

Washington State First Steps News

A Newsletter for Maternity Support Services & Infant Case Management Providers

Issue 13

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The Value of Spacing Pregnancies

Submitted by Chris Knutson, Nurse Consultant and Joyce McCollough, Site Consultant, Family Planning and Reproductive Health, DOH

Women want to know when it is most safe to be pregnant. When pregnancies occur—their timing and spacing—is crucial to healthy mothers and healthy babies.

An analysis of 67 international studies* involving more than 11 million pregnancies worldwide has concluded that millions of infant deaths could be avoided with better family planning.

Spacing babies too close together raises the risk of complications like premature birth and low birth weight. Women can maximize their chances of having healthy babies by spacing their pregnancies *at least* 18 months apart.

For each month under 18 months between pregnancies, the risk of premature birth increases 1.9 percent. Pregnancy and nursing use up nutrients in a woman's body, and for a woman to get pregnant again before she has a chance to recover nutritionally may mean high risks for the baby.

Ninety-five percent of women do not want another child within two years of giving birth. Yet only 40 percent are using a birth control method. First Step providers are in a unique position to educate women about spacing their pregnancies and using a birth control method. Modern birth control methods are very safe for most women. Statistically, all birth control methods are safer than carrying a pregnancy to term.

Encourage women to talk to a health care provider about which birth control method is best for them. Your clients can find free or low-cost family planning services in most communities. Men and women can get services at both.


Any woman who had Medicaid coverage during her pregnancy is eligible for a year of family planning services after her pregnancy ends. At the end of that extended year of services they can apply for the TAKE CHARGE family planning program for uninterrupted access to family planning. For the number of the nearest family planning clinic, clients can look in the yellow pages under Birth Control or call the Family Planning Hotline at 1-800-770-4334.

*Published in *The Journal of the American Medical Association* April 2006. 



Did You Know?

The First Steps Family Planning Performance Measure training has been successfully converted into an online training and is now accessible on the Department of Health SmartPH website. The course contains three modules. The first includes detailed information about the history and value of performing the First Steps Family Planning Performance Measure. The second module focuses on enhancing motivational interviewing skills, including two 4 minute videos demonstrating client centered interventions. The third is a comprehensive overview of up-to-date family planning methods.

To access the training, contact your agency First Steps Coordinator for registration instructions. 



**LOOK for an article on
Birth Control Methods
For New Mothers
in the next issue of
First Step News.**



From the First Steps Database: County Profiles in Print and on the Web!

Submitted by Laurie Cawthon, MD, MPH, Research and Data Analysis.

The newest report from FSDB, **County Profiles: Birth and Unintended Pregnancy Statistics, 1990-2006** (Report Number 9.91), is available on the DSHS Research and Data Analysis website at <http://www1.dshs.wa.gov/rda/research/9/91.shtm>. To obtain a hard copy of this report, call (360) 902-0707, or send email to Nora Ellsworth at ellswnm@dshs.wa.gov. Please include the name of the report, the report number, your name and your mailing address.


This report, the fifth in its series, presents birth and unintended pregnancy statistics for each of the 39 counties in Washington State. These data include selected demographic and pregnancy-related indicators obtained from vital statistics, Medicaid administrative records, and PRAMS survey data collected on a sample of women who gave birth. This report describes maternal characteristics, births, and abortions by the woman's county of residence. This is the first in the series of County Profiles published by RDA to include the numbers and types of obstetric providers who attended births that occurred in the stated county.

Key findings at the state level include:

After a stable period during the 1990s, the number of births to Washington women increased by 9% from 2002 to 2006. Medicaid-funded deliveries topped 40,000 for the first time and represented 47.1% of deliveries statewide. The largest growth in Medicaid deliveries occurred among Non-Citizens. In some counties, the increase in deliveries to non-citizens was particularly striking

- Prenatal care access has declined since 2002, reflected by both decreases in first trimester prenatal care entry and increases in late (*third trimester*) or no prenatal care. Medicaid women continue to have lower rates of first trimester entry than higher-income non-Medicaid women.
- Declines in prenatal care access appear to be tied to increasing workload for obstetric providers. While the number of births increased by 9% from 2001 to 2006, the number of obstetric providers has decreased by 13% during the same time period. Consequently the average number of deliveries attended by OB providers has increased 27%, from 40.4 deliveries per OB provider in 2001 to 51.2 deliveries per OB provider in 2006.

Potential strategies to improve prenatal care access and obstetric provider supply are discussed.

Send your comments or questions about the **County Profiles** to fsdb@dshs.wa.gov. 



MSS Behavioral Health Specialist Credentialing Changes

Submitted by Becky Peters, Behavioral Health Consultant, DOH

During the last legislative session, legislation passed that impacts Behavioral Health Specialists who are currently credentialed as Registered Counselors. The following summary provides an overview of the legislation. Most MSS Behavioral Health Specialists who are currently registered counselors will fall under the agency affiliated category. Individuals who are independent contractors with MSS agencies as Behavioral Health Specialists will need to be Licensed, Licensed Associates or Certified Counselors. Agency Affiliated Counselor qualifications are established by the regulating program, in this case First Steps. The qualifications for BHS will not change in terms of education, experience, and supervision at this time. Please contact Becky Peters by phone at (360) 236-3532 or email her at Rebecca.peters@doh.wa.gov.





Summary of Key Provisions of 2SHB 2674 Registered Counselors Credentialing Bill

Effective Date:	Most of the bill is effective July 1, 2009. This means that most registered counselors need to continue to register in the same way they have been through June 30, 2009. Until July 1, 2009, the current rules remain in force, with a few exceptions. Two changes that occur when the bill takes effect June 11, 2008, are related to peer counseling and continuing education.
Elimination of Registered Counselor Credential:	After July 1, 2009, the Department of Health (DOH) will no longer issue Registered Counselor credentials. Registered Counselor credentials are abolished July 1, 2010.
New Credentials That Will be Issued:	<p>Starting July 1, 2009, credentials from the Department of Health for staff who are currently registered counselors under this act will be:</p> <ul style="list-style-type: none"> • Agency Affiliated Counselor • Licensed Social Work Associate – Advanced • Licensed Social Work Associate – Independent Clinical • Licensed Mental Health Counselor Associate • Licensed Marriage and Family Therapist Associate • Certified Chemical Dependency Professional Trainee • There will also be two new private practice credentials, Certified Counselor and Certified Adviser.
Agency Affiliated Counselor:	<p>This credential is for persons engaged in counseling and employed by an agency or facility operated, licensed, or certified by the state of Washington, and who are not otherwise credentialed. Applicants must provide satisfactory documentation that they are employed by an agency or have an offer of employment from an agency. Agency Affiliated Counselors will be required to notify the department of health if they are either no longer employed by the agency identified on their application or are now employed with another agency, or both. Agency Affiliated Counselors may not engage in the practice of counseling unless they are currently affiliated with an agency. As of July 1, 2009, Agency Affiliated Counselors will no longer need to provide disclosure information to clients, as that requirement will pertain only to Certified Counselors and Certified Advisers.</p> <p>As the law is currently interpreted, most MSS Behavioral Health Specialists will fall into this category. Exceptions will be those who are independent contractors. The State MSS team will continue to set the qualifications and experience requirements for the MSS Behavioral Health Specialist and have input into continuing education and supervision requirements. Independent contractors will need to meet the credential requirements for another credential as well as those imposed by the MSS BHS position.</p>
Associate:	This is for prelicensure candidates who have a graduate degree in a mental health field under RCW 18.255.090 and who are gaining the supervision and experience necessary to become a Licensed Independent Clinical Social Worker (LICSW), a Licensed Advanced Social Worker (LASW), or a Licensed Mental Health Counselor (LMHC). Associates must work under the supervision of an approved supervisor, and must provide a form disclosing their associate status during the first professional contact with a client or patient. If an Associate License lapses, the individual must submit an updated declaration that s/he is working toward full licensure.
Certified Chemical Dependency Professional Trainee:	This is for individuals working towards the education and experience requirements for certification as a Chemical Dependency Professional (CDP). The trainee must submit a declaration that s/he is actively pursuing the experience requirements to be a CDP. Practice must be under the supervision of a CDP. The first 50 hours of face to face contact must be under direct observation. A trainee certification may only be renewed 4 times.
Certified Counselor and Certified Adviser:	There is significant tightening of education requirements and scope of practice for these private practice credentials, with some provision for “grandfathering” registered counselors who have been practicing at least 5 years. See sections 4, 7, and 8 of bill 2SHB 2674 for more detailed information on grandfathering. Certified Advisers will not be allowed to treat clients with a GAF < 61. Certified Counselors can treat clients with a GAF < 61 under a plan of treatment referred by a physician, psychiatric ARNP, or licensed MHP. A Certified Counselor could not be the sole practitioner for a client with a GAF < 50.
Peer Counseling:	The bill adds peer counseling to the list of counseling that is exempt from the provisions of this chapter of RCW. Peer counseling is defined as “the practice of counseling by peer counselors who use their own experience to encourage and support people with similar conditions or activities related to the training of peer counselors.” Peer counselors who limit themselves to this practice are not required by this law to have a credential from the Department of Health. They are still required to be certified by the Mental Health Division for their services to be billable under Medicaid. The Mental Health Division is currently reviewing their requirements for certifying peer counselors.
Elimination of Registered Counselor Credential:	After July 1, 2009, the Department of Health (DOH) will no longer issue Registered Counselor credentials. Registered Counselor credentials are abolished July 1, 2010.



For more information about this topic and others affecting the counseling professions visit the DOH websites:

Registered Counselor https://fortress.wa.gov/doh/hpqa1/hps7/Registered_Counselor/default.htm

Licensed Mental Health Counselor https://fortress.wa.gov/doh/hpqa1/hps7/Mental_Health_Counselor/default.htm

Licensed Social Worker https://fortress.wa.gov/doh/hpqa1/hps7/Social_Worker/default.htm



Native American Women's Dialog on Infant Mortality Mobilizing American Indian/Alaska Native Communities to Respond to the High Infant Mortality Rate

Submitted By Leah Henry-Tanner (Nez Perce), Native American Women's Dialog on Infant Mortality (NAWDIM) Coordinator

The infant mortality rate of a community is used as a benchmark in evaluating community health. The Native communities of Washington State experience an infant mortality rate that is disproportionately higher than the general population. Since a community's infant mortality rate measures community health, it is important to address the stressors that cause the community to be unhealthy. As indigenous peoples, we need to recognize that the continuing impact of colonialism has caused our communities to be extremely stressed and dangerously unhealthy.



NAWDIM's work focuses on the need to address oppression and the impact of racism in American Indian/Alaska Native (AI/AN) families that lead to poor birth outcomes. Its analysis of oppression centers on the continuing impact of colonialism, racism, sexism, and class inequality in indigenous communities. The goal is to mobilize AI/AN people of Seattle-King County to address the high infant mortality rate by providing information to the communities and engaging in critical dialogue. Our motto is: Healthy Women and families create strong communities, strong communities create powerful Nations, and powerful Nations protect our sovereignty.

NAWDIM was formed in March 2001 when American Indian/Alaska Native women were brought together by Public Health – Seattle & King County and Intra Afrikan Konnections to learn about the high infant mortality rate in the AI/AN community of Seattle & King County. The AI/AN women were from state and local agencies and community based organizations. The women took their concerns to Dr. Alonzo Plough, then – Director of Public Health – Seattle & King County and were able to secure funding from his office. A community organizer/ **NAWDIM** coordinator was hired to direct the project in December 2001.



NAWDIM, United Indians of All Tribes Foundation, Intra Afrikan Konnections, and Public Health Seattle-King County collaborated in initiating a community action project to address infant mortality in the AI/AN community. A grant from the Office of Minority Health enabled the **NAWDIM** coordinator to develop a popular education strategy by offering classes in cradleboard making and education on infant mortality and SIDS in indigenous communities to 50 women in the summer of 2003. The classes were facilitated and issues related to poor birth outcomes were identified and discussed. Class participants were encouraged to share their own birth stories and the issues/stressors they faced. Many class participants reported how empowering the opportunity was and that it helped lead to healing.



Last year **NAWDIM** received a grant from the CJ Foundation for SIDS to continue this successful method of reaching AI/AN women and families and is working with the Urban Indian Health Institute and Seattle Indian Health Board to recruit participants. **NAWDIM** is also currently working with the SIDS Foundation of Washington to organize additional cradleboard making classes in the Puget Sound area.

While funding for **NAWDIM** from the Office of Minority Health ended in late 2004, the collective continues to meet and plan activities to educate and mobilize the AI/AN community. The SIDS Foundation of Washington has supported **NAWDIM** by funding its work in 2005 through the High Risk Initiative. In 2006 **NAWDIM** received a grant from the CJ Foundation for SIDS. Additionally, the Portland Area Indian Health Board provided funding for **NAWDIM's** strategic planning activities in September 2006. The **NAWDIM** collective continues to seek funding to support its work and develop a funding strategy during the strategic planning process.

Current **NAWDIM** partners are: Urban Indian Health Institute, Seattle Indian Health Board, Public Health – Seattle & King County, SIDS Foundation of Washington, United Indians of All Tribes Foundation, and concerned community members. One of **NAWDIM's** founding mothers is Emma Medicine White Crow, who serves on the Governor's Interagency Council on Health Disparities.

- The **NAWDIM** coordinator participates in a Perinatal Periods of Risk (PPOR) workgroup organized by the Urban Indian Health Institute. Other participants in this effort include staff from Public Health – Seattle & King County, NW Portland Area Indian Health Board, and Oregon State Department of Health. This group came together to look at a deeper analysis of the health and poor birth outcomes for AI/AN women because in spite of the decline of the overall infant mortality rate, the rate for this constituency continues to be significantly higher compared with the general population. This disparity has not shown improvement in the last 10 years and may in fact be widening. This information is important to American Indian/Alaska Native families because the PPOR approach can identify gaps in the community, target resources, and assist in mobilizing the community to lower the infant mortality rate. An analysis has been conducted for Washington State and the group is working on a regional analysis that includes Idaho and Oregon. The findings of the Washington State PPOR analysis have been shared with community members, tribal government officials, and allies. For more information about the Washington State and regional PPOR analysis or to arrange for a presentation, please contact Shira Rutman at the Urban Indian Health Institute, (206) 812-3030, or email to shirar@uihi.org.



Washington State Division of Alcohol and Substance Abuse - Pregnant & Parenting Women (PPW) with Chemical Dependency Issues

Submitted By Sue Green, Family Services Manager, Division of Alcohol and Substance Abuse, HRSA, DSHS

What does DASA* offer?

- Chemical dependency treatment for women that includes the families, especially the babies and toddlers.
- Intervention for a pregnant chemically dependent woman, which may *prevent a drug or alcohol exposed baby*.
- Intervention for a chemically dependent woman which may *prevent an unintended pregnancy*, and a drug or alcohol exposed baby.
- Priority access into outpatient and residential chemical dependency treatment services.
- Resources regarding Fetal Alcohol Spectrum Disorders (FASD)

PPW Residential Chemical Dependency Programs

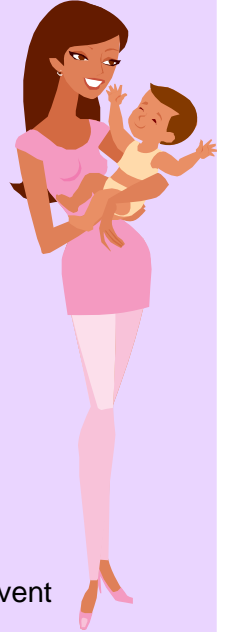
10 sites statewide, for a total of 153 beds

- Chemical dependency treatment services for pregnant, postpartum, and parenting women.
- Addresses the issues specific to women in relation to chemical dependency and their children.
- Service provision and length of stay is variable and is determined by the needs of the woman.
- Maximum length of stay is six months.

Therapeutic Childcare

Available in 9 of the PPW Residential Chemical Dependency Programs (130 slots)

- Developmental assessment
- Play therapy
- Behavioral modification
- Individual counseling
- Self esteem building
- Family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior
- Parent education and parenting plan



Chemical Using Pregnant (CUP) Detoxification

- DSHS funded inpatient hospital program for acute detoxification and medical stabilization of pregnant chemically dependent women and their fetuses.
- Provides both medical and drug/alcohol treatment services at pre-approved hospitals statewide.
- Available at:

Grays Harbor Community Hospital/Aberdeen	(360-533-8500)
Swedish Medical Center/Ballard	(206-781-6350)
Providence Medical Center/Everett	(425-258-7390)
Valley General Hospital/Monroe	(360-794-1405)
St. Peter Hospital/Lacey	(360-456-7575)

Outpatient Chemical Dependency Treatment Services

Many agencies provide specific services to meet the needs of PPW, which may include on-site or off-site childcare.

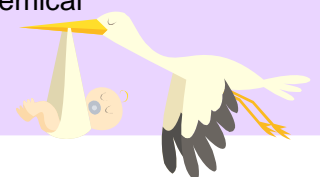
PPW Housing Support Services Programs

11 sites statewide, for a total of 149 support services slots

- Up to 18 months of housing support services for women who are pregnant, postpartum or parenting and for their children who reside in drug and alcohol free residences.
- These services are classified as support services, rather than treatment services.

Crisis Nurseries (Yakima County at <http://www.epicnet.org/> and King County at <http://www.childhaven.org/new/>)

- Crisis nursery services for children of parents with chemical dependency issues.
- Care for children birth through six years of age, while their parents participate in chemical dependency services.
- Includes both day childcare and respite care.



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Parent Child Assistance Program (PCAP)*

- King, Pierce, Yakima, Cowlitz, Spokane, Skagit, and Grant Counties, as well as the Spokane Tribe of Indians.
- 554 slots statewide.
- For the highest risk women who abuse alcohol and/or drugs during pregnancy.
- These women are not typically successful or effectively engaged with other community service providers.
- Paraprofessional advocacy services up to the target child’s third birthday.
- Identification and prioritization of realistic goals, steps to meet goals, and evaluation of progress towards goals.
- Referral to chemical dependency treatment, recovery, and follow-up, to include residential and outpatient treatment.
- Support for utilization of local resources.
- Provision of funds for food, unmet health needs, other necessities, and incentives as needed.

Safe Babies Safe Moms

- Snohomish, Benton-Franklin, and Whatcom Counties
- 270 slots statewide
- For the highest risk women who abuse alcohol and/or drugs during pregnancy.
- Comprehensive program that includes:
 - PPW Residential and Outpatient Chemical Dependency Treatment
 - PPW Housing Support Services
 - Targeted Intensive Case Management (TICM) up to three years.
- Intensive case management and behavior rehabilitative services for pregnant and parenting alcohol and drug abusing women.
- For women who have a history of multiple system involvement and need services of longer duration and greater intensity than women enrolled in or served by other resources.
- Children of these women may suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their home, communities, and other settings.



Parent Trust*

- Family support groups for families recovering from chemical dependency.
- Uses a family support philosophy and creating community networks with family support agencies in participating communities.
- Develop and maintain *Families in Recovery* groups, which provide family support and skills development with specific focus on the parenting and family issues of recovering families.
- Available in most of the PPW residential chemical dependency treatment programs.

Fetal Alcohol Syndrome Diagnostic and Prevention Network (FASDPN)*

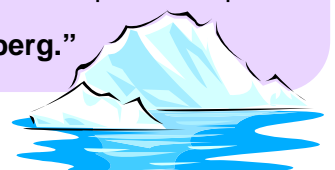
- Community and Professional Training – University of Washington
- Regional Network Site Training (*Spokane and Pullman*)
- Trainings include:
 - Fetal alcohol related diagnosis;
 - The roles in providing complex intervention needs for individuals diagnosed with fetal alcohol related issues;
 - How to identify birth mothers of children diagnosed with prenatal alcohol damage and assist them in avoiding subsequent fetal alcohol exposed births by referral to existing alcohol treatment and/or family planning programs.



Iceberg Newsletter

Iceberg is a quarterly international educational newsletter on FASD (*Fetal Alcohol Spectrum Disorders*) published by the Fetal Alcohol Syndrome Information Services (FASIS), a parent/professional partnership.

“Because the problems we readily see are only the tip of the iceberg.”



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Fetal Alcohol Syndrome Family Resource Institute (FAS*FRI)*

- This service provides the citizens of the State of Washington a service dedicated to improving the lives of children and families impacted by fetal alcohol exposure.
- This service is provided from the viewpoint of parents who have been directly affected by fetal alcohol exposure, whether they are birth, adoptive, foster, grand, or step parents.
- Training
- Advocates
- Information and resources 1-800-999-3429



Fetal Alcohol Syndrome Interagency Workgroup (FASIAWG)

- Established by the Legislature in 1995
- Legislatively mandated state agencies that attend:
 - DSHS (DASA, CA, HRSA, JRA, DDD, MHD)
 - DOC
 - OSPI
 - DOH
- The state agencies listed above executed an interagency agreement to ensure the coordination of identification, prevention, and intervention programs for children who have fetal alcohol exposure, and for women who are at high risk of having children with fetal alcohol exposure.
- A process for community advocacy groups to participate in the review and development of identification, prevention, and intervention programs administered or contracted for by the agencies executing the agreement.


How to Access Services

- Direct admission into PPW Residential or CUP sites
- Can access through an ADATSA Assessment Entity
- PPW Resource Guide at <http://www1.dshs.wa.gov/pdf/hrsa/dasa/PregnantWomenGuide.pdf>
- 24 Hour Alcohol/Drug Helpline at 1-800-562-1240

***Websites**

DASA	http://www1.dshs.wa.gov/DASA/
DASA Greenbook (directory of all DASA certified programs statewide)	http://www1.dshs.wa.gov/DASA/services/certification/GB.shtml
FASDPN	http://depts.washington.edu/fasdpn/
FASD Center for Excellence	http://www.fascenter.samhsa.gov/
FAS*FRI	http://www.fetalalcoholsyndrome.org/
Iceberg Newsletter/FASIS	http://www.fasiceberg.org/
Parent Trust	http://www.parenttrust.org/
PCAP	http://depts.washington.edu/fadu/
Washington State Alcohol/Drug Clearinghouse	http://clearinghouse.adhl.org
Washington State Fetal Alcohol Spectrum Disorders (includes FASIAWG)	http://www.fasdwa.org

Additional Information, contact:

Sue Green
 Family Services Manager
 Division of Alcohol and Substance Abuse
 360-725-3732
greensr@dshs.wa.gov 




Navigating DSHS – A Resource

The Department of Social and Health Services has created a booklet to assist in providing clients with information about various DSHS services. This booklet can be downloaded from the website and will be a valuable resource for First Steps staff!

You'll find the PDF file at

<http://www1.dshs.wa.gov/geninfo/pubs3.html#zero> .

The publication number is DSHS 22-1199. 



WorkFirst Pregnancy to Employment


Submitted By Stacey Bushaw, WorkFirst and Social Services Prog. Mgr, Community Services Division/ESA, DSHS

Every pregnant woman or parent(s) with a child under the age of one year is eligible to participate in the Pregnancy to Employment (P to E) pathway. The goal is to allow parents to learn how to work, look for work, or prepare for work while still meeting the family's needs. The P to E Pathway provides a way for parents to:

- Build a healthy family relationship,
- Prepare them for engagement in WorkFirst activities while assuring the family's medical and other needs are addressed, and
- Become self-sufficient.

As passed by the 2007 Legislature, Second Substitute Bill 6016 changed the good cause infant exemption by allowing parents with an infant under the age of one year to be exempt for up to 12 months in a parent's lifetime. The bill also added language that directs the department to mandate mental health, chemical dependency, domestic violence and parenting skills.

- On July 22, 2007, we implemented **Phase One – 12 Month Lifetime Limit** was implemented by:
 - ✓ Exempting parents with a child under the age of one year from WorkFirst participation requirements for up to 12 months in a parent's lifetime if the parent chooses to claim the exemption.
 - ✓ Eliminating all reference to the one-time, part-time exemption clients previously had for one child between the ages of 4 and 12 months.
- On February 1, 2008, the following **Phase 2 – Pregnancy to Employment Pathway Redesign** policy changes were implemented:
 - ✓ Mandatory participation in mental health and/or chemical dependency treatment for up to 20 hours per week if the parent's assessment identifies these issues even if the parent is:
 - In the third trimester of pregnancy.
 - Claiming the infant exemption.
 - Claiming the 12-week postpartum deferral period.
 - ✓ Allowing a 12-week postpartum exemption period to parents with an infant between 0-12 weeks of age who have already used their 12 months in a lifetime infant exemption.
 - ✓ Imposing sanctions if the parent does not participate as required in available mental health and/or chemical dependency treatment.

Each participant in the P to E pathway must participate in an assessment with the WorkFirst Social Worker (WFSW) to identify family needs including any potential issues such as mental health and/or chemical dependency, and determine which WorkFirst activities are appropriate. 

Moving Along: Good-Bye Mo

Submitted By Talia Baker, HRSA 

Please join me in sending our friend and co-worker Maureen Lally on to a new position with Aging and Disability Services Administration. She has been the First Step program manager position for Infant Case Management since 2004. Those of us who have worked with her at HRSA and DOH will dearly miss her calm demeanor, compassionate heart, and analytic mind.

We are especially grateful for her help in eliminating "The 20 Terrible Things" that have plagued our wonderful program. But we will have to let her go—Mo has a background working with aging adults and leaves us with anticipation of expanding her career. Maureen's last day with us will be July 18, 2008. So-long friend, and lots of luck along the way! 