Eastern Illinois Intact Family Recovery Program Evaluation

Final Report

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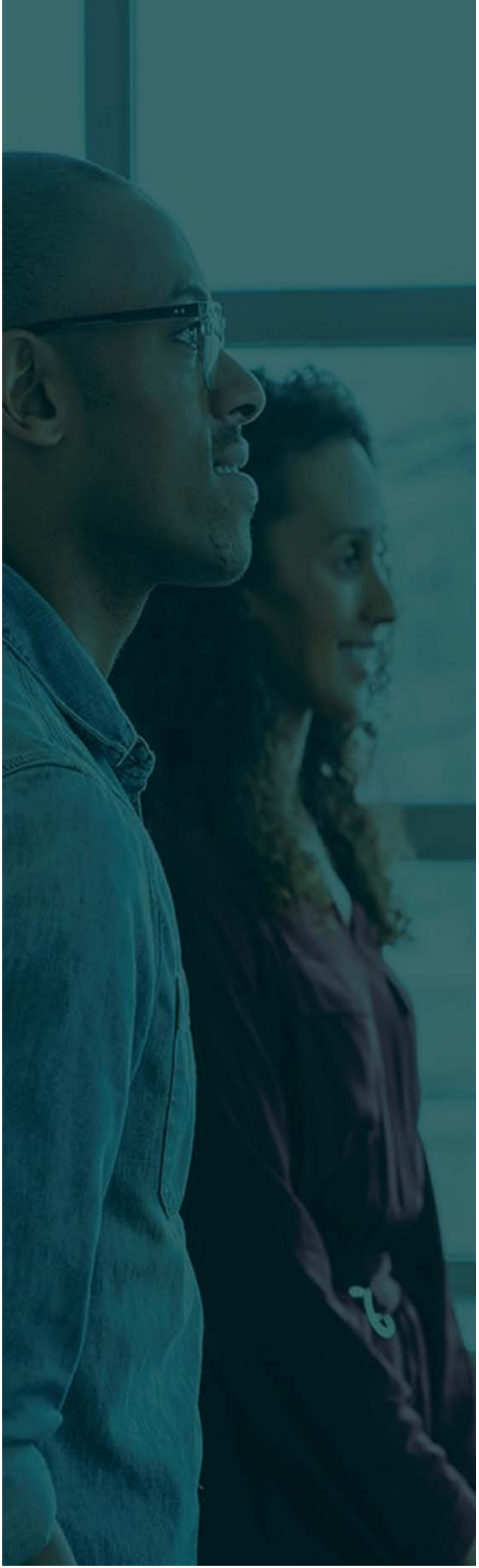

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EASTERN ILLINOIS INTACT FAMILY RECOVERY (EIL IFR) PROGRAM: OVERVIEW

What is the EIL IFR Program?

Parental substance misuse is a long-standing challenge in the child welfare system and contributes to a range of negative outcomes for parents and children. Parental substance misuse disrupts family stability and cohesion and endangers the safety and well-being of children (Ryan et al., 2016). The number of children entering foster care attributable to parental substance use increased by 20 percent from 2000 to 2020 (AFCARS, 2020). Further, research shows that children of parents with a substance use problem have more difficulties in academic, social, and family functioning and are at higher risk for mental and behavioral problems (Peleg-Oren & Teichman, 2006). However, 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).

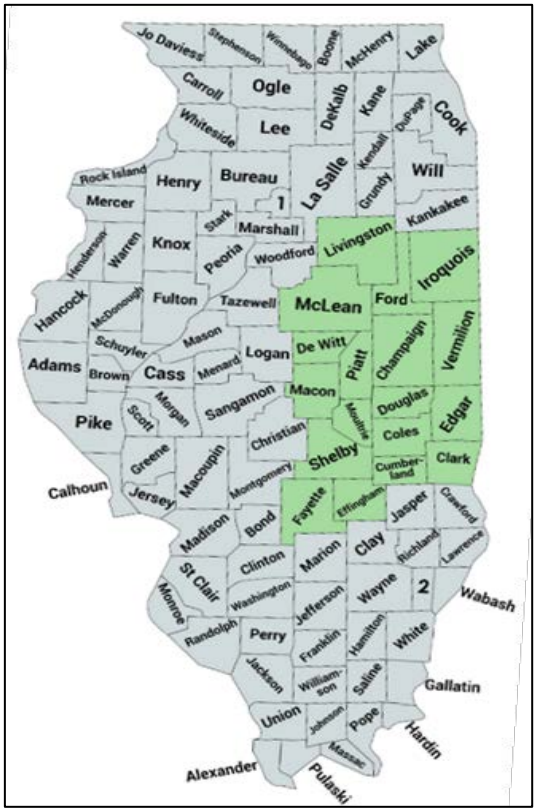
The EIL IFR program was a five-year project funded in 2019 by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) under its Regional Planning Grant (RPG) initiative (Grant #90CU0107). RPG grantees were required to (1) provide services that increase the well-being, 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. The EIL IFR program met each of these requirements by (1) expanding use of recovery coordinators in the Illinois Department of Children and Family Services' (DCFS) Intact Family Services (IFS) program in 18 counties in east-central 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 EIL IFR program evaluation.

This report summarizes evaluation activities conducted across the five years of the EIL IFR project. We begin by describing the EIL IFR program and the services that were delivered to participants. Next, we provide an overview of the EIL IFR program evaluation. Our evaluation included an outcome evaluation that assessed the impact of EIL 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 EIL IFR program.

EIL 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.

Figure 1. EIL IFR Program Map



The 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 SUDs who received IFR were more likely to complete substance use treatment and achieve stable reunification with their children. The Illinois Regional Partnership, led by ICOY, expanded this model to provide IFR services to any family with a parent who has SUD, not just those who have a substance-exposed infant. From 2017 to 2022, the partnership implemented and tested this model in our ACF-funded Illinois Intact Family Recovery (IL IFR) program in seven northern Illinois counties. For this project, we replicated the IL IFR program model in east-central Illinois to continue testing the model among mostly rural populations.

The project sought to enroll 480 families in EIL IFR services in 18 counties in east-central Illinois: Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Fayette, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby, and Vermilion (see Figure 1).[1] Four child welfare program partners were randomly selected to serve as intervention or comparison sites. Intervention sites provided Intact + recovery coordinator services. Comparison sites provided Intact only (i.e., "treatment as usual"). The Baby Fold (BF) and the Center for Youth and Family Solutions (CYFS) were randomly selected to be

[1] Initial program implementation included 16 counties: Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby, and Vermilion. In November 2021, the evaluation expanded to include Effingham and Fayette Counties to increase enrollment after Intact supervisors noted that they receive more SUD-involved referrals from those counties.

intervention group agencies. Bethany Christian Services (BCS) and One Hope United (OHU) were randomly selected to be comparison group agencies. Each site aimed to serve 120 families. Chestnut Health Systems (Chestnut) was the project's substance use treatment partner and was responsible for hiring and supervising the recovery coordinators.

Standard IFS case assignment procedures were used to assign families to child welfare provider partners. DCFS determined whether a family was eligible for IFS and assigned families to a licensed Intact Family provider. DCFS staff responsible for assigning families to 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 EIL 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 Adult Substance Use Screen or the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); be 18 years or older; live in one of the 18 counties in our EIL IFR partnership; and agree to participate in the program. All families that participated in the EIL IFR project, regardless of whether they were case assigned to an intervention or comparison group site, were eligible to receive services for 6 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 intervention or comparison groups, received the complete range of Intact services. Families assigned to intervention 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 (client visits involving both the recovery coordinator and the Intact worker) at varying intervals depending on the parent's phase of substance use treatment. Parents in the initial phase of substance use treatment (i.e., initial referral and receipt of substance use treatment) received weekly joint visits; parents who completed substance use treatment received monthly joint visits.

Partner sites enrolled participants in the EIL IFR program from October 1, 2020, through March 31, 2024. EIL IFR services were provided through September 30, 2024. A total of 259 participants enrolled in the program; 109 were intervention group participants and 150 were comparison group participants. CYFS served 74 participants; BF served 35 participants; BCS served 64 participants; and OHU served 86 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.

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 EIL IFR program on family and child outcomes.

Methods

All ACF RPG grantees were required to participate in the national cross-site evaluation led by Mathematica. 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 Mathematica. In accordance with Mathematica's data-sharing agreement, no cross-site measures that were publicly available were administered to participants who completed interviews after the cross-site data collection ended in September 2024.

In parallel with the national cross-site evaluation, AHP conducted a local evaluation to provide more granular insights into program implementation and client outcomes. Data for the local evaluation was collected through biweekly evaluation check-in calls with Intact supervisors and recovery coordinators and through additional outcome evaluation measures collected in the client interview. The evaluation check-in calls aimed to track program and evaluation eligibility and enrollment, client access to and receipt of substance use treatment services, and program discharge and closure outcomes.

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 and Recruitment

ELIGIBILITY CRITERIA

Similar to EIL 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 an SUD assessed by the CFS 440-5, and (4) agree to receive IFR services (intervention sites) or IFS services (comparison sites). For cases where SUD was not clearly documented in the DCFS referral, EIL IFR program staff administered the ASSIST, a short, standardized tool developed by the World Health Organization that screens for substance use and related problems in adults, to confirm parental substance misuse and program eligibility.

RECRUITMENT AND ENROLLMENT

Within the first few weeks of program enrollment, EIL 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 phone interviews that ask about substance use, mental health, children, and parenting and the collection of information from IFS case records and DCFS; and (4) participants will receive a gift card for each interview they complete.

EIL IFR program staff gave an evaluation referral form to clients who expressed interest in participating in the study. Clients either filled in their contact information on this form or gave their verbal or written consent to allow program staff to fill it out on their behalf. EIL IFR staff submitted completed referral forms to AHP. AHP 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

AHP researchers conducted structured phone interviews to assess longitudinal changes in outcomes with all participants who enrolled in the evaluation. Phone interviews were conducted with parents who met eligibility criteria (described above) from the intervention and control group sites and who agreed to participate in the EIL IFR program evaluation. AHP used Research Electronic Data Capture (REDCap) to collect and manage data. REDCap is a secure, Health Insurance Portability and Accountability Act–compliant web application for collecting and managing data. AHP researchers asked for participants' permission to reach out to secondary contacts and EIL IFR program staff to assist in locating participants for their interviews, when needed.

As described above, AHP researchers conducted participant interviews at baseline (EIL IFR program enrollment), 9-month follow-up, and 18-month follow-up. Participants initially received a $30 gift card for

each interview they completed. Additional funding in 2022 allowed incentives to be increased to $80 per interview.

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 October 2020. Measures were administered at all interview time points unless otherwise indicated. As described below, three measures—the Addiction Severity Index Lite (ASI-Lite); the Parental Stress Scale (PSS); and the Stigma, Intact Family Services and Strengths—were developed for the local evaluation and were not shared with Mathematica as part of the cross-site evaluation.

PARENT OUTCOME MEASURES

ASI-Lite. The ASI-Lite assesses participants' psychiatric status and drug and alcohol use. A 22-item version of this instrument containing only psychiatric status questions was used for the evaluation. Psychiatric status questions assess participants' mental health problems (e.g., depression, anxiety, suicidality) during the past 30 days and in their lifetime. The assessment asks participants to report the number of times they have been treated for any psychological or emotional problem in a hospital/inpatient setting and in an outpatient/private setting. The ASI-Lite also includes a client-rated perception scale ranging from 0 (not at all) to 4 (extremely) to gauge clients' perception of the severity of their problems and the importance of treatment in each area. The cross-site evaluation did not assess psychiatric status, so these data were not shared with Mathematica.

Addiction Severity Index Self-Report (ASI-SR). The ASI-SR (McLellan et al., 1980, 1992) 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 (including, heroin, other opioids, sedatives, hallucinogens, cannabis, and methamphetamine) during the past 30 days, the number of days they have experienced alcohol and drug problems in the last 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. The score for the client-rated perception is rated on a scale of 0 to 4, where 0 = not at all, 1 = slightly, 2 = moderately, 3 = considerably, and 4 = extremely. This scale is used to assess individuals' perceptions of the severity of their problems and importance of treatment in each assessed area.

Based on responses to the ASI-SR, two composite scores are created—one for alcohol use and one for non-alcohol drug use (McClellan et al., 2006). The alcohol use composite scale is created using the items asking respondents about how often in the last 30 days they (1) drank alcohol, (2) drank alcohol to intoxication, (3) experienced alcohol problems, and (4) have been bothered by alcohol problems, as well as (5) how important treatment for these problems is to them and (6) how much money they spent on alcohol. High alcohol use is determined based on a cutoff of .20 for women and .22 for men. Individuals who scored above these cutoffs identified as "high alcohol users." The non-alcohol drug use composite score is created using items related to drug use behaviors over the previous 30 days,

including (1) use of opioids, barbiturates, sedatives, stimulants, cannabis, and hallucinogens; (2) use of more than one substance on one day (polysubstance use); (3) whether they have experienced drug problems; (4) whether they have been bothered by drug problems; and (5) how important treatment is for these problems. Women who scored greater than .15 and men who scored greater than .10 were identified as “high drug users.”

Center for Epidemiological Studies-Depression (CES-D) Scale. The CES-D (Radloff, 1977) assesses the presence and severity of depressive symptoms during the past week. Participants rate how often they experienced each symptom along a 4-point scale ranging from 0 (rarely or never) to 3 (most or all of the time). The CES-D 12 (12-item version) was used in the cross-site evaluation. Items are summed for a total CES-D score that ranges from 0 to 36. Higher scores indicate a greater number of depressive symptoms and greater depressive symptom severity. The CES-D also includes clinical cutoffs: (1) “not depressed” includes scores of 4 or lower, (2) “mildly depressed” includes scores between 5 and 9, (3) “moderately depressed” includes scores between 10 and 14, and (4) “severely depressed” includes scores over 15.

Trauma Symptoms Checklist-40 (TSC-40). 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 (Briere & Runtz, 1989). 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 4-point scale ranging from 0 (never) to 3 (often). Items are summed for each subscale and total scale scores, respectively. The TSC-40 allows for a total score range of 0 to 120. The six subscales also have a range of 0 to a maximum depending on the number of items in each subscale. The anxiety and depression subscales range from 0 to 24; the dissociation subscale ranges from 0 to 12; the sleep disturbance subscale ranges from 0 to 18; the SATI subscale ranges from 0 to 18; and the sexual problems subscale ranges from 0 to 24. Higher scores indicate greater levels of trauma symptoms and trauma severity.

Parental Stress Scale (PSS). 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 (Berry & Jones, 1995). Participants rate their agreement with each item along a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items that ask about positive parenting behaviors are reverse scored before being included in the sum for the total score. Items are summed for a total parental stress score ranging from 18 to 90, with higher scores indicating greater levels of parenting stress. The cross-site evaluation did not require use of the PSS, so PSS data was not shared with Mathematica.

Adult Adolescent Parenting Inventory 2 (AAPI-2). The AAPI-2 is a 40-item instrument that assesses parenting and child-rearing attitudes (Bavolek & Keene, 1984). The AAPI-2 consists of five constructs: Construct (A) Expectations of children, on which higher scores indicate more realistic expectations (scored from 7 to 35); Construct (B) Empathy towards children’s needs, on which higher scores indicate high levels of empathy (scored from 10 to 50); Construct (C) Corporal punishment, on which higher scores indicate alternatives to corporal punishment are valued (scored from 11 to 55); Construct (D) Parent-child family roles, on which higher scores indicate viewing a child as a child rather than as a

caregiver or peer (scored from 7 to 35); and Construct (E) Children's power and independence, on which higher scores indicate that an individual values children's independence (scored from 5 to 25). 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-ups. Forms are normed based on parent gender and rescaled so that each scale is scored from 1 to 10, with the same interpretation as above (Bavolek, 2001). Higher AAPI-2 scores indicate a lower risk of child-rearing behaviors associated with abusive parents.

Stigma, Intact Family Services and Strengths. 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. AHP used qualitative analyses (see Analyses section) to examine participants' responses to these questions. These data were not required for the cross-site evaluation and were not shared with Mathematica.

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 ages 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 did not administer every child well-being assessment to every participant; we only administered those that "matched" the age of the focal child.

Child Behavior Checklist (CBCL). The CBCL assesses children's behavior and emotional and social functioning (Achenbach & Rescorla, 2001). The CBCL-Preschool Form (CBCL-PS/1.5–5, 99 items) is used to assess children aged 1.5–5 years and the CBCL-School Age Form (CBCL-SA/6–18, 112 items) is used to assess children aged 6–18 years. Parents rate their child's behavior along a 4-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 scores compare the raw scores to what would be typical compared to responses for children of the same gender and similar age.

The CBCL-PS was administered to families with children between the ages of 1.5 and 5 years old. This scale is similar to the CBCL-SA and includes additional subscales, which are aligned with diagnostic criteria applicable to this age group. Each of the 12 subscales assesses externalizing and internalizing behaviors, which in turn create a total scale. For children 6 to 18 years old, the CBCL-SA was used. This scale has eight subscales that measure externalizing and internalizing behaviors and are combined to create a total score. Scores for the CBCL-SA are provided on a normed t-distribution, meaning that an average score is 50 and a standard deviation is 10. Norm scores are based on child age and sex. For both the CBCL-PS and the CBCL-SA, higher scores indicate greater behavioral problems and lower emotional and social functioning.

Infant/Toddler Sensory Profile (ITSP). 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 (Dunn & Daniels, 2002). 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 from 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. This scale is a measure of general, auditory, visual, vestibular, and oral processing. It is composed of five subscales: (1) Low registration, measuring awareness of sensations; (2) Sensation seeking, measuring children's interest in sensations; (3) Sensation sensitivity, measuring children's noticing and reaction to sensations; (4) Sensation avoiding, measuring children's need to compare or avoid sensations; and (5) Low threshold, an aggregate of sensation sensitivity and sensation avoiding scales, measuring active and passive self-regulation. Each item response is assigned a score on a 5-point scale that reports how frequently infants respond to sensory experiences; a score of 1 is assigned to "almost always" and a score of 5 to "almost never." Lower scores indicate high levels of responsiveness to stimuli; higher scores indicate low responsiveness to stimuli. For children between the ages of 0 (birth) and 6 months, the ITSP 0–6 months was administered. For children aged 7–36 months, the ITSP 7–36 months was administered. The ITSP 0–6 uses the same subscales as the ITSP 7–36, with a focus on adapting the measures of sensory processing to infants.

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 EIL IFR program, defined as evaluation enrollment through program closure or termination. Standardized forms (i.e., service logs), created by Mathematica for the cross-site evaluation, were used to collect data on services provided to participants by Intact workers and recovery coordinators. Mathematica 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; referrals to external services; and engagement in services. The logs also documented who provided the service (i.e., Intact worker, recovery coordinator) and the individuals receiving services (i.e., participant, focal child).

The evaluation team trained recovery coordinators and Intact supervisors on 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 and visits they did alone with clients. Intact supervisors completed service logs for Intact workers' individual visits with families. AHP researchers tracked visit dates reported during biweekly 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 Mathematica. AHP researchers coded common services using Mathematica'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 EIL 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' treatment progress during biweekly check-in calls with Intact supervisors and recovery coordinators. This progression was tracked for parents whose initial treatment episode was after enrolling in the EIL IFR program, as well as for parents who were receiving substance use treatment when they enrolled in the EIL IFR program.

Figure 2. Substance Use Treatment Progression

The evaluation team also tracked outcomes for participants within 30 days after successfully completing 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 substance use treatment.
- **Relapsed—returned to treatment:** Relapse occurred (i.e., participant used alcohol or drugs), but participant returned to substance use treatment.
- **Relapsed—engaged in EIL IFR services:** Relapse occurred, but participant remained engaged in EIL IFR services and continued to work with their recovery coordinator and/or Intact worker.
- **Relapsed—disengaged from EIL IFR services:** Relapse occurred, and participant left or chose to stop receiving EIL IFR services.

Program Discharge/Closure Outcomes

EIL 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 EIL IFR services and/or did not complete all required program components or substance use treatment, participant was incarcerated, or site closed the participant's case for program noncompliance.

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

- **Substance use treatment completed:** Participant completed initial substance use treatment or was actively engaged with treatment at the time their case was closed.
- **Substance use treatment not completed:** Participant did not complete initial or any substance use 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 from Intact supervisors' and recovery coordinators' reports of participants' substance use at EIL IFR program discharge. EIL IFR SUD stability at closing was coded as follows:

- **Stable:** Participant was not using substances at the time the case was closed, participant was stable on medication-assisted recovery (MAR), or their substance use does not interfere with their quality of life or parenting.
- **Actively using:** Participant was using substances at the time the case was closed.
- **Unknown:** Participant's substance use status is unclear at the time of closing.
- **OD—death:** Participant died due to overdose.

Analyses

QUANTITATIVE ANALYSIS

We evaluated baseline sociodemographic characteristics, including age, gender, race, and ethnicity, across all participants and between intervention and comparison groups. Baseline demographics, interview scores, and reports of substance use and mental health symptoms were compared between groups using appropriate group comparison methods (t-tests for continuous variables, Fisher's exact test for counts) and evaluated using standardized mean difference comparisons to ensure baseline equivalence.

After identifying baseline differences, we compared intervention and comparison groups on all demographic variables and baseline interview outcomes to investigate how much groups differed on these variables. To account for any baseline differences, we applied inverse probability of treatment weighting (IPTW) using key pre-enrollment characteristics to ensure balance between groups based on their estimated likelihood of being assigned to an intervention site. Based on observed characteristics before evaluating intervention effects (e.g., the impact of IFS + recovery coordinator services versus IFS "only"), this approach allowed us to ensure that intervention and comparison groups were as similar as possible at baseline. We applied the weights generated through IPTW in subsequent analyses unless otherwise specified.

We analyzed parent and child outcomes using linear and logistic regression, with intervention group participation (intervention or comparison) and interview time point (baseline, 9-month follow-up, 18-month follow-up) as predictors. Regression models were used to estimate marginalized means for each analysis, which allowed us to compare average scores across time and between groups for continuous outcomes and to compare probability of an outcome across time and between groups for binary outcomes. The estimated marginal means provide results in real-world terms (e.g., scores, days of enrollment) rather than in statistical terms.

To evaluate the effects of outcomes and demographic variables on other outcomes, we used multiple regression analyses as follows: We used logistic regressions to identify the effects of depression, trauma, education level, employment, marital status, age, living situation, and number of children on participants' status as high alcohol users and high drug users. We also used linear regression to identify the effects of depression, trauma, education level, employment, marital status, age, living situation, and number of children on participants' parental stress (PSS) and depression symptoms (CES-D). We used a linear regression including participants' parental stress (PSS), children's gender, children's living situation and whether they reside with the participant, intervention group, and the interview period to evaluate the effects on child well-being (measured by CBCL-PS and CBCL-SA).

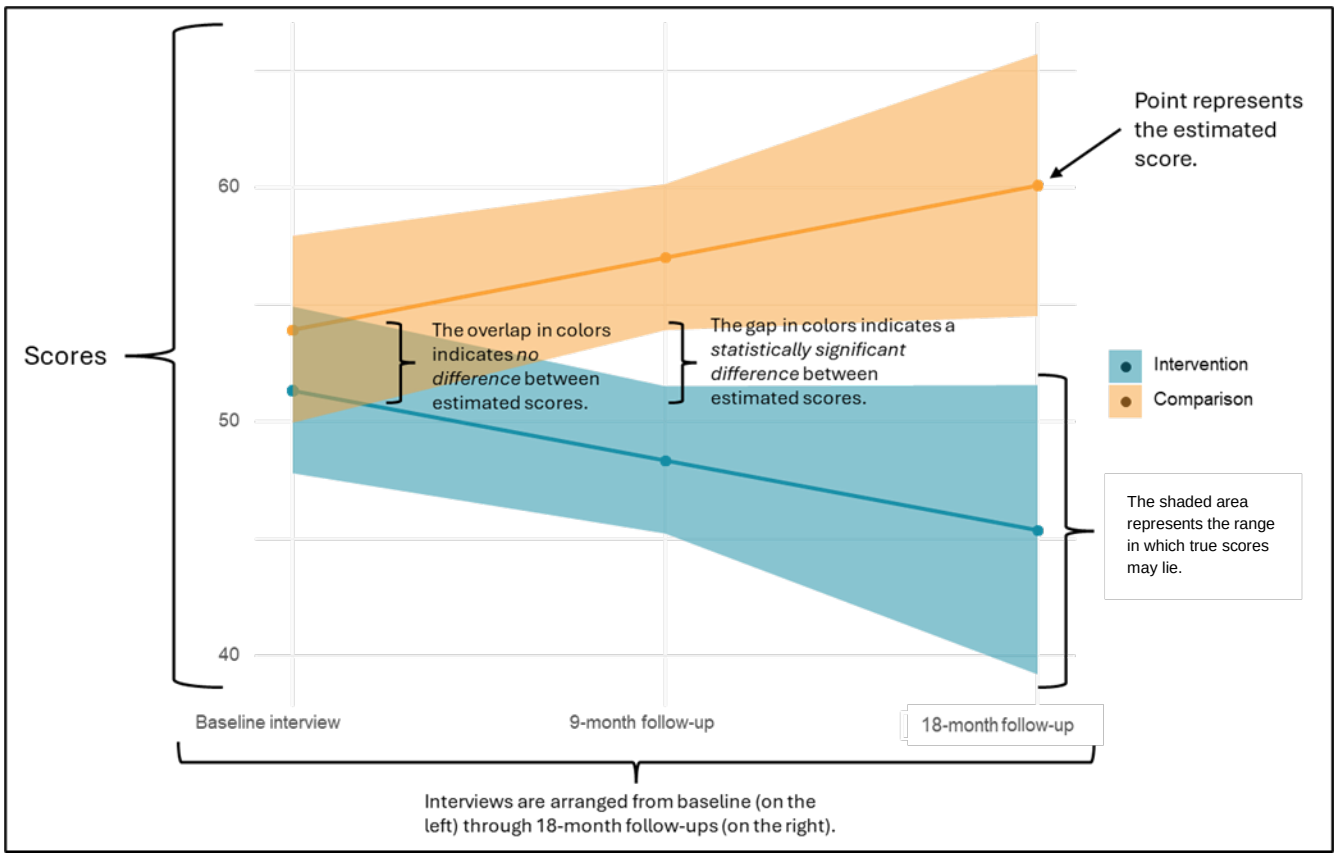
The effects of the program on participant retention in the intervention were assessed by comparing the intervention and comparison groups. Program tenure (in days), successful case closure (successful vs. unsuccessful), and child placement status (remain in home with parents vs. foster care placement) were included as outcomes in regression analyses, with intervention group participation, number of IFR worker contacts (Intact worker and recovery coordinator contacts), number of IFR workers each family worked with, and SUD assessment/treatment status (ranging from "never completed SUD assessment" to "began substance use treatment") as predictors. Program tenure was modeled using a negative binomial regression; successful case closure and child placement status were modeled using logistic regressions.

Additional models were constructed comparing evaluation participants to non-evaluation participants on tenure, successful case closure, and child placement. There were 92 additional non-evaluation participants who received IFS and IFR services included in these separate models. Due to the lack of pre-baseline data, it was not possible to estimate weights for non-evaluation participants. As a result, analyses with non-evaluation participants are unweighted.

To evaluate the relationship between outcomes and child placement status, successful case closure, and SUD stability, we used participants' final interview scores and the program closure information. We used the Phi statistic (represented by Φ) to compare variables which are both either 1 or 0, which included High Alcohol and High Drug use. For the remaining variables, we used point biserial correlations, which allowed us to compare continuous variables with placement, success, and SUD stability, which are binary variables, represented as either a 1 or a 0.

Interpreting Graphs

Figure 3. Estimated Marginal Means Example Graph



This graph provides information on how to interpret the graphs in the following sections. (Note: The first graph appears on page 26). Along the bottom of the graph, you will see that the three interview time points (baseline, 9-month follow-up, and 18-month follow-up) are represented equidistantly, from left to right. Along the left side of the graph, the numbers indicate possible scores for each outcome. On the graph itself, the solid points connected by lines represent the model estimated score for each group at each interview time point. For all graphs, the intervention group is represented by blue, while the comparison group is represented by orange. The shaded areas around both lines represent the confidence interval, or the range of possible scores. Where these shaded areas overlap indicates that there is an overlap in possible scores between both groups, meaning no statistically significant difference in scores (i.e., outcomes). When the shaded areas do not overlap, the white area between represents a statistically significant difference between the intervention and comparison groups' scores.

QUALITATIVE ANALYSIS

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 Excel to conduct all qualitative analyses.

Results

Evaluation Enrollment and Interviews Completed

Of the 259 individuals who enrolled in EIL IFR services, 238 were eligible for the evaluation. Table 1, below, documents evaluation enrollment progression by site and for the total sample.

Table 1. Evaluation Enrollment by Site

	CYFS	BF	BCS	OHU	Total
Eligible for the evaluation	72	35	56	75	238
Informed about the evaluation	72	35	56	71	234
Declined, no referral form signed	8	1	15	15	39
Completed referral form	64	34	41	56	195
Declined after signing referral form	11	3	14	15	43
Enrolled in evaluation	52	31	27	41	151

A total of 151 participants, or 63%t of the eligible sample, enrolled in the evaluation and completed baseline interviews. As shown in Table 2, of the enrolled sample, 103 participants (68%) completed 9-month follow-up interviews and 72 (48%) completed 18-month follow-up interviews. More than half of evaluation participants were intervention group participants (n = 83, 55%). Thirty-four percent of evaluation participants were CYFS clients; 21% were BF clients; 18% were BCS clients; and 27% were OHU clients.

Table 2. Number of Interviews Completed by Group

	Intervention Group	Comparison Group	Total
	N (%)	N (%)	N (%)
Baseline	83 (100%)	68 (100%)	151 (100%)
9-month follow-up	57 (69%)	46 (68%)	103 (68%)
18-month follow-up	39 (47%)	33 (49%)	72 (48%)

Note: Percentages for each column indicate the proportion of interviews for that group completed at each follow-up point relative to the baseline for that group. Evaluation enrollment and all baseline interviews were completed in April 2024. To allow adequate time for analyses, no follow-up interviews were administered after December 31, 2024. As a result, not all participants who completed a baseline interview were eligible to complete a 9-month or 18-month follow-up interview.

Table 3. Number of Interviews Completed by Site

	Baseline (N=151)	9-Month Follow-Up (N=103)	18-Month Follow-Up (N=73)
CYFS	52	35	29
BF	31	22	11
BCS	27	19	16
OHU	41	27	17

Participant Demographic Characteristics

Participant demographic information was collected at the baseline interview (see Table 4). Most evaluation participants identified as White (n = 118, 78%), female (n = 121, 80%), and had an average age of 32 years old (*SD* = 6.7). Intervention group participants were significantly more likely to be African American or multiracial compared to comparison group participants (p = .003). At baseline, 38% of participants reported having attained at least a high school diploma. More than half (57%) of participants were unemployed. Most (73%) reported a yearly income of less than $25,000, with 43% reporting a yearly income of less than $10,000. Slightly less than half (40%) of participants were single/unmarried. Most (70%) participants reported living in their own home or apartment.

Table 4. Participant Demographic Characteristics

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	N (%)	N (%)	N (%)
Race and Ethnicity			
African American	16 (19%)	3 (4%)	19 (13%)
American Indian or Alaska Native	1 (1%)	0 (0%)	1 (1%)
White	56 (67%)	62 (91%)	118 (78%)
Multiracial	10 (12%)	2 (3%)	12 (8%)
Hispanic	6 (7%)	3 (4%)	9 (6%)
Gender			
Female	69 (82%)	52 (76%)	121 (80%)
Male	14 (18%)	16 (24%)	30 (20%)
Education			
Up to 8th grade	5 (6%)	1 (1%)	6 (4%)
Some high school	12 (15%)	17 (25%)	29 (19%)
High school diploma/GED	33 (40%)	24 (35%)	57 (38%)
Some vocational/technical school	2 (2%)	1 (1%)	3 (2%)
Vocational/technical diploma	2 (2%)	1 (1%)	3 (2%)
Some college	23 (28%)	18 (27%)	41 (27%)
Associate's degree	4 (5%)	4 (5%)	8 (5%)
Bachelor's degree	2 (2%)	2 (3%)	4 (3%)
Employment Status			
No	45 (54%)	41 (60%)	86 (57%)
Yes	38 (46%)	27 (4%)	65 (43%)
Largest Source of Income			
Public assistance	21 (25%)	20 (29%)	41 (28%)
Support from other individuals	13 (16%)	12 (18%)	25 (17%)
Wages/salary	26 (31%)	19 (28%)	45 (30%)
Other	23 (28%)	17 (25%)	40 (26%)
Annual Income			
$0–9,999	33 (40%)	32 (48%)	65 (43%)
$10,000–19,000	17 (20%)	10 (15%)	27 (18%)
$19,001–24,999	8 (10%)	8 (12%)	16 (11%)
$25,000–34,999	11 (13%)	11 (16%)	22 (15%)
$35,000–49,999	10 (12%)	6 (9%)	16 (11%)
$50,000 or higher	4 (5%)	1 (1%)	5 (3%)

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
Marital Status			
Single (unmarried/not cohabitating)	30 (36%)	30 (44%)	60 (40%)
Married	6 (7%)	9 (13%)	15 (10%)
Cohabitating	33 (40%)	14 (21%)	47 (31%)
Divorced	8 (10%)	8 (12%)	16 (11%)
Separated	5 (6%)	5 (7%)	10 (7%)
Widowed	1 (1%)	2 (3%)	3 (2%)
Living Situation			
Own home/apartment	56 (67%)	49 (72%)	105 (70%)
Someone else's home/apartment	22 (27%)	16 (24%)	38 (25%)
Homeless/shelter	3 (4%)	2 (3%)	5 (3%)
Hotel/motel	2 (2%)	0 (0%)	2 (1%)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Age	32.2 (6.6) years	32.7 (6.8) years	32.5 (6.7) years
Age range	20–50 years	19–54 years	19–54 years
Number of Children	2.88 (1.45) children	2.84 (1.51) children	2.86 (1.47) children
Children range	1–7 children	1–9 children	1–9 children

FOCAL CHILDREN DEMOGRAPHIC CHARACTERISTICS

Focal child demographic information was reported by participants and collected at baseline interviews (see Table 5). Most focal children were male (54%, n = 82), White (68%, n = 103), and non-Hispanic (88%, n = 133). Thirteen percent (n = 20) were African American, 16% (n = 24) were multiracial, and 2% (n = 3) identified as another race. The intervention group had a higher percentage of African American and multiracial children than the comparison group (χ^2 (n = 148) = 22.42, p <.001). The intervention group also had a higher proportion of Hispanic children compared to the comparison group (p = .045). Children ranged in age from 2 months to 16 years, with an average age of 6 years. Slightly more than half were male (n = 82, 54%). At the time of the baseline interview, nearly all children lived in a private residence (n = 145, 96%) and lived with a biological parent (n = 153, 95%). At baseline, most (91%, n = 138) focal children had Medicaid insurance; 88% (n = 73) of intervention group children had Medicaid, compared to 96% of children (n = 65) in the comparison group. Eighty-six percent of households (n = 130) included the focal child's biological mother, while only 30% of households (n = 55) included the focal child's biological father. Very few households (5%, n = 7) did not include either the focal child's biological father or mother, while more than one-quarter (n = 41) of households included both the child's biological mother and father.

Table 5. Focal Child Demographic Characteristics

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	N (%)	N (%)	N (%)
Race and Ethnicity			
African American	16 (42%)	4 (6%)	20 (13%)
White	44 (53%)	59 (87%)	103 (68%)
Multiracial	21 (25%)	3 (4%)	24 (16%)
Other races	2 (2%)	2 (3%)	4 (3%)
Hispanic	14 (17%)	4 (6%)	18 (12%)
Gender			
Female	33 (40%)	36 (53%)	69 (46%)
Male	50 (60%)	32 (47%)	82 (54%)
Housing			
Private residence	78 (94%)	67 (99%)	145 (96%)
Homeless/shelter, other locations	5 (6%)	1 (1%)	6 (4%)
Resides with Biological Parent			
No	6 (7%)	2 (3%)	8 (5%)
Yes	77 (93%)	66 (97%)	143 (95%)
Medicaid Status			
No	10 (12%)	3 (4%)	13 (9%)
Yes	73 (83%)	65 (96%)	138 (91%)
Household Composition			
Both biological parents in household	25 (30%)	16 (23%)	41 (27%)
Neither biological parent in household	2 (2%)	5 (8%)	7 (5%)
Biological mother in household	72 (87%)	58 (85%)	130 (86%)
Biological father in household	34 (41%)	21 (31%)	55 (37%)
Participants not living with any children	5 (6%)	10 (21%)	15 (11%)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Age	5.6 (3.2) years	5.7 (3.1) years	5.6 (3.1) years
Range (years)	Birth–15 years	Birth–15 years	Birth–15 years

Lifetime Mental Health Problems and Treatment

We asked participants about their lifetime history of mental health problems, conditions, and treatments (Table 6) during the baseline interview. Most participants reported having experienced anxiety (n = 114, 75%), difficulty concentrating (n = 91, 60%), and use of psychiatric medications (n = 100, 66%) at least once in their lives. Nearly half reported experiences of depression (n = 71, 47%), suicidal ideation (n = 71, 47%), and violent behavior (n = 68, 45%). One-third of participants (n = 51, 34%) reported having attempted suicide at least once in their lives. Lifetime experiences of mental health issues were similar across both the intervention group and the comparison group.

Participants in both groups reported similar experiences with inpatient and outpatient treatments. Intervention and comparison group participants had, on average, experienced two inpatient treatments. On average, adults in the intervention group reported four outpatient treatments, compared to two outpatient treatments for adults in the comparison group; however, this difference was not statistically significant. Participants reported that receiving mental health treatment was slightly to moderately important, with an average score of 2.5 out of 5, whereby 5 represents "highly important."

Table 6. Lifetime Mental Health Conditions and Treatment Receipt

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
Mental Health Condition	N (%)	N (%)	N (%)
Anxiety	61 (73%)	53 (78%)	114 (75%)
Difficulty concentrating	52 (63%)	39 (57%)	91 (60%)
Depression	38 (46%)	33 (49%)	71 (47%)
Hallucinations	13 (16%)	11 (16%)	24 (16%)
Psychiatric disability assistance	2 (2%)	1 (1%)	3 (2%)
Psychiatric medications	55 (66%)	45 (66%)	100 (66%)
Suicidal ideation	38 (46%)	33 (49%)	71 (47%)
Suicide attempt	29 (35%)	22 (32%)	51 (34%)
Violent behavior	32 (39%)	36 (53%)	68 (45%)
Treatment	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Number of inpatient treatments	1.5 (3.89)	1.9 (6.01)	1.7 (4.94)
Number of outpatient treatments	3.8 (9.05)	2.3 (4.21)	3.1 (7.3)
Mental health treatment importance	2.5 (1.89)	2.9 (2.06)	2.7 (1.97)

BASELINE EQUIVALENCE

We evaluated baseline differences between demographic and baseline outcome variables by calculating Standardized Mean Differences (SMD), which is a measure of the distance between two groups on the variable of interest. Variables with low (<.10) SMD can be said to be "balanced," or directly comparable. Variables with a high SMD (>.20) may indicate imbalance between the groups, meaning that analyses may be biased. Table 7 provides SMDs for variables used to compare groups before entering Intact/IFR services.

At baseline, the groups had a large difference on participants' employment, race, income, and substance use and on children's race, gender, ethnicity, residence, and status of living with their biological father.

Table 7. Balance Table for Observed and Weighted SMD

Matching Variable	Observed SMD	Weighted SMD
Adult		
Gender	0.14	0.03
Education level	0.17	0.16
Employment	0.27*	0.21*
Race	0.66*	0.08
Income	0.32*	0.14
Age	0.12	0.03
Number of children	0.01	0.03
Age when first child born	0.19	0.12
Number of children living with family	0.06	0.15
Days of substance use	0.03	0.03
Any substance use	0.04	0.02
Alcohol use	0.12	0.11
Polysubstance use	0.35*	0.06
Child		
Gender	0.28*	0.13
Ethnicity	0.35*	0.02
Residence type	0.28*	0.20*
Medicaid	0.33*	0.18
Race	0.87*	0.31*
Age	0.02	0.02
Lives with biological father	0.23*	0.04
Lives with biological mother	0.05	0.01

*SMD exceeds cutoff of .20, indicating imbalance between groups.

After identifying baseline differences, we used IPTW based on these variables to balance groups based on how likely they are to be enrolled at an intervention site. Based on observed characteristics before evaluating intervention effects, (i.e., the impact of IFS + recovery coordinator services versus IFS "only"), this approach allowed us to ensure that intervention and comparison groups were as similar as possible at baseline. Balance between groups means that we can compare groups based on the intervention to identify changes that may have occurred because of enrollment into recovery services. Without IPTW, differences between groups is more attributable to the baseline differences between groups. When using IPTW, this difference can be adjusted for, to reduce differences between intervention and comparison groups at baseline.

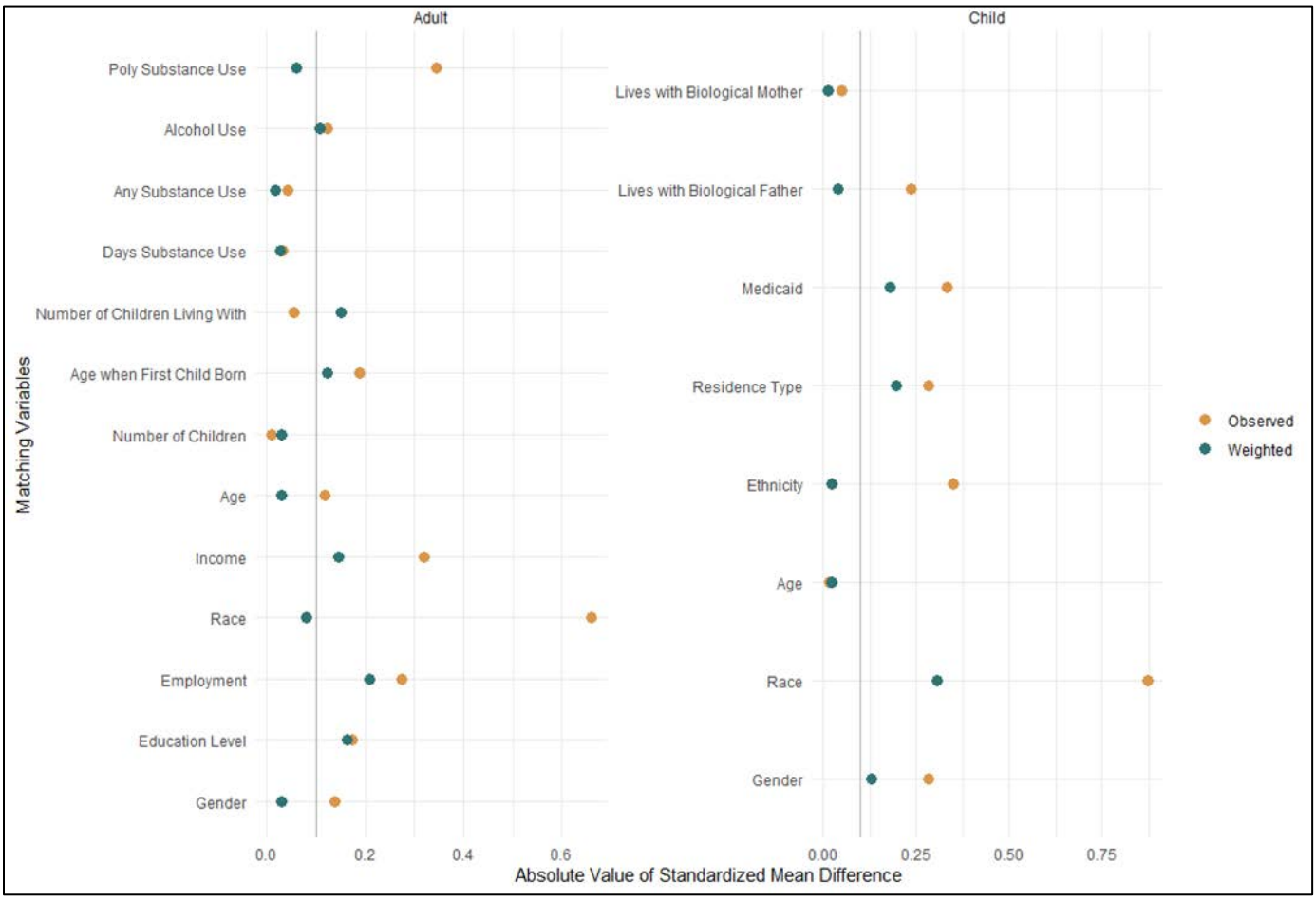
Groups were balanced based on the variables listed in Table 7. One model was used for outcomes related to adults, and a separate model was used for outcomes related to children. For the adult model, groups were matched on adults' age, race, education, employment, income, number of children, age when first child was born, number of children living with them, total number of days of substance use in the last 30 days, reports of any substance use in the last 30 days, alcohol use in the last 30 days, and use of more than one substance in the last 30 days. For models with outcomes related to children, groups were matched on children's age, gender, ethnicity, Medicaid coverage, residence, and whether

they lived with their biological parents. Both models reduced SMDs to acceptable levels for group comparison, except for adults' employment and children's residence type and race.

Following the balancing procedure, groups differed only on participants' employment and children's residence and race. These differences were reduced by weighting and were closer to the liberal cutoff of .2, making comparisons between both groups possible.

Figure 4 shows the average differences between groups on each of the variables noted. As the dot moves further to the right, the difference between intervention and comparison groups grows larger. The green dot shows the effect that IPTW has on bringing a statistical balance to the groups. As these dots are further to the left, the difference between the intervention and comparison group is less. Ideally, the green dots should be to the left of the thick vertical line (which is at .10), or closer to the thick line than the yellow dots are. This graph shows an overall improvement in the balance between intervention and comparison groups, meaning that it is more possible to make direct comparisons between them.

Figure 4. Love Plot for Group Comparison Before and After IPTW



Substance Use and Mental Health

NOTEWORTHY RESULTS

- At baseline, one-third of all participants were considered "high alcohol users;" at 18-month follow-up, less than 20% of participants were considered "high alcohol users." Comparison group participants showed the greatest decrease in alcohol use over time.
- There were no changes in high drug use over time for either intervention or comparison groups.
- There were no changes in depression or anxiety for either group across the course of the evaluation.

ALCOHOL USE

We used ASI-SR data to assess participant alcohol use at each time point.

Baseline. At baseline, adults reported an average of 2.5 days of alcohol use over the last 30 days, with approximately 1 day of drinking to intoxication and experiencing 1 day of problems related to alcohol. Adults reported spending more than $15 per day on alcohol. Using a single item to measure problems related to alcohol—ranging from 0 (not at all [problematic]) to 4 (extremely [problematic])—the intervention group reported statistically significantly lower concern with alcohol problems (M = 0.82, SD = 3.26) than the comparison group (M = 2.38, SD = 6.62; t = 3.02, p = .003). Similarly, on a single-item scale, the intervention group placed statistically significantly less importance on alcohol treatment (M = 1.12, SD = 1.13) than the comparison group (M = 1.99, SD = 1.76; t = 3.34, p = .001). Overall, 17 percent (n = 14) of adults in the intervention group were high alcohol users compared to a statistically significantly higher 41% (n = 28) in the comparison group (p = .001). There were no other statistically significant differences between the groups.

Table 8. Participant Baseline Alcohol Use

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
Alcohol Use	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of alcohol use	2.49 (5.92)	2.51 (5.29)	2.5 (5.62)
Days of alcohol intoxication	1.04 (3.68)	0.63 (1.74)	0.85 (2.97)
Days of alcohol-related problems	0.82 (3.26)	2.38 (6.62)	1.52 (5.10)
Money spent on alcohol ($)	15.86 (39.75)	18.38 (44.43)	16.99 (41.80)
Bothered by alcohol	0.88 (0.59)	1.31 (1.04)	1.07 (0.85)
Treatment importance	1.12 (1.13)	1.99 (1.76)	1.51 (1.50)
	N (%)	N (%)	N (%)
High alcohol use	14 (17%)	28 (41%)	43 (28%)

9-month follow-up. At the 9-month follow-up interview, both the intervention group and the comparison group reported less than 2 days of alcohol use (M = 1.84, SD = 3.27), less than 1 day of alcohol use to intoxication (M = 0.44, SD = 1.07), and less than 1 day of alcohol-related problems (M = 0.47, SD = 1.7). Both groups reported spending around $12 on alcohol over the last 30 days (M = 12.12, SD = 24.68), reported low concern about alcohol (M = 1.15, SD = 0.53), and had similar rates of high

alcohol users (20%, n = 26). The intervention group placed statistically significantly lower importance on treatment for alcohol-related problems than the comparison group (t = 2.27, p = .03). There were no other statistically significant differences between intervention and comparison groups at the 9-month follow-up interview.

Table 9. Participant Alcohol Use at 9-Month Follow-Up Interview

	Intervention Group (N=57)	Comparison Group (N=46)	Total Sample (N=103)
Alcohol Use	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of alcohol use	1.89 (3.45)	1.78 (3.06)	1.84 (3.27)
Days of alcohol intoxication	0.60 (1.29)	0.24 (0.67)	0.44 (1.07)
Days of alcohol problems	0.23 (1.15)	0.76 (2.18)	0.47 (1.70)
Money spent on alcohol ($)	11.54 (25.89)	12.83 (23.35)	12.12 (24.68)
Bothered by alcohol	1.14 (0.61)	1.15 (0.42)	1.15 (0.53)
Treatment importance	1.44 (1.13)	2.09 (1.64)	1.73 (1.42)
	N (%)	N (%)	N (%)
High alcohol use	10 (18%)	16 (35%)	26 (20%)

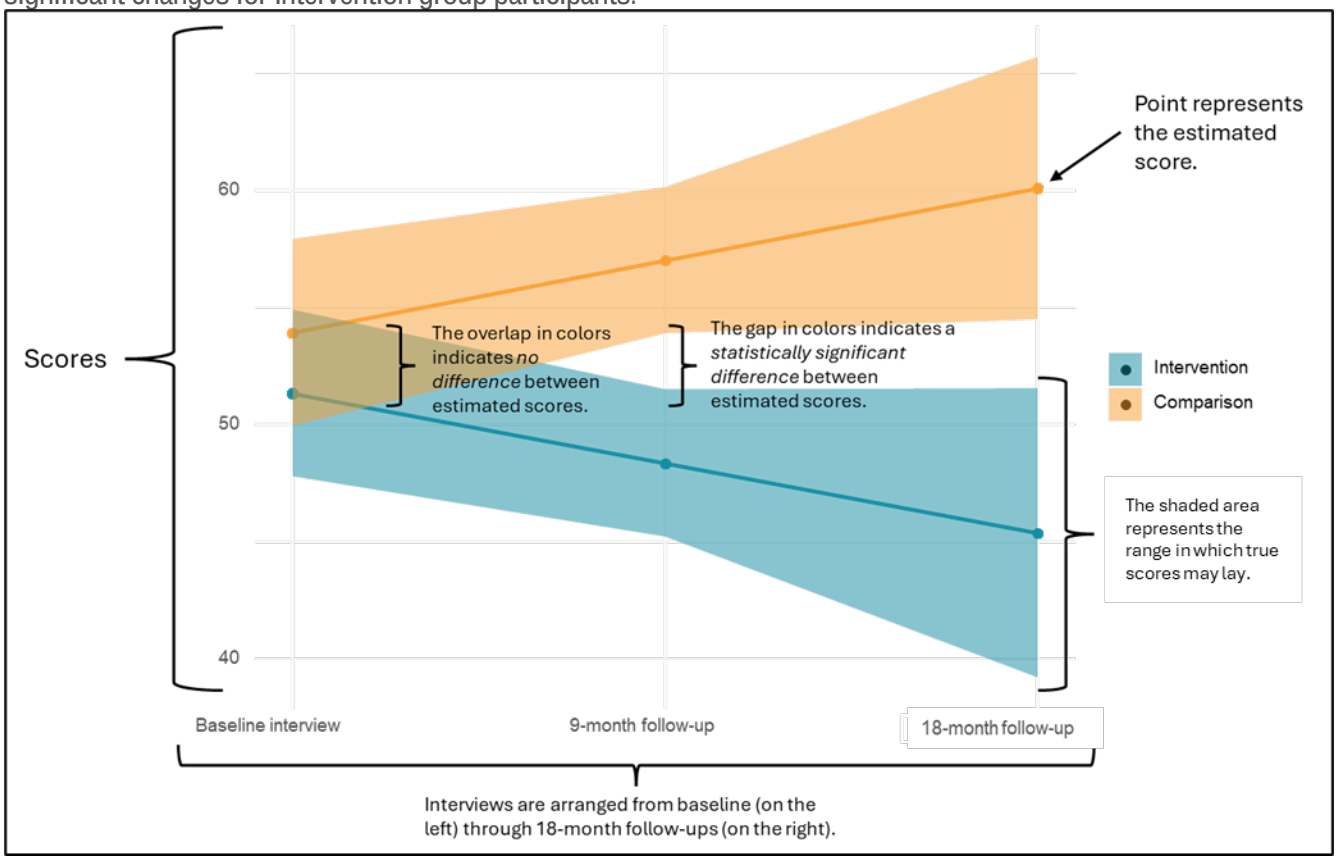
18-month follow-up. At the 18-month follow-up, both the intervention group and the comparison group reported less than 2 days of alcohol use (M = 1.36, SD = 3.21), less than 1 day of alcohol use to intoxication (M = 0.41, SD = 1.36), and less than 1 day of alcohol problems (M = 0.60, SD = 3.77). Both groups reported spending around $6 on alcohol over the last 30 days (M = 6.16, SD = 11.53). They reported low concern about alcohol (M = 1.11, SD = 0.59) and similar levels of treatment importance for alcohol problems (M = 1.41, SD = 1.21). Both groups had similar rates of high alcohol users (19%, n = 14). There were no statistically significant differences between intervention and comparison groups at the 18-month follow-up interview.

Table 10. Participant Alcohol Use at 18-Month Follow-Up Interview

	Intervention Group (N=39)	Comparison Group (N=33)	Total Sample (N=73)
Alcohol Use	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of alcohol use	1.32 (2.79)	1.39 (3.71)	1.36 (3.21)
Days of alcohol intoxication	0.65 (1.78)	0.12 (0.42)	0.41 (1.36)
Days of alcohol problems	0.35 (1.92)	0.91 (5.22)	0.60 (3.77)
Money spent on alcohol ($)	5.00 (10.50)	7.58 (12.69)	6.16 (11.53)
Bothered by alcohol	1.12 (0.72)	1.09 (0.38)	1.11 (0.59)
Treatment importance	1.32 (1.12)	1.52 (1.33)	1.41 (1.21)
	N (%)	N (%)	N (%)
High alcohol use	7 (18%)	7 (21%)	14 (19%)

Alcohol use over time. Change in alcohol use variables were modeled using weighted regressions as outlined in the Methods section above. Each of the alcohol use items are included in identifying individuals who are considered to have high alcohol use, which is represented as a binary indicator (1 = high alcohol use, 0 = no high alcohol use). As a result, the individual alcohol use variables (days of alcohol use, days of alcohol intoxication, etc.) are not included in the longitudinal analyses, as the high alcohol use indicator provides a clearer picture of alcohol use than any single item can. At baseline, there were statistically significantly fewer adults in the intervention group classified as high alcohol users compared to the comparison group (t = -3.75, p > .001). At the 9- and 18-month follow-ups, there were no statistically significant differences between the numbers of adults classified as high alcohol users in the intervention and comparison groups. The comparison group showed a significant decrease in the number of high alcohol users over time (slope = -2.07, p = .04), while the intervention group remained consistent over time.

Figure 5. Comparison group participants show a significant decrease in high alcohol use over time. There were no significant changes for intervention group participants.



DRUG USE

Baseline. At baseline, both the intervention group and the comparison group reported use of illicit drugs, including cannabis, opioids, stimulants, and sedatives. Cannabis was most common, with over half of participants reporting use in the last 30 days (59%, n = 89). Opioids were the least common, with three total reports of opioid (heroin or non-heroin opioids) use in the prior 30 days. There were no

statistically significant differences in the use of substances over the previous 30 days between the groups.

Both the intervention group and the comparison group reported 2 days of use of more than one substance (i.e., polysubstance use) (M = 2.03, SD = 5.54) and 3 days of problems related to drug use in the past 30 days (M = 2.91, SD = 7.07). Intervention group participants reported statistically significantly lower scores for being bothered by drug use (M = 1.07, SD = 0.75) than comparison group participants (M = 1.75, SD = 1.24, t = 3.99, p <.001), and reported that treatment (M = 1.60, SD = 1.43) was less important compared to the comparison group (M = 2.91, SD = 1.94, t = 4.50, p <.001). Intervention group participants were less likely to be categorized as having high drug use than comparison group participants (p =.007). There were no other statistically significant differences in baseline drug use between the groups.

Table 11. Participant Baseline Drug Use

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
Drug Use	N (%)	N (%)	N (%)
Amphetamines	2 (2%)	7 (10%)	9 (6%)
Cannabis	48 (58%)	41 (60%)	89 (59%)
Cocaine	6 (7%)	1 (1%)	7 (5%)
Hallucinogens	1 (1%)	4 (6%)	5 (3%)
Heroin	0 (0%)	1 (1%)	1 (1%)
Opioids	0 (0%)	2 (3%)	2 (1%)
Sedatives	1 (1%)	3 (4%)	4 (3%)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of polysubstance use	2.00 (6.05)	2.07 (4.88)	2.03 (5.54)
Days of drug problems	2.39 (7.03)	3.54 (7.12)	2.91 (7.07)
Bothered by drug use	1.07 (0.75)	1.75 (1.24)	1.38 (1.05)
Treatment importance	1.60 (1.43)	2.91 (1.94)	2.19 (1.80)
	N (%)	N (%)	N (%)
High drug use	24 (29%)	34 (50%)	59 (40%)

Note: No participants reported use of barbiturates or methadone at baseline.

9-month follow-up. At the 9-month follow-up, participants in both the intervention group and the comparison group reported use of cannabis, stimulants, and hallucinogens. Cannabis was most common, with nearly half of participants reporting use in the last 30 days (48%, n = 49). There were no statistically significant differences in the use of substances over the previous 30 days between the groups.

Both groups reported an average of 1 day of use of more than one substance (M = 1.14, SD = 3.85) and 2 days of problems related to drug use (M = 2.37, SD = 6.65) in the past 30 days. Intervention and comparison groups reported similar levels of being bothered by drug use (M = 1.25, SD = 0.71) and similar levels of treatment importance (1 = 1.90, SD = 1.62). Thirty percent (n = 31) of all participants

were classified as high drug users. There were no statistically significant differences between the groups.

Table 12. Participant Drug Use at 9-Month Follow-Up

	Intervention Group (N=57)	Comparison Group (N=46)	Total Sample (N=103)
Drug Use	N (%)	N (%)	N (%)
Amphetamines	1 (2%)	1 (2%)	2 (2%)
Cannabis	25 (44%)	24 (52%)	49 (48%)
Hallucinogens	1 (2%)	0 (0%)	1 (1%)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of polysubstance use	1.05 (3.22)	1.24 (4.54)	1.14 (3.85)
Days of drug problems	1.72 (5.45)	3.17 (7.88)	2.37 (6.65)
Bothered by drug use	1.18 (0.54)	1.35 (0.87)	1.25 (0.71)
Treatment importance	1.68 (1.42)	2.17 (1.83)	1.9 (1.62)
	N (%)	N (%)	N (%)
High drug use	16 (28%)	15 (33%)	31 (30%)

Note: No participants reported use of barbiturates, cocaine, heroin, methadone, opioids, or sedatives at 9-month follow-up.

18-month follow-up. At the 18-month follow-up, participants in both the intervention group and the comparison group reported use of cannabis, stimulants, and opioids. Cannabis was most common, with nearly half of the adults in the sample reporting use in the last 30 days (44%, n = 32). There were no statistically significant differences in the use of substances over the previous 30 days between the groups.

Both groups reported fewer than 1 day of use of more than one substance (M = 0.68, SD = 3.90) and 2 days of problems related to drug use (M = 1.59, SD = 6.63) in the past 30 days. Intervention and comparison groups reported similar levels of being bothered by drug use (M = 1.18, SD = 0.75) and similar levels of treatment importance (1 = 1.73, SD = 1.49). Twenty-three percent (n = 17) of all adults were classified as high drug users. There were no statistically significant differences between the groups.

Table 13. Participant Drug Use at 18-Month Follow-Up

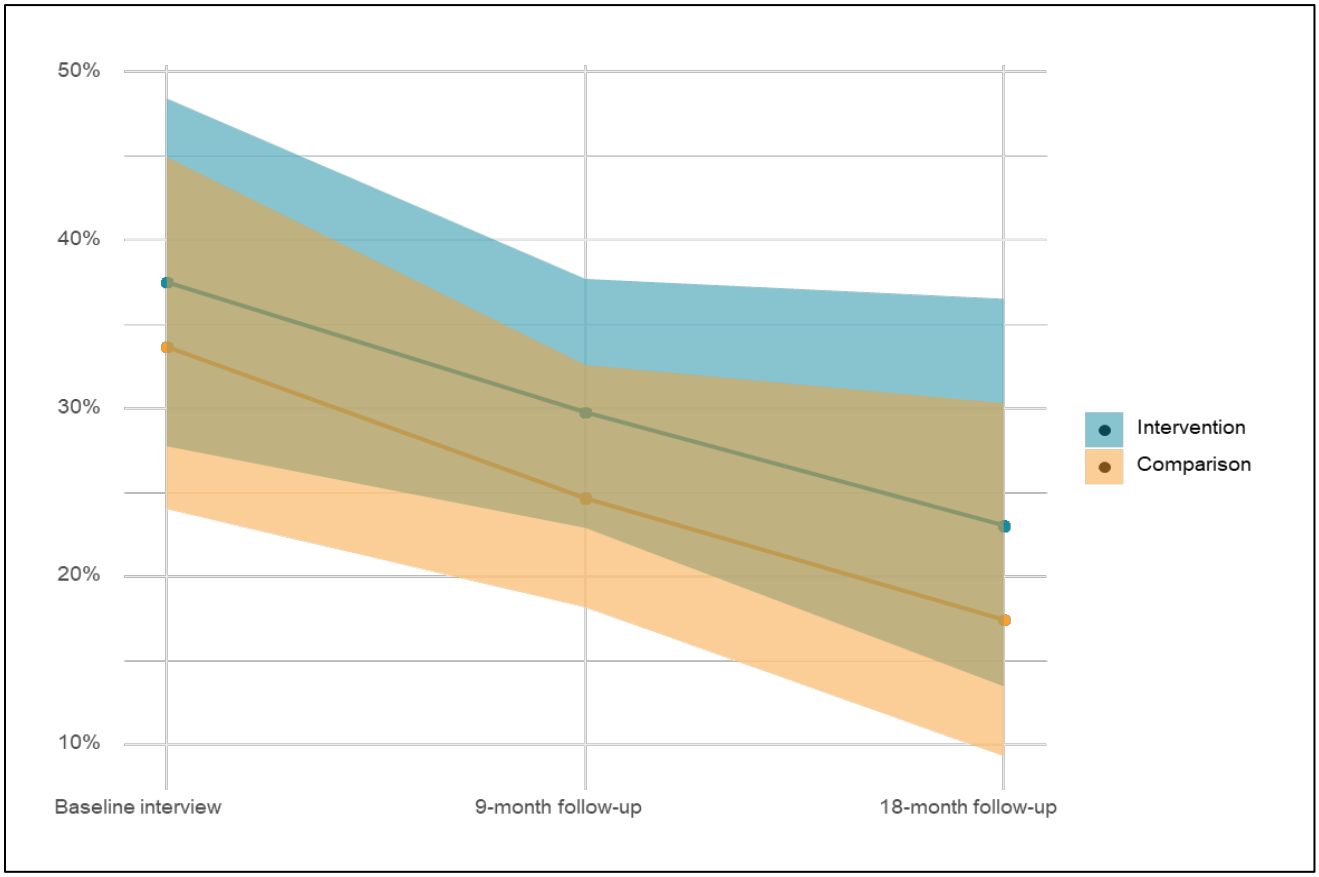
	Intervention Group (N=39)	Comparison Group (N=33)	Total Sample (N=73)
Drug Use	N (%)	N (%)	N (%)
Amphetamines	0 (0%)	1 (3%)	1 (1%)
Cannabis	14 (35%)	18 (55%)	32 (44%)
Cocaine	1 (2%)	0 (0%)	1 (1%)
Opioids	0 (0%)	2 (6%)	2 (3%)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days of polysubstance use	0.05 (0.22)	1.45 (5.76)	0.68 (3.90)
Days of drug problems	1.38 (5.66)	1.85 (7.26)	1.59 (6.39)

	Intervention Group (N=39)	Comparison Group (N=33)	Total Sample (N=73)
Bothered by drug use	1.18 (0.75)	1.18 (0.77)	1.18 (0.75)
Treatment importance	1.62 (1.48)	1.85 (1.52)	1.73 (1.49)
	N (%)	N (%)	N (%)
High drug use	8 (20%)	9 (27%)	17 (23%)

Note: No participants reported use of barbiturates, hallucinogens, heroin, methadone, or sedatives at 18-month follow-up.

Drug use over time. Each of the substance use items are used in identifying individuals who are considered to have high drug use. As a result, they are not included in longitudinal analyses, as the high drug use indicator provides a clearer picture of drug use than any single item can. When weights are applied to cases, there were no statistically significant differences between intervention and comparison groups at any time point, and there were no significant changes in the number of adults identified as high drug users over time.

Figure 6. There were no statistically significant changes in high drug use for either group over time.



DEPRESSION

We used the CES-D Scale to assess depression. Scores for both the intervention group and the comparison group were similar, with a mean score of 11.9 (SD = 9.93) out of 36 across the total sample, with higher scores indicating higher levels of depression (Table 14). Scores decreased slightly

at each subsequent interview, with both groups reporting a mean score of 8.86 (SD = 8.57) at the 18-month follow-up.

Table 14. Participant CES-D Scores Across Interview Time Points and Groups

	Intervention Group (N=83)	Comparison Group (N=63)	Total Sample (N=151)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Baseline	11.67 (9.33)	12.18 (10.69)	11.9 (9.93)
9-month follow-up	9.77 (9.58)	10.61 (9.84)	10.15 (9.66)
18-month follow-up	8.97 (10.03)	8.73 (6.52)	8.86 (8.57)

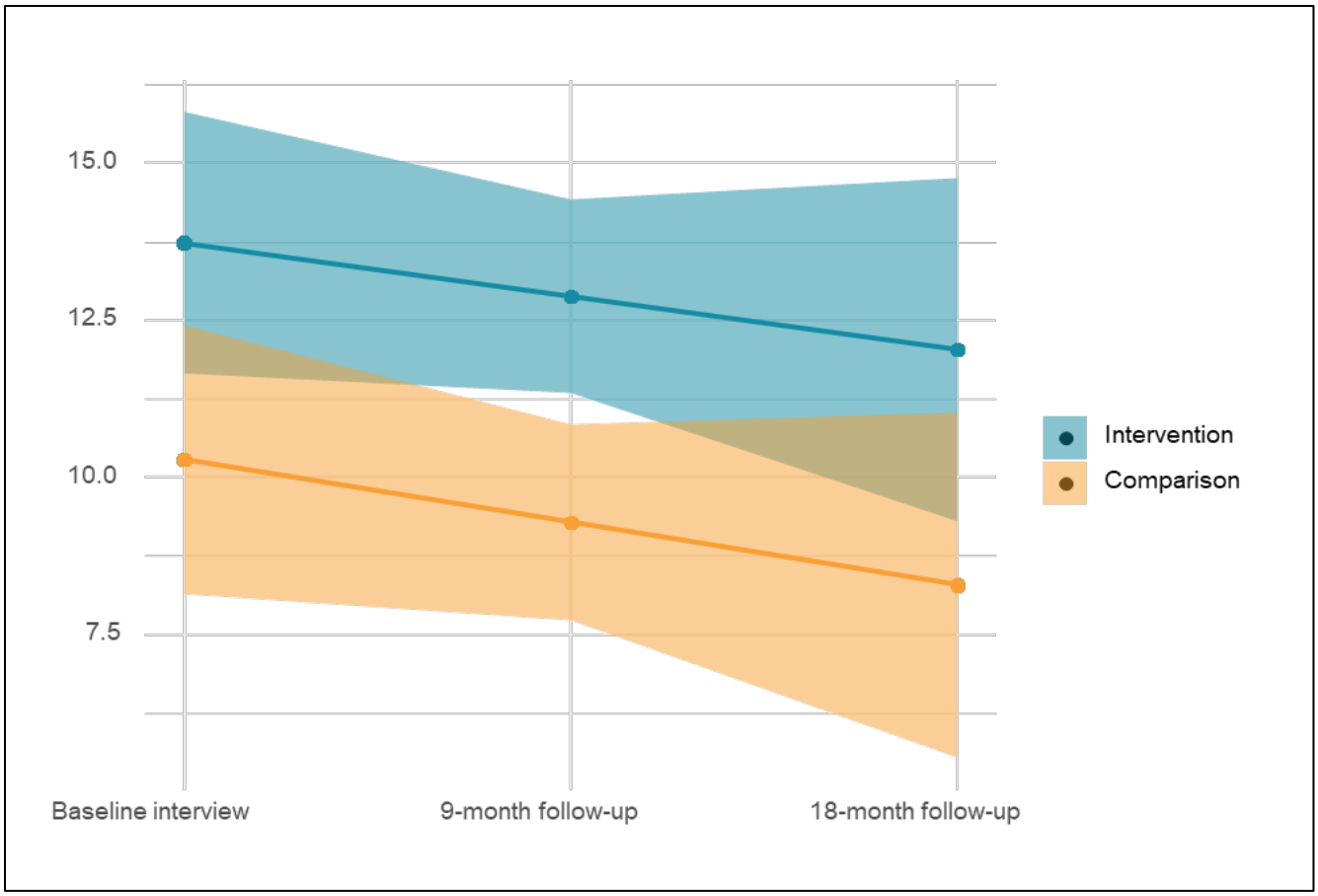
The CES-D can also be used to generate clinical scores ranging from “not depressed” through “severely depressed” (Table 15). At baseline, 31% of both groups scored low enough on the CES-D to be considered “not depressed”, while nearly 40% received a score that placed them in the “severely depressed” category. There were no statistically significant differences in the rates of clinical scores between intervention and comparison groups.

Depression (CES-D) over time. Intervention group participants reported statistically significantly higher levels of depression than comparison group participants (t = 2.27, p = .02) at the 9-month interview. When compared across each interview, both groups remained within the “moderately depressed” clinical category (scores between 9 and 14). Neither group showed statistically significant changes in depression scores over time.

Table 15. CES-D Scores

	Intervention Group	Comparison Group	Total Sample
Baseline	N = 83	N = 68	N = 151
	N (%)	N (%)	N (%)
Not depressed (<= 4)	25 (30%)	22 (32%)	47 (31%)
Mildly depressed (4 < x <= 9)	5 (18%)	15 (22%)	30 (20%)
Moderately depressed (9 < x <= 14)	13 (16%)	6 (9%)	19 (13%)
Severely depressed (>=15)	30 (36%)	25 (37%)	55 (36%)
9-month follow-up	N = 57	N = 46	N = 103
	N (%)	N (%)	N (%)
Not depressed (<= 4)	26 (46%)	19 (41%)	39 (38%)
Mildly depressed (4 < x <= 9)	8 (14%)	6 (13%)	14 (14%)
Moderately depressed (9 < x <= 14)	4 (7%)	5 (11%)	9 (9%)
Severely depressed (>=15)	19 (33%)	16 (35%)	35 (34%)
18-month follow-up	N = 39	N = 33	N = 73
	N (%)	N (%)	N (%)
Not depressed (<= 4)	19 (49%)	11 (33%)	30 (42%)
Mildly depressed (4 < x <= 9)	7 (18%)	10 (30%)	17 (24%)
Moderately depressed (9 < x <= 14)	6 (15%)	2 (6%)	8 (11%)
Severely depressed (>=15)	8 (21%)	10 (30%)	18 (25%)

Figure 7. Both the intervention group and the comparison group showed moderate, non-significant decreases in depression scores. At 9-month follow-up, intervention group scores were higher than comparison group scores.



ANXIETY

We used a single item to assess anxiety, with participants reporting if they had experienced anxiety during the 30 days prior to the interview. The intervention group and the comparison group were similar, with 63% (n = 95) reporting anxiety in the last 30 days at baseline (Table 16). Scores decreased slightly at each subsequent interview, with 52% (n = 38) of participants reporting anxiety in the previous 30 days at the 18-month follow-up. There were no significant differences in reports of anxiety between the intervention group and the comparison group at any time point.

Table 16. Participant CES-D Scores Across Interview Time Points and Groups

	Intervention Group (N=83)	Comparison Group (N=63)	Total Sample (N=151)
	N (%)	*N (%)*	*N (%)*
Baseline	51 (61%)	44 (69%)	95 (63%)
9-month follow-up	33 (58%)	31 (67%)	64 (62%)
18-month follow-up	19 (48%)	19 (58%)	38 (52%)

Anxiety over time. There were no statistically significant differences in anxiety reports between the intervention and comparison groups at any interview point. Additionally, there were no significant changes in reports of anxiety over time within each group.

TRAUMA SYMPTOMS

Table 17 shows the TSC-40 scores for each group at each time point. TSC-40 subscale and total scores are reported. At baseline, both the intervention group and the comparison group reported similar levels of trauma symptoms, with a total mean score of 33.62 (*SD* = 22.67). At the 9-month follow-up interview, the total mean score was 28.38 (*SD* = 21.08). At the 18-month follow-up interview, the total mean score was 30.52 (*SD* = 23.81). There were no statistically significant differences between intervention and comparison group scores across any subscale or total scores at any interview period. Overall, participants reported low levels of trauma.

Table 17. Trauma Symptom Checklist-40 (TSC-40) Scores

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Baseline			
Anxiety	5.67 (4.41)	6.41 (5.31)	6.01 (4.83)
Depression	7.60 (5.62)	8.30 (5.12)	7.92 (5.39)
Dissociation	4.64 (4.02)	5.47 (4.26)	5.01 (4.14)
SATI	3.84 (3.76)	3.99 (3.55)	3.9 (3.65)
Sexual problems	3.26 (4.04)	2.97 (3.63)	3.13 (3.85)
Sleep disturbances	7.19 (5.03)	8.43 (4.92)	7.75 (5.00)
Total Score	31.95 (22.68)	35.65 (22.65)	33.62 (22.67)
9-month follow-up			
Anxiety	4.75 (4.15)	5.89 (4.57)	5.26 (4.36)
Depression	6.25 (4.90)	7.07 (5.66)	6.61 (5.24)
Dissociation	3.74 (3.71)	4.54 (3.93)	4.10 (3.81)
SATI	2.77 (3.20)	3.43 (3.49)	3.07 (3.33)
Sexual problems	2.09 (3.24)	2.44 (3.46)	2.25 (3.33)
Sleep disturbances	6.98 (4.85)	7.31 (5.60)	7.13 (5.17)
Total Score	26.68 (19.36)	30.48 (23.08)	28.38 (21.08)
18-month follow-up			
Anxiety	5.56 (5.69)	5.18 (3.92)	5.38 (4.89)
Depression	6.79 (6.35)	7.06 (4.74)	6.92 (5.64)
Dissociation	4.54 (4.48)	4.76 (3.34)	4.64 (3.97)
SATI	3.79 (4.07)	3.12 (2.39)	3.48 (3.39)
Sexual problems	2.70 (3.63)	2.13 (2.91)	2.44 (3.31)
Sleep disturbances	7.63 (5.97)	8.24 (4.97)	7.92 (5.50)
Total Score	30.62 (27.77)	30.39 (18.32)	30.52 (23.81)

Trauma symptoms over time. For the total TSC-40 score, there were no statistically significant differences between intervention and comparison groups in trauma symptoms at baseline, 9-month, or 18-month interviews (Figure 8), and neither group showed a significant change in total scale scores over time. There was no statistically significant difference in anxiety, depression, dissociation, sexual problems, or sleep disturbances subscale scores between intervention and comparison groups at any point in time, and neither group showed a statistically significant change in scores over time. At 9-month follow-up, intervention group scores on the SATI (Estimated M = 4.18, SE = 0.30) are statistically significantly higher than comparison group scores (Estimated M = 3.00, SE = 0.30, p = .01). There were no other statistically significant differences between intervention and control groups, and neither group showed a statistically significant change in trauma symptoms over time.

Figure 8. Intervention group participants have significantly higher scores on the SATI at the 9-month follow-up interview compared to comparison group participants. There were no other significant differences or changes.

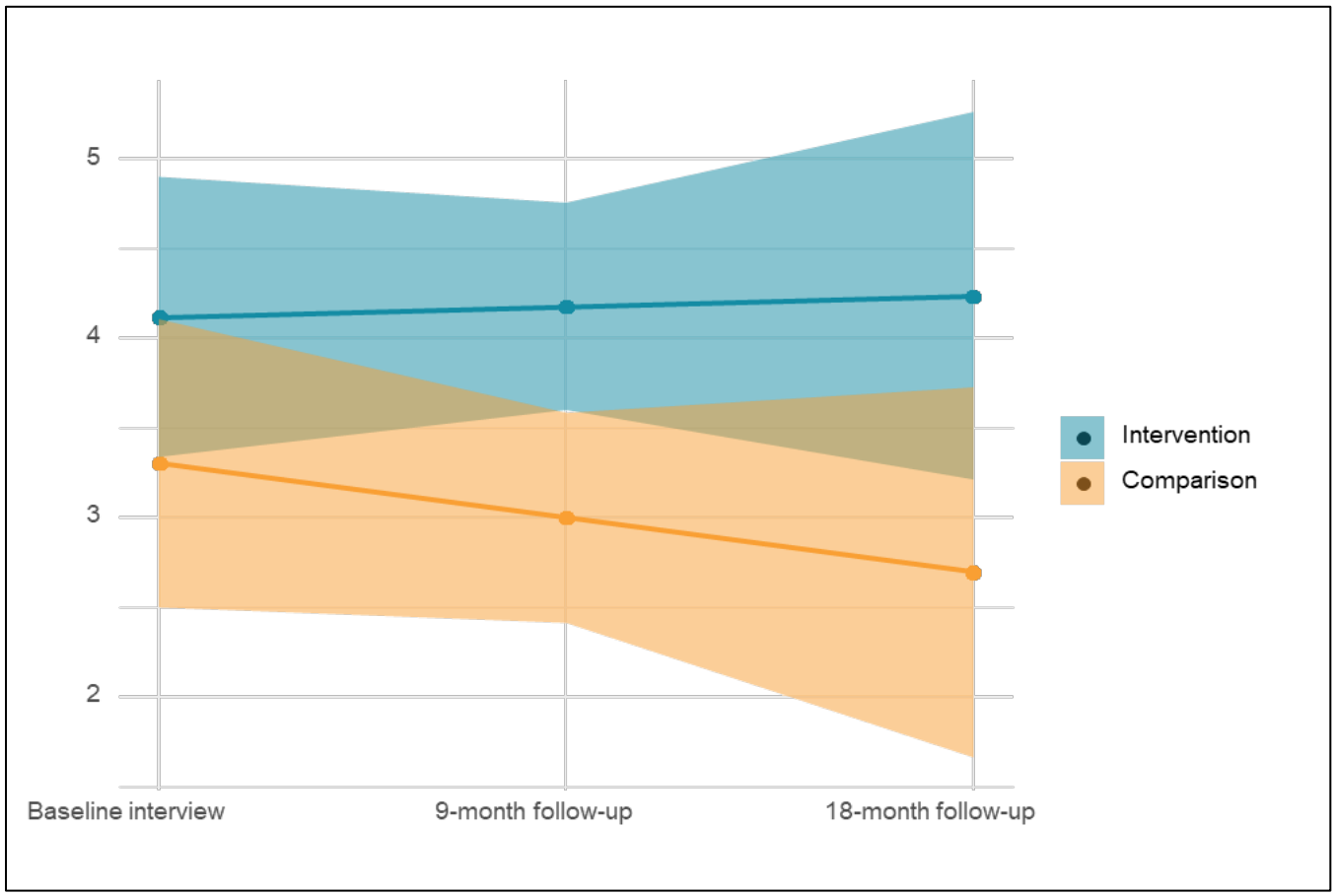
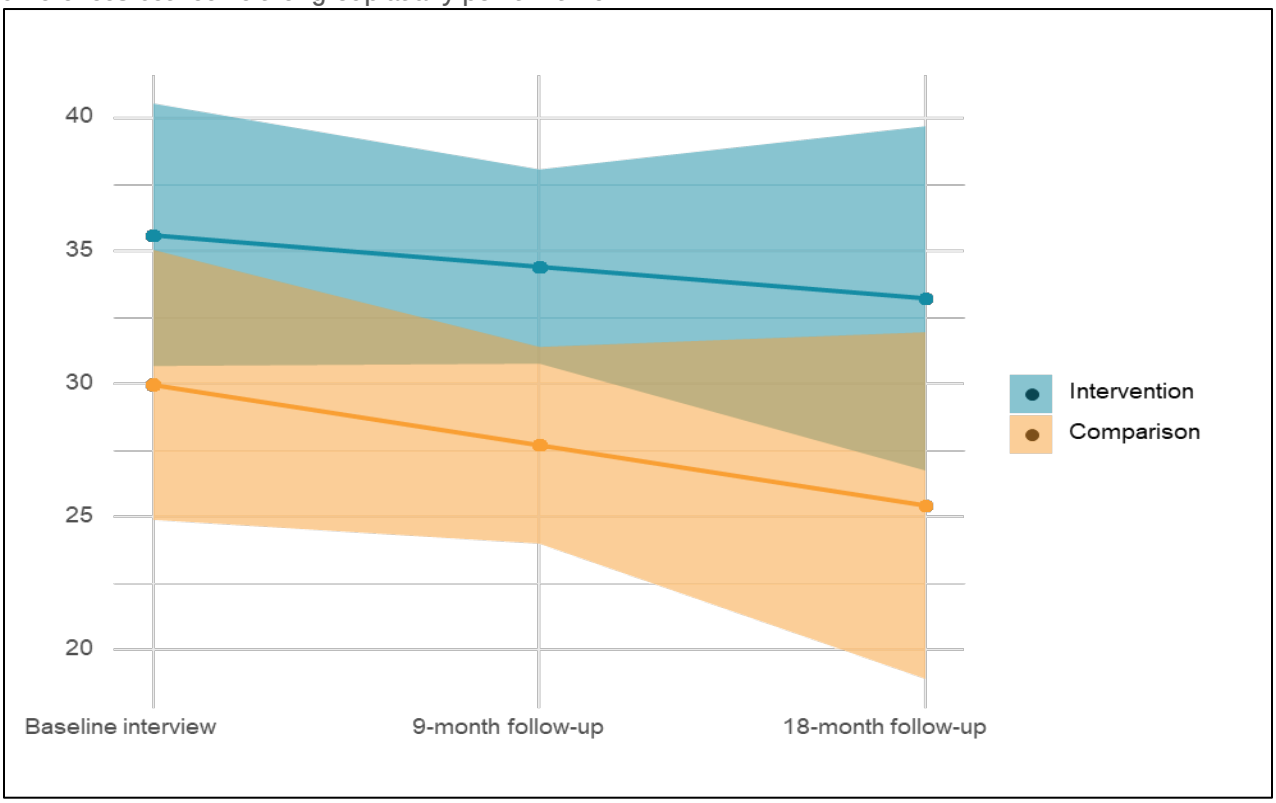


Figure 9. Neither group showed any statistically significant changes over time for TSC-40 scores. There were no differences between either group at any point in time.



Parenting Stress and Attitudes

NOTEWORTHY RESULTS

- Participants in both the intervention group and the comparison group reported low levels of parenting stress at each interview time point.
- Participants in both the intervention group and the comparison group showed improvement in the use of alternatives to corporal punishment over time, but only the intervention group changes were statistically significant.
- Both groups showed a decrease in valuing children's independence, indicating an increase in expectations of obedience.
- The intervention group showed a significant decrease in appropriate family roles, indicating an increase in parents treating children as peers rather than having age-appropriate peer groups.

PARENTAL STRESS

Across all interviews and both groups, PSS scores consistently ranged between 35 and 38 out of a possible overall score of 90, indicating low levels of parenting stress (Table 18). No significant differences were observed between intervention and comparison groups at any interview time point.

Table 18. PSS Scores

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Baseline	37.27 (8.48)	35.22 (8.17)	36.16 (8.35)
9-month follow-up	37.52 (7.50)	36.44 (7.77)	36.93 (7.63)
18-month follow-up	35.82 (7.22)	36.95 (7.65)	36.42 (7.42)

Parental stress over time. There were no statistically significant differences between intervention and comparison groups in parental stress scores at baseline, 9-month, or 18-month interviews. There were also no statistically significant changes across time.

PARENTING AND CHILD-REARING ATTITUDES

Across all interview time points from baseline to 18-month follow-up, both the intervention group and the comparison group reported similar scores on all AAPI-2 subscales. Scores reflected higher levels of positive expectations, empathy, use of non-corporal discipline, support for appropriate family roles, and encouragement of children's independence (Table 19).

Table 19. AAPI-2.5 Form A and Form B Combined Standard Scores

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Baseline[1]			
Expectations of children	1.99 (0.11)	2.00 (0.00)	1.99 (0.08)
Parental empathy towards children's needs	1.95 (0.22)	1.91 (0.29)	1.93 (0.25)
Use of corporal punishment	1.93 (0.27)	1.97 (0.17)	1.95 (0.23)
Parent-child family roles	1.96 (0.19)	1.98 (0.12)	1.97 (0.16)
Children's power and independence	2.70 (0.56)	2.58 (0.61)	2.64 (0.58)
9-month follow-up[1]			
Expectations of children	2.00 (0.00)	2.00 (0.00)	2.00 (0.00)
Parental empathy towards children's needs	1.98 (0.14)	1.93 (0.25)	1.96 (0.20)
Use of corporal punishment	2.00 (0.00)	2.00 (0.00)	2.00 (0.00)
Parent-child family roles	1.96 (0.20)	1.98 (0.15)	1.97 (0.18)
Children's power and independence	2.12 (0.62)	2.11 (0.68)	2.11 (0.65)
18-month follow-up[1]			
Expectations of children	2.00 (0.00)	2.00 (0.00)	2.00 (0.00)
Parental empathy towards children's needs	1.97 (0.16)	1.97 (0.19)	1.97 (0.17)

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
Use of corporal punishment	2.00 (0.00)	1.97 (0.19)	1.98 (0.12)
Parent-child family roles	1.97 (0.16)	2.00 (0.00)	1.98 (0.12)
Children's power and independence	2.14 (0.63)	2.14 (0.58)	2.14 (0.60)

[1]AAPI Form A used at baseline; Form B used at 9- and 18-month follow-ups. All scores standardized.

Parenting and child-rearing attitudes over time. There were no statistically significant differences between intervention and comparison groups for the Expectations of Children scale or the Parental Empathy Towards Children's Needs scale, and there were no statistically significant changes over time for either group. There were no differences between intervention and control groups on the Use of Corporal Punishment scale (i.e., valuing alternatives to corporal punishment) at any time point. However, intervention group participants showed a statistically significant increase in scores over time (slope = .01, p = .01). For the Parent-Child Family Roles scale; intervention group scores were statistically significantly lower than comparison group scores at the 9-month (difference = -0.06, p <.001) and 18-month follow-up (difference = -0.11, p < .001) interviews. Intervention group adults showed a statistically significant decrease in scores over time (slope = -0.01, p = .01). For the Children's Power and Independence scales, there were no differences between the intervention and comparison group at any point in time. Both groups did show a significant decrease in scores from baseline to 18-month follow-up (intervention: slope = -0.02, p <.001; comparison: slope = -0.03, p <.001).

Figure 10. Intervention group participants showed an increase in valuing non-corporal punishment over time.

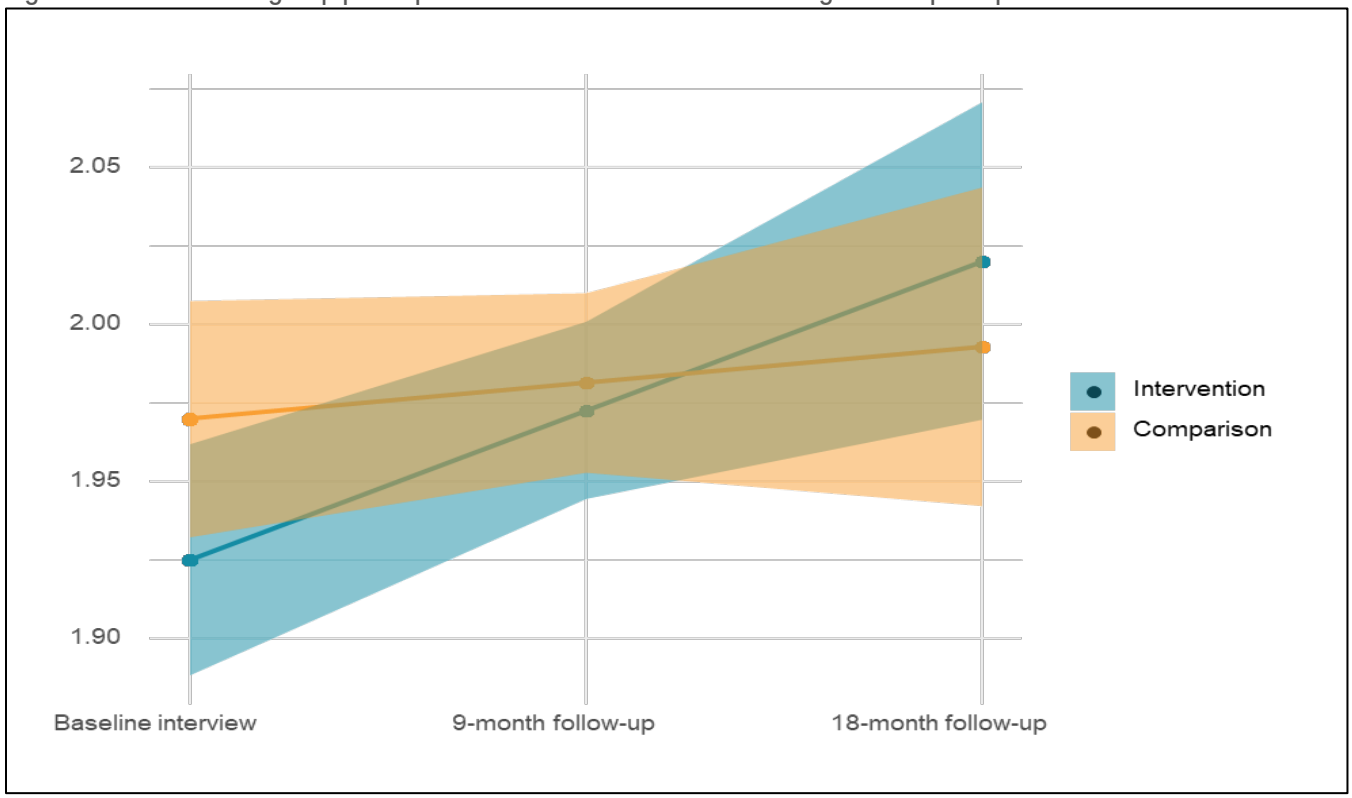


Figure 11. Intervention group participants showed a decrease in valuing appropriate parent-child roles over time.

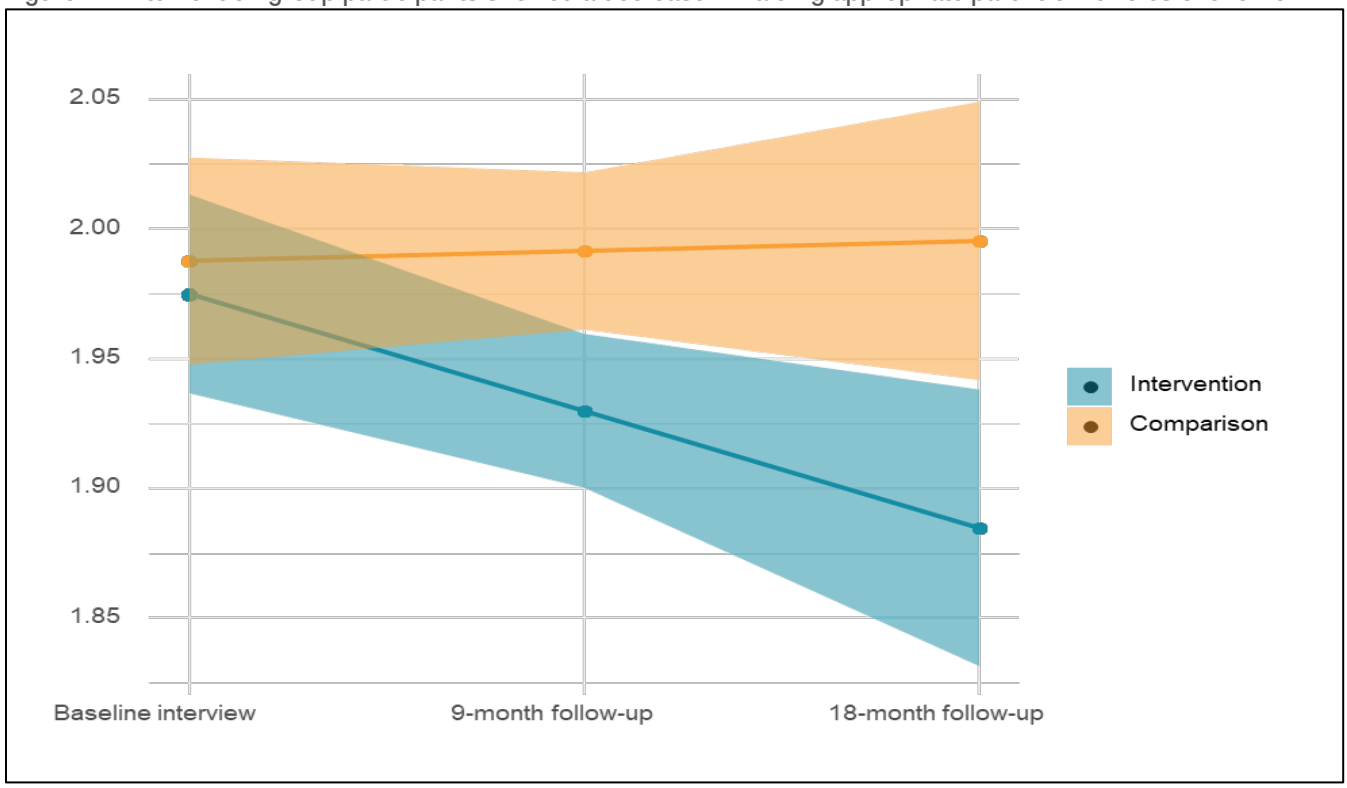
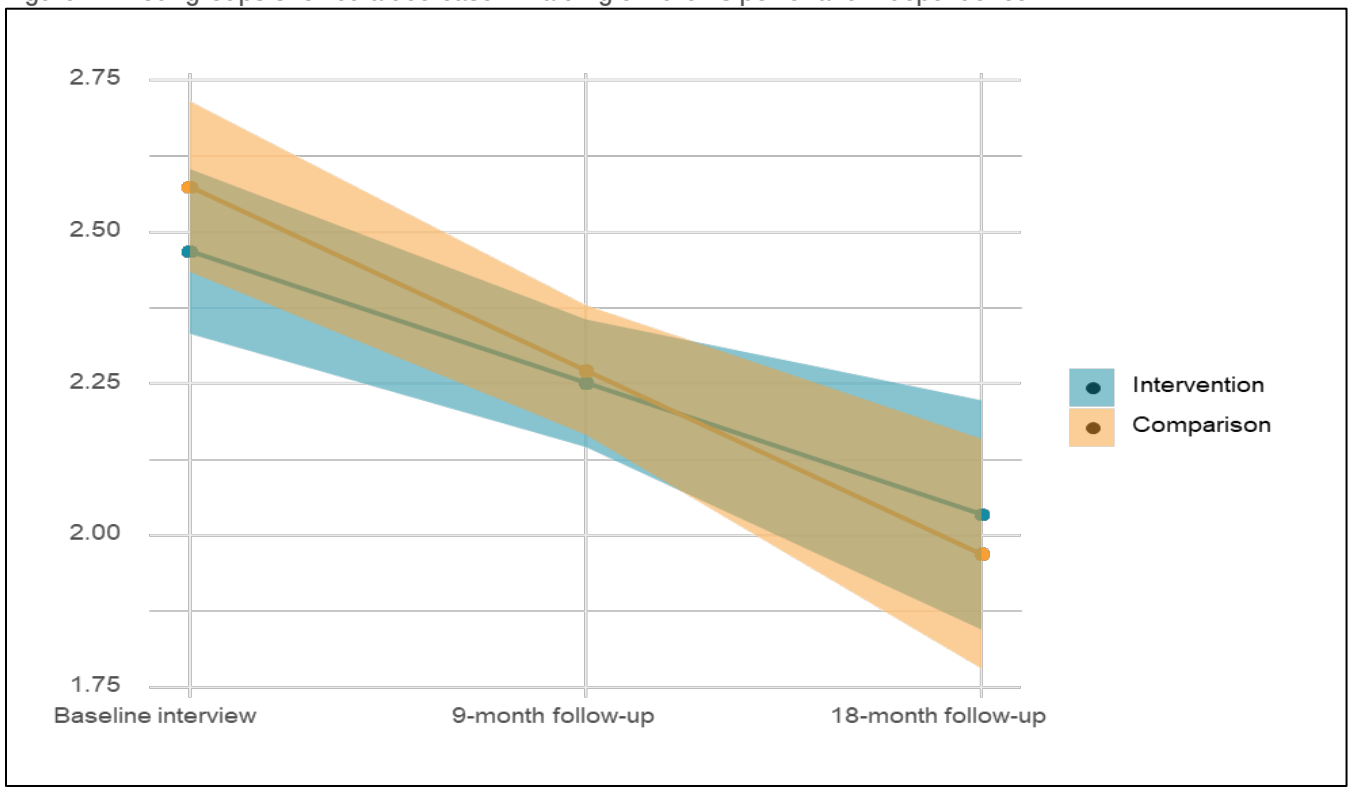


Figure 12. Both groups showed a decrease in valuing children's power and independence.



Child Functioning and Social-Emotional Well-Being

Child functioning and social-emotional well-being was measured based on the age of the focal child at the time of the interview.

NOTEWORTHY RESULTS

- Comparison group children showed a significant increase in sensation avoidance scores over time, indicating that they became less avoidant to unfamiliar sensations.
- Intervention group children showed significant decreases in ITSP Sensation Sensitivity scores over time, indicating that they became more responsive to all types of sensation over time.
- Intervention group children had statistically significantly lower scores on the CBCL-PS Externalizing and Total scales at 9- and 18-month follow-up than comparison group children. This suggests that intervention group children had fewer behavioral problems than intervention group children.

CHILD FUNCTIONING (ITSP 0 TO 6 MONTHS)

The ITSP 0-6 was administered to participants whose focal child was 0 (birth) to 6 months old. This measure was administered at baseline only to the 10 participants whose focal child was aged 0 to 6 months. The ITSP 0-6 was not administered at the 9- or 18-month follow-up interviews because there were no focal children aged 6 months or younger. At baseline, children in the intervention group had statistically significantly higher scores on the Sensation Seeking subscale (M = 13.00, SD = 2.58) compared to the comparison group (M = 7.17, SD = 1.60, t = -4.03, p = .01). There were no other significant differences between groups.

Table 20. ITSP 0 to 6 Months Baseline Scores

	Intervention Group (N=4)	Comparison Group (N=6)	Total Sample (N=10)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Sensation avoiding	24.50 (0.58)	21.00 (4.36)	22.56 (3.61)
Low registration	50.75 (3.30)	49.00 (4.74)	49.78 (4.02)
Sensation seeking	13.00 (2.58)	7.17 (1.60)	9.50 (3.57)
Sensation sensitivity	55.75 (1.50)	50.80 (6.42)	53.00 (5.32)
Low threshold	80.25 (1.50)	71.80 (10.01)	75.56 (8.41)

CHILD FUNCTIONING (ITSP 7 TO 36 MONTHS)

The ITSP 7-36 was administered to participants whose focal child was aged 7 to 36 months. At baseline, this measure was administered to 20 participants. No statistically significant differences were observed between the intervention and comparison groups across the five subscales. The ITSP 7-36 was administered to 13 participants at the 9-month follow-up. There were no statistically significant differences between groups across the five subscales. The ITSP 7-36 was administered to 4 participants at the 18-month follow-up (n = 4), including only 1 participant in the intervention group. Therefore, it was not possible to make a statistical comparison across all subscales between groups.

There were no statistically significant differences between intervention and comparison groups at any interview.

Table 21. ITSP 7 to 36 Months Scores

	Intervention Group	Comparison Group	Total Sample
Baseline	N=14	N=6	N=20
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Sensation avoiding	51.15 (5.67)	48.60 (4.83)	50.44 (5.44)
Low registration	49.08 (5.07)	44.75 (9.00)	48.06 (6.17)
Sensation seeking	34.15 (9.49)	27.40 (8.02)	32.28 (9.40)
Sensation sensitivity	49.15 (5.37)	45.40 (2.70)	48.11 (5.00)
Low threshold	100.31 (10.23)	94.00 (7.45)	98.56 (9.76)
9-Month Follow-Up	N=7	N=6	N=13
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Sensation avoiding	47.57 (4.83)	50.80 (4.82)	48.92 (4.89)
Low registration	46.86 (5.64)	46.00 (5.66)	46.46 (5.43)
Sensation seeking	33.57 (12.31)	32.00 (13.49)	32.92 (12.23)
Sensation sensitivity	41.57 (6.53)	41.2 (7.60)	41.42 (6.65)
Low threshold	89.14 (7.17)	94.00 (10.10)	90.91 (8.22)
18-Month Follow-Up	N=1	N=3	N=4
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Sensation avoiding	59 (-)	46.33 (4.51)	49.50 (7.33)
Low registration	55 (-)	47.33 (2.31)	49.25 (4.27)
Sensation seeking	54 (-)	22.67 (1.15)	30.50 (15.70)
Sensation sensitivity	55 (-)	41.67 (8.39)	45.00 (9.56)
Low threshold	114 (-)	88.00 (12.49)	94.50 (16.52)

ITSP 7-36 over time. The same regression models were used to evaluate changes in child functioning and social-emotional well-being outcomes across time and between intervention and comparison groups for ITSP 7-36 scores. Due to the overall low sample size, these scores may be unstable and could differ at larger sample sizes. There were no statistically significant differences between groups or changes over time for the Low Registration, Sensation Seeking, or Low Threshold scales. Children in the comparison group showed a statistically significant increase in scores over time on Sensation Avoidance (slope = -0.56, p = .03). Children in the intervention group showed a statistically significant decrease in Sensation Sensitivity scores over time (slope = 0.89, p = .04). There were no other statistically significant comparisons.

Figure 13. Comparison group children showed a significant increase in sensation avoidance over time. The increase for children in the intervention group was not significant.

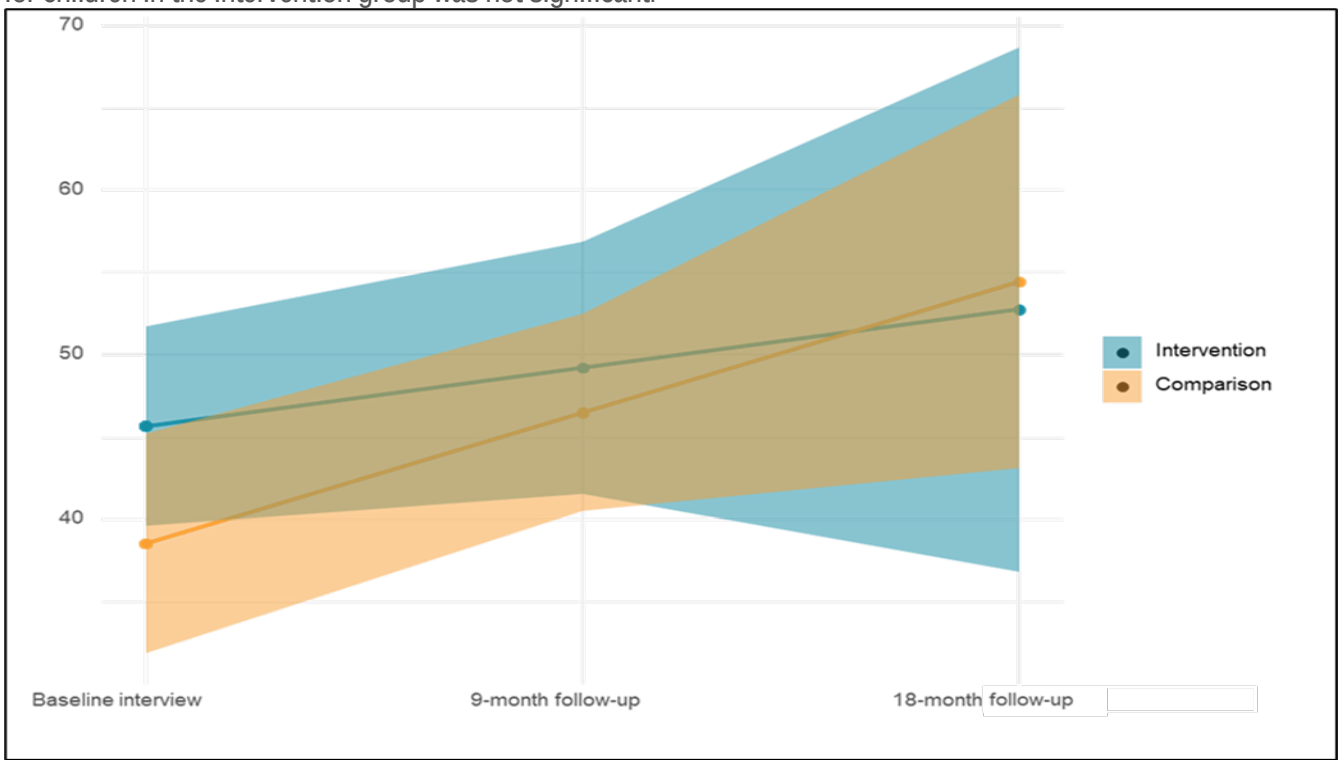
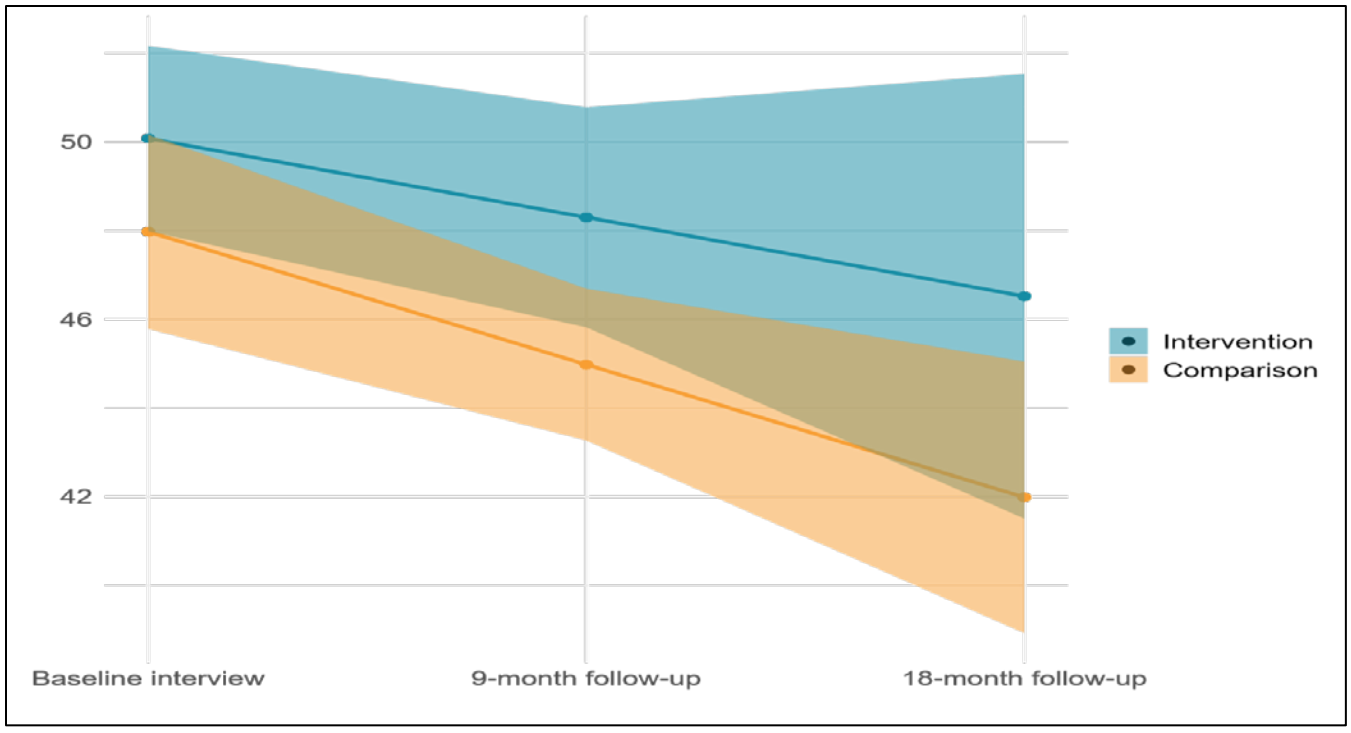


Figure 14. Intervention group children showed a significant decrease in sensation sensitivity over time. The decrease for children in the comparison group was not significant.



CHILD SOCIAL-EMOTIONAL WELL-BEING (CBCL-PS)

Baseline. The CBCL-PS was administered to participants whose focal child was 1.5 to 5 years old. At baseline, about 46% (n = 70) of families completed the CBCL-PS (Table 22). There were no statistically significant differences between the intervention and comparison groups on any of the subscales or the total scale.

Table 22. CBCL-PS Baseline Standardized Scores

	Intervention Group (N=40)	Comparison Group (N=30)	Total Sample (N=70)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behaviors	55.03 (7.86)	56.28 (8.69)	55.56 (8.19)
Attention problems	57.87 (8.34)	56.68 (7.11)	57.34 (7.78)
Externalizing	50.72 (12.71)	52.83 (12.29)	51.62 (12.49)
Anxiety problems	55.16 (9.12)	55.17 (8.29)	55.16 (8.69)
Emotionally reactive	56.63 (8.38)	57.47 (9.32)	57.00 (8.75)
Somatic complaints	52.74 (4.86)	52.80 (7.42)	52.77 (6.06)
Withdrawn/depressed	54.79 (6.51)	56.13 (8.64)	55.39 (7.50)
Internalizing	49.30 (12.7)	51.55 (11.99)	50.29 (12.35)
Affective problems	54.64 (6.80)	55.68 (8.38)	55.10 (7.50)
Anxious/depressed	55.92 (8.35)	54.70 (7.49)	55.39 (7.96)
Attention deficit/hyperactivity	56.67 (7.44)	56.74 (7.97)	56.70 (7.62)
Oppositional defiant	54.97 (7.14)	56.57 (8.25)	55.67 (7.63)
Pervasive developmental problems	56.00 (8.97)	57.87 (9.23)	56.81 (9.07)
Sleep problems	54.34 (5.66)	56.45 (9.24)	55.29 (7.50)
Total CBCL-PS Score	49.38 (13.54)	52.41 (13.53)	50.66 (13.52)

9-month follow-up. The CBCL-PS was administered to 41% of participants at 9-month follow-up (n = 42). Children in the intervention group scored statistically significantly lower on the Pervasive Developmental Problems subscale (M = 55.20, SD = 7.34) compared to children in the comparison group (M = 61.41, SD = 10.47; $t = 2.12$, $p = .04$). There were no other statistically significant differences observed between the groups.

Table 23. CBCL-PS 9-Month Follow-Up Standardized Scores

	Intervention Group (N=26)	Comparison Group (N=16)	Total Sample (N=42)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behaviors	54.28 (6.66)	59.71 (13.13)	56.48 (10.03)
Attention problems	57.31 (7.49)	61.18 (9.10)	58.84 (8.28)
Externalizing	50.20 (11.32)	58.59 (14.72)	53.60 (13.30)
Anxiety problems	54.80 (7.05)	59.35 (9.18)	56.64 (8.19)
Emotionally reactive	56.44 (7.56)	60.18 (11.10)	57.95 (9.22)

	Intervention Group (N=26)	Comparison Group (N=16)	Total Sample (N=42)
Somatic complaints	53.00 (5.44)	55.00 (4.76)	53.76 (5.23)
Withdrawn/depressed	54.08 (5.86)	57.76 (10.21)	55.53 (7.97)
Internalizing	50.60 (11.11)	57.62 (11.23)	53.34 (11.55)
Affective problems	54.08 (6.37)	55.35 (6.99)	54.60 (6.57)
Anxious/depressed	55.04 (6.52)	55.88 (7.04)	55.37 (6.65)
Attention deficit/hyperactivity	57.27 (7.56)	61.82 (7.84)	59.07 (7.91)
Oppositional defiant	53.80 (6.30)	57.71 (8.89)	55.38 (7.6)
Pervasive developmental problems	55.20 (7.34)	61.41 (10.47)	57.71 (9.16)
Sleep problems	54.40 (4.85)	57.29 (7.59)	55.57 (6.19)
Total CBCL-PS Score	50.33 (12.69)	57.94 (12.74)	53.38 (13.1)

18-month follow-up. The CBCL-PS was administered to 28% of families at 18-month follow-up (n = 20). Children in the intervention group scored statistically significantly lower on the Oppositional Defiant subscale (M = 51.40, SD = 3.10) than the comparison group (M = 58.40, SD = 8.03, t = 2.57, p = .03). Children in the intervention group also scored statistically significantly lower on the Externalizing subscale (M = 43.30, SD = 10.10) compared to comparison group children (M = 57.30, SD = 11.80, t = 2.24, p = .04). There were no other statistically significant differences between groups.

Table 24. CBCL-PS 18-Month Follow-Up Standardized Scores

	Intervention Group (N=10)	Comparison Group (N=10)	Total Sample (N=20)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behaviors	52.10 (4.91)	59.3 (9.53)	55.70 (8.25)
Attention problems	54.60 (5.21)	59.40 (8.50)	57.00 (7.29)
Externalizing	46.30 (10.1)	57.30 (11.80)	51.80 (12.09)
Anxiety problems	56.30 (8.14)	56.00 (7.10)	56.15 (7.44)
Emotionally reactive	57.70 (11.78)	61.70 (10.66)	59.70 (11.12)
Somatic complaints	52.30 (5.12)	53.70 (5.52)	53.00 (5.23)
Withdrawn/depressed	52.90 (4.95)	54.50 (5.46)	53.70 (5.14)
Internalizing	49.20 (13.75)	53.30 (13.32)	51.25 (13.34)
Affective problems	54.50 (6.88)	57.80 (7.36)	56.15 (7.14)
Anxious/depressed	54.30 (6.06)	54.40 (5.02)	54.35 (5.41)
Attention deficit/hyperactivity	55.90 (8.37)	60.10 (6.52)	58.00 (7.62)
Oppositional defiant	51.40 (3.1)	58.40 (8.03)	54.90 (6.93)
Pervasive developmental problems	54.80 (6.39)	55.90 (8.10)	55.35 (7.13)
Sleep problems	55.40 (5.64)	57.60 (7.50)	56.50 (6.56)
Total CBCL-PS Score	47.40 (12.91)	57.50 (13.23)	52.45 (13.74)

Child social-emotional well-being—CBCL-PS scores over time. Children in the intervention group had significantly lower scores on the Externalizing subscale at 9-month (p > .001) and 18-month

(p > .001) follow-up interviews, compared to comparison group children. Children in the intervention group had significantly lower CBCL-PS Total scores at 9-month (p > .001) and 18-month (p = .04) follow-up interviews, compared to comparison group children. Neither intervention nor comparison group children showed statistically significant changes over time. There were no other statistically significant comparisons.

Figure 15. Intervention group children had lower externalizing scores at 9- and 18-month follow-ups.

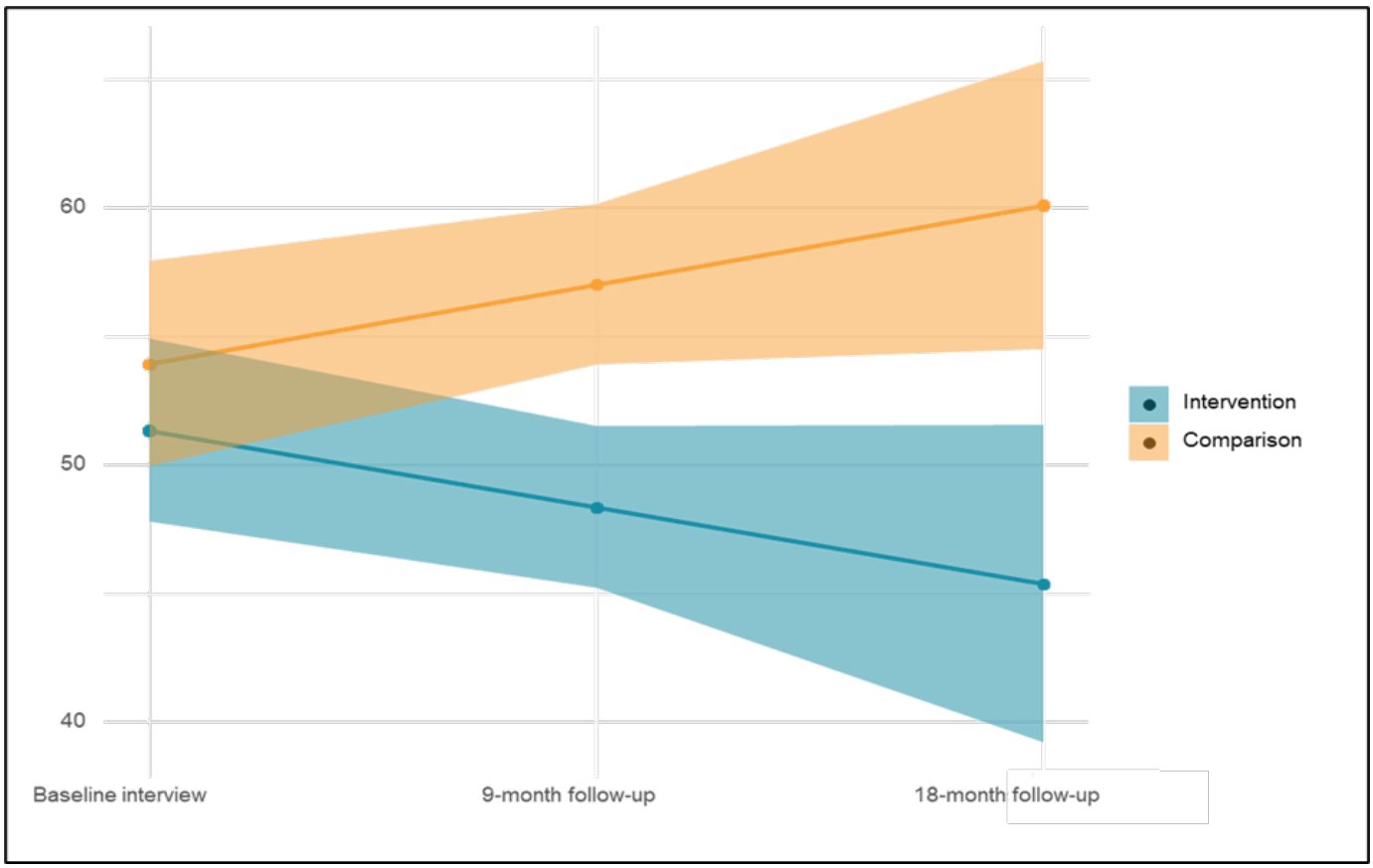
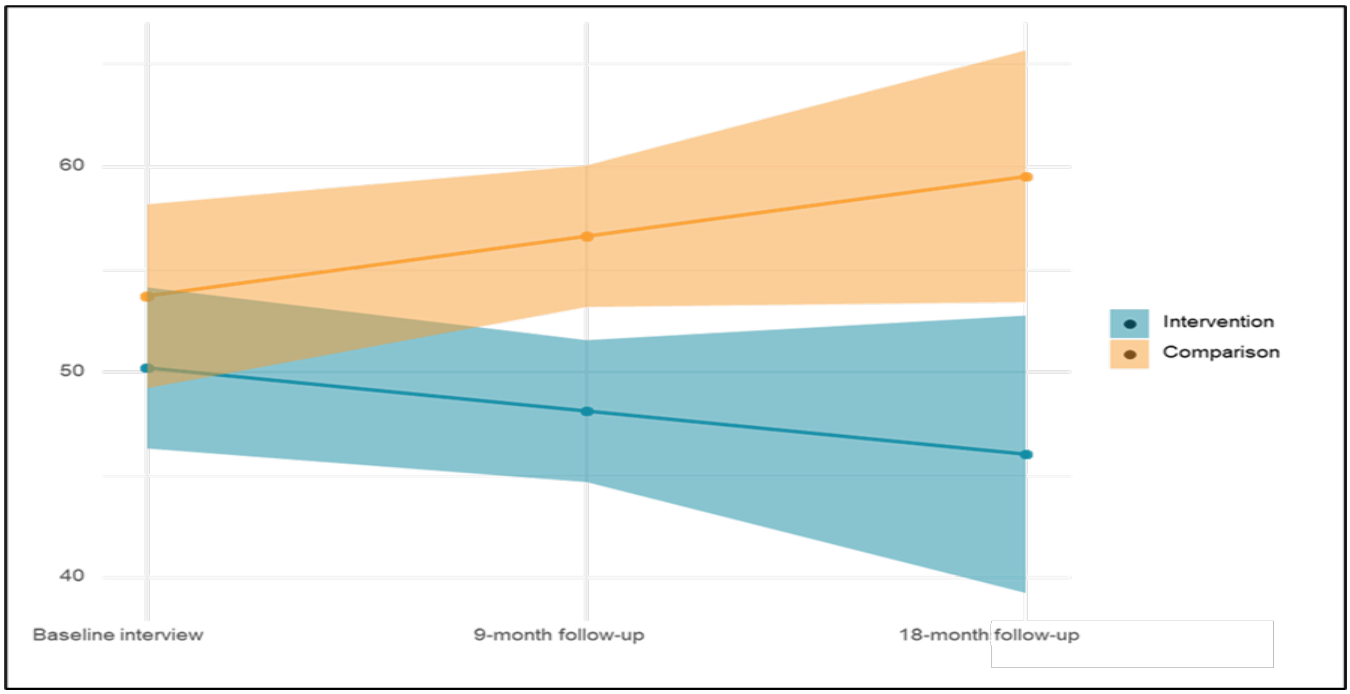


Figure 16. Intervention group children had lower CBLC-PS Total scores at 9- and 18-month follow-ups.



CHILD SOCIAL-EMOTIONAL WELL-BEING (CBCL-SA)

Baseline. The CBLC-SA was administered to participants whose focal child was aged 6 to 18 years old. Forty-three percent (n = 66) of participants completed the CBCL-SA at baseline (Table 25). There were no significant differences between intervention and comparison groups on any scale or subscale. Mean scores for both the intervention group and the comparison group for externalizing and internalizing symptoms were approximately within one standard deviation above 50, indicating that behaviors fell within expected ranges for children's age and sex (Achenbach & Rescorla, 2001).

Table 25. CBCL-SA Baseline Standardized Scores

	Intervention Group (N=36)	Comparison Group (N=30)	Total Sample (N=66)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behavior	61.58 (12.38)	59.17 (9.63)	60.48 (11.20)
Rule-breaking behavior	59.40 (8.50)	57.31 (7.73)	58.45 (8.16)
Externalizing	58.54 (13.23)	56.45 (12.12)	57.59 (12.68)
Anxious/depressed	57.40 (8.11)	57.11 (8.85)	57.27 (8.37)
Withdrawn/depressed	56.03 (7.53)	57.17 (8.72)	56.55 (8.05)
Somatic complaints	55.53 (6.24)	55.53 (6.79)	55.53 (6.44)
Internalizing	53.69 (12.00)	52.56 (12.92)	53.19 (12.32)
Attention problems	59.58 (9.57)	58.87 (8.73)	59.26 (9.14)
Social problems	59.43 (8.13)	58.50 (8.55)	59.00 (8.27)
Thought problems	60.34 (8.99)	59.70 (10.65)	60.05 (9.72)
Total CBCL-SA Score	58.58 (12.28)	55.54 (12.37)	57.24 (12.31)

9-month follow-up. At the 9-month follow-up interview, 46% (n = 48) of participants completed the CBCL-SA (Table 26). No significant differences were observed between groups, with mean scores at or less than one standard deviation from 50, indicating externalizing and internalizing behaviors fell within the expected ranges.

Table 26. CBCL-SA 9-Month Follow-Up Standardized Scores

	Intervention Group (N=24)	Comparison Group (N=24)	Total Sample (N=48)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behavior	55.96 (7.58)	57.88 (11.03)	56.92 (9.42)
Rule-breaking behavior	57.52 (8.18)	53.48 (5.97)	55.59 (7.42)
Externalizing	52.82 (11.17)	50.76 (11.86)	51.81 (11.42)
Anxious/depressed	54.40 (6.44)	55.58 (8.03)	54.98 (7.21)
Somatic complaints	54.17 (6.27)	54.26 (7.10)	54.22 (6.63)
Withdrawn/depressed	55.52 (6.59)	54.38 (6.96)	54.96 (6.73)
Internalizing	49.39 (12.99)	48.61 (13.44)	49.00 (13.07)
Attention problems	56.08 (6.45)	57.57 (8.96)	56.79 (7.71)
Social problems	57.33 (7.92)	55.39 (7.44)	56.38 (7.67)
Thought problems	55.33 (7.60)	58.17 (10.01)	56.72 (8.88)
Total CBCL-SA Scores	52.95 (12.83)	49.90 (14.18)	51.35 (13.47)

18-month follow-up. At the 18-month follow-up interview, the CBCL-SA was administered to 61% of participants (n = 44) (Table 27). Since the previous interview, one child had aged into the school-age range, while five families in the comparison group had dropped out of the evaluation. No significant differences were observed between groups, and mean scores remained at or less than one standard deviation from 50, indicating most externalizing and internalizing behaviors fell within the expected ranges.

Table 27. CBSL-SA 18-Month Follow-Up Standardized Scores

	Intervention Group (N=25)	Comparison Group (N=19)	Total Sample (N=44)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Aggressive behavior	58.33 (10.17)	56.11 (7.31)	57.44 (9.11)
Rule-breaking behavior	57.00 (7.29)	53.56 (5.47)	55.59 (6.76)
Externalizing	54.88 (11.23)	51.47 (10.24)	53.53 (10.85)
Anxious/depressed	53.92 (6.18)	55.58 (7.88)	54.62 (6.91)
Somatic complaints	55.59 (7.61)	56.63 (7.75)	56.02 (7.60)
Withdrawn/depressed	57.07 (7.02)	55.83 (7.34)	56.58 (7.10)
Internalizing	51.69 (10.91)	52.06 (13.05)	51.84 (11.69)
Attention problems	57.00 (8.33)	56.17 (5.65)	56.66 (7.29)
Social problems	57.46 (8.20)	57.17 (6.20)	57.34 (7.37)

	Intervention Group (N=25)	Comparison Group (N=19)	Total Sample (N=44)
Thought problems	57.85 (8.70)	56.00 (8.51)	57.09 (8.58)
Total CBCL-SA Score	53.68 (12.52)	51.81 (12.58)	52.95 (12.42)

Child social-emotional well-being—CBCL-SA scores over time. No statistically significant differences were observed between intervention and comparison groups on scores for the Externalizing or Internalizing subscales or Total scale at any interview point. Additionally, there were no significant changes in scores over time within each group.

Figure 17. Both groups showed a non-significant decrease in externalizing scores over time.

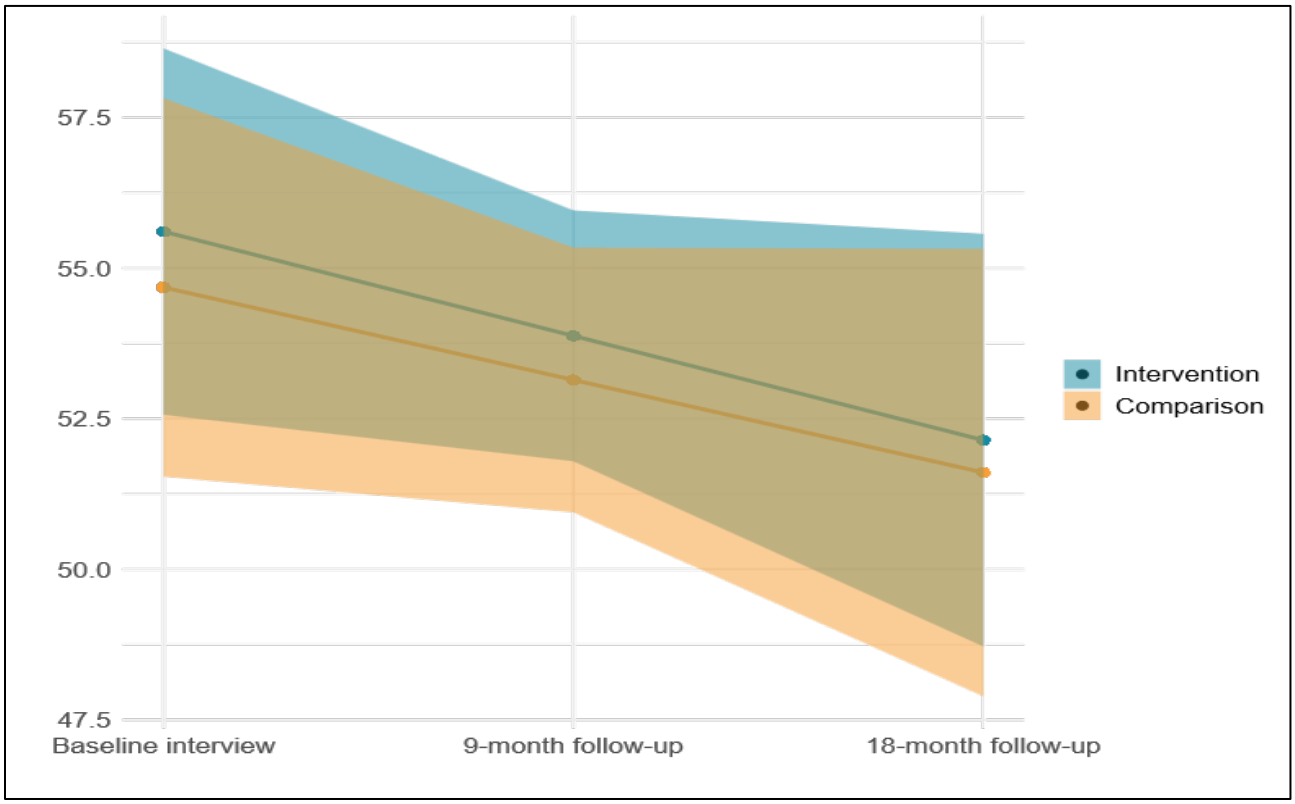


Figure 18. Both groups showed a non-significant decrease in internalizing scores over time.

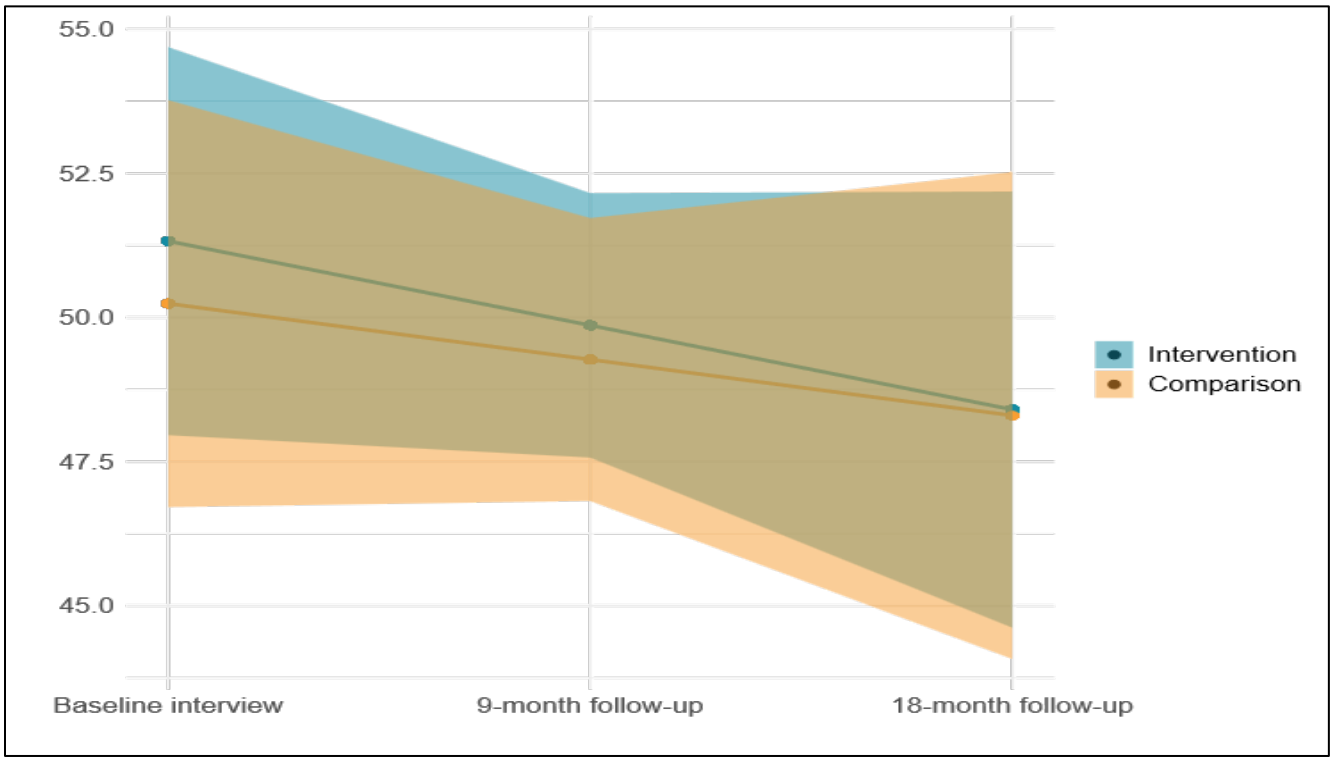
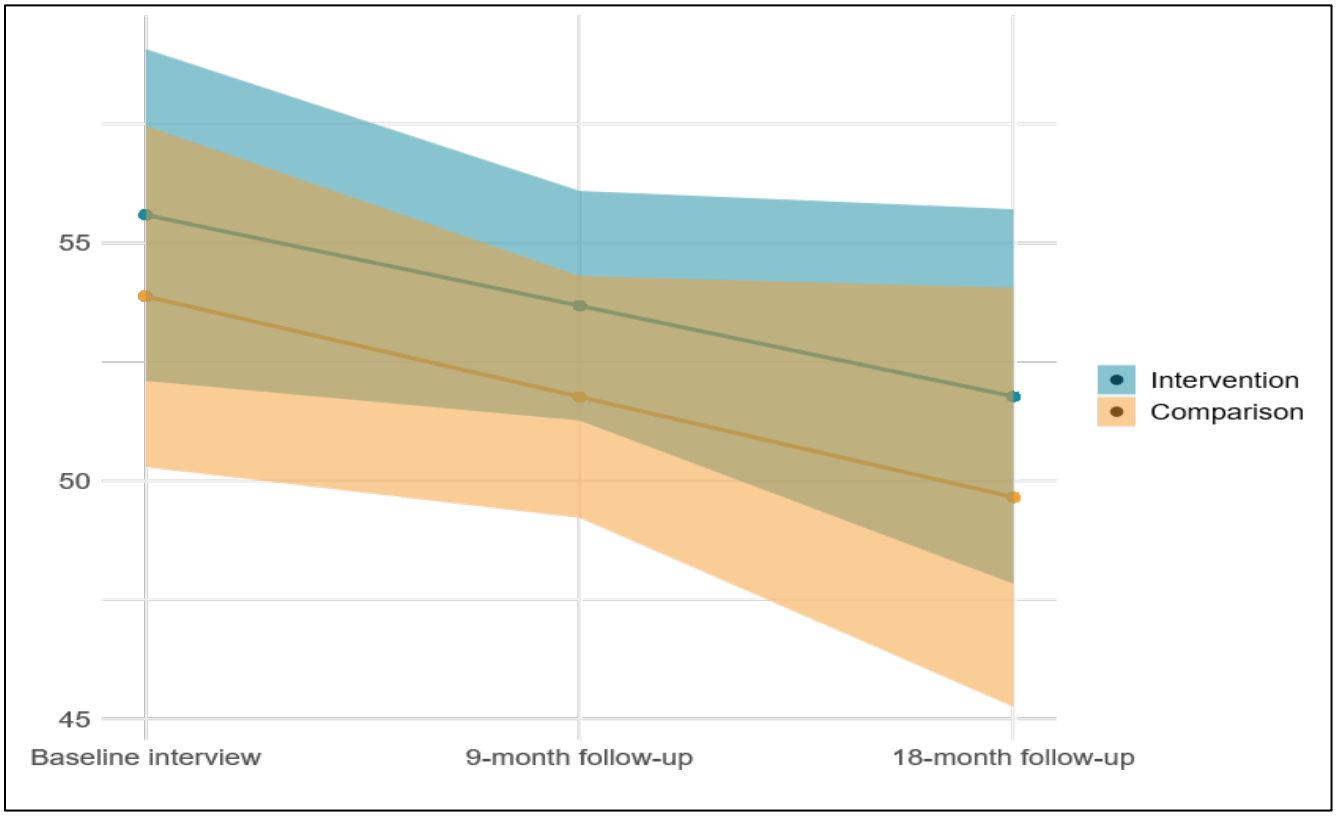


Figure 19. Both groups showed a non-significant decrease in total scores over time.



Relationships Between Outcomes, Demographics, and Program Success

NOTEWORTHY RESULTS

- Intervention group participants were less likely to be high alcohol users compared to the comparison group.
- Male participants were more likely to be high drug users compared to female participants. Intervention group participants were less likely to be high drug users compared to comparison group participants.
- Participants who reported higher depression symptoms also reported higher parental stress.
- Higher parental stress was associated with reduced well-being for children.

SUBSTANCE USE

Alcohol use. We used logistic regression to estimate the effect of outcome and demographic variables on whether participants scored as high alcohol users on the ASI-SR. Participants in the intervention group were less likely to be high alcohol users compared to the comparison group (p = .005). Participants with higher TSC-40 scores, indicating greater trauma symptom experience, were more likely to be high alcohol users (p = .004). Participants who attended college (p = .001) or had less than a high school diploma (p = .024) were more likely to be high alcohol users, compared to participants with a high school diploma or equivalent. Married participants were more likely than single participants to be high alcohol users (p = .022). There were no other significant relationships.

Table 28. Coefficient Table for Logistic Regression Predicting High Alcohol Use

Characteristic	OR[1]	p-value
(Intercept)	1.13	0.90
Gender		
Female[2]	-	-
Male	0.87	0.80
Education		
High school/GED[2]	-	-
Attended college	3.70	0.001
Less than high school diploma	2.44	0.024
Relationship Status		
Single[2]	-	-
Cohabitating	0.99	>0.90
Divorced/separated	1.52	0.30
Married	3.55	0.022
Widowed	0.00	>0.90
Living Situation		
Own home/apartment[2]	-	-
Homeless/shelter	1.73	0.40
Someone else's home/apartment	0.63	0.20
Employment Status		
Employed full-time[2]	-	-
Employed part-time	0.54	0.20

Characteristic	OR[1]	p-value
Unemployed	0.85	0.80
Self-employed	0.36	0.012
Annual Income		
$0–$9,999[2]	-	-
$10,000–$19,000	0.45	0.10
$20,000–$24,999	0.88	0.80
$25,000–$34,999	0.50	0.15
$35,000–$49,999	0.43	0.20
$50,000+	3.12	0.20
Age	0.98	0.40
Number of Children	0.91	0.30
Evaluation Group		
Comparison[2]	-	-
Intervention	0.41	0.005
Interview Time Point	0.97	0.20
CES-D Score (Depression)	0.96	0.095
TSC-40 Total Score (Trauma)	1.03	0.010

[1]OR = Odds Ratio
[2]Reference Group

Drug use. We used logistic regression to estimate the effect of outcome and demographic variables on whether participants scored as high drug users on the ASI-SR. Men were significantly more likely to be high drug users ($p < .001$); 80% or more of the male participants at each time point were identified as high drug users, and men made up only a small proportion of participants. Participants in the intervention group were less likely to be high drug users ($p = .02$). Finally, participants with high CES-D scores, who reported greater symptoms of depression, were more likely to be high drug users ($p = .03$). There were no other significant relationships.

Table 29. Coefficient Table for Logistic Regression Predicting High Drug Use

Characteristic	OR[1]	p-value
(Intercept)	0.44	.40
Gender		
Female[2]	-	-
Male	35.30	<0.001
Education		
High school/GED[2]	-	-
Attended college	0.76	0.50
Less than high school diploma	0.84	0.70
Relationship Status		
Single[2]	-	-
Cohabitating	1.05	0.90
Divorced/separated	2.04	0.11
Married	1.58	0.40
Widowed	0.78	0.80
Living Situation		
Own home/apartment[2]	-	-
Homeless/shelter	1.24	0.80

Characteristic	OR[1]	p-value
Someone else's home/apartment	1.18	0.70
Employment Status		
Employed full-time[2]	-	-
Employed part-time	1.14	0.80
Unemployed	0.81	0.80
Self-employed	0.79	0.62
Annual Income		
$0–$9,999[2]	-	-
$10,000–$19,000	0.62	0.30
$20,000–$24,999	1.19	0.70
$25,000–$34,999	0.76	0.60
$35,000–$49,999	0.30	0.058
$50,000+	1.21	0.90
Age	1.00	>0.90
Number of Children	0.81	0.11
Evaluation Group		
Comparison[2]	-	-
Intervention	0.48	0.019
Interview Period	0.97	0.20
CES-D Score (Depression)	1.06	0.029
TSC-40 Total Score (Trauma)	1.00	0.80

[1]OR = Odds Ratio
[2]Reference Group

PARENTAL STRESS AND DEPRESSION

Parental stress. We used regression analysis to evaluate the relationships between parental stress, depression and trauma symptoms, and demographics. Participants who reported high scores on the CES-D, thus greater depression symptomology, reported higher levels of stress (p = .03). Parents with less than a high school diploma reported lower levels of stress compared to participants with a high school diploma. There were no other significant relationships.

Table 30. Coefficient Table for Linear Regression Predicting Parental Stress

Characteristic	Estimate	p-value
(Intercept)	34.73	< .001
Gender		
Female[1]	-	-
Male	0.48	0.72
Level of Education		
High school/GED[1]	-	-
Attended college	-0.81	0.47
Less than high school diploma	-2.37	0.04
Relationship Status	-1.67	0.13
Single[1]	-	-
Cohabitating	0.83	0.52
Divorced/separated	-0.80	0.63

Characteristic	Estimate	p-value
Married	2.73	0.35
Widowed	3.02	0.30
Living Situation		
Own home/apartment[1]	-	-
Homeless/shelter	-3.75	0.10
Someone else's home/apartment	-1.65	0.11
Employment		
Employed full-time[1]	-	-
Employed part-time	2.39	0.13
Unemployed	0.13	0.96
Self-employed	-1.72	0.13
Income		
$0–$9,999[1]	-	-
$10,000–$19,000	-1.34	0.29
$20,000–$24,999	-1.64	0.29
$25,000–$34,999	-0.33	0.82
$35,000–$49,999	0.05	0.87
$50,000+	-0.70	0.83
Age	0.05	0.55
Number of Children	-0.12	0.72
Evaluation Group		
Comparison[1]	-	-
Intervention	-0.58	0.52
Interview Period	0.06	0.36
CES-D Score (Depression)	0.17	0.025
TSC-40 Total Score (Trauma)	0.05	0.12

[1]Reference Group

Depression. We used regression analysis to evaluate the relationships between depression and trauma symptoms and demographics. Participants who reported high scores on the TSC-40, meaning they reported higher levels of trauma symptoms, also reported higher scores on the CES-D ($p < .001$), meaning they reported greater depression symptoms. Participants who made between $25,000 and $34,999 per year reported significantly fewer depressive symptoms than participants who reported making less than $10,000 per year ($p = .03$). Additionally, depression scores decreased significantly over time ($p = .02$). There were no other significant relationships.

Table 31. Coefficient Table for Linear Regression Predicting Depression

Characteristic	Estimate	p-value
(Intercept)	2.28	.26
Gender		
Female[1]	-	-
Male	-1.87	0.07
Level of Education		
High school/GED[2]	-	-
Attended college	-0.99	0.23

Characteristic	Estimate	p-value
Less than high school diploma	-0.45	0.60
Relationship Status		
Single[1]	-	-
Cohabitating	-0.49	0.54
Divorced/separated	0.91	0.34
Married	0.71	0.58
Widowed	3.56	0.11
Living Situation		
Own home/apartment[1]	-	-
Homeless/shelter	-1.07	0.51
Someone else's home/apartment	1.03	0.19
Employment		
Employed full-time[1]	-	-
Employed part-time	-1.52	0.19
Unemployed	0.34	0.68
Self-employed	0.23	0.68
Income		
$0–$9,999[1]	-	-
$10,000–$19,000	-1.59	0.09
$20,000–$24,999	-0.87	0.45
$25,000–$34,999	-2.30	0.03
$35,000–$49,999	-1.51	0.20
$50,000+	1.16	0.63
Age	-0.13	0.81
Number of Children	-0.10	0.70
Evaluation Group		
Comparison[1]	-	-
Intervention	0.90	0.18
Interview Period	-0.11	0.17
TSC-40 Total Score (Trauma)	0.34	< 0.001

[1]Reference Group

CHILDHOOD WELL-BEING

Well-being—preschool age. We used regression analysis to evaluate the relationships between childhood well-being as measured by the CBCL-PS, parental stress, and demographics. The children of participants who reported high scores on the PSS, thus higher parental stress, reported higher levels of total behavioral problems ($p < .001$). There were no other significant relationships.

Table 32. Coefficient Table for Linear Regression Predicting CBCL-PS Scores

Characteristic	Estimate	p-value
(Intercept)	-33.68	.12
Gender		
Female[1]	-	-
Male	3.65	0.42
Living Situation		
Private residence[1]	-	-
Homeless/shelter	21.17	0.14
Age	-0.26	0.88
Child Resides with Bio Parent	16.87	0.24
Evaluation Group		
Comparison[1]	-	-
Intervention	-4.62	0.33
Interview Period	0.22	0.55
Parent PSS Score (Stress)	1.50	< 0.001

[1]Reference Group

Well-being—school age. We used regression analysis to evaluate the relationships between childhood well-being as measured by the CBCL-SA, parental stress, and demographics. The children of participants who reported high scores on the PSS, thus higher parental stress, reported higher levels of total behavioral problems (p = .003). Male children and older children reported higher levels of behavioral problems as well (p = .02). There were no other significant relationships.

Table 33. Coefficient Table for Linear Regression Predicting CBCL-SA Scores

Characteristic	Estimate	p-value
(Intercept)	-16.89	.38
Gender		
Female[1]	-	-
Male	10.72	0.02
Living Situation		
Private residence[1]	-	-
Homeless/shelter	-1.07	0.51
Age	2.22	0.02
Child Resides with Biological Parent	-4.90	0.68
Evaluation Group		
Comparison[1]	-	-
Intervention	2.68	0.55
Interview Period	-0.41	0.17
Parent PSS Score (Stress)	0.94	0.003

[1]Reference Group

Service Utilization and Program Utilization

NOTEWORTHY RESULTS

- Intervention group participants had a greater number of contacts with Intact workers than comparison group participants did.
- Case management services were the most common service utilized throughout the program.
- Evaluation participants were enrolled in Intact services for longer than non-evaluation participants.
- Participants who did not complete substance use treatment had shorter program tenures.

The evaluation collected data about Intact and IFR services, service utilization, and program engagement, which are presented below along with information from individuals who consented to the evaluation interviews and service data collection. We compared this data with data from participants who chose not to participate in the evaluation interviews. Results from analyses to assess differences between the intervention and comparison groups, with applicable weights, are presented below.

A total of 234 program participants were invited to participate in the evaluation (Table 34). Of these, 64% (n = 151) enrolled in the evaluation and completed baseline interviews. Most families at the intervention sites chose to participate (78%, n = 83), while slightly more than half of the comparison group families chose to participate (54%, n = 68). Throughout the following section, data are not available for all participants; participants with missing data are not included in the analyses.

Table 34. Evaluation and Non-Evaluation Participants by Group

	Intervention Group (N=107)	Comparison Group (N=127)	Total Sample (N=234)
	N (%)	N (%)	N (%)
Evaluation participant	83 (78%)	68 (54%)	151 (64%)
Non-evaluation participants	24 (22%)	59 (46%)	83 (35%)

SERVICE UTILIZATION

Families in the intervention group had a significantly greater number of contacts with Intact workers compared to those in the comparison group ($t = 8.74$, $p < .001$) (Table 35). On average, intervention group families had an average of 38.8 total contacts with Intact workers, compared to 22.1 contacts among families in the comparison group. Additionally, families who participated in the evaluation had a significantly higher number of contacts with both Intact workers and recovery coordinators compared to families who chose not to participate in the evaluation.

Table 35. Service Utilization: Recovery Coordinator and Intact Worker Contacts

	Intervention Group	Comparison Group	Total Sample
Evaluation Participants (N = 141)	Mean (*SD*)	Mean (*SD*)	Mean (SD)
Mean # of recovery coordinator contacts	32.9 (21.2)	---	32.9 (21.2)
Mean # of Intact worker contacts	38.8 (22.7)	22.1 (11.9)	29.1 (19.1)

	Intervention Group	Comparison Group	Total Sample
	N (%)	N (%)	N (%)
Total # of recovery coordinator contacts	3224 (100%)	---	3224 (100%)
Total # of Intact worker contacts	3804 (56%)	2979 (44%)	6783 (100%)
All participants (N = 233)	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Mean # of recovery coordinator contacts	34.2 (20.8)	28.3 (22.4)	30.8 (22.5)
Mean # of Intact worker contacts	32.6 (19.6)	23.1 (17.1)	29.1 (19.1)
	N (%)	N (%)	N (%)
Total # of recovery coordinator contacts	2601 (80%)	623 (20%)	3224 (100%)
Total # of Intact worker contacts	4603 (68%)	2180 (32%)	6783 (100%)

Table 36 shows that service logs (or service contacts) were available for 141 (93%) participants (i.e., cases) who enrolled in the evaluation and consented to service data collection. On average, there were 26 service logs for each enrolled case. A total of 3,671 service logs were recorded during the evaluation, with 98.2% of the logs documenting the types of services provided. On average, the length of time between enrollment and first service was 45.73 days. The intervention group received services sooner, at an average of 39.0 days, compared to the comparison group, at an average of 54.0 days.

SERVICE TYPE AND FOCUS

Service logs completed by Intact supervisors and recovery coordinators documented information on the type and focus of each service episode (i.e., Intact worker and/or recovery coordinator visit) as shown in Table 36. Case management or service coordination made up 91.2% of all service logs (n = 3288). Transportation services comprised 3.2% (n = 116) of service logs, screening or assessment services made up 3.1% (n = 111) of service logs, and court or legal services made up 2.5% (n = 90) of service logs.

Service logs also captured the focus of each service episode, with each log potentially having multiple foci. Service focus data in Table 36 reflect their distribution across 3,605 service logs. Consistent with EIL IFR's goals, the most common focus across all service logs was adult SUD (63.4% of service logs, n = 2285), followed by life skills (45.8%, n = 1650), parenting skills (43.4%, n = 1565), and mental health treatment (36.7%, n = 1322).

The case-level data are reported in the right-hand column of Table 36. Nearly all families received life skills services (97.9%, n = 138), SUD services (96.5%, n = 136), parenting services (94.3%, n = 133), and mental health services (89.4%, n = 126). Most cases (70.9%, n = 100) received services marked as "Other", indicating they did not fall into the existing service foci.

Table 36. Service Type and Focus Reported on Service Logs for All Services and Cases

	Service Logs (N=3605)	Cases (N=141)
Service Type	N (%)	N (%)
Case management or service coordination	3288 (91%)	141 (100%)
Transportation	116 (3%)	35 (25%)

	Service Logs (N=3605)	Cases (N=141)
Screening or assessment	111 (3%)	69 (49%)
Court or legal	90 (2%)	31 (22%)
Service Focus		
Assessments (*any*)	116 (3%)	48 (34%)
Child development screening	65 (2%)	21 (15%)
Needs assessment	50 (1%)	31 (22%)
Evaluation data collection	1 (0%)	1 (1%)
Health services (*any*)	415 (12%)	92 (65%)
Medical care	350 (10%)	88 (62%)
Health education	80 (2%)	34 (24%)
Life skills services (*any*)	1650 (46%)	138 (98%)
Personal development	663 (18%)	106 (75%)
Safety planning	550 (15%)	118 (83%)
Academic education	346 (10%)	87 (62%)
Family decision making	290 (8%)	85 (60%)
Financial planning	143 (4%)	52 (37%)
Employment training	53 (1%)	23 (16%)
Material support (*any*)	976 (27%)	117 (83%)
Housing	588 (16%)	97 (69%)
Transportation	274 (8%)	62 (44%)
Financial	257 (7%)	76 (54%)
Mental health services (*any*)	1322 (37%)	126 (89%)
Mental health treatment	1181 (33%)	124 (88%)
Behavior management	231 (6%)	59 (42%)
Trauma processing	59 (2%)	29 (21%)
Parenting services (*any*)	1565 (43%)	133 (95%)
Parenting skills	709 (20%)	101 (72%)
Childcare	206 (6%)	59 (42%)
Family activities	717 (20%)	110 (78%)
Parent–child visit facilitation	156 (4%)	27 (19%)
SUD services (*any*)	2285 (63%)	136 (97%)
Adult SUD services	2221 (62%)	136 (97%)
Discharge recovery planning	105 (3%)	59 (42%)
Youth SUD services/prevention	8 (0%)	5 (4%)
Medication-assisted treatment	59 (2%)	10 (7%)

	Service Logs (N=3605)	Cases (N=141)
Other services (*any*)	637 (18%)	100 (71%)
Family crisis support	133 (4%)	49 (35%)
Court or legal	504 (14%)	86 (61%)
Other	37 (1%)	18 (13%)

Notes: Sums of service counts by service focus may be less than the sum of each component service in the cluster because families could receive multiple services/modalities within the same visit/service log. Data are reported on the 141 cases with service log data recorded.

PROGRAM RETENTION

All participants. We used the number of days between program enrollment and case closure to assess program retention, as reported in Table 37. Families who chose to participate in the evaluation remained enrolled in Intact services (M = 256.53.12, SD = 146.58) significantly longer than families who did not participate (M = 213.89, SD = 135.91; $t = 2.24$, $p = .03$). There were no differences in the number of days in IFR services between evaluation and non-evaluation families.

Table 37. Program Retention in Days for Evaluation and Non-Evaluation Participants

	Evaluation Participants (N=147)	Non-Evaluation Participants (N=85)	Total Sample (N=232)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days in Intact services	256.53 (146.58)	213.89 (135.91)	240.91 (143.95)
Days in IFR services	221.52 (132.22)	196.38 (117.54)	212.31 (127.36)

We used a regression analysis to investigate the number of days in services for all participants for whom data was available ($N = 232$), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who worked with participants, SUD assessment status at baseline, whether they were enrolled in the intervention or comparison group, and whether they consented into the evaluation interviews. Enrollment in the intervention group was not statistically significantly associated with more days enrolled ($p = .60$). Participants who had more meetings with Intact workers had longer program tenures (i.e., were in the program for a longer time) ($p < .001$), while participants who had more meetings with recovery coordinators had shorter program tenures ($p < .001$). Each Intact worker meeting was associated with 5.81 more days in the program (SE = 0.57, $p < .001$), while each recovery coordinator meeting was associated with 2.18 fewer days in the program (SE = 0.64, $p < .001$). Table 38 provides more information.

Participants who were referred for an SUD assessment but did not complete it or who were referred for treatment after an assessment but never began treatment spent statistically significantly fewer days in the program compared to the reference group of parents who were referred for treatment and began treatment ($p < .001$). Participants who were referred for and began treatment were enrolled for an estimated 258 days (SE = 12.7), participants who did not complete an assessment were enrolled for an average of 163 days (SE = 11.0), and families in which the focal parent was referred for but never began treatment were enrolled for an average of 160 days (SE = 13.4).

Table 38. Negative Binomial Model Predicting Program Retention for All Participants

Characteristic	IRR[1]	p-value
(Intercept)	1.20	<0.001
Total # Intact worker meetings with participants	1.03	<0.001
Total # Intact workers who worked with participants	1.00	>0.9
Total # recovery coordinator meetings with participants	0.99	<0.001
Total # recovery coordinators who worked with participants	0.99	>0.9
SUD assessment status		
Referred for treatment and began treatment[2]	1.00	
Current or recent treatment	0.79	0.002
Never referred for assessment	0.92	0.50
Never completed assessment	0.63	<0.001
Not referred for treatment	0.94	0.50
Referred for treatment, never began treatment	0.62	<0.001
Self-referral	1.15	0.40
Evaluation group		
Comparison[2]	1.00	
Intervention	1.29	0.047
Evaluation participant	1.03	0.6

[1]IRR = Incidence Rate Ratio
[2]Reference Group

Evaluation participants only. As Table 39 shows, intervention group families were retained in Intact services significantly longer (M = 286.01, SD = 165.28) than comparison group families (M = 212.41, SD = 110.19; t = 3.13, p = .002). Significant variation was observed in the number of days families remained enrolled, with a range of 13 days to a maximum of 734 days.

Table 39. Program Retention in Days for Evaluation Participants

	Intervention Group (N=83)	Comparison Group (N=68)	Total Sample (N=151)
	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Days in Intact services	286.01 (165.28)	212.41 (110.19)	252.12 (146.79)
Days in IFR services	236.52 (151.87)	-	

We used a regression analysis to investigate the number of days in services for evaluation participants for whom data was available (N = 151), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, and whether they were enrolled in the intervention or comparison group. Using a regression to identify the number of days in services for evaluation participants, enrollment in the intervention group was significantly associated with more days in the program (p = .01), with intervention group families remaining enrolled for an average of 55.07 more days than comparison group families (SE = 22.13, p = .013). The number of meetings with Intact workers (p < .001) was significantly associated with more days in the program, while the number of recovery coordinator meetings was significantly associated with fewer days enrolled in the program (p < .001). For every additional Intact worker meeting, participants remained enrolled an estimated 5.83

more days (SE = 0.45, $p < .001$), while each additional recovery coordinator meeting was associated with an estimated 1.5 fewer days in the program (SE = 0.41, $p < .001$). Participants who were referred for an SUD assessment but did not complete it or who were referred for substance use treatment after an assessment but never began treatment were enrolled for fewer days compared to the reference group of participoants who were referred for treatment and began treatment ($p < .001$). Participants who were referred for and began treatment were enrolled for an average of 253 days (SE = 10.9)—compared to participants who did not complete an assessment, at 195 days of enrollment (SE = 10.8), and participants who were referred for but never began treatment, at 166 days of enrollment (SE = 11.6). Table 40 provides additional details.

Table 40. Negative Binomial Model Predicting Program Retention for Evaluation Participants

Characteristic	IRR[1]	p-value
(Intercept)	1.09	<0.001
Total # Intact worker meetings with participants	1.02	<0.001
Total # Intact workers who worked with participants	1.04	0.20
Total # recovery coordinator meetings with participants	0.99	<0.001
Total # recovery coordinators who interacted with participants	0.94	0.30
SUD assessment status		
Referred for and began treatment[2]	1.00	
Current or recent treatment	.90	0.11
Never referred for assessment	1.23	0.06
Never completed assessment	0.77	<0.001
Not referred for treatment	1.03	0.70
Referred for treatment, never began treatment	0.66	<0.001
Self-referral	1.02	0.90
Evaluation group		
Comparison[2]	1.00	
Intervention	1.27	0.01

[1]IRR = Incidence Rate Ratio

[2]Reference Group

Successful Closure, Child Placement, and Substance Use Stability

NOTEWORTHY RESULTS

- Participants who did not complete SUD assessments or did not attend substance use treatment when referred were less likely to have a successful closure or SUD stability at case closure and were more likely to have children placed in foster care.

SUCCESFUL PROGRAM CLOSURE

All participants. Successful program closure was determined based on participants completing substance use treatment and other Intact service requirements and their children remaining in the

home. At the time of analysis, 222 participants across the program had closure data available. For all participants, nearly half (45%, n = 101) of program closures were successful. The intervention group had significantly fewer successful closures compared to the comparison group (p = .003).

Table 41. Rates of Success at Closure for All Participants

	Intervention Group (N=99)	Comparison Group (N=123)	Total Sample (N=222)
	N (%)	N (%)	N (%)
Successful closure	29 (29%)	71 (58%)	100 (45%)
Unsuccessful closure	70 (71%)	52 (42%)	122 (55%)

We used a logistic regression analysis to investigate the success at closure for all participants for whom data was available (N = 222), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, whether they were enrolled in the intervention or comparison group, and whether they consented into the evaluation interviews. Participants were less likely to successfully close out of the program than unsuccessfully close out (45%, SE = 0.03). There was no statistically significant association between enrollment in the intervention group and the probability of children remaining in the home with the participant at program closure (p = .2). Families choosing to participate in the evaluation were more likely to have a successful closure (p = .013), with evaluation participants having a probability of 49% (SE = 0.05) of successful closure and non-evaluation participants having a 38% (SE = 0.03) probability of successful closure. Table 42 provides additional details.

Table 42. Logistic Regression Predicting Successful Closure for All Participants

Characteristic	OR[1]	p-value
(Intercept)	1.00	>0.9
Total # Intact worker meetings with participants	1.00	>0.9
Total # Intact workers who worked with participants	1.17	0.6
Total # recovery coordinator meetings with participants	0.49	0.2
Total # recovery coordinators who worked with participants	1.01	0.6
Evaluation group		
Comparison[2]	1.00	
Intervention	0.37	0.2
Evaluation participant	2.53	0.013

[1]OR = Odds Ratio

Evaluation participants. There were 133 evaluation participants with closure data available for analysis. Among this group, half (n=66) had a successful closure. Families in the intervention group had a lower rate of successful closure compared to the comparison group (p = .002).

Table 43. Rates of Success at Closure for Evaluation Participants

	Intervention Group (N=72)	Comparison Group (N=61)	Total Sample (N=133)
	N (%)	N (%)	N (%)
Successful closure	25 (35%)	41 (67%)	66 (50%)
Unsuccessful closure	47 (65%)	20 (33%)	67 (50%)

We used a regression analysis to investigate the success at closure for evaluation participants for whom data was available (*N* = 133), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, and whether they were enrolled in the intervention or comparison group. Evaluation participants were more likely to have successful program closures than not (probability = 52%, SE = 0.04). As shown in Table 44, there were no statistically significant differences between the groups and the probability of successful closure ($p > .9$). The number of recovery coordinator contacts was significantly associated with fewer days enrolled in the program ($p = .02$). For every 10 additional recovery coordinator contacts, the probability of successful closure fell by 1% (SE = 0.04, $p = .02$).

Table 44. Logistic Regression Predicting Successful Closure for Evaluation Participants

Characteristic	OR[1]	p-value
(Intercept)	0.40	0.3
Total # Intact worker meetings with participants	1.03	0.068
Total # Intact workers who interacted with participants	1.47	0.2
Total # recovery coordinator meetings with participants	0.65	0.4
Total # recovery coordinators who interacted with participants	0.96	0.02
Evaluation group		
Comparison[2]	1.00	
Intervention	1.00	>0.9

[1]OR = Odds Ratio

[2]Reference Group

CHILD PLACEMENT

All participants. Of the 232 total cases with closure information, 52 percent of participants' (N=121) children remained in the home with the program participant. Based on a Fisher's exact test, it was more likely for intervention group participants' children to remain in the home compared to comparison group families' children ($p < .001$).

Table 45. Children Remaining in Home with Participant—All Participants

	Evaluation Participants (N=147)	Non-Evaluation Participants (N=85)	Total Sample (N=223)
	N (%)	N (%)	N (%)
Intervention group (N=105)	47 (32%)	10 (12%)	57 (26%)
Comparison group (N=127)	46 (31%)	23 (27%)	69 (31%)

We used a logistic regression analysis to investigate the likelihood of children remaining at home for all participants for whom data was available (*N* = 232), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, whether they were enrolled in the intervention or comparison group, and whether they consented into the evaluation interviews. As shown in Table 46, for all participants, the probability of children remaining at home with their families at program closure was 54% (SE = 0.03). There was no association between group assignments and the probability of children remaining in the home (*p* = .5). Evaluation participants were more likely to have children remain in the home compared to non-evaluation participants (*p* < .001), with evaluation participants having a 68% (SE = 0.05) probability of children remaining in the home and non-evaluation participants having a 39% (SE = 0.05) probability of children remaining in the home. Participants who were referred for an SUD assessment but did not complete it (*p* = .012), or who were referred for treatment after an assessment but never began treatment (*p* = .002) were statistically significantly less likely to have children remain in the home (i.e., their children were more likely to go into foster care placement at program closure). Participants who were referred for and began treatment had an estimated probability of 60% (SE = 0.05) for children to remain in the home—compared to participants who did not complete an assessment, with a probability of 41% (SE = 0.08), and participants who were referred for but never began treatment, with a probability of 26% (SE = 0.09) of children remaining in the home with the participant. In sum, participants who did not complete SUD treatment had a greater likelihood of their children going into foster care placement at program closure.

Table 46. Logistic Regression Predicting Children Remaining in the Home: All Participants

Characteristic	OR[1]	p-value
(Intercept)	1.62	0.4
Total # Intact worker meetings with participants	0.98	0.084
Total # Intact workers who interacted with participants	1.04	0.9
Total # recovery coordinator meetings with participants	0.60	0.4
Total # recovery coordinators who interacted with participants	1.01	0.6
SUD assessment status		
Referred for treatment and began treatment[2]	1.00	
Current or recent treatment	0.85	0.7
Never referred for assessment	0.28	0.4
Never completed assessment	0.61	0.012
Not referred for treatment	1.23	0.7
Referred for treatment, never began treatment	0.15	0.002

Characteristic	OR[1]	p-value
Self-referral	0.37	0.3
Evaluation group		
Comparison[2]	1.00	
Intervention	1.79	0.4
Evaluation participant	3.23	<0.001

[1]OR = Odds Ratio

[2]Reference Group

Evaluation participants. We used a logistic regression analysis to investigate the likelihood of children remaining at home for evaluation participants for whom data was available (*N* = 147), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, and whether participants were enrolled in the intervention or comparison group. For families who chose to participate in the evaluation, neither the intervention nor the comparison group were more likely to have children remain in the home at closure (*p* = .08) (Table 47). Children remained in the home more often than they were placed in foster care (probability = 65%, SE = 0.04). There was no association between group assignment and the probability of children remaining in the home with the participants at program closure (*p* = .9). The number of recovery coordinator visits was associated with the probability of foster care placement with family (*p* = .04). Participants who were referred for an SUD assessment but did not complete it (*p* = .002) were less likely to have children remain in the home. Participants who were referred for and began treatment had an estimated probability of 78% (SE = 0.06) for children to remain in the home, compared to families in which participants did not complete an assessment with an estimated probability of 35% (SE = 0.11).

Table 47. Logistic Regression Predicting Children Remaining in the Home: Evaluation Participants

Characteristic	OR[1]	p-value
(Intercept)	2.04	0.4
Total # Intact worker meetings with participants	1.03	0.2
Total # Intact workers who interacted with participants	1.13	0.7
Total # recovery coordinator meetings with participants	0.96	0.04
Total # recovery coordinators who interacted with participants	0.80	0.7
SUD assessment status		
Referred for treatment and began treatment[2]	1.00	
Current or recent treatment	1.40	0.6
Never referred for assessment	0.45	0.001
Never completed assessment	0.01	0.4
Not referred for treatment	1.05	>0.9
Referred for treatment, never began treatment	0.34	0.2
Self-referral	0.58	0.7
Evaluation group		
Comparison[2]	1.00	

Characteristic	OR[1]	p-value
Intervention	0.75	0.8

[1]OR = Odds Ratio

[2]Reference Group

SUD STABILITY

SUD stability, all participants. Of the 231 total cases with SUD stability information, 60% (N=138) were determined to be stable at program closure, meaning they were either not actively using substances, were stable on MAR, or their substance use did not interfere with their parenting or quality of life. Evaluation participants were more likely to have SUD stability at closure than non-evaluation participants (p = .009).

Table 48. SUD Stability at Program Closure: All Participants

	Evaluation Participants (N=147)	Non-Evaluation Participants (N=85)	Total Sample (N=232)
	N (%)	N (%)	N (%)
Intervention group (N=105)	51 (35%)	10 (12%)	61 (26%)
Comparison group (N=127)	46 (31%)	32 (38%)	78 (34%)

We used a logistic regression analysis to investigate SUD stability at closure for all participants for whom data was available (N = 232), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, whether they were enrolled in the intervention or comparison group, and whether they consented into the evaluation interviews. As shown in Table 49, for all participants, the probability of SUD stability at closure was 60% (SE = 0.03). There was no association between enrollment in the intervention group and the probability of SUD stability (p > .9). Evaluation participants were more likely to achieve SUD stability by closure compared to non-evaluation participants (p = .016), with evaluation participants having a 67% probability (SE = 0.04) and non-evaluation participants having a 49% (SE = 0.05) probability of SUD stability. Participants who were referred for a substance use assessment but did not complete it (p < .001) or who were referred to treatment after an assessment but never began treatment (p = .003) were statistically significantly less likely to achieve SUD stability at closure. Participants who were referred for and began treatment had an estimated probability of 73% (SE = 0.05) of achieving stability—compared to participants who did not complete an assessment, with an estimated probability of 16% (SE = 0.06), and participants who were referred for but never began treatment, with an estimated probability of 30% (SE = 0.10).

Table 49. Logistic Regression Predicting SUD Stability for All Participants

Characteristic	OR[1]	p-value
(Intercept)	1.46	0.5
Total # Intact worker meetings with participants	0.99	0.4
Total # Intact workers who interacted with participants	1.48	0.2

Characteristic	OR[1]	p-value
Total # recovery coordinator meetings with participants	0.86	0.8
Total # recovery coordinators who interacted with participants	1.01	0.7
SUD assessment status		
Referred for treatment and began treatment[2]	1.00	
Current or recent treatment	1.33	0.6
Never referred for assessment	1.22	0.8
Never completed assessment	0.06	<0.001
Not referred for treatment	0.64	0.4
Referred for treatment, never began treatment	0.14	<0.001
Self-referral	0.52	0.4
Evaluation group		
Comparison[2]	1.00	
Intervention	1.00	>0.9
Evaluation participant	2.43	0.016

[1]OR = Odds Ratio

[2]Reference Group

Evaluation participants. We used a logistic regression analysis to investigate SUD stability at closure for evaluation participants for whom data was available (*N* = 1), with the number of meetings with both Intact workers and recovery coordinators, the number of Intact workers and recovery coordinators who interacted with participants, SUD assessment status at baseline, and whether they were enrolled in the intervention or comparison group. For families who chose to participate in the evaluation, neither intervention nor comparison group was more likely to have SUD stability at closure (*p* = .11). Evaluation participants were likely to achieve SUD stability (probability = 71%, SE = 0.04). There was no statistically significant association between enrollment in the intervention group and the probability of SUD stability at the end of the program (*p* = .11). Participants who were referred for a substance use assessment but did not complete it (*p* < .001), or who were referred for treatment after an assessment but never began treatment (*p* = .007) were less likely to achieve SUD stability. Participants who were referred for and began treatment had an estimated probability of 90% (SE = 0.06) of achieving stability—compared to participants who did not complete an assessment, with an estimated probability of 33% (SE = 0.11), and participants who were referred for but never began treatment, with an estimated probability of 47% (SE = 0.14). Table 50 provides additional details.

Table 50. Logistic Regression Predicting SUD Stability for Evaluation Participants

Characteristic	OR[1]	p-value
(Intercept)	3.39	0.2
Total # Intact worker meetings with participants	1.01	0.8
Total # Intact workers who interacted with participants	1.78	0.2
Total # recovery coordinator meetings with participants	0.98	0.3
Total # recovery coordinators who interacted with participants	0.48	0.3
SUD assessment status		
Referred for treatment and began treatment[2]	1.00	
Current or recent treatment	0.43	0.3
Never referred for assessment	0.59	0.7
Never completed assessment	0.05	<0.001
Not referred for treatment	0.19	0.056
Referred for treatment, never began treatment	0.09	0.007
Self-referral	0.24	0.3
Evaluation group		
Comparison[2]	1.00	
Intervention	5.38	0.11

[1]OR = Odds Ratio

[2]Reference Group

Relationships Between Parent and Child Outcomes and Program Closure

We used correlations to evaluate the relationships between parent and child outcomes and program closure outcomes. Table 51, below, shows that there are no significant relationships between parent and child outcomes, successful program closure, child placement, or SUD stability.

Table 51. Correlation Results Between Parent and Child Outcomes and Program Closure

	Successful Program Closure	Children Remain in Home	SUD Stability
	Φ (*p*)	**Φ** (*p*)	**Φ** (*p*)
High Alcohol Use	0.10 (0.24)	-0.07 (0.42)	-0.01 (0.89)
High Drug Use	-0.07 (0.44)	-0.12 (0.17)	-0.08 (0.36)
	r (*p*)	*r* (*p*)	*r* (*p*)
CES-D	-0.13 (0.12)	-0.07 (0.38)	-0.09 (0.31)
TSC-40 Total	-0.12 (0.17)	-0.07 (0.43)	-0.05 (0.53)
AAPI - Expectations of Children	0.10 (0.26)	-0.04 (0.67)	-0.11 (0.23)
AAPI - Empathy Towards Children	0.12 (0.17)	0.03 (0.73)	0.02 (0.78)
AAPI - Corporal Punishment	0.00 (1.00)	0.02 (0.81)	0.04 (0.66)
AAPI - Family Roles	0.11 (0.24)	0.01 (0.90)	0.05 (0.60)
AAPI - Power and Independence	-0.04 (0.64)	-0.04 (0.66)	-0.03 (0.72)
PSS	0.01 (0.90)	-0.06 (0.49)	-0.03 (0.70)

	Successful Program Closure	Children Remain in Home	SUD Stability
CBCL-PS Internal	0.04 (0.82)	0.08 (0.63)	-0.06 (0.70)
CBCL-PS External	0.11 (0.49)	0.07 (0.66)	-0.04 (0.78)
CBCL-PS Total	0.11 (0.50)	0.12 (0.46)	-0.01 (0.94)
CBCL-SA Internal	0.12 (0.32)	0.06 (0.61)	0.15 (0.19)
CBCL-SA External	0.00 (1.00)	-0.01 (0.95)	0.14 (0.22)
CBCL-SA Total	0.10 (0.42)	0.07 (0.55)	0.12 (0.33)
ITSP - Low Registration	-0.13 (0.65)	-0.24 (0.39)	0.04 (0.90)
ITSP - Sensation Seeking	-0.35 (0.21)	-0.04 (0.90)	-0.29 (0.29)
ITSP - Sensation Sensitivity	-0.19 (0.53)	-0.25 (0.39)	-0.18 (0.53)
ITSP - Sensation Avoiding	-0.23 (0.43)	0.03 (0.93)	0.09 (0.77)
ITSP - Low Threshold	-0.56 (0.05)	-0.12 (0.70)	-0.23 (0.45)

Stigma

As previously noted, the interview protocol included an open-ended question that asked participants about the negative reactions and perceptions they had experienced because of their involvement with DCFS. Participant responses were reviewed by AHP researchers and analyzed for emergent themes. Participant responses were then coded into five categories: enacted stigma, perceived stigma, self-stigma, positive social support, and those that chose not to disclose their DCFS involvement to others ("kept private"). Participants reported experiencing the following types of stigma related to their involvement with DCFS across all time points**.**

ENACTED STIGMA

Enacted stigma refers to an individual's direct experiences of discrimination and negative attitudes from others regarding their involvement with DCFS and their substance use. Forty-five 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), people on social media, and the general public. This stigma included negative comments (e.g., "my child's dad told me I've been a bad mom and that DCFS is going to take my kids"), negative assumptions about their parenting (e.g., "they hear DCFS and alarms go off"), distrust (e.g., "people don't trust me to watch their kids anymore"), avoidance (e.g., "my family doesn't talk to me at all anymore since becoming DCFS involved"), gossip (e.g., "everyone I knew talked behind my back"), and sometimes restricted job opportunities (e.g., "it stopped me from getting a job at my child's school, I cannot volunteer in the classroom").

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 et al., 2014). Forty-one percent of participants reported perceived stigma (e.g., "nobody has said anything to me directly, but I feel it—I feel judged and looked down upon").

Among participants who reported perceived stigma, around 10 percent 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 live in a small town, and I know how people talk; we did everything we could so nobody would know”). 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. Nine percent of participants reported feelings of shame or embarrassment because of their DCFS involvement (e.g., “it was extremely embarrassing and destroyed my confidence as a parent”).

KEPT DCFS INVOLVEMENT PRIVATE

Ten percent of participants reported that they chose not to disclose their DCFS involvement to others or chose to tell only a few trusted people, such as immediate family members. Participants reported choosing to keep their DCFS involvement private due to shame, embarrassment, fear of judgement or being the subject of gossip.

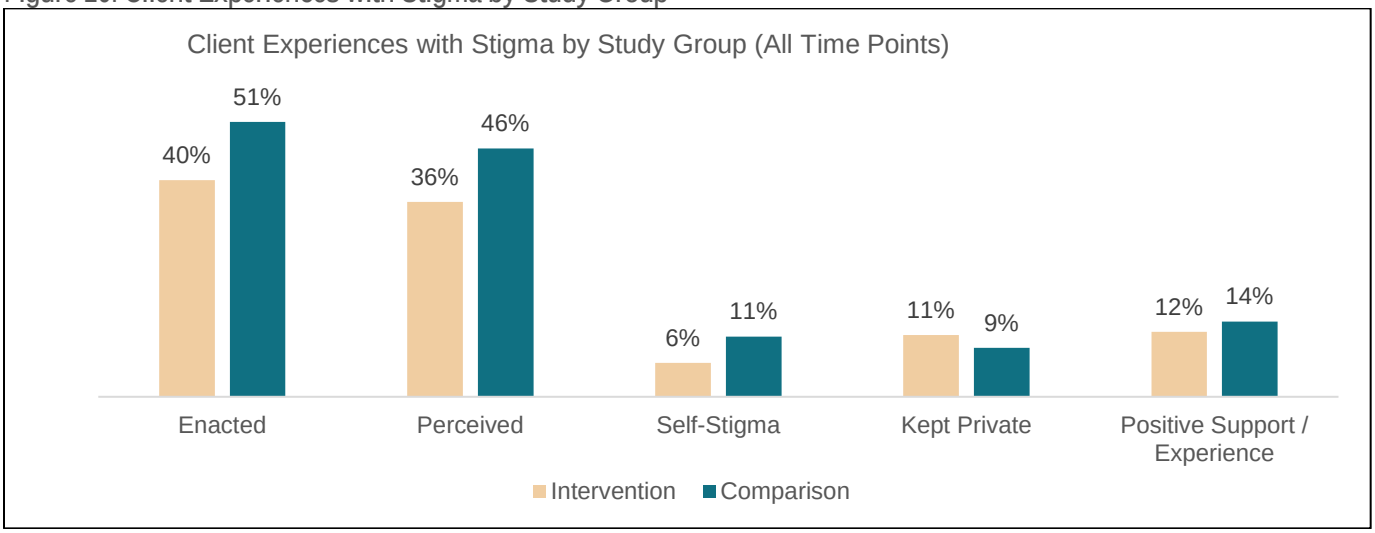
POSITIVE SOCIAL SUPPORT

In contrast, some participants (13%) shared that they received positive social support from others for their involvement with DCFS. Positive support came from family, friends, and case workers. Some participants communicated their lives have significantly improved as a result of their involvement with DCFS and Intact provided meaningful support for their families (e.g., “I tell people that DCFS helped me a lot and I am glad they are in my life”).

INTERVENTION AND COMPARISION GROUP EXPERIENCES WITH STIGMA

A greater percentage of clients in the comparison group than in the intervention group reported experiencing enacted, perceived, and self-stigma. Additionally, a slightly higher percentage of comparison group clients reported receiving positive social support or experiences with their DCFS involvement across all time points. In contrast, a slightly higher percentage of intervention group clients reported choosing to keep their DCFS involvement private (Figure 20).

Figure 20. Client Experiences with Stigma by Study Group



Participant Strengths

We concluded each interview by asking participants to identify three personal strengths. Across all interview time points, the most frequently listed strengths were “good parent,” “hard worker,” and “resilient.” In the word cloud below (Figure 21), 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., “intuitive”).

Figure 21. Participants’ Identified Personal Strengths Across All Interview Time Points

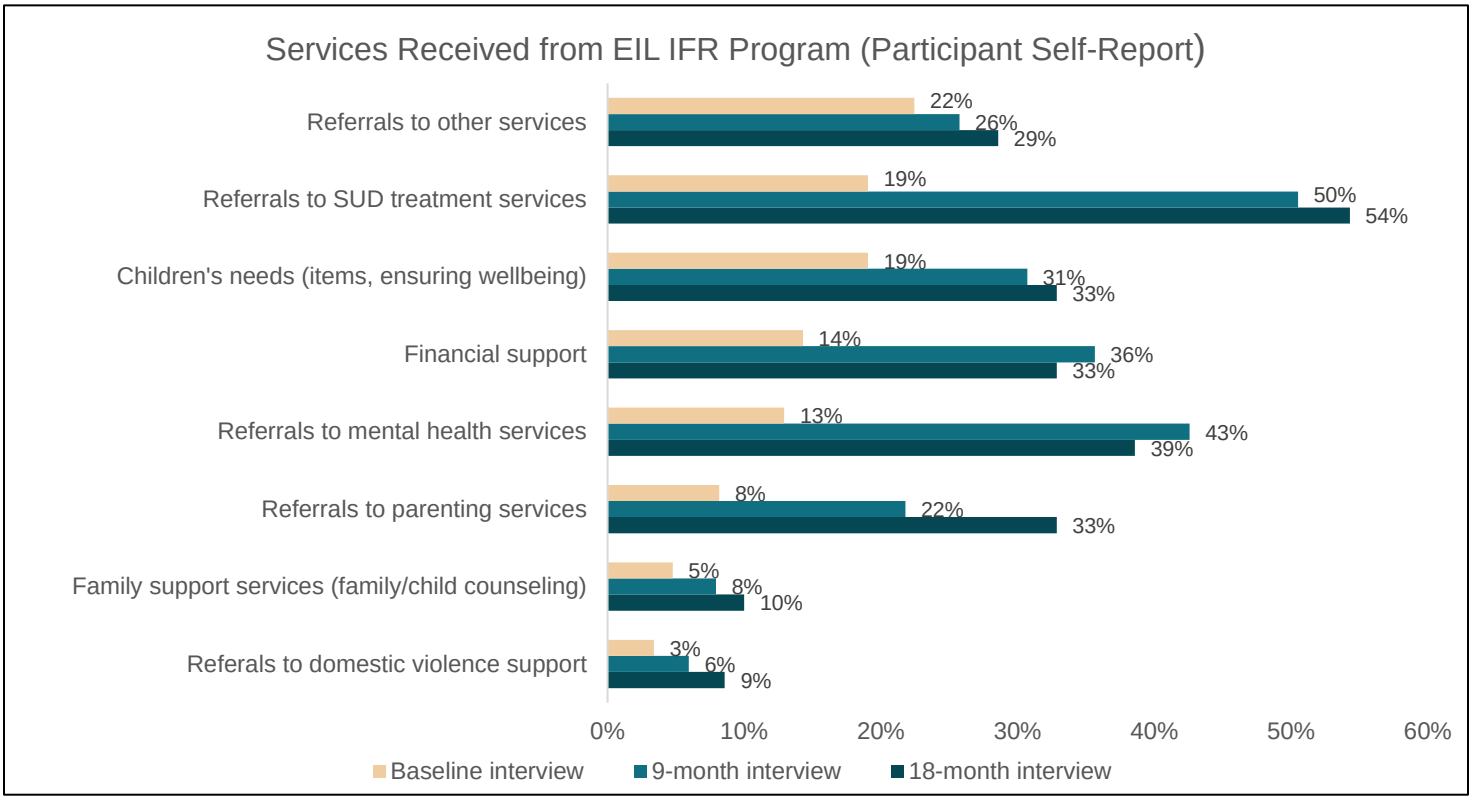
Participant Self-Report of Services Received

The interview protocol asked participants to list the services they received from the EL IFR program. As shown in Figure 22, participants reported being referred or connected to a variety of services and supports. By the 18-month time point, 54% of participants reported that the EIL 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 (39%). A third (33%) reported receiving help meeting their children's material and physical well-being needs and financial support.

Few differences were observed between services reported by intervention and comparison group participants at 9-month and 18-month follow-up interviews. At the 9-month follow-up, a greater percentage of intervention group participants reported receiving family support services (13%), referrals to parenting services (27%), and mental health services (44%) than comparison group participants (2%, 15%, and 41%, respectively). However, a higher proportion of comparison group participants (59%) reported that their EIL IFR program referred them to substance use treatment compared to intervention group participants (44%).

These trends continued at 18-month follow-up, with a higher percentage of intervention clients reporting receipt of referrals to domestic violence support (14%), family support (14%), parenting services (35%), and mental health services (46%) than comparison group clients (3%, 7%, 31%, and 28%, respectively). However, a slightly higher percentage of comparison group clients reported receiving financial support (36%), items for children (33%), and referrals to substance use treatment (55%) than intervention group clients (30%, 32%, and 54%, respectively). A higher percentage of comparison group clients also reported receiving referrals to other services (39%) than intervention group clients (19%), which included linkages to housing, transportation, and employment.

Figure 22. Receipt of EIL IFR Services (Participant Self-Report)



EIL IFR Program Participation Benefits

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

- **Increased personal and family stability:** Participating in the EIL IFR program helped parents "get their lives together." Thirty-three 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.
- **Supportive program staff:** Twenty-eight percent of participants found it helpful and supportive to regularly meet with program staff.
- **Improved parenting:** Twenty-five percent of participants reported that the program helped them become better parents and that they felt closer to their children.
- **Improved accountability:** Twenty-four percent of participants said that the program helped them stay accountable while working toward their goals.
- **Increased connections to community resources:** Eighteen percent of participants reported that EIL IFR program staff helped connect them to a wide range of community services that they did not know about and/or had not been able to access in the past.

- **Improved behavioral health:** Seventeen percent of participants reported that the program helped them understand and cope with their mental health and substance use problems.
- **Increased abstinence:** Seventeen percent of participants reported that the program helped them attain and maintain abstinence from alcohol or drug use.
- **Regained guardianship of their children:** Three percent of participants reported that participating in the program helped or would help them regain guardianship of their children.

The statements below highlight how participants described the EIL IFR program's impact on themselves and their families across interview time points. Comments have been edited to protect participant confidentiality.

"I needed to make several changes in my life. I was thankful for having someone to be accountable to. This (EIL IFR program) really held me accountable with my sobriety."

"They helped me meet with a mental health counselor and I'll start counseling soon. They gave me financial help and checked in with my child to make sure they were safe. They are helping me improve my patience and attitude."

"They helped tremendously. They helped us be a stronger family."

"I learned a lot from them, like how to be a parent and how to be there for my kids."

"I think all the services helped me. I learned a lot of tools; they guided me toward resources to use in case I got myself in a similar situation again so I would know what to do. My Intact worker and recovery coordinator were helpful."

"The program absolutely helped. They helped me fix my car, they gave me resources for recovery meetings and connected my children to counseling—my child gained a lot from that experience. Finding resources can be hard if you don't know what you're doing and I wouldn't have found these services without them."

"My recovery coordinator was amazing! He was always checking in on me and would ask about my day; I appreciated that. He printed off pamphlets on stress relief, anxiety, how to grieve and things of that nature. He was very helpful."

"They connected me to drug and mental health counseling. It was extremely helpful to me and my children and helped me get on the right path of being a parent."

While the majority of participants found services beneficial at the 9-month follow-up, a little over a quarter (26%) said services were not helpful. A slightly greater percentage of comparison group participants (29%) than intervention group participants (23%) reported that services were not helpful.

Limitations

We encountered several outcome evaluation challenges that resulted in an unanticipated non-random 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 comparison group participants.

NON-RANDOM PARTICIPANT ASSIGNMENT

We chose a quasi-experimental design for our outcome evaluation in which child welfare partner organizations were randomly selected prior to program implementation to be intervention or comparison group sites. We chose to randomize at the site versus participant level to avoid potential treatment contamination (i.e., a recovery coordinator working with a comparison group participant). Non-random participant assignment results in groups that are not directly comparable. This was addressed using IPTW to identify the probability that a family would receive IFR through assignment to the intervention group. We used weighted analyses based on this probability to allow a quasi-experimental comparison, though IPTW is not perfect, and imbalance remained between intervention and comparison groups at baseline interviews.

LOWER-THAN-ANTICIPATED DCFS REFERRALS TO EIL IFR PROGRAMS

As described in greater detail in the Process Evaluation section, our EIL IFR program partners received fewer referrals of eligible parents from DCFS than originally anticipated. Fewer referrals to EIL 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 EIL IFR programs are discussed in the Process Evaluation section.

ATTRITION

We achieved a 68% completion rate for 9-month follow-up interviews and a 48% 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 EIL IFR program staff to update participant contact information and help locate participants. We also increased interview incentives from $30/interview to $80/interview.

Due to attrition, 18-month follow-up interviews become more difficult to compare with baseline and 9-month interviews. Due to the smaller sample size, it is more unlikely to detect statistically significant differences between intervention and comparison groups at this final interview, or between this interview and previous interviews. The reduced sample size results in larger standard errors, larger confidence intervals, and larger *p*-values, reducing what could be statistically significant differences with equal sample sizes to non-statistically significant differences with the current sample size.

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) A greater percentage of eligible clients at control sites declined the evaluation. To help address this, we held regular refresher trainings for new and current Intact staff for how to discuss the evaluation with clients. The AHP evaluation team also sent a monthly newsletter to all implementation staff that highlighted the number of clients enrolling into the program and evaluation and reminded Intact workers about the gift card incentive they would get for sending a client referral to the evaluation team. The newsletter also featured tips on how to talk to clients about the evaluation to encourage them to consider participating. (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. 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.

LACK OF SAMPLE DIVERSITY

As shown in Table 4, most evaluation participants were White and female. Results were therefore not generalizable to males or people of color.

DATA COLLECTION INCONSISTENCIES

Families either did not agree to participate in the evaluation or agreed to participate after having been enrolled in services for some amount of time. More than 200 families were involved in Intact and IFR services over the course of the evaluation. Of these, only 151 agreed to take part in evaluation interviews. The result is insufficient data to generate probability weights for use in analyses where all families are included and limited samples for interview-based outcome analyses. Families who choose not to participate may have chosen for reasons related to the evaluation, services, and so on, which could mean that results could be different had these families been included in the full evaluation.

Families also may not have agreed to have their services recorded at the beginning of their time receiving services, or they may not have agreed to have their services recorded at all. Of the 151 families enrolled in the evaluation, only 141 agreed to have their service data recorded, and many of these families received services before agreeing to this participation, meaning they may not have had all services recorded. This reduces our ability to evaluate the services that families received during their enrollment and the potential effects of services on their outcomes.

DIFFERENCES BETWEEN GROUPS AT BASELINE

Intervention and comparison groups showed differences at baseline, meaning that they were not directly comparable. IPTW was used to reduce differences between intervention and comparison groups, but even this process did not fully eliminate differences that may have ensured valid comparisons at 9- and 18-month follow-ups. As a result, differences or changes over time may be the result of regression to the mean, between-group differences that were not measured, or other changes.

PROCESS EVALUATION

The EIL IFR qualitative process evaluation documented the program's development and implementation over time. The process evaluation included project challenges and barriers encountered, effective strategies to overcome those challenges, and other lessons learned about implementing this collaborative, cross-systems project. Qualitative process evaluation data included:

- Document review of all EIL IFR meeting minutes
- EIL IFR staff focus groups and key informant interviews
- Key informant interviews on program implementation and lessons learned, conducted with EIL IFR program staff at the end of the project
- Client mental health focus groups

Document Review

AHP researchers reviewed the minutes from all EIL IFR meetings. These include minutes from program planning and implementation meetings, Executive Committee and Supervisory meetings, and recovery coordinator meetings.

Document Review: Methods and Analyses

AHP researchers uploaded meeting minutes to Dedoose, a web-based platform for qualitative 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. Our qualitative data results describe project components and processes, as well as implementation challenges and successes.

Document Review: Results

EXECUTIVE COMMITTEE MEETINGS

Executive Committee meetings were held monthly during the EIL IFR project planning phase (December 2019 – September 2020) and quarterly in the implementation phase (October 2020 – August 2024). Meeting participants included executive-level representatives from each of the eight partner agencies—BCS, OHU, CYFS, BF, Chestnut; the AHP evaluation team; ICOY; and key state agencies—DCFS and the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery (IDHS/SUPR). Executive Committee meetings' topics focused on EIL IFR program roles and responsibilities, training and technical support needs, and implementation barriers and solutions.

SUPERVISORY MEETINGS

Supervisory meetings were convened monthly in each project region from November 2020 through September 2024. Supervisory meetings included representatives from ICOY and AHP as well as

supervisors from each EIL 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 April 2021 to July 2024. Participants included recovery coordinators and representatives from ICOY and AHP. Between April 2021 and July 2022, we included recovery coordinators from the Northern Illinois Intact Family Recovery (NIL IFR) program in these meetings to provide opportunities for NIL IFR recovery coordinators to share their experiences and expertise with EIL IFR recovery coordinators. During the meetings, participants networked, shared service delivery challenges and successes, and identified strategies to address challenges related to working with the Intact teams.

Document Review Results

This section presents findings from the qualitative analyses of meeting minutes across the following domains:

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

Project Implementation

PROGRAM PLANNING PHASE ACTIVITIES

The EIL IFR program had a 12-month planning period from October 2019 through September 2020. During the planning period, ICOY and AHP organized introductory meetings and site visits to inform partners about the program and held monthly Executive Committee meetings to help develop relationships between partners and prepare them for program implementation. The following EIL IFR project components were developed in the meetings that took place during the planning period.

EIL IFR program governance structure. EIL IFR partners established the program governance structure during the planning phase, which consisted of the Executive Committee and Supervisory meetings. The Executive Committee planned and designed the EIL IFR program structure, determined program operations, problem-solved overall program implementation, determined and reviewed outcome goals, set an evaluation process, assessed training needs, and identified the program direction.

Development of the EIL IFR program plan. The Executive Committee developed the EIL IFR program plan, which provided an overview of EIL IFR services, implementation timeline, target

population, referral and admission procedures, recovery coordinator job description, service delivery, treatment and discharge goals, and client and program reporting. The program plan also clarified the roles and responsibilities of the Intact worker and recovery coordinator. Partners decided that ASSIST would be used across all sites as a universal SUD screening tool for clients, to ensure that clients referred to the program have an identified substance use issue.

EIL IFR PARTNER ENGAGEMENT

Close collaboration between all partners was a critical component of EIL IFR project and evaluation implementation. To foster and maintain partners' support for the program and evaluation, ICOY and AHP convened ongoing meetings and trainings and implemented a variety of engagement strategies, as described below. These strategies also established opportunities for partners to discuss and troubleshoot implementation issues and program challenges.

Site visits during EIL IFR program planning phase. ICOY and AHP conducted site visits in December 2019 with each program partner. During these visits, ICOY and AHP met with program leadership, explained the EIL IFR program and evaluation, and obtained feedback from partners about what would work best for program implementation at their agency.

Supervisory meetings. Monthly supervisory meetings provided opportunities for partners to review and provide input on program and evaluation materials and processes. During these meetings, partners also discussed and developed strategies to resolve service delivery and evaluation challenges.

DCFS engagement. Throughout the planning phase and implementation of the EIL IFR program, DCFS representatives were included in Executive Committee and Supervisory meetings. Maintaining engagement with DCFS helped IFR partners identify issues related to program referrals. It also allowed IFR partners to educate DCFS about the IFR program to help close communication gaps and ensure that DCFS staff were aware of the IFR program. Partners were also able to discuss challenges related to the child welfare system, such as frequent Intact staff turnover.

Ongoing EIL IFR program and evaluation trainings. ICOY and AHP delivered trainings for program staff about the EIL IFR program and evaluation regularly throughout the project period. ICOY also provided program partners with access to a learning collaborative library. Participating in the various trainings provided supervisors and frontline staff with opportunities to better understand the EIL IFR program, its evaluation goals, and implementation model. Trainings also provided education on a variety of substance use– and child welfare–related topics.

Evaluation check-in calls. AHP conducted evaluation check-in calls with recovery coordinators weekly and with Intact supervisors biweekly. During these calls, AHP and program staff built rapport, monitored participant eligibility and enrollment in EIL IFR services and the evaluation, and documented IFR service receipt and case closures. These calls also helped identify and resolve service delivery and evaluation challenges in real time.

Evaluation newsletters. AHP created a monthly newsletter about the program and evaluation and shared it with all recovery coordinators, Intact workers, and supervisors. The newsletter provided staff with an overview of the project, gave updated information on evaluation progress (i.e., number of

participants enrolled at each site and number of interviews completed), and shared practical tips for EIL IFR service delivery, how to engage participants in the evaluation, and self-care.

CROSS-SYSTEMS COLLABORATION AND RESOURCE SHARING

EIL IFR program child welfare and substance use treatment partners implemented the following strategies to strengthen their collaboration and improve their care for IFR clients.

Cross-systems learning and training. Recovery coordinators completed various DCFS trainings as part of their onboarding to the IFR program to deepen their knowledge and understanding of the child welfare system. Both recovery coordinators and Intact staff reported that working together allowed them to better understand each other's roles and areas of expertise. For example, recovery coordinators learned how to approach cases involving children, while Intact staff reported that they appreciated the recovery coordinators' expertise in substance use treatment. In some instances, Intact staff invited recovery coordinators to review additional cases to help determine the need for recovery support. Intact sites also invited recovery coordinators to participate in team meetings where cases were discussed in a group setting, providing recovery coordinators with more opportunities to learn about IFS and child welfare processes.

Cross-systems communication and collaboration. Partners implemented a variety of strategies to improve their communication and collaboration. Strategies included joint supervision meetings during which the recovery coordinator, Intact worker, Intact supervisor, and substance use treatment supervisor learned from one another, problem-solved, and discussed client care, treatment plans, and team members' roles and responsibilities. Supervisors sent frequent reminders to remind IFR staff to keep each other informed and updated and encouraged the practice of sending "joint" emails (including both Intact worker and recovery coordinator) to ensure alignment and clear communication about a shared case. Intact supervisors provided support to recovery coordinators by providing reflective supervision and helping them work through vicarious trauma. Substance use treatment partners also created a resource folder that they shared with IFR partners. Partners collaborated on connecting clients to not only substance use treatment, but a range of services. For example, when child welfare partner sites struggled with long wait times for clients to receive mental health treatment, the substance use treatment partner offered to refer clients to their agency for care.

SUBSTANCE USE TREATMENT CHALLENGES AND SOLUTIONS

Substance use treatment access and availability. Throughout program implementation, EIL IFR program partners reported various challenges with client access to substance use treatment services. Partners reported challenges with long waitlists and obtaining timely information from treatment agencies about client engagement and progress. Partners also reported that some substance use treatment agencies provided clients with no treatment recommendations after completing their substance use assessments. EIL IFR program partners disagreed with these assessment outcomes and attributed the discrepancies to staffing shortages within those treatment agencies. Partners at comparison sites reported ongoing challenges with getting clients into substance use treatment services, noting that it could take between three and six months to get clients fully enrolled in substance use treatment.

EIL IFR program partners implemented a range of strategies to improve client access to treatment services. Partners worked to establish relationships with certain substance use treatment agencies that experienced fewer issues related to waitlists and information sharing. IFR staff also traveled to treatment agencies and spoke directly with staff, which helped establish stronger collaborations and improved communication and information sharing. Recovery coordinators further streamlined client access to substance use treatment by directly connecting clients to treatment agencies with whom they were familiar and worked on an ongoing basis. When treatment agencies assessed clients with "no treatment recommendations," recovery coordinators continued to work with clients based on their self-determined recovery needs and assisted them with reaching their recovery goals. Within the IFR project, the substance use treatment partner, Chestnut, communicated any new updates and changes in processes with the child welfare partner sites. For example, Chestnut updated child welfare partner sites on new processes it had implemented for client "walk-ins" to complete substance use assessments.

Drug screening. Clients enrolled in the IFR program were sometimes required to comply with drug screens to verify their abstinence from illicit substances. However, partners reported challenges with long wait times for clients to obtain drug screening from DCFS-contracted drug testing providers. Clients also at times faced transportation barriers and were unable to travel to complete their drug test. To help resolve these issues, one EIL IFR partner implemented a process for conducting drug screens at home with clients on an as-needed basis. Recovery coordinators also helped clients connect with out-of-home drug screening when needed.

IMPACT OF COVID-19 ON EIL IFR SERVICES

The early months of EIL IFR program implementation occurred in 2020 during the COVID-19 pandemic and stay-at-home order, which impacted program and service delivery.

Partners experienced a decrease in referrals from DCFS overall, including a decrease in SUD-related referrals. At the same time, the cases they received were more complex and included an increase in domestic violence–related referrals. Partners also suggested that this shift to more complicated cases may have affected whether cases were referred to their organization's Intact program—more serious cases may have been diverted to foster care instead of being referred to Intact services. They also observed that DCFS seemed to prioritize more serious cases of abuse and neglect during this period.

The pandemic imposed a virtual environment, which hindered team-building efforts at the start of implementation. Virtual staff interactions and meetings lacked the effectiveness of meeting in person and made it challenging to establish a strong, cohesive team. Further, staff were often unavailable for calls, emails, and virtual meetings due to illness, negatively impacting communication and collaboration on shared IFR cases.

Service delivery was also affected by the pandemic. Partners' policy restrictions regarding in-person contact prevented staff from directly providing transportation for clients. EIL IFR partners and various providers delivered care to clients through virtual or telehealth visits. However, partners reported that virtual/telehealth services for substance use treatment were less effective than meeting in person; clients had a harder time focusing in virtual meetings. Virtual visits with families were also not as effective as in-home visits for building rapport with clients and assessing safety.

Despite these challenges, partners expressed that by the time the EIL IFR program started, they had largely adapted to (i.e., were used to) working within the constraints of the COVID-19 pandemic. They continued to engage families, provide referrals, conduct meetings, and maintain active team communication. One partner highlighted an innovative approach their team took to building and maintaining rapport with families, which involved visiting families through a window at their homes while talking to them by phone.

Recovery Coordinators

In the EIL IFR program, recovery coordinators were co-located at the child welfare partner sites and embedded in Intact teams. Recovery coordinators and Intact workers worked in tandem to deliver services to EIL IFR clients. Recovery coordinators conducted individual visits with clients and participated in joint client visits with the Intact worker on a weekly, biweekly, or monthly basis based on client need. Recovery coordinators' primary role was to connect clients to substance use treatment and support them throughout the treatment and recovery process. Recovery coordinators scheduled and conducted assessments, accompanied participants to treatment appointments, provided relapse prevention strategies, conducted or coordinated drug testing, and connected clients to community-based recovery support services.

RECOVERY COORDINATOR BENEFITS

Intervention sites reported that clients and the Intact teams experienced several benefits from working with recovery coordinators.

Encouraged client engagement in services. Partners reported that recovery coordinators skillfully developed close rapport with clients. Recovery coordinators encouraged clients to partner with them by enrolling in the IFR program, assisted clients to engage in substance use treatment services, and motivated clients to remain engaged in treatment services. If clients relapsed, recovery coordinators worked with clients to get them back on track. Recovery coordinators often reported that their clients were motivated to stay engaged in treatment services and that many continued to maintain abstinence from substances after completing treatment. Supervisors shared that clients who participated in IFR expressed gratitude for the support and encouragement they received from the recovery coordinators.

Increased accountability for clients. Partners reported that having recovery coordinators on cases provided clients with an additional layer of accountability. Recovery coordinators kept clients informed about their treatment status and drug screen results. Additionally, recovery coordinators pointed out warnings signs of a substance use problem to clients who were in denial.

> *"I think it is helpful to them in making it clear that the substance use is an issue as opposed to if they were just meeting with me, we would just focus on finances or parenting. But having a person there that is dedicated to helping them with substance use highlights that this is an issue that needs to be addressed." (Intact worker)*

Improved client access to substance use treatment. Partners reported that recovery coordinators developed strong ties with local substance use treatment agencies, which helped accelerate getting clients into treatment services. Partners also reported that recovery coordinators used their expertise and understanding of services to give clients a variety of treatment options to choose from. Additionally, recovery coordinators encouraged clients to engage in supportive services outside of substance use treatment that might facilitate their recovery.

Met clients where they were. Partners reported that recovery coordinators applied a harm reduction approach to meet clients where they were and address their unique needs. For example, if clients were not ready or able to participate in higher levels of substance use treatment, recovery coordinators helped clients develop strategies to reduce their substance use or provided clients with less structured treatment approaches (i.e., attending Narcotics Anonymous or Alcoholics Anonymous groups, or educating clients about relapse prevention).

Provided additional support for Intact staff and clients. Partners frequently reported that recovery coordinators provided extra support to both the Intact teams and clients. The recovery coordinator's focus on client substance use allowed Intact workers to focus on addressing clients' parenting, child safety, and other needs. Recovery coordinators and Intact workers routinely communicated about their joint cases and collaborated on client service coordination. Intact workers and recovery coordinators both reported that they felt they operated as a team. Supervisors reported that the recovery coordinators provided Intact staff and clients with invaluable substance use expertise and treatment resources. Intact workers reported that recovery coordinators were an additional source of support for families. Further, the rapport recovery coordinators built with clients helped foster team communication with families.

> *"It's been nice to work together and feels more like a team when it's me, [the recovery coordinator], and the parent figuring out how to help them solve issues."*
> *(Intact worker)*

RECOVERY COORDINATOR CO-LOCATION CHALLENGES AND SOLUTIONS

The co-location of recovery coordinators on Intact teams presented several challenges. These challenges were addressed in Executive Committee, Supervisory, and recovery coordinator meetings. Co-location challenges and their solutions are described below.

Communication and collaboration with Intact workers. During the first few months of program implementation, recovery coordinators and Intact teams encountered several communication and collaboration challenges. Intact workers and recovery coordinators initially faced challenges scheduling and coordinating visits to EIL IFR participants, including handoff calls (i.e., meetings with DCFS staff to learn about the new Intact case), transitional visits (handoff meetings with DCFS, the Intact team, and the family where DCFS informs the family that their case is being moved to the Intact team), and required joint home visits. Further, collaboration was difficult because Intact workers had their own workflow and processes and had to adapt to adding recovery coordinators to their team. Early in

program implementation, Intact workers did not consistently share important information about participants' substance use with the recovery coordinators. Recovery coordinators also faced challenges obtaining needed information about their clients from Intact workers in a timely manner.

Strategies to resolve communication and collaboration challenges included the following:

- Weekly supervision that included the Intact supervisor, recovery coordinator, and Intact worker. During these meetings, the recovery coordinator received updates on clients and any other programmatic changes.
- Monthly joint supervision meetings that included the Intact supervisor, recovery coordinator's supervisor, Intact worker, and recovery coordinator.
- The practice of service providers copying both the Intact worker and the recovery coordinator on email communications so that both received updates about their clients.

These strategies improved communication and information sharing between recovery coordinators and Intact workers.

DCFS Referrals

The EIL IFR project's successful enrollment of families depended on DCFS referrals to Intact service programs at child welfare provider partners. DCFS referrals of eligible parents were lower than anticipated throughout the project.

LOWER-THAN-ANTICIPATED REFERRALS OF FAMILIES WITH SUBSTANCE MISUSE

EIL IFR program partner sites reported ongoing challenges with the low number of DCFS referrals of parents with substance misuse to their Intact programs. Program partners reported that DCFS referrals to their Intact programs were primarily families that experienced environmental concerns, domestic violence, child developmental delays, and mental health–related problems. Additionally, program sites reported that DCFS did not always correctly assess parents' substance use; some parents who were referred to DCFS were later determined by IFR staff to not have an SUD, and some parents who DCFS reported did not have an SUD were later determined to by IFR staff to have substance use problems. Program partners addressed these issues during the Executive Committee and Supervisory meetings. ICOY, AHP, and program partners also met with DCFS administrators to understand the reasons behind the low numbers of substance use–related referrals to Intact services. DCFS administrators explained that various factors affected how cases were referred to Intact services, including the size of the county in which the referral took place (i.e., smaller counties generated fewer referrals), staffing shortages with DCFS investigators, and capacity-related issues at Intact provider agencies. They further explained that cases involving ongoing use of illicit substances (methamphetamine, heroin, etc.) that severely compromised child safety were referred to protective custody instead of Intact services. During partner meetings, several strategies were identified and implemented to increase enrollment of eligible families with substance misuse into IFR:

- To help identify additional clients for the IFR program, partners began using the ASSIST tool to screen all clients referred to Intact services for potential substance-related issues, not only clients with indicated or confirmed substance misuse noted in the initial referral.

- To help increase opportunities to enroll additional eligible cases into the IFR program, program partners agreed to expand the IFR service area to two additional counties.
- Supervisors conducted thorough checks of Intact referrals from DCFS to assess whether families had any history of SUD or substance misuse allegations that indicated potential eligibility for the IFR program.

REFERRAL HOLDS AND SLOW REFERRALS

EIL IFR program partners reported DCFS referral holds at various time points throughout the project. DCFS implemented referral holds when a child welfare partner's Intact program was at capacity, due to either the number of active cases at that site or a shortage of Intact workers. While on hold, partner sites did not receive new referrals until existing cases closed and/or the site hired additional staff.

Partners also frequently reported periods of few or slow referrals into their Intact—and subsequently IFR—programs. These delays were attributed to a variety of potential causes, most notably DCFS internal staff shortages and changes to referral processes. At one point, DCFS was reportedly operating with a third of their usual number of investigators. Staff shortages at DCFS caused what partners described as a "bottleneck," during which sites experienced periods of decreased numbers of referrals followed by sudden influxes of referrals. Partners also reported that referrals decreased or were delayed because DCFS instituted new processes (for example, requiring clients to have a safety plan in place before they could be referred for Intact services). Additionally, partners reported that cases appeared to be more complex since the COVID-19 pandemic, leading some cases to be directly referred to foster care placement rather than to Intact services.

Staffing

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

STAFFING SHORTAGES AND TURNOVER

All EIL IFR program partner sites reported ongoing issues with hiring and retaining staff. Sites with multiple locations reported periods of being overstaffed at some offices and understaffed at others. Partner sites also experienced temporary vacancies as staff took medical, maternity, bereavement, or other personal leave. Turnover occurred for all staff roles: supervisors, Intact workers, and recovery coordinators. Staff turnover, whether temporary or permanent, placed additional strain on the remaining staff. When short-staffed, program staff struggled to manage caseloads while also taking on the responsibilities of several roles in addition to their usual workload. To help manage existing caseloads, partner sites requested DCFS referral holds to stop receipt of new Intact cases.

Partner sites reported that hiring new staff took considerable time, with some positions remaining vacant for up to six months. Partners reported that it was challenging to fill open positions with qualified applicants, which they attributed to low pay and competition from DCFS, which offered higher salaries for roles requiring similar qualifications. When sites were able to hire new staff, the lengthy onboarding process was at times delayed for months due to updated DCFS requirements for background checks and licensing.

Staff turnover affected not only referrals into the EIL IFR program, but also families enrolled in the program. Frequent transitions in Intact workers and supervisors disrupted the continuity of care for families and left clients with the burden of repeatedly having to retell their stories to new program staff.

Partner sites implemented a range of strategies to mitigate issues related to staff turnover. One site created a new position to exclusively recruit and retain new staff. Partner sites also raised salaries to retain current staff and attract new hires. During EIL IFR program meetings, partners shared strategies they used to retain staff, which included providing high levels of support and flexibility, work–life balance, and manageable caseloads.

Training

ICOY and AHP provided trainings and resources throughout the program to address various needs identified during Intact staff focus groups and at Executive Committee, Supervisory, and recovery coordinator meetings. These trainings included the following.

CROSS-TRAINING WEBINARS

To foster learning across child welfare and substance use treatment provider staff, ICOY provided numerous cross-training learning collaborative webinars throughout the project period. Learning collaboratives topics included trauma-informed care, domestic violence and trauma, suicide prevention, immigration and trauma, youth with mental health challenges, serving clients with systemic trauma, and the social-emotional consequences of sexual trauma. Webinars from NAADAC, the Association for Addiction Professionals, were also offered.

EIL IFR PROGRAM AND EVALUATION TRAININGS

At the start of program implementation, ICOY and AHP delivered trainings for staff about the EIL IFR program and evaluation procedures and protocols. Training materials (i.e., program flow chart, Parent Memorandum of Agreement, eligibility checklists, ASSIST) were shared during trainings and subsequently emailed to all participants. As program implementation continued, partners reported issues with IFR staff communication and collaboration. Partners also reported challenges related to recovery coordinators' and Intact workers' understanding of the procedures, roles, and responsibilities associated with the IFR program and its evaluation. Consequently, ICOY and AHP held annual program and evaluation "refresher" trainings to reinforce IFR staff understanding of the program goals, clarify evaluation objectives, and ensure that staff roles and program procedures were clear. Program and evaluation trainings were provided as needed when new staff joined the program. IFR staff reported that the trainings helped clarify staff roles and addressed questions about program procedures.

Evaluation Recruitment and Enrollment Challenges and Solutions

The EIL IFR program experienced several evaluation participant recruitment and enrollment challenges. These challenges were shared during Executive Committee, Supervisory, and recovery coordinator meetings, as well as in focus groups that took place in November and December 2022. The evaluation recruitment and enrollment challenges and solutions are summarized below.

COMPARISON SITE RECRUITMENT

Partners implemented a range of strategies at the onset of program implementation to set evaluation recruitment up for success. Building on lessons learned from the NIL IFR program, EIL IFR program partners agreed to assign "evaluation champions" at comparison sites to facilitate participant enrollment in the evaluation. Evaluation champions were existing staff members at comparison sites who were chosen by comparison site supervisors. Their primary responsibility was to introduce the evaluation to eligible clients. Evaluation champions conducted the ASSIST screening tool with clients to determine SUD eligibility, informed eligible clients about the evaluation, and encouraged client participation in the evaluation. The role of evaluation champion proved helpful; Intact workers expressed their appreciation of having an evaluation champion to coordinate evaluation-related needs, such as identifying eligible clients and asking them whether they would like to participate in the evaluation. However, comparison sites still recruited and enrolled fewer clients in the evaluation than intervention sites. This may have been partly due to staff turnover at comparison sites, including in the role of evaluation champion, which led to evaluation-related responsibilities being shifted to other Intact staff. Clients declined participating in the evaluation due to lack of interest, time constraints, overwhelming program demands and competing personal obligations. Strategies to address these issues included:

- Evaluation training was provided for all new Intact workers and supervisors, as well as an annual evaluation refresher training for all IL IFR staff.
- The evaluation team maintained close communication with evaluation champions and other Intact staff responsible for engaging clients in the evaluation to help ensure that eligible clients were informed about the evaluation. This included having evaluation champions participate in biweekly evaluation check-in calls.
- AHP sent "thank you" Target, Walmart, and Starbucks gift cards to comparison site Intact supervisors, Intact workers, and evaluation champions for each evaluation referral.
- The EIL IFR program area was expanded to include Effingham and Fayette Counties to help increase the number of eligible referrals into the IFR program and evaluation.

LOWER-THAN-ANTICIPATED PARTICIPANT ENROLLMENT IN THE EVALUATION

Participant enrollment in the evaluation was lower than anticipated at the intervention sites as well as the comparison sites. This was primarily due to the lower-than-anticipated number of DCFS referrals to the program. The primary reasons clients declined to participate in the evaluation were lack of interest and competing time commitments. Clients who declined often felt unable "to do one more thing". Some clients initially expressed interest in the evaluation and agreed to have their contact information shared with AHP. However, when AHP staff later contacted them to enroll them in the evaluation, they declined to participate.

The AHP evaluation team and program partners adopted several strategies to help recruit and enroll eligible families into the evaluation. Procedures were reviewed and revised if clients or agency staff found them burdensome. The strategies identified during partner meetings and implemented to increase client enrollment in the evaluation included:

- Providing project partners with an eligibility checklist to help staff evaluate client eligibility and enroll clients into the program and evaluation.
- Providing annual evaluation "refresher" trainings to all IFR staff and offering "as-needed" trainings to new staff. Trainings provided staff with detailed information about evaluation eligibility and strategies for encouraging eligible clients' participation. For example, staff were informed that evaluation interviews could be conducted over multiple sessions to make scheduling easier for clients.
- Increasing the gift card incentive to $60 per evaluation interview, and later to $80 per interview, after project partners shared that the initial incentive of $30 per interview was insufficient to encourage client participation in the evaluation.
- Offering clients enrolled in the evaluation $10 gift cards when they confirmed or updated their contact information between interviews.

EIL IFR Staff Focus Groups and Key Informant Interviews

AHP conducted focus groups and key informant interviews in November and December 2022 with Intact workers and supervisors from the four child welfare partner sites. The goal of the focus groups was to gather input from Intact workers and supervisors on their experiences with the EIL IFR program and evaluation, their perceptions of the program's impact on families, and their interactions and experiences working with recovery coordinators.

EIL IFR Staff Focus Group and Key Informant Interview Methods and Analyses

The focus group protocol covered the following topic areas: participants' understanding of the IFR project, overall experience implementing the program and evaluation, challenges and strategies with implementing the IFR program, perceptions of client satisfaction with the program, and strategies for improving the program. Comparison site Intact workers and supervisors were asked additional questions about what they thought it would be like to work with recovery coordinators at their organizations.

Twenty individuals participated in the staff focus groups. This included seven Intact workers and five supervisors from the comparison sites, and four Intact workers and four supervisors from the intervention sites. Focus groups were conducted by the AHP evaluation team. Individuals who could not participate in the focus group were invited to complete a one-on-one key informant interview with an AHP team member. The focus group and key informant interview protocols used the same questions. AHP developed the focus group and key informant interview protocols and methods, which were approved by AHP's IRB.

Key informant interviews were conducted with four Intact workers who were unable to participate in the scheduled focus groups. All participants were interviewed using the same protocol. The focus groups and key informant interviews were conducted virtually via Zoom. Participants' responses to protocol

questions were transcribed in Word documents. With participants' permission, the focus groups and key informant interviews were audio-recorded to ensure accuracy of recorded responses. All completed focus groups and key informant interview audio recordings were stored on AHP's secure server. AHP evaluators conducted qualitative coding and thematic analyses to code and categorize interview responses.

EIL IFR Staff Focus Group and Key Informant Interview Results

The following section summarizes results from the staff focus groups and key informant interviews. We present key findings in the following domains:

- Understanding of the IFR project and evaluation
- IFR program and evaluation roles and responsibilities
- Overall experience with IFR
- IFR staff collaboration challenges and solutions
- Impact of IFR on clients

Understanding of the IFR Project and Evaluation

To implement a program like IFR, key staff must have a working knowledge of the underlying model. Questions in this section of the focus group and key informant interview protocol asked participants to describe their understanding of IFR project and evaluation goals.

A total of 12 participants described their understanding of the goals of the IFR program and evaluation. Responses were coded into the following categories:

- **Test the effectiveness of co-locating recovery coordinators in Intact:** Seven participants (35%) reported that the goal of the IFR project was to test the effectiveness of incorporating recovery coordinators into Intact programs.
- **Expand the use of recovery coordinators to improve outcomes for families:** Six participants (30%) reported that a goal of the IFR project was to expand the use of recovery coordinators in Intact programs to improve treatment engagement and recovery outcomes for Intact families impacted by parental substance use.
- **Obtain client feedback on the IFR program:** Four participants (20%) reported that a goal of the IFR program was to gather client feedback on the program and on how to better serve families with substance use issues.
- **Coordinate treatment and recovery support for Intact families:** Two participants (10%) reported that an IFR program goal was to help coordinate treatment and recovery support services for Intact families and communicate with treatment providers.

- **Provide added support to clients with substance use issues:** Two participants (10%) reported that an IFR project goal was to provide extra support to clients who have substance use issues while they are in treatment and help them achieve sobriety.

Participants were also asked about what information or additional training their teams might need to better understand the IFR program and evaluation. Eight participants (40%) reported that it would be helpful to receive additional information and training about the roles and responsibilities of Intact workers and recovery coordinators for coordinating substance use services for clients. They also expressed a need for greater clarity about the AHP client interviews for the evaluation, as well as more information on how recovery coordinators are assigned to Intact cases.

Program and Evaluation Roles and Responsibilities

Intact workers were asked to describe their IFR program roles and responsibilities. Three participants (15%) reported that Intact workers are responsible for coordinating joint visits with the recovery coordinator. Two participants (10%) reported that Intact workers assist the recovery coordinator with submitting referrals for substance use treatment assessments and drug screens. One participant (5%) reported that Intact workers maintain primary responsibility for cases, engage clients in services to address their needs outside of substance use, and attend regular staffing meetings to ensure both the Intact worker and the recovery coordinator who work with IFR clients are on the same page.

Supervisors from intervention sites were asked to describe their IFR roles and responsibilities. Two supervisors (10%) provided responses to these questions. They reported that supervisors in the IFR project are responsible for identifying eligible cases for the IFR program and helping to build and maintain collaboration between recovery coordinators and Intact workers. Supervisors are also responsible for providing data to the AHP evaluation team. One supervisor reported that the supervisor's role includes ensuring clients make an informed decision about participating in the IFR program. Six supervisors (30%) also reported that there was confusion about whether attendance was required at the EIL IFR Supervisory and Executive Committee meetings.

Comparison site participants were also asked to describe Intact workers' IFR project roles and responsibilities. Eight participants (40%) provided responses to these questions. They reported that Intact workers are responsible for coordinating a wide range of services for the clients or their family members, which could include connecting them to mental health services, substance use treatment resources and support, transportation, and public assistance.

Participants were asked to describe their IFR evaluation roles and responsibilities. Eight participants (40%) reported that Intact workers are responsible for informing and encouraging clients to participate in the evaluation. Three participants (15%) reported that Intact workers coordinate with the evaluation champion regarding evaluation needs. Two participants (10%) reported that one of the Intact workers' responsibilities is to provide feedback about the IFR program by participating in focus groups and key informant interviews organized by the AHP evaluation team. One participant (5%) additionally reported that Intact workers are responsible for conducting the ASSIST screen to verify if a client is eligible for the IFR evaluation.

Participants were also asked to provide feedback about their overall experiences with the IFR evaluation. Five participants (25%) reported that IFR evaluation responsibilities were manageable for their teams and not burdensome. However, one participant (5%) reported that some Intact workers complained they did not have time for evaluation activities.

Overall Experience with IFR

Participants were asked to describe their overall experiences implementing the IFR program and evaluation. Six participants (30%) reported having positive experiences with the IFR program and evaluation. They reported that it was helpful for the Intact worker and client to have the recovery coordinator conduct on-the-spot drug screens. Moreover, including the recovery coordinator on the case allowed the Intact worker to have more time to meet client parenting and other needs. Families felt more supported with a recovery coordinator on their case. One participant reported that the ASSIST tool was easy to use and aided discussions with clients around substance use.

Four participants (20%) reported some negative experiences with the IFR program. They reported that transitional visits may be overwhelming for some families due to the presence of a recovery coordinator. Participants suggested that recovery coordinators not attend transitional visits and instead be introduced later, allowing families more time to adjust before engaging with IFR services. Coordinating joint visits proved challenging, as well as adjusting to working with an additional team member, for some Intact workers. Recovery coordinator staff turnover also presented a challenge. One participant noted that some recovery coordinators were rigid and not flexible enough to meet clients' needs.

Participants were asked to provide feedback about how Intact workers on the IFR project could have been better supported. Three participants (15%) suggested that ICOY should have communicated more directly with Intact workers to give updates on how the IFR project was proceeding. Intact workers should have been given more opportunities to share ongoing feedback about IFR. Three participants (15%) reported that Intact workers should have been given more guidance and clarity around program and evaluation eligibility and procedures. One participant (5%) suggested that recovery coordinators should have received more training on the IFS program and DCFS policies.

IFR Program Benefits

Participants described the few benefits their Intact staff experienced as a result of the IFR program:

- **Additional support for Intact workers:** Four participants (20%) reported that Intact workers received additional support on cases and timely updates about clients' substance use treatment and recovery.
- **Expertise in SUDs:** Three participants (15%) reported that recovery coordinators provided helpful SUD-related expertise and resources that Intact workers are often not equipped with.

"It is nice to not feel like I must be an expert on substance abuse. The recovery coordinator can do screens and is good at asking the right questions about the client's substance use. I don't have to worry about something falling through the cracks."

Participants also described several benefits that clients received from the IFR program:

- **Accountability:** Four participants (20%) reported that recovery coordinators helped keep their clients accountable about their substance use. Recovery coordinators provided specialized guidance to clients who were in denial about their substance-related issues, encouraging them to recognize that they had a problem. Recovery coordinators also kept clients regularly informed about their treatment status and drug screen results.

"I think recovery coordinators make it clear to clients that substance use is an issue they can help with. If the client meets with me, we may just focus on financial things or parenting. However, having a person there that is dedicated to helping the client with substance use really shows clients that this is an issue that needs to be addressed."

- **Additional support:** Two participants (10%) reported recovery coordinators built trusting relationships with clients and provided families with additional support. Together, Intact workers and recovery coordinators were able to be a team for clients.

"It has felt more like a team when it's me, the recovery coordinator, and the parent figuring out how to solve issues."

- **Specialized substance use treatment support to clients:** Three participants (15%) reported that clients benefited from recovery coordinators' substance use treatment education and expertise. Recovery coordinators were able to assess clients' various relapse triggers and encourage them to engage in services outside of treatment to support their recovery. Drawing on their own experiences, recovery coordinators offered clients multiple treatment options to support informed decision making.

"[The recovery coordinator] encourages clients to get in any other services that might be beneficial for them and brainstorm with the family about what else might help. In one case one of the parents would use arguments with the dad as a reason for

relapse. [The recovery coordinator] encouraged them to look at doing couples counseling so they can communicate better and help prevent relapse."

Program Challenges, Solutions, and Resources Needed

Participants were asked to describe IFR program implementation challenges. Challenges included issues related to roles and responsibilities, collaboration between recovery coordinators and Intact workers, and IFR client experiences:

- **Challenges related to IFR roles and responsibilities:** Five participants (25%) reported issues related to confusion and disagreement regarding Intact worker and recovery coordinator program roles and responsibilities. Intact workers and recovery coordinators sometimes disagreed on how to manage clients' treatment. Moreover, the division of responsibilities between Intact workers and recovery coordinators was sometimes unclear, leading some Intact workers to feel that recovery coordinators occasionally did not "stay in their lane."
    - **Solutions:** Supervisors held more frequent supervisory meetings with recovery coordinators to address collaboration issues. They also encouraged joint visits between Intact workers and recovery coordinators to promote communication and reduce misinformation. One supervisor suggested that recovery coordinators receive more comprehensive training on DCFS and IFS to enhance understanding of Intact policies and procedures.
- **Challenges coordinating joint visits:** Seven participants (35%) reported challenges with coordinating joint visits with recovery coordinators. These challenges included scheduling joint visits, reaching recovery coordinators and keeping them informed about new referrals, and ensuring they were included in the transitional visits with Intact workers to meet families. Intact workers often had demanding schedules, making it difficult to schedule visits with recovery coordinators. The frequency of the joint visits, along with coordinating schedules with the recovery coordinators, proved especially difficult due to Intact workers' other responsibilities.
    - **Solutions:** Participants addressed these challenges by clearly communicating with recovery coordinators about scheduled visits and scheduling them in advance when possible.
- **Communication challenges:** Two participants (10%) reported that sometimes recovery coordinators failed to inform Intact workers about important case information in a timely manner.
    - **Solutions:** Participants implemented a range of strategies to improve communication within the IFR team and ensure detailed and timely information sharing. One approach involved recovery coordinators informally briefing and debriefing Intact workers before and after joint visits. Intact workers also received thorough after-visit summaries from recovery coordinators following completed individual client visits. Communication among Intact workers, recovery workers, and clients often occurred through group text messages. One participant reported that having the recovery coordinator co-located at the Intact site facilitated positive and streamlined communication. Joint and individual supervision

meetings were both helpful for improving communication and collaboration between the Intact workers and recovery coordinators.

Participants also described IFR program challenges that impacted clients:

- **Presence of a recovery coordinator at the transitional visit:** Five participants (25%) felt that too many people present at the transitional visit can be threatening or overwhelming to families, especially for families who were reluctant to accept Intact services.
- **Challenges related to having an additional staff person on the case:** Two participants (10%) felt that having a recovery coordinator on the case can be overwhelming or burdensome for the client. Participants reported that some clients complained about the number of visits required by IFR.
    - **Solutions:** To help relieve the burden of visiting the client twice in one week (one joint visit, and one additional individual visit with the recovery coordinator), one team replaced one in-person visit with a phone visit instead. The team also made adjustments to scheduling joint visits to accommodate clients' requests.

> *"Scheduling is difficult. Some clients are like 'I can't stand the multiple appointments. I have kids, a house to run, and I work a job. Then I have you coming this day, and she wants to come that day.' So, when we have clients that are on the verge of quitting, you have to compromise. So, I'll tell them that we will make every effort to come out together so there is only one appointment. That works well."*

Comparison Partner Sites' Perspectives About IFR

Participants from comparison sites were asked to share their opinions and feedback on the IFR program, including their perceptions of its potential impact on their organization's Intact workers and clients if implemented. Six participants (30%) reported that including recovery coordinators on the Intact team would support Intact workers by relieving their workload, allowing Intact workers to focus on providing other types of support to the case. Three participants (15%) reported that having a recovery coordinator on the case would help keep Intact workers efficiently informed about clients' substance use–related care and progress. One participant (5%) reported that recovery coordinators' knowledge and expertise would offer Intact workers valuable substance use–related support. Participants also recognized the challenges of involving an additional person on the Intact team. Five participants (25%) reported that coordinating joint visits with a recovery coordinator could be challenging. Four participants (20%) reported that requiring Intact workers to document recovery coordinators' activities through their case notes in the administrative system could create additional burden.

Participants also shared what they believed about how clients would be impacted if there was a recovery coordinator on the team. Ten participants (50%) reported that they believed clients would benefit from the added support. Five participants (25%) reported that clients may feel overwhelmed by having an additional person to work with.

Participants provided various perspectives on how they would implement the IFR program at their organizations. Two participants (20%) reported that joint visits may be overwhelming for clients and suggested that it might be more beneficial for clients to meet with the recovery coordinator separately to build a trusting relationship. Both participants explained that it would be unhelpful for Intact workers to be present during clients' time with the recovery coordinators, particularly when clients are discussing details of their recovery process. Two other participants (20%) reported that it would be helpful for clients if recovery coordinators were older people with lived experience and familiarity working with this population.

Almost all participants from the comparison sites (75%, n = 9) believed clients would benefit from the added support recovery coordinators can offer. Seven participants reported several considerations they thought were important: Recovery coordinators should have a clear understanding of their roles and responsibilities, personal experiences with substance use recovery, and strong communication and collaboration skills. Recovery coordinators should also be able to document their activities in case notes shared with providers or otherwise not create additional burden or work for the Intact workers. Participants also noted that in certain situations, involving a recovery coordinator could potentially cause more harm than good (i.e., if a case has complex needs, or if the service recipient is not ready or willing to engage with a recovery coordinator). However, clients may benefit from meeting with recovery coordinators separately to build relationships with them. Families who understand that IFR participation is voluntary and are willing to engage with the services are more likely to benefit from working with recovery coordinators.

> *"Recovery coordinators can help coordinate and bring a different perspective to client treatment. A lot of our clients go to substance use treatment because they have to in order to close their case. If there is someone like a recovery coordinator present, it may help them understand that this is something for them to work on more than just something to check off."*

Key Informant Interviews on Program Implementation and Lessons Learned

Between February and April 2025, AHP researchers conducted key informant interviews with EIL IFR executive leadership, Intact supervisors, and Intact workers from each of the four child welfare provider partner sites, as well as with recovery coordinators and their supervisor from the substance use treatment provider partner site. The objective of these interviews was to gather insights on participants' experiences with the implementation of the EIL IFR program, including identifying facilitators of successful implementation, challenges encountered, and strategies employed to address those challenges.

Program Implementation and Lessons Learned Key Informant Interview Methods and Analyses

AHP developed the key informant interview protocol, which assessed the following topics:

- Understanding of the IFR project and evaluation
- Program leadership and management
- IFR program implementation successes
- IFR program implementation challenges and solutions

Fourteen individuals participated in the key informant interviews. This included 10 participants from intervention sites and 4 participants from comparison sites. Comparison site participants included one Intact worker, one supervisor, one participant on the executive leadership team, and one participant who held both an executive leadership role and a supervisory role during IFR implementation. Intervention site participants included three Intact workers, two recovery coordinators, two Intact supervisors, one recovery coordinator supervisor, one executive leadership participant, and one participant who held both an executive leadership role and a supervisory role during IFR implementation. Interviews were conducted by the AHP evaluation team. AHP developed the interview protocol and methods, which were approved by AHP's IRB.

The interviews were conducted virtually via Microsoft Teams and lasted 30–60 minutes. Participants' responses to protocol questions were transcribed in Word documents. With participants' permission, the interviews were audio-recorded to ensure accuracy of recorded responses. All completed audio recordings were stored on AHP's secure server. AHP evaluators conducted qualitative coding and thematic analyses to code and categorize interview responses.

Program Implementation and Lessons Learned Key Informant Interview Results

Understanding the IFR Project and Evaluation

Participants were asked to describe their understanding of the goals of the IFR program. All 14 participants provided responses, which were coded into the following categories:

- **Support families with SUD:** Ten participants (71%) reported that a primary IFR program goal was to support families affected by SUD by connecting them with treatment, recovery support, and educational services.
- **Improve outcomes for clients and families:** Six participants (43%) reported that the IFR program aimed to improve family outcomes, including supporting parental recovery and family reunification or stability.
- **Evaluate the effectiveness of the IFR model:** Four participants (29%) reported that an IFR program goal was to evaluate the effectiveness of the IFR model.

- **Promote interagency collaboration:** One participant (7%) reported that the IFR program intended to enhance collaboration between child welfare and substance use treatment providers to improve service coordination for families.
- **Increase understanding of SUD:** One participant (7%) reported that an IFR program goal was to better understand how SUDs affect families involved in the child welfare system.

Participants were asked what additional resources would have helped them or their teams understand IFR program goals, roles, and responsibilities. Two participants reported that they felt they understood the IFR program goals, roles, and responsibilities and that additional resources and support were not needed to help them understand the program. Six participants identified several resources (detailed below) that they received that supported their understanding of IFR program goals, roles, and responsibilities. Five participants reported that meetings and trainings with ICOY and AHP—such as supervisory meetings, program trainings, and refresher trainings—were particularly helpful for clear communication and ongoing clarification. Two participants found evaluation team data, including outcome metrics and newsletters, to be useful. Handouts about the program and guidance from their colleagues served as helpful reminders about program expectations.

Twelve participants reported the following resources would help clarify IFR program roles, goals, and responsibilities for them and their teams:

- **Additional IFR program training:** Eight participants (57%) reported that additional, ongoing training on the IFR program would have improved understanding of IFR program goals, roles, and responsibilities. Trainings were perceived to be particularly beneficial for Intact workers who expressed resistance to the program. Participants also emphasized the value of including both Intact and SUD provider teams together in trainings. Ongoing or continuous training for new staff was also identified as a need.
- **IFR program informational materials:** Six participants (43%) reported a need for more informational materials to help them better understand the IFR program. Suggestions included providing a one-page fact sheet for new staff and sharing data on client outcomes more frequently to support progress tracking and program deliverables.
- **Clarification on recovery coordinator/Intact worker roles:** Four intervention site participants (29%) reported a need for clearer guidance on the distinct roles and responsibilities of the recovery coordinator and Intact worker.
- **Additional meetings with ICOY/AHP:** Three participants (21%) reported that having additional meetings with ICOY and AHP would have helped clarify IFR program goals, roles, and responsibilities. One comparison site participant reported that their engagement in the IFR program was limited and participation in the regular evaluation check-in meetings would have helped increase their understanding about the program. Joint meetings—including ICOY, AHP, and IFR program implementation staff—would also have helped project staff align on outcomes, deliverables, and overall program understanding.

- **Recovery coordinator supervisor attendance at supervision meetings:** One participant (7%) reported that it would have been helpful to have the recovery coordinator's supervisor attend more supervision meetings to help delineate staff roles and responsibilities.
- **Explanation of IFR to agency leadership:** One participant (7%) reported that it would have been helpful for their agency's leadership to understand the IFR program. Leadership seemed unfamiliar with the IFR program, making it challenging to get buy-in for IFR program goals.

Project Leadership and Management

Executive leadership and supervisory staff were asked to describe their roles and responsibilities in implementing the IFR program. Participants described their roles in the IFR program to include providing program oversight, enrolling clients in the evaluation, facilitating collaboration between agencies, collecting data, attending meetings, improving workflows, and serving as an evaluation champion.

LEADERSHIP ENGAGEMENT IN THE IFR PROGRAM

Executive-level and supervisory staff were asked to describe their engagement in the IFR program, including changes in their involvement in the program and what encouraged or discouraged their participation in the program.

Six participants (43%) described changes in their participation and support for the IFR program over time. Three participants (21%) reported that their level of engagement in the IFR program was directly affected by a change in their role, which led to decreased or increased engagement in the IFR program. Three participants (21%) reported that their involvement in the IFR program decreased due to poor interactions with program staff, reduced need for their attention to the program, or a change in their role. In contrast, two participants (14%) reported that their engagement in the IFR program increased over time, driven by a need to fill in due to staff shortages or expanded responsibilities following a role change.

Six executive and supervisory staff (43%) identified factors that discouraged their participation in the IFR program. Key challenges included collaboration issues between Intact workers and recovery coordinators (n = 3, 21%) and feeling overwhelmed by competing work demands (n = 3, 21%). Additional factors that discouraged participants from participating in the IFR program were staff turnover, limited referrals, and being in the comparison group (each reported by one participant, 7%).

Six participants (43%) provided insight into what encouraged them to stay engaged in the IFR program. Five participants (36%) reported that they were encouraged to participate because of the value they perceived in collaborating with the substance use treatment partner or child welfare partner agency. This included improved access to resources and networking opportunities and recovery coordinators relieving some of the burden on Intact workers. Four participants (29%) reported that they were encouraged to participate in the IFR program because they believed it provided additional support for clients with SUD. Comparison site participants reported that despite not working with any recovery coordinators, they recognized their value.

LEADERSHIP FEEDBACK ON DATA RECEIVED AND ADDITIONAL DATA NEEDS

Executive-level and supervisory staff were asked if the data provided by AHP about the IFR program was helpful and what other data would have been helpful to them and their organizations.

Eight participants (57%) provided feedback on the usefulness of the data provided by the evaluation team. Six participants (43%) reported that the data was helpful because it provided insight into referrals and program participation across sites, demonstrated the program's impact on clients, highlighted implementation challenges, and supported site accountability.

Two participants (14%) reported mixed feedback, reporting that while the data provided a useful snapshot of program activity and enrollment, it lacked depth in some areas. These participants expressed a desire for an end-of-year summary and raised concerns that some clients—such as those who declined participation in the program or left the program early—may have been excluded from the data.

Five participants (36%) reported suggestions for additional data that would have been helpful to their organizations. Suggestions included the following types of data: outcome data from sites with recovery coordinators, comparisons between control and intervention sites, information on cases that were disrupted during the program, clients' visit attendance rates, service access and service completion data, and an end-of-project impact summary.

IFR Program Implementation Successes

This section summarizes what participants reported worked well with IFR program implementation, including benefits clients received from participating in the IFR program, and changes that took place in the Intact teams after participating in the program.

EFFECTIVE COMMUNICATION AND COLLABORATION

Eight participants (57%) reported that communication and collaboration between recovery coordinators and Intact workers functioned effectively once program expectations and processes were clearly understood and when staff bought into the IFR program. Participants emphasized the importance of timely, two-way communication and consistent information sharing to support informed decision making for client care. Effective communication took place through phone calls, weekly supervision meetings (including the recovery coordinator, Intact worker, and Intact supervisor), and joint supervision meetings (including recovery coordinators, Intact workers, and their respective supervisors).

ADDITIONAL SUPPORT FOR INTACT WORKERS AND CLIENTS

Six participants (43%) reported that the recovery coordinators' presence, expertise, and contributions made cases easier to manage and provided additional support for Intact workers and clients. Intact workers appreciated having an additional person on the case who could be an extra set of eyes on the family. Recovery coordinators were able to provide phone support and additional check-ins with clients where the Intact workers often lacked time. Recovery coordinators also connected clients to substance use treatment and other supportive services faster than the Intact workers could on their own.

"I really appreciated that additional support and just knowing that there were other eyes [on the case] and someone who was more experienced in this (substance use treatment)."

JOINT SUPERVISION

Seven participants (50%) reported that having regular joint supervision meetings helped Intact workers and recovery coordinators improve communication, resolve challenges, establish a fuller assessment of a client's wellness, provide feedback, and strategize on cases. Four participants (28%) reported that joint supervision meetings offered an opportunity to ensure greater accountability and coordinate specific plans for shared cases. One participant (7%) reported that joint supervisions provided dedicated time to share expertise on topics such as drug screens and substance use treatment and recovery resources.

"I think just getting everybody on the same page, making sure that we all have the same information so that we could try to work together to support the client as much as we could."

CLIENT BENEFITS

Participants reported that clients who participated in the IFR program experienced a range of benefits. Eight participants (58%) reported that clients benefited from working with an additional person (i.e., a recovery coordinator) who contributed to a more robust support system for them. This included clients receiving additional emotional support, accountability, encouragement, and motivation. Seven participants (50%) reported clients were connected to substance use treatment and supportive services. Six participants (43%) stated that clients benefited from recovery coordinators' specialized knowledge and expertise in substance use. Three participants (21%) reported that clients were connected to other support services, such as bus passes, gas cards, domestic violence resources, or funds for household expenses. Three participants (21%) reported that recovery coordinators provided transportation for their clients. Two participants (14%) reported that clients benefited from IFR by receiving gift cards for completing IFR evaluation interviews. Another two participants (14%) informed interviewers that the recovery coordinators' ability to perform at-home drug screens was beneficial. One participant (7%) noted that recovery coordinators motivated clients with praise, support, and accountability. One participant (7%) noted that the presence of a male recovery coordinator facilitated greater rapport building with male clients.

"Substance use disorder is an incredibly difficult thing to overcome. It's one thing to send somebody to treatment, but it's another to have an extra support person to help them get the treatment and help them move through those stages of change and increase their motivation."

IFR PROGRAM IMPACT ON INTACT TEAMS

Six participants (43%) reported that participating in IFR improved their Intact teams' ability to make referrals and coordinate services with community providers. Participants attributed these improvements to things they learned while the IFR program was implemented. For example, they learned about local resources, gained direct ties to substance use treatment providers, and learned about how to properly refer and work with a family experiencing substance-related issues. Six participants (43%) also reported that involvement in the IFR program improved their own or their teams' understanding of SUD or harm reduction. They developed an understanding that addiction is not a choice and that underlying mental health issues can contribute to substance use. They also learned about harm reduction and various harm reduction techniques. Three participants (21%) reported that they or their team changed how they engaged with clients due to participating in the IFR program. These changes included approaching families struggling with substance use with more compassion and understanding, as well as having improved conversations around treatment services.

"The recovery coordinator talked about the harm reduction model—like, if the client has been decreasing their (substance) use but hasn't totally stopped, what is the path of least harm? It's easy for DCFS to say they (the client) need to go to inpatient if they're not stopping (their substance use). But if they're decreasing their use, outpatient treatment is still working. We've been able to advocate more if the client just needs more time to get there (stabilized) in treatment. Sometimes DCFS jumps the gun, but we're able to say the client is making progress, even if it doesn't look the way that we had thought it would."

IFR Program Implementation Challenges and Solutions

Intervention site participants were asked to describe challenges with implementing the IFR program, including the collaboration between Intact workers and recovery coordinators, as well as any issues that might have been experienced by IFR clients. Ten participants identified the following challenges.

STAFF-SPECIFIC INTERPERSONAL CHALLENGES

Eight participants (57%) reported that communication and collaboration challenges were primarily linked to specific individuals rather than a widespread issue across all Intact or recovery coordinator staff. One participant (7%) described a situation in which a recovery coordinator made an Intact worker feel uncomfortable, leading to the Intact worker's reluctance to partner with the recovery coordinator.

Two participants (14%) reported concerns regarding unprofessional behaviors by a recovery coordinator, which included the dissemination of incorrect information to clients, breaches of confidentiality, and overstepping their role in the IFR program.

Six participants (43%) reported that their teams worked to address these issues by following up with supervisory staff to help correct the situation, implementing more joint meetings, and working through the specific communication and collaboration issues among each other directly.

CONFUSION ABOUT ROLES AND RESPONSIBILITIES

Seven participants (50%) reported that there were issues with recovery coordinators and Intact workers understanding each other's roles and responsibilities on shared cases. Some participants indicated that confusion over roles was primarily an issue at the beginning of the program that resolved over time. One participant (7%) reported that there were times the recovery coordinator failed to understand specific DCFS and Intact policies and best practices.

To address these challenges, three participants (21%) reported that their program organized additional meetings among team members to help review and clarify roles and responsibilities in the program.

COMMUNICATION AND COLLABORATION ISSUES

Seven participants (50%) reported ongoing challenges with communication and collaboration, namely related to scheduling joint visits and information sharing. Barriers included poor communication about scheduled visits, reluctance from some Intact workers to engage in joint visits, scheduling conflicts or inflexibility, and instances of recovery coordinators missing planned visits. In some cases, the added burden of coordinating joint visits was exacerbated by staffing shortages, leading some staff to abandon attempts to schedule them altogether. Two participants (14%) reported challenges with sharing case information between the Intact workers and recovery coordinators. This included sharing important information in a timely manner and correct information. One participant (7%) reported that for some cases, joint home visits with the recovery coordinator and Intact worker never occurred.

Two participants (14%) reported that their program addressed challenges with scheduling joint visits by implementing a regular schedule for these visits. This approach helped streamline coordination but was only effective with clients who had consistent availability and could commit to scheduled times.

INTACT WORKER BURDEN

Five participants (36%) reported that collaboration with recovery coordinators sometimes placed additional burdens on Intact workers. Participants noted that miscommunication—such as a recovery coordinator providing clients with inaccurate information—created extra work for the Intact worker to correct. Other participants reported that the effort required to coordinate and follow through on joint visits was strenuous. Additionally, the triadic nature of the relationship between the client, recovery coordinator, and Intact worker often necessitated ongoing verification of information across parties, contributing to additional time and effort from the Intact worker.

LACK OF BUY-IN FOR THE IFR PROGRAM

Five participants (36%) reported that limited buy-in from some staff members hindered effective implementation of the IFR program. This lack of buy-in may have discouraged prospective clients from

accepting IFR and resulted in a lack of adherence to the program model (i.e., fewer joint visits occurred than were required). Three participants (21%) reported that there was a significant lack of buy-in from certain staff, particularly Intact workers with longer tenure. These staff seemed reluctant to change how they managed their cases to accommodate a recovery coordinator. For example, they might not have communicated in a timely manner with recovery coordinators about their cases or about scheduling joint visits, or they were resistant to letting the recovery coordinators assist with substance-related issues.

One participant (7%) reported that their program attempted to address issues with lack of buy-in by involving supervisory staff in one-on-one meetings with Intact workers who were resistant to the IFR program model.

JOINT SUPERVISION CHALLENGES

Joint supervision meetings were an important component of IFR program implementation. They provided a structured space for Intact workers, recovery coordinators, and their supervisors to coordinate and discuss shared cases. Nine participants (64%) reported a variety of challenges related to scheduling, attendance, and engagement. Attendance issues were reported by four participants (29%), with one participant reporting that their site eventually discontinued joint supervision due to declining participation of key staff, and another participant reporting that meetings were shortened because of low engagement. When joint supervision meetings took place, four participants (28%) reported that some staff were disengaged or wanted to rush through the meeting quickly. Three participants (21%) reported that scheduling conflicts—such as court appearances or home visits—complicated efforts to schedule joint supervision meetings. Two participants (14%) reported that the bulk of communication about a case occurred directly between the Intact workers and recovery coordinators, which made it unnecessary to discuss the same information again in a joint supervision. One participant (7%) reported that their program eventually discontinued holding joint supervision meetings entirely and staff only communicated directly with one another. One participant (7%) expressed frustration over the time spent having to listen to discussions about other workers' cases while they felt preoccupied with their own work responsibilities. One participant (7%) reported that differences of opinion about care management between the recovery coordinator/supervisor and the Intact team sometimes led to disagreements during joint supervision meetings. Another participant (7%) expressed concern that, despite the intent of joint supervision meetings, they did not improve staff understanding of the recovery coordinator's role.

Participants reported that their teams employed various strategies to address the attendance and engagement issues they experienced during joint supervision meetings. Two participants (14%) reported that they raised attendance issues with direct supervisors, though one participant noted this had little effect. One participant (7%) reported that supervisors sent follow-up summaries to those unable to attend, which helped keep everyone on the same page. Another participant (7%) reported that their team worked together to find time for joint supervision meetings that accommodated all team members, though they admitted this did not always result in better attendance. One participant (7%) reported that their supervisor emphasized the expectation to attend joint supervision meetings to all staff. One participant (7%) reported that their supervisors allowed staff to leave once they had discussed their clients, which reduced their time burden. To help promote engagement, one participant

(7%) prepared structured agendas for the meetings. Another participant reported that they handled tense discussions during joint supervision meetings by redirecting the conversation to other topics and following up with team members about these discussions after the meeting(s).

SERVICE PROVISION CHALLENGES

Intact workers, recovery coordinators and their supervisors described challenges that sometimes made it difficult to provide services to clients, along with the strategies they used to address those challenges:

- **Client engagement:** The most cited barrier to service provision was client engagement, which was reported by nine participants (64%). Engagement issues included clients not being ready to engage in substance use treatment services, clients feeling pressure to engage in IFR, and clients participating in IFR to avoid further court actions or obtain needed resources rather than for SUD and other services. Some participants also reported that DCFS workers' presence during the initial transitional visit at times made clients feel pressured to participate in IFR, or clients perceived the Intact workers and recovery coordinators to be allied with DCFS. In these cases, clients were reluctant to engage with IFR. One participant (7%) also reported that clients might decline continued engagement in IFR due to feeling overwhelmed with the required services, especially because participation in the program was optional.

> *"Clients learned about the IFR program at the transitional visit, and DCFS would pressure them to cooperate. Some clients did not want to work with us but agreed because they felt pushed into it by DCFS, and then it would be difficult to get them to complete anything, even after DCFS had left. I think that families sometimes get pushed into these 'voluntary' programs. That applies to Intact too, not just the IFR program."*

- **Service availability:** Five participants (36%) reported that the availability of substance use treatment services was a challenge due to a lack of providers in the region to meet demand.
- **Service accessibility:** Service accessibility was also an issue. Five participants (43%) reported that despite service availability, clients faced barriers in accessing services due to issues such as transportation challenges, work conflicts, and lack of childcare.
- **IFR geographic service area:** Two participants (14%) reported that the large geographic area of the EIL IFR program made it time-consuming and burdensome for staff to travel to provide services to clients.
- **Team collaboration challenges:** Two participants (14%) reported challenges delivering services due to difficulties collaborating with Intact workers. This included instances where Intact workers were reluctant to engage with the recovery coordinators, at times "gatekeeping" by not sharing appointment times and other key client information. Additional barriers included ongoing confusion regarding the roles and responsibilities of IFR team members (n = 1, 7%) and staff difficulties with remembering to include recovery coordinators in client visits and supervision meetings (n = 1, 7%).

"For us as Intact workers, we typically work on our own with our own individual families. There is not a lot of communication with other caseworkers unless we need help with coverage or there's a big problem. I'm used to working on my own and getting things done, so I had to remind myself to share that information with the recovery coordinator. Sometimes, the day before a visit I'd remember that I didn't check with the recovery coordinator to see if they were available, too."

Client Mental Health Focus Groups

The EIL IFR evaluation data showed that more than half of participants experienced mental health problems (serious depressive and anxiety symptoms). In the spring of 2024, AHP researchers conducted focus groups with clients enrolled in the EIL IFR evaluation. The purpose of the focus groups was to ask participants about their access to and use of mental health services. The results are summarized below.

Client Mental Health Focus Group Methods and Analyses

AHP developed the focus group protocol, which assessed the following topics:

- Client experiences accessing mental health services
- Mental health service satisfaction
- Barriers to accessing mental health services
- Other mental health needs
- Impact of DCFS involvement on mental health
- Suggestions to improve access to mental health services

Two focus groups were conducted with six participants via Zoom, lasting 30–45 minutes each. The focus groups were audio-recorded and then transcribed in Microsoft Word. AHP researchers conducted qualitative coding and thematic analyses.

Client Mental Health Focus Group Results

Focus group participants reported that their Intact team connected them and their family members to mental health services. Sixty-seven percent of participants reported that they were connected to mental health services by their Intact workers, and 50% of participants reported that they received the help they needed. Intact staff helped connect them to local services, services they did not know existed, and services that accepted their insurance. Intact staff also helped connect participants to mental health services more quickly. Participants who did not want or need mental health services reported that Intact staff helped them by alleviating stress related to finding housing and childcare. They appreciated that they were not forced to participate in mental health services.

Participants appreciated that the mental health services they received did not require insurance, accommodated their work schedules, had short wait times, and had friendly staff. They disliked long wait times to access mental health services. Participants reported that the mental health services they received were helpful to them and their families to strengthen their relationships.

Participants also reported various challenges and barriers that affected their access to mental health services. They faced barriers with accessing mental health treatment services due to lack of transportation, work schedule conflicts, and lack of adequate childcare. Other challenges included issues around health insurance—participants either did not have health insurance, or the mental health services in their areas did not accept their form of insurance. Participants also reported a lack of mental health services available in their areas, presenting the difficulty of having to travel long distances to receive services. Another barrier to accessing mental health services was clients' reluctance to open up to Intact staff about their mental health needs out of fear of being judged.

Finally, participants reported that involvement with DCFS made them feel inadequate, embarrassed, and stressed. Some participants felt they were treated unfairly. They believed that parents involved with Intact need access to counseling, medication, and other services that help them learn coping skills. Participants suggested that parents receive assistance with childcare, transportation, and accessing low-cost/free mental health services. They also recommended connecting parents to services that engage both the parent and the child, as well as services located nearby. Intact staff could support parents' access to mental health services by helping make connections with appropriate staff at treatment provider agencies. They also reported that helping parents access additional helpful resources, such as food pantries and donation services, could facilitate connections to mental health services.

CONCLUSIONS

The EIL IFR program served 259 participants with SUD in four sites in east-central Illinois. Participants received EIL IFR services for approximately seven months.

Significant outcome evaluation results include:

- The typical EIL IFR client was a 32-year-old single, White, non-Hispanic woman who was unemployed and earned less than $10,000 a year.
- The typical focal child was a 6-year-old, White, non-Hispanic boy who was enrolled in Medicaid. Most lived with at least one of their parents.
- The percentage of EIL IFR comparison group participants who reported high alcohol use significantly decreased over time.
- Preschool-age focal children in the intervention group experienced significantly lower levels of internalizing problems at the 9-month follow-up interview than did control group children of the same age. Lower internalizing problems include lower mood disturbances, anxiety, and somatic complaints.

- Preschool-age focal children in the intervention group experienced significantly lower levels of externalizing problems at the 9-month and 18-month follow-ups than did control group children of the same age. Lower externalizing problems include attention problems and aggressive behavior (disobedience, fighting, or showing defiance).
- Intervention group parents' scores were significantly lower than comparison group parents' scores at the 9-month and 18-month follow-ups and showed significant decreases in scores over time. This finding suggests that intervention group parents viewed their children as children—rather than as peers who could take on responsibilities or behaviors typically associated with parents. Additionally, parents gained a more appropriate understanding of the role of children and traditional family roles over time.
- All EIL IFR program participants showed improvements in how much they value their children's independence.
- Participants who were referred for but did not attend substance use treatment were more likely to have their children placed into foster care. This finding suggests that recovery coordinators can play an important role in family stability by encouraging parents to participate in and complete substance use treatment.
- Participants who reported more severe depressive symptoms reported higher levels of parental stress. Higher levels of parental stress were in turn associated with poor child well-being. These findings, together with client mental health focus group results, emphasize the impact of parental mental health on the family and the importance of connecting IFR participants to mental health services.
- EIL IFR program benefits, as reported by evaluation participants, include improved parenting, family stability, and behavioral health.
- Successful implementation of the EIL IFR program depended on sustained commitment, collaboration, and communication across program implementation staff. A significant challenge in the program was related to roles and responsibilities for recovery coordinators and Intact workers, and their communication and collaboration. Specifically, workers struggled with scheduling joint visits and having regular communication and supervision meetings about their cases. These challenges were addressed effectively through joint supervision and by organizing meetings to clarify roles and responsibilities.
- A persistent challenge was the lower-than-anticipated number of referrals from DCFS for families with parental substance misuse to the child welfare partners' IFS programs. DCFS administrators indicated that referral patterns to Intact services were influenced by county size and capacity constraints within Intact service provider agencies. They further clarified that cases involving severe compromises to child safety due to ongoing illicit substance use resulted in referrals to protective custody rather than Intact services. EIL IFR partners addressed low enrollment by implementing the ASSIST to screen all clients referred to Intact services for potential substance-related issues, Additionally, the project expanded the IFR program to two additional counties.

- Staff implementing the EIL IFR program reported numerous benefits that staff and clients experienced. Intact workers received additional support from the recovery coordinator on the case. They had additional time to meet other clients' needs, received timely updates about clients' substance use treatment/recovery progress, and benefited from the recovery coordinators' SUD-related expertise and resources. Intact teams experienced improvements in how they worked with clients with SUD. They learned about local resources, gained direct ties to substance use treatment providers, and learned how to properly refer and progress with a family experiencing substance-related issues. Intact teams also reported that their understanding of SUD and harm reduction increased.

The EIL IFR program successfully served hundreds of families by providing access to recovery coordinators who connected participants to substance use treatment and other needed SUD education, recovery, and support services. Participants in the program reported several EIL IFR benefits: the program helped them "get their lives together." For example, the program helped them finish school, get a job, or secure stable housing. The program also helped them stay accountable and better understand and cope with their mental health and substance use problems. The EIL IFR program builds on the success of an earlier IL IFR program conducted in northern Illinois, where families reported similar successes and benefits. We are continuing to examine the implementation of the IFR model through an ongoing study in the East St. Louis region of Illinois. Combining data from all IFR programs will further our understanding of how the IFR program improves parent and child outcomes and inform strategies for long-term program sustainability.

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