ABANDONED INFANTS ASSISTANCE PROGRAM

Cross-Site Evaluation Summary
September 30, 2010 – September 29, 2011

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Introduction to the Abandoned Infants Assistance (AIA) Program

Infant abandonment resulting from substance abuse and HIV infection during pregnancy posed significant challenges for hospitals beginning in the 1980s. Since then, programs have been developed and a number of solutions have been implemented to reduce lengthy infant hospital stays. However, challenges for ensuring the ongoing safety, permanency, and well-being of the infants at risk of abandonment – even with these interventions – still persist across the United States.

Abandoned Infants Assistance (AIA) Act

In 1988, Congress passed the AIA Act. The AIA Act aimed to prevent the abandonment of infants and young children affected by parental substance abuse and/or HIV and to develop family support systems or alternative safe and stable child placements, when necessary. Today, funding from the AIA Act equips collaborative initiatives to better address the complex issues associated with infant abandonment and the impacts of HIV and substance abuse on young children. Over the years, various intervention strategies have emerged from the work of AIA projects that address the issues faced by families in which children are at risk for abandonment. The ongoing work associated with the AIA program seeks to promote the safety, permanency, and well-being of the children and instill protective factors in their families.

AIA Projects

Since passage of the AIA Act in 1988:

- The U.S. Department of Health and Human Services (DHHS) has realized far-reaching effects by providing funds to the National AIA Resource Center and 94 service demonstration projects to improve the lives of vulnerable children and families.
- In FY 2011, the Children’s Bureau funded the National AIA Resource Center and 17 AIA demonstration service projects located in 12 states and the District of Columbia.
- These projects use a number of different models to deliver comprehensive services to families.
- Each of these projects has differences in their target population.
- AIA grantee organizations have included hospitals, community-based child and family service agencies, universities, and public child welfare agencies.
- The grantees are committed to preventing child abandonment by developing approaches to assist families, with particular emphasis on addressing the effects of HIV/AIDS and drug exposure on infants and children. They aim to build the capacity of families to provide safe, stable homes for their children, while also enhancing the capacity of foster care and other service providers to meet the complex needs of the children, when needed.

Cross-Site Evaluation

In 1996, AIA projects first submitted de-identified participant data to the National AIA Resource Center. The data were aggregated and analyzed to characterize AIA participants and services across all projects.

- In 2002, the National AIA Resource Center contracted with the University of Missouri-Kansas City Institute for Human Development to oversee the cross-site evaluation.
- This report summarizes FY 2011 cross-site data collected from each of the 17 AIA-funded projects.
- Caution should be exercised in interpreting the reported findings due to substantial differences in the interventions employed by the 17 projects, as well as demographic differences in the populations served and criteria for participation. In addition, program participants varied in degree of engagement with the AIA projects. Some variation in the extent of project participation in the cross-site evaluation also occurred.
- Despite these limitations, this report aims to describe the families served, the interventions designed to support them, some indicators of the success of AIA projects, and some recommendations based on the findings.

Comprehensive AIA Projects in Fiscal Year 2011

Overview of Comprehensive AIA Project

Seventeen comprehensive AIA service demonstration projects were funded between September 30, 2010 and September 29, 2011 (FY 2011). See the Appendix for a list of these projects.

All 17 projects reported participant-centered cross-site data describing the enrolled biological mothers and designated “index children” (typically the youngest child in the family), as well as the program activities and services.

During FY 2011, the 17 AIA projects served 1,491 families, and the AIA Cross-Site Evaluation collected information regarding 1,483 mothers and 1,353 index children within these families. The following sections of this report discuss specific subgroups of the families:

- The 769 mothers and the 679 index children who enrolled during FY 2011;
- The 462 mothers and 448 children with final information collected in FY 2011;
- The 312 women served during FY 2011 identified as HIV-positive or having AIDS; and
- The 1,092 women served in FY 2011 who had been identified as having substance abuse issues (i.e., substance abuse history, substance abuse at the time of program entry, or use during the most recent pregnancy).

Sixteen of the 17 AIA projects also estimated the broader population that benefited from their program activities during FY 2011. Approximately 5,623 individuals engaged with the AIA projects in some way during FY 2011. This estimate included 3,341 children, 1,715 mothers, 176 fathers, and 391 other caregivers.

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2 Numerous circumstances contribute to the seeming incongruity between the numbers of mothers and children served in a given year. For example, a child may not yet be born, a child may be placed with another caregiver, multiple index children may be served, and the target population may vary across projects.

3 Time 2 is designated as the most effective time for the AIA project to collect final information from participants prior to discharge from their program. Receipt of Time 2 data collected during FY 2011 is used as a proxy for participation having ended in FY 2011. In some instances, program participation may have continued beyond the collection of Time 2 data.
Profile of Newly Enrolled Families in Fiscal Year 2011

Information about characteristics of mothers, index children, and other family members was submitted at Time 1 (intake and shortly thereafter). This information was updated at Time 2 (prior to discharge) and submitted with information about the services that each family accessed.4

Families at Program Entry

These findings describe the 769 mothers and 679 children who entered an AIA project during FY 2011. Together they represent 807 families from 17 AIA projects.5

- The 679 children lived in these arrangements at their enrollment: with the parent either at home (74%) or in residential treatment (2%), with relatives (5%) or in formal kinship care (4%), in foster care (8%), hospitalized (4%), in another (1%) or unreported (1%) arrangement.
- Five hundred thirty-eight newly enrolled families (67%) had other children besides the index children. More than half (54%) of the 1,181 other children in the families received AIA services.
- Families were referred to the AIA project by hospitals (34%), public welfare agencies (28%), other community agencies (7%), treatment programs (9%), law enforcement or courts (3%), self-referral (8%), family or friends (6%), and other or unidentified entities (5%)

Biological Mothers at Enrollment

Initial Mother Profile. Information from 769 biological mothers contributes to this profile at entry:

- Maternal age ranged from 13 to 53 years, with a mean of 27 years.
- The race of the women enrolled in FY 2011 was white for 52%, black for 29%, American Indian or Alaska Native for 1%, Asian for 1%, Native Hawaiian or Pacific Islander for < 1%, multiracial for 7%, and unknown for 9% of the women.
- The 279 participants who considered themselves Hispanic identified their race as white (67%), multiracial (10%), American Indian/Alaska Native (1%), black (1%), and Native Hawaiian or Pacific Islander (< 1%), with race unknown for 21%. Spanish was the primary language in the home of 19% of the Hispanic participants.
- Time 1 information included the self-identified nationality of 59 Hispanic and 9 non-Hispanic participants.6 The Hispanic women reported these nationalities:
  - Mexican or Mexican-American (53%);
  - Dominican Republic and U.S. Territory of Puerto Rico in the Caribbean (37%);
  - Honduras and Panama in Central America (5%); and
  - Colombia, Ecuador, and Venezuela in South America (5%).
- The non-Hispanic women identified with these countries:
  - Trinidad and Puerto Rico in the Caribbean (33%);
  - Guyana in South America (11%);
  - Germany and Scotland in Europe (22%);
  - Korea in Asia (11%);
  - Namibia in Africa (11%); and
  - Multi-national heritage from the countries of Ireland, Holland, and India (11%).

4 Throughout this report, small variations in sample size are due to missing information on given variables. Percentages may not total to 100% due to rounding computations.
5 As stated, a number of variations (e.g., in child placement, in time of delivery, and in program design) resulted in different sample sizes of mothers and children newly enrolled in FY 2011.
6 This excludes those who identified a continent (e.g., American or African) or identified their nationality as the “United States.”
Most mothers were single and never married (70%); 14% were married; 11% were separated, divorced, or widowed; and the marital status of 5% was unknown or categorized as “other.”

Half of the mothers enrolled had completed high school or earned a GED.

Overall, 521 (68%) had some monthly cash income. Of those, 12% had both employment earnings and non-employment income, 18% had employment earnings only, 68% had non-employment income only, and source was unknown for 2%. Thirty-two percent of the 499 mothers with no employment earnings had income from Temporary Assistance for Needy Families (TANF) benefits. The mean monthly income was $1,144 for those with employment earnings and $524 for those with no employment earnings.

Eighty-eight percent of the mothers reportedly had non-cash income at the time of enrollment, including 88% with Medicaid, 81% with food stamps, 67% with Women, Infants and Children (WIC) benefits, and 19% with housing subsidies or public housing.

At the time of enrollment, 82% were living in a house or apartment, 4% were in residential treatment, and 4% were homeless. The remaining 10% includes individuals residing in a boarding house or a single room occupancy hotel/motel (1%), those in a supported living arrangement (2%), and those who were incarcerated (2%), with 3% in other unidentified housing arrangements and 2% having this information missing or unknown.

Twenty-two percent lived with no other adults, 27% lived with their partner, 39% lived with parents or other relatives, 8% lived with non-relatives, and 10% lived in other arrangements.\(^7\)

Of enrolled women, 32% were pregnant at intake, 6% had recently delivered, and 59% had not delivered within the past 30 days; the pregnancy status for 3% of mothers was not reported.

Information about prenatal care was available for 697 of the 769 newly enrolled women (91%). Prenatal care began in the first trimester for 64%, in the second trimester for 23%, and in the third trimester for 7% of the 697 mothers. Four percent received no prenatal care, and 2% received prenatal care for an undetermined amount of time.

**Maternal Risk Factors.** These known risk factors of the 769 newly enrolled women placed their families, their children, and the women themselves at risk:

- A history of substance abuse for 80%;
- HIV-positive status or AIDS for 11%; and
- Each of the following risks exhibited by at least 20% of mothers: adult domestic violence victimization (38%), psychiatric illness (33%), criminal conviction (34%), sexual abuse as a child (23%), removal of a child from the home (30%), and physical abuse as a child (21%). Figure 1 displays the most common risk factors.

\(^7\) More than one category could be selected.
**Substance Use.** Six hundred fifty of the 769 women entering AIA projects (85%) had identified substance abuse issues, including 611 with a substance abuse history, 481 who had used during pregnancy with the index child (which includes 105 women whose only substance use during pregnancy was tobacco), and 146 who were using at the time of program entry.

- Of the 376 women who used drugs during pregnancy with the index child, 49% used 1 drug, 32% used 2 drugs, 11% used 3 drugs, 4% used 4 drugs, 2% used 5 or more drugs, and 2% did not specify the drug or drugs used. The preceding numbers exclude the 105 women who reported using only tobacco during their pregnancies and excluded tobacco as a specified drug.
- Two hundred eighty-eight women reportedly smoked when pregnant with the index child, and 63% of those who smoked used from one to six other substances (alcohol or other drugs), as well.
- Of the 376 women with reported substance use during pregnancy (excluding tobacco use only), 51% used marijuana, 30% drank alcohol, 29% used opiates (not including methadone), 26% used cocaine (including 17% using crack cocaine and 13% using powdered cocaine), 16% used methadone, 13% used amphetamines, 4% used barbiturates, 2% used PCP, and 4% used some other drug. The most common combinations of drug usage were alcohol and marijuana (14%), alcohol and cocaine (12%), cocaine and marijuana (11%), marijuana and opiate (11%), and methadone and other opiates (10%). Five percent used cocaine, marijuana, and alcohol during pregnancy. Seventy-four percent of those who used alcohol also used at least one other drug (excluding tobacco) during pregnancy. Of the 650 women with substance abuse issues, 33% accessed treatment within the previous 6 months prior to program entry, and 16% accessed treatment earlier. Duration of treatment occurring prior to AIA program entry ranged from 1 month to 7 years, with an average of 5 months and 13 days.
- The 317 women who accessed treatment before enrolling in an AIA project used a range of these methods: detoxification (21%), residential (43%), outpatient (60%), inpatient hospital-based (3%), self-help (35%), or other methods (3%).
- These previous treatment completion rates were reported at enrollment: detoxification (76%), residential (78%), outpatient (46%), and inpatient hospital-based treatment (83%). Overall, 51% of women who had accessed treatment prior to AIA enrollment had completed at least some form of treatment.  

**Index Children Newly Enrolled during Fiscal Year 2011**

**Initial Child Profile.** These characteristics describe the 679 children newly enrolled in FY 2011:

- Child age ranged from newborn to 14 years, with a mean of 21 months (median age of 6 months).
- Fifty percent were male and 50% were female.
- Children were identified as white/Caucasian (44%), black/African American (31%), American Indian/Alaska Native (1%), Asian (<1%), native Hawaiian or Pacific Islander (<1%), multiracial (16%), and of unknown race (7%).
- Two hundred eighty children were identified as Hispanic/Latina(o), which included children whose race was identified as white (62%); black (3%); multiracial (18%); and American Indian (1%), with the remaining 16% being unspecified.

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8Because many forms of self-help treatment do not focus on completion, self-help treatment is excluded from the analysis of completion rates in this report.
Child Risk Factors. Some birth information was reported for 637 of the 679 children enrolled in FY 2011:

- Gestational age of 601 infants ranged from 25 to 44 weeks, for a mean of 38.1 weeks (with gestational age unknown for 78 infants). The rate of preterm births (< 37 weeks) was 19%, which is greater than the national average of 11.7% for 2011.9
- Average birth weight was 3,009 grams for 482 infants enrolled in AIA projects (with birth weight unknown for 197 infants). Reported birth weights ranged from 482 grams to 4,649 grams, with 12% at risk due to low birth weight and 3% at risk due to very low birth weight10 (compared to 8.1% and 1.4% national averages in 2011, respectively).11
- Infants spent a mean of 5 days in the hospital after birth, compared to a national average of 3.6 days.12 Forty-three (8%) of 508 infants were known to have stayed in the hospital beyond medical necessity, and did so for a mean of 11 days. The reason for the extended stay was Child Protective Services involvement 20% of the time, the mother’s inability or unwillingness to care for the infant 3% of the time, and unidentified 77% of the time.
- Nineteen percent of the 679 infants were known to have required special care at birth,13 and 4% of them were known to have had congenital abnormalities.
- Seventy-seven newly enrolled children were reportedly exposed to the HIV virus at birth, including 75 whose mothers were HIV-positive and 2 whose mothers’ HIV status was unknown. By the time of AIA enrollment, 62 of the 77 children exposed to the virus at birth (81%) reportedly tested negative for the HIV virus and 5 (6%) tested positive, while the HIV status was unknown for 10 (13%).
- Sixty percent of 679 newborns were tested for drugs at birth. According to available toxicology reports for 403 newborns, 38% tested positive for drugs. Of the 144 newborns with positive toxicology reports, the most commonly identified substances found were methadone (33%), marijuana (30%), opiates (24%), crack cocaine (19%), and amphetamines (10%).
- A child protective services case was active for 60% of the index children at Time 1.

Birth Outcomes for Infants of Mothers Served during Pregnancy. For 175 infants that enrolled during FY 2011, the mother was pregnant at enrollment in the AIA project. Their birth information was compared to birth information of the infants of 478 mothers who did not enroll during pregnancy. While there were some statistically significant differences in outcomes, the effect sizes were very small, suggesting that little of the difference was associated with pregnant or postpartum status at enrollment.14

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10 Very low birth weight is defined as < 1,500 grams; low birth weight is defined as 1,500 - 2,499 grams.
13 Examples of special care needs at birth include isolette, parenteral feeding (IV, NG-feeding tubes), heart monitor, and apnea monitor.
14 Gestational age: Respective means of 39 weeks for infants of pregnant enrollees and 38 weeks for infants of postpartum enrollees; \( F(1,586) = 11.86, p =.001, \eta^2 = .02 \). Incidence of special health care needs at birth: Four percent of infants of pregnant enrollees and 16% of infants of postpartum enrollees had special health care needs at birth; \( x^2 (1) = 4.33, p < .05 \).
Families that Completed Participation in Fiscal Year 2011

Biological Mothers

Length of Participation of Mothers. AIA projects provided Time 2 information for 462 participants in FY 2011. The length of time between Time 1 and Time 2 data collection points was available for 460 of the mothers; by Time 2, they had participated in the AIA project an average of 7 months 19 days.

Services Received by Mothers. Time 2 data documenting the services delivered by the AIA project and by other agencies to which they were referred were available for 462 participants.

- AIA projects provided a number of direct services to the mothers who needed them, including case management for 87%, in-home services for 83%, parenting classes for 74%, and transportation services for 70%. Services were provided to support biological fathers or the mother’s partner for 32% of AIA families that needed these services by program completion.

- AIA projects referred 64% of participating mothers to some form of medical care, including primary care, prenatal, and/or postnatal care.

Changes over Time in Sources of Income. Four statistically significant changes occurred between Time 1 and Time 2 in the sources of cash income and non-cash income benefits of participating mothers. Increases over time were seen in the number of mothers receiving TANF benefits (29% to 35%); Medicaid (79% to 87%); housing subsidies (19% to 23%); and Food Stamps (77% to 82%). There were no significant changes in reported mean monthly cash income from Time 1 to Time 2. Figure 2 presents these findings.

![Figure 2. Changes over Time in Sources of Income during AIA Participation](image)

Time 2 Participation Status for Mothers. Projects provided information about the AIA program status of participants at Time 2. Of the 462 participants, 34% completed the program, 20% continued to receive additional program services, 9% withdrew, 5% relocated, 4% transferred to another agency, 9% were terminated for noncompliance, 1% were institutionalized, 3% left for other unspecified or unknown reasons, and 15% were unable to be located. Two mothers (1%) died in FY 2011.

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15 Time 1 occurred during the person’s initial enrollment in the AIA project. This window extended for a short period of time after intake, to aid in the determination of client engagement and the collection of initial data. Duration of this Time 1 data collection window was typically 1 to 2 months. Time 2 occurred at a project-defined time prior to termination or discharge from the AIA project. In determining Time 2, projects were to consider what point in time prior to termination would render the most reliable data for the largest percentage of families.

16 Sample sizes were 414, 336, 361, 306, and 230 for these five services, respectively.

17 Sample size was 324 women who needed some form of medical care (primary medical care for 317, prenatal care for 199, and postnatal care for 207 women).

18 Sample sizes for the sources of income ranged from 312 to 349.
**Time 2 Results for Mothers Based on AIA Program Participation.** Time 2 results were compared for two groups of participants: (1) 251 mothers who either continued to receive AIA services at Time 2 or completed AIA program requirements, and (2) 208 mothers who prematurely discontinued participation in the AIA project without completion (excluding 3 mothers whose status was unknown). Statistically significant differences were seen in the percentages of mothers in these two groups experiencing the following positive outcomes at Time 2: having cash income, having non-cash income, having a housing subsidy, the absence of alcohol and drug use, and the completion of drug treatment. The percentage of women achieving each outcome was higher for those who continued or successfully completed the AIA program requirements than for those who discontinued their involvement prematurely. Figure 3 presents the statistically significant differences associated with program participation at Time 2.

![Figure 3. Differences in Results Based on Mother's AIA Program Participation at Time 2](image)

**Index Children**

**Length of Participation of Child.** The length of time between Time 1 and Time 2 was documented for 444 of the 448 children for whom Time 2 data were submitted in FY 2011.\(^{19}\) Logically, the duration was similar to that reported for mothers. Children spent an average of 7 months, 8 days in AIA programs, with length of time ranging from 6 days to 2 years, 3 months.

**Child Services Received.** Time 2 data for 448 children indicated the services they received from the AIA project and/or other agencies to which their family was referred.\(^{20}\)

- A majority of children received case management (78%), infant development assessment (57%), and child development/education services (66%) directly from the AIA projects.
- Children were most frequently referred by AIA projects to community partners for these types of services: health care (68%), nutrition services (49%), and child care (35%).

**Time 2 Participation Status for Children.** The following AIA program status was identified at Time 2 for 448 of the children: completion of program requirements (34%), continuation of services after data submission (21%), caregivers’ withdrawal from the AIA project (9%), loss of contact (18%), relocation (5%), referral or transfer to another program (5%), return to biological caregiver (1%), child death (<1%), adoption (<1%), and unspecified reasons (5%). Two children died from congenital illnesses.

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\(^{19}\) AIA projects assessed whether children received services through the completion of child program requirements independent of whether the biological mother completed her program requirements.

\(^{20}\) Sample size for the various types of child services ranged from 151 to 370. Children not needing services were excluded from the sample.
Time 2 Results for Children Based on AIA Program Participation. Of 448 children, 250 continued or completed the AIA program at Time 2; 191 children prematurely discontinued, and status was unknown for 7 children. These statistically significant positive outcomes were seen at Time 2 for the children who continued or successfully completed the program: higher percentages of children placed with the biological parent and lower percentages with active child protective services involvement.

Differences Associated with HIV/AIDS Status of Participants

Participant Characteristics

Three hundred and twelve of the 1,483 mothers who were served by AIA projects in FY 2011 were HIV positive or had AIDS. Of these, 96% were served by five AIA projects, and the remaining 4% were dispersed among six other AIA projects.

Fifty-three percent of the index children were living with the biological parent; 5% were living with other relatives, 7% were in adoptive or pre-adoptive homes, 4% were in foster care, and 31% were in other or unknown placements. Two hundred fifteen of the 312 HIV-positive women also had a total of 421 non-index children, including 319 who lived in the home.

Differences were seen in the incidence of HIV-positive status or AIDS among the AIA participants, based on race/ethnicity. The racial/ethnic composition of the HIV/AIDS population served by AIA projects was 22% Hispanic (any race), 71% non-Hispanic African-American (black), 5% non-Hispanic Caucasian (white), and 2% other, mixed, or unreported race/ethnicity.

Most participants with HIV/AIDS had cash income at intake (83%), although 15% had no cash income. This information was unknown for 2%.

Fourteen percent of mothers with HIV/AIDS had used drugs and/or alcohol during pregnancy, while 47% had not; it was unknown whether drugs and/or alcohol were used during pregnancy of 39% of the mothers with HIV. Mothers with HIV/AIDS had a history of the risk factors displayed in Figure 5.

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21 HIV/AIDS status was negative for 1,033 and unknown for 138 of the 1,483 mothers served in FY 2011.
Services Accessed

Only 75 women with an identified HIV-positive or AIDS diagnosis completed Time 2 in FY 2011. By Time 2, the following percentages of women with HIV/AIDS who needed these services had accessed them: case management (76%), HIV treatment (72%), medical care (71%), HIV education and prevention (69%), parenting classes (68%), mental health counseling (59%), HIV screening and assessment (57%), and permanency planning (52%), financial/entitlement assistance (51%), in-home services (49%), housing assistance (48%), legal/advocacy services (47%), food and/or clothing donations (41%), family planning (37%), prenatal care (28%), adult education assistance (28%), and pre- and post-HIV test counseling (23%).

Child Placement at Time 2

According to Time 2 child placement information for mothers with HIV-positive status or AIDS:

- Forty index children (53%) lived at home with the biological parent (37 without and 3 with CPS involvement), 4 (5%) lived with relatives, 5 (7%) had permanent guardianship plans, 3 (4%) lived in a foster care home, and placement was unknown for 23 children (31%).
- Sixty-two of the women also had a total of 80 non-index children. Sixty-one non-index children lived in the homes of 33 biological parents.

Child HIV Status

Due to medical advances, only 27 of 203 infants exposed to HIV at birth were identified as HIV-positive at intake, while the status was negative for 153 and unknown for 17 infants. Of the 27 children that were HIV-exposed at birth and HIV-positive at intake, only 5 were documented as HIV-positive by Time 2; 3 were negative, and the status of the other 19 children was unknown. No new cases of HIV positive infants were reported among those who were not HIV exposed at birth and HIV-negative at Time 1.

Differences Associated with Substance Abuse

Participant Characteristics

Initial information about substance abuse was available for 1,246 of the 1,483 women served by AIA projects in FY 2011; of these, 1,092 (88%) were initially identified with substance abuse issues. This group included 1,025 mothers with a substance abuse history, 830 who used during pregnancy with the index child, and 248 who were using at the time of program entry. The following statistically significant differences were found when comparing the 1,092 women with substance abuse issues to the 154 women without identified substance abuse issues at enrollment:

- A lower percentage of substance users than non-users:
  - Had any cash income at enrollment (71% vs. 88%);
  - Had index children living with a biological parent (76% vs. 88%); and
  - Accessed prenatal care during the first trimester (63% vs. 82%).

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22 Sample size for the various types of service ranged from 1 to 93.
23 Sample with information about HIV exposure is 1,155 children (not only those enrolled in FY 2011).
24 Fourteen of the 830 women who used during pregnancy reported tobacco as the only drug used. The specific substances used during pregnancy (excluding tobacco) were known for 694 women; 1 substance was used by 44%, 2 substances were used by 32%, 3 substances were used by 15%, and from 4 to 7 substances were used by 9% of substance-abusing pregnant women.
25 The sample size for the individual participant characteristics ranged from 1,073 to 1,197.
26 Also, a lower percentage of the subset of women who used drugs during pregnancy accessed prenatal care during the first trimester (60% vs. 79%).
A higher percentage of substance users than non-users:
- Enrolled in the AIA project during or shortly after pregnancy (39% vs. 18%);\(^{27}\)
- Had children removed from the home prior to enrollment (33% vs. 11%);
- Had a history of psychiatric illness (59% vs. 17%);
- Had engaged in prostitution (11% vs. 2%);
- Had a criminal conviction (43% vs. 3%);
- Had probation/parole status (21% vs. 1%); and
- Reported a history of selling drugs (18% vs. 0%).

Relationships among the nine risk factors documented at intake were examined for the 1,092 mothers served by AIA projects in FY 2011. Figure 6 displays risks co-occurring with substance abuse problems.

![Figure 6. Risk Factors for Mothers with Substance Abuse Issues (n=1,092)](image)

Racial/Ethnic Differences in Substance Abuse

The racial/ethnic composition of the substance-abusing population served by AIA projects was 38% Hispanic (any race), 25% non-Hispanic African-American (black), 31% non-Hispanic Caucasian (white), and 5% other or unreported race/ethnicity. When examining the drug usage of substance-abusing participants from the three most prevalent racial/ethnic groups, statistically significant differences were seen in their usage of 7 specific drugs and tobacco:\(^{28}\)
- Marijuana use by 30% of Hispanic, 49% of black, and 38% of white participants;
- Opiate use by 24% of Hispanic, 3% of black, and 26% of white participants;
- Methadone use by 24% of Hispanic, 3% of black, and 26% of white participants;
- Amphetamine use by 13% of Hispanic, 2% of black, and 11% of white participants;
- Barbiturate use by 4% of Hispanic, <1% of black, and 8% of white participants;
- Cocaine use (in either crack or powder form) by 12% of Hispanic, 20% of black, and 14% of white participants; and
- Tobacco use by 33% of Hispanic, 59% of black, and 53% of white participants.

Drug Usage and Substance Abuse Treatment by Time 2

Among the 462 women with Time 2 data submissions in FY 2011 were 379 women with substance abuse issues – 371 whose substance abuse problems were known at enrollment and 8 whose problems were discovered during participation. Fifty-eight percent of the 379 women were not using drugs at Time 2, while 11% were known to be using drugs at that time. The drug usage of 31% was unknown.

\(^{27}\) Also, a higher percentage of the subset of mothers who used drugs during pregnancy enrolled in AIA during or shortly after pregnancy (47% vs. 14%).

\(^{28}\) The sample size for usage of the individual drugs ranged from 972 to 1,019.
Two hundred thirty-nine participants (63%) were known to have accessed treatment during AIA program participation, while 24% had not. Access to treatment for the remaining 13% during their AIA participation was unknown.

- The length of time in treatment ranged from less than 1 month to 87 months, with a mean duration of 6 months.\(^{29}\)
- Outpatient treatment was accessed by the highest percentage of the 194 mothers (79%). Other forms included self-help programs (31%), residential treatment (26%), detoxification (13%), hospital-based (2%), and other unspecified treatment options (3%).
- Of the 91 women who reported more than one type of treatment occurring since Time 1, the most commonly reported concurrent substance abuse treatment methods were outpatient with self-help (64%), residential with outpatient treatment (43%), residential treatment with self-help (39%), outpatient treatment with detoxification (19%), and detoxification with residential treatment (14%).
- The following treatment completion rates were reported for mothers who accessed at least one type of treatment while enrolled in AIA projects: 35% for outpatient treatment, 64% for residential treatment, 77% for detoxification, 50% for hospital-based, and 20% for other unspecified treatment options. Altogether, 42% of the women who accessed treatment were known to have completed at least one form of treatment during their AIA involvement.\(^{30}\)

**Other Accessed Services**

By Time 2, the highest percentages of participants with substance abuse issues accessed these other needed services: case management (99%), in-home services (88%), transportation (84%), parenting classes and training (84%), child care services (67%), recovery support (67%), mental health counseling (66%), and primary medical care (63%).\(^{31}\)

**Child Placement at Time 2**

Following is Time 2 information reported in FY 2011 pertaining to placement of children of participants with substance abuse issues:

- Index child placement information was available for 319 of the 379 participants with substance abuse issues. Seventy-eight percent of the index children were living with the biological parent (76% at home and 2% at a residential treatment facility). Ten percent were living with relatives or in formal kinship foster care, 7% were placed in foster care, and 3% were in other living arrangements.\(^ {32}\)
- Both Time 1 and Time 2 information was available about the placement of non-index children in families of 220 mothers with substance abuse problems.\(^ {33}\) Sixty percent of the 314 non-index children were living at home with the biological parent at Time 1, and 66% were living there at Time 2.
- By Time 2, the number of non-index children living in the biological parent’s home increased for 18 participants, decreased for 10 participants, and stayed the same for 192 participants.

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29 Length of time in treatment was documented for 194 participants.
30 Since many forms of self-help treatment do not focus on completion, self-help is excluded from the analysis of completion rates.
31 Sample size for the various types of service ranged from 245 to 350. For each type of service, the sample was limited to the participants identified as needing the given service.
32 Less than one percent of the children were placed in each of the following categories: pre-adoptive or adoptive home, standby guardianship, group home or residential care, and other.
33 This sample is limited to participants for whom the total number of non-index children was unchanged between Time 1 and Time 2.
Discussion and Implications

Program Goals

The following goals have guided the AIA program since its inception:

- To provide protection and permanency for infants and young children at risk of abandonment,
- To identify and address the needs of children with drug exposure and/or HIV/AIDS, and
- To provide care and support for infants and young children affected by HIV/AIDS or substance abuse.

Implications for Policy

This report summarizes characteristics of participants in the AIA program, including both strengths and challenges of the families. Of special note is the increase in the number of children and mothers served by the AIA projects in FY 2011. While AIA projects employed varying interventions, each project addressed issues posed by families affected by HIV/AIDS and substance abuse, as well as other co-occurring risks. The resulting outcomes have relevance for social policy.

Benefits for Children

Accessing Child-Related Services. Children served in AIA projects in FY 2011 received support that focused on enhancing their safety, permanency, and well-being. Most of the children received these services directly from AIA projects:

- Case management, coordinating efforts across child welfare agencies, health providers, treatment programs, courts, and other organizations;
- Permanency planning services, accessed by over half of the mothers that were identified with HIV/AIDS issues; and
- Developmental services of child development/education and infant development assessment.

AIA projects also referred the majority of children for pediatric health care. The combination of developmental services and health care services has been found to be positively associated with children being placed with their mothers at AIA program completion. ³⁴

Positive Outcomes for Children. For over half of the children that received AIA services in FY 2011, their mothers successfully continued in the program or completed program objectives. Mothers who continued or completed program requirements of the AIA project had statistically better outcomes than those who discontinued without success, particularly with regard to having their children remain in the home and having no active child protective services case. This may suggest that the comprehensive services provided by AIA projects and critical relationships with capable professionals give parents the capacity to be more responsive to the individual needs of their children.

Alternatives for Children. When children needed other placement options and the involvement of child protective services, personnel in many of the AIA projects offered an array of services that supported others in the extended family who were involved with the child. Staff from some AIA projects report communicating and coordinating with child protective services staff to promote the well-being of the children they serve. Based on the relationships that AIA personnel build with extended families, their perspectives may at times assist others in determining best placement options for children.

Benefits for Mothers

Accessing Parent Services. AIA projects provided coordinated case management and access to a broad array of intensive individualized services for families in FY 2011 to mitigate the risk of abandonment and to promote the safe and healthy development of their children.

- Mothers most often accessed in-home services, parenting classes, and transportation services directly from AIA projects.
- AIA projects frequently referred families to other agencies for primary medical care, including prenatal and postnatal care.
- Increases in the percentages of women accessing TANF, Medicaid, housing subsidies, and food stamps during their participation in AIA projects suggest benefits from assistance to meet basic needs while mothers focus on their recovery, health care, and their preparation for employment.

Positive Outcomes for Mothers and Families. Mothers’ success in continuing or completing their AIA program objectives was also associated with other positive outcomes for themselves and their families. When comparing the mothers who continued or completed the program requirements with mothers that left the program prematurely:

- Higher percentages of mothers who continued or successfully completed AIA program participation had cash income, employment earnings, and/or housing subsidies.
- Higher percentages of mothers who continued or completed AIA program participation were not using drugs or alcohol.

When mothers experience these positive outcomes, their children are also likely to benefit from increased stability in the family.

Alternatives for Parents. Even when mothers who enroll in an AIA project do not get education degrees, employment, or housing subsidies, their AIA involvement may still contribute to their family’s stability. Care coordination and access to both general and specialized services to meet their basic needs and address their serious risks aim to foster their long-term capacity to contribute to their child’s well-being.

Implications for Practice

FY 2011 findings also contribute to the discussion of effective practices and strategies that promote family stability and child well-being. The breadth of services offered and the degree to which interventions are individualized for each family suggest that AIA projects design family-focused programs that are well-coordinated with other agency initiatives in their communities.

Risks and Protective Factors Experienced by Families

Parent Risks. Most AIA participants who enrolled in FY 2011 faced serious problems related to substance abuse (particularly a history of substance abuse or usage of drugs during pregnancy) and/or a diagnosis of HIV/AIDS. Additionally, many experienced domestic violence as adults and/or physical and sexual abuse as children. A participant’s criminal conviction, psychiatric illness, or removal of a child from her home frequently added to her other risk factors. These challenges jeopardized their families, contributing to the involvement of child protective services and the placement of the children with other caregivers.
Child Risks. The children enrolled in AIA projects in FY 2011 had a higher incidence of preterm births, lower birth weight, and longer hospital stays after birth than the national averages. Furthermore, positive drug tests at birth, HIV exposure, and special health care at birth compounded the risks for some of the children at program entry.

Protective Factors. Despite the vulnerability from these risks at enrollment, protective factors were also present in participating families. A majority of participants had some monthly cash income, and a majority lived in a house or apartment. Most received prenatal care, and most accessed such public benefits as Medicaid, food stamps, and WIC. It is important that AIA projects identify and strengthen other available protective factors for individual participants and their children, such as their coping skills, dispositions, and resilience. It is likely that this also involves determining the availability of helpful family, friends, or other natural supports in the community. These assets can function as a foundation upon which AIA projects can build other vital supports for the families.

Professional Practice Recommendations Based on FY 2011 Findings

The characteristics and circumstances presented by AIA participants in FY 2011 required AIA personnel to fill a variety of roles. Whether they conduct assessments, offer counseling, provide education, coordinate care, or fill any number of other roles with families, strong relational competencies are necessary. They need skills and knowledge to build rapport, listen actively, communicate clearly, and facilitate engagement of participants in their own decision-making to achieve the positive outcomes desired. Additionally, transfer of knowledge and skill to participants to strengthen their parenting and relationships with their children is also vital. Findings related to differences associated with race and ethnicity and the unique issues the families faced suggest that culturally competent and trauma-informed practices are also pivotal to effectiveness.

It is important that personnel also demonstrate competency in engagement with staff from other agencies, not only to coordinate services, but also to address overarching infrastructure issues in the community at large, e.g., service availability and capacity, external influences, and professional development. A growing body of knowledge about the negative effects of toxic and traumatic stress on child development is emerging to inform practice in the field. Due to their roles in developing an infrastructure for coordinated care, AIA projects are strategically positioned to build community approaches that reduce stress to tolerable levels. 35

AIA personnel also require ongoing reflective supervision, support, and professional development to adapt to families’ changing needs and to assimilate new information in the field. Practice profiles that clearly delineate the functions of each role and the acceptable levels of competency required are very helpful in ensuring effective service delivery.

Implications for Evaluation

Evaluation strategies have been underway to focus on the desired outcomes for children specified in the AIA legislation. The cross-site evaluation in FY 2012 piloted additional data collection items to document child safety, child permanency, and child well-being for each participating family, according to the professional judgment of AIA project personnel. Health, cognitive development, and behavioral functioning are components that researchers contend should be included in measurement of the wellbeing of young children. 36 Follow-up conversations with AIA Project Directors and Project Evaluators about their operationalization of the new cross-site evaluation items will assist in determining the degree to which these components inform the new data collection items.


New AIA cross-site evaluation measures related to fetal alcohol spectrum disorder (FASD) were also instituted last year. The American Academy of Pediatrics developed a new toolkit that may be useful in promoting dialogue among pediatricians, AIA project staff, and evaluators about enhanced FASD screening and usage of FASD diagnostic tools.  

A survey to assess protective factors for the child and family was introduced to Project Directors and Evaluators for piloting in AIA projects. Follow-up discussion with them about the usefulness of this instrument within their projects is recommended. Similarly, continued dialogue with personnel from other home visitation initiatives that promote evidence-based practices will benefit individual AIA projects and the AIA Cross-Site Evaluation. Collective efforts across projects will be beneficial in determining benchmarks and evaluation instruments that are appropriate for the populations served by AIA projects.

FY 2011 is the second year of a 3-year period in which all of the same grantees continued to receive AIA funding. Thus, it is an opportune time to collect detailed data describing 3 years of service to their selected populations, to identify commonalities across projects, and to examine the efficacy of clusters of service packages implemented. Replicating and expanding the study by Reich and Fuger to examine this set of projects and their populations will determine whether the same service clusters emerge and continue to be associated with the same positive outcomes for children.

Due to the complexity of comprehensive home visiting programs, a traditional experimental research design may be an inadequate model to best evaluate AIA projects. A multifaceted approach is necessary to understand fully the interventions and the benefits for children and families through their participation in AIA projects. Program evaluation is especially difficult when considering that a high degree of flexibility may be necessary to individualize the interventions and to engage families in strategies that best meet their needs. This variability adds challenges to evaluating program fidelity and determining the degree to which they are maintaining program standards.

A number of constructs are difficult to incorporate into a cross-site evaluation of projects that serve diverse populations and implement varied interventions. Nonetheless, continued efforts are recommended to promote the selection or development of consistent rubrics across projects for measuring participants’ engagement with the AIA project and for defining successful completion of the program objectives. These efforts will enhance the ability of the cross-site evaluation to determine the degree to which children and families are accessing and benefiting from the interventions implemented by the AIA projects.

Additional data collection at the program and community levels, supplementary to the participant focused evaluation, would assist the cross-site evaluation in defining the roles of AIA projects within their communities. Measurement of interagency collaboration, professional training, organizational infrastructure, and contextual factors of AIA projects within their communities would help to determining the necessary elements for implementation of a systemic approach.

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Appendix

AIA Project Profiles – FY 2011

**Cherish the Families (North Ft. Lauderdale, FL).** Cherish the Families is a home-based family support program that provides comprehensive transdisciplinary services to meet the complex needs of families affected by substance abuse and/or HIV. The program’s goal is to prevent the abandonment of children under age three who are in the dependency system. This includes enhancement of the stability of children’s child care placements by provision of training and coaching to enhance teachers’ abilities to create emotionally supportive environments and to address challenging behaviors which children in foster care often present.

**CRADLES (Austin, TX).** Cradles is an in-home visiting program providing comprehensive intensive case management services and targeted parent education and support to mothers at high risk for abandoning their infants due to substance abuse and/or HIV/AIDS.

**Early Support for Lifelong Success (New York, NY).** The Family Center’s Early Support for Lifelong Success (ESLS) Program aims to increase safety, well-being and permanency for HIV-exposed children ages 0-7 through comprehensive home-based services which include developmental and family assessment, parent support and education, social and developmental activities, play therapy, individual and family counseling, case management, advocacy, medical case management, permanency planning, legal services and diverse psycho-educational and support groups.

**Family Centered Home Visitation (Philadelphia, PA).** Family Centered Home Visitation provides comprehensive home-based support services, with an emphasis on infant and family mental health and parent-child relationships, to HIV-positive caregivers and their children, to prevent abandonment and out-of-home placement and promote safety, permanency and healthy development.

**Family Connect (Pinellas Park, FL).** Home-based support services include counseling, and parenting skills training designed to improve family functioning with an emphasis on substance abuse, HIV/AIDS and other environmental issues that impact the safety of children and stability of the family.

**Family Options II (Chicago, IL).** Family Options II provides comprehensive permanency planning for families affected by HIV/AIDS, including in-home social work, peer outreach services, formalized consumer involvement, counseling, and legal services.

**Family Outpatient Program (El Paso, TX).** Services provided by the Family Outpatient Program include trauma-informed substance abuse and mental health treatment, in-home parenting, activities to promote attachment with their child, childcare and transportation assistance. Family education and counseling are also provided to the extended family.

**Family Ties (Washington, DC).** Family Ties offers comprehensive permanency planning services to decrease the risk of abandonment of children affected by HIV/AIDS.

**FRESH Start (Holyoke, MA).** FRESH Start is a peer-mentoring home visiting program for substance using pregnant women and new parents providing intensive case management, recovery coaching, parenting support, developmental assessments for infants through referral, and cross-systems collaboration and training.

**Great Starts (Knoxville, TN).** Great Starts offers structured, long-term treatment for women who are pregnant or have given birth to drug-exposed and/or HIV-positive children.
Healthy Connections for Intact Families (Toledo, OH). St. Vincent Mercy Medical Center’s Intact Families program provides care coordination and mental health services integrated with outpatient healthcare facilities in collaboration with Family Drug Court, residential facility, and chemical dependency treatment. The program provides supportive services for women who are pregnant or within three months of the birth of their babies.

Lifelong Families (Chicago, IL). Lifelong Families promotes the stability of families affected by HIV through mental health services, childhood educational support, permanency planning, housing, and other comprehensive services.

Mission Inn (Grand Rapids, MI). Mission Inn serves infants and young children who have been or are affected by substance abuse or HIV/AIDS. Services include, but are not limited to: case coordination, substance abuse treatment, home-based infant mental health services, developmental assessments, and training and education.

Primeros Pasos (Santa Cruz, CA). “Primeros Pasos (‘First Steps’)” is an early identification, intervention and substance abuse prevention and treatment program offering services to substance-abusing pregnant and parenting women and their families.

Project Stable Home (Los Angeles, CA). Project Stable Home is a relationship-based, multidisciplinary home visitation program to support child-parent attachment and protective factors to prevent neglect, abuse and abandonment of at-risk children from birth to age three.

Reflejos Familiares (Albuquerque, NM). Reflejos Familiares (Family Reflections) offers intensive, relationship-based case management and developmental services in the home to families affected by substance abuse including pregnant women and families with children up to 3 years of age. Parent infant support groups are provided using the Circle of Security Parenting© program.

TIES (Kansas City, MO). TIES is a comprehensive, interagency home-based program serving substance abusing mothers prenatally and postpartum with their infants and other family members.