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## Preliminary evaluation of contingent meals and telephone use to improve evidence-supported family therapy session attendance in mothers referred by Child Protective Services for substance abuse

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### ABSTRACT

Persons referred by Child Protective Services (CPS) for substance abuse evidence high rates of nonattendance to therapy sessions, taxing systems of care and exacerbating outcomes. This study examined the influence of two telephone-based incentive programs on therapy session attendance in mothers who were referred by CPS for substance abuse. After baseline therapy session attendance was established in an evidence-based clinic that incorporated a telephone engagement intervention (Phase I), participants were provided free cellular telephones with limited minutes and permitted to order free meals delivered by the therapist during upcoming sessions (Phase II). The third phase was similar to Phase II, but participants were provided unlimited minutes. Results indicated that participants' attendance was significantly improved when meals and cellular telephone minutes were contingent on attendance. Although the percentage of sessions attended by participants during Phase III was higher than Phase II, unlimited minutes and meals did not significantly enhance attendance relative to limited minutes and meals. Session attendance for significant others of these participants was significantly higher during Phase III as compared with Phase I. Session attendance of significant others was statistically similar between Phase I and II and between Phase II and Phase III. Study implications and recommendations for future research and practice are discussed in light of the findings.

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Child welfare; enlistment; Family Behavior Therapy; substance abuse; telephone engagement; treatment attendance

At least 70% of parents receiving psychological treatment within the umbrella of Child Protective Services are estimated to abuse substances (Donohue, Romero, & Hill, 2006; Dunn et al., 2002; Hamilton & Browne, 1999; Walsh, MacMillan, & Jamieson, 2003), with up to two thirds of the children of these parents being negatively affected by parental substance abuse (Young, Boles, & Otero, 2007). Parents who abuse illicit drugs evidence lower compliance in

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family preservation services than parents who do not abuse substances (Littell & Tajima, 2000).

It has long been established that individuals afflicted with substance use disorders lack motivation to attend treatment programs (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Corrigan & Bogner, 2007; Palmer, Murphy, Pisell, & Ball, 2009; Newman, 1997). Moreover, these individuals attend scheduled treatment sessions less frequently than individuals who are referred for mental health issues that do not involve substance abuse (Jackson, Booth, McGuire, & Salmon, 2006; Livianos-Aldana, Vila-Gomez, Rojo-Moreno, & Luengo-Lopez, 1999; Mitchell & Selmes, 2007). For instance, Famularo and colleagues (1989) found that only 21% of parents with a substance use disorder kept at least one therapy appointment per week, and 80% of parents with a substance use disorder were classified as having not received adequate treatment due to poor retention and compliance. Poor therapy session attendance is high among individuals who are referred for child maltreatment (e.g., Donohue, Ammerman & Zelis, 1997; Chaffin et al., 2009; Chaffin, Funderburk, Bard, Valle, & Gurwitsch, 2011), and therapy session attendance appears to be particularly poor among caregivers who have been identified to maltreat their children and abuse substances concurrently (Gregoire & Schultz, 2001). In addition, court orders mandating treatment for child maltreatment and substance abuse appear to be largely ineffective in fostering engagement (Beckerman & Fontana, 2001; McWey, Holtrop, Wojciak, & Claridge, 2015).

Home-based services are often utilized in populations that are difficult to engage into treatment, especially families experiencing problems related to child maltreatment and substance abuse (Alonso-Marsden et al., 2013; Henggeler, Pickrel, Brondino, & Crouch, 1996; Slesnick & Prestopnik, 2004). However, despite the recent interest in home-based services as a means to enhance family engagement, only one half of scheduled home-based sessions are attended on average, and attrition rates for these programs remain relatively high, ranging from 20% to 80% (Gomby, 2005). This is especially concerning because engagement and retention of families in home-based services are critical to enhancing overall family outcomes (Brand & Jungmann, 2014; Gomby, 2005).

Several interventions have been developed to improve therapy session attendance, including phone calls and token gifts (see review by Lefforge, Donohue, & Strada, 2007). Telephone calls are especially appealing in populations with substance abuse problems because they are relatively inexpensive and effective. For instance, Donohue et al. (1998) compared a 10-minute telephone attendance intervention with a standard telephone orientation call in youth who were receiving substance abuse treatment. The intensive telephone intervention involved a range of components, including disclosure of information about the treatment program, esteemed reputation of the

assigned clinician, and empathic responses specific to the reason for referral. Calls were also made to youth and their parents, and it was disclosed that refreshments would be available during each intervention session attended. Directions to the clinic were provided and subsequently solicited, and it was indicated that refreshments would be offered at the upcoming intervention session. Findings revealed that this intensive telephone call intervention resulted in greater attendance (89%) than a standard orientation telephone call intervention (60%).

Although therapy session attendance is particularly poor when substance abuse and child maltreatment are concurrently indicated, it appears that no interventions have been favorably evaluated to improve attendance rates in this population (Lefforge et al., 2007). Under this backdrop, the following feasibility study involved an evaluation of two contingency management attendance interventions in mothers who were identified to neglect their children and abuse illicit drugs. Session attendance was also evaluated for their adult significant others. The study consisted of three phases. In the first phase, all participants in an evidence-based treatment program were scheduled to receive weekly engagement telephone calls prior to each scheduled therapy session. After baseline therapy session attendance was established, participants were provided limited cell phone minutes and meals were provided for each person in their family contingent on therapy session attendance. After family therapy session attendance was stabilized in the second study phase, the cell phone plan was changed to allow for unlimited talk time. It was expected that the incentives would significantly enhance family treatment session attendance, particularly when talk time was unlimited.

## Method

### Participants

Participants were 35 mothers who were court ordered to assessment by Child Protective Services (CPS). Participants and their adult significant others (e.g., parents, spouses, supportive friends) who were interested in attending therapy sessions in this study were referred by CPS to a home-based family treatment program for child neglect and drug abuse. These mothers were randomly assigned to receive family-based behavioral treatment as part of a treatment outcome study assessing the efficacy of Family Behavior Therapy for mothers with concurrent child neglect and drug abuse (see Donohue et al., 2014a). Inclusionary criteria for the study were (1) official report of child neglect to CPS within the previous 4 months, (2) evidence of illicit drug use during the previous 4 months per self-report of participant or CPS caseworker, (3) evidenced drug abuse or dependence according to results of the Structured Clinical Interview 4th Edition (SCID-IV;

First, Spitzer, Gibbon, & Williams, 1996), (4) child living with the identified participant or it was the intention of the court to return the child to the participant's home, (5) not referred primarily for domestic violence or sexual abuse, and (6) participant's willingness to have at least one adult participate in treatment.

Mean age of participants was 29.0 ( $SD = 7.7$ ) and the mean age of the identified child was 3.6 ( $SD = 3.42$ ). On average, mothers had 2.5 ( $SD = 1.41$ ) children living in their homes. Fourteen mothers (40%) identified themselves as White, 10 as African American (28.6%), six as Hispanic (17.1%), two as Asian American (5.7%), two as American Indian (5.7%), and one (2.9%) as Pacific Islander. Fourteen (40%) participants reported to be single, 15 participants were cohabitating (42.9%), and six reported being married (17.1%). Twenty-eight mothers were unemployed (80%), four reported a part-time job (11.4%), and three reported full-time employment (8.6%).

Using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*DSM-IV-TR*) (American Psychiatric Association, 2000) diagnostic criteria, nine participants (12.5%) were diagnosed with current cannabis dependence, 13 (18.1%) with cannabis abuse, five (6.1%) with alcohol dependence, two (2.4%) with alcohol abuse, 25 (34.7%) with methamphetamine dependence, 13 (18.1%) with methamphetamine abuse, three (4.2%) with opioid dependence, one (1.4%) with opioid abuse, five (6.1%) with cocaine dependence, and two (2.8%) with cocaine abuse.

### **Retention**

Four (11.4%) participants discontinued treatment without attending a single session, three (8.6%) attended four or fewer sessions, and 28 (80.0%) attended eight or more sessions (range: 8–20).

### **Measure**

The primary measure in this study was the percentage of home-based treatment sessions attended by participants and their adult significant others. A session was recorded as missed if they cancelled the session without rescheduling or were not home when the providers arrived at the scheduled time. For significant others, a session was recorded as missed only if a significant other was not present during a completed session.

### **Intervention**

Family Behavior Therapy for child welfare (FBT-CW; Donohue et al., 2014b) is based on the community reinforcement approach (Azrin, Sisson, Meyers, & Godley, 1982; Hunt & Azrin, 1973). FBT-CW is a home-based treatment that includes (1) treatment planning, (2) contingency management, (3) stimulus control to encourage spending less time with individuals and situations that have involved substance use and other problem behaviors and more time with positive

influences, (4) self-control to decrease urges to use drugs and engage in other impulsive behaviors, (5) communication skills training to increase assertiveness and establish positive social relationships with others, (6) financial management, (7) job-getting training, (8) child management skills training, and (9) emergency prevention and management (Urgelles, Donohue, Wilks, Van Hasselt, & Azrin, 2012). Significant others are incorporated to assist implementation of behavioral intervention components (e.g., modeling skills, driving participants to therapeutic activities, encouraging participation in prosocial activities that do not involve drug use, assisting completion of therapeutic assignments). This treatment model allows participants to experience natural consequences for undesired behaviors as well as positive reinforcement for behaviors that are consistent with treatment planning. Family Behavior Therapy has demonstrated success in controlled trials involving adults and adolescents (Azrin et al., 1996; Azrin et al., 2001; Azrin, Donohue, Besalel, Kogan, & Acierno, 1994; Azrin, McMahon, et al., 1994; Donohue et al., 1999; Donohue et al., 2014a).

### **Procedure**

Upon being referred for treatment, the referring caseworker was contacted to determine participant eligibility. Eligible participants were then contacted by telephone to preliminarily assess that all inclusion/exclusion criteria were met with the exception of having a SCID-IV substance abuse and dependence diagnosis per SCID-IV. The SCID-IV was scheduled to occur along with a battery of tests specific to the presenting problem within 7 days of being referred to treatment by the caseworker. Mothers were involved with CPS for the duration of their treatment. Treatment included up to 20 sessions over a 6-month period. The study consisted of three phases that were sequentially initiated in the clinic. Study Phase I (engagement telephone calls to the participant's personal phone) lasted 44 weeks (baseline), Study Phase II (provision of cell phone, engagement telephone call, contingent limited minutes and meals) lasted 26 weeks, and Study Phase III (provision of cell phone, engagement telephone call, contingent meals and unlimited telephone minutes) lasted 60 weeks. The study was approved by the local Institutional Review Board, and a certificate of confidentiality was obtained to restrict participant data in the unlikely event of a judicial mandate. All participants completed informed consent. No adverse events were indicated in this study.

### **Intervention phases**

#### ***Phase I (engagement telephone calls to personal phone number; baseline).***

Attempts were made to contact participants on their personal phone number(s) (i.e., landline and/or cell phones) 2 to 3 days prior to each scheduled treatment session once per week for approximately 10 minutes. A structured protocol was utilized during these telephone calls, based on whether participants attended their

last scheduled session or not. The protocol included the following components: (1) introduction of self and program, (2) assessment of immediate stressors or emergencies, (3) query of next scheduled appointment, (4) query and problem solving of potential barriers to make appointment, (5) discussion of positive activities client can engage in with family, (6) query of practice assignment for the week, and (7) query of feedback for therapy and enlistment call. Engagement specialists were trained in the use of this structured step-by-step protocol prior to interacting with participants. If participants did not answer engagement calls, they were contacted up to three times prior to each scheduled session. If a participant completed an engagement call with the engagement specialist, calls would stop until 2 to 3 days before their next scheduled session. If participants did not respond to engagement calls, therapists still went to the home at the scheduled session time.

*Phase II (provision of cell phone with engagement call and contingent limited minutes and meals).* Participants were provided a cell phone with up to 300 minutes of talk time per month. Attempts were made to contact participants on these cell phones 2 to 3 days prior to each scheduled treatment session once per week for approximately 10 minutes. If participants did not answer engagement calls, they were contacted up to three times prior to each scheduled session. For the most part, the same structured protocol that was utilized during Phase I was utilized in Phase II. However, the participants were additionally informed that if they attended their weekly scheduled psychotherapeutic session, they would be permitted to use up to 75 minutes of talk time throughout the next week. That is, if participants did not attend the respective session, their minutes would be suspended until they reengaged in treatment. Participants were also permitted to request one prepackaged meal from a menu for each family member who attended the upcoming therapy session. If participants did not answer the engagement calls prior to the scheduled session, meals were not brought to session. Thus, meals were contingent on answering the engagement call and attending session. Meals were not provided to families if (1) an engagement call was not completed prior to the session or (2) if mothers were not present for a scheduled session. If mothers' missed a session, they were still given the opportunity to receive meals for attending future sessions.

*Phase III (provision of cell phone and engagement call with contingent meals and unlimited minutes).* Participants were provided a cell phone with unlimited minutes of talk time per week. Attempts were made to contact participants on these cell phones 2 to 3 days prior to each scheduled treatment session once per week for approximately 10 minutes. If participants did not answer engagement calls, they were contacted up to three times prior to each scheduled session. The structured protocol that was utilized during Phase II was also utilized in Phase III. Participants were informed that if

they attended their weekly scheduled treatment session, they would be permitted unlimited minutes of talk time throughout the next week instead of 75 minutes. However, if a session was missed, all minutes were suspended until they attended a subsequent session. As in Phase II, participants were permitted to request one prepackaged meal for each family member who attended the upcoming therapy session. Meals were not provided to families if (1) an engagement call was not completed prior to the session or (2) if mothers “no-showed” a session. If mothers’ missed a session, they were still given the opportunity to receive meals for attending future sessions.

## Results

Descriptive analyses were conducted to examine therapy session attendance for each of the three study phases. Additionally, a chi-square test for trend was calculated across the three phases of the study to test the hypothesis of an increasing trend in the percentage of participants and the percentage of significant others attending sessions, owing to the increase in incentives. An overall test for increasing trend was conducted first, with Bonferroni-corrected multiple comparisons for Phase I to Phase II and for Phase II to Phase III if the overall trend was significant. Data from participants that discontinued treatment at any point were included in the analyses. In all cases, exact one-tailed p-values were calculated.

On average, mothers attended 16.95 treatment sessions ( $SD = 4.80$ ) and their significant others attended 11.42 of those treatment sessions ( $SD = 6.31$ ). The percentage of calls completed and the percentage of sessions attended during each study phase are presented in Table 1 for the participants and their significant others. The percentage of completed calls (vs. noncompleted calls) and percentage of therapy sessions attended (vs.

**Table 1.** Percentage of engagement calls completed and intervention sessions attended by participants and their significant others during each of the three study phases.

Intervention component	Components	% Completed calls	% Attendance for participants	% Attendance for significant other
Phase I (TC; baseline)	Weekly phone calls to personal phone	30	46	40
Phase II (TCLM+M)	Weekly phone calls to provided cell phone w/ limited minutes + meals contingent on therapy session attendance	49	69	42
Phase III (TCUM+M)	Weekly phone calls to provided cell phone w/ unlimited minutes + meals contingent on therapy session attendance	57	75	48

*Note.* TC = telephone calls; TCLM + M = telephone calls with contingent limited minutes and meals; TCUM + M = telephone calls with contingent unlimited minutes and meals.

nonattended) is presented in Table 1. There was a 29% increase from Phase I to Phase III for participant attendance, and a 6% increase from Phase II to Phase III. This trend across phases was significant for participants from Phase I to Phase III ( $\chi^2 = 46.28, p < .001$ ); further, there was a significant positive increase in attendance from Phase I to Phase II ( $\chi^2 = 24.13, p < .001$ ) but not from Phase II to Phase III ( $\chi^2 = 1.71, p = .116$ ). For significant others there was an 8% increase in the percentage of therapy sessions attended from Phase I to Phase III, and a 6% increase from Phase II to Phase III. The trend from Phase I to Phase III was significant for significant others ( $\chi^2 = 3.27, p = .039$ ); however, increases between Phase I to Phase II ( $\chi^2 = .284, p = .330$ ) and between Phase II to Phase III ( $\chi^2 = 1.28, p = .151$ ) were not significant.

## Discussion

In this study of mothers court ordered by CPS for substance abuse, telephone talk time and food incentives were found to increase rates of home-based session attendance to an evidence-based family therapy when these incentives were provided contingent on session attendance. Specific to cost, unlimited talk time did not increase the mothers' attendance significantly more than limited minutes (75 minutes of talk time per week). However, relative to baseline session attendance, the unlimited phone plan was necessary to facilitate significant improvement in rates of session attendance for the significant others of these mothers. In explaining these results, it is important to point out that telephone contact time between the engagement specialists and the mothers and their significant others increased as the intensity of intervention increased. It is our belief that increased talk time facilitated between-session therapeutic interactions that have been shown to be important in maintaining rapport, trust, and confidence in treatment providers (Lambert & Barley, 2001). These kinds of relational issues may be particularly important with this population given that parents under investigation for child maltreatment are often mistrustful of mental health professionals (Donohue, Holland, Lopez, Urgelles, & Allen, 2014; Fals-Stewart, Fincham, & Kelley, 2004). Moreover, the provision of food, telephone talk time, and support probably had an immediate positive impact on the mothers and their family, motivating them to invest further in treatment.

Although our hypotheses were generally confirmed, it is important to emphasize that participants were not randomly assigned to a single condition but rather were tracked over time as differing levels of incentives were offered depending on the phase(s) of the study that were occurring during each participant's treatment. The duration of time mothers were involved with CPS prior to entering the study was not assessed. One of the primary limitations of this study concerns its lack of a control group. Thus, it is possible that the observed changes in attendance rates may have been

influenced by extratreatment factors associated with the passage of time (e.g., increased sensitivity of treatment staff to the importance of therapy session attendance) or changes in the therapeutic relationship over time. However, it is important to note the end points of attendance in each phase were relatively stable going into the next phase. Therefore, future investigations will need to incorporate tighter experimental control, such as the utilization of random assignment of participants to attendance intervention conditions to definitively establish the relative influence of the attendance interventions that were examined in the current study. Nevertheless, the results of the current study suggest contingently earned cell phone use and meals have the potential to improve home-based session attendance in mothers who have been found to neglect their children and abuse illicit drugs within the child welfare system, providing a method of engaging caregivers who are at high risk to prematurely withdraw from evidence-supported treatment.

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