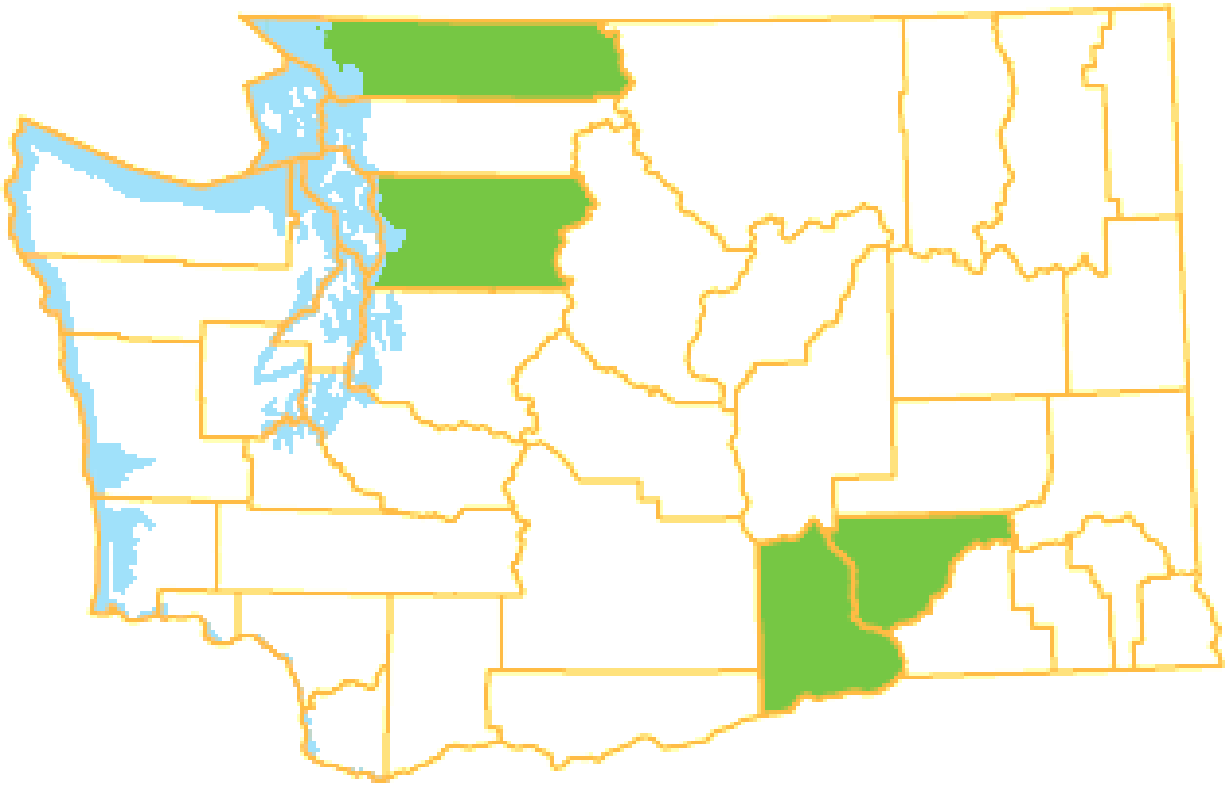
Safe Babies, Safe Moms

Program Evaluation



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

Washington State Department of Health

Safe Babies, Safe Moms

Program Evaluation

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EXECUTIVE SUMMARY

The Safe Babies, Safe Moms program was funded through a budget proviso that directed DSHS to develop and implement comprehensive programs for alcohol- and drug-abusing women and their young children. Funds were used to increase the availability of chemical dependency treatment, to implement new services called Targeted Intensive Case Management, and to enhance housing support services. The design of program services was based on the 1999 DSHS-DOH *Report to the Legislature: A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803).*

Comprehensive services are offered through the Safe Babies, Safe Moms program by a triad of core service providers:

- A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site. TICM provides referral, support, and advocacy for substance abuse treatment and continuing care. TICM assists clients in accessing and using local resources, and TICM agencies provide behavioral health services, parenting education, and child development services.
- Long-term residential treatment for chemical dependency provides a positive recovery environment with structured clinical services in a 24-hour live-in setting. While mothers are in residential treatment, therapeutic childcare is provided for their children. Clients may also participate in outpatient CD treatment.
- Housing support services offer up to 18 months of housing for women and children in a transitional house and provide recovery support and linkages to community services.

Several components of the Safe Babies, Safe Moms program have been identified as critical features, key to its successful outcomes:

- Cross-system collaboration was implemented in the coordination of services to individual clients by holding regular multi-disciplinary staff meetings with the client in attendance. Community meetings of local providers facilitated problem solving of system issues.
- A strong and varied specialized behavioral health curriculum was developed by TICM agencies in response to identified client needs. Classes addressed basic life skills and personal development, and individual counseling was provided to augment other community resources and when those resources were not available to individual clients.
- Discretionary funds were used to support basic client needs. The availability of these funds saved case managers' time, offered incentives to clients to remain active in the program, and supplied some basic needs for goods at critical times.
- The need for parenting education was met at two sites by adopting an established curriculum that was flexible and comprehensive.
- While CD treatment providers advocate a very structured approach to treating chemical dependency, including defined rules and sanctions for violating those rules, TICM was based on a harm reduction model of service provision, and clients were maintained in the program despite periods of relapse or non-compliance.

The basic design of the program and these key components were implemented successfully, and the Safe Babies, Safe Moms pilot projects achieved the following accomplishments:

- Three pilot sites—Benton-Franklin Counties, Snohomish County, and Whatcom County—served 453 substance-abusing women from January 2000 through June 2003. Services provided to clients included:
  - TICM: An average of 7 hours per month of targeted intensive case management for 14.5 months in active status (on average) for 442 clients (who agreed to participate in research).
  - CD treatment: An average of 3.5 months (108 days) of residential CD treatment for 189 clients who had completed or exited treatment as of March 31, 2003.
  - Housing support services: An average of 7.4 months (224.4 days) of housing support services for transitional housing for 61 clients who had exited housing support services as of March 31, 2003.

- Case managers identified an average of 7.5 (of 12) major needs per client. Each major need represented a significant life challenge. More than 80% of clients were reported as having each of the three most frequent needs:

  (1) Achieving and maintaining abstinence from drugs and alcohol,

  (2) Stabilizing mental health problems and improving behavioral health issues, and

  (3) Developing a healthy alcohol/drug-free social support system.

  Case managers helped clients to enroll in CD treatment programs, to remain in treatment, and to follow through with aftercare.

- Case histories revealed that clients were entangled in a complex web of rules, regulations, and laws administered most prominently through the criminal justice system, child protective services, and WorkFirst. With the guidance and advocacy of the case manager, many clients were able to comply with the requirements of these systems, avoid further penalties, and achieve successes like reinstatement of the client's driver's license and reunification with children previously removed from the client's custody.

- Working agreements (Memoranda of Understanding) were established between the Safe Babies, Safe Moms programs and regional or local administrators. These agreements clarified roles and responsibilities of staff in different agencies and organizational units and made explicit the expectations for cross-system collaboration in day-to-day activities.

Improvement in the health status of infants born to clients enrolled in Safe Babies, Safe Moms was demonstrated by improved birth outcomes: for pregnant women who enrolled in the program before their baby was born, the rate of low birth weight (4.4%) was reduced by 72%, compared to the low birth weight rate for infants whose mothers enrolled after the baby was born (15.6%). The decrease in the low birth weight rate was more than twice the decrease (34%) seen for infants born to women who received prenatal treatment for chemical dependency. The mechanism for reduction in low birth weight was primarily through reduction in infants small for gestational age.

By increasing communication between service providers, developing cross-system collaboration, and implementing a comprehensive program consisting of Targeted Intensive Case Management, treatment for chemical dependency, and housing support services, the Safe Babies, Safe Moms program achieved the first steps in meeting its goal to help clients become more functional family units and to be financially independent, safe, healthy, and drug- and alcohol-free.

INTRODUCTION

Safe Babies, Safe Moms, a pilot program intended to serve substance abusing women and their young children, began enrolling clients in January 2000. This comprehensive program seeks to improve the health and welfare of substance abusing mothers and their young children by early identification of pregnant substance abusers, improved access to and coordination of health care services and chemical dependency treatment, and family-focused early intervention services for mothers and their young children. The design of program services was based on program goals outlined in the 1999 DSHS-DOH *Report to the Legislature, A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803).*

This project is a collaborative effort between the Washington Department of Social and Health Services (DSHS)—Division of Alcohol and Substance Abuse (DASA), Medical Assistance Administration (MAA), Research and Data Analysis (RDA), Children's Administration (CA), Economic Services Administration (ESA)—and the Department of Health (DOH).

A proviso in the 99/01 DSHS budget funded pilot projects to develop and implement comprehensive programs for alcohol and drug abusing women and their young children. Funds were used to increase availability of chemical dependency treatment, to implement new services called Targeted Intensive Case Management (TICM), and to enhance housing support services.

Substance abusing mothers who are pregnant or parenting children under age three are offered a comprehensive array of services. Service providers may include case managers, behavioral health specialists, social workers, chemical dependency treatment counselors, and child development specialists. Services are offered in three communities: Benton-Franklin, Snohomish, and Whatcom counties. The three pilot sites served 453 substance-abusing women from January 2000 through June 2003.

Safe Babies, Safe Moms Community Service Providers

Program Components	Pilot Program Sites		
	Benton-Franklin	**Snohomish**	**Whatcom**
Targeted Intensive Case Management (TICM)	Benton-Franklin Health District	Pacific Treatment Alternatives[1]	Brigid Collins Growing Together[1]
Residential Chemical Dependency Treatment	Casita del Rio[2]	Evergreen Manor	
Housing Support Services	Casita del Rio[2]	Catholic Community Services – Tree of Life	Catholic Community Services

This report describes how services evolved since the previous RDA report (March 2001), as the program matured and cross-system problems were identified and addressed. Client characteristics, service utilization, and mother- and child-based outcomes available to date are also included. While the availability of follow-up data for program clients is limited by the amount of time elapsed since enrollment, preliminary data are reported.

[1] From January 2000 through June 2001, the TICM provider was Providence Everett Medical Center.
[2] From January 2000 through April 2003, the residential CD treatment and housing support services provider was Rivercrest Villa.

Naomi A. (not her real name) entered the Safe Babies, Safe Moms program with the following needs: a healthy alcohol/drug-free support system, family planning method, employment, basic needs, maternity support services, driver's license, medical and dental care, transportation, and smoking cessation.

At enrollment, Naomi had an infant and was already in a residential chemical dependency (CD) treatment program. Her older children had been removed from her custody by Child Protective Services (CPS) and were living with relatives. Naomi lived in a rural neighborhood known for drug activity. She reported that she had used methamphetamine and marijuana regularly for years. Although she had been able to stop using during her previous pregnancies, her addiction had progressed to the point where she could not stop during her most recent pregnancy.

The case manager encouraged Naomi to complete inpatient and outpatient treatment. The case manager

- *made home visits to see the client after she was discharged from inpatient treatment*
- *encouraged her to seek support at 12-step meetings, select a 12-step sponsor, and develop refusal skills so that she could maintain sobriety in her home environment*
- *referred the client to medical and dental resources*
- *provided support and advocacy for the client in helping her work with CPS to have her children returned to her custody*
- *helped the client obtain her driver's license*
- *provided transportation and moral support for client to obtain her driver's license*
- *helped the client with financial support for daily expenses when her partner was unemployed and in treatment*
- *provided information about different family planning methods.*

Naomi has achieved nearly two years drug-free and sober. She has custody of her youngest child. One of her children previously placed with relatives has been returned to her custody. She attends 12-step meetings regularly and has a sponsor. She has demonstrated refusal skills and boundary setting with her partner, old friends, and relatives. She has adequate medical care and her youngest child is fully immunized, appears healthy, and is well bonded to the mother. Since she got her driver's license, she has been able to obtain a regular, full-time job, can pay her bills, has purchased a reliable vehicle, has medical insurance coverage for family and has transitioned off public assistance. Naomi is pleased with the family planning method that she obtained.

CLIENT NEEDS AND SERVICES PROVIDED

This report begins with the stories of the clients who received services, the needs identified by their case managers, and their successes and failures in achieving the goals of Safe Babies, Safe Moms—to support mothers and their children in becoming more functional family units, financially independent, safe, healthy, and drug-free.

Case managers were asked to record the needs of clients upon program entry, the services provided, and the client's status as of April – June 30, 2003. Case managers completed these records on 272 clients on their current caseloads. This section is based on analysis of these reports from case managers.

Safe Babies, Safe Moms clients faced a complex array of issues that impacted their ability to be drug-free and sober and to raise healthy children. Case managers identified client needs at program entry and provided individualized services for the highest priority needs. Table 1 shows the most frequently identified client needs and the proportion of women with each need, as recorded by the case manager.

Table 1. Client Needs Identified by Case Managers

1 Achieving and maintaining abstinence from drugs and alcohol (85%)

2 Stabilizing mental health problems and improving behavioral health issues (84%)

3 Developing a healthy alcohol/drug-free social support system (80%)

4 Meeting basic needs with discretionary funds (76%)

5 Facilitating positive parent-child relationships (75%)

6 Finding long-term, safe, and drug-free housing (66%)

7 Increasing self-sufficiency and capability for independent living (63%)

8 Reducing involvement with the criminal justice system (61%)

9 Attaining educational goals (55%)

10 Obtaining medical and dental care (55%)

11 Obtaining and using an effective family planning method (48%)

12 Improving job skills and work readiness (15%)

On average, case managers identified an average of 7.5 of these needs for each client. In some cases, few client needs were identified because clients were lost to follow-up soon after enrollment. In other cases, needs may have been met by providers other than the case manager. For example, some clients who were participating in chemical dependency (CD) treatment prior to enrollment in Safe Babies, Safe Moms may not have needed additional help from the case manager to achieve and maintain abstinence from drugs and alcohol. On the other hand, 89% of these women received CD treatment, in addition to case management services, and case managers identified the needs listed above as being unmet despite services offered by CD treatment programs and other community resources.

1 **Achieving and maintaining abstinence from drugs and alcohol** was the most frequently reported need for women enrolled in Safe Babies, Safe Moms. Case managers reported that 85% of their clients needed their help with this issue. Involvement with drugs and alcohol had led to a wide range of problems for these clients, including CPS intervention, unintended pregnancy when the client forgot her oral contraceptives, arrests, convictions, fines, jail time, ineligibility for services such as WorkFirst due to felony drug charges, and alienation from family members with whom clients might have had close healthy relationships.

Case managers supported and encouraged clients to stop using drugs and alcohol; connected them to inpatient and outpatient treatment programs and housing support services; transported clients to assessment and treatment for chemical dependency; connected their clients to drug testing and drug courts as appropriate; helped mothers secure child care; contacted women by phone or mail while in treatment and sent gifts upon graduation. Case managers helped clients maintain compliance with treatment, and advocated on their behalf. Case managers worked closely with outreach workers, Chemical Dependency Professionals, and Housing Coordinators to be sure the client was connected with appropriate treatment-related services.

Chemical dependency services available to program participants included detoxification, assessment, outpatient treatment, intensive outpatient treatment, long-term residential (inpatient) treatment, recovery services, and housing support services, in addition to community-based support groups.

Case 1: *Antonia C. (not her real name) had a long history of alcohol, heroin, and cocaine abuse. She had lost custody of her children and had lost many positive relationships because of her drug use. In addition, she was involved with the criminal justice system. As a Safe Babies, Safe Moms participant, she was assessed for chemical dependency and placed in residential treatment. A team staffing was held to coordinate services and help the client comply with court orders and CPS provisions. The case manager wrote letters, attended court, and advocated on the client's behalf with CPS, her attorney and in court. The case manager also made arrangements for the client to receive appropriate medical and dental care.*

Today Antonia is drug-free and sober and is a successful parent. She attends support groups in her community. Her CPS case is closed and she continues with medical care.

Case 2: *The case manager arranged for a CD assessment for Kristin C. (not her real name) at program entry since the client was pregnant and using methamphetamine regularly. The case manager arranged for admission to a residential CD treatment program after the client had previously abandoned treatment at a different facility. The case manager used motivational interviewing skills to encourage Kristin to participate in treatment. The case manager advocated for the client to attend an intensive outpatient program until she could access the inpatient bed. After she completed inpatient treatment, the case manager advocated for Kristin to progress to an intensive outpatient transitional treatment program. The case manager continued to encourage the client to attend 12-step meetings, seek a 12-step sponsor and work through the steps.*

Kristin successfully completed both inpatient and outpatient treatment programs. She has now achieved more than two years drug-free, and nearly one year of sobriety.

2 Stabilizing mental health problems and improving behavioral health issues were cited as client needs nearly as frequently as achieving and maintaining abstinence. Case managers identified mental health problems or behavioral health issues for 84% of their clients. These issues often interfered with the client's ability to live a drug-free, sober and self-sufficient life.

The following conditions were those recorded most frequently: depression; anxiety or anxiety disorder; loss, grief, other family issues; history of physical, emotional, or sexual abuse; suicidal ideation; difficulty with memory or concentration; and post-traumatic stress disorder.

The most frequently identified behavioral health issues included the following: relationship and conflict resolution; self-esteem; parenting skills; anger management; social outlets; and the need to establish healthy drug-free relationships

Case managers advocated for mental health services as indicated and encouraged clients to use these services and to follow through with recommended treatment, including taking medications as prescribed. Case managers provided or referred clients for a wide range of mental health and behavioral health services, including assessment, individual counseling, group counseling, support groups, Dialectical Behavior Therapy, grief and loss and family counseling, and medication evaluation and treatment. Over time, the sites adapted their individual and group counseling and developed classes to address the presenting behavioral health needs. In addition to formal classes and groups, staff hosted parties, and offered picnics and lunches to help meet the clients' needs for positive social interactions. One case manager described her role in the following way:

> I feel that my role has been as a part of a team (including her counselor and probation officer) trying to help this young woman just survive. So far we have succeeded.

Case 3: *Heidi C. (not her real name) entered the Safe Babies, Safe Moms program needing individual counseling, medication evaluation and management. While Heidi attended inpatient treatment, the case manager advocated for individual counseling. After completing inpatient treatment, Heidi was referred to the behavioral health specialist to work on relationships and issues related to events in her past. She was assessed as having multiple mental health conditions and was referred to a local psychiatrist for medication evaluation and follow up. The case manager provided assistance with transportation and discussed observations about client's behaviors and her condition with Heidi's therapist. Heidi was able to work through some issues related to her childhood history of abuse and neglect, and her mood improved after starting medication.*

Case 4: *Paula G. (not her real name) entered the program with needs for new life skills, awareness and control of her emotions, conflict resolution, solution-focused living, stress regulation, communication skills, and parenting classes. She also needed support, advocacy, help applying for services, legal assistance, individual counseling and group identification.*

Paula was referred to behavioral health groups at the TICM agency. She participated in a parenting group for more than a year. Her child was brought to these classes so she could learn to interact with her child. Paula was active in group sessions, met with the Behavioral Health specialist and her case manager regularly. The agency was a safe haven for her.

Paula is drug-free and sober and has a strong support network with her sponsor and Narcotics Anonymous (NA). She has made great progress on her mental health issues, processes her guilt and shame, and is learning new skills. One key skill she developed is the ability to ask for help. It has been no small feat for this client, and that her child is in process of transitioning back to the home evidences her success.

3 Developing a healthy alcohol/drug-free social support system was the third most frequently identified need for women in the Safe Babies, Safe Moms program. Case managers reported that 80% of their clients needed to develop new relationships and hobbies or other recreational activities that did not involve drugs or alcohol. Many women were surrounded by friends who abused alcohol or other drugs; some were isolated and had no friends; others were involved in physically or emotionally abusive relationships. Some women needed an outlet for their creativity. They needed to learn how to participate in drug-free, positive activities with other people.

Classes and groups offered by the TICM agencies gave clients an opportunity to explore healthy ways to interact with other people. Case managers encouraged women to participate in Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings or to get involved in local sports or religious events. Groups that explored emotions and relationships were too threatening for some clients with social anxiety; for one such client, the case manager suggested she begin with a Dining group, where clients shared in meal preparation, setting the table, and sharing a meal.

Case 5: *Kim G. (not her real name) was in need of a drug-free and sober support network. Her parents were both alcohol abusers, and her mother also used drugs. Her partners and friends were substance abusers. The case manager encouraged Kim to attend 12-step groups, select a 12-step sponsor and to attend behavioral health groups. The case manager supported and encouraged her decision to join a Narcotics Anonymous sports team. The case manager encouraged Kim to separate from her partner after he beat her. Later the case manager encouraged her to set clear boundaries with her child's father who had been sentenced to prison for felony drug offenses. Kim maintained sobriety for nearly a year, attending meetings and choosing a sponsor. However, eventually the client began to associate with old friends and slipped into unhealthy relationships again.*

Case 6: *Rosalinda M. (not her real name) has a long history of substance abuse and had developed her life around the drug culture. She was incarcerated for a drug felony. She learned how to be tough; her language and attitude were those of a street savvy addict. She needed to learn new behavioral and social skills: how to talk, develop constructive (healthy) relationships, appropriate language and behavior. She needed faith—faith that someone cared for her and would be her advocate. She needed a role model so she might understand what a healthy social support network looks like. She needed interactive parenting skills.*

Rosalinda received postpartum care, long term chemical dependency treatment, on-going case management, behavioral health groups, individual counseling, social support, i.e., AA/NA groups, a sponsor, and interaction with other sober parenting women. She received services from a variety of social services agencies, including services for battered women, legal services, services for women with young children, and housing assistance, until she became self sufficient.

Rosalinda has had great success. She has developed a strong, sober support network. She attends AA/NA regularly and has established a close relationship with a sponsor. She successfully completed a CD treatment program, and as a result developed a number of supportive friends. She has been working for more than a year and her last employee performance review was glowing. She has been proactive in offering her services to help other women. She has been drug-free for over two years and has maintained employment for more than one year.

4 Three-fourths of clients (76%) received **discretionary funds to meet basic needs**. Many client needs for goods and services were difficult or impossible to meet through established systems. Small monetary funds were available to purchase critical items for clients, to supplement other funding sources. Discretionary funds were used most frequently to purchase items such as clothing, basic needs, rent/ security deposit, utilities, car seats, baby items, food, diapers, and bedding.

Case managers reported that as a result of these expenditures one woman continued with counseling, TICM classes, recovery program, and appears to be drug free. Incentives and rewards have shown others that the case managers are proud of their accomplishments. The ability to help another woman in time of need reduced her stress and helped her stay focused on her goals. Another client improved her skills in budgeting by distinguishing between necessities and luxuries. The client now only approaches the case manager for assistance after first exhausting all other possible resources already available within the community. Another case manager noted that the ability to use discretionary funds allowed her to make life a little easier in bad situations.

Case 7: *The case manager used discretionary funds to provide maternity clothing, and basic baby items (bottles, shampoo, clothing) for Lesa G. (not her real name) while she participated in inpatient treatment. Other basic necessities for a baby, such as a stroller, were purchased when the client moved to a shelter. Bus passes permitted the client to seek employment. Once Lesa obtained full-time employment, the case manager provided bus passes to assist her in getting to work. When Lesa moved from the shelter, the case manager provided basic furniture for the mother and her child. The case manager provided nicotine replacement supplies for smoking cessation and a grocery card when Lesa was short on funds and needed formula and diapers. Finally, the case manager provided shopping cards to assist with buying baby clothing and baby proofing items for her home.*

As a result of these expenditures, Lesa was able to provide for basic needs of her child, she was able to use public transportation to look for employment, and she obtained a full time job. She paid all her bills and transitioned off TANF, but still needed some financial support from time to time with basic items (groceries, baby supplies). Lesa was able to provide basic necessities for her child when she obtained her own home. She attempted to adopt a healthier non-smoking lifestyle, but has since resumed smoking. Lesa was able to improve the safety of her home once her child became a toddler.

5 Facilitating positive parent-child relationships was identified as a need for 75% of Safe Babies, Safe Moms clients. More than half of the clients were involved with CPS and 13% had an open CPS case. Some clients have been accused of being neglectful and were thought to be unable to care for their children due to drug/alcohol use, lack of parenting skills, lack of stable housing, or family violence. Consequences have included monitoring by CPS, restricted visits between mothers and their children, placement of children in foster care or relative care, and termination of parental rights.

Case managers worked closely with Child Protective Services (CPS), Child Welfare Services (CWS), and Indian Child Welfare (ICW) workers, Guardians ad Litem, attorneys, the Courts and/or Foster Parents in order to ensure that the client stayed in compliance with the court-ordered requirements to help facilitate the eventual return of the child(ren) to the parent's care when appropriate. Case managers provided advocacy and support for their clients by:

- attending court hearings
- attending necessary staffings with CPS and client's attorney
- communicating with CPS about client progress
- advocating for the client's child to be reunited with client while the client was in treatment
- arranging regular visitation with the children and observing parenting
- providing transportation to supervised visits with child
- providing supervision for visits between client and child
- connecting clients with parenting classes and with court ordered services
- working with community agencies and CPS in order to get more services placed in the home
- assisting with the transition of the children to the home
- seeking dependable housing
- connecting clients with behavioral specialists
- arranging intensive family services
- working as a team with the CPS worker and the client, helping the client to see the CPS worker in a more positive light, not as "the enemy"
- supporting a mother in her decision to do an open adoption, reassuring her that she was not a "bad mother"

Many mothers were re-united with children not in their custody, especially older children. Case managers reported that these were almost always really good for the children. Only once was the case manager not pleased that a woman was parenting.

Case 8. *When Paulette M. (not her real name) entered the Safe Babies, Safe Moms program, her child had been in and out of foster care. Paulette struggled with completing her CD treatment. She completed an inpatient treatment program and progressed to out patient treatment. She relapsed and entered another inpatient treatment program. Finally, with advocacy, encouragement, and contact with CPS, she enrolled in a program that she was able to complete. She needed consistency, long-term sobriety, life skill changes, parenting education, safe and secure housing, sustainable employment, a dependable vehicle, insurance, and a child safety seat.*

Paulette has demonstrated change, self-sufficiency, commitment and consistency and her child is in the process of returning home. In addition, she has safe, reliable transportation for herself and her child.

6 Finding long-term, safe, and drug-free housing was identified as a need for nearly two-thirds (66.2%) of Safe Babies, Safe Moms clients. For some clients, retaining custody of their child was tied to securing safe and stable housing.

Some women were homeless or living in shelters at the time of enrollment (15.1%); other clients needed alcohol- and drug-free surroundings after graduation from inpatient treatment (16.9%). Others were in unsafe or unhealthy situations (5.1%), for example, at risk of domestic violence, or living in a drug-related house or community. These women faced major challenges in securing safe and stable housing, primarily because of their history of drug use and criminal behavior, and an inability to pay the bills.

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

Case 9: *Angela F. (not her real name) was essentially homeless, residing with relatives who were beginning to be very resentful about her and her children being in their home. The case manager referred Angela to transitional housing, helped her deal with housing authorities within the local community, and wrote a letter of support on her behalf. In transitional housing, Angela was able to gather items such as furniture and provide a comfortable home for her children. She is now living in an apartment. Due to her drug felony, she was rejected by all of the housing authorities. Therefore, although she has her own place, she is living in very inadequate circumstances: the client, her boyfriend, and five children are living in a small apartment because that is all they can afford.*

Case 10: *At intake, Veronica D. (not her real name) was living in an area known for drug activity and use. Soon after intake, the client's abusive ex-partner assaulted her. The case manager provided advocacy to help Veronica access outpatient treatment and transitional housing. The case manager advocated with the management of the client's apartment complex to allow her to move without cost due to her domestic violence situation. Veronica has gained the necessary support to stay clean and sober, has avoided contact with her ex-partner, and is in a safer environment.*

Case 11: *Pamela H. (not her real name) needed clean and sober housing after completing inpatient treatment. The case manager discussed potential housing options with Pamela, and referred her to local transitional housing agencies and local shelters. The case manager obtained applications with local housing providers, helped the client fill out applications and placed the client's name on waitlists. The case manager advocated with the local transitional housing program to admit Pamela and assisted her with documentation needed for the application. As a result, Pamela was accepted into a transitional housing program where she is currently doing well.*

7 Increasing self-sufficiency and capability for independent living was identified as a need for more than sixty percent (62.9%) of Safe Babies, Safe Moms clients. More than twenty percent (21.3%) of the clients needed help with basic life skills, such as cooking, cleaning, laundry, shopping, transportation, organizing and setting priorities, budgeting and paying bills, and, most importantly, taking care of themselves and their children. Nearly ten percent (9.9%) needed to obtain a driver's license.

Case managers identified the following barriers to self-sufficiency: transportation, drug felonies, childcare, lack of education, developmental disabilities and lack of self-confidence.

Case managers connected clients with appropriate referrals for community education and support. They provided advice and encouragement. They assisted clients in obtaining a driver's license or a bus pass and learning to ride the bus. Their agencies offered classes on cooking, budgeting and parenting. When appropriate, case managers assisted clients with enrollment in TANF and food stamps. They helped clients obtain treatment for chemical dependency, mental health, and behavioral health services to assist the client in being able to function socially and reliably.

Case managers reported that, upon exit from the program, 18.4% of the women were able to reduce or eliminate their dependence on public assistance, while 6.6% obtained the public assistance they needed to adequately care for themselves and their children. Overall 25% of clients were employed at exit, including 7.4% with full-time employment.

Case 12: *Shannon McD. (not her real name) entered the program with needs for income, job skills and sustainable employment. Initially the case manager helped her apply for TANF benefits. The case manager encouraged Shannon so she would have the confidence to continue her education and a work-study opportunity. She began to receive TANF and food stamps. Later, Shannon became employed and increased her earned income, allowing for a reduction in TANF benefits and more income for herself and her family. Shannon reported improved feelings of self esteem after she started receiving income. She reported she was able to purchase gifts for her children, and did not have to rely on charity.*

Case 13: *Shania P. (not her real name) struggled with budgeting, money management, transportation, and cooking. The case manager worked with her to develop budgets. Shania has tried to manage her finances, but still struggles due to a lack of organizational skills. The case manager helped her write advocacy letters to reduce fines on unpaid traffic tickets with the goal of having her driver's license reissued. Shania learned to communicate successfully to resolve traffic tickets and unpaid fines to the point that she was able to get her driver's license. She learned about health and nutrition by attending a class offered by the TICM agency and was inspired to try new recipes and cook healthier food for her family.*

Case 14: *Jane R. (not her real name) needed to learn basic skills like budgeting, accessing community resources, using Medicaid transportation and public transportation, cooking and self-care and child care. The case manager helped Jane prepare budgets, and explained the economics of budgeting and managing money. The case manager helped her learn to plan a grocery list and shop. The case manager taught Jane to ride public transportation. The case manager taught her how to use Medicaid transportation, how to cook using simple recipes, and discussed self-care and childcare with the client. As a result, Jane is much more independent, has less stress about managing on her own, has used Medicaid and public transportation, uses community resources like the food bank, uses good parenting skills and practices self-care skills.*

8 Reducing involvement with the criminal justice system was identified as a need for more than sixty percent (60.7%) of Safe Babies, Safe Moms clients. Criminal histories for clients enrolled in Safe Babies, Safe Moms included the following issues:

- Unpaid fines
- Shoplifting / Theft
- Drug possession / trafficking
- Failure to appear
- Driving under the influence
- Major driving violation
- Assault
- Outstanding warrants
- Prostitution

Four percent of clients were in jail at program entry or entered the Safe Babies, Safe Moms program upon release from jail. Ten percent of clients were on probation, parole, or court supervision at the time of program entry.

Case managers provided support and encouragement to help clients understand and resolve the consequences of their behavior. They encouraged clients to keep appointments with their probation officers, and follow all recommendations of the court. They accompanied clients to court, advocated for clients through letters to the court, and visited clients while in jail.

Case 15: *At intake, Shayla T. (not her real name) had several legal charges, including assault, failure to appear, and contempt of court. She reported that she had been incarcerated five times. The case manager provided support and encouragement toward completing legal requirements. At exit, Shayla had been incarcerated only briefly, and she was no longer on probation or awaiting any charges.*

Case 16: *At intake, Debra S. (not her real name) had jail time, fines to pay, and community service hours to perform. She also had a charge on her record that she maintained was not accurate. The case manager credits mental health counseling with helping Debra get through her struggles with resolve and good humor. Debra received some legal assistance and is pursuing a course to try to get her offense history changed. After becoming drug free, she set about getting fines paid, jail time and community service hours completed, and has not incurred any new fines or legal obligations.*

Case 17: *Carly W. (not her real name) entered the Safe Babies, Safe Moms program with extensive involvement with the criminal justice system: drugs, shoplifting, assault, and failure to appear. Her house had been raided for illegal activity. The case manager worked to have Carly granted alternative sentencing and to build wrap-around services for her. Carly learned a great deal from that program and has taken responsibility and changed her life. She has had no further involvement with the criminal justice system. She successfully completed alternative sentencing requirements and has made necessary changes to her life.*

Case 18: *Cassidy W. (not her real name) had convictions for drugs, theft, and a major traffic offense. She had been incarcerated several times, with the longest incarceration lasting a few months. The case manager provided Cassidy with appropriate chemical dependency referrals, since her crimes all took place when she was heavily impaired by drugs. The case manager also helped her remain in compliance with probation requirements. Cassidy is engaged and doing well in her recovery and is consistent in following through on her obligations.*

9 Attaining educational goals was identified as a need for more than half of the clients (55.1%). Lack of a General Educational Development (GED) was an issue for 42.3% of clients, and an additional 12.9% needed education beyond a GED. A few women had specific educational goals such as learning skills to care for a special needs child, or training for a medical service career .

Fear of failure, limited concentration skills, and limited reading skills were identified as barriers to educational advancement. However, the most frequently mentioned barrier was competing priorities, i.e., other, more pressing issues in the woman's life, such as completing chemical dependency treatment, or stabilizing her home life, or gaining employment.

To assist women in furthering their education, case managers provided information, transportation, and assistance with applications or financial aid for community GED programs. Financial assistance was provided for GED fees or licenses such as a cosmetology license or a city business license. Some clients were referred to job training or internship programs through the TRAC (Training, Rehabilitation, Assessment, and Consultation) Associates program.

Case managers reported that 4.4% of women received their GED, 11.8% completed some classes, and 5.1% completed job training. Nearly five percent (4.8%) interrupted their educational plans to address more pressing needs in their lives.

Case 19. *Bianca S. (not her real name) entered the program with less than a high school education. The case manager encouraged her to get her diploma or GED. When Bianca learned that she could attend a program to get her diploma, she began the program and completed the majority of the required tests. Bianca ceased her educational advancement when issues related to her child in foster care became a priority.*

Case 20. *Nancy S. (not her real name) needed to work on completing her GED in order to be more employable in the future. The case manager supported Nancy while she completed her GED and attended her graduation ceremony. Nancy is planning on taking college level courses in the future.*

Case 21. *Carla R. (not her real name) needed high school completion, vocational training and/or college education. She was referred to a GED completion program, and was guided through the college registration and enrollment process. Her case manager found her an on-the-job training program. As a result, Carla earned her GED, and then enrolled in a paralegal program. She attended less than one year before transportation and childcare became a problem. She plans to return to school once her youngest child is in school. Carla is currently working part time.*

10 Obtaining medical and dental care was identified as a need for more than half (54.8%) the Safe Babies, Safe Moms clients. Common issues included the need for prenatal, delivery or postpartum care (21.3%) and for dental care for the mother or her children (13.2%). Case managers reported a wide range of additional acute and chronic medical problems.

Case managers assisted with referring clients to suitable medical and dental providers who accepted medical coupons and were taking new patients, making sure that transportation to and from each of the appointments had been arranged. They reminded clients to follow through with appointments and treatment. They obtained assessments for children and facilitated enrollment in therapeutic childcare.

Case 22: *Veronica W. (not her real name) needed medical testing to rule out permanent damage from domestic violence injuries. She needed dental repair for teeth knocked out during domestic violence. The case manager had to remind the client many times before she finally got the tests done. Veronica took care of getting to the dentist on her own. Her appearance was improved by dental work, contributing to a positive reinforcement of her value as a person.*

Case 23: *Patsy Q. (not her real name) had a history of medical problems during pregnancy, was not going for regular prenatal visits, and was eventually homeless. When the case manager became aware that the client was homeless, she tried to find Patsy. She finally found the client at a hospital, apparently for treatment of injuries. The case manager made appointments and took the client to see an obstetrician. The client delivered her baby prematurely, but the infant's six-month Denver, adjusted for premature birth, was normal.*

Case 24: *Rosalee S. (not her real name) needed both medical and dental services. Her child appeared to have developmental delays. The case manager referred Rosalee to dental clinics accepting medical coupons. She received dental care; eventually she had oral surgery and obtained dentures. The case manager arranged for the client to work with a child development specialist (CDS). The CDS worked with her child on developmental delays and helped the client access a special program through the local school district. The case manager referred the client for maternity support services to receive medical care and post-birth visits.*

Rosalee was able to resolve her dental issues, thereby improving her general health. She had prenatal care and follow up with a nurse to have additional support after the birth of a subsequent child. The older child received early intervention to address developmental delays.

11 Obtaining and using an effective family planning method was identified as a need for 47.8% of Safe Babies, Safe Moms clients. Case managers reported that many of the women who enrolled in the Safe Babies, Safe Moms program needed better knowledge of or access to family planning methods. Some had previously been unsuccessful in using various forms of birth control. They needed information, access to services, and motivation to take charge of their family planning needs.

Case managers discussed birth control with clients. They focused on:

- the importance of avoiding unintended pregnancies;
- disease prevention;
- the necessity of using birth control methods properly and consistently;
- overcoming psychological or motivational barriers to effective use of family planning methods; and
- finding the best birth control method for each woman's health, lifestyle and beliefs.

Case managers encouraged and assisted clients in learning about and accessing birth control methods through agencies such as Planned Parenthood, and provided transportation when needed. Case managers helped the clients receive the monetary support available for such services.

Case managers reported that 24.6% of clients had or were considering sterilization procedures.

Case managers report that clients began using the following birth control methods:

- depo-provera
- birth control pills
- abstinence
- condoms
- contraceptive patch
- intra-uterine device (IUD)
- mini-pill

Case 25. *Halee S. (not her real name) entered the program having lost custody of all her children. The case manager encouraged Halee to have a sterilization procedure. She followed through and had the procedure.*

Case 26: *Taralynne A. (not her real name) had never used any family planning method, resulting in several unintended pregnancies. The case manager educated her about different methods and disease prevention. At exit, the client reported that she planned to get an IUD and had used another birth control method regularly since program entry.*

12 Improving job skills and work readiness was identified as a need for 15% of women enrolled in Safe Babies, Safe Moms. Case managers reported that many of the women (13.6%) who enrolled in the Safe Babies, Safe Moms program possessed few work skills, and had little employment experience. Some were able to find employment on occasion, but were unable to retain their jobs. Some women were unemployed because they were in the later stages of pregnancy or had just given birth. Some women were unemployed because other issues, such as recovery from chemical dependency, were taking precedence in their lives. Other women chose not to work so they could care for their young children in their home.

Case managers supported clients by discussing their employment goals, and by referring them to agencies such as WorkFirst, the Division of Vocational Rehabilitation, Goodwill Industries, or community trades and careers programs as appropriate. Case managers noted that all services that help the client become clean and sober ultimately help her become more responsible, reliable and employable.

Case 27: *Janet R. (not her real name) had no job skills, and her case manager referred her to WorkFirst for job training and resume writing. As a result, Janet graduated from a service training program. Although she has training and has made multiple applications in her field, she has not been hired because of her legal record. Out of desperation she took a job where she felt neither she nor her sobriety was safe. She has recently re-enrolled in another training program with WorkFirst.*

Case 28: *Dana P. (not her real name) was required to participate in the WorkFirst return-to-work program. She had little past work experience in other than low wage jobs. Case managers supported Dana during her transition from treatment to work-related activities by assisting her with childcare-related issues and time management skills, and by simply providing moral support during this period of adjustment when many women (young, single mothers) in recovery often are somewhat reluctant to go to work and can become quite overwhelmed by the daunting prospect of balancing work and home life. Dana was enrolled in a WorkFirst-approved job readiness program to gain valuable work experience. However, she was forced to drop out due to some health issues and a high overall level of stress and anxiety about program requirements. She hopes to return to a work preparation program once her current issues are resolved.*

PROGRAM DESCRIPTION

This section describes program development and implementation as of March 2003. The features have been generalized across the three sites. Individual site descriptions follow the general program description. While program development began with the conceptual model described below, services evolved as the programs matured and cross-system problems were identified and addressed.

BACKGROUND

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

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

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

Targeted Intensive Case Management contracts were awarded to the Benton-Franklin Health District in the Benton-Franklin Counties, and to Providence Everett Medical Center in Snohomish and Whatcom Counties. The TICM contracts were re-bid in 2001 in Snohomish and Whatcom Counties. Pacific Treatment Alternatives was awarded the TICM contract in Snohomish County; Brigid Collins Growing Together was awarded the TICM contract in Whatcom County. Residential CD treatment contracts were awarded to Rivercrest Villa in Benton-Franklin and Evergreen Manor in Snohomish County. Housing Support Services contracts were awarded to Rivercrest Villa in Benton-Franklin and Catholic Community Services in Snohomish County.

PROGRAM ADMINISTRATION

Safe Babies, Safe Moms is a partnership between state- and community-level agencies and organizations and requires effort at each level to successfully implement and administer this program. Members of the State Implementation Team include representatives from each of the collaborating agencies: DASA, MAA, RDA, CA, ESA and DOH. The Community Implementation Teams may include representatives from the local chemical dependency treatment provider(s), TICM contractor, housing support services coordinator, drug and alcohol county coordinator, Division of Children and Family Services (DCFS), Community Services Office (CSO) outreach workers, First Steps workers and Women, Infants and Children (WIC) workers. Any other community agencies interested in the program or serving the same population are invited to attend as well.

CONCEPTUAL MODEL

The Safe Babies, Safe Moms State Implementation team developed a Client Flow Diagram that represents the conceptual model of the comprehensive program (*Comprehensive Program Evaluation Project: Program Development and Implementation*, March 2001, pages 6 and 7). The purpose of providing comprehensive services is to help support clients to become more functional family units: to be financially independent, safe, healthy, and drug-free. The goal of this pilot project is to evaluate the impact of comprehensive services on the lives of substance-abusing women and their young children.

Safe Babies, Safe Moms Client Flow Diagram (prepared August 2000) identified several key program components:

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

Clients may be referred to the program by medical practitioners; professionals working in the legal system, including jail staff, probation officers, and drug court personnel; and DSHS staff, such as Child Protective Services (CPS) workers, First Steps providers and CSO staff (including Temporary Assistance to Needy Families [TANF] case managers). Chemical dependency treatment staff who believe that their clients meet eligibility requirements and would benefit from participation in a comprehensive program may also refer.

Once the client has been referred to and deemed eligible for Safe Babies, Safe Moms, TICM staff are responsible for active outreach to engage the client into program services. Active outreach may include repeated contact by mail or phone, and home visits as appropriate. When the client agrees to accept program services, case managers: 1) conduct an intake interview including assessing the severity of a client's addiction; 2) develop and facilitate a service plan; and 3) coordinate core provider services.

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

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

Behavioral health services are a core service for clients in this program. Behavioral health specialists conduct a needs assessment to determine whether or not each client has behavioral or other mental health issues. Depending upon the client's need, the behavioral health specialist may provide services or the client may be referred to community mental health services. The Behavioral Health Specialist may offer classes or groups and individual and family therapy to clients as appropriate.

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

Parenting education services are provided to teach clients how to care for themselves, manage stress and anger, use communication skills, develop realistic expectations of their children, use positive discipline and deal with challenging behaviors.

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

ELIGIBILITY AND ENROLLMENT

Women were determined to be eligible for the Safe Babies, Safe Moms pilot project if they met the following criteria:

- family income level at or below 200 percent of the federal poverty level (FPL);
- current substance use or recent history of substance abuse;
- current pregnancy or mother of a child less than three years old (If the woman's child/children have been removed from her custody, the plan must be to return the child/children to the mother's care.);
- eighteen years of age or older (Seventeen-year-old women may enter the program by exception if they meet other eligibility criteria and are pre-approved by the TICM provider, Safe Babies, Safe Moms partners, and the MAA TICM program manager.);
- current or past involvement with multiple intervention systems; and
- agreement to participate fully in all recommended components of the program.

After enrollment, clients remain eligible for program services until their youngest child's third birthday. If a client is enrolled in the program and her pregnancy is terminated, or if she loses permanent custody of her youngest child, the client may remain in the program for three years from the initial enrollment date.

The TICM providers in Snohomish County and Benton-Franklin County were required to serve a minimum of 90 active women per year.[3] The TICM contractor in Whatcom County was required to serve a minimum of 54 active women per year.

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[3] A client was considered active if either of the following conditions was met:

1. Any of the following services were delivered within the month: Chemical dependency treatment, Recovery Program, behavioral health, child development, parenting education, housing, family planning, or;
2. At least 1 hour of TICM case management time was recorded and at least three of the following services were delivered: transportation, work, child care, child protective services, WIC, basic needs, dental care, domestic violence, medical care, mental health care, vision care, probation office, education, vocational training, legal services, smoking cessation, or maternity support services.

REFERRALS AND OUTREACH

TICM agencies reported referral sources for the 442 Safe Babies, Safe Moms clients participating in research (table below):

- Chemical dependency (CD) treatment providers referred more women (30%) to TICM than any other source. Child Protective Services (CPS) ranked second, having referred 20% of the women to this program, with physicians referring an additional 14%.

Table 2. Referral Sources for Safe Babies, Safe Moms Women

Referral Source (N = 442)	Number	Percent of Total
CD treatment staff	131	30%
CPS	88	20%
Physician	62	14%
CSO staff	40	9%
Counselor	28	6%
Law enforcement, other legal	21	5%
Self	20	5%
Family, friend	18	4%
Other	31	7%
Missing	3	1%

Data Source: Safe Babies, Safe Moms Client Intake Form

Targeted intensive case management incorporates active outreach to engage the woman in services and advocacy to be sure that needed services are accessed and used. TICM contractors made presentations to community agencies concerned with issues such as:

- CD treatment
- Maternal and child health
- Family planning
- Behavioral Health
- Child protection, foster care, adoption
- Family advocacy
- WorkFirst
- Domestic violence
- Housing
- Food insecurity
- Homelessness
- Criminal justice

PROGRAM COMPONENTS

Services funded through the Safe Babies, Safe Moms program include Targeted Intensive Case Management (TICM), chemical dependency treatment, and housing support services.

- A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each Safe Babies, Safe Moms site. TICM provides referral, support, and advocacy for substance abuse treatment, and continuing care. TICM assists women in accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal services. Behavioral health screening, assessment, counseling, and referrals are also provided.

  The multidisciplinary TICM team consists of the following professional staff: Targeted Intensive Case Manager(s); Early Child Development/Parenting Specialist; Behavioral Health Specialist; and Supervisor.

- Safe Babies, Safe Moms long-term residential treatment provides a positive recovery environment with structured clinical services. Qualified addiction treatment personnel staff the treatment centers and provide a planned regimen of patient care in a 24-hour live-in setting. Ongoing assessment identifies current status and needs in financial, environmental, psychosocial, developmental, educational, behavioral, and emotional domains.

  While mothers are in residential treatment, therapeutic childcare is provided for their children. Additional services may focus on domestic violence, childhood sexual abuse, linkages to medical care and legal advocacy, mental health issues, family planning, employment skills and education, and provision of safe, affordable drug-free housing.

  Safe Babies, Safe Moms clients may also participate in outpatient treatment programs including Intensive Outpatient Treatment (a concentrated program of individual and group counseling, education, and other activities) and/or Outpatient Treatment (individual and group treatment services of varying duration and intensity appropriate for the individual client's needs).

  Once primary treatment (either residential or intensive outpatient) is completed, clients continue to maintain their sobriety through relapse prevention activities such as outpatient CD treatment, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other recovery support meetings.

- Safe Babies, Safe Moms provides housing support services for women and children who stay up to 18 months in a transitional house. Recovery support and linkages to community-based services are provided. Women are eligible for housing support services if they are pregnant, postpartum, or parenting at the time they enter transitional housing; currently in treatment for chemical dependency or have completed treatment within the last 12 months; at or below 200% of the federal poverty level (FPL); and not actively using alcohol or other drugs (DASA, 2003).

PROGRAM PARTICIPATION

From January 2000 through June 2003, 453 women were enrolled in Safe Babies, Safe Moms. Of the 442 women who agreed to participate in the research, 196 women were actively enrolled; 125 women were enrolled, but had not received the quantity of services required to be considered active (active status is determined by the case manager); 81 women had graduated from the program; 40 women had been enrolled by the Providence Everett Medical Center TICM providers (Snohomish and Whatcom Counties), had not officially graduated from the program, but had not re-enrolled with the new providers when the new TICM contracts went into effect.

Service Use

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

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

- Chemical Dependency (CD) treatment, provided to 89% of clients, was the most commonly received service. CD treatment reported here may include assessments and outpatient treatment as well as inpatient or residential treatment. Clients may also attend AA or NA meetings (not reported here).

Table 3. Service Use

Type of Service	Women Receiving the Service	
	Number	Percent of Total
CD treatment*	393	89%
Basic needs	383	87%
Transportation	382	86%
Medical care	381	86%
Parenting education*	369	83%
Family planning	362	82%
WIC	354	80%
Child development*	346	78%
Behavioral health*	339	77%
CPS	330	75%
Recovery*	317	72%
Housing*	316	71%
Childcare	312	71%
Legal services	308	70%
Mental health care	259	59%
Work	246	56%
Probation services	158	36%
Dental care	141	32%
Education	139	31%
Domestic violence services	121	27%
Vocational training	77	17%
Smoking Cessation Groups	77	17%
Vision care	58	13%
Total Number of Women	**442**	

*Safe Babies, Safe Moms funds all or part of these services.

Data Source: Safe Babies, Safe Moms TICM Monthly Services Report Form

- Over 75% of clients received each of the following services: behavioral health services (counseling towards behavioral change), services relating to child development, parenting education, transportation services, family planning, WIC, help with basic needs and/or medical care.

- Three-fourths of the women (75%) received services from CPS.

- Over one-half (from 56% to 72%) of clients received each of the following: services related to recovery, housing, work, childcare, mental health and legal services.

- Over one-quarter (from 27% to 36%) of clients received each of the following services: dental care, domestic violence services, probation services and services related to education.

Case Management, Residential Treatment, and Housing Support Services

Case management services are recorded using the TICM Monthly Services Report form, which includes total case management time per client and type of services received by each client.

- On average, case managers spent 7 hours per month per active client. Most clients received less than 10 hours per month in case management services. Thirty-nine percent of clients received between 6 and 10 hours of case management time per month. Case managers averaged 7 hours per month per active client. The time spent with each client varies and is determined by individual needs.

Residential treatment information is reported monthly by the CD provider and includes admission and exit dates as well as client status during treatment.

- Two hundred fourteen Safe Babies, Safe Moms clients entered residential CD treatment with an average stay of more than three months (108 days) per treatment episode. Some clients entered or exited the Residential Treatment program more than once, resulting in 264 residential treatment episodes for 214 clients (slightly less than half of all Safe Babies, Safe Moms clients).

Transitional housing data are reported monthly and include admission and exit dates and client status during residence.

- Eighty-five Safe Babies, Safe Moms clients have entered transitional units since this program began. Approximately one-third (34%) occupied their respective units for 120 days or less; slightly more than one-third (39%) occupied their units for 121 days or longer; less than one-third (27%) were still receiving housing support services, or were missing an exit date as of March 31, 2003.

Table 4. Case Management Services

Time Spent per Month per Client (active clients)	Number	Percent
0 – 10 hours	376	85%
11 – 20 hours	60	14%
21 or more hours	6	1%
Average hours per month per client	*7.0*	

Data Source: Safe Babies, Safe Moms TICM Monthly Services Report Form

Table 5. Residential Chemical Dependency Treatment

Length of Stay	Number	Percent
0 to 14 days	24	9%
15 to 30 days	25	9%
31 to 60 days	28	11%
61 to 90 days	30	11%
91 to 120 days	37	14%
121 to 150 days	25	9%
151 or more days	70	27%
Still in treatment or missing exit date (as of March 31, 2003)	25	9%
Total Events	**264***	
Average (mean) for those who have exited	108	

*214 clients had 264 residential treatment episodes

Data Source: Safe Babies, Safe Moms Treatment Services Monthly Report Form

Table 6. Housing Support Services for Transitional Housing

Length of Stay	Number	Percent
Less than or equal to 90 days	23	26%
91 – 120 days	7	8%
121 – 240 days	11	12%
241 or more days	24	27%
Still receiving housing support services or missing exit date (as of March 31, 2003)	24	27%
Total Events	**89***	
Average (mean) for those who have exited	**224.38**	

*85 clients had 89 transitional housing episodes

Data Source: Safe Babies, Safe Moms Housing Support Services Monthly Report Form

SPECIALIZED CASE MANAGEMENT SERVICES

With the initiation of program activities in January 2000, new TICM agencies began to develop an array of services to meet the service needs envisioned in the 1999 report, *A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children*. Several critical program components will be described in more detail:

- Behavioral health services;
- Child development;
- Parenting education;
- Family planning; and
- Discretionary funds

These descriptions of specialized services focus primarily on services developed by TICM agencies after January 2000. Similar services may be offered at residential CD treatment facilities; however, with a thirty-year history of operation, Evergreen Manor, for example, had developed many of its services prior to the implementation of Safe Babies, Safe Moms.

Behavioral Health

Behavioral health and mental health problems commonly occur in combination with chemical dependency. Behavioral health services are one of the core program services, and a behavioral health specialist is a required member of the TICM staff. Because counseling services for women without diagnosed mental illness are generally not available from community-based mental health agencies, it is especially important that the TICM team include a behavioral health specialist who can provide one-on-one and group counseling for clients and assist in referring clients to existing community resources. The key role of the Behavioral Health Specialist was recognized in the initial stages of program development in 1998 (*A Comprehensive Program*, page 37).

The primary focus of behavioral health interventions, to facilitate positive behavioral change, was specified in the Special Terms and Conditions for TICM agencies. While the focus was established, the clinical methods for reaching this goal needed to be developed. At program inception, community staff overall had limited experience in providing behavioral health services to substance abusing women with children. Both state and local staff had limited knowledge of what specific activities and techniques would comprise effective behavioral health services for these clients.

By March 2001, activities of the behavioral health specialist included conducting a needs assessment to determine whether or not each client had behavioral or other mental health issues. Depending upon the client's needs, the behavioral health specialist might provide behavioral health services or, if she met service criteria, the client might be referred to community mental health services. The Behavioral Health Specialist offered classes focusing on anger management and self-esteem as well as individual, family, and group therapy to clients as appropriate.

Since March 2001, the balance between individual and group therapy has shifted to more group therapy as more staff have been trained, more groups have been started, and more clients have responded well to group settings. As of May 2003, eleven different groups were offered across all three sites. Getting all these groups up and running represents a significant accomplishment for all the sites:

- Program staff received formal/informal training in techniques for specific types of group therapy.
- All three sites are offering more and more groups, some earlier than others.
- Program staff have developed experience in facilitating groups and have some kind of credentials for doing different kinds of group therapy.

Activities of the Behavioral Health Specialist include individual and group counseling services. The following table summarizes the behavioral health classes and groups offered across the three sites:

Table 7. Behavioral Health Services

	Benton-Franklin Counties	Snohomish County	Whatcom County
Acupuncture			X
Constructive Chaos – a Drama workshop		X	
Creative Discovery	X		
Dialectical Behavior Therapy (DBT)	X	X	X
Exploring Emotions		X	
Individual Therapy	X	X	X
Interpersonal Relationships		X	
Mask Making		X	
Moral Reconation Therapy (MRT)	X		
Self-Care		X	
Yoga for Stress Release		X	

Data Source: Safe Babies, Safe Moms TICM Providers

Individual Therapy (Benton-Franklin, Snohomish and Whatcom)

In Snohomish County, case managers may offer individual therapy to clients on a limited basis. At intake, during the administration of the Addiction Severity Index, case managers determine if the client has a history of mental health issues or has any previous diagnoses from a mental health professional. If the client appears to need mental health services, the case manager consults with the Behavioral Health Specialist to determine whether the client is eligible to receive services through any community mental health agencies, and works to obtain services through these agencies. When the client's needs are greater than what can be provided through other community agencies, or the client is not eligible for individual therapy through these agencies, or the client would not be best served by group therapy, individual therapy may be provided.

TICM staff in Snohomish County have also developed a relationship with a medical practice located in Everett, to provide medication evaluations for clients who are not eligible for services (e.g., clients who have no medical coverage), or for those clients whose mental health issues are more complicated than can be managed by their general physician and might benefit from the use of psychotropic medications.

The Brigid Collins Growing Together Program (Whatcom County) integrates group and individual clinical work with case management to enhance both activities. The Behavioral Health Specialist's approach to individual therapy is grounded in relational theory, a theoretical framework that acknowledges the profound importance of relationships in the development of a healthy Self. The Parenting and Child Development Specialist, certified in Children's Mental Health, works with mothers to support effective parenting. The Comprehensive Addictions and Psychological Evaluation (Hoffmann, 2002) is used as a triage tool.

Groups offered across the three sites

Acupuncture (Whatcom)
Acupuncture is offered in a group setting by a Licensed Acupuncturist. Acupuncture has been successful in helping some addicts with withdrawal symptoms, cravings and relapse prevention. It is helpful in emotion regulation and is used as a medium to educate clients about the mind-body connection and mindfulness, as taught in individual and group therapy.

Constructive Chaos – a Drama workshop (Snohomish)
Through dramatic exercises, women are taught to use and hear their own voices, to reconstruct their language, how to interact with authority and productively speak their minds. Women graduate having gained confidence knowing they can represent themselves with authority and conviction.

Creative Discovery (Benton-Franklin)
Creative Discovery develops self-esteem and socialization skills while providing a creative outlet. While engaging in a wide variety of art and craft projects, clients discover their ability to accomplish a worthwhile goal and develop relationships with other women in recovery.

Dialectical Behavior Therapy (Benton-Franklin, Snohomish and Whatcom)
Dialectical Behavior Therapy (DBT) has been found to be a particularly effective therapy for addressing issues associated with borderline personality disorders. Using a combination of behavioral and cognitive therapy, it attempts to change patterns of behavior typically associated with borderline diagnosis.

The Whatcom County Dialectical Behavior Therapy Skills Training is a psycho-educational curriculum designed to teach skills in four areas: interpersonal relations, emotion regulation, distress tolerance and mindfulness. Clients learn skills to help them reduce negative behaviors and increase behaviors that are effective. The training was designed to assist people with borderline personality disorder and other difficult-to-treat patients. The duration of the course is eight months.

What is DBT?

Dialectical Behavior Therapy (DBT), developed by Marsha Linehan, Ph.D., is a systematic cognitive behavioral approach to working with individuals with borderline personality disorder (BPD).

DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, residing within an overarching dialectical world view that emphasizes the synthesis of opposites. The fundamental dialectic in DBT is between validation and acceptance of the client as she is, within the context of simultaneously helping her change. Acceptance procedures in DBT include mindfulness (e.g. attention to the present moment, assuming a non-judgmental stance, focusing on effectiveness) and a variety of validation and acceptance-based stylistic strategies. Change strategies in DBT include behavioral analysis of maladaptive behaviors and problem-solving skills training, contingency management (i.e., reinforcers, punishment), cognitive modification, and exposure-based strategies.

In recent application of DBT to substance dependent women with BPD, DBT subjects had greater reduction in illicit substance use (measured by both structures interview and urinalyses) both during treatment and at follow-up and greater improvements in global functioning and social adjustment at follow-up (Linehan et al., 1999). This study provides more support for DBT as an effective treatment for severely dysfunctional BPD patients across a range of presenting problems.

Exploring Emotions (Snohomish)
The focus of the Exploring Emotions class is to identify emotions that cause problems for the participants. Participants are encouraged to explore new ways of responding to particular emotions. The group focuses

on providing support, teaching skills, and giving feedback and encouragement to participants as they try new ways of responding to challenging situations.

Interpersonal Relationships (Snohomish)
The goal of the Interpersonal Relationship class is to improve relationships with partners by teaching self-respect and introducing clients to new ways of seeing and presenting themselves. Participants learn communication skills, boundary setting, goal achievement, problem solving, and conflict resolution.

Mask Making (Snohomish)
Mask Making is an experiential, exploratory workshop. After discussing the history, culture, and religious use of masks, women help each other to make a mold of their own faces. They decorate the exterior of the molds creating a mask that identifies how they believe other people see them. They decorate the interior of the mask as they see themselves. Each participant writes a paper describing their mask and presents it to the group.

Moral Reconation Therapy (MRT)(Benton-Franklin)
MRT is a cognitive-behavioral therapy that seeks to affect how participants think and make decisions. Participants are taught to apply reasoning and social and moral standards to their decision-making process. This class uses *How to Escape Your Prison* (Little and Robinson, 1986) as the textbook.

Self-Care (Snohomish)
Self-care workshops are usually one-day events focusing on such topics as hair care, working wardrobes and use of color, aromatherapy, light and music therapy.

Yoga for Stress Release (Snohomish)
This series of classes offers personal time to focus on relaxation of the mind and calming the body. Women learn awareness and focus through exercises and simple stretches. They learn mindfulness and attention by focusing on the present moment. The goal of this workshop is to allow women familiarity with peacefulness so they may incorporate this into their daily lives.

Child Development

Child development services are one of the core services provided in this program, and a child development specialist is a required member of the TICM staff. It is generally agreed that children born to substance-using women benefit from developmental and behavioral assessment and educational programs designed to meet their individual needs, and that interventions for the drug-exposed child need to be accompanied by intervention for the mother. Abuse of alcohol or drugs is associated with developmental delay, in addition to low birth weight, infant mortality and medical complications. Many developmental delays or behavioral problems among drug-exposed children may resolve with early childhood intervention.

The importance of child development activities, including screening for developmental delay, referral, assessment, and treatment services, was recognized in the initial stages of program development in 1998 (*A Comprehensive Program*).

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

Therapeutic Childcare provides child development services to children of mothers in Residential CD Treatment, including developmental assessment using standardized instruments; play therapy; behavior modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior or the child's environment to prevent dysfunctional behavior. Fifteen slots are available at Evergreen Manor, and 16 slots at Casita del Rio for children of Safe Babies, Safe Moms clients.

The Denver II, a general developmental screening test, has been used by TICM agencies to identify children who need follow-up for potential diagnosis of developmental delays or disabilities. The Child Development Specialist performs testing for all index children beginning at birth and for all children up to age three. Children with suspect Denver II results are referred to community providers as appropriate for assessment and interventions specific to any particular types of delay diagnosed. Since the Safe Babies, Safe Moms program began, 1015 Denvers have been performed for 339 children (as of March 30, 2003).

Parenting Education

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

In the DSHS-DOH report *A Comprehensive Program* (1999), parenting skills training and family relationship enhancement to promote continually improving parent-child relationships were identified as components of a comprehensive program most likely to yield successful outcomes. Early childhood development skill training and support for parents were identified as one function of TICM, and training parents in early childhood development was included in the role of the TICM.

The Special Terms and Conditions of the TICM provider agreements reflect a similar emphasis on parenting education: The TICM provider will coordinate a parenting curriculum with other treatment providers for continuity of care. All women enrolled in TICM will be expected to participate in the parenting curriculum.

By March 2001, the content of parenting classes included effective communication, sharing feelings with children, misbehavior, and discipline. Classes were offered in household management, budgets, and cooking. The TICM provider, the CD facility, the housing support services provider, or another agency within the community may offer parenting classes.

By June 2003, two sites (Snohomish County and Benton-Franklin) adopted the ***Make Parenting A Pleasure*** curriculum (developed by the Birth To Three organization, Eugene, Oregon) to provide parent education and support. ***Make Parenting A Pleasure*** was designed to help parents learn practical stress management and communication skills, gain greater understanding of their children, learn effective parenting skills and positive approaches to discipline, and build a support network.

Make Parenting A Pleasure begins by recognizing the importance of parents as individuals. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult/adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to a wide range of parent education programs. It contains sufficient material for a several month to a year-long program.

In Snohomish County, ***Make Parenting A Pleasure*** was implemented as a 12-week program. Children currently placed out-of-home are brought to the class for participation. They join their parents for lunch, then may go to the child care room for 45 minutes while parents review homework and participate in a facilitated discussion of the day's topic. The children then re-join the group for a planned play activity that focuses on attachment and positive parenting skills.

In Benton-Franklin, parenting classes modeled after ***Make Parenting A Pleasure*** were offered at both Rivercrest and the TICM site.

By June 2003, six classes or groups related to parenting education and life skills training were offered across the three sites:

Table 8. Parenting Education Classes and Life Skills Training

	Benton-Franklin Counties	Snohomish County	Whatcom County
Car Seat Training	X		
Dining on a Budget/Nutrition	X	X	
Making Parenting a Pleasure	X	X	
Parent-Trust Support Group			X
Prenatal instruction/ Individual childbirth education	X		
Process Parenting Group			X

Data Source: Safe Babies, Safe Moms TICM Providers

Car Seat Training (Benton-Franklin)
Two car seat experts (recognized as Child Passenger Safety Technicians by the National Highway Traffic Safety Administration after attending an intensive five-day training on Standardized Child Passenger Safety Technical Training) provide individual instruction on how to keep children as safe as possible in the car. Free car seats are available after completion of the training.

Dining on a Budget (Snohomish)
The cooking/nutrition curriculum includes food values, health, and budgeting. Women share recipes and cook meals. They learn table manners, appropriate conversation, how to set casual and formal tables, and how to prepare a buffet. Women completing the series of classes earn a set of cookware.

Parent-Trust Support Group (Whatcom)
The Parent Helping Parent Support Group is a collaboration between Parent Trust, Chambers and Wells Counseling Services, Inc., and Brigid Collins Growing Together. This group, which meets at Chambers and Wells, is designed as a mutual, self-help support model in which the format is venting, problem solving and celebrating. The group is open to male and female parents in recovery, and its participants are not limited to Growing Together clients.

The Parent-Trust Support Group is a component of Parent Trust for Washington Children whose mission is to build communities of strong, healthy families dedicated to helping each other and keeping children safe from harm. Funded by the Department of Social and Health Services, King County, numerous corporate and individual sponsors, and United Way, the State Office of Parent Trust has provided community services since 1978, including professional training and development, statewide networking and consultation, ongoing support and technical assistance, community organizing, and training curriculum.

Prenatal instruction/individual childbirth education (Benton-Franklin)
This instruction is available at the client's request. The curriculum includes relaxation techniques, what to expect during labor and delivery and what medical interventions are available.

Process Parenting Group (Whatcom)
The format for the first half of this group is a process group in which the participants are able to vent, problem solve, and explore the parenting issues with which they are coping. During the second half, staff provide direct, topic-focused parenting education. Topics have included Positive Discipline and Alternatives to Punishment; Developmental Ages and Stages; Infant Development; Toddler Development; Dealing With Temper Tantrums and Anger; and the Impact of Substance Abuse on Children. Materials are drawn from a variety of sources including the Growing Together video library. Each week, children's library books are introduced to the group and reading to children is modeled and encouraged.

Family Planning

Safe Babies, Safe Moms seeks to reduce subsequent unintended pregnancies for clients. While family planning was not identified as one of the original core services, the TICM team in each of the three sites offers family planning education and unintended pregnancy prevention services and referrals.

Case managers ensure that clients receive family planning, counseling, education, and information on how to access birth control methods. If the client does not have medical coverage for family planning services, the targeted intensive case manager assists her in accessing these services. The TICM provider in Benton-Franklin Counties hired a nurse Family Planning Educator. She conducted family planning classes for clients, both in the TICM office and in the CD treatment facility. In other counties, where TICM staff had not been specifically trained in the delivery of family planning services, the case manager ensured that clients were referred to an appropriate agency such as Planned Parenthood or the CSO family planning social worker.

Discretionary Funds

These clients have basic needs for goods and services that have been difficult or impossible to meet through established support systems. Hence, the program includes a provision for case managers, at their discretion, to access small funds to meet client needs. Discretionary funds are intended to supplement, not to replace, other funding sources. These funds are available to purchase small, critical items for clients, rather than the case manager's spending many hours trying to access other funding sources.

Discretionary funds are disbursed through the TICM contractor in Snohomish and Whatcom Counties. In Benton-Franklin Counties, a separate contract was negotiated with the Benton-Franklin Human Services Agency to dispense these program funds since the Benton-Franklin Health District did not have a mechanism in place to do so in a timely fashion. Benton-Franklin Human Services in turn contracted with Casita del Rio to disperse these funds. Subsequently, as of July 1, 2003, the Benton-Franklin Health District was contracted to disburse discretionary funds.

TICM providers have used discretionary funds for the following purposes:

- Medical and dental needs
- Hygiene-related needs (such as diapers, soap, shampoo, toilet paper, tooth paste)
- Car seats and other safety devices
- Educational needs/tuition
- Job skills training
- Special occasions like birthdays, treatment milestones, graduations, births
- Transportation
- Basic needs such as food, clothing, furniture, rent, security deposits, utility bills

Staff report that they regularly use discretionary funds for the following items as well:

- Incentives for participation in the Safe Babies, Safe Moms activities
- Childcare while the mothers attend Safe Babies, Safe Moms classes

Discretionary funds are important to meet individual needs that cannot otherwise be met. The narratives presented earlier in this report provide additional detail regarding the use and effectiveness of discretionary funds.

STATE AGENCY PARTNERS

In addition to the DSHS Division of Alcohol and Substance Abuse (agency lead for this pilot project) and Medical Assistance Administration Division of Program Support (lead for TICM), other state agency partnerships have been developed with the Department of Health Maternal and Infant Health (MIH) section, Child Protective Services, WorkFirst, and Medicaid transportation.

Department of Health (DOH) Maternal and Infant Health (MIH) section

DOH Maternal and Infant Health (MIH) section supports healthy birth outcomes by improving health and support services for pregnant and postpartum women and their infants. MIH oversees the Maternal Substance Abuse and Screening Provider Initiative. The purpose of this program is to establish universal screening by interview, observation and self-report as the standard of prenatal/postpartum care in Washington State, improve provider screening skill and effectiveness, and increase the number of women identified and women who enter treatment. State level and Regional Perinatal Program training efforts address these goals. The four Regional Perinatal Programs receive annual funding to provide professional education using creative approaches such as individualized practice training and follow up, professional educational website, as well as conferences and professional meeting exhibits. Special emphasis has been placed on working with the Comprehensive Pilot Programs for Drug and Alcohol using Women and their Children (Safe Babies, Safe Moms).

DOH Perinatal Program training efforts trained a total of 4,539 health care professionals statewide between January 2000 and June 2003. Of this number, 1044 were physicians and midwives. This represents approximately 57% of providers who deliver babies in Washington State. Trainers provided local training to medical providers and their staff in the catchment areas of the Safe Babies, Safe Moms projects. That effort resulted in eight practice site trainings in Snohomish, two in Whatcom and twenty-one in Tri Cities between January 2000 and June 2003. Approximately 41 physicians, 27 nurse practitioners and midwives, 82 nurses and 73 other practice staff attended. (Numbers may be duplicated as some professionals attended more than one training).

DSHS Children's Administration Child Protective Services

Children's Administration (CA) promotes families and seeks to ensure the safety and protection of children. CA both provides direct services and works in partnership with community-based public and private organizations. Child Protective Services (CPS), operated by the Division of Child and Family Services of CA, respond to reports of abuse and neglect through screening and investigation. If a report is substantiated, the Division of Child and Family Services provides services to protect the child. Services may include in-home protective services, temporary out-of-home care or on-going placements. As needed, the Division of Child and Family Services provides permanency planning and intensive treatment services through the Child Welfare Services (CSW) program.

For two and one-half years Snohomish County had a CPS liaison specifically assigned as a Safe Babies, Safe Moms team member while dedicated funds were available to support this person. After this funding was eliminated, the CPS liaison was no longer assigned to the Safe Babies, Safe Moms team. TICM staff are working to re-establish the formal relationship once again since it had been an effective tool in coordinating services for Safe Babies, Safe Moms clients.

In Snohomish County, CPS granted approval for children who had been removed from custody to go to parenting classes with their mothers if approved by the CPS worker on a case by case basis.

The Benton-Franklin Safe Babies, Safe Moms program has a signed Memorandum of Understanding (MOU) with CPS. The MOU formalizes the relationship between these two partners who have many clients in common. The MOU outlines the roles and responsibilities of each partner, identifies how they will work together, and provides guidance for resolving issues. CPS staff have attended community meetings and some staffings.

A CPS representative has attended Whatcom staff meetings when their clients were discussed. A Memorandum of Understanding has been signed to formalize the relationship between the Whatcom County Safe Babies, Safe Moms program and CPS.

DSHS Economic Services Administration WorkFirst

Economic Services Administration (ESA) administers welfare grants, related employment training, and child care to very low-income persons in the following groups: disabled and unemployable persons, persons who have children under age 18, and pregnant women. ESA also administers food assistance services. Persons age 16 or older who are part of a TANF family or assistance unit are required to participate in WorkFirst. WorkFirst services include job search, basic education (including high school/GED completion, remedial education, and English language proficiency), jobs skills training, customized job skills training, subsidized community jobs, one year of post-secondary education (career counseling as well as limited academic education and vocational instruction), and on-the-job training. Pregnant women and parents of infants may choose to work and/or receive services such as parenting, nutrition and work preparation classes.

The case manager for each WorkFirst participant prepares an individual responsibility plan (IRP) that describes the specific activities that will qualify as participation for that client. In order for Safe Babies, Safe Moms clients to receive WorkFirst participation credit for program activities, the program activities must be part of the individual responsibility plan and the service provider must report that the client was in attendance for the scheduled activities. In addition, credit for participation is awarded in specific units of time, and TICM staff have learned that by combining different program activities in the same block of time, it is easier for clients to receive credit for the activity.

Each of the Safe Babies, Safe Moms sites has worked to increase the partnership with WorkFirst. In Snohomish County, TICM staff have begun to attend WorkFirst meetings to encourage coordination. A Memorandum of Understanding (MOU) to ensure that eligible Safe Babies, Safe Moms activities are appropriately reported and accurately counted as WorkFirst activities has been signed by all Snohomish County CSO Administrators and PTA. In Benton-Franklin, the MOU has been completed with two CSOs.

In Whatcom County, WorkFirst is an active partner with Safe Babies, Safe Moms: staff from the programs attend each other's meetings as they relate to their clients; TICM staff report the number of hours clients spent on WorkFirst-approved activities; and a Memorandum of Understanding has been signed.

DSHS Medical Assistance Administration Medicaid Transportation

Through the Medicaid Transportation Program, MAA assures access to necessary non-emergency medical services for all Medicaid clients who have no other means of transportation. MAA contracts with regional brokers to screen client requests for transportation and to arrange the most appropriate method of transportation.

Because TICM funding includes Medicaid funds, Safe Babies, Safe Moms clients were eligible to receive transportation services to attend behavioral health groups or parenting classes offered at the TICM agency, as well as medical appointments for maternity, pediatric, and other care. In the early phases of program implementation, case managers often transported clients to appointments. Use of the Transportation Program provided more efficient transportation services, permitted better use of the case managers' time, and helped clients to attend needed services.

COMMON ACTIVITIES ACROSS SITES

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

Staffings are held to discuss the progress of clients in the program. They may be led by the TICM Supervisor or other TICM staff. Attendees may include TICM staff (case managers, Behavioral Health Specialists, Child Development Specialists, and sometimes a program manager or administrator), CD staff, Housing Support Services staff, a CPS representative, and a WorkFirst representative. Other community providers and members of the State team who oversee the TICM, CD treatment services, and evaluation components of the program may also attend these staffings and other meetings as appropriate.

Multi-disciplinary team meetings are similar to the staffings in that they discuss the progress of individual clients, and the same staff are invited to attend from the various agencies. However, these meetings are unique in that the client is also in attendance. Other community members may also be invited such as friends, family or religious affiliates.

Community meetings were established to provide a forum for all community service providers to discuss issues that relate to the development and implementation of this program. Issues that have been discussed include site updates, service provision territories and crossing boundaries, training needs, outreach efforts, use of discretionary funds, and research-related issues.

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

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

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

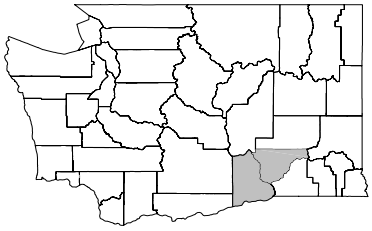
Training

All TICM case managers were required to attend training in the administration of the Addiction Severity Index (ASI). As MAA, DASA and TICM staff became more aware of the particular needs of women in the Safe Babies, Safe Moms program, they sought additional training. For example, in order to better meet participants' behavioral health needs, several staff received formal training in Dialectical Behavior Therapy and Moral Reconation Therapy. As well, DOH staff provided motivational interviewing training to Safe Babies, Safe Moms providers.

The Denver II was originally administered by Child Development Specialists who were trained and experienced with the assessment tool. Eventually, the case managers took over the task in order to reduce the workload of the Child Development Specialists. In Benton-Franklin, some case managers were nurses who were also trained and experienced with the tool, making this an easy transition. Case managers who had no former experience with the Denver II received training from the Child Development Specialists or through the Denver training video and manual.

In addition, MAA or DASA provided, helped arranged or suggested that TICM providers train their staff in basic case management (Everett only), family planning, methamphetamine, and chemical dependency issues. Finally, in response to specific challenges facing the sites, MAA worked with staff at all three of the sites to help them understand triangulation (clients pitting workers/ professionals against each other), and the importance of multi-disciplinary staffings to overcome this challenge.

Benton-Franklin Counties



Benton County, in the south-central region of Washington, is bordered on three sides by the Columbia River and by Oregon on the south. Benton County is over 1,700 square miles, a large portion of which is the U.S. Department of Energy, Hanford Site. The total population is 142,475 (census 2000). Almost two-thirds of county residents live in Kennewick (54,693) or Richland (38,708). Manufacturing, professional services, and government are the largest industries.

Franklin County encompasses 1,242 square miles and is bordered by the Columbia and Snake Rivers in southeastern Washington. Over half of the county's 49,347 (Census 2000) population is concentrated in Pasco (32,066), one of the Tri-Cities. In 2001 Franklin County had the highest birth rate in Washington, the second highest rate of births with Medicaid-paid maternity care, and the third highest rate of Medicaid women who had late or no prenatal care.

In Benton-Franklin Counties, Safe Babies, Safe Moms is a collaborative effort between the Benton-Franklin Health District administering TICM (Targeted Intensive Case Management), and Casita del Rio providing Residential Chemical Dependency (CD) Treatment and Housing Support Services.

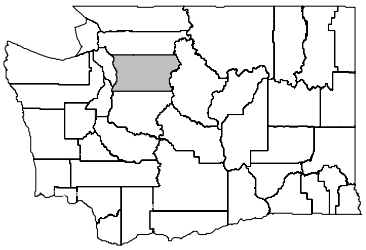
At the Benton-Franklin Health District, seven TICM staff members, working together with a supervisor (also a TICM staff member) and an administrator, serve as case managers with a current average caseload of 15 clients. A number of these employees also have specialty areas, including family planning, child development, and behavioral health (duties within these specialty areas may be shared among the case management staff as appropriate). Case managers with special training in behavioral health and child development reduced their caseloads to focus more on work within their specialty areas.

In Benton-Franklin Counties, no Residential Chemical Dependency (CD) Treatment or Housing Support Services were available prior to the inception of Safe Babies, Safe Moms. Women who needed these services were referred out of county. Rivercrest Villa, a residential CD treatment facility developed as part of the Safe Babies, Safe Moms program, operated from January 2000 to mid-April 2003. After that, Casita del Rio assumed responsibility for residential CD treatment and housing support services.

As of March 2001, the CD treatment staff of 22 employees included an administrator, an intake clerk, a clinical supervisor, two Chemical Dependency Professionals (CDPs), one nurse, six childcare workers, eight residential technicians, and one driver. Rivercrest Villa staff offered individual and group therapy sessions; educational classes; therapeutic child care; healthcare monitoring and review; assistance with shopping; and transportation to court, state agencies (such as the DSHS or WIC) and other appointments. Fifteen beds were allocated to serve women in this program with 15 beds for their children. Two facilities were purchased for transitional housing with a total of 10 housing support services slots.

At Rivercrest Villa, problems with facilities management and accounting arose on a number of occasions. According to the Tri-City *Herald* (Trumbo, 2003), Rivercrest Villa was cited for a "failure…to document how they've spent state and federal money on the program." A state licensing review cited Rivercrest Villa for not having the required number of counselors on staff. In mid-April 2003, the contract to operate Rivercrest Villa and the Detox Center was revoked. A new operator was named before the end of the month. The facility, renamed Casita del Rio, is now operated by Triumph Treatment Services out of Yakima. The contract between DASA and Casita del Rio is for 16 beds for women, 16 beds for children, and 4 beds for housing support services for transitional housing.

Snohomish County



Snohomish County, located in western Washington, covers an area of over 2000 square miles, with a population of 606,024 (Census 2000). Most residents live in urban areas within fifteen miles of Puget Sound, but the bulk of the county is a rural area containing mountains, national forest, and wilderness. The largest cities are Everett (91,488), Lynnwood (33,847) and Edmonds (39,515). Manufacturing is the largest industry due to the Boeing manufacturing facility. Rural Snohomish County has a timber- and salmon-dependent economy.

In Snohomish County Safe Babies, Safe Moms is a collaborative effort between Pacific Treatment Alternatives administering TICM (Targeted Intensive Case Management), Evergreen Manor providing Residential Chemical Dependency Treatment and outpatient treatment, and Catholic Community Services Tree of Life Program providing Housing Support Services for Transitional Housing and outpatient chemical dependency treatment services.

Evergreen Manor is a certified chemical dependency treatment facility established in Snohomish County in 1973. With over eighty-five employees, Evergreen Manor offers a full range of treatment services including detoxification, residential treatment and a recovery house program for women, out-patient drug/alcohol treatment, and out-patient anger management and domestic violence programs. The intensive in-patient program for women was implemented with the Safe Babies Safe Moms project in 2000. Currently sixteen beds are allocated to serve women in this program, with up to an additional sixteen beds for their children.

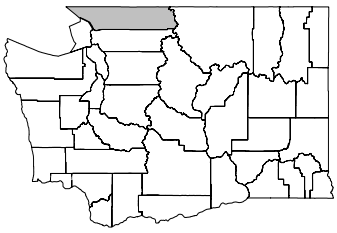
The twelve core staff of the residential program include two chemical dependency professionals, two mental health interns, five residential monitors, a part-time chaplain, the facilities manager, who also serves as the day care services manager, and the clinical manager. Additional staff include three daycare workers and a part time nurse.

The residential program provides treatment for residents, targeted to the unique needs of pregnant and parenting women in recovery. They attend group and individual counseling, and additional mental health counseling (including family counseling) as needed. They attend classes such as parenting, relapse prevention, nutrition, budgeting, stress management, spirituality, smoking cessation and a family group. They spend a minimum of three hours per week working with their children in the therapeutic day care and have an opportunity for almost daily exercise. The staff spends a total of four hours per week discussing and coordinating the treatment plan of each resident.

Housing Support Services and Outpatient CD Treatment are offered through Catholic Community Services Tree of Life program. Thirty housing support slots are available in two apartment complexes in the Everett area. Through the Tree of Life program, residents receive outpatient CD treatment services. Computers and a childcare facility are also available. Shelter Plus Care funds may be available to assist with housing when women do not meet the requirements of the Tree of Life program, or no units are available. Outpatient CD services are also available in other outpatient chemical dependency programs in Snohomish County. Pacific Treatment Alternatives has also become a Shelter Plus Care provider, expanding the ability to meet the needs of the clients.

Pacific Treatment Alternatives staff include a psychologist, behavioral health specialists, group facilitators, a parent educator and case managers. In addition to case management services, Targeted Intensive Case Management staff provide behavioral health services consisting of individual counseling and group therapy. They offer five weekly or bi-weekly groups. Childcare is offered on site during all classes.

Whatcom County



Whatcom County, in the northwestern corner of the state at the Canadian border, contains over 2,100 square miles. Most of the county is composed of wilderness, and the population is 166,814 (Census 2000). Bellingham (67,171), the home of Western Washington University, and Lynden (9,020) are the largest cities. Eastern Whatcom County is a rural area with a timber- and salmon-dependent economy. Services and manufacturing are the largest industries.

The Whatcom County site offers Targeted Intensive Case Management (TICM), outpatient CD treatment services and housing support services. TICM services are contracted through Brigid Collins Growing Together. Outpatient CD services are offered by local CD treatment providers. Housing support services are operated by Catholic Community Services.

TICM staff include six employees in various positions and a manager who oversees operation of the site. Two employees serve as case managers. The Behavioral Health specialist also supervises the TICM staff. One TICM employee serves as the Child Development Specialist, and one TICM staff member is responsible for administrative work.

Additional services are offered by the Brigid Collins Growing Together program. They include Dialectical Behavioral Therapy Skills-training groups, Individual Therapy, a Parent-Trust Support Group, a Process Parenting Group and Acupuncture. Child care is offered on site during all classes.

No residential chemical dependency treatment facility is located in Whatcom County. Whatcom clients in need of residential CD treatment may be referred to Evergreen Manor or Casita del Rio (formerly Rivercrest Villa) as appropriate, but space may not be available. If space is not available at one of these CD facilities, clients may enter another facility elsewhere in the state or may receive outpatient treatment when appropriate.

Targeted intensive case managers work closely with local inpatient and outpatient CD facilities in order to enhance continuity of care and establish effective service plans. The TICM agency cooperates with treatment recommendations for clients and assists as needed in motivating clients to participate in a treatment recommended recovery program.

METHODS

DATA SOURCES

The primary sources of information for this report were quantitative and qualitative data collection instruments, and historical data from program administrative databases.

Quantitative and Qualitative Data Collection Instruments

Primary data collection includes several instruments submitted for each client, such as an intake form, and a client evaluation form focusing on client skills and client needs. In addition, three standardized instruments are administered: the Addiction Severity Index (ASI) modified for use with pregnant women, the Parenting Stress Index (PSI), and the Denver Developmental Screening Test (Denver II).

Agency Databases

Data were extracted from three databases maintained by Washington's Department of Social and Health Services (DSHS): the First Steps Database (FSDB), established and maintained by the Division of Research and Data Analysis (DRDA); the Treatment and Report Generation Tool (TARGET), maintained by Division of Alcohol and Substance Abuse (DASA); and the Case and Management Information System (CAMIS), maintained by the Division of Children and Family Services.

The First Steps Database provides a single repository for data elements from different source files (birth certificates, infant death certificates, maternal and infant services paid by Medicaid, and Medicaid eligibility history). Birth certificates provided by the Center for Health Statistics of the Department of Health contain data on prenatal care, pregnancy outcomes, and background information for all births to Washington State residents. The FSDB links birth certificates to Medicaid claims and eligibility. Medicaid claims contain extensive information on Medicaid payments for maternal and infant care, type of medical care, and medical diagnoses.

The Treatment and Report Generation Tool records information on publicly-funded treatment services for substance abusers in Washington State. TARGET contains demographic, assessment, admission, treatment activity, and discharge data from treatment facilities across the state.

The Case and Management Information System (CAMIS) is maintained by the Division of Children and Family Services. It contains information on referrals to Child Protective Services and out-of-home placements. Accepted referrals involve allegations serious enough to constitute abuse if substantiated upon investigation. The CAMIS database was started in July 1991 and was implemented on a statewide basis in early 1992. Information from CAMIS was linked to the First Steps Database for this study.

Observation/Participant Observation

Evaluation staff observed community service providers interpreting and implementing the State team's vision of the program at the State Implementation Team Meetings, client staffings, and community meetings.

Program Documents

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

COMPARISON GROUPS

Women enrolled in the Safe Babies, Safe Moms program were compared to other low-income pregnant and parenting substance abusing women in Washington State. Both groups were divided into those who received an intervention (either Safe Babies Safe Moms, with or without treatment for chemical dependency, or chemical dependency treatment alone) before their baby was born and those who had no intervention during pregnancy. First, we show the general characteristics and birth outcomes for both Safe Babies, Safe Moms clients and other identified substance abusers. Then, we compare characteristics and birth outcomes for those with and without prenatal intervention.

Safe Babies, Safe Moms Women

This category includes 442 women who enrolled in the Safe Babies, Safe Moms program between January 2000 and December 2002. Of the 453 total women enrolled, 442 (98%) agreed to participate in research; ten women declined participation; one person was under the age of 18. For analyses using birth certificate data (limited to women with deliveries in 2001 or prior, N=305), this group was further divided into two groups:

1. Women who entered the Safe Babies, Safe Moms program **after** their baby was born (N=213);
2. Women who entered the Safe Babies, Safe Moms program **before** their baby was born (N=92).

Identified Substance Abusers

This category includes women with Medicaid-paid maternity services, who gave birth during the time from January 1, 2000 through December 31, 2001, and were identified as substance abusers in the First Steps Database (N=3,964). This category was further divided into two groups:

1. Women who had no treatment for chemical dependency (CD) during pregnancy (N=2429);
2. Women who received treatment for chemical dependency (CD) during pregnancy (N=1475).

The following types of information were used to determine if a woman was a substance abuser:

- Drug withdrawal in the newborn indicated on the birth certificate;
- Medical diagnoses (ICD-9 codes) from Medicaid claims for the mother or for the child; and
- Codes for treatment for chemical dependency (including DRGs, hospital procedure codes, and outpatient procedures from both Medicaid claims and TARGET).

Other Medicaid Women

This category includes women with Medicaid payments for maternity services, who gave birth during the time from January 1, 2000 through December 31, 2001, were identified in the First Steps Database, but had no known history of substance abuse (N=63,927).

Women who had been enrolled in Safe Babies, Safe Moms and those who were identified as substance abusers were excluded from the Medicaid category so that each comparison group is mutually exclusive.

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Table 9
Characteristics of Safe Babies, Safe Moms Children At Program Entry

Age of Index Children* **(N = 449)**	**Number**	**Percent**
Not yet Born	171	38%
Birth – 11 months	175	39%
12 – 23 months	74	16%
24 – 35 months	28	6%
43 months	1	0%
Average (mean)	*10 months*	

Residence of Index Children (N = 449)	**Number**	**Percent**
Mother	138	31%
Father	4	1%
Both Parents	13	3%
Grandparent	21	5%
Other relative	17	4%
Friend	1	0%
Foster family	77	17%
Not yet born	171	38%
Other	6	1%
Missing data	1	0%

Number of Children in Families at Program Entry (including 278 Index Children)	**Number/Percentage of Families**		**Total Number of Children**
0	52	12%	0
1	121	27%	121
2	98	22%	196
3	90	20%	270
4	37	8%	148
5	27	6%	135
6	13	3%	78
7	3	1%	21
8	1	0%	8
Total Children			**977**
Average (mean)			*2.21*

Number of Children Living with Mother at program entry (including Index Children)	**Number/Percentage of Families**		**Total Number of Children**
0	237	54%	0
1	127	29%	127
2	45	10%	90
3	20	5%	60
4	9	2%	36
5	4	1%	20
Total Children			**333**
Average (mean)			*0.75*

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

Data Source: Safe Babies, Safe Moms Client Intake Form

FINDINGS

CHARACTERISTICS OF SAFE BABIES, SAFE MOMS CHILDREN AT PROGRAM ENTRY

One of the requirements for entry into the Safe Babies, Safe Moms program is that a woman have at least one child under three years of age or be pregnant at the time of enrollment. Our study defines the unborn baby or the youngest child under three as the index child. This child is the one whose outcomes are most likely to be impacted by the program. The mother's program eligibility is based on the age of the index child. Case managers at each of the pilot sites reported child characteristics and developmental status.

The general characteristics of the index child and the client's other children and the family composition are presented on the facing page.

- Participants had a total of 977 children (including the index children), with an average of over 2 children (2.21) per client. Of these, 333 children (34%) lived with their mothers at the time they entered the program.

- The average age of Safe Babies, Safe Moms clients' index children was 10 months at program entry. Over one-third (39%) of the children were aged 0 months (newborn) to 11 months, and another 16% were between the ages of 12 to 23 months at intake. Over one-third (38%) of the children were not yet born at intake.

- About one-third (34%) of Safe Babies, Safe Moms index children were living with their mothers or both parents, while 17% lived with foster families. Foster family custody was more frequent than placement with a child's grandparents, father, and other family members combined.

- The average number of children living with their mothers at program entry was 0.75. This number includes index children.

Table 10

Safe Babies, Safe Moms Clients Substance Abuse History

	Women for whom the substance is their major problem		Women who have used the substance in the past 30 days	
	Number (%) (Total N = 442)	Average age at first use of this substance	Number (%) (Total N = 442)	Average age at first use of this substance
Both drugs and alcohol	106 (25.2%)	13.7	56 (13.3%)	13.9
Alcohol	47 (11.2%)	12.6	91 (21.6%)	12.4
Heroin	7 (1.7%)	22.7	7 (1.7%)	24.3
Methadone	0 .		1 (0.2%)	28.0
Opiates	7 (1.7%)	19.0	11 (2.6%)	16.8
Barbiturates	0 .		1 (0.2%)	22.0
Sedatives	5 (1.2%)	23.6	9 (2.1%)	23.4
Cocaine	60 (14.3%)	18.5	47 (11.2%)	19.4
Amphetamine	97 (23.0%)	18.4	49 (11.6%)	16.9
Cannabis	41 (9.7%)	14.6	72 (17.1%)	12.9
Hallucinogens	0 .		4 (1.0%)	16.8
Inhalants	0 .		2 (0.5%)	15.5
Multiple drugs	49 (11.6%)	14.1	51 (12.1%)	13.1
At Risk	2 (0.5%)		0	
Missing	21 (5.0%)		0	

Average age at first alcohol use	12.8	(N=411)
Average age at first drug use	15.2	(N=399)
Average age at first use of any substance	12.0	(N=411)

Data Source: ASI (at program entry)

Behavioral Risk Factors at Program Entry

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

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

Service providers report that clients are very interested in parenting their children, including those that may be in foster care. Although active parenting may be the desired goal of many clients, the reality of such parenting can be very stressful, especially for women who are trying to establish a drug-free and sober lifestyle. In addition to concentrating on their own recovery, many of these clients must learn how to parent effectively.

Client Substance Abuse History

Upon program entry, women were asked to identify the substance constituting their major problem.

- Multiple substances were the major problem for 37% of the women (both drugs and alcohol 25%; multiple drugs 12%); these women began using drugs and alcohol at an average age of 14.

- Amphetamines were the major problem for 23% of the women; these women began using amphetamines at an average age of 18.

- Cocaine was the major problem for 14% of the women; these women began using cocaine at an average age of 18.

- Alcohol was the major problem for an additional 11% of the women; these women were the youngest first time users, with an average age of 13 at first use.

Women were also asked to identify all substances they had used in the last 30 days, including substances not identified as their major problem.

- Alcohol was the most prevalent substance (22%), with an average age of 14 at first use.

- Cannabis was the most prevalent drug (17%), with an average age of 13 at first use, followed by amphetamines (12%), with an average age of 17 at first use, and cocaine (11%), with an average age of 19 at first use.

- Both drugs and alcohol were used by 13% of the women, with an average age of 14 at first use. Multiple drugs were used by 12% of the women, with an average age of 13 at first use.

For women who used drugs within the last 30 days, the average age of first use for any drug was 15. For women who used alcohol or drugs within the last 30 days, the average age of first use for any substance was 12.

Table 11

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

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
How do clients feel about certain parenting practices?					
My children go to bed about the same time every night.	3%	10%	18%	40%	29%
I feed my children when they are hungry.	2%	2%	5%	21%	70%
I hug my child as often as I can.	1%	1%	4%	14%	80%
My children bathe regularly.	2%	1%	4%	22%	71%
I am too lenient when my child misbehaves.	14%	28%	34%	16%	7%
I rarely talk to my children about their day.	33%	32%	25%	7%	3%
I need help with my parenting skills.	6%	16%	28%	37%	13%
I often lose my temper when my child misbehaves.	37%	31%	23%	6%	2%
I discipline my children when they misbehave.	5%	5%	31%	42%	16%
How do clients feel about drug use?					
I can safely use small amounts of illicit drugs.	76%	8%	6%	3%	5%
Drugs are not really that dangerous.	82%	11%	2%	2%	4%
I believe that I will lead a drug-free life.	3%	2%	9%	27%	59%
I understand that using drugs can harm a baby.	2%	0%	1%	8%	89%
How do clients feel about their own needs?					
I never really learned how to find a job.	36%	32%	8%	15%	8%
I need a lot of help with transportation.	12%	15%	16%	21%	35%
I can handle most of my problems.	4%	15%	32%	40%	8%
I look forward to receiving training in this program.	1%	1%	8%	39%	52%
I need to get help with housing.	11%	13%	14%	17%	44%

Data Source: Safe Babies, Safe Moms Client Self Evaluation Form (at program entry)

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

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

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

Client Self Evaluation Forms were completed at program entry. While this form was designed for use at entry and at exit so that the responses could be compared, only 45 exit forms were completed to date due to limited elapsed time for clients to complete the program and many clients being lost to follow-up prior to completion of research forms. Such a low number of evaluation forms completed at exit does not permit useful comparison of entry and exit data.

Parenting Attitudes and Behaviors

Most clients (94%) in this program report that they agree or strongly agree with the statement that they hug their child as often as they can. A majority of clients (58%) report that they discipline their children when they misbehave. More than two-thirds of clients (69%) report that their children go to bed at about the same time each night, and most clients (93%) agree or strongly agree with the statement that they bathe their children regularly.

Substance Use Beliefs

Over 80% of clients report that they believe they will lead a drug-free life and disagree with the statement that they can safely use small amounts of illicit drugs. Similarly, most clients (93%) disagree or strongly disagree with the statement that drugs are not really that dangerous. In fact, almost all (97%) clients believe that using drugs can harm a baby.

Client Needs

Less than one-half (48%) of clients reported that they could handle most of their problems. More than one-half (56%) of clients reported that they need a lot of help with transportation, and almost two-thirds (61%) reported that they need help with housing. Over 20% of clients never really learned how to find a job, and 91% reported that they were looking forward to receiving training in this program.

Parenting Stress Level

The level of parenting stress is based upon client responses recorded on the Parenting Stress Index (PSI) Short Form. The client completes the initial PSI at intake (or shortly after) if she has recent parenting experience, or after she has gained such experience if she does not. The client completes a second PSI six months after the first.

As of March 31, 2003, a total of 159 clients had completed both the initial and the six-month follow-up PSI, with responses to all questions completed.

Table 12

Parenting Stress Index: Average Scores at Program Entry and Six Months' Follow-Up

	Average Scores		
	Safe Babies, Safe Moms Clients		Average Score of National Comparison Group
	Entry (N=159)	Six Months Follow-up (N=159)	
Total Stress (TS)	76	70	69
Parental Distress (PD)	30	28	25
Parent-Child Dysfunctional Interaction (PCDI)	21	19	19
Difficult Child (DC)	25	24	25

Data Source: PSI-Short Form administered by case managers
PSI-Short Form includes national comparison group scores.

Participation in Safe Babies, Safe Moms is associated with a reduction in overall parenting stress:

- At six-months follow-up, clients' parenting stress levels (average score = 70) were significantly lower than at intake (average =76). (p=.0001)
- Clients' parenting stress levels at intake (average score = 76) were higher than that of the comparison group (average = 69).
- The improvement in the PSI scores at six months' follow-up was due to improved scores on two subscales: the average score for the Parental Distress Index decreased from 30 to 28 and the average score for Parent-Child Dysfunctional Interaction Index decreased from 21 to 19. The average Difficult Child score decreased slightly from 25 to 24.

Family Planning Services

Safe Babies, Safe Moms seeks to reduce subsequent pregnancies for clients. The targeted intensive case management team offers family planning education and unintended pregnancy prevention services and referrals. Not enough time has elapsed since the inception of the program to measure the number of subsequent births. One available measure of program outcomes is the use of family planning methods.

Family planning methods used during the year prior to program enrollment were compared to methods used during the year after enrollment. Medicaid expenditures were used to identify family planning methods. One hundred ninety-nine (N=199) women received Medicaid services during the period September 1997 through February 2002, and were enrolled in Safe Babies, Safe Moms prior to February 1, 2001. Because some family planning methods, such as condoms, may have been obtained without Medicaid claims, these numbers likely underreport actual use of certain family planning methods. Claims data provide no indication of user effectiveness, which should improve after Safe Babies, Safe Moms. No information about the frequency of sexual abstinence was available.

Family planning methods were classified according to reversibility and effectiveness. Hysterectomies and tubal ligations were categorized as non-reversible; IUDs, implantable systems, hormonal and oral contraceptives were categorized as more effective (reversible) methods; diaphragms and condoms were categorized as less effective methods.

Table 13. Family Planning Methods

	Year Prior to Enrollment		Year After Enrollment	
	Number	Percent	Number	Percent
Non-Reversible Methods	3	1.5%	5	2.5%
More Effective Methods	55	27.6%	76	38.2%
Less Effective Methods	6	3.0%	1	0.5%
No Identifiable Method	135	67.8%	117	58.8%

Data Source: Medicaid Management Information System (MMIS)

Participation in Safe Babies, Safe Moms is associated with more effective family planning behaviors:

- At one year follow-up, 81 clients (41%) were using non-reversible or more effective methods.
- A small, but significant number of clients (5) had hysterectomies or tubal ligations following enrollment in the program.

The number of clients using more effective methods increased by 38%, from 55 in the year before enrollment to 76 in the year after enrollment.

Table 14. Developmental Status of Children of Safe Babies, Safe Moms Clients

Children with Normal Denver Scores		
At birth	12 of 12	100%
At 1 week	5 of 5	100%
At 1 month	83 of 93	89%
At 2 months	81 of 89	91%
At 4 months	106 of 123	86%
At 6 months	104 of 127	82%
At 9 months	104 of 123	85%
At 12 months	97 of 115	84%
At 15 months	78 of 88	89%
At 18 months	81 of 98	83%
At 2 years	76 of 102	75%
At 3 years	31 of 40	78%

Data Source: Denver II administered by case managers

Child Development

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

Developmental delays in infants and young children are often difficult if not impossible to detect through routine physical examinations performed by health providers.

Results of Denver developmental screening are shown below:

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

- Among children tested at age two to three years, between 75% and 78% demonstrated normal development. Results for six children in this age range were suspect, indicating possible developmental delay.

Because the prevalence of suspect Denver II results is known to increase with the child's age (Frankenburg et al., 1996), it is difficult to interpret the significance of these findings. The findings may indicate appropriate test administration: what can be measured at a young age is far more restricted than what can be measured at an older age. Almost 90% of children born since their mothers enrolled in Safe Babies, Safe Moms demonstrated normal development. This is an encouraging finding; however, these children may reveal developmental delay in the future as time passes. The higher rate of suspect results among older children (35 children tested at two and three years) may be consistent with better ascertainment of delay as children age. These findings are also consistent with a higher prevalence of delay among children born to mothers with low educational attainment, poverty, and chaotic lives.

Table 15
CHARACTERISTICS OF SUBSTANCE ABUSING WOMEN

Mother-Based Measures	All Safe Babies-Safe Moms Mothers (N=305)		All Other Identified Substance Abusers 2000-2001 (N=3,904)		Other Medicaid Women 2000-2001 (N=63,927)	
Race						
White	227	(74.4%)	2,598	(66.5%)	35,483	(55.5%)
Hispanic	23	(7.5%)	260	(6.7%)	16,059	(25.1%)
African American	18	(5.9%)	333	(8.5%)	3,841	(6.0%)
Native American	17	(5.6%)	502	(12.9%)	2,228	(3.5%)
Asian	1	(0.3%)	66	(1.7%)	4,124	(6.5%)
Other or Unknown	19	(6.2%)	145	(3.7%)	2,192	(3.4%)
Age (years)						
Under 20	38	(12.5%)	824	(21.1%)	12,577	(19.7%)
20 - 24	102	(33.4%)	1,265	(32.4%)	23,833	(37.3%)
25 - 29	65	(21.3%)	848	(21.7%)	14,955	(23.4%)
30 - 34	66	(21.6%)	605	(15.5%)	8,124	(12.7%)
> 35	34	(11.1%)	362	(9.3%)	4,421	(6.9%)
Unknown	0	(0.0%)	0	(0.0%)	17	(0.0%)
Average Age (mean)	**26.3**		**25.0**		**24.6**	
Marital Status						
Married	54	(17.7%)	792	(20.3%)	30,591	(47.9%)
Not Married	247	(81.0%)	3,079	(78.9%)	33,126	(51.8%)
Unknown	4	(1.3%)	33	(0.8%)	210	(0.3%)
Educational Attainment						
Some/No Elementary	20	(6.6%)	272	(7.0%)	6,116	(9.6%)
Some High School	103	(33.8%)	1,387	(35.5%)	14,186	(22.2%)
High School Graduate	98	(32.1%)	1,332	(34.1%)	22,650	(35.4%)
Some College	53	(17.4%)	520	(13.3%)	11,436	(17.9%)
College Graduate	6	(2.0%)	44	(1.1%)	3,387	(5.3%)
Unknown	25	(8.2%)	349	(8.9%)	6,152	(9.6%)
Less than 12 yrs. education	**123**	**(40.3%)**	**1,659**	**(42.5%)**	**20,302**	**(31.8%)**
Mean No. Years Education	**11.3**		**11.2**		**11.5**	
No. Prior Children (Liveborn)						
None	79	(25.9%)	1,212	(31.0%)	25,327	(39.6%)
One	75	(24.6%)	945	(24.2%)	18,161	(28.4%)
Two	65	(21.3%)	732	(18.8%)	10,510	(16.4%)
Three	42	(13.8%)	429	(11.0%)	4,865	(7.6%)
Four	19	(6.2%)	242	(6.2%)	1,971	(3.1%)
Five or More	21	(6.9%)	222	(5.7%)	1,789	(2.8%)
Unknown	4	(1.3%)	122	(3.1%)	1,304	(2.0%)
Mean No. Prior Children	**1.7**		**1.6**		**1.2**	
Smoking Status						
Yes	153	(50.2%)	2,063	(52.8%)	10,832	(16.9%)
No	119	(39.0%)	1,586	(40.6%)	51,824	(81.1%)
Unknown	33	(10.8%)	255	(6.5%)	1,271	(2.0%)

Data Source: First Steps Database birth certificates

Characteristics of Safe Babies, Safe Moms and Comparison Groups

From January 2000 through June 2003, the Safe Babies, Safe Moms pilot projects served 453 women. Four hundred forty-two (442) women agreed to participate in the study. Three hundred five (305) Safe Babies, Safe Moms were identified in the First Steps Database as having given birth during or before 2001. Characteristics of these mothers are presented in Tables 15 and 16, and outcomes for their children (N=309) are presented in Table 17. In each table, Safe Babies, Safe Moms clients are compared to all other identified substance abusers and all other Medicaid women.

- The proportion of white women among Safe Babies, Safe Moms clients (74%) was higher than among other substance abusers (67%) and all other Medicaid women (56%). The proportion of Native Americans among other substance abusers (13%) was higher than for Safe Babies, Safe Moms clients (6%) and all other Medicaid women (4%). The proportion of Hispanic women was higher among all other Medicaid women (25%) than among Safe Babies, Safe Moms clients (8%) and other Medicaid substance abusers (7%). These differences are consistent with the race/ethnicity distribution in communities represented by each group and with the prevalence of substance abuse in different racial/ethnic groups.

- Safe Babies, Safe Moms clients, with an average age of 26.3 years, were slightly older than other identified substance abusers (average age 25.0) and other Medicaid women (average age 24.6 years). These differences are also reflected in the age distributions: the proportion of women age 30 or older among Safe Babies, Safe Moms women (33%) was higher than among other substance abusers (25%) and all other Medicaid women (20%); the proportion of women under the age of 20 among Safe Babies, Safe Moms clients (13%) was lower than among other substance abusers (21%) and all other Medicaid women (20%).

- The proportion of unmarried women was approximately the same among Safe Babies, Safe Moms clients (81%) and other identified substance abusers (79%). This is substantially higher than the 52% reported for all other Medicaid women.

- The proportion of women who had less than 12 years of education was similar for Safe Babies, Safe Moms women (40%) and other identified substance abusers (43%). These proportions are considerably higher than the 32% reported for all other Medicaid women.

- The average number of prior children was similar for Safe Babies, Safe Moms mothers (1.7) and Medicaid identified substance abusers (1.6), and higher than all other Medicaid mothers (1.2).

- The rate of smoking during pregnancy was approximately the same among Safe Babies, Safe Moms women (50%) and other identified substance abusers (53%). These rates are much higher than the 17% smoking rate for all other Medicaid women.

Table 16
CHARACTERISTICS OF SUBSTANCE ABUSING WOMEN

Mother Based Measures	All Safe Babies-Safe Moms Mothers (N=305)		All Other Identified Substance Abusers 2000-2001 (N=3,904)		Other Medicaid Women 2000-2001 (N=63,927)	
No. Prenatal Visits						
None	4	(1.3%)	131	(3.4%)	302	(0.5%)
1 to 4	30	(9.8%)	428	(11.0%)	3,057	(4.8%)
5 to 9	94	(30.8%)	1,085	(27.8%)	17,300	(27.1%)
10 to 14	99	(32.5%)	1,294	(33.1%)	29,418	(46.0%)
15 to 20	22	(7.2%)	274	(7.0%)	5,447	(8.5%)
More than 20	6	(2.0%)	88	(2.3%)	1,258	(2.0%)
Unknown	50	(16.4%)	604	(15.5%)	7,145	(11.2%)
Fewer than 10 visits	**128**	**(42.0%)**	**1,644**	**(42.1%)**	**20,659**	**(32.3%)**
Mean No. of Visits	**9.2**		**9.1**		**10.4**	
Trimester Prenatal Care Began						
First Trimester	162	(53.1%)	2,095	(53.7%)	42,769	(66.9%)
Second Trimester	74	(24.3%)	879	(22.5%)	12,629	(19.8%)
Third Trimester	23	(7.5%)	271	(6.9%)	2,507	(3.9%)
No Prenatal Care	4	(1.3%)	130	(3.3%)	300	(0.5%)
Unknown	42	(13.8%)	529	(13.6%)	5,722	(9.0%)
Later or No Prenatal Care	**27**	**(8.9%)**	**401**	**(10.3%)**	**2,807**	**(4.4%)**
Mean Mo. when PNC began	**3.4**		**3.4**		**3.0**	
Enhanced Maternity Care Services						
Received First Steps MSS	193	(63.3%)	2,733	(70.0%)	44,334	(69.4%)
Medicaid Eligibility Status						
Grant Recipients	199	(65.2%)	2,216	(56.8%)	14,694	(23.0%)
Medicaid Only	68	(22.3%)	1,304	(33.4%)	24,373	(38.1%)
First Steps Expansion	23	(7.5%)	381	(9.8%)	24,830	(38.8%)
Non Medicaid	14	(4.6%)	0	(0.0%)	0	(0.0%)
Medicaid Eligibility Missing	1	(0.3%)	3	(0.1%)	30	(0.0%)

Data Source: First Steps Database birth certificates

Table 16 displays some of the services received by Safe Babies, Safe Moms women, other identified substance abusers, and all other Medicaid women.

- The proportion of women who had fewer than 10 prenatal visits was approximately the same among Safe Babies, Safe Moms clients and identified substance abusers (42%). This is higher than the 32% for other Medicaid mothers with no known substance abuse.

- The proportion of women who began prenatal care in the first trimester was approximately the same among Safe Babies, Safe Moms women and identified substance abusers (53% versus 54%). This is substantially lower than the 67% of other Medicaid mothers who began prenatal care during the first trimester. Similarly, the proportion of women who began prenatal care during the third trimester or received no prenatal care was approximately the same for the Safe Babies, Safe Moms women and identified substance abusers (9% versus 10%), but higher than the proportion of Medicaid mothers with no known substance abuse (4%).

- The rate of receipt of Maternity Support Services was very similar for Medicaid identified substance abusers (70%) and Medicaid mothers with no known substance abuse (69%). The rate was slightly lower for Safe Babies, Safe Moms women (63%).

- The proportion of women who were grant recipients was greatest for Safe Babies, Safe Moms clients (65.2%). The proportion of grant recipients was lower among other identified substance abusers (56.8%) and lowest of all for other Medicaid women (23%).

Table 17
OUTCOMES FOR CHILDREN WITH SUBSTANCE ABUSING MOTHERS

Child-Based Outcomes	All Safe Babies-Safe Moms Children (N=309)		Children of All Other Identified Substance Abusers 2000-2001 (N=3,964)		Children of Other Medicaid Women 2000-2001 (N=64,733)	
Number of Infants						
Born Dead (Fetal Deaths)	0	(0.0%)	31	(0.8%)	348	(0.5%)
Born Alive (Liveborn)	309	(100.0%)	3,933	(99.2%)	64,385	(99.5%)
Neonatal Deaths	1	(0.3%)	19	(0.5%)	230	(0.4%)
Post-Neonatal Deaths	0	(0.0%)	13	(0.3%)	118	(0.2%)
Alive at 1 year	308	(99.7%)	3,901	(98.4%)	64,037	(98.9%)
Infant Mortality Rate (per 1000)		**3.2**		**8.1**		**5.4**
No. Infants This Birth (liveborn)						
One (singleton)	301	(97.4%)	3,816	(97.0%)	62,819	(97.6%)
Multiple Births (twins, etc.)	8	(2.6%)	117	(3.0%)	1,566	(2.4%)
Birthweight* (grams)						
Very Low (<1500 g.)	3	(1.0%)	92	(2.4%)	521	(0.8%)
Medium Low (1500-2499 g.)	34	(11.3%)	355	(9.3%)	2,475	(3.9%)
Normal (2500+ g.)	262	(87.0%)	3,352	(87.8%)	59,622	(94.9%)
Unknown	2	(0.7%)	17	(0.4%)	201	(0.3%)
Total Low Birthweight	**37**	**(12.3%)**	**447**	**(11.7%)**	**2,996**	**(4.8%)**
Mean Birthweight	**3,204**	**(7lbs. 1oz.)**	**3,195**	**(7lbs. 1oz.)**	**3,398**	**(7lbs. 8oz.)**
Gestational Age*						
Preterm Birth, < 28 weeks	1	(0.3%)	48	(1.3%)	261	(0.4%)
Preterm Birth, 28 to 36 weeks	60	(19.9%)	599	(15.7%)	5,531	(8.8%)
Term/ Post-Term, > 36 weeks	232	(77.1%)	3,105	(81.4%)	56,400	(89.8%)
Unknown	8	(2.7%)	64	(1.7%)	627	(1.0%)
Total Preterm	**61**	**(20.3%)**	**647**	**(17.0%)**	**5,792**	**(9.2%)**
Mean Gestational Age	**38.3**		**38.4**		**39.0**	
Small for Gestational Age*						
Yes	39	(13.0%)	483	(12.7%)	4,800	(7.6%)
No	254	(84.4%)	3,252	(85.2%)	57,216	(91.1%)
Unknown	8	(2.7%)	81	(2.1%)	803	(1.3%)
Five-Minute Apgar						
7 or lower	13	(4.3%)	221	(5.8%)	2,174	(3.5%)
8	39	(13.0%)	457	(12.0%)	5,604	(8.9%)
9	235	(78.1%)	2,980	(78.1%)	51,709	(82.3%)
10	17	(5.6%)	231	(6.1%)	4,549	(7.2%)
Missing	5	(1.7%)	75	(2.0%)	697	(1.1%)
Accepted CPS Referrals**	N=285		N=3458		N=56,749	
Birth to 1 year	156	(54.7%)	1395	(40.0%)	2,556	(4.5%)
Out of Home Placement**	N=285		N=3458		N=56,749	
Birth to 1 year	108	(35.9%)	1,008	(29.0%)	512	(1.0%)

*Singleton Liveborn Births used in calculations
** The child was born at least 1 year prior to the end of our data, September 30, 2002.

Data Source: First Steps Data Base, Children's Administration Case And Management Information System

Table 17 displays child outcomes for the children of Safe Babies, Safe Moms, all identified substance abusers, and all other Medicaid women. Although the infant mortality rate for Safe Babies, Safe Moms children (3.2 per 1000) was lower than that for children of other identified substance abusers (8.1 per 1000), this difference was not statistically significant. The fetal death rates were also not significantly different.

- The low birth weight rate for Safe Babies, Safe Moms children and identified substance abusers (12% for each group) was much higher than that for children of other Medicaid women with no known substance abuse (5%).

- The highest rates of pre-term birth (delivery before the 37th week of gestation) occurred among Safe Babies, Safe Moms children (20.3%), and children of identified substance abusers (17%). Just 9.2% of children of Medicaid mothers with no known substance abuse were pre-term.

- The proportion of children who were small for gestational age was approximately the same for Safe Babies, Safe Moms children (13%) and other identified substance abusers (12.7%). These rates were considerably higher than for children of Medicaid mothers with no known substance abuse (7.6%).

- The proportion of children with a score of 8 or less on the five-minute Agar test was approximately the same for Safe Babies, Safe Moms and Medicaid identified substance abusers' children (17.3% and 17.8, respectively), and higher than the scores of children of Medicaid mothers with no known substance abuse (12.4%).

- The rate of accepted CPS referrals was more than 12 times greater for Safe Babies, Safe Moms children than for children of Medicaid mothers with no known substance abuse (54.7% versus 4.5%). The rate of accepted CPS referrals was also very high (40%) among other identified substance abusers.

- The highest rate of out-of-home placements occurred among Safe Babies, Safe Moms children (36%). The next highest rate was for children of other identified substance abusers (29%). The lowest rate was for children of Medicaid mothers with no known history of substance abuse (1%).

Summary:

Safe Babies, Safe Moms clients and other identified substance abusers were very similar in their characteristics, and very different from other Medicaid women. The Safe Babies, Safe Moms clients and other identified substance abusers were higher risk, and their children had poorer birth outcomes than children of all other Medicaid women. On a number of measures, Safe Babies, Safe Moms clients were somewhat higher risk than other identified substance abusers: they were slightly older, had less education, had more prior children, and received public assistance more frequently. Similarly, birth outcomes for Safe Babies, Safe Moms children were slightly worse than those for other identified substance abusers. Overall, Safe Babies, Safe Moms clients appeared to be representative of low-income substance abusing women in Washington, with a slight tendency to be higher risk.

Table 18
CHARACTERISTICS OF SUBSTANCE ABUSING WOMEN

	Safe Babies-Safe Moms				All Other Identified Substance Abusers 2000-2001			
	Program Entry After Baby Born (N=213)		Program Entry Before Baby Born (N=92)		No CD Treatment During Pregnancy (N=2,429)		CD Treatment During Pregnancy (N=1,475)	
Mother-Based Measures								
Race								
White	165	(77.5%)	62	(67.4%)	1,644	(67.7%)	954	(64.7%)
Hispanic	16	(7.5%)	7	(7.6%)	168	(6.9%)	92	(6.2%)
African American	11	(5.2%)	7	(7.6%)	192	(7.9%)	141	(9.6%)
Native American	9	(4.2%)	8	(8.7%)	289	(11.9%)	213	(14.4%)
Asian	1	(0.5%)	0	(0.0%)	43	(1.8%)	23	(1.6%)
Other or Unknown	11	(5.2%)	8	(8.7%)	93	(3.8%)	52	(3.5%)
Age (years)								
Under 20	34	(16.0%)	4	(4.3%)	542	(22.3%)	282	(19.1%)
20 - 24	69	(32.4%)	33	(35.9%)	822	(33.8%)	443	(30.0%)
25 - 29	44	(20.7%)	21	(22.8%)	521	(21.4%)	327	(22.2%)
30 - 34	42	(19.7%)	24	(26.1%)	336	(13.8%)	269	(18.2%)
> 35	24	(11.3%)	10	(10.9%)	208	(8.6%)	154	(10.4%)
Average Age (mean)	**26.1**		**27.0**		**24.6**		**25.5**	
Marital Status								
Married	40	(18.8%)	14	(15.2%)	510	(21.0%)	282	(19.1%)
Not Married	169	(79.3%)	78	(84.8%)	1,903	(78.3%)	1,176	(79.7%)
Unknown	4	(1.9%)	0	(0.0%)	16	(0.7%)	17	(1.2%)
Educational Attainment								
Some/No Elementary	16	(7.5%)	4	(4.3%)	163	(6.7%)	109	(7.4%)
Some High School	74	(34.7%)	29	(31.5%)	877	(36.1%)	510	(34.6%)
High School Graduate	67	(31.5%)	31	(33.7%)	857	(35.3%)	475	(32.2%)
Some College	36	(16.9%)	17	(18.5%)	291	(12.0%)	229	(15.5%)
College Graduate	4	(1.9%)	2	(2.2%)	18	(0.7%)	26	(1.8%)
Unknown	16	(7.5%)	9	(9.8%)	223	(9.2%)	126	(8.5%)
Less than 12 yrs. education	**90**	**(42.3%)**	**33**	**(35.9%)**	**1,040**	**(42.8%)**	**619**	**(42.0%)**
Mean No. Years Education	**11.3**		**11.5**		**11.2**		**11.3**	
No. Prior Children (Liveborn)								
None	57	(26.8%)	22	(23.9%)	786	(32.4%)	426	(28.9%)
One	51	(23.9%)	24	(26.1%)	609	(25.1%)	336	(22.8%)
Two	52	(24.4%)	13	(14.1%)	457	(18.8%)	275	(18.6%)
Three	27	(12.7%)	15	(16.3%)	245	(10.1%)	184	(12.5%)
Four	11	(5.2%)	8	(8.7%)	139	(5.7%)	103	(7.0%)
Five or More	12	(5.6%)	9	(9.8%)	122	(5.0%)	100	(6.8%)
Unknown	3	(1.4%)	1	(1.1%)	71	(2.9%)	51	(3.5%)
Mean No. Prior Children	**1.6**		**2.0**		**1.5**		**1.7**	
Smoking Status								
Yes	106	(49.8%)	47	(51.1%)	1,291	(53.1%)	772	(52.3%)
No	84	(39.4%)	35	(38.0%)	995	(41.0%)	591	(40.1%)
Unknown	23	(10.8%)	10	(10.9%)	143	(5.9%)	112	(7.6%)

Data Source: First Steps Database birth certificates

Characteristics of Women and their Children With and Without Prenatal Interventions

The mother and child characteristics are presented for women who received prenatal interventions (Safe Babies, Safe Moms services, or CD Treatment), compared to those who did not. Those who did not receive prenatal intervention were defined as those women who entered the Safe Babies, Safe Moms program **after** their baby was born (N=213), and other identified substance abusers who had no CD treatment during pregnancy (N=2429). Those who received prenatal interventions are defined as those women who entered the Safe Babies, Safe Moms program **before** their baby was born (N=92) and other identified substance abusers who received treatment for chemical dependency during pregnancy (N=1475).

As displayed on Table 18, in general, no remarkable differences were found between women who began receiving prenatal interventions after their child was born and those who began receiving prenatal services before their child was born.

Women who entered the Safe Babies, Safe Moms program before their baby was born were slightly older (average age 27 years old) and included the smallest proportion of women less than 20 years of age. Similarly, this group had the highest average number of prior children (2.0).

Table 19
CHARACTERISTICS OF SUBSTANCE ABUSING WOMEN

	Safe Babies-Safe Moms				All Other Identified Substance Abusers 2000-2001			
	Program Entry After Baby Born		Program Entry Before Baby Born		No CD Treatment During Pregnancy		CD Treatment During Pregnancy	
Mother Based Measures	**(N=213)**		**(N=92)**		**(N=2,429)**		**(N=1,475)**	
No. Prenatal Visits								
None	4	(1.9%)	0	(0.0%)	115	(4.7%)	16	(1.1%)
1 to 4	25	(11.7%)	5	(5.4%)	318	(13.1%)	110	(7.5%)
5 to 9	68	(31.9%)	26	(28.3%)	676	(27.8%)	409	(27.7%)
10 to 14	65	(30.5%)	34	(37.0%)	766	(31.5%)	528	(35.8%)
15 to 20	13	(6.1%)	9	(9.8%)	143	(5.9%)	131	(8.9%)
More than 20	3	(1.4%)	3	(3.3%)	49	(2.0%)	39	(2.6%)
Unknown	35	(16.4%)	15	(16.3%)	362	(14.9%)	242	(16.4%)
Fewer than 10 visits	**97**	**(45.5%)**	**31**	**(33.7%)**	**1,109**	**(45.7%)**	**535**	**(36.3%)**
Mean No. of Visits	**8.7**		**10.4**		**8.6**		**10.0**	
Trimester Prenatal Care Began								
First Trimester	107	(50.2%)	55	(59.8%)	1,280	(52.7%)	815	(55.3%)
Second Trimester	59	(27.7%)	15	(16.3%)	528	(21.7%)	351	(23.8%)
Third Trimester	16	(7.5%)	7	(7.6%)	197	(8.1%)	74	(5.0%)
No Prenatal Care	4	(1.9%)	0	(0.0%)	115	(4.7%)	15	(1.0%)
Unknown	27	(12.7%)	15	(16.3%)	309	(12.7%)	220	(14.9%)
Later or No Prenatal Care	**20**	**(9.4%)**	**7**	**(7.6%)**	**312**	**(12.8%)**	**89**	**(6.0%)**
Mean Mo. when PNC began	**3.5**		**3.1**		**3.5**		**3.2**	
Enhanced Maternity Care Services								
Received First Steps MSS	125	(58.7%)	68	(73.9%)	1,617	(66.6%)	1,116	(75.7%)
Medicaid Eligibility Status								
Grant Recipients	124	(58.2%)	75	(81.5%)	1,301	(53.6%)	915	(62.0%)
Medicaid Only	55	(25.8%)	13	(14.1%)	855	(35.2%)	449	(30.4%)
First Steps Expansion	22	(10.3%)	1	(1.1%)	271	(11.2%)	110	(7.5%)
Non Medicaid	11	(5.2%)	3	(3.3%)	0	(0.0%)	0	(0.0%)
Medicaid Eligibility Missing	1	(0.5%)	0	(0.0%)	2	(0.1%)	1	(0.1%)

Data Source: First Steps Database birth certificates

Table 19 describes services received by women in the four groups. Women who received prenatal interventions, those who enrolled in Safe Babies Safe Moms before their baby was born and those who received prenatal CD treatment, generally received more services, earlier in their pregnancies:

- The average number of prenatal visits was higher for Safe Babies, Safe Moms clients who enrolled before their baby was born (10.4 visits) than for those who enrolled after their baby was born (8.7 visits). The average number of prenatal visits was higher for identified substance abusers with CD treatment during pregnancy (10.0 visits) than for those who received no CD treatment during pregnancy (8.6 visits).

- The proportion of women who received prenatal care during the third trimester or not at all was lower among Safe Babies, Safe Moms women who enrolled before their baby was born (7.6%) than among those who enrolled after their baby was born (9.4%). The proportion of women who received prenatal care during the third trimester or not at all was lower among identified substance abusers with CD treatment during pregnancy (6.0%) than among those with no CD treatment during pregnancy (12.8%).

- The proportion of women receiving Maternity Support Services (MSS) was higher among Safe Babies, Safe Moms women who enrolled before their baby was born (73.9%) than among those who enrolled after their baby was born (58.7%). The proportion of women receiving Maternity Support Services (MSS) was higher among identified substance abusers with CD treatment during pregnancy (75.7%) than among those with no prenatal treatment during pregnancy (66.6%).

- The proportion of women who were grant recipients at the time of delivery was higher among Safe Babies, Safe Moms women who enrolled before their baby was born (81.5%) than among those who enrolled after their baby was born (58.2%). The proportion of women who were grant recipients was higher among identified substance abusers with CD treatment during pregnancy (62.0%) than among those with no CD treatment during pregnancy (53.6%).

Summary:

Women who enrolled in Safe Babies, Safe Moms before their baby was born and those with CD treatment during pregnancy received more services than those without these prenatal interventions. They had more prenatal visits, began prenatal care sooner, received MSS more frequently, and received a cash grant more often.

Table 20
CHARACTERISTICS FOR CHILDREN WITH SUBSTANCE ABUSING MOTHERS

	Safe Babies-Safe Moms				All Other Identified Substance Abusers 2000-2001			
	Program Entry After Baby Born (N=215)		Program Entry Before Baby Born (N=94)		No CD Treatment During Pregnancy (N=2,466)		CD Treatment During Pregnancy (N=1,498)	
Child-Based Outcomes								
Number of Infants								
Born Dead (Fetal Deaths)	0	(0.0%)	0	(0.0%)	20	(0.8%)	11	(0.7%)
Born Alive (Liveborn)	215	(100.0%)	94	(100.0%)	2,446	(99.2%)	1,487	(99.3%)
Neonatal Deaths	0	(0.0%)	1	(1.1%)	14	(0.6%)	5	(0.3%)
Post-Neonatal Deaths	0	(0.0%)	0	(0.0%)	7	(0.3%)	6	(0.4%)
Alive at 1 year	215	(100.0%)	93	(98.9%)	2,425	(98.3%)	1,476	(98.5%)
Infant Mortality Rate (per 1000)		**0.0**		**10.6**		**8.6**		**7.4**
No. Infants This Birth (liveborn)								
One (singleton)	211	(98.1%)	90	(95.7%)	2,375	(97.1%)	1,441	(96.9%)
Multiple Births (twins, etc.)	4	(1.9%)	4	(4.3%)	71	(2.9%)	46	(3.1%)
Birthweight* (grams)								
Very Low (<1500 g.)	2	(0.9%)	1	(1.1%)	69	(2.9%)	23	(1.6%)
Medium Low (1500-2499 g.)	31	(14.7%)	3	(3.3%)	250	(10.5%)	105	(7.3%)
Normal (2500+ g.)	176	(83.4%)	86	(95.6%)	2,049	(86.3%)	1,303	(90.4%)
Unknown	2	(0.9%)	0	(0.0%)	7	(0.3%)	10	(0.7%)
Total Low Birthweight	**33**	**(15.6%)**	**4**	**(4.4%)**	**319**	**(13.4%)**	**128**	**(8.9%)**
Mean Birthweight	**3,172**	**7lbs. 0oz.**	**3,279**	**7lbs. 4oz.**	**3,146**	**6lbs. 15 oz.**	**3,277**	**7lbs. 4oz.**
Gestational Age*								
Preterm Birth, < 28 weeks	0	(0.0%)	1	(1.1%)	39	(1.6%)	9	(0.6%)
Preterm Birth, 28 to 36 weeks	43	(20.4%)	17	(18.9%)	418	(17.6%)	181	(12.6%)
Term/ Post-Term, > 36 weeks	162	(76.8%)	70	(77.8%)	1,881	(79.2%)	1,224	(84.9%)
Unknown	6	(2.8%)	2	(2.2%)	37	(1.6%)	27	(1.9%)
Total Preterm	**43**	**(20.4%)**	**18**	**(20.0%)**	**457**	**(19.2%)**	**190**	**(13.2%)**
Mean Gestational Age	**38.3**		**38.5**		**38.2**		**38.7**	
Small for Gestational Age*								
Yes	34	(16.1%)	5	(5.6%)	317	(13.3%)	166	(11.5%)
No	171	(81.0%)	83	(92.2%)	2,013	(84.8%)	1,239	(86.0%)
Unknown	6	(2.8%)	2	(2.2%)	45	(1.9%)	36	(2.5%)
Five-Minute Apgar								
7 or lower	8	(3.8%)	5	(5.6%)	144	(6.1%)	77	(5.3%)
8	31	(14.7%)	8	(8.9%)	284	(12.0%)	173	(12.0%)
9	162	(76.8%)	73	(81.1%)	1,841	(77.5%)	1,139	(79.0%)
10	11	(5.2%)	6	(6.7%)	146	(6.1%)	85	(5.9%)
Missing	3	(1.4%)	2	(2.2%)	51	(2.1%)	24	(1.7%)
Accepted CPS Referrals**	N=203		N=82		N=2,167		N=1,291	
Birth to 1 year	113	(55.7%)	43	(52.4%)	981	(45.3%)	414	(32.1%)
Out of Home Placement	N=203		N=82		N=2,167		N=1,291	
Birth to 1 year	77	(37.9%)	31	(37.8%)	700	(32.3%)	308	(23.9%)

* Singleton Liveborn Births used in calculations
** The child was born at least 1 year prior to the end of our data, September 30, 2002.

Data Source: First Steps Data Base, Children's Administration Case And Management Information System

As displayed in Table 20, no significant differences associated with prenatal entry into Safe Babies, Safe Moms or CD treatment during pregnancy were observed for fetal mortality or infant mortality. Both fetal and infant deaths occur infrequently; thus the power of this study to detect differences for these measures was low because of the small number of births in the study.

- The low birth weight rate was much lower for infants whose mothers entered Safe Babies, Safe Moms before their baby was born (4.4%) than for those whose mothers enrolled after their baby was born (15.6%). This represents a 72% reduction in low birth weight. The low birth weight rate was also lower for infants born to identified substance abusers who received CD treatment during pregnancy (8.9%) than for those whose mothers had no CD treatment during pregnancy (13.4%). This represents a 34% reduction in low birth weight.

- The proportion of infants born prematurely (before the 37th week of gestation) was the same for infants whose mothers entered Safe Babies, Safe Moms before their baby was born (20%) than for those whose mothers enrolled after their baby was born (20%). The rate of prematurity was lower for infants born to substance abusers who received CD treatment during pregnancy (13.2%) than for those whose mothers had no CD treatment during pregnancy (19.2%). This represents a 31% decrease in prematurity.

- The proportion of small for gestational age infants was much lower for those whose mothers entered Safe Babies, Safe Moms before their baby was born (5.6%) than for those whose mothers enrolled after their baby was born (16.1%). The proportion of small for gestational age infants was slightly lower for those born to identified substance abusers who received CD treatment during pregnancy (11.5%) than for those whose mothers had no CD treatment during pregnancy (13.3%). For mothers who entered Safe Babies, Safe Moms before their baby was born, small for gestational age was decreased by 65%; for women who received CD treatment during pregnancy, small for gestational age was reduced by 14%.

- The proportion of infants with low Apgars (8 or less) at five minutes was lower for infants whose mothers entered Safe Babies, Safe Moms before their baby was born (14.5%) than for those whose mothers enrolled after their baby was born (18.5%). The proportion of infants with low Apgars was lower for infants of substance abusers who received CD treatment during pregnancy (17.3%) than for those whose mothers had no CD treatment during pregnancy (18.1%).

- The rate of accepted CPS referrals was not significantly different for infants whose mothers entered Safe Babies, Safe Moms before their baby was born (52.4%) and those whose mothers enrolled after their baby was born (55.7%). The rate of out-of-home placement was essentially the same for infants born to Safe Babies, Safe Moms women who entered the program before their baby was born (37.8%) and those whose mothers enrolled after their baby was born (37.9%).

- The rate of accepted CPS referrals was lower for infants born to identified substance abusers who received CD treatment during pregnancy (32.1%) than for those whose mothers had no CD treatment during pregnancy (45.3%). The rate of out-of-home placement was lower for children born to identified substance abusers who received CD treatment during pregnancy (23.9%) than for those whose mothers had no CD treatment during pregnancy (32.3%).

In summary, infants born to women who entered Safe Babies, Safe Moms before their baby was born and those born to identified substance abusers with CD treatment during pregnancy had better birth outcomes than those born to women who entered Safe Babies, Safe Moms after their baby was born and those born to identified substance abusers without CD treatment during pregnancy. Improved outcomes included birth weight, gestational age, size for gestational age and the five-minute Apgar. The greatest improvements were demonstrated in rates of low birth weight and small for gestational age: women who entered Safe Babies, Safe Moms before their baby was born had a 72% reduction in low birth weight, and

a 65% reduction in small for gestational age; women with CD treatment during pregnancy had a 34% reduction in low birth weight, and a 14% decrease in small for gestational age. Women with CD treatment during pregnancy also had a 31% reduction in prematurity. Low birth weight may be caused by either premature birth or small for gestational age birth. These findings indicate that the mechanism for the reduction in low birth weight for Safe Babies, Safe Moms clients is primarily through a reduction in the proportion of infants who were small for gestational age. For women with CD treatment during pregnancy, longer gestational ages (reduced prematurity) contribute more to the reduction in low birth weight.

DISCUSSION

The Safe Babies, Safe Moms pilot projects have faced many challenges during three and one-half years of operation. Foremost has been the challenge to meet the profound and complex needs of the clients the program is intended to serve. While many clients were lost to follow-up or were known to have relapsed into abuse of alcohol or other drugs (and one mother died), many clients also achieved remarkable progress. It is difficult to imagine how these women could have begun to resolve their issues with Child Protective Services (CPS) or criminal justice systems without effective treatment for chemical dependency and the help of a professional case manager.

The Client Needs and Services Provided chapter in this report describes women entangled in a web of rules, regulations, and laws that are often incomprehensible to clients and with which they are unable to comply. While becoming drug-free and sober, clients needed extensive and sophisticated help from case managers to extricate themselves from the power of these systems. Successes like reunification with children previously removed from the mother's custody or reinstatement of the client's drivers license seem out of reach for the typical client without the guidance and advocacy of her case manager.

Case managers also faced challenges of professional boundaries, both maintaining appropriate distance from clients while actively providing services and bridging boundaries with service providers from other professional disciplines. These challenges were ongoing throughout the study period. Our prior report, *Comprehensive Program Evaluation Project: Program Development and Implementation* (2001), described territorial issues and differing philosophies of professional disciplines involved in providing services to Safe Babies, Safe Moms clients.

A number of strategies were implemented to improve cross-system collaboration. Multi-disciplinary staff meetings were convened regularly, with the client in attendance when her progress was reviewed. Community meetings were held on a regular basis, with representation from relevant local service providers. Achieving consistent attendance from all disciplines was sometimes difficult, and this hampered problem solving. The State Team was available for consultation and resolved many issues informally. The vertical nature of different administrations within DSHS limited the success of informal resolution in some cases; in these situations, State-level program managers sought to clarify roles and responsibilities by establishing written Memoranda of Understanding between the Safe Babies, Safe Moms program and regional or local administrators. Case managers and line staff then had a clearer understanding of the expectations of cross-system collaboration in this program. More than two years, with persistent dedication from the program manager, were required to establish signed Memoranda of Understanding with local or regional administrators of Economic Services Administration and Children's Administration at all three sites. With minimal leadership and direction from executive management from within DSHS, completing the Memoranda of Understanding was a challenging, time-consuming, and formidable task.

Maintaining quality performance by local Safe Babies, Safe Moms providers also proved to be a challenge. At one site, the contract for Targeted Intensive Case Management (TICM) was re-bid and a new provider selected at the end of the first year and a half of the project. At another site, the contract for management of the Chemical Dependency (CD) treatment facility was re-assigned after nearly three and one-half years of operation. While the disruption in client services was minimized, these transitions were nevertheless challenging. The new providers' staff required training and orientation to program philosophy and protocols.

The challenges in establishing contracts with providers whose performance met quality standards are countered by the outstanding performance of current providers. Overall, the dedication, flexibility, responsiveness, and creativity demonstrated by the current providers have been remarkable. The curricula produced by TICM providers represent a well-developed resource, based on substantial investment. The skills and knowledge of the case managers will be an on-going resource to their communities. The

dedication of the TICM providers is particularly remarkable as the continuation of the Safe Babies, Safe Moms program was in jeopardy on two occasions due to uncertain availability of funds to support the program. While funding uncertainties resulted in client anxiety, some staff turnover, and additional training needs, all the TICM agencies continued serving clients and were available to continue their contracts once funds were made available.

A key aspect of quality performance was the ability and willingness of local service providers to implement the program as designed. Competent program administration and charismatic leadership were the hallmarks of successful local agencies. Local providers were expected to adopt the conceptual model of the Safe Babies, Safe Moms program both philosophically and in practice. An unresolved conflict arose with a provider of housing support services, a resource in scarce supply. Faith-based values prevented one service provider from attending State Team meetings when family planning services and avoiding unintended pregnancy were discussed. While providers were not required to attend State team meetings, the provider's unwillingness to attend State Team meetings when the agenda included discussion of family planning services calls into question this provider's support of their clients' use of safe and effective family planning methods, other than abstinence.

The goal of the Safe Babies, Safe Moms program is to help support clients to become more functional family units, to be financially independent, safe, healthy, and drug- and alcohol-free. The amount of time elapsed since clients enrolled is still relatively short, so longer-term program outcomes are not yet available for analysis. Children born to Safe Babies, Safe Moms clients are healthier, based on improved birth weight. The low birth weight rate of children whose mothers enrolled in Safe Babies, Safe Moms before their baby was born (4.4%) decreased by 72% when compared to children whose mother were enrolled after their baby was born (15.6%). This decrease in the low birth weight rate was more than twice the decrease (34%) seen in a similar analysis comparing low birth weight for children whose mothers received prenatal treatment for chemical dependency (without TICM) (8.9%) and children of substance abusers who did not receive prenatal CD treatment (13.4%).

Similar improvements were observed for the proportion of infants born small for gestational age: a 65% reduction in small for gestational age associated with prenatal enrollment in Safe Babies, Safe Moms, and a 14% reduction associated with CD treatment during pregnancy. Women with CD treatment during pregnancy also had a 31% reduction in premature birth. Improved birth outcomes suggest these infants will have lower risk of health problems associated with low birth weight and will incur lower medical care costs during infancy and early childhood.

Specific reasons for the improved birth outcomes associated with TICM and CD treatment provided by the Safe Babies, Safe Moms program, compared to CD treatment alone, remain to be explored. One possible explanation might be that Safe Babies, Safe Moms clients were not as high risk as other substance abusing pregnant women in Washington, and thus were more responsive to services. However, comparison of the risk profiles of the clients does not support this hypothesis. Safe Babies, Safe Moms clients appeared to be somewhat higher risk than the typical pregnant substance abuser.

In fact, such a large reduction in low birth weight rate, a primary outcome measure for many programs designed to serve this population, has been reported in other studies. One study found that the magnitude of the reduction in low birth weight was proportional to the amount of CD treatment received: the greater amount of CD treatment, the greater the reduction in low birth weight (Daley et al., 2001). Such a model suggests that the reduction in low birth weight seen among Safe Babies, Safe Moms clients may have occurred because the clients received more services. This possible explanation does not consider, however, the philosophical differences between TICM and CD treatment.

TICM and CD treatment are different types of service, and these differences may be important in achieving the outcomes observed. TICM follows a non-punitive model, often referred to as a harm reduction model. While clients could be (and were) discharged from CD treatment for non-compliance

and rule violations, TICM agencies were not to discharge clients from services (unless a physical threat to the case manager was perceived). Case managers saw themselves as active advocates for their clients, across multiple systems and life issues, a very different primary role from most CD treatment staff. Other research also supports the role of the harm reduction model in improving outcomes for pregnant substance abusers (Nadelmann et al., 1994; Kumpfer et al., 1998).

In addition, some mothers who enrolled in Safe Babies, Safe Moms before their baby was born received TICM for some time before they were able to enter residential CD treatment. While the support and advocacy provided by TICM may offer sufficient nurturing to encourage normal growth of the fetus, residential CD treatment is a drug- and alcohol-free environment including room and board. CD treatment during pregnancy may achieve a reduction in prematurity by requiring clients to be drug- and alcohol-free and providing a safe environment. A harm reduction model, such as that offered by TICM while clients were on wait lists for residential treatment, may achieve improved birth outcomes through a different mechanism.

The most likely explanation for the dramatic improvement in birth outcomes associated with the Safe Babies, Safe Moms program is that typically clients received both CD treatment and TICM. Case managers helped clients enroll in CD treatment programs, to remain in treatment, and to follow through with aftercare. With increased resources, CD treatment was available to more clients. Before, during, and after CD treatment, case managers provided guidance and advocacy to help clients become financially independent, safe, healthy and drug- and alcohol-free.

While the finding of improved birth outcomes for infants of Safe Babies, Safe Moms clients enrolled before their baby was born is robust and shows that program enrollment was associated with better health status of newborns, program impact in two other key areas was modest or minimal. No significant difference was observed in the rate of accepted CPS referrals or out-of-home placement for Safe Babies, Safe Moms clients enrolled before their baby was born compared to those enrolled after their baby was born. CD treatment during pregnancy was associated with a nearly thirty percent reduction in both referrals and placements, compared to rates for identified substance abusers who received no CD treatment during pregnancy. The most likely explanation for the absence of a reduction in CPS referrals for Safe Babies, Safe Moms clients is that these clients received considerable scrutiny both from their case managers and other community providers. Case managers are mandatory reporters of child abuse and neglect, and regular multi-disciplinary staff meetings may also have contributed to more referrals in the short-term. Out-of-home placement may have been voluntary, to permit the client to focus on treatment for chemical dependency, or other issues.

The second area with modest program impact was use of effective family planning methods. Anecdotal evidence suggests that this outcome is related to the CPS outcomes because many clients choose to have another baby after they have lost custody of a prior child. Despite the efforts of case managers and other providers to provide education and counseling about family planning methods, findings from administrative data and the case histories described in the Client Needs and Services Provided chapter both showed modest increase in use of more effective family planning methods. Many clients have long histories of involvement with CPS, and, based on this experience, they do not see the benefit of long-term birth control. More progress in recovery from chemical dependency, individual responsibility, and personal growth, and more time, may be necessary to observe substantially greater use of family planning methods by these clients.

In addition, some client needs were very difficult to meet with available community resources. The need for long-term, safe, drug-free housing for these women and their children exceeded available housing resources. Subsidized housing was unavailable to many clients because of prior felony convictions. One TICM agency, recognizing the specialized skills needed to make the best use of available housing, designated a housing specialist who offered a group session on housing once a week. As well, this agency located funding to provide additional housing resources. The need for affordable childcare also exceeded

available resources. Clients with open CPS cases were not permitted to provide childcare for other clients so they could not share this responsibility. TICM agencies offered childcare services while clients participated in group activities.

An important limitation of this evaluation at this point in time is the short duration of follow-up and amount of time for data collection and analysis of outcomes other than immediate birth outcomes. Although the costs of state-level administrative data are relatively low compared to data collection by local providers, and administrative data is more objective than client self-report, each administrative database has time lags between the occurrence of events and the availability of corresponding data in the database. Data for two full years of follow-up was possibly available only for clients enrolled in the first year of the pilot project (2000). For clients enrolled in the third year (2002), the duration of follow-up was six months or less. Life changes of the magnitude sought by this project are very difficult to achieve and to measure with such short follow-up.

CONCLUSION

The Safe Babies, Safe Moms program was funded through a budget proviso that directed DSHS to develop and implement comprehensive programs for alcohol- and drug-abusing women and their young children. Funds were used to increase the availability of chemical dependency treatment, to implement new services called Targeted Intensive Case Management, and to enhance housing support services. The design of program services was based on program goals outlined in the 1999 DSHS-DOH *Report to the Legislature: A Comprehensive Program for Alcohol and Drug Abusing Mothers and Their Young Children (Response to RCW 13.34.803).*

Comprehensive services are offered through the Safe Babies, Safe Moms program by a triad of core service providers:

- A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site. TICM provides referral, support, and advocacy for substance abuse treatment and continuing care. TICM assists clients in accessing and using local resources, and TICM agencies provide behavioral health services, parenting education, and child development services.

- Long-term residential treatment for chemical dependency provides a positive recovery environment with structured clinical services. Qualified addiction treatment personnel provide a planned regimen of patient care in a 24-hour live-in setting. While mothers are in residential treatment, therapeutic childcare is provided for their children. Clients may also participate in outpatient CD treatment.

- Housing support services offer up to 18 months of housing for women and children in a transitional house. Recovery support and linkages to community-based services are also provided.

Our previous report, *Comprehensive Program Evaluation Project: Program Development and Implementation* (2001), identified factors critical to the successful implementation of the pilot projects. These factors included preliminary planning among service providers, conducting staffings, and holding community meetings; the importance of the team approach; leadership for community providers and program staff; sufficient flexibility in administrative structures to integrate the program model; location of CD treatment, housing units, and TICM agencies in the same community; and involvement of community partners in program development. These factors all serve to improve or enhance communication among the service providers. Successful program development and implementation were attributed to the communication that takes place every day between and among the service providers and the State team.

Several components of the Safe Babies, Safe Moms program have been identified as critical features, key to its successful outcomes:

- Cross-system collaboration was implemented in the coordination of services to individual clients by holding regular multi-disciplinary staff meetings with the client in attendance. As well, community meetings of local providers facilitated problem solving of system issues.

- A strong and varied specialized behavioral health curriculum was developed by TICM agencies in response to identified client needs. Classes addressed basic life skills and personal development, and individual counseling was provided to augment other community resources and when those resources were not available to individual clients.

- Discretionary funds were used to support basic client needs. The availability of these funds saved case managers' time, offered incentives to clients to remain active in the program, and supplied

some basic needs for goods at critical times. Discretionary funds were felt to reduce relapse into prostitution, drug trafficking, and other criminal activities.

- The need for parenting education was met at two sites by adopting an established curriculum that was flexible and comprehensive.

- While CD treatment providers advocate a very structured approach to treating chemical dependency, including defined rules and sanctions for violating those rules, TICM was based on a harm reduction model of service provision, and clients were maintained in the program despite periods of relapse or non-compliance.

The basic design of the program and these key components were implemented successfully, and the Safe Babies, Safe Moms pilot projects achieved the following accomplishments:

- Three pilot sites served 453 substance-abusing women from January 2000 through June 2003. Services provided to clients included:

  - TICM: An average of 7 hours per month of targeted intensive case management for 14.5 months in active status (on average) for 442 clients (who agreed to participate in research).
  - CD treatment: An average of 3.5 months (108 days) of residential CD treatment for 189 clients who had completed or exited treatment as of March 31, 2003.
  - Housing support services: An average of 7.4 months (224.4 days) of housing support services for transitional housing for 61 clients who had exited housing support services as of March 31, 2003.

- Case managers identified an average of 7.5 (of 12) major needs per client. Each major need represented a significant life challenge. More than 80% of clients were reported as having each of the three most frequent needs:

  (4) Achieving and maintaining abstinence from drugs and alcohol,

  (5) Stabilizing mental health problems and improving behavioral health issues, and

  (6) Developing a healthy alcohol/drug-free social support system.

- Case managers helped clients to enroll in CD treatment programs, to remain in treatment, and to follow through with aftercare.

- Case histories revealed that clients were entangled in a complex web of rules, regulations, and laws administered most prominently through the criminal justice system, child protective services, and WorkFirst. With the guidance and advocacy of the case manager, many clients were able to comply with the requirements of these systems, avoid further penalties, and achieve successes like reinstatement of the client's driver's license and reunification with children previously removed from the client's custody.

- Working agreements (Memoranda of Understanding) were established between the Safe Babies, Safe Moms programs and regional or local administrators. These agreements clarified roles and responsibilities of staff in different agencies and organizational units and made explicit the expectations for cross-system collaboration in day-to-day activities.

One outcome in particular demonstrates improvement in the health status of infants born to clients enrolled in Safe Babies, Safe Moms. For pregnant women who enrolled in the program before their baby was born, the rate of low birth weight (4.4%) was reduced by 72%, compared to the low birth weight rate

for infants whose mothers enrolled after the baby was born (15.6%). The decrease in the low birth weight rate was more than twice the decrease (34%) seen for infants born to women who received prenatal treatment for chemical dependency compared to infants born to identified substance abusers without prenatal CD treatment. The mechanism for reduction in low birth weight was primarily through reduction in infants small for gestational age. Additional outcomes will be reported in a subsequent report scheduled for completion in December 2003.

By increasing communication between service providers, developing cross-system collaboration, and implementing a comprehensive program consisting of Targeted Intensive Case Management, treatment for chemical dependency, and housing support services, the Safe Babies, Safe Moms program achieved the first steps in meeting its goal to help clients become more functional family units and to be financially independent, safe, healthy, and drug- and alcohol-free.

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