Special Connections Annual Report

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Colorado Division of Behavioral Health

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Special Connections Annual Report 2009

Introduction:
The Special Connections program began in 1993, and is a program jointly managed by the Department of Health Care Policy and Financing and the Division of Behavioral Health within the Colorado Department of Human Services. Over the past few years, there has been a significant increase in expenditures for this program, which reflects two things: 1) an increase in the utilization of residential treatment services and 2) the waiver which allows Special Connections participants to continue their treatment up to 1 year post-partum, assuming continued eligibility for Medicaid.

Women who participate in residential treatment are present a more complicated clinical picture than women who are served in outpatient treatment. They generally have more medical and emotional/behavioral complications that interfere with their ability to participate in treatment, and they frequently come from social environments in which substance use and sometimes criminal activity are common. They may have little to no family or positive social support, and they often need help to learn to live a sober lifestyle and to take care of their infants.

About the data used in this report:
This annual report provides information regarding the participants in the Special Connections program. One source of information is the Special Connections Screening Criteria form, which has been renamed the Pregnancy Risk Assessment, and is incorporated into the Division of Behavioral Health's electronic treatment database (Drug and Alcohol Coordinated Data System, or DACODS). This instrument is completed at admission for all pregnant women (not only those in Special Connections) who enter treatment in Colorado. The Pregnancy Risk Assessment collects information regarding factors that contribute to the risk of having a poor birth outcome due to substance use during pregnancy. An example of such a variable would be route of administration of a woman's primary drug, with oral administration being less risky than injection. Recovering friends and family, or friends and family who do not use substances would be more likely to result in a positive pregnancy outcome than would homelessness or living with other people who are actively using drugs or alcohol.

Another source of information is the Special Connections database, which is a Microsoft Access database housed at the Division of Behavioral Health. This database contains information regarding both admissions and pregnancy outcomes. The only data item that links the Special Connections database with DACODS is client name. An audit carried out during FY 2008 revealed that there were several ways in which information between the two databases could be missed, including the batch upload process used in storing DACODS (a name might appear in the Special Connections database but not in DACODS because there were errors in the original data submission).

The Special Connections database is linked to the Department of Health Care Policy and Financing's MMIS system via client Medicaid identification numbers. Here services paid to the Division of Behavioral Health are recorded, and can be used to identify that

billings have been done properly and that the services paid for out of MMIS are appropriate and were delivered to Special Connections clients. The linkage between these two data sources also allows for identification of clients participating in treatment during the waiver period (between 60 days and 1 year post partum) for those whose Medicaid eligibility remains intact. This is done by comparing the estimated delivery date recorded in the Special Connections database with the date of the service billed to assure that the services were delivered during the time in which they were eligible.

About outpatient vs. residential treatment services: The decision as to whether a woman would most benefit from outpatient or residential services is made based upon the use of criteria known as the American Society of Addiction Medicine Patient Placement Criteria (2nd version, Revised), also known as the ASAM PPC2R. The factors taken into account are:

1. Acute withdrawal/intoxication potential (alcohol and tranquilizers have the highest risk during withdrawal, and withdrawal from opiates can cause severe distress to the fetus)
2. Biomedical conditions or complications, such as HIV+, hepatitis, diabetes or other conditions requiring treatment during treatment;
3. Emotional/behavioral risks and complications, such as risk of suicide, untreated mental illness, low level of cognitive functioning, for example;
4. Readiness to change (also known as motivation for treatment)
5. Continued problem/relapse potential (how likely is the woman to develop the supports needed to live a sober lifestyle);
6. Recovery environment (does she live in drug free housing, does her family support her efforts at recovery, does she know people who don't use substances, for example)

For a brief summary of the substance use disorder treatment provided in Colorado, please see the document at the end of this report entitled: Perinatal Substance Use and Treatment Services in Colorado, 2008 Prevalence and Treatment Access

Special Connections Program Specific Data for Fiscal Year 2009:

The Alcohol and Drug Abuse Division, later the Division of Behavioral Health, take the information for this report from a Microsoft Access database that has been maintained continuously since 1992. This data is reported individually to the Division of Behavioral Health by Special Connections treatment staff via fax and telephone, upon program enrollment and upon the resolution. As pregnant women are identified to have substance use disorders, they are admitted to treatment at one of the Special Connections treatment sites. If they are found to be Medicaid eligible, they are enrolled into the Special Connections program and their information is entered into the Access database.

The following information is gleaned from the Special Connections Access database:

Number of clients served: 190

This reflects a lower than usual number of pregnant women admitted to treatment. Many factors may contribute to this lower number, including the perceived increase in stigma against pregnant women with substance use disorders, local law enforcement attempts to incarcerate or otherwise penalize pregnant women for their substance use, or changing practices among county departments of social/human services which encourage placement at birth of any infant found to be substance-exposed in utero.

Gestational age (trimester) at enrollment: The average gestational age at admission was 4 months, 28 days, approximately in the middle of the second trimester. Given that this length of time falls toward the middle of the second trimester of pregnancy, it appears that for those women who do enroll in treatment, they are beginning treatment soon enough in their pregnancies to minimize further damage to their fetuses. First trimester admissions are ideal, but the ambivalence that some women experience about coming to treatment appears generally to be somewhat resolved by the fourth or fifth month of pregnancy.

Retention rate (through birth): 88 (46%) Please see attached table for history regarding admission and retention rates in treatment. Since 1992, the highest rate of retention in treatment has been 67%, and the lowest rate of retention has been 37%, directly after the inception of the program. This puts this 46% retention rate toward the bottom of the range of retention rates over the years.

A variety of techniques are used to help retain pregnant women in treatment, including the use of motivational incentives, transportation and child care which is offered through the individual program providers, and access to primary health care for both the woman and her children. The counselors in this program are generally very experienced in working with pregnant women, and are good at providing services that make treatment accessible to them.

Rate of low birth weight for infants of women enrolled through birth: 15 infants or 17%

Rate of normal birth weight for infants of women enrolled through birth: 73 infants or 83%

Sources of referrals to the program:

Referral source	**# of referrals**	**% of referrals received**
Criminal Justice	61	32%
Departments of Social Services	34	18%
AOD Treatment Providers	28	15%
Self, Family or Friends	23	12%
Other	21	11%
Health Care Providers	15	8%
Unknown	4	2%

Missing	4	2%
Total:	190	

Data from DACODS:

The following set of data is taken from the Division of Behavioral Health's Drug and Alcohol Coordinated Data Set (DACODS). This is data reported by treatment providers back to DBH upon admission and discharge of each client receiving services through Colorado's licensed Substance Use Disorder treatment programs. The number of admits and discharges in DACODS are not equivalent to the admission data collected in the Special Connections Access database, because the DACODS data set includes **all** pregnant women admitted to treatment during FY 2009. This data reflects a total of 422 admissions for 277 individuals.

Some of the information collected on DACODS was once collected by hand and entered into the Special Connections database. Now the DACODS system includes the information collected by the Special Connections Risk Assessment form, and this information is no longer available through the Special Connections database. The Pregnancy Risk Assessment Form is now electronic, and is required to be filled out whenever a client is endorsed as being pregnant on her admission DACODS. Hence, the data contained below reflects not only the 190 pregnant women served through Special Connections, but also the additional 87 pregnant women served outside of the Special Connections program.

Average length of client participation in the program by admission level of care:
Outpatient treatment (92 clients): 115 days
Intensive outpatient treatment (7 clients) 42 days
Transitional residential treatment (6 clients) 119 days
Therapeutic community (8 clients) 110 days
Intensive residential treatment (21 clients): 19 days

Please note that the numbers above total 134 clients, for an overall mean length of stay of 97 days among all modalities. These 134 records constitute those treatment admissions for which there is also a discharge on file (necessary to calculate length of stay). When this data was extracted from the DACODS system, there were an additional 143 treatment admissions from which the women involved continued to receive treatment. The 97-day average length of stay is slightly longer than the minimum amount of treatment identified in the NIDA Principles of Effective Drug Treatment publication, and indicates that in general pregnant women are getting sufficient doses of treatment to be effective.

Age of clients at admission to treatment: (277 records, of which 170 are valid): The largest percentage of pregnant clients admitted to treatment were between the ages of 21 to 33 (40.1 %). This group was followed by the 15 to 20 age group (13.0%) and the 34 to 45 age group (8.3%). The remaining 38% records contained no valid response to this item. It follows logically that the largest group admitted to treatment would be in the 21

– 34 year age range, as participation of adolescents in the Special Connections program tends to be relatively infrequent, and women in the older age range may have already had their children or may be more reluctant to come to treatment.

Primary substance: Out of 277 responses, 38% were missing this data item. Of the responses reported, marijuana was endorsed most frequently as the primary substance (24.7%)followed by methamphetamine (24.1%) and alcohol (20.6%). These percentages are very close together, and most of the women enrolled in Special Connections use more than one substance. Of secondary substances reported, 26.5 % were marijuana and 22.9% were alcohol. It is difficult to tell from this data what the most common combination of substances might be, given that most people using substances tend to be polysubstance users. The high frequency of endorsement of marijuana as both primary and secondary substance for pregnant women admitted to treatment may either indicate that they were more comfortable sharing their marijuana use than their use of other substances, or that marijuana use is perceived as a problem needing treatment more frequently than it used to be. Given the high level of referrals from the criminal justice system, in which use of marijuana or any illicit substance can be cause for revoking probation or parole, perhaps what we see here is a reflection of the values and requirements of the primary referral source to Special Connections.

Frequency of use: 38.2% of women reported daily use of their primary substance. 30.6% reported use between 3 and 5 times per week, and 25.3% reported monthly use. Women who used in a binge pattern or 3 or more times daily constituted 5.9% of the respondents. For those women who reported monthly use of their primary substance, it is possible that the frequency of their substance use is actually greater, but that since the information was gathered at admission, they may not have felt able to report this information more accurately.

Age of clients at first use of primary substance: 38.8% of pregnant women reported first use to have occurred when they were younger than 15 years of age. 31.2% of pregnant women admitted to treatment reported their first use to have taken place when they were between 15 and 20 years of age. Those whose first use was when they were between the ages of 21 and 34 constituted 28.8% of admissions, and those whose first use was when they were between the ages of 34 and 45 were 13.5% of admissions.

Tobacco use: 63.2% of pregnant women reported daily use of tobacco at treatment admission.

Trimester of pregnancy at admission to treatment: 47.6% of pregnant women admitted to treatment in FY 2009 were in their first trimester of pregnancy. 27.1% were in their second trimester of pregnancy, and 25.3% were in their third trimester of pregnancy.

Prenatal care status: 68.2% of pregnant women admitted to treatment were already receiving prenatal care on a routine basis. Another 15.3% were receiving prenatal care, but not routinely. 11.2% were not yet receiving prenatal care but were willing to access

it. 5.3% were not receiving prenatal care at admission, with no plans to access it. (Linkage and incentives to participate in prenatal care are used with these women to ensure that their pregnancies progress in as healthy a way as possible).

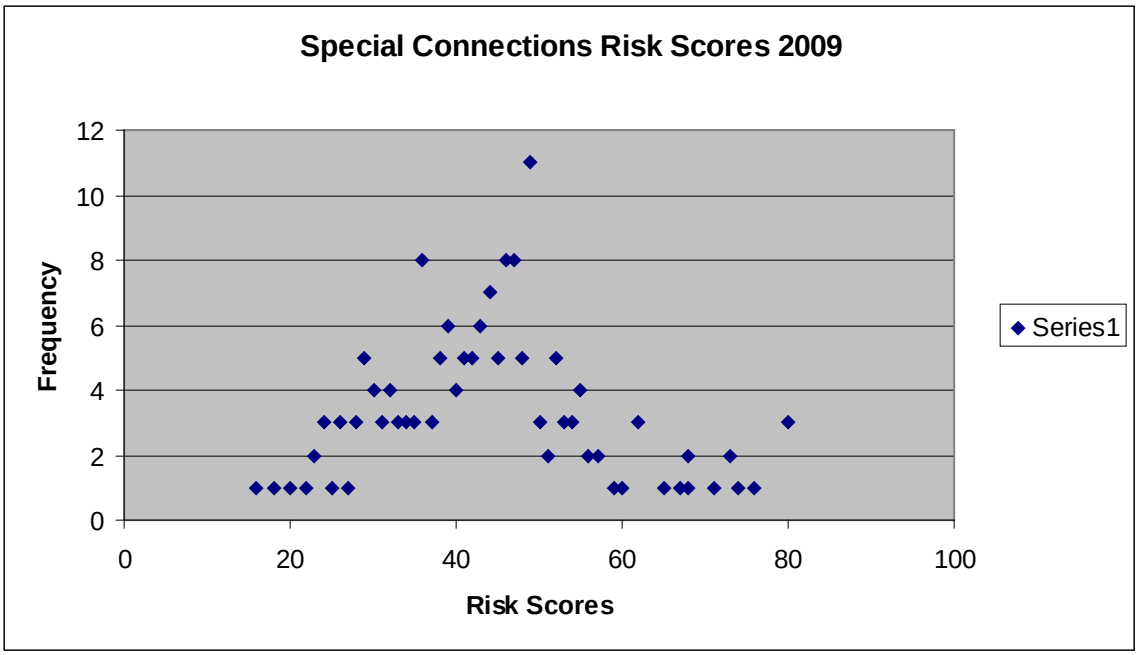
Family substance use disorder history: 38.8% of pregnant women admitted to treatment in FY 2009 had family histories of substance use disorders or had family members who were actively using. 30.0% reported having family members in recovery, and 31.2% reported no family history of substance use disorders.

Family/child custody status: 35.8% of pregnant women admitted to treatment had children who lived outside of their mother's home. For 32.5%, this was their first pregnancy and they had no other children. 17.2% had just one other child, and 10.1% had two or more children. 4.5% of women admitted to treatment had three or more children living with them.

Risk assessment tool and risk scores: The Special Connections Screening Criteria form is now electronic and is attached to the DACODS system as a pop-up screen that appears any time the "yes" response box is checked under "pregnancy." This information is no longer collected in the Special Connections database.

Below is a graph showing the distribution of risk scores for women admitted to the Special Connections program during FY 2009. The average risk score in this data set is 43.7.

Please note also that the Special Connections Screening Criteria/Risk Assessment results are not related to the criteria used to determine the appropriate level of care for each woman. A woman with a high Risk Assessment score may nevertheless be able to participate well in outpatient treatment, while a woman with a relatively low score may require residential services. The Risk Assessment is based upon information about risk to the pregnancy, and the ASAM PPC2 is related to the amount of support and structure a woman may need to complete treatment successfully.



Fiscal information is taken from the records (hard copy) of DBH's fiscal department, which is cross walked with information from MMIS wherever possible. To determine how many clients received what types of service, each of these information sources provides a piece of the picture. Women who received services under the waiver were determined by comparing their dates of delivery with their dates of service, to be sure that these services took place during the first year post partum. Counts of clients receiving each service were also taking from billings submitted by each program to DBH for payment. The amount of overlap between women receiving residential services and those receiving outpatient services is difficult to determine and would need to be counted by hand also. Clinically, it is best practice for people being treated to participate in a period of outpatient/aftercare services following a residential stay.

Number of clients who received Waiver services: 79

Number of clients who received outpatient services: 182

Number of clients who received outpatient services <u>only</u>: 42

Number of women who received residential services: 140

Number of re-enrolled clients who participated in the program during a previous pregnancy: 26

Average expenditure per client (outpatient): $619

Average expenditure per client (residential): $15,210

Total expenditures for waiver services: $488,866.59

Total expenditure per waiver client for waiver services: $6,188.19

Total expenditures for non-waiver services: $855,806.73

Average expenditure per non-waiver client for non-waiver services: $4,388.75

Total expenditures for FY 2008-2009: $1,344,673.32

Special Connections Birth Outcomes since 1992:
Please see the table attached below for the birth outcomes of Special Connections clients since 1992. The retention rate in treatment in 2009 was less than the program average for the past 18 years. Many factors are reported to have influenced this number, including a political climate in which women have been afraid to seek treatment for fear of prosecution. In FY 2010, special emphasis has been placed upon outreach and retention in treatment, particularly for pregnant women, among our publicly funded programs. We expect that some new public awareness materials (such as posters, brochures, outreach kits and specific meetings with healthcare providers, to name a few) will help to increase our enrollment and retention numbers.

Year	Admits	Birth Outcomes reported	Normal birthweight	Low birthweight	Retention rate	%low birthweight births	% normal birthweight/total births	% Normal birthweight/ women entered tx
1992	42	5	5	0	12%	0%	100%	12%
1993	172	33	26	7	19%	21%	79%	15%
1994	309	115	96	19	37%	17%	83%	31%
1995	288	159	132	27	55%	17%	83%	46%
1996	303	149	129	20	49%	13%	87%	43%
1997	316	189	159	30	60%	16%	84%	50%
1998	283	180	152	28	64%	16%	84%	54%
1999	291	183	161	22	63%	12%	88%	55%
2000	295	172	148	24	58%	14%	86%	50%
2001	259	174	144	30	67%	17%	83%	56%
2002	245	147	125	22	60%	15%	85%	51%
2003	279	157	140	17	56%	11%	89%	50%
2004	334	163	151	12	49%	7%	93%	45%
2005	339	187	159	28	55%	15%	85%	47%
2006	317	165	139	26	52%	16%	84%	44%
2007	261	124	104	20	48%	16%	84%	40%
2008	282	141	129	12	50%	9%	91%	46%
2009	190	88	73	15	46%	17%	83%	38%
Total	4805	2531	2172	359	53%	14%	86%	45%

Perinatal Substance Use and Treatment Services in Colorado, 2008
Prevalence and Treatment Access

Colorado Division of Behavioral Health

Substance Use by Pregnant Women in the U.S.

Substance Use by Pregnant Women & Girls	15-17 yrs	18-25 yrs	26-44 yrs		15-44 yrs
Alcohol [1]	15.8 %	9.8 %	12.5%		11.6 %
Tobacco[2]	24.3 %	27.1 %	10.6%		17.3%
Non-medical use prescription medication[3]	18.2%	9.6%	2.9%		6%
Illicit Drug	8%		1.6%		4.3%

In Colorado

Of **70,737 babies** born in Colorado (to women age 15-44) in 2006, it is estimated that

- 8,205 were exposed to alcohol in utero;
- 12,237were exposed to tobacco in utero;
- 4,244 were exposed to the non-medical use of prescription medications &
- 3,042 were exposed to an illicit substance e.g. heroin, cocaine etc.

Impact of Prenatal Substance Exposure

Any alcohol or drug use during pregnancy is potentially harmful to the unborn child. If a mother is not treated and continues to use during her pregnancy, her substance exposed (SE) newborns is at high risk for:

- Premature delivery
- Low birth weight
- Neurological & congenital problems
- Increased risk for SIDS (sudden infant death syndrome)

[1] *Alcohol Use Among Pregnant Women & Recent Mothers 2002-2007* [National Survey Drug Use and Health (NSDUH): 9/2/2008]
[2] *Cigarette Use Among Pregnant Women and Recent Mothers* (NSDUH: 2/9/2007)
[3] Chapter "Misuse of prescription drugs by pregnancy status" at http://oas.samhsa.gov/Women.htm

- Developmental delays
- Neglect or abuse (2 –3 times higher than non SE Newborns)
- Mental health & substance abuse problems as they age.

Research indicates that interrupting the mother's substance use and providing comprehensive services for mother and child significantly improves

- Birth outcomes
- Children's development

Women Who Use During Pregnancy

While women across all racial, ethnic, religious and socioeconomic groups use substances during pregnancy, we know most regarding those women who have received substance abuse treatment services through publicly funded programs. Research indicates that women served in these programs are likely to have:

- Co-occurring mental health disorders
- Experienced trauma as a child &/or adult
- Be on Medicaid or lack health coverage
- Be impoverished &/or lack stable housing
- Experienced partner &/or community violence
- Legal problems

Reasons Women in General (Ages 18 – 49) Give for Failing to Pursue Treatment[4]

Although we have some idea why women fail to pursue substance abuse treatment, we do not know the actual per cent of pregnant women or adolescents deterred from treatment for these reasons. The following information pertains only to women in general, ages 18-49, who recognized that they needed substance abuse treatment but, for varying reasons, did not pursue it.

[4] *Substance Use Treatment Amongst Women Of Childbearing Age* (NSDUH:10/4/2007)

Reasons Identified	
Not Ready to Stop	36.1 %
Cost/Insurance Barriers	34.4 %
Social Stigma	28.9 %
Did Not Feel the Need for Treatment/Could Stop On Own	15.5 %
Did not know where to get treatment	13.2 %
No Time	4.7 %
Felt Treatment Wouldn't help	2.7 %
Other	15 %

Pregnant and Parenting Women Face Additional Barriers

Pregnant women face additional barriers to substance abuse treatment. Due to the severity of their addiction and the complexity of their problems, many require intensive services; however, few treatment programs provide the programming and supports that pregnant women require. In addition, many traditional residential programs are reluctant to accept pregnant women due to concerns regarding liability. Barriers to treatment for pregnant and postpartum women include:

- Stigma
- Fear they will lose custody of their children if they admit to use
- Fear of criminal prosecution/incarceration
- Lack of / inability to access gender specific treatment
- Lack of healthcare coverage
- Lack of childcare and/or transportation

Access to Women's Gender-Specific Treatment in Colorado for Pregnant Women:

Overall, pregnant women must travel great distances in Colorado in order to access substance use disorder treatment to meet their specific needs. The figures below show the average distance between the county seat in each county and the closest Special Connections treatment provider. This represents a rough estimate of the distance a woman might be expected to travel in order to access services, depending upon where she lives in the state.

Distance is calculated using the average distance between each county's county seat and the closest Special Connections provider in each region.

SSPA 1 (Northeast Colorado) 68 miles
SSPA 2 (Denver Metro Area) 17 miles
SSPA 3 (Colorado Springs and surrounding areas) 52 miles

SSPA 4 (Southeast Colorado) 59 miles
SSPA 5/6 (Southwest and Northwest Colorado) 81 miles
SSPA 7 (Boulder) 0 miles

Continuum of Care[5]

Research from the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMSHA) indicate that women are more likely to remain in treatment and evidence the greatest benefits when services are gender specific, family focused, allow the woman to keep her children in treatment with her and include both clinical and support services. The degree of structure and support a woman requires varies depending upon the severity of her use, the presence of co-occurring mental health problems and socioeconomic problems as well as the degree of support available to her in her environment. In other words, "one size does not fit all". The intensity of services a woman requires may also vary over time. The ideal system of care for pregnant and parenting women includes a continuum of treatment and support services that range from low to high intensity.

Level of Intervention	Type of Service
Low intensity	General home visiting services e.g. Bright Beginnings
Moderate intensity	Specialized substance abuse case management /home visiting programs e.g. Direct Link, Family Nurse Partnership
Moderate intensity	Women's gender specific outpatient substance abuse treatment
Moderate/High intensity	Women's gender specific intensive outpatient / day treatment
High intensity	Women's gender specific residential treatment that allows women to keep their newborns/children in treatment with them

Publicly Funded Perinatal Substance Abuse Treatment Services in Colorado

Statewide Substance Use Disorder Treatment funding for women's gender-specific treatment is approximately $3 million, consisting of half federal, half state general fund dollars. Colorado's 4 Managed Services Organizations (MSOs) provide gender specific services for pregnant and parenting women in all 7 sub-state regions; available services vary by MSO according to their funding and community resources. These services are partially funded by the Colorado Department of Human Services Division of Behavioral Health through Federal and State dollars. Medicaid also provides funding for pregnant

[5] *Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and ~~Challenges~~*, ~~Substance~~ Abuse and Mental Health Services Administration (SAMHSA 2007)

women's treatment through the Special Connections program, which is a collaboration between the Department of Health Care Policy and Financing and the Department of Human Services.

MSO services All MSOs are required to provide:

- Outpatient women's gender specific substance abuse services
- Treatment priority for pregnant substance using women

Array and availability of specific service types varies by sub-state area

Special Connections Services: These services are funded by Medicaid for pregnant and post partum women up to one year after the birth of their babies; contingent upon continued Medicaid eligibility; treatment must begin during pregnancy to be eligible for post-partum services

Special Connections Sites:

- **Addiction Research and Treatment Services:** Located in Denver, provides residential therapeutic community outpatient and intensive outpatient services.
- **Arapahoe House:** Located in Denver, Littleton and Westminster, provides intensive residential, transitional residential, outpatient and intensive outpatient treatment as well as specialized women's case management**;**
- **Boulder County Health Department:** Located in Boulder and Longmont, provides outpatient and intensive outpatient services.
- **Centennial Mental Health Center:** Located in Sterling, provides outpatient and intensive outpatient treatment services.
- **Crossroads' Turning Points:** Located in Alamosa and Pueblo, provides intensive residential, intensive outpatient and outpatient treatment services
- **Jefferson County Department of Public Health and Environment:** Located in Lakewood, provides outpatient treatment services.
- **Larimer Center for Mental Health** Located in Fort Collins and Loveland, provides outpatient mental health and substance use disorder treatment.
- **North Range Behavioral Health:** Located in Greeley, provides outpatient treatment services.

- **Southwest Colorado Mental Health Center:** Located in Durango, provides outpatient treatment services.

Residential Treatment Facilities in Colorado Which Provide Women's Gender Specific Services

Few programs in Colorado provide specialized treatment for women, and even fewer allow women to keep their newborns or other children with them in treatment. In 2008, only three residential facilities in Colorado provided services designed to meet the social, psychological, and health care needs of pregnant and parenting women. The following programs will accept pregnant women and /or parenting women and their children. Bed counts reflect the total number of beds available for women and children; capacity in each program varies depending on the distribution of adults and children.

Publicly Funded Residential Facilities

Arapahoe House Aspen Center for Women: Intensive Residential program has 16 beds, serves pregnant, post partum women and their children. Accepts Medicaid as well as other funding sources.

The Haven (a program of the Addiction Research and Treatment Services) Therapeutic community, 26 beds, serves pregnant and post partum women with their children up to age 18 months. Accepts Medicaid as well as other funding sources.

Colorado West Regional Mental Health Center (Grand Junction): Transitional residential program, 6 – 10 beds for pregnant and newly post-partum women with their infants**.**

Crossroads' Turning Points: Intensive Residential program, 16 beds, accepts Medicaid as well as other payment sources.

Birth Outcomes for Pregnant Women treated through Special Connections

Since 1992, 86 % of babies born to women who completed the Special Connections program have weighed in at above 5 pounds, 8 ounces, which is considered the threshold between low and normal birth weight. Overall, this represents 1,970 of 2,302 births to women with diagnoses of substance abuse or dependence.