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Peer mentoring services, opportunities, and outcomes for child welfare families with substance use disorders

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ABSTRACT

Peer recovery support services (PRSS) in child welfare are being provided by peer mentors in sustained recovery from substance use disorders (SUD) to parents with acute SUD. Previous retrospective interviews demonstrate that peer mentors engage parents in family-centered systems of care through relationships and empowerment. However, the specific profile of services provided is unknown. Personnel challenges and opportunities for persons in recovery serving as peer mentors are described in the literature without understanding the frequency of both. As enthusiasm for hiring peer mentors grows, it is important to understand the specific services provided, the risks and opportunities associated with hiring individuals in recovery, and the impact of mentor services on outcomes. This knowledge can assist in developing training, implementation guides, policies, job expectations, and program evaluation strategies. This is a prospective study of 28 family mentors providing PRSS services to 783 families with child maltreatment and parental SUD over 8 years in a family-centered integrated program with SUD treatment providers. We describe mentor services overall, during the early engagement period, in rural and urban settings, and test the association between services and child/parent unification status at case closure; we identify the proportion of peer mentors that experienced employment challenges and career advancement opportunities. Results demonstrate the complexity of service provision overall and in differing contexts. Face to face visits with children were associated with greater likelihood of parent/child unification at case closure and 64.3% of peer mentors experienced career advancement opportunities. The implications of these findings are discussed.

1. Introduction

As the guiding paradigm for substance use disorder (SUD) treatment evolves from an acute care model to a recovery model, peer recovery support services (PRSS) are increasingly important "to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life" (White, 2009, p. 16). PRSS are provided by individuals in long term recovery to individuals with more acute SUD to promote recovery in three life domains: 1) sobriety, 2) emotional, relational, and physical health, and 3) positive and self-directed participation in the family and community (Reif et al., 2014). PRSS have been increasingly used in behavioral health treatment (White, 2009) and are endorsed and grant supported by the Substance Abuse and Mental Health Services Administration (SAMSHA) as a fundamental component of recovery (SAMHSA, 2009). Under certain conditions, such as having state training and certification processes, some PRSS may be billable through Medicaid under the Affordable Care Act. Although generalizing the evidence supporting the effectiveness of PRSS is limited by varying models of service delivery, current studies suggest that in SUDS treatment PRSS are associated with reduced rates of relapse, increased retention and satisfaction with treatment, improved relationships with providers (see Reif et al., 2014 for a review of extant studies), and reduced homelessness (Boisvert, Martin, Grosek, & Clarie, 2008).

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1.1. Mentors in family centered systems of care

In contrast to employment in SUD treatment where the focus is on the adult, PRSS in child welfare are a more recent innovation designed to focus on the family. Peer supports may be employed in family-centered systems of care where services are coordinated toward common goals of fostering adult recovery and parental capacity, strengthening adult/child bonding, and promoting child safety and permanency (Berrick, Young, Cohen, & Anthony, 2011; Drabble, Haun, Kushins, & Cohen, 2016; Frame, Berrick, & Knittel, 2010; Leake, Longworth-Reed, Williams, & Potter, 2012; White & Evans, 2014). Family-centered systems of care are more complex than services delivered by different agencies independently (Laudet & Humphreys, 2013); thus implementation of PRSS is more complex in such systems (Bohannan, Gonzalez, & Summers, 2016). The complex challenges in child welfare include balancing the needs for child safety with the parent's need for treatment and continued contact with their children, the urgency for timely access to services given child welfare timelines and child safety concerns, the involuntary status of parents, the work between systems each with different priorities and policies, and the additional services required for coaching sober parenting and supporting relatives and foster parents who care for children.

Implementing a family-centered system of care requires a changed service delivery paradigm in child welfare, SUD treatment, and court agencies toward a number of practices such as including parents as partners in decision making (Huebner, Young, Hall, Posze, & Willauer, 2017). Consequently PRSS must be directed toward cross-agency collaborative efforts to achieve outcomes important to both the parent and the child while strengthening the parent/child relationship. Because of the increased complexity of family-focused services, the term PRSS is often replaced by terms such as 'peer mentor' or 'family mentor'. In this paper, we use the term family mentor to highlight the collaborative and family-centered role of PRSS in child welfare.

A common theme in family-centered system of care literature is the perceived benefit of family mentors in engaging the parents (Werner, Young, Dennis, & Amatetti, 2007). Engagement is both a process of involving the parents in services and an outcome when parents and providers agree upon a course of action and work toward common goals. Parents in child welfare face numerous barriers to engagement including their involuntary status (Kemp, Marcenko, Hoagwood, & Vesneski, 2009) and differences in expectations between providers and parents (Altman, 2008; Huebner, Durbin, Cordell, & James, 2016). Because family mentors are thought to engage parents and the START protocol specifies intensive mentor services initially in the case, we hypothesized that there would be differences in service provision by mentors early and later in the START intervention.

Several qualitative studies in child welfare focused on identifying the family mentor mechanisms that support change. Based on retrospective interviews of clients, practitioners, and PRSS staff, two studies proposed similar conceptual models (Leake et al., 2012; Rockhill, Furrer, & Duong, 2015). Change processes activated by family mentors included building caring relationships with parents and engaging them in services, putting parents in charge to promote their autonomy and confidence, providing concrete guidance to parents to decrease their uncertainty, and facilitating the navigation of complex systems each with differing expectations. A common explanatory theme is the value of shared experiences between mentors and parents as critical to inspiring trust and hope (e.g., Drabble et al., 2016; Williamson & Gray, 2011).

1.2. Family mentor challenges and opportunities

A second line of inquiry in the conceptual and qualitative work to date has focused on the challenges and opportunities inherent in employing family mentors. Although any employee may face personal and professional challenges, family mentors have unique risks such as the possibility of relapse; a personal history that may trigger strong feelings of guilt, trauma or transference; and personal difficulties stemming from their SUD such as problems with children or finances that may compete with job duties (SAMHSA, 2009). When serving as a mentor, relationships with child-welfare involved parents may be less structured and familiar than the other professional relationships, fostering the potential for violating boundaries (Leake et al., 2012). Alberta, Ploski, and Carlson (2012) identified the personnel challenges of hiring family mentors into professional systems when experience is their only official credential and previous felony convictions may be a barrier. Sears et al. (2017) found from interviews that child welfare mentor/caseworker teams needed time to develop trust and that supervisors had to encourage teams to talk about personal struggles that affected their work. On the other hand, authors mention the potential benefits to workers including professional development and opportunities (Berrick et al., 2011; Sears et al., 2017), gainful employment, reinforcement of their recovery and self-confidence, and a sense of community (Leake et al., 2012).

1.3. Status of current outcome research on family mentors

Studies suggest that family mentor services for families with SUD and child maltreatment are associated with improved reunification rates (Ryan, Choi, Hong, Hernandez, & Larrison, 2008), decreased racial disparity in reunification rates (Ryan, Perron, Moore, Victor, & Park, 2017), increased speed of treatment initiation and length of treatment (James, Rivera, & Shafer, 2014), improved parental outcomes (Berrick et al., 2011; Huebner, Willauer, Posze, Hall, & Oliver, 2015) and parent engagement and satisfaction (Drabble et al., 2016). Within the system of care, family mentors have been described as a catalyst toward a changed culture by serving as information resources, participating in policy development, and modeling successful recovery (Huebner, Willauer, Brock, & Coleman, 2010; Williamson & Gray, 2011).

With the exception of the child welfare studies by Ryan et al. (2008, 2017) that used random assignment to mentor/non-mentor groups and James et al. (2014) that used propensity score matching to test the effects of mentors, the current research on family mentors has primarily been descriptive, theoretical or qualitative. Subjectively, this literature seems designed to promote mentor services as a useful adjunct to current treatment and tends to be highly positive. We failed to find any study that described the specific services provided by family mentors in child welfare that would support replication or fidelity standards. We also failed to find any prospective study on the proportion of family mentors in child welfare that experience relapse, violation of boundaries, or expanded professional opportunities. In this study, family mentors operate as one intervention component in a complex START intervention, complicating teasing out the effects of any specific strategy. We hypothesized that there would be an association between specific family mentor services and family status at case closure.

1.4. Problem statement and research questions

As the momentum, enthusiasm, evidentiary support and inclusion of family mentors into service delivery systems progresses, it is important to move beyond concepts to understand what family mentors do in different contexts, how these practices may influence outcomes, and what proportion of mentors experience challenges and opportunities. This information will support development of hiring, retention, and capacity building protocols for family mentors, defining best practices and implementation fidelity standards, and replication of evaluation studies.

This prospective study is designed to describe the functions of family mentors as provided in the context of the Sobriety Treatment and Recovery Teams (START) (Huebner, Willauer, & Posze, 2012) program to answer these research questions: