J Urban Health
https://doi.org/10.1007/s11524-024-00857-9

ORIGINAL ARTICLE

Characterizing Multisystem Barriers to Women's Residential SUD Treatment: A Multisite Qualitative Analysis in Los Angeles

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Accepted: 15 February 2024

Abstract Residential substance use disorder (SUD) treatment programs are challenged by the differing values of the problem-solving court (PSC) and child welfare (CW) systems, along with communication barriers between staff. This study aimed to understand, from the viewpoints of SUD treatment providers, how divergent values and communication barriers adversely affect women's residential SUD treatment. We conducted qualitative semistructured interviews with 18 SUD treatment clinicians and six directors from four women's residential SUD treatment programs. Using a thematic analysis framework, we identified salient themes across specified codes. Analysis revealed six main themes, suggesting differing values and communication barriers across the SUD, PSC, and CW systems adversely affect the provision of SUD treatment. For differing values, three main themes emerged: (a) unaddressed trauma and fear of mental health treatment seeking; (b) perceptions of mothers with a SUD; and (c) the Adoption and Safe Families Act (ASFA) timeline as a barrier to SUD treatment provision. For communication barriers, three themes emerged: (a) inadequate communication and responsiveness with PSC and CW systems adversely affect treatment coordination, induce patient stress, and treatment disengagement; (b) lack of PSC and CW communication regarding child visitation planning adversely affects treatment motivation and

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Published online: 17 April 2024

retention; and (c) competing ASFA, PSC, and CW priorities and inadequate cross-system communication adversely affect treatment planning. Treatment providers face significant barriers in providing effective treatment to women simultaneously involved in the CW and PSC systems. Aligning values and addressing communication barriers, changes in policy, and enhanced cross-system training are crucial. Additionally, it is essential to reevaluate the ASFA timeline to align with the long-term treatment needs of mothers with a SUD. Further research should explore the viewpoints of patients, CW, and PSC staff to gain deeper insights into these SUD treatment barriers.

Keywords Substance use disorder · Problem-solving court · Child welfare · Values · Communication

Introduction

Substance use disorders (SUD) are commonly associated with criminal justice involvement, as evidenced by an estimated 63% of individuals in jail and 58% in prison having a SUD. This frequently leads to family separation given that 47% of individuals in jail or prison are parents of minors [1, 2]. For women with SUD involved in both the criminal justice and child welfare (CW) systems, problem-solving courts (PSC) have become a crucial multisystem intervention model [3, 4]. PSCs were developed to more effectively address the overlapping and interconnected SUD-related problems that bring many women into the CW and criminal justice systems, including: (a) child maltreatment and neglect related to addiction and (b) crimes associated with having a SUD. PSCs arose from the success of the drug court model for addressing SUDs in the justice-involved population.

The first drug court began in Miami, Florida, in 1989 during the peak of the crack cocaine epidemic in the United States, diverting offenders with a SUD into residential or outpatient SUD treatment instead of incarceration [5]. In response to the success of drug courts in diverting criminal offenders with a SUD into treatment instead of jail or prison, the California judicial system implemented PSCs in 2006 to address the wider range of specific social service needs of defendants, including the complex needs of mothers with a SUD and their children [4].

This widely used multisystem SUD treatment intervention model requires active interagency communication and collaboration among organizations (i.e., those representing SUD treatment, PSC, and CW) and staff to realize the full synergistic potential of a multisystem intervention approach [6–8].

While prior research on multisystem collaborative efforts for PSC- and CW-involved mothers with a SUD has shown promise, significant barriers to treatment provision remain.

Frequently cited barriers included: (a) differing values between systems, as detailed in Table 1 [9, 10] and (b) inadequate communication and responsiveness among interorganizational professionals, which lead to challenges in providing SUD treatment.

Differing values between systems may clash leading to disagreements between stakeholders, especially if SUD treatment and family reunification goals conflict with CW and PSC system priorities, policies, and legal constraints. Poor communication may arise from: (a) challenges faced by SUD treatment

Table 1 Description of differences in stakeholder values and missions

Primary stakeholder values
Substance use disorder treatment: The SUD treatment and recovery of the patient
Child welfare: The safety and well-being of the child
Problem-solving court (drug, reentry, and family treatment courts): Reduction of criminal offending and recidivism
Primary stakeholder missions
Substance use disorder treatment system: To promote community-based SUD treatment and recovery support services for individuals and families in communities affected by SUDs. This includes improved access and reduced barriers to (i.e., family reunification, employment, and housing) while promoting effective SUD treatment and recovery support services
Child welfare system: Promoting child safety and well-being by collaborating with communities to strengthen families, keeping children at home whenever possible, and connecting them with stable homes in times of need
Problem-solving court (drug, reentry, and family treatment courts): To combine judicial supervision with SUD treatment services that are rigorously monitored and focused on recovery to reduce recidivism, improve public safety, and offender outcomes

providers in contacting CW and PSC staff regarding crucial cross-system concerns, such as child custody or legal matters related to mutual clients in residential SUD treatment, and (b) confusing or unclear communication about client expectations and responsibilities, including coordination of child visitation and court decisions impacting SUD treatment provision [6].

Prior research on multisystem collaboration for families in residential SUD treatment, concurrently involved with the criminal justice and CW systems, has been conducted primarily from the viewpoints of the PSC and CW systems [8, 11]. No known prior research has qualitatively investigated SUD treatment provider (clinician and director) viewpoints on how differing values and communication challenges between the SUD treatment, CW, and PSC systems impact women's residential SUD treatment provision [8, 12, 13]. These barriers affect the full potential of multisystem SUD treatment intervention models for PSC- and CW-involved women in residential treatment [6, 9, 14]. Given that SUD treatment providers have overall treatment responsibility and are tasked with being the primary collaborative agent between the patient and staff members from the PSC and CW systems, their viewpoints are critical.

The focus on women's residential treatment, rather than outpatient treatment, is motivated by the increased oversight, interaction, and need for collaboration among staff between systems. These factors are more pronounced in residential treatment and have significant implications to the provision of care and associated outcomes. Both residential treatment providers and their patients in residential settings face increased SUD treatment challenges when navigating multiple systems simultaneously. Unpacking these barriers could pave the way for improving multisystem alignment and enhanced treatment for this at-risk population. To better understand and characterize how differing values and communication barriers between systems affect treatment provision, this study explored two important research questions:

(1) How do differing system values between the SUD treatment, PSC, and CW systems affect women's residential SUD treatment provision for clinicians and directors?
(2) What communication barriers between the SUD treatment, PSC, and CW systems affect women's residential SUD treatment provision for clinicians and directors?

Methods

To address these aims, we employed a qualitative approach to identify and characterize the viewpoints of clinician and directors who provide residential SUD treatment to women who are concurrently involved with the PSC and CW systems. We specifically focused on the divergent values and communication challenges between systems that affect SUD treatment provision.

Participant and Program Samples

A sample of SUD treatment clinicians ($n = 18$) and directors ($n = 6$) at four women's residential SUD treatment programs (six treatment sites) in Los Angeles County was recruited. All participants were involved in the administration of SUD treatment to women who were simultaneously involved with the PSC and CW systems. Of the four SUD treatment programs spanning six sites, each site was represented by one of the six directors in the study sample. Two programs had representation from four clinicians each and two programs were represented by five clinicians each. Among these programs, three of the six sites allowed children to stay with their mothers during treatment. Uniform distribution of directors and clinicians across SUD treatment programs ensured robust treatment provider representativeness [15]. Variability in provider (i.e., clinician or director) viewpoints and residential treatment modality (i.e., whether children are allowed to stay with their mothers during treatment) was important because programmatic issues may differ among program types based on the population served.

Purposive sampling was employed to recruit treatment providers from two program modality types. Using a complete directory of 212 contracted SUD treatment programs serving adults across the continuum of care in Los Angeles County, we compiled a list that met the study's sampling strategy and participant inclusion criteria (see Fig. 1). Of the 46 adult residential treatment programs and 7 residential perinatal programs, six women's residential treatment programs met the study's inclusion criteria. Four programs agreed to participate and two declined due to staffing and coordination challenges stemming from the COVID-19 pandemic. Each SUD treatment program modality was selected based on a sampling strategy aiming

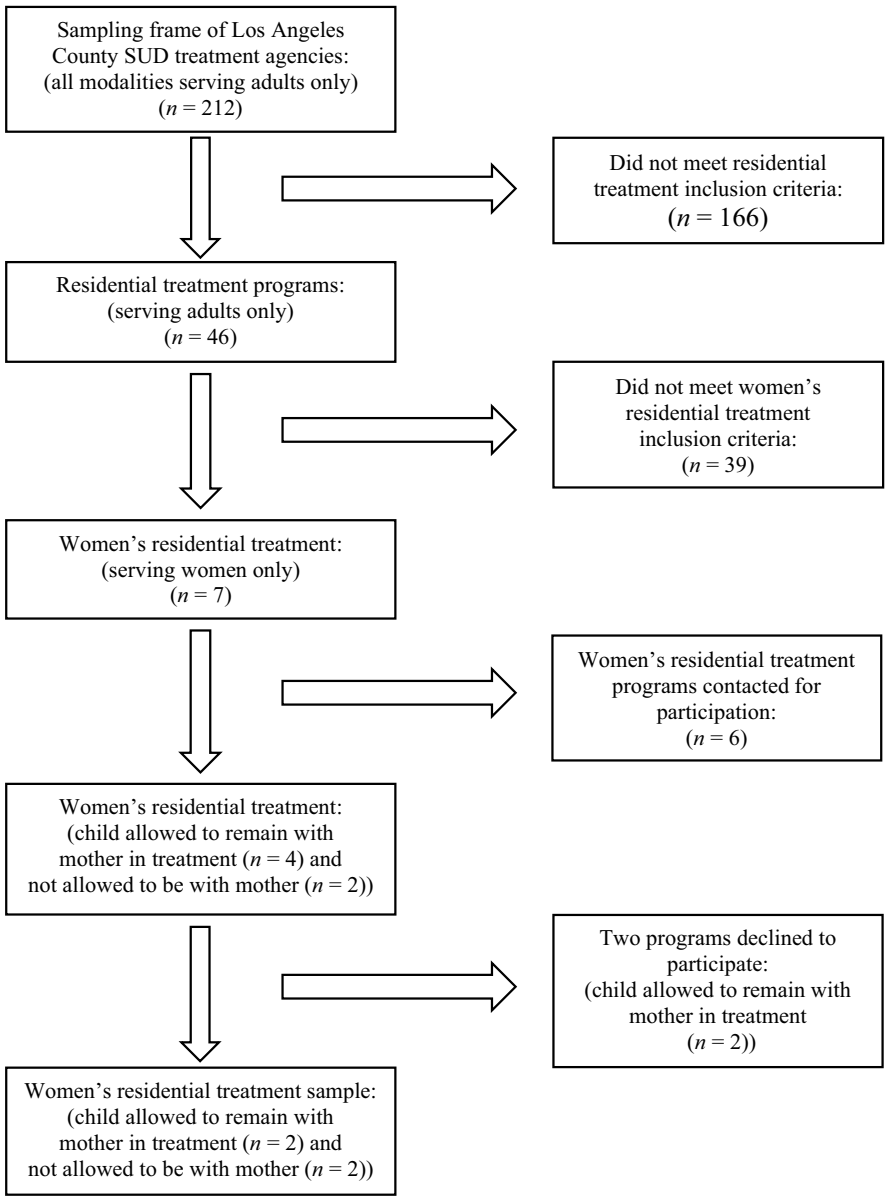

Fig. 1 Women's residential SUD treatment program selection. Source: The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (2016)

for maximum variation. Program inclusion criteria included agencies that: (a) allow children to remain with their mother during treatment or (b) those that do not. This sampling strategy was designed to ensure we obtained data and expertise specific to the treatment provision of mothers simultaneously involved with the PSC and CW systems [15]. After initial email contact, we verified that the programs treated women involved with the PSC and CW systems and then obtained informed consent to participate. All procedures were approved by the University of Southern California Institutional Review Board.

Procedures

We conducted in-depth semi-structured interviews ($n = 24$) via the Zoom platform. Using an interview guide, all participants were asked 14 open-ended questions, beginning with: "In your view, how would you characterize the differing values and priorities of the courts and child welfare agencies as it relates to SUD

treatment provision?" and "In what ways do you as a clinician [or director] communicate or collaborate with child welfare workers or court staff?" Prompts and probes were used to encourage continued narrative descriptions. These narratives delved into key factors, exploring: (a) how and what differing PSC and CW value-oriented viewpoints and practices adversely affect SUD treatment provision and (b) how cross-system communication challenges between PSC and CW staff members with SUD treatment providers adversely affect treatment provision. All interviews were audio recorded, with a mean duration of 1.15 hours. After each interview, a standard form was used to collect participant and program characteristics data from each participant. Each participant received a $100 gift card as compensation for their involvement in the study.

Data Analysis

Interviews were transcribed verbatim, deidentified, and uploaded into ATLAS.ti (version 9.1.7) qualitative software for analysis. Participant sociodemographic and SUD treatment program characteristics were described as means (standard deviations) and percentages as appropriate using Stata version 15.1. Aside from the a priori theme exploring the impact of communication barriers and organizational values on SUD treatment provision across PSC, CW, and SUD settings, the coding structure emerged organically during data analysis. This project used a thematic analysis framework involving the following stages: familiarization with the data, creating a codebook, coding of transcripts, finalization of the coding structure, and reviewing themes and subthemes [16, 17]. A consensus coding methodology was used by two trained coders, whereby open coding of qualitative data, identification of salient themes, and a taxonomy that represented thematic hierarchies (subthemes) were established [16–18]. To determine consistency among raters, an interrater reliability analysis using kappa statistics were performed for each research question and their respective themes independently. For Research Question 1, the interrater reliability was found to be $\kappa = .89$ ($p < .001$). For Research Question 2, the interrater reliability was found to be $\kappa = .92$ ($p < .001$). The salience of themes was assessed using two criteria: (a) the frequency that themes reoccurred across the interview transcripts and (b) the emphasis placed on a given theme by a participant [19].

Results

Participant Characteristics

Table 2 presents the sociodemographic characteristics for 18 clinicians and six directors. Of the 24 participants, all identified as women with a mean age of 47.3 years. Thirteen participants (54.2%) identified as Hispanic, eight (33.3%) as White non-Hispanic, and three (12.5%) as Black non-Hispanic. The mean length of time participants were employed at their respective programs was 6.3 years, with a range of 6 to 325 months (0.5 to 27.1 years). Nine participants had a master's degree, and five were either a licensed clinical social worker or licensed marriage and family therapist. Each of the four programs required patient progress reporting updates to the CW and PSC systems. Most participants (66.67%) described their cross- system collaboration with the CW and PSC systems as a "basic level of exchange," whereas three (12.50%) characterized it as "developing or implementing" and only five (20.83%) said it involved "active cross-system engagement planning."

Key Findings

We identified six main themes, suggesting differing values and communication challenges between the SUD, PSC, and CW systems adversely affect the provision of SUD treatment. For differing values, three main themes were identified: (a) unaddressed trauma and fear of mental health treatment seeking; (b) perceptions of mothers with a SUD; and (c) the Adoption and Safe Families Act (ASFA) timeline as a barrier to SUD treatment provision. For communication challenges, three themes emerged: (a) inadequate communication and responsiveness with PSC and CW systems adversely affect treatment coordination, induce patient stress, and treatment disengagement; (b) lack of PSC and CW communication regarding child visitation planning adversely affects treatment motivation and retention; and (c) competing ASFA, PSC, and CW priorities and inadequate cross-system communication adversely affects treatment planning.

Unaddressed Trauma and Fear of Mental Health Treatment Seeking

Judges within the PSC system often impose a standardized treatment approach, such as mandatory

Table 2 Participant sociodemographic and treatment provider characteristics ($n=24$)

Characteristics	Clinicians ($n=18$) *n* (%)	Directors ($n=6$) *n* (%)	Total ($n=24$) *n* (%)
Age (*M*, SD)	45.56 (11.91)	52.33 (11.34)	47.25 (11.90)
Age (range)	23–62	40–71	23–71
Sex (% female)	18 (100)	6 (100)	24 (100)
Race and ethnicity			
Hispanic	11 (61.11)	2 (33.33)	13 (54.17)
White non-Hispanic	4 (22.22)	4 (66.67)	8 (33.33)
Black non-Hispanic	3 (16.67)	0 (0.00)	3 (12.5)
Hispanic ethnicity			
Central American	1 (5.60)	1 (16.67)	2 (8.33)
Cuban	1 (5.60)	0 (0.00)	1 (4.17)
Mexican, Chicana	8 (44.44)	1 (16.67)	9 (37.50)
South American	1 (5.60)	0 (0.00)	1 (4.17)
Time at agency (*M*, SD in months)	55.72 (72.36)	136.17 (89.69)	75.83 (82.98)
Time at agency (range in months)	6–325	24–286	6–325
Degree			
SUD certification	7 (38.89)	0 (0.00)	7 (29.17)
Associate	4 (22.22)	1 (16.67)	5 (20.83)
Bachelor's	1 (5.56)	2 (33.33)	3 (12.50)
Master's	6 (33.33)	3 (50)	9 (37.50)
License type			
Licensed clinical social worker	1 (5.56)	1 (2.78)	2 (8.34)
Licensed marriage and family therapist	2 (11.11)	1 (9.71)	3 (20.82)
Other	5 (27.78)	1 (16.67)	6 (25)
None or not at this time	10 (55.56)	4 (66.67)	13 (54.16)
Child allowed to remain with parent in treatment			
Yes	7 (38.89)	3 (50)	10 (41.67)
No	11 (61.11)	3 (50)	14 (58.33)
Progress reporting updates required (%)			
CW	18 (100)	6 (100)	24 (100)
PSC	18 (100)	6 (100)	24 (100)
Probation or parole	18 (100)	6 (100)	24 (100)
Collaboration level[a]			
Basic exchange	14 (77.78)	2 (33.33)	16 (66.67)
Developing or implementing	2 (11.11)	1 (16.67)	3 (12.50)
Active cross-system engagement and planning	2 (11.11)	3 (50)	5 (20.83)

[a]Reflects participant viewpoints on the level of collaboration their SUD treatment agencies have with the PSC and CW systems and staff

participation in Narcotics Anonymous meetings and domestic violence or anger management groups. However, these one-size-fits-all requirements do not address the unique treatment needs of women with extensive trauma histories, reflecting a discrepancy in values between the SUD treatment needs of these women and the court's mandates. These divergent values can create barriers in addressing the treatment needs of mothers while also meeting PSC system requirements. One provider expressed the challenges these factors present to SUD treatment provision.

> You know, they [PSC] do have a lot of demands that may not be consistent with the clients'

> unique treatment needs. Most of these women have extensive trauma histories. You know, I've seen minute orders [PSC treatment mandates] that say, they need to do six months of treatment with a mainly one-size-fits-all approach with the same required NA [Narcotics Anonymous] meetings and groups such as domestic violence and anger management, which does not address the underlying issue of trauma the patient needs to address. (Clinician 101C)

Participants shared how patients are hesitant to address their co-occurring mental health conditions, fearing it will reflect adversely on their reunification and child custody case. Mothers with mental health disorders were described as frequently facing stigmatization by the CW and PSC systems, labeled as being unable to care for their children. This stigma often deters mothers from seeking essential co-occurring mental health treatment. One clinician stated:

> Sometimes they need mental health treatment, but they feel if they go to mental health, this is going to be a strike against them in getting their kids back. They don't know, this is how they're feeling, I'm getting what they're telling me, what they're feeling, so they stonewall. They will stonewall. They won't be open for getting a mental health evaluation. (Clinician 204C)

Perceptions of Mothers with a SUD

CW workers sometimes lack an understanding of the SUD treatment process, viewing relapses punitively or as a moral failing rather than recognizing they often occur during treatment. Their demeaning language and negative assumptions about a mother's chances of reunification with her child reveal a need for greater awareness that SUD is a medical condition and requires support rather than judgment within the CW and PSC system. The following treatment provider shared:

> Personally, I've seen, and I've heard where a social [CW] worker will say to the mother, "Well, this is not the first time that you're doing it [relapse], so why should I continue to help you when you're going to do it again and putting your child at further risk?" So, instead of encouraging [them], … the verbiage that they use with these women sometimes, they're so demeaning to them. One of the things that really upsets me [is when they say], "Well, it doesn't matter what you're doing [treatment progress in other areas] because you're still not going to get him back, the judge is not going to give you your child back." You don't know that. They don't know that; they don't know what the judge is going to say or think, but they [CW workers] do that. (Director 402D)

Relatedly, some CW workers may see return to use as evidence that an individual is incapable of change. One provider described it this way:

> There's a lot of social workers that are like, "Oh, no, sorry. You [the mother] failed." And then they go, and they recommend termination of child visitations or reunification [CW progress reports to the PSC], and that also starts as an excuse for the client, gives them an excuse just to leave [abandon treatment]. They have more fear tactics than they do empathy tactics. (Clinician 201C)

The ASFA Timeline as a Barrier to SUD Treatment Provision

The PSC and CW systems strictly follow the federal child adoption timeline requirements established by the ASFA in 1997. This timeline often conflicts with the needs of SUD family treatment and recovery. The ASFA mandates the termination of parental rights if a child has been in temporary foster care settings for 15 of 22 consecutive months [20]. Mothers most often enter residential treatment later in the ASFA timeline. For example, women who enter treatment after some period of incarceration will have already been separated from their children, often for several months. This means there is a shorter amount of time to fulfill PSC, CW, and ASFA requirements that would forestall adoption and reinstate parental child custody rights. This impending adoption and permanency hearing timeline often leads patients to become hyperfocused on meeting CW and PSC requirements to avoid losing their children, instead of engaging in their SUD treatment. One clinician shared:

> I think the way it affects treatment provision is actually—of course you have to meet the requirements of maintaining sobriety and whatnot. But what it does is, it does again impede some of the participation here, engagement here, because they're so focused on the adoption hearing or the placement hearing, or the "I got to [complete the CW group requirements]. What can I do? My child's going to get adopted out. What can I do? Of course, it's going to be on their mind all the time. So, it does impede in them being able to focus on their treatment when it is that late in the game [regarding the ASFA timeline]. (Clinician 307C)

CW staff, at times, may provide reduced attention and support to patients in residential treatment at a later stage in the ASFA timeline, often due to the impending closure of their child custody cases. This reduction in support could be attributed, in part, to high caseloads and lower expectations of treatment success for this subset of the population. This negatively affects substance use disorder treatment provision, as it becomes challenging to keep clients engaged in therapy, ultimately impacting both the patient's progress in treatment and their ongoing relationship with their child.

> I think that's where you get the disengaged social workers. We can't get information because they are at that length of time [end of the 15- to 22-month ASFA timeline] where they're shutting it down [CW and PSC child custody case]. How am I supposed to keep it open and honest with the individuals [patients] I'm working with and keep them engaged in treatment? At this point on the ASFA timeline and with a disengaged social worker, how am I supposed to move the client forward in treatment and still have this relationship with their child? Maybe not as the legal guardian but a mother that's still participating in their life. (Clinician 306C)

Inadequate communication and responsiveness with PSC and CW systems adversely affect treatment coordination, induce patient stress, and treatment disengagement.

Participants described how challenges in cross-system communication between CW workers, SUD treatment providers, and patients can impact treatment provision and patient engagement. The following quote highlights how this may lead to greater stress and ultimately disengagement with SUD treatment.

> I think it affects their [patient's] treatment engagement and our ability to provide treatment drastically, because when we or the client can't get ahold of their social workers, the communication … they don't respond and things like that, the clients tend to … they lose engagement, for one. For two, they lose hope, and it brings more stress on them because when they're trying to get information or just receive some kind of response or visit and they're not getting anything from the social worker, it stresses them out even more. (Clinician 306C)

Both clinicians and directors shared experiences regarding the challenges of communication leading to lack of coordination with PSC and CW workers on important SUD treatment planning and family reunification objectives. One director stated:

> A lot of times, we're not able to get calls back within a reasonable timeframe. It'll take us about a good three to four days for us to get a call back. I think that's a huge challenge, especially when we're working with patients that are eager to start getting those unmonitored visits or monitored visits or even calling their kids and they know there's restraining orders and that they need to get approval from the social [CW] worker or the courts. (Director 302D)

One treatment clinician described having to obtain crucial cross-system SUD treatment planning information from the patient instead of from PSC or CW staff, which would be more accurate and coordinated.

> We're at the back burner, we don't know. I mean, we find out what's going to happen next because of the patients coming back from court, conveying information to us. At least my experience, I've never had a social worker, or an attorney call me or email me to let me know what the next process is with reestablishing visitation or reunification planning. I usually follow up with my patient after court like, "Hey, how did the court go? What's expected from you?"

> Planning or updates from the DCFS [CW system] and courts would help us, and the patients prepare for whatever is expected from them in their treatment that will improve reunification with the child. (Clinician 202C)

Lack of PSC and CW communication regarding child visitation planning adversely affects treatment motivation and retention.

Child visitation planning is a powerful treatment engagement and incentive mechanism for mothers undergoing SUD treatment. However, inadequate communication and responsiveness with the CW worker can adversely affect this potent incentive and motivational treatment mechanism. The following quote describes how this manifest in the treatment planning and treatment provision process.

> That's how we lose women in our program. Like I said, it's my reward [mother's incentive and motivation]. They see it [child visitation] as a reward. Those are the main things [mother's goal]: "I'm here because I want this. I'm doing it, I know it's not going to be instant, but I'm working towards it so I will have some sort of visit, or see my kid, or have some type of contact with my son or my daughter." And it doesn't happen because of, sometimes, social workers [CW workers] don't answer. You try to contact them, and yes, their focus [patients'] goes into, "Why am I doing this if I don't get anything back?" (Clinician 403C)

Participants highlighted a major challenge in retaining patients in residential SUD treatment: mothers feeling powerless due to a lack of information about their children. This issue is exacerbated when CW workers fail to communicate or respond to inquiries regarding their children's status or court-approved visitation plans. One director emphasized how this adversely affects SUD treatment retention.

> That is absolutely so true because when they don't hear from the [CW] worker, they do start to panic. And every day, sometimes two, three times a day, they'll be in the office [of the clinician or director, asking], "Can I call my worker? Can I call my worker?" It becomes obsessive. Women often leave if they don't hear from them because they feel powerless and they feel like they are so out of control with what's going on with their kids, that if they leave and go … that maybe they could do something on the outside that they can't get done here. It's very frustrating. That's one of the biggest problems we have with retaining women and children in treatment. It's very difficult. (Director 401D)

Competing ASFA, PSC, and CW Priorities and Inadequate Cross-system Communication Adversely Affect Treatment Planning

Participants described the ASFA timeline and additional PSC group and CW requirements as a barrier to SUD treatment provision. Treatment mandates can include attending different CW and PSC groups (e.g., domestic violence, parenting, and anger management) and may supersede or be added onto the SUD treatment plan and program curriculum. Participants expressed how women who come into SUD residential treatment and have ongoing concurrent child custody cases become psychologically stressed and hyperfocused on CW and PSC case requirements to secure child visitations or forestall impending child adoption proceedings. One director described it this way:

> It's like they're in a constant state of fear and survival [regarding CW and PSC child custody status], like, "What do I got to do next? What do I got to do? What do I got to do?" So, it's perpetual stress on them and they aren't able to focus on their treatment, on themselves. Yeah, it's really hard to do the actual recovery work with them. We're not able to really do some of the heavy work with recovery that they need during the little time that we have them [residential treatment]. (Director 303D)

Participants described how mothers often become overwhelmed trying to meet the group completion requirements and expectations mandated by the PSC and CW systems, particularly when beginning residential treatment later in the ASFA timeline. These court-ordered mandates can shift the mothers' focus away from addressing the SUD and toward meeting PSC and CW requirements due to fear of losing custody of their children. These two focal points compete and may contradict the overall goal of treating the

underlying addiction. The following provider explains it this way:

> We've seen mothers who kept thinking, "Well, it doesn't matter what I'm going to do. They're going to take them [children] anyway because I've only got four months to go [before permanency or adoption proceedings]. They want me to do this, this, and this [PSC and CW-mandated group requirements in addition to SUD treatment groups], and there's no way I can get it all done." So, they want to give up. They say, "Why even try?" (Clinician 307C)

Discussion

This study explored the viewpoints of SUD treatment clinicians and directors on the multisystem challenges and barriers that emerge when providing care to women concurrently involved with the PSC and CW systems. Results show how the incongruence of values across these systems, combined with the ASFA's timeline constraints and adoption focus, negatively affects treatment provision. Additionally, treatment providers described challenges in cross-system communication, specifically delayed or inadequate responsiveness, from CW and PSC workers. This impacted cross-system coordination, particularly concerning child visitation and family reunification processes, which contributed to the barriers that treatment providers experienced in providing effective treatment.

Research Question 1

This question explores the influence of divergent system values among the SUD treatment, PSC, and CW systems on the provision of residential SUD treatment for women. It seeks to identify the challenges and barriers that differing values across systems present to clinicians and directors in providing effective treatment.

Treatment providers described that the PSC and CW systems use a standardized, one-size-fits-all approach with their cross-system clients in SUD treatment. However, consistent with prior research, a standardized approach is often inadequate for addressing the needs of women that have a co-occurring SUD, especially those with complex trauma histories [21–24]. Findings from this study are also consistent with prior research which demonstrates that mothers often avoid seeking mental health treatment due to fear and stigma. Specifically, mothers undergoing SUD treatment may hesitate to pursue mental health care due to concerns that this treatment may be viewed negatively by the CW and PSC systems and impact ongoing child custody cases or affect child visitation or child custody rulings [25–27]. These findings deepen our understanding of how fear and stigma, rooted in historically entrenched values and biases, negatively affect residential treatment for mothers concurrently navigating PSC and CW cases [24]. For example, the clinical and shared decision-making processes between the clinician and their patients are shaped by the complex interplay of differing system values of the PSC and CW systems. This influence on decision-making between the clinician and the patient underscores the need for interventions and strategies that address the fear and stigma associated with child custody loss and mental health treatment seeking.

Participants described that they often observe limited understanding from the PSC and CW systems and staff on the struggles faced by mothers during SUD treatment. This limited understanding is linked with entrenched system values and biases, as some staff members may perceive a relapse as a moral failing [28, 29]. For example, if a mother undergoing SUD treatment experiences a relapse, a limited understanding of SUD as a diagnosed medical condition, along with entrenched value-oriented biases, might lead some staff to perceive the relapse as a personal failure. This perception can impact their responsiveness and supportiveness during the treatment process. These findings align with observations from previous research whereby differing values often lead to punitive CW and PSC decision-making on important child visitation and reunification planning [30].

Results from this research highlight a gap in knowledge or training among the CW and PSC systems regarding common trajectories and symptoms of a SUD, including its chronic nature as a medical condition characterized by relapses [8, 29, 31, 32]. This observation may reflect the notion of deep-rooted beliefs and biases within the criminal justice and CW systems which may require additional training. Findings from this study suggest that such training should

be integrated with educational content that recognizes SUD as a medical condition, emphasizing that punitive decision-making is counterproductive to mothers' treatment and recovery, as well as their family dynamics. By shifting the multisystem intervention focus to the evidence-based understanding that a SUD is a medical condition, this training can contribute to more effective treatment and family reunification outcomes.

Consistent with prior research, this study showed that the ASFA's stringent timelines (adoption within 15 to 22 months) can indirectly impact parental SUD treatment [6, 10, 33]. This study highlights specific ways in which the timeline: (a) increases pressure on treatment providers and mothers to meet ASFA timeline and CW and PSC group requirements to forestall loss of child custody and (b) heightens parental stress and anxiety leading to a higher likelihood of treatment dropout or return to use. Consequently, mothers may prioritize ASFA, CW, and PSC requirements over SUD treatment, which may not be in the best interest of their treatment and family reunification goals. In doing so, the ASFA, PSC, and CW systems inadvertently compete with SUD treatment, prioritizing the ASFA timeline mandates at the expense of the family's SUD treatment needs.

Research Question 2

This question explores the communication challenges and barriers that exist between the SUD treatment, PSC, and CW systems that affect the provision of residential SUD treatment for women. It seeks to identify specific challenges in communication that clinicians and directors encounter with these systems and their staff, highlighting the complexities of delivering effective treatment in an integrated multisystem treatment context. This study also reinforces previous research underscoring the ways in which inadequate communication between CW workers and SUD treatment providers may impact SUD treatment provision [6, 33, 34].

Communication challenges lead to delays in cross-system child visitation coordination which can be felt as punitive, induce patient stress, and undermine SUD treatment motivation [35–37]. Findings indicate that enhanced communication and improved responsiveness among systems, their staff, and the patients may improve treatment provision, engagement, and motivation while reducing psychological stress and increasing retention in treatment [38, 39].

Relatedly, as the ASFA timeline approaches the 15–22-month mark, respondents experienced disengagement, or reduced supportiveness, on the part of CW workers when the threat of child custody loss intensifies and CW cases approach closure. This period of time can be particularly complicated for remaining engaged in treatment as mothers navigate the impending child custody loss and ongoing SUD treatment participation. Furthermore, it becomes challenging for clinicians to determine how best to move clients forward in treatment while maintaining a connection between the mother and child, even if the parent may no longer serve as the legal guardian. These results align with prior research, underscoring the importance of active communication with CW workers and the courts in supporting the clinical treatment of mothers and their children throughout the ASFA timeline [6, 10, 40].

Mothers in residential treatment with concurrent PSC and CW cases typically attend periodic court hearings that assess CW and criminal justice case dispositions, review treatment progress, and make rulings regarding child custody and criminal justice cases. Results of this research suggest that insufficient communication and coordination with PSCs result in treatment providers frequently relying on patients for information regarding crucial court dispositions and rulings. This can lead to clinicians receiving incomplete or inaccurate information, which can adversely affect implementation of an effective, unified, and aligned multisystem treatment plan for patients and their families [6]. It can also result in confusion and frustration for patients. They may feel overwhelmed and burdened by the responsibility of providing information, which they might not fully understand, to their CW workers and SUD treatment providers.

Implications

This study highlighted significant policy and practice implications. It underscores the need to better align the differing values between the CW, PSC, and SUD treatment systems that adversely affect treatment for mothers and their families. One specific implication is to improve SUD training among the CW and PSC workforce. Establishing cross-system training policies and practices that align values and reduce the

stigma associated with SUD as a chronic health disorder is crucial. Importantly, training should underscore that return to use is a symptom of a chronic health disorder and should not be viewed punitively among PSC and CW decision-makers [28, 29]. Such initiatives will pave the way for a supportive and nonjudgmental treatment environment, thereby promoting the engagement and retention of mothers in residential treatment, as well as fostering mental health treatment-seeking behaviors. For example, the Family Treatment Court Best Practice Standards are a set of guidelines that represent the accumulated knowledge of 30 years of practice experience and scholarly research [41]. It outlines the criteria for ongoing interdisciplinary training, focusing on areas like integrating SUD and mental health treatment, aligning of cross-system values, and fostering active communication across systems.

Reevaluating and adjusting the ASFA timeline to better align with the long-term treatment needs of parents and families with a SUD is long overdue. It is important to engage policymakers and cross-system stakeholders in discussions about adding flexibility to the ASFA timeline that balances child protection priorities with the equally essential concerns of women's treatment and family reunification goals. Introducing co-developed strategies could include enabling greater flexibility for SUD treatment providers, CW workers, and PSC systems in managing ASFA timeline constraints while supporting the long-term treatment needs of parents and families. This would pave the way for enhanced multisystem collaboration and a more robust residential SUD treatment environment for providers and their patients.

Actively improving communication and coordination between systems could enhance treatment motivation by linking it closely with family reunification planning. This could also increase patient motivation and reduce the likelihood of patients prematurely leaving treatment. Additionally, improved coordination of child visitation is also a way to increase patient motivation and foster active engagement with each system. For example, leading CW, PSC, and SUD treatment organizations nationwide champion policies and best practices that involve active cross-system communication and collaboration. This is facilitated through interagency meetings that address patient challenges and progress while aligning family-centered treatment approaches [6, 10, 40].

Insufficient communication and coordination across systems, resulting in confusion for both providers and patients, may require an additional position within this multisystem context. For example, recommendations might include the creation of a cross-system liaison or cross-system case manager role to facilitate communication and coordination between the three systems and patient. This individual would be tasked with overseeing and streamlining communication across the PSC, CW, and treatment systems for individual cases, ensuring that information is both accurate and current [42, 43]. This ensures clinicians, directors, and their patients have a clearer understanding of any changes in client expectations and requirements set forth by the PSC and CW systems. Additionally, a cross-system liaison would reduce the burden of managing necessary communication and coordination between systems. This role is particularly important in relation to the patient's continually changing child custody, legal status, and treatment progress during their residential care.

The evolution of PSC underscores the pivotal role of multisystem treatment models that address the complex treatment needs of women and their families. The uptake, practice, and full integration of the PSC multisystem intervention model across states and counties remains unclear due to several barriers and challenges to implementation including: (a) inadequate resources, (b) lack of coordination, (c) poor communication between staffs and agencies, and (d) different value-oriented and philosophical approaches [41, 44]. In addition, not all PSC (e.g., reentry, drug, and family treatment courts) are designed, staffed, or trained in the best practices of this important integrated multisystem intervention. Further, despite the acknowledged benefits of a multisystem intervention approach, few PSC programs are family centered or maximize the full scope of an integrated systems approach to meet the needs of both the patient and their family [8].

The Family First Prevention Services Act of 2018 offers states and counties additional federal funding to support children and families through substance use and mental health treatment, aiming to prevent foster care placements [45]. This legislation highlights a funding framework for child welfare and SUD treatment providers to develop robust systems that prioritize the recovery and well-being of both children and their families. Coupled with

the Family Treatment Court Best Practice Standards for multisystem PSC implementation, there are funding and evidence-based guidelines available to support the alignment of differing intersystem values, as well as to enhance cross-system training and communication protocols [30].

This study's insights from clinicians and directors provide an insider's view, underscoring barriers in providing residential SUD treatment to mothers concurrently involved with the CW and PSC systems. These findings emphasize the pressing need for aligning differing system values, enhancing communication, and policy reforms to effectively address these challenges and improve treatment outcomes for this vulnerable population.

Limitations

As with all research, this study has limitations. First, the sample was nonrandom and limited to a single urban county in California with a large patient caseload. Additionally, we used a purposive sample of clinicians and directors from two different residential treatment modalities. This approach limits the transferability of findings to other treatment settings such as outpatient treatment or telehealth. Second, the study relied on self-reported viewpoints from residential SUD treatment providers without triangulating it with perspectives from patients or CW and PSC staff. Third, given the research was conducted in a large urban city, its findings may not be transferable to rural settings, which often have limited SUD treatment services or fewer multisystem treatment interventions. Fourth, the study's analysis inherently reflects the viewpoints and potential bias of SUD treatment providers within the PSC and CW context. Additionally, findings from this research should be regarded as preliminary evidence suggesting that divergent intersystem values, further exacerbated by inadequate cross-system communication, negatively impact the provision of women's SUD treatment. Nonetheless, capturing the viewpoints of treatment providers on existing barriers in parental SUD treatment can inform the development of strategies to address these concerns.

Conclusions

This study highlights significant barriers faced by clinicians and directors in providing residential SUD treatment for mothers concurrently involved in the CW and PSC systems. Findings underscored the need for improved communication and collaboration across systems and the importance of aligning or at least better understanding, system values, and priorities to address the complex needs of women and their families. The implications of this research emphasize the necessity for enhanced training and policy modifications to achieve these goals, as well as reevaluating the ASFA timeline to better align with the long-term residential treatment needs of mothers. Future research should explore the viewpoints of patients, as well as CW and CJ staff, to triangulate findings. Such efforts will deepen our understanding of the challenges impacting these multisystem treatment interventions that affect women's SUD treatment success.

Acknowledgements This research was supported by a grant from the California State University Office of the Chancellor and the Chancellor's Doctoral Incentive Program. The ideas and opinions expressed herein are those of the authors, and endorsement of those opinions by funders is not intended nor inferred. The authors are grateful to the SUD treatment directors and clinicians from the four study programs who participated in this research.

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Data Availability The data supporting the findings of this study are available from the corresponding author, D.R., upon reasonable request. The data are not publicly available due to the sensitivity of interview transcripts containing information that could compromise research participant privacy and their relatioships with other agencies.

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