Safe Babies
A Program of ZERO TO THREE™

Voices of Families:

Insights from Washington State Listening Sessions

ZERO TO THREE
Early connections last a lifetime

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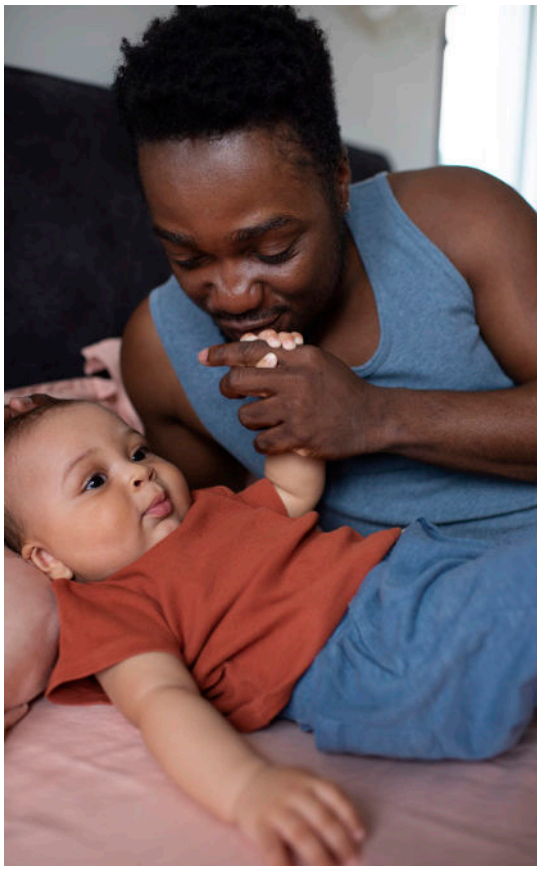
SUMMARY

In April and May 2024, parent leaders and staff from the Safe Babies National Resource Center at ZERO TO THREE conducted listening sessions with families living in Washington State. The listening sessions team consisted of two ZERO TO THREE parent leaders who had used substances while pregnant, State Innovation Specialist Erinn Havig (who previously worked for the Washington Department of Children, Youth, and Families [DCYF]), and the Clinical Manager for Substance Use Disorders and Parent Leadership. This work was funded by the Ballmer Group, requested by DCYF. There were multiple in-person opportunities (in order of occurrence) including families in the Seattle area (King County), Bremerton (Kitsap County), Port Angeles (Clallam County), Tacoma (Pierce County), Spokane (Spokane County), and Everett (Snohomish County). There was also an online virtual session including families from Puyallup and Ferry County.

Thirty-five parents participated in the listening sessions and were compensated for their time via Visa gift cards that could be used to benefit their families. Two of the participants were fathers. Approximately half of the participants shared information describing a diverse cultural heritage, although race, ethnicity, and gender were not formally collected. These identity aspects appear as descriptions in the quotes featured throughout this report, including information such as having to ask one's tribe for help.

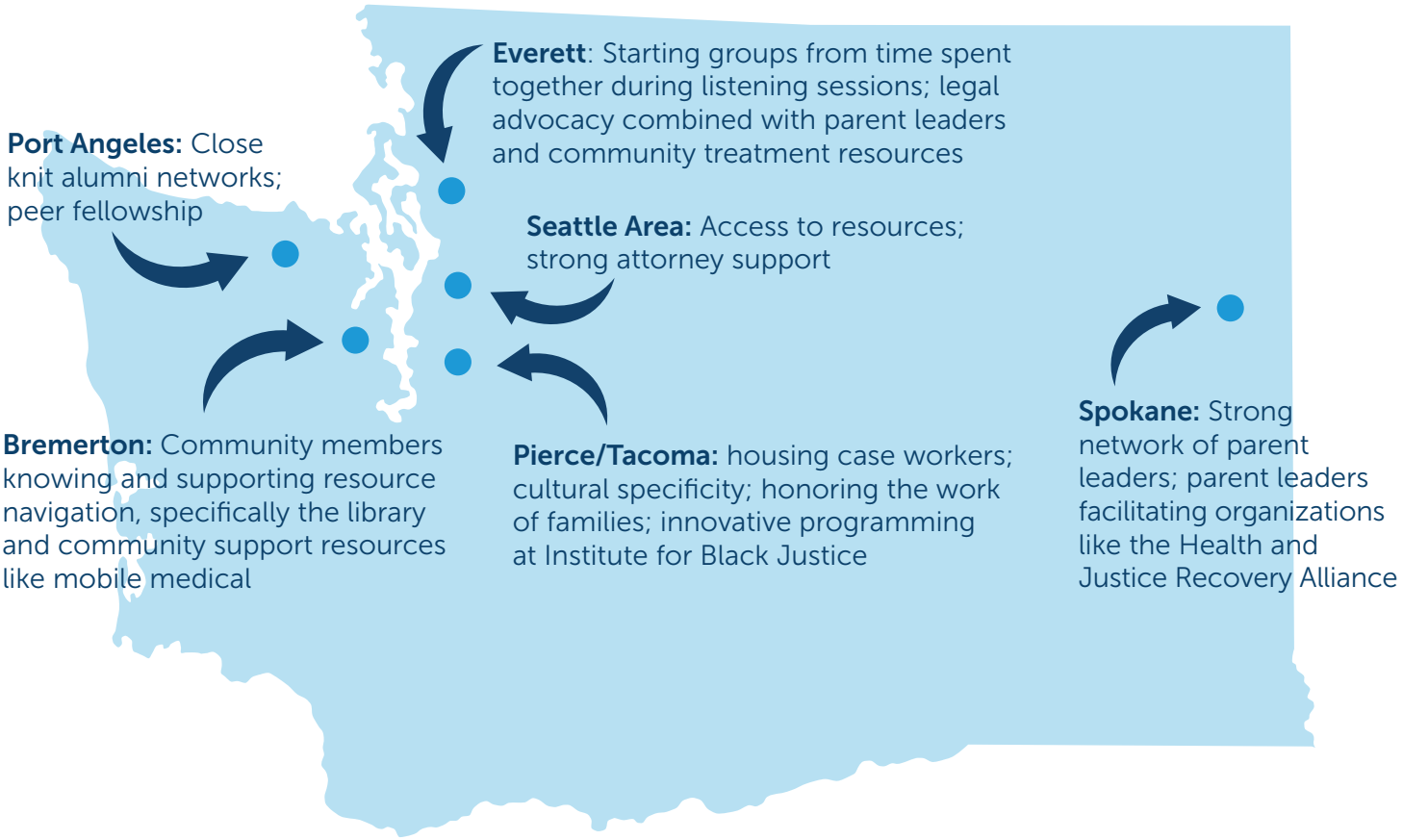


Outreach to identify listening sessions participants was conducted in multiple ways. The two most successful strategies involved a combination of known systems relationships and parent leader community outreach. Flyers were shared virtually in advance with many community organizations, specifically those that were part of the Perigee Fund's Community Collaboratives that Keep Families Together. Erinn Havig participated in that group during employment with DCYF and built relationships with

many of the agencies that were funded. Outreach efforts were also directed at various DCYF employees, Early Childhood Courts, Family Treatment Courts, the Office of the Public Defense, and others.

There was mixed attendance from systems providers, as well as several no-shows and cancellations. Because the listening sessions team already had dates scheduled in various locations, team members consistently reached out to parent leaders and agencies when nearby or in town to ask to be connected with families. The most robust and consistent responses occurred when parent leaders reached out to other parent leaders. When a listening session team had downtime between interviews and sessions, they explored local resources and asked questions about the community. For example, in Bremerton we had two cancellations so the team tried to walk the experience of families in navigating resources by going to the library, WIC office, Family Centers, and mobile medical clinics as well as NA meetings.

— Strengths From Each Community —



WHAT DID WE LEARN?

On the following pages are detailed descriptions of the key themes explored during the listening sessions. Each area describes a theme, provides key quotes, and includes some initial recommendations or resources.

— Key Themes —

1. Treatment Services

2. Health Care

3. Peer Support

4. Relationship with Child Welfare & Service Providers

5. Service Availability for All Families

6. Domestic Violence

7. Housing

AREA 1: Treatment Services

Access to and quality of treatment services was a major theme across locations (particularly access to treatment prior to DCYF involvement). Access to family treatment with partners and kids was a barrier. Access to detox services during pregnancy was described as risky and particularly difficult and was compounded for individuals with mental health diagnoses. The quality of services greatly varied. The service locations are often very far away, with limited transportation available. Gaps in post-treatment follow-up are difficult for families and may contribute to a return to substance use.

Key Quotes

> *"Quitting cold turkey was so difficult, but I couldn't get in anywhere."*
>
> — A Parent in King County

> *"I chose to do drug court. At my drug court graduation, someone who was supposed to be a treatment provider slipped a bag of dope into my hand. I spiraled from there."*
>
> — A Parent in an Urban Area

> *"I have trauma and can't get into treatment because of it. Anyone who uses drugs probably has trauma, so providers should not make that a barrier."*
>
> — A Parent in King County

> *"It's so important to remember that there are different pathways to recovery and for the system to respect that as a need."*
>
> — A Parent in Pierce

> *"Since graduating treatment, my entire focus is on just trying to stay clean and keep moving. I am all alone except for my baby. I have been using since I was 14. I need to learn how to feel and experience emotions without the drugs to numb it. It is scary to think of doing that with a new baby."*
>
> — A Parent in Pierce

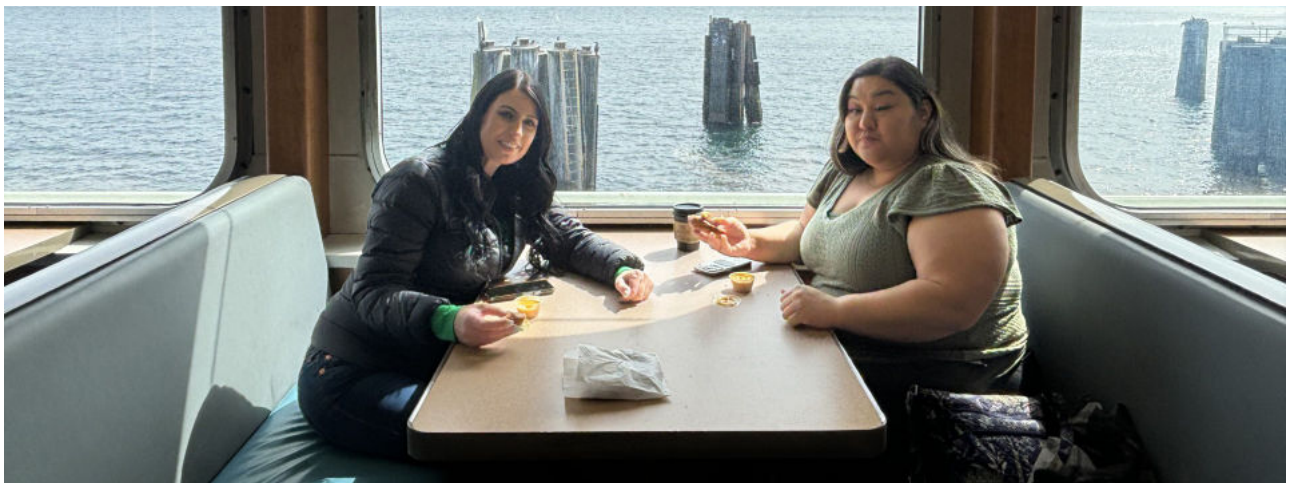
Recommendations

- **Collaborate with other statewide agencies like Health Care Authority and Department of Health to open additional treatment facilities, specifically those that can support pregnant mothers with dual diagnoses.** One example is the Meadowlark Initiative, Montana's comprehensive health system that supports American Indian families.[1]
- **Access additional resources for integrated health efforts,**[2] including a recent report by the National Council for Mental Wellbeing describes many integrated health efforts. Additionally, many states are utilizing the Certified Community Behavioral Health Clinics (CCBHCs) through the National Council to achieve integrated health efforts. Other programs are offering resources like "Intakepalooza" that is offered by Children's Wisconsin to have massive events of coordinated services for children's mental health. These could be replicated by having coordinated resource fairs that offer concrete supports and an opportunity to meet and have an intake with various providers.
- **Provide thorough aftercare services** in collaboration with other agencies, especially for those traversing communities.
- **Target efforts that improve the accessibility of care coordination and continuity at different levels.** One strategy is to add a question to contract start checklists that asks, "does this contract improve accessibility to care coordination or continuity" and having an open field for an answer. Planting the idea that this is important can be one lever for change thinking.
- **Contract with and offer detox and residential programs that serve pregnant mothers.** For example, one family spoke of having a contact at the shelter who remained with them throughout their journey to help navigate what was next and keep them grounded. This need could be fulfilled by a peer or recovery support role and help with the transition from active use to long-term recovery. There is fear of going to detox and not knowing what lies ahead, so having a plan for housing can be a big support for those going into treatment. Clean and sober houses can help provide post-treatment support.
- The window for opportunity for detox is key. It must be available when needed and accessible. In one case, there was no detox accessibility available for 34 weeks. Many listening session participants described believing that medical clinics are worried about the legal risk in treating them and that this is why they were not allowed to detox.
- With the recognition that impending birth may be a motivating factor for getting into treatment, one strategy might be to **target this population with things like**

1. The Meadowlark Initiative. (2023, January). *Evaluation 2022*. https://mthf.org/wp-content/uploads/Meadowlark-Evaluation_Jan-2023.pdf
2. National Council for Mental Wellbeing. (2024, July 23). *Advancing perinatal health care integration*, https://www.thenationalcouncil.org/resources/advancing-perinatal-health-care-integration

mobile ultrasound and connection to home visitors and doulas to help build the attachment of parents to their babies.

- With many parents describing finding out that they were pregnant during ER visits, another option might be **a partnership between a local detox facility and the hospital to provide delivery preparation and assistance.** This could help communities with fewer resources have more immediately available options for pregnant mothers.
- Several great organizations already exist throughout the state, and having an access point helps with the receipt and trust of services. The FIRST Clinic has an open door. The First Step Family Support Center also has an open-door policy, as well as a Parent- Child Assistance Program (PCAP). Strengthening the network between organizations can facilitate warm handoffs, and increasing funding to these types of organizations can provide a measure of hope to pregnant mothers in need of immediate help by meeting some of their concrete support needs. Using CAPTA or Title IV-B funding can help fund family support networks and provide families an initial connection.
- **Another option might be to replicate an effort like the helpline in Hawaii that offers initial screening and then prioritizes the pregnant population to access services.** Because it is a referral service, the program follows individuals until they get into treatment, with the goal of achieving the easiest access possible.
- **Add a training or community campaign to increase relational coordination for the social service and helping professionals population.** There could be a training or a community campaign to strengthen relationships – a quick 30-minute training that goes along with hanging fliers. This can include strategies like how to engage in a conversation and keep the person there while you get resources on the line. The relational aspect and how parents are treated helps reduce fear and stigma and increases the likelihood of engaging in services. This could be offered through Within-Reach to all service providers.



Safe Babies Parent Leaders Lindsay Calvari and Kim Nabarro on the WA State Ferry.

AREA 2: Health Care

There was feedback that OB-GYNs were disregarding or not even acknowledging the issues of pregnant mothers using substances, even when explicitly stated. Very few individuals spoke of positive experiences in obtaining support, reporting a lack of education about substance use disorder across all levels of health care – from support staff and reception to doctors to those in labor & delivery and the NICU.

Key Quotes

> *I felt judged and isolated."*
>
> — A Mom in Seattle

> *I signed forms for them to test my pee. They wouldn't treat me without me signing that form. So I know they tested it but they never said anything to me about it being positive."*
>
> — A Mom in Spokane

> *They told me to just come in whenever but that was not the case. I packed my bag, went to the ER, did a simplistic intake, and then they told me there were no beds and to come back tomorrow. If you are pregnant and using, you need a bed right now."*
>
> — A Mom in Everett

> *I used with three of my pregnancies, and I was scared to go to the doctor because I was using. Even when I admitted using in pregnancy, they just said, 'Okay, be careful.' At the clinic,a resource brochure would have been helpful."*
>
> — A Mom in Everett

> *Knowing what I know now, doula services would have been so helpful."*
>
> — A Parent in Spokane

> *I think my doctors knew. Were they scared or is it against HIPAA for them to say anything? With later pregnancies, I knew about PCAP and how to navigate them. It would have helped to have access to them."*
>
> — A Mom from Puyallup

Recommendations

- It was widely stated by parents that doctors and medical providers should openly address substance use during pregnancy. The difficulty and mistrust that is created when parents sign a form that acknowledges their urine will be tested and then have a doctor say nothing is confusing and adds shame at a time when they should be receiving help and support. Multiple moms stated that their doctors knew they were using and did not offer resources. This is a critical and key opportunity for action. **Connecting pediatricians to resources like Help Me Grow would be a positive step toward helping people who give birth navigate resources.**
- **Additional training for medical providers about having conversations with their patients is crucial.** One state that has done a lot of work in this area is Hawaii. Having peers with lived expertise in health care systems would be a great asset to engaging individuals struggling with substance misuse and assisting them with addressing treatment needs. One modality that might work is offering continuing medical education (CME) credits and tools that emphasize having a conversation with every pregnant mother about substances and sending home every patient with a resource list in small-card format (similar to the domestic violence conversations had during home visits).
- **Offer universal educational resources to providers, including a section on substance use during pregnancy.**

Parent leaders Lindsay Calvari and Kim Nabarro preparing for a listening session in Pierce County.

One suggestion is to have posters in medical exam rooms or cards with resources provided to every parent. It is also recommended to use a strategy of sharing resources for parents to take even if they deny use, so that they can share the resources with a friend.

- **Collaborate with agencies like Department of Health and provide health care providers with access to and training in harm reduction.** This may be an opportunity for applying or opioid settlement funding to address these specific populations.
- **Provide OB-GYNs and all other medical staff with training in the foundations of infant/early childhood mental health.** Examples include the benefits of naming and nurturing bonding and attachment, addressing mothers as mom, and using ultrasounds to build relationships. Also

provide education about mothers as experiencing substance use disorder rather than being the cause of harm. This creates an opportunity to understand and identify the role that a parent might want to have with their child.

- **Provide cross-collaborative training about Plans of Safe Care, using a peer navigator to have conversations that are engaging around supporting mothers and their babies. If all the hospital staff could be part of a Plan of Safe Care, they could serve as partners and not only as surveillance.** This includes making sure that plans include support and are actionable. There may also need to be a focus on learning how to recognize a family's strengths.
- **Access to a phone, transportation, and housing are frequent barriers, with a root in the social determinants of health. There may be ways to use a Medicaid Section 115 waiver to help address health-related social needs.**[3] Some states have had success in using waivers to pay for welcome baby boxes with food and diapers for 12 weeks postpartum (Delaware) or for diapers for children under the age of 2 (up to 200 diapers over 60 days in Tennessee).

Bremerton had a mobile Health Bus that could provide immediate medical services. Parking that day was near areas where many who experienced houselessness were staying and a short walking distance to a church offering additional social services. Providers that network like this provide seamless service and someone to stay with a pregnant person while waiting for the next step.

3. Orris, A., Bailey, A., & Sullivan, J. (2024, February 27). *States can use Medicaid to help address health-related social needs.* Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/states-can-use-medicaid-to-help-address-health-related-social-needs

AREA 3: Peer Support

Washington State has one of the most robust networks of peer support. Of particular note from the listening sessions is the belief that having a way to access peer support services prior to child welfare involvement would be the most accessible option for engaging families. In the state, there is already a peer support structure in place, which makes this an area of powerful strength. Peer support becomes the hope and holds the hope for families to receive a non-judgmental approach. Currently, the state's Parents for Parents (P4P) program cannot get involved until after child welfare involvement (specifically dependency) is established. It might be possible to use this robust and trained network to partner in new ways.

Key Quotes

> *"I wish there would have been more people with lived experience. I have had nine different social workers, and some were extremely difficult. They just kept saying, 'I am his legal guardian.' Being able to talk with another parent would have helped me not get so angry."*
>
> — A Parent in Port Angeles

> *"I need someone to see me, face to face. I need to see that someone else has done this to their baby and still gets to parent and can love their baby."*
>
> — A Parent in Clallam County

> *"My P4P advocate helped me be honest with my social worker. I thought I had CPS outsmarted."*
>
> — A Parent in Pierce County

> *"I skipped my shelter care hearing because I was so scared. I wish I had had a peer to talk to."*
>
> — A Parent in Spokane

> *"Having a P4P advocate helps so much. She explains exactly why CPS is adding stuff to what I have to do. She helps me figure out how not to get frustrated when my social worker says, 'You have to do such and such.' I know I have to. You don't need to keep saying it like that."*
>
> — A Parent in a Rural Area

> *"This is scary to think about. If someone with lived experience said it, though, it would be 1,000% better."*
>
> — A parent in Pierce County
> (after reading the proposed call script)

> *"An individual mentioned how she started a mom group to talk about the struggles she experienced. (Almost everyone in the focus group wanted similar experiences.)*

Recommendations

- **Peer support needs training and other supports to be a legitimate, well-paid field.** This should include recovery support and training like that provided for case managers. Peer supports could partner with PCAP or other outreach agencies like Within Reach.
- From the stories shared by participants, individuals who are struggling with perinatal substance use disorders are often judged within their own using community. **Provide people who give birth with opportunities to find peers with this shared experience** because it can be very powerful for seeing that change is possible.
- Oregon has peers in every field because the state prioritizes the peer workforce. This approach would require prioritizing a similar workforce, as well as training those already in the field.
- There is also a need for more facilitated and supported groups in this area to connect their own networks of support. This is a clear situation where you already have the workforce but may need to work on accessing them in a different way.
- Peer parents are also well prepared to enhance social connections to build protective factors, which may make prevention funding like CBCAP/CAPTA Part II a possibility. For example, parents stated that peers also invited them to meetings and knew/could tell when they had been using and would offer to take them to an NA/AA meeting without judgment.
- **Key places to add peer support specifically include WIC offices, OB-GYN offices, hospitals, and detox or treatment centers.** Recovery peer mentors in Oregon and the Makua Allies in Hawaii are two examples of this type of effort in other states.
- **Create peer job descriptions** around each role if roles can be expanded. Peer parents would require support around maintaining mental wellness, healing, and sobriety.
- **There should be information available about the benefits of the peer workforce.** The feedback from the Spokane area was very specific that there is a perception that peer parent roles are seen as competing and taking away jobs from social workers and other social service providers. Teaming approaches that emphasize the strengths of each perspective would help to alleviate this tension or to at least name it explicitly so it can be discussed.

Health Justice Recovery Center co-hosted a listening session at their Wellness Recovery Center in Spokane. The homelike environment and childcare provided allowed participants a level of comfort and on-going support.

AREA 4: Relationship with Child Welfare and Service Providers

Mandatory reporting requirements were reported as being intimidating and a barrier to parents accessing services. Also, while some parents had positive and respectful relationships with their DCYF workers, most reported extremely negative interactions with DCYF staff.

Key Quotes

> *CPS says I am supposed to do all of this on my own but what if we don't want to. My baby's father and I want to work together and eventually live together, but I'm afraid to tell the truth about that to any CPS worker."*
>
> — A Mom in Port Angeles

> *In an urban area, a parent described a very difficult birth, with her CPS worker saying someone would be back to check in on her later. However, the parent was then encouraged by hospital staff to go home and shower because the baby would have a NICU stay. After the parent left as directed, the hospital called the CPS worker back to say that the child had been abandoned. The parent tried to explain the situation to her CPS worker but was told they "had seen it all before" and that these were just "excuses."*

> *In a different urban area, a youth who had been in care and had her own social worker shared a story of having her mother with her in the delivery room. Within moments of the baby emerging from the new mother's birth canal, a male CPS worker entered the room to check in on her. The young parent described the fear coursing through her body and how she immediately started crying and yelling for her mom to come and take the baby so that CPS couldn't take the baby instead. The CPS worker said he was just checking in on her, but the young parent immediately felt like she was in trouble and reported significant fear about getting out of the hospital with her baby. The mom also disclosed that she had experienced sexual assault from a male a few years before getting pregnant, which may have aggravated her response.*

> *"The only person on my side was my dad, who has dementia. My social worker actually asked me, "Do you feel like we are bullying or intimidating you? Because then we can't allow you to relinquish." Of course I felt bullied! I was continually asked things like, 'What are you doing? You don't think we check your social media?' But I couldn't tell her that."*
>
> — A Parent in Spokane

> *"Be honest and don't surprise me during the Family Team Decision Making meeting. They had already decided to take my baby before the meeting started but I didn't know that. I thought we were there to talk about options but they had already decided."*
>
> — A Parent in a Rural Area

> *"Every time we finish something, they keep adding more services. I addressed the concerns that brought us in and they keep adding more!"*
>
> — A Parent in a Rural Area

> *"One parent in a rural area was pregnant and also had a two-year-old. She was using substances and experiencing significant domestic violence. She described a failed attempt to leave her partner, which resulted in significant bodily harm. When she went to leave again, her male partner returned home during her attempt. She was able to escape to a neighbor's home to call the police, who loaded her and the young child into a police vehicle to take to a shelter. She asked the police officer if she could get her stuff and her child's clothes/belongings and was advised that she could not "if she wanted to live." She was then reported to CPS and told one of the reasons they decided to place the child out of home was that she failed to provide adequate clothing and food. The mom was later reunited with her child but vowed to never trust the police or CPS again.*

> *"I wanted to feel human, not judged. I felt like a piece of shit by the system."*
>
> — A Listening Group

> *"Once they got the results from my UA, I could tell by how I was being treated. CPS talked to the medical staff about my baby like I wasn't even in the room. I wanted to eat, sleep, and console, but I need support too. It's hard to receive support if you don't even talk to or look at me."*
>
> — A Listening Group

Recommendations

There are no easy answers to these complex situations. The point of these listening sessions was to hear families' experiences and what might help and they shared their perspective openly. At the crux of this is the way people feel, and their likelihood to engage may be a place for some recommendations. These are some recommendations that might be used to help build a more trauma-sensitive response.

- **Access and support to trauma informed care training to all professionals who are fielding referrals.**
- **Provide training for mandatory reporters about ways that they can report and support.**
- **Direct DCYF to call parents by their names and use appropriate language regarding substance use.** (For example, saying someone's UA was "positive" for methamphetamine, rather than "dirty.")
- **Offer training from those with direct experience/empathy training.** This helps put a face to what is going on during painful moments for parents. Some panels like those previously conducted in Spokane might be useful in this situation.
- **Consider changing Mandated Reporting Policies and Practices.** One resource[4] is the Birth Parent National Network resource about mandated reporting.
- **Follow the example of the Florida PAUSE Framework** as a way to think critically, slow down, and engage families to talk about their needs. As DCYF develops the Community Pathway, this could be a natural opportunity to incorporate well-being and engaging families to talk about their needs.

The First Step Family Support Center in Port Angeles provides diapers and many other supports and concrete supports to families. Having stickers like this directly on packages of diapers makes it easy for families to find their phone number.

- **Build common knowledge around Plans of Safe Care.** If medical providers were more aware of the social worker role and the tools that CPS uses, maybe medical staff could identify strategies more effectively. (It often feels like once CPS is involved, there is a big "X" on the door of helping.)
- Keep teaching moms and parents all about newborn care, and help develop additional plans around the process of explaining how and why to parents.
- **Provide access to in-home services that offer coordinated support before and after CPS becomes involved.** Examples include IHBS home builders in Hawaii and in-home Family, Safety, Risk, and Permanency services in Iowa. Consider expanding existing family preservation

4. What Parents Say About Mandated Reporting.pdf

services in Washington to increase slots and availability. This might be done through utilization of Child Parent Psychotherapy with the Mental & Behavioral Health Team at WithinReach for example.

- **Provide DCYF investigators with training on age-appropriate questions.** Several parents were asked how they discipline their baby. As they had just given birth, this question felt frustrating and unanswerable. This may be part of the question-gathering process to explore parental disciplinary practices, but parents may need help applying this to their newborn, especially if they are a first-time parent.
- **Adopt a disease mindset with substance use disorder.** Several parents described feeling like they just needed to stop using and not being able to do so on their own, followed by spiraling into feelings of worthlessness. Use new trainings in motivational interviewing to help families identify, recognize, and make a plan. This may be useful for DCYF investigators.

AREA 5: Service Availability for All Families

Parents across the state mentioned that service availability and access were barriers to entering into services. For example, many dads were able to access treatment while their partner was pregnant, while the person who gave birth was not able to do so. Depending on the location, services were available but varied in quality. For example, Everett had multiple services available for medication-assisted treatment and detox, and the proximity to Seattle meant access to additional care, while participants in more rural areas were limited to one provider and often completely cut off from their support systems. There were also very few options available for whole-family treatment, with barriers including having to choose which child/children to take along to treatment.

Interpretation of policy was another area where differences were noted. HB 1227, the Keeping Families Together Act, was explicitly brought up at two Western Washington locations. Participants in the Spokane regional area said they wished there was some type of policy to prioritize providing supports to keep families together. This might represent a difference in the interpretation and application of policy.

A family room at the Family Support Center in Port Angeles. This setting created calm and focus to meet with families.

Key Quotes

> *The baby's dad got to go to treatment, but due to a COVID outbreak and me being pregnant, I wasn't allowed to go along."*
>
> — A Mom in Port Angeles

> *I was able to access treatment through my tribe but had to disclose the domestic violence going on to get access. They were great and set everything up but they could only pay for 30-day detox and nothing after. What was I supposed to do after?"*
>
> — A Mom in Spokane

> *If you want to go to treatment, you have to find a place for your kids. There are some facilities that exist but only if your children are under the age of 5. I had a 13-year-old, a 3-year-old, and a 1-year-old."*
>
> — A Mom in Spokane

> *My biggest problem was insurance. I needed in-patient but Medicare was my primary due to disability and they would not approve my treatment. Medicaid was my secondary, and I finally got treatment after navigating all that. It's only easy to get services if you are normal. I had a diagnosis of PTSD, pregnant, and using, and no one would see me."*
>
> — A Mom in Clallam County

> *The hospital told me to just come in whenever but that was not the case. I packed my bag, went to the ER, did a simplistic intake, and they told me there were no beds now and to come back tomorrow. If you are pregnant and using, you need a bed right now. START was really good but I had to wait a long time. Even when I was 32 weeks and one day, they would not take me until I had two days clean."*
>
> — A Mom in Everett

Recommendations

- **Prioritize funding pregnancy-related treatment services, including universal access to MAT and detox services.**
- **Pilot a few family-based treatment providers where whole families can receive treatment and support together.** (Key Recovery was mentioned a few times as a center where whole families received support.)
- Continue to clarify policy and check in on implementation across the state. One potential is to partner with P4P or other parent leaders to help explain the changes that are happening with HB 1227 and what it means for early access to services.

AREA 6: Domestic Violence

Recurring themes in the interviews conducted were that of domestic violence being co-presenting. Little was mentioned about any services known to be available, especially outside of CPS involvement. It was noted that CPS often would keep children from reunifying without the willingness of mothers to separate from their abusers. Moms also discussed not understanding the dynamics of domestic violence or understanding how common it is, especially in connection with substance use. Multiple interviewees discussed unwillingness to leave their abusers, especially while in a vulnerable state such as pregnancy.

Key Quotes

> *I needed treatment for our whole family. I tried with their dad. He changed when doing pills."*
>
> — A Parent in Eastern WA

> *When I left, I didn't have access to a license, ID, insurance, etc., and I couldn't get these items without money or resources." (One individual shared her story of going to the high school she graduated from to get a copy of the yearbook to prove her identity.)*
>
> — A Parent in Clallam County

> *Attempting to leave takes a lot of planning and sneaking around. One parent reported that she took her son out of the car seat and started walking down a dirt road. The baby's father caught her, beat her badly, and took the child to another location.*
>
> — A Parent in Clallam County

> *With domestic violence and drug use, they will take my kids, so it limits reaching out. I wanted someone to sit with me on the sidewalk and treat me like a human."*
>
> — A Parent in Spokane

> *When police respond, they can be tricky, which creates problems with trust. In one situation the police said, "Whoever has the kids keeps them." They asked the father to bring the kid outside to get a look at him and then removed the child and gave him to the mother. The sheriff then took the baby and brought both parents to a shelter.*
>
> — A Parent in Pierce County

Recommendations

- **Screen pregnant moms for domestic violence** (not in presence of their partner). There are excellent practices within Washington home visiting programs and in partnership with the Washington State Coalition Against Domestic Violence that could be replicated or prioritized for pregnant and substance using populations.
- **Offer services to partners.** While this is rarely a permanent fix, most victims are unable to leave their perpetrating partners, especially during pregnancy. Providing services for the family and the perpetrating partner would allow for oversight until the person harmed feels ready to leave. One parent shared that the only help she was allowed to take was rent and food but that it let her build a relationship with someone outside of her home.
- **Provide clearer paths and access to domestic violence advocates, possibly including having advocates at community events or playgroups.**

AREA 7: Housing

Themes regarding access to housing that is affordable, safe, and meets the need of the family size were consistent across various communities. The additional fear expressed by parents about losing their child due to housing was another common theme. During the listening sessions, we heard feedback regarding short-term solutions for housing assistance. However, challenges with being able to sustain the cost of housing once a short-term program ended was prevalent. In some situations, families were left with no other option than to live with other family members due to the cost of living and housing availability. A challenge is that not all individuals have safe family or friends to stay with. This can cause additional concerns to maintaining custody and/or supporting reunification. Another concern was that housing programs are often located in neighborhoods where there are more frequent rates of substance use.

The Safe Babies team attending the graduation at Institute for Black Justice. We were able to partner with the agency to provide listening sessions in groups and individually before and after graduation.

Key Quotes

> *Housing was my hardest barrier. I was so embarrassed to have relapsed. Oxford and PCAP saved me."*
>
> — A Parent in Port Angeles

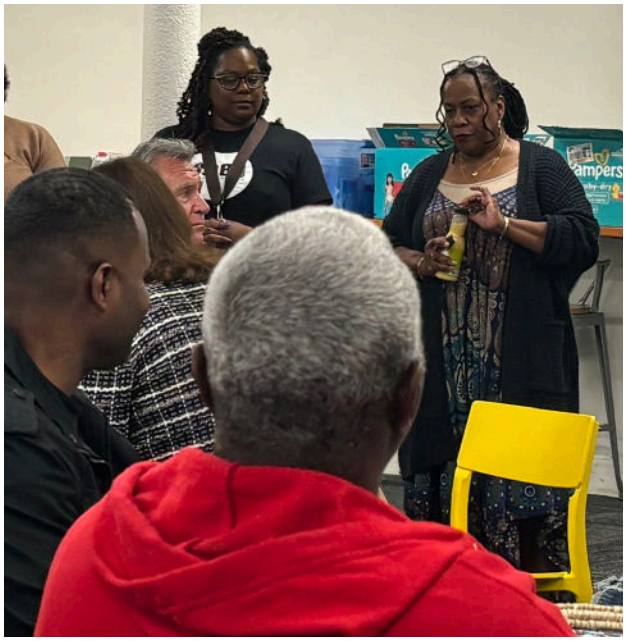
> *The case manager at True Hope was persistent. She worked every day on finding housing for my partner, our baby, and me. The case manager came and visited me in the hospital after I had my baby. She treated me like a person."*
>
> — A Parent in Pierce

> *I have been trying to get housing for six years on my own. I can't get anything under $900. My current apartment is $1,200 for a one-bedroom that is like 400 square feet."*
>
> A Parent in Pierce

> *I didn't want to get mixed up with fentanyl. The whole neighborhood felt infested. Even when I was buying drugs, I would go to Bremerton and I spent tons on fentanyl test strips to make sure I avoided it but sometimes I wondered if it could be in our food or drinks in the shared housing fridge."*
>
> A Parent in Clallam

Recommendations

- Increase access to Family Unification Program vouchers and prioritize enrollment for families into programs like ECEAP that have family self-sufficiency supports.
- Providing incentives to housing programs that are able to maintain clean and sober facilities may increase safety.
- When family and friends are the only choice, **help parents create a safety plan and provide access to harm-reduction supports** (e.g., lockboxes, Narcan, fentanyl testing strips).



Institute for Black Justice staff at their CHIMEs graduation.

OVERALL RECOMMENDATIONS

Families participating in the listening sessions said the thing that would help them the most would be to feel treated as human beings, which they described as being looked in the eye, being communicated with clearly and directly, having their names used, and being given space to think before answering questions. The parent leaders from ZERO TO THREE who were conducting the sessions highlighted in a debrief with staff that meeting families where they are and keeping in mind that people are often in survival mode could also be helpful.

Following models like domestic violence advocacy work and motivational interviewing that allow pregnant mothers to have some agency in meeting their basic needs could be one way to build relationships to dive deeper into some areas. Recommendations included offering services and supports for meeting basic needs as a way to open the door, offering application support and service navigation support (e.g., getting a cell phone, WIC, TANF, Medicaid, housing), or even offering food/drink, hygiene assistance, clothing, camping/shelter items. This exhibits a level of understanding of their experiences and current reality that helps foster achievable goals. Another recommendation was to provide information about such issues as personal rights and pregnancy, as well as resources for preparing parents to raise their children.

Parents also said they feel most comfortable talking with other parents. The ZERO TO THREE parent leaders were able to start listening sessions with a very brief overview of their history, which included the message that they want to listen and that they also used during their pregnancies and are not here to judge. This created an instant rapport. Almost every group we talked to suggested having an outreach person with firsthand experience who will "sit on the curb with you." Due to the nature of relationships and outreach efforts, many parents who participated came from organizations with strong community orientation, which often included staff with lived experiences. These were the resource people called out as being most able to recognize the early signs that someone is in trouble, and the people who created accountability and deep support systems that lasted beyond the time of CPS involvement.

To increase the engagement of pilot participants, open and repetitive engagement is recommended. Multiple participants recommended starting with universal tools like a resource card that is available to every OB-GYN/doula, CSO worker, family center, and WIC office that outlines the basics of services. If a trusted person is providing the

number, it is easier to call. If you receive the same information multiple times, it keeps it present.

During initial calls, offer concrete and tangible resources like diapers, food, rental assistance, maternity clothing, insulated water bottles, or care package with hygiene items. Other resources like mobile showers and mobile medical clinics are also greatly appreciated. Providing newborn baby clothes, sleep sack, or baby box items might be a way to acknowledge the parenting journey. Even a safe and secure file folder for gathering important baby-related documents, like birth certificates and any prenatal appointment paperwork of a medical nature, would be helpful.

Some parents expressed a particular preference for text messaging options, noting that if they don't recognize a number, they are not likely to answer a call. Parents noted that it feels like a flood of information on a phone call as opposed to sitting and reading a text.

We recommend texting first and following up with a phone call. We also recommend having a trusted partner make an introduction whenever possible. This includes attorneys, other parents, and culturally based service providers like the Institute for Black Justice and PCAP workers.

Specific to scripting, most parents immediately reacted to the partnership with DCYF/CPS with several commenters chuckling/laughing and stated that in no way would they respond to someone who was in partnership with DCYF. Because the nature of this pilot is a partnership with DCYF, handling that relationship must be done carefully. A balance between being open/transparent and describing the exact nature of the relationship is key. For example, "We know it can be scary to have a call from an agency that is working with CPS, and we would like to be clear about exactly what we share with CPS and what we do not need to share."

Diaper bank shelves at the First Step Family Support Center in Port Angeles.

A couple parents said that anything that feels like it involves collecting information from you at the beginning is off-putting. For example, when calling 211, parents reported that they would have to answer more than 10 questions before receiving a number that they had already found through a basic Google search. Several participants said that even hearing the phrase "gathering information" would make them hang up due to fear of CPS. Making the questions and the reasons for asking them clear is a helpful strategy. Additionally, provide supports in making resource connections by working alongside and engaging families in a problem-solving approach that is person-centered. **Strategies that are responsive to families' concrete needs are strongly recommended.** For example, consider adding the following language to client outreach text messages after the original script:

- *This is _____ from WithinReach: Help Me Grow. WithinReach can help you connect to important resources like food and diapers during your pregnancy and after the birth of your child. Is there a good time to call to speak with you?* (Describe HMG as connecting to resources to support them in their pregnancy)
- *"We would like to help you learn about newborn care during pregnancy, and how home visiting could be beneficial."*
- Start with, *"We are excited to hear about your pregnancy,"* instead of only providing a service description.
- *"We can connect you to diapers, medical support, etc."* (Then describe who you are.)

To increase enrollment in voluntary prevention services, **we recommend employing peer parent supports to talk directly with referred pregnant mothers.** Parents were very explicit in the listening sessions that they worry about what others think about them and feel less judged if it is another parent that also used a substance during their pregnancy. In places where parents were able to connect with peer support, they felt seen, heard, and hopeful. If a peer is employed by the outreach agency, the scripts can be similar but they take on a new meaning. It opens different communication and understanding by starting with, *"I am with Within Reach: Help Me Grow Washington as a parent with the lived experience of using substances while I was pregnant and I am here to talk and help you connect to any resources you are looking for (food, medical, etc.)"*

Another recommendation is along the policy spectrum. Parents from multiple counties said they could not obtain peer support until their shelter care hearing. In exploring this area, we learned that Revised Code of Washington 2.70.080 defined the starting point. With all the changes that are happening throughout Washington with the Thriving Families Initiatives, the Keeping Families Together Act, and the upcoming transitions with the Family First Prevention Services Act, **we recommend requesting a policy change to allow P4P peer support to happen further upstream. Additionally, we recommend that the pilot agencies partner with P4P to have additional contract hours to provide support to the identified target clients (pregnant and using substances) with a livable wage salary for P4P staff.** This firsthand experience piece is a strength in Washington State and being able to partner further upstream is rewarding to people who give birth and families, peers and staff, and the system at large.

Because we had parent leaders asking the questions and facilitating with support from other staff, there were some additional conversations and insights. One parent leader suggested asking parents participating in the listening sessions to share what their friends and smoking circle told them about CPS while they were pregnant. Answers included, *"Have a home birth to avoid CPS;" "Don't tell CPS anything;" "They get money to take your baby;" "If you quit now, it will kill your baby;" "Your baby is going to come out deformed;"* and *"As long as you stop the day before giving birth, your UA won't show anything."* One participant described a friend who didn't go to the doctor and overdosed her baby during pregnancy at seven months and then had to be induced to deliver her dead fetus. The fact that such comments have been made about CPS in different ways over the years emphasized to the listening sessions team a need for peer-to-peer education in changing these dynamics and responses. This led to several of the recommendations about providing a resource list in case your friend needs it or hiring a well-compensated and supported peer support field.

As the sessions evolved, the parent leaders also began asking what online searches parents had conducted while pregnant. Several of the parents said they had Googled such search terms as *"pregnant & treatment," "pregnancy with drugs,"* and *"fentanyl & pregnancy."* These terms could be specifically used in marketing and on websites to increase the likelihood of finding them or sponsored search results if funding was made available.

The conversations with fathers were also uniquely insightful. These participants were asked for more details about what they thought and how they behaved during pregnancy. Many fathers played a role in supporting their partner's substance use. Due to shame around using while pregnant, some fathers described preferring to be the one to take all the blame and do all the arranging of getting drugs to use together. This sometimes let couples hide the pregnancy longer, which was often desired because "there is a lot of reporting on each other in the using community." Other fathers encouraged their partners to stop using and tried to help them locate services. This may be a potential additional pathway. Both male and female participants indicated that male

partners were willing to allow access to services (e.g., housing, food, medical, treatment) and were often an important ally in making that happen. Pursuing this pathway with the Fatherhood Council might lead to some additional resources and strategies. Partnering with fathers could also help with some of the typical barriers seen from dads in this group that match other studies. These include providers talking to fathers, asking questions about their goals and how they are doing as parents, and making them feel welcome. Fathers also struggled with feelings of guilt and being new to parenting. One dad described being sent to the store to "get stuff for the baby" and getting the wrong size of everything and that his first baby "came out all slimy and gray" and how he felt immediate guilt and shame that they had messed the baby up with their use.

There is one final area that needs to be mentioned in this report. Because the listening sessions team was interviewing people who all had personal journeys of substance use during pregnancy, there were many moments of tenderness and vulnerability that persist to this day with these families. Approximately 30% of participants shared statements like, *"Even if you get clean, your child can still come out damaged;" "I have one daughter who is blind and I ask myself every day if it was the domestic violence or not getting clean that did it;"* and *"I feel judged when I ask my pediatrician about my toddler's behavior because I know they are thinking it is all my fault."* There are so many opportunities to focus on building protective factors with families who are exiting the child welfare system and who only have light touches with or have been screened out by the system. This could prevent future referrals for struggling to parent a high-needs child because parents are embarrassed to ask for help. Expanding the service continuum to more families could also help with this effort.

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