

Illinois AODA IV-E Waiver Demonstration

Interim Evaluation Report

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Waiver Demonstration

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**Prepared for
Illinois Department of Children and Family Services
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EXECUTIVE SUMMARY

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

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

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

Evaluation Design: The classical experimental design is the best way to determine causal connections between interventions and outcomes. Prior to JCAP assessment, potential participants have been referred to child welfare agencies that were randomly assigned to either the demonstration or cost neutrality (control) group. The parents that are assigned to agencies serving only the control group receive substance abuse services that were available prior to the demonstration waiver (it is not a “no-treatment” control group). The parents that are assigned to agencies serving the demonstration group receive the regular services plus the services of a Recovery Coach. The Recovery Coach works with the parent, child welfare caseworker, and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and provide ongoing support to the parent and family throughout the duration of the child welfare case. The evaluation focuses on the effects of the availability of Recovery Coach services relative to the substance abuse service options that would have been available in the absence of the waiver. The evaluation is designed to test the hypothesis that the provision of Recovery Coach Services positively affects the drug-recovery process and key child welfare outcomes.

Specifically, the evaluation addresses the following four research questions:

1. Are parents in the demonstration group more likely to access and complete AODA treatment?
2. Are children in the demonstration group more likely to be safely reunified with their parents?
3. Do children in the demonstration group spend less time in foster care?
4. Are families in the demonstration group less likely to experience subsequent maltreatment?

Sources of Data: The evaluation of the demonstration project utilizes multiple sources of data and multiple methods of data collection. Data pertaining to placement, permanence, and child safety come from the Department of Children and Family Services’ integrated database. Substance abuse assessment data come from the Juvenile Court Assessment Program (JCAP). Subsequent to the temporary custody hearing, JCAP staff complete the AOD assessment and make initial treatment referrals. In addition to a wide variety of demographic information (e.g., employment status, living situation, public aid recipient), these assessment data include substance abuse histories and indications of prior substance exposed infants. Substance abuse treatment data come from the Treatment Record and Continuing Care System (TRACCS). This system is managed by Caritas and includes surveys completed by child welfare workers, Recovery Coaches, and treatment providers. Additional services data come from the Department’s Automated Reporting and Tracking System (DARTS). This system is managed by the Office of Alcoholism and Substance Abuse (OASA) and includes service dates and levels of care. Another source of data is the quarterly reports from TASC, with information on treatment and progress for demonstration group clients. Our final source of data comes from interviews with caseworkers and the review of case records.

These data supplement the administrative analyses and provide additional insights into the treatment process.

Implementation and Services: Between April 2000 and March 31, 2002 164 parents (representing 283 children) were assigned to the control group and 368 parents (representing 585 children) were assigned to the experimental group. The Recovery Coach services offered to the demonstration group clients are provided by Treatment Alternatives for Safe Communities (TASC). Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. The primary goal for the Recovery Coach is to actively address the substance abuse problems of caretakers. Addressing these problems is hypothesized to help parents move towards reunification as safely and quickly as possible. A secondary goal is to facilitate information sharing between child welfare, AODA providers and court systems so that both reunification and other concurrent permanency decisions are based on accurate and timely information.

Findings Specific to the Four Research Questions:

1. Are parents in the demonstration group more likely to access and complete AODA treatment? There is evidence to suggest that the demonstration group is more likely to access substance abuse treatment (60% control vs. 69% demonstration). Moreover, there is additional evidence to suggest that these same clients are accessing substance services more quickly (median days: 28 control vs. 14 demonstration).
2. Are children in the demonstration group more likely to be safely reunified with their parents? As of March 31, 2002, only 6.0% of the children in the control group and 8.4% of the children in the demonstration group were living in the home of their parents. This difference is not statistically significant. Regarding permanency goals, the majority of children in both the demonstration and control group have “return home” as their permanency goal (69% demo vs. 75% control respectively).
3. Do children in the demonstration group spend less time in foster care? Children in the demonstration group experience fewer days in care relative to the children in the control group (282 for the demonstration group vs. 309 days for the control group). It should be noted that there are no differences between the demonstration and control groups in terms of the number of foster care placements (3.67 for the demonstration group vs. 3.79 for the control group).
4. Are families in the demonstration group less likely to experience subsequent maltreatment? There are no significant differences between the rates of subsequent allegations of maltreatment. The rates of subsequent maltreatment are low (4% for both the demonstration and control group).

Additional Findings of Interest:

- The caretakers in this project have long and serious histories of substance abuse. On average, these caretakers have delivered more than three substance exposed infants.
- There are significant delays in the Juvenile Court between temporary custody and adjudication. The statutory expectation is an adjudication hearing within 90 days of temporary custody. We report significantly longer delays between these two events (on average, 217 days for the control group and 225 days for the demonstration group).
- The projected IV-E cost in the demonstration group is \$12,131,383. This figure is \$845,431 less than the multiplied average from the cost neutrality group, so the waiver is cost neutral.
- In the demonstration group, only 58 caretakers have successfully completed substance abuse treatment. Out of those, only six have been reunified with one or more children, according to data TASC has provided. We will be further exploring this issue in the near future, to determine the status of the remaining 52 parents with a view towards the status of their situations in the Juvenile Court.

Summary: The AODA waiver was based on the premise that Recovery Coaches could engage families more quickly in the substance abuse treatment process. Moreover, through monitoring, encouragement, and advocacy, it was hypothesized that the use of Recovery Coaches would have a positive effect on treatment duration and treatment completion and via more timely access and higher completion rates, children in the demonstration group would experience higher rates of family reunification. Despite the more timely access (and higher rate of access) to substance abuse treatment, significant differences with regards to reunification have yet to emerge. However, as this demonstration continues for another two years, it is possible that timely access to service and increased participation rates will eventually translate into higher rates of program completion and family reunification.



1: INTRODUCTION

Overview of the Demonstration

This Interim evaluation report is prepared for the Illinois Department of Children and Family Services by the Children and Family Research Center as required by the Terms and Conditions of this child welfare demonstration project with the Children's Bureau of the Administration for Children and Families. The report covers the period April 2000 to March 2002. In general, the data presented in this report run through March 31, 2002. However, the treatment data for demonstration group participants runs through September 30, 2002. The format for this report follows the requirements for child welfare demonstration projects in the ACF draft Program Instruction issued February 2001 (Log No. ACYF-CB-PI-2001)

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

It is hypothesized that the provision of Recovery Coach services will positively affect key child welfare outcomes (e.g. permanency)

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

Purpose

Substance abuse is a major problem for the children and families involved with public child welfare. Substance abuse may compromise appropriate parenting practices and increases the risk of child maltreatment. Moreover, barriers to substance abuse treatment delay reunification and permanence. The purpose

of this demonstration project is to improve permanency outcomes for children of parents with substance abuse problems. To achieve this purpose, Recovery Coaches assist parents with obtaining AODA treatment services and negotiating departmental and judicial requirements associated with drug recovery and permanency planning.

Background/Context

The purpose of this demonstration project is to improve permanency outcomes for children of parents with substance abuse problems.

The issue of how multiple service systems can collaborate effectively to deal with the problems of parental alcohol and other drug abuse (AODA) continues to challenge governmental efforts to ensure family permanence and the safety and well being of neglected and abused children. Studies document the heavy toll that parental drug addiction exacts on families and children who come to the attention of state child protection authorities. According to Young, Gardiner, and Dennis (1998), at least 50 percent of the nearly one million children indicated for child abuse and neglect in 1995 had caregivers who abused alcohol or other drugs. A 1994 report issued by the U.S. Government Accounting Office (GAO) estimated that the percentage of foster children with parental drug abuse as a reason for children's coming into care rose from 52 percent in 1986 to 78 percent in the cities of Los Angeles, New York, and Philadelphia (U.S. Government Accounting Office, 1994). A 1998 GAO study of child protection systems in Los Angeles, California and Cook County, Illinois documented that substance use was a problem in over 70 percent of active foster care cases (U.S. Government Accounting Office, 1998).

The AODA demonstration project in Illinois estimates that approximately 67 percent of the families with children in placement have substance abuse problems.

Implementation Status

Of families ever assigned between April 2000 and March 30 2002 to the AODA demonstration in the Cook County, 164 parents of 283 children were assigned to the control group and 368 parents of 585 children were assigned to the demonstration (experimental) group.

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

From the onset of the project through March 31, 2002, JCAP (Juvenile Court Assessment Project) has provided 739 assessments to DCFS involved family

members in the IV-E AODA project. With increased awareness of the project, referrals are now getting to JCAP earlier in the case and meeting the 90-day eligibility time requirement of the project. Of those eligible for the project, 368 clients have been assigned into the Demonstration group receiving the enhanced AOD services delivered by Recovery Coaches.

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

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

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

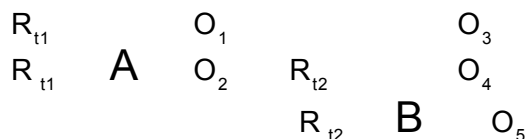
METHODOLOGY

Design

Eligibility: Eligible families for the demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. Of all those eligible, cases are then randomly assigned to the control and treatment conditions. Random assignment occurs at the agency level. Random assignment successfully created statistically equivalent groups at the parent and child levels. Child welfare agencies and DCFS offices were stratified by program size and geographical/language service area and randomly assigned to control and demonstration groups within strata. The demonstration groups within strata were randomly split into two groups. At the start of phase two, a “flip of the coin” will determine which of the two demonstration groups becomes Demo B. The random assignment has produced statistically equivalent groups (see below).

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

The design is as follows:



where R_{t1} represents agencies that have been randomly assigned at time 1 to either the control or experimental group; \mathbf{A} represents the intervention of the “Recovery Coach”; O_1 is the first measurement of the control group; O_2 is the first measurement of the experimental group (a posttest because it occurs after the intervention); R_{t2} represents the experimental agencies that have been randomly assigned at time 2 to either Demo A or Demo B groups; \mathbf{B} represents the additional intervention of enhanced services (which is currently being conceptualized) ; O_3 represents the second measurement of the control group; O_4 represents the second measurement of Demo A group; and O_5 represents the first measurement of Demo B group.

The State has created a second experimental group, called Demonstration B. Participants in this experimental group will be chosen as set forth above. For the participants in this group, the Recovery Coach will utilize the Substance Abuse Progress Matrix in collaborating with the Child welfare worker, treatment provider and parent. The matrix will also be used in clinical supervision, staffings, and family meetings.

The progress of the clients in this group will be tracked through the use of this matrix. Data from the use of this matrix will help to provide more information regarding treatment progress (or the lack of it). The use of the matrix will also be a useful tool to inform permanency decisions at Juvenile Court. It is hoped that the use of the matrix will enable staff working with the client to provide focused assistance with respect to problems occurring during the treatment process, as well as problems arising in Juvenile Court which may hinder or delay permanency decisions. It is hoped that this additional intervention will provide concrete direction to assist members of this group in their treatment and in their movement towards permanency. Clients began to be assigned to this group on May 1, 2003.

Research Questions

The evaluation addresses the following four research questions:

1. Are parents in the demonstration group more likely to access and complete AODA treatment?
2. Are children in the demonstration group more likely to be safely reunified with their parents?
3. Do children in the demonstration group spend less time in foster care?
4. Are families in the demonstration group less likely to experience subsequent maltreatment?

Data Collection Procedures

Data collection tracks each stage of the process of each case: the initial drug abuse assessment of the parent at JCAP (Juvenile Court Assessment Project), treatment engagement and process. Sources of data come from JCAP, the Recovery Coaches and TASC (Treatment Alternatives for Safe Communities), the court system, DCFS MARS/CYCIS databases, and OASA (Office of Alcoholism and Substance Abuse) with respect to clients who have signed consents for the examination of information of records other than DCFS. Two major sources of data collection are the TRACCS forms and the AODA integrated database, explained below. Data collected includes each parent's progress with respect to treatment, and each child's progress to a permanency goal.

The following table illustrates the principal data sources and the types of data provided by each of them.

Type of Data>	Control	Demo	Client Characteristics	Assessment	Treatment	Permanency	Outcomes
Source of Data							
AODA integrated Database	X	X	X				
JCAP Data	X	X	X	X			
TRACCS	X	X	X		X		
TASC		X	X		X		
MARS/CYCIS	X	X	X			X	X
OASA/DARTS	X	X			X		

NOTE: the TRACCS forms are sent to and completed by the caseworkers, the recovery coaches and the treatment (AOD) providers.

Service Collection Tool – TRACCS Forms:

Caritas has been hired to staff the JCAP site and also to coordinate the computer-based data collection integrated system called TRACCS (Treatment Record and Continuing Care System). TASC (Treatment Alternatives for Safe Communities) is responsible for the Recovery Coaches and supervisory staff.

The service collection tool is being integrated into a system called Treatment Record and Continuing Care System (TRACCS). TRACCS forms have been sent to POS child welfare workers for data collection following the training at each agency for the past 3 quarters. Training began in January 2002, and the first forms were sent to agencies in February 2002. The TRACCS forms are also sent to drug treatment providers and Recovery Coaches. After the first form has been filled out and returned, subsequent forms are sent pre-filled, so that only new and current information needs to be provided. As of September 30, 2002, ninety-one percent of the TRACCS forms were returned. At the time of this report, however, only some of the TRACCS information is available.

TRACCS forms have also been sent to the AODA Treatment providers for data collection for the past two quarters. As of September 30, 2002, fifty-five percent of the TRACCS forms were returned. Similarly, the overall return rate for forms sent to the Recovery Coaches was 71%.

The OASA—DCFS Integrated Database

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

Limitations on data collection

The issue of informed consent has limited the collection of data with respect to drug treatment and mental health records. As of September 30, 2002, approximately 30% of clients in the project have signed research consents. The signed consent gives permission to review substance abuse and public aid records. To address this relatively low response rate, the research committee redesigned the consent form. Rather than simply stating "yes" or "no" demonstration participants are now given the following three options:

- Yes, by signing this form, I understand that I am giving you permission to review my DCFS, DHS, and DPA assessment service and treatment records only.
- Not at this time, but you may contact me within the next nine months to see if I would reconsider signing this form.
- No, I do not wish to give my consent.

The revised consent was recently approved by the appropriate Institutional Review Boards and is currently being used in the field.

2: PROCESS ANALYSIS

Service Delivery

The members of the control group receive a substance abuse assessment at JCAP. They are then referred for drug treatment and further services are provided by their assigned caseworker. The demonstration group receives similar services and the assistance of a Recovery Coach.

Functions of the Recovery Coaches:

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

Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery.

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

Clinical Assessment: Recovery Coaches ensure that a comprehensive range of assessments in addition to the AODA assessment is completed, either through the child welfare caseworker or as designated by the Recovery Coach. Depending on the needs of the parent, these assessments can evaluate need for mental health, parenting, housing, domestic violence, and family support needs.

Benefits Identification and Advocacy: Recovery Coaches work with the parents to identify potential sources of public assistance. Recovery Coaches assist the parent in obtaining benefits and in meeting the responsibilities and mandates associated with the benefits.

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

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

Case Management: Proactive case management with and on behalf of the parent is a priority of the Recovery Coach. Case management activities are intended to remove any barriers to a parent engaging in AODA treatment, retaining a parent in treatment, and re-engaging parents who may have dropped out of treatment. A Recovery Coach is assigned to a parent throughout and beyond the treatment process to help ensure a parent is actively engaged in aftercare services in their community and in recovery support activities. The range of support from the Recovery Coach extends through the time period after children have been returned to a parent's custody. Recovery Coaches stay involved with a family through this potentially stressful time, as it has been identified as a vulnerable time for parents often correlated with relapse. In addition to working directly with the parent, the Recovery Coach's case management responsibilities include regular contact with the AODA treatment agency and child welfare worker. This includes attending or preparing reports for child and family team meetings, joint and interagency staffings, and administrative case reviews and court appearances.

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

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

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

The demonstration group services (those assigned Recovery Coaches) are provided for the duration of the case. These services may also be continued for a period of time subsequent to the case closing in Juvenile Court.

Training

Extensive trainings have been provided for private agency staff, treatment providers and Recovery Coaches.

Trainings with Private Agency Personnel: Throughout this reporting period, project staff conducted individual training sessions with approximately 40 private agency placement teams contracted to serve DCFS involved families. Currently in Illinois, DCFS contracts with private agencies to serve approximately 80% of the families in Cook County who have open cases with the department. These trainings provided specific information regarding the IV-E AODA project design such as: eligibility requirements and random assignment; specific project features; projected goals and outcomes, along with clarifying roles and responsibilities of child welfare caseworkers and Recovery Coaches. In addition to increasing awareness regarding the project and exploring better ways to collaborate, these trainings have also covered proper completion of the data collection tool (TRACCS Form), as well as the process involved in obtaining signed research consents from parents in the study. These trainings have proven to be beneficial in improving awareness regarding the project and increasing the collaborative efforts between the child welfare worker and Recovery Coach.

Trainings with OASA/DCFS Initiative Treatment providers: Throughout this reporting period, project staff conducted individual training sessions with approximately 18 treatment providers contracted through the OASA/DCFS Initiative. Much like the trainings with the child welfare agencies, these trainings provided specific information regarding the IV-E AODA project design such as: eligibility requirements and random assignment; specific project features; projected goals and outcomes, along with clarifying roles and responsibilities of child welfare caseworkers, Recovery Coaches and treatment counselors. Specific goals of these trainings have been to focus on the outreach efforts and role of the Recovery Coaches and how best to collaborate with the treatment counselors to provide optimal and seamless delivery of services to the clients.

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

Training for Recovery Coach Staff: The Recovery Coaches have participated in the following professional development seminars, among others:

- ❑ Issues of Diversity in Clinical Work and Evidence Based Practice in Mentally Ill Substance Abuse (MISA)
- ❑ Treatment Mock Court Room Training
- ❑ Principles of Recovery Management
- ❑ Neuroscience of Addiction

- ❑ Implications of Neuroscience on Case Management
- ❑ Clinical Skills in Addiction/Brain Disease Case Management

The staff at JCAP and TASC are also available to assist caseworkers and treatment providers with any problems or questions which may arise.

Role of the Courts

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

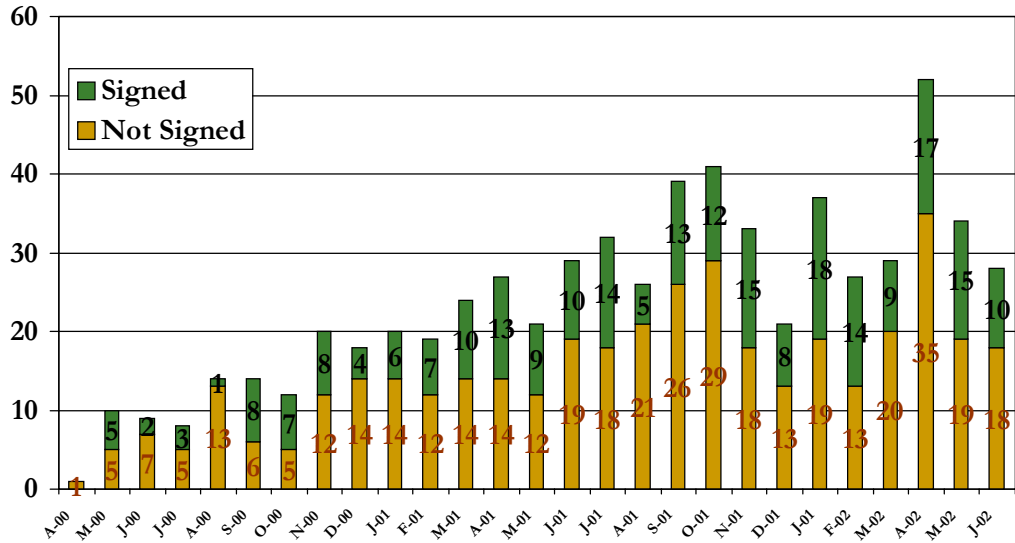
Although the Recovery Coach may present reports to the court regarding treatment progress, the waiver demonstration staff do not have any direct input into the legal process. Waiver demonstration staff are however in contact with the General Counsel of DCFS regarding any court issues which may arise.

Implementation Concerns:

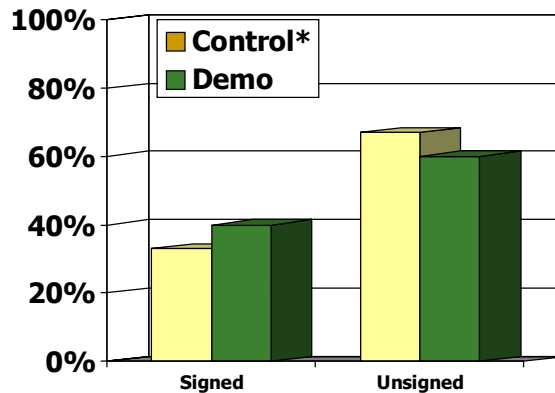
There have been some complications with certain aspects of implementation of the Waiver. The following is a summary of such complications.

Status of Demonstration group clients no longer receiving Recovery Coach Services: As of September 30, 2002 the Recovery Coaches have discontinued services with a total of 127 clients. More than 50% of these clients' permanency goals have been changed to termination of parental rights. Another 23% have been unavailable (unable to contact) for six consecutive months, while other clients have been incarcerated subsequent to the case being referred. Concerted efforts need to take place between the General Counsel's office and the court system to evaluate the timeframes of the children's cases remaining open in Juvenile court.

Research Consents: During the first 15 months, there were 93 signed research consents (38% of referrals); during next 12 months there were 150 signed consents (38% of referrals). See chart below. We expect the recently revised consent will increase this rate.



Research Consents by Group: The following chart shows the percentage of consents signed in the control and demonstration groups. Logistic regression analysis of odds of consent showed no significant differences by age, race, employment status, drug choice, or number of children.



Permanency decision delays in Juvenile Court: There are prescribed time frames for each decision stage in Juvenile Court; each stage constitutes a major decision point with respect to the movement of the child towards permanency. The prescribed time frame from temporary custody (TC) to adjudication (trial) is 90 days from the date of temporary custody; the dispositional hearing should take place within 120 days from the date of temporary custody; and the first permanency hearing should occur with one year from the date of temporary custody. As of June, 2002, we found that there were significant delays beyond the prescribed time frames, as follows:

Control Group

	Temporary custody to Adjudication	Temporary Custody to Disposition	Temporary Custody to first Permanency Hearing
AVERAGE	217	268	355
MEDIAN	202	248	336

The average time from TC to adjudication was 217 days in the control group and 225 days in the demonstration group.

Of the 318 control group cases examined, we found that 106 cases had not yet had their first permanency hearing. Five of these cases had TC dates in 2000, and 48 had TC dates in 2001.

Demonstration Group

	TC to Adjudication	TC to Disposition	TC to first Permanency Hearing
AVERAGE	225	269	368
MEDIAN	199	247	359

In the demonstration group, 275 children appear to have had no permanency hearing listed. Of these, 25 had TC dates in 2000, 89 had TC dates in 2001, and 161 had TC dates in 2002. Seven hundred demonstration cases were examined for this analysis.

The time frames are significant because in general, according to statute, a parent can be found to be unfit for failure to make reasonable efforts to correct the conditions which led to the removal of the child or reasonable progress toward the return of the child within 9 months after adjudication. Longer delays to adjudication result in longer delays to permanence.

3: Population and Characteristics

Caretakers:

As of March 31, 2002, 532 parents and 868 children are enrolled in the project. Of the 532 parents, 368 (30%) have been randomly assigned to the demonstration group and 164 (70%) have been assigned to the control group.

Cumulative Totals as of March 31, 2002:

The majority of caretakers in the demonstration are female, African-American, and have incomes of \$0-\$7,400 a year.

	Control Group	Demo Group	Total
Parents	164	368	532
Families	140	304	444
Children	283	585	868

The following table displays the characteristics of the parents in the Waiver. It is important to note that the two groups are statistically equivalent:

Variables	Demonstration (N=365)	Control (N=157)	
Age	33 yrs.	33 yrs.	
Gender:	73%	73%	Female
Ethnicity:	80%	84%	African-American
	4%	6%	Hispanic
Marital Status:	10%	10%	Married
Shelter:	4%	5%	Homeless
Employment Status:	66%	69%	Not working
Education:	44%	47%	< High School
Primary Substance:	36%	38%	Cocaine
	40%	38%	Opioids

In addition, the following table displays that the characteristics of mothers are statistically equivalent:

Variables	<u>Demonstration</u> (N=271)	<u>Control</u> (N=120)	
Age	31 yrs.	31 yrs.	
N of assigned children	2	2	
Ethnicity:	82%	86%	African-American
	4%	4%	Hispanic
Marital Status:	9%	8%	Married
Shelter:	6%	6%	Homeless
Employment Status:	72%	73%	Not working
Education:	48%	43%	< High School
Primary Substance:	43%	46%	Cocaine
	41%	40%	Opioids

The great majority of caretakers are female:

	N=164	N=368	(COLUMN %)	
Gender	Control	Demo	Control %	Demo %
Female	121	271	73.78	73.64
Male	43	97	26.22	26.36

The following tables provide information with respect to employment, education, marital status, race, and living arrangement of the caretakers as of March 31, 2002.

Race	N=164	N=368	(COLUMN %)	
	Control	Demo	Control %	Demo %
Asian/Pacific Islander	1	1	0.61	0.27
Black	138	295	84.15	80.16
Hispanic: Mexican	1	14	0.61	3.8
Hispanic: Puerto Rican	6	10	3.66	2.72
Other race	1	0	0.61	0
White	17	48	10.37	13.04

EMPLOYMENT	N=164	N=368	(COLUMN %)	
	Control	Demo	Control%	Demo%
Employed	0	1	0	0.27
Full Time	10	25	6.1	6.79
Not in Labor Force	5	7	3.05	1.9
Part time	6	20	3.66	5.43
Unemployed	107	236	65.24	64.13
Unknown	36	79	21.95	21.47

EDUCATION	N=164	N=314	(COLUMN %)	
	Control	Demo	Control%	Demo%
Less than high school	75	163	51.37	51.91
High school or GED	38	103	26.03	32.8
Some college/vocational	10	13	6.85	4.14
Graduated college/Vocational/trade school	2	2	1.37	0.64
Unknown	21	33	14.38	10.51
Missing Data	18	54	11.0	14.7

MARITAL STATUS	N=164	N=368	(COLUMN %)	
	Control	Demo	Control%	Demo%
Divorced	10	22	6.1	5.98
Married	15	38	9.15	10.33
Never married	122	279	74.39	75.82
Separated	14	19	8.54	5.16
Unknown	2	4	1.22	1.09
Widowed	1	6	0.61	1.63

LIVING ARRANGEMENT	N=164	N=368	(COLUMN %)	
	Control	Demo	Control%	Demo%
Alone	29	68	17.68	18.48
Community shelter	2	8	1.22	2.17
Family	86	186	52.44	50.54
Friends	33	76	20.12	20.65
Homeless	9	16	5.49	4.35
Other	3	7	1.83	1.9
State Institution	1	2	0.61	0.54
Unknown	1	5	0.61	1.36

Presenting problems of Caretakers:

In order to be included in the Waiver, a parent must have a substance abuse problem. As previously mentioned, JCAP staff are responsible for conducting the substance abuse assessments. In Illinois, the use of illegal substances per se does not constitute child maltreatment. However, the birth of a child who has illegal substances in its blood constitutes an allegation of neglect.

Risk of Harm and Substance Related allegations are the two major types of indicated maltreatment.

The following table displays the allegation of maltreatment associated with entry into the demonstration project. That is, the most recent allegation prior to random assignment. There are no significant differences between the control and demonstration groups.

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

The JCAP (Juvenile Court Assessment Process) assessment data also contains other information regarding presenting problems for caretakers. These data are entered at the time the caretaker is assessed for substance abuse problems. The following tables display some of the information collected from the assessment.

Number of Substance Exposed Infants (SEI):

Number SEIs						
AODA group	Mean	N	Std. Deviation	Minimum	Maximum	Median
Control	3.77	135	2.443	0	10	3
Demo	3.73	285	2.459	0	12	3
Total	3.74	420	2.451	0	12	3

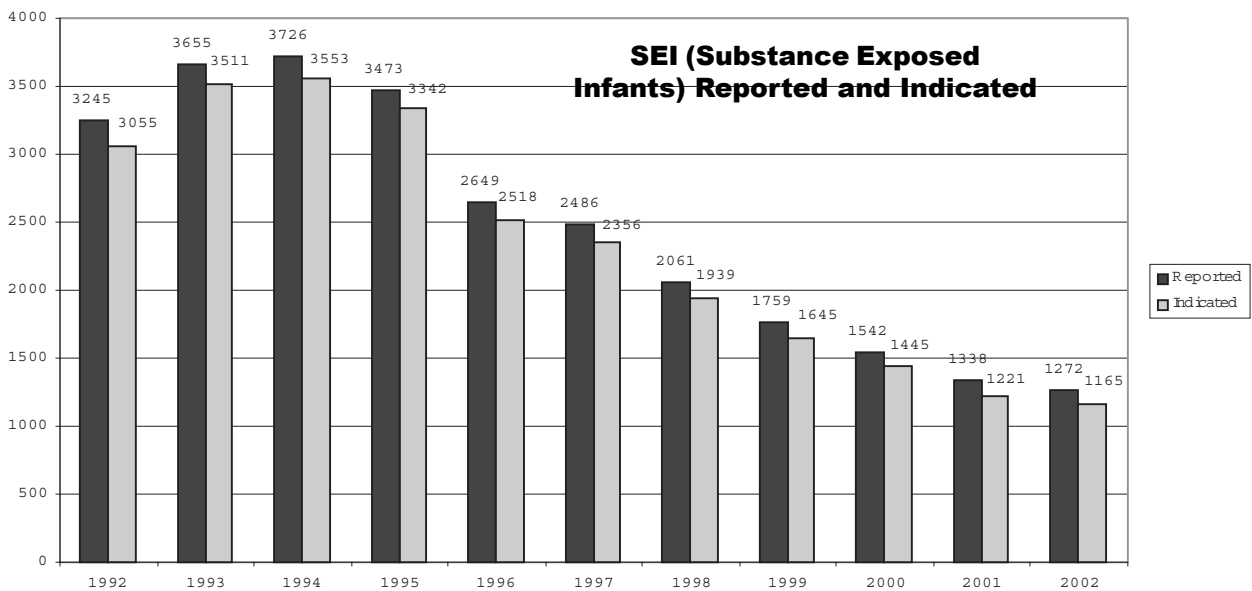
Of the total number of responses, 420, the average number of SEIs for these caretakers was about 3.7 for each group. This suggests that a large number of mothers have experienced substance abuse problems for a significant period of time prior to their involvement with the demonstration project:

The chart following shows the number of SEIs by JCAP year. It appears that in 2002 there is a decrease in the average number of SEIs. The reason for this is not clear; this is an issue which will be explored in more depth in future reports.

Number of SEIs

AODA group	JCAP Year	Mean	N	Minimum	Maximum	Median
Control	2000	4.64	33	1	9	5
	2001	3.83	88	0	10	3
	2002	1.36	14	1	3	1
	Total	3.77	135	0	10	3
Demo	2000	4.52	54	1	11	4
	2001	3.93	195	0	12	4
	2002	1.44	36	1	3	1
	Total	3.73	285	0	12	3
Total	2000	4.56	87	1	11	5
	2001	3.9	283	0	12	4
	2002	1.42	50	1	3	1
	Total	3.74	420	0	12	3

To illustrate the problem of substance abuse in child welfare, the following chart displays the number of cases indicated for SEI (substance exposed infant) in Illinois between 1992 and 2002:



In order to be included in the Waiver, a parent must have a substance abuse problem. As previously mentioned, JCAP staff are responsible for conducting the substance abuse assessments. In Illinois, the use of illegal substances per se does not constitute child maltreatment. However, the birth of a child who has illegal substances in its blood constitutes an allegation of neglect.

Cocaine is the most common drug of choice (36.1%), followed by opioids (26.5%) and alcohol (23.5%).

Primary drug of choice: N=532

	Control	Demo	Total
No response	1	4	5
	0.60%	1.10%	0.90%
ALCOHOL	37	88	125
	22.60%	23.90%	23.50%
COCAINE	62	130	192
	37.80%	35.30%	36.10%
MARIJUANA	16	47	63
	9.80%	12.80%	11.80%
OPIOIDS	45	96	141
	27.40%	26.10%	26.50%
PCP	2	3	5
	1.20%	0.80%	0.90%
OTHER	1	0	1
	0.60%	0.00%	0.20%
Total	164	368	532
	100.00%	100.00%	100.00%

The two major substances used by caretakers were cocaine and opioids; the major frequency for cocaine was several times per week.

Of those who said that their primary drug was cocaine, 38.54% responded that they used cocaine several times per week:

Cocaine Use Frequency	N=192	Control	Demo	Total
No Response		1	3	4
	%	1.61	2.31	2.08
NO USE	Count	1	4	5
	%	1.61	3.08	2.6
LESS THAN ONCE A WEEK	Count	16	20	36
	%	25.81	15.38	18.75
ONE TIME PER WEEK	Count	10	16	26
	%	16.13	12.31	13.54
SEVERAL TIME PER WEEK	Count	20	54	74
	%	32.26	41.54	38.54
ONCE A DAY	Count	3	11	14
	%	4.84	8.46	7.29
2-3 TIMES A DAY	Count	8	16	24
	%	12.9	12.31	12.5
MORE THAN 3 TIMES PER DAY	Count	2	5	7
	%	3.23	3.85	3.65
UNKNOWN	Count	1	1	2
	%	1.61	0.77	1.04
TOTALS	Count	62	130	192
	%	100	100	100

The majority of those who indicated that their primary drug was cocaine stated that they started to use cocaine between the ages of 17 to 21; the next largest group started using between the ages of 22-29:

Age of first use		Control	Demo	Total
	Count	1	5	6
	%	1.6	3.8	3.1
<12	Count	1	1	2
	%	1.6	0.8	1
13-16	Count	7	8	15
	%	11.3	6.2	7.8
17-21	Count	28	48	76
	%	45.2	36.9	39.6
22-29	Count	24	51	75
	%	38.7	39.2	39.1
30>	Count	1	17	18
	%	1.6	13.1	9.4
	Count	62	130	192
	%	100	100	100

Most caretakers started using drugs between the ages of 17 and 29, and have had previous treatment for substance abuse.

The majority of caretakers (JCAP data respondents - n=327, 61.5%) have participated in previous treatment for substance abuse:

		GROUP		Total
		Control	Demo	
Previous Treatment for Substance Abuse Problems	No Response	1	7	8
		0.60%	1.90%	1.50%
	No	61	136	197
		37.20%	37.00%	37.00%
	Yes	102	225	327
		62.20%	61.10%	61.50%
Total		164	368	532
		100.00%	100.00%	100.00%

11.6% of caretakers in the control group, and 9.5% in the demonstration group, said that they had had thoughts of suicide:

Income levels: 89% of the control group and 83.7% of the demonstration group (n=532) had annual incomes of \$0 - \$7,400 per year.

Other issues pertaining to caretakers:

The caseworkers (Child Welfare Workers), in their responses to the TRACCS forms, noted the existence of other issues, in addition to substance abuse, in

the lives of their clients, and also rated the progress their clients were making on some of these issues, as follows:

Apart from substance abuse, caseworkers stated that the majority of their clients had parenting skills deficits and housing issues.

N=355 (114 Control group, 241 Demonstration group)	Control %	Demo %
% of clients with mental health issues	27.9	29.6
% of clients with parental skills deficits	77.9	81.5
% of clients who have completed services regarding parenting skills issues	4.1	7.7
% of clients who have made substantial progress regarding parenting skills issues	3.3	6.4
% of clients who have made reasonable efforts in dealing with parenting skills issues	11.5	10.3
% of clients who have made unsatisfactory progress regarding parenting skills issues	55.7	45.5
% of clients with housing issues	61.5	46.4
% of clients with domestic violence issues	18.0	21.9
Clients who did not receive AODA services during the last reporting period	37.7	29.6
Clients who were awaiting AODA services during last reporting period	5.7	3.9
% of clients needing child care services	6.6	10.7
% of clients who have completed services regarding substance abuse issues	7.9	2.1
% of clients who have made unsatisfactory progress regarding substance abuse issues	45.6	54.8

Child Characteristics

To ensure statistically equivalent groups, we also compare the characteristics of children in the demonstration and control groups. The following table displays these comparisons:

Variables	Demonstration (N=490)	Control* (N=241)	
Age at TC Hearing	3.8 yrs.	3.9 yrs.	
Gender	38%	37%	Removed as infant
	49%	48%	Female
Ethnicity:	82%	86%	African-American
	4%	7%	Hispanic
Allegation:	12%	9%	Abuse
	26%	20%	Substance exposed
	34%	43%	Neglect
	18%	20%	Risk of harm
	11%	8%	No allegation
First Placement	38%	48%	Hospital/Shelter
	42%	38%	Kinship Home

*none of these differences are statistically significant

	N=283	N=585	(COLUMN %)	
Race	Control	Demo	Control %	Demo %
African American	238	467	84.1	79.83
Hispanic	16	40	5.65	6.84
Other	0	7	0	1.2
Unknown	0	6	0	1.03
White	29	65	10.25	11.11

Sex	N=283	N=585	(COLUMN %)	
	Control	Demo	Control %	Demo %
Female	134	287	47.35	49.06
Male	149	298	52.65	50.94

The majority of children have had one placement prior to entering this demonstration. The major placement for children in the demonstration is with relatives.

Special needs: The overwhelming number of children in the experiment do not have special needs, as recorded on DCFS databases. According to these records, only 3.89% of the children in the control group and 4.27% of those in the demonstration group are characterized as being in need of mental health services. But independent data collected on the well-being of children in foster care shows that approximately 40% of foster children have mental health problems. Thus administrative are inadequate for assessing child well-being.

Placement Histories

The following table displays the number of prior placements (prior to the TC date associated with this demonstration) for the control and demonstration groups. Again, there are no significant differences between the two groups.

Number of Prior Placements	Control %	Demonstration %
1	84.80%	91.60%
2	3.3	3.3
3	9.6	3.8
> 3	<1%	<1%

Placement Types

The major placement type for children children in both groups (41.5% control group and 48% in the demonstration group) is in the home of a relative; the second major placement type is in a private agency foster home:

Placement Types				
		Control	Demo	TOTAL
Foster Home Adoption	Count	3	2	5
	%	1.06	0.34	0.58
Foster Home Boarding	Count	7	26	33
	%	2.46	4.44	3.80
Foster Home Private Agency	Count	77	170	247
	%	27.11	29.06	28.42
Foster Home Specialized	Count	47	31	78
	%	16.55	5.30	8.98
Group Home	Count	2	0	2
	%	0.70	0.00	0.23
Home Adoptive Parent	Count	4	8	12
	%	1.41	1.37	1.38
Hospital/Health Facility	Count	1	0	1
	%	0.35	0.00	0.12
Home of Parent	Count	17	49	66
	%	5.99	8.38	7.59
Home of Relative	Count	118	281	399
	%	41.55	48.03	45.91
Independent Living	Count	0	2	2
	%	0.00	0.34	0.23
Institution Private	Count	5	9	14
	%	1.76	1.54	1.61
Runaway	Count	3	4	7
	%	1.06	0.68	0.81
Subsidized Guardianship	Count	0	3	3
	%	0.00	0.51	0.35
	TOTALS	284	585	869
	%	100	100	100

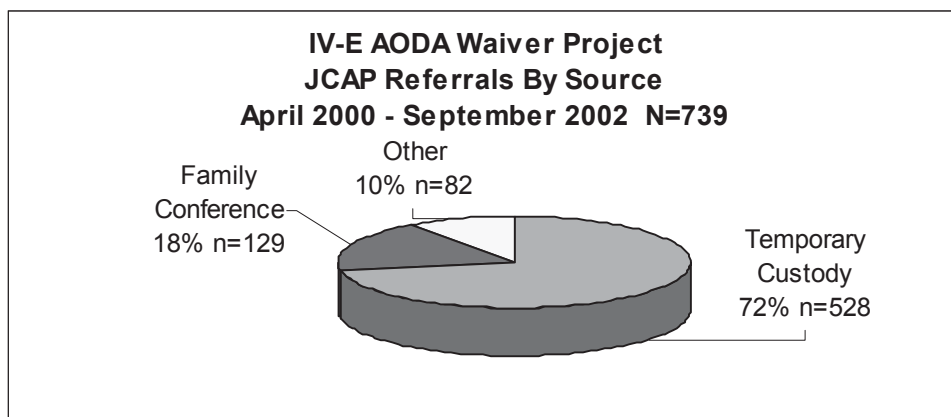
4: Process Indicators

Referrals:

Estimated Referrals: Data used in the original AODA waiver application to ACF indicated that as of February 1999 there were over 17,000 families with children in substitute care in Cook County. The evaluation design of the proposal used a monthly average of 195 families entering foster care in Cook County based on the ten-month period ending April 30, 1999. Based on data available at the time, projections were made that 25% of the child intakes would involve SEI findings and another 25% would involve serious drug use by parents. This led to an estimate in the original proposal that approximately 100 families per month would be suitable candidates for assignment to the project.

Actual practice and experience has differed greatly from the assumptions and projections in the original proposal. Based on the number of cases assigned to the waiver demonstration in the first 30 months, it appears that our initial estimate (projected 1,500 clients) is still possible. However, to achieve this projected total, we need an average of 42 new cases for the next 18 months.

Referrals to the project continue to be closely monitored and efforts to reach projected numbers continue to be explored. The chart below indicates that, as of September 30, 2002, of the 739 IV-E AODA eligible referrals from JCAP, 528 (72%) have originated from the Temporary Custody hearings, 129 (18%) from the Court Family conferences and 82 (10%) from other legal hearings and workers' outreach efforts. Additional outreach efforts to parents attending the Court Family conferences will be the focus with the goal of referring parents for an assessment at JCAP while still within the 90 days from the temporary custody eligibility time allotment.



The table below indicates the increase in total referrals to JCAP throughout the past three fiscal years. Even though each year there has been an increase in total number of referrals, 30% of clients are assessed as not needing treatment

and therefore a treatment recommendation is not indicated and the client is not eligible for the waiver. Included below is the total number of IV-E AODA eligible clients along with the specific assigned research group for each client. Of the total JCAP assessments provided to DCFS clients between FY-01 through the current FY-03, an average of 30% clients meet eligibility requirements for the IV-E AODA Project.

	Referrals to JCAP	Treatment not Indicated	Treatment Indicated	IV-E AODA Eligible	IV-E AODA Eligible (%)	IV-E AODA Control Group	IV-E AODA Demo Group
FY-00	546	249 (46%)	297 (54%)	20	4%	4	16
FY-01	569	212 (37%)	357 (63%)	226	40%	75	151
FY-02	1030	238(23%)	792 (77%)	400	39%	113	287
FY-03*	301	117 (39%)	184 (61%)	93	31%	19	74
Total	2,433	816(33%)	1630 (67%)	739	30%	211	528

* 1st quarter only

The table below designates the type of court hearings referring for alcohol and other drug abuse assessments to JCAP.

Total Referrals to JCAP April 2000 – September 2002

Referral from Type of Hearing	FY 2000	FY 2001	FY 2002	FY2003 (1 st Qtr)*	Cumulative TOTAL
Temporary Custody Hearing	216	219	399	83	917
Court Family Conference	108	118	209	58	493
Dispositional Hearing	46	24	60	10	140
Status Progress Hearing	132	126	207	62	527
Permanency Planning Hearing	17	55	100	46	218
Trial	24	20	26	16	86
Return Home	2	2	0	2	6
Other	1	5	29	7	42
Unknown	42	0	0	17	59
Total JCAP Referrals	588	568	1,030	301	2,488

The majority of referrals to the demonstration come at the TC hearing.

Judges, court personnel and child welfare workers refer clients to JCAP for AODA assessments not only to determine the level of care and arrange an intake appointment for a client with a known substance abuse problem, but also to rule out a substance abuse issue for clients where this has not yet been determined or evaluated effectively. The following chart summarizes the number of referrals made to treatment facilities based on the results of the AODA assessments.

Total JCAP Referrals	April 2000 – September 2002			
Referrals to Treatment	FY 2000	FY 2001	FY 2002	FY 2003
Successful Treatment Placements	172	267	360	140
Referrals placed on waiting list	32	3	6	3
Referred and refused treatment	18	1	18	15
Pending medical clearance	14	4	36	0
Pending psychological clearance	18	8	23	1
Other	85	73	35	25
Treatment not indicated	249	212	238	117
Total JCAP Referrals	588	568	1,030	301

NOTE: “Referrals to Treatment” indicates that, at the time of assessment, the JCAP staff had made a successful referral to treatment for the client.

Treatment Process Indicators for the Demonstration Group:

Length of time from referral to first contact; to completed assessment; to service onset

Clients in the demonstration group have their first contact with their Recovery Coach at the same time they have their substance abuse assessment at JCAP. At that same time, they are also referred for appropriate treatment, and the JCAP staff make the referral to the treatment provider.

Rate of Engagement between Recovery Coach Program and Client

As designed, Recovery Coaches and substance abusing caretakers are supposed to meet face-to-face on the same day as the JCAP assessment. This timely meeting is believed to speed up the treatment (or at least referral) process. For the purposes of this evaluation, we define “client engagement” as a face-to-face meeting between the Recovery Coach and parent that occurred within 48 hours of the JCAP assessment. The table below highlights engagement statistics through the first quarter of fiscal year 2003. One will note a steady increase in the percentage of clients engaged in treatment within 48 hours.

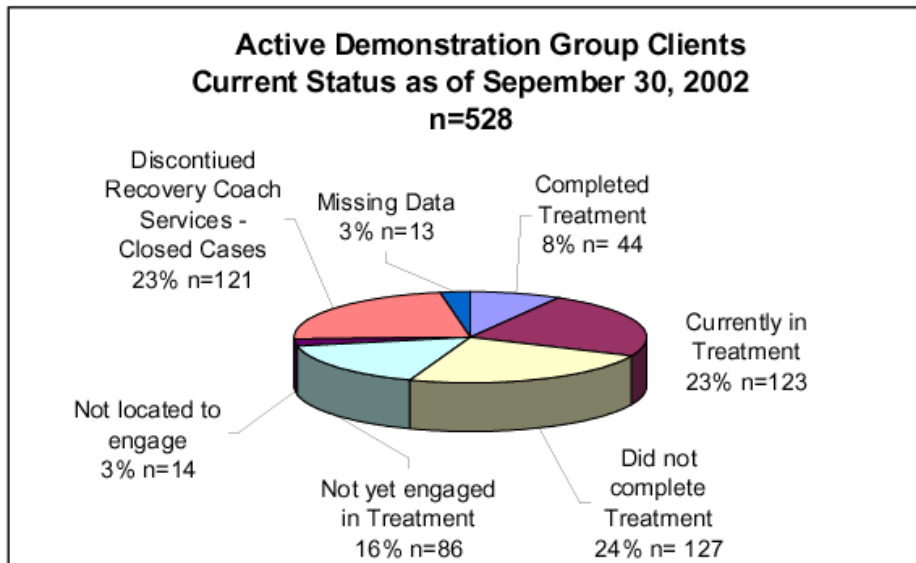
At the end of FY 02 the percentage of clients engaged within 48 hours was 89%.

Time Period	Number of Cases	% of Clients Engaged Within 48 hrs.
FY 2000	16	60%
FY 2001	151	79%
FY 2002	287	89%
FY 2003* (1 st Quarter)	74	92%
Total Demo clients	528	

Matching Client Needs with Substance Abuse Services: All of the caretakers with substance abuse problems have been offered substance abuse treatment services. However, not all caretakers have accepted services or completed these services.

Current Status and Treatment Participation with Demonstration Group

As of September 30, 2002, 528 clients had been referred to the Demonstration group. This is an increase of 160 clients within this reporting period. The chart below includes all 528 cases assigned to the Demonstration Group as of September 30, 2002 including clients who have completed treatment (44 or 8%), currently engaged in treatment (123 or 23.2%), those clients that failed to complete treatment (127 or 24%), and clients that have not yet been engaged in treatment (86 or 16.2%). In addition, the chart below also includes the closed cases – clients no longer being served by Recovery Coaches (121), pending clients unable to locate (14) and the clients (13) who were unable to be reviewed due to missing data. The following chart illustrates this data.



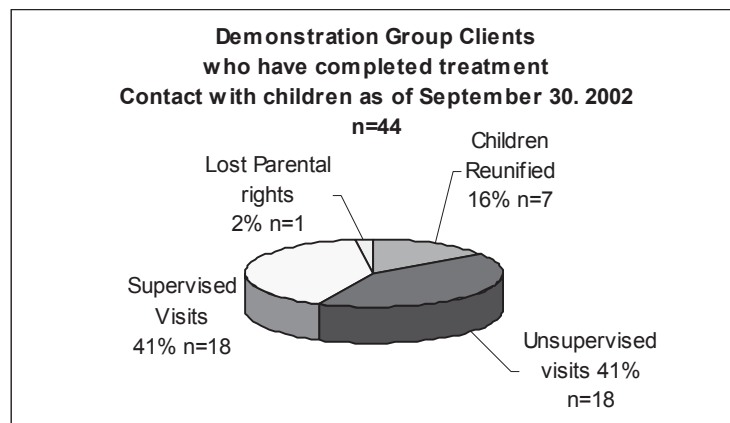
As of September 30, 2002, 380 (71%) of the total number (528) of Demonstration Group clients currently fit the criteria of active client.

Treatment Participation for Active Cases

Active clients are those clients either currently participating in treatment, completed treatment, entered treatment at least one time or have not yet engaged in formal treatment programs but are in regular contact with Recovery Coaches. As of September 30, 2002, 380 (71%) of the total number (528) of Demonstration /Group clients currently fit the criteria of active client. Treatment participation is calculated below for the 380 active cases only and does not include pending cases (clients referred by JCAP whom Recovery Coaches have been unable to contact despite outreach efforts) or cases that have already been closed and Recovery Coaches are no longer providing services.

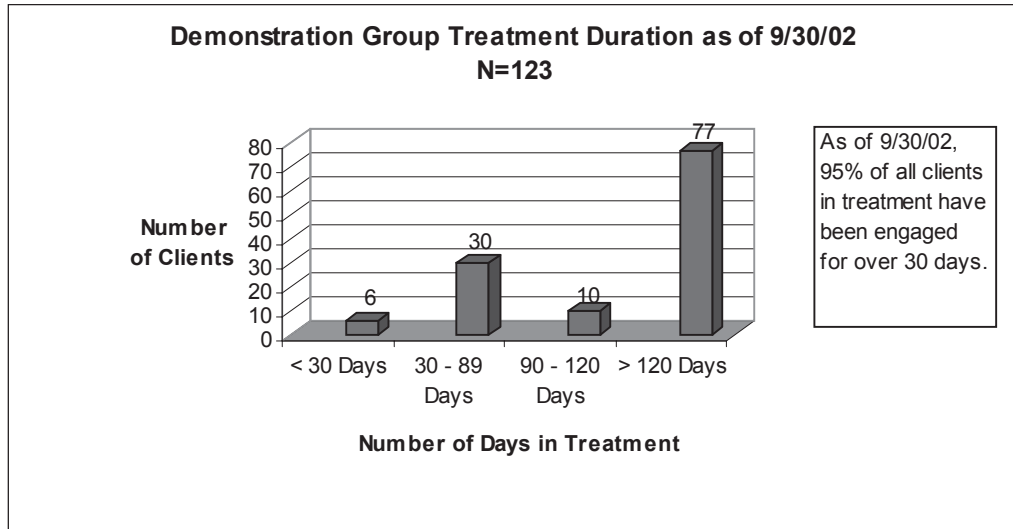
Of the total 380 active clients assigned to the Demonstration Group, 44 clients have completed all recommended levels of care and are participating in after care activities. This is an increase of 16 clients from the last reporting period. These clients have completed all recommended levels of care and are working closely with Recovery Coaches and caseworkers on completing additional tasks in their service plans.

Of these 44 clients, all but one is currently visiting regularly with their children. These parents report strong motivation to achieve the anticipated goal of reunification with their children. Currently, seven, (16%) of the 44 clients that have completed all treatment recommendations have successfully been reunified with their children and continue to remain in contact with their Recovery Coach. One parent lost parental rights but still continued to complete all treatment recommendations. The remaining 36 clients who also have completed treatment recommendations are working toward reunification with their children; 18 have unsupervised visits and 18 have supervised visits with their children. The reunification status of these clients will be included in future progress reports as those figures become available. In addition, we anticipate the reunification numbers to continue to increase within the next reporting period based on the large amount (123) of clients currently attending treatment programs. See chart following.



As of September 30, 2002, a total of 123 clients have successfully engaged and remained in an appropriate level of care. Of the total 123 clients in treatment, 117 clients, (95%) have been engaged for more than 30 days. Recovery Coaches have found that if a parent is able to remain engaged in treatment for 30 days, the chances of continued commitment to treatment remain high. This reporting period also shows a marked improvement in the amount of clients remaining in treatment for more than 120 days. As of September 2002, 77 clients have remained engaged in some form of treatment for more than 120 days. Of the 6 clients who have been in treatment for less than 30 days, 4 clients have been involved with the program for less than 30 days.

As of September 30, 2002, out of a total of 123 clients who have successfully engaged and remained in an appropriate level of care, 117 clients, (95%) have been engaged for more than 30 days.

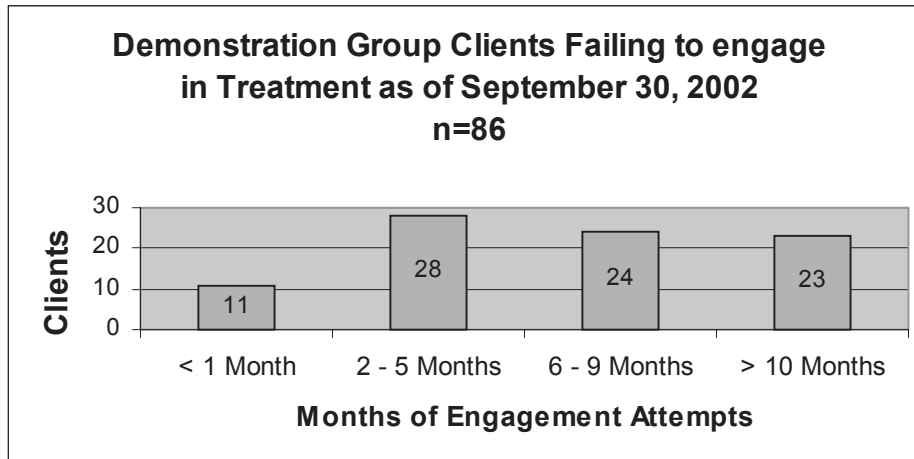


As of September 30, 2002, total of 127 clients have been engaged in treatment, but then failed to reenter the next level of care recommended or have left treatment against medical advice. These clients have participated in a treatment program at some point in time while involved in the project but have not successfully completed all treatment requirements. The majority of these clients remain engaged with the Recovery Coaches, and are either attempting to reengage in services or continue to fail to comply with treatment appointments and recommendations.

Of the total 127 clients who did not complete treatment, 49 clients, (39%) were engaged in services for less than 30 days. This figure supports the notion that engagement into treatment services takes at least 30 days in order to provide consistent attendance and follow through. Recovery Coaches provide an aggressive outreach strategy to reengage these particular clients to the appropriate level of care and provide education around relapse, relapse prevention, and harm reduction.

As of September 30, 2002, 86 clients have been in contact with a Recovery Coach but have failed to enter a recommended treatment program. Even though the client is given an intake appointment on the day of the JCAP assessment, the resistance and denial that is displayed by the parent often interferes with the client's ability to follow through with the referral to attend treatment. Engagement and perseverance from the Recovery Coach with the client is key in accomplishing positive treatment outcomes. It is often the relationship established with the Recovery Coach that helps overcome these defenses, thereby supporting the client in attending the treatment appointment.

Recovery Coaches continue to establish linkages to treatment providers in an attempt to engage these clients to enroll into a treatment facility. The chart below shows the specific number of clients who, after several months of engagement attempts, chose not to participate in treatment services.



The table below summarizes the current treatment participation status of all current Demonstration Group clients as of September 30, 2002 and compares them to the totals from the previous year.

Treatment Progress	Definition	Period ending Sept. 2001	Period ending Sept. 2002
Completed Treatment	Fulfilled all Treatment Recommendations	12 (3%)	44 (8.3%)
Currently in Treatment	Engaged in a Treatment Facility	52 (14.1%)	123 (23.2%)
Did not complete treatment	Did not complete Treatment - re-engaging	58 (15.7%)	127 (24%)
Not yet engaged in treatment	In Contact w/ Recovery Coach - not in TX	70 (19%)	88 (16.2%)
	Total active = All clients Working with Recovery Coaches	192 (52.1%)	380 (71.9%)
Not located to engage	Never had contact with Recovery Coach	26 (4%)	14 (2.6%)
Closed Cases – Discontinued Services	Recovery Coaches no longer serving client	0 (0%)	121 (22.9%)
Missing Data	Data not available at time report was written	8 (2%)	13 (2.4%)
	Total Demonstration Group Clients	368	528

Termination of services by Recovery Coaches:

Within this last reporting period, the AODA Waiver Task Force (consisting of consisting of DCFS administrators, established in to oversee efforts to increase referrals to the project and to provide additional support and professional guidance) was instrumental in developing protocols and criteria regarding the discontinuation of Recovery Coach services. Services are discontinued when clients assigned to the demonstration group consistently resist all outreach efforts by the child welfare case manager, Recovery Coach and treatment provider. These particular clients have been informed and are aware that they are at risk of having their parental rights terminated due to non-compliance but are unable or unwilling to participate in services and interventions to deal with dysfunctional areas in their lives. If a client repeatedly states for six consecutive months that he/she will not enter treatment, does not want Recovery Coach services, and/or does not want custody of their children, Recovery Coach services will be terminated.

As of September 30, 2002 121 cases are no longer receiving Recovery Coache services. More than half, 54%, of these parents have either voluntarily surrendered their parental rights or the courts have changed the permanency goal to termination of parental rights.

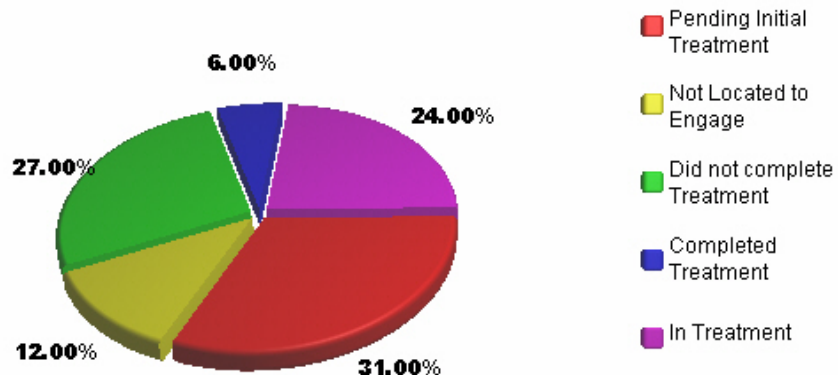
Recovery Coach Services are also terminated when parental rights are terminated.

Additional Service Indicators

The two following charts compare the total number of clients from one year ago, September 2001 to September 2002. (Closed cases are not included.) There is a marked improvement in the number of clients that have both completed treatment and/or are still participating in substance abuse treatment. At the end of September 2001, 30% of the clients in the demonstration group had either completed all treatment recommendations or were currently participating in a treatment program. By the end of September 2002, the percentage increased to a total of 42% of clients completing all levels of care or currently participating in treatment.

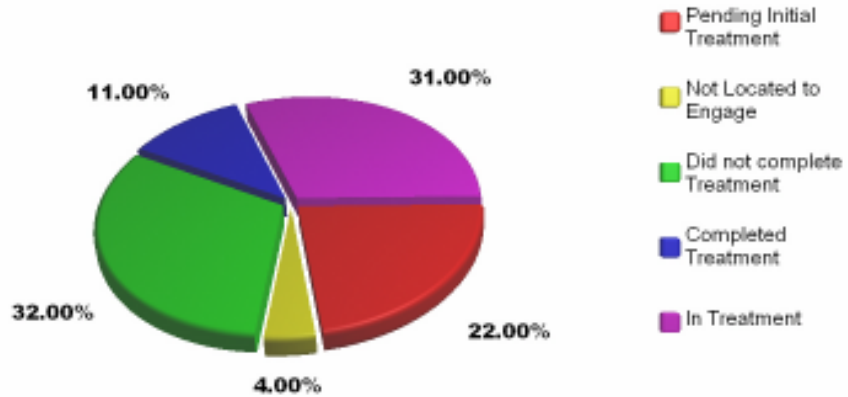
Demonstration Group Treatment Status as of Sept. 30, 2001

N = 218

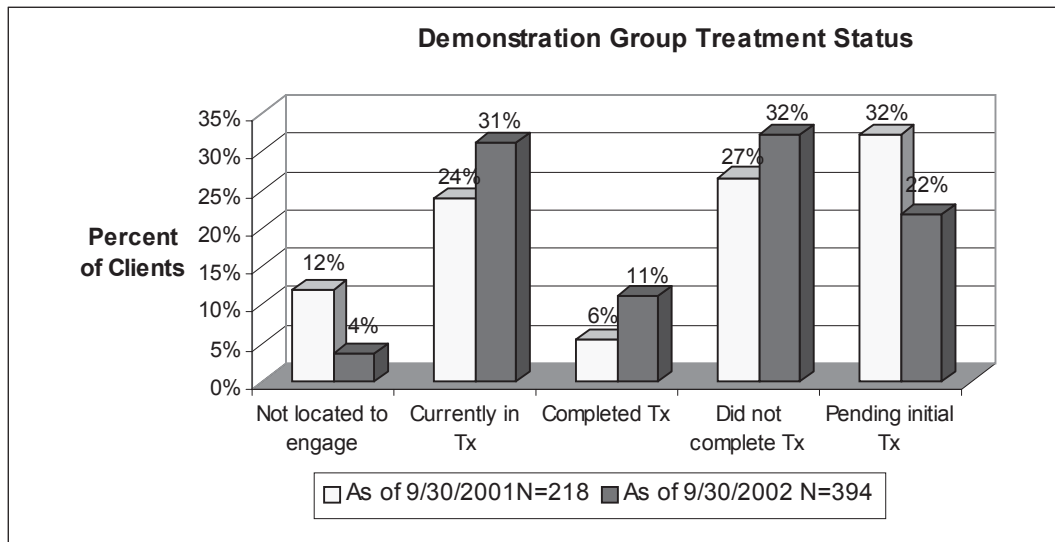


**Demonstration Group Treatment Status as of
Sept. 30, 2002**

N=394



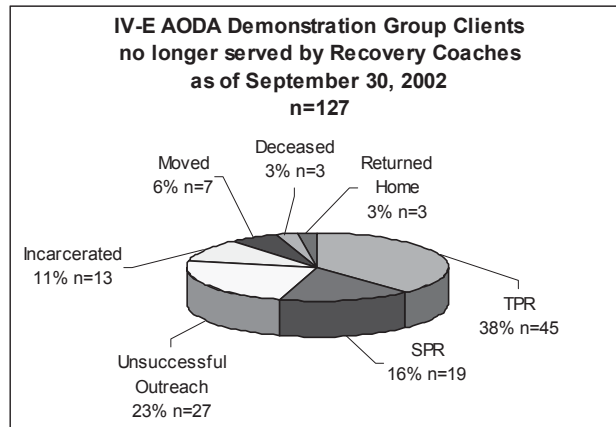
The chart below signifies additional improvements from one year ago ending in September 2001 up to the current reporting period ending in September 2002. Specific improvements can be noted for demonstration clients with a reduction in the number of clients who are difficult to locate for engagement, along with a reduction in clients not yet engaged in treatment (pending initial treatment).



As of September 30, 2002 121 cases are no longer receiving Recovery Coach services, formerly called closed cases. Even though Recovery Coaches have closed these cases, many remain open in with DCFS.

More than half, 54%, of these parents have either voluntarily surrendered their parental rights or the courts have changed the permanency goal to termination of parental rights. After 6 – 12 consecutive months of outreach attempts, Recovery Coaches report no contact with another 23 % of the parents who are

either unable to locate or resisting all attempts to engage in services. When incarcerated, the parent becomes unserviceable for the Recovery Coach. All efforts are made to link these clients to treatment programs within the judicial system. It has been reported that a small percentage of clients have moved out of state. Three parents have died of natural causes. See the chart below for an illustration of this data.



Substance Abuse Services: DARTS data analysis

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

Some of the comparisons are further separated by consent status. As previously noted, a percentage of caretakers refused to sign a letter of consent. This consent authorized the sharing of information between DCFS and OASA. Without consent, we are unable to link treatment records (DARTS data) with other data sources (e.g., demographics, caseworker reports). However, OASA did produce some aggregate reports for those without consent.

The service data reflect treatment activity between April 2000 and June 2002. The caretakers represented in these analyses entered the demonstration project between April 2000 and March 31, 2002. By selecting March as our cut off date, we allow a minimum of three months to elapse between JCAP assessment and date of first treatment episode. Although somewhat arbitrary, three months seems to offer families adequate opportunity to access some level of substance abuse treatment.

Access to Substance Abuse Services:

As of March 31, 2002 a total of 534 caretakers completed the JCAP assessment. Of these 534 caretakers, 163 are in the control group and 371 are in the demonstration group. Overall, 66% accessed substance abuse services subsequent to the JCAP assessment. Of those in the control group, 60% have a treatment episode subsequent to the JCAP assessment. Of those in the experimental group, 69% have a treatment episode subsequent to the JCAP assessment. The chi-square statistic ($X^2 = 3.74$, $df = 1$) and associated p-value (.053) indicate that this difference is marginally significant. The comparisons are displayed in the following table.

Assigned Group	Accessed Substance Abuse Services		totals
	No	Yes	
Control	65 (40%)	98 (60%)	163
Experimental	116 (31%)	255 (69%)	371
totals	181 (34%)	353 (66%)	534 (100%)

Time to First Treatment Episode:

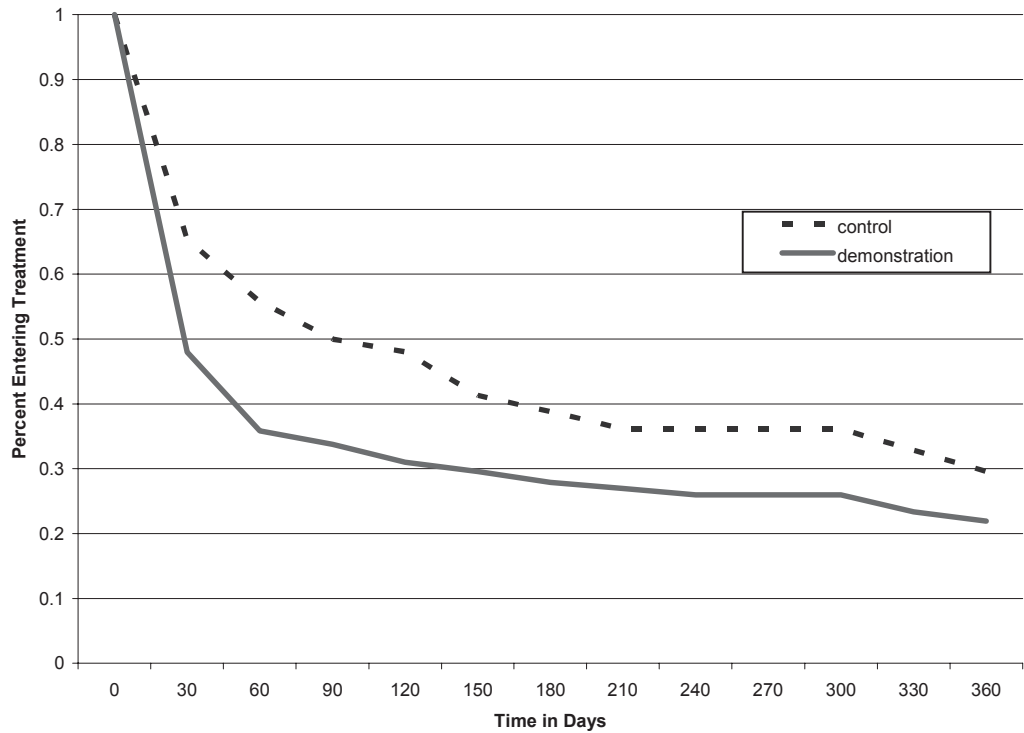
The following table displays the time to first treatment episode for all 534 caretakers. The time intervals refer to the number of months between the JCAP assessment and the first treatment episode. It appears the demonstration group is not only more likely to access treatment, but they are also more likely to access treatment more quickly.

Time since JCAP	Assigned Group	
	Control	Experimental
1 month	55 (34%)	160 (43%)
2 months	68 (42%)	194 (52%)

Life Table: Comparing Time to First Treatment Episode:

The previous table compares the access to treatment at two points in time (one and two months). To better understand the timing of these events, we ran survival analyses and produced a life table. The survival lines for both the control and demonstration group are displayed in the following chart. One will note that shortly after the JCAP assessment (represented as 0 days), the two lines begin to diverge. At one month (30 days), the difference is quite noticeable. The Wilcoxon (Gehan) statistic (5.627, $df = 1$, $p < .05$) indicates that the trajectories of these lines are significantly different. It should be noted that these analyses are limited to those caretakers that signed the informed consent (thus providing access to treatment start and stop dates).

Time Between JCAP Assessment and First Treatment Episode



It appears the demonstration group is not only more likely to access treatment, but they are also more likely to access treatment more quickly.

Summary Statistics for Caretakers with Signed Consents:

	Control	Demonstration
Mean days between assessment & first TX episode	61	46
Median days between assessment & first TX episode	28	14
Minimum days between assessment & first TX episode	1	0
Maximum days between assessment & first TX episode	330	569

Summary Statistics for Caretakers without Signed Consents:

	Control	Demonstration
Mean days between assessment & first TX episode	73	65
Median days between assessment & first TX episode	26	18
Minimum days between assessment & first TX episode	0	0
Maximum days between assessment & first TX episode	574	447

Treatment status, control and demonstration group:

According to caseworkers completing the TRACCS forms, (N=355) 18.9% of clients in the control group, and 17.2% in the demonstration group were characterized as “not accessible” (where these cases were still open to the caseworker/DCFS) .

The caseworkers also reported (again, TRACCS forms data, N=355) that 45.9% of the control group and 40.3% of the demonstration group were receiving no treatment. Similarly, the Recovery Coaches reported that in the demonstration group 34.5% were receiving no treatment, and that 23.1% were classified “unknown” as regards treatment status.

5: OUTCOMES

The outcomes of primary interest are permanency and child safety. The outcomes presented in this report are based on a comparison between the experimental and control group. As the Illinois AODA waiver utilizes an experimental design, simply comparing the two groups is appropriate. Two sources of data provide the foundation for the outcome analyses. The first source of data comes directly from the foster care agency case records. We selected a random sample of 50 cases (25 in each group) and collected both case record and caseworker interview data. The second source of data comes from the DCFS Integrated Database. This database includes a variety of client (e.g., demographics, placement history) and social service (e.g., placement records) information.

In 2002, an implementation case study was done. In part, the purpose of the implementation study was to explore (with a bit more depth than permitted with administrative data) the history of the caretakers (e.g., substance use, prior SEI), permanency planning and permanency outcomes. Key findings include:

- Parents in the project have long, serious substance abuse histories.
- Many of these parents have delivered multiple (e.g., more than 3) substance exposed infants
- Many of these parents have never parented any of their children (i.e., all placed with DCFS)
- The potential for reunification for parents with chronic drug problems and multiple SEIs may be quite low
- Juvenile Court moves very slowly to terminate parental rights even in the absence of any cooperation by parents with treatment plans.
- Of the 50 cases selected, 37 (74%) had the goal of return home: 18 in control & 19 in demo; despite the goal of reunification, case notes seem to indicate that the termination of parental rights seems likely in 32 (64%) of these 50 cases: 14 in control & 18 in demo
- Five children in the demo group have had finalized adoptions. (Four in 2001, one in 2002)
- In the demonstration group, slightly more children whose cases have been closed are living with their parents (81%) as compared with the control group (70%).

Parents in the project have long, serious substance abuse histories. Many of these parents have never parented any of their children (i.e., all placed with DCFS)

- According to permanency goal data, approximately the same percentage of children are moving towards adoption and subsidized guardianship in each group (demo group 3% vs. control group 2%)

PERMANENCE

Reunification (administrative data): As of March 31, 2002, 6% of the children in the control group and 8.4% of the children in the demonstration group were living in the home of their parents. Not all of these cases, however, were closed cases. Some of these children may have been living with their parents prior to the closure of the case in Juvenile Court. Closure of a case in Juvenile Court does not always mean immediate closure by DCFS. The Department may keep the case open for a period of time after closure in Juvenile Court to provide aftercare services and to ensure that the children are safe.

With respect to closed cases only, according to administrative data, as of March 31, 2002, a total of 34 cases (1.8% in the control group and 5.8% in the demonstration group) had been closed by DCFS.

By the end of 2002, again with respect to closed cases only, 13% of the children in the demonstration group had been reunified as compared with 8.3% of the children in the control group (percentages of the total numbers of children in the respective groups).

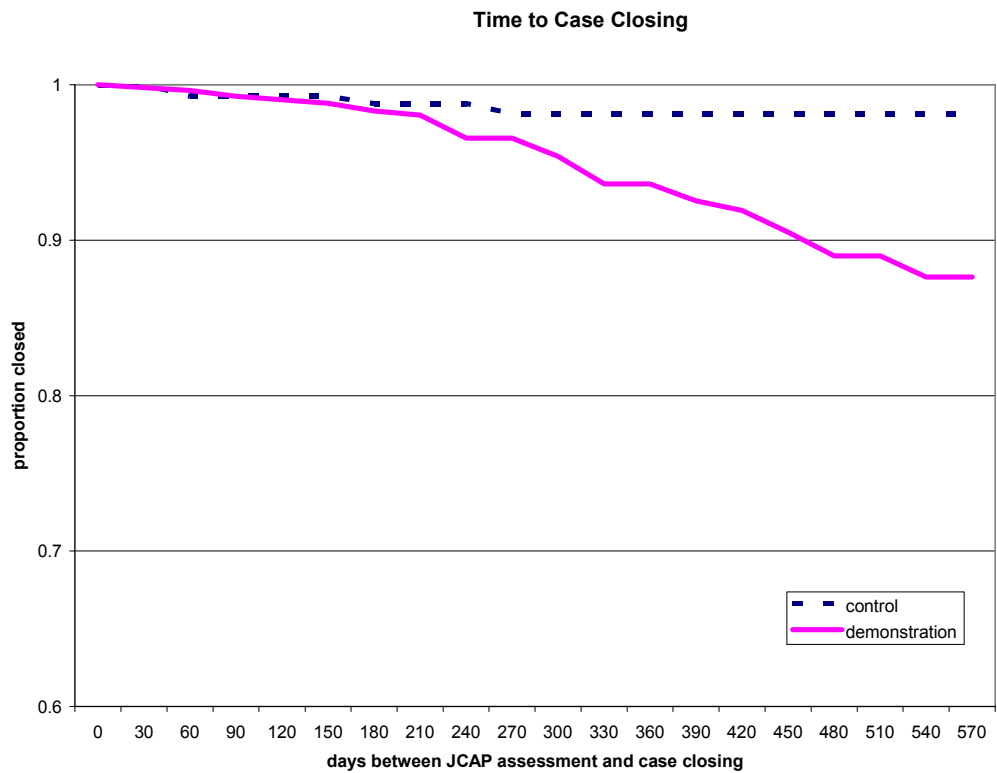
By the end of 2002, again with respect to closed cases only, 13% of the children in the demonstration group had been reunified as compared with 8.3% of the children in the control group

Unsupervised visitation:

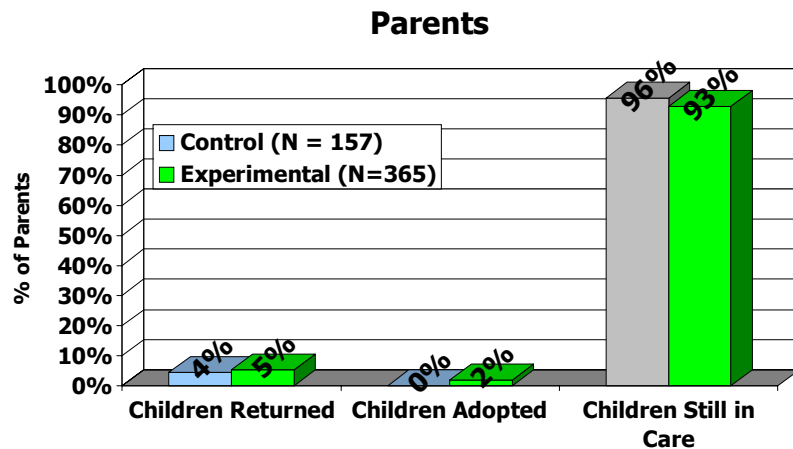
Caseworkers completing the TRACCS forms (N=355) reported that 3.3% of caretakers on the control group and 4.7% of those in the demonstration group were having *unsupervised visits* with their children. Unsupervised visitation is usually an indication of preparation for reunification.

Time to Permanence: To ascertain the amount of time it takes to reach permanency, we calculate the time (in days) from case opening to case closing (DCFS case closing that is).

To understand the relationship between participation in the demonstration group and the timing of case closing, we ran survival analyses and produced a life table. The survival lines for both the control and demonstration group are displayed in the following figure. The trajectories of these lines indicate that very few cases have closed. These trajectories remain fairly consistent until approximately the seventh month. At this point in time, cases in the demonstration appear to close at a higher rate as compared with those in the control group. Sixteen months (480 days) subsequent to the JCAP assessment, 98% of the control group cases remained open compared to 89% of the demonstration group.



The permanency outcomes between April 2000 and March 2002 are displayed in the chart below. There are no significant differences between the control and demonstration group: 96% of the children in the Control group and 93% of the children in the demonstration group are still in substitute care placement. Two percent of the children in the demonstration group have been adopted, compared to none in the control group. Four percent of the children in the control group and five percent of the children in the demonstration group have been returned to their parents.



Permanency Goals: As of March 31, 2002, the majority of children in the project continue to have “return home” as their permanency goal: 75.27 % in the control group vs. 69.4 % in the demonstration group. Similarly, approximately the same percentage of children appear to be moving towards the termination of parental rights and possible adoption (7.69% in the demonstration group vs. 7.07% in the control group).

Permanency Goal	N=283		N=585		(COLUMN %)	
	Control	Demo	Control %	Demo %	Control %	Demo %
Remain at home	0	3	0	0.51		
RH w/l 5 months	23	26	8.13	4.44		
RH w/l one year	190	380	67.14	64.96		
Return Home pending status hearing	21	51	7.42	8.72		
SubCare Pending Court Determination	20	45	7.07	7.69		
Adoption providing TPR completed	3	9	1.06	1.54		
Guardianship	3	9	1.06	1.54		
Independence	3	6	1.06	1.03		
No Home, Disability	2	1	0.71	0.17		
Missing	18	55	6.36	9.4		

As of March 31, 2002, the majority of children in the project continue to have “return home” as their permanency goal.

Placement Stability: One measure of permanence is placement stability. For the purpose of this report, we estimate placement stability by exploring the average number of placements per child. The estimates displayed in the following table indicate that the average number of placements is not significantly different when comparing the demonstration (3.67) and control (3.79) groups. Overall, children experience an average of 3.71 placements.

For the entire population as of March 31, 2002:

NUMBER of PLACEMENTS

Mean	3.71
Median	3.00
Minimum	1
Maximum	29

Control versus demonstration group:

AODA Group		Statistic	Std. Error
Number of Placements	Control	Mean	3.79
		Median	3.00
		Minimum	1
		Maximum	22
Demonstration	Mean	3.67	.122
		Median	3.00
		Minimum	1
		Maximum	29

Length of Stay in Placement: On average, children in the demonstration group spend less time in placement as compared with the children in the control group (282.85 days vs. 308.85 days).

For the entire population:

Time in Placement

Mean	291.34
Median	264.00
Minimum	5
Maximum	705

Control versus Demonstration group:

AODA Group		Statistic	
Time in Placement, Days	Control	Mean	308.85
		Median	286.00
		Minimum	10
		Maximum	705
Demonstration	Mean	282.85	
		Median	252.00
		Minimum	5
		Maximum	705

The Waiver design does not specifically track child and family well being. However, within the next year, we hope to have more data with respect to this topic, once a joint database between DCFS and Juvenile Court becomes an actuality. At the present time, the subtopics of juvenile arrests, status offenses, and juvenile delinquency are not applicable.

Very few children have experienced subsequent maltreatment (indicating high level of safety). There are no significant differences between the two groups.

Child Safety: The primary goal of the demonstration project is to improve permanence. However, we are also interested in the safety of children. A quick permanency decision that compromises child safety is unacceptable. The following table displays the percentage of children that are associated with a report of maltreatment subsequent to random assignment. Very few children have experienced subsequent maltreatment (indicating high level of safety). There are no significant differences between the two groups.

Allegations of Maltreatment Subsequent to Random Assignment

Type of Maltreatment	Demonstration %	Control %
Physical Abuse	0	0.01
Neglect	0	0
Sexual Abuse	0	0.01
Risk of Harm	3	3
Substance Related	1	1
Inadequate Supervision	0	0.01

COST BENEFIT ANALYSIS

This is a difficult component for an interim report since much of the cost and little of the benefit may be observable at this point. That is, many of the children are still in foster care. Nevertheless, it may be helpful to at least identify:

Cost Neutrality Formula

First, calculate the cumulative per child IV-E expenditures in the cost neutrality (control) group and multiply dollar average by the number of children ever assigned to the demonstration group to generate IV-E claim.

Second, if the actual IV-E cost in the demonstration group is less than generated IV-E claim, then the waiver is cost neutral.

AODA Cost Neutrality Calculations

Recovery Coach efforts to engage parents in drug treatment increases the chances for recovery and reunification or provides grounds for expedited TPR and adoption which are less costly than long-term foster care.

The cumulative per child IV-E expenditures in the cost neutrality group through December 31, 2002 was **\$16,201**, which when multiplied by the **801** children ever assigned to the demonstration group generates a IV-E claim of **\$12,976,814**

The projected IV-E cost in the demonstration group is **\$12,131,383**, which is **\$845,431** less than the multiplied average from the cost neutrality group, so the waiver is cost neutral.



SUMMARY AND CONCLUSIONS

Substance abuse is a major problem in child welfare. It is estimated that the abuse of alcohol and other drugs not only increases the risk of child maltreatment, but delays and often obstructs efforts to reunify children and families. The Illinois Department of Children and Family Services applied for a Title IV-E waiver in June 1999 and approval was granted by ACF for a five-year demonstration on September 29, 1999. The purpose of this demonstration project is to improve permanency outcomes for children of parents with substance abuse problems. To achieve this purpose, Recovery Coaches assist parents with obtaining AODA treatment services and negotiating departmental and judicial requirements associated with drug recovery and permanency planning. This report serves as an interim update and evaluation of the progress of the Illinois AODA waiver.

Eligible families for the demonstration include foster care cases opened on or after April 28, 2000 in Chicago and suburban Cook County. To qualify for the project, parents in substance affected families were referred to the Juvenile Court Assessment Program (JCAP) at the time of their Temporary Custody hearing or at any time within 90 days of the hearing. JCAP staff conducted AODA assessments and referred families for treatment, if indicated. The parents that were randomly assigned to the control group received traditional substance abuse services. This was not a “no treatment” control group. The parents that were randomly assigned to the demonstration group received traditional services plus the services of a Recovery Coach. The Recovery Coach worked with the parent, child welfare caseworker, and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and provide ongoing support to the parent and family through the duration of the child welfare case. It was hypothesized that Recovery Coaches would positively affect key child welfare outcomes (e.g. permanency). More specifically, the evaluation focused on the following four research questions (1) Are parents in the demonstration group more likely to access and complete AODA treatment? (2) Are children in the demonstration group more likely to be safely reunified with their parents? (3) Do children in the demonstration group spend less time in foster care? (4) Are families in the demonstration group less likely to experience subsequent maltreatment?

Treatment access: the demonstration group is more likely to access substance abuse treatment (60% control vs. 69% demonstration). Similarly, there is additional evidence to suggest that these same clients are accessing substance services more quickly (median days: 28 control vs. 14 demonstration). We are currently unable to report on rates of treatment completion.

Reunification: only 6.0% of the children in the control group and 8.4% of the children in the demonstration group were living in the home of their parents. This difference is not statistically significant. Regarding permanency goals, the majority of children in both the demonstration and control group have “return home” as their permanency goal (69% vs. 75% respectively).

Length of time in substitute care placement: children in the demonstration group experienced fewer days in foster care relative to the children in the control group (282 for the demonstration group vs. 309 days for the control group). It should be noted that there were no differences between the demonstration and control groups in terms of the number of foster care placements (3.67 days for the demonstration group vs. 3.79 days for the control group).

Safety: there were no significant differences between the rates of subsequent allegations of maltreatment. The rates of subsequent maltreatment are quite low (4%) for both the demonstration and control group.

In closing, the demonstration is achieving some of its stated objectives with regards to access to substance abuse treatment (demonstration group more likely to access treatment) and with regards to time to first treatment episode (demonstration group accesses substance abuse treatment more quickly). However, we do not see major differences between the control and demonstration groups with regards to reunification or safety. Given the difficulty and amount of time associated with substance abuse recovery (especially for parents with extensive history of substance abuse), these findings are not entirely surprising. Many parents in the project have chronic problems with alcohol and drugs. The repeated delivery of substance exposed infants indicates the seriousness of such problems. Thus, it is possible that these families require additional time to recover and reunify. Despite the difficulties and length of time associated with recovery, we anticipate that the timely entry into care and increased participation rates will eventually translate into higher rates of program completion and reunification.



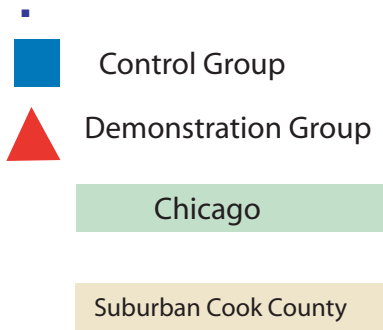
AODA IVE Waiver

AODA Population:
Geographic and
Demographic
Charts

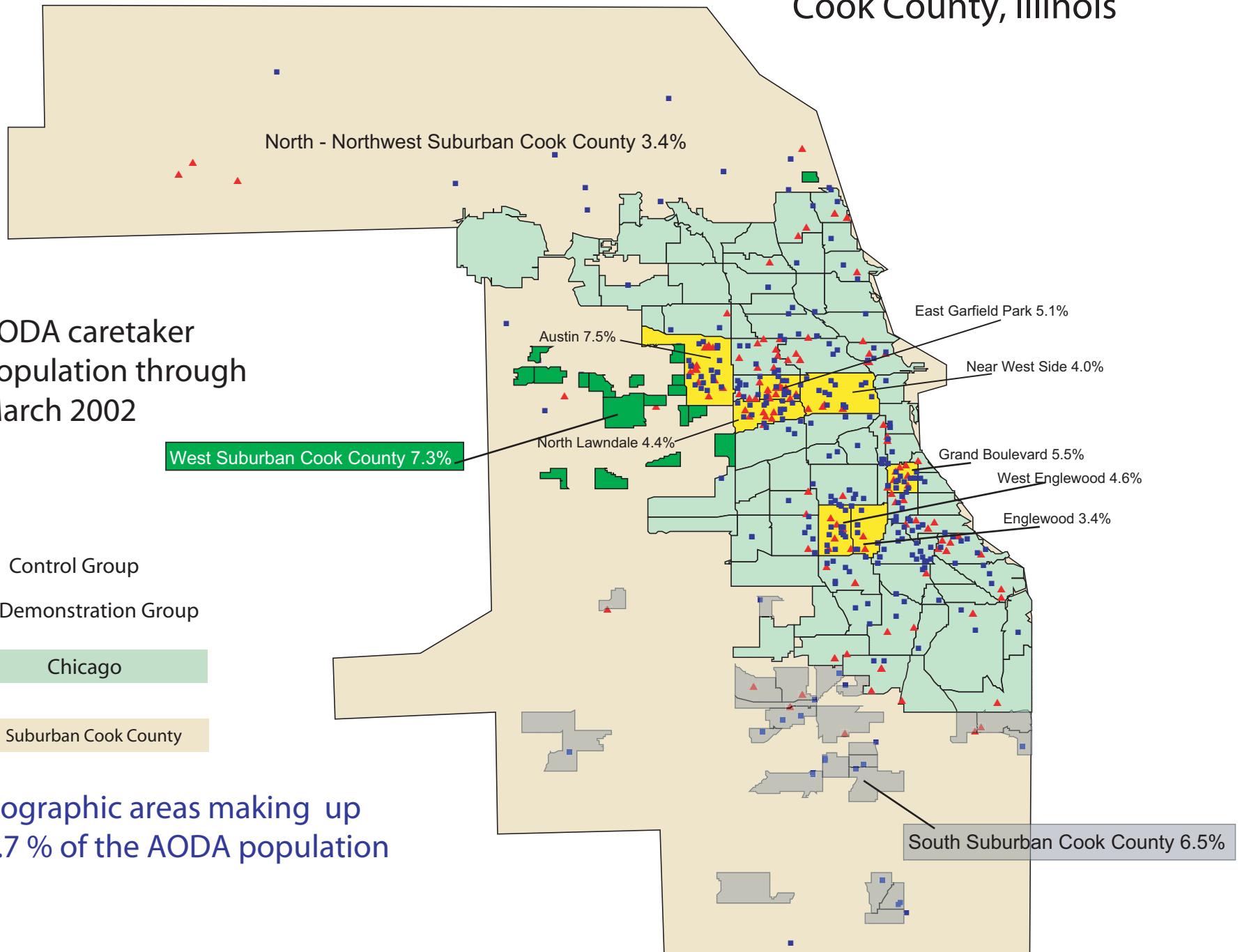
Federal Interim Report
May 2003

Cook County, Illinois

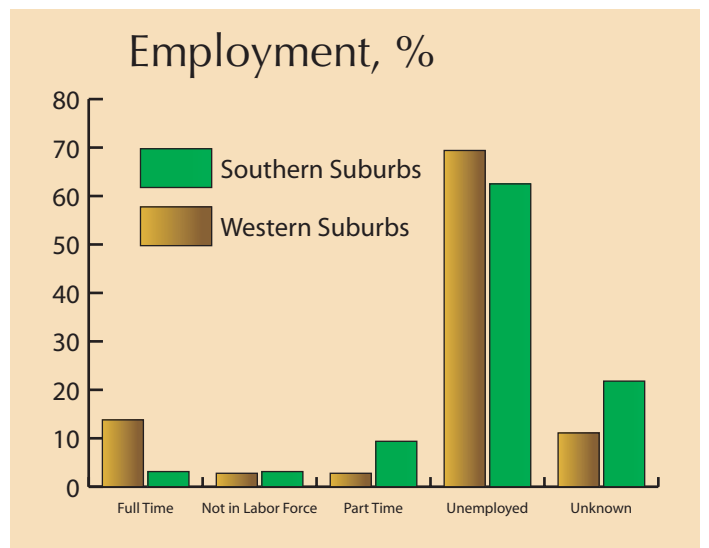
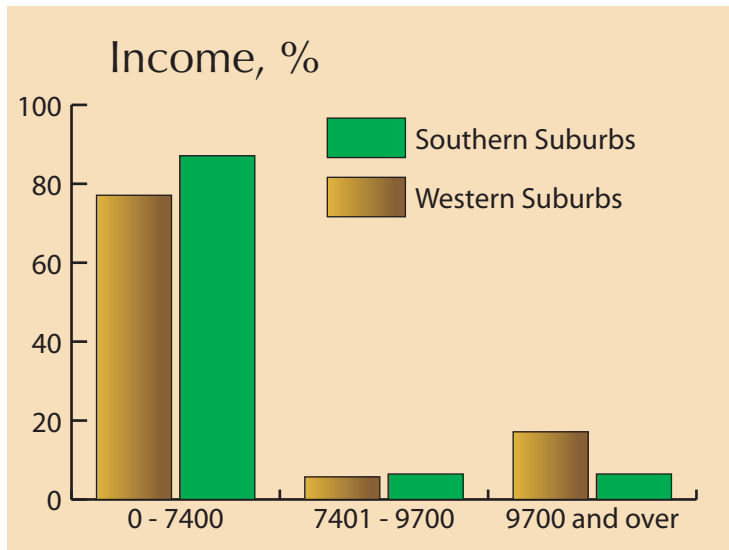
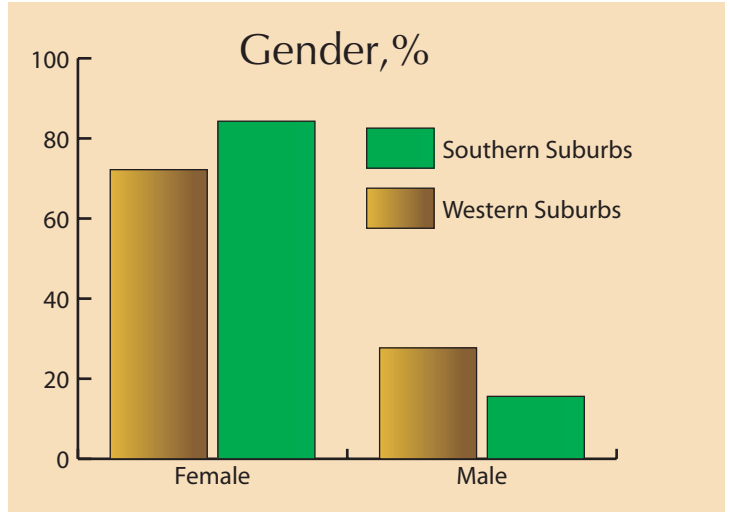
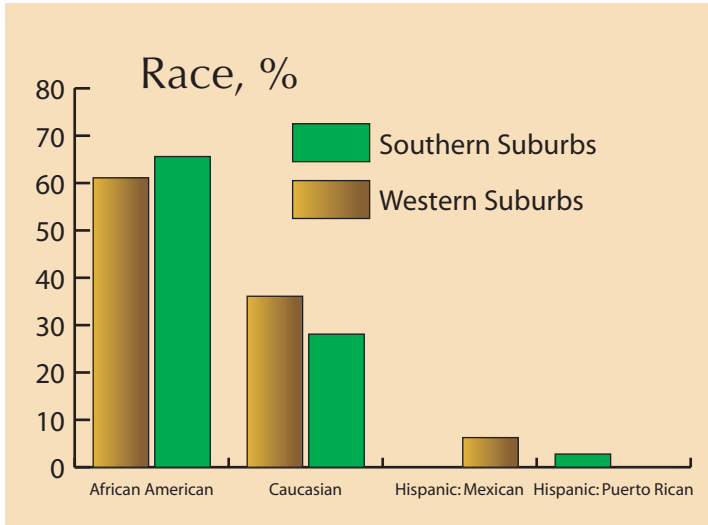
AODA caretaker
population through
March 2002



Geographic areas making up
51.7 % of the AODA population



Selected Demographics for AODA Caretakers in Western and Southern Suburbs

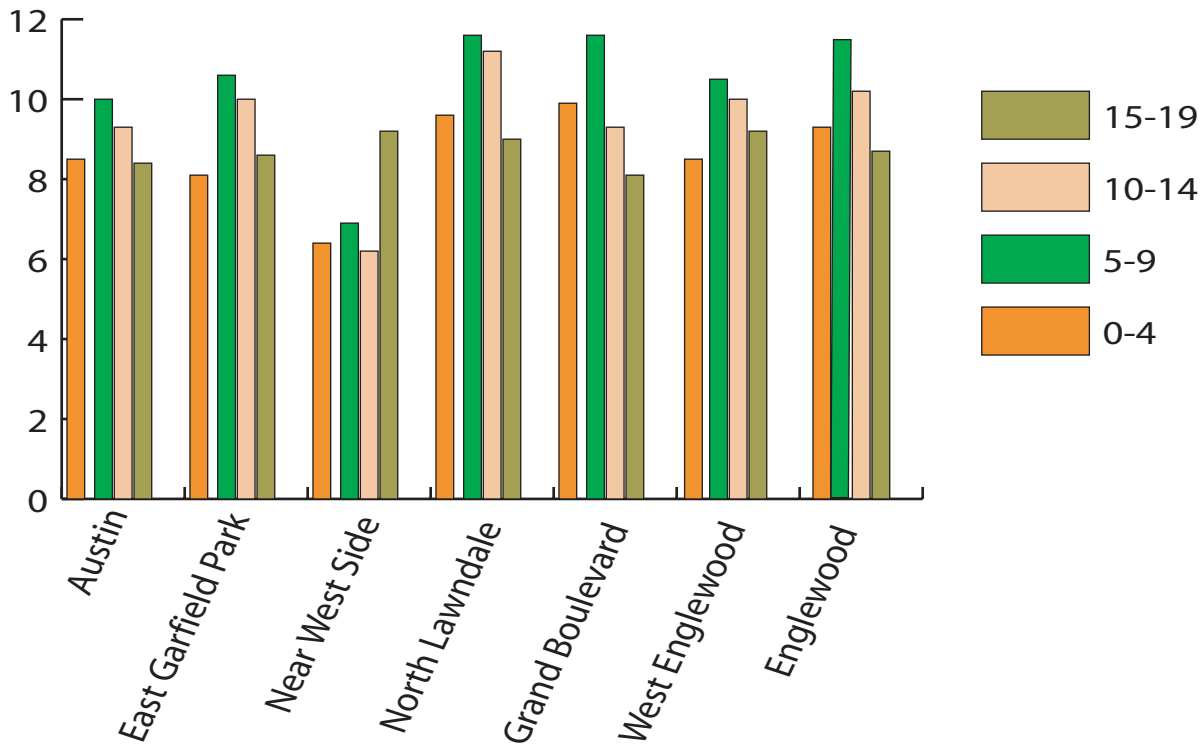


AODA IVE

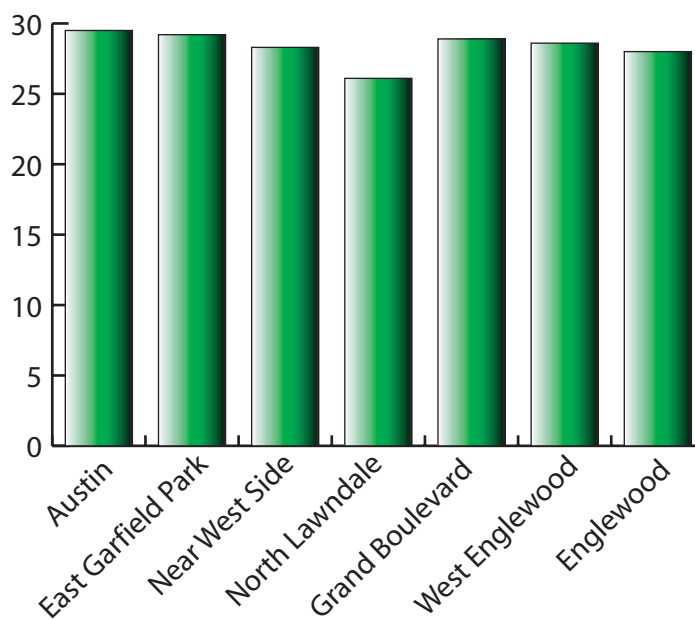
Selected Demographics for seven City of Chicago Communities which contain the larger numbers of the AODA caretaker population

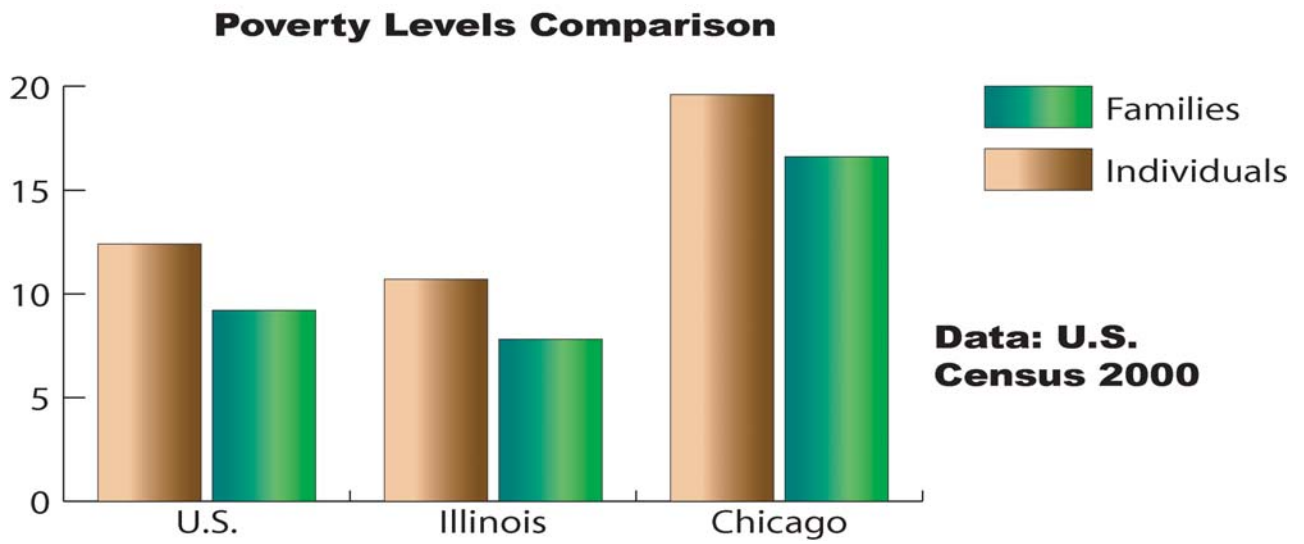
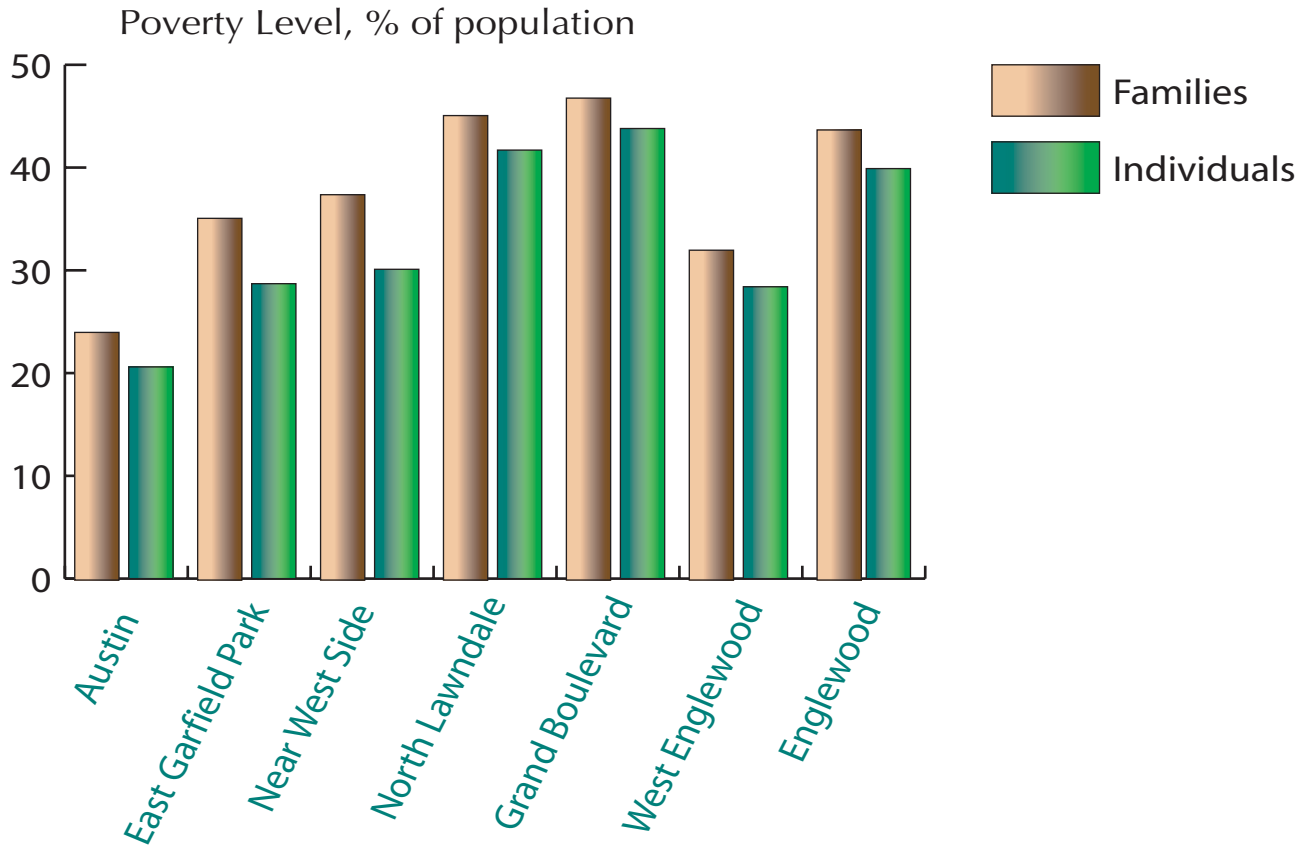
(All data from U.S. 2000 Census)

Ages of children, % of population

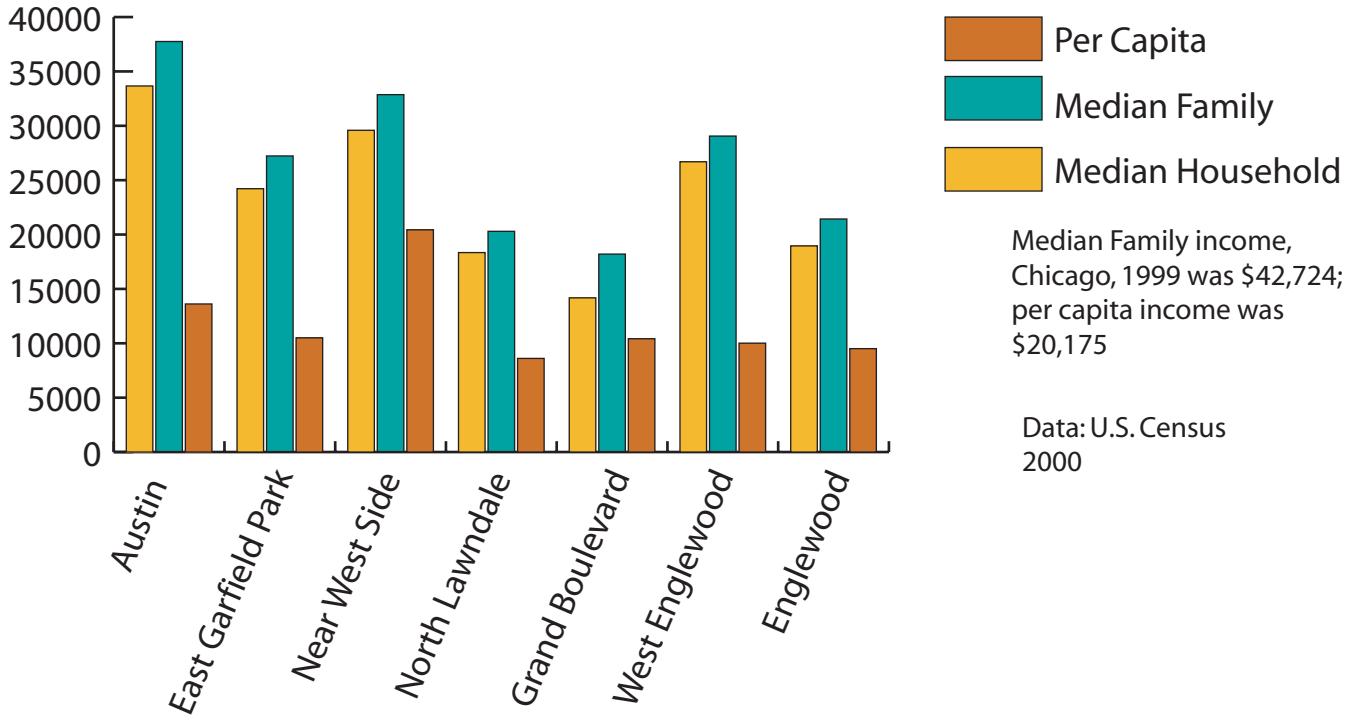


Median age





Income (In Dollars)



Unemployment Rate (% of Civilian Labor Force)

