ORANGE COUNTY NEEDS-BASED TREATMENT INTERVENTION FOR MOTHER'S ENGAGEMENT

ON TIME

Final Report

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EXECUTIVE SUMMARY

Engaging with substance-abusing parents who are in the child welfare system so that they can enroll and complete treatment services and safely parent their children is a challenge to the child welfare system, the treatment system, and the family court systems. Over the past several years, a series of national reports have addressed the intersections of these three systems spotlighting the barriers between systems and making recommendations to improve services for children and families. In its 1999 Report to Congress, *Blending Perspectives and Building Common Ground*, the federal Department of Health and Human Services recommended five major responses to the Adoption and Safe Families Act as it affected the timetables for substance-abusing parents in the child welfare system. The ON TIME project tested three of those five recommendations: (1) building collaborative working relationships; (2) assuring timely access to comprehensive alcohol and other drug (AOD) treatment services; and (3) improving agencies' ability to engage and retain clients in care and to support ongoing recovery (DHHS, 1999).

Overview of ON TIME

The Orange County Needs-based Treatment Intervention for Mothers' Engagement (ON TIME) project was created (1) to respond to the new and faster time lines created by welfare and child welfare legislation, and (2) to test the effectiveness of outreach, intervention, engagement and re-engagement strategies using motivational interviewing techniques with women involved with the child welfare system. Outreach recovery mentors were trained to apply these techniques in an effort to increase substance abusers' motivation to enroll and complete treatment.

Intervention took place at the initial court hearing, subsequent hearings, and other places agreed upon by the client. Recovery mentors were out stationed at the dependency court each morning and were on-call to both clients and attorneys throughout the day. At each of the critical stages of the dependency court process, the recovery mentors intervened with the women to ensure that they engaged and remained in the AOD treatment process.

Research Methods

The ON TIME evaluation consists of three components: (1) assessing the implementation of ON TIME; (2) evaluating treatment outcomes relative to changes in self-reported client functioning; and, (3) comparing the substance abuse treatment engagement rates and child welfare status of the treatment group with a comparison group of women who met the criteria for the ON TIME program in the year prior to its implementation. Data have been collected at intake, during treatment, and at post-treatment follow-up. Four primary outcomes were assessed: decreased substance use, increased treatment compliance, increased family stability, and increased participation in employment activities.

The original evaluation plan called for collection of child welfare outcome data at 18 months after project initiation. However, county budget priorities in an era of fiscal cutbacks precluded this data collection from being accomplished. Electronic abstraction by CFF staff was not allowed due to county interpretations regarding confidentiality, despite other counties having protocols in place to allow such abstraction. In addition, the time commitment for CFS staff to

obtain files for CFF staff's data abstraction was decided to not be feasible since abstraction would have to be done by hand. Although CFF and Orangewood offered to pay overtime to a CFS staff member to download the required reports for CFF's data abstraction, the decision was not timely and the strategy was not feasible in concert with data analyses already underway. However, CFS staff did create a special report of some outcome variables related to case closures and child placements. The limitation of not having the full records for comparative purposes between groups and over the length of the study is a major limitation to data interpretation and project conclusions. However, the two groups' records were electronically marked with a special project code in the data system so the county has the capacity to assess longer-term outcomes regarding child safety and permanency in the future.

Major Findings

Organized by the five major research questions set forth in section 3, the major findings are:

Program Implementation

1. Can an effective system to conduct outreach and intervention services to engage substance-abusing mothers whose children have been placed in protective custody be developed and implemented across Orange County's public and private systems?

    a. *Finding 1*: The program was implemented and achieved positive outcomes for more than two hundred substance-abusing mothers in the child welfare system.
    b. *Finding 2*: As implemented, the program achieved several forms of closer collaboration among the major parties at the child welfare-treatment-family court intersection. Yet numerous barriers to further cooperation were encountered and proved resistant. Highly positive responses from defense attorneys were one major breakthrough.
    c. *Finding 3*: ON TIME was one of few AOD innovations that provided training for paraprofessional level staff in the motivational interviewing process. These women went through the rigorous training, implemented the program strategies, and used motivational interviewing techniques with over 238 women over a 22-month period, demonstrating the viability of using such staff in this role. A training manual was developed and is available to other jurisdictions.
    d. *Finding 4*: The demonstration program has not as of late 2002 been sustained with institutionalized funding, due in part to the local effects of the state budget crises and in part to a lack of substantial support from local stakeholders.

2. Do ON TIME intervention and engagement services increase the likelihood that the child welfare-involved mother is linked to substance abuse treatment services and engages in substance abuse treatment?

    a. *Finding 5*: Assessment of the engagement effort and the role of the recovery mentors suggests that better treatment engagement and retention results were achieved for the ON TIME group than for a comparison group.

Treatment Outcomes

3. Does implementation of ON TIME result in improvements in meeting the substance abuse treatment needs of the target population?

    a. *Finding 6*: Treatment outcomes for the ON TIME target group were significantly favorable compared to those of the comparison group for toxicology screens and retention in treatment at six months into the study.

Comparison Group on Family-Related Outcomes

4. Does providing ON TIME services result in successful treatment completion, decreased substance use, and increased family and employment-related outcomes?

    a. *Finding 7*: The ON TIME group used fewer substances at nine months than at three months into the study. Findings related to the comparison group are unavailable due to data collection restraints and case records unavailable to CFF.
    b. *Finding 8*: The comparison group achieved more positive family-related outcomes during the period assessed, largely as an artifact of their being in the child welfare system longer than the ON TIME group; this finding is not yet conclusive and requires further assessment of the ON TIME clients, which can be achieved through special coding already in place in the child welfare information system.
    c. *Finding 9*: Employment rates increased for the ON TIME sample when comparing the 3 and 9-month follow-up interviews. Findings related to the comparison group are unavailable as CFF was not able to review client charts.

Summary

In the areas targeted for change, considerable progress was made. Although it was not possible to collect some of the key data on child welfare outcomes, the project demonstrated important results that promise improvements in the areas where client engagement approaches were expected to be productive, notably successful training and implementation of the program, clients' engagement with treatment, treatment outcomes, and suggestive but not yet conclusive findings on family-related outcomes.

CHAPTER I. INTRODUCTION

This chapter discusses the background of the Orange County Needs-based Intervention for Mother's Engagement (ON TIME) project. This chapter also details the planning and development process, and provides a brief project description. The following chapter provides a recent review of the literature on substance abuse, women's treatment, and child welfare and concludes with a discussion of the need for collaboration between these systems. Chapter III presents the study evaluation design and methodology, describes the target population, and includes the data collection instruments. Chapter IV provides a discussion the process evaluation and documentation, describes the planning and implementation of the ON TIME project, including barriers to the study effort and lessons learned. The client treatment outcomes and services effectiveness results are presented in Chapter V. Chapter VI presents the comparison group data on family-related outcomes and a case study is provided in Chapter VII. Chapter VIII addresses GPRA reporting requirements and Chapter IX provides a summary discussion of the ON TIME project.

Project Planning and Development

There is a critical need for more effective collaboration among social service systems. These systems include: (1) child welfare system, responsible for the investigation and intervention of child abuse and neglect; (2) the substance abuse treatment system, responsible for providing alcohol and drug treatment for families; and (3) the public welfare system, responsible for providing income assistance for needy families. Often the same families must interface with each of these systems, leading to fragmented services and conflicting requirements. The Adoption and Safe Families Act of 1997 (ASFA) places increased time constraints on families in the child welfare system, giving parents 12 months to prove that they are suitable caretakers or risk losing parental rights. Since the passing of the Personal Responsibility and Work Opportunity Act of 1996, parents in the TANF system have a maximum of 60 months to find a job, maintain employment and become self-sufficient. When the parent is also involved in the use or abuse of alcohol or illicit drugs, the ability to parent and maintain employment may be affected by a third set of timetables, since substance abuse recovery focuses on "one day at a time for the rest of your life." Each of these "clocks" operates independently, while a fourth one—the child development clock—continues to affect the lives of children in these systems.

Children and Family Futures (CFF) staff began to work in the intersection of substance abuse and child welfare in the mid-1990's, providing technical assistance, consultation and evaluation to public and private agencies. During this same period, the new federal and state legislation was being implemented that would impact families involved in both the child welfare system as well as the welfare system. It was also becoming increasingly evident that a sizable number of children in the foster care system often remained in out-of-home care for an extended amount of time. The average length of stay in out-of-home care increased each year from 1990 to 1999, with 3,883 children in out-of-home care in the 1998-1999 fiscal year (Orange County Health Care Agency, 2002).

The genesis of ON TIME's program development was based on the release of a report funded by the County of Orange Health Care Agency on the types of prevention, intervention and treatment

programs available for families in children's agencies. The report was developed by the Orangewood Children's Foundation (OCF) and the California Women's Commission on Alcohol and Drug Dependency (CWCADD). In 1997-1998, OCF and CWCADD conducted a series of interviews and focus groups with Orange County civic leaders, county staff, alcohol and drug (AOD) treatment and prevention professionals, and peer leaders. The interviews focused on current knowledge and efforts to address the AOD prevention and treatment needs among children and families served by the child welfare system and its network of community-based providers (CWCADD, 1998). The report found that there were few prevention-related activities targeting children in the child welfare agencies and few primary prevention programs operating within civic organizations. In response to these findings, CWCADD began a series of prevention training activities targeted to community-based organizations including group homes serving Orange County's foster children and various women's civic organizations.

In the fall of 1998, CFF began a series of collaborative meetings between the various stakeholders in Orange County (OC). The stakeholders involved in these planning meetings included women in recovery from AOD dependence, OCF (the applicant), and the Orange County Behavioral Health Department, including the Director of Behavioral Health and the Deputy Director of Alcohol and Drug Services. The Directors of Children and Family Services and Family Self Sufficiency, the two relevant divisions within the Department of Social Services, were also active participants in the planning and development of the proposal. There were two county-level oversight committees involved in the planning of the ON TIME project: The Children's Coordinating Council, which oversees the county's planning efforts for services affecting children and families, and the County's Alcohol and Drug Advisory Board, which includes members appointed by the Board of Supervisors, and is responsible for providing oversight and coordination of Alcohol and Drug Services. In addition, a diverse group of clients and women in recovery from Heritage House (the county's only residential program for women and their children) and women from La Familia (the county's largest provider of AOD services to Latinas) were convened to solicit their views on program development. The joint meetings between the stakeholders focused on results of the OCF/CWCADD project and explored ways to move forward in addressing the treatment and prevention needs among the county's child welfare population.

An ON TIME steering committee was created in the spring of 1999 which included members from each of the various stakeholder groups. The initial activities included planning, reviewing and authorizing the grant proposal. Shortly after the grant award notice in the fall of 1999, the steering committee was expanded and had the primary responsibility of monitoring implementation of the project and to ensure that issues of gender and culture were addressed both in the implementation of the program and in interpretation of the data. Of particular importance was the assistance the steering committee provided in reviewing the progress of the ON TIME project on a regular monthly basis and making recommendations to county stakeholders on results achieved.

Project Description

The Orange County Needs-based Intervention for Mother's Engagement (ON TIME) project was created to respond to the new and faster time lines created by welfare and child welfare

legislation, and to test the effectiveness of outreach, intervention, engagement and re-engagement strategies using motivational interviewing techniques with women involved with the child welfare system.

There are specific timelines in child welfare services that are enforced through the court system, which offer several opportunities to intervene with a mother who is entering the child welfare system. In an effort to help these women meet the timelines of the various systems, ON TIME utilized four "recovery mentors" who had experiential knowledge of AOD recovery and were hired by Southern California Alcohol and Drug Programs (SCADP) from the communities served by child welfare services. One of the recovery mentors was bilingual in Spanish and bicultural. All of the mentors were trained to provide motivational interviewing techniques that are based on stages of change in the recovery process. These techniques have been shown to be effective in other populations to increase substance abusers' motivation to change (Miller, 1999).

At each of these critical child welfare time points, ON TIME recovery mentors made contact with clients and utilized motivational techniques and their familiarity with clients' lives to ensure that the client engaged and remained engaged in the AOD treatment process. The client representatives in the planning process described these recovery mentors as "reverse sponsors" (someone who consistently calls the client instead of the client calling the sponsor). The recovering women participating in program development determined that the recovery mentors' primary roles were to offer hope of recovery to the substance-dependent mother, be a role model of a clean and sober lifestyle, be a guide through the dependency court system, be a support system to the mother, and continue to reach out with the message of recovery—even when the mother might not be ready or willing to engage in a formal treatment program.

The recovery mentor served in a formalized support role as the women transitioned from the court system, through AOD treatment, resumed their parenting responsibilities, and participated in vocational services on their way to becoming employed and economically self sufficient. A procedure was established for contacting the recovery mentor if the client dropped out of treatment or missed an appointment. If dropout occurred, the recovery mentor re-engaged the woman through phone contact, visiting at her home, through informal neighborhood networks, at her court appearances, or by coordinating with the social worker to make contact during visits with her children (when appropriate). The primary goal of these contacts was to use stages of change and motivational techniques to re-engage clients with the AOD treatment system.

The ON TIME intervention took place at the initial court hearing, subsequent hearings, or any place that is safe and agreed upon by the client. The recovery mentors were stationed at the dependency court each morning and were on-call to both clients and attorneys throughout the day. At each of the critical stages of the dependency court process, the recovery mentors would intervene with the women and ensure that they engaged with and remained in the AOD treatment process. The recovery mentors provided referrals, immediate linkages to treatment providers, and arrange for transportation if necessary. Below is a listing of three possible intervention points.

ON TIME intervention #1. The first contact that a family has with child welfare services is generally with an Emergency Response (ER) social worker who must quickly assess the

potential risk to the child of child abuse and/or neglect (CA/N). If the child is put in protective custody, a court hearing called the Detention Hearing is held within 72 hours to determine if the child will be detained. At this time, if a mother has an AOD problem or if AOD abuse is identified as part of the abuse allegations, the mother's attorney referred the client to ON TIME. The recovery mentor was then available at the hearing for immediate intervention.

ON TIME intervention #2. The Disposition Hearing is held at approximately 3 weeks after the Detention Hearing. The Social Worker presents evidence on the allegations and the court rules to "substantiate" or "fail to substantiate" the allegations of CA/N. The court determines if the child is to remain in court-ordered protective custody or is to be returned to the parent's custody. During the investigation phase leading up to the Disposition Hearing, the recovery mentors made contact with the mother and assisted the mother in determining her "readiness to change" using tools developed by a Los Angeles-based women's treatment agency. The recovery mentor would ensure that linkage to a gender- and culturally appropriate AOD treatment provider was made that an AOD assessment was conducted. The assessment and treatment linkage was based on the ASI and Cal-ASAM.

ON TIME intervention #3. If treatment engagement was successful, the mother would enter AOD treatment before the Disposition Hearing. If treatment engagement was not successful by the Disposition Hearing date, the recovery mentors continued to make outreach and engagement efforts with the mother. If in the period between the Disposition Hearing and the 6-month Court Review, sufficient progress was made in the client's family reunification (FR) case plan, the court could order that the child be returned to the parent's custody. During the six months of FR, the recovery mentors worked with AOD treatment providers and child welfare workers to ensure that the mother remained in treatment. If resolution of the child's custody was not made at the 6-month hearing, there was another case review by the court 12 months after child custody placement. Under the ASFA legislation of 1997, every child must have a permanent plan for his/her care by the 12-month court hearing. Successful ON TIME linkages helped to ensure that the 12-month permanency hearing included reunification with the child's family.

The research component attached to the ON TIME project allowed for comparison of ON TIME recruited clients to a sample of women who would have been eligible for the project 6-8 months prior to project start-up. The groups were matched on the risk score regarding substance use from the Structured Decisions Making strength and risk assessment. There were no significant differences between the groups on risks to children from the parents' substance disorder. Clients were initially assessed using the Addiction Severity Index (ASI) and the California Implementation of American Society of Addiction Medicine Patient Placement Criteria (Cal-ASAM). In addition, they were assessed at several stages of the dependency court system on their readiness to change, level of care needed for substance abuse treatment, satisfaction with treatment and changes in severity of their alcohol and other drug-related consequences (see Chapter III for a description of the instruments). UCLA's Drug Abuse Research Center (DARC) conducted follow-up interviews with the clients at 3 and 9-months post intake.

There were 6 steps that were followed, from client identification to problem resolution, throughout the implementation of the project:

1. Client identification—ON TIME staff identifies eligible clients;
2. Court- and neighborhood-based interventions—ON TIME recovery mentors intervene with clients beginning in the ER phase of child welfare services;
3. Linkages to AOD treatment providers—ON TIME recovery mentors provide linkage to AOD providers by using motivational interviewing and stages of change techniques;
4. Re-engagement techniques—in the event that a woman leaves treatment, ON TIME recovery mentors utilize re-engagement techniques to re-motivate clients in the change process;
5. Data collection activities—ON TIME recovery mentors submit stages of change assessment tools to the evaluation team; DARC conducts telephone follow-up interviews; the evaluation team pays specific attention to issues of client confidentiality, gender and culture;
6. Problem resolution—the Steering Committee, in coordination with the Project Director, meets on a regular basis to discuss issues related to program implementation, resolve any issues that arise, and provide interpretation of evaluation findings.

Summary

The ON TIME project was developed to respond to the new and faster timelines of the Adoption and Safe Families Act and the Temporary Assistance for Needy Families program. After the Orangewood Foundation and the California Women's Commission on Alcohol and Drug Dependency released a report which indicated a gap in services for families in the child welfare system, Children and Family Futures convened a group of various stakeholders to plan, review and authorize a proposal to the Center for Substance Abuse Treatment. The outcome of this proposal and the award of the grant led to a steering committee being developed to plan and implement the ON TIME project.

The project was centered on the four outreach recovery mentors and the services that they would provide to the women involved in the child welfare system who had substance abuse issues. The outreach efforts tracked the timelines of the dependency court and children's services agencies, with immediate intervention focusing on engagement into treatment. The research component of the project ensured that the mentors were providing research-based best practices such as utilizing the Addiction Severity Index, American Society of Addiction Medicine's Patient Placement Criteria and a measure of motivation to change. The use of the mentors as paraprofessionals to support substance-involved women led to the successful implementation of the ON TIME project.

CHAPTER II. LITERATURE REVIEW

Introduction

Parents abuse alcohol and other drugs at lower rates than do adults without children; yet, 11 percent of U.S. children (8.3 million) live with at least one parent who is either alcoholic or in need of treatment for the abuse of illicit drugs. A small subset of those children comes to the attention of child welfare services each year. Children who are victims of child abuse and/or neglect (CA/N) and have parents who have substance use disorders, have been found to be younger, are more likely to be the victims of severe and chronic neglect, and are more likely to from families with more severe problems than other children in the child welfare system (CW). Once in foster care, children whose parents have substance use disorders tend to remain in care for longer periods of time than other children and are more likely to be placed in foster care rather than being served while remaining at home. Recent studies have documented that children from drug-abusing households were reunified with their parents at only half the rate of children from non-drug-abusing households. The consequence for the child with these family issues can be severe and life-long (U. S. Department of Health and Human Services [DHHS], 1999).

Child Welfare-Involved Families and the Need for AOD Treatment

In the late 1980s, there was a sharp increase in reported cases of CA/N. Some attributed this increase to be associated with the crack cocaine epidemic and the abuse of other drugs, particularly alcohol (Besharov, 1994; Center on Addiction and Substance Abuse [CASA], 1999 Young, 1997a). The 1999 DHHS report to Congress on the issue stated that "most studies find that for between one third and two-thirds of children involved with the child welfare system, parental substance abuse is a contributing factor. Lower figures tend to involve child abuse reports and higher findings most often refer to foster care" (DHHS, 1999).

To date, there are no published state- or national-level studies using a representative sample and sound methodologies of families in the CW system on the extent of AOD problems among parents in the CW population. Several estimates have been made among limited samples (General Accounting Office [GAO], 1991; Magura, Lauder, Krange, & Whitney, 1998), non-randomly selected CW cases (Young, 1997c; Young, Gardner, & Dennis, 1998), historical case reviews (GAO, 1998), or by asking child welfare workers and administrators to estimate the extent of the problem (CASA, 1999; Child Welfare League of America, 1997). These smaller-scale and non-representative studies consistently yield a range of 60% to 80% of CW cases that have significant AOD-related problems as factors in the CA/N allegations (Young et al., 1998). Recent studies have also documented that children from drug-abusing households are reunified with their parents at only half the rate of children from non-drug-abusing households and that the children of substance abusers stay in foster care considerably longer than children whose parents did not abuse drugs (Besharov & Baehler, 1994).

The "Four Clocks"

Numerous sources have described the impact of the passage of the Adoption and Safe Families Act (ASFA) in 1997 and welfare reform (Temporary Assistance to Needy Families [TANF]) in

1996 on substance-abusing parents and their children. Children and Family Futures (CFF) describes the contradictory effects as the "speeding up" of mandates in terms of significant "clocks" that operate in the lives of families affected by substance use disorders and CA/N (Young et al., 1998). CFF developed the metaphor of the *four clocks* to describe the faster timelines under ASFA and TANF—the first two clocks—and contrasted them with a third clock of substance abuse recovery which, particularly in early sobriety, focuses on "one day at a time for the rest of your life." These three clocks operate in isolation from the last clock and the most important one for children—the stages of child development affecting children despite these legislative mandates and parents' recovery status. In part, these conflicting time frames form a basis of understanding of efforts that are underway across the country to more adequately respond to the problem of substance use disorders among families involved in the child welfare system.

Complicating the child welfare and substance abuse linkage issue is the cyclical nature of substance use disorders that becomes evident when the parent seeking treatment may improve and then relapse. He or she may enter and exit treatment several times while the child continues to develop (McAlpine, Marshall, & Doran, 2001). "Substance abuse can impair a parent's judgment and priorities, rendering the parent unable to provide the consistent care, supervision, and guidance children need" (DHHS, 1999). This situation is further exacerbated by the gap between treatment need and treatment service availability. Data from 1997 indicate that fewer than half of substance-abusing parents living with children under 18 years of age received treatment for their substance abuse problems (DHHS, 1999).

The treatment gap and characteristics of each of the systems involved in this issue adds further complexity (Substance Abuse and Mental Health Services Administration [SAMHSA], 2000b). Child welfare services are responsible for ensuring that children are safe in permanent homes and that parents are afforded reasonable efforts to reunify, including substance abuse treatment services. Family courts[1] are responsible for ensuring the protection of individual's rights and for enforcing compliance with the intent and timelines of the child welfare laws. While treatment providers are not mandated to participate in this process, these agencies, particularly those serving women, are critical partners in ensuring that children are safe and parents enter recovery. Yet achieving a common effort among all three of these systems (child welfare, treatment and the courts) demands extraordinary efforts due, in part, to the mandates, training, values, and methods of the three systems that are often quite different. The need for inter-agency collaboration is crucial and unavoidable (Young et al., 1998).

Preparing the substance-involved parent to re-assume responsibility for his/her child, within the very limited time period allotted by ASFA and TANF, has required new partnerships and approaches to meet these families' needs. A variety of approaches have been attempted by CW and AOD agencies in states and communities throughout the nation, in cooperation with family courts in some cases. In general, these approaches are creating new staffing patterns and linkages among the staff from different agencies. A review of seven of these model projects by Children and Family Futures (CFF) was published by the SAMHSA (Young & Gardner, 2002).

[1] We refer to Family Courts as the judicial system responsible for ensuring the legal rights of individuals and protection of children named in court petitions involving allegations of child abuse/neglect and specifies protective custody issues. Many jurisdictions also refer to these courts as Juvenile or Dependency Courts.

Prior to this document, from 1998 to 2000, five major national reports on alcohol and other drug problems in child welfare were published. These reports focused on the practice and system-level barriers between the systems and clinical practice changes that needed to be made.

The first of the national reports, *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy*, was authored by CFF staff and published by the Child Welfare League of America (CWLA) (Young et al., 1998). This publication included four new contributions to the field:

- It identified differences in values across systems and provided a mechanism to reach common principles though a collaborative values inventory;
- It provided the first framework for categorizing child welfare-substance abuse issues that needed a systemic approach across systems;
- It provided the first categorization of practice models then being piloted in sites across the country in the mid-1990s; and,
- It developed the metaphor of "the four clocks," since used widely to specify the different schedules and underlying assumptions used in the child welfare, welfare, substance abuse, and child development fields as they affect the lives of children and their parents.

ASFA is not the only legislation implemented at the state and local level that is affected by substance abuse in families. Substance abuse is pervasive in its impact on children and families, and it co-occurs with, and is affected by, several other problems and programs. For example, the systems involved in addressing domestic violence, mental health, early childhood development and childcare, education, and juvenile justice are all impacted by substance use and have an unavoidable, intricate connection with these families. An over-emphasis upon child welfare-treatment agency relations as the bilateral relationship ignores two kinds of complexities in the real worlds of families and the communities they live in—the complexity of clients' lives and the complexity of the categorical systems constructed to respond to families' needs.

Family and Community Dynamics

Substance abuse can be regarded as a disorder that can be transmitted both genetically, and by the community and family environment. The legal and illegal use of AOD can affect children through a number of avenues, which include but are not limited to prenatal exposure *in utero*. This has very powerful policy implications, including its message that prenatal drug exposure, while very important in its effects on children, *is only one of the several ways that children can be affected by alcohol and other drugs.* Children are also exposed to AOD through their parents' and caretakers' use, abuse, or dependency, through commercial media messages advertising alcohol and tobacco, and community norms and regulations regarding AOD use. The legality of the substance, as well as the way in which children are exposed to its use, plays a significant role in its effect on the child, with more emphasis often given to illicit drugs than to the harmful effects of tobacco and alcohol (Young et al., 1998).

Both prenatal *and* postnatal exposure to alcohol, tobacco, and other drugs can affect children in lasting ways, resulting in severely impacted individuals: children who fail to form secure

attachments to their caregivers because of their parents' inability to give them sustained attention; children who come home from school to a home where violence and substance abuse are frequent; children who grow up in neighborhoods where there are ten times as many liquor outlets and ads as in the rest of the community; adolescents who receive daily messages that to use alcohol and tobacco is to be surrounded by attractive people having fun. All of the effects of AOD exposure in the settings of family and community can have severe consequences for the child (Young, Gardner & Dennis, 1998). Perhaps the most critical of those effects is when the child is also a victim of child abuse and/or neglect (Children of Alcoholics Foundation [COAF], 1996).

The Link between Substance Abuse and Family Violence

Substance abuse and aggressive behavior often co-exist (Levy & Brekke, 1990). Batterers are reported to be three times more likely than non-batterers to be alcohol abusers (Harner, 1987). While the exact relationship between violence and addiction is not clearly understood, the fact that they are correlated is not in dispute. Parents, particularly mothers, with substance use disorders were often themselves the victims of childhood abuse and/or neglect (Howard, 2000). Studies have demonstrated that adults with childhood histories of abuse or neglect are at greater risk for repeating this cycle of dysfunctional behavior than adults without these histories (DHHS, 1999). Physical and sexual abuse, domestic violence, and other forms of trauma, physical and mental health issues, coupled with multi-generational family dysfunction are all frequently occurring issues among parents who have abused or neglected their own children (Howard, 2000). Although reports vary, many drug-dependent women report incest and molestation as children (19% to 55%) prior to their substance abuse (Langan & Pelissier, 2001; Messina, Burdon, & Prendergast, in press). Many have argued that the trauma that results from such abuse is a key contributor to women's chronic AOD abuse (Greene, Haney, & Hurtado, 2000; Henderson, 1998; Stevens & Glider, 1994; Wolf-Harlow, 1999), and that the severity of substance abuse and early victimization are stronger predictors of criminal activity for women than for men (McClellan, Farabee, & Couch, 1997). Coles (1995) states, "these problems probably contribute to the development of addiction and interfere with recovery." This issue of "which came first" reinforces the need for comprehensive family-centered responses to substance use disorders and child abuse/neglect including a focus on a continuum of prevention, intervention and treatment.

In addition, the impact of stress, divorce, illegal activity in the house, the lack of positive parenting models for numerous generations, and the possibility that children have a temperament that makes them more difficult to parent resulting from their parents' addiction all combine to make the mixture of violence and addiction more likely and more harmful for the children caught up in that circumstance (COAF, 1996).

The special circumstances of children in families characterized by both violence and addiction should be emphasized, since these are cases that present unusual dangers to women and children. In a 1995 forum, the problem of "twice at risk" children—those exposed to parental addiction and family violence—was examined in depth (COAF, 1996).

Some may be cautious in cautious in linking substance abuse treatment and child welfare, instead focusing solely on AOD treatment and ignoring related disorders. This may mean neglecting equally important conditions that require more than AOD treatment. Whether one believes that family violence and trauma and violence prevention initiatives are newly relabeled concerns which have been on society's agenda for a long time, or new ways of seeing and working on important problems, it is unquestionable that the links between violence and addiction are substantial ones and that treating either of these family conditions without taking the other into account is a hopelessly narrow effort (Conner & Ackerly, 1994).

Poverty

Research also suggests a linkage among child welfare, substance abuse, and poverty. When poverty exists, it is more likely that child welfare and substance abuse problems also exist. For example, compared to children of families that earn $30,000 or more per year, children of families earning less than $15,000 per year were 10 times or more likely to experience some form of maltreatment, to be harmed by some variety of abuse, to be neglected, to be a victim of physical abuse, to be sexually abused, to die from maltreatment, and to be emotionally and educationally neglected (DHHS, 1996). These differences were more pronounced in children of single-parent families than those living with both parents.

Data from the 1994-95 National Household Survey on Drug Abuse suggests that, compared with parents with no drug use problems, parents with drug use problems had less education, were less likely to be employed full-time, more likely to be unemployed, less likely to be married, and more likely to have a family member who participated in welfare programs (DHHS, 1999). These differences were more pronounced among women than men.

Taken together, these findings suggest that poverty is a common factor that enhances children's risk for poorer physical, social, emotional, and educational well-being and families' involvement with substance abuse. To the extent that these factors related to poverty are accounted for and ameliorated, CW, family courts, and AOD agencies, can help in breaking the inter-generational cycle of child abuse, neglect, and substance use disorders.

Stigma

Stigma is an important factor to be addressed when working with substance abusing parents in the child welfare system. They are affected by negative stereotypes in regard to both issues: substance use and being perceived as neglectful parents. The perceived and observed negative response of others toward individuals with substance use disorders, particularly those who have abused or neglected their children, is a barrier to seeking services. Sources of societal stigma vary, but often stigma is rooted in a belief that substance use disorders are a moral weakness rather than a medical condition and public health issue. Persons seeking substance abuse services often suffer from other societal stigmas—race/ethnicity, gender, sexual orientation, and/or mental illness (SAMHSA, 2000a). Changing attitudes towards persons with substance use disorders begins with an understanding of the differences between the medical condition of addiction and associated negative behaviors.

To facilitate a supportive/positive social environment, SAMHSA (2000a) recommended that actions be taken to increase public awareness of substance abuse problems, communicate the benefits of drug treatment, and provide encouragement to those who are actively in treatment or recovery. Reducing social stigma associated with participation in CW and substance abuse services may result in greater motivation for families to seek help and/or continue their involvement in these services, thereby enhancing the likelihood of positive family outcomes and reducing negative outcomes.

Substance Abuse Treatment Issues

Theoretical Framework

Rogers (1959) asserted that three critical elements were necessary in a therapist's role to establish an atmosphere for client change: accurate empathy, non-possessive warmth, and genuineness. Research subsequent to Rogers' work has supported that these elements are important conditions to establish an effective therapeutic relationship and to promote recovery from addictive behaviors (Luborsky et al, 1985; Miller et al., 1980; Valle, 1981). The Prochaska & DiClemente (1982) model describes the series of changes that a person must pass through in order to change or resolve a problem. The stages delineated are (1) pre-contemplation, (2) contemplation; (3) determination; (4) action; (5) maintenance; and (6) relapse (Prochaska & DiClemente, 1982). They suggest that change can be visualized as a circle with segments of the circle representing stages in the change process, and they use Rogers' concepts to develop techniques of motivational interviewing to assist people in changing behaviors.

Miller and Rollnick (1991) further developed these stages into therapeutic techniques based on motivational interviewing. The techniques are used to help people recognize and respond to current or potential problems that need a significant behavioral change. Responsibility for change is placed with the individual, while the therapist uses persuasive language rather than coercive action or threats. The therapist plays a supportive role using emphatic and non-confrontational approaches that focus on client choices. Measurement of these techniques and stages of change have been used in predicting behavior change related to HIV risks (e.g., Anderson et al., 1996). Little work has been published on the use of the stages of change model in linking clients to AOD treatment. Research related to the inclusion of these aspects in treatment planning has found that matching of treatment intervention to the client's stage of change was beneficial in some situations (Farabee et al., 1995; Saunders, Wilkinson & Allsop, 1991). The following logic model shows the major independent variables which are the ON TIME outreach and, if necessary, re-engagement services resulting in successful treatment participation, completion, family reunification, and longer-term family/economic stability.

MAJOR INDEPENDENT VARIABLES		**MAJOR DEPENDENT VARIABLES**		
ON TIME outreach & Intervention with Mothers based on Stages of Change and Motivational Techniques	Engagement and Re-engagement in AOD Services	Successful Treatment Completion	Family Reunification and Employment	Family Stability and Economic Self Sufficiency

Outreach for Engagement in AOD Treatment

Outreach efforts to assist in client engagement in treatment are rarely done in practice. Typically, AOD treatment agencies, particularly in large states such as California, have extensive wait lists to enter treatment. However, when outreach has been conducted, demonstrations and targeted outreach efforts have been shown to be effective (Zanis, McLellan, Alterman, & Cnaan, 1996) and are cost effective, with cost offsets achieved primarily in criminal justice and health care costs (Pinkerton, Holtgrave, DiFranceisco, Stevenson, & Kelly, 1998; Wright-DeAguerro, Gorsky, & Seeman, 1996). Peer outreach (specifically, the indigenous leader model) has been shown to reduce HIV risk among substance abusers (Booth & Weibel, 1992) and to link at-risk women to care (Brown & Weissman, 1993; Weissman & Brown, 1995, 1996). Use of culturally based natural support systems has also been shown to affect outcomes (Quinlan, 1995).

Outreach involves assessing a clients' motivation to change their behavior. Developing motivation to change has been conceptualized as a series of stages through which people progress as they think about making changes (Prochaska & DiClemente, 1984). Change occurs in steps or stages: "people…must move from being unaware or unwilling to do anything about the problem to considering a possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time" (DiClemente, 1991).

Cultural Issues across the Systems

An institutional barrier that must be addressed is the disproportional representation of families of color in the child welfare system and the diversity of families served by these programs. Diversity encompasses differences in age, race/ethnicity, gender, national origin, physical and mental ability, emotional ability, religion, language, sexual orientation, and socioeconomic background among other characteristics (Hall, 1997). Besharov and Baehler (1994) found that the adoption rate for African American children of substance abusers was approximately 9%.

The underlying premise of the cultural congruency hypothesis is that culture and ethnic differences among clients can lead to differences in client needs, service utilization, and treatment outcomes. Cultural competence has been defined as "a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups." This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports (Orlandi, 1992).

Gender issues among Substance Abusing Mothers

While both fathers and mothers are involved in the child welfare system, the connections between protective services and treatment present critical issues for women, since female-headed families are disproportionately included in both child welfare and TANF populations. Research specifically examining the treatment needs of AOD-dependent mothers involved in CW is limited, but the existing research on women's treatment has depicted a population with special

problems and needs. Recent studies have found that women entering treatment programs are at a substantial disadvantage compared with their male counterparts and were more likely than men to present greater challenges to treatment practitioners (Henderson, 1998; Langan & Pelissier, 2001; Messina et al., in press; Prendergast, Wellisch, & Falkin, 1995). In addition, substance abusing women often have problems that cut across several social service systems: mental health (dual diagnosis; history of sexual and/or physical abuse); child welfare (women who have prenatally exposed their children to substances); and criminal justice (violence). However, research suggests that for some of these areas, women may be more vulnerable and have poorer outcomes than men when they have substance abuse problems.

For example, women have been found to respond to and metabolize substances differently than men and potentially become dependent on drugs more rapidly than men (National Institute on Drug Abuse [NIDA], 1999b). Substance abuse treatment programs need to be cognizant of these differential responses and differential needs in the recovery process. This requires providing programs for women that are specifically designed to recognize and respond to their unique needs. Of critical importance is the recognition that a woman's role in society as a wife, caregiver, and mother create specific issues such as shame, guilt, and lack of esteem that must be addressed in the treatment milieu. An understanding of the sexuality, parenting, and cultural issues of women has been documented to be a vital part of the treatment process.

In addition, women who are alcohol or drug-dependent often have issues such as social isolation, low self-esteem, loneliness, posttraumatic stress disorder and depression (Center for Substance Abuse Treatment [CSAT], 1994; Corrigan, 1980). In addition, women are more often diagnosed with co-occurring psychiatric and substance abuse disorders than men (Clark, 2001; Henderson, 1998). It is estimated that 1 in 12 women over the age of 18 may be diagnosed with serious mental illness in any given year, compared to 1 in 20 men (Carmen, 1994; Helzer & Pryzbeck, 1988). Among a sample of those with alcohol abuse or dependence disorders, 65% of women compared with 46% of men had a second mental health diagnosis (Anthony & Helzer, 1991). In women with a primary diagnosis of mental illness, 31% (compared with 19% of men) had a second diagnosis of drug abuse or dependence.

Women who have been diagnosed with two disorders are more likely than men to be diagnosed with a third problem—physical and sexual abuse (Zweben, Clark, & Smith, 1994). Additionally, higher levels of alcohol problems are found in women with histories of abuse (Amaro, Fried, Cabrad, & Zuckerman, 1990; Covington & Kohen, 1984; Hein & Scheier 1996; Rohsenow, Corbett, & Devine, 1988; Swett, Cohen, Surrey, Compaine, & Chavez, 1991). Co-occurring disorders in women with histories of trauma are associated with high rates of posttraumatic stress disorder (PTSD) (Fullilove et al., 1993). In a study that examined the relationship between PTSD and substance abuse, Cottler and colleagues (1992) found that female gender and cocaine or opiate use were the strongest predictors of both exposure to a traumatic stressor and the subsequent development of PTSD. AOD-dependent women who enter treatment also often come from highly dysfunctional families, with histories of mental illness, suicide, violence, and substance abuse (Langan & Pelissier, 2001). As a result, mothers with substance use disorders have an increased likelihood of requiring multiple services including psychological and trauma services.

Women's patterns of substance abuse are also more closely linked to their opposite sex relationships than they are for men (Covington & Surrey, 1997; Henderson, 1998; Langan & Pelissier, 2001). Women tend to define themselves and their self-worth in terms of their relationships, and relapse to drug use is often related to ongoing and/or failed relationships (Covington & Surrey, 1997; Stevens & Glider, 1994). In addition, a high percentage of drug-dependent women report physical or sexual abuse by husbands or boyfriends (Brown, Sanchez, Zweben, & Aly, 1996), and partner opposition to recovery can include elements of intimidation, threats, and violence (Amaro & Hardy-Fanta, 1995). To break the cycle of abuse, AOD-dependent women need to develop strong interpersonal skills that will help them deal with past abuse while learning appropriate skills for coping with future relationship issues.

These issues point to the need for a comprehensive diagnostic assessment of mothers at intake as a means of informing CW and treatment staff of their diverse psychological needs. Sensitivity to these types of issues is necessary for women to form trusting relationships with treatment staff. It is important to both support women and give messages of empowerment to assist them in learning how to deal with life issues, and to modify how they perceive themselves and their relationships (Finkelstein, 1996). Substance abuse treatment programs serving pregnant and parenting women that address these multiple needs have found significant improvements in the pre- and post-treatment ratings of overall well being. A study of 50 programs for pregnant and parenting women found that 38% of women were employed 6 months following treatment, compared to 7% before treatment. There was also less involvement with child protective services post-treatment, and 60% of the clients reported being alcohol and drug-free 6 months post-treatment (CSAT, 2001).

Gender- and culture-congruent interventions play a potentially critical role among women with AOD-related problems. Some program providers also believe that an all female counseling staff is the best practice for women participating in treatment. Gender-specific staff can promote a strong therapeutic alliance and provide strong female role models, supportive peer networks, and attention to women's patterns of abuse from childhood to adulthood (Grella, Polinsky, Hser, & Perry, 1999). The largest demonstration project specific to the AOD-CW population found that many clients denied AOD-related problems, were resistant to services, thought that a sober lifestyle was frightening, and were distrustful of the formal service systems (LTG Associates, 1995). They found that, to be effective in working with a diverse clientele, treatment staff need to have several traits: sensitivity; patience and ability to be non-judgmental; respect for clients; creativity; flexibility; and, perseverance. Staffs need to have adequate experience in working with multi-problem families and be able to provide culturally and linguistically competent services. These include appropriate and effective methods of assessment and approaches that are grounded within the families' cultural framework (LTG Associates, 1995).

A consistent indicator of successful substance abuse treatment outcomes is the length of time the patient stays in care. Although appropriate duration depends on the individual's specific characteristics, for most patients, the threshold for any significant improvement is reached only at three months in treatment (NIDA, 1999a).

Issues of Collaboration

Despite the extent of the problem and the increased awareness among CW, TANF, and AOD agencies, few jurisdictions have developed effective linkages between the systems (CASA, 1999; Young et al., 1998). On behalf of specific clients, AOD providers built the few system linkages that do exist between AOD and CW, but professionals in both fields acknowledge that there have been few efforts to systematically provide outreach, intervention or treatment services with the parents who are involved with child protective services (CASA, 1999). Some jurisdictions are just beginning to develop and test models of linkages between the TANF and AOD treatment systems (Legal Action Center, 1997). Young & Gardner (1998) have document seven models of linked practice operating in sites across the country. Currently however, very little is known about the effectiveness of these new interventions.

The most widely developed and implemented model of intervention for women is the use of a multi-disciplinary team approach. This model was primarily developed in the late 1980s and early 1990s through federal and state grants to provide comprehensive treatment to women and women with children. The Center for Substance Abuse Treatment (CSAT) summarized the findings from these comprehensive projects in 1995. They found that when using multi-disciplinary teams: 95% of pregnant women entering treatment reported uncomplicated, drug-free births; 81% of those referred by the criminal justice system have no new charges following treatment; 75% who successfully completed treatment remained drug free; 46% obtained employment following treatment; and 40% eliminated or reduced their dependence on welfare (CSAT, 1995).

At the same time, however, the CW system has become increasingly concerned about the low rates of women from their caseloads who successfully enter and complete AOD treatment (CWLA, 1997). To examine this difficult connection between CW and AOD treatment, the General Accounting Office (1998) conducted case reviews of CW files from California and Illinois. Among mothers in California with documented AOD-related problems and children who were in foster care for more than one year, 40% never entered AOD treatment, and 40% of those who entered treatment failed to complete it. Only 7.8% completed the treatment regimen. Magura and colleagues (1998) conducted follow-up interviews 30 months after admission with a group of 173 crack-dependent mothers. They found that 28% completed treatment, 9% were still active in treatment, 13% transferred to other treatment programs while almost half (49%) exited treatment before completion. These results are part of the growing evidence that suggests that better system linkages and intervention services between CW, TANF, and AOD treatment are needed (CASA, 1999; DHHS, 1999; GAO, 1998; Young et al, 1998).

The multiple issues affecting parents and children in the child welfare, substance abuse, and family court systems create a demand for new forms of formal collaboration. Meeting these demands requires two kinds of collaborative skills: (1) generic skills, drawing upon several decades of literature and practice in the arenas of collaboration, interprofessional education, and services integration; and (2) collaborative attitudes and skills specific to the arenas of substance abuse, child welfare, and family court.

Unique Barriers to Collaboration among CW, TANF, and AOD Systems

A number of studies have listed and codified the barriers to collaboration in an attempt to enhance collaboration by understanding its impediments. Many of these point to the poor attitudinal bases of collaboration. The lack of those attitudes may be more important than the organizational barriers. Others stress categorical funding, discipline-bound training and in-service education, and a lack of attention to sustainability of one-time funding as barriers to collaboration (Gardner, 1998; Kagan, 1991).

In the CW-AOD context, collaboration flows from the realization that neither agency can achieve its outcomes—safe children in stable homes with adults who are functioning well—without the resources, expertise, and cooperation of the other. The literature on collaboration among the systems affecting children of substance-abusing parents highlights five major categories of barriers between the two systems that must be addressed:

- Different definitions of who within the family is the client—the child or the parent—which results in different attitudes toward clients with AOD-related problems;
- Different training and education in recognizing and responding to AOD problems;
- Attitudes toward the other systems, founded in part on myths;
- Different timing factors in working with clients; and,
- Different funding streams and information systems mandated by those funding sources (DHHS, 1999; Young et al., 1998).

A particular issue that arises recurrently in working across CW, TANF, and AOD treatment agencies is the question of confidentiality of client data. Despite a plethora of literature on this topic, including a recent Technical Assistance Publication (TAP) that focused on the welfare population and a report of a special forum held by CSAT and Children's Bureau (SAMHSA, 1996, 1999), the issue of confidentiality arises in virtually every initial discussion among the different agencies. It is a very real issue, but some have found that the invocation of the problem is often a signal that the agencies are in a pre-trust position with each other, rather than experiencing a real legal barrier to collaboration (Young & Gardner, 2002).

At the heart of the collaboration challenge in working across these specific systems is the decision about returning or keeping children with their family, based on a judgment that children are safe and parents are in fact in recovery. Ideally, this is a deeply collaborative process, requiring a comprehensive evaluation combining risk assessment that is inherent in the child protective services function, assessment of parenting skills, assessment of a child's (or a group of siblings') developmental progress and potential delays, and assessment of treatment progress through monitoring tools used by treatment agencies. All of these must be communicated to a family court that is willing and able to use these assessments to make a thoughtful, rational decision about a child and family's future (Hohman & Butt, 2001).

The children of women with multiple vulnerabilities such as substance abuse, mental illness, and their own experiences of violence, have needs that should be addressed as part of the treatment delivery for the mother (Gaensbauer, 1996). Post-traumatic symptoms are common for children who experience violence in the home (Pynoos, 1993), and other effects including developmental

regression (Arroyo & Eth, 1995), developmental delays and language disorders (Kurtz, 1994), aggression, anxiety, and academic problems (Pynoos, Frederick, & Nader, 1987). Prenatal exposure to substances has been linked with premature birth, fetal anomalies, growth retardation, and neonatal withdrawal syndromes (Clark, 2001). Among children in family foster care, those who had been exposed to substances prenatally were more likely to develop behavioral problems in school than age mates who were not exposed (McNichol & Tash, 2001). The needed collaboration across the systems to address these complex issues requires substantial, even extraordinary, efforts in an environment that is often resource-short, lacking in training for agency staff, pressed for deadlines, and lacking adequate information about clients' needs and community capacity. However, there is also widespread belief and emerging evidence (Young, 2002; Young & Gardner, 2002) that to the extent that inter-agency collaboration is achieved, service delivery to families and children will be optimized.

Technical Assistance, Training, and Information Needs

Implementing a community-based family support system focused on these issues clearly requires multiple sources of technical assistance and training. Critical training areas for social service professionals involve enhancing knowledge and skills in several areas: recognition and knowledge of substance abuse; understanding the cultural context of substance use and abuse; accessing treatment resources; implementing effective case management and outreach; working with relapse prevention; assessing worker safety; and, practicing special permanency planning techniques (Tracy, 1994; Tracy & Farkas, 1994). For example, a recent assessment of case files by one of the contractors who evaluated the Federal Family Preservation/Family Support Program estimated that only 29% of the families in the programs funded by this source have substance abuse problems (DHHS, 2001). Another state has reported three years in a row that only 1-2% of its foster care caseload was affected by substance abuse. These figures, and the lower figures that emerge from several other reviews of actual case files, are dramatically inconsistent with much higher estimates and results of in-depth assessments cited earlier. The discrepancy appears based upon the extent to which workers: (1) may not recognize substance abuse problems on intake; (2) may simply not have any space on their forms or in their information systems in which to indicate whether substance abuse is a problem, since most state laws provide specific legal grounds for taking action in the CPS system and substance abuse *in itself* is rarely included as a condition that needs to be documented; or (3) may be reluctant to identify a problem for which they believe there are no resources to respond with effective treatment (CASA, 1999; DHHS, 1999).

Training content for substance abuse staff includes: how the child welfare systems works; the timelines and mandates of the child welfare system; trends in local CW and out-of-home care rates; local resources in CW (e.g., parenting education, shelters, foster homes); substance use disorders as a family disease; family dynamics in substance abusing families and the impact on parenting; CW confidentiality laws and procedures; resources available for family-oriented interventions and family support/aftercare; the developmental impact of AOD use—including pre- and post-natal exposure—on children; and, the language and culture of the AOD system (Young et al., 1998).

A study of the results of an interdisciplinary training on substance abuse and child maltreatment found that participation in training was associated with significant increases in knowledge and with increased rates of drug and alcohol services being received by protected services cases in the training region (Chaffin, Kelleher, & Harber, & Harper, 1994). Effective sharing of knowledge among stakeholders involved in the substance abuse treatment and child welfare milieus can also result in positive changes in attitudes and practice as discussed in the National Treatment Plan Initiative, *Changing the Conversation* (SAMHSA, 2000a; 2000b). Training also provides an opportunity for social service professionals to assess their own attitudes and values about substance abusing parents. In addition, training may assist direct care providers and foster families to consider personal attitudes and practices around addiction, their own use of substances including alcohol and tobacco, and the example it provides to children in their care (SAMHSA, 1993). Attitudes that may limit a social service professional in their efforts to engage clients, conduct a screening or develop appropriate intervention strategies include stigmatizing substance-abusing parents and doubting a parent's capacity for recovery (Tracy & Farkas, 1994). It may also help both child welfare professionals and alcohol and drug treatment providers focus on the family as the client rather than separately addressing the concerns of addicted parents and their children (Scott & Campbell, 1994).

To effect systems change and to institutionalize new practices, technical assistance and training must address the inter-relationship of the CW, TANF, and AOD treatment systems. Technical assistance in numerous state and communities over the past several years, led to the development of a 10-element framework, a corresponding assessment tool and matrix of standard, better, and promising practices to guide technical assistance efforts. The assessment tool allows communities to assess their level of collaborative efforts and to prioritize their strategies to:

- Create common principles;
- Improve practice issues for parents and children;
- Develop common outcome measures and evaluation strategies;
- Address communication and information systems barriers;
- Develop training and staff development programs;
- Address relationships with courts and other needed services; and,
- Develop comprehensive funding strategies and program sustainability.

Summary

It remains difficult to document the extent of AOD treatment needs among the child welfare population. However, five conclusions are clear from the literature: (1) a high percentage of mothers who are reported with allegations of CA/N need AOD services; (2) a smaller but significant portion of women who receive income assistance also need assistance with AOD-related problems to attain and to sustain employment; (3) multiple treatment effectiveness studies have documented the benefits derived from AOD treatment that is designed around best practices principles; (4) outreach and linkage to services for women with problems in multiple life areas can be effective; and, (5) services to this group of women must be delivered in culture/gender-congruent approaches. The interventions described below are intended to respond to these conclusions, especially the needs for links among public assistance, child welfare, and AOD treatment systems.

CHAPTER III. EVALUATION DESIGN AND METHODS

The ON TIME evaluation consists of three components that address the original research questions: (1) evaluating the implementation of ON TIME; (2) assessing treatment outcomes relative to changes in self-reported client functioning; and (3) comparing the substance abuse treatment engagement rates and child welfare status of the treatment group with a comparison group of women who met the criteria for the ON TIME program in the year prior to its implementation. Data have been collected at intake, during treatment, and at post-treatment follow-up.

This chapter presents the ON TIME research design including hypotheses/research questions that guide the study, target client population, data collection procedures, schedule, and instruments/measures. In addition, the methodological limitations of the study are delineated and addressed. The chapter concludes with some closing comments about the study design.

Evaluation Component 1: Process Evaluation

This research component includes an assessment of the changes that took place in the child welfare and substance abuse systems as they responded to the new legislated client timelines and the operations of the ON TIME project. This evaluation includes observations of the planning, development, implementation, and operation of the ON TIME program. These observations provided continuous feedback to inform the development and conduct of the project and generated the information needed to assess the program effects for CSAT's Government Performance and Results Act (GPRA) measure *Bridging the Gap between Knowledge and Practice*. The following are among the key process concepts assessed:

- Staffing—recruitment and retention strategies, obstacles, and barriers
- Intra- and interagency coordination—characteristics of members, their organizations and histories, and strategies to achieve interagency cooperation and coordination
- Operational procedures—the structure of the steering committee and its subcommittees, frequency and results from their meetings, and changes in the social service and substance abuse treatment systems
- Formal and informal communication process—how information is shared and communicated
- Formal and informal decision making—how decisions are made, level of participation in decision making across agencies, and how the decisions are implemented
- Adoption of "best practices" in Orange County for the services delivered (a CSAT GPRA measure

The process evaluation to document the development and implementation of the ON TIME project began with the inception of the project and continued through the third year. The tasks of the project co-director included: attending steering committee meetings, serving as observer-participant in meetings of the county and treatment agency staff, and providing narrative documentation on the status of the various decisions made, issues, and issue resolution. In addition the co-director archived all reports, steering committee meeting minutes, documents, and selected instrumentation, including treatment protocols, agreements across agencies, policies

and procedure guidelines and manuals, assessment and referral protocols, and observational notes. The co-director paid special attention to early planning and implementation, including the steps involved in establishing linkages with other agencies, referral processes, staff recruitment and training, and client recruitment and engagement activities. Additional activities for the process evaluation included qualitative methods such as records review, key informant interviews, key personnel interviews, and focus groups to understand the issues related to program planning and implementation.

Evaluation Component 2: Client Treatment Outcomes and Services Effectiveness

A pre- to post-treatment outcome evaluation assessed client outcomes and service effectiveness. Client functioning, defined as the severity of substance abuse-related problems measured on the Addiction Severity Index (ASI), was assessed at treatment entry and at 9-months post-intake. Services received by the client during this period were identified. Treatment outcomes were assessed in terms of changes in client functioning (as measured by scores on the ASI) relative to clients' individual characteristics and configurations of substance abuse treatment services utilization. Client stages of change, utilizing the Stages of Change Tool, were assessed at the initial contact and at 21 to 30-days post contact.

Evaluation Component 3: Comparison Group on Family-Related Outcomes

A quasi-experimental design utilized a comparison group of women who met criteria for the program (e.g., child abuse/neglect disposition hearing, allegations of substance-related problems, and age 18 and over) in the year prior to ON TIME's implementation. The comparison group was matched using the Structured Decision Making scores related to substance use, abuse or dependency described in Chapter III. The primary outcomes measured in the comparison group were severity of alcohol and drug use at intake to the child welfare system, children's placement status 12-months, status of child welfare case at 6 and 18-months, and new reports of child abuse and neglect. While admission and completion to the substance abuse treatment system and length of time in treatment were other outcomes that we intended to measure, unforeseen circumstances, as explained in the introduction, made it impossible to measure these variables.

Hypotheses and Research Questions

The following is a list of the original research questions pertaining to the process evaluation, intake, assessment, service utilization, treatment outcome, and policy and planning.

Process Evaluation

1. Can an effective system to conduct outreach and intervention services to engage substance-abusing mothers whose children have been placed in protective custody be developed and implemented across Orange County's public and private systems?
2. Do ON TIME intervention and engagement services increase the likelihood that the child welfare-involved mother is linked to substance abuse treatment services and engages in substance abuse treatment?

Treatment Outcomes

3. Does implementation of ON TIME result in improvements in meeting the substance abuse treatment needs of the target population?
4. Does providing outreach to mothers who withdraw from substance abuse treatment facilitate their re-engagement?

Comparison Group on Family-Related Outcomes

5. Does providing ON TIME services result in successful treatment completion, decreased substance use, and increased family and employment-related outcomes in comparison to women who met criteria for the program in the year prior to its implementation?

Description of the Target Population

Orange County (OC), located between Los Angeles and San Diego, ranks fifth among the most populated counties in the United States and is the second largest county in California with an estimated population of 2.846 million people. At its current rate of growth, OC will surpass 3 million people by the year 2005. In 2000, Whites accounted for 51.3% of the county's overall population, Hispanics were 30.8%, Asian and Pacific Islanders were 13.5% and African-Americans were 1.5%. OC is relatively young with a median age of 33.3 years. The racial/ethnic makeup of its large youth population shows that 42.4% of children in the county are Hispanic (Orange County Health Care Agency, 2002).

Following the recession of the early 1990's and the 1994 bankruptcy of OC, the economy rebounded; the overall unemployment rate is currently below those of the state and the nation. Poverty has been increasing, however, both in total number of persons living in poverty and the proportion of the total population. The poverty rates are highest among persons under age 18, with 16-31% of the youth population living below the federal poverty level in 1999.

Among the children who are placed in protective custody through CW services, there is an under-representation of Asian/Pacific Islanders and slight under-representation of Hispanics in relationship to their overall percentage in the county population (see Table 1). However, the statewide trend is an increase in the proportion of Latino children in foster care with a corresponding decrease in whites. In OC, there is a large over-representation of African-American children and a slight over-representation of White children in out-of-home care compared to their overall county representation. In comparison to the county's racial/ethnic makeup, Asian/ Pacific Islanders are also under-represented in the AOD treatment group, while African-Americans and Hispanics are over-represented (see Table 1). Although the data in Table 1 are somewhat dated, they were the baseline data that was available when the proposal was submitted. The AOD treatment data are presented for "unique" clients rather than the total admissions to treatment. It should be noted that these data are not based on racial/ethnic group distribution of the need for treatment.

Table 1 . Orange County Race/Ethnicity Totals and in Selected Service Areas

1997 DATA	Total County		Age 0 to 17		CW out-of-Home Care		Children CalWORKs		AOD Service Admissions	
	N	%	N	%	N	%	N	%	N	%
Asian & Pacific Islander	315,127	11.7	89,296	12.4	120	3.5	15,693	26.1	191	2.3
African-American	50,874	1.9	16,898	2.3	319	9.4	2,745	4.6	303	3.6
Hispanic	746,841	27.9	288,354	40.2	1,304	38.4	26,967	45.1	2,793	33.7
Non-Hispanic White	1,552,007	58.0	319.528	44.6	1,648	48.5	13,189	22.1	4,857	58.6
All Others	12,826	0.5	3,465	0.5	8	0.2	1,204	2.1	148	1.8
Total	**2,677,675**	**100.0**	**717,541**	**100.0**	**3,399**	**100.0**	**59,798**	**100.0**	**8,292**	**100.0**

Target Client Population

The ON TIME population for the pre/post study were all adult Orange County women who met the program criteria: at least one child placed in protective custody because of child abuse or neglect allegations, age 18 and over, and substance abuse allegations in the child welfare petition.

Data Collection Procedure, Schedule, and Instruments/Measurements

Each client referred to ON TIME services was approached to participate in the research project at the first contact with ON TIME recovery mentors. The nature of the study was explained to the client, and the client was invited to sign an informed consent form to participate in the study and to be contacted at a later date by UCLA research staff for follow-up phone interviews at three and/or nine months post-intake. Clients who consented were asked for locator information which was used to locate the client for the follow-up interviews. Those who completed the initial intake assessments received $20 gift certificates. Those who completed the follow-up interviews were paid $10 for the first interview and $15 for the second, both in the form of money orders mailed to their designated addresses.

Drug treatment is typically characterized by a high dropout rate, which in the first few weeks can be up to 50% or higher in some cases. This high treatment dropout rate should be modified by the program goal of client engagement and re-engagement. However, an estimated 10% attrition rate for post-treatment follow up was factored into the research design. DARC has developed highly successful tracking strategies to ensure high-quality follow-up data with low client attrition. Using information provided at enrollment and recorded on the locator form, DARC staff contacted the client at 3- and 9-months after intake for the telephone interview. This method was successfully used by DARC in the Target Cities Evaluation of Los Angeles for CSAT in 1995-1997. A sample of over 400 clients in outpatient programs resulted in a 92% re-

interview rate at 6 months after treatment, and a 83% re-interview rate at the 24-month post-treatment point (Fiorentine, 1997; Fiorentine & Anglin, 1996; 1997; Fiorentine, Anglin, Gil-Rivas, & Taylor. 1997).

The three-month time frame was chosen to: (1) capitalize on the client's ability to recall specific services received while in treatment and to accurately rate satisfaction and services received; (2) allow researchers to stay in touch with clients and thereby increase the 9-month follow-up rate; and (3) allow a brief assessment of client status. The nine-month time frame was selected to: (1) increase the number of clients who completed treatment; and (2) allow for assessment of longer term treatment effects.

UCLA interviewers conducted by phone, two follow-up interviews each lasting approximately 20 minutes which clients at 3- and 9-months post intake. The first interview (252 questions) was composed of TOPPS II items, the In-Treatment Experience Survey, and questions assessing the client's perceptions of their recovery mentor. Clients' locator forms are also updated at this time. The survey includes questions about clients' treatment satisfaction and treatment services received by using the Treatment Services Review (TSR; McLellan, Alterman, Cacciola, Metzger, & O'Brien, 1992), which surveys clients with respect to the different types and frequencies of treatment services received in the past three months (both within the treatment program and outside the program), focusing on the same seven problem areas as the ASI Lite.

The second interview (207 questions) focused on treatment satisfaction (portion of the In-Treatment Experience Survey) and includes the ASI Lite CF TOPPS II, which provides treatment outcome data (e.g., treatment retention, changes in problem severity) and questions assessing the client's perception of their recovery mentor.

The following section includes a description of the instruments used in the ON TIME study.

The Addiction Severity Index (Lite) Clinical Factors TOPPS II form (ASI Lite CF TOPPS II: referred to as the "ASI Lite") was modified from the Addiction Severity Index (ASI; McLellan, Luborsky, Woody, & O'Brien, 1980; McLellan et al., 1992) which is a structured interview that assesses problem severity, both past 30 days and lifetime, in seven areas: alcohol use, drug use, employment, family and social relationships, legal, psychological, and medical status. The modified instrument combines ASI Lite CF questions (116) with TOPPS II questions (34) for a total of 150 questions. The ASI Lite CF includes the ASI Lite (which is a simplified version of the full ASI) and nine additional items (included in the full ASI) to allow calculation of composite scores in the seven areas. Composite scores measured repeatedly over time are used as measures of change. The TOPPS II questions (e.g., number or days stayed overnight in a hospital for medical problems in the past 30 days and 6 months, number of times arrested in past 30 days and 6 months) were developed as part of a 19 state consensus process to allow for interstate comparisons. TOPPS II items measure a wide range of behavioral changes, including alcohol and drug use, employment, criminal activity, housing situation, family and social relationships, and medical issues.

The California Alcohol and Drug Data Set (CADDS). CADDS is California's version of the Treatment Episode Data (TEDS) minimum data set required by CSAT for all publicly-funded substance abuse treatment programs. In its form as CADDS, TEDS is augmented to capture California-specific information not required by CSAT (e.g., CalWORKS/TANF participation). Data collected via CADDS (27 items) identify the types of services provided and describe the demographics of the population receiving those services.

The California approach to the *American Society of Addiction Medicine Patient Placement Criteria form (CAL-ASAM PPC II)* is a two-page clinical tool used to guide the selection of the most appropriate form of treatment in various levels of care for substance abusing populations. The tool aids clinicians in deriving the answers to three questions: What is the level of care needed by the client? What is the level of care to which the client was admitted? What is the reason for any difference?

Treatment Services Review (TSR) surveys clients in terms of the different types and frequencies of treatment services received in the past three months (both within the program and outside the program), focusing on the same seven problem areas as the ASI Lite (McLellan, Alterman, Cacciola, Metzger, & O'Brien, 1992). Service intensity for each problem domain was calculated by summing up the number of times that services were received in the respective domain within the past three months while in treatment. Sample service items in the drug problem domain include: attended a drug education session, NA or CA, and a drug relapse prevention group or session. Similarly, the frequency of having discussed a particular topic in the individual or group sessions was also recorded.

Stages of Change Rating Tool. Stages of Change was assessed using a tool developed by PROTOTYPES (Brown, Melchior, Panter, Slaughter, & Huba, 2000) based on the Transtheoretical Model of Stages of Change (Prochaska & DiClemente, 1983) and adapted from the rating scheme developed by Biener and Abrams (1991). The tool assesses participants' readiness to make life changes in seeking drug abuse treatment; counseling; reducing risk behaviors; and seeking employment. Ratings are on an 11-point Likert-type scale ranging from 0 ("I do not plan to make the specific change in the next six months") to 10 ("For more than six months, I have taken steps or been involved in treatment/counseling"). The Stages of Change Rating Form was re-administered at 21 days post intake.

Structured Decision Making (SDM) is a series of assessments used by Children and Family Services (CFS) to assess the level of risk for child abuse and neglect. The intent of the SDM project has been to ensure that child welfare workers are provided with the best tools possible to help in making critical case assessments and decisions. The SDM assessment used for the ON TIME study is the Family Strengths and Needs Assessment. This assessment is used at various stages of the dependency court case. The initial assessment is intended to be completed by the intake social worker within the first 72 hours of the inception of the case, with follow-up assessments at 3 weeks, and every six months afterwards, prior to the case plan update. This assessment has 11 items, including substance abuse/use, household relationships, domestic violence, social support systems, parenting skills, and mental health/coping skills. Each caretaker in the family is rated in four levels, with scores of either: +3, 0, -3 or -5. For substance abuse/use, the scores represent: +3= teaches and demonstrates a healthy understanding of alcohol

and drugs; 0=alcohol and prescribed drug use; -3=alcohol or drug abuse; -5=chronic alcohol or drug abuse. The substance abuse/use scores were used to select the comparison group for the study, with scores of –3 and –5 selected as comparisons. The scores were also used to determine whether ON TIME and comparison groups had similar ratings at the initial stage of their dependency court case.

Orange County is one of several states and counties in the country that has used SDM as a tool to identify clients with substance use, abuse, or dependency allegations. While SDM had been used since early 1998, the implementation of the ON TIME project and the need to find a comparison group led to its first use for research purposes. CFS was able to use the SDM scores of the ON TIME clients to match with a comparison group of women in the year prior to implementation of the project. This ability to detect CFS clients who had AOD allegations in their dependency court case without having to do a hardcopy case review was an essential step in the research process. ON TIME project staff give much credit to the CFS staff who spent substantial time utilizing the SDM for purposes of the research of ON TIME.

The *Informed Consent Form* is a 6-page document that explains the ON TIME study to eligible participants and obtains their permission for later contact and interviewing.

The *Locator Form* collects information that UCLA uses to contact clients who have agreed to participate in the ON TIME study. This form contains 34 questions although users are required to provide information on only three contacts.

Comparison Group Data Abstraction

The CFS workgroup began discussion on the first phase of the secondary data analysis requirements in summer 2000. The CFF Research Director introduced the draft data collection tool, whereby information from client files would be extracted. This tool became known to be the *Secondary Data Analysis Tool (SDAT)*, and was revised several times, with input from CFS, UCLA and CFF staff during monthly meetings. This process was finalized by summer 2001, when the data collection activities were to begin.

After a satisfactory level of inter-rater reliability was achieved, three to four CFF staff members abstracted data at the CFS offices during the months of August and September 2001 and collected data from both the ON TIME sample as well as the comparison sample. Three of these staff members had previous experience with CFS case files, thus reducing the amount of time needed for training. The fourth staff member received extensive training on how to abstract data for the purposes of this project. CFS staff also reviewed the completed *Secondary Data Analysis Tool (SDAT)* to ensure the abstracted data was accurate. Secondary data was only available for the first 6 months of the court case for both the ON TIME and comparison group samples, due to data collection which began in August 2001. It often takes 13-15 months for the "12-month" hearing for clients, thus the 12-month court reports were not yet available.

The workgroup resumed discussions in spring 2002 regarding the second phase of data abstraction activities to begin in early summer 2002. Meetings focused on determining the sample for both the ON TIME and comparison groups, and on increasing the sample sizes to

increase the strength of the results. Discussions also focused on whether project staff could have access to the CFS child welfare database to abstract the information in a timelier manner. Initially, CFS offered to have their staff download information electronically, but due to imminent county budget decreases, they were not able to provide CFF with any court report information for both the ON TIME and comparison samples. Although CFS was able to provide a subset of information, as detailed below, this reduced the amount of information that is available regarding the samples for comparability.

UCLA DARC was able to utilize the subset of data from CFS to analyze outcome data in summer 2002 for the following data elements for the identified ON TIME sample and comparison cases:

- Prior Child Abuse Reports (CAR) before the current child welfare case
- Subsequent CAR's during or after the current child welfare case
- Structured Decision Making (SDM) scores if available
- Number and location of placements for each child during the current child welfare case
- Reason for placement change for each child
- Outcome of each case, including location of last or final placement
- Substance Abuse entry and completion for each mother, utilizing the client's CADDS identification number

Analysis

Data analysis was performed by Children and Family Futures' subcontractor, UCLA's Drug Abuse Research Center (DARC). Qualitative data was analyzed using appropriate qualitative methods including content analysis. Quantitative data in each of the evaluation components was analyzed using descriptive statistics (means, frequency, standard deviation, etc.,) and statistical models were developed and tested to examine specific policy and research questions. The summary statistics provided useful information about group characteristics for different program types or about client behaviors during critical time periods. Various group comparisons were conducted to answer specific questions about changes in programs and clients and to evaluate the effectiveness of different program practices. Where appropriate, baseline differences (e.g., client characteristics) were controlled in the analysis.

Statistical analyses included group comparison with Chi-square test and repeated measures ANOVA. Cross-sectional analyses were conducted for data collected at each time point, and longitudinal models were applied, as repeated measures over time became available. Two sets of dependent variables were of major interest: treatment utilization and outcomes. The level of treatment utilization was indicated by the number of times, duration, and intensity of treatment participation. The analyses also characterized other aspects of treatment utilization (e.g., type of modality, type of discharge) and explored the possible development of a topology or classification of distinctive utilization patterns. Multiple outcomes included AOD use, criminality, problem severity (in the seven areas measured by the ASI-Lite), HIV risks, employment, child custody status, legal status, welfare utilization, and health status.

CHAPTER IV. PROCESS EVALUATION AND DOCUMENTATION

This chapter describes the planning and implementation of the ON TIME project and discusses the intended outreach and intervention efforts, barriers to some of these efforts, and the actual process that occurred during the project's operations.

Phase I: Planning

The purpose of the ON TIME project was to implement and test strategies of AOD outreach, intervention, engagement, and re-engagement services to mothers who have been reported for CA/N and who need AOD treatment and recovery services. Intervention and outreach was conducted at the time of the initial court hearing after the removal of the child(ren), with subsequent follow-up visits to ensure appropriate linkage to substance abuse treatment. While initially it was envisioned that the recovery mentors were to have limited contact with clients, the needs of the clients often led to more intensive interaction coupled with case management services.

As discussed in Chapter 1, the planning began in the fall of 1998 as a result of a series of interviews and focus groups with OC civic leaders, county staff, and AOD treatment and prevention professionals and peer leaders. The resulting report from these meetings led to joint meetings of the various stakeholders and the project partners on ways to move forward in addressing the treatment and prevention needs among the county's child welfare population. These meetings led to the development of the ON TIME proposal to the Center for Substance Abuse Treatment.

Project Partners

To develop such a collaborative among public and private systems, it was necessary to gain buy-in from local entities that had an interest in serving this population. With Children and Family Futures' current and past relationships, CFF staff were able to assemble a group of stakeholders that in turn formed the steering committee. Below is a description of the various stakeholders who participated in the planning of the ON TIME project.

Orangewood Children's Foundation (OCF). OCF is a non-profit organization that incorporated in 1986 with the mission of eliminating child abuse/neglect in Orange County by promoting efforts and services that encourage strong, healthy families and supportive communities. OCF has provided both direct and support services on behalf of dependent children and those children at risk of abuse and neglect in Orange County for the past 18 years. OCF has effective working relationships with the Orange County Social Services Agency and the Children and Family Services Department. In addition, OCF is the contract agency for the County's Family Preservation and Support Program to prevent child abuse through collaborative community action. In 1997, OCF entered into a partnership with California Women's Commission on Addictions (CWCA) to prevent AOD-related CA/N. The proposed ON TIME program is a result of these prior efforts on AOD-related issues in CA/N. OCF has a history of partnership with the County of Orange and other organizations and has formal and informal subcontracting arrangements with a variety of individuals and organizations. OCF has staff who are capable and

experienced in managing government contracts including reporting, data/record keeping, and subcontracting.

Southern California Alcohol and Drug Programs (SCADP). SCADP provided services to this project via its Heritage House program in Costa Mesa. SCADP was established in 1972 to prevent and treat substance abuse and related problems, especially as they relate to special populations. The agency is one of the largest providers of non-profit substance abuse treatment in Southern California, and serves over 5,000 men, women, and children each year. SCADP provides 35 separate programs comprising 350 residential beds and 1000+ outpatient counseling slots. The agency is well known for its services for women and their children, and operates eight residential treatment sites and two outpatient programs specifically for this population. A local leader in the field of women's addiction treatment, SCADP opened Foley House in 1986—the first women's treatment program in Southern California to accept and provide counseling for the children of substance-abusing women. The establishment of Foley House was among the first steps taken by the treatment field to address a woman's greatest barrier to recovery—the lack of child care during recovery.

At the request of the County of Orange Health Care Agency, SCADP opened Heritage House in 1992—Orange County's first residential recovery program for women and children. Heritage House has a capacity of 16 mothers, and targets low-income and homeless pregnant and parenting women and their children (under the age of 10). The six month treatment program utilizes an integrated modal which combines public health, Therapeutic Community, and medical modal strategies. A 12-week aftercare component is provided for participants following completion of residential treatment. Heritage House comprises eight separate cottages located on one-half acre in Costa Mesa. Funded by Orange County Health Care Agency, the program is licensed by the State of California as a Drug/Medi-Cal provider. Orange County Health Care Agency secured additional funding to provide a second location for Heritage House, and this location provides 20 additional treatment beds for women and 30 beds for children.

California Hispanic Commission on Alcohol and Drug Abuse (CHCADA). CHCADA is a non-profit organization operating AOD treatment and recovery programs targeted to the Hispanic community in several California counties. In OC, CHCADA operates two bilingual/bicultural programs for Latinas: La Familia and Casa Elena. La Familia is a family-based treatment/ recovery program providing outpatient AOD services and is based in the central city of Santa Ana. Casa Elena is a six-bed alcohol recovery home located in the city of Anaheim offering a 90-day live-in residential alcohol recovery program. La Familia provided consultation services on the development and delivery of the recovery mentors' training, assist in identifying women to be hired as mentors, and provide outpatient treatment for women from the ON TIME program. In addition, they will provide linkage to Casa Elena for Latinas whose children have been removed from their custody and need a residential treatment program. They also served as steering committee members during the initial phases of development.

Children and Family Futures (CFF). CFF conducts policy analysis and program evaluation on AOD issues among social service populations, including welfare recipients and families involved in child welfare services. CFF was incorporated in 1996 as a non-profit organization and is based in the city of Irvine. CFF provides technical assistance and training on the development of

measures of effectiveness and strategic planning. CFF staff are the evaluators of the Sacramento County Dependency Drug Court and Orangewood Children's Foundation's Bridges to Higher Education Program. They have authored multiple publications on AOD, welfare, and child welfare including the 1998 CWLA publication, *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy.* CFF served as the evaluators of ON TIME, and also provided the direct supervision of the recovery mentors. While SCADP originally provided the clinical supervision to the recovery mentors, changes in staffing at SCADP led to CFF undertaking this responsibility. CFF oversaw all evaluation activities, research, planning, and implementation, data interpretation, report writing and dissemination of findings.

UCLA Drug Abuse Research Center (DARC). DARC was founded in 1972 and is a multidisciplinary group of social science and public health investigators who conduct research into drug abuse and related topics. Since 1980, DARC has completed more than 70 research projects in diverse areas pertaining to drug abuse: epidemiology and natural history, treatment process and outcomes, special populations, criminal justice issues, HIV/AIDS, research methodologies, research training, and drug policy. DARC has earned a national reputation for its research expertise and high-quality findings, which have proven useful in supporting the development of policies and programs to reduce drug abuse and to address its impacts. In support of Director Dr. M. D. Anglin are co-Director Richard Rawson, Ph.D., Associate Director Yih-Ing Hser, Ph.D. Seventeen Ph.D.-level scientists and 7 Master-level researchers are assisted by a core of 20 staff trained in interviewing, data entry and management, and statistical analysis.

Phase II: Project Development

Steering Committee

ON TIME was guided by a steering committee that was directly linked through its members to the major planning and oversight committees for Orange County's children and families (The Children's Coordinating Council and System of Care Committee) and AOD programs (the Alcohol and Drug Advisory Board). The following County positions were represented: (1) the Director of Children and Family Services; (2) the Director of Family Self-Sufficiency (OC's CalWORKS/TANF program); (3) the Director of Behavioral Health; (4) the Deputy Director of Alcohol and Drug Services; and (5) the Presiding Judge from the Dependency Court.

The role of the steering committee was to provide oversight of the project and to expedite problem solving across the public and private sector agencies and staff. OC operates a network of treatment/recovery services through seven outpatient sites including intensive outpatient treatment for pregnant and parenting women. In addition, the County contracts with private non-profit agencies to deliver the full continuum of AOD treatment and recovery services.

Shortly after the ON TIME proposal was accepted by CSAT, project partners began joint meetings to discuss the details of logistics of the project. The steering committee had their first meeting in October 1999. The steering committee met monthly through February 2001, with quarterly meetings thereafter. The members of the committee were instrumental in assisting the

ON TIME project to represent and establish communications with Orange County agencies that serve women substance abusers in the child welfare system. Members made key decisions that enabled the project to move forward.

It is worthwhile to note here the steering committee members' dedication to the success of the project. Members from each agency consistently attended the monthly/quarterly meetings, with the Director of Family Self-Sufficiency (CalWORKS/TANF agency) attending regularly and the Director of Children and Family Services attending and sending senior management staff to the meetings.

Project Staffing

The ON TIME Project was successful in the recruitment of qualified staff to develop and implement the project. Experienced in women's substance abuse treatment issues, the dependency court system, and the child welfare system, project staff were instrumental in the development and implementation of the project. Staff coordinated the steering committee meetings, ensured effective communication of the agencies and established linkages with community agencies. During the first year of project implementation, it was necessary to recruit and hire staff to replace two of these initial staff members. This transition to new staff went smoothly and the new staff were trained on the policies and procedures of the project.

Children and Family Services Workgroup

This workgroup was established in January 2000 to develop policies and procedures for client eligibility and identification, access to client court reports, and confidentiality. Other issues addressed were access to official buildings, communication between the recovery mentors and CFS social workers, and discussion of the requirements for the secondary data records. Meetings were initially biweekly, and when appropriate, were reduced to monthly meetings.

Issues Related to Delays in Project Implementation

Project staff initially hoped for implementation to begin in April 2000. Yet unforeseen policies and procedures related to research, confidentiality and collaborative agreements, described below, necessitated postponing recruitment until all issues were agreed upon.

Protection of Research Subjects. After several meetings with the social services agency (SSA) and revisions of the research protocol, the Orange County Health Care Agency's Human Subjects Review Committee and UCLA's Institutional Review Board approved the ON TIME project to begin client recruitment in May 2000. A particular issue stemmed from the IRB's concern regarding social workers, who have a great deal of influence on the removal and placement of children, were originally envisioned as the referral source for program participation. Subsequent meetings with SSA and the Public Defenders' Office, the attorney group representing parents as their legal advocates, led to an agreement that the parent's attorney would be the referral source rather than the social workers. IRB approval was obtained with this new protocol and OPRR issued the Certificate of Confidentiality shortly afterwards. The

research protocol was reviewed and re-approved each year by both the Orange County and UCLA Institutional Review Boards.

Communication Protocol. CFF project staff, having prior experience in developing protocols between systems, was aware that in order for this project to be effective, a protocol establishing communication paths across systems must be drafted, approved and implemented. There was initially strong resistance on the part of the defense counsel, due to the possibility that reporting information (e.g., substance use by their client) might lead to negative outcomes for their clients. This resistance led to multiple meetings in a several month process as each agency discussed their "need to know." While attorneys were initially against reporting any information that the recovery mentors obtained (i.e., substance use) to CFS, the opinion of CFS was that they needed all pertinent information about the case to make an informed decision about the safety and well-being of the children in their cases.

During this negotiation phase, an unfortunate event occurred where two former project staff members indicated to the attorneys that "we," meaning project staff and recovery mentors, would not disclose any information obtained about the clients to the social workers. This error in communication led to the need for more meetings in which the project staff could assure the social workers that there would in fact be an open line of communication.

After several months of discussion and negotiations, all parties approved the communication protocol one month prior to project implementation. The communication protocol included the following information: (1) knowledge of treatment participation; (2) attendance at self-help meetings; (3) knowledge of child abuse and/or neglect; (4) threats of harm to self or other; (5) new incidents of domestic violence; (6) client intent to leave the county with children; (7) change in household composition; and, (8) knowledge of continued alcohol or drug use.

At the time of recruitment into the project, the client provided consent for the exchange of information. Approximately 5% of the women who were approached by the recovery mentor refused to participate in the project. The recovery mentor completed the communication protocol within 21 days of the initial court hearing, and monthly thereafter. The communication protocol was shared with both the mothers' attorney and her social worker. If either party had any questions, they were to contact either the recovery mentor or her clinical supervisor.

The intended outcome of the communication protocol was that it would become standard practice for treatment agencies to report treatment progress to the CFS social workers, in an effort to ensure the women were receiving appropriate services and reasonable efforts. Although both the attorneys and social workers supported the use of the communication protocol, it is unknown whether this exchange of information was sustained beyond the ON TIME project.

Memorandum of Understanding (MOU). Children and Family Services, Orangewood Children's Home, CFF, SCADP, and UCLA DARC drafted the MOU to set forth the responsibilities of each agency. The MOU had several revisions, with the first draft completed by April 2000. All parties, including CFS' County Counsel, approved the final draft in July 2000.

There came an unforeseen barrier with the final draft, CFS' County Counsel decided that the Orange County Board of Supervisors must review the MOU due to direct access to CFS clients and confidential court records, which added another 5 weeks delay to project start-up. The Board reviewed and approved the MOU on August 15, 2000, which allowed the ON TIME recovery mentors to begin client recruitment the following day.

Marketing and Awareness of Project

The ON TIME project conducted several presentations during project implementation to introduce the project and garner support. Initial presentations were for the attorney groups and the intake and investigations staff at Children and Family Services. These presentations included information on:

- Background of project
- Goals of the project
- Communication Protocol
- Addiction and treatment
- Stages of change
- Level of care
- Research protocol
- Referral process

ON TIME staff also presented information about the project at several conferences and at several community forums, including:

- Orange County Alcohol and Drug Advisory Board, February 2000
- Attorney representatives for clients, June 2000
- Judges and Attorney representatives, July 2000
- Orange County Perinatal Substance Abuse Network, July 2000
- CFS, Dependency Intake and Investigations Unit, August 2000
- CFS, Special Programs and Continuing Services Units, October 2000
- SAMHSA's *Third National Conference on Women*, Orlando, Florida, June 2001
- CFS, Focus group of social workers, November 2001
- Orange County Children's Services Coordination Committee, March 2002
- PROTOTYPES' *Healing our Village* Conference, Los Angeles, California, May 2002
- Family Violence and Sexual Assault Institute, *7th International Conference on Family Violence*, September 2002

Intra- and Interagency Coordination

Often, programs that provide services to families and children are fragmented, and focus on only one issue. Child welfare services seek to ensure that a family is stable, healthy, and provides a safe environment for children through services such as case management, referrals to substance

abuse treatment, parenting, and income support programs. Yet, the focus of CW is child safety, with many of these other services under the control of other agencies. Substance abuse treatment providers, on the other hand, are focused on parents' recovery process, often unaware of issues involving their clients' children, or that they are involved in the child welfare system.

A main goal of the ON TIME project was to increase communication among these systems. With this increased communication, it was envisioned that there would be increased collaboration, exchange of information, and new policies and procedures on working with this population. The steering committee was the main formal arena for this process, with many informal contacts going on throughout the project.

At the policy level, project staff saw increased communication via the steering committee meetings, subcommittee meetings, and an overall willingness to assist this population. Both social services and dependency court officials have a heightened awareness of the substance abuse treatment needs of women in the dependency court system. Through presentations by project staff, these agencies received education on substance abuse assessment, motivational interviewing and level of care.

A major generic obstacle to closer coordination was gaps in services, other resources, and staffing, which accentuated the other differences among systems. It was apparent to project staff prior to project implementation that Orange County is lacking adequate and appropriate substance abuse treatment, with only one residential treatment provider for women and children, and no intensive outpatient service providers offering more than 4 hours per week of treatment. Project staff provided technical assistance to attorneys and social services staff on the needs of these clients and the benefits of referring clients to appropriate treatment.

Recovery Mentor Training

Curricula and training materials were developed in conjunction with staff and clients from La Familia and Heritage House. PROTOTYPES, a national leader in training and outreach to women with multiple vulnerabilities (mental health, substance abuse, trauma and HIV/AIDS) assisted in the development of the training and outreach model. Each of these agencies emphasized outreach techniques and competencies that have proven effective in their work with women in different minority populations. In addition, staff from the Sacramento County Alcohol and Drug Treatment Initiative, who have implemented a nationally recognized training program on motivational interviewing and stages of change for child welfare and human service professionals over the past five years, served as consultants on the training development.

Each of the four mentors was in recovery and had experience working with the substance abuse treatment system. Other qualifications included having their own experiences in the child welfare system, as well as having certification in substance abuse counseling. One recovery mentor was bilingual. The recovery mentors were extensively trained during the first two months of employment in the areas of child welfare, motivational interviewing (Miller &

Rollnick, 1991) and court procedures. Other areas of training include linkage to treatment, gender specific issues, domestic violence, cultural competency, public assistance and mental health. Due to a delay in project start-up, the recovery mentors were available to attend conferences and workshops in these areas, with positive feedback, suggesting that the additional training was beneficial.

The recovery mentors also had the opportunity to participate in a pilot project at Heritage House, the only provider of two residential programs for women and children in the county. They implemented the ON TIME protocol to 15 women and found that the protocol was acceptable to this sample of women. Instruments included: CADDS, ASI, Stages of Change Form and the Cal-ASAM. The pilot project allowed the recovery mentors to pilot the ON TIME instruments and to become familiar with the reactions of the population of women who served as their clients.

Phase III: Client Contact

Access to Court Reports

Initially, procedures were developed so that client reports were available to the ON TIME Coordinator (CFF staff) the afternoon before the initial court hearing. The CFF Project Coordinator would then review the court report to ensure that the client had substance abuse allegations, and inform the recovery mentors the number of clients eligible for ON TIME. The following morning, CFS would inform the Coordinator of the court room for each eligible client.

Once the project began, it was determined that the Coordinator could review the cases and contact the recovery mentors in the mornings. A brief meeting between the Coordinator and the mentors was held each morning at the court house to discuss the number of cases and determine which mentor would track each case. The mentors would then be available outside of each court room to engage with the clients.

Referrals from Attorneys

The original proposal made clear that the referral to the ON TIME project was to originate at CFS. CFS would identify those cases where substance abuse was involved in the child abuse and neglect allegation, and refer their clients to ON TIME if appropriate. During the initial stages of project development and IRB approvals, however, this process was modified so that the mothers' advocate – her attorney – referred clients to ON TIME. This change in protocol was made for the protection of human clients involved in research projects, as mentioned above. After several meetings with project partners and discussions with the Human Subjects and Institutional Review Boards, it was decided that the use of social services as a referral gave an impression of undue coercion due to the fact that CFS makes the decision on whether the child(ren) return home.

As stated above, the intention was to have CFS refer their clients to ON TIME. This referral process would have facilitated a cooperative agreement between CFS and the AOD treatment providers, with the recovery mentors acting as brokers. The shift to attorney referrals

systematically changed the purpose of ON TIME, which was to change the CW and AOD systems so that there is more collaboration and provision of services to women in the child welfare system. As a result, it was demonstrated in a focus group that CFS social workers, particularly those in continuing services, were largely uninformed about the project and administrators had less contact with program operations.

As a result of the change in recruitment procedures, ON TIME began with the mothers' attorney receiving the court report from CFS, and an ON TIME brochure attached signified that the mother was eligible to participate in the project. The attorneys would then discuss the project with their client and the client would decide whether she wanted to participate. The ON TIME Coordinator would have knowledge of what court room the mother was in, and inform the recovery mentors so that they would be available to the client if she decided to approach the recovery mentor.

Initially not all of the mothers' attorneys approved of the project, and some advised their clients not to participate. Project staff presented the ON TIME project to the attorney groups on several occasions, explaining the recruitment, engagement and follow-up process, as well as addiction and treatment theories. Within 2 months of project start-up, several attorneys agreed that ON TIME recovery mentors could benefit most of their clients, with one attorney referring all of her clients. Even with this agreement, there were instances when the attorney felt that their client should not participate in ON TIME, and there were two attorneys who refused to refer their clients. These initial reservations by the attorneys were eventually reversed, and by 3-4 months into the project all but one attorney referred most of his or her clients to the project, and although it took approximately 9-12 months, all eventually were on board with the project.

One barrier to the referral process is that there are 3-4 different attorney groups that may represent the mother. A public defender, juvenile defender, conflict attorney or private attorney may represent the mother, depending on whether another family member has already been assigned to the public defender. This necessitated informing and building relationships with each of these attorney groups so that referrals could be made to the project. The skills, training, and concerted efforts by the recovery mentors, including building rapport and the demonstrated success with their cases, eventually overcame these initial reservations. As one recovery mentor stated:

> *In order to establish relationships with the attorneys so that they would begin to trust us and refer their clients to the project, we would hang around in the hallways, introduce ourselves to all the attorneys, and eventually by virtually word of mouth they would begin to trust us. By having strong relationships with several of the attorneys, it made it easier to navigate the courthouse and we became part of the system.*

Social Worker Communication

There were challenges throughout the ON TIME project in developing and maintaining relationships between the recovery mentors and the children's social workers in Children and Family Services. A number of possible explanations included: (1) the change in clients' social workers at key points in the dependency court case, which may include different social workers

at emergency response, intake, investigative, continuing, and intensive supervision; (2) lack of familiarity of many social workers with the ON TIME project; and, (3) the requirement that the mothers' attorney must refer his or her client to the project and thus the social worker may not be informed that her client is participating. The caseloads and resultant responsibilities of social workers may also have affected their view of ON TIME as requiring one more administrative burden added to their already full schedules.

The issue of frequent changes in social workers and unfamiliarity with the project became evident when CFS reported that they were not receiving the communication protocols on a consistent basis. After discussions among steering committee members and conference calls among key members, it was decided that another form of communication was necessary. Once a client was recruited into the project, an email was sent to the current social worker, letting him or her know that the client was participating in the project. The social worker also received a call from the recovery mentor within the first two weeks to discuss treatment issues. There was positive feedback with this change in procedures, resulting in a number of social workers making frequent contact with project staff. One social worker that had called to request an ON TIME recovery mentor for her client, stated that she had heard wonderful things about the project, and wanted a recovery mentor to help her client.

While positive relationships existed, some philosophical and trust issues with some of the social workers still persisted. For example, for some social workers, the narrow orientation to child safety issues meant the history and credentials of the recovery mentors were suspect. As one recovery mentor stated, *"I was unsure of our relationship. I was felt uneasy that information could be taken out of context and might potentially harm my clients. The relationship did not feel trusting for the most part."* This need for trust across systems, as mentioned in the literature review, is a frequent issue in all sites that have instituted programs to respond to the issue of substance abuse among parents in child welfare. It is not an unexpected occurrence and in sites that have sustained staff connections across systems the trust among workers is greatly enhanced.

Attorney and Social Worker Feedback

During the fall of 2001, project staff began to develop plans for sustaining the project beyond federal funding. Project staff distributed a brief, 5-minute survey via email to CFS social workers and attorneys to ascertain their impressions of the ON TIME project. A focus group of social workers was then convened as a forum to discuss the project's strengths and barriers. While the response rate for the survey was minimal (an email was sent to over 50 social workers), the overall impression of the project was favorable. All of the attorneys who returned the survey (n=8), had positive responses and indicated that they would like the project to continue beyond the current funding period.

There were 14 social workers (28%) who responded to the survey (out of 50 surveys sent) and there were mixed feelings about the project. Many of the social workers felt that the recovery mentors were not helpful to their clients, yet these same workers were unaware that their client had participated in the project. One social worker commented that she appreciated having a

recovery mentor for her client at the initial court hearing, and others indicated that their clients appreciated having a recovery mentor.

Client Recruitment

Client Eligibility. The ON TIME population for the pre/post-study were all adult OC women who met the program criteria. Initially, the criteria for inclusion into the project was: (1) a woman; (2) at least 18 years of age; (3) with at least one child removed from her custody due to child abuse and/or neglect allegations; (4) in need of AOD treatment services; and, (5) she must have been eligible and/or receiving CalWORKS. After the first three months of recruitment, however, the CalWORKS eligibility requirement was removed due to the low numbers of women eligible for ON TIME who were receiving CalWORKS in Orange County (17% of women eligible for ON TIME) and who were assessed with AOD problems. This led to low numbers of eligible women that the recovery mentors could recruit. The Director of CalWORKS in Orange County suggested that the reason why so few women were on CalWORKS was due to the fact that many families will have reached their time limit of receiving aid, due to the time limit requirements of TANF.

The criteria set for "in need of AOD services" was that the initial court report (Detention Hearing Report) included alcohol or other drug use, abuse or dependency as one of the general neglect allegations. An average of 2,200 petitions for protective custody are filed each year in the county representing an average of 1,000 mothers (approximately 80 mothers per month) (Orange Count Health Care Agency, 1999). Approximately half of those mothers (40) are CalWORKs recipients and a conservative estimate is that half (20) of those have AOD problems. Those figures suggest that approximately 20 mothers per month would be eligible for ON TIME services.

Recruitment. Intake to the study occurred over 19 months, from August 2000 to September 2001 for those participating in both 3- and 9-month interviews, and an additional 8 months (May 2002) for those clients who participated in just the 3-month interview. All women who met the program criteria and agreed to participate were included in the study.

While recruitment started out slowly, in part due to worker acceptance from both the attorneys and social workers, enrollment soon increased to 10-20 per month. Due to a delay in project start-up, the estimated number of recruited clients was decreased to 250 clients for the entire 18-months of the project. During the 19 months of intervention 238 women were recruited into the project. Each client referred to ON TIME services was approached to participate in the research project at the time of the first contact with ON TIME recovery mentors. The nature of the study was explained to the client, and the client was invited to sign an informed consent form. The client also completed a tracking/locating form used by DARC in federally funded studies. This information was used to locate the women for the follow-up interviews.

Issues in Client Recruitment. The recovery mentors received training on the dependency court process prior to client outreach, preparing them for what to expect at each phase of the process. While this training gave them a foundation for understanding the system, they discovered that the actual day-to-day events in the court house were much more complicated. Throughout the

history of the project, project staff and recovery mentors addressed a variety of barriers to increasing the outreach and recruitment rate. Below is a description of the barriers and their resolution.

Engagement with clients at their initial court hearing. It was difficult to determine who the target client was. Although the recovery mentors knew which court room they were assigned to, they were not aware of who the client was. While the recovery mentors had the names of the eligible clients and their respective court rooms, it was difficult to identify the clients by name. They relied on the mothers' attorneys to refer their clients to the project. Initially the recovery mentors were not to approach the clients unless given prior approval by the attorney. Thus, if the client never approached the recovery mentor, it was unknown whether: (1) the attorney had referred the client; (2) the client refused to participate; (3) the client could not locate the recovery mentor; or (4) the client had not attended the hearing.

This issue was resolved by the recovery mentors navigating the court house, networking and building relationships with attorneys, court officers and public health nurses. Over time, these individuals came to trust the recovery mentors and would seek them out and make a direct referral to the project.

Juggling recruitment with the demands of an increasing caseload. The need for the recovery mentors to recruit clients to meet the enrollment targets of the project while also required to provide communication with CFS was challenging. In particular, the case management needs of the clients were much more intense than had been anticipated or designed in the project. The recovery mentors felt pressured to continue recruitment, even when faced with an ever increasing caseload of clients who needed a high degree of intensive case management services. The recovery mentors tended to fluctuate between high and low rates of recruitment, depending on the needs of their caseload.

These issues were problem solved in brainstorming sessions that were held to find more effective ways to manage the two competing priorities. The recovery mentors received extensive training on effective case management and were supported in their efforts by project staff. In addition, access to the dates of clients' 21-day hearings enabled recovery mentors to provide outreach to clients who had not been contacted at the initial hearing. The dependency court has up to 15 hearings per day, which makes it difficult to find ON TIME eligible clients. The recovery mentors learned tactics over several months that increased their rate of contact and subsequent recruitment into the project. One of these tactics, as quoted by one recovery mentor, was to "get to know all the court personnel, including those who check-in the clients, the public health nurses, the court officers, etc." so that they are familiar with the recovery mentors and more amenable to assisting them in contacting clients.

Women in Custody. Women who are involved in the criminal justice system in addition to the child welfare system have increased demands placed on them, which makes it less likely that they will engage and remain in substance abuse treatment. While there are substance abuse treatment programs in jails and prisons, if there is no engagement at that point, once they are released it is less likely they seek treatment. In July 2001, during project implementation, California's Proposition 36 was passed which allowed for substance abuse treatment instead of

incarceration for non-violent offenders. While this was a major step in ensuring access to treatment for this population, it also had an initial impact on the number of treatment slots available for addicted individuals in the child welfare system. Proposition 36 individuals had first priority for treatment slots, thus limiting treatment availability for women involved in the child welfare system.

A significant percentage (25%) of ON TIME eligible clients were incarcerated at the time of their initial court hearing. It is at this initial court hearing that recovery mentors strove to engage women and motivate a change in behavior. Incarcerated women are brought to court and held in "holding cells," thus eliminating the possibility that contact with a recovery mentor occurred in the court building. Historically individuals have not been able to visit inmates in the holding cell; thus, it became a task of one recovery mentor to develop a procedure whereby they could visit with these women either at the court hearing or at the local detention facility. The process was slow, but eventually contact was approved between the client and recovery mentor either in the holding cell or in the courtroom. Security clearance for most of the recovery mentors was also authorized so the recovery mentors could visit the clients at the detention facility at their discretion.

It was seen as an essential step in the treatment process for these women to engage with the recovery mentors, even while still in custody. Many women were released in just a few days or weeks, thus allowing for entry into a treatment program during the early stages of the dependency court process. Contact with women who were not scheduled to be released for many months or years were limited, yet the recovery mentors continued to exchange letters and were available to the clients via collect calls.

Treatment Barriers. An assumption was made early in project implementation that if there were an allegation of AOD in the initial court report, the client would be required to enter treatment. Recovery mentors would then engage with the clients and motivate them to enter treatment in the early stages of the dependency court process. The recovery mentors began to realize, however, that a barrier to immediate AOD treatment engagement was that often treatment was not a requirement in their child welfare case plan until after their dispositional hearing, 21-30 days after their children were removed from their custody for CA/N. Instead, the women were only required to provide random urine toxicology screens during this 3-4 week period while CFS investigated the CA/N and AOD allegations. Thus, clients would inform the recovery mentors that they only had to participate in random toxicology screens. Because project staff only received the detention hearing report, and not the subsequent disposition hearing court report, recovery mentors had to rely on the clients to inform them of their case plan requirements. For some clients, treatment was only a requirement if they had a positive toxicology screen. Reasons for this included: (1) past history of drug use with no current allegations; (2) only the father or significant other had substance abuse allegations; or, (3) often, attorneys do not ask for treatment unless the client receives a positive toxicology screen. In some jurisdictions that have implemented program reforms, this issue has been addressed through agreements between parents' attorneys and the social service agency that facilitates the parent seeking and entering treatment prior to the court order.

A review of 22 ON TIME cases in the winter of 2001 found that while 91% were required to enter AOD treatment at their dispositional hearing, only 64% of the women were actually enrolled in treatment. While the recovery mentors' main goal was to ensure that the client was involved in the services required by the court, the AOD treatment requirement was often not reported to the recovery mentor, signifying that clients either were not informed that treatment was required, were not clear that it was a condition of their case plan, or they were not forthcoming with this information to the recovery mentors.

The dearth of substance abuse treatment services for women in Orange County was also a barrier in treatment engagement. As mentioned previously, there are few residential slots for women and no intensive outpatient programs beyond the county-funded perinatal programs of 4 hours per week. The recovery mentors used their knowledge of community resources to develop highly creative solutions, including linking clients to sober living programs, self-help meetings, and other gender-appropriate services.

Clients who were in the methadone maintenance program also found barriers to appropriate substance abuse treatment. While they were receiving the required medication, often they were not receiving treatment, counseling, or other services. In some cases, these clients would be referred by social workers to the Perinatal Program, the county AOD treatment program for women with children, however this program does not accept clients on methadone. Most other programs also would not accept clients on methadone, such as the dual-diagnosis programs or gender-specific programs. It was not until after mid-way through the project that the recovery mentors discovered that there were two programs in the county that would accept methadone maintenance clients. These clinics were not approved by CFS, however, and the recovery mentors needed to work with the social workers to educate them on the benefits of these programs. Few mothers were able to take advantage of these programs and the treatment service available for opiate-addicted mothers in the county remains a significant barrier to family stability.

Recovery Mentor Experiences

Since the role of the recovery mentors was a central feature of the project, it is important to convey not only the chronology and operational details of their work, but also some of the texture of their experience. In interviews with the recovery mentors, several key observations emerged:

- The importance of, and power, in their own past experience in ensuring credibility and rapport with hard-to-engage clients;
- The learning curve each of the recovery mentors needed to go through on her own, moving their own levels of expectation upward as they came to understand the nature of the job and how to do it, and as their own confidence built over time;
- Their shift from initial client engagement roles to gradually wider responsibilities for case management and "working the system" on behalf of clients who were not going to get connected with services without this help; they realized that clients needed more follow-up instead of just making a referral and assuming clients could navigate the community resource system on their own;

- Their recognition over time that treatment programs differed widely in their rules of eligibility, their openness to providing services to women with children, and their effectiveness—and that placement and referral decisions in the court and by workers in the agencies did not always take these differences into account; and,
- The recovery mentors training in using assessments such as the ASI and ASAM-PPC enabled them to refer clients to the most appropriate programs—and that the systems they were working with were often not able or willing to pay much attention to ensuring this kind of "fit."

Some quotes from the recovery mentors illustrating these issues include:

We moved the bar up on ourselves, from at first just wanting to get into court, and then wanting to have our first clients, and then really seeing how we could make a difference for women who needed help.

We began to see what the system did and didn't offer, and then saw what was needed in addition to AOD treatment –child care, mental health services, and so on.

The court and social services seemed to have a one size fits all attitude, and what we were seeing was that the programs they most often referred to weren't meeting some of the clients' needs.

If we didn't follow through with a client, the whole thing would fall apart—we saw that our work was in vain if we didn't follow it all the way—but each of those follow-up phone calls and contacts meant fewer women that we could work with.

We tried to use the ASI and ASAM patient placement criteria, but traditionally the systems in Orange County don't utilize these assessments. Sometimes we just didn't have the energy to fight it, and we ended up going along with a placement in an agency whether we thought it was effective or not.

The women said they could trust me, and I could tap into my own history to make them feel at ease, and I could identify with them in lots of ways. I knew the street talk, I knew some of the places they had been and I could tell them why they needed to hang in.

It is clear that the recovery mentors made a positive impact in the lives of the women they served. Throughout the project a number of clients contacted the Project co-Director directly, relating that they never would have recovered from substance abuse or regained custody of their children without the help of the recovery mentors. A few quotes from clients capture these impacts:

- *"You saved my life."*
- *"You're the only one who understands me."*
- *"Just by being there has meant so much to me."*

A former mother in the child welfare system, now a substance abuse counselor at a local treatment provider, also made this comment,

When I was in the system, I wished that I had had a mentor, and now that I work in the field I am very glad to see that the ON TIME mentors are available.

The relationship between recovery mentor and client was demonstrated to be essential to engagement and entry into treatment. Although exact data are not available on the actual number of women who regained custody of their children—or whose children were placed in safe, stable homes—due to the termination of the project and the lack of available data on these medium-range outcomes, the efforts of the recovery mentors unquestionably impacted the lives of the women and families that they served.

Other Issues

Case Management

Although initially the goals of outreach, engagement, intervention and re-engagement into treatment were thought to be sufficient, it soon became evident that the recovery mentors' roles would be extended to include additional case management tasks. These ancillary case management tasks included housing, transportation, child care, domestic violence and mental health services.

The needs of the women in the child welfare system were substantial. Many of the women in the program had extensive mental health issues such as depression, bipolar disorder and anxiety disorders. Many had histories of CA/N as children and have experienced trauma and victimization as adults, including domestic violence. All of these factors have an impact on client outcomes, and whether a woman will succeed in substance abuse treatment and have her children returned to her custody. Yet responding to all of these needs is not the accountable task of any one agency. As clients continued to enroll in the ON TIME program, it was evident that the recovery mentors would not be able to assist clients with all of their needs. Discussions at steering committee meetings resulted in the suggestion for decreasing the recovery mentors' case management tasks, including ensuring that once the client was in treatment, the treatment provider would become the clients' primary contact. Another suggestion was to encourage clients to seek outside social support from family members, faith-based organizations and self-help groups. These suggestions, however, did not achieve the desired results since the child welfare staff, health care agency staff with AOD oversight responsibilities, and treatment providers staff felt themselves responsible for case management that went beyond their own narrow roles. Each agency tracked its own performance indicators—clients referred, clients discharged, children placed—but none accepted the responsibility of case management for the full range of the client's needs or for her family, where that was relevant, across the three or more systems involved. As a result, in the summer of 2001, the recovery mentors were given additional training by CFF staff in case management methods.

Family Reunification

Initially family reunification was a major goal of the project whenever possible, yet it became clear that a more appropriate goal was permanency for the child. Often the court and CFS may consider a case to be on "fast track" when reunification is considered doubtful due to prior substance-exposed infants, loss of custody of prior children, or the death of a sibling. In addition there are instances when the client has chosen not to regain custody of her children. In these instances the recovery mentors focused their efforts on engagement, retention, and relapse prevention for the clients so that they may recover and hopefully prevent future involvement in child welfare services.

Vocational and Employment

As mentioned earlier, one of the original requirements for eligibility for the ON TIME project was that they receive cash assistance from CalWORKS, California's implementation of TANF. To enhance the client eligibility rate and to enable the generalization of results to a wider population of families, the public assistance requirement was removed as project inclusion criteria two months after project start-up. The Director of Family Self-Sufficiency, the CalWORKS division in Orange County, made this major policy decision. This decision was in response to two issues within the child welfare and CalWORKS programs. First, both the national TANF caseloads as well as Orange County CalWORKS caseloads have decreased in the past years, although evidence is unclear on whether the remaining cases have more substance abuse problems, and second, women do not receive cash assistance 30 days after the loss of custody of their children. Therefore, expanding the eligibility criteria to include "needy families" rather than "receiving cash assistance" is more responsive to the needs of the population. The significance of this issue lies in part in the fact that the current CalWORKS (state TANF funds) allocation for substance abuse services for Orange County is $5 million.

Project staff continued to track the number of women who were receiving aid. Throughout the almost two years of client recruitment, only 17% of the clients were receiving cash aid at the time of the detention hearing. It is unknown, however, how many of them re-qualified for aid after reunification. In addition, to promote employment outcomes on the short-term basis, recovery mentors were instructed on the use of the Self-Directed Search (SDS) to enable clients to begin considering vocational/career goals (Holland, 1971). The SDS is used by vocational and employment staff to assist clients in learning their career interests. Recovery mentors administered the Self-Directed Search to approximately 20 clients. As an outcome measure, the intention of the project was to document the socioeconomic and employment status of all ON TIME and comparison clients via primary and/or secondary data. While CFS staff had initially stated that they would provide data relating to their economic status for all ON TIME clients and the comparison group, unforeseen staff and budget cuts in CFS resulted in this data element being dropped from the study.

Summary

ON TIME project staff were excited and motivated to begin project implementation, despite the numerous barriers which required perseverance and determination. The steering committee remained actively involved in the project, with consistent attendance at meetings as well as engagement in proactive efforts to provide effective services for this population. Many key stakeholders in the county, including the child welfare, substance abuse treatment and family court systems, supported the project at its inception. The primary contractor and subcontractors sought to market the program by making presentations to various community meetings and having regular contact with management and frontline staff in the child welfare and substance abuse treatment agencies.

The recovery mentors participated at weekly staff meetings for support and to receive feedback, which in turn led to increased motivation to continue to support their work with the substance-involved women in the child welfare system. The mentors used their interpersonal skills to engage with the clients' attorneys and social workers as well as the clients. As time progressed, the mentors became familiar players in the dependency court, with the attorneys and social workers relying on their assistance with substance-involved women. A major outcome of the project was the relationship that developed between the parents' attorneys and the mentors. By the time that project sustainability discussions were being held, parent attorneys wrote letters of support to attempt to ensure that the program would continue. Even with this support, there continued to be social workers who were unaware of the ON TIME project, and project staff made efforts to increase awareness of the project.

The client recruitment efforts of the mentors were ongoing and had to be counter-balanced with the case management needs of their existing caseload. The mentors encountered barriers to client engagement (incarcerated clients) as well as treatment entry (no intensive services; clients receiving methadone), yet were consistently proactive in working through these barriers. The issues of intensive case management, family reunification and employment existed in each case, complicating the engagement and recruitment efforts. ON TIME project staff, the recovery mentors, and the steering committee members remained dedicated to assisting this population.

CHAPTER V.
CLIENT TREATMENT OUTCOMES AND SERVICES EFFECTIVENESS

The ON TIME study collected data from adult clients at multiple time points, including intake and during treatment. In addition, the study included follow-up interviews at 3- and 9-months post-intake. The purpose of this chapter is to describe the characteristics of the clients who were a part of the ON TIME data collection at each data collection stage.

Study Design

The ON TIME outcome evaluation used a pre- to post-treatment design to assess client outcomes and service effectiveness. Client functioning, defined as the severity of substance abuse-related problems measured on the Addiction Severity Index (ASI), was assessed at treatment entry and at 9-months post-intake. Services received by the client during this period were identified. Treatment outcomes were assessed in terms of changes in client functioning (as measured by scores on the ASI) relative to clients' individual characteristics and configurations of substance abuse treatment services utilization. Client stages of change, utilizing the Stages of Change Tool, were assessed at the initial contact and at 21 to 30-days post contact.

Sample

The present analyses includes 238 women who were enrolled into the ON TIME project. Demographic and background characteristics are presented in Table 2. The overall study sample was 52% Caucasian and 34% Hispanic. The mean age was 30.6 years (SD=7.0), with the majority of clients between 26-35 years of age (46%). Approximately 57% of the clients graduated from high school or obtained a GED. At intake, only 16% of the clients were married, however, there was equal representation among those single and divorced/separated (44% and 40%).

Overall, the sample reported low levels of employment (10% were employed full-time and 13% worked part-time). More than one-third (36%) of the clients were under some type of legal supervision (probation, parole, diversion). Forty-five percent of the clients reported amphetamine or methamphetamine as their primary drug problem. An additional, 21% cited alcohol as their primary problem. Heroin (11%), marijuana (10%), and crack/cocaine (9%) were the next most prevalent primary drug problems reported by clients. In terms of secondary drug problems, marijuana (18%), amphetamine (17%), alcohol (16%), and crack/cocaine (11%) were the most prevalent.

Table 2. Client Intake Demographics

	N	%
Race/Ethnicity		
African American	6	2.6
White	121	52.8
Hispanic	79	34.5
Asian	2	0.9
American Indian/Alaskan Native	3	1.3
Multiracial	11	4.8
Other	7	3.1
Educational Status		
Less than high school	99	42.9
High school/GED	67	29.0
At least some college	65	28.1
Current Marital Status-(n=202)		
Single/never married	89	44.1
Divorced/separated/widowed	81	40.1
Married	32	15.8
Age		
18-25	64	27.0
26-35	108	45.6
36-45	63	26.6
46 +	2	0.8
Average Age	30.6	7.0

Data Sources/Instruments/Measures

Data used for the present analyses include: the ASI Lite CF TOPPS II form, which provides information on clients status at intake; and the ASAM PPC form; which indicates the modality the client entered (e.g., outpatient drug free, residential). A detailed description of the instruments can be found in Chapter III.

Client Pre-Treatment Characteristics

Client Problem Severity

Client problem severity in the seven areas measured by the ASI was obtained from the composite scores. As shown in Table 3, employment problems constituted the most severe problems followed by psychiatric, family, medical, legal, drug problem severity.

Table 3. ASI Composite Scores

Variable	Mean	SD
Alcohol	0.08	0.16
Drug	0.10	0.11
Medical	0.16	0.27
Employment	0.73	0.29
Family	0.23	0.19
Legal	0.13	0.18
Psychiatric	0.31	0.23

Client Placement Criteria

According to the California approach to the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC), low intensity residential services (32%) or early intervention (29%) was indicated for the majority of the clients, yet most of the clients received either outpatient (35%) or intensive outpatient (28%) treatment (see Table 4). Most discrepancy was observed between intensive outpatient and low intensity residential services. The most common reasons treatment differed from what was indicated included client preference (23%), provider judgment (17%), criminal justice preference (16%), unavailability of service (5%), and family responsibility (4%).

Table 4. ASAM Placement Criteria

	% Indicated	% Received
Outpatient detoxification	1.3	0.9
Clinically monitored residential detoxification	0.9	3.1
Early intervention	29.0	15.7
Outpatient services	10.4	35.0
Intensive outpatient services	6.9	28.3
Day treatment	0.9	0.4
Low intensity residential services	32.5	7.2
Medium/high intensity residential services	13.0	6.3
Residential medically monitored intensive services	5.2	0.4
Opioid maintenance	0.0	2.7

Medical status

Almost half of the clients had been hospitalized for medical problems sometime in their lives, averaging 2.6 episodes (see Table 5). About 8% of the clients had stayed overnight in a hospital and 23% had visited an emergency room in the 30 days prior to intake. More than 18% of the clients had a chronic medical problem that interfered with their daily lives and almost an equal percentage (17%) were taking prescribed medication on a regular basis for a physical problem.

About 5% of the clients acknowledged receiving a pension for a physical disability while more than one third (37%) of the clients had experienced medical problems in the 30 days prior to intake. One third (33%) had been troubled by these medical problems and 11% rated their need for medical treatment as "considerable" or "extreme."

Table 5. Medical Status

	N	% or Mean (SD)
Ever been hospitalized	103	49.8
Average no of hospitalizations (SD)		2.61 (6.9)
Stayed overnight in hospital in past 30 days	17	8.2
Stayed overnight in hospital in past 6 months	26	12.6
Visited emergency room in past 30 days	47	22.7
Visited emergency room in past 6 months	28	13.5
Experiencing chronic medical problems	38	18.4
Taking prescription medication for a physical problem	35	16.9
Receives pension for physical disability	10	4.8
Had medical problems in past 30 days	77	37.2
Been troubled or bothered by medical problems in past 30 days	75	36.2
Treatment needed for medical problems		
Not at all	137	66.5
Slightly	31	15.0
Moderately	16	7.8
Considerably	8	3.9
Extremely	14	6.8

Employment and Income Sources

Almost half of the clients (44%) were not employed or seeking work prior to the intake interview (see Table 6). Approximately 10% of the clients were employed full-time, 13% were employed part-time, and 33% were not employed but were seeking work. About half (46%) had a driver's license and one third (33%) had an automobile available.

Approximately 24% of the clients reported receiving legal wages from a job, while 45% received income from the earnings of a mate, family, or friends. The next most frequently reported source of income was money from welfare/public assistance (23%) followed by cash from a pension, or other benefits or social security (11%). Only about 3% received unemployment compensation. Almost 43% reported that a majority of their support was provided by another. Only 2% reported receiving income from illegal activities. The average monthly legal income in the 30 days prior to the intake assessment was $257 (SD=$863). The average monthly illegal income was $29 (SD=240). Clients reported being paid for an average of 4 (SD=9) days of work in the past 30 days and about 2 people on average (SD=1) depended on the client for the majority of

their food and shelter. Few clients had received any job training in the 30 days or 6 months prior to the intake interview. Almost 40% had experienced employment problems in the past 30 days and a similar percentage (42%) had been troubled or bothered by these problems. More than 17% reported a "considerable" or "extreme" need for employment counseling at intake.

Table 6. Employment Status and Support Sources

	N	% or Mean (SD)
Employment Status		
Full-time	24	10.4
Part-time	30	12.6
Unemployed	76	32.9
Not in Labor Force	101	43.7
Transportation		
Has valid driver's license	95	45.9
Has automobile available	68	32.9
Support Source		
Employment	50	24.3
Unemployment compensation	7	3.4
Welfare/public assistance (includes CalWORKS, WIC, GR, & food stamps)	48	23.3
Pensions, benefits, Social Security	23	11.2
Mate, family, or friends	94	45.4
Majority of support provided by another	87	42.6
Average no. of days paid for working in past 30 days (SD)		4.2 (8.6)
Average no. of people depending on client for majority of food, shelter, etc (SD)		1.5 (1.4)
Average monthly legal income (SD)		256.64 (862.53)
Average monthly illegal income (SD)		28.99 (236.95)
Job Training		
Has been enrolled in vocational, training, or educational program in past 6 months	8	3.9
Has been enrolled in vocational, training, or educational program in past 30 days	3	1.4
Employment Problems and Counseling Need		
Had employment problems in past 30 days	81	39.3
Been troubled or bothered by employment problems in past 30 days	86	41.5
Counseling need for employment problems		
Not at all	116	56.3
Slightly	19	9.2
Moderately	30	14.6

Considerably	28	13.6
Extremely	13	6.3

Substance Use and Treatment History

Amphetamine/methamphetamine (45%) was the most common primary drug problem at intake, followed by alcohol (21%), heroin (11%), and marijuana (10%) (see Table 7). Almost half (48%) of the clients had not used their primary drug in the 30 days prior to intake although 52% acknowledged some illicit use in the same period. Most had used illicit drugs at some point in their lifetime (85%). Aside from alcohol, the most frequently used drugs in the 30 days prior to intake were amphetamine/methamphetamine (28%) and marijuana (16%). The most common route of administering the primary drug was smoking (46%), followed by oral (25%) and injection (13%). On average, clients spent about $9 (SD=$42) on alcohol and $71 (SD=$267) on drugs in the 30 days prior to intake.

Table 7. Substance Use

Primary Drug	**N**	**%**
Amphetamines	104	45.0
Alcohol	48	20.8
Crack/cocaine	21	9.1
Heroin/other opiates	26	11.3
Marijuana	24	10.4
Other	5	2.2
None reported	3	1.3
Secondary Drug		
Amphetamines	40	17.3
Alcohol	38	16.5
Crack/cocaine	26	11.3
Heroin/other opiates	6	2.6
Marijuana	41	17.8
Other	7	3.0
None reported	73	31.6
Primary Drug Use Frequency		
No use	99	47.8
Monthly	34	16.4
At least weekly	52	25.1
At least daily	22	10.6
Used in Past 30 Days		
Any illicit drug	123	51.7
Amphetamine/methamphetamine	67	28.2
Alcohol	59	24.8

Crack/cocaine	16	6.7
Marijuana	38	16.0
Heroin/other opiates	16	6.7
Other	23	9.7
Ever Used in Lifetime		
Any illicit drug	203	85.3
Amphetamine/methamphetamine	138	58.0
Alcohol	127	53.4
Crack/cocaine	63	26.5
Marijuana	79	33.2
Heroin/other opiates	47	19.8
Other	40	16.8
Route of Administration		
Oral	50	24.6
Smoking	93	45.8
Injection	27	13.3
Other	33	16.3
Fiscal Burden of Use		
Average amount spent on alcohol in past 30 days (SD)		8.85 (41.64)
Average amount spent on alcohol in past 30 days (SD)		70.92 (267.27)

Almost half (48%) had received prior alcohol treatment, while less than 20% had received prior drug treatment (see Table 8). Many clients (36%) had attended 12-step meetings in the 30 days prior to intake. Twenty-one percent had experienced alcohol problems and 59% had experienced drug problems. Similar percents reported being bothered by their alcohol or drug problems. More than 7% reported a "considerable" or "extreme" for alcohol treatment, while 27% reported a "considerable" or "extreme" need for treatment drug problems.

Table 8. Treatment History

Treatment History	**N**	**%**
Prior drug treatment	40	19.4
Prior alcohol treatment	98	47.6
Average no. of drug treatments (SD)		0.4 (1.3)
Average no. of alcohol treatments (SD)		1.2 (2.3)
Attended 12-step groups in past 30 days	73	35.8
Average no. of days treatment in outpatient setting in past 30 days		3.5 (8.3)
Had alcohol problem in past 30 days	43	21.0
Been troubled by alcohol problem in past 30 days	42	20.5
Treatment needed for alcohol problems		
Not at all	163	79.5

Slightly	17	8.3
Moderately	10	4.9
Considerably	8	3.9
Extremely	7	3.4
Had drug problem in past 30 days	121	59.3
Been troubled by drug problem in past 30 days	120	58.5
Treatment needed for drug problems		
Not at all	85	41.5
Slightly	34	16.6
Moderately	30	14.6
Considerably	23	11.2
Extremely	33	16.1

Legal status

Sixty-four percent of the clients reported no criminal justice intervention at intake, while 27% were on probation, 4% were on some type of parole, and 4% were incarcerated (see Table 9). The clients averaged 2.9 arrests in their lifetime prior to intake. Almost 44% of the clients had been arrested for drug charges in their lifetime and one-quarter had been arrested for parole or probation violations (24.9%). Almost 19% had been arrested for shoplifting or vandalism and about 8% had been arrested for burglary or assault. Almost 20% of the clients had been charged with driving while intoxicated or a major driving violation in their lifetime. Twenty percent had been arrested in the 30 days prior to intake, while more than one-third had been arrested in the 6 months prior to intake. Half of the clients (50%) had been convicted of a charge in their lifetime while a much smaller percentage were awaiting charges, trial, or sentencing at intake (16%). Forty-eight percent of clients had been incarcerated in their lifetime, for an average of 5.4 months, and 30% had been incarcerated in the 30 days prior to intake. About 6% had engaged in illegal activities for profit in the prior 30 days.

Table 9. Interactions with the Criminal Justice System (CJS)

Legal Status at Intake (from CADDS)	**N**	**% or Mean (SD)**
None	146	64.0
Probation	61	26.7
Parole/CDC	5	2.2
Parole/Other	3	1.3
Diversion	4	1.8
Incarcerated	9	3.9
Treatment admission prompted by CJS	84	41.2
Currently on parole or probation	81	39.5
Has been arrested in lifetime for:		
Shoplifting/vandalism	38	18.5

Parole/probation violations	51	24.9
Drug charges	90	43.9
Forgery	15	7.3
Weapons offense	4	1.9
Burglary	17	8.3
Robbery	9	4.4
Assault	16	7.8
Prostitution	9	4.4
Contempt of court	4	1.9
Other	35	17.1
Has been charged in lifetime for:		
Disorderly conduct, vagrancy, public intoxication	12	5.8
Driving while intoxicated	31	15.2
Major driving violations	38	18.5
Has been arrested in past 30 days	41	25.0
Has been arrested in past 6 months	70	34.1
Has been convicted in lifetime	102	49.8
Currently awaiting charges, trial, or sentencing	32	15.6
Incarcerated in lifetime	98	47.8
Incarcerated in past 30 days	62	30.2
Average no. of months incarcerated in lifetime (SD)		5.4 (14.4)
Engaged in illegal activities for profit in past 30 days	13	6.3
Troubled by legal problems		
Not at all	112	54.9
Slightly	31	15.2
Moderately	32	15.7
Considerably	15	7.4
Extremely	14	6.9
Counseling needed for legal problems		
Not at all	119	58.3
Slightly	32	15.7
Moderately	26	12.7
Considerably	16	7.8
Extremely	11	5.4

At intake, more than half of the clients said they were not troubled by their current legal problems (55%), while less than 15% were considerably or extremely troubled by their current legal problems. Similarly, more than half (58%) said they did not need counseling for legal problems, and 13% were in considerable or extreme need for legal problems counseling (13%).

Family and Social Relationships

At intake, two-thirds of clients were living independently and about 22% were homeless (see Table 10. More than half (56%) were satisfied with their living arrangements. Half of the clients spent their free time with family (50%) and half spent their free time either with friends (30%) or alone (20%). Almost 63% were satisfied with spending their free time this way. Some clients reported currently living with someone who had an alcohol problem (18%) or used illegal drugs (21%). The majority of the clients (80%) had been abused physically and 44% had been abused sexually in their lifetimes. Many clients had experienced serious conflicts with family members (42%) or other people (33%) in the 30 days prior to intake.

Eight percent of the clients were pregnant at intake and most had received prenatal care (88%). Clients averaged 2.6 children and 99.0% had at least one child under the age of 18 years. Almost all (91%) of the clients reported that they had one or more children removed from their care by Children's Protective Services, and about 17% had lost parental rights to one or more children. About half had been troubled by family problems (53%) or social problems (45%) in the 30 days prior to intake and about half reporting needing treatment for these problems.

Table 10. Family and Social Relationships

Living Arrangements	**N**	**% or Mean (SD)**
Homeless	45	22.3
Dependent living	22	10.9
Independent living	135	66.8
Satisfied with living arrangement	111	55.8
With whom spend free time		
Family	100	50.0
Friends	61	30.5
Alone	39	19.5
Satisfied with spending free time this way	126	62.7
Current relationships		
Roommate has alcohol problem	37	18.2
Roommate uses illegal drugs	42	20.7
Prior abuse		
Ever been abused physically	162	80.2
Ever been abused sexually	88	43.8
Prior conflict		
Had serious conflicts with family in past 30 days	85	41.7
Had serious conflicts with other people in past 30 days	67	33.0
Parenting Status		
Currently pregnant	17	8.3
If pregnant, received prenatal care	15	88.2
No. of children <18 years among clients		

1	59	28.9
2	49	24.0
3	47	23.0
4 or more	47	23.0
Average no. of children (SD)		2.6 (1.5)
Had one or more children removed by CPS	184	90.6
Lost parental rights to one or more children	31	17.1
Family/social problems and treatment need		
Been troubled by family problems in past 30 days	106	52.5
Counseling need for family problems		
Not at all	101	50.0
Slightly	47	23.3
Moderately	24	11.9
Considerably	14	6.9
Extremely	16	7.9
Been troubled by social problems in past 30 days	90	44.6
Counseling need for social problems		
Not at all	116	57.4
Slightly	48	23.8
Moderately	22	10.9
Considerably	8	9.4
Extremely	8	9.4

Mental Health Status

More than one-quarter of the clients reported having inpatient (26%) or outpatient (30%) mental health treatment at some point in their lives, while a much smaller percentage had experienced similar events in the 30 days (3%) or 6 months (5%) prior to intake (see Table 11). Only 3% were receiving a pension for a psychiatric disability. More than three quarters reported having experienced depression (77%) and 72% reported serious anxiety in their lifetime. Many clients reported having experienced hallucinations (20%), trouble understanding or concentrating (43%), or controlling violent behavior (48%). More than 30% of the clients had been prescribed medications for psychological or emotional problems. About a quarter (22%) reported having attempted suicide or experienced serious thoughts of suicide (30%) at some times in their lives. Three-quarters of the clients had experienced psychological or emotional problems in the 30 days prior to intake and a similar percentage (76%) had been troubled by these problems. About 75% expressed a need for mental health treatment and almost one-third of clients stated a considerable or extreme need for mental health treatment (32%).

Table 11. Mental Health Status

Ever been treated for psychological/emotional problems in:	N	% or Mean (SD)
Hospital or inpatient setting	54	26.5
Outpatient or office setting	61	29.9
Stayed overnight in hospital for psychiatric problems in past 30 days	7	3.5
Stayed overnight in hospital for psychiatric problems in past 6 months	11	5.5
Receives pension for psychiatric disability	6	3.0
Ever experienced:		
Depression	158	77.5
Serious anxiety	148	72.5
Hallucinations	41	20.1
Trouble understanding	88	43.1
Trouble controlling violent behavior	97	47.8
Serious thoughts of suicide	61	30.0
Suicide attempt	45	22.2
Ever been prescribed medication for psychiatric problem	65	32.0
Mental health problems and treatment need		
Had psychological or emotional problem in past 30 days	154	75.5
Been troubled by emotional problems in past 30 days	154	75.9
Treatment need for psychological/emotional problems		
Not at all	50	24.6
Slightly	53	26.1
Moderately	36	17.7
Considerably	32	15.8
Extremely	32	15.8

Stages of Change Rating Tool Results

Results indicate (Table 12) that during the first three weeks of their participation in the ON TIME programs, the women had significantly increased their readiness to make lifestyle changes such as entering drug abuse treatment, seeking counseling for emotional problems, decreasing chances of physical harm (i.e., domestic violence) and seeking employment. There were no changes in terms of reducing HIV risk behaviors, however.

Table 12. Intake and 21-Day Stages of Change

	Intake		21-Day		
Variable	Mean	SD	Mean	SD	**t-test**
Readiness to enter drug treatment	4.91	3.47	5.87	3.30	-5.57***
Readiness to enter counseling for emotional problems	5.11	2.52	6.07	2.27	-6.32***

Readiness to reduce risk of HIV	4.40	5.40	4.77	5.60	-1.50
Readiness to decrease chances of physical harm	5.05	5.13	5.48	5.17	-2.08*
Readiness to seek employment, education, training	5.59	3.08	6.09	2.88	-2.55*

Note: *p<.05, **p<.01, ***p<.001

Treatment Outcomes

Overall Follow-Up Outcome Status

Table 13 presents information on the follow-up rates for the three- and nine-month post-intake interviews conducted by UCLA staff. Of the 238 clients targeted for the three-month follow-up, 87.4% were interviewed, 11% were not located, less than 1% refused the interview when contacted, and less than 1% were incarcerated (a number of other clients were also incarcerated, but UCLA was able to conduct the interview) or deceased. If clients who could not be interviewed due to death or incarceration were excluded, 89% of the clients were been interviewed.

Table 13. 3- and 9-Month Follow-Up Rates

	3-Month Follow-Up (n=238)		9-Month Follow-Up (n=183)	
	N	**%**	**N**	**%**
Interviewed	208	87.4	145	79.2
Not located	26	10.9	28	15.3
Refused	2	0.8	3	1.6
Deceased	1	0.4	1	0.6
Incarcerated	1	0.4	5	2.8
Deported	0	0.0	1	0.6

There were 183 clients were in the study long enough to be eligible for the nine-month interview. UCLA staff were able to interview only those clients who were recruited nine months before the end of the study. Of these, 79% have been interviewed, 15% were not located, 3% were incarcerated, 2% refused the interview when contacted, and less than 1% were deceased or could not be interviewed as they had been deported. If clients who could not be interviewed due to death, incarceration, or deportation were excluded, 83% of the eligible clients have been interviewed. Note that not all data elements were completed for all clients at each of the assessment points, thus sample sizes vary depending on the combination of data elements and specific time points. To maximize the sample size and data utilization, we use the maximal number of clients who have the complete data relevant to the specific research question.

Client Status at 3-Month Follow-Up Interview

At the 3-month follow-up interview, clients were asked to briefly describe their current treatment status (see Table 14). Most clients appeared to be doing relatively well at this time point. More than half (60%) were still in an AOD treatment program. Almost all clients had abstained from alcohol (98%) and drugs (87%) in the 30 days prior to the interview. Almost three-quarters had attended self-help groups in the same time period (72%). Almost 40% of the clients were on

probation or parole (37%) and very few of the clients had been arrested in the prior 30 days (4%). Forty percent of the clients were either employed or attending school or job training and about 55% were in the community and not using drugs.

Table 14. Client Status at 3-Month Follow-Up Point (n=208)

	N	%
Still in substance abuse treatment	125	60.1
Abstained from alcohol in past 30 days	203	97.6
Abstained from illegal drugs in past 30 days	181	87.0
Attended self-help groups in past 30 days	150	72.1
On probation or parole	78	37.5
No arrests in past 30 days	199	95.7
Employed for pay and/or attending school or job training	83	39.9
In community, not using drugs	114	54.8

Services Received and Treatment Satisfaction

Services received during treatment were derived from the TSR administered at the three-month follow-up interview. Results of analyses conducted on the need for services in specific problem domains and services received in the respective area assessed at the three-month follow-up interview are presented in Table 15. Areas in which the clients expressed the most need for services are employment, family/social, and physical/sexual abuse. Services received by ON TIME clients were most frequently in the areas of drug problems, parenting problems, and mental health problems.

Table 15. Needs Expressed and Services Received at 3-Month Follow-Up Interview

	Need (%)	Services Received (%)
Medical Problem	13.9	9.1
Employment Problem	61.1	23.1
Alcohol Problem	9.6	32.2
Drug Problem	16.8	65.9
Legal Problem	20.7	27.9
Family/Social Problem	53.4	25.5
Mental Health Problem	32.2	42.3
Parenting Problem	15.8	52.6
Physical/Sexual Abuse	51.7	18.7
HIV		42.3
Social Services		4.3
Survival Services		4.3

Approximately 25% of the clients reported that they had not received any services after intake. Of those clients who had received services, the majority felt the services they received in treatment to be helpful and were generally satisfactory (see Table 16). Satisfaction with the specific service areas was highest in alcohol and drug services, followed by psychological services and alcohol services, and were lowest in social and survival (emergency goods, housing, transportation) services.

Table 16. Clients' Responses to 3-Month Post-Intake Client Satisfaction Survey

How helpful or satisfactory has the program overall been in providing:	N	%
Medical Services		
Very helpful	2	1.3
Pretty helpful	15	9.5
Somewhat helpful	2	1.3
A little helpful	2	1.3
Not at all helpful	2	1.3
Did not need service	135	85.4
Employment Services		
Very helpful	19	12.0
Pretty helpful	21	13.3
Somewhat helpful	6	3.8
A little helpful	2	1.3
Not at all helpful	7	4.4
Did not need service	103	65.2
Alcohol Counseling		
Very helpful	36	22.8
Pretty helpful	22	13.9
Somewhat helpful	2	1.3
A little helpful	1	0.6
Not at all helpful	4	2.5
Did not need service	93	58.9
Drug Counseling		
Very helpful	93	58.9
Pretty helpful	27	17.1
Somewhat helpful	8	5.1
A little helpful	4	2.5
Not at all helpful	10	6.3
Did not need service	16	10.1
Criminal Legal Services		
Very helpful	18	11.4

Pretty helpful	22	13.9
Somewhat helpful	17	10.8
A little helpful	1	0.6
Not at all helpful	5	3.2
Did not need service	95	60.1
Family Services		
Very helpful	28	17.7
Pretty helpful	19	12.0
Somewhat helpful	8	5.1
A little helpful	2	1.3
Not at all helpful	3	1.9
Did not need service	98	62.7
Mental Health Services		
Very helpful	47	29.8
Pretty helpful	28	17.7
Somewhat helpful	9	5.7
A little helpful	2	1.3
Not at all helpful	6	3.8
Did not need service	66	41.8
Parenting Skills/Childcare Services		
Very helpful	9	5.7
Pretty helpful	5	3.2
Somewhat helpful	4	2.5
A little helpful	1	0.6
Not at all helpful	1	0.6
Did not need service	138	87.3
HIV/AIDS Prevention Education and Counseling		
Very helpful	41	26.0
Pretty helpful	18	11.4
Somewhat helpful	22	13.9
A little helpful	3	1.9
Not at all helpful	3	1.9
Did not need service	71	44.9
Physical/Sexual Abuse Services		
Very helpful	17	10.8
Pretty helpful	2	1.3
Somewhat helpful	3	1.9
A little helpful	0	0.0
Not at all helpful	6	3.8

Did not need service	130	82.3
Traditional Social Services/Case Management		
Very helpful	7	4.4
Pretty helpful	3	1.9
Somewhat helpful	1	0.6
A little helpful	1	0.6
Not at all helpful	6	3.8
Did not need service	140	88.6
Survival Services		
Very helpful	7	4.4
Pretty helpful	3	1.9
Somewhat helpful	2	1.3
A little helpful	1	0.6
Not at all helpful	8	5.1
Did not need service	137	86.7

As presented in Table 17, about two-thirds of the clients strongly agreed that the treatment services they had received were timely, effective, and satisfactory, while a similar percentage strongly agreed that the staff respected her background and believed that she could change or improve her life.

Table 17. Clients' Responses to 3-Month Post-Intake Client Satisfaction Survey

Received services in timely manner	**N**	**%**
Strongly agree	104	66.2
Somewhat agree	39	24.8
Neutral	2	1.3
Somewhat disagree	6	3.8
Strongly disagree	6	3.8
Location of services was convenient		
Strongly agree	96	60.8
Somewhat agree	40	25.3
Neutral	5	3.2
Somewhat disagree	5	3.2
Strongly disagree	12	7.6
Asked to participate in recovery or treatment plan		
Strongly agree	95	60.1
Somewhat agree	34	21.5
Neutral	11	7.0
Somewhat disagree	0	0.0

Strongly disagree	18	11.4
Staff respected background		
Strongly agree	108	68.4
Somewhat agree	41	26.0
Neutral	5	3.2
Somewhat disagree	1	0.6
Strongly disagree	3	1.9
Staff helped client believe they could change or improve their life		
Strongly agree	109	69.9
Somewhat agree	38	24.4
Neutral	4	2.6
Somewhat disagree	0	0.0
Strongly disagree	5	3.2
Learned skills to help better manage life		
Strongly agree	102	65.4
Somewhat agree	39	25.0
Neutral	7	4.5
Somewhat disagree	3	1.9
Strongly disagree	5	3.2
Would return to program if needed services in future		
Strongly agree	102	65.8
Somewhat agree	30	19.4
Neutral	9	5.8
Somewhat disagree	1	0.7
Strongly disagree	13	8.4
Would recommend program to friend		
Strongly agree	105	67.3
Somewhat agree	37	23.7
Neutral	6	3.9
Somewhat disagree	0	0.0
Strongly disagree	8	5.1
Received the kind of services wanted		
Strongly agree	98	63.2
Somewhat agree	39	25.2
Neutral	8	5.2
Somewhat disagree	3	1.9
Strongly disagree	7	4.5
Service helped me deal more effectively with problems		
Strongly agree	99	63.9

Somewhat agree	37	23.9
Neutral	8	5.2
Somewhat disagree	1	0.7
Strongly disagree	10	6.5
Overall, satisfied with services received		
Strongly agree	99	63.9
Somewhat agree	40	25.8
Neutral	7	4.5
Somewhat disagree	0	0.0
Strongly disagree	9	5.8

Service intensity and frequency of individual and group counseling sessions in specific problem domains are listed in Table 18. Although the scales for service intensity across problem domains are not comparable, the overall pattern appears to suggest that services and counseling related to drugs and alcohol were most frequently provided, followed by services addressing psychological/emotional problems. In addition, there were relatively low levels of services provided with regard to medical, employment, family, and legal problems. Problems discussed in the individual and group sessions followed a similar pattern, with drugs and alcohol being discussed most often, psychological/emotional problems next, followed by problems in other areas.

Table 18. Service Intensity for Problems

	Service Intensity	**Individual Counseling**	**Group Counseling**
	Mean (SD)	**Mean (SD)**	**Mean (SD)**
Medical	0.08 (0.4)	0.21 (1.2)	0.21 (1.9)
Employment	0.60 (2.8)	0.34 (0.9)	0.23 (1.1)
Alcohol	10.8 (29.5)	1.6 (3.9)	6.1 (15.1)
Drug	19.5 (33.8)	3.3 (4.9)	11.5 (17.9)
Legal	1.4 (6.9)	0.82 (4.3)	0.34 (1.2)
Family/Social	2.2 (5.3)	1.5 (3.5)	0.47 (2.1)
Mental Health	9.4 (25.8)	2.3 (6.2)	1.6 (6.1)
Parenting	3.1 (5.2)	1.0 (1.8)	2.1 (4.1)
Physical/Sexual Abuse	3.0 (12.7)	2.3 (12.0)	0.66 (2.4)
HIV	0.29 (0.6)	0.22 (0.5)	0.39 (1.0)
Social Services	0.23 (2.2)	0.05 (0.4)	0.17 (2.1)
Survival	0.03 (0.2)	0.03 (0.2)	0.0 (0.0)

Relationships between Client Problem Severity and Service Intensity

There were overall significant correlations between alcohol and family problem severity (ASI severity scores at intake) and services received during the three months following intake, indicating that clients with alcohol and family problems were receiving the relevant services. The highest correspondence between problem severity and service provision was in the alcohol area (correlations ranged from .20 to .25). Client problem severity in the seven ASI domains at intake was, in general unrelated to treatment satisfaction except in the family area; clients with greater severity of mental health issues were more satisfied with the mental health services they received.

Relating Treatment Services and Retention to Post-Intake Outcomes

In order to understand how treatment outcomes are related to treatment process measures (e.g., treatment retention, treatment satisfaction, and treatment services intensity), we separated the sample into two groups: success and no success. Success is defined as no drug use or crime (including no arrest) and living in the community (not confined in a controlled environment) in the past 30 days prior to the 3-month follow-up interview.

At the 3-month interview, about half (52%) of the clients met the success criteria. As shown in Table 19, clients with success were more likely to still be in treatment at the three-month interview (70% vs. 49%) than clients without success. Clients with success reported greater levels of satisfaction with treatment services and treatment staff than clients without success. There were no differences in the number of services received by either group. The clients without success, however, received more intensive drug services than clients with success.

Table 19. Service Intensity and Satisfaction on Successful Outcome at the 3-Month Follow-Up

	Success	**No Success**
	(N=109)	**(N=99)**
Still in treatment program**	76 (69.7%)	49 (49.5%)
	Mean (SD)	**Mean (SD)**
Number of services used	2.0 (2.0)	1.9 (2.1)
Treatment Satisfaction		
Treatment convenience and respectfulness*	4.5 (0.6)	4.3 (0.7)
Treatment effectiveness and satisfaction*	4.6 (0.6)	4.2 (1.1)
Satisfaction with counselor*	4.3 (0.8)	4.0 (1.1)
Satisfaction with medical services	4.3 (0.9)	4.0 (1.2)
Satisfaction with social services	3.8 (0.9)	3.8 (0.7)
Service Intensity		
Service intensity for medical problems	0.11 (0.5)	0.04 (0.2)
Service intensity for employment problems	0.41 (1.2)	0.81 (1.2)
Service intensity for alcohol problems	7.3 (14.5)	14.7 (39.8)
Service intensity for drug problems*	14.9 (18.5)	24.5 (44.6)

Service intensity for legal problems	1.0 (3.6)	1.8 (9.3)
Service intensity for family/support	2.4 (5.8)	2.0 (4.8)
Service intensity for psychiatric problems	6.2 (11.1)	12.9 (35.3)
Service intensity for parenting/social support/abuse/HIV/survival	2.5 (5.4)	3.5 (15.8)

Note: *p<.05, **p<.01, ***p<.001

Client Status at 9-Month Follow-Up Interview

At the 9-month follow-up interview, clients continued to do relatively well at this time point (see Table 20). Half (51%) were still in a AOD treatment program and all clients reported abstaining from alcohol and almost all abstained from drugs (97%) in the 30 days prior to the interview. The majority of clients reported attending self-help groups in the same time period (74%). There slightly were more clients were on probation or parole (46%) and a few more clients had been arrested in the prior 30 days (8%). On the other hand, almost half of the clients were employed or attending school or job training (47%) and about 65% were in the community and not using drugs.

Table 20. Client Status at 9-Month Follow-Up Point (n=145)

	N	%
Still in substance abuse treatment	74	51.4
Abstained from alcohol in past 30 days	145	100.0
Abstained from illegal drugs in past 30 days	140	96.6
Attended self-help groups in past 30 days	107	73.8
On probation or parole	67	46.2
No arrests in past 30 days	133	91.7
Employed for pay and/or attending school or job training	68	46.9
In community, not using drugs	94	64.8

At the 9-month interview, about 65% of the sample (n=94) met the success criteria. As shown in Table 21, clients with success were more likely to still be in treatment at the nine-month interview. There were no differences between clients with success or without success in terms of levels of satisfaction with treatment services and treatment staff. There were also no differences in the number of services received or service intensity reported by either group.

Table 21. Service Intensity and Satisfaction on Successful Outcome at the 9-Month Follow-Up

	Success	No Success
	(N=94)	**(N=50)**
Still in treatment program*	55 (59.1)	19 (37.3)
	Mean (SD)	**Mean (SD)**
Number of services used	2.3 (2.2)	1.8 (2.1)
Treatment Satisfaction		

Treatment convenience and respectfulness	4.3 (0.7)	4.2 (0.7)
Treatment effectiveness and satisfaction	4.5 (0.8)	4.0 (1.2)
Satisfaction with counselor	4.2 (0.9)	3.7 (1.2)
Satisfaction with medical services	4.1 (1.1)	3.8 (1.2)
Satisfaction with social services	3.8 (0.8)	3.8 (0.8)
Service Intensity		
Service intensity for medical problems	0.10 (0.4)	0.08 (0.6)
Service intensity for employment problems	0.8 (3.3)	0.5 (1.2)
Service intensity for alcohol problems	11.6 (24.5)	11.7 (42.3)
Service intensity for drug problems	21.5 (29.0)	19.6 (43.7)
Service intensity for legal problems	2.0 (9.7)	0.8 (1.8)
Service intensity for family/support	3.0 (6.0)	1.8 (5.3)
Service intensity for psychiatric problem	11.3 (32.6)	10.3 (22.4)
Service intensity for parenting/social support/abuse/HIV/survival	2.7 (5.2)	4.6 (21.8)

Note: *p<.05, **p<.01, ***p<.001

Addiction Severity Index

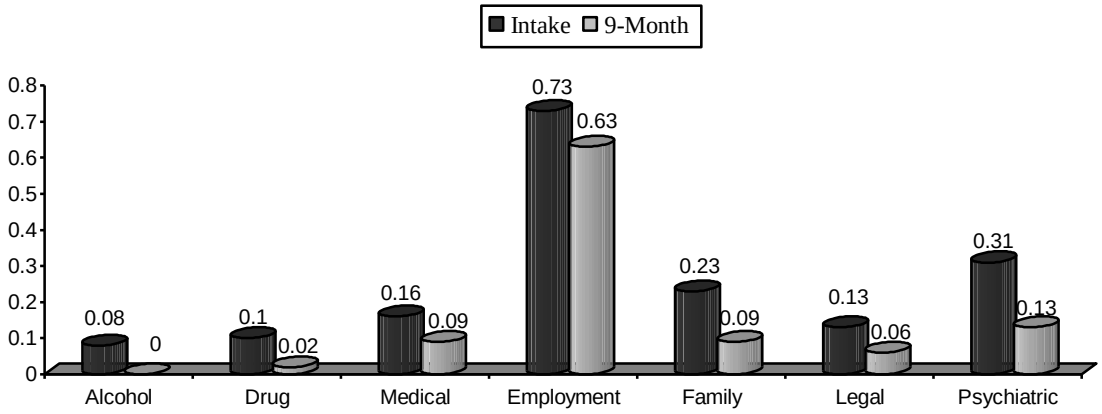
Differences between severity scores at intake and the 9-month follow-up (see Table 22 and Figure 1) were significant in each of the seven ASI domains, suggesting that overall there were significant improvements in all areas. Changes in composite scores in the seven ASI domains are calculated in two ways. First, we used a paired t-test to test changes over time, including clients' problem severity scores at intake as their own controls to assess treatment outcomes.

Table 22. Severity of Problems by Domain at Intake and 9-Month Follow-Up

	Intake	9-Month Follow-Up	t-test
Alcohol*	0.08 (0.16)	0.00 (0.01)	-5.43***
Drugs*	0.10 (0.11)	0.02 (0.06)	-9.22***
Medical*	0.16 (0.27)	0.09 (0.25)	-4.28***
Employment*	0.73 (0.29)	0.63 (0.31)	-4.34***
Family*	0.23 (0.19)	0.09 (0.16)	-7.36***
Legal*	0.13 (0.18)	0.06 (0.16)	-3.75***
Psychiatric	0.31 (0.23)	0.13 (0.23)	-9.01
Psychiatric*	0.31 (0.23)	0.13 (0.23)	-9.01***

Note: *p<.05, **p<.01, ***p<.001

Figure 1. Addiction Severity Index Composite Scores at Intake and 9-Month Follow-Up



The second method we used to estimate treatment effect was to measure change (or improvement) in severity levels among clients who reported at least some problem severity in the ASI domains at intake. Difference scores were calculated for the clients by subtracting the composite scores at post-intake from those at intake. The means of the differences (M) are presented as an average improvement in the clients' symptoms (see Table 23). Any positive value of M with a significant statistic test result indicates improvement following intake. Table 23 shows that the ON TIME treatment effects in all seven domains had a significant impact on clients' problem severity. The greatest improvement (M=0.32) occurred in the employment domains and the least improvement (M=0.11) was observed in the family area. However, point estimates of the average effect size, or the M's, only partially describes the impact of treatment.

Table 23. Significant Treatment Effect Size in ASI Domains among Those Who Reported at Least Some Problem in the Relevant Domain at Intake

Measure	N	M	d	t
Alcohol	46	0.21	1.07	7.3***
Drug	91	0.14	1.26	12.0***
Medical	64	0.22	1.10	8.8***
Employment	51	0.32	0.89	6.4***
Family	133	0.11	0.38	4.3***
Legal	109	0.20	0.78	8.1***
Psychiatric	105	0.26	1.12	11.5***

Note: ***p<.001

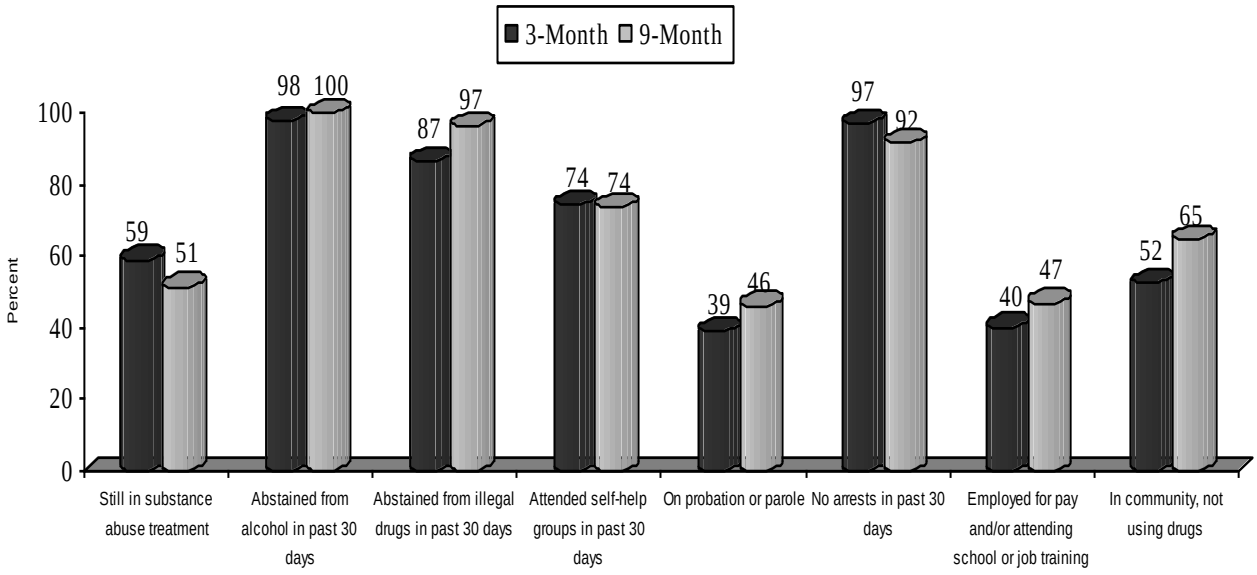
The absolute size of M is a consequence of the arbitrariness in the decisions made by the researcher and in the method to construct the scale. They are not directly comparable to each other across the effect measured in different domains. Therefore, the Cohen's d statistic (d) was calculated to evaluate the stability and the comparability of the treatment effect. The highest d statistic occurred in the measure of drug issues (d=1.26), which had an absolute effect size of 0.11. Thus the implication is that drug abuse treatment may have the greatest impact on clients' drug use severity compared to the other domains. The treatment effect was less stable (d=0.38)

and less effective (M=0.11) on the clients' family status as a measure of treatment outcome. While significant treatment effects were found in all seven measured domains, the evaluation of M and d indicates that treatment programs have large effect sizes, and therefore greater impact of clients' drug use, psychological issues, medical need, alcohol use, employment status, legal issues, and family relationships, in that order.

Status at Intake, 3- and 9-Month Follow-Up

Overall statuses at 3-month and 9-month post intake for the sample are provided in Figure 2.

Figure 2. Client Status at 3- and 9-Month Follow-up Points



The percentage of clients who were in treatment at the 9-month interview compared to the 3-month interview decreased by about 9%; however 51% in treatment at 9-months post intake is longer than average lengths of stay for substance abuse treatment populations. Abstinence levels from both alcohol and drugs increased at the nine-month interview. In addition, when treatment success is defined as free from drug use and criminal activity while living in the community (not in a controlled environment) in the past 30 days, the rate of success at the nine-month interview increased to 65% from 52% at the three-month interview. Further, employment rates increased by 6.6% over the same time period.

Several measures were repeatedly taken at intake, three-month follow-up interview, and nine-month follow-up interview. The results of the selected measures are presented in Figures 3-4. As shown in these figures, there are reductions in negative behaviors (e.g., drug use, arrest, hospitalization) and increases in positive behaviors (e.g., employment) from intake, to three-month follow-up, and to a greater extent at the nine-month follow-up.

Figure 3. Primary Drug Use at Intake, 3-Month, and 9-Month Follow-Up

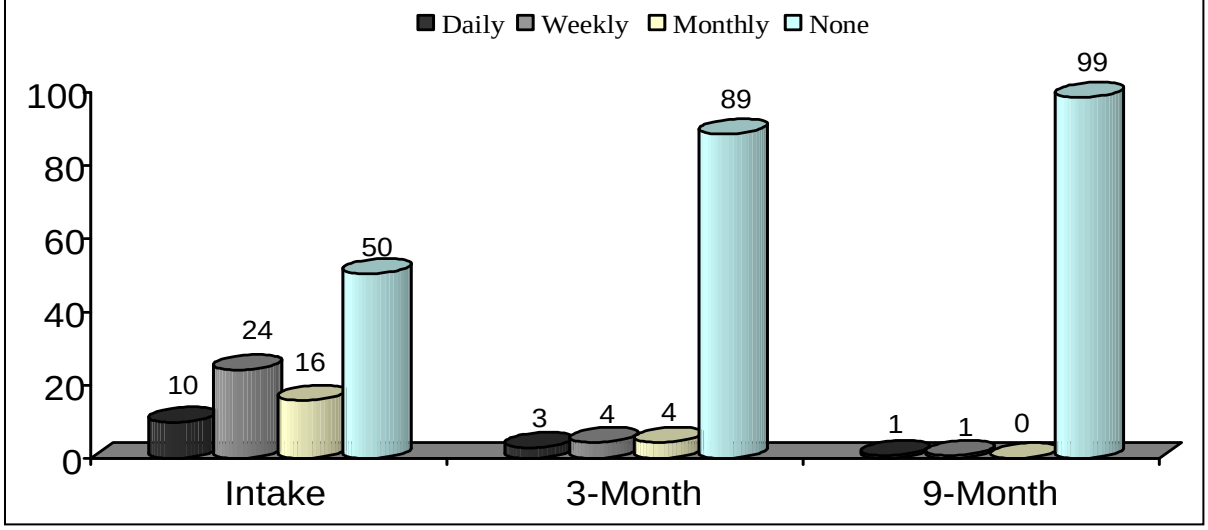
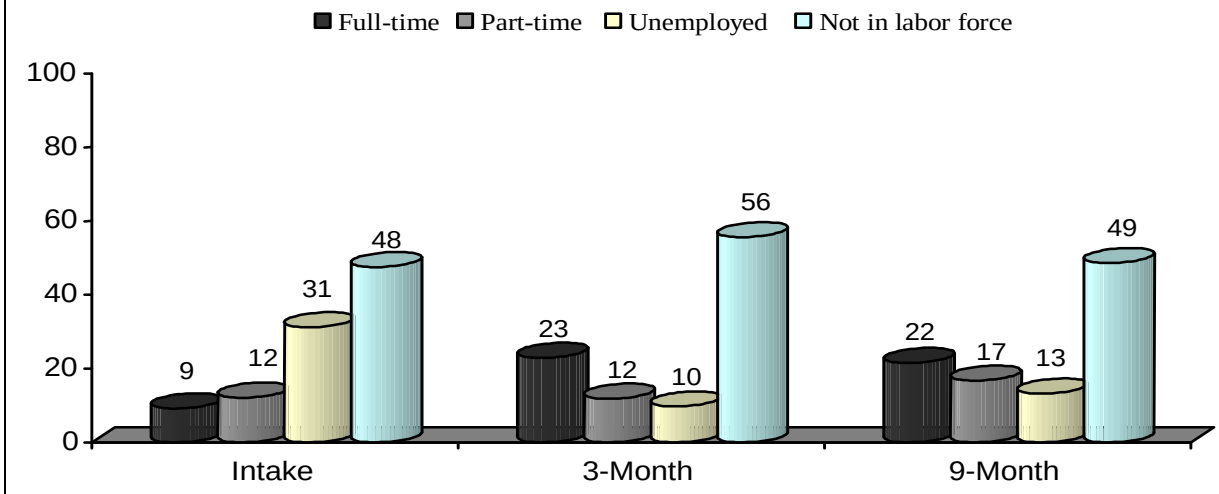


Figure 4. Employment Rate at Intake, 3-Month, and 9-Month Follow-Up



Summary

Characteristics at Intake

- ON TIME mothers were 52% Caucasian and 34% Hispanic
- Mean age of 30.6 years
- Over half (57%) were high school graduates or had obtained their GED
- Few (16%) were married with 40% single and 44% separated or divorced
- Clients averaged 2.6 children each
- Employment was a particular problem for this population with 23% employed and 44% of clients were not employed or seeking employment
- Nearly one-quarter (22%) were homeless
- Just over one-quarter (26%) of clients received inpatient mental health services and 30% received outpatient mental health services
- The majority (70%) expressed a need for mental health services
- Half (49.8%) had been hospitalized sometime in their lives
- Over one-third were in the criminal justice system with 36% on probation, parole, or a diversion program
- Nearly half of clients (45%) stated methamphetamine was their primary drug
- Low-intensity residential was indicated for 32% of clients while 7.2% received that service
- Early intervention was indicated for 29% of clients and 15.7 % received
- Most clients received outpatient (35%) or intensive outpatient (28%) treatment
- Nearly half (48%) of clients received prior alcohol treatment and 19.4% received prior drug treatment

Engagement, Treatment and Overall Outcomes

The Stages of Change ratings indicated that during the first three weeks of ON TIME participation, the women had significantly increased their readiness to make lifestyle changes in the majority of domains. The majority of ON TIME clients were contacted and interviewed for the follow-up interviews at 3 (89%) and 9 (83%) months. More than half (60%) remained in treatment at the 3-month interview, and 51% at the 9-month interview. At 3-months post intake, almost all clients abstained from alcohol (97%) and drugs (87%), while at 9-months all abstained from alcohol and 97% abstained from drugs. In addition:

- Criminal justice system involvement remained high with 40% on probation or parole at 3-months and 46% at 9-months
- The percentage of clients employed increased from 40% employed or attending training at 3 months to 47% at 9 months
- Service participation most often reported at 3 months were AOD treatment, parenting and mental health
- Three-quarters (75%) of clients received services (medical, employment, alcohol and drug, parenting, etc.; see Table 16) within the first 3-months of their intake into ON TIME, with the majority satisfied with their treatment services

- Satisfaction with services was highest for AOD treatment, followed by psychological, with the lowest satisfaction for social and survival (emergency goods, housing, transportation) services
- Just over two-thirds 67% of clients strongly agreed that the treatment services were timely, effective and satisfactory

At the three-month interview, 52% of clients met the success criteria (no drug use or crime, and living in the community), while 65% of clients at the 9-month interview met the criteria. These clients were more likely to be in treatment at both the 3- and 9-month interviews. The ASI scores for the clients were significantly improved when comparing the 3- and 9-month interviews, suggesting that overall there were improvements in all seven domains of the ASI. In addition, scores show that there are reductions in negative behaviors and increases in positive behaviors from intake, to the 3-month, and to a greater extent at the 9-month interview.

CHAPTER VI. COMPARISON GROUP ON TREATMENT AND FAMILY-RELATED OUTCOMES

This chapter compares the substance abuse treatment engagement rates and child welfare status of the ON TIME sample with a comparison group of women who met the criteria for the ON TIME program in the year prior to its implementation**.** The purpose was to determine if providing ON TIME services resulted in successful treatment completion, decreased substance use, and increased family and employment-related outcomes in comparison to women who met criteria for the program but did not receive ON TIME services.

Study Design

A quasi-experimental design utilized a comparison group of women who met criteria for the program (e.g., child abuse/neglect disposition hearing, allegations of substance-related problems, and age 18 and over) in the year prior to ON TIME's implementation. The primary outcomes measured in the comparison group were severity of alcohol and drug use at intake to the child welfare system, children's placement status 12-months, status of child welfare case at 6 and 18-months, new reports of child abuse and neglect, and services provided by CFS. Standard services included: safety and risk assessments; referrals to services such as substance abuse treatment, counseling, parenting and domestic violence services; assistance with ancillary services such as child care, transportation and housing; and ongoing case management. In addition to these services, ON TIME clients received the ON TIME intervention, which was focused on outreach, engagement, motivational interviewing and direct linkage to substance abuse treatment with the use of recovery peer mentorship and modeling of a sober lifestyle.

Sample

To compare the differences between the ON TIME sample and a comparison sample, 6-month client records were reviewed for 80 clients (42 ON TIME and 38 comparison) and electronic data from the county's Child Welfare Services/Case Management System (CWS/CMS) was obtained for an additional 74 clients (35 ON TIME and 39 comparison clients) at the 12 and 18-month follow-up period. The comparison sample was selected by matching the substance use scores on the Structured Decision Making (SDM) assessment tool for each group (see below).

Data Sources/Instruments/Measures

Data from the *Structured Decision Making* (SDM) tool was used to determine whether ON TIME and comparison groups had similar alcohol and drug abuse/dependency ratings at the initial stage of their dependency court case. The SDM is a series of assessments used by CFS to assess the level of risk for child abuse and neglect. As stated in Chapter III, this assessment has 11 items, including substance abuse/use, household relationships, domestic violence, social support systems, parenting skills, and mental health/coping skills. Each caretaker in the family is rated in four levels, with scores of either: +3, 0, -3 or -5. For substance abuse/use, the scores represent: +3= teaches and demonstrates a healthy understanding of alcohol and drugs;

0=alcohol and prescribed drug use; -3=alcohol or drug abuse; -5=chronic alcohol or drug abuse. The SDM scores were used to select the comparison group for the study, with scores of –3 and –5 selected as potential subjects in the comparison group.

Data used for the present analysis include: reports of prior and subsequent child abuse and neglect, including allegation, alleged perpetrator (mother or someone else), and disposition of allegation (substantiated or unsubstantiated); status of child welfare case, including placement of each child and whether the case has closed and the SDM tool described above**.** *Status of child welfare cases* includes placement status of the child(ren): family reunification (i.e., out of home care), family maintenance (i.e., returning home to mother, father, or both parents), or permanent plan (i.e., adoption, long-term foster care, or legal guardianship); status of case (i.e., open or closed), number of service components (i.e., family reunification, family maintenance, and permanent placement), and number of days children were in out of home care. In the case of family reunification, the child welfare case is still open pending return to family (family maintenance) or permanent plan. AOD treatment-specific data was also abstracted from the California Alcohol and Drug Data System (CADDS). See Chapter III for a description of the CADDS.

Data used for this analysis also included hard copy case files provided by CFS. The files available for CFF evaluation staff included petitions and court reports for each dependency court hearing up to the date of data abstraction. Petitions were the initial paperwork the police officers and social workers completed to allege child abuse and/or neglect (CA/N). Court reports were the narrative documents that CFS social workers completed after each court hearing related to the CA/N allegation. Included in court reports were the names and ages of children, parents or legal guardians, current addresses, current allegations, any history of CA/N; parents' criminal history, and narrative information gathered from interviews of key individuals. These key individuals included the children, if appropriate, witnesses, parents and individuals that provided supporting evidence such as police, hospital personnel and others.

ON TIME evaluation staff reviewed hard copy client case files in late summer 2001. Information that was available for review included social worker generated reports prepared for court hearings and social worker documentation in the case file for 6 to 8 months of the dependency court case. While the project had been in implementation for one year, the intake period of the mothers meant that these cases had not been open in the system long enough to have had their 12-month hearing.

CFS staff provided space at their offices for CFF evaluation staff to abstract data from hard copy case files. For approximately 2 months these staff reviewed client files, abstracting data and completing the *Secondary Data Analysis Tool* (SDAT) (see Chapter III). Inter-rater reliability was assured by having 2 CFF staff and CFS staff review the same cases until each SDAT contained the same data.

Results

Pre-Treatment Characteristics

The ON TIME and comparison groups did not differ on demographic characteristics such as race/ethnicity, educational status, marital status, or age (see Table 24). There were also no differences between the two groups in terms of their number of children or the age of their children.

Table 24. Demographics for ON TIME and Comparison Group

	ON TIME (n=42)	Comparison Group (n=38)
Race/Ethnicity		
African American	5%	5%
White	61%	49%
Hispanic	29%	37%
Asian	5%	5%
American Indian/Alaskan Native	0%	2%
Multiracial	0%	2%
Educational Status		
Less than high school	41%	50%
High school/GED	22%	25%
At least some college	37%	25%
Current Marital Status		
Single/never married	36%	49%
Divorced/separated/widowed	52%	33%
Married	12%	18%
Average Age	31.0	29.7
Parenting Status		
Average number of children	2.9	2.9
Age of children		
0 to 1 year	27%	31%
2 to 5 years	25%	26%
6 to 11 years	34%	24%
12 to 15 years	10%	16%
16 to 18 years	1%	2%

Note: All differences were nonsignificant.

ON TIME mothers were found to have significantly more substantiated physical abuse (24% vs. 5%) than the comparison group (see Table 25). ON TIME mothers were also more likely to have a psychiatric diagnosis (38% vs. 19%) and report being a victim of domestic violence (74% vs.

35%) than the comparison group. The comparison group, however, had significantly more prior arrests than the ON TIME sample.

Table 25. Characteristics and Contributing Factors of Child Abuse and Neglect Allegations for ON TIME and Comparison Group

	ON TIME (n=42)	Comparison Group (n=38)
Perpetrator of CA/N		
Mother only	19%	19%
Father only	0%	0%
Both parents	81%	81%
Substantiated Allegations		
Physical abuse**	24%	5%
Serious emotional abuse	14%	7%
Sexual abuse	2%	0%
Severe physical abuse, child under 5	2%	0%
Cruelty/ritualistic abuse	2%	0%
Abuse of siblings	31%	29%
Failure to protect	100%	97%
No provision for support	12%	22%
Contributing Substance Abuse Issues		
Alcohol abuse by mother	38%	35%
Drug abuse by mother	88%	86%
Had prior treatment episodes	86%	55%
Contributing Medical/Psychiatric Issues		
Mother had medical/physical disability	5%	5%
Mother had psychiatric diagnosis*	38%	19%
Mother had developmental disability	2%	2%
Contributing Criminal Behavior		
Mother had 1-3 prior arrests*	57%	79%
Mother had 4 or more prior arrests	43%	21%
Mother Involved in Domestic Violence	26%	44%
Mother's Role in Domestic Violence		
Victim**	74%	35%
Perpetrator	3%	9*
Both victim and perpetrator	23%	57%

Note: *p<.05, **p<.01, ***p<.001

Severity of Alcohol and Other Drug Use. Results from the SDM indicate that approximately half of the ON TIME sample (47%) and comparison group (55%) and had a score of –5, indicating chronic alcohol or drug abuse (see Table 26). In addition, more than one third of both groups

(37% and 35%, respectively) were rated by CFS to have some alcohol or drug abuse (-3). The mean SDM value for ON TIME sample was the –3.4 and –3.8 for the comparison group, indicating some alcohol or drug abuse. No differences were found between either group in terms of their SDM score.

Table 26. Structured Decision Making Risk Assessment

	ON TIME (n=77)	Comparison Group (n=77)
Risk of Substance Abuse		
Healthy alcohol and prescribed drug use (0)	16.4%	10.3%
Alcohol or drug abuse (-3)	37.0%	34.6%
Chronic alcohol or drug abuse (-5)	46.6%	55.1%?
Mean SDM value (SD)	-3.4 (1.8)	-3.8 (1.6)

Preliminary 6 Month Data

During the review of client paper records during the summer of 2002, data that were available to the ON TIME researchers was information for approximately six months of the child welfare case. At that point, there were no significant differences in the children's placement at three weeks into the case (jurisdiction/disposition hearing). At six months into the dependency court case, the children of ON TIME clients were significantly more likely to be placed with grandparents compared to children of the comparison sample (see Table 27). There were no differences between the two groups in terms of whether the children were returned to the mother or father. A higher percentage of the ON TIME clients entered AOD treatment before the 6-month review hearing (46% vs. 24%) than the comparison group, yet these differences were not statistically significant. In addition, ON TIME clients had fewer positive urine toxicology screens (43% vs. 18%), fewer ON TIME clients left or were discharged from treatment prematurely (31% vs. 50%).

Table 27. Children's and Mother's Status at 6 Months for ON TIME and Comparison Group

	ON TIME (n=42)	Comparison Group (n=38)
Children's Living Arrangements		
At jurisdiction/disposition hearing		
Placed with mother	10%	13%
Placed with father	8%	11%
Placed with grandparents	26%	19%
At 6-Month Review Hearing		
Placed with mother	12%	12%
Placed with father	8%	11%
Placed with grandparents*	24%	18%
Mother's Substance Abuse Treatment Status		
Client entered treatment prior to 6 month review hearing	46%	24%

Client left or was discharged from treatment program	31%	50%
Client left one treatment program and enrolled in another	7%	29%
Client successfully completed AOD treatment	11%	17%

Note: *p<.05

Child Welfare and Treatment Outcomes at 12- and 18-Months

Child Abuse Reports (CAR). Approximately half of the ON TIME mothers (51%) and matched comparison group (49%) had prior CARS (not including the current CAR) (see Table 28). The ON TIME clients (M=3.4) and comparison group (M=3.0) had approximately the same number of prior CARS relating to their children. The alleged perpetrator could be listed as either the mother or someone "other" than the mother. Of the 154 comparison and ON TIME women, half (n=77) had been alleged to be the perpetrator of prior child abuse or neglect. There were no differences in the number of prior CARS among the two groups. There were also no differences in the number of prior CARS against "others" between the ON TIME sample and the comparison group. In addition, there were no differences in the number of substantiated and unsubstantiated CARS against either the mothers or "others" between the two groups.

Table 28. Child Abuse Reports for On Time and Comparison Group

	ON TIME (n=77) Mean (S.D.)	**Comparison Group (n=77) Mean (S.D.)**
Prior Child Abuse Reports (CARS)		
Average no. of prior CARS in family	3.3 (3.3)	3.0 (2.3)
Mothers with prior CARS	50.6%	49.4%
Average no. of prior CARS against mother	3.1 (2.2)	2.2 (1.9)
Prior CARS against someone other than mother	33.8%	26.0%
Average no. of prior CARS against someone other than mo.	2.0 (1.5)	2.7 (1.9)
Average no. of substantiated prior CARS	1.8 (0.9)	1.8 (1.0)
Average no. of substantiated prior CARS against mother	1.8 (0.7)	1.6 (0.9)
Average no. of substantiated prior CARS against someone other than mother	1.4 (0.5)	1.9 (0.4)
Average no. of unsubstantiated prior CARS	2.7 (1.9)	2.5 (2.0)
Average no. of unsubstantiated prior CARS against mother	2.4 (1.8)	1.2 (1.7)
Average no. of unsubstantiated prior CARS against someone other than mother	1.8 (1.2)	2.1 (1.5)
Subsequent Child Abuse Reports (CARS)		
Average no. of subsequent CARS	1.6 (0.9)	1.8 (0.9)
Mothers with subsequent CARS	18.2%	22.1%
Average no. of subsequent CARS against mother	1.6 (0.7)	1.4 (0.6)
Subsequent CARS against someone other than mother	31.2%	15.6%
Average no. # of subsequent CARS against someone other than mother (SD)	1.4 (0.7)	1.5 (0.7)

Average no. of substantiated subsequent CARS	1.2 (0.6)	1.5 (0.7)
Average no. of substantiated subsequent CARS against mother	1.2 (0.4)	1.4 (0.5)
Average no. of substantiated subsequent CARS against someone other than mother (SD)	1.1 (0.3)	1.3 (0.5)
Average no. of unsubstantiated subsequent CARS	1.3 (0.5)	1.5 (0.8)
Average no. of unsubstantiated subsequent CARS against mother (SD)	1.3 (0.5)	1.1 (0.3)
Average no. of unsubstantiated subsequent CARS against some other than mother (SD)	1.8 (1.2)	2.1 (1.5)

In terms of subsequent CARS, there was no difference between the ON TIME sample and comparison group in the number of subsequent CARS against the mother or "others," or whether the subsequent CAR was substantiated against either the mother or someone else.

California Alcohol and Drug Data System (CADDS). Data from the CADDS system was extracted as of October 2002. The CADDS system contained information for 67 of the ON TIME sample and 52 of the comparison group sample (see Table 29). These 119 clients accounted 360 AOD treatment admissions, including readmissions to treatment. No differences were found in terms demographic characteristics such as ethnicity, employment, and whether the client was receiving CalWORKS/TANF. ON TIME clients were, however, significantly more likely to be homeless than the comparison group (25% vs. 17%) and were significantly more likely to be between the ages of 18 and 21 (9% vs. 3%).

Table 29. On Time and Comparison Group Clients with Matched CADDS Data

	ON TIME		**Comparison group**		**ALL Clients**	
	N	**%**	**N**	**%**	**N**	**%**
Unique clients (unduplicated admissions)	67		52		119	
No. of Admissions (including re-admits)	207		153		360	
First time treatment admissions	49	73.1	41	78.1	90	75.6
Number of pregnant women at admission	8	11.9	4	7.6	12	10.1
Number of treatment episodes (Percent Clients)						
1 episode	19	28.4	19	36.5	38	31.9
2 episodes	16	23.9	13	25.0	29	24.4
3 or more episodes	32	47.7	20	38.5	52	43.7
Ethnicity (Percent Admissions)						
White	109	54.0	75	46.7	184	52.1
African American	16	7.9	13	8.6	29	8.2

Hispanic	66	32.7	57	37.7	123	34.8
Asian/Pacific Islander	5	2.5	5	3.3	10	2.8
American Indian/Alaska Native	3	1.5	1	0.7	4	1.1
Other	3	1.5	0		3	0.8
Client Attributes (Percent Admissions)						
12 to 17 years of age	5	2.4	1	0.6	6	1.7
18 to 21 years of age *	18	8.5	5	3.3	23	6.4
Homeless *	50	25.3	23	16.7	73	21.2
Full-time employment	18	8.7	11	7.2	29	8.1
Welfare to work	3	2.0	3	3.2	6	2.5
Drug use in the past month (Percent Admissions)						
Opioids	44	21.3	34	22.2	78	21.7
Cocaine/crack	39	18.8	33	21.6	72	20.0
Marijuana	11	5.3	8	5.2	19	5.3
Methamphetamine	45	21.7	43	28.1	88	24.4
Alcohol	44	21.3	40	26.1	84	23.3
Alcohol and illicit drugs	33	15.9	29	18.9	62	17.2
Injecting drugs	29	14.0	28	18.3	57	15.8
Legal Status (Percent Admissions)						
On probation	45	21.7	42	27.5	87	24.2
On parole	9	4.3	2	1.3	11	3.1
Diversion from any court	5	2.4	2	1.3	7	1.9
Incarcerated	0		0		0	
Treatment Modality (Percent Admissions)						
Day Program-intensive	6	2.9	6	3.9	12	3.3
Outpatient Methadone Detox	15	7.3	11	7.2	26	7.2
Outpatient Methadone Maintenance	12	5.8	13	8.5	25	7.0
Outpatient Drug Free	125	60.7	90	58.8	215	59.9
Residential Detox	12	5.8	7	4.6	19	5.3
Residential Drug Free	36	17.5	26	17.0	62	17.3

Status of Treatment Completion (Percent Admissions)						
Not discharged treatment episodes	2	1.0	2	1.3	4	1.1
Discharged treatment episodes	205	99.0	151	98.7	356	98.9
Completed	52	25.4	43	28.5	95	26.7
Not completed with satisfactory progress	19	9.3	17	11.3	36	10.1
Not completed with unsatisfactory progress	100	48.8	60	39.7	160	49.9
Referred or transferred	34	16.6	31	20.5	65	18.3
No. of Treatment Episodes Occurred After Detention Date or Case start Date (including re-admits)	113		79		192	
Status of Treatment Completion (% Admissions)						
Not discharged treatment episodes	2	1.8	0		2	1.0
Discharged treatment episodes	111	98.2	79	100.0	190	99.0
Completed	31	27.9	25	27.9	56	29.5
Not completed with satisfactory progress	10	9.0	7	9.0	17	8.9
Not completed with unsatisfactory progress	47	42.3	29	42.3	76	40.0
Referred or transferred	23	20.7	18	22.8	41	21.6
Status of Discharged Treatment Episodes						
Positive (Completed, Satisfactory, Referred)	64	57.7	50	63.3	114	60.0
Negative (Unsatisfactory)	47	42.3	29	36.7	76	40.0
Days in Treatment by Modality among Discharged Episodes	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**N**	**Mean (SD)**
Day Program-intensive	6	120.3 (95.1)	6	142.7 (279.6)	12	131.5 (199.4)
Outpatient Methadone Detox *	15	11.1 (5.8)	11	15.8 (5.2)	26	13.1 (5.9)
Outpatient Methadone Maintenance	12	217.2 (210.1)	13	251.0 (237.2)	25	234.7 (220.6)
Outpatient Drug Free	123	155.7 (135.5)	88	150.5 (171.4)	211	153.5 (151.1)
Residential Detox	12	5.6 (3.1)	7	5.7 (1.6)	19	5.6 (2.6)
Residential Drug Free	36	52.5 (73.4)	26	56.5 (84.7)	62	54.2 (77.7)
Average Days from Detention or Case Start Date to the first Treatment	57	94.2 (130.6)	41	114.4 (148.6)	98	102.7 (138.0)

Note: *p<.05

Regarding prior treatment episodes and use of drugs at intake, there were no significant differences in the treatment modality (type of treatment) or drug use in the past month (the month prior to intake) or number of treatment episodes per client. There were also no significant differences in the status of treatment completion, even when comparing positive (completed treatment, satisfactory discharge or referred to another treatment provider) and negative (unsatisfactory discharge).

On TIME clients, however, spent fewer days in outpatient methadone detox than the comparison group (11 days vs. 16 days). The ON TIME sample remained in outpatient treatment for more days than the comparison group (123 days vs. 88 days) and in residential treatment for 36 days versus 26 days. While these are not significant, it does indicate that the ON TIME sample remained in treatment for longer periods of time than the comparison group.

Status of Child Welfare Case. There were no significant differences in the children's placement at 12 months (Table 30). At 18 months, mothers in the comparison group were significantly more likely to have their children placed in long-term foster care, adoption, legal guardianship, whereas the mothers in the ON TIME subsample were more likely to be in the process of family reunification (see Table 31). Similarly among open cases, the mothers in the ON TIME sample were more likely to be in the process of family reunification. This difference is related to the fact that the comparison groups' child welfare case began 6-9 months prior to the ON TIME group, thus allowing for more time for a permanent plan for the children to occur. There was no difference between the samples in terms of closed cases. Although there was no difference in the mean days of out of home care, the comparison group had significantly more service components (i.e., family reunification, family maintenance, or permanent plan) related to their case. This may relate to the fact that the comparison group cases were open 6-9 months longer than the ON TIME cases.

Table 30. Children's Placement at 12 months of Court Case

	On TIME (n=151)	Comparison Group (n=124)
Placement of Children		
County Shelter/Receiving Home	2.0%	6.6%
Court Specified Home	0.67%	0.82%
Foster Family Agency Certified Home	34.0%	23.8%
Foster Family Home	19.3%	19.7%
Group Home	4.0%	7.4%
Relative Home	40.0%	41.8%

Note: No statistical differences were found between the two groups

Table 31. Status of Child Welfare Cases at 18 Months

	ON Time (n=150)	Comparison Group (n=122)
Status of Case* **		
Family Reunification	33.3%	5.7%
Family Maintenance-Father	14.7%	11.5%
Family Maintenance-Mother	16.7%	18.0%
Family Maintenance Both Parents	6.7%	7.4%
Permanent Plan	28.7%	57.4%
Case Closure		
Case Closed	n=71	n=106
Family Reunification	N/A	N/A
Family Maintenance-Father	15.5%	12.3%
Family Maintenance-Mother	12.7%	16.0%
Family Maintenance Both Parents	11.3%	5.7%
Permanent Placement	60.6%)	66.0%
*Case Open**	n=79	n=16
Family Reunification	63.3%	43.8%
Family Maintenance-Father	13.9%	6.3%
Family Maintenance-Mother	20.3%	31.3%
Family Maintenance Both Parents	2.5%	18.8%
Permanent Plan	N/A	N/A
Mean number of service components (SD)		
Family Reunification**	2.2 (0.5)	2.7 (0.8)
Family Maintenance-Father	2.6 (0.7)	2.4 (0.6)
Family Maintenance-Mother	3.0 (0.4)	3.0 (0.9)
Family Maintenance Both Parents	3.1 (0.9)	2.8 (0.4)
Permanent Placement	2.9 (0.4)	3.0 (0.6)
Mean days of out of home care (SD)		
Family Reunification	N/A	N/A
Family Maintenance-Father	427.4 (116.2)	334.8 (277.7)
Family Maintenance-Mother	552.3 (109.7)	634.7 (182.2)
Family Maintenance Both Parents	522.1 (114.1)	592.6 (159.6)
Permanent Plan	381.4 (173.9)	422.0 (225.7)

Note: n indicates number of children, not number of mothers; *p<.05, **p<.01, ***p<.001

Summary

A quasi-experimental design was used to compare the ON TIME clients to a sample of women who met the criteria for the project in the year prior to ON TIME implementation. Client case records were reviewed and electronic data abstracted to determine whether there were differences in: (1) severity of alcohol use, abuse or dependency; (2) treatment entry; (3) treatment completion; (4) children's placement status; and, (5) subsequent reports of child abuse and/or neglect.

Pretreatment Characteristics

There were no differences between the groups on demographic characteristics, number of children or ages of children. ON TIME clients had significantly more substantiated physical abuse (24% vs. 5%), more likely to have a psychiatric diagnosis (38% vs. 19%), and were more likely to be a victim of domestic violence (74% vs. 35%) than the comparison group. However, the comparison group had significantly more arrests than the ON TIME clients (57% vs. 79%). There were no significant differences on the scores on the Structured Decision Making at intake, with approximately half of the ON TIME clients (47%) and the comparison group (55%) rated as chemically dependent, or a chronic drug and alcohol user. Finally, there were no differences in the number of prior (before the current child welfare case) child abuse reports (CAR), the alleged perpetrator, or whether the CAR was substantiated between the ON TIME clients and comparison group.

Preliminary 6-Month Data

Children of ON TIME clients were significantly more likely to be placed with grandparents than the children of the comparison group. Although not significant, a higher percentage of the ON TIME clients entered AOD treatment before the 6-month review hearing (46% vs. 24%), had fewer positive urine toxicology screens (43% vs. 18%), or left or were discharged from treatment prematurely (31% vs. 50%) than the comparison group.

Child Welfare and Treatment Outcomes at 12- and 18-Months

There were no differences in subsequent CARS, whether the mother was the perpetrator, or whether the CARS were substantiated between the ON TIME clients and the comparison group. There were no significant differences in child placement at 12 months (18-month placement data was unavailable). However, children of ON TIME clients were more likely to be in the process of Family Reunification services than the comparison group women (children were more likely placed in long-term foster care, adoption or legal guardianship).

As of October 2002, the CADDS system reported that ON TIME clients were significantly more likely to be homeless (25% vs. 17%) and to be between the ages of 18 and 21 (9% vs. 3%) than the comparison group. The CADDS also reports that there were no significant differences in the type of treatment, drug use in the month prior to intake, or the number of treatment episodes. When comparing positive to negative treatment discharge, there also were no significant differences between the groups. However, ON TIME clients spent less days in outpatient

methadone detox (11 days vs. 16 days), and remained in outpatient treatment for more days and in residential treatment (36 days vs. 26 days) than the comparison group (123 days vs. 88 days), While these are not significant, it does indicate that the ON TIME sample remained in treatment for longer periods of time than the comparison group.

In conclusion, while many of the differences were not significant, the ON TIME clients entered treatment sooner, were more likely to remain in outpatient and residential treatment, and were more likely to be in Family Reunification services than the comparison group.

CHAPTER VII. CASE EXAMPLE

Throughout the 20 months of client contact, the recovery mentors engaged with 238 child welfare-involved mothers who had substance abuse issues. To fully capture this experience, and to describe both the challenges and accomplishments of the recovery mentors, a case example is being presented. While certainly each client was different and had unique experiences, this excerpt captures some of the flavor of the recovery mentor-client relationship. Each of the assessment instruments below were completed by an outreach recovery mentor during the engagement and intervention process.

Client Characteristics

The client is a 30-year-old single, unemployed Caucasian female who presented with her mother at family dependency court. The client has 3 children who were placed in protective custody in the summer of 2000. The client reported that she had 12 years of education and previous work experience as a union cashier in a major retail chain. She described being terminated 1 year ago for testing positive for marijuana. The client related past suicidal ideation with no suicide attempts. Although the client was not married she reported living with her children's father, who is an addict, for most of the last 11 years. The client reported being the victim of domestic violence, where both parties where drinking, within the last 30 days. The client also acknowledged needing help and appeared very willing to enter treatment.

Children's Characteristics

To determine whether the client's children had any special needs, the recovery mentor both reviewed the Children and Family Services' Detention Hearing Report and administered the Client Feedback Report. This report was developed by CFF staff to complement the ASAM-PPC form. One item on the report asked the client whether any of her children have medical, behavioral, developmental or educational problems. The client reported the following information:

1. A 2 1/2 year-old boy with no identified special needs
2. A 3 1/2 year-old boy with no identified special needs.
3. An 8-year-old girl who is in school and has no identified special needs.

Child Abuse and Neglect Allegations

The client is charged with general neglect due to ongoing drug use and emotional instability, evidenced by clients' journal entries of suicidal ideation and drug use. The client reported that boyfriend's mother is "very vindictive" and that she initiated the CA/N allegations by taking client's journals to the judge who was presiding over boyfriend's past domestic violence case (where he was taken in on a warrant for failing to complete anger management classes).

Mother's Substance Use and Treatment History

The client related a 4-year history of marijuana use, a 3-year history of cocaine use, and reported she drinks alcohol "periodically". She also reported one prior AOD treatment episode, and said that she began use of marijuana immediately after being discharged. The client's responses to substance use history on the ASI Lite appeared unreliable to the recovery mentor, as there were inconsistencies between content of conversation and responses to assessment questions, which may be due to pending children's court case.

Exacerbating Circumstances

The client related being the victim of domestic violence in the last 30 days, with the following pending: a restraining order filed against father of children and a restraining order filed against client by father of children. The client reported that she moved from San Diego to Orange County, and was staying with her mother, as she has no other place to live due to her financial situation. The client reported that she lives with maternal grandmother in Orange County who drinks alcohol. In addition, the client is unemployed, relates being diagnosed with vertigo after the domestic violence occurred, reports being very anxious and has history of anxiety and depression, and appears to be emotionally enmeshed with the father of her children, and is consumed by his and the paternal grandmother's behaviors.

Stages of Change Scale

The client appears to be at a *moderate* level of readiness to make changes in *all* areas:
1. Substance abuse
2. Emotional well being
3. Decreasing risky sexual behavior
4. Decreasing further physical harm
5. Furthering education/employment
The client appears to be at the *determination/preparation* level in regard to change, and will require some motivational work to move into action.

ASAM/Client Feedback Form

D1) Acute Intoxication/Withdrawal Potential: Client rated *high* (low-risk)
D2) Biomedical Conditions: Client rated *moderate* (medium-risk)
D3) Emotional/Behavioral: Client rated *moderate* (medium-risk)
D4) Treatment Acceptance/Resistance: Client rated *moderate* (medium-risk)
D5) Relapse Continued Use Potential: Client rated *high* (low-risk)
D6) Recovery Environment: Client rated *low* (high-risk)
ASAM Placement Level Indicated: III.1 (Low Intensity Residential Services)
ASAM Placement Level Received: I (Outpatient Services)

Reason for Difference: Since Low Intensity Residential Services were not readily available or affordable, client chose to go to outpatient treatment and was referred to the Orange County Perinatal Program*. *The Perinatal Program is a 4 hour per week program designed for parenting substance-abusing women. In addition to one therapy session per month, women attend a series of weekly group sessions that focus on parenting, relapse prevention and recovery, assertion and anger management. Urine toxicology testing is on-site and referrals are provided for mental health and domestic violence services.

Change Plan Worksheet

By completing the Change Plan Worksheet (adapted from Miller, 1999), the client was able to prioritize her goals and outline concrete steps to achieve them. Since the client's major goal was to be reunited with her children and regain her self-esteem, she was helped to understand that substance abuse treatment and abstinence would be necessary. The client was able to see how following the case plan initiated by Social Services was of utmost importance and agreed to have her recovery mentor call the outpatient Perinatal Program that afternoon to initiate an appointment. The client saw "getting back with her boyfriend" as an obstacle that might interfere with her goal of abstinence and reuniting with her children. She chose to write down activities such as spending more time with her family and "sober" friends, attending a 12-Step meeting, writing, reading, praying, calling her recovery mentor and watching television as an alternative when she felt triggered to use substances or contact her boyfriend. She also agreed to post her Change Plan Worksheet up in her room to remind her of her intentions and goals.

Addiction Severity Index Ratings at Intake

The Client's Composite Scores Indicated:
Extreme Severity in Medical Status: thyroid condition that required daily medication, and diagnosed with vertigo.
Considerable Severity in Family/Social Status: Children in protective custody, domestic violence and custody issues with boyfriend. Significant altercations between boyfriend and paternal grandmother mother.
Moderate Severity in Employment/Support Status: Unemployed; supported by mother.
Moderate Severity in Psychiatric Status: History of suicidal ideation, history of anxiety and depression. Currently prescribed Paxil.

Response of Client to Motivational Interviewing Procedure

The client was enthusiastic about the ON TIME program, as she said that she needed someone to support her through the dependency court process. She was very comfortable that her recovery mentor had been through some of the same experiences, and had "come out on the other side." She signed the consent form and understood why certain information might be disclosed to her Social Worker. The client felt enlightened when she received the personal feedback information, as she was well aware of how bad her life had become. She said that she wants her children back and will do whatever it takes. She feels very positive about being involved with the ON TIME project and feels it has helped her to get into immediate action to start her recovery process, and reunite with her children.

Client Treatment Episode

The client attended orientation at Aliso Viejo Intensive Perinatal Program one week after initial contact with recovery mentor. She was scheduled for her initial urine toxicology screen the week following her initial court hearing, and started treatment in early September 2000. The client was drug tested 2 times per week and all tests were negative. She also participated in treatment diligently, and graduated in September of 2001.

Recovery Mentor's Feelings about the Motivational Interviewing Intervention

"I was glad to finally utilize my skills, and see the results of motivational interviewing strategies to make an impact on someone's willingness to get into action. I feel this timely intervention significantly increased her sense of control over her circumstances and empowered her to move forward quickly and enroll in treatment before other influences could inhibit or distract her.

I feel that the Change Plan Worksheet was particularly helpful as it gave the client something concrete to work with and keep her focused on her goal. I feel the CADDS [AOD system reporting forms mandated by state] was the least helpful in that it is used for demographics and has no impact on the client's behavior changes.

I feel my experience as an "addict" in recovery, and being a single mom who has struggled with similar issues, was the basis for this woman's feeling genuine trust and respect for me. I felt the client could "identify" with me and she felt hopeful that recovery was possible for her too.

I view the client's dependency on her boyfriend as a major issue that could have impeded her from maintaining sobriety and stability. Continuous reinforcement of her primary goal (to reunite with her children) and the positive steps she is taking to achieve this are vital to the client's self-esteem, sobriety, and successful detachment from boyfriend."

Status of Client as of February 2002

Substance Abuse Treatment

Regular contact was maintained with client throughout the ON TIME project. The recovery mentor attended all court dates (Disposition, Six-month review, Twelve-month review, and intermittent reviews), as well as maintaining a minimal of one phone contact per month, in addition to being available for the client as needed for support. The recovery mentor attended the client s' treatment graduation to support her commitment and achievement in recovery.

Child Welfare Services

The client's children where removed from the client's custody due to neglect in the summer of 2000. The client was granted visitation with her children shortly after. Overnight visits began in January 2001. The child welfare case was transferred to Family Maintenance and the children were placed in their mother's custody 12 months after the children were removed. The client graduated from the substance abuse treatment program in September 2001. The child welfare case was closed in 18 months after case inception.

CHAPTER VIII. GPRA REPORTING

The Substance Abuse and Mental Health Services Administration (SAMHSA), the department over CSAT, uses these four criteria to measure its accountability to the Government Performance and Results Act (GPRA):

- Assuring Services Availability (by increasing utilization and promoting systems improvement);
- Meeting Unmet and Emerging Needs (by implementing proven strategies and interventions, coupled with increasing utilization);
- Bridging the Gap between Knowledge and Practice (by generating new evidence-based information and facilitating adoption of evidence-based strategies); and,
- Strengthening Data Collection to Improve Quality and Enhance Accountability (by ensuring that data are available for the most critical areas of need and that the data are both timely and useful) (SAMHSA, 2002).

The ON TIME project addressed one of the four required GPRA objectives: "Bridging the Gap between Knowledge and Practice." Under GPRA, annual performance plans are to clearly inform the Congress and the public of (1) the annual performance goals for agencies' major programs and activities, (2) the measures that will be used to gauge performance, (3) the strategies and resources required to achieve the performance goals, and (4) the procedures that will be used to verify and validate performance information (GAO, 2001).

Bridging the Gap between Knowledge and Practice

The ON TIME project sought to seek knowledge which would enhance the treatment engagement and retention of maternal substance abusers, a primary area of interest for SAMHSA and other NIH institutes. Specifically, the project sought to determine whether recovering women with addiction certification can be competently trained to administer a comprehensive AOD assessment battery and utilize motivational interviewing techniques with culturally-similar women encountering analogous situations to their own histories. ON TIME was one of a very few studies that provided training for paraprofessional level staff in the motivational interviewing process. These women went through the rigorous training, implemented a pilot project, and conducted the motivational interviewing on over 238 women over a 22-month period, demonstrating the viability of training such interviewers.

The ON TIME project addressed this issue systemically by the coordinated efforts among the child welfare, welfare, treatment system, and attorney groups to develop an agreement to provide outreach to AOD-involved mothers, assisting them with treatment efforts, and enhancing the probability that their families will remain intact. The process of developing the Communication Protocol is an example of the coordinated efforts of these various systems. While each agency was concerned about the welfare of their client, they were able to compromise and develop an effective communication process.

The determination of the impact of the ON TIME intervention on the target population results from positive feedback received from social services, attorney groups, and clients concerning the high quality of the recovery mentors' skills. The recovery mentors utilized research-based techniques in a field situation, providing intensive outreach and intervention to substance abusing women.

Promote the Adoption of Best Practices

The delay in enrollment into the ON TIME project allowed the recovery mentors to introduce these "best practices" into the 20-provider agency of Southern California Alcohol and Drug Programs (SCADP). The director of SCADP requested that the recovery mentors train staff at these facilities, resulting in the implementation of these state-of-the-art assessment techniques across Orange and Los Angeles Counties. This enabled the ON TIME project to incorporate state-of-the-art assessment tools such as the ASI Lite and ASAM PPC, computer-assisted interviewing, and motivational interviewing into their standard practice.

The extent to which the project has led to long-term changes within the Orange County Dependency Court System is uncertain. While there appears to be increased communication among the child welfare staff and attorney groups, ongoing, consistent collaboration has yet to occur. Regarding the enthusiasm for this project by CFS social workers and the cooperation of the attorney groups in the recruitment process, CFF continued to receive calls through summer 2002 from social workers inquiring as to the status of the project after its ending.

CHAPTER IX. SUMMARY AND DISCUSSION

Summary

Process Evaluation

Facilitating treatment systems change and improving family outcomes were the goals of the ON TIME project. The ON TIME project staff was able to successfully bring together administrative, management and frontline level staff in the county child welfare, family support and health care agencies, with substance abuse treatment provider staff, and with dependency court staff including both the judicial and attorney staff. These individuals participated in efforts to increase linkages among agencies, improve services to clients and track outcomes.

The extensive classroom and on-the-job training that the recovery mentors received was an important part of the project. The use of AOD paraprofessionals in utilizing motivational interviewing strategies with women in the child welfare population was innovative and demonstrated the viability of using such staff in this role. The mentors received constant feedback from those that they came into contact each day that their assistance was invaluable, including the defense attorneys, a number of social workers, and staff at local treatment agencies, as well as the majority of the ON TIME clients.

A training manual has been developed and is available for other jurisdictions who are interested in developing a program similar to ON TIME. Included in the manual is background material on the development of ON TIME, the theoretical framework for motivational enhancement therapy, tools and examples on setting up collaborative relationships, training curricula for paraprofessionals, outreach and intervention strategies and assessment tools used to engage and motivate women into substance abuse treatment. The manual will be available to order on CFF's website: www.cffutures.org.

The goals and purpose of the ON TIME project were satisfied in a number of ways (increased collaborative efforts between the systems; positive findings related to treatment and child and family stability), yet the long-range goal of sustaining the project beyond federal funding was not. There are number of reasons why the project was not sustained. Despite the overwhelming support of the defense attorneys, and the consistent efforts of the steering committee members to find ways to overcome any barriers the project may face, the project was not continued. One main reason for this was the state and local budget cuts in both the substance abuse treatment and child welfare systems, leading to hiring freezes and reduced services. The other reason was the lack of support from the county child welfare and health care agency staff. Regardless of the fact that during project development and implementation the heads of these agencies were in full support of the project and were represented at each steering committee meeting, they were ultimately not convinced that the ON TIME project was a necessary component to the child welfare system in a period of resource constraints.

Client Treatment Outcomes and Services Effectiveness

Women recruited for the ON TIME project were mostly Caucasian and Hispanic, high school graduates and single with two children. Almost half were unemployed, one-fifth was homeless, half had co-occurring mental health issues, and one-third was involved in the criminal justice system. The primary drug for almost half was methamphetamine, and over half had received substance abuse treatment prior to this project.

The mentors used a variety of research-based instruments to assess the clients' readiness to change (Stages of Change), client's problem severity (ASI), appropriate level of care (Cal-ASAM), and to identify the types of services provided and describe the demographics of the population receiving those services (CADDS). These instruments documented that the clients had significantly increased their readiness to make lifestyle changes and that there were improvements in all seven domains of the ASI, with reductions in negative behaviors and increases in positive behaviors. In addition, the Cal-ASAM showed that although clients were assessed to need either early intervention or residential substance abuse treatment, they instead received outpatient treatment services.

The services that the clients received included alcohol and drug services, parenting, mental health, social and survival services. The majority of clients reported that they received services during the first three months of their participation in ON TIME, and they were satisfied with the services they received. They were highly satisfied with AOD services and mental health services, with least satisfaction with social and survival services. Approximately two-thirds of clients felt that the services that they received were timely, effective and satisfactory.

Substance abuse treatment has its limitations in the county, such as having only two residential treatment providers that accept children and no intensive outpatient services. The most intensive outpatient treatment in the county is the county's program for pregnant and parenting women and their families (two 4-hour sessions per week). In addition, the mentors had difficulty at times in finding an appropriate treatment provider, especially for women who were receiving methadone or had several children. While the ON TIME project was able to modify existing structures already in place in the county, it remains to be seen whether these changes are lasting in the absence of the critical role played by the recovery mentors at the service delivery level and the steering committee at the policy level.

Comparison Group on Treatment and Family-Related Outcomes

The third component of the ON TIME project was to compare the ON TIME clients to a sample of women who had entered the child welfare system in the year prior to project implementation. Client case records were reviewed and researchers found that at intake into the child welfare system, there were no significant differences between the two groups related to demographics, number or age of children, severity of alcohol or drug use, or number of prior treatment episodes.

The comparison group was selected by matching the severity of alcohol or drug use determined by the child welfare services caseworker at intake. Approximately one-half of each group was assessed as having chronic substance abuse issues, while over one-third of each group was rated

as having some alcohol or drug abuse. When comparing data abstracted from the CADDS system, there were no significant differences in the type of treatment, recent drug use, or the number of prior treatment episodes. ON TIME clients were more likely to enter treatment sooner and they remained in treatment longer than the comparison group.

When comparing groups on family-related outcomes, children of ON TIME clients were more likely to be in the process of family reunification, while the children of the comparison group were placed in long-term foster care, adoption or legal guardianship. No differences were found in subsequent child abuse reports or the number of substantiated reports. In conclusion, the clients who participated in the ON TIME project fared better than a sample of women who did not participate in both treatment and family-related outcomes.

Discussion

The Role of the Recovery Mentors

One of the lessons of the recovery mentors' work with clients and with agencies was the inherent strain in working toward two competing objectives: fully engaging clients, with all the time and empathy that task requires, and "working the system" on behalf of the client. These goals are linked to each other, but the time required for each is a tradeoff with the time required for the other; a recovery mentor devoting her time to getting resources for her client from a wide variety of agencies—or a single recalcitrant one—may not have the same rapport with clients developed by a recovery mentor who is able to spend a good deal of time with the client. The critical shift, as described in the process documentation, came when the recovery mentors were trained as case managers in response to recognition of the extensive needs of the clients that were not being met by the participating agencies. While increasing the ability of the recovery mentors to meet clients' needs, it had the effect of reducing the number of clients whose needs could be met.

The effects of this, according to the recovery mentors and their supervisors, were several:

- It reduced the time they could spend with individual clients and thus the total number of clients they could serve; and,
- It placed a higher premium on the skills of assessing what clients needed and where to get it from among the large number of public and private agencies with resources

These effects are driven by two realities which the ON TIME project documented clearly:

- The absence of resources which many clients need to succeed in treatment and to achieve family stability, coupled with the time constraints facing workers in the CW and AOD systems who lacked the time needed to get these resources from other agencies for their clients; and,
- The relatively high needs of the women selected for the ON TIME program, given their co-occurring problems, as reviewed in Chapter V.

The latter point is important; the needs of the women who were clients were extensive, with a caseload in which most of the clients were unemployed, one-third of the women had mental

health treatment history, and one-quarter of the clients had visited an emergency room within the month prior to their intake to ON TIME. ASI scores revealed that women in the program had highest severity scores for psychiatric and employment needs—both of which can require negotiations with multiple outside agencies to address. Child welfare workers whose caseloads had expanded and who had not gotten the relief they expected from state caseload funding, once the state budget crisis began to worsen, were simply not able to play the case management role required to move these parents through the treatment and services systems. To the extent possible for the women in their caseloads, the ON TIME recovery mentors sought to fill this gap.

Sustainability and Systems Change

On the issue of feasibility of the program, positive results were achieved. But on the issue of capacity to make systems changes and to sustain the project without federal funding, the picture is less positive.

Project Sustainability. The initial sustainability plan was developed in broad outline prior to project start-up, out of a conviction on the part of Children and Family Futures and OCF staff that many demonstration projects typically wait too long to develop specific options for future funding based on outcomes that new funders are willing to support (Gardner, 1998). The county agencies—both social services and health services—were obvious possibilities for continuation funding beyond the initial federal funding.

These funding options were reviewed, and several potential sources were addressed as options, including Proposition 10 (a California tobacco tax used for projects for children 0-5, from which the County received $46 million in 2001-2002), tobacco settlement funds (from which Orange County receives approximately $30 million a year), the Health Care Agency's AOD treatment funding (which includes a total of more $35 million from multiple funding sources including the federal block grant and state funds and a 2002 targeted expansion CSAT grant of up to $500,000, and TANF funding for family support programs and welfare incentive grant funding.

Despite the potential availability of these funds, when the final decision to continue financial support for ON TIME staffing and research had to be made in spring 2002, the project was not funded. At least four factors appear to explain this outcome:

- Despite the number of potential sources identified early in the ON TIME project, by the time the decisions had to be made, many of these were mostly or fully expended or allocated to other purposes. The most notable exceptions, tobacco settlement funds and Proposition 10 funds, were not available due to interpretations of what the funds could be used for by staff or advisory groups controlling the funding.
- There is no coordinated process for making decisions about overall AOD treatment funding in Orange County, since the separate funding sources each have their own allocation process. As a result, separate approaches needed to be made to each of these, and deadlines had passed for some of them.
- The state's budget crisis was rapidly worsening and was certain to affect county spending, which made county agencies far more cautious about assuming responsibility for any new programs, no matter how positive their outcomes. This affected welfare

incentive funds, which had been reduced by the state, and a 15% cut across the board had been announced for all state agencies in May 2002.

- As noted above, a commitment had been made by leadership of the CFS unit to compile the research data needed to make it possible to extend the client outcomes analysis further than the original 6 month period, but as the project ended, CFS lacked staff resources to locate case records for CFF to collect the data. The additional evidence needed to confirm the initial positive results has not yet been collected, which may affect the ultimate potential for renewed funding of some portion of the project.

With respect to the final issue, it seems likely that the leadership of the child welfare agency in Orange County was motivated by other priorities and caution due to the state's worsening budget crisis and its local effects. As noted above, the child welfare workers ended up less enthusiastic about the project than the defense attorneys who had originally been far more negative, with only half of social workers responding favorably to continuation of the project, while all the attorneys were favorable.

CFF has continued the role of a single recovery mentor in the courthouse on a part-time basis. This recovery mentor continues to engage clients at the time of their initial court hearing, encouraging either the mother or father to enter substance abuse treatment if necessary, and providing referrals to other support services. The Office of the Public Defenders has been very appreciative of this effort and its staff welcomes the recovery mentor's presence.

Systems Change Issues. The project documented again what the literature in this field has emphasized repeatedly: at several critical points in the three systems involved—child welfare, AOD treatment, and the family courts—the "normal" working of the systems reduces the likelihood that parents with AOD problems will get treatment in a timely fashion and will be reunified with their children. The most important of these system barriers spotlighted by the project were:

- Information systems changes, including the inability of staff to use either the CWS/CMS system or the CADDS system, or its sub-systems of SDM, to routinely track ON TIME clients over a long enough period to assess the full effectiveness of its changes;
- Staff roles that leave gaps in support services to clients, especially case management across the two systems involved;
- The sheer caseloads of workers in the child welfare system, reducing the amount of time they are able to spend with any one parent, child, or family;
- The typical client engagement process, which was the target for the central practice change of the project, meant that the recovery mentors were added temporarily to a system that lacks the time or staff for sustained engagement or the motivational training and methods used by the recovery mentors;
- Multiple funding systems with no central allocations process or overview of the total in the different funding streams, making sustainability planning an ad hoc process depending upon many separate decisions, without any forum that provides an overview of the relative priority of sustaining an innovation such as ON TIME

- A lack of either client outcomes monitoring or agency effectiveness monitoring that would enable shifting resources from less effective to more effective programs.[2]

Many of these have been documented in prior projects and written materials; their re-occurrence in the Orange County setting confirm the continuing power of these barriers to systems change, and the difficulty of expecting any one innovation such as ON TIME to penetrate these obstacles to change. A comprehensive plan that addresses the full range of these obstacles—or at least intervenes with more of them than ON TIME was able to—may offer a more fertile field for sustaining innovation and systems change. When the worsening fiscal climate was added to these obstacles, the effort to continue support for ON TIME became even more uphill.

Resources Issues are Systems Issues

Finally, resources issues should be recognized as the systemic barriers they proved to be. In both the child welfare and AOD treatment systems, resources gaps affected what happened once clients had been better engaged through the work of the recovery mentors. The two most important resources gaps affecting the project were:

1. The inadequate time which social workers had—and perceived themselves to have—to manage their families' cases, including their progress into and through treatment programs; and,
2. The inadequate resources available in the treatment system itself once clients got there, with some programs offering a dosage of program intensity well below what clinical standards suggest these multi-problem clients really needed.

A fair appraisal of the support given by the child welfare and treatment agencies involved must take these underlying resources gaps into account. In other demonstration projects, training interventions alone, or changes in screening and assessment tools alone, have proven inadequate to make up for similar resources gaps, and the ON TIME experience seems to corroborate these other experiences. The lesson, again, was that changing one feature in an inter-related system with at least ten separable elements[3] does not change the whole system, and it is the operations of the whole system that ultimately affects clients' success.

Conclusion

These lessons drawn from the demonstration project confirm both the value of the innovation—the recovery mentors and their client engagement roles—and the difficulty of changing the larger system in which they operated. Client engagement remains a critical intervention point in the

[2] At one point in the attempt to sustain the project, efforts were made to connect with the tobacco settlement funding process, but ON TIME project staff were told that the project was not seen as appropriate for funding from the TSA source. In learning a few months later that some AOD treatment programs had been funded, ON TIME staff asked what outcomes were being used to measure the effectiveness of the funded programs, and were told that "outcomes were not really emphasized in the contracting process." Annual reports on this grant process indicate that client counts are the primary form of reporting results of funding.

[3] These ten elements can be found in the Center for Substance Abuse Treatment's Technical Assistance Publication #27, Navigating the Pathways, in the references section of this report.

overall effort to improve outcomes for women and children in the child welfare system who are affected by substance disorders. But the challenge of sustaining the efforts required to improve client engagement is a large one, requiring long-term vision of what all three systems could be: the child welfare, substance abuse treatment, and family court systems. The timing of this particular intervention, concluding just as the largest state and local fiscal downturn of the past few decades began to affect California and Orange County, was especially unfortunate, but that timing does not invalidate the importance of the innovation and the hope that it could be institutionalized beyond this project.

CHAPTER X. REFERENCES

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