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The Impact of Foster Care and Temporary Assistance for Needy Families (TANF) on Women's Drug Treatment Outcomes

Cathleen A. Lewandowski, Ph.D., LCSW

School of Social Welfare University at Albany, State University of New York

Twyla J. Hill, Ph.D. [Associate Professor]

Department of Sociology Wichita State University

Abstract

This study assesses the impact of having a child in foster care and receiving cash benefits through Temporary Assistance for Needy Families (TANF) on women's completion of a residential drug treatment program. The study's hypothesis was that drug treatment completion rates for women who had children in foster care and/or who were receiving TANF would differ from women who did not receive these services. The sample included 117 women age 19 to 54, in a Midwestern state. Findings suggest that women with a child or children in foster care were less likely to complete treatment. Women receiving cash benefits were also somewhat less likely to complete treatment than women not receiving these services. Women with children in foster care had similar levels of psychological, employment, and drug and alcohol concerns as other women, as measured by the Addiction Severity Index. Future research should focus on identifying strategies that enhance retention rates of these vulnerable women. Implications for improving treatment retention are discussed in light of the Adoption and Safe Families Act of 1997 and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Text

The purpose of this study was to assess how having a child in foster care, and/or receiving cash benefits through Temporary Assistance for Needy Families (TANF) impacted women's residential drug treatment completion rates. The study took place at a women's residential drug treatment center in the Midwest where drug treatment, child welfare, and TANF are provided through three different agencies who work independently of each other, and where there is little, if any, interagency collaboration.

Examining the impact of foster care and welfare on women's drug treatment completion rates seems especially relevant in light of the passage of the Adoption and Safe Families Act of 1997 (ASFA) and the Personal Work and Responsibility Act of 1996 (PRWORA). As service delivery systems, child welfare, TANF, and substance abuse services have separate goals, philosophies, legal mandates, and timelines. With the new ASFA timelines, low-income women in recovery are expected to completely overcome their addiction in a relatively short period of time (Azzi-Lessing & Olsen, 1996). While not empirically tested, these various

Corresponding author: Cathleen A. Lewandowski, Ph.D., LCSW Associate Professor and Director Center for Human Services Research School of Social Welfare University at Albany, State University of New York 135 Western Avenue Richardson Hall, 207 Albany, New York 12222 clewandowski@uamail.albany.edu 518-591-8784.

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timelines make it more difficult for mothers to work toward recovery. For example, accounts from pilot tests of women's residential drug treatment programs suggest that women be allowed to progress at their own rate and be offered services they could use. Personnel from some of the pilot projects suggested that they felt pressured to emphasize a rapid reentry into the workforce. Additionally, child welfare would often dictate the level and timing of parenting classes when women are in drug treatment. Requirements from both of these agencies put tremendous pressure on these pilot sites to rush women through drug treatment (CSAT, 2001).

Previous research has examined how women's substance abuse and drug treatment involvement has impacted outcomes that are desirable to child welfare and welfare agencies, but there has been less attention on how these services impact outcomes that are desirable to drug treatment programs; namely, ongoing recovery. Further, though the agencies often serve the same clients, there is a paucity of studies that examine the impact of child welfare, welfare, and drug treatment program within one study. To illustrate, a study in the child welfare arena examined how mothers' participation in drug treatment impacted the well-being of their children who were in foster care (Haight, 2005). Similarly, in the welfare arena, one study examined the relationship between TANF recipients' history of substance abuse and their employment functioning (Gorske, Larkby, Daley, Yenerall, & Morrow, 2006). While the well-being of children and having employment are certainly important, less is known about how having a child in foster care and TANF work requirements affect women's recovery process.

Several studies indicate that better drug recovery outcomes are achieved when women receive more services, in addition to drug treatment services (Ashley, Marsden, & Brady 2003; Smith, 2002; Sun, 2000). However, voluntary and involuntary services may differ in their overall benefit. Based on current policies, foster care services and receiving TANF cash benefits have consequences associated with noncompliance, and these consequences may mitigate the potential benefit of additional services (Beckman, 1994).

The study's hypothesis was that residential drug treatment completion rates for women who had a child in foster care and/or who received TANF cash benefits would differ from completion rates of women who did not receive these services. The study used a nondirectional hypothesis since this was an exploratory study. While most studies indicate that women who have their children with them in treatment were likely to complete treatment (Hughes, Coletti, Neri, Urmann, 1995; Knight, Logan, & Simpson, 2001; Nishimoto & Roberts, 2001; Stahl, Sicillian, & Anthony, 1995; Szuster, Rich, Chung, & Bisconer; Strantz, & Welch, 1995), at least one study suggests that women who had custody of their children and who had significant child care responsibilities were less likely to complete treatment (Knight, Logan, & Simpson, 1999). Further, much of the relevant TANF research is descriptive, and there is little research that assesses the impact of receiving TANF cash benefits on women's drug treatment outcomes (Gutman, Ketterling & McLellan 2003; Keese & Williams, 1997; Montoya, Atkinson & Struse, 2001).

In child welfare, drug abuse is often viewed as the most serious problem (Bush & Sainz, 1997), and is a factor in three-fourths of all foster care placements (Day, Robison, & Sheikh, 1998). Substance abuse places women at risk for poor parenting and losing their children (Brady & Randall, 1999; Kettinger, 2000). Losing custody of their children due to drug use is a major threat for women in treatment (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1995). Women were willing to receive drug treatment when referred by child welfare agencies, even though they may perceive child welfare to be intrusive and unfair (Carten, 1996). Once referred, women must decide whether or not they will complete drug treatment, and the factors that impact women's drug treatment decisions are complex. Women's responsibilities for children and the related services they receive are often factors that are part of this decision-making

process and may contribute to whether they complete treatment. One study found that women who had two or more children with them in treatment, or who reported a child welfare case open tended not to complete treatment (Knight, et al, 2001). On the other hand, another study indicated that women whose children were in foster care and who completed drug treatment were more likely to be reunified with their children (Smith, 2003).

Overall, there is a lack of current data to examine post-1996 TANF reform and the literature generally relies on self-report data. Based on nationally representative datasets, less than 20% of recipients use illegal drugs in a given year. Because of the lack of data, the impact of welfare reform on the subgroup of poor women who also may use drugs are largely unknown (Pollack, Danziger, Jayakody, & Seefeld, 2001). Two recent studies of African-American women who received TANF services found that they had a high level of childhood abuse and psychiatric impairment (Gorske, et al., 2006), and were more likely to engage in unsafe and illegal activities than women who continued to receive benefits (Lam, Wechsberg, & Zule, 2002).

One TANF study found that drug treatment completion was associated with maintaining employment (Metsch, McCoy, Miller, McAnany, & Pereyra, 1999). Since this study was conducted with out-of-treatment women, it provides little insight into how receiving TANF cash benefits affects women while they are in drug treatment. TANF recipients who have substance abuse concerns often have other physical and mental health disorders and face many complex barriers, such as domestic violence. A study of one state's TANF participants found that chemical dependency of the payee or payee's partner, mental health concerns, and child welfare involvement were the major challenges facing their TANF recipients (Keese & Williams, 1997). In contrast, a more recent study found that there were no significant differences in psychosocial barriers between drug users and nonusers in a welfare-to-work program (Montoya, et al., 2001).

Additional research is needed on the effectiveness of drug treatment for women (Hanson, 2002), especially since many women are referred to drug treatment from child welfare or welfare agencies (Grella, 2006). Further, the inflexible timelines established by ASFA and PRWORA seem to be in juxtaposition to current research on the recovery process. Recovery for most individuals is a highly individualized process, and treatment is most effective when treatment providers respond to the uniqueness of each individual (CSAT, 2001; DiClemente, 2006). The strict timelines imposed by ASFA and PRWORA may work against treatment providers' ability to address each woman's individual situation. While this exploratory study does not address all the complexities found when women are served by more than one agency, it does seek to shed some light on how such a treatment environment might affect women's recovery. Specifically, this study seeks to contribute to our understanding of whether having a child in foster care or receiving cash benefits impacts women's drug treatment completion rates.

Methods

This study is part of a larger research project examining the impact of this multiple agency service environment on women's drug recovery outcomes over time. Project data were gathered using both retrospective data collected when women first entered residential treatment and prospective data collected on significant service events occurring during the study period. Data on women's drug treatment history, foster care, and TANF cash assistance, were collected using a Services Life History Calendar developed for this study. Secondary data from women's case records were used to gather information on whether or not women completed treatment, demographic data and scores on the Addiction Severity Index (ASI) (McLellan, Luborsky, O'Brien, & Woody, 1980). Both bivariate and multivariate statistics were used. Approval for

the study was obtained from the Institutional Review Board for the Protection of Human Subjects (IRB) prior to any data being collected, including pilot study data.

Site Description

The study took place in a private non-profit drug treatment program for women, located in the Midwest. The agency provides a serial comprehensive drug treatment program for up to 60 women. The service components included in their residential treatment program have been found to have positive associations with treatment completion and other desirable treatment outcomes for women (Ashley et al., 2003). As a serial program, the agency offers inpatient, or residential treatment (21-30 days), intensive outpatient (4-6 weeks), and outpatient treatment for one year in a sequential manner. While some residential programs may be longer than 30 days, this agency's residential component is limited to 30 days, brought about by changes in health care financing and the onset of managed care.

The residential treatment program uses a 12-step model, emphasizing cognitive behavioral approaches to treatment intervention. The program provides comprehensive services, including drug treatment, nursing services, housing, on-site day care, and education on HIV and other sexually transmitted diseases. The residential program also treats pregnant women, and women can bring their children with them into treatment. Counselors work with eligible women to apply for TANF cash benefits immediately upon admission. At the time of this study, the site did not apply gender specific interventions beyond providing comprehensive services and providing treatment services for women only.

Sample

The study population was all women entering residential treatment during a nine-month period in 2003. Systematic random sampling was used where every other woman entering residential treatment was invited to participate. Due to resources available for the study, all women entering treatment were not included in the study, and the decision was made to use systematic random sampling as a means to obtain a representative sample of women receiving treatment during this time period. Of women selected to participate, some would decline and others would leave treatment prior to being invited to participate. Women who indicated a willingness to participate received a written copy of the informed consent that was approved by the IRB. Prior to signing, the researcher and participant reviewed the letter, and the researcher responded to questions about any part of the study. Women and the researcher would sign two copies of the letter of informed consent. The women received one copy and the other was retained in locked files, along with other study data.

All women in the study were given a minimal cash incentive of \$7.00 to complete the initial interview. A total of 117 women agreed to participate and were interviewed. However, data on whether women had completed residential treatment were missing for four women, resulting in 113 women for the bivariate and multivariate analyses. This number is slightly less than half of the women entering residential treatment during the study period. Nonetheless, the sample appears to be fairly representative of women served by the agency during this time period. Of the 128 women entering treatment that were not included in the sample, 76% were Euro-American, and 34% had less than a high school degree. Only 15% of these women did not have children.

The 117 women in the sample ranged in age from 19 to 64, with a mean age of 32.5 (s.d. = 9.19). Few of the women (20%) were currently married, but more than half (57%) have been married in the past. In terms of ethnicity, 82 (70%) were Euro-American, 15 (13%) were African-American, 8 (7%) were Hispanic, 4 (3%) were Asian-American, and 8 (7%) were Native American. Approximately 60% had either a high school degree or its equivalent, and

21% had some college or a college degree, usually a two-year degree. Only 19% had not graduated from high school. Most women (75%) had at least one previous drug treatment episode, and 44%, or 52 women, had 2 or more previous treatment episodes. Slightly under half (42%) reported being multiple drug users when they first entered treatment.

Several women in the sample had been convicted of drug charges, making them ineligible for TANF cash benefits, as the 1996 “Gramm Amendment” imposed a lifetime ban on Food Stamps, and TANF aid to individuals convicted of drug felonies (Pollack, Danziger, & Jayakody, 2001). Though states were granted discretion to modify or revoke the TANF ban, the ban was in place in this state when this study took place. Over one-third (37%) of the women in the sample were pending incarceration at the time of admission. Drug charges were the most frequent reason for women to be pending incarceration (14, or 12%), followed by parole violations (7, or 6%). Though women convicted of drug felony charges could not receive TANF cash benefits, they may still receive medical and food assistance. In fact, a large number of women (43 or 37%) received medical and food assistance.

Variables

The dependent variable was treatment completion, a dummy variable, and indicated whether women had successfully completed residential drug treatment. Treatment completion was coded “1” when: 1) staff indicated in women's chart that they had successfully completed residential treatment, 2) women had spent the maximum of 30 days in residential treatment, or 3) women were transferred to another facility to complete their treatment program and they successfully completed treatment at the new facility. Women were coded “0” for not completing treatment when 1) they voluntarily discharged themselves from treatment without enrolling in another program, or 2) were involuntarily discharged from treatment as a consequence of not adhering to the treatment guidelines. The independent variables were having a child or children in foster care and TANF cash benefits, and were also dummy variables, indicating whether or not women received these services. Control variables included assessments of drug and alcohol addiction severity, and having employment and psychiatric problems as measured by the ASI (Leonhard, Mulvey, Gastfriend, & Schwartz, 2000). Age, marital status, race/ethnicity, and drug treatment history were the demographic variables that were also included as control variables.

For the multivariate analysis, having a child or children in foster care was measured as yes or no. Not having children in foster care placement was used as the comparison category. Receiving cash benefits was a yes/no question. Not receiving cash benefits was the comparison category. Marital status was recoded into a dichotomous variable, with 0 equal to married and 1 equal to all other marital statuses. Married was used as the comparison category. Race/ethnicity also was recoded, with 0 equal to White/Non-Hispanic and 1 equal to all other races/ethnicities. White/Non-Hispanic was used as the comparison category. For the variable education, 0 was equal to less than a high school education and 1 was equal to a high school diploma or more education. A high school diploma or more was used as the comparison category. Age and drug treatment history were continuous variables. Age was defined as age at entry into this treatment episode. Previous drug treatment was measured as the number of times participants were in residential drug treatment before this treatment episode.

Data Collection Instruments and Procedures

Data were collected from both primary and secondary sources. Primary data were collected using the Services Life History Calendar (SLHC), an instrument that was developed for this study. Secondary data were collected from the agency's computerized database and participants' treatment records. The database provided women's ASI that was completed within 24 hours of entering residential treatment by the agency's intake staff. As part of its assessment,

the ASI assigns respondents overall scores on alcohol use/abuse, drug use/abuse, employment problems, and psychological problems. Participants' treatment records were used to collect demographic data, and to compare women's responses during interviews with data found in their treatment record.

Development of the SLHC followed timeline follow-back procedures described by Freeman, Thornton, Camburn, and Young-DeMarco (1998) and Axinn, Pearce and Ghimire (1999). The timeline follow-back procedure is a relatively simple approach to collect longitudinal data. Such timeline follow-back procedures have been shown to increase reliability of the data by allowing participants to place events in the context of other events occurring in a similar time period (Schwartz & Sudman, 1996). In the substance abuse arena, it has been used to measure alcohol consumption over time (Sobell & Sobell, 1992).

To increase reliability, the SLHC was pilot-tested and revised, based on feedback from women in the pilot test and consultation with researchers and practitioners prior to the study's implementation. For the pilot study, the researcher consulted with drug treatment and social service providers to review the initial SLHC, and identify the accuracy of types of drug treatment, child welfare, and welfare services available. Using this initial draft, the researcher interviewed 11 women in a separate residential treatment program. Participants were informed that they were participating in a pilot study, and that they would be asked to provide feedback on the SLHC instrument. The SLHC was revised after each interview, based on participants' feedback. This process of revision continued until the researcher used the SLHC with several participants who stated that they had no additional comments on the instrument. None of the women participating in this initial pilot study were included in the study's final sample.

As is the case with other timeline methods, the format of the SLHC helps women recall the progression of events by relating each service event, such as having a child placed in foster care, to events in other areas of service. This also increases the reliability of the data. Timeline follow-back procedures, such as the SLHC, have been found to have face validity in drug treatment research (Sacks, Drake, Williams, Banks, & Herrell, 2003). Additionally, previous research suggests that participants' engagement in the interview process can make a substantial difference in the instrument's validity (Vinson, Reidinger, & Wilcosky, 2003).

Data Analysis

Bivariate and multivariate statistics were used. Bivariate statistics were used to examine the relationship between the independent variable of treatment completion, the dependent variables of foster care and TANF cash benefits, and the control variables. Cox regression was used for the multivariate analyses, to test the study's hypotheses while taking the control variables into account. Cox regression, and other types of event history analysis, has effectively been used to study the process of drug recovery (Willett & Singer, 1993). Cox regression is particularly suitable for this study because it controls for the effect of time, using information about relative order of duration rather than exact timing (Yamaguchi, 1991). Since we do not have the exact date of exit for those women who did not complete treatment, we used person-week records to estimate the length of treatment. Though the sample for the multivariate analysis is relatively small (113), sufficient power is accomplished through inclusion of multiple records per participant. Since data from completed interviews in event history analysis remained in the analysis even if the respondent did not finish residential treatment, the high attrition rate did not affect the sample size.

Data were organized into a "person-period" format (Willett & Singer, 1993) for the multivariate analysis. In this study, a person-week format was used so that each woman has twenty-four records; twelve for the three months, or twelve weeks preceding admission and twelve for the three months following admission into residential drug treatment. As data collection was

staggered, the time indicators denote the sequence of weeks for each individual rather than specific dates. The values of time-invariant predictors or control variables (e.g. marital status, race/ethnicity, and education) are constant for each person across all records. The time-varying variables, or independent variables, are receiving cash benefits and having a child in foster care. The event indicator, completion of residential treatment, is a dummy variable indicating whether this event occurred in the time period referenced by the record.

Results

Most of the women had children, as approximately 90% or 105, were mothers. Of these 105 women, only 27, or 23% of the women brought their children with them. For a few of these women, the state had legal custody of their children, while they retained physical custody. Only 24 women (21%) had children in foster care. Some women were receiving the supportive child welfare and TANF services designed to preserve families and increase financial independence at the time they were admitted into residential treatment. Nineteen women (17%) were receiving either family preservation or informal supervision through the child welfare agency. Twenty-five women (21%) were accepted for TANF cash benefits, and another 8 had applied for benefits after entering treatment.

Overall, 92 of the 117 women (73%) had completed residential drug treatment, 21 (18%) had not completed treatment, and information for 4 women (3%) was missing, bringing the sample size to 113. It is difficult to compare this completion rate with rates reported in the literature, as these treatment completion rates were measured after a longer interval. For example, one residential treatment program for women reported that 27% of women left treatment prematurely, but was measured within the first 90 days (Knight, Hood, Logan, & Chatham, 1999). The 11 original grantees that piloted CSAT women's residential treatment programs reported an overall dropout rate of 38%, but this was also measured between 30 and 60 days of treatment or after 6 to 9 months in the residence (CSAT, 2001). Thus, given the shorter time period of 30 days to measure residential treatment completion, an overall rate of 18% of women who did not complete treatment may be comparable to that of other residential treatment programs reported in the literature.

The bivariate analysis indicated that women who received cash benefits or who had a child in foster care were less likely to complete treatment than women who did not receive these services. As indicated in Table 1, 38% of women who received cash benefits did not complete treatment and 62% completed treatment and these differences were statistically significant ($\chi^2 = 6.5$, $p < .05$). Of women who did not receive cash benefits, 14% did not complete treatment and 86% completed treatment. However, women who had not received TANF at all during the year prior to entering treatment were more likely to complete treatment than women who were dropped from TANF, having received it for part of the year prior to entering treatment (91% and 65% respectively).

Although the results were not statistically significant, women with children in foster care were somewhat less likely to complete treatment than women without children in foster care placement. Of women with children in foster care placement, 25% did not complete treatment and 75% completed treatment. A larger percent of women with children who were not in foster care completed treatment, as only 17% did not complete treatment, compared to the 25% rate of women with children in foster care. It should be noted that mothers who brought their children with them into treatment had a similar completion rate to mothers whose children were in foster care (69% and 75% respectively). Most women without children or with children over 18 completed treatment (82%).

T-tests were used to compare women who completed treatment with those who did not complete treatment on their overall alcohol use/abuse, drug use/abuse, employment problems and psychological severity scores as measured by the ASI (Table 2). Again the results were not statistically significant, probably due to the small sample size. The results do suggest that women with higher psychiatric problems scores were less likely to complete treatment than women with lower scores. Alcohol use, drug use, and employment severity scores seemed not to affect likelihood of treatment completion. T-tests were also used to compare women with a child in foster care or who received cash benefits with those who didn't receive these services. Our findings indicated that there were no significant differences on the alcohol, drug, employment, or psychiatric severity scores between women receiving these services and those who did not receive these services.

For the Cox regression analyses, all records were used because receiving cash benefits and having a child or children in foster care, the variables of theoretical importance, are time-variant. While completion rates for all women were examined in the bivariate analysis, women without minor children were not included in the multivariate analysis shown in Table 3. The exclusion of women without minor children brings the sample to 100 women for that analysis only. Records for all 113 women were used for the multivariate analysis presented in Table 4.

As shown in Tables 3 and 4, Model 1 measures the effects of the control variables on the dependent variable. Model 2 combines the control variables with the independent variables of foster care and TANF cash benefits. Model 3 combines the control variables with the independent variables of problem severity scores. Model 4 is the most parsimonious model, retaining only the control variables significant in the prior models and the theoretically important independent variables.

In terms of the independent variables in Model 4, women with a child or children in foster care were less likely to complete residential treatment than other women with children under the age of 18. The risk of not completing treatment was 28% higher for women with a child or children in foster care than for other women with minor children. Model 4 also indicates that younger women were slightly less likely to complete treatment. For each previous drug treatment episode, the risk of not completing treatment increased by 10%. Women with higher drug and alcohol usage scores were more likely to complete treatment, however, than women with lower drug and alcohol usage scores. Women's employment problems score did not have significant effects. Having psychiatric problems greatly increased the risk that women would not complete treatment. Marital status, education, and race/ethnicity were not significant factors.

To separately determine the effects of TANF cash benefits, the analyses were also run for all 113 women and without the foster care variable, using 2713 records (Table 4). The findings indicated that women receiving cash benefits were less likely to complete treatment than women not receiving cash benefits. The risk of not completing treatment was 32% higher for women who received cash benefits than for women who did not. For women with minor children, having a child in foster care seems to be a greater deterrent to completing treatment than receiving benefits, as the TANF variable was not a significant predictor in the analysis including only mothers. The analysis including all women, however, suggests that receiving cash benefits also negatively impacts women's likelihood of completing treatment.

Discussion

These results support our hypothesis that residential drug treatment completion rates for women who have children in foster care will differ from those of women who received residential drug treatment only. As shown in model 4 of the first Cox regression analysis (Table 3), women

with a child or children in foster care were less likely to complete treatment than other women with children under age 18 years of age. This finding is consistent with earlier research suggesting that women with fewer children remained in treatment longer (Ingersoll, Lu, & Haller, 1995). Even when taking alcohol, drug, employment, and psychological problems into account, women with children in foster care were less likely to complete treatment than other women in treatment. Women receiving TANF cash benefits were also less likely to complete treatment than women not receiving cash benefits (Table 4). These results also support our hypothesis that residential drug treatment completion rates for women who receive TANF cash benefits will differ from women who receive drug treatment only.

Women who have children must confront a plethora of complex factors that weigh upon their decision of whether or not to complete treatment. Because of the complexity of the issues, and the exploratory nature of this study, the reasons for these differences in treatment completion rates cannot be ascertained. For example, it is not known whether these differences were due to the individual services and their respective mandates, the way service providers interacted with each other and with the women and families they served, or whether characteristics of the women themselves could account for these different completion rates. While it is critical to study factors that predict treatment retention, ultimately there are too many factors that contribute to an individual's decision to remain in treatment, and the overall goal of being able to predict treatment compliance for any population is elusive (Kolden, Howard, Bankoff, Maling, & Martinovich, 1997).

Women whose children are in foster care may feel “pushed out” of treatment, when facing the hurdles and short time frame they have to complete child welfare requirements for reunification with their children. Similarly, women who receive cash benefits may feel an urgency to meet TANF requirements that may affect their decision to leave treatment. It is also possible that women who receive TANF may experience a “pull,” or a “check effect,” that precipitates their departure. Swarz, Hsieh, and Baumohl (2003) describe such a phenomenon with disability payments. In their study, participants tended to purchase illegal drugs close to the time they received their disability payment. In our study, it is not known whether TANF recipients experienced consequences beyond the three-month follow-up period as a result of not completing treatment.

Women with the highest completion rates were those who had not received any TANF benefits during the past year, as 91% of these women completed treatment (Table 1). Women who had been dropped from TANF during the twelve months prior to entering treatment had similar treatment completion rates as women who still received TANF (65% and 67% respectively), suggesting that these women may have more in common with each other than women who are not receiving TANF. Instead of being in foster care, children of women who had been dropped from TANF were primarily in the custody of their biological fathers, grandparents, or other relatives. Though the exact reasons that these children were placed in the custody of their father or relatives were beyond the scope of this paper, it is possible these women relinquished custody to focus on their own recovery.

Young and Gardner (1998) described the impact of ASFA and PRWORA on women in drug recovery as the dilemma of the “four clocks.” As a first clock, ASFA requires that children achieve permanency within twelve months of being placed in foster care. For the second clock, PRWORA mandates that women can only receive a total of five years of benefits. Third, drug recovery programs emphasize a one-day-at-a-time philosophy. As a fourth clock, women in treatment may feel the pressure of their children's developmental timetable, especially younger children, while they are in treatment.

Though each agency has different priorities, they all share a common goal of women's recovery. For child welfare, recovery means mothers can provide a safe and stable home for their children. For welfare agencies, recovery lays the groundwork for self-sufficiency and ultimate independence from receiving cash benefits. Given their shared purpose and the reality of the "four clocks," it is imperative that child welfare, welfare, and drug treatment agencies work together toward their common goal. Findings from preliminary pilot studies suggest that such collaborative arrangements can benefit clients (Young & Gardner, 2002). Since first identifying the "four clocks," Young and Gardner (2002) have added the concept of the "fifth clock," to signify that time is running out on child welfare, welfare, and drug treatment agencies which fail to develop cooperative working agreements. In the absence of agency leadership to develop such collaborative programs, policy makers may step in and mandate change.

Although illicit drug use is rare among TANF recipients, most women who do use drugs have spent some time receiving cash assistance. Identifying TANF recipients with drug use disorders would have major implications for public health, whether or not women achieved economic self-sufficiency. While drug use among TANF recipients is a concern, other barriers to self-sufficiency, such as depression, post-traumatic disorder, physical health problems, education, and transportation are even larger concerns (Pollack, et al. 2001). Again, the lower completion rates of TANF recipients suggest that these women face more barriers to self-sufficiency than women who do not receive TANF.

While these results suggest that receiving cash benefits under current legislative mandates do not necessarily foster drug treatment completion, sanctioning, or further restricting access to benefits may not be the answer. Additionally, as suggested by these preliminary findings, foster care placement does not appear to encourage women's recovery through treatment completion. Sanctioning and loss of custody of children can be viewed as punishment, which also has mixed results in fostering recovery. Rather than extinguishing behaviors, punishment may simply suppress them (Craighead, Craighead, & Illardi, 1995). As discussed previously, women who lose benefits may engage in risky illegal activities, at risk to themselves, their families, and society (Wechsberg, et al., 2002).

Though we can point to some trends and tendencies, research does suggest that recovery is highly individualized (DiClemente, 2006). In light of this, perhaps decisions on whether women should retain custody of their children and/or receive cash benefits should be based on their individual situation, instead of mandating a "one size fits all" approach through legislation. Building flexibility into child welfare, welfare, and drug treatment policies could encourage staff in all three agencies to fully engage women in their recovery process. Being fully engaged with your client, establishing rapport, and taking an individualized approach to recovery has been shown to be effective in fostering recovery (DiClemente, 2006). In contrast, the current system, with its legislative mandates may inadvertently encourage providers to be more passive and less engaged with these most vulnerable women because many of the important decisions have already been made.

In terms of limitations, the study could benefit from a longer follow-up period, and a larger sample size. Future studies should follow women for at least twelve months, which corresponds to child welfare's 12-month timeframe. These findings may not be generalizable to all women's drug treatment programs, especially when the program employs a different treatment approach. Other drug treatment programs may use more structured women-specific interventions, may have longer periods of residential treatment, or may operate within a state that uses a waiver for the Gramm amendment. While the study's methodology may limit generalizability, these findings do lend support to the benefits of interventions that apply women-specific interventions (Wechsberg, Sule, & Lann, 2004), and those that seek to increase coordination between these three service delivery systems (McLellan, et al., 2003).

Implications

These findings suggest several implications for social work practice and policy. Having mothers who are drug-free and actively working on their recovery program is in the interest of all three service delivery systems, and not just drug treatment agencies. Since women served by more than one agency do not seem to differ in the severity of their concerns, it is critical that we understand how having a child in foster care and receiving cash benefits impacts women who are in drug treatment.

Previous research suggests that substance-abusing women on welfare may be more likely to complete drug treatment when there are additional services working together to address their multiple concerns (McLellan, et al, 2003). Treatment protocols should seek to build on the positive relationships of parents and their children as a way to foster recovery (Collins, Grella, & Hser, 2003). While much progress has been made, more needs to be done to develop treatment programs for women. For example, it is possible that women with children may have different treatment needs than women who do not have children. Both groups of women could benefit from more individualized approaches to treatment.

Residential treatment for women should include a holistic approach, and include a broad range of psychosocial assessments (Comfort & Kaltenbach, 2000). A family-centered model and the woman-focused intervention are two approaches that offer a broad perspective and that research suggests may benefit women served by these agencies. The family-centered approach can improve reunification outcomes for children by addressing the treatment needs of their families, including substance abuse (Lewandowski & Pierce, 2004). A culturally-specific woman-focused intervention has been effective in increasing women's self-efficacy and improving drug treatment outcomes (Wechsberg, et al., 2004).

Policymakers should explore options for introducing flexibility into existing child welfare, welfare, and drug treatment policies. In building flexibility, these agencies should be encouraged to work together, and develop collaborative partnerships. Leadership is needed within substance abuse treatment, child welfare, and welfare agencies to develop systematic strategies to promote interagency collaboration. To be successful, agency leaders should promote role clarity, mutual respect, and having a unified purpose among the three agencies (Lewandowski & GlenMaye, 2002).

Finally, policy makers should increase their efforts to foster women's drug recovery, with a special emphasis on how ASFA and PRWORA may be impacting women's drug recovery process. Though ASFA may be successful in reducing time children spend in foster care, the policy does little to decrease the number of children entering foster care because of parental substance abuse. Policy makers are divided on how welfare reform impacts women and their children. Proponents of reform argue that requiring mothers to get jobs provides the most reliable pathway out of poverty, while opponents argue that reforms have stressed parents in ways that result in poorer child outcomes (Chase-Lansdale, Coley, Lohman, & Pittman, 2006). As noted by Metsch and Pollack (2005), PRWORA was enacted during a period of prosperity, and it is not known whether the new system will be as effective during more difficult economic times.

Directions for Future Research

Future research should focus on how the established legislative timelines affect women in recovery. Studies with a larger sample could shed more light on the relationship between the range of services women may receive and their drug recovery outcomes. With a larger sample, future research could also evaluate the interaction effects between the services women receive and individual women's characteristics, such as having employment and psychiatric problems.

In light of current mandates, research should especially focus on how losing custody of her children and/or her cash benefits affects women and their families as they progress through their recovery process. These dual losses, potentially a consequence of the “four clocks,” may have a profound effect on vulnerable families. Some states do require TANF participants to undergo drug testing, and sanction those who test positive (Howard, 2000). Though there were very few women in this sample who were actually sanctioned by TANF, further research is needed to assess the impact of sanctioning and pressures to find employment on women's drug recovery outcomes. Implementation studies should also be conducted to evaluate how the current state of the art in addiction research can continue to be incorporated into women's drug treatment programs.

Though these findings are preliminary, the study was conducted in a context where there was little collaboration between the drug treatment, child welfare, and welfare agencies. Given that ASFA and PRWORA remain in effect, further research is needed to assess how collaborative agency partnerships affect women's drug treatment completion rates. Such studies should also assess how these partnerships affect foster care placement decisions and the impact of cash benefits on women's recovery and their drug treatment outcomes.

In closing, it has been several years since Young and Gardner (2002) challenged agencies through the metaphor of the fifth clock, to develop collaborative interagency relationships. Meanwhile, mothers who are in drug treatment must conduct an elaborate juggling act to continue in recovery, keep their family together, and maintain some form of economic viability. For them, the clocks are still ticking, and time is, in fact, running out.

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Table 1

Treatment Completion Rates by Characteristics and Supportive Services (N = 113)

	Complete (%)	Not Complete (%)
Education		
Less than HS	19 (83)	4 (17)
HS, GED, or more	73 (81)	17 (19)
Ethnicity		
White/non-Hispanic	65 (82)	14 (18)
African, Hispanic, Asian, and Native-American	27 (80)	7 (20)
Parental Status		
Not Mothers or all children over age 18	18 (82)	4 (18)
Mothers with children less than 18	74 (81)	17 (19)
Mothers who brought children with them to treatment	18 (69)	8 (31)
Mothers with children in state custody	33 (87)	5 (13)
Mothers whose children were in relatives' care	23 (85)	4 (15)
Current Services and Supports		
Family Preservation	8 (89)	1 (11)
Foster care	18 (75)	6 (25)
TANF	13 (62)	8 (38)
Financial Supports Received during last year		
Financial support from family	22 (71)	9 (29)
TANF for part of the year	11 (65)	6 (35)
No TANF	68 (91)	7 (9)

Table 2
Comparison of Mean ASI Severity Scores by Treatment Completion (N = 113)

ASI Severity	Treatment Completion	n	Mean	Std. Deviation	t-test
Alcohol	Not Complete	21	.168	.2664	-0.791
	Completed	92	.220	.2741	
Drug	Not Complete	21	.175	.1189	-0.068
	Completed	92	.177	.1224	
Employment	Not Complete	21	.688	.4460	0.145
	Completed	92	.673	.3961	
Psychiatric	Not Complete	21	.425	.2752	1.644
	Completed	92	.325	.2461	

* p<.05;
** p < .01;
*** p<.001

Table 3

Risk Ratios of Characteristics Affecting Completion of a Residential Drug Treatment Program

Independent Variables	Model 1	Model 2	Model 3	Model 4
Age	0.978**	0.981**	0.981**	0.979**
Marital Status	0.925			
Race/Ethnicity	1.075			
Education	0.893			
Previous Drug Treatment	1.055*	1.064**	1.097***	1.099***
Child in Foster Care		1.233 ⁺		1.275*
Receiving Cash Benefits		1.138		
Overall Alcohol Score			0.553**	0.542**
Overall Drug Score			0.118***	0.123***
Overall Employment Problems Score			0.915	
Overall Psychological Problems Score			4.250***	4.394***
χ^2	15.441**	16.737**	68.253***	71.528***

⁺
p < .1;*
p < .05;**
p < .01;***
p < .001

Table 4

Risk Ratios of Characteristics affecting Completion of a Residential Drug Treatment Program (without foster care variable)

Independent Variables	Model 1	Model 2	Model 3	Model 4
Age	0.959***	0.964**	0.968***	0.969**
Marital Status	0.947			
Race/Ethnicity	1.117			
Education	0.814 ⁺			
Previous Drug Treatment	1.109***	1.123***	1.149***	1.149***
Receiving Cash Benefits		1.366**		1.318*
Overall Alcohol Score			0.531**	0.543**
Overall Drug Score			0.214***	0.189***
Overall Employment Problems Score			0.884***	
Overall Psychological Problems Score			4.971***	4.813***
χ^2	72.175***	75.728***	150.473***	153.655***

⁺ p < .1;

* p < .05;

** p < .01;

*** p < .001