



Illinois Alcohol and Other Drug Abuse (AODA) Waiver Demonstration: Final Evaluation Report

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Prepared for:
The State of Illinois
Illinois Department of Children and Family Services
Bryan Samuels, Director

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CHILDREN AND FAMILY RESEARCH CENTER

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EXECUTIVE SUMMARY

This final report is submitted by the Illinois Department of Children and Family Services as required by the Terms and Conditions of its child welfare demonstration project with the Children's Bureau of the Administration for Children and Families. The report covers the period April 2000 to June 2005. The format for this report follows the requirements for child welfare demonstration projects in the ACF draft Program Instruction issued February 2001 (Log No. ACYF-CB-PI-2001)

Background: Alcohol and other drug abuse are major problems for the children and families involved with public child welfare. Substance abuse compromises appropriate parenting practices and increases the risk of child maltreatment. It is estimated that one-half of children taken into foster care in Illinois are removed from families with serious drug problems. Because untreated substance abuse delays reunification, children removed from such families tend to remain in care for a long time. As a result of this delay, as many as 70 percent of children in foster care on any given day are from families in which alcohol and other drug abuse presents significant barriers to rehabilitation and permanence.

IV-E Waiver: In 1999, the Illinois Department of Children and Family Services applied for a Title IV-E waiver to improve reunification and other family permanency and safety outcomes for foster children from drug-involved families. To achieve this purpose, Illinois has received waiver authority to redirect IV-E dollars to fund Recovery Coaches to assist birth parents with obtaining needed AODA treatment services and in negotiating departmental and judicial requirements associated with drug recovery and concurrent permanency planning. USDHHS approved the State's application in September of 1999 and the demonstration was implemented in April of 2000. The Children and Family Research Center at the University of Illinois at Urbana-Champaign is the independent evaluator of the demonstration. This is the second of three waivers (subsidized guardianship, AODA, and training) that have been granted to the State of Illinois by ACF since May of 1997.

Target Population: Eligible families for the demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. To qualify for the project, parents in substance involved families are referred to the Juvenile Court Assessment Program (JCAP) at the time of their Temporary Custody hearing or at any time within 90 days of the hearing. JCAP staff conduct AODA assessments and refer families for treatment.

Evaluation Design: An experimental design is the best way to determine causal connections between interventions and outcomes. Prior to JCAP assessment, potential participants have been referred to child welfare agencies that were randomly assigned to either the demonstration or cost neutrality (control) group. The parents that are assigned to agencies serving only the control group receive substance abuse services that were available prior to the demonstration waiver (it is not a "no-treatment" control group). The parents that are assigned to agencies serving the demonstration group receive the regular

services plus the services of a Recovery Coach. The Recovery Coach works with the parent, child welfare caseworker, and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and provide ongoing support to the parent and family through the duration of the child welfare case. Thus, the evaluation studies the effects of the availability of Recovery Coach services relative to the substance abuse service options that would have been available in the absence of the waiver. The evaluation is designed to test the hypothesis that the provision of Recovery Coach services positively affects the drug-recovery process and key child welfare outcomes. This final report addresses the following evaluation questions:

Questions Related to Substance Abuse Services

- Are parents in the demonstration group more likely to access AODA treatment services compared with parents in the control group?
- What percent of caregivers are completing substance abuse treatment? Does the progress achieved in substance abuse treatment increase the likelihood of achieving family reunification?
- What factors help explain the likelihood of completing AODA treatment services?

Questions Related to Safety

- Are families in the demonstration group less likely to experience subsequent reports of maltreatment?
- Are families in the demonstration group less likely to experience a subsequent SEI?

Questions Related to Visitation and Permanence

- Are children in the demonstration group more likely to achieve family reunification and/or permanence compared with families in the control group?
- When reunification does occur, are children in the demonstration group likely to be reunified in a shorter period of time?
- Are families in the demonstration group more likely to visit (unsupervised and supervised) their children in foster care?

Additional Questions Related to the Recovery Coach Model and Reunification

- Does the turnover of recovery coaches impact key AODA and child welfare outcomes?
- Are AODA families experiencing problems in addition to substance abuse?
- Are multiple problem families less likely to achieve reunification?
- Is more better? Is the amount or type of services provided by recovery coaches related to the completion of AODA treatment and/or family reunification?

Question Related to Cost Neutrality

- Is the waiver demonstration cost neutral?

Sources of Data: The evaluation of the demonstration project utilizes multiple sources of data and multiple methods of data collection. Data pertaining to placement, permanency, and child safety come from the Department of Children and Family Services' integrated database. Substance abuse assessment data come from the Juvenile Court Assessment Program (JCAP). Subsequent to the temporary custody hearing, JCAP staff complete the AOD assessment and make initial treatment referrals. In addition to a wide variety of demographic information (e.g., employment status, living situation, public aid recipient), these assessment data include substance abuse histories and indications of prior substance exposed infants. Substance abuse treatment data come from the Treatment Record and Continuing Care System (TRACCS). This system is managed by Caritas and includes surveys completed by child welfare workers, recovery coaches, and treatment providers. Additional services data come from the Department's Automated Reporting and Tracking System (DARTS). This system is managed by the Division of Alcoholism and Substance Abuse (DASA) and includes service dates and levels of care. Our final source of data comes from interviews with caseworkers and the review of case records. These data supplement the administrative analyses and provide additional insights into the treatment process. For the vast majority of the final report the data run through June 30, 2005. In a few instances, the data run through December 31, 2004.

Implementation and Services: Between April 2000 and June 30, 2004, 366 parents (representing 569 children) were assigned to the control group and 943 parents (representing 1,367 children) were assigned to the experimental group. The Recovery Coach services offered to the demonstration group clients are provided by Treatment Alternatives for Safe Communities (TASC). Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. The primary goal for the Recovery Coach is to actively address the substance abuse problems of caregivers. We hypothesize that by addressing the substance abuse problem in a timely manner, immediately connecting families with substance abuse treatment providers and helping to re-engage families as necessary will help parents achieve family reunification more quickly – as compared with families in the control group.

Summary of Findings:

Questions Related to Substance Abuse Services

- Are parents in the demonstration group more likely to access AODA treatment services compared with parents in the control group? No. Although according to DARTS data, it appears that caregivers in the demonstration group were more likely to access substance abuse services (84% vs. 77%) this difference is not statistically significant. However, caregivers in the demonstration group did access substance abuse services more quickly (74 days vs. 108 days) (Pages 2-11 to 2-12). Yet, according to TRACCS data, records indicate that 71% of the demonstration group actively participated in treatment compared to 52% of the control group (Pages 2-13 to 2-15). This difference is statistically significant.

- What percent of caregivers are completing substance abuse treatment? Does the progress achieved in substance abuse treatment increase the likelihood of achieving family reunification? According to TRACCS data, 410 (43%) of the demonstration group completed at least one level of care compared to 83 (23%) caregivers in the control group (Page 2-15). This difference is statistically significant. In addition, 22% of the caregivers in the demonstration group completed all recommended levels of treatment (Page 3-1). This includes: detoxification, outpatient treatment, intensive outpatient treatment, residential/inpatient treatment and recovery homes. Finally, progress within substance abuse treatment increases the likelihood of achieving family reunification Page 3-8 to 3-9).
- What factors help explain the likelihood of completing AODA treatment services? Age, education, employment and the primary drug of choice were some of the factors associated with treatment completion. Caregivers with at least a high school education were more likely to complete treatment. Employed caregivers were more likely to complete treatment relative to unemployed caregivers. Heroin users were the least likely to complete substance abuse treatment. (Pages 3-1 to 3-2)

Questions Related to Safety

- Are families in the demonstration group less likely to experience subsequent reports of maltreatment? The caregivers in the demonstration group are significantly less likely to be associated with a subsequent allegation of maltreatment (25% vs. 30%). (Page 3-12)
- Are families in the demonstration group less likely to experience a subsequent SEI? The female caregivers in the demonstration group are significantly less likely to be associated with a subsequent SEI (substance exposed infant) (14% vs. 20%). On a related note, caregivers that complete substance abuse treatment are significantly less likely to have subsequent SEIs (7.9% vs. 18.8%). (Page 3-13)

Questions Related to Visitation and Permanence

- Are children in the demonstration group more likely to achieve family reunification and/or permanence compared with families in the control group? Yes. Children in the demonstration group are more likely to achieve reunification relative to children in the control group (15.5% vs. 11.6%). This difference is statistically significant. (Page 3-3)
- When reunification does occur, are children in the demonstration group likely to be reunified in a shorter period of time? Yes. On average, children in the demonstration group are reunified in 522 days as compared with 707 days for

children in the control group. This difference is statistically significant. (Page 3-4)

- Are families in the demonstration group more likely to visit (unsupervised and supervised) their children in foster care? No. There are no differences between the demonstration and control groups with regard to the likelihood or frequency of supervised or unsupervised visits. (Pages 2-18 to 2-19)

Additional Questions Related to the Recovery Coach Model and Reunification

- Does the turnover of recovery coaches impact key AODA and child welfare outcomes? Yes. Families associated with more than two recovery coaches are significantly less likely to achieve family reunification. (Page 3-11 to 3-12)
- Are AODA families experiencing problems in addition to substance abuse? Yes. The vast majority of families are dealing with co-occurring problems. Approximately 62% of the families are dealing with at least three problems simultaneously. Such problems include domestic violence (30%), mental health (40%) and problems associated with housing (56%). (Pages 2-20, 3-5 to 3-8)
- Are multiple problem families less likely to achieve reunification? Yes – although it's not the co-occurring problem per se. The analyses indicate that it's not the additional problem itself that decreases the likelihood of reunification but rather the lack of demonstrated progress made within these problem areas. (Pages 3-8 to 3-10)
- Is more better? Is the amount or type of services provided by recovery coaches related to the completion of AODA treatment and/or family reunification? Yes. Families were less likely to achieve reunification and less likely to complete substance abuse treatment when recovery coaches were spending a significant amount of time focusing on client engagement issues. In contrast, when recovery coaches focused more time on case management services, transporting clients to various appointments, having frequent contacts with clients and consulting directly with treatment providers, the likelihood of both reunification and treatment completion increased. (Page 3-12)

Question Related to Cost Neutrality

- Is the waiver demonstration cost neutral? The AODA waiver demonstration saved \$5,615,534.57 as of September 2005. Thus, the waiver remains cost neutral – more precisely – generating savings that the State can then reinvest in other child welfare services.

Summary Conclusions and Recommendations: Substance abuse is a major problem in child welfare. The abuse of alcohol and other drugs increases the risk of child maltreatment. Moreover, substance abuse delays and often obstructs efforts to reunify children and families. The Illinois Department of Children and Family Services applied for a Title IV-E waiver in June 1999 and approval was granted by ACF for a five-year demonstration on September 29, 1999. The purpose of this demonstration project was to improve permanency outcomes for children of parents with substance abuse problems. To achieve this purpose, Recovery Coaches assist parents with obtaining AODA treatment services and negotiating departmental and judicial requirements associated with drug recovery and permanency planning. This report serves as the final evaluation of the Illinois AODA Waiver Demonstration.

Overall, the Illinois AODA waiver was successful and the findings to date are encouraging. Caregivers in the demonstration group (those receiving recovery coach services) accessed substance abuse services more quickly, were more likely to achieve family reunification and were less likely to be associated with a subsequent report of maltreatment as compared with caregivers in the control group. Yet, one might still consider the likelihood of achieving reunification low (11.6% for the control group and 15.5% for the demonstration group). Beyond simply comparing the outcomes associated with the control and demonstration group it appears that at least two issues are limiting or obstructing the reunification process (1) co-occurring problems and (2) lack of progress within problem areas. The majority (62%) of families are dealing with at least three major problems simultaneously. Such problems include domestic violence, mental health and problems associated with housing. Moreover and perhaps of greater concern is the lack of progress being made within each problem area – including substance abuse. As rated by child welfare caseworkers only 42% of caregivers are making “substantial” or “complete” progress in substance abuse. The estimates for progress are even lower for domestic violence (24%), housing (23%) and mental health (23%). The multivariate models indicate that this lack of progress within co-occurring problem areas is significantly decreasing the likelihood of achieving family reunification. Thus, even if AODA interventions resolve or sufficiently address addiction issues, it appears family reunification will remain unlikely unless other co-occurring problems are addressed. It seems that savings generated from AODA waiver (approximately \$5.6 million) might be most effective and efficiently targeted for services that address the co-occurring problems that interfere with critical substance abuse and child welfare outcomes.

Chapter 1 INTRODUCTION

Review of Literature and Overview of the Demonstration

The effective collaboration of multiple service systems to deal with the problems of parental alcohol and other drug abuse (AODA) continues to challenge governmental efforts to ensure family permanence and the safety and well being of neglected and abused children. Research documents the heavy toll that parental drug addiction exacts on families and children who come to the attention of state child protection authorities. According to Young, Gardiner, and Dennis (1998), at least 50 percent of the nearly one million children indicated for child abuse and neglect in 1995 had caregivers who abused alcohol or other drugs. A 1994 report issued by the U.S. Government Accounting Office (GAO) estimated that the percentage of foster home placements due in part to parental drug use rose from 52% to 78% between 1986 and 1991 in the cities of Los Angeles, New York, and Philadelphia (U.S. Government Accounting Office, 1994). A 1998 GAO study of child protection systems in Los Angeles, California and Cook County, Illinois documented that substance use was a problem in over 70 percent of active foster care cases (U.S. Government Accounting Office, 1998). If child welfare systems are to achieve desirable permanency and safety outcomes, the development of innovative service strategies and agency partnerships are necessary.

Parental substance abuse often compromises appropriate parenting practices, creates problems in the parent-child relationship, and significantly increases the risk of child maltreatment (Famularo, Kincherff & Fenton, 1992; Jaudes, Ekwo & Van Voorhis, 1995; Kelleher, Chaffin, Hollenberg & Fisher, 1994). Once involved in the child welfare system, substance abusing parents are more likely to experience subsequent allegations of maltreatment as compared with nonsubstance abusing parents in the child welfare system (Smith & Testa, 2002). In addition to the increased risk of maltreatment, access to and engagement with treatment providers is often limited (Maluccio & Ainsworth, 2003). Consequently, children of substance-abusing parents remain in substitute care for significantly longer periods of time, and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system (U.S. Government Accounting Office, 1998).

Access and Engagement: Access to substance abuse treatment is limited for substance abusing parents. Overall, in the United States, approximately one-third of all individuals who need treatment receive it (SAMSHA, 1997). The supply of treatment services for women with children is especially inadequate (Price, 1997). Problems of child care are known to limit access to treatment for women. Women with children often do not participate in outpatient substance abuse treatment because they are unable to obtain child care (Marsh & Miller, 1985; Blume, 1990). And, parents, more than non-parents, remain in residential treatment for shorter periods of time (Gerstein, Johnson & Larson, 1997). Lack of adequate transportation is also known to be a significant barrier to treatment

access for both women and men (Marsh & Miller, 1985; Marsh, D'Aunno & Smith, 2000). Once enrolled in treatment, many clients – especially parents involved in the child welfare system – fail to complete it (Gregoire & Schultz, 2001). For these reasons, substance abusing parents in the child welfare system require significant outreach and support throughout the treatment process.

The impact of substance abuse treatment on parents, especially parents involved in the child welfare system, has received limited attention. Although it's known that substance abuse treatment is effective for clients who remain in treatment for at least three months, only a few studies have examined treatment effectiveness for clients involved in the child welfare system. Marsh, D'Aunno & Smith (2000) used a non-equivalent control group design to examine the impact of enhanced services for substance abusing women with children in the Illinois child welfare system. The study compared clients who received enhanced services with those who received regular substance abuse treatment. The use of linkage services, specifically transportation, child care and outreach, resulted in increased use of social services for child welfare clients; and, the increased use of social services was related to decreased substance use. Smith and Marsh (2002) used the same sample of 148 substance abusing mothers involved in the Illinois child welfare system to examine the impact of matching client-identified needs with services. They found that matched counseling services (domestic violence, family counseling) were associated with reports of reduced substance use while matched social services (housing, job training, legal services) were associated with clients' satisfaction with treatment. These studies indicate the benefits of substance abuse treatment for reducing substance use for women with children involved in the child welfare system. Moreover, these studies begin to identify the specific services and service delivery strategies required to effectively integrate substance abuse treatment into child welfare practice.

Substance Abuse and Reunification: Family reunification remains a primary focus and represents a primary goal for child welfare systems because it respects the primacy of parent-child attachments and the role of the biological family in human connectedness (Maluccio & Ainsworth, 2003). However, this goal has been difficult to achieve for addicted parents in the child welfare system. In a recent study of substance exposed infants in Illinois, Budde and Harden (2003) report that only 14% of substance exposed infants entering care in 1994 were reunified after nearly seven years. If child welfare systems intend to increase reunification for substance abusing families, the development and evaluation of innovative treatment strategies is necessary.

The Need for Service Integration: To confront the problems associated with substance abuse in child welfare, strategies for integrating substance abuse treatment and child welfare services are of increasing interest. Descriptions by Young, Gardner & Dennis (1998) and Maluccio & Ainsworth (2003) point to a number of important elements in service innovations designed to integrate substance abuse and child welfare services. Service linkage mechanisms that connect clients to services from different systems are an important element in integrated models (D'Aunno, 1997). Examples of such mechanisms include *ad hoc* referrals, case management services and co-location of services. Other common mechanism used to integrate child welfare and substance abuse services include

the screening of child welfare clients for substance use, cross-training of child welfare and substance abuse workers and case supervision. (For a review of programs incorporating some or all of these elements see Maluccio & Ainsworth, 2003).

Rationale, Development and Purpose of the Illinois AODA Model

To test a service integration model for the growing numbers of substance-involved families in the Illinois child welfare system, the Illinois Department of Children and Families Services (IDCFS) initiated a Title IV-E AODA Waiver Demonstration Project in April 2000. Title IV-E waivers permit States to by-pass federal regulations related to the financing of foster care services in order to develop and test improved strategies for serving children and families. The AODA demonstration project in Illinois utilizes an existing service relationship between the Department of Alcoholism and Substance Abuse (DASA) and the Illinois Department of Children and Family Services (IDCFS)¹. The purpose of the AODA Waiver Demonstration was to test a model of intensive case management in the form of a recovery coach. The use of a recovery coach was intended to increase the access to substance abuse services, improve substance abuse treatment outcomes, shorten the length of time in substitute care placement, and affect child welfare outcomes including increasing rates of family reunification and decreasing the risk of continued maltreatment.

To achieve these stated goals, recovery coaches engage in a variety of activities including comprehensive clinical assessments, advocacy, service planning, outreach, and case management. The clinical assessments focus on a variety of problem areas such as housing, domestic violence, parenting, mental health, and family support needs. Advocacy refers to assisting parents in obtaining benefits and in meeting the responsibilities and mandates associated with the benefits. The outreach activities ensure that recovery coaches work with substance abusing families in their community and improve communication between the child welfare worker and AODA treatment facilities to ensure a seamless delivery of services. Recovery coaches visit the family home and the AODA treatment provider agencies. Recovery coaches also make joint home visits with the child welfare caseworkers and/or AODA agency staff. At least one recovery coach is always on call during evenings, weekends, and holidays to address emergencies as they may arise. Recovery coaches also have access to outreach/tracker staff that specialize in identifying and engaging hard to reach/locate parents. Finally, recovery coaches engage in information sharing with child welfare and juvenile court personnel. The information sharing is intended to help inform permanency decisions. Recovery coach services are provided for the duration of the case. Such services may also be continued for a period of time subsequent to case closing.

¹ Three other states, Delaware, Maryland, and New Hampshire also have substance abuse waiver demonstrations. For a description of these programs see Cornerstone Consulting Group, Inc., 1999.

Assumptions of the Recovery Coach Model: A relationship should exist between the individual activities that comprise social work interventions and the problem that a particular intervention intends to address. This relationship is based on assumptions about the causes of a particular problem. Disjointed service systems often result in limited access to needed services. The program theory underlying the Illinois AODA Waiver Demonstration is a basic access-linkage model that posits that programmatic outcomes improve when the program elements include (a) careful assessment of client problems, (b) tailored treatment plans so that specific services are matched with or designed to address specific problems and (c) specific linkage mechanisms (e.g. referral, onsite services or intensive case management) that increase access to these services.

Empirical evidence supports the development and implementation of a recovery coach model in child welfare. Evidence shows that clients achieve better outcomes (e.g. stay in treatment longer, complete treatment at higher rates) when assigned to individual counselors (McLellan & McKay, 1998). This is especially true when such counselors are experts in a particular area of need. Rather than refer and connect families with outside experts, an individual counselor, such as a recovery coach, offers a specialized orientation that is essential for working effectively with families (Young, Gardner & Dennis, 1998).

Significant barriers exist between child welfare and substance abuse services systems (Young, Gardner & Dennis, 1998). These barriers certainly exist with regard to service infrastructure (e.g. referral systems, timely access) but also with regard to fundamental beliefs about clients. For example, each service system must address the question, “Is the client the child or the family?” In the current system, child welfare agencies tend to focus on the children as the primary client and the AODA agencies tend to focus on the parent as the primary client. The recovery coach model in Illinois attempts to resolve and address competing agendas by ensuring independence. The recovery coaches in Illinois are not employees of child welfare or AODA treatment agencies. This independence helps ensure that recovery coaches’ primary concern will be the families they serve. The recovery coaches are employed by a non-affiliated social service agency (Treatment Alternatives for Safe Communities). The recovery coaches are required to participate in a variety of DCFS and DASA trainings that cover a variety of topics including addiction, relapse prevention, DSM IV, ASAM, fundamentals of assessment, ethics, service hours, client tracking systems, service planning, case management and counseling.

The Illinois Department of Children and Family Services’ application for a Title IV-E waiver project was submitted in June 1999 and approval was granted by ACF for a five-year demonstration on September 29, 1999. This was the second of three waivers (Subsidized Guardianship, AODA, Training) granted to Illinois by ACF. Project implementation began on April 28, 2000. The proposal as approved by ACF seeks to improve child welfare outcomes by providing enhanced alcohol and other drug abuse (AODA) treatment services to substance affected families served in the Illinois child welfare system.

Eligible families for the demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. Of those eligible, cases are then randomly assigned to the project. To qualify for the project, parents in substance affected families are referred to the Juvenile Court Assessment Project (JCAP) at the time of their Temporary Custody hearing or at any time within 90 days of the hearing. JCAP staff conduct AODA assessments and refer families for treatment, if indicated. The parents that are randomly assigned to the control group receive traditional child welfare services. The parents that are randomly assigned to the demonstration group receive traditional child welfare services plus the services of a Recovery Coach to assist in the follow up procedures regarding the treatment recommendation and referral. The Recovery Coach works with the parent, child welfare caseworker, and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and provide ongoing support to the parent and family through the duration of the child welfare case. We hypothesize that the provision of Recovery Coach services will positively affect key child welfare outcomes (e.g. permanency).

Implementation Status

This final report focuses on the families assigned to the AODA waiver between April 2000 and June 2004; 366 parents of 569 children were assigned to the control group and 943 parents of 1,367 children were assigned to the experimental group.

The AODA demonstration project utilizes the existing OASA/DCFS Initiative services as the foundation for enhanced treatment services. Since the implementation of the AODA waiver, the facilitation of an on-site AODA assessment project provided by Caritas (Juvenile Court Assessment Project, JCAP) serves DCFS involved family members immediately following the temporary custody hearing at Juvenile Court. Judges, attorneys, and child welfare workers may refer parents for an assessment and caseworkers escort the parent to JCAP for an assessment and same day treatment referral. Court personnel and caseworkers receive feedback regarding the results of the assessment within one day of the referral. A more in-depth narrative report is submitted to the courtroom prior to the next court date.

The Recovery Coach services offered to the demonstration group are provided by Treatment Alternatives for Safe Communities, (TASC). Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. These services, outlined below, continue to be refined.

The primary goal for the Recovery Coach AODA enhancement is to actively address the substance abuse problems of caregivers. Addressing these problems will help parents move towards reunification as safely and quickly as possible. A secondary goal is to facilitate information sharing between child welfare, AODA providers and court systems so that permanency decisions are based on accurate and timely information.

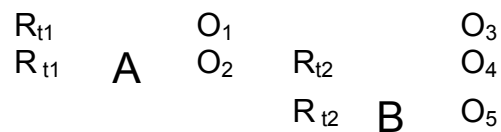
Cases are referred to the Recovery Coaches after the parent has met eligibility requirements for the project and the Juvenile Court Assessment Program (JCAP) has completed the AODA assessment. Recovery Coaches meet with the parent, JCAP assessor, and child welfare worker at the conclusion of the assessment to discuss the referral arrangements and initial service planning. An on-call Recovery Coach is stationed each day at the JCAP office in Juvenile Court to expedite initial engagement with parents.

Random assignment of agencies and offices successfully created statistically equivalent groups at the parent and child levels.

METHODOLOGY

Design

Eligibility: Eligible families for the demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. Of all those eligible, cases are then randomly assigned to the project. Random assignment occurs at the agency level. The design is as follows:



where R_{t1} represents agencies that have been randomly assigned at time 1 to either the control or experimental group; **A** represents the intervention of the “recovery coach”; O_1 is the first measurement of the control group; O_2 is the first measurement of the experimental group (a posttest because it occurs after the intervention); R_{t2} represents the experimental agencies that have been randomly assigned at time 2 to either Demo A or Demo B groups; **B** represents the additional intervention of enhanced services (which is currently being conceptualized); O_3 represents the second measurement of the control group; O_4 represents the second measurement of Demo A group; and O_5 represents the first measurement of Demo B group. The sampling plan had two components: Child welfare agencies and DCFS offices were stratified by program size and geographical/language service area and randomly assigned to control and demonstration groups within strata. The demonstration groups within strata were randomly split into two groups. At the start of phase two, a “flip of the coin” will determine which of the two demonstration groups becomes Demo B. The random assignment has produced statistically equivalent groups.

Parents are assigned to child welfare agencies and DCFS offices according to the existing random assignment procedures used by the Department’s Case Assignment Placement Unit (CAPU). The agency/office designation determines to which experimental condition the family case is assigned.

Research Questions

A primary focus of the AODA waiver was to improve permanency outcomes for children. The evaluation of this waiver does address and focus on permanency outcomes. However, a variety of other questions in a variety of other domains are addressed as well. The specific questions follow:

Questions Related to Substance Abuse Services

- Are parents in the demonstration group more likely to access AODA treatment services compared with parents in the control group?
- What percent of caregivers are completing substance abuse treatment? Does the completion of substance abuse treatment increase the likelihood of achieving family reunification?
- What factors help explain the likelihood of completing AODA treatment services?

Questions Related to Safety

- Are families in the demonstration group less likely to experience subsequent reports of maltreatment?
- Are families in the demonstration group less likely to experience a subsequent SEI?

Questions Related to Visitation and Permanence

- Are children in the demonstration group more likely to achieve family reunification and/or permanence compared with families in the control group?
- Are families in the demonstration group more likely to visit (unsupervised and supervised) their children in foster care?

Additional Questions Related to the Recovery Coach Model and Reunification

- Does the turnover of recovery coaches impact key AODA and child welfare outcomes?
- Are AODA families experiencing problems in addition to substance abuse?
- Are multiple problem families less likely to achieve reunification?
- Is more better? Is the amount or type of services provided by recovery coaches related to the completion of AODA treatment and/or family reunification?

Question Related to Cost Neutrality

- Is the waiver demonstration cost neutral?

Sources of Referral and Data Collection Procedures

Juvenile Court Assessment Project: The Juvenile Court Assessment Project (JCAP) provides alcohol and drug assessments for adults 18 years and older. JCAP is located on site at the Juvenile Court Building in order to provide convenience and easy accessibility for parents who have lost custody of their children and who are in need of an assessment to determine if a referral to drug treatment is appropriate and necessary. The availability of assessments being conducted at the Juvenile Court building remains beneficial to DCFS involved clients as the number of assessments being conducted each year remain steady at approximately 1,000 per year. Of these 1,000 referrals approximately 61% resulted in referrals to treatment providers indicating that treatment was necessary. Of the clients indicated for treatment, approximately 50% were eligible for the IV-E AODA project because they met the following eligibility requirements: (1) Cook County Illinois Case, (2) Temporary Custody of their child(ren) had been granted to DCFS and (3) Parents were assessed at JCAP within 90 days of the Temporary Custody Hearing

JCAP Assessments are available to all parents that have lost custody of their children. The chart below designates the total number of JCAP assessments given treatment referrals, along with the number of those referrals that met eligibility requirements for the AODA Waiver. Approximately 50 percent of all assessments needing treatment referrals are eligible for the Waiver. The remaining 50% usually do not meet the eligibility requirement of having the assessment conducted within 90 days of the temporary custody hearing. Even though these clients are ineligible for the IV-E Waiver Project and Recovery Coach services, they do benefit from the on-site accessibility of an AODA assessment and a same day intake appointment being arranged for them.

The JCAP assessors conduct a thorough screen and assessment in an attempt to determine if the client is appropriate for a treatment recommendation and referral. It remains consistent that approximately 34% of all assessments conducted at JCAP do not result in a treatment referral based on self-report. Often due to the inaccuracy of a client's self-report, the client does not meet ASAM criteria and therefore a treatment recommendation is not indicated at the time of the assessment. Juvenile court judges also refer clients to JCAP to rule out any possibility of a drug or alcohol problem existing within the family system. A juvenile court judge may also issue a court order for the client to participate in a urinalysis screening. The results of the urinalysis screen take several days to reach the court, caseworker and client. If the results are positive, the caseworker makes every attempt to bring the client back to JCAP for another assessment.

Repeat Assessments:

As of December 31, 2004, JCAP data indicates that of the 1,651 clients that did not qualify initially for a treatment referral, 154 clients (9%) returned to JCAP for another assessment. Of those 154 clients returning to JCAP for another assessment, 108 (70%) met the criteria for a treatment referral. Of these 108 clients, 103 (95%) met criteria at their second assessment and 5 clients (5%) met criteria at their third assessment.

JCAP records indicate that of the 154 people returning to JCAP for another assessment, 43% came at the request of Juvenile Court judges. Positive urinalysis results conducted by the caseworker or ordered by the judge comprise another 21% of the repeat assessments. Caseworkers accompanying clients back to JCAP accounted for an additional 10% of people returning for another assessment. At the time of this analysis, the reason for the repeat assessment was unknown for 15% of the clients returning. JCAP is currently recording the reason for all clients returning for a repeat assessment.

The largest group of JCAP referrals (approximately 35%) originates from the temporary custody hearing. The court family conference takes place 55 days following the temporary custody hearing. Parents are often encouraged by court personnel or caseworkers to complete an AODA assessment following the conference. If a parent does not comply at the time of the court family conference, the judge will usually insist on an AODA assessment to be completed following the status hearing. JCAP assessors complete the assessment and send results to the courtroom prior to the next court date. A successful treatment referral takes place when an intake appointment has been made within 48 hours of the JCAP assessment. Approximately 70% of all referrals met this time requirement.

Data and Data Collection: The collection of data was designed to track the clients throughout the treatment process – this includes the initial drug abuse assessment at JCAP (Juvenile Court Assessment Project) through the completion or termination from substance abuse treatment programs. The evaluation of the Illinois AODA waiver utilized multiple sources of data with respect to clients who have signed consents for the examination of information of records other than DCFS (e.g. payment records for the provision of substance abuse services in Illinois) including JCAP, individual recovery coaches, TASC (Treatment Alternatives for Safe Families), IDCFS MARS/CYCIS databases (e.g. placement records, allegations of maltreatment), and DASA (Department of Alcoholism and Substance Abuse) The two primary sources of data are the TRACCS forms and the AODA integrated database, explained below.

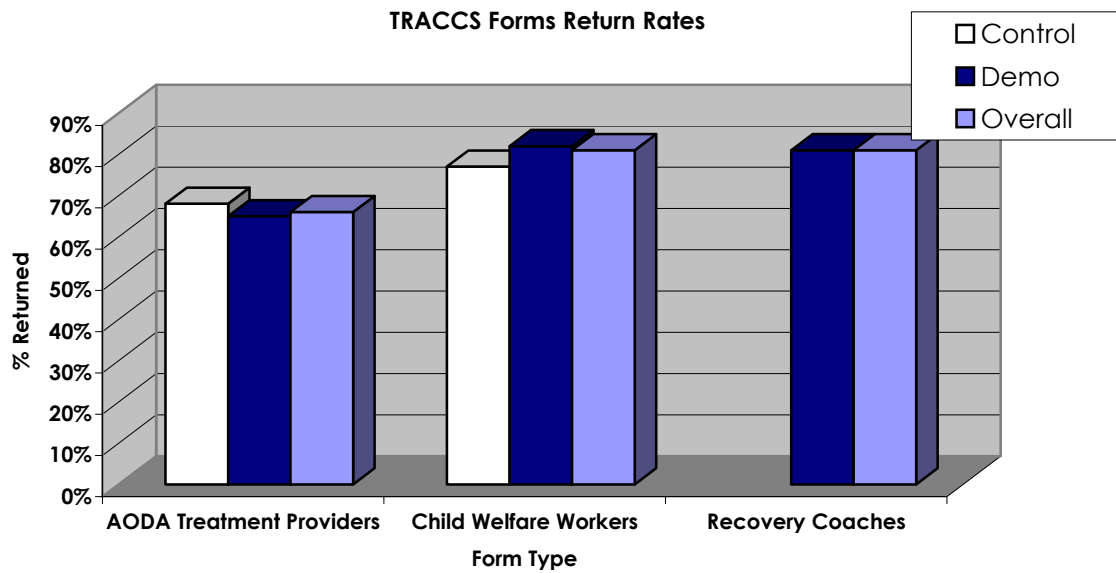
Service Collection Tool - TRACCS Forms:

The service collection tool is integrated into a system called Treatment Record and Continuing Care System (TRACCS). The chart below indicates the expected number of forms and the percentage of forms returned from the AODA treatment provider, the Child Welfare Worker and the Recovery Coach as of December 31, 2004.

TRACCS forms are sent quarterly to the child welfare workers for data collection purposes. Training on these forms began in January 2002, and the first forms were sent to the agencies in February 2002. As of December 31, 2004, an overall 81% of the TRACCS forms have been completed and returned by the Child Welfare Workers.

The Recovery Coaches have also been completing TRACCS forms on a monthly basis since the implementation of the project. As of December 31, 2004, an overall 81% of the TRACCS forms were returned. Previously, most of the outstanding forms were cases

that are no longer being served by Recovery Coaches. A reporting system has been developed between the Recovery Coach administrator and the TRACCS coordinator regarding changes in case status to rectify outstanding forms. In addition, another in-service training was conducted to assist Recovery Coaches in completing the TRACCS forms accurately. Recovery Coaches report that it takes approximately one hour to complete each form. Each Recovery Coach completes anywhere from 20 - 30 forms each month. In an effort to increase the compliance rate, this particular TRACCS form was redesigned. Since TASC generates much of this information into an existing TASC database, a system was designed for Recovery Coaches to access the information directly and attach that information to the TRACCS form.



The DASA—DCFS Integrated Database

The goal of this data integration initiative was to create a joint database, which stores child welfare and substance abuse service data taken from the Illinois Department of Children and Family Services (IDCFS) and the Division of Alcoholism and Substance Abuse (DASA). The child welfare data are taken from the DCFS integrated database. This database tracks child abuse and neglect investigations and child welfare service information (e.g., substitute care placement records). The Division of Alcoholism and Substance Abuse provides substance abuse service data. These data are extracted from the DARTS system (Department’s Automated Reporting and Tracking System). The DARTS system records client information and the provision of substance abuse services.

Data Collection Limitations

The issue of informed consent has limited the collection of data with respect to “official” drug treatment records. The DARTS data are only available for clients that sign a letter (grant permissions) of informed consent. As of June 30, 2004, approximately 28% of the Control group and 34% of the Demonstration group clients have signed research consents agreeing to give permission to review other pertinent records. During previous reporting periods, the research committee redesigned the research consent offering the additional option of not signing at the time of the JCAP assessment. It seems that this additional option has not increased the rate of informed consent.

Chapter II PROCESS ANALYSIS

Key Features

IV-E AODA Project Staff Work Group

The IV-E AODA project is a collaboration of concerted efforts by both DCFS personnel and private agency staff contracted to provide direct services to IV-E AODA clients. A work group consisting of members from the Children and Family Research Center, the Division of Service Intervention, and a liaison from the Case Assignment Unit, along with private agency administrators and coordinators, meet monthly to discuss ongoing efforts and continual implementation of the project.

The Department has contracted with Caritas to provide assessments and referrals at the JCAP site. An additional contract exists with Caritas to coordinate the computer-based data collection integrated system called TRACCS (Treatment Record and Continuing Care System). In addition, the Department contracts with TASC (Treatment Alternatives for Safe Communities) to provide the complete array of Recovery Coach services and supervisory staff.

Currently in Illinois, DCFS provides child welfare contracts to private agencies to serve approximately 80% of the families in Cook County who have open cases with the department. (In the IV-E Waiver in Cook County, 90% of the parents are served by private agencies.) The private agency or DCFS team serving the client at the time the parent is assessed at JCAP determines eligibility for the waiver project. In past reporting periods, issues surrounding the delay in assigning cases to the designated research group were discussed as a major barrier to the project. Improved communication between the DCFS case assignment unit and the JCAP assessors has improved the case assignment and coding process. The majority of cases are now assigned within the same day of the JCAP assessment and cases are coded by the end of each week. As a result of timely case assignment, a Recovery Coach liaison meets with the caseworkers and clients on the day of the JCAP assessment to begin the engagement process immediately.

Trainings with Private Agency Personnel

Throughout previous reporting periods, project staff continued conducting individual training sessions with private agency placement teams contracted to serve DCFS involved families. These trainings provided specific information regarding the IV-E AODA project design. In addition to increasing awareness regarding the project and exploring better ways to collaborate, these trainings have also covered proper completion of the data collection tool (TRACCS Form), as well as the process involved in obtaining signed research consents from parents in the study. These trainings have proven to be beneficial in improving awareness regarding the project and increasing the collaborative efforts between the child welfare worker and Recovery Coach. Project staff continues to provide training upon request as staff turnover occurs at the private agencies.

Trainings with DASA/DCFS Initiative Treatment providers

Throughout this reporting period and previous reporting periods, project staff conducted individual training sessions with many of the treatment providers contracted through the DASA/DCFS Initiative. Much like the trainings with the child welfare agencies, these trainings provided specific information regarding the IV-E AODA project design such as: eligibility requirements and random assignment; specific project features; projected goals and outcomes, along with clarifying the roles and responsibilities of child welfare caseworkers, Recovery Coaches and treatment counselors. Specific goals of these trainings have been to focus on outreach efforts, role of the Recovery Coaches, and how best to collaborate with the treatment counselors to provide optimal and seamless delivery of services to the clients.

In addition to increasing awareness regarding the project and exploring better ways to collaborate, these trainings have also covered proper completion of the required data collection tool (TRACCS Form) completed each month by the treatment counselor. Since implementing trainings at each individual provider's site, the compliance rate of TRACCS forms being completed on time and correctly has greatly improved from 54% completion to 60% completion as of December 31, 2004.

Training for Recovery Coach Staff

TASC's Recovery Coaches have participated in the following professional development seminars during this reporting period:

- Criminal Thinking
- Drug Recognition
- TASC Clinical Policy and Procedures Update
- Understanding Gay, Lesbian, Transgender and Transsexual Identities
- Domestic Violence and Culture
- Clinician Self Care

Recovery Coaches new to the staff participate in staff orientation and clinical series training for two weeks: topics include understanding addiction, relapse prevention, DSM IV, ASAM, fundamentals of assessment, ethics, service hours, client tracking system, service planning, and case management and counseling skills.

Role of the Courts

The Juvenile Court of Cook County is the site for the legal proceedings involving the parents and children in the Waiver. The court determines if temporary custody is warranted and if reasonable efforts to prevent placement have been made. The adjudication hearing determines whether abuse and/or neglect findings are supported. Subsequent to this hearing, the court holds a dispositional hearing which determines whether, for example, the child should be returned home, or should be made a ward of the court and placed in the guardianship of the Department of Children and Family Services. The court also holds permanency hearings, the first one occurring at least one year after the date of temporary custody. In the permanency hearing, the court sets the

permanency goal for the case – such as return home, adoption, termination of parental rights, and the like. Throughout this process the court monitors the progress of the parents and the safety and well being of the children.

Although the recovery coach may present reports to the court regarding treatment progress, the waiver demonstration staff do not have any direct input into the legal process. Waiver demonstration staff are however in contact with the General Counsel of DCFS regarding any court issues which may arise.

Service Delivery

The AODA demonstration project utilizes the existing DASA/DCFS Initiative treatment services as the foundation for enhanced services. Since the implementation of the AODA waiver, the facilitation of an on-site AODA assessment project provided by Caritas (Juvenile Court Assessment Project, JCAP) serves DCFS involved family members immediately following the temporary custody hearing at Juvenile Court. Judges, attorneys, and child welfare workers may refer parents for an assessment and same day treatment referral. Court personnel and caseworkers receive feedback regarding the results of the assessment within one day of the referral. A more in depth narrative report is submitted to the court prior to the next court date.

The Recovery Coach services offered to the demonstration group clients are provided by Treatment Alternatives for Safe Communities (TASC). Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. These services outlined below continue to be refined.

The primary goals for the Recovery Coach AODA enhancement is to actively assist parents of substance affected families to address their AODA problems along with helping parents move towards reunification as safely and quickly as possible. A secondary goal is to facilitate information sharing between child welfare, AODA providers and court systems so that permanency decisions are based on accurate and timely information.

Cases are randomly assigned to the Demonstration group and are referred to the Recovery Coaches after the parent has met eligibility requirements for the project and the Juvenile Court Assessment Program (JCAP) has completed the AODA assessment. A Recovery Coach intake liaison meets with the parent, JCAP assessor, and child welfare worker at the conclusion of the assessment to discuss the referral arrangements and initial service planning. The Recovery Coach liaison is stationed each day at the JCAP office in Juvenile Court to expedite initial engagement with parents and workers.

Clinical Assessment

Recovery Coaches ensure that a comprehensive range of assessments in addition to the AODA assessment is completed, either through the child welfare caseworker or as designated by the Recovery Coach. Depending on the needs of the parent, these

assessments can evaluate need for mental health, parenting, housing, domestic violence, and family support services.

Benefits Identification and Advocacy

Recovery Coaches work with the parent to identify any entitlement or other program resources that the family may be eligible to receive. Recovery Coaches assist the parent in obtaining benefits and in meeting the responsibilities and mandates associated with the benefits.

Service Planning

Recovery Coaches work with parents to prioritize issues identified in the clinical, benefits, and other assessments. The parent and the Recovery Coach mutually develop a plan with goals and tasks that will meet the requirements and demands of the multiple agencies and systems involved with the family. Recovery Coaches help ensure that the DCFS service plan, the AODA agency's treatment plan and other requirements are coordinated. A significant component of the service planning and case management efforts undertaken by Recovery Coaches relates to assisting families to respond to and coordinate the numerous service providers involved in their lives.

Outreach

Recovery Coaches work with the substance affected families in their communities making regular home visits and visits to AODA treatment agencies. Joint home visits with the child welfare caseworkers and/or AODA agency staff are also conducted. At least one Recovery Coach is always on call during evenings, weekends, and holidays to address emergencies as they may arise. Recovery Coaches also have access to Outreach/Tracker staff that specializes in identifying and engaging hard to reach parents. Each team of Recovery Coaches is assigned a Tracker.

Case Management

Proactive case management with and on behalf of the parent is a priority of the Recovery Coach. Case management activities are intended to remove any barriers to a parent engaging in AODA treatment, retaining a parent in treatment, and re-engaging parents who may have dropped out of treatment. A Recovery Coach is assigned to a parent throughout and beyond the treatment process to help ensure a parent is actively engaged in aftercare services in their community and in recovery support activities. Recovery Coach services continue even after children have been returned to a parent's custody. Recovery Coaches stay involved with a family through this potentially stressful time, as it has been identified as a vulnerable time for parents often correlated with relapse.

In addition to working directly with the parent, the Recovery Coach's case management responsibilities include regular contact with the AODA treatment agency and child welfare worker. This includes attending or preparing reports for child and family team meetings, joint and interagency staffings, and administrative case reviews and court appearances.

Drug Testing

Through the DCFS contract with TASC, Recovery Coaches have access to random urine toxicology testing to monitor a parent's compliance with program requirements. Recovery Coaches are able to obtain toxicology samples at their offices or in parent's homes as necessary. Results are often available the next day and can be readily available and communicated to the caseworker and/or the courts

Reporting

Recovery Coaches provide a written report to the child welfare caseworker regarding the parent's progress in AODA treatment and recovery on a monthly basis. This report to the caseworker helps ensure that the necessary information from AODA treatment is provided to the courts and other involved agencies.

Permanency Assessment and Recommendations

In addition to the regular monthly progress reports to the child welfare caseworker, Recovery Coaches also prepare a Permanency Assessment and Recommendation report for the caseworker. This comprehensive report assesses the parent's progress in treatment and recovery as well as other areas identified in the service plan. The report also provides a recommendation to the caseworker regarding the safety of the child if custody is returned to the parent. The caseworker can then incorporate the permanency assessment and recommendation into their report to the court at the permanency hearing.

Implementation of Demonstration Group B Enhancements

As of June 30, 2004, 125 caregivers were assigned to an enhanced demonstration group (referred to as Demo B). This proposed service package was initially developed from best practice knowledge available at the time of the original waiver request and was based on identified gaps in the system of services at that time. An ongoing planning and development process has ensued to determine the best possible combination package of enhanced and expanded services for families in the child welfare system impacted by alcohol and other drugs.

Limited funds at the state level initially delayed implementation of the "Demo B" component of the project. This lack of funds also reduced the scope of Demo B services being planned and the emphasis shifted to attempting to impact the speed at which permanency decisions are made in order to move cases through the judicial system more expeditiously.

To accomplish this, the Recovery Coaches worked with the identified Demo B families and agencies to provide more comprehensive and better information on treatment progress and prognosis for safe and successful reunification. The Recovery Coaches are using a new tool to help measure a parent's progress in treatment and recovery. The "Indicators for Progress in the Substance Abuse Recovery Process" (Progress Matrix), developed by the Department's Inspector General, are being completed quarterly with each Demo B parent and the results shared with the caseworker and the courts. Recovery

Coaches make attempts to meet more frequently with Demo B caseworkers to staff cases and plan for services.

Population and Characteristics

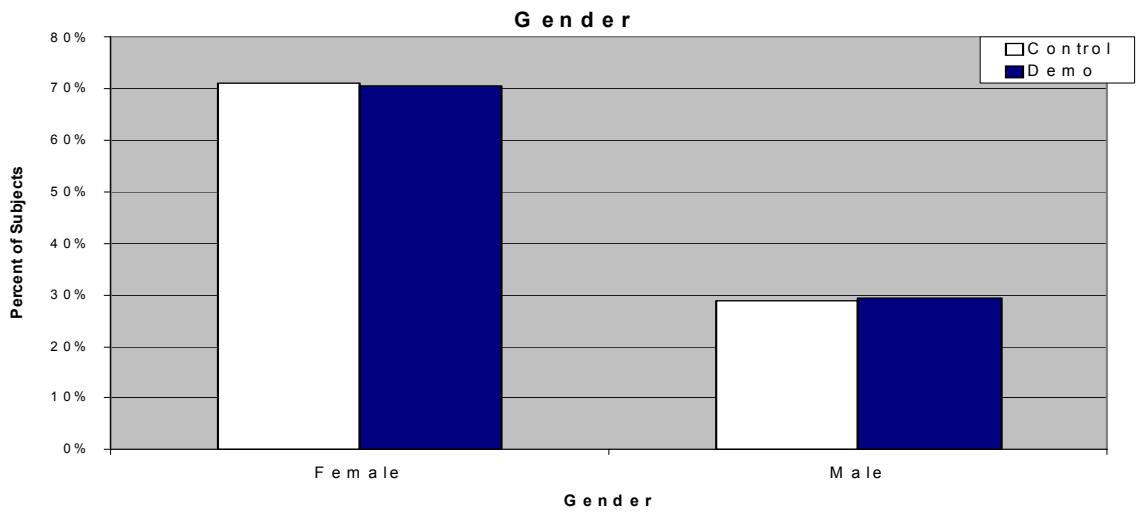
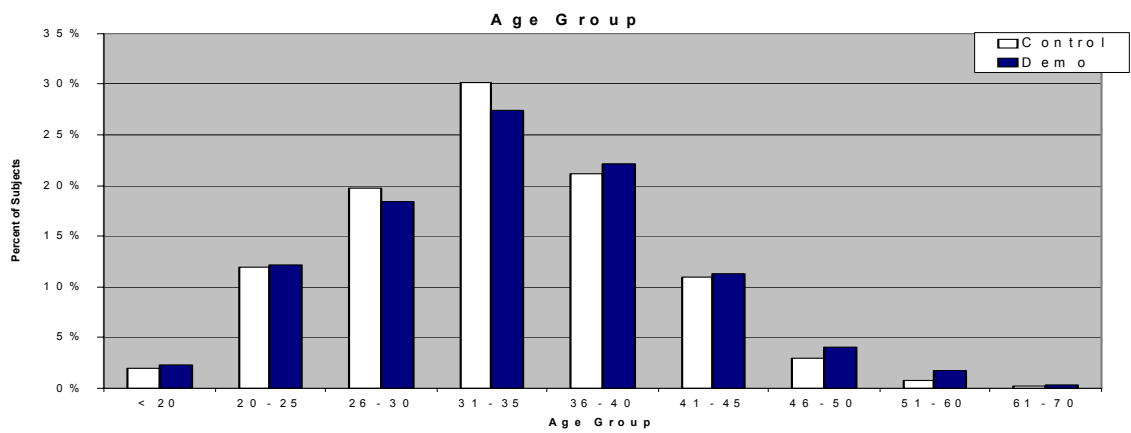
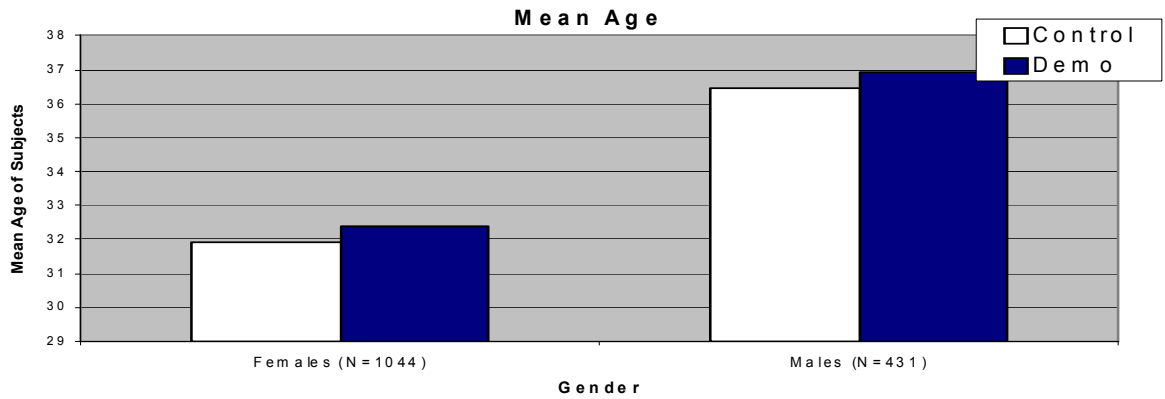
As of June 30, 2004, 1,309 caregivers and 1,936 children were enrolled in the waiver demonstration. These children and families were nested within 87 social service agencies. There are no significant differences between the experimental and control group. Thus, it appears the random assignment created equivalent groups. At the time of the temporary custody hearing when clients were inducted into the project, substance abuse treatment was available to both or only one parent in the household. Twenty-two percent of the families had both parents participating in the project. The average age of the youngest caregiver in the house was approximately 32 years old at the time of referral. Eighty-one percent were African American, 6% were Hispanic and 12% were white. Seventy-eight percent of the caregivers were unemployed, 40% were high school graduates, and 32% were receiving public aid at the time of random assignment. Fifty-six percent of the families reported having no medical insurance, and 21% reported current legal problems. Thirteen percent of the families were comprised of three or more children. Sixty-four percent of the families had at least one prior substance exposed infant before referral to the demonstration waiver. Forty-two percent had more than one prior substance exposed births. This indicates that a substantial proportion of families have experienced substance abuse problems for a significant period of time prior to their involvement with the demonstration project. The following bar charts display demographic characteristics of the control and demonstration groups. There are no differences between the control and demonstration groups. Thus, it appears the random assignment procedures produced equivalent groups.

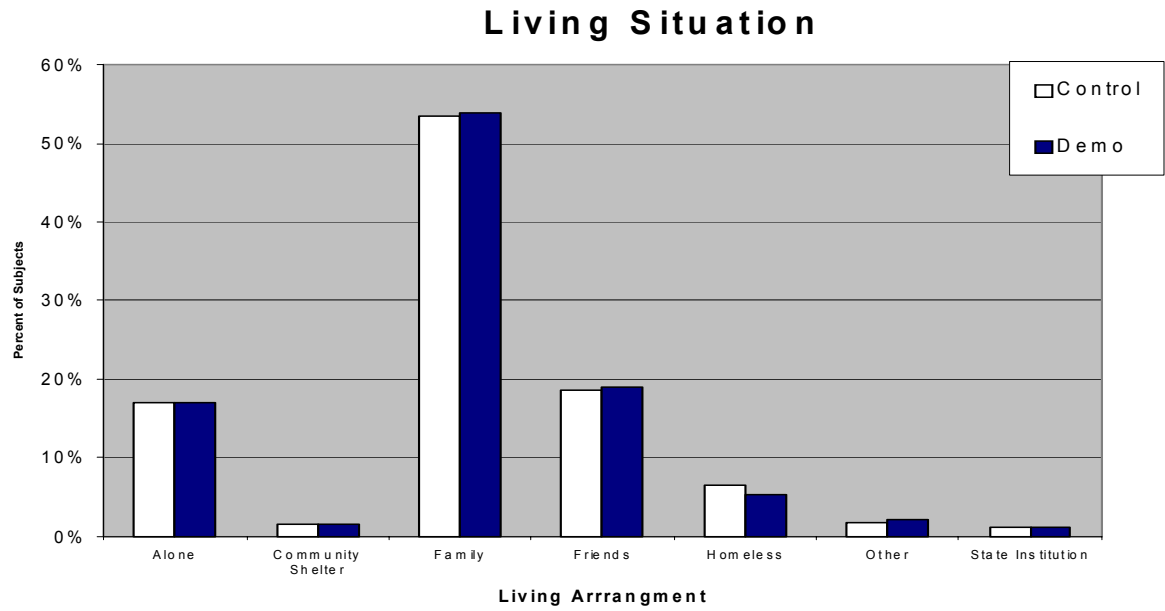
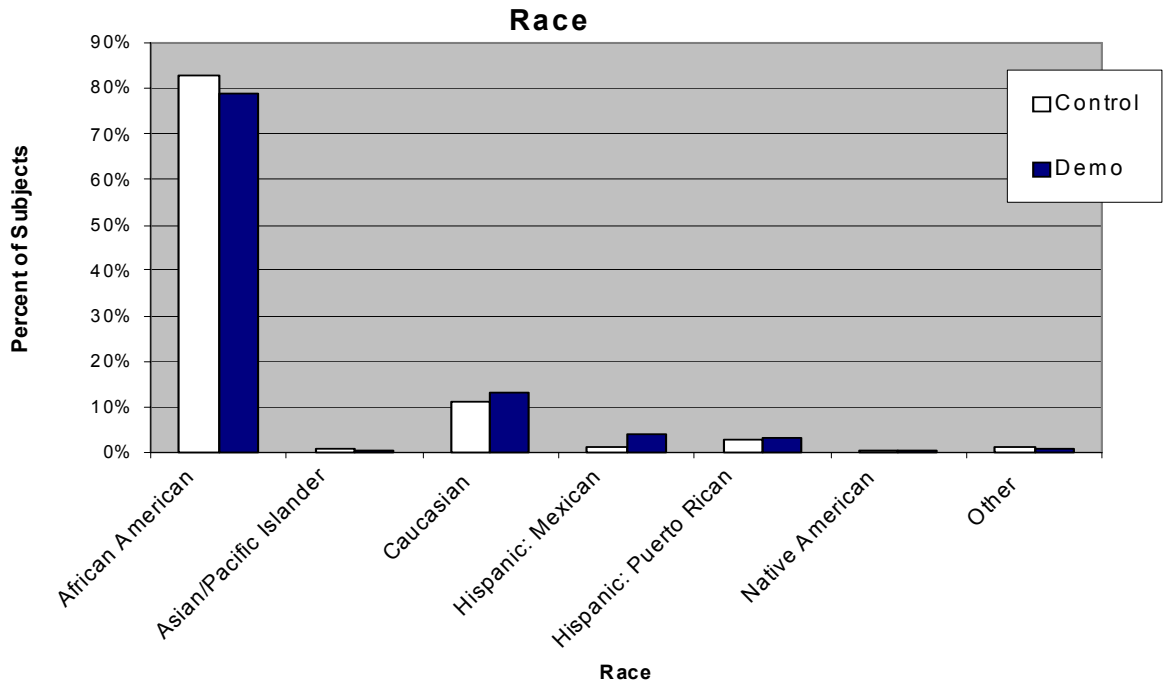
Parent Characteristics	Control & Demo Groups
Both Parents in Project	22%
Age of Youngest Parent	32
African American	81%
White	12%
Hispanic	6%
Unemployed	78%
High School Graduate	40%
Receiving Public Aid	21%
No Medical Insurance	56%
Current Legal Problems	21%
Three or more Children	13%
Previous Substance Exposed Infant	64%
More than One Substance Exposed Infant	42%

At the child level – like the caregiver level – there are no differences between the control and demonstration groups. Of the 1,936 children involved with the AODA demonstration waiver, 53% were male and 47% were female. The average age at the time of the temporary custody hearing was 3.8 years old. As of June 30, 2005 (the cut off for this report) children were, on average, 7.2 years old. Approximately 25% of the children were associated with a substance exposed allegation and approximately 36% were associated with at least one allegation of neglect. With regard to race, 1,554 (80%) of the 1,936 children are African American, 218 (11%) are white and 128 (7%) are Hispanic. Approximately 10% of the 1,936 children experienced at least one prior out-of-home placement.

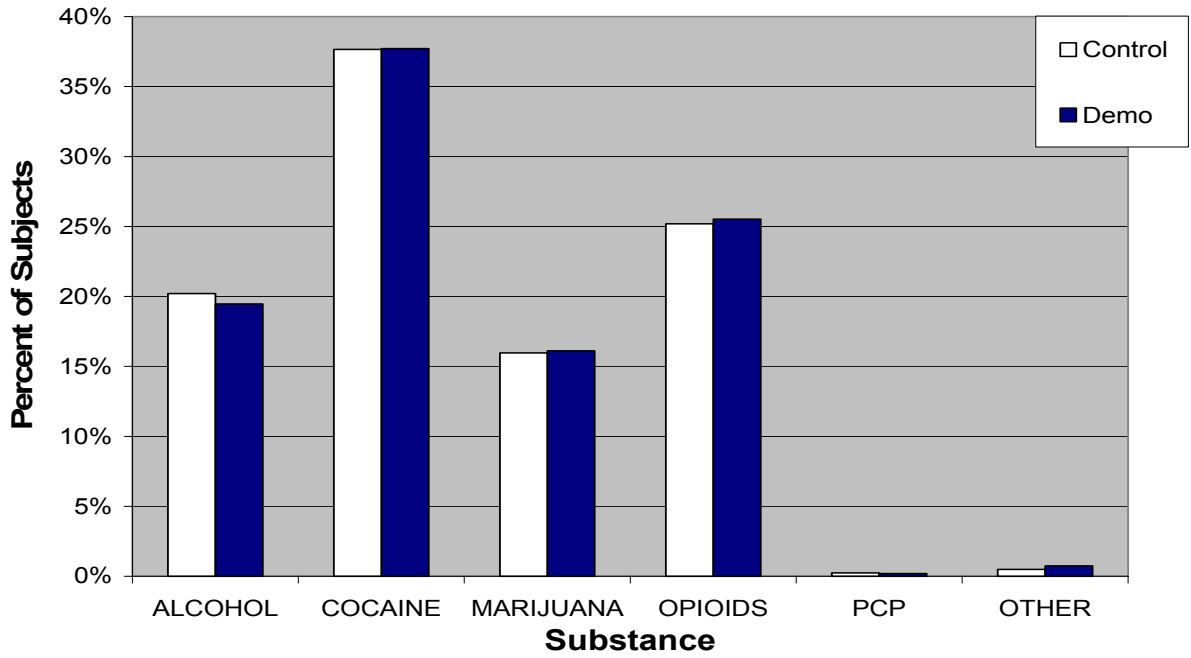
Child Characteristics	Control & Demo Groups
Male	53%
Female	47%
Average Age at time of Custody	3.8
Average age	7.2
Associated with Substance Exposed Allegation	25%
Associated with at least Allegation of Neglect	36%

Caregiver Demographic Graphs:

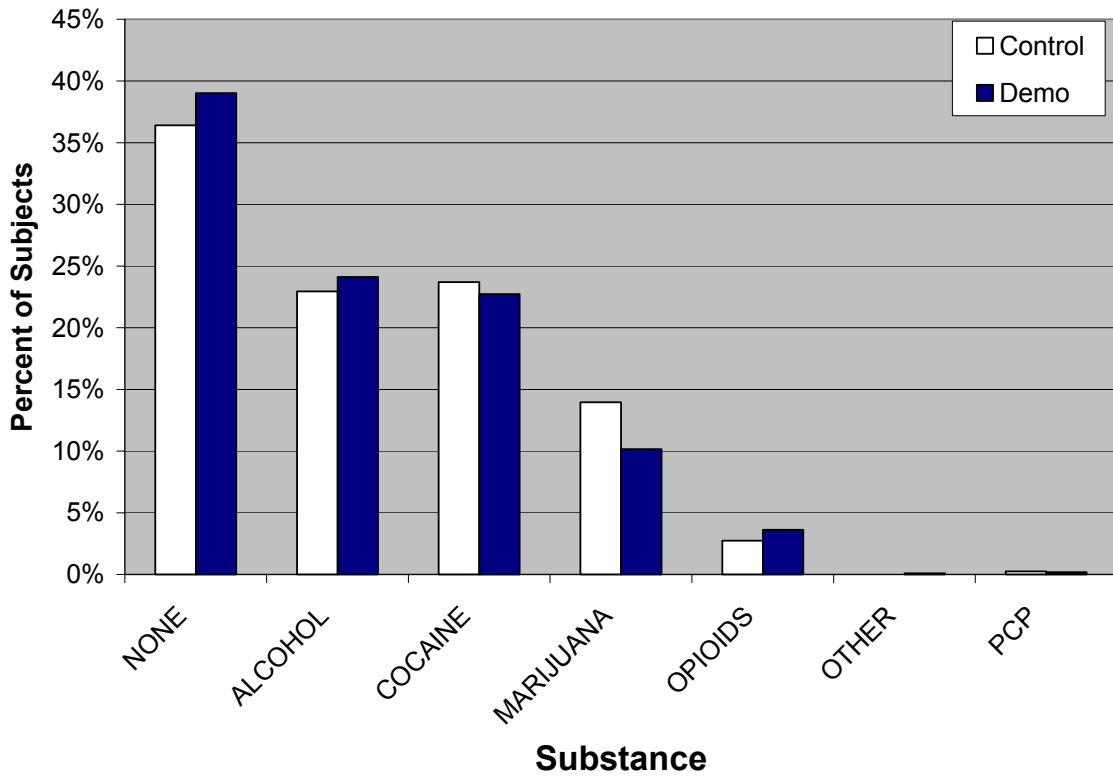




Primary Substance



Secondary Substance



Substance Abuse Services

DARTS data analysis:

A primary goal of the recovery coach is to speed up the treatment process. In part, this goal is achieved by facilitating a timely entry into a substance abuse service setting. To monitor the time between initial assessment and date of first treatment episode, we utilize the State of Illinois' Automated Reporting and Tracking System (DARTS). This database includes a variety of treatment related information including (but not limited to) intake date, termination date, level of care, and reason for service closing. For the purposes of this report, we are primarily interested in the time between the JCAP assessment and the first treatment episode. The tables display comparisons between the demonstration and control groups.

The service data reflect treatment activity between April 2000 and June 2004. The caregivers represented in these analyses entered the demonstration project between April 2000 and June 2004. Life tables are used to describe and display the time to first treatment episode. We focus specifically on the number of days between JCAP assessment and the first treatment episode. The life tables used in the current study are divided into 30 day intervals. For each interval, we calculate the number and proportion of cases that enter the respective interval (risk set), the number of cases that experience the event of interest (accessed substance abuse services), and the number of cases that were censored in the respective interval. Cases are censored if access to substance abuse services does not occur before the end of data collection. Although parents may eventually receive services, the case is censored (i.e., removed from further analysis) because this event was not observed during the period of data collection. In addition to comparing the time between JCAP and substance abuse treatment, we also compare the overall proportion of cases accessing substance abuse services. It's possible that although the trajectories may look different (e.g. experimental group accesses services more quickly) there may be no difference when comparing the overall proportion of cases in the experimental and control group that receive services. We use cross-tabulations and chi-square statistics when comparing the likelihood of accessing substance abuse services.

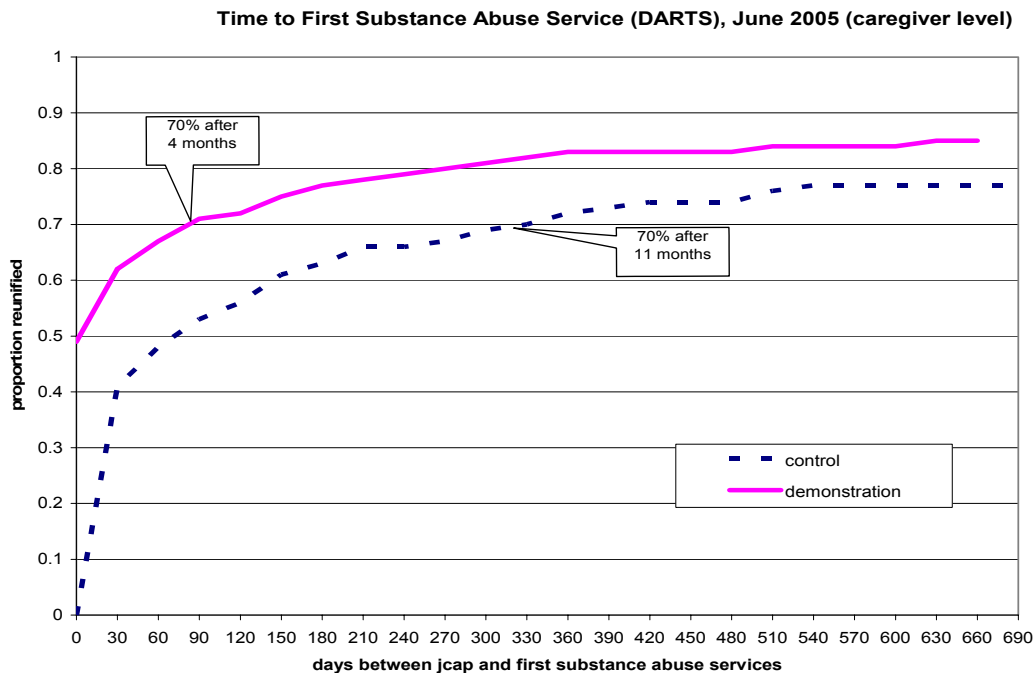
Access to Substance Abuse Services:

As of June 30, 2004 a total of 1,309 caregivers completed the JCAP assessment. Of these 1,309 caregivers, 422 agreed to share their substance abuse treatment data (via informed consent). Of these 422, 101 are in the control group and 321 are in the demonstration group. Of those in the control group 77% have a treatment episode subsequent to the JCAP assessment. Of those in the demonstration group, 84% have a treatment episode subsequent to the JCAP assessment. The chi-square statistic ($X^2 = 2.27$, $df = 1$) and associated p-value (.105) indicate that this difference is close to statistically significant at the .10 level. The comparisons are displayed in the following table.

Assigned Group	Accessed Substance Abuse Services		totals
	No	Yes	
Control	23 (23%)	78 (77%)	101
Demonstration	52 (16%)	269 (84%)	321
totals	75 (18%)	347 (82%)	422 (100%)

Life Table: Comparing Time to First Treatment Episode:

The previous table compares the overall percent of families that accessed substance abuse services – through June 2004. To better understand the timing of these events we produced a life table. The survival lines for both the control and demonstration group are displayed in the following chart. One will note that shortly after the JCAP assessment (represented as 0 days), the two lines begin to diverge. At one month (30 days), the difference is quite noticeable. The Wilcoxon (Gehan) statistic (3.83, df = 1, p<.05) indicates that the trajectories of these lines are significantly different. After four months, approximately 70% of the caregivers in the demonstration group accessed substance abuse services – compared with the eleven months it took the caregivers in the control group to achieve this same level of access. Thus, it appears from the chi-square and life table analyses that although caregivers in the demonstration group are not significantly more likely to access substance abuse treatment, these caregivers are more likely to access services more quickly.



Summary Statistics for Caregivers with Signed Consents:

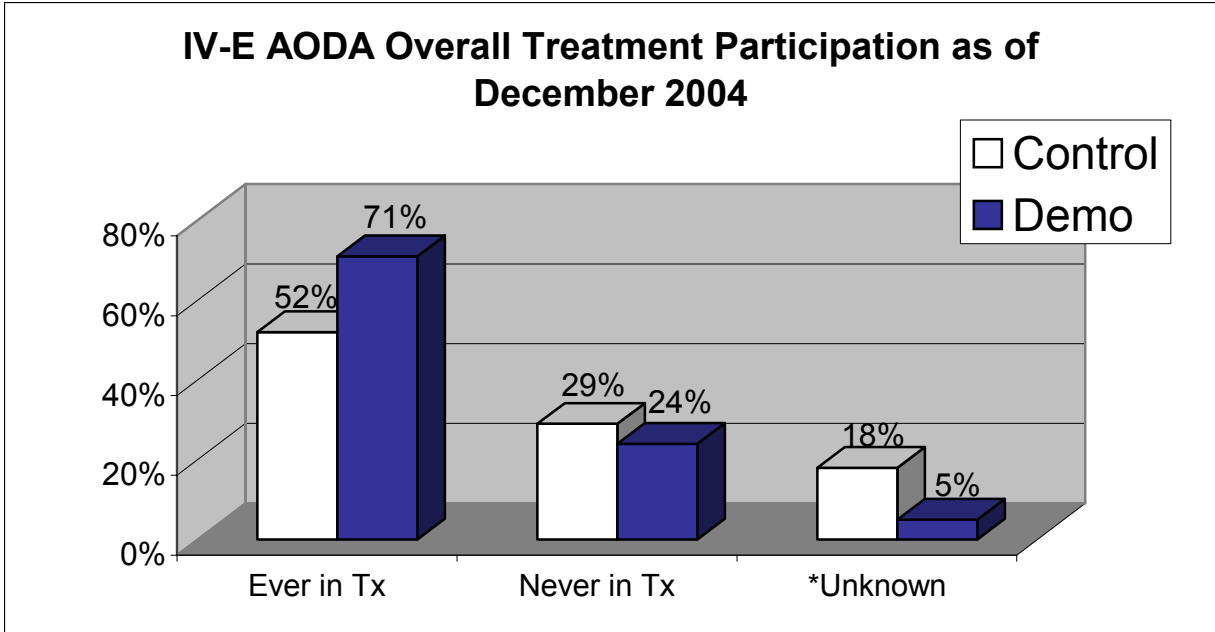
Demonstration	Control	
Mean days between assessment & first TX episode	108	74
Minimum days between assessment & first TX episode	0	0
Maximum days between assessment & first TX episode	1128	1230

TRACCS Data Analysis:

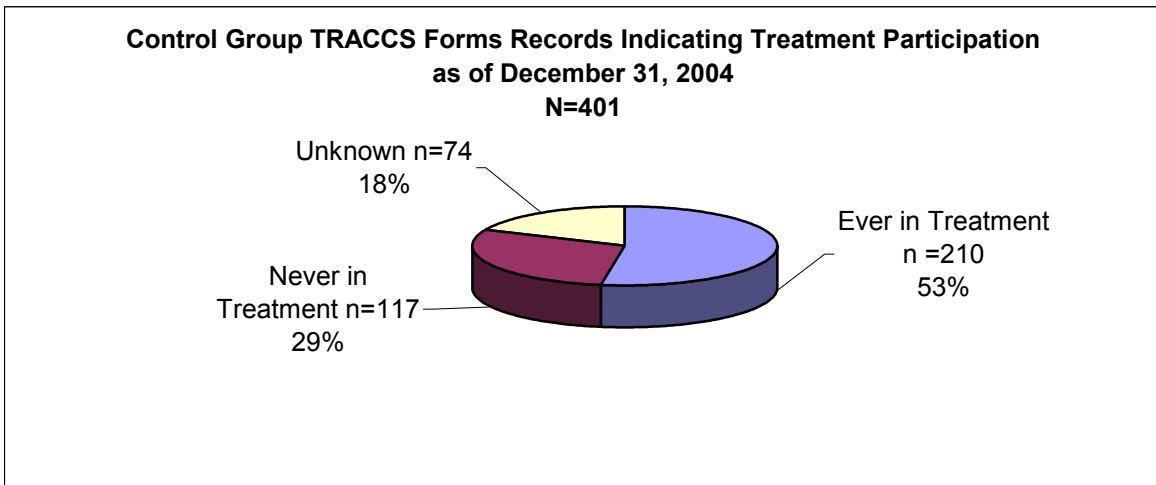
Overall Treatment Participation for Control and Demonstration Groups:

TRACCS forms are being collected from three sources: AODA treatment providers, caseworkers, and Recovery Coaches (Demonstration Group only). According to information received from TRACCS forms, 210 (52%) clients in the Control Group have participated in treatment as compared to 765 (71%) clients in the Demonstration Group. “Never in treatment” indicates that TRACCS forms have been completed and returned stating that there is no record or knowledge of treatment participation for those particular clients. The “unknown “ category indicates that no TRACCS forms have been returned by any of the three sources for those clients. This may be due to new clients to the project whose treatment status and TRACCS forms have not yet been completed or it could also represent clients who have not been in contact with their caseworkers or Recovery Coaches at any time. Recovery Coaches provide monthly TRACCS forms on each of the demonstration clients. The treatment participation is unknown for 5% of the Demonstration Group as compared to 10% of the Control Group clients whose data collection is dependent solely upon the caseworker and potential AODA provider.

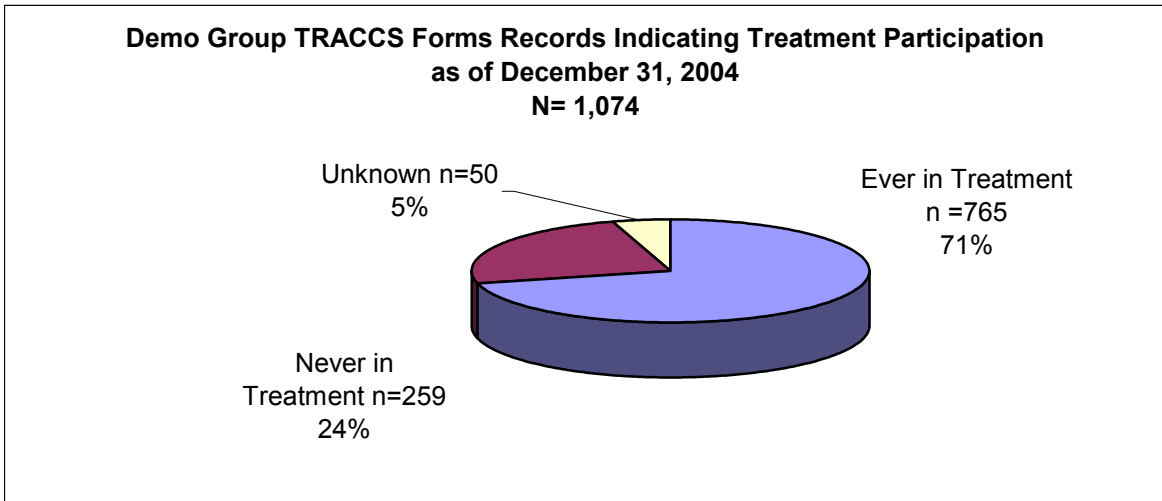
The graph below indicates the impact that the continuity and assertive outreach attempts offered by the Recovery Coaches have had on assisting Demonstration group clients to participate in treatment



The pie charts below represent the differences in treatment participation for the Control and Demonstration group clients.



Recovery coaches continue to engage the clients who have never engaged in treatment despite countless outreach efforts. On an average, 60 outreach attempts are provided before the Recovery Coaches even consider discontinuing services to clients. Continuous efforts are employed for 6 consecutive months once a client becomes difficult to engage or make contact with. Usually the Recovery Coach or outreach worker is able to make contact with the client and attempts to reengage the client and offer treatment services.



Treatment Completion for Control and Demonstration Groups:

The following table displays the total number of forms collected for each client and the percentage of clients who had ever completed a level of care in AODA treatment. According to the TRACCS data, 23% of the Control group clients ever completed an entire treatment episode (Level of Care) compared to 43% of Demonstration group clients.

	Number of Clients	Completed Level of Care in AODA Treatment*	% of Total Clients
Demo	943	410	43%
Control	366	83	23%

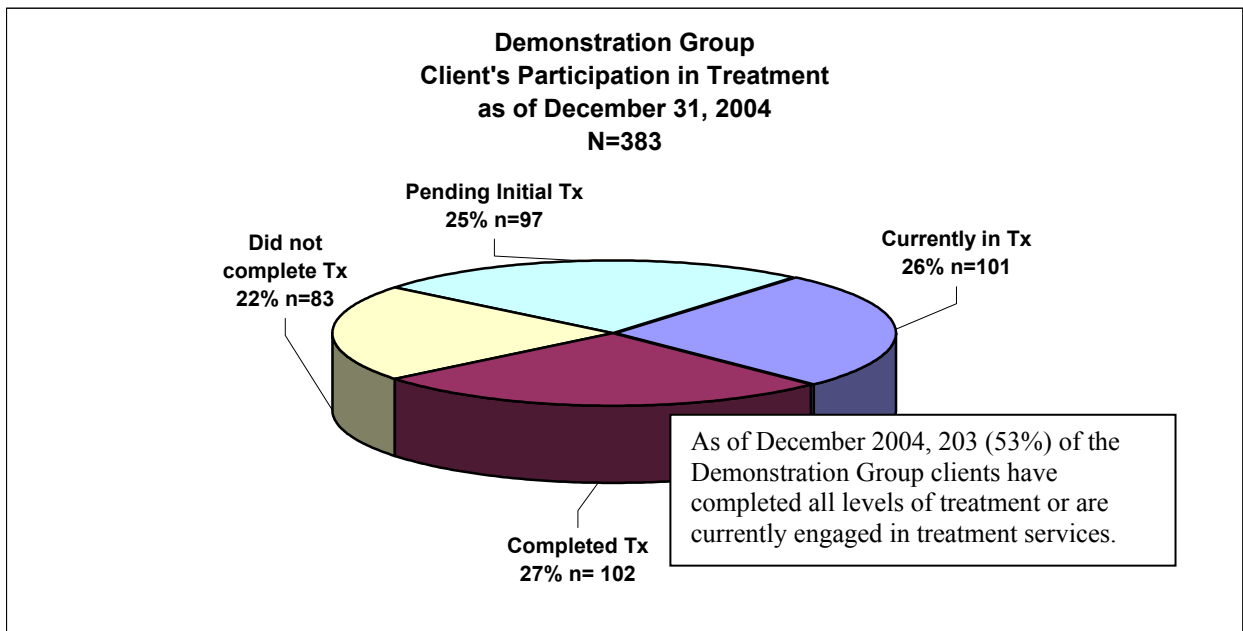
*TRACCS forms collected from one of the three sources: Recovery Coach, AODA treatment facility or Child Welfare Worker

Additional Treatment Participation Outcomes for Demonstration Group clients

The following treatment participation data is gathered from both the TRACCS forms and also the reports written each quarter by TASC. As of December 31, 2004, 765 (71%) of the total 1,074 have been engaged in treatment services. Of these clients, a total of 497 (46%) of clients ever assigned to the Demonstration group engaged in treatment, but did not successfully complete treatment or did not transition into the next level of recommended care. Of these 497 clients, 189 (38%) re-entered another treatment

program. As of December 31, 2004, 68 (14%) not only re-entered treatment, but eventually completed all treatment recommendations.

The on-site availability of AODA assessments and the assertive outreach and engagement practices of the Recovery Coaches are proving to show positive treatment engagement outcomes. The graph below indicates the current treatment and case status of the 383 active clients assigned to the Demonstration Group who are currently being served by the Recovery Coaches. This number represents 36% of the 1,074 total clients ever assigned to the Demonstration group. Active cases do not include cases no longer being served by Recovery Coaches. As of December 31, 2004, 203 (53%) of the active clients have either completed all levels of treatment or are currently engaged in treatment.

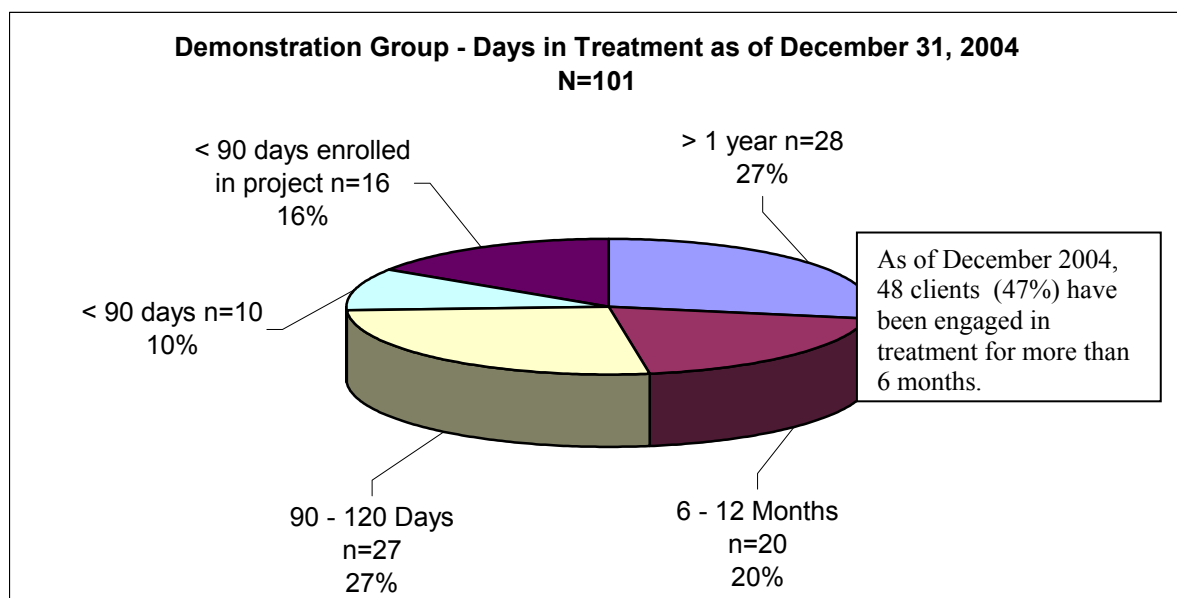


As of December 31, 2004, 101 clients are currently engaged in treatment services, 102 clients have completed all levels of service, and 83 clients have participated in treatment but have unsuccessfully completed the program and/or have failed to transition into the next level of care. Currently, 97 clients are in contact with their Recovery Coaches but have yet to engage in treatment. As indicated in the chart above, only 5 clients have not been able to be located by Recovery Coaches despite several home visit attempts and diligent search efforts. Outreach attempts will continue to be made for six consecutive months before services are discontinued and the case closed with the Recovery Coach. As of December 31, 2004, Recovery Coaches have discontinued services to 704 clients.

As of December 31, 2004, 83 clients have been engaged in treatment, but then failed to reenter into the next level of care or have left treatment against medical advice. These clients have participated in a treatment program at some point in time while involved in

the project, but have not successfully completed all treatment requirements or have failed to enter the next level of care deemed appropriate for recovery. The majority of these clients remain in contact with their Recovery Coaches as outreach attempts will continue to be provided to reengage clients into appropriate levels of care.

The chart below represents the number of days the Demonstration Group clients remain in treatment. As of December 31, 2004 of the total 101 clients engaged in treatment, 48 clients (47%) have been engaged in treatment for more than 6 months, 28 (27%) have been involved in services for more than 1 year and an additional 20 clients (20%) for more than 6 months.



Recovery Coaches have found that if a parent is able to remain engaged in treatment for 90 days, the chances of completing treatment remain high. Twenty-seven clients (27%) have been in treatment between 90 – 120 days. Of the 26 clients (26%) that have been engaged for less than 90 days, 16 (16%) of those clients have entered the project within the past 90 days and therefore were engaged in treatment almost immediately. The remaining 10 clients have been enrolled in the project for several months and have not been able to engage in treatment services for more than 90 days at a time.

Caregiver/Child Interactions

Visitation status

The visitation status of caregivers is captured within the caseworker TRACSS form. As of June 30, 2005, 1116 (85.2%) of the 1,309 caretakers had at least one completed TRACCS form. Of these 1116 caretakers, 803 (72.0%) are in the demonstration group and 313 (28.0%) are in the control group. Visitation data are captured for all children. We present data specific to the first child – as all families have at least one child in substitute care placement. Data are presented for both supervised and unsupervised visits.

Supervised visitation of child 1

The data represent the average number of visitations per month. The TRACCS forms capture total visits within a three month period. We divided this number by three – to represent the average number of visits per month. For example, if one caretaker had a total of 36 visitations reported within 3 TRACCS forms – this caretaker would have 4 average visitations per month [$36 / (3 \text{ forms} \times 3)$]. Approximately 18.6 % of the control group and 20.5 % of the demonstration group had no supervised visits as of June 30, 2005. This difference is not statistically significant.

Number of Visits	Control	%	Demo	%	Total
0	56	18.6	154	20.5	210
1	118	39.2	257	34.2	375
2	56	18.6	124	16.5	180
3	30	10.0	82	10.9	112
4	19	6.3	69	9.2	88
5	6	2.0	29	3.9	35
6	4	1.3	10	1.3	14
7	3	1.0	7	0.9	10
8	3	1.0	2	0.3	5
9	0	0.0	6	0.8	6
10	2	0.7	7	0.5	6
11	0	0.0	3	0.4	3
12	2	0.7	1	0.1	3
13	1	0.3	2	0.3	3
14	0	0.0	2	0.3	2
25	1	0.3	0	0.0	1
Missing	12	3.8	51	6.4	64
Total	313	100	803	100	1116

Unsupervised visit of child 1

Of 1099 caretakers with at least one TRACCS form, 66 (21.1%) caretakers in the control group experienced at least one unsupervised visit compared to 195 (24.3%) caretakers in the demonstration group. This difference is not statistically significant ($X^2 = 1.285$, $df = 2$, $p. >05$).

Unsupervised Visit	Control	%	Demo	%	Total
Yes	66	21.1	195	24.3	261
No	238	76.0	576	71.7	814
Unknown	2	0.6	9	1.1	11
Missing	7	2.3	23	2.9	30
Total	313	100.0	803	100.0	1116

Presenting problems of Caregivers:

In order to be included in the Waiver, a parent must have a substance abuse problem. As previously mentioned, JCAP staff are responsible for conducting the substance abuse assessments. In Illinois, the use of illegal substances per se does not constitute child maltreatment. However, the birth of a child who has illegal substances in its blood constitutes an allegation of neglect. The following table displays the allegation of maltreatment associated with entry into the demonstration project. That is, the most recent allegation prior to random assignment. There are no significant differences between the control and demonstration groups.

Allegations of Maltreatment Just Prior to Random Assignment

<u>Type of Maltreatment</u>	<u>Demonstration %</u>	<u>Control %</u>
Physical Abuse	4	3
Neglect	21	20
Sexual Abuse	1	1
Risk of Harm	33	33
Substance Related	24	24
Inadequate Supervision	17	19

TRACCS Data: Other Important Caregiver Demographics – Co-occurring Problems:

In addition to administrative and assessment data, the final report uses data captured on service plan forms. The TRACCS forms are sent quarterly to the child welfare caseworkers in the field. The forms capture a wide range of demographic and treatment related information. One component of the TRACCS form focuses specifically on the problems families are experiencing and the progress families are achieving. Each quarter, child welfare caseworkers complete TRACCS forms and indicate whether or not a family is experiencing problems with domestic violence, housing, or mental health. The caseworker assessment is simply a yes or no response – does the problem exist? Next to each problem area is a space for the caseworker to record a progress code. The progress codes are as follows: 1 = unsatisfactory progress, 2 = reasonable effort/commitment, 3 = substantial progress and 4 = complete progress).

Of the 1,309 caregivers involved with the demonstration waiver as of June 30, 2004, approximately 30% report problems with domestic violence, 56% problems with housing and 40% mental health problems. There are no differences between the control and demonstration group with regard to the report of additional problems. That is, additional problems co-occurring with substance abuse. In the outcomes chapter of this final report, we present multivariate models that focus on the relationship between co-occurring problems and family reunification.

Chapter III OUTCOMES

The outcomes of primary interest are family reunification/permanency, child safety and cost neutrality. The outcomes presented in this report are based on a comparison between the experimental and control group. As the Illinois AODA waiver utilizes an experimental design, simply comparing the two groups is appropriate. The vast majority of data in the outcomes chapter comes from the Illinois DCFS Integrated Database. This database includes a variety of client (e.g., demographics, placement history) and social service (e.g., placement records) information. In this outcomes section, we also move beyond simple comparisons (e.g. did the program work?) and investigate aspects of the demonstration waiver that might be improved – and thus result in even better outcomes (e.g. higher rates of reunification). We focus particular attention on what factors impact the likelihood of achieving family reunification. Specifically, we focus on the turnover of recovery coaches and the presence of co-occurring problems within the family system.

COMPLETING SUBSTANCE ABUSE TREATMENT

Very few substance abusing caregivers involved with the child welfare system enter and complete substance abuse treatment (NIDA, Office of Technology Assessment, 1992; Substance Abuse and Mental Health Services Administration, 2002; U. S. General Accounting Office, 1998). In a recent study of custodial mothers with substance abuse problems, only 20% either completed or were enrolled in substance abuse treatment. Moreover, even for those that enroll in treatment, dropouts and relapses are common experiences (Hser, Anglin, Grella, Longshore, & Predergast, 1997). Such low success rates with regard to the completion of substance abuse treatment are of great concern to child welfare systems because treatment completion is a significant predictor of family reunification. Smith (2003) examined the impact of substance abuse treatment compliance among 159 substance abusing caregivers involved in child welfare. The findings indicate that treatment completion improved the likelihood of reunification. Unfortunately little is known about the factors that help explain this outcome. The following analyses address this gap and make a unique contribution to the literature by identifying a wide range of factors that explain the completion of substance abuse treatment for caregivers involved with child welfare.

Data on treatment completion were only available for the caregivers assigned to the experimental group. Thus, the sample is limited to these caregivers. The sample is also limited to the caregivers enrolled in the waiver demonstration prior to April 1, 2004 (n=871). The treatment completion data run through June 30, 2004. Designating the cutoff data as April 1, 2004 allowed caregivers at least three months to complete substance abuse treatment. Overall, 22% completed all levels of substance abuse treatment.

The regression models indicate that age, employment, outstanding legal issues, physical symptoms including current depression episodes and difficulties memorizing or

concentrating, and primary drug of choice have significant effects on treatment completion. Compared with heroin users, the likelihood of treatment completion for alcohol users is 71% greater and for cocaine users the likelihood of completion is 59% greater than for heroin users. Marijuana users are about three times more likely to complete treatment than heroin users. Age is also a significant predictor of treatment completion – older caregivers are more likely to complete substance abuse treatment. Controlling for the other covariates in the model, the likelihood of treatment completion among caregivers with current outstanding legal issues is, on average, 69% greater than for those caregivers without current outstanding legal issues. Unemployment decreases the likelihood of treatment completion for caregivers by 30%. Caregivers with depression symptoms are two times more likely to complete their treatment than those who are symptom free, while caregivers experiencing recent difficulties of memorizing or concentrating are 64% less likely to complete their treatment.

Two major challenges in working with substance abusing parents could potentially explain the low treatment completion rate in this study: co-occurring problems and lack of accessible treatment facilities. First, prior studies highlight the issues related to co-occurring problems. For example, Marsh, D'Aunno and Smith (2000) note that many substance abusing families simultaneously struggle with parental problems, domestic violence, mental health, poverty and issues related to child maltreatment. Caregivers in the current study also report a variety of co-occurring problems at intake. One-third of caregivers experienced violence, and about 45% of caregivers reported that they do not have any source of income. About 18% of caregivers had mental health problems and 22% of caregivers had medical problems. While there are few integrated services available in current child welfare practices to address these multiple problems, the untreated co-existence of more than one dysfunctional problem in parents may substantially jeopardize their ability to recover from substance abuse.

Prior studies have also focused on the lack of accessible substance abuse treatment services nationwide (Young, Gardner, & Dennis, 1998). This is particularly true for women with children. For example, if a parent has custody of the children and requires residential treatment, there may be an additional barrier since many of these programs do not allow children to live in the facility (GAO, 2003). Of 871 caregivers, 39 (5%) caregivers indicated that they have other children living with them, and those living with children had a lower rate of treatment completion than those living without children (22.2% vs. 12.8%) ($\chi^2=1.936$, $df=1$, $p>.05$). Despite statistical non-significance, this finding suggests the necessity of future development of substance abuse treatment services that are sensitive to the need of caregivers living with children.

In closing, these analyses focused on a wide variety of factors that explain the rate of completion of substance abuse treatment for caregivers in the child welfare system. To date, very few studies have focused on this particular topic. The findings indicate a variety of factors that might be incorporated into pre-treatment assessments – so that child welfare caseworkers can initiate preventive measures to decrease attrition and improve treatment completion. Hopefully, this in turn will improve outcomes in the child welfare system.

FAMILY REUNIFICATION AND PERMANENCE

A primary objective of the AODA waiver demonstration was to increase the likelihood of family reunification. Historically, substance abusing families achieve very low rates of reunification. The following table displays the living arrangement of children (n=1,936) enrolled in the demonstration waiver as of June 30, 2004. These placements reflect the children’s living situation as of June 30, 2005. A total of 66 (11.6%) children in the control group were returned home as compared to 212 (15.5%) children in the demonstration group. This difference is statistically significant ($X^2 = 5.0, p < .05$). That is, children in the demonstration group are more likely to achieve reunification as compared with children in the control group. For the children that remain in a substitute care placement, the vast majority (approximately 74%) still have “return home” as their permanency goal.

IV-E AODA Children Living Arrangement Type as of June 30, 2005

Living Arrangement Type	Control	%	Demo	%	Total
<i>Home of Parent (HMP)</i>	66	11.6	212	15.5	278
<i>Home of Adoptive Parent (HAP)</i>	94	16.5	188	13.8	282
<i>Subsidized Guardianship (SGH)</i>	41	7.2	80	5.9	121
Foster Home Adoptive (FHA)	0	0	1	.1	1
Foster Home Private (FHP)	124	21.8	331	24.2	455
Foster Home Specialized (FHS)	69	12.1	48	3.2	117
Home of Relative Foster Care (HMR)	136	23.9	428	31.3	564
*Institutional Settings	12	2.2	23	1.7	35
**Other (OTH)	27	4.7	56	4.0	83
Total	569	100%	1,367	100%	1,936

*Includes Group home, hospital/health facility, detention and correction, independent living settings.

**Includes Unauthorized placement, unknown whereabouts, abducted and deceased.

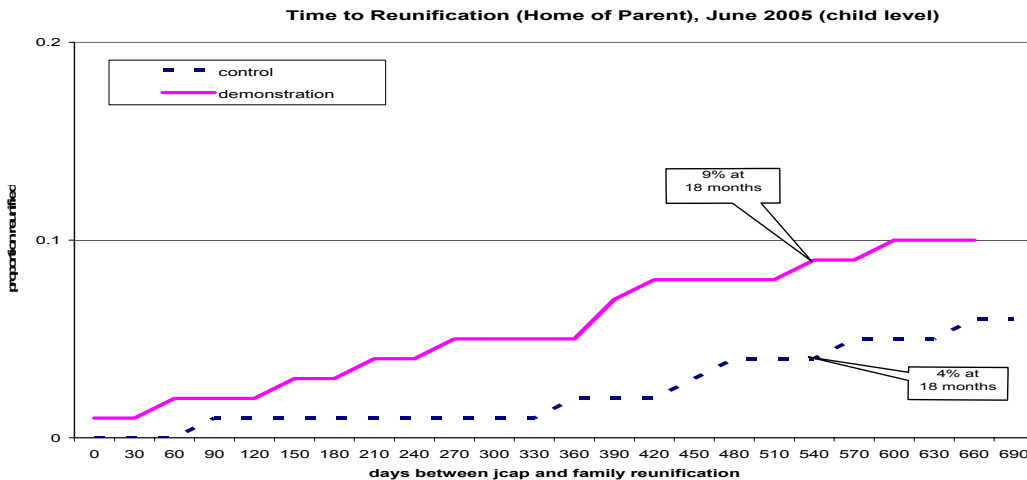
The following table displays the permanency categories for the control and demonstration groups – this time separating the children assigned to Demo group B. There are now five possible group assignments: control group (C1) before the introduction of Demo B, Control group (C2) after the introduction of Demo B, Demonstration group (D) before the introduction of Demo B, Demonstration group (DA) (after the introduction of Demo B) and Demonstration group (DB). The percentages indicate that the children in the Demo B group have slightly higher odds of achieving reunification (9%) as compared with C2 (6%) and even DA (6%). However, these differences are not statistically significant.

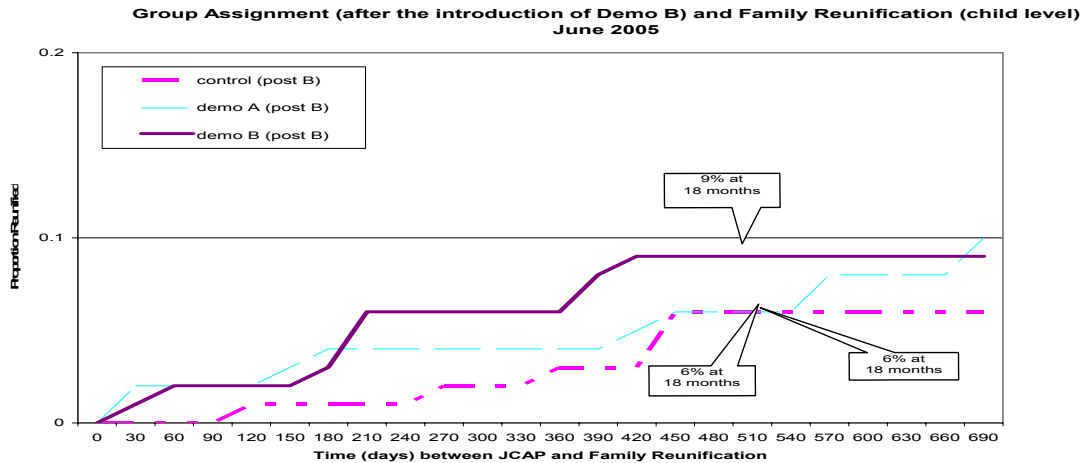
IV-E AODA Children Living Arrangement Type as of June 30, 2005 – including Demo B

Living Arrangement Type	C1	C2	D	DA	DB
<i>Home of Parent (HMP)</i>	59 (13%)	7 (6%)	182 (18%)	7 (6%)	16 (9%)
<i>Home of Adoptive Parent (HAP)</i>	91 (20%)	3 (3%)	182 (18%)	4 (3%)	2 (1%)
<i>Subsidized Guardianship (SGH)</i>	41 (9%)	0 (0%)	79 (8%)	1 (1%)	0 (0%)

The Timing of Achieving Family Reunification:

The following figures display the timing of family reunification. The first figure displays the rate of achieving family reunification for the control and demonstration group overall. The second figure displays the rate of achieving family reunification for control and demonstration groups after the introduction of Demo B. The trajectories displayed in the first figure indicate that children in the demonstration group spend significantly less time in out of home care – that is – these children are reunified in a significantly shorter period of time. On average, children in the demonstration group achieve reunification in significantly fewer days as compared with children in the control group (522 days vs. 707 days, $p < .01$). The trajectories displayed in the second figure seem to suggest that the children in the Demo B group are reunified more quickly – as compared with children in the control group or in the Demo A group. Yet these differences are not statistically significant. It’s possible that the smaller samples sizes in the Demo B comparisons are resulting in p-values that exceed .05 (the standard cutoff for statistical significance).





Additional Factors that Impact the Likelihood of Family Reunification

Co-occurring Problems:

Child welfare clients with co-occurring problems -- such as substance abuse, mental health, domestic violence and housing problems -- are recognized as difficult clients to serve and often do not achieve positive outcomes in the child welfare system. Several integrated service models have been developed specifically for multiple problem families in the child welfare system. Yet little is known about the effectiveness of such models (Ryan, Marsh, Testa & Louderman, in press, WCDVS, 2004; for a review, see Maluccio & Ainsworth, 2003). Relatively few evaluations of integrated service models focus on child welfare outcomes such as reunification. These studies indicate that even the most intensive efforts result in low rates of reunification (Ryan, Marsh, Testa & Louderman, under review). To better understand why low rates of reunification persist, even after the receipt of integrated services, the following analyses focus on families in the child welfare system who simultaneously experience multiple problems. Specifically we focus on substance abuse, domestic violence, housing and mental health and the role these problems play in achieving reunification. We examine whether it's necessary for families to make progress in each problem area in order to achieve family reunification.

Domestic Violence and Child Welfare: Domestic violence is a major challenge confronting child welfare systems. Recent estimates indicate that between 30% and 60% of families involved with public child welfare also experience domestic violence (Edleson & Eisikovits, 1996; Findlater & Kelly, 1999). Such violence in the family home increases the risk of child maltreatment and the risk of substitute care placement (Straus & Gelles, 1990). With regard to reunification, the presence of violence in the home is a major contributor to the disruption of the family reunification process. Hess, Folaron and Jefferson (1992) report that domestic violence is responsible for the disruption of approximately 56% of failed attempts of reunification. Oftentimes these problems emerge when initial treatment plans fail to identify domestic violence as a co-occurring problem (Aron & Olson, 1997). Only in recent years are child welfare systems

and domestic violence initiatives collaborating in the pursuit of child and partner safety (Findlater & Kelly, 1999).

Housing and Child Welfare: The problem of housing is well documented throughout the literature and impacts both family and child outcomes (Jones, 1998; Courtney, McMurtry and Zinn, 2004). Children living in families that are unable to secure safe, affordable and stable housing are at an increased risk for a variety of negative outcomes including serious injury (Jones, 1998). Thus, these children and families are also at an increased risk of involvement with public child welfare systems (Steinbock, 1995; Park, 2004). Once in the system, families with housing problems are significantly less likely to achieve reunification (Jones, 1998). With regard to housing services, caregivers often report that housing assistance is one of the most important components of treatment planning (Kauffman, 1997). Similarly, the receipt of housing assistance has been found to increase the likelihood of reunification (Hoffman & Rosenheck, 2001) and decrease the future risk of maltreatment (Ryan & Schuerman, 2004).

Mental Health and Child Welfare: There is a broad literature describing the mental health needs of families involved with public child welfare. Dependent children with mental health and substance problems spend more time in foster care, are more likely to bounce between multiple foster homes and are less likely to experience reunification relative to dependent children without such problems (Horwitz, Simms & Farrington, 1994; Newton, Litrownik & Landsverk, 2000; Landsverk, Davis, Ganger, Newton & Hohnson, 1996). At the caregiver level, researchers estimate that up to 70% of parents involved with child welfare services have at least one mental health problem (Faller & Bellamy, 2000). Such problems routinely interfere with appropriate parenting practices and may even exacerbate the circumstances that bring parents to the attention of child welfare systems (D & S Associates, 1997).

The review of the literature reveals that the study of co-occurring problems is not a recent phenomenon. Yet, the vast majority of this literature focuses only two simultaneous problems (e.g. domestic violence and child maltreatment). Moreover, we could not find any studies that focus on how the progress within these problem areas impacts outcomes in the child welfare system. A primary objective of the current study is to advance this body of knowledge by investigating the role of multiple problems for caregivers involved with public child welfare. We focus not only on the presence of co-occurring problems, but also the progress achieved within each problem area. Finally, we examine how the existence of co-occurring problems may interfere with the reunification process.

The sample used in the current study is limited to the families who had at least two completed service plan forms. We selected families with at least two forms (as opposed to families with only one completed form) so that we could investigate progress within each problem area. Although progress could be achieved within one quarter, we felt a minimum of two quarters of service plan data would provide a more accurate description of (1) the problems experienced within each family system and (2) the amount of progress achieved within each problem area. Of the original 996 families, 724 (73%) had at least two completed forms and thus comprise the sample used in the current study.

Missing Data Analysis: We conducted missing data analysis to determine if there were any significant differences between the families with at least two forms compared to the families with no service plan forms. The analyses reveal that only one family characteristic was different between the two groups. The families with completed forms were more likely to have at least one member of the family employed at least part-time. There were no differences with regard to age of caregivers, race, education, primary substance use, number of children in the family, group assignment, involvement with the adult correctional system, or reunification

In addition to administrative and assessment data, the current study analyzes data captured on service plan forms. The Department of Children and Family Services contracted with a local organization to provide assessments and referrals at the JCAP site. An additional contract exists with this organization to coordinate the computer-based integrated data collection system called TRACCS (Treatment Record and Continuing Care System). The TRACCS forms are sent quarterly to the child welfare caseworkers in the field. The forms capture a wide range of demographic and treatment related information. One component of the TRACCS form focuses specifically on the problems families are experiencing and the progress families are achieving. We focus on three problem areas: domestic violence, housing, and mental health and also look at the progress families are achieving in these areas.

Each quarter, child welfare caseworkers complete TRACCS forms and indicate whether or not a family is experiencing problems with domestic violence, housing, or mental health. The caseworker assessment is simply a yes or no response – does the problem exist? Next to each problem area is a space for the caseworker to record a progress code. The progress codes are as follows: 1 = unsatisfactory progress, 2 = reasonable effort/commitment, 3 = substantial progress and 4 = complete progress). In the current study we aggregate from the record (i.e., individual TRACCS form) to the family level. We use the highest progress code achieved in the current analyses. That is, at the aggregate level families are assigned a code of “4” if in any quarter the child welfare caseworker reported “complete progress” in addressing the specified problem.

Bivariate Relationships: To assess the relation between reunification outcomes and having specific problems and progress on problems, Tables 1, 2, and 3 display the likelihood of achieving reunification by total problems, by each problem subgroup and by progress made within each subgroup. The “substance abuse only” row in Table 3 represents the group of families with AODA problems only. That is, the child welfare caseworker indicated no problems with domestic violence, housing or mental health. There are at least two important items to note. First, very few families are dealing with the problem of substance abuse (8%) only. The majority of substance-abusing families in this sample (62%) are dealing with at least three problems simultaneously. It’s also important to note that families are more likely to achieve reunification when they are not experiencing co-occurring problems. Overall, 12% of the families achieved reunification. However, 21% of the families dealing only with substance abuse achieved reunification. The difference between the probability of reunification for the substance

abuse only group compared to the group of families with additional co-occurring problems is statistically significant ($X^2 = 5.08$, $df = 1$, $p < .05$).

Table 1
Number of Family Problems by the Likelihood of Reunification (n=724)

Problems indicated by Caseworker	Not Reunified	Reunified	Totals
Substance abuse only	44 (79%)	12 (21%)	56 (8%)
One additional problem	191 (89%)	23 (11%)	214 (30%)
Two additional problems	222 (88%)	30 (12%)	252 (35%)
Three additional problems	180 (89%)	22 (11%)	202 (27%)
Totals	638 (88%)	87 (12%)	724 (100%)

Table 2 displays the relative probability of achieving reunification by each problem area. There are no statistically significant differences between the families with mental health, domestic violence and housing problems and those without such problems. That is, the mere presence of the problem does not seem to be associated with the likelihood of reunification.

Table 2
Specific Problem Area by Likelihood of Reunification (n=724)

Problem Area	Not Reunified	Reunified
Domestic Violence		
No problem	87%	13%
Yes – has problem	90%	10%
Housing		
No problem	87%	13%
Yes - problem	88%	12%
Mental Health		
No problem	87%	13%
Yes – has problem	89%	11%

* $p < .05$, ** $p < .01$

Table 3 displays the likelihood of achieving reunification by the progress made within each problem area. The first column of Table 3 displays the percentage of families (with each particular problem) in each progress category. Two pieces of information are important to note with regard to progress and reunification. First, very few families are making complete or even substantial progress in terms of addressing the substance abuse, mental health, domestic violence and housing problem areas. For example, of the 724 families only 18% have achieved complete progress in substance abuse treatment. On

average, these families have been enrolled in the demonstration waiver for over two years. So one could certainly argue that families have had sufficient time to address substance abuse issues and achieve “complete progress.” According to the child welfare caseworker, 43% of families are making unsatisfactory progress with regard to substance abuse treatment. The distribution of progress achieved is similar for domestic violence, housing and mental health. The second item worth noting is that progress ratings are significantly associated with family reunification. This is true for all problem areas. Families in the top two progress categories (substantial progress or complete progress) are more likely to achieve reunification as compared to the families in the bottom two progress categories (reasonable efforts or unsatisfactory progress). Finally, it’s important to note that progress is not the sole determinant of reunification – as there are a small percentage of families who achieved reunification without making any progress.

Table 3
Progress as Reported by Child Welfare Caseworker by Likelihood of Reunification

Problem Area	% progress	Not Reunified	Reunified
Substance Abuse**			
Complete	18%	74%	26%
Substantial	24%	87%	13%
Reasonable effort	15%	91%	9%
Unsatisfactory	43%	93%	7%
Domestic Violence**			
Complete	15%	75%	25%
Substantial	9%	76%	24%
Reasonable effort	18%	90%	10%
Unsatisfactory	58%	95%	5%
Housing**			
Complete	10%	69%	31%
Substantial	13%	83%	17%
Reasonable effort	22%	88%	12%
Unsatisfactory	55%	93%	7%
Mental Health**			
Complete	5%	58%	42%
Substantial	18%	88%	13%
Reasonable effort	20%	92%	8%
Unsatisfactory	56%	93%	7%

*p<.05, **p<.01

In summary, the bivariate analyses indicate that it's not the problem itself that decreases the likelihood of reunification, but rather the lack of demonstrated progress made within these problem areas. In relation to the underlying program theory, these results indicate that having access to and receiving services is – without some progress in resolving the problem – insufficient to affect the child welfare outcome of family reunification. We use this information in the development of our multivariate model. That is, we use the progress measures as independent variables.

Survival Analysis: The important relation between progress on co-occurring problems and reunification is reinforced by a survival analysis. The results from the Cox regression are displayed in Table 4. The table includes the coefficient and standard error for each independent variable as well as the hazard ratio. A hazard ratio greater than 1 indicates a higher likelihood of reunification. A hazard ratio less than 1 indicates a lower likelihood of reunification. If 1 is subtracted from the hazard ratio and the remainder is multiplied by 100, the resultant is equal to the percentage change in the hazard of achieving family reunification. Of the 724 families, 87 (12%) achieved reunification. The Cox regression model was developed in two separate steps. We entered a variety of demographic information in the first step. We then entered four variables indicating progress (or lack thereof) in each of the four problem areas: substance abuse, domestic violence, housing, and mental health. The progress variables are dummy coded. A value of “0” indicates that families either don't have the specific problem² or that families are making complete or satisfactory progress. A value of “1” indicates that families are either making only reasonable efforts or unsatisfactory progress. The housing variable was dropped from the final model because it was constant once we controlled for progress in the other three problem areas.

We find that four variables help explain reunification for substance abusing families in the child welfare system. Not surprisingly, the hazard ratio associated with progress in substance abuse treatment indicates that, in an intervention focusing on reducing substance use, families unable to make sufficient progress were 42% less likely to achieve reunification. Regarding multiple problems, families unable to make sufficient progress in the area of domestic violence were 53% less likely to achieve reunification. This is true even after controlling for a variety of demographic characteristics and controlling for the progress made in the area of substance abuse. The coefficient associated with mental health progress was marginally significant ($p = .052$). The direction and size of this coefficient also suggests that families unable to make progress in the area of mental health were 39% less likely to achieve reunification. Finally, the age of the caregiver is related to reunification. Each additional year of age increase the hazard of reunification by 4%.

² This is true for domestic violence, housing and mental health. This is not true for substance abuse – as all families have substance abuse issues.

Table 4
Cox regression: Multiple problems and family reunification

Independent Variables	B	S.E.	Exp (B)
Demographic Characteristics			
Age of youngest caregiver	.04*	.02	1.04
African American	-.20	.35	.82
Hispanic	.32	.47	1.38
Parents living together (1=yes)	.15	.27	1.16
High school education	.15	.23	1.16
Unemployed	-.03	.27	.97
One child in the family	-.61**	.23	.54
Prior SEI	.07	.24	1.07
Adult corrections	-.25	.27	.78
Group assignment (1=demonstration)	.01	.24	1.00
Progress in Problem Areas			
Substance abuse	-.54*	.24	.58
Domestic violence	-.75**	.28	.47
Mental health	-.49	.25	.61

*p<.05, **p<.01

Turnover of Recovery Coaches:

In addition to the impact of co-occurring problems on the likelihood of family reunification, we explore the impact of recovery coach turnover within the demonstration group. The turnover of caseworkers has concerned child welfare administrators for decades. High turnover rates, often attributed to low pay, poor working conditions and bureaucratic constraints, interfere with the provision of timely child and family services (Government Accounting Office, 1995; Anderson, 1994). Consequently, children associated with multiple caseworkers often experience more negative outcomes. Shapiro (1976) reported that caseworker stability contributed to the likelihood of achieving family reunification. Specifically, children associated with only one caseworker were significantly more likely to be returned to the home of his/her biological parents. In the following analyses, we use cross-tabs and chi-square analyses to investigate the effects of turnover within the recovery coach model. These analyses are limited to 1,037 children in the demonstration group that had cases open between 3 and 9 quarters. We dropped the children that were recently involved with the demonstration – as their families were unlikely to have experienced any changes with regard to recovery coaches. Of these 1,037 children, 280 (27%) were associated with only one recovery coach and 348 (34%) were associated with three or more recovery coaches. Using cross-tabs and chi-square, it

appears the likelihood of achieving family reunification is associated with the turnover of recovery coaches. Specifically, children associated with three or more workers are less likely to achieve reunification as compared with the children associated with two or fewer recovery coaches (9.8% vs. 14.1%, $X^2 = 3.88$, $df = 1$, $p < .05$).

Is More Better? Effects of Specific Recovery Coach Services

This final evaluation is concerned primarily with “did the program work?” However, in an effort to move beyond this question and address “what about the program (recovery coach model) seems to work best” we focus on the specific services that recovery coaches provide. We investigate whether such services impact (1) the likelihood of completing substance abuse treatment and (2) the likelihood of achieving family reunification. These analyses are limited to the families in the demonstration group. Several specific services had a significant impact on both reunification and the completion of substance abuse treatment. Families were less likely to achieve reunification and less likely to complete substance abuse treatment when recovery coaches were spending a significant amount of time focusing on client engagement issues. In contrast, when recovery coaches focused more time on case management services, transporting clients to various appointments, frequent contacts with clients and consulting directly with treatment providers, the likelihood of both reunification and treatment completion increased.

CHILD SAFETY

The primary goal of the demonstration project is to improve permanence. However, the demonstration is also designed to protect the safety of children. A quick permanency decision that compromises child safety is unacceptable. As of June 2005, the total number of caregivers with at least one post JCAP allegation (both unfounded and indicated) was 348 (27% of the overall 1,309 caregivers). When comparing post JCAP allegations between the control and demonstration group, significant differences emerge. Specifically, 30.3% of the caregivers in the control group and 25.1% of the caregivers in the demonstration group are associated with at least one post JCAP allegation. This difference is significant at the .05 level.

Subsequent Reports of Maltreatment

Post JCAP Allegation	Demo (%)	Control (%)	Total
Yes	237 (25.1)	111 (30.3)	348 (26.6)
No	706 (74.9)	255 (69.7)	961 (73.4)
Total	943 (100)	366 (100)	1309 (100)

Post JCAP SEI	Demo (%)	Control (%)	Total
Yes	28 (4.2)	8 (3.1)	36 (3.9)
No	641 (95.8)	253 (36.9)	894 (96.1)
Total	669 (100)	261 (100)	930 (100)

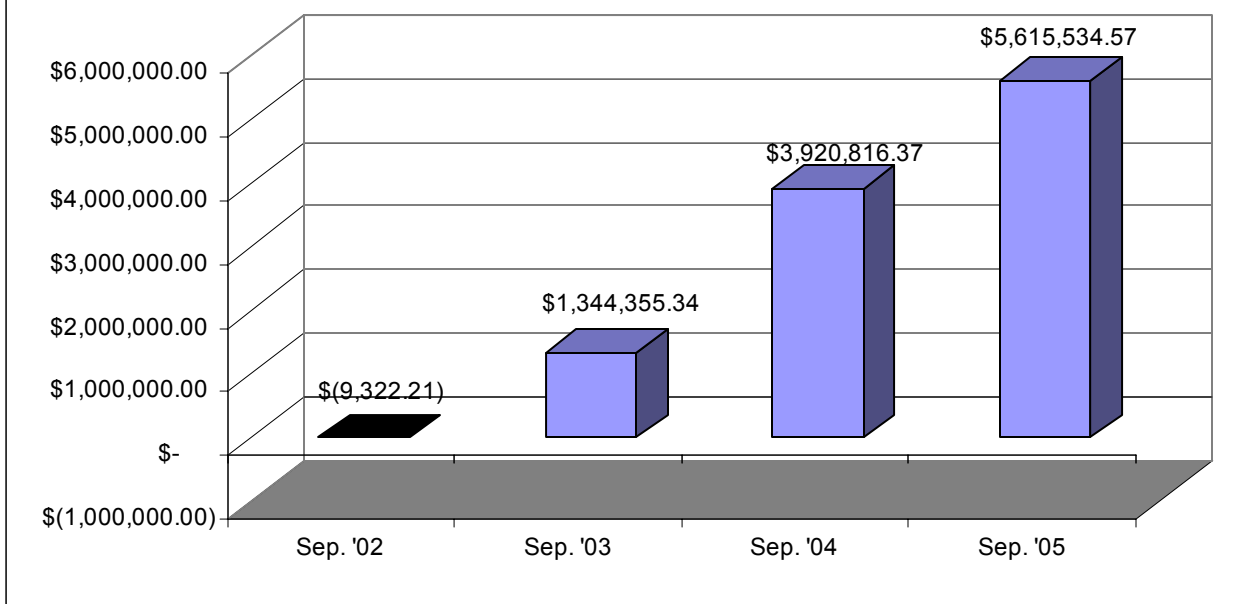
Subsequent Reports of Substance Exposed Infants (SEI)

Of 931 female caregivers, 142 caregivers (15.3 %) had at least one post JCAP SEI allegation including 91 caregivers (13.6 %) from Demo group and 51 caregivers (19.5 %) from Control Group. This difference is statistically significant ($X^2 = 5.15$, $df=1$, $p<.05$). Related to subsequent SEIs, women that don't complete substance abuse treatment are approximately twice as likely to have a post JCAP SEI (7.9% vs. 18.8%). This finding supports (i.e. provides empirical evidence) that getting parents into substance abuse treatment and keeping them there through program completion is an important objective – and one that is tied to critical outcomes.

COST NEUTRALITY

The formula for calculating the cost neutrality is based on the cumulative IV-E payments for the control group and then divided by the number of children ever assigned to that control group. This dollar amount is the average IV-E payment that is then multiplied by the number of children ever assigned to the Demonstration group. After all foster care and adoption claims are calculated, the demonstration group has incurred less calculated costs than the control group. The chart below shows the savings calculated in the month of September each year. As of September 30, 2005 the state is able to reinvest \$5,615,534.57 to include any expense or service that could otherwise be funded under title IV-B.

Total IV-E AODA Claim savings/loss: Includes all foster care and adoption claims as of September 2005



Chapter IV

SUMMARY, CONCLUSIONS, RECOMMENDATIONS and FUTURE DIRECTIONS

The purpose of this study was to test the efficacy of recovery coach services for substance abusing caregivers in the child welfare system. We focused on two outcomes: access to substance abuse treatment and family reunification. The results indicate that families receiving recovery coach services were more likely to access substance abuse treatment. The results also indicate that families receiving recovery coach services are more likely to achieve family reunification. Specifically, the odds of achieving reunification were 1.28 times greater for families assigned to the recovery coach group.

These are important findings and make a unique contribution to the literature because (1) very few substance abusing families in the child welfare system achieve family reunification, (2) there are almost no experimental studies of effective interventions for substance abusing families in the child welfare system and (3) recent legislation makes it clear that if family reunification is still the primary goal for child welfare systems, the timeline and milestones associated with recovery from substance abuse must coincide with the timeline associated with permanence and the termination of parental rights.

Reunification: The likelihood of achieving family reunification for substance abusing parents is extremely low. Of all children entering foster care in 1994, only 19% were still in care as of June 30, 2000 (approximately six years) (Goerge & Lee, 2000). In comparison, 86% of substance exposed infants entering care in 1994 failed to return home before January 2002 (approximately 7.5 years) (Budde & Harden, 2003). Interventions that can increase the likelihood of family reunification should be considered by state child welfare agencies – even if such increases are modest. In the current study we report that 15.5% of the families receiving recovery coach services achieve family reunification (relative to 11.6% in the control group). This 15.5% certainly doesn't reflect the ideal, but considered within the historical context of family reunification for substance abusing families in Illinois this percentage is not entirely discouraging. No single intervention will resolve all the issues associated with reunification for substance abusing families. Recovery coaches seem to be part of the solution.

It's also important to note that many factors contribute to reunification. One should not assume that treatment gains are the sole determinant of reunification. Similarly, one should not assume that low rates of reunification are the result of ineffective services. The culture within family courts, risk-averse judges and co-existing problems within the family system may all contribute to low reunification rates for children in substance abusing homes. The current study did not focus on the effectiveness of substance abuse services. Rather we focused on the effectiveness of the recovery coach model and specifically whether or not this model was associated with timely service access and reunification. It seems important for future research to drill further into the recovery coach model and investigate the relative efficacy of specific substance abuse services. If

the available substance abuse services are ineffective, it won't matter how quickly child welfare systems can connect clients and treatment providers.

Few Experimental Studies: One concern noted throughout the social service literature is the need for more experimental research. In part, the lack of experimental research has given rise to a surge of concerns about the quality of empirical evidence in the applied social sciences (Boruch, Snyder & DeMoya, 2000). With an increasing awareness of the need for “best practices” or “evidence based practice” in child welfare, these concerns are only likely to mount. The current study addresses this concern by taking advantage of the random assignment incorporated into a Title IV-E waiver project.

Waivers provide states with greater flexibility to use title IV-E funds for programs and services intended to facilitate permanence. The demonstration projects are required to be cost neutral and perhaps even decrease expenditures through reduced foster care spells. There are currently 26 waiver demonstrations in 17 states. Illinois has three of these waiver demonstrations. The primary advantages of implementing a waiver demonstration include the flexibility to develop innovative treatment approaches that otherwise would be denied, and the authority to randomly assign families. The benefits of a randomized trial in the field can not be overstated. Random assignment assures that groups are equivalent from the outset, assures that one can make legitimate statements about the role that chance plays in results, and helps to minimize interpretative problems that affect nearly every other evaluation design (Boruch et al., 2000). In short, the current study makes a unique contribution to the literature and an important contribution to child welfare practice because the use of random assignment provides compelling evidence that the benefits of recovery coach services are significant. This evidence satisfies the call for “best practice” and helps to address the concerns regarding quality research in the applied social sciences.

Legislation: The Adoption and Safe Families Act (ASFA) has decreased the permanency timelines from 18 to 12 months. Moreover, states are expected to move towards the termination of parental rights for children in care 15 out of the past 22 months. Although this requirement has been challenged in several states and despite the use of exceptions, the authors of ASFA clearly intended for states to shorten the timelines associated with permanence. The shortened timelines raise at least two questions specific to ASFA and substance abusing caregivers in the child welfare system.

First, are the new permanency timelines realistic or even appropriate given the length of time it takes to achieve sobriety? Recovery from substance abuse often takes years and often includes multiple relapses. The notion of “two clocks” is commonly used to highlight the difference between the time one is permitted to achieve permanence relative to the time one needs to achieve sobriety (National Center on Addictions and Substance Abuse, 1999). The findings of the current study are important because recovery coaches decrease the amount of time it takes substance abusing parents to access treatment, and increase overall participation rates. If innovative methods can be developed that shorten the recovery clock (by reducing access delays), the ASFA guidelines and in particular the permanency timelines might appear more realistic and appropriate.

The focus of this study was on the effectiveness of the recovery coach model in child welfare. Yet, an additional finding emerged that should inform the continued development of interventions for substance abusing caregivers in the child welfare system. From the analyses presented in this final evaluation, it appears that at least two issues are limiting or obstructing the reunification process (1) co-occurring problems and (2) lack of progress within problem areas. The majority (62%) of families are dealing with at least three major problems simultaneously. Such problems include domestic violence, mental health and problems associated with housing. Moreover and perhaps of greater concern is the lack of progress being made within each problem area – including substance abuse. As rated by child welfare caseworkers only 42% of caregivers are making “substantial” or “complete” progress in substance abuse. The estimates for progress are even lower for domestic violence (24%), housing (23%) and mental health (23%). The multivariate models indicate that this lack of progress within co-occurring problem areas is significantly decreasing the likelihood of achieving family reunification.

To the extent that families are able to make progress in specific problem areas, they are more likely to achieve reunification. The overall proportion of family reunification is 14%, but of the families dealing only with a substance abuse problem, the rate increases to 21%. Further, the progress in each problem area is significantly related to reunification. What we learn from these findings, then, is that it’s not necessarily the existence of co-occurring problems, but rather the ability to make progress within these problem areas that is associated with reunification. In other words, those families showing substantial progress in each of the problem areas are more likely to be reunified.

Overall, it appears that when child welfare interventions are designed to increase assessment and access to substance abuse service, few families make complete progress on substance abuse. Even fewer make progress on problems that are not the focus of the intervention. A limitation of this final evaluation is that we do not know whether clients received or perceived that they received services addressing the co-occurring problems. This limitation derives from the fact that the information about the existence of problems and progress made is derived completely from the perspectives of the caseworker. Previous research has shown little agreement between service providers and service recipients about services delivered and received. In national studies of substance abuse treatment organizations, service provider estimates about services provided consistently exceeded clients estimates of services received (Allison, Hubbard & Rachal, 1985; Gerstein et al., 1997). It is known that when child welfare clients specify the nature of their problems and then receive services for these problems, they are much more satisfied with the services received (Smith & Marsh, 2002). A fundamental principle of social work holds that interventions will be more effective when they are responsive to the client’s definition of the problem. In the current evaluation, we have no information about the client’s perspective on the problem, on whether they received services for the problem or whether they were making progress. It is possible that providers may mis-specify the problems and under-estimate progress being made. In future evaluations, collection of data regarding co-occurring problems and related services should be collected from multiple sources.

With regard to future direction in AODA waiver demonstrations, it's also important to note that courts play a central role in determining whether families will be reunited. It is the responsibility of the child welfare worker to provide concrete evidence that the client has made progress on the problems that brought them into the system. For clients in the Illinois AODA waiver, progress needed to be demonstrated on both parenting and substance abuse. Early results from the evaluation indicated that progress in these two areas was insufficient. Clients who addressed parenting problems, completed substance abuse treatment and consistently provided evidence to the courts of being substance free frequently still did not achieve reunification. Future AODA initiatives and evaluations might consider collecting data with regard to court systems and processes. Such data might capture perceptions, attitudes and beliefs regarding substance abusing caregivers in the child welfare system – and the perceived costs and benefits associated with family reunification. Understanding the role of the courts might be best accomplished by including multiple county courts in future AODA demonstrations.

In closing, achieving family reunification for substance abusing parents in the child welfare system requires innovative and integrated treatment strategies. The Illinois AODA demonstration waiver is a model of service integration that focuses on intensive case management to link child welfare clients to substance abuse services. The final evaluation of this demonstration indicates that substance abuse services can be accessed more quickly and the likelihood of reunification can be slightly increased with the implementation of a recovery coach model. In that regard, the Illinois AODA demonstration was successful. However, as the likelihood of reunification remains low, it seems that future AODA initiatives will be greatly improved and significantly more effective if they incorporate treatment strategies specifically designed to address a range of co-occurring problems. The implication for Title IV-E Waiver Demonstrations is to recognize that program participants face numerous problems in addition to their child welfare and substance abuse problems. Substance-involved families in the child welfare system are likely to be families confronting a number of problems with very few resources. Furthermore, receiving targeted services that enable families to make progress in co-occurring problem areas – in addition to making progress on their substance abuse problems – is an important part of resolving or addressing their child welfare problems. Successful integrated-service programs must identify the range of specific problems that clients are dealing with and insure that they can address and resolve these problems in order to increase the likelihood of family reunification.

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