Implementation Evaluation of the Los Angeles Target Cities Project - October 1, 1990-September 31, 1993

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Preface

This report presents results of an implementation evaluation of the Los Angeles Target Cities project during its first funding period (October 1, 1990 to September 30, 1993). This is one of three documents about the Target Cities process evaluation prepared by RAND, under a subcontract to the UCLA Drug Abuse Research Center. The other two reports describe analyses of client flows (Greenwood, P. W. and Mohamad, R. [1993], *Analysis of Quantitative Client Information Reported by Providers for the Los Angeles Drug Treatment Program for the Period October 1990 - May 1993*, DRU-568), and financial impact of the project (Greenwood, P. W. and Mohamad, R. [1994], *The Impact of the Target Cities Project on Drug Treatment Funding in Los Angeles*, DRU-702). Results of an impact evaluation are forthcoming from the UCLA Drug Abuse Research Center.
Acknowledgments

Any process evaluation requires the cooperation and participation of many people. We thank all those involved in Target Cities for sharing their experiences, knowledge, and perspectives with us.

County ADPA staff and administrators spent many hours responding to our questions and providing us with documentation. We are especially appreciative of the support provided by Dick Browne, Cynthia Farias-Manguia, Carol Fox, Pauline Lopez, and Oscar Rascon. State ADP and CSAT administrators also were available to respond to questions and offer guidance and information.

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Executive Summary:
Implementation Evaluation of Los Angeles Target Cities Project

Target Cities is a federally funded program intended to improve the quality, effectiveness, and efficiency of publicly funded drug treatment services in large, drug impacted cities. Los Angeles was one of eight cities nationwide selected to participate in this demonstration project in 1990. The Los Angeles project focused primarily on the services provided by outpatient (non-residential), drug-free programs located within the City of Los Angeles. The project was funded through a cooperative agreement between the State Department of Alcohol and Drug Programs (ADP) and the Office of Treatment Improvement (OTI, later reorganized to become the Center for Substance Abuse Treatment or CSAT). Approximately $4 million per year for three years (1991-1993 fiscal years) was awarded to the State of California for Target Cities.

The Los Angeles Target Cities plan underwent significant changes during the first year. Following the planning process, major elements of the project included:

- Establishment of five Community Resource Centers (CRCs), each serving a specific geographic region of Los Angeles, to conduct intakes, assessments and referrals; develop cooperative linkages with a variety of ancillary services, including Vocational Rehabilitation, DPSS, and medical care; assist in meeting clients’ transportation needs; provide community outreach; and provide technical assistance to outpatient drug free and perinatal agencies in their region.

- Establishment of two Perinatal Service Centers (PSCs), to provide intensive outpatient services to drug abusing women and their children.

- Enhancements to outpatient drug free (OPDF) treatment within 17 agencies, intended to increase comprehensiveness (and, to a lesser extent, intensity) of services.

- Development of an automated client intake, assessment, and referral management information system (MIS), to support assessment, referral, and case management functions.

The first phase of Target Cities extended from October 1, 1990 to September 31, 1993. The County awarded contracts to participating Target Cities agencies on May 28, 1991, and enhanced service delivery began September 1, 1991.

This report presents partial results from a process evaluation of the Los Angeles Target Cities project during its first funding period. Additional results from the process
evaluation are presented in separate RAND reports.¹ The implementation evaluation is based on four sources of information: (a) analyses of an NTIES survey administered as part of the national Target Cities evaluation; (b) individual interviews with representatives of participating Target Cities agencies, subcontractors, and administrators from the County, State, and CSAT; (c) reviews of project documentation; and (d) direct observation and attendance at PAC meetings.

Results

Overview of implementation. Target Cities was characterized by continuing uncertainty about project objectives, strategies, and responsibilities. For example, over eight different statements of goals and objectives were in circulation at various times during the project.

The document that appears to best capture the goals and objectives of Target Cities, following revisions after the proposal was approved by funding, is the Los Angeles Drug Program Enhancement Project Management Implementation Plan (March, 1991, see Appendix D). A review of the elements of this plan indicate that, for the most part, the Target Cities plan was implemented as intended.

Community Resource Centers (CRCs). Target Cities established five geographically dispersed CRCs. The CRCs were housed within agencies that were already county contractors; each of these agencies also sponsored an OPDF unit that was participating in Target Cities. Each CRC was responsible for a specific geographic region that included between two and five outpatient treatment agencies and, in two areas, a perinatal center. The CRCs were allocated $107,561 in the first year (1990-91) and $147,476 in the second and third project years.

Major activities of the CRCs included: (1) providing intake, assessment, and referral services; (2) improving client access to ancillary services by identifying and developing cooperative agreements with ancillary service providers, compiling this information into resource directories, and providing on-site services in the areas of public assistance, vocational rehabilitation, and health care; (3) providing technical assistance to area enhancement agencies; (4) providing community outreach, in order to better inform potential referral sources about the CRC and to raise awareness about substance abuse issues; (5) assisting in meeting clients' transportation needs; and (6) conducting special

projects, ranging from distribution of holiday gift baskets to development of a parenting manual.

CRCs faced a number of key challenges to their implementation and effectiveness. CRCs were designed to work closely with the Target Cities MIS, but the system did not come on line until mid-1993. Until the MIS was ready for use, the CRCs were further constrained by the requirement to use the Clinical Intake and Assessment Instrument (CIAI), which providers viewed as inappropriate and unhelpful. Throughout the course of the project, CRC efforts to strengthen linkages with ancillary services were hindered by a shortage of needed services in Los Angeles. Of most concern, however, was strained relations between CRCs and the OPDFs affiliated with different agencies. The CRCs and those OPDFs often did not share the same expectations and perceptions, contributing to ongoing tension and generally distant relations.

**Outpatient Drug Free (OPDF) agencies.** Close to $4 million -- almost one third of the total budget -- were allocated to the 17 OPDFs involved in Target Cities over the three-year funding period. The allocation to each OPDF was $75,649 per year. The OPDFs were expected to enhance services in several ways -- by augmenting staff, by implementing at least ten of 14 possible supplemental services (e.g., life skills training, family services, health, fitness and nutrition, aftercare), and by increasing their use of ancillary resources.

Results indicate that OPDFs did broaden their access to assessment resources, especially for psychiatric and physical examinations and screening for AIDS and tuberculosis. In addition to conducting more comprehensive assessments, the OPDFs increased the intensity of their direct services, adding more group and classroom-type activities to their treatment programs. Access to ancillary services for clients also increased. Compared to before the Target Cities program began, agencies increased access to services for housing, child care, transportation, legal assistance, vocational training, academic training, and medical care (especially primary care).

At least 15 of the 17 OPDFs hired new staff with their Target Cities support. Most assigned staff specific responsibilities related to enhancing treatment, but specific responsibilities varied widely. Most agencies reported that Target Cities enabled them to hire culturally appropriate staff.

Target Cities generated considerable activity among OPDF providers. At the same time, there was great variation in how the 17 agencies implemented the Target Cities project. For example, all hired new staff, but they used these staff in many different ways. Similarly, providers varied in the ways in which they operationalized and implemented supplemental services. Such services as life skills or relapse prevention ranged from
periodic presentations that were not incorporated into treatment plans to multiple-session programs that were fully integrated into the treatment process. This lack of quality standards created a diverse and diffuse array of interventions.

**Perinatal Service Centers (PSCs).** Two PSCs were established during Target Cities. In contrast to outpatient drug free treatment, the PSCs were intended to offer more intensive services customized to the needs of pregnant women or women with children. The allocation to each perinatal service center was $291,342 per year.

Each PSC could serve approximately 25 women. The PSCs admitted a total of 209 women between September 1991 inception and June 1993. The treatment programs resembled outpatient drug free programs, although the PSCs encouraged women to come in several times per week or even daily if possible.

The PSCs made a number of important contributions to the Los Angeles drug treatment system. They expanded the system's capacity for serving pregnant and postpartum women, and they increased diversity of treatment models by combining intensive outpatient drug treatment services with a variety of other services needed by women and their children. Perhaps most important is that the PSCs offered an opportunity for treatment providers, especially outpatient treatment providers, to learn more about the needs of pregnant and postpartum women and to experiment with the design of treatment programs responsive to these needs.

Although the PSCs were implemented as intended, both providers and project administrators were generally disappointed in their effectiveness. Specific problems they encountered include low retention rates and low attendance rates, a lack of criteria to guide the determination of which women to place in PSCs versus OPDFs, and a lack of mechanisms for disseminating the lessons learned about women's treatment needs.

**Management information system (MIS).** Target Cities supported development of a MIS for participating agencies, called the Client Referral and Intake System (CRIS). The system was developed by a subcontractor (Creative Socio-Medics) under contract to the County.

CRIS came on line almost two years later than expected, in January, 1993. Providers began using CRIS in May, 1993, and its use was required by 1994. By the close of the first Target Cities funding period, all Target Cities agencies were using the CRIS. The CRIS included the following elements:

- A Screening Input form, for reporting information from initial client contacts, often by telephone but sometimes walk-ins, before an intake or assessment was conducted;
An Assessment Input form, for reporting information used to better understand the clients' background and needs so that an appropriate referral could be provided;

An Admission Input form, used to obtain more detailed information to develop a treatment plan upon a client's admission to an OPDF program;

A Discharge/termination form, used when clients successfully or unsuccessfully terminated treatment; and

A general wait list to which clients could be added if appropriate treatment program(s) were unable to accommodate them.

The original MIS plan also included a decision tree component to guide referrals. This component was not implemented and was later dropped.

Specific concerns about the CRIS related to perceived imbalances by providers in the amount of work required to input data to the system in relation to the benefits accruing to them from the system. An additional concern was whether the providers and the County would be able to sustain the system after Target Cities funding is withdrawn.

**Linkages to ancillary services.** The Target Cities project used three primary strategies to develop linkages to ancillary services. First, the County Alcohol and Drug Program Administration established linkages through a combination of contractual arrangements (cooperative agreements) and staff hires that enabled CRCs to serve as host sites for ancillary service delivery. Specifically, the CRCs served as host sites for a DPSS liaison, Vocational Rehabilitation counselors, and (in the third year) physicians' assistants or nurse practitioners. A fourth cooperative agreement with the City of Los Angeles Office of Criminal Justice Planning provided a linkage to City government.

In addition to the County cooperative agreements, the providers themselves were pro-active in identifying, contacting, and seeking agreements with service providers in their region. Providers reported making 6,405 referrals to organizations with which they had cooperative agreements between October 1990 and May 1993. However, most of these referrals were clustered within a relatively small group of agencies. For example, staff reported making five or more referrals to only 176 (29%) of the 604 organizations with which cooperative agreements had been established.

In addition to cooperative agreements, CSAT directed the Target Cities to participate in two broad initiatives -- The Head Start and Faith Initiatives -- that required collaboration with other community-based organizations. The local Head Start initiative received supplemental funding through a grant from the Department of Health and Human Services. Although participants responded positively to the Head Start initiative, geographic factors and Head Start eligibility requirements limited the number of agencies
and clients that benefited from this collaboration. The CRCs invested substantial time in the Faith Initiative, especially in relation to the limited resources provided. This initiative had at best mixed support from Target Cities agencies, however, most of whom already had established contacts with clergy in their communities.

These efforts led to increased access for Target Cities agencies to a range of ancillary services including vocational training, child care, and medical care. Against this positive backdrop, however, are several concerns about the Target Cities activities related to establishing cooperative agreements. One concern is the cost efficiency of the effort to develop cooperative agreements. All CRCs and most OPDFs and PSCs spent substantial staff time in this endeavor, leading to some duplication of effort. Further, many of the cooperative agreements were not used. Fewer than one third of the cooperative agreements listed in the continuation proposal, for example, resulted in five or more referrals from Target Cities staff over a two-year time period. Thus, the cost of establishing many agreements (particularly the staff time needed to identify and meet with other organizations) was in many cases quite high in relation to the benefits that resulted for agency staff and clients.

Another concern is that cooperative agreements cannot overcome the gaps in the network of social and human services in Los Angeles. Some of the services that clients needed most, ranging from health care to housing, were simply unavailable. A third concern is that cooperative agreements were often established without in-depth or standardized assessments for quality.

Summary

Among the major accomplishments of Target Cities were:

- Established five regional Community Resource Centers to provide additional intake, assessment, and referral services, to build a network of ancillary services, and to support and coordinate regional outpatient drug free agencies;
- Strengthened linkages to ancillary services, including medical care, welfare, and vocational rehabilitation;
- Established two Perinatal Service Centers to increase system capacity and enhance services for pregnant women and mothers and children;
- Integrated service enhancements into outpatient drug free treatment within 17 agencies, including (but not limited to) life skills training, relapse prevention, and recreational activities;
- Increased outpatient drug free agencies’ access to assessment resources and ancillary services;
• Increased awareness of staff and directors about the needs of special populations, especially women and clients of color, and enhanced special services for these populations throughout the system;

• Developed and partially implemented a management information system for client intakes, assessments and referrals;

• Increased the standardization of intakes and assessments so that a common core of information was collected; and

• Increased communication and contact among drug treatment providers, and between drug treatment providers and (a) other social service agencies; and (b) local, state, and federal government.

Specific implementation problems or barriers Target Cities encountered included:

• Early resistance to the concept of centralized intake and subsequent changes to the proposed project plans, leading to delays in start-up and lasting ambiguity about some aspects of the Target Cities goals, strategies, and responsibilities;

• Tension and distance in relations between Community Resource Centers and outpatient drug free units that were not in the same agency;

• A lack of quality standards for outpatient enhancements, leading to considerable variation in the intensity and nature of those enhancements;

• Difficulty among Perinatal Service Centers due to high rates of client drop-out and insufficient support from related social services;

• Delays in establishing the MIS, and concerns among providers about the benefits of the MIS for them in relation to the time needed to support and participate in the MIS; and

• Dissatisfaction among providers with their relationship to CSAT (and, to a lesser extent, other administrators) due to "top down" directives perceived as inappropriate and sometimes harmful to agencies or clients.

Despite these problems, significant change occurred at the level of both individual agencies (e.g., through the enhancements to treatment and through staff hires) and at the systemwide level (e.g., through the development of CRCs, the MIS, and the various meetings among participants). The effects of these, and other accomplishments, on client retention and success in treatment will be determined by the results of the forthcoming outcome evaluation.
Chapter I:
Introduction and Methods

Target Cities is a federally funded program intended to improve the quality, effectiveness, and efficiency of publicly funded drug treatment services in large, drug impacted cities. Los Angeles was one of eight cities nationwide selected to participate in this demonstration project in 1990. The Los Angeles project focused primarily on the services provided by outpatient (non-residential), drug-free programs located within the City of Los Angeles. The project was funded through a cooperative agreement between the State Department of Alcohol and Drug Programs (ADP) and the Office of Treatment Improvement (OTI, later reorganized to become the Center for Substance Abuse Treatment or CSAT). Approximately $4 million per year for three years (October 1, 1990 through September 31, 1993) was awarded to the State of California for Target Cities. (Subsequently, CSAT awarded the State support for a two-year continuation project, thereby extending Target Cities into 1995.)

This report presents results of an implementation evaluation of the Los Angeles Target Cities project. This is one of three reports emerging from a process evaluation of the project\(^1\). Specific questions to which this report responds include:

- Was the project implemented as intended? How if at all did implementation deviate from the proposal and management plan?
- How was the Target Cities project implemented? What was accomplished and achieved?
- What barriers or obstacles to implementation did participants encounter? How did they address these barriers, and what were the effects of the barriers upon the implementation process? What factors facilitated implementation?
- What were the attitudes of participants about the Target Cities project? What did they consider to be its strengths and weaknesses? What did they learn about how to enhance drug treatment services in Los Angeles?
- What lessons are to be learned from Target Cities regarding efforts to create systemic change in drug treatment? What strategies appear effective for creating meaningful change? What blocks the change process?

This report does *not* address the effects of Target Cities on client outcomes, such as services received, retention and relapse. These issues are addressed in the impact evaluation (forthcoming). Further, this report (and the process evaluation overall) did *not* aim to evaluate, rate, or provide detailed descriptions of the performance of each individual agency, but rather was intended to focus on the manner in which Target Cities influenced the Los Angeles outpatient treatment system.

**Background and Overview of the Los Angeles Target Cities Project**

**Request for Applications.** The Office of Treatment Improvement (OTTI) 1990 Request for Applications (RFA) for Target Cities indicated that the program was intended to improve the quality and effectiveness of treatment services in cities with critical needs, the accessibility of treatment services, and the infrastructure that supported those services. Specific objectives for individual programs were to: improve patient retention and reduce relapse; improve staff retention and quality; provide a full range of drug treatment, health and social services; improve utilization of drug treatment resources; and improve treatment services for targeted groups (e.g., women, minorities, adolescents). In addition, the RFA stated that funded programs were to serve as models for other cities to study. Although Target Cities was a relatively unstructured initiative, sites did need to comply with certain requirements. The RFA spelled out four mandatory activities:

1. Improve coordination among local drug abuse treatment providers, law enforcement, health, and other human services agencies.

2. Establish enhanced central intake and referral facilities, including automated client tracking.

3. Implement measures to ensure quality of services, and a wider range of services to meet patient needs; and

4. Implement activities that focus on improving services for members of designated target groups -- either adolescents, minorities, pregnant women, female addicts and their children, or residents of public housing projects.

Further, the RFA specified that funded activities were to be overseen by a policy steering group composed of state, city, and county administrators as well as representatives of provider organizations. The selection of local plans and strategies was to be based upon a comprehensive needs assessment carried out by the State, which was expected to document that there were drug abuse problems of crisis proportions.

Eligibility for Target Cities funding was limited to states requesting support on behalf of cities with populations over 315,000. OTI chose to contract with states rather than with cities directly because they assumed that initial state involvement would facilitate continuation funding after the federal grants ended.
Letters of intent were due at OTI by April 1, 1990. Proposals were due May 23, 1990. Support could be requested for up to three years, and the average award was expected to be about $4 million per year.

California’s response. The State Department of Alcohol and Drug Programs (ADP) sponsored a within-state competition to select the site for the Target Cities proposal. Seven cities submitted concept papers. Los Angeles and San Francisco emerged as finalists. Although OTI appeared to support San Francisco, the decision to support a proposal for Los Angeles was based partly on the quality of the concept papers and partly on the fact that Los Angeles had recently been designated by Office of National Drug Control Policy as a high intensity area for drug trafficking.

The Los Angeles plan. The Los Angeles plan was written by County and State administrators working together. OTI restrictions limited the focus to drug treatment providers located within the City of Los Angeles. The County chose to further restrict the project to outpatient drug free providers serving an adult co-educational population. With one exception\(^2\), the providers included in the Target Cities plan already held contracts with the County. The proposal was organized around four “key objectives”:

1. Improve retention rates of clients and utilization of drug treatment resources through the implementation of regional intake and assessment units.
2. Ensure the provision of comprehensive services to clients in need of drug abuse treatment through the development of interagency collaborative agreements and working arrangements with related social service, educational, vocational and criminal justice systems.
3. Improve retention and decrease relapse rates of clients, particularly persons of color, by increasing the comprehensiveness and intensity of outpatient drug services.
4. Improve treatment services and outcomes for drug abusing pregnant women and women and their children, particularly women of color, through provision of intensive drug-related and ancillary day treatment services with a specific emphasis on case management for the purpose of providing coordinated services.

The proposal also described 23 separate activities that would be conducted to achieve the project objectives. Major elements of the plan included:

\(^2\) The original Target Cities proposal included one agency that was not currently a County contractor. After funding was awarded, this agency was dropped from the project, partly because of the difficulty the County faces in establishing new contractual relations.
• A network of five Regional Intake and Assessment Units (RIAU s) to be operated by existing providers, which would be phased in over a 15-month period.

• A supplementary interactive computerized network to come on-line in the second year.

• Three Perinatal Service Centers (PSCs) to provide intensive treatment for pregnant women and women with small children.

• Comprehensive services, to be obtained through collaborative agreements and staff training.

• Enhancements to 18 participating outpatient drug free (OPDF) programs, including staffing modifications to ensure a maximum 1:20 staff to client ratio; bilingual and bicultural services; satisfaction of minimum training standards; ongoing case management; relapse prevention and aftercare; family counseling; vocational training; transportation; and child care.

The proposal requested a total of $12,099,582 for a three-year period starting on October 1, 1990. The proposed first year budget was $4,729,815. California submitted the Los Angeles proposal on May 21, 1990. A site visit team came to Los Angeles in August, 1990. Funding was awarded September 30, 1990.

Project planning. The Los Angeles Target Cities plan underwent significant modification shortly after funding was awarded. At least three factors account for these changes. First, budget reductions led to some design changes. Second, the Los Angeles proposal was written quickly (in about two weeks). Although providers did sign letters of support, they did not fully understand the Target Cities plan. When they learned that the project involved the creation of centralized intake units, they sharply criticized the plan. Third, the leadership of the County Alcohol and Drug Program Administration (ADPA) changed. With that change in leadership came a new emphasis on social rather than clinical models of drug treatment and therefore a new outlook on Target Cities.

Major changes included budget modifications; reduction from three to two PSCs; reduction from 18 to 17 OPDFs; and, most important, replacement of the five RIAUs with five "Community Resource Centers" (CRCs) that provided additional points of entry to the treatment system and increased comprehensive services through linkages with ancillary service providers. These changes are described further in later sections of this report.

Table 1 below displays a timeline for the project planning period. Following the OTI award in September 1990, the County began holding Project Agency Meetings (PAM) and, as required, the State convened the Project Advisory Committee (PAC) to coordinate implementation. By mid winter 1991, the participants in the treatment network had clarified the major changes they wished to make to the original plan as described in the proposal, and County officials sent a letter requesting approval for these changes to
the State ADP Department. The County awarded contracts to providers on May 28, 1991. These contracts gave providers a 90 day start-up period. Enhanced delivery of services to clients through the Target Cities project began in September 1991.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Winter, 1990</td>
<td>RFA released</td>
</tr>
<tr>
<td>May 21, 1990</td>
<td>Proposal submitted</td>
</tr>
<tr>
<td>September 30, 1990</td>
<td>Los Angeles proposal approved for funding</td>
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<tr>
<td>October, 1990</td>
<td>Project Agency Meetings (PAM) begin</td>
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<tr>
<td>November, 1990</td>
<td>Project Advisory Committee (PAC) meets for first time</td>
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<tr>
<td>February 26, 1991</td>
<td>County ADPA sends letter to State ADP requesting changes</td>
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<tr>
<td>May 28, 1991</td>
<td>County awards contracts to OPDFs, CRCs, and PSCs</td>
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<tr>
<td>August 23, 1991</td>
<td>County sponsors first Target Cities training workshop</td>
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<tr>
<td>September 1, 1991</td>
<td>CRCs and PSCs begin serving clients; OPDF enhancements are implemented</td>
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Appendix A lists the participating agencies in Target Cities, including 17 Outpatient Drug Free units, five Community Resource Centers, and two Perinatal Service Centers. All the Community Resource Centers and Perinatal Service Centers were housed within agencies that also had OPDF units participating in Target Cities. In this way, the County avoided the time consuming and cumbersome process of establishing new contracts. In total, Target Cities spanned 16 different drug treatment agencies.

Project evaluation. The cooperative agreement between the State and OTI mandated process and impact evaluations, to determine if the Target Cities project was successful in enhancing drug treatment outcomes. (In addition, OTI/CSAT sponsored a national evaluation of all eight Target Cities.) The original Los Angeles Target Cities proposal specified that the evaluation would be conducted by faculty from a local university. Several months following project initiation, the State assumed responsibility for evaluation. Toward the end of the first project year, the State approached the UCLA Drug Abuse Research Center (DARC) about the possibility of conducting the evaluation, which agreed to do so and in turn subcontracted with RAND for the process evaluation. DARC and RAND officially began activities related to evaluation in October 1992, although some informal data gathering activities were initiated as early as June, 1992.

Budget. Target Cities was funded through a cooperative agreement with the State of California. Relative to grants and contracts, cooperative agreements are more flexible and enable the funder to play an active role in guiding and overseeing implementation. The State then established a contract with the County, which in turn modified its existing
contracts with treatment agencies to provide supplemental funding for Target Cities. In addition, the County established contracts or cooperative agreements with the State Department of Vocational Rehabilitation, the Public Health Foundation, Deloitte and Touche, the City of Los Angeles Office of Criminal Justice Planning, Head Start, Creative Socio-medics, Dr. P.C. Kintaudi (in year 3), and the UCLA Drug Abuse Research Center.

Table 2 shows the original budget allocations to each of the major components of Target Cities for each of the three project years. The expected allocation to each OPDF was $75,649 per year; the allocation to each community resource center was $107,561 in the first year (1990-91) and $147,476 in the second and third project years; and the allocation to each Perinatal Service Center was $291,342 per year. A RAND report on drug treatment resources and expenditures (Greenwood and Mohamed [1994], *The Impact of the Target Cities Project on Drug Treatment Funding in Los Angeles, DRU-702*) indicates that Target Cities support represented an approximate 10 percent increase in publicly funded drug treatment revenue. This report also notes that first year expenditures of Target Cities funds varied substantially across agencies. For example, first year expenditures by the five CRCs ranged from under $10,000 to over $100,000.

Because providers did not spend their full allocations in 1990-91, the County was able to carry $900,704 forward to 1991-92 and $1,017,141 to 1992-93. As a result, the original budget allocations (as presented in Table 2) were revised in subsequent years.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CRCs</td>
<td>$537,805</td>
<td>737,380</td>
<td>737,380</td>
<td>2,012,565</td>
</tr>
<tr>
<td>OPDFs</td>
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<td>1,286,033</td>
<td>1,286,033</td>
<td>3,858,099</td>
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<tr>
<td>PSCs</td>
<td>582,684</td>
<td>582,684</td>
<td>582,684</td>
<td>1,748,052</td>
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<tr>
<td>Contracts</td>
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<td>729,379</td>
<td>1,033,852</td>
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<tr>
<td>County Admin.</td>
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<td>417,873</td>
<td>1,253,619</td>
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<tr>
<td>State Admin.</td>
<td>204,393</td>
<td>204,393</td>
<td>204,393</td>
<td>613,179</td>
</tr>
<tr>
<td>Total</td>
<td>4,087,866</td>
<td>3,957,742</td>
<td>4,262,215</td>
<td>12,307,823</td>
</tr>
</tbody>
</table>

Table 3 displays the County subcontractors and their first year budget allocations. Since not all of this money was spent in the first year, carry-over savings in subsequent years enabled larger allocations and support for new initiatives, such as subcontracts with health care providers.
### Table 3: First Year Subcontractors and Budget Allocations

<table>
<thead>
<tr>
<th>Subcontractors</th>
<th>First Year Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Service Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Asian American Drug Abuse Program (OPDF &amp; PSC)</td>
<td>$366,991</td>
</tr>
<tr>
<td>Avalon Carver Community Center (OPDF)</td>
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<tr>
<td>Behavioral Health Services (2 OPDFs &amp; CRC)</td>
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<tr>
<td>Didi Hirsch Psychiatric Services (OPDF)</td>
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<tr>
<td>Do It Now Foundation (OPDF)</td>
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<tr>
<td>El Proyecto del Barrio (OPDF, CRC, &amp; PSC)</td>
<td>$474,552</td>
</tr>
<tr>
<td>Family Service of Los Angeles (OPDF)</td>
<td>$75,649</td>
</tr>
<tr>
<td>I-ADARP (OPDF)</td>
<td>$75,649</td>
</tr>
<tr>
<td>Joint Efforts (OPDF &amp; CRC)</td>
<td>$183,210</td>
</tr>
<tr>
<td>La Clinica del Pueblo (OPDF)</td>
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<tr>
<td>Los Angeles Centers for Alcohol and Drug Use</td>
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<tr>
<td>People Coordinated Services (OPDF)</td>
<td>$75,649</td>
</tr>
<tr>
<td>Sunrise Community Center (OPDF)</td>
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<tr>
<td>Tarzana Treatment Center (OPDF)</td>
<td>$75,649</td>
</tr>
<tr>
<td>Watts Health Foundation (OPDF &amp; CRC)</td>
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<tr>
<td>West Area Opportunity Center (OPDF &amp; CRC)</td>
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<tr>
<td><strong>Other Subcontracts</strong></td>
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<td>L.A. Office of Criminal Justice Planning</td>
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<td>Evaluation</td>
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<td>Dept. of Public Social Services</td>
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<tr>
<td><strong>Total Subcontracts</strong></td>
<td><strong>$3,465,600</strong></td>
</tr>
</tbody>
</table>

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3 Does not include County and State administrative and project management costs.
Methods

RAND obtained information about the implementation of the Los Angeles Target Cities project from four sources: (a) a National Treatment Improvement Evaluation Studies (NTIES) survey administered by NORC as part of the national Target Cities evaluation; (b) individual interviews with representatives of all participating Target Cities agencies, subcontractors, and administrators from the County, State, and CSAT; (c) reviews of archival documents; and (d) direct observation and attendance at PAC meetings. Each of these is discussed below.

NTIES Baseline Administrative Report (NBAR) survey. The NBAR survey provided descriptive information about drug treatment agencies and self-reports by agency administrators about the perceived impacts of CSAT support. The questionnaire included modules related to: (a) staffing and organization; (b) budget; (c) assessment; (d) treatment; (e) on-site and ancillary services; (f) client characteristics; (g) discharge criteria; and (h) agency goals and philosophy. Agencies were instructed to respond for the reference year beginning June 1991.

The NBAR survey was conducted by NORC, which agreed to share the Los Angeles questionnaires with DARC and RAND. The survey was administered by mail. All 17 OPDF agencies, two PSCs, and five CRCs in the Los Angeles Target Cities project completed an NBAR. Surveys were completed between July 1993 and February 1994.

Despite this strong response by Los Angeles Target Cities participants, not all responses could be used for this evaluation. In particular, the survey questions proved a poor fit for the activities of the five Community Resource Centers. Due to substantial missing data and other problems with data quality, the CRC survey results are not reported here.

Further, many caveats are needed in interpreting NBAR data. First, the questions included in the NBAR do not necessarily match the priorities and aims of the local Target Cities project. For example, the Los Angeles Target Cities effort emphasized the development of cooperative agreements as a means of increasing clients' access to ancillary services, but NBAR provides only limited and indirect information about these activities. Similarly, NBAR offers little information about many of the enhancements that OPDF providers implemented, including life skills training and recreation.

A second limitation of the NBAR is that the results are often difficult to interpret. Due to the length and specificity of the questionnaire, many respondents did not complete

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4 Some providers sent their completed survey directly to NORC. By prior agreement, NORC staff then sent copies to DARC. Other providers sent their completed surveys to DARC, which then copied and forwarded them to NORC for processing for the national evaluation.
all the items, so there is considerable missing data. Some questions are ambiguous. For example, in response to a question about caseloads, some respondents provided the average caseload per counselor while others provided the aggregate caseload for the unit as a whole, and we therefore cannot accurately interpret the results. In addition, many questionnaires contained internal inconsistencies, since respondents provided conflicting answers to similar questions (e.g., about staffing, revenues, or caseload). Although many questions asked respondents to provide data for the reference year starting in June 1992, there is some evidence that respondents did not consistently comply with these instructions. Further, many respondents answered the questionnaire based on general impressions and recall rather than a review of program records; such recollections may be biased.

Despite these shortcomings, the NBAR dataset yields standardized information about Target Cities that contribute to both an aggregate profile of the Los Angeles Target Cities project and comparisons among providers. Further, although some items are flawed, others are straightforward and easily interpreted. Thus, the NBAR serves an important role in constructing a picture of the Los Angeles Target Cities project.

To determine if the changes observed in Target Cities agencies differed from those observed in non-participating agencies, a modified NBAR survey was administered to a comparison group of eight OPDF agencies that were not funded under Target Cities. For administration to the comparison group, items that did not apply to outpatient providers or specifically mentioned CSAT or Target Cities were dropped from the questionnaire. Comparison group agencies were paid $50 each as an incentive to complete the survey.

The comparison group provided some insight into the question of whether the changes reported by Target Cities OPDF agencies might have occurred even without the Target Cities project. The comparison agencies were all County contractors serving adult co-ed populations, but because they were located outside the Los Angeles city limits, they were ineligible for participation in Target Cities. Unfortunately, very limited data exist to establish the comparability of the Target Cities and comparison group agencies at baseline. Although we cannot make any causal inferences from the between-group comparisons about the effects of Target Cities, we can use them to generate hypotheses and to confirm or question findings obtained through other methods.

The NBAR survey was intended to provide baseline measures for longitudinal research, and NTIES has designed a follow-up instrument. However, the follow-up survey was not administered during the first Target Cities funding period, so only the NBAR data were available to the evaluation.
Interviews. The NBAR survey provided some standardized information about the activities of Target Cities agencies, and the perceived impact of the Target Cities project on staffing, operations, assessment, and treatment. The design of the NBAR, however, did not provide opportunities for respondents to indicate (a) the major accomplishments or contributions of Target Cities, particularly if those contributions were outside the areas probed by NBAR, (b) the weaknesses or shortcomings of the Target Cities effort, and (c) obstacles to and facilitators of implementation of the Target Cities project. In particular, the NBAR did not fully address some of the issues that Los Angeles emphasized, such as strengthening referrals and cooperative agreements and developing an MIS system (CRIS). Thus, interviews were conducted with representatives of participating agencies.

Semi-structured interview forms for OPDFs, CRCs, PSCs, and others (e.g., administrators) were developed at RAND and revised following pilot testing. Representatives from each participating agency were interviewed to determine: (a) how Target Cities funds were being used within the agency; (b) the perceived effects of Target Cities on agency structure and staffing, activities and services, and linkages and external relationships; (c) factors that hindered or facilitated implementation of the Target Cities plan; and (d) attitudes toward Target City, including perceived effectiveness and suggestions for increasing program effectiveness. The interview instruments are displayed in Appendix B.

Interview respondents were the individual(s) with responsibility for the Target Cities project implementation. In some cases, this was the agency director, but more often the respondent was a middle manager, such as the Director of Outpatient Services, Coordinator of Enhancement Services, or OPDF Supervisor. We also spoke with staff from County ADPA, State ADP, CSAT, and the State Department of Vocational Rehabilitation. In all, interviews were administered to over 48 different participants in the Target Cities project. To encourage respondents to speak freely, confidentiality for both individuals and agencies was assured.

Evaluators encountered several problems in administering this interview. First, because DARC and RAND did not officially begin the Target Cities evaluation until October 1992, the interviews necessarily involved some retrospective data collection. This task was rendered more difficult than usual by high levels of turn-over among administrators at the County, State, and Federal levels. Between 1991 and 1993, County ADPA had three different directors. In addition, the staff person responsible for coordinating implementation of Target Cities moved out of state in 1993. The State also experienced turn-over in both the leadership of ADP and project oversight. At the federal level, turn-over and restructuring increased the difficulty of finding respondents who could
provide an accurate account of the development of the Target Cities concept. Many agencies, too, experienced turn-over in managers and staff. As a result, some of the key informants about Target Cities were either unavailable or available only on a limited basis to the evaluators.

A second difficulty associated with the interviews was that few respondents were able to provide detailed historical accounts of their involvement in Target Cities. For example, few were able to construct critical incident timelines, and few had detailed records that enabled them to reconstruct history.

A third limitation was that, in order to minimize burden, interviews were limited to two hours; in about half the cases, evaluators had to end the interview before addressing all the issues in the interview guide.

Fourth, respondents were aware that future funding for the LA Target Cities project depended in part on their performance. They may therefore have been less than fully candid about their concerns and problems.

In addition to interviews with managers, line staff (generally treatment counselors or "enhancement" counselors) were interviewed at roughly half the participating OPDF agencies. These interviews enabled us to determine if staff perceived the Target Cities project differently from managers. The interviews indicated that line staff had generally much lower awareness and understanding of the Target Cities project compared to managers; in those cases where line staff knew about Target Cities, however, their responses closely matched those provided by the managers. Thus, the discussion of results in subsequent chapters does not break out line staff from managers.

**Document collection and review.** In addition to the interviews and NBAR analysis, the process evaluation included reviews of written materials. These included: (a) the original proposal submitted in 1990; (b) the continuation proposal submitted in 1993; (c) quarterly reports; (d) minutes of PAC meetings; (e) contract supplements between the County and the providers, as well as the contract between the County and the State; (f) specifications for the MIS; (g) materials disseminated at County-sponsored training workshops; (h) planning materials, including a detailed management plan prepared for OTI soon after funding was awarded; and (i) copies of correspondence, briefing charts, and an informational binder.

At project inception, the quarterly reports looked especially promising as a source of comprehensive, quantitative, and standardized information about project implementation. Unfortunately, however, a variety of problems with these reports rendered them of limited use for the implementation evaluation.
Particularly disappointing were the quantitative sections of the quarterly reports. Among the problems we observed were: (a) poorly defined data elements that were interpreted in different ways by different providers; (b) inconsistency in reported data across quarters (e.g., the year-to-date statistics did not consistently equal the sum of the quarterly statistics); (c) inaccurate data (e.g., over-estimation of the number of clients treated in the 1992-93 grant year); (d) internal inconsistencies within tables; (e) confusion of unduplicated and duplicated counts (e.g., elements that were supposed to be unduplicated counts appeared to be duplicated counts); (e) differences between some worksheets submitted to the County by Target Cities agencies and the numbers published in the quarterly reports; and (f) inaccurate legends. As a result, all of the quantitative data in the quarterly reports must be treated with caution, and much cannot be used for evaluative purposes. The shortcomings of the quantitative data are described further in later chapters of this report (see Chapters III, IV, and V).

The qualitative sections of the quarterly reports are somewhat more useful but also have limitations, particularly since reporting formats changed over time. Further, the Target Cities participants differed significantly in the specificity, volume, and type of information submitted for inclusion in these reports. In addition, follow-up interviews revealed that at least one agency submitted more information to County ADPA than was actually included in the bound reports, suggesting that the reports provide only a partial record of activities.

**Direct observation.** By attending PAC meetings, evaluators could directly observe the concerns of participants and the nature of inter-agency interactions. The meetings provided information about emerging priorities for the project, plans, and problems related to implementation. In addition, the group process revealed information about the relationships among providers and between providers and administrators. Thus, notes from PAC meetings constituted another source of data for the process evaluation.

**Organization of This Report**

This report presents findings from the implementation evaluation. The organization of the report corresponds to the major structural elements of the Target Cities project. Chapter II provides an implementation overview, focusing on the extent to which the Target Cities management plan was actually implemented. Chapters III through V provide detailed descriptions of implementation of Target Cities within CRCs, OPDFs, and PSCs respectively. Chapters VI through VIII discuss major systemic initiatives linked to Target Cities -- the Management Information System, the development of cooperative and collaborative agreements with ancillary service providers, and the linkages and relationships among providers and between providers and administrators. Finally, Chapter
IX provides a summary of the major themes and findings and discusses future challenges facing Target Cities in its second funding period and beyond.

The results that follow are based on the information available to researchers as of June 1994. The Target Cities project has changed significantly since that time, and results should not be interpreted as applicable to the current structure and operations of Target Cities.
Chapter II: Implementation Overview

A key intent of the process evaluation was to determine if the Los Angeles Target Cities project was implemented as intended. This assessment was rendered difficult, however, by substantial ambiguity about the Target Cities goals and plans. This chapter first discusses the factors that contribute to this ambiguity, and then reviews implementation based on the best available documentation.

Target Cities Goals and Strategies

Implementation of the Target Cities project was marked by confusion among participants about the primary goals and objectives of the project as well as the major strategies for achieving these goals, and the allocation of responsibility for implementing the strategies. As discussed, the original proposal specified four "key objectives:" (1) Improve retention and utilization of drug treatment resources through the implementation of regional intake and assessment units; (2) Ensure the provision of comprehensive services through the development of interagency collaborative agreements; (3) Improve retention and decrease relapse rates of clients, particularly persons of color, by increasing the comprehensiveness and intensity of outpatient drug services; and (4) Improve treatment services and outcomes for drug abusing pregnant women and women and their children, particularly women of color, through provision of intensive drug-related and ancillary day treatment services. Almost immediately, however, these key objectives began to shift. The major changes include:

- Objective one: The providers did not support the concept of Regional Intake and Assessment Units. As a result, the RIAUs were replaced by Community Resource Centers. In so doing, the objective shifted in emphasis from centralized intake to "centralized support" for OPDFs, especially through "the development of dynamic ancillary and other human services networks and development of vigorous collaborative linkages between traditional as well as non-traditional human services providers" (County ADPA, 1991). This shift is described in more detail in Chapter III.

- Objective three: In response to provider feedback, the emphasis in OPDF enhancement shifted from increasing "comprehensiveness and intensity" to addressing issues of comprehensiveness but not necessarily intensity by focusing on clients' "distal service needs" as a means of incorporating "a stronger community planning and environmental perspective" (County ADPA, 1991).

- Objective four: The original proposal for "day treatment services" emphasizing case management for drug-abusing women and children was replaced by a plan for "perinatal service center activities" that incorporated a
stronger emphasis on "participant empowerment" (letter from Oscar Rascon to Queen Esther Watson, February 26, 1991). Also, the number of PSCs dropped from three to two.

• Although objective two was not formally modified, the shift from RIAUs to Community Resource Centers contributed to lasting ambiguity regarding the units charged with responsibility for establishing interagency collaborative agreements and working arrangements with other agencies.

The original proposal further specified 23 major activities that would be implemented in order to achieve each key objective. These, too, were modified following funding. The changes for which we were able to obtain written documentation include:

• Activity one, under key objective one, to "implement automated intake, referrals, and assessment units" was replaced by implementation of the Community Resource Centers.

• Activity one, under key objective two, to "increase the number of staff in each program to reflect a maximum of 1:20 staff to client ratio was rejected as incongruent with the shift in emphasis toward fulfilling clients' distal needs. Rather than augmenting counseling staff, County ADP recommended that OPDFs hire "community workers" instead (often referred to as "enhancement counselors") who would establish links with ancillary services needed by clients and/or directly implement enhanced services.

• The eleven activities originally proposed to implement key objective four were replaced by a new set of 15 activities (see Chapter V).

When the DARC/RAND evaluation team began its work, RAND compiled a list of activities and objectives drawn from a broad base of documentation provided by the County and State to the evaluators. The Evaluation Advisory Board (a group of representatives from local Target Cities agencies, County ADPA, and State ADP), however, responded that this list was not an accurate summary of their responsibilities. In follow-up, staff from both the County and State provided informal lists of objectives that, in their opinion, better captured the nature of Target Cities. (Note that these lists were neither reviewed nor approved by project leaders and were provided to the evaluators for information only.) Later, different albeit complementary sets of objectives were developed for various purposes (e.g., the continuation proposal). Appendix C presents some of the different lists of project goals, objectives, and strategies.

Although these lists differed in a number of ways, they showed general agreement on most aspects of Target Cities including:

• Establishment of an MIS for intakes, assessments and tracking;
• Strengthening client access to ancillary services through cooperative and collaborative agreements;
• Promoting staff development through training;
• Improving services for clients of color;
• Improving and expanding services for pregnant and postpartum women;
• Establishing five community resource centers; and
• Enhancing outpatient treatment through development of at least some of the following: life skills, relapse prevention, fitness and nutrition, recreation, alumni activities, family services, and/or aftercare services.

Further, most but not all the documents reviewed for this report included among their objectives providing child care and transportation services. Less consistently mentioned was reducing staff to client ratios, adding or strengthening case management, offering screening and referrals through the CRCs, and increasing the intensity as well as the scope and quality of OPDF treatment.

Despite broad agreement, the lack of a single statement of goals and objectives on which providers and administrators were in agreement contributed to some sense of ambiguity and increased the difficulty of describing the project to others. Of more importance, however, was the lack of clarity regarding the distribution of responsibility among the Target Cities participants for implementing strategies to achieve goals and objectives. For example, few agencies invested substantial resources in staff training, but the County devoted an FTE to training and organized several training sessions per year. No plans existed, however, to indicate to the evaluators whether this level of activity was congruent with the intentions and expectations of project planners. Similarly, confusion persisted regarding the distribution of responsibility between OPDFs and CRCs for establishing cooperative and collaborative relationships. In many cases, both the CRC and the OPDFs within a specific region pursued these activities, raising the risks of duplication of effort and lack of coordination.

Further increasing the difficulty of clarifying project objectives was the high level of turn-over among project administrators at the County, State, and Federal levels. None of the administrators directly involved in proposal preparation were still involved in the Los Angeles Target Cities project by the end of the first funding period. County ADPA had three directors between proposal preparation and the spring of 1993, and the Target Cities project coordinator also left the project in its third year. At the State level, both the ADP director and Target Cities project supervisor turned over during the course of the project. At the Federal level, the reorganization of OTI to CSAT was accompanied by changes in leadership and program officers. As different administrators became involved in Target Cities, project priorities and approaches inevitably shifted to some degree.
The lack of consensus or clarity about objectives created special difficulties for this process evaluation. It was tempting to ignore areas where disagreement exists and focus instead on only those areas where participants are in agreement. Yet this approach would not capture the diversity and contributions of the overall Target Cities effort. On the other hand, by accepting the full range of objectives and strategies — including those about which disagreement exists — we experienced considerable difficulty in making fair judgments about the level or degree of project implementation.

The document that appeared to best capture the goals and objectives of Target Cities, following revisions after the proposal was approved by funding, is the Los Angeles Drug Program Enhancement Project Management Implementation Plan (March, 1991, see Appendix D). OTI requested that the project team prepare this plan when it awarded the Target Cities funding to the State; the plan was authored by staff at County ADPA. It remains the only document that provided evaluation specifications. Thus, we used this document as our guide for assessing project implementation, recognizing that it might not fully reflect the informal evolution of Target Cities over time.

In the following section, then, we briefly describe the extent to which the implementation of Target Cities met the Evaluation Specifications for Objectives provided in this plan.

Implementation of Key Objectives

Key Objective One: Improve retention rates of clients and utilization of drug treatment resources through the implementation of regional intake and assessment units.

Activity 1.1: Develop and implement five community resource centers. This objective was achieved. All five CRCs were operational at the designated start date for enhanced services (Sept. 30, 1990). Their activities are described in more detail in Chapter III.

Activity 1.2: Develop and implement automated intake and assessment client data system. Evaluation Specification: Developed and implemented management information system at 50% of project sites by October 1991, and in the remaining sites by April 1992. This objective was not achieved within the specified time period. The MIS contractor, Creative Socio-Medics, did not have a signed contract with the County until February, 1992. The automated intake and assessment system was not introduced until Spring 1993. However, computer hardware was purchased and installed in agencies on schedule. Further, by the end of the project the automated intake and referral system was operational at all sites. Chapter VI describes the development process, including the reasons for delays.
Activity 1.2b: Develop and implement assessment decision tree element of automated system. Evaluation Specification: Assessment decision tree element of management information system operational in year two. Due to delays in implementing the intake and referral system, the decision tree element was not implemented during the Target Cities project's first term of funding (3 years). During the continuation funding period, Los Angeles County ADPA decided to drop this element from the MIS, due to provider disinterest and the lack of clear criteria to guide matching decisions.

Key Objective Two: Ensure the provision of comprehensive services to clients in need of drug abuse treatment through the development of interagency collaborative agreements and working arrangements with related social service, educational, vocational and criminal justice systems.

Activity 2.1: Develop and implement formal collaborative and cooperative agreements with public and private drug, health, social and other human services providers. Evaluation Specification: Cooperative agreements with local drug program providers, the City of Los Angeles Office of Criminal Justice Planning, the State Department of Vocational Rehabilitation, and the Los Angeles County Department of Public Social Services have been signed. This objective was successfully implemented, with some modifications. Specifically, the County Health Department was not able to establish a cooperative agreement with DPSS and therefore decided to hire a former DPSS supervisor as a liaison. The DPSS liaison and a representative of the State Department of Vocational Rehabilitation each rotated among the CRCs, spending one day per week in each CRC. This system was initiated in Fall 1991. A cooperative agreement with the City Office of Criminal Justice Planning was also established during the first project year; representatives of this office attended the PAC meetings and Target Cities training sessions, and were available for informal consultation, discussion, and information exchange.

Activity 2.2: Develop and implement interagency linkage protocols and procedures, and training sessions. Evaluation Specification: Project agencies have increased and enhanced their ability to develop and implement interagency linkages. This objective was achieved. A number of meetings and committees -- most notably the Project Advisory Committee (PAC), Project Agency Meetings (PAM), monthly CRC meetings, and monthly regional meetings, as well as some specialized planning groups such as the MIS advisory group and the Evaluation Advisory Board, provided opportunities for regular interaction and exchange among participating agencies. Further, the County established a formal procedure for interagency referrals, specifying that agencies that could not serve a particular client should refer to client to the Drug Abuse
Program Office (DAPO) telephone referral service. We were unable to verify the extent to which this procedure was followed, however.

Additional interagency linkages resulted from the efforts of the CRCs, PSCs, and most OPDFs to establish cooperative agreements with other service providers in their area. To our knowledge, formal protocols or procedures for developing such agreements were not established at the project or County level, although some agencies developed their own procedures and forms for cooperative agreements.

Interagency training sessions were provided by the County ADP several times per year, usually on a quarterly basis.

Activity 2.3a & 2.3b: Develop project interagency network support system involving public, private and project agencies. Develop and implement dynamic community and networking activities involving the community resource centers, outpatient drug programs, and perinatal service centers. Evaluation Specifications: Collaboration networking meetings have been held between private and public agencies. Dynamic networking activities between project components and other agencies have been conducted. These activities were implemented. Participation in the PAC meetings, for example, included not only participating agencies but also representatives for the County, State, and federal governments; Head Start, Vocational Rehabilitation, City Office of Criminal Justice Planning, and occasionally a consumer (client) representative(s).

Activity 2.4. Develop and implement project process and outcome evaluation.
Evaluation Specification: An outcome and process evaluation has been developed and implemented to evaluate successful completion of the goals and objectives described in this implementation plan. These activities were implemented. This report is one of three RAND reports that provide process evaluation findings. The outcome evaluation report(s) are in development.

Key Objective Three: Improve retention and decrease relapse rates of clients, particularly persons of color, by increasing the scope and quality of outpatient drug services.

Activity 3.1: Augment outpatient drug programs to increase staffing patterns ensuring the provision of and access to bilingual and bicultural services. Evaluation Specification: The outpatient drug programs have hired full time staff augmenting existing staff ensuring a reduction in the staff-to-client ratio. This objective was partly achieved. As discussed in more detail in Chapter IV, NBAR survey results indicated that at least 15 of the 17 participating OPDFs hired new staff with Target Cities funding. Further, at least 10 agencies hired "culturally appropriate" staff, suggesting if not clearly
specifying that clients in need of bilingual services were more likely to obtain them as a result of the Target Cities project. However, data were less clear regarding reductions in the staff-to-client ratio. Project documentation and interviews suggest that most new staff were assigned responsibilities related to enhancing treatment by obtaining or delivering ancillary and supplemental services to staff. Some of these new staff did not carry a caseload. In such cases, the staff to client ratio was not necessarily reduced, although counselors were presumably better able to perform their jobs since enhancement staff were available to assume other duties such as intakes and assessments, referrals, outreach, case management, and planning special events and services. Other agencies assigned their new hires a portion of the caseload but then accepted more clients into treatment. Still others did in fact reduce staff to client ratios through new hires. Most agencies used a combination of these strategies.

**Activity 3.2: Develop and implement training sessions for project staff to increase level of cultural competency and awareness of the needs of persons of color.** Evaluation Specification: 55% of project agency staff have increased cultural competency and awareness of the needs of people of color. This activity was conducted, although we cannot determine from available data whether the outcomes of training achieved the evaluation specification. Most of the County-sponsored training programs addressed multicultural issues and at least one specifically addressed this topic. Although fewer than 55% of agency staff attended any single meeting, it was expected that those who did attend would share the lessons and materials with their co-workers. In addition to the County-sponsored training workshops, at least five OPDFs provided in-service training to staff specifically about multicultural issues.

The effect of these training sessions and workshops on the nature and quality of services for people of color is unknown. Further data collection and analysis would be needed to determine if these training sessions improved counseling skills and services and/or client outcomes. However, County evaluations of the training sessions revealed that participants rated these events highly and found them informative and useful.

**Activity 3.3: Develop and implement policies and procedures ensuring access to and provision of comprehensive services specific to project participant needs.** Evaluation Specification: Project agencies have implemented policies and procedures ensuring access to and the provision of comprehensive services. These activities were implemented, although the extent to which such policies and procedures in fact increased clients' use of services is unknown pending the results of the outcome evaluation. As described above, a representative of the State Department of Vocational Rehabilitation and a DPSS liaison rotated among the CRCs to facilitate client access to these agencies.
During the third year of the project, the County arranged for physicians' assistants to also rotate among the CRCs to increase client access to medical assessments and services. Furthermore, the CRCs, PSCs, and most OPDFs developed cooperative agreements with service providers in their region to increase clients' access to services ranging from housing and shelter to legal services and health care.

Activity 3.4: Develop and implement relapse prevention strategies. Develop and implement project activities involving participant's family. Evaluation Specification: Relapse prevention, family activities and alumni activities have been implemented. These activities were implemented. County contracts with providers required OPDF programs to offer at least 10 of 14 supplemental service activities. These supplemental services included alumni activities and some family activities (e.g., home visits, parenting enrichment). Although relapse prevention was not specifically listed, providers included it within other activities and services (e.g., life skills training). The quarterly reports confirm that all three of these activities were implemented.

However, since relapse prevention was not defined, and since family and alumni activities can take many forms, we found substantial variation among providers in the manner in which they implemented these provisions. For example, family activities spanned family counseling to recreational or social outings. Alumni activities varied in frequency and in attendance. Relapse prevention ranged from one-shot didactic presentations to ongoing group discussion and counseling.

Data aggregated from quarterly reports for the Continuation proposal indicates that between project inception and June 1993 (when the proposal was submitted), 1,353 clients participated in alumni or aftercare activities and 2,222 clients participated in parent enrichment activities. Relapse prevention was not broken out as a separate category, but some providers consider life skills training (provided to 1,537 clients), social activities (provided to 3,587 clients), health and fitness training (provided to 645 clients) or community support groups (provided to 3,364 clients) to help protect against relapse. Further, at least one of the County sponsored training sessions was devoted to relapse prevention.

Activity 3.5: Same as 2.1.

Activity 3.6: Develop and implement procedures for baby sitting activities at project sites. Develop and implement procedures for transportation assistance to project participants. Evaluation Specification: Transportation and baby sitting needs of project participants have been met. These activities were only partially implemented. On-site child care services proved problematic across the board due to insurance and liability concerns. CRCs provided some type of baby-sitting or child care (not always on-site)
when parents were using CRC services, and the PSCs also provided on-site baby-sitting. Six of the OPDFs were able to provide some on-site child care, although facilities were less than ideal in most cases and the service was limited. Other agencies let small children stay with their mothers during counseling sessions. Another five OPDF agencies were able to provide some referrals for child care services off site. The number of OPDFs with on- or off-site access to child care services increased from 3 prior to Target Cities to 11 following funding. Nonetheless, these services were in some cases limited, and simply did not work for every parent in need.

The Head Start initiative represented an important effort to fulfill parents' need for baby sitting services, yet this was only a partial solution to fulfilling clients' child care needs. The initiative was active in only three of the five CRCs. Some agencies did not have any Head Start facilities located close enough to them to provide a practical alternative. In other cases, restrictions on Head Start eligibility made this option unavailable to many parents.

Many interview respondents believed that Target Cities made substantial contributions to reducing obstacles to treatment related to transportation, and half mentioned improved transportation services as a major accomplishment of Target Cities. Four of the five CRCs bought vans to serve the agencies in their region. All the agencies had access to bus tokens, and all the CRCs (and some agencies) had access to some taxi vouchers. Nonetheless, these steps did not address some of the most important transportation barriers clients faced. The vans were typically available for special services (e.g., transporting clients to the CRC, doctor, or other appointments) and special events. Further, bus tokens and taxi vouchers were limited in availability. As a result, many clients who faced a long, complex, or dangerous commute to treatment received limited assistance. It would be unrealistic, however, to expect the Target Cities agencies to overcome the commuting difficulties inherent to the Los Angeles area.

Activity 3.7: Develop and implement minimum training standards for staff development and provide training for all staff. Evaluation Specifications: Developed and implemented minimum training standards for staff development and training for all staff. These activities were partially implemented. The County ADPA sponsored periodic (quarterly or more) staff training sessions for Target Cities agencies. Further, at least 14 agencies (all of those responding) reported that one or more staff members had participated in an external training activity in the past year. Thus, participation in training was widespread. However, as far as we can determine, minimum training standards for staff development were not developed.
Key Objective Four: Improve treatment services and outcomes for drug abusing pregnant women and women and their children, particularly women of color.

Activity 4.1. Develop and implement perinatal services ensuring access to and provision of comprehensive services specific to women's needs. Evaluation Specification: Two perinatal service centers have been implemented to improve treatment services for drug abusing pregnant women and women with children. This activity was implemented as intended through the operations of the PSCs at El Proyecto del Barrio (EPDB) and the Asian American Drug Abuse Program (AADAP).

Activity 4.2. Implement individual, family and group discussions and other activities for the perinatal service center participant. Evaluation Specification: Individual, family and group discussion activities have been implemented at the two perinatal service centers. This activity was mostly achieved. Both PSCs offered individual, family, and group counseling sessions. Participation of family members in treatment, however, was somewhat erratic, especially since spouses and partners of many enrolled women were themselves drug users.

Activity 4.3. Develop and implement networking activities interfacing with private, public and quasi-public obstetric and postpartum services. Evaluation Specification: Networking activities have been implemented at the two perinatal service centers interfacing with private, public, and quasi-public obstetric and postpartum services. This activity was accomplished. One PSC was able to offer on-site medical services for pregnant and postpartum women and their children. The other PSC referred clients to off-site providers, including specialty clinics for women, for medical care. Staff from the PSCs estimated that all women received (or were referred to) primary medical care and, as needed, pregnancy/post-partum care. Between 40% and 50% received (or were referred to) medical care for their children. For most of its first three years of operation, however, one PSC lacked the resources to assure that all clients were tested for AIDS and Tuberculosis.

Activity 4.4. Develop interdepartmental collaborative agreements to access county contracted private and quasi-public perinatal and postpartum services ensuring pre- and post-natal care for pregnant and postpartum women. Evaluation Specification: Interdepartmental collaborative agreements accessing county contracted private and quasi-public perinatal and postpartum services ensuring pre- and post-natal care for pregnant and postpartum women have been implemented. These specifications were met. See discussion for Activity 4.3.
Activity 4.5. Develop and implement referral network, and extensive resource information and assistance to help project participant obtain health, medical and other human services. Evaluation Specification: Referral network and extensive resource information and assistance to help project participant obtain health, medical and other human services have been developed at both perinatal service centers. This activity was implemented. Fortunately, PSC staff were able to draw on the existing referral networks and resource information within their agencies. One agency had an on-site medical facility as well as a CRC that identified a broad range of local resources. The other had well established ties to regional service providers.

Activity 4.6. Develop and implement life skills training, health education sessions, and child development and parenting classes. Evaluation Specification: Life skills training, health education sessions, and child development and parenting classes have been implemented. Both agencies provided these services and classes as an integral aspect of their treatment plans. This evaluation did not attempt to determine how the concepts of life skills, health education, child development, and parenting were operationalized, however, so that we do not know the content of these services in detail.

Activity 4.7: Develop and implement in-service training to selected obstetric, neonatal and pediatric health care providers in public/private and county contracted health care services. Evaluation Specification: 50% of selected obstetric, neonatal, and pediatric health care providers in public/private and county contracted health care services received training. This objective was partially achieved. PSC staff spent considerable time and energy trying to develop training materials and interest medical providers in their services. Medical providers were, however, generally disinterested in attending the training sessions and attendance was low. Given the time needed to plan training activities and the lack of interest in the target audience, the PSCs concentrated their efforts in other areas.

Activity 4.8: Develop and implement vigorous linkages with project community resource centers, Dept. of Children Services, maternal/child health service, local regional health centers and other agencies ensuring that children ages 0-3 receive developmental assessment and services. Evaluation Specification: Vigorous linkages with project community resource centers, Dept. of Children's Services, maternal/child health services, local regional health centers and other agencies ensuring that children receive development assessment and services have been implemented. These activities were partly implemented. Both agencies were able to refer women and their children to agencies for developmental assessments, and one was able to provide some of the services on site. However, we could not determine the percentage of children receiving these
services. Linkages with other agencies varied in nature and degree. Both agencies worked closely with and received most referrals from the Department of Children's Services (DCS), but both expressed dissatisfaction with the intensity of DCS follow-up.

Activity 4.9: Develop peer support network for drug abusing pregnant women promoting supportive relationships with each other. Evaluation Specification: Peer support network for drug abusing pregnant women promoting supportive relationships with each other has been implemented. This objective was achieved, based on staff reports. Both agencies emphasized the development of strong peer support networks through group counseling, informal relations, recreational and social outings, and participation in 12-step groups. Both also tried to establish a physical environment conducive to peer interaction and support. The extent to which these networks continued beyond treatment and/or the degree to which the women themselves experienced a sense of belonging to a supportive network is unknown pending the results of the outcomes assessment.

Activity 4.10: Recruit, train, and supervise volunteer recovering women to lead education and discussion groups, physical fitness and social/recreational activities. Evaluation Specification: Recovering women have been recruited, screened, and trained to perform volunteer services. This activity was only partially implemented. Only one of the two PSCs used volunteers at the time the NBAR surveys were completed, and the total contributions of volunteers were modest. One problem with using recovering women as volunteers was that the programs had relatively few successful completers, due to both their short time of operation and high drop-out rates. However, between half and two thirds of the staff in each PSC were themselves recovering substance abusers.

Activity 4.11. Develop and implement relapse prevention training for project staff. Evaluation Specification: Relapse prevention strategies have been implemented at the perinatal centers. Interview respondents at both PSCs indicated that relapse prevention was included in the treatment regimen. Staff received training in relapse prevention.

Activity 4.12. Develop and implement participant alumni activities. Evaluation Specification: Alumni activities involving program graduates have been implemented. Both PSCs provided some means for program graduates to continue their ties to the agency, such as alumni activities, special events, or other on-site activities (e.g., 12-step meetings). Lack of interest among women was cited as a major obstacle to developing more alumni activities.

Activity 4.13. Develop and implement procedures for baby sitting activities at project sites. Develop and implement procedures for transportation assistance to project
participants. Evaluation Specifications: Transportation and baby sitting needs or project participants have been met. The evaluation specification was partly achieved. Both PSCs provided on-site baby sitting, but staff from both agencies mentioned that a lack of sufficient child care was an obstacle to women's entering and continuing in treatment. Some assistance with transportation was provided through the use of bus tokens, taxi vouchers, and the CRC-owned vans. Again, however, transportation problems were cited as a continuing obstacle to treatment.

Activity 4.14. Develop and implement the perinatal service center's physical environment which will maximize informal exchanges among women. Evaluation Specification: The perinatal center's physical environment maximizes informal exchanges among women. Both PSCs designed their physical environment to provide an informal, comfortable, and supportive place for women. The extent to which women in fact engaged in informal exchanges, however, is unknown.
Chapter III: 
Community Resource Centers

This chapter describes findings from the implementation evaluation related to the Community Resource Centers (CRCs), including the development of the CRC concept, the major activities and accomplishments of the CRCs, and challenges faced by the CRCs. This chapter focuses on the first Target Cities funding period, from project inception through August, 1993.

Information about the implementation and achievements of the CRCs were derived from three sources. First, interviews were conducted with all CRC directors. In addition, County ADPA staff and administrators, State ADP administrators, and CSAT program officers were interviewed about the history and development of the CRCs. Further, OPDF staff and directors were asked about their interactions with the CRCs. Second, observation at PAC meetings provided supplemental opportunities to learn about CRC activities and interactions. Third, project documentation and especially the quarterly reports provided descriptive information about CRC activities.

It was expected that the quarterly reports would offer additional information about the productivity of the CRCs, particularly regarding the numbers and types of referrals made by the CRCs. However, these data were too flawed for use in this evaluation. The tables published in the quarterly reports contain inaccurate legends, internal inconsistencies, and discrepancies from worksheets submitted by the CRCs. In addition, several key data elements were interpreted in different ways by different CRCs, and hence were impossible to interpret at an aggregate level.

The NBAR survey, which was also expected to provide quantitative data for this evaluation, was not well suited to the CRC functions. Although the CRC directors did complete the survey, their responses contained a high volume of missing data and inconsistencies, probably reflective of the poor fit between the CRC activities and the survey questions. For example, when asked if their units had performed certain types of assessments prior to obtaining CSAT support, about half the CRC respondents answered affirmatively, although the CRCs did not exist before CSAT support was provided. As a result of such problems, NBAR responses for CRCs are not presented here.

History of the CRCs

Although the idea of establishing central intake units as entry points to drug treatment is over 20 years old, the concept received fresh attention in 1990 when an Institute of Medicine assessment of drug treatment recommended the implementation of "utilization management" methods, including central intake.
Utilization management describes arrangements to define access to effective treatment while keeping costs at efficient levels (Gray and Field, 1989). Good utilization management works to ensure that a fully appropriate and needed range of services is used and that different service components are coordinated. The most fundamental principles of such management are that access to and utilization of care should be controlled and managed on a case basis by 'neutral gatekeepers' or central intake personnel (although the central intake function may need to be dispersed geographically). These personnel should be regulated by certification standards and undergirded by time-limited, performance-accounted licenses and contracts.\(^1\)

By centralizing the intake function, the Institute of Medicine argued that clients would benefit from higher quality assessments with more appropriate referrals and more intensive case management. The system would also benefit because higher cost treatment could be avoided when lower cost alternatives were available. A related recommendation was that all publicly supported treatment providers be required to participate in a "client-oriented data system" that would enable providers or administrators to track clients through the system and compile information about client characteristics and treatment duration, components, and outcomes. This type of information system is integral to the concept of utilization management.

OTI's RFA for Target Cities was released at about the same time the Institute of Medicine volume was in publication. The RFA required central intake as a key Target Cities strategy. The central intake requirement read as follows:

Establishment of enhancement of central intake and referral facilities, including automated patient tracking and referral systems, and the development of appropriate computer and management information system capabilities to support such facilities. (OTI, 1991, p.4)

In an appendix to the RFA, central intake units were described as serving "an entire city" in most cases from a single central location. The primary functions of the central intake unit were, at minimum:

...to evaluate the treatment needs of drug abusers, and to refer them to an appropriate external program for treatment. The unit would: interview applicants; put together a personal history; undertake medical, psychological, and other tests if required; and then supply the information to the treatment program. (OTI, 1991, p. 20)

In response to the RFA, one of the four key objectives on which the Los Angeles proposal was based was the development of "Regional Intake and Assessment Units" (RIAUs). The proposal argued that Los Angeles was too spread out to be served by a single intake unit for the entire city; instead, the establishment of five regional intake units were better suited to the city's needs. The proposal described these units as "magnets" that would attract residents in need of treatment and then provide "screening, intake and assessment, referral and client follow-up services" (p. 12). In addition, each unit would hire an outreach worker as a community liaison. The work of the RIAUs would be supported by the development of an "Automated Intake, Referral and Assessment System" that would function as an "integrated data collection and case tracking system" (p. 12).

The RIAU sites proposed by Los Angeles were not "neutral gatekeepers" as envisioned by the Institute of Medicine, however, but rather were long-established agencies serving diverse populations and regions within Los Angeles. All had been County-contractors for ten years or more.

Although both the proposed RIAU sites and the larger group of OPDF providers provided letters of support for the Target Cities plan, providers were minimally involved in proposal preparation and most were unfamiliar with the components of the Target Cities initiative. According to several observers, the announcement that regional intake units would be established was met with fierce resistance. Some providers had been working in drug treatment long enough to remember an earlier, unsuccessful attempt to implement central intake in Los Angeles in 1969-1974.

Local opposition to centralized intake was sufficiently strong that County officials decided a different approach was called for. Thus, County ADPA administrators worked with an outside consultant in the summer of 1990, meeting individually with agency directors to discuss the RIAU concept. Following this consultation process, the County suggested replacing the regional intake units with "community referral centers" that would have the primary mission of increasing clients' access to a range of services by building referral networks. After further discussion with providers, the concept of "Community Resource Centers" evolved.

Due to these changes, a comprehensive description about the mission and responsibilities of the CRCs was never produced. However, correspondence between the County and the State related to the changing nature of the CRCs and the first year contracts with the CRCs provide some clues about their evolving role. A January 18, 1991 letter from County ADPA Director Rochelle Ventura to Deputy Director of the State Department of Alcohol and Drug Programs John P. Erickson, proposed the
following change in project goals and objectives. This change was forwarded from the State to OTI for approval.

The Regional Intake and Assessment Unit (RIAU) component was reconfigured to reflect more of a community and environmental approach to the improvement of drug treatment services. The RIAUs are now known as Community Resource Centers. The automated intake, assessment and referral elements of the project remain a vital part of our overall goals and objectives. However, instead of physically centralizing this activity, all project sites, including the CRC, will have the capability and responsibility to conduct intakes, assessments and ancillary services referrals. Also, the CRC may refer project participants to its own outpatient drug program only if the participants meet admission requirements. However, referral of project participants who do not meet its own outpatient drug program admission requirements will be deferred to the Drug Abuse Program Office (DAPO) Information and Referral Unit... The principal focal activity of the CRCs will be on the development of dynamic ancillary and other human services networks and development of vigorous collaborative linkages between traditional as well as non-traditional human services providers. The CRCs will provide centralized support for area project outpatient drug and perinatal programs.

The first year contracts with CRC providers, administered on May 28, 1991, provide the following description of CRCs:

Community resource center services are services which include: collaborative and cooperative linkages with public and private social and health service providers; intake, assessment, and ancillary services referrals; development and maintenance of client-related ancillary resources; community planning and organizing activities; outreach and networking; network linkages support; increased access to a comprehensive range of specific services needed by each program client; and the utilization of computerized/automated intake and referral.

Thus over the one-year period from proposal submission to the establishment of contracts between the County and the providers (in May, 1991), the concept of RIAUs was replaced by CRCs, and their responsibilities shifted from providing centralized intake to developing a dynamic network of services and resources that could extend and support the efforts of outpatient drug treatment providers.

As a result of this revised role for the CRCs, the County Drug Abuse Program Office Information and Referral Unit was assigned a more significant role than previously, since CRCs were supposed to direct clients who were not suitable for their own agency to this unit. As a result, the project budget was adjusted to fund an additional staff member for this unit (see March 14, 1991 letter from Oscar Rascon to Queen Esther Watson).
One final change occurred during this year-long start-up period as well. The Asian American Drug Abuse Program (AADAP), one of the five agencies originally proposed to serve as an RIAU site, withdrew and was replaced by the West Area Opportunity Center (WAOC). Although early plans called for AADAP to serve the coastal region, the agency did not have a presence in that area. WAOC, however, was well established there.

County contracts with the five CRC sites were established on May 28, 1991; the effective date for the contracts was September 1, 1991, giving the CRCs 90 days for start-up. Unlike the OPDF providers which at least had established programs, the CRCs had to start from scratch, hiring staff (or moving agency staff into new positions), designing (and sometimes finding) office space, and developing program plans. First year allocations to CRCs were $107,561 each and were expected to increase slightly in subsequent years. Quarterly reports indicate that each CRC hired between three and five full-time staff, with up to six additional part-time staff, most of whom split their time between the CRC and other units within the agency.

The contracts between the County and the CRCs specified five activities the CRCs were to conduct within their region: (1) development of cooperative and collaborative linkages with service providers; (2) development of a "dynamic ancillary referral network"; (3) regular meetings with the OPDFs and (if applicable) PSC; (4) outreach, consultation and technical assistance services to participating drug treatment providers; and (5) development of intake and assessment services, including a walk-in client reception area; first level intake to be followed by referral either to the home agency or County Drug Abuse Program Office Information and Referral Unit; ancillary services referrals; and use of the new Management Information System.

Shortly after the CRCs began operations, the County signed a contract with the State Department of Vocational Rehabilitation (on September 21, 1991), at which point Vocational Rehabilitation counselors began working in each CRC at least one day per week. County ADPA hired a liaison to the Department of Public Social Service in December 1991, who also began at that time to rotate among the CRCs. A cooperative agreement for on-site medical services, including health screenings and testing for HIV and Tuberculosis, was established in the third project year.

Table 4 displays the names, locations, and agencies served by the five CRCs. A companion report (Greenwood and Mohamad [1994], *The Impact of the Target Cities Project on Drug Treatment Funding in Los Angeles, DRU-702*) shows that the agencies selected to administer the CRCs varied considerably in size (as measured by level of funding), program mix, and relationship to their OPDF program.
<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Modality</th>
<th>Planning Area</th>
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<tbody>
<tr>
<td>Behavioral Health Services</td>
<td>Community Resource Ctr.</td>
<td>East</td>
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<td>Behavioral Health Services</td>
<td>Outpatient Drug Program</td>
<td>East</td>
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<td>Behavioral Health Services</td>
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<td>LACADA</td>
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<td>Do it Now Foundation</td>
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<td>Sunrise</td>
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<td>San Fernando Valley</td>
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<td>El Proyecto del Barrio</td>
<td>Perinatal Service Center</td>
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<td>El Proyecto del Barrio</td>
<td>Outpatient Drug Program</td>
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<td>Tarzana Treatment Center</td>
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<td>IADARP</td>
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<td>La Clinica del Pueblo</td>
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<td>Watts Health Foundation</td>
<td>Community Resource Ctr.</td>
<td>South Central</td>
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<tr>
<td>Watts Health Foundation</td>
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<td>AADAP</td>
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<td>Avalon Carver</td>
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<td>People Coordinated Srvs</td>
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<td>West Area Opportunity Ctr.</td>
<td>Community Resource Ctr.</td>
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<td>Family Services of LA</td>
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<td>Didi Hirsch CMHC</td>
<td>Outpatient Drug Program</td>
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Activities and Accomplishments of the CRCs

The CRCs engaged in a variety of activities serving the needs of several different target audiences including:

(a) individuals seeking information about or access to substance abuse treatment;
(b) individuals already receiving substance abuse treatment and in need of ancillary support services (e.g., public assistance, medical care);
(c) individuals (both within and outside the drug treatment system) seeking information about or referrals to social services other than drug treatment;
(d) drug treatment agencies, especially but not exclusively Target Cities agencies; and
(e) other community-based organizations, agencies, and services.

Among the activities the CRCs conducted to support these diverse audiences were: developing cooperative agreements and referral networks; participating in community events and providing outreach services; conducting intakes and assessments; providing technical assistance to OPDFs and PSCs in their region ranging from responding to requests for information to offering workshops and training sessions; organizing monthly meetings of OPDFs and PSCs in their region; assisting in meeting clients’ transportation needs; participating in the Faith and (for three CRCs) Head Start Initiatives; and hosting staff from the State Department of Vocational Rehabilitation, a liaison to DPSS, and physician's assistants on a rotating basis.

Beyond this common core of activities, the CRCs tried to customize services to the needs of their region. The East Los Angeles and San Fernando Valley CRCs, for example, emphasized services to family and youth, particularly for Hispanics. The Coastal Region and South Bay CRCs concentrated on the development of a referral network of ancillary services. The South Central CRC focused at an early stage on obtaining health care and other basic services for clients entering outpatient drug treatment. Further, each CRC conducted some special projects of their own design, such as the development of a parenting manual or the distribution of holiday baskets to clients and community members.

Table 5 summarizes the activities of the CRCs, divided into seven categories. First, each CRC provided intake, assessment, and referral services. This included: serving as an initial contact for individuals or agencies seeking information about or referrals to drug treatment; conducting assessments using either the Client Intake and Assessment Instrument (CIAI) or, in the third project year, the MIS system; and providing referrals
### Table 5: Activities of the CRCs

<table>
<thead>
<tr>
<th>I. Conduct intakes and assessments; provide referrals &amp; case management</th>
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<tbody>
<tr>
<td>Conduct intake interviews or full-scale assessments</td>
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<tr>
<td>Refer new clients to drug treatment programs</td>
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<tr>
<td>Refer current clients to ancillary services that they need or want</td>
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<tr>
<th>II. Identify and facilitate the provision of ancillary services</th>
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<tr>
<td>Identify social and human services in the community</td>
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<tr>
<td>Develop formal and informal cooperative agreements</td>
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<td>Develop resource directories</td>
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<tr>
<td>Host DPSS staff liaison, Vocational Rehabilitation staff member, and medical providers</td>
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<th>III. Enhance the outpatient drug treatment system</th>
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<tr>
<td>Hold regular meetings with enhancement agencies</td>
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<tr>
<td>Provide technical assistance and training to enhancement agencies</td>
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<tr>
<td>Respond to requests for information and assistance from enhancement agencies</td>
</tr>
<tr>
<td>Train OPDF staff in use of MIS</td>
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<tr>
<td>Collect books, videos, brochures, and other resource materials</td>
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<th>IV. Outreach to community</th>
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<tbody>
<tr>
<td>Give presentations to community groups</td>
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<tr>
<td>Develop fact sheet and brochures about CRC for community members</td>
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<tr>
<td>Work on the Head Start and Faith Initiatives</td>
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<td>Help/refer community members even if they do not need or want drug treatment</td>
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<tr>
<th>V. Assist in meeting clients' transportation needs</th>
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<tbody>
<tr>
<td>Drive clients in van</td>
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<tr>
<td>Distribute bus tokens or taxi vouchers</td>
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<tr>
<th>VI. Conduct special projects (These are examples. Not all CRCs performed these special projects and some special projects are not listed here.)</th>
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<tbody>
<tr>
<td>Solicit donations for goods and services for clients and their families</td>
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<tr>
<td>Coordinate patient use of mobile medical facility</td>
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<tr>
<td>Obtain tickets to sporting or cultural events for clients</td>
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<td>Develop parenting manual</td>
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<th>VII. Planning and administration</th>
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<tr>
<td>Develop forms and procedures for use in CRC</td>
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<tr>
<td>Write quarterly reports, fulfill other paperwork requirements</td>
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<tr>
<td>Organize and conduct monthly meeting for regional enhancement agencies</td>
</tr>
<tr>
<td>Attend PAC, PAM, CRC, and other Target Cities-related meetings</td>
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<tr>
<td>Learn to administer the CIAI; Translate CIAI into Spanish</td>
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</table>
based on intake or assessment results. In addition, the CRCs assisted individuals both
within and outside the drug treatment system who needed referrals to other social and
human services, such as emergency food and shelter, medical care, counseling, or job
training. The involvement of CRCs in intake and assessment activities increased
throughout the first three years of the project. By the third project year, two of the CRCs
were conducting almost all the assessments for the OPDF within their agency. Other
clients were self-referred or referred from other social and human service agencies. The
CRCs’ involvement in intakes and assessments expanded even further during the
continuation funding period (years 4 and 5).

Second, each CRC contributed to strengthening the network of ancillary services
in their region. As described above, the CRCs served as host sites for the State
Department of Vocational Rehabilitation, a liaison to DPSS, and (in the third year),
physician's assistants for health screening and testing. The Vocational Rehabilitation staff
and DPSS liaison visited each CRC weekly; the physician’s assistants increased from four
to 16 hours per week per CRC. In this way, Target Cities clients could receive assistance
at the CRCs from staff who understood their needs and could coordinate ancillary services
with drug treatment.

As another strategy for strengthening the network of ancillary service providers,
the CRCs developed cooperative agreements to facilitate the provision of services to
Target Cities clients. Information about ancillary service providers were organized into
directories and made available to the enhancement agencies. One CRC, for example,
listed close to 500 agencies in their resource directory, including services for children,
youth and family services; health care (e.g., dental, medical, mental health); education;
emergency shelters and food distribution; employment and job training; housing assistance;
legal services; and drug treatment services such as outpatient and residential agencies,
detox facilities, and sober living homes.

Third, each CRC provided services directly to the enhancement programs in their
area. For example, most maintained resource materials (e.g., informational brochures,
books, and videotapes) that could be used for training and professional development.
They provided training to OPDFs and PSCs on the new Target Cities MIS, with follow-up
consultations as needed. They translated an assessment instrument (the Client Intake and
Assessment Instrument) into Spanish so that it could be administered to Spanish-speaking
clients. They also hosted monthly meetings for the OPDF and PSC agencies in their
region, which offered opportunities for joint problem-solving, dissemination of
information, and training and technical assistance. Most CRCs also periodically hosted
special training sessions, on a diverse array of subjects (e.g., AIDS, hearing loss, DPSS
policies, and dealing with difficult people), and they presented at County-sponsored training workshops.

Fourth, each CRC engaged in community outreach. Staff attended and, in some cases, co-sponsored community events such as health fairs. They spoke at meetings of local agencies, clubs, and community-based organizations. They developed a brochure introducing the CRCs to the community. The CRCs also participated in the Faith Initiative, seeking to improve linkages to local clergy, and three CRCs participated in a collaborative venture with Head Start (see Chapter VII).

Fifth, the CRCs provided assistance in meeting clients' transportation needs. Four of the five CRCs purchased vans and provided transportation services to OPDF clients to help them get to the CRC or other appointments and to attend special events and outings. All the CRCs had bus tokens and taxi vouchers to disseminate to clients in need of this assistance.

Sixth, each CRC could cite at least one, and usually several, special projects, ranging from development of a special parenting manual to arranging for a mobile medical van to visit enhancement agencies.

In addition to these activities, the CRCs devoted considerable time to planning and administration. Respondents uniformly mentioned that more staff time than originally anticipated was needed to establish the CRCs, respond to the reporting requirements of Target Cities, and attend meetings related to Target Cities. These administrative requirements cut into the time available for other activities.

When asked what they considered to be the major contributions of the CRCs to the system, the CRC directors cited improved services, access to a broader array of services, and increased system capacity. For example:

The resources we've been able to obtain for our clients (is the most important accomplishment). There are fewer homeless, fewer hungry people on the streets. Also, Target Cities has brought our agency together to respond to clients in a more coordinated and intensive way... The CRC has enabled (the agency) to handle more people.

It's been wonderful... The service providers don't have the time to do what we do. They can concentrate more on the treatment themselves, getting these people clean and sober. But we've been the ones to give (clients) a lot of the confidence and self esteem to get back out into the community. We've worked closely with Vocational Rehabilitation, Social Services. We help when (clients) need their physicals, their teeth fixed, their eyeglasses... Not only have we been able to provide the medical things that they need but life things. I mean food, clothes, a place to live... And the staff have gone out and had the time to work well with the clients, be able to follow
up on them, get their family, include them... Most communities don't have these services... Because of our services we make it a better place for everybody around.

I think because of our outreach and our resources we know the availability of services out there... Our hands aren't tied the way they used to be...

And we've gotten to know people at other treatment places... Because of our relationships the clients are being treated a lot nicer.

(The major impact is) Getting more people funneled into the system...

We've increased the number of people getting help. (And) the workshops and technical assistance (help) the community to get their needs met.

**Intakes and Referrals**

**Intakes.** A separate RAND report (Greenwood and Mohamad [1993], *Analysis of Quantitative Client Information Reported by Providers for the Los Angeles Target Cities Drug Treatment Program for the Period October 1990 - May 1993, DRU-568*) provides information about the clients served by the CRCs including the number of initial contacts, referral sources, the number of intakes begun and completed, client characteristics, and referrals to various treatment modalities. For example, between October 1990 and May 1993, CRCs reported a total of 5,923 client contacts, most (69%) by telephone. This represents 57% of all client contacts with Target Cities agencies. The CRCs initiated 2,801 intakes and completed 1,865 intakes. About one third (34%) of clients were primarily crack cocaine users, 23% used other forms of cocaine, and 14% were primarily heroin users.

Because the CRCs were more established and mature by the third project year, a closer look at the clients served during this year may be in order. Year-to-date figures in the 8/31/93 quarterly report show 7,687 "initial contacts" with the CRCs. Of these, roughly two thirds (65%) were telephone contacts and the remaining one third (35%) were walk-ins. The number of initial contacts reported by the CRCs ranged from a low of 698 to a high of 3,756 for the year.

Further investigation, however, reveals that different CRCs interpreted this data element in different ways. For example, the CRC with the largest number of initial contacts provided a count of all referrals that the CRC provided. If a single individual received more than two or three referrals in a single interaction with the CRC, these appear to have been counted separately. Further, the "initial contacts" for this CRC included contacts with individuals seeking drug treatment, contacts with individuals already in drug treatment and seeking ancillary services, and contacts with individuals who were not in drug treatment and were not seeking drug treatment. In contrast, another
CRC reported that their "initial contact" count included only people calling the CRC for the first time, seeking either substance abuse or ancillary referrals and services. Still another CRC reported that their "initial contact" count referred only to those seeking access to drug and alcohol services and did not include individuals seeking ancillary services. Due to this confusion in interpretation, the breakdowns of initial contacts by referral source are difficult to interpret. We cannot determine if differences across the CRCs reflect real differences in referral patterns as opposed to the different base used for reporting. As a result, these figures are not presented here.

Reports about completed intakes are more informative. The 8/31/93 Quarterly Report indicates that the five CRCs completed 2,541 intakes during 1992-93. The number of completed intakes per CRC ranged from a low of 417 to a high of 631 for the year. Over half (55%) of the completed intakes were females. Three quarters (74%) were between 25 and 44 years of age. Six percent (6%) were homeless, and another 4% lived in public housing. Almost half (44%) received public assistance. Ethnic breakdowns indicate that the largest percentage of completed intakes were Hispanic (41%), followed by black (34%), and white (21%). Other ethnic groups accounted for less than 1% each of completed intakes, for a total of 4% of all intakes.

Across all five CRCs, crack was the primary drug of abuse for 37% of completed intakes. Other forms of cocaine addiction followed, at 20%. Other primary drugs of abuse included heroin (15%), marijuana or hashish (9%), alcohol (6%), PCP (4%), and other hallucinogens (3%). All other primary drugs of abuse each accounted for no more than one percent of completed intakes, for a total of 6%.

Referrals. Although the quarterly reports did include some data on referrals, a variety of problems reduced their usefulness for this evaluation. The tables contained numerous internal inconsistencies, and the roll-up legend is inaccurate. Also, a follow-up interview with one CRC director indicated discrepancies between the numbers that were reported on worksheets submitted to the County and the numbers that were published in the quarterly reports. Further, the year-to-date figures for 1992-93 did not equal the sum of previous quarters. Finally, there again appear to be differences in the manner in which the CRCs interpreted the data elements.

The qualitative sections of the quarterly reports, however, offer partial insight into the referral activities of the CRCs. Specifically, copies of the Daily Register Log were provided for one CRC regularly in the 1992-93 quarterly reports, and copies of the Referral Log Form and accompanying Services Request Forms were provided for another CRC for the fourth quarter (June through August, 1993). The extent to which these
forms are representative of all CRCs, and all quarters, is unknown, and caution is therefore required in efforts to generalize from these records to all CRCs.

Records for one CRC for the quarter ending 8/31/93 indicate that the CRC received 375 requests for referrals during the quarter (noted on the Referral Log Form), for an average of 6.25 requests per work day. During this quarter, staff completed 269 Services Request Forms. (Although both the Referral Log and Services Request Forms provided information about referrals, the Services Request Forms had more complete information and therefore were used as the basis for this analysis. The findings for the Referral Log are generally consistent with those shown here for the Services Request Forms.) The 269 Services Request Forms addressed the needs of approximately 250 individuals. Outcomes of these requests are displayed in Table 6. (Note that there is some potential for error because this tabulation was done by hand and required some interpretation, e.g., of handwriting and abbreviations.)

<table>
<thead>
<tr>
<th>Referral or Service Provided</th>
<th>Percent Receiving*</th>
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</thead>
<tbody>
<tr>
<td>referred to non-Target Cities drug treatment providers</td>
<td>34%</td>
</tr>
<tr>
<td>referred to the home agency</td>
<td>13%</td>
</tr>
<tr>
<td>referred to Target Cities agencies outside the region</td>
<td>11%</td>
</tr>
<tr>
<td>referred to services other than drug or alcohol treatment</td>
<td>10%</td>
</tr>
<tr>
<td>scheduled or provided transportation</td>
<td>8%</td>
</tr>
<tr>
<td>referred to on-site ancillary services</td>
<td>5%</td>
</tr>
<tr>
<td>referred to Target Cities agencies in the region</td>
<td>4%</td>
</tr>
<tr>
<td>no referral -- client did not show for appointment or return call</td>
<td>15%</td>
</tr>
</tbody>
</table>

* Base = 269 Services Request Forms included in the Quarterly Report

This table indicates that about one third of those requesting services were referred to non-Target Cities drug treatment providers, including detox, residential, methadone maintenance, and outpatient. Slightly under one third (28%) were referred to Target Cities agencies; the CRC's home agency received the largest share of these referrals. About 10% were referred to services unrelated to substance abuse. Other services provided included transportation for Target Cities clients (8%) and access to on-site ancillary services (5%). Finally, 15% did not show up for scheduled appointments, did not return telephone calls, or reported that they changed their minds about treatment and therefore could not obtain referrals.
Both the Services Request Forms and Daily Log Forms for this CRC also noted the referring agencies from which requests originated. Approximately 17% of clients were referred to the CRC from the home agency, 10% were referred from other Target Cities agencies within the region, and 2% were referred from Target Cities agencies outside the region. Most others were self-referred, although a variety of agencies and organizations also sought services from the CRC.

Another CRC's Daily Register Logs were also included in the 1992-93 quarterly reports. The Logs for the third quarter (March through May 1993) were most easily read and were therefore used for this analysis\(^2\). These Logs listed a total of 1,042 referrals for the quarter provided through 859 client contacts, or slightly over 14 client contacts per work day. (Due to the large number of contacts, we could not determine an unduplicated count of individuals served.) As shown in Table 7 below, about one quarter (24%) of the referrals provided by the CRC were to services and programs within the home agency. Target Cities agencies in the region received 2% of referrals, while other Target Cities agencies received 4% of the referrals. Another 6% of referrals were provided to on-site ancillary services. The remaining 64% of referrals were made to non-Target Cities drug treatment providers and to other social services. (Note that there is some potential for error because this tabulation was done by hand and required some interpretation, e.g., of handwriting and abbreviations. Tables 6 and 7 cannot be directly compared, since the CRCs included different information in their logs.)

<table>
<thead>
<tr>
<th>Referral or Service Provided</th>
<th>Percent Receiving*</th>
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</thead>
<tbody>
<tr>
<td>referred to non-Target Cities agencies**</td>
<td>64%</td>
</tr>
<tr>
<td>referred to the home agency</td>
<td>24%</td>
</tr>
<tr>
<td>referred to on-site ancillary services</td>
<td>6%</td>
</tr>
<tr>
<td>referred to Target Cities agencies outside the region</td>
<td>4%</td>
</tr>
<tr>
<td>referred to Target Cities agencies in the region</td>
<td>2%</td>
</tr>
</tbody>
</table>

* Base = 1,042 referrals listed on Daily Register Log Forms
** includes both substance abuse and other services

As far as can be determined from these Logs, roughly one quarter (25%) of requests originated from programs and services within the CRC's home agency, and about 5% of

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\(^2\) Copy quality of some logs was poor, and some entries to these logs could not be read.
requests originated from other Target Cities agencies. The remainder were self-referred or originated in non-Target Cities agencies.

To the extent the referral information reviewed here is representative of the total group of CRCs, it suggests that, by the third project year, the CRCs were receiving six to 14 telephone or walk-in contacts per day, not including appointments with Vocational Rehabilitation, DPSS, and medical care providers. The largest percentage of the CRC referrals were made to non-Target Cities agencies and services, including both substance abuse treatment and other social services.

The referral information further suggests that the CRCs had substantially more contact with their home agency than with other Target Cities agencies. The home agency was more likely than the other Target Cities agencies in their region to initiate requests of the CRC, and the CRC was more likely to provide new client referrals to the home agency than to any other agency. Several factors might help to explain this pattern. Geographic proximity and organizational ties probably facilitated communications between the CRCs and other units within the home agency. In addition, these CRCs' home agencies offered a diverse array of programs and services, which perhaps contributed to relatively high numbers of referrals within these agencies. Further, clients may have sought out the CRCs because they wanted to use the services of those agencies.

Challenges and Barriers Facing the CRCs

Despite considerable progress in development of the CRCs during the first funding period, they did encounter a number of problems. Many of these were related to the start-up phase of operation and therefore would be expected to decline over time (e.g., during the continuation funding period). This section reviews the challenges facing the CRCs through August, 1993.

Project management and administration. The delay in establishing the MIS was a major problem for the CRCs, who were unable to coordinate intakes, assessments and referrals as originally planned without it. The CRCs also were hindered with regard to their case management goals by the absence of the MIS. Not surprisingly, CRC directors also felt their resources were insufficient for the jobs facing them. For example, one respondent said, "What we really need is... more money.” Several directors also felt that the project reporting requirements were excessive and that too much time was spent filling out reports and attending meetings. Given limited resources, they wanted to spend less time on administration and more time on direct service to clients, agencies, and community organizations.

CIAI. The Client Intake and Assessment Instrument (CIAI), introduced by CSAT to Los Angeles Target Cities in the fall 1992, was widely perceived as too long and
intrusive for use in an initial intake. CRC directors resented the top-down imposition of this instrument, felt it was of limited use as a clinical tool, and were concerned that it might deter clients from continuing in treatment. One director said:

I think these CIAIs take up a lot of time. We have the capabilities to do so much more for clients. I think that if the CIAIs could be reduced a lot it would (help)... Because it is intrusive and I don't think a lot of that stuff is necessary to do an appropriate assessment and referral... I mean those questions are very intense and they are very usable for treatment as a whole but I think that when you come in as an initial contact, they can turn a lot of clients off, especially when they're sitting there and they need treatment and they need treatment right away...It's very, very hard for them to sit through it.

At the time that the CRC director interviews were being conducted, the CIAI was in widespread use. Several months later, however, the implementation of the MIS largely ameliorated the problems associated with the CIAI, because the volume of information that was required by the County was revised downward.

**Lack of services.** A major responsibility of the CRCs was the development of a network of ancillary services. Yet a number of directors noted that some of the services most needed by clients were in short supply or unavailable. Low cost or free preventative medical and dental care was insufficient in several areas. Affordable child care was difficult to find in all regions. Some directors cited legal services as another unmet need. Appropriate long-term housing, especially for clients with children, was problematic. Several directors also mentioned a need for more county slots in detox programs.

**Building community relations.** All the CRC directors faced the challenge of introducing the concept of a Community Resource Center to a variety of public and private social service agencies and community based organizations. Most received a warm reception from the community and reported that significant progress had been made in raising community awareness of the CRCs and in developing strong relations with other service providers in the community. One director said, for example, "We're known with a very strong and good reputation within the community... but there's other people out there that don't know us.... so we're connecting."

At least one CRC, however, faced the challenge of overcoming community resistance or skepticism about the new CRC. One director explained:

A lot of people in the community are well known and they've been here for so many years... and all of a sudden we're going to these meetings and making ourselves known. We're the new kid in town and to get the trust
has really been difficult... There have been some agencies that have just stayed away from us.

**Relations with OPDFs.** The contractual and descriptive language about CRCs indicated that they were to serve both the community and the agencies in their region, but the exact nature and level of these services was not specified, thereby opening the door to a range of expectations. The relationships between the CRCs and the enhancement programs within the same agency were uniformly positive and productive. Relationships between the CRCs and the enhancement programs from other agencies, however, were often colored by distrust and confusion, with physical distance further limiting the levels of contact and assistance provided. Although substantial progress was made in improving relations, concerns remained into the third year of the project.

**Relations with OPDFs: The CRC perspective.** The CRC directors were aware of the need to build relations with the OPDFs and PSCs, and they devoted considerable effort toward achieving this goal. The CRC directors recognized that some administrators in the enhancement programs perceived the CRCs as favoring the home agency. In response, each CRC worked to establish an independent identity that acknowledged not only their link to their home agency but also their responsibilities to the broader community. The CRC directors also sought to open lines of communication and distribute resources as evenly and fairly as possible. Several directors provided compelling descriptions of this problem:

I think that in LA at large, some of the providers think that maybe we service the agency that's on site better. But we don't. We probably try harder (to service the others). They think that we're partial or biased or something just because we're housed somewhere. But understand that that's not the case.

When doing the CIAl, if you ask which OP program they want to go to they're going to say here, because it's the closest to where they live. It's clear that most of the clients coming through our CRC are going into treatment at (the home agency).

Having our agencies assigned to cooperate with us (is a barrier). Not only our agencies but other agencies in Los Angeles. They see us as more their enemy sometimes than as their ally. They think that we're taking away the clients or whatever, their numbers. They're always thinking about their numbers.

A related problem was that some OPDFs held unrealistic expectations with regard to both the volume and nature of CRC services, especially in the early months of the project. Because the CRC responsibilities had not yet been clarified, OPDFs and PSCs
maintained a wide variety of hopes and expectations, some of which were beyond the scope of the CRCs’ responsibilities. In addition, the challenges of start-up also limited the services that the CRCs could initially provide. Some CRC directors suggested that these unrealistic expectations contributed to provider resentment, especially since the CRCs received more funding than the enhancement programs. For example:

There's a fundamental problem: When the CRC was created, services were not in place. So we developed them as we went along. It would have been better to have them in place, establish exactly what it is that we could do. Because the CRC oversold what they could do... The programs have high expectations about what we can do for them.

The tension in the beginning was really bad. Even now, the CRCs are not in favor with the providers, and they'll always find fault with us. We know and accept this. We're prepared for it.

Another problem was that some OPDFs and PSCs did not comply with CRC policies and procedures for accessing the vans. The CRCs needed advance notice to schedule the vans and therefore established protocols for agencies to use in making requests, but some agencies did not consistently follow these protocols. If the agencies were unable to gain quick access to the van, however, the result was sometimes increased tension in their relationship with the CRC.

To address these problems and perceptions, the CRC directors and staff invested considerable effort in outreach to the OPDFs and PSCs within their regions. The monthly meetings with providers were an important, although not the sole, strategy for clarifying expectations and improving communication. Some CRCs also worked to educate the executive leadership of their own agency about the need for the CRC to be perceived as independent and working on behalf of all the Target Cities agencies in the region, not only the home agency. These efforts were successful in improving inter-agency relations, particularly at the level of line staff relationships.

(The solution lies in) keeping up communications, giving each other support, assistance. It's constant, ongoing... The meetings are important... It's kind of like a marriage. Always find out about areas for improvement, problems, or concerns.

(Agency name) doesn't use us quite as much because they like to be autonomous. But I send staff over there to deal with their clients or the counselors... That has been one of my priorities -- to establish good relationships.

We need to get information to counselors on how the CRC could help.
I'm not sure how to improve. We've always tried to provide the best possible services. We've always given them each the same opportunities. We've provided information in writing about what's available.

*Relations with OPDFs: The OPDF perspective.* OPDF staff and directors from agencies that sponsored CRCs were uniformly positive in their assessment of the CRCs’ services. Interview respondents from eight of the 11 OPDF agencies that were not linked to CRCs, however, expressed some concerns about relations with the CRCs. Some comments include:

(From the director of the OPDF in the same agency as the CRC): Our relationship with the CRC is very good... The CRC meets with the providers all the time. People are really being served by the CRC. The director is knowledgeable and well liked... (and) is extremely effective.

(From the director of a different OPDF in the same region): I haven't been real pleased with (the CRC). I've kind of felt that they had the services but there have been some barriers to us in trying to get access to them. For instance, we didn't even know what cooperative agreements they had established until the first time that we did the quarterly reports... But it felt like what they had was really for their program. It didn't feel like it was necessarily for our program... I don't know that they've specifically said to us, "What should we be doing?" or "What do you need of us?" Rather they've identified the needs that they thought were important for us.

(From the director of an OPDF in the same agency as the CRC): There was some resistance (toward the CRC) that has let up. This CRC staff is effective. They are fair about how they distribute resources, aren't biased toward one agency. There has been trust-building, meetings, ironing out, talking to the OPDF staff. I see it as a good system now.

(From the director of another OPDF director in the same region): I had (the CRC director) come here and talk to the staff but things then fell through the cracks. It's not a hostile relationship. I just feel a great conflict having the CRC attached to an OPDF. They should be one or the other... They do more for (the home agency) than for us. It's caused too many conflicts.

Similar patterns were observed in each of the five regions, although the intensity of these concerns varied.

Some OPDF directors were also disappointed by a perceived lack of service or assistance from the CRC, especially given the project resources devoted to CRCs. "Given the money, we could have gotten more," said one. Other respondents explained:

The CRC relationship has been a problem for us... There are some good things and they do try to help, but for the most part, we don't use the services. The trust factor is not there. I would like to be able to monitor
what the CRC does. I want to know how our input can be implemented...
I would like to know what services we should be able to take advantage of.

Relations are difficult at best. There are some personality conflicts, which
we have all worked hard to overcome... But they are slow to respond, for
example, in getting the van for transport. And although we're supposed to
have monthly meetings, we went for months without one. And the
meetings I've attended have been a waste of time...

Further, some OPDF directors found the efforts and activities of the CRC to be of
little assistance to them, generally due to geographic distance or because the enhancement
program was engaged in similar activities. For example, some OPDF agencies had pre-
existing ties to Vocational Rehabilitation that met their needs, so they did not need the
CRC to help them make this connection. Others had their own ties to service providers.
One OPDF director said of the CRC:

They've done a lot of developing service agreements but a lot of the
resources we already had before or else they are not accessible to our
clients. Either they're too far away or the fees are too high... When we
have a client with a need for a particular service, if we call the CRC, they
call back with something we already had. There's not all that much around.

OPDF respondents also noted that they received few new client referrals from the
CRCs. Of the 11 OPDFs that did not include a CRC within the home agency, seven
reported receiving between zero and three referrals over the past month. (The other four
agencies did not answer the question, either because they did not have the information or
were not asked due to time limitations.) These reports could not be empirically verified.
The referral information for two CRCs presented in the previous section, however,
indicates that the CRCs provided OPDFs outside their home agency with up to 15 new
client referrals per quarter, or about 5 new clients per month if 100% followed through on
the referral. CRC directors further explained that their referrals reflected a variety of
factors including the clients' stated preferences, place of residence, language, or other
needs. The perception among OPDFs that CRCs were providing them with low numbers
of referrals, however, fueled concern that the full implementation of centralized intake
within Los Angeles would disadvantage agencies that did not house a CRC. Since referral
procedures have changed substantially in the continuation funding period for Target Cities,
it is likely that OPDFs are now obtaining many more new client referrals from the CRCs,
and provider concerns about this issue may be decreasing.

Uncertainty about the future, including whether CRCs would continue to exist
beyond the Target Cities project, discouraged providers from vigorously striving to
improve relations with the CRCs. Providers who did not support the CRC concept or
were concerned about the possibility of centralized intake had an added disincentive to work out their differences with the CRCs. Under these conditions, the directors had little motivation to support the CRC or use the services they were offering. Instead, these providers assumed a passive "wait and see" stance. This left the CRCs in a double bind -- their long-term prospects depended in part on the quality of relations they could establish with providers, yet providers had low motivation to work on these relations until they believed that the CRCs were a permanent fixture.

Nonetheless, this evaluation found some evidence of improvement over time. Three OPDF respondents from agencies that did not include a CRC described patterns of increasing contact with, and reliance upon, the CRC. Almost all the agencies were able to cite examples of one or more special services their CRC provided, ranging from TB tests for staff and clients to distribution of holiday baskets and taxi vouchers. Further, the strong relations between OPDFs and CRCs within the same agency provided a model of CRC-OPDF collaboration that could be emulated elsewhere.

Summary

The transition from RIAUs to CRCs left a legacy of ambiguity about the mission of these units. If CRCs are to be effective in their serving the outpatient agencies in their regions, both CRCs and OPDFs must share the same set of expectations about their mutual responsibilities. In addition, the CRCs must be able to provide services that are valued and needed by the agencies. They also must be perceived as fair, impartial, and supportive of the agencies. Unfortunately, none of these conditions were consistently met during the first three years of the Target Cities project in Los Angeles.
Chapter IV:
Outpatient Drug Free Providers

Close to $4 million -- almost one third of the total budget -- were allocated to the 17 OPDFs involved in Target Cities over the three-year funding period. OPDFs received more funding in total than any other component of the project. In this chapter, we describe the implementation of Target Cities within the OPDFs, including perceived accomplishments, effects of Target Cities on OPDF services and organizations, and the challenges and problems OPDFs faced related to Target Cities.

We obtained information about the implementation of the Target Cities project within OPDFs from four sources. First, we received copies of responses to the NBAR survey for each of the 17 OPDF providers. This report presents results for those survey items of most relevance to Los Angeles. For example, items related to residential treatment were excluded since the Los Angeles Target Cities project included only outpatient providers. Items related to revenues were also excluded because the completed surveys had large amounts of missing data and answers that were clearly incomplete and/or inconsistent with other, more credible information sources (i.e., County records). The sections of the questionnaire that contribute to an understanding of the Los Angeles OPDF providers concern: (a) use of Target Cities support for assessment procedures; (b) treatment services and intensity; (c) use of CSAT support for medical and health-related services; (d) types of staff hired with Target Cities support; (e) use of Target Cities support for staff training; and (f) use of Target Cities support to improve or renovate treatment facilities and equipment. Survey instructions asked respondents to answer the survey based on the reference year June 1, 1992 to May 31, 1993.

Although the NBAR asked respondents to describe changes in their organizations over time, we cannot determine from these responses alone whether such changes can be attributed to the impact of the Target Cities project. Thus, to provide additional information that would help determine the effects of Target Cities on OPDF agencies, the evaluation team administered a modified NBAR to a comparison group of eight OPDF agencies (see methods section in Chapter I for more information).

Due to the small sample size (17 experimental and 8 comparison group agencies), tests of significance do not yield statistically significant results. In this chapter, we present differences between groups that appear conceptually (though not statistically) significant. Interpretation of these comparisons must be approached with caution. Extreme values from a single provider can have a strong effect on means or frequency distributions.
It was expected that additional quantitative information about OPDFs could be obtained from the quarterly reports. However, inconsistencies and inaccuracies in these reports reduce their usefulness for evaluation purposes. More specifically, the number of clients served by OPDFs appears to be significantly overstated in the 1992-93 quarterly reports. Further, data elements for ancillary services received by OPDF clients were intended to indicate unduplicated counts, but appear to be a mixture of duplicated and unduplicated counts across the OPDF agencies. Thus, only a small proportion of the quarterly report data are relevant to this evaluation.

Supplementing the quantitative data obtained from NBAR results are interview findings. At least one representatives from each participating agency was interviewed to determine: (a) how Target Cities funds were being used within the agency; (b) the effects of Target Cities on agency structure and staffing, activities and services, and linkages and external relationships; (c) factors that hindered or facilitated implementation of the Target Cities plan; and (d) attitudes toward Target City, including perceived effectiveness and suggestions for increasing program effectiveness. Interviews with County, State, and federal administrators also provided information about the OPDFs. Most interviews were conducted between April and August 1993.

Finally, observation at PAC meetings and training sessions provided additional opportunities to learn about the activities and interactions of the Target Cities OPDFs.

**History of OPDFs in Target Cities Project**

In most Target Cities nationwide, the enhancement plan involved a variety of modalities including outpatient drug free (OPDF), residential, detox, and methadone maintenance. In Los Angeles, however, only one modality -- OPDF -- was involved. The primary purpose for the emphasis on OPDF was a widespread perception by County and State administrators that this modality most needed strengthening. Interviews with a variety of County officials involved in proposal preparation and/or early planning related to Target Cities indicated that the focus on OPDF providers grew out of concern about low rates of treatment completion coupled with the recognition that OPDF providers were facing new challenges (e.g., serving women with children, HIV positive clients, and clients from a broad range of cultural and linguistic backgrounds). The original Target Cities proposal offers further justification for the decision to focus on OPDF providers:

Outpatient counseling services are more readily available following detoxification. However, due to the fact that these outpatient programs are understaffed, underfunded and often narrowly focused on drug specific counseling, client attrition rates for this modality are high. The client
frequently leaves the program before treatment completion because a comprehensive follow-up and aftercare are not available.

The need for special on-site of ancillary services in all outpatient programs is critically important for client retention and successful treatment outcome. Our annual Client Treatment Satisfaction Survey has regularly documented client satisfaction with drug counseling staff but also frustration because other needed support or special services were not available.

The ethnic and cultural diversity of Los Angeles has created additional difficulties in client retention rates. Services and staff in outpatient programs do not always reflect the target service group, nor are they specially trained in multicultural issues and needs. (pp. 8-9)

A supplemental reason for focusing on OPDFs was that other modalities, especially residential, were receiving increased levels of support through other means.

The funding guidelines for Target Cities limited participation only to providers who were located within City limits. The locally developed Target Cities design further limited participation to OPDFs that: (1) served an adult co-ed population, and (2) were already existing country contractors in good standing.

The original Los Angeles Target Cities proposal described several ways in which Los Angeles would enhance outpatient treatment. Of most relevance to OPDFs was the key objective, "Improve retention and decrease relapse rates of clients, particularly persons of color, by increasing the comprehensiveness and intensity of outpatient drug services." Specific activities linked to this objective in the proposal and relevant to the OPDFs included: (1) increasing the number of staff in each program to achieve a maximum 1:20 staff to client ratio; (2) hire new staff and train existing staff to ensure the provision of bilingual and bicultural services; (3) develop and implement minimum training standards for staff development and provide training for all staff; (4) implement ongoing case management services for all clients; (5) implement relapse prevention, family counseling, and aftercare services; and (6) provide funding for child care and transportation services to ensure equal access to services. These activities were to be implemented within 18 agencies who had contracts to provide outpatient substance abuse services for the County.

Following funding, at least two changes relevant to the OPDFs were implemented. First, the number of participating agencies was reduced from 18 to 17. One OPDF was considered "high risk" at proposal preparation and was subsequently unable to make the changes required to be removed from this probationary status. It was therefore dropped from the Target Cities program early in 1991. The funds allocated to this provider were redistributed among the remaining participants.
Second, the focus of staffing changed from reducing staff to client ratios to increasing links with ancillary services. For example, an attachment to a January 18, 1991 letter from County ADPA Chief Rochelle Ventura to State Department of ADP Deputy Director John Erickson described a departure from the original plan to reduce staff to client ratios:

The outpatient drug program (ODP) emphasis has also been varied to incorporate a stronger community planning and environmental perspective. From conversations with our providers, we have determined that client services in this modality can best be enhanced by addressing the client's "distal" systems needs (i.e., housing, mental health, medical, job, child services, financial, social services, vocational, education, perinatal, and legal). We have determined that the original objective to decrease client-to-staff ratios to allow existing staff more time with their clients will not facilitate these needs.

The letter went on to propose an augmentation of ODP counseling staff with the equivalent of a half time "community worker" for each site rather than additional counseling staff. (The March, 1991 Management Implementation Plan, however, was less clear about staffing, including an objective to reduce the "staff-to-client ratio" but specifying only that staffing patterns should "ensure the provision of and access to bilingual and bicultural services.")

The final set of participants, then, included 17 ODP units from 16 different agencies. Each was budgeted an allocation of $75,649 per year. The contracts between the County and the providers stipulated that ODPs were expected to provide the following services:

A. Ensuring that the client is registered in the Management Information System (MIS).
B. Completion of in-depth assessment of clients.
C. If the client is deemed unacceptable for agency services, agency calls ADPA for appropriate referral.
D. Working with the nearest community resource center for housing, vocational rehabilitation, social services, health services, and other client needs.
E. Collection and inputting of intake and assessment data into the MIS.
F. Collection and inputting of discharge data into the MIS.
G. Providing services to previously unserved ethnic clients with limited English speaking capability.
H. Providing networking and community outreach to increase linkage to specific services needed by program clients.

In addition, each provider was required to establish measurable objectives in ten of 14 areas: (1) awareness and education presentations; (2) community outreach and linkages; (3) community events and special projects; (4) social and recreational activities; (5) alumni activities; (6) resource library; (7) parenting enrichment; (8) life skills education; (9) health, fitness, or nutrition education; (10) home visits; (11) community support groups; (12) evening hour activities; (13) technical assistance; and (14) volunteers.

Activities and Accomplishments of the OPDFs

As described above, OPDFs were responsible for implementing at least ten supplemental services from a list of such services developed by the County. The Target Cities continuation proposal provides aggregate measures of OPDF accomplishments. Table 8 reproduces the proposal’s report on OPDF enhancements.

<table>
<thead>
<tr>
<th>Type of Enhancement Activity</th>
<th>Number of Clients Attending (9/91 through 5/93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness/education presentations</td>
<td>3,969</td>
</tr>
<tr>
<td>Community outreach/linkages</td>
<td>5,338</td>
</tr>
<tr>
<td>Community events/special projects</td>
<td>2,201</td>
</tr>
<tr>
<td>Social/recreational activities</td>
<td>3,587</td>
</tr>
<tr>
<td>Alumni/aftercare activities</td>
<td>1,353</td>
</tr>
<tr>
<td>Parent enrichment activities</td>
<td>2,222</td>
</tr>
<tr>
<td>Life skills training</td>
<td>1,537</td>
</tr>
<tr>
<td>Health, fitness, or nutrition training</td>
<td>645</td>
</tr>
<tr>
<td>Community support groups</td>
<td>3,364</td>
</tr>
<tr>
<td>Technical assistance</td>
<td>615</td>
</tr>
<tr>
<td>Evening hour activities</td>
<td>4,888</td>
</tr>
<tr>
<td>Home visits</td>
<td>212</td>
</tr>
<tr>
<td>Volunteer hours</td>
<td>2,413</td>
</tr>
</tbody>
</table>

1 Source: County of Los Angeles, Department of Health Services, Alcohol and Drug Program Administration (June 25, 1993), Los Angeles Target Cities Project Continuation Proposal, pp. 37-38.
Caution is required in using these data based on the confusion evident in the quarterly reports regarding duplicated and unduplicated counts. The evaluation team did not have any means to independently verify this table. The results suggest that the 17 OPDFs reached large numbers of clients through supplemental services. Evening hour activities, educational presentations, social activities, and community support groups were among the most widespread enhancements.

Table 8 reflects the widespread implementation of supplemental services, but these numbers do not indicate which services were perceived as most significant or important by providers. Therefore, as part of the interview, each OPDF respondent was asked to describe the most important changes their agency implemented in response to the Target Cities project. Their top of mind responses by no means indicate all ways in which Target Cities prompted change in OPDFs, but do provide valuable clues about how OPDFs perceived and prioritized their responsibilities. Ten (10) of 17 providers responded to this question without focused probing. Table 9 summarizes their responses. Over half mentioned that stronger linkages with community agencies was a major contribution of the Target Cities program, enabling the agencies to better able to meet clients' ancillary needs. For example:

The key effect of enhancements is making more doors available for post-treatment... We're doing this through networking, creating referrals, cooperative agreements... Our treatment services are basically the same... Mainly it's just networking more within the community, bringing a cohesion to the treatment process, having more options for dealing with all of the problems that surround drug use -- homelessness, hunger, poverty, violence.
Table 9: Major Accomplishments of OPDFs in the Los Angeles Target Cities Project

<table>
<thead>
<tr>
<th>Type of Accomplishment</th>
<th>% Mentioning*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved referrals, linkages to community, &amp; ability to meet clients’ needs other than substance abuse counseling alone</td>
<td>60%</td>
</tr>
<tr>
<td>Improved case management</td>
<td>40%</td>
</tr>
<tr>
<td>Increased staffing</td>
<td>30%</td>
</tr>
<tr>
<td>Improved client access to health care</td>
<td>30%</td>
</tr>
<tr>
<td>Improved direct services to clients, such as better counseling, education or treatment</td>
<td>30%</td>
</tr>
<tr>
<td>Provided social/recreational services</td>
<td>20%</td>
</tr>
<tr>
<td>Brought agencies together</td>
<td>20%</td>
</tr>
<tr>
<td>Improved ability to assist with transportation</td>
<td>20%</td>
</tr>
<tr>
<td>Acquired training &amp; informational resources</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Base = 10 OPDF agencies

Note: Responses sum to more than 100% since some respondents cited multiple accomplishments.

Other major achievements of the Target Cities project from the point of view of OPDF administrators were improved case management (mentioned by 40% of respondents), increased staffing (30%)², better access to health care for clients (30%), improvements to counseling or other direct services provided to clients (30%), the ability to provide social/recreational services for clients (20%), more unity among providers (30%), the ability to assist clients with transportation between home and the OPDF (20%), and acquiring information and training materials (10%).

Some OPDF agencies (approximately three) used their Target Cities funds to support basic operations. Most (about 11) used their Target Cities funds for incremental improvements such as new staff or ancillary activities. A third group, however, (approximately three) seemed to more fully integrate Target Cities activities and

² Note that most OPDFs used Target Cities funding to support staff. This table reflects the percentage of interview respondents citing increased staff as a "major accomplishment" of the project.
philosophy into their program structure and operations. Agencies that were fiscally healthy and organizationally stable before the Target Cities project were better able to implement enhancements. One administrator commented, "There has to be something there to enhance in the first place for Target Cities to work."

In the following sections, we provide more detailed information about the effects of Target Cities on specific elements of the OPDF agencies' programs, including: intakes and assessments, direct services, ancillary services (both non-medical and medical), staffing, and facilities.

**Intakes and Assessments**

**Intakes.** As described in a companion report (Greenwood and Mohamad [1993], *Analysis of Quantitative Client Information Reported by Providers for the Los Angeles Target Cities Drug Treatment Program for the Period October 1990 - May 1993, DRU-568*), the OPDFs initiated 2,917 intakes and completed 1,902 between October 1990 and May 1993. Slightly under one third (35%) of clients seen were primarily crack cocaine users, followed by other forms of cocaine users (20%), and heroin users (12%). OPDFs offered referrals to about 2,580 clients; of these, 43% were referred for OPDF treatment, while the remainder were referred to residential (30%), detox (21%), intensive outpatient (3%), and methadone maintenance (2%). As discussed earlier, however, much of the quantitative information in the quarterly reports cannot be used for evaluation purposes due to poor data quality.

**Assessments.** The NBAR survey included questions about eight different types of assessments. Respondents were asked to indicate if they had access to these assessments, either on-site or off, whether the assessment was conducted prior to the Target Cities project, and how often the assessments were done. They were also asked to rate the impact of Target Cities on the assessment as either negative, neutral, or positive. Table 10 below summarizes responses.
Table 10:
Impact of Target Cities on Assessment Capabilities of OPDFs

<table>
<thead>
<tr>
<th>Type of Assessment</th>
<th>% with access (either on or off-site)</th>
<th>% with access before Target Cities</th>
<th>How often done (mean % of time)*</th>
<th>% rating effect of Target Cities as positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>100%</td>
<td>92%</td>
<td>89%</td>
<td>50%</td>
</tr>
<tr>
<td>Financial</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>54%</td>
</tr>
<tr>
<td>Psychiatric (by a nurse or technician)</td>
<td>45%</td>
<td>27%</td>
<td>50%</td>
<td>27%</td>
</tr>
<tr>
<td>Psychiatric (by a psychiatrist)</td>
<td>58%</td>
<td>33%</td>
<td>25%</td>
<td>36%</td>
</tr>
<tr>
<td>Physical (by a nurse-practitioner)</td>
<td>58%</td>
<td>36%</td>
<td>98%</td>
<td>46%</td>
</tr>
<tr>
<td>Physical (by a doctor)</td>
<td>86%</td>
<td>58%</td>
<td>85%</td>
<td>71%</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>93%</td>
<td>92%</td>
<td>96%</td>
<td>50%</td>
</tr>
<tr>
<td>AIDS test</td>
<td>93%</td>
<td>75%</td>
<td>43%</td>
<td>50%</td>
</tr>
<tr>
<td>TB test</td>
<td>86%</td>
<td>58%</td>
<td>63%</td>
<td>57%</td>
</tr>
</tbody>
</table>

* Base = Those with access to the assessment

Note: Due to missing data, cell sizes range from 3 to 14.

The results indicate that the Target Cities project increased providers' access to each type of assessment, with the exception of financial and urinalysis assessments, both of which were already in widespread use. For example, the percentage of providers with access to psychiatric evaluations by a psychiatrist increased from 33% prior to the Target Cities project to 58% by the time the NBAR was administered. Access to physical exams by a medical doctor rose from 58% to 86%, and the number of providers able to administer AIDS tests rose from 75% to 93%.

Comparisons of Target Cities agencies to eight non-participating agencies is consistent with the conclusion that Target Cities increased the range of assessment resources available to providers. As shown in Table 11, a higher proportion of Target Cities OPDFs than comparison group OPDFs provided each type of assessment, with the exception of psychiatric evaluations by a psychiatrist. Attribution of these differences to Target Cities, however, must be approached with caution. For example, our findings give
little cause to believe that Target Cities increased providers' access to or use of urinalysis tests, although we find substantial between-group differences for this item.

Table 11:
Comparison of Target Cities vs. Comparison Group OPDF Assessment Capabilities

<table>
<thead>
<tr>
<th>Type of Assessment</th>
<th>% of Target. Cities OPDFs with access on- or off-site</th>
<th>% of comparison OPDFs with access on- or off-site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Financial</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Psychiatric by a nurse</td>
<td>45%</td>
<td>33%</td>
</tr>
<tr>
<td>Psychiatric by a psych.</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td>Physical by a nurse prac.</td>
<td>58%</td>
<td>33%</td>
</tr>
<tr>
<td>Physical by a doctor</td>
<td>86%</td>
<td>57%</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>93%</td>
<td>50%</td>
</tr>
<tr>
<td>AIDS test</td>
<td>93%</td>
<td>63%</td>
</tr>
<tr>
<td>TB test</td>
<td>86%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Interviews with OPDF directors and staff supplemented NBAR results. Consistent with the survey responses presented here, interview respondents noted that Target Cities increased their access to assessment resources, particularly related to clients' physical and mental health needs. In addition, the interview respondents identified two other changes associated with the Target Cities project: the implementation of the Client Intake and Assessment Instrument (CIAI), and the development of the MIS. Providers were sharply critical of the Client Intake and Assessment Instrument (CIAI), and also expressed concerns about the MIS (see Challenges and Barriers section later in this chapter). Thus, the positive impact of Target Cities with regard to increasing access to assessment resources was offset to some degree by frustration related to instrumentation and the MIS. Direct Services

Providers were asked about how the Target Cities project had changed the nature of the direct services they provided to clients, including individual, family and group counseling and education services. OPDF respondents described a wide diversity of enhancements, particularly life skills training, drug education, parenting, nutrition, health and fitness, social and recreational activities, groups for women or Spanish-speaking clients, increased family counseling, self-help groups, and alumni groups. These "top of mind" responses are summarized in Table 12.
Table 12:
Perceived Impact of Target Cities Project on Direct Services:
Top of Mind Responses in Interviews

<table>
<thead>
<tr>
<th>Service</th>
<th>% mentioning*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life skills group or class</td>
<td>25%</td>
</tr>
<tr>
<td>Social or recreational events for clients or alumni</td>
<td>25%</td>
</tr>
<tr>
<td>Parenting classes</td>
<td>19%</td>
</tr>
<tr>
<td>Guest speakers</td>
<td>19%</td>
</tr>
<tr>
<td>Physical exams or other health care</td>
<td>13%</td>
</tr>
<tr>
<td>Group sessions for youth in school</td>
<td>6%</td>
</tr>
<tr>
<td>Family counseling</td>
<td>6%</td>
</tr>
<tr>
<td>Drug education curriculum</td>
<td>6%</td>
</tr>
<tr>
<td>Spanish-speaking therapy</td>
<td>6%</td>
</tr>
<tr>
<td>Self-help groups</td>
<td>6%</td>
</tr>
<tr>
<td>More time for direct services</td>
<td>6%</td>
</tr>
<tr>
<td>Health classes (including education about STDs)</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Base = 16 OPDF agencies
Note: Responses sum to more than 100% since some respondents cited multiple enhancements.

Table 12 indicates that about one quarter of OPDF respondents cited the introduction of life skills training and social or recreational events as key enhancements linked to Target Cities. Slightly under one fifth cited parenting classes and guest speakers as significant enhancements. Life skills activities ranged from interpersonal skill development to practice advice on issues such as money management. Life skills training was expected to fill gaps in clients' skills and knowledge and thereby strengthen their coping skills. Social and recreational activities included outings to museums, sporting events, and performances as well as parties and picnics. These activities helped to clients strengthen their bonds to the OPDF agency, develop supportive relations with others, and
learn how to spend leisure time when they are not using drugs. The social activities also enabled staff to observe clients in non-treatment settings. Parenting classes reflect the growing numbers of women in treatment and were intended to help clients break negative intergenerational cycles and also build their own abilities to cope with the stresses of being a parent. Guest speakers spanned a broad array of subjects and offered opportunities to combine the benefits of life skills training with those of social events.

The diversity of enhancements suggests that providers adopted those innovations that were perceived as most useful for their clients (within the constraints of available resources). Implementation of enhancements such as life skills, health, drug education, relapse prevention, or parenting training varied widely, ranging from one-shot presentations by guest speakers to fully developed curricula. It is beyond the scope of this evaluation to document all the variations in direct services, much less to attempt to determine their impacts. The outcome evaluation (forthcoming) will describe in more detail the impact of the overall Target Cities project on client outcomes.

The NBAR provides more standardized information about the impact of Target Cities on direct services. Of particular relevance are items related to treatment intensity and services to special populations.

**Treatment intensity.** NBAR questions examined the impact of Target Cities on the intensity of treatment, as measured in two ways — the number of treatment sessions received by a "typical" client, and the frequency or length of treatment sessions. Questions addressed five components of treatment: group counseling, individual counseling, classroom-type sessions, 12-step meetings, and urinalysis testing. Results are summarized in Table 13.

<table>
<thead>
<tr>
<th>Table 13: Impact of Target Cities on Treatment Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Has Target Cities led to...</strong></td>
</tr>
<tr>
<td>( % responding &quot;yes&quot;)</td>
</tr>
<tr>
<td>Type of session</td>
</tr>
<tr>
<td>Group counseling</td>
</tr>
<tr>
<td>Individual counseling</td>
</tr>
<tr>
<td>Classroom-type sessions</td>
</tr>
<tr>
<td>12-step meetings</td>
</tr>
<tr>
<td>Urinalysis tests</td>
</tr>
</tbody>
</table>

*Note: Due to missing data, cell sizes range from 10 to 13.*
The table indicates that Target Cities was associated with an increased frequency of both classroom activities and group counseling, with less widespread effects on individual counseling, 12-step meetings, and urinalysis tests. Increased group and classroom sessions reflects the emphasis within the Los Angeles Target Cities project on services such as life skills training and relapse prevention, which are often delivered in these settings.

Comparison of the frequency with which Target Cities and non-Target Cities OPDF agencies provided various treatment sessions supports the finding that Target Cities promoted increased frequency of group and classroom-type sessions. On average, a typical client in a Target Cities OPDF agency attended a group counseling session more than once a week, while a typical client in a comparison group agency attended group counseling just once a week. Similarly, a typical client in a Target Cities agency attended a classroom-type session 2-3 times a month, compared to once a month for clients in comparison group agencies. No differences were observed in the frequency of 12-step meetings. Clients in comparison group agencies, however, participated in individual sessions slightly more often than did clients in Target Cities agencies (once per week for comparison group clients compared to less than once per week for Target Cities).3

Services to special populations. One section of the NBAR questionnaire probed how CSAT affected services to four special populations: dual diagnosed; abused or battered; pregnant; and on probation or parole. Table 14 below displays responses.

Most of those responding (90%) characterized Target Cities as having a moderate to strong impact on services for pregnant women. This is congruent with the original plans for the Los Angeles Target Cities project, which identified pregnant women as a target group. The least impact was perceived for services to those with dual diagnoses.

Table 14: Impact of Target Cities on Services to Special Populations

<table>
<thead>
<tr>
<th>Level of Impact Population</th>
<th>No Impact</th>
<th>Small Impact</th>
<th>Moderate Impact</th>
<th>Great Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Diagnosed</td>
<td>12%</td>
<td>63%</td>
<td>25%</td>
<td>0</td>
</tr>
<tr>
<td>Battered/Abused</td>
<td>12%</td>
<td>13%</td>
<td>75%</td>
<td>0</td>
</tr>
<tr>
<td>Pregnant</td>
<td>0</td>
<td>10%</td>
<td>70%</td>
<td>20%</td>
</tr>
<tr>
<td>Probation/Parole</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Note: The number of agencies responding to these questions ranged from 8 to 10.

3 This evaluation did not address between-group differences in the content of these counseling sessions.
Other NBAR results indicate that, on average, about 47% of Target Cities OPDF clients served during the reference year (June 1, 1992-May 31, 1993) were on probation or parole, 35% were abused or battered, about 8% were pregnant, and 7% were dual diagnosed. By comparison, 41% of comparison group clients served during this time period were on probation or parole, 20% were abused or battered, 8% were pregnant, and 24% were dual diagnosed.

Ancillary Services

The majority of OPDFs sought to develop new services or referral sources in order to help clients meet needs beyond drug treatment. By striving to link OPDF treatment to other services that clients needed, respondents expected to increase treatment effectiveness and reduce retention. Clients would become more attached to the OPDF and see the agency as their primary site for services of all kinds. They would also be better able to focus on drug treatment because their other needs would be addressed.

OPDFs used four strategies to increase ancillary services. First, they had access to services available at the Community Resource Centers -- vocational rehabilitation, a DPSS liaison, and (later) medical screenings and assessment. Second, they could call upon the CRC for assistance in locating ancillary services. Third, they could build relations with ancillary service providers, including both formal cooperative agreements and more informal relationships. Fourth, they could expand the services provided by the outpatient unit itself.

The interview responses underscored the importance of this component to the Target Cities effort. Every agency reported an increase in the numbers and types of referrals that staff provided to clients for ancillary services. Agencies varied, however, in the vigor with which they pursued cooperative agreements and the degree to which they themselves tried to identify ancillary services versus relying on the CRC. OPDFs in the same home agency as the CRC (N=6) tended to rely on their CRC to identify ancillary services and establish cooperative agreements; the remainder were about evenly split between those who actively pursued cooperative agreements and those who assumed a more passive posture.

NBAR results provide further indication of the effectiveness of the Target Cities project in increasing access to ancillary services for OPDF clients. The discussion that follows considers non-medical ancillary services first, followed by medical services.

Non-medical services. As shown in Table 15 below, well over three quarters of the providers were able to facilitate clients' access to five different types of services: housing; child care; legal services; academic training; and vocational training. Further, the number of providers offering these services increased during the Target Cities project.
Most providers reported that they relied on CSAT support to either a "moderate" or "great" extent in delivering these services to clients. The exception to this pattern is legal services, for which only 39% of providers relied heavily on CSAT support.

Note that fewer than one quarter of clients received these ancillary services on average. We cannot determine from the NBAR responses the degree to which this reflects client demand or need for services versus availability (supply). Providers' comments in the interviews, however, suggest that, at least in some categories, the supply of needed services was insufficient to meet client needs.

Table 15:
Impact of Target Cities on OPDF Access to Ancillary Services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>% providing service (either on- or off-site)</th>
<th>% providing service before CSAT</th>
<th>mean % of patients receiving service*</th>
<th>% rating CSAT support as moderate or great</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Assistance</td>
<td>93%</td>
<td>43%</td>
<td>23%</td>
<td>77%</td>
</tr>
<tr>
<td>Child Care</td>
<td>86%</td>
<td>23%</td>
<td>27%</td>
<td>54%</td>
</tr>
<tr>
<td>Legal/paralegal</td>
<td>86%</td>
<td>31%</td>
<td>7%</td>
<td>39%</td>
</tr>
<tr>
<td>Academic training</td>
<td>86%</td>
<td>36%</td>
<td>11%</td>
<td>54%</td>
</tr>
<tr>
<td>Vocational training</td>
<td>86%</td>
<td>43%</td>
<td>19%</td>
<td>69%</td>
</tr>
</tbody>
</table>

* Base = Those with access to the service
Note: Due to missing data, cell sizes range from 8 to 14.

Although the NBAR questionnaire did not have questions about transportation services, such services were an important component of the Los Angeles Target Cities project. The OPDFs had access to bus tokens and (generally though the CRC) taxi vouchers for distribution to clients with transportation problems. The CRC vans also were used to help transport clients to special appointments and services. In interviews with the evaluation team, eight respondents mentioned improved access to transportation services as an important accomplishment of Target Cities; three had prior access to a van. The remainder either didn't mention transportation services (N=3) or had been largely unable to address this need (N=3).
Medical services. Enhanced access to medical care was a key component of Target Cities nationwide. Thus, NBAR probed the degree to which service delivery units had access to a range of health-related services and the extent to which Target Cities funds supported these services. Results document the effectiveness of the Target Cities project in increasing OPDF providers' access to health care services for their clients (see Table 16). Especially noteworthy is the number of agencies with access to primary medical services, which increased from about one third (36%) prior to Target Cities to 100% by the time the NBAR was completed. Interestingly, however, only a minority of patients were actually using these services. Although the NBAR does not indicate the reasons for low utilization rates, interviews pointed to the limited capacity of some service providers. Medical services may have been provided only to those with the greatest need or a lack of alternatives.

Table 16:
Impact of Target Cities on OPDF Access to Medical Services

<table>
<thead>
<tr>
<th>Type of Medical Service</th>
<th>% providing service (either on- or off-site)</th>
<th>% providing service before CSAT</th>
<th>mean % of patients receiving service*</th>
<th>mean % support by CSAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Medical Services</td>
<td>100%</td>
<td>36%</td>
<td>34%</td>
<td>18%</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>83%</td>
<td>55%</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>Pregnancy/Postpartum</td>
<td>75%</td>
<td>46%</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Contraception</td>
<td>67%</td>
<td>50%</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>67%</td>
<td>40%</td>
<td>3%</td>
<td>13%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>67%</td>
<td>20%</td>
<td>2%</td>
<td>13%</td>
</tr>
</tbody>
</table>

* Base = Those with access to the service
Note: Due to missing data, cell sizes range from 5 to 12.
As shown in Table 17, Target Cities providers were more likely than non-participating agencies to have access to a range of medical services.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>% of Target Cities OPDFs providing on- or off-site</th>
<th>% of comparison OPDFs providing on- or off-site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Medical</td>
<td>100%</td>
<td>33%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>83%</td>
<td>67%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>Contraception</td>
<td>67%</td>
<td>50%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>67%</td>
<td>40%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>67%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Respondents were also asked about their involvement in treating AIDS and Tuberculosis. Five OPDFs provided at least some medical services specifically related to treating AIDS. These providers were asked the extent to which their AIDS-specific services were the result of CSAT support. Responses showed great variation, ranging from "not at all" to "a great extent." On average, these providers responded that the Target Cities project was responsible for AIDS-specific services "to some extent" (about 2.2 on a 4 point scale, with higher numbers indicating higher levels of support).

Similarly, only five respondents (overlapping in three cases with the above set of five) provided medical services related to treating TB. Again, these providers were asked the extent to which their TB-related services were the result of CSAT support. Four of the five responded that the Target Cities project was responsible "to a moderate extent" (3 on a 4-point scale), while one responded that Target Cities had no impact on their TB-related services.

**Staffing and Operations**

Because staffing patterns and other organizational factors changed over time, interview, quarterly report, and NBAR responses were often inconsistent. Quarterly reports indicate that the number of staff within the OPDFs partially or fully supported with Target Cities funds ranged from two to nine. This section presents NBAR results about OPDF staffing augmentations during the first Target Cities funding period. (Some of these results, however, were not usable for this evaluation due to poor data quality.)

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Staffing patterns. The NBAR asked if agencies had specifically designated staff as case managers, outreach workers, or staff training specialists. Agencies with such staff were asked to indicate how many full-time equivalent staff (FTE) were added with CSAT funding. Results are displayed in Table 18 below. Of those agencies responding to the questions, 63% had designated case managers on staff, 47% had outreach workers, and 20% had staff training specialists. Agencies with such specialists on staff had, on average, about 1 FTE for the function. Across all the OPDF agencies, the NBAR analysis indicates that CSAT funds were used to support 9.5 FTE case managers, 7 outreach workers, and 2.1 staff training specialists.

By comparison, surveys of eight non-Target Cities agencies reveal that only 25% had case managers on staff, 38% had outreach workers, and 13% had staff training specialists. These findings are consistent with the suggestion that Target Cities increased OPDF providers' focus on these areas, particularly for case management.

Table 18:
Staff Specialists in Target Cities vs. Comparison Group OPDFs

<table>
<thead>
<tr>
<th>Type of Specialist</th>
<th>% of Target Cities OPDFs with specialist on staff*</th>
<th>Mean FTE added with CSAT support**</th>
<th>% of Comp. Grp. OPDFs with specialist on staff***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Managers</td>
<td>63%</td>
<td>1.1</td>
<td>25%</td>
</tr>
<tr>
<td>Outreach Workers</td>
<td>47%</td>
<td>1.0</td>
<td>38%</td>
</tr>
<tr>
<td>Staff Training</td>
<td>20%</td>
<td>1.07</td>
<td>13%</td>
</tr>
</tbody>
</table>

* Base = 15 OPDFs who responded to the relevant items  
** Base = Target Cities OPDFs with specialist on staff  
*** Base = 8 non-Target Cities agencies

The NBAR survey asked how case managers distributed their time across 11 tasks and how outreach workers distributed their time across eight different settings. Results reveal that those agencies with designated case managers and outreach workers used these staff in different ways.

First, the nature of the case management function varied across agencies. For example, the percentage of time case managers allocated to discharge and aftercare planning ranged from 0 to 40%. The same range emerged for time allocated to obtaining and making referrals. Time spent on tracking and monitoring ranged from 2% to 50% of case managers' time. Further, within agencies, case workers were spread thin. On average, case workers divided their time among 7.6 activities, so that few were able to spend more than a few hours a week on any single activity.
Similar variation was observed in outreach workers' activities. For example, the percentage of time that outreach workers allocated to work in schools ranged from 0 to 40%; time allocated to housing projects ranged from 0 to 50%; and time allocated to social service agencies ranged from 5 to 60%. On average, outreach workers divided their time among 6.1 different settings.

Respondents were also asked if they had used Target Cities support to fund changes in staffing other than those described above. Almost three quarters (73%) of those responding to the question had made some additional staffing changes. The types of changes are displayed below:

**Table 19:**

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>% of Target Cities OPDFs*</th>
<th>% of Comp. Grp. OPDFs**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit/hire culturally appropriate staff</td>
<td>67%</td>
<td>25%</td>
</tr>
<tr>
<td>Recruit/hire more experienced staff</td>
<td>33%</td>
<td>50%</td>
</tr>
<tr>
<td>Recruit/hire credentialled staff</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Increase supervision of staff</td>
<td>20%</td>
<td>63%</td>
</tr>
<tr>
<td>Retain staff due to better pay or work environment</td>
<td>40%</td>
<td>0</td>
</tr>
</tbody>
</table>

* Base = 15 OPDFs who responded to the relevant items
** Base = 8 non-Target Cities agencies
Note: Percentages sum to over 100% since some respondents made multiple types of staffing changes.

Relative to the comparison group, Target Cities agencies were more likely to have hired culturally appropriate staff and to have taken steps to improve staff retention. Non-Target Cities agencies, on the other hand, were more likely to have hired experienced staff or increased supervision of staff.

In summary, 15 of 16 OPDFs responding to the relevant items in the NBAR survey had made some staffing changes with CSAT support. The majority of agencies making staffing changes chose to hire more culturally appropriate staff. Beyond this, however, there was considerable variation in the types of staff hired with CSAT funds, and new staff responsibilities varied widely. The activities of case managers and outreach workers in particular differed significantly across agencies.
Note that, due to some ambiguity in the questionnaire, agencies may have responded based on either their current staffing or their staffing during the reference year. Further, staffing patterns tend to change over time. As a result, the findings related to staffing presented here may reflect only one phase of the first Target Cities funding period.

**Staff development.** The NBAR instrument included a number of items about staff training. Only three Target Cities agencies had designated staff training specialists on staff; of these, two used Target Cities funds to support the position. In addition, two agencies reported using Target Cities funds to develop training materials, such as manuals or documentation. Thus, relatively little of the Target Cities funds was used to hire or support staff charged with providing training programs or developing training materials.

The OPDFs showed higher levels of participation in external than in internal training activities, however. Fourteen (14) agencies -- all of those responding -- indicated that some staff had participated in at least one external training activity in the year that started June 1, 1992. Similarly, all but one of the comparison group agencies indicated that some staff had participated in external training during that same time period. On average, four staff members per Target Cities agency and six staff members per comparison group agency participated in some external training activity. Agency expenditures for external training ranged from 0 to $2,000 with a mean of $644. Comparison group expenditures ranged from 0 to $3,000, with a mean of $600. (Note that the County did provide free training sessions for Target Cities participants, so that Target Cities staff could have participated in external training with zero expenditures.)

Target Cities respondents were also asked to indicate the percentage of external training expenditures due to Target Cities support. Responses ranged from 0 to 100%, with a mean of 47%. Given the similarity between the Target Cities and comparison group expenditures for external training, it is possible that the Target Cities agencies shifted training expenses from other sources to the project instead of actually augmenting external training. Further investigation would be needed to confirm this hypothesis.

Finally, respondents were asked about the types of external training provided with CSAT support. Although no more than half the respondents supported training in any particular area, responses clustered in five categories: drug specific skills such as relapse prevention; cultural sensitivity; social services; AIDS; and information systems. Note that County ADPA provided training programs for Target Cities providers in each of these areas. Table 20 displays responses.
Table 20:  
Top 3 Areas of Training for OPDF Staff  
Provided with Target Cities Support

<table>
<thead>
<tr>
<th>Type of External Training</th>
<th>% of OPDFs providing training to one or more staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/drug specific skills</td>
<td>50%</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>50%</td>
</tr>
<tr>
<td>Social services/supports</td>
<td>40%</td>
</tr>
<tr>
<td>AIDS</td>
<td>40%</td>
</tr>
<tr>
<td>Information systems</td>
<td>40%</td>
</tr>
<tr>
<td>Generic clinical skills</td>
<td>20%</td>
</tr>
<tr>
<td>Medical disorders</td>
<td>10%</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>0</td>
</tr>
<tr>
<td>Sexual or physical abuse issues</td>
<td>0</td>
</tr>
<tr>
<td>Discharge and aftercare planning</td>
<td>0</td>
</tr>
<tr>
<td>Vocational services</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Results are based on the 10 respondents who answered this question. Percentages sum to over 100% since many agencies provided training in more than one area.

In summary, relatively few Target Cities participants invested significant resources in internal staff training. Although participation in external training was widespread, the OPDF providers varied in their expenditures for such activities and in their reliance upon Target Cities to support staff participation in training. External training activities focused on drug specific skills, cultural sensitivity, social services, AIDS, and information systems.

Use of Target Cities Support for Facilities, Supplies, and Equipment

Several NBAR survey items probed use of CSAT funds for operational costs, including rent or mortgage payments, property taxes, utilities, insurance, external supplies and services, and one-time expenses for space renovation and equipment. Responses are difficult to interpret due considerable missing data and ambiguity in responses. The results that follow are based on those providing answers that can be clearly interpreted.

Yearly operating costs (other than salaries). Nine OPDF respondents completed all questions about the use of Target Cities funds for yearly expenses including rent or mortgage, property taxes, utilities, and external supplies and services. Responses were summed to provide an aggregate measure of Target Cities funds applied to operating expenses. The mean expenditure was $20,897, or slightly more than one quarter of the Target Cities allocation of $75,649 to OPDF participants. Expenditures varied widely across agencies, however, ranging from a low of $4,019 to a high of $41,647. Table 21 provides more detail about these expenditures.
Table 21:
Use of Target Cities Funds for OPDF Operating Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean $</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>$6,216</td>
<td>$0</td>
<td>$22,500</td>
</tr>
<tr>
<td>Insurance</td>
<td>$918</td>
<td>$0</td>
<td>$4,273</td>
</tr>
<tr>
<td>Utilities</td>
<td>$730</td>
<td>$0</td>
<td>$2,500</td>
</tr>
<tr>
<td>external services</td>
<td>$13,213</td>
<td>$4,019</td>
<td>$27,697</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$20,897</td>
<td>$4,019</td>
<td>$41,647</td>
</tr>
</tbody>
</table>

Note: Due to missing data, cell sizes range from 9 to 14.

Expanding or renovating space. Three providers specified that they renovated space with CSAT funds. Only one, however, indicated the amount of CSAT funding used for this purpose ($9,230). We cannot determine precisely from the NBAR data the number of agencies that expanded space using CSAT support, but responses indicate that at least three agencies (other than those engaged in renovations) did so. The cost of such expansions cannot be determined from responses. Thus, at least six OPDFs renovated or expanded space using Target Cities funding.

Equipment and furnishings. Providers were asked to indicate how much of their Target Cities allocation was spent buying or renting equipment, vehicles, or furniture. These results were difficult to interpret due to missing data and ambiguity in the responses. Fortunately, nine respondents provided a project-to-date total for all equipment and furnishings. These total expenditures averaged $5,993 and ranged from 0 to $21,888.

Challenges and Barriers Facing the OPDFs

Despite substantial gains in access to assessment and ancillary resources, enhanced staffing, and increased support for facilities and equipment, the OPDFs did encounter some problems that limited their ability to enhance services as planned. One important barrier was the inadequate supply of needed social services within Los Angeles (see Chapter III for more discussion of this barrier). In addition, the advances in child care and transportation associated with Target Cities did not fully meet needs in these areas. As a result, over half of OPDF directors cited limitations in transportation and child care services as posing continuing obstacles to treatment.

Second, although participation in Target Cities increased the OPDF agencies' access to assessment services, these benefits were offset to some degree by the strong negative reaction to the Client Intake and Assessment Instrument (CIAI), which the agencies were required to administer until the MIS came on line in the third project year.
The OPDF respondents were in strong agreement with the CRC directors about the inappropriateness of this instrument (see Chapter III for more discussion).

The delay in the MIS was another source of frustration. This delay posed obstacles to the OPDFs in their efforts to more tightly coordinate intakes, assessments, and referrals with CRCs and other service providers.

A fourth problem was the tension between some OPDFs and the CRCs. Distrust of and, occasionally, conflict with the CRCs not only reduced OPDFs’ enthusiasm for Target Cities but may also have acted to suppress use of services offered by the CRCs. As relationships improved, OPDFs were able to take better advantage of the CRC capabilities. This issue is discussed in more detail in Chapter III.

Fifth, OPDF agencies faced a number of ambiguities with regard to their responsibilities under Target Cities. In the absence of clear directions and procedures, providers made their best guess about how to proceed, based on both their interpretation of Target Cities plans and policies as well as local needs. For example, some providers believed that they were expected to vigorously establish cooperative agreements; others believed that this was the responsibility of the CRCs. Some believed that reducing client to staff ratios was a major goal for Target Cities; others believed that this goal had been dropped or modified. Such confusion accounts for some of the diversity in OPDF activities and increases the risk of gaps, redundancies, or inconsistencies in the implementation of Target Cities.

Finally, the OPDFs for the most part lacked clear definitions or standards to guide implementation of Target Cities enhancements. For example, most OPDF providers chose to provide life skills education as one of their required supplementary service activities. However, the frequency and nature of these activities varied. Some providers integrated life skills into all treatment plans, others kept it as an optional, extracurricular activity. Some providers used outside staff to deliver life skills training; some used their own counselors. Some focused life skills training on issues such as interpersonal communication; others focused this activity on practical issues such as how to ride a bus, find a job, or open a bank account. As a result, information that an agency offers "life skills training" as part of their Target City enhancements conveys little about the content, organization, or intensity of the service. This same concern applies to many other enhancements -- life skills is just one example. This is not to say, however, that diversity itself is problematic. In fact, one could argue that the flexibility of Target Cities is a strength, since providers could select the services that best fit the needs of their target populations. The likelihood of creating systemic change, however, is probably higher if
clear definitions and standards are available to assist agencies in implementing their choices.

**Summary and Discussion**

Target Cities generated considerable activity among OPDF providers. Across all agencies, we observed changes in intake and assessment procedures, direct services, ancillary services, and operations and staffing as a result of the Target Cities support. In particular, Target Cities led to: (a) increased agency access to resources for assessment (b) more group and classroom-type sessions; (c) increased agency access to ancillary services; (d) more staff training; and (e) hiring new, culturally appropriate staff.

At the same time, we observed considerable variation in how the OPDF agencies implemented the Target Cities project. For example, all hired new staff, but they used these staff in many different ways. Almost all used Target Cities funding to meet some operational costs, but the percentage of funds used for such purposes varied widely. Almost all increased staff training, yet the topics emphasized in training varied. Some modified treatment plans to increase client exposure to individual or group counseling, others added recreational or classroom-type activities, and still others made few changes to the core treatment program. Many actively sought ancillary services for their clients, although some did not — and the types of ancillary services available to clients varied.

At least two factors may explain the diversity and breadth in OPDF providers' activities. First, providers differed in their interpretations of their responsibilities. Second, the providers were a diverse group with regard to such dimensions as the stability of the agency funding situation, prior access to ancillary resources such as medical care, client population, size of agency or OPDF program, and support for the Target Cities philosophy and strategies. Thus, diversity in implementation may reflect differing needs and priorities across the agencies.

Does the high level of activity related to Target Cities add up to meaningful enhancements to treatment? One hypothesis is that the opportunity for each provider to select those enhancements best suited to their agency and client needs should have resulted in strong improvements in client outcomes. Another hypothesis, however, is that the diverse enhancements were too broad and unfocused to have significant impacts at the level of client outcomes. The outcome evaluation will address these competing hypotheses.
Chapter V: Perinatal Service Centers

This chapter reviews implementation of the two Perinatal Service Centers (PSCs): one at El Proyecto del Barrio, and one at the Asian American Drug Abuse Center. The chapter describes the development of the PSC concept, the nature of the treatment programs offered by the PSCs, and the challenges and barriers the PSCs faced during the first funding period for Target Cities.

Information about the PSCs was obtained from interviews and observation, NBAR responses, and reviews of documentation, including the quarterly reports. This implementation evaluation focused less on the PSCs than on the CRCs and OPDF units, however. Because PSCs were housed in agencies that also had OPDFs and, in one case, a CRC in Target Cities, interview time was limited since the same respondent needed to discuss other agency activities. Additionally, although both PSCs filled out the NBAR, missing data reduced the usefulness of the results. Quarterly reports, too, provided limited information about the PSCs and were subject to the same problems described elsewhere in this report.

History of the PSCs

Key objective four in the original Target Cities proposal emphasized the need for services geared toward pregnant and postpartum women, especially in light of increasing numbers of women seeking drug treatment. The proposal pointed out that services for substance abusing mothers and their children are highly fragmented, which contributes to drop-out from treatment and relapse. In response to the need for coordinated service delivery for women and their children, the Los Angeles plan included the development and implementation of specifically designated perinatal services. Unlike other OPDF units, the plan intended for the PSCs to restrict services only to drug-abusing women, offer a higher level of intensity in treatment, and coordinate both drug treatment and other medical, social, family, and human services. The proposal offered the following description of the PSCs:

The proposed day treatment programs will build on existing resources available in the surrounding areas. The programs will be 6 months in length, 5 hours a day, and will be open 6 days a week. Services will be provided for pregnant women and mothers who have been assessed as having moderate to severe problems with drugs and/or alcohol, but are still able to maintain some semblance of stability and support in their lives. These women more often than note require more extensive services than outpatient programs provide. They need extended daily programming to assist them in establishing or re-establishing a stable life situation. (p.58)

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The proposal requested funding for three PSCs, each of which would engage in 11 specific activities. However, following funding, three important changes were instituted. First, as a result of a reduction in budget and early negotiations with both CSAT and the providers, the number of PSCs was reduced from three to two. Second, the concept of day treatment was dropped as infeasible and too expensive. Instead, the new PSCs were designed as “intensive outpatient” programs, occupying a middle ground between day treatment and traditional OPDF. Third, as a result of this change in concept, the original set of 11 perinatal activities were replaced by a slightly modified set of 14 activities (see Appendix D for a list of these activities).

The two PSCs are located within El Proyecto del Barrio (which also sponsors an OPDF and a CRC) and the Asian American Drug Abuse Program (which also sponsors an OPDF). Both began operations in the fall, 1991.

The contracts between the County ADPA and the PSCs, administered on May 28, 1991 offer the following description of the PSCs:

Perinatal services centers (PSCs) are non-residential programs that provide recovery services to drug and alcohol using pregnant and postpartum women and their infants. The program services should be available a minimum of eight hours per day, five days per week. Participants return to their own residence at night. The primary purpose of these services is to provide a planned program in a social setting structured to maximize habilitation or rehabilitation of participants. These programs are used to provide services more intensive than a visit but less extensive than 24 hour residential service in a clean, drug and alcohol free, sober environment...

The contracts listed 14 services which the PSCs were supposed to provide:

A. Develop and implement activities ensuring access to and provision of comprehensive services specific to the need of pregnant and postpartum women.
B. Implement individual, family, and group discussions...
C. Develop and implement networking activities interfacing with private, public, and quasi-public obstetric and postpartum services...
D. Develop and implement a referral network and extensive resource information and assistance...
E. Develop and implement life skills training, health education sessions, and child development and parenting classes.
F. Develop and implement in-service training to selected obstetric, neonatal, and pediatric health care providers.
G. Develop and implement vigorous linkages with project community resource centers, the Department or Children Services, maternal/child health services, local
regional health center, and other agencies ensuring that project participant's
c aloth receive development assessment and services.
H. Develop a peer support network for drug abusing pregnant women...
I. Recruit, train, and supervise volunteer recovering women...
J. Develop and implement relapse prevention strategies and activities.
K. Develop and implement project participant alumni activities.
L. Develop and implement activities for baby sitting services...
M. Develop and implement activities for transportation assistance...
N. Develop environment conditions at the PSCs which will maximize informal
 exchanges among women.

Like the CRCs, the PSCs were new units specially created by the Target Cities
 support. Unlike CRCs, both PSCs received supplementary funding from the State (for a
 MediCal program) and patient fees. Nonetheless, Target Cities support of $291,342 per
 year constituted the core funding for the PSCs.

Also unlike the CRCs, the PSCs have had the advantage of a clear mission and
target audience. They also functioned relatively independently of other Target Cities
 agencies. Although they have largely succeeded in implementing their assigned
 responsibilities, they have nonetheless faced a variety of challenges.

Overview of PSCs

A companion report (Greenwood and Mohamad [1993], Analysis of Quantitative
 Client Information Reported by Providers for the Los Angeles Target Cities Drug
 Treatment Program for the Period October 1990 - May 1993, DRU-568) provides
 information about the intake and assessment activities of the two PSCs, based on data
 presented in quarterly reports. Between October 1990 and May 1993, the PSCs had 164
 client contacts, most (76%) by telephone. They began 109 intakes and completed 96
 intakes. Most clients were referred from other social services agencies (46%) and “other”
 organizations, probably the Department of Children’s Services (34%). About half (49%)
 the clients seen primarily used cocaine other than crack, 27% were primarily crack cocaine
 users, and 4% were primarily heroin users. The PSCs provided referrals to 94 individuals
 -- all but two (98%) were referred to intensive outpatient services (i.e., the PSCs).

Since Target Cities included only two PSCs, we have not attempted to construct
 an aggregate profile for this evaluation. Instead, we briefly describe each PSC, focusing
 on areas of similarity and difference. We then discuss some of the common challenges
 they face.
PSC #1. During the first term of funding for Target Cities, this agency had the ability to serve up to 25 women in its PSC; the case census typically runs between 20 and 25. The Center had three dedicated staff, although up to seven other staff within the agency also provided services to the unit. Most staff and services were bi-lingual (Spanish and English). In the reference year June 1, 1992 - May 31, 1993, this PSC served 49 women. The Department of Children's Services and Probation were the main referral sources for the PSC.

Clients were diverse with regard to ethnicity and race. Of those served during the reference year, 35% were Spanish speaking, 33% were white, 18% were African American, and 14% were "other," primarily English-speaking Hispanics. Almost all (95%) were victims of sexual or physical abuse or battering. About 10% were pregnant. Relatively few (5%) were also suffering from mental illness (dual diagnosed), and only 2% were on probation or parole. Most lived in poverty, and over half were unable to pay at least half the costs of treatment. Crack cocaine was the most common drug of abuse.

Upon entry to the PSC, all clients received an on-site financial assessment, physical examination (by either a doctor or a nurse practitioner), urinalysis, AIDS test, and TB test. Clients were referred off-site for psychosocial or psychiatric assessments as needed -- up to 20% of clients received these assessments.

As required by the County, the PSC developed treatment plans for new clients within 30 days of admission and updated them at 90-day intervals thereafter. The PSC aimed to keep women in treatment for at least nine months. The program tried to match clients to their primary counselor on the basis of demographic characteristics and counseling needs.

A typical treatment program included group counseling (several times per week); individual counseling (usually once per week), classroom type activities (2-3 times per month), 12-step programs (2-3 times per week), and periodic random urinalysis tests. About half the women in the PSC were also enrolled in the home agency’s OPDF, so their treatment regimen included elements of both programs. Although the PSC staff hoped women would attend treatment sessions several days per week, at minimum, in reality attendance varied widely.

Treatment emphasized supportive group therapy, social learning, and individual behavior therapy. In addition to drug treatment, the PSC emphasized providing medical care and providing broad range of on-site services. The resources of the agency assisted in achieving these goals.

The PSC tried to "empower women through knowledge" by strengthening their support systems and providing counseling and education. Treatment included components
for drug and alcohol awareness, nutrition, relapse prevention, self defense, and Lamaze classes for pregnant women. In addition to group counseling, support groups included 12-step groups and groups for incest and abuse survivors. Both day-time, evening, and limited Saturday groups were provided to facilitate participation. The PSC also sponsored social and recreational outings for women and their families.

On-site ancillary services included physical examinations, testing for infectious diseases, assistance in paying for prescription drugs, medical services for pregnant and postpartum women, contraception, and some pediatric services. The CRC, located within the same building, also helped women get services related to housing, transportation, vocational rehabilitation, and DPSS. The PSC offered baby-sitting on site while women attended counseling and educational sessions.

PSC # 2. During the first term of funding for Target Cities, this PSC had the ability to serve up to 24 women in its PSC. During the first funding period for Target Cities, the Center had up to six full-time and five part-time staff. Unlike PSC # 1, this PSC was self-contained and did not use staff (other than managers) or services of other programs within their agency. In the reference year June 1, 1992 - May 31, 1993, the PSC served 69 women. Of these, 46 were served due to Target Cities support, and the remainder participated in a State-funded program for MediCal recipients. The Department of Children's Services was the primary referral source for the PSC, and close to 100% of clients were referred by the Department of Children's Services (DCS).

Of the clients served during the reference year, almost all (97%) were African American, and most were crack cocaine users. Almost three quarters (70%) were victims of sexual or physical abuse or battering. About 20% were pregnant. Relatively few (10%) were also suffering from mental illness (dual diagnosed), and only 5% were on probation or parole. Most lived in poverty, and at least 75% were unable to pay at least half the costs of treatment.

Upon entry to the PSC, all clients received an on-site psychosocial and financial assessment and urinalysis test. Unlike the other PSC, this unit lacked on-site facilities for physical examinations, so clients in need of these services were referred off-site. Their files were reviewed by a part-time medical director. Between 50 and 100% of clients were referred off site for physical examinations (by either a physician or a nurse practitioner) and AIDS and TB tests. A smaller number (5%) were referred off site for psychiatric assessments.

As required by the County, this PSC developed treatment plans for clients within 30 days of admission, and updated the plans at 90-day intervals thereafter. They aimed to keep women in treatment for six months at minimum. The program tried to match clients
to their primary counselor on the basis of demographic characteristics and counseling needs.

A typical treatment program included daily group counseling, individual counseling (usually 2-3 times per month), classroom type activities (2-3 times per month), 12-step programs (about once a month on site), and periodic random urinalysis tests. Services were offered three hours per day at minimum. Although staff wanted women to attend more often, clients attended 6-8 sessions per month on average, compared to 3-4 sessions per month for the OPDF.

Treatment emphasized supportive group therapy, task oriented and problem solving group therapy, and social learning. Primary treatment goals included abstinence from drugs, improved family relations and parenting skills, improved physical health, change of environment, and better life skills.

At the time of interview, the PSC was open Monday through Saturday but was considering closing on Saturdays due to low attendance. Treatment groups included a women's support group and relapse prevention group. Education groups included health education and parenting skills. Social and recreational activities included a life skills course, acupuncture, physical fitness, and Saturday social activities.

On-site ancillary services included housing assistance, baby sitting, legal assistance, and vocational counseling. Clients were referred to off-site medical facilities for a range of health services, such as primary medical care, psychiatric care, pregnancy and postpartum care, contraception, and pediatric services.

Challenges and Barriers Facing the PSCs

The PSCs made a number of important contributions to the Los Angeles drug treatment system. They represented an expansion of the system's capacity for serving pregnant and postpartum women, and they increased diversity of treatment models by combining intensive outpatient drug treatment services with a variety of other services needed by women and their children. Perhaps most important is that the PSCs provided an opportunity for treatment providers, especially outpatient treatment providers, to learn more about the needs of pregnant and postpartum women and to experiment with the design of treatment programs responsive to these needs. Although the PSCs were largely implemented as intended, both providers and project administrators expressed concern about their effectiveness. The outcome evaluation addresses these concerns through an analysis of client-level outcomes. This section describes some of the issues that need to be resolved for the PSCs to continue to grow in effectiveness and impact.
Low retention rates. Both PSCs found it difficult to retain women in treatment. One PSC reported a treatment completion rate of about 15%. The other did not report a completion rate but indicated in interviews that relatively few women successfully completed their treatment regimen. Although information about the average duration of treatment was unavailable for this evaluation, anecdotal evidence suggests that many women dropped out of treatment after just a few weeks. For example, the impact evaluators could not identify sufficient numbers of women to interview within the PSCs who met the eligibility criteria for inclusion in the study of eight weeks in treatment. Staff in the PSCs cited four factors contributing to high drop-out rates.

First, many of the PSC clients had spouses or partners who abused drugs or alcohol and actively resisted the women's efforts to change their substance abuse patterns. Even if women did not encounter active resistance from family, they rarely received the level of support needed to comply with a demanding treatment regimen. For example, spouses were often unwilling to adjust their work schedules, help out with housework, or share child care to accommodate the woman's treatment program. Some spouses objected to their partner's intense involvement in activities that did not include them. In response to these family pressures, the PSCs attempted outreach to families, and invited spouses to participate in treatment in a variety of ways (e.g., family counseling sessions; recreational or social events). Nonetheless, some family members simply weren't interested or continued to resist -- and without family support, many women left treatment prematurely.

A second factor contributing to high drop-out was lack of child care or transportation. Although the PSCs provided assistance to help women overcome these barriers, they could not completely alleviate these difficulties. For example, long bus rides with an infant or toddler, often involving transfers or trips through rival gang territories, were strong disincentives to attending treatment. Although babysitting was available during counseling sessions, it did not address some special needs (e.g., if a child needed to be taken to or picked up from school or day care at specific times).

The third and most significant barrier to persistence, however, was a lack of oversight by the Department of Children’s Services (DCS). Both PSCs obtained most of their referrals from DCS. Staff noted that when a DCS caseworker was closely monitoring a woman, the client was likely to attend treatment regularly. When monitoring was light or inconsistent, however, the clients tended to lose motivation. Further, staff pointed out that DCS caseworkers were so overloaded that they were eager to close cases. If a woman persisted in treatment for a relatively short period of time (e.g., one to three months), her DCS caseworker was likely to close her case and facilitate returning the children to her home if they had been removed. Without external pressure to attend
treatment, however, most women stopped coming to the PSC. From the treatment providers' point of view, these women needed more time in treatment and, by leaving early, greatly increased their risk of relapse. One PSC director noted that the DCS Family Preservation Unit was particularly problematic. By keeping children with their mothers, this unit removed a strong incentive for treatment — namely, fear of losing custody of one's children. Another respondent said that her PSC used to obtain referrals from a DCS "high risk unit" that closely monitored women. When this unit was closed due to budget cuts, the respondent said, both referrals and retention declined. PSC staff also wanted parole and probation officers to also keep the pressure on women to attend treatment. One respondent said that justice and DCS workers are not "fully committed to treatment" and noted that clients "will not get the skills to stay clean until these agencies work in cooperation with drug treatment."

Yet another obstacle to remaining in treatment in the PSCs was conflicting demands among social service agencies. For example, if children are removed from the home, the mother loses her AFDC support. Yet most women in the treatment population rely on this money for basic living expenses. In order to meet the conditions for getting their children back (e.g., having appropriate housing), some women needed to find employment rather than attend treatment. Thus, PSC staff noted that AFDC rules served as disincentives to remaining in treatment.

It should be emphasized that low retention and high drop-out rates are characteristic of the target population for services. These problems were not unique to the Target Cities PSCs but rather characterize the majority of perinatal treatment programs.

Less intensity than anticipated. For the time period in which clients did remain in treatment, few fully complied with the relatively demanding PSC treatment programs. For example, the PSCs recommended frequent, ideally daily, visits for clients. In reality, however, attendance was erratic. One PSC estimated that clients attended sessions 6-8 times per month on average -- far less than planned or hoped. The other PSC did not estimate how often clients came for treatment, but staff noted that trying to get clients to attend consistently for a half day or longer was their single biggest challenge.

Infrequent attendance was perceived to have a variety of negative effects. The PSCs found it more difficult to engage clients in the treatment process when they did not attend regularly. As a result, staff noted that the women progressed more slowly and faced a higher risk of relapse. The women also were less able to benefit from and participate in the supportive environment (including ancillary services and informal social networks among clients) the PSCs offered. Thus, infrequent attendance appeared to increase the likelihood of dropping out.
This pattern raises the question of whether the more intense treatment regimen associated with the PSCs might inadvertently raise the likelihood of attrition from treatment, if clients are unable to comply with the regimen. On the other hand, by setting high expectations, the PSCs may achieve stronger results, even if not all clients consistently meet these expectations. Empirical study is needed to measure the outcomes of treatment programs such as the PSCs with high expectations that relatively few clients may meet vs. those with lower expectations that more clients might meet.

**Placement in the OPDF unit vs. PSC.** Both PSCs faced the challenge of deciding which women should be placed in PSC vs. OPDF. One respondent said, "Just because a client is referred to the perinatal center doesn't mean she necessarily belongs there." Both PSCs lacked criteria for determining which women should be assigned to an OPDF, a PSC, or to some combination of the two. Given the high (and increasing) number of women seeking OPDF treatment and the limited number of slots available, what criteria should be used to assign women to PSCs vs. OPDFs? At the time of interview, neither agency had resolved this issue. Relevant factors for consideration could include the level of intensity of outpatient treatment needed, the level and type of family needs, types of ancillary services needed, or the informal program environment and social climate. Further planning and research is needed to determine which women are most likely to benefit from the extra intensity, family-oriented services, and emphasis on informal social support networks that the perinatal programs provided. Further, without criteria to guide referrals to PSCs versus OPDFs, the two units were to some extent in competition for clients and resources, which was not necessarily in the best long term interests of their sponsoring agencies.

One of the PSCs had a relatively fluid relationship with the agency’s OPDF, with about half the clients assigned to both units. In contrast, the other PSC maintained a sharp boundary between these units, and they were located in separate buildings. Nonetheless, both were troubled by this issue.

**Dissemination of lessons learned.** The original plans for the PSCs included training and technical assistance activities to health care providers. The experience of the PSCs, however, is that interest was slight and did not justify the time and effort needed to organize training events.

PSCs have the potential to serve as an important training and technical assistance resource for other drug treatment providers. They also have the potential for system-level interventions, for example by educating DCS, medical providers, DCS, and probation or parole officers about the treatment process. For the most part, however, this did not occur. Efforts to reach out to medical providers, in particular, proved frustrating and
brought little response. Thus, the PSCs have not yet found mechanisms to actualize their potential role as systemic change agents.

Further, there were few procedures or mechanisms in place within Target Cities through which PSC could efficiently share the lessons learned regarding treatment for drug-abusing women and their children. An important exception was the County-sponsored training sessions, several of which included materials and presentations relevant to women and children. As the PSCs continue to gain expertise in meetings women’s needs, they can provide leadership with the Los Angeles drug treatment community regarding effective responses to drug addicted women. To do so, however, requires the creation of opportunities for discussion and exchange of information.

It is understandable that the PSCs have devoted most of their resources to developing, monitoring, and refining their own programs. At the time of interview, staff certainly did not feel that they had unlocked the secrets of effective treatment for this population and, indeed, were struggling to strengthen their programs and improve retention. However, without some procedures or mechanisms for dissemination, the PSCs can have only limited systemic effects, and providers might well waste scarce resources in the future reinventing the wheel.
Chapter VI:
Management Information System

Development of an automated intake, assessment, and tracking system is integral to the concept of central intake and was part of the original OTI plan for Target Cities. Thus, this has been an important component of the Los Angeles Target Cities plan since project inception. The MIS was to serve as a critical tool for assisting the CRCs in assessments, referrals, and case management. It was to assist the OPDFs and PSCs by improving information about new clients and by supporting their assessment, case management and referral activities. The MIS was also intended to serve the Los Angeles drug treatment system at large, by generating needed data, improving communications, and providing enhanced information for planning programs and services.

Target Cities has by now made substantial progress toward achieving this objective, through the development of the Client Referral and Intake System (CRIS). Implementation of the CRIS, however, faced many delays. The system was not operational until April, 1993, well into the project’s third year, and development of some basic system components was still underway as this report was being prepared.

A comprehensive assessment of the system’s contribution to the treatment system awaits its full implementation. In this section, then, we review the implementation of the CRIS during the first three years of Target Cities, and we describe some potential issues that could affect its usefulness now and in the future. Because enhancements were still being added to the CRIS as this report was in preparation, this chapter is unable to fully describe all its capabilities. Rather, this discussion offers a snapshot of the CRIS as the first Target Cities funding period was coming to a close. Information about the CRIS is derived from interviews with MIS specialists in County ADPA, interviews with providers, and reviews of documents including the specifications for CRIS.

History of the MIS

The Los Angeles Target Cities proposal specified that a firm called Maximus would design the MIS system, originally known as ARIAS, for Automated Referral, Intake, and Assessment System. After funding was awarded, however, several factors delayed the award of contract. First, at the time Target Cities was funded, the County was also developing a new MIS for accounting and administration, and ADPA had to satisfy the leadership of the County Health Department that the proposed Target Cities MIS was sufficiently different in purpose and design to justify a separate contract and project. Then, the County legal counsel decided that an RFP process rather than a contracting protocol was needed, and that, rather than award the contract to Maximus,
ADPA needed to solicit bids and proposals in a competitive process. This of course required additional time.

Following a review of proposals in 1991, Creative Socio-Medics was selected as the contractor for MIS development. A December 1991 briefing overview prepared by the ADPA specified that the MIS would be operational by March or April, 1992.

Following the announcement that the MIS contract had been awarded to Creative Socio-Medics, however, the firm originally selected brought legal action against the County. While this lawsuit was pending, the County could not authorize Creative Socio-Medics to begin its work. This issue was resolved in the summer of 1992, and Creative Socio-Medics began work with a signed contract on August 11, 1992.

During this difficult time period, County counsel also advised the Target Cities administrators against discussing the legal action with the providers. Thus, from the point of view of the providers, there was an inexplicable and frustrating delay. Providers would periodically ask about the MIS during PAC meetings, but the County, State, and CSAT administrators were unable to explain the reasons for the delay in depth, contributing to some tensions between providers and administrators. By late 1993, word had gotten out and providers knew the reason for the delay, but this new information could not fully compensate for several months of apparent bureaucratic obfuscation.

Before contract issues were fully resolved, the County was able to take two important steps. First, they continued work on the conceptual design for CRIS by developing and elaborating a flow chart of clients' flow through the treatment system. Since the original plan had assumed the MIS would primarily support a centralized intake structure, some reconceptualization was needed.

Second, the County purchased and began installing microcomputers in all Target Cities agencies. Some agencies had no prior experience with computers and therefore needed substantial technical assistance from County ADPA staff. Installation of the on-site equipment was also a lengthy process due to the time needed for selecting equipment, negotiating with vendors, waiting for orders to be filled, and working with staff at each site. The microcomputers were installed at all agencies by September 1992, although purchase of the minicomputer needed for the CRIS network could not be completed until after the contract with Creative Socio-Medics was signed.

Once the contract with Creative Socio-Medics was established, detailed planning began. To guide this process, a team from County ADPA worked with the contractor and some providers to develop detailed specifications. Interested providers were invited to attend a Client Referral and Intake System Workgroup that met frequently (usually weekly) throughout the fall and into the winter of 1992-1993. However, minutes of these
meetings indicate fairly low levels of provider participation. Between October 14 and November 10, for example, only one to three providers attended the weekly meetings, although critical decisions were being made about the CRIS during this time.

A conceptual design for the CRIS was presented to the Target City providers on January 18, 1993. Responses indicated that additional design work was needed, but the County decided to accept the plan and improve it as implementation proceeded rather than lengthen the delay in establishing the MIS still further.

The CRIS went on-line in a testing mode in late January, 1993. Providers were informed that they could begin using CRIS in May, 1993. During the spring and summer, providers had the option of using CRIS but were not required to do so; by 1994 use of CRIS became mandatory for Target Cities participants.

Modifications to the system have continued through the present. The first major modification -- substituting a PRS identifier for a client name to better protect client confidentiality -- was implemented in August, 1993. These and other milestones are displayed in the time line below.

Table 22:
CRIS Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>August, 1992</td>
<td>Contract with Creative Socio-Medics signed</td>
</tr>
<tr>
<td>September, 1992</td>
<td>Installation of microcomputers in agencies completed</td>
</tr>
<tr>
<td>November, 1992</td>
<td>Installed minicomputer</td>
</tr>
<tr>
<td>January, 1993</td>
<td>CRIS is on line for testing</td>
</tr>
<tr>
<td>May, 1993</td>
<td>Providers invited to begin using CRIS</td>
</tr>
<tr>
<td>March, 1993</td>
<td>Perinatal (N=14) computers purchased and installed</td>
</tr>
<tr>
<td>August, 1993</td>
<td>First major modification to CRIS (use of PRS identifiers)</td>
</tr>
<tr>
<td>November, 1993</td>
<td>Enhancements component added to CRIS</td>
</tr>
<tr>
<td>January, 1994</td>
<td>Zip code matching logic added to CRIS</td>
</tr>
<tr>
<td>July, 1994</td>
<td>Phase 1 expansion (51 additional providers join CRIS)</td>
</tr>
<tr>
<td>September, 1994</td>
<td>Phase 2 expansion (8 additional providers join CRIS)</td>
</tr>
<tr>
<td>October, 1994</td>
<td>Perinatal system comes on line with CRIS</td>
</tr>
</tbody>
</table>
Elements of the CRIS

By the close of the first Target Cities funding period, all Target Cities agencies (CRCs, OPDFs, and PSCs) were using the CRIS. The CRIS included the following elements:

(a) A screening Input Form, for reporting information from initial client contacts, often by telephone but sometimes walk-ins, before an intake or assessment was conducted;

(b) An Assessment Input form, for reporting information used to better understand the clients’ background and needs so that an appropriate referral could be provided;

(c) An Admission Input Form, used to obtain more detailed information to develop a treatment plan upon a client’s admission to an OPDF program;

(d) A Discharge/termination Form, used when clients successfully or unsuccessfully terminated treatment; and

(e) A general waitlist to which clients could be added if appropriate treatment program(s) were unable to accommodate them.

The assessment and admission forms are based largely, although not exclusively, on the Client Intake and Assessment Instrument developed by CSAT. Los Angeles providers began using this form in November 1992 despite widespread misgivings and concerns about its usefulness and quality. In the CRIS, however, answers to some items are required, while answers to many others, including most of the items considered objectionable by providers, are optional. Thus, the providers can provide a minimal core of information or, if desired, supplement the core with further information about the client’s history and characteristics. Other factors guiding the content of the forms included County and State needs (such as the data required for CADDs/PRS reporting), the Target Cities quarterly report format, and the interests and recommendations of providers.

To date, CRIS offers limited information directly to providers. Specifically, providers are able to review and print the information they input. In addition, they can review and print intakes and assessments conducted by other agencies if those agencies referred the client of interest to them for treatment (i.e., if they have filled out an admissions input form for the client). Due to confidentiality concerns, the agency that conducts the intake and provides the referral cannot gain access to the client’s subsequent records. (Thus, the referring agency cannot use the CRIS alone to follow-up on referrals.)

One challenge that CRIS faces is maintaining accurate and timely discharge data. To address this problem, CRIS will not enable providers to “re-admit” clients to their own
agency until a discharge/termination form is completed by the agency that first admitted him or her. This reduces some slippage due to agencies lagging behind in submitting discharge forms.

Since the continuation of Target Cities was funded, additional modifications have been made. In November, 1993 an Enhancements screen was added, enabling providers to indicate all ancillary services provided to clients or to which clients were referred, such as medical services, DPSS, vocational rehabilitation, shelter, food, etc. In January, 1994 a referral function was introduced that uses matching logic to indicate the treatment programs, by modality, closest the client’s home zip code. More recently, the waitlist was broken down by modality in order to better meet provider needs. Standard reports, including the quarterly reports, are still in preparation, but County ADPA tries to respond to provider queries for information. Additionally, all County Perinatal programs plan to use the CRIS to facilitate better tracking and information about this growing component of the substance abuse treatment population.

The original plan for the MIS included a second phase, during which a decision tree would be developed for referring clients to treatment agencies. This was not initiated during the first Target Cities funding period and has since been dropped. One reason was a lack of provider support for this component. Providers were concerned that the decision tree represented an effort to replace clinical judgment with a rigid computerized formula for referrals. Another reason this component was dropped was because the research literature provides no clear guidelines for developing decision tree logic based on empirical investigations of matching clients to agencies, modalities, or counselors. Therefore, the County re-assessed this component and decided it would not be cost effective to proceed with it.

**Issues and Concerns about CRIS**

We have identified three major questions affecting the future of CRIS. This evaluation cannot provide definitive answers to the questions raised here; this discussion is instead intended to identify issues for further consideration by Target Cities participants and administrators. These questions emerge from our interviews with providers and County ADPA staff, from our review of written records, and from our past experience as evaluators with large-scale MIS efforts.

1. **Do the benefits to providers outweigh the hassles and costs?** The accuracy and effectiveness of the CRIS requires cooperation from CRCs, OPDFs, and PSCs. Those familiar with CRIS argue that it offers many advantages to Target Cities agencies. These include: the ability to compile accurate statistics on clients served, which is of increasing concern to policymakers and funders; the opportunity to obtain standardized
high quality information about clients referred to them (or by them); access to special
reports on topics of interest; fair and equitable referrals, with consideration for wait lists
and availability; enhanced case management capabilities; and potential time savings of
automation over traditional paper-and-pencil records and files. Yet, interviews with
providers suggested that relatively few were experiencing these benefits as the first
funding period came to a close, and many felt that the CRIS was consuming substantial
staff time and energy.

By far the most frequent complaint during CRIS's early stages was that data entry
was a highly time consuming practice. Most providers took notes on intake and admission
forms, and entered the data later (generally in batches). At least in the initial months with
CRIS, data entry was more time consuming than the previous practices. Since most
agencies did not have enough support staff to maintain the data entry, counselors or other
professional staff often were required to spend part of their time doing data entry, a
tedious and generally unpopular activity, especially for staff with little experience with and
enthusiasm for computers. For example:
The computer program is badly set up. The response categories aren't
adequate so you end up having to put in inaccurate information to get through
it. At this point I've only got two or three clients in the computer. The rest
are still on paper. We're supposed to do the interview at the terminal but our
computer is not in an area where we can assure privacy. We can't move the
phone line. So we do it on paper first, and I just haven't had the staff time to
put them on the system. It takes an hour just to do that. The information we
get is no more helpful than what we got the way we've always done it.

Another frequently expressed concern was that providers received little back for
their efforts. One described CRIS as "a black hole." These providers were not necessarily
clear about exactly what types of information or feedback they wanted from the CRIS, but
they knew they wanted something more than what they were receiving.

More specifically, OPDF directors noted that they could not generate analyses and
reports themselves, from within their agency. Similarly, some CRC directors expressed
disappointment that their agency would be unable to track clients on the system following
referral to an OPDF. Although the County was willing to run reports for providers on
request, at least one respondent indicated that he/she would be reluctant to ask the County
for some information of interest to them.

The need to protect both client and agency confidentiality does limit the degree to
which providers can be provided access to the CRIS (or any MIS). For example, few
agencies would be comfortable giving another agency access to information about their
intake, admission, and completion rates. At the individual client level, protections for
confidentiality are essential. Nonetheless, these important restrictions limit agency access to information they would like to obtain and contributes to a sense that the value of the output (at the agency level) does not justify the time involved in input.

Some of the elements of CRIS were of little use to some providers. For example, a number of ODPF agencies continued using internally developed intake and assessment instruments, so that the CRIS screens were a supplement to, rather than a replacement for, existing procedures. Fortunately, the core set of items on CRIS (those required) were generally viewed as reasonable, especially in relation to the CIAI. In addition, however, most agencies continued to make hand tabulations or use in-house computer data bases, because they were not ready to fully trust the system and because they could not extract aggregated information from the system independently.

Beyond this, the CRIS did not replace the need for agencies to also complete CADDs/PRS forms. And the CRIS waitlist and referral functions did not replace the telephone system now in place for OPDFs and CRCs to try and secure detox beds. Further, CRIS did not generate the reports needed for the Target Cities quarterly reports, so that agencies had had to continue providing the County with quarterly reports as they did prior to CRIS coming on line.

Additionally, the wait list component of CRIS was of limited interest to OPDF providers, who tend to maintain short to no wait lists. The logic of the wait list and referrals components of CRIS were based on the CRCs functioning as centralized intake units. Since this was not the case during the first funding period, the wait list and (anticipated) referral functions were not perceived as highly useful. (Now that the CRCs are conducting substantially more screenings and assessments, these functions of the CRIS appear to be gaining in use and popularity.)

In short, during its first few months of operation, CRIS was generally experienced as an add-on to existing screening, intake, and assessment procedures. It did not relieve agencies of the necessity to keep other kinds of records or submit other required forms. Agencies could not obtain aggregated information or other reports of interest to them and had only limited ability to track clients. Thus, for many, the costs -- largely the time needed for data entry -- were apparent but the benefits were unclear.

As the County and the MIS contractors continue adding enhancements to CRIS and as providers become more familiar and comfortable with the system, the advantages and benefits of the system may become more apparent while burden associated with it may decline. Further, as the CRCs continue to conduct a higher proportion of screenings, assessments, and referrals, OPDF providers may find the CRIS both more useful and less demanding.
2. Will CRIS provide accurate, timely, and complete data? If providers fail to perceive much benefit from CRIS, they are likely to assign a lower priority to data entry and related tasks. Under these conditions, data quality is likely to suffer. Providers may enter data late, so that routine reports (e.g., quarterly reports) are not based on up-to-date information. Errors may increase if the forms pile up to the point where staff fatigue sets in before data entry is completed, or staff may make mistakes if they are rushing to finish the data entry task and move on to something that seems more important.

Further, if the CRIS is to provide accurate data, the providers must share common definitions of each element. The County has already discovered data elements that are subject to varying interpretations, and staff are working to standardize reporting practices. For example, quarterly reports asked for the numbers of intakes that were begun and completed. Some providers counted any contact with a potential client as an “intake begun.” Others waited until they had scheduled and initiated a formal intake interview. The former group tends to report more “intakes begun” but also has a lower percentage of “intakes completed.” If data on “intakes begun” and “intakes completed” are to be interpretable, such ambiguities must be resolved. Similarly, agencies did not share common criteria for terminations, e.g., when clients simply failed to return to treatment. Some would hold the case open for many months hoping and trying to get the client back in treatment. Others would formally discharge the client after some period of time elapsed without contact. The task of identifying elements and issues that need clarification is underway and probably will continue for some time. Once this is accomplished, however, there will be an ongoing need to train new staff and refresh the skills of experienced staff.

A related issue is the nature of the incentives and disincentives for providers to comply. Under Target Cities, providers had a strong incentive to participate in CRIS, since a refusal to participate could lead to negative consequences, such as losing funding. On the other hand, full cooperation with the MIS could conceivably lead to negative consequences for the agencies as well. For example, one can imagine using CRIS data to compare or rank agencies on the basis of treatment completion rates. Such measures could embarrass some agencies. Yet these are precisely the types of numbers that, once available, are of interest to policymakers. Thus, one must consider the possibility that compliance with the CRIS could leave agencies vulnerable to criticism as a result of their openness in reporting, especially with regard to terminations and discharges. This issue did not emerge from interviews with providers or County officials. Rather, respondents almost uniformly suggested that providers were trying their best to comply and felt a strong obligation to do so. Nonetheless, we raise this issue for consideration, since it can and has undermined other MIS efforts.
3. Is CRIS sustainable? What will happen to CRIS after the Target Cities funding is withdrawn? The system will need continued enhancements and modifications, as well as ongoing maintenance of software and hardware including periodic upgrades. The source of funding for this is unclear. To date, participating agencies have received free hardware and software from County ADPA, but the County probably cannot continue this practice indefinitely. When agencies need to decide how to allocate limited resources, they may not be able to support continued participation in the CRIS. A secondary issue is whether providers will have non-monetary incentives to participate in CRIS after the Target Cities project (which requires participation) ends. Hopefully, the benefits of CRIS will be apparent by that time, and the system will have achieved a level of institutionalization that ensures its continuation.
Chapter VII: 
Linkages With Ancillary Services

Drug treatment clients typically have an array of needs and problems, many of which extend beyond the traditional domain of substance abuse counseling yet influence the likelihood of retention and success in treatment. Further, those in treatment face an increased risk of some communicable diseases (e.g., AIDS, tuberculosis), so that coordination between substance abuse services and ancillary medical services could provide valuable public health interventions of benefit not only to the client but to the community at large. Thus, the Los Angeles Target Cities effort placed a high priority on strengthening linkages to ancillary services. Every CRC and most of the providers devoted considerable time and resources to identifying and establishing relationships with other social service providers.

Interview respondents described many potential benefits of this activity. First, a network of ancillary services enables Target Cities agencies to address clients’ needs in a holistic manner, thereby increasing clients’ overall well-being and likelihood of success in treatment. Respondents also suggested that stronger relationships between OPDF agencies and ancillary service providers would result in better care for clients that were referred for ancillary services. Third, the process of developing linkages enabled staff to assess the quality and suitability of local services for their clients through on-site visits and meetings with staff. Fourth, the agreements enabled staff to identify possible community resources for their own professional development. Fifth, respondents suggested that stronger linkages leverage their own agency outreach activities and lead to more referrals to drug treatment agencies.

The Target Cities project used three primary strategies to develop linkages to ancillary services. First, the County Alcohol and Drug Program Administration established linkages through a combination of contractual arrangements (cooperative agreements) and staff hires that enabled CRCs to serve as host sites for ancillary service delivery. Second, the providers themselves were pro-active in identifying, contacting, and seeking agreements with service providers in their region. Third, CSAT directed the Target Cities to participate in two broad initiatives -- The Head Start and Faith Initiatives -- that required collaboration with other community-based organizations. This section provides brief descriptions of each strategy and discusses the overarching issues related to the widespread effort to strengthen linkages.
County Cooperative Agreements

Among the ancillary services targeted in the original Los Angeles Target Cities proposal and early planning documents were vocational rehabilitation, public assistance, and medical care.¹ For each service, the County made arrangements for the CRCs to serve as host sites for service delivery, although the specific approaches varied. These services were among the most popular aspects of Target Cities from the providers' point of view. Even those OPDF directors who were critical of the CRC concept recognized the potential benefits of increasing client access to needed services. Several suggested that the CRCs might expand this function, thereby serving as facilities through which a broad variety of services might be delivered. In practice, however, actual use of the ancillary services varied.

Department of Vocational Rehabilitation. Early in the Target Cities project, the County sought to establish cooperative agreement with the State Department of Vocational Rehabilitation. Due to difficulties reaching agreement about resources and the complexities of contract negotiation, a contract was not signed until September 26, 1991. Under the terms of this agreement, the Vocational Rehabilitation Department dedicated two FTE to the Target Cities project. Each CRC hosted a Vocational Rehabilitation counselor at least once a week. These counselors provided two primary services: (a) screening and assessing clients for eligibility for Vocational Rehabilitation services; and (b) consultation to OPDF and CRC staff and clients.

Referrals to the Vocational Rehabilitation counselors were slow in the first project year. Procedures for OPDFs and CRCs to refer were unclear at first; as this problem was getting corrected (spring, 1992) Vocational Rehabilitation, caught up in a state budget crisis, was unable to see clients (in July and August 1992) because it had no budget allocation.

Although verbal reports indicate that referrals to Vocational Rehabilitation increased in the second half of the project, data about referrals are unavailable. Referrals to Vocational Rehabilitation were not reported in quarterly reports, the continuation proposal, or other Target Cities documentation made available to the evaluators. Indirect support for this finding emerges from the NBAR survey data, which show that providers increased their access to vocational training resources as a result of Target Cities support.

¹ In addition, the County established a cooperative agreement with the City of Los Angeles Criminal Justice Planning Office. This evaluation did not address this agreement. The continuation proposal notes that this cooperative agreement was intended to "coordinate resources and services offered through City departments... and help (Target Cities agencies) navigate the City's bureaucracy on their behalf." (p. 41)
However, use of these services was low -- respondents estimated that 16% of clients on average were referred to vocational training programs.

Despite widespread positive attitudes toward the cooperative agreement between the County and Vocational Rehabilitation, several factors may have depressed use of this service. First, as discussed in previous sections, some OPDFs were located far away from their regional CRC; in these circumstances, clients did not necessarily have an easier time getting to the CRC than the regional Vocational Rehabilitation office. Second, some agencies had strong pre-existing contacts with Vocational Rehabilitation and preferred to use established referral practices rather than switch to the CRC. Third, the requirements for eligibility for Vocational Rehabilitation exclude large numbers of OPDF clients. Specifically, clients must be clean and sober for 60 days -- given an average treatment duration of 7 weeks, relatively few clients will persist in treatment long enough to attain eligibility for Vocational Rehabilitation through the Target Cities agreement. Together these factors raised questions, for some OPDF directors, about cost effectiveness -- although they did not object to the concept of strengthening linkages with Vocational Rehabilitation, three interview respondents wondered aloud if the benefits to clients and agencies justified the total cost.

Department of Public Social Services (DPSS). Although the County tried to establish a cooperative agreement with the Department of Public Social Services (DPSS), they were unable to complete a contract. As an alternative, County ADPA hired a DPSS supervisor to serve as a DPSS liaison. From the perspective of providers, however, this arrangement was similar to Vocational Rehabilitation -- the DPSS liaison spent one day per week in each of the CRCs, meeting with clients and consulting with counselors and case managers in the region.

The DPSS liaison began work for the County ADPA in December 1991. Major responsibilities included: (a) educating staff about DPSS, such as the services that are available to clients, how to access services, and how to cut through the bureaucracy; and (b) providing direct services to Target Cities clients. Many of the direct services to clients included filing formal complaints and/or facilitating quick responses to emergency requests or appeals. Among those with special needs were pregnant women, mothers (who are trying to coordinate the requirements of DPSS, Department of Children’s Services, and their drug treatment plan), clients with AIDS, undocumented clients, and homeless clients. In addition to one-on-one consultations, the liaison held workshops at regional CRC meetings, and, as requested, provided training sessions at OPDF agencies as well. Further, the liaison offered telephone consultation to agencies that needed her services on days when she was working in another region of the County.
Although the evaluation team was unable to obtain complete data on utilization of the DPSS liaison, statistics for one four-month period (January through April, 1993) indicated 444 client contacts (including telephone and in-person contacts; note that the number of individuals served would be less). In addition, 123 staff attended workshops and training sessions during this time.

Interview responses suggest that the DPSS liaison acted as an advocate for Target Cities clients and agencies within the DPSS system. In contrast, the State Department of Vocational Rehabilitation appeared to assume less of an advocacy role, and instead viewed its responsibility as facilitating access to services for those eligible.

Staff and administrators in Target Cities were uniformly positive about the DPSS liaison. The only concern raised in response to this arrangement was that staff wanted even more access to the DPSS liaison and suggested that the demand was excessive for one individual. The high regard that the providers held for the liaison (Pauline Lopez) contributed to the success of this element of Target Cities.

Medical care. Medical care arrangements were managed through agency referrals for the first two years of the project. In the third year, however, arrangements were made for physicians' assistants, under the supervision of a doctor, to again rotate among the CRCs, providing testing for infectious diseases such as TB and HIV and offering limited medical assessment and treatment services. In the few months of time in which this element was in operation during the first funding period, providers indicated appreciation for enhanced access to medical services. However, implementation faced several hurdles. First, all CRCs needed to provide appropriate space for the medical providers, which required modifications to some facilities. Second, a small number of agencies had pre-existing access to medical services (e.g., some agencies had in-house health clinics), and therefore did not derive substantial benefit from this cooperative agreement. Third, the supervising physician, physician's assistants, and providers initially had somewhat different expectations, and County intervention was needed to clarify roles and responsibilities. By the time this element was finally in place, Target Cities was well into its third year of funding. Despite these hurdles, this was probably the most widely-used CRC-based service, and hours per week per CRC increased from an initial commitment of four to 16.

Cooperative Agreements by Providers

In addition to the County-sponsored cooperative agreements, the CRCs and treatment providers in Target Cities also developed their own cooperative agreements. This process involved identifying services to which clients could be referred, learning about these services, educating the services about the drug treatment agency, and establishing an agreement to accept one another's referrals. In addition, most agencies
organized information about ancillary services into a directory or computerized database for others in their agency or region to access.

Beyond these broad commonalities, the cooperative agreements took many different forms. Some CRCs and OPDFs developed written forms to record information about the ancillary services and/or the nature of the agreements between the organizations. Others relied on verbal agreements. Some cooperative agreements were informational only -- the written form recorded basic descriptive information and the standard procedures through which clients or counselors could access ancillary services. Other agreements, however, provided for special treatment for Target Cities clients, such as reduced fees, guaranteed slots, or a certain number or type of free services. Some agreements were in effect, at least informally, long before the Target Cities project began. Others represented new affiliations and new relationships.

Although some providers listed new cooperative agreements in their quarterly reports, the most complete set of information about cooperative agreements appears in the continuation proposal. Between May 1991 and May 1993, Target Cities agencies established 604 cooperative agreements. This list is incomplete since it includes information for only 14 Target Cities agencies. The total number of cooperative agreements established by Target Cities participants is probably higher.

Further, this record of cooperative agreements is unstandardized and therefore difficult to interpret. Some providers recorded their verbal agreements, others only recorded their written agreements, and still others did not specify whether the agreements were written or verbal. Some recorded agreements with CRCs or OPDFs in Target Cities, and others did not. Some included long-established referral sources, such as Probation or the Department of Children’s Services, and others did not. Nonetheless, a review of this list offers the best overview available of the nature of cooperative agreements.

The 604 cooperative agreements listed span a broad set of services, including drug and alcohol treatment services (e.g., sober living homes, residential programs, other OPDF providers), personal counseling (e.g., crisis hotlines, domestic violence, parenting), education and job training (including vocational rehabilitation), childcare providers, legal services, food and shelter, health services (e.g., AIDS testing or education, dental care, optometry, podiatry, physicians), and diverse social services ranging from haircuts and toy donations to energy assistance and taxi vouchers.

Providers reported making 6,405 referrals to the organizations with which they had cooperative agreements. However, most of these referrals were clustered within a relatively small group of agencies. For example, staff reported making five or more
referrals to only 176 of the organizations -- 29% of the total set of cooperative agreements.

In addition, Target Cities agencies reported 3,779 referrals to their agencies from these organizations. Again, the referral sources tended to cluster. Only 106 organizations referred five or more clients to the Target Cities agencies with which they had a cooperative agreement over a two-year period -- 18% of the total set of cooperative agreements.

Because the new MIS developed for Target Cities tracks the number and type of referrals to ancillary services, future reports may have better information about actual patterns of referrals, rather than simply the number of agreements established. There is currently no mechanism for tracking the percentage of clients who in fact receive ancillary services as a result of cooperative agreements. The outcome evaluation (forthcoming) will indicate, however, whether Target Cities clients compared to non-Target Cities clients received a broader array of services.

**CSAT Target Cities Initiatives**

The Head Start and Faith Initiatives provided another means of tightening the relationships between Target Cities agencies and other social service providers.

**Head Start Initiative.** In 1991, Los Angeles County of Education Head Start Grantee and ADPA were awarded a $100,000 grant from the Department of Health and Human Services to link Head Start and Target Cities. The project, called Substance Abuse Assessment, Referral, and Training (ART), was intended to increase access to Head Start for eligible children whose parents were in drug treatment; it also aimed to increase Head Start teachers' awareness of substance abuse issues. Activities focused on three CRCs and three Head Start ART schools and included staff training and cross-training, parent education and outreach, referrals, and case management. This evaluation does not address the Head Start Initiative in depth since it was evaluated separately. Interviews with providers, however, indicated mixed reactions to the Head Start Initiative. All were appreciative of the effort by Head Start to increase linkages to OPDFs and CRCs; some providers, however, were disappointed that they were unable to benefit from increased linkages with Head Start, either because Head Start did not have child care centers in their area or because few clients met the Head Start eligibility requirements. Despite some restrictions, NBAR results indicate that Target Cities agencies increased their access to child care services during the course of the project; the Head Start initiative contributed to this accomplishment.

**Faith Initiative.** Recognizing the influential role of clergy particularly in many minority communities, both CSAT and the State urged providers to strengthen and expand
their linkages with local churches. Such linkages were expected to increase community awareness of substance abuse issues, raise the profile of the CRCs and OPDFs in the community, open new referral pipelines to treatment, and expand ancillary services by tapping into the network of church-sponsored social services. The faith initiative represented a formal effort to achieve these objectives. In the second year of the project, CSAT gave Los Angeles (and the other Target Cities) an additional $4,000 for this purpose. The funds were distributed among the CRCs, so that each received $800.

Without exception, the CRCs and other providers queried about the faith initiative recognized the important role the church plays in community life. As a formal project, however, the Faith Initiative encountered several major obstacles. Chief among these was the County’s inability to actively support the initiative due to County counsel concerns about violating the separation of church and state. Further, several providers noted that the Faith Initiative was introduced by CSAT after implementation of Target Cities had begun — to them, the Faith Initiative represented a major new demand that far exceeded the resources available and another example of a top down management style that did not take provider experience, needs, or perspectives into account. Although a small group of CRC staff and directors spent significant time trying to plan a conference for clergy, the conference did not occur and most providers chose to address the Faith Initiative through independent (and often pre-existing) outreach efforts to local clergy.

Summary and Discussion

By almost any measure, Los Angeles Target Cities project succeeded in strengthening linkages to a wide range of ancillary service providers. This is among the most significant achievements of the project. Clients and their counselors can now access vocational rehabilitation, DPSS, and medical services directly at their local CRC, thereby increasing articulation among program requirements, ensuring that clients gain access to needed services, and reducing cumbersome bureaucracy. Supplementing these centralized arrangements are a complex web of locally-developed cooperative agreements. In the first two years of the project, over 600 cooperative agreements were established, thereby increasing both the visibility of Target Cities agencies and the resources available to clients and staff.

NBAR results supplement interview findings and further support the finding that Target Cities expanded agency linkages to ancillary services. Compared to before the Target Cities project began, Target Cities agencies today report more access to vocational training, child care, and medical services among others. Against this positive backdrop, however, are several concerns about relying on cooperative agreements to meet clients’ needs for ancillary services and thereby provide comprehensive services.
Cost efficiency. One concern is the cost efficiency of the effort to develop cooperative agreements. All CRCs and most OPDFs and PSCs spent substantial staff time in this endeavor. In some cases, there was duplication of effort across CRCs and OPDFs. CRCs established cooperative agreements with organizations that were well known to local OPDFs, for example, or both a CRC and an OPDF in the same region established agreements with the same organization. Further, many of the cooperative agreements were rarely, if ever, used. Fewer than one third of the cooperative agreements listed in the continuation proposal, for example, resulted in five or more referrals from Target Cities staff over a two-year time period. Thus, the cost of establishing many agreements (particularly the staff time needed to identify and meet with other organizations) was in many cases quite high in relation to the benefits that resulted for agency staff and clients. The absolute number of cooperative agreements is probably less important than their quality, and particularly their responsiveness to client and agency needs.

Although all CRC representatives were enthusiastic about the effort to develop cooperative agreements, OPDFs provided mixed opinions, often related to the ratio of costs (effort) to benefit. For example:

The written ones (cooperative agreements) are no better (than long-standing informal relations). We get them just to look good on the quarterly reports.

People (i.e., external agencies) like having the working relationship (with the OPDF), they like knowing the staff, being able to work with us... But it takes a long time to actually get it all down on paper. And I'm not sure how valuable it is. How necessary. I understand the concept, but I'm not sure.

Limited services. A second concern is that cooperative agreements cannot overcome the gaps in the network of social and human services in Los Angeles. Some OPDF and CRC directors explained the problem this way:

There's only one shelter in the area, it's often full, and the clients don't like it there anyway. Medical services are almost impossible to get. I couldn't find a dentist for under $130 to help a client... The belief that services are available and all we need to do is access them is a fantasy.

We need stronger relationships with inpatient programs. All of the waiting and complicated procedures (create problems for us). I wish there were more detox beds... And housing is a huge issue with our clients... We need more, better services for bilingual groups. Spanish-speaking clients can't get the things they need...

We would like to see a stronger medical component. Dual diagnosis services are not well supported. We need ways to get people psychiatric evaluations more easily. Recently, someone was sent here by a mental health agency.
They didn't have a substance abuse problem. The agency was just looking for somewhere to send them.

Thus, although cooperative agreements help agencies make better use of the services that are available, many clients will continue to experience unmet needs.

**Lack of quality standards/control.** A third concern is that cooperative agreements were often established without in-depth -- and certainly without standardized -- assessments for quality. In most cases, staff lacked the expertise to evaluate ancillary services. Even if staff did try to evaluate quality of the ancillary service, however, this information was rarely recorded in written form for others to access. Although quality assessments would be extremely difficult to implement, the lack of such information sometimes deterred staff from relying upon cooperative agreements to make referrals.

**Sustainability.** A final concern about cooperative agreements is sustainability. Certainly, verbal agreements are often dependent on relationships among individual staff. The written cooperative agreements were an effort to institutionalize these relationships. Nonetheless, some staff indicated that they were reluctant to make referrals when they did not know anyone in the ancillary organization. Further, given rapid staff turn-over and the constantly changing array of services provided by community-based organizations, some respondents noted that cooperative agreements would need frequent updating to maintain their usefulness.
Chapter VIII:
Administration and Organizational Relations

Through its focus on linkages and relations among providers, Target Cities represents a systemic change effort. In addition to the intra-agency enhancements described in previous chapters, the project also sought to modify the relations among providers. The implementation of different types of cooperative agreements and the development of the MIS, described in previous chapters, were part of this systemic change strategy.

The administration of the project is another systemic intervention. The Target Cities RFA read, "The target cities program is also designed to enhance collaboration among State, local and Federal officials in seeking improvements in the treatment system" (p. 3). By asking providers to work cooperatively with one another, and with County, State, and Federal administrators, CSAT led to new linkages and new relations among these organizations.

The bi-monthly meetings of the Project Advisory Committee (PAC), convened and facilitated by the State, provided a forum in which representatives from all participating Target Cities agencies, including ancillary service providers, could gather to discuss policy and programmatic issues of common concern. Numerous other work groups and committees also promoted inter-agency contact and communication. These included: (a) regional meetings convened by each CRC to bring together the OPDFs, PSCs and the CRC, generally on a monthly basis; (b) CRC directors' meetings, that provided opportunities for the CRC directors to share their progress and concerns several times per year; (c) quarterly training sessions sponsored by the County for Target Cities agencies, often including presentations by Target Cities staff to their peers; (d) intermittent Project Agency Meetings (PAM), convened by the County, that focused on the nuts and bolts of Target Cities implementation; and (e) a variety of special work groups, e.g., an MIS work group, a continuation proposal work group.

This chapter describes how Target Cities administration affected inter-organizational relations. Four sets of relations are reviewed: (a) Relations among providers; (b) Relations between providers and County administrators; (c) Relations between providers and State administrators; and (d) Relations between providers and CSAT administrators.

Relations Among Providers

Among the major impacts of Target Cities was to increase the level of contact and communication among providers. OPDF and CRC directors repeatedly told the
evaluators that, prior to Target Cities, they rarely talked or met with their peers from other agencies. Through the PAC and PAM meetings, training sessions, and other project activities, directors and some staff become more familiar with other agencies.

In general, the CRC directors had more contact with one another than did the OPDF directors. This reflects both structural factors (i.e., the CRC directors met regularly) and process (since the CRCs were new, directors were more interested in sharing needs and concerns).

Increased contact among agencies brought opportunities for informal consultation and cross-training. OPDFs could learn how peer agencies had handled specific types of problems or challenges, or they could obtain information about assessment and counseling methods that could then be used to enhance treatment. Further, increased contact among agencies could provide social support for staff, thereby raising morale and decreasing turnover. The extent to which these benefits were in fact realized, however, cannot be determined from the interviews and other data collected for this evaluation. Further, increased contact also resulted in some unintended negative effects, including conflict and competition, particularly between OPDFs and CRCs. Finally, the relationship between increasing inter-agency contact and enhancing treatment outcomes is, at best, indirect, and most providers perceived only modest benefits for clients.

Most respondents felt that increased contact among agencies was a positive outcome of Target Cities. For example, one OPDF director said, "The project has provided a vehicle for the outpatient programs to get together. This seldom happened before." Some CRC directors said:

We work as one... All of us are getting along really well... We share ideas, if there's a problem we get the solution... We really respect each other at a personal level, intellectual level, (and) professional level.

I've heard that before (the Target Cities project), the providers hardly ever saw each other. They were just out doing their own thing. Since Target Cities, has come about, it's unified the whole city of LA. They still may have some problems and issues and concerns, but yes, they're working as one. They're finding out that we all need to work together and help each other.

On the other hand, a number of respondents noted that interagency contacts were generally superficial in nature, due to differences among providers, a history of competition among some agencies, and limited time for informal discussion and networking.

Further, higher levels of contact did not necessarily translate into higher levels of cooperation. In particular, tensions between the CRCs and OPDFs had a chilling effect on
inter-organization relations. Dialogue between CRCs and OPDFs was in some cases helpful in reducing tensions, but concerns remained within all five Target Cities regions. These negative relations also spilled over to other units within the agencies hosting CRCs. For example, one OPDF director said,

As far as enhancements go, we don't have much interaction (with other agencies) at all. We've invited them along on things, but we don't get much response. It's open on our part. They have problems with our CRC, so it affects relations with our outpatient program too.

Even where Target Cities participants were pleased to have higher levels of peer contact and networking, the benefits for clients were perceived as indirect. Higher levels of inter-agency contact did not produce more cross-referrals. OPDF directors explained that clients generally select an OPDF agency based on location. As a result, they did not expect increased communication among agencies to lead to more referrals. One director said, for example, "Cross referrals are unchanged, and I don't know why they would or should change. Our clients are in our immediate area. The client populations don't cross."

**Relations Between Providers and County ADP Administrators**

The early weeks of Target Cities were marked by distance and disagreement between providers and County. The OPDF directors were only minimally involved in proposal preparation and therefore did not feel a sense of investment in or ownership over the project in its early stages. Further, they strongly objected to the concept of centralized intake. Numerous respondents referred to a "provider revolt" or "rebellion" when centralized intake was introduced. Following this rocky start, however, relations improved markedly.

Both providers and County administrators generally responded that Target Cities had improved their relationships with each other. First, Target Cities produced considerably more in-person contact between agency heads and County administrators, leading to collegial relationships that supplemented memos, telephone calls, and County-initiated audits and site visits. Beyond that, several providers mentioned that the County staff tried to support and assist providers by providing training sessions, responding to questions, and trying to intervene on behalf of providers in response to their concerns. Representative comments include:

We've become more close to the County administrators. We see them all the time now. It's always been good, but it's better. They are very supportive, and they are trying to be helpful in maintaining the whole project.

We call them, we meet with them. It's much better... The more you work on projects and try to implement things and have to meet them in a relationship,
you learn to you respect each other's opinions and ideas... Every month I've seen a difference.

On the other hand, some providers were disappointed that County administrators did not move more quickly to implement the MIS. Others wanted the County to provide more information, better follow-up to requests from providers, more advocacy on behalf of the providers in negotiation with the State and CSAT, and more leadership in writing the continuation proposal. For the most part, however, providers expressed appreciation for County administrators' efforts to work with them and seek their input.

**Relations Between Providers and State ADP Administrators**

Most providers had little understanding of the State's role in Target Cities. On the one hand, providers enjoyed meeting administrators from the State and believed that the opportunity to talk informally with them was helpful to both Target Cities and other programs overseen by the State. On the other hand, some providers wanted more information about the State's contributions to Target Cities. They knew that the State had received a substantial sum of money from CSAT, but they did not know the specific responsibilities of the State. For example, one OPDF coordinator said, "What is their role, their power? I would like to know what they can change, what they cannot change." In addition, a number of interview respondents said that disagreements between the State and the County about Target Cities implementation (e.g., related to the Faith Initiative and budget allocations) had a negative impact on the project.

Throughout the first three years of the Target Cities project, the State organized and directed bi-monthly (6/year) meetings of the Project Advisory Committee (PAC), a group that included representatives of all participating agencies, ancillary services, consumer (client) representative evaluators, and administrators from the County, State, and CSAT. These meetings received mixed reviews. Some participants found them very effective, others noted only that they had improved, and some were highly critical. By the end of the first funding period, however, a consensus was emerging that the PAC meetings could improve. A specific concern was that they focus on policy issues, as opposed to programmatic details, and that they lead to specific action items rather than general discussions (that one respondent called "gripe sessions") about member concerns.

**Relations Between Providers and CSAT Administrators**

Although the Target Cities participants were appreciative of CSAT support and recognized that the project officer(s) went to considerable effort to attend PAC meetings, most were disappointed in their relationship with CSAT. In particular, providers objected to top-down initiatives imposed upon treatment agencies with little consultation. Interview respondents gave a number of examples, although the introduction of the CIAI
and Faith Initiative stand out. Beyond this, providers felt that CSAT was unclear and occasionally inconsistent in its expectations. Providers also felt harshly and unfairly judged during a site visit by CSAT leaders in June 1992. Representative comments include:

What did they want from Target Cities as a whole? They got upset because we didn't do things the way they wanted. Well, who's fault is that?... CSAT wasn't clear about what they wanted.

They don't understand the needs of the clients and the providers... Come and spend a day or two with the providers, drive around the neighborhood, find out what's actually going on here.

With the state and feds, there is a big communications gap between them and us. We need more cooperation, more action... An example of this communications gap is with the CIAI revisions and the Spanish translations. They asked for our help, our advice, but nothing ever came of it... The Faith Initiative was the same thing. It was obviously important to them politically, but they couldn't get it together.

Over the three years they have changed direction, put emphasis on different areas and different times... Another thing is figuring out what information they want from us. The result is that we have to do tabulations in retrospect.

Summary

Implementation of the Target Cities project increased the level of contact and communications among providers, and between providers and County, State, and Federal drug treatment administrators. Although most providers cited increased contact with peers and administrators as a positive aspect of Target Cities, the relationships that resulted varied in quality.

Target Cities provided opportunities for OPDFs and CRCs to learn more about the activities of other agencies and to become better acquainted with professional peers. However, the perceived impacts of this change were modest. Cross-referrals were unchanged, and distrust between OPDFs and CRCs (with spillover effects to other agencies in some cases) inhibited communication and cooperation.

In general, Target Cities strengthened relations between providers and County administrators despite a difficult beginning. Relations with the State were strained by uncertainty about the State's responsibilities and perceived tensions between the State and the County. Providers were also critical of CSAT for their perceived top-down management style, especially with regard to the CIAI and the Faith Initiative.
Chapter IX: Discussion

Summary

The Los Angeles Target Cities project sought to enhance outpatient drug free treatment by increasing the breadth and quality of service and strengthening linkages with ancillary services. Seventeen (17) outpatient drug free agencies serving adult, coed populations in Los Angeles City were allocated $75,649 per year to increase the comprehensiveness and intensity of their services by adding new components (e.g., life skills or recreational events) and increasing agreements with and referrals to other medical, social, and human services. In addition, Target Cities funds were used to establish two Perinatal Service Centers, which provided specialized services for women and their children through a more intensive outpatient regimen than most other outpatient services. Third, five Community Resource Centers were established to provide additional points of entry to the drug treatment system, offer intake assessment and referral services; coordinate and support the activities of participating OPDFs in their region, and increase client and staff access to ancillary services. A management information system was planned and partially implemented to provide the County with standardized information about intakes, assessments, admissions and discharges and to support referrals, wait lists, and scheduling among providers. Other activities included County-sponsored training workshops and the Head Start and Faith initiatives. An advisory committee of drug treatment providers, project subcontractors, and government (County, State, and Federal) administrators provided guidance and oversight to Target Cities activities.

Among the major accomplishments of Target Cities are:

- Established five regional Community Resource Centers to provide additional intake, assessment, and referral services, to build a network of ancillary services, and to support and coordinate regional OPDFs;
- Strengthened linkages to ancillary services, especially medical care, DPSS, and vocational rehabilitation;
- Integrated service enhancements into outpatient drug free treatment, including (but not limited to) life skills training, relapse prevention, and recreational activities;
- Increased OPDF agency access to assessment resources and ancillary services;
- Established two Perinatal Service Centers to increase system capacity and enhance services for pregnant women and mothers and children;
- Increased the standardization of intakes and assessments so that a common core of information was collected;
- Increased communication and contact among drug treatment providers, and between drug treatment providers and (a) other social service agencies; and (b) local, State, and Federal government; and
Increased awareness of staff and directors about the needs of special populations, especially women and clients of color, and enhanced special services for these populations throughout the system.

Specific implementation problems or barriers Target Cities encountered included:

- Early resistance to the concept of centralized intake and subsequent changes to the proposed project plans, leading to some delays in start-up and lasting ambiguity about some aspects of the Target Cities goals, strategies, and responsibilities;
- Tension and distance in relations between CRCs and OPDFs that were not in the same agency;
- A lack of quality standards for outpatient enhancements, leading to considerable variation in the intensity and nature of those enhancements; and
- Difficulty within PSCs due to high rates of client drop-out and insufficient support from related social services such as DCS and DPSS;
- Delays in establishing the MIS, and some concerns among providers about the benefits of the MIS for them in relation to the time needed to support and participate in the MIS;
- Dissatisfaction among providers with their relationship to CSAT (and, to a lesser extent, other administrators) due to "top down" directives perceived as inappropriate and sometimes harmful to agencies or clients.

Despite these problems, significant change was observed at the level of both individual agencies (e.g., through the enhancements to treatment and through staff hires) and at the systemwide level (e.g., through the development of CRCs, the MIS, and the various meetings among participants). The effects of these, and other accomplishments, on client retention and success in treatment will be determined by the results of the forthcoming outcome evaluation.

At this time Target Cities faces the challenges related to (a) maintaining and institutionalizing the successful aspects of Target Cities, (b) continuing the implementation process in some key areas, and (c) improving some aspects of implementation.

Fortunately, Los Angeles was awarded a continuation grant, so the Target Cities project end date is now 1995 instead of 1993. The continuation project brings challenges of its own, however, including the integration of other modalities into Target Cities, strengthening the intake role of the CRCs, and maintaining enhancements on a significantly reduced budget. This remainder of this chapter reviews five key challenges facing Target Cities in the continuation funding period and beyond.

**Sustainability**

The future of the CRCs, PSCs, and OPDF enhancements largely depends on resources. Target Cities has been the sole funding source for the CRCs, the primary funding source for PSCs, and a key funding source for OPDFs. Among OPDFs, Target Cities funds supported enhancement staff at most agencies; although these staff have
differing responsibilities, their presence enables the agency to increase the breadth of services provided. Further, the project has supported development of the MIS, including purchase and installation of hardware in participating agencies.

Unless another funding source is identified, many elements of Target Cities will be significantly downsized or dismantled at the conclusion of the continuation period(s). Beyond this, however, uncertainty about funding affected implementation in a number of ways.

The perception that CRCs were probably, or even potentially, going to be closed within a few years provided disincentives to OPDF directors to work with the CRCs. As discussed in Chapter III, a number of issues caused considerable tension between OPDFs and CRCs, including ambiguity about responsibilities and perceptions of bias in referral patterns. However, instead of addressing these issues directly, many OPDF directors preferred a "wait and see" attitude, recognizing that Target Cities funding was of limited duration and that CRCs might represent nothing more than a short-term experiment. This placed the CRCs in a difficult position. If they did not work out their relationships with OPDFs to ensure broad support, the feasibility of continuing funding decreased. However, until OPDF providers perceive that CRCs are around to stay, the directors had little motivation to resolve the issues surrounding them.

Similarly, the PSCs had little motivation to refine their programs -- and clarify relations with OPDFs -- until their long-term directions were clarified. When Target Cities ends, the PSCs may continue, but they may look very different. It makes little sense for the system to lodge expertise in women's needs within the PSCs when there is no assurance that these units will continue in their current form. A related concern was that PSCs might inadvertently hurt the OPDFs by draining away referrals (and referral sources) or other resources. Again, uncertainty about the future increased the difficulty of addressing and resolving such issues.

The long term sustainability of the MIS is also open to question. Even if the County obtains funding to support the administrative costs of maintaining the MIS, agencies will in all likelihood have to bear the costs of upgrading and maintaining hardware and software. Unless providers perceive substantial benefits to them accruing from the system, they will be unlikely to assign it a high priority in budgeting, staffing, or work assignments. Further, if the system is used to rank or rate agencies, and especially if agencies experience negative impacts of such evaluations, their long term support for the MIS and motivation to participate could be expected to decline.

Finally, the cooperative agreements also need continuing attention and financial support if they are to remain useful. Staff will need to renew and update agreements in
response to changing client and agency needs. Changes to ancillary service programs and agencies will also have implications for cooperative agreements. And without ongoing informal relationships between agency staff, the significance of a formal cooperative agreement is questionable.

Thus, without continued support, the duration of many elements of Target Cities is questionable. Although some systemic change has been achieved, these changes are largely dependent on external resources. Further, without assurance that the Target Cities plan will persist over time, agencies are understandably reluctant to invest the time needed to fine tune the system and resolve some knotty problems. Although OTI/CSAT intended Target Cities to provide seed money rather than long term support, additional funding sources (other than CSAT) are not apparent.

Centralized Intake

Although Los Angeles replaced its original plan to develop regional intake units with community resource centers, CSAT and project administrators continued to press for movement toward centralized intake. The rationale for central intake is based on the Institute of Medicine (1990) observations that (1) the need for treatment far outstrips capacity; and (2) there is a need to reduce caseloads and increase average quality, performance, and retention. The Target Cities RFA described the advantages of Central Intake as adding "to the rapidity and flexibility" of the drug treatment system response capabilities. In addition, the RFA suggested that, relative to individual agencies, central intake units are better able to detect systemwide changes in treatment needs and gaps in services (p. 21).

In response to the CSAT funding guidelines, the CRCs have assumed increasingly active roles in intake and assessment, particularly during the continuation funding period (1994-1996). Of particular note is that the County-sponsored toll-free number for information about drug treatment referrals now connects callers directly to their closest CRC. The CRCs screen the calls and, as appropriate, provide assessments and referrals to drug treatment agencies. At the same time, however, the OPDFs also continue to accept and encourage direct referrals using their established networks.

The vast majority of OPDF providers interviewed for this project expressed negative attitudes toward centralized intake. They did not believe that such a system would serve clients well, especially given the size of Los Angeles and the "patchwork quilt" of diverse neighborhoods that constitute the city. Although the Target Cities RFA specifies that central intake units "do not replace the existing outreach, case finding, and intake procedures of local treatment programs" (p. 20), many providers believed that implementation of centralized intake meant transferring responsibility for these and related
activities (e.g., referrals) from agencies to CRCs. They were concerned that the system would become more bureaucratic, less culturally sensitive, and slower to respond to client and neighborhood needs. They feared that sensitive and experienced clinical judgment would be replaced by rigid protocols and policies. The current system, in which CRCs are not independent entities but are affiliated with an agency, led to additional concerns about how referrals would be distributed among agencies.

Whatever the desirability of centralized intake for Los Angeles, the lack of enthusiastic support from providers is likely to pose a major obstacle to successful implementation. The agencies would need to be provided with a stronger rationale than has been offered to date, and implementation would need close supervision. Further, referral sources, including Department of Children's Services, Probation, Parole, and other agencies would also need to be convinced of the benefits to them from use of centralized intake facilities instead of the agencies they are used to working with.

There are additional reasons to question the appropriateness of centralized intake for Los Angeles. For example, Haaga and McGlynn (1993)¹ point out that there is no conclusive evidence to support any particular matching strategy, and in many communities the differences between existing programs are quite limited. The matching problem may be further aggravated by evidence that the most effective matching is between client and counselor, rather than clients and programs.

Although centralized intake was not fully implemented within the first Los Angeles Target Cities project, the project did substantially increase coordination. For example, agencies agreed to obtain a common core of information, to be reported to the County in a (more or less) standardized fashion, although they continued to use in-house instruments and procedures. Further, by housing some resources (such as physician's assistants or doctors, Vocational Rehabilitation representatives and a DPSS liaison) within CRCs, Target Cities promoted the quality and comprehensiveness of care in a more cost effective manner than asking every agency to acquire these resources on their own.

This emergent model of coordinated intake offers some of the same advantages of centralized intake without raising agency concerns about losing control of their referrals and client base. Like the concept of centralized intake, coordinated intake offers better access to ancillary services and increased data (through the MIS). Shared resources both improves quality and strengthens cost effectiveness of the system. Similarly, the introduction of CRCs as another source of intakes, assessments, and referrals might enable

treatment agency staff to focus more on case management or provide more intensive treatment.

A shortcoming of coordinated compared to centralized intake is that quality controls are more difficult to implement. On the other hand, the ability for agencies to develop procedures and tools customized to the local environment could perhaps enhance quality in relation to a single procedure applied to all clients.

The Los Angeles system, then, offers an opportunity to review and assess the effectiveness of coordinated intake as an alternative to both traditional, decentralized (or autonomous) intakes, and proposed centralized intakes. Not the least of the benefits of coordinated in relation to centralized intake, at least within Los Angeles, is the higher level of participant acceptance and cooperation. For such a test to be valid and meaningful, however, Los Angeles providers would need assurance that they would not lose control of their referral sources or their intake, outreach, assessment, and referral procedures.

Comprehensiveness vs. Focus

The Los Angeles Target Cities project assigned a high priority to increasing the breadth of treatment. This goal was manifested in a number of different strategies, most notably through the development of cooperative agreements and the addition of new components to outpatient drug free treatment.

Although this evaluation does not indicate the effects of these modifications on treatment outcomes, there are good reasons to expect that a more holistic approach to treatment would increase client access, retention and success. Referrals to ancillary services can help to remove barriers to effective treatment, improve coordination among the requirements and recommendations of different services, and strengthen an individual’s commitment and bond to the treatment agency. A broader range of services can increase the intensity and quality of treatment while providing clients with valuable skills and information.

On the other hand, the push for more comprehensive treatment raises the risk that, in trying to serve all clients’ needs, agencies may dilute their core mission and reduce quality of their basic services, especially if resources decline over time. In other words, given limited resources, are OPDFs and other providers better off providing a more limited range of services with a high degree of quality control vs. a broader range of services that cannot be subject to the same level of review and oversight?

Comprehensiveness is neither good nor bad in itself. Rather, its value depends on the service delivery context. If agencies maintain a clear understanding of their purpose and priorities, and if resources and staff skills are sufficient to enable quality control over a broad range of programs and services, a more comprehensive approach may well prove
highly effective. On the other hand, if in increasing the comprehensiveness of services, OPDFs (or other providers) lose sight of their priorities or spread staff too thinly over numerous activities, program quality will suffer.

A related issue is the need to better understand the limits or boundaries of comprehensiveness. For example, over two thirds of the agencies with which Target Cities had cooperative agreements received fewer than five referrals over a two-year period. Even making allowances for under-reporting, the cost effectiveness of the effort to develop as many cooperative agreements as possible appears low. Time and energy might have been better spent on a more focused approach to identifying and securing services that staff and clients clearly needed, even if that resulted in a smaller total number of cooperative agreements.

Lack of Services

As discussed in previous chapters of this report, many drug treatment providers noted that their efforts to strengthen linkages with ancillary services could not overcome the fundamental limitations of the social service systems in Los Angeles. Despite vigorous efforts to establish cooperative agreements, clients still experience unmet needs related to health care, psychiatric or psychological services, child care, housing, transportation, detoxification and (to a lesser degree) residential treatment. Given current political conditions in Los Angeles and nationally, the availability of social services is unlikely to increase in the near future.

Thus a challenge facing the Target Cities project in the future is to develop strategies for addressing clients’ unmet needs when the larger system of social and human services is inadequate. One of the strengths of Target Cities to date is that it has successfully demonstrated several models for increasing client access to services including formal and informal cooperative agreements, hiring staff in County ADPA with specialized knowledge of ancillary services, and coordinating initiatives that may include joint grant-writing. In future months, however, administrators may need to decide how or whether to advocate for specific ancillary services and/or how to reallocate scarce resources to better address client needs.

Lack of Quality Standards

Although the Los Angeles Target Cities project was supposed to establish quality standards for Target Cities services, this did not systematically occur. For example, the supplemental enhancement services that the OPDFs were responsible for providing were never clearly defined or described, and implementation varied widely. Similarly, the PSCs were not guided by quality indicators for their services. Quality standards for the CRCs, too, were largely unspecified. As new units, the PSCs and CRCs needed flexibility to
modify their programs. In the future, however, quality standards will become increasingly important, both to guide planning and implementation and to evaluate units' performances.

Further, although the County provided quarterly training workshops and many agencies supplemented these with in-service or external training opportunities for staff, minimum training standards were not implemented as intended in the management plan. A similar lack of standardization emerged in reporting and data collection. Different providers defined the same data elements in different ways, so that the resulting information must be interpreted and used only with great caution.

Despite considerable effort to develop cooperative agreements among agencies, these agreements for the most part do not (and probably cannot) provide quality assessments of potential referrals. Thus, some staff were reluctant to use the cooperative agreements while others did so without knowing whether the services to which they were referring clients met minimum standards of quality for that field.

The lack of specific quality standards suggests an important direction for the future. The purpose of such standards should not be to force agencies to provide the same services, but rather to ensure that all meet minimum standards of quality and that all agree on a common definition for data elements and specific types of services (e.g., life skills training, relapse prevention).

Provider-Administrator Relations

This evaluation underscores the need for provider involvement in planning, as well as implementation, of Target Cities and other treatment innovations. Providers responded negatively when programs and procedures were imposed upon them, regardless of the merit of those decisions. When top-down mandates were of questionable value (as in the case of the CIAI), provider-management relations deteriorated still further, reduced morale, and distracted providers from the basic mission and purposes of the project.

Agency directors and staff in Los Angeles believed that they had more knowledge and expertise in some aspects of drug treatment than did administrators at the County, State, or Federal levels. They wanted to be consulted before decisions were made, and they wanted information about project administration (e.g., the development of the MIS) throughout the course of the project. This approach is congruent with the evaluation literature, which repeatedly points to the importance of staff involvement and participation for program effectiveness.

Nonetheless, the sheer number of individuals and agencies involved in Target Cities, the need in some cases for quick decision-making, and the physical distance among Target Cities participants and administrators increased the difficulties of communication. The bi-monthly PAC meetings could not fully address provider concerns in this regard.
Further, the requirement to keep some information confidential (e.g., the legal action surrounding the MIS contract) also inhibited open communication. Finally, participants had differing opinions about some aspects of the project, which were difficult to resolve in a group setting.

The cooperative agreement between CSAT and the State gave CSAT a relatively high level of control over and involvement in Target Cities (especially when compared to funding strategies such as grants). When CSAT administrators had concerns about the Los Angeles project, they expected the system to respond. Unfortunately, the Los Angeles treatment providers did not always understand CSAT needs and expectations until CSAT reacted critically to the Los Angeles plan. In some instances, the Los Angeles providers did not always agree with CSAT needs and expectations, but felt forced to change their procedures anyway.

Thus, a challenge for the future is to find ways to more clearly communicate administrative expectations up front, to incorporate provider feedback into planning in a collegial rather than conflict-driven manner, and to provide opportunities for productive discussion between providers and administrators. In this way, providers will develop a stronger sense of ownership and investment in new initiatives, which increases the likelihood and success and sustainability.

Conclusion

The Target Cities project generated substantial activity and change among outpatient providers in Los Angeles. In addition to the creation of five new Community Resource Centers, two new Perinatal Service Centers, and an MIS, the project stimulated enhancements to outpatient drug free treatment, stronger linkages with ancillary services, and increased communication among providers. Future challenges facing Los Angeles including finding ways to sustain and institutionalize those aspects of the Target Cities project that prove effective; determining the appropriate model for intakes among at least three choices -- decentralized, centralized, and coordinated -- and completing implementation of the model; finding the appropriate balance between ensuring comprehensive treatment and more focused, specialized services; obtaining needed ancillary services that are in short supply within Los Angeles; developing quality standards; and enhancing relations between providers and administrators to build a sense of ownership and investment in Target Cities among providers.
APPENDIX A:

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PROJECTS IN TARGET CITIES
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APPENDIX B:

INTERVIEW PROTOCOLS
INTERVIEW FOR OPDE DIRECTORS

- Explain purpose of interview
- Review major topics to be discussed
- Stress confidentiality

PART I: INTRODUCTION AND CONTEXT

I'd like to begin by asking you a few background questions about this OPDE program.

1. Is this the only site? YES ____ NO ____
   a) If no, where are the other sites located?

2. What programs are offered in addition to the OPDE?
   Probes:
   - List names of programs
   - Geographical locations
   - Primary services and activities provided
   - Client populations served by each

(IF THERE ARE ADDITIONAL PROGRAMS:
3. How many FTE staff are employed by the host agency? # ____)

4. How many FTE staff are employed for the OPDE program itself? # ____

5. How would you describe the predominant client characteristics and needs of the communities that you serve—with regard to substance abuse treatment services?
   Probes:
   - What are the drugs of choice in this community?
   - How have the needs of the populations you serve changed in recent years? What do you perceive to be the emerging needs?
   - Where does the host agency get most of its referrals?
   - Does the agency target particular subgroups of substance abusers such as women, adolescents, crack users, etc.? Note target populations.
6. Do you have any handouts that describe the agency in general and/or the OPDE program elements? May I have a copy?

Next I'd like to ask you a little about how you first got involved with the OPDE program.

7. Did you work for this agency prior to the Target Cities project?

   YES ____   NO ____

Probes:
   • If yes, has your role stayed the same throughout the past 3 years?
   • If no, what were you doing prior to joining the OPDE?
   • When did you begin work with the OPDE?
     MONTH _______ YEAR _______
   • (Clarify respondent's title and role)
8. You mentioned earlier that the OPDE currently has (# AT Q. 4) FTE employees, including yourself, to carry out the various activities we just discussed. Could you tell me the primary duties and responsibilities of each staff member with regard to the Target Cities project?

Probes:
- When were they hired?
- Are all of these staff paid with the Target Cities funding, or are they paid using other funding sources? (Determine the % of time covered by LATC)

9. Next I'd like to ask about the major funding sources for the OPDE.

Probes:
- Do you currently receive funding from sources other than LATC?
  YES ____ NO ____
- What are your major sources of funding now?

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<thead>
<tr>
<th>Source</th>
<th>Amount (If known)</th>
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<td>LATC</td>
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<td>Federal government</td>
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<td>State government</td>
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<td>Local government</td>
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<td>Host agency general support</td>
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<td>Client fees</td>
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- Other than the LATC money, how stable has your funding been since the Target Cities project was started in May of 1991?
- Did support from other funding sources decline, increase, or stay about the same?
- Did you obtain any new sources of funds other than LATC?
PART II: IMPLEMENTATION HISTORY

Next I'd like to get your perspectives on how your OPDE has evolved over the course of the LATC project.

10. How did you first hear about the Target Cities project? How did you first get involved?

11. When did your OPDE first begin implementing enhancement activities?)

MONTH _____ YEAR _____

PROBE FOR EITHER A DATE OR A PHASE IN PERIOD.

12. When would you say the implementation process was completed? That is, by what date was the program that exists today essentially in place? (Explain if necessary that this information will help us determine how to compare client characteristics and outcomes before and after enhancements were implemented.)

MONTH _____ YEAR _____

13. Please describe the major changes in the OPDE as a result of your participation in Target Cities? (LET RESPONDENT ANSWER IN HIS/HER OWN WORDS)

PROBE FOR EACH OF THE FOLLOWING)

(a) ODPE Programmatic Activities and Functions: What if any changes related to __ have occurred in your OPDE as a result of the Target Cities project?

- Intake and assessment
- Direct services
- Case management
- Referrals
- Outreach
- Linkages/networking with other agencies
- Faith and Head Start initiatives
- Technical assistance
- Staff training
- Data collection and analysis
- Program Management and Administration
- Program resources, including equipment, space, materials
- Other activities
14. **USE THESE PROBES AS NEEDED TO FILL IN ANY GAPS?**

a) **Intake and assessment:** Could you describe the procedures that are currently in place for assessing clients' needs? When did you first start using the Client Intake and Assessment Instrument (CIAI)?

b) **Direct services:** What direct services does your OPDE currently provide on site.

Probes:
- Is child care provided (on or off-site)?
- Is transportation assistance provided?
- Other direct services?
- To what extent are these services used?

c) **Case management:** Does your agency provide case management services? What are the duties of the case manager? How are client treatment plans designed, prepared and implemented? How frequently are they reviewed? Who participates in the process?

d) **Referrals:** What are the specific client referral procedures that are used by your OPDE?

Probes:
- What types of followup, if any, does the OPDE do to see if client needs are being met?
- When and how are client referrals tracked?
- What forms and procedures are used (logs, forms, etc.)

e) **Outreach:** What types of community outreach activities have been undertaken?

f) **Faith and Head Start initiatives:** How have you participated in the faith and Head Start initiatives?
g) **Staff training.** What types of staff training does your OPDE provide to OPDE staff, other providers, other agencies/organizations?

Probes:
- Type of training sessions
- Number of training sessions
- Target audiences
- Dates training occurred

i) **Data collection and analysis:** What types of data do you routinely collect on:

1) Number of intakes
2) Client characteristics
3) Status dates
4) Service dates
5) Retention or dropout rates
6) Number of client referrals
7) Number of clients served
8) Client satisfaction
9) Other data for tracking program activities or impacts

DETERMINE WHETHER SYSTEMS ARE AUTOMATED OR HARDCOPY. OBTAIN COPIES OF RELEVANT DOCUMENTS OR REPORTS IF POSSIBLE.

j) **Equipment and Resources.** Has your OPDE used its LATC funding or other outside funding to purchase or develop resources or equipment that were needed to meet the project goal and strategy? This includes things like a video library, reading material, computer software, transportation equipment.

- List resources or equipment purchased/developed
- For each item mentioned, determine if purchase was made with Target Cities funding.

k) **Other activities:** Are there any other activities of the OPDE that you haven't already described? Include both activities funded by Target Cities support and other sources of support.
15. Next I'd like to find out more about the relationships that your OPDE has established with other agencies.

a) What types of cooperative agreements has your OPDE established? How many cooperative agreements do you have now? With what agencies?

Probe for types of agencies:
- drug treatment providers
- health or mental health
- education
- legal/law enforcement/judicial/correctional
- human service agencies
- DPSS (confirm that agency has this link through their CRC)
- Vocational Rehabilitation (confirm that agency has this link through their CRC)

a) How did your OPDE go about establishing cooperative agreements?

- Did your OPDE establish these agreements or did the CRC in your region establish these agreements? (IF CRC, Skip to b)
- How did you decide which agencies to target?
- How did you approach them?
- What were the primary obstacles to establishing these agreements?

b) What kinds of services have you received from those agencies with which you have cooperative agreements?

- Are services provided on site at the OPDE? on site at the CRC?
- Do LATC clients get preferential enrollment?
- Do agencies provide training or technical assistance?
- Do agencies give LATC agencies or clients a break in price?

c) What kinds of services have you provided to those agencies with which you have cooperative agreements?

d) Do you have information about the number of referrals you have provided to these agencies over the last month (or quarter or year)?

   ___YES    ___NO

IF YES: Can we obtain a copy of this information from you?
e) Do you have information about the number of referrals you have received from these agencies over the last month (or quarter or year)?

   YES  NO

IF YES: Can we obtain a copy of this information from you?

f) What issues must be addressed for continued progress in establishing cooperative agreements and working arrangements with other service providers?

g) In addition to those agencies with whom you have cooperative agreements, with what agencies have you strengthened your informal linkages?

h) With what agencies or services do you want stronger linkages?

   Probe:
   - What services do your clients may need that are currently unavailable to them?
   - What issues need to be resolved in order for this to occur?
16. Now I'd like to give you a copy of a generic time line that we've assembled to pinpoint critical milestones in the Target Cities project. We'd like you to take a few minutes to review the time line and tell us what you consider to be the major milestones in the development of your OPDE.

PROBE FOR THE DATES WHEN CRITICAL ACTIVITIES AND FUNCTIONS WERE PHASED IN. SEE Q 12-13.

Probe: Looking back, what do you consider to be the major milestones in the development of this OPDE? What stands out as the most significant or biggest events?

17. As you think back over the past 3 years, what obstacles, barriers, or problems have you encountered related to the Target Cities project? In your opinion, what factors have interfered with the implementation of the project? (IF NEEDED: For example, the MIS was delayed and is only now coming online. Many providers consider this to be a barrier to the successful implementation of Target Cities. In your opinion, what other challenges have you faced in implementing target cities?)
There are a number of LATC related meetings that are conducted on a regular basis. Please tell me whether you usually attend the following meetings, and the date you first attended each one. Let's start with the ...

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k) How useful do you think these meetings are? How could they be improved?
PART V: LINKAGES and SYSTEM RELATIONSHIPS

Next I'd like to discuss your interactions with the key actors in the Target Cities project -- including the CRC and the other providers as well as the county, state and federal staff at OTI and CSAT. Let's start with your relationships with your CRC.

19. How would you characterize relationships between your OPDE program and the CRC in your region?

Probe for indicators:
- Degree of cordiality
- Open, friendly
- Formal
- Frequency of contact
- Accepting of inputs

a) In a typical month, how often do you or your staff have formal meetings with CRC staff or managers in your region?

RECORD THE USUAL NUMBER OF MEETINGS PER MONTH:

#_____

b) In a typical month, how often do you or your staff have informal telephone or in-person contact?

RECORD THE USUAL NUMBER OF CONTACTS PER MONTH:

#_____

c) How much direct interaction is there between the OPDE counselors and the CRC staff?
20. What other kinds of assistance have you received from the CRC in your region since the inception of the CRC?

PROBE FOR TYPE OF ASSISTANCE AND WHEN IT OCCURRED.

Types of possible assistance:
- Outreach
- Technical assistance
- Training
- Liaison with other agencies
- Crisis intervention
- Other

21. Over the last 3 months, what kinds of assistance have you received from the CRC in your region?

PROBE FOR TYPE OF ASSISTANCE AND WHEN IT OCCURRED.

Types of possible assistance:
- Outreach
- Technical assistance
- Training
- Liaison with other agencies
- Crisis intervention
- Other

22. Over the past month, how many referrals did you receive from the CRC?

# OF REFERRALS _____
23. How could relations with the CRC in your region be improved or strengthened? What issues need to be resolved for this to occur?

24. How would you characterize relationships between your OPDE and the other OPDEs in your region?

Probe for indicators:
- Degree of cordiality
- Open, friendly
- Formal
- Frequency of contact
- Accepting of inputs

a) In a typical month, how often have you had contact with other OPDE staff or managers through organized meetings?

RECORD THE USUAL NUMBER OF MEETINGS PER MONTH:

#_____  

b) In a typical month, how often have you had informal telephone or in-person contact with other OPDE staff or managers?

RECORD THE USUAL NUMBER OF CONTACTS PER MONTH:

#_____
c) How many referrals do you receive from other OPDEs in a typical month? How many over the past 3 months? What percentage of your total referrals per month does this represent?

# OF REFERRALS IN A TYPICAL MONTH ______
# OF REFERRALS OVER LAST 3 MONTHS ______

d) Over the past 3 months, how if at all have the OPDEs worked together? What issues have you jointly addressed or on what activities have you collaborated?

25. Over the past month, how many referrals did you provide to each of the OPDEs in your region?  # OF REFERRALS ______

26. How could relations with the OPDEs in your region be improved or strengthened? What issues need to be resolved for this to occur?
27. How would you characterize your relationship with the county, state and federal agencies that have participated in LATC?

Probe:
- How has participation in LATC influenced or modified your relationships with the LA County Dept. of Health Services Alcohol and Drug Program Administration?
- How can the County administration be more useful or helpful to you?
- How can the California Department of Alcohol and Drug Programs be more useful or helpful?
- How can OTI/CSAT be more useful or helpful?
PART VI: FUTURE DIRECTIONS FOR LATC

Before we finish the interview I'd like to ask you a few questions about how well you think the LATC has served the substance abuse treatment community and what could be done to improve the program's effectiveness.

28. In retrospect, what would you do differently if you could re-do LATC?

Probes:
- What advice would you offer to a city that was just starting up a target cities project?
- Would you have used the LATC money in the same way?
- How could LATC funding be better used to serve your community?
  That is, what changes if any would you like to see in the goals, strategies, administration, or any other aspects of the project?

29. Focusing on Los Angeles, what issues remain to be resolved if LATC is to achieve its goals and objectives?
30. How do you think the conversion of CRCs to CIUs will impact the treatment system in LA?

Probes:
- Why is it a good or a bad idea?
- What problems do you anticipate?
- How will it impact relationships among CRCs, providers, other agencies?
- How will it impact the current activities and functioning of the CRC?

31. How could your OPDE better serve your community? That is, what changes if any would you like to see in the goals, strategies, administration, or any other aspects of the OPDE?

END OF INTERVIEW
Thank the respondent and leave the following handouts (if needed)

- Time line
- Caseload characteristics
- Referrals to OPDEs
- Funding sources
INTERVIEW FOR CRC DIRECTORS

- Explain purpose of interview
- Review major topics to be discussed
- Stress confidentiality

PART I: INTRODUCTION AND CONTEXT

I'd like to begin by asking you a few background questions about this CRC and the host agency ________________.

1. Is this the only site? YES ____ NO ____
   a) If no, where are the other sites located?

2. What programs are offered in addition to the CRC and the OPDF?
   Probes:
   - List names of programs
   - Geographical locations
   - Primary services and activities provided
   - Client populations served by each

3. How many FTE staff are employed by the host agency? # ____

4. How many FTE staff are employed by this CRC? # ____

5. How would you describe the predominant client characteristics and needs of the communities that you serve—with regard to substance abuse treatment services?
   Probes:
   - What are the drugs of choice in this community?
   - How have the needs of the populations you serve changed in recent years? What do you perceive to be the emerging needs?
   - Where does the host agency get most of its referrals?
   - Does the agency target particular subgroups of substance abusers such as women, adolescents, crack users, etc.? Note target populations.
Next I'd like to ask you a little about how you first got involved with the host agency and the CRC.

6. Did you work for (THE HOST AGENCY) prior to joining the CRC?

    YES  NO

Probes:
- If yes, what was your role prior to joining the CRC?
- If no, what were you doing prior to joining the CRC?
- When did you join the CRC? MONTH _____ YEAR _____
- Did you begin as the Director? If no, when did you assume the director position?
- Did any of your staff work for the host agency prior to joining the CRC? If yes, not their prior positions/duties at the host agency.
PART II: IMPLEMENTATION HISTORY

Next I'd like to get your perspectives on how the Target Cities project has evolved over time and how the specific activities of this CRC have evolved since the CRC first opened.

7. How did you first get involved in the Target Cities project?

8. Did you participate in the initial proposal preparation? YES___ NO___
   a) IF YES, What was your contribution to the proposal preparation?
   b) IF NO: Why not? Did other members of your staff participate in the initial proposal preparation?

9. Have you read the initial proposal? YES ___ NO ___

10. When did the doors of the CRC first open? MONTH ____ YEAR ____

11. It's our understanding that there were delays in getting the initial Target Cities funding. How did these delays in funding affect the CRC's ability to meet its goals and objectives?
12. Could you tell me a little about how this CRC's activities and functions have evolved over time since you first opened in (DATE IN Q. 10)? We're particularly interested in when critical activities or functions were phased in.

a) First, could you tell me what activities and functions were in place when the CRC first opened? (Determine which of the 10 programmatic activities/functions listed in Question 13 were in place at that time.)

b) How have your activities and functions changed over time? (Probe for dates when these activities/functions were implemented.)

c) What activities and functions are currently in place, and how does this compare with those activities that were in place when you first opened the CRC?

d) What are the similarities and differences between the activities and functions of your CRC compared with the other four CRCs?

CRC Programmatic Activities and Functions

- Intake and assessment
- Direct services
- Case management
- Referrals
- Outreach
- Linkages/networking with other agencies
- Cooperative agreements
- Faith and Head Start initiatives
- Technical assistance
- Staff training
- Data collection and analysis
- Other activities
13. Could you give me examples of how you've used the Target Cities funding to implement specific activities to meet the goals and objectives of the Target City project? Let's start with Intake and Assessments.

**CRC Programmatic Activities and Functions**

a) **Intake and assessment:** Could you describe the procedures that are currently in place for assessing clients' needs? When did you first start using the Client Intake and Assessment Instrument (CIAI)?

b) **Direct services:** What direct services does your CRC currently provide on site at the CRC?

Probes:
- Are medical examinations done on site?
- Is child care provided (on or off-site)?
- Is transportation assistance provided?
- Other direct services?
- To what extent are these services used?

c) **Case management:** Does your agency provide case management services? What are the duties of the case manager? How are client treatment plans designed, prepared and implemented? How frequently are they reviewed? Who participates in the process?

d) **Referrals:** What are the specific client referral procedures that are used by your CRC.

Probes:
- What types of followup, if any, does the CRC do to see if client needs are being met?
- When and how are client referrals tracked?
- What forms and procedures are used (logs, forms, etc.)

e) **Outreach:** What types of community outreach activities have been undertaken?

f) **Faith and Head Start initiatives:** How have you participated in the faith and Head Start initiatives?
g) **Technical assistance:** What type of technical assistance does your CRC provide to agencies and individuals in such areas as substance abuse counseling, treatment groups, computers, workshops, or other areas where TA is requested?

Probes:
- staff development/training as it relates to assessments and referrals
- preparation of forms/reports/procedures relevant to client services
- translation services, advocacy services, etc., for clients to facilitate service delivery

h) **Staff training.** What types of staff training does your CRC provide for CRC staff or others? Do you provide training to OPDF staff, other providers, other agencies/organizations?

Probes:
- Type of training sessions
- Number of training sessions
- Target audiences
- Dates training occurred

i) **Data collection and analysis:** What types of data do you routinely collect on:

1) Number of intakes
2) Client characteristics
3) Status dates
4) Service dates
5) Retention or dropout rates
6) Number of client referrals (total and by OPDE)
7) Number of clients served
8) Client satisfaction
9) Other data for tracking program activities or impacts

**DETERMINE WHETHER SYSTEMS ARE AUTOMATED OR HARDCOPY. OBTAIN COPIES OF RELEVANT DOCUMENTS OR REPORTS IF POSSIBLE.**

j) **Other activities:** Are there any other activities of the CRC that you haven't already described? Include both activities funded by Target Cities support and other sources of support.
14. Next I'd like to talk about the relationships that your CRC has established with other agencies such as the Department of Public and Social Services, the Dept. of Vocational Rehabilitation, criminal justice agencies, community agencies, private businesses, service providers, other agencies and organizations.

a) With what agencies have you strengthened your informal linkages?

Probes:
- local drug abuse providers
- health
- mental health
- education
- law enforcement
- judicial
- correctional
- human service agencies

b) Do you have information about the number of referrals you have provided to these agencies over the last month?  __YES  __NO

IF YES: Can we obtain a copy of this information from you?

  __YES  __NO

c) Do you have information about the number of referrals you have received from these agencies over the last month?  __YES  __NO

IF YES: Can we obtain a copy of this information from you?

  __YES  __NO

d) With what agencies or services do you want stronger linkages?

Probe:
- What services do your clients may need that are currently unavailable to them?
- What issues need to be resolved in order for this to occur?
15. What types of cooperative agreements has your CRC established? How many cooperative agreements do you have now? With what agencies?

Probes for types of agencies:
- local drug abuse providers
- health
- mental health
- education
- law enforcement
- judicial
- correctional
- human service agencies

a) How did your CRC go about establishing cooperative agreements?
- How did you decide which agencies to target?
- How did you approach them?
- What were the primary obstacles to establishing these agreements?

b) What kinds of services have you received from those agencies with which you have cooperative agreements?
- Are services provided on site?
- Do LATC clients get preferential enrollment?
- Do agencies provide training or technical assistance?
- Do agencies give LATC agencies or clients a break in price?

c) What kinds of services have you provided to those agencies with which you have cooperative agreements?
- Are services provided on site
- Do their clients get preferential enrollment?
- Do you provide training or technical assistance?
- Do you give agencies or clients a break in price?

d) What are the rights and responsibilities of the parties involved (is it a written or verbal agreement?)

e) What are the specific client referral policies or procedures that were agreed upon?

f) What issues must be addressed for continued progress in establishing cooperative agreements and working arrangements with other service providers?
16. You mentioned earlier that the CRC currently has (# AT Q. 4) FTE employees, including yourself, to carry out the various activities we just discussed. Could you tell me the primary duties and responsibilities of each staff member with regard to the Target Cities project?

Probes:
- When were they hired?
- Are all of these staff paid with the Target Cities funding, or are they paid using other funding sources? (Determine the % of time covered by LATC)

17. Next I'd like to ask about the major funding sources for this CRC.

Probes:
- Do you currently receive funding from sources other than LATC? YES____ NO ____
- What are your major sources of funding now and how much money do you receive from each source?

-- LATC $ ____________
-- Federal government $ ____________
-- State government $ ____________
-- Local government $ ____________
-- Client fees $ ____________
-- Host agency general support $ ____________
-- Other ____________
-- Other ____________
-- Other ____________
-- Other ____________

- Other than the LATC money, how stable has your funding been since the Target Cities project was started in May of 1991?
- Did support from other funding sources decline, increase, or stay about the same?
- Did you obtain any new sources of funds other than LATC?
- Did your costs increase or decrease significantly over this time?
18. Has your CRC used its LATC funding or other outside funding to purchase or develop resources or equipment that were needed to meet the project goal and strategy? This includes things like a video library, reading material, computer software, transportation equipment.

Probe:
- List resources or equipment purchased/developed
- For each item mentioned, determine if purchase was made with Target Cities funding.

19. Now I'd like to give you a copy of a generic time line that we've assembled to pinpoint critical milestones in the Target Cities project. We'd like you to take a few minutes to review the time line and tell us what you consider to be the major milestones in the development of your CRC.

PROBE FOR THE DATES WHEN CRITICAL ACTIVITIES AND FUNCTIONS WERE PHASED IN. SEE Q 12-13.

Probes:
- Our records indicate that the project was approved for funding on September 30, 1990 but that providers didn't get their contract from the county until May 28, 1991. Is that correct?
  
  If not, please put the correct dates on the time line.

- Did your CRC become operational on September 1, 1991 as indicated on the time line?

- Looking back, what do you consider to be the major milestones in the development of this CRC? What stands out as the most significant or biggest events?

PROBE FOR KEY EVENTS DURING THE FOLLOWING TIME PERIODS:
- What were the major events of the early months of the project from 9/30/90 to 12/30/90?

- What were the major events of 1991?

- What were the major events of 1992?

- What were the major events of 1993 so far?
20. The next question is about special training sessions or workshops that you or your staff have attended in connection with the Target Cities project. Please think about the period from the inception of the project until now.

(a) First, could you tell me whether you or your staff attended any training sessions that were sponsored by the county?

Probe for each session:
- What types of training was provided?
- When was the session conducted?
- How many staff from your CRC attended this session?
- Who organized and conducted the session?
- How useful was it for your CRC?
- What could have been done to improve the effectiveness of this training?

(b) What type of interagency cross-trainings have you or your staff participated in, not counting the county training sessions?

Probe for each session:
- What types of training was provided?
- When was the session conducted?
- How many staff from your CRC attended this session?
- Who organized and conducted the session?
- How useful was it for your CRC?
- What could have been done to improve the effectiveness of this training?

(c) What types of intra-agency training sessions have you organized for your own CRC staff in response to the goals or requirements of the LATC project?

Probes:
- Who delivered the training session?
- May we have copies of curricula or other materials?
- When were training sessions presented?
- How did these training sessions address multicultural/multilingual issues, if at all?
- How did these training sessions address relapse prevention, family counseling, or aftercare services, if at all?
21. There are a number of LATC related meetings that are conducted on a regular basis. Please tell me whether you usually attend the following meetings, and the date you first attended each one. Let's start with the ...

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PART III: GOALS AND OBJECTIVES

22. What do you consider to be the major goals of the Target Cities effort? That is what outcomes did you hope or expect to achieve?

23. How has your CRC gone about trying to achieve these goals? How do the activities that you described earlier relate to these goals?

24. How, if at all, have your goals for Target Cities changed over time?

Probes:
- Why did your goals change over time?
- Note whether impetus for change was changing community needs vs changing values or attitudes on the part of the CRC/providers/county/state/federal officials.

25. To what extent do you think these goals have been achieved?

Probe for each goal mentioned:
- What has not yet been achieved?
- What factors have prevented or hindered the program for achieving all of its goals?

26. Do you think that the other LATC participants have a different view of the major goals of the Target Cities effort?

Probe:
- Note which groups/individuals have different views (county, state, OTI, other CRCs or LATC providers)
- Note how and why views have changed over time.

27. In your opinion, what have been the major impacts or effects of your CRC on the treatment system in LA?

PROBE FOR SPECIFIC DATA THAT MIGHT BE AVAILABLE TO SUPPORT THE DIRECTOR’S VIEW/IMPRESSIONS.
28. Considering all the different functions assigned to the CRCs, what factors have been particular barriers to implementation? That is, what has occurred to hinder or slow down the implementation process? What has facilitated the implementation process?

PROBE FOR POSITIVE AND NEGATIVE FACTORS INFLUENCING IMPLEMENTATION.

Possible factors:

- Staffing issues (availability, skill level, abilities, etc.)
- Level of cooperation with other agencies/organizations
- Data or information needed to implement LATC
- MIS operability
- Adequate funding

29. What issues must be addressed to strengthen the effectiveness of the CRC in the future?
PART V: LINKAGES and SYSTEM RELATIONSHIPS

Next I'd like to discuss your interactions with the key actors in the Target Cities project — including the other CRCs and the providers as well as the county, state and federal staff at OTI and CSAT. Let's start with your relationships with the ODPE providers in your region.

30. How would you characterize relationships between your CRC and the OPDE LATC treatment providers in your region?

Probe for indicators:
- Degree of cordiality
- Open, friendly
- Formal
- Frequency of contact
- Accepting of inputs

a) In a typical month, how often do you or your staff have formal meetings OPDE staff or managers in your region?

RECORD THE USUAL NUMBER OF MEETINGS PER MONTH:

#_____

b) In a typical month, how often do you or your staff have informal telephone or in-person contact?

RECORD THE USUAL NUMBER OF CONTACTS PER MONTH:

#_____

c) How much direct interaction is there between the OPDE counselors and the CRC staff?

31. What other kinds of assistance have you provided to the OPDEs in your region since the inception of the CRC?

PROBE FOR TYPE OF ASSISTANCE AND WHEN IT OCCURRED.

Types of possible assistance:
- Outreach
- Technical assistance
- Training
- Liaison with other agencies
- Crisis intervention
- Other
32. **Over the last 3 months**, what kinds of assistance have you provided to the OPDEs in your region?

PROBE FOR TYPE OF ASSISTANCE AND WHEN IT OCCURRED.

Types of possible assistance:
- Outreach
- Technical assistance
- Training
- Liaison with other agencies
- Crisis intervention
- Other

33. How could relations with the treatment providers in your region be improved or strengthened? What issues need to be resolved for this to occur?

34. **Over the past month**, how many intakes have you conducted?  
   
   # ______

   Probe:
   - Over the past month, how many referrals did you provide to each of the OPDEs in your region?

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35. **Over the past 3 months**, how many intakes have you conducted?  
   
   # ______

   Probe:
   - Over the past 3 months, how many referrals did you provide to each of the OPDEs in your region?

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36. What are your criteria for making referrals to the OPDEs or other providers?

Probes:
- Availability of services
- Geographical location
- Relationship with provider (inter- or intra-agency)

37. How would you characterize relationships between your CRC and the other CRCs?

Probe for indicators:
- Degree of cordiality
- Open, friendly
- Formal
- Frequency of contact
- Accepting of inputs

a) In a typical month, how often have you had contact with CRC staff or managers through organized meetings?

RECORD THE USUAL NUMBER OF MEETINGS PER MONTH:

#_____

b) In a typical month, how often have you had informal telephone or in-person contact with CRC staff or managers?

RECORD THE USUAL NUMBER OF CONTACTS PER MONTH:

#_____

c) How many referrals do you receive from other CRCs in a typical month? How many over the past 3 months? What percentage of your total referrals per month does this represent?

# OF REFERRALS IN A TYPICAL MONTH ______
# OF REFERRALS OVER LAST 3 MONTHS ______
% OF TOTAL REFERRALS PER MONTH ______ %

d) Over the past 3 months, how if at all have the CRCs worked together? What issues have you jointly addressed or on what activities have you collaborated?
38. How would you characterize your relationship with the county, state and federal agencies that have participated in LATC?

Probe:

- How has participation in LATC influenced or modified your relationships with the LA County Dept. of Health Services Alcohol and Drug Program Administration?
- How can the County administration be more useful or helpful to you?
- How can the California Department of Alcohol and Drug Programs be more useful or helpful?
- How can OTI/CSAT be more useful or helpful?
PART VI: FUTURE DIRECTIONS FOR LATC

Before we finish the interview I'd like to ask you a few questions about how well you think the LATC has served the substance abuse treatment community and what could be done to improve the program's effectiveness.

39. In retrospect, what would you do differently if you could re-do LATC?

Probes:
- What advice would you offer to a city that was just starting up a target cities project?
- Would you have used the LATC money in the same way?
- How could LATC funding be better used to serve your community? That is, what changes if any would you like to see in the goals, strategies, administration, or any other aspects of the project?

40. Focusing on Los Angeles, what issues remain to be resolved if LATC is to achieve its goals and objectives?

41. How do you think the conversion of CRCs to CIUs will impact the treatment system in LA?

Probes:
- Why is it a good or a bad idea?
- What problems do you anticipate?
- How will it impact relationships among CRCs, providers, other agencies?
- How will it impact the current activities and functioning of the CRC?
- What criteria are most important for making referrals to service providers?

42. How could your CRC better serve your community? That is, what changes if any would you like to see in the goals, strategies, administration, or any other aspects of the CRC?
END OF INTERVIEW

Talk about our need to followup with a phone call, questionnaire, another visit?

Thank the respondent and leave the following handouts (if needed)

- Time line
- Caseload characteristics
- Referrals to OPDEs
- Funding sources
COUNTY AND STATE ADMINISTRATORS:

INTERVIEW GUIDELINES

NOTE: Because the nature of various administrators' involvement in LATC differs so widely, each interview will need to be geared to the particular individual and office. Areas for consideration are described below. Not all items will be appropriate for all respondents; and interviews with some respondents may include some issues not shown here. Both County and State administrators will be interviewed.

1. What were the administrator's major responsibilities on the project? How much time does the administrator spend on the project? On what activities or functions did they spend the most time? What are the most challenging or problematic aspects of these responsibilities? What are the most rewarding aspects of these responsibilities?

2. Did the administrator contribute to shaping original program specifications? Why or why not? In retrospect, was the project plan as described in the proposal a good fit for the needs of the LA community? How could it have been stronger?

3. How have the original program specifications been changed? What were the reasons for these changes? When were these changes instituted?

4. Has LATC been implemented as intended? What interventions or enhancements have been implemented? What was intended or planned, but not implemented? What were the major barriers to implementation?

5. What is the level, nature, and quality of communication between the administrator and project participants? How does the administrator characterize his/her relationships with providers, other administrators, and contractors? What were the major coordination problems or challenges? How were these problems addressed?

6. How does the administrator characterize the overall effectiveness of LATC? What are its major accomplishments and achievements? (Clarify schedule and timing for major achievements.) What are the perceived effects of the project on providers, clients, and the community overall? Where has it fallen short? What may be the enduring changes stemming from this project? What is likely to die when funding is terminated?

7. Were resources adequate to achieve project objectives? If not, what was needed? Was the distribution of resources timely and orderly? Did LATC funding substitute for other funding or did it provide a real supplement?
8. What would the administrator do differently next time around? What advice would the administrator offer to colleagues in another city who were just getting started?

9. Which if any CRCs, OPDEs, or PSCs stand out as particularly successful in implementing LATC specifications? What if any of the programs, services, initiatives, or events sponsored by LATC stand out as especially successful or effective?

10. How is the administrator’s department currently organized to manage the LATC project? Who else is involved and what are their responsibilities? What is their principal source of influence or power over the project? How does this group coordinate their efforts, and how do they communicate with other administrative units involved in the project? How and why has project management changed over the course of the project? What are the major challenges in managing the project?

11. What are the particular issues or problems that the administrator is currently trying to address? Describe the problem(s) and the steps that the administrator is taking in response.
NOTE: Because the nature of the contractors' involvement in LATC differs so widely, each interview will need to be geared to the particular organization. Areas for consideration are described below. Not all items will be appropriate for all respondents; and interviews with some respondents will include some items not shown here. Respondents include: (a) medical contractor; (b) Public Health Foundation; (c) State Department of Rehabilitation; (d) Office of Criminal Justice Planning; and (e) Creative SocioMedics; (f) Deloitte & Touche; (g) Head Start; and (h) Faith community representative.

1. What special expertise does contractor bring to the LATC project? What are the activities and functions of the contractor?

2. What is the contractor's past experience in working in the field of substance abuse? What is their past experience in LA County?

3. How and why did contractor first get involved in the Target Cities project? Did they participate in a competitive process? What motivated contractor to get involved in LATC? What did contractor hope to accomplish or achieve through participation in LATC?

4. Is there a formal contract or other document that describes what services the contractor was expected to provide to target cities and what the project would provide in response? Have the original specifications been changed at all? If yes, why and how? When was the contract signed? When was it amended? When did work actually begin?

5. To what extent has contractor been able to implement the strategies delineated in their contract or agreement with the county? What barriers did they encounter? What issues must be addressed for continued progress?

6. How has contractor participated in LATC planning and implementation? What services has contractor provided? What activities and events has contractor organized or participated in? What meetings does contractor attend, and what types of input does contractor provide in these meetings?

7. What does contractor consider to be the major milestones or accomplishments of their participation in the LATC project?

8. What was the timing or schedule for the major milestones and/or initiation of new services and programs?
9. What does contractor consider to be the major disappointments or problems associated with their participation in the LATC project?

10. What is the nature of the relationship between the contractor and the treatment community, including the OPDEs, CRCs and PSCs? What is the nature and level of communication between contractor and providers? On what types of projects have they collaborated? What services has the contractor offered to the providers?

10. How could relations between contractor and the treatment providers be improved or strengthened? What issues need to be resolved for this to occur?

11. What is the nature of the relationships between the contractor and the County, State, and CSAT? What is the nature and level of communication between contractor and administration? On what types of projects have they collaborated? What services has the contractor provided to administration?

12. How could relations between contractor and county, state, or federal administration be improved or strengthened? What issues need to be resolved for this to occur?

13. In retrospect, what would contractor do differently if he/she could re-do involvement in LATC?

14. What advice would contractor offer to someone from a similar organization in another city that was just starting a target cities program?

15. In contractor's opinion, how effective or successful is the Los Angeles Target Cities project? What have been its major achievements? In what ways has it fallen short of expectations or hopes?
APPENDIX C:

EXAMPLES OF GOALS AND OBJECTIVES STATEMENTS
APPENDIX C:
VARIOUS STATEMENTS OF GOALS AND OBJECTIVES

I. ORIGINAL PROPOSAL TO OTI

Key objective one: Improve retention rates of clients and utilization of drug treatment resources through the implementation of regional intake and assessment units. Activity one: Implement automated intake, referrals and assessment units. Activity two: Develop and implement the automated intake, referral and assessment system.

Key objective two: Ensure the provision of comprehensive services to clients in need of drug abuse treatment through the development of interagency collaborative agreements and working arrangements with related social service, educational, vocational and criminal justice systems. Activity one: Establish formal collaborative agreements with local drug abuse providers, health, mental health, education, law enforcement, judicial, correctional and human service agencies to ensure the implementation and maximum utilization of the proposed project. Activity two: Develop and implement interagency programming and trainings. Activity three: Interagency network enhancement and utilization.

Key objective three: Improve retention and decrease relapse rates of clients, particularly persons of color, by increasing the comprehensiveness and intensity of outpatient drug services. Activity one: Increase the number of staff in each program to reflect a maximum of 1:20 staff to client ratio. Activity two: Ensure the provision of and access to bilingual and bicultural services to all clients through the hiring of new staff and the implementation of trainings for all outpatient treatment staff. Activity three: Develop and implement minimum training standards for staff development and provide training for all staff. Activity four: Implement ongoing case management services for all clients entering treatment to ensure access to and provision of comprehensive services specific to individual needs. Activity five: Implement relapse prevention, family counseling, and aftercare services. Activity six: Ensure the provision of vocational services to every client in need through the establishment of an on-site service contract and collaborative agreement with the State Department of Vocational Rehabilitation. Activity seven: Provide funding for child care and transportation services to ensure equal access to services.

Key objective four: Improve treatment services and outcomes for drug abusing pregnant women and women and their children, particularly women of color, through provision of intensive drug-related and ancillary day treatment services with a specific emphasis on case management for the purpose of providing coordinated services. Activity one: Implement ongoing case management services for all clients entering treatment services to ensure the access to and provision of comprehensive services specific to individual needs. Activity two: Implement individual, family and group counseling for all clients for the purpose of developing alternative behaviors to drug abuse. Activity three: Ensure the provision of vocational services to every client in need through the establishment of an on-site service contract and collaborative agreement with the State Department of Vocational Rehabilitation.
Rehabilitation. Activity four: Implement life skills training to help develop skills in the areas that will assist clients to cope with life problems and situations without the use of drugs. Activity five: Implement educational modules in order to present factual information to clients regarding health issues. Activity six: Implement child development and parenting education. Activity seven: Ensure that all children ages 0-3 of women participating in the program receive complete developmental assessments and services. Activity eight: Implement physical fitness training and leisure time and recreational activities to encourage clients to utilize their leisure/free time in a more constructive drug free manner and increase social skills. Activity nine: Ensure pre- and post-natal care for pregnant and postpartum women. Ensure adequate medical care for women participating in the program and their children. Activity ten: Implement relapse prevention, and aftercare services. Activity eleven: Providing funding for child care and transportation services to ensure equal access to services.
"The Target Cities grant has four objectives. The first objective is to improve both the retention rates of clients in treatment programs and the utilization of drug treatment resources through development and implementation of five community resource centers (CRCs) and a management information system (MIS).

The second objective is to reduce dropout and relapse rates of clients particularly by increasing the scope of services through outpatient drug-free counseling enhancement services (ODF) at 16 local drug abuse services agencies. The third objective aims at improving drug treatment services and outcomes for drug-abusing pregnant women and their children, and particularly women of color, by establishing two perinatal services centers.

The fourth objective provides for comprehensive drug treatment and ancillary services through cooperative agreements with the City of Los Angeles Office of Criminal Justice Planning, the State Department of Vocational Rehabilitation, and the Los Angeles County Department of Public Social Services."
III. FIRST YEAR CONTRACTS
MAY 28, 1991

Outpatient drug free counseling enhancement services will include additional staff training, community outreach and networking activities, collaborative and cooperative linkages support, increased access to a comprehensive range of specific services needed by each program client and the utilization of computerized/automated intake and referral...

Specific services to be provided are as follows: A. Ensure client is registered in the Management Information System (MIS). B. Completion of in-depth assessment of client. C. If client is deemed unacceptable for agency services, agency calls ADPA for appropriate referral. D. Work with the nearest Community resource center for housing, vocational rehabilitation, social services, health services, and other client needs. E. Collection and inputting of intake and assessment data into the MIS. F. Collection and inputting of discharge data into the MIS. G. Provide services to previously unserved ethnic clients with limited English speaking capability. H. Provide networking and community outreach to increase linkage to specific services needed by program clients....

Contractor agrees to provide service activities identified in the Service Activity Addendum of this exhibit.

Perinatal services centers (PSCs) are non-residential programs that provide recovery services to drug and alcohol using pregnant and postpartum women and their infants. The program services should be available a minimum of eight hours per day, five days per week. Participants return to their own residence at night. The primary purpose of these services is to provide a planned program in a social setting structured to maximize habilitation or rehabilitation of participants. These programs are used to provide services more intensive than a visit but less extensive than 24 hour residential service in a clean, drug and alcohol free, sober environment...

Specific services to be provided hereunder are as follows: A. Develop and implement PSC activities ensuring access to and provision of comprehensive services specific to the need of pregnant and postpartum women. B. Implement individual, family, and group discussions and other activities for the PSC participant. C. Develop and implement networking activities interfacing with private, public, and quasi-public obstetric and postpartum services. D. Develop and implement a referral network and extensive resource information and assistance to help program participant obtain health, medical, and other services. D. Develop and implement life skills training, health education sessions, and child development and parenting classes. F. Develop and implement in-service training to selected obstetric, neonatal, and pediatric health care providers in public, private, and county-contracted health care services. G. Develop and implement vigorous linkages with project community resource centers, the Department or Children Services, maternal/child health services, local regional health center, and other agencies ensuring that project participant's children receive development assessment and services. H. Develop a peer support network for drug abusing pregnant women promoting supportive relationships with each other. I. Recruit, train, and supervise volunteer recovering women to lead education and discussion groups, physical fitness, and social/recreational activities. J. Develop and implement relapse prevention strategies and
activities. K. Develop and implement project participant alumni activities. L. Develop and
implement activities for baby sitting services, suing project participant volunteers, at
project sites. M. Develop and implement activities for transportation assistance to project
participants. N. Develop environment conditions at the PSCs which will maximize
informal exchanges among women.

Community resource center services are services which include: collaborative and
cooperative linkages with public and private social and health service providers; intake,
assessment, and ancillary services referrals; development and maintenance of client related
ancillary resources; community planning and organizing activities; outreach and
networking; network linkages support, increase access to a comprehensive range of
specific services needed by each program client and the utilization of a
computerized/automated intake and referral...

Specific services to be provided are as follows: A. Develop and implement
collaborative and cooperative linkages with public, private, and other social, economical,
health, legal, vocational, and mental health service providers. B. Develop a dynamic
ancillary referral network in the center's area of responsibility. C. Meet on a regular basis
with project outpatient drug free (ODF) programs and perinatal service centers located in
the center's area of responsibility. D. Develop and implement outreach, consultation and
technical assistance services to project ODF programs in the center's area of responsibility.
E. Develop and implement intake and assessment procedures to include: 1) walk-in client
reception area; conduct first level intake and either refer client to center's own ODF or the
Alcohol and Drug Program Administration information and referral resource; 3) provide
ancillary services referrals...; 4) document referrals and first level intake information in the
MIS; 5) implement and administer client referral postcard tracking system and document
in MIS; 6) implement and administer termination of ancillary referral services tracking
system and document in MIS. (County of Los Angeles Department of Health Services,
IV. STATE INPUT TO EVALUATION TEAM ABOUT OBJECTIVES
FALL, 1992

The primary goal of the Los Angeles Target Cities project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles...

PROCESS OBJECTIVES

When the process under question supports Target Cities goals and patient needs, the CRCs, OPDFs, and PSCs (as appropriate) will:

1. Improve resource use by developing automated intake, assessment and data tracking through a management information system.

2. Increase comprehensive drug treatment and ancillary services through agreements with related social, human service, health, educational, vocational, and criminal justice systems.

3. Increase the scope and quality of treatment to improve retention and decrease relapse especially among people of color by increasing staff and staff training, peer support, fitness, family and alumni activities, and providing more child care, transportation and related comprehensive services.

4. Improve treatment services, especially for women of color and their children, by developing resources and linkages for postpartum services, interdepartmental collaborative agreements, referral networks for health, medical and other human services, life skills, health, peer support, child development, parenting classes, and development services.

OUTCOME OBJECTIVES

1. Improve patient retention and reduce relapse as measured by a) time in drug treatment; b) involvement with drug program service, ancillary and referral regimens and c) completion of recommended programs (e.g., status at termination).

2. Increase the effectiveness of recovery services as measured by a) alcohol and other drug use; b) education, home life management skills, employment and volunteerism; c) criminal activity, arrests, and revocation of parole and probation.
V. COUNTY INPUT TO EVALUATION TEAM ABOUT OBJECTIVES
FALL, 1992

LADPEP intends to support the mission of CSAT by: 1) expanding access to treatment, 2) improving treatment effectiveness by reducing recidivism, relapse, and morbidity, and increasing patient functioning, and 3) reducing external costs of addiction.

PROCESS OBJECTIVES

When the process under question supports this mission and the needs of clients, the CRCs, OPDFs, and PSCs (as appropriate) will:

a. Hire more indigenous staff and community workers to reach 1:20.
b. Provide a greater number of cultural and language services.
c. Develop collaborative plans with public and private agencies.
d. Develop an implement a follow-up contact plan for every client.
e. Implement an automated intake and assessment client data system.
f. Implement a training program to increase staff: 1. assessment and referral skills; 2. awareness of needed of people of color; 3. ability to motivate clients to achieve quality sobriety; 4. ability to identify and use relapse prevention strategies.
g. Use comprehensive services specific to each client's need.
h. Use case management with input from clients, treatment staff and related service providers.
i. Implement relapse prevention, family counseling, and aftercare.
j. Provide on-site vocational, child care, and transport services.
k. Develop referral networks of health, medical, and other services for clients including pre and postnatal care for women/children.
l. Providing parenting, life skills, and child development raining.
m. Provide physical fitness, recreation, peer support networks, family, and alumni activities.

CLIENT OUTCOME OBJECTIVES

a. Decrease the amount and frequency of alcohol and other drug use.
b. Increase the number who have jobs or work as volunteers.
c. Decrease criminal activity, arrests, and time on parole.
d. Increase support of and communication with family members.
e. Increase the number who participate in faith/community events.
f. Decrease the number of sick days and improve health status.
g. Increase the time spent with supportive family members and friends.
h. Increase the number who help neighbors and friends.
i. Increase the number who complete treatment and related programs.
j. Increase the length of time clients remain in treatment.
VI. CONTINUATION PROPOSAL
SUMMARY OF PROJECT OBJECTIVES IN PROGRESS REPORT (P. 29)
JUNE 1993

- To develop five Community Resource Centers (CRCs) to enhance societal supports for treatment providers and offer screening and referral services;
- To develop contracts and collaborative agreements with public and private social and human services agencies to create linkages between drug treatment, health, education, criminal justice, and human services;
- To enhance drug treatment services at 16 drug treatment agencies and two Perinatal Services Centers;
- To providing training and technical assistance for treatment provider staff;
- To create an automated information and referral service to refine the screening, assessment, intake and referral processes; and
- To provide specialized services for people of color and pregnant, postpartum, and parenting women who have drug problems.
VII. REPORTING FORMAT FOR QUARTERLY REPORTS

Objective 1: To develop five community resource centers to enhance societal supports for treatment providers and offer screening and referral services.

Objective 2: To develop contracts and collaborative agreements with public and private social and human services agencies to create linkages between drug treatment, health, education, criminal justice and human services.

Objective 3: To enhance drug treatment services at 16 drug treatment agencies and two perinatal services centers.

Objective 4: To provide training and technical assistance for treatment providers staff.

Objective 5: To create an automated information and referral service to refine the screening, assessment, intake and referral processes.

Objective 6: To provide specializes services for people of color and pregnant, postpartum, and parenting women who have drug problems.
APPENDIX D:

MANAGEMENT IMPLEMENTATION PLAN
# COOPERATIVE AGREEMENTS FOR TREATMENT IMPROVEMENT PROJECTS IN TARGET CITIES
## LOS ANGELES DRUG PROGRAM ENHANCEMENT PROJECT MANAGEMENT IMPLEMENTATION PLAN

## PROJECT DESCRIPTION

### A. PROGRAM GOAL:
The primary goal of the Los Angeles Drug Program Enhancement Project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles through a collaborative effort between the California State Department of Alcohol and Drug Programs, the Los Angeles County Alcohol and Drug Program Administration and the City of Los Angeles.

### B. Key Objectives

| #1 | Improve retention rates of clients and utilization of drug treatment resources through the implementation of Community Resource Centers and an automated intake, assessment and client data tracking system. |
| #2 | Ensure the provision of comprehensive drug treatment and ancillary services through the development of collaborative and cooperative agreements with related social, human service, health, vocational and criminal justice systems. |

### C. Evaluation Specifications For Objectives

| 1.1 | Developed and implemented management information system at 50% of project sites by October 1991, and in the remaining sites by April 1992. |
| 1.2b | Assessment decision tree element of management information system operational in year two. |
| 2.1 | Cooperative agreements with local drug program providers, the City of Los Angeles Office of Criminal Justice Planning, the State Department of Vocational Rehabilitation, and the Los Angeles County Department of Public Social Services have been signed. |
| 2.2 | Project agencies have increased and enhanced their ability to develop and implement interagency linkages. |
| 2.3a | Collaboration networking meetings have been held between private and public agencies. |
| 2.3b | Dynamic networking activities between project components and other agencies have been conducted. |

### D. Major Activities:

| 1.1 | Develop and implement five Community Resource Centers. |
| 1.2 | Develop and implement automated intake and assessment client data system. |
| 1.2b | Develop and implement assessment decision tree element of automated system. |
| 2.1 | Develop and implement formal collaborative and cooperative agreements with public and private drug, health, social and other human services providers. |
| 2.2 | Develop and implement interagency linkage protocols and procedures, and training sessions. |
| 2.3a | Develop project interagency network support system involving public, private and project agencies. |
| 2.3b | Develop and implement dynamic community and networking activities involving the community resource centers, the outpatient drug programs and the perinatal service centers. |
**COOPERATIVE AGREEMENTS FOR TREATMENT IMPROVEMENT PROJECTS IN TARGET CITIES**

**LOS ANGELES DRUG PROGRAM ENHANCEMENT PROJECT MANAGEMENT IMPLEMENTATION PLAN**

### PROJECT DESCRIPTION

#### A. PROGRAM GOAL:
The primary goal of the Los Angeles Drug Program Enhancement Project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles through a collaborative effort between the California State Department of Alcohol and Drug Programs, the Los Angeles County Alcohol and Drug Program Administration and the City of Los Angeles.

#### B. Key Objectives

<table>
<thead>
<tr>
<th>2.4</th>
<th>An outcome and process evaluation has been developed and implemented to evaluate successful completion of the goals and objectives described in this implementation plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The outpatient drug programs have hired full time staff augmenting existing staff ensuring a reduction in the staff-to-client ratio.</td>
</tr>
<tr>
<td>3.2</td>
<td>55 percent of project agency staff have increased cultural competency and awareness of the needs of people of color.</td>
</tr>
<tr>
<td>3.3</td>
<td>Project agencies have implemented policies and procedures ensuring access to and the provision of comprehensive services.</td>
</tr>
<tr>
<td>3.4</td>
<td>Relapse prevention, family activities and alumni activities have been implemented.</td>
</tr>
<tr>
<td>3.5</td>
<td>See C. 2.1</td>
</tr>
<tr>
<td>3.6</td>
<td>Transportation and baby sitting needs of project participants have been met.</td>
</tr>
</tbody>
</table>

### C. Evaluation Specifications For Objectives

#### D. Major Activities:

<table>
<thead>
<tr>
<th>2.4</th>
<th>Develop and implement project process and outcome evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Augment outpatient drug programs to increase staffing patterns ensuring the provision of and access to bilingual and bicultural services.</td>
</tr>
<tr>
<td>3.2b</td>
<td>Develop and implement training sessions for project staff to increase level of cultural competency and awareness of the needs of persons of color.</td>
</tr>
<tr>
<td>3.3</td>
<td>Develop and implement policies and procedures ensuring access to and provision of comprehensive services specific to project participant needs.</td>
</tr>
<tr>
<td>3.4a</td>
<td>Develop and implement relapse prevention strategies.</td>
</tr>
<tr>
<td>3.4b</td>
<td>Develop and implement project activities involving participant's family.</td>
</tr>
<tr>
<td>3.5</td>
<td>See D. 2.1</td>
</tr>
<tr>
<td>3.6a</td>
<td>Develop and Implement procedures for baby sitting activities at project sites.</td>
</tr>
</tbody>
</table>
**A. PROGRAM GOAL:**
The primary goal of the Los Angeles Drug Program Enhancement Project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles through a collaborative effort between the California State Department of Alcohol and Drug programs, the Los Angeles County Alcohol and Drug Program Administration and the City of Los Angeles.

<table>
<thead>
<tr>
<th>B. Key Objectives</th>
<th>C. Evaluation Specifications For Objectives</th>
<th>D. Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>#4: Improve treatment services and outcomes for drug abusing pregnant women and women and their children, particularly women of color.</td>
<td>3.7 Developed and implemented minimum training standards for staff development and training for all staff.</td>
<td>3.6b Develop and implement procedures for transportation assistance to project participants.</td>
</tr>
<tr>
<td></td>
<td>4.1 Two perinatal service centers have been implemented to improve treatment services for drug abusing pregnant women and women with children.</td>
<td>3.7 Develop and implement minimum training standards for staff development and provide training for all staff.</td>
</tr>
<tr>
<td></td>
<td>4.2 Individual, family and group discussion activities have been implemented at the two perinatal service centers.</td>
<td>4.1 Develop and implement perinatal services ensuring access to and provision of comprehensive services specific to women's needs.</td>
</tr>
<tr>
<td></td>
<td>4.3 Networking activities have been implemented at the two perinatal service centers interfacing with private, public and quasi-public and postpartum services.</td>
<td>4.2 Implement individual, family and group discussions and other activities for the perinatal service center participant.</td>
</tr>
<tr>
<td></td>
<td>4.4 Interdepartmental collaborative agreements accessing county contracted private and quasi-public perinatal and postpartum services ensuring pre- and post-natal care for pregnant and postpartum women have been implemented.</td>
<td>4.3 Develop and implement networking activities interfacing with private, public and quasi-public obstetric and postpartum services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.4 Develop interdepartmental collaborative agreements to access county contracted private and quasi-public perinatal and postpartum services ensuring pre- and post-natal care for pregnant and postpartum women.</td>
</tr>
</tbody>
</table>
### A. PROGRAM GOAL:

The primary goal of the Los Angeles Drug Program Enhancement Project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles through a collaborative effort between the California State Department of Alcohol and Drug programs, the Los Angeles County Alcohol and Drug Program Administration and the City of Los Angeles.

### B. Key Objectives

| 4.5 | Referral network and extensive resource information and assistance to help project participant obtain health, medical and other human services have been developed at both perinatal service centers. |
| 4.6 | Life skills training, health education sessions, and child development and parenting classes have been implemented. |
| 4.7 | 50 percent of selected obstetric, neonatal and pediatric health care providers in public/private and county contracted health care services received training. |
| 4.8 | Vigorous linkages with project community resource centers, Dept. of Children Services, maternal/child health services, local regional health centers and other agencies ensuring that children receive developmental assessment and services have been implemented. |
| 4.9 | Peer support network for drug abusing pregnant women promoting supportive relationships with each other has been implemented. |

### C. Evaluation Specifications For Objectives

| 4.5 | Develop and implement referral network, and extensive resource information and assistance to help project participant obtain health, medical and other human services. |
| 4.6 | Develop and implement life skills training, health education sessions, and child development and parenting classes. |
| 4.7 | Develop and implement in-service training to selected obstetric, neonatal and pediatric health care providers in public/private and county contracted health care services. |
| 4.8 | Develop and implement vigorous linkages with project community resource centers, Dept. of Children Services, maternal/child health service, local regional health centers and other agencies ensuring that children ages 0-3 receive developmental assessment and services. |
| 4.9 | Develop peer support network for drug abusing pregnant women promoting supportive relationships with each other. |
COOPERATIVE AGREEMENTS FOR TREATY IMPROVEMENT PROJECTS IN TARGET CITIES
LOS ANGELES DRUG PROGRAM ENHANCEMENT PROJECT
MANAGEMENT IMPLEMENTATION PLAN

PROJECT DESCRIPTION

A. PROGRAM GOAL:
The primary goal of the Los Angeles Drug Program Enhancement Project is to improve the quality and effectiveness of drug abuse recovery services in the City of Los Angeles through a collaborative effort between the California State Department of Alcohol and Drug programs, the Los Angeles County Alcohol and Drug Program Administration and the City of Los Angeles.

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<tr>
<th>B. Key Objectives</th>
<th>C. Evaluation Specifications For Objectives</th>
<th>D. Major Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.10 Recovering women have been recruited, screened, and trained to perform volunteer services.</td>
<td>4.10 Recruit, train and supervise volunteer recovering women to lead education and discussion groups, physical fitness and social/recreational activities.</td>
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<tr>
<td>4.11 Relapse prevention strategies have been implemented at the perinatal centers.</td>
<td>4.11 Develop and implement relapse prevention training for project staff.</td>
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<td>4.12 Alumni activities involving program graduates have been implemented.</td>
<td>4.12 Develop and implement participant alumni activities.</td>
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<tr>
<td>4.13 Transportation and baby sitting needs of project participants have been met.</td>
<td>4.13a Develop and implement procedures for baby sitting activities at project sites.</td>
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<tr>
<td>4.14 The perinatal center’s physical environment maximizes informal exchanges among women.</td>
<td>4.13b Develop and implement procedures for transportation assistance to project participants.</td>
<td>4.14 Develop and implement the perinatal service center’s physical environment which will maximize informal exchanges among women.</td>
</tr>
</tbody>
</table>