Capstone

Bridging the Housing Divide: Building an Equitable Recovery Ecosystem to Support Two-Parent Families in Recovery

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Short Overview

The social issue revolves around the structural deficit in substance use disorder (SUD) recovery services, particularly the lack of programs designed to explicitly support and incorporate two-parent family units. Recovery capital encompasses essential elements such as access to housing, employment, peer support, and family integration. However, many services focus primarily on individuals or single caregivers in recovery, leaving two-parent families with no viable pathway to remain together while engaging in structured recovery supports (National Center for Juvenile Justice, n.d.). This gap forces families into untenable choices: separating into gender-specific sober living environments or remaining in unsafe or unstable housing.

Family stability is a crucial protective factor against relapse in SUD recovery, but SUD affects families in diverse and complex ways. Both parents may be potentially struggling with SUD, one parent may in recovery while the other continues to use, or only one parent being affected (Wfmh, 2025). These dynamics can strain relationships, disrupt parenting, and lead to adverse outcomes for children, including emotional distress, behavioral challenges and increased risk of child welfare involvement (McCabe et al., 2025). Despite these risks current systems rarely provide integrated supports such as couples counseling, co-parenting resources, or on-site childcare, services that are essential for maintaining unity and supporting whole family recovery.

Two parent families across socioeconomic backgrounds face additional challenges in balancing recovery, employment, housing stability, and effective parenting (Washington State Office of Financial Management, 2025). In Washington State, where more than 70% of children live with both parents, the near-total absence of integrated sober living options for these families represents a significant public health and child welfare gap. Stakeholders participating in the community needs assessment for this project rated the need for two-parent recovery housing at 4.9 out of 5, underscoring the urgency of intervention.

The proposed Integrated Family Residential Model directly addresses this deficit by creating family-centered transitional housing units that allow two-parent households to remain intact while accessing structured recovery supports. By situating families in townhome-style units within stable neighborhoods and providing wraparound services, including parenting support, couples and family therapy, child specialists, employment navigation, and peer recovery services; the model strengthens family stability, increases recovery capital, and reduces the likelihood of child welfare involvement. This approach reframes recovery from an individual endeavor to a whole-family process, aligning with family systems theory and the socio-ecological model to promote sustained, equitable recovery outcomes.

Social Positionality

My motivation for focusing on the lack of integrated recovery capital services for two-parent families stems from my 13 years in continuous recovery, a personal journey that includes eight years as a substance use disorder professional, during which I've worked across various modalities of care. This combined background grants me intimate knowledge of the systemic gaps, therapeutic limitations, and the profound, long-term commitment required for sustained recovery. I understand that SUD is often only a small, visible piece of a much larger life and societal puzzle that needs to be solved.

My core belief is that everyone deserves a fair chance at recovery. This conviction drives me to look beyond individual pathology to address the social determinants and structural barriers that impede equitable access to care. I am particularly passionate about protecting our future: the children impacted by this disorder. Furthermore, for genuine healing to occur, we must

continually examine how addiction plays a detrimental role in society and advocate for systemic changes that foster healthier communities.

My professional practice has highlighted a significant and persistent gap in the continuum of care: the severe lack of appropriate sober living facilities for two-parent family units, as well as the lack of funding. While I acknowledge the valid issues and risks associated with safety, relapse, and liability in providing such housing, the current system often necessitates the separation of nuclear families, contradicting the fundamental right of a family unit to remain intact. I see tremendous, untapped potential for growth, motivation, and stability when couples in recovery are allowed to support one another and raise their children together within a structured, safe environment. Addressing this gap by developing two-parent family sober living is a critical step toward a more holistic, supportive, and equitable recovery ecosystem.

Evidence of Social Problem

In 2024 an estimated 48.4 million people aged 12 or older in the United States experienced a SUD within the past year (Substance Abuse and Mental Health Services Administration, 2025). Data from SAMHSA indicates that substance use continues to rise annually. While precise figures for two-parent households with a parent in recovery are unavailable, research suggests that roughly one in four children lives with at least one parent struggling with SUD (McCabe et al., 2025). In 2023, 71.1% of children were reported to live with both parents (National Center for Juvenile Justice, n.d.), and if SUD prevalence mirrors the general population, millions of children are growing up in two-parent households affected by SUD and the challenges of recovery.

Accurate prevalence data for SUD remains limited due to the sensitive nature of the topic. Nonetheless, diagnostic assessments have enabled some demographic tracking. In Washington, 25.9% of young adults aged 12 to 25 were identified as having an illicit drug use disorder, and 2.33% had an opioid use disorder (Wfmh, 2025). Recent data for adults over 25 is unavailable. Notably, 70.4% of two-parent families in Washington state live together (Social-economic Conditions, 2025). With Washington suspected to have higher rates of substance use than the national average, and the proportion of two-parent families aligning with broader trends, it is reasonable to estimate that one or two out of every four children in the state are living with a parent affected by SUD.

Socioeconomic status (SES) is a major factor affecting the recovery capital of two-parent families. Financial instability and unemployment often force families to rely on welfare services, including state medical coverage, which can restrict access to essential supports like couples or family counseling and limit treatment options (Smith et al.,2025). Limited resources also make childcare difficult to obtain, creating barriers to accessing needed services, a challenge well documented among families navigating parental substance use (Hanson et al., 2019; Lander et al., 2013). Additionally, parents in these families frequently take on dual roles as family managers, and traditional gender roles may further contribute to disparities in support and access, particularly for mothers who often shoulder disproportionate caregiving and service coordination responsibilities (Smith et al., 2025; Kelley et al., 2015).

Parents in minority communities often encounter heightened systemic distrust and apprehension when engaging with support services, especially those connected to public health or child welfare (Henninger & Sung, 2013). For instance, Black and Hispanic families are disproportionately subject to scrutiny by child protective services (CPS) (National Center for Juvenile Justice, n.d.). As a result, parents in recovery may hesitate to seek treatment, fearing increased visibility to these systems regardless of their progress, which creates a significant

systemic barrier to accessing comprehensive support for two-parent families, and greatly related to poverty and stigma.

There has been a notable evolution in SUD treatment, shifting from acute medical models, primarily focused on medical stabilization and detoxification, to approaches that emphasize long-term recovery. Historically, acute detoxification in the United States was largely reserved for alcohol use and often viewed as a moral failing. The opening of inebriate hospitals in the 1950s marked a turning point, introducing the Minnesota Model, which incorporated principles from Alcoholics Anonymous (A.A.) and provided structured, residential treatment for several weeks (Henninger & Sung, 2013). The success of this model led to its widespread adoption and expansion. Contemporary treatment models now include harm reduction strategies, meeting clients where they are, and recognizing substance use as one of several interconnected issues. Achieving sustained recovery requires more than medical intervention; individuals need access to safe housing, financial stability, recovery support, family support and a sense of purpose. However, the integration of family support into SUD treatment has been slow, only recently becoming a more consistent part of treatment engagement.

Theoretical Framework

The theoretical foundation for this project draws primarily on family systems theory and the socio-ecological model, two frameworks that illuminate why existing SUD recovery structures fail to meet the needs of two-parent families and how an integrated residential model can more effectively support whole-family stability.

Family Systems Theory

Family systems theory conceptualizes the family as an interdependent emotional unit in which the functioning of each member affects the entire system (Hanson et al., 2019). When substance use enters the family environment, the resulting disruptions—role instability, impaired communication, and heightened stress—are not isolated to the individual parent. Instead, they reverberate across the entire family system, influencing parenting capacity, relational functioning, and child wellbeing. Research shows that interventions focused solely on the individual often overlook these relational dynamics, leading to fragmented care and poorer long-term outcomes (Huebner et al., 2021; Isler et al., 2017).

For two-parent families, this gap is especially consequential. Co-parenting relationships, shared caregiving responsibilities, and the interdependence of parental roles mean that recovery processes unfold within a relational context. Family systems theory therefore supports the need for interventions that preserve family unity, strengthen relational functioning, and address the interconnected patterns that shape recovery trajectories.

Socio-Ecological Model

The socio-ecological model complements this perspective by situating SUD recovery within multiple layers of influence such as individual, relational, community, and societal (Carmody, 2024; Henninger & Sung, 2013). Recovery is shaped not only by personal motivation or treatment engagement but also by structural conditions such as housing stability, access to childcare, neighborhood safety, employment opportunities, and interactions with systems like child welfare or the legal system.

Two-parent families often encounter overlapping ecological pressures: limited access to family-appropriate housing, inconsistent availability of couples or family therapy, and systemic barriers that make it difficult to engage in treatment without risking family separation. The socio-ecological model underscores that without addressing these broader contextual factors, even evidence-based clinical interventions remain insufficient.

Integration of Frameworks

Together, these frameworks highlight the core problem identified in this capstone: the current recovery ecosystem is structurally misaligned with the realities of two-parent families. Family systems theory demonstrates why separating parents into individual or gender-segregated programs disrupts the very relational processes that support recovery. The socio-ecological model explains how systemic barriers—housing shortages, childcare gaps, and punitive child welfare responses—further destabilize families and impede long-term recovery.

The proposed integrated family recovery housing model is grounded in these theoretical insights. By treating the family as the primary unit of intervention and addressing ecological barriers through wraparound supports, the model aligns with both frameworks and offers a pathway toward sustained, whole-family recovery.

Interventions

SUD treatment, housing stability, wraparound services and supportive social policies are deeply interconnected in shaping recovery outcomes, resilience, and long-term wellbeing. Best practices in these domains emphasize trauma informed treatment, integrated house models and family centered approaches that recognize the unique vulnerabilities of individuals and single parents navigating recovery. Yet there remains a critical gap in understanding how two-parent families experience and access these supports. By reviewing interventions and policies that have proven impactful, this analysis seeks to highlight both effective strategies and areas where systemic blind spots persist, ultimately pointing toward more equitable frameworks that address the diverse realities of family structures in recovery.

Micro-level Interventions

Micro-level interventions focus on direct treatment, relational repair among family members, and parenting support for individuals and families navigating SUD. Recovery is profoundly shaped by family dynamics and trauma histories, making it essential to address both individual and relational needs within the family system.

The intersection of motherhood and SUD presents complex challenges, including the tension between recovery and parenting, and the difficulties of engaging with external systems such as child protective services (Smith et al., 2025). This high-stress environment often fosters negative outcomes and feelings of hopelessness. Women in recovery face unique barriers, including stigma and intense caregiving responsibilities (Lander, 2013). Effective gender-responsive programming must integrate parenting support to improve engagement and outcomes.

While most research assumes a single caregiver model, the dynamics of co-parenting in two-parent families represent a significant gap in understanding how shared responsibility influences treatment outcomes (Tach et al., 2022). Interventions that address these complex challenges include:

Trauma-Informed Care (TIC)

TIC recognizes that parental SUD often co-occurs with histories of trauma, chronic stress, and disrupted attachment patterns. These factors significantly influence parenting capacity, emotional regulation, and the ability to maintain safe, consistent caregiving practices. Research demonstrates a strong association between parental substance use and increased risk of child maltreatment, not solely because of substance use itself but because trauma-related dysregulation undermines a parent's ability to respond sensitively to their child's needs (Tach et al., 2022).

For two-parent families, TIC approaches must account for how trauma manifests within the couple's relational system. Partners may trigger one another's trauma responses, escalate conflict, or reinforce maladaptive coping patterns. Conversely, when both parents receive trauma-responsive support, they can develop shared language, co-regulation strategies, and collaborative parenting practices that strengthen the entire family system. This highlights the need for trauma-informed interventions that are not only individually focused but also relationally oriented, addressing how trauma impacts the couple's interactions, parenting partnership, and collective recovery trajectory.

Behavioral Couples Therapy (BCT)

BCT is one of the few types of evidence-based interventions that directly targets the relational context of substance use. BCT has demonstrated strong outcomes in improving communication, reducing conflict, and increasing relationship satisfaction, all of which are protective factors against relapse (Kelley et al., 2015). By involving both partners in treatment, BCT acknowledges that recovery unfolds within a shared environment where each partner's behaviors, stressors, and coping strategies influence the other.

However, BCT's traditional scope is limited: it focuses primarily on the couple dyad and often excludes the broader family system, including children. This omission is particularly significant for two-parent families, where parenting responsibilities, child behavior, and family routines are central components of daily life. Without integrating the needs of children or the complexities of co-parenting, BCT may fall short in addressing the full ecological reality of families navigating recovery. The model's strengths: relational repair, improved communication, and shared accountability, are essential but insufficient on their own for families who must simultaneously manage sobriety, parenting demands, and systemic pressures such as child welfare involvement.

Family-Based Recovery (FBR) Model

The FBR model represents a major shift by embedding SUD treatment directly into the home environment for parents of infants and toddlers. FBR prioritizes child safety while enabling children to remain in the home, with their parents' developing recovery in real time, and has demonstrated positive outcomes in reducing substance use and maintaining family structure, strengthening parent-child relationship and reducing the likelihood of child removal (Hanson et al., 2019). Its home-based structure enables clinicians to observe daily routines, address safety concerns immediately, and support parents in applying new skills under authentic conditions, leading to reductions in substance use and improvements in family stability.

Mezzo-level Interventions

At the mezzo-level, recovery is shaped by the environments in which individuals and families live, particularly housing stability and community-based supports. These interventions recognize that treatment alone is insufficient without the infrastructure that sustains safety, caregiving, and social connection.

Housing First Approach

The provision of stable housing, often decoupled from requirements of immediate sobriety (a "Housing First" approach), has emerged as a crucial intervention, particularly for vulnerable populations with co-occurring SUDs. Research on interventions for homeless, substance-abusing mothers demonstrates that providing rental assistance and independent housing, combined with intensive supportive services and case management, is necessary to successfully engage women in treatment and address multiple needs simultaneously (Slesnick & Erdem, 2012). This approach directly contradicts the traditional model by establishing a secure

environment first, thereby improving retention in substance abuse treatment programs and leading to statistically significant reductions in substance use and homelessness.

Community-Based Recovery Housing

Beyond simple dwelling provision, the structure of the living environment plays a critical role in fostering sustained recovery. Community-based recovery housing models, such as Oxford Houses, exemplify successful mezzo-level interventions by focusing on peer-governed community infrastructure. These self-run, democratic residential homes emphasize mutual support, accountability, and the creation of a surrogate "family" environment.

Recovering in Home with Children

For parents in recovery, specifically, the living environment must support caregiving and family stability. Studies of recovery homes that allow children to live with their parents highlight that the presence of children and the resulting supportive social atmosphere are beneficial not just for family reunification, but for the entire household's recovery process (Legler et al., 2013). This shared living arrangement enhances the mother's sense of community, provides essential practical support (e.g., shared childcare), and creates a positive, supportive environment that reinforces abstinence and self-efficacy among all residents. Furthermore, research by Isler et al. (2017) exploring the familial dynamics in these settings found that the supportive social bonds and the sense of security generated within these peer-driven environments are key factors in preventing relapse, suggesting that recovery outcomes are heavily dependent on the quality and stability of the social infrastructure provided by the housing context.

Macro-Level Interventions

Interventions at this level target policies, funding streams and governmental systems that either promote or impede long-term recovery for entire populations.

Family First Prevention Services Act

A critical example of a macro-level intervention is the Family First Prevention Services Act (FFPSA), a major piece of federal legislation signed into law in 2018, designed to fundamentally shift child welfare funding away from costly long-term foster care and toward preventative services, specifically addressing parental SUD and the resulting neglect (Carmody, 2024). A key component of the FFPSA is the requirement that the prevention funds are mandated to be used for only federally approved, evidenced-based practices, thereby driving the implementation of effective, family focused SUD interventions.

Trauma-Informed Care

There are several key strengths to mention when looking at the future of SUD integrated care and resources. The Family-Based Recovery model provides that by embedding treatment in homes to reduce SUD and maintain family structure (Hanson et al.,2019), complemented with a growing focus on trauma-informed care, which equips parents with emotional regulation skills to repair attachment ruptures linked to child maltreatment risk (Tach et al., 2022).

Housing

The Housing First approach demonstrating success by decoupling housing from abstinence, thereby improving treatment retention and significantly reducing substance use and homelessness (Slesnick & Erdem, 2012). Furthermore, peer-governed recovery housing fosters mutual support and social stability, which are key factors in preventing relapse (Legler et al., 2013; Isler et al., 2017). Lastly, FFPSA ensures the sustainability of these efforts for SUD family-focused evidenced based interventions (Carmody, 2024).

Despite significant progress in developing integrated and family-centered care, a critical systemic gap persists in understanding the needs of two-parent families in recovery. Much of the

existing research and intervention design assumes a single-caregiver model when addressing SUD and parenting (Tach et al., 2022). This blind spot is evident as studies like those on BCT, while beneficial for the couple, have historically lacked the inclusion of the family unit (Kelley et al., 2015). Consequently, the specific dynamics of co-parenting and shared responsibility and how they influence treatment engagement, adherence, and long-term outcomes remain largely unexamined. This oversight risks leaving a significant portion of the population without supports tailored to their family structure, highlighting the need for research that accurately reflects the diverse realities of family life in recovery.

Even the most promising interventions, such as Family-Based Recovery, depend on addressing structural gaps in the support system. In adapting a personal strategy, beginning at the assessment level by formally integrating a family systems value system into the SUD evaluation would help to accurately capture the relational dynamics of two parent units. Crucially, the micro-level must be structurally supported at the mezzo level, if two-parent families lack housing that explicitly accommodates them these interventions remain inaccessible. Thus, this capstone project aims to highlight the urgent need for and facilitate the creation of designated recovery housing options for two-parent families. By simultaneously valuing and assessing the complexity of the two-parent family and providing a stable environment for their residence, the full potential of family-centered treatment can be unlocked, establishing a more equitable pathway to sustained, whole-family recovery.

Stakeholder Information

Methodology and Sample

Due to the constraints of the research timeline and to maximize community reach, the required interviews/listening sessions were adapted into a community-based, anonymous online survey of 14 questions, found in Appendix A. This methodology allowed for the collection of both quantitative and rich qualitative data from a broader range of community stakeholders. The data gathered were analyzed using a thematic synthesis approach. Open-ended responses were coded to identify recurring concepts, feelings, and recommendations, while quantitative data were used to provide statistical context and measure consensus. The findings of this analysis are detailed in the remainder of this section.

The survey was distributed primarily targeting a multi-faceted group of stakeholders: parents currently or formerly managing SUDs, individuals with lived experience, engaged community members, and behavioral health/medical professionals. Recruitment utilized a convenience sampling method, disseminating the survey link primarily through social media platforms, specific behavioral health community Facebook groups, and LinkedIn to access a network of those knowledgeable about the issue. The full survey instrument is included in Appendix A.

A total of ten community stakeholders participated in these surveys, representing a wide range of roles, including parents and caregivers 60%, individuals with lived experience of substance use recovery 80%, behavioral health and medical professionals, 60% certified peer counselors, 10% and community members or neighbors 60%. Their connection to the issue was both personal and professional: some had navigated recovery while parenting, others worked directly in treatment or child welfare systems, and many observed the impact of recovery housing gaps in their neighborhoods. Responses came from several counties across Washington State, including Pierce, Kitsap, Douglas, and King, reflecting regional diversity and shared concerns.

Participants consistently defined family recovery housing**,** particularly for two-parent households, as a critical unmet need. They described the challenges families face when both parents are in recovery, including housing instability, employment barriers, childcare shortages, transportation difficulties, parenting stress, CPS involvement, food insecurity, and lack of community support.

Lived experiences highlighted how recovery is deeply intertwined with family stability. Parents emphasized the importance of recovering alongside their children rather than being separated. Many noted that existing programs are fragmented and often focus on individuals rather than families, leaving parents without tangible or effective supports. While family resource centers and shelters exist, they are limited, often have long waitlists, and rarely offer comprehensive services for families seeking recovery together. Stakeholders also pointed to disparities: families with children face unique barriers compared to single adults, and systemic gaps in CPS/legal navigation create inequities that hinder recovery. Cultural and community-specific needs were identified as inconsistently addressed, further complicating access to effective support.

The needs described by participants spanned both service and policy priorities. Service priorities included on-site childcare, family and couples therapy, parenting classes, job training and employment support, peer recovery coaching, case management and goal planning, recreational and family bonding activities, and stronger connections with schools, healthcare, and food security resources. Policy priorities focused on affordable and accessible housing designed specifically for families in recovery, integration of Department of Children, Youth and Families (DCYF) navigation support into housing programs, and funding streams that prioritize family-centered recovery rather than individual-focused models. Equity-based approaches were emphasized as essential to reducing systemic barriers.

Stakeholders identified several strategies for addressing these priorities. Housing design was a recurring theme, with many advocating for independent units per family rather than shared multi-family houses, located in safe neighborhoods with affordable rent and bundled utilities. Structure, accountability, and clear boundaries were seen as necessary to create supportive environments. Integrated supports were also highlighted, including separate clinical services for each parent, family therapy, child-specific clinical teams, and peer and professional support available around the clock. Respondents emphasized the importance of community partnerships, calling for collaboration among mental health and substance use treatment centers, housing authorities, nonprofits, schools, law enforcement, DCYF, and local governments. They also underscored the systemic impact of family recovery housing, noting that lower relapse rates would reduce crime, strengthen family stability, and ease the burden on DCYF, courts, law enforcement, and emergency departments while increasing productivity and community connectedness.

Overall, stakeholders framed family recovery housing as more than shelter; it is a pathway to dignity, connection, and systemic reform. They envisioned holistic programs that meet basic needs, support parents and children together, and reduce fragmentation across systems. Recovery housing was described as both a personal lifeline for families and a community-wide investment that strengthens resilience, reduces costs, and restores hope.

Needs Statement

Stakeholders were equally clear about what is needed. With a unanimous agreement that the absence of recovery housing for two-parent families represent a critical service deficit, the need for a comprehensive family-centered model that integrates clinical supports such as

couples and family therapy; with practical stabilization resources including on-site childcare, parenting classes, case management and peer-recovery coaching. Their vision is a low-barrier, holistic environment capable of supporting both immediate safety and long-term stability. In short, to strengthen family stability and increase recovery capital, Washington must expand sober living models to include two-parent units, shifting from individual-focused care to an integrated family residential model that prevents forced separation and provides essential wraparound supports.

Description of Project

Overview

The Integrated Family Residential Model (IFRM) is a family-centered transitional housing program designed specifically for two-parent households in recovery from SUD. The project, named Legacy Bridge Homes, provides safe, stable housing paired with comprehensive wraparound supports that allow families to remain intact while engaging in structured recovery services. The program will serve two-parent families with children who are exiting inpatient or intensive outpatient SUD treatment, are in good clinical standing, and require a stable environment to maintain sobriety, rebuild family functioning, and prevent child welfare involvement. Parents will provide rent at a sliding fee scale rate.

The project will be situated in a cluster of independent, townhome-style units located in a safe, resource-rich neighborhood in Washington State. This model preserves family autonomy while ensuring immediate access to on-site clinical supports, schools and public transportation. Within this environment, families will participate in a structured program that includes clinical, vocational and residential engagement. The model reframes recovery as a whole-family process, aligning with family systems theory and the socio-ecological model to promote long-term stability and resilience.

Activities

Program launch begins with the furnishing and child safety-certification of the residential units. Upon entry, each family will collaborate with staff to develop an individualized family recovery plan that includes a formal child safety plan, outlining clear procedures in the event of relapse or safety concerns. Parents will participate in ongoing recovery accountability measures, including regular UA testing and verification of compliance with SUD and mental health treatment. Throughout their stay, families will have access to on-site childcare, enabling parents to attend treatment, work, or participate in program activities without the barrier of inconsistent childcare.

The program will deliver a full continuum of clinical services: couples and family therapy, parenting classes, trauma-informed individual counseling, and child-development support, provided by licensed clinicians and child specialists. Peer recovery coaches will support both parents through mentoring, relapse-prevention planning, and daily problem-solving.

To operationalize vocational engagement, a unique component of the program is the operation of a small, program-owned bakery that serves as a workforce development internship and financial-stability pathway for parents. Through structured shifts, hands-on training, and supportive supervision, parents can build work ethic, gain employment experience, and develop transferable skills while earning income. Participation in the bakery also supports financial recovery by helping parents work toward savings goals, debt repayment, and long-term economic stability. Additionally, revenue generated by the bakery contributes to the

program's self-sufficiency, reducing reliance on external funding and strengthening sustainability.

Families will also receive employment and education navigation services, such as resume development, job placement assistance, and school enrollment support. Weekly community-building activities including family dinners, workshops, and recovery groups will foster connection, accountability, and a sense of belonging. The program will maintain close coordination with CPS/DCYF to support family preservation and reduce punitive system involvement, facilitated by ongoing progress monitoring, regular check-ins, and consistent drug screening to ensure safety and compliance.

As families progress into the final stage of the program, they will begin preparing for long-term housing stability through structured homeownership pathways. Parents will either partner with Habitat for Humanity to complete sweat-equity hours toward building a home of their own or enroll in a first-time homebuyer course, such as an FHA-approved class, to qualify for reduced-rate mortgage options. The 30- to 36-month program period provides families with the time and support needed to repair credit, build savings, and establish a sustainable financial plan. By the end of the program, families are positioned to transition into permanent housing or homeownership, allowing them to experience the tangible rewards of their progress while opening space for the next family entering the program.

Resources and Personnel

Carrying out this project requires a combination of dedicated personnel, stable housing infrastructure, and strong community partnerships. Core staffing includes:

- Leadership & Admin: Program director and administrative support
- Clinical Team: Licensed Family, Marriage and Child Therapists, Case Managers/MSWs
- Support Staff: Certified peer recovery coaches, childcare providers, employment specialist, on-call safety staff

These roles ensure that families receive comprehensive clinical, relational, and practical supports throughout their stay. Additional resources include fully furnished townhome units, on-site childcare space, transportation supports, technology for case management, and operational capacity for the program-owned bakery, which functions as a workforce development and financial stability pathway for parents.

Recruitment of professionals will draw from multiple pipelines to ensure a diverse, qualified team. Licensed clinicians and case managers will be recruited through professional networks, local universities, and behavioral health associations. Peer recovery coaches will be sourced through Washington's peer certification boards and recovery community organizations. Childcare providers and support staff will be hired through early-learning networks and community job boards. The program will also cultivate partnerships with local MSW, MFT, and counseling programs to create internship and practicum opportunities, expanding capacity while supporting workforce development. All staff will receive training in trauma-informed care, family systems approaches, and culturally responsive practice to ensure alignment with the program's mission.

Outreach

To ensure that two-parent families in recovery are aware of and able to access the program, outreach will be conducted through a coordinated network of referral partners already engaged with parents navigating SUD. The program will collaborate closely with inpatient and outpatient treatment centers, hospitals, and detox facilities to create a seamless transition from

clinical care into stable housing. CPS/DCYF caseworkers and family treatment court teams will be key partners in identifying families at risk of separation who would benefit from a family-preservation-focused residential option. Additional outreach will occur through community health clinics, peer support networks, and recovery community organizations, ensuring that families connected to both formal and informal support systems are reached.

To support these partnerships, the program will distribute clear, accessible outreach materials including flyers, and referral packets to providers across the region. Staff will offer presentations and brief in-service trainings to treatment teams, case managers, and community partners to ensure they understand eligibility criteria, referral pathways, and the program's integrated, family-centered approach. This multi-layered outreach strategy ensures that families most in need of stable housing and wraparound supports are informed about the program and can access it without unnecessary barriers.

Timeline

Phase 1: The Nesting Phase (Months 1-6)

The first six months prioritize clinical stabilization and the process of unlearning survival mode through heavy clinical oversight. Families work closely with staff to establish a formal Safety Plan and participate in frequent family therapy. To advance, residents must maintain 180 days of continuous sobriety and demonstrate a stabilized "Safe Parent" protocol. During this period, parents engage in "therapeutic work" at the program's social enterprise, The Recovery Crumb bakery, for 10–15 hours per week to rebuild a sense of personal accomplishment.

Phase 2: The Architecture Phase (Months 7–18)

Upon entering the second phase, the focus shifts toward building broader Recovery Capital, including credit repair, career development, and deeper community integration. Financial literacy education evolves from basic bill paying to aggressive saving for a future mortgage. Parents move into full-time roles at the bakery or work with specialists to secure external community employment. This window is statistically the most likely time for a clinical setback; therefore the 36-month timeline incorporates a restorative grace period. This allows families to utilize a clinical contingency window to address and correct behavioral "slips" through intensive re-stabilization protocols without necessarily forfeiting their graduation date or housing status. This ensures that the recovery process remains a learning trajectory rather than a grounds for immediate expulsion (Hanson et al., 2019).

Phase 3: The Builder Phase (Months 19-30)

In the third phase, families focus on Sweat Equity and achieving tangible homeownership. This stage requires close coordination with land-trust partners, such as Habitat for Humanity, and the initiation of the mortgage pre-approval process. Residents also move into leadership roles as House Leads, helping new families navigate Phase 1, which reinforces their own recovery through service to others. Graduation readiness is assessed here based on the completion of required community service hours and vocational milestones.

Phase 4: The Bridge/Extension Window (Months 31-36)

The final six months serve as a soft launch into total independence. This extension is automatically granted for families awaiting a specific home closing date or finishing a degree. During this time, the family begins paying step-up rent that matches their projected future mortgage payment to practice their new budget in a supported environment. These funds are held in a moving grant account for the participant and returned to the family upon their successful transition into a permanent home or a new market-rate lease.

Goals and Outcomes

The long-term goal of this project is to strengthen family stability and increase recovery capital among two-parent households affected by substance use disorder by providing 30–36 months of integrated recovery housing, clinical support, and structured pathways toward financial independence and transition to stable, independent housing. By preventing forced family separation and addressing ecological barriers such as housing instability, childcare shortages, and limited access to relational supports, the program aims to create sustained whole-family recovery and reduce the likelihood of child welfare involvement.

The project's outcomes focus on improving family functioning, supporting sustained sobriety, and increasing economic stability. The first outcome centers on enhancing family stability and co-parenting capacity. The program aims for at least 85% of families to remain intact with no CPS removals during residency, and for 80% of parents to show measurable improvement in family functioning on the North Carolina Family Assessment Scale (NCFAS; Appendix D) within six months. Additionally, 75% of families are expected to demonstrate reduced parenting stress, as measured by the Parenting Stress Index (PSI; Appendix E), within the first nine months. The second outcome focuses on sustained recovery, with a goal that 75% of parents maintain continuous sobriety for at least six months, verified through UA logs and treatment compliance. 90% of participants will complete individualized relapse-prevention plans and show increased recovery capital scores, and families who experience a relapse will successfully complete the Behavioral Grace Contract at least 80% of the time, preventing displacement while maintaining child safety.

The third outcome emphasizes economic and housing stability. The program anticipates that 60% of parents will secure full-time employment or enroll in education or training programs within nine months, and that 70% of families will transition to permanent housing or enter a homeownership pathway within 12–18 months after completing Phase 3. Participation in the program's bakery social enterprise is expected to support financial literacy and debt reduction, with 80% of parents demonstrating improved budgeting skills and progress toward savings goals. These outcomes will be measured using standardized tools including the NCFAS, PSI, Recovery Capital Scale, UA logs, and employment and housing data collected at intake, every three months, and at program exit to ensure consistent, data-driven evaluation.

Measuring Success

The success of this project will be evident through observable improvements in family stability, recovery progress, and economic independence among participating two-parent households. Successful implementation will be reflected in families remaining intact without CPS removals, demonstrating stronger co-parenting skills, and showing reduced parenting stress as they progress through the program's phases. Additional signs of success include consistent sobriety, improved emotional regulation, and increased engagement in treatment and relapse-prevention planning.

Economic and housing stability will also serve as key indicators, with families securing employment, increasing their financial literacy, reducing debt, and transitioning toward permanent housing or homeownership. These outcomes align with the program's graduation benchmarks, which require families to achieve "Ready" status in four domains:

- Wellness: 24 months of continuous abstinence and a Recovery Capital Scale score of 150+.
- Financial: A FICO score of 620+ and completion of HUD-certified homebuyer education.

- Vocational:12 consecutive months of full-time employment or enrollment in a degree-bearing program.
- Family Functioning: Demonstrated mastery of Safe Parent protocols and successful case closure or prevention of involvement with CPS/DCYF.

Collectively, these changes demonstrate that families are not only maintaining sobriety but also building the long-term recovery capital necessary for sustained wellness and independence.

Project achievements will be measured using a combination of standardized assessment tools, program monitoring systems, and longitudinal data collection. Family functioning and parenting capacity will be evaluated using the NCFAS (Appendix D), and PSI (Appendix E) at intake and every three months, allowing the program to track improvements in stability, protective capacity, and stress reduction over time. Sustained recovery will be measured through urinalysis logs, treatment compliance records, and increases in Recovery Capital Scale (RCS; Appendix G) scores, which capture growth in internal, social, and community-based recovery resources. Economic and housing outcomes will be monitored through employment records, income verification, credit-score tracking, and documentation of transitions into permanent housing or homeownership pathways via the Monthly Check-In seen in Appendix F. These measures directly correspond to the four "Ready" domains, ensuring that progress toward graduation is both observable and quantifiable. All data will be collected by program social workers, case managers, and peer recovery coaches, ensuring consistent evaluation across all families. Together, these tools provide a comprehensive picture of the program's impact and allow for ongoing adjustments to support long-term success.

Barriers

Implementing a long-term, family-centered recovery housing model for two-parent households presents several predictable challenges. One of the most significant is the risk of relapse, which is a normal and expected part of the recovery process. In traditional housing programs, relapse often results in immediate eviction or family separation, creating trauma for children and destabilizing the entire household. To address this, the program incorporates a structured, evidence-aligned Relapse Prevention Grace Plan that allows families to remain housed while ensuring child safety. This includes the Safe Parent Protocol (Appendix H), in which the non-using parent immediately assumes full supervision of the children, and the Behavioral Grace Contract(Appendix I), a one-time, 30-day stabilization pathway that includes increased UA monitoring, temporary loss of privileges, clinical reassessment, and when needed, a short "bakery sabbatical"(vocational medical leave) to allow the using parent to focus exclusively on treatment. These safeguards ensure that relapse is treated as a clinical issue rather than a punitive one, while maintaining strict child-safety standards aligned with DCYF expectations.

Another is fear of CPS involvement, which can discourage families from seeking help or disclosing struggles. The program mitigates this by embedding child-safety planning into every phase of care, training parents in safety-organized practice, and maintaining transparent communication with DCYF. This approach reduces fear, increases trust, and positions the program as a partner in family preservation rather than a surveillance mechanism.

Funding limitations also pose a challenge, as few existing funding streams are designed for two-parent recovery housing or long-term transitional models. The program addresses this through a braided funding strategy that includes state grants, philanthropic support, sliding-scale program fees/rent, and revenue from the program's social-enterprise bakery. This

diversified model increases sustainability and reduces vulnerability to single-source funding loss.

Neighborhood resistance also known as "not in my backyard" (NIMBYism) may also arise when establishing recovery housing in residential areas. To reduce opposition, the program will engage in early community outreach, highlight safety protocols, and emphasize the broader community benefits of family stability, reduced crime, and increased economic participation.

Finally, staff burnout is a potential barrier given the intensity of family-centered work and the emotional demands of relapse-response protocols. The program will maintain a high staff-to-family ratio, provide reflective supervision, ensure manageable caseloads, and offer ongoing training in trauma-informed care, safety-organized practice, and crisis de-escalation.

Together, these strategies create a robust infrastructure that anticipates challenges and responds with clinical, relational, and structural supports designed to keep families intact, safe, and steadily progressing toward long-term stability.

Political Climate Factors and Policy Considerations

The policy landscape in Washington State strongly influences the implementation of this project. The model aligns with the Family First Prevention Services Act (Carmody, 2024) which prioritizes keeping children safely with their families and funding prevention-focused, evidence-based services. Washington's broader emphasis on family preservation, recovery-oriented systems of care, and housing-first principles also supports the program's goals. However, most existing funding streams and housing policies are designed for individuals or single-parent households, leaving two-parent families without appropriate recovery housing options. This gap highlights the need for continued advocacy and policy development.

The program's relapse-response structure including the Safe Parent Protocol (Appendix H) and the Behavioral Grace Contract (Appendix I), fits within Washington's child-safety statutes and safety-organized practice, ensuring that relapse is treated clinically while maintaining strict protective-capacity standards. At the same time, ongoing debates around harm reduction, behavioral health funding, and the role of child welfare in responding to parental substance use may influence public perception and regulatory requirements. By grounding the model in evidence-based practices and demonstrating clear benefits for child safety and family stability, the project is well-positioned within the current political climate.

Budget

Washington State incurs substantial annual costs when families become involved with the DCYF, including expenditures for CPS investigations, in-home services, foster care placements, and administrative oversight. These system-level costs represent a significant public burden that increases when families lack stable housing and recovery supports. According to the Annual Progress and Services Report (APSR), Washington allocates considerable resources each year to child welfare responses, underscoring the financial impact of family instability and system involvement (Washington State Department of Children, Youth, and Families, 2024). Legacy Bridge Family Homes offers a prevention-oriented alternative that reduces the likelihood of CPS involvement and the associated public expenditures. By stabilizing two-parent households through housing, childcare, and wraparound supports, the program offsets costs that would otherwise be absorbed by DCYF, making the proposed budget both fiscally responsible and aligned with statewide prevention priorities.

Personnel is the largest expense in the Legacy Bridge Homes budget, totaling $658,000, because the model requires licensed clinicians, case managers, peer recovery coaches, childcare staff, and safety personnel who maintain small caseloads and provide intensive, family-centered services. As outlined in Appendix J, housing costs of $242,400 cover leases for six townhome units, utilities, insurance, and maintenance to ensure each family has a stable, independent living environment. Program operations ($56,000) and direct family support funds ($40,000) provide transportation, parenting curricula, drug-testing supplies, emergency assistance, and child-focused materials that allow parents to fully engage in treatment. Evaluation costs ($18,500) support required assessment tools and data tracking to monitor outcomes. Startup funds of $50,000 establish the Recovery Crumb Bakery, the program's workforce-development component, which provides job training and contributes to long-term sustainability through earned revenue.

In conclusion, family-centered recovery housing represents a critical opportunity to address the intersection of substance use disorders, child welfare involvement, and family instability. By supporting parents in recovery while maintaining family unity, this project has the potential to improve outcomes for both parents and children while reducing the long-term social and economic costs associated with family separation.

References:

Carmody, C. (2024). Evidence-based practice criteria's effect on the implementation of the Family First Prevention Services Act in Nebraska and Colorado. *Evaluation and Program Planning*, *104*, 102428. https://doi.org/10.1016/j.evalprogplan.2024.102428

Hanson, K. E., Duryea, E. R., Painter, M., Vanderploeg, J. J., & Saul, D. H. (2019). Family-Based Recovery: An Innovative Collaboration between Community Mental Health Agencies and Child Protective Services to Treat Families Impacted by Parental Substance Use. *Child Abuse Review*, *28*(1), 69–81. https://doi.org/10.1002/car.2545

Henninger, A., & Sung, H. (2013). History of substance abuse treatment. In *The Encyclopedia of Criminology and Criminal Justice* (pp. 2257–2269). https://doi.org/10.1007/978-1-4614-5690-2_278

Huebner, R. A., Hall, M. T., Walton, M. T., Smead, E., Willauer, T., & Posze, L. (2021). The Sobriety Treatment and Recovery Teams program for families with parental substance use: Comparison of child welfare outcomes through 12 months post-intervention. *Child Abuse & Neglect*, *120*, 105260. https://doi.org/10.1016/j.chiabu.2021.105260

Isler, B., Mineau, M., Hunter, B., Callahan, S., Gelfman, N., Bustos, Y., Dovale, I., Peterson, A., & Jason, L. A. (2017). Relationship Themes Present between Parents and Children in Recovery Homes. *Alcoholism Treatment Quarterly*, *35*(3), 200–212. https://doi.org/10.1080/07347324.2017.1317483

Kelley, M. L., Bravo, A. J., Braitman, A. L., Lawless, A. K., & Lawrence, H. R. (2015). Behavioral Couples Treatment for Substance Use Disorder: Secondary effects on the reduction of risk for Child abuse. *Journal of Substance Abuse Treatment*, *62*, 10–19. https://doi.org/10.1016/j.jsat.2015.11.008

Lander, L., Howsare, J., & Byrne, M. (2013). The Impact of Substance use Disorders on families and Children: From Theory to practice. *Social Work in Public Health*, *28*(3–4), 194–205. https://doi.org/10.1080/19371918.2013.759005

Legler, R., Chiaramonte, D., Patterson, M., Allis, A., Runion, H., & Jason, L. (2012, December 27). *The effects of children on the process of recovery in Oxford Houses*. *Journal of Groups in Addiction& Recovery*, 7, 281-293 https://pmc.ncbi.nlm.nih.gov/articles/PMC3716387/

McCabe, S. E., McCabe, V. V., & Schepis, T. S. (2025). US children living with a parent with substance use disorder. *JAMA Pediatrics*. https://doi.org/10.1001/jamapediatrics.2025.0828

National Center for Juvenile Justice. (n.d.). *Living arrangements of children, 1970-2023*. https:/www.ojjdp.gov/ojstatbb//population/qa01201.asp?qaDate=2023&text=yes&print=yes&maplink=link2

Slesnick, N., & Erdem, G. (2012). Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomized Pilot. *Behavioral Medicine*, *38*(2), 36–48. https://doi.org/10.1080/08964289.2012.657724

Social-economic conditions. (2025). Washington State Office of Financial Management. https://ofm.wa.gov/data-research/washington-trends/social-economic-conditions/#section-one-parent-and-two-parent-families

Smith, B. T., Davidov, D. D., Gannon, M., Groth, C. P., & Kristjansson, A. L. (2025). Parenting through the eyes of mothers with substance use disorder: Implications for treatment and related services. *Drug and Alcohol Dependence*, *274*, 112782. https://doi.org/10.1016/j.drugalcdep.2025.112782

Substance Abuse and Mental Health Services Administration. (2025). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

Tach, L., Morrissey, M. B., Day, E., Vescia, F., & Mihalec-Adkins, B. (2022). Experiences of Trauma-Informed care in a family drug treatment court. *Social Service Review*, *96*(3), 465–506. https://doi.org/10.1086/721234

Washington State Department of Children, Youth, and Families. (2024). 2025 Annual Progress and Services Report (APSR). https://dcyf.wa.gov

Wfmh. (2025, August 12). *Washington Drug and Alcohol statistics*. World Forum for Mental Health. https://www.wfmh.org/stats/washington-drug-alcohol-statistics#:~:text=separately%20for%20clarity.-,Illicit%20Drug%20Use%20(2021%E2%80%932022),among%20women):%208%25.

Appendix A

Survey Form

This survey aims to understand community needs, perceptions, and priorities related to developing recovery housing for two-parent families in recovery from substance use disorders. Responses will help shape services that strengthen families and support children's stability and well-being.
Your participation is completely voluntary. Your participation is completely voluntary. Your responses will be kept anonymous and confidential and will only be used for the purposes of this research paper. By clicking the link and submitting the survey, you are providing your consent to participate.
The survey will take approximately 5-10 minutes to complete and includes questions about your views on the issue, existing services, and community priorities.
If you have any questions, please contact me at davisil@uw.edu
Thank you for your valuable time and contribution.
Sincerely,
Illyana Davis, UW Tacoma MSW Graduate Student
Faculty Instructor: Anindita Bhattacharya, MSW, PhD; Email: ab4050@uw.edu

Survey Questions:

1.What best describes you (select all that apply)

- Parent/caregiver
- person with lived experience of substance use recovery
- Behavioral health or medical professional
- community member or neighbor

2. If you are a person with lived experience, were you a parent at the time of seeking recovery?

- Yes
- No
- Not applicable

3.What county are you located in?

4. In your opinion, how much need is there in our community for family (two parent) recovery housing? (1= no need, 5 = very high need)

5. What challenges do families face when both parents are in recovery? (select all that apply)

- Stable housing
- Employment
- Childcare
- Transportation
- Parenting stress
- Lack of community support
- Reconnecting with children or CPS involvement

- Food security
- Other:

6. What would make a recovery home feel safe and supportive for families?

7. What barriers might prevent families from entering or staying in recovery housing? (select all that apply)

- cost or lack of funding
- limited availability for families
- fear of stigma or judgment
- losing custody of children
- strict or unrealistic program rules
- safety or privacy concerns
- other

8.What recovery or family support resources already exist in your area?

9. What's missing that would help families in recovery thrive?

10. Who or what organizations should be involved in supporting family recovery housing?

11. How could the community as a whole benefit from family recovery housing?

12. Is there anything else you would like to share about supporting families in recovery?

13. Are you willing to be contacted for a further conversation about your thoughts? please write your email, or phone number here. I will be the only person to have this information.

Redacted: Appendix B through J