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MEMORANDUM

To: DHW/BPA PWWC PROVIDERS  
DATE: March 15, 2010  
FROM: Sherry L. Johnson, Program Specialist   
Bethany Gadzinski, Bureau Chief, Bureau of Substance Use Disorders 

SUBJECT: DRAFT OF 'Pregnant Women and Women with Children (PWWC) Treatment Service Continuum'

We would like to take this opportunity to thank you for your participation in the meetings held on January 07, 2010 and February 18, 2010 in which DHW, BPA, and the PWWC Specialty providers gathered. During this time we discussed the PWWC audit results, special issues pertaining to treating this population, funding, and revisions to the 'Pregnant Women and Women with Children (PWWC) Treatment Service Continuum – State of Idaho Department of Health and Welfare' guideline.

During our 02/18/2010 session the question was posed – 'What constitutes a Best Practice?' I contacted Kara Mandell, AOD Research Analyst - National Association of State Alcohol and Drug Abuse Directors, who has worked closely with the Center for Substance Abuse Treatment (CSAT) Women's Treatment Coordinators. Kara responded 'There is no formal definition of best practices. They can be anything that a State or provider identifies as leading to good outcomes. On the other hand, evidence-based practices must be shown to produce positive outcomes through rigorous empirical experiments (most preferably a study where clients are randomly assigned to one of several interventions). Evidence based practices also must be replicated in different places and among different populations unless otherwise noted. Some details about the definition of evidence based practices can also vary, and different people use different metrics to define what amount of research is necessary (for example, Oregon requires that practices must be supported by two peer reviewed publications).

SAMHSA maintains a registry of evidence-based programs and practices ([www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)), some of which address family relationships, parenting and services for children. You can search for any of your key words to find applicable programs. You might look at [Celebrating Families](#), [The Incredible Years](#), and [Strengthening Families](#). Unfortunately, many of the programs in the registry are proprietary, and expensive to implement. We're also working with the National Center to identify States that do a good job providing services to children whose parents enroll in substance abuse treatment to learn more about what those States do; that product should be available this summer.'

Just announced, The Women's TIP is now available! TIP 51, *Addressing the Specific Needs of Women*, reviews gender-specific research and best practices regarding the specific substance abuse treatment needs of women. This TIP provides practical clinical and administrative information to help respond to these treatment needs, including information about specific treatment issues and strategies across substance abuse treatment services  
<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=tip51>

Please review the attached Draft and let me know if you have any corrections. I would appreciate any revisions by March 26<sup>th</sup>, 2010. You can send them to me directly: [JohnsoS2@dhw.idaho.gov](mailto:JohnsoS2@dhw.idaho.gov).

**Pregnant Women and Women with Children (PWWC)  
Treatment Service Continuum  
State of Idaho Department of Health and Welfare  
(Revised March, 2010)**

The purpose of this outline is to foster the development of a state-of-the-art recovery for women with substance use disorders and to foster the healthy development of the children of substance-abusing women in the State of Idaho. The goal, in Idaho, of substance use disorders services is to support a woman's journey to a healthy lifestyle for herself, and for her family whenever possible. Because alcohol and drug dependent women tend to have few economic and social resources, comprehensive treatment is extremely important. The purpose of comprehensive treatment is to address a woman's substance use in the context of her health and her relationship to family, community, and society. This relationship is influenced by gender, culture, race and ethnicity, social class, sexual orientation, and age.

Treatment that addresses the full range of a woman's needs is associated with increasing abstinence and improvement in other measures of recovery, including parenting skills and overall emotional health. Treatment that addresses alcohol and other drug abuse only may well fail and contribute to a higher potential for relapse.

**Section A: Assessment and Evaluation for Pregnant Women and Women With Dependent Children (Includes Women Who are Attempting to Regain Custody of Those Children)**

The Addicted Mother

It is required that a GAIN-I assessment of the women take place with the expectation that all clinical indicators (treat/defer/refer) are executed by the provider as required.

The woman needs to be assessed by a Qualified SUD Professional with assurance that her disclosure is confidential according to the CFR 42 Federal Guidelines. The women's legal circumstances need to be reviewed and fully understood. If she is on probation, in Drug Court, involved with Child Protective Services or on parole, effort should be made to obtain appropriate consents for information sharing and to develop an effective team approach to her services. There is a greater probability of effective services and positive outcomes if the treatment system and the criminal justice system collaborate in the spirit of creating a safe and non-shaming environment for the woman suffering addictive disease, while assuring the required accountability of legal requirements.

In coordinating the treatment activities with the provision of other appropriate services (which includes health, social, correctional, criminal justice, education, vocational rehabilitation, and employments services) the treatment provider must utilize written agreements with other agencies. The written format for this collaboration shall be in the form of Memorandums of Understanding (MOU) or Memorandums of Agreement (MOA). The treatment provider will record documentation of collaboration in the client record.

### Children's Assessment

The Provider may either provide the following services or arrange for the provision of the evaluations/assessments. This is pertinent primarily to residential services and intensive outpatient programs that offer the component of integrating children's therapy and child care services – often day programs. Additionally, this would include the existing programs in which services are currently provided at programs with the designation of Half-way house program approval certification, in which children are included in the living arrangements with their mother. The key is that the children are treated in the same setting as their mother.

1. Documentation of a medical screening which includes immunization and fetal alcohol/drug effects
2. The Qualified Professional needs to collect collateral information from involved Mental Health, Child Protection, or other agencies at admission. This will assist providers in understanding family dynamics at admission. This would include any history of sexual or physical or other abuse issues the child has incurred. This gives the therapist insight into the acting out potential of the child in addition to the clinical needs that will present themselves while the child is in the treatment environment. The collateral information needs to include the previous goals established for the woman and her children for post-discharge. This allows for proactive treatment planning and effective collaboration with involved agencies.
3. A developmentally-focused screening may be done by Infant/Toddler program staff, the Early and Periodic Screening, Diagnosis and Treatment Service Coordinator, the child's local school, or, if the child is in foster care, the foster care program.

The provider needs to engage minor children that do not reside with, or are not treated in the same setting as their mother, in the treatment process as much as possible.

1. Treatment plans include family reunification goals with children
2. Documentation of screening, evaluation and assessment services arranged for or provided by the agency

Continued monitoring of children in the treatment setting is necessary as the children will likely act out the effects of having lived in an environment affected by addictive disease and trauma.

## Section B: Medical Interventions

It is preferable to have a healthcare professional available to consult directly with the program. It is imperative to note that Block-Grant funded programs must use the Block Grant as the 'payment of last resort' and only for those who have no other financial means for obtaining services for pregnant women and women with dependent children.

- ❖ **Medical assessments** and subsequent care should be provided through arrangements with healthcare facilities accessible to individuals in the community or on-site, and should include the provision of preventive and primary medical care (including prenatal care, if appropriate); medical or medically supervised detoxification services, where clinically indicated; linkage to psychiatric care; provision of or established referral linkages as needed for acute medical care; testing and treatment for hepatitis, tuberculosis, HIV and HIV disease, sexually transmitted diseases, anemia and malnutrition, hypertension, diabetes, cancer, liver disorders, eating disorders, gynecological problems, dental and vision problems, and poor hygiene.
- ❖ **Women's Health Services.** Pre/post-natal care should be provided either on-site or through referral, for nutrition, family planning, and general gynecological services to those women deemed appropriate.
- ❖ **Pharmacotherapy intervention** should be provided on an as-needed basis and should include provision of, or established referral linkages, for concomitant assessment and monitoring by qualified medical or psychiatric staff. Interventions should promote equal access to treatment for all women based on assessment of their ability to participate in treatment.
- ❖ **Urinalysis** should be used where clinically appropriate, and should be conducted on an initial and random basis. The program should follow informed consent guidelines responsive to State reporting requirements, if applicable.
- ❖ **Infant and Child Health Services.** Infant and child health services should be provided either on-site or through referral and should include the following: primary and acute healthcare for infants and children, including immunizations, nutrition services (including assessment for WIC eligibility), and a developmental screening by qualified personnel. For treatment programs without medical personnel on-site, a back-up medical plan that identifies a protocol for pediatric emergencies must be in place.
- ❖ **Community Based Support.** Public health nursing and/or social work visits should be provided to high-risk postpartum women and their infants, especially to new mothers and those who are discharged within 24 hours after delivery. Linkages and referrals should be established with community based agencies.

- ❖ **Counseling for HIV-positive/AIDS Patients.** The program must provide for pre- and post-test counseling for HIV-positive/AIDS patients as well as individual counseling and support groups. Staff should be properly trained to intervene on behalf of those who are HIV-positive, whether symptomatic or asymptomatic. The training would include sensitivity when counseling this population and identification of community resources. Appropriate care for HIV-positive children must also be assured.

### **Section C: Treatment Services for Women and their Children Across the Continuum of Care:**

This section will focus on treatment services pertinent to all three (3) proposed Levels of Care for Pregnant Women and Women with Dependent Children (Halfway House (III.1), IOP and OP) in the State of Idaho. *(ALL ASAM LEVEL OF CARE REQUIREMENTS MUST BE A PART OF THESE PROGRAMS AS OUTLINED IN THE MOST CURRENT VERSION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE PATIENT PLACEMENT CRITERIA).* These items include physician availability and other standards.

The following Levels will outline the proposed clinical content that would meet that standard. The same Best Practice models, approaches, and promising programs need to be offered as a part of each level of care based on the level of care's hour requirements. This will assure continuity of care in addition to quality of care across the spectrum. It will also demand collaboration between those clinicians providing different levels of care.

### **Recommended Treatment Components for Outpatient and Intensive Outpatient Level of Care:**

The goal is to offer a consistent clinical repertoire to all levels of care serving the PWWC clientele. These are the recommended core components to be implemented according to the ASAM-driven criteria and IDAPA standards for each level.

The Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Women with Co-Occurring Disorders and Violence Study (WCDVS) was one of the first large-scale studies to investigate promising models for treating women with complex problems. Four Trauma-specific and integrated models of treatment for substance abuse clients with trauma histories, symptoms, or posttraumatic stress disorder (PTSD) were utilized in the study. Each of these models focused on the first stage of treatment: establishing safety and stabilization. The models are listed below. In addition to the other structured programming, during the course of treatment the provider will incorporate one of the models below (or similar evidence based, gender-responsive model):

1. **ATRIUM** – The Addictions and Trauma Recovery Integration Model (Miller & Guidry, 2001)
2. **HELPING WOMEN RECOVER** – Developed by Stephanie S. Covington at the Institute for Relational Development (Covington, 1999).
3. **SEEKING SAFETY** – Developed by Dr. Lisa Najavits at Harvard Medical School/McLean Hospital under a grant funded in 1992 by the National Institute on Drug Abuse (NIDA) (Najavits, 2002)
4. **TRAUMA RECOVERY AND EMPOWERMENT MODEL** – Developed by Dr. Maxine Harris and colleagues at Community Connections in Washington, DC (Harris, 1998)
5. **TRIAD** – Developed by and implemented at one of the WCDVS sites (Herman, 1992a, 1992b)

Gender-responsive treatment involves respect for the power abuses that the female client and her child (ren) have incurred in their lifetimes. It is imperative to create an atmosphere of safety in order to prevent a reenactment of abuse. If power abuse prevails in the treatment setting the woman will simply maintain a defensive posture, move into an adaptive pattern and leave treatment without freely sharing or internalizing information that will build her skills in recovery. This is why Motivational Interviewing and Motivational Enhancement Therapies are the best approaches to integrate in a gender-responsive setting. They are empowering and respectful, and focus on the building of intrinsic skills even if there are external pressures to get help.

Women have very special needs in the group setting in treatment. In order to be considered gender-responsive and “A Healing Environment” Stephanie Covington emphasizes the following (p. 27, “Helping Women Recover”):

**SAFETY:** *It is free of physical, emotional, and sexual harassment.*

*Spoken and unspoken rules of conduct provide appropriate boundaries. Although it may be impossible for the facilitator to guarantee safety in her agency or institution, it is imperative that the group be a safe place.*

**CONNECTION:** *Exchanges among the facilitator and group members feel mutual rather than authoritarian. The group member's sense that the facilitator wants to understand their experience, is present with them when they recall painful experiences, allows their stories to affect her, and is not overwhelmed by their stories. The facilitator respects each woman's uniqueness while affirming ways in which she and women are alike. As the facilitator models this kind of mutual, empathic, respectful, compassionate connection, similar connections grow among the women.*

**EMPOWERMENT:** *The facilitator models how a woman can use her power with and for others, rather than either using power over others or being powerless.*

*She sets firm, respectful, and empathic limits. Rather than reacting out of her own sadness, anger, or helplessness, she models how to take responsibility for those feelings and sets limits that do not blame group members. She encourages group members to believe in and exercise their abilities. As the women watch one another begin to exercise power by speaking and acting, they grow more comfortable exercising their own power.*

In building strong and effective gender-responsive addiction treatment programs all of these issues need to be assessed on an ongoing basis by treatment providers. In addition to the other structural programming, during the course of treatment the provider will incorporate one of the models below, or a similar evidence based or best practices, gender responsive model.

### **The Evidence Based Practices for Addiction Treatment:**

#### “Matrix”: including continuing care:

This is a cognitive-behavioral treatment program for the treatment of addiction that the State advocates as a best practice in their residential and intensive outpatient programs. It also includes a family component therefore, the Multi-family Group is recommended for each level of care. This is also a manualized treatment program that can assure evidence-based positive outcomes and treatment consistency if implemented with fidelity to the model. Most treatment providers are trained and using Matrix at this time. Matrix Model consultants state that the program is based on Motivational Interviewing and Motivational Enhancement Therapies. Its proactive, non-confrontive, proactive treatment style is part of its success. Matrix Model must be used in its entirety as the basis of any program and then adjunct clinical services can be added as needed (in this case it would be the “Helping Women Recover”).

#### Motivational Interviewing and Motivational Enhancement Therapies:

The interviewing is a style and a technique that involves rolling with client resistance in a respectful manner. The goal is to assist the client in gaining intrinsic motivation as opposed to just extrinsic/external motivators that will carry them toward recovery. Motivational Enhancement Therapies support treatment interventions that match a client’s current level of motivation and stage of readiness to change. This is different than traditional models that “confront denial”. The current research supports the effectiveness of meeting a client at their level of motivation and stage of readiness to change and assisting them in resolving the natural ambivalence that people experience when considering any change in their lives. This model also advocates the trust-building and safety needs that women and their children need to recover.

“Celebrating Families...An Educational Support Group for Parents in Early Recovery and Their Children: (or other best practices program, contingent upon the level of care) What makes this program special is that it is adapted to educate and support parents in early recovery in gaining communication skills pertinent to enhancing their relationships with their children. The children receive education and support along with their parent. The “Celebrating Families” Curriculum Manual (p.5) describes the programs Objectives as:

1. To break the cycle of addiction in families by
  - a. Providing a safe, nurturing place for participants (children and parents) to talk and explore their feelings and choices
  - b. Facilitating trust through a process of bonding with consistent role models
  - c. Assisting participants in developing their self-awareness and self-worth
  - d. Educating participants about chemical dependency as a disease and how it affects family members
2. To decrease participants' use of alcohol and other drugs by increasing their knowledge and use of healthy living skills:
  - a. Participants will develop better communications skills
  - b. Participants will learn how to appropriately express their feelings
  - c. Participants will be able to demonstrate anger management skills
  - d. Participants will increase their knowledge of the impact of alcohol, prescription and illegal drugs on children, individuals, and families.
  - e. Participants will be able to use problem solving and decision making skills.
  - f. Participants will develop coping skills to deal with stressful situations.
  - g. Participants will develop a list of resources they can turn to for help.

“Celebrating Families” is a psycho educational support program that includes just parents and their children. The Multi-Family Group (when appropriate) includes all those in the family who has been impacted by the disease and is based on the Matrix Model.

**Idaho Infant Toddler Program:**

Each family entering state funded substance abuse treatment with an infant or toddler may meet criteria for access to the Idaho Infant Toddler Program. The program includes the following components:

- Evaluation and Assessment — activities to determine a child's current developmental status;
- Individualized Family Service Planning — a plan that addresses the child's and family's unique needs;
- Early Intervention Services — therapeutic and support services provided in a "natural setting" such as the home or a childcare center;
- Service Coordination — activities which ensure needed services are available, accessible, and cost-effective;
- Procedural Safeguards — parent's rights which guarantee timeliness and confidentiality;
- Transition Planning — procedures to help families access appropriate services when a child leaves the Infant Toddler Program;

Additional information regarding this program can be found using the following link:

[http://www.healthandwelfare.idaho.gov/Portals/Rainbow/Manuals/FACS/ITP\\_eManual/Idaho Infant Toddler Program\\_eManual.htm](http://www.healthandwelfare.idaho.gov/Portals/Rainbow/Manuals/FACS/ITP_eManual/Idaho_Infant_Toddler_Program_eManual.htm)

**Level III.I: “Clinically Managed Low Intensity Residential Treatment Services” or Halfway House Living:**

Women entering this level of care meet the ASAM criteria for Level III.I. According to ASAM requirements for this level of care, the women need to receive at least 5 structured clinical groups per week. It is recommended that these 5 hours include:

- ❖ 1 Hour of Gender-Responsive Group
- ❖ 1 Hour of Matrix-Modeled Group geared toward Continuing Care
- ❖ 1.5 Hours of Evidence Based Family Marital Life Skills (For the women and children)
- ❖ 1.5 Hours of Multi-Family Group

Please note that the above is the minimum based on ASAM Criteria. Ideally a woman and her children would initially receive at least 9 hours of addiction treatment, which is equivalent to Level II.I, Intensive Outpatient Service. Additional non-clinical requirements include a weekly House Meeting, weekly Family Management Skills group, daily structured or unstructured family time, and attendance at 12-Step Groups. (Preferably including a Women’s-only Meeting) These women will be re-entering the work force and/or school or vocational training and their children will be busy at their studies and re-entering, also. This is an “interim” level whereby the woman is working toward implementing her Continuing Care Plan and gaining support while she and her children re-establish themselves in the community.

**Level II.I (Intensive Outpatient Service)**

ASAM-driven Intensive Outpatient Treatment for Women and their children requires at least 9 hours of addiction treatment. Ideally, the IOP for PWWC population would offer hours for the client that is working or is in school during the day.

**Level I (Outpatient Services)**

Level One Outpatient Treatment involves the same design as above, but less than 9 hours per week. The woman and child’s treatment schedule is designed as needed based on the treatment plan using the same menu of treatment components.

**D. Case Management**

Addicted pregnant women and women with children face a complex array of issues that impact their ability to be drug-free and sober and to raise healthy children. Because of this, Case Management Standards for Recovery Support Services (RSS) must be incorporated into the treatment services. Case Management services must include service planning, linkage to other services, client advocacy and monitoring service provisions. The provider must ensure that the Case Management Service Plan for a PWWC client will provide for the following services:

### **1. Achieving and maintaining abstinence from drugs and alcohol:**

Clients will be encouraged and supported to stop using drugs and alcohol; connect them to inpatient and outpatient treatment programs and housing support services; arrange for the transportation of clients to assessment and treatment for chemical dependency if needed; connect clients to drug testing and drug courts as appropriate; help mothers secure child care; contact women by phone or mail while in treatment; help clients maintain compliance with treatment, and advocate on their behalf.

### **2. Stabilizing mental health problems and improving behavioral health issues:**

Advocate for mental health services as indicated and encourage clients to use these services and to follow through with recommended treatment, including taking medications as prescribed.

### **3. Developing a healthy alcohol/drug-free social support system:**

Work with clients to develop new relationships and hobbies or other recreational activities that do not involve drugs or alcohol. These may include participation in Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings, joining groups that explore emotions and relationships, or getting involved in local sports or religious events.

### **4. Facilitating positive parent-child relationships:**

Work with the Regional CP/SA Liaison Caseworker to provide advocacy and support for their clients.

- ❖ Attending court hearings whenever possible
- ❖ Attending necessary staffing with CPS and client's attorney
- ❖ Communicating with the CP/SA Liaison about client progress
- ❖ Advocating for the client's child to be reunited with client while the client is in treatment
- ❖ Observing parenting skills whenever possible and providing feedback
- ❖ Arranging for or providing transportation to supervised visits with child
- ❖ Connecting clients with parenting classes and with court ordered services
- ❖ Working with community agencies and the CP/SA Liaison in order to get more services placed in the home
- ❖ Assisting with the transition of the children to the home
- ❖ Seeking dependable housing
- ❖ Connecting clients with behavioral specialists
- ❖ Arranging intensive family services
- ❖ Working as a team with the CP/SA Liaison and the client, helping the client to see the CPS worker in a more positive light, not as 'the enemy'

**5. Finding long-term, safe, and drug-free housing:**

Assist clients with accessing housing through Section 8 (Housing Authority), Habitat for Humanity, domestic violence services, local shelters, transitional housing, or Shelter Plus Care. The assistance will include help with applications, advocacy, transportation, encouragement and motivation. Case managers will also assist clients by helping them comply with the housing program's regulations.

**6. Increasing self-sufficiency and capability for independent living**

Connect clients with appropriate referrals for community education and support and provide advice and encouragement. Assist clients in obtaining a driver's license or a bus pass and learning to ride the bus, agencies offering classes on healthful cooking, budgeting, parenting, etc. When appropriate, case managers will assist clients with enrollment in TAFI and food stamps.

**7. Reducing involvement with the criminal justice system:**

Provide support and encouragement to help clients understand and resolve the consequences of their behavior. Encourage clients to keep appointments with their probation officers, and follow all recommendations of the court. If appropriate, accompany clients to court, and advocate for clients through letters to the court. Appropriate consents to share information will be encouraged to facilitate a team approach that integrates treatment with criminal justice system requirements and interventions.

**8. Attaining educational goals:**

Assist women in furthering their education; provide information, transportation, and assistance with applications or financial aid for community GED programs, job training programs or higher education.

**9. Obtaining medical and dental care:**

Assist with referring clients to suitable medical and dental providers, making sure that transportation to and from each of the appointments has been arranged. Remind clients to follow through with appointments and treatment.

**10. Obtaining and using an effective family planning method**

Provide needed information on ways to access services, and motivation to take charge of their family planning needs. Encourage and assist clients in learning about and accessing birth control methods through agencies such as Planned Parenthood, and provide transportation when needed. Help the clients receive the monetary support available for such services.

**11. Improving job skills and work readiness:**

Support clients by discussing their employment goals, and by referring them to agencies such as IdahoWorks, Vocational Rehabilitation, Goodwill Industries, or community trades and careers programs as appropriate.

**12. Respite Care:**

Support clients by helping to create a plan for respite care for the child(ren) if the client needs a break or “timeout”.

Original Document 2005:

Bethany Gadzinski, Department of Health and Welfare, 2005

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Sherry L. Johnson, Department of Health and Welfare, 2007

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