Mutually Beneficial Collaboration:
Using Evaluation to Improve Service Delivery

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Treating individuals with substance abuse problems is a complex and difficult task. Clients enter treatment with a wide range of needs, and programs vary in their ability to meet those needs. Providers that desire to have effective programs must, by necessity, continually ask themselves if what they are doing is working. If it is working, then why is it working? If it is not working, then why not? Answering those questions can be difficult because there are so many factors to consider. Programs must, therefore, have a clear understanding of the treatment process and the factors that affect outcomes. Utilizing a model of treatment that breaks the process into parts helps in this understanding.

According to Simpson (1997), substance abuse treatment can be conceptualized as a dynamic process whereby recovery happens as a result of participation in a therapeutic environment. It involves a complex interaction between pre-treatment client characteristics that include problem severity and motivation, programmatic factors such as the availability of counseling and appropriate services, and the quality of the therapeutic relationship between client and counselor. The longer a client remains in treatment and engages in interventions that address their needs, the greater the likelihood of positive and sustained change (Hubbard et al., 1989; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999; Simpson, Joe, & Rowan-Szal, 1997; Simpson & Sells, 1982). The complexity of this model illustrates why programs have problems determining their effectiveness. Not only must they determine whether or not they are providing an appropriate array of services, but they must also determine what needs clients have, whether or not available services are utilized, if gaps exist between needs and services, and what barriers program participants face.

In the course of providing daily services, it is difficult for treatment agencies to objectively analyze their programs. Loyalties to a particular treatment philosophy, tunnel vision, or an inability to "think outside the box" may prevent an agency from recognizing problems and making needed changes. Those who do acknowledge problems and seek avenues for change often collaborate with other treatment providers, adapting new strategies for use with their clientele. Although collaboration can be highly beneficial, what works for one agency may not work for another. To determine what strategies are effective, programs must conduct some form of evaluation.

In general, two types of evaluation mechanisms exist for treatment providers: internal evaluation conducted by the agency itself and external evaluation conducted by an institution that is not affiliated with the provider. Both options have benefits. Internal evaluation is typically less expensive, less cumbersome, and can address descriptive questions regarding who receives treatment and what services are rendered. Often, internal evaluation relies on anecdotal evidence of what seems to be working. Although such perceptions are important, they are often guided by staff expectations or beliefs about the clients rather than on empirical evidence of trends that appear within the client population. External evaluation is typically more expensive, requires more effort in collaboration and data collection, but can provide a more objective account of what is taking place within the agency. In addition to answering descriptive questions, external evaluators can apply more rigorous statistical techniques to answer questions pertaining to reasons why some clients leave treatment early and risk factors associated with relapse.

Increasingly, collaborative relationships are forming between treatment agencies that want to provide effective interventions and research institutions that want to study substance abuse issues. Although such collaboration seems natural and can be mutually beneficial for both groups, lack of communication about the goals of a joint project or the needs of each participant can result in gridlock—data may not be collected adequately or reports may not be provided to the treatment agency. Unfortunately, even under the most desirable conditions, treatment agencies may not be provided with feedback that is meaningful to them. The key to successful treatment evaluation research is the relationship that exists between the research and clinical staff (Chatham & Simpson, 1994). The purpose of this paper is to illustrate how a collaborative relationship between a treatment agency and research institution can be mutually beneficial, particularly for monitoring and improving service provision.

The Collaborating Agencies

This paper is based upon a collaboration between The Salvation Army's First Choice program (First Choice) and the Institute of Behavioral Research (IBR) at Texas Christian University, both located in Fort Worth, Texas. First Choice is a long-term (12-month) residential program for women with children. It provides specialized gender-specific treatment for adult clients which includes drug, alcohol, and tobacco recovery, life skills, and parenting training. Services for children are also provided and include childcare for children younger than age 6 and after-school support groups, play therapy, family therapy, and recreational activities for those aged 5 and older. First Choice maintains agreements with numerous social service agencies in the area that allow the facility to provide a comprehensive continuum of care through direct service or through referrals. The program was established in response to a community needs survey that indicated female substance abusers needed a treatment center into which they could take their children. With funding through the Texas Commission on Alcohol and Drug Abuse, The Salvation Army opened the program in May, 1990. For a more complete description of the program, see Knight, Hood, Logan, & Chatham (in press).

The Institute of Behavioral Research has a long history in research on substance abuse issues ranging in scope from local evaluations to national studies. Staff of the IBR conduct evaluations of substance abuse and behavioral interventions provided by community-based programs, including both prevention and treatment. In 1995, after having been in operation for 5 years, First Choice approached the IBR about evaluating the women and children's program. The joint venture was in direct response to the Center for Substance Abuse Treatment's (CSAT) announcement that funding was available for agencies that could provide data on the effectiveness of their programs. The partnership between First Choice and the IBR enabled the agency to double its capacity from 10 to 20 apartments, provided enhanced services to women and children in the program, and contributed to knowledge about the effectiveness of programs for women and children.

The overarching goals of the evaluation were to (1) document the characteristics of the women and children admitted to the program, (2) document the services provided to them, and (3) examine how specific aspects of the treatment process impact both during-treatment and post-treatment outcomes (Knight et al., in press). In order to fulfill requirements of the evaluation design, data was collected at intake, monthly and quarterly during treatment, at discharge, and at 6- and 12-months after discharge. Data on demographic information, victimization histories, mothers' psychosocial functioning, number of sessions attended, ancillary services received, and discharge status were collected using treatment assessment forms

developed at Texas Christian University and modified for the project (Simpson & Knight, 1998). Children's demographic data were also collected through these forms.

First Choice began its expansion in October 1995 with funds provided by CSAT. By April 1996, the evaluation design was refined, instrument development was completed, staff was trained on evaluation issues, and data collection began. The partnership formed between these two agencies presented a challenge to First Choice, which had never participated in a research project. Prior to the joint venture, program effectiveness was determined primarily through anecdotal evidence. Information about the characteristics of clients served and the percentage who graduated was based on estimations.

Adapting to a research plan was challenging. Although they had been providing treatment services for five years, the staff at First Choice still had to learn about how research is conducted throughout the treatment process. First Choice staff members had to adjust to new forms that were implemented for the data collection. They also had to learn new procedures for completing paperwork so that it would be uniform with all clients. They had to be flexible because after the forms were implemented, a number of revisions required for CSAT's cross-site evaluation resulted in changes to data collection procedures. However, the knowledge and experience of the research team eased the transition. By conducting training with the staff and by working patiently with them, frequently on a one-on-one basis, the evaluation team helped staff to begin rapidly collecting data and overcome hurdles. The initial work of the evaluation team with the First Choice staff paid off. Within a few short months the research was integrated into the program and data was being collected smoothly. The research team's commitment to excellence made the evaluation experience a very positive one.

From the onset of the federally funded project, it was clear that in order for the partnership to be beneficial to both agencies good communication, mutual respect for each other's skills and a careful defining of roles would be of important (Chatham & Simpson, 1994). Therefore, not only was First Choice staff expected to provide accurate information to the research team in a timely manner, but the research team was expected to provide First Choice staff with reports that were also informative and timely. This reciprocal exchange of information resulted in a series of reports designed to address fundamental questions of the administration at First Choice.

First Choice administrative staff was interested in expanding the kinds of services they were providing and also wanted to know if those services were effective. In order to know which parts of the program needed to be enhanced, they needed two pieces of information. First, they needed to know more about the target population. Who are the clients, and what problems do they face? Second, they needed to examine the types of services that would be needed to meet the needs of the clients. Are these services being provided? Are the ones in place effective for the population?

These and other fundamental questions can be organized into four general categories: (1) Is the program reaching the women who need treatment? (2) Are women receiving the services as intended? (3) What can be done to improve the quality of services provided? (4) How can communication be improved (both within First Choice and between First Choice and external agencies)? This chapter is organized around these four questions. A description of the issues that arose regarding evaluation findings and how this new knowledge was utilized by the agency to modify existing treatment components is presented in the material below.

Is the Program Reaching Women Who Need Treatment?

Recent research suggests that women are more likely to enter and remain in treatment programs that provide specialized services such as childcare, parenting training, and counseling on abuse issues (Beckman & Amaro, 1986; Copeland & Hall, 1992; Stevens, Arbiter, & Glider, 1989). The longer clients stay in treatment, the greater the likelihood they will have positive and sustained outcomes at follow-up (Hubbard et al., 1989; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999; Simpson, Joe, & Rowan-Szal, 1997; Simpson & Sells, 1982). For this reason, it is important for programs to set goals that define who they will accept into treatment. Decisions about what constellation of services to provide follow decisions about the target population. It is not uncommon for goals regarding the target population to be vague or nebulous, which leads to later uncertainty about whether or not the goals were met. Setting clear, specific, measurable goals was the first step in developing a comprehensive evaluation system. With help from the research team, the process of goal setting began in earnest.

The target population included women of childbearing age (18-45) who were pregnant or had a maximum of 4 children. The women should have a primary diagnosis of substance abuse with cocaine, alcohol, and amphetamines as the leading drugs of choice. They should have custody of their children or be in the process of getting custody. The ethnicity of the participants should be 33% Caucasian, 33% African-American, and 33% Hispanic. In addition to the aforementioned items, it was recognized that most of the women would be unemployed and would have experienced physical, sexual, or emotional abuse. More than half would be involved in the criminal justice system and about 33% would have a secondary diagnosis of a mental health problem. Many would have physical health issues that would need to be addressed.

Most of the stated goals would not require additional recruiting efforts. However, prior to the evaluation it was estimated that approximately 7% of clients were Hispanic. The agency wanted to increase enrollment of Hispanic women to more accurately reflect the ethnic composition of the local community and address the need for treatment among these women as identified through local needs assessment (Challenge, 1994). Consequently, First Choice allocated staff and other resources toward improving outreach efforts within the Hispanic community. Bilingual therapists were hired to provide chemical dependency groups and other education modules in their native language, and translators were provided as needed. An Hispanic Outreach Coordinator was hired to increase communication between the agency and the community. Spanish brochures were printed and distributed, and Spanish literature was provided. First Choice also worked on accessing medical professionals who specialized in working with this population of women.

Although recruiting and interventions were aimed primarily at substance abusing women, First Choice also intended to provide services to children. Therefore, it was important to define the characteristics of the children. Children were expected to range in age from birth to 12 years old. Families could have up to 4 children. It was expected that as many as 50% of the children would have experienced abuse or neglect. As many as 30% would demonstrate behavioral difficulties. About 25% would have been exposed to drug use in utero.

Within the first year of the project, a comprehensive report detailing characteristics of women and children admitted to the program was provided to First Choice by the IBR (the report was updated annually). Table 1 summarizes these descriptive data from a sample of 96 women and 148 children who were admitted to the program between April 1, 1996, and December 31, 1998. The majority of women were between 25 and 34 years of age (62%) and either Caucasian (45%) or African American (37%). Only 15% were Hispanic. Most were unmarried (72%) and

had obtained at least a GED or high school diploma (61%). Nineteen percent were pregnant, and 86% had 1 or more children living with them at the facility. Their drugs of choice were primarily cocaine or crack (44%) and alcohol (28%). Fifty percent were unemployed at admission and another 8% had only odd jobs. Women in this sample reported a high degree of victimization (e.g., 90% reported physical abuse; 37% reported incest). Ninety-three percent reported one or more arrests in their lifetime, and 58% reported some current legal status (e.g., 39% on probation, 10% with an outstanding warrant). Fifty-one percent of the sample reported formal action having been taken against them by child welfare agencies for child abuse or neglect. In terms of health status, 68% reported one or more physical health problems (e.g., STD, asthma), and 63% reported one or more mental health problems (e.g., depression, anxiety).

Children in treatment with their mothers ranged in age from 0 to 13 years, with 58% younger than age 5. Forty-nine percent were female, 38% were African American and 34% Caucasian. Most (66%) were living with their mothers prior to treatment, and 34% were reunited with their mothers at treatment entry. Mothers reported that over half (57%) of the children had been abused, 68% were exposed to nicotine in utero, and 59% were exposed to drugs in utero (see Table 2). Thirty-five percent had one or more physical health problems (e.g., asthma, vision impairment). Of the 99 children aged 2-13 whose mothers completed the CBCL, a total of 42% were identified as having internalizing problems and 37% as having externalizing problems (see Table 3). Seventeen percent were classified as problematic on both scales.

These data provided documented evidence that First Choice was reaching most of its goals for the target population. However, data also indicated that the goal of treating more Hispanic clients was not being met. Data from the first 9 months of the evaluation indicated that only 9% of clients were Hispanic—significantly lower than the goal of 33%. As a result, First Choice further enhanced outreach efforts by meeting with Hispanic community representatives regarding unique characteristics of this group and ways to reach them. Based on the group's recommendations, outreach staff began attending Hispanic 12-step meetings to increase awareness of treatment opportunities at First Choice. Brochures were distributed at a wider range of community locations, and outreach staff participated in health fairs designed to reach the Hispanic community. Subsequent IBR reports kept the program apprised of the percentage of Hispanic admissions, which remained at a constant 15%. Through conversations with community leaders and Hispanic clients who were in treatment, it became clear that in order to achieve the original goal, First Choice would have to modify the program to better meet the needs of Hispanic women. Such changes might include bringing in more extended family members, adding additional family components and doing considerably more outreach. Unfortunately, resources were simply not available to implement these changes.

Although the goal was not fully achieved, the evaluation provided documented evidence that outreach efforts had doubled the percentage of Hispanic clients receiving treatment at First Choice. Furthermore, periodic reports describing the characteristics of the population in the program increased awareness of the progress toward those goals, and the reports effectively kept program staff more accountable in their efforts toward reaching them.

Comparing the original goals to the data received demonstrated that the needs of the women were underestimated especially in the area of mental health problems. The discrepancy between the initial goals and the actual problems identified helped First Choice to see that additional services needed to be implemented. This was just one area of need that was discovered. Other needs would be uncovered as the program began to look at data related to whether the women and children were accessing the services already being provided.

Are Women and Children Receiving Services as Intended?

Recent research suggests that clients who receive services targeted toward their specific needs are more likely to stay in treatment longer, complete treatment, and have better outcomes at follow-up (McLellan et al., 1997; McLellan, Woody, Luborsky, O'Brien, & Druley, 1983). For example, clients with more severe problems show increased attendance, reduced problem severity, and reduced substance abuse after participation in a high-structure, behaviorally oriented versus a low-structure, facilitative counseling approach (Thornton, Gottheil, Weinstein, & Kerachsky, 1998). Others suggest that clients with more severe psychological problems generally are more likely to complete treatment when they develop a strong alliance with a therapist (Petry & Bickel, 1999) or if psychological services are available (Broome, Flynn, & Simpson, 1999). Similar trends have been documented for pregnant women who receive specialized services (Weisdorf, Parran, Graham, & Snyder, 1999). These studies suggest that not only should a program determine the characteristics of the clients they serve but should also pay attention to whether or not it is providing specialized services to meet clients' needs.

Utilization of Services

As part of the original grant proposal, First Choice set specific goals regarding what services were to be provided to women and children. Women in the program would be provided with 19 group sessions per week, which would include chemical dependency education, didactic process groups, life-skills education, recreation and parenting. Clients would be provided with one individual counseling session per week. They would also receive referrals to a network of local agencies for necessary services that could not be provided on-site. Those referrals would include medical services through Medicaid providers, Tarrant County Mental Health and Mental Retardation for mental health services, Women's Center for sexual abuse counseling, Texas Rehabilitation Commission for vocational training and job placement, etc.

Because the first 90 days of treatment are considered to be critical in terms of positive treatment outcomes (Simpson, Joe, & Brown, 1997; Simpson & Sells, 1982), reports describing the type and intensity of services utilized during that period were provided to First Choice annually. Counselors completed a monthly tracking record for each client documenting (a) the number and type of sessions attended on site, (b) whether or not ancillary services were received for specific issues (e.g., medical, parenting), and (c) the level of program compliance (e.g., requirements completed, rule violations). Table 3 summarizes the data from a sample of 80 women who were admitted to the program between April 1, 1996, and November 30, 1998 and who were in treatment for at least 30 days. On average, clients attended 3.8 individual sessions and 13.9 group sessions during the first 30 days of treatment. The average number of sessions increased between months 1 and 2 but was relatively stable between months 2 and 3. Structured group counseling was the most common method of service delivery followed by open discussion groups, individual counseling, and other groups (including recreation).

An examination of the use of community linkages for clients with special needs indicated that, in general, the percentage of clients utilizing ancillary services differed across the 3 months depending on the type of service (see Table 4). The most frequently provided ancillary services during month 1 were related to the establishment of community linkages—contacts with housing agencies and 12-step programs. These were followed by services addressing welfare, food, and clothing needs. Next in frequency were medical, psychological, and educational services and contacts with parole/probation officers. The percentage of clients receiving these ancillary

services generally decreased between months 1 and 2. This is understandable because these are the needs that must be addressed when a woman and her children are settling into the treatment facility if the family unit is to remain in treatment. During months 2 and 3, the use of ancillary services dealing with resolution of anger, rape, or trauma increased, as did psychological testing and job/vocational training. Use of several services remained stable over time including educational services, welfare services, 12-step programs, contacts with the Child Protective Services, and contacts with criminal justice officials.

The data presented in the above report documented that First Choice was providing a relatively treatment-intensive program, even for a residential facility. First Choice not only provided a large number of sessions in which clients could participate, but it used a variety of methods for treating clients, including individual and group counseling. These data also documented the fact that First Choice staff made use of community agencies by referring clients for specialized services not available at the facility. In using community linkages, First Choice was able to provide more comprehensive treatment than would otherwise be possible. Participation varied by client, suggesting the treatment program was often tailored to meet the specific needs of each client.

Although the report described above documented important characteristics of the program and provided evidence that First Choice was meeting its programmatic goals, it also suggested that some clients were attending very few sessions. Administrative staff at First Choice received these reports and noticed that the averages in session attendance were lower than expected. Staff interpreted this to mean that the clients were not as engaged in treatment as they had thought. This had serious implications for the overall success of the program because clients who engage in treatment, that is to say that they attend more sessions and develop positive relationships with counselors, are more likely to remain in treatment longer and to show improvements in drug use and psychological and social functioning (Joe, Simpson, Greener, & Rowan-Szal, 1999; Simpson, Joe, Rowan-Szal, & Greener, 1995, 1997). First Choice immediately set about to utilize the IBR reports to make programmatic changes to correct the problem.

Examining the system of accountability at First Choice showed a basic weakness. Clients could be absent from groups if they had legitimate appointments and brought back documentation of those appointments. It appeared that clients were scheduling many appointments (WIC, food stamps, AFDC, medical, meetings with case managers from other community service programs, etc.) that conflicted with scheduled counseling sessions. The mothers and their children were also frequently ill due to poor or non-existent medical care before they entered treatment. These illnesses were frequently passed between the children in a family so that the mothers with more children were absent more frequently. Additionally, mothers occasionally used the excuse of illness to be able to stay out of programming for a day. After discerning the core problems, the staff set about to find solutions. They rewrote the policies to state that clients would not be eligible to leave the program on weekend passes unless they physically attended 75% of the groups. As an added incentive, clients who attended 100% of the groups in any week received certificates that could be exchanged for additional pass time. These changes gave the clients strong encouragement for program attendance and participation. Anecdotal evidence from therapists and subsequent IBR reports describing the range in attendance suggested that session attendance improved for clients. The problem of frequent illness still existed but the change in the point system may have helped to eliminate non-legitimate illness.

In addition to identifying the problem with session attendance, this report documented that family therapy sessions were not occurring. As the staff examined reasons for low attendance, two problems were discovered. First the counselors did not have specific training in this area and, second, childcare was not available during the evening hours when extended family members' schedules enabled them to participate. After discovering the root problems, it was decided that a family therapist should be hired to resolve the first issue. No adequate solutions were reached for the childcare problem, however, so even though a family therapist was hired, there was only a minimal increase in family therapy sessions. The availability of the IBR reports allowed the program to examine the data, diagnose problems, and make needed changes to the program.

Barriers to Utilization

The wide variation in session attendance evidenced in the reports inspired discussions between First Choice and IBR staff about the factors that might be preventing women from participating fully. Two predominant themes emerged: childcare responsibility and client deviance. In direct response to concerns voiced by First Choice staff, the evaluation team began a series of studies in which it examined if and how these two areas were related to treatment retention and completion.

Number of children. One feature of the First Choice program that had specific implications for a woman's level of participation in treatment was the presence of her children. Having children in a treatment center added a whole new dimension of challenges. First Choice had long known that many of the women were gone frequently to appointments involving the children. The question was to what extent parental responsibilities were interfering with clients' ability to participate in scheduled activities.

While women were in sessions, younger children (infant through age 5) were cared for at the therapeutic child care facility on site, and school-aged children attended the local public school. After school activities were provided for school age children so that women could attend groups until 4:00 p.m. each day. Although providing these opportunities for childcare enabled women to participate in treatment, the responsibility of caring for their children on a daily basis sometimes conflicted with their ability to fulfill treatment requirements. The evaluators examined the relationship between the number of children in treatment and length of stay and found that women with 2 or more children were more likely to drop out prematurely (Knight et al., in press). It was hypothesized that mothers who experienced more parenting stress were leaving treatment early. However, parenting stress was not associated with the number of children in treatment or with length of stay (Knight & Logan, 1997).

Other researchers have suggested that having more children is associated with shorter length of stay when treatment demands on the mother are relatively high (Strantz & Welch, 1995). Together, these studies suggest that adding the logistics of caring for additional children to a demanding treatment schedule may place too great a burden on some women. As mentioned previously, anecdotal evidence from discussions with First Choice staff suggested that the more children a woman had, the more meetings she missed because of illnesses and scheduled medical appointments. Furthermore, she had less time in the evenings to complete homework assignments and spent more time dealing with parenting issues. Brown and colleagues (Brown, Sanchez, Zweben, & Aly, 1996) suggest that having children in treatment but limiting the number of children enables mothers to more effectively manage their responsibilities as parents and to focus on their own recovery.

Although these studies suggest that it is difficult for women to participate fully in treatment when they are responsible for several children, they do not address the effects that separation may have on the children who do not enter treatment with their mothers. Separating children from their mothers can have serious implications. Both mother and child may have difficulty adjusting to the separation, and without adequate support from the treatment agency and from those who are caring for the child, problems associated with being apart may interfere with a woman's full participation in treatment. Therefore each program must make decisions about what is best for their clients based upon several factors: the needs of each child, the program's ability to handle a larger number of children, the availability of local resources for those who are not in treatment with the mother, and the impact that separation may have on a family. Further research is needed to better understand how factors associated with separation and parental responsibility are related to women's treatment engagement, and ultimately to how well each family member functions following treatment.

The evaluators communicated their findings to First Choice staff along with information from other sources regarding this issue. All of these factors gave First Choice a reason to examine how many children the women were allowed to bring into the program. Staff began to look for alternatives for some of the children so that the mothers could bring in a smaller number of children and have a greater likelihood of success in the program. Local resources for the children included safe family members, Foster Care, and children's homes. First Choice also began exploring possible program improvements for the future that might increase a woman's likelihood to succeed in the program if she has a larger number of children. Sick childcare, live-in mother's helpers, and cafeteria meals are alternatives currently under consideration.

Criminal justice involvement. The program staff knew from evaluation reports that a large percentage of clients had prior involvement with the criminal justice system. Although they had no documented evidence, they suspected that these clients were not as successful in treatment. They appeared to be attending fewer sessions and displaying more inappropriate behavior than clients without criminal involvement. Furthermore, no interventions were in place to address the problems. First Choice staff voiced their concerns to the evaluation team in order to determine if criminal justice issues should be addressed more specifically throughout treatment.

Studies examining the role of legal involvement in treatment retention have documented that clients under legal pressure are more likely to remain in treatment longer (Hiller, Knight, Broome, & Simpson, 1998). Such clients are monitored by parole or probation officers and often fear the consequences (namely re-incarceration) of violating the terms of their probation or parole. In this sample, criminal justice was not associated with retention (Knight et al., in press), however those who were arrested during the 6 months prior to treatment entry were less likely to complete treatment (Knight, Logan, & Simpson, 1999). These results suggest that although they may be equally likely to stay in treatment, criminally involved women are less likely to complete program requirements.

After receiving these reports from the research team, First Choice began searching for additional resources to incorporate into the program to address criminal thinking patterns. The program made an initial change by initiating a newcomers group for women in the first 30 days of treatment. This group focused on compliance and adapting to the treatment environment. In addition, the program began to look for additional resources in this area which would address issues of dishonesty, manipulation, thinking that wrong-doing is all right if a person does not get caught, etc. The curriculum would address the problem of not thinking things through or looking

at the consequences of the action, failing to take personal responsibility, and living within the law. Addressing issues that develop due to incarceration such as lack of trust and lack of internal self-governing structure would also be helpful. Such a curriculum should be easy for counselors to use and understand and should have interactive, experiential exercises for clients.

The question of whether the women and children were receiving the services as intended appeared to be simple at the onset. It is easy to see, however, how complex these questions can become. In this case, the initial question led to a series of other questions. Had it not been for the interactive nature of the collaboration between First Choice and the IBR, the questions would have gone unanswered. With the help of the evaluation team, the First Choice program gained a greater understanding of what services were being utilized and what factors may have prevented the utilization of those services. The program also discovered some of the areas in which improvements needed to be made.

What Can Be Done to Improve the Quality of Services Provided?

Data collected from clients helped First Choice to have a greater understanding of the families. The staff of the program felt that as a result, they were able to provide more appropriate interventions and services, however, there were still questions to be answered and improvements to be made. Information provided by the IBR reports suggested 4 areas of unmet needs among women at First Choice. First, a relatively high proportion of women reported psychological symptoms at treatment entry. Although opportunities for diagnosis and treatment of such problems were available, it was not clear whether clients with needs were actually receiving substantial services. Second, women reported a high degree of substance use among family members and friends, but inte0rventions designed to address these issues and assist them in developing positive support networks were not incorporated into the program. Third, all women were responsible for parenting young children and half (52%) reported a high degree of parenting stress. Although parenting classes were provided, a uniform curriculum for addressing parenting issues was not routinely employed. Finally, the need for a more standardized assessment protocol for developing individual treatment plans was expressed by treatment staff.

Dual Diagnosis

Although First Choice anticipated that a percentage of the women would have problems with a secondary diagnosis, evaluation reports demonstrated that more women had difficulties in this area than anticipated. Unfortunately, the county mental health services were usually at maximum capacity, which frequently caused clients to have to wait significant periods of time before receiving services. When the need was demonstrated through the IBR reports, First Choice began looking for alternative resources to fill this need. One of the needs was for psychological assessment that was conducted by licensed psychologists. The state rehabilitation service was able to help by providing pre-vocational assessments. First Choice also received financial assistance from a private donor to alleviate this problem. Through these two sources and by utilizing the county services when possible, First Choice was able to get clients a portion of the services they needed. More opportunities for diagnosis and treatment of psychological problems now exist.

Social Networks

Prior to the beginning of the project in 1995, the primary venue for the clients to develop supportive relationships was through community 12-step programs. First Choice also had a

mentor program in place with a local church that encouraged the women to begin relating to other people who were not in their peer group and who were not using drugs or alcohol. During the project, an evaluation study examining risk factors associated with non-completion found that measures of social deviance (recent arrests and deviant peers) were statistically significant predictors. When the reports from the IBR indicated that an intervention aimed at reducing social deviancy would be helpful, the solution came in the form of a psycho-educational module which had previously been developed by the IBR called "Straight Ahead, Transition Skills for Recovery" (Bartholomew, Simpson, & Chatham, 1993). This module provided a curriculum that teaches clients how make use of established social networks and build new networks to help them in their recovery efforts during and following treatment.

When it was first implemented, First Choice staff thought that "Straight Ahead" was most appropriate for clients who were close to completing the program. After presenting the material, however, the feedback received from the staff and clients indicated that the material needed to be presented much earlier. All future presentations of the material were for new clients. The module seemed to work very well for clients who were in the early phases of treatment.

Parenting

Data collected by the IBR indicated that First Choice had been doing some parenting skills training, but the classes were not curriculum-based and were highly unstructured. First Choice and the IBR worked together to implement a parenting module that would be effective with the clients in the program. The first effort was to adapt a previously developed curriculum. The pilot run of this curriculum clearly demonstrated that it was not amenable to the program. Presentation of the material was staff-intensive, the clients had difficulty understanding and utilizing the material, and the staff found some of the activities to be contrary to recovery skills they were teaching in other groups. For example, clients were encouraged to ignore their children's inappropriate behavior. Although ignoring can be an effective tool for shaping behavior, many women had been ignoring both the positive and negative behavior of their children for years. The staff felt that for these women, activities encouraging attentiveness must be emphasized before practicing those that emphasize ignoring.

After evaluation indicated problems with the pilot module, the IBR went to work developing a new curriculum that would meet the needs of the clients and be easy for the staff to implement. Both staff and clients were included in the needs assessment and development of the new module. Ideas on what topics should be covered, what activities would be helpful, and how best to structure sessions were solicited by the evaluation team through focus groups and meetings with individual staff members. It was determined that the module must be comprehensive in scope but specific in providing detailed information and instructions for conducting sessions. Given that most staff at First Choice had multiple responsibilities, they wanted a curriculum that would specify exactly what was to be done in each session. The IBR responded by developing a parenting manual and curriculum that was pre-packaged, presented information efficiently, and required minimal preparation time. Furthermore, the curriculum was based upon philosophies of parenting that were complementary to agency policies.

The newly developed module, entitled "Partners in Parenting" (Bartholomew, Knight, Chatham, & Simpson, 1998), was piloted with good results. Both counseling staff and child care staff were trained on the content presented in the manual—specifically on expectations for development, parenting styles, and specific discipline strategies. The inclusion of child care providers facilitated communication among therapeutic and childcare staff, improved teachers'

knowledge of parenting strategies taught by counselors, and provided teachers with specific strategies to employ in their classrooms.

Although no formal assessment was made during these developmental stages, anecdotal evidence from clients and staff suggested that the quality of treatment improved because of the development and implementation of the parenting module. Through the process of developing the parenting module, First Choice found what type of training was needed for the women and how to more effectively conduct the parenting classes. Once the number of women who participate in "Partners in Parenting" is sufficient, the evaluation team plans to examine the effectiveness of the module in lowering parenting stress, improving family functioning, and improving women's beliefs about and use of various discipline strategies.

Standardized Assessment

Early in the project, First Choice staff requested that standardized instruments with clinically meaningful scores be utilized whenever possible in order to develop more effective individual treatment plans. In particular, information about psychological symptoms would be useful in determining appropriate treatment goals and in accessing specialized services such as clinical diagnosis and pharmacological treatment. Ultimately, the goal was to ensure a good match between a woman's needs and the interventions she received.

Clinical symptoms. First Choice was looking for an assessment tool that could be utilized by the program to identify emotional and psychological problems. The evaluation team recommended a computerized version of the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1996), a brief, multidimensional self-report inventory that screened for a broad range of psychological problems and symptoms of psychopathology. The computerized assessment was subsequently incorporated into the program as part of the intake process. Clients entered responses directly into a computer file from which profiles were generated. Although staff was trained on how to interpret the profiles, the information was not routinely used to inform treatment planning. Reasons why this information was not used are numerous and highlight some of the challenges that must be overcome if evaluation efforts are to be used to inform agencies about the needs of individual clients.

Most of the barriers to utilizing the SCL-90-R profiles involved staffing issues. First, the assessment specialist who administered the SCL-90-R to clients was not directly involved in treatment planning. She worked with clients to complete the instruments and placed the profiles in client files. Counselors were not always aware when profiles had been completed and often did not look for them in client files. A second barrier involved training issues. Counselors received training on interpreting profiles, but received little guidance on how to match specific services to specific clinical symptoms. A third barrier involved staff resources, particularly regarding varying levels of education and time available to develop treatment plans. Many of the counselors came directly out of college or graduate school and were entry-level. These staff members usually had not worked extensively with assessments and were unfamiliar with how best to utilize the information in treatment planning. Furthermore, although the counselor to client caseload is low at First Choice, the level of need of the clients is extremely high, which consumes a large amount of counselor time. Unfortunately, staff members usually do not have the time available that would be needed to study the profiles and learn to integrate the information into their work with clients.

Reading ability. Clients at First Choice needed to read at the minimum of a 6th grade level to be able to understand the materials used for research. For this reason, the evaluation

staff requested that The Wide Range Achievement Test-3 (WRAT3; Wilkinson, 1993) be administered to all clients to determine reading level. At intake, the Reading subtest (an assessment of word recognition in which respondents are asked to read as many of the 42 words on the test form as they can) was individually administered. Scores were based on the number of words respondents accurately pronounced.

Although the WRAT-3 was originally intended as a tool for ensuring that clients could read evaluation forms, it became a therapeutic tool for identifying clients with poor literacy skills. When a woman was identified as reading below the 6th grade level, she not only received assistance in completing evaluation instruments but she also received special literacy-based services. Those services included referring the clients to literacy classes, giving assignments using audio cassettes instead of doing reading assignments, working more with art and music in client sessions, utilizing visual aids in therapy groups, and going over rules and instructions verbally instead of through written materials.

Early in this project First Choice recognized that the evaluation team had very different resources than it did. The IBR had researched substance abuse treatment issues for years and was familiar with studies that proved helpful to the program. By drawing on those resources and by inviting the evaluation team to actively participate in finding solutions, First Choice was able to objectively determine what elements of the program should be modified and access available resources. The collaborative effort directly contributed to the overall good of the program, thus benefiting the clients.

How Can Communication Be Improved?

Regular communication in the form of written reports and research updates was an essential component of the First Choice/IBR collaboration. These written reports helped to foster trust between the agency and researchers. They provided concrete confirmation of the work being done and allowed the program to make informed decisions about services being provided to clients. Having current information about the status of the research was extremely helpful for First Choice as it was becoming common for funding and licensing agencies to require either external or internal evaluation in order to secure funding. With the data from the research project and the evaluation plan in place, First Choice was able to satisfy a number of these requirements.

Justification for Needs

In addition to making program changes, First Choice used the information provided by the research team to develop a needs list. Once compiled, the needs were communicated to funding agencies and community volunteers using the data to support the requests. This information also helped First Choice develop strategic plans for future improvements to the program.

A specific example of data's demonstrating the needs of the program involved the children's mental health. As mentioned earlier, of the 99 children ages 2-13 whose mothers completed the CBCL, a total of 42% were identified as having internalizing problems and 37% as having externalizing problems. Seventeen percent were classified as problematic on both scales. This data confirmed that the children had needs equal to those of the adults. As a result, the children's staff was given additional training and supervision, and an outside contractor was brought in to provide supplemental therapy for the children with the most severe needs. New children's programs such as music therapy, martial arts training and a spiritually based after-

school program were also implemented. Having additional staff to work with the children was established as a future goal for the agency.

Advisory Committees

Reports from the IBR were also utilized to provide information to First Choice staff, the First Choice Advisory Committee, and the county community Advisory Board. Through written reports and oral presentations by the evaluation team, all parties involved with the oversight of the program received information about the client population. This information helped all of the groups to be more aware of the needs of the clients and inspired each member to be more invested in the program. All groups were now in a position to make more informed decisions about the course of the program based on the needs discovered through the research.

The Community and Beyond

Research findings can also be useful when presenting needs to legislators and policy makers. First Choice utilized the research to advocate for clients in the state legislature. As the state began moving toward managed care, the length of the program was to be shortened. Members of the First Choice Advisory Committee wrote letters and visited legislators to present data findings that showed that a longer stay was generally better for clients. This effort is ongoing. Using research in this manner can effect changes that will benefit a broader range of clients in the community and beyond. First Choice also utilized the research findings to secure additional services such as dual diagnosis and additional training for clients within the community. Seeing the numbers of women who were involved in the criminal justice system and who had involvement with child welfare, First Choice was inspired to foster deeper and stronger relationships with agencies in both of those areas. By strengthening the relationships between these groups, workers were kept informed and additional services were secured.

Communication Within First Choice

Another benefit of the relationship between the agency and research team that has not been mentioned was consistency. Becoming involved in a research project required that data collection procedures be followed consistently. Because the research process began at pre-intake and continued through 1 year of client follow-up, First Choice became much more consistent in its adherence to the assessment process. All clients went through the same steps when completing the paperwork. This level of consistency was absent from the program prior to the onset of the data collection.

Additionally, the staff of the program received training from the IBR in data collection, methods of teaching parenting skills, implementation of training modules, administration of standardized assessments, theories of child development, and the specific components of therapeutic communities. All of this training was initiated to help further the research but was of great benefit to the program. Because of the training provided by the research team, the staff became more competent in their jobs, better at data collection, and more interested in seeing the research project succeed.

A second benefit of the evaluation in improving communication within First Choice involved the implementation of a Management Information System (MIS). Use of a MIS is essential to ensure prompt collection of time-sensitive forms (Chatham & Rowan-Szal, 1993). The evaluation team utilized a comprehensive computerized tracking system to monitor data collection. As the project progressed, it became apparent that First Choice staff also could

benefit from using the MIS. Instead of waiting for the research team to provide the monthly missing data list, which might reach First Choice after requested data had been sent, the First Choice data coordinator could keep MIS records for the agency. This could speed up and simplify the data tracking process for First Choice. Consequently, a scaled-down version of the MIS used by the evaluation team was developed for use at the agency. The data coordinator was then able to generate reports detailing when forms should be administered to clients, check whether or not forms had been administered, and track forms sent to the research team. The research team's missing data reports were used to check for accuracy and to ensure communication between the research team and First Choice. In addition to increased agency accountability, direct access to the MIS enabled First Choice staff to produce their own reports describing the demographic characteristics of the women and children in treatment.

Conclusions

The collaborative efforts between The Salvation Army First Choice program and the Institute of Behavioral Research represents work that is ongoing. To date, much has been learned from the evaluation efforts, but much more work is needed to determine whether or not the programmatic changes made as a result of evaluation findings were effective. Anecdotal evidence suggests that modifications in the program resulted in positive changes—better identification of client needs, better curriculum, and better communication between clients and staff as well as between staff and the community. However, this project was not designed to empirically assess the impact of evaluation on program monitoring and service provision. Clearly, the program has changed because of the reciprocal exchange of information. Albeit difficult, future projects should attempt to examine how evaluation reports impact treatment components and how resulting changes impact the quality of treatment available to clients.

First Choice originally initiated the collaborative relationship with the Institute of Behavioral Research in order to secure federal funding for its substance abuse treatment program for women with dependent children. As an additional benefit, First Choice knew that a high quality evaluation would provide data about the program's effectiveness that could be used toward future funding efforts. Although the administrative staff of First Choice knew that much would be gained from external evaluation, there were a number of benefits that came as surprises. The interplay between the two agencies made First choice aware of client characteristics, unmet needs, and program weaknesses. The agency staff learned that some goals were achievable and others were not. Almost more valuable than the insights gained were the solutions offered by the evaluation team. Those solutions were above and beyond what the program could have provided as the result of internal evaluation. Overall, First Choice has a greater understanding of the work it does and areas that still need improvement. Staff members have better tools with which to do their work and have made important changes to the program.

The evaluation of The Salvation Army First Choice program is not yet near completion. Plans call for a series of studies examining factors that facilitate or impede a client's ability to develop a good relationship with her counselor, how engagement in various program components relates to positive change during treatment, and how pre- and during-treatment factors relate to outcomes at follow-up. The specific areas under investigation are being determined in part through discussions with First Choice staff, and findings will again be communicated through written reports and oral presentations.

Now that the project is toward the end of its federal funding cycle, the evaluation efforts are viewed by First Choice as equally as valuable as the funding itself. Had First Choice

Administrative staff known at the beginning of the project how beneficial the evaluation was going to be to the program, they would have sought it out even if it had not been required for the receipt of CSAT funding.

In a mutually beneficial collaboration such as the one described in this paper, the evaluation team and the program formed a true partnership. Each partner contributed information and resources toward the common good. This was accomplished though good communication with an overarching sense of cooperation. Each agency was committed to the task and to the goals. This model of collaboration is strongly recommended for other providers who want to know what is going on in their programs and want to achieve excellence in service delivery.

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Table 1

Client Characteristics at Admission (N=96)[1]

	Number of Women	Percent
Age		
Younger than 25	16	17
25-34	59	61
35 and older	21	22
Race/Ethnicity		
Caucasian	43	45
African American	36	37
Hispanic	14	15
Other	3	3
Marital Status		
Never Married	32	33
Married	14	15
Living as Married	13	13
Divorced/Separated/Widowed	37	39
Pregnancy Status		
Pregnant	18	19
Not Pregnant	78	81
Number of Children in Treatment		
0	13	14
1	48	50
2	23	24
3	10	10
4 or More	2	2
Education		
Less than High School Graduate	35	37
High School Graduate or GED	30	31
Post High School	31	32
Primary Drug of Choice (N=94)		
Alcohol	26	28
Cocaine/Crack	41	44
Methamphetamines	11	12
Hallucinogens	6	6
Marijuana	6	6
Other Illegal Drugs	4	4

Table 1 (Continued)

	Number of Women	Percent
Daily Drug Use in the 6 Months Prior to Admission		
Alcohol	28	29
Crack	28	29
Marijuana	21	22
Methamphetamine	9	9
Cocaine	4	4
Heroin	4	4
Heroin + Cocaine	3	3
Sedatives	3	3
Financial Status		
Income Below Poverty Line	85	89
Receiving Public Assistance	72	75
Employment Status		
Unemployed (disabled)	13	14
Unemployed (needed at home)	20	21
Unemployed (looking for work)	9	9
Employed (odd jobs)	8	8
Employed (part time)	13	14
Employed (full time)	27	28
In Jail	6	6
Medical Benefits		
No Insurance	48	50
Medicaid	45	47
Other	3	3
Victimization History		
Any Abuse	94	98
Emotional/Psychological	90	94
Physical Abuse	86	90
Sexual Abuse (N=95)	71	75
Incest Survivor (N=95)	35	37
Criminal Justice Involvement		
One or More Prior Arrests	89	93
Arrested within Last 6 Months	31	32
Current Legal Status	56	58
Probation	37	39
Outstanding Warrant	10	10
Case Pending	1	1
Formal Action for Child Abuse/Neglect		
No formal action	47	49
One or more formal actions	49	51

Table 1 (Continued)

	Number of Women	Percent
Physical Health Problems (N=94)		
One or more Problem	65	68
STD's	28	30
Asthma	18	19
Other	17	18
Physical Disability	13	14
Physical Trauma	8	9
Eating Disorder	8	9
Hepatitis	7	7
Seizures	5	5
Tuberculosis	4	4
Mental Health Problems (N=94)		
One or more Problem	60	63
Depression	45	48
Anxiety	22	23
Psychological Trauma	20	21
Bipolar Disorder	16	17
Other DSM-IV	12	13
Antisocial Personality	8	9

Table 2

Child Characteristics at Admission (N=148)*

	Number of Children	Percent
Age		
0-4 Years old	85	58
5-10 Years old	58	39
11-13 Years old	5	3
Gender		
Male	76	51
Female	72	49
Race/Ethnicity		
African American	56	38
Caucasian	50	34
Hispanic	23	15
Other	19	13
Living Arrangements Prior to Admission		
Mother	98	66
Grandparents	16	11
Foster Family	7	5
Other Relative	7	5
Father	7	5
Other	4	2
Unborn	9	6
Victimization History		
Any Abuse	84	57
Emotional/Psychological	78	53
Physical Abuse	19	13
Sexual Abuse	11	7
Nicotine Exposure In Utero		
Exposure	101	68
No Exposure	47	32
Drug Exposure in Utero		
Exposure	87	59
No Exposure	61	41

Table 2 (Continued)

	Number of Children	Percent
Physical Health Problems		
One or more Problem	51	35
Asthma	22	15
Other Resp. Condition	15	10
Vision Impairment	15	10
Childhood Infectious Condition	11	8
Hearing Impairment	5	3
Brain Injury	1	1
Internalizing Behavior Problems (N=99)**		
Normal	57	58
Borderline	12	12
Clinical	30	30
Externalizing Behavior Problems (N=99)**		
Normal	62	63
Borderline	14	14
Clinical	23	23

* Data collected using the TCU Child Intake Form.
** Profiles computed according to Child Behavior Checklist (CBCL) guidelines for children aged 2 years and older.

Table 3

Client Session Attendance During the First Three Months of Treatment

Type of Session	Month 1 (N=80)			Month 2 (N=67)			Month 3 (N=63)		
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range
Individual Counseling	3.8	2.3	0-11	4.2	1.7	0-8	4.2	1.7	0-8
Group Counseling (total)	13.9	6.8	1-30	20.1	7.2	6-33	22.8	8.2	7-41
Structured Group	9.1	5.0	0-22	13.2	5.5	0-26	15.3	6.4	4-31
Open Discussion Group	4.8	2.7	1-13	6.9	3.0	1-14	7.6	3.3	2-15
Family Counseling*	.1	.3	0-2	.1	.5	0-4	.1	.6	0-4
Life Skills Education**	.7	1.1	0-5	1.5	1.7	0-6	1.0	1.3	0-6
Other***	1.9	1.8	0-9	3.1	2.1	0-9	4.1	3.0	0-15
Total Sessions	20.5	8.0	4-42	29.0	8.2	12-42	32.3	9.5	14-48

* Month 3 data based on N = 60.
** Month 3 data based on N = 62.
*** Month 2 data based on N = 66.

Table 4

Number Clients Receiving Ancillary Services During their First Three Months of Treatment

Ancillary Service Received	Month 1 (N=80) Freq.	%	Month 2 (N=68) Freq	%	Month 3 (N=63) Freq	%
Medical Services/Tests	60	75	37	54	34	54
Psychological Services/Tests	26	33	23	34	27	43
Job/Vocational Training	4	5	7	10	7	11
Education	24	30	23	34	21	33
Legal Assistance	11	14	7	10	9	14
Welfare/AFDC/Food Stamps/etc.	69	86	57	84	55	87
Food/Clothing	68	85	58	85	54	86
Anger Resolution	15	19	25	37	27	43
Rape & Trauma	9	11	18	27	23	37
Alcoholics Anonymous	76	95	62	91	59	94
Narcotics/Cocaine Anonymous (NA/CA)	74	93	64	94	62	98
Contacts with Parole/Probation Officer	34	43	30	44	32	51
Contacts with Court/Judges	8	10	5	7	5	8
Contacts with Housing Agencies	80	100	2	3	3	5
Contacts with CPS	19	24	16	24	14	22