DEPARTMENT OF HEALTH CARE SERVICES

WOMEN AND CHILDREN'S RESIDENTIAL TREATMENT SERVICES PROGRAM

2023 ANNUAL REPORT TO THE LEGISLATURE

October 2024

Published March 2026

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EXECUTIVE SUMMARY

Health and Safety Code (HSC) Section 11757.65 was added by Senate Bill (SB) 1014 (Committee on Budget and Fiscal Review, Chapter 36, Statutes of 2012) for State Fiscal Year (SFY) 2012-13. This bill requires the Department of Health Care Services (DHCS) to work collaboratively with counties to provide an annual report to the Legislature on the fiscal and programmatic status of the Women and Children's Residential Treatment Services (WCRTS) program.

The WCRTS program consists of residential perinatal substance use disorder (SUD) treatment programs in the following six counties: Alameda, Los Angeles, Marin, San Diego, San Francisco, and San Joaquin. DHCS worked with the counties to gather SFY 2022-23 data for the WCRTS Program 2023 Annual Report to the Legislature. This includes allocation and expenditure data submitted by WCRTS program county coordinators, SUD treatment services data from the California Outcomes Measurement System Treatment (CalOMS Tx), and programmatic updates obtained through direct surveys to WCRTS program county coordinators and their providers.

BACKGROUND

The WCRTS program was initially funded in 1993 through a national competitive bidding process from the United States (U.S.) Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), specifically the Center for Substance Abuse Treatment (CSAT). The outcome of the bidding process led to a five-year demonstration grant from the CSAT to achieve the WCRTS program. As a demonstration grant, the program focused on pregnant and parenting women's (PPW) unique needs and circumstances when few specialized treatment programs existed. The terms of the demonstration provided the foundation of the WCRTS program goals and outcomes described in this report.

The SFY 1998-99 budget for the former California Department of Alcohol and Drug Programs included $3.1 million of State General Fund (SGF) allocated to WCRTS programs previously funded by CSAT grants. In SFY 1999-2000, the SGF for the WCRTS programs increased to $3.6 million to offset a decrease in federal support.

In SFY 2000-01, the SGF allocation increased to $6.1 million as the federal grant award expired for all programs. Under 2011 realignment, funds are now allocated to the counties by the California State Controller's Office from the WCRTS Special Account. The

Special Account is within the Behavioral Health Subaccount of the Local Revenue Fund 2011. The passage of SB 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2012) included language that specifies funds in the WCRTS Special Account would total approximately $5.1 million.

INTRODUCTION

DHCS must collaborate with WCRTS counties and annually report the fiscal, programmatic, and treatment data to the Legislature. Pursuant to HSC Section 11757.65, the WCRTS programs must pursue four primary goals and achieve four outcomes for PPW in residential SUD treatment settings.

The four primary goals are:

1. Demonstrate that alcohol and other drug (AOD) treatment services delivered in a residential setting and coupled with primary health, mental health, and social services for women and children can improve overall treatment outcomes for women, children, and the family unit as a whole.
2. Demonstrate the effectiveness of six-month or 12-month stays in a comprehensive residential treatment program.
3. Develop effective, comprehensive service delivery models for women and their children that can be replicated in similar communities.
4. Provide services to promote safe and healthy pregnancies and perinatal outcomes.

The four outcomes include:

1. Preserving family unity.
2. Promoting healthy pregnancies.
3. Enabling children to thrive.
4. Freeing women and their families from SUD.[1]

[1] This report uses "SUD" as preferred clinical terminology, as directed by the DHCS' Behavioral Health Information Notice No. 23-054 and consistent with the current edition of the Diagnostic and Statistical Manual of Mental Disorders, medical societies, professional organizations, recovery advocates, and federal guidance regarding the use of non-stigmatizing, person-centered language

FISCAL AND PROGRAMMATIC STATUS

Expenditures

One-twelfth of the annual WCRTS program allocation is distributed monthly to each participating county. WCRTS program providers must report detailed expenditures for the annual cost reporting process to their respective counties. As part of the reporting realignment initiated in SFY 2022-23, the expenditures of the WCRTS programs are now submitted by the counties to the DHCS perinatal services program. The WCRTS program is continuously appropriated, does not expire, and can be retained for use in subsequent years; therefore, counties may expend under or over their WCRTS allocation in a single SFY.

Table 1 displays the WCRTS expenditure data information for SFY 2022-23.

Table 1. Annual Allocation and Expenditure by County

WCRTS County	Annual Allocation	SFY 2022-23 Expenditure
Alameda	$687,665	$687,665
Los Angeles	$2,132,488	$1,912,801
Marin	$728,485	$340,668
San Diego	$553,940	$553,940
San Francisco	$182,286	$182,286
San Joaquin	$819,136	$819,136
Total	$5,104,000	$4,496,496

Client Outcomes at Discharge: California Outcomes Measurement System Treatment (CalOMS Tx)

Client outcomes were assessed by examining the percentage of discharged participants who met or did not meet the criteria for each specified outcome measure (e.g., no primary drug use at discharge). Missing and unknown data exists due to administrative discharges when clients decline to state or are unable to answer during standard discharges.

Data Collection and Report Methodology

CalOMS Tx is California's data collection and reporting system for SUD treatment services. Data collection includes the time of the recipient's admission and discharge. The CalOMS Tx data and the percentage of administrative discharges can be used to measure and compare service recipients' outcomes across multiple years.

There are substantial variations in the percentage of administrative discharges found across years, counties, and specific treatment service types. An administrative discharge is intended to be used when the service recipient leaves the treatment program abruptly, and the provider is unable to contact them (in person or by phone). Therefore, minimal data is reported to close the corresponding CalOMS Tx admission record administratively, indicating the service recipient is no longer in the program. Since the service recipient cannot be located, outcome data is not available to be collected. In contrast, when a service recipient remains in treatment as planned and is available for a standard discharge interview (in person or by phone), a standard discharge report is completed and contains the necessary service recipient functioning data to measure outcomes. For some discharge questions, a client may decline to answer or be unable to respond.

In general, it is reasonable to assume that the outcomes for service recipients discharged administratively would be less favorable than for those who complete their program with a planned discharge. Thus, generalizing outcomes from only treatment service recipients with standard discharges (from the service recipient with planned discharges) creates a positive bias. Outcome measurement bias and variability are reduced when the administrative/missing discharge data are factored into comparisons across fiscal years and between counties or providers. Based on these findings, the methodology was revised in 2020, and the results incorporated in the report reflect the use of the revised methodology.

Client Outcomes at Discharge

Table 2 indicates 240 clients were served in the WCRTS program in SFY 2022-23.

Table 2. Client Outcomes at Discharge, SFY 2022-23

California HSC Section 11757.65	CalOMS Tx Domain	Outcome Measure	Discharges Meeting Desired Criteria		Discharges Not Meeting Desired Criteria		Discharges Containing Missing / Unknown Data	
			n	%	n	%	n	%
(a)(2)(A) Demonstrate AOD Services Improve Treatment Outcomes	AOD Use	No Use of Primary Drug	144	60.0%	49	20.4%	47	19.6%
	Social / Family	Stable Housing	137	57.1%	56	23.3%	47	19.6%
		No Children Living Elsewhere	105	43.8%	71	29.6%	64	26.7%
	Medical / Physical Health	No Medical Problems	143	59.6%	33	13.8%	64	26.7%
		HIV Tested	148	61.7%	24	10.0%	68	28.3%
	Mental Health (MH)	No Emergency Services for MH	171	71.3%	5	2.1%	64	26.7%
(b)(1) Preserving Family Unity	Social / Family	No Family Conflict	142	59.2%	34	14.2%	64	26.7%
		No Arrests	189	78.8%	4	1.7%	47	19.6%
(b)(2) Promoting Healthy Pregnancies	AOD Use	No Needle Use	174	72.5%	2	0.8%	64	26.7%
		No Use of Primary Drug	144	60.0%	49	20.4%	47	19.6%
(b)(3) Enabling Children to Thrive	Social / Family	Parental Rights Not Terminated	149	62.1%	27	11.3%	64	26.7%
(b)(4) Freeing Women and their Families from Substance Abuse	Employment / Education	Employed	5	2.1%	188	78.3%	47	19.6%
		Enrolled in Job Training	54	22.5%	122	50.8%	64	26.7%
	Social / Family	Social Support >= 8 days	157	65.4%	36	15.0%	47	19.6%

Improved Treatment Outcomes

WCRTS programs indicated that best practices involve integrated care, which combines SUD treatment, mental health treatment, medical treatment, and coordination with other social service providers.

The following highlights client outcomes at discharge in improving overall AOD treatment outcomes:

- During the reporting period, 60 percent of women met the No Use of Primary Drug criteria at discharge.
- Approximately 57 percent of the women had stable housing at the end of their treatment.
- About 44 percent of women indicated they had no children living elsewhere at their discharge, and 62.1 percent did not have their parental rights terminated, keeping families intact.
- No needle use at discharge was reported by 72.5 percent of women.
- 71 percent of women reported no need for emergency services for their mental health at discharge.
- 78 percent noted no arrests by the end of their treatment.

Programmatic Data

Program Goals

This section reviews the four primary goals outlined in HSC Section 11757.65. DHCS requested that counties and providers submit programmatic data to demonstrate how WCRTS programs successfully achieved each primary goal. Below is DHCS' analysis of the program goal data submitted for SFY 2022-23.

Demonstrate Comprehensive Alcohol and Other Drug (AOD) Treatment Services

All WCRTS counties reported providing integrated services for the families served by their programs. Comprehensive screening and assessments were conducted to identify the needs and monitor the treatment for PPW in recovery, applying a whole-person approach to coordinated and comprehensive care. As a result, women and their children were referred to appropriate physical and mental health care services, including obstetrics and gynecological, prenatal care, dental, mental health, vision care, and children's health services at neonatal and pediatric clinics. Some programs included

ancillary education programs on subjects such as women's safety and situational awareness, sexual health and sexually transmitted infection, and tobacco use disorder prevention. In addition, social services such as benefits acquisition, housing, transportation, mental health treatment and counseling services for trauma, domestic violence, family issues, and co-occurring disorders were provided through the WCRTS programs and external contracts.

All WCRTS programs provided services helping navigate systems such as medical insurance, benefit programs, child welfare, probation, and collaborative courts. Upon intake, clients received medical assessments, comprehensive physical exams, and mental health evaluations by trained staff and clinicians. All clients in the WCRTS programs were offered case management services to ensure that physical, mental health, and social service needs were secured and maintained.

WCRTS programs utilized various evidence-based practices in treatment delivery, such as Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Motivational Interviewing, relapse prevention, and the Wellness Recovery Action Plan (WRAP). A Los Angeles County provider reported adding Medication-Assisted Treatment, an evidence-based treatment, in combination with counseling and other therapeutic techniques to the whole-person approach they find very successful. A Marin County provider described investing in considerable training for all staff in evidence-based practices to ensure confident utilization of the practices for delivering services. This service provider also provided staff training to help them understand and address the criteria for SUD and relevant mental health disorders as outlined in the Diagnostic and Statistical Manual of Mental Disorders (5th edition). This approach helped clients and staff better identify needs and strategies for long-term stabilization and recovery, improving symptom identification and management.

Demonstrate Effectiveness of 6-12 Month Stays

Counties reported that the length of stay in residential treatment significantly determines treatment effectiveness. A San Francisco County provider with stays of at least six months indicated that 70 percent of participating clients completed the program successfully. Of the 13 women who completed the program, 12 moved into housing with full custodial rights of their children. A San Diego County provider reported that 15 women were pregnant during residential treatment, and six gave birth while at the program; all six infants were born free from substances.

WCRTS program clients gained the tools to become stable, well-functioning parents during treatment. Longer stays allowed women to develop the parenting skills they

lacked upon admission, learn life skills and healthy coping strategies, and receive support with reunification goals. A Los Angeles County provider noted a high treatment completion rate of over 90 percent. Many of the women attributed their completion to the ability to have their children with them during their stay. The same program reported that several women with babies under six months of age learned critical nurturing parenting techniques and received coaching on developing a healthy attachment with their infants. Another Los Angeles County provider reported that many children demonstrated more positive behaviors at the end of treatment, partly due to the healthy parenting techniques their mothers learned and practiced during their stay. Children's tantrums and outbursts decreased, and greater compliance with parenting directives was noted.

Comprehensive Service Delivery Models

All WCRTS programs provided a continuum of care for women and their children through various resources and referrals to community-based services. Services included, but were not limited to, on-site recovery meetings and supportive sponsorship opportunities; individual and group counseling education sessions with AOD counselors, therapists, and case managers; and utilization of evidence-based practices.

Additionally, services applied in most of the WCRTS programs included culturally appropriate and gender-specific curricula while incorporating trauma-informed practices. Providers described quality improvement strategies to identify patterns in treatment, make changes in treatment approaches, if applicable, and explored new service delivery models to ensure best practices are in place. A provider in Alameda County has included acupuncture, chiropractic care, and medical case management led by nursing staff to help mothers navigate the medical system successfully.

All WCRTS programs used evidence-based practices such as Nurturing Parenting, Seeking Safety, WRAP, and peer support services. Additionally, women had access to domestic violence education and health education groups as designated through their assessments and treatment plans. Many WCRTS programs noted that instead of a standard treatment plan, they are utilizing the California Advancing and Innovating Medi-Cal Behavioral Health Initiative's Specialty Mental Health Services, Drug Medi-Cal Initiative's, and Drug Medi-Cal – Organized Delivery System problem list referenced in DHCS guidance outlined in the Behavioral Health Information Notice (BHIN) 22-019. The problem list outlines symptoms, conditions, diagnoses, and risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other service encounters. It is designed to capture a person's unique needs. Providers can add

problems to the problem list that are not diagnoses, embracing a whole-person integrated approach to care.

Services for Safe and Healthy Pregnancies and Perinatal Outcomes

All WCRTS programs indicated offering health and nutrition groups that promoted healthier eating habits and lifestyles for women and their children. Parenting education and bonding opportunities were in place to teach mothers the best practices in child development and self-care, and breaking destructive coping patterns developed as a result of SUD. Women were also provided SUD education and individual counseling guided by best practices determined by each county. A San Diego County provider reported 107 women successfully transitioned to a lower level of care after experiencing the residential treatment. Most women in the program reunified with their children, and many returned as alumni to give peer support and guidance to their community.

Resources were in place to ensure women received prenatal care and transportation to their scheduled appointments or support navigating telehealth options. Additionally, WCRTS clients received education on the harmful effects that tobacco, drugs, and alcohol have on the unborn fetus, reproductive health, and family planning. Moreover, women received assistance with referrals to the Women, Infants, and Children program. A provider in Los Angeles County incorporated a new service called Real Talk, Real Options, into their array of services. Real Talk, Real Options is focused on integrating discussions around sexual and reproductive health in SUD treatment settings, observing that these conversations are vital in supporting overall health and well-being.

WCRTS programs reported that perinatal support was provided to women through parent-child therapy, individualized parenting plans, and recurring mental health services. A few Los Angeles County WCRTS providers reported utilizing the Maternity Assessment Management Access and Service – MAMA Neighborhood program, a regional name for the "Strong Start for Mothers and Newborns" initiative created by the U.S. Department of Health and Human Services to reduce preterm births and improve outcomes for newborns and pregnant women.

Program Outcomes

The following section reviews the four program outcomes outlined in HSC Section 11757.65. The following analysis of SFY 2022-23 programmatic outcome data reported to DHCS by the WCRTS County programs and Client Outcomes at Discharge CalOMS Tx data demonstrated that all programs achieved the intended outcomes, and many policies and strategies were continued with diligence and ingenuity as a result of the COVID-19 Public Health Emergency (PHE).

Preserving Family Unity

All six counties indicated meeting the outcome of "preserving family unity" through case management strategies and partnership with multiple services, including referrals to affordable housing following residential treatment. Collaboration with agencies like the county Department of Children and Family Services to promote family reunification, child visitation, and family stability was noted as an essential program strategy.

Treatment program support for reunification strengthened WCRTS clients' confidence in parenting and problem-solving within a family unit and supported retention in ongoing treatment and stability in sobriety. A Los Angeles County provider described mothers who regained custody of their children by learning how to bond with them successfully and building appropriate parenting skills. The provider facilitated this learning by providing space and support for supervised child visitation, parenting skills education, and referrals to outside agencies for supporting services. For instance, by referring their clients to the Department of Rehabilitation, many individuals could attend community college classes shortly after transitioning to a lower level of treatment. This allowed them to obtain general equivalency diplomas, high school diplomas, or vocational training, which increased their employability and provided greater stability for their families.

In another example, an Alameda County provider reported scheduling all clients to have weekly shifts at the on-site child enrichment program. WCRTS clients were supervised by counselors/child development specialists in applying parenting skills learned in a group (e.g., positive discipline, behavior management, and distress tolerance) with their children and other residents' children. During these visits and weekly shifts, WCRTS clients received real-time feedback and practiced appropriate parenting skills. The shifts at the on-site enrichment program included mothers who did not have custody of their children and were working on reunification.

Promoting Healthy Pregnancies

The promotion of healthy pregnancies was a focus of all WCRTS programs. All programs described that pregnant women received necessary medical services through a network of medical clinics and on-site services, with many programs recognizing that the long-term holistic approach better assists a mother in managing SUD issues during pregnancy. Women received nutritional education, parenting skills training, pregnancy planning, infant bonding, child development training, and post-partum depression screening in the WCRTS programs. Individual and group services assisted mothers with concerns and issues they encountered upon discharge. As shown in Table 2, Client

Outcomes at Discharge, SFY 2022-23, less than 1 percent of women reported intravenous drug use at discharge.

A program in Marin County described how all pregnant or women with post-partum depression received comprehensive pregnancy and perinatal assessments that included a discussion of the history of all pregnancies, prenatal care, drug use before and during pregnancy, self-care practices, and general health and medical issues. All women had a birth plan consistent with their health and treatment plan and available community resources. Post-partum depression in women was assessed, monitored, and treated (if appropriate). The relationship with the father or co-parent and intimate relationships were also evaluated, and if the relationships posed barriers to SUD treatment, they were addressed in the treatment plan.

Enabling Children to Thrive

Various children's services and activities were in place in all WCRTS program counties to fulfill the outcome of "enabling children to thrive." These services included but were not limited to parent-child therapy, referrals to child counseling, parenting groups, on-site child visitations, and collaboration with agencies, such as county Public Health Departments. In many cases, cooperative childcare was provided in shifts supervised by staff to ensure each mother could participate fully in education and support groups. All six counties also reported providing comprehensive psychoeducation such as parenting classes, domestic violence prevention education, healthy relationship courses, mother-baby bonding classes, and family skills courses to assist women with parenting. In SFY 2022-23, just over 62 percent of the women reported that their parental rights were not terminated at discharge.

All childcare services provided through WCRTS programs were therapeutic and developmentally appropriate to address a child's developmental delays, including emotional and behavioral issues. Services were tailored to each child to support their individual needs. A San Diego County provider reported that childcare services were available at the program site with a fully developed program of age-specific activities. Their licensed childcare program offered care in a structured setting while the mother participated in on-site treatment services. The services included education on the effects of SUD on the development of infants and children, the unique needs of infants and children exposed to SUD, and skills relating to discipline, physical health, nutrition, and age-appropriate activities. Individualized parenting groups were provided weekly to increase parenting skills development.

Freeing Women and their Families from Substance Abuse

The services provided, such as SUD counseling, therapy, and connection to outside natural support systems, help relieve women from stress and pressure that exacerbate SUD. Other services reported included teaching mindfulness and meditation, walking and other exercise strategies, and care coordination to address clients' immediate and ongoing needs. All WCRTS program counties reported various stress-relieving and trauma-informed approaches, such as coaching on building healthy relationships, domestic violence intervention, financial support and planning, housing stability in sober environments, and relapse prevention. The San Joaquin County Family Ties program described Medication-Assisted Treatment services as an essential factor in women's success.

Additionally, program collaboration with law enforcement and justice systems, mental health programs, and local government agencies encouraged mothers to remain in treatment. Educational and vocational training were included in clients' treatment plans to ensure clients' self-sufficiency and full functioning, which further encourages, strengthens, and reinforces the recovery of the populations served. Nearly 23 percent of women reported being enrolled in job training at discharge, and 65 percent had social supports in place for more than eight days in the first month after discharge.

WOMEN AND CHILDREN'S RESIDENTIAL TREATMENT SERVICES PROGRAM AND COVID-19 PUBLIC HEALTH EMERGENCY

WCRTS counties and providers were asked to describe any ongoing program modifications due to the COVID-19 PHE. Many counties reported continued low and delayed enrollment due in part to ongoing PHE practices. Programs noted that significant COVID-19 outbreaks still occurred, delaying enrollment and initiation of treatment with new clients, often risking a loss of motivation for treatment. However, quarantine times were reduced from a maximum of seven to three days, reducing wait times for treatment access. As the PHE concluded, all WCRTS programs adhered to the U.S. Center for Disease Control guidelines, regulations, and health and safety orders.

WCRTS programs endured ongoing challenges for workforce retention and recruitment. Programs reported staff deaths due to COVID-19, which exacerbated staff shortages.

Compassion fatigue, otherwise known as "burnout," was very apparent as it became necessary for less staff to cover more. Team-building activities like in-person holiday celebrations and other events were reestablished to improve workplace morale and unity. A Marin County provider described utilizing the Mentored Internship Program, a DHCS-funded Behavioral Health Workforce Development initiative, to increase the state's behavioral health workforce, particularly with SUD treatment providers, to be able to attract several interns, ultimately expanding the program's staffing. The training and use of peer support specialists also effectively filled staffing gaps.

A couple of treatment programs creatively used the period of reduced admissions to address facility remodeling for compliance with Americans with Disability Act regulations after noting the PHE requirements for social distancing increased accessibility significantly. One provider noted they "gained more robust mindfulness of the universal health precautions" such as personal protective equipment while delivering care and "are now equipped to accommodate for any future PHE" with policy and procedures developed and established. Many have noted that having the communication infrastructure and technology in place will allow telehealth practices to continue as a regular choice of service delivery.

WCRTS providers reported that clients received drug treatment services, case management, therapeutic services, and modified structured activities during quarantine periods. All WCRTS counties indicated that despite the barriers and challenges of the COVID-19 PHE, SUD perinatal services continued effectively and uninterrupted.

DATA LIMITATIONS

There are several limitations to the data presented in this report due to the following:

- Federal and state privacy laws regulate the data shared for public release and publication. Given the small number of participants, this report does not include the number of admissions or discharges by program or county due to privacy regulations and the potential risk of identification of program participants.
- Many CalOMS Tx discharges are submitted to DHCS as administrative discharges, which do not include the client functioning data necessary to measure treatment outcomes.
- When a client declines to provide an answer or is unable to answer a question during a standard discharge, the treatment outcome is unknown.

- CalOMS Tx does not collect information on the children accompanying their mothers to treatment. Therefore, outcomes are limited to the clients' experiences and to those clients who completed the discharge process at each program.
- The summarized information provided by counties through the survey, under WCRTS survey results, gives an overview of how the programs operate, per self-report. The information provided by the counties includes evidence-based programs utilized by the providers for groups and information on program operations to address meeting each of the HSC Section 11757.65 goals and objectives. Data limitations of this section include the following:
    - Limitations of self-reporting with no verification procedure in place.
    - Not all programs provided detailed information about meeting each HSC goal and objective.
    - The HSC goals and objectives overlap, causing repetitive responses from counties in the survey.
    - The survey may have been interpreted differently by each county.
    - Some county responses provided unnecessary information, leaving the interpretation of answers to the survey questions by the analyst.
- Because there is no control group, it is difficult to determine if the resulting outcomes are due to the WCRTS program model or if these outcomes are due to other factors.

CONCLUSION

The WCRTS program continues to serve the community in valuable and significant ways. The county and provider survey responses, and the CalOMS Tx data indicate the WCRTS program has a beneficial and life-changing impact on program participants and their families. DHCS will continue to monitor program goals and outcomes, as described in HSC Section 11757.65, for those counties participating in the WCRTS program. In addition, DHCS will work to improve data collection and reporting processes with the counties using the new survey collaboration process. These efforts remain a high priority for DHCS as the Department continually seeks to strengthen services for PPW with SUD.