HHS Public Access

Author manuscript

J Child Fam Stud. Author manuscript; available in PMC 2018 August 01.

Published in final edited form as:

J Child Fam Stud. 2017 August ; 26(8): 2224–2236. doi:10.1007/s10826-017-0739-z.

Family Assisted Contingency Management within the Context of Evidence-Supported Treatment for Child Neglect and Drug Abuse

Brad Donohue[1], **Christopher P. Plant**[1], **Travis A. Loughran**[1], and **Anali Torres**[1]

[1]University of Nevada, Las Vegas, U.S.A., 4505 S. Maryland Pkwy, Las Vegas, NV 89154

Abstract

Contingency management (CM) has extensively been shown to be effective in reducing substance use disorders, but its effects in reducing child maltreatment have yet to be determined. The current study provides preliminary support for the utilization of an innovative family-assisted CM component in 18 mothers who were referred to an evidence-supported behavioral treatment for concurrent child neglect and drug abuse by Child Protective Service caseworkers. In the examined CM, participants were invited to indicate from a list of common actions incompatible with child neglect (i.e. positive parenting actions), the extent to which these actions had been experienced utilizing a 3-point scale (almost never, sometimes, almost always). For each item that was indicated to be *almost never* or *sometimes* experienced, the participants were queried to indicate if the neglect incompatible action should be targeted as a therapeutic goal. Contingencies were subsequently established in which the participants were rewarded by involved family members for their completion of therapeutic goals. At baseline, results indicated that there was a negative association between the number of neglect incompatible parenting actions that were infrequently experienced and child abuse potential. A hierarchical multiple regression analysis showed that the number of neglect incompatible actions targeted as therapeutic goals at baseline, but not the number of positive parenting actions experienced infrequently at baseline, predicted reduced child maltreatment potential following treatment. These findings suggest the examined CM may assist evidence supported behavioral treatment specific to child neglect and drug abuse.

Keywords

contingency management; child neglect; drug abuse; goals; mothers

Correspondence concerning this article should be addressed to Brad Donohue, Department of Psychology, University of Nevada, Las Vegas, NV, 89154-5030. bradley.donohue@unlv.edu.

Compliance with Ethical Standards

All procedures in this study were approved by the appropriate institutional review board for research with human subjects. All participants completed informed consent prior to the initiation of study procedures. BD: Designed and executed the study and collaborated on writing the paper. CP: Prepared and analyzed the data and collaborated on the writing the paper. TL: collaborated in writing the paper. AT: Collaborated on writing the paper.

Brad Donohue, Christopher Plant, Travis Loughran and Anali Torres declare no conflict of interests.

Introduction

More than three million reports of child maltreatment are made to child welfare agencies each year in the United States (U. S. Department of Health and Human Services, 2012). About 70% of these cases involve mothers who have been identified for child neglect (Appleton, 2012; Dufour et al., 2008), which is characterized by the omission of adequate caregiving that endangers the psychological and physical wellbeing of children, such as insufficient nutrition, medical treatment, supervision, protection, education and dangerous and unsanitary living conditions (see Lutzker, 1990). Substance abuse occurs in more than half of all cases of child maltreatment (Cash & Wilke, 2003; Donohue, Romero & Hill, 2005) and influences child neglect by lowering motivation and rationale thinking specific to parenting (Sprang, Clark & Bass, 2005). Several evidenced-based, behavioral treatment programs target problematic antecedents to child neglect either directly or indirectly, including Multisystemic Therapy for Child Abuse and Neglect (MST-CAN; Swenson et al., 2010), Parent Child Interaction Therapy (PCIT; e.g., Lanier et al., 2014), Project Safecare (e.g., Gershater-Molko, Lutzger & Wesch, 2003), Project 12-Ways (Lutzker & Rice, 1984), and Family Behavior Therapy (FBT; Donohue, Azrin et al., 2014). Family Behavior Therapy and MST-Building Stronger Families, a modified version of MST-CAN (MST-BSF; Schaeffer, Swenson, Tuerk & Henggeler, 2013), have been shown to treat child neglect and drug abuse concurrently. Both of these programs are focused on client goal development. However, the relative contribution of goal setting and contingency management within these comprehensive and successful programs has yet to be examined through componential analysis (see extensive reviews of CM by Dallery, Meredith, & Budney, 2012; Petry, 2012; Petry et al., 2014).

Family assisted contingency management is a central component of comprehensive behavioral treatments for substance abuse, such as the Community Reinforcement Approach and Family Training (CRAFT; Meyers, Dominguez, & Smith, 1996), Community Reinforcement Approach (Stitzer, Jones, Tuten, & Wong, 2011) and Family Behavior Therapy (FBT; Donohue & Allen, 2011; Donohue & Azrin, 2012). A central component of these programs is an emphasis on the incorporation of significant others to monitor contingencies and provide rewards for drug abstinence. Although CM methods (i.e. Conditional Cash Transfer; CCT) have been implemented by government agencies to enhance the utilization of health services and the overall well-being of children in poverty (Owusu-Addo & Cross, 2014), these methods have yet to be utilized in the behavioral treatment of families who have evidenced child neglect. There are two important factors that may have contributed to the absence of CM approaches in child neglect: (1) child neglect includes a wide-array of often co-existing and complicated antecedents that are difficult to manage in existing CM systems, and (2) it is relatively difficult to determine target behaviors because child neglect involves the omission of desired behaviors (Lutzker, 1990).

Consistent with the reviewed findings of Owusu-Addo and Cross (2014), we believe CM approaches are capable of addressing child neglect by focusing on its antecedent stimuli, and using rewards that are culturally and environmentally appropriate, salient (Lussier et al., 2006), and more reinforcing than behaviors that are associated with child neglect (Kirby, Benishek, Dugosh, & Kerwin, 2006). For instance, a baby's rash may be prevented by

teaching a significant other to contingently reward caregiver efforts to check diapers every few hours by cooking dinner, or a child's illness may be prevented by contingently providing backrubs to a caregiver for her efforts to assure children are seeing a medical doctor regularly, wearing coats, eating healthy meals and so on. We also believe rewards and target behaviors need to be rapidly identified to facilitate the expeditious development of contingencies that are likely to enhance treatment retention (Meyers et al., 2002) and complement other behavioral interventions (e.g., child management skills training, relapse prevention).

Therefore, in the current study we examine the relative contribution of an innovative family-assisted CM intervention within a comprehensive, evidence-based treatment targeting child neglect and substance abuse (i.e., FBT). In doing so, mothers who were referred to evidence-based behavioral treatment for child neglect and substance abuse were taught to recognize parenting behaviors that were incompatible with child neglect, and to establish parenting goals targeting these actions. The participants' significant others were taught to contingently reward goal achievement. It was hypothesized that the number of child neglect incompatible parenting behaviors evidenced at baseline would be negatively associated with child maltreatment potential at baseline. It was also hypothesized that the number of positive parenting actions evidenced during baseline would not be associated with the participants' child maltreatment potential following treatment, whereas the number of positive parenting actions targeted as therapeutic goals in CM at the initiation of treatment would predict improvements in child maltreatment potential following treatment. The latter finding would support the relative contribution of family-assisted CM in lowering child maltreatment potential.

Method

Participants

Participants included 18 mothers who were referred by county child protective service agency (CPS) caseworkers for behavioral treatment to assist substance use disorder and child neglect. Each participant in this study received Family Behavior Therapy (see Donohue, Azrin et al., 2014). Study inclusion criteria were that the mother: (a) was reported to CPS for child neglect; (b) was living with the child victim who prompted the referral (or it was the intention of the Court to return the child to the mother's home); (c) was identified as using illicit drugs during the 4 months prior to the referral; (d) evidenced symptoms that were consistent with illicit drug abuse or dependence during the baseline assessment utilizing the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Health Disorders, fourth edition (SCID-IV; First, Spitzer, Gibbon, & Williams, 1996); (e) had at least one adult individual willing to participate in her treatment; and (f) was not primarily referred due to sexual abuse perpetration or domestic violence. Demographics are presented in Table 1. The study was approved by the local Institutional Review Board and study data was protected by a Certificate of Confidentiality from the federal government.

Procedure

Method of Recruitment and Context of Treatment—Department of Family Services (DFS) offices were informed of the study and its inclusionary criteria through email and onsite presentations. Referrals were made by DFS caseworkers through telephone or fax. Upon DFS referral, an intake specialist contacted the caseworker and separately the participant by telephone to determine if inclusionary criteria were met. Qualifying participants were scheduled to obtain informed consent and complete the pretreatment baseline assessment. Participants completed up to 20 sessions over a six 6-month period of FBT for child neglect and drug abuse (see outcome study published by Donohue et al., 2014). This intervention emphasized cognitive and behavioral skill development through behavioral role-playing, therapeutic practice assignments, and utilization of family support systems to assist caregivers in attending sessions and accomplishing their treatment goals specific to their parenting behaviors and substance use. Multiple interventions were implemented sequentially and cumulatively and included: (a) contingency management for neglectful parenting (e.g. described above in Measures section) and substance abuse), (b) communication skills training, (c) environmental control (e.g. identifying and managing antecedents and consequences to problematic behaviors), (d) self-control skills training to manage substance use urges and impulses to engage in undesired behaviors, and (e) child management skills training, (f) emergency management, and (g) job-getting skills training, and (h) financial management skills training. The number of times CM was implemented throughout treatment was at the discretion of the participant. All participants completed at least two sessions of CM. Substance abuse was targeted utilizing CM in a manner similar to child neglect. However, the influence of this intervention component on treatment outcome was not a focus in the current study.

Immediately following treatment, a post-treatment assessment battery was administered. Trained assessors independent from the treatment program and blind to the treatment received by participants administered baseline and post-treatment assessments in the participants' homes. The assessments consisted of a large battery of tests. However, the Child Abuse Potential Inventory (CAPI) was the only measure used for analyses in the current study. Participants were compensated for their time with a $50 gift card for use at local store for the pretreatment assessment, and $100 for the 6 months post-treatment assessment.

Measures

Family Supported Contingency Management (CM)—Family Supported Contingency Management (CM) was developed to assist participants in 1) identifying actions that were incompatible with child neglect, 2) converting these actions into child neglect incompatible parenting goals, and 3) monitoring and rewarding established goals throughout the course of treatment. This intervention was also aimed at motivating the participants' significant others (SO) in the provision of contingent rewards for goal achievement of participants.

In developing CM, a series of focus groups were convened to initially generate a standardized list of commonly reported neglectful parenting behaviors (e.g., not feeding children from major essential food groups, providing or permitting children to eat too much

"junk food, permitting children to be soiled). For each neglectful parenting behavior a positive parenting behavior was generated that was incompatible with child neglect, and that could be targeted in treatment (e.g., "Make sure your children eat from all the major food groups each day, including (1) breads and cereals, (2) vegetables and fruits, (3) milk and other dairy products, and (4) meat, chicken, or fish"; "Keep your children clean, including their body and teeth," Make sure your children avoid junk food"). Focus groups emphasized brainstorming analysis in the generation of items. An assistant moderator at the doctoral level was responsible for recording comprehensive notes, utilizing a process facilitation approach with low content control and high process control while a moderator at the doctoral level directed discussion and identified key ideas. The moderator and assistant moderator were both experts in the treatment of child neglect and substance abuse. Other focus group members included five providers at the Bachelors level with experience in assessment and treatment involving parents in the child welfare system.

Through the aforementioned process, a standardized list of 35 child neglect scenarios was developed. Each scenario was identified to occur in at least one case involving child neglect as per self-reports of the focus group members. For each child neglect scenario a positive parenting behavior was originated. Each positive parenting behavior was required to be conceptually incompatible with the respective child neglect scenario, according to group consensus. The resulting positive parenting practices are included in the first column of the Positive Parenting Goals Worksheet (see Appendix A). To assist disclosure, the response set endpoints (e.g., almost always, almost never) were developed to imply even the best parents may be unable to accomplish optimum parenting actions all the time.

In utilizing the worksheet, if the participant endorses "almost always" for an item the next parenting action (item) is queried. If the participant endorses "sometimes" or "almost never" for an item (neglect incompatible parenting behavior is considered to be infrequently occurring), the participant is considered to be at risk for neglectful parenting and asked if the child neglect incompatible parenting action should be set as a goal. For each endorsed goal the participant is queried to indicate what could be done to make the goal easier to accomplish. Once the respective goal is set, the participant's significant other is queried to suggest a contingent reward for goal completion. Throughout treatment, participants and their SOs review whether specific goals were achieved or missed each day of the week, and descriptive praise and rewards are provided for goal accomplishment.

Child Abuse Potential Inventory (CAPI)—The CAPI (Milner, 1990, Milner, 1986) is a 160-item self-report measure used for the detection of child abuse in parents and caregivers. Higher scores are indicative of a greater likelihood of child maltreatment potential. The CAPI includes an overall Abuse Scale as well as six factor scales: Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problems with Others. It also contains three validity scales: Lie, Random Response, and Inconsistency. The Abuse Scale has been shown to be a good predictor of future child neglect (Ayoub & Milner, 1985). In the current study, only the CAPI Abuse Scale was utilized.

Data Analyses

Preliminary analyses were conducted to determine adequate adherence to CM intervention components through both provider and independent reviewers' ratings. These adherence ratings were correlated with primary outcome measures to evaluate whether adherence influenced the number of treatment goals set by participants. The number of neglect incompatible parenting actions endorsed as infrequently occurring and the number of positive parenting goals set at baseline were correlated with baseline drug use to determine whether drug use should be considered in primary analyses. Subsequently, the number of neglect incompatible parenting actions endorsed as infrequently occurring was correlated with baseline child maltreatment potential to ensure the identified parenting actions were relevant to child maltreatment. Finally, a hierarchical multiple regression was conducted to determine whether the number of neglect incompatible parenting actions endorsed as infrequently occurring and the number of positive parenting goals set at the beginning of treatment predicted child maltreatment potential following treatment, while controlling for social desirability (CAPI Lie).

Results

The method used to determine adherence to the CM intervention has been evaluated in previous clinical trials and has been formally demonstrated to be a reliable and valid method (Azrin et al., 2001; Donohue et al., 2014; Sheidow et al., 2008). Protocol checklists with each essential procedure required to implement the CM intervention was used by the therapeutic providers during treatment to guide intervention implementation and ensure treatment fidelity. Protocol adherence was calculated by computing the number of protocol procedures reported to have been implemented by the providers and dividing this number by the total number of prescribed protocol instructions. Results indicated that 94% of the protocol instructions were implemented by providers, suggesting high adherence to the FBT CM intervention. Also, 13% of sessions involving the CM intervention were randomly coded by independent reviewers who were blind to provider assessments of their treatment integrity scores. Results indicated that 91% of the protocol procedures were implemented through independent review, suggesting providers' estimates of protocol adherence were reliable.

Fidelity scores were correlated with the number of parenting actions set as treatment goals to determine whether provider adherence to CM protocol was associated with the mothers' willingness to target their parenting practices in treatment. Results showed that fidelity scores were not significantly correlated with the number of treatment goals set ($r = -.074$, $p = .769$). However, adherence was 90% or above for all providers, suggesting a possible ceiling effect in evaluating the effects of fidelity to the CM component.

The number of neglect incompatible parenting actions endorsed as infrequently occurring, and the number of positive parenting goals set at baseline were correlated with baseline drug use. Drug use was not associated with positive parenting actions endorsed as occurring infrequently ($r = -.113$, $p = .657$) or goals set ($r = .161$, $p = 524$), suggesting that the number of positive parenting actions and goals set are not associated with the mothers' drug use. Therefore, drug use was not considered in the primary analyses.

The percentage of participants who endorsed each neglect incompatible parenting action as occurring infrequently during baseline assessment and the percentage of participants who set each parenting action as a treatment goal are listed in Table 2. Relevant to our first hypothesis, it was expected that the number of child neglect incompatible parenting actions indicated to be infrequently performed at baseline would be associated with child maltreatment potential at baseline. Bivariate analyses confirmed this hypothesis ($r = .63$, $p < .01$), suggesting the positive parenting behaviors included in CM are probably relevant to the prevention of child maltreatment.

A hierarchical multiple regression analysis was conducted to confirm our hypothesis that the number of child neglect incompatible parenting actions endorsed at baseline assessment as occurring infrequently would not predict child maltreatment potential at post-treatment assessment, but the number of parenting actions set as goals during baseline would predict child maltreatment potential at post-treatment assessment. The CAPI Abuse scores at pre-treatment assessment were controlled in the first model of the regression, and the overall model, as predicted, was statistically significant, $R = .856$, $F(1,16) = 43.95$, $p < .001$, $R^2 = .733$, $adjR^2 = .716$. The number of child neglect incompatible parenting actions endorsed as occurring infrequently and the number of goals set at the initiation of treatment were included as predictors of post-treatment CAPI Abuse scores in the second model. The additional variance explained by the predictor variables in the second model was significant, $R = .902$, $\Delta F(2,14) = 3.067$, $p < .05$, $\Delta R^2 = .08$. The total number of goals set at the initiation of treatment significantly predicted child maltreatment potential following treatment, $t(16) = -2.164$, $p < .05$, $b = -9.81$, $\beta = -.529$, whereas the number of neglect incompatible parenting actions endorsed as occurring infrequently did not predict CAPI Abuse scores ($p > .05$). These results are summarized in Table 3. Thus, setting a greater number of treatment goals in the examined CM appears to be important in reducing child maltreatment potential, regardless of the number of parental risk factors for child maltreatment preceding treatment.

Discussion

Although well established as an integral component of behavioral interventions designed to treat substance abuse, family supported CM (Donohue & Allen, 2011; Meyers et al., 1996) has yet to be explored as a viable option for treating child neglect. Therefore the purpose of the current study was to examine the impact of an innovative family-supported contingency management program in reducing the potential for child neglect in mothers diagnosed with a substance use disorder. Results showed the number of child neglect incompatible parenting actions endorsed at the initiation of treatment was negatively associated with child maltreatment potential. Relevant to treatment, the number of child neglect incompatible parenting actions set as goals by participants upon treatment initiation, but not the number of neglect incompatible parenting actions endorsed as occurring infrequently, predicted reductions in child maltreatment potential at the conclusion of treatment. Thus, mothers who desire to set a relatively limited number of child neglect incompatible goals at the initiation of evidence-supported treatment appear to be at risk for child maltreatment.

These results are consistent with behavioral theories that suggest problematic behaviors result from maladaptive environmental contingencies, and can be assisted with contingency

management (Donohue et al., 1998). Along this vein, frequent monitoring of goal progress has been found to result in *small* to *medium* effects on treatment outcomes in meta-analyses (Harkin et al., 2015). In the current study participants monitored and openly reviewed their goals with the providers and supportive others during treatment sessions, and supportive others were taught to contingently provide encouragement and rewards for goal accomplishment on a weekly basis. Therefore, the positive impact of goal setting in the current study was complemented by contingency management. This family assisted CM intervention is inherently consumer driven and provides mothers autonomy in determining the positive parenting practices they desire to set as goals. Autonomy plays an integral role in motivating behavior (Deci & Ryan, 2000) and the results of previous studies have indicated that increased motivation in treatment is predictive of enhanced outcomes (Bauer, Strik & Moggi, 2014; Breda & Heflinger, 2007; Fitzpatrick & Weltzin, 2014).

The results of this study, although preliminary, suggest family assisted CM may complement evidence-supported behavioral treatment in preventing child maltreatment through the identification of parenting behavior goals that appear to be incompatible with child neglect when rewarded by family members. Consistent with consumer driven intervention, family assisted CM provides mothers autonomy in determining child neglect incompatible parenting behaviors they desire to set as goals. Family assisted CM also provides a much needed standardized assessment of child neglect incompatible parenting actions, as well as an intervention tool that may be utilized to inspire mothers to attempt selected actions as therapeutic goals. Therefore, although definitive conclusions regarding the efficacy of family assisted CM are not possible based on the preliminary findings in this uncontrolled study, the results do suggest future controlled examination of the developed intervention is warranted.

Acknowledgments

This study was supported with a grant from the National Institute on Drug Abuse (1R01DA20548-01A1).

Appendix A

Positive Parenting Goals Worksheet

Client ID#: _____Clinician: _____Session #:
_____Date of Session: _____

- **Review Positive Parenting Goals Rationale before preceding to the Positive Parenting Goal Worksheet**

How often have you been able to (positive parenting behavior)?	**“would you like to (“ ”) as a goal?”**	**“what would make it easier for you to (positive parenting behavior)?” (Empathize, Solicit Info, Volunteer help)**	**Assist in defining goals behaviorally/ specifically.**
Make sure your children eat from all the major food groups each day, including (1) breads and cereals, (2) vegetables and fruits, (3) milk and other dairy products, and (4) meat, chicken, or fish ☐ almost never	☐ no (proceed to next positive parenting behavior) ☐ yes		

Positive Parenting Goals Worksheet

Client ID#: _____Clinician: _____Session #:
_____Date of Session: _____

- **Review Positive Parenting Goals Rationale before preceding to the Positive Parenting Goal Worksheet**

How often have you been able to (positive parenting behavior)?	**"would you like to (" ") as a goal?"**	**"what would make it easier for you to (positive parenting behavior)?" (Empathize, Solicit Info, Volunteer help)**	**Assist in defining goals behaviorally/ specifically.**
☐ sometimes ☐ almost always (proceed to next positive parenting behavior)			
Make sure your children eat breakfast, lunch and dinner every day or get enough to eat each day. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Make sure your children avoid junk food. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Make sure your children exercise regularly. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
How often have you been able to (positive parenting behavior)?	"would you like to (" ") as a goal?"	"what would make it easier for you to (positive parenting behavior)?"	Assist in defining goals behaviorally/ specifically.
Keep your children's clothes clean (including clean diapers, if parent has an infant). ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your children clean, including their body and teeth. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your home clean. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep pests like bugs and rats out of your home. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Make sure children don't come into contact with sharp objects. ☐ almost never ☐ sometimes	☐ no (proceed to next positive parenting behavior) ☐ yes		

Positive Parenting Goals Worksheet

Client ID#: _____Clinician: _____Session #:
_____Date of Session: _____

- **Review Positive Parenting Goals Rationale before preceding to the Positive Parenting Goal Worksheet**

How often have you been able to (positive parenting behavior)?	**"would you like to (" ") as a goal?"**	**"what would make it easier for you to (positive parenting behavior)?" (Empathize, Solicit Info, Volunteer help)**	**Assist in defining goals behaviorally/ specifically.**
☐ almost always (proceed to next positive parenting behavior)			
Cover exposed electrical wires or unplugged electrical outlets (if parent has a small child). ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep small objects off the floor that can be swallowed by small children or that can be tripped on. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep medicines and poisons like cleaning detergents and pesticides where your children can't get them. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Get your children check ups and vaccinations on time from the medical doctor, eye doctor, dentist or other healthcare professionals. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Get your children medical services when they're ill, hurt, or need glasses or other medical aids or medications. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Monitor or supervise your children at all times. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Dress your children in clothing that fits, and is not too hot or too cold. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Get your children toys and books that are at the right educational level. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		

Positive Parenting Goals Worksheet

Client ID#: _____Clinician: _____Session #:
_____Date of Session: _____

- **Review Positive Parenting Goals Rationale before preceding to the Positive Parenting Goal Worksheet**

How often have you been able to (positive parenting behavior)?	**"would you like to (" ") as a goal?"**	**"what would make it easier for you to (positive parenting behavior)?" (Empathize, Solicit Info, Volunteer help)**	**Assist in defining goals behaviorally/ specifically.**
Get your children to school or daycare on time. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Assist your children with homework. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Give your child affection, like giving hugs or saying "I love you." ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Praise your children each day. ☐ almost never ☐ sometimes ☐ almost always (proceed to next behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Talk, play, and read with your children each day. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Discipline your children when undesired behaviors occur. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your children away from pornographic movies, or sexual toys. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your children away from alcohol or drugs. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your children from watching movies that are too mature for them, such as PG-13 and R rated movies. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Keep your children from seeing or hearing you or others making love. ☐ almost never ☐ sometimes	☐ no (proceed to next positive parenting behavior) ☐ yes		

Positive Parenting Goals Worksheet

Client ID#: _____Clinician: _____Session #:
_____Date of Session: _____

- **Review Positive Parenting Goals Rationale before preceding to the Positive Parenting Goal Worksheet**

How often have you been able to (positive parenting behavior)?	**"would you like to (" ") as a goal?"**	**"what would make it easier for you to (positive parenting behavior)?" (Empathize, Solicit Info, Volunteer help)**	**Assist in defining goals behaviorally/ specifically.**
☐ almost always (proceed to next positive parenting behavior)			
Avoid verbal arguments with adult significant others when your children are present. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid physical arguments with adult significant others when your children are present. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid swearing and yelling in front your children. ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid drinking alcohol ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid anger ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid stress ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
Avoid spending time with other drug users ☐ almost never ☐ sometimes ☐ almost always (proceed to next positive parenting behavior)	☐ no (proceed to next positive parenting behavior) ☐ yes		
WHAT OTHER POSITIVE PARENTING BEHAVIORS HAVE BEEN DIFFICULT FOR YOU?: _____. ☐ almost never ☐ sometimes ☐ almost always (assessment completed)	☐ no (assessment completed) ☐ yes		

References

Appleton JV. Perspectives of neglect. Child Abuse Review. 2012; 21:77–80.

Ayoub CC, Milner JS. Failure to thrive: Parental indicators, types, and outcomes. Child Abuse and Neglect. 1985; 9:491–499. [PubMed: 4084828]

Azrin NH, Donohue B, Teichner GA, Crum T, Howell J, DeCato LA. A controlled evaluation and description of individual-cognitive problem solving and family-behavior therapies in dually-diagnosed conduct-disordered and substance-dependent youth. Journal of Child & Adolescent Substance Abuse. 2001; 11:1–43.

Bauer S, Strik W, Moggi F. Motivation as a predictor of drinking outcomes after residential treatment programs for alcohol dependence. Journal of Addiction Medicine. 2014; 8:137–142. [PubMed: 24637624]

Breda CS, Heflinger CA. The impact of motivation to change on substance use among adolescents in treatment. Journal Of Child and Adolescent Substance Abuse. 2007; 16:109–124.

Cash SJ, Wilke DJ. An ecological model of maternal substance Abuse and child neglect: Issues, analyses, and recommendations. American Journal of Orthopsychiatry. 2003; 73:392–404. [PubMed: 14609401]

Dallery, J., Meredith, SE., Budney, AJ. Contingency management in substance abuse treatment. In: Walters, ST., Rotgers, F., editors. Treating substance abuse: Theory and techniquee. 3rd. New York, NY, US: Guilford Press; 2012. p. 81-112.

Deci EL, Ryan RM. The “what” and “why” of goal pursuits: Human needs and the self-determination of behavior. Psychological Inquiry. 2000; 11:227–268.

Donohue, B., Allen, DN. Treating adult substance abuse using family behavior therapy: A step-by-step approach. Hoboken, NJ, US: John Wiley & Sons Inc; 2011.

Donohue, B., Azrin, NH. Family Behavior Therapy: A Step-By-Step Approach to Adolescent Substance Abuse. Hoboken, NJ: John Wiley & Sons, Inc; 2012.

Donohue B, Azrin NH, Bradshaw K, Van Hasselt VB, Cross CL, Urgelles J, Allen DN. A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. Journal of Consulting And Clinical Psychology. 2014; 82:706–720. [PubMed: 24841866]

Donohue B, Romero V, Hill HH. Treatment of co-occurring child maltreatment and substance abuse. Aggression and Violent Behavior. 2006; 11:626–640.

Dufour S, Lavergne C, Larrivée M, Trocmé N. Who are these parents involved in child neglect? A differential analysis by parent gender and family structure. Children and Youth Services Review. 2008; 30:141–156.

Fitzpatrick ME, Weltzin T. Motivation for change as a predictor of eating disorder treatment outcomes using a brief self-report YBC-EDS in a residential eating disorder population. Eating Behaviors. 2014; 15:375–378. [PubMed: 25064284]

First, MB., Spitzer, RL., Gibbon, M., Williams, JBW. Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV). Washington, D.C.: American Psychiatric Press, Inc; 1996. 1996

Gershater-Molko RM, Lutzker JR, Wesch D. Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at-risk for child maltreatment. Journal of Family Violence. 2003; 18:377–386.

Harkin B, Webb TL, Chang BI, Prestwich A, Conner M, Kellar I, Sheeran P. Does monitoring goal progress promote goal attainment? A meta-analysis of the experimental evidence. Psychological Bulletin. 2015; 142:198–229. [PubMed: 26479070]

Kirby KC, Benishek LA, Dugosh KL, Kerwin ME. Substance abuse treatment providers’ beliefs and objections regarding contingency management: Implications for dissemination. Elsevier Drug & Alcohol Dependence. 2006; 89(1):19–27.

Lanier P, Kohl PL, Benz J, Swinger D, Drake B. Preventing maltreatment with a community-based implementation of parent–child interaction therapy. Journal of Child and Family Studies. 2014; 23:449–460. [PubMed: 24443637]

Lussier JP, Heil SH, Mongeon JA, Badger GJ, Higgins ST. A meta-analysis of voucher-based reinforcement therapy for substance use disorders. Addiction. 2006; 101(2):192–203. DOI: 10.1111/j.1360-0443.2006.01311.x [PubMed: 16445548]

Lutzker JR. Behavioral treatment of child neglect. Behavior Modification. 1990; 14:301–315. [PubMed: 2198017]

Lutzker JR, Rice JM. Project 12-Ways: Measuring outcome of a large in-home service for treatment and prevention of child abuse and neglect. Child Abuse & Neglect. 1984; 8:519–524. [PubMed: 6542822]

Meyers, RJ., Dominguez, T., Smith, JE. Community rein-forcement training with concerned others. In: Hasselt, VB., Hersen, M., editors. Sourcebook of psychological treatment manuals for adult disorders. New York: Plenum Press; 1996. p. 257-294.

Meyers RJ, Miller WR, Smith JE, Tonigan JS. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. Journal Of Consulting And Clinical Psychology. 2002; 70(5):1182–1185. DOI: 10.1037/0022-006X.70.5.1182 [PubMed: 12362968]

Milner, J. The Child Abuse Potential Inventory Manual. DeKalb, IL: Psytec Inc; 1986.

Milner, J. An Interpretive Manual for The Child Abuse Potential Inventory. Dekalb, IL: Psytec Inc; 1990.

Owusu-Addo E, Cross R. The impact of conditional cash transfers on child health in low- and middle-income countries: A systematic review. International Journal of Public Health. 2014; 59:609–618. [PubMed: 24898173]

Petry, NM. Contingency management for substance abuse treatment: A guide to implementing this evidence-based practice. New York, NY, US: Routledge/Taylor & Francis Group; 2012.

Petry NM, DePhilippis D, Rash CJ, Drapkin M, McKay JR. Nationwide dissemination of contingency management: The Veterans Administration initiative. The American Journal On Addictions. 2014; 23(3):205–210. DOI: 10.1111/j.1521-0391.2014.12092.x [PubMed: 24724876]

Schaeffer CM, Swenson CC, Tuerk EH, Henggeler SW. Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. Child Abuse & Neglect. 2013; 37:596–607. [PubMed: 23768938]

Sheidow AJ, Donohue B, Hill HH, Henggeler SW, Ford JD. Development of an audio-tape review system for supporting adherence to an evidence-based practice. Professional Psychology: Research & Practice. 2008; 39:553–560.

Stitzer, ML., Jones, HE., Tuten, M., Wong, C. Community reinforcement approach and contingency management interventions for substance abuse. In: Cox, WM., Klinger, E., editors. Handbook of motivational counseling: Goal-based approaches to assessment and intervention with addiction and other problems. 2nd. Wiley-Blackwell; 2011. p. 549-569.

Swenson CC, Schaeffer CM, Henggeler SW, Faldowski R, Mayhew AM. Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. Journal of Family Psychology. 2010; 24:497–507. [PubMed: 20731496]

U.S. Department of Health and Human Services (DHHS). Child Maltreatment 2011. Washington, DC: Government Printing Office; 2012. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

Table 1

Participant Demographics (n = 18)

Variables	N or Mean	% of Sample or SD
Ethnicity:		
Caucasian	6	33%
African American	7	39%
Hispanic	2	11%
Asian American	2	11%
Native American	1	6%
Mother Mean Age (years)	29.28	7.21
Identified Child Mean Age (years)	3.22	3.42
Marital Status:		
Single	8	44%
Cohabitating	9	50%
Married	1	6%
Employment Status:		
Unemployed	15	88%
Part-Time	2	11%
Full-Time	1	6%
Substance Diagnosis:		
Marijuana Abuse	4	21%
Marijuana Dependence	1	6%
Hard Drug Abuse	3	17%
Hard Drug Dependence	7	39%
Lifetime Drug Diagnosis	3	17%

Table 2

Percentage of Participants Reporting Infrequent Performance of Each of the Child Neglect Incompatible Parenting Actions, and Percentage of Participants Targeting Each of the Child Neglect Incompatible Parenting Actions as a Treatment Goal (n = 18)

Antecedent to Child Neglect	% of Participants Endorsing Each Parenting Action as Infrequently Occurring	% of Participants Targeting Each Parenting Action as a Goal
-Eat from all major food groups each day	44.4	38.9
-Eat breakfast, lunch and dinner or get enough to eat each day	16.7	16.7
-Avoid junk food	83.3	44.4
-Exercise regularly	27.8	22.2
-Clothes are clean (including diapers for infants)	11.1	5.6
-Children clean (body and teeth)	22.2	16.7
-Keep home clean	16.7	27.8
-Keeps pests out of home (bugs, rats, etc.)	16.7	16.7
-Sharp objects away	5.6	5.6
-Electrical wires or outlets covered	38.9	27.8
-Keep small objects off the floor (swallowing and tripping hazards)	55.6	38.9
-Keep medicines and poisons away (cleaning agents, pesticides, etc.)	22.2	16.7
-Get children regular check-ups and vaccinations on time	44.4	33.3
-Get children medical services when needed	5.6	5.6
-Monitor and supervise children at all times	5.6	5.6
-Proper clothing for children	0.0	0.0
-Toys and books at appropriate educational level	16.7	11.1
-School and daycare on time	11.1	11.1
-Assist children with homework	5.6	5.6
-Express affection (hugs, say “I love you,” etc.)	5.6	5.6
-Praise child each day	11.1	11.1
-Talk, play and read to child each day	16.7	16.7
-Discipline undesired behaviors	27.8	27.8
-Keep pornographic materials and sexual toys away	5.6	5.6
-Keep drugs and alcohol away	33.3	22.2
-Keep away age-inappropriate media	33.3	33.3
-Keep children away from seeing or hearing you or others making love	0.0	0.0
-Avoid verbal arguments with others when child present	61.1	55.6
-Avoid physical arguments with adult significant others when child present	22.2	22.2
-Avoid swearing or yelling in front of child	33.3	55.6
-Avoid alcohol	33.3	22.2
-Avoid anger	55.6	38.9
-Avoid stress	88.9	66.7
-Avoid urges or cravings (substance use)	66.7	55.6
-Avoid spending time with other drug users	94.4	88.9

Table 3

Number of Endorsed Positive Parenting Actions Occurring Infrequently and Number of Positive Parenting Actions Set as Treatment Goals Predicting Post-Treatment Child Maltreatment Potential, while Controlling Child Maltreatment Potential at Baseline (n = 18)

	Post-Treatment Child Maltreatment Potential	
Predictor	**ΔR^2**	**β**
Step 1: Child Maltreat. Baseline	.733**	
Step 2: # Endorsed Neglect Actions	.08*	.284
# Parenting Goals Set		−.529*

*$p < .05$,

**$p < .01$.