Illinois AODA IV-E Waiver Demonstration Interim Evaluation Report

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CHILDREN AND FAMILY RESEARCH CENTER

This is a project of the Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign, which is funded in part by the Department of Children and Family Services. The views expressed herein should not be construed as representing the policy of the University of Illinois or the Department of Children and Family Services.

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STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
ERWIN MCEWEN, DIRECTOR

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

Children and Family Research Center
School of Social Work
University of Illinois at Urbana-Champaign

Prepared for
Illinois Department of Children and Family Services
Erwin McEwen, Director

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.

Target Population: Eligible families for the demonstration include foster care cases opened in two regions: (1) on or after April 28, 2000 in Chicago and suburban Cook County as of April 2000, and (2) Madison and St. Clair Counties as of July 2007. To qualify for the project, parents in substance-involved families are referred to the Juvenile Court Assessment Program (in Cook County) or screened by a recovery coach (in the two southern counties) at the time of their Temporary Custody hearing or at any time within 180 days of the hearing (before January 1, 2007, the eligibility time line was at the time of their Temporary Custody hearing or at any time within 90 days of the hearing). If substance abuse is identified as a problem – families are randomly assigned to one of two treatment conditions.

Evaluation Design: An experimental design is the best way to determine causal connections between interventions and outcomes. Within the expanded waiver demonstration we have two

random assignment protocols. In the southern counties the random assignment occurs at the individual level. The assignments are made via a secure web page by the recovery coaches. Individuals are assigned to either a control group (services as usual) or the demonstration group (services as usual plus the services of a recovery coach). In Cook County the random assignment occurs at the agency level. 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 random assignment groups are identical to the groups offered in the two southern counties. That is, the parents assigned to agencies serving only the control group receive substance abuse services that were available prior to the demonstration waiver (it is not a "no-treatment" control group). The parents that are assigned to agencies serving the demonstration group receive the regular services plus the services of a Recovery Coach. The Recovery Coach works with the parent, child welfare caseworker, and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary, and provide ongoing support to the parent and family through the duration of the child welfare case. Thus, the evaluation studies the effects of the availability of Recovery Coach services relative to the substance abuse service options that would have been available in the absence of the waiver. For the first five years of the demonstration, the evaluation was designed to test the hypothesis that the provision of Recovery Coaches Services positively affected the drug-recovery process and key child welfare outcomes. With regard to the expanded waiver demonstration, we are testing the hypothesis that Recovery Coach Services positively affect progress in the following domains: substance abuse, mental health, housing, and domestic violence. Such progress will in turn improve key child welfare outcomes (e.g. permanence, time in care, safety).

The IV-E AODA Project integrated additional key enhancements to increase the Recovery Coach program's efficacy and client service delivery capacity. Program partners have used client outcomes and feedback as opportunities to identify ways in which the project can improve service delivery and provide the most effective service(s) possible. This extension and expansion enabled additional enhancements to be added to the Recovery Coach program's efficacy and client service delivery capacity in order to address key barriers to reunification including: 1) *housing*, 2) *mental health*, and 3) *domestic violence*.

Sources of Data: The evaluation of the demonstration project utilizes multiple sources of data and multiple methods of data collection. Data pertaining to placement, permanency, and child safety come from the Department of Children and Family Services' integrated database. Substance abuse assessment data come from the Juvenile Court Assessment Program (JCAP). Subsequent to the temporary custody hearing, JCAP staff complete the AOD assessment and make initial treatment referrals. In addition to a wide variety of demographic information (e.g., employment status, living situation, public aid recipient), these assessment data include substance abuse histories and indications of prior substance exposed infants. Substance abuse treatment data come from the Treatment Record and Continuing Care System (TRACCS). This system is managed by Caritas and includes surveys completed by child welfare workers, recovery coaches, and treatment providers. 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 December 31, 2008, 686 parents (representing 949 children) were assigned to the control group and 1,720 parents (representing

2,249 children) were assigned to the experimental group. These parents were nested within 87 social service agencies. The Recovery Coach services offered to the demonstration group clients are provided by Treatment Alternatives for Safe Communities (TASC). Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. The primary goal for the Recovery Coach is to actively address the substance abuse problems of caregivers. The demonstration waiver assumes that by addressing the substance abuse problem in a timely manner, immediately connecting on families with substance abuse treatment providers and helping to re-engage families as necessary will help parents achieve family reunification more quickly – as compared with families in the control group.

Questions Related to Substance Abuse Services

1. Are parents in the demonstration group more likely to access AODA treatment services compared with parents in the control group? Yes, 73% of the caregivers in the demonstration group participated in substance abuse treatment, as compared with 66% in the control group.

2. What factors help explain the likelihood of completing AODA treatment services? Age, education, employment and the primary drug of choice were some of the factors associated with treatment completion. Caregivers with at least a high school education were more likely to complete treatment. Employed caregivers were more likely to complete treatment relative to unemployed caregivers. Heroin users were the least likely to complete substance abuse treatment.

Questions Related to Safety

1. Are families in the demonstration group less likely to experience a subsequent substantiated report of maltreatment? There is no difference with regard to substantiated allegations of maltreatment subsequent to random assignment. As of December 2008, 17% of the caregivers in the demonstration group and 18% of the caregivers in the control group are associated a subsequent substantiated allegations.

Questions Related to Visitation and Permanence

1. Are children in the demonstration group more likely to be safely reunified with their parents? Yes. As of December 31, 2008, 19% of the children in the control group and 23% of the children in the demonstration group were living in the home of their parents. This difference is statistically significant. Regarding permanency goals, the majority of children in both the demonstration and control group have "return home" as their permanency goal (37% for both the demonstration and control group).

2. When reunification does occur, are children in the demonstration group likely to be reunified in a shorter period of time? Yes. On average, children in the demonstration group experience a faster reunification than children in the control group (689 days for the demonstration group vs. 815 days for the control group). This difference is statistically significant.

3. Are families in the demonstration group more likely to visit (unsupervised and supervised) their children in foster care? No. There are no differences between the demonstration and

control groups with regard to the likelihood or frequency of supervised or unsupervised visits.

4. Are there any specific substance abuse services related to family reunification for cases involving SEI? To answer this question, a study was conducted using a sample of 210 female caretakers in Demonstration Group and their children. The analysis results indicate that, female caretakers receiving residential treatment in combination with transitional treatments (e.g. outpatient, recovery homes) are more likely to achieve treatment progress. And consequentially, the better chance of achieving treatment progress leads to higher family reunification rates.

5. Are second generation families (i.e., the current caretakers who were child welfare cases when they were children) less likely to achieve reunification? To answer this question, a study was conducted using a sample of 1,033 caretakers in Demonstration Group and their 1,917 children. Among the caretakers, 87 (8%) are second generation cases, and the remaining 946 (92%) cases are first generation. We follow the families for three years subsequent to their JCAP assessment date. The second generation families are 67% less likely to achieve family reunification as compared with the first generation families. The second generation families also experience significantly higher rates of maltreatment subsequent to JCAP (Second Generation 35% vs. First Generation 15%). Second generations also report a wider range of co-occurring problems (e.g. mental health problems, domestic violence) at the time of random assignment.

6. Does the recovery coach model achieve similar results (with regard to reunification) when comparing across primary drugs of choice? When selecting the three most common substance of choice (alcohol, cocaine, and opioids), caretakers from the demonstration group had higher rates of reunification in families where the primary substance was opioids and mixed substances (i.e. two parents reporting different primary drugs). The reunification rates were not statistically different when comparing the effects of the recovery coach model for alcohol and cocaine users.

Question Related to Cost Neutrality:

1. The waiver demonstration cost neutral? The AODA waiver demonstration saved $6,996,904 as of June 2009. Thus, the waiver remains cost neutral – more precisely – generating savings that the State can then reinvest in other child welfare services. These costs savings include the additional costs of the expansion to St. Clair and Madison Counties.

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. The evidence indicates that parents assigned to the recovery coach group were significantly more likely to achieve family reunification as compared to parents assigned to the control group. There were no differences with regard to subsequent reports of maltreatment –

indicating that families are not being reunified too quickly. Moreover, children in the recovery coach group spent significantly fewer days in foster care as compared with children in the control group. Finally, the Illinois AODA waiver demonstration saved the State almost 7 million dollars through June 30, 2009.

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 December 2008. In general, the data presented in this report run through December 31, 2008. However, the chapter on process indicators runs from April 1, 2009 through June 30, 2009; providing the reader with the most recent estimates. 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.

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 180 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 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).

Implementation Status

Of families ever assigned between April 2000 and December 31, 2008 to the AODA demonstration in the Cook County, 686 parents of 949 children were assigned to the control group and 1,720 parents of 2,249 children were assigned to the demonstration (experimental) group.

The AODA demonstration project utilizes the existing DASA/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 December 31, 2008, JCAP (Juvenile Court Assessment Project) has provided 7,392 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, 1,720 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:

$$\begin{array}{llllll} R_{t1} & & O_1 & & & O_3 \\ R_{t1} & A & O_2 & R_{t2} & & O_4 \\ & & & R_{t2} & B & O_5 \end{array}$$

where $\mathbf{R_{t1}}$ represents agencies that have been randomly assigned at time 1 to either the control or experimental group; **A** represents the intervention of the "Recovery Coach"; $\mathbf{O_1}$ is the first measurement of the control group, $\mathbf{O_2}$ is the first measurement of the experimental group (a posttest because it occurs after the intervention); $\mathbf{Rt_2}$ represents the experimental agencies that have been randomly assigned at time 2 to either Demo A or Demo B groups; **B** represents the additional intervention of enhanced services (which is currently being conceptualized); **O3** represents the second measurement of the control group; $\mathbf{O_4}$ represents the second measurement of Demo A group; and $\mathbf{O_5}$ 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 DASA (Division 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	Clients Characteristics	Assessment	Treatment	Permanency	Outcomes
AODA Integrated Database	X	X	X				
JCAP Data	X	X	X	X			
TRACCS	X	X	X		X		
TASC		X	X		X		
DASA/ DARTS	X	X			X		

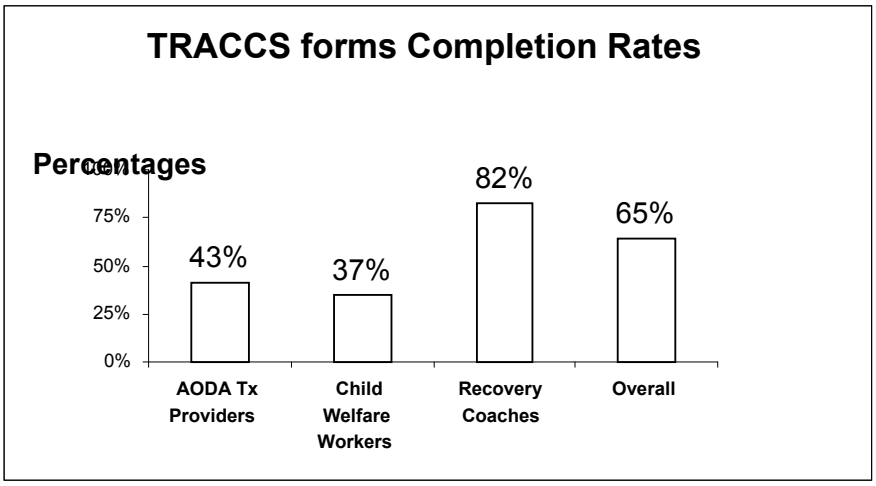
NOTE: the TRACCS forms are sent to and completed by the caseworkers, the recovery coaches and the treatment (AOD) providers.

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 filled out by three types of service providers, including drug treatment providers, recovery coaches, and case workers. The chart below indicates the expected number of forms and the percentage of forms returned from the AODA treatment provider, the child welfare worker (CW), and the Recovery Coach (RC) for Fiscal Year 2008 in Cook County. The chart below reflects forms that were sent out and returned from July 1, 2007 through June 30, 2009.

AODA	Expected	Received	Pct.		CW	Expected	Received	Pct.		RC	Expected	Received	Pct.
Totals	631	272	43%		Totals	3,873	1,447	37%		Totals	5,894	4843	82%



The DASA—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 Division of Alcoholism and Substance Abuse (DASA). The child welfare data are taken from the DCFS integrated database. This database tracks child abuse and neglect investigations and child welfare service information (e.g., substitute care placement records). The 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 December 31, 2008, approximately 21% 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 AODA demonstration project utilizes the existing DASA/DCFS Initiative treatment services as the foundation for enhanced services. Since the implementation of the AODA waiver, an on-site AODA assessment project, JCAP (Juvenile Court Assessment Project) 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 a same day treatment referral. Court personnel and caseworkers receive feedback regarding the results of the assessment within one day of the referral. A more in depth narrative report is submitted to the court prior to the parent's next court date.

In Cook County, from the onset of the project through June 30, 2009, JCAP has provided 2,597 assessments to DCFS involved family members enrolled in the IV-E AODA project. With increased awareness of the project, caseworkers and court personnel are referring clients to JCAP earlier in the case and meeting the 180-day eligibility time requirement of the project. Of those eligible for the project, 730 (28%) parents have been assigned to the Control Group and 1,867 (72%) parents have been assigned into the Demonstration group.

In St. Clair and Madison Counties, from July 15, 2007 through June 30, 2009, TASC Court Assessment Project (TCAP) has provided 101 assessments to involved family members in the IV-E AODA project. With increased awareness of the project, caseworkers and court personnel are referring clients to TCAP. Of those eligible for the project, 25 (25%) parents have been assigned to the Control Group and 76 (75%) parents have been assigned into the Demonstration group.

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.

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.

In Cook County, cases are randomly assigned to the Demonstration group and are referred to the Recovery Coaches after the parent has met eligibility requirements for the project and the Juvenile Court Assessment Program (JCAP) has completed the AODA assessment. A Recovery Coach liaison meets with the parent, JCAP assessor, and child welfare worker at the conclusion of the assessment to discuss referral arrangements and initial service planning. The Recovery Coach

liaison is stationed each day at the JCAP office in Juvenile Court to expedite initial engagement with parents.

In St. Clair and Madison Counties, cases are randomly assigned to the Demonstration group and are referred to the Recovery Coaches after the parent has met eligibility requirements for the project and the TASC Court Assessment Program (TCAP) has completed the AODA assessment.

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

Trainings with Private Agency Personnel: Throughout previous reporting periods, project staff continued conducting individual training sessions with private agency placement teams contracted to serve DCFS involved families. These trainings provided specific information regarding the IV-E AODA project design. In addition to increasing awareness regarding the project and exploring better ways to collaborate, these trainings have also covered proper completion of the data collection tool (TRACCS Form), as well as the process involved in obtaining signed research consents from parents in the study. These trainings have proven to be beneficial in improving awareness regarding the project and increasing the collaborative efforts between the child welfare worker and Recovery Coach. Beginning in March 2007 meetings were held with Private Agency staff to update them on the project, and five-year extension as well as share outcome related data from the previous 5 years. Trainings have continued throughout the fall and winter of 2007. Specifically, in November 2007, a workshop was conducted in conjunction with staff from the DCFS Inspector General's office to all child welfare staff in both St. Clair and Madison Counties to discuss the impact of alcohol and other drugs and to discuss how the IV-E AODA waiver will be utilized in these counties. At the end of January 2008, project staff conducted follow-up outreach meetings and focus groups to private agency personnel to increase referrals to the project and to evaluate program implementation. Project staff continues to provide training to the child welfare agencies in all three counties upon request as staff turnover occurs.

Trainings with DCFS Personnel: Project staff has provided trainings with the DCFS placement teams carrying 10% of the remaining cases involved with the Department. Beginning in March 2007 meetings were held with DCFS staff to update them on the project and five-year extension, as

well as share outcome related data from the previous 5 years. All DCFS workers in St. Clair and Madison Counties were required to attend the November trainings to orient them to the IV-E AODA waiver in these counties. Throughout this current reporting period, project staff has conducted outreach meetings to DCFS personnel, both investigators and follow-up workers to increase referrals to the project. At the end of January 2008, and February 2009, project staff conducted follow-up outreach meetings and focus groups to increase referrals to the project and to evaluate program implementation.

Trainings with DASA/DCFS Initiative Treatment providers: Throughout this reporting period and previous reporting periods, project staff conducted individual training sessions with many of the treatment providers contracted through the DASA/DCFS Initiative. Much like the trainings with the child welfare agencies, these trainings provided specific information regarding the IV-E AODA project design such as: eligibility requirements and random assignment; specific project features; projected goals and outcomes, along with clarifying roles and responsibilities of child welfare caseworkers, Recovery Coaches and treatment counselors.

Trainings with all treatment providers in St. Clair and Madison Counties took place in April 2008 and February 2009 and will continue to take place on an individual basis throughout this fiscal year. Meetings are being scheduled with DASA treatment providers in Cook County to update them on the project and five-year extension, as well as share outcome related data from the previous 5 years.

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.

As of August 1, 2008 and continuing on for the current fiscal year, many of the treatment providers experienced budget cuts from their DASA funding stream. Consequently, this has caused some of the ancillary treatment services and programs to be cut that had been available to DCFS parents. The reality of these cuts have made it more challenging for parents to access treatment programs, and has made the availability of Recovery Coach services more imperative.

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.

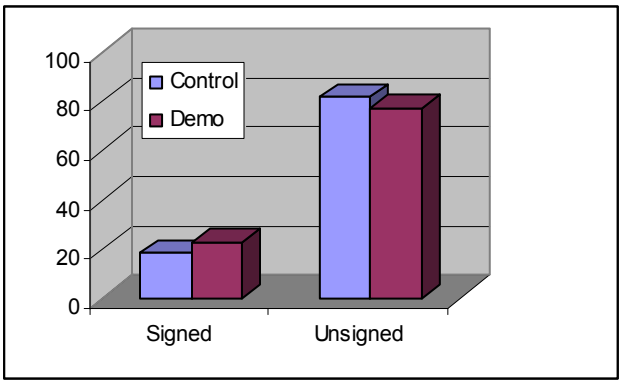
Although the Recovery Coach may present reports to the court regarding treatment progress, the waiver demonstration staff do not have any direct input into the legal process. Waiver demonstration staff are however in contact with the General Counsel of DCFS regarding any court issues which may arise.

Implementation Concerns:

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

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). As of December 2008 the overall consent signed rate was 21%.

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.



3: Population and Characteristics

Caretakers:

As of December 31, 2008, 2,406 parents and 3,198 children are enrolled in the project. Of the 2,406 parents, 1,720 (71%) have been randomly assigned to the demonstration group and 686 (29%) have been assigned to the control group.

Cumulative Totals as of December 31, 2008:

	Control Group	**Demo Group**	**Total**
Parents	686	1,720	2,406
Families	531	1,319	1,850
Children	949	2,249	3,198

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**	**Control**	
	(N=1,720)	(N=686)	
Age	33 yrs.	33 yrs.	
Gender:	66%	66%	Female
Ethnicity:	76 %	80%	African American
	7%	6%	Hispanic
Marital Status:	10%	9%	Married
Shelter:	6%	7%	Homeless
Employment Status:	79%	77%	Not working
Education:	53%	52%	< High School
Primary Substance:	34%	33%	Cocaine
	23%	25%	Opioids
	22%	21%	Alcohol

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

Variables	**Demonstration**	**Control**	
	(N=1,127)	(N=456)	
Age	32 yrs.	31 yrs.	
N of assigned children	2	2	
Ethnicity:	77%	80%	African American
	6%	6%	Hispanic
Marital Status:	9%	9%	Married
Shelter:	7%	9%	Homeless
Employment Status:	86%	89%	Not working
Education:	57%	54%	< High School
Primary Substance:	42%	42%	Cocaine
	26%	28%	Opioids
	15%	13%	Alcohol

The majority of caretakers are female:

Gender	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Female	456	1,127	66.5	65.5
Male	230	593	33.5	34.5

The following tables provide information with respect to employment, education, marital status, race, and living arrangement of the caretakers as of December 31, 2008.

Race	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Asian/Pacific Islander	3	4	0.4	0.2
Black	550	1,312	80.2	76.3
Hispanic: Mexican	22	68	3.2	4.0
Hispanic: Puerto Rican	21	56	3.1	3.3
Hispanic: Cuban	1	2	0.1	0.1
Other race	10	29	1.5	1.6
White	79	249	11.5	14.5

Employment	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Employed	3	8	0.4	0.5
Full Time	62	171	9.0	9.9
Not in Labor Force	41	103	6.0	6.0
Part Time	33	114	4.8	6.6
Seasonal Worker	2	15	0.3	0.9
Unemployed	499	1,215	72.7	70.6
Unknown	46	94	6.7	5.5

Education	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Less than high school	360	891	52.5	51.8
High school or GED	246	641	35.9	37.3
Some college/vocational	28	74	4.1	4.3
Graduated college/Vocational/trade school	3	12	0.4	0.7
Missing Data	49	102	7.1	5.9

Marital Status	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Divorced	45	118	6.6	6.9
Married	63	173	9.2	10.1
Never married	523	1,293	76.2	75.2
Separated	44	113	6.4	6.6
Widowed	8	19	1.2	1.1
Unknown	3	4	0.4	0.2

Living Arrangement	N=686	N=1,720	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Alone	105	286	15.3	16.6
Family	392	975	57.1	56.7
Friends	102	264	14.9	15.3
Homeless	47	98	6.9	5.7
Other	19	51	2.8	3.0
Institution	19	46	2.8	2.7
Unknown	2	0	0.3	0.0

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.

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	7	5
Neglect	13	18
Sexual Abuse	10	10
Risk of Harm	27	25
Substance Related	30	31
Inadequate Supervision	13	11

Primary drug of choice: N=2,406

Caretakers are asked to identify their primary drug of choice. Cocaine is the most common drug of choice (33.7%), followed by opioids (23.6%) and alcohol (21.6%). There is no significant difference on the primary drug of choice between demonstration group and control group.

	Control	Demo	Total
ALCOHOL	141	379	520
	20.6%	22.0%	21.6%
COCAINE	229	582	811
	33.4%	33.8%	33.7%
MARIJUANA	133	329	462
	19.4%	19.1%	19.2%
OPIOIDS	168	400	568
	24.5%	23.3%	23.6%
PCP	6	11	17
	0.9%	0.6%	0.7%
OTHER	4	10	14
	0.6%	0.6%	0.6%
No Response	5	9	14
	0.7%	0.5%	0.6%
Total	686	1,720	2,406
	100%	100%	100%

Of cocaine users (i.e. those who said that their primary drug was cocaine), 65.2% responded that they used cocaine at least several times per week:

Cocaine Use Frequency	N=811	Control	Demo	Total
NO USE	Count	14	43	57
	%	6.1	7.4	7.0
LESS THAN ONCE A WEEK	Count	58	140	198
	%	25.3	24.1	24.4
SEVERAL TIMES PER WEEK	Count	77	192	269
	%	33.6	33.0	33.2
ONCE A DAY	Count	7	24	31
	%	3.1	4.1	3.8
2-3 TIMES A DAY	Count	23	94	117
	%	10.0	16.2	14.4
MORE THAN 3 TIMES PER DAY	Count	6	15	21
	%	2.6	2.6	2.6
UNKNOWN	Count	2	4	6
	%	0.9	0.7	0.7
No Response	Count	7	15	22
	%	3.1	2.6	2.7
TOTALS	Count	229	582	811
	%	100%	100%	100%

Regarding the start age of cocaine use, around 40 percent said that they started to use cocaine between the ages of 22 to 29; the next largest group (32.7%) started using between the ages of 17-21:

Age at first use		Control	Demo	Total
< 12	Count	2	5	7
	%	0.9	0.9	0.9
13-16	Count	26	44	70
	%	11.4	7.6	8.6
17-21	Count	67	198	265
	%	29.3	34.0	32.7
22-29	Count	98	222	320
	%	42.8	38.1	39.5
30>	Count	25	91	116
	%	10.9	15.6	14.3
No Response	Count	11	22	33
	%	4.8	3.8	4.1
Total	Count	229	582	811
	%	100%	100%	100%

The majority of caretakers (JCAP data respondents N=1,398, 58.1%) have participated in previous treatment for substance abuse:

		GROUP		Total
		Control	Demo	
Previous Treatment for Substance Abuse Problems	No Response	6	22	28
		0.9%	1.3%	1.2%
	No	285	695	980
		41.5%	40.4%	40.7%
	Yes	395	1,003	1,398
		57.6%	58.3%	58.1%
Total		686	1,720	2,406
		100%	100%	100%

12.2% of caretakers in the control group, and 10.8% in the demonstration group, said that they had had thoughts of suicide.

Income levels: 91.0% of the control group and 86.6% of the demonstration group had annual incomes of $0 - $7,400 per year.

Other issues pertaining to caretakers:

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:

	Control %	Demo %
% of clients with mental health issues	43.4	40.9
% of clients who have made at least substantial progress regarding mental health	10.4	10.6
% of clients with housing issues	52.2	50.3
% of clients who have made at least substantial progress regarding housing	11.8	11.6
% of clients with domestic violence issues	30.5	30.9
% of clients who have made at least substantial progress regarding domestic violence issues	8.7	7.7
% of clients with parental skills deficits	66.3	63.1
% of clients who have made at least substantial progress regarding parenting skill issues	25.2	21.8
% of clients needing child care services	17.6	30.0
% of clients who have made unsatisfactory progress regarding substance abuse issues	67.2	74.5

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**	**Control**	
	(N=2,249)	(N=949)	
Age at TC Hearing	3.6 yrs.	3.5 yrs.	
	51%	51%	Removed as infant
Gender:	46%	47%	Female
Ethnicity:	76%	80%	African American
	8%	7%	Hispanic
Allegation:	7%	7%	Abuse
	20%	21%	Substance exposed
	32%	29%	Neglect
	31%	32%	Risk of harm
	10%	11%	No allegation
First Placement	27%	28%	Hospital/Shelter
	35%	27%	Kinship Home

Race	N=949	N=2,249	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
African American	758	1,704	79.9	75.8
Hispanic	68	174	7.2	7.7
Other	14	42	1.5	1.9
Unknown	0	0	0.0	0.0
White	109	329	11.5	14.6

Sex	N=949	N=2,249	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Female	445	1,041	46.9	46.3
Male	504	1,208	53.1	53.7

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 9.3% of the children in the control group and 8.9% 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 %	Demo %
1	42.8%	48.9%
2	36.1%	31.3%
3	9.8%	8.8%
> 3	11.3%	11%

Placement Types

The major placement type for children in both groups as of December 31, 2008 is in the home of a relative (19.7% control group and 21.5% in the demonstration group); the second major placement type is in a private agency foster home (13.1% control group and 13.5% in the demonstration group):

Placement Types		Control	Demo	TOTAL
Foster Home Adoption	Count	16	23	39
	%	1.7	1.0	1.2
Foster Home Boarding	Count	14	33	47
	%	1.5	1.5	1.5
Foster Home Private Agency	Count	124	303	427
	%	13.1	13.5	13.4
Foster Home Specialized	Count	111	178	289
	%	11.7	7.9	9.0
Group Home	Count	3	8	11
	%	0.3	0.4	0.3
Home Adoptive Parent	Count	238	554	792
	%	25.1	24.6	24.8
Home of Parent	Count	192	533	725
	%	20.2	23.7	22.7
Hospital/Health Facility	Count	3	11	14
	%	0.3	0.5	0.4
Home of Relative	Count	187	484	671
	%	19.7	21.5	21.0
Independent Living	Count	23	54	77
	%	2.4	2.4	2.4
Institution Private	Count	14	25	39
	%	1.5	1.1	1.2
Runaway	Count	0	0	0
	%	0.0	0.0	0.0
Subsidized Guardianship	Count	4	0	4

	%	0.4	0.0	0.1
Other Placements	Count	20	43	63
	%	2.1	1.9	2.0
TOTALS	Count	949	2,249	3,198
	%	100	100	100

4: Process Indicators

The Recovery Coach Program employs a proactive case management strategy that emphasizes outreach to engage and retain parents in treatment and other services needed for recovery. The goal of the program is to engage parents into program services at the beginning of their DCFS cases, allowing sufficient time for them to engage in treatment services. The desired outcomes for the program are: 1) to place substance-abusing parents into treatment for a sustainable about of time to increase their chances of recovery, 2) to aid them in their reunification with one or more children, or 3) when it is not possible or advisable for parents to reunify with their children, RCP attempts to close these cases quickly in order to expedite the permanent placement of children.

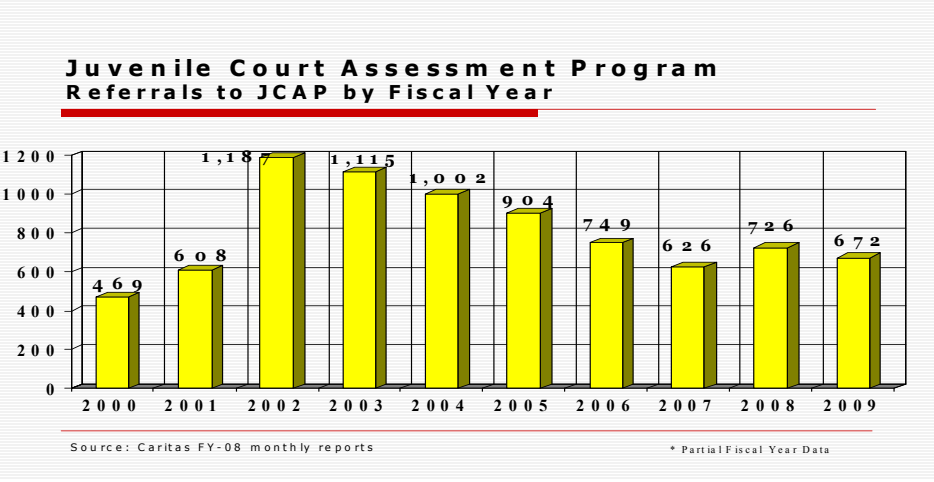
For purposes of this report we provide a quarterly update of Recovery Coach Program activities that occurred between April 1, 2009 and June 30, 2009. The report is divided into two sections. The first section provides an overview of the number of new referrals received during this reporting period, and the status of open client cases as of June 30, 2009. The section concluded with a brief summary of program completion rates for cases terminated during the reporting period. The second section provides a six month treatment provider profile update, including length of time from treatment referral to intake and admission and treatment completion rates. This report presents the most recent and accurate data available from TASC's Client Tracking and Management Information Systems.

Referrals and Assessment

Referral

In Cook County, DCFS refers parents to the Juvenile Court Assessment Program (JCAP) at the time of their temporary custody hearing or at any time within 180 days of that hearing. JCAP staff is responsible for conducting the AODA clinical assessment, if found eligible, parents are then randomly assigned to the control or demonstration group. Parents that are randomly assigned to the demonstration group are referred to TASC for RCP services. During this quarter 41 parents were referred to Cook County RCP Services. All 41 parents were engaged into services on the same day of their referral to the program.

The following graphs and chart refer to Cook County – JCAP Subjects only.



JCAP Referrals for AODA Assessments – April 2000 – June 2009

	Referrals to JCAP	TX Indicated	% of TX Indicated	IV-E Eligible	% IV-E Eligible
	469	182	39%	20	11%
FY01	608	433	71%	225	52%
FY02	1187	832	70%	402	48%
FY03	1115	684	61%	373	55%
FY04	1003	542	54%	300	55%
FY05	904	571	63%	297	52%
FY 06	749	524	70%	227	43%
FY 07	626	440	70%	193	44%
FY 08	726	484	67%	284	59%
FY 09	**672**	**461**	**68%**	239	52%

In St. Clair and Madison Counties parents are referred to TASC at the time of their temporary custody hearing or at any time within 180 days of the hearing. TASC staff is responsible for conducting the AODA clinical assessment, if found eligible, the parents are randomly assigned using a computerized system at the time of the assessment to determine assignment into the control or demonstration group. During this quarter TASC received 19 DCFS referrals for AODA clinical assessments in St. Clair county and 16 DCFS referrals for AODA clinical assessments in Madison County.

Total Referrals from July 15, 2007 – June 30, 2009

Fiscal Year 2008-09	St. Clair	Madison	Total
Referred to TCAP			
Eligible for IV-E	**49**	**52**	**101**
Not Eligible for IV-E	2	5	7
No substance Abuse	6	14	20
TOTAL REFFERED	**57**	**71**	**128**
IV – E Eligible	**St. Clair**	**Madison**	**Total**
Control	15	9	24
Demo with Recovery Coaches	34	43	77
TOTAL	**49**	**52**	**101**

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

Total Referrals to JCAP:

Referral from Type of Hearing	FY 2005	FY 2006	FY 2007	FY 2008 (1st & 2nd Qtr)	Cumulative Total
Temporary Custody Hearing	298	177	205	387	1,067
Court Family Conference	142	115	58	163	478
Dispositional Hearing	42	38	25	31	136
Status Progress Hearing	226	236	168	254	884
Permanency Planning Hearing	117	123	117	181	538
Trial	57	35	24	29	145
Return Home	2	2	1	1	6
Other	23	24	28	49	124
Unknown	0	0	0	0	0
Total JCAP Referrals	907	750	626	1,095	3,378

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				
Referrals to Treatment	FY 2005	FY 2006	FY 2007	FY 2008
Successful Treatment Placements	433	384	324	539
Referrals place on waiting list	34	18	16	14
Referred and refused treatment	30	43	30	63
Pending medical or Psychiatric clearance	19	32	18	37
Client Incarcerated	25	33	28	39
Other	6	14	24	47
Client Not Referred to Treatment	360	225	186	356
Total JCAP Referrals	907	749	626	1,095

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

Assessment

Staff in St. Clair County completed 16 AODA assessments during this quarter (see table bellow). Of these, 12 parents were found acceptable for services (three parents were randomly assigned to the control group, and nine parents were assigned to the demonstration group), four parents were

found ineligible for services. Four parents in St. Clair County are still pending completion of their AODA assessment by TASC. All parents that were randomly assigned to the demonstration group in St. Clair County were engaged into RCP services on the same day of their AODA assessment. Staff in Madison County completed 15 AODA assessments during this quarter. Of these, 13 parents were found acceptable for services (six parents were randomly assigned to the control group, and seven parents were assigned to the demonstration group). Two parents were referred by DCFS for a "clinical assessment only". Four parents in Madison County are still pending completion of their AODA assessment by TASC. All parents that were randomly assigned to the demonstration group in Madison County were engaged into RCP services on the same day of their AODA assessment.

Assessment Status By County as of June 30, 2009

County	Pending Assessment	Assessment only	Ineligible	Assigned to Control Group	Assigned to Demo Group	Avg. # of Days to Assessment
St. Clair	4 20%	0 --	4 20%	3 15%	9 45%	18 days
Madison	4 21%	2 10%	0 --	6 32%	7 37%	18 days

Treatment Status, Length of Time in Treatment, Visitation, and Recovery Support Services

Treatment Status

At the close of this quarter, the RCP active caseload included 355 IV-E cases. The following section describes the treatment status of all open clients as of June 30, 2009. Table 2 provides a breakdown of treatment status for all clients by county.

Of the 355 active RCP parents in Cook County, nearly 35% had completed all treatment requirements, 25% were currently in treatment, and 20% were pending reengagement into treatment. At the close of this quarter, 70 parents in Cook County were still pending initial engagement into treatment, of these approximately half have been with the Recovery Coach Program for over six months. RCP staff continue to conduct extensive outreach with these clients to encourage their participation in treatment, however some of these cases will be reviewed during the next quarter to determine if TASC should discontinue services due to lack of response to outreach or non-compliance.

At the end of this reporting period St. Clair County had 28 open cases. Of these, 14% of the active parents had completed all treatment requirements, 32% were currently in treatment, and 32% were pending reengagement into treatment. At the close of this quarter, St. Clair County had six parents pending initial engagement into treatment, of these two parents have been with the RCP for over six months. These two cases will be reviewed to determine if TASC should discontinue services.

Of the 26 open clients in Madison County, 46% of the parents were currently in treatment and 27% were pending reengagement into treatment. Seven clients in Madison County are pending initial engagement into treatment; however all of these parents have been with RCP for less than 90 days. RCP staff will continue to conduct extensive outreach with these clients to encourage their participation in treatment as soon as possible.

Open Clients Treatment Status by County as of June 2009

Area	Open Clients	Pending Initial TX	Pending Re-engagement	Currently In TX	Completed All TX
Cook	355	70 20%	71 20%	91 25%	123 35%
St. Clair	28	6 22%	9 32%	9 32%	4 14%
Madison	26	7 27%	7 27%	12 46%	0 --

Length of Stay in Treatment

As of June 30, 2009, 80% of the active parents in Cook County have been placed into treatment at least one time since entering the program. The median length of stay in treatment for these parents was 174 days. Seventy-nine percent of the active parents in St. Clair and 73% of the active parents in Madison County have been placed into treatment at least one time since entering the program. The median length of stay in treatment for parents that have participated in substance abuse treatment in Madison and St. Clair counties was 126 days. The table below provides a breakdown of the length of stay for clients by service area.

Length of Time in Substance Abuse Treatment by County as of June 2009

Area	Open Clients	No TX days	≤ 90 days	91-180 days	181-365 days	366+ days
Cook	355	70 20%	81 23%	65 18%	73 20%	66 19%
St. Clair	28	6 22%	9 32%	5 18%	4 14%	4 14%
Madison	26	7 27%	6 23%	6 23%	2 8%	5 19%

Visitation Status

Analysis of visitation status data for the 409 active RCP parents indicated that a majority of the parents continue to have supervised visitation status with their children (see table below).

Clients DCFS Visitation Status by County as of June 2009

Service Area	VISITATION STATUS						
	Reunified w/ 1 or more child	Supervised visits	Unsupervised visits	Parent declining visits	Agency Interference	Parent Incarcerated	Whereabouts unknown
Cook	24	255	49	24	0	1	2
N=355	6.8%	71.8%	13.8%	6.8%	--	.3%	.6%
St. Clair	0	25	0	0	1	0	1
N=28	--	89.3%	--	--	3.8%	--	3.8%
Madison	0	22	2	0	1	0	2
N=26	--	84.6%	7.7%	--	3.6%	--	7.1%

Recovery Support Services

The table below provides a summary of mental health and domestic violence services that were delivered to clients in Cook, St. Clair and Madison Counties between April 1, 2009 and June 30, 2009.

Recovery Support Services by County

Mental Health Services Referral	Completed Service	Receiving Service	Pending Re-engagement	Pending Initial Service
Cook	32	38	15	9
St Clair	--	2	1	--
Madison	--	5	1	1
Domestic Violence Services Referral	**Completed Service**	**Receiving Service**	**Pending Re-engagement**	**Pending initial Service**
Cook	28	7	8	6
St Clair	--	--	--	1
Madison	--	2	--	--

Housing Referrals

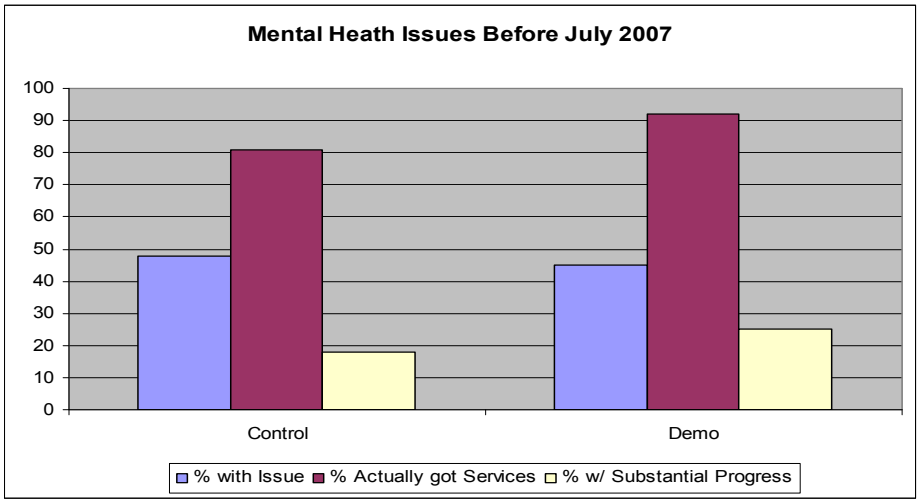
All three RCP service areas are currently providing all parents who are in need of housing assistance with referrals to the DCFS housing advocacy. Currently all RCP clients are reviewed by the RCP staff for current housing needs and if the client is found to be in need of housing services, the client is referred. There were no referred to DCFS's housing assistance program during this reporting period.

Process Indicators since July 2007 (date of expanded waiver demonstration)

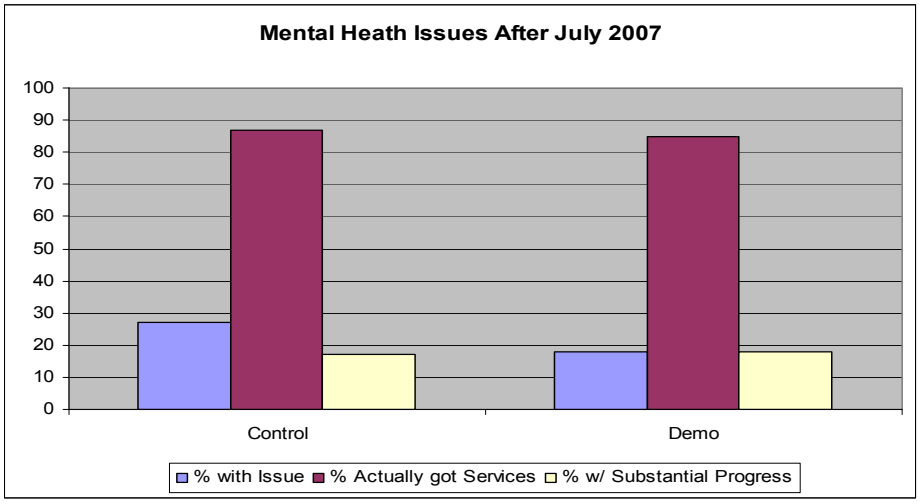
The AODA Waiver expanded in July 2007. The objective of the expanded waiver was to provide target services in three specific areas: mental health, domestic violence, and housing. We report on how activities and progress look both before and after the waiver expansion date.

In terms of mental health issues, the demonstration group before the expanded waiver demonstration (July 2007) had a lower percentage of caretakers with mental health issues than the control group (i.e., 45% vs. 48%). After July 2007, the demonstration group still had lower percentage of caretakers with mental health issues than the control group (i.e., 18% vs. 27%). Before July 2007, a higher percentage of clients with mental health issues in the demonstration group actually got services compared to the control group (i.e., 92% vs. 81%). After July 2007, the percentage difference in terms of services actually received actually became closer (i.e., 87% for the demonstration and 85% for the control group). Before, the expanded waiver, the demonstration group had a higher percentage in terms of individuals making al least substantial progress (i.e., 25% vs. 18%) in mental health treatment. After, the percentage difference became closer (i.e., 18% for the demonstration and 17% for the control group).

Before July 2007:

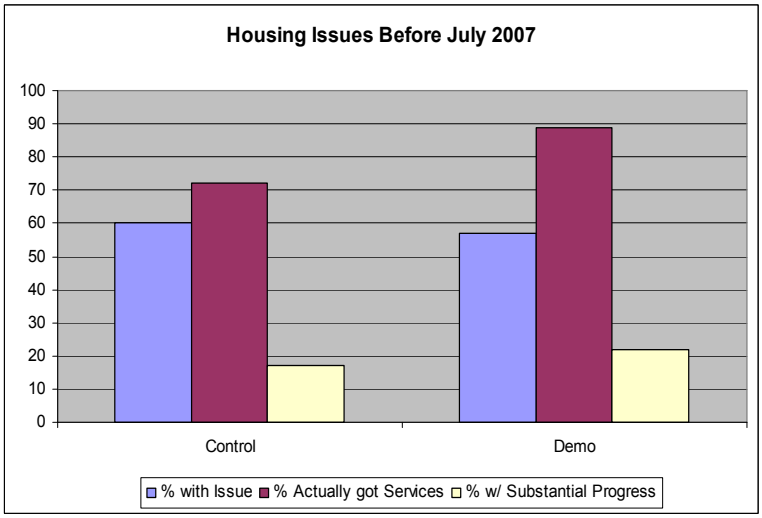


After July 2007:

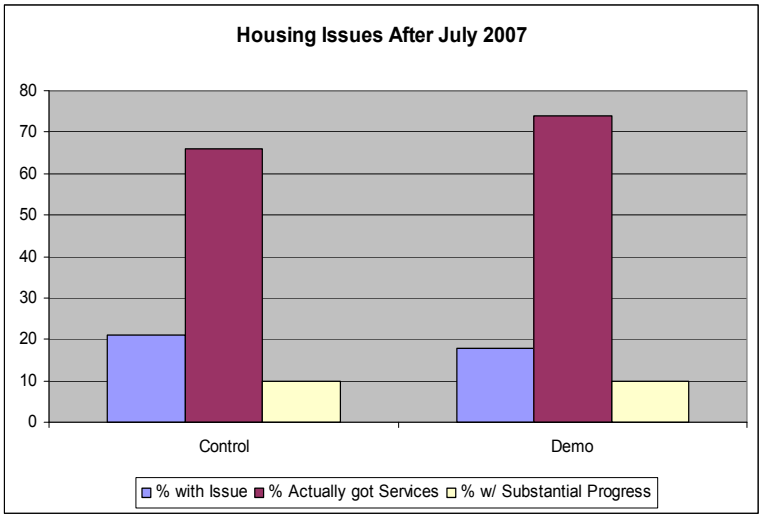


In terms of housing issues, the demonstration group before the expanded waiver demonstration had a lower percentage of caretakers with housing issues than the control group (i.e., 57% vs. 60%). After July 2007, the demonstration group still had lower percentage of caretakers with housing issues than the control group (i.e., 18% vs. 21%). Before July 2007, a higher percentage of clients with housing issues in the demonstration group actually got services compared to the control group (i.e., 89% vs. 72%). After July 2007, still a higher percentage of clients with housing issues in the demonstration group actually got services compared to the control group (i.e., 74% vs. 66%). Before, the expanded waiver, the demonstration group had a higher percentage in terms of individuals making al least substantial progress (i.e., 22% vs. 17%) in mental health treatment. After, both groups had the same percentage (i.e., 10%).

Before July 2007:

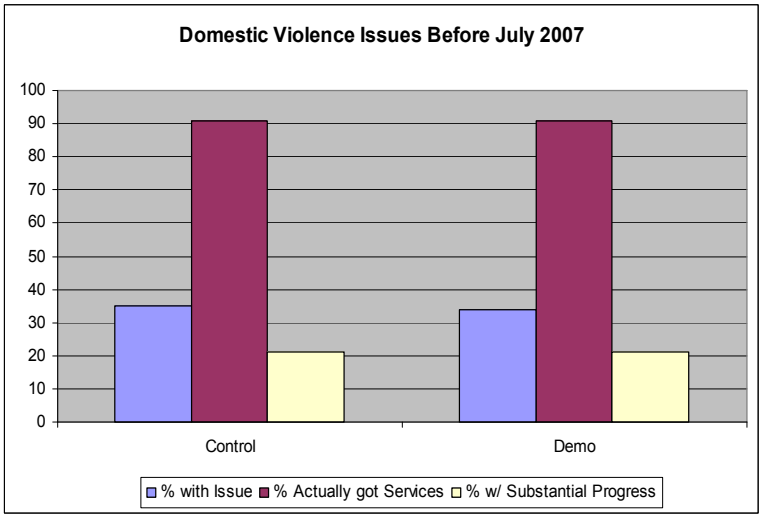


After July 2007:

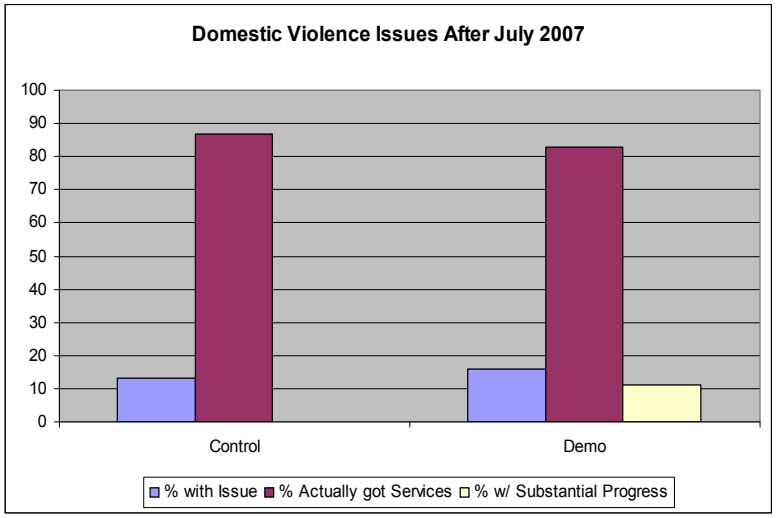


In terms of domestic violence issues, the demonstration group before the expanded waiver demonstration had a slightly lower percentage of caretakers with domestic violence issues than the control group (i.e., 34% vs. 35%). After July 2007, the demonstration group still had higher percentage of caretakers with domestic violence issues than the control group (i.e., 16% vs. 13%). Before July 2007, both groups had the same percentage of clients with domestic violence issues that actually got services (i.e., 91%). After July 2007, a higher percentage of clients with domestic violence issues in the demonstration group actually got services compared to the control group (i.e., 87% vs. 83%). Before, the expanded waiver, both groups had the same percentage in terms of individuals making al least substantial progress (i.e., 21%). After, the difference percentage wise became very noticeable (i.e., 11% vs. 0%).

Before July 2007:



After July 2007:



TASC Closing Status and Permanency Outcomes

Between April 1, 2009 and June 30, 2009, RCP closed 31 cases. The following section describes the closing status for cases that were closed during this timeframe.

During this quarter Cook County RCP closed a total of 24 cases, of these, four cases ended in reunification, two cases ended with subsidized guardianship, and five cases ended in parental rights being terminated. Ten cases in Cook County were closed and discontinued services pre-permanency because TASC RCP was unable to engage client despite outreach attempts, two parents were closed due to incarceration, and one client was terminated from services with a neutral outcome.

During the same timeframe St. Clair County RCP closed four cases, one case ended in reunification, and three cases were closed and discontinued services pre-permanency because staff were was unable to engage client despite outreach attempts. Madison County RCP closed two cases that ended in parental rights being terminated and one case was closed and discontinued services pre-permanency because staff were was unable to engage client despite outreach attempts.

Closing Status for RCP Cases Closed Between April and June 2009

Status of Case at Closing (N=31)	Cook (N=24)	St. Clair (N=4)	Madison (N=3)
Successful Discharge from RCP			
• Reunified with one or more child	4	1	--
Unsuccessful Discharge - Expedited Placements of child			
• Subsidized Guardianship	2	--	--
• Goal changed-termination of parental rights	5	--	2
Unsuccessful Discharge – Pre-permanency			
• Unable to engage client despite outreach attempts	10	3	1
• Parent incarcerated	2	--	--
Neutral – clients moved out of state	1	--	--

Although some clients are unsuccessful discharged from program services, RCP has been able to close these cases quickly in order to expedite the permanent placement of children in subsidized guardianship homes (within 710 days compared to 968 days to case closing in the control group).

According to the 1998 GAO study, cases where children were placed in foster care due to substance abuse by their parents closed, on average, in 56 months. TASC, however, has been successful in expediting case closings, regardless of outcomes (i.e. cases closed by reunification or to expedite the permanent placement of children) in much less time. For example, the program was able to close 55 percent of the cases within two years compared to the control groups closing only 48 percent of its cases within 2 years. The following table shows a comparison between the length of time to case closing between the control and demonstration groups.

Length of Time for Case Closing for Control and RC Groups

Length of Time to Case Closing April 2000 to March 2008	Control Group		RC Demo	
	Number	Percent	Number	Percent
Case closed within 1 year	33	9%	123	13%
Case closed within 2 years	147	39%	403	42%
Case closed within 3 years	77	20%	196	20%
Case closed within 4 years	60	16%	136	14%
Case closed within 5 years	27	7%	42	4%
Total cases closed	**380**	**100%**	**961**	**100%**

The program has also been discontinuing services to clients when their goals are changed to termination of parental rights or when parents surrender their parental rights. A DCFS case may continue in the court system for some time to achieve a final permanency arrangement for the child. Additionally, there are cases in which TASC can document early in the case that the parent is unwilling to comply, yet the court case often times continues for many months. The system could benefit from expedited decision making in these cases. DCFS staff continues to review cases in which TASC discontinued services some time ago due to a parents' non-compliance yet the case is still open in the system. This review may reveal some of the reasons cases linger in the system.

Treatment Provider Profile

While the Recovery Coaches are responsible for engaging clients in treatment, the substance abuse treatment community is our partner in retaining clients in treatment and having them complete treatment to facilitate the parents' recovery. The TASC-Recovery Coach program uses a large number of providers to serve clients, including more than 40 treatment providers that participate in the DASA/DCFS Initiative who provide over 70 different treatment programs. The efficiency and effectiveness of treatment providers serving this population are assessed along the following criterion that is consistent with providers DASA/DCFS Initiative contracts and included:

- **Length of time from treatment referral to intake appointment:** how quickly clients, who were referred by TASC, are seen by treatment facilities for intake assessment. The benchmark is within two days for IV-E Initiative providers.

- **Treatment referral outcome:** Outcome of referral for Recovery Coach Clients regardless of referral source.

- **Length of time from intake to admission:** how quickly clients enter treatment after intake assessment. The benchmark is within seven days.

- **Treatment outcome data**: number and type of discharge by treatment providers.

Treatment Discharge Outcomes by County

Analysis of treatment discharge data indicated that 125 clients were discharged from substance abuse treatment during this 6-month reporting period. As shown in 9, the overall completion rate for parents discharged from treatment in Cook County was 57%. The overall completion rate for parents discharged from treatment in St. Clair was eight percent; completion rate for parents discharged from treatment in Madison County was 23%. Treatment discharges in St. Clair County and Madison County have average completion rates that are below average for the quarter. Staff in both counties have expressed concerns with clients leaving treatment and/or continue to use while engaged in treatment. RCP south staffs participate in clinical staffing, all clients engaged in treatment will be staffed on a bi-monthly basis to discuss any treatment issues and develop a plan to assist the client in achieving a successful discharge.

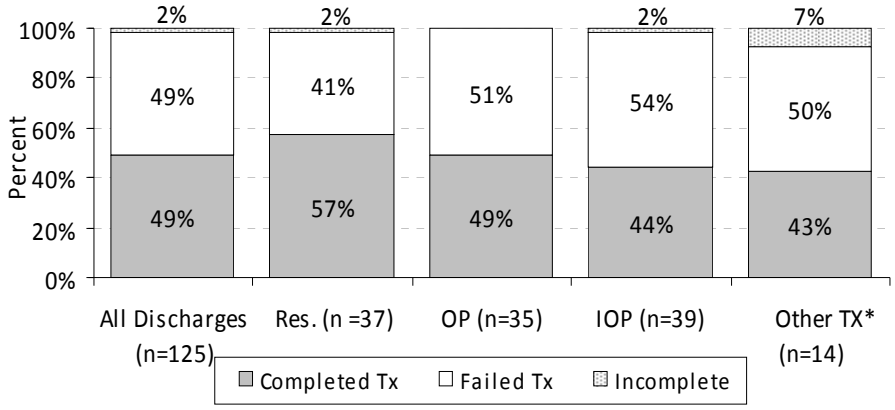
Treatment Discharge Outcomes by County

Mental Health Services Referral	Total Discharged	Completed Treatment	Failed Treatment	Incomplete Treatment
Cook	100	57 (57%)	42 (42%)	1 (1%)
St Clair	12	1 (8%)	9 (75%)	2 (17%)
Madison	13	3 (23%)	10 (77%)	--

Discharge Outcomes by Treatment Modality

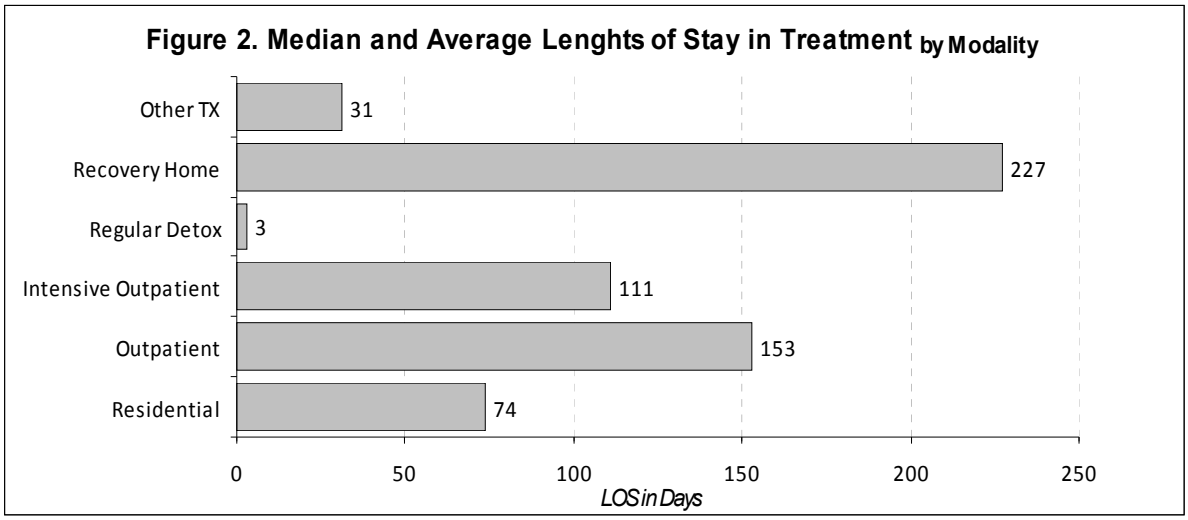
Figure 1 presents reason for discharge by modality. The treatment completion rate was highest among clients discharged from residential treatment (57%), followed by outpatient treatment (49%), intensive outpatient treatment (44%), and other treatment modalities (43%).

Figure 1. Discharge Outcomes by Treatment Modality



Median Length of Stay in Treatment (LOS)

Among all treatment discharges, the median length of stay (LOS) in treatment was longest for recovery home treatment (227 days), followed by outpatient treatment (111 days), intensive outpatient treatment (153 days), residential treatment (74 days), other treatment (31 days) and regular detox (3 days) 41 days and halfway home treatment (52 days).



5: OUTCOMES

The outcomes of primary interest are family reunification/permanency, child safety and cost neutrality. The outcomes presented in this report are based on a comparison between the experimental and control group. As the Illinois AODA waiver utilizes an experimental design, simply comparing the two groups is appropriate. 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. 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 this outcomes section, we also move beyond simple comparisons (e.g. did the program work?) and investigate additional questions of interest that help us understand the experiences and outcomes associated with substance abusing families in the child welfare system. Specifically, we present findings from three studies focused on (1) the effectiveness of treatment services for mothers with substance exposed infants, (2) second generation families involved with AODA, and (3) the termination of parental rights for families involved with AODA.

FAMILY REUNIFICATION AND PERMANENCE

Reunification (administrative data): As of December 31, 2008, 20% of the children in the control group and 24% of the children in the demonstration group were living in the home of their parents. This difference is statistically significant – meaning recovery coaches significantly improve the likelihood of family reunification. 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.

IV-E AODA Children Living Arrangement Type as of December 31, 2008

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	192	20.2	533	23.7	725
Home of Adoptive Parent (HAP)	238	25.1	554	24.6	792
Subsidized Guardianship (SGH)	4	0.4	0	0.0	4
Foster Home Adoptive (FHA)	30	3.2	56	2.5	86
Foster Home Private (FHP)	124	13.1	303	13.5	427
Foster Home Specialized (FHS)	111	11.7	178	7.9	289
Home of Relative Foster Care (HMR)	187	19.7	484	21.5	671
*Institutional Settings	55	5.8	115	5.1	170
**Other (OTH)	8	0.8	26	1.2	34
Total	**949**	**100%**	**2,249**	**100%**	**3,198**

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

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

We were also interested in whether or not the effects of the demonstration vary by drug of choice.

The next three tables show AODA children's living arrangements by their caretakers' primary drug of choice, that is, alcohol, cocaine, opioids, and mixed (i.e., cases were there are two caretakers with different primary drug of choice). For the alcohol and cocaine groups, there are no statistically differences. In contrast, for the opioid and mixed drug families, the families assigned to the recovery coach condition (demonstration group) are significantly more likely to achieve family reunification. We plan to investigate further how the recovery coach model might achieve different results for various sub populations.

IV-E AODA Children Living Arrangement Type as of December 31, 2008 for Alcohol Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	27	20.5	98	23.5	125
Home of Adoptive Parent (HAP)	29	22.0	77	18.5	106
Subsidized Guardianship (SGH)	0	0.0	1	0.2	1
Foster Home Adoptive (FHA)	5	3.8	1	0.2	6
Foster Home Private (FHP)	20	15.1	66	15.8	86
Foster Home Specialized (FHS)	15	11.4	40	9.6	55
Home of Relative Foster Care (HMR)	14	10.6	105	25.2	119
*Institutional Settings	20	15.1	21	5.0	41
**Other (OTH)	2	1.5	8	1.9	10
Total	**132**	**100%**	**417**	**100%**	**549**

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

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

IV-E AODA Children Living Arrangement Type as of December 31, 2008 for Cocaine Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	52	22.5	138	22.9	190
Home of Adoptive Parent (HAP)	88	38.1	197	32.7	285
Subsidized Guardianship (SGH)	2	0.9	0	0.0	2
Foster Home Adoptive (FHA)	6	2.6	11	1.9	17
Foster Home Private (FHP)	25	10.8	63	10.4	88
Foster Home Specialized (FHS)	20	8.7	39	6.5	59
Home of Relative Foster Care (HMR)	32	13.9	115	19.1	147
*Institutional Settings	3	1.3	37	6.1	40
**Other (OTH)	3	1.3	3	0.5	6
Total	**231**	**100%**	**603**	**100%**	**834**

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

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

IV-E AODA Children Living Arrangement Type as of December 31, 2008 for Opioids Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	28	13.8	78	22.2	106
Home of Adoptive Parent (HAP)	77	37.9	105	29.8	182
Subsidized Guardianship (SGH)	0	0.0	0	0.0	0
Foster Home Adoptive (FHA)	0	0.0	9	2.5	9
Foster Home Private (FHP)	17	8.4	43	12.2	60
Foster Home Specialized (FHS)	15	7.4	30	8.5	45
Home of Relative Foster Care (HMR)	49	24.1	55	15.6	104
*Institutional Settings	14	6.9	26	7.4	40
**Other (OTH)	3	1.5	6	1.7	9
Total	**203**	**100%**	**352**	**100%**	**555**

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

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

IV-E AODA Children Living Arrangement Type as of December 31, 2008 for Mixed Drugs Families

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	6	6.5	40	20.8	46
Home of Adoptive Parent (HAP)	22	23.7	56	29.2	78
Subsidized Guardianship (SGH)	0	0.0	0	0.0	0
Foster Home Adoptive (FHA)	9	9.7	8	4.2	17
Foster Home Private (FHP)	13	14.0	32	16.7	45
Foster Home Specialized (FHS)	10	10.8	13	6.8	23
Home of Relative Foster Care (HMR)	24	25.8	32	16.7	56
*Institutional Settings	6	6.5	9	4.6	15
**Other (OTH)	3	3.2	2	1.0	5
Total	**93**	**100%**	**192**	**100%**	**285**

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

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

Closed Cases

With respect to closed cases only, according to administrative data, as of December 31, 2008, a total of 1,419 cases (41% in the control group and 46% in the demonstration group) had been closed by DCFS. By the end of 2008, again with respect to closed cases only, 40% of the children in the demonstration group had been reunified as compared with 33% of the children in the control group (percentages of the total numbers of children in the respective groups). Among closed cases, children in demonstration group are significantly more likely to achieve reunification as compared with children in control group ($p < 0.05$).

Permanency Outcomes - Closed Cases	Control	% Closed	Demo	% Closed	Total
Permanency Outcomes - Closed Cases	**Control**	**% Closed**	**Demo**	**% Closed**	**Total**
Home of Parent (HMP)	140	13%	474	19%	614
Home of Adoptive Parent (HAP)	269	26%	624	25%	893
Other	26	3%	71	3%	97
Total Closed	**435**	**42%**	**1,169**	**47%**	**1,604**

In addition to reunification, child welfare systems also value a broader array of permanency settings. These settings include reunification, adoption, and subsidized guardianship. As of December 31, 2008, no significant differences emerged between the control and demonstration group: 45.7% of the children in the Control group and 48.3% of the children in the demonstration group achieved permanency.

The living arrangement outcomes to date are useful, but as families are joining the demonstration project at various points in time, the reunification estimates might be difficult to understand – as some families have had multiple years to achieve reunification and others only a few months (e.g. families assigned in mid 2008). For this reason, we developed a table to display the living arraignment of children five years after random assignment. Since the latest data in the DCFS Integrated Database is until December 31, 2008, we limited our follow-up sample to cases with JCAP assessment dates between April 2000 and December 2003. 1,529 cases having JCAP assessment dates within the range were included. For each case in the sample, we found his/her living arrangement on the exact date, which was five years later than his/her assessment date. Comparing control and demonstration groups on five-year-later living arrangements, we found that, children in demonstration group were more likely to achieve permanence through reunification (21.5% vs. 25.6%) and adoption (33.8% vs.37.6%). Consequentially, a smaller proportion of children in demonstration group were still in foster care at the five year mark (24.3% vs. 15.6%).

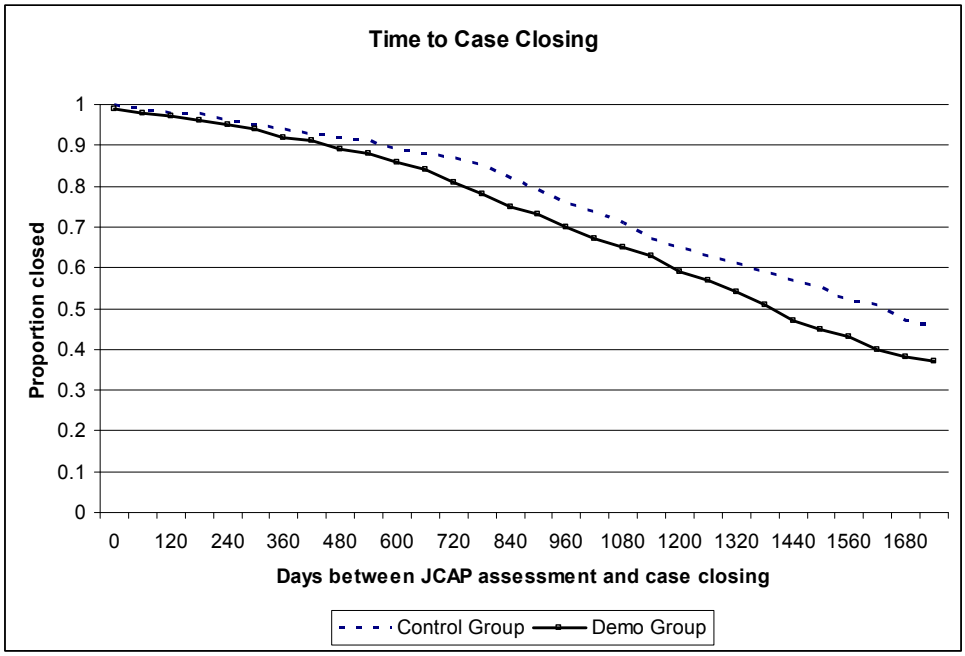
IV-E AODA Children Living Arrangements 5 Years after JCAP Date (for children with JCAP dates between April 1, 2000 and December 31, 2003, N=1,529).

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	100	21.5	272	27	372
Home of Adoptive Parent (HAP)	157	33.8	400	43	557
Subsidized Guardianship (SGH)	8	1.7	10	0.9	18
Foster Home	113	24.3	166	15.6	279
Home of Relative Foster Care (HMR)	50	10.8	133	12.5	183
*Institutional Settings	30	6.5	64	4	94
**Other (OTH)	7	1.5	19	1.8	26
Total	**465**	**100%**	**1,064**	**100%**	**1,529**

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

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

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 two trajectories remain fairly consistent during the first year. The trajectories of the lines indicate that very few cases have closed within one year since entering the AODA Project. At the point of one year later (360 days), 94% of the control group cases remained open compared to 92% of the demonstration group. The differences between the two groups became more apparent at the point of two years later subsequent to the JCAP assessment (720 days). At that point, 87% of the control group cases remained open compared to 81% of the demonstration group. At the point of four years later (1440 days) subsequent to the JCAP assessment, over half (53%) of cases in the demonstration closed as compared with 43% of cases in the control group.



Permanency Goals: As of December 31, 2008, 33.5% of the children in the control group vs. 34.1% in the demonstration group had "return home" as their permanency goal. In the control group, 29.3% of the children appear to be moving towards the termination of parental rights (TPR) and possible adoption vs. 28.6% in the demonstration group. We have 1,306 (40.8%) children total that are awaiting TPR in order to either get adopted or continue with substitute care (41.1% in the control vs. 40.7% in the demonstration group). These differences are not significant. Additional and more detailed information about the termination of parental rights is included at the end of this chapter on outcomes.

Permanency Goal	N=949	N=2,249	(COLUMN %)	
	Control	Demo	Control %	Demo %
Remain at home	1	2	0.1	0.1
Return Home w/in 5 months	83	239	8.7	10.6
Return Home w/in one year	235	529	24.8	23.5
Return Home pending status of hearing	31	53	3.3	2.4
SubCare Pending Court Determination	112	272	11.8	12.1
Adoption providing TPR completed	278	644	29.3	28.6
Guardianship	57	162	6.0	7.2
Independence	64	134	6.7	6.0
No Home, Disability	10	16	1.1	0.7
Missing	78	198	8.2	8.8

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 (6.50) and control (6.73) groups. Overall, children experience an average of 6.57 placements.
For the entire population as of December 31, 2008

NUMBER of PLACEMENTS
Control versus demonstration group:

	AODA Group		Statistic	Std. Error
Number of Placements	Control	Mean	6.73	7.35
		Median	4	
		Minimum	1	
		Maximum	75	
	Demonstration	Mean	6.50	7.66
		Median	4	
		Minimum	1	
		Maximum	150	

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 (1,158 days vs. 1,218 days).

For the entire population:

Time in Placement

Mean	1,175.64
Median	1,123
Minimum	1
Maximum	5,649

Control versus Demonstration group:

	AODA Group		Statistic	Std. Error
Time in Placement, Days	Control	Mean	1,218.18	722.05
		Median	1,143	
		Minimum	3	
		Maximum	4,305	
	Demonstration	Mean	1,157.69	695.54
		Median	1,106	
		Minimum	1	
		Maximum	5,649	

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 at the family

level with a report of maltreatment subsequent to random assignment. Very few families experienced subsequent maltreatment (indicating high level of safety). There are no significant differences between the two groups, indicating that permanency decision are not being made too quickly and the recovery coach program does not compromise child safety.

Allegations of Maltreatment Subsequent to Random Assignment

Post-JCAP Maltreatment (most severe) for caregivers

Type of Maltreatment	Demonstration %	Control %
Physical Abuse	0.6	0.4
Neglect	0.3	0.1
Sexual Abuse	0.1	0.1
Risk of Harm	6.3	7.0
Substance Related	8.3	8.3
Inadequate Supervision	1.4	1.6
None	83.0	82.4

Brief Summary of Additional Illinois AODA Research Reports

Title: Substance Exposed Infants, Mothers, and Family Reunification

The purpose of this study was to investigate and identify if any specific substance abuse services are related to treatment progress and family reunification for cases involving substance exposed infants. For this study a diverse sample of 210 mothers and their substance exposed infants in the Illinois Title IV-E Alcohol and Other Drug Abuse (AODA) waiver demonstration. We use a variety of survey and administrative data sources, including official reports of maltreatment, detailed records of treatment services, and caseworker assessments of caregiver problems and treatment progress. We utilize logistic regression, survival analysis, and life tables to model the effects of specific treatment components on achieving treatment progress and reunification.

Findings: The results from the regression models are displayed in the table below. Only the independent variables concerning treatment components are statistically significant. Specifically, compared with mothers who received other treatments (not including residential), the odds are 2.677 times greater for mothers who got residential treatment only, while the effect is marginal with regard to statistical significance ($p = 0.065$); the odds of achieving progress in substance abuse treatment are 14.702 times greater for mothers who received residential treatment combined with other community base transitional services. This odds ratio indicates that, residential treatment is most effective when it is combined with other community base transitional services. Residential treatment is no more effective when provided in isolation (i.e. without transitional services.

Independent variables	b	S.E.	Exp (b)
Child demographics			
Male	-.408	.403	.665
African American	-.510	.506	.601
Caretaker demographics			
Prior SEI	-.633	.428	.531
Health insurance	.333	.404	1.395
Service need			
Domestic violence counseling	.103	.408	1.108
Mental health services	-.404	.456	.668
Treatment components			
residential only	.985	.533	2.677
residential combined	2.688***	.475	14.702
χ^2, do			46.011 (8)

* p<0.05, ** p<0.01, *** p<0.001.

We use a different type of regression model (Cox Regression) to understand the likelihood and timing of family reunification. The results are displayed in the table below. Model 1 contains demographic characteristics, service needs variables, and two dummy variables about mother's treatment components. The hazard ratio (coefficients in cell) associated with "residential treatment combined" is 3.893 indicating that mothers who received residential and transitional community based services are significantly more likely to achieve family reunification. Model 2 includes an additional dummy variable about whether mothers achieved progress in substance abuse. Adding

the variable of mother's progress in substance abuse improves the overall model fit dramatically (χ^2 = 30.808, df = 12, p < .001). The variables of treatment components no longer show significant impact on reunification. Rather the only significant effect emerging is associated with mother's progress in substance abuse. The hazard ratio of achieving family reunification is 8.724 indicating that compared with mothers who never achieved progress in substance abuse, the likelihood of family reunification for mothers who achieved progress in substance abuse is 7.724 times greater. It appears that treatment type matters – in that it facilitates progress – and progress facilitates reunification.

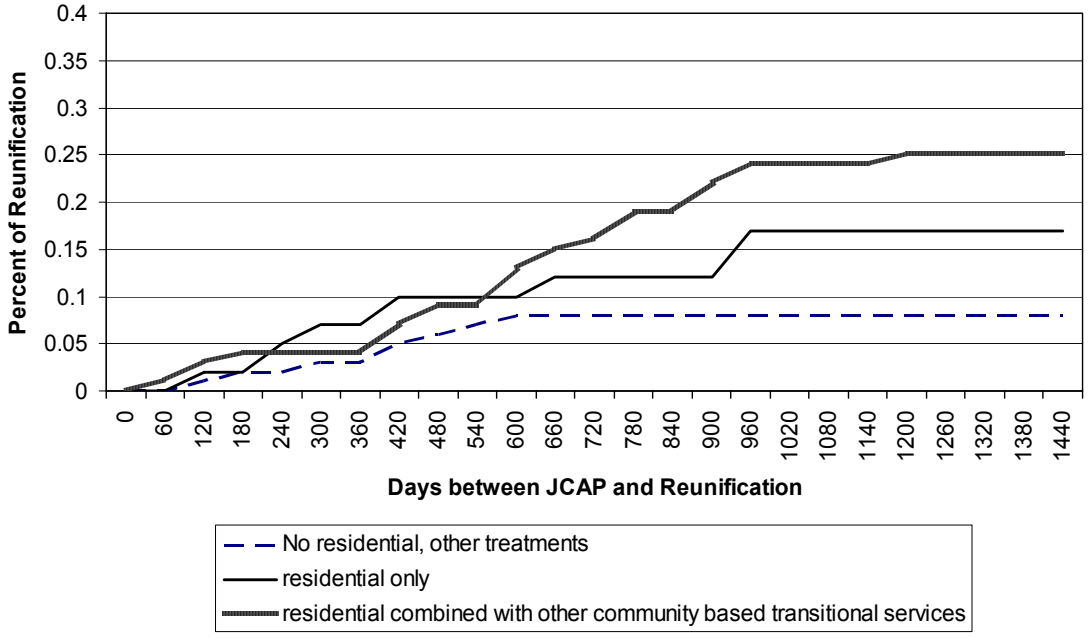
	Model 1			Model 2		
	Coeff.	SE	Exp(b)	Coeff.	SE	Exp(b)
Child demographics						
Male	.268	.419	1.308	.403	.414	1.496
African American	.796	.678	2.217	1.084	.730	2.956
Caretaker demographics						
Age	-.043	.043	.958	-.022	.047	.978
High School	-.019	.433	.981	-.360	.463	.697
Unemployed	.274	.757	1.315	.410	.760	1.507
Prior SEI	.024	.444	1.024	.335	.453	1.398
Health insurance	-.092	.417	.912	-.379	.437	.685
Service need						
Domestic violence counseling	-.302	.423	.739	-.436	.440	.646
Mental health services	-.197	.464	.821	-.237	.487	.789
Treatment components						
residential only	.539	.595	1.715	.025	.635	1.025
residential combined	1.359**	.489	3.893	.180	.553	1.197
Achieving progress in substance abuse treatment						
Yes				2.166***	.532	8.724
–2 log likelihood		248.256			229.594	
χ^2, df, Sig.		9.799, 11, .549			30.808, 12, .002	

- p<0.05, ** p<0.01, *** p<0.001.

Life table. To better understand the timing of achieving reunification, we produced a life table. The survival lines for the three groups getting different treatment components are displayed in the figure below. Note that eight months after the JCAP assessment (represented as 240 days), the three lines begin to diverge. During the period of eighth month and twentieth month (represented as 240 days to 600 days), children whose mothers got residential treatment only achieved highest reunification rate; children whose mothers got residential treatment combined with other community base transitional services achieved second highest reunification rate; while children whose mothers got treatments not including residential treatment had the lowest reunification rate. After the twentieth month (represented as 600 days), over ten percent of children, whose mothers got residential

treatment combined with other community based transitional services, achieved reunification. The reunification rate of this group of children kept increasing relatively faster than the other two groups. Until the thirtieth month (represented as 900 days), over 20 percent of children, whose mothers got residential treatment combined with other community base transitional services achieved reunification. The process of reunification grew much slower for the other two groups. Specifically, towards the end of observation period, less than 20% of the children, whose mothers got residential treatment only, and less than 10% of the children, whose mothers got other treatments not including residential treatment achieved reunification. Consistent with the findings reported earlier, it appears that treatment components not only impact the probability for mothers to achieve progress in substance abuse, but also impact the pace for children to achieve reunification.

Figure 1. Time between JCAP and Reunification



Title: Second Generation Families in the Illinois AODA Waiver Demonstration

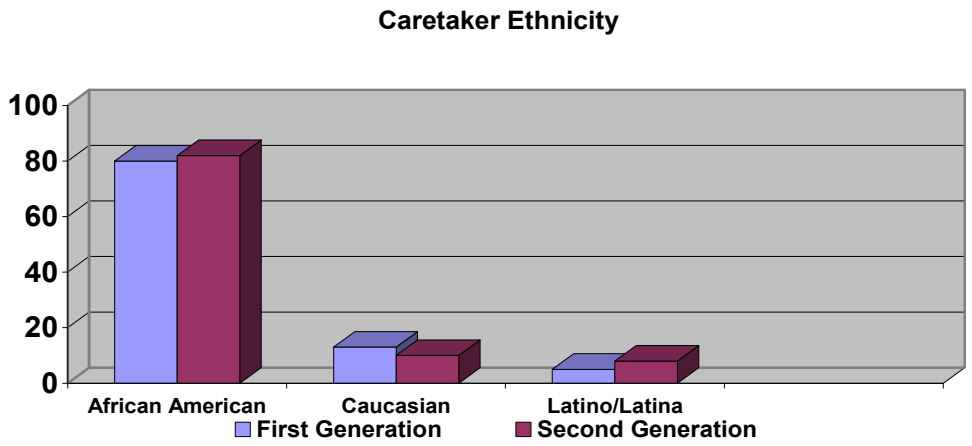
This study used data from families, which entered into the AODA Program between April 28, 2000 and June 30, 2004. The original AODA sample is composed of 1,309 caregivers and 1,953 children. The present study focuses on a subsample of 1,033 caregivers and 1,917 children. For children with more than one caregiver, we selected the mothers as the primary caretakers.

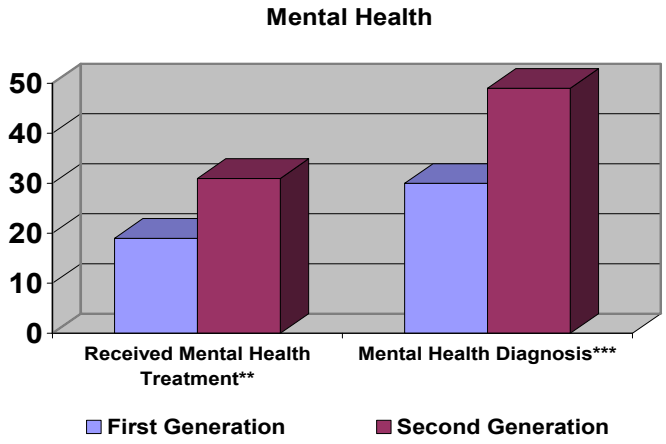
The present study employs three different data sources: (1) the Treatment Alternatives for Safe Communities (TASC) monthly report, which contains information on caregivers living situation and service needs, (2) the JCAP assessment, which assesses drug and alcohol involvement, along with other demographic information, and (3) the Illinois Integrated Database, which contains demographic, foster care, and maltreatment data on all IL children.

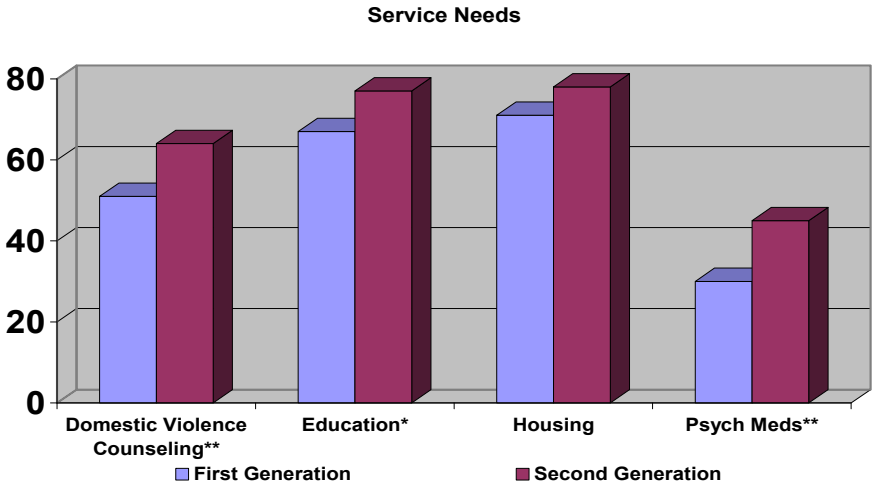
Three models were composed: unconditional, level 1, and level 2 (The table presented is for the third model). The unconditional model includes only the dependent measure. The level 1 model estimates the effects of the child-level characteristics (e.g., age, race, and gender). The level 2 model estimates the effects of mothers' characteristics (e.g., age, living situation, drug of choice, and service needs) in addition to the level 1 estimates.

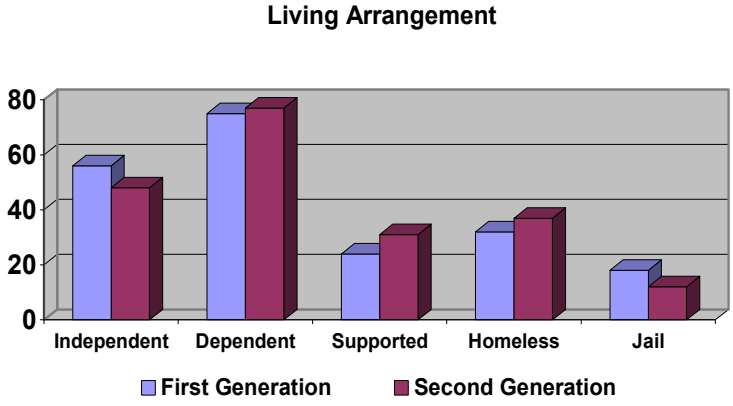
The bivariate results confirm our hypothesis that second generation families experience many more problems at the time of case opening. The HLM results partially confirm our second hypothesis that permanency rates are lower for second generation families. Specifically, there were significant HLM findings for reunification, but not subsidized guardianship. Second generation families were 67% less likely to be reunited as compared to first generation caregivers 3 years following entry into the AODA Demonstration. African American, Hispanic/Latino/Latina, Asian Americans, and Native Americans were all less likely to be reunified in comparison with European Americans. Parental compliance with psychotropic medication, and not having a need for psychotropic services were both associated with a greater odds of being reunified.

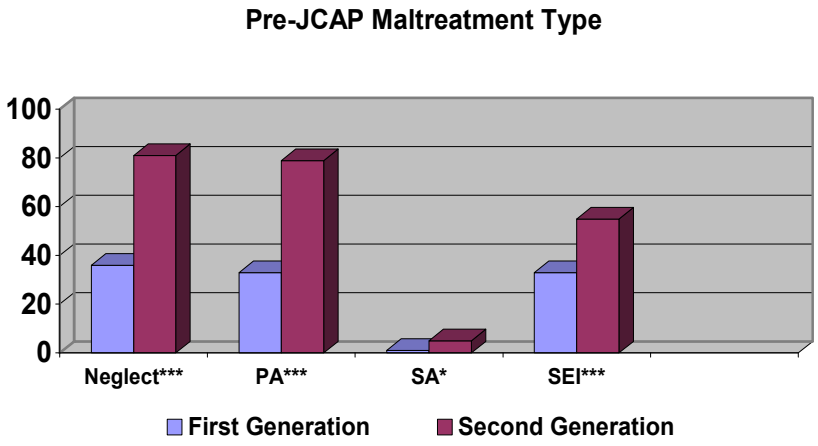
Pre-JCAP caregiver-level variables by generation status:



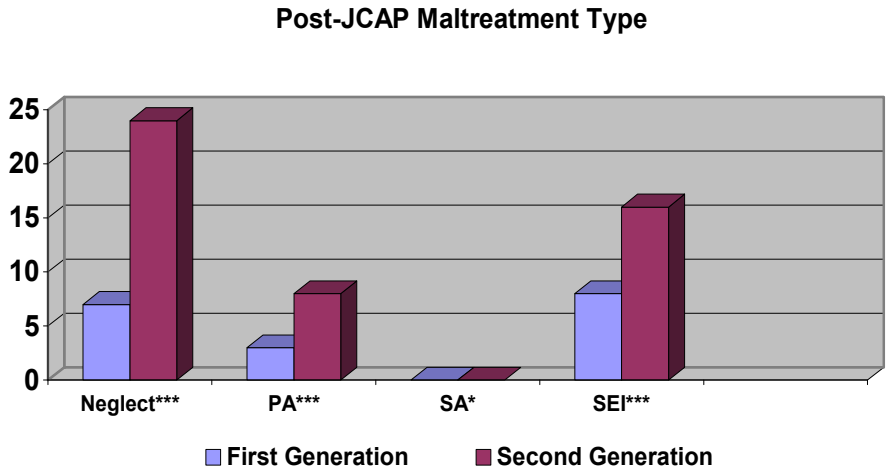

Mental Health
50
40
30
20
10
0
Received Mental Health Treatment**
Mental Health Diagnosis***
First Generation
Second Generation


Service Needs
80
60
40
20
0
Domestic Violence Counseling**
Education*
Housing
Psych Meds**
First Generation
Second Generation


Living Arrangement
80
60
40
20
0
Independent
Dependent
Supported
Homeless
Jail
First Generation
Second Generation



Post-JCAP caregiver-level variables by generation status:



HLM Analysis of reunification (children = 1,917; caregivers = 1,033)

Fixed effects	Level 1 & 2 Model		
	Coeff.	S.E.	O.R.
Intercept	-1.37**	0.48	0.25
Child variables			
Age	-0.00	0.01	1.00
Gender (1=male)	0.15	0.08	1.16
Race (white)			
Black	0.70	0.41	2.02
Hispanic	0.82	0.49	2.27
Caretaker variables			
Gender (1=male)	0.17	0.23	1.18
Age	-0.00	0.01	1.00
Race (white)			
Black	-1.20**	0.41	0.30
Hispanic	-0.99*	0.51	0.37
Other	-1.89**	0.66	0.15
Maltx. report	-0.10	0.19	0.90
Medication compliance	0.51*	0.25	1.67
Living situation (none)			
Independent living	0.49***	0.15	1.64
Dependent living	-0.64***	0.20	0.52
Homeless	-0.66***	0.18	0.52
Jail	-0.81***	0.20	0.44
Supported living	0.46**	0.17	1.58
Drug of choice (alcohol)			
Cocaine	0.54**	0.19	1.71
Opiates	0.33	0.24	1.39
Marijuana	0.37	0.26	1.44
Other	0.39	0.44	1.48
Service needs (none)			
Domestic violence	0.05	0.17	1.05
Education	-0.02	0.19	0.98
Housing	0.72***	0.20	2.05
Medication	-0.83***	0.24	0.43
Mental health	-0.33	0.18	0.72

Prenatal care	-0.12	0.17	0.89
Second generation	-0.67**	0.26	0.51
Random effects			
Variance component	2.58		
D.f.	1009		
χ^2	1213.81***		

* $p \leq .05$, **$p \leq .01$, ***$p \leq .001$

Summary: Second generation CPS-involved families experienced a wider range of co-occurring problems and were significantly less likely to achieve reunification, even after controlling for a wide range of important covariates. Thus, it is crucial for practitioners to be aware of families' intergenerational maltreatment histories, as the depth and breadth of problems within these family systems may be greater as compared with first generation cases.

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.

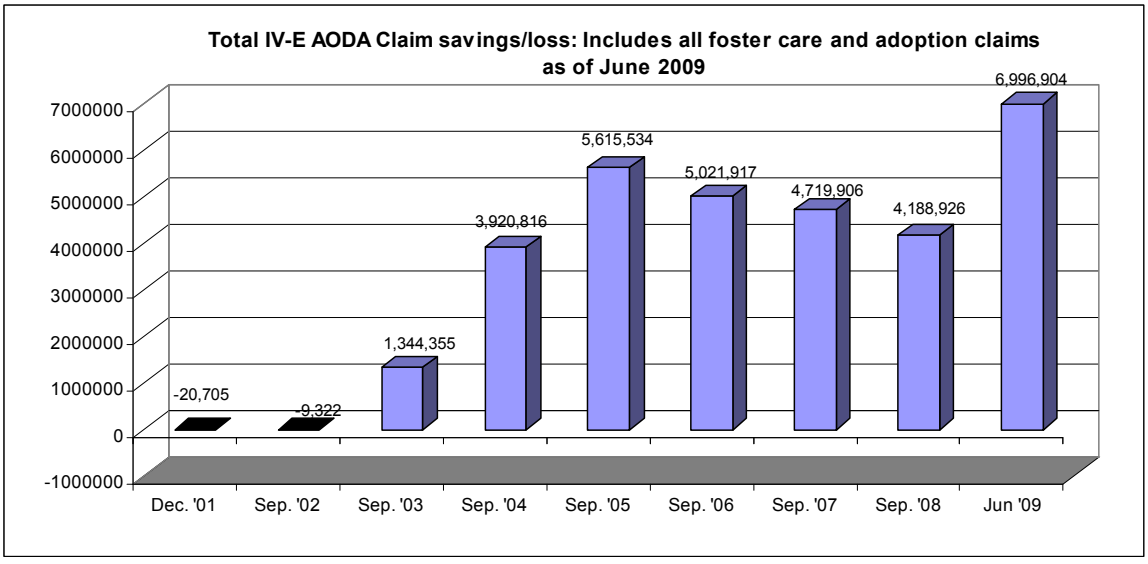
Second, if the actual IV-E cost in the demonstration group is less than generated IV-E claim, then the waiver is cost neutral.

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 September 30, 2008 was $8,831, which when multiplied by the 1,936 children assigned to the demonstration group generates a IV-E claim of **$17,096,380**.

The AODA waiver demonstration saved $6,996,904 as of June 30, 2009.



6: 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 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.

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 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?

Overall, the Illinois AODA waiver is achieving success; increasing the likelihood that families will access substance abuse treatment services, shortening the time children spend in substitute care settings, increasing the likelihood of reunification, and saving the State of Illinois money. In addition to these key outcomes, our report notes three additional findings of interest: (1) mothers associated with substance exposed infants achieve the best outcomes when they participate in residential treatment plus some form of transitional services in the community. The provision of residential treatment without transitional supports is less effective. (2) Second generation families (former child wards, now parents) experience more problems and achieve worse outcomes that first generation families. We will give additional thought to this population in the coming year. (3) The recovery coach model might work best with certain types of drug users. In the coming year we will focus on various sub populations within the AODA demonstration to better understand how the recovery coach model interacts with various type of substance abusing caregivers in child welfare.

In closing, achieving family reunification for substance abusing parents in the child welfare system requires innovative and integrated treatment strategies. The Illinois AODA demonstration waiver is a model of service integration that focuses on intensive case management to link child welfare clients to substance abuse services. This interim report indicates that substance abuse services can be accessed more quickly and the likelihood of reunification can be slightly increased with the implementation of a recovery coach model.

Federal Interim Report
September 2009