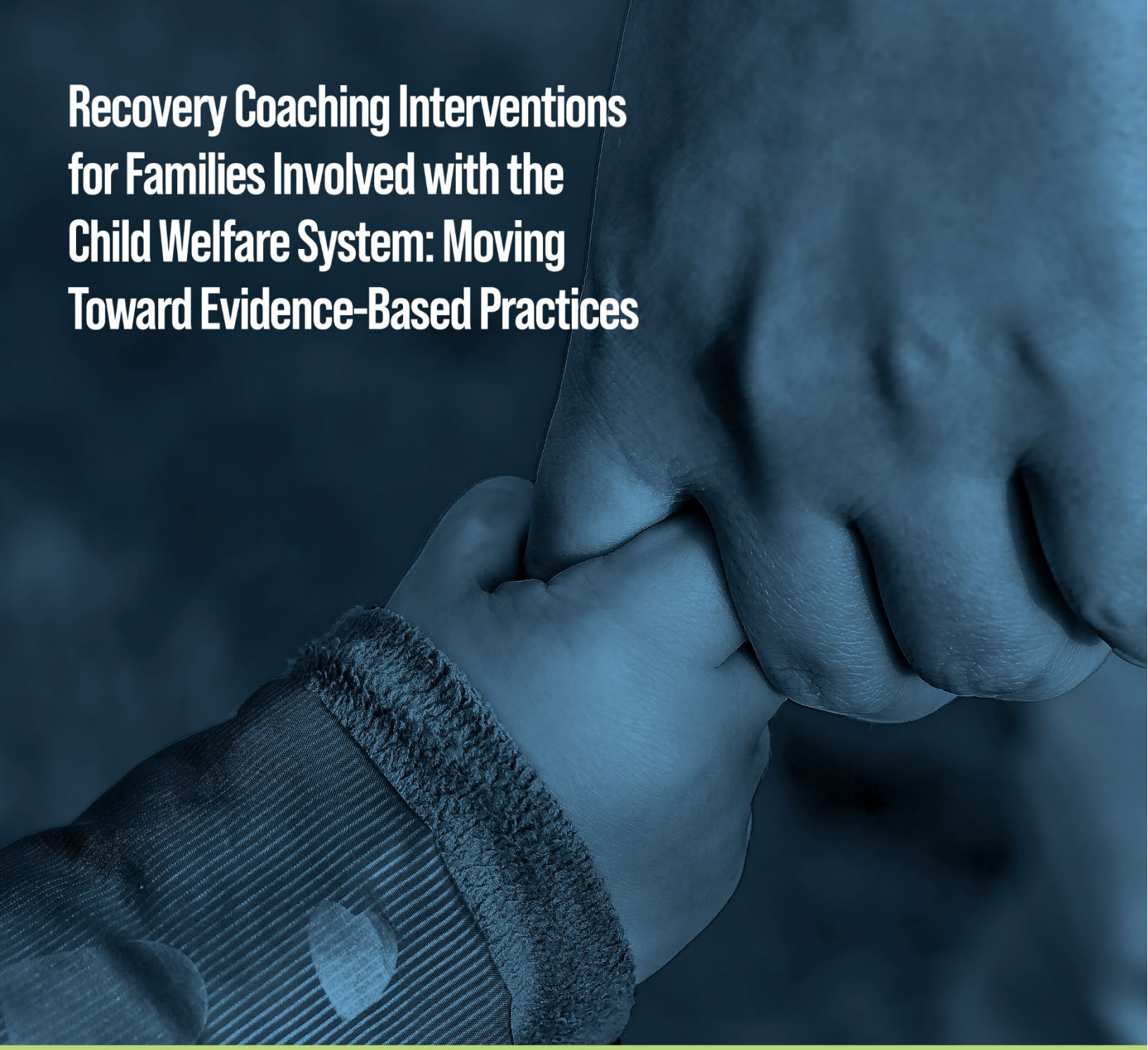
Recovery Coaching Interventions for Families Involved with the Child Welfare System: Moving Toward Evidence-Based Practices



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R3

Expanding Evidence on Replicable Recovery and Reunification Interventions for Families

RECOVERY COACHING INTERVENTIONS FOR FAMILIES INVOLVED WITH THE CHILD WELFARE SYSTEM: MOVING TOWARD EVIDENCE-BASED PRACTICES

OPRE Report 2021-53

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Overview

This report – part of the first phase of the *Expanding Evidence on Replicable Recovery and Reunification Interventions for Families (R3)* project – describes features of select interventions that use recovery coaches in the child welfare system, characterizes their current stage of readiness for replication and further evaluation, and informs a long-term effort by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) to build high-quality evidence on recovery coaching interventions for families involved with the child welfare system. Section 8082 of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. Law 115-271) called for HHS to replicate a promising family recovery and reunification intervention that uses recovery coaches, and conduct a three-part evaluation: a pilot study, impact study, and implementation study. As a first step, the R3 research team conducted a systematic scan and identified nine eligible interventions to consider for replication and further evaluation.

Using a framework specifically designed by the R3 research team to assess the readiness of these interventions for replication and further rigorous evaluation, the assessment found that readiness varied widely among the interventions. No intervention was strong in all readiness areas, and none was universally weak. As a whole, this group of interventions had a clearly stated theoretical base and were highly applicable to the child welfare services environment. Their readiness was mixed in terms of potential for replication and scaling up. The interventions were least ready in terms of the strength of available evaluation evidence. Overall, the field of recovery coaching in child welfare is in the beginning stages of developing a high-quality evidence base with opportunity for the field to continue building knowledge.

Purpose

Parental substance misuse is one of the most common reasons families become involved in the child welfare system. Though successful completion of substance use disorder (SUD) treatment is but one of many factors considered in court decisions to reunify children with their parents, those who engage in and complete treatment are more likely to reunify with their children. Recovery coaching—more common in the SUD treatment and recovery support services field—emerged in select child welfare systems in the late 1990s and grew throughout the first decade of the 2000s. In the child welfare system, recovery coaches work with parents with SUD who either have had or are at risk of having a child removed from the home. Coaches aim to increase access to and engagement in treatment and other services to support parents' recovery, coordinate with child welfare agency staff, and ensure treatment and recovery progress is incorporated into plans to either maintain children with their families of origin or place them with other permanent families.

It has become an increasingly common strategy intended to help improve access to and engagement in treatment and recovery support services with the ultimate goal of parental recovery and family reunification when possible. Yet, we are just beginning to understand the effectiveness of this strategy through evaluation.

With the field in the early stages of building evidence about this strategy, ACF launched a long-term effort in 2019 to learn more about effective family recovery and reunification interventions that use recovery coaches and help inform policymakers' and practitioners' decisions about how to best spend limited resources. This report shares the results of the initial step in ACF's overall effort to move recovery coaching interventions in child welfare to the next level of evidence.

Key Findings and Highlights

Readiness Factors that Support Implementation

Of the nine recovery coaching interventions assessed by the R3 research team, Oregon Parent Mentor Program and START received the highest ratings for potential replicability and scalability.

- Both interventions currently operate in multiple jurisdictions, have some technical assistance and training infrastructure, and have well-documented procedures and detailed manuals.

Most interventions did not have a comprehensive manual or a cohesive set of materials for implementing the intervention.

- The recovery coaching interventions that lacked strong documentation may be theoretically sound and worth further development and evaluation. However, among these nine interventions, those that were well defined and had a foundational set of materials and other implementation supports were better positioned for the next stage of evidence building.

Most of the nine recovery coaching interventions had clearly articulated logic models or theories of change, and demonstrated high applicability to child welfare.

- Six of the interventions demonstrated high applicability to child welfare, primarily because they were designed with that system in mind.

  Three interventions, Massachusetts FRESH Start, Recovery Specialist Volunteer Program (RSVP), and Summit Co. STARS, were no longer operating at the time of this report.

Readiness Factors Related to the Strength of the Available Evidence

Together with the potential for replication and scaling, the strength of the available evidence is an important consideration in determining readiness. Strength of the available evidence is based on both the quality of studies' design/analysis and the direction of findings.

There was limited evidence on which to assess this factor. Thus, most of the recovery coaching interventions had "low" readiness in terms of the quality and findings of prior evaluations.

Three interventions showed some promise based on the strength of their available evidence:

- The Family Recovery and Reunification Program was the only one of the nine interventions with prior favorable findings from an experimental study in any of the primary outcome domains (i.e., permanency, child safety, parental substance use, and SUD treatment compliance).
- Oregon Parent Mentor Program was the only intervention besides Family Recovery and Reunification Program to be previously evaluated with an experimental study design. That evaluation suggested neutral findings (i.e., no statistically significant effect on primary outcomes) from a small sample that did not rule out potentially larger effects. We consider these results to be inconclusive due to the limitations of the design.
- The only other intervention supported by a mix of neutral and favorable findings (and no unfavorable findings) was START, which used a quasi-experimental study design.

The other six interventions were limited by evaluations with small samples, unclear matching procedures and non-equivalent study groups, and evaluation designs not intended to isolate the effect of the recovery coaching component from that of other service components. These challenges made it difficult to draw conclusions about the strength of the evidence on those interventions.

Methods

The research team conducted a systematic scan for recovery coaching interventions and assessed the identified interventions on their readiness for future replication and evaluation. The scan identified 1,594 potentially eligible interventions. Of those, we confirmed that nine interventions met eligibility criteria to be considered for replication and evaluation. Using a pre-specified rubric, we assessed the readiness of these nine interventions on six factors: the clarity of its underlying logic, potential for replication, potential for scaling up, applicability to the child welfare services environment, the quality of prior evaluation design and analysis, and the direction of prior evaluation findings.

1. Introduction

Parental substance use disorder (SUD) is one of the most common reasons families become involved in the child welfare system, driven in part by the opioid epidemic and ongoing misuse of alcohol and other drugs (Radel et al., 2018; U.S. Department of Health and Human Services (HHS), 2019). Families with children in out-of-home care due to SUD[1] are among the least likely to reunify, in part due to the conflicting timelines of the child welfare system and the SUD treatment and recovery process (see "Reconciling the 'Two Clocks'" at right). These families are also at higher risk for subsequent child maltreatment reports and re-entry into foster care than are families involved in the child welfare system but not affected by SUD (Jones & LaLiberte, 2017; Mowbray et al., 2017).

Reconciling the "Two Clocks"

Part of the challenge for family reunification efforts in the child welfare system lies in the discordant timelines and differing expectations of this system versus the SUD treatment and recovery process (Ryan et al., 2006; Ryan et al., 2017; HHS, 2016):

- The **child welfare system**'s primary concern is the child, and it is required by law to establish permanency for the child as quickly as possible—be it through reunification with parents or through permanent placement with a relative, guardian, or adoptive caretaker.
- In contrast, SUD treatment agencies focus primarily on the parent's **treatment and recovery**, which they consider a long-term, potentially cyclical process.

Though successful completion of SUD treatment is but one of many factors considered in court decisions to reunify children with their parents, studies show that those who *do* complete treatment are more likely to reunify (Green, Rockhill, & Furrer, 2007; Smith, 2003; Choi, Huang, & Ryan, 2012). Yet many traditional SUD treatment programs are limited in their ability to identify and address the factors that help parents access and stay engaged in treatment and other services in the community (Eddie et al., 2019). Further, child welfare staff may lack the specialized knowledge needed to help parents access and engage in SUD treatment and recovery, and they may not have the capacity to give it their full attention (Radel et al., 2018).

Recovery coaching—more common in the SUD treatment and recovery field—emerged in select child welfare systems in the late 1990s to address these gaps and support parents working toward recovery and ultimately reunification with their children when possible. In the child welfare system, recovery coaches work with parents with SUD who either have had or are at risk of having a child removed from the home. Coaches aim to increase access to and engagement in treatment and other services to support parents' recovery, coordinate with child welfare agency staff, and ensure treatment and recovery progress is incorporated into

[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines **SUD** as the recurrent use of alcohol and/or other drugs causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

plans to either maintain children with their families of origin or place them with other permanent families.

Recovery coaching in child welfare grew throughout the first decade of the 2000s, but we are just beginning to understand its effectiveness through evaluation. An intervention seeking the designation of "evidence-based" typically progresses through multiple stages of development and evaluation to build evidence of its effectiveness before it is ready for broad dissemination and scale up. Exhibit 1.1 represents the general stages of evidence-building based on several different models (Permanency Innovations Initiative Evaluation Team, 2015; Framework Workgroup, 2014; Epstein & Klerman, 2012). Currently, most recovery coaching interventions in child welfare are in the first three stages of evidence building depicted below, with few having completed an initial evaluation of any kind (Stage 3).

Exhibit 1.1: Stages of Evidence-Building

A key step in moving the field of recovery coaching in child welfare toward evidence-based practice is to understand the range of recovery coaching interventions that have been implemented and evaluated, identify interventions that show promise for improving outcomes, and gauge their promise ("readiness") for Stage 4: replication and further evaluation. Policymakers, researchers, and practitioners should consider multiple factors when determining an intervention's readiness for the next stage of evidence building. Without a foundation to support strong implementation, Stage 4 is not likely to provide useful information about effectiveness (Epstein & Klerman, 2012). Readiness thus includes factors such as a well-defined set of goals, practices, and fidelity standards; sound theories about how and why the interventions should work; and systems for training and supervising staff, tracking activities, and measuring outcomes (Epstein & Klerman, 2012).

This report—part of the first phase of the *Expanding Evidence on Replicable Recovery and Reunification Interventions for Families* (R3) project—has two purposes for two audiences:

- First, for the interested public, it describes features of select recovery coaching interventions in child welfare and characterizes their current stage of development.

- Second, it is designed to inform a long-term effort by ACF to replicate and rigorously evaluate promising recovery coaching interventions in child welfare to inform future potential efforts to scale effective interventions.

The report comprises:

1) **Background**—the emergence of recovery coaching in child welfare and the range of characteristics that distinguish these interventions (Section 2, Recovery Coaching in Child Welfare);

2) **Methodological approach**—a framework for understanding the readiness of recovery coaching interventions for replication and further evaluation from multiple perspectives, including evidence of effectiveness from prior evaluations (Section 3, Identifying and Assessing Recovery Coaching Interventions);

3) **Findings**—a summary of the readiness of nine recovery coaching interventions for replication and further evaluation (Section 4, Readiness for Replication and Evaluation); and

4) **Conclusions**—next steps for continued learning about recovery coaching approaches in child welfare and about the opportunity to move the field toward evidence-based practice (Section 5, Conclusion).

About the Expanding Evidence on Replicable Recovery and Reunification Interventions for Families (R3) Project

The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. Law 115-271) authorized the U.S. Department of Health and Human Services to replicate and evaluate an intervention using recovery coaches for families engaged in the child welfare system due to parental SUD. The intervention shall adhere closely to elements that have shown promise in improving parental recovery outcomes, increasing reunification, and protecting children.

ACF's Children's Bureau and Office of Planning, Research, and Evaluation are sponsoring the first phase of the **Expanding Evidence on Replicable Recovery and Reunification Interventions for Families (R3)** project, a feasibility study that will lay the foundation for ACF to conduct the evaluation of selected recovery coaching interventions. The R3 research team is led by Abt Associates in partnership with the University of Michigan and Faces & Voices of Recovery.

2. Recovery Coaching in Child Welfare

"Recovery Coach" Terminology

The "recovery coach" role in child welfare takes a wide variety of job titles such as peer support specialist, peer recovery coach, parent mentor, family mentor, recovery coach peer mentor, and recovery specialist, among others.

In this report, we use **recovery coach** as a generic term referring to coaches whether they have lived experience with SUD or not. Of them, we use **"peer"** recovery coach or recovery coach **"with lived experience"** to specifically refer to those who themselves are in recovery from SUD. They may or may not also have lived experience with the child welfare system.

The literature sometimes juxtaposes the support provided by a peer recovery coach versus a **"recovery specialist"** with specialized training. However, someone with lived experience of SUD could also have specialized training, and a recovery specialist could have lived experience that makes them able to empathize and identify with their client's experience.

We use the term *recovery coach* to encompass the full range of qualifications.

Recovery coaches in the child welfare system provide a variety of supports to families facing SUD, across different types of child welfare interventions. There is no universal definition for the role, and recovery coaches perform a wide variety of functions depending on the service environments in which they are embedded. As the child welfare field has adopted recovery coaching as a strategy, the term "recovery coach" has broadened beyond the peer recovery coach role common in the SUD treatment and recovery support field to include the recovery specialist role (see box at left).

This section provides a brief background on the origins of recovery coaching in child welfare from two service delivery traditions: the SUD treatment and recovery field's *peer recovery coaching* model, and the mental health services field's *intensive case management* model. It then describes the range of functions recovery coaches might play in child welfare and some distinguishing features of recovery coaching interventions.

Recovery coaches in the SUD treatment and recovery field grew in the mid-1990s out of two longstanding support roles: "patient navigators" who help people with chronic medical conditions navigate the health care system, and "mutual aid" support groups that provide informal recovery monitoring and support using volunteers in recovery from SUD. In this way, recovery coaches filled a critical need for structured support services to engage people in treatment and recovery and connect them to resources with the potential to support their long-term recovery and well-being (Eddie et al., 2019).[2]

Historically, recovery coaching in the SUD treatment and recovery field required the coach to have lived experience with SUD (a "peer" recovery coach). **Peer recovery coaching** is based on the premise that people must be empowered to choose their own pathway to recovery without judgment. A

[2] SAMHSA defines **recovery** as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." Recovery is not an end state, and it does not mean a person no longer has a SUD.

further premise is that the coach's experiential knowledge (lived experience) and expertise (training) in recovery promotes credibility and trust with their clients and may enhance their effectiveness in providing recovery support.

Generally, peer recovery coaches in the SUD treatment and recovery field use their lived experience and position outside of the treatment environment to establish strong relationships with recovering clients based on trust, mutual understanding, and respect; coach clients on sober living skills and serve as a model and inspiration for recovery; connect clients to resources to further their chosen recovery path; help clients navigate treatment and systems of care; and assist with goal setting and planning (HHS, 2015).

The **intensive case management model** (ICM) was another service delivery tradition that influenced the emergence of recovery coaching in child welfare. ICM is a longstanding high-intensity approach to care for people with severe behavioral health conditions living in the community. ICM features multi-disciplinary teams of clinicians, nurse practitioners, housing specialists, and others that provide direct services and persistent outreach to an individual in home or community settings. An ICM team has a small caseload (fewer than 20) and is available around the clock (Dieterich et al., 2017). Typically, ICM team members are not required to have lived experience.

2.1. The Emergence of Recovery Coaching Interventions in Child Welfare

While recovery coaching was taking hold in the SUD treatment and recovery field, two interventions with distinct approaches to recovery coaching began in child welfare. These two interventions adapted the recovery coach role for a child welfare services environment, taking into account both the complex needs of parents with SUD and the requirements placed on these parents by the multiple systems with which they were involved. One intervention required recovery coaches to have lived experience (a peer recovery coach) and the other drew more heavily from the ICM model. These two approaches are consistent with the "peer" and "recovery specialist" models detailed by the National Center on Substance Abuse and Child Welfare (2019).

- ***Sobriety Treatment and Recovery Teams (START).*** This intervention began as part of a larger project funded by the Annie E. Casey Foundation in 1997 in Cleveland, Ohio. A systems-reform effort, START was designed to address the disjointed and mismatched SUD and child welfare systems affecting these families and to integrate direct services for parents with SUD. START introduced a team approach that paired child welfare caseworkers with trained peer recovery coaches called "family mentors"—parents who had lived experience with both SUD and the child welfare system. Each caseworker–family mentor pair shared a small caseload and conducted home visits together, with the family mentors providing peer recovery support services adapted for child welfare–

involved families. By 2007, the Kentucky Department of Community Based Services adopted the START model and began refining it for replication in several counties.

- ***Family Recovery and Reunification Program.*** In 2000, the Illinois Department of Children and Family Services started a recovery coaching intervention to address the high numbers of parents with SUD in its child welfare system and the associated low reunification rates. The Family Recovery and Reunification Program drew on the ICM model and research evidence that suggested one-on-one support from a counselor can improve access to and engagement in treatment (Ryan et al., 2006). Clinically trained recovery coaches, who were not required to have lived experience with SUD, provided specialized case management focused on removing barriers to accessing and completing SUD treatment for parents whose children had been removed from the home. "Clinically trained" means that these recovery coaches have credentials in social work, substance use counseling, or a related field. The addition of recovery coaches was also intended to allow the child welfare caseworker more time to focus on other areas of case management for the family.

Since then, recovery coaches (particularly from the peer recovery coach tradition) have become more common within the child welfare system (Huebner et al., 2018). Despite growing interest, to date there is limited evidence about the effectiveness of recovery coaching in promoting SUD recovery or improving child welfare outcomes. In the SUD treatment and recovery field, two recent reviews of peer recovery coaching evaluations concluded that the evidence, though mixed and with many neutral findings, does not rule out the potential for positive effects on substance use and treatment outcomes (Bassuk et al., 2016; Eddie et al., 2019). However, both reviews noted that the quality of the evaluation designs that produced this evidence is generally poor, and most studies lack clarity on the recovery coach role and documentation of the intervention components.

In the child welfare field, one evaluation of the Family Recovery and Reunification Program used an experimental design and yielded promising results for permanency (Ryan et al., 2006; Ryan et al., 2016). But the majority of the evaluations of recovery coaching in child welfare lack this rigorous approach. The absence of reliable evidence coupled with the urgency of the problem leaves child welfare practitioners with little to guide their decisions about whether and how to implement recovery coaching interventions.

2.2. The Functions of Recovery Coaches in Child Welfare

In the child welfare system, recovery coaches typically work with parents with SUD who either have had or are at risk of having a child removed from the home. Coaches work with child welfare agency staff to coordinate services across the child welfare and SUD treatment systems; and they ensure treatment progress is incorporated into plans to either maintain

children with their families of origin or place them with other permanent families ("permanency planning").

Exhibit 2.1 shows the range of functions that recovery coaches can perform in child welfare. These functions are not present in all recovery coach interventions, and interventions may vary in how each function is carried out. They may conduct joint home visits with the child welfare caseworker, remove barriers to accessing and engaging in treatment, advocate for the parent, help the parent navigate the child welfare system, testify in permanency hearings, and coordinate between child welfare and SUD treatment services to promote successful outcomes (e.g., treatment, recovery, and family permanency or reunification).

Exhibit 2.1: Range of Recovery Coach Functions in Child Welfare*

Function	Description
Supporting access to and retention in treatment	• Helps parent connect with an appropriate SUD treatment provider. • Accompanies or assists parent with transportation to initial treatment sessions. • Motivates parent to stay engaged with treatment over time.
Case management / reducing barriers to treatment and recovery	• Performs case management duties related to engaging with SUD treatment and recovery, such as removing barriers to accessing and staying in treatment (e.g., transportation, childcare, and housing). • Does not replace a child welfare agency caseworker. Instead, coordinates with and complements the case management duties of the caseworker.
Monitoring, drug testing, or reporting to child welfare or court	• Monitors parent's progress in SUD treatment and community recovery activities. • May conduct drug testing and monitor results. • Provides written progress reports to child welfare or the court on the parent's progress. • Provides input on court filings and reports; attends and testifies in court; provides input on child safety plan.
Conducting home visits	• Holds regular meetings with parent in the home to provide support and case management. • May make home visits together with the child welfare caseworker.
Goal setting and service planning	• Identifies and prioritizes goals with parent and makes plan for achieving them. Includes goals of child welfare and treatment provider; may or may not include parent's own goals. • Uses motivational interviewing to facilitate a goal-setting discussion; helps parent identify and take ownership of goals.
Building "recovery capital" (the internal and external resources that can be used to support recovery)	• Helps build parent's personal resources such as problem-solving skills, self-awareness, self-efficacy, hopefulness, and interpersonal skills. • Coaches on or models sober life skills and/or sober parenting. • Facilitates connections to recovery communities and other social supports.
Navigating systems	• Helps families understand, coordinate, and organize the requirements of multiple systems. • Coordinates between the child welfare, courts, and SUD treatment systems on behalf of the parent/family.

Function	Description
Attending collaborative meetings	• Attends family decision-making meetings and other cross-system meetings with child welfare, treatment providers, and courts. • Helps staff understand SUD treatment and recovery process. • Advocates for parent and provides support during meetings.

* These functions are not present in all recovery coaching interventions, and interventions may vary in how a function is carried out.

The specific functions taken on by a recovery coach tend to be driven by the type of recovery coaching intervention in which they are embedded. In the following section, we outline some distinguishing features of recovery coaching interventions in child welfare.

2.3. Distinguishing Features of Recovery Coaching Interventions

Recovery coaching interventions in child welfare have various structures, service strategies, and approaches to cross-system collaboration, offering policymakers and practitioners a variety of choices in selecting an approach that will best fit their community contexts.

2.3.1 Intervention Structure

Supervising organization. A variety of organizations hire, train, and supervise recovery coaches. One approach is for the child welfare agency itself to supervise and embed the recovery coaches in its offices. Another common approach is for the child welfare agency or other entity leading the program to contract with an independent organization for recovery coaching services. These partners can be a range of organizations including treatment and recovery support service providers, family and children's services providers, and legal services providers.

Setting. Some recovery coaching interventions are embedded in a family treatment court or traditional court, making recovery coaching part of the core set of services it provides.

Staffing. Interventions vary on the lived experience, education, and certification needed to be a recovery coach. Education requirements range from a high school diploma or equivalent to a four-year postsecondary degree. Interventions with fewer educational requirements tend to use a peer recovery coaching model, which prioritizes lived experience with recovery from SUD and sometimes also with the child welfare system. Such peer recovery coaching interventions typically require recovery coaches to receive formal training and (if available) to complete state peer recovery coach certification requirements. Other, less common recovery coaching interventions do not require lived experience but require a two- or four-year postsecondary degree, alcohol or other drug counselor or specialist certification, professional experience in human services, or a combination of the three. These interventions tend to use an intensive case management approach. Criminal background checks are typically required by organizations that hire recovery coaches but having a criminal history does not necessarily disqualify an individual from the recovery coach role.

2.3.2 Service Strategy

Client focus. Some recovery coaching interventions are family centered, an approach that recognizes that treatment and recovery take place in the context of the family and parent-child relationships, and thus work with all family members. For example, these interventions may have a parenting skills component, assess the needs of children and develop service plans for them, or include family members in collaborative meetings. Parent-focused interventions attend primarily to the parents' SUD treatment and recovery process, prioritizing parents' outcomes as a key step toward reunification.

Compliance vs. self-directed approach. Recovery coaching interventions vary in how they encourage parents' engagement in and completion of SUD treatment. At one end of the spectrum are interventions based primarily on parents meeting externally set goals and requirements (i.e., of child welfare or family court). In these interventions, recovery coaches are more likely to conduct drug tests and other forms of compliance monitoring as part of their duties. At the other end of the spectrum are interventions that emphasize self-direction and empowerment, in which recovery coaches encourage and support parents to identify their own recovery goals and desire for change. Other interventions may sit somewhere in the middle, incorporating elements of both approaches.

Intervention points. A recovery coach can begin working with a parent or family at any point in the child welfare process. Some recovery coaching interventions have been designed specifically for intact families, focusing on preventing foster care placement. Others are designed for families where the child has already been removed from the home. Still others have a more general approach and do not target specific intervention points. Further, some interventions target certain child age ranges, such as prenatal to 6 months or birth to age 5; others do not specify age ranges.

2.3.3 Level of Cross-System Collaboration

Recovery coaching interventions take different approaches to cross-system collaboration—focusing on systems-level collaboration, case-level collaboration, or a combination of both. The systems of SUD treatment and recovery, child welfare, and family and juvenile court intersect as families affected by SUD move through the child welfare system. Close coordination of these systems can help provide the continuum of services to meet families' needs and avoid duplication.[3]

- Some interventions include broad, systems-level collaboration efforts such as entering into formal partnerships (e.g., preferential treatment admissions for parents involved in

[3] Although there have been many efforts in the last 20 years to integrate SUD treatment with child welfare services (Maluccio & Ainsworth, 2003), institutional and organizational barriers to collaboration continue (Radel et al., 2018; National Center on Substance Abuse and Child Welfare, 2019).

child welfare), developing a shared set of goals and procedures, and cross-training staff across agencies.

- Other interventions focus collaboration efforts at the case level, ensuring that staff from different agencies coordinate on case management plans and share information necessary for permanency planning and understanding the parents' recovery progress.

2.3.4 Summary

Interventions vary widely in recovery coaching functions and other features, including their structures, service strategies, and levels of cross-system collaboration. A key step in moving the field to the next stage of development is to understand the range of interventions that have been implemented in child welfare, identify interventions that show promise for improving outcomes, and gauge their readiness for replication and further evaluation. In the next section, we briefly describe the process we undertook to identify and assess existing interventions on their readiness.

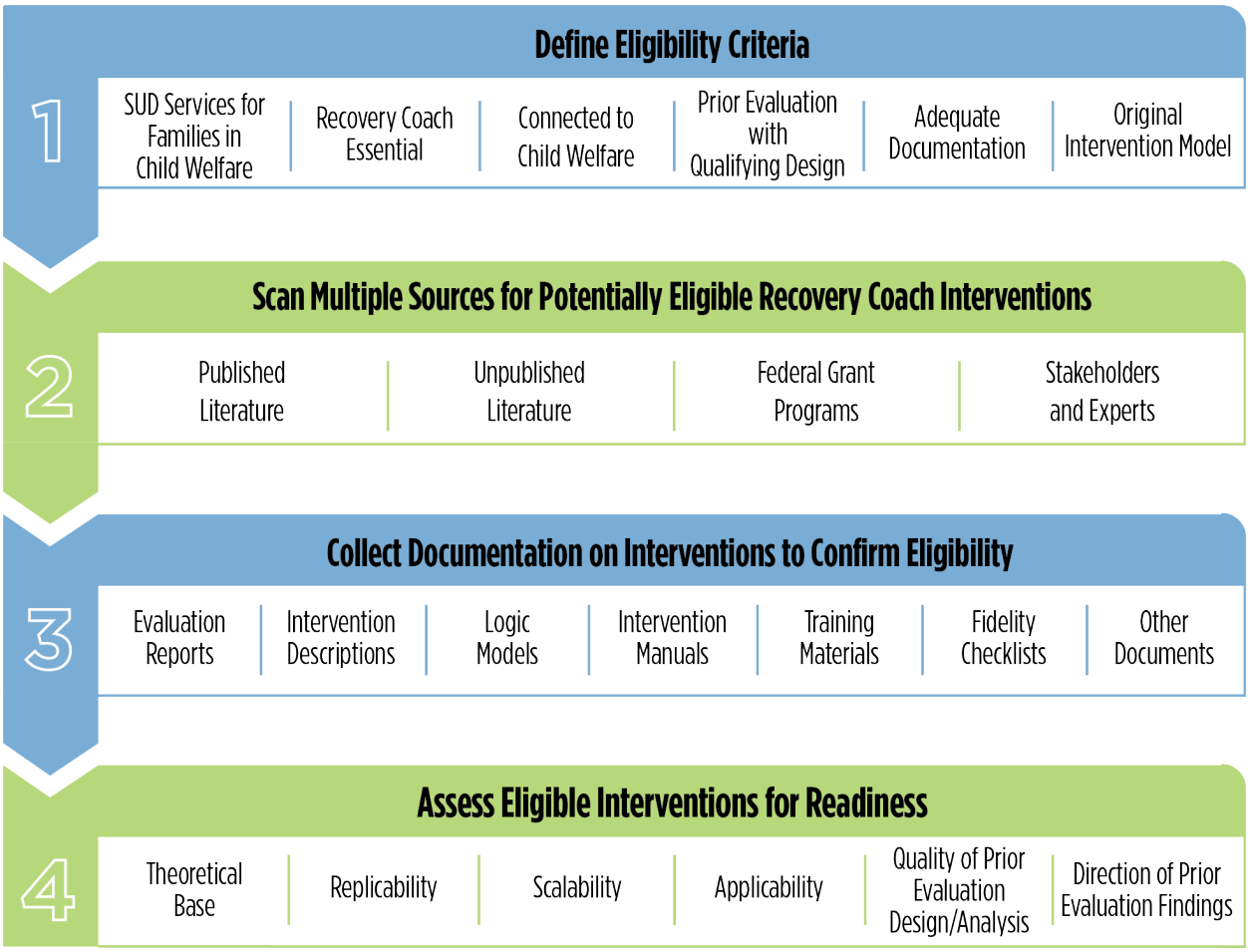
3. Identifying and Assessing Recovery Coaching Interventions

Guided by the SUPPORT for Patients and Communities Act, ACF aims to build high-quality evidence on recovery coaching interventions for families involved with the child welfare system due to SUD. Achieving this goal means first identifying recovery coaching interventions that show enough early promise ("readiness") to merit offering them in new settings (*replication*), and then evaluating whether the interventions work as intended (*effectiveness evaluation*). The following section describes how the research team conducted a systematic scan for recovery coaching interventions and assessed the identified interventions on their readiness for future replication and evaluation.

3.1. Scan and Assessment Process

The scan and assessment process comprised four steps, shown in Exhibit 3.1 and briefly described below, through which we narrowed the universe of interventions to those best suited for replication and further evaluation. Please see the Technical Appendix for additional detail.

Exhibit 3.1: Scan and Assessment Process



First, we defined the criteria for an intervention to be considered eligible for potential replication and evaluation. An eligible recovery coaching intervention was required to have the following six characteristics:

1. Service delivery model for families involved in child welfare primarily due to SUD;
2. Recovery coaching is an "essential" service component;
3. Closely connected to the child welfare system;
4. Evaluated previously using a qualifying research design;[4]
5. Adequate documentation to assess the intervention's readiness; and
6. An original intervention model (i.e., for interventions implemented in multiple locations, additional replications of the same intervention were excluded).[5]

Defining an Essential Service Component

Two considerations helped to define recovery coaching as essential to an intervention:

- When interventions combined (bundled) multiple services, recovery coaching had to be a well-defined and prominent feature without which the intervention would be meaningfully altered.
- Parent partner or parent coaching interventions that emphasized parenting and child welfare systems navigation were not eligible unless their primary focus was access, engagement, and retention in SUD treatment and recovery.

Second, we scanned four sources to identify *potentially eligible* recovery coaching interventions: published literature, unpublished literature, topically relevant federal grant programs, and recommendations from stakeholders and experts in the fields of child welfare and SUD treatment and recovery. The scan covered the time period from January 1990 through February 2020. We gathered initial descriptions of recovery coaching interventions from these sources and screened the interventions for the potential to meet the eligibility criteria.

Third, we collected additional documentation on the potentially eligible interventions. This included any available research studies, logic models, program manuals, training materials, and fidelity checklists, which we used to confirm that interventions met the eligibility criteria.

Last, we assessed the *confirmed eligible* interventions on their readiness for replication and evaluation using a rubric (i.e., a scoring guide) developed by the research team. The rubric assessed six factors that equally contribute to an intervention's readiness for replication and evaluation: theoretical base, replicability, scalability, applicability, quality of prior evaluation

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[4] Qualifying designs were: an experimental, quasi-experimental, pretest-posttest, posttest only with comparison, or cohort longitudinal study design. The design must have analyzed at least one outcome in one of four **outcome domains**: permanency, child safety, parent substance use, or SUD treatment compliance. Studies that were solely descriptive or qualitative or that did not analyze one of those four outcome domains were excluded.

[5] For example, the START intervention has been replicated in several states, with perhaps minor modifications not affecting the essential components; rather than treating each of these as separate interventions, we considered them to be replications of the same national model as documented in the START manual.

design and analysis, and direction of prior evaluation findings (see Exhibit 3.2). For additional detail on the rubric, please see the Technical Appendix.

Exhibit 3.2: Readiness Factors Assessed by the Rubric

Factors	Definition
Theoretical Base	Clear articulation of the mechanisms most responsible for change (similar to what one might find in a logic model)
Replicability	Extent to which a manual and other materials are adequate to replicate the intervention in other locations with fidelity
Scalability	Extent to which the intervention developer or a technical assistance provider has materials or capacity to support implementation of the intervention on a larger scale to reach more families
Applicability	Fit of the intervention in the child welfare services environment
Quality of Prior Evaluation Design and Analysis	The extent to which a prior study's research design and execution have the potential to demonstrate with confidence that an intervention improves key outcomes*
Direction of Prior Evaluation Findings	Based on the size and direction of prior research findings, the extent to which an intervention may improve key outcomes

* Design and execution standards from ACF's Title IV-E Prevention Services Clearinghouse informed the rubric (Wilson et al., 2019).

3.2. Recovery Coach Interventions Eligible for Replication and Evaluation

The scan identified 1,594 potentially eligible interventions. Of those, we confirmed that nine interventions met the eligibility criteria to be considered for replication and evaluation (see Appendix Exhibit A5 for more detail). Using the rubric described above, we characterized that group of nine interventions on their level of readiness. This section provides an overview of the nine interventions' service delivery strategies and recovery coach functions. Section 4 describes the nine interventions' levels of readiness for replication and evaluation.

As shown in Exhibit 3.3, the interventions have much in common, but they also reflect a variety of approaches intended for different contexts. For ease of summarizing, we first highlight the interventions designed to be delivered by recovery coaches with lived experience with SUD (six interventions), followed by the interventions that did not require the recovery coaches to have lived experience (three interventions). Lived experience is just one of the dimensions that can be used to compare the interventions, and we note others in the discussion below and in Exhibit 3.3.

Interventions requiring recovery coaches to have lived experience vary with respect to the point of intervention and the type of organization supervising the recovery coach services.

- Three share a primary focus on preventing foster care placements among intact families that have come to the attention of child welfare due to parental substance misuse, including substance-exposed newborns (Arizona Parent-to-Parent, Massachusetts FRESH Start, and START).
- Three interventions do not specify an intervention point, serving families at risk of losing custody as well as those that have already lost custody (Oregon Parent Mentor Program,

Santa Clara Mentor Parent Program, and Summit Co. STARS). Beyond that commonality, the three interventions exhibit unique features. Oregon Parent Mentor Program emphasizes a self-directed, parent empowerment approach. Santa Clara Mentor Parent Program is designed for a family treatment court; the peer recovery coaches are employed by a legal services provider and their interactions are protected by attorney-client privilege. Summit Co. STARS focused on trauma services for families and parenting skills in addition to peer recovery coaching.

- START's peer recovery coaches are trained, supervised, and embedded in the child welfare agency, whereas Arizona Parent-to-Parent and Massachusetts FRESH Start use independent service providers.
- Of these six interventions, none requires the peer recovery coaches to have prior experience in a human services profession or postsecondary education.

Interventions *not* requiring lived experience for recovery coaches share several common features, including the intervention point, coaches with professional experience, and case management functions.

- These three interventions (Family Recovery and Reunification Program, Recovery Specialist Voluntary Program (RSVP), and Specialized Treatment and Recovery Services (Sacramento STARS)), primarily serve families with children in out-of-home care. RSVP is an adaptation of Sacramento STARS.
- For all three, independent service providers with a focus on behavioral health and SUD recovery employ the recovery coaches.
- These interventions require the coaches to have alcohol and other drug counselor or specialist certification, experience with human services, and some postsecondary education. The coaches' functions include case management, drug-testing—which is not a function in any of the six interventions whose recovery coaches must have lived experience—and reporting to child welfare and the courts on parents' progress.
- Two of the interventions, RSVP and Sacramento STARS, are designed to be part of a juvenile court or family treatment court.

Exhibit 3.3: Features of Nine Interventions Eligible for Replication and Evaluation

Intervention Name	Intervention Features					Recovery Coach Requirements		
	Organization supervising RC	Court setting?	Point of intervention	Child age range	RC conducts drug testing?	Education or certification	SUD lived experience?	CW lived experience?
Arizona Parent-to-Parent Recovery Program (Arizona Parent-to-Parent)	Health care provider		Anytime	Any age; priority to SENs		None specified	✓	✓
Family Recovery and Reunification Program (FRRP)	Non-profit treatment and recovery support provider		After removal	Not specified	✓	4-year degree preferred; AOD certification		
Massachusetts Family Recovery Engagement Support of Hampden County (FRESH) Start (Massachusetts FRESH Start)	Non-profit family services provider		At risk of removal	Prenatal and <6 months		None specified	✓	
Oregon Parent Mentor Program	Non-profit family services provider		Anytime	Not specified		High school diploma/GED; peer recovery coach certification	✓	✓
Recovery Specialist Voluntary Program (RSVP)	Non-profit behavioral health management company	✓	After removal	<18 years	✓	2-year degree or 2+ years' experience		
Santa Clara Mentor Parent Program	Non-profit legal services provider	✓	Anytime	0-3 years		None specified	✓	✓
Sobriety Treatment and Recovery Teams (START)	Child welfare agency		At risk of removal	0-5 years		High school diploma/GED	✓	
Specialized Treatment and Recovery Services (Sacramento STARS)	Non-profit treatment/ behavioral health provider	✓	After removal	0-18 years	✓	AOD certification		
Summit County (Ohio) Collaborative on Trauma, Alcohol and Other Drug, and Resiliency-building Services for Children and Families (Summit Co. STARS)	Local providers		Anytime	Not specified		Pass certification exam	✓	

AOD = Alcohol and Other Drugs

RC = Recovery Coach

SENs = Substance-Exposed Newborns

4. Readiness for Replication and Evaluation

The research team assessed the nine eligible interventions on readiness for replication and evaluation along six factors using a rubric developed specifically for the R3 project to provide a nuanced and multi-angled picture of recovery coaching interventions' readiness for replication and evaluation: theoretical base, replicability, scalability, applicability, quality of prior evaluation design and analysis, and direction of prior evaluation findings (defined below and in Exhibit 3.2).[6]

Readiness varied widely among the interventions. No intervention was strong on all six factors, and none was universally weak. As a whole, this group of interventions had a clear theoretical base and were highly applicable to the child welfare services environment. Their readiness was mixed in terms of potential for replication and scaling up. The interventions were least ready in terms of the quality of their prior evaluation evidence.

Below we discuss assessment results by readiness factor. The Technical Appendix contains a profile of each intervention with further details on its readiness assessment.

4.1. Theoretical Base

An intervention's theoretical base explains why and how, in theory, the services offered should benefit participants. It may be articulated as a logic model, theory of change, or narrative description. To assess the readiness of an intervention's theoretical base, we considered the extent to which an intervention's documentation clearly communicated the mechanisms most responsible for change. We rated readiness using a four-point scale (*cannot rate, low, moderate,* and *high readiness*). Interventions with high or moderate ratings provided clear rationales for how the intervention would benefit participants.[7]

Most interventions had clearly articulated theories of change or logic models.

All provided a theoretical rationale for why and how their services would achieve desirable outcomes. As shown in Exhibit 4.1, we rated five of nine at high readiness in this area (Arizona Parent-to-Parent, Massachusetts FRESH Start, Oregon Parent Mentor Program, Santa Clara Mentor Parent Program, and START). These had clearly delineated links between intervention

[6] Our assessments provided preliminary indications of readiness; they were not formal reviews of an intervention's effectiveness as a Title IV-E Prevention Services Clearinghouse review would provide. The ratings from our assessments were based solely on the documentation available for each intervention as of February 2020. Given the purpose of the assessments and resource constraints we did not conduct author queries.

[7] The research team did not assess the plausibility of the theoretical base provided, only the existence of one and its level of clarity. Thus, a high or moderate rating on that factor did not necessarily mean that the intervention's proposed pathway to its outcomes was sound or that the intervention was likely to achieve its goals.

components and outcomes. We rated four at moderate readiness (Family Recovery and Reunification Program, RSVP, Sacramento STARS, and Summit Co. STARS) because they provided less specific information about the links among inputs, activities, mediators, and outcomes and they offered more general descriptions of their underlying mechanism of change.

Exhibit 4.1: Readiness Ratings on Theoretical Base

Theoretical Base Clear articulation of the mechanisms most responsible for change (similar to what one might find in a logic model)				
	Cannot Rate	Low	Moderate	High
Arizona Parent-to-Parent				✓
Family Recovery and Reunification Program			✓	
Massachusetts FRESH Start				✓
Oregon Parent Mentor Program				✓
RSVP			✓	
Santa Clara Mentor Parent Program				✓
START				✓
Sacramento STARS			✓	
Summit Co. STARS			✓	

4.2. Replicability and Scalability

Replicability indicates the ease with which an intervention could be replicated with fidelity in other locations by other providers. When assessing this domain, we considered the extent to which a procedures manual, training manual, or other documentation was available and provided adequate detail to support replication of the intervention with fidelity or integrity to the model. Closely related, scalability reflects the ability to implement an intervention on a larger scale to benefit more people—in the same location or at new locations—while maintaining fidelity. When rating scalability, we considered the extent to which the intervention developer or a technical assistance provider had written documentation or capacity to support and guide the intervention's growth. We assessed replicability and scalability separately using the same four-point scale (from *cannot rate* to *high readiness*).

Interventions that received high ratings for replicability tended to also receive high ratings for scalability (and vice versa).

Two interventions, Oregon Parent Mentor Program and START, received the highest ratings in both domains, indicating they have already demonstrated the capacity to replicate and scale up their interventions. Though it is possible that some additional resources may be needed to reinforce the current capacity, both interventions currently operate in multiple counties with

direct assistance from the program developer and have well-documented procedures and detailed manuals.

Four interventions rate low on replicability and either low or moderate on scalability: Arizona Parent-to-Parent, Massachusetts FRESH Start, Santa Clara Mentor Parent Program, and Summit Co. STARS. Review of the available documentation suggested that it would take a significant effort and investment of resources to build the capacity necessary for replication and scaling.

Exhibit 4.2: Readiness Ratings on Replicability and Scalability

Replicability **Extent to which a manual or other materials are adequate to replicate the intervention in other locations with fidelity**				
	Cannot Rate	**Low**	**Moderate**	**High**
Arizona Parent-to-Parent		✓		
Family Recovery and Reunification Program			✓	
Massachusetts FRESH Start		✓		
Oregon Parent Mentor Program				✓
RSVP			✓	
Santa Clara Mentor Parent Program		✓		
START				✓
Sacramento STARS			✓	
Summit Co. STARS		✓		
Scalability **Extent to which the intervention developer or a technical assistance provider has materials or capacity to support implementation of the intervention on a larger scale to reach more people**				
	Cannot Rate	**Low**	**Moderate**	**High**
Arizona Parent-to-Parent			✓	
Family Recovery and Reunification Program			✓	
Massachusetts FRESH Start			✓	
Oregon Parent Mentor Program				✓
RSVP			✓	
Santa Clara Mentor Parent Program		✓		
START				✓
Sacramento STARS		✓		
Summit Co. STARS		✓		

4.3. Applicability

Applicability ratings reflect the suitability of an intervention for the current child welfare services environment. When rating applicability, we considered the service environments for which an intervention was designed and whether or not the intervention was currently operating at the time of the review.

The interventions demonstrated high applicability to child welfare, primarily because they were designed with that system in mind.

Because one eligibility criterion for an intervention to be considered for replication and evaluation was connection to the child welfare system (see Section 3.1), most interventions (six of nine) received the highest rating on applicability. We rated the other three—Massachusetts FRESH Start, RSVP, and Summit Co. STARS—as *moderate* for readiness in this area. These three interventions were designed for child welfare environment but no longer operate in their original forms, which may make them less ready for integration into current child welfare systems.

Exhibit 4.3: Readiness Ratings on Applicability

Applicability Fit of the intervention in the child welfare services environment				
	Cannot Rate	Low	Moderate	High
Arizona Parent-to-Parent				✓
Family Recovery and Reunification Program				✓
Massachusetts FRESH Start			✓	
Oregon Parent Mentor Program				✓
RSVP			✓	
Santa Clara Mentor Parent Program				✓
START				✓
Sacramento STARS				✓
Summit Co. STARS			✓	

4.4. Prior Evaluation Evidence

When gauging readiness for replication and evaluation, we looked to prior evaluations of the nine recovery coaching interventions. Although an evaluation's findings tend to attract the most attention, its design is equally, if not more, important. In fact, an understanding of "what works" is determined by both the nature of findings (their direction and statistical significance) *and* the quality of the research (design and analysis methods) that produced them. Favorable evaluation findings can suggest that an intervention may benefit participants only if the quality of the research design gives us confidence that the intervention actually produced the favorable findings.

The most rigorous research designs for establishing causality compare outcomes for participants in an intervention versus an equivalent group of people who did not participate, using a randomized controlled trial (RCT) design or a quasi-experimental design (QED). If well executed, these designs allow for some level of causal attribution (i.e., the intervention may be responsible for the observed outcomes). Without one of these designs, or if the design was not well executed, we are less certain that the findings—whether favorable, neutral, or unfavorable—accurately reflect the intervention's effects.

To highlight the distinct contributions of evaluation design and analysis quality relative to the direction of evaluation findings, we separately assessed these two aspects of prior evaluations, as described below. The Title IV-E Prevention Services Clearinghouse design and execution standards (Wilson et al., 2019) informed our approach. However, **the resulting assessments reported here have a different purpose than the Prevention Services Clearinghouse; they are intended to assess an intervention's readiness and potential for the next level of evidence-building, rather than identify existing evidence-based interventions**. A systematic evidence review was beyond the scope of this project, and the results of our assessments do not reflect an intervention's potential for meeting the Prevention Services Clearinghouse evidence standards.

4.4.1 Quality of Prior Evaluation Design and Analysis

This factor conveyed whether a prior study's findings could be attributed to the recovery coaching component of the intervention based on the research design. For each intervention, we reviewed qualifying evaluations on six features: the type of research design, presence of subgroups, confounding factors, attrition, baseline equivalence, and the statistical models used to estimate the intervention's effects.[8] We then gave the intervention an overall rating on this readiness factor using a four-point scale from *cannot rate* to *high readiness* (please see the Technical Appendix for more detail on the ratings criteria).

The interventions ranged from low to moderate readiness based on their prior evaluation designs.

Using the Title IV-E Prevention Services Clearinghouse design and execution standards as a guide, we could not rate any of the recovery coaching interventions unequivocally as *high* in readiness based on the available documentation. This is not surprising for a relatively new field that has produced few quantitative evaluations. Two interventions had *moderate* readiness based on the evaluation design quality; seven had *low* readiness (Exhibit 4.4).

[8] As footnoted in Section 3, qualifying evaluations could use an experimental, quasi-experimental, pretest-posttest, posttest only with comparison, or cohort longitudinal study design to examine at least one outcome in one of four domains: permanency, child safety, parent substance use, or SUD treatment compliance. Studies that were descriptive, qualitative, or did not examine one of those four outcome domains were excluded.

- ***Two interventions were tested with RCTs.***[9] The Family Recovery and Reunification Program and Oregon Parent Mentor Program used the most rigorous evaluation design, where individuals were randomly assigned either to a treatment group offered the recovery coaching intervention or to a control group offered usual services without a recovery coach. If well executed, this design can attribute any findings, favorable or unfavorable, to the intervention. Based on the available documentation, prior evaluations of the Family Recovery and Reunification Program and Oregon Parent Mentor Program used designs that were of at least moderate quality.
- ***Five interventions used QEDs in prior evaluations.*** These evaluations compared outcomes for participants in the intervention versus outcomes among a similar (sometimes statistically matched) group of individuals who did not receive the intervention. When well designed, quasi-experimental studies can provide strong evidence of effects, approaching that of RCTs. The QEDs of these five interventions had several weaknesses based on publicly available information.

Evaluations of Sacramento STARS and Summit Co. STARS were not intended to provide evidence specific to the recovery coaching component—the focus of the current effort. These evaluations compared the package of recovery coaching services and other services provided by the program versus usual services. As a result, we characterized these two interventions as having *low* readiness on the design/analysis quality factor for the purposes of R3.

For the other three interventions that were evaluated using QEDs—Arizona Parent-to-Parent Program, Santa Clara Mentor Parent Program, and START—we could not confirm that the treatment and comparison groups were equivalent enough at the beginning of the study to rule out factors other than the intervention to have produced the results.[10] Without certainty about the study groups' equivalence, we characterized these interventions as having *low* readiness on the design/analysis quality factor.[11]

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[9] As of the time of this report, an RCT of START was complete but results were not yet available. The RCT was conducted in one county in Kentucky.

[10] For Arizona Parent-to-Parent and START, publicly available documentation did not provide results of the statistical equivalence of the analytic sample of treatment and comparison groups at baseline. For the Santa Clara Mentor Parent Program, evaluators formed the study groups from two dissimilar groups (families who chose to participate in the intervention versus families who chose not to participate), leading to a substantially different characteristics confound. In addition, the evaluation of the Santa Clara Mentor Parent Program was not intended to provide evidence specific to the recovery coach component.

[11] In December 2020, the Title IV-E Prevention Services Clearinghouse rated START as "promising," determining it to have one favorable effect on a target outcome using a design meeting moderate design and execution standards. The Clearinghouse's policy is to query authors for information needed to determine a study rating. This level of review was beyond the scope of the R3 project.

- ***Two interventions used non-experimental designs in prior evaluations.*** The remaining two interventions also had *low* readiness based on the design and analysis quality of their prior evaluations. Massachusetts FRESH Start used a single-group pretest-posttest design to measure the difference in participants' outcomes before and after they participated in the recovery coach intervention. Pretest-posttest designs do not provide reliable or valid evidence of intervention effects. Rather, the findings describe progress over time; and it is not possible to tell whether changes are due to the intervention or to some other factor. The RSVP evaluation described outcomes among participants after they received the recovery coach intervention. Although it compared participants' outcomes to statewide benchmarks, without comparison to similar non-participants' outcomes, the evaluation could not validly or reliably measure effects.

Exhibit 4.4: Readiness Ratings on Quality of Prior Evaluation Design and Analysis

Quality of Prior Evaluation Design and Analysis The extent to which a study design and its execution have the potential to demonstrate with confidence that an intervention improves key outcomes				
	Cannot Rate	Low	Moderate	High
Arizona Parent-to-Parent		✓		
Family Recovery and Reunification Program			✓	
Massachusetts FRESH Start		✓		
Oregon Parent Mentor Program			✓	
RSVP		✓		
Santa Clara Mentor Parent Program		✓		
START		✓		
Sacramento STARS		✓		
Summit Co. STARS		✓		

4.4.2 Direction of Prior Evaluation Findings

The final readiness factor is the direction of prior evaluation findings. Below we present the overall ratings on this factor for each intervention, followed by a closer look at the prior findings by outcome domain. Ratings on this factor reflect the extent to which prior findings, as a whole, suggest that an intervention may or may not improve primary outcomes. We limited the assessment to findings reported on statistical differences between treatment and comparison groups or over time, on a full sample. We considered outcome measures in the domains of permanency, child safety, parent substance use, and SUD treatment compliance (defined in Outcome Domains box).[12] Ratings are on a five-point scale of *cannot rate*, *mixed unfavorable*, *mixed unfavorable and favorable*, *neutral*, and *mixed favorable* (please see Exhibit 4.5 below and the Technical Appendix for more detail on these ratings).

Outcome Domains

- **Permanency** reflects the stability of a child's living situation; it is measured by such outcomes as reunification, legal guardianship, and adoption.
- **Child safety** refers to outcomes that indicate a child's physical, emotional, or developmental safety; it includes indicators of child maltreatment and risk of maltreatment.
- **Parent substance use** refers to indicators of a parent's or caregiver's problematic intake of substances, including SUD diagnosis and measures of use or misuse.
- **SUD treatment compliance** signifies such events as entry, time to entry, retention, and completion of SUD treatment.

Overall, the interventions have mixed readiness in terms of their prior evaluation findings.

- Of the nine interventions, the Family Recovery and Reunification Program and START received the highest ratings for findings (*mixed favorable*). Their evaluations detected at least one statistically significant favorable effect in a primary outcome domain, some neutral effects, and no unfavorable effects. However, as described above, we have more confidence in the Family Recovery and Reunification Program's findings due to its evaluation design (as noted, results from a recent RCT of START were not yet available for review).
- The Oregon Parent Mentor Program had *neutral* evaluation findings, suggesting that the intervention produced no benefit or harm. This study had a relatively small sample, and the results do not rule out true effects of larger magnitude. We consider these results to be inconclusive due to limitations of the design.

[12] The research team defined the first three outcome domains using the Title IV-E Prevention Services Clearinghouse design and execution standards (Wilson et al., 2019). The fourth outcome domain (SUD treatment compliance) derives from the distinct goal of recovery coach interventions to support treatment and recovery from SUD.

- Two interventions, Arizona Parent-to-Parent and Sacramento STARS, were *mixed unfavorable and favorable*. Program participants fared worse than those in the comparison group on one or more outcomes across domains, and they also fared better or the same on one or more outcomes across domains.
- Findings from Summit Co. STARS were either *unfavorable* or *neutral* on one or more outcomes.
- We were unable to assess the findings from three interventions due to issues with their study designs.[13]

Exhibit 4.5: Readiness Ratings on Direction of Prior Evaluation Findings

Direction of Prior Evaluation Findings Based on the size and direction of findings, the extent to which an intervention may improve the key outcomes of permanency, child safety, parent substance use, or SUD treatment compliance					
	Cannot Rate	**Mixed Unfavorable**	**Mixed Unfavorable and Favorable**	**Neutral**	**Mixed Favorable**
Arizona Parent-to-Parent			✓		
Family Recovery and Reunification Program					✓
Massachusetts FRESH Start	✓				
Oregon Parent Mentor Program				✓	
RSVP	✓				
Santa Clara Mentor Parent Program	✓				
START					✓
Sacramento STARS			✓		
Summit Co. STARS		✓			

NOTE: Check marks indicate direction of outcome findings across all domains and evaluations.

KEY:

Cannot Rate = Study designs prevented assessment of findings (e.g., no tests of statistical significance reported and not enough information to independently calculate significance; findings pertain to a subgroup and not the full study sample; potential confounds).

Mixed Unfavorable = Author reports both neutral findings (no statistically significant group differences) and one or more statistically significant differences favoring the comparison group. No statistically significant differences favoring the treatment group.

Mixed Unfavorable and Favorable = Author reports one or more statistically significant differences favoring the comparison group and one or more statistically significant differences favoring the treatment group.

Neutral = Author reports only neutral findings (no statistically significant group differences).

Mixed Favorable = Author reports one or more statistically significant differences favoring the treatment group. May be mixed with neutral findings. No statistically significant differences favoring the comparison group.

[13] The study design issues included lack of an adequate comparison group, potential design confounds, and inadequate information with which to calculate statistical significance.

Overall, prior evaluations suggest limited evidence of effectiveness, and more rigorous evaluation is needed to draw conclusions.

Below we summarize the evaluation findings by outcome domain to highlight any patterns or gaps in the existing evidence (see Exhibit 4.6). To assist in weighing the direction of findings with the quality of each study's design, Exhibit 4.6 includes each intervention's evaluation design type, whether it provides findings specific to the recovery coach component, and our assessment of its design/analysis quality alongside the findings for each outcome domain.

Overall, these recovery coaching interventions have mixed evidence on permanency and child safety outcomes, and no or limited evidence on parent substance use and SUD treatment compliance.

Permanency

Six of the nine interventions provided mixed evidence that recovery coaching services may affect permanency.

- Three interventions did not measure permanency in a way that provided evidence about the effect of recovery coaching (denoted as N/A).
- One of the two interventions evaluated with studies of moderate design quality (Family Recovery and Reunification Program) reported favorable effects on reunification and time to reunification, with neutral effects on adoption, time to adoption, or re-entry into foster care. The other intervention (Oregon Parent Mentor Program) reported neutral effects on five measures of permanency.
- Two interventions evaluated with studies of lesser design quality also reported a mix of favorable and neutral findings on permanency. The evaluations of START had a mix of neutral and favorable effects on rates of placement in state custody, and favorable effects on rates of re-entry into foster care. Similarly, the evaluations of Sacramento STARS reported a mix of favorable and neutral effects on both reunification and time to reunification.
- The evaluation of Arizona Parent-to-Parent reported unfavorable findings on out-of-home placement; neutral findings on child remained in foster care, child achieved permanency, and time to reunification; and favorable findings on reunification.
- Summit Co. STARS reported unfavorable findings for length of out-of-home placement and time to reunification, with no effect on three other permanency measures.

Child Safety

Six of the nine interventions had favorable and neutral effects on child safety, and no unfavorable effects.

- Three interventions either did not measure child safety outcomes or did not do so in a way that provided evidence about recovery coaching's effects (N/A).
- The evaluation of the Family Recovery and Reunification Program reported both neutral and favorable effects on subsequent reports of child abuse or neglect. The Oregon Parent Mentor Program evaluation found no effects on substantiated maltreatment.
- Four interventions (all of lesser design quality) reported a mix of neutral and favorable findings on child safety. START is the only other intervention, besides the Family Recovery and Reunification Program, that reported favorable findings on a measure of child safety (i.e., recurrence of substantiated maltreatment within 6 months). Arizona Parent-to-Parent, Sacramento STARS, and Summit Co. STARS also measured recurrence of substantiated maltreatment but reported no effect on this child safety outcome.

Parent Substance Use

There is no evidence on the interventions' possible effects on parent substance use.

- Seven of the nine interventions did not measure this outcome in prior evaluations. The other two measured it only with the program participants, which prevents drawing conclusions about the extent to which any changes in this outcome were due to the intervention.

SUD Treatment Compliance

There is limited evidence of the interventions' benefits on SUD treatment compliance.

- One intervention with an evaluation of moderate design quality (Family Recovery and Reunification Program) reported positive effects on time to SUD treatment service receipt and treatment completion. The other two interventions that examined this outcome domain (Arizona Parent-to-Parent and Sacramento STARS) had lesser quality designs coupled with mixed findings, which prevents insight into effects on outcomes such as entry into treatment, treatment duration, and treatment completion.

Exhibit 4.6: Overview of the Evaluation Designs and Findings by Outcome Domain

Intervention Name and Evaluation Design	Quality of Design & Analysis	Permanency	Child Safety	Parent Substance Use	SUD Treatment Compliance
Arizona Parent-to-Parent QED Recovery coach–specific findings	Low	+ – O	O	Not measured	+ –
Family Recovery and Reunification Program RCT Recovery coach–specific findings	Moderate	+ O	+ O	Not measured	+
Massachusetts FRESH Start Pre-post	Low	N/A	Not measured	Not measured	N/A
Oregon Parent Mentor Program RCT Recovery coach–specific findings	Moderate	O	O	Not measured	Not measured
RSVP Adaptation of Sacramento STARS Descriptive post-only on treatment group comparing to state benchmarks	Low	N/A	Not measured	Not measured	N/A
Santa Clara Mentor Parent Program QED No recovery coach–specific findings	Low	N/A	N/A	N/A	N/A
START QED Recovery coach–specific findings [a]	Low	+ O	+	Not measured	N/A
Sacramento STARS QED No recovery coach–specific findings	Low	+ O	O	Not measured	+ – O
Summit Co. STARS QED No recovery coach–specific findings	Low	– O	O	N/A	Not measured

[a] START consists of other core services besides the family mentor, but is treated by this review as a test of the recovery coach component because the mentor/caseworker dyad is the central feature of the model.

KEY:

+ = favorable findings; author reports statistically significant difference between groups favoring treatment group

− = unfavorable findings; author reports statistically significant difference favoring comparison group

O = neutral findings; author reports no statistically significant difference between groups

N/A = no findings to report on differences between groups or over time; subgroup findings; or no statistical test reported/reviewers unable to calculate

Not measured = no evaluation; did not measure

5. Conclusion

Recovery coaches fill an important role helping families involved in the child welfare system due to SUD access the support needed to improve recovery and reunification outcomes. Parents with SUD who complete a treatment program are more likely to reunify with their children than those who do not. Thus, there is a clear need for support services such as recovery coaching that focus on improving access to and engagement in SUD treatment and the recovery process. Though recovery coaching in child welfare is increasingly common, the field is in the early stages of building evidence, and much is unknown about the effectiveness of this strategy. The 2018 SUPPORT Act provides a unique opportunity to build the evidence base about effective recovery coaching interventions, and ultimately to inform policymakers' and practitioners' decisions about how to best support families and spend limited resources.

This report describes the steps we took to understand the range of recovery coaching interventions in child welfare, identify interventions that show promise for improving outcomes, and gauge their readiness for replication and further evaluation.

As a whole, the nine interventions we assessed have engaged in the first three stages of evidence-building (see Exhibit 5.1). They are established interventions that have had some time to mature and learn from initial implementation experiences, and they have been evaluated at least once. For the R3 effort, to be a promising candidate for Stage 4 (replication and further evaluation), an intervention's potential for replicability and scalability is equal in importance to its initial evidence. This is because if the intervention is eventually found to be effective, broad dissemination and scale up (Stage 5) requires clear documentation, implementation materials, technical support, and tested processes to support implementation of the intervention. Thus, even if initial evidence appears promising, further evaluation of effectiveness of an intervention that lacks potential for replicability and scalability is imprudent (Epstein & Klerman, 2012).

Exhibit 5.1: Stages of Evidence-Building

5.1. Summary of Readiness for Replication and Evaluation

Using a pre-specified rubric, we assessed the readiness of each intervention based on six factors: the clarity of its underlying logic, potential for replication, potential for scaling up, applicability to the child welfare services environment, the quality of prior evaluation design and analysis, and the direction of prior evaluation findings. Exhibit 5.2 summarizes the readiness ratings across all nine interventions and all six readiness factors.

Exhibit 5.2: Readiness Assessment Results At A Glance

	Readiness Factors that Support Implementation				Readiness Factors Related to Strength of the Initial Evidence	
Intervention	**Theoretical Base**	**Replicability**	**Scalability**	**Applicability**	**Quality of Prior Evaluation Design and Analysis**	**Direction of Prior Evaluation Findings**
Arizona Parent-to-Parent	High	Low	Low	High	Low	Mixed Unfavorable and Favorable
Family Recovery and Reunification Program	Moderate	Moderate	Moderate	High	Moderate	Mixed Favorable
Massachusetts FRESH Start	High	Low	Low	Moderate	Low	Cannot Rate
Oregon Parent Mentor Program	High	High	High	High	Moderate	Neutral
RSVP	Moderate	Moderate	Moderate	Moderate	Low	Cannot Rate
Santa Clara Mentor Parent Program	High	Low	Low	High	Low	Cannot Rate
START	High	High	High	High	Low	Mixed Favorable
Sacramento STARS	Moderate	Moderate	Low	High	Low	Mixed Unfavorable and Favorable
Summit Co. STARS	Moderate	Low	Low	Moderate	Low	Mixed Unfavorable

KEY (Direction of Evaluation Findings):

Cannot Rate = Study designs prevented assessment of findings (e.g., no tests of statistical significance reported and not enough information to independently calculate significance; findings pertain to a subgroup and not the full study sample; potential confounds).

Mixed Unfavorable = Author reports both neutral findings (no statistically significant group differences) and one or more statistically significant differences favoring the comparison group. No statistically significant differences favoring the treatment group.

Mixed Unfavorable and Favorable = Author reports one or more statistically significant differences favoring the comparison group *and* one or more statistically significant differences favoring the treatment group.

Neutral = Author reports only neutral findings (no statistically significant group differences).

Mixed Favorable = Author reports one or more statistically significant differences favoring the treatment group. May be mixed with neutral findings. No statistically significant differences favoring the comparison group.

5.1.1 Readiness Factors that Support Implementation

Oregon Parent Mentor Program and START received the highest ratings for potential replicability and scalability.

- Both interventions currently operate in multiple jurisdictions, have some technical assistance and training infrastructure, and well-documented procedures and detailed manuals.

Overall, the interventions had varying levels of documentation that would allow others to replicate and scale them.

- Most interventions had clearly articulated logic models or theories of change.
- Six of the interventions demonstrated high applicability to child welfare, primarily because they were designed with that system in mind.
- Three interventions, Massachusetts FRESH Start, RSVP, and Summit Co. STARS, were no longer operating at the time of this report.

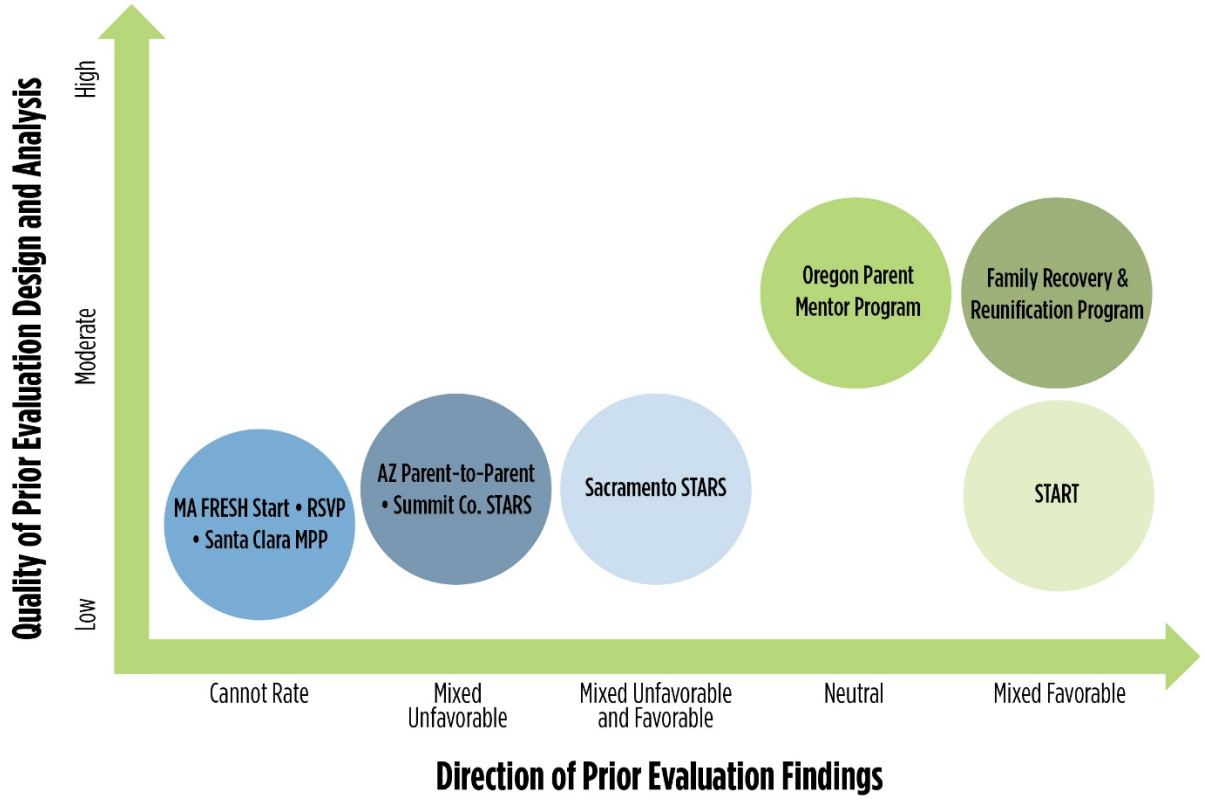
With a few exceptions, most did not have a comprehensive manual or a cohesive set of materials for implementing the model.

- The recovery coaching interventions that lacked strong documentation may be theoretically sound and worth further development and evaluation. However, among these nine interventions, those that are well defined and have a foundational set of materials and other implementation supports are better positioned for the next stage of evidence building.

5.1.2 Readiness Factors Related to the Strength of the Available Evidence

Together with the potential for replication and scaling, the strength of the available evidence—as observed at the intersection of quality of design/analysis and direction of findings—is another factor in determining readiness. Exhibit 5.3 compares the nine recovery coaching interventions we assessed on the strengths of their design/analysis and findings.

Exhibit 5.3: Intersection of Quality of Prior Evaluation Design and Direction of Findings



Most of the recovery coaching interventions had low readiness in terms of the quality and findings of prior evaluations.

Three interventions showed some promise based on the strength of their available evidence:

- The Family Recovery and Reunification Program was the only one of the nine interventions with prior favorable findings from an experimental study in any of the primary outcome domains (i.e., permanency, child safety, parental substance use, and SUD treatment compliance).
- Oregon Parent Mentor Program was the only intervention besides Family Recovery and Reunification Program to be previously evaluated with an experimental study design.[14] This intervention had neutral findings (i.e., no statistically significant effect on primary outcomes) from a small sample that did not rule out larger effects. We consider these results to be inconclusive due to the limitations of the design.

[14] As of this report in summer 2020, an RCT of START was complete but results were not yet available. The RCT was conducted in one county in Kentucky.

- The only other intervention supported by a mix of neutral and favorable findings (and no unfavorable findings) was START. It used a quasi-experimental study design, which provided a lower level of confidence in the results.

The other six interventions were limited by evaluations with small samples, unclear matching procedures and non-equivalent study groups, and evaluation designs not intended to isolate the effect of the recovery coaching component from that of other service components. These challenges made it difficult to draw conclusions about the strength of the evidence on those interventions.

Overall, based on our assessment of these nine interventions, the field of recovery coaching in child welfare is in the beginning stages of developing a high-quality evidence base with opportunity for the field to continue building knowledge.

5.2. Next Steps for Expanding Evidence on Recovery Coaching in Child Welfare

As the child welfare field continues to adopt a culture of evidence-based practice, and recovery coaching in child welfare continues to expand, future evaluation efforts should learn from and improve on the field's early stage of evidence building. This report shares the results of the initial step in ACF's overall effort to move recovery coaching interventions in child welfare to the "next level" of evidence.

This long-term effort:

- will produce the evidence-based guidance that practitioners and policymakers need to implement and improve recovery coaching interventions in child welfare to support families;
- will contribute to creating a culture of evidence-based practice in child welfare; and
- may lead to increasing the number of recovery coaching interventions that are supported or well supported by evidence in the Title IV-E Prevention Services Clearinghouse.

Based on our assessment of the readiness of these interventions, the next step calls for replicating strong candidates in new locations and testing them with a rigorous impact evaluation. This type of evaluation could answer key questions: *Can a model that has shown promising improvements in reunification rates in one location be replicated in another location and produce similar results? Can a model with weaker evidence but strong readiness for replicability and scalability sustain or improve upon earlier results?*

Answers to these and other questions will contribute needed evidence about recovery coaching interventions in child welfare.

References

Bassuk, E., Hanson, J., Greene, R., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63,* 1-9.

Choi, S., Huang, H., & Ryan, J. (2012). Substance abuse treatment completion in child welfare: Does substance abuse treatment completion matter in the decision to reunify families? *Children and Youth Services Review, 34,* 1639-1645.

Choi, S., & Ryan, J. (2006). Completing substance abuse treatment in child welfare: The role of co-occurring problems and primary drug of choice. *Child Maltreatment, 11,* 313-325.

Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *The Cochrane Database of Systematic Reviews, 1*(1), CD007906.

Eddie, D., Hoffman, L., Vilsaint, C., Abtry, A., Bergman, B., Hoeppner, B., Weinstein, C., & Kelly, J. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology*, *10,* 1052.

Epstein, D., & Klerman, J. (2012). When is a program ready for rigorous impact evaluation? The role of a falsifiable logic model. *Evaluation Review, 36*(5), 375-401.

Framework Workgroup. (2014). *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014

Green, B., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare outcomes? A statewide longitudinal analysis. *Children and Youth Services Review, 29,* 460-473.

Huebner, R., Hall, M., Smead, E., Willauer, T., & Posze, L. (2018). Peer mentoring services, opportunities, and outcomes for child welfare families with substance use disorders. *Children and Youth Services Review, 84,* 239-246.

Jones, A. S., LaLiberte, T. (2017). Risk and protective factors of foster care reentry: An examination of the literature. *Journal of Public Child Welfare, 11*(4-5), 516-545.

Maluccio, A., & Ainsworth, F. (2003). Drug use by parents: A challenge for family reunification practice. *Children and Youth Services Review, 25*(7), 511-533.

Mowbray, O., Victor, B., Ryan, J., Moore, A. & Perron, B. (2017). Parental substance use and foster care reentry. *Journal of Social Work Practice in the Addictions,* 17(4), 352-373.

National Center on Substance Abuse and Child Welfare. (2019). *The use of peers and recovery specialists in child welfare settings* (Technical Assistance Tool). Retrieved from https://ncsacw.samhsa.gov/files/peer19_brief.pdf

Permanency Innovations Initiative Evaluation Team. (2015). *Permanency Innovations Initiative (PII) approach to evaluation.* OPRE Report 2015-86. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, and Office of Planning, Research and Evaluation.

Radel, L., Baldwin, M., Crouse, G., Ghertner, R., & Waters, A. (2018). *Substance use, the opioid epidemic, and the child welfare system: Key findings from a mixed methods study.* ASPE Research Brief. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Ryan, J., Marsh, J., Testa, M., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services: Findings from the Illinois Alcohol and Other Drug Abuse Waiver Demonstration. *Social Work Research,* 30(1), 95-107.

Ryan, J., Perron, B., Moore, A., Victor, B. & Park, K. (2017). Timing matters: A randomized control trial of recovery coaches in foster care. *Journal of Substance Abuse Treatment,* 77, 178-184.

Ryan, J., Victor, B., Moore, A., Mowbray, O., & Perron, B. (2016). Recovery coaches and the stability of reunification for substance abusing families in child welfare. *Children and Youth Services Review,* 70, 357-363.

Semanchin, A., & LaLiberte, T. (2017). Risk and protective factors of foster care reentry: An examination of the literature. *Journal of Public Child Welfare, 11(*4-5), 516-545.

Smith, B. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare, 82*(3), 335-365.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2019). *Adoption and Foster Care Analysis and Reporting System (AFCARS) report.* Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport26.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2015). *Core competencies for peer workers in behavioral health services*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health. Ch. 5, Recovery: The many paths to wellness. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

Wilson, S. J., Price, C. S., Kerns, S. E. U., Dastrup, S. D., & Brown, S. R. (2019). *Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures, version 1.0*, OPRE Report 2019-56. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://preventionservices.abtsites.com/themes/ffc_theme/pdf/psc_handbook_v1_final_508_compliant.pdf