



California Women, Children and Families Technical Assistance Project (CaIWCF)

Perinatal Environmental Scan a Snapshot of California's Perinatal Alcohol & Other Drug Problems, Services and Policies

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Prepared for the Department of Alcohol and Drug Programs
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Executive Summary

Introduction and Methodology

The Department of Alcohol and Drug Programs (ADP) requested that Children and Family Futures (CFF) conduct a perinatal environmental scan to determine the status of perinatal services for women with substance use disorders, assess current trends in this area, and formulate recommendations for prioritization and planning. Research methods included a focus group with Office of Perinatal Substance Abuse (OPSA) staff; reviews of relevant reports and scientific literature; analyses of California reports and research; analyses of public data from the Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration (SAMHSA); and qualitative analyses of key informant interviews and focus groups.

The California Department of Alcohol and Drug Programs (ADP) Office of Perinatal Substance Abuse (OPSA) asked Children and Family Futures, Inc. (CFF) to conduct a Perinatal Environmental Scan (PES) to:

- √ determine the status of perinatal services for women with substance use disorders;
- √ assess current trends; and
- √ formulate recommendations for prioritization and planning.

Prior to the start of the PES research, CFF held a focus group with the staff of OPSA and conducted a statewide Women and Perinatal Technical Assistance Needs Assessment. The Perinatal Environmental Scan included a review of women, pregnant women and parenting women.¹ The PES addressed five research questions.

- Question 1: What is the prevalence of substance use and need for treatment among California women?
- Question 2: How do services in California compare with treatment needs and with evidence-based practice?
- Question 3: What are the interagency initiatives affecting substance-using women, including pregnant women, parenting women and their children in California?
- Question 4: How do we ensure quality of services and best utilization of resources?
- Question 5: How can we reduce substance exposure in California children?

To answer these questions, CFF combined information drawn from a literature search, quantitative analysis, and key informant expertise.

- √ The **literature search** included: research articles; ADP reports, treatment standards and guidelines; other California departments' reports; and federal materials on women's and family treatment models.
- √ **CFF analyzed federal data** from the California sub-sample of federal data reports from: the National Survey on Drug Use and Health (NSDUH); the Treatment Episode Data Set (TEDS); and the National Survey of Substance Abuse Treatment Services (N-SSATS).

√ **CFF conducted key informant and focus group interviews.** A total of 33 respondents from 19 counties participated. A roster of informants is included as Attachment 1 to this report. Key informants included treatment providers from statewide associations, county alcohol and drug program administrators, county perinatal service coordinators, researchers and the Director's Advisory Council Women's Constituent Committee.

Question 1: What is the prevalence of substance use and the need for treatment among California women?

California Women, 2005

- More than 2 million women reported recent binge alcohol use²
- Almost 1 million women reported recent illicit drug use³
- Of those using illicit drugs or alcohol, approximately 979,000 met the criteria for substance abuse or dependence⁴
- 952,000 women would have benefited from but did not receive treatment for alcohol problems and 367,000 women would have benefited from but did not receive treatment for illicit drugs⁵
- 63,000 women were admitted to treatment⁶

Pregnant Women in California, 2005

- An estimated 100,000 infants are born prenatally exposed to alcohol each year⁷, and an estimated 20,000 to 60,000 are born prenatally exposed to illicit drugs⁸
- Fewer than 4,000 pregnant women entered treatment in California in 2005⁹

California Parents, 2005

- Nationally, among parents living with their children, 8 percent of fathers and 4 percent of mothers were dependent on or abused substances in the past year¹⁰
- An estimated 849,000 California children live with a parent who abuses or is dependent on alcohol or illicit drugs¹¹
- Approximately 103,000 parents were admitted to treatment¹²

Treatment need for women, pregnant women and parents exceeds treatment access more than tenfold.

Question 2: How do services in California compare with treatment needs and with evidence-based practice?

California's service delivery system is based on a continuum of services that includes prevention, intervention, treatment and recovery support.

Prevention and Intervention

The five-stage framework developed by the National Center on Substance Abuse and Child Welfare (NCSACW) serves as a framework for preventing substance-exposed births. This

framework includes five intervention points for both parents and children: pre-conception, during pregnancy, at-birth, infancy and preschool, and among older children.

- The extent of current Substance Abuse Prevention and Treatment (SAPT) Block Grant prevention set-aside funds that address women or pregnant women is not known. The environmental prevention strategies within California do not specifically target women and pregnant women; however, women also benefit from these prevention efforts.
- There is a range of community-based and individual-based prevention strategies that can prevent and reduce substance use problems in women, pregnant women and families.
- Maternal, child and adolescent health (MCAH) agencies have established collaborative perinatal-specific prevention efforts in many counties across California. These efforts often include: prenatal care provider training, screening at prenatal clinics, education programs and assessment and treatment linkages. In some counties, brief intervention services are provided on-site at prenatal clinics.

Gender Responsive Treatment

A substantial body of research identifies unique characteristics of women with substance use disorders.¹³ Girls and women differ from boys and men in many aspects, including their reasons for initiating substance use; the consequences they experience; barriers and motivations for entering treatment; treatment service needs; relapse risks; and recovery support needs.

Gender responsive treatment addresses the needs of women with substance use disorders.¹⁴ Federal and state funding and evaluations of comprehensive service models and specific practice interventions have established an array of effective services. The Center for Substance Abuse Treatment (CSAT) Comprehensive Treatment Model for Women and Their Children includes three inter-related circles defining core, supportive and community services.¹⁵ Common themes and characteristics of gender responsive services as described in the box to the right are found throughout the literature. Key informants expressed concern that quality programs be available across the lifespan of women and not be based on women's pregnancy and parenting status.

Characteristics of Gender-Responsive Services

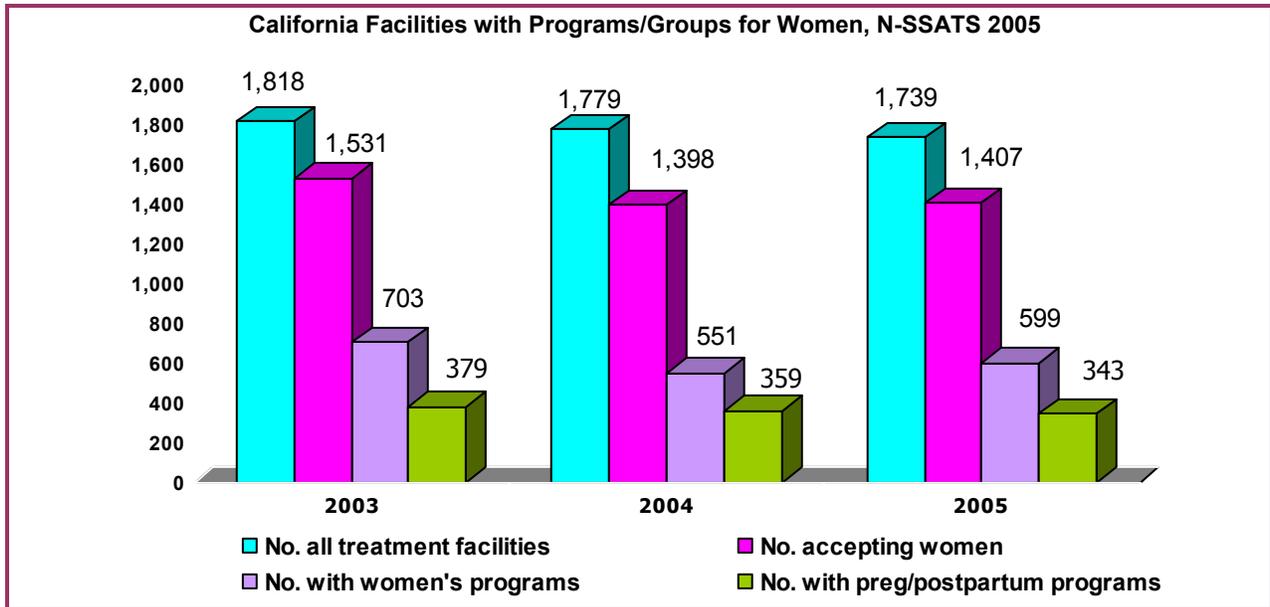
- Relational
- Address the different pathways to use, consequences of use, motivation for treatment, treatment issues and relapse prevention needs unique to women
- Strength-based, motivational
- Comprehensive
- Trauma informed
- Provided in an environment in which women feel safe and comfortable

Some programs in California have developed improved services through evidence-based practices such as motivational enhancements, increased mental health services, trauma services, children's therapeutic services, and comprehensive services. These programs rely on a range of collaborations and funding streams. **While programs exist, comprehensive, gender responsive services are not the universal standard of care.**

The majority of facilities accepting women do not offer a woman-specific program or group. Having a woman-specific program or group is a minimal measure of the gender responsiveness of a facility.

- 81 percent of California's 1739 treatment facilities accepted women in 2005

- Approximately 57 percent of California treatment facilities accepting women *do not* offer a specialized program or group specifically designed for women
- Three out of four (76 percent) California treatment facilities accepting women *do not* offer a specialized program or group specifically designed for pregnant/post-partum women
- There are 314 programs in the California Perinatal Services Network (PSN). Informants felt that perinatal programs have more gender responsive, comprehensive services for women and families than non-perinatal programs. (It is not clear whether informants were thinking of all 314 PSN providers or selective programs.)



While California could do a better job of delivering gender responsive services, California is doing better than the country as a whole.

California Compared to the Nation		
	California 2005	National 2005
Percent Female Admissions	35.5	32.0
Percent of Facilities with Women's Program or Group	34.4	32.8
Percent Females Pregnant at Admission	5.7	3.9
Percent of Facilities with Pregnant/ Postpartum Women's Program or Group	19.7	14.1

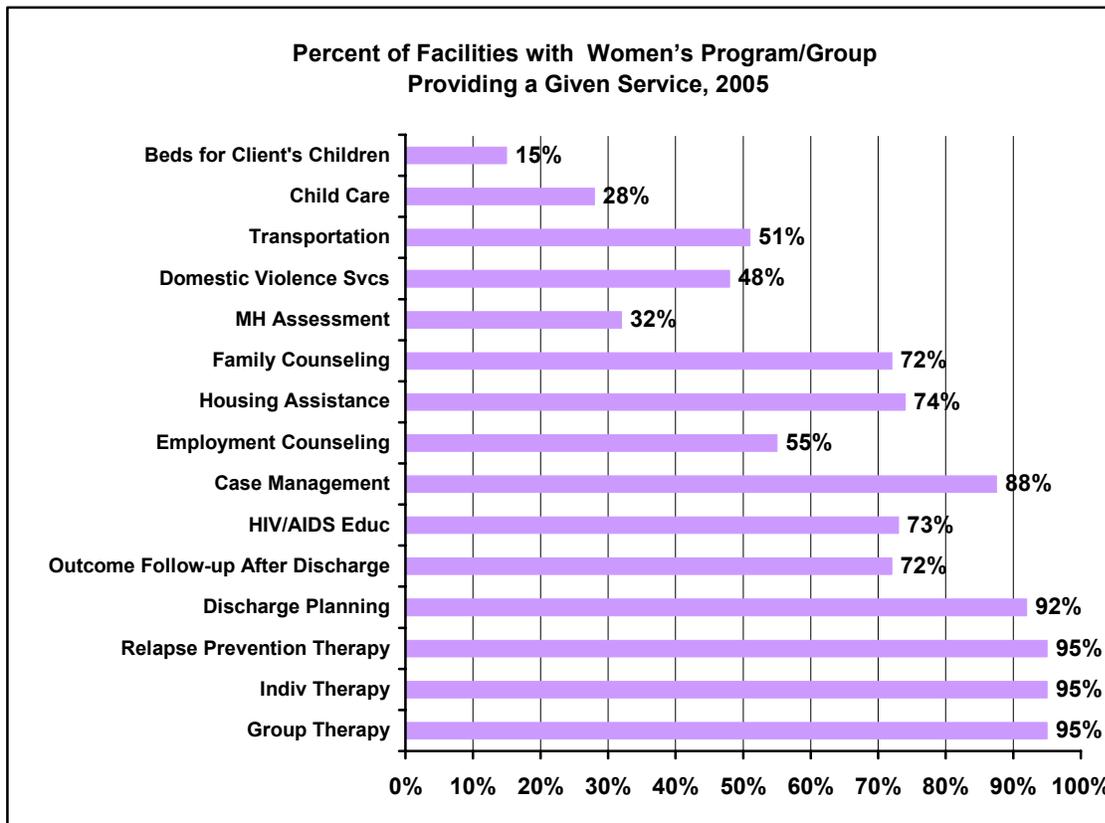
Sources: Online analysis of TEDS 2005 Computer file (admissions); N-SSATS 2005 State & U.S. Profiles (programs)

- In California, women made up 35.5 percent of all treatment admissions in 2005. The national average is 32 percent.
- California and New York admit more women to treatment than any other state.
- California's treatment system has more facilities with a specialized program or group for women than the national average.
- California also leads the nation in admissions and specialized programs or groups for pregnant women.

Array of Services Offered

The N-SSATS also asks providers what types of services they offer. By self-report, of the 599 facilities indicated whether they offer a women specific program or group:

- 45 percent do not provide employment assistance
- 28 percent offer no family counseling
- 68 percent do not offer mental health assessments
- 26 percent do not offer housing assistance
- 13 percent do not provide case management, and
- 72 percent do not provide child care



It is also worth noting that the respondents are asked a closed-ended question (yes or no responses) regarding services they offer; there is no indication of the frequency or quality of services delivered. There is no data available on services for children.

Question 3: What are the interagency initiatives affecting substance-using women, including pregnant women, parenting women and their children in California?

Women with substance use problems typically have a host of other problems as well. Collaboration with the other service delivery systems which impact women allows for the development of policies and programs which more effectively meet women's complex needs. A collaborations matrix was developed to illustrate the types of collaborative activities.

Collaborations were identified with multiple service systems at the provider, county and statewide levels.

Collaborations Matrix			
This matrix is intended to be illustrative, not comprehensive. It contains a sample of collaborations based upon a limited set of interviews.			
	Provider Level Collaborations	County Level Collaborations	State Level Collaborations
Community Level Prevention and Education	<ul style="list-style-type: none"> • Participation in community prevention coalitions • Prevention of pregnancy, AOD use and delinquency 	<ul style="list-style-type: none"> • SPF planning and prevention activities (may not specifically address perinatal population) 	<ul style="list-style-type: none"> • GPAC, but perinatal population not specifically addressed (ADP, lead) • FASD Taskforce (ARC, lead)
Health and Prenatal Care	<ul style="list-style-type: none"> • Collaborations for health care • Brief interventions and engagement at clinics and hospitals • HIV testing/counseling 	<ul style="list-style-type: none"> • Prenatal screening at clinics coordinating groups (e.g., SART) • SB 2669 training /implementation • HIV Taskforces 	<ul style="list-style-type: none"> • FASD Taskforce (ARC, lead) • DHS Office of Women's Health Survey • DHS Immunization Collaborative
Mental Health	<ul style="list-style-type: none"> • Integrated services • Trauma services • Collaboration for mental health services 	<ul style="list-style-type: none"> • Integrated departments • Co-Occurring Taskforces • Cross-Training • Prop 63 planning groups 	<ul style="list-style-type: none"> • COJAC (DMH and ADP, joint leads)
Criminal Justice	<ul style="list-style-type: none"> • Funded programs • Client support to meet probation requirements 	<ul style="list-style-type: none"> • Prop 36 advisory and planning groups 	<ul style="list-style-type: none"> • Prop 36 Advisory Group, but perinatal not specifically addressed, (ADP, lead)
Domestic Violence	<ul style="list-style-type: none"> • Integrated services for victims • Integrated services for perpetrators • Referrals • Participation in domestic violence prevention programs 	<ul style="list-style-type: none"> • Participation in domestic violence prevention councils 	<ul style="list-style-type: none"> • Domestic Violence Task Force (Attorney General, lead) • Domestic Violence, Mental Health & Substance Abuse Curriculum Advisory Board (MCAH, lead) • Greenbook Leadership Group (Administrative Office of the Court, lead)
CalWORKs & Employment	<ul style="list-style-type: none"> • CalWORKS-funded treatment services • Employment programs 	<ul style="list-style-type: none"> • Joint planning for treatment services • CADPAAC CalWORKs Workgroup 	<ul style="list-style-type: none"> • TANF Reauthorization Planning Committee (DSS, lead) • Annual CalWORKs Conference Planning Committee (DSS, lead)
Child Welfare & Dependency Drug Courts	<ul style="list-style-type: none"> • Co-locating in Dependency Courts • Funded for treatment services • Coordination and reporting for clients 	<ul style="list-style-type: none"> • Family to Family • Participation in SIP development • Cross-Training • MOUs and funding for treatment • Dependency drug court development and oversight committees 	<ul style="list-style-type: none"> • State Interagency Team, (DSS, lead) • State Interagency Team, AOD Workgroup (ADP, lead) • California Blue Ribbon Commission on Children in Foster Care (Judicial Council, lead)

Collaborations Matrix			
This matrix is intended to be illustrative, not comprehensive. It contains a sample of collaborations based upon a limited set of interviews.			
	Provider Level Collaborations	County Level Collaborations	State Level Collaborations
Early Childhood	<ul style="list-style-type: none"> • Funding from First 5 agencies • Referrals and collaborations for services 	<ul style="list-style-type: none"> • Collaborative effort to fund EPSDT services for children at treatment sites • School readiness initiatives (though ADP may not participate) 	<ul style="list-style-type: none"> • California Interagency Coordinating Council on Early Intervention (DDS, lead) • First 5 Special Needs Initiative (but does not address substance exposure) • Safe from the Start
Children and Youth Services	<ul style="list-style-type: none"> • Adolescent family treatment models • Afterschool programs at treatment programs • Referrals and collaborations for services 	<ul style="list-style-type: none"> • Prevention collaborations with schools • Safe and drug-free schools 	<ul style="list-style-type: none"> • Youth Services Coordination Assessment
Housing	<ul style="list-style-type: none"> • Seeking housing resources • Housing development • Sober living 		<ul style="list-style-type: none"> • COJAC supportive housing taskforce • Housing committee
Family Resource Centers	<ul style="list-style-type: none"> • Referrals and collaborations 	<ul style="list-style-type: none"> • Planning and training meetings 	

The Perinatal Scan also reviewed selected trends within other service systems that may impact alcohol and other drug treatment services for women and families.

Children Welfare System

- United States Administration for Children and Families Safe and Stable Families will offer grants for family treatment for methamphetamine.
- Child Welfare Services Redesign has created service improvement opportunities at the county level.
- California received a Title IV-E waiver for child welfare funding. They have been used in other states to support funding treatment and client engagement efforts.
- The Child Abuse Prevention and Treatment Act (CAPTA) amendments require hospitals to notify Child Protective Services of infants affected by drug abuse and require developmental assessments of all 0-2 year-olds in substantiated abuse and neglect cases.

Health

- The Maternal, Child and Adolescent Health field has increased interest and planning on prenatal substance use.
- There has been increased knowledge about early brain development, alcohol-related neurological disorders and school readiness for children.
- Domestic violence service providers have an increased awareness of the need to address substance abuse and mental health.

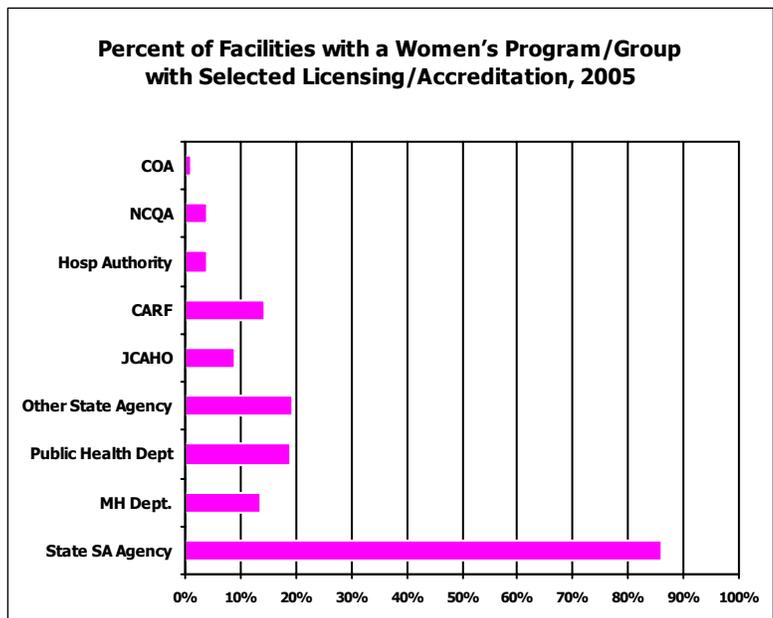
Criminal Justice and Corrections

- The California Department of Corrections and Rehabilitation is working to improve programming for female offenders.
- The Drug Endangered Children collaborations are increasing collaboration and awareness of the dangers for children in methamphetamine production environments.

Question 4: How do we ensure quality of services and best utilization of resources?

Licensing and Accreditation

Most of the women's treatment facilities are licensed and/or certified by the State Department of Alcohol and Drug Programs. Others have mental health (13.5 percent), public health licenses (18.9 percent) or other state agency (19.2 percent) licenses or accreditations. Additionally, 8.8 percent are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) 14.4 percent by the Commission on the Accreditation of Rehabilitation Facilities (CARF), and 3.8 percent on the National Committee for Quality Assurance. Only 1.2 percent have been accredited by the Council on Accreditation for Children and Family Services (COA).¹⁶



Outcome Measures and Data Analysis

- While stakeholders *believe* that treatment providers are delivering quality services, outcome evaluation is limited.
- Some administrators actively review and monitor data reports. Most rely on site visits and a series of programmatic, policy and fiscal audits.
- Providers and counties are hopeful that the California Outcome Management System (CalOMS) will fill information gaps and produce data on services and outcomes that they can use for planning and quality improvement.
- Most funding is not linked to results. Several informants would like more cost-to-benefit data. There is no assessment of how funds are used to respond to community/individual treatment needs. Drug Medi-Cal (DMC) is based on allowable costs rather than results.

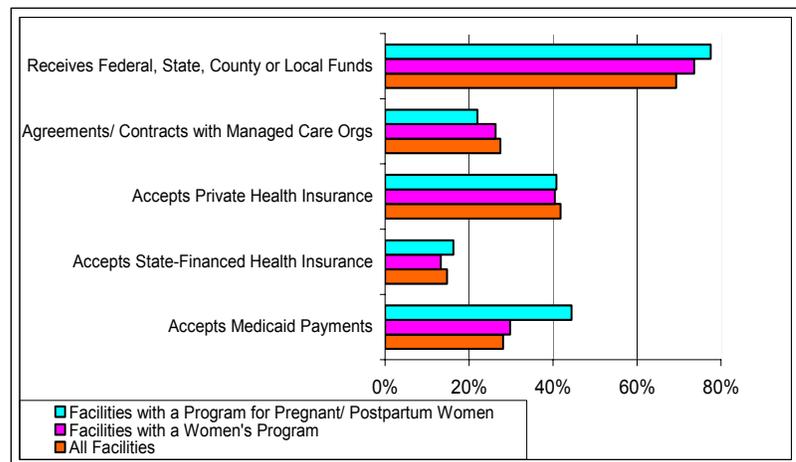
Perinatal Standards and Guidelines

- Perinatal Services Network

- The Perinatal Services Network (PSN) includes programs receiving state or federal perinatal funds. These programs can serve pregnant and parenting women with children under the age of 17, though many programs place a younger limit on the ages of children. These programs are expected to meet the Perinatal Services Guidelines.
- Programs serving pregnant or parenting women that do not receive perinatal funds are not included in the Perinatal Services Network.
- The ADP Perinatal Services Guidelines are referenced in contracts. Key informants felt that providers exceed these minimal standards and had not reviewed them recently.
- Two counties have developed, but not yet implemented, increased perinatal standards based on research and best practices.
- General consensus among key informants is that the perinatal guidelines should be reviewed with language updates and to determine whether more extensive revisions are feasible.
- Across the State - there are no consistent definitions for gender responsive or culturally responsive services. There are no standardized definitions or measures for evaluating quality or effectiveness of women or family services among California stakeholders.

Funding

Women’s programs are less likely to have private funds such as private health insurance or managed care contracts. They are more likely to receive government funding and Medicaid. Programs with a specialized program or group for pregnant women are significantly more likely to receive Medicaid payments. More than 77 percent of these facilities received federal, state or local funding.



Question 5: How can we reduce substance exposure in California children?

- With the exception of Sacramento County, key informants indicated minimal impact from the CAPTA requirements or California SB 2669 which requires a risk assessment for exposed infants.
- There is an increasing recognition of the importance of prevention and early intervention to address prenatal substance abuse.
- In many counties, collaborative efforts are underway in maternal and child health to improve OB/GYN screening and referrals. In some counties, AOD assessments, engagement services, and brief interventions are occurring on-site.

- There are some innovative outreach and children’s service programs through collaborations with County First 5 Commissions and children’s mental health providers.

Selected Findings and Recommendations

The Perinatal Environmental Scan provides an initial analysis of prevalence, practices, policies and partners impacting perinatal substance use within the landscape of California. Children and Family Futures developed recommendations based upon the data analysis, key informant interviews and literature review. The findings and recommendations of the Perinatal Environmental Scan inform planning efforts at three distinct but overlapping levels of planning and capacity building: (1) ADP and OPSA internal planning and capacity building; (2) capacity building within the alcohol and drug field – ADP/OPSA in conjunction with CADPAAC, treatment providers and other stakeholders; and (3) cross-system capacity building with external agencies.

SELECTED FINDINGS

- √ The term “perinatal” is used to refer to different populations of women and children in different contexts.
- √ Across the state, there is not a consistent concept or implementation of gender responsive services.
- √ There is increasing interest in family-based services.
- √ Recognition of the importance of prevention and early intervention is spreading to address prenatal and childhood substance exposure.
- √ Interagency collaboration is occurring, but there are gaps and room for improvement.
- √ There is significant concern about funding and maintaining existing programs. Some new or untapped federal, private and other funding options with flexibility may be available.

RECOMMENDATIONS

ADP and OPSA Internal Planning and Capacity Building

- √ Expand OPSA’s functions to include a larger focus on Children, Youth and Family Services, while retaining a separate emphasis on the unique issues faced by women and the demand for gender-specific and culturally competent programs.
- √ Expand communication and communicate more with the field to disseminate evidence-based practices on family-centered treatment.
- √ Identify the best methods of delivering technical assistance, training, and communication strategies for women, perinatal and family service providers.
- √ Expand analysis of available data from ADP and other state agencies; develop fact sheets and white papers.
- √ Develop an effective data analysis and reporting system as part of California Outcomes Measurement System (CalOMS) that allows for evaluation of women, perinatal and family services, including implementation of the Perinatal Services Guidelines.

- √ Develop a white paper(s) and training protocol on gender responsive services, drawing upon available research and literature. Build consensus on key components and best practices.

Capacity Building within the Alcohol and Drug Field

- √ Build consensus on terminology used by treatment providers, counties and the state (can be a part of the strategic plan).
- √ Convene a work group of County Alcohol and Drug Program Administrators Association of California (CADPAAC) members and treatment providers to review the perinatal services guidelines (in this context perinatal is referring to guidelines for pregnant and parenting women), suggest language updates, and formulate a recommendation as to whether the guidelines should be updated to be more prescriptive and inclusive of evidence-based practices. The work group could explore transitioning the Perinatal Services Guidelines to voluntary standards for all publicly funded programs serving women, with sections that address women, pregnant women and families, while considering the context of CalOMS and the emergence of evidence-based data in the review.
- √ Review Perinatal Drug Medi-Cal standards, funding and practices as well as Medicaid requirements to determine if there are waivers or additional service categories that are possible. If there are benefits to making changes, this work could be referred to the Perinatal Standards Workgroup to ensure complementary practices.
- √ Consider a statewide conference or an annual event in which evidence-based, gender-specific programs are fostered and effective clinical interventions are emphasized.

Cross-System Capacity Building with External Agencies

- √ Develop a funding inventory that identifies non-ADP funds which could be used to expand services for women, pregnant women and families.
- √ Develop a white paper on possible approaches to collaborating with child welfare.
- √ Work in collaboration with other state agencies on current initiatives in the area of prevention and early intervention in responding to the effects of prenatal and post-natal substance exposure.
- √ Conduct a comprehensive survey of the county-level collaborations occurring within California that address these issues, describing their functions and funding streams, identifying available data measuring the impact of these collaboratives and summarizing promising practices.
- √ Review current interagency collaborative involvement and assess the potential impact on perinatal services, including the prospects of expanded support for comprehensive family-based services.
- √ Develop a strategic plan with benchmarks and baselines in each of the broad areas where ADP envisions an ongoing partnership with its sister agencies.
- √ In collaboration with the Judicial Council and the Department of Social Services, seek resources to convene a statewide meeting on Dependency Drug Courts similar to the early Proposition 36 implementation meetings.

- √ Schedule a series of introductory meetings between ADP, OPISA, and the Associate Director/Administrator of Female Offender Services in both adult and juvenile services to identify current planning and implementation activities and opportunities for collaboration and information sharing.
- √ Request information and data analysis on how Proposition 36 and Drug Courts have expanded services for women, including specific data on participation, services, and outcomes, including family outcomes. From this data, develop a planning tool for the Proposition 36 Advisory Committee and counties to use for quality improvement and to shape revisions to programs.

I. Introduction and Methodology

The Department of Alcohol and Drug Programs (ADP) requested that Children and Family Futures (CFF) conduct an environmental scan to provide a current assessment of the perinatal services field, to identify trends and environmental factors affecting perinatal populations and to formulate recommendations for prioritization and planning within ADP's Office of Perinatal Substance Abuse (OPSA).

Research questions were formulated in consultation with ADP and study methods were agreed upon. The study methods included: a focus group with OPSA staff in March 2006; reviews of relevant reports and scientific literature; analyses of public data sources and reports accessed at the Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration (SAMHSA); and, qualitative analyses of key informant interviews and focus groups. The research literature review was conducted as a component of the CalWCF Technical Assistance (TA) project, which compiles and disseminates research summaries that address an array of women's prevention and treatment issues. A thorough search is conducted using relevant terms and multiple search engines and results are prioritized. The articles are categorized by specific topics and disseminated to the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the Perinatal Treatment Network and other treatment providers.

This report provides an overview summary including the background and intent of the project, research and data analysis methods, findings and overall recommendations. There are four appendices which provide more detailed information.

- Appendix 1: Data Summary
- Appendix 2: Key Informant Interview Summary
- Appendix 3: Collaborations Matrix
- Appendix 4: Findings from the California Women, Children & Families Technical Assistance Survey: January, 2006

II. Background

In 1986, ADP developed a report on alcohol-related birth defects which recommended pilot projects for pregnant and parenting women and local coalitions on perinatal issues. By 1988, both the Department of Social Services (DSS) and the Department of Developmental Services (DDS) were experiencing increases in their caseloads of infants affected by alcohol and other drugs (AOD). In 1989, a coordinated State interagency group was created to respond to these issues. This led to the creation of the Options for Recovery program. In 1990, OPSA was created within ADP. A major expansion of these services took place in 1991, with new program guidelines issued and the commissioning of a prevalence study, which took place in 1992. By 1993, the Federal government required a funding set aside in the Substance Abuse Prevention and Treatment (SAPT) Block Grant to be used for pregnant and parenting women's services. The Perinatal Substance Exposure Study report was issued in 1993, and documented that over 69,000 newborns were prenatally exposed to alcohol and other drugs that year in California.¹⁷

At present, OPSA oversees a statewide network of nearly 300 publicly-funded perinatal alcohol and drug treatment programs, the Perinatal Services Network. In 2004-05, these programs served over 38,500 pregnant and parenting women. Of these, 3,000 unique pregnant women were served statewide.¹⁸

The Perinatal Services Network is made up of those programs that currently receive perinatal set aside funding. Most of these programs rely on a combination of funding including Federal and State perinatal set aside funds, Drug Medi-Cal, contracts through other State or County departments (e.g. California Department of Corrections and Rehabilitation (CDCR) or CalWORKs). There are other programs which serve pregnant and parenting women, but do not receive any perinatal set aside funding and are not considered a part of the Perinatal Services Network. This is true of programs funded through Drug Medi-Cal, CalWORKs, child welfare or other non-SAPT Block Grant public funds, privately funded State licensed programs for women or women with children, and general population programs serving pregnant and parenting women.

III. Major Trends in the Perinatal Environmental Scan

Focal Points for Capacity Building and Planning

There are three inter-related areas of planning which are pertinent to the Perinatal Environmental Scan: internal ADP and OPSA strategic planning and capacity building; planning and capacity building within the broader network of the alcohol and drug field; and cross system capacity building with other State departments and agencies. These multiple areas of planning and capacity building are needed to ensure that services are: 1) comprehensive (e.g., the needed range of clinical treatment, clinical supports and environmental supports); 2) inclusive of the full continuum of services (e.g., the range from prevention, intervention, treatment and recovery); 3) available and accessible to women, children and their families; and, 4) provided in ways shown to be effective.

Internal ADP and OPSA Planning and Capacity Building

As part of the California Health and Human Services Agency, ADP serves as the Single State Authority for oversight and implementation of services funded by the Substance Abuse Prevention and Treatment Block Grant. ADP is also the fiscal and programmatic oversight department for the delivery of alcohol and other drug prevention and treatment services funded from other State initiatives. Efforts related to improving prevention and treatment services for the perinatal population therefore fit within the priorities of the ADP Strategic Plan and draw on the internal capacities and resources of ADP's Program Services Division, the Office of Perinatal Substance Abuse and other ADP Divisions and offices. Capacity and infrastructure development are needed for ADP/OPSA to offer the leadership, communication and alliances necessary to meet the needs of women and families with substance use problems.

The AOD Field's Planning and Capacity Building

To deliver alcohol and other drug prevention and treatment services throughout the State of California, ADP works closely with County Alcohol and Other Drug Program Administrators. The Administrators are responsible for direct treatment service delivery or for contracting with treatment agencies for services. In addition, there are several statewide treatment provider networks and the County Alcohol and Drug Program Administrators Association of California (CADPAAC) that work together with ADP to improve access to quality treatment and prevention services throughout the State. Improving alcohol and other drug policy and practice in California involves the engagement of ADP, County Administrators, treatment providers and other stakeholders in planning and development.

Cross-System Collaboration for Planning and Capacity Building

Women and the children and families affected by substance use disorders are generally involved with multiple service systems. The nature of the illness and its consequences affect a variety of areas of life functioning and require services from a variety of disciplines, experts and systems to prevent occurrence, to intervene in disease progression and to remedy the adverse consequences they experience. As such, the implementation of effective comprehensive services for women and families involves collaboration across many disciplines and service delivery systems including the range of departments within the Health and Human Services Agency and other critical partners such as the Department of Corrections and Rehabilitation and the courts.

If the AOD system is to build high quality services it requires cross-systems linkages and resources beyond those under the direct supervision and direction of ADP. It is also important to recognize that decisions and funding streams outside the control of ADP are significant to AOD providers. In practice state and local agencies in corrections, juvenile justice, mental health, education, and child development are key players in the AOD field but are often outside of the jurisdiction of ADP.

The Demand for Comprehensiveness

There are at least three conceptual models that are relevant for assessing perinatal services:

- ADP's Continuum of Care: the continuum of prevention, intervention, treatment and recovery supports as applied to women, their children and their families;
- The Center for Substance Abuse Treatment's (CSAT) model of comprehensive services¹⁹, which includes three inter-related circles defining core, supportive and community services; and
- A five-stage framework developed for assessing State policy toward substance-exposed births, developed by the National Center on Substance Abuse and Child Welfare (NCSACW).²⁰

These three models all emphasize services and supports that require extensive resources outside the control of the treatment agency itself. Comprehensive family-centered treatment across the continuum of substance abuse prevention and treatment includes services from other disciplines and agencies such as child development, mental health, primary health, special education, family income support and employment. The treatment system cannot fund or monitor comprehensive family-centered treatment by itself. Therefore, system wide collaboration with the agencies in these fields at both State and local levels is critical to achieve comprehensive and effective family-centered treatment.

The Strategic Opportunity for Partnerships

Several State interagency and local collaboratives address the needs for some portion of the perinatal services population. Many of these initiatives are summarized in Appendix 3: Collaborations Matrix. The matrix is based on a sampling of programs and counties; it is not intended to be exhaustive of all efforts but provides a 2006 baseline which could be updated over time.

There are opportunities that could allow for expansion of services via new partnerships, resources, and flexibility aimed at women, children and families. These opportunities include:

- Proposition 10 funding for children ages 0 to 5 has been used by some providers and counties for prevention, early intervention, data collection and treatment services, linking in some cases with maternal and child health agencies;
- Proposition 63, the Mental Health Services Act (MHSA) funding can include pregnant and parenting women with an emphasis on co-occurring disorders among women and early mental health services for their infants and children if these groups are prioritized in State and local planning;
- The new Title IV-E Child Welfare waiver for child welfare funding, which has been used in other States to support funding treatment and client engagement efforts;

- New Federal attention to the issue of prenatal exposure through new mandates for notifying child protective services of drug-affected newborns, for developmental assessments of younger children in child abuse and neglect cases and a new set of grants for services to substance-exposed newborns through the Child Abuse Prevention and Treatment Act (CAPTA); and,
- Proposition 36 (SACPA) refunding with new requirements and an opportunity to review impact on women and men with children;
- Increased recognition of the rehabilitation needs of adult and juvenile female offenders in the criminal justice system combined with restructuring of the Department of Corrections and Rehabilitation to better meet the rehabilitation needs of inmates, parolees and probationers.²¹

IV. An Emerging Framework for Women and Family Services

Underpinning these cross-system opportunities and demand for comprehensiveness in service delivery is a profound recognition that substance abuse services are evolving to include all family members in the approach to intervention and supporting recovery. Long recognized as a “family disease” both in its transmission and impact, services have not traditionally been developed or funded in ways that encourage the focus of intervention to include the family. Rather, traditional public-sector approaches have focused on the individual and considered family members as “collaterals” or encouraged their participation in limited “family week” type approaches.

The impetus for family-centered services comes from at least two bodies of evidence. First, adolescent treatment studies have documented that effective outcomes are achieved when family members are involved in the treatment milieu and intervention program.²² Second, the past decade of research on effective treatment for women has documented the importance of relationships to women and that treatment strategies must incorporate a relational view of interventions.²³ Research has also documented that women who were able to maintain relationships and custody of all of their children while in treatment had significantly better treatment outcomes than women whose children were separated from their mother.²⁴

This evolution of family-centered practice follows a 30-year history which saw the emergence of treatment and services for women with substance use disorders.²⁵ First, women were served in men’s programs using male-dominated models. In the 1970s, women-specific services emerged; however, the approaches remained based on treatment strategies effective for men. Significant funding and development efforts by SAMHSA, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism have produced a body of evidence on the specific nature of women’s substance use and related treatment interventions.

Family-based services originated from the residential programs for pregnant and parenting women that emerged in the early 1990s. SAMHSA established Residential Women and Children and Pregnant and Parenting Women (RWC/PPW) programs, which funded the development of model programs. These programs were designed to provide services for women with their children. The concept was that these women could continue to meet their parenting responsibilities, bonding with children would be protected, child care would be provided, and these activities would allow for the women’s treatment needs to be met. These early programs learned that the children had significant therapeutic needs of their own. They also found a high incidence of poor parenting skills and minimal attachment ability within many of these families. Programs struggled to meet the array of unexpected needs of children and families.

Although some programs served all families, regardless of number or age of children, most of these early programs placed limits on the number and ages of children. These limits were placed for logistical, milieu, and clinical reasons. In most programs, older children, fathers, domestic partners, and other family members received no services or limited services. These individuals were often not included in a healing process that resulted in only partial family recovery and limited support for the women as they left treatment. For some families, the divisions actually created new problems and further rifts in family functioning.

For more than 10 years, programs have struggled with the financial, programmatic, and policy barriers to serving whole families. A few have successfully overcome such hurdles and show promising results.²⁶ New opportunities are creating momentum to more firmly establish the comprehensive family-centered treatment model. These include the following:

- Increased recognition of the need
- Skill and success in collaboration across service systems
- Increased awareness of the effect of parental substance use disorders on children
- Renewed attention to the importance of family
- Research showing the importance of family for women's recovery support
- A broadened understanding of multidisciplinary and integrated services

Family-centered treatment meets the need for parental treatment for substance use disorders and the need for support services for family recovery.

Figure 1 (below) depicts the Family-Based Services Continuum. All types of services identified in this table support family members and family involvement. Programs that offer no family-based services or that do not recognize the importance of family on treatment outcomes are not included in this continuum. The continuum describes five different levels of family-based services. The levels range from family involvement, a minimum standard of service, to family-centered services, to comprehensive family-based treatment, the most comprehensive level. Programs fall along this continuum, depending on who is welcome and the services they receive. Figure 1 identifies a title, core components (what), participants (who), and anticipated outcomes (outcomes) for each of the five levels.

The continuum provides a framework and definition that allows for a more in-depth discussion of family-based services. The terms used to describe services vary across counties and programs and must remain flexible because meanings vary across collaborative agencies and because funding streams often use strictly defined categories and terminology.

At one end of the continuum, Level 1, are women's treatment programs that focus primarily on the individual but address family relationships as an integral part of the treatment process. Level 1 programs serve women who may or may not have children, single women, senior women, young women, pregnant women, women who have lost custody of their children, and women who have minor children with other caretakers. Although services focus on the women, these programs are included on the family services continuum because they provide services using a family-relationships framework.

Level 2 programs serve women who are accompanied by their children. Although the focus is on women, these programs provide child care and other basic services to their children with the primary goal of supporting women's treatment and recovery. Treatment plans are developed for the women only. These plans may have objectives related to parenting and family relationships; however, the program does not specifically address the service needs of the children. Parenting classes may be offered, but not family counseling, to improve family functioning. These programs allow women to attend treatment and often to retain custody of their children and provide for their children's safety.

Level 3 programs, which are from Women's and Children's Services, emerged as the RWC/PPW programs and found that more child- and family-based services were needed in most client families. Level 3 programs address children's service needs including developmental delays, prenatal substance exposure, and emotional issues. Mothers and children all have treatment (or case) plans. The programs actively engage parents to develop parenting skills and increase their ability to address the complex needs of their children. For children in the child welfare system, Level 3 programs can serve a dual role by supporting mothers toward abstinence and improved parenting and ensuring the health and safety of children. These

programs offer services for both women and their children. Often Women's and Children's Services programs limit the number or ages of children, and services for additional family members are not available.

Level 4, Family Services, provides treatment and case plans for women and their children, as described in Level 3. In addition, the children's father or other family members receive services to support the women's recovery. These participants do not have treatment plans of their own, however, they participate in counseling sessions and other program support that results in a more effective family system and creates a more supportive environment that encourage ongoing abstinence for women with substance use disorders.

Finally, Level 5, Comprehensive Family-Centered Treatment, provides services for women who use substances, their children, and the children's father or other family members. All members of the family have individualized case plans and share an integrated family plan. Male partners with substance use disorders access their own treatment services (possibly in a different location or in a different program than that of mothers) including; family counseling, employment, and reentry services. In addition, children, often with behavioral or emotional problems of their own, receive individualized services.

This framework serves as a backdrop to understanding the range of programs and services that are in place in California and suggests a vision for future directions in the services continuum, the type of comprehensive services needed and the strategic planning that is necessary to achieve that vision.

Figure 1. Family-Based Services Continuum

Level	1	2	3	4	5
What	Women's Treatment With Family Involvement	Women's Treatment With Children Present	Women's and Children's Services	Family Services	Family-Centered Treatment
Who	Services are provided to women including pregnant women and women with or without children. Individual is the focus of intervention. Services are offered in context of family relationships framework. May have limited family education, counseling, or visitation.	Women are at center of treatment but have children with them. Provides child care and basic needs but no service plan for children. Children's presence is primarily to support women's participation in treatment.	Women bring children to treatment. Women and each child have case plans and receive services. Parenting support and parenting skills provided. Some children and other family members may be excluded.	Women's and children's services with some other family members' services to support women's recovery. Women and children have case plans, but fathers and other family members do not.	Women, children, fathers, and other family members all participate and all have case plans. Family unit is supported in communication and decision-making.
Outcomes	<ul style="list-style-type: none"> ▪ Improves outcomes for women compared with programs without family context. ▪ Allows women whose children have been removed to meet court requirements. ▪ Improves birth outcomes over programs without family context. 	<ul style="list-style-type: none"> ▪ Allows for visitation. ▪ Allows for parent/child attachment. ▪ Provides for safety of children. ▪ Having children helps motivate mothers toward recovery. ▪ Increased reunification. 	<ul style="list-style-type: none"> ▪ Improved treatment retention/outcomes for women. ▪ Early screening/intervention for developmental delays. ▪ Increased reunification. ▪ Improved child outcomes. ▪ Improved family functioning. 	<ul style="list-style-type: none"> ▪ Improved treatment retention/outcomes for women. ▪ Further improved child outcomes. ▪ Limited improved outcomes for other family members. ▪ Further improvements in family functioning. 	<ul style="list-style-type: none"> ▪ Family transformation. ▪ Increased family functioning. ▪ Improved treatment retention/outcomes for women. ▪ Improved outcomes for all family members. ▪ Increased percentage of families remaining intact. ▪ Further improved child outcomes.
<p>As more members of the family are present and able to access services, potential for improved short- and long-term outcomes for all members involved.</p>					
Fathers	Men's treatment	Fathers and their children with them but no therapeutic services or case plans for children.	Fathers and their children receiving services.	Fathers and their children with some other family member services to support the fathers' recovery.	Whole family services with male who abuses substances as center of family.

V. Summary of Research Questions and Findings

To complete the Perinatal Environment Scan, Children and Family Futures developed a scope of work in February 2006, including five key questions to guide the project. These questions and key findings are summarized below and discussed in detail later in the report. The methodology included a review of both quantitative and qualitative data to assess the current need and services for perinatal populations. Feedback on the internal and external strengths, weaknesses, and opportunities affecting women and families with substance use disorders was also reviewed.

1. What is the prevalence and scope of California's prevention and treatment needs/services for women of child-bearing age, pregnant women, parenting women and their children?

- An estimated 1 million illicit drug users in California in 2005 were women.
- An estimated 317,680 female Californians were either dependent on or abused substances in 2005.
- In 2005, an estimated 367,000 California women needed but did not receive treatment for illicit drugs.
- An estimated 952,000 California women needed but did not receive treatment for alcohol problems.
- There were approximately 62,800 treatment admissions for women in 2005 representing approximately 35% of all admissions.
- Pregnant women accounted for 5.7% (n=3,539) of the female admissions in California.
- An estimated 100,000 infants are born prenatally exposed to alcohol each year, and an estimated 20,000 to 60,000 are born prenatally exposed to illicit drugs.
- An estimated 849,000 California children live with a parent who abuses or is dependent on alcohol or illicit drugs
- Among parents living with their children, 8% of fathers and 4% of mothers were dependent on or abused substances in the past year
- In 2004, there were 10,882 women serving a state prison sentence; an overall 1522% increase since 1977. By 2001, the number of women sentenced to prison had dropped by 10%, and correctional managers attributed Proposition 36 as the largest driving factor driving the decline.

2. What are the key issues and opportunities relative to addressing prenatal and post-natal substance exposure in California's children?

- The policy context among several ADP State partners has shifted to present new opportunities for funding and flexibility.
- The definition of perinatal varies widely among funders and providers, and an effort is needed to clarify what is meant by use of the term among ADP, its partner agencies and providers.
- Prevention of substance use and related disorders among women are included in the discussion of pre-pregnancy and prenatal efforts in this report. Across the State and counties, there is great variability in how prevention for women is targeted. Treatment for parents also serves as a direct approach to prevention of substance use as well as other developmental risks and consequences for their children.
- The perinatal field has developed exemplary models of family-centered treatment, and is seeking stronger networking opportunities and links to ADP.

- Interviews with key stakeholders and trends in the field suggest that ADP consider reorganizing OPSA to include a broader definition of family-centered treatment and to address the longer-term concerns regarding children of parents with substance use disorders.

3. How has the perinatal services network and its members changed over time? What are service providers actually doing? How does it compare with treatment needs? What are the current challenges facing the Perinatal Services Network (PSN)? How can ADP and other State and local agencies be of better service to the perinatal services network?

- Approximately 31% of the treatment facilities in California reported having programs or groups specifically for women.
- One out of 5 facilities (20%) reported having programs for pregnant or postpartum women.
- According to the National Survey of Substance Abuse Treatment Services (N-SSATS) the number of facilities that offer a specialized program or group for women has fallen from 703 in 2003 to 599 in 2005. Likewise the number of facilities reporting a specialized program for pregnant women fell from 379 to 343.
- Approximately 8% of the facilities in California reported on the annual survey of treatment facilities that they had residential beds for the clients' children.
- Treatment providers express the need to participate in multiple collaborative efforts in order to provide comprehensive services for women and their children.
- Respondents suggest that improved networking and communication between ADP/OPSA and counties/providers would assist them in their efforts.

4. What is broad-stroke inventory of State and Federal interagency initiatives which affect substance using women, pregnant women, parenting women and their children in California? What role does ADP have in these efforts?

- There is a range of collaborative efforts underway at the State, County and treatment provider levels.
- A matrix of collaboratives (Appendix 3) summarizes the wide array of perinatal-relevant collaboratives, including those in which ADP is an active convener or member and those in which its involvement is not as active.
- These initiatives make clear that comprehensive, family-centered treatment in the perinatal setting requires interagency efforts beyond the resources of ADP and suggests that expanded partnerships with other agencies are possible.

5. How are quality and effectiveness defined in prevention and treatment services related to women and their children? How is ADP measuring accountability and encouraging quality, effective perinatal and family services? What are the best uses of ADP staff and technical assistance resources?

- While there are strong examples of California-specific evaluations that document cost offsets and programs' effectiveness, in general the field is not using state-of-the-art evaluation methods in documenting the impact and effectiveness of perinatal services. Stronger efforts to increase accountability for results, using the new California Outcome Measurement System (CalOMS) tools, will require analytical capacity at both State and local levels that is being built but not yet in place,

- Counties and providers also stressed the importance of on-site visits and on-going communication as important ways of monitoring and ensuring quality service delivery.
- Accountability efforts must track both parents' outcomes in treatment and child outcomes in developmental and other measures of well-being, working cooperatively with data collection efforts in other systems, especially child welfare services (CWS) and maternal and child health (MCH). A separate perinatal/family treatment-centered review of CalOMS capacity could be undertaken by a representative group of perinatal and family treatment providers. Recommendations to counties, ADP and other State agencies would be made for improvements in evaluation and accountability systems
- Revising the perinatal guidelines was a specific suggestion made by respondents.
- A strategic plan for a multi-year approach to perinatal services and family-centered treatment is both necessary and possible. It should be undertaken with a strong emphasis on accountability for improved outcomes for children and families.

VI. Summary of Data

The following highlights are of key data items and critical data gaps that provide an overview of federal data available on California. Appendix 1 contains detailed data from 2004. Information in this summary is updated to reflect 2005 data where available. The data come from analyses conducted by CFF and reference materials from other national and state reports. The sources are primarily from the national and California subset of three primary Federal data sources:

- National Survey on Drug Use and Health (NSDUH)
- Treatment Episode Data Set (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)

Prevalence Estimates

National estimates of AOD use among women have been derived from the National Survey on Drug Use and Health (NSDUH). The NSDUH is the primary source of statistical information on the use of alcohol and drugs by the U.S. population. In 2005, 7.6 million (6.1% of the female population) women were current illicit drug users and 15.1 million women (12.1% of the female population) aged 12 and older reported any illicit drug use in the past year.²⁷ These numbers represent 38.7% of the 19.7 million current illicit drug users and 43.3% of the estimated 35 million past year illicit drug users in the United States. During the same time period, 19.1 million women participated in binge drinking (representing 34.6% of all binge drinkers), defined as five or more drinks on at least one occasion in the past 30 days.²⁸

While there were gender differences among the overall sample in the NSDUH, when age cohorts were examined, gender differences were no longer apparent. A recent trend among youth shows that the rate of current illicit drug use was similar for boys and girls aged 12 to 17, (10.1% and 9.7% respectively) and the rates of past month alcohol use were not significantly different (15.9% for males vs. 17.2% for females).²⁹

Among pregnant women aged 15 to 44, 3.9% reported using illicit drugs in the past month, 12.1% reported past month alcohol use and 3.9% reported past month binge drinking.³⁰ In 2005, 8.0 million women (6.4% of the female population) in the United States were dependent on or abused alcohol or other illicit drugs in the past year.³¹ Women represented 36.1% of the 22.2 million Americans with AOD dependence or abuse.

Although California-specific prevalence estimates are available through the NSDUH, they are not reported by gender. In 2005, 2.6 million Californians reported current (i.e., past month) illicit drug use and 5.8 million reported past month binge alcohol use. In addition, 880,000 Californians were dependent on or abused illicit drugs in the past year.³² Based on the national NSDUH numbers, gender estimates for California have been extrapolated. Based on the estimate of 38.7% of current illicit drug users in the United States being female, it is estimated that approximately 1 million illicit drug users in California in 2005 were women (2.6 million times 38.7%). Based on national figures, it is also estimated that approximately 317,680 female Californians (36.1% of 880,000) were either dependent on or abused substances in 2005.

Treatment Need

In 2005, the estimated number of persons aged 12 or older in the United States needing treatment for an alcohol or illicit drug use problem was 23.2 million (9.5% of the total population). An estimated 2.3 million of these people (.9% of the total population and 10 % of the people who needed treatment) received treatment at a substance abuse treatment facility. Thus, there were 20.9 million persons (8.6% of the total population) who needed but did not receive treatment at a substance abuse facility in 2005.³³ Of the estimated 20.9 million people who needed but did not receive treatment in 2005, an estimated 1.2 million (5.6%) reported that they felt they needed treatment for their alcohol or drug use problem. Of the 1.2 million persons who felt they needed treatment, 296,000 (25.5%) reported that they made an effort but were unable to get treatment and 865,000 (74.5%) reported making no effort to get treatment.

In 2005, approximately 8.3 million women nationally needed substance abuse treatment, but only 9.5% received it.³⁴ During the same time, an estimated 849,000 Californians needed but did not receive treatment for illicit drug use and 2.2 million needed but did not receive treatment for alcohol use³⁵. Although there are no gender-specific numbers for California, this data can be extrapolated from the national numbers of women who used substances in the past year (43.3%) and the estimated number of Californians who needed but did not receive treatment. Thus, it is estimated that approximately 367,000 (43.3% of 849,000) women needed but did not receive treatment for illicit drugs and 952,000 women needed but did not receive treatment for alcohol problems in California (43.3% of 2.2 million).

Treatment Admissions

In 2005, there were 1.849 million annual admissions to publicly-funded treatment for abuse of alcohol and drugs in the United States.³⁶ Women represented 31.9% (N=590,759) of those admissions.³⁷ Pregnant women only accounted for 3.9% of the female admissions nationally. The primary drugs of abuse for all women entering treatment in the United States were: alcohol only (16.9%), alcohol with a secondary drug (14.4%), heroin (13.6%), marijuana (13.2%) and methamphetamine (13.2%).³⁸ The remaining 28.6% was comprised of other drugs of abuse. In California, the TEDS data indicate there were 179,535 treatment admissions during 2005.³⁹ Women represented 35.5% of the admissions.⁴⁰

California has substantially higher rates of methamphetamine admissions than other states. Although methamphetamine admissions account for a small percentage of all treatment admissions nationally, there are important differences by gender and pregnancy status to consider. Nationally, women represented about 31.9% of all treatment admissions in 2005. However, methamphetamine admissions for women are a much higher percentage of their overall admissions than for men – 12% compared to 6.6%. Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents.

In 2004, women between the ages of 35-49 represented the largest age group presenting for treatment in California, followed by 25-34 year-old women (see Figure 2). Pregnant women accounted for 5.7% (n=3,539) of the female admissions in California (see Figure 2). It is important to note that of the 18-24 year-old women who entered treatment, more than 11% were pregnant. While only 2.4% of young women ages 12-17 entering treatment were pregnant; they represent 4% of the total population of pregnant women served in California.

Figure 2: California Admissions by Gender, Pregnancy Status and Age of Client			
Age Group	Female Admissions	Pregnant Admissions	Percent of Pregnant Admissions

	N	%	N	%	%
12-17 yrs	5,657	9.1%	136	2.4%	4.0%
18-24 yrs	11,143	17.9%	1,292	11.6%	38.3%
25-34 yrs	17,221	27.6%	1,414	8.2%	41.9%
35-49 yrs	24,359	39.0%	516	2.1%	15.3%
50 yrs and over	4,010	6.4%	19	0.5%	0.6%
TOTAL	62,390	100.0%	3,377	5.4%	100.0%

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Based on administrative data reported by States to TEDS through October 04, 2005.

Caucasian women represent over half (52.9%) of the female treatment admissions in California (see Figure 3). Hispanic women represent the second largest racial/ethnic group of women admitted to treatment. Hispanic women are slightly over-represented in the percentage of pregnant treatment admissions (see Figure 3). The majority of women admitted to treatment in California during 2005 reported methamphetamine (40.1%) as their primary drug of abuse, followed by heroin/other opiates (18.4%), alcohol (18.0%), cocaine/crack (11.1%) and marijuana (10.5%). As shown in Figure 3, pregnant women are disproportionately represented among women seeking treatment for methamphetamine or stimulants. Of pregnant women entering treatment, more than half (55.6%) reported methamphetamine/stimulants as their primary drug.

Figure 3: California Admissions by Gender, Pregnancy Status, Race/Ethnicity and Primary Substance of Abuse, 2004			
	TEDS Percent of Female Admissions	TEDS Percent of Pregnant Women	Percent from Perinatal Program Annual Report*
Race/Ethnicity			
Alaskan Native (Aleut, Eskimo, Indian)	0.2	0.2	0.0
American Indian (Other than Native Alaskans)	1.9	1.7	2.2
Asian or Pacific Islander	2.0	1.8	1.8
Black	15.8	15.4	18.0
Caucasian	47.2	42.7	48.7
Other single race	4.1	4.2	0.0
Hispanic (all races)	28.8	34.0	29.3
Primary Substance			
Alcohol	18.0	9.2	16.0
Cocaine/Crack	11.1	11.0	11.5
Marijuana	10.5	11.4	9.2
Heroin/Other Opiates	18.4	11.3	21.1
Meth/Other Stimulants	40.1	55.9	36.3
Other	2.0	1.2	5.9

* ADP's Perinatal Program reports on the Perinatal Services Network; which includes programs funded through perinatal set aside funds. The Perinatal Services Network programs serve both pregnant and parenting women. Some pregnant and parenting women are served in non-Perinatal Services Network programs.
SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Based on administrative data reported by States to TEDS through October 04, 2005 and the Office of Perinatal Substance Abuse, Department of Alcohol and Drug Programs Annual Report, 2004.

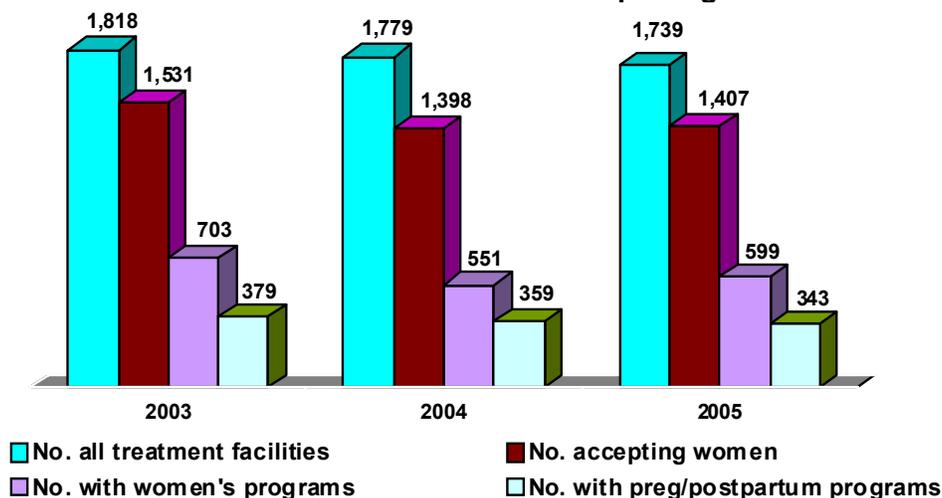
Treatment Facilities and Services

According to the N-SSATS, 32% of the facilities providing substance abuse treatment in the United States had programs or groups specifically for women and only 14.1% had programs for pregnant or postpartum women. In California, 34.4% of the treatment facilities reported having programs or groups specifically for women and 20% had programs for pregnant or postpartum women.⁴¹ In addition, 8% of the facilities in California reported to N-SSATS that they had residential beds for the clients' children. Figure 4 provides a comparison of national versus California estimates.

Figure 4: Number of Programs for Women and Pregnant/Postpartum Women, 2005		
	California	National Average
Percent of Admissions that are Female	35.5	32.0
Percent of Facilities with Women's Programs	34.4	32.8
Percent Females Pregnant at Admission	5.7	3.9
Percent of Facilities with Pregnant/Postpartum Women's Programs	20.0	14.1

The number and trend of these women's programs and those with services for pregnant or postpartum women over the past three years are shown in Figure 5.

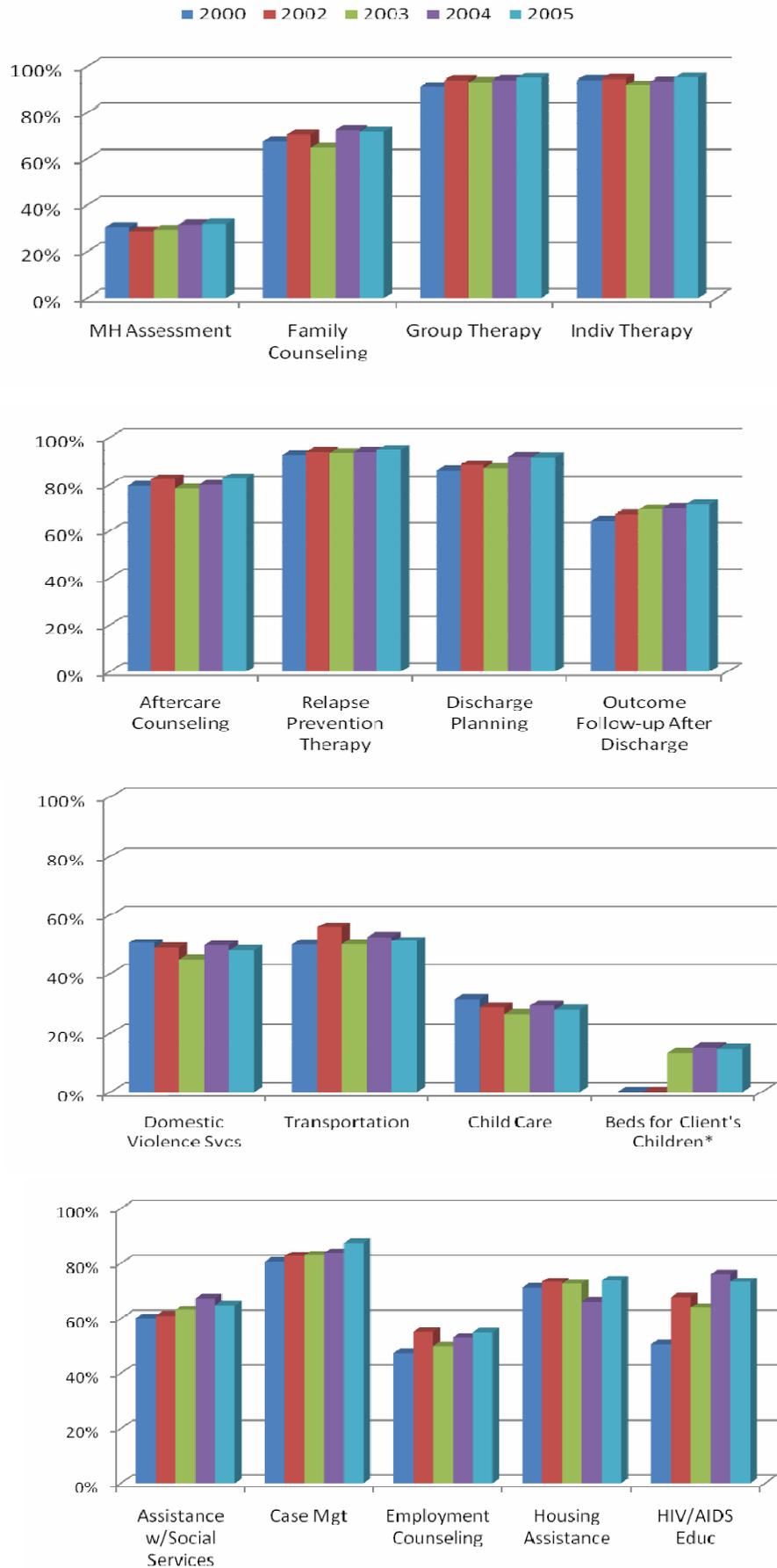
Figure 5: Total and Number of Treatment Facilities reporting Women's Services



The data shows that the number of facilities declined by 4% between 2003 and 2005. Between 2003 and 2004 there was a 21% reduction in the total number of facilities that reported offering a women's program or group. However, a promising indicator is an 8% increase in facilities offering programs or groups for women between 2004 and 2005. The number of facilities offering a special program or group for pregnant women declined by 9%, dropping from 379 to 343.

The service array offered by the facilities with a women's program have showed some minor fluctuations over the past few years. More importantly these data show that many of the critical services included in comprehensive services models (e.g., transportation, child care, employment services and domestic violence services) are not provided by the majority of facilities offering programs for women. The percent of facilities offering various services components are shown for the past five years in Figure 6 on the following page.

Figure 6: Percent of California Facilities with a Women’s Program Providing Given Service



Female Participants in SACPA, Drug Courts and the Criminal Justice System
Women Participating in Drug Courts and SACPA

In the final report for the Comprehensive Drug Court Implementation Act of 1999, outcome data related to women addressed pregnancy outcomes. Two hundred forty-five women gave birth, including 174 adults and 71 juveniles. Ninety-four percent of the participants gave birth to babies without substances in their systems at the time of birth.⁴²

An earlier report on the Drug Court Partnership Act did not provide any analyses by gender. However, it does have two social outcomes related to families. It reports on family-related accomplishments. While there are data regarding the percentage of total clients retaining or gaining custody of their children, the information is not sufficient to evaluate effectiveness in preserving families. For example, from January 2000 to September 2001, 2,892 participants completed drug court programs with 22% retaining custody of children and 6% gaining custody of their children.⁴³ It is unclear how many participants lost custody of their children during this same time period. Counties reported 31% were reunited with families, 7% gained family visitation rights and 8% were current in child support. Additionally, the report indicated that 95% of all babies born while their mothers participated were drug-free at birth.⁴⁴

The current reports on the evaluation of the Substance Abuse and Crime Prevention Act (SACPA /Prop 36) also give limited information about female participation and outcomes. Between July 1, 2004 and June 30, 2005, 27.2% of the clients referred to treatment by SACPA were female (27.9% from SACPA probation, 19.3% from SACPA parole).⁴⁵ This is roughly the same percentage as previous years. Female SACPA treatment clients were significantly more likely to have had a prior treatment experience (29.3%) than male SACPA clients (24.5%).

SACPA clients, both female and male, had similar treatment durations, however. Approximately 77.8% of clients completed 30 days of treatment, 60% completed 60 days and 47.9% completed 90 days of treatment.⁴⁶ Treatment completion rates of SACPA clients differed slightly by gender, with 31.1% of male and 34.6% female SACPA clients completing treatment (see Figure 7). These completion rates are similar to other criminal justice (but not SACPA) and non-criminal justice populations (see Figure 7).⁴⁷

Figure 7: Treatment Completion Rates for SACPA and Other Populations by Gender

	Men Completing Treatment		Women Completing Treatment	
	N	%	N	%
SACPA	22,359	31.1	7,887	34.6
Criminal Justice – not SACPA	25,807	36.5	10,469	37.8
Non-Criminal Justice	47,068	31.5	31,230	29.3

N=144,820. Source: Longshore et al., 2007.

Incarcerated Women

Nationally, the number of women in state prisons has increased 757% in the past three decades, growing at more than twice the rate of the male prison population.⁴⁸ In 1977, the United States imprisoned 10 women per 100,000 female residents; in 2004, the rate had grown to 64 per 100,000. In 2004, this equated to 96,125 women in prison nationwide.

Women’s higher growth rate is due in part to the small number of women who were incarcerated in 1977 relative to the number of men, so that increases show up as larger proportional growth against smaller base figures. Women’s higher growth rate is also due to an increase in the

number of women arrested and an increase in the female imprisonment rates.⁴⁹ The proportion of women convicted of violent offenses has decreased since 1979, while the number of women incarcerated for drug offenses has increased. In 2004, drug offenses accounted for nearly one-third of female incarcerations.⁵⁰

While imprisonment rates have increased nationally, there is tremendous variation among states and regions. For example, 129 of every 100,000 women in Oklahoma are serving a state prison sentence while Massachusetts imprisons 11 women for every 100,000 women. California ranks 22nd in the country, with 61 of every 100,000 women serving a State prison sentence (6.6% of all prisoners being female, equaling 10,882 female prisoners).⁵¹ Since 1977, California has seen a 1522% increase in the number of female prisoners and ranks 6th among the states in terms of female prisoner population growth over the past three decades. The growth rate slowed to only 1% from 1999 to 2004, however. Enactment of SACPA (Proposition 36) has diverted tens of thousands of people arrested for possession of drugs. By 2001, the number of women sentenced to prison had dropped by 10%, and correctional managers attributed Proposition 36 as the largest driving factor driving the decline.⁵²

In 2004, the Little Hoover Commission report entitled “Breaking the Barriers for Women on Parole” reported about characteristics of women in the state prison system in California. An estimated 80-85% of women offenders in prison were reported to have a substance abuse problem and 62% used drugs in the month prior to the offense.⁵³ The number of incarcerated women in California has grown steadily so that in 2004, there were more than 25,000 women under the jurisdiction of the California Department of Corrections and Rehabilitation including 10,973 women in institutions.

Although an estimated 80-85% of women offenders in prison were reported to have a substance use disorder, treatment beds are only available for only approximately 60% of the female inmates and parolees needing treatment (see Figure 8). The Department of Corrections and Rehabilitation (CRC) provides Forever Free, an in-prison therapeutic community-based substance abuse treatment for 1,794 women, approximately 18% of the female inmate population (see Figure 8). Annually, the Female Offender Treatment and Employment Program (FOTEP) provides 989 parolees who have participated in-custody treatment with residential treatment in 13 counties upon release. The Substance Abuse Services Coordination Agency (SASCA) and the Parole Services Network provide treatment for parolees. SASCA serves 1,298 women annually (12.5% of the total SASCA population) and the Parole Services Network serves 463 women annually (14% of the Parole Services Network population). In addition, the Substance Abuse Treatment and Recovery (STAR) program is a curriculum based engagement program which seeks to motivate substance abusers to attend recovery activities after they are released. Approximately 1,400 women are served annually (see Figure 8). CRC funds three community based correctional facilities which provide residential treatment for women. The Family Foundations Program serves 70 women; the Leo Chesney Community Correctional Facility serves 220 female inmates in Sutter County. In both of these programs, women may bring their children under the age of six. The Drug Treatment Furlough offers 150 beds for women in community based residential treatment programs.⁵⁴

Figure 8. Correctional and Community Based Programs Serving Female Inmates

Program	Number of Women Served Annually
Forever Free	1,794
STAR	1,397
SASCA	1,298
FOTEP	989
Parole Services Network	463
Leo Chesney Community Correctional Facility	220
Drug Treatment Furlough	150
Family Foundations	70

The Little Hoover Commission (2004) *Breaking the Barriers for Women on Parole*. Retrieved from www.lhc.ca.gov/tlmdir/177/report177.pdf

Children of Alcohol and Drug Using Parents

Recent studies have documented that adverse childhood environments can have as much or more of an impact than prenatal substance exposure. In 2001, more than 6 million children (9% of American children) lived with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year.⁵⁵ The rates vary by child age; the percentage of children under the age of 6 with a parent with a substance use disorder is 9.8% and among those ages 6 to 17, it is an estimated 8.3%.

Of these children, more than 4 million children nationwide lived with a parent who abused or was dependent on alcohol; almost 1 million lived with a parent who abused or was dependent on an illicit drug; and, more than 0.5 million lived with a parent who abused or was dependent on both alcohol and an illicit drug.⁵⁶ Among parents living with their children, 8% of fathers and 4% of mothers were dependent on or abused alcohol or an illicit drug during the past year.

Figure 9 shows these national data applied to the estimated number of children in California. There are nearly 310,000 children and age 6 and 530,000 children between the ages of 6 and 17 who live with at least one parent with a substance use disorder. The projected total of children is over 840,000 California children (8.8%).

Figure 9: Estimated California Children Living with a Substance Dependent or Abusing Parent in Last Year¹

	Estimated California Population ²	Estimated percent living with parent with substance use disorder ³	Estimated number living with parent with substance use disorder ⁴
Estimated number of children under 6	3,159,402	9.8%	309,621
Estimated number of children ages 6 to 17	6,391,656	8.3%	530,507
PROJECTED TOTAL	9,551,058	8.8%	840,129

¹ Includes alcohol abusing/dependent/ and/or drug abusing/dependent
² US Census Bureau: 2004 American Community Survey, General Demographic Characteristics: 2004
³ Extrapolated from: Substance Abuse and Mental Health Services Administration (2003), The NHSDA Report: Children living with substance-abusing or substance dependent parents. June 2, 2003
⁴ Generated using estimated number of children in California and national reporting of substance abuse and dependence. Under-reporting is common, so estimate may understate the number of children.

Children of Parents in Treatment

Studies have found that approximately 58% of adults in treatment are parents.^{57,58} The estimated percentage of parents is based on an analysis of 15,618 consecutive admissions in 13 California counties, which found that 58.9% of the individuals in treatment were parents of minor children.⁵⁹ Data from a nationally representative sample of alcohol and drug treatment facilities found that 56.6% of clients admitted to treatment had a child under the age of 18.⁶⁰ In this last study, female clients were more likely than male clients to have minor children (69.2% vs. 52.5%).⁶¹

Applying these national estimates to the number of female and male admissions in California results in approximately 121,000 men and 43,200 women admitted to substance abuse treatment who have minor children.

Information Gaps

In reviewing available data, some of the most important findings concern what data are not readily available—or not collected at all. Some of the most important data gaps related to outcomes for women and children include:

- Current prevalence data on substance use during pregnancy and substance-exposed births, on which statewide data has not been updated since 1992
- Total number of women screened for substance use during pregnancy; positive screen results; screens that result in a referral to treatment, treatment access, engagement and treatment outcomes of pregnant women
- Data on referrals of substance-exposed infants to child welfare agencies, as mandated by new amendments to the Federal Child Abuse Prevention and Treatment Act (CAPTA)
- Data on referrals to Regional Centers for developmental assessments of 0-2 year olds with substantiated child abuse and neglect cases as mandated by the new Federal CAPTA amendments
- Prevalence data, treatment need, treatment access and outcomes among parents in the child welfare system (in which recording substance use is an optional field), particularly the subset of parents in which treatment is a condition of family reunification
- Children of substance abusers (COSAs) predominate the population of children in out of home placement. Prevalence, treatment need, treatment access and outcomes for adolescents in the child welfare system who have significantly higher rates of substance use and need for treatment compared to youth not in foster care
- Prevalence, treatment need, treatment access and outcomes for CalWORKs participants for whom targeted funding has been made available since 1998
- Data from Proposition 36 (SACPA)-funded agencies on characteristics and treatment outcomes for women (or men) with minor children
- Timely access to California-specific information submitted to State agencies for monitoring treatment need across service systems, treatment access and outcomes for women and children

VII. Themes from Focus Groups and Interviews

A total of 33 interviews with respondents from 19 counties participated in the key informant interviews and focus groups. The following section summarizes the focus groups and more detailed interviews with key stakeholders. Appendix 2 details the specific methods including interview questions, respondents, data analysis methods and the summary of detailed responses.

Pregnancy and Child Related Issues

Respondents were asked to describe their agencies' and counties' perinatal services for women and families, therapeutic services for children and relationships with medical clinics and hospitals regarding referrals and prenatal care. Stakeholders were also asked their opinion on available opportunities for improving access to quality treatment services for women, children and families and strategies to address prenatal and post-natal substance exposure.

Respondents' observations and recommendations can be grouped into four categories: 1) prenatal; 2) at birth; 3) early intervention for children; and, 4) children's services across the developmental spectrum. All interviewees identified existing services and progress towards addressing pregnancy and child-related needs as well as noting limitations and additional needs.

- Many counties have established prenatal health clinic screening and intervention programs. The level of intervention and effectiveness varied. Some respondents described other intervention activities as well including outreach and engagement approaches for specific populations and collaborations with high risk pregnancy programs.
- With one exception, respondents identified limited effects or no effects of at-birth interventions through Federal CAPTA mandates or SB 2669. None of the respondents had data on current prevalence of substance-exposed infants. Some counties are in the process of expanding hospital-based collaborations. There are also some innovative models of direct collaborations with hospitals resulting in treatment admissions.
- Some respondents identified gaps in accessing early child intervention services and described current programs as working at capacity.

Gender Responsiveness, Cultural Responsiveness, and Family Centeredness

Participants were asked to rate perinatal and other women's services on a scale of one to five for gender responsiveness, cultural responsiveness and family centeredness. While the process yielded some interesting findings, the scores varied so significantly that it did not produce meaningful averages. Variation appeared to be based on respondents' expectations and personal understanding of the terms versus actual capacity. There is a need to build consensus on what constitutes culturally responsive, gender responsive and family centered services as well as how to measure and define these qualities.

Family Treatment

Participants were asked whether they see family treatment as the next evolutionary step in perinatal and family services and what they see as challenges or barriers to its implementation.

The general consensus was that family treatment was a good treatment strategy, with participants describing a continuum of family services progressing from family involvement to whole family treatment services. Several of the provider respondents indicated that they currently offer family treatment services, while recognizing that this is not yet the norm in the field. Respondents also expressed concern that family-based treatment not replace gender-specific services, rather that family-based services supplement gender specificity in services. Funding and staffing issues were identified as primary barriers to family-based treatment. Respondents described systemic impediments to family treatment that resulting from categorical funding and narrow definitions of eligibility.

Accountability

The key informant interviews asked specific questions about measuring accountability and quality improvement. Questions included how accountability is currently measured, data collection needs and possible roles for the State. Most respondents indicated that they were using some form of standard monitoring and evaluation protocols. Several respondents cited the CalOMS project as a significant opportunity to improve data collection, analyses, and use in program planning. Respondents also addressed the need for expanded evaluation efforts and knowledge about research and best practices. Some frustration was expressed with ADP's staffing limitations and inability to respond with timely analytical support for accountability efforts at local levels. Expanded training, provider network meetings and more emphasis on evidence-based practices were felt to be improvements that would strengthen accountability and eventually help with resource issues.

Views About OPSA Purpose and Recommended Activities

Respondents were asked their perspectives and to provide feedback regarding the OPSA's purpose, recommended activities for their involvement, and key areas where ADP can facilitate improving prevention and treatment services for women, children, and families with substance use disorders and related problems. Primary feedback included:

- OPSA's role of the office depends on the definition of perinatal. If a comprehensive family-centered definition is used, a broader role for OPSA is needed. There was consensus that the narrowest definition of perinatal as ending at 60 days post-partum was inconsistent with best practices, the findings of many child and brain development studies and County practice.
- Respondents felt strongly that OPSA or another part of ADP needs to have resources to monitor and advocate for quality services for all women irrespective of their role in child-bearing and parenting.
- Regarding OPSA's current activities, there were a wide range of responses including: 1) lack of awareness that OPSA existed; 2) lack of clarity and understanding of the purpose, mission and current activities; and, 3) lack of knowledge pertaining to reduced staffing and activities. Respondents who were familiar with OPSA expressed concern that there had been a notable decrease in communication (e.g. in-person meetings and email exchanges) and activity, particularly within the last three to five years.
- Shifting roles for OPSA staff were suggested that would expand their involvement in communication with the Perinatal Services Network, provide analysis of data including cost offsets affecting children to the field, advocate for this population of women and children with other State agencies, increase the monitoring of County-level quality and impact, provide guidance on coordinated funding, participate in interagency collaboration at higher levels of State staff, and revise the perinatal services guidelines (further

discussed below). A strategic plan for the office was felt to be an appropriate goal by some.

- Several respondents indicated the importance of OPSA being involved in expanding the dissemination and implementation of research and evidence-based practices into treatment programs, especially integrating trauma-informed, trauma-specific and gender responsive services.

ADP and CADPAAC

CADPAAC members were asked what opportunities they see for ADP and CADPAAC to work together strategically to address perinatal and family issues. Funding support to provide services aligned with an expansion of family treatment was a priority in responses; others emphasized quality improvement. Several CADPAAC members suggested addressing problems with Drug Medi-Cal, including limitations on the types of services that are reimbursable, low reimbursement rates and minimal certification standards. Some respondents indicated the need to expand dissemination of research and best practices at a programmatic level.

Staying Up-to- Date and Networking

Respondents were asked how they stay informed about Federal, State and other local initiatives and what their counterparts are doing. The majority of respondents rely on CADPAAC to stay abreast of Federal, State and local trends. Listservs, internet and informal communication were also identified as a means of networking. Perinatal coordinators did not feel adequately linked with each other on a statewide basis. Respondents also suggested the need for stronger links among perinatal treatment coordinators and annual conferences emphasizing funding and evidence-based practices.

Perinatal Services Guidelines

Respondents were asked if they use the Perinatal Services Guidelines (PSG) and whether they think they should be strengthened. Some respondents were not aware of the PSG. Many respondents indicated that although PSG have been built into program services, monitoring instruments and contracts, they had not been reviewed for a long time. Some providers and two counties have drafted their own standards or workplans. Overall, respondents recommended that the PSG be reviewed. Some respondents believed they should be strengthened; others reserved their opinion contingent on a review process. Some respondents pointed out that quality improvement and funding are closely linked. It was also noted that improved quality could potentially improve funding prospects as higher-quality programs would be able to attract expanded resources through better outcomes, compared with lower-dosage, less effective programs. Respondents recommended that a review process include CADPAAC and provider representatives, including representatives from small counties.

Making a Significant Impact and Improving Access to Quality Treatment Services

Respondents were asked how ADP can make a significant, positive impact in perinatal services and how access to quality treatment services can be improved. The majority of responses focused on categories of funding, including Drug Medi-Cal, Federal funding and other options, including Proposition 10 and Proposition 63. Several respondents felt that placing a greater

emphasis on data was critical to the perinatal field's ability to make its case with other funders. Problems of analytical support from ADP were also mentioned by several respondents. Other suggestions included:

- Updating the PSG, expanding research, communication and collaborations
- Addressing the whole continuum of care by "moving upstream" to broaden prenatal and pre-pregnancy prevention efforts, as well as emphasizing aftercare and recovery through greater emphasis on housing, workforce development and income support.

Collaborative Efforts

Participants were asked to discuss their involvement in local or interagency initiatives that impact women with substance use disorders, their children and their families. All participants identified some collaborative activity, with varying degrees of participation. These ranged from a high degree of involvement at the national, State and local levels, to less involvement in some counties. Collaborations were identified with the following service systems: health, child welfare, CalWORKs, Family Resource Centers (FRCs), First 5 (Proposition 10), and Early Intervention (Part C of the Individuals with Disabilities Education Act). Respondents indicated minimal collaboration between perinatal and criminal justice offices though there is collaboration within administrative offices and programs. Collaborative activities were described as sometimes time-competitive and uncoordinated.

The collaborations matrix (Appendix 3) is intended as a tool for understanding the results of the interviews examining inter-agency collaborations at the provider, County and State levels. The matrix is comprised of key topic areas that require extensive collaborative efforts at each level of the system to provide the continuum of comprehensive services needed by women, children and families. The services and topic areas are:

- Community level prevention and education
- Health and prenatal care
- Mental health
- Criminal justice
- CalWORKs
- Child welfare agencies and dependency drug courts
- Domestic violence
- Early childhood education, school readiness and other young children's therapeutic services
- Children and youth services
- Housing
- Family resource centers (FRCs) and economic development.

The examples of collaborative efforts that are underway are organized according to provider, County and State level collaborations. In addition, current gaps and accomplishments of note are highlighted. Since the matrix is based upon a limited sample of interviewees (not all counties were contacted), the information presented should be viewed as illustrative rather than a comprehensive listing of inter-agency collaborations.

As indicated, there are inter-agency collaborations occurring at the provider, County and State levels throughout the eleven topic areas. Clearly, some providers and agencies are more extensively involved in collaborations when compared to their counterparts. Some of the larger providers are actively involved in multiple collaborations and established networks which are pivotal in facilitating access to multiple funding sources. The development of key partnerships

resulting in increased funding has enabled some providers to offer comprehensive, family-centered services that integrate trauma-informed, trauma-specific and evidence-based practices into their programs. Providers often have working relationships across systems through case management functions.

Several counties recognize the increasing importance of health and prenatal care, focusing efforts on the prevention and intervention of substance-exposed infants. Several counties have implemented Chasnoff's 4P's Plus screening, assessment, referral and treatment (SART) model or a similar screening process. Counties vary in the depth of development of these efforts, with some counties much further along in the process than others. Their involvement ranges from attending collaborative meetings and initial screening to offering brief intervention, engagement and referral services at medical clinics throughout the community.

There were varying levels of collaborations between treatment providers, child welfare services and/or CalWORKs in serving women, their children and their families. Examples of these efforts include the development of drug dependency courts, model programs and interdepartmental MOUs. In contrast, some areas appear to have diminished collaborative activity, particularly in areas related to women's criminal justice, HIV and domestic violence. An emerging area with significant potential for collaboration is integrating services with family resource centers (FRCs). Clearly, there is an impressive array of collaboratives occurring among providers, counties and the State. However, despite noteworthy accomplishments, there are also gaps that are important to address. These gaps are further addressed in the initial findings and recommendations section below.

VIII. Initial Findings and Recommendations

The following section summarizes the primary findings drawn from the data, the interviews and the literature. The findings have been grouped into three categories for introducing findings relevant for planning purposes: ADP and OPSA Internal Planning and Capacity Building; Capacity Building within the Alcohol and Drug Field and Cross System Capacity Building with External Agencies. Each finding is followed by recommendations which flow from those findings and general knowledge and trends in the field.

ADP and OPSA Internal Planning and Capacity Building

- **FINDING: OPSA has roles with a range of populations including: women regardless of parenting status, pregnant women, parenting women and their families.**

The Perinatal Services Network (PSN) is defined through funding rather than type of service or population. The PSN includes the programs for pregnant and parenting women with minor children that *receive perinatal set aside funds*. It does not include programs that serve pregnant and parenting women but are funded solely through Drug Medi-Cal, SAPT Block Grant, child welfare or CalWORKs funding unless the program also has set aside funding.

Recommendation: OPSA's functions should be expanded to include a larger focus on Children, Youth and Family Services, while retaining a separate emphasis in that redefined office on the unique issues faced by women and the demands of gender-specific and culturally competent programs.

- **FINDING: ADP/OPSA functions should shift in several critical areas. Stakeholders noted limited leadership capacity, communication and clear direction of OPSA and offered a number of suggestions for ADP and OPSA activities.**

Respondents expressed a lack of communication from OPSA and a desire for OPSA to bring increased networking among perinatal services providers and funders. Some respondents felt isolated and unable to effectively learn from other programs. The technical assistance needs assessment showed the need for a multi-modal approach to communicating and disseminating knowledge.

Recommendation: Expand communication and communicate more with the field including helping to diffuse evidence-based practices on family-centered treatment. OPSA should work with CFF and other providers to identify the best methods of delivering technical assistance and training and expanded communication strategies for women, perinatal and family service providers. Communication plans should be multi-modal including both high-tech and low-tech methods of communicating. ADP should explore holding a separate conference or creating a focal point at its annual statewide conference to disseminate information on best practices with this population.

Several respondents indicated that reports and evaluations would be helpful for fund development, outcome monitoring and quality improvements. Respondents indicated that data submitted to ADP is often not utilized to its fullest in County and provider-level planning nor to monitor process improvement and outcomes. Data is not used to monitor the implementation and impact of the Perinatal Services Guidelines. Further, respondents suggested that white

papers and fact sheets are a useful method of delivering information across service sectors and geographic areas.

Recommendation: *Expand analysis of available data from ADP and other State agencies; develop fact sheets and white papers. Develop an effective data analysis and reporting system as part of CalOMS. Develop a stronger relationship with the Office of Research Analysis (ORA) to identify ways to compile data and use it to evaluate perinatal and women and family service delivery including the implementation of the Perinatal Services Guidelines. Work with stakeholders to identify critical topics for white papers relevant to perinatal, women's, children and family issues.*

- **FINDING: Across the State, there is not a consistent concept or implementation of gender responsive services**

Over the last twenty years, a significant body of research has emerged which describes effective treatment practices for addressing women with substance use disorders.⁶² Gender responsive treatment is comprehensive, strength-based and motivational, trauma-informed, culturally relevant, relational (including family) and addresses the different pathways to use, consequences of use, motivation for treatment, treatment issues and relapse prevention needs specific to women. During the interview process, wide variation in how administrators and providers perceived gender responsive services was noted. Key informants articulated the need for direct and deliberate methods of diffusing research and evidence based practices.

Recommendation: *Develop a white paper(s) and training protocols on gender responsive services drawing upon available research and literature. Build consensus on key components and best practices. Consider a statewide conference or an annual event in which evidence-based, gender-specific programs are fostered and effective clinical interventions are emphasized.*

Capacity Building within the Alcohol and Drug Field

- **FINDING: The term perinatal is used to refer to different populations of women and children within different contexts.**

Within the AOD field there is no consensus on the definition of perinatal. When one person speaks of perinatal, they may be talking about pregnant and post-partum women (defined as 60 days by some programs and as a much longer period by others), another is referring to all women and a third is referring to pregnant and parenting women.⁶³ Perinatal, particularly within health care, typically refers to pregnancy and the post-partum period (60 days). Within alcohol and drug services, parenting women are typically included in the term "perinatal." The Office of Perinatal Substance Abuse (OPSA) is responsible for the Perinatal Services Network. The Perinatal Services Network is defined by the source of funding a program receives rather than exclusively by the population served. Perinatal Services Network programs are those that receive state or federal perinatal set-aside funds, and serve pregnant and parenting women with children up to age 18. Some Perinatal Services Network programs place different age restrictions on children.

Pregnant and parenting women are also served in programs that are not part of the Perinatal Services Network as well as within the Perinatal Services Network. Programs outside the Perinatal Services Network do not receive any perinatal set aside funding. They may serve pregnant and parenting women and be funded through non-perinatal Drug Medi-Cal, CalWORKs, child welfare or other non-SAPT Block Grant public funds, contracts through other State or County departments (e.g. California Department of Corrections and Rehabilitation

(CDCR) or CalWORKs), Proposition 10, privately funded State licensed programs for women or women with children, and general population programs serving pregnant and parenting women. Likewise, Perinatal Services Network programs may also receive other sources of funding in addition to Federal and State perinatal set aside funds.

Growth in perinatal services expanded the development of comprehensive services for women with substance use disorders. Many advocates whom initially worked to develop and advocate for services for women are the same who worked to establish perinatal programs, and now family-based programs. These advocates express concern that quality programs be available across the lifespan of women and not be based on women's pregnancy and parenting status. They agree that pregnancy is a special time in a woman's life, in which there are more costs and potential consequences of alcohol and drug use. They also recognize the importance of children in women's recovery; and support for increased family-based services. It appears common for the "perinatal" program to serve as the hub of knowledge on women, pregnant women, parenting women, affected children and whole family services.

Recommendation: *Build consensus on terminology used by treatment providers, counties and the State. Gender responsive, comprehensive services should be available to all women, regardless of pregnancy or parenting status. To the extent that priorities need to be set with limited resources, programs with a two-generation impact should be emphasized. We suggest moving away from funding-determined definitions and toward a descriptive seamless continuum of services for women, pregnant (perinatal) women and families (including single-parent women). This continuum must take into account the developmental spectrum as girls, adolescents, women of child-bearing age and maturing women's needs evolve and differ across the life span. This would allow for better communication and a better articulated continuum of services. Service design needs to allow people to move between categories and provide for the specialized needs of both pregnant women and parents. Parenting women and their children should be identified as families (regardless of other participants). Building this consensus can be a part of a strategic planning effort.*

- **FINDING: The Perinatal Services Guidelines were developed in 1994 and should be reviewed and updated to reflect the state of knowledge in the field. There is an emerging continuum of family based services for which there are currently no guidelines or standards.**

The PSGs were originally developed in 1994. They were reviewed and some updates were made in 1997. More current knowledge recognizes best practices such as case management, evaluation and client monitoring, children's services and trauma services, which are not addressed within the guidelines.

There are a number of research findings which encourage family-based treatment for at-risk families. These include: increased identification of the developmental effects of prenatal and post-natal substance exposure and therapeutic interventions; research on the impact of relationships on women's substance use, client engagement, treatment retention and relapse; cultural competent service delivery; prevalence of family violence; need for safety planning; and, guidelines for adolescent-based family treatment approaches.

Policy trends have also resulted in an increased need for family treatment. Policy trends include: changes in child welfare policy and time limits for reunification; evolution of dependency drug courts; and, increased numbers as well as attention and programming for incarcerated parenting women with substance use problems. Respondents indicated a high degree of interest in family-based services. There are at least 20 moderate to high service-level family-based programs in California and an increasing trend in the development of dependency drug

courts. Nevertheless, staffing needs and funding considerations were seen as barriers to expanding family treatment.

Recommendation: *Convene a work group of CADPAAC members, treatment providers and other stakeholders, to review the Perinatal Services Guidelines (in this context perinatal is referring to guidelines for pregnant and parenting women), suggest language updates, and formulate a recommendation as to whether the guidelines should be updated to be more prescriptive and inclusive of evidence-based practices. The work group should explore transitioning the PSGs to voluntary standards for all publicly funded programs serving women, with sections that address women, pregnant women and families. The guidelines should be reviewed in the context of CalOMS and the emergence of evidence-based data to effectively monitor the implementation of the guidelines.*

- **FINDING: There are opportunities for ADP to work with other stakeholders to improve funding including an evaluation of Perinatal Drug Medi-Cal limitations, joint proposals and inter-agency collaboration.**

Drug Medi-Cal contains policies which informants state are not indicative of good practice or deter from financial feasibility including a maximum of 16 beds in residential programs and an end of eligibility for Perinatal Drug Medi-Cal at 60 days post-partum. Any program which a County chooses not to fund (typically because it does not meet quality standards) but which is able to become certified, may contract directly to ADP for Perinatal Drug Medi-Cal. One respondent commented that for cost-effectiveness, counties and programs should be required to use Perinatal Drug Medi-Cal for eligible clients prior to engaging them in perinatal set-a-side funded services. The funding mechanism primarily funds group counseling and limited individual counseling and not other services that may benefit pregnant women with substance use disorders.

Recommendation: *Review perinatal Drug Medi-Cal standards, funding and practices as well as Medicaid requirements to determine if there are waivers or additional service categories that are possible. If there are benefits to making changes, this work could be referred to the Perinatal Standards Workgroup to ensure complementary practices.*

Cross-System Capacity Building with “External” Agencies

- **FINDING: There is significant concern about funding and maintaining existing funded programs; at the same time, there is new flexibility in Federal and potential private funding options.**

Most key informants discussed challenges related to funding. The providers of model programs identified the need to obtain funding from multiple funding streams in order to meet the comprehensive needs of women and families. Several informants expressed concern that while increased accountability and a move towards family-centered treatment were both desirable, without additional resources it could place too much burden on resource-limited providers. Concerns regarding the limitations of Drug Medi-Cal such as no reimbursement for case management were noted. The projected Federal and State funding for perinatal treatment services in California has remained relatively stable at approximately \$47.5 million. While in some counties, CalWORKs, child welfare, public health, criminal justice and private foundations have contributed to the availability of treatment services for women and families, the extent to which these funds have been used not known. To deliver comprehensive services involves working with other departments and multiple funding sources. There are new funds and regulations within several collaborative partners that offer possible funding for expanded alcohol

and other drug services including: child welfare, CalWORKs, supportive and affordable housing, co-occurring disorders, and corrections.

Recommendation: *Develop a funding inventory that identifies non-ADP funds which could be used to expand services for women, pregnant women and families. Develop a white paper on Title IV-E programs and possible approaches to collaborating with child welfare. Review the potential collaborative opportunities described in this paper and select those that appear to have the greatest short run (1-2 years) and longer –range (3 years and beyond) potential.*

- **FINDING: There is increasing recognition of the importance of prevention and early intervention to address prenatal substance abuse.**

The American College of Obstetrics and Gynecology (ACOG) states that no alcohol or drug use during pregnancy is safe. Multiple factors determine the effects of fetal exposure to alcohol or other drugs. Earlier interventions and reductions in use reduce the impact of fetal exposure. Post-natal effects of parental substance use also contribute to sub-optimal development and life trajectories. Despite the risks, pregnant women continue to drink and use illicit drugs albeit at lower rates as pregnancy advances. In addition to the high life time costs to the mother and child, prenatal and post-natal substance exposure is expensive – costing unknown billions in medical, developmental, special education, foster care and often future incarceration costs. Counties have continued to take advantage of the multiple opportunities for intervention before pregnancy, during pregnancy, at birth and throughout early and later childhood. In particular, counties throughout California have formed collaboratives which are seeking to increase prenatal screening and intervention, with leadership from maternal and child health in several counties and varying involvement of County child welfare, treatment and other agencies.

Recommendation: *Working in collaboration with other State agencies, review the findings of the recent Department of Health Services (DHS) survey of County Maternal Child and Adolescent Health (MCAH) directors on prenatal screening as part of a broader assessment of current initiatives in the area of prevention and early intervention in responding to the effects of prenatal and post-natal substance exposure. Conduct a comprehensive survey of the County-level collaborations occurring within California that address these issues, describing their functions and funding streams, identifying available data measuring the impact of these collaboratives and summarizing promising practices developed by these collaboratives.*

- **FINDING: Cross-State agency collaboration is happening with several agencies, but there are gaps in this arena and room for improvements**

While much of the initial funding and leadership of the 1980s was based in the AOD field, current collaborations often arise from interest in child welfare, maternal child and family health, or criminal justice. ADP, CADPAAC, and treatment providers are often dependent on the resources and priorities of the other service systems. The Perinatal Environmental Scan report includes a collaborations matrix as a planning tool to illustrate trends and gaps in collaboration.

From 1989 to 1994, ADP served as the lead agency of the State Interagency Taskforce on Perinatal Substance Abuse (SITF). This collaboration created communication channels and inter-departmental learning where none had existed previously. This was a time of tremendous growth in services for pregnant and parenting women; likewise, other service systems previously unaware of AOD problems began to identify substance abuse-related issues. Since that time, funding for services for pregnant and parenting women has leveled. Other priority populations outside the established infrastructure (e.g., Proposition 36 and adolescents - which include pregnant/parenting women) received support. The OPSA focus group, historical

documents and a review of literature indicate that there is continuing cross-State agency collaboration, though ADP's participation has diminished as staff levels have been reduced.

ADP is currently participating in a number of active State-level collaborations that address women, perinatal and family issues. The DSS State Interagency Team grew out of Child Welfare Redesign and has had an alcohol and drug workgroup with a pending action plan. The Domestic Violence Taskforce has regularly monthly meetings in which ADP participates; however, the agenda appears to primarily be information sharing and support for the Attorney General's efforts. The Interagency Coordinating Council of the Early Start Collaborative recently completed a planning and priority setting session. Infant mental health is one of the targeted areas of development. The Fetal Alcohol Spectrum Disorder (FASD) Taskforce is an independent public-private partnership of parents and professionals committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. The strategic plan adopted in December of 2005 includes goals related to increasing public awareness of FASD and prevention, reducing the number of women who drink during pregnancy and improving availability and accuracy of data and public policy efforts.

Both within the current State Interagency Team, with its AOD working group, and in other, more bilateral forums, ADP has the opportunity to explore in depth a series of closer partnerships on each of these collaborative ventures. The collaborative matrix suggests the range of activities already under way; it should be updated and corrected by all participating agencies. The criminal and juvenile justice arenas, in particular, could benefit from a separate working group convened jointly by ADP and these agencies that would review (1) the current flow of funding for clients of these agencies, (2) the standards and outcomes measures now in use, and (3) the personnel demands for quality staffing of these agencies and their local counterparts.

The development and implementation of Dependency Drug Courts has resulted in significant local level collaboration between the alcohol and drug treatment services, child welfare services and the family/dependency/juvenile courts. There are currently approximately 20 Dependency Drug Courts in California. Numerous other counties would like to initiate Dependency Drug Courts. There are limited data available on the evaluations of these courts. Sacramento County has funded its own long-term evaluation of its efforts. San Diego and Santa Clara Counties are part of the national cross-site evaluation funded by CSAT.

Significant collaborations have also resulted in the emergence of drug courts and the implementation of the Substance Abuse and Crime Prevention Act (SACPA). These collaborations have resulted in treatment expansion for women with substance use disorders. Reports on these programs provide limited evaluation of the access, services or outcomes specific to women participating in Drug Courts and SACPA.

While ADP has formed strong collaborative relationships with the California Department of Corrections and Rehabilitation (CDCR), only minimal collaborative activities have expressly addressed issues of criminal justice involved substance using women and their families. CDCR has been actively engaged in restructuring and increasing rehabilitation services. There is considerable opportunity for cross-system collaboration in which ADP could support CDCR efforts to improve gender responsiveness, substance abuse treatment and comprehensive aftercare for female offenders and their families.

There is complexity in California's policy environment around collaboration in planning and delivering perinatal services. Collaborations occur at different levels, with different partners and for different purposes. There are collaborations at federal, state, local and provider levels, and what occurs at each of these levels affects decisions in other levels. There are also multiple systems with which the AOD field has sought to collaborate (e.g., mental health, child welfare,

maternal child health, etc.). Policies created in one system can enhance or detract from the ability to collaborate. The number of service systems participating in a collaborative effort may also vary. Finally, collaborations exist for different purposes. There are four stages of collaborations: information sharing, supportive relationships relying on external funding, joint efforts to change the rules of service delivery and redirect current funding, and integrated funding and service delivery. The type of collaboration depends upon the leadership, purpose, resources, and communication of those entering the partnerships.

Recommendation: ADP/OPSA should review these and other interagency collaboratives and assess their potential impact on perinatal services, including the prospects of expanded support for comprehensive family-based services. In particular, the OPSA should pursue opportunities presented by Proposition 10, Proposition 63, and work with DSS and counties to support family treatment as a service under the new Title IV-E Child Welfare waiver.

Recommendation: Based on collaborative assessments of current efforts, a strategic plan with benchmarks and baselines should be developed in each of the broad areas where ADP envisions an ongoing partnership with its sister agencies. In the arena of early childhood and substance-exposed births, this strategic plan could draw upon materials already submitted to the SIT, as reviewed in a new partnership with the state Commission on Children and Families.

Recommendation: In collaboration with the Judicial Council, and the Department of Social Services, seek resources to convene a statewide meeting on Dependency Drug Courts similar to the early Proposition 36 implementation meetings. The purpose of this meeting would be to share evidence based practices, variations in implementation, outcomes and evaluations and provide networking opportunities for both established and newly emerging Dependency Drug Courts.

Recommendation: Schedule a series of introductory meetings between ADP OPSA, the Associate Director/Administrator of Female Offender Services in both adult and juvenile services to identify current planning and implementation activities and opportunities for collaboration and information sharing.

Recommendation: Request information and data analysis on how Proposition 36 and Drug Courts have expanded services for women including specific data on participation, services, and outcomes, include family outcomes. From this data develop a planning tool for the Proposition 36 Advisory Committee and Counties to use for quality improvement and to shape revisions to programs.

IX. Conclusion

Based on recent changes in the policy context of perinatal services in California, an opportunity exists for ADP/OPSA to play a larger leadership and support role and to impact women's access to quality services to meet their needs. Some of the findings to consider as ADP proceeds in service improvement include the following.

- ◆ The term "perinatal" refers to different populations in different contexts.
- ◆ The demand for substance use treatment among women, pregnant women and parenting women exceeds the availability of services.
- ◆ The majority of treatment facilities in California do not yet offer gender-responsive services. There is, however, significant interest in learning more about the implementation of gender-responsive services, research-based practices and using outcomes to inform service planning.
- ◆ In a majority of California counties, there has been an increase in screening and education to prevent substance use among pregnant women as a result of collaborations with County Maternal, Child and Family Health.
- ◆ Interventions which address the needs of prenatally and postnatally exposed children are available but gaps still exist.
- ◆ There is an emerging interest in family-based treatment services.
- ◆ There is significant concern about funding and maintaining existing funded programs.
- ◆ Collaborations were identified with multiple service systems at the provider, county and statewide levels.
- ◆ The field is optimistic that CalOMS, updated Perinatal Services Guidelines and other evaluative efforts could result in improved quality assurance and resource utilization, but there is concern about cost.

The Perinatal Environmental Scan is a useful tool for three types of planning: 1) internal ADP and OPSA strategic planning; 2) planning and capacity building within the broader network of the alcohol and drug field; and, 3) cross-system capacity building with other State departments and agencies. The findings and recommendations serve as a framework for developing a strategic plan for technical assistance resources and support to ADP/OPSA.

X. Notes and References

- ¹ Within the alcohol and other drug (AOD) field there is no consensus on the definition of perinatal. Perinatal, particularly within health care, typically refers to pregnancy and the post-partum period (60 days) but within AOD services parenting women are typically included. Perinatal Services Network programs are those that receive state or federal perinatal set-aside funds, and serve pregnant and parenting women with children up to age 18, though the programs often place different age restrictions on children. Pregnant and parenting women are also served in programs that do not receive perinatal funding and are not part of the Perinatal Services Network.
- ² Extrapolated from Office of Applied Studies (OAS). (2007). Overview of findings from the 2005 National Survey on Drug Use and Health (NSDUH). Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH defines binge alcohol use as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.
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- ⁴ Ibid. NSDUH identified a respondent was defined with abuse of a substance if he or she met one or more of the four criteria for abuse included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association [APA], 1994) and did not meet the definition for dependence for that substance. Additional criteria for alcohol and marijuana abuse are that if respondents reported a specific number of days that they used these drugs in the past 12 months, they must have used these drugs on 6 or more days in that period.
NSDUH defined a respondent with dependence on illicit drugs or alcohol if he or she met three out of seven dependence criteria (for substances that included questions to measure a withdrawal criterion) or three out of six criteria (for substances that did not include withdrawal questions) for that substance, based on criteria included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994). Additional criteria for alcohol and marijuana dependence since 2000 are that if respondents reported a specific number of days that they used these drugs in the past 12 months, they must have used these drugs on 6 or more days in that period.
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- ⁷ The California Maternal and Infant Health Assessment, 2003, survey of women post-delivery found that 19 percent of women reported drinking alcohol during their pregnancy.
- ⁸ Four studies produce prevalence rates for drug use during pregnancy the NSDUH, IDEAL and the California Prenatal Substance Exposure Study prevalence rates range from 3.5 percent to 11 percent. Prevalence rates were applied to the number of births in California in 2004.
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- ⁶³ ADP itself uses the following definition: "Perinatal Definition: To qualify for publicly funded perinatal substance abuse treatment services a woman must be either: pregnant and substance using; or parenting and substance using, with a child or children ages birth through 17 years. This includes a woman who is attempting to regain legal custody of her child(ren)."

Appendix 1:
Data Summary

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Introduction

This appendix contains data relevant to the delivery of a comprehensive continuum of services to prevent and reduce substance use disorders among women, children and families. The purpose of these data is to provide detailed background for the Perinatal Environmental Scan summary.

The data come from analyses conducted by Children and Family Futures (CFF) and reference materials from other national and State reports. The sources are primarily from the national and California subset of three primary Federal data sources:

- National Survey on Drug Use and Health (NSDUH)
- Treatment Episode Data Set (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)

Prevalence Estimates

National estimates of alcohol and other drug (AOD) use among women have been derived from the NSDUH. The NSDUH is the primary source of statistical information on the use of alcohol and drugs by the U.S. population. In 2004, 7.6 million women (6.1% of the female population) were current illicit drug users and 15.1 million women (12.2% of the female population) aged 12 and older reported any illicit drug use in the past year.¹ These numbers represent 39.7% of the 19.1 million current illicit drug users and 43.5% of the estimated 34.8 million past year illicit drug users in the United States. During the same time period, 18.5 million women participated in binge drinking (representing 33.8% of all binge drinkers), defined as five or more drinks on at least one occasion in the past 30 days.²

While there were gender differences among the overall sample in the NSDUH, when age cohorts were examined, the gender differences were no longer apparent. However, a recent trend shows that among youth aged 12 to 17, the rate of current illicit drug use was similar for boys and girls (10.6% for both) and the rates of past month alcohol use were not significantly different (17.2% for males vs. 18.0% for females).³

Among pregnant women aged 15 to 44, 4.6% reported using illicit drugs in the past month, 11.2% reported past month alcohol use and 4.5% reported past month binge drinking.⁴ These rates vary by gestation, with 10.6% of women in their first trimester, 1.9% of second trimester women and 1.1% of third trimester women reporting binge drinking.⁵

In 2004, 7.7 million women (6.2% of the female population) in the United States were dependent on or abused alcohol or other illicit drugs in the past year.⁶ Women represented 33.4% of the 22.5 million Americans with AOD dependence or abuse.

Although California specific prevalence estimates are available through the NSDUH, they are not reported by gender. In 2004, 2.6 million Californians reported current (i.e., past month) illicit drug use and 5.9 million reported past month binge alcohol use. In addition, 904,000 Californians were dependent on or abused alcohol or other illicit drugs in the past year.⁷ Based

on the national NSDUH numbers on rates by gender, estimates for California women have been extrapolated. An estimated of 39.7% of current illicit drug users in the United States were female, it is estimated that 1 million illicit drug users in California in 2004 were women (39.7% of 2.6 million). Based on national figures again, it is also estimated that approximately 2 million female Californians were binge drinkers (33.8% of 5.9 million) and 302,000 female Californians (33.4% of 904,000) were either dependent on or abused substances in 2004.

The California Department of Health Services, Office of Women's Health, in collaboration with the State of California Department of Alcohol and Drug Programs (ADP) and other State departments conducts an annual survey of women's health examining patterns of abstention, drinking and heavier drinking among women based on several core measures. An analysis, which combined surveys conducted between 1997 and 2002, found that 49.6% of the women sampled were drinkers and 50.4% were abstainers.⁸ Only 1.4% of the sample reported drinking 60 or more drinks in the month (which was classified as chronic drinking) and 7.2% of women engaged in binge drinking at least once in the prior month. Younger women (ages 18-24) drank at higher rates than older women. Caucasian women had the highest rate of alcohol consumption (57.9%) followed by US-born Hispanics (46.7%), African Americans (45.7%) and other populations, including Asian women (36.5%). The lowest rate of alcohol consumption reported (21.6%) was among foreign-born Hispanics.⁹

Children of Alcohol and Drug Using Parents

Children of substance abusers (COSAs) have a wide variety of problems and potential risk factors.^{10,11,12} These factors include:

- effects of prenatal exposure
- unstable and unsafe family environments
- greater likelihood of experiencing childhood trauma, violence, abuse or neglect
- developmental and cognitive delays and deficits
- proximity to and accessibility of alcohol and other drugs
- family norms and values which encourage alcohol and drug usage
- living part of their lives in out of home care and removed from their birth parents.

Recent studies have documented that adverse childhood environments can have as much or more of an impact than prenatal exposure. In 2001, more than 6 million children (9% of American children) lived with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year.¹³ The rates vary by child age however. The percentage of children under the age of 6 with a parent with a substance use disorder is 9.8% and 8.3% among those ages 6 to 17.

Of these children, more than 4 million lived with a parent who abused or was dependent on alcohol; almost 1 million lived with a parent who abused or was dependent on an illicit drug; and, more than 0.5 million lived with a parent who abused or was dependent on both alcohol and an illicit drug.¹⁴ Among parents living with their children, 8% of fathers and 4% of mothers were dependent on or abused alcohol or an illicit drug during the past year.

Figure 1 shows these national data applied to the estimated number of children in California. There are nearly 310,000 children and age 6 and 530,000 children between the ages of 6 and 17 who live with at least one parent with a substance use disorder. The projected total of children is over 840,000 California children (8.8%).

Figure 1: Estimated California Children Living with a Substance Dependent or Abusing Parent in Last Year¹			
	Estimated California Population ²	Estimated percent living with parent with substance use disorder ³	Estimated number living with parent with substance use disorder ⁴
Estimated number of children under 6	3,159,402	9.8%	309,621
Estimated number of children ages 6 to 17	6,391,656	8.3%	530,507
PROJECTED TOTAL	9,551,058	8.8%	840,129
¹ Includes alcohol abusing/dependent/ and/or drug abusing/dependent ² US Census Bureau: 2004 American Community Survey, General Demographic Characteristics: 2004 ³ Extrapolated from: Substance Abuse and Mental Health Services Administration (2003), The NHSDA Report: Children living with substance-abusing or substance dependent parents. June 2, 2003 ⁴ Generated using estimated number of children in California and national reporting of substance abuse and dependence. Under-reporting is common, so estimate may understate the number of children.			

The California Health Interview Survey (CHIS) is a telephone survey of children, adolescents and adults throughout the State. CHIS inquires about numerous health related topics, including questions regarding alcohol use. Survey results showed that non-parenting adults were more likely to drink alcohol than parenting adults. Approximately 58% of adults indicated that they drank alcohol in the last month including 50.1% of single parents with children and 56.4% of married parents with children.¹⁵ Data on children growing up in families with illicit drug use is limited.

Fetal alcohol spectrum disorder (FASD) is caused by maternal alcohol consumption during pregnancy. FASD can include physical abnormalities, mental retardation and health problems. Long-term effects of prenatal alcohol or substance exposure may include: long-term cognitive deficits, learning disabilities and poor social adjustment in older children.^{16,17} Older children prenatally exposed to stimulants and other substances may have limited expressive language and small but significant deficits in IQ in the language ability areas. Over-stimulation and self-regulation difficulties have been observed with cocaine-exposed children and these effects may be seen in children exposed to other stimulants.

Prenatal exposure to alcohol or other drugs is only one factor of a myriad of other factors which place COSAs at risk. Children of parents who use substances may experience sub-optimal home environments (e.g., lack of appropriate and consistent boundaries, family instability). Chaotic home environments and parenting may contribute to developmental, behavioral, health and mental health problems and subsequent delinquency or alcohol/drug usage. Children who are exposed to the production, manufacturing and sales of illicit drugs have additional health and safety risks. All of these associated environmental factors, combined with biological factors, place children of substance abusers at increased risk for early onset of alcohol and other drug

problems, as well as predisposing them to a significant number of other problems. Unfortunately, there is little data available regarding the prevalence or needs of COSAs.

Prenatal and post-natal exposure to alcohol and drugs in a family and the lifestyle effects of those drugs have consequences in children’s development. Prenatal and postnatal effects can be mitigated by the care received after birth and during childhood, but may require specialized interventions. When children of substance abusers enter service systems (child welfare, parenting, regional centers, preschools) these systems do not screen, assess, diagnosis, address or track alcohol or drug involved families. If systems establish better screening and surveillance tools then early intervention and better outcomes could be achieved.

Prevalence of Alcohol and Drug Use During Pregnancy

An infant is substance-exposed if it has been exposed in utero to alcohol, licit or illicit drugs ingested by the mother. The American College of Obstetrics and Gynecology holds the position that there is no safe amount of alcohol that can be consumed during pregnancy. The effects of substance exposure depend on many factors, including the timing, frequency, substance and intensity of the exposure. The effects of substance exposure are often not detected. In some instances, the resulting developmental, health and behavioral problems may not be addressed until children enter school; other children never get help.

Figure 2 shows estimates of alcohol exposed births in California and the projected number of youth under 18 who may be affected by alcohol exposure. It is estimated that more than 100,000 infants are born each year in California who have been prenatally exposed to alcohol (see Figure 2). From 1987 to 2004, as many as 1.9 million California children were exposed to alcohol in utero.¹ The California Maternal and Infant Health Assessment (MIHA) is an annual statewide survey of women who recently gave birth. In the 2003 MIHA survey, approximately 19% of women reported drinking during their pregnancy.¹⁸

Figure 2: Alcohol Exposed Births in California	
Number of Births in California ¹	540,827
Estimated percent of pregnant women who drink alcohol ²	19.0%
Projected number of births with alcohol exposure	105,181
¹ Source: State of California Department of Health Services, Birth Records	
² Source: California Maternal and Infant Health Assessment, 2003	

It is estimated that between 20,000 and 60,000 California infants are prenatally exposed to illicit drugs each year (see Figure 3). There are three primary sources of data from which drug exposed births can be extrapolated: the NSDUH data on the percent of pregnant women reporting illicit drug use in the past month;¹⁹ the 1992 California Perinatal Substance Exposure Study²⁰ and initial results from the Infant Development, Environment and Lifestyle (IDEAL) study.²¹

The NSDUH estimated that 8.0% of women report use in the last month of their first trimester of pregnancy and 4.6% reported use in their last month of any trimester (see Figure 3). This

¹ Approximately 10 million infants were born in California in the 18 year period from 1987-2005. Assuming the rate of alcohol use during pregnancy each year was 19% then 1.9 million of these infants were born exposed to alcohol.

equates to 43,266 and 24,878 Californians prenatally exposed, respectfully. The NSDUH is useful in estimating prenatal exposure due to the magnitude of the study, the completeness of data set and the fact that it addresses substance use during the last month by trimester of pregnancy (thus capturing first trimester substance use). Since a significant number of pregnancies involving prenatal substance use do not lead to live births, it is possible that the NSDUH presents an over estimate of rates of prenatal substance use.

Figure 3: Prenatal Exposure to Illicit Drugs in California		
Data source used to extrapolate rate of substance exposure	Rate	Projected number of California drug exposed births¹
NSDUH, report of use in last month, sampling first trimester of pregnancy	8.0%	43,266
NSDUH, report of use in last month, sampling from all trimesters of pregnancy	4.6%	24,878
CA Perinatal Substance Exposure Study, positive test at time of delivery	3.5%	18,929
IDEAL, self-report or meconium testing	11.0%	59,491
¹ California Department of Health Services reported 540,827 births in 2003. Estimates calculated by applying the substance exposure rate derived from the named study above to the number of California births.		

The 1992 California Perinatal Substance Exposure Study included a comprehensive evaluation of 29,000 births throughout California and found that 3.5% of women had a positive drug test at the time of delivery.²² This equates to 18,929 California children prenatally exposed (see Figure 3). By testing maternal urine, the study accounts for limitations in self-reporting. The study, however, is fifteen years old and use of drugs may have changed since the study was conducted. The study captured drug use at the time of delivery. Pregnant women who stopped substance use prior to delivery are not included.

Lastly, the IDEAL study used meconium testing to confirm negative self-reports. It found that 11.0% of pregnant women (equating to 59,491 California children) self-reported prenatal substance use or had a positive meconium test with the birth of their child (see Figure 3). Information about births in Los Angeles is included as well as data on national rural and urban settings. One limitation of the data is the fact that it concentrates on pregnant women in cities or regions identified as having a high rate of methamphetamine use. Thus, it may overstate prevalence of prenatal drug use.

The above studies deal solely with prenatal alcohol or illicit drug use. In 1992, there was a statewide testing of 30,000 women which documented that 11.35% of all births were substance-exposed to alcohol and illicit drugs, based on detection methods at that time. This percentage corresponds to approximately 70,000 births a year.²³

Summary

- An estimated 1 million illicit drug users in California in 2004 were women
- An estimated 302,000 female Californians were either dependent on or abused substances in 2004

- There are an estimated 840,000 California children living with a parent who has a substance use disorder
- An estimated that 100,000 infants are born each year in California who have been prenatally exposed to alcohol and approximately 20,000 and 60,000 California infants are prenatally exposed to illicit drugs each year

Prevalence Estimates for Special Populations

Substance Abuse and Child Welfare

Despite recent attention to the prevalence of parental substance use disorders among families in child welfare services (CWS), there is very little national and State data on the number of children who are in foster care as a result of parental substance use disorders. For more than a decade, anecdotal reports have suggested that a sizable majority of families involved with child welfare services are affected by substance use disorders. But studies that have examined the prevalence of substance abuse among parents in the child welfare population have found widely varying rates. National reports in the late 1990s often cited studies that indicated that from 40% to 80% of CWS-involved families have substance use problems.^{24,25} The Department of Health and Human Services in its Report to Congress in 1999 stated that between one-third and two-thirds of children in CWS are affected by substance use disorders.²⁶ They suggest that the lower estimate is based on cases in which children were not removed from the parents' care and the higher estimate is based on cases in which children were placed in protective custody.

Women with Co-Occurring Disorders

The NSDUH estimates that almost 2% of the general female population in the United States has co-occurring mental health and substance use disorders.²⁷ This corresponds with the 2001 estimate that 1.5% of Californians met criteria for both severe mental illness and substance abuse or dependence.²⁸

In the special population of Perinatal Service Network (PSN) participants in 2003-2004 included 15.2% individuals with co-occurring disorders and 84.8% without a co-occurring disorder.²⁹ In 2001, an estimated 962,000 of adult Californians (4%) perceived an unmet need for mental health treatment; women were twice as likely as men to perceive an unmet need. Forty-five percent of women with illicit drug dependence or abuse and 31% of women with alcohol dependence or abuse also had a serious co-occurring serious mental illness.³⁰

Women Participating in Drug Courts and SACPA

In the final report for the Comprehensive Drug Court Implementation Act of 1999, outcome data related to women addressed pregnancy outcomes. Two hundred forty-five women gave birth, including 174 adults and 71 juveniles. Ninety-four percent of the participants gave birth to babies without substances in their systems at the time of birth.³¹

An earlier report on the Drug Court Partnership Act did not provide analyses by gender. However, it does have two social outcomes related to families. It reports on family-related accomplishments. While there are data regarding the percentage of total clients retaining or gaining custody of their children, the information is not sufficient to evaluate effectiveness in preserving families. For example, from January 2000 to September 2001, 2,892 participants completed drug court programs with 22% retaining custody of children and 6% gaining custody of their children.³² It is unclear, however, how many participants were parents or how many participants lost custody of their children during this same time period. Counties reported 31% were reunited with families, 7% gained family visitation rights and 8% were current in child support. Additionally, the report indicated that 95% of all babies born while their mothers participated were drug-free at birth.³³

The current reports on the evaluation of the Substance Abuse and Crime Prevention Act (SACPA or Prop 36) also give limited information about female participation and outcomes. Between July 1, 2001 and June 30, 2004, 26.9% of the clients referred to treatment by SACPA were female (27.9% from SACPA probation, 19.3% from SACPA parole).³⁴ This is roughly the same percentage as previous years. Female SACPA treatment clients were significantly more likely to have had a prior treatment experience (29.3%) than male SACPA clients (24.5%). Female and male SACPA clients had similar treatment durations, however. Approximately 76% of clients completed 30 days of treatment, 60% completed 60 days and 49% completed 90 days of treatment.³⁵ Treatment completion rates of SACPA clients also did not differ by gender, with 33.7% of male and 36.0% female SACPA clients completing treatment (see Figure 4). These completion rates are similar to other criminal justice (but not SACPA) and non-criminal justice populations (see Figure 4).³⁶

Figure 4: Treatment Completion Rates for SACPA and Other Populations by Gender

	Men Completing Treatment		Women Completing Treatment	
	N	%	N	%
SACPA	21,216	33.7	7,533	36.0
Criminal Justice – not SACPA	27,550	39.9	11,065	38.7
Non-Criminal Justice	46,547	34.9	31,319	31.5

N=145,230. Source: Longshore et al., 2005.

Incarcerated Women

Nationally, the number of women in state prisons has increased 757% in the past three decades, growing at more than twice the rate of the male prison population.³⁷ In 1977, the United States imprisoned 10 women per 100,000 female residents; in 2004, the rate had grown to 64 per 100,000. In 2004, this equated to 96,125 women in prison nationwide.

Women's higher growth rate is due to the small number of women who were incarcerated in 1977 relative to the number of men, so that increases show up as larger proportional growth against smaller base figures. Women's higher growth rate is also due to an increase in the number arrested and an increase in the female imprisonment rates.³⁸ The proportion of women convicted of violent offenses has decreased since 1979, while the number of women

incarcerated for drug offenses has increased. In 2004, drug offenses accounted for nearly one-third of female incarcerations.³⁹

While imprisonment rates have increased nationally, there is tremendous variation among states and regions. For example, 129 of every 100,000 women in Oklahoma are serving a state prison sentence while Massachusetts imprisons 11 women for every 100,000 women. California ranks 22nd in the country, with 61 of every 100,000 women serving a State prison sentence (6.6% of all prisoners being female, equaling 10,882 female prisoners).⁴⁰ Since 1977, California has seen a 1522% increase in the number of female prisoners and ranks 6th among the states in terms of female prisoner population growth over the past three decades. The growth rate slowed to only 1% from 1999 to 2004, however. Enactment of Proposition 36 (SACPA) has diverted tens of thousands of people arrested for possession of drugs. By 2001, the number of women sentenced to prison had dropped by 10%, and correctional managers attributed Proposition 36 as the largest driving factor driving the decline.⁴¹

In 2004, the Little Hoover Commission report entitled “Breaking the Barriers for Women on Parole” reported on characteristics of women in the state prison system in California. An estimated 80-85% of women offenders in prison were reported to have a substance use disorder and 62% used drugs in the month prior to the offense.⁴² The number of incarcerated women in California has grown steadily so that in 2004, there were more than 25,000 women under the jurisdiction of the California Department of Corrections and Rehabilitation including 10,973 women in institutions.

The Department of Corrections and Rehabilitation (CRC) provides Forever Free, an in-prison therapeutic community-based substance abuse treatment for 1,794 women, approximately 18% of the female inmate population (see Figure 5). Annually, the Female Offender Treatment and Employment Program (FOTEP) provides 989 parolees who have participated in-custody treatment with residential treatment in 13 counties upon release. The Substance Abuse Services Coordination Agency (SASCA) and the Parole Services Network provide treatment for parolees. SASCA serves 1,298 women annually (12.5% of the total SASCA population) and the Parole Services Network serves 463 women annually (14% of the Parole Services Network population). In addition, the Substance Abuse Treatment and Recovery (STAR) program is a curriculum based engagement program which seeks to motivate substance abusers to attend recovery activities after they are released. Approximately 1,400 women are served annually (see Figure 5). CRC funds three community based correctional facilities which provide residential treatment for women. The Family Foundations Program serves 70 women; the Leo Chesney Community Correctional Facility serves 220 female inmates in Sutter County. In both of these programs, women may bring their children under the age of six. The Drug Treatment Furlough offers 150 beds for women in community based residential treatment programs.⁴³

Figure 5. Correctional and Community Based Programs Serving Female Inmates	
Program	Number of Women Served Annually
Forever Free	1,794
STAR	1,397
SASCA	1,298
FOTEP	989
Parole Services Network	463
Leo Chesney Community Correctional Facility	220
Drug Treatment Furlough	150

Families Receiving CalWORKs

Of PSN participants from July 1, 2003 to June 30, 2004, 12.5% were CalWORKs recipients and 39.9% were eligible for Medi-Cal.⁴⁴ In 2001, the average monthly caseload of CalWORKs Welfare to Work enrollees in California was 289,675, of which a total of 5,319 per month (less than 2%) were referred for substance abuse services and 2,454 (46% of those referred to treatment) recipients per month received substance abuse services.⁴⁵ An NHSDA report estimates that 5.6% of cash assisted families included a person reporting past month heavy alcohol use and 11.5% reported illicit drug use.⁴⁶ The average monthly caseload in CalWORKs in 2004-2005 was 490,090 families.⁴⁷

At the county level, a California Institute of Mental Health (CIMH) evaluation of Kern and Stanislaus county CalWORKs recipients found that approximately 10% had a substance abuse or dependence problem.⁴⁸ The Los Angeles County Evaluation (LACES) reviewed 883 AOD treatment clients who were CalWORKs recipients (91% were female). LACES measures the number of days substances were used out of the last thirty years to document reductions in drug use. The evaluation data showed significant reductions in alcohol and drug usage (58-90% depending on drug of choice) but only slight improvements in employment at discharge: 4.5% were employed full-time and 4.6% were employed part-time.⁴⁹

Summary

- The majority of CWS-involved families have problems associated with substance abuse or dependence
- Among PSN participants, 45% of women with illicit drug dependence or abuse and 31% of women with alcohol dependence or abuse also had a serious co-occurring serious mental illness
- In 2004, there were 10,882 women serving a state prison sentence; a 1522% increase since 1977. By 2001, the number of women sentenced to prison had dropped by 10%, and correctional managers attributed Proposition 36 as the largest driving factor driving the decline.
- Although an estimated 80-85% of women offenders in prison were reported to have a substance use disorder, treatment beds are only available for only approximately 60% of the female inmates and parolees needing treatment.

Treatment

Treatment Need

In 2004, the estimated number of persons aged 12 or older in the United States needing treatment for an alcohol or illicit drug use problem was 23.4 million (9.8% of the total

population). An estimated 2.3 million of these people (1.0% of the total population and 9.9 % of the people who needed treatment) received treatment at a specialty facility. Thus, there were 21.1 million persons (8.8% of the total population) who needed but did not receive treatment at a specialty substance abuse facility in 2004.⁵⁰

Of the 21.1 million people who needed but did not receive treatment in 2004, an estimated 1.2 million (5.8%) reported that they felt they needed treatment for their alcohol or drug use problem. Of the 1.2 million persons who felt they needed treatment, 441,000 (35.8%) reported that they made an effort but were unable to get treatment and 792,000 (64.2%) reported making no effort to get treatment.

In 2004, approximately 8.1 million women needed substance abuse treatment, but only 9.4% received it. Of those women who did not receive treatment, 93.1% felt did not need treatment.⁵¹

An estimated 861,000 Californians needed but did not receive treatment for illicit drug use and 2.1 million needed but did not receive treatment for alcohol use in 2004.⁵² Although there are no gender-specific numbers for California, this data can be extrapolated from the national numbers of women who had used substances in the past year (43.5%) and the estimated number of California who needed but did not receive treatment. Thus, it is estimated that 375,000 (43.5% of 861,000) women needed but did not receive treatment for illicit drugs and 924,000 women needed but did not receive treatment for alcohol problems in California (43.5% of 2.1 million).

Treatment Admissions

In 2004, there were 1.875 million annual admissions to publicly-funded treatment for abuse of alcohol and drugs in the United States.⁵³ Women represented 31.5% (N=590,261) of those admissions.⁵⁴ Pregnant women accounted for 3.8% of the female admissions nationally. The primary drugs of abuse for all women entering treatment in the United States were: alcohol only (17.7%), alcohol with a secondary drug (15.5%), heroin (14.4%), marijuana (13.0%) and methamphetamine (11.5%).⁵⁵ The remaining 27.9% was comprised of other drugs of abuse.

Although nationally methamphetamine admissions account for a small percentage of all treatment admissions, there are important differences by gender and pregnancy status to consider. In the nation, women represented 31.5% of all treatment admissions in 2004. However, methamphetamine admissions for women are a much higher percentage of their overall admissions than for men – 11% compared to 6%. Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents. While young girls represent a smaller number of overall admissions, young girls between 12 and 14 years old represented 70% of youth admitted to treatment for methamphetamine. In addition, the percentage of all admissions increased from 6% in 1993 to 20% in 2003 for pregnant females, in contrast to an increase from 4% to 11% for non-pregnant females and 1% to 6% for males.

In California, there were 181,749 treatment admissions during 2004.⁵⁶ Women represented 34.6% of the admissions.⁵⁷ Women between the ages of 35-49 represented the largest age group presenting for treatment in California, followed by 25-34 year-old women (see Figure 6). Pregnant women accounted for 5.4% (n=3,411) of the female admissions in California (see Figure 6). It is important to note that of 18-24 year-old women who entered treatment, more than

11% were pregnant. While only 2.4% of young women aged 12-17 were pregnant; they represented 4% of the total population of pregnant women served in California.

While the majority of the 3,411 pregnant women were likely served by Perinatal Services Network (PSN) programs, some may have participated in general population treatment or Drug Medi-Cal only funded treatment. Thus, these women are excluded from PSN reports.

Figure 6: California Total Admissions, Female Admissions and Pregnant Admissions by Age of Client

Age Group	Female Admissions		Pregnant Admissions		Percent of Pregnant Admissions
	N	%	N	%	%
12-17 yrs	5,657	9.1%	136	2.4%	4.0%
18-24 yrs	11,143	17.9%	1,292	11.6%	38.3%
25-34 yrs	17,221	27.6%	1,414	8.2%	41.9%
35-49 yrs	24,359	39.0%	516	2.1%	15.3%
50 yrs and over	4,010	6.4%	19	0.5%	0.6%
TOTAL	62,390	100.0%	3,377	5.4%	100.0%

Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set. Based on administrative data reported by States to TEDS through October 04, 2005.

Caucasian women represent almost half (47.2%) of the female treatment admissions in California (see Figure 7). Hispanic women represent the second largest racial/ethnic group admitted to treatment. Hispanic women are slightly over-represented in the percentage of pregnant treatment admissions (see Figure 7). The majority of women admitted to treatment in California during 2004 reported methamphetamine (40.1%) as their primary drug of abuse, followed by heroin/other opiates (18.4%), alcohol (18.0%), cocaine/crack (11.1%) and marijuana (10.5%) (see Figure 7). As shown in Figure 7, pregnant women are disproportionately represented among women seeking treatment for methamphetamine or stimulants. Of pregnant women entering treatment more than half (55.6%) reported methamphetamine/stimulants as their primary drug problem.

Figure 7: California Total Admissions, Female Admissions and Pregnant Admissions by Race/Ethnicity and Primary Substance of Abuse

	TEDS Percent of Female Admissions	TEDS Percent of Pregnant Women	Perinatal Program Annual Report*
Race/Ethnicity			
Alaskan Native (Aleut, Eskimo, Indian)	0.2	0.2	0.0
American Indian (Other than Native Alaskans)	1.9	1.7	2.2
Asian or Pacific Islander	2.0	1.8	1.8
Black	15.8	15.4	18.0
White	47.2	42.7	48.7
Other single race	4.1	4.2	0.0
Hispanic (all races)	28.8	34.0	29.3
Primary Substance			

Alcohol	18.0	9.2	16.0
Cocaine/Crack	11.1	11.0	11.5
Marihuana	10.5	11.4	9.2
Heroin/Other Opiates	18.4	11.3	21.1
Meth/Other Stimulants	40.1	55.9	36.3
Other	2.0	1.2	5.9
* ADP's Perinatal Program reports on the PSN; which includes programs funded through perinatal set-aside funds. The PSN programs serve both pregnant and parenting women. Some pregnant and parenting women are served in non-PSN programs.			
Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Based on administrative data reported by States to TEDS through October 04, 2005 and the Office of Perinatal Substance Abuse, Department of Alcohol and Drug Programs Annual Report, 2004.			

Children of Parents in Treatment

Studies have found that approximately 58% of adults in treatment are parents.^{58,59} The estimated percentage of parents is based on an analysis of 15,618 consecutive admissions in 13 California counties, which found that 58.9% of the individuals in treatment were parents of minor children.⁶⁰ Data from a nationally representative sample of alcohol and drug treatment facilities which found that 56.6% of clients admitted to treatment had a child under the age of 18.⁶¹ In this last study, female clients were more likely than male clients to have minor children (69.2% vs. 52.5%).⁶²

Applying these national estimates to the number of female and male admissions in California results in approximately 121,000 men and 43,200 women admitted to substance abuse treatment who have minor children.

A California study found that 27.1% of parents in treatment had one or more of their children removed by CWS and 36.6% of parents in treatment had their parental rights terminated.⁶³ Extrapolated to the total number of adults in treatment in 2004, these percentages indicate that approximately 300,000 parents (27.1% of 1.106 million) had one or more children removed by CWS and approximately 109,000 had parental rights terminated. The California study also revealed that the percentage of parents who had parental rights terminated varied significantly by the type of treatment the parent received. Among parents with a child removed by CWS, the percentage who had their parental rights terminated was 29% for those in outpatient programs, 53% for those in residential programs and 80% in for those in narcotic treatment (primarily methadone maintenance).⁶⁴

A review of data compiled from the CSAT Pregnant and Parenting Women and Residential Women and Children programs reviewed data from 4,520 children who entered treatment with their mothers.⁶⁵ The majority of children were in the custody of their mother's only (67%). These children displayed a number of risks associated with poor physical, academic or socio-emotional outcomes. Risk factors included homelessness, placement in an intensive care unit at birth, family low-income status, not living in a two parent home. Out of eleven risk factors, children displayed an average of six. Children from the treatment centers were twice as likely to have asthma; three times as likely to have hearing problems; and seven times more likely to have vision problems than national averages.⁶⁶ Seventeen percent of the children's mothers reported

that their child received special instruction (e.g., special education) and 24% reported being contacted by the school regarding a behavior problem.⁶⁷

Treatment Facilities and Services

Many treatment facilities do not provide the specialized services that women need. According to N-SSATS, approximately 30.2% of the facilities providing substance abuse treatment in the United States offered programs or groups specifically for women and only 14.1% provided a program for pregnant or postpartum women in 2004.⁶⁸ In California, 31% of the treatment facilities reported having programs or groups specifically for women and 20% had programs for pregnant or postpartum women.⁶⁹ In addition, just over 10% of the facilities in California had residential beds for the clients' children. Figure 8 provides a comparison of national versus California estimates.

Figure 8: Number of Programs for Women and Pregnant/Postpartum Women

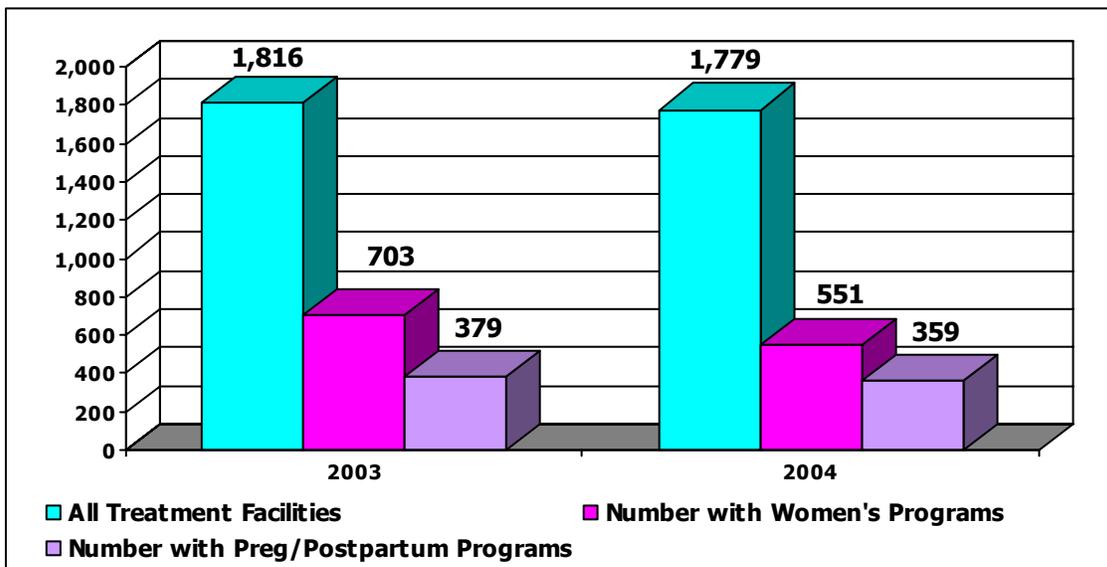
	California ¹	National Average ²
Percent of Female Admissions	34.7	31.5
Percent of Facilities with Women's Programs	31.0	30.2
Percent Females Pregnant at Admission	5.4	3.8
Percent of Facilities with Pregnant/Postpartum Women's Programs	20.2	14.1

¹ Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2006). *National Survey of Substance Abuse Treatment Services (N-SSATS), 2004* – Computer file. Online analysis conducted May 25, 2006

²Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2005). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2004*.

The number and trend of these women's programs and those with services for pregnant or postpartum women over the past two years are shown in Figure 9.

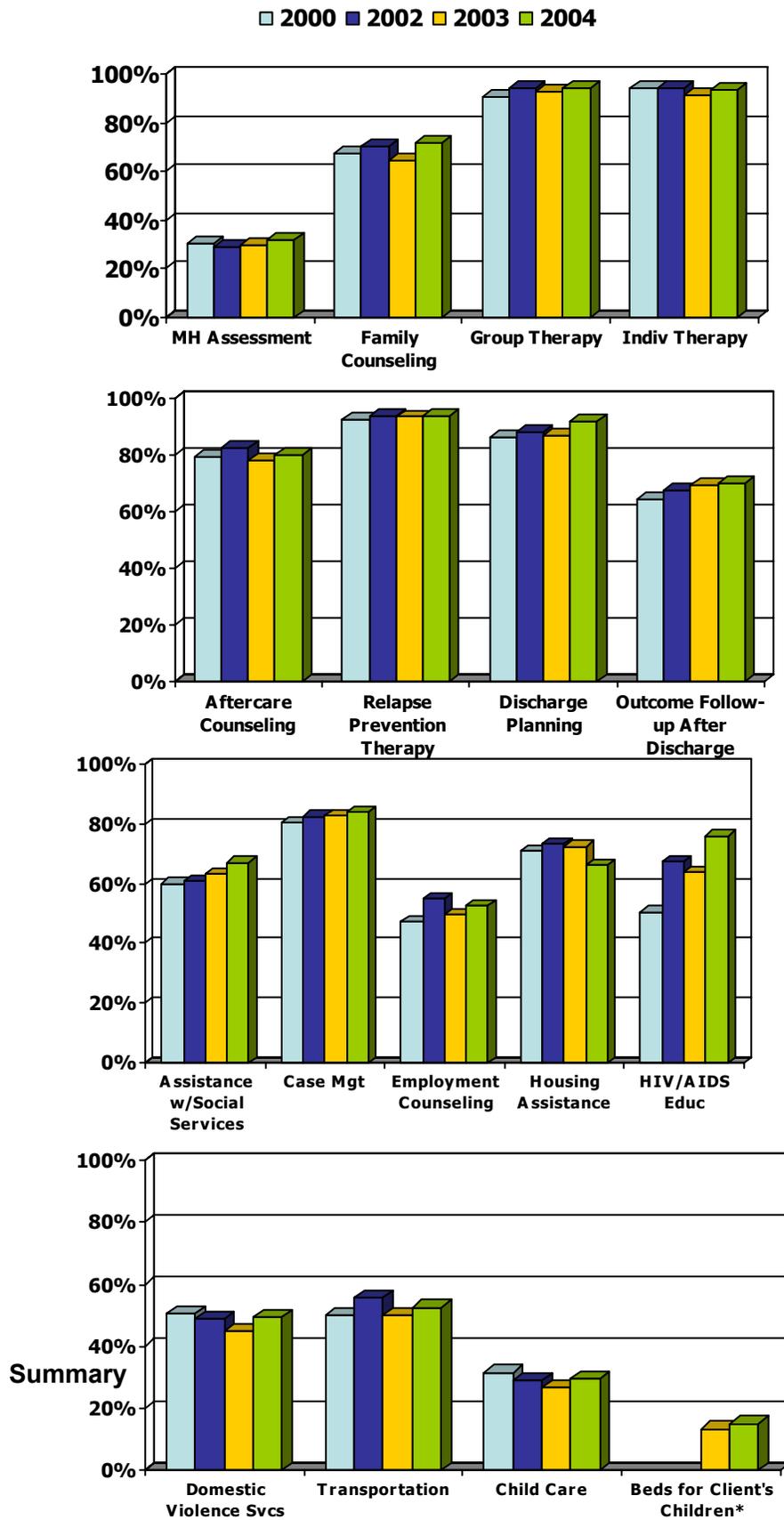
Figure 9: Total and Number of Treatment Facilities reporting Women's Services



While the total number of facilities fell by 2% between 2003 and 2004, the data shows a 21% reduction in the total number of facilities that reported offering a women's program or group. The number of facilities offering a special program or group for pregnant women fell by 5% from 379 to 359.

The service array offered by the facilities with a women's program have showed some minor fluctuations over the past few years. More importantly these data show that many of the critical services included in comprehensive services models (e.g., transportation, child care, employment services and domestic violence services) are not provided by the majority of facilities offering programs for women. The percent of facilities offering various services components are shown for the past four years in Figure 10.

Figure 10: Percent of California Facilities with a Women’s Program Providing A Given Service



- In 2004, an estimated 375,000 California women needed but did not receive treatment for illicit drugs
- An estimated 924,000 California women needed but did not receive treatment for alcohol problems
- There were approximately 62,400 treatment admissions for women in 2004 representing approximately 34% of all admissions
- Pregnant women accounted for 5.4% (n=3,411) of the female admissions in California
- Despite limitations of data on treatment need, it is possible to contrast the services provided to approximately 3,400 pregnant women with needs for treatment and supportive services for a group of women and children estimated at 133,000-150,000 women and nearly 70,000 newborns annually
- Approximately 121,000 men and 43,200 women admitted to substance abuse treatment were parents of minor children

Recovery Support Challenges and Issues

In addition to data on prevalence and treatment issues, there are other related issues that affect the recovery of women who are in substance abuse treatment. The list below reflects many of these issues.

Health Insurance

California has a higher percentage of uninsured women aged 18-84 than the nation as a whole, especially among low income women. In California, the Henry J. Kaiser Family Foundation estimates that 66.8% of adult women aged 18-64 have private health insurance, 11.2% have Medi-Cal and 22% are uninsured. Among women with incomes less than 200% of the federal poverty level, nearly 40% do not have health insurance which equals more than 4.1 million women.⁷⁰

Tobacco

Over the past 20 years, the smoking prevalence among women in California has steadily declined from 25.2% in 1985 to 11.1% in 2005.⁷¹

Intimate Partner Violence

The California Women's Health Survey findings indicate that 5.8% of women reported experiencing intimate partner physical domestic violence.⁷²

HIV and AIDS

Women are fastest growing population with AIDS in California with 11.8% of AIDS cases and 13.1% of all HIV cases in 2004 being among women. Eighty-five percent of women diagnosed with HIV or AIDS are within child bearing age. African American women comprise 34.1% of new HIV/AIDS cases among women and Latinas comprise 22.2% of new cases.⁷³ Since 1981,

11,398 adult/adolescent women have been diagnosed with AIDS and there have been 651 identified cases of pediatric AIDS. Thirty-six percent of female transmission is from injection drug use and 45% of adult/adolescent AIDS transmission is from heterosexual contact. Of the pediatric cases, 68% are transmitted from a mother with or at risk for HIV infection. Approximately half (51.5%) of women participating in the California Women's Health Survey reporting that they had a new sex partner in the last year indicated that they had talked about the risk of AIDS with their partner.⁷⁴

Education and Employment

Ultimately the goal of alcohol and drug treatment is to help women to reduce substance use and improve their economic and social well-being. For families with children, the additional goal of supporting the development of healthy children with minimal risk factors and maximum protective factors.

Women entering treatment have significant hurdles to overcome in order to achieve economic well-being. Only 57% of women entering treatment have graduated from high school and more than half of the pregnant women who entered treatment have less than twelve years of education.⁷⁵

Less than 10% of pregnant women entering treatment and only 13.2% of women admitted to treatment are employed.⁷⁶ Perhaps even more significant, most women (61.7%) entering treatment are not a part of the labor force. Income and employment are often long-term recovery goals. Education, job training and job development services are provided in comprehensive treatment programs, however, this challenge is reflective of economic barriers for women as a whole.

In California 55% of women are in the labor force. For full-time, year-round workers, women are paid on average only about 76% of what men are paid; for women of color, the gap is even wider. In 2004, women's median annual earnings were only \$.76 for every \$1.00 earned by men. For women of color, the gap is even worse – only \$.69 for African American women and \$.58 for Latinas.⁷⁷ These women face significant personal barriers in seeking and retaining employment. Overall, 15.3% of California families with children below age 18 live below the poverty level. In female headed households with children under 18 more than 32.5% are below poverty level.⁷⁸

Housing

Safe, affordable housing is an important element in maintaining recovery from substance use. Comprehensive substance abuse treatment assists women and families to identify safe, affordable housing for on-going support. California led the nation in having the highest median housing value and the highest median rent in 2003. Median rent was identified as \$844 per month and the median housing cost equaled \$334,426.⁷⁹ A report by the National Low Income Housing Coalition titled "*Out of Reach 2005*" found that the Fair Market Rent for a 2 bedroom apartment in California was \$1,149 per month. For a family to expend no more than 30% of their income on housing, this rent requires an hourly wage of \$22.09 per hour 40 hours per week, 52

weeks per year. An individual earning minimum wage in California (\$6.75 per hour) must work 131 hours per week in order to meet this rent.⁸⁰

Summary

- California has a higher percentage of uninsured women aged 18-84 than the nation as a whole, especially among low income women
- Women are fastest growing population with AIDS in California with 11.8% of AIDS cases and 13.1% of all HIV cases in 2004 being among women
- Women entering treatment have significant barriers to employment including low educational attainment and a lack of work skills which need to be overcome in order to achieve economic self-sufficiency
- California led the nation in having the highest median housing value and the highest median rent in 2003 yet safe, affordable housing is an important element in maintaining recovery from substance abuse or dependence

Information Gaps

In reviewing available data, some of the most important findings concern what data are not readily available—or not collected at all. Some of the most important data gaps related to outcomes for women and children include:

- Current prevalence data on substance use during pregnancy and substance-exposed births
- Total number of women screened for substance use during pregnancy; positive screen results; screens that result in a referral to treatment, treatment access, engagement and treatment outcomes of pregnant women
- Data on referrals substance-exposed infants to child welfare agencies, as mandated by new amendments to the Federal Child Abuse Prevention and Treatment Act (CAPTA)
- Data on referrals to Regional Centers for developmental assessments of 0-2 year olds with substantiated child abuse and neglect cases (as mandated by the new Federal CAPTA amendments) who have parents with substance use disorders or those who were confirmed to be prenatally substance-exposed
- Prevalence data, treatment need, treatment access and outcomes among parents in the child welfare system (in which recording substance use is an optional field), particularly the subset of parents in which treatment is a condition of family reunification
- Prevalence, treatment need, treatment access and outcomes for adolescents in the child welfare system who have significantly higher rates of substance use and need for treatment compared to youth not in foster care
- Prevalence, treatment need, treatment access and outcomes for CalWORKs participants for whom targeted funding has been made available since 1998
- Data from Proposition 36 (SACPA)-funded agencies on characteristics and treatment outcomes for women (or men) with minor children
- Timely access to California-specific information submitted to State agencies for monitoring treatment need across service systems, treatment access and outcomes for women and children

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Appendix 2:

Key Informant Interview Summary

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Introduction and Methodology

Introduction

As part of a Perinatal Environmental Scan commissioned by the Department of Alcohol and Drug Programs (ADP), Children and Family Futures' (CFF) California Women, and Children and Families Technical Assistance Project (CalWCF) conducted interviews and focus groups with key informants. The purpose of this data collection was to develop a better understanding of the current status of perinatal services throughout the state and to garnish a broad understanding of the trends. The content is intended to be illustrative rather than comprehensive.

CalWCF received input from a total of thirty-three experts. Fourteen interviews and three focus groups were conducted during the months of March and April 2006. One informant submitted written responses in lieu of an interview. Informants represented nineteen counties, both rural and urban. A roster of participants is included as Attachment 1 and the instruments are in Attachment 2.

Methodology

Interviewees included several County Alcohol & Drug Program Administrators Association of California (CADPAAC) Executive Committee members, treatment agencies and constituent representatives. Seven County Alcohol and Drug Program Administrators and staff representing small, medium and large counties were interviewed. Two administrators had additional staff participate in the interviews. At the County administrator's suggestion, two perinatal services coordinators were interviewed in lieu of the administrators themselves. Treatment representatives included four members of the California Perinatal Treatment Network (CAPTN), the California Hispanic Commission on Alcohol and Drug Abuse (CHCADA), California Alcohol and Drug Program Executives (CADPE) and the California Association of Addiction Recovery Resources (CAARR). Three researchers participated, including the ADP Medical Director's Office. One of the focus groups was held with the Director's Advisory Council (DAC) and the Women's Constituent Committee (WCC).

To ensure the accuracy and integrity of information, the interviews and focus groups were digitally recorded with the respondents' permission along with written notes. Data analyses incorporated the use of standard qualitative methods, including the development of a coding scheme and grouping of common themes. In the interview notes which follow, the term "some" equates to between two and four respondents and "several" means four or more respondents. When the term "administrator" is used, it refers to County Administrator respondents. "Programs" or "providers" refers to direct service treatment agency respondents. The term "counties" refers to counties represented by the key informants as a whole. These notes provide an overview of the findings and common themes from the key informant process.

SUMMARY OF INTERVIEW RESPONSES

Gender and Cultural Responsiveness & Family Centeredness

Summary

Participants were asked to rate perinatal and other women's services on a scale of one to five for gender responsiveness, cultural responsiveness, and family centeredness. While the process yielded some interesting findings, the likert scores varied significantly to the extent that it did not produce valid mean scores. Variation appeared to be more based on respondents' expectations and personal understanding of the terms versus actual capacity. Response analysis indicated there is a need to build consensus on what constitutes culturally responsive, gender responsive, and family centered services and how to measure it.

Common Themes

Cultural Responsiveness:

- Some respondents referred to a mental health cultural competency planning and reporting requirement that is not conducted in drug and alcohol services. Two respondents indicated that they felt CADPAAC would resist a requirement of a cultural competency plan but they also seemed to feel that this process was beneficial.
- Some respondents reported challenges to delivering culturally responsive services because their county is experiencing rapid diversification and demographic changes.
- Some respondents used the availability of services for monolingual Spanish speakers as criteria for meeting cultural responsiveness. In some counties, there are limited or no services available for monolingual Spanish speaking participants. Several other counties do not have Spanish language capacity.
- Several counties expressed limited ability to adequately serve Asian and/or Pacific Islander communities.
- Two respondents emphasized the importance of class and poverty status as highly important (racial/ethnic background).

Gender Responsiveness:

- Some respondents reported that they know of or have programs that use approaches which are not gender sensitive or responsive (e.g., black out periods).
- Several programs and counties have sought consultation and training assistance from national leaders on implementing trauma informed and other gender responsive services in their programs.
- Several respondents described their perinatal services at a higher level of gender responsive and family centeredness (and often cultural responsiveness) than their other programs which also serve women.
- Some respondents indicated that they see a lack of services in general and especially a lack in gender responsive services available for adolescent girls.

Family Centeredness

- Several respondents have begun to discuss the components and meaning of family-centeredness and delivery of a family centered model.
- Many respondents identified the availability of expanded family-centered services through collaborations with children service agencies.
- Family therapy, family participation, serving women with children, and children's treatment were all used as part of a definition of family-centered services by one or more respondents.
- Several provider respondents indicated that they have family treatment for adolescents.

Collaboratives

Summary

Participants were asked to discuss their involvement in local or interagency initiatives that impact substance abusing women, children, and families. All participants identified some collaborative activity. Respondents indicated there were varying degrees of participation in collaboratives ranging from a high degree of involvement at the national, state, and local levels, to a lesser degree of participation. Collaborations were identified with the following service systems: health, child welfare, CalWORKs, family resource centers, First 5, and early intervention. Few respondents described significant involvement with domestic violence or HIV agencies. No respondents identified a strong collaboration between perinatal staff and criminal justice offices however; all treatment providers had relationships with County probation and parole offices.

- The most frequently cited type of collaboration was partnering with health care provider agencies for screening and intervention during pregnancy and/or at birth. The level of service delivery and perceived benefits in reducing substance use varied between respondents. These efforts are primarily being led by maternal, child and family health departments.
- There are a variety of collaborations between AOD and child welfare agencies. Types of collaboration include outreach/intervention, funding and dependency drug court development or oversight. In some counties AOD services are involved in child welfare redesign efforts.
- Respondents described a range of collaborations with CalWORKs agencies including funding for treatment services, and on-site outreach and education at CalWORKs offices and delivery of assessment services for the CalWORKs program. Some respondents reported comprehensive programs through CalWORKs.
- Collaboration with Family Resource Centers (FRCs) may be an emerging opportunity for the AOD field. Two counties reported collaborative efforts for training FRCs and locating AOD services within FRCs.
- Four respondents identified First Five Commissions as a collaborative agency. Several respondents felt under-funded by Proposition 10 and First Five Commissions.
- Overall, there is some level of collaboration between AOD and mental health fields in all of the counties. The level of collaboration ranges from integrated management and services to collaborative arrangements for treatment. Respondents expressed interest in Proposition 63 as an opportunity for funding and at the same time, they expressed concern for overall mental health funding as a constriction on collaborative services.
- All providers reported some type of collaborative relationship with children's early intervention service agencies and/or regional centers.

Common Themes

General Collaboratives:

- One respondent questioned the value of many collaborative meetings. The respondent indicated that collaboration must result in action: “Get moving forward.”
- One County administrator indicated that he has 37 meetings per month.
- Several administrators sit on the Death Review Boards (One administrator specified an alcohol death review board; another specified a child death review board).
- Several counties are experiencing a reduction in residential perinatal and other services delivered through Prop 36.
- Some administrators noted that they have active collaborations with probation and parole, but no contact between criminal justice and perinatal services. (Treatment providers communicate with probation/parole).
- Two administrators referred to attending child welfare redesign meetings.
- Alameda County has a Perinatal Substance Abuse Taskforce which includes participation from the health care officer, public health, and behavioral health. High level administrators are looking at perinatal substance abuse, promoting integration of public health, mental health, AOD, and other agencies to address problems. In 2002-2003, 12 staff traveled to the Children’s Research Triangle (CRT) in Chicago, Illinois to develop a strategic plan. They established two goals: 1) access to quality treatment (hence the development of perinatal standards) and 2) early intervention.
- Contra Costa County has a perinatal substance abuse partnership where line staff attended a conference and developed recommendations. This partnership is led by an employee from public health. Stakeholders are to expand interest and communication regarding perinatal services as well as shaping policy. AOD participates, but they are not the lead agency.
- Fresno County established an Interagency Advisory Committee (SART) comprised of county supervisors of substance abuse units for child protective services, Prop. 36 representatives, public health nurses, the child development coordinator, and others. The Chair of the SART Collaborative, Babies First, and First 5 work with all local health care providers for early identification which help trigger referrals to treatment. The collaborative formed four years ago and has grown to help all women in need. The group meets bimonthly to keep the referrals coming in and maintain communication with all key players.
- Sacramento’s administrator sponsored a collaborative group of DV/AOD/MH/CPS service partners to reduce barriers. They hold informal quarterly brown bags to share information and review clinical case staffing. The focus is on policy networking, and building.
- CADPAAC was cited as a primary source of information by all of the Administrators. Provider CEO’s reported involvement in a variety of task forces and collaboratives at the local, state and national levels. Several cited treatment consortiums including CAADPE, CAARR, CAPTN, county provider networks, and County commissions. Many respondents are also involved in addressing co-occurring mental health and AOD problems, Prop. 63, Prop. 36, domestic violence, homelessness and HIV councils.

Health Collaboratives:

- One administrator discussed the role of ADP and CADPAAC in collaborative efforts. “There are several different efforts underway to address perinatal AOD use (e.g., MCAH, Chasnoff). It would be helpful if these various efforts were linked so that they can inform, and not undermine each another.
- Several respondents discussed the development of, or need for, strategies to better work with women who screen positive at prenatal clinics. Some of the examples of interventions included: engagement services, brief intervention at prenatal care providers, warm referrals to treatment programs and creating a seamless service system.
- Alameda County has actively approached addressing intervention at prenatal clinics focusing on screening and referrals. In Alameda County, the OB/GYN staff had been responsible for engagement and referrals. Behavioral Health Services created a Links to Recovery hotline so that OB/GYN staff would not have to spend time finding referral agencies. The Links to Recovery hotline is in English and Spanish and provides prenatal staff with specific referrals. Problems with follow-up continue and they are now exploring additional linkages with treatment services.
- A respondent from Contra Costa described a collaborative process within their county. They do screening at medical offices. They are currently hiring (funded by First 5) a consultant to make recommendations about expanding outreach and engagement services. They have a treatment program (BornFree) that conducts on-site intervention at health clinics in one region of the county. They will be starting to have a brief intervention program at the health clinic.
- A provider described the CAPRI program in El Dorado and Alpine Counties: The program provides a full-time counselor to work with the doctor’s office in this Chasnoff-based model.
- Fresno County also has a screening and referral program. They started with Chasnoff’s model about five years ago. They still have routine monthly meetings. The administrator noted, however, that they do not get a lot of referrals from the medical clinics and suggested that perhaps women are being referred to the insurance-based programs. A provider in the area estimated that they get approximately one referral per month. As part of the collaboration, the program director provides training for staff and teaches about substance abuse in an OB/GYN class at Fresno State University
- Humboldt County has also been actively involved in screening, assessment, referral, and treatment. According to one respondent, they started the 4Ps Plus in prenatal clinics in 2004. Presently they are looking at trends geographically so that they can roll out a larger effort. They reported that there is a substance abuse trained public health nurse working with the perinatal program who goes to the doctor’s offices and contacts women to engage them in treatment/assessment. They are holding informal lunch meetings for nurses to get to know more about substance use and treatment. They are also being trained on motivational interviewing. The MCAH director meets monthly with the Director of Perinatal Programs.
- Humboldt County has an Infant Risk Assessment conducted at hospital for exposure to alcohol or other drugs.

- Kern County: Averages 12,000 births per year. AOD administration is working closely with the MCH Director. For one and a half years Kern has held a partnering meeting with hospital based social workers on what to do with Presley (SB 2669) and CAPTA. The Public Health Department had found that no one was referred to treatment and there was no protocol. Now they are working with outpatient physical health clinics.
- Kern County is convening a Perinatal Substance Abuse Prevention Project (PSAPP). CPSP paraprofessionals have embedded a modified 4Ps and other assessments. All women at one clinic are screened with a warm hand off to treatment. Next they want to work with a medical group on the more affluent neighborhood.
- Los Angeles County developed a risk assessment protocol for publicly funded hospitals. The Administrator indicated that there is some screening occurring in prenatal clinics but that there is no current funded county-wide collaborative effort with MCAH or hospitals. Los Angeles County has centralized AOD screening and assessment centers and “warm” lines that are used as points of entry. The treatment providers in Los Angeles indicated that they receive referrals directly from hospitals. One estimated 4-8 referrals per month for women delivering toxicology positive babies and pregnant women using emergency room services. Another program is co-located with health services and they also engage in home visits to encourage participation. One Los Angeles provider wanted to conduct assessments at time of birth in local hospitals and was told that it would violate HIPAA.
- Orange County: There is a perinatal substance abuse initiative which is a collaborative of public health, social services and AOD services led by public health. The goal is ensure access to prenatal care regardless of substance use status. The initiative provides transportation and medical attention for substance using pregnant women who have had contact with substance abuse services – even those identified in outreach efforts or who are not in treatment.
- Sacramento County: SB 2669 protocols were created when the law passed however, respondents reported that the implementation has been inconsistent. They are using the 4Ps Plus for perinatal screening. Public health nurses have been hired to work with the clinics to increase medical office “warm” referral handoffs. A respondent suggested that among doctors working with the general population, many react with a “Not In My Back Yard” attitude of “substance use is not in my practice.” Sacramento County is striving for an integrated and seamless delivery system from Hospitals → CPS → AOD.
- Solano County practices street outreach and engagement; including a specific program for pregnant teens.
- In Sonoma County, the Perinatal AOD Action Team (PAODAT) was formed in 2003 with the following goal: “Every pregnant woman in Sonoma County will be screened and assessed for alcohol and other drug use and will have immediate access to treatment that will benefit her, her child and her family.” An action plan was developed with three supporting goals, 1) create public awareness and community engagement in eliminating tobacco, alcohol and other drug use among pregnant mothers; 2) strengthen the linkages between Sonoma County medical, mental health and treatment providers; and 3) increase the capacity of Sonoma County to provide residential and outpatient alcohol and other drug abuse treatment when women request the services. This group has been meeting on a monthly basis to implement each of these goals. The entire Action Team meets quarterly to measure progress on meeting key objectives.

- Sonoma County: The five main labor and delivery hospitals adopted individual protocols after SB 2669 was passed. A draft County-wide protocol has recently been developed and is currently being reviewed by County Counsel.
- Statewide: One respondent identified the need to train Nurse Midwives to be more sensitive to substance using women.

Child Welfare Collaboratives:

- Contra Costa County has a children and family services collaborative. Contra Costa County ADPA has been working with child welfare for 5-6 years. They have an MOU between child welfare and substance abuse services and are currently defining roles and line staff communication. There is no direct treatment funding from child welfare. Child welfare has an early intervention and outreach specialist program which involves paraprofessionals who are legally exempt from testifying to engage and refer parents to treatment.
- Fresno County respondents indicated that child welfare is doing assessments for substance abuse. Collaboration appears to occur directly with providers rather than at the administrative level.
- Kings County Children and Family Services pays for assessments for youth on probation, incarcerated, or separated from families. Other treatment costs are covered through ADPA.
- In Los Angeles County, ADPA has an MOU with the Department of Children and Family Services (DCFS) that funds 10 agencies to implement treatment for the reunification of families as part of Promoting Safe and Stable Families. DCFS provides the funding and ADPA oversees treatment delivery through contract agencies. Some treatment providers are going with children's services workers on home visits to conduct risk assessments. One provider explained, "We go to the homes and really find out who can we bring in from the family, if anyone, who can help keep the child safe." Also, ADPA, DCFS and the courts are exploring establishment of a Dependency Drug Court. They have established a pilot of \$50,000 with the Judicial Council.
- Orange County: There is a new dependency drug court project. The oversight group meets at least monthly. There is a new collaboration emerging that is looking at how to measure the number of substance exposed births and plan for service improvements.
- Sacramento County has been identified and recognized for its integration and collaboration with Child Protective Services (CPS) which began in 1994 with a cross-system AOD initiative. They maintain a formal financial funding transfer agreement (not an MOU) for child welfare funding. The alcohol and drug program receives data on hospital referrals, specifically exposure, as well as CPS data and maintains close ties with CPS. The collaborative system includes public health, child welfare and alcohol and drug services under the same agency. Alcohol and drug services are participating in child welfare redesign. There are also workgroups meeting monthly and a bi-monthly coordinated, collaborative management team.

Cal WORKs Collaboratives:

- Kern County: CalWORKs funds treatment through the County ADPA. Child welfare does not pay for treatment. In an effort to maximize dollars, they assess whether a child welfare client was receiving TANF at the time the children were removed. If the client was receiving TANF, then they are eligible for CalWORKs funded treatment. The Administrator indicated that child welfare clients, who are not pregnant using Medi-Cal, must wait for a bed. They may receive interim services however, they are often not getting the level of treatment they need. Alcohol and drug services has a gatekeeper at the Dependency Court however, the “no show” rates are very high.
- Alameda County: A social services representative attends the perinatal bimonthly provider meeting. CalWORKs provides funding for treatment, though the funding has reduced.
- Los Angeles: ADPA collaborates with Public Services to provide treatment for General Relief and CalWORKs recipients. The funds have been reduced but they are negotiating for continued outreach. CalWORKs clients are screened for alcohol, drug and mental health problems through a set of centralized assessment and screening centers.
- Sacramento: CalWORKs families are all screened assessed and linked to services. “There are multidisciplinary staff teams combining community based organization treatment staff with county perinatal and CalWORKs staff out stationed at provider sites and the CalWORKs offices.”

Domestic Violence Collaboratives:

- Some treatment providers indicated that they have contracts to address both domestic violence and substance use needs.
- Humboldt County: They have a domestic violence coordinating council (DV services, CWF, DA, and Planned Parenthood) in which they are involved.

Family Resource Centers (FRCs)

- Humboldt County. They are working to configure a more integrated differential response team involving social services, mental health, public health, and family resource centers. There is a cross training committee working with FRCs and DHS (including mental health, public health, and social services). An FRC liaison committee provides support for school sites and problem solving. There is a community coalition on Methamphetamine. Their monthly provider meeting is for all health and human services contractors in the county.
- Sacramento: They are establishing 9 family resource centers in the county as part of child welfare redesign. They are working to make sure that AOD is part of the FRCs. Currently, there are 3 neighborhood multi-service centers with AOD staff.

First 5 Collaboratives:

- Contra Costa: First 5 has a Perinatal Substance Abuse Review Committee convened by the First 5 Commission’s Executive Director that meets bimonthly. When the initiative

was first funded, Contra Costa's First 5 Commission identified perinatal substance abuse as a priority area. They fund a treatment program and the funds enable the provider to offer longer treatment, more services and more mental health services for children.

- Solano County: The First 5 Commission funds two different collaborative efforts for pregnant substance users. One is an outreach, engagement and comprehensive case management program for pregnant teens. Pregnant teens with AOD problems are provided individual, group and family counseling, transportation, comprehensive assessments, support for perinatal appointments, day treatment, child care, and education. The other collaborative is called First 5 Solano Perinatal Substance Abuse which serves pregnant and post-partum women. It includes outreach, screening, and treatment services.
- Several respondents indicated low funding level of First Five Commissions and the need to pressure First 5 to address substance abuse and fund services.

Children's Early Intervention Services Collaboratives:

- All treatment providers interviewed indicated that they have a variety of collaborative relationships with child development service providers. Some provide services on-site while others had "warm" referral procedures.
- Alameda County: A collaborative planning process held by First 5, public health, and behavioral health led to collaboration between EPSDT mental health providers and alcohol and drug programs. Three collaborative planning meetings were followed by an RFP process in which children's mental health and AOD treatment teams responded. All funding went to mental health services, not treatment agencies but they are providing the services to children whose mothers are in treatment, at the treatment site.
- Several provider respondents discussed the need to provide training for Head Start, preschools, Early Start and other points of intervention. Preschool staff also need support on how to help these children. One respondent noted that young children leaving the program are being expelled from preschool because of aggressive behavior and behavior problems. "These children need interventions now, before problems get worse, but the preschools need help to keep them in school." Another respondent indicated that Early Start and Head Start staff need knowledge to avoid over-stimulation of substance exposed infants.

Pregnancy and Child Related Issues

Summary

Pregnancy and child related issues surfaced while answering questions pertaining to perinatal services, interagency work, and future opportunities for ADP. Respondents were asked to describe the perinatal and other services for women and families, therapeutic services for children, and relationships with medical clinics and hospitals regarding referrals and prenatal care. They were also asked their opinion on available opportunities for improving access to quality treatment services for women, children, and families and strategies to address prenatal and postnatal substance exposure. Respondent observations and recommendations are grouped into four categories: prenatal, at birth, early intervention for children and children's development services.

- Many counties have established health clinic screening and intervention programs. The level of intervention and effectiveness of those programs vary. Some respondents described other intervention activities including outreach and engagement approaches for specific populations and collaborations with high risk pregnancy programs.
- With one exception, respondents identified limited effects or no effects of at-birth interventions through CAPTA or SB 2669. Some counties are in the process of expanding hospital based collaborations. There are some innovative models of direct collaborations with hospitals that are resulting in treatment admissions.
- Some respondents identified a gap in access to early child intervention services. Levels of service appeared to vary tremendously between specially funded children's treatment services and the range of services available through other treatment providers.
- Some providers reported developmental pre-school style childcare. In most counties child care involves child care staff (educational requirements vary) with some developmental materials available but in a "babysitting" environment.
- A few respondents recommended a universal screening process for children ages 0-3.
- Several respondents noted limited resources for addressing specialized needs of older children whose parents are in treatment.

Common Themes

Prenatal:

- Several treatment providers noted that the clients are not going to prenatal care until after they are in treatment. One provider said that 70% of her clients are getting extremely limited prenatal care. Instead, they are going to the hospitals, giving birth and then coming to treatment facilities.
- Some respondents noted gaps in services for pregnant adolescents and teen parents.
- There are no consistent procedures on methadone in treatment. Some counties still have no access.
- Some respondents identified a need for more line staff training around perinatal exposure and pregnancy issues.

Birth:

- Overall, counties are not seeing any policy or programmatic changes related to hospital reporting as a result of CAPTA.
- A challenge expressed by most respondents is balancing the need for early intervention and funding for treatment with the message that “substance use in and of itself does not equal child abuse.”
- While hospitals in several counties developed protocols in response to SB 2669, most respondents reported that they see no implementation or spotty implementation of SB 2669. One respondent suggested a lesson learned from SB 2669, “We cannot legislate appropriate practice when there is limited capacity or interest and high stigma.”
- One respondent discussed the complex needs of pregnant women: “There are a lot of factors that impact birth – nutrition, health, smoking, stress, etc. We need to send the message to all women that all these things affect the woman and her baby’s health. ... Because when a woman is in residential treatment, ... we feed them nutritious foods, they have safe housing, there is only one area onsite that they are able to smoke, there’s supervision so they get their needs met.”

Early Identification of Children’s Needs:

- One respondent addresses the complex nature of problems: “Children’s problems are tied to poverty. Substance exposure from chronic binge drinking or tobacco is an exception. Less substance exposure is important, but nutrition, domestic violence, stress, racism all contribute to the complexity of the needs.”
- One challenge respondents discussed is how to identify kids early so they get treatment before they need it and before they go to school. Alameda County is looking at a pediatric model to identify early with different settings.

Children’s Services:

- All of the programs provide therapeutic services for children, either directly or via collaborations and referrals. Some have shortages in services. Several programs have direct funding for therapeutic services for children, as well as for the parents.
- One respondent summarized the need for early intervention services as follows. “California Children Services have a High Risk Infant Follow-Up (HRIF) Program that provides developmental testing and services to those who meet the eligibility criteria. There are also Regional Centers that partner with this program to serve those 0 to 5 years of age. Both of these programs are at capacity. The criteria is set to serve those with a high degree of impairment. If these children could be identified and offered intervention services at an earlier age, the costs to other systems could be reduced.”
- Alameda County: Collaborations exist between treatment providers and children’s mental health services.
- Several providers described developmental child care settings as the primary place in which children’s services are offered.

- One respondent expressed her frustration, “When children enter foster care they can get services. If they stay with their mother in treatment it is more difficult to access therapeutic services for them.”
- One provider noted that children’s services equate with early substance abuse prevention. The children are the highest risk group for developing substance use disorders themselves.

Family Treatment

Summary

Participants were asked whether they see family treatment as a next evolutionary step in perinatal and family services and what they see as challenges or barriers to its' implementation. The general consensus is that family treatment is a good treatment strategy. Participants' descriptions demonstrate a continuum of family services progressing from family involvement to whole family treatment services. Respondents expressed concern that family treatment not supplant women's treatment. Funding and staffing issues were identified as the primary barriers to family treatment.

Common Themes

Continuum of Family Involvement:

- One respondent suggested that while family treatment sounds good to say there are steps needed to strengthen family engagement first. Another respondent indicated that better family engagement and education is a first step.
- Another suggested that we should move towards family treatment for all populations not just women.
- While approving the concept of family treatment, several respondents also expressed serious concern that it will further blur population specific services. Respondents communicated the need to protect the gender responsiveness of treatment services.
- Several respondents described the need for individualized assessment, including risk assessment.
- Many treatment providers offer a continuum of family based services where there is family involvement on some level.
- Several respondents noted that family treatment should be developed in the context of best practices and evidence based approaches along with the delivery of technical assistance. Several respondents were hesitant about family treatment remaining undefined and without criteria for how to do it responsibly.
- Several respondents indicated a concern for protecting diverse family types (gay, single parent etc). Several respondents noted that in developing family services protocols must address violence and trauma. One respondent asked, "How is family defined? Who decides?"
- A respondent indicated that ideally programs can work with women before they are with their family – "must reunite the woman with herself." Another discussed a development process for the woman in recovery to decide if she wants to be with a partner. And another stated "We must assess who is safe and can support their needs."

Barriers:

- Two respondents indicated that ADP licensing is a barrier. Programs are prohibited from having a husband and wife live together in residential treatment. Child care licensing may also be problematic.
- Several respondents indicated the need for adequate staffing and more clinical staff. Respondents also discussed the need for staff training. One respondent asked, “Can this family cross-collaborative approach work given our current workforce?” Two respondents noted the need for domestic violence training for AOD line staff.
- One respondent felt that women’s treatment providers will resist involvement of male partners. “There is a firewall between women’s treatment and men.”

Funding Issues:

- Most participants noted that a lack of funding to support comprehensive family treatment services is a barrier. One respondent indicated, “If there is funding for it, we will do it.”
- Several respondents expressed concern that family treatment not supplant services for women specifically. One respondent stated that she sees family as a code word, “... to mean men and partners and a loss of services for women.”
- One respondent describes the need to “blend fiscal streams that serve multiple needs.”

Treatment Challenges;

- Several respondents noted that there are conflicting priorities between children’s services, CalWORKs/TANF and treatment that challenge the delivery of services for children and families.
- There are several programmatic challenges noted by respondents. These included the need to address domestic violence, and unhealthy relationships within the context of family treatment; time constraints affecting single parent families; family apathy; and the clinical considerations of older children.
- Lack of services for older children was noted as a problem by several respondents.

Accountability

Summary

Questions on how accountability is currently measured, data collection needs and possible roles of the state were asked. Most respondents indicated the presence of standard monitoring and evaluation protocols. Respondents also discussed provider meetings and training methods used to improve services. Several respondents cited CalOMS as a significant opportunity to improve data collection, analysis and program planning. Several respondents addressed the need for evaluation, knowledge about research and best practices.

Common Themes

Monitoring and Accountability:

- Some counties have a specialized staff member responsible for perinatal contracts/services while others spread these functions across more than one staff member. In Alameda, Orange, and Contra Costa counties, there is one program specialist who handles all of the perinatal contracts. In Los Angeles County, perinatal contracts are spread across monitoring staff.
- Monitoring approaches: County respondents used a variety of methods for oversight of treatment programs including the following: regular on-site attendance at sites; provider meetings; collaborations; audits including fiscal and management audits; monthly reports; and data review. One county indicated that new programs receive more monitoring than older programs. In counties with both contractors and county operated services there are different monitoring practices and accountability for contracted services than for county systems.
- One administrator cited the use of an RFQ process every three years to help maintain quality programs. Another administrator is exploring use of a new monitoring process that will fit with measuring outcomes and evaluations suggested by evidence based practices.
- Several administrators described a collaborative and supportive relationship with providers. One cited an effort to “create conversations”. However, in another county, the relationship between programs and county monitoring staff was described as shifting to an “us versus them” approach due to turnover of county-monitor staff.
- Counties have regular provider meetings. One county cited having sub-provider meetings (CalWORKs providers meet bimonthly, adolescent monthly, etc.) Another administrator stated, “We have goal and objective requirements in the county contracting process and have monthly provider meetings to discuss progress towards compliance.” Another smaller county referred to a contract providers’ meeting which brings all contract service providers across disciplines together (mental health, children’s services, alcohol and drug, and domestic violence).

Data and Data Collection

- All respondents appeared to value data and access to data. Two respondents described the need for data on the cost effectiveness and outcomes of treatment in order to educate Boards of Supervisors and other governing bodies.
- Some counties noted that they have Drug Medi-Cal programs funded via the State that do not have county contacts and therefore, no county monitoring.
- The new CalOMS data system will provide a systematic tracking system to measure outcomes. Several respondents discussed CalOMS and how it is, or will be, changing their access to data and the potential role of data in program evaluation. There is wide variation in capacity and interest in data collection between counties.
- Currently some counties get reports on their services prior to or concurrent to sending data to ADP. Others are dependent upon ADP for getting data back. One county administrator indicated that they have not received reports back from ADP for two years.
- Respondents cited several methods of obtaining data including: using evaluations of specific programs (e.g., drug court) and then applying results to the broader population; using waiting list data from treatment programs to identify needs; getting data from child welfare and CalWORKs programs; and accessing data from the county Fetal Infant Mortality Review (FIMR) program.
- Several providers indicated a process of obtaining customer satisfaction measures by using surveys focus groups, etc.
- The larger providers interviewed all have the capacity for internal data and program evaluation but noted that not all providers are able to do this.
- Some programs collect data on children such as birth information (drug exposure, positive toxicology, birth weight), progress in treatment plans using the Ages and Stages Questionnaire (ASQ) and/or Denver results.
- One respondent stated, “We need to find out how to use the research. We kind of know what things work and what things don’t. That’s why I’m talking about innovation and looking at different ways of doing things. Philosophically, people are just stuck in an old way of doing things regardless of what the numbers continue to show to them. “

At the State Level

- There needs to be good outcome measures for both quality and effectiveness. All participants referencing CalOMS seemed to believe that it has good measures. One respondent noted that a gender responsive subset of outcomes should be measured and evaluated.
- Some respondents suggested more accountability between OPSA and counties. One respondent suggested looking at data county by county and using it as part of a self correcting system. ADP could evaluate who is getting into services, who is staying in treatment and who is leaving. This effort could start with a pilot project with data from three counties.
- One respondent suggested that ADP look at treatment process and outcomes and conduct a cost-benefit analysis. Another stressed the need for funding in order to conduct long term evaluation.

- Several respondents addressed the need for knowledge about research and best practices. Several expressed concerns as to whether OP/SA/ADP staff are familiar with the research and can evaluate services. One respondent suggested delivering training and help to organizations to successfully adopt best practices and hold them accountable for outcomes. Another respondent spoke to the availability of quality research on women and effective program elements for women, but also expressed the need for support in order for these elements to be institutionalized.
- One respondent suggested the creation of a program that would focus on professional training programs for the AOD system and programs. A state level person could work with the professional schools (nursing) and create internships. This is an untapped resource. ADP could develop a model that can be replicated else where. Technical assistance can be offered on the types of agreements, supervision models, public/private collaboration that will be needed.

Views About OPSA's Purpose and Recommended Activities

Summary

Respondents were asked what they saw as OPSA's purpose, what types of activities they would like to see OPSA involved with and ways ADP can improve opportunities for women, children and families with substance abuse problems. Respondents did not have a clear sense of the current activities of OPSA. Those familiar with OPSA are aware of reduced staffing and activity. Respondents expressed a lack of visible activity from OPSA during the last three to five years. The types of activities suggested by respondents fell under the themes of planning, establishing a continuum of services, monitoring, funding, communications and collaboration. Most respondents identified the service population following from perinatal services funding. Several respondents felt that OPSA must address overall needs of women since there is no other office responsible for women.

Common Themes

Women, Pregnant Women, Parenting Women, Parents, Families – Who is the target population?

- Respondents see the primary purpose of OPSA as overseeing accountability for the perinatal dollars and encouraging gender responsive treatment throughout the State and across all services. One respondent viewed OPSA's purpose as "to address programs funded by the perinatal set aside to be sure that perinatal funds are spent appropriately and have a full continuum." Another respondent stated, "OPSA should oversee the use of CA State General Funds for perinatal treatment and underscore the visibility of perinatal treatment." One respondent stated, "The title of the office "Office of Perinatal Substance Abuse" indicates a very narrow population served."
- One respondent suggested a three prong purpose: build a quality services network; serve as a communication hub; and build collaborative networks.
- Respondents felt that perinatal and postnatal is only one of populations served. Most respondents use the term "perinatal" in reference to pregnant and parenting women just as the guidelines do. Few use the Drug Medi-Cal or medical definition of "pregnant through approximately 60 days post-partum."
- Several respondents were troubled that "perinatal has become a substitute term for women." One respondent described "the only reason we got gender responsive services established was because of motherhood. It made women important enough for pilot programs and research studies. As a result, gender responsive treatment has become recognized. Still many women and almost all girls in treatment do not receive gender responsive services." Several respondents indicated that other parts of ADP should address women. One noted that since there is no other gender specific entity that OPSA has an obligation to address needs of women. Another respondent stated, "I would like to focus on the whole life cycle for women and perinatal issues. If you really care about family centered care, then you better care about the grandmothers, as well as the children, because they might be the ones taking care of those children."
- Several respondents indicated displeasure with the Medi-Cal definition of perinatal (pregnant and then up to 60 days postpartum). One respondent called it "a crazy and shortsighted approach. This is not the correct time for discharge."

- Some respondents felt that OPSA should be broadened so that all programs can get information on gender, family, and children. One respondent asked, “Why are perinatal programs doing one thing for women, but other alcohol and drug programs serving women don’t offer the same services? All staff working with women and families should have access to evidence based practices and gender responsive approaches, not just through the perinatal programs. One respondent indicated that men with children are also under-served and should be addressed by OPSA.
- Two others felt that OPSA should address whole families noting that people change categories. “A woman might be in one category today and a different one tomorrow due to reunification, removals, and boyfriends.” Another said, “Addiction is a family disease. It’s the funding that dictates it and the provider of services. No matter who is suffering from addiction, the whole family goes into recovery together.”

Responses Addressing Background and Capacity Issues

- Several respondents suggested that OPSA go back to doing what they were doing during the Options era. They described the push to create programs in late 80s which has kind of gone away, leveled off activity. Many respondents were unaware that OPSA exists.
- One respondent expressed the view that perinatal substance use is a sensitive political issue that is not going away and that will remain health and treatment oriented only if ADP gives it priority. Otherwise it will become a more punitive orientation led by child welfare or criminal prosecution.
- Some respondents questioned the competency of staff due to unanswered questions, and lack of knowledge in the field. One respondent stated, “Well recently, I haven’t seen too much activity. I think that’s part of the problem. I think they did have stronger people. I couldn’t even tell you the person who’s coordinating it. We’ve lost a little ground there.” Another stated, “I would like OPSA to know the network as it stands right now. I don’t think they do and therefore, they don’t understand the gaps.”

Strategic Planning

- Several respondents made comments and recommendations related to the need for OPSA to do some planning. Individual comments included:
 - Get involved with research studies; learn about results and improvements in treatment get involved with the Centers for Excellence and other Federal resources.
 - Identify where we are at and make it better.
 - Develop a conscious plan and work towards it.
 - OPSA could take a stronger leadership role. Establish communication, conduct studies, commission papers, advocate for women, increase visibility of issue, and infuse evidence based practices.
 - Need to assess where things currently stand in order to move forward and rebuild ADP’s State leadership role within perinatal services.

- Focus first on advanced services again. Conduct more fact finding regarding what is available across the system and collaborations then move into more policy and collaborations.
- Consider changing the name: office of women, children, and families?
- Increase visibility and family focus.
- Respondents indicated a high level of interest in OPSA working to improve treatment. Some of the suggestions included: Develop a way to bring knowledge to our state in a concentrated, logical way; establish an aggressive movement to improve treatment, develop policies and protocols that help improve services; identify of best practices in California; disseminate best practices to use to improve programs; and share data to use in proposal development.

Continuum of Services

- Some respondents spoke to the opportunity to develop a continuum that includes prevention. One respondent described the opportunity to impact children and young girls through prevention efforts. “We now know more about some of the issues that are important to young girls and children that we might impact through both prevention and youth services. Those issues are around, trauma, socialization, development of identity all of those issues that we know impact women later in adulthood.”
- Respondents identified specific service needs unique to pregnant women and other issues true for all women. One respondent stressed the importance of addressing the substance abuse needs of clients and referring/collaborating for other service needs.
- Some respondents indicated a need for improved outreach and engagement. One respondent stated, “The treatment system is passive. Getting people to come in more requires aggressive recruitment.”
- Several respondents communicated the importance of building the knowledge base of OPSA/ADP around research based practices. One respondent stated, “There were two California sites in the women and violence study. I don’t think OPSA knows what we really found in that study. They need to know about trauma and trauma informed services.”
- Several respondents discussed the role of the perinatal services guidelines and OPSA’s role in a possible review or update of them.

Advocacy

- Several respondents saw an advocacy role for OPSA including advocating for needs of women, pregnant women and families within ADP initiatives, legislative advocacy and increasing advocacy tools.
- Several recommended ADP get involved with publishing reports, data and outcomes including those that describe effective models, service needs of pregnant and parenting women.
- Several respondents expressed a need for advocacy. Some were concerned about increased punitive measures and prosecution of women for substance use disorders, including drug endangered children child endangerment.

- One respondent suggested that ADP could expand funding by addressing current trends. For example, addressing the methamphetamine epidemic among pregnant women or conducting research on effects of methamphetamine on fetal development.
- Respondents expressed a desire for a variety of data collection and data sharing approaches. Examples included providing data on the validity of different practices, data to advocate for funding and available data on perinatal issues available (e.g., substance exposed births).
- One respondent called on ADP to do a cost analysis and cost savings outcome study. “We’ve had CalData, CalTOPS, CalOMS and all of them show how much money is saved for every dollar invested in treatment. There is nothing that says anything about the cost saving related to the children. I think the cost savings would be incredible. ADP should do this study.”

County Monitoring

- Most respondents were unclear what role OPSA has in relationship to county perinatal programs. Most recognized that they have administrative oversight for perinatal programs in California. Several thought that they monitor counties but noted minimal involvement.
- Respondents felt that OPSA staff should know them, their programs and the services they offer.
- One respondent suggested that each county submit an annual plan. Other respondents indicated that OPSA’s role should be of supporting efforts of providers and counties.

Funding

- Most respondents discussed the need for funding. Specific comments included:
 - ADP should be more active and take any action that would increase funding for perinatal services.
 - Establishing funding to support county systems to improve access is needed.
 - Increase funding to help coordinate integrated continuum of care.
 - Take a look at 20% prevention set aside dollars. Child intervention is prevention and should be coming out of prevention money, not treatment.
 - We need more perinatal services. In collaboration with the field, ADP needs to figure out how to do it and address cuts in funding.
 - Fund case management through Medi-Cal.

Keep us connected as a field

- Most respondents indicated a role for OPSA in communication across the field. Specific comments and suggested included:
 - We need more perinatal services.

- Take a stronger role in linking us together via meetings, leadership, and newsletters.
- Convene perinatal and other women's' treatment providers meetings and serve as a touchstone for them.
- "I think it would be really nice if they worked with the whole perinatal network. They could call us together and sit down with us and really ask what we think some of the issues are and what we should focus on for the next couple of years."
- Establish a better link between what ADP does at the county level. Ten years ago counties had perinatal councils, now they are gone.
- Hold an Annual women's conference on perinatal and other women's services.

Collaboration

- Specific state collaborations were recommended by several of the respondents. Two respondents suggested that ADP take a lead role in a state interagency taskforce on women and children and families with high level participation and a meaningful agenda.
- Respondents also suggested working with other individual state departments including Health, MCH, CDCR, DSS and DDS.
- Several respondents suggested that ADP facilitate and problem solve on statewide issues. Examples included: uneven response on toxicology positive births, challenges in providing co-occurring services, and collaborating with MCH over difficulties in implementing prenatal screening and intervention.

ADP and CADPAAC

Summary

CADPAAC members were asked what opportunities they see for ADP and CADPAAC to work together strategically to address perinatal and family issues. A few respondents noted that perinatal services must be a priority for CADPAAC and ADP and integrated into their strategic plans in order to expand activity in this area. Responses fell into three primary themes: addressing funding, communication and quality improvement. Related to funding, the most frequent recommendation was to review Perinatal Drug Medi-Cal and work towards an improved method of calculating funding. Communication included planning and continued exchange of feedback and information. Quality improvement recommendations are related to reviewing the perinatal services guidelines and increasing use of evidence-based practices.

Common Themes

Funding

- The most common responses had to do with funding issues. Several of the administrators expressed an interest in working together on revamping and revising Drug Medi-Cal to: 1) allow funds to be used for more types of services; have reimbursement rates make sense and, 2) explore feasibility of reducing restrictions (e.g., restriction on 16 beds or less, no patch grants). Several respondents reported that many counties are no longer using Drug Medi-Cal.
- Other funding-related recommendations included:
 - Identify funding streams that support family treatment as now all funding is individual based.
 - Funding for women and trauma.
 - Pilot models including collaboration on Federal grants.
 - Identify Federal and other funding sources as well as other creative ways to expand resources.
 - Identify evidence based practices and develop funding and structure that will result in implementation.

Communication

- CADPAAC used to have a women's committee, then changed to social services committee (OPSA came to meetings). Now it's called treatment committee. One respondent suggested that ADP and CADPAAC work together to establish a place where people can come and participate in perinatal and women's issue discussions.
- Several respondents indicated that on-going communication is very important.
- One respondent recommended ADP and CADPAAC work together to provide networking and communication opportunities for providers and County perinatal service coordinators (who do not normally attend CADPAAC).

- One respondent liked the idea of social marketing efforts that would let a lot of people know that help is out there via media and billboards.

Quality Improvement

- Several respondents suggested that reviewing and possibly updating the perinatal services guidelines as a collaborative project of CADPAAC and ADP would result in quality improvement.
- Other capacity building and quality related suggestions included:
 - Improve integration of co-occurring services in women's treatment.
 - Offer training and TA.
 - Work together to expand implementation of research and best practices at a program level.
 - Develop data analysis and reports.
- CADPAAC conducts an annual prioritization of issues. One administrator indicated that while perinatal services are important, CADPAAC has other more emergent priorities. Two respondents indicated that perinatal priorities should be built into strategic plans and acted on accordingly.
- One respondent suggested that there are several different efforts underway to address perinatal AOD use (e.g., MCAH, Chasnoff) and it would be helpful if these various efforts were linked so that one effort doesn't undermine another. This could all happen under the leadership of ADP and CADPAAC.

Perinatal Services Guidelines

Summary

Respondents were asked if they use the Perinatal Services Guidelines (PSG) and whether they should be strengthened. Many respondents indicated that the PSG have been built into program services, monitoring instruments and contracts, but that they had not been looked at for a long time. Some providers and two counties have drafted their own standards or work plans. Overall, respondents recommended that the PSG be reviewed and the language updated. Some respondents believed they should be strengthened. Others reserved their opinion dependent upon a review process. Challenges identified included funding limitations, preventing implementation of stronger standards, and addressing the varied needs across the state in one document. Respondents recommended that a review process include CADPAAC and provider representatives from small, medium and large counties.

Common Themes

Uses of Perinatal Services Guidelines

- Several respondents were unfamiliar with the guidelines or their uses. Others indicate some moderate uses of the guidelines as follows: in contracts; as monitoring tool; and for new program start up. Generally, respondents believed that the guidelines are minimum standards and that current treatment providers exceed those standards.
- One provider described the current status as follows, “They are a basis and a foundation. I think we’ve gone way, way beyond it. Before, folks really applied those guidelines. If you had a grant then you were held accountable to that. The State used to come out, the County used to come out and all the sudden just everything stopped.”
- Some administrators and providers stated that they thought the current guidelines were working fine and offered no opinion on whether they should be reviewed or strengthened. Others commented that they were not familiar with them.

The current Perinatal treatment guidelines were described by respondents as follows:

- On the positive: Pretty comprehensive, focused on the issues, broad enough that agencies can build in services they want.
- On the negative side: Sometimes they are too vague, sketchy and don’t describe what to do.
- Several respondents noted that they are not standards with statutory requirements. One respondent commented that they are guidelines not standards and since they have no teeth, they are not that important.

Overall, participants were cautious about the term “strengthened” and suggested an initial review.

- At a minimum, a field review and updating of language with training to counties and providers were suggested. Others indicated a more thorough revamping of the guidelines and bringing them in alignment with best practices and evidence based practices.

- One participant responded, “They are very minimalist. Quality treatment is important but how much strengthening depends on capacity.”

Specific areas to be addressed included the following respondent statements:

- Change them to be more specifically directive.
- Guidelines should be specific to where substance use treatment stops so it does not get muddled with other services. Require a continuum of care. We don’t need to duplicate services. Case management is missing.
- Review them to identify ways to reducing paperwork and bureaucratic mechanisms that get in the way of client services.
- Incorporate new language.
- Address trauma informed practice and trauma specific services. Research on depression specifically and the needs for mental health issues/co-occurring issues should be included.
- Type of personnel for treatment, especially child care worker standards.
- Address family centered approach and intergenerational issues.
- Address services for children.
- Look at the national evaluation for pregnant and postpartum programs. They were able to come up with evidence based practices that appear to work.
- Contra Costa drafted a perinatal work plan to roll out over the next year or two. It has several domains of treatment followed by 5-6 sentences on each service. It does not have standards on outcomes such as percent with minimal lengths of stay, etc. Used TIPS and TAPS to create it.
- Alameda Taskforce created perinatal treatment standards in order to meet their goal of providing access to quality treatment. They plan to work with treatment providers on rolling out these standards.

CONCERN: Can you implement stronger standards without addressing funding gaps?

Several respondents noted that implementing higher standards will take more higher level staff which takes additional funding. One administrator hopes that strengthening the perinatal standards will increase funding. Another administrator suggested that additional guidelines could be tied to additional funding. Other comments related to funding included:

- Case management, transportation etc are required but are we funding providers to do this?
- Alcohol and drug programs are underfunded.
- Great to have guidelines, but the funding doesn’t follow it.
- Review Medi-Cal too.
- It’s one thing to say how to strengthen the guidelines, but then it comes back to money. Would like to have a licensed day care versus a co-op.

- Only suggestion is that without additional funding it is hard to get stricter. If staff is asked to do more they may need additional dollars.
- If ADP changes them, then programs will need more funds to carry out the stronger guidelines.
- Drug Medi-Cal benefit should address broader needs: child care, housing and vocational services.
- Need training funds, support for programs to implement new standards.
- Increased expectations – need higher salaries and better funding.

Suggestions in terms of the process for reviewing the guidelines included:

- ADP should create a process to evaluate the Perinatal Guidelines with input from providers rather than just change them.
- OPSA should take the lead. OPSA staff should spend time in programs before they change the standards. Go to programs.
- Using a work group is a good approach because it is time-limited with a clear goal. One respondent suggested the following: CADPAAC could provide data and participate in workgroup. It is recommended to have significant provider participation from a variety of agencies. Perhaps the CADPAAC Treatment Committee could work with an ADP workgroup to review them and make recommendations.
- Contra Costa County: Guidelines were drafted. They will be holding quarterly meetings with all providers to review them line by line. They will discuss and build consensus on what is doable and what needs funding.
- Alameda County process: First they called 8 or 9 large counties and asked if they had revised standards they could share, but they all said no and instead requested copies of Alameda's work. Hired Marty Jessup to develop standards and an implementation plan. To develop the Perinatal standards, they held meetings and focus groups, gathered data for a baseline. Then wrote recommendations for the standards and went back and clarified them. They are now starting an education, training and policy development process. They do not want to issue the standards without supporting providers. This is probably a 3 year process.
- Collect and analyze data. Do runs on what population looks like.
- Review research. Look at Federal PPW and RWC evaluation for EBP.

Challenge: Balancing County and State roles and responsibilities.

- One respondent stated: "It would be very helpful if the guidelines came from the State. It would reinforce their importance."
- Another respondent cautioned that, "Updating the guidelines is a good intention, but the manpower to carry it out is difficult. Do not tackle it unless you really want to work on them."
- One respondent stated, "I am not sure what you can cover in guidelines that everyone can meet with current funding and meet the needs in both small and large counties. Small communities will need some sort of consultation process to be sure they fit."

Staying up to Date

Summary

Respondents were asked how they stay informed about federal, state and other local initiatives and what their counterparts are doing. The majority of respondents rely on CADPAAC to stay abreast of Federal, state and local trends. List serves, internet and informal communication were also identified as ways they stay connected.

Common Themes

- CADPAAC was a primary source respondents referred to for helping them stay up to date.
- List serves and internet was mentioned by a majority of respondents for how they stay in touch with what occurs outside of their community. Specific references included: SAMHSA news, PATTC, ADPI. Other organizations including CIMH, CFF, CWLA, and the local Maternal and Child Health Director were also cited as resources.
- State organizations and activities that were cited by one or more respondents included: COJAC, CAPTN, DAC, CAADPAC, CADPE, CAARR, Prop. 36 and licensing and certification committee.
- Respondents also referred to informal networking with colleagues via committee participation, conversations, phone calls, and conferences as a way of learning about what works in other places.
- Most of the county “perinatal service coordinators” and treatment providers who are not involved with CADPAAC, communicated a lack of connection and desire for more connection.
- Several respondents cited lack of time affecting their ability to stay informed.
- Several respondents indicated that they review research and literature.
- One national provider organization that has services in California uses alignment teams to brainstorm problems. They are working to adopt an incentive programs approach for clients that uses a positive rather than punitive approach. To begin implementation, they held a day long retreat followed by mini-workshops, trainings, and incentives to make the shift.

Making a Significant Positive Impact and Improving Access to Quality Treatment Services

Summary

Respondents were asked how ADP can make a significant positive impact in perinatal services and how access to quality treatment services can be improved. The majority of responses provided answers in the categories of funding, updating the Perinatal Services Guidelines, expanding research, communication, and collaborations.

Common Themes

- **Funding related strategies.** Specific examples included leveraging CWS redesign for increased local funding; working with criminal justice for funding treatment for women coming out of prison; accessing Prop. 63 funds; developing funding for adequate services and appropriate service level including more long term residential treatment; expanding funded prevention services to include services for children whose parents are in treatment and start up funding and time for real startup.

- **Review and update Perinatal Services Guidelines and Drug Medi-Cal certification standards.** Several administrators noted that in their counties there are programs that applied for Drug Medi-Cal, but because they did not meet quality standards, the county did not approve contracting with them and then they received contracts through the State. One respondent referred to Drug Medi-Cal as based on “cost containment not on quality services.” Another respondent suggested developing strong standards and reimbursement rates and seeking Federal waivers. Several respondents noted that funding should encompass more than group and limited individual counseling and that perinatal should not end at 60 days post-partum. One respondent suggested that strengthened standards could allow the field to serve different populations, pursue other funding, and apply for waivers.

- **Maintain current programs.** Respondents expressed concern about losing existing services. Several respondents have closed programs or reduced some services. Respondents indicated that they have experienced cuts to perinatal budgets. One respondent stated that, “Perinatal was priority a time ago, now methamphetamine is. We need to remind people that the perinatal drug of choice is methamphetamine.” One respondent indicated that “opportunities are diminishing.” An administrator discussed the need to “do more with less.”

- **Research.** Several respondents indicated that the field would benefit if ADP could produce reports, data, and advocacy including white papers with policy recommendations. One respondent stated, “Data, Data, Data, analysis of data at a county, program and statewide level.” Another respondent discussed the size and purpose of the research unit at ADP, “ORA is very small and just works on data

collection. ADP needs to strengthen the research group emphasize analysis and best practice information.” Another respondent stated, “We can get more money if ADP would do evaluation of cost savings.”

- **Communication and quality improvement within the field.** One respondent recommended “paying attention to the Perinatal Treatment Network and developing a strong network in California through building communication, getting to know providers and getting a sense of the needs and gaps in services, introducing evidence based practices, infusing with new funding.” Other suggestions included: sharing knowledge statewide, especially about research to practice; spreading knowledge on innovations (e.g. family treatment); strengthening the role of TA providers on helping to promote research to practice; updating website; creating a newsletter; helping programs to make the shifts so they will implement strategies we know what works best; being more directive with counties and programs that need help so they access TA; and getting more involved in direct support of programs in everyday business.
- **Promote collaboration on State, county and provider levels.** Some respondents indicated that they would like to see ADP work toward the establishment of an interagency taskforce on women, children and families with higher level stakeholders and state agencies and a meaningful agenda. Agencies cited included: DSS, CDCR, HUD, and MCH. Other suggestions included addressing children’s issues such as universal screening, childhood obesity and outreach to students. One respondent recommended establishing links between Dependency Court initiative drug courts and OPSA.
- **Advocacy/Women’s focus.** Several focus group members suggested creating an Office of Women’s Services at a higher and different level than OPSA. Several respondents addressed women’s specific needs with comments such as, “Be sure that the main focus is for women, not just babies.” “Reduce punitive responses for parenting women.” “There is no other gender specific entity so there’s an obligation to address the needs of women,” and “We need comprehensive engagement and resources to take care of women.”
- **Planning.** One respondent suggested putting together a strategic 5-year plan on elements to improve perinatal services. Others discussed identification of a conscious plan and working towards it.
- **Ensure a complete continuum of services.** Several respondents recommended expanding prevention. “Move upstream, pre-pregnancy education, intervention, and treatment ... before and during pregnancy.” One respondent suggested supporting early intervention, treatment, and family education with a model similar to the Solano early identification, engagement, and then treatment.

- **Co-occurring disorder treatment.** Several respondents addressed the need to improve services for women and families with trauma histories. Cuts in mental health budgets pose significant problems for the substance use treatment field. One respondent suggested that some women (e.g., CalWORKs clients) prefer to access mental health services (less stigma) than substance use treatment. Another respondent suggested creating an array of behavioral health services for women who have trauma and other needs, but who are not severely mentally ill. One respondent cited the ongoing need to reduce stigma for psychotropic medications.
- **Safe, affordable housing.** Several respondents noted a shortage of safe affordable housing as a barrier to ongoing recovery. Job training, transportation and a full array of step-down services were also noted. One barrier cited is that when programs are started, it is difficult to sustain them.
- **Cultural competency.** Several respondents discussed cultural barriers including language barriers as well as limited culturally specific services. One respondent noted that mental health requires a cultural competency plan but AOD does not. Adding that there is also not a gender responsiveness plan. Another noted that counselor certification does not really address cultural competency or gender responsiveness and many staff are waived out (MFTs, LSCWs). One respondent indicated that CADPAAC would not support a requirement of submitting gender responsiveness or cultural responsiveness plans.
- **Workforce development.** A respondent suggested piloting an internship program for professional schools that promotes public-private partnerships. One respondent stated, “We must be smarter, well trained and have the highest possible quality including good staff ... don’t waste clients time.”
- **Family Resource Centers.** As family resource centers are expanding, some counties are working to ensure that substance use prevention, intervention, and treatment are available within them.
- **Advocacy.** One respondent stated “We have better knowledge of substance abuse and options now, but we got lackadaisical, once programs were funded we looked away from policy and national level, now we are losing ground.” Another said, “We need policies that bring alternative sentencing and resources for women and families to stay together in treatment rather than prison.” One respondent compared our field to the tobacco field. “In tobacco, it took a long time. We stayed with it now there are real policy and cultural shifts. Perhaps the strong consumer movement in tobacco advocacy also really helped.” Another respondent said, “We don’t want the children or women to be harmed. Let them bring their children into treatment and I think we’re going to have better than 66% success rates. I think we have to save the mother and child. We have got to give the mother a chance. I think the women need to be given the opportunity and support.”

ATTACHMENT 1

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ATTACHMENT 2

QUESTIONAIRES

CADPAAC

Key Informant Interview Questions

Introduction

1. Tell me a little about yourself and your background in relation to serving women?

Perinatal Services

2. Tell me about the perinatal and other services for women & families in your county. Who do you serve and what type of services do you offer? Are services provided directly by the county or through contractors? Do you differentiate pregnant postpartum from other women?
3. On a scale of 1 to 5 with one being not responsive and 5 being entirely responsive – rate your overall service delivery system and explain. A. Gender responsive? B. Culturally responsive? C. Family-centered?
4. What percentage of births were identified as SEB in the Vega study (the prevalence study in 1992) for your county? What data do you get or have available to help you evaluate prevalence, needs, services and outcomes for pregnant and parenting women in your county?

Interagency Work

5. Are you involved in local collaboratives or interagency initiatives that affect substance using women, children and families? Can you tell me a little about them? What agencies do you speak with at least twice per month?
6. Have there been any changes in reporting SEB births as a result of CAPTA? Have you been involved in efforts to implement SB2669 or other medical referrals?
7. Are you aware of faith-based, medically based, or other programs for women with substance use disorders and their children in your county that fall outside of the perinatal services network? Do they interact with your office, other government agencies or other treatment providers?
8. Are you aware of the work that your counterparts are doing in other communities, States or at a Federal level? How do you stay plugged into State and national information?
9. A. How do you measure accountability and encourage quality, effective services perinatal and family services? B. How do you know what the treatment providers are doing?

ADP and Future Opportunities

10. Let's talk a little about the ADP. A. Who do you think OPSA should serve and how do see OPSA's purpose? B. What would you like to see OPSA involved with in order to better help women, children and families in your community or perinatal services as a whole?

11. What opportunities do you see for ADP and CADPAAC to work together strategically to address perinatal and family issues (e.g., research, studies, legislation).
12. A. How do you use the Perinatal Services Guidelines? B. Do you think ADP should explore strengthening the perinatal guidelines? If yes, do you have specific ideas or suggestions? Why?
13. Do you think family treatment is a next step in the evolution of services that address women, children and family needs? What do you see as the challenges or barriers to implementing family treatment? What do you see as some of the key issues and opportunities relative to addressing prenatal and postnatal substance exposure in California's children?
14. What opportunities do you see for improving access to quality treatment services for women, children and families or addressing other issues affecting women, children and families?
15. If there were one thing that ADP could do that would make a tremendous positive impact in perinatal services what would it be?
16. Any other comments or discussion?

Perinatal Environmental Scan

Treatment Provider/CAPTAN Key Informant Interview Questions

1. Tell me about yourself, your program and the perinatal and other services for women & families you offer. Who do you serve and what type of services do you offer, where? Do you differentiate pregnant and postpartum women from other women or women with children with prevention and treatment needs? How? Do you offer family-based treatment? Tell me about CAPTN (purpose, structure and current activities).
2. A. Are you involved in local collaboratives or interagency initiatives that affect substance using women, children and families? Can you tell me a little about them? B. What agencies do you speak with at least twice per month?
3. A. Do you have a relationship with medical clinics or hospitals where they refer women for treatment? B. How many referrals do you get from them per month? C. Have there been any changes in reporting SEB births as a result of CAPTA? D. Have you been involved in efforts to implement SB2669 or other medical referrals?
4. Are you aware of the work that your counterparts are doing in other communities, States or at a Federal level? How do you stay plugged into State and national information?
5. On a scale of 1 to 5 with one being not responsive and 5 being entirely responsive – Prototypes, LA and Ventura County and California's overall substance use treatment service delivery system. A. Gender responsive? B. Culturally responsive? C. Family-centered?
6. How do you think that California perinatal services have changed over time?
7. What do you see as the primary purpose of ADP's Office of Perinatal Substance Abuse? Who do you think OPASA's work should help?
8. OPASA has moved into the prevention side of ADP, under the Manager of Youth Services Coordination. A. What are some of the increased opportunities that result in being located in Prevention? B. What areas of your purpose that might be more challenged to fulfill?
9. What would you like to see OPASA involved with in order to better help women, children and families in your community or perinatal services as a whole?
10. A. What accountability measures for quality and effectiveness of treatment and prevention services for women do you think there should be? How do you think ADP should encourage quality, effective perinatal and family services?
11. Do you use the Perinatal Services Guidelines? How? Do you think ADP should explore strengthening the perinatal guidelines? If yes, do you have specific ideas or suggestions? Why?
12. What role do you see ADP/OPASA having with other state departments to improve services for women and families? Are there specific departments or inter-agency work that you think are important? What?
13. Do you think family treatment is a next step in the evolution of services that address women, children and family needs? What do you see as the challenges or barriers to implementing family treatment?
14. What do you see as some of the key issues and opportunities relative to addressing prenatal and postnatal substance exposure in California's children?

15. What opportunities do you see for the Office of Perinatal Services to address issues affecting women, children and families with substance use disorders? Are there specific items you would like to see ADP work on in collaboration with CAPTN or CFF?
16. If there were one thing that ADP could do that would make a tremendous positive impact in perinatal services what would it be?
17. Other comments and questions.

Women's Constituent Committee
Focus Group Questions

1. A. Do you differentiate pregnant and postpartum women from other women or women with children with prevention and treatment needs? How? B. Who do you think OPSA should serve and how do you see OPSA's purpose?
2. On a scale of 1 to 10 with one being not responsive and 10 being entirely responsive – rate California's overall service delivery system and explain. A. Gender responsive? B. Culturally responsive? C. Family-centered? D. What are some of the innovations, successes and challenges in each of these areas?
3. A. How do you think the perinatal services network and its members have changed over time? B. Do you have thoughts on how ADP and other state and local agencies can support the work of the perinatal services network?
4. A. What would you like to see OPSA involved with in order to better help women, children and families in your community or perinatal services as a whole? B.
5. A. What accountability measures for quality and effectiveness of treatment and prevention services do you think there should be? C. How do you think ADP should encourage quality, effective perinatal and family services?
6. Do you use the Perinatal Services Guidelines? How? Do you think ADP should explore strengthening the perinatal guidelines? If yes, do you have specific ideas or suggestions? Why?
7. What role do you see ADP/OPSA having with other state departments to improve services for women and families? Are there specific departments or inter-agency work that you think are important? What?
8. Do you think family treatment is a next step in the evolution of services that address women, children and family needs? What do you see as the challenges or barriers to implementing family treatment?
9. OPSA has moved into the prevention side of ADP, under the Manager of Youth Services Coordination. A. What are some of the increased opportunities that result in being located in Prevention? B. What areas of the purpose might be more challenged to fulfill?
10. What do you see as some of the key issues and opportunities relative to addressing prenatal and postnatal substance exposure in California's children?
11. What opportunities do you see for the Office of Perinatal Services to address issues affecting women, children and families with substance use disorders?
12. If there were one thing that ADP could do that would make a tremendous positive impact in perinatal services what would it be?

Treatment Provider Questions

Perinatal Services

1. Tell me a little about the perinatal and other services for women & families you offer. B. Who do you serve and what type of services do you offer? C. Do you differentiate pregnant and postpartum women from other women or women with children? How? D. Do you offer family-based treatment? Do you have therapeutic services for children?
2. On a scale of 1 to 5 with one being not responsive and 5 being entirely responsive – rate your services and explain. A. Gender responsive? B. Culturally responsive? C. Family-centered?
3. On a scale of 1 to 5 with one being not responsive and 5 being entirely responsive – rate your county’s overall service delivery system and explain. A. Gender responsive? B. Culturally responsive? C. Family-centered?
4. A. What data do you get or have available to help you evaluate prevalence, needs, services and outcomes for pregnant and parenting women in your county? B. How do you measure accountability and encourage quality, effective services? C. Do you collect data on children or only women?

Interagency Work

5. A. Are you involved in local collaboratives or interagency initiatives that affect substance using women, children and families? Can you tell me a little about them? B. What agencies do you speak with at least twice per month?
6. A. Do you have a relationship with medical clinics or hospitals where they refer women for treatment? B. How many referrals do you get from them per month? C. Have there been any changes in reporting SEB births as a result of CAPTA? D. Have you been involved in efforts to implement SB2669 or other medical referrals?
7. Are you aware of the work that your counterparts are doing in other communities, States or at a Federal level? How do you stay plugged into State and national information?

ADP and Future Opportunities

8. Let’s talk a little about the ADP. A. Who do you think OPSA should serve and how do see OPSA’s purpose? C. What would you like to see OPSA involved WI in order to better help women, children and families in your community or perinatal services as a whole?
9. Do you think ADP should explore strengthening the perinatal guidelines? If yes, do you have specific ideas or suggestions? Why?
10. Do you think family treatment is a next step in the evolution of services that address women, children and family needs? What do you see as the challenges or barriers to implementing family treatment?
11. What opportunities do you see for improving access to quality treatment services for women, children and families or addressing other issues affecting women, children and families?
12. What do you see as some of the key issues and opportunities relative to addressing prenatal and postnatal substance exposure in California’s children?

13. If there were one thing that ADP could do that would make a tremendous positive impact in perinatal services what would it be?

14. Any other comments or discussion?

Perinatal Environmental Scan
Other Key Informant Interview Questions

1. Tell me a little about your background and work related to women and perinatal substance use. What are some of your current projects?
2. How do you think the perinatal services have changed over time?
3. On a scale of 1 to 5 with one being not responsive and 5 being entirely responsive – rate California’s overall service delivery system. A. Gender responsive? B. Culturally responsive? C. Family-centered? D. What are some of the innovations, successes and challenges in each of these areas?
4. A. What do you see as the primary purpose of OPSA? Do you differentiate pregnant and postpartum women from other women or women with children with prevention and treatment needs? How?
5. What would you like to see OPSA involved with in order to better help women, children and families in your community or perinatal services as a whole?
6. A. What accountability measures for quality and effectiveness of treatment and prevention services do you think there should be? B. How do you think ADP should encourage quality, effective perinatal and family services?
7. Do you use the Perinatal Services Guidelines? How? Do you think ADP should explore strengthening the perinatal guidelines? If yes, do you have specific ideas or suggestions? Why?
8. Do you think family treatment is a next step in the evolution of services that address women, children and family needs? What do you see as the challenges or barriers to implementing family treatment?
9. Do you think inter-agency collaboration is important to improve outcomes for women, pregnant women and parenting women with substance use disorders? Are there specific departments and collaborations you think are especially important?
10. What opportunities do you see to address issues affecting women with substance use disorders?
11. What do you see as some of the key issues and opportunities relative to addressing prenatal and postnatal substance exposure in California’s children?
12. Are you aware of the work that your counterparts are doing in other communities, States or at a Federal level? How do you stay plugged into State and national information?
13. If there were one thing that ADP could do that would make a tremendous positive impact in perinatal services what would it be?
14. Other comments and questions.

Appendix 3 Collaborations Matrix

This matrix is intended to be illustrative, not comprehensive. It contains a sample of collaborations based upon a limited set of interviews.

	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
Community Level Prevention and Education	<ul style="list-style-type: none"> ▪ Program marketing ▪ AOD Prevention programs in schools ▪ SAPs ▪ Mentoring & youth development initiatives – discouraging teen pregnancy, delinquency & AOD use ▪ Some treatment providers involved in prevention coalitions 	<ul style="list-style-type: none"> ▪ Some administrators noted that the prevention & perinatal programs not connected ▪ Humboldt Methamphetamine Coalition ▪ Sacramento family resource center ▪ Sonoma County PAODAT Coalition 	<ul style="list-style-type: none"> ▪ Limited Discussion of Social Marketing Campaign with CADPAAC ▪ Office of Women’s Health – questions ▪ Early Start & Healthy Start collaboratives ▪ Until recently, little communication between ADP perinatal & prevention staff ▪ Methamphetamine Health Promotion Campaign 	<ul style="list-style-type: none"> ▪ Statistics on pregnancy show continued AOD use ▪ Prevention & treatment communities have had limited communication; since perinatal has primarily been part of treatment, little perinatal prevention communication or action 	<ul style="list-style-type: none"> ▪ Restaurant signs & alcohol labels citing risk during pregnancy ▪ In some communities- more awareness that AOD use during pregnancy is unhealthy ▪ Some mentoring & youth development programs addressing both teen pregnancy & AOD use
Health and Prenatal Care	<p>PRENATAL</p> <ul style="list-style-type: none"> ▪ Access to prenatal care regardless of treatment status – Orange County, Solano County teens ▪ Access to prenatal care for those in treatment including transportation; Many providers indicated that few clients participate in prenatal care prior to entering treatment 	<p>PRENATAL</p> <ul style="list-style-type: none"> ▪ Many counties have a collaborative public health, parental screening program (e.g., Chasnoff SART); Range from those with collaborative meetings & screening only to those with engagement specialist (Kern, Sonoma) to those with brief intervention 	<p>PRENATAL</p> <ul style="list-style-type: none"> ▪ Fetal Alcohol Spectrum Disorder (FASD) Task Force ▪ WIC 4 questions screening (though minimal follow-up) ▪ DHS limited TA for counties on addressing substance abuse ▪ DHS Immunization Collaborative ▪ MCH Directors Planning ▪ Medi-Cal and MR MIBB provide for 	<p>PRENATAL</p> <ul style="list-style-type: none"> ▪ Statistics on pregnancy show continued AOD use ▪ NIMBY among private practice physicians & hospitals ▪ State Interagency Team on Perinatal Substance Abuse (SITF) no longer convenes (crosses service systems) 	<p>PRENATAL</p> <ul style="list-style-type: none"> ▪ Perinatal Drug Medi-Cal ▪ Increase in collaborative services to engage those entering prenatal care in abstinence via education, engagement ▪ Substance free births of individuals entering treatment ▪ Improved prenatal care, nutrition, etc. of individuals in treatment, hence positive birth outcomes ▪ Kaiser model

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	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
	<ul style="list-style-type: none"> ▪ Access prenatal care ▪ Access WIC <p>BIRTH</p> <ul style="list-style-type: none"> ▪ Provider engaging clients at birth in hospital ▪ Referrals from hospitals vary – some get a lot & others very few ▪ Number of drug free births used as outcome measure ▪ Collaborations with high risk pregnancy & infant programs <p>ACUTE/CHRONIC CARE</p> <ul style="list-style-type: none"> ▪ Several treatment providers interviewed offer HIV testing, education & counseling ▪ Providers offer case management enrollment, access, transportation, language, prescription assistance 	<p>services provided at medical clinics (Alameda, Contra Costa BornFree)</p> <ul style="list-style-type: none"> ▪ No administrator & one provider discussed direct HIV collaborations related to perinatal services <p>BIRTH</p> <ul style="list-style-type: none"> ▪ Kern County partnering meetings with hospitals on Presley (SB 2669) & CAPTA ▪ Sonoma County recent revised hospital protocol currently under review by county counsel ▪ Sacramento County closes collaborative system between hospital, child welfare, & county treatment 	<p>prenatal health care</p> <p>BIRTH</p> <ul style="list-style-type: none"> ▪ Passage of SB 2669, no implementation funding & limited evaluations 	<p>BIRTH</p> <ul style="list-style-type: none"> ▪ Spotty participation in development of hospital SB 2669 protocols; appear to be agreement no standard implementation; no apparent implementation of CAPTA requirement – limited awareness of it, some opposition to it ▪ No current ADP, OPSA & MCH direct collaboration <p>ACUTE & CHRONIC CARE</p> <ul style="list-style-type: none"> ▪ Limitations in HIV funding & non-Medi-Cal indigent health care 	<p>ACUTE & CHRONIC CARE</p> <ul style="list-style-type: none"> ▪ Medi-Cal now covers dental care for pregnant women (Denti-Cal)

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	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
	<ul style="list-style-type: none"> ▪ Dental care access noted challenge 				
Mental Health	<ul style="list-style-type: none"> ▪ Providers interviewed are working on adoption of trauma-informed services either via Lisa Najavits' Seeking Safety or involvement of Stephanie Covington & her curriculum ▪ Majority of larger providers becoming mental health providers or hiring clinical staff 	<ul style="list-style-type: none"> ▪ Participation in Proposition 63 planning ▪ EPSDT, treatment provider team building & collaborative funding - Alameda County ▪ Collaboration funded by Proposition 10 in Contra Costa ▪ Humboldt County – dually enrolled clients ▪ Los Angeles & San Diego cited co-occurring disorders workgroups 	<ul style="list-style-type: none"> ▪ COJAC has identified survivors/victims of trauma as priority populationsⁱ ▪ COJAC has broad participation & buy-off from both department heads ▪ CADPAAC concurred with the “Co-Occurring Disorders Workgroup” recommendation to identify priority populations as a strategy to move forward with limited resources; including pregnant women & parents with co-occurring substance abuse & mental health problems; CADPAAC added victims of trauma priority population 	<ul style="list-style-type: none"> ▪ Challenges in accessing adequate funding ▪ Challenges in blending funding streams ▪ Limitations of Medi-Cal ▪ ADP licensing – have a psychiatrist but cannot dispense medications ▪ Continued turf issues & poor communication in many communities ▪ Linkages with mental health services – mixed, some providers cannot access quality services 	<ul style="list-style-type: none"> ▪ Licensing issues related to co-occurring disorders for the most part have been resolved ▪ More acceptance of psychotropic medications among treatment providers ▪ Increased knowledge of co-occurring disorders & improved diagnosis ▪ Better communication in many communities (but not all)

Appendix 3 Collaborations Matrix

This matrix is intended to be illustrative, not comprehensive. It contains a sample of collaborations based upon a limited set of interviews.

	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
<p>Domestic Violence</p>	<ul style="list-style-type: none"> ▪ Some providers funded to provide treatment & domestic violence services; collaborative relationships for client services ▪ Participation in local taskforces 	<ul style="list-style-type: none"> ▪ No references ▪ AOD participation on Domestic Violence Prevention Councils 	<ul style="list-style-type: none"> • Domestic Violence Task Force (Attorney General, lead) • Domestic Violence, Mental Health & Substance Abuse Curriculum Advisory Board (MCAH lead) <ul style="list-style-type: none"> ▪ Greenbook Leadership Group (Administrative Office of the Court, lead) ▪ Domestic Violence TA contract addresses substance abuse & mental health populations & issues ▪ PROTOTYPES active involvement in domestic violence field. 	<ul style="list-style-type: none"> ▪ Individuals with substance use disorders often identified as non-compliant by domestic violence agencies ▪ In early & mid 1990s significant effort on cross-training was conducted 	<ul style="list-style-type: none"> ▪ Prevention programs adopting the AOD model; better culturally specific services ▪ Cross-training in early 90s ▪ Access to legal support ▪ Limited increased knowledge of addiction among domestic violence providers & vice versa

Appendix 3 Collaborations Matrix

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	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
Criminal Justice	<p>DRUG COURTS & PROP 36</p> <ul style="list-style-type: none"> ▪ Provision of treatment for drug courts & Proposition 36 clients <p>INCARCERATED WOMEN</p> <p>EX OFFENDERS</p> <ul style="list-style-type: none"> ▪ Family foundations programs funded by CDC ▪ Aftercare contracts with CDC 	<p>DRUG COURTS & PROP 36</p> <ul style="list-style-type: none"> ▪ Several counties noted reductions in availability of treatment services funded through Proposition 36, particularly residential treatment ▪ County administrators did not directly reference relationship between perinatal services, drug court & Proposition 36 ▪ 29 counties include family counseling as allowable use of Prop 36 funds 	<p>DRUG COURTS & PROP 36</p> <p>Advisory Group EX OFFENDERS</p> <ul style="list-style-type: none"> ▪ Little Hoover Commission, report on the reorganization plan & strategic plan integrating the youth authority & the CDCF did not address the 22,000 women offenders; they recommended creation of a Director of Women’s Programs;ⁱⁱ ▪ OPSA staff not in collaborations related to female offenders or Proposition 36 		<p>DRUG COURTS & PROP 36</p> <p>INCARCERATED WOMEN</p> <p>EX OFFENDERS</p> <ul style="list-style-type: none"> ▪ Little Hoover Commission issued report <i>Breaking the Barriers for Women on Parole</i> in December 1994
CalWORKs	<ul style="list-style-type: none"> ▪ Most providers have clients who are involved with CalWORKs ▪ Some providers funded specifically for CalWORKs clients by social services 	<ul style="list-style-type: none"> ▪ Sacramento County – integrated with treatment ▪ Los Angeles County - agreements with AOD administration for treatment slots ▪ Fresno, treatment funding 	<ul style="list-style-type: none"> ▪ ADP participation in original CalWORKs planning ▪ ADP Participation in CalWORKs Conference Planning Committee (DSS lead) ▪ TANF Reauthorization Planning Committee (DSS lead) 	<ul style="list-style-type: none"> ▪ DSS & ADP collaborative workgroup on CalWORKs no longer meets ▪ Limited data analysis ▪ DSS program for funding treatment services discontinued 	<ul style="list-style-type: none"> ▪ Improved screening & referral in many communities (but not all) ▪ Some specialized funding for CalWORKs ▪ Budget cuts with re-authorization ▪ Job approach not always relevant for AOD clients ▪ Doesn’t address needs of drug felons

Appendix 3 Collaborations Matrix

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	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
<p>Child Welfare Agencies and Dependency Drug Courts</p>	<ul style="list-style-type: none"> ▪ Collaborations for outreach & engagement (stationing at courts & home-visits) ▪ Collaborations for concurrent treatment & other child welfare requirements (case planning, dependency courts involvement, provision of services & child visitations) 	<ul style="list-style-type: none"> ▪ Sacramento County has integrated system ▪ Out-stationing of staff at courts ▪ Range of funding collaborations including child welfare funding treatment directly, or through agreement with county administration ▪ Oversight committees for dependency drug courts promote additional collaboration ▪ Assessment-based collaborations ▪ There are approximately 20 dependency drug courts in California according to California's Administrative Office of the Courts estimates ⁱⁱⁱ ▪ Family to Family 	<ul style="list-style-type: none"> ▪ State Interagency Team formed as product of Child Welfare Redesign working on interagency child welfare projects including child welfare information system (DSS lead) • State Interagency Taskforce AOD Workgroup (ADP lead) • Greenbook Leadership Group (Administrative Office of the Court, lead) ▪ California Blue Ribbon Commission on Children in Foster Care (Judicial Council, lead) ▪ Participation with the Judicial Council upon request ▪ Title IV-E Child Welfare waiver 	<ul style="list-style-type: none"> ▪ 24.9% of court-appointed counsel (n=185) & 25.5% (n=141) of county council report substance abuse as an area where additional training would be useful ▪ Innovations such as shared custody between treatment providers & mothers have not been conducted 	<ul style="list-style-type: none"> ▪ Funding of dependency drug courts ▪ Option for Title IV-E Child Welfare waiver to address substance abuse issues as in other States

Appendix 3 Collaborations Matrix

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	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
Early Childhood Education, School Readiness and Other Young Children's (< 5) Therapeutic Services	<ul style="list-style-type: none"> ▪ Collaborations with regional centers & other programs children may need ▪ Access preschool, Head Start & other programs for children of parents in treatment ▪ Some providers offer services for children (e.g., child development centers, developmental assessments & therapeutic nurseries) 	<ul style="list-style-type: none"> ▪ Contra Costa County substance abuse identified as a priority area by First 5 Commission 	<ul style="list-style-type: none"> ▪ Perinatal Services Guidelines address child care need ▪ Interagency Coordinating Council for Early Start (DDS Lead) ▪ California First 5 has a Special Needs Project that addresses two areas: 1) children with disabilities & other special needs & 2) mental health; This project has not yet addressed, or collaborated with substance abuse treatment 	<ul style="list-style-type: none"> ▪ Proposition 10 Special Needs Taskforce does not address prenatal exposure ▪ Limited available data ▪ Training for preschool staff 	<ul style="list-style-type: none"> ▪ Head Start & Early Start parenting programs; ▪ Universal preschool initiatives increasing access ▪ Models of AOD-preschool collaborations: Head Start Free to Grow & Starting Early, Starting Smart Casey model ▪ Agreement pending between DSS & DDS on implementing referrals for developmental assessment mandated for all substantiated CPS cases of 0-2 year olds; issue of how to screen for substance abuse problems
Children and Youth Services	<ul style="list-style-type: none"> ▪ Family treatment with teen at the center & parents ▪ Family treatment with the parent at the center & the youth ▪ Some providers offer youth services including case management, mental health & after school/ day care services 	<ul style="list-style-type: none"> ▪ Violence Prevention Coalitions ▪ Delinquency prevention initiatives 	<ul style="list-style-type: none"> ▪ GPAC ▪ Interagency Coordinating Council of Early Start ▪ Brighter Futures (Attorney General's Office) ▪ CDCR redesign 		

Appendix 3 Collaborations Matrix

This matrix is intended to be illustrative, not comprehensive. It contains a sample of collaborations based upon a limited set of interviews.

	Provider Level Collaborations	County Level Collaborations	State Level Collaborations	Gaps	Accomplishments of Note
Housing	<ul style="list-style-type: none"> ▪ Some providers are developing supportive housing ▪ Increased housing as part of recovery support ▪ Collaborations with housing providers 	<ul style="list-style-type: none"> ▪ Minimal references other than need ▪ Participation in homeless service planning (Kings & Los Angeles counties) 	<ul style="list-style-type: none"> ▪ Corporation for Supportive Housing participation at COJAC ▪ AB34 & 2034 (though minimal family services) ▪ IC bond 	<ul style="list-style-type: none"> ▪ Cited as significant barrier 	<ul style="list-style-type: none"> ▪ Supportive housing for families with co-occurring disorders ▪ Large scale planning initiatives to end homelessness including Oakland, Los Angeles, & San Francisco counties
Family Resource Centers, Economic Development, etc.	<ul style="list-style-type: none"> ▪ - Some providers address EITC, economic development, access to community resources as part of recovery management & relapse prevention 	<ul style="list-style-type: none"> ▪ Humboldt & Sacramento collaborations with FRC development 	<ul style="list-style-type: none"> ▪ Department of Vocational Rehabilitation provides a range of assessment, job training, & employment services 		

ⁱ Co-Occurring Joint Action Council [COJAC]; (2005, September); *Action plan for California*; Retrieved May 6, 2006, from <http://www.cojac.ca.gov/pdf/STATE%20ACTION%20PLAN.pdf>

ⁱⁱ Little Hoover Commission; (2005, February 23); *Reconstructing government: A review of the Governor's reorganization plan, reforming California's youth and adult correctional agency*; Retrieved May 6, 2006, from <http://www.lhc.ca.gov/lhcdir/179/report179.pdf>

ⁱⁱⁱ Administrative Office of the Courts Center for Families, Children and the Courts [CFCC]; (2005, November); *California juvenile dependency court improvement program reassessment*; Retrieved May 6, 2006, from <http://www.courtinfo.ca.gov/programs/cfcc>



Findings from the California Women, Children & Families Technical Assistance Survey

January 2006

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Findings from the California Women, Children and Families Technical Assistance Survey

January 2006

Summary

The California Women, Children and Families Technical Assistance Project (CalWCF) provides technical assistance to improve access and the quality of treatment services for women, including pregnant and parenting women, with substance use disorders and their families. Children and Family Futures (CFF) was awarded the CalWCF contract by the State of California Department of Alcohol and Drug Programs (ADP). To identify the most critical topics and methods of technical assistance service delivery, CalWCF conducted a needs assessment through a brief on-line survey. Eighty-four respondents representing 39 counties participated in the assessment; two-thirds of the respondents identified themselves as treatment providers. Overall, the assessment calls for maintaining an array of technical assistance delivery methods and the capacity to deliver technical assistance on a wide variety of topics.

Respondents were asked whether they had low interest, moderate interest or high interest in receiving technical assistance and training on forty different topics within the categories of: Practice/Clinical; Children's Issues; Management and Collaborations. Eleven of the top 15 topics fall in the category of Practice/Clinical, two in Children's Services, and two in Collaborations/Systems. The top 6 topics identified are listed below.

- Improving Treatment Retention for Women
- Working with Women with Co-Occurring Domestic Violence & Substance Use Disorders
- Working with Women with Co-Occurring Mental Health and Substance Use Disorders
- Addressing Methamphetamine Addiction Among Women and Families
- Motivational Interviewing and Other Effective Outreach and Intervention Strategies
- Developing Culturally Competent Treatment Services

While clearly there are topics, especially those listed above, for which there is strong interest across the State, all of the topics had more than 10% of recipients expressing high interest. Regional Trainings and Conferences (75.0%), Written Updates on Current Research or Policy (66.7%) and On-site Consultation (57.1%) were the most preferred delivery methods.

Findings from the California Women, Children and Families Technical Assistance Survey

January 2006

Introduction and Background

Children and Family Futures (CFF) operates the California Women, Children and Families Technical Assistance Project (CalWCF) through a contract awarded by the State of California Department of Alcohol and Drug Programs (ADP). CalWCF makes technical assistance and training available to providers, counties and other stakeholders to improve access and the quality of treatment services for women, including pregnant and parenting women with substance use disorders and their children.

A needs assessment was conducted to ensure that the intended audience and stakeholders of CalWCF have input in determining: 1) technical assistance needs; 2) materials to be produced and developed; and, 3) topics for meetings and conferences. This CFF brief highlights the results of the assessment.

Needs Assessment Methodology

Data collection was conducted via a brief on-line survey developed by CFF in collaboration with ADP. The initial topics were generated by CFF staff based on experiential knowledge of what areas of technical assistance are germane to the areas of the provision of treatment services for substance using pregnant and parenting women and their children. Individuals without on-line access requested and received a paper copy of the survey which was returned and then inputted by CalWCF staff. A printed copy of the needs assessment survey is included as Attachment 1.

The primary challenge in conducting the needs assessment was the lack of an available electronic mail database of peri-natal and women's substance use disorder treatment providers in California. CalWCF sent written correspondence informing recipients of the on-line survey and requesting email addresses to an ADP mailing list which contained all licensed or certified treatment providers (serving men and women) in California. Through this process, and other outreach efforts, CalWCF developed a database of email addresses (n= 150) for future communication.

To analyze the data in the needs assessment, several questions were included: 1) the respondent's county; 2) the primary focus of the organization; 3) who is primarily served by the organization; 4) the specific populations served by the respondent's primary role in their organization; 5) level of interest in several topic areas; and, 6) method(s) of delivery for the information. Operational definitions of these areas are described below.

County. County refers to the primary county served by the organization. Two respondents indicated more than one county served.

Organizational Focus. The responses indicating the type of respondent organizations included program administration, health/public health/domestic violence, substance abuse treatment, mental health, child welfare services, research/evaluation, CalWORKs/Department of Social Services, community support services, Proposition 36/Drug Court/PPN, advocacy, juvenile/family court, prevention or intervention services and other. Respondents were limited to one answer to identify the primary focus of their organization.

Who is Served by Organization. The respondents were asked to indicate who is primarily served by their organization. Respondents were limited to one population selection out of the following choices: Women with Substance Use Disorders, Pregnant/Parenting Women with Substance Use Problems and their Children, Women with Co-occurring Substance Use and Mental Health Disorders, Children/Youth/Families, Girls/Adolescents at Risk of Substance Use Disorders, Individuals with Mental Health Problems, Pregnant Women, Providers and others.

Populations Served. The respondents indicated if there is a specific population that they serve. Responses included: Child Welfare Involved, Rural, Homeless, Incarcerated/Formerly Incarcerated, Lesbian/Gay/Transgender, People with Disabilities, Deaf/Hard of Hearing, African American, Asian/Pacific Islanders/Filipinos, Latinos/Latinas and Native Americans. Participants could respond with more than one answer.

Technical Assistance Topic Area Level of Interest. Respondents were given a series of technical assistance topic areas such as Practice and Clinical Issues, Children's Issues, Management Issues and Collaboration/Systems Issues. The respondents were asked to rate their level of interest in receiving technical assistance in each topic by choosing one of the following responses: 1 (little or no interest); 2 (moderately interested); and, 3 (extremely interested).

Technical Assistance Method of Delivery. Respondents were asked to select preferred method(s) of delivery for technical assistance and training. The possible choices included: Regional Training and Conferences, Webcasts, Web-based Tutorials, On-site Consultation (1-2 sessions on one topic), In-depth On-site Consultation (more than 2 sessions on one topic), Phone

Consultation, Checklists and Other Written Documents, Breakthrough Series (on-going learning/change work groups), Written Updates on Current Research or Policy, or Listserv and/or Bulletin Boards.

The data from the on-line survey was cleaned and then transferred to SPSS for the analyses. Descriptive statistics (mean, frequency, standard deviation) and summary statistics provided useful information about group characteristics for the different analytic comparisons. Significant results from the analyses are summarized in the results section.

Respondent Characteristics

Eighty-four respondents completed the brief on-line survey. The surveys came from 39 counties throughout the state of California (see Table 1). The largest percent of respondents were from Los Angeles County (17.9%), San Diego County (9.5%), Sacramento County (7.1%) and Orange County (6.0%).

Table 1: Responses by County Served (n=84)

County	N	%
Alameda	1	1.2
Calaveras	2	2.4
Colusa	1	1.2
Contra Costa	1	1.2
El Dorado	1	1.2
Fresno	3	3.6
Glenn	1	1.2
Humboldt	1	1.2
Imperial	1	1.2
Kern	2	2.4
Lake	1	1.2
Lassen	1	1.2
Los Angeles	15	17.9
Madera	1	1.2
Marin	3	3.6
Monterey	1	1.2
Napa	1	1.2
Nevada	1	1.2
Orange	5	6.0
Placer	2	2.4

County Continued	N	%
Plumas	1	1.2
Riverside	1	1.2
Sacramento	6	7.1
San Bernardino	2	2.4
San Diego	8	9.5
San Francisco	3	3.6
San Joaquin	2	2.4
Santa Clara	1	1.2
San Mateo	2	2.4
Santa Barbara	1	1.2
Santa Clara	1	1.2
Santa Cruz	3	3.6
Shasta	2	2.4
Sierra	1	1.2
Solano	2	2.4
Stanislaus	1	1.2
Sutter/Yuba	1	1.2
Tehama	1	1.2
Tulare	1	1.2

More than 26% of the respondents reported that their organization primarily serves both women and men with substance use disorders, while 42.9% primarily serve women, pregnant/parenting women or women with co-occurring disorders (see Table 2).

Table 2: Primary Population Served by Organization

	N	%
Women and Men with Substance Use Disorders	22	26.2
Pregnant/Parenting Women with Substance Use Problems and their Children	19	22.6
Others	17	20.2
Women with Substance Use Disorders	13	15.5
Women with Co-occurring Substance Use and Mental Health Disorders	4	4.8
Children, Youth and Families	4	4.8
Providers	4	4.8
Individuals with Mental Health Problems	1	1.2

Two-thirds of the respondents reported the primary focus of their organization is substance abuse treatment (see Table 3).

Table 3: Organizational Focus

	N	%
Substance Abuse Treatment	56	66.7
Other (i.e., have multiple focuses)	11	13.1
Program Administration	5	6.0
Community Support Services	3	3.6
Health, Public Health, Domestic Violence	2	2.4
Advocacy	2	2.4
Mental Health	1	1.2
Child Welfare Services	1	1.2
CalWORKs/Department of Social Services	1	1.2
Proposition 36/Drug Court/Parole Provider Network	1	1.2
Prevention/Intervention Services	1	1.2

In addition, the respondents identified a number of specific populations that they serve (see Table 4 and Figure 1). For example, 77.4% serve child welfare involved clients; 76.2% serve

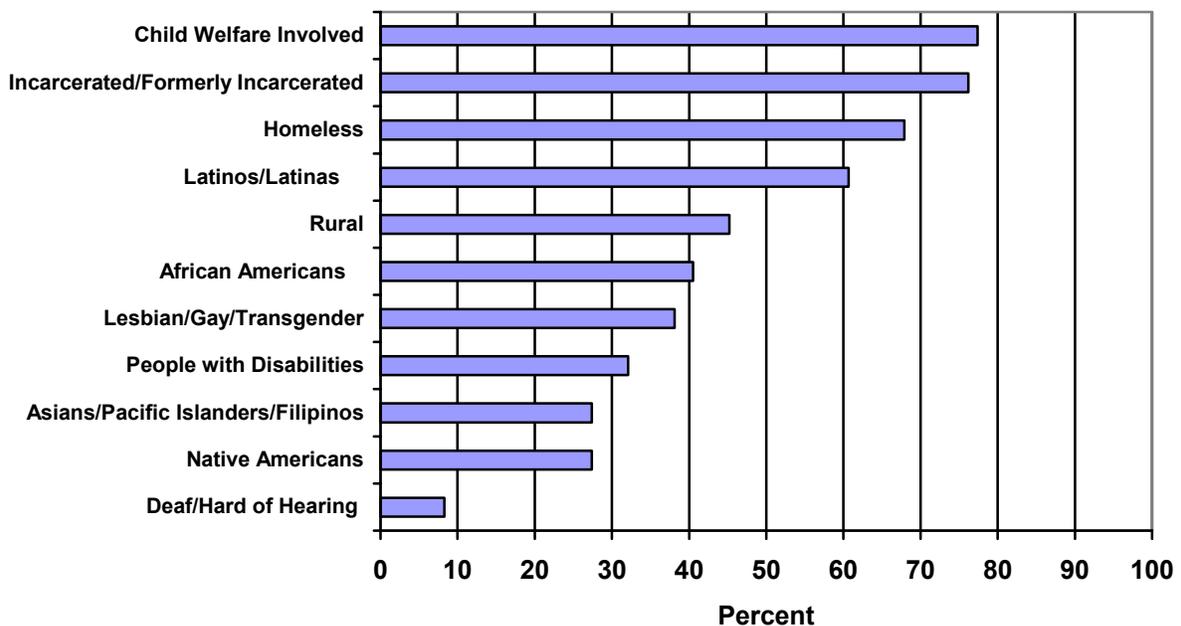
incarcerated/formerly incarcerated clients; 67.9% serve the homeless; and 60.7% specifically serve Latino/Latina clients.

Table 4: Specific Populations Served

Populations Served*	N	%
Child Welfare Involved	65	77.4
Incarcerated/Formerly Incarcerated	64	76.2
Homeless	57	67.9
Latinos/Latinas	51	60.7
Rural	38	45.2
African Americans	34	40.5
Lesbian/Gay/Transgender	32	38.1
People with Disabilities	27	32.1
Asians/Pacific Islanders/Filipinos	23	27.4
Native Americans	23	27.4
Deaf/Hard of Hearing	7	8.3

*Note: Respondents could answer more than one population served. Thus, the total populations served will equal more than 100%.

Figure 1. Populations Served

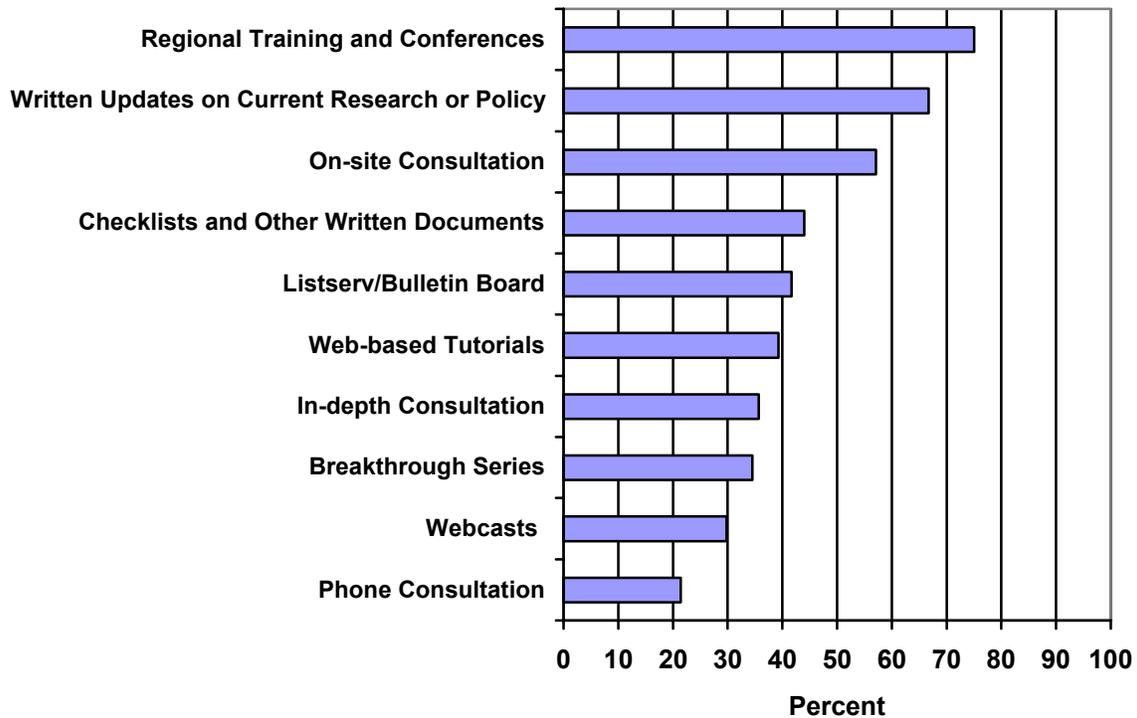


Preferred Method of Technical Assistance Delivery

The survey also solicited feedback on the preferred methods of technical assistance delivery. The methods of technical assistance delivery included: Regional Training and Conferences, Webcasts, Web-based Tutorials, On-site Consultation (1-2 sessions on one topic), In-depth On-site Consultation (more than 2 sessions on one topic), Phone Consultation, Checklists and Other Written Documents, Breakthrough Series (on-going learning/change work groups), Written Updates on Current Research or Policy or Listserv and/or Bulletin Boards.

Overall, (See Figure 2), the respondents preferred Regional Training/Conferences (75.0%), Written Updates on Current Research and Policy (66.7%) and On-site Consultation (57.1%) as methods of technical assistance delivery. There was far less interest in Phone Consultation (21.4%) and Webcasts (29.8%). Of the ten methods listed, respondents identified an average of five methods of preferred technical assistance delivery. Responses tended to cluster together, with some respondents preferring more “technologically advanced” delivery and others preferring more traditional (on-site consultation, telephone, etc.)

Figure 2. Preferred TA Delivery Method



Topics of Interest

Four major topic areas were prioritized by CalWCF as important to stakeholders. The four topic areas are:

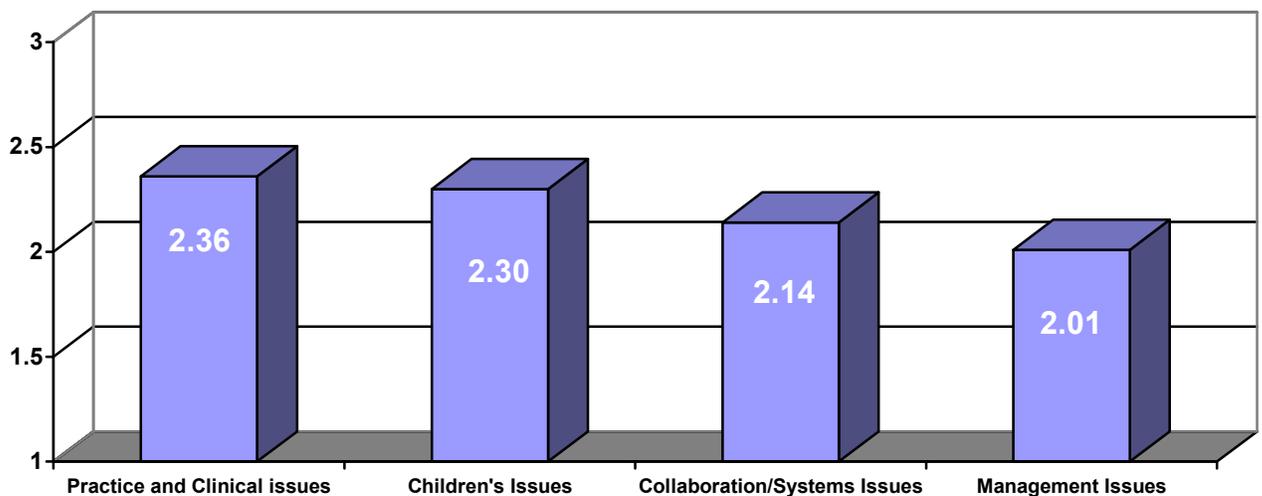
- Practice and Clinical Issues
- Children's Issues
- Management Issues
- Collaboration/Systems Issues

The respondents were asked to rate their level of interest in receiving technical assistance in each of the specific topic areas. The level of interest scores ranged from 1=little or no interest, 2=moderate interest and 3=high interest. Mean level of interest scores were computed for each topic area as well as the individual items comprising each topic area.

General Interest by Category

Overall there was moderate-high interest in Practice and Clinical Issues and Children's Issues and moderate interest in Collaborations/Systems Issues and Management Issues (See Figure 3). Total mean scores by topic area for all respondents show a slightly higher level of interest in Practice and Clinical Issues (Mean=2.36) followed by Children's Issues (Mean=2.30), Collaboration/Systems Issues (Mean=2.14) and Management Issues (Mean=2.01). Detailed figures indicating each topic and the level of interest are contained in Attachment 2.

Figure 3. Mean Summary by Topic Area



Mean Scores for Specific Topic Areas

The mean scores on the individual items indicated that the top five highest levels of interest are Practice and Clinical issues. For example, technical assistance regarding Improving Treatment Retention for Women (Mean=2.67) had the highest overall mean, followed closely by Women with Co-occurring Domestic Violence (Mean=2.66) and Mental Health (Mean=2.65) Disorders, Addressing Methamphetamine (Mean=2.65) and Motivational Interviewing and other effective strategies (Mean=2.55). Table 5 presents each of the individual items in rank order by mean score.

Table 5: Overall Mean Score by Item

Topic	Mean Score
Improving Treatment Retention for Women	2.67
Working with Women with Co-Occurring Domestic Violence and Substance Use Disorders	2.66
Working with Women with Co-Occurring Mental Health and Substance Use Disorders	2.65
Addressing Methamphetamine Addiction Among Women and Families	2.56
Motivational Interviewing and Other Effective Outreach and Intervention Strategies	2.55
Developing Culturally Competent Treatment Services	2.53
Case Management Strategies for Counselors	2.52
Overview of Evidence Based Treatment Strategies	2.50
Effects of Parental Substance Use on Child Development	2.50
Assessing and Improving the Gender Responsiveness of Substance Use Services for Women and Families	2.42
Overcoming Obstacles to Recovery: Poverty and Employment	2.41
Gender Responsive Treatment for Women in Outpatient Settings	2.40
Family Treatment Models	2.40
Overcoming Obstacles to Recovery: Housing Shortages	2.38
Screening and Intervention in Substance Use Disorders	2.37
Creating a Trauma Informed Program	2.33
Reducing Systemic and Programmatic Barriers to Serving Families	2.29
Staffing Issues and Staff Training	2.29
Addressing Community Challenges to Support Relapse Prevention	2.28
Prenatal Substance Exposure, FASD	2.26

Topic	Mean Score
Designing Programs Relevant for Specific Populations of Women/Families (e.g., immigrants, racial/cultural groups, deaf/hard of hearing)	2.23
Fund Development	2.23
AOD Training for WIC, CalWORKs, Domestic Violence Providers, MCH, or Others Serving Women, Pregnant Women and Children	2.20
Identifying Collaborations and Funding for Therapeutic Services for Children	2.19
Developing Cross-System Measures of Effectiveness	2.19
Collaborating to Prevent Prenatal Substance Exposure and FASD	2.18
Residential Programs and Client Parenting	2.17
AOD Prevention, Mentoring and Intervention Strategies for Adolescent Girls	2.14
Implementing Programs Relevant for Incarcerated Women and Parolees with Substance Use Problems	2.09
Opportunities and Strategies for Working with Child Welfare: Mandates, Redesign and County Planning	2.05
Facilitation and Guidance to Support Cross-Systems Practices	2.04
Addressing the Needs of Geographically Isolated Women with Substance Use Disorders	2.00
Sample MOUs, Policies and Procedures	1.98
Automated Systems, Data collection and Outcomes, CalOMS	1.95
Integrating the Chronic Care Model into Current Treatment Practices	1.93
Organizational Development & Change Management	1.93
Facility Issues (e.g. NIMBY, confidentiality, selection)	1.86
Implementing The Institute of Medicine Continuum of Care	1.69
Program Design, Start Up, Licensing & Certification	1.64
Board of Directors Training	1.55

Topics with the Highest and Lowest Level of Expressed Interest

In addition to calculating mean scores for the individual items, we examined the items with the highest and lowest level of expressed interest. Items with over 50% of the respondents indicating “high interest” in receiving technical assistance in that area are presented below (Table 6). The items with “high interest” correlate very highly with those receiving the highest mean score (see Table 5 above). For example, Improving Treatment Retention for Women was both the top ranked item in terms of mean score and with the highest level of interest.

The majority of the items scoring very high were from the Practice and Clinical Issues topic area. For example, 12 of the 17 items in the Practice and Clinical Issues topic area and 3 out of the 5 items in the Children’s Issues had over 50% of the respondents indicating “high interest.” In contrast, none of the 7 Management Issues items and only 2 out of the 11 Collaboration/Systems Issues items had over 50% indicating “high interest.”

Table 6: Items with Highest Level of Expressed Interest

Topic	Percent with high interest
Improving Treatment Retention for Women	76.2
Working with Women with Co-Occurring Mental Health and Substance Use Disorders	76.2
Working with Women with Co-Occurring Domestic Violence and Substance Use Disorders	73.8
Addressing Methamphetamine Addiction Among Women and Families	67.5
Developing Culturally Competent Treatment Services	65.1
Motivational Interviewing and Other Effective Outreach and Intervention Strategies	64.3
Case Management Strategies for Counselors	63.1
Effects of Parental Substance Use on Child Development	61.9
Overview of Evidence Based Treatment Strategies	58.3
Family Treatment Models	57.1
Assessing & Improving the Gender Responsiveness of Substance Use Services for Women & Families	56.0
Gender Responsive Treatment for Women in Outpatient Settings	56.0
Overcoming Obstacles to Recovery: Poverty and Employment	55.0
Overcoming Obstacles to Recovery: Housing Shortages	54.8
Screening and Intervention in Substance Use Disorders	53.7
Prenatal Substance Exposure, FASD	51.0
Creating a Trauma Informed Program	50.6
Fund Development	46.4
Designing Programs Relevant for Specific Populations of Women/Families (e.g., immigrants, racial/cultural groups, deaf/hard of hearing)	46.4
AOD Training for WIC, CalWORKs, Domestic Violence Providers, MCH, or Others Serving Women, Pregnant Women and Children	46.4
Addressing Community Challenges to Support Relapse Prevention	46.3
Reducing Systemic and Programmatic Barriers to Serving Families	45.8
Identifying Collaborations and Funding for Therapeutic Services for Children	45.2

Topic	Percent with high interest
Residential Programs and Client Parenting	45.2
Staffing Issues and Staff Training	44.0
Developing Cross-System Measures of Effectiveness	44.0
Collaborating to Prevent Prenatal Substance Exposure and FASD	41.3
Implementing Programs Relevant for Incarcerated Women & Parolees with Substance Use Problems	40.0
AOD Prevention, Mentoring and Intervention Strategies for Adolescent Girls	39.3
Facilitation and Guidance to Support Cross-Systems Practices	31.0
Addressing the Needs of Geographically Isolated Women with Substance Use Disorders	30.0
Sample MOUs, Policies and Procedures	28.6
Opportunities & Strategies for Working with Child Welfare: Mandates, Redesign & County Planning	27.4
Organizational Development & Change Management	26.5
Automated Systems, Data collection and Outcomes, CalOMS	26.5
Facility Issues (e.g. NIMBY, confidentiality, selection)	22.6
Integrating the Chronic Care Model into Current Treatment Practices	21.4
Program Design, Start Up, Licensing & Certification	17.9
Implementing The Institute of Medicine Continuum of Care	16.7
Board of Directors Training	11.9

There were three items that stood out as having “little or no interest” as expressed by the majority of the respondents. These included: Implementing the Institute of Medicine Continuum of Care (47.6%), Board of Director’s Training (57.1%) and Program Design, Start-Up, Licensing & Certification (53.6%).

Discussion of Findings

Results indicate that CalWCF should maintain the capacity to provide technical assistance on a wide array of topics. For each of the 40 topics contained in the survey, at least 10% of respondents indicated a high level of interest. Only three topics had a majority (but less than 60%) indicate that they were not interested in technical assistance on the subject. In order to meet the varying needs and priorities of administrators, programs and other stakeholders serving women, including pregnant and parenting women with substance use disorders, and their families, CalWCF should maintain the capacity to provide technical assistance on all of the

topics surveyed. CalWCF should not be limited to only these topics but have the flexibility and capability to respond to other requests as they arise.

While there was some level of interest in all of the topics, several topics stood out as result of high interest and demand. Table 7 contains the top 15 topics. These topics all lend themselves well to the delivery of specific technical assistance and training, reaching direct service staff. To ensure delivery of technical assistance that is of interest to the majority of respondents, CalWCF should develop training events, in-depth technical assistance services and products from among these topics.

The preference for technical assistance regarding Practice and Clinical Issues may reflect the fact that two-thirds of the respondents work in substance abuse treatment. Less than one-fourth (22.6%) of the respondents indicated that the primary population they serve is Pregnant/Parenting Women with Substance Use Disorders yet a majority of respondents have high interest in Effects of Parental Substance Use on Child Development (61.9%), Family Treatment Models (57.1%), and Prenatal Substance Exposure, FASD. The high interest of receiving technical assistance related to Children’s Issues may reflect the larger movement in the field toward family based treatment.

Table 7: Top 15 Topics by Both Mean Score and Percent with High Interest

Topic	Mean Score	Percent with high interest
Improving Treatment Retention for Women	2.67	76.2
Working with Women with Co-Occurring Domestic Violence and Substance Use Disorders	2.66	73.8
Working with Women with Co-Occurring Mental Health and Substance Use Disorders	2.65	76.2
Addressing Methamphetamine Addiction Among Women and Families	2.56	67.5
Motivational Interviewing and Other Effective Outreach and Intervention Strategies	2.55	64.3
Developing Culturally Competent Treatment Services	2.53	65.1
Case Management Strategies for Counselors	2.52	63.1
Overview of Evidence Based Treatment Strategies	2.50	58.3
Effects of Parental Substance Use on Child Development	2.50	61.9
Assessing and Improving the Gender Responsiveness of Substance Use Services for Women and Families	2.42	56.0
Overcoming Obstacles to Recovery: Poverty and Employment	2.41	55.0
Gender Responsive Treatment for Women in Outpatient Settings	2.40	56.0

Family Treatment Models	2.40	57.1
Overcoming Obstacles to Recovery: Housing Shortages	2.38	54.8
Screening and Intervention in Substance Use Disorders	2.37	53.7

The results further indicate that it is important for CalWCF to use a variety of technical assistance service delivery approaches, including a mix of technology-based and personal-based methods. The majority of respondents preferred receiving technical assistance through Regional Training and Conferences, through Written Updates on Current Research or Policy and On-site Consultation. Dramatically less interest was expressed for Phone Consultations or Webcasts. Furthermore, while many agencies steer away from Regional Trainings and Conferences as a way for improving knowledge and service delivery, the overwhelming preference for this method of technical assistance delivery indicates that they are a valued method of receiving technical assistance.

Conclusion and Next Steps

CalWCF will utilize the results of this needs assessment to develop and implement a technical assistance and training plan. The following other points will be a part of the CalWCF service delivery.

- The delivery of technical assistance on an array of topics with a focus on clinical and practice issues allows for customized services to meet the diverse needs.
- The development of training events and written products which address improving treatment retention for women and co-occurring disorders will enable CalWCF to address the most significant TA priority.
- The continued use of an array of technical assistance service delivery methods including a balance of “high tech” and “low tech” options is necessary while moving the field toward more technology advanced methods.
- There is high interest in CalWCF developing and distributing research and policy updates.

The results of this needs assessment can also inform the work of ADP’s Office of Peri-natal Services and other technical assistance contractors.

Attachment 1: Sample of Survey



California Women, Children and Families

Technical Assistance Project

Technical Assistance Survey

Children and Family Futures has recently been awarded a contract by the State of California Department of Alcohol and Drug Programs for the California Women, Children and Families Technical Assistance Project (CalWCF TA Project). CalWCF makes technical assistance and training available to providers, counties and other stakeholders in order to improve access to, and quality of, treatment services for women, including pregnant and parenting women and their children, with substance use disorders.

This survey gathers information regarding the technical assistance needs of agencies serving women, children and families. Your insights will help the Project to develop relevant technical assistance and training services. This information will be incorporated into our technical assistance plan and will help prioritize the delivery of technical assistance services. Results of this survey will remain confidential and will be reported in aggregate form. We will email tabulated results when all the responses have been received. Thank you for taking the time to complete this short survey.

If you would like to receive CalWCF information please complete the following:

Contact Information (optional)

Name: _____

Title: _____

Organization: _____

Phone Number: _____

Email: _____

Mailing Address: _____

- I would like to join the listserv and receive periodic updates on current research or trends in women's services.**
- I would like to be a part of a network of women/men committed to women's AOD treatment.**
- I would like a technical assistance application.**
- I would like to receive a copy of the results of this survey.**

1. What is the geographic audience of your organization? (pick one)

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Entire State | <input type="checkbox"/> Small County | <input type="checkbox"/> City |
| <input type="checkbox"/> Region/multiple counties | <input type="checkbox"/> Mid-Size County | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reservation | <input type="checkbox"/> Large County | |

What county are you based in? _____

2. What is the primary focus of your organization?

- | | |
|--|---|
| <input type="checkbox"/> Program administration | <input type="checkbox"/> Health, public health or domestic violence |
| <input type="checkbox"/> Substance use Treatment | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Child Welfare Services | <input type="checkbox"/> Research and Evaluation |
| <input type="checkbox"/> CalWORKs, DPSS | <input type="checkbox"/> Community support services |
| <input type="checkbox"/> Proposition 36/Drug Court/PPN | <input type="checkbox"/> Advocacy |
| <input type="checkbox"/> Juvenile/Family Court | <input type="checkbox"/> Other |
| <input type="checkbox"/> Prevention or Intervention Services | |

3. Who is primarily served by your organization?

- | | |
|--|--|
| <input type="checkbox"/> Women with substance use disorders | <input type="checkbox"/> Children, youth and families |
| <input type="checkbox"/> Women and men with substance use disorders | <input type="checkbox"/> Girls/adolescents at risk of substance use disorders |
| <input type="checkbox"/> Individuals with mental health problems | <input type="checkbox"/> Providers |
| <input type="checkbox"/> Pregnant women | <input type="checkbox"/> Women with Co-Occurring Substance Use and Mental Health Disorders |
| <input type="checkbox"/> Pregnant and parenting women with substance use problems and their children | <input type="checkbox"/> Other |

4. Is there a specific population that you primarily serve?

- | | |
|---|---|
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Child Welfare Involved |
| <input type="checkbox"/> Incarcerated/formerly incarcerated | <input type="checkbox"/> Lesbian/Gay/Transgender |
| <input type="checkbox"/> African American | <input type="checkbox"/> Rural |
| <input type="checkbox"/> Latina/Hispanic | <input type="checkbox"/> Deaf/Hard of Hearing |
| <input type="checkbox"/> Asian/Pacific Islander/Filipino | <input type="checkbox"/> People with Disabilities |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Other |

5. In the questions that follow, please indicate your level of interest in accessing technical assistance and training in each of the topic areas.

Topic		Level Of Interest		
		Little or No Interest	Moderate Interest	High Interest
Practice and Clinical Issues				
1.	Integrating the Chronic Care Model into Current Treatment Practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Implementing The Institute of Medicine Continuum of Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Overview of Evidence Based Treatment Strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Screening and Intervention in Substance Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Developing Culturally Competent Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Designing Programs Relevant for Specific Populations of Women/Families (e.g., immigrants, racial/cultural groups, deaf/hard of hearing. (Please list what population in the other box below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Implementing Programs Relevant for Incarcerated Women and Parolees with Substance Use Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Motivational Interviewing and Other Effective Outreach and Intervention Strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Addressing Methamphetamine Addiction Among Women and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Case Management Strategies for Counselors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Assessing and Improving the Gender Responsiveness of Substance Use Services for Women and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Improving Treatment Retention for Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Working with Women with Co-Occurring Mental Health and Substance Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Working with Women with Co-Occurring Domestic Violence and Substance Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Creating a Trauma Informed Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Addressing the Needs of Geographically Isolated Women with Substance Use Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Gender Responsive Treatment for Women in Outpatient Settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Topic	Level Of Interest		
	Little or No Interest	Moderate Interest	High Interest

Children's Issues				
1.	Prenatal Substance Exposure, FASD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Effects of Parental Substance Use on Child Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Residential Programs and Client Parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Family Treatment Models	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Identifying Collaborations and Funding for Therapeutic Services for Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	The ABCs of Child Protective Services and the Dependency Court	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Management Issues				
1.	Reducing Systemic and Programmatic Barriers to Serving Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Fund Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Board of Directors Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Organizational Development & Change Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Staffing Issues and Staff Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Automated Systems, Data collection and Outcomes, CalOMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Facility Issues (e.g. NIMBY, confidentiality, selection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Topic	Level Of Interest		
	Little or No Interest	Moderate Interest	High Interest

Collaboration/System Issues				
1.	Opportunities and Strategies for Working with Child Welfare: Mandates, Redesign and County Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Collaborating to Prevent Prenatal Substance Exposure and FASD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Sample MOUs, Policies and Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Facilitation and Guidance to Support Cross-Systems Practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Program Design, Start Up, Licensing & Certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Overcoming Obstacles to Recovery: Housing Shortages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Overcoming Obstacles to Recovery: Poverty and Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Addressing Community Challenges to Support Relapse Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Developing Cross-System Measures of Effectiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	AOD Training for WIC, CalWORKs, Domestic Violence Providers, MCH, or Others Serving Women, Pregnant Women and Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	AOD Prevention, Mentoring and Intervention Strategies for Adolescent Girls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. In general, in learning about new programs, policies or procedures, how would you prefer this information be delivered to you? Please check all that apply.

- Regional Training and Conferences
- Web Casts
- Web Based Tutorials
- On-Site Consultation (1-2 sessions on one topic)
- In-Depth Onsite Consultation (more than 2 session on one topic)
- Phone Consultation
- Checklists & Other Written Documents
- Breakthrough Series (on-going learning/change work groups)
- Written Updates on Current Research or Policy
- Listserv and/or Bulletin Board

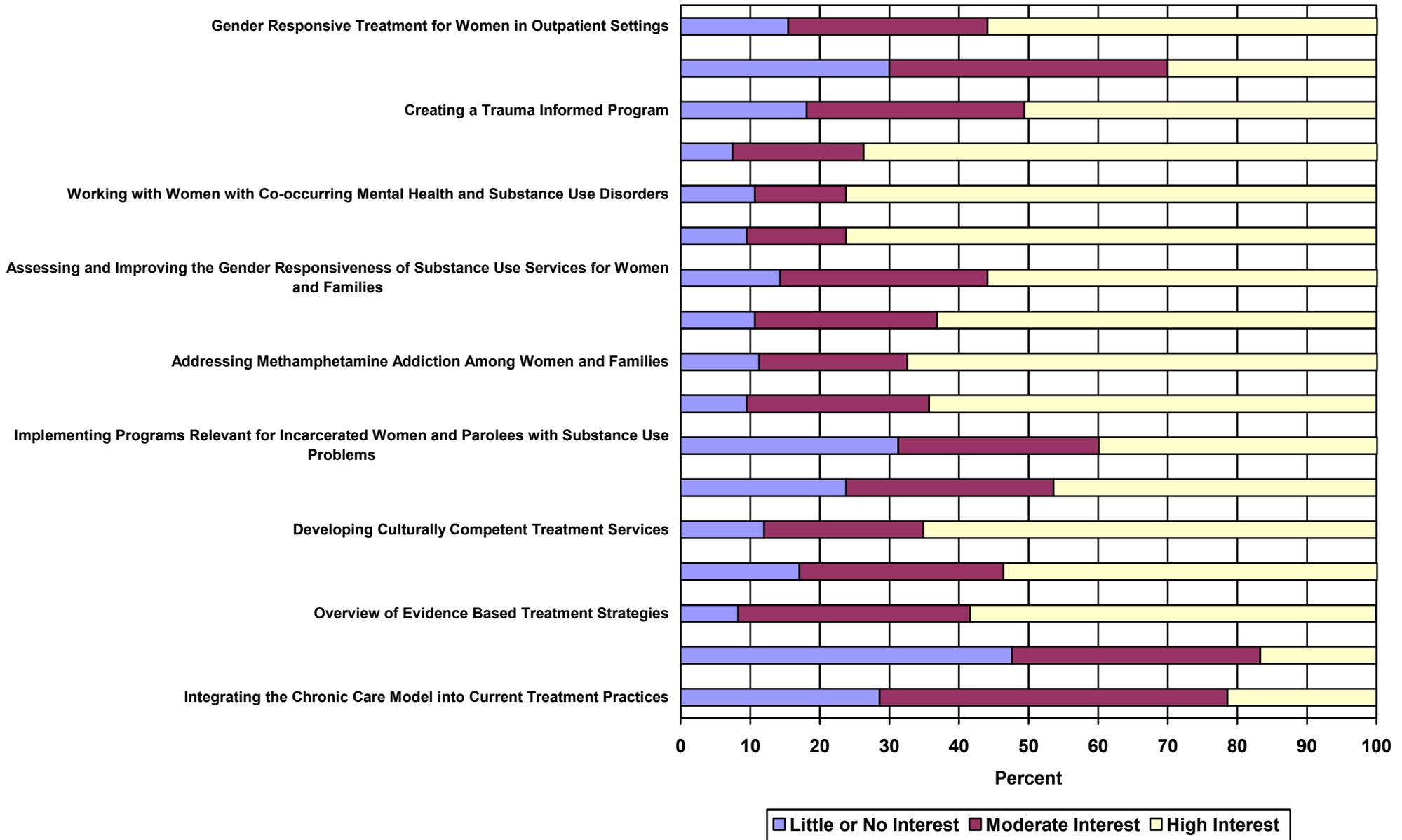
7. Is there anything else you would like to tell us?

**Thank you for participating in this Needs Assessment.
Please return by fax to
Deborah Werner at 714.505.3626 or
Mail to Children and Family Futures, Attn: Deborah Werner
4940 Irvine Boulevard, Suite 202, Irvine, CA 92620.**

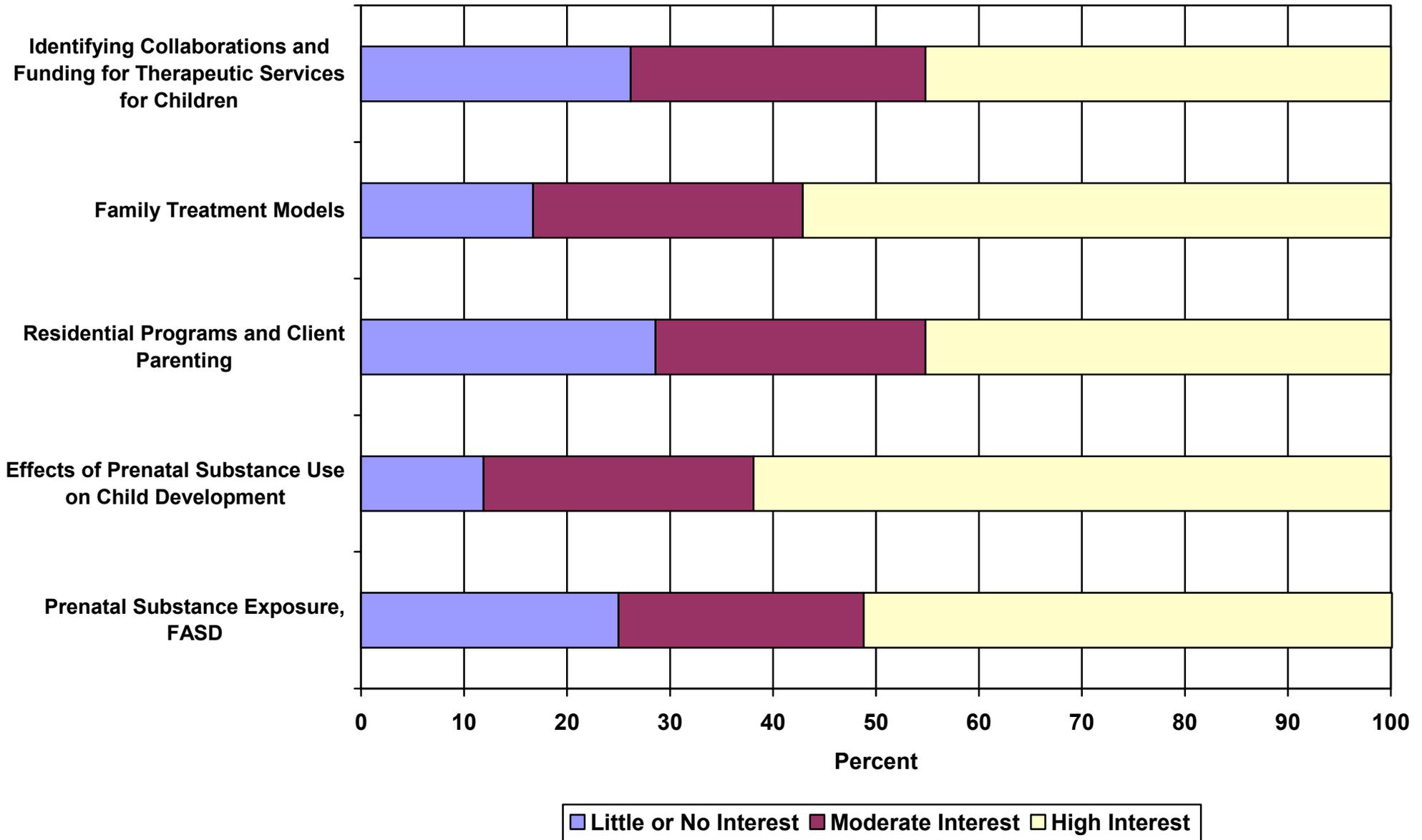
Attachment 2:

Detailed Figures on Frequency of Responses

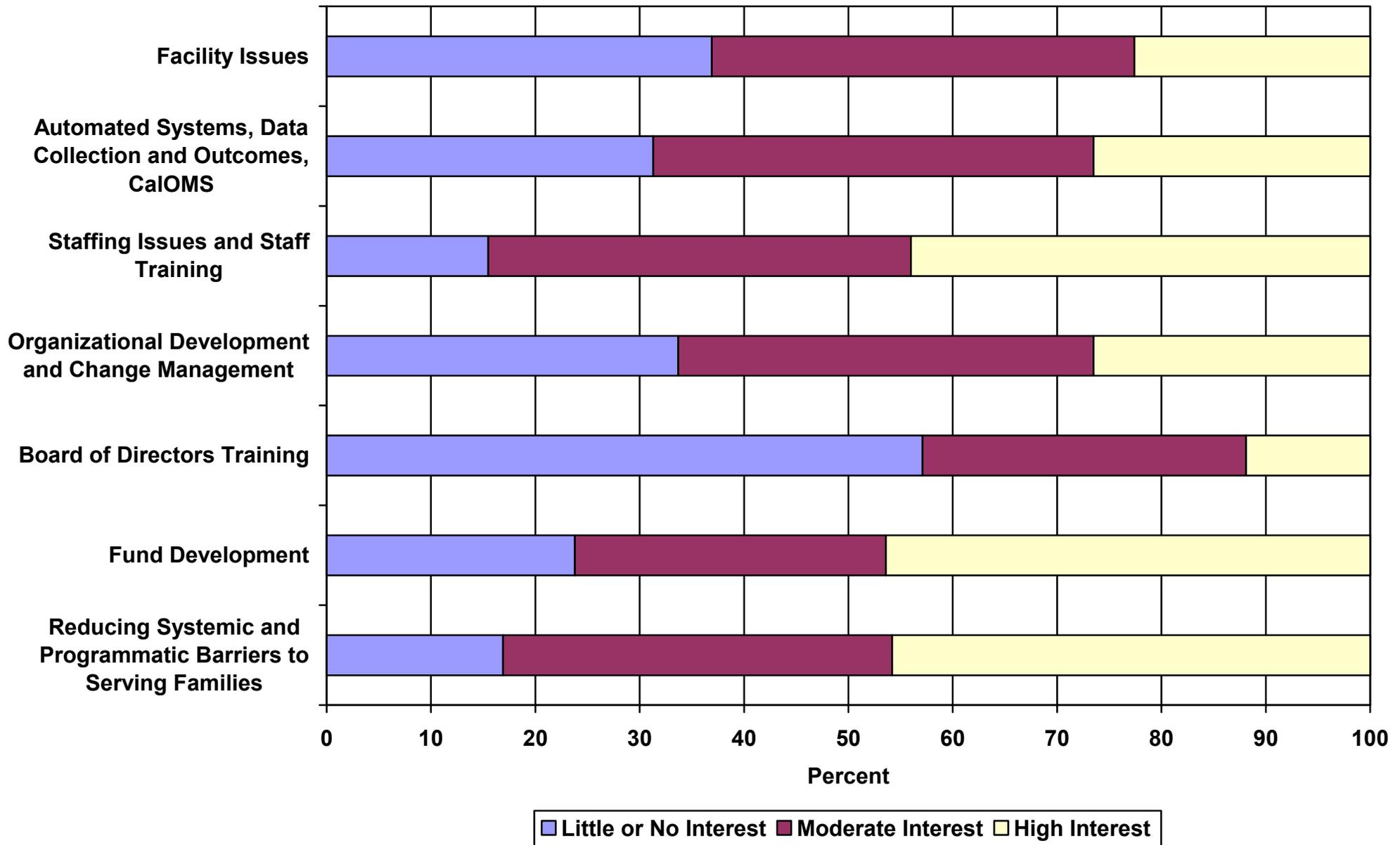
Level of Technical Assistance Interest in Practice and Clinical Issues



Level of Technical Assistance Interest in Children's Issues



Level of Technical Assistance Interest in Management Issues



Level of Technical Assistance Interest In Collaboration/Systems Issues

