Semi-Annual Report
Rocky Mountain
Quality Improvement Center Grantees
Idaho Pre-Treatment Program

July 2004

Prepared by
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I. Introduction

A. Description of the Program.

Substance abuse treatment, particularly tailored to the needs of women and parents, is under-funded and insufficient to meet national needs. In Idaho, when substance abuse treatment was at capacity in June 2002, the average waiting period for substance abuse treatment was 23.1 days, and there was a 27.5% drop out rate during the interim period. An assumption of the proposed Pre-Treatment program for the three Idaho Department of Health and Welfare (IDHW) regions is that parents are more likely to enter and complete treatment if supported and encouraged during the wait period. In addition, parents who need substance abuse treatment and complete it will be more successful in keeping their children at home, or in reuniting with them (if separated by Child Protective Services, CPS). A strong body of research suggests that using motivational interviewing counseling strategies improves the rate of entry and retention in substance abuse treatment (Miller & Rollnick, 2002).

The purpose of the Pre-Treatment program is to maintain contact with the parent during the waiting period for treatment, help the parent stay engaged through supportive individual and group meetings, and increase the motivation for treatment entry. Eligible participants are parents who have been referred to child protection and have potential substance abuse issues. The children of these parents must be at home or just recently placed in shelter care.

The program is being implemented in three Idaho Department of Health and Welfare regions of the state: Region I, northern Idaho; Region III southwestern Idaho; and Region IV, south central Idaho. At the heart of the program is locating three different Substance Abuse Liaisons (SALs) in the Child/Family Services (CFS) offices in each of these regions. The SALs provide substance abuse assessments, direct referral to the treatment provider, and pre-treatment services until entry into treatment. The goals of the pre-treatment program are to 1) engage parents while waiting for treatment, 2) increase motivation for treatment entry, 3) improve treatment retention/completion, and 4) decrease out-of-home placement and child protection re-referrals for abuse/neglect of the children during the intervention. Motivational Interviewing (MI) strategies (Miller & Rollnick, 2002) are being used to assess the parents' stage of change and support them through individual and group meetings while waiting for treatment.

B. Description of the Logic Model and Program Intervention

The primary interventions for the Pre-Treatment program are:

1) Build collaborations between DHW and substance abuse providers.

Collaborative relationships are designed to occur at multiple levels. At the management level, The Chief, Idaho Bureau of Child and Family Services (Chuck

Halligan) is Project Manager of the Pre-Treatment program. The Project Co-Manager is the Idaho Substance Abuse Project Manager (Pharis Stanger). The Substance Abuse Liaisons are contracted from local substance abuse treatment providers. They are officed within the Child and Family Service Office in the three regions. At the worker level, Child Protection social workers are the referral source for the SA Liaisons, who are readily available for consultation. Monthly conference calls include substance abuse provider representatives as well as the SA Liaisons, Program Managers from the three regions, the Project Manager and Co-Manager, the Director of Idaho Child Welfare Research and Training Center (ICWRTC), the Substance Abuse Trainer from ICWRTC and the project evaluator.

2) <u>Hire and train substance abuse liaisons in three regions of Idaho on the use of Motivational Interviewing techniques and documentation.</u>

Two SA Liaisons were contracted 16-20 hours a week through local substance abuse treatment providers to provide Pre-Treatment services and documentation. One SA Liaison in Region III was only able to work half-time providing SA assessments. However, another person will be trained to fulfill the other one/half of that position beginning fall, 2004. Training for the SA Liaisons has occurred on three different occasions; June 25-26, 2003; Oct 16-17, 2004; and Jan 6, 2004. A fourth training will be scheduled in August, 2004 to train the new one/half time SA liaison as well as provide a refresher training for the other liaisons. Motivational Interviewing training is provided by Carla Jakabosky, MSW, who is an experienced trainer, and the Substance Abuse Consultant from ICWRT. Training for documentation needed for the project evaluation was provided by Diane Davis, PhD, evaluator for the program.

3) <u>SA Liaisons will provide education and support to parents referred to the program through individual and group meetings.</u>

When Child Protective (CP) social workers have reason to believe that drug/alcohol abuse is a problem in a CP referred family, they can refer the parent(s) to the SA Liaison for a substance abuse assessment and direct referral to treatment if needed.

However, parents may not receive an assessment or access treatment immediately for several reasons: there may be a waiting list for the particular type of treatment; the parent may not perceive the need for treatment right away; or the parent has other situations that prevent immediate access to treatment (child care needs, jail time, etc). In such events, the SA Liaison utilizes a Motivational Interviewing approach to assist parents in finding intrinsic reasons that would motivate them to assess their alcohol or drug use, enter treatment, or to stay motivated to wait for treatment when it becomes available.

The SA Liaisons offer individual meetings or weekly support group meetings for the parents who do not enter treatment immediately. Child care and transportation are available for parents to attend meetings. In each meeting, parents will review their motivation for change using the Socrates motivational assessment instrument and develop written weekly goals for themselves, their children, and their family. Parents may attend until they are ready to enter treatment and/or when a treatment slot opens. Typically, the SA Liaisons meet

with Pre-Treatment families 3 to 4 times. The open-ended format means that parents may attend only one meeting or as many as needed.

When parents do enter treatment, the SA Liaison provides case coordination with the treatment facility. This includes providing a drug/alcohol assessment to the statewide substance abuse provider (BPA) for approval and facilitating treatment entry to the local provider (introducing parents to staff, describing program elements and expectations, etc.).

C. Description of the Program Evaluation Design

The basic evaluation design is described in the Logic Model included in Appendix A. The research hypotheses to be tested are:

1) Caregivers with substance abuse issues who complete substance abuse treatment will be more successful in keeping their children at home, or in reuniting with them (if separated by CPS).
2) Caregivers are more likely to enter and complete treatment if supported and encouraged during a wait period for treatment.
3) Motivational Interviewing strategies will increase treatment entry and completion.

Quantitative evaluation methods will include:

1) Comparing the participants of the Pre-Treatment program to an earlier baseline group of caregivers who did not have a substance abuse liaison on three measures: treatment entry/completion, recurrence of maltreatment, and whether the child was returned home.
2) Comparing the pre-treatment participants across other regions in the state on treatment entry/completion, recurrence of maltreatment, and whether the child was returned home.
3) Using a within group comparison of the MI problem recognition and taking steps scores (Socrates) at the beginning of the Pre-Treatment program and at the end of the program.

Qualitative evaluation methods will include:

1) Observations of the SA Liaisons to measure fidelity with use of MI techniques.
2) Periodic interviews with project partners, documentation of internal team meetings, and documentation of changed policies and procedures to measure improvements in communication, coordination, and collaboration among the liaisons, the provider agencies, and the DHW.
3) Interviews with selected clients to measure their evaluation of the Pre-Treatment program services.

Evaluation tools created by the design team include the Initial Data Referral Form, the Parent Data Form, Informed Consent Form, Weekly Goal Sheet, Pre-intervention Summary Sheet, Post-intervention Summary Sheet, and the Contact Sheet. In addition, a shortened version of the Socrates (Alcohol) and Socrates (Drug) is used to collect information on the caregiver's "problem recognition," and the extent to which they are "taking steps."

II. Process Evaluation Results

A. Program Implementation Activities and Experiences

1. What is the status of program implementation?

The pre-treatment program has been fully implemented in Regions I and IV. In Region III, the Substance Abuse Liaison position was filled with a person who could only work part-time during the school year. Consequently, although trained in the documentation and MI techniques, he could not implement the program fully until June, 2004, when he was able to work full-time through the summer. By September, 2004, it is anticipated that another part-time person can be hired to fill out the position during the next school year.

2. Did implementation occur as planned?

Implementation occurred as planned in terms of hiring the SA Liaisons, and training them in MI techniques and documentation. Hiring, however, was later than anticipated. Substance Abuse Liaisons for Region I and IV were hired in April, 2003 and the hiring for Region III was the end of July. Documentation changes and further training of the SA Liaisons pushed the beginning of data collection from June to October, 2004. Currently, the number of referrals in each region to the Pre-Treatment program is significantly lower than anticipated.

B. Program Start-up Activities

1. Finalizing and Operationalizing Project Proposal

The original project proposal was designed to build on the already existing pilot program in Region III and V, where a Substance Abuse Liaison had been contracted to perform drug/alcohol assessments (within the CFS office) with caretakers suspected of drug/alcohol problems in relation to their CP referral. As an extension of this popular pilot project and in response to growing waiting lists for substance abuse treatment throughout Idaho, the RMQIC proposal was designed to offer pre-treatment services during the wait period. The philosophy of Motivational Interviewing and the emphasis on client-centered practices were expected to enhance the client's abilities to identify their problems and to take steps to change in a more positive direction. The design and implementation team selected Regions I, III, IV for the Pre-Treatment program.

The design of the program has remained essentially intact; however, adjustments/challenges occurred prior to operationalizing the project:

1) <u>Staff continuity</u>.

Early in the implementation phase, there was a period of several months with no clear leadership of the project. Although the original Pre-Treatment project manager was slated to be Chuck Halligan, departmental reorganization and subsequent duties as State-wide Program Manager, Children's Mental Health, precluded his active involvement. In February, Mechelle Schoen,

Program Manager in Region III, was appointed as acting project manager of the grant. Communication problems regarding baseline data collection and grant implementation were reported. She subsequently resigned from the department the end of April, 2003. Shortly thereafter, Chuck Halligan resumed the position of the grant project manager.

A gap in staffing also occurred when the SA Liaison that was hired in Region III became a graduate student, and was unable to work the additional hours needed for the Pre-Treatment project. This problem has been temporarily solved this summer, when Tom is not in school. Plans are in the process to hire another part-time SA Liaison in Region III during the next school year.

2) Evaluation Requirements.

Although the original proposal was written and accepted with a minimum evaluation component (caretaker attitude changes and follow-through to substance abuse treatment), it became clear by June, 2003 that this was not an adequate design for the Request for Proposal requirements in the RMQIC grant. An outside evaluator, Diane Davis, PhD, was hired through the Idaho Research and Training Center in July, 2003. Subsequently, data collection instruments were redesigned and the project received IRB approval through Eastern Washington University. The implementation of the data collection system was delayed due to these unanticipated needs.

2. Staffing and Staff Training

Many CFS staff have and continue to contribute significant time and effort to the design and ongoing implementation of the Pre-Treatment program. These include Idaho Central Office staff: Chuck Halligan, Program Manager, Children's Mental Health (grant project manager); Shirley Alexander, Program Manager, Children and Family Services; Mardell Nelson, Manager, Planning, Evaluation and Training; Pharis Stanger, Program Manager, Substance Abuse; and Lynn Sanderson, Family and Community Services Planner. Regional Program Managers who contribute on a regular basis include Rob Gregory, Region I; Kurt Lyles, Region IV, and Art Dodson, Region III. Chiefs of Social Work include Brenda Evans, Region III, Randy Geib, Region I, and Carol Fowler, Region IV. Contributors from the Idaho Child Welfare Research and Training Center include Patty Gregory, Director and Carla Jakabosky, Substance Abuse Consultant/Trainer.

Staff hired specifically for the Pre-Treatment grant consists of three part-time SA Liaisons (16-20 hours a week) who are certified drug/alcohol counselors (CADAC), and one part-time evaluator (PhD).

Challenges and the strategies to overcome them include:

1) Building Relationships.

One of the principle anticipated challenges for the SA Liaisons was the development of positive relationships with the CP staff and local SA providers. Relationships with CP staff have been greatly enhanced by co-locating in the same office. Informal as well as formal contacts are occurring – not just about referrals to the SA Liaisons, but about questions that social workers have about substance abuse issues. Although the SA Liaison in

Region I has an office in a local SA provider office, she also has an office at the CFS office, and attends many meetings and staffings in that location. In addition, the SA Liaisons provided initial training to the staff on the scope and purpose of the grant, and continue to consult informally on case situations.

Relationships with SA providers in each region have been enhanced by having a consistent and reliable "go-between" on Child Protective cases to screen and assess drug/alcohol problems and "shepard" the paperwork through the BPA approval process. SA Liaisons have also provided Pre-Treatment services that enable clients to stay in a holding pattern until the SA provider has an opening. Relationships to the local providers have become so positive that in many cases, the SA Liaison client gets preferential treatment and access for their clients. This positive development is believed to have contributed to the decreased waiting list time for CP clients.

2) Hiring.

Since the number of personnel in the CFS is limited by legislative authority and there were no new positions available, the SA Liaisons for the Pre-Treatment program were hired and supervised by local substance abuse providers in each region. There was also the expectation that this arrangement would provide stronger linkages and collaboration, which would carry forward to the future. Timely hiring of the SA Liaisons was delayed by the possibility of changing the state-wide substance abuse contractor in the spring of 2003. In addition, it became very difficult to find a qualified person with substance abuse certification in Region III. For several months, Sue Rose Salmon, the SA Liaison hired for Region IV, carried out the activities for both regions until Tom Hogan was hired the end of July, 2003.

3) Application of Motivational Interviewing Techniques.

Making changes to the role of the substance abuse counselors has been challenging. Because the fundamental assumption of motivational interviewing is that the client is the "expert" on their life, and consequently the counselor role is to assist them in finding internal motivation for change at their own pace, the practices of motivational interviewing are different from the traditional, more "directive" or "confrontational" role of substance abuse counselors. In addition, CP social workers may also be putting pressures on the SA Liaisons to "get them into treatment" regardless of the parent's stage of change or motivation to change. Additional training for two days in October, 2003 and another day of training in January, 2004 was helpful in surfacing SA Liaison concerns about the model and how it could be used effectively with the difficult situations they are encountering. Observations of the SA Liaisons with clients to check fidelity to the model indicate that use of MI is increasing.

3. Development and Refinement of Program Elements

1) Build collaborations between DHW and substance abuse providers.

In Region III and IV, building collaborative relationships between the SA Liaison, local substance abuse providers, and DHW staff had a solid beginning because of the pilot program in Region III prior to the grant, the carry-over of that SA Liaison to the Pre-Treatment program in those regions, and the proximity of the two regions (20 miles apart). In Region I, the previous substance abuse experience of the SA Liaison who was hired was critical to quickly building these relationships. As described above, the process of continuing to build collaborations is ongoing, and greatly enhanced by the proximity and availability of the SA Liaison to meet the informal as well as formal needs of the DHW staff.

2) Hire and train substance abuse liaisons in three regions of Idaho on the use of motivational interviewing techniques and documentation.

The hiring process in Region I involved meeting the local substance abuse contractor regarding recruitment of candidates, developing a job description, selecting an interview panel (CW Chief of Social Work, SA Contractor, Supervisor), and interviewing the candidates. In addition, office space within DHW had to be developed and equipment requisitioned. In Region IV, the hiring was simplified by recruiting Sue Rose Salmon from the pilot program in Region III. Hiring for Region III was prolonged because of lack of qualified candidates and the state-wide contract transfer to a different substance abuse provider.

Training for the SA Liaisons has occurred on three different occasions; June 25-26, 2003; Oct 16-17, 2004; Jan 6, 2004. A fourth training will be scheduled in August, 2004 to train the new one/half time SA liaison as well as provide a refresher training for the other liaisons. Motivational Interviewing training is provided by Carla Jakabosky, MSW, who is an experienced trainer, and the Substance Abuse Consultant from ICWRT. Training for documentation needed for the project evaluation was provided by Diane Davis, PhD, evaluator for the program. Preparation for the training involved coordination and design meetings with the two principal trainers, gathering supplies and handouts, securing room sites, developing feedback forms, coordinating training dates with all parties, and enlisting Patty Gregory to give an overview of state evaluation priorities for the future in relation to the Idaho Program Improvement Plan.

3) SA Liaisons will provide education and support to parents referred to the program through individual and group meetings.

In order for CP social workers to refer parents to the Pre-Treatment program, they were introduced to SA liaisons, oriented to the Pre-Treatment Project and introduced to the referral forms. The SA Liaisons also attended staff meetings to clarify questions regarding eligibility and the scope/limitations of the program. The SA Liaisons prepared for the individual and group meetings at the trainings described above.

4. Program Partnership Strengthening and Building

The Pre-Treatment program expanded several existing partnerships: the training and evaluation component is connected to the ongoing partnership with the Idaho Child Welfare Research and Training Center, and by extension to Eastern Washington University.

The substance abuse provider Road to Recovery had already participated in the pilot program in Region III, and had hired that Substance Abuse Liaison. Within the Department of Health and Welfare, several relationships were strengthened. Adding Region IV and I to the program brought in those Program Managers and Chiefs of Social Work. At Central Office, the Program Manager of Substance Abuse was connected administratively to the project. Currently, the Program Manager, Pharis Stanger, has acted as a mediator and advocate between the SA Liaisons and the state-wide substance abuse contract agency (BPA). The SA Liaisons in each region built relationships to the local substance abuse providers and BPA personnel who approve services through frequent interactions, role clarifications, and services to clients. Because referred parents are sometimes involved in the criminal justice system, relationships to probation departments have also been strengthened and built through the SA Liaisons.

The interconnectedness among the SA provider who hired and supervises the SA Liaison, DHW who houses the grant, and the Substance Abuse Office within DHW who contributes funding to the SA Liaison, has created some billing and allocation of time challenges that continue to need periodic attention.

5. Community Service Providers and Public Education

Other than the community partnerships described above, public education regarding the project has consisted of the presentation of the project at the RMQIC Conference in Boise, June 15-16, 2004 and the National Child Welfare and Substance Abuse Conference in Baltimore, July 14-15, 2004.

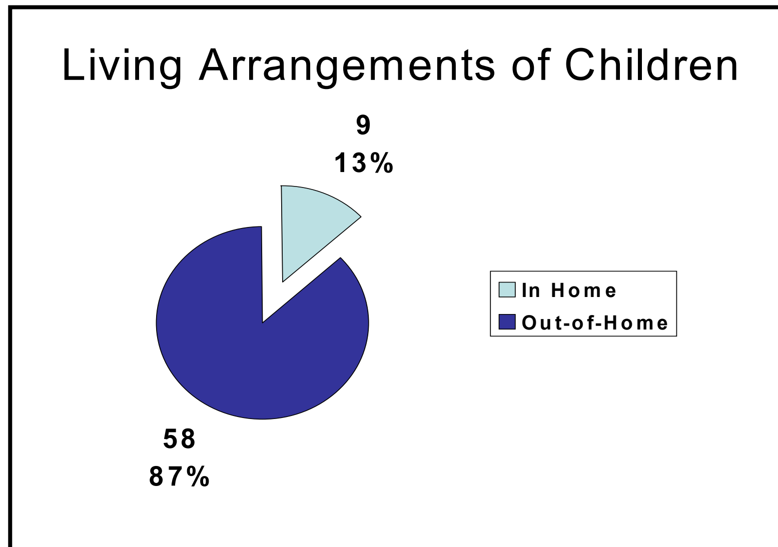
6. Family Recruitment

The approaches and activities developed to recruit families to the Pre-Treatment program was the orientation of CP Social Workers and caseworkers in each region to the purpose of the program, the Referral Form, and the introduction of the SA Liaison. Orientation took place in a variety of ways: formally, through staff meetings and individual meetings with the SA Liaisons, and informally through the everyday interaction of the SA Liaisons with the CP staff.

An unanticipated challenge was the lack of parents referred to Child Protection, whose children remained at home. In order to include more families, the criteria for eligible referrals expanded in April, 2003 to children who are already in out-of-home placement when they enter the Pre-Treatment program, provided this is a recent development (temporarily out of the home while professionals complete the assessment, or the assessment of the case was just completed and the child has been

placed out of the home with a goal of reunification). As shown in Chart 1, the number of children out-of-home greatly outnumbers the children in-home at the time of referral, as of June 2003. This may reflect the seriousness of the cases that are being referred to the program.

Chart 1



C. Provision of Services to Family

1. Family Engagement

(The information for this section is the result of observations of meetings with parents in each region, and interviews with SA Liaisons). Family engagement varies slightly by region, but in general it begins with the CP social workers formally referring a family through the written referral or informally by seeing the SA Liaison in the building and saying something like, "just took a baby from the hospital…mom will be calling you." In Region I, the CP Social Worker has to make a formal referral for it to be acted on; in Region III the SA Liaison will go to the referring worker and get the written referral. Telephoning a potential client is seen as a "chance to align with the client." Because the CP Social Worker is usually "tough," the SA Liaisons make an attempt to set a positive tone, draw out the client's perspective of the situation if they are willing to talk about it, and educate the client on what a drug/alcohol assessment actually entails ("Do you know what this means?"). An effort is made to distinguish the role of the SA Liaison from the role of the CP Social Worker. For example, in Region I, Dixie Taylor frequently tells the parent "my job is to be your advocate." The SA Liaisons try to make an appointment with the parent as soon as possible, within one or two days. Scheduling is somewhat more complex in Region III because there are four different offices (Nampa, Caldwell, Payette, and Emmett) and six different CP Social Workers/case managers.

In spite of these efforts to start out with the parents in a positive, client-centered approach, 8% of the clients drop out from the initial referral. SA Liaisons speculate that the no-show rate is the result of such factors as the seriousness of the problem

(methamphetamine is the major drug of choice), negative history with child protection, and/or lack of trust or motivation.

The first face-to-face meeting with the caregiver is a continuation of the positive, neutral tone of the telephone conversation. In Region III, Tom Hogan usually begins with "what got you here?" to allow the parent to tell their own story in their own way. He also makes sure that early on the parent is clear about the confidentiality policies and that he is a mandated reporter. While Dixie Taylor will frequently begin with the question "what happened with Child Protection," Tom Hogan doesn't refer to CP initially until the parent brings them up. The SA Liaisons exercise their clinical judgment as to whether to proceed with the drug/alcohol assessment questions, based on the client's understanding of the problem and willingness to take steps to change (Motivational Interviewing stages of change). Observations in each region confirm that the SA Liaisons are using Motivational Interviewing techniques, such as open ended questions ("tell me about your week…," "what do you need to do for the kids to come home…"), reflections, affirmations, summarization, scaling questions ("what puts you at a four in your recovery?"), eliciting the client's perspective ("what do you think you need in terms of treatment help?"), and asking about barriers (transportation).

There are three conditions that would trigger the invitation to the parent to enter the Pre-Treatment program: 1) if the client needs treatment based on the drug/alcohol assessment findings and there is a wait list, 2) if the parent is unwilling to proceed right away with the drug/alcohol assessment but willing to continue to meet with the SA Liaison to work on their concerns, and 3) if the parent is particularly high risk and needs frequent contact before entering treatment, even though the wait may be short. The Pre-Treatment program is explained as a support resource and parents are asked to sign the Consent Form. If the parents agree to participate, they are given a Pre-Socrates to establish their current "problem recognition" and "taking steps" stage of change.

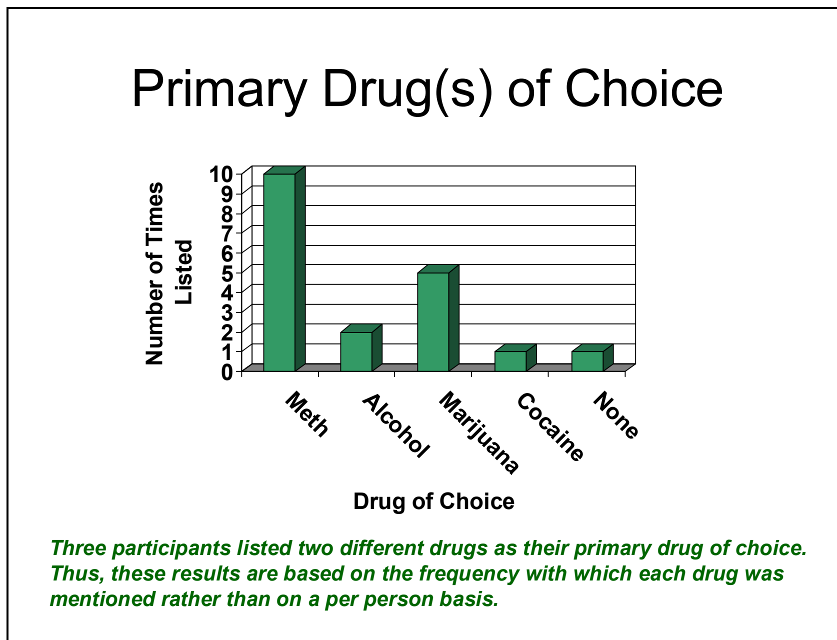
From October, 2003 to April, 2004, there was a consistent wait list in Region I. Dixie Taylor had enough parents waiting for treatment in that period that she was able to maintain a Pre-Treatment Group that met weekly. In Region III, it was more difficult to set up a group because of the parents being referred from four different CFS locations, and the minimum amount of time available to the SA Liaison, working part-time. In Region III and IV, most Pre-Treatment contacts were individual, not group meetings, although a small group did occur for a short period in Region IV. The PreTreatment groups and individual contacts are characterized by using the Socrates Stage of Change instrument for measuring current "problem recognition" and the extent of "taking steps" to change. In addition, the Weekly Goal Sheet is used to collaborate with parents on short-term goals for themselves, their children, and their family. In Region I, if parents are accepted into treatment at the Port of Hope facility where Dixie Taylor has another office, clients are introduced to potential SA counselors at the facility in an effort to make a positive transition.

Service provision in all regions includes telephone follow-up, advocacy and mediation on behalf of clients with community resources such as Adult Probation, BPA, and the SA providers. Ongoing educational efforts with CP staff continue, via staff meetings, special trainings put on by the SA Liaisons, and even bringing

caseworkers to visit the local substance abuse providers. Service provision also includes frequent meetings and telephone calls with the CP social worker regarding the status of the parent. In Region I, Dixie Taylor sends a monthly report that she designed to communicate the current status of attendance/participation, stabilization of family environment, ability to be an effective parent, extent client is addressing own needs, and any other relevant issues. When parents who are scheduled for treatment actually enter treatment, the Pre-Treatment program case is closed.

There are many challenges to family involvement. One of the most challenging may be that the majority of the substance abuse problems for the parents in these regions revolve around the abuse of methamphetamines. In a preliminary analysis of the 16 parents who had completed the Pre-Treatment program by June, 2004, Chart 2 shows that the primary drug of choice for 10 of them was methamphetamines. The effects of methamphetamine abuse can be mood swings, anxiety, anger, violence, paranoia, isolation, depression, insomnia, hallucinations, convulsions, kidney failure, and suicide. Parents who abuse this substance may present with weight loss, teeth grinding, dry itchy skin, facial picking, and resort to lies, denial, and manipulation to avoid the consequences of their use. Brain scans of people who use methamphetamines show damage that persists months and even years after the individual stops using the drug. Consequently, methamphetamine abusers may be even harder to engage than other, more "traditional" substance abuse addicts.

Chart 2



The skill and substance abuse experience of the SA Liaisons has been invaluable in meeting this challenge. The primary adjustment made to the Pre-Treatment program for the complexity of client needs has been to make the application of the program flexible, client friendly, and at the clinical discretion of the SA Liaisons. For example, the Pre-Treatment program is introduced when the SA Liaison judges the parent is ready to consider this option (not always the first session). The parent may participate a variable length of time (as little as one session to as many as it takes to

enter treatment). Participation may be interrupted, depending on the circumstances (interrupted by jail time, unreachable), and then picked up again. The Socrates Form was redesigned to eliminate the category of "feeling ambiguity" because it was difficult for the clients to address these questions. Although an ideal research design may demand more consistency in application, the reality of these family's circumstances have made these adjustments necessary.

A second challenge to family involvement has been the paperwork required from the SA Liaisons for BPA approval of funding of treatment. The standards were so exacting that the SA Liaisons would typically get "correction/more information needed" or "notice of clarification" type responses from BPA several times for each case, causing treatment delay. Other problems have included technical problems in sending the information (fax machines not working), and unclear guidelines for submission. These problems surfaced during the monthly telephone conferences of the principal grant partners and were referred to Pharis Stanger, Program Manager, Substance Abuse for resolution. Although problems still continue to occur, the SA Liaisons report that they may have secured a special "status" with BPA that has facilitated the approval process for their clients.

2. Summary of Family Participation

There were 239 persons referred to the Substance Abuse (SA) Liaisons for a drug and alcohol assessment from October 1st, 2003 through June 30th, 2004. Of these, 192 completed an assessment, which is an 8% drop out rate from the initial referral. Nineteen people who completed an assessment were found not to need treatment. This leaves 173 people who were eligible to enroll in the Pre-Treatment program. Of these people, 31 elected to enroll in Pre-Treatment. This is represented in Figure 1. We recently began collecting the reasons why people choose not to enroll in Pre-Treatment. While we do not know the reasons for all of the people that chose not to participate, we do have data for about one-third of the eligible referrals. The majority of reasons why clients chose not to enroll in Pre-treatment were refusal to participate (due to working, living too far away, or having no time) and failure to follow through (including no contact and not showing up for scheduled appointments). Figure 2 shows the breakdown of referrals for each region during the specified periods. From left to right, the first number listed is the total number of all referrals to the substance abuse liaison (for that region). The second number listed is the number of people who were referred, yet did not complete an assessment. The third number column shows the number of people (out of the total referrals) who elected to enroll in the Pre-Treatment program. The final column shows the percentage of people that elected to enroll in the Pre-Treatment program out of the total number of referrals.

Table 1 Referral and Pre-Treatment Descriptives

All Regions October 2003 - June 2004	
Total # Referrals	239
Number (of total) Enrolled in Pre-Treatment	31
Number (of total) completing assessment	192
Percentage (of total referrals) in Pre-Treatment	12.97%
Percentage (of total referrals) completing assessment	80.33%

Table 2 Breakdown of Referrals by Region and Dates

	October 2003 - December 2003			
	Total Number of Referrals	Number (of total) not completing assessment	Number (of total) Enrolled in Pre-Treatment	Percentage (of total referrals) in Pre-Treatment
Coeur d'Alene	18	2	9	50.00%
Boise	20	4	5	25.00%
Nampa	32	0	3	9.38%
All Regions	70	6	17	24.29%

	January 2004 - March 2004			
	Total Number of Referrals	Number (of total) not completing assessment	Number (of total) Enrolled in Pre-Treatment	Percentage (of total referrals) in Pre-Treatment
Coeur d'Alene	16	2	5	31.25%
Boise	19	19	1	5.26%
Nampa	60	0	4	6.67%
All Regions	95	21	10	10.53%

	April 2004 - June 2004			
	Total Number of Referrals	Number (of total) not completing assessment	Number (of total) Enrolled in Pre-Treatment	Percentage (of total referrals) in Pre-Treatment
Coeur d'Alene	28	8	1	3.57%
Boise	20	11	1	5.00%
Nampa	26	1	2	7.69%
All Regions	74	20	4	5.41%

Overall, approximately 13% of the total number or referrals elected to enroll in the Pre-Treatment program. Of these 31 people, fifteen clients are in Coeur d'Alene, seven are in Boise, and nine are in Nampa. Figure 3 shows the current status of all of the Pre-treatment clients. Twenty-two clients have now completed the Pre-Treatment

program. Of these 22 clients who completed the Pre-Treatment program, 14 remain in treatment, four have been discharged (three due to moving, one due to jail), one is awaiting funding, one was assessed not to need treatment, one did not follow through with treatment, and one went to jail. Of all of the Pre-Treatment clients, the whereabouts of 5 are currently unknown. Also, only one client has been dropped from the Pre-Treatment program, and this was due to non-attendance.

Table 3 Current Status of Pre-Treatment Clients (by assessment date)

October 2003 - December 2003	
Remains in Treatment	8
Remains in Pre-Treatment	1
Whereabouts Unknown	4
Discharged from Treatment (moved)	2
Waiting List	1
No Show	1
No Treatment Needed	1
TOTAL	18

January 2004 - March 2004	
Remains in Treatment	5
Remains in Pre-Treatment	1
Whereabouts Unknown	1
Discharged from Treatment (moved)	1
Awaiting Funding	1
In Jail	1
TOTAL	10

April 2004 - June 2004	
Remains in Treatment	1
Discharged from Treatment (jail)	1
No Follow Through	1
TOTAL	3

Dixie Taylor, the substance abuse liaison from Region I, provided the following narrative on July 7th, 2004, to tell the story of participants who were successful in the Pre-Treatment program:

On October 6th, 2003, CPS referred Bill & Mary*, parents of twins born positive at birth for cannabis. Bill was assessed and signed all pretreatment documentation on October 6th. Mary was assessed and signed all pretreatment documentation on October 7th. Both clients attended their first pretreatment group on November 5th. Mary remained in the pretreatment group until she entered Intensive Outpatient treatment. Bill remained in the pretreatment group until January 7th, 2004, when he was able to attend Intensive Outpatient. His wait was due to the waiting*

list for Intensive Outpatient and he could not attend the group that Mary attended. Bill remains in outpatient treatment at this time and Mary was discharged from a women's process group on July 1st, 2004. She had successfully completed recommended treatment. Bill is approaching a discharge date in near future. Both clients have reported continued abstinence during the time in treatment. CPS returned their twin babies to their care about 3 months ago. They both have related to me that the experience in pretreatment gave them a more positive entrance to the treatment experience and they would recommend that all individuals attend a pretreatment format prior to entering treatment.

The pretreatment group both clients attended was a highly engaged group of individuals. Motivational interviewing (MI methods were used to engage and encourage their progress and increase their level of motivation. Both clients completed the SOCRATES form after each group. They related a willingness to change and utilized the group process that was both educational and process based. This didactic treatment is used at the Port of Hope as a basis for treatment. By using MI skills and other counseling skills, both remained engaged and working in the pretreatment group. The weekly goals sheet was an instrument that was used to keep the clients focused on the continuation of methods of changing behavior and focusing on methods they could incorporate on a weekly basis.

One of the elements that has greatly influenced the positive outcome for these clients and others that have followed in pretreatment was the tremendous support of Marlene Scott, Director of Port of Hope in Coeur d'Alene, Idaho, and Rick Dixon, the Clinical Director of the Port of Hope. Also, the effort of the CD counselors to assist me in placing individuals in treatment was a great asset for the success of the pretreatment program.

* Names have been changed.

D. Partnership and Community Service Providers Involvement (ongoing).

The primary vehicle for maintaining partnership involvement has been through monthly telephone conferences that includes Liz Lovell, Road to Recovery, Shirley Alexander, Diane Davis, Randy Geib, Rob Gregory, Carla Jakabosky, Dixie Taylor; Art Dodson, Brenda Evans, Carol S. Fowler, Patty Gregory , Tom Hogan, Kurt Lyles, Sue Rose Salmon, Lynn Sanderson, and Pharis Stanger.

Agendas for these teleconferences may include such topics as number and tracking of referrals, status of wait lists, discussion of data collection instruments, reviewing agendas for conferences, discussion of concerns regarding BPA, and Pre-Treatment processes. In addition, most of the team attended the RMQIC conferences in Denver (September, 2003) and Boise (June, 2004) in which submeetings and meetings of the individual members occurred.

E. Service Outputs

January 2003 - December 2003	
Number of Families Served	16
Number of Children Served	31
In-Home Children	5
Out-of-Home Children	26

Products:
Code Book for Data Collection
Data Collection Forms:

1. RMQIC Initial Data Referral Form
2. Signed Consent Form
3. Contact Sheet
4. Participant Data Form
5. My Weekly Goals
6. Post-Intervention Summary Sheet
7. Participant Satisfaction Form
8. Socrates 8Alcohol - revised
9. Socrates 8Drug - revised

January 2004 - June 2004	
Number of Families Served	13
Number of Children Served	26
In-Home Children	1
Out-of-Home Children	25

Totals to June 2004	
Number of Families Served	29
Number of Children Served	57
In-Home Children	6
Out-of-Home Children	51

Products:
Data Collection Form for SA Liaisons that includes all referrals and disposition
Motivational Interviewing Curriculum
PowerPoint Presentation of Pre-Treatment program to June 2004

F. Lessons Learned from Implementation.

A critical objective of the Pre-Treatment program was to establish a positive working relationship with the local substance abuse providers in each region. The SA Liaisons have exceeded expectations in this regard. They have established good working

relationships with the primary providers in each region, and consistently deliver a reliable "product" (clients for treatment that have been approved for funding by BPA or other entities). It appears that an "unintended consequence" may have resulted from doing such a good job attaining this objective: the long waiting lists that existed when the program was proposed are much shorter, and on occasion, do not occur at all for the clients of the SA Liaisons. In Region I, the Port of Hope treatment center makes the clients of Dixie Taylor a priority for treatment slots. We suspect that the treatment centers in the other regions are doing the same. At a later date, interviews with the Substance Abuse providers will help uncover this phenomenon. It is good news for parents to be able to enter treatment more quickly, but it does affect the number of participants in the Pre-Treatment Groups.

Other developments have affected the lower number of participants than expected. The first is the competing role requirements in the SA Liaison position. The SA Liaisons have been pressured by the SA provider that hired and supervises them to perform drug/alcohol assessments as that is how the provider gets reimbursed. There were several "kinks" in the billing for Pre-Treatment hours and the allocation of time to the Pre-Treatment program, which caused confusion about the role of the SA Liaison in relation to the Pre-Treatment role of their job. The second factor is the part-time position in Region III, where the SA Liaison has not added time to fully implement the Pre-Treatment program until June, 2004. These factors reinforce the idea that start up and implementation take longer than initially foreseen.

A suggestion for future implementation of grant projects would be to hold a meeting of the principals shortly after the grant is awarded to discuss in detail project resources and specific requirements in terms of the scope of the project and the evaluation design. Questions to address might be: how realistic is the implementation plan? Are the resources from the grant adequate for what is required? What are the specific requirements of the final evaluation, and what are the periodic reporting requirements? What are the cross-site evaluation expectations of the grantee? In the case of the Pre-Treatment program, this type of conference early on may have helped clear up the expectations for evaluation and the expectation around curriculum development, or may have caused the project to focus in one or two regions instead of three, given the budget constraints.

Technical assistance from RMQIC has been helpful at all stages and available by phone and frequent site visits. The RMQIC Conferences in September, 2003 and again in June, 2004, where all the projects were brought together to compare notes and progress were very illuminating. It seemed particularly relevant because the projects are all in neighboring states, and are working on similar objectives. The monthly telephone conferences with the Project Directors, and the newly started conference call with evaluators are another helpful means to problem-solve. The fact that the principle staff at RMQIC knows the principle players in the program and the context in which the program exists makes consultation more meaningful.

III. Program Evaluation Results

A. Description of the Program Evaluation Activities

The following evaluation activities were initially specified in the evaluator's contract with the Idaho Research and Training Center for the period from September, 2003 to September, 2004:

- Finalize data collection instruments
- Make arrangements with BPA data collection system for client treatment disposition
- Make arrangements with FOCUS data collection system for client CPS disposition
- Write application for Institutional Review Board approval, modify accordingly
- Set up data collection system on SPSS
- Co-design (with curriculum author) and implement 2 days of training of SA Liasons
- Co-design (with curriculum author) "case scenarios" that can be used as quality control tests with SA liaisons during the first year
- Enter data, periodic quality control checks
- Monitor data collection system and trouble-shoot glitches
- Participate in monthly conference calls
- Collaborate with Center Director regarding challenges of evaluation implementation.
- Attend RMQIC meeting September, 2004 and others as needed during this contract year
- Write quarterly reports for RMQIC on evaluation progress for IDHW; submit to the Center for review.
- Complete second year project reports as required by the grantee.

In response to the final development of the Logic Model (Appendix A) in May, 2004, and the additional activities required for a more thorough process evaluation, the following activities were added to the contract:

- Attend RMQIC Conference in Boise, June 15, 16, 2004
- Observe SA Liaisons for fidelity to MI
- Design structured interview format for Program Managers, SA Liaisons, Chiefs of Social Work, and local SA Providers
- Design staff meeting questions with CPS and schedule in the three regions
- Interview Program Managers, Chiefs, SA Liaisons, and CP Social Workers in the three regions
- Review tapes, reconstruct interviews, note emerging themes
- Gather descriptions of non-participating regions' SA liaison programs for regional comparisons

Allocation of Tasks: Data input, descriptive analysis, ongoing tracking missing data from SA Liaisons, developing code book and co-developing data collection system on

SPSS, recording process of training session of SA Liaisons, creating charts and graphs, co-developing interview schedules for process evaluation are handled by Amber Cleverly, Research Assistant, School of Social Work, Eastern Washington University and supervised by Diane Davis. All other activities are handled by Diane Davis, PhD, Professor, School of Social Work, EWU.

Challenges:

1) As described earlier, the required scope of the evaluation did not become clear to the project team or the evaluator until the final Logic Model was developed through a meeting of principal RMQIC staff and project staff in May, 2004. This issue has been resolved by an agreement of the principals on the Logic Model and the activities specified therein, and by increasing the activities and reimbursement of the evaluator.
2) The long-term outcomes of treatment completion, child safety, and child permanence depend on the secondary data source of the BPA (substance abuse) and FOCUS (DHW) data systems. These two systems are in the process of merging, and the expected problems are being worked out. It is anticipated that in the fall of 2004, the data required for this evaluation will be accessible.
3) The planned collection of baseline data for the three regions occurred early in program implementation, but the data is difficult to interpret because of non-uniform collection procedures. An attempt will be made to clean up the data by tracking the clients identified through the merged state-wide system.

B. Program evaluation findings

As can be seen in Section C.2., the project is not at the point of having long-term outcomes. However, because the project was presented at the National Child Welfare and Substance Abuse Conference in Baltimore, July 14,15, 2004, very preliminary data was analyzed. The data was derived from the 16 clients who had completed the Pre-Treatment program by June, 2003.

1) Immediate indicators for Implementation Activity #2: Clients attending meetings. Chart 3 indicates that clients had a mean of 4.19 total contacts with a mean of 3.19 pre-treatment contacts.
2) Intermediate indicators for the Implementation Activity #2: Clients in the pre-treatment group will show greater readiness for change and treatment motivation after the motivational interview. Chart 4 indicates that 42% (n=5) of clients increased their recognition of an alcohol problem; 31% (n=4) increased their recognition of a drug problem. Chart 5 indicates that 50% (n=6) of clients increased taking steps to change their alcohol problem and 31% (n=4) increased taking steps to change their drug problem.

Although these are very preliminary findings, it increases confidence that the project is going in the right direction.

Chart 3

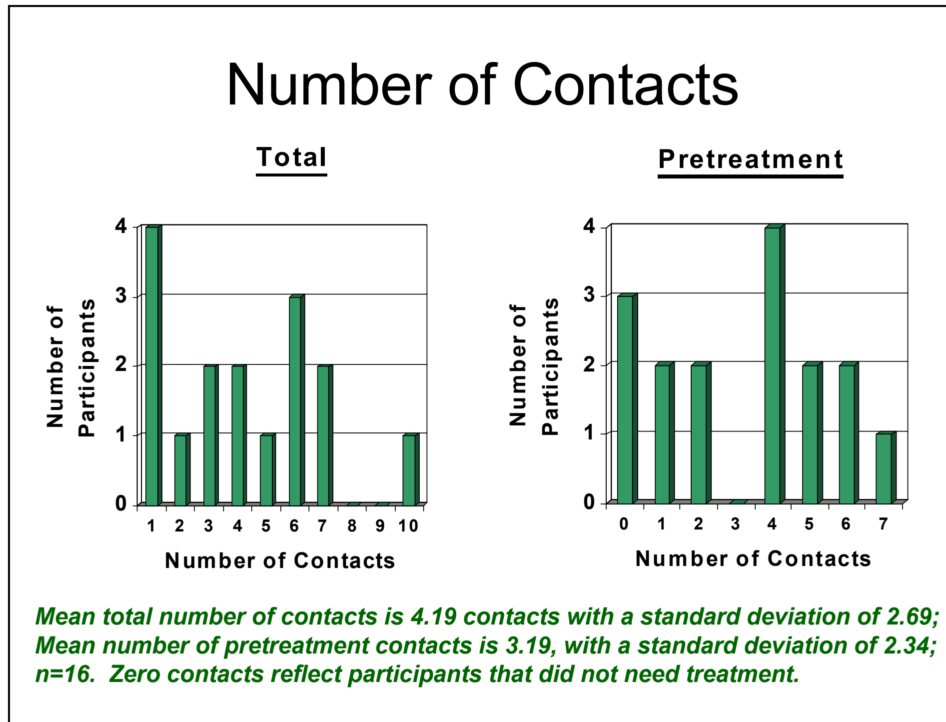


Chart 4

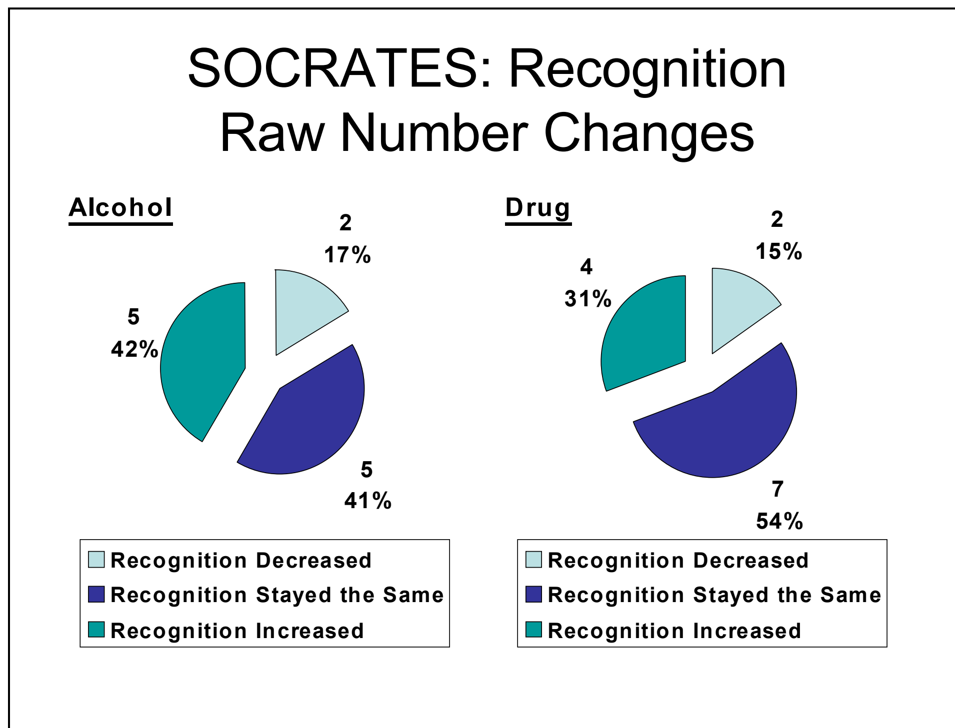
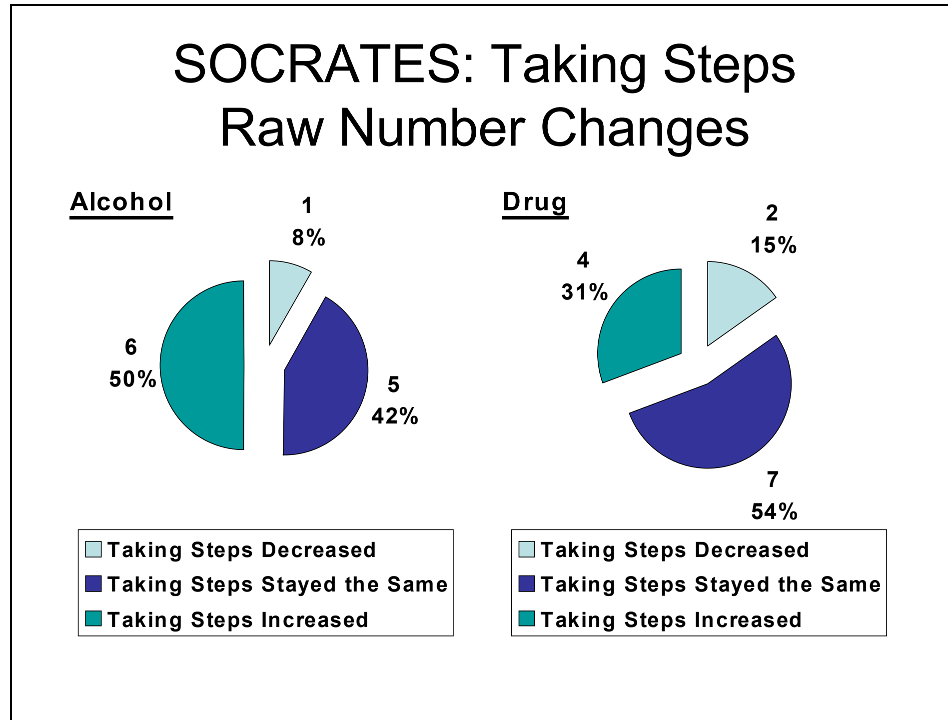


Chart 5



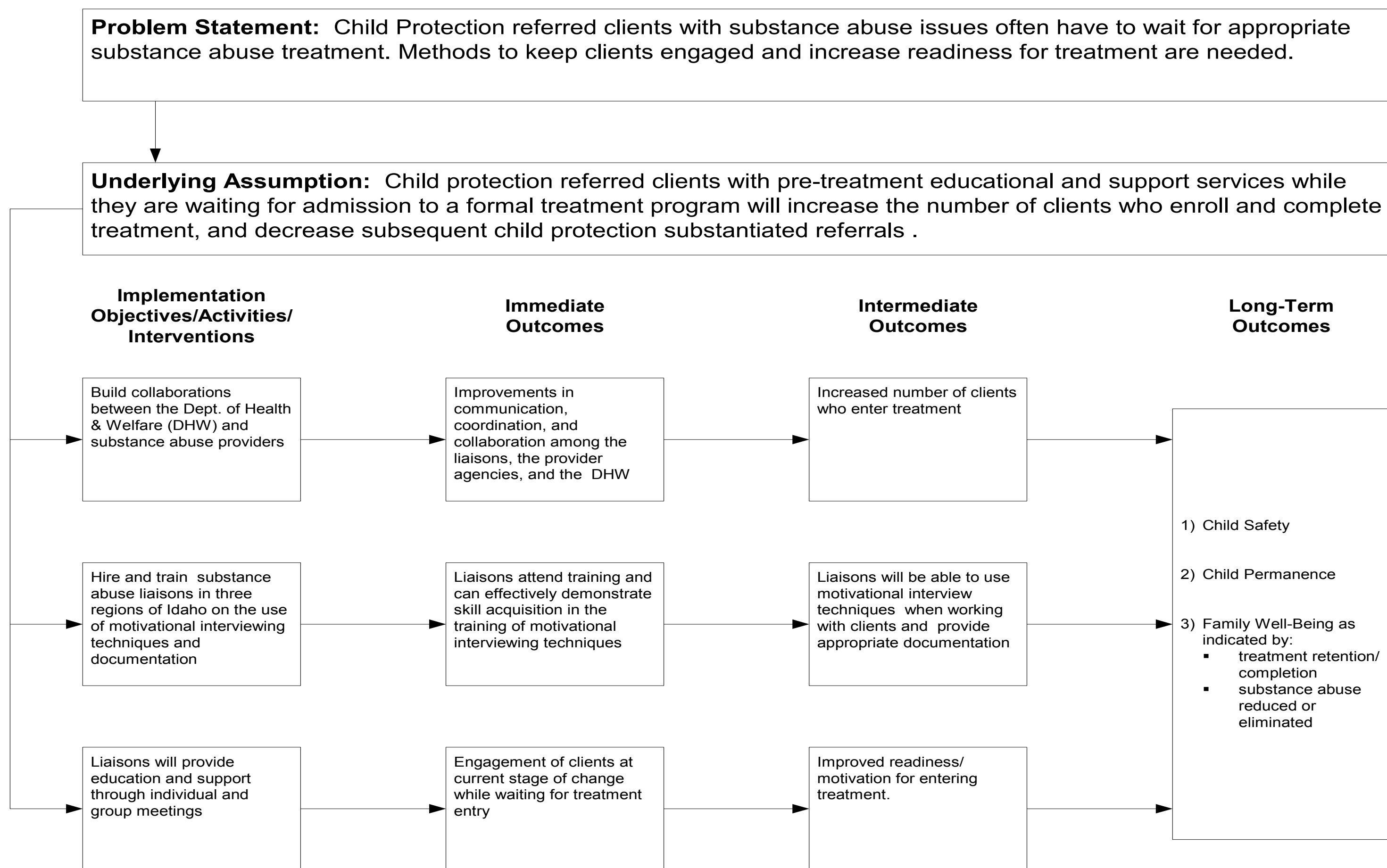
V. Sustainability.

The Idaho DHW system is learning the importance of having a certified substance abuse counselor closely connected to the Child Protection staff in order to facilitate the disposition and treatment of parents who are affected by substance abuse. There is already a commitment to expand the SA Liaison and Pre-Treatment program to all regions in the state. The project manager is hopeful that this can be funded through a combination of federal dollars and other sources, for example, TANF/SSBG, PSSF (Family Preservation, Time-limited Family Reunification), and Substance Abuse funding.

References

Miller, W.R. & Rollnick, S. (2002). Motivational Interviewing, Preparing People for Change. 2nd Edition, NY: Guilford Press

APPENDIX A



Idaho Pre-Treatment Evaluation Methods

Implementation Activity #1: Build collaborations between the Dept. of Health & Welfare (DHW) and substance abuse providers		
Outcomes:	**Indicators**	**Methods**
Immediate: Improvements in communication, coordination, and collaboration among the liaisons, the provider agencies, and the DHW	1. DHW staff have a liaison who they can refer clients to for assessment and pre-service treatment 2. Improved communication and cross-systems education regarding the dual issues associated with child maltreatment and substance abuse.	1. Interviews with project partners 2. Documentation of formal and informal interactions and activities between DHW, liaisons, and SA providers 3. Track the number of referrals from DHW to liaisons in each region
Intermediate: Increased number of clients who enter treatment	1. Number of program clients who enter treatment compared with baseline rates and cross-regional comparisons	Collect and analyze substance abuse provider data on client treatment entry dates and compare with baseline data and regional statistics
Long-Term: Child safety	Decrease in subsequent child maltreatment substantiated referrals from program entry to identified time points 30/60/90 days up to 6 month time point	Review/comparison of DHW case data from FOCUS (SACWIS) from program entry to identified time points 30/60/90 days within 6 month time point
Long-Term: Child permanence	1. Children remain in the home at program entry and 6-month follow-up 2. Children in out-of-home placement are returned in a timely manner	Review/comparison of DHW case data from FOCUS from program entry and 30/60/90 days within a 6 month period.
Long-Term: Family well-being	1. Treatment retention/completion 2. Substance abuse reduced/eliminated	Review/compare client data from substance abuse provider and percentages of clients authorized for treatment who enter and complete treatment for all regions before and after the project. Comparison data from non-participating regions will also be gathered for treatment retention and completion.

Implementation Activity #2: Hire and train substance abuse liaisons in three regions of Idaho on the use of motivational interviewing techniques and documentation

Outcomes:	Indicators	Methods
Immediate: Liaisons attend training and can effectively demonstrate skill acquisition in the classroom on motivational interviewing techniques	1. Liaisons attend training 2. Liaisons demonstrate skill acquisition in the classroom training	1. Documentation of attendance 2. Observation of liaisons skill practice and demonstration during training 3. Analysis of liaisons self-report of training satisfaction and skill acquisition
Intermediate: Liaisons will be able to use motivational interview techniques when working with clients and provide appropriate documentation	1. The use of motivational interviewing in their work with clients 2. Liaisons provide completed documentation to the evaluator 3. Clients report supported and motivated by their work with liaisons	1. Evaluator observes and rates liaisons' motivational interviewing work with clients 2. Evaluator receives completed client documentation from liaisons 3. Client satisfaction forms administered at the end of pre-treatment
Long-Term: Child safety	Decrease in subsequent child maltreatment substantiated referrals from program entry to identified time points 30/60/90 days up to 6 month time point	Review/comparison of DHW case data from FOCUS (SACWIS) from program entry to identified time points 30/60/90 days within 6 month time point
Long-Term: Child permanence	3. Children remain in the home at program entry and 6-month follow-up 4. Children in out-of-home placement are returned in a timely manner	Review/comparison of DHW case data from FOCUS from program entry and 30/60/90 days within a 6 month period.
Long-Term: Family well-being	3. Treatment retention/completion 4. Substance abuse reduced/eliminated	Review/compare client data from substance abuse provider and percentages of clients authorized for treatment who enter and complete treatment for all regions before and after the project. Comparison data from non-participating regions will also be gathered for treatment retention and completion.

Implementation Activity #3: Liaisons will provide education and support through individual and group meetings		
Outcomes:	**Indicators**	**Methods**
Immediate: Engagement of clients at current stage of change while waiting for treatment entry	1. Clients setting weekly goals for self, child and family 2. Clients attending group/individual meetings 3. Clients report that liaison listened, understood, and supported them	1. Completion of weekly goal sheets and sending them to the evaluator 2. Client contact sheets from weekly meetings 3. Client satisfaction forms, and follow-up interviews 4. Interviews with liaisons
Intermediate: Improved readiness/motivation for entering treatment.	Clients in the pre-treatment group will show increased readiness for change	Analyze/compare stage of change from initial assessment to treatment entry via Socrates A/D (pre/post)
Long-Term: Child safety	Decrease in subsequent child maltreatment substantiated referrals from program entry to identified time points 30/60/90 days up to 6 month time point	Review/comparison of DHW case data from FOCUS (SACWIS) from program entry to identified time points 30/60/90 days within 6 month time point
Long-Term: Child permanence	5. Children remain in the home at program entry and 6-month follow-up 6. Children in out-of-home placement are returned in a timely manner	Review/comparison of DHW case data from FOCUS from program entry and 30/60/90 days within a 6 month period.
Long-Term: Family well-being	5. Treatment retention/completion 6. Substance abuse reduced/eliminated	Review/compare client data from substance abuse provider and percentages of clients authorized for treatment who enter and complete treatment for all regions before and after the project. Comparison data from non-participating regions will also be gathered for treatment retention and completion.