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Illinois AODA IV-E Waiver Demonstration Final Evaluation Report

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

Prepared for
Illinois Department of Children and Family Services
Richard H. Calica, 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 substance abuse delays reunification, children removed from such families tend to remain in care for significantly longer periods of time. Since 2000, the Illinois Department of Children and Family Services has been engaged in developing, implementing and modifying a coaching intervention to speed up parental recovery from substance abuse and in turn improve child and family outcomes. This report serves as the independent evaluation of such efforts.

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, we tested the hypothesis that reunification rates would improve even more if caseworkers were given the authority to address housing, mental health and domestic violence problems within the family home (that is, given the authority to actually connect families with services).

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 May 31, 2012, 1,000 parents (representing 1,455 children) were assigned to the control group and 2,325 parents (representing 3,119 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.

Regarding outcomes, the demonstration waiver and the evaluation of the wavier focused primarily on permanency, safety and cost neutrality. Yet, similar to national movements in child welfare, we are also *very much interested in broader measures of child well-being*. Thus, in the current report, we expand our analyses to look at one additional outcome of interest; contact with the juvenile justice system. Specifically, we test whether adolescents associated with the Recovery Coach group are significantly less likely to have contact (i.e. arrest) with the juvenile justice system in Cook County. This evaluation report also includes additional analyses on how the State of Illinois can improve permanency outcomes (that is, increase the effectiveness of the Recovery Coach model) for substance abusing families.

QUESTIONS RELATED TO REUNIFICATION AND PERMANENCY

1. Are children in the demonstration group more likely to be safely reunified with their parents? Yes. As of March 31, 2012, 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. Although this difference (4 percentage points) may appear relatively small, this increase represents an increase of 21% above what was achieved by the control group. This difference is statistically significant. (Page 44).

2. How about the time it takes to achieve reunification? When reunification with the biological parent 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 (770 days for the demonstration group vs. 900 days for the control group). That is a difference of 130 days or approximately 4.3 months. (page 47-48)

3. Do the revised procedures of the expanded waiver since 2007 improve reunification? Yes. We select two cohorts, one before and one after the 2007 modifications (i.e. expansion of the waiver demonstration). We compare reunification records of both cohorts within two years after the JCAP assessment date. The demonstration group in both admission cohorts had a higher reunification rate than the control group. But after the waiver expansion in 2007, the difference between the experimental and control group increased (indicating the modifications made in 2007 increased the effectiveness of the recovery coach model) (Page 49).

4. Regarding permanence, significantly more children in the demonstration group achieved permanence (reunification, adoption or subsidized guardianship) as compared with children in the control group (58% vs. 50%) (Page 44). This represents a 16% increase in permanence.

5. To compare permanency rates at a single point in time, we follow 2,615 cases for five years. Comparing control and demonstration groups on five-year-later living arrangements, we find that children in the demonstration group were significantly more likely to achieve permanence through reunification (24% vs. 18%) and adoption (30% vs. 28%). There were no differences when comparison subsidized guardianship at the five year mark. Thus, at five years, the Recovery Coaches increased reunification by 33% - and consequently reduced the number of children remaining in long term foster care placements. (Page 47).

Questions Related to Safety

1. So more children are reunified in the demonstration group. But are the families equally safe? That is, are the subsequent rates of maltreatment equal across groups? Yes, there is no difference with regard to substantiated allegations of maltreatment subsequent to random assignment. As of June 2012, 19% of the caregivers in the demonstration group and 20% of the caregivers in the control group are associated a subsequent substantiated allegations (Page 50-51)

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. Among the participants, 49% of the caregivers in the demonstration group participated in substance abuse treatment, as compared with 29% in the control group. There is significant difference on treatment entry between demonstration group and control group (Page 31). In general, caregivers in the demonstration group enter treatment in a slightly faster pace. On each of their own JCAP assessment dates, 25% of caregivers in the demonstration group enter treatment, and 17% of caregivers in the control group enter treatment. For caregivers in the demonstration group, 28% enter treatment within two months (60 days), and 33% enter treatment within twelve months (360 days). Comparatively, only 23% of caregivers in the control group enter treatment within twelve months (360 days) (Page 31).

2. 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 substances of choice (alcohol, cocaine, and opioids), caretakers from the demonstration group had higher rates of reunification in families where the primary substance was alcohol and opioids users. The reunification rates were not statistically different when comparing the effects of the recovery coach model for cocaine and mixed substances (i.e. two parents reporting different primary drugs) (Page 45-46).

Question Related to the Revised Procedures in 2007

1. Do the revised procedures of the expanded waiver since 2007 improve the services in three specific areas: mental health, domestic violence, and housing? Again we select two cohorts, one before and one after the 2007 waiver expansion. The comparisons indicate that the revised procedures in 2007 improved the delivery of services and the progress achieved within families specific to domestic violence and mental health. No improvements (related to the modified waiver demonstration) were observed with regard to housing. (Page 35-38).

QUESTION RELATED TO IMPROVING THE INTERVENTION: THE TIMING OF ENGAGEMENT

1. Early engagement matters in the use of Recovery Coaches in child welfare. Although the overall effectiveness of the Recovery Coach model is demonstrated in the current evaluation, the effectiveness of this model diminishes as the time between the temporary custody hearing and the formal screening/referral process increases. Looking forward, we need to better understand how to engage families (i.e. screen, connect with workers, connect with service providers) as close to the temporary custody hearing as possible (Page 52).

QUESTION RELATED TO BROADER MEASURE OF CHILD WELL-BEING: JUVENILE DELINQUENCY

1. The use of recovery coaches in child welfare (i.e. addressing substance abuse at the parental level) significantly decreases the risk of juvenile delinquency. Integrated and comprehensive approaches are necessary for addressing the complex and co-occurring needs of families involved with child protection. Recovery coaches not only improve traditional child welfare outcomes such as reunification and permanency, but also broader measures of child well-being such as involvement with the juvenile justice system. These additional benefits (in the broader domain of child well-being) should be included in future evaluations and benefit costs analyses - as the savings associated with reduced crime would be substantial (and currently not calculated as part of the savings of the current demonstration project) (Page 55).

QUESTION RELATED TO TREATMENT MODALITY:

1. Residential treatment is beneficial in terms of both treatment progress (directly) and family reunification (indirectly), but only when residential services are delivered in combination with transitional services. In an economic climate where states are making significant cuts to health and human services, expensive treatment programs such as residential centers for substance abusing parents are likely targets. The empirical evidence presented in the current evaluation report indicates that such targeting would be misguided, as residential programs, in combination with less restrictive and less expensive transitional services improve outcomes in both substance abuse treatment and child welfare domains (Page 58).

QUESTION RELATED TO SECOND GENERATION FAMILIES:

1. Second generation families refer to people who are currently involved in DCFS as caregivers but were involved with DCFS as children. In the waiver sample, 16% of caregivers (548 out of 3,325) are second generation. Second generation families experience significantly more risk factors at the time of case opening and their odds of achieving reunification decrease by 32% as compared with first generation families (even after controlling for a wide range of important covariates). Practitioners must be aware of families' intergenerational histories, as the depth and breadth of problems within these family systems may be greater as compared with first generation cases (Page 64).

QUESTION RELATED TO COST NEUTRALITY:

1. The waiver demonstration cost neutral? Yes. As of March 2012, the Illinois AODA waiver demonstration saved $6,141,925. 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. Even greater savings are observed/anticipated when factoring in the significant reduction in juvenile offending (Pages 65-66)

CONCLUSIONS

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 are more likely to achieve family reunification as compared to parents assigned to the control group***. Moreover, children in ***the recovery coach group spent significantly fewer days in foster care*** as compared with children in the control group. There were no differences with regard to subsequent reports of maltreatment – indicating that families are not being reunified too quickly. ***The changes introduced by Illinois and approved by the Children's Bureau in 2007 significantly improved the Recovery Coach model.*** With regard to additional measures of child well-being, ***adolescents associated with recovery coaches were significantly less likely to have contact with the juvenile justice system***. With regard to improving upon the recovery coach intervention, the program works best (highest reunification rates) when families are engaged within a relatively short period of time (within one month from the temporary custody hearing). Finally, ***the waiver demonstration saved the State of Illinois at least $6,141,925*** through March 31, 2012.

1: Introduction

Overview of the Demonstration

This Final 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 May 2012. In general, the data presented in this report run through May 31, 2012. However, the chapter on process indicators runs from December 2011 through March 2012; 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 May 2012 to the AODA demonstration in the Cook County, 1,000 parents of 1,455 children were assigned to the control group and 2,325 parents of 3,119 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 May 31, 2012, JCAP (Juvenile Court Assessment Project) has provided 10,193 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, 2,325 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.

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 design is as follows:

$$
\begin{array}{lll}
R_{t1} & & O_1 \\
R_{t1} & A & O_2
\end{array}
$$

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).

Research Questions

The evaluation addresses the following six 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?

5. In looking at broader measures of child well-being, are children in the demonstration group less likely to have contact with the juvenile justice system?

6. Is the Waiver demonstration cost neutral?

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
MARS/CYSIS						X	X
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		

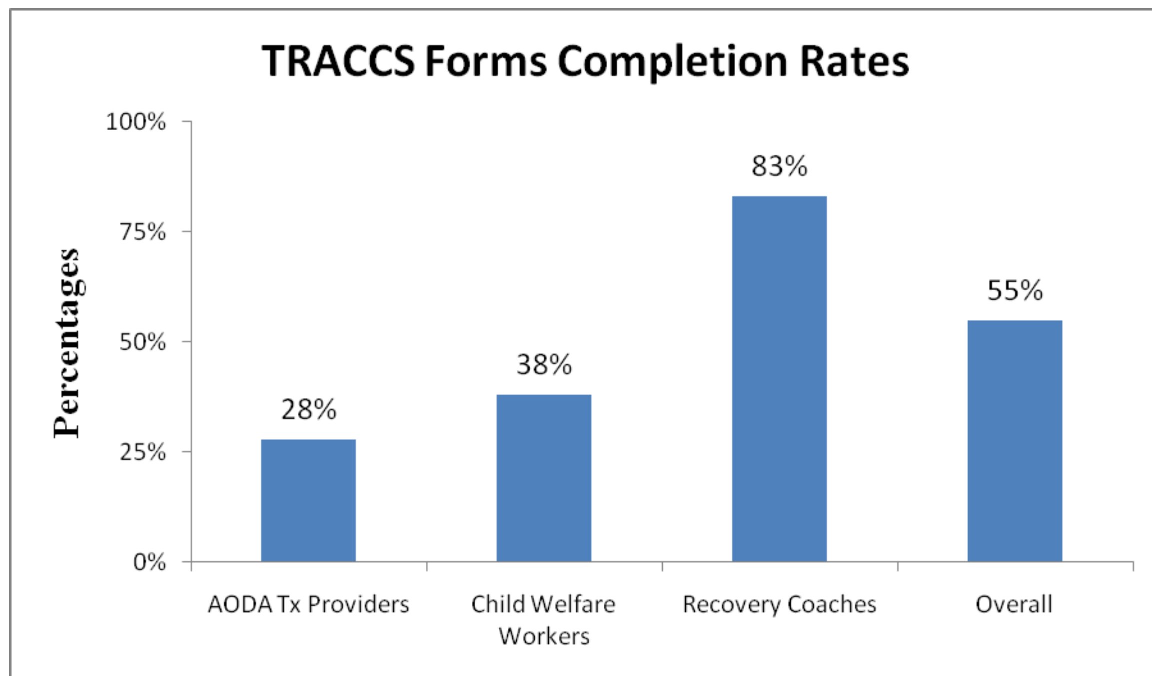
NOTE: the TRACCS forms are sent to and completed by the caseworkers, the recovery coaches and the treatment (AOD) providers.

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 2011 in Cook County. The chart below reflects forms that were sent out and returned from July 1, 2010 through June 30, 2011.

AODA	Expected	Received	Pct.		CW	Expected	Received	Pct.		RC	Expected	Received	Pct.
Totals	241	68	28%		Totals	2,087	803	38%		Totals	1,455	1,213	83%



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, 2011, approximately 21% of clients in the project have signed research consents. The signed consent gives permission to review substance abuse and public aid records. We view this consent rate as low and are working with JCAP staff to increase rates.

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 May 31, 2012, JCAP has provided 9,676 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, 895 (29%) parents have been assigned to the Control Group and 2,154 (71%) parents have been assigned into the Demonstration group.

In St. Clair and Madison Counties, from July 15, 2007 through May 31, 2012, TASC Court Assessment Project (TCAP) has provided 517 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, 105 (38%) parents have been assigned to the Control Group and 171 (62%) 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 continued to provide training throughout the past few years 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. These outreach meetings were successful in increasing referrals in all three counties.

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 were 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. It has been a continual challenge to motivate treatment provider counselors to complete the TRACCS forms each month. Many of the treatment providers experienced budget cuts from their DASA funding stream throughout the past few years. 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:

- Ethics and Code of Conduct
- DCFS Housing – Norman Fund Assistance
- Issues regarding Fatherhood
- Tobacco Education Training
- Emotional Freedom Techniques
- LGBT Education
- 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.

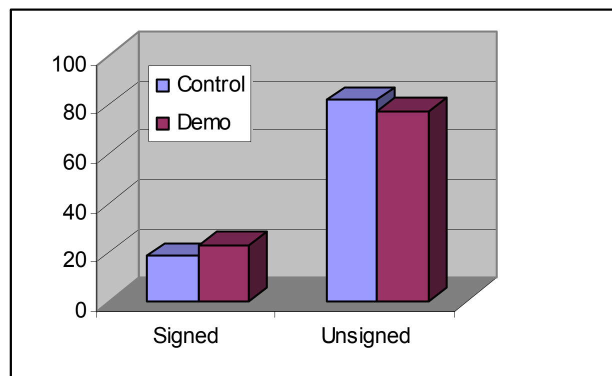
Although the Recovery Coach may present reports to the court regarding treatment progress, the waiver demonstration staff do not have any direct input into the legal process. Waiver demonstration staff are however in contact with the General Counsel of DCFS regarding any court issues which may arise.

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 May 31, 2012, 3,325 parents and 4,574 children are enrolled in the project. Of the 3,325 parents, 2,325 (70%) have been randomly assigned to the demonstration group and 1,000 (30%) have been assigned to the control group.

Cumulative Totals as of May 31, 2012:

	Control Group	Demo Group	Total
Parents	1,000	2,325	3,325
Families	754	1,705	2,459
Children	1,455	3,119	4,574

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	Control	Demonstration	
	(N=1,000)	(N=2,325)	
Age	33 yrs.	33 yrs.	
Gender:	65%	65%	Female
Ethnicity:	70%	70%	African American
	7%	8%	Hispanic
Marital Status:	10%	11%	Married
Shelter:	6%	6%	Homeless
Employment Status:	82%	82%	Not working
Education:	58%	57%	< High School
Primary Substance:	26%	29%	Cocaine
	24%	22%	Opioids
	22%	22%	Alcohol

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

Variables	**Control**	**Demonstration**	
	(N=650)	(N=1,507)	
Age	31	32	
N of assigned children	2	2	
Ethnicity:	69%	70%	African American
	6%	7%	Hispanic
Marital Status:	9%	10%	Married
Shelter:	8%	8%	Homeless
Employment Status:	93%	91%	Not working
Education:	61%	61%	< High School
Primary Substance:	33%	36%	Cocaine
	21%	19%	Opioids
	15%	16%	Alcohol

The majority of caretakers are female:

Gender	N=1,000	N=2,325	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Female	650	1,507	65%	65%
Male	350	818	35%	35%

The following tables provide information with respect to employment, education, marital status, race, and living arrangement of the caretakers as of May 31, 2012.

Race	N=1,000	N=2,325	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Black	700	1,637	70%	70%
Caucasian	211	453	21%	19%
Hispanic	66	185	7%	8%
Other	23	51	2%	2%

Employment	N=1,000	N=2,325	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Full time (35+ hours)	100	231	10%	10%
Part time (<35 hours)	64	152	6%	7%
Employed	7	7	1%	0%
Seasonal Worker	4	20	0%	1%
Unemployed	712	1,667	71%	72%
Not in Labor Force	61	139	6%	6%
Unknown	52	109	5%	5%

Education	N=1,000	N=2,325	(COLUMN %)	
	Control	Demo	Control %	Demo %
Less than high school	522	1,195	52%	51%
High school or GED	347	845	35%	36%
Some college/vocational	67	138	7%	6%
Graduated college/Vocational/trade school	9	27	1%	1%
Missing Data	1	0	0%	0%

Marital Status	N=1,000	N=2,325	(COLUMN %)	
	Control	Demo	Control %	Demo %
Married	98	265	10%	11%
Never married	746	1,700	75%	73%
Divorced	73	174	7%	7%
Separated	68	152	7%	7%
Widowed	9	23	1%	1%
Unknown	6	11	1%	0%

Living Arrangement	N=1,000	N=2,325	(COLUMN %)	
	Control	Demo	Control %	Demo %
Homeless	59	151	6%	6%
Alone	163	389	16%	17%
Family	557	1,307	56%	56%
Friend	149	328	15%	14%
Institution	22	54	2%	2%
Unknown	50	96	5%	4%

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 %
Sexual Abuse	1	1
Physical Abuse	5	6
SEI	21	22
Neglect	22	21
Risk of Harm	24	24
No Indicated Maltreatment	27	27

Primary drug of choice: N=3,325

Caretakers are asked to identify their primary drug of choice. Cocaine is the most common drug of choice (28%), followed by opioids (23%) and marijuana (23%), and alcohol (22%). There is no significant difference on the primary drug of choice between demonstration group and control group.

Primary drug of choice	N=1,000	N=2,325	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Alcohol	217	522	22%	22%
Cocaine	260	664	26%	29%
Marijuana	242	527	24%	23%
Opioids	236	516	24%	22%
Other	21	38	2%	2%
No Response	23	47	2%	2%

Of cocaine users (i.e. those who said that their primary drug was cocaine), 53% responded that they used cocaine at least several times per week:

Cocaine Use Frequency	N=260	N=664	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
No use	25	51	10%	8%
Less than once a week	67	161	26%	24%
One time per week	34	64	13%	10%
Several times per week	81	226	31%	34%
Once a day	10	27	4%	4%
2-3 times a day	23	97	9%	15%
More than 3 times per day	8	17	3%	3%
Unknown	3	5	1%	1%
No Response	9	16	3%	2%

Regarding the start age of cocaine use, around 39 percent said that they started to use cocaine between the ages of 22 to 29; the next largest group (31%) started using between the ages of 17-21:

Age at first use	N=260	N=664	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
<12	3	7	1%	1%
13-16	32	64	12%	10%
17-21	74	215	28%	32%
22-29	110	252	42%	38%
30>	29	101	11%	15%
No response	12	25	5%	4%

The majority of caretakers (JCAP data respondents N=1,830, 55%) have participated in previous treatment for substance abuse:

Previous Treatment for Substance Abuse Problems	N=1,000	N=2,325	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Yes	548	1,282	55%	55%
No	432	980	43%	42%
No response	20	63	2%	3%

Regarding mental illness symptoms, 11% of parents in the control group, and 11% in the demonstration group, said that they had had thoughts of suicide.

Income levels: 88% of the control group and 87% 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. There are no differences between the control and demonstration groups in either (1) percentage reporting the problem/need or (2) the percentage making at least substantial progress.

	Control %	Demo %
% of clients with mental health issues	35%	36%
% of clients who have made at least substantial progress regarding mental health	7%	9%
% of clients with housing issues	40%	41%
% of clients who have made at least substantial progress regarding housing	7%	9%
% of clients with domestic violence issues	25%	28%
% of clients who have made at least substantial progress regarding domestic violence issues	6%	7%
% of clients with parental skills deficits	51%	53%
% of clients who have made at least substantial progress regarding parenting skill issues	15%	17%
% of clients needing child care services	11%	12%
% of clients who have made at least substantial progress regarding substance abuse issues	20%	21%

Children

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=1,455)	(N=3,119)	
Age at TC Hearing	3.7 yrs.	3.7 yrs.	
	41%	43%	Removed as infant
Gender:	49%	46%	Female
Ethnicity:	72%	73%	African American
	2%	4%	Hispanic
Allegation:	7%	7%	Abuse
	16%	18%	Substance exposed
	31%	27%	Neglect
	29%	32%	Risk of harm
	18%	17%	No allegation
First Placement	14%	14%	Hospital/Shelter
	34%	42%	Kinship Home

Race	N=1,455	N=3,119	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Black	1,041	2,274	72%	73%
Caucasian	358	657	25%	21%
Hispanic	32	128	2%	4%
Asian	1	7	0%	0%
Not Reported	23	53	2%	2%

Sex	N=1,455	N=3,119	**(COLUMN %)**	
	Control	Demo	Control %	Demo %
Female	711	1,483	49%	48%
Male	738	1,626	51%	52%
Unknown	6	10	0%	0%

Placement Histories

The following table displays the number of prior placements (placements that ended prior to the TC date associated with this demonstration) for the control and demonstration groups. For the majority of children, this is their first substitute care placements. Again, there are no significant differences between the two groups.

Number of Prior Placements	Control %	Demo %
0	79%	78%
1	13%	13%
2	5%	6%
3	1%	2%
> 3	2%	2%

Placement Types

The major placement type for children in both groups as of March 31, 2012 is in the home of a relative (18% control group and 17% in the demonstration group); the second major placement type is in a private agency foster home (10% control group and 9% in the demonstration group):

Placement Types		Control	Demo	TOTAL
Foster Home Adoption	Count	13	25	38
	%	1	1	1
Foster Home Boarding	Count	30	47	77
	%	2%	2%	2%
Foster Home Private Agency	Count	147	288	435
	%	10%	9%	10%
Foster Home Specialized	Count	133	176	309
	%	9%	6%	7%
Group Home	Count	7	6	13
	%	0	0	0
Home Adoptive Parent	Count	384	890	1274
	%	26%	29%	28%
Home of Parent	Count	283	707	990
	%	19%	23%	22%
Hospital/Health Facility	Count	5	4	9
	%	0	0	0
Home of Relative	Count	269	544	813
	%	18%	17%	18%
Independent Living	Count	41	109	150
	%	3%	3%	3%
Institution Private	Count	21	35	56
	%	1	1	1
Runaway	Count	0	0	0
	%	0	0	0
Subsidized Guardianship	Count	78	200	278
	%	5	6	6
Transitional Living	Count	3	20	23
	%	0	1	1
Youth in College	Count	6	8	14
	%	0	0	0
Other Placements	Count	15	44	59
	%	1	1	1
Missing	Count	20	16	36
	%	1	1	1
TOTALS	Count	1455	3119	4574
	%	100	100	100

4: Process Indicators

The Recovery Coach Program (RCP) 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 amount 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.

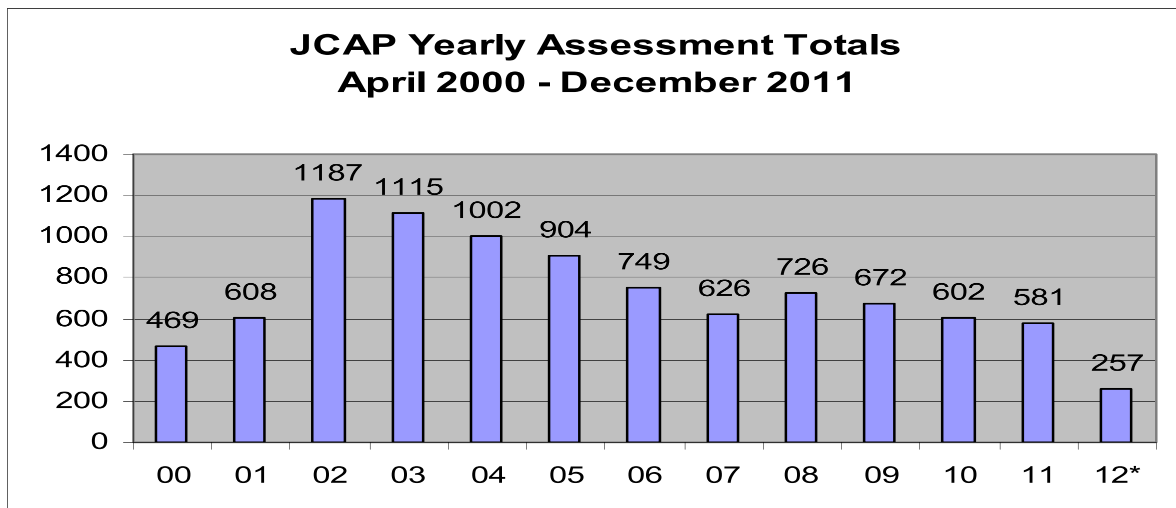
In this chapter we present data on process indicators – to better understand how families are referred and move through the demonstration waiver project. Some of the data presented represent the entire AODA observation period (April 2000 to March 2012) and other estimates represent process measures as reported during the most recent quarter (December 2011 to March 2012).

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. You will notice JCAP referral reached an all time high in 2002 (1,187) and have since declined and remained relatively stable (High 500s and 600s) over the last four years.

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



*Denotes only 6 months of the Fiscal Year

The following table displayed the percentage of referrals that is indicated or identified as having a substance abuse problem. The indication rate has remained relatively stable through the life of the AODA waiver demonstration (approximately 69%).

JCAP Referrals for AODA Assessments – April 2000 – December 2011

	Referrals to JCAP	TX Indicated	% of TX Indicated	IV-E Eligible	% IV-E Eligible
FY 00*	469	182	39%	20	11%
FY 01	608	433	71%	226	52%
FY 02	1187	832	70%	400	48%
FY 03	1115	684	61%	371	54%
FY 04	1003	542	54%	293	54%
FY 05	904	571	63%	285	50%
FY 06	749	524	70%	218	42%
FY 07	626	440	70%	186	42%
FY 08	726	484	67%	283	58%
FY 09	672	459	68%	233	51%
FY 10	602	418	69%	242	58%
FY 11	581	426	73%	240	56%
FY 12*	257	177	69%	95	54%

*Denotes only 6 months of the Fiscal Year

In St. Clair and Madison Counties parents are referred to the TASC Court Assessment Project.

The TASC Court Assessment Project (TCAP) provides alcohol and drug assessments for adults 18 years and older in St. Clair and Madison Counties to parents who have lost custody of their children. Referrals are often made by the judges, attorneys and case workers once a case has been scheduled for a shelter care hearing to determine if alcohol and other drug use is a part of the family dysfunction. After the referral has been made to TASC, an assessment is scheduled and a recovery coach will make outreach attempts to contact and engage the parent to conduct the assessment. Since this process differs from the Cook County on –site JCAP assessment, referrals to TCAP are often in the pending stage since the Recovery Coaches in St. Clair and Madison Counties are not located at the court houses as in Cook County.

Once the assessment is conducted, the TASC assessor makes the treatment recommendation regarding the level of care appropriate for the parent. At that point the TASC Recovery Coach Supervisor randomly assigns the parents into either the control or demonstration group using the computerized selection program designed by the independent evaluators. Once assigned to the Demonstration group, the recovery coaches begin outreach efforts to engage parents in the project and arrange transportation and engagement into treatment services. As of December 31, 2011, as seen in the chart below, 472 total referrals were made to both counties and 322 (68%) parents not only resulted in AODA assessments being conducted, but were also eligible for the IV-E AODA Waiver project in St. Clair & Madison Counties.

Total Referrals from July 15, 2007 – December 31, 2011

Fiscal Year 2008-11	St. Clair	Madison	Total
Referred to TCAP			
Eligible for IV-E	**121**	**201**	**322**
Not Eligible for IV-E	59	91	150
TOTAL REFFERED	**180**	**292**	**472**
IV – E Eligible	**St. Clair**	**Madison**	**Total**
Control	32	84	116
Demo with Recovery Coaches	89	117	206
TOTAL	**121**	**201**	**322**

As of December 31, 2011, and of 322 parents enrolled in the IV-E project, specifically, 116 (36%) parents were randomly assigned into the Control group and 206 (64%) were randomly assigned into the Demonstration group. Of the assessments resulting from the initial referral from court, a total of 150 (32%) did not meet eligibility requirements for the IV-E AODA waiver project.

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 December 31, JCAP has provided 3,102 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, 912 (29%) parents have been assigned to the Control Group and 2,190 (71%) parents have been assigned into the Demonstration group.

In St. Clair and Madison Counties, from July 15, 2007 through December 31, 2011, TASC Court Assessment Project (TCAP) has provided 322 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, 116 (36%) parents have been assigned to the Control Group and 206 (64%) parents have been assigned into the Demonstration group.

Cook County			St. Clair and Madison Counties		
Group	**Total**	**% of Total**	**Group**	**Total**	**% of Total**
Control	912	29%	Control	116	36%
Demo	2,190	71%	Demo	206	64%
Totals	**3,102**	**Parents**	**Totals**	**322**	**Parents**

We are also interested in the point of contact between the JCAP referral and the life of a child welfare case. The following table displays the overall referrals by hearing type since fiscal year 2005. The most frequent point of contact is at the time of the temporary custody hearing (1,482), followed by status progress hearing (1,467), permanency planning hearing (826), and court family conferences (754).

Referrals to JCAP by Hearing Type:

	FY-05	FY-06	FY-07	FY-08	FY-09	FY-10	FY-11	FY-12*	Total
Temporary Custody	299	177	205	269	184	**158**	**136**	**54**	**1,482**
Court Family Conference	143	114	58	106	104	**107**	**86**	**36**	**754**
Dispositional Hearing	42	38	25	14	33	**20**	**23**	**15**	**210**
Status Hearing	227	235	167	156	194	**190**	**202**	**96**	**1467**
Permanency Hearing	117	123	117	135	111	**90**	**88**	**45**	**826**
Other	82	60	44	25	29	**18**	**31**	**2**	**291**
Unknown	0	2	10	21	17	**19**	**15**	**9**	**93**
Total JCAP Referrals	910	749	626	726	672	**602**	**581**	**257**	**5,123**

*Denotes only 6 months of the Fiscal Year

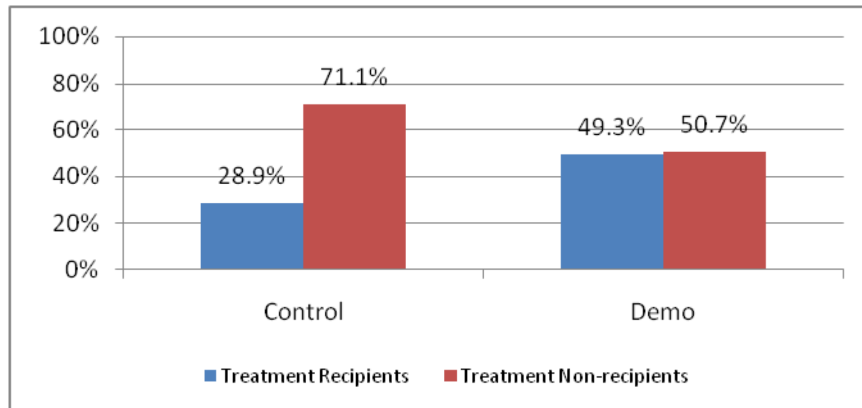
Judges, court personnel and child welfare workers refer clients to JCAP for AODA assessments not only to determine the level of care and arrange an intake appointment for a client with a known substance abuse problem, but also to rule out a substance abuse issue for clients where this has not yet been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

Follow Referrals to Treatment	**FY-05**	**FY-06**	**FY-07**	**FY–08**	**FY-09**	**FY–10**	**FY-11**	**FY-12**
Successful Treatment Appointments	432	380	322	370	316	292	277	116
	78%	72%	73%	76%	75%	70%	65%	66%
Placed on Waiting List	33	17	16	9	6	5	4	2
Referred and refused Treatment	30	43	28	33	52	52	79	32
Pending Medical/Psych Clearance	19	32	18	23	24	28	33	8
Other	31	53	56	53	63	33	33	17
Missing Data	7	0	0	0	0	8	0	0
Sub-total	552	525	440	488	461	418	426	175
Treatment not Indicated	358	224	186	238	211	184	155	82
Total	910	749	626	726	672	602	581	257

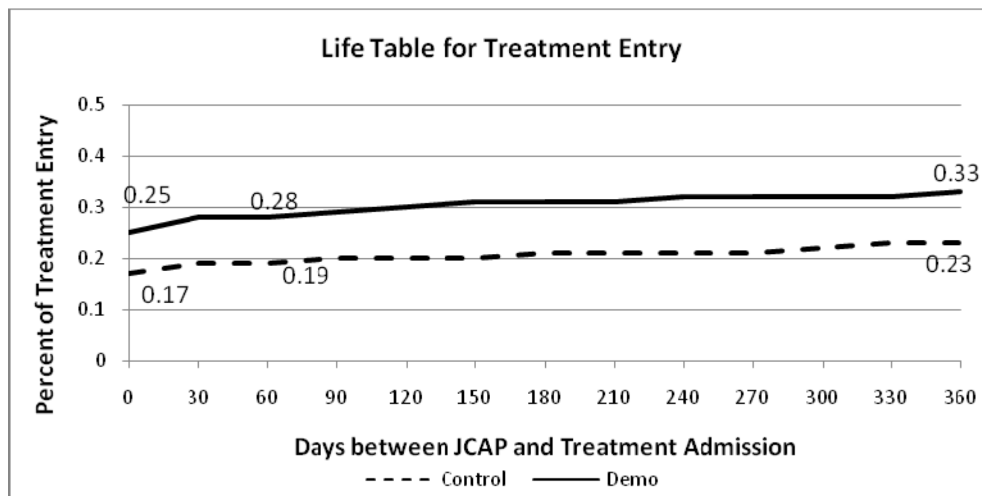
*Denotes only 6 months of the Fiscal Year

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

Treatment entry: after JCAP assessment, the JCAP staff follows up with the results of treatment referral. The record of successful referral indicates that the client starts treatment. Among the participants, 49.3% of caregivers in the demonstration group enter treatment, and 28.9% of caregivers in the control group enter treatment. There is significant difference on treatment entry between demonstration group and control group.



Time to enter treatment: To ascertain the amount of time it takes to enter treatment, we calculate the time (in days) from JCAP assessment date to the first AOD treatment admission date. To understand the relationship between participation in the demonstration group and the timing of treatment entry, 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. On each of their own JCAP assessment dates, 25% of caregivers in the demonstration group enter treatment, and 17% of caregivers in the control group enter treatment. For caregivers in the demonstration group, 28% of them enter treatment within two months (60 days), and 33% of them enter treatment within twelve months (360 days). Comparatively, only 23% of caregivers in the control group enter treatment within twelve months (360 days).



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

Treatment Status

III. Status of Demonstration

A. Services provided:

At the close of the most recent quarter (3/2012),
The Recovery Coach Program (RCP) active caseload included 394 IV-E cases. The following section describes the monitoring status of all clients active at the end of the quarter. Table 2 below provides a breakdown of treatment status for clients by county.

Of the 302 RCP parents served in Cook County, 28% were in treatment, 34% completed treatment, 20% were pending initial engagement in treatment, 11% were pending re-engagement into treatment, and two clients had no current status.

Of the 30 clients served in St. Clair County, 40% were in treatment, 30% completed treatment, 7% were pending initial engagement, and 23% were pending re-engagement into treatment.

Of the 62 clients served in Madison County, 38% were in treatment, 18% completed treatment, 10% were pending initial engagement, and 19% were pending re-engagement into treatment.

Table 2: Active Clients Monitoring Status by County

County	In TX	Completed TX	Pending Initial Engagement	Pending Re-engagement	No Status
Cook n=302	86 (28%)	104 (34%)	58 (20%)	53 (11%)	2 (0%)
St. Clair N=30	12 (40%)	9 (30%)	2 (7%)	7 (23%)	0
Madison n=62	26 (42%)	11 (18%)	6 (10%)	19 (31%)	0

Length of Stay (LOS)
Sixty-three percent of RCP clients active at the close of the quarter had participated in a level of substance abuse treatment (see Table 3 below). Of the 200 Cook County parents who participated in substance abuse treatment, the average length of stay was 330 days. Of the 21 parents engaged in substance abuse treatment in St. Clair County, the average length of stay was 261 days. And in Madison County, 37 parents engaged in substance abuse treatment for an average of 196 days.

Table 3: Active Client Length of Time in Substance Abuse Treatment by County

County	<=90 Days	91-180 Days	181-365 Days	>=366 Days
Cook (n=200)	**42 (22%)**	**30 (16%)**	**51 (27%)**	**65 (35%)**
St. Clair (n=21)	**3 (14%)**	**6 (29%)**	**7 (33%)**	**5 (24%)**
Madison (n=37)	**9 (24%)**	**8 (22%)**	**16 (43%)**	**4 (11%)**

Recovery Support Services

Clinical Program Enhancements:

Beginning in January of 2007, 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. As evidenced in the final report from the independent evaluator, there are three principal areas in which enhancement of service delivery should have a positive impact on permanency and reunification rates: 1) *housing*, 2) *mental health*, and 3) *domestic violence*.

Recovery Coaches are able to access substance abuse treatment for parents, communicate with treatment providers and relay information from treatment providers to interested parties. Yet, it had been found that when a client had additional service needs such as mental health, domestic violence or housing, the likelihood of reunification decreased. For the first five years of the program design, Recovery Coaches identified these issues and made recommendations to the caseworker and the court. At times delays in linking clients to these services had occurred, and delays had the potential to negatively impact parents' ability to access needed support and assistance.
Due to the ongoing, individual relationship that they have established with the parents, Recovery Coaches are well positioned for ongoing assessments of their clients' needs above and beyond substance abuse treatment. With Recovery Coaches being able to make more timely referrals specifically concerning mental health, housing, and domestic violence, the program will be able to respond more quickly to these critical barriers to recovery and reunification.

As of September 2007, the Recovery Coaches in Cook County implemented a quarterly Clinical Client Services review packet. The packet consists of screening tools developed to identify non-substance abuse client issues. Specifically the packet consists of a Domestic Violence Screen, Mental Health Screen and a Housing screen, also included in the packet is the Master Recovery plan. The Master Recovery Plan is a TASC clinical tool that incorporates client and staff input to develop and implement service delivery. The Recovery Coach Staff is currently using this packet to identify service needs and to initiate referrals in these areas. This reflects the expanded service delivery protocol. The Recovery Coaches in Cook County have started to see an increase in clients receiving these ancillary services and feedback from clients has been positive overall.

- *Increased Access to Housing Resources*. Inadequate and/or unsafe housing is a barrier to reunification, and in some instances to recovery. The enhanced *RCP* model includes increased access to DCFS housing related resources, including Norman housing assistance and Reunification funds, which are available for families in the process of reunifying. In addition to increasing access to DCFS resources, the *RCP* has expanded its efforts to identify other local housing resources that can be accessed for clients.

- *Increased Mental Health Services.* The enhanced model includes increased Recovery Coach expertise and involvement in mental health services for *RCP* clients. In January 2007, TASC hired a Clinical Supervisor with mental health and substance abuse expertise to lead a specialized Dual Diagnosis Team and to work with current MISA coaches to supervise mental health service delivery in Cook County. This team consists of 5 mental health workers. TASC has hired a contractual Clinical Case Consultant, who evaluates cases with mental health issues and provides

recommendations and support. The Mental Health team has assumed responsibility of intake and case assignment. This has increased the level of consistency in case assignment and clinical assessment. In addition, a mental health screen was developed and implemented as a part of the waiver extension. All new clients are screened using this tool and all existing clients have been screened as of August 2007. These screenings take place every three months.

- *Domestic Violence Services.* Domestic violence is another significant barrier to reunification for the parents of the *RCP*, as well as to overall achievement of the program's permanency goals. In reviewing program evaluation data to date, and through interviews with current Recovery Coaches, it is hypothesized that this issue will be most effectively addressed through two areas: improved assessment of the parent, and increased Domestic Violence training for Recovery Coaches. A protocol has been developed and implemented for service delivery. Recovery coaches have been trained to utilize the DCFS Domestic violence screen on all parents to assist them in identifying both victims and batterers. If a parent is found to have issues of domestic violence, the Recovery Coach is to notify the DCFS worker to ensure a direct referral is made to a service provider.

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 January 1, 2012 and March 30, 2012.

Table 5 below provides a summary of mental health, domestic violence, and housing services provided to RCP clients active at the close of the quarter.

Table 5: Active Client Recovery Support Services by County

County	RSS Service	In Service	Completed Service	Pending Initial Engagement	Pending Re-engagement
Cook n=42	Domestic Violence	3	6	1	1
	Mental Health	10	15	3	3
	Housing*	0	2		
St. Clair n=14	Domestic Violence	0	3	0	1
	Mental Health	6	3	1	0
	Housing*	1	0		
Madison n=79	Domestic Violence	4	8	16	2
	Mental Health	15	12	16	6
	Housing*	2	0		
RSS Total		**41**	**49**	**37**	**13**

***Referral Only**

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.

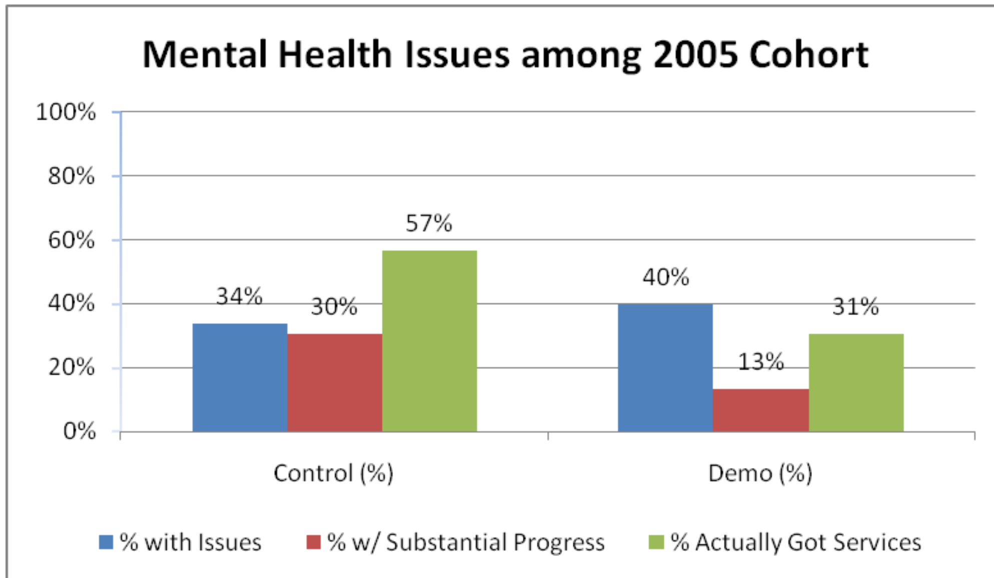
Process Indicators since July 2007 (date of expanded waiver demonstration)

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. We select the 2005 admission cohort to represent the cases admitted before the waiver expansion date, and select the 2008 admission cohort to represent the cases after the waiver expansion date. We followed the periodical TRACCS forms of both cohorts within two years since the JCAP assessment date.

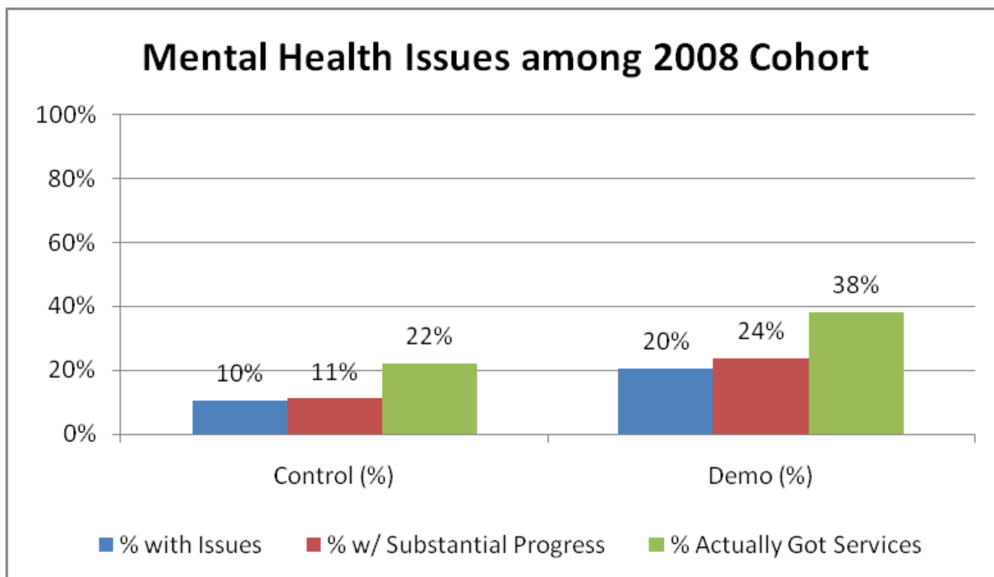
In terms of mental health issues, the demonstration group in 2005 admission cohort (July 2007) had a higher percentage of caretakers with mental health issues than the control group (i.e., 40% vs. 34%). For 2008 admission cohort, the demonstration group still had higher percentage of caretakers

with mental health issues than the control group (i.e., 20% vs. 10%). For 2005 admission cohort, a lower percentage of clients with mental health issues in the demonstration group actually got services compared to the control group (i.e., 31% vs. 57%). In contrast, for 2008 admission cohort, a higher percentage of clients with mental health issues in the demonstration group actually got services compared to the control group (i.e., 38% for the demonstration and 22% for the control group). For 2005 admission cohort, the expanded waiver, the demonstration group had a lower percentage in terms of individuals making at least substantial progress (i.e., 13% vs. 30%) in mental health treatment. For 2008 admission cohort, a higher percentage of clients with mental health issues in the demonstration group actually made at least substantial progress (i.e., 24% for the demonstration and 11% for the control group).

2005 Admission Cohorts:

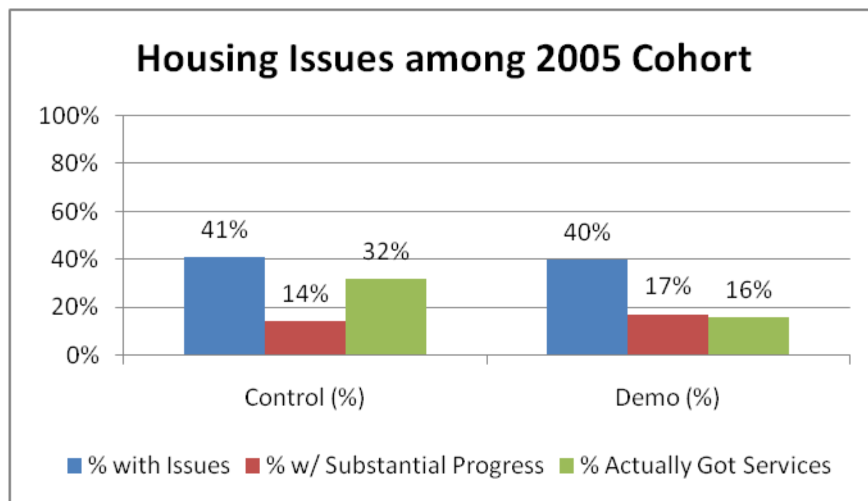


2008 Admission Cohorts:

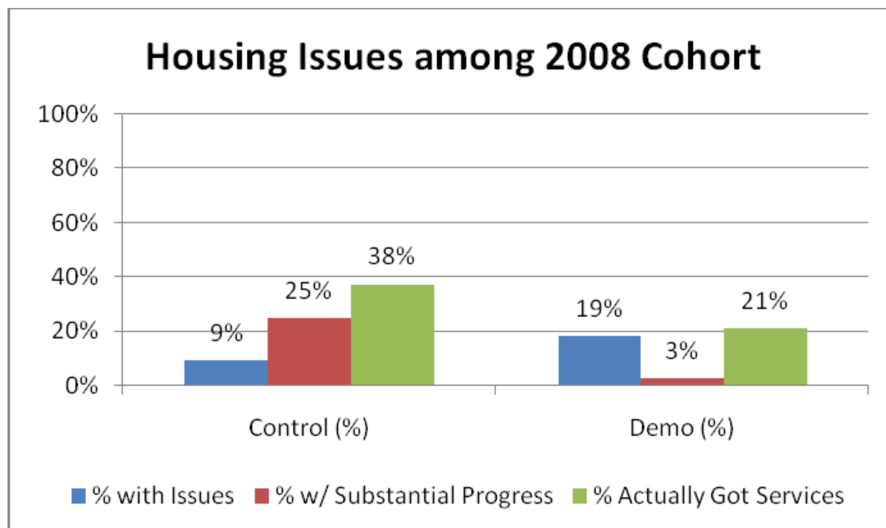


In terms of housing issues, the demonstration group in the 2005 admission cohort had a slightly lower percentage of caretakers with housing issues than the control group (i.e., 40% vs. 41%). For the 2008 admission cohort, the demonstration group had a higher percentage of caretakers with housing issues than the control group (i.e., 19% vs. 9%). For the 2005 cohort, a lower percentage of clients with housing issues in the demonstration group actually got services compared to the control group (i.e., 16% vs. 32%). For the 2008 cohort, still a lower percentage of clients with housing issues in the demonstration group actually got services compared to the control group (i.e., 21% vs. 38%). For the 2005 cohort, the demonstration group had a higher percentage in terms of individuals making at least substantial progress (i.e., 17% vs. 14%) in housing. In contrast, for the 2008 cohort, the demonstration group had a lower percentage in terms of individuals making at least substantial progress (i.e., 3% vs. 25%).

2005 Admission Cohorts:

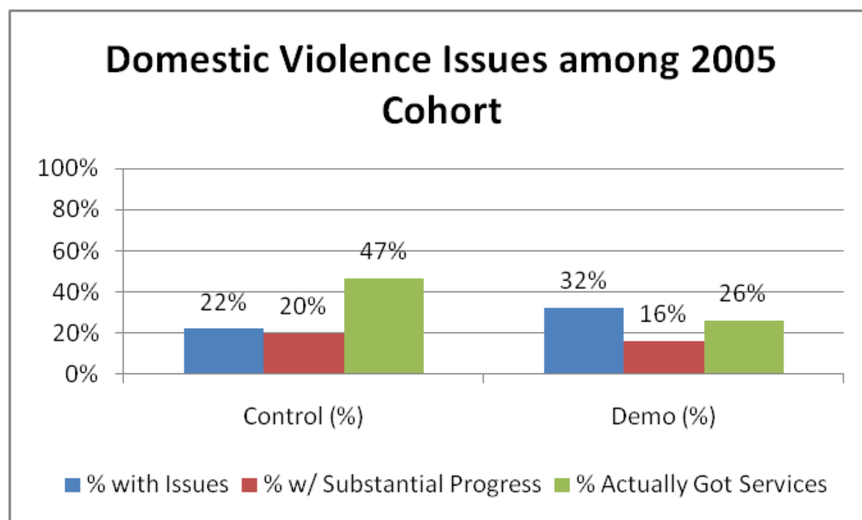


2008 Admission Cohorts:

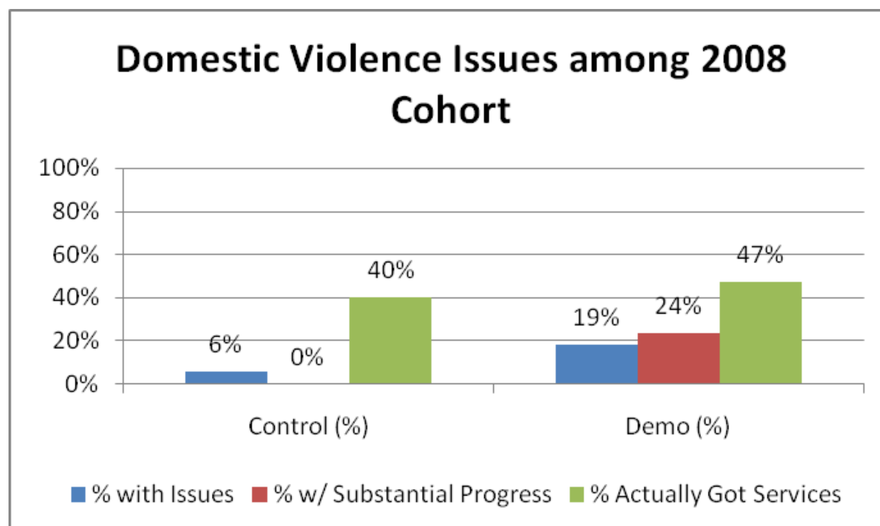


In terms of domestic violence issues, the demonstration group in the 2005 cohort had a higher percentage of caretakers with domestic violence issues than the control group (i.e., 32% vs. 22%). For the 2008 cohort, the demonstration group still had higher percentage of caretakers with domestic violence issues than the control group (i.e., 19% vs. 6%). For the 2005 cohort, a lower percentage of clients with domestic violence issues in the demonstration group actually got services compared to the control group (i.e., 26% vs. 47%). For the 2008 cohort, a higher percentage of clients with domestic violence issues in the demonstration group actually got services compared to the control group (i.e., 47% vs. 40%). For the 2005 cohort, , a lower percentage of clients with domestic violence issues in the demonstration group made at least substantial progress in domestic violence compared to the control group (i.e., 16% vs. 20%). In contrast, for the 2008 cohort, a higher percentage of clients with domestic violence issues in the demonstration group made at least substantial progress compared to the control group (i.e., 24% vs. 0%).

2005 Admission Cohorts:



2008 Admission Cohorts:



TASC Closing Status and Permanency Outcomes

Between September 30, 2011 and December 31, 2011 Recovery Coaches closed 65 cases. The following section evaluates the RCP termination status by county (Table 7 below).

Cook County closed 52 cases during the quarter. Of these, 10 cases closed successfully in reunification. Of the unsuccessful terminations, nine cases resulted in subsidized guardianship, 12 cases in the termination of parental rights, and 15 closed because TASC RCP was unable to engage the parent, and six terminations were neutral.

During the quarter, St. Clair County closed 5 cases. Of these cases, four cases were terminated because TASC RCP was unable to engage the parent and one case because of the termination of parent rights.

In Madison County, eight cases closed during the quarter. Of these, five cases ended because of the termination of parent rights, two cases were closed because TASC RCP was unable to engage the parent, and one termination was neutral.

Table 7: Closing Status

Status of Case Closings (n =)	Cook (n = 52)	St. Clair (n = 5)	Madison (n = 8)
Successful Discharge / Reunited With Children	10	0	0
Unsuccessful Discharge / Expedited Placement			
Subsidized Guardianship	9	0	0
Termination of Parental Rights / Surrendered Rights	12	1	5
Unsuccessful Discharge / Pre-Permanency			
Unable to Engage Client	15	4	2
Parent Incarcerated	0	0	0
Neutral	6	0	1

Although some clients are unsuccessful discharged from program services, the demonstration group has been able to close these cases quickly in order to expedite the permanent placement of children in home of parent (update) 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. The demonstration group, 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 Demonstration Group was able to close 47% of its cases within three years compared to the Control Group closing only 40% of its cases within three years. The table below shows a comparison between the length of time in which DCFS has officially closed cases between the control and demonstration groups.

Length of Time for Case Closing for Control and Demonstration Groups

April 2000 to December 2011	Control Group		Demo Group	
	Number	%	Number	%
Cases closed within 3 years	260	40%	755	47%
Cases closed within 4 or more years	384	60%	852	53%
Total cases closed	**6446**	**100%**	**1,607**	**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 treatment provider 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 treatment provider 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:

This section provides a six month (July, 2011 through December, 2011) treatment provider profile, including treatment referral outcomes and treatment completion rates.

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:

- Treatment referral outcome: Outcome of referral for Recovery Coach clients.
- Treatment outcome data: number and type of discharge by treatment providers.

Referral to Treatment Outcomes by County and Provider

For the period between July 1, 2011 and December 31, 2011, the Recovery Coach Program made 187 referrals to treatment. Table 8 highlights the number of referrals made to specific treatment providers by county and referral outcome during this reporting period.

During the six-month period staff in Cook County made 105 referrals to treatment, with 96% of the referrals found acceptable for admission by the treatment provider.

Staff in St. Clair County made 44 referrals to treatment, with 55% of the referrals made found acceptable for admission by the treatment provider, though 41% of the client referrals failed to keep their intake appointment.

Staff in Madison County made 38 referrals to treatment during the reporting period, with 97% the clients referred to treatment found acceptable for admission by the treatment provider.

Treatment Discharge Outcomes by County and Treatment Provider

Analysis of substance abuse treatment outcome data indicates that 140 clients were discharged from substance abuse treatment during this 6-month reporting period, with a 48% completion rate statewide. The completion rate for parents discharged from treatment in Cook County was 54%, in St. Clair County 30%, and 42% in Madison County.

- **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 the most recent 6 month period (1/09 – 6/09). As shown in the following table, 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.

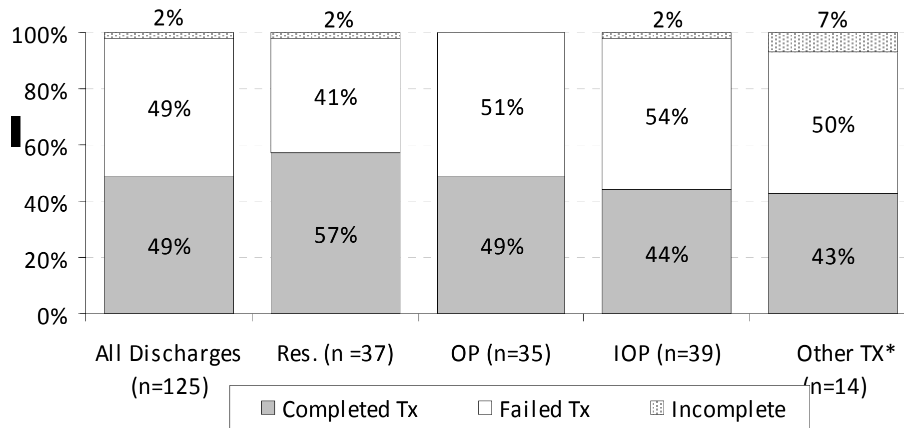
Treatment Discharge Outcomes by County

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

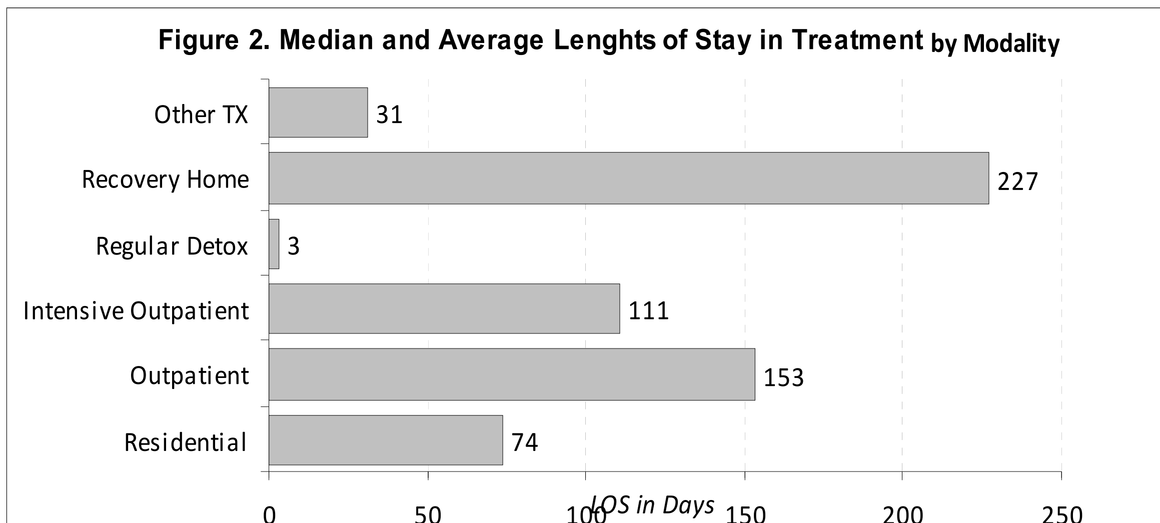
Figure 1 presents reason for discharge by modality. The treatment completion rate was highest among clients discharged from residential treatment (57%), followed by outpatient treatment (49%), intensive outpatient treatment (44%), and other treatment modalities (43%).

Figure 1. Demonstration Group Discharge Outcomes by Treatment Modality



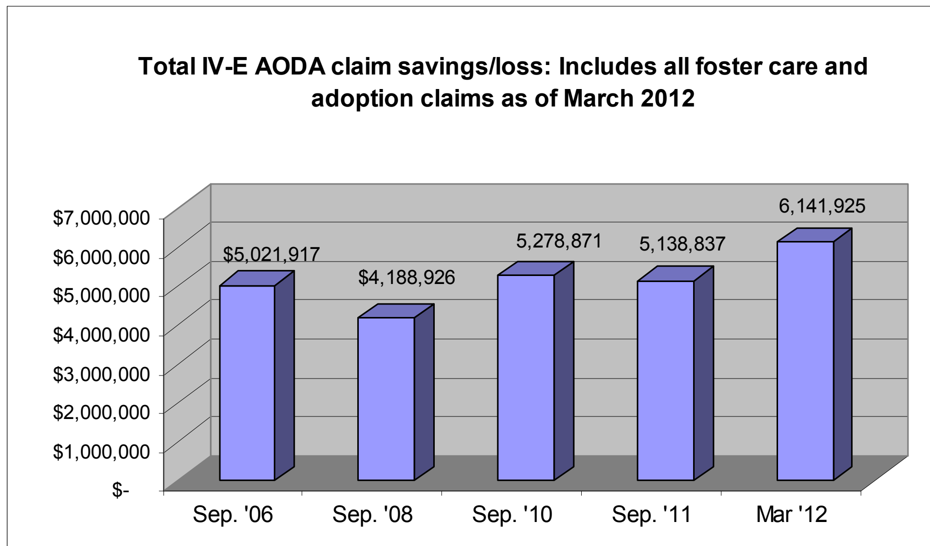
Median Length of Stay in Treatment (LOS)

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).



Cost Neutrality Status

The cost savings generated by the IV-E waiver as of March 2012 is currently $6,141,925.00 and includes the additional costs of the expansion to St. Clair and Madison Counties.



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 two studies focused on (1) whether or not the timing of substance abuse screening relative to the temporary custody hearing matters with regard the likelihood of achieving reunification, and (2) the use of recovery coaches in child welfare (parent level intervention) as a means to decrease the risk of juvenile delinquency (child level outcome).

FAMILY REUNIFICATION AND PERMANENCE

Reunification (administrative data): As of March 31, 2012, 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 – 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 March 31, 2012

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	283	19%	707	23%	990
Home of Adoptive Parent (HAP)	384	26%	890	29%	1274
Subsidized Guardianship (SGH)	78	5%	200	6%	278
Foster Home Adoptive (FHA)	13	1%	25	1%	38
Foster Home Private (FHP)	147	10%	288	9%	435
Foster Home Specialized (FHS)	133	9%	176	6%	309
Home of Relative Foster Care (HMR)	269	18%	544	17%	813
*Institutional Settings	113	8%	232	7%	345
**Other (OTH)	15	1%	41	1%	56
Missing Data	20	1%	16	1%	36
Total	**1,455**		**3,119**		**4,574**

*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 cocaine and mixed drug families, there are no statistical differences. In contrast, for the alcohol and opioid groups, 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 March 31, 2012 for Alcohol Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	48	20%	155	28%	203
Home of Adoptive Parent (HAP)	41	17%	89	16%	130
Subsidized Guardianship (SGH)	14	6%	37	7%	51
Foster Home Adoptive (FHA)	0	0%	1	0%	1
Foster Home Private (FHP)	27	11%	49	9%	76
Foster Home Specialized (FHS)	29	12%	36	7%	65
Home of Relative Foster Care (HMR)	50	21%	115	21%	165
*Institutional Settings	26	11%	55	10%	81
**Other (OTH)	2	1%	10	2%	12
Missing Data	0	0%	5	1%	5
Total	**237**		**552**		**789**

*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 March 31, 2012 for Cocaine Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	75	25%	176	24%	251
Home of Adoptive Parent (HAP)	127	43%	285	39%	412
Subsidized Guardianship (SGH)	16	5%	34	5%	50
Foster Home Adoptive (FHA)	0	0%	7	1%	7
Foster Home Private (FHP)	14	5%	49	7%	63
Foster Home Specialized (FHS)	23	8%	25	3%	48
Home of Relative Foster Care (HMR)	21	7%	93	13%	114
*Institutional Settings	11	4%	50	7%	61
**Other (OTH)	5	2%	15	2%	20
Missing Data	5	2%	0	0%	5
Total	**297**		**734**		**1,031**

*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 March 31, 2012 for Opioids Users

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	39	14%	124	24%	163
Home of Adoptive Parent (HAP)	109	39%	155	29%	264
Subsidized Guardianship (SGH)	18	6%	34	6%	52
Foster Home Adoptive (FHA)	6	2%	5	1%	11
Foster Home Private (FHP)	20	7%	53	10%	73
Foster Home Specialized (FHS)	16	6%	39	7%	55
Home of Relative Foster Care (HMR)	41	15%	68	13%	109
*Institutional Settings	23	8%	44	8%	67
**Other (OTH)	2	1%	3	1%	5
Missing Data	3	1%	2	0%	5
Total	**277**		**527**		**804**

*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 March 31, 2012 for Mixed Drugs Families

Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	48	17%	102	16%	150
Home of Adoptive Parent (HAP)	62	22%	213	34%	275
Subsidized Guardianship (SGH)	14	5%	39	6%	53
Foster Home Adoptive (FHA)	3	1%	10	2%	13
Foster Home Private (FHP)	30	11%	63	10%	93
Foster Home Specialized (FHS)	27	10%	41	6%	68
Home of Relative Foster Care (HMR)	69	24%	121	19%	190
*Institutional Settings	25	9%	36	6%	61
**Other (OTH)	3	1%	6	1%	9
Missing Data	3	1%	1	0%	4
Total	**284**		**632**		**916**

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

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

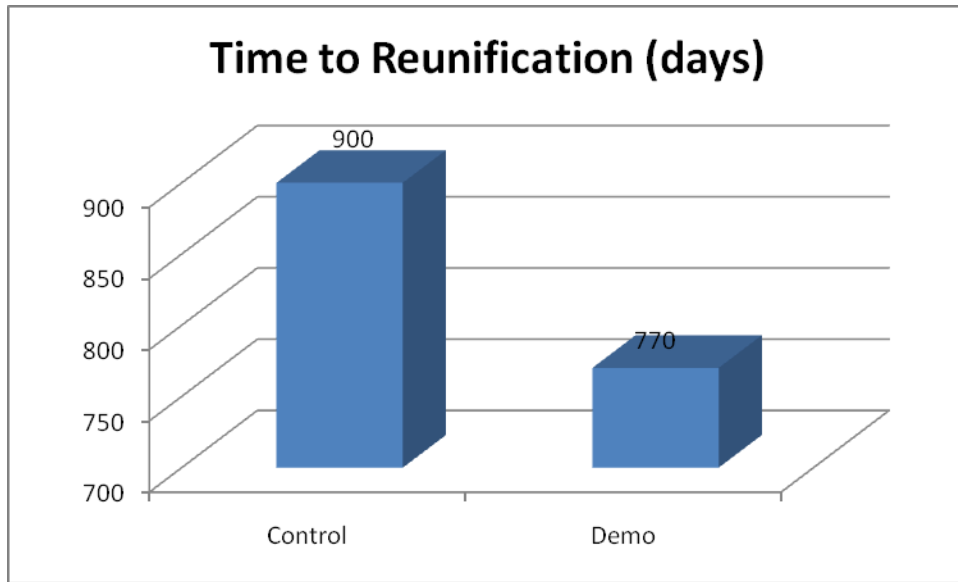
The living arrangement outcomes to date are useful, but as families are joining the demonstration project at various points in time, the reunification estimates might be difficult to understand – as some families have had multiple years to achieve reunification and others only a few months (e.g. families assigned in the beginning of 2012). 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 Jun 30, 2011, we limited our follow-up sample to cases with JCAP assessment dates between April 2000 and Jun 30, 2006. 2,615 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 (24% vs. 18%) and adoption (30% vs. 28%). Consequentially, a smaller proportion of children in demonstration group were still in foster care at the five year mark (15% vs. 23%).

IV-E AODA Children Living Arrangements 5 Years after JCAP Date (for children with JCAP dates between April 1, 2000 and June 30, 2006, N=2,615).

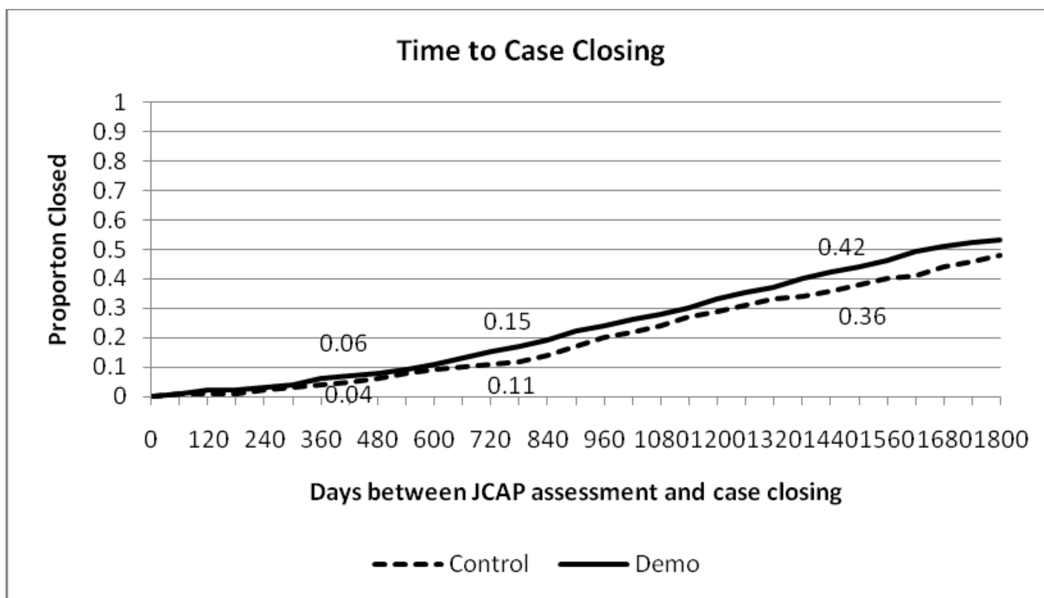
Living Arrangement Type	Control	%	Demo	%	Total
Home of Parent (HMP)	139	18%	441	24%	580
Home of Adoptive Parent (HAP)	212	28%	560	30%	772
Subsidized Guardianship (SGH)	63	8%	133	7%	196
Foster Home	177	23%	285	15%	462
Home of Relative Foster Care (HMR)	94	12%	242	13%	336
*Institutional Settings	44	6%	117	6%	161
**Other (OTH)	34	4%	74	4%	108
Total	763		1,852		2,615

*Includes Group home, hospital/health facility, detention and correction, independent living settings.
**Includes Unauthorized placement, unknown whereabouts, abducted and deceased.

Time to Reunification: The relative likelihood of achieving reunification is important. Perhaps equally important is the time it takes to achieve this goal. The following figure displays the number of days it takes families to achieve reunification. On average, it took 900 days for families in control group to achieve reunification. In contrast, it took 770 days for families in the demonstration group to achieve reunification. That is a difference of 130 days, or 4.3 months.



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), 4% of the control group cases were closed compared to 6% 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, 11% of the control group cases were closed compared to 15% of the demonstration group. At the point of four years later (1440 days) subsequent to the JCAP assessment, 42% of cases in the demonstration closed as compared with 36% of cases in the control group.



Permanency Goals: As of March 31, 2012, 35% of the children in the control group and 35% in the demonstration group had "return home" as their permanency goal. In the control group, 30% of the children appear to be moving towards the termination of parental rights (TPR) and possible adoption vs. 31% 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 (39% in the control vs. 41% in the demonstration group). These differences are not significant.

Permanency Goal	N=1,455	N=3,119	(COLUMN %)	
	Control	Demo	Control %	Demo %
Remain at home	4	8	0%	0%
Return Home w/in 5 months	205	454	14%	15%
Return Home w/in one year	304	614	21%	20%
Return Home pending status of hearing	19	39	1%	1%
SubCare Pending Court Determination	131	327	9%	10%
Adoption providing TPR completed	434	957	30%	31%
Guardianship	144	321	10%	10%
Independence	99	235	7%	8%
No Home, Disability	14	19	1%	1%
29	5	12	0%	0%
Missing	96	133	7%	4%

Extension and Reunification: The AODA Waiver expanded in July 2007. We select the 2005 admission cohort to represent the cases admitted before the waiver expansion date, and select the 2008 admission cohort to represent the cases after the waiver expansion date. We follow reunification records of both cohorts within two years after the JCAP assessment date. The demonstration group in the 2005 admission cohort had a higher reunification rate than the control group (i.e., 18% vs. 13%). For the 2008 admission cohort, the reunification rates of both groups increase. Moreover, the difference between the two groups became larger (i.e., demo vs. control = 22% vs. 15%).

	HMP among 2005 Cohort (%)	HMP among 2008 Cohort (%)
Control	13%	15%
Demo	18%	22%

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 (4.42) and control (4.58) groups. Overall, children experience an average of 4.47 placements.
For the entire population as of March 31, 2012

NUMBER of PLACEMENTS
Control versus demonstration group:

	AODA Group		Statistic	Std. Error
Number of Placements	Control	Mean	4.58	7.88
		Median	3	
		Minimum	1	
		Maximum	133	
	Demonstration	Mean	4.42	7.01
		Median	3	
		Minimum	1	
		Maximum	101	

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 (1,354 days vs. 1,369 days).

For the entire population:

Time in Placement

Mean	1358.38
Median	1,172
Minimum	1
Maximum	4,063

Control versus Demonstration group:

	AODA Group		Statistic	Std. Error
Time in Placement, Days	Control	Mean	1,368.84	926.70
		Median	1,172	
		Minimum	10	
		Maximum	4,027	
	Demonstration	Mean	1353.66	899.33
		Median	1,172	
		Minimum	1	
		Maximum	4,063	

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 parents 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 %
Sexual Abuse	0	0
Physical Abuse	1	1
SEI	8	9
Neglect	3	2
Risk of Harm	7	8
None	81	80

Brief Summary of Additional Illinois AODA Research Reports Completed in 2012

Recovery Coaches and Engagement in Child Welfare: Timing Matters

Parental substance abuse significantly decreases the likelihood of achieving family reunification in child welfare. Historically, the relationship between substance abuse and long stays in foster care was explained by insufficient treatment options. Yet even when parents in the child welfare system receive priority access to treatment facilities, reunification rates remain low. What else might help explain this relationship? In the current study we focus on the timing of family engagement. Specifically we explore the timing of substance abuse screening relative to the temporary custody hearing- and we investigate whether or not timely screening matters with regard to the delivery of an intervention designed to engage families, speed up recovery and increase the likelihood of achieving reunification.

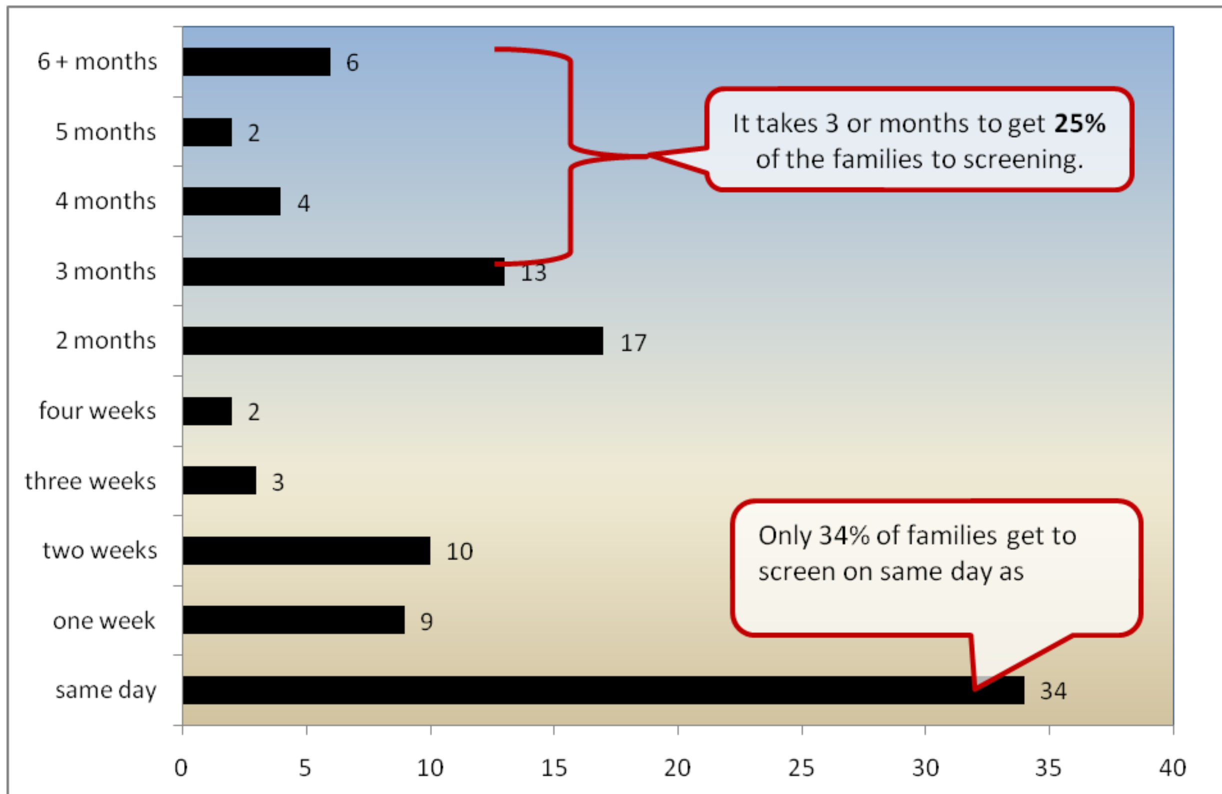
Methods: The current study is longitudinal and utilizes an experimental design. Because we are interested in estimating the likelihood of families achieving reunification (something that often takes considerable time), we limit our sample to include only those families that were enrolled in the Illinois Title IV-E AODA Demonstration Waiver prior to January 1, 2009. This sample selection process provides all families at least three years to achieve reunification. As of January 1, 2009, 1,792 families were associated with the waiver demonstration, 507 (28%) assigned to the control group and 1,285 (72%) assigned to the demonstration group. Families in the demonstration group received traditional services plus the services of a recovery coach. We display descriptive statistics and use chi-square analyses to investigate potential differences between the experimental and control groups. We then present a frequency bar graph (to display the time between temporary custody and screening) and a bar graph generated from cross tabulations (to display the relationship between the effectiveness of the recovery coach model and the timing of JCAP screening).

Results: For many families, a significant delay exists between the temporary custody hearing and the screening for substance abuse problems. Specifically, 25% of the 1,792 families associated with the waiver demonstration, at least three months pass before the initial screening for substance abuse is completed. Thirty-four percent of the families are screened on the same day as their temporary custody hearing. The timing of screening matters with regard to the effectiveness of the Recovery Coach intervention. When families are screened and connected with the waiver demonstration within two months from the temporary custody hearing – Recovery Coach services significantly increase the likelihood of achieving reunification.

The random assignment procedures worked, in that there were no differences with regard to any parent or child characteristics. There were no differences with regard to race, age at JCAP, employment status in the home, primary substance of choice, number of siblings, housing problems or parental mental health problems. With regard to the timing of assessment, there is considerable variation with regard to how much time (in days and months) elapse between the temporary custody hearing and the substance abuse screen at JCAP (see Figure 1). Ideally, parents get screening at the temporary custody hearing. Currently, this happens 34% of the time. One quarter

of all families don't get screened within the first three months post temporary custody. The question that emerges from this figure is – does it matter? Does the success of the intervention depend on the timing of assessment?

Figure 1.



To answer the question of "does it matter" we create two additional figures that compare the effects of the recovery coach model by the timing of assessment (see Figures 2 and 3).

Figure 2.

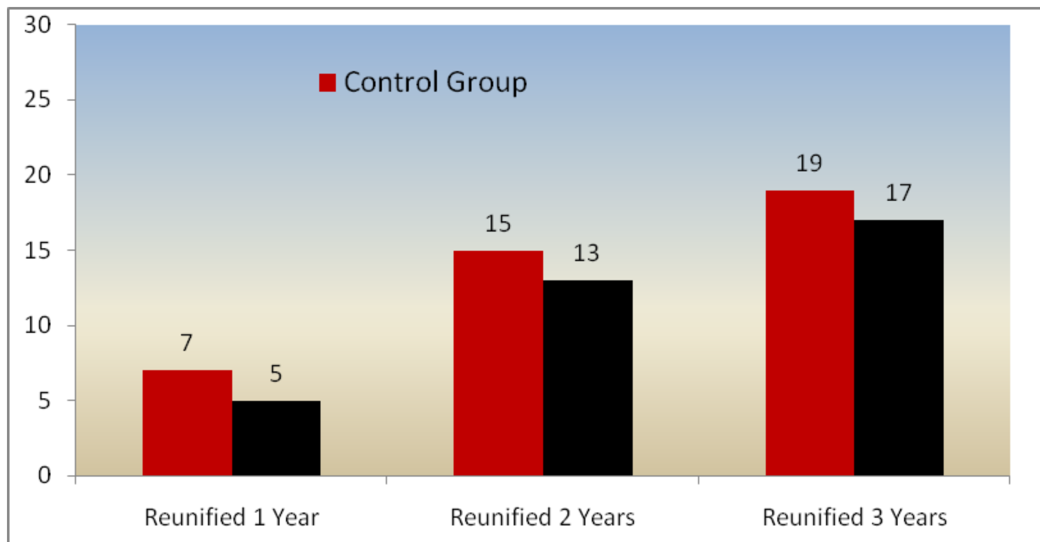
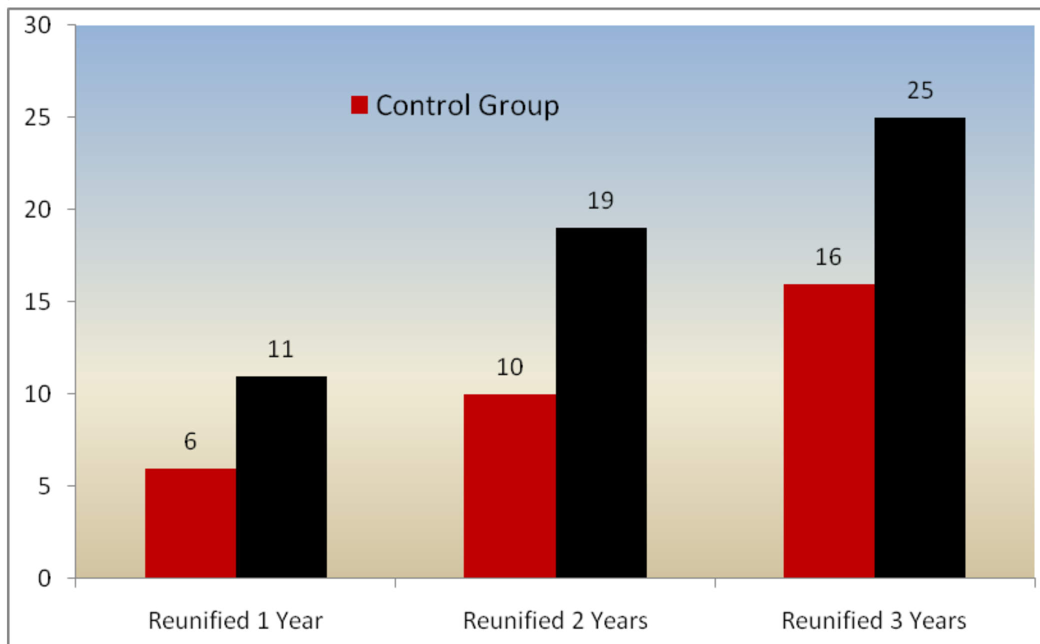


Figure 3.



The figures clearly indicate that timing does matter. Figure 2 represents the reunification rates (at 1, 2 and 3 years) for those families that were not screened for at least three months (25% of all families). You will note that the reunification rates are nearly identical for these families. The bars may look to favor the control group, but these differences are statistically non-significant. Figure 3 represents the reunification rates (again at 1, 2 and 3 years) for the families that were screened within two months. You will note that the demonstration group (families assigned to work with recovery coaches) are more likely (statistically significant) to achieve reunification.

Conclusions: Early engagement matters in the use of Recovery Coaches in child welfare. Although the overall effectiveness of the Recovery Coach model has been demonstrated in previous reports/publications, the effectiveness of this model diminishes (and in fact vanishes) as the time

between the temporary custody hearing and the formal screening/referral process increases. Looking forward, the field needs to better understand how to engage families (i.e. screen, connect with workers, connect with service providers) as close to the temporary custody hearing as possible.

Recovery Coaches in Child Welfare: Decreasing Juvenile Delinquency by Addressing Parental Substance Abuse

Parental substance abuse presents a major challenge to child welfare and public health systems. Substance abuse compromises parenting practices and jeopardizes the healthy development of children in the home. Among other adverse child outcomes, prior research clearly documents the increased risk of juvenile delinquency associated with long term parental substance abuse. The objective of the current study is to evaluate the use of recovery coaches in child welfare (parent level intervention) as a means to decrease the risk of juvenile delinquency (child level outcome).

METHODS: The current study is longitudinal and utilizes an experimental design. Studying the AODA data, we limit our sample to include only those children that were reunified with their biological parents. We also limit the sample to include only those youth that are realistically eligible for a delinquency petition in the juvenile court. The juvenile delinquency (official arrests) data run through March 2012. We selected youth that were at least 12 years of age as of March 31, 2012. Of the total sample (n=453), 136 (30%) were associated with the control group and 317 (70%) were associated with the experimental (recovery coach) group. Families in the experimental group received traditional services plus the services of a recovery coach. We display descriptive statistics and use chi-square analyses to investigate potential differences between the experimental and control groups. We use survival analysis (SPSS Cox Regression v.14) to examine the influence of individual variables on survival rates.

RESULTS: Of the 453 reunified youth associated with the waiver demonstration, 19% of the control group and 9% of the experimental group were associated with a subsequent juvenile arrest. Cox proportional hazards modeling indicates that youth in the experimental group were significantly less likely to be associated with an arrest subsequent to temporary custody.

Descriptive Statistics and Chi-Square Analyses: In the larger waiver demonstration, the random assignment procedures worked, in that there were no differences with regard to any parent or child characteristics. However, in the current study we focus only on those families that achieved reunification. We compare the groups to better understand (and control for) differences that may now exist. Indeed, there exist a few significant differences between the youth in the

experimental and control groups (see Table 1). The experimental group has slightly more males (46% v. 41%) and was less likely to be associated with housing problems (65% v. 72%). The experimental group was also spent less time in a substitute care setting (822 days v. 1,092 days). Basically, reunification is achieved in significantly fewer days for the families associated with the recovery coaches. There were no differences with regard to race, age at JCAP, employment status in the home, primary substance of choice, number of siblings or parental mental health problems.

Table 1

Comparison of Experimental and Control Group (n=453)

Characteristic	**Experimental Group (*n* = 317)**	**Control Group (*n* = 136)**
	%	%
African American	76	79
Male	46	41
Employed	21	22
Primary Substance Alcohol	33	28
Housing is an issue	65	72
Parent has mental health issue	55	52
Parenting skills an issue	69	73
	N	N
Length of time in substitute care (days)	822	1092
Average number of children in home	3.9	4.2
Average age at JCAP (years)	8.1	7.9

Survival Analysis: The results from the Cox regression are displayed in Table 2. The table includes the coefficient and standard error for each independent variable as well as the hazard ratio. A hazard ratio greater than 1 indicates a higher likelihood of a juvenile arrest. A hazard ratio less than 1 indicates a lower likelihood of a juvenile arrest. If 1 is subtracted from the hazard ratio and the remainder is multiplied by 100, the resultant is equal to the percentage change in the hazard of arrest. Of the 453 youth, 56 (12.4%) are associated with a juvenile arrest after JCAP (19% control group v. 9% experimental group). The Cox regression model includes caregiver and youth characteristics, and random assignment group.

We find that five variables help explain the likelihood of a juvenile arrest. Older youth (at the time of temporary custody) and males are significantly more likely to experience a subsequent juvenile arrest. Parents self-identified as primarily alcohol users (as compared with cocaine and heroin users) are significantly less likely to be associated with an adolescent that subsequently gets involved with the juvenile justice system. In contrast adolescents associated with parents identified (by the caseworker) as struggling with parenting skills are more likely to subsequently get involved with the juvenile justice system. Regarding the primary focus of the current study, controlling for other important covariates, youth associated with the experimental group were significantly less likely to be associated with a subsequent juvenile arrest. Specifically, the hazard of arrest decreases by 52% for youth whose parents are working with recovery coaches.

Table 2
Cox regression: Recovery Coaches and Subsequent Juvenile Arrests (n=453)

Independent Variables	B	S.E.	Exp (B)
Child Age	.39**	.05	1.48
African American	.35	.40	1.42
Sex (1=male)	.80**	.29	2.23
Time is substitute care	.01	.01	1.00
Single Parent	-.24	.31	.79
Employed Parent	-.29	.35	.74
Two children in family	.49	.67	1.64
Three plus children in family	.46	.61	1.58
Alcohol is primary substance	-.81**	.38	.44
Housing problems	-.56	.40	.57
Parent MH problems	.62	.35	.79
Parenting skills deficits	.94*	.46	2.56
Recovery coach group (1=yes)	-.74**	.29	.48

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

CONCLUSIONS: The use of recovery coaches in child welfare (i.e. addressing substance abuse at the parental level) significantly decreases the risk of juvenile delinquency. Integrated and comprehensive approaches are necessary for addressing the complex and co-occurring needs of families involved with child protection. The effects of this approach extend beyond the traditional measures of safety and permanency. These additional benefits (in the broader domain of child well-being) should be included in future evaluations and benefit costs analyses - as the savings associated with reduced crime would be substantial.

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 160 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, life tables, and survival analysis to model the effects of specific treatment components on achieving treatment progress and reunification.

Findings:

Predicting Treatment Progress: The results from the regression models are displayed in the Table 1. Only the variable "residential combined" is significantly associated with the probability of making treatment progress. Specifically, compared with mothers who received other treatments (not including residential), the odds of making treatment progress are 9.14 times greater for mothers who received residential treatment combined with other community based transitional services. This odds ratio indicates that, residential treatment is most effective when it is combined with other community based transitional services.

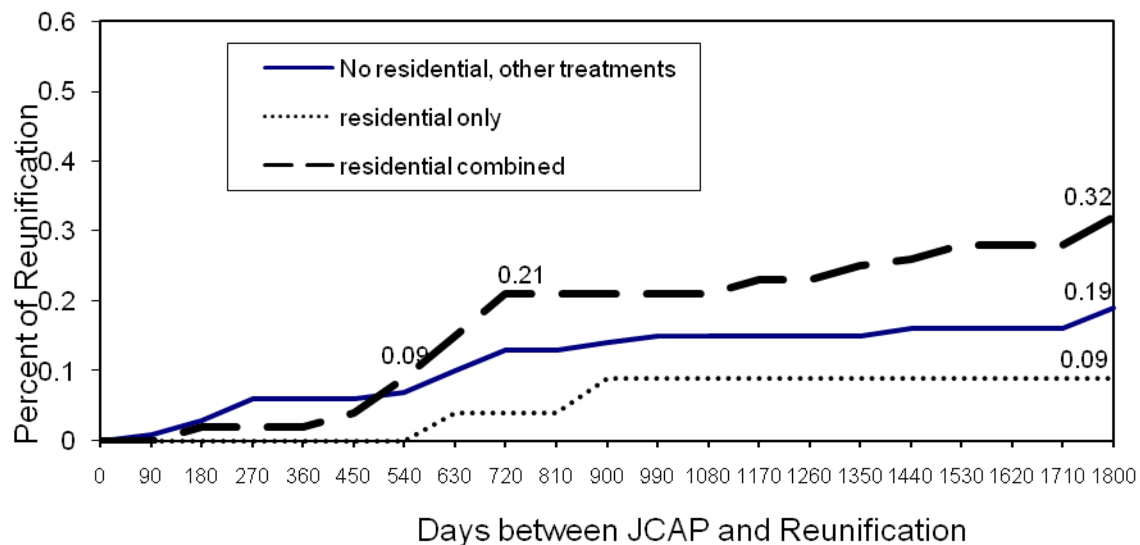
Table 1. Logistic Regression: predicting treatment progress (*n*=160)

Independent variables	b	S.E.	Exp (b)
demographics			
White	.69	.66	2.00
Hispanic	-.30	1.10	.74
Age	-.04	.04	.96
Never Married	-.44	.52	.65
Less than High School	-.42	.43	.66
Co-occurring problems			
Medical Problem	-.45	.45	.64
Mental Health Problem	-.31	.62	.73
Public Assistance	.57	.40	1.77
Prior SEI	-.18	.51	.84
primary drug of choice(reference group: Alcohol and Marijuana)			
Cocaine	-.19	.83	.83
Opioids	.24	.90	1.27
Treatment components (reference group: No residential, other treatments)			
residential only	.78	.61	2.19
residential combined	2.21***	.50	9.14
χ^2, df, p	37.85, 13, <0.01		

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

Predicting Family Reunification: We construct a life table and Cox regression models to understand the timing of family reunification in relation to treatment components. The life table is descriptive and is displayed in Figure 1. The life table presents the cumulative percentages of reunification for the three treatment groups.

Figure 1. Cumulative Proportions of Reunification over Time by Treatment Group



From beginning until the 15th month (represented as beginning to 450 days), parents in the other treatment group achieved highest reunification rate; parents in the residential treatment combined with other community based transitional services group achieved second highest reunification rate; while parents in the residential treatment only group had the lowest reunification rate. After the 18th month (represented as 540 days), nearly 10% of children, whose mothers received residential treatment combined with other community based transitional services, achieved reunification. The reunification rate of this group keeps increasing significantly faster than the other two groups. At the 24th month (represented as 720 days), over 20% of parents in the residential treatment combined with other community based 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 10% of the children, whose mothers got residential treatment only, and less than 20% of the children, whose mothers got other treatments not including residential treatment achieved reunification. From these bivariate analyses it appears that treatment components not only impact the probability for mothers to make treatment progress, but also impact the pace for children to achieve reunification.

The results from the Cox Regression are displayed in Table 2. The regression model focuses on the rates of achieving family reunification. The Exp(b) represents the hazard ratio of achieving family reunification. A hazard ratio greater than 1 indicates a higher likelihood of achieving family reunification, whereas a hazard ratio less than 1 indicates a lower likelihood of achieving family reunification.

Table 2. Cox Regression: predicting the rate of family reunification (n=160)

	Coeff.	SE	Exp(b)
Demographics			
White	-1.19	.72	.30
Hispanic	-12.47	379.28	.00
Age	-.06	.04	.95
Never Married	.030	.52	1.03
< High School	-.659	.38	.52
Co-occurring problems			
Medical Problem	-.18	.43	.83
Mental Health Problem	.07	.61	1.07
Public Assistance	.18	.38	1.20
Prior SEI	-.06	.46	.94
Primary drug of choice(reference group: Alcohol and Marijuana)			
Cocaine	.88	1.08	2.40
Opioids	-.12	1.11	.88
Treatment components (reference group: No residential, other treatments)			
residential only	-2.04*	.87	.13
residential combined	-1.00	.58	.37
Making treatment progress			
Yes	2.75***	.52	15.68
–2 log likelihood		273.33	
χ^2, df, p		55.21, 14, <0.01	

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

The model contains demographic characteristics, co-occurring problems, primary drug of choice, specific treatment components, and treatment progress. The goodness of fit statistic indicates a good model fit (χ^2=55.21, df=14, pb.01). The variable “treatment progress” is significantly associated with family reunification (pb.001). The hazard ratio of achieving family reunification (Exp(b) =15.68) indicates that compared with mothers who failed to make treatment progress, the likelihood of achieving family reunification for mothers who made treatment progress is 15.68 times greater. The variable “residential only” is also significantly associated with reunification. Mothers who received only residential treatment are significantly less likely to achieve reunification as compared with mothers in the other treatment group.

CONCLUSIONS: The current study clearly identifies residential and transitional treatment components as having a significant and positive impact on treatment progress (directly) and family reunification (indirectly). In an economic climate where states are making significant cuts to health and human services, expensive treatment programs such as residential centers for substance abusing parents are likely targets. The empirical evidence presented in the current study indicates that such targeting would be misguided, as residential programs, in combination with less restrictive and less expensive transitional services improve outcomes in both substance abuse treatment and child welfare domains.

Second Generation Families in the Illinois AODA Waiver Demonstration

Second generation individuals refer to people who are currently involved in DCFS as caregivers, and had been involved in DCFS as children during their childhood/adolescence. In the AODA sample, 16% of caregivers (548 out of 3,325) are second generation. The prevalence of second generation individuals varies by county. It is more prevalent in ME counties as compared with Cook County (29% vs. 15%). As shown in the Table 1, there is no significant difference on second generation prevalence between groups in both Cook County and ME counties.

Table 1. the distribution of second generation by county and group

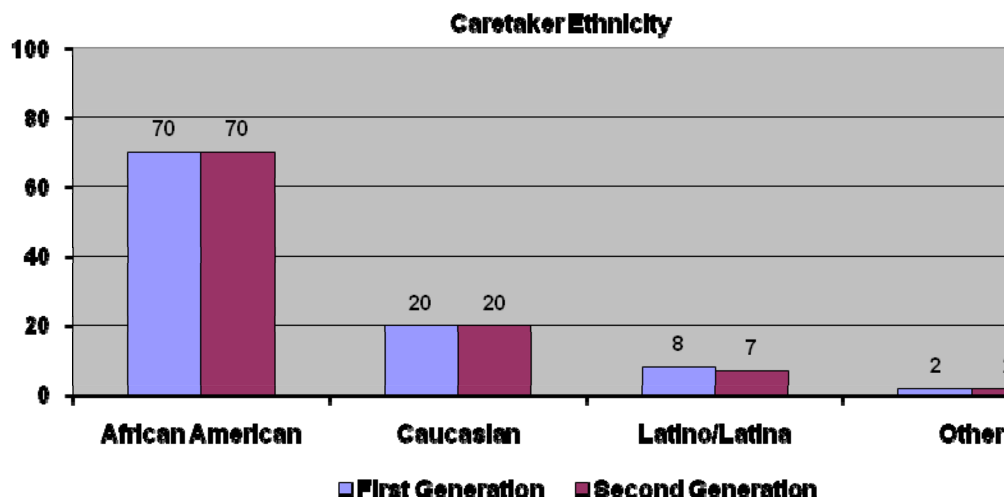
	Control (N)	Demo (N)	Control (%)	Demo (%)
Cook County	129	339	14%	16%
ME Counties	29	51	28%	30%

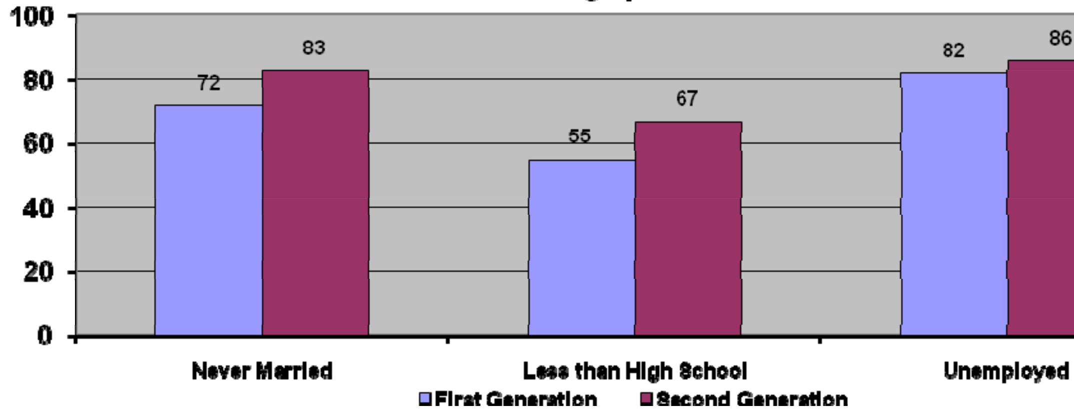
This study aims to compare second generation and first generation (i.e. non-second generation) on their pre- and post-JCAP variables.

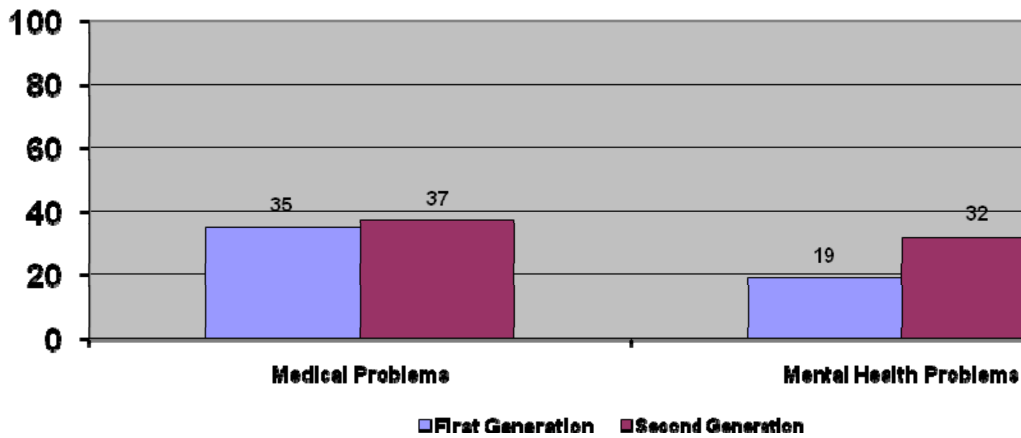
Finding:

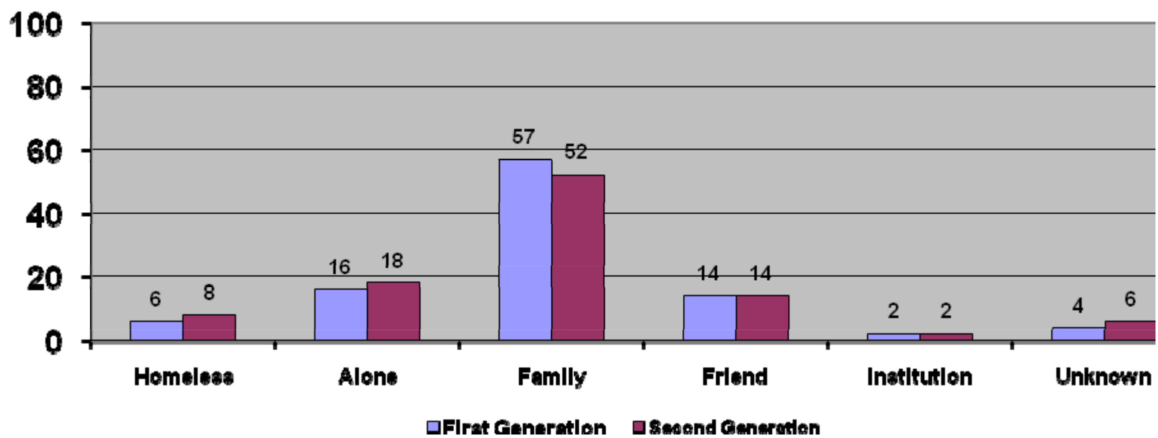
Bivariate analysis: The bivariate results confirm our hypothesis that second generation families experience many more problems at the time of case opening.

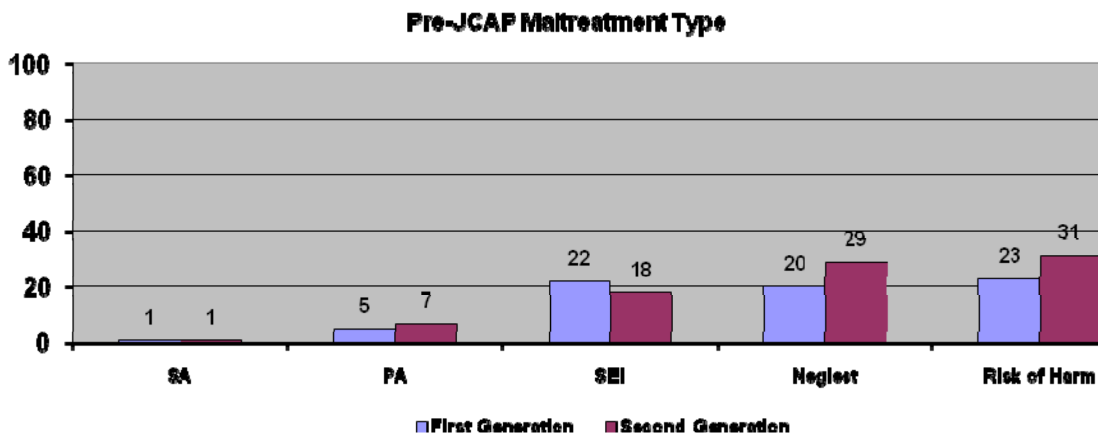
Pre-JCAP caregiver-level variables by generation status:



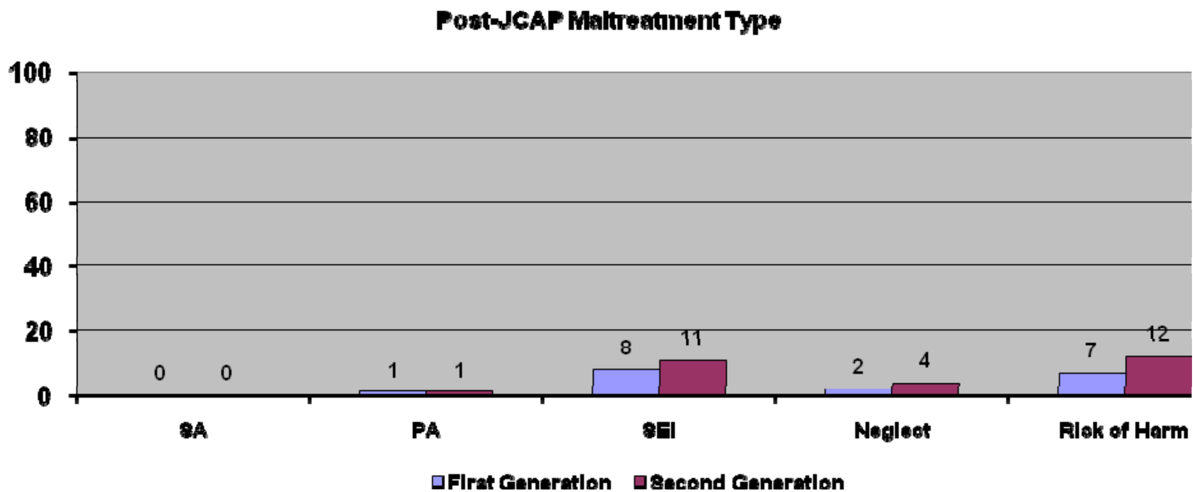

Demographics
100
80
60
40
20
0
72
83
55
67
82
86
Never Married
Less than High School
Unemployed
First Generation
Second Generation


Co-occurring Problems
100
80
60
40
20
0
35
37
19
32
Medical Problems
Mental Health Problems
First Generation
Second Generation


living Arrangement
100
80
60
40
20
0
6
8
16
18
57
52
14
14
2
2
4
6
Homeless
Alone
Family
Friend
Institution
Unknown
First Generation
Second Generation



Post-JCAP caregiver-level variables by generation status:



Logistic regression: We run logistic regression to study the effect of second generation status on reunification. The dependent variable indicates whether the individual achieved reunification with at least one of his/her children within two years after JCAP assessment. As shown in Table 2, we control demographic variables and the variables related to substance abuse in the model. The result shows that second generation is associated with lower likelihood of reunification (Exp(B)=.68). That is, the second generation caregivers are 32% less likely to achieve reunification than the non-second generation caregivers. Some demographic variable are also statistically significant in the model. Specifically, Caucasian are more likely to achieve reunification than African American (Exp(B)=1.33); caregivers with high school level degree or higher are more likely to achieve reunification than those without high school level degrees (Exp(B)=1.26); caregivers of mental health problems are less likely to achieve reunification than those not (Exp(B)=.62). The number of children related to each caregiver is also associated with reunification rate. Each more child is related to 17% increase on the likelihood of reunification. This is understandable, since the reunification variable is aggregated from all children of the same caregiver.

Table 2. Logistic regression (N=3,325)

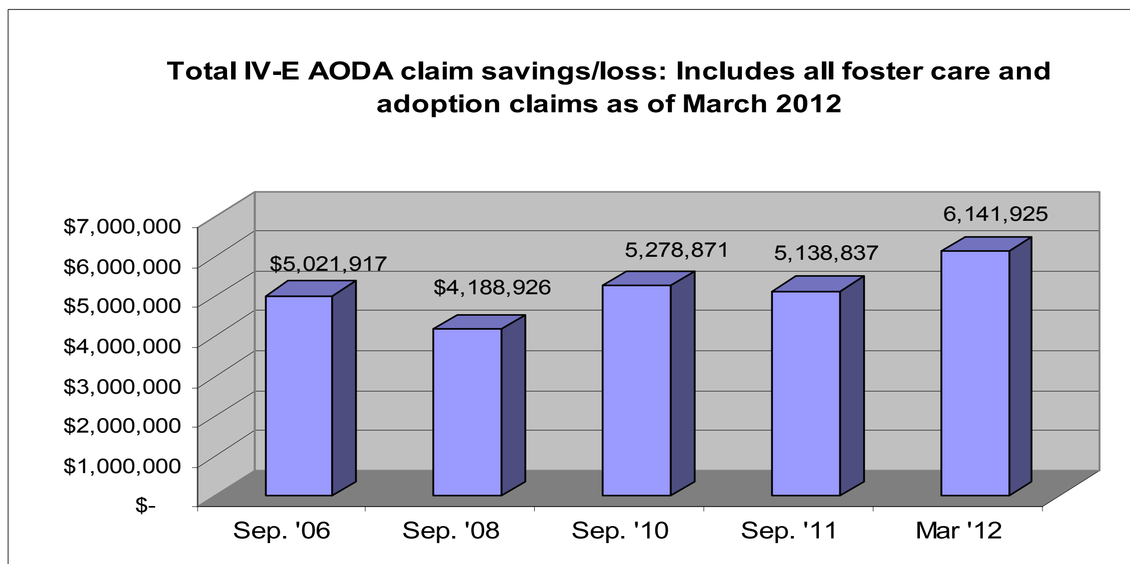
	B	S.E.	Exp(B)
Intercept	-2.14***	.42	.12
Age on jcap date	.01	.01	1.01
Number of children in AODA	.16***	.03	1.17
Female (reference group: male)	.06	.12	1.06
Race (reference group: African American)			
Caucasian	.29*	.13	1.33
Hispanic	.02	.20	1.02
Other	-.08	.37	.92
Medical Problems	.08	.11	1.09
Never Married	-.21	.12	.81
Living Arrangement (reference group: homeless)			
Alone	-.15	.23	.86
Family	-.21	.21	.81
Friend	-.43	.24	.65
Institution	-.68	.45	.51
Unknown	-.01	.31	.99
High School or Beyond	.23*	.11	1.26
Mental Health Problems	-.48***	.15	.62
Primary Drug of Choice (reference group: Alcohol)			
cocaine	.17	.15	1.19
marijuana	.20	.17	1.22
opioids	-.10	.16	.91
other or missing	-.06	.29	.94
Second generation	-.39*	.17	.68
$\chi 2$, df, p	55.32, 19, <.01		

Conclusion: 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

Cost Neutrality Formula

The Illinois waiver demonstration has generated cost savings for the State since 2000. These costs savings have largely been associated with savings from foster care placements. The demonstration group saves money two ways. First, children associated with the demonstration group (assigned to a Recovery Coach) are significantly more likely to return to the home of their biological parent(s). Second, when reunification is achieved, it is achieved in a significantly shorter period of time for children in the demonstration group (on average 4.3 months shorter). As there are several thousand children associated with this demonstration waiver, these two findings create substantial and significant cost savings. We calculate the cost savings associated with foster care (and other substitute care setting placements) as follows: 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. If the actual IV-E cost in the demonstration group is less than generated IV-E claim, then the waiver is cost neutral. As of March 2012, the Illinois AODA waiver demonstration saved $6,141,925. This money can be reinvested in other programs for children and families.



We also recognize that potential cost savings are generated in other child and family outcomes. In the current evaluation we report on the significant reduction in juvenile offending for adolescents associated with the Recovery Coach intervention (9% for youth in the demonstration group as compared with 19% for youth in the control group). There a variety of formulas for calculating savings (in dollars) associated with juvenile crime reduction. Yet the formula described by Cohen (1998) and then again by Cohen and Piquero (2009) in the *Journal of Quantitative Criminology* is considered a gold standard. The authors note that saving one high risk 14 year old from a life of crime generates an estimated cost savings between $2.6 and $5.3 million dollars. Crime is relatively expensive considering the costs associated with a heavy drug user are $370,000-$970,000 and between $243,000 and $388,000 for a high school dropout (Cohen & Piquero, 2009).

Early interventions are seen as generating increased cost savings as antisocial and deviant behaviors that emerge early generally continue from childhood and into adolescence and adulthood. In the current demonstration waiver, the juvenile arrest rate was reduced by approximately fifty percent. Twenty five adolescents associated with the control group were associated with a juvenile arrest. This estimate would be reduced to approximately 12 or 13 adolescents if all the families had received the services of a recovery coach. It is obviously too early to state whether the demonstration saved an adolescent "from a life of crime." It is possible (and likely) that some of these youth will go on to have contact with the juvenile justice and adult correctional system. Yet, these early results are encouraging – as it is likely via reduced time in the foster care system and improved family conditions (e.g. substance abuse, domestic violence and mental health) that several youth will avoid entry into the justice system. Even if the demonstration simply prevented the criminal careers of only three high risk adolescents – such prevention would more than double the current savings to Illinois. In future reports – and as the adolescents associated with this demonstration waiver transition into adulthood – we will track specific costs associated with a range of important developmental milestones such as criminal involvement, college participation, employment and substance use.

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 a final 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 six 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, (5) In looking at broader measures of child well-being, are children in the demonstration group less likely to have contact with the juvenile justice system AND (6) is the Waiver demonstration cost neutral?

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 two additional findings of interest: (1) The timing of screening matters with regard to the effectiveness of the Recovery Coach intervention. When families are screen and connected with the waiver demonstration within two months from the temporary custody hearing – Recover Coach services significantly increase the likelihood of achieving reunification. (2) The use of recovery coaches in child welfare (i.e. addressing substance abuse at the parental level) significantly decreases the risk of juvenile delinquency.

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 final 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. The final report also indicates that minor adjustments to the waiver demonstration can produce even better outcomes for families and generate additional savings for the State.

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