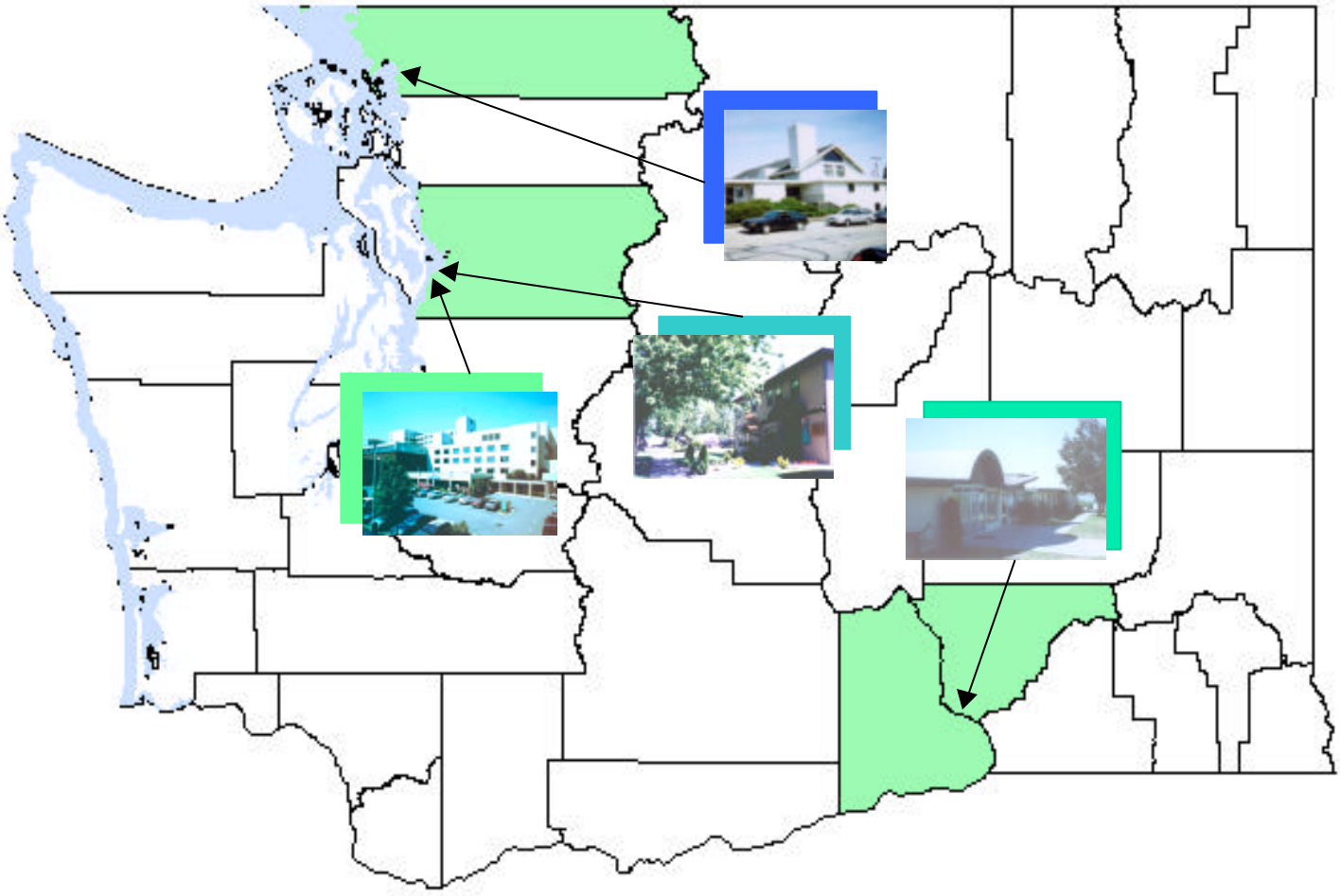
Comprehensive Program Evaluation Project

Program Development and Implementation



Washington State Department of Social and Health Services
Division of Alcohol and Substance Abuse
Medical Assistance Administration
Children's Administration
Research and Data Analysis

Washington State Department of Health

Comprehensive Program Evaluation Project: Program Development and Implementation

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When ordering, please refer to
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Program Development and Implementation

EXECUTIVE SUMMARY

The Comprehensive Program Evaluation Project (CPEP) is a pilot program intended to serve substance abusing women and their young children. The project is a collaborative effort between the Department of Social and Health Services (DSHS)—Division of Alcohol and Substance Abuse (DASA), Medical Assistance Administration (MAA), Research and Data Analysis (RDA), Children's Administration (CA)—and the Department of Health (DOH).

The comprehensive program seeks to improve the health and welfare of substance abusing mothers and their young children by early identification of pregnant substance abusers, improved access to and coordination of health care services and chemical dependency treatment, and family-focused early intervention services for mothers and their children.

This report emphasizes process evaluation and focuses on issues surrounding program development and implementation during the first service year, calendar year 2000. Preliminary data describing client characteristics, service utilization, and specific outcomes are included. The purpose of this evaluation is to describe practices that are demonstrated to be effective and challenges faced during program implementation.

KEY FINDINGS

- Three pilot sites—Benton-Franklin Counties, Snohomish County, and Whatcom County—served 194 substance abusing women and their children in the first program year, January through December 2000.

- More than half (57%) of these women were over age 25, 73% were Caucasian, and 68% were single. Thirty-eight percent of these women were pregnant at program entry. These women have a total of 443 children, in addition to their unborn children, for an average total of 2.65 children per woman. Thirty-one percent of these children were living with their mothers.

- All 194 women received Targeted Intensive Case Management (TICM) with an average of 11 hours of case management per client per month. Case management services include conducting intake interviews, developing service plans, and coordinating comprehensive services.

- Over 80% of these women received chemical dependency treatment services, including residential (inpatient) and outpatient services. Ninety-two (47%) women received residential chemical dependency treatment, with an average stay of 90 days.

- Over 30% of enrolled women received transitional housing services, including assistance with obtaining transitional or subsidized housing. Twenty-seven (14%) women occupied transitional housing units. All residential treatment beds and transitional housing units are at capacity, and vacancies are filled immediately as they arise.

- Nearly 80% of enrolled women reported using illicit drugs or a combination of drugs and alcohol before CPEP enrollment. Twenty percent were at risk of using drugs or alcohol.
- The majority of women reported conventional parenting attitudes and behavior and understood the dangers involved in drug use; however, less than half (41%) of CPEP clients reported that they were able to handle most of their problems. Based on the Parenting Stress Index (PSI), program participants had high levels of parenting stress because of their own distress and not because they have difficult children.
- The low birthweight rate for infants born to CPEP clients (9%) was intermediate between that for infants born to known substance abusers (14%) and that for infants born to other Medicaid women in 1999 (6%).
- Challenges for community service providers included building a multidisciplinary team, establishing and maintaining service provision and professional boundaries, and cross-training pilot site staff.

CRITICAL IMPLEMENTATION FACTORS

Communication among service providers has resulted in successful program implementation. The following key factors were identified:

- Preliminary planning, including discussion about the day-to-day activities, such as sharing information and conducting meetings, is required to serve this population.
- State and community providers must work together to share information, identify shared values, and build a team to meet the needs of this population.
- To communicate and reinforce the vision of this comprehensive program, State staff must provide leadership for community providers and staff. Similarly, community providers must provide on-going leadership to program-level staff.
- State staff must provide continuing support to programs by attending meetings, promptly answering questions, providing feedback about performance expectations, and helping to identify and meet training needs.
- Serving this population may require innovative ways to conduct business and providers must adapt their practices to the program model and the needs of this population.
- Having important resources, such as targeted intensive case management, residential treatment beds, and transitional housing units, in the same community allows women to stay in a familiar location and enhances the ability of service providers to communicate with each other.

CONCLUSION. The communication that takes place everyday between and among the service providers and State staff has been critical to the successful implementation of this program. This increased communication is a new and challenging way of conducting business—a way in which service providers truly work together to meet the comprehensive needs of this population.

INTRODUCTION

The Comprehensive Program Evaluation Project (CPEP) is a pilot program intended to serve substance abusing women and their young children. This project is a collaborative effort between the Department of Social and Health Services (DSHS)—Division of Alcohol and Substance Abuse (DASA), Medical Assistance Administration (MAA), Research and Data Analysis (RDA), Children's Administration (CA)—and the Department of Health (DOH).

The comprehensive program seeks to improve the health and welfare of substance abusing mothers and their children by early identification of pregnant substance abusers, improved access to and coordination of health care services and chemical dependency treatment, and family-focused early intervention services for mothers and their children. The design of program services was based on program goals outlined in the 1999 DSHS-DOH *Report to the Legislature, A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803)*.

This report emphasizes process evaluation and focuses on issues surrounding program development and program implementation during the first service year, calendar year 2000. The purpose of completing this evaluation is to describe practices that are demonstrated to be effective and to identify challenges faced during program implementation. Client characteristics, service utilization, and outcome data available to date will also be included.

An outcome evaluation report describing mother- and child-based outcomes will be available by December 31, 2003. The availability of follow-up data for program clients enrolled in year one will be fairly limited at this point and quite limited for those enrolled after year one. A minimum of three years follow-up data on program clients will be available in 2006.

Background

A proviso in the 99/01 DSHS budget funded pilot projects to develop and implement comprehensive programs for alcohol and drug abusing women and their young children. The program components described in the 1999 *Report to the Legislature: A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803)* were designed to serve Medicaid-eligible women who gave birth to drug- or alcohol-affected infants. This comprehensive program model was adopted as the foundation for the implementation of the pilot projects.

Selection of pilot sites was based on the proviso requirements that the pilot programs be implemented in several locations and that at least one site be located in a rural community. Available funds limited the number of potential sites to two or three. As program development became more refined, with consideration of budgetary impacts, three sites were sought: one urban site with all program components, one rural site with all components, and one rural site with no in-county residential chemical dependency treatment facilities (although program participants can access outpatient chemical dependency treatment services available in the

county). Availability of funds was announced to a wide audience, and a meeting was held with potential applicants.

Proposals were solicited from counties with at least 40 births per year to Medicaid women identified as substance abusers (through linked records from the Division of Alcohol and Substance Abuse and Medical Assistance Administration claims data, contained in the First Steps Database). Yakima and Spokane Counties were not included in the client services solicitation because these counties had already been designated for the Parent-Child Assistance Program (PCAP) expansion. Program staff from Medical Assistance Administration, Division of Alcohol and Substance Abuse, and Department of Health scored proposals according to pertinent criteria, and offers were made to the counties with the highest-scoring proposals.

Current Program

Pregnant and/or parenting women are offered a variety of services, including targeted intensive case management (TICM), chemical dependency (CD) treatment, transitional housing, behavioral health services, and parenting education. Service providers may include case managers, behavioral health specialists, social workers, chemical dependency treatment counselors, and child development specialists. These services are offered locally in three Washington communities: Benton-Franklin, Snohomish, and Whatcom counties.

CPEP Community Service Providers

Program Components	Pilot Program Sites		
	Benton-Franklin	**Snohomish**	**Whatcom**
Targeted Intensive Case Management (TICM)	Benton-Franklin Health District	Providence Everett Medical Center – CUPPWYC*	Providence Everett Medical Center – CUPPWYC*
Residential Chemical Dependency Treatment	Rivercrest Villa	Evergreen Manor	
Transitional Housing	Rivercrest Villa	Catholic Community Services – Tree of Life	

**Comprehensive Unified Program for Parenting Women and their Young Children*

Program Administration

CPEP is a partnership between state- and community-level agencies and organizations and requires effort at each level to successfully implement and administer this program. Members of the State Implementation Team include representatives from each of the collaborating agencies: DASA, MAA, RDA, CA, and DOH. The Community Implementation Teams may include representatives from the local chemical dependency treatment provider(s), TICM contractor, transitional housing coordinator, drug and alcohol county coordinator, Division of Children and Family Services (DCFS), and Community Services Office (CSO) outreach workers.

During the initial phase of program implementation, the State Implementation team identified the need to clearly define each team's roles and responsibilities. They are as follows:

1. CPEP Community Implementation Teams are responsible for coordinating and making decisions about day-to-day pilot site operations.

2. CPEP State Implementation Team is responsible for the following:

    a) Oversight of day-to-day operations of the local pilot projects. Some members of the State team attend and actively participate in all local implementation, coordination, and planning meetings and client staffings;

    b) Coordination between CPEP teams and task planning with action steps and team member responsibilities clearly stated; and

    c) Regular briefing and communication to up-line (State) managers about implementation issues and day-to-day operational decisions.

The Community Implementation Teams usually meet once per month to discuss local program issues and concerns, such as access (or lack thereof) to resources in their respective communities or the need for provider training. The State Implementation Team meets bimonthly to discuss both local- and state-level program issues and concerns, such as the provision of community provider training or the clarification of state policies.

Conceptual Model

The CPEP State Implementation team developed and refined a Client Flow Diagram that represents the conceptual model of the comprehensive program (see pages 6 – 7). The purpose of providing comprehensive services is to help support clients to become more functional family units: to be financially independent, safe, healthy, and drug-free. The goal of this pilot project is to evaluate the impact of comprehensive services on the lives of substance-abusing women and their young children.

This model was initially presented to each site as a way to communicate the State team's vision of the program. The model has been a focal point in discussions where important process decisions need to be made and continues to play an important role in guiding both the development and implementation of this program.

Several components are contained in the CPEP Client Flow Diagram, including:

- Referral sources and outreach efforts;
- Targeted Intensive Case Management (TICM);
- Residential chemical dependency treatment;
- Parenting education;
- Behavioral health services;
- Transitional housing; and
- Outpatient chemical dependency treatment.

Clients may be referred to the program by a number of sources. Medical professionals practicing in a pilot site community who suspect or identify substance abuse may refer women to CPEP. The Department of Health (DOH) is actively working with community medical providers to encourage the use of screening guidelines to identify substance-abusing patients (Taylor, 1999). Professionals working in the legal system, including jail staff, probation officers, and drug court personnel may also refer clients to CPEP. DSHS staff, such as Child Protective Services (CPS) workers and CSO staff (including Temporary Assistance to Needy Families [TANF] case managers) may refer chemically dependent women or those at risk of substance abuse to CPEP. Referrals may also come from chemical dependency treatment staff who believe that their clients meet eligibility requirements and would benefit from participation in a comprehensive program.

Once the client has been referred to and deemed eligible[1] for CPEP, TICM staff are responsible for active outreach to engage the client into program services. Active outreach efforts go beyond attempting to contact the client through the mail or even by phone. Case managers routinely make repeated contact and home visits as appropriate. When the client agrees to accept program services, case managers: 1) conduct an intake interview including assessing the severity of a client's addiction; 2) develop and facilitate a service plan for the client; and 3) coordinate core provider services.

Case managers use information obtained during the intake process to develop a service or care plan for each client. Care plans identify the core services needed by the client, including chemical dependency treatment, behavioral health services, such as individual or group counseling, and parenting education. The need for child development services may also be indicated in the care plan. Case managers often provide access to these core services, but they may also provide other services, such as family planning counseling, household management skills training, and transportation to and from community agencies as appropriate.

Chemical dependency treatment, a CPEP core service, may include residential and/or outpatient treatment. Once residential chemical dependency treatment is completed, some clients may enter transitional housing and continue to maintain their sobriety through relapse prevention activities, such as outpatient chemical dependency treatment, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other recovery support meetings.

Behavioral health services are another core service for clients in this program. Behavioral health specialists conduct a needs assessment to determine whether or not each client has behavioral or

[1] All clients enrolled in CPEP must meet certain eligibility requirements. The eligibility requirements for this program are as follows:

1) Client receives an income that is at or below 200% of the Federal Poverty Level (FPL);
2) Client has a history of substance abuse, current substance use, and/or be at risk of use;
3) Client is currently pregnant or has one or more children under age 3;
4) Client has current and/or past involvement in multiple intervention systems; and
5) Client agrees to participate in all recommended components of the program which may include Targeted Intensive Case Management (TICM), Residential Chemical Dependency Treatment Services, Transitional Housing, and/or Outpatient Chemical Dependency Treatment Services.

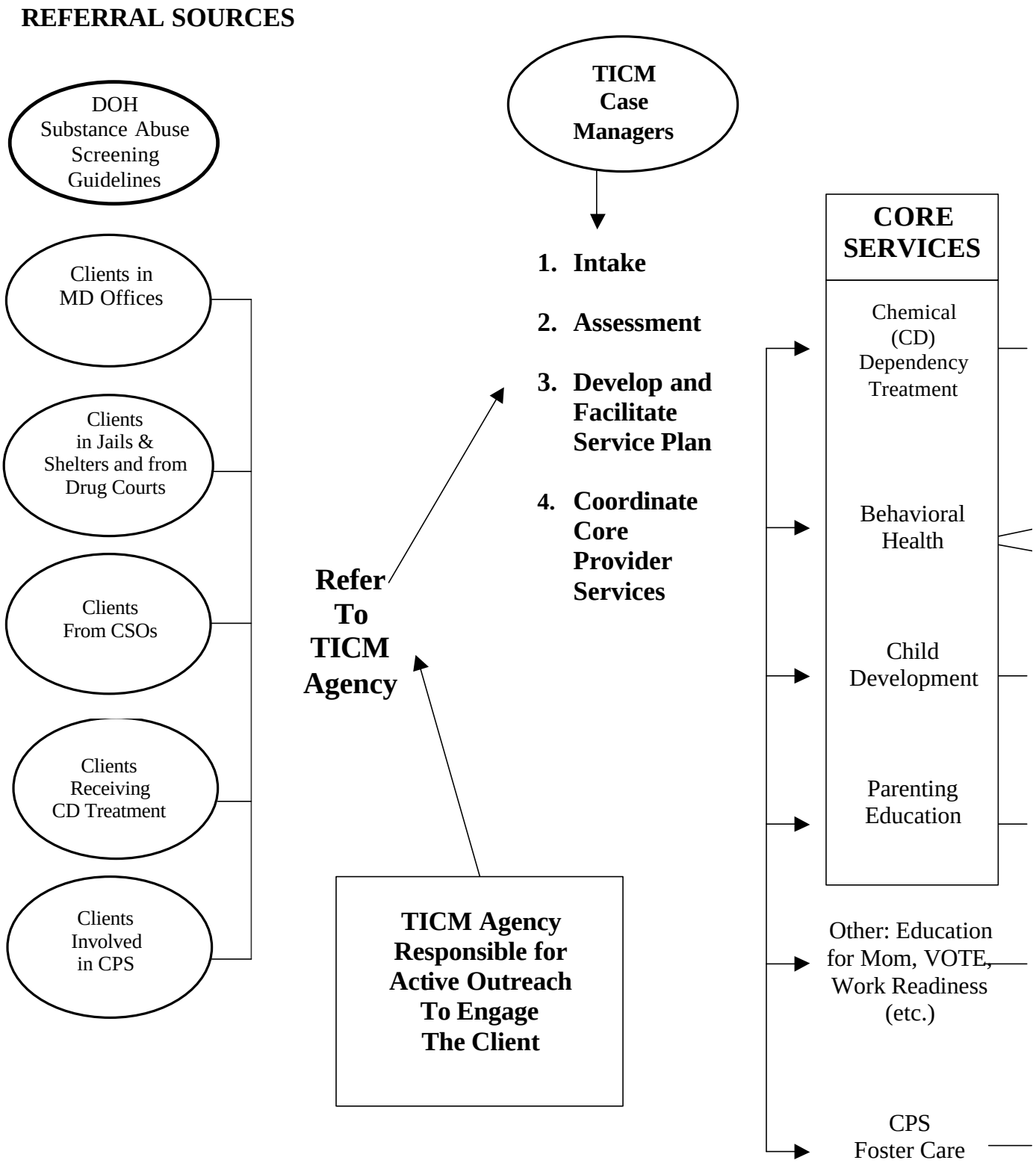
Clients who do not meet the above requirements are referred to like services in their respective communities.

other mental health issues. Depending upon the client's need, behavioral health services may be provided by the behavioral health specialist or the client may be referred to community mental health services. The Behavioral Health Specialist may offer classes focusing on anger management and self-esteem as well as offering individual and family therapy to clients as appropriate.

Child development services are routinely provided both within the residential CD treatment facilities and also by TICM staff. These services include routine developmental assessments and referral for further assessment and services if developmental delay is suspected or identified. The child development specialist typically assesses a client's parenting skills as well and may offer or refer to parenting education classes as appropriate. The child development specialist may also meet with clients individually to address specific parenting issues.

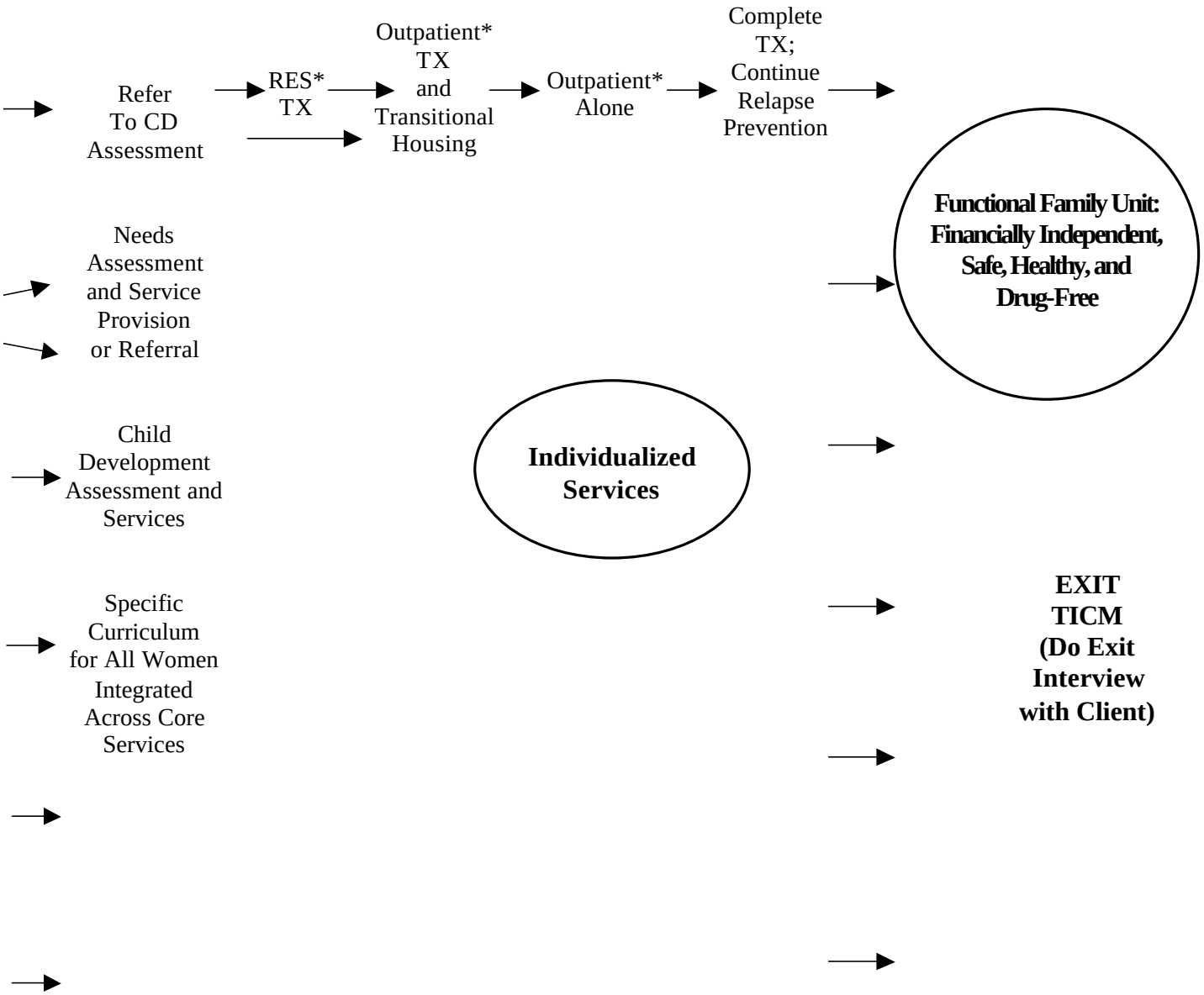
Case managers often provide other services, such as helping clients complete education, training, or employment applications and accessing resources, such as financial aid and childcare. In addition, case managers may help clients with open CPS cases by acting as a liaison between the client and a CPS worker or by supervising a client's visit with her children living in foster care. Other individualized services, such as facilitating access to affordable dental care, supplying car seats for young children, or purchasing books on parenting and recovery may also be provided based upon client need(s).

CONCEPTUAL



*Note: Paths of individual clients may vary from this model

MODEL


Refer To CD Assessment
RES* TX
Outpatient* TX and Transitional Housing
Outpatient* Alone
Complete TX; Continue Relapse Prevention
Needs Assessment and Service Provision or Referral
Child Development Assessment and Services
Specific Curriculum for All Women Integrated Across Core Services
Individualized Services
Functional Family Unit: Financially Independent, Safe, Healthy, and Drug-Free
EXIT TICM (Do Exit Interview with Client)

METHODS

The primary sources of information for this report were quantitative data collection instruments, observation/participant observation, program documents, and informal interviews.

Data Sources

Quantitative Data Collection Instruments

Primary data collection includes several instruments submitted for each client, such as an intake form, a form to determine risk of substance use, and a client evaluation form focusing on client skills and client needs. In addition, three standardized instruments are administered: the Addiction Severity Index (ASI) modified for use with pregnant women, the Parenting Stress Index (PSI), and the Denver Developmental Screening Test (Denver II). Data from these sources are included in the CPEP database. Preliminary data from this database will be reported here.

Prior to this report, community service providers were asked to evaluate the program by completing a brief questionnaire containing a combination of five statements and questions. The results of this preliminary program evaluation are described in the November 2000 *Comprehensive Program Evaluation Project: Program Evaluation Preliminary Report.*

Observation/Participant Observation

Evaluation staff had many opportunities (at client staffings and community meetings) to observe community service providers interpreting and implementing the State team's vision of the program. The importance of the program to service providers was evident from their enthusiastic reports at the legislative update meeting on August 23, 2000. Evaluation staff also participated in community provider meetings, observing the positive interaction among the service providers.

Program Documents

Several documents were reviewed, including service provider contracts; program pamphlets designed by community providers; community meeting minutes; and other forms of written communication, such as informal notes and electronic mail messages.

Informal Interviews

Evaluation staff had numerous conversations with various service providers, including TICM staff, chemical dependency (CD) treatment providers, transitional housing providers, and other community service providers.

Variables

This section describes the variables obtained from project data collection forms and used in the tables presented in this report.

Demographic Characteristics

Client characteristics were obtained from the CPEP Client Intake Form and Parenting Stress Index (PSI). The Client Intake Form, a brief questionnaire about the client and her children, was completed by case managers at enrollment.

The PSI, a 36-item questionnaire about parenting stress, is administered for the first time at program enrollment (or shortly thereafter) provided that the client has recent parenting experience. If the client does not have recent parenting experience (because she may be pregnant with her first child or her children have always been in foster care), the PSI will be administered as soon as the client gains some parenting experience. This may occur after the birth of her child or after the client has been reunited with her children. The PSI is administered for the second time six months later. Providers issued the Short Form of the Parenting Stress Index which uses identical questions as the PSI full-length test, but can be administered in less than 10 minutes while still providing reliable data.

Characteristics of Mothers

Age: Mother's age was computed from the enrollment date and either the mother's date of birth (as reported on the PSI) or the Personal Identifier Code (PIC) as recorded on the Client Intake Form.

Race/Ethnicity: Maternal race was determined by self-report as recorded on the PSI.

Marital Status: Mother's marital status was determined by self-report as recorded on the PSI.

TANF Status: Mother's TANF status was determined by self-report as recorded on the Client Intake Form.

Pregnancy Status: Mother's pregnancy status was determined by self-report as recorded on the Client Intake Form.

Referral Source: Referral source was determined by self-report as recorded on the Client Intake Form.

Characteristics of Children

Age of Index[2] Children: An index child's age was computed from the child's date of birth as reported on the Client Intake Form and the enrollment date.

Residence of Index Children: Residence of the index child (or children in the case of twins) was determined by self-report as recorded on the Client Intake Form.

Ages of Other Children: Ages of the other (non-index) children were computed from the birth dates for other children as reported on the Client Intake Form and the enrollment date.

Residence of Other Children: Residence of the other children was determined by self-report as recorded on the Client Intake Form.

Behavioral Risk Factors

The Substance Use Risk, Parenting Stress Index (PSI) and Client Self-Evaluation forms were the sources for these measures. The Substance Use Risk form is a screening tool for determining whether or not a client: 1) is or has a history of using alcohol or other drugs; or 2) is at risk of using alcohol or other drugs. Case managers complete this form at program enrollment. The Client Self-Evaluation form is a 25-item inventory of statements used to reflect a client's skills and needs. The client completes this form shortly after program enrollment (provided that client has some parenting experience) or shortly after gaining such experience. The PSI is administered twice–once when it is determined the client has recent parenting experience, and once more six months later.

Substance Abuse History or Risk: Substance abuse history or risk (of substance abuse) was determined by self-report as recorded on the Substance Use Risk form.

Client Skills/Needs: Client skills/needs were determined by self-report as recorded on the Client Self-Evaluation form.

Parenting Stress Level: The level of parenting stress is measured by examining three sources of stress that affect the parent-child systems: 1) child characteristics, 2) parent characteristics, and 3) situational/demographic life stress. A client's stress level was calculated based upon a number of responses to parent-child questions as recorded on the PSI.

Service Use

The Targeted Intensive Case Management (TICM) Monthly Services Report was the source for the following measures. TICM staff record the type of services received, and indicate whether case managers provided the services. These data are then reported to evaluation staff each month.

[2] The index child is the youngest child (unborn or up to age 3), who serves as the basis for program eligibility.

Chemical Dependency Treatment: Crisis intervention, diagnosis and evaluation, inpatient and outpatient treatment, and sobriety maintenance counseling.

Behavioral Health: Assessment and evaluation; individual, group and family counseling; anger-management and self-esteem classes. These services may be provided by the Behavioral Health Specialist or other professionals.

Child Development: Activities designed to assess and maximize a child's physical, emotional, and functional development, including screening for possible developmental delays and planning age-appropriate activities for children in therapeutic child care.

Parenting Education: Parenting education classes or other parenting services.

Transitional Housing: Assisting clients with application for transitional, subsidized, or other safe, stable, and sober housing, and with receipt of such housing.

Transportation: Assessment, busing or van services and eligibility for DSHS Medical Assistance Transportation services.

Family Planning: Contraceptive methods awareness and education, including abstinence education.

Work: Assistance with employment-related tasks, such as completion of job applications or resumes.

Childcare: Subsidized childcare through provider, state, county, or private sources.

CPS (Child Protective Services): Assessment and intervention related to reports of child abuse and neglect, domestic violence investigation and intervention, child/foster placement, family reconciliation services, and adoption.

WIC (Women Infant and Children): Nutritious food assistance program, including food vouchers, nutrition assessment, breastfeeding promotion, nutrition education, and referrals.

VOTE (Vocational and Occupational Training and Education): Vocational and health evaluation, transportation and assistance in preparing for, locating, and maintaining employment.

Basic Needs: Services that meet clients' food, clothing, and shelter needs.

Dental Care Services: Emergency, preventive, and restorative dental care.

Domestic Violence Services: Physical, emotional and sexual abuse prevention and therapy services provided by state-contracted local providers.

Medical Care: Maternity services, care of acute and chronic medical problems, and preventive health services.

Mental Health Care: Assessment, individually tailored treatment planning, support, and monitoring by a community mental health agency when intensive intervention is required.

Vision Care: Eye examination and prescription.

Probation Services: Individual rehabilitation and monitoring for women with a history of involvement in the criminal justice system.

Education: School completion, equivalency tests and related issues.

Vocational Training: Job training and assistance (other than in the VOTE program).

Legal: Court appointments, legal counseling and advice.

Other: Receipt of other services (not listed above).

Case Management Time: Number of hours spent on case management activities, including providing services or access to services listed above.

The sources for additional service use measures were the Residential Treatment Provider and Transitional Housing Provider forms submitted each month.

Length of Stay in Residential Treatment: duration of inpatient chemical dependency treatment from the date of admission through the date of discharge from the CD treatment facility.

Length of Stay in Transitional Housing: duration of residence in a transitional housing unit from the date of admission through the date of discharge as reported by the transitional housing provider.

Child Outcomes

The Newborn Health Status forms were used as the source for these measures. Medical professionals are asked to complete Newborn Health Status forms for all index children up to age 12 months. If a medical professional returns a blank form, a member of the TICM staff attempts to locate the requested information in hospital records.

Birthweight: The weight of the newborn child is recorded on the Newborn Health Status form. Birthweight is a primary indicator of the health of the newborn infant. Newborn infants weighing 5.5 pounds (2500 grams) or greater are considered to be normal birthweight while infants weighing less than 5.5 pounds at birth are considered Low Birth Weight (LBW). Infants with a birthweight less than 2500 grams and more than 1500

grams are considered Medium Low Birth Weight (MLBW); infants weighing less than 3.3 pounds (1500 grams) are considered Very Low Birthweight (VLBW).

Apgar Score: The Apgar score rates the overall health of an infant. The Apgar score uses a scale of 1 to 10, with 10 indicating optimum health status. The Apgar score determined at 5 minutes after delivery was used for this analysis. In a previous study examining the relationship between biologic risk factors and environmental variables, Apgar scores less than 8 were associated with significantly poorer cognitive performance (Breitmayer and Ramey, 1986).

Gestational Age: Gestational age was estimated by the physician. The gestational age of a newborn infant is a measure of maturity of the newborn at delivery. The expected duration of pregnancy is 40 weeks, and infants who are more than 37 weeks of gestation age are considered full-term. Infants born at 37 weeks or earlier are considered premature. Premature delivery is one of the two main causes for low birthweight.

Pregnancy Complications: Selected complications of pregnancy are included on the Newborn Health Status form.

- Abruptio Placentae
- Placenta Previa
- Multiple births
- Preclampsia/Eclampsia
- No prenatal care
- Other complications

Denver Developmental Assessment

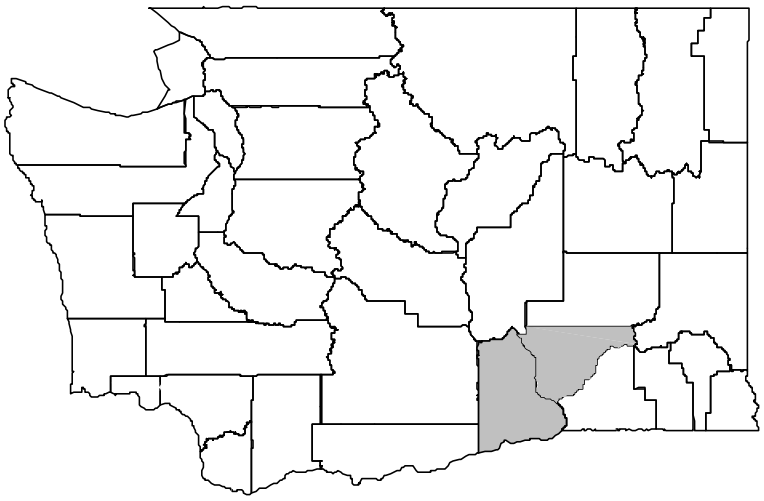
The Denver Developmental Screening Test (Denver II) is a standardized instrument used to assess whether or not a young child may have a developmental delay. The test administrator observes both the child's behavior and the child's performance on a number of specific tasks, such as smiling spontaneously by age 2 months or the ability to play pat-a-cake by 12 months, respectively. Most observations are recorded using a "P" for successfully completing the behavior or task or a "F" for failing to complete the desired behavior or task. The test administrator then evaluates the child's overall performance using one of three categories: 1) Normal (passing most or all age-appropriate activities indicating no delay); 2) Suspect (failing to engage in age-appropriate behaviors or perform age-appropriate tasks indicating possible delay); or 3) Untestable (refusing to engage in age-appropriate behavior or perform age-appropriate tasks).

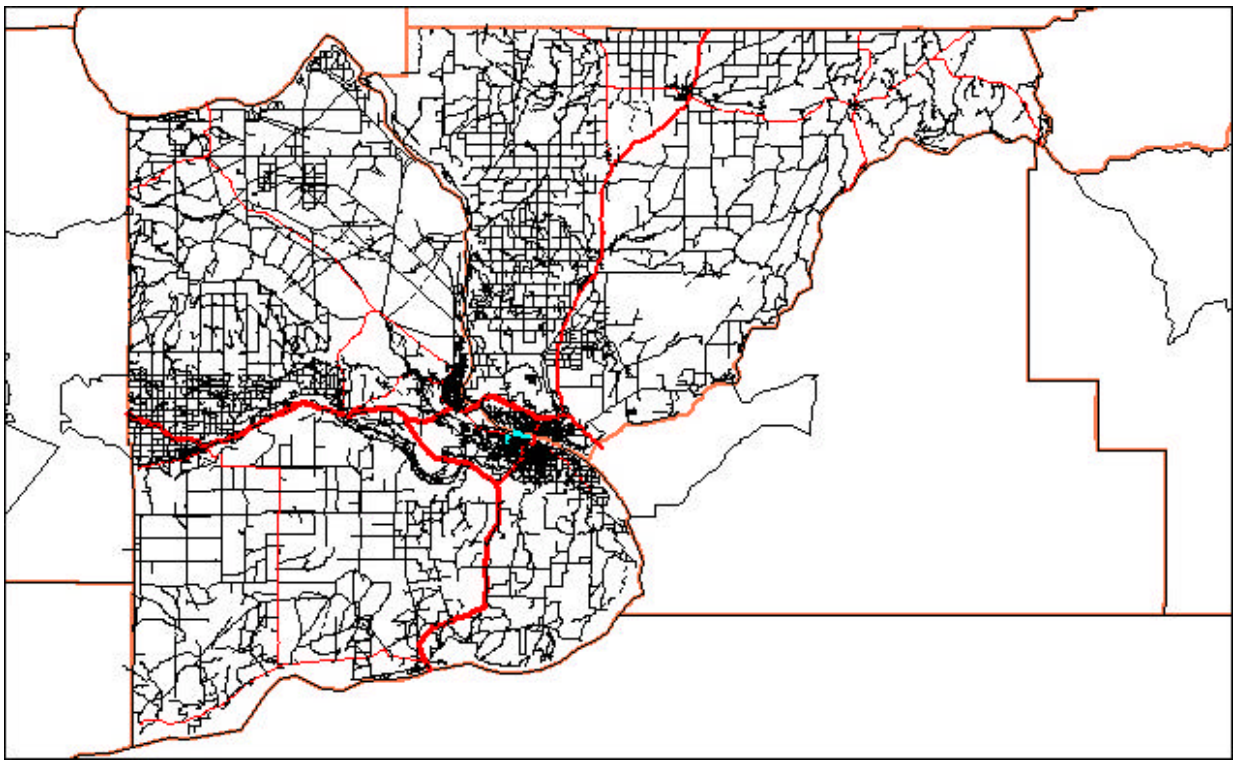
PILOT SITE DESCRIPTIONS

Benton-Franklin Counties

Targeted Intensive Case Management Agency
Benton-Franklin Health District

Residential Chemical Dependency Treatment Center and Transitional Housing
Rivercrest Villa





Benton and Franklin Counties

The Benton-Franklin Health District provides services to both counties. Benton County is in the south-central region of Washington and is bordered on three sides by the Columbia River and by Oregon on the south. Benton County is over 17,000 square miles, a large portion of which is the U.S. Department of Energy, Hanford Site. The total population is 138,900 (1999 estimate). Almost two-thirds of the county residents live in Kennewick (50,950) or Richland (36,880). Manufacturing, professional services, and government are the largest industries.

Franklin County encompasses 1,242 square miles and is bordered by the Columbia and Snake Rivers in southeastern Washington. Over half of the county's 45,100 (1999 estimate) population is concentrated in Pasco (26,600), one of the Tri-Cities. Between 1994 and 1998 Franklin County had the highest birth rate in Washington, the fourth highest rate of births with Medicaid-paid maternity care, and the highest percent of Medicaid women who had late or no prenatal care.

Profile	**Benton *(rank)*** [*]	**Franklin *(rank)*** [*]	
Population 1999	138,900 *(10)*	45,100 *(21)*	
Population Using DSHS Services 1998	20.8% *(29)*	51.8% *(1)*	
Income Per Capita 1999	$22,807 *(7)*	$17,311 *(36)*	
Unemployment Rate 1999	5.6% *(25)*	9.4% *(6)*	
High School Dropout Rate 1993 – 97	4.39% *(33)*	13.5% *(1)*	
Child Abuse (accepted CPS referrals) 1993 – 97	47.9 per 1,000 *(16)*	53.2 per 1,000 *(11)*	
Domestic Violence (adult arrests) 1993 – 97	5.91 per 1,000 *(27)*	7.55 per 1,000 (15)	
Birth Data 1994-98 Average	**Benton**	**Franklin**	**Washington**
Number of Births (annual)	2,005	1,026	78,130
Births with Medicaid-Paid Maternity Care (%)	44%	72%	42.0%
Married (% of Medicaid)	48.6%	50.1%	47.2%
Married (% of non-Medicaid)	91.1%	89.4%	91.6%
Late or No Prenatal Care (% of Medicaid)	7.6%	9.9%	5.1%
Late or No Prenatal Care (% of non–Medicaid)	2.2%	2.9%	1.6%
Low Birthweight (% of Medicaid, singleton liveborn)	5.2%	5.0%	5.5%
Low Birthweight (% of non-Medicaid singleton liveborn)	3.6%	4.8%	3.6%
Alcohol and Drug Abuse Rate for Adults at or Below 200% Poverty Level (1999)	**Benton**	**Franklin**	**Washington**
Current Need for Substance Abuse Treatment	10.7	7.6	11.2
Lifetime Alcohol or Other Drug Use Disorder	15.4	10.4	15.5
Past 18–Month Alcohol or Drug Use Disorder	7.6	5.7	8

[*] Rank of 39 Washington Counties, 1997

Benton-Franklin Pilot Site

Targeted Intensive Case Management (TICM) services are offered through the Benton-Franklin Health District. A TICM office was initially set up within the residential chemical dependency facility (Rivercrest Villa) in March 2000, but operational challenges developed as both these components were trying to establish their respective roles within the program. In September 2000, the TICM staff returned to two different Benton-Franklin Health District offices with the goal of securing independent office space. In November 2000, new office space was obtained, and all case managers are now in the same location.

Eight TICM staff members perform a variety of tasks and work together with a supervisor and an administrator who manage the CPEP program. The eight employees serve as case managers with a current average caseload of 15 clients. A number of these employees also have specific specialty areas, including family planning, behavioral health, and child development (although duties within these specialty areas may be shared among the case management staff as appropriate). Eventually, the case managers with special training in behavioral health and child development will reduce the size of their caseloads so they can focus more on doing work within their specialty areas.

Residential Chemical Dependency (CD) Treatment and Transitional Housing are offered through Rivercrest Villa. This residential CD treatment facility did not exist prior to the establishment of this program. Formerly, women in need of these services were sent out of county to obtain them. The CPEP contractor converted an abandoned nursing home into a facility offering chemical dependency treatment. Sixteen beds have been allocated to serve women in this program with 22 beds for their children. The contractor also purchased two houses to serve as transitional housing facilities with a total of 14 beds.

CD treatment staff includes 22 employees in various positions. Those positions include an administrator, an intake clerk, a clinical supervisor, two Chemical Dependency Professionals (CDPs), two nurses, six employees providing childcare, eight residential technicians, and one driver. Rivercrest Villa staff work to provide a number of services to clients, including individual and group therapy sessions; educational classes; therapeutic child care; healthcare monitoring and review; assistance with shopping; and transportation to court, state agencies (such as the DSHS or WIC) and other appointments.

Other community resources involved in program implementation include the Benton-Franklin Human Services Agency offering outpatient treatment, the drug and alcohol assessment center, and the DSHS Community Services Office which houses DCFS staff.

Challenges

Two major challenges arose for this site. The first program development challenge was converting an abandoned nursing home into a licensed chemical dependency facility. Several permits were required, inspections had to be conducted, and some nearby residents did not welcome a chemical dependency facility in their neighborhood.

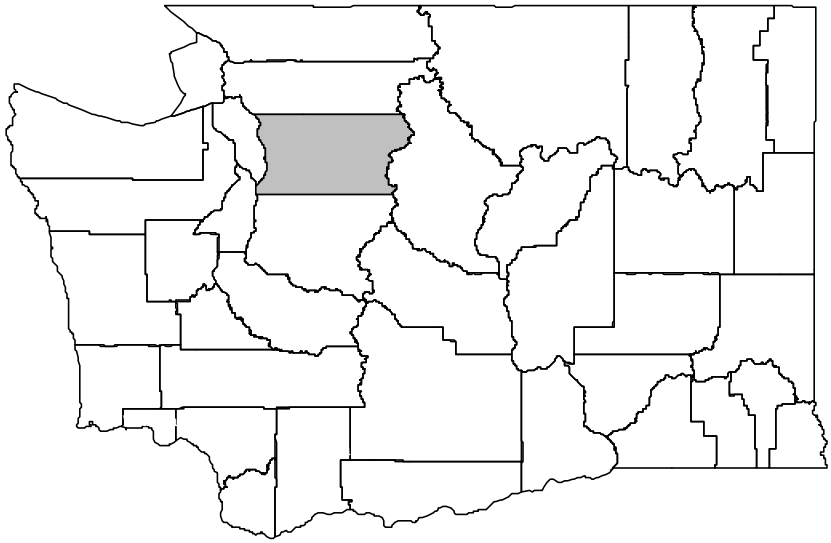
The second major challenge for this site was the difficulty for TICM staff to access program funds for miscellaneous client needs, such as recovery books and child car seats. Contract funding practices at the TICM agency did not allow for immediate access to these funds, so a separate contract was negotiated with the Benton-Franklin Human Services Agency to dispense these program funds.

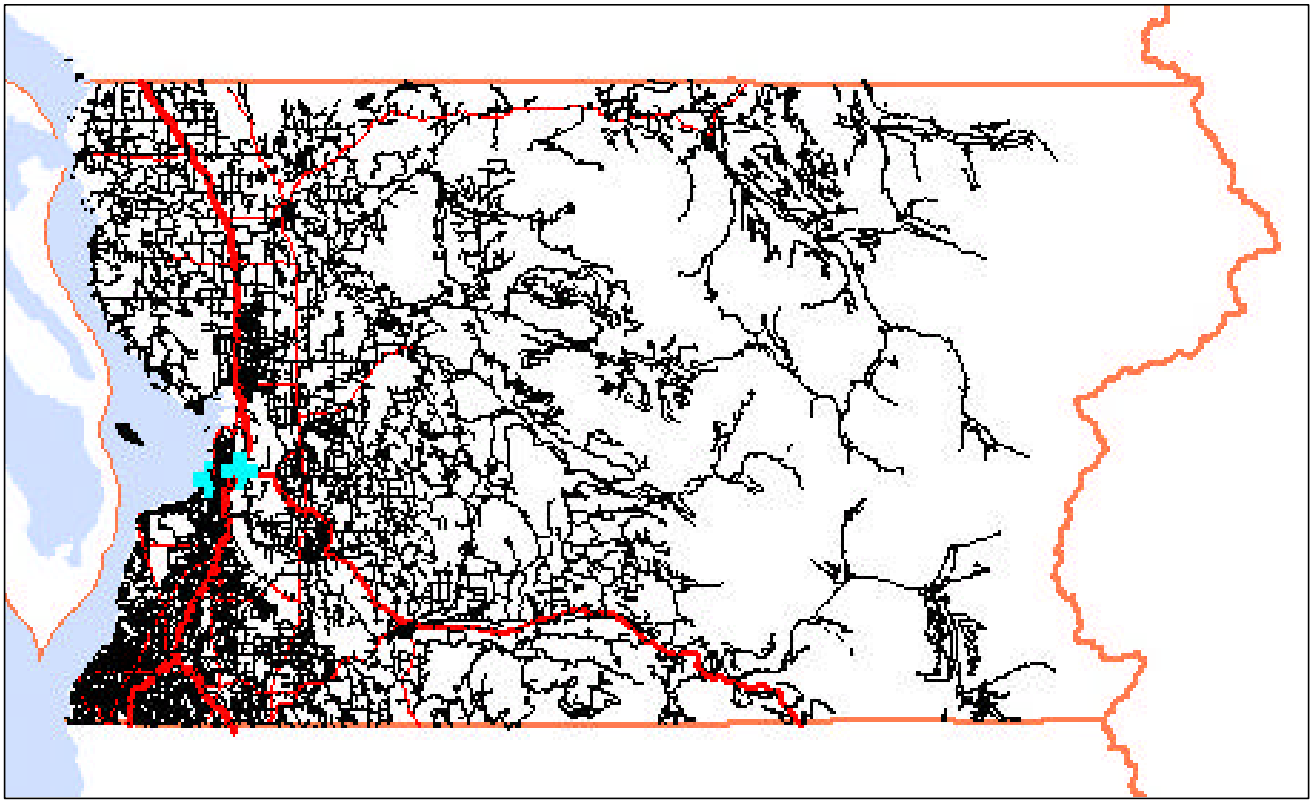
Snohomish County

Targeted Intensive Case Management Agency
Providence Everett Medical Center

Residential and Outpatient Chemical Dependency Treatment Center
Evergreen Manor

Transitional Housing and Outpatient CD Treatment
Catholic Community Services
Tree of Life





Snohomish County

Snohomish County, located in western Washington, covers an area of over 2000 square miles. Snohomish is the third most populous county in the state, with a population of 583,300 (1999 estimate). Most residents live in urban areas within fifteen miles of Puget Sound, but the bulk of the county is a rural area containing mountains, national forest, and wilderness. The largest cities are Everett (86,730), Lynnwood (33,140) and Edmonds (38,610). Manufacturing is the largest industry due to the Boeing manufacturing facility. Rural Snohomish County has a timber- and salmon-dependent economy.

Profile	**Snohomish**	**Rank out of 39 Counties**
Population 1999	583,300	3
Population Using DSHS Services 1998	17%	36
Income Per Capita 1999	$24,438	4
Unemployment Rate 1999	3.9%	32
High School Dropout Rate 1993 – 1997	5.72%	25
Child Abuse (accepted CPS referrals) 1993 – 97	38.08 per 1,000	27
Domestic Violence (adult arrests) 1993 – 97	7.69 per 1,000	14
Birth Data 1994-98 Average	**Snohomish**	**Washington**
Number of Births (annual)	7,962	78,130
Births with Medicaid-Paid Maternity Care (%)	32.0%	42.0%
Married (% of Medicaid)	46.2%	47.2%
Married (% of non-Medicaid)	92.1%	91.6%
Late or No Prenatal Care (% of Medicaid)	4.1%	5.1%
Late or No Prenatal Care (% of non-Medicaid)	1.3%	1.6%
Low Birthweight (% of Medicaid, singleton liveborn)	5.4%	5.5%
Low Birthweight (% of non-Medicaid singleton liveborn)	3.4%	3.6%
Alcohol and Drug Abuse for Adults at or Below 200% Poverty Level (1999)	**Snohomish**	**Washington**
Current Need for Substance Abuse Treatment	11.5	11.2
Lifetime Alcohol or Other Drug Use Disorder	16.1	15.5
Past 18-Month Alcohol or Drug Use Disorder	8	8

Snohomish County Pilot Site

Targeted Intensive Case Management (TICM) services are offered through the Children's Center at Providence Everett Medical Center (PEMC). PEMC remodeled two large rooms on one of their Everett campuses—one room to house the TICM staff and the second for conferences, staffings, and other meetings.

TICM staff includes nine employees in various positions as well as a manager to oversee the operation of the program. Six of these employees serve as case managers, with a current average caseload of 14 clients. One case manager has more supervisory responsibilities and carries a smaller caseload. Two members of the TICM staff work in specific areas (behavioral health and child development) and sometimes perform case management tasks for clients. One TICM staff member is responsible for administrative work. In addition, the PEMC medical director specializing in addiction medicine provides clinical supervision during the staffings.

Residential and Outpatient Chemical Dependency (CD) Treatment is offered through Evergreen Manor. This residential chemical dependency treatment facility was established in the community prior to this project and has experience providing CD treatment services to pregnant and parenting women. Sixteen beds have been allocated to serve women in this program, with up to 18 beds for their children.

CD treatment staff consists of 20 employees in various positions, including an executive director, a clinical director, a manager of residential and daycare services, six counselors, a chaplain, three daycare workers, six resident monitors, and one nurse. Evergreen Manor staff work to provide a number of services to clients, including assessments and treatment planning, individual and group counseling, therapeutic child care, parenting plans development, and group activities (such as lectures for clients and their families).

Transitional Housing and Outpatient CD Treatment are offered through Catholic Community Services Tree of Life program. Twelve units are available in two separate apartment complexes located in the Everett area. Through the Tree of Life program, transitional housing residents receive outpatient chemical dependency treatment services. Computers and a childcare facility are also available to residents.

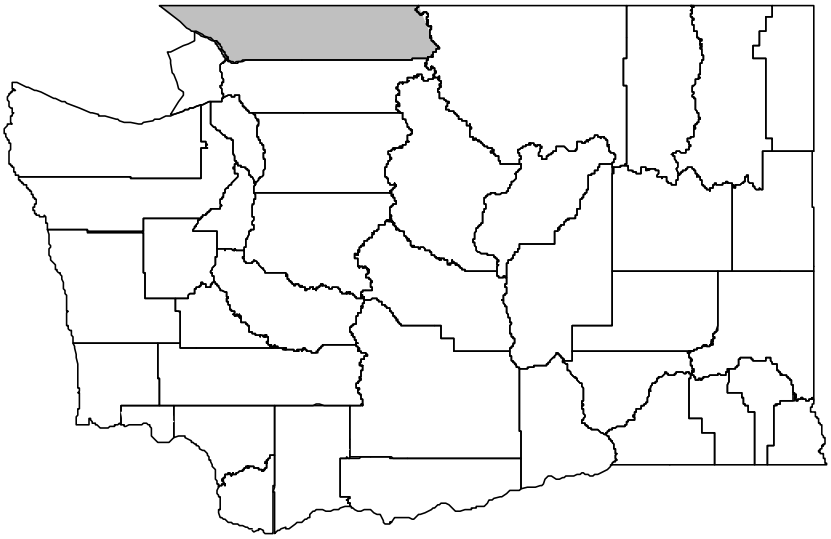
Other community resources involved in program implementation include Secure Beginnings (a program that serves chemically dependent women with diagnosed mental illness), a CPS liaison, county drug and alcohol outreach workers, and Everett CSO staff.

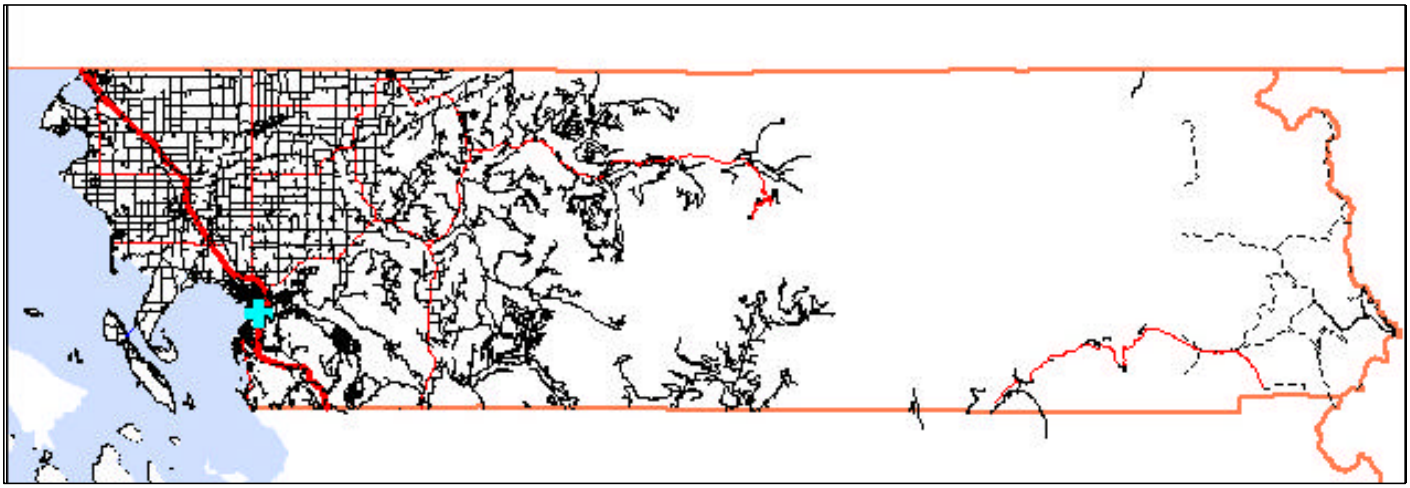
Challenges

The major challenge for this site was adequate program administration and leadership. The administrator who wrote the original application to provide TICM services, and who provided the necessary leadership to implement contract expectations, resigned in April 2000. That position remained vacant for six months and was not filled until October 2000.

Whatcom County

Targeted Intensive Case Management Agency
Providence Everett Medical Center





Whatcom County

Whatcom County, in the northwestern corner of the state at the Canadian border, contains over 2,100 square miles. Most of the county is composed of wilderness, and the population is 161,300 (1999 estimate). Bellingham (57,830), the home of Western Washington University, and Lynden (7,315) are the largest cities. Eastern Whatcom County is a rural area with a timber- and salmon-dependent economy. Services and manufacturing are the largest industries.

Profile	**Whatcom**	**Rank out of 39 Counties, 1997**
Population 1999	161,300	9
Population Using DSHS Services 1998	20.3%	30
Income Per Capita 1999	$21,438	16
Unemployment Rate 1999	5.2%	26
High School Dropout Rate 1993 – 97	5.0%	30
Child Abuse (accepted CPS referrals) 1993 – 97	28.41 per 1,000	34
Domestic Violence (adult arrests) 1993 – 97	7.17 per 1,000	18
Birth Data 1994-98 Average	**Whatcom**	**Washington**
Number of Births (annual)	1,929	78,130
Medicaid-Paid Maternity Care (%)	43.0%	42.0%
Married (% of Medicaid)	51.4%	47.2%
Married (% of non-Medicaid)	94.1%	91.6%
Late or No Prenatal Care (% of Medicaid)	5.8%	5.1%
Late or No Prenatal Care (% of non-Medicaid)	1.1%	1.6%
Low Birthweight (% of Medicaid, singleton liveborn)	4.8%	5.5%
Low Birthweight (% of non-Medicaid singleton liveborn)	2.5%	3.6%
Alcohol and Drug Abuse for Adults at or Below 200% Poverty Level (1999)	**Whatcom**	**Washington**
Current Need for Substance Abuse Treatment	14.1	11.2
Lifetime Alcohol or Other Drug Use Disorder	18.9	15.5
Past 18-Month Alcohol or Drug Use Disorder	10.4	8

Whatcom County Pilot Site

This site offers Targeted Intensive Case Management (TICM) and outpatient CD treatment services only. TICM services are contracted through the Children's Center at Providence Everett Medical Center (PEMC); however, this site operates independently of the Snohomish County site. The TICM office is located in the Brigid Collins House, a new building that houses programs designed to serve women and children. Outpatient CD services are offered by local CD treatment providers.

TICM staff includes six employees in various positions and a manager in Snohomish County who oversees operation of the site. Three of these employees serve as case managers with a current average caseload of 14 clients. The Behavioral Health specialist also carries a few cases and supervises the TICM staff. One TICM employee serves as the Child Development Specialist, and one TICM staff member is responsible for administrative work. The agency has also hired a local psychologist to provide clinical supervision during staffings.

No residential chemical dependency treatment facility or transitional housing provider is located in this county to serve these clients as part of this program. Whatcom clients in need of residential CD treatment may be referred to Evergreen Manor or Rivercrest Villa as appropriate, but space may not be available. If space is not available at one of these CD facilities, clients may enter another facility elsewhere in the state or may receive outpatient treatment when appropriate.

Other community resources involved in program implementation include Chronic Abuse/Neglect Task Force, CPS, and staff at the Bellingham CSO.

Challenges

Two major challenges arose for this site. The first was the need to send clients out of county for residential chemical dependency treatment in a CPEP-contracted facility. TICM staff attempt to maintain long-distance relationships with out-of-county clients, but are unable to see them as frequently as those clients remaining in Whatcom.

The second challenge was the lack of transitional housing facilities for clients residing in Whatcom. Service providers report that housing is a very important need for clients in this program, and negotiations for transitional housing in the county are currently underway.

Common Activities Across All Sites

Group activities, such as meetings and training sessions are common to all sites. Two key meetings take place between components of the program and other community providers:

- Staffings to discuss the progress of clients in the program; and
- Community meetings to discuss program issues and concerns.

Additional meetings take place within specific components of the program (such as a meeting that would include all members of the TICM staff). Program staff also attend training sessions as needed. (See list below.)

Staffings may be led by the TICM Supervisor or other TICM staff. Attendees may include TICM staff (case managers, Behavioral Health Specialists, Child Development Specialists, and sometimes a program manager or administrator), CD staff, Transitional Housing staff, and a CPS liaison. Other community providers may also be in attendance, including Pediatric Interim Care (PIC) program staff (Snohomish County), Medical Consultant (Snohomish County), and sometimes the CSO Outreach Worker (Snohomish). Members of the State team who oversee the TICM, CD, and evaluation components of the program may also attend these staffings and other meetings as appropriate.

Clients may be discussed in the following order:

- Pending clients who have been referred to the program but have not yet agreed to participate;
- Existing clients who are not yet participating in the research (most are 17 years of age); and
- Existing clients who are participating in the research (the majority of clients).

The process of discussing clients consists of the following steps:

- Client's name is identified by the TICM Supervisor or another TICM staff member facilitating the meeting;
- American Society of Addiction Medicine (ASAM) assessment information is presented by either CD staff or Transitional Housing staff;
- Current client issues are then identified and discussed by pertinent service providers, such as a CD provider and a case manager; and
- Staffing participants then discuss issues and needed action as appropriate.

Community meetings were established to provide a forum for all community service providers to discuss issues that relate to the development and implementation of this program.

Issues that have been discussed include:

- Site updates
- Service provision territories and crossing boundaries
- Training needs
- Outreach efforts
- Use of discretionary funds
- Research-related issues

The community meetings are used in different ways. In Snohomish County, the TICM staff, the CD staff, the Transitional Housing staff, and sometimes the CPS liaison attend the community meeting. The issues of concern (listed above) are raised and discussed in detail. This is often the same group of service providers that attend the staffings.

In Benton and Franklin Counties, the community meeting is attended by the TICM staff, members of the CD treatment and transitional housing staff, the outpatient treatment coordinator, the CPS liaison, and representatives from the neighboring Community Services Offices (CSO). The issues of concern (listed above) are raised with the idea that other (less-involved) community service providers can help solve problems encountered in the program.

The site in Whatcom County does not have a defined community meeting. Instead, they discuss program issues in an established meeting of community service providers (i.e., The Chronic Abuse/Neglect Task Force).

Training issues have been identified throughout the implementation of the pilot project. Both formal and informal training has been provided to the TICM and CD staff members as needed. Formal training has included:

- Addiction Severity Index (ASI) training
- Case Management and Chemical Dependency Issues
- Confidentiality Issues and Ethics
- Motivational Interviewing

Whatcom County staff members have also attended time management and family planning message trainings.

Informal training has taken place among the Snohomish County service providers. Two service providers (one TICM staff member and one CD staff member) discussed their experiences working with the CD population, highlighting the ways in which members of this population interact with various staff members.

FINDINGS

Client Characteristics, Behavioral Risk Factors, Service Utilization, and Child Outcomes

Characteristics of Women

	Number	Percent
Age (n = 194)		
< 20	11	6%
20 – 24	54	28%
25 – 29	41	21%
30 – 34	42	22%
> = 35	28	14%
Missing	18	9%
Average (mean)	*27.6*	
Youngest	*18.0*	
Oldest	*42.0*	
Race / Ethnicity (n = 140)		
White	102	73%
Hispanic	14	10%
African American	9	6%
American Indian	8	6%
Asian / Pacific Islander	1	1%
Other	3	2%
Missing	3	2%
Marital Status (n = 140)		
Single	95	68%
Divorced	19	14%
Married	16	11%
Separated	9	6%
Missing	1	1%
On TANF (n = 194)		
	104	54%
Pregnant at Intake (n = 194)		
	73	38%
Referral Source (n = 194)		
CPS	55	28%
CD treatment center	42	22%
Medical provider	23	13%
CSO staff	15	8%
Law enforcement, other legal	14	7%
Counselor	11	6%
Self	9	5%
Family, friend	8	4%
Other	8	4%
Missing	7	4%

Characteristics of Women

Since the local pilot programs began enrolling clients in early 2000, 198 women have been served (as of December 31, 2000).[3] TICM providers in Benton-Franklin and Snohomish Counties will serve a minimum of 75-100 women per year. Whatcom County (offering TICM only) will serve a minimum of 40 women per year. All TICM providers have enrolled sufficient numbers of women to meet their minimum enrollment expectations. Since November 15, 2000, residential treatment facilities in Benton-Franklin and Snohomish Counties have been at full capacity with a combined total of 15 women on waiting lists.

- The average age of enrolled women was almost 28 years old, with ages ranging from 18 to 42 years old. Thirty-four percent were less than 25 years old.[4]

- Most women (73%) identified themselves as White or Caucasian, while 25% identified themselves in other ethnic or racial groups (including Hispanic, 10%; African American, 6%; American Indian, 6%; Asian, 1%).

- Eleven percent of women enrolled were currently married. Twenty percent were separated or divorced from a spouse. The remainder were single or never married (95 of 140 women, or 68%).

- More than half the women (54%, or 104 of 194) were receiving Temporary Aid to Needy Families (TANF) at intake. Most women were Medicaid-eligible, and all clients met the project eligibility requirement for income (at or below 200 percent of the Federal Poverty Level).

- Thirty-eight percent of the 194 participants were pregnant at intake.

- More women (28%) were referred to this program by Child Protective Services (CPS) than by any other source. Chemical Dependency (CD) treatment providers referred 22% of the women to this program, while medical providers referred 13%.

[3] Of the 198 total women enrolled, 194 (98%) have agreed to participate in research.

[4] Age data were available for 176 women, or 91% of the research participants. Race and marital status were available for 140 women, or 72% of the research participants. Most of this demographic data was collected from the Parenting Stress Index (PSI), which was only administered to women with recent parenting experience.

Characteristics of Children

		Number	Percent
Age of Index Children* (n = 195)			
Not yet Born		73	37%
Birth – 11 months		75	38%
12 – 23 months		33	17%
24 – 35 months		14	7%
Average (mean)		*11 months*	
Custody Status of Index Children (n = 195)		**Number**	**Percent**
Mother		61	31%
Not yet born		43	22%
Missing		36	19%
Foster family		32	16%
Other relative		9	5%
Grandparent		6	3%
Other		5	3%
Father		2	1%
Friend		1	1%
Number of Children in Families (including 195 Index Children)	**Number of Families**	**Total Number of Children**	**Percent**
1	50	50	10%
2	52	104	20%
3	38	114	22%
4	31	124	24%
5	15	75	15%
6	7	42	8%
7	1	7	1%
Total Children		**516**	
Average (mean)		*2.65*	
Number of Other Children Living with Mother (excluding Index Children)	**Number of Families**	**Total Number of Children**	**Percent**
0	134	0	
1	34	34	34%
2	15	30	30%
3	8	24	24%
4	3	12	12%
Total Children		**100**	
Average (mean)		*0.51*	
Number of Other Children Living Elsewhere (excluding Index Children)	**Number of Families**	**Total Number of Children**	**Percent**
0	90	0	
1	38	38	17%
2	34	68	31%
3	19	57	26%
4	7	28	13%
5	6	30	14%
Total Children		**221**	
Average (mean)		*1.14*	

*The index child is the youngest child (unborn or up to age 3), who serves as the basis for program eligibility.

Characteristics of Children

One of the requirements for entry into the program is that a woman have at least one child under three years of age or be pregnant at the time of enrollment. Our study defines the unborn baby or the youngest child under three as the index child. This child is the one whose outcomes are most likely to be impacted by the program. While little outcome data are available at this time, the general characteristics of the index child and the client's other children and the family composition are presented here.

- Participants had a total of 516 children (including the index children), with an average of over 2 children (2.65) per client. Of these, 31% lived with their mothers.

- The average age of CPEP clients' index children was 11 months at program entry. Over one-third (38%) of the children were aged 0 months (newborn) to 11 months, and another 17% were between the ages of 12 to 23 months at intake. Over one-third (37%) were not yet born at intake.

- About one-third (31%) of index children born to CPEP clients were in the legal custody of their mothers, while 16% lived with foster families. Foster family custody was more frequent than placement with a child's grandparents, father, and other family members combined.[5]

- In addition to the index child (one per woman), the average number of other children living with their mothers at intake was 0.51, and the average number of other children who were not living with their mothers at intake was 1.14. (The sum of the average number of other children living with their mothers and the other children not living with their mothers, 0.51 + 1.14 =1.65, is one child less than the average including the index child, 2.65.)

[5] Residence data are only available on index children (59%) who were born at the time of enrollment.

Behavioral Risk Factors at Program Entry

Client Substance Use

	Number	Percent		Number	Percent
Using either alcohol/drugs	153	79%	Using alcohol	18	12%
			Using drugs	64	42%
			Using both	71	46%
			Total	**153**	**100%**
At risk for using alcohol/drugs	39	20%	Alcohol risk	6	15%
			Drug risk	10	26%
			Both risk	18	46%
			Missing	5	13%
			Total	**39**	**100%**
Missing	2	1%			
Total	**194**	**100%**			

Behavioral Risk Factors at Program Entry

Behavioral health and mental health problems commonly occur in combination with chemical dependency. Behavioral health services are one of the core program services, and a behavioral health specialist is a required member of the TICM staff. Because counseling services for women without diagnosed mental illness are generally not available from community-based mental health agencies, it is especially important that the TICM team include a behavioral health specialist who can provide one-on-one and group counseling for clients and assist in referring clients to existing community resources.

Parenting education is one of the core services provided in this program. In a study of comprehensive substance abuse treatment programs, Nelson-Zlupko (1998) reported that parenting skills training is the most frequently self-identified need of pregnant substance abusing women. This comprehensive program offers parenting classes to clients or access to such classes while participating in the program.

Service providers report that clients are very interested in parenting their children, including those that may be in foster care. Although active parenting may be the desired goal of many clients, the reality of such parenting can be very stressful, especially for women who are trying to establish a clean and sober lifestyle. In addition to concentrating on their own recovery, many of these clients must learn how to parent effectively. According to Grant et al. (1999), the lives of substance abusing women are often characterized by poverty, violence, chaotic living conditions, and alienation from health and social service providers. Service providers report that a number of clients have had to learn how to manage their households, including setting up budgets that cover food and diapers for their children. Also some women need to learn how to cook nutritious and inexpensive meals. One client with a special interest in cooking plans to compile a cookbook to help other clients achieve this goal. Clients with school age children have the additional responsibilities of enrolling those children in school, encouraging school attendance, and monitoring completion of homework.

Client Substance Use at Program Entry

- Virtually all clients (99%) in this program were reported to be using alcohol or other drugs or were at risk of using such substances: 79% were using, 20% at risk, and 1% missing.

- Most (88%) of the women known to be using alcohol or other drugs reported using drugs or a combination of drugs and alcohol rather than alcohol alone.

- Almost three-fourths (72%) of at-risk clients were at risk of using drugs or a combination of drugs and alcohol.

Client Skills and Needs at Program Entry: Client Self-Evaluation Form

	Strongly Disagree %	Disagree %	Neutral %	Agree %	Strongly Agree %
How do clients feel about certain parenting practices?					
My children go to bed about the same time every night.	4%	12%	22%	37%	25%
I feed my children when they are hungry.	2%	2%	5%	22%	69%
I hug my child as often as I can.	1%	1%	3%	17%	75%
My children bathe regularly.	2%	2%	3%	27%	66%
I am too lenient when my child misbehaves.	16%	21%	37%	17%	8%
I rarely talk to my children about their day.	35%	31%	23%	7%	2%
I need help with my parenting skills.	6%	10%	27%	40%	17%
I often lose my temper when my child misbehaves.	33%	27%	25%	10%	4%
I discipline my children when they misbehave.	5%	4%	27%	46%	18%
How do clients feel about drug use?					
I can safely use small amounts of illicit drugs.	74%	8%	9%	1%	5%
Drugs are not really that dangerous.	81%	7%	3%	3%	5%
I believe that I will lead a drug-free life.	3%	3%	8%	27%	59%
I understand that using drugs can harm a baby.	2%	0%	2%	8%	87%
How do clients feel about their own needs?					
I never really learned how to find a job.	38%	28%	10%	15%	8%
I need a lot of help with transportation.	11%	16%	15%	18%	39%
I can handle most of my problems.	8%	14%	37%	36%	5%
I look forward to receiving training in this program.	1%	1%	6%	34%	58%
I need to get help with housing.	11%	10%	11%	19%	48%

Client Skills and Needs at Program Entry

The Client Self-Evaluation Form is a twenty-five (25) item inventory designed to assess both client skills and client needs at program enrollment (provided the client has recent parenting experience) or shortly after obtaining some parenting experience. Clients are asked to evaluate their level of agreement (or disagreement) with statements reflecting their current parenting attitudes and behaviors, beliefs about substance use, and their need for help with housing, employment, and transportation.

This form addresses clients' feelings about parenting practices. Specific questions are based on common themes in the child development literature. For example, certain parenting practices, such as hugging a child, represent important ways to show love (Dinkmeyer et al., 1997). Using discipline rather than punishment is a way to help a child learn to be responsible (Dinkmeyer et al., 1997; Brazelton, 1992). The importance of routines for daily activities provides opportunities for consistent positive interaction (Turner and Hamner, 1994).

Clients receive parenting education while participating in CPEP and are asked again about their parenting practices at program exit. Parenting classes cover such topics as misbehavior and the use of discipline as well as effective communication and sharing feelings with children. Classes may be offered by the TICM provider, the CD facility, the transitional housing provider, or another agency within the community.

Parenting Attitudes and Behaviors

Most clients (92%) in this program report that they agree or strongly agree with the statement that they hug their child as often as they can. Nearly two-thirds (64%) of clients report that they discipline their children when they misbehave. A majority of clients (62%) report that their children go to bed at about the same time each night, and most clients (93%) agree or strongly agree with the statement that they bathe their children regularly.

Substance Use Beliefs

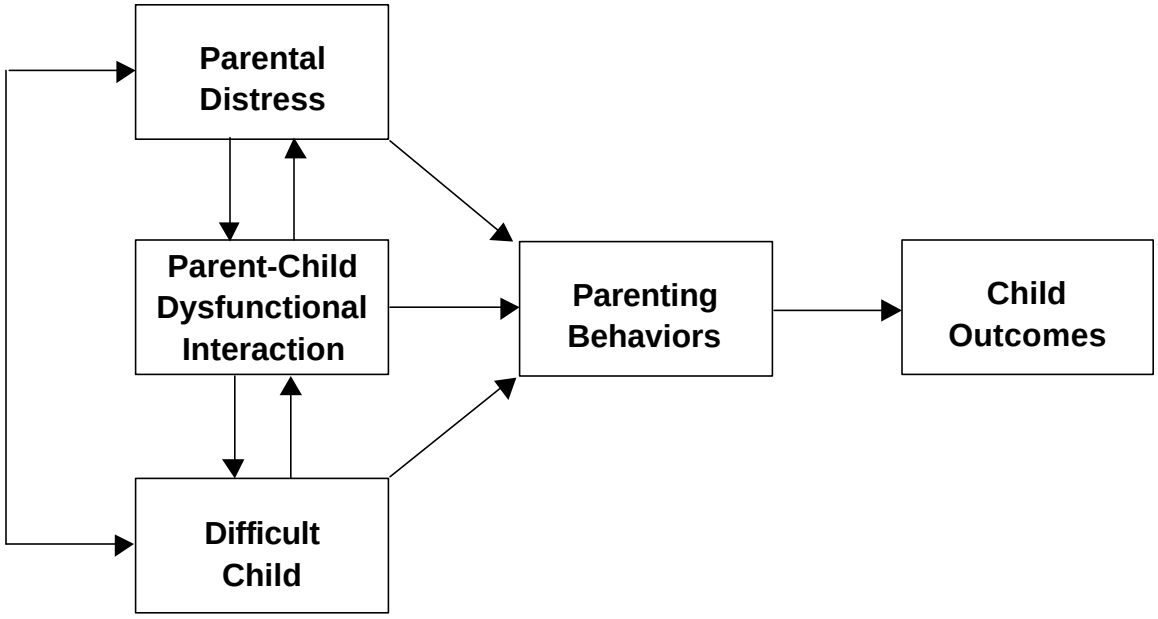
Over 80% of clients report that they believe they will lead a drug-free life and disagree with the statement that they can safely use small amounts of illicit drugs. Similarly, most clients (88%) disagree or strongly disagree with the statement that drugs are not really that dangerous. In fact, almost all (95%) clients believe that using drugs can harm a baby.

Client Needs

Less than one-half (41%) of clients reported that they could handle most of their problems. Almost one-half (47%) of clients reported that they need a lot of help with transportation, and two-thirds (67%) reported that they need help with housing. Over 20% of clients never really learned how to find a job, and 92% reported that they are looking forward to receiving training in this program.

The findings reported here reflect data gathered at or near program enrollment and serve as baseline measures of client skills and needs. These skills and needs will be assessed again at program exit.

PSI Conceptual Model



Parenting Stress Index: Average Scores and Percentiles

	Average (median) Scores		Proportion of Clients in Low, Average and High Percentiles of Stress		
	CPEP	Comparison Group	Lowest Stress: at or below 20th Percentile	Average Stress: at or below 50th Percentile	High Stress: at or above 80th Percentile
Total Stress (TS)	78	69	16%	31%	42%
Parental Distress (PD)	31	25	11%	28%	50%
Parent-Child Dysfunctional Interaction (PCDI)	26	19	9%	41%	29%
Difficult Child (DC)	26	25	24%	49%	26%

Parenting Stress Levels and Parenting Skills at Program Entry

The figure on the facing page by Richard Abidin (1995) illustrates the relationships between the PSI scales, parent behaviors towards children, and child outcomes. Brook (1993 and 1996) demonstrated that reducing parental substance abuse could have positive effects on the parent-child bond by enhancing parental personality traits and strengthening the parent-child bond.

A total of 141 CPEP clients completed the Parenting Stress Index Short Form (PSI/SF). Scores were calculated using client responses to the PSI compared to a national sample of parents (comparison group).

The Total Stress (TS) score measures the overall level of parenting stress. The TS score relates to the stresses associated with the role of parenting and not to other client life roles.

- The average Total Stress Index score for CPEP clients was 78, much higher than the comparison group average of 69. More than twice as many CPEP client scores (42%) fell into the high stress category (80th percentile) compared to 20% of the comparison group.

Parental Distress is a measure of the distress a parent is experiencing in her role as a parent. Stresses associated with the PD indicator include an impaired sense of parenting competence; restrictions placed on other life roles, such as an employee, spouse, or student; conflict with the child's other parent; lack of social support systems; and the presence of depression.

- The average CPEP score for Parental Distress Index was 31, higher than the comparison group who scored 25. Half of CPEP client scores fell in the high distress category (80th percentile), while only 11% fell into the low distress category (20th percentile).

Parent-Child Dysfunctional Interaction focuses on the parent's perception of the degree that the child is a negative element in her life. Common manifestations of this perception are that the parent perceives herself as abused or rejected by the child, or the parent feels disappointed and alienated from the child. Higher scores may indicate that the child-parent bond is threatened or was never adequately established.

- The average CPEP Parent-Child Dysfunctional Interaction Index (PCDI) CPEP score was 26, slightly higher than the comparison group score of 19. Almost one-third (29%) of CPEP client scores fell into the high stress category (80th percentile) compared to 20% of the comparison group.

The Difficult Child indicator focuses on some of the behavioral characteristics of the child that might make him or her difficult to manage. Although some of these child characteristics may be innate and matters of temperament, they also include learned behaviors, such as noncompliance, defiance, and demanding behavior.

- The average CPEP Difficult Child (DC) score was 26, basically the same as that for the comparison group (25). Almost one-half (49%) of CPEP scores fell at or below the 50th percentile of the comparison group.

Based on the results of the PSI, CPEP clients experience parenting stress because of their own distress and not because they have difficult children.

Service Use

Type of Service	Women Receiving the Service	
	Number	Percent of Total
CD treatment*	161	84%
Behavioral health*	153	80%
Child development*	120	63%
Parental education*	131	68%
Transitional housing*	62	32%
Transportation	153	80%
Family planning	99	52%
Work	61	32%
Child care	113	59%
CPS	127	66%
WIC	143	74%
VOTE*	4	2%
Basic needs	148	77%
Dental care	22	11%
Domestic violence services	19	10%
Medical care	92	48%
Mental health	58	30%
Vision	9	5%
Probation services	2	1%
Education	3	2%
Vocational training	0	0%
Legal services	21	11%
Any other service	9	5%
Total Number of Women**	**192**	

* CPEP funds all or part of these services.

** Although there are 194 women in the program as of 12/31/00, two of these women entered the program at the end of December, and their names did not appear on the Monthly Services Report.

Service Use

CPEP case managers use intake information to develop a care plan outlining needed services and establishing appropriate goals for each client in the program. Once the care plan is created, case managers facilitate access to community resources by making referrals to appropriate agencies or by contacting representatives of those agencies. Case managers contact clients on a regular basis, monitoring services received and progress toward established goals. At the end of each month, case managers complete a Monthly Services Report indicating all services received by each client in a given month.

For this analysis, a woman was counted as having received a service if the Monthly Services Report form indicated that she received a particular service for one or more months. The following table lists services, as well as the total number and percent of all clients who received these services.

- Chemical Dependency (CD) treatment, provided to 84% of clients, was the most commonly received service. CD treatment reported here may include assessments and outpatient treatment as well as inpatient or residential treatment. Additional clients may attend AA or NA meetings (not reported here).

- Over three-fourths (80%) of clients received behavioral health services (counseling towards behavioral change), transportation services, and/or help with basic needs.

- Almost three-fourths (74%) received WIC.

- Over one-half of clients received services relating to child development, parental education, childcare, CPS, and/or family planning; almost half received medical care.

- Nearly one-third (32%) of clients received services related to transitional housing. Those services may include assisting clients with the applications for transitional, subsidized, or other sober housing as well as with receipt of such housing. Transitional housing has been provided to 27 clients thus far, or 14% of research participants.

- Almost one-third (32%) of clients also received work-related services, such as assistance with employment applications or resumes.

Case Management Services

Time Spent per Month per Client	Number	Percent
0 – 10 hours	110	57%
11 – 20 hours	64	33%
21 or more hours	19	10%
Average hours per month per client	*11.1*	

Residential Treatment

Length of Stay	Number	Percent
0 to 14 days	11	11%
15 to 30 days	13	13%
31 to 60 days	14	14%
61 to 90 days	19	19%
91 to 120 days	14	14%
121 to 150 days	11	11%
151 or more days	18	18%
Total Events	**99***	
Average (mean)	90	

*92 clients had 99 residential treatment episodes.

Transitional Housing

Length of Stay	Number	Percent
Less than or equal to 90 days	8	30%
91 – 120 days	3	11%
121 – 240 days	9	33%
241 or more days	7	26%

Case Management, Residential Treatment, and Transitional Housing

Three major types of service providers represented by different agencies comprise the required components of CPEP: Targeted Intensive Case Management (TICM), residential CD treatment, and transitional housing.

Case managers provide a variety of services or access to community resources, such as family planning or transportation. Case management services are recorded using the TICM Monthly Services Report form, which includes total case management time per client and type of services received by each client.

- The majority of case managers spent between 0 and 10 hours per month per client. Thirty-five percent of clients received between 6 and 10 hours of case management time per month. Case managers averaged 11.1 hours per month per client. The time spent with each client varies and is determined by individual needs.

Residential CD treatment includes inpatient individual and group therapies and education toward achieving sobriety. Residential treatment information is reported monthly by the CD provider and includes admission and exit dates as well as client status during treatment.

- Ninety-two CPEP clients entered residential CD treatment with an average stay of three months (90 days). Some clients entered or exited the Residential Treatment program more than once, resulting in 99 residential treatment episodes for 92 clients (slightly less than half of all CPEP clients).

Transitional housing provides a supportive and sober residence for clients recently discharged from CD residential treatment. Transitional housing data is reported monthly and includes admission and exit dates and client status during residence.

- Twenty seven CPEP clients have entered transitional units since this program began. Over one-half (59%) of these clients in transitional housing have occupied their respective units for 121 days or longer.

Child Outcomes: Newborn Health Status

	Number	Percent
Birthweight		
VLBW (less than 1500 grams)	0	0
MLBW (greater than or equal to 1500 grams and less than 2500 grams)	6	9%
Normal (greater than or equal to 2500 grams)	58	86%
Missing	3	4%
Average (mean)	*3230 grams*	
Five-Minute Apgar		
7 or lower	3	4%
8	6	9%
9	50	75%
10	3	4%
Missing	5	7%
Need for Intensive Care		
Yes, needed care	15	22%
Missing	8	12%
Time in NICU		
Never	44	66%
1 day	2	3%
2 – 7 days	5	7%
9 days	1	1%
Missing	15	22%
Average (mean) stay in NICU (days)	*2.7*	
Gestational Age		
<= 32 weeks	0	0
33 – 34 weeks	1	1%
35 – 37 weeks	16	23%
38 – 42 weeks	47	67%
Missing	6	8%
Pregnancy Complications		
Abruptio placentae	1	2%
Placenta previa	0	0
Multiple births	1	2%
Preclampsia / eclampsia	0	0
No prenatal care	3	4%
Other (includes breech-1, VBAC-1, fetal distress-1, hemorrhage-1)	24	38%

Child Outcomes: Newborn Health Status

Improving the health and welfare of substance abusing mothers and their young children is a primary goal of this program. Service providers collect information on the health of the newborn at birth and routinely measure the developmental status of children for three years. Based on the results of these developmental assessments, CPEP providers refer clients to other community service providers as appropriate. Data shown on the facing and following pages describe the health and developmental status of children born to CPEP clients.

The Newborn Health Status form requests information related to the delivery of the newborn, such as baby's weight, gestational age, and delivery complications as well as the pediatrician's assessment of whether or not the newborn was affected by mother's substance use. A total of 67 children had Newborn Health Status forms: 43 children were born prior to program enrollment, and 24 children were born after their mothers enrolled in the program.

- The average birthweight for infants born to CPEP clients was 3230 grams (7 pounds). The rate of low birthweight (less than 2500 grams or 5.5 pounds) for these infants was 9%. This rate was intermediate between that for infants born to known substance abusers (14%) and that for infants born to other Medicaid women in 1999 (6%).

- Four percent of infants born to CPEP clients scored 7 or less on the five-minute Apgar. This rate of low Apgar scores was intermediate between that for infants born to known substance abusers (6.6%) and that for infants born to other Medicaid women in 1999 (3.4%).

- Almost one-quarter (22%) of infants born to CPEP clients required care in the Neonatal Intensive Care Unit (NICU), and 10% required 1-7 days of care in the NICU.

- Nearly one-quarter (24%) of infants born to CPEP clients were less than 38 weeks gestational age. This rate of prematurity was intermediate between that for infants born to known substance abusers (28%) and that for infants born to other Medicaid women in 1999 (16%).

- One client’s pregnancy was complicated by an abnormal condition of the placenta known as abruptio placentae. One pregnancy resulted in the birth of twins (multiple birth). A number of additional conditions, such as breech birth, fetal distress, and hemorrhage, were noted on the form. Other conditions noted were less serious complications. (Vaginal birth after cesarean section (VBAC) is a delivery method, not a pregnancy complication.)

- Pediatricians reported that 12% (n = 8) of infants born to CPEP clients were drug-affected (data not shown here). Forty-eight percent of CPEP infants were not drug-affected, and pediatricians or other medical providers did not report the drug-affected status of the remaining 40% of CPEP infants.

Child Outcomes: Developmental Status

Children with Normal Denver Scores		
At birth	7 of 7	100%
At 1 week	9 of 9	100%
At 1 month	24 of 24	100%
At 2 months	32 of 33	97%
At 4 months	23 of 26	88%
At 6 months	26 of 29	90%
At 9 months	7 of 11	64%
At 12 months	14 of 17	82%
At 15 months	7 of 7	100%
At 18 months	8 of 11	73%
At 2 years	6 of 12	50%
At 3 years	1 of 2	50%

Child Outcomes: Developmental Status

Child development services are one of the core services provided in this program. It is generally agreed that children born to substance-using women benefit from developmental and behavioral assessment and educational programs designed to meet their individual needs. While no studies have consistently shown that exposure to a specific drug other than alcohol *in utero* leads to a specific developmental dysfunction, abuse of alcohol or drugs is associated with developmental delay, in addition to low birthweight, infant mortality, and medical complications. Many developmental delays or behavioral problems among drug-exposed children may resolve with early childhood intervention.

Developmental delays in infants and young children are often difficult if not impossible to detect through routine physical examinations performed by health providers. In this program, the Denver II, a general developmental screening test, is used to identify children who need follow-up for potential diagnosis of developmental delays or disabilities. The Denver is administered according to a standard schedule, which begins shortly after program enrollment. For children enrolled in CPEP from birth, testing is administered at nine required ages and at three optional ages. Testing is performed by the Child Development Specialist for all index children beginning at birth and for all children up to age three. Children with suspect Denver II results are referred by the Child Development Specialist for follow-up and appropriate interventions specific to any particular types of delay diagnosed.

Results of Denver developmental screening are shown on the facing page:

- Over 80% of tests performed for children at age six months or younger indicated normal development.

- Among children tested at age 18 months to three years, 50 to 73% demonstrated normal development. Results for six children in this age range were suspect, indicating possible developmental delay.

Because the prevalence of suspect Denver II results is known to increase with the child's age (Frankenburg et al., 1996), it is difficult to interpret the significance of these findings. The findings may indicate appropriate test administration: what can be measured at a young age is far more restricted than what can be measured at an older age. Almost 90% of children born since their mothers enrolled in CPEP demonstrated normal development. This is an encouraging finding; however, these children may reveal developmental delay in the future as time passes. The higher rate of suspect results among older children (25 children tested at 18 months to three years) may be consistent with better ascertainment of delay as children age. These findings are also consistent with a higher prevalence of delay among children born to mothers with low educational attainment, poverty, and chaotic lives.

DISCUSSION

In our preliminary report (Farmer et al. 2000), we asked community service providers to rate the amount of work it takes to serve clients as a team. Service providers mentioned that it is a challenge to work as a team with people trained in different disciplines. This study concluded that to create a team that works well together, service providers must:

- Build trust among team members;
- Take time to learn about other systems and how to work well together; and
- Understand the importance of communication.

A further conclusion of this study was that the team approach to serving this population is a unique and essential aspect of this program.

Other researchers have noted the importance of the team approach in serving substance abusing women. Garcia (1997) emphasized that chemical dependency interventions that also address the needs of children must be coordinated among the different agencies in order to avoid conflicts in service delivery. Inter-agency collaboration is an important element to address the needs of both mothers and their children. McEwen (1994) also recognized that the problems facing human services professionals are so complex that collaboration and a multidisciplinary approach are required to address each situation. He attributes this complexity to the high degree of specialization in health care that has led to fragmentation.

CPEP Community Implementation teams are comprised of providers from agencies whose priorities may focus on different individuals, such as mothers or children, or different client issues, such as alcohol and drug addiction and recovery or supportive services. Providers also have diverse professional backgrounds and training, such as a Masters of Social Work (MSW) or Chemical Dependency Counselor (CDC), and hence, each profession may approach the treatment and care of the clients differently.

Three different approaches to the treatment or care of this population are represented in this program, based on the professional discipline and program affiliation of staff: CD treatment providers, TICM staff, and Child Protective Services (CPS) workers.

CD treatment providers advocate a very structured approach to treating chemical dependency. These providers initially impose the goal of abstinence upon clients entering their programs and then reinforce the importance of that goal in various structured activities. Activities include established classes, therapy groups, and meal times resulting in a very structured living situation. Clients are also made aware of defined rules and sanctioned for violating those rules. CD facilities use mechanisms, such as behavioral contracts, to gain compliance with those rules. Although the CD treatment environment requires a certain level of structure that facilitates the monitoring and evaluation of clients to “determine strengths, weaknesses and perceived problems and needs” (Gaedeke, 1991), individual treatment plans are tailored to the needs of each client enrolled in the program.

Case managers advocate caring for clients through acceptance and assistance, and ground their work in an understanding of clients’ experiences (HHS, 1998). TICM staff strive to establish

long-term relationships with clients by engaging in a number of client-centered activities, such as helping clients meet their immediate needs in a timely manner. Case managers begin to serve clients by "getting [their] basic needs met before treatment is possible." The case manager may emphasize acquiring life necessities, such as a safe housing environment, before attending to substance abuse issues (HHS, 1998). TICM staff support clients by teaching skills, such as budgeting, locating or providing childcare, helping clients complete paperwork, taking clients shopping for needed items, and helping clients acquire transportation to access needed services. By developing an ongoing relationship with clients, case managers can increase service utilization by assisting clients in accessing services. Moreover, the case manager can ensure that clients will receive adequate support in "dealing with crises, coping with bureaucratic confusion and acquiring personal and social skills" (Goering et al., 1989).

Child Protective Services (CPS) workers focus on the welfare of the client's children and are concerned with anything that might put the children at risk of neglect or abuse, including a child's parents. According to Health and Human Services protocols, CPS workers are interested in client progress as it might pertain to parenting abilities, and they follow legal guidelines and goals for the establishment of a safe and permanent home for the child (1995). When interests between child and parent compete, the focus of service is foremost upon the child (DSHS, 2000). CPS workers expect other service providers to make referrals as appropriate and will provide information to other service providers if open CPS cases exist.

Barriers to effective teamwork among practitioners from different disciplines may be rooted in several factors: assessment of client needs exclusively through the framework of team members' particular discipline; leadership and group processes; different protocols, professional languages, and goal-setting strategies. Team members may believe that their discipline is primary to the treatment and recovery of the client and that other practices or disciplines are ancillary. Team members may also see themselves as representatives of their discipline rather than as members of a whole that transcends individual discipline boundaries. Moreover, team members may feel disempowered if their particular area of expertise is not directly utilized in the treatment plan. The authority or professional hierarchy within the interdisciplinary team is not equally divided, nor is the pressure equal among all members to reach consensus: "professions with a lower status may feel more compelled to conform to group norms rather than more autonomous, higher status groups." In addition to different conceptual models and service delivery practices, semantic and professional language and terminology can also jeopardize successful teamwork (Sands, 1990; Mailick and Ashley, 1981).

Two types of territorial issues were encountered in the process of program implementation. The first type relates to service provision. As service providers begin to work as a team, they must work to identify, establish, and maintain boundaries with regard to caring for or treating clients. TICM staff develop care plans, while the CD staff are required to develop and maintain treatment plans. Both plans may be developed simultaneously, but the plans are not necessarily developed in conjunction with each other, nor do the service providers always share with each other the information contained in their respective plans. Further, the CD treatment providers believe that their treatment plan takes precedence over the care plan while the client is in chemical dependency treatment and is not subject to approval by the team, even when other team members are trained in the treatment of chemical dependency.

The second type of territorial issue involves professional roles, or the expected behaviors based on the professional role of the service provider. A comprehensive program such as this one

attempts to meet a variety of clients' needs and requires providers to know a great deal about the clients and their individual needs. In an effort to meet those needs, community service providers tend to become intimately involved in clients' lives. Determining when this high level of involvement becomes personal rather than professional involvement (or over-involvement) is not defined consistently among various service providers. For example, some community providers have objected to the behavior of other community service providers resulting in a temporary withdrawal of participation in this program.

The sharing of information among staff members and disciplines is an important aspect of comprehensive substance abuse programs. Cross-training allows practitioners from different disciplines to better understand the needs of the client by learning more broadly about the extent of the client's problems. Cross-training also allows a team to overcome unforeseen barriers in areas where the particular practitioner may lack expertise (HHS, 1998).

State team members have identified certain organizational strengths at various sites leading them to suggest cross-training of site staff. For example, the Benton-Franklin staff visited the Snohomish site to see how they conducted their staffings. Benton-Franklin staff saw that all clients could be discussed within a couple of hours by using the American Society for Addiction Medicine (ASAM) criteria assessment to begin the discussion of each client. By completing these assessments prior to the staffings, service providers could discuss pertinent client issues in a shorter period of time. Snohomish staff visited the Benton-Franklin site to see how they conducted their community meetings. Snohomish staff saw that a variety of community service providers can attend that meeting (and that those providers can serve as valuable resources with the ability to help resolve problems faced by this client population). Snohomish County staff members also saw that meeting minutes were taken and distributed on a regular basis.

Whatcom County staff received some training from the Snohomish County staff on how to create and maintain charts and administer the Denver Developmental Screening Test (Denver II). Providence Everett Medical Center (PEMC) administers both of these sites.

Community service providers raise issues and identify problems that need to be discussed by members of the CPEP State team. We have addressed this need in two ways:

- State team members have regularly attended both staffings and community meetings; and
- State team members discuss issues/problems identified at the community level during the State team meeting.

For example, the community service providers reported that some women did not want to enter residential treatment in another county because they wanted to remain in the same county as their children (who were often in foster care). The CPS liaison on the State team informed the other team members that it was possible for children to be placed in foster care within the same county as the residential treatment facility.

CONCLUSION

Several factors have been identified as critical to the successful implementation of the CPEP pilot projects. Most of these critical factors have one characteristic in common: they serve to improve or enhance communication among the service providers. In a preliminary evaluation of this program, CPEP service providers identified communication as a requirement for improving working relationships (or collaboration) among community service providers (Farmer et al., 2000). McEwen (1994) also recognized the importance of communication in the health care system. He advocated for the value of interdisciplinary collaboration achieved through communication-focused activities, such as patient conferencing.

Preliminary Planning Among Service Providers About Sharing Information, Conducting Staffings, and Holding Community Meetings

Service providers have access to resource materials that facilitated program development and implementation at the local level. The 1999 DSHS-DOH *Report to the Legislature, A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803)* outlines program goals and recommended services for substance abusing clients participating in a comprehensive program. The CPEP State Implementation Team developed the conceptual model for this program that identifies how clients might be referred to the program as well as the types of services that may be received by clients. Together these documents outline the vision for the comprehensive program, which service providers can use to plan for the implementation of a comprehensive program in their respective communities. Planning among service providers requires extensive discussion about the day-to-day activities required to serve this population, such as negotiating the details of sharing information, conducting staffings, and holding community meetings.

Importance of the Team Approach at the State and Community Levels

The team approach to serving substance abusing mothers and their young children is an essential aspect of this program at both the state and community levels. Members of the CPEP State Implementation Team who represent all of the collaborating agencies in this program have diverse backgrounds in education, professional training, and work experiences, including exposure to different work cultures and adherence to unique agency requirements. In the regular meetings of the State team, members identified shared values. Discussion of these shared values facilitated the development of a shared vision of the comprehensive program.

The CPEP State Implementation Team continues to meet regularly to discuss issues and problems raised by the community providers during program implementation. Community issues are often heard firsthand by State team members attending provider meetings, and the preliminary discussion between those State team members and the community providers reinforces the shared vision of the program. State staff then share these community provider concerns with the CPEP State Implementation Team for a more thorough discussion, which further reinforces the vision of this program.

Community service providers indicated that working together increases communication and collaboration. This ensures that adequate services are received by clients (Farmer et al., 2000). For example, many of the clients have open Child Protective Services (CPS) cases, so the CPS

liaison is often able to provide additional information about the clients during the staffings. The CPS liaison is also a resource for providing direction to case management (CM) and chemical dependency (CD) staff about appropriate times and circumstances to make CPS referrals.

Agencies that communicate frequently have more opportunities to discuss issues and to resolve problems that may arise. On occasion, CM and CD staff have indicated difficulties working with various CPS personnel, and the CPS liaison has helped to resolve those issues. In some cases, the CPS liaison provided the name of the supervisor to contact when CPEP staff had difficulty interacting with CPS workers. The prospect of reunification or maintaining custody of children is a powerful incentive for women to comply with their treatment plans. For this reason, it is very important to include CPS in a comprehensive program serving substance abusing women and their young children.

Leadership for Community Providers and Program Staff

State staff provide leadership to community service providers by demonstrating their commitment to the success of the program through regular attendance at and participation in provider meetings. State staff also work with individual program staff members to help identify pilot site needs and then respond to those needs as appropriate. This type of leadership has been fundamental for communicating and reinforcing the vision of the comprehensive program.

Leadership at the community level for program staff is essential for implementing a program that reflects the shared vision of the program. Community leaders must understand this vision well enough to answer the questions raised during the day-to-day operation of the pilot sites. In addition, community leaders must also be able to think creatively about meeting client needs without compromising the vision of the program.

Need for Continuing Support and Training of Program Staff

The CPEP State Implementation team has played a pivotal role in shaping and reinforcing the vision of this program. State staff frequently attend provider meetings for three important reasons: 1) State staff representing different programs model collaborative working relationships; 2) State staff answer program implementation questions in a timely manner; and 3) State staff provide feedback regarding pilot site performance expectations. It will be essential to continue ongoing participation in the meetings at the sites to ensure efficient operations.

Throughout the first year of this program, various training needs have been identified. Those needs include information on chemical dependency and motivating clients into treatment. Training on both of these topics has resulted in an increased understanding of client needs and the ways in which different service providers approach the treatment or care of clients. This increased understanding facilitates communication among service providers.

Administrative Structure Flexible Enough to Integrate the Program Model

Some settings may be more appropriate for Targeted Intensive Case Management than others. For example, established rules and practices in highly bureaucratic organizational structures may prevent access to resources, such as discretionary program funds, which are needed to serve this population in a comprehensive manner. Serving this population may require innovative ways to

conduct business, and providers must be able to adapt their practices to the program model and the needs of this client population.

Several CD Beds and Transitional Housing Units for Clients Located in Pilot Site Counties

Most of the women who enter this program need residential CD treatment and transitional housing in addition to TICM services. Having all of these components in one area results in a number of benefits. For example, women can stay in a familiar location to receive needed services. Service providers from multiple agencies and clients can easily communicate with one another when those agencies are located in the same area. Proximity can also enhance communication among service providers.

In the Benton-Franklin area, an abandoned nursing home was converted into a residential CD treatment facility. The process for accomplishing this conversion included several steps. First, the service provider had to engage a realtor to find a suitable building to house a residential CD treatment facility. Second, the service provider had to ensure that the facility met the Department of Health (DOH) building code requirements. (For further information, see Washington Administrative Code [WAC] 246-325.) Finally, the service provider had to submit an application and be approved for or certified as a Division of Alcohol and Substance Abuse (DASA) CD treatment program. (For further information, see WAC 388-805.)

Community Partners Involved in Development of CPEP

Community partners are local agencies or service providers that may offer support services to women in this program. Some of these partners include the Community Services Office (CSO), the local Women Infant and Children (WIC) office, and community mental health agencies. Knowledgeable representatives from these agencies may attend community meetings and share information about the services available to CPEP clients. Service providers can then use this information to help clients gain access to needed services without duplicating those services.

Summary

Successful program development and implementation can be attributed to the communication that takes place everyday between and among the service providers and the State team. This increased communication between agencies and across State and community levels is a new way of conducting business. Service providers are working together, and clients who are actively participating in the program are receiving the comprehensive services that they need.

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APPENDICES

Appendix A: Pilot Site Description Data Sources

Population and Income Per Capita. County data on population and per capita income come from the *1999 Washington State Data Book* published by the Washington State Office of Financial Management.

Population Using DSHS Services. These data are drawn from Washington State Department of Social and Health Services (DSHS) *Clients and Client Expenditures by County for Fiscal Year 1998 (July 1 1997 through June 31 1998)*. Research and Data Analysis. Olympia WA.

Child Abuse, Domestic Violence Adult Arrests, High School Dropout Rate. This information is published in the *2001 Risk and Protection Profile for Substance Abuse Prevention in Washington State*, by the DSHS, Division of Alcohol and Substance Abuse and Research and Data Analysis, Olympia WA.

Unemployment Rates. Rates per county were drawn from the *1999 Annual Average Washington State Resident Civilian Labor Force*, published by the Washington State Employment Security Department, Labor Market and Economic Analysis Branch. Olympia, WA.

Number of Births. These data are reproduced from the DSHS publication, *2001 County Profiles: Birth and Unintended Pregnancy Statistics 1991-1998.* The number of births are calculated based on source data from the Washington State Department of Health Center for Health Statistics, and on population estimates from the Washington State Office of Financial Management.

Marital Status, low birthweight, late or no prenatal care. These data come from birth certificate information collected by the Washington State Department of Health Center for Health Statistics as provided by the DSHS First Steps Database.

Births with Medicaid-Paid Maternity Care. From 2001 *County Profiles: Birth and Unintended Pregnancy Statistics:* The percent of births with Medicaid-paid maternity care represents the proportion of total births identified as receiving Medicaid-paid maternity care. DSHS, Research and Data Analysis.

Current Need for Substance Abuse Treatment, and Alcohol or Other Drug Use Disorder. Information for these data is from the DSHS *1999 County Profile on Substance Use and Need for Treatment Services.* Division of Alcohol and Substance Abuse and Research and Data Analysis.

Appendix B: Pilot Eligibility Inquiry Form

Comprehensive Pilot Program for Substance Abusing Women and Their young Children

☐ Snohomish County
☐ Whatcom County

PILOT ELIGIBILITY INQUIRY FORM

☐ Benton-Franklin Counties

Potential Client Name:	Referral Name:
Date of Birth: Age:	Agency:
Social Security Number:	
Medicaid PIC (if known):	
Address:	Address:
Phone:	Phone:
Alternate/Message Phone Number:	Today's Date:

Women who are eligible to receive services from the Comprehensive Pilot Program for Substance Abusing Women and Their Young Children *shall*:

❑ yes ❑ no Meet the 200% of Federal Poverty Level (FPL). *Refer to chart on reverse side of this form. If no, make appropriate referral.*

❑ yes ❑ no Have a history of substance abuse, current substance use, and/or at risk of substance use.

❑ yes ❑ no Currently be pregnant. ❑ 1st Tri ❑ 2nd Tri ❑ 3rd Tri
OR
Have a child(ren) under age 3.

❑ yes ❑ no Have current and/or past involvement in multiple intervention systems.

❑ Legal
❑ CPS
❑ Mental Health (MH)
❑ Other: _____

❑ Chemical Dependency (CD)
❑ Pediatric Interim Care (PIC)
❑ Hospital Emergency Room
❑ Other: _____

❑ yes ❑ no Agree to participate in <u>all</u> recommended components of the program including Targeted Intensive Case Management (TICM), Outpatient Chemical Dependency Treatment Services, Residential Chemical Dependency Treatment Services, and/or Transitional Housing. *(If the client does not choose to participate in <u>all</u> recommended components, refer to like services as recommended)*

Comments: _____

_____

_____

_____

_____ _____ _____ _____

Printed Name Signature Agency Date

This form is the same for all pilot sites, please do not alter.

200% of Federal Poverty Level – 1999

Size of Family	200% of FPL Yearly	200% of FPL Monthly	Size of Family	200% of FPL Yearly	200% of FPL Monthly
1	$16,480	$1,373	6	$44,680	$3,723
2	$22,120	$1,842	7	$50,320	$4,193
3	$27,760	$2,313	8	$55,960	$4,663
4	$33,400	$2,783	Each add'l	$5,640	$ 470
5	$39,040	$3,253			

The Department of Social and Health Services is pleased to offer this innovative pilot program. The project is a state level collaborative effort between Medical Assistance Administration (MAA), Division of Alcohol and Substance Abuse (DASA), Department of Health (DOH), and Research and Data Analysis (RDA).

PROGRAM COMPONENTS:

Targeted Intensive Case Management (TICM)
Administered by MAA

Pregnant, Postpartum, and Parenting Women (PPW) Residential Chemical Dependency Treatment Services, with Therapeutic Childcare
Administered by DASA

PPW Transitional Housing
Administered by DASA

Medical Screen: Substance Use Risk
Administered by DOH

Program Evaluation
Administered by RDA

PROGRAM DESCRIPTION:

- Services provided to high-risk substance abusing women and their young children include referral, support, advocacy for substance abuse treatment and relapse prevention; and accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parenting skill training, child welfare, child care, transportation, and legal services.
- Specialized long-term residential programs serve the highest-risk substance abusing women and their children. Ongoing assessment is designed to identify needs through systematic collection of data to determine current status and needs in fiscal, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility domains.
- The purpose of long-term residential care is to provide necessary components of a positive recovery environment. Eligibility at this level of care is based on minimal withdrawal complications.
- Specialized long-term residential care includes structured clinical services staffed by qualified addiction treatment personnel who provide a planned regimen of patient care in a 24-hour live-in setting.
- Specialized PPW programs offer a number of enhancements, including the availability of therapeutic childcare for children under six (one or more children may participate while the mother is in treatment). Additional services include a focus on domestic violence, childhood sexual abuse, linkage to medical care and legal advocacy, mental health issues, employment skills and education, and safe, affordable housing.
- High-risk substance abusing PPW need a safe and stable living environment to stabilize, develop, and maintain sufficient recovery skills. The purpose of transitional housing is to provide up to 18 months of safe housing and support services for women who are pregnant, postpartum, or parenting and their children in drug and alcohol-free residences.

PRIORITY POPULATIONS /CLIENT PROFILE:

- Substance abusing pregnant women with children under age 6 (in or out of the home care, unless parental rights are terminated).
- Substance abusing pregnant women not already receiving chemical dependency services.
- Substance abusing pregnant women already receiving chemical dependency services.
- Non-pregnant substance abusing women with children under age 3 (in or out of the home care, unless parental rights are terminated).

COLLABORATING AGENCIES:

The comprehensive pilot program works closely with community service providers to ensure services are available and accessible to meet the needs of women and their families. Many agencies work as referral sources and notify the Targeted Intensive Case Managers (TICM) of eligible clients for participation in the program. TICM's work closely with the PPW residential, outpatient and transitional housing programs.

Original: ❑ TICM file
Copy: ❑ Referral
❑ Physician (if appropriate)
❑ CD Treatment Service(s) (Residential, Transitional Housing, Outpatient)

Appendix C: Study Description

COMPREHENSIVE PROGRAM EVALUATION PROJECT

Study Description

You are eligible for a new program that provides pregnancy care and drug treatment services to women and their young children, such as:

- Prenatal and well-baby care
- Treatment for drug and alcohol use
- Short-term housing
- Parenting education

Taking part in this program means that you may be referred to other services as needed.

This program will be evaluated to find out if it works. This involves giving permission to release confidential records to the research team. The research team may need to talk with the agencies that provide program services to you so they can get complete information to evaluate the program.

This study is voluntary. You can refuse to release confidential records without losing any program services available to you.

What is the study?

Researchers from DSHS Research and Data Analysis are studying this program to see if it helps women and their young children. They want to find out what type of services women and children need. They want to know if these services change the lives of mothers and their children and the best way to offer these services in other communities.

What would I be asked to do?

To study this program, the researchers will ask your permission to use information about:

- Your participation in this program and the services you receive
- Your drug and alcohol treatment
- The health of your baby when he/she was born
- Private information on your baby's birth certificate

The researchers would combine this with information about:

- Your job history and the money you earned
- Your history of criminal arrests and convictions, if you had any
- Whether you are working with Child Protective Services

COMPREHENSIVE PROGRAM EVALUATION PROJECT

Study Description

How long will the study last?

The researchers are asking for this information for the 2 years before you give birth to 3 years after your baby is born. The study plans to end in 2004.

How will my privacy be protected?

The researchers will not use your name in any reports. All information about you will be locked in file cabinets. Only people working on the study will see and hear the information about you. The researchers will destroy all information that could identify you at the end of the study. **Information they collect about you will only be used to study this program, and no other reason.**

Who can I call if I have questions?

You can call Dr. Laurie Cawthon, or the project director, Dr. Yvette Farmer toll-free at (877) 890-2635. They are with the DSHS Division of Research and Data Analysis.

Revised: May 15, 2000

Appendix D: Consent for Release of Information

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Research and Data Analysis
PO Box 45204
Olympia, WA 98504-5204

Comprehensive Program Evaluation Project (CPEP)

M.L. Cawthon, M.D., Public Health Physician, Principal Investigator
(360) 902-0712
Yvette M. Farmer, Ph.D., Research Investigator, Project Director
(360) 902-0719

CONSENT FOR RELEASE OF INFORMATION

By signing this form, I, _____, give permission for
(Print complete client name)

_____ to release the following information to the
(Agency name)

researchers named above:

- My participation in the CPEP (including forms filled out by my case manager, discussions with program staff about the services I receive, and evaluations of my progress in the program);
- My alcohol/drug treatment records (including assessments about my risk of alcohol or drug use, and level of addiction); and
- Medical information about me and my newborn child, _____ (child name). This includes information about my pregnancy, the delivery of my baby, and my baby's health.

I also give my permission for these researchers to combine this with information about:

- My arrests and convictions in Washington State Patrol records and
- The number of hours I worked and the money I earned in Employment Security Department records.

Information from the State Patrol and Employment Security will cover 5 years. This includes the 2 years before the birth of my youngest child to the 3 years after the birth of my baby named above. The researchers will only use this information to find out if the CPEP works.

I can cancel this permission any time I want, except for information was already given to the researchers. This permission will end on January 1, 2004, unless I cancel it before then.

Subject's Signature	Print Name Here	Date
Subject's Signature	Print Name Here	Date
Other Responsible Person	Print Name Here	Date

cc: Client
Treatment Agency
Researcher

Revised: May 15, 2000

Appendix E: Client Intake Form

CPEP CLIENT INTAKE FORM

Date _____/_____/_____ SSN _____-_____-_____

Name _____ _____ _____
Last First M.I.

Address_____
Street Apt.
_____
City State Zip

Referral Source (Please check one)

_____Physician
_____CSO Staff
_____Law Enforcement Staff
_____CPS Staff
_____Other_____
Specify

Is Client currently on TANF? _____Yes _____No

Medicaid ID# _____

Pregnancy Status

_____ Pregnant Expected Due Date _____/_____/_____

_____ Not Pregnant Baby's Name _____
Last First M.I.

Date of Birth _____/_____/_____

Baby lives with (Please check one)

_____ Mother _____ Father
_____ Grandparent(s) _____ Other Relative
_____ Friend _____ Foster Family
_____ Other _____
Specify

Revised 02/01/00

Other Children

Please list the names and dates of birth of all children currently living with the client.

Name (first and last)	Date of Birth
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

Please list the names and dates of birth of all children currently living with someone else (e.g., another relative, foster family, etc.).

Name (first and last)	Date of Birth
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

Note to Case Manager: Please attach Addiction Severity Index to this form

Revised 02/01/00

Appendix F: Screen: Substance Use Risk

Comprehensive Pilot Program for Substance Abusing Women and Their Young Children

❑ Snohomish County
❑ Whatcom County
❑ Benton-Franklin Counties

Client Name: _____ PIC: _____ SSN:_____

SCREEN: SUBSTANCE USE RISK
To be administered face to face with the client

I. If client is **known to be using** alcohol or other drugs, check boxes in Section I only and go on to Section IV.

	Self Identification	Positive Medical Finding	Court Related History	Other (please specify)
ALCOHOL	❑	❑	❑	❑
OTHER DRUG	❑	❑	❑	❑

II. If client is not known to be using alcohol or other drugs, please ask the following questions (4P's)

❑ yes ❑ no 1. Has either one of your parents had a problem with alcohol or drugs?
❑ yes ❑ no 2. Does your partner have a problem with alcohol or drugs?
❑ yes ❑ no 3. Have you had a problem with alcohol or drugs in the past?
❑ yes ❑ no 4. Have you used any drugs or alcohol during this pregnancy? (Mark yes, even if not currently using, as deserves follow-up.)

If client answers YES to either question 3 or 4, then follow up with CAGE questions (5 through 8) and check the boxes.

❑ yes ❑ no 5. Have you ever felt (do you feel) the need to cut down the amount you drink or use drugs?
❑ yes ❑ no 6. Have you ever been (do you get) annoyed or angry because someone criticized your drinking or drug use?
❑ yes ❑ no 7. Have you ever felt (do you feel) guilty about your drinking or drug use?
❑ yes ❑ no 8. Have you ever had a (do you ever) drink or use drugs first thing in the morning to steady your nerves or to get you going (as an eye-opener)?

III. Any YES answer to questions 2-8 indicates use or significant risk of use, these clients are Comprehensive Pilot Program eligible. (You may decide risk exists, regardless of screening responses.) Do responses indicate:

❑ USE ❑ RISK OF USE ❑ NO RISK (2-8 negative, and no other indicator of risk)

If use, or risk of use, what? ❑ alcohol ❑ other drugs ❑ both ❑ don't know

IV. If use or risk of use determined, what is your plan for the client?

❑ Targeted Intensive Case Management ❑ Maternity Case Management ❑ Maternity Support Services

Comments:
_____

_____ _____ _____ _____
Printed Name Signature Agency Date

Original: ❑ TICM file
Copy: ❑ Research and Data Analysis (RDA) (**Yvette Farmer; PO Box 45204; Olympia, WA 98504-5204**)
❑ Referral
❑ Physician (if appropriate)
❑ CD Treatment Service(s) (Residential, Transitional Housing, Outpatient)

This form is used for research purposes, please do not alter.

Appendix G: Client Self-Evaluation Form (Intake)

Comprehensive Program Evaluation Project (CPEP)

CLIENT SELF-EVALUTION FORM (Intake)

Name_____ Date_____

Please read the following statements and indicate your feelings using the following scale:

1 – Strongly Disagree (SD)
2 – Disagree (D)
3 – Neutral (N)
4 – Agree (A)
5 – Strongly Agree (SA)

	SD	D	N	A	SA
My children go to bed about the same time each night	1	2	3	4	5
I never really learned how to find a job.	1	2	3	4	5
I feed my children when they are hungry.	1	2	3	4	5
My family members rarely argue with one another.	1	2	3	4	5
I hug my child as often as I can.	1	2	3	4	5
I can safely use small amounts of illicit drugs.	1	2	3	4	5
I need a lot of help with transportation.	1	2	3	4	5
My children bathe regularly.	1	2	3	4	5
I am frustrated most of the time.	1	2	3	4	5
I am too lenient when my child misbehaves.	1	2	3	4	5
Drugs are not really that dangerous.	1	2	3	4	5
My stress level has decreased lately.	1	2	3	4	5
I rarely talk to my children about their day.	1	2	3	4	5
I can handle most of my problems.	1	2	3	4	5
My family members usually cooperate with each other.	1	2	3	4	5
I need help with my parenting skills.	1	2	3	4	5
I believe that I will lead a drug-free life.	1	2	3	4	5
I look forward to receiving training in this program.	1	2	3	4	5
I understand that using drugs can harm a baby.	1	2	3	4	5
My family members support my sobriety.	1	2	3	4	5
I often lose my temper when my child misbehaves.	1	2	3	4	5
I need to get help with housing.	1	2	3	4	5
I have a better outlook on life.	1	2	3	4	5
I discipline my children when they misbehave.	1	2	3	4	5
People think that I have a negative attitude about things.	1	2	3	4	5

Revised 02/01/00

TARGETED INTENSIVE CASE MANAGEMENT (TICM)
Monthly Services Report

Date ___/___/___ Case Manager _____

CLIENT NAMES	TICM CLIENT -RELATED SERVICE TIME	CD TX	BEHAVIORAL HEALTH	CHILD DEVELOPMENT	PARENT EDUCATION	TRANSITIONAL HOUSING	TRANSPORTATION	FAMILY PLANNING	WORK	CHILDCARE	WIC	VOTE	OTHER
ALL SERVICES													

1. For TICM Client-Related Service Time: indicate the total number of hours spent this month providing both face-to-face and non-face-to-face services to each client.
2. For all services columns except OTHER: use a "P" to indicate services that case managers provided; and use an "X" to indicate that services were provided by someone else.
3. For OTHER Column: use the following guide to indicate type of service provided – BN = Basic Needs
   DC = Dental Care
   DV = Domestic Violence Services
   MC = Medical Care
   MH = Mental Health Care
   VC = Vision Care

Revised 01/31/00

Appendix I: Monthly Update Form for Residential Providers

MONTHLY UPDATE FORM FOR RESIDENTIAL PROVIDERS

Date _____/_____/_____ Provider Name _____

Please enter the date of admission and discharge, if applicable. Then, indicate the status of each client where appropriate (e.g., still in treatment, treatment completed, left AMA, rules violation, unable to find, etc.).

CLIENT NAME	ADMISSION DATE	DISCHARGE DATE	STATUS

Revised 02/01/00

Appendix J: Monthly Update Form for Transitional Housing Providers

MONTHLY UPDATE FORM FOR TRANSITIONAL HOUSING PROVIDERS

Date _____/_____/_____ Provider Name _____

Please enter the date of admission and discharge, if applicable. Then, indicate the status of each client where appropriate (e.g., still in housing, secured permanent housing, left without notice, etc.).

CLIENT NAME	ENTRY DATE	EXIT DATE	STATUS

Revised 01/02/00

Appendix K: Newborn Health Status

NEWBORN HEALTH STATUS

Date _____/_____/_____ Completed by: _____

Mother's name _____ Mother's DOB_____/_____/_____

Medicaid ID #_____

Baby's name _____ Delivery Date _____/_____/_____

Baby's weight _____lbs. _____oz. Apgar Scores (1 minute) _____
(5 minute) _____

NICU use:

☐ No
☐ Yes ----------Length of stay in NICU: _____days

Gestational Age: _____weeks

Please indicate pregnancy complications:

☐ Abruptio placenta
☐ Placenta previa
☐ Multiple births
☐ Preclampsia/Eclampsia
☐ No Prenatal Care
☐ Other: _____

Method of Delivery:

☐ Caesarean
☐ Vaginal

Was the mother given a Breathalyzer and/or Urine/Blood Toxicology Screen?

☐ No
☐ Yes ---------- ☐ Alcohol
☐ Drug(s)_____

In your opinion, has this child been affected by drug or alcohol use?

☐ No
☐ Yes

What criteria did you use to make this determination?

_____

_____

Revised 0 2/01/00

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