Iowa PPW

The Iowa Pregnant and Postpartum Women's Residential Treatment Program

THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Iowa Pregnant and Postpartum Women
Year 3 Report
November 2018

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EXECUTIVE SUMMARY

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) is under contract with the Iowa Department of Public Health (IDPH) for evaluation of the Iowa Residential Treatment for Pregnant and Postpartum Women (PPW) Program. The PPW program is intended to expand the availability of comprehensive, residential substance use disorder treatment, prevention and recovery support services for pregnant and post-partum women and their minor children, including services for non-residential family members of both the women and the children. The purpose of this report is to assess whether the Iowa PPW grant was used to implement an evidence-based program that provides recovery support services and addresses behavioral health disparities across three residential treatment sites (Area Substance Abuse Council, Heartland Family Services and Jackson Recovery Centers) from September 30, 2015 to September 29, 2018.

Key Findings

Treatment Outcomes

- Three-hundred-twenty clients were admitted between February 1, 2016 and September 29, 2018.
- The treatment completion rate was 69.7%. The median length of stay was 73.5 days.
- Treatment completion significantly varied across sites. JRC had the highest treatment completion rate at (84.5%). ASAC (67.0%) and HOM (66.7%) had similar treatment completion rates and HFS had the lowest treatment completion rate (40.9%)
- Length of stay was significantly lower for Iowa PPW clients (73.5 days) compared to pregnant clients enrolled in IDPH-funded Women's and Children's residential treatment centers (90.0 days). However, rates of treatment completion were significantly higher for Iowa PPW clients (69.7%) than for Women's and Children's clients (47.6%).
- Although the length of stay was similar for clients receiving MAT (74.0 days), the treatment completion rate among clients receiving MAT (87.8%) was higher than the PPW treatment completion rate (69.7%) and was higher than the treatment completion rate at any one agency.
- One-hundred forty-seven children were reunited with one or more parents.
- Within the past 30 days of the follow-up survey, 94.3% and 91.5% of clients abstained from alcohol and illicit drugs, respectively
- Clients reported significant improvements in health including reduced feelings of anxiety, depression, trouble remembering, and difficulty controlling violent behavior.
- There was a significant reduction in the percentage of clients experiencing homelessness from intake to five to eight months post-admission; however, 29.1% of clients at follow-up were not housed.
- Clients reported significantly higher levels of social support from intake to follow-up in both the Assessment Recovery Capital and GPRA surveys.

Service Provision

- Agencies spent over $227,000 in recovery support services, of which nearly a quarter was spent on clothing for clients and their children.
- Clients and their families received over 3,700 hours of parenting education classes.
- Two-hundred thirty-seven children and supportive adults received an evidence-based intervention or participated in parenting education.
- Fifty-eight clients received Medication-Assisted Treatment (MAT) to treat addiction to alcohol, methamphetamine, marijuana, and opioids.
- All agencies reported having at least one staff member who can train others in Seeking Safety, 24/7 Dads, and Naloxone administration.
- In the third year of PPW, all agencies implemented a NiaTX quality improvement project to enhance service delivery to PPW's target population.

Recommendations

- **Expand the use of MAT**. Completion of Iowa PPW was higher among clients using MAT; however, only two of the four PPW agencies reported using MAT for PPW clients. At these two agencies, MAT was used to treat a variety of substance use disorders (alcohol, methamphetamines, marijuana, and opioids). Expanding the usage of MAT across agencies could results in higher levels of PPW treatment completion.
- **Continue asking fathers what permits and prohibits participation and adjust services accordingly**. Surveys with participating fathers revealed transportation, schedule conflicts, and distance to the treatment center were significant barriers to participation. Fathers also reported that learning new things, spending time with family, and connecting with families were motivating factors. Agencies are encouraged to survey more fathers to assess the representativeness of these findings and modify PPW programming to encourage father participation.
- **Find new avenues to promote 24/7 Dads.** Agencies have recorded the 24/7 Dads intervention for very few fathers. Additionally, only 13 out of 37 fathers surveys had heard of 24/7 Dads. Agencies are encouraged to find methods to improve reporting of participation in 24/7 Dads for current participants and to actively promote the intervention when developing family treatment plans.
- **Ask agencies to share successes and challenges of implementing quality improvement projects.** Sharing procedures and outcomes of quality improvements promotes an exchange of ideas that may considerably enhance service delivery across all agencies.
- **Address agency differences in treatment completion and client satisfaction.** For the second year in a row, clients at ASAC reported being less satisfied with program services and some aspects of client-staff interaction.

- **Encourage agencies to find alternative means to fund recovery support services and Coordinator positions after grant funding ends.** All agencies reported that they would be unable to continue providing gas cards and utility supports after grant funding ends and two agencies would no longer be able to provide bus passes. Additionally, two agencies reported being unable to support their Children's Coordinator Position when grant funding ends.
- **Address agency disparities in treatment completion.** JRC has the highest rates of treatment completion across all three years of PPW implementation. HFS has routinely had the lowest levels of treatment completion. Clients' demographics and patterns of substance use do not explain these differences. More information is needed at the agency level to explore and reduce disparities in treatment completion.

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PROGRAM DESCRIPTION

The Iowa Department of Public Health was awarded a three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). The purpose of this grant was to expand the availability of comprehensive, residential substance use disorder treatment, prevention and recovery support services for pregnant and post-partum women and their minor children, including services for non-residential family members of both the women and their children.

Three established residential treatment programs in major cities throughout Iowa implemented the Iowa Pregnant and Postpartum Women's Residential Treatment Program (Iowa PPW): Area Substance Abuse Council in Cedar Rapids, Heartland Family Service in Council Bluffs and Jackson Recovery Centers in Sioux City. A fourth residential treatment program, House of Mercy in Des Moines, began enrolling clients in Iowa PPW in October 2017. Eligibility for Iowa PPW included being a woman who was either pregnant or postpartum (given birth within one year of admission to PPW) with an income below the poverty line.

The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducted the evaluation component of the project. The Consortium's evaluation involved the collection of data to assess the degree to which project goals and objectives were met. The evaluation included data from The Government Performance and Results Act (GPRA), information collected from residential treatment providers, and interviews with staff providing PPW services. This report provides data for clients admitted during the third year of the grant period from September 30, 2017 to September 29, 2018. The report also includes results from data aggregated throughout the grant from September 30, 2015 to September 29, 2018.

Site Descriptions

Each PPW site is located in a highly populated area of Iowa. HOM in Des Moines and ASAC in Cedar Rapids are located in the first and second most populated cities in Iowa, respectively. JRC located in Sioux City, Iowa is the fourth largest city in Iowa and HFS in Council Bluffs, the seventh largest city in Iowa. All sites admitted their first PPW client in February 2016.

Each Iowa PPW program differs in its Women's and Children's Residential program capacity. HOM has the largest program capacity with 72 beds for women and children in residential treatment followed by ASAC with 36 beds and JRC with 30 beds. HFS has the smallest program capacity with 10 to 12 beds, but also has the longest programmatic length of stay at approximately four to six months. Both ASAC and JRC have a programmatic length of stay between three to four months. HOM does not have a set programmatic length of stay.

Program Goals and Objectives

The central purpose of Iowa PPW is to expand the availability of comprehensive residential substance use disorder treatment, prevention and recovery support services for pregnant and postpartum women and their minor children. Iowa PPW also provides services for non-residential family members of both

the women and children. The following goals originate from the Iowa PPW grant application and are used as benchmarks to assess the success of the PPW program:

Goal 1: Implement an evidence-based program and increase the number of pregnant and postpartum women served with evidence-based programming at three Women and Children's Centers.

Goal 2: To allow client choice in selecting recovery supports while focusing on gender specific issues for pregnant and women in residential treatment for substance use disorders.

Goal 3: To reduce behavioral health disparities among pregnant and postpartum women who as a population tend toward a higher incidence of substance use disorder and related problems.

Appendix A lists corresponding objectives and evaluation question for each goal along with the indicators and data sources used to assess progress towards goal completion. The following section discusses methods of sample selection and data collection implemented to assess program success.

DATA

Data were collected from a variety of sources including:

- Government Performance and Results Act (GPRA) instrument completed at admission, discharge, and five to eight months post-admission (follow-up)
- Additional forms developed by the Consortium at client and agency levels
- Treatment admission data from IDPH's Central Data Repository (CDR)
- Key informant interviews with provider staff
- Site visit reports
- Memorandums of Agreement/Understanding
- Meeting notes and agendas
- NiaTX Quality Improvement Change Project Forms
- Client Success Stories

A unique client number links client level data across the GPRA, CDR, and Consortium forms. Grant admissions began in February 2016. Data presented in this report represent 320 clients admitted through September 29, 2018. In addition, data is reported for 264 discharged clients and 213 clients five to eight months post-admission (follow-up). Additional information regarding processes used to evaluate data gathered are described throughout the report.

Staff were asked to collect success stories from PPW clients who had either graduated or were near completion of the program. The evaluation team supplied each agency with a success story collection template containing suggested questions to help staff collect and organize clients' experiences. In some cases, the staff member wrote the story from interviews with the client and submitted it to the evaluation team. In other cases, the evaluation team created the story through notes staff left on the success story collection form. All names in the following stories are pseudonyms to protect client confidentiality. Client success stories are presented throughout the report.

Data collected will be used to address four major themes representing distinct phases in program delivery: 1) client recruitment, 2) client retention, 3) assessing client outcomes, and 4) program sustainability.

CLIENT RECRUITMENT

The following section will discuss trends in client admissions throughout all three years of the grant, and in the 2018 fiscal year, to identify periods of consistently low and high PPW admissions. Clients' socio-demographics and substance use prior to admission are then discussed. In addition, because the goal of PPW is to provide services to the client and her children and family, demographics of participating children and supportive adults are assessed. In the third fiscal year of Iowa PPW, all agencies were required to participate in a quality improvement project, based on The University of Wisconsin-Madison's NiaTX model, which is designed to improve access and retention in behavioral health treatment. NiaTX model offers methods for treatment centers to deliberately plan for, implement and measure improvements in client access and retention. JRC's quality improvement project is discussed in this section of the report.

Trends in Admissions

From September 1, 2016 to September 29, 2018 Iowa PPW served 320 pregnant and postpartum women. Targeted and actual PPW admissions and monthly PPW admission counts will be discussed below.

Intake Coverage

Iowa PPW proposed to provide direct services to 120 pregnant or postpartum clients during each year of implementation. Because agencies did not begin admitting clients until the second quarter of 2016, the admissions target was reduced to 110 clients for the 2017 fiscal year. Figure 1 shows the number of clients admitted and the targeted number of clients by fiscal year. The number of pregnant and postpartum clients admitted to Iowa PPW has steadily increased from 85 in 2016 to 134 in 2018. The intake coverage rate, the percent of pregnant and postpartum clients admitted relative to target admission goals, increased from 58.3 % for the 2016 fiscal year to 111.7% for the 2018 fiscal year.

Figure 1. Intake Coverage by Fiscal Year

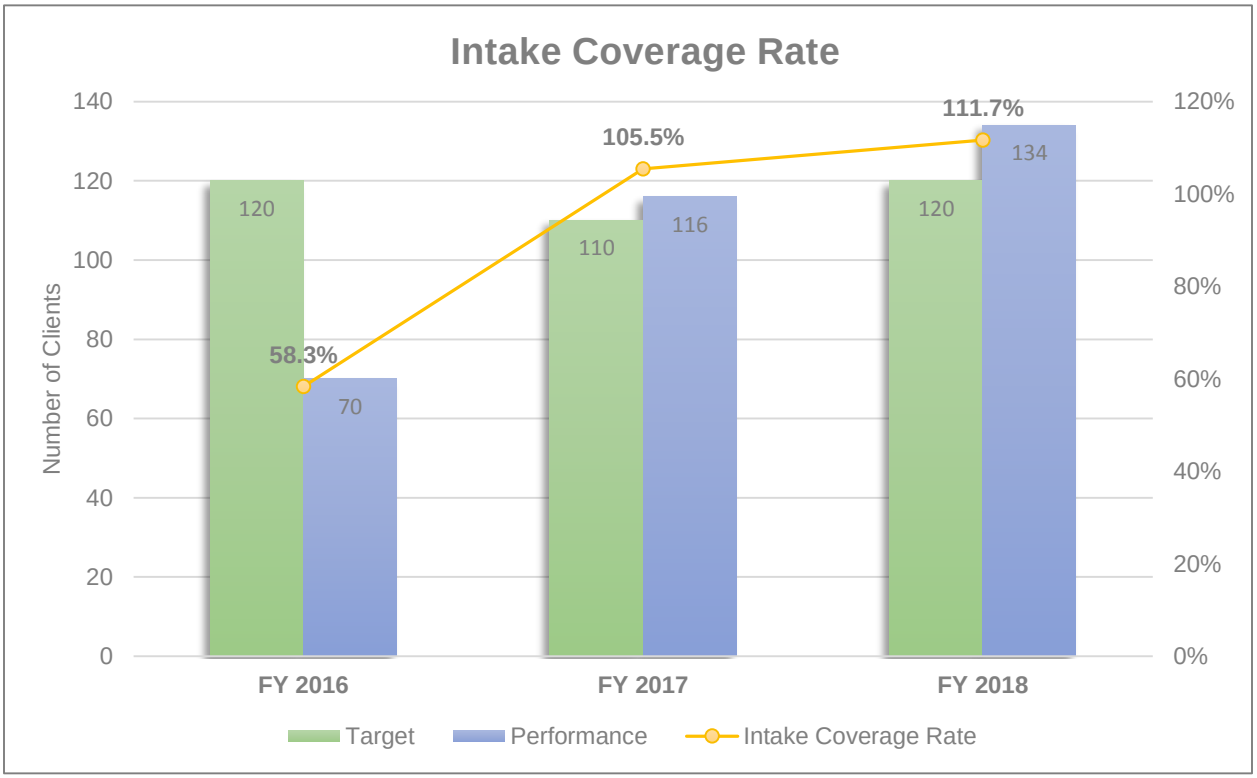
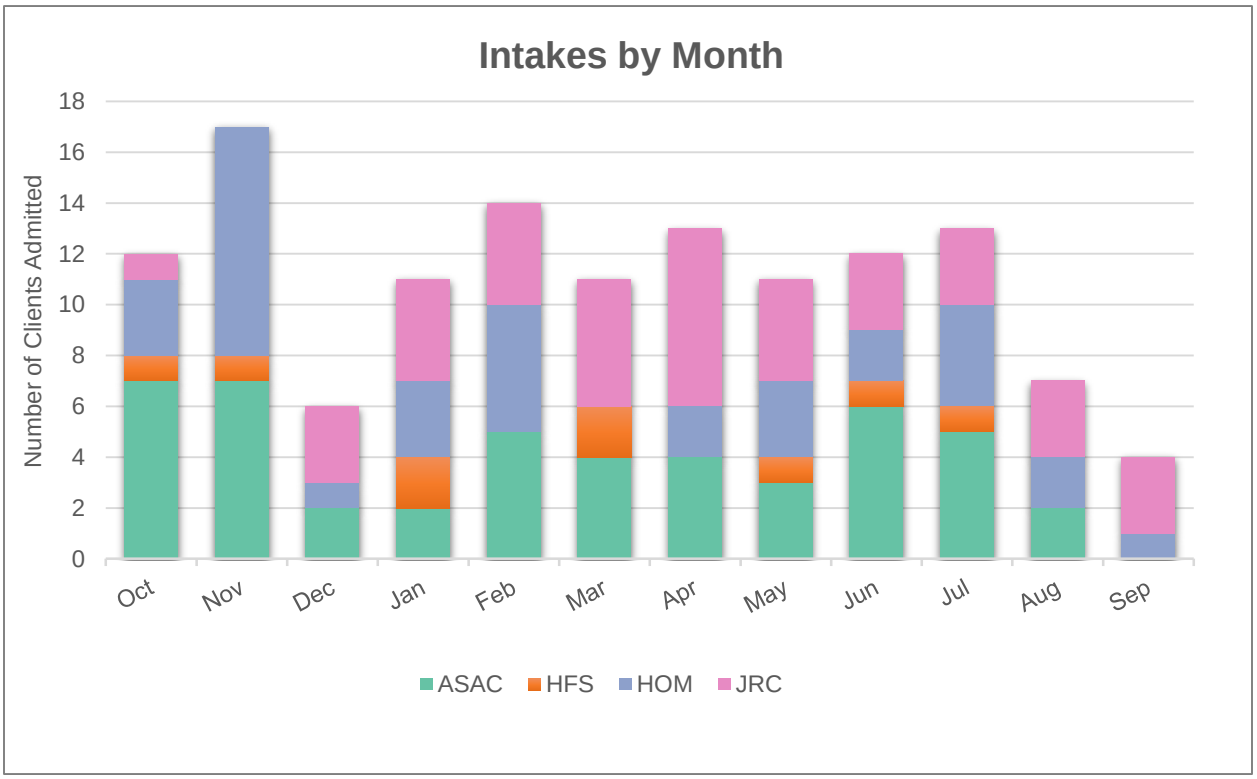


Figure 2 illustrates patterns in Iowa PPW admissions during the 2018 fiscal year. Overall, admissions remained steady between ten and fifteen clients per month from January to July. However, agencies may need to modify or enhance existing recruitment methods during December, August, and September, when admissions are historically lower, to meet admissions targets. The pattern of lower admissions during these months mirrors patterns for the 2017 fiscal year. Clients with children may refrain from entering treatment when children are starting school in the late summer or during winter holidays.

Figure 2. Number of Clients Admitted to PPW Program by Month



Baseline Client Characteristics: Demographics

Table 1 displays baseline demographic characteristics of the 320 pregnant and postpartum clients enrolled in PPW since September 30, 2015. The median age of all clients is 27 years. In general, most clients were White/Caucasian (75.6%), had at least a high school diploma or GED (70.3%), and had given birth to at least one child (94.1%). Furthermore, within the 30 days prior to admission to PPW, 39.7% of clients received income from public assistance and 79.1% of clients were either living at someone else's residence, in residential treatment, or were experiencing homelessness. A nearly equal percentage of clients were pregnant (48.8%) and postpartum (51.2%). Almost half (47.5%) of all clients reported having one or more children removed from their custody due to a protective order and nearly a quarter (22.5%) reported losing custody of one or more children.

Nearly three-quarters of clients (74.3%) had received substance use disorder (SUD) treatment services prior to their current admission, from an organization receiving public funding. More than 80% of clients

in this study were screened for mental health disorders. Of these, three-quarters (77.5%) had positive screening results.

Table 1. Baseline Client Characteristics

Client Characteristics	n = 320
Age (median)	27.0
Race/Ethnicity	
White/Caucasian	75.6%
Black/African American	4.7%
Native American/Alaska Native	6.6%
Asian/Pacific Islander	0.3%
More Than One Race/Ethnicity	8.1%
Hispanic/Latino	4.7%
Educational Achievement	
0 – 11 Years	27.8%
High School Diploma/GED	42.5%
Post-Secondary Education	29.7%
Receive Public Assistance Income (Past 30 Days)	39.7%
Living Arrangements (Past 30 Days)	
Someone Else's Residence	32.2%
Residential Treatment	23.8%
Homeless	23.1%
Own/Rent Residence	20.9%
Maternal Status	
Postpartum	51.2%
Pregnant	48.8%
Given Birth to a Child	94.1%
Have Child(ren) Living with Others Due to Protective Order	47.5%
Lost Custody of a Child	22.5%
Previously Received SUD Treatment	74.3%
Co-occurring Mental Health Disorder (n = 267)	77.5%

Baseline Client Characteristics: Substance Use

Figure 3 presents clients' reported primary substance use and frequency of use prior to admission for all clients admitted since September 30, 2015. Information about the clients' primary, secondary, and tertiary substance use were taken from the Central Data Repository (CDR). Twenty-four client records could not be located in the CDR, because either the UCN did not match across Consortium, CDR, and SPARS records and/or the client's record was not flagged with the PPW special initiative code in the CDR. Therefore, baseline substance use of 296 clients is described below.

A majority of clients (65.5%) reported methamphetamine as their primary substance used prior to admission. At 14.2%, marijuana was the second most commonly reported primary substance. Seven percent (7.1%) of clients indicated opiates or other synthetics, and 5.7% reported alcohol as their primary substance at admission. Forty percent of clients reported using their primary substance daily. On average, clients reported using their primary substance for 10 years, and one quarter (24.3%) of clients used their primary substance for 14 years or more.

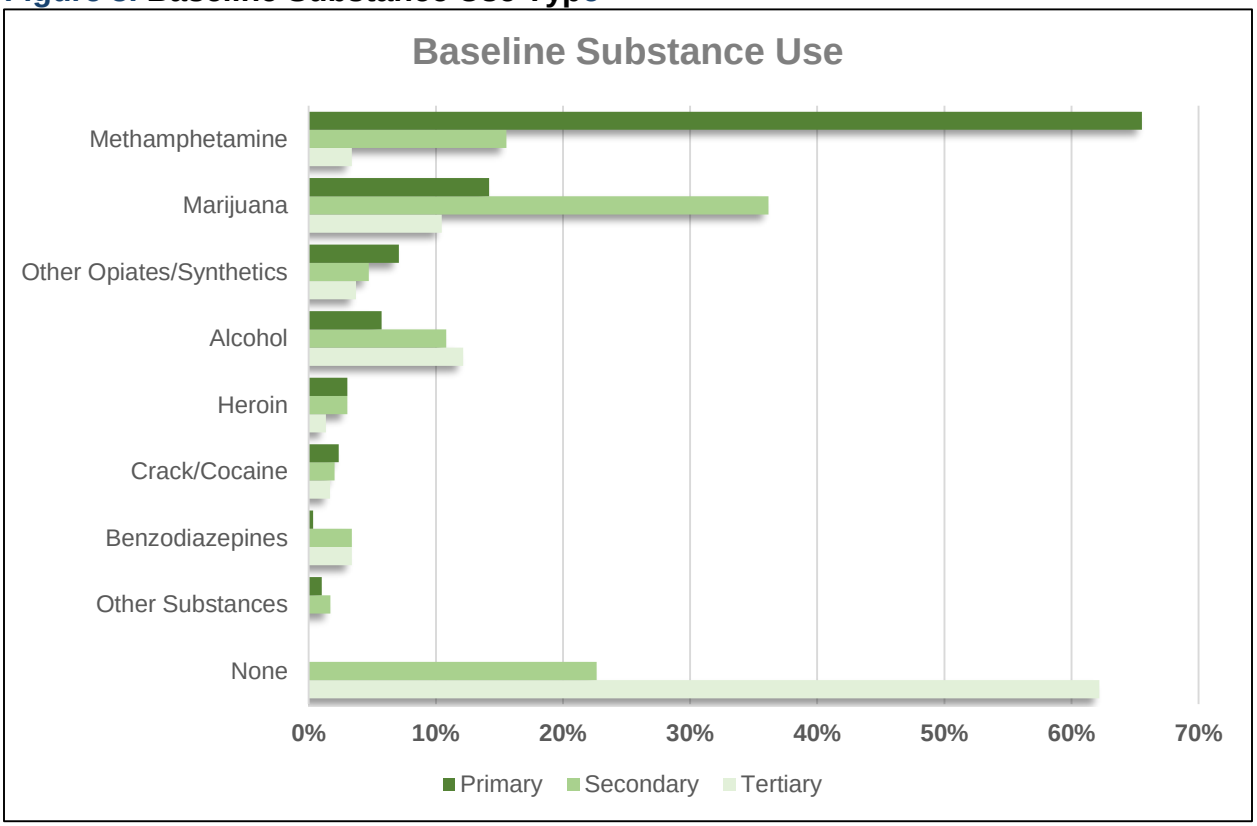
Over three-quarters (77.4%) of clients reported using more than one substance. Among these clients, marijuana was the most frequently used secondary substance, followed by alcohol, then other opiates/synthetics. A quarter (25.3%) of clients who used a second substance reportedly used their secondary substance daily.

Over one-third (37.9%) of clients reported using a third substance. Alcohol was the most commonly reported tertiary substance, followed by marijuana, then other opiates/synthetics.

Twenty percent (20.9%) of clients used either heroin, non-prescription methadone, or other opiates/synthetics as their primary, secondary or tertiary substance.

Over one-third (34.1%) of all clients reported using substances intravenously. There were significant differences in intravenous drug use across agencies (Fisher's Exact Test; $p<0.05$). Only 2.7% of HOM clients and 5.9% of HFS clients reported intravenous drug use in the 30 days prior to admission, while 22.1% and 17.0% of clients reported using intravenous drug use prior to admission to ASAC and JRC, respectively.

Figure 3. Baseline Substance Use Type



Clients' Children

Table 2 displays demographic characteristics of children born to the client at the time of discharge from PPW. Data reflect all clients discharged from PPW since September 30, 2015. Clients reported giving birth to 584 children. Slightly more females (52.3%) than males (47.7%) were born to PPW clients. A majority of the children was white (69.7%), followed by Native American (11.7%) and Hispanic/Latino (10.2%). The clients' children ranged in age from zero to 25 years, with a median age of 3 years. Forty percent of children (40.2%) were involved in an open DHS case.

Table 2. Demographics of Children Born to Client

Child Characteristics	n = 584
Gender	
Male	47.7%
Female	52.3%
Race and Ethnicity	
White	69.7%
Native American	11.7%
Hispanic	10.2%
Black	4.8%
Two or More	2.6%
Other	1.0%
Age (Median)	3.0
DHS Involvement	40.2%

Supportive Adults

Table 3 shows the number of Iowa PPW clients' adult family members participating in PPW since the beginning of the grant in September 30, 2015. There were 118 adult family member participants. Nearly half (47.5%) of adult family member participants represent the clients' partners and/or fathers of the clients' children. Excluding these fathers and/or father figures of the clients' children, very few male relatives participated in PPW (six participants). In contrast, 56 adult family members were female, which included the clients' mothers, grandmothers, aunts, and sisters. A large majority of family members was white (75.4%). The second largest racial/ethnic group of adult family participants was Hispanic/Latino. Adult family member participants ranged in age from 19 to 79 years of age, with a median age of 45 years.

Table 3. Demographics of Supportive Adults

Adult Supportive Adult Characteristics	n = 118
Relationship to Client	
Partner/Father of Child	47.5%
Mother	28.8%
Sister	10.2%
Grandmother	6.8%
Father	2.5%
Brother	1.7%
Aunt	0.9%
Cousin	0.9%
Grandfather	0.9%
Gender	
Male	52.5%
Female	47.5%
Race and Ethnicity	
White/Caucasian	75.4%
Hispanic/Latino	12.7%
Black/African American	5.1%
Native American	5.1%
Other	0.9%
Two or More	0.9%
Age (Median)	45

Sharon's Story

"I had no home and just stayed wherever I passed out. I had no income and all I did was use drugs. I didn't have friends and was not connected with my community. I was just around people I could use with"

After being arrested and charged with a felony and leaving mental health course unadvised, pregnant Sharon was given the option to go to prison or treatment. Sharon chose treatment. At Family Works Sharon was able to apply new skills with staff present to work through her crisis. Her newly gained coping skills have helped her feel less fearful of other people and have built a foundation for her to learn how to have friendships in her life. Sharon has "changed [her] self-esteem entirely" and has gained more confidence and tolerance about being a new mom again. Sharon has also ended an unhealthy using relationship and is working on a sober relationship with her daughter's father through family visits and relationship counseling. While she was "not successful" with Intensive Outpatient services in the past, Sharon stated Iowa PPW worked for her because, "I needed [to be] somewhere that would hold me accountable until I learned how to hold myself accountable."

Nearing graduation from the program, Sharon says she is, "happy, responsible, confident, self-aware, and contemplative". She is living in a structured environment surrounded by positive sober supports and plans to begin seeking employment soon. Sharon hopes to "have a happy family with my daughter and boyfriend and [live] in a sober living environment. I want my children to be happy and have bright futures."

Strategies to Increase Client Admissions

During phone interviews, PPW staff described strategies used to recruit pregnant and postpartum clients. Staff-reported strategies fall into four categories: 1) adding pregnant and postpartum clients to their high priority client list, 2) educating community service organizations, 3) partnering with community organizations, and 4) word-of-mouth recruitment by PPW clients.

Several agencies reported already having pregnant women on their high priority client list prior to PPW. However, after implementing PPW, they added postpartum women to their list of high priority clients. One staff noted that adding postpartum clients to the agency's high priority client list was in line with their focus on promoting mother-infant bonding. Another agency indicated that, in addition to adding postpartum women to their high priority list, they advocated for local referral sources to place pregnant and postpartum women at the top of their prioritized client lists.

A few staff members also discussed seeking new opportunities to educate community agencies about PPW, and using their existing organizational memberships as a platform to educate their peers about PPW. Organizations that primarily serve families, children, and women were identified as audiences that were most receptive to their efforts.

All agencies expressed that growing their network through partnerships with a variety of local organizations increased client referrals. PPW staff reported collaborating with the following types of organizations:

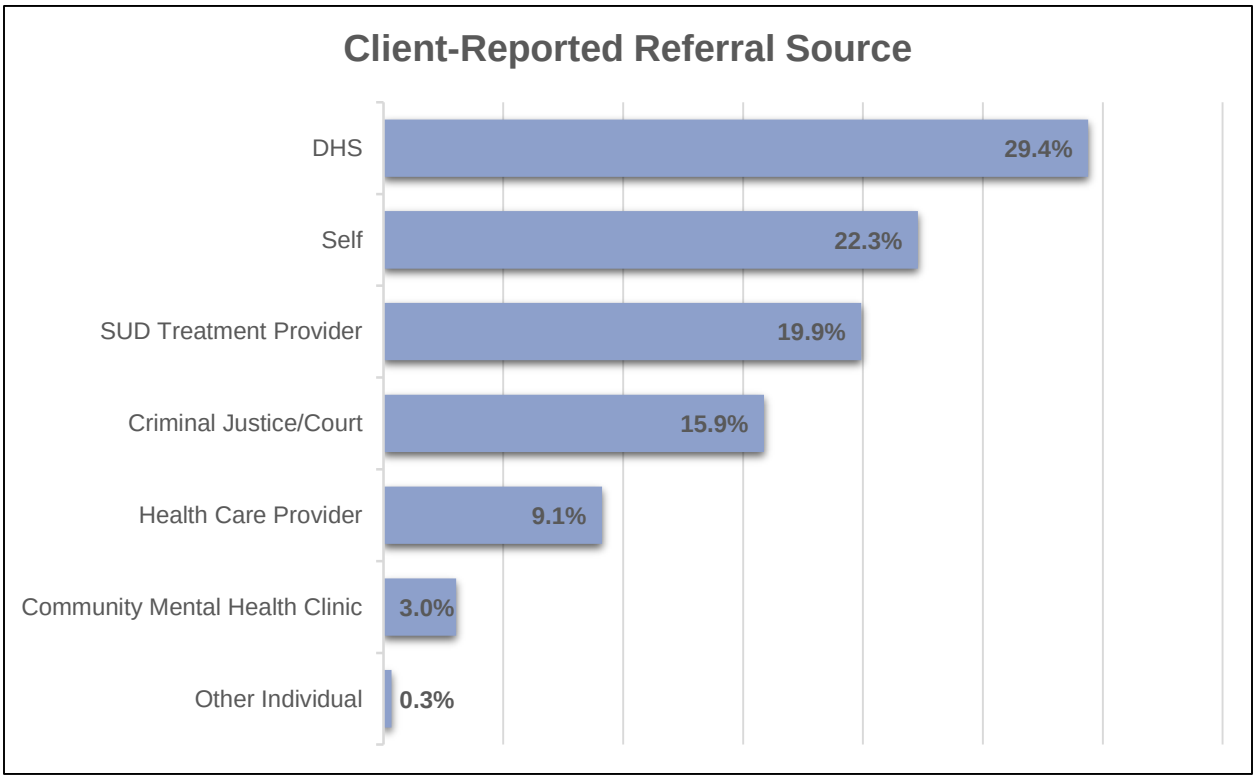
- Churches
- Community Advocacy Groups
- Low Income Service Programs
- Hospitals
- Department of Human Services
- Probation Officers
- Outpatient Treatment Providers
- Treatment Centers in Jails
- Domestic Violence Coalitions
- Area Education Agencies
- Family Treatment Court

- Cultural Groups

Lastly, one staff member discussed how one client with an exceptionally positive perspective of PPW encouraged several other women to enroll in PPW. In reference to the client, a staff reported, “I think we’ve gotten about six referrals from that one success[ful client]”.

Figure 4 shows the distribution of client-reported referral source. The most commonly reported referral source was DHS. Over one-quarter of clients reported being referred to PPW by DHS. Self-referrals were the second most common referral source (22.3%), followed by a substance use disorder (SUD) treatment provider (19.9%). This finding is similar across all fiscal years. While these data do not reflect staff reports of increased recruitment from community organizations, it should be noted that a client might be encouraged to enroll in PPW by a variety of sources, all but one of which cannot be coded on the intake form. Perhaps only the most personally salient source was mentioned when asked who referred them to the program.

Figure 4. Client Reported Referral Source



Quality Improvement Project #1: Increasing Admissions

***Problem**:* Some PPW agencies have experienced challenges reaching PPW client admissions targets. For example, analyses discussed above indicate admissions are routinely low in winter and late summer months, leaving agencies with the need to increase admissions during these months or in other months to make up for periods of low admissions. Low levels of admissions can have negative consequences for the agencies in the form of disincentives and lower revenue.

***Solution*.** JRC staff expressed that they could increase admissions by connecting with current clients and referring agencies throughout the community. Staff communicated with referring agencies and current clients through mail, email, and in-person communications.

Action. Beginning in April 2018, PPW staff at JRC informed current referrals, community members, and patients about their Women and Children's Center and PPW. This first cycle of the project involved staff presentations at community meetings, sending letters and emails to current referring DHS staff, informing internal referrals about PPW, and educating staff at other agencies working with PPW's target population in the community. The second cycle of the quality improvement project involved developing contacts with local labor and delivery physicians and administrative staff. JRC staff worked with the internal marketing team to develop a plan to disseminate information regarding PPW and JRC's Women and Children's Center to mothers in need of residential treatment for addiction during pregnancy and postpartum.

Staff have decided to continue presenting information about PPW at community meetings, educating internal referrals, and informing staff at other community agencies working with PPW's target population. Rather than send letters to DHS referrals, staff have decided to discuss PPW with DHS staff in-person during monthly staffing, community meetings, and at the time of client referrals. To assess whether the additional efforts to recruit new clients influenced client admissions, staff compared the number of admissions from April through June 2017 to admissions from April through June 2018. No significant change in client admissions was observed; however, more time may be needed for a shift in admissions and referral patterns to take place.

Overview

PPW agencies admitted 134 clients in the 2018 fiscal year. Since 2016 the intake coverage rate, the percent of pregnant and postpartum clients admitted relative to target admission goals, has risen steadily from 58.3% in 2016 to 117% in 2018. All clients admitted throughout the duration of the grant were mostly White/Caucasian (75.6%), had at least a high school diploma (72.2%) and had given birth to at least one child prior to admission (94.1%). Methamphetamine was the most commonly reported substance (84.1%) followed by marijuana (60.8%) and alcohol (23.6%). Clients gave birth to 584 children before admission of which 40.2% had an open DHS case. One hundred eighteen supportive adults participated in PPW programming including 56 fathers of children. Lastly, in the 2018 fiscal year, PPW agencies attempted to increase client admission by 1) adding pregnant and postpartum clients to their high priority client list, 2) educating community service organizations, 3) partnering with community organizations, and 4) encouraging current PPW clients to share their experiences with others who may benefit from the program.

CLIENT RETENTION

The following section of the report presents patterns in clients' treatment engagement and retention. Descriptions of services and practices employed by PPW agencies to retain and engage clients in treatment are also included; these include Recovery Support Services, Evidence-Based Practices, Medication-Assisted Treatment, and actions undertaken to engage fathers of children.

Length of Stay and Treatment Completion

To assess how length of stay and discharge status for PPW clients compares to similar clients enrolled in other substance use disorder treatment programs, the following section includes length of stay and treatment completion for two comparison groups:

1) Pregnant clients admitted to a residential treatment program receiving state funding and
2) Pregnant clients admitted to a Women's and Children's program receiving state funding.

Both comparison groups were sampled from the Central Data Repository. Only clients admitted in the same period as PPW clients were eligible for selection (February 1, 2016 – September 29, 2018). Furthermore, comparison group clients could not be selected if they were enrolled at a PPW site within this timeframe.

Length of Stay

For PPW, length of stay is defined as the number of days clients spend enrolled in the program from admission to discharge. As of September 29, 2018, 264 clients (82.5% of admitted clients) discharged from Iowa PPW since the inception of the grant. Table 4 shows the range and median length of stay for PPW clients and comparison clients.

The median length of stay for PPW clients is significantly longer than the length of stay for the residential comparison sample ($t = 8.77$; $p<0.001$). However, the length of stay for PPW clients is significantly shorter than the length of stay for Women's and Children's sample ($t=1.85$; $p<0.05$). The median length of stay for PPW clients is 73.5 days compared to a median length of stay of 13.0 days for the residential sample and 90.0 days for the Women's and Children's sample. The mean length of stay for all groups is higher than the median suggesting the mean is inflated due to relatively long lengths of stay. For example, while the median length of stay is between two and three months for PPW and Women's and Children's clients, Table 4 shows the maximum length of stay for PPW clients and Women's and Children's clients are nearly a year long at 388 and 303 days, respectively. In addition, while median length of stay ranged from 69.5 days to 88.5 days among PPW agencies, the agency differences in length of stay were not statistically significant (Kruskal-Wallis Test; $p>0.1842$).

Table 4. Length of Stay for PPW and Comparison Group Clients

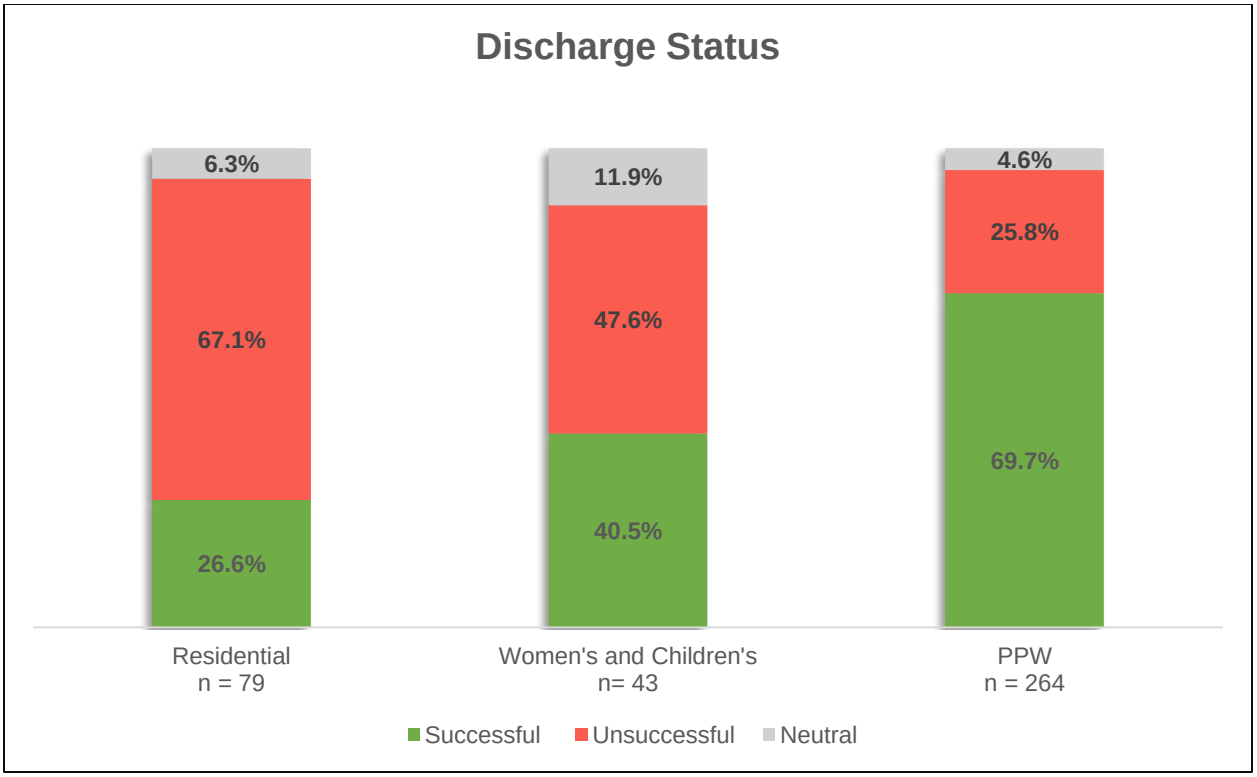
Length of Stay	Residential n = 79	Women's and Children's n = 43	PPW n = 264
Range Days	0.0 – 134.0	0.0 – 303.0	1.0 – 388.0
Median Days	13.0	90.0	73.5
Mean Days	24.1	94.2	77.1

Treatment Completion

Treatment completion is measured at the time of the clients' discharge and is classified as either successful, unsuccessful, or neutral. These analyses classify a client as successfully completing treatment if she graduated from PPW. Clients who left against staff advice, were involuntarily discharged due to nonparticipation or rule violation, or incarcerated due to an offense committed while in treatment were classified as unsuccessfully completing treatment. Clients who died during treatment, were referred to another program or service, transferred to another facility for health reasons, or incarcerated due to an old warrant were considered to have a "neutral" completion status.

Figure 5 shows the treatment completion status for all clients discharging from PPW since September 30, 2015 and for comparison group clients. A significantly higher percentage of PPW clients completed the program successfully (69.7%) compared to residential comparison group (26.6%) (X^2 (2) = 48.74; p<0.001) and Women's and Children's comparison group (40.5%) clients (X^2 (2) = 14.26; p<0.01). In fact, the proportion of clients successfully and unsuccessfully completing treatment for PPW and residential sample group clients was nearly flipped. While 69.7% of PPW clients successfully completed the program, a nearly equal proportion of residential comparison group clients (67.1%) did not successfully complete the program. However, there was no significant difference in discharge status between the Women's and Children's sample and the residential treatment sample (X^2 (2) = 4.44; p>0.109).

Figure 5. Treatment Completion for PPW and Comparison Group Clients

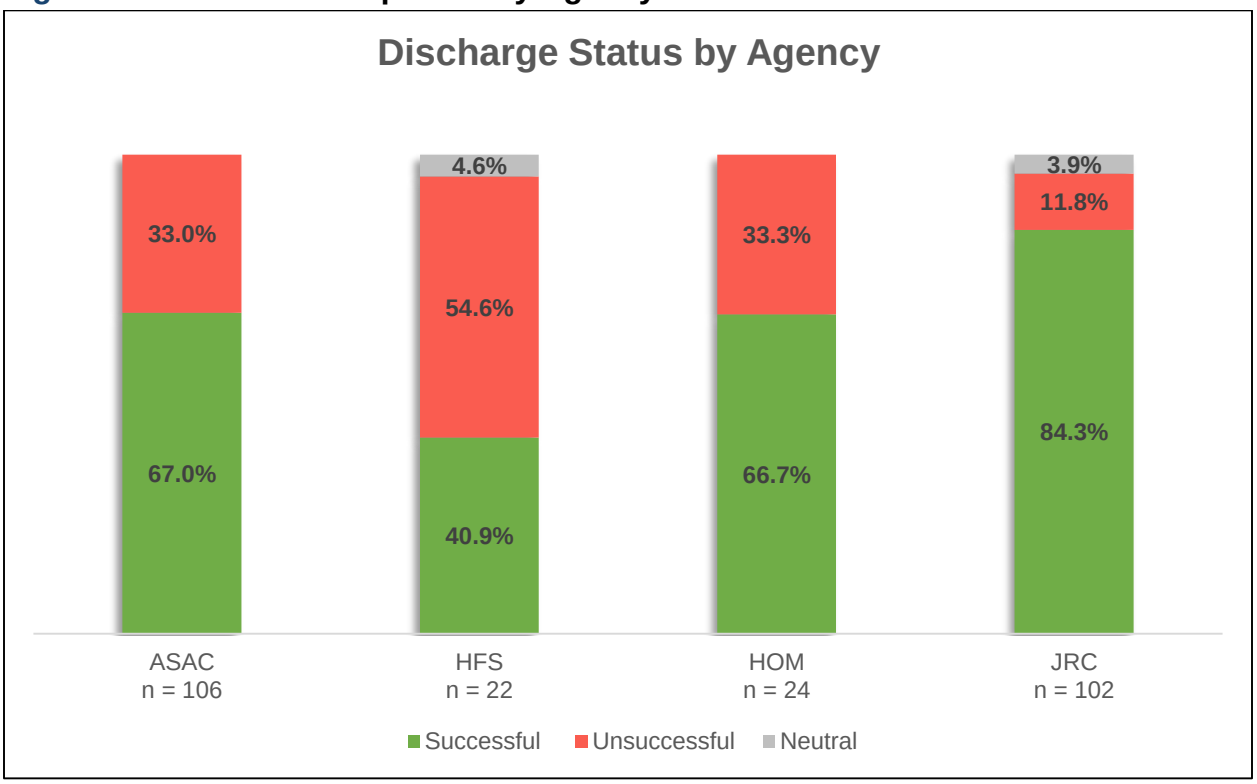


Discharge Completion Rates by Agency

Figure 6 shows rates of treatment completion for each Iowa PPW agency. Ten client records were omitted from this analysis because the unique client identifier did not match across Consortium, SPARS, and CDR records leaving a sample size of 254 clients discharging from PPW since the

beginning of the grant. There are three discharge categories: successful; unsuccessful (clients discharged from the program due to noncompliance, lack of treatment progress, or client leaving); and neutral (clients discharge from the program due to a managed care decision, referral to another program, incarceration, or death). JRC has the highest treatment completion rate at 84.3% followed by ASAC and HOM at 67.0% and 66.7%, respectively. HFS has the lowest treatment completion rate at 40.9%. The observed disparities in treatment completion rates by agency are statistically significant (Fisher's Exact Test, $p < 0.001$). More investigation on an agency level is needed to explain these differences in treatment completion since client-level characteristics (substance type, pregnant/postpartum status, demographics, and mental health) do not explain agency differences.

Figure 6. Treatment Completion by Agency



Discharge Status and Assessment of Recovery Capital

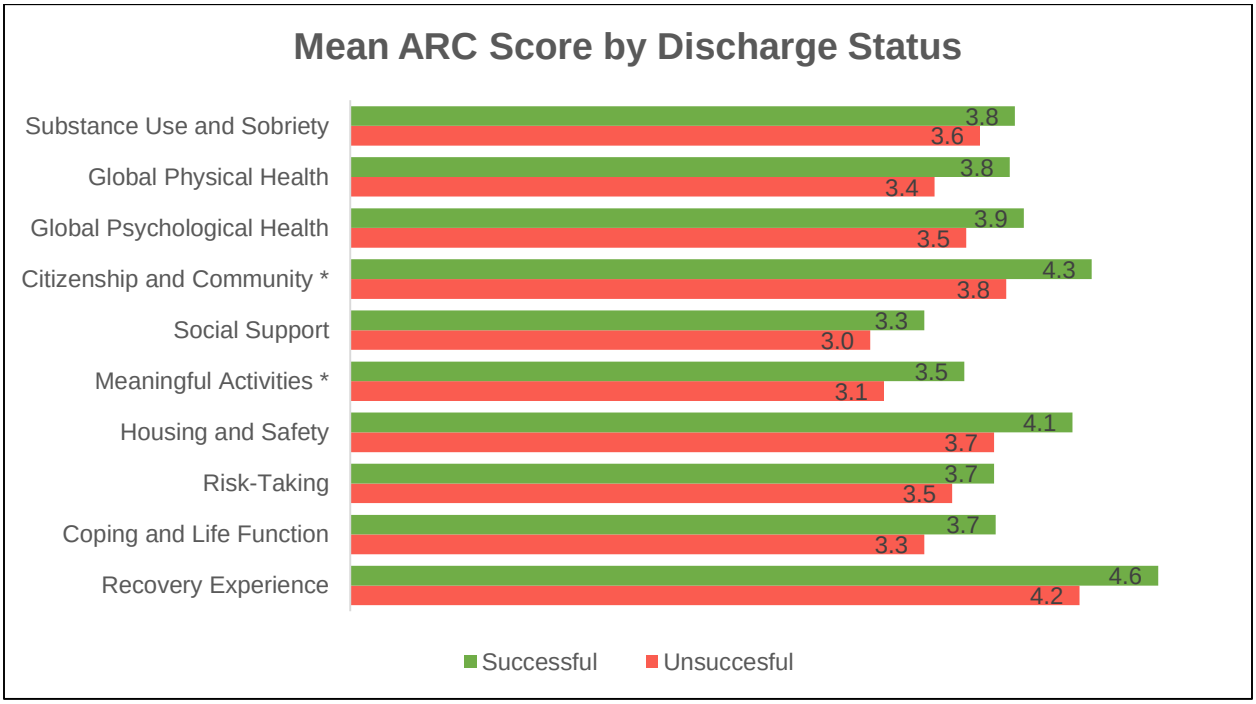
Additional analyses were run to test for differences in discharge status by substance use, injection use, frequency of substance use, family participation, living status, drug court participation, giving birth during treatment, and DHS involvement; however, none was significantly different. However, clients' Assessment of Recovery Capital (ARC) score at intake was significantly associated with discharge status. The following section will discuss these analyses in detail.

Of the 264 clients discharged by throughout the duration of the program, 182 clients also completed an Assessment of Recovery Capital (ARC) at intake. Excluding seven clients with a neutral discharge, the total ARC score for clients successfully completing the PPW program (38.7) was significantly larger than the total ARC score for clients not successfully completing the PPW program (34.9) (Kruskal-Wallis Test; $p<0.05$).

Figure 7 shows the ARC score by dimension for 124 clients successfully completing PPW and 51 clients not completing PPW. There was a significant difference in ARC scores for two dimensions:

Citizenship and Community (Kruskal-Wallis Test; p <0.05), and Meaningful Activities (Kruskal-Wallis Test; p<0.05). For these two dimensions, clients who successfully completed treatment had significantly higher mean levels of recovery capital than clients who did not complete treatment. These results suggest clients who desire to contribute to the community and society and who have access to and engagement in training, education, and leisure activities at intake were more likely to successfully complete treatment.

Figure 7. Treatment Completion and ARC Score



Engaging Fathers

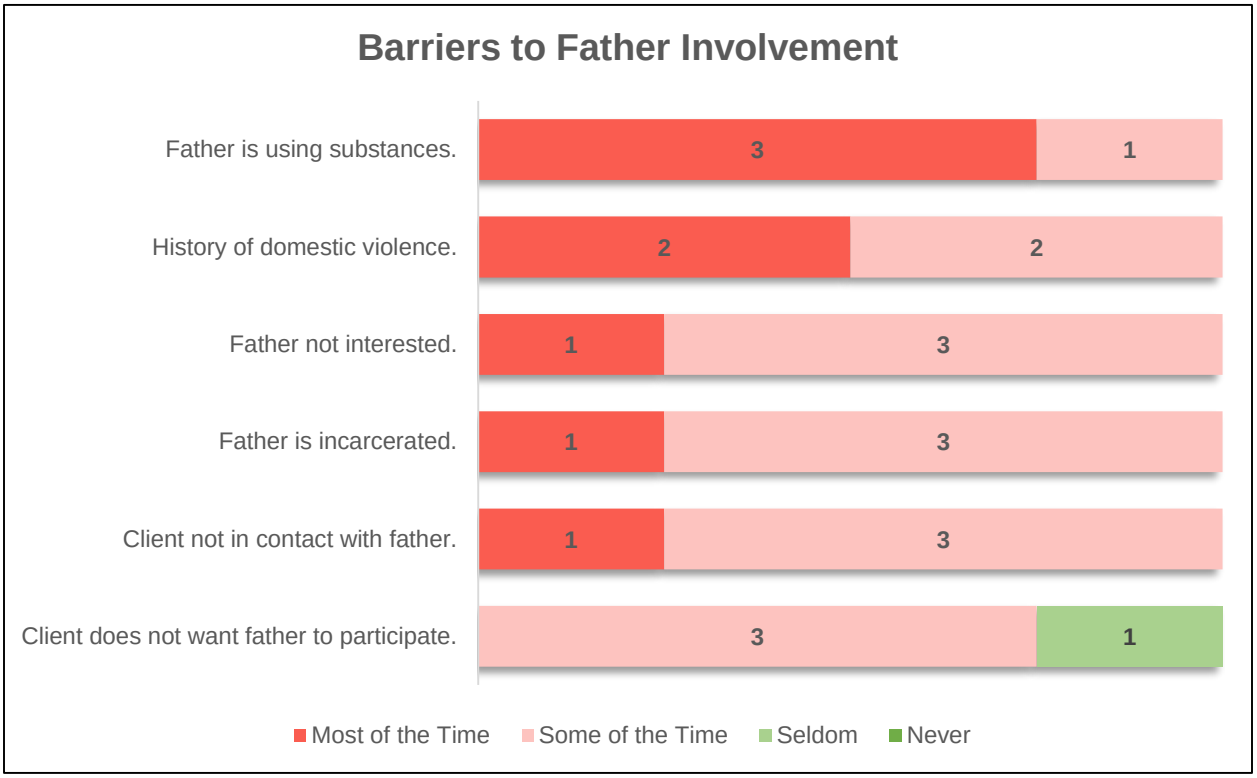
Encouraging fathers of the clients' children to be involved with the clients' recovery was a focal aim for the third fiscal year of PPW. The section below will discuss challenges and solutions in engaging fathers from the perspectives of PPW staff and currently engaged fathers.

Staff-Reported Challenges

Figure 8 displays staff rankings of common barriers to father involvement in an end of the year survey given to staff in the third quarter of the 2018 fiscal year. Because each agency submitted one response, only four responses are presented in the figure. Staff were asked whether the barrier to father involvement occurred "most of the time", "some of the time", "seldom" or "never". According to staff, the most frequently occurring barrier to father involvement was the father's substance use. Three of the four agencies indicated that the father's substance use was a barrier to the father's involvement "most of the time". The second most common barrier to fatherhood involvement among the four agencies was a history of domestic violence with two agencies reporting domestic violence as a barrier "most of the time" and two agencies reporting it as a barrier "some of the time". Only one agency reported fathers' lack of interest, fathers' incarceration, and clients' lack of contact with the father as barriers to father involvement "most of the time". The remaining three agencies reported the barriers occur "some of the

time". Lastly, three agencies reported the clients' desire to exclude the father from participation was a barrier "some of the time", and one agency reported the barrier seldom occurs.

Figure 8. Staff-Reported Barriers to Father Involvement



In addition, staff had the opportunity to describe challenges to involving fathers in PPW during in-depth interviews with the evaluator in the program's third quarter of the 2018 fiscal year. The results of the interview and the end of year survey revealed challenges in engaging three types of fathers:

- Significant others who were "unsuitable" for participation
- Significant others who were "suitable" for participation
- Absent fathers

Fathers who were incarcerated, actively using substances, and/or had a history of domestic violence were categorized as fathers who were not suitable for participation. PPW staff faced challenges in engaging these fathers in PPW largely due to DHS policy, inability to participate due to incarceration, and clients' desire to block a father-client relationship. While fathers without an active addiction problem or history of domestic violence were considered suitable for participation, staff experienced getting these fathers involved due to feelings of anger towards the client and/or engaging in a new relationship with someone other than the client. Lastly, absent fathers could not be located and thus were not able to be engaged in the program.

"Unsuitable" Fathers

A common theme in interviews and in the end of the year evaluation survey was the inability of fathers to participate in the program due to their current life situation. According to the interviewees, fathers

were often unable to participate in PPW due to their current problems with substance use, domestic violence, or incarceration.

Tara's Story

Prior to coming to the HOI, I was only concerned about myself and using. *My boyfriend and I were living in hotels or with friends. I was unemployed and dependent on others to support me. I had lost custody of my daughter. Fun consisted of using and more using. My relationships with my family were not good because of my using and selfishness.*

I completed treatment last year but relapsed the day after discharge. I was so consumed with using that I didn't care about my children or my family. After losing custody of my 1-year-old daughter and finding out I was pregnant again, I knew I needed to go back to treatment. I came to Heart of Iowa because I needed help. I had lost custody of my daughter and wanted her back. I'm thankful that I was referred to Heart of Iowa because this is what I really needed. It was treatment and I was allowed to bring my children with me. Upon entering the program, I was also pregnant with my third baby.

I had my doubts about treatment based on my past experience (failure), believing I could not stay sober. Since coming to Heartland of Iowa, I've been sober for 79 days. I have never had this much success in the past. I lost my daughter and since coming here, they placed me on trial placement and now I am getting custody back. I recently went to court and the case is being closed. I'm feeling good about myself and my life is coming together. I have more patience with my children, ages two and one and will soon give birth to my baby in October. I'm now super close to my mom and siblings. My relationships with my dad and brother are also improving.

I was in treatment last year and used the day after I discharged. This time it's different because I have a parent partner, I'm going to AA/NA meetings and have the support I need to stay on the right path. The longer treatment and support has been very helpful and motivating. I want my children to have me in their life permanently, and a stable place to live.

PPW staff indicated that reaching out to "unsuitable" fathers was considerably difficult due to DHS regulations. Several interviewees indicated DHS prohibited the participation of some fathers or wanted fathers "completely out of the picture" due to their current life situation. In some cases, there was a no contact order in place making it unlawful for the father to engage with his partner and/or children.

Staff also indicated clients sometimes hindered engagement of "unsuitable" fathers. The anticipation of judgment some clients felt about returning to a relationship with an "unsuitable" partner encouraged clients to block the formation of a father-clinician relationship. As one interviewee stated, "...a lot of times the girls feel like they don't want to disappoint the counselor by going back to the relationship." For example, one clinician describes a situation where the client indicated she wanted to move back into a relationship with the father of her children with whom she shared a history of "brutal" domestic violence. The clinician reported encouraging the client to have a family therapy session with the father of her children before she discharged, but the client regularly rejected the suggestion. In what the clinician describes as a way to go around the clinician and block the formation of a client-father relationship, the client scheduled the father to pick up his children on a day the clinician was not there.

Staff also identified a cultural barrier underlying “unsuitable fathers”. Interviewees discussed how the presumption that men are less important to children’s development in American culture creates lower expectations for men to seek treatment for their substance use problems. Rather than there being a focus on *both* parents being “sober and parenting appropriately”, staff stated some fathers felt it was the mother’s responsibility to go to treatment even if the father was actively using substances. One clinician stated, “I’ve heard plenty of dads who have [told the clients] you go through and get treatment and get the kids back and then we will be together”. Holding the bar of childcare responsibility lower for fathers than for mothers contributes to the belief that, compared to the mother’s substance use, the fathers’ substance use has fewer consequences for the child’s development. Staff described how this cultural orientation trickled down into their own agencies and influenced how they engaged fathers of PPW children. Staff discussed an underlying desire to protect the clients and their children from “damaging” fathers and often saw fathers as entities in need of inspection before permitting their interaction with their children and the client.

“Suitable” Fathers

Staff also encountered barriers in engaging fathers who did not have a substance use problem, who were not incarcerated, and who did not have a history of domestic violence. “I deal with a lot of angry fathers”, said one clinician, “[The fathers] are upset their kids are there, upset they don’t get food coming home, they’re not getting the food they had before, they’re upset about the cost of treatment…they’re upset they are having to bring the child for a visit.” In general, these “suitable” fathers may feel that the mothers’ treatment is an inconvenience and departure from the way they were used to living.

Another barrier staff faced when engaging these fathers is they were pursuing a relationship with someone other than the client. Staff indicated that when fathers of the children “moved on” both the father and the client were reluctant to establish a positive co-parenting relationship.

“Absent” Fathers

Lastly, PPW staff reported that some clients did not know the father of their child and thus staff were unable to engage the father in treatment. In other cases, the client knew who the father was, but they were not in communication with the father. One staff member summarized this situation, “…a lot of [clients] aren’t really engaged in the relationship or parenting at all with some of those fathers.” These “absent” fathers are likely the most difficult fathers to reach since, “in some of these relationships the men feel like they don’t have any responsibility for the child.” However, interviews and surveys indicate clients generally want the father to participate and to have a meaningful relationship with their children.

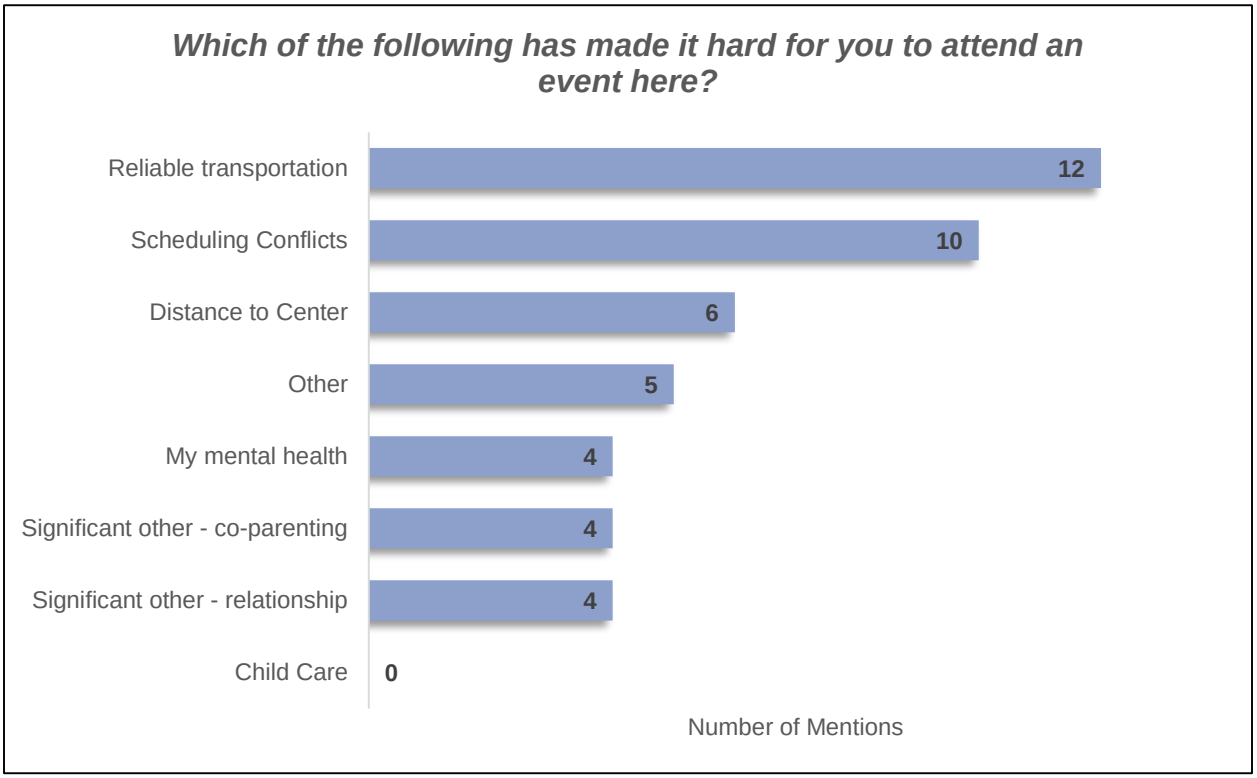
Father-Reported Barriers

Agency staff also asked fathers participating in PPW or outpatient services to identify common barriers to PPW participation using the Fatherhood Survey (see Appendix X). Agencies obtained responses from 39 fathers from June 2018 to September 2018.

Figure 9 shows father-reported barriers to program attendance in descending order. Numbers represent number of mentions rather than number of fathers since respondents could report more than one barrier. The most commonly cited barrier was reliable transportation. Over one-quarter of fathers completing the survey felt reliable transportation to the facility made it difficult for them to attend an

event. Ten fathers also indicated they were unable to attend PPW due to scheduling conflicts and six fathers felt the distance to the center was too far. Barriers falling in the "other" included fathers inability to attend due to incarceration, getting sick, and misremembering the date and time of the event. Only four fathers indicated their romantic or co-parenting relationship with their significant other in treatment or their mental health was a barrier to participating in PPW activities. No father reported childcare as a barrier to PPW participation.

Figure 9. Father-Reported Barriers to Participation



Overcoming Barriers to Father Involvement

The following section reviews solutions to father engagement from both father and staff perspectives. Potential methods suggested to overcome barrier to father involvement include shifting organizational culture at PPW agencies, training staff to implement 24/7 Dads, and offering more accessible family programming and father services that are in line with fathers' interests and needs.

Shifting Organizational Culture

While, as one interviewee stated, moving away from the mother as the most important caretaker is a "cultural shift that is way bigger than us", staff reported making agency-wide changes in program implementation to create a culture where father involvement is encouraged and expected.

Some interviewees indicated their organization effectively handled situations where the father wanted to participate in their significant other's treatment; however, they felt challenged in actively reaching out to fathers not expressing a desire to participate. Offering PPW at their site urged providers to consider "how can we invite the dads like we invite the moms to participate?" One interviewee recounts what fatherhood involvement looked like at their agency before and after PPW:

> ***"Having supervised the program prior to PPW years ago, attitudinally we were way different then. We didn't include the men then very much. We were kind of angry at the men, and our actions with the women had impacted the lives of them and their kids. So I think attitudinally we have made huge, huge changes. That's what they're going back to anyway so we need to try to engage [fathers] and get them help as well while the woman is here."***

Working towards the goal of improved father outreach, and subsequently, father participation, one agency now routinely invites the fathers to the initial client meeting. For this agency, inviting fathers to the clients' first meeting has led to effective family sessions later in the clients' treatment. In addition, Intake Specialists at another PPW agency now ask for the fathers' information upon the clients' admission so staff regularly can reach out to fathers. Another interviewee mentioned an easy way to reach out to fathers is to offer them the same information about their children as they offer to mothers, "especially because they have the right to that information".

Another interviewee stated she has had success with engaging "unsuitable" fathers with a history of domestic violence, substance use, and/or incarceration by informing clients of the clinicians' desire to bring in the father/partner to educate the couple rather than discourage the relationship all together. Additionally, in the event the father is not able to visit with children unattended, staff can work with the father to arrange DHS supervised visits.

Lastly, an interviewee explained how the fathers themselves have likely internalized the cultural norm of fathers as non-primary child caregivers. In order to assist fathers in shifting their own perspective of the importance of fatherhood, the staff member suggested, "…get(ting) the fathers to realize that dad is just as important as mom in your life, [and] get them to look at their own lives. Your dad was or wasn't around and how does that effect you?"

Training Staff

At the end of the 2017 fiscal year, staff began training to implement the 24/7 Dads program across all Iowa PPW sites. The National Fatherhood Initiative's 24/7 Dads is a fatherhood program designed to assist men's improvement in parenting skills and fathering knowledge. The core components of the program include developing self-awareness, self-caring and parenting, fathering and relationship skills.

Eleven staff members attended the 24/7 Dads Training Institute on August 2, 2017. Topics covered in the training included how to facilitate a 24/7 Dads group, identifying retention and recruitment strategies, and investigating previous evidence of program effectiveness. Since the training in August 2017, the IDPH Program Director has held monthly joint Seeking Safety and 24/7 Dads Provider Calls where clinicians discuss challenges and successes in implementing these two evidence-based practices. Furthermore, each agency has at least one person who is able to train other staff members to implement 24/7 Dads.

Nevertheless, results from the Fatherhood Survey suggested that only 13 out of 37 dads completing the survey had heard of the 24/7 Dads program. Some staff suggested fathers may have not been aware of the 24/7 Dads since it is offered through the agency's outpatient services. In addition, one agency has advocated for offering 24/7 Dads in jails and prisons for incarcerated fathers so they are more prepared for responsible fatherhood once they are able to father their children full time.

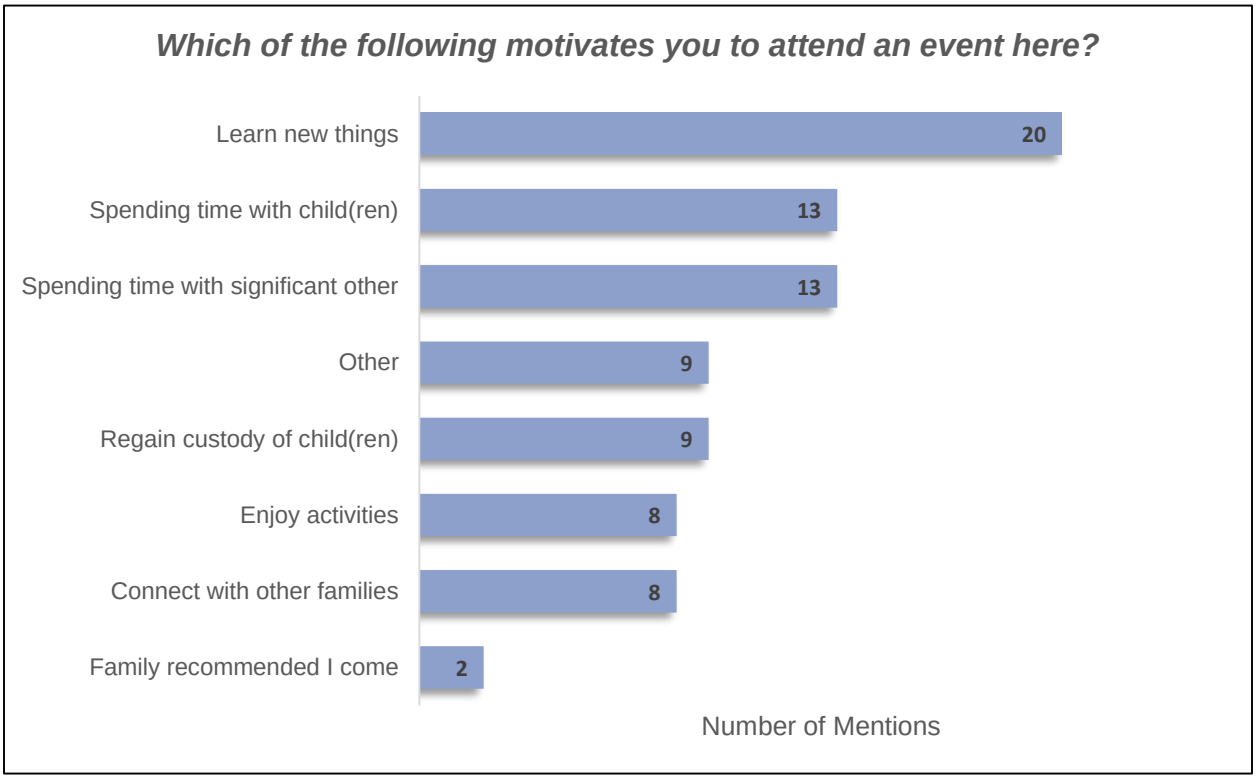
More Accessible Events and Visitation

Surveys given to fathers participating in PPW programming revealed transportation to the center was one of the biggest barriers to attendance. While PPW can offer fathers gas cards to alleviate the cost associated with traveling to PPW events, one staff member commented, "…even if you give them gas cards, it still takes a long time to get here and back." Furthermore, some fathers do not have access to a reliable vehicle to use gas cards and instead use public transportation. Another barrier was due to scheduling conflicts. During interviews staff noted that some fathers have work schedules that conflict with PPW programming.

While staff can work with fathers to arrange transportation to programming and can alternate programming days and times to create more accessible events and visitations, staff can also find out what types of events fathers may be more interested in attending. Fathers may be more likely to overcome transportation and scheduling conflicts to attend events they find personally interesting. The following three figures present results from the Fatherhood Survey taken by 39 fathers participating in a PPW event from June to August 2018 describing factors motivating fathers to attend events and types of events and services they find most appealing.

Figure 10 illustrates fathers' responses to the question, "Which of the following motivates you to attend an event here?" Numbers represent mentions and not number of fathers since respondents could report more than one motivator. A majority of fathers (60.0%) indicated that the biggest motivator to participate in a PPW event was to learn new things. The second most common motivators to father attendance were spending time with children and significant others. A roughly equal number of fathers reported attending because they enjoy the activities, want to connect with other families like theirs, and regain custody of their children. Only two fathers reported being motivated to come due to family encouragement. Responses in the "other" category include fathers who reported being motivated to stay sober, out of the criminal justice system, seek help, and have others to talk to.

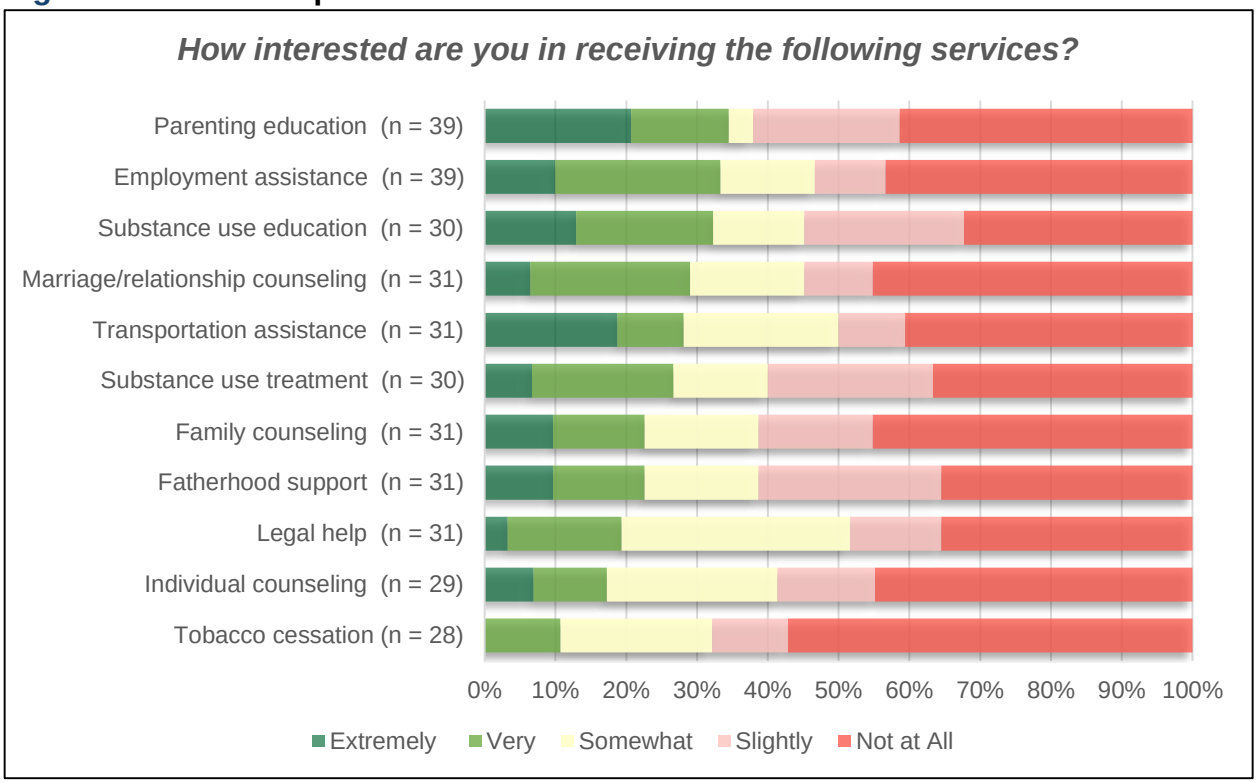
Figure 10. Father-Reported Motivators to Participation



Agencies implementing PPW can also improve father engagement through providing services and/or linkages to services fathers want and need. Figure 11 shows fathers' responses to the question, "How interested are you in receiving the following services?" Responses are displayed in descending order so that services with the highest levels of interest ("extremely" and "very" interested) are listed first.

In general, over half of fathers responding to the question either expressed not being interested in the services "at all" or were only "slightly" interested in services. Parenting education, employment assistance, transportation assistance, and substance use education were of interest to several fathers. Interestingly, while marriage/relationship counseling was appealing to several fathers, fewer fathers expressed interest in family counseling, fatherhood support, and individual counseling.

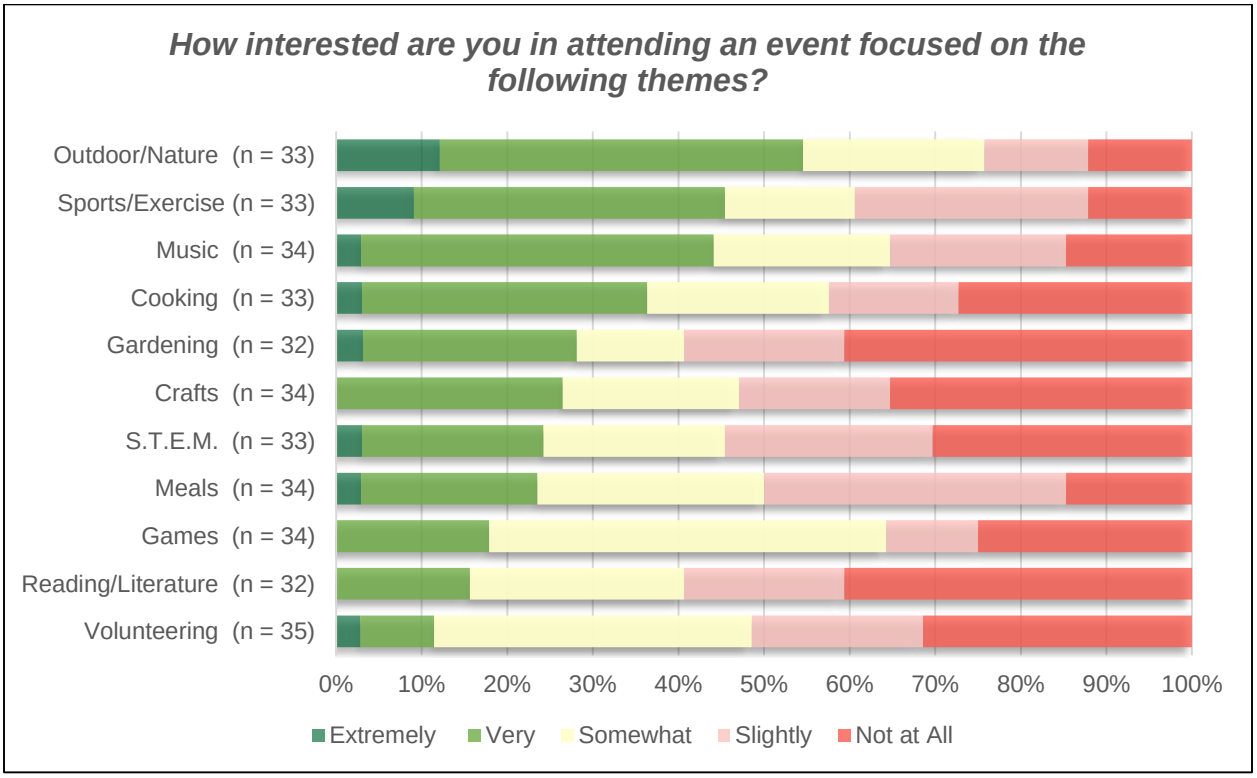
Figure 11. Father-Reported Interest in Services



Agencies implementing PPW may also attempt to orient family activities towards themes that are of interest to fathers. Figure 12 shows fathers' responses to the question, "How interested are you in attending an event focused on the following themes?" Responses are displayed in descending order so that services with the highest levels of interest ("extremely" and "very" interested) are listed first.

Over half of fathers reported being "extremely" or "very" interested in activities involving outdoors/nature. A sizeable portion of fathers also expressed interest in sports/exercise and music. Fewer than 20% of fathers responding to the question expressed interest in games, reading/literature, or volunteering.

Figure 12. Father-Reported Interest in Activities



Recovery Support Services

The second goal of Iowa PPW is to allow client choice in selecting recovery supports while focusing on gender specific issues for pregnant and postpartum women in residential treatment for substance use disorders. Recovery support services are designed to support personalized recovery plans and promote client engagement in treatment. The following section will describe Recovery Support Service utilization and describe HFS' quality improvement project designed to implement Recovery Peer Coaching as a new recovery support service to improve client retention and engagement in treatment.

Figure 13 displays the amounts billed to PPW for recovery support services by category for the first, second, and third fiscal year. There are 13 categories of recovery support services: bus, cab, care coordination, childcare, clothing, education, gas, GPRA coordination, recovery peer coaching, pharmacological interventions, sober living activities, utilities, and wellness. Recovery support service amounts are displayed in descending order. A total of $227,886.30 were spend on recovery support

services on all clients. GPRA coordination is the largest amount spent on recovery support services ($82,080.00) followed by clothing ($53,200.41). A nearly equal amount was spent on education ($21,910.87) and utilities ($20,869.63). Childcare was the least used recovery support since PPW agencies already provide childcare as a part of their Women's and Children's programming. In addition, recovery peer coaching was a recovery support added in the 2018 fiscal year and thus was not billable to PPW in previous years.

Figure 13. Recovery Support Service (RSS) Spending

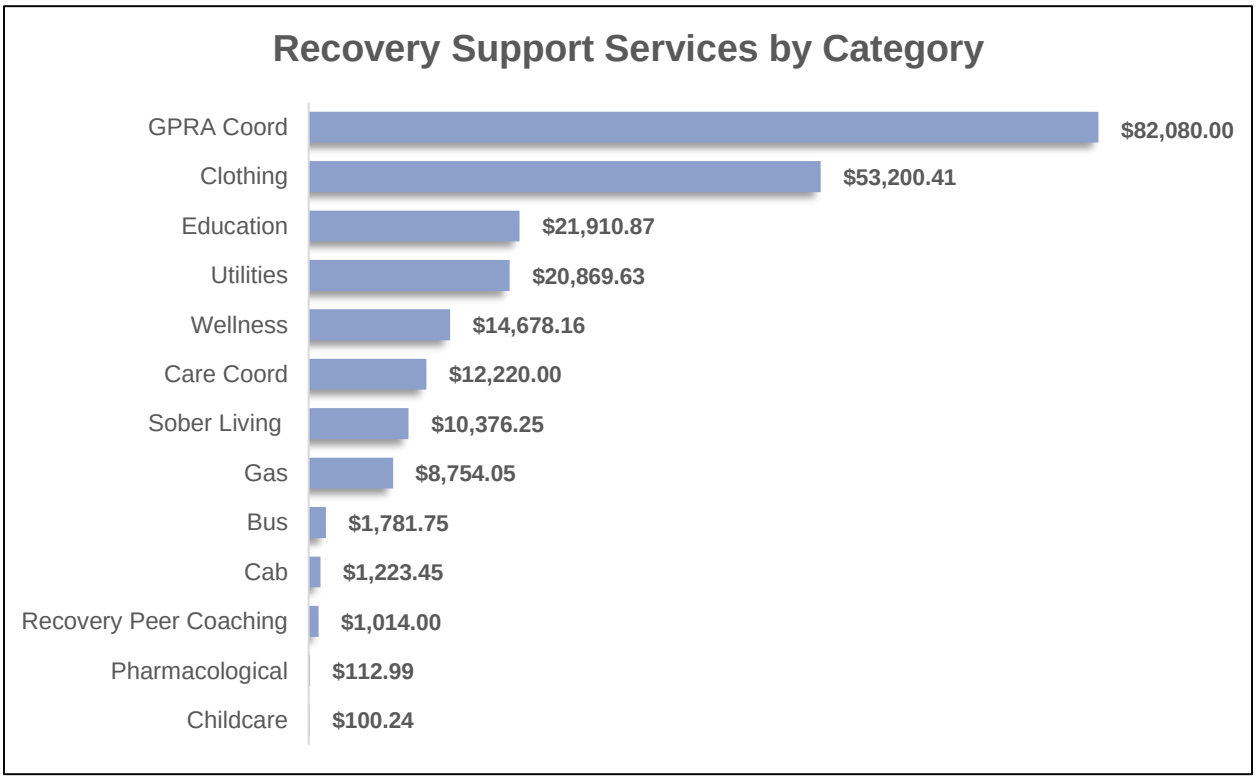


Table 5 displays the number of clients receiving each recovery support service category and the median amount spent on each client per category since the beginning of PPW. RSS categories are presented in descending order starting with the category with the largest number of clients. Because every client must complete GPRA intake, discharge, and follow-up interviews, GPRA coordination is the RSS category with the largest number of clients. Clothing is the second most used RSS with 266 clients using an average of $242.72. Clothing support represents the largest per client median of all RSS categories. While care coordination was the RSS category with the third highest number of client recipients, the median amount spent was low at $50.00 representing five units of care coordination per client.

Table 5. Median RSS Spending by Category

RSS Category	Number of Clients Receiving RSS	Median Amount
GPRA Coordination	316	$230.00
Clothing	266	$242.72
Care Coordination	229	$50.00
Education	187	$133.00
Utilities	170	$118.72
Gas	132	$50.00
Wellness	109	$159.60
Sober Living	102	$49.50
Bus	50	$20.00
Cab	24	$41.83
Recovery Peer Coaching	15	$52.00
Pharmacological Intervention	2	$56.50
Child Care	1	$100.24

Quality Improvement Project #2: Recovery Peer Coaching

Problem. Tailoring treatment services to client needs and preferences can improve client retention, but can create challenges for treatment agencies to meet each client's needs. Staff felt some clients flourish in group counseling environments while other clients feel safer in a one-on-one environment.

Solution. In the 2018 fiscal year, recovery peer coaching was added as a new billable service. In the same year, HFS staff recruited a recently graduated PPW client to become a Peer Recovery Coach to work with both PPW and non-PPW clients. HFS staff wanted to assess whether recovery peer coaching for PPW clients would help increase client treatment engagement and outcomes. The coach not only helped clients find ways to remain abstinent, but also helped connect them with additional support and education. The Peer Recovery Coach also taught them practical skills associated with being a caregiver such as cleaning, cooking and managing finances. HFS staff found the Peer Recovery Coach especially helpful since she was familiar with the program procedures and expectations. According to one HFS staff member,

"I think it's been very helpful for [the clients] to have that connection and I think especially since she's a graduate of here makes it so much more powerful for them to feel like 'I can do this and I can get where she is'."

Action. HFS staff working with PPW gave surveys to current clients to assess strengths and weaknesses of meeting with a Peer Recovery Coach. Afterwards, a staff member shared results of the surveys in an interview with the Peer Recovery Coach. During the interview, the Peer Recovery Coach was also able to reflect on how the position and what could be done to further meet the needs of her clients. As a result of the surveys and interview, it was concluded that clients wanted more sessions with the Peer Recovery Coach, and that the services should be advocated more often, especially during a client's admission to the residential program. Next steps include sending the current Peer Recovery Coach to training so that she can learn to train others to become peer recovery coaches.

Medication-Assisted Treatment (MAT)

Medication assisted treatment (MAT) is the use of medications, often in conjunction with counseling, to treat substance use disorders including dependency/addiction. Administering MAT is another method employed by agencies to help clients stay in treatment longer by reducing intense withdrawal symptoms.

Beginning December 2017, PPW agencies tracked clients receiving Medication-Assisted Treatment (MAT). Agencies reported the date MAT started, the type of MAT used, the type of substance the client used, route of MAT administration, and whether the client was referred to continue MAT services at discharge. MAT information was also collected retroactively for discharged clients.

Two agencies reported MAT use by 58 clients. Of these clients, alcohol (n = 25) was the most common substance for which clients' were treated with MAT. Opioids were the second most common substance for which clients were treated with MAT (including fentanyl, heroin, hydrocodone, methadone, and oxycodone). Seven clients received MAT for methamphetamine use. Table 6 presents the number and types of MAT therapy administered to clients during treatment by substance the client used. Six clients received more than one type of MAT therapy, therefore the sample size for MAT administrations (n=64) exceeds the number of clients receiving MAT.

The most common type of MAT therapy administered was Naltrexone with 45 clients. Twenty-five of these clients received Naltrexone for alcohol use disorder. Twelve clients received Naltrexone to treat methamphetamine addiction and seven clients used Naltrexone to treat opioid use disorder. Only one client received Naltrexone to treat marijuana addiction. Buprenorphine and Methadone were used to treat opioid use disorders with 15 and 4 clients receiving this type of MAT, respectively. PPW staff referred all clients still using MAT at discharge to continue MAT services at their own agencies or at an external organization.

Table 6. MAT Usage During Treatment

Substance Used	MAT Therapy Used		
	Naltrexone	Buprenorphine	Methadone
Alcohol	25	0	0
Methamphetamine	12	0	0
Opioid	7	15	4
Marijuana	1	0	0
Total	***45***	***15***	***4***

Forty-nine of the 58 clients receiving MAT services discharged from PPW. Of these 49 clients receiving MAT, 87.8% successfully completed the PPW program compared to 69.2% of all PPW clients. While the rates of successful treatment completion were higher for clients receiving MAT, clients' length of stay were the same for both groups at 74 days.

Evidence-Based Practices

All PPW agencies implemented Seeking Safety with all clients. Seeking Safety is an evidence-based counseling model that is designed to assist clients in acquiring safety in their personal relationships, thinking, behavior and emotions. In addition, Seeking Safety is intended to help clients address traumatic experiences and substance use disorder without the necessity of revisiting traumatic experiences.

Each agency has designated a therapist or counselor who leads Seeking Safety sessions with clients. In addition, each agency identified one staff member who, as a Site Trainer, is responsible for training future staff members in Seeking Safety to improve program sustainability after grant funding ends. Therapists and counselors that implement Seeking Safety across other programs within the agency participate in a monthly Seeking Safety provider conference call.

Nichole's Story

Nichole described her living situation as "chaotic" prior to Iowa PPW. *Living with her son and significant other out-of-state, she remained sober but was surrounded by people using alcohol and marijuana on a daily basis. Nichole managed to leave this challenging situation and move back to Iowa, but relapsed and lost custody of her son. She tried outpatient services to assist with her recovery, but pregnant with another child, Nichole knew she needed "something more".*

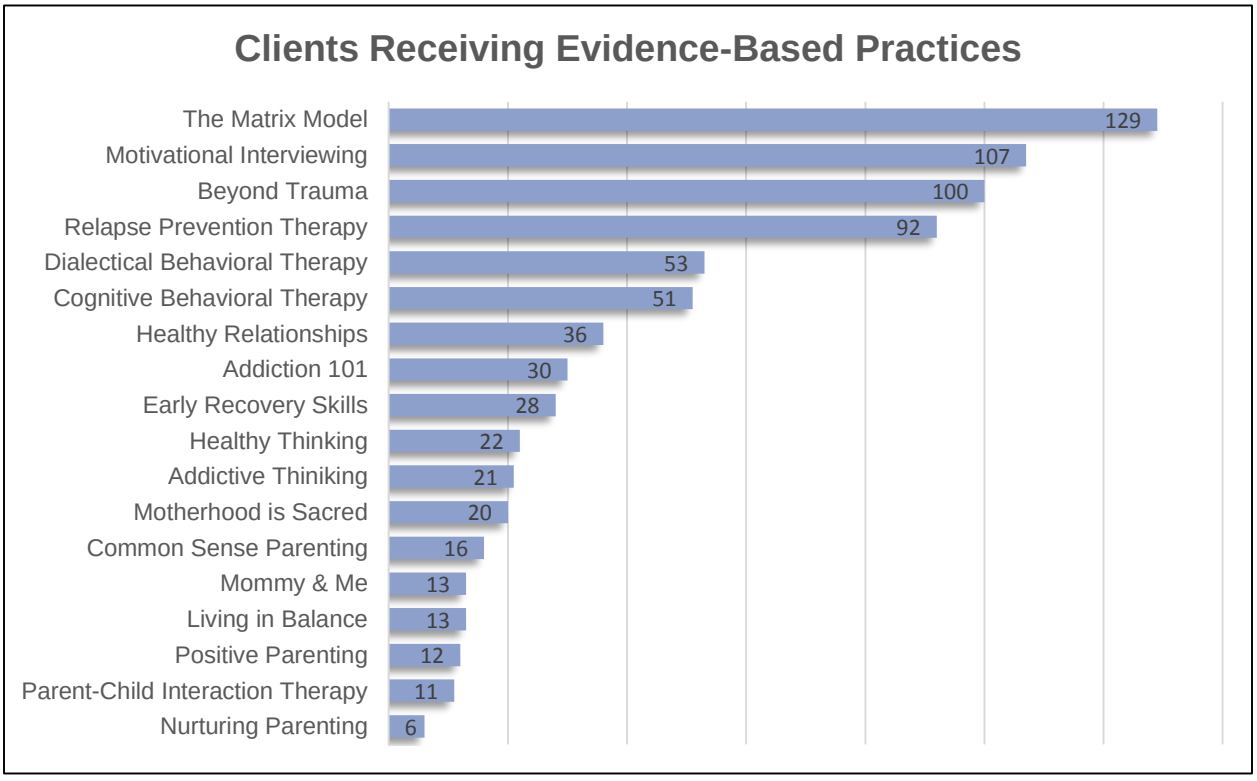
As a previous client of House of Mercy's inpatient program, she already understood the program's expectations, schedule, and support and was open to what the program had to offer. During treatment, Nichole learned how to apply recovery tools to her everyday life. She also developed more positive relationships with her family and developed a support network of "people who are clean and sober today." Upon admission to PPW, Nichole felt DHS "wanted to rip [her] family apart," but she now holds the perspective that DHS "want[s] my family to be together in healthy ways". Nichole's DHS case was closed in 2018 and she now enjoys spending time with her two boys. Her goals today include "being self-sufficient outside of HOM while maintaining stability and living a life in recovery."

In addition to Seeking Safety, each agency implements a variety of targeted evidence-based interventions. Each month, agencies completed an evaluation form listing types of evidence-based interventions, assessments, and screenings completed with each client, child, or supportive adult. Figure 14 presents the number of clients receiving an evidence-based intervention other than Seeking Safety at least one time during the duration of the grant in descending order.

The Matrix Model was the most common evidence-based practice implemented. Three of the four PPW agencies implemented The Matrix Model with 129 clients. Motivational Interviewing was the second most implemented evidence-based practice which was also implemented in three out of four PPW agencies. One hundred clients received the Beyond Trauma curriculum, which was primarily implemented at JRC. Ninety-two clients received Relapse Prevention Therapy across three PPW agencies. Addiction 101, Early Recovery Skills, Healthy Thinking, Addictive Thinking, and Living in Balance was implemented solely by HOM.

Family-oriented evidence based interventions Iowa PPW staff provided include Healthy Relationships, Mommy & Me, Positive Parenting, Common Sense Parenting, Nurturing Parenting, Parent-Child Interaction Therapy (PCIT) and Motherhood is Sacred. Fifty-clients received an evidence-based intervention focused on family (16.3%). Furthermore, PPW agencies implemented 3,707.1 hours of parenting education from June 2016 to September 2018 reach nearly one-quarter (74.1%) of clients. On average, clients received 15.6 hours of parenting education.

Figure 14. Evidence-Based Interventions Implemented



Family-Oriented Interventions

Since all Iowa PPW clients are parents or parents-to-be, family-oriented evidence-based interventions are an appropriate means to address the need for clients to improve family relationships.

Family Receipt of Evidence-Based Interventions and Screenings

Clients' children and supportive family members also received evidence-based interventions. Because a unique identifier was not given to each child or supportive adult, Table 7 represents an estimated number of children and supportive family members receiving evidence-based interventions based on monthly evidence-based practice tracking forms. Data represent all three years of PPW. Relationship type is based on the relationship to the client. An estimated 96 children and 141 supportive adults received an evidence-based intervention or parenting education class. Please note that the number of supportive adults presented in Table 7 is higher than number of supportive adults reported at clients' admission since additional family members may decide to participate after the clients' admission. The clients' significant other and/or father of the clients' children was the most common supportive adults receiving an evidence-based intervention. The client's mother, father, and sister were the second, third and fourth most common supportive adults receiving an evidence-based intervention. Other supportive adults include aunts, cousins, and significant others' parents. Parent-Child Interaction Therapy, Nurturing Parenting, Mommy and Me, 24/7 Dads, Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT) were among the most common evidence-based interventions received by clients' children and supportive adults. In addition, 187 children were screened for Fetal Alcohol Spectrum Disorder of which 48 screened positive.

Table 7. Family Receipt of Evidence-Based Practices

Relationship Type	Number Receiving EBP or Parenting Education Class
Child	96
Significant Other / Child's Father	46
Mother	38
Father	19
Sister	17
Grandmother	7
Other Supportive Adult	14
Total	***237***

Family Programming

All three agencies provide approximately four hours of programming that includes family education, family therapy and family visitation. HFS also offers family fun nights, which provide clients with an opportunity to have a meal with their visiting family members and to participate in activities such as playing board games, doing crafts, and fishing. As part of a NIATx quality improvement project implemented in the 2017 fiscal year, HFS staff ask family fun night participants to complete a survey to identify family members' perspectives on the accessibility and function of the events.

Table 8 presents the results of the Family Night Survey given to clients in February and August 2018. All 13 family members answered all questions on the survey with the exception of one respondent who did not answer the first question, “Does the time and day work for your schedule? If not what times or days work better?” Of the twelve respondents answering this question, 100% agreed that the time and day worked well for their schedule. Additionally, all 13 family members responded positively to the question, “How likely are you to come back to family night?” Nine participants (69.2%) felt the length of family night was sufficient. Respondents were also given the opportunity to identify areas in which they would like additional involvement. Eight respondents wanted more opportunities for visitation and three respondents were interested in learning more about relapse prevention. Only one respondent each was interested in family counseling or family education.

Table 8. HFS Family Night Survey Results

	Yes (%) n = 13
Timing of Programming (n = 12)	100.0
Length of Programming	69.2
Family Member Will Return	100.0
Preferences for Further Family Involvement	
Family Counseling	7.7
Family Education	7.7
Visitation	61.5
Relapse Prevention Education	23.1

Memorandums of Agreement/Understanding

Memorandums of Agreement (MOAs) and Memorandums of Understanding (MOUs) are formal documents outlining agreements between two business entities. A description of MOUs and MOAs Iowa PPW agencies developed with other organizations to support PPW services are in the Year One Evaluation Report. Staff submitted MOUs and MOAs yearly to assess whether organizational networks established through MOUs and MOAs expanded, contracted or remained unchanged.

Table 9 presents organizations with whom Iowa PPW agencies had developed MOUs and MOAs in the 2018 fiscal year. MOAs/MOUs received in 2018 were compared to those received in 2017 to assess change in organizational networks. The first column presents the names of organizations with whom agencies developed MOAs and MOUs. The second column shows the expiration date of the MOA or MOU as presented in the document.

- Dates listed in grey indicate agreements existing in the 2017 fiscal year that were not renewed for the 2018 fiscal year.
- Dates list in yellow represent agreements existing in the 2018 fiscal year that expired before the end of the 2018 fiscal year (September 30, 2018).
- Dates listed in green represent agreements that were active during the entire 2018 fiscal year.

ASAC. Of the four MOAs/MOUs ASAC developed in the 2016 fiscal year, three were renewed so that they were effective in the 2018 fiscal year. Nevertheless, agreements with the Young Parent Network, Abbe Center for Community Health, and the Eastern Iowa Health Center expired in the third quarter of the 2018 fiscal year. The agreement with the Linn County Agricultural Extension Council expired before the beginning of the 2018 fiscal year.

HFS. HFS developed one agreement with the Visiting Nurses Association, which expired in the second quarter of the 2017 fiscal year.

JRC. Ten MOAs/MOUs were developed between JRC and local organizations supporting Iowa PPW within the first year of PPW. Three of the MOAs/MOUs (Briar Cliff University's Baccalaureate Program, Briar Cliff University's Graduate Program and the Community Action Agency of Siouxland) extended into the 2018 fiscal year and seven agreements expired in the 2017 fiscal year. The agreements with Briar Cliff University's Baccalaureate and Graduate programs will extend into the 2019 fiscal year.

HOM. Five MOAs/MOUs were developed between HOM and local organizations including the Des Moines Public School Early Special Education Program, Mercy Pediatrics, Orchard Place, and Promise Jobs. All of the MOUs/MOAs were established to enhance HOM's referral network rather to utilize outside organizations for PPW service provision. None of the memorandums included an expiration date.

Table 9. MOAs/MOUs

2018 MOAs/MOUs	Expiration Date
ASAC	
Abbe Center for Community Mental Health	6/30/2018
Eastern Iowa Health Center	6/30/2018
Linn County Agricultural Extension Council	12/31/2016
Young Parents Network	6/30/2018
HFS	
Visiting Nurse Association	4/1/2017
JRC	
Briar Cliff University (Baccalaureate Level)	12/31/2019
Briar Cliff University (Graduate Programs)	8/31/2019
Community Action Agency of Siouxland Crossroads for Women and Children	3/31/2018
Council on Sexual Assault and Domestic Violence	6/30/2017
Iowa Coalition Against Domestic Violence	9/30/2017
Iowa Judicial Branch—Woodbury County Family Treatment Court	1/31/2017
Morningside College	5/27/2017
Sanctuary Transitional Housing	6/30/2017
Siouxland Human Investment Partnership—Early Childhood Iowa	6/30/2017
Siouxland WIC	9/30/2017

Table 9. continued

2018 MOAs/MOUs	Expiration Date
HOM	
Des Moines Public School Early Childhood Special Education Program-AEA	---
Mercy Pediatrics	---
Orchard Place	---
Promise Jobs	---

Overview

Two hundred sixty-four clients discharged from PPW over three years of implementation. The median length of stay was 73.5 days, which was significantly longer than pregnant clients entering residential treatment at other IDPH-funded treatment agencies but significantly lower than pregnant women admitted into Women's' and Children's Programs. While PPW client's length of stay was shorter compared to the Women's and Children's client sample, PPW had significantly higher rates of treatment completion than both comparison samples.

Agencies reported difficulties engaging fathers in PPW primarily due to the fathers' substance use and history of domestic violence. Additionally, PPW staff conveyed that the cultural expectations of fatherhood staff and fathers internalized created a significant barrier to fully engaging fathers in the treatment process. Fathers participating in PPW expressed that the lack of transportation, schedule conflicts, and the distance to the center were significant barriers to participation. Learning new things, spending time with their families, and connecting with other families were viewed as facilitators to fathers' participation.

Since the inception of Iowa PPW, clients received over $227,000 in recovery support services and provided over 3,700 hours of parenting education. Furthermore, 237 children and supportive adults received evidence-based interventions to encourage the formation of healthy, supportive families.

CLIENT OUTCOMES

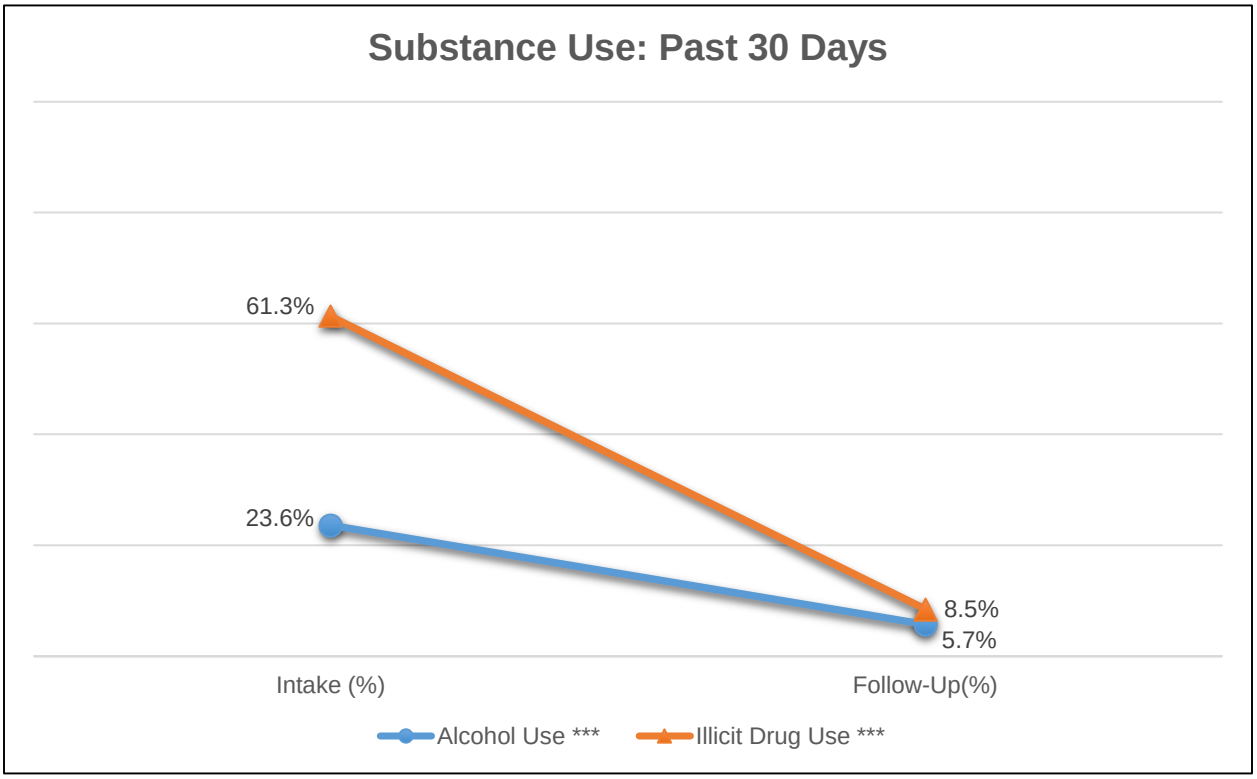
Of the 320 pregnant and postpartum clients admitted to PPW throughout the duration of the grant, 213 completed a follow-up interview five to eight months post admission. The following section will discuss changes in substance use, mental, physical and emotional health, involvement with the judicial system, and recovery support from admission to follow-up. Asterisks next to the legend titles in figures represent statistically significant differences in the indicator for intake to follow-up.[1] In addition, this section presents birth outcomes of infants born to PPW clients and levels of client satisfaction with multiple aspects of PPW and the agencies implementing the program.

[1] * $p < 0.05$; ** $p<0.01$, *** $p< 0.001$

Substance Use

Clients report their usage of alcohol and illicit drugs 30 days prior to the admission and follow-up interviews. Figure 15 shows 61.3% of clients reported using an illicit drug 30 days prior to admission; however, at follow-up only 8.5% of clients (11 clients) reported using an illegal drug within the last 30 days representing an 86.2% decrease in past 30 day illicit drug use (McNemar's Test = 106.31; p<0.001). Similarly, clients reported a 75.8% reduction in past 30-day alcohol use from intake to follow-up (McNemar's Test = 31.39; p<0.001.

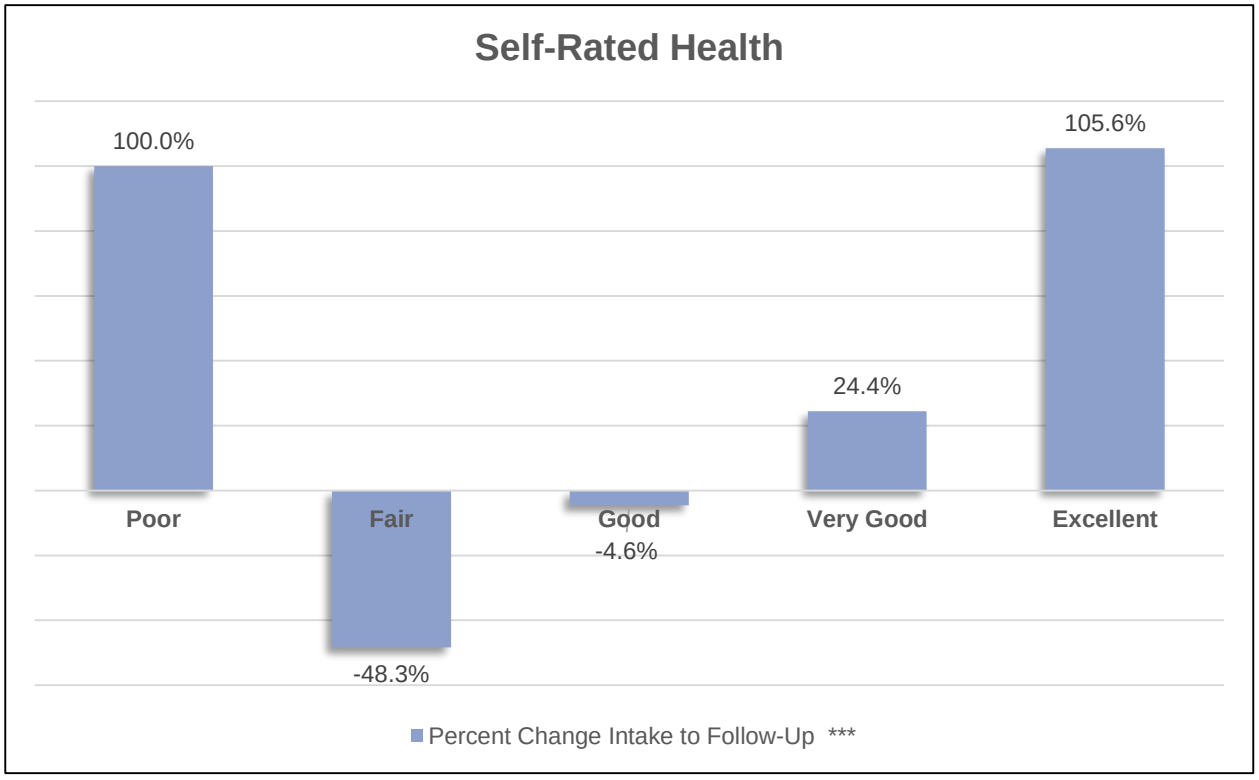
Figure 15. Client Substance Use within Past 30 Days



Physical, Psychological and Emotional Health

Clients were asked to rate their overall health at the time of admission to PPW and five to eight months post-admission (follow-up). Self-rated health is generally accepted as a global measure of health that approximates objective health status[2]. Figure 16 shows the percent change in clients' reported health status from intake to follow-up. In general, clients self-rated health significantly increased between intake and follow-up (Friedman's Test = 13.19; $p<0.001$). The percentage of clients rating their health as "excellent" increased from 8.5% at admission to 17.4% at follow-up representing an over 100% increase in excellent health ratings. The percentage of clients reporting poor health also increased by 100%; however, only a few clients reported poor health at intake (n=3) or follow-up (n=6).

Figure 16. Change in Self-Rated Health



[2] Wu, S., Wang, R., Zhao, Y., Ma, X., Wu, M., Yan, X., & He, J. (2013). The relationship between self-rated health and objective health status: a population-based study. *BMC public health*, *13*, 320. doi:10.1186/1471-2458-13-320.

Figure 17 shows changes in client-reported psychological and emotional health from intake to follow-up. Clients were asked how many days in the past 30 days they experienced:

- Anxiety
- Depression
- Hallucinations
- Trouble controlling violent behavior
- Trouble understanding, concentrating or remembering,
- A suicide attempt

Percentages in Figure X represent clients who reported one or more days of the psychological/emotional health indicator. Clients reported a significant decrease in experiencing any anxiety (McNemar's Test = 16.06; p<0.001), depression (McNemar's Test = 23.82; p<0.001), trouble controlling violent behavior (McNemar's Test = 15.36; p<0.001), and trouble understanding, concentrating or remembering (McNemar's Test = 18.18; p<0.001) within the past 30 days from admission to follow-up. There were also sizeable percent decreases in client-reported hallucinations (39.9%) and suicide attempts (66.7%); however, the differences were not statistically significant.

Figure 17. Changes in Psychological/Emotional Problems

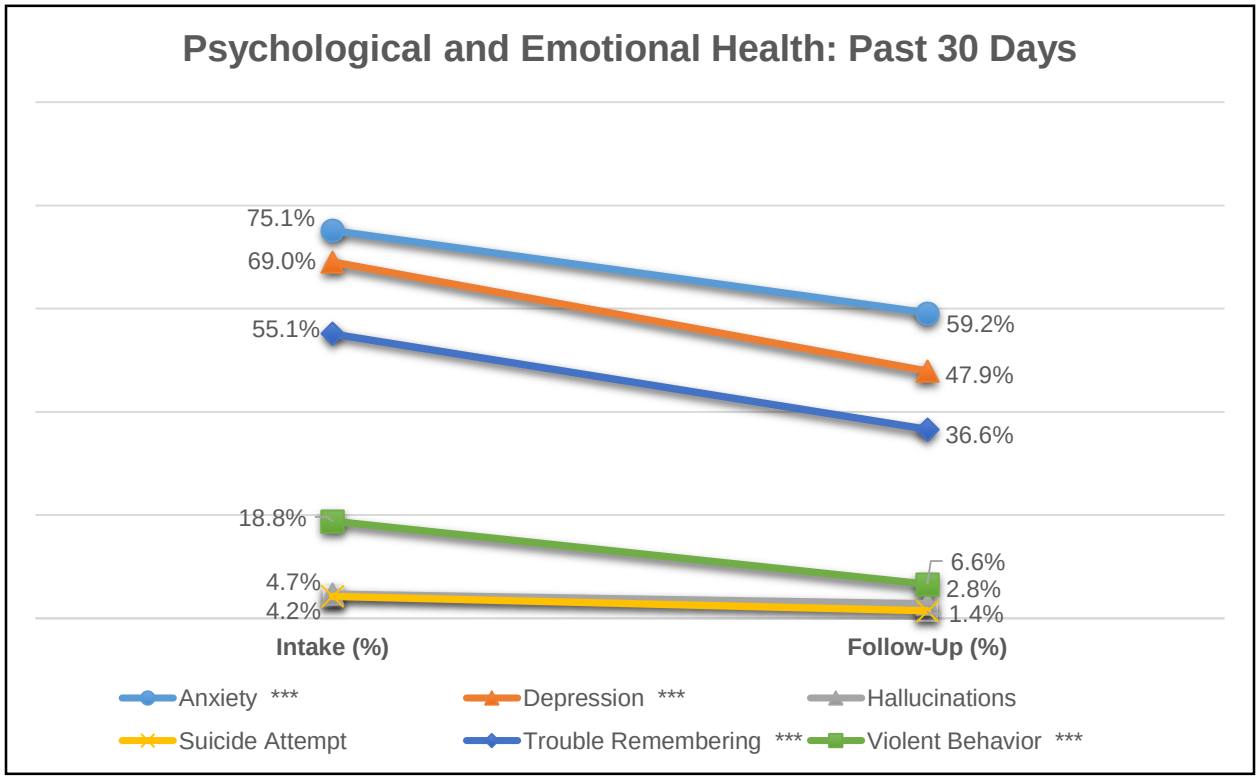
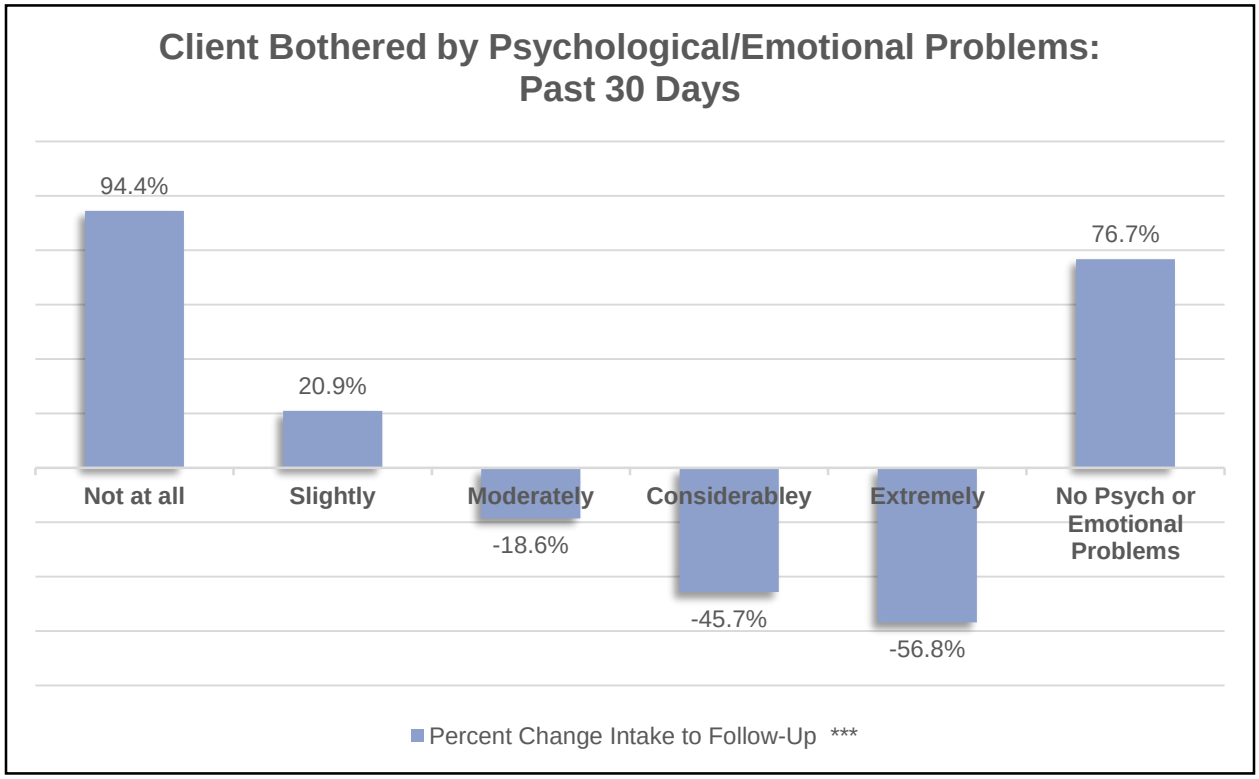


Figure 18 shows changes in client ratings of how much psychological/emotional problems have bothered the client in the past 30 days from intake to admission. Overall, clients reported they were bothered less by physical/emotional problems within the past month at follow-up than at admission (Friedman's Test = 18.63; $p<0.001$). The largest percent decrease (94.4%) was among clients reporting they were not bothered at all by their psychological/emotional problems. Furthermore, the proportion of clients indicating they did not experience any psychological/emotional problems at all increased from 14.1% at intake to 24.9% at follow-up. Among clients reporting some discomfort from psychological/emotional problems at intake and follow-up, the severity of discomfort decreased so that higher ratings of discomfort decreased more than lower levels of discomfort.

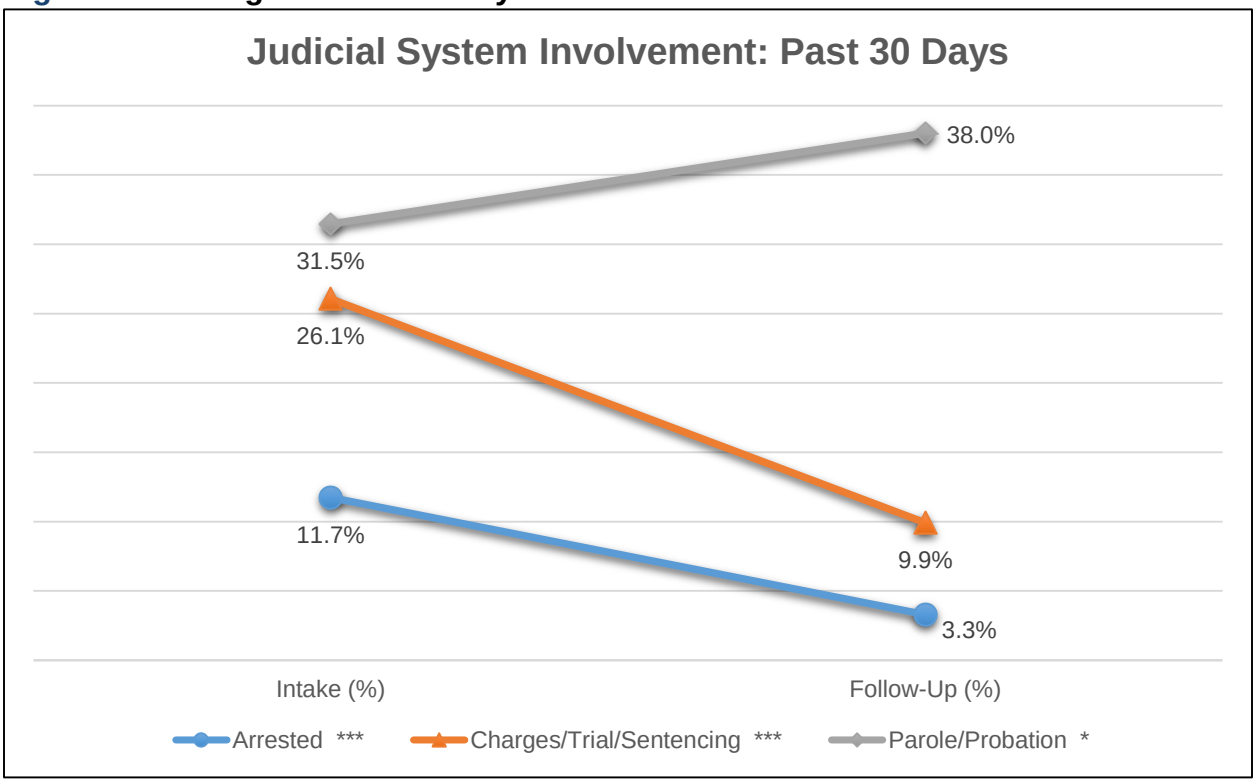
Figure 18. Changes in Disturbance from Psychological/Emotional Problems



Judicial System Involvement

Figure 19 illustrates changes in clients' involvement in the judicial system from intake to follow-up. The largest percent change was in the percentage of clients reporting an arrest within the past 30 days (72.0% decrease). At admission, 11.7% of clients reported an arrest within the past 30 days compared to 3.3% at follow-up (McNemar's Test = 11.57; p<0.001). Additionally, there was a 62.0% difference in the percent of clients awaiting charges, trial, or sentencing from admission (26.1%) to follow-up (9.9%) (McNemar's Test = 22.23; p<0.001). Interestingly, while the percent of clients reporting an arrest or awaiting trial, charges or sentencing significantly decreased from admission to follow-up, the percentage of clients reporting parole or probation significantly increased from 31.5% at admission to 38.0% at follow-up (McNemar's Test = 6.13; p<0.05).

Figure 19. Changes in Judicial System Involvement



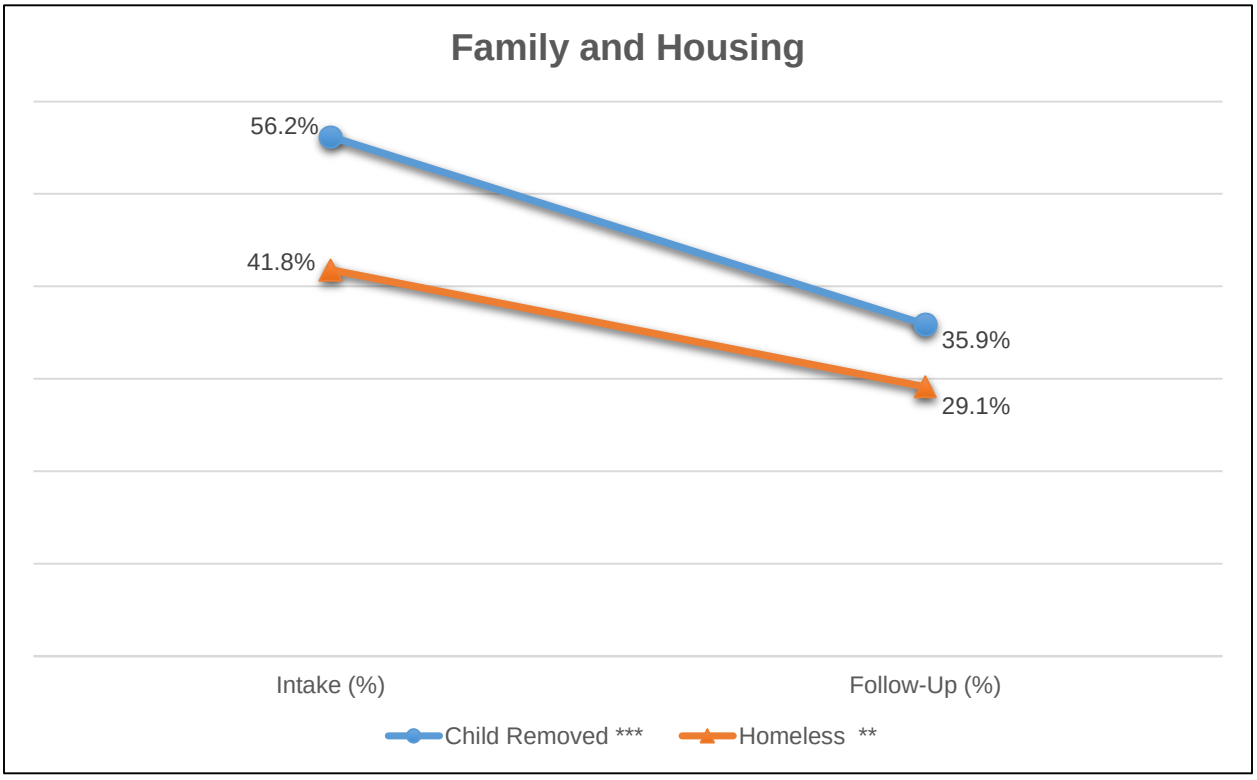
Family and Housing

One way Iowa PPW supports the cohesion of the family unit is to advocate for family reunification. Starting January 2017, agencies began reporting the number of clients' children who had an open reunification case or had been reunified with the client or the child's father. Upon clients' discharge from PPW, 107 children were reunited with the client, 22 children were reunited with their father, and 18 children were reunited with both of their parents. Ages of reunified children ranged from infanthood to 17 years of age with a median of 3 years of age.

Figure 20 shows that the percentage of clients reporting any child living temporarily with another person due to a protective order decreased significantly from intake (56.2%) to follow-up (35.9%) (McNemar's Test = 21.35; $p<0.001$).

In addition, significantly fewer clients (30.3% decrease) reported homelessness at follow-up compared to discharge. Nevertheless, 29.1% of clients remained homeless at five to eight months post-admission.

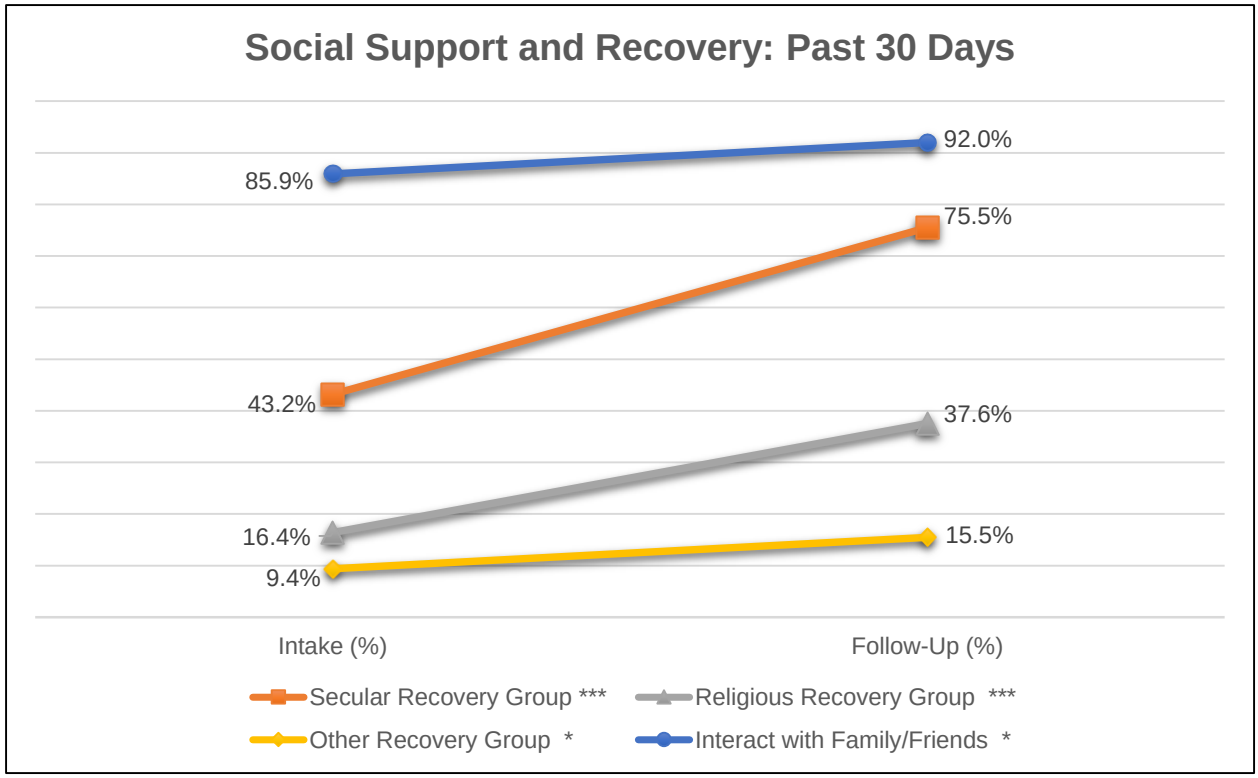
Figure 20. Changes in Family and Housing



Social Support and Recovery

Clients were asked to report whether they attended voluntary self-help groups for recovery within the past 30 days at admission and follow-up. The largest percent difference in past-30 day recovery group attendance was seen in attendance at religious/faith affiliated recovery self-help groups (a 128.6% increase) (McNemar Test = 27.74; p<0.001). The average number of times clients reported attendance within the past 30 days also significantly increased from intake (4.1 times) to follow-up (4.8 times) (t=-2.1459; p<0.05). The number of clients reporting attending a non-religious voluntary self-help group within the past 30 days also significantly increase from intake to follow-up (McNemar Test = 42.13; p<0.001). However, clients did not report a significant increase in the number of times they attended a secular self-help group within the past 30 days from intake to follow-up. Significantly more clients also reported going to a self-help group that they did not consider to be secular or religiously affiliated (McNemar Test = 4.57; p<0.05). There was also a small yet significant increase in the number of clients reporting they had interacted with family and/or friends supportive of their recovery within 30 days of intake and follow-up (McNemar Test = 4.12; p<0.05).

Figure 21. Change in Social Support and Recovery



Assessment of Recovery Capital (ARC)

Beginning October 24, 2016, clinicians asked clients to complete the Assessment of Recovery Capital (ARC) upon admission to Iowa PPW and five to eight months post-admission[3]. The complete ARC instrument is present in Appendix B. The ARC measures the internal and external resources an individual can use to sustain recovery from substance use[4]. The ARC contains ten dimensions:

1. Substance Use and Sobriety
2. Global Psychological Health
3. Global Physical Health
4. Citizenship and Community Involvement
5. Social Support
6. Meaningful Activities
7. Housing and Safety
8. Risk Taking
9. Coping and Life Functioning
10. Recovery Experience.

The instrument contains five items per dimension, therefore the maximum ARC score for any dimension is five and the maximum score for the total summed score of all dimensions is 50.

Over half of the clients (n = 129) completing the ARC upon admission to Iowa PPW also completed the ARC five to eight months post-admission. Table 11 compares the mean ARC score for each of the dimensions and all combined dimensions (Total ARC score) at admission and follow-up for all clients with both an intake and follow-up ARC across all three grant years. The Social Support dimension had the lowest mean at admission (3.3). The Recovery Experience dimension had the highest mean at admission (4.7). At follow-up, all dimensions had a mean score above 4.0. Mean ARC scores significantly increased for all dimensions except for the Recovery Experience dimension, which neither increased nor decreased. The mean total ARC score increased from 38.9 to 44.0 indicating that, on average, clients responded positively to five more items on the follow-up ARC compared to the intake ARC.

[3] Groshkov, T., Best, D., & White, W. (2013). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. Drug and Alcohol Review, 32(2), 187-194.

[4] Grandfield, R. & Cloud, W. (1999). Coming Clean: Overcoming Addiction without Treatment. New York: New York University Press.

Table 11. Changes in ARC Dimension Scores from Intake to Follow-Up

Dimension	Admission (Mean)	Follow-Up (Mean)	Change from Admission to Follow-Up
Substance Use and Sobriety	3.9	4.4	Increase ***
Global Psychological Health	3.9	4.5	Increase ***
Global Physical Health	3.8	4.4	Increase ***
Citizenship and Community	4.2	4.5	Increase **
Social Support	3.3	4.4	Increase ***
Meaningful Activities	3.4	4.1	Increase ***
Housing and Safety	4.1	4.6	Increase ***
Risk-Taking	3.7	4.2	Increase ***
Coping and Life Function	3.8	4.3	Increase ***
Recovery Experience	4.7	4.7	Same
Total ARC Score	***38.9***	***44.0***	***Increase ******

Table 12 provides a more in-depth view of changes in the ARC score from admission to follow-up by assessing individual ARC items for all clients admitted to PPW since September 30, 2015. The first column of the table lists the ARC item and the second and third columns present the percent of clients responding positively to the ARC item at admission and follow-up, respectively. The third and fourth columns display the percentage difference between clients responding positively to the ARC item at admission and follow-up and the domain the item falls under, respectively. Table 12 includes 21 items with at least a ten percent change in positive responses from admission to follow-up. Items at the top of the table represent items with the largest increase in the percent of positive responses from admission to follow-up.

With the exception of the Citizenship and Community and Recovery Experience domains, each dimension contained one or more items with at least a ten percent change from admission to follow-up. The Social Support dimension was the only dimension in which there was a significant percent increase of clients providing positive responses for all five items. Both the Global Physical Health and Meaningful Activities dimensions contained three items with at least a ten percent change in positive responses from admission to follow-up. Eight ARC survey items decreased from intake to follow-up; however, none of the differences was statistically significant.

Table 12. Changes in ARC Items from Intake to Follow-Up

ARC Item	Yes at Admission (%)	Yes at Follow-Up (%)	Percent Change	Domain
I am actively involved in leisure and sport activities.	26.4%	46.5%	76.5% ***	Meaningful Activities
I am free from worries about money.	27.1%	45.7%	68.6% ***	Risk-Taking
I do not let other people down.	55.0%	82.2%	49.3% ***	Coping & Life Function
I get lots of support from friends.	**58.9%**	**86.8%**	**47.4% *****	**Social Support**
I am satisfied with my involvement with my family.	**60.5%**	**87.6%**	**44.9% *****	**Social Support**
In general, I am happy with my life.	62.8%	89.9%	43.2% ***	Global Psychological Health
I am happy with my personal life.	**62.0%**	**86.0%**	**38.8% *****	**Social Support**
I have had no recent periods of substance intoxication.	62.8%	85.3%	35.8% ***	Substance Use & Sobriety
I have access to opportunities for career development).	65.9%	89.1%	35.3% ***	Meaningful Activities
I feel I am in control of my substance use.	65.1%	86.8%	33.3% ***	Substance Use & Sobriety
I sleep well most nights.	62.8%	82.2%	30.9% ***	Global Physical Health
I feel physically well enough to work.	73.6%	90.7%	23.2% ***	Global Physical Health
I am proud of my home.	69.0%	83.7%	21.3% **	Housing & Safety
I get the emotional help and support I need from my family.	**69.8%**	**84.5%**	**21.1%*****	**Social Support**
I meet all of my obligations promptly.	68.2%	82.2%	20.5% **	Coping & Life Function
My living space has helped to drive my recovery journey.	74.4%	89.1%	19.8% ***	Housing & Safety
I engage in activities that I find enjoyable and fulfilling.	76.7%	89.1%	16.2% **	Meaningful Activities
I have a special person that I can share my joys and sorrows with.	**81.4%**	**93.0%**	**14.3% ** **	**Social Support**
I have the personal resources I need to make decisions about my future.	81.4%	93.0%	14.3% **	Risk-Taking
I look after my health and wellbeing.	82.2%	93.8%	14.2% **	Coping & Life Function
I cope well with everyday tasks.	80.6%	91.5%	13.5% *	Global Physical Health

Birth Outcomes

An objective of Iowa PPW is to improve safe and healthy pregnancies through the provision of health and wellness services. While it cannot be said with certainty whether or not Iowa PPW services improved client pregnancies, we can compare birth outcomes between Iowa PPW clients with estimates of pregnancy outcomes for women using tobacco. Pregnancy outcomes among women using tobacco was chosen since over four-fifths of Iowa PPW clients used tobacco and because scientific literature indicates that pregnancy outcomes can vary considerably by the type of substance women used during pregnancy. Data for the tobacco comparison sample contain pregnancy outcomes for 1,219,159 singleton births in Missouri from 1989 to 2005.[5] The two birth outcomes of focus are gestational age and birth weight.

For women who were postpartum at admission, the birth weight and gestational age of the most recent child(ren) was assessed. Analysis also include the birth weight and gestational age of infants born to clients during treatment from June 2016, when the evaluation team began collecting birth outcomes, to September 2018. The following section describes two common pregnancy outcomes: low birth weight and preterm birth. Low birth weight is defined as an infant weighing less than five pounds and eight ounces (2,500 grams) at birth. An infant is considered “preterm” if he or she is born earlier than 37 weeks.

Table 13 describes pregnancy outcomes for 171 births to clients who were postpartum at admission and 31 live births to clients who delivered during treatment. Birth weights of children born to clients before admission range from 1 pound 11 ounces to 9 pounds 14 ounces. The average birth weight for infants born to PPW mothers prior to admission was 7 pounds and 0 ounces and was 7 pounds and 2 ounces for children born during treatment. This is roughly equal to the median birth weight of children born to mothers using tobacco in the Missouri sample (6 pounds and 15 ounces). A smaller percentage of clients gave birth to children with a low birth weight during treatment (10.3%) than before treatment (16.5%). Unfortunately, two clients miscarried during treatment.

Regarding preterm birth, 16.4% of infants born to clients before treatment were preterm compared to 9.7% of infants born to clients during treatment. Gestational ages of infants at birth ranged from 25 to 43 weeks for infants born to clients before treatment and 31 to 40 weeks for infants born during treatment. Nevertheless, the median gestational age for both groups is 39 weeks. The mean gestational age for infants in the Missouri sample was 38.8 weeks.

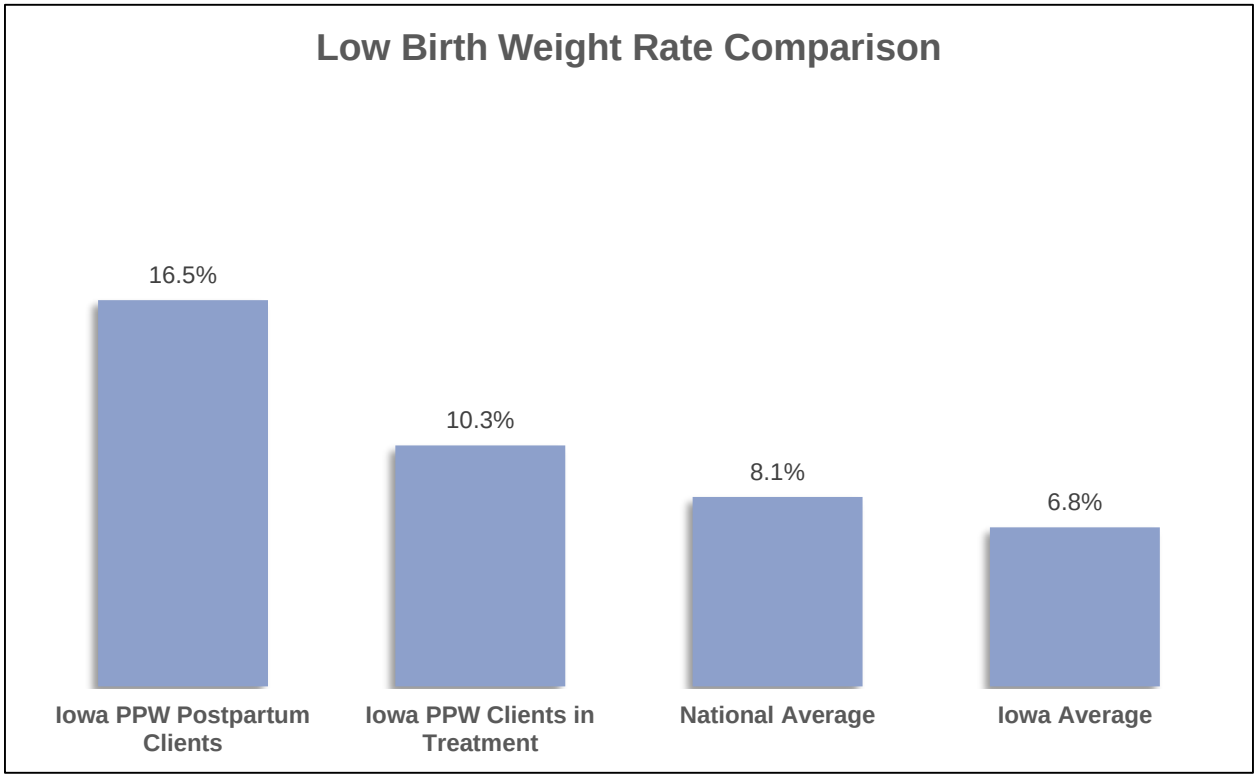
[5] Preventive Medicine 2010: The Annual Meeting of the American College of Preventive Medicine (ACPM): Abstract 212669. Presented February 19, 2010.

Table 13. Birth Outcomes of Iowa PPW Clients

	Births to Postpartum Clients n = 171	Births to Clients in Treatment n = 31
Birth weight		
Range	1 lb., 11 oz. – 8 lbs., 15 oz.	3 lbs., 4 oz. – 9 lbs., 0 oz.
Median	7 lbs., 0 oz.	7 lbs., 2 oz.
Low Birth Weight (%)	16.5%	10.3%
Gestational Age		
Range	25 – 43 weeks	31 – 40 weeks
Median	39 weeks	39 weeks
Preterm (%)	16.4%	9.7%

Figure 22 compares low birth weight rates from the two Iowa PPW samples (births prior to treatment and births during treatment) with national and state rates. In the United States, approximately one in twelve infants (8.1%) are born with low birth weight. The low birth weight rate is even lower among infants born in Iowa at 6.8%.

Figure 22. Comparison of Low Birthweight Rates



Katie's Story

Nearly two years ago Katie came to realization that she could not "feel this way anymore." *She had tried and failed at recovery several times in the past, but this time she knew something had to change. She felt spiritually bankrupt and her confidence was as low as it had ever been. Despite not wanting to go, she walked through the doors of Jackson Recovery Centers' Women and Children's Center. She didn't feel long-term treatment was going to help her as she had been through the program before. This time, she was pregnant with another child in tow. After a week in treatment, she realized this time around things were going to be different, because she knew she had to do things differently. She worked on herself, how to balance life and motherhood and other relationship issues. Katie learned over time that she was a good mom, daughter and friend. She completed treatment at the Center with a confidence she had never had before. She soon moved into a sober living house out of town with her son. During that time, they were able to strengthen their bond and her son learned to be a kid again.*

They moved back to the area a few months later so she could give birth to her third son, her "miracle baby." For the first time since she was a teenager, she has a home of her very own and with each day that passes, she soaks in the memories and is grateful to be able to experience this time sober.

Besides being a mother, Katie needed to find a passion in her life and she says she has found that, after being hired at Jackson. She works closely with women struggling, just like she had been to stay sober and find recovery. She says working with the women helps her own sobriety and helps her stay accountable to herself and her family. Katie looks forward to one day returning to school and continuing her work to help others the way she was helped.

Client Satisfaction

PPW staff ask clients to complete a confidential client satisfaction survey upon discharge from PPW. There is no collection of a unique identification number that would link clients' survey to any other data collected for evaluation purposes. The full client satisfaction survey can be found in Appendix C.

Dimensions of Client Satisfaction

The following section reports results from 158 completed client satisfaction surveys completed during the first, second, and third years of PPW for the following four dimensions: 1) Client-Counselor Interaction, 2) Staff-Client Interaction, 3) Building and Facility, and 4) Program Services. The full Client Satisfaction Survey is located in Appendix C. Tests were run to assess significant differences for each question by agency, fiscal year, and client demographics (race/ethnicity, age, and whether the client was still receiving services at the time the survey was completed). Only statistically significant differences are discussed.

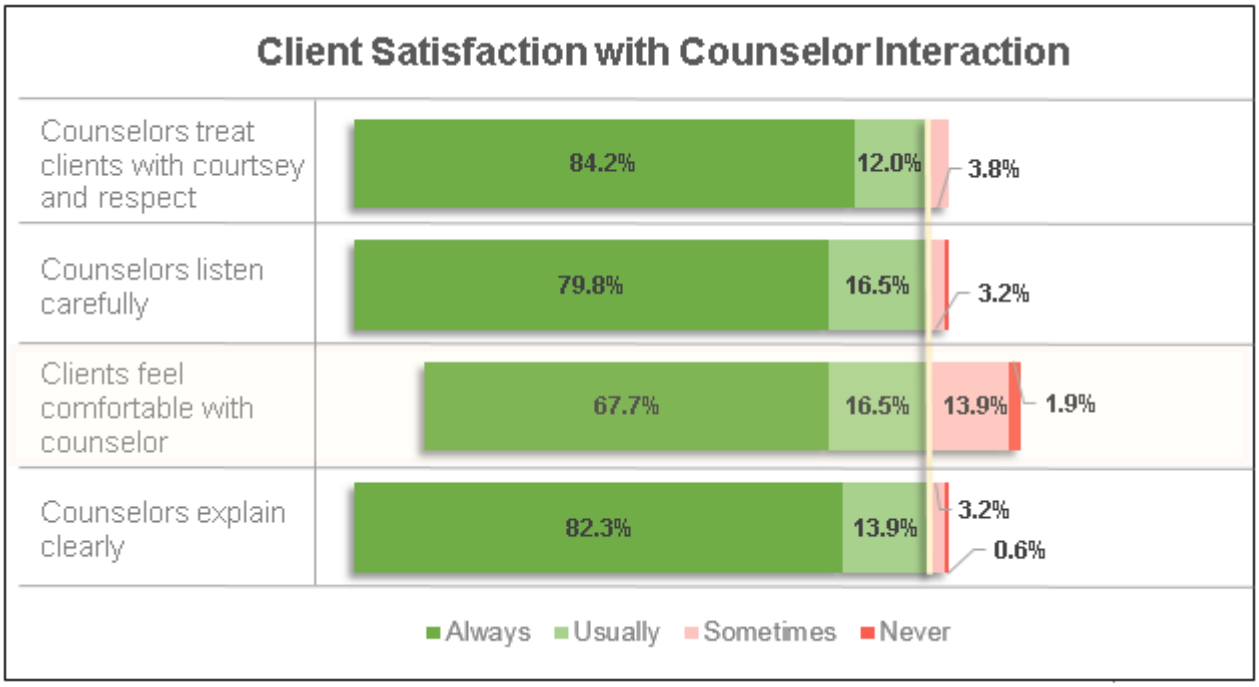
Client-Counselor Interaction

Figure 23 displays clients' perceptions of their interaction with counselors. Clients rated how often:

- counselors treat clients with courtesy and respect
- counselors listen carefully to clients
- clients feel comfortable discussing concerns about their treatment with counselors
- counselors explain things to clients in a way they can understand

In general, clients reported feeling counselors *always* treat them with courtesy and respect, listen carefully, and explain things to them in a way they can understand. While the median response category for the statement, "Clients feel comfortable discussing concerns about their treatment with counselors", the percent of clients reporting that the *always* or *usually* feel comfortable was lower than the percent of clients reporting similarly to the other three related survey items. Nearly 16% of clients reported that they *never* or *sometimes* feel comfortable discussing treatment concerns with their counselors.

Figure 23. Client Satisfaction: Client-Counselor Interaction



Client-Staff Interaction

Figure 24 displays clients' perceptions of their interaction with staff members other than the counselor. Clients were asked to rate how often staff:

- treat clients with courtesy and respect
- listen carefully to clients
- explain things to clients in a way they can understand

In general, clients reported that staff *always* explain things in a way that they can understand. However, the median response category was *usually for* the following two items: "Staff treat clients with courtesy and respect" and "Staff listen carefully to clients. No clients reported that staff *never* treat them with respect, listen carefully, or explain things clearly.

Clients reporting being referred to PPW from a criminal justice organization or an "other" individual or institution felt staff treated clients with courtesy and respect less often than clients reporting a referral from a health care provider, DHS, or self-referral. Less than 10% of clients referring themselves to PPW (n = 43) or being referred to a health provider (n = 40), or DHS (n = 55) reported staff *sometimes* treat them with courtesy and respect. In contrast, one-third of clients with a criminal justice referral and half of clients referred by another individual or institution reported staff *sometimes* treat them with courtesy or respect.

There were also significant differences in satisfaction with client-staff interaction by agency. Clients discharged from ASAC reported lower levels of satisfaction with how frequently staff listened to clients (Dunn's test; $p<0.01$) and explained things to clients in a way they could understand (Dunn's test; $p<0.01$).

Figure 24. Client Satisfaction: Client-Staff Interaction

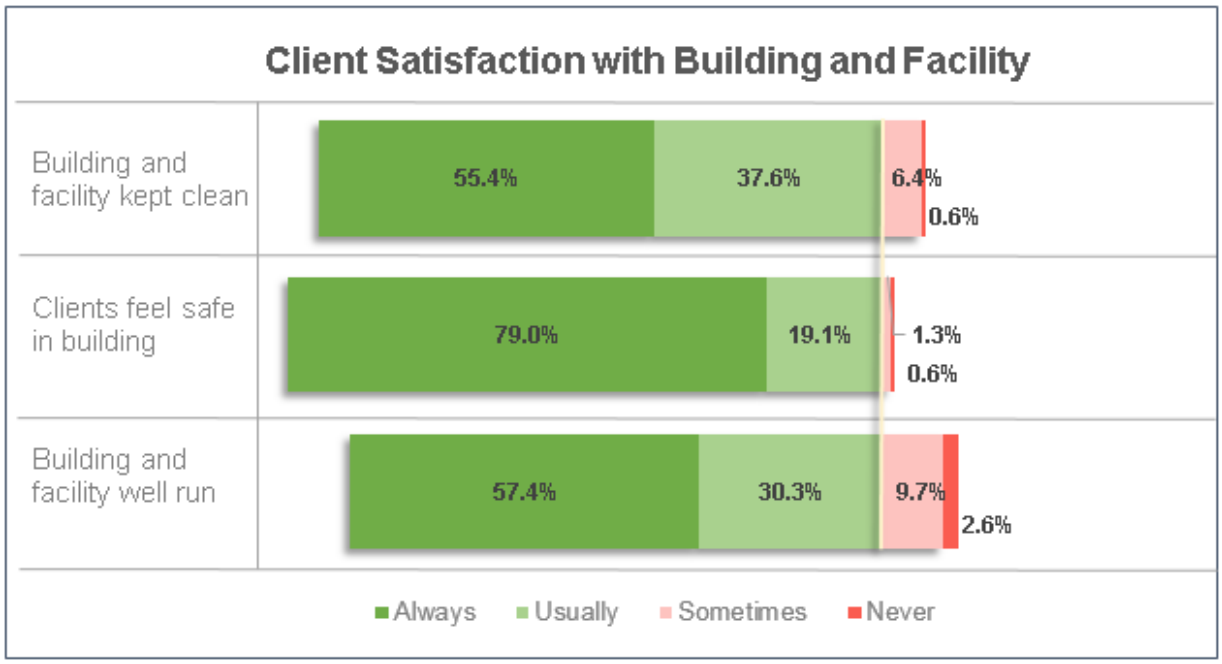
Building and Facility

Figure 25 shows clients' perceptions of the building and facility housing Iowa PPW grant services. Clients were asked to rate how often:

- rooms, bathrooms and hallways were kept clean
- clients felt safe when they were in or around the building
- the facility and building seem efficient and well run

Figure 25 shows 79.0% of clients *always* felt safe in the building. Furthermore, over half of clients reported that the building and facility was *always* kept clean (55.4%) and was well run (57.4%).

Figure 25. Client Satisfaction: Building and Facility



Program Services

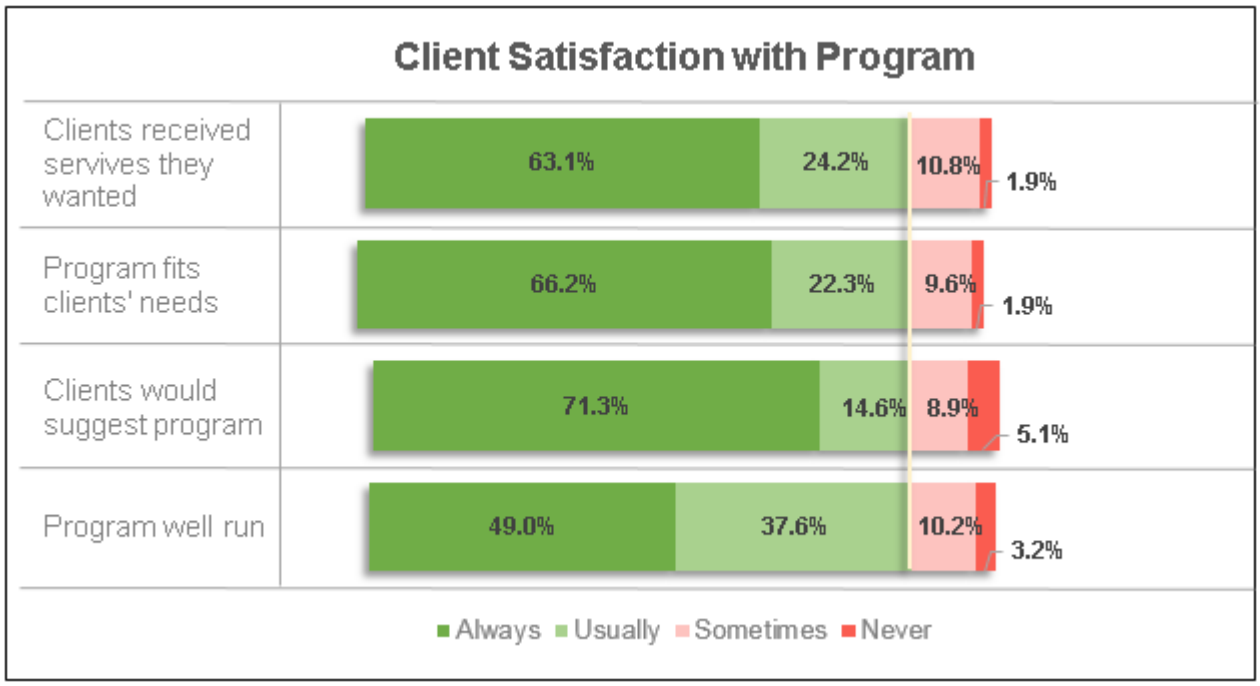
Figure 26 illustrates clients' perceptions of the Iowa PPW program services in general. Clients were asked to rate how often:

- clients received the services they wanted
- the program seems to fits the clients' needs
- the client would suggest this program to a friend or family member
- programs seem efficient and well run

Over two-thirds of clients (71.3%) would *always* suggest the program to a friend or family member. Additionally, nearly two-thirds of clients reported the program *always* provided the services they wanted (63.1%) and fit the clients' needs (66.2%). However, less than half of all clients (49.0%) felt that the program was *always* well run.

There were significant agency differences for each of the survey items asking about program services. For each of these items, clients discharged from ASAC expressed lower levels of satisfaction compared to JRC clients (Dunn's Test; $p<.05$). For one item, "program seems efficient and well run", ASAC clients provided lower satisfaction ratings than both JRC and HOM.

Figure 26. Client Satisfaction: Program



Satisfaction and Dissatisfaction with Services

Figure 27 displays clients' perceptions of how *satisfied* or *dissatisfied* they were with the:

- services they received
- help they received for the problem they came for
- quality of the services they received

Over half of all clients reported feeling *very satisfied* with the services, help, and quality of services they received. Fewer than one in ten clients were either *uncertain, dissatisfied,* or *very dissatisfied* with the services they received.

There were significant agency differences for each of the survey items asking about satisfaction with services. For each of these items, clients discharged from ASAC expressed lower levels of satisfaction compared to JRC clients (Dunn's Test; p<.01).

Figure 27. Client Satisfaction: Services

Clients were also able to include comments about the PPW program at the end of the Clients Satisfaction Survey. All open-ended responses are displayed in Appendix D. Figure 28 is a word cloud generated from all open-ended responses received since September, 30, 2015. The most commonly occurring words in the open-ended responses are indicated the more prominent text (i.e. larger font). The most commonly used word was “help” as seen in the center of the Figure 28.

Figure 28. Word Cloud of Open-Ended Client Satisfaction Survey Responses

Quality Improvement Project #3: Improving Follow-Up GPRA Rates

Problem: Obtaining quality follow-up data helps agencies understand the effects of their programming on their clients. Not only can client outcomes data help agencies fine tune their practices, but staff can also use outcomes to education the community and potential funders about the program’s impact in the target population. However, contacting clients five to eight months post-admission can pose challenges since some clients may have moved, do not have accurate collateral contact information, or in some cases, do not wish to be contacted. Furthermore, some agencies such as ASAC expressed having limited staff to track clients and conduct follow-up interviews.

Solution: Staff at ASAC developed a new form called the "PPW Request Form" containing contact information of clients' supports. Whenever a client requests a recovery support, the client must update and sign the form. ASAC staff expected the quality of collateral contact information to improve since clients would be required to routinely update the information rather than complete it only once at admission. When it is time to locate clients for the GPRA follow-up survey, PPW staff at ASAC hoped to have more accurate data on the clients' location and therefore improve the likelihood of collecting follow-up data.

Action: Several ASAC staff provided feedback on the form in early March 2018 before giving the form to patients for their feedback at the end of the month. After the form was finalized, new staff were trained to implement the PPW Request Form in June 2018. Next steps include implementing the form during clients' Care Navigation sessions.

Overview

Between February 1, 2016 and September 29, 2018, 213 clients completed a follow-up GPRA survey. At follow-up 94.3% and 91.5% of clients reported abstinence from alcohol and illicit drugs within the past 30 days of the survey, respectively. Clients also reported a significant increase in health in general and expressed fewer instances of anxiety, depression, trouble remembering, and difficulty controlling violent behavior. Clients were also more likely to be housed at follow-up; however, 29.1% of clients were experiencing homelessness at follow-up.

Upon discharge from PPW, 107 children were reunified with the client, 22 children were reunited with their fathers, and 18 were reunited with both of their parents. Additionally, multiple aspects of recovery capital, or the resources an individual can use to sustain recovery, increased from intake to follow-up.

Finally, clients generally expressed satisfaction with the PPW program including its services and the agencies' facilities, counselors, and staff. However, several aspects of the client satisfaction significantly varied across agencies.

SUSTAINABILITY

End of Year Survey

PPW agencies were asked to identify how service provision would change once PPW funding was ended. Table 14 presents results of the survey asking staff whether they plan to discontinue, reduce, or continue offering services after PPW funding ends in 2019. The sample size for the table is four since agencies were permitted to submit only one survey per agency

Childcare was the only service that all four agencies could provide after grant funding ends. Three agencies also indicated that they could continue providing educational/vocational training, family education nights, pharmacological interventions and Seeking Safety Groups while one agency indicated they would need to reduce these services or discontinue them (Seeking Safety group) after grant funding ends. Two agencies each also indicated they could continue funding Sober Living Activities, and the Children's Coordinator, Parent Coordinator, and Recovery Peer Coaching positions at their current levels.

Services highlighted in Table 14 represent services that over half of PPW agencies would be unable to continue funding after PPW grant funding ends. All agencies reported being unable to continue

providing gas cards and utility support services. Two agencies reported being unable to provide bus passes, and one agency reported being unable to support evaluation efforts.

Table 14. Number of Agencies Sustaining PPW Services After Grant Ends

	Remain Unchanged	Reduce	Discontinue
Child Care	4	0	0
Education/Vocational Training	3	1	0
Family Education Night	3	1	0
Pharmacological Interventions	3	1	0
Seeking Safety Groups	3	0	1
Children's Coordinator Position	2	0	2
Family Fun Night	2	2	0
Parent Coordinator Position	2	2	0
Recovery Peer Coaching	2	1	1
Sober Living Activities	2	2	0
Wellness	1	3	0
Bus passes	0	2	2
Clothing/personal items/child needs	0	4	0
Evaluation	0	3	1
Gas cards	0	0	4
Utility and Cell phone	0	0	4

Staff were also asked if they had at least one staff member who could train other staff in four evidence-based practices: 24/7 Dads, Love & Logic, Naloxone Administration, and Seeking Safety. All four agencies indicated they had at least one staff member able to train others in 24/7 Dads, Naloxone Administration, and Seeking Safety. Three agencies reported having one staff member able to train others in Love & Logic.

Another way in which agencies can improve program sustainability is to expose several staff at each agency about PPW's purpose and related practices. Onboarding staff may not only help maintain program quality throughout the duration of the grant but may also help sustain the program by potentially increasing the number of staff advocating for increased service delivery to pregnant and postpartum women at their agency and in the community. A description of ASAC's quality improvement project designed to improve PPW onboarding practices follows.

Quality Improvement Project #4: Onboarding Staff

Problem. Several staff mentioned staff turnover was a significant barrier to implementing the PPW program during interviews for the Year 2 Evaluation Report. When staff members working with PPW left the position, agencies found it difficult to re-train existing and new staff to manage the grant.

Solution. Staff suggested it would be beneficial to have one staff member who could "own" the project rather than share grant responsibilities among staff who may have limited knowledge of grant guidelines and procedures. While this is a great suggestion, not all agencies were able to support financially one team member to take ownership of the PPW program. Instead, it was suggested to create a PPW protocol document listing vital aspects of grant maintenance and to continually update and share the document with other staff. In the event of staff turnover, program quality may be more stable if the locations of documents, methods of gathering data, and timelines and procedures of report generation are available to new or provisional staff.

Action. PPW staff at HOM took on this task as their quality improvement project beginning April 2018. Prior to the creation of the PPW protocol document, staff familiar with PPW procedures and guidelines developed a pre-test survey to assess other HOM employee's knowledge of the PPW grant and grant practices. Two staff members currently working with the PPW grant then developed 1) a manual documenting the vital aspects, practices, and procedures associated with PPW and 2) a PowerPoint presentation based on the manual to be to train other HOM staff. The staff training took place in October 2018. Training participants will take a post-test survey at least thirty days after the training to assess whether their knowledge of the PPW grant and grant practices increased after attending the training and to identify opportunities to improve the training.

CONCLUSION

A wide array of recovery support services, evidence-based practices, programming and coordination with outside agencies were used to deliver an evidence-based program to serve pregnant and postpartum clients, their children and network of supportive adults from February 1, 2016 to September 29, 2018. Below are the responses to evaluation question based on Iowa PPW goals.

Goal 1: To implement an evidence-based program and increase the number of pregnant and postpartum women served with evidence-based programming at three Women and Children's Centers.

a. Did Iowa initiate PPW services at three high volume community based substance use disorder treatment centers?

   *Answer: **Yes**. All Iowa PPW sites initiated services at three high volume community based substance use treatment centers by February 26, 2016. Iowa PPW admitted 184 clients in the first and second fiscal years.*

b. Did Iowa provide training in Seeking Safety to staff at the three substance use disorder treatment centers?

   *Answer: **Yes**. In February 2016, 16 staff were trained in Seeking Safety. In the 2017 fiscal year, staff from each agency deepened their knowledge of Seeking Safety by attending two additional Seeking Safety trainings*.

c. Hire or appoint a Care Coordinator who works at least 20 hours a week on Iowa PPW?

   *Answer: **Yes**. Each PPW site hired or appointed a Care Coordinator who works at least 20 hours a week on Iowa PPW.*

d. Does the Care Coordinator lead the Seeking Safety training and ensure program delivery to the target population?

*Answer: **Partially**. A therapist or counselor, rather than the Care Coordinator, leads Seeking Safety training and ensures program delivery to the target population.*

Goal 2: To allow client choice in selecting recovery supports while focusing on gender specific issues for pregnant and postpartum women in residential treatment for substance use disorders.

a. Did Iowa identify service gaps that hinder successful completion of substance use disorder treatment program by pregnant and postpartum women?

*Answer. **Yes**. Through questionnaires and semi-structured interviews in 2017, staff identified housing, employment and finances, and unhealthy relationships as barriers to successful treatment completion. In 2018, interviews and surveys focused on how to increase client retention through engagement of fathers and other supportive adults.*

b. Did Iowa provide essential health and wellness services, which improve safe and healthy pregnancies and improve health outcomes?

*Answer: **Yes**. Throughout the three years of implementation, 109 Iowa PPW clients received $14,678.16 in recovery support funding for wellness services. Clients also reported significantly higher levels of self-rated health and fewer psychological and mental health problems such as anxiety and depression five to eight months post-admission.*

c. Did Iowa provide essential services that are focused on improving parenting skills, family functioning, economic stability and quality of life?

*Answer: **Yes**. Throughout three years of PPW, clients received 3,707 hours of parenting education. Clients also received seven different types of family-oriented evidence-based interventions. Lastly, one agency implemented a quality improvement project to use recovery peer coaching to increase clients parenting skills, economic stability and quality of life.*

d. Do providers offer at least four additional hours of weekend programming per month that increases extended family involvement?

*Answer: **Yes**. All three Iowa PPW implementation sites reported implementing at least four hours of weekend programming per month to involve clients' extended family. A quality improvement project in progress at HFS revealed an overwhelming majority of participants of family night programming are likely to return and are generally satisfied with the accessibility of family night programming.*

e. Do Care Coordinators develop and implement an extended recovery support services array that supports women, children and extended family members

*Answer: **Yes**. Over $227,000 in recovery support funds were spent on Iowa PPW clients, their minor children, and extended family. Clothing, utility, and transportation services were used to support clients' children and supportive adults.*

Goal 3: To reduce behavioral health disparities among pregnant and postpartum women who as a population tend toward a higher incidence of substance use disorder and related problems.

a. Do Care Coordinators develop comprehensive treatment plans for the women as well as a family treatment plan?

*Answer: **Yes**. Staff at each agency identified three components to treatment plan development: screening, goal development and service planning. PPW agencies reported implementing new strategies to obtain more information about fathers in order to incorporate into the program as soon as possible.*

b. Did Iowa increase and expand services to pregnant and postpartum women and their families involved in adult, juvenile and family Drug Court?

*Answer: **Not yet.** Interviews with Care Coordinators and supervisory staff indicates that the services available to pregnant and postpartum women and their families in adult, juvenile and family drug court largely remain unchanged after implementation of the Iowa PPW grant. In addition, analyses indicate RSS spending was similar for clients who do and do not report involvement in Drug Court.*

c. Did Iowa improve the treatment success rate by 5% at each center?

*Answer: **Partially**. Compared to 2016, HFS had the largest increase in treatment success rate (111.6%). JRC increased its treatment success rate by 26.4% and ASAC increased its treatment success rate by 4.2%. However, compared to 2017, the treatment success rate decreased for ASAC (3.7%), HFS (25.8%), and JRC (7.9%).*

RECOMMENDATIONS

Recommendations

- **Expand the use of MAT**. Completion of Iowa PPW was higher among clients using MAT; however, only two of the four PPW agencies reported using MAT for PPW clients. At these two agencies, MAT was used to treat a variety of substance use disorders (alcohol, methamphetamines, marijuana, and opioids). Expanding the usage of MAT across agencies could results in higher levels of PPW treatment completion.
- **Continue asking fathers what permits and prohibits participation and adjust services accordingly**. Surveys with participating fathers revealed transportation, schedule conflicts, and distance to the treatment center were significant barriers to participation. Fathers also reported that learning new things, spending time with family, and connecting with families were motivating factors. Agencies are encouraged to survey more fathers to assess the representativeness of these findings and modify PPW programming to encourage father participation.
- **Find new avenues to promote 24/7 Dads.** Agencies have recorded the 24/7 Dads intervention for very few fathers. Additionally, only 13 out of 37 fathers surveys had heard of 24/7 Dads. Agencies are encouraged to find methods to improve reporting of participation in 24/7 Dads for current participants and to actively promote the intervention when developing family treatment plans.

- **Ask agencies to share successes and challenges of implementing quality improvement projects.** Sharing procedures and outcomes of quality improvements promotes an exchange of ideas that may considerably enhance service delivery across all agencies.
- **Address agency differences in treatment completion and client satisfaction.** For the second year in a row, clients at ASAC reported being less satisfied with program services and some aspects of client-staff interaction.
- **Encourage agencies to find alternative means to fund recovery support services and Coordinator positions after grant funding ends**. All agencies reported that they would be unable to continue providing gas cards and utility supports after grant funding ends and two agencies would no longer be able to provide bus passes. Additionally, two agencies reported being unable to support their Children's Coordinator Position when grant funding ends.
- **Address agency disparities in treatment completion.** JRC has the highest rates of treatment completion across all three years of PPW implementation. HFS has routinely had the lowest levels of treatment completion. Clients' demographics and patterns of substance use do not explain these differences. More information is needed at the agency level to explore and reduce disparities in treatment completion.

APPENDIX A

Table 15. Program Goals, Questions and Data Sources for Evaluation

Evaluation Question	Measures	Data Sources
Goal 1: Program Implementation—To implement an evidence-based program and increase the number of pregnant and postpartum women served with evidence-based programming at three Women and Children's Centers.		
a. Did Iowa initiate PPW services at three high volume community based substance use disorder treatment centers?	Earliest intake data by provider; Number of clients served by each provider	GPRA Intake Interviews, Intake Notification Form
b. Did Iowa provide training in Seeking Safety to staff at the three substance use disorder treatment centers?	Number and demographics of staff receiving Seeking Safety Training per provider	Staff Training Tracking Form
c. Did each provider hire or appoint a Care Coordinator who works at least 20 hours a week on Iowa PPW?	Date Care Coordinator hired; Job description for Care Coordinator; Care Coordinator credentials	Job Description of Care Coordinator, Survey Care Coordinators
d. Does the Care Coordinator lead the Seeking Safety (SS) training and ensure program delivery to the target population?	Names of therapists/ counselors leading SS and undergoing advanced SS training	Seeking Safety Provider Meeting Notes, Staff Training Tracking Form
Goal 2: Provide Recovery Support Services—To allow client choice in selecting recovery supports while focusing on gender specific issues for pregnant and postpartum women in residential treatment for substance use disorders.		
a. Did Iowa identify service gaps that hinder successful completion of substance use disorder treatment by pregnant and postpartum women?	Identification of service gaps by agency staff; Clients' statement of needed services	Client Satisfaction Survey; Interviews with Care Coordinators and supervisory staff
b. Did Iowa provide essential health and wellness services which improve safe and healthy pregnancies and improve health outcomes?	Number and description of services provided, comparison of number of preterm, low birth weight, and infant deaths to national averages	Evidence Based Practices Tracking Form, Recovery and Support Services Tracking Form, Agency Intake Notifications, Agency Discharge Notifications, Peer-reviewed journal articles

Table 15. Program Goals, Questions and Data Sources for Evaluation (continued)

Evaluation Question	Measures	Data Sources
c. Did Iowa provide essential services which are focused on improving parenting skills, family functioning, economic stability and quality of life?	Number and description of services, number of clients experiencing improved quality of life	Recovery Support Services Tracking Form; Evidence Based Practices Tracking Form
d. Do providers offer at least four additional hours of weekend programming per month that increases extended family involvement?	Number of hours weekend programming per month offered, Description of weekend programming activities	Interviews with Care Coordinators and supervisory staff, Agency feedback survey
e. Do Care Coordinators develop and implement an extended recovery support services array that supports women, children and extended family members?	Type and frequency of services offered; Description of agencies with which providers have MOAs/MOUs	Recovery Support Services Tracking Form, Evidence Based Practices Tracking Form; Agency MOAs and MOUs
Goal 3: Address Behavioral Health Disparities—To reduce behavioral health disparities among pregnant and postpartum women who as a population tend toward a higher incidence of substance use disorders and related problems.		
a. Do Care Coordinators develop comprehensive treatment plans for the women as well as a family treatment plan?	Description of methods used to develop treatment plans for clients and their families	Interviews with Care Coordinators
b. Did Iowa increase and expand services to pregnant and postpartum women and their families involved in adult, juvenile and family Drug Court?	Number of clients and participating family members involved in Drug Court.	Intake and Discharge Notification Form
c. Did Iowa improve the treatment success rate by 5% at each center?	Number of clients completing treatment by provider (baseline)	GPRA Discharge Interview

APPENDIX B

Assessment of Recovery Capital (ARC)

Please place a ✓*only* in the boxes for statements that you agree with and that describe your experiences as of today.

I am currently completely sober.	☐
I feel I am in control of my substance use.	☐
I have had no 'near things' about relapsing.	☐
I have had no recent periods of substance intoxication.	☐
There are more important things to me in life than using substances.	☐

Section 1: Total ✓ = ____

I am able to concentrate when I need to.	☐
I am coping with the stresses in my life.	☐
I am happy with my appearance.	☐
In general I am happy with my life.	☐
What happens to me in the future mostly depends on me.	☐

Section 2: Total ✓ = ____

I cope well with everyday tasks.	☐
I feel physically well enough to work.	☐
I have enough energy to complete the tasks I set myself.	☐
I have no problems getting around.	☐
I sleep well most nights.	☐

Section 3: Total ✓ = ____

I am proud of the community I live in and feel part of it – sense of belonging.	☐
It is important for me to contribute to society and or be involved in activities that contribute to my community.	☐
It is important for me to do what I can to help other people.	☐
It is important for me that I make a contribution to society.	☐
My personal identity does not revolve around drug use or drinking.	☐

Section 4: Total ✓ = ____

I am happy with my personal life.	☐
I am satisfied with my involvement with my family.	☐
I get lots of support from friends.	☐
I get the emotional help and support I need from my family.	☐
I have a special person that I can share my joys and sorrows with.	☐

Section 5: Total ✓ = ____

I am actively involved in leisure and sport activities.	☐
I am actively engaged in efforts to improve myself (training, education and/or self-awareness).	☐
I engage in activities that I find enjoyable and fulfilling.	☐
I have access to opportunities for career development (job opportunities, volunteering or apprenticeships).	☐
I regard my life as challenging and fulfilling without the need for using drugs or alcohol.	☐

Section 6: Total ✓ = ____

I am proud of my home.	☐
I am free of threat or harm when I am at home.	☐
I feel safe and protected where I live.	☐
I feel that I am free to shape my own destiny.	☐
My living space has helped to drive my recovery journey.	☐

Section 7: Total ✓ = ____

I am free from worries about money.	☐
I have the personal resources I need to make decisions about my future.	☐
I have the privacy I need.	☐
I make sure I do nothing that hurts or damages other people.	☐
I take full responsibility for my actions.	☐

Section 8: Total ✓ = ____

I am happy dealing with a range of professional people.	☐
I do not let other people down.	☐
I eat regularly and have a balanced diet.	☐
I look after my health and wellbeing.	☐
I meet all of my obligations promptly.	☐

Section 9: Total ✓ = ____

Having a sense of purpose in life is important to my recovery journey.	☐
I am making good progress on my recovery journey.	☐
I engage in activities and events that support my recovery.	☐
I have a network of people I can rely on to support my recovery.	☐
When I think of the future, I feel optimistic.	☐

Section 10: Total ✓ = ____

APPENDIX C

Client Satisfaction Survey

	Less than a week (1)	Less than a month (2)	More than a month (3)
1. How long have you been receiving services? (1)	❍	❍	❍

2. What month and year were you admitted to [insert agency name]? (MM/YYYY)
3. Are you still in treatment at [insert agency name]?

❍ Yes (1)
❍ No (2)

4. What month and year were you discharged from [insert agency name]? (MM/YYYY)
5. Who referred you to [insert agency name]?

❍ Self (21)
❍ Health Care Provider (22)
❍ Community Mental Health Clinic (23)
❍ Alcohol/Drug Abuse Provider (24)
❍ Other Individual (25)
❍ Employer/EAP (26)
❍ School (27)
❍ TASC (28)
❍ OWI (29)
❍ Other Criminal Justice/Court (30)
❍ Civil Commitment (31)
❍ Promise Jobs (32)
❍ Zero Tolerance (33)
❍ Drug Court (34)
❍ Other Community (38)
❍ DHS Child Abuse (39)
❍ DHS Child Welfare (40)
❍ DHS Drug Endangered Child (41)
❍ DHS Other (42)
❍ Division of Vocational Rehabilitation (43)
❍ Parole Board (44)
❍ State Probation (45)
❍ Federal Probation (46)

These questions are about your Counselor. If you had more than one, pick the one you had the most contact with.

	Never (1)	Sometimes (2)	Usually (3)	Always (4)
6. How often did your counselor treat you with courtesy and respect? (1)	❍	❍	❍	❍
7. How often did your counselor listen carefully to you? (2)	❍	❍	❍	❍
8. How often did you feel comfortable raising any concerns that you had about your treatment? (3)	❍	❍	❍	❍
9. How often did your counselor explain things to you in a way you could understand? (4)	❍	❍	❍	❍

These questions are about Other Staff in the agency you interacted with other than your counselor.

	Never (1)	Sometimes (2)	Usually (3)	Always (4)
10. How often did staff treat you with courtesy and respect? (1)	❍	❍	❍	❍
11 .How often did staff listen carefully to you? (2)	❍	❍	❍	❍
12. How often did staff explain things to you in a way you could understand? (3)	❍	❍	❍	

These questions are about the physical facility and building where you received services.

	Never (1)	Sometimes (2)	Usually (3)	Always (4)
13. How often were the rooms, bathrooms, and hallways kept clean? (1)	❍	❍	❍	❍
14. How often did you feel safe when you were in or around the building? (2)	❍	❍	❍	❍
15 .How often did the facility and building seem efficient and well run? (3)	❍	❍	❍	❍

These questions are about the Program you received in general.

	Never (1)	Sometimes (2)	Usually (3)	Always (4)
16.How often did the program seem efficient and well run? (1)	❍	❍	❍	❍
17.How often would you suggest this program to a friend or family member? (2)	❍	❍	❍	❍
18.How often did the program seem to fit your needs? (3)	❍	❍	❍	❍
19.How often did you get the kind of service you wanted? (4)	❍	❍	❍	❍

10. Please indicate how dissatisfied or satisfied you were with:

	Very Dissatisfied (1)	Dissatisfied (2)	Uncertain (3)	Satisfied (4)	Very Satisfied (5)
20. The service you received? (1)	❍	❍	❍	❍	❍
21. The help you received for the problem you came for? (2)	❍	❍	❍	❍	❍
22. The quality of the services you received? (3)	❍	❍	❍	❍	❍

	Under 18 (1)	18 to 24 (2)	25 to 34 (3)	35 to 44 (4)	45 to 54 (5)	55 or over (6)
23. How old are you? (1)	❍	❍	❍	❍	❍	❍

24. Are you... ?

❍ Male (1)

❍ Female (2)

	White (1)	Black (2)	Hispanic or Latino (3)	Other (4)
25. What best describes you? (1)	❍	❍	❍	❍

26. Would you please take a few minutes to describe what about the service experience stands out:

APPENDIX D

Table 16. Open-Ended Responses to Client Satisfaction Survey by Agency

ASAC
Groups not always organized but pretty structured environment.
The only reason I was able to have my children back right away was because of the Heart of Iowa. I received treatment, support, PPW, help with Christmas gifts, Family pictures, clothing, sober activities, building up supports, and re-building a foundation.
They involve your kids in with your treatment.
The love, care and compassion.
I got custody of my kids in our own apartment.
Helped me with all of my needs.
I was able to deliver a healthy baby and was able to be in treatment with a newborn. I was able to avoid having DHS involved. I was able to gain my mental health again and gain sobriety.
Lack of structure and communication.
The ability to keep my children and have our own apartment on site.
The staff was always open/available to discuss different issues or areas of concern. I enjoyed my stay here and I learned a lot of different coping skills.
Groups lead help you learn to live a healthy sober life outside the facility. Not repetitive about just one topic, assisted well with mental health, medical, pregnancy concerns.
Lots of resources, lists of all meetings, and I got therapy in facility and outside.
The genuineness!
Staff and client relationships, staff seems to truly care about clients here at ASAC.
Learning to cope. I loved my counselor.
Liked the apartment settings very much, however groups were very disorganized and schedules were always uncertain.
Having our own apartments and having our children with us was wonderful. Counselors were great, and for the most part, treatment is good.
I would have to say the people who not only run this place but the ones that fill it as well are genuine, down to earth people and very easy to relate to. They're knowledgeable and love to recognize positive behaviors in one another.
I would recommend this place to anyone wanting to change their life.
great place helped me and still helps me relive my life. Thank you!
That they are willing to work with me to get me the help I need for my situation.

Table 16. Open-Ended Responses to Client Satisfaction Survey by Agency (continued)

ASAC
They involve your kids in with your treatment.
Great classes
Always there to help. Emotional Support. Able to have mental health needs met. The PPW program and its coordinator.
HFS
I felt as if staff was very compassionate with me and my kids.
That they had programs to help get things we needed. (ex PPW)
PPW really helped me get ready for my baby when I was pregnant and helped me feel more sufficient in being able to bring my baby into the world knowing I was able to get her the things she needed.
Respectful, helpful, and caring.
The program does work if your will to make the commitment to change and let it help you!
It was very helpful.
HOM
It only works if you want to put the effort into making the changes in your life to maintain recovery.
People are open and positive peers to be around. Staff being open and always someone available to talk to and listen to me.
My counselor was very helpful and understanding and took the time to listen.
The counselors. Every area was covered. Substance abuse, parenting, mental health and education.
Everyone is very friendly
JRC
I liked, well, loved that staff had experience by living proof.
The overall help I needed was met...Thank you!
The staff/therapists are always willing to go above/beyond for the ladies here at WCC.
Primary groups- I enjoyed getting to do assignments with our small groups and therapist. It helped to cope with past situations.
Everyone was so welcoming and very supportive/understanding.
The program structure and service provided was just what I needed and this is an amazing program.

Table 16. Open-Ended Responses to Client Satisfaction Survey by Agency (continued)

JRC
The way they take roll call and making sure they know where everyone is, and how welcoming the community is when I came in.
My experience at JRC WCC has truly been amazing! I couldn't have asked for a more fulfilling experience to get well and find my true self. It has definitely been an experience that I will carry for the rest of my life. Thank you from the bottom of my heart!
The love, care, and support.
Everything helped me achieve my goals. I recommend this to anyone who needs help.
Excellent therapists! I would highly recommend this facility to other women because it has helped me in ways I could never imagine. Support, resources, structure, stability for both mother and child.
The ability to get all the books I got and all the stuff I was able to get for my child.
Everything, I loved it here, it is not as bad as I thought.
I like that the 12 Steps and NA program are strongly pushed.
Great Recovery based program. Very Positive staff.
The time and value put in to each patient.
The loving feeling in the community and staff.
Meditation/education group was the best!!!
Staff listened to my needs.
They took time to deal with the real issue, besides just stop drinking/using.
It was a good place for me. It help me in many was with my mental illness to my drug problem.
The steps of recovery.
Liked attending group regularly.
Everyone helps each other out, questions get answered. It's a great place to call home.
The understanding and compassion from every single employee here. I never felt judged or scared to be sick or honest. I always felt respected and cured for I was never alone!
How the staff and therapist can relate to the life I once lived.
They help me get myself back.
I learned a lot here, being ready for change helped a great deal also.
Unconditional love, support, non-judgmental, a very good 12 step program.

Table 16. Open-Ended Responses to Client Satisfaction Survey by Agency (continued)

JRC
That they really care about your kids and fight hard for you to get in their care.
I like how most staff genuinely care about you and help you understand the process and help through the steps.
All the other women at W.C.C. and how caring they are for one another.
Being able to have your children while you're working on yourself is amazing. It gave me opportunities to become a better parent.
The honesty everyone had.
The night staff give the best recovery talks and advice. She helped me a lot! My therapist is a great therapist. She is straight up, blunt and full of wisdom! I am very happy she was my therapist.
Helps build Sober Support.
This place is a good program. I'm thankful for it.
I think this is a good program. My therapist was awesome. I have learned a lot in my recovery. Helped me get sponsor 12 steps started.
It was a wonderful experience here at WCC and I thank all the staff and therapists very much. Thank you all.
Caring people and staff.
I loved my Therapist and all the staff. I would recommend Jackson Recovery Services to anyone.
Helped me focus on myself help recover self emotional issues
How well my therapist understood me and how helpful all of the group sessions were for me.
How easy and comfortable I felt opening up to my counselor, staff and other peers. The amount of education on dealing with addiction, mental health and support from an emotionally abusive relationship has been a huge help to my recovery and life.