009; Ryan et al., 2006; Semidei et al., 2001; USDHHS, 1999). Within the spectrum of such collaborative models (e.g., cross-agency referral, co-located offices), one family-centered model gaining increased attention is mother–child residential treatment. These programs provide in-patient substance abuse services for mothers, therapeutic services for children, and programming directed at supporting the family unit (Conners, Bradley, Whiteside-Mansell, & Crone, 2001; Killeen & Brady, 2000; Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2009). Models of mother–child residential treatment vary across locales (Child Welfare Information Gateway, 2014; Osterling & Austin, 2008), involving professionals from different disciplinary backgrounds (e.g., substance abuse treatment, child welfare, mental and physical health), engaging mothers and children through different methods (e.g., therapeutic childcare, parent–child interactive therapy), and operating under different administrative, funding, and policy parameters (e.g., as a single agency versus agency partnerships; utilizing state versus federal funding streams). Given these complexities, guiding literature and studies on implementation of these collaborative models are limited.

This paper contributes to the knowledge of mother–child residential treatment programs. Specifically, we examine facilitators and barriers to

* Corresponding author at: 328 DeSaussure, College of Social Work, University of South Carolina, Columbia, SC 29208, United States. Tel.: +1 803 777 2373.
E-mail address: iachini@mailbox.sc.edu (A.L. Iachini).

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interagency collaboration for mother–child residential treatment programs in one southeastern state and then explore whether these influences vary based on the developmental stage of the collaborative. First, we review extant literature on mother–child treatment, the importance of interagency collaboration to such treatment, theoretical frameworks on interagency collaboration, and facilitators and barriers to interagency collaboration. Next, we describe our qualitative needs assessment research conducted with six partnerships for mother–child residential treatment. Finally, we discuss implications of this research for child and family service practitioners, policymakers, and researchers, with specific recommendations for maximizing the positive impact of mother–child residential treatment for children and families served.

2. Background

2.1. Mother–child residential treatment programs for substance use

Mother–child residential treatment programs for substance use support both mothers and their children in order to "reintegrate both mother and child back into the community" (Killeen & Brady, 2000, p. 24). These programs not only provide mothers with comprehensive substance abuse treatment, but also often allow children to reside with their mother in the treatment facility. Frequently, children have access to their own services and have treatment plans as well (Killeen & Brady, 2000). Given the larger movement toward family-centered treatment for women with substance use disorders (Werner, Young, Dennis, & Amatetti, 2007), many of these mother–child residential substance use treatment programs also offer other supportive services to mothers and their children through the development of collaborative partnerships with other service sectors (e.g., health, mental health, employment, education, housing).

To date, mother–child residential treatment programs have demonstrated promising positive outcomes for both mother and child (Osterling & Austin, 2008). Conners et al. (2001) found that mothers who graduate from these programs tend to relapse less often and experience greater family cohesion than those who drop out of the programs. In addition, Killeen and Brady (2000) found that women who graduated from a mother–child residential treatment program experienced improved parental functioning compared to those who did not. Other positive outcomes include greater retention of mothers in treatment (Hughes et al., 1995; Metsch et al., 2001; Osterling & Austin, 2008) and better mental health outcomes for mothers (Wobie, Eyler, Conlon, Clarke, & Behnke, 1997). Mothers are also said to develop "enhanced coping skills and newfound knowledge about alternatives to physical punishment" (Carlson, 2006, p. 109). Accordingly, improved outcomes are noted for children in these programs, including decreased problems with internalizing and externalizing behaviors (Killeen & Brady, 2000).

2.2. The importance of inter-agency collaboration for mother–child residential treatment

As mother–child residential treatment programs focus not only on promoting the mother's recovery, but also prioritize improving the child's developmental outcomes and strengthening the family unit, many of these programs cross the traditional boundaries of isolated programs being provided by substance abuse agencies alone. Child welfare agencies, mental health agencies, primary care providers, housing supports, and vocational rehabilitation agencies are often needed for a comprehensive continuum of care that supports the differing needs of mothers and their children (Werner et al., 2007). By design, then, the success of these mother–child residential treatment programs often hinges on inter-agency collaboration.

Inter-agency collaboration has been defined as when there are "fully shared services among agencies and an increasing loss of autonomy of individual agencies replaced by collective policy-making" (Tseng, Liu, & Wang, 2011, p. 798). Partnerships between agencies can exist at varying stages across the continuum of integration, ranging from cooperation (where there is differential power in agency decision-making) to coordination (where agencies work together and make some accompanying procedural and policy shifts to accommodate the other) to ultimately collaboration (Claiborne & Lawson, 2005; Tseng et al., 2011). Inter-agency collaboration is considered the ideal state of integration between agencies, where there is a joint pursuit of mutual goals that are encouraged and supported through policies and programs within each organization (Smith & Mogro-Wilson, 2008). However, achieving this level of integration is not a simple feat, and partners are likely to struggle along the way as they work through various stages of the continuum.

2.3. Theoretical frameworks on inter-agency collaboration

Several theoretical frameworks have been advanced to help identify and contextualize potential influences on inter-agency collaboration (Claiborne & Lawson, 2005; Reilly, 2001; Tseng et al., 2011). Common to all of these frameworks is an emphasis on the developmental stage of the collaborative and how developmental stage can serve as a critical progress marker to the identification of potential facilitators and barriers to progression into a subsequent stage. Reilly (2001) described these stages most succinctly, suggesting that inter-agency collaboration results through the following sequence of stages: identification of a need/problem, formation of the collaborative, implementation of a program/service via the collaborative, engagement/maintenance of the collaborative, and then ultimately resolution of the need and evolution of the collaborative itself. What might facilitate or hinder the progression of a collaborative, however, is proposed to differ by developmental stage (Reilly, 2001; Tseng et al., 2011). For example, processes to support interagency collaboration may be more important in the formation and implementation stages, whereas the effectiveness of the collaborative in achieving its goals may be more critical to the engagement/maintenance stage (Reilly, 2001). Thus, the nature of the challenges to inter-agency collaboration may be different depending on where these fall along the continuum of collaborative development. Thus, improving our understanding of influences upon interagency collaboration based on developmental stage can help shape the future development of inter-agency collaborative efforts around mother–child residential treatment programs.

2.4. Facilitators and barriers to collaboration between substance abuse agencies and other service agencies

In recent years, there has been increasing attention to inter-agency collaboration within child- and family-serving fields and sectors (e.g., education, child welfare, mental health, healthcare, juvenile justice; Anderson-Butcher & Ashton, 2004; Chuang & Lucio, 2011; Darlington, Feeney, & Rixon, 2005; Haight, Bidwell, Marshall, & Khatiwoda, 2014; Kingsnorth, Lacombe-Duncan, Keilty, Bruce-Barrett, & Cohen, 2015; Palinkas et al., 2014). For example, research has examined inter-agency collaboration between child welfare and mental health (Darlington et al., 2005), child welfare and juvenile justice (Haight et al., 2014), and child welfare, juvenile justice, and mental health agencies (Palinkas et al., 2014). Collaboration among schools, child welfare, mental health agencies, and other community organizations also has received attention (Anderson-Butcher & Ashton, 2004; Chuang & Lucio, 2011; Lee et al., 2012).

Together, these studies have illuminated some critical influences on inter-agency collaboration among different child- and family-serving organizations. These include leadership (Kingsnorth et al., 2015; Palinkas et al., 2014), organizational processes (Darlington et al., 2005; Palinkas et al., 2014), and training or resource availability (Darlington et al., 2005; Haight et al., 2014). Stakeholder perceptions of trust, communication among partners, and profession/discipline-specific boundaries also have been noted to influence the extent of collaboration