4

Treating AOD Problems: Practices, Innovations, and Effectiveness

The AOD field has begun to address the issues of children and families in treatment programs. Child welfare agencies and workers have not generally been familiar with these changes, however. Some observers familiar with both CWS and AOD systems believe that the AOD field has changed more than CWS in the areas where the two systems interact. Some of these changes were primarily due to the federal and state funding provided to AOD agencies for pregnant and parenting women's treatment programs, since the populations served by those programs overlap to some extent with the CWS population. But what has been missing is a needed connection between CWS and the mainstream of AOD treatment that goes beyond earmarked funding for categorical programs for some CWS clients.

The AOD treatment system is neither a black box of psychotherapies nor a monolithic entity admitting every client into a set treatment protocol involving "substitution" or "detox" medication. Recent developments in assessment and matching protocols have improved client-focused needs assessment and referral to appropriate services. The Center for Substance Abuse Treatment (CSAT) has recently published a report on the diverse strategies used in AOD treatment [CSAT 1997]. This chapter focuses on the most important AOD treatment innovations and suggests how these changes might help forge stronger links between CWS and AOD.

Comprehensive AOD Treatment and Disease Management

As described by the Director of the National Institute on Drug Abuse, comprehensive treatment is a mixture of pharmacological and behavioral therapy approaches that provide the tools for managing the chronic, relapsing disease of alcohol and drug dependence over the

long term [Leshner 1994]. The time period that is emphasized in modern AOD approaches is a critical distinction; continuing disease management is stressed, not one-shot treatment. The disease management approach to drug dependence, in this sense, is similar to physicians managing patients with chronic conditions such as diabetes and hypertension, and is distinct from emergency services administered for acute illnesses.

One recent summary from the behavioral treatment field highlighted the following features of disease management:

- A treatment focus on a costly, chronic condition, disease, or diagnosis;
- A coordinated approach across multidisciplinary treatment teams;
- Use of evidence-based best practices proven to be highly effective;
- An education-intensive orientation that focuses on both patient and provider;
- An approach to care management that emphasizes both clinical efficacy and cost-effectiveness; and
- A method of systematic data collection that is clinically and financially evaluative [Vega 1998].

In contrast, CWS agencies often approach AOD problems from a "one-shot approach" rather than from a longer term disease management perspective. This plays out in practice in at least two critical ways: (1) instituting drug-testing programs, which are used as a measure of readiness to parent, with failed drug tests interpreted as clear markers of "failed" treatment; and (2) in expectations of treatment outcomes and clients' compliance with treatment protocols.

In the AOD treatment field, in contrast, positive drug urine tests are more commonly seen as an indication that a client requires more

structure and intensity in the treatment program. State-of-the-art AOD treatment adjusts the intensity and structure provided to a client based on the client's progress and improved ability to exercise personal responsibility. These adjustments to program intensity are depicted in Table 3, which is adapted from a model developed by Dr. Vivian Brown, CEO of PROTOTYPES, and Dr. George Huber of The Measurement Group from evaluation documents of PROTOTYPES Women's Center in Pomona, California.* PROTOTYPES, Centers for Innovation in Health, Mental Health and Social Service programs include each of the levels of care so that they can respond to differing needs of women and their children.

The American Society of Addiction Medicine (ASAM) has developed patient placement criteria to assess which treatment options and levels of intensity are appropriate for clients [ASAM 1996]. Complete details, explanation, and training on implementing the criteria are available through ASAM.** This range of care allows some clients to participate in treatment services while they are also completing elements in their child welfare plan (e.g., parenting classes) or complying with job participation requirements under TANF. However, it is clear that clients who are more impaired require more intensive levels of care. In addition, clients who are not successful in a specific level of care generally require more intensive services and structure in their treatment plan. Unfortunately, CWS staff unfamiliar with the AOD system often see treatment as a bipolar set of extremes, involving either no-cost 12-step programs or expensive residential treatment.

Determination of the appropriate level of care is made by assessing a client's level of functioning in six life areas:

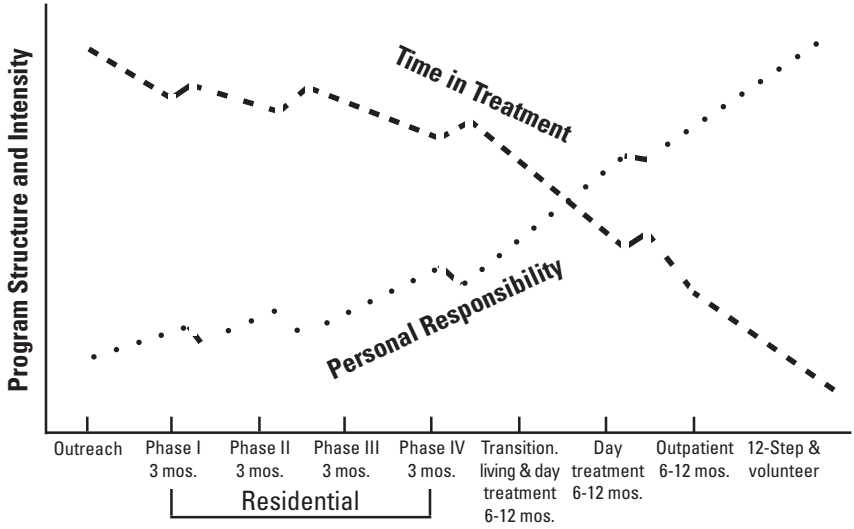
- Acute intoxication and/or withdrawal potential,
- Biomedical conditions,

---

* PROTOTYPES Women's Center, Dr. Vivian Brown, Executive Director. 5601 West Slauson Avenue, Suite 200, Culver City, CA 90230; 310/649-4347.

** The American Society of Addiction Medicine can be contacted at 4601 N. Park Avenue, Suite 101, Chevy Chase, MD 20815; 301/656-3920; e-mail: email@asam.org; URL: www.asam.org).

Table 3. Results of Adjusting Intensity and Severity of Treatment



- Emotional/behavioral conditions and complications,
- Treatment acceptance/resistance,
- Relapse/continued use potential, and
- Recovery environment (family and social situations).

The AOD field has reached some consensus in attempting to standardize treatment according to the levels-of-care distinction. In addition to detoxification services that can be delivered within each of the levels of care, ASAM PPC-2 criteria include three levels of outpatient care and four levels of residential care, as follows:

- Level 0.5 Early Intervention
- Level I Outpatient Services
  - I-D Ambulatory Detoxification without Extended On-site Monitoring

  - I Outpatient Treatment
- Level II Intensive Outpatient/Partial Hospitalization Services
  - II-D Ambulatory Detoxification with Extended On-site Monitoring
  - II.1 Intensive Outpatient Treatment
  - II.5 Partial Hospitalization Treatment
- Level III Residential/Inpatient Services
  - III.1 Clinically Managed, Low-Intensity Residential Treatment (Halfway House; Supportive Living Environment)
  - III.2-D Clinically Managed Inpatient Detoxification Services (Social Detoxification)
  - III.3 Clinically Managed, Medium-Intensity Residential Treatment (Extended Residential Program)
  - III.5 Clinically Managed, Medium/High-Intensity Residential Treatment (Therapeutic Community)
  - III.7-D Medically Monitored Inpatient Detoxification Services
  - III.7 Medically Monitored Intensive Inpatient Treatment
- Level IV Medically Managed Intensive Inpatient Services
  - IV-D Medically Managed Inpatient Detoxification Services
  - IV Medically Managed Intensive Inpatient Treatment

Once in treatment, there are several approaches that are used. The specific therapeutic approaches are generally divided into three categories, with some adding a fourth: (1) physical methods, (2) psychological methods, (3) social methods, and (4) spiritual methods [Coles 1995; Mee-Lee 1995]. The categories are described in Table 4.

The CWS perception of AOD treatment as a one-shot approach affects what child welfare workers expect from their clients. CWS workers at times express their frustration that even when they are

Table 4. Therapeutic Approaches to AOD Treatment

Physical Methods	Psychological Methods	Social Methods	Spiritual Methods
Detoxification	Group, family, and individual psychotherapy	Legal strategies	Religiously oriented self-help groups
Medications	Aversion therapy	Rehabilitation	
Acupuncture	Behavior modification	Social skills training	
		Self-help groups and mutual aid	

able to make the linkage for AOD services for clients, they simply don't comply with treatment. In a recent meeting in a large county, that perception was expressed by an individual who represents children in juvenile dependency court actions. With unconscious irony, she stated, "We know all that research says that treatment is successful, but they just don't stay in treatment." Although multiple failed attempts to stop smoking (and resultant relapses) are readily accepted as common, the public is less willing to tolerate multiple attempts to stop the use of illicit drugs or the abuse of alcohol. We will return to this issue of treatment effectiveness below.

Treatment Innovations

Treatment Outcomes

Over the past decade, under considerable pressure from managed care in the behavioral health arena and other funders of AOD services, the AOD field has changed significantly, developing and implementing systems to evaluate treatment outcomes. Although states and local governments are at different stages of implementation, there has been an implicit consensus reached on the types of outcomes that are desired and measured among AOD agencies serving publicly funded clients. An important development has been the field's acceptance of outcomes in clients' daily functioning as measures of progress that go beyond total abstinence from AOD use. While abstinence is a desired goal, AOD agencies recognize that clients improve their level of functioning in multiple areas of daily living even before they reach abstinence. Obviously, millions of middle-income parents who are not abstinent are deemed adequate parents by society.

Treatment Is About Human Beings

For all the importance of treatment protocols, levels of care, and managed care coverages, it is sometimes possible to lose sight of the reality that treatment is about human beings. The connection between a counselor, a peer helper, an outreach worker, and a person trying to recover from addiction is a profound bond that rests as much on human relationships as on programmatic design. Every day, a good program draws the line between what treatment can do and what an AOD-dependent person must do for herself, and that choice is always mediated by a relationship of trust between two human beings. Assuring that workers in this field have the right training is critical, but assuring that they are good, resilient human beings is equally important, because what they are asked to do is to help individuals and families to change their lives, without any assurances that they will succeed. That these workers do succeed as often as they do is remarkable; that they keep trying to make a difference in the lives of other people is equally remarkable.

Ongoing efforts are identifying optimum measurement techniques and indicators of improved levels of functioning. Currently, the domains that are included in most client-level outcome systems are physical health, social and family relationships, mental health status, legal problems and criminal behavior, and employment/economic self-sufficiency. An important task for both the CWS and AOD fields is to clarify measures related to parenting competency, which have not generally been included in AOD outcomes research.

Managed Care

Although several states have implemented managed care approaches to financing AOD treatment, the vast majority of those states have only included the Medicaid portion of state and federal funding in those financing plans. However, many states and communities have implemented components of managed systems of care, such as matching clients to appropriate levels of care.

As previously discussed, AOD treatment varies in regard to the "intensity" of services delivered and in the degree of structured monitoring provided to the client [Young & Gardner 1997]. There are obvious cost differences between care in a highly structured setting and less intensive outpatient care. As noted in Chapter 1, this can further complicate the AOD-CWS connection, due to the role of managed care companies that can override treatment decisions made by AOD counselors and CWS workers. Authorizations for treatment, the level of care to be provided, and length of stay allowed in managed care settings may be determined by managed care staff who might be less familiar with the case and the special treatment needs of women involved with CWS.

Matching Services to Immediate Needs

A major component of early AOD treatment engagement is understanding the areas of life functioning that are being affected by the client's AOD use. The domains mentioned above are included in a biopsychosocial assessment and are linked to specific services in the treatment plan that address that domain. There is recent evidence that addressing the need that the client perceives as most urgent results in more effective client engagement in the treatment process and leads to better outcomes. The parallel in CWS, of course, is the family preservation worker who engages with a new family by asking what the family perceives as its most important needs, as opposed to simply starting weekly counseling sessions on parenting.

The innovation in AOD services is that, regardless of the level of care that the client is in (residential or outpatient), a comprehensive assessment enables the AOD worker to focus on the area of life that the client perceives as most urgent. Substance-abusing clients come to treatment with a host of interpersonal, legal, medical, financial, and other concerns. Making the connection between the immediate crisis that the client is experiencing and his/her substance use ensures that treatment addresses the reality of the client's related problems, rather than providing treatment in a vacuum that ignores those other issues.

Medications Development

Neurobiology and recent advances in biomedical research technology have developed new knowledge about molecular and cellular mechanisms involved in the disease of AOD abuse. For example, the ability to conduct noninvasive brain imaging has made it possible to study the effect of AOD abuse on the brain to literally "see a brain on drugs." Drug abuse researchers have identified and genetically specified the molecular brain receptors of all major abused drugs. These discoveries are leading to new medications that block the chemical actions of abused substances. At present, medications are available for use with opiate-dependent clients. Methadone has been used effectively since the early 1970s; LAAM (l-alpha-acetylmethadol) was made available in 1993. Naltrexone was approved in 1984 and is also being used in the treatment of alcoholism. Buprenorphine is in the clinical trail stage of development for opiate addiction. The development of medications for cocaine, however, is in its infancy.

Motivational Interviewing

Recent advances in AOD treatment research have repeatedly shown that persons who are coerced to participate in AOD treatment have similar outcomes as those who voluntarily participate in treatment. In fact, some treatment providers have specialized in conducting "interventions" with persons who are not yet able or willing to admit that their AOD use is the cause of substantial family, work, and health-related problems. Intervening with a person who has not yet admitted that he/she is "powerless" over alcohol and other drugs is a primary component of early treatment protocols and allows the individual to move past denial to a willingness to change.

This early work by treatment professionals is sometimes referred to as "raising the bottom," (i.e., not waiting until the client "hits bottom") so that the individual and society do not have to incur the higher costs of continued drug dependence. Ultimately, individual motivation is an important ingredient in recovery, but motivation can be greatly enhanced by AOD professionals providing cognitive, supportive, and behavioral interventions during early stages of recovery.

Much of the understanding of these early phases of treatment is based on work by Prochaska and DiClemente [1985], who proposed that change is a process rather than a discrete event. The change process has been described in phases with distinct goals for working with a client at each phase, as shown in Table 5 [Bell & Rollnick 1996].

Contingency Contracting

The vast majority of clients entering AOD treatment do so with an implicit contingency contract: for example, in response to a spouse's ultimatum ("go to treatment or get a divorce"); as a condition for regaining a driver's license; in order to keep a job; or as the result of "a nudge from the judge," the phrase used by many people in recovery to indicate how they got to mandated treatment. Contingency contracting relies on these and other motivations for a person to seek treatment, promote desired behaviors, and sanction undesired behavior. Critical components of contingency contracting are that the contingencies must be mutually agreed on, carefully monitored, consistently applied, and involve the significant others and institutions connected to the individual [Morgan 1996]. In CWS, this corresponds to the general idea of "differential sanctions," in which clients are rewarded or sanctioned as they progress in compliance with CWS requirements and the severity of their behavior.

The Philosophy and Continuum of Harm Reduction

Although harm reduction is often a lightning rod for debate about legalization of illicit drugs, the basic operating principle of harm reduction is that any positive change in AOD use helps. Harm reduction (HR) draws a distinction between intervention models requiring total abstinence as a prerequisite for access to treatment and those that focus on incremental improvements in lifestyle, which will ideally lead to abstinence and improved parental functioning. Harm reduction strategies seek to reduce the risks associated with AOD abuse and can achieve immediate improvement in individual and family functioning. The goal is to equip substance users to reduce the harm caused by their use to themselves, their families, and their community. Specific targets of HR strategies include improving the user's health sta-

Table 5. Phases in the Change Process

Phase	Aim of Intervention
Precontemplation	To increase the perception of risks associated with substance use by providing information and feedback
Contemplation	Explore the positive and negative consequences of use and tip the balance toward change
Determination	Preparation for change by strengthening the commitment to change by helping the client to determine the best course of action to take
Action	Acknowledge that the client may experience a sense of ambivalence and need a sense of reward for any success achieved
Maintenance	Requires continued vigilance toward the change process and achievement of personal goals
Relapse	Although not desirable, is a normal part of the change process and interventions are geared to minimizing problems associated with lapse or relapse by renewing the commitment to change

tus and reducing family violence, criminal behavior, poor parenting practices, and neglect or inattention to children's needs. Most HR strategies accept abstinence as the appropriate end goal but believe that even for those clients for whom abstinence is not achievable, major changes in life functioning are possible.

Harm reduction strategies are based on a public health approach to AOD problems and include such practices as strict laws against driving while intoxicated, designated drivers, and nicotine replacement patches and gum. For the illegal drugs, harm reduction strategies include decreasing the spread of HIV through needle-bleaching programs, Arizona's example of releasing nonviolent drug offenders with court jurisdiction over treatment compliance, agencies devising a "safety plan" for children with appropriate child care if parents are planning to use alcohol or other drugs, determining if the client's patterns of use could be altered to reduce associated harm, and determining if the method of drug use can be changed to a less harmful method.

Several reviewers of this guidebook commented that harm reduction strategies may be a part of the common ground that could be

expanded as the conceptual bridge between AOD and CWS. From the CWS side, the overwhelming concern for child safety means that reducing potential harm to children is part of the basic mission of the agency. Therefore, a CWS/AOD dialogue about harm reduction can focus on the central issue of reducing harm to children while considering the behavior of parents in treatment and in recovery.

Treatment Effectiveness

Despite 25 years of research documenting treatment effectiveness* and cost offsets derived from AOD treatment [Langenbucher 1994], the perception persists among the public and many policymakers that treatment "doesn't work." Thus, it is necessary to deal with that skepticism in any discussion about expanding treatment services and linking them to the needs of parents in the CWS system.

Effectiveness of Treatment Among the General Population

At the macro level, several recent national- and state-level studies have documented outcomes derived from AOD treatment and have found rates of AOD recovery similar to those of other diseases that require a behavioral change component as part of the treatment regimen. In addition, research conducted by McLellan and his colleagues documented that AOD treatment compliance is comparable to compliance rates among patients treated for diabetes and hypertension, two other chronic diseases requiring major behavioral changes. Less than one-half of diabetics comply with their medication protocols and fewer than 30% of persons with high blood pressure comply with the medication and prescribed diets [McLellan et al. 1995].

CSAT released its National Treatment Improvement Evaluation Study (NTIES) in 1997. The study included more than 4,400 clients

* Two national studies prior to DATOS (described in this report) were the Drug Abuse Reporting program (DARP), which included treatment admissions between 1969 and 1973, and the Treatment Outcome Prospective Study (TOPS), which studied admissions between 1979 and 1981. DATOS included treatment admissions between 1991 and 1993.

in the outcome analysis from 78 treatment centers across the country. Looking for changes in behavior from before treatment to after treatment, they found that drug use was cut by half, criminal behavior was reduced up to 80%, employment significantly increased, homelessness decreased, and there were significant improvements in physical and mental health leading to reductions in medical costs [SAMHSA 1997].

The National Institute on Drug Abuse in 1997 released findings from the Drug Abuse Treatment Outcome Study (DATOS), which tracked 10,000 drug abusers from almost 100 treatment programs who entered treatment between 1991 and 1993 in 11 cities. This is the third national outcome study since 1969. DATOS also used a before-to-after protocol and included four treatment types (outpatient methadone, long-term residential, outpatient drug-free, and short-term inpatient programs). DATOS found that drug use dropped significantly and that there were significant reductions in illegal acts and suicidal thoughts/attempts, while employment increased [Meuller & Wyman 1997]. Research has clearly demonstrated that among clients who are "harder to serve," those who receive "more support services in addition to basic drug abuse treatment were more likely to be abstinent at one-year follow-up than those who received fewer support services" [Anglin et al. 1997].

In addition, several state-level studies have documented the cost offsets that are derived from improving clients' functioning and the resultant decrease in societal costs resulting from AOD treatment.* Specifically, California found that $7 is saved for $1 investment in treatment [Gerstein 1994]; Oregon found that $5.60 in criminal justice, public assistance, health care, and victim and theft losses were avoided for every $1 spent on AOD treatment [Finigan 1996].

Remarkably, however, most analyses of the cost offsets of treatment done in the AOD system have excluded foster care from the

---

* See two compilations of state-level data on treatment effectiveness: Young, N. K. (1994). *Invest in treatment for alcohol and other drug problems: It pays* and Young, N. K. (1996). *Alcohol and other drug treatment: Policy choices in welfare reform*. Both are published and available from the National Association of State Alcohol and Drug Abuse Directors, Washington, DC; 202/293-0090.

calculations of treatment savings. Since much of the AOD research originated with prison populations, researchers have been more focused on cost offsets in the criminal justice, health, and employment systems. This exclusion has also been true of some of the studies assessing programs for pregnant and parenting women. One researcher admitted in a discussion with a federal official a few years ago, "We never thought to add data about foster care in the research design." This is another indicator of the distance between the two systems; it is difficult to document what an evaluation *doesn't* look for in its evaluation of outcomes.

Effectiveness of Treatment Among Women and Their Children

Many examples of successful women-oriented treatment programs have been documented by recent evaluation research. In 1995, the Center for Substance Abuse Treatment (CSAT) published findings from a study of its grantees that were administered by its Women and Children's Branch [CSAT 1995]. They found the following:

- Of women in treatment ...
  - 95% reported uncomplicated, drug-free births;
  - 81% who were referred by the criminal justice system have no new charges following their treatment;
  - 75% who successfully completed treatment remained drug free;
  - 46% obtained employment following treatment; and
  - 40% eliminated or reduced their dependence on welfare.
- Of their children ...
  - 65% were returned from foster care, and
  - 84% who participated in treatment with their mothers improved their school performance.

Each of the women's specialized treatment programs developed under CSAT funding has documented significant gains among the women and children enrolled. The majority of these programs have developed multidisciplinary approaches to meet the multiple needs of

women and their children. The two programs highlighted here have developed linkages with a comprehensive network of providers and have documented outcomes in multiple domains. For example, PROTOTYPES Women's Center in Pomona, California, serves 80 women and 50 children at any one time in its residential treatment program. Follow-up research conducted by The Measurement Group* of 124 women six months after they departed from the PROTOTYPES residential program, compared outcomes for women who were in the program less than 180 days (short stay) with those who were in the program 180 days or longer (long stay). The evaluation found important differences among women who stayed in treatment more than six months as shown in Table 6.

These outcomes remain fairly consistent in the longer term as evidenced by Gateway Community Services in Jacksonville, Florida.** Almost 430 children were served in a three-year period of the residential and outpatient treatment program; 945 children did not reside with their mother when she was admitted to the residential program; 364 were reunified. There were 131 women who were pregnant at the time of admission, 130 babies were born drug free (one woman delivered a baby with a positive toxicology screen the same week she was admitted to treatment). The 364 children who were reunified with their mothers were given the Learning Accomplishment Profile when they were reunified with their mothers and after one year of participating in the extensive therapeutic services provided by the program. The developmental lag that can exist between drug-exposed children and their peers (in this sample, it was primarily in language and cognitive areas) had virtually disappeared by the second assessment point. Just over one-quarter of women admitted to Gateway's specialized programs were referred by the Department of Children and Families, as shown in Table 7. The predominant drug used by the women was cocaine, as shown in Table 8.

---

* The Measurement Group, Dr. George Huba. 5811 A Upland, Culver City, CA 90230.

** Gateway Community Services, Dr. Virginia Borrok, President/CEO. 555 Stockton Street, Jacksonville, FL 32204; 904/387-4661.

Table 6. Comparison of Length of Stay in Treatment

Outcome Domain	Short Stay < 180 days	Long Stay > 180 days	Total Sample
AOD Abstinence	70%	94%	85%
Employment	48%	63%	57%
No New Arrests	72%	96%	87%
Homelessness	9%	4%	6%

Table 7. Sources of Referral

	Percentage of Admissions		
Referral Source	Residential	Outpatient	Total
Department of Children and Families	11%	52%	28%
Other AOD Provider	24%	20%	22%
Legal System	34%	4%	21%
Voluntary	26%	2%	16%
Hospital	5%	9%	8%
Public Health	2%	12%	6%

Table 8. Drugs Used by Women in Study

	Percentage of Women	
Primary Drug Used At Admission	Residential Program	Outpatient Program
Cocaine	44%	70%
Cocaine and other drugs	47%	19%
Alcohol	7%	7%
Prescription abuse	1%	1%
Marijuana	1%	3%

Among women served by Gateway's Women's Recovery Program, the overall treatment completion rate is comparable to many other AOD treatment agencies. Among women admitted to residential treatment, 46% completed treatment, and among women admitted to intensive outpatient services, 49% completed treatment. To evaluate the program, a random sample of 60 women was followed for four years (30 women were discharged from the residential program and

30 from intensive outpatient services). At one year after their treatment discharge:

- 72% of the women reported being clean from alcohol and other drugs;
- 64% attained education and/or vocational skills necessary for employment;
- 52% were employed one year after discharge; and
- 92% reported no further involvement with police, court, or probation one year after discharge.

A network of community-based programs serving women and their children in New York City has recently documented AOD treatment outcomes that were reported by Magura and his colleagues from the National Development and Research Institutes and the New York City Administration for Children's Services [Magura et al. 1998]. Women who had given birth to a drug-exposed infant were given priority for treatment admission; women with children less than 6 years old were also eligible for the program. Families received home-based casework, social services, and substance abuse treatment. The program used public contracts with community-based and culturally sensitive family service agencies and outpatient substance abuse treatment. The program goals were to prevent foster care placement and to provide adequately for the family's needs.

The evaluators followed 173 mothers for an average of 30 months after their admission to treatment. Similar to Gateway's data described above, 49% of women exited treatment before completion. There were 13% who transferred to other programs; 28% had completed treatment at the follow-up point and 9% were still in treatment. Projecting from the 49% who exited treatment to the 9% who were still in treatment gave a projected overall completion rate of 33% of the 173 treatment admissions.

In the overall group, there were no significant reductions between admission and one-year follow-up in the percentage of parents with

Funders and Effectiveness

It is also important to recognize that some public agencies in both CWS and AOD fields have not done all that they could to use their own authority to address the issue of the effectiveness of treatment. When a public child welfare agency is critical of the effectiveness of treatment, but has done little to document the actual experience of their own clients as they go in and out of treatment, it makes it harder to change the treatment system. Similarly, in some consolidated agencies with responsibility for both AOD and CWS issues, when an agency is at the same time funding AOD treatment providers and criticizing the effectiveness of AOD treatment for its CWS clients, it does raise the question of why the providers are still funded and why contract oversight is not being used to leverage better outcomes or change providers.

children in out-of-home care. However, parents who completed or were still participating in treatment were significantly less likely to have children in foster care (16%) than parents who left treatment or were transferred (30%). Parents who completed or were still in treatment were also significantly less likely to have children living elsewhere at follow-up (20%) compared to parents who left treatment or were transferred (48%).

Important distinctions were apparent, however, among parents who did not have children in foster care when they were admitted to treatment. Only 6% of parents who completed or were still active in treatment had children placed in foster care between admission and follow up. But 23% of parents who left or transferred had some children placed in foster care at follow-up. There were too few parents who had children in foster care at admission to evaluate reunification rates.

Producing these results is much less costly than jail, prison, or foster care costs. For example, the publicly funded reimbursement rates in California for the treatment continuum at PROTOTYPES ranges in reimbursement levels from $41.16 for a MediCal-reimbursed group session (in California, Medicaid is called MediCal and covers

drug treatment for a woman while she is pregnant and 60 days after the birth of her baby), to intensive outpatient care that is reimbursed at the rate of $72.75 per day, and on to the residential therapeutic community at a rate of $85 per day for a woman and her child. The additional costs of treatment are paid by private grants and fundraising activities.

CASE STUDY

Prior to implementation of training in Sacramento County, there were 11 AOD treatment groups conducted by AOD counselors. After participating in the Level III training, social workers, nurses, and AOD counselors instituted 24 additional groups. The different types of groups included AOD information and education, pretreatment groups for clients waiting for space at a community provider, and AOD intervention and supports.

A total of 165 parents who were assessed for AOD problems were randomly selected from the CWS caseload for follow-up. The 165 parents had 530 children; at the first assessment point, 247 children were living with their parent. Of the 165 parents, 50 graduated from group treatment, 39 dropped out, 37 were assessed with an AOD problem but never attended a group, and 39 were assessed as "no AOD problem" and were selected as a comparison. The chart on page 96 highlights the improvements in children's custody status among group treatment graduates and the decline in the percentage of children living with their parents among those parents assessed with AOD problems who did not participate in the group services. The percentage change is calculated between the time that their parents were assessed for AOD problems and at three-months postassessment. (One-year follow-up data are currently being collected.)

Despite these findings of treatment effectiveness and cost savings, CWS workers often tell us that what they need in dealing with specific families in their caseloads is help from AOD agencies in making earlier decisions about moving children to more stable homes when parents are not successful in treatment, as is increasingly required in concurrent planning. This is an area for which the AOD field must take responsibility. AOD practitioners could offer much assistance to CWS in

	Children's Living Arrangement - Number (and Percent)					
Parents' Status	At Assessment		At 3-month Follow-up		Percentage Change from Assessment to 3-month Follow-up	
	Living w/ parent	Not w/ parent	Living w/ parent	Not w/ parent	Living w/ parent	Not w/ parent
Graduated	61 (25%)	91 (37%)	76 (37%)	79 (26%)	+48%	-30%
Dropped out	64 (25%)	75 (31%)	44 (21%)	104 (34%)	+15%	+10%
Never attended	51 (26%)	36 (15%)	32 (16%)	62 (21%)	-24%	+33%
No AOD problem	71 (28%)	42 (17%)	53 (26%)	58 (19%)	-7%	+12%
Total	247 (100%)	244 (100%)	205 (100%)	303(100%)	--	--

helping to determine early signs of "readiness to change." However, CWS workers must also take responsibility to understand AOD treatment and to work with AOD professionals in determining when AOD-abusing parents are able to protect and nurture their children.

To move away from a one-shot treatment and toward a disease management approach, *CWS will need to move beyond a one-size-fits-all approach to AOD problems with the knowledge that one method and one set of rules will not work for all clients.* However, there are commonalities among programs that have documented treatment effectiveness. Key ingredients in effective drug treatment programs have been delineated by Waltman:

- Easy accessibility,
- Treatment flexibility,
- Involvement of other family members,
- Matching treatment to salient client variables,
- Good therapists,
- Motivated clients,
- Client accountability for their sobriety,

- Focused treatment approaches,
- Follow-up of dropouts and program graduates, and
- Aftercare supportive services [Waltman 1995].

In addition, client characteristics associated with better outcomes have been identified. Of particular importance are employment, social/family support, and having a mental health diagnosis in addition to the substance abuse. In a recent review of treatment outcomes, 11 factors were identified as critical variables and are listed in Table 9 [Alemi et al. 1995]. Two things are clear: (1) women involved with the child welfare and welfare systems in many cases will fall into the harder-to-serve group, and (2) these clients will therefore need more intensive services, and in some cases, more time to succeed in moving to work. For CWS clients, as discussed above, the time required may conflict with the timetables for termination of parental rights, TANF limits, or the needs of the child.

Enhancing Effectiveness: The Special Needs of Women

In working with the child welfare and general welfare populations, special consideration should be made for the treatment needs of women. Reviews of the literature on women's treatment issues often mention the following critical components of women's AOD treatment programs:

- Many women seeking treatment for AOD problems have been victims of physical and/or sexual abuse; these complex issues can often be triggers for relapse and most often need to be addressed in gender-specific programs by women treatment professionals. The term "women with multiple vulnerabilities" refers to women who enter AOD treatment with co-occurring mental health disorders, HIV risk and/or disease, and trauma (either family violence or sexual assault histories).

Table 9. Critical Variables Affecting Treatment Outcomes

Domain	Client Barriers to Success	Client Strengths and Assets
Age	Under age 30	Over age 30
Employment	Unemployed with little work history	Stable employment history
Motivation	Little acceptance of AOD problems	Desire to recover
Consequences and sanctions	Little fear of AOD-related consequences (e.g., loss of job or custody of children)	Fear of consequences reinforced by sanctions
Physical and social environment	Return to a neighborhood where drugs are readily available and with a drug-using peer group	Little contact with a "drug culture" and fewer life stressors (e.g., poverty)
Legal status and peer criminality	Numerous pretreatment arrests and a peer group involved with criminal acts	Few pretreatment arrests and a noncriminally involved peer group
Social Support	Family members or peers who cause interpersonal conflicts or fail to support goals of recovery	Family members and peer who exert pressure to stop substance use and provide emotional support for recovery
History of drug use	Using a variety of drugs, frequent drug use, younger age at onset of addiction, a longer course of addiction, and few days of sobriety prior to entering treatment	Use of a primary substance, older onset of addiction, a period of abstinence prior to treatment admissions
History of treatment	Numerous treatment attempts	Longer length of time in treatment
Dual diagnosis and psychological problems	Significant psychiatric problems, high levels of anger, depression, childhood sexual abuse	No concurrent psychiatric disorders
Chronic illness	Significant chronic illnesses (e.g., arthritis, back pain, asthma, emphysema, ulcers)	Good physical health

- The three greatest barriers to women seeking and remaining in treatment are stigma, fear of losing custody of their children, and the lack of child care for their children while they are in treatment.

- Specialized services for women should include health and nutrition, intervention for family and community violence, intervention for children who may be affected by prenatal drug exposure, housing needs, parenting education and skill building, vocational training, and employment assistance [DHHS 1995]. In addition, many women's providers have added literacy training, therapeutic recreation, and vocational skill building. A family focus in designing and implementing these programs is critical.

- Additional components that are specifically added for the population of parents in treatment who are involved with the child welfare system include shared family care and the use of volunteers and kinship care to support parents in treatment [Barth 1994].

AOD treatment providers have responded to these special needs of women and have developed programs that either deliver these multiple services on site or in coordination with other service providers.

The Need for Targeted Intervention and Prevention for Children "in the System"

More comprehensive assessment and targeted intervention is needed for all children, youth, and families who overlap the child welfare and juvenile justice systems. Although attention to prenatally exposed infants is critical and renewed efforts have focused attention on services for adolescents, interventions for younger children (ages 5 to 12) of substance-abusing parents are still scarce, and these "middle children" are at high risk of developing their own AOD problems. This section reviews the needs of all three of these age groups of children.

The needs of children of alcoholics (COAs) and children of substance abusers (COSAs) can be viewed in a developmental approach. It is well established that infants and young children have specific needs for adequate bonding and attachment with their caregivers. In recent years, we have gained new insights into the critical early years for brain development in young children. These early years for children with substance-abusing parents become critical years for intervention to assure that children receive appropriate stimulation, opportunities for brain development, and emotional well-being through bonding and attachment for infants and younger children.

We are continuing to miss the large group of children between early childhood and adolescence who need AOD interventions. These children—neither adolescents nor in the 2 to 5 percent of CWS children who were identified as prenatally exposed—should be a critical subset served by any expansion of AOD treatment services for children.

Look for the Other Children in the Family

In assessing prevalence, it is extremely important for child welfare agencies to assume that AOD is a family disease and *to look for involved siblings*. Recent work by Richard Barth and Barbara Needell of the Child Welfare Research Center at the University of California at Berkeley concluded that abandoned and neglected infants brought into foster care in 1995 had siblings in foster care in a ratio of 1.7 siblings for every infant in foster care. Barth and Needell conclude, "Clearly, a few parents who continue to generate births of children born exposed to substances have a substantial impact on the foster care caseload."

The childhood years also require opportunities to develop self-concept and self-esteem that are cultivated through curiosity, initiative, and independence. For COAs and COSAs, these opportunities are often disrupted, which interferes with normal development. These children need services that specifically address their families' AOD problems, including group interventions with their peers and formal treatment. They also need supportive adults to reinforce the message that their parents' AOD abuse is not their fault and is not the path their own life needs to take. The Children of Alcoholics Foundation states that support groups for school-age children help to build resiliency and protective factors in the following ways [Richardson & Weinstein 1997]:

- Bolstering self-esteem,
- Providing support,
- Providing consistency,
- Teaching coping skills,
- Encouraging adaptive distancing,
- Providing a positive adult role model, and

- Encouraging mutual aid.

The National Association for Children of Alcoholics has developed an excellent set of core competencies needed by health care providers in caring for children and adolescents in families affected by substance abuse [NACA 1997]. They suggest three levels of competencies based on the levels of responsibility that the health care provider takes for the care of children. Needed competencies range from awareness and communication skills in Level I, to assessment and care management in Level II, to medical and behavioral treatment in Level III.*

For youth who become chemically dependent, a developmental perspective and approach to treatment is imperative. Most AOD treatment programs were originally developed for adult males. Just as the AOD field has adapted to a growing need for treatment services that are responsive to the unique needs of women, the AOD field must also be responsive to the unique needs of adolescents. The Berkshire Farm Center and Services for Youth in New York has developed treatment programs based on a clear delineation of the differences between adult and youth AOD treatment.** Bob Kirkman and Bill Hill of Berkshire Farm contributed the following section on youth-oriented treatment.

Recent advances in AOD treatment have shown that programs for youth must include the characteristics, maturational effects, and developmental processes of adolescents into their program design and delivery. The critical differences between youth and adults' AOD-related problems and treatment include the following:

- *Rapid progression.* Adolescents often make the progression from first use to full chemical dependence within a period of 6 to 18 months; among adults, a two- to seven-year period is common to develop a chemical use disorder.

---

* National Association for Children of Alcoholics, Sis Wenger, Executive Director. 11426 Rockville Pike, Suite 100, Rockville, MD 20852; 301/468-0985.

** Berkshire Farm Center and Services for Youth. 13640 Route 33, Canaan, New York 12029; 518/781-4567.

- *Narrow repertoire of coping skills*. Unlike adults, who often arrive at the chemically dependent stage with an array of coping strategies developed by life experiences, adolescent chemical dependence is such that the development of these strategies is curtailed at the stage in which they began using alcohol, tobacco, and other drugs. For this reason, treatment of adolescent chemical dependence requires habilitation focus and requires more comprehensive treatment intervention than adult rehabilitation models.

- *Stronger denial system*. Adolescents experience a stronger system of denial because, unlike adult addicts/alcoholics, they typically have not experienced the years of negative consequences related to their AOD use that adults have. As a result, they tend to have more difficulty connecting their problems to their drug use.

- *Stronger enabling system*. There is a wider acceptance of drug use by the adolescent peer group and this greater acceptance supports and normalizes drug taking and drug-related behavior.

- *Maturational delays*. Adolescents experience cognitive, affective, and behavioral/maturational delays directly caused by drug use. The younger that drug use is initiated, the greater the delays experienced in the maturation process.

- *Developmental issues*. Chemical dependence impacts negatively on the adolescent developmental tasks of individuation, separation, and autonomy. These are necessary developmental processes for transitions to young adulthood.

Given these characteristics and developmental processes, adolescents tend to be less willing and able to adapt to "abstinence only" programs in comparison to adults. Berkshire Farms has found that their adolescent programs need to embrace a motivational approach

that reinforces the continuum from harm reduction to abstinence. Their program model is depicted in Table 10.

Review: Implications of AOD Treatment Innovation for CWS

Throughout this discussion of AOD treatment, the child welfare implications have been evident:

- The need to deal with the skepticism, lack of information, and different time frames of the CWS worker;
- The importance of operating on the assumption that children who are the focus of a CPS complaint and their siblings are affected directly by their parents' AOD abuse and may need intervention or treatment themselves;
- The need to consider the developmental stages of children from infancy through adolescence in assessing the impacts of parental substance abuse and the need for treatment for the children as well;
- The need to understand what AOD treatment can and cannot accomplish; and
- The importance of balancing both realistic expectations and solid information about different forms of AOD treatment as they support women and their children in moving toward the goal of a stable family.

Child welfare agencies do not need to be, nor should they try to become, experts in AOD treatment. They need to know enough about their own clients, however, to interact with the AOD system in more depth than merely handing a client a list of phone numbers of treatment centers or assuming that clients with substance abuse problems will never be able to gain control of their lives. The AOD field has the burden of communicating its successes and methods more clearly with

Table 10. Adolescent Program Model

	Engagement along the Continuum of Treatment	
HARM REDUCTION TO ABSTINENCE	*Motivation Phase*	• Development of a framework to evaluate whether a problem exists in major life areas • Identification of goals • Identification of problems • Identificationand development of strategies and techniques to meet goals and to overcome barriers to goal attainment • Development of a *Community Safety Plan*
	Stabilization Phase	• Client establishes a personal focus of treatment • Development of a problem management plan emphasizing: 1. Feeling management 2. Urge management strategies 3. Behavior and situational management strategies • Development of a *Community Problem Management Plan*
	Early Recovery Phase	• Formal relapse prevention planning • Recovery-based lifestyle planning • Development of a *Community Recovery Plan*

child welfare agencies with whom they share clients; the CWS field has the burden of listening and linking this new information into their efforts to preserve families and keep children safe and nurtured.

Summary: Treatment Effectiveness and the CWS Client

As noted in this section, several studies of women's treatment programs cluster their findings around the figure of one-third of parents, typically mothers, who successfully complete treatment on their first admission to a program. Other data and lengthy discussion with sev-

AOD Treatment Pays, Even When It Succeeds for Only Some Parents

Due to the high cost of out-of-home care, if treatment succeeds and families are reunified for only one-third of the parents referred from the CWS system, the costs that are avoided far exceed the total costs of AOD treatment. So treatment does not need to succeed for all clients to produce a net positive result.

A hypothetical scenario. One hundred women are treated at the highest average treatment cost ($6,800 per client in residential care in the NTIES study), for a total of $680,000. They average 1.5 children each for a total of 150 children.

If children average seven years in out-of-home care, at a low estimate of $6,000 per year, the total foster care cost is $42,000 per child. If 30 parents reunify with 45 children (which is a conservative success rate), the foster care costs avoided by those 45 are $1,890,000, repaying the total treatment cost for the original 100 women three times over.

When the other offsets from AOD treatment and avoided out-of-home care (e.g., reduced health care, criminal justice, and welfare costs) are added in, the ratio improves even more substantially, even if it is assumed that some public costs are still borne once the children are reunified.* The benefits increase further if an assumption is made that some portion of the parents are not successful on their first treatment episode but continue with subsequent readmissions and succeed, as evidence strongly suggests.

---

* Assumptions of Treatment Costs and Benefits for CWS Clients: (1) It is assumed that parents who are referred for AOD treatment are from the more serious portion of the CPS caseload, with a greater likelihood of having their parental rights terminated. (2) It is assumed that the average episode in foster care, which is 12 months for *all* children, is much longer for children with AOD-abusing parents. An estimate of 7 years has been derived from experience in Los Angeles County and is used in these figures. (3) It is assumed that once these children are reunified, half will require Medicaid and other public subsidies for 4 years at an average cost of $5,000 per child beyond foster care costs, or a total cost of $450,000. It is further assumed that the other half will require no public subsidy, saving $787,500 more in nonfoster care costs. Thus the net savings in nonfoster care costs is $337,500.

eral exemplary providers suggest that the percentage improves to one-third of the remainder, or 22% of the total, who become successful completers after multiple attempts. The evidence is strong that the more readmissions, the more likely will be eventual successful completion. Thus, a total of slightly more than one-half of the admissions to a given program can be assumed to become successful completers—some after one episode of treatment admission, the others after multiple admissions to a program.

Clearly, if the developmental "clock" and the new federal requirements for time limits in both welfare and child welfare services are taken into account, some of these "successful" completers will still have lost their rights to be primary caretakers of their children by the time they are successful in treatment. But it also signals clearly that treatment for a significant segment of parents—though definitely not all—has the potential to reunite many of these parents with their children in a more stable family. That is the first and primary child welfare outcome against which AOD treatment is fairly measured.

But there is a second outcome as well: for those parents for whom the clock ran out before they successfully completed a program, it also says that these birth parents can continue as active, positive participants in the lives of their children, even though they are not serving as primary caretakers. That outcome must be contrasted with the "disappearing parent" who is so common in child welfare cases, resulting in serious negative effects on children in later life. The significance of reconnecting birth parents and children is also important in the context of kinship care, where relatives may make the reconnection process easier.

The importance of this is that it becomes a more refined position for advocates of closer AOD-CWS ties than claiming that all CWS families will benefit from AOD treatment. All CWS families with AOD problems *should be offered treatment appropriate to their needs*—and they should be compelled to at least enter treatment. But not all will complete it successfully after one or even repeated admissions. The realities of treatment include failure with some clients and success with others—sometimes with clients who may have seemed hope-

less but who persevere throughout many obstacles, supported by professionals, peers, friends, and kin and driven by a deep desire to be reunited with their children.

The real achievements of treatment should not be discounted, but neither should the claim be made that treatment works for most clients in a single treatment episode. A balanced explanation of the effects of treatment on families should be part of the public education and social marketing of treatment. The point is that treatment does work for a significant group of clients *over time*, in ways that assure that treatment pays off and brings genuine improvement in the lives of children and families.

References

Alemi, F., Stephens, R. C., Llorens, S., & Orris, B. (1995). A review of factors affecting treatment outcomes: Expected treatment outcomes scale. *The American Journal of Drug and Alcohol Abuse*, *21* (4), 483-509.

American Society of Addiction Medicine. (1996). *Patient placement criteria for the treatment of substance-related disorders* (2nd ed.). Chevy Chase, MD: Author.

Anglin, M. D., Hser, Y., & Grella, C.E. (1997). Treatment histories: The long view of addiction. *NIDA Notes*, 12(5), 8.

Barth, R. P. (1994). Long-term in-home services. In D. Besharov (Ed.), *When drug addicts have children*. Washington, DC: Child Welfare League of America.

Bell, A., & Rollnick, A. (1996). Motivational interviewing in practice: A structured approach. In F. Rotners, D.S. Keller, & J. Morgenstern (Eds.). *Treating substance abuse: Theory and technique*. New York: The Guilford Press.

Center for Substance Abuse Treatment [CSAT]. (1997). *50 strategies for substance abuse treatment*. Rockville, MD: Author. May be ordered through the National Clearninghouse for Alcohol and Drug Information at 800/729-6686 or electronically at http://www.samhsa.gov.

Center for Substance Abuse Treatment [CSAT]. (1995). *Producing results*. Rockville, MD: Author.

Coles, C. D. (1995). Addiction and recovery: Impact of substance abuse on families. In G. H. Smith, C. D. Coles, M. K. Poulsen, & C. K. Cole (Eds.), *Children, families, and substance abuse: Challenges for changing educational and social outcomes* (pp. 40-44). Baltimore, MD: Paul H. Brookes Publishing Co.

Finigan, M. (1996). *Societal outcomes & cost savings of drug and alcohol treatment in the State of Oregon.* Salem, OR: Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources and Governor's Council on Alcohol and Drug Abuse Programs.

Gerstein, D. R., Johnson, R. A., Harwood, H., Fountain, D., Suter, N., & Malloy, K. (1994). *Evaluating recovery services: The California drug and alcohol treatment assessment*. Sacramento, CA: California Department of Alcohol and Drug Programs.

Langenbucher, J. W., McCrady, B. S., Brick, J., & Esterly, R. (1994). *Socioeconomic evaluations of addictions treatment*. Piscataway, NJ: Center on Alcohol Studies, Rutgers University.

Leshner, A. (1994). A comprehensive strategy for improving drug abuse treatment. *Journal of Substance Abuse Treatment, 11* (6), 483-486.

Magura, S., Laudet, A. I., Kange, S. Y., & Whitney, S. (1998). *Effectiveness of comprehensive services for crack-dependent mothers with newborns and young children*. New York: National Development and Research Institutes, Inc.

McLellan, A., Metzger, D. A., Alterman, A. I., Woody, G. E., Durell, J., & O'Brien, C. P. (1995). *Is addiction treatment "worth it"? Public health expectations, policy-based comparisons.* Philadelphia, PA: The Penn-VA Center for Studies on Addiction and the Treatment Research Institute.

Mee-Lee, D. (1995). Matching in addictions treatment: How do we get there from here? In N.S. Miller (Ed.). *Treatment of the addictions: Applications of outcomes research for clinical management* (pp. 113-127). New York: The Haworth Press.

Morgan, T. J. (1996). Behavioral treatment techniques for psychoactive substance use disorders. In F. Rogters, D. W. Keller, & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp. 202-240). New York: The Guilford Press.

Meuller, M. D., & Wyman, J. R. (1997). Study sheds new light on the state of drug abuse treatment nationwide. *NIDA Notes*. 12(5): 1, 4-8.

National Association for Children of Alcoholics. (1997). *Core competencies for involvement of health care providers in the care of children and adolescents in families affected by substance abuse*. New York: Author.

Prochaska, J. O., & DiClemente, C. C. (1985). Toward a comprehensive model of change. In W. R. Miller & N. Health (Eds.), *Treating addictive behaviors: Processes of change*. New York: Plenum Press.

Richardson, B., & Weinstein, N. (1997). *Support groups that work*. New York: Children of Alcoholics Foundation.

Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Substance Abuse Treatment. (1997). *National treatment improvement evaluation study summary*. Rockville, MD: U.S. Department of Health and Human Services, Center for Substance Abuse Treatment. Details of the study can be downloaded from the CSAT website at http://www.health.org/nties97.

Vega, P. (1998). Disease management: Moving from fledgling concept to revolution in behavioral health care. *Behavioral Disease Management Report*. Providence, RI: Manisses Publications.

U.S. Department of Health and Human Services [DHHS], Public Health Services, Substance Abuse and Mental Health Services Administration. (1995). *Effectiveness of substance abuse treatment.* DHHS Publication No (SMA) 95-3067: 37-44. Washington, DC: U.S. Department of Health and Human Services.

Young, N. K., & Gardner, S. L. (1997). *Implementing welfare reform.* Washington, DC: Drug Strategies and Irvine, CA: Children and Family Futures.

Waltman, D. (1995). Key ingredients to effective addictions treatment. *Journal of Substance Abuse Treatment*, 12(6), 429-439.