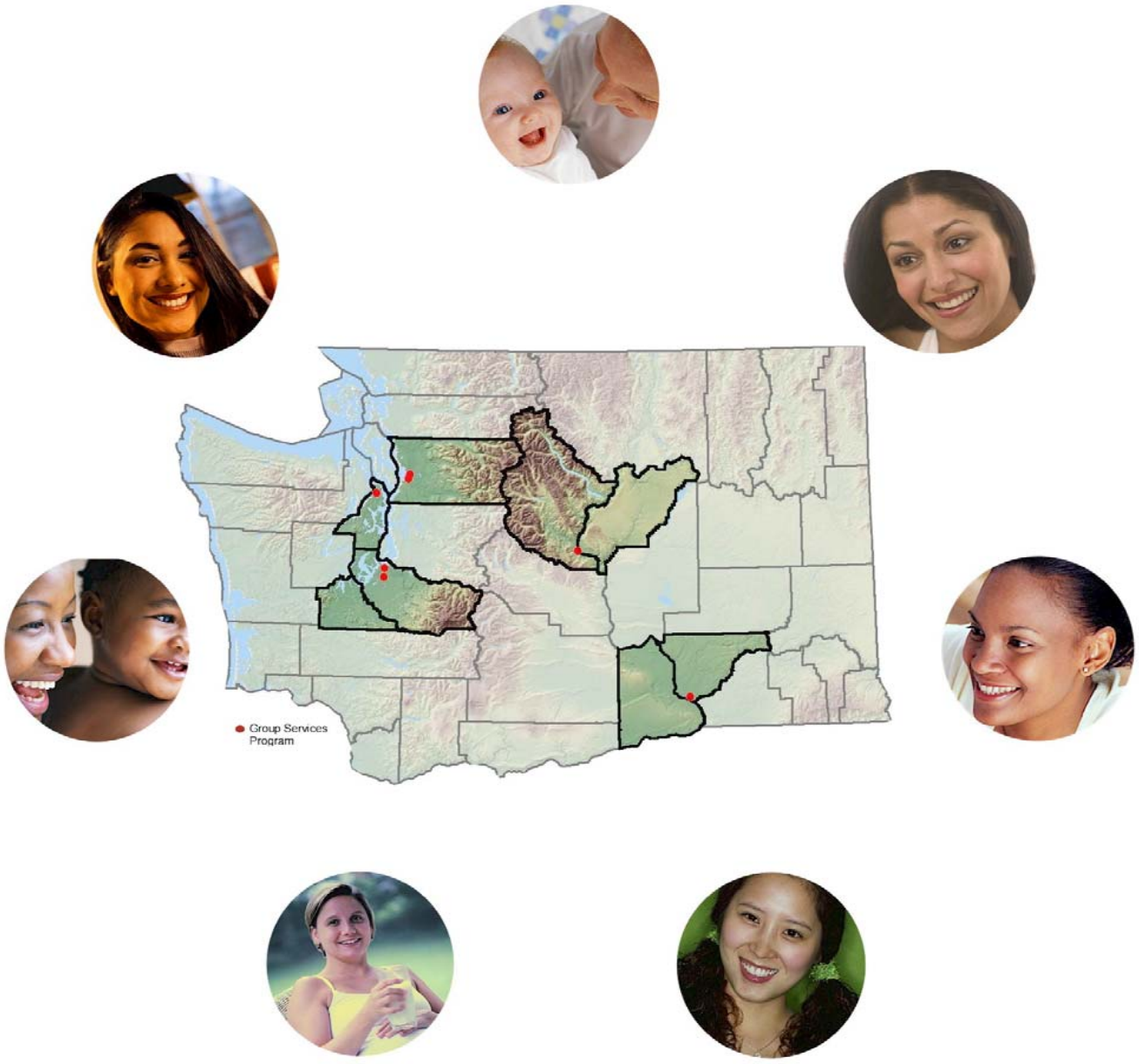
Group Services For Pregnant and Parenting Women

An Exploratory Study



Washington State Department of Social and Health Services
Management Services Administration
Research and Data Analysis Division

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Pregnant and Parenting Women
An Exploratory Study

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Table 1. Summary of Critical Factors for Successful Group Services

Critical Factors	Bienestar	Centering Pregnancy®	Childbirth Education	Life Skills	Pacific Treatment Alternatives	Women's Education Seminars	Young Women's Group
Charismatic, dedicated, and resourceful leaders possessing a clear vision and the ability to inspire enthusiasm and passion for their vision in others.	✓	✓	✓	✓	✓	✓	✓
Caring, empathetic, and flexible group facilitators/leaders who create a safe, supportive, and nurturing environment.	✓	✓	✓	✓	✓	✓	✓
One-on-one recruitment by individuals familiar to the clients.	✓			✓	✓	✓	✓
Desirable incentives such as delicious food, fun craft activities, and small prizes.	✓	✓	✓	✓	✓	✓	✓
Collaborative relationships with community programs and organizations.	✓	✓	✓	✓	✓	✓	✓

EXECUTIVE SUMMARY

Since First Steps expanded eligibility for maternity care to 185% of the Federal Poverty Level (FPL) in 1989, the number of deliveries funded by Medicaid has increased from 17,984 in FY 1988 to 36,915 in CY 2004. In addition to prenatal and postpartum medical care, First Steps clients are eligible for Maternity Support Services (MSS) which includes risk assessment, education, intervention, and counseling. Along with an increase in the number of clients served, annual payments for MSS rose from $360 per client in 2001 to $570 in 2005.[1]

Offering services in a group setting instead of one-on-one has the potential to lower per client costs, improve patient outcomes, and increase patient social support. To explore group service provision, we studied seven programs offering group services to pregnant and parenting women in Washington State. Key program characteristics were identified through interviews and written surveys with group facilitators and program managers. We present our findings to serve as a resource for program managers and providers who may seek to offer services to pregnant and parenting women in a group setting.

Major Findings

Although each program targets a distinct population and offers a wide variety of services, similarities emerged. As summarized in Table 1, programs shared common characteristics regarding program leaders and group facilitators, recruitment methods, incentives, and partnerships with community organizations.

Program representatives indicated that most clients benefit from participating in group services. Pregnant and parenting women participating in group services benefit by:

- Creating their own social support network and relationships with peers.
- Realizing that others have similar issues and concerns.
- Receiving more information from facilitators and other group members.
- Learning and reinforcing new skills by participating in group activities, such as experiential learning exercises.
- Spending more time with providers and, thereby, receiving more education and services.

Providers also benefit by offering group services to clients. It is much more efficient for providers to present information once to a group than to do so repeatedly to individuals throughout the day. Serving more clients in a two-hour group session than in two hours of individual visits lowers per patient costs and allows providers to spend more time with clients.

Implementation Considerations

Adopting a group service model for MSS has the potential to contain per client costs while maintaining or increasing service quality. State program managers offered the following

[1] Conlon, D. Health and Recovery Services Administration Payments for Maternity Support Services by Date of Service, Fiscal Years 2001-2005 Dates of Service Only. Washington State Department of Social and Health Services, 3/13/2006.

innovative and thoughtful ideas that could be implemented in the context of MSS.

- Assess client's "readiness" for group participation using a screening tool.
- Receive assistance providing food and nutrition education by forming partnerships with programs, such as Women, Infants, and Children[2] or the Expanded Food and Nutrition Education Program.[3]
- Offer groups based on risk factors prevalent in the client population; for example, smoking cessation groups or diabetes support groups.
- Gain community support, recognition, and linkages to additional services by creating partnerships with other programs and organizations.
- Ensure groups are led by effective and skilled facilitators by keeping group service provision optional for MSS providers.

State program managers also considered the challenges of providing MSS in a group setting, including evaluating the effectiveness of group services with respect to birth outcomes, balancing MSS core services with the members' interests, and ensuring providers understand the subtleties of providing group services. Measurable outcomes should be defined before program initiation. If possible, outcome measures should support program goals or relate to the client's well-being. To keep clients engaged, First Steps' Basic Health Messages might be incorporated into various group activities, such as games, group discussions, or experiential activities.

Offering MSS in a group setting is one way to provide high quality services while addressing increasing client caseloads and service costs. Key factors among these group services programs were visionary leaders, effective facilitators, incentives (particularly food), outreach conducted by recruiters known to members of the target population, and community partnerships.

Conclusion

The seven groups included in this study are particularly remarkable for their responsiveness to identified community needs. While community needs and target populations differed across the seven sites, similar strategies were developed to meet these needs and serve the clients. Group leaders implemented common strategies to achieve successful groups—groups with regular attendance, relevant and client-centered curricula, and the potential to be self-sustaining. Even more important, successful groups provide the benefits of social support to promote and reinforce healthy behaviors, socialization and personal development, education and information.

Group services are becoming more widespread in medical care throughout the U.S. By recognizing basic factors critical to group facilitation, a wide range of providers have the opportunity to improve client services with this cost-effective strategy and to meet unique needs of their community members.

[2] The Women, Infants, and Children (WIC) program is administered by the Food and Nutrition Service (FNS), a Federal agency of the U.S. Department of Agriculture.
[3] The Expanded Food and Nutrition Education Program (EFNEP) is administered by the Cooperative State Research, Education, and Extension Service (CSREES), an agency within the U.S. Department of Agriculture.

INTRODUCTION

The Washington State Department of Social and Health Services (DSHS) and the Department of Health (DOH) jointly implemented the First Steps program in 1989, in response to the Maternity Care Access Act of the same year. Through education, early intervention, and other activities that support families in making positive health care decisions, First Steps has achieved remarkable success in improving access to prenatal care, decreasing low birth weight, and reducing infant mortality.[4] In addition to expanding Medicaid eligibility and increasing reimbursement, key components of the First Steps program include Maternity Support Services (MSS), Infant Case Management (ICM), and additional support services.

MSS are preventive health services that supplement medical coverage for Medicaid-eligible women during pregnancy and the postpartum period. To promote positive pregnancy and parenting outcomes, MSS are provided as early in pregnancy as possible. Services include assessment, health education, intervention, and counseling, all of which are delivered by an inter-disciplinary team of professionals and paraprofessionals to provide a comprehensive care plan.

Since First Steps increased eligibility for maternity care to 185% of the Federal Poverty Level (FPL) in 1989, the number of deliveries funded by Medicaid has increased from 17,984 in FY 1988 to 36,915 in CY 2004. Of all Washington State deliveries in 2004, 46% were Medicaid-funded. As the number of pregnant women on Medicaid's caseload has grown, what was initially viewed as a program success now represents a substantial and growing expenditure for the Health and Recovery Services Administration (HRSA). At more than $250 million per year, maternity care represents one of HRSA's largest expenses.

In particular, the total cost of MSS reimbursed by HRSA increased substantially from 2001 to 2005. Along with an increase in the number of clients served, annual payments for MSS rose from $360 per client in 2001 to $570 in 2005.[5] To address the need to contain these costs, HRSA explored alternatives to one-on-one service delivery, and ultimately funded three pilot sites to provide prenatal services in group settings. Low client volume and high per-client costs forced the discontinuation of two pilot sites after the first year. The pilot site at CHC La Clinica, which served 79 women as of June 2005, was continued for another year.

As caseloads continue to increase and as clients use more services, HRSA still strives to provide MSS in a more cost-containing, quality-maintaining manner. Evidence from published studies indicates that providing care in group settings may lower per-client costs, improve clinical outcomes, and provide greater social support for patients, all while offering the same content as in one-on-one care.[6] At a recent national group care conference, providers described how group visits increased patient satisfaction and compliance with care, improved communication between

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[4] Cawthon, 1999.

[5] Conlon, D. Health and Recovery Services Administration Payments for Maternity Support Services by Date of Service, Fiscal Years 2001-2005 Dates of Service Only. Washington State Department of Social and Health Services, 3/13/2006.

[6] Grady and Bloom, 2004; Walker and Rising, 2004; Rising et al., 2004; Ickovics et al., 2003; Rising, 1998; and Hoyer et al., 1994.

provider and patient, and reduced emergency department visits.[7] This report focuses on seven Washington State programs that provide group services to pregnant or parenting women and their family members (Table 2).

Table 2. Group Care Programs by Agency, Target Population, and Areas Served

Program Name	Name of Agency	Population Served	Area Served
Bienestar	Community Health Center La Clinica	Spanish-speaking, Hispanic pregnant women	Benton and Franklin Counties, and outlying areas
Childbirth Education	Bates Technical College	Pregnant women and their support persons	Pierce and Thurston Counties
Centering Pregnancy	Family Planning of Chelan and Douglas Counties	Pregnant women seeking midwifery care	Chelan and Douglas Counties
Life Skills Classes	Step by Step Family Support Center	MSS clients and their families/friends	Pierce County
Safe Babies, Safe Moms Classes	Pacific Treatment Alternatives	Chemically dependent pregnant or parenting women	Snohomish County
Women's Education Seminars	Everett Community Services Office (CSO)	English- and Russian/ Ukrainian-speaking pregnant or parenting women	Everett CSO Catchment Area
Young Women's Group	Port Gamble S'Klallam Tribe Community Health Department	Young (18–30) tribal women living on the reservation	Port Gamble S'Klallam Tribal Reservation

Purpose

This qualitative study explores existing programs that successfully provide group services to pregnant or parenting women. The report describes program characteristics across seven selected sites and highlights key factors contributing to their success, especially with respect to leadership and group facilitation, client recruitment, incentives, and linkages to other community services. We base program success on the number of clients served, attendance at group sessions, and program reputation in the community. Findings from this report may serve as a resource for providers offering group services to pregnant and/or parenting women.

This report presents the observations of persons actively involved in providing group care at selected sites throughout Washington. Through written surveys and semi-structured in-person interviews, these program representatives communicated their strategies for providing group prenatal and parenting services, the challenges they face, and their visions for the future of their respective programs.

[7] Bernstein, 2006.

LITERATURE REVIEW

A few published studies have examined the effectiveness of group care and services. Previous research provides a historical context for our study, a framework for analyzing the data presented in this report, and information with which to compare and contrast our own findings. Each article selected for inclusion in this literature review focused on the provision of clinical care, services, and/or support in a group setting. We paid close attention to group characteristics, facilitator qualities and training, group processes and methods, and outcomes.

Evaluations of group programs have focused not only on prenatal care, but also on postpartum, well-child, and diabetes care, as well as mutual support groups for pregnant teens, parents, and/or for long-term recipients of Temporary Assistance for Needy Families (TANF). In these studies, group care is generally associated with similar or better clinical outcomes, greater patient satisfaction, improved self-efficacy, increased knowledge, the development of support networks and problem-solving skills, a greater sense of trust in one's provider, and the efficient use of resources.[8] Studies revealed lower repeat birth rates among teens, longer intervals between births, greater care compliance and satisfaction, and better clinical outcomes for infants among prenatal group-care participants when compared to women who receive individual care.[9] An evaluation of home visits and hospital-based group visits after early postpartum discharge revealed that group visits produced similar clinical outcomes at a lower cost.[10] Studies of group well-child care found that patient satisfaction and provider time required were similar to individual care, but attendance at visits was better and emergency department utilization lower.[11] The diabetes group care studies reported better or similar clinical outcomes, self-efficacy, problem-solving ability, and satisfaction with care for group participants compared to subjects receiving individualized care.[12] According to four studies of parenting support groups, many participants found that their parenting skills improved, that they gained a sense of empowerment, and that they became more knowledgeable about community resources.[13] Table 3 summarizes this research. For detailed information about the reviewed studies see Appendix A, available on the Research and Data Analysis website at http://www1.dshs.wa.gov/rda/research/9/84.shtm.

Although limited in number, existing group care studies across a range of situations show that group care is a cost-effective method of service delivery with which participants are generally satisfied. Moreover, outcomes are the same or better for group participants compared to those receiving one-on-one care or services. These results indicate that the delivery of care and services in a group setting may be a viable alternative to individual care in many circumstances.

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[8] Trento et al., 2004 (diabetes); Novick, 2004 (prenatal); Anderson-Butcher et al., 2004 (TANF); Grady and Bloom, 2004 (prenatal); Clancy et al., 2003 (diabetes); Ickovics et al., 2003 (prenatal); Rothenberg and Weissman, 2002 (prenatal and parenting); Rickheim et al., 2002 (diabetes); Trento et al., 2001 (diabetes); Escobar et al., 2001 (postpartum); Wituk et al., 2001 (parenting); Sadur et al., 1999 (diabetes); Rising, 1998 (prenatal); Taylor et al., Sept. 1997 (well-child); Taylor et al., June 1997 (well-child); Hoyer et al., 1994 (prenatal); Whitson, 1993 (prenatal); Kagey et al., 1981 (parenting); and Osborn and Woolley, 1981 (well-child).

[9] Grady and Bloom, 2004; Ickovics et al., 2003; Rothenberg and Weissman, 2002; Rising, 1998; Hoyer et al., 1994.

[10] Escobar et al., 2001.

[11] Osborn and Woolley, 1981; Taylor et al., June 1997; Taylor et al., Dec. 1997.

[12] Trento et al., 2004; Clancy et al., 2003; Rickheim et al., 2002; Trento et al., 2001; Sadur et al., 1999.

[13] Anderson-Butcher et al., 2004; Kagey et al., 1981; Wituk et al., 2001; Rothenberg and Weissman, 2002.

Table 3. Overview of Group Care Research

Study Type, Author(s), & Date	*Group Characteristics*					
	Target Populations	**Sample Sizes**	**Group Sizes**	**Session Frequency**	**Session Duration**	**Facilitators**	**Results/Outcomes**
Prenatal Services							
▪ Grady and Bloom, 2004 ▪ Ickovics et al., 2003 ▪ Rothenberg and Weissman, 2002 ▪ Rising, 1998 ▪ Hoyer et al., 1994	▪ Pregnant minority teens ▪ Poor black and Hispanic pregnant women ▪ Pregnant teens ▪ Ethnically diverse pregnant women, many Medicaid recipients ▪ Low-income, black, pregnant adolescents	65–458 subjects	8–12 subjects	Weekly	1.5 hours	▪ Social worker, with assistance from various educators, volunteers, and master's students ▪ Nurse midwife or obstetrician and an assistant, each trained in Centering Pregnancy® (CP) and group process.	▪ The percentage of repeat births among study participants was less than the national average for teen mothers (15% versus 22%) and a majority of participants did not have a second birth until three to four years later when they were no longer in their teens. ▪ CP group care participants had a significantly lower rate of low-birth weight and pre-term births. ▪ Full-term and pre-term infant birth weight was significantly greater for subjects who received group prenatal care. ▪ Overall satisfaction with CP group prenatal care in one study was 9.2 on a scale of 1 (worst) to 10 (best), and breastfeeding and identification of a pediatric provider were reported in significantly higher proportions among group care subjects. ▪ 96% of group care participants reported that they preferred CP group care, and they had significantly lower emergency department usage during their third trimesters. ▪ Greater care compliance, lower repeat pregnancy rates, longer gestational periods, lower self-criticism scores, and a greater sense of mastery of the labor and delivery process.

Study Type, Author(s), & Date	*Group Characteristics*						
	Target Populations	**Sample Sizes**	**Group Sizes**	**Session Frequency**	**Session Duration**	**Facilitators**	**Results/Outcomes**
Postpartum Care							
Escobar et al., 2001.	Low-risk mothers and newborns	1,014 mother-infant pairs	Up to 9 mother-infant pairs	Once	1.5–2 hours	Registered nurse certified as a lactation educator (trained with 20 hours of classroom instruction and a two-week preceptorship)	▪ When comparing home visits to hospital-based group visits after early postpartum, comparable clinical outcomes were achieved, although higher maternal satisfaction was associated with home visits. ▪ Costs of home visits versus group visits were $265 and $22, respectively. ▪ Neither setting for service delivery was associated with significantly increased continuation of breastfeeding
Well-Child Care							
▪ Osborn and Woolley, 1981 ▪ Taylor et al., June 1997 ▪ Taylor et al., Dec. 1997.	▪ Mothers and infants up to 6 months old ▪ Mothers and infants 0 to 4 months old with at least one risk factor (e.g., poverty, history of child abuse, etc.).	78–210 mother-infant pairs	3–6 mother-infant pairs.	3–7 visits	45–60 minutes	▪ Pediatrician, a family physician, or a family nurse practitioner ▪ Two nurse practitioners who followed a specified curriculum centered on general parenting topics.	▪ Significantly more well-child care visits were completed among the intervention subjects, they sought less advice between visits, and they spent significantly more time discussing personal issues and significantly less time discussing the physical aspects of care. ▪ The time required for each subject in this study was virtually equal across the intervention and control groups, as was satisfaction with care. ▪ Maternal interaction, child development, health utilization, health status, care compliance, and provider time required were similar for the intervention and control groups. ▪ A significantly higher proportion of children receiving individual care in this study had emergency visits during the study period.

Study Type, Author(s), & Date	*Group Characteristics*						
	Target Populations	**Sample Sizes**	**Group Sizes**	**Session Frequency**	**Session Duration**	**Facilitators**	**Results/Outcomes**
Diabetes Care							
▪ Trento et al., 2004 ▪ Clancy et al., 2003 ▪ Rickheim et al., 2002 ▪ Trento et al., 2001 ▪ Sadur et al., 1999.	▪ Individuals with Type 2 diabetes not treated by insulin ▪ Individuals with uncontrolled Type 2 diabetes ▪ Individuals with poorly controlled diabetes	84–185 subjects	4–20 subjects	▪ Weekly ▪ Monthly ▪ Quarterly	1–3 hours	▪ Diabetes Nurse Educator and 2 diabetologists ▪ Physician and a nurse educator ▪ Diabetes nurse and a dietitian ▪ (in at least 2 of the studies, the facilitators were specifically trained in group processes)	▪ Clinical outcomes for group care subjects were either better or similar to those of subjects who received individualized care, and self-reported knowledge, self-management behaviors/self-efficacy, problem-solving abilities, satisfaction with care, and quality of life generally improved for group care subjects over the study periods and when compared with the control subjects. ▪ Group diabetes care subjects had significantly lower hospital discharge/utilization rates after the intervention than the control subjects did.
Parenting Support							
▪ Anderson-Butcher et al., 2004 ▪ Rothenberg and Weissman, 2002 ▪ Wituk et al., 2001 ▪ Kagey et al., 1981.	▪ Long-term TANF recipients/ parents ▪ New parents ▪ Latino parents in rural areas ▪ Minority teen parents	9–118 subjects	5–23 subjects	▪ Weekly ▪ Twice Per Month	1–2.5 hours	▪ Employment counselor or social worker ▪ Volunteer parents who took part in eight, 2.5-hour sessions about the birth experience and parental stress, along with 2 sessions about group process and	▪ Tangible outcomes included knowledge gains, particularly with regard to community resources and supports, along with improvement of parenting, social, and problem-solving skills. ▪ A sense of empowerment, heightened responsibility, and enhanced self-esteem was also reported. ▪ Benefits enjoyed by the participants' families included better spousal communication and the acquisition of new social skills by the participants' children who attended the children's group.

Study Type, Author(s), & Date	*Group Characteristics*						
	Target Populations	**Sample Sizes**	**Group Sizes**	**Session Frequency**	**Session Duration**	**Facilitators**	**Results/Outcomes**
						communication ▪ Volunteers trained in basic parenting and group facilitation skills ▪ Social worker, with assistance from various educators, volunteers, and master's students	▪ 94% of 98 respondents to a follow-up survey mailed to participants after two years of the program stated that the group had been helpful to them, and 62% reported agreement with the statement that their skill in child-caring improved due to the support group. ▪ Latino parents in rural communities indicate that participants in self-help parenting groups were satisfied with their group experience. ▪ Latino parents' knowledge of child development improved, along with their patience with their children, their coping ability, and their communication skills. ▪ 24% of minority teen participants were no longer on public assistance, and only one participant (0.01%) had been reported to the child welfare agency.

METHODS

SITE SELECTION

We selected seven programs to represent models of group care for pregnant or parenting women. First Steps state program managers identified successful group care programs based principally on client recruitment, group session attendance, and community recognition.

Another consideration was the target population served by each program. To represent the diverse client population in Washington, we selected programs targeting high risk populations and low risk populations, including programs for non-English speaking clients. The programs selected are listed in Table 2 of the Introduction.

Informant Selection

Program managers or administrators were contacted by telephone. They were asked to complete a written survey and to identify key program staff, preferably group facilitators, for in-person interviews.

Between August and November 2005, 21 program representatives were interviewed: 15 group facilitators, 3 executive directors or program managers, and 3 individuals who served as both facilitators and managers.

One individual from each program was contacted by phone to schedule an interview at the program site. This contact person was responsible for notifying other program staff of the interview date and time. Table 4 shows the number of individuals interviewed from each program.

Table 4. Total Interviewed by Program

Program	Total Interviewed
Bienestar	4
Childbirth Education	2
Centering Pregnancy	2
Safe Babies, Safe Moms Classes	6
Life Skills Classes	3
Women's Education Seminars	3
Young Women's Group	1

DATA COLLECTION AND ANALYSIS

Written Survey

A two-page written survey about general program characteristics was emailed to program managers, who completed and returned the survey by email or to the researcher during the site interview. The survey is available at http://www1.dshs.wa.gov/rda/research/9/84.shtm. With one exception, everyone who returned the written survey also completed an interview.

Interviews

Interviews were semi-structured. A general interview guide was designed to address program history, client enrollment and outreach, group characteristics, program activities and curriculum, and program perspectives. The interview guide was tailored to each program according to program characteristics. Interview questions were sent by email to each contact prior to the interview to give program representatives time to reflect upon their program characteristics. Interviewees were told the intent of the report and asked for their permission to record the interview on audiotape. Although the structure of the interview generally followed the guide, the process was flexible and program representatives had the opportunity to focus on individual priority issues. A typical interview took approximately 2–2.5 hours to complete. The interview guide is available at http://www1.dshs.wa.gov/rda/research/9/84.shtm.

Interviews were conducted at the program sites. The data collected consisted of audiotapes, field notes, written records, and printed information. Audiotapes were transcribed and data sorted into interview notes. Notes were reviewed to select appropriate highlighted information. Direct quotations from program representatives or materials provided by them are italicized in the report.

LIMITATIONS

Data for the most part reflect the views of the program staff interviewed and direct observations by the research team, and may not be representative of *all* individuals involved in these or other group care programs. In addition, changes in program activities may have occurred after interviews were concluded.

We identified successful programs based mainly on client recruitment, group session attendance, and recognition in the community. We did not address program effectiveness with respect to birth or parenting outcomes because data on birth outcomes or parenting outcomes were not available.

FINDINGS

Program representatives were asked several general questions about program characteristics, goals, challenges, future directions, and other issues. Their responses revealed that the specific direction and emphasis of the selected group programs vary with the needs of their respective clients. The seven programs presented in this report use a broad range of group-based formats for delivering services to pregnant and/or parenting women, in some cases with differing purposes and goals, target populations, and critical factors.

Some programs, such as Bienestar and CenteringPregnancy®, are directed exclusively toward pregnant women; others provide services to pregnant *and* parenting women; and at least one welcomes the families and friends of clients to its group sessions. Many programs serve predominantly single mothers and Medicaid recipients. Recruitment methods vary across groups. Each program serves a relatively diverse clientele and develops partnerships with other community organizations.

This report also summarizes program representatives' beliefs regarding the keys to program success and the essential characteristics of effective group facilitators. They identified leaders with vision, skilled group facilitators, incentives, personalized outreach conducted by recruiters familiar to the target population, and community partnerships as critical factors for success. Common responses among many program representatives about necessary facilitator attributes included experience, dedication, enthusiasm, creativity, empathy, and leadership skills.

The findings of this study are organized into two sections:

- **Program Descriptions: pages 11-38**

  This section provides an overview of each group program, lists selected local and state-level demographic data, and outlines distinctive characteristics of each program.

- **Critical Factors: pages 39-44**

  This section presents important factors for program success identified by program representatives across the group programs.

BIENESTAR
Community Health Center La Clinica
Pasco, Washington

The goals of Bienestar are *"stress reduction, socialization, and prenatal education."*

Bienestar, Spanish for "well-being," began in October 2004 as a First Steps pilot program offering prenatal services in a group setting. Bienestar offers education to pregnant Hispanic women in Benton and Franklin Counties and outlying areas. The entire program is conducted in Spanish because few participants are bilingual. Providers at CHC La Clinica applied for the pilot program grant because it allowed them to expand group programs they already offered. In addition to one-on-one Maternity Support Services (MSS), CHC La Clinica offers groups for first-time mothers, childbirth education, and breastfeeding support.

CHC La Clinica has served the Hispanic community of Pasco and Kennewick since 1981. The agency's mission is to provide medical, dental, mental health, and support services in a compassionate and culturally sensitive manner to all people, without prejudice to race, color, creed, gender, or economic status. Many of CHC La Clinica's administrative staff and providers are bilingual (English and Spanish). According to the Washington State Office of Financial Management, Franklin County had the highest percentage of persons age 5 and older living in Washington households where Spanish is spoken (41.4%). This is seven times higher than the percentage statewide (5.8%).[14]

Many women enroll in the program during the second trimester of pregnancy. Most clients are Spanish-speaking, age 18–30, and recent immigrants to the United States. Social isolation is the major issue for these women because they have left family and friends, are experiencing a new culture, and lack transportation. Offering services in a group setting gives clients an opportunity to interact with other pregnant women, create a support network, and learn about pregnancy, childbirth, and parenting.

Most clients learn about Bienestar from First Steps and WIC staff. First Steps staff distributes flyers to clients who they feel would benefit from attending a group and also provides the program coordinator with a list of potential clients. Ongoing one-on-one outreach is very important for engaging clients with the program. Group facilitators call clients several times to invite them to each group meeting and to arrange transportation, if needed. Incentives—including food, door prizes, and car seats—help with recruitment and attendance, and most clients complete the program. Clients sometimes drop out, however, due to relocation or preterm delivery.

Three or four bilingual facilitators lead each session. In their roles as one-on-one First Steps MSS providers, facilitators are familiar to the clients. Group facilitators are trained in motivational interviewing, group facilitation, group processes, and stages of change theory, and use table-based coaching[15] during small group discussions to engage clients.

[14] Washington Trends, Washington State Office of Financial Management. Olympia, Washington. Available at: http://www.ofm.wa.gov/trends/tables/map207.asp.
[15] Table-based coaching involves giving personal instruction to each participant instead of the entire group (Kang, 2006).

Bienestar (CHC La Clinica)	
Service Area:	**Average Group Size:**
Benton and Franklin Counties	14 participants
Target Population:	**Program Length:**
Spanish-speaking Hispanic pregnant women	8 weeks (1 session/week)
Number Served Annually:	**Session Duration:**
89	2.5 hours
Proportion Medicaid:	**Sample Topics Addressed:**
100%	Stress Reduction, Nutrition, Infant Bonding

Selected Characteristics of Women Who Gave Birth in 2004			
	Benton County (N=2,158)	**Franklin County (N=1,321)**	**WA State (N=80,433)**
Race/Ethnicity*			
White	66.6%	30.4%	64.7%
Hispanic	26.7%	65.9%	17.5%
African American	1.2%	0.6%	3.4%
Native American	0.6%	0.2%	1.8%
Asian/Pacific Islander	2.4%	1.7%	8.4%
More than one race/other/unknown	2.6%	1.3%	5.3%
Live Birth Rates (per 1,000 women)**			
Birth rate of women ages 15–44	69.1	115.2	62.8
Women ages 15–19	37.4	72.5	31.2
Births with Medicaid-Paid Maternity Care*			
Number of Medicaid Births	1,160	907	36,915
Percent of Total Births	53.8%	68.9%	45.9%
Percent Received Maternity Support Services	64.8%	77.9%	71.0%
Percent with Maternal Smoking (Yes)	15.3%	4.3%	16.8%
Percent Low Birth Weight, singleton liveborn	6.3%	5.9%	5.7%
Percent of Medicaid Births to Non-Citizens	19.5%	49.8%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (6/14/2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).

The group meets for 2.5 hours each week for eight weeks. The curriculum focuses on stress reduction. Clients learn how stress affects health, thinking, behavior, learning, memory, and performance. The program teaches clients relaxation and stress reduction tools to use during pregnancy and for the rest of their lives. They also learn stress reduction activities to teach their children. One tool clients practice is The Calming Skill™, which group facilitators learned at the two-day Calming Ourselves in Stressful Moments™ training program. The program, developed by the Comprehensive Health Education Foundation,[16] helps early childhood caregivers, teachers, parents, and children to manage stress.

Each session follows a prenatal group process model developed by Stepping Up at the University of Washington, School of Nursing. The prenatal group process model, an adaptation of McDonald's Baby FAST model, centers on social interaction and experiential learning.[17]

The first half-hour of each session begins with a craft activity like scrap booking. Some clients arrive early to work on their craft projects. Scheduling the craft activity at the beginning of the session ensures that late arrivals do not miss important educational discussions and activities.

The educational portion of each session includes large and small group discussions, games, and songs. A bilingual nutritionist from a partnering agency presents a nutrition lesson and clients break into small groups to prepare a meal. The session was lengthened from 2 to 2.5 hours to allow enough time for the cooking activity, socialization, and eating that follow.

The session ends with the raffle of a large gift basket. Every client wins at least once during the program. The purpose of the raffle is to give each client a sense of optimism and hope, knowing that she will win one day. Clients attending six or more sessions receive an infant car seat provided by the Community Health Plan of Washington. Group facilitators said that clients enjoy the socialization, activities, and relaxation.

Clients often stay and socialize after the session ends. Facilitators have found a considerate way to signal the end of the session and bid the clients good-bye. One facilitator sings an Irish lullaby from her childhood, including each client's name in the song to personalize it. Singing the lullaby incorporates one curriculum topic—the importance of traditions in families—into each session.

The needs and personality of the group influence which topics are addressed. Discussing sensitive topics in a group setting creates an atmosphere of anonymity. Group facilitators can bring up issues, such as domestic violence, in the group without confronting individual clients directly. Clients who are more comfortable discussing sensitive topics help build confidence and increase support in the group. After attending the group sessions, clients tend to become more comfortable approaching facilitators to discuss issues one-on-one.

Program Challenges

Clients' lack of transportation poses one major challenge to the program. Some clients rely on their support persons for transportation and often arrive late to the sessions. Group facilitators help

[16] http://www.chef.org/programs/calming.php (last accessed October 13, 2005).
[17] Kang, 2006.

clients overcome this by discussing how to purchase a bus pass and use public transportation. Clients who use public transportation are acknowledged with a round of applause during the session. A vehicle is also available on meeting days for transportation.

Another issue is child care during the session. Children, who are deemed too distracting, may not attend group sessions. Although child care is a covered First Steps service and can be arranged by program staff, clients prefer to have family members care for their children. In the Hispanic culture, family members traditionally provide child care. Program staff would like to make child care available on-site for all clients.

Designing and implementing a successful program requires much time. Program staff is sometimes challenged by the amount of time needed to prepare the curriculum, contact clients, and organize the group. The entire First Steps staff has supported the pilot program in some way, whether by referring clients or asking businesses to make donations for program raffles.

Future Directions

Bienestar is in its second year of serving clients in a group setting. The program changes continually to meet the needs of its clients. Program staff ensures that the program helps clients to lose their fear of being in a different culture, to create their own social support network, and to learn how to access available services. How to measure the success of the program remains a challenge, although program staff has started conducting client surveys at the beginning and end of the program.

CENTERINGPREGNANCY®
Family Planning of Chelan and Douglas Counties
Wenatchee, Washington

"Centering Pregnancy empowers caregivers and their clients by bringing women out of exam rooms and into groups for their prenatal care."[18]

CenteringPregnancy® integrates the risk assessment, education, and social support components of prenatal care in a group setting.[19] Women have their initial prenatal care appointment in the usual manner, with history and physical examinations at a clinic. They then join 8–12 other women with similar due dates and meet regularly throughout their pregnancies. A prenatal provider and an assistant trained in the *Centering* program model lead the group together. Nurse-midwife Sharon Rising organized the first CenteringPregnancy® group in 1994 while teaching at Yale University's School of Nursing. The program is offered at over 80 sites across the U.S. and Canada.

The *Centering* program at Family Planning of Chelan and Douglas (FPCD) Counties began in 2003 with a $10,000 grant from the March of Dimes. The grant covered the cost of books, supplies, training for two midwives, and furnishings for a comfortable meeting room. FPCD, a non-profit United Way Member Agency, provides a continuum of care, ranging from family planning, screening, testing, and treatment for reproductive health issues to prenatal and postpartum care. FPCD has served Chelan and Douglas counties since 1971.

New clients hear about *Centering* from former participants or after a positive pregnancy test at FPCD. Most clients (70%) are non-Hispanic white, 30% are Hispanic, and 1% are American Indian. Many are single mothers age 18–30.

The group meets monthly until the fifth month of pregnancy, then biweekly through the early postpartum period. Support persons and older children are encouraged to attend and to participate in group discussions and activities. Discussion-based sessions permit more time for provider-patient interaction. A bilingual facilitator translates for Spanish-speaking clients and their support persons.

At the beginning of each *Centering* session, clients check their own blood pressure, weight, and urine, and record the results in their medical records. These self-care activities empower the women and encourage them to take responsibility for their health. The Certified Nurse Midwife (CNM) then meets individually with each client for the medical assessment component of the session, which includes listening to the fetal heartbeat, checking for uterine growth, and addressing client questions. If necessary, a private exam may be performed during a session break or scheduled for a separate visit.

The education component consists of a general curriculum with adjustments for learning objectives set by the clients. Because the program includes a mother's book with reading exercises,

[18] http://www.centeringpregnancy.org/
[19] Rising, SS. (1998). Centering Pregnancy: an interdisciplinary model of empowerment. *J of Nurse-Midwifery*. 43(1): 46-54.

CenteringPregnancy® (Family Planning of Chelan and Douglas Co.)	
Service Area:	**Average Group Size:**
Chelan and Douglas Counties	8 participants
Target Population:	**Program Length:**
Women seeking midwifery care	8–10 sessions
Number Served Annually:	**Session Duration:**
50	2 hours
Proportion Medicaid:	**Sample Topics Addressed:**
90%	Prenatal Care, Childbirth Education, Parenting

Selected Characteristics of Women Who Gave Birth in 2004

	Chelan County (N=895)	Douglas County (N=453)	WA State (N=80,433)
Race/Ethnicity*			
White	49.2%	54.5%	64.7%
Hispanic	47.2%	43.3%	17.5%
African American	0.1%	0.2%	3.4%
Native American	0.9%	0.7%	1.8%
Asian/Pacific Islander	0.6%	0.2%	8.4%
More than one race/other/unknown	2.1%	1.1%	5.3%
Live Birth Rates (per 1,000 women)**			
Birth rate of women ages 15–44	69.3	67.9	62.8
Women ages 15–19	40.6	42.2	31.2
Births with Medicaid-Paid Maternity Care*			
Number of Medicaid Births	583	292	36,915
Percent of Total Births	65.1%	64.5%	45.9%
Percent Received Maternity Support Services	80.8%	71.9%	71.0%
Percent with Maternal Smoking (Yes)	3.4%	4.1%	16.8%
Percent Low Birth Weight, singleton liveborn	5.8%	5.9%	5.7%
Percent of Medicaid Births to Non-Citizens	39.6%	33.6%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).

worksheets, and homework, clients must have basic reading and writing skills. During the first session, clients identify topics most important to them. This is repeated about mid-way through the program because clients may have experienced changes in their pregnancy or learning objectives. Guest speakers are invited to present special topics, such as massage and child care basics.

Risk assessments are conducted at the initial appointment and throughout the program. Women are encouraged to complete some assessments, such as the parenting and discipline attitudes assessment, with their partners. The midwife reviews the assessments with each client and places copies in her chart. Identified risks are continually addressed during prenatal care, either in private or, if the client is willing and feels comfortable, in the group discussion.

Group facilitators initiate and guide the sessions, but the clients ultimately choose discussion topics. In one *Centering* group, clients expressed anxiety and concerns at the beginning of the program about the labor and birth process. Although this topic is usually discussed during the fifth session, the facilitators adjusted the schedule to meet the clients' needs.

Groups with sociable clients are usually more interactive than groups with mostly quiet, introverted clients. A facilitator's role is to initiate and invite clients into the discussion by asking open-ended questions and probing for more information. Discussions of sensitive topics differ with each group according to the clients' openness and the group's stage of development. Some clients are willing to discuss personal issues like domestic violence. Other clients prefer to discuss personal concerns in private with the CNM.

Group facilitators believe that diversity improves a group by increasing the clients' support of one another. Clients who have had a previous birth, for example, share their experiences with those who are primiparous. Clients with access to their own transportation often provide rides to those without access. Older clients tend to look after younger group members. The bilingual facilitator translates conversations between Spanish- and English-speaking clients.

Most women enrolled in *Centering* complete the entire program. Clients sometimes switch to conventional one-on-one care because of scheduling conflicts or new medical risks. Also, some women are not comfortable in a group setting and prefer one-on-one care.

Incentives include activities like belly painting and belly casting. Clients receive instructions and supplies to make plaster casts of their bellies at home. Another group activity is belly painting. Women who were not comfortable painting their bellies painted a pumpkin instead. Facilitators provide a healthy snack for break time. After each client has given birth, the group meets for the last session to take pictures, share birth and parenting experiences, and complete program evaluations. A volunteer from each *Centering* group creates a scrapbook of photos to display in the library at FPCD, and each client receives a group photo of mothers with infants.

Program Challenges

One challenge has been to find enough women with similar due dates. If the number of women is too small, they may have to wait to join a program beginning a few weeks later.

Future Directions

Centering is a cost-effective way for FPCD to provide prenatal care and education to its clients. Providers do not have to repeat the same messages to individuals throughout the day. Midwives normally schedule half-hour prenatal visits with patients. In two hours, the length of a *Centering* session, a midwife would normally see four patients. A *Centering* session usually includes 8–10 women, making it more cost-effective than one-on-one care. Front desk staff has fewer appointments to schedule because all *Centering* sessions are scheduled at the beginning of the program.

CHILDBIRTH EDUCATION PROGRAM
Bates Technical College
Tacoma, Washington

"Bates Childbirth Education is dedicated to educating the new family group in choices, options, and skills relating to the childbearing years."

The Childbirth Education (CBE) program at Bates Technical College (BTC) provides information about prenatal care, labor and delivery, and newborn issues to pregnant women and their support persons in Pierce and Thurston counties. CBE began in 1975 as an extension of the Childbirth Education Association of Tacoma. Although CBE has its roots in Lamaze,[20] it stresses a woman's right to choose the childbirth method(s) most comfortable to her. A fundamental precept of CBE is that informed decision-making leads to a positive childbearing experience. Since its inception, BTC has taught CBE to more than 25,000 couples.

The majority (83%) of women who enroll in CBE are white and 15% are African American; the remaining 2% of participants claim another race or ethnicity for themselves. Approximately two-thirds of participants pay their own tuition and may receive reimbursement for claims they submit to their health insurance carriers. CBE, however, does not collect this information. The First Steps Medicaid program pays tuition for the remaining one-third of participants. State funding has increased participation of low-income women in CBE.

Each participant may bring two guests to CBE classes. This approach differs markedly from the early 1970s, when a father had to present a certificate attesting his completion of a childbirth class to be a delivery attendee. Today, partners/spouses regularly attend classes to learn about the childbirth process, often along with a doula. A doula "mothers the mother" by providing support and suggestions to the pregnant woman and her partner.[21] CBE partners with BTC's Birth Doula Training program to provide CBE participants with doula interns at no cost. Participants benefit from the extra support during childbirth, and interns gain valuable experience.

Participants learn about CBE in many ways. Program brochures are available in physician offices and at the six locations where classes are offered. The BTC website contains information about class schedules and registration. Participants may register by mail, by fax, online, or in-person at a site. Some participants are also referred by Maternity Support Services (MSS) providers, health departments, and the WIC clinic at Bethel School. Free informational sessions about CBE are held monthly at participating sites.

CBE classes, which typically include 6 couples, are offered in three different formats: one day, two day, and eight weeks of one class per week. All formats include 2.75 hours of postpartum instruction; however, only 8.5 hours are spent on prenatal instruction in the one-day class, whereas the two-day and the eight-week classes include 17 hours and 19.25 hours of prenatal instruction, respectively. One site offers teen-only classes. The one-day class is offered in both English and Spanish, and two of the twelve CBE instructors are bilingual.

[20] Lamaze is a method of childbirth that consists of childbirth education classes, relaxation, breathing techniques, and continuous support from a partner, and is designed to reduce pain and facilitate delivery without drugs.
[21] http://www.dona.org/mothers/index.php

Childbirth Education (Bates Technical College)	
Service Area:	**Average Group Size:**
Pierce and Thurston Counties	6 couples
Target Population:	**Program Length:**
Pregnant women and their support persons	8 weeks, 2 days, or 1 day (3 formats)
Number Served Annually:	**Session Duration:**
480 couples	22, 19.75, or 11.25 hours (totals for each format)
Proportion Medicaid:	**Sample Topics Addressed:**
34%	Nutrition, Labor Coping Practices, Breastfeeding

Selected Characteristics of Women Who Gave Birth in 2004

	Pierce County (N=10,101)	Thurston County (N=2,564)	WA State (N=80,433)
Race/Ethnicity*			
White	64.6%	76.1%	64.7%
Hispanic	13.0%	8.2%	17.5%
African American	6.7%	1.8%	3.4%
Native American	1.3%	1.9%	1.8%
Asian/Pacific Islander	8.0%	6.9%	8.4%
More than one race/other/unknown	6.2%	5.1%	5.3%
Live Birth Rates (per 1,000 women)**			
Birth rate of women ages 15–44	63.8	56.8	62.8
Women ages 15–19	33.6	25.8	31.2
Births with Medicaid-Paid Maternity Care*			
Number of Medicaid Births	4,292	1,010	36,915
Percent of Total Births	42.5%	39.4%	45.9%
Percent Received Maternity Support Services	70.7%	74.7%	71.0%
Percent with Maternal Smoking (Yes)	18.4%	24.7%	16.8%
Percent Low Birth Weight, singleton liveborn	6.2%	5.7%	5.7%
Percent of Medicaid Births to Non-Citizens	12.9%	6.7%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).

The state mandates a minimum of eight hours of childbirth education to cover core topics such as pregnancy, labor and birth, breastfeeding/lactation consultation, and postpartum issues. CBE emphasizes its commitment to positive health behaviors and informed consent. Participants also learn about changes during pregnancy, remedies, warning signs, and possible complications. Unlike some childbirth education classes, CBE does not provide medical services; instructors believe that this allows them to act as consumer advocates for participants.

A typical class in the eight-week CBE consists of 2.5 hours of instruction and 1–1.5 hours of discussion, followed by an additional hour of labor coping practices, body mechanics, and Kegel exercises. Although it is necessary to cover the required curriculum components, the instructor's creative and flexible methods for "engaging the students" and addressing their needs are equally important. Instructors develop activities that require interaction between students and the instructor and/or among the students themselves and are designed to demonstrate and reinforce learning by using hands-on activities and role play.

Approximately two-thirds of participants complete the eight-week CBE; however, the shorter programs have higher completion rates (75–100%). Course evaluations indicate that the classes help participants gain confidence and make informed decisions about the labor and delivery process. BTC helps CBE participants stay connected by having one postpartum session and offering a parenting class. Some reasons cited by those who do not complete the program include lack of transportation, scheduling conflicts with work or school, and early delivery.

Most CBE instructors have completed a part-time, two-year intensive training program at BTC. In addition to childbirth education, the training covers classroom instruction, teaching styles, adult learning theory, and group facilitation, including a hands-on practicum. Unlike many other programs, the BTC CBE instructor training program does not require a student to have a nursing or other medical background; a high school diploma is sufficient. BTC offers continuing education to its childbirth education staff and encourages them to attend conferences. One such conference, for the International Childbirth Education Association, Inc. (ICEA),[22] provides training and certification in childbirth education worldwide. Another conference, sponsored by Doulas of North America (DONA) International,[23] trains and certifies professional birth doulas in over 20 countries.

Program Challenges

Declining annual enrollment presents a major challenge for BTC's CBE. At its peak in 1986, the program taught 1,274 couples, but enrollment declined by almost 300 couples in 1987. By 1999, the number of participating couples had decreased to 437. This reduction is due, in part, to competition from other programs in the region, particularly hospital-based ones. Hospitals previously functioned as client referral sources for CBE. A change in the public's perception about the need for childbirth education and class content has also contributed to lower enrollment. Program staff believes that the availability of epidurals has reduced public interest in CBE because women do not realize that childbirth education encompasses more than labor and birth.

[22] www.icea.org
[23] www.dona.org

To meet the challenge of declining enrollment, program staff periodically reinvents the CBE program. CBE staff conducts free, monthly informational classes at participating sites to educate pregnant women about childbirth classes and to recruit them to the program. These potential CBE participants learn that Medicaid covers childbirth education, and that scholarships are available to others who do not qualify for Medicaid but need financial assistance. To boost enrollment, CBE staff also presents consumers with more choices to meet their changing needs. Free classes—Introduction to HypnoBirthing,[24] Birthing Options,[25] and Signing With Your Baby[26]—are offered at certain partner sites. Also, in addition to the multiple-session CBE, a one-day CBE class is offered that may fit better into many working women's schedules.

The shorter CBE curriculum, despite its popularity, gives rise to other concerns. Some key benefits offered in typical group care settings are lost with the one-day CBE. A one-day curriculum reduces the time available for group activities designed to reinforce learning, which results in less social interaction and lower participant satisfaction. Differences in evaluative responses by Thurston and Pierce county participants illustrate this. For instance, in April 2005, 87.6% of participants in the Pierce County CBE programs strongly agreed that they had sufficient opportunity to ask personal questions, and 80.9% indicated that they would recommend the class to others. Conversely, only 69.5% and 55.2% of participants in the Thurston County CBE, which has more limited site choices and offers only one-day classes, reported similarly.

Another challenge is to promote group cohesion by identifying sufficient commonalities among highly diverse participants. The different learning styles of teens and adults, for example, may pose difficulties when trying to develop an interconnected group. Teens, unlike many adults, generally need constant stimulation in class. Teens also face many issues that adults do not. Arranging transportation is more of a problem for teens than for adults. Instructors must develop classes for teens that are interactive, appropriate to their literacy levels, and that build personal relationships. As a result of theses challenges, BTC implemented a teens-only CBE class in 1989.

Future Directions

BTC is in the process of constructing a permanent building where CBE will have a dedicated classroom.

The program administrator's willingness to "think outside of the box"—to be creative and reinvent the program when necessary—has contributed to CBE's success. Other important factors include: many years of experience with childbirth education; collaboration with community partners; a variety of locations for classes; low staff turnover; committed instructors; and lower tuition fees due in part to state support of the program.

[24] HypnoBirthing uses slow breathing, visualization, and self-hypnosis to make labor and birth more comfortable.
[25] Birthing Options provides participants with resources and choices for giving birth.
[26] Signing With Your Baby teaches parents early communication with their baby through sign language.

LIFE SKILLS CLASSES
Step by Step Family Support Center
Milton, Washington

"The goals of the Life Skills Classes are to help minimize client isolation, to connect our clients to both people and resources, and to educate them in different areas that relate to healthy living."

The Step by Step Family Support Center, a non-profit First Steps provider, offers Life Skills Classes to MSS clients. Life Skills Classes provide education in various life skills, dinner, and craft time. While Step by Step serves clients in King, Pierce, and Snohomish counties, the first three series of Life Skills Classes were held in Pierce County.

A Step by Step caseworker was inspired to create the Life Skills Classes after discussions with the director, who had participated in Washington State's two-day brainstorming workshop for First Steps coordinators. The MSS staff wanted to provide more than home visits—they also wanted to provide their clients with support, socialization, and education. The first series of classes were offered in Spring 2004.

Women participating in the Life Skills Classes represent all stages of pregnancy, including the first postpartum year. Most program participants receive medical coverage through Medicaid. Group participants are 40% white, 30% African American, and 20% Hispanic, with smaller proportions of American Indians (3%), Asians/Pacific Islanders (5%), and other races (2%).

First Steps caseworker involvement is key to recruiting clients and keeping them engaged in group classes. Caseworkers invite their MSS clients to join the classes, make reminder calls the day of class, and arrange transportation when needed. Familiarity with the person extending the invitation to join the group is believed to be essential for successful recruitment.

Incentives for both recruitment and attendance include hot meals for the entire family, child care, weekly crafts, door prizes, and Baby Bucks. Baby Bucks can be spent at the Care Net store in Tacoma for diapers, clothing, cribs (for 8 Baby Bucks), car seats, or other items. Participants also receive weekly take-home gifts, often related to the topic discussed in class that day. After the presentation on finances, for example, clients received a bill organizer.

Although the Life Skills Classes originally targeted pregnant and parenting women, group sessions grew to include the women's friends, family members, and the fathers of their babies. Average group size varies with location. The Life Skills Classes are held in two locations in Pierce County: the Lighthouse Christian Center in Puyallup, and Soma Church in Tacoma. The average group size at the Lighthouse Christian Center is 10 clients, with the total group numbering 30. At Soma Church, 30 clients attend group classes, with the total group numbering 75.

Each series of Life Skills Classes consists of eight weekly two-hour sessions in the evening. The environment is inviting, loving, and accepting. Upon arrival, clients receive name tags and door prize tickets. During the first hour of the session, dinner is served and winners of the door prizes announced. After dinner, children go to childcare and parents move to the class area. The next half hour is dedicated to the presentation of the evening's life skills topic. Health and wellness topics

Life Skills Classes (Step by Step Family Support Center)	
Service Area:	**Average Group Size:**
Pierce County	10 and 30 clients (varies by location)
Target Population:	**Program Length:**
Pregnant and parenting women	8 weeks (1 evening session/week)
Number Served Annually:	**Session Duration:**
150–175	2 hours
Proportion Medicaid:	**Sample Topics Addressed:**
95%	Motherhood, Parenting, Conflict Resolution

Selected Characteristics of Women Who Gave Birth in 2004		
	Pierce County (N=10,101)	**WA State (N=80,433)**
Race/Ethnicity*		
White	64.6%	64.7%
Hispanic	13.0%	17.5%
African American	6.7%	3.4%
Native American	1.3%	1.8%
Asian/Pacific Islander	8.0%	8.4%
More than one race/other/unknown	6.2%	5.3%
Live Birth Rates (per 1,000 women)**		
Birth rate of women ages 15–44	63.8	62.8
Women ages 15–19	33.6	31.2
Births with Medicaid-Paid Maternity Care*		
Number of Medicaid Births	4,292	36,915
Percent of Total Births	42.5%	45.9%
Percent Received Maternity Support Services	70.7%	71.0%
Percent with Maternal Smoking (Yes)	18.4%	16.8%
Percent Low Birth Weight, singleton liveborn	6.2%	5.7%
Percent of Medicaid Births to Non-Citizens	12.9%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).

vary at each series and include Motherhood, Parenting, Smoking/Tobacco, CPR/Choking, Conflict Resolution, Basic First Aid, Cooking/Nutrition, Finances, Organization, Sexuality/Healthy Relationships, Celebrating Recovery, and the Community Resource Fair. Presentations occur in a relaxed environment. Participants may ask questions during the talk or discussion period. A 20–30 minute period for crafts or another activity follows, during which clients have the opportunity to socialize with other adults.

In the planning stages, a Director of Development was hired to oversee the entire program. She serves as coordinator, facilitator, organizer, and fundraiser. She also recruits guest speakers and locates organizations willing to support Life Skills Classes by providing facilities and volunteers. First Steps caseworkers help facilitate group classes. Guest speakers are recruited through referrals, word of mouth, the hosting organization, Step by Step staff, and health care centers. All speakers volunteer their time.

Each series of Life Skills Classes concludes with evaluations by the program staff and the core group of caseworkers and volunteers. Caseworkers receive feedback from clients during one-on-one sessions and, informally, during the drive home from classes. Caseworkers report that clients love the crafts, socializing, and structured activities for both themselves and their children—so much that when the series ends, clients want to know when the next one begins.

Participants remain connected after the eight-week Life Skills Classes end. During the classes, clients often develop relationships with volunteers, other clients, and Step by Step employees other than their caseworker. Additionally, Step by Step offers reconnecting events like summer cookouts and an annual Christmas party that drew approximately 750 people last year.

The Life Skills Classes partners with faith-based organizations and other community organizations. Because Step by Step is a non-profit organization, it can accept resources from other non-profit entities, such as churches. Faith-based organizations are Step by Step's primary source of volunteers. Churches also host group classes by providing rooms, kitchens, and sound equipment, all at locations convenient for clients. Staff hand-pick a core group of 3–5 individuals at each church to help define the program, brainstorm resources, and recruit other needed volunteers. The total number of volunteers ranges from 75–100. Volunteers serve as table facilitators, provide child care, prepare for classes, serve dinner, hold babies during craft time, clean up, provide transportation, build relationships, and extend invitations to stay connected with the clients. Volunteers often become mentors to individual clients. The Tacoma Rescue Mission provides dinner for clients and their families.

Life Skills Classes also collaborated with Mothers of Preschoolers (MOPS), an international Christian non-profit organization, to offer a one-day luncheon/class in Fall 2005 focusing on creative discipline. The staff wanted to find ways to help connect their clients to local MOPS groups, which, in the case of the Des Moines MOPS group, meet biweekly, offer presentations on health topics in a group setting, and provide childcare.

Program Challenges

The primary challenge faced by clients is transportation. Caseworkers regularly provide transportation for several clients each week. Additionally, volunteers are recruited to provide rides. Friends who drive clients are reimbursed for gas money.

Funding is also an ongoing challenge. Funds raised provide for social activities like crafts, foot spa treatments, gas reimbursements, weekly take-home gifts, craft materials, and thank-you dinners for church volunteers. The average weekly cost of the initial series of classes was $13.54 per client, including family members (or $3,251 for 30 clients over 8 weeks).

Future Directions

In addition to continuing the Life Skills Classes in Pierce County, one caseworker is starting a series of classes for MSS clients on a smaller scale in Snohomish County. She will conduct group classes in the morning, serve juice and muffins, schedule speakers, and provide child care. The majority of the clients are Spanish-speaking, and the caseworker's friend has volunteered to be a translator.

Everyone involved with the Life Skills Classes volunteers their time and expertise. "*You know it comes from the heart because there's no way to explain why volunteers and our caseworkers, who already put in a lot of hours, are willing to give up an evening every week for two months—there is no other explanation for it—it does come from the heart.*" Committed volunteers, from the community and First Steps staff, make the dream of the Life Skills Classes a reality.

SAFE BABIES, SAFE MOMS OF SNOHOMISH COUNTY TARGETED INTENSIVE CASE MANAGEMENT (TICM) PROGRAM

Pacific Treatment Alternatives
Everett, Washington

The program at Pacific Treatment Alternatives helps alcohol and substance abusing mothers and their children become self-sufficient, safe, healthy, drug-free, and better parents.

Pacific Treatment Alternatives (PTA) is the Targeted Intensive Case Management (TICM) provider for the Safe Babies, Safe Moms (SBSM) program in Snohomish County. As a TICM provider, PTA is responsible for providing specialized services at no cost to pregnant and parenting women who abuse drugs or alcohol. Groups and classes augment individual client services related to behavioral health, child development, and parenting education. As the program has evolved over time, the balance between individual and group therapy services has shifted toward group services. PTA currently offers eleven classes on a variety of topics.

PTA first provided services to clients in group settings in 1969 as a chemical dependency treatment agency. In 1992, PTA extended services through two programs, Pregnancy Outreach and Pregnant and Parenting Women, to include chemically dependent pregnant and parenting women. In 2001, PTA was contracted as the TICM provider for the Snohomish County SBSM program. In addition to TICM, the SBSM program consists of two other components: chemical dependency treatment and housing support services, provided respectively by Evergreen Manor and Catholic Community Services.[27]

PTA serves women who use alcohol or drugs and are either pregnant or parenting a child younger than age 3. Clients are eligible for services until their youngest child's third birthday and unlike other programs, cannot lose their eligibility during this time. The program is based upon a model of client-centeredness and universal acceptance. PTA's mantra has become "*How can we help?*"

The agency director is a clinical psychologist with a background in agency administration and fiscal management. The program manager is a Chemical Dependency Professional with years of experience serving pregnant women. All staff are credentialed Mental Health Professionals or Chemical Dependency Professionals with Bachelor's degrees and, in many cases, Master's degrees. PTA encourages educational development for staff members by funding continued education, training, and conference attendance.

The sources of client referrals reflect the program's reputation. More then a quarter of all clients are self-referred or referred by a friend, often a program graduate. The Children's Administration of DSHS refers an additional 25% of clients. Counselors at partnering agencies, hospitals, and the Visiting Nurse Services of the Northwest provide added referrals.

In addition to coordinating services, case managers encourage clients to attend group classes, particularly those that would help clients reach the goals they establish with their case managers.

[27] Cawthon L and Westra K. (2003). Safe Babies, Safe Moms Program Evaluation. Research and Data Analysis: Olympia, Washington. Report Number 4.36e.

Targeted Intensive Case Management (Pacific Treatment Alternatives)	
Service Area:	**Average Group Size:**
Snohomish County	6 Participants (range 8–16)
Target Population:	**Program Length:**
Alcohol and substance abusing pregnant and parenting women	Pregnancy until youngest child's 3rd birthday
Number Served Annually:	**Session Duration:**
200 mothers and 400 children	1–3 hours, depending on the class
Proportion Medicaid:	**Sample Topics Addressed:**
90%	Parenting, Relapse Prevention, Dialectical Behavior Therapy

Selected Characteristics of Women Who Gave Birth in 2004		
	Snohomish County (N=8,507)	**WA State (N=80,433)**
Race/Ethnicity*		
White	70.0%	64.7%
Hispanic	12.2%	17.5%
African American	2.1%	3.4%
Native American	1.5%	1.8%
Asian/Pacific Islander	9.3%	8.4%
More than one race/other/unknown	4.9%	5.3%
Live Birth Rates (per 1,000 women)**		
Birth rate of women ages 15–44	61.9	62.8
Women ages 15–19	25.1	31.2
Births with Medicaid-Paid Maternity Care*		
Number of Medicaid Births	3,220	36,915
Percent of Total Births	37.9%	45.9%
Percent Received Maternity Support Services	66.7%	71.0%
Percent with Maternal Smoking (Yes)	17.7%	16.8%
Percent Low Birth Weight, singleton liveborn	4.7%	5.7%
Percent of Medicaid Births to Non-Citizens	21.4%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).

Group facilitators believe that it is more difficult to motivate clients to attend classes initially. Once clients start attending classes, they realize the benefits and continue to attend. Case managers use motivational interviewing techniques or coordinate with other partnering agencies to engage clients. Clients will receive WorkFirst credits if their Individual Responsibility Plan[28] includes class attendance, and housing support partners require class attendance to receive housing services.

PTA currently offers a variety of classes that address such topics as parenting, child development, life skills, domestic violence, safety, assertiveness, education, housing, communication, relationships, interpersonal development, yoga, and walking for exercise. Some classes have a curriculum based on a predetermined number of weeks, while other classes are ongoing. Because most clients have children, onsite child care is provided.

To address the special needs of alcohol and drug abusing pregnant and parenting women, group facilitators have synthesized curricula from other programs for parenting, domestic violence, chemical dependency, and Dialectical Behavior Therapy[29] (DBT). Classes are added and curricula altered in response to changes in client needs and new developments in care.

The organization of each class is similar. It begins with eating and a check-in period. If class is held during lunchtime, a meal is provided; otherwise, snacks are served. The check-in period allows women to share what has happened in their lives during the past week. In some classes, check-in may also include an icebreaking activity.

An instruction period follows, with a discussion of issues that emerged during check-in or a new topic introduced by the facilitator. In some classes, clients participate in experiential exercises like parenting and assertiveness. Experiential exercises reinforce what the clients learn in class. Each session ends with a brief written evaluation asking clients to list three things they learned about the topic, to rate their knowledge about the topic before and after the class, to describe what they liked about the group, and to suggest improvements.

Most clients graduate from the program. Clients who drop out have typically relapsed or returned to old behaviors, family, and friends. Clients who drop out are not dis-enrolled, but become inactive. About half of the clients who leave the program return before their eligibility ends.

Group facilitators believe that client diversity adds to the richness of the group. Differences among clients reveal that problems like substance abuse and domestic violence are not unique to a particular age group or race. Older clients help younger ones by sharing their life experiences.

Clients' drugs of choice shape group dynamics. Multiple drug subcultures exist. The culture surrounding alcohol, for example, is very different from that of heroin. The facilitator's role in the group is to draw attention to the commonalities shared by all addicts. Clients whose treatment

[28] An Individual Responsibility Plan (IRP) is a working document that clearly defines the specific activities, timeframes, and expectations for each WorkFirst participating family member. The IRP may also indicate what support services WorkFirst will provide to enable the person to participate.

[29] Dialectical Behavior Therapy (DBT) is a comprehensive cognitive behavioral treatment for complex, difficult-to-treat mental disorders. DBT with a substance abusing population focuses on increasing skills relevant to avoiding drug use, and focuses on teaching core mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance skills that clients can apply to current problems.

includes methadone are often sleepy. Group facilitators have instituted a no-sleeping policy in sessions; clients are responsible for keeping themselves awake by taking breaks or chewing gum.

PTA ensures that clients receive comprehensive services by seeking out and partnering with existing community programs. Creating partnerships and linkages to services allows PTA to focus their efforts on case management and behavioral health. PTA has formed relationships through outreach activities to educate community service providers about the program, including the services offered and the method for referring clients. Staff turnover also provides an opportunity to create new partnerships by hiring individuals with varied backgrounds and connections to organizations that are not already associated with PTA.

Program Challenges

PTA currently enrolls 125 active clients per month—its maximum allowable caseload—and routinely receives more referrals than it is contracted to serve. To ensure that pregnant women receive services, PTA has restricted program enrollment to pregnant and parenting women with children less than 1 year old. In light of growing caseloads, a balance must be struck between providing as many services to as many clients as possible, on the one hand, and maintaining positive outcomes, on the other.

Because clients are enrolled in the program as long as 3.5 years, case managers and facilitators must set boundaries and remain non-judgmental with their clients. Staff members are sometimes overwhelmed by the intense issues their clients face. PTA responds to these challenges by hiring professionals with academic training and experience working with this clientele. The supportive leadership at PTA helps staff cope when clients experience a setback.

Future Directions

Staff would like to create a structured, educational childcare program and ensure that children with developmental difficulties enroll in appropriate educational programs. Currently, the Little Red School House assesses children for developmental delays.

WOMEN'S EDUCATION SEMINARS
Everett Community Services Office
Everett, Washington

"Our goal is to remove barriers to women's economic self-sufficiency."

The Women's Education Seminars (WES) provides information about life skills, child-rearing, community resources, and other topics to pregnant and parenting women (with children younger than 1 year old) in the CSO's catchment area. WES was started in 2003 by two social workers at the CSO located in Everett (Snohomish County). Programs like WES are not among the standard services offered at CSOs, and therefore do not generally receive state funds. The two program organizers have donated their time to develop, fund, staff, and implement WES at the CSO.

All WES participants are Medicaid recipients, and many, if not all, receive Temporary Assistance for Needy Families (TANF). Pregnant participants are usually in their second or third trimester when they enroll in the WES program. WES participants represent more than 14 different cultural backgrounds; many are Russian/Ukrainian immigrants who adhere to the Pentecostal or Evangelical Christian faith and believe that the tenets of their religion conflict with family planning and birth control. Most (80%) are ages 18–29. By the end of its twelfth seminar series in June 2005, WES had served 30 English-speaking, 56 Russian/Ukrainian-speaking, and 3 Spanish-speaking women.

Participants learn about WES through flyers distributed to local health districts, the local tribe's First Steps providers, and child protective services, or by letters mailed directly to women appearing on social workers' case lists for the Pregnancy to Employment (PTE) program.[30] These women can receive work credit for attending WES. Clients may be referred to the WES program by social workers and/or case managers, and many referrals come from the caseloads of the two social workers who administer and facilitate WES sessions. After clients have been referred, the needs of specific groups are identified based on a two-hour assessment[31] conducted with each participant. Tentative dates are scheduled; space is reserved; arrangements for interpreters and childcare are made; and invitations are sent to clients two weeks before the seminar date, followed a week later by a second flyer and a reminder phone call.

The WES seminar series, offered at no cost to participants, consists of six weekly sessions of four hours each. Each seminar is limited to 12 participants. Topics addressed in sessions typically include life skills and anticipatory guidance, child development, birth control, parenting and legal issues, the First Steps program, child protective services, domestic violence prevention, self care, dental health, immunizations, child safety/car seats, children with special needs, child care resources, community resources, healthy nutrition, smoking cessation, chemical dependency

[30] Pregnancy to Employment (PTE) provides pregnant women and those with children up to 1 year old with alternatives for meeting TANF work requirements. The program also offers access to other state and federal programs, such as First Steps.

[31] The assessment protocol, which comes directly from the Social Services Manual, is "The Pregnancy to Employment Assessment." It is used statewide by CSO TANF social workers for every TANF woman who is pregnant or parenting a child under year of age.

Women's Education Seminars (Everett Community Service Office)	
Service Area:	**Average Group Size:**
Everett CSO Catchment Area	9–10 participants (range 3–11)
Target Population:	**Program Length:**
Pregnant and parenting women	6 weeks (1 session/week)
Number Served Annually:	**Session Duration:**
33	4 hours
Proportion Medicaid:	**Sample Topics Addressed:**
100%	First Steps, Child Development, Job Readiness

Selected Characteristics of Women Who Gave Birth in 2004

	Everett CSO (N=2,328)	Snohomish County (N=8,507)	WA State (N=80,433)
Race/Ethnicity*			
White	66.9%†	70.0%	64.7%
Hispanic	13.8%†	12.2%	17.5%
African American	3.1%†	2.1%	3.4%
Native American	1.7%†	1.5%	1.8%
Asian/Pacific Islander	9.2%†	9.3%	8.4%
More than one race/other/unknown	5.3%†	4.9%	5.3%
Live Birth Rates (per 1,000 women)**			
Birth rate of women ages 15–44	71.2†	61.9	62.8
Women ages 15–19		25.1	31.2
Births with Medicaid-Paid Maternity Care*			
Number of Medicaid Births	1,038†	3,220	36,915
Percent of Total Births	44.6%†	37.9%	45.9%
Percent Received Maternity Support Services		66.7%	71.0%
Percent with Maternal Smoking (Yes)	18.4%†	17.7%	16.8%
Percent Low Birth Weight, singleton liveborn	6.2%†	4.7%	5.7%
Percent of Medicaid Births to Non-Citizens	8.8%†	21.4%	20.3%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).
**Source: Age Specific Live Birth Rates by County of Residence, 2004, Center for Health Statistics, Washington State Department of Health (2005).
† Two year average for 2001-2002.

prevention and treatment, job readiness, the PTE program, transportation, and advocacy by the Northwest Justice Project.

The session format is very relaxed to permit and encourage frequent interaction between presenters, facilitators, and participants. Participants may interject or ask questions at any time. Program administrators facilitate WES sessions, often in conjunction with professionals from community partners. Program administrators emphasize the need to establish trust with and among the participants, and to create an atmosphere where participants feel comfortable. Toward the end, refreshments are provided and the importance of maintaining confidentiality within the group is stressed. Family members, with the occasional exception of infants, are not allowed at the sessions.

Due to the diverse WES clientele, services are culturally appropriate and client-centered. For instance, printed materials distributed during the seminar sessions are translated in each participant's native language and interpreters are provided for Spanish- and Russian/Ukrainian-speaking participants. The same Russian/Ukrainian interpreter provides her services at the Russian seminars offered. She is very knowledgeable about the WES program and is able to convey the interpreted information in context. Although the agenda for each seminar session is structured, the format is flexible. This allows session content to be adapted to participants' needs, as determined by the pre-seminar assessments or recommendations from the referral source(s). As the program administrators noted, the Spanish- and Russian/Ukrainian-speaking women who immigrated to the United States face problems that differ from their English-speaking counterparts born here. For example, smoking cessation services are not provided to the Russian/Ukrainian women because their religious beliefs prohibit smoking, but they and Hispanic women are particularly interested in immigration issues, which are not raised by English-speaking participants.

Each six-week WES seminar ends with evaluations by program participants and a graduation ceremony. Participants reported liking the speakers, the flexibility of the program, the support provided, the company of other women, cooking classes, the opportunity to earn PTE work credit, "*the caring of the facilitators*," and the information they received. Some stated that they wanted "*to learn more*" or "*to know more*," and others expressed interest in longer sessions or an extended seminar series. Unbeknownst to them, participants who completed evaluations received gift cards. At the graduation ceremony, participants are presented with certificates of completion to symbolize their success and to enhance their sense of self-esteem. All program completers, facilitators, presenters, seminar organizers, and caseload workers are invited to the graduation ceremony. A graduate from each group attends the first seminar session of the next series to welcome new WES participants. Reasons cited by the fewer than one-third of participants who do not complete the program were acceptance into educational programs, removal of a child from the home, or delivery of a baby during the seminar series.

Program administrators plan and organize seminar sessions with the help and support of community partners. One program administrator, a Ukrainian refugee active in the refugee community, is trilingual and was an adult education teacher; the other, a Native American, worked as a First Steps social worker for six years. Each has about eight years of experience as a social worker. Neither program administrator has formal training in group process or facilitation. Using a grassroots approach and capitalizing on contacts already established with First Steps providers, program administrators enlisted the help of eighteen organizations in the community to

develop the WES program. These community partners provide client referrals, in-kind contributions, seminar presentations, and assistance with agenda development.

Program Challenges

Securing adequate funding for the WES program is a major challenge. Program staff wants to obtain grants, donations, and/or government support in order to include participants who speak Marshallese and Arabic, offer more activities during sessions, buy more car seats, provide nutritious refreshments, extend the length of each seminar by a few weeks, give better incentives to participants, and hire a program assistant. However, since program administrators also work full-time as social workers at the Everett CSO and have large caseloads, the time they can devote to pursue additional funds is limited. One administrator said they would be "*lucky*" if they could continue providing WES services in the near or distant future.

Another challenge faced by program administrators is recruiting Hispanic women. To encourage their attendance, a Hispanic eligibility determination worker well-known in the community personally called each of 23 Hispanic women originally enrolled in WES, but only three ultimately participated. The immigration status of Hispanic women, many of whom are illegal immigrants fearful of attending programs offered at government offices, may account for their low turnout. In addition, because undocumented women are ineligible for TANF, social workers do not have contact with them and cannot encourage their participation in WES. Furthermore, in contrast to the Russian interpreter, the Spanish interpreter was less familiar with the WES program and may have been unable to communicate information as effectively.

Future Directions

Program administrators said they would structure a WES group for Hispanic women differently in the future. Possible solutions include partnering with Familia Unitas[32] or Sea Mar,[33] moving to a different location, providing more information about immigration and legal issues, and shortening the length of sessions. To function, the WES program requires a great deal of time, energy, and dedication. Program administrators and professional staff from community partners have put forth tremendous effort and resources to make it possible. Program administrators attribute the success of WES largely to this collaborative, grassroots approach.

[32] Familias Unidas is a Latino Resource Center in Everett offering a variety of services, education, and support. (http://www1.co.snohomish.wa.us/Departments/Human_Services/Divisions/Admin/Latino/default.htm)

[33] Sea Mar Community Health Center is a community-based organization committed to providing quality, comprehensive health and human services to diverse communities, specializing in service to Latinos. (http://www.seamar.org/)

YOUNG WOMEN'S GROUP
Port Gamble S'Klallam Tribe Community Health Department
Kingston, Washington

"The goal of the Young Women's Group is to provide a peer support group for young women to learn about health, form a social support network, and become empowered to make healthy choices for themselves, their babies, and relationships in life – to provide young women with the tools necessary to plan for their futures."

The Young Women's Group, a peer support group for young women of childbearing age in the Port Gamble S'Klallam Tribe, combines health education on a range of topics with instruction in a traditional Native skill or craft. The group meets at the Tribe's Community Health Department on the reservation.

The Port Gamble S'Klallam Reservation is located on 1,340 acres of mostly forested land on the northern tip of the Kitsap Peninsula. Port Gamble Bay, which forms the western border of the reservation, and streams supporting local salmon runs are important natural resources for the Tribal community. About half of the 1,000 enrolled Tribal members reside on the reservation, together with other Native Americans and non-Indians. The total reservation population is 932.

The Community Health Department on the reservation provides health and social services to the Tribal community. The department's staff—three nurses, a health educator, two community health representatives, and an office manager—provides a range of services, including a maternal child health program that offers First Steps, WIC, health education, car safety restraint training, transportation, immunizations, elder case management, prescription delivery, and outreach. One key focus area, Fetal Alcohol Syndrome (FAS) prevention, included education for pregnant women, elders, and children. What was lacking in their programs, they felt, was a strong educational component for young women ages 16–25. The Health Educator had the idea to create a peer support group where young women could learn together and support each other. Instead of focusing on only one topic, the Health Educator also wanted to educate women on many different health and wellness issues. She planned the project in 2002 and wrote a successful grant to the March of Dimes. Group classes started in January 2003.

The inspiration to create the peer support group came from two areas. The pregnancy rate for young women age 25 or younger on the reservation is high, and it was difficult to educate these women about health issues. Secondly, the lack of a social support network for women became apparent during one-on-one MSS client meetings. Some clients had severed their existing relationships as part of their efforts to abstain from alcohol or drugs.

The Health Educator, a Tribal member living on the reservation, sends out personal invitations, writes a community memo, and uses one-on-one outreach and word of mouth to build support and excitement about the support group. A list of potential clients, women ages 18–30, is generated from the Tribal community database. Invitations to join the group are sent to women on the list who live on the reservation. The group is limited to 10 participants. Reminder calls are made the day of meetings and transportation, if needed, is arranged. Because the young women already knew the Health Educator, who is also a member of the Tribe, recruitment has been successful.

Young Women's Group (Port Gamble S'Klallam Tribe Community Health Dept.)	
Service Area:	**Average Group Size:**
Port Gamble S'Klallam Reservation	10 participants
Target Population:	**Program Length:**
Women ages 18–30	6 months (biweekly sessions)
Number Served Annually:	**Session Duration:**
10	2 hours
Proportion Medicaid:	**Sample Topics Addressed:**
95%	Self-Esteem and Self-Love, Wellness Wheel, Fetal Alcohol Syndrome

Selected Characteristics of Women Who Gave Birth from 2000 to 2004 (5 Yr. Total)

	Port Gamble S'Klallam Reservation (N=56)	WA State* (N=395,584)
Race/Ethnicity		
White	17.5%	66.3%
Hispanic	0.0%	16.0%
African American	0.0%	3.8%
Native American	75.4%	2.0%
Asian/Pacific Islander	0.0%	8.3%
More than one race/other/unknown	7.1%	1.1%
Births with Medicaid-Paid Maternity Care		
Number of Medicaid Births	46	174,814
Percent of Total Births	80.7%	44.2%
Percent Received Maternity Support Services	84.8%	71.1%
Percent with Maternal Smoking (Yes)	28.3%	18.2%
Percent Low Birth Weight, singleton liveborn	8.9%	5.4%
Percent of Medicaid Births to Non-Citizens	0.0%	18.9%

*Source: Characteristics of Women by County, 2004. First Steps Database (2005).

Craft activities, food, and Native American speakers provide the incentives for recruitment and attendance. Participants in the first Young Women's Group made traditional button blankets, large blanket-type shawls made of wool with mother-of-pearl buttons. Having Native American speakers is important because most have lived on a reservation and understand the participants' culture and communication styles.

Women enrolled in this first group included pregnant women, postpartum women, mothers, and women trying to get pregnant. Pregnant women and mothers received one-on-one MSS services from two group facilitators. Ages ranged from 18–30, with 90% of participants being Native American and 10% non-Hispanic white. Almost half the participants were single mothers. Most program participants (95%) received medical coverage through Medicaid. Spouses do not attend group sessions due to the sensitive nature of the topics discussed (e.g., domestic violence and self-esteem). If a mother is breastfeeding, her child is allowed to attend the group.

The initial Young Women's Group met twice a month for two hours in the evening over the course of six months. All participants sign a confidentiality agreement at the first session, promising to keep all things said and done in the group completely confidential. To generate discussion, each group session begins with an icebreaker activity where everyone draws a card from the "question jar." The first hour of the session is dedicated to a presentation on the evening's health topic. A discussion period follows the presentation, allowing participants to ask questions and share their thoughts about the topic. A light dinner is then provided. During the second hour, a Native elder taught classes on traditional button blanket making. This large craft project took five months to complete.

At the first group session, participants chose the health and wellness topics to be presented. The Health Educator feels that this process is significant because it gives participants a stake in the process from the beginning. The health topics selected for the first Young Women's Group included: Nutrition, Wellness Wheel, Peer Solutions to Wellness Wheel, Stress Reduction, Relationships, Self-Esteem and Self-Love, FAS, Substance Abuse, Fatherhood, Resources/Planning Ahead, Folic Acid, and Family Planning.

The Health Educator and the Maternal Child and Community Health Nurse with the Tribal Community Health Department developed, organized, and facilitated the Young Women's Group, and also delivered presentations at two group sessions. They emphasized that having a Tribal member serve as a facilitator contributed to the success of recruiting and facilitating the group. Outside speakers—provided by community partners, other Tribal programs, contacts made at the Tribe's annual Health Fair, and referrals—are invited to share their expertise so that women have access to multiple sources of health information.

The Health Educator's successful grant proposal provided $2,400 for the peer support group. This award funded supplies for the blanket project (wool, mother-of-pearl buttons, sewing machine), light dinners, payment for two speakers, and traditional gifts for three speakers.

Clients fill out an evaluation at the end of each group session. They reported liking the variety of topics, supportive friends, comfortable environment, presenters' knowledge, and the crafts. When asked what they would do differently, two said they would "*try to be more healthy and plan my*

next pregnancy"; another said "*self-love, to think about my decisions before I do my choices*." When asked what they learned in this group that they didn't know before, answers included: "*I learned many of us go through the same things*"; "*I learned about ways I can improve my health, ways of dealing with stress and alternatives to unhealthy behaviors*"; "*I learned a lot of information about birth control, about FAS*."

Program Challenges

The six-month program duration was noted as a challenge to achieving full attendance at each session. Both the six-month series duration and the two-hour duration of sessions were determined by the traditional button blanket craft project. Although 10 women signed up for the group, only 6 core people attended throughout the entire period. If participants missed two or more sessions, they felt they were too far behind the others in making their blankets to attend. The facilitators believe a shorter time period may help retain more clients.

Future Directions

The next Young Women's Group will target pregnant and new moms under the age of 25. The group will meet once a week for 1.5–2 hours for six weeks and include simple crafts—body pillows, baby books, or a family tree—and a graduation ceremony. Two Mental Health Counselors from the Tribal Wellness Center, both mothers with young children, will be added as group facilitators. Panel presentations covering issues such as breastfeeding, self-esteem, and substance abuse may be included to give participants a range of different views and experiences. Although the next group currently being planned lacks grant funding, the Health Educator does not foresee a problem. She believes that group classes can be developed inexpensively by coordinating resources and using other programs and services.

The dedication, time, and energy of the Health Educator and the Community Health Nurse, in conjunction with guest speakers from community partners and other Tribal programs, have made this program successful.

CRITICAL FACTORS

Despite variation across programs, certain factors were generally acknowledged as critical to their success. During interviews, program representatives described what made their programs *really* work, and commonalities began to emerge. We highlight several factors repeatedly identified as important for success: leaders with a clear vision, effective group facilitators, incentives and recruitment strategies to encourage participation, and community partnerships.

LEADERSHIP

> *"I had this vision, dream of [creating these group classes]; the director of our agency invested funding; a community organization opened up their facility to us because they 'got really excited about what [we] wanted to achieve.' "*

"Leaders are visionary, honest motivators and dedicated to people."[34] This aptly describes many of the program representatives interviewed for this report. The success of these group programs is attributable to the individuals with the drive and ingenuity to develop them. These intuitive people recognized specific needs in their communities, envisioned ways to meet them, and used their creativity and resourcefulness to turn those visions into reality. They garnered support from administrators at their respective agencies, wrote grants, networked, identified appropriate partners and resources, and established linkages with those partners. The persistence, heart-felt commitment, energy, and compassion of these visionaries were essential for the development and implementation of these group programs.

EFFECTIVE FACILITATORS

> *"I think that interpersonal warmth is probably a quality that makes our program excellent."*

Effective group facilitators combine leadership and facilitation skills. At five of seven sites, the individuals with the vision to create the group were also full- or part-time facilitators and presenters. Facilitators plan, develop, coordinate, and organize group sessions. They also recruit participants, invite clients, purchase food, design and produce fliers, and arrange transportation.

The goals of these five groups include socialization, creating support networks, and education. All program representatives identified similar personal qualities and skills as essential for successful group facilitators: enthusiasm, warmth, empathy, genuineness, flexibility, good organizational and listening skills, and knowledge. Group facilitators must also have the ability to inspire and empower participants, and to create a supportive and nurturing environment. Other important attributes cited by program representatives include a sense of humor; cross-cultural skills; and computer skills, needed to make invitations, flyers, and other materials. Group facilitation of substance-abusing pregnant and parenting women requires additional skills, such as boundary-setting and training in mental health or crisis intervention.

[34] Diaz, 1999.

Facilitators at most sites hold professional degrees in community health education, nursing, psychology, or social work, and have experience as case managers, mental health professionals, chemical dependency professionals, labor and delivery nurses, or midwives. Although one site requires only a high school diploma, childbirth education students complete a two-year, part-time curriculum in maternal and child health, with additional training in group development and teaching. Upon completion, students are certified as childbirth educators. Another site combines the strengths of several individuals—masters of ceremony, who are humorous; someone with organizational skills, enthusiasm, and passion; participants' caseworkers; and church volunteers—to provide the qualities and skills for effective group facilitation.

While program representatives acknowledged that command of subject matter is important, the attribute of professionalism elicited qualifying statements from several sites. "*Professionalism coupled with humanitarianism and warmth, the heart*." "*The formal edge doesn't go over very well; they do not respond well to that—they don't relate*." "*Someone cannot come in wearing corporate clothes and expect our population who is 200% of FPL to look at you like you can be empathetic with their needs*."

Are effective group facilitators born or made? Most program administrators reported that anyone can learn about group facilitation, group dynamics, communication, and computer skills, but a successful facilitator must also possess certain personal qualities. Program representatives emphasized that "*you cannot create the enthusiasm, care, and genuineness by giving someone a paycheck*." Program representatives repeatedly referred to the necessity of "*having the heart to do this work*." The literature emphasizes the importance of integrity, empathy, caring, listening skills, enthusiasm, flexibility, the capacity to inspire, the ability to create a supportive and nurturing environment, and the skills needed to read the underlying dynamics of the group.[35]

RECRUITMENT/OUTREACH

> *"Participants need to be recruited by someone they trust."*

Program representatives stressed the importance of using program contacts that were familiar to clients. Often, clients were familiar with program facilitators in their capacity as First Steps one-on-one MSS providers or case managers. When program facilitators were unfamiliar to clients, knowing the individual who made the referral—for example, a First Steps provider—proved important. When clients are referred to a program by a source they trust, some of that trust is transferred to the program. One program representative commented that First Steps caseworkers "*did an incredible job*" connecting clients to their classes.

One-on-one outreach was essential to persuade clients unfamiliar with services or those less willing to accept services to enroll in programs, and to encourage their continued attendance. Contacting clients prior to each session served not only as a reminder, but also as an opportunity to encourage reluctant clients to attend and to offer assistance with transportation. As one program

[35] Anderson-Butcher et al., 2004; Project Kaleidoscope, 2005; Schuman, 2005.

representative commented, "*the reminder calls prior to the event*" boosted recruitment and participation. Another stated, "*People always need a reminder call and they might need a ride*."

Table 5. Referral Sources and Recruitment Methods

Group Program	*Referral Sources*	*Recruitment Methods*
Bienestar	First Steps providers, WIC staff	One-on-one outreach, Flyers
Centering Pregnancy®	Family Planning of Chelan & Douglas Co., Word-of-mouth	Pregnancy counseling session at FPCD
Childbirth Education	Medical care providers, MSS providers, WIC staff	Flyers at partner agencies, Brochures at providers' offices, Free informational classes
Life Skills Classes	First Steps Caseworkers, Word-of-mouth	One-on-one outreach
Safe Babies, Safe Moms TICM (at PTA)	Children's Administration, Word-of-mouth, Partner agencies	One-on-one outreach, Flyers
Women's Education Seminars	Pregnancy to Employment social workers, Child Protective Services, Tribal First Steps providers, Health Districts	Flyers at partner agencies One-on-one outreach Personal invitations and mass mailing to Pregnancy to Employment clients
Young Women's Group	Tribal Community Database	One-on-one outreach Personal invitations Community memorandum

INCENTIVES

> *"One of our biggest draws, I think personally, you have to have an incentive, a craft, food for sure."*

Each program offered at least one incentive to participants. We defined an incentive as an item, activity, or service offered to clients to encourage enrollment and attendance, over and above the education component of the program. Table 6 displays a list of incentives offered by each program.

Incentives offered at each program varied by client characteristics, program length, and available resources. To provide meaningful incentives, programs must understand their clients' unique needs and motivations. Incentives ranged from pleasurable activities like crafts and door prizes, to basic needs like food, housing, and transportation.

Food, often a meal, was the incentive most frequently offered at group meetings. Food creates a relaxed atmosphere and provides an opportunity for group members to socialize. Clients living in group housing really appreciated delicious meals. One facilitator credited "*the good lunches that I served*" with increasing attendance in her group.

Table 6. Incentives Offered by Programs

Group Program	*Incentives*
Bienestar	Meal Crafts/Activities – scrapbook, picture frames, scarves, games Transportation, if needed Door prizes and gift baskets Infant car seat Special Events – Reunion for past clients
Centering Pregnancy®	Snacks Crafts/Activities – belly casting, belly painting, race socks Special Events – Reunion for all past CenteringPregnancy® clients
Childbirth Education	Doula intern provided at no cost Condensed courses – one day and two day
Life Skills Classes	Meal and leftovers to take home, desserts Crafts/Activities – fleece pillows, holiday cards, drawings, Mom's Picture Brag Book Transportation or gas money, if needed Child care Baby Bucks to buy clothes, diapers, car seats, etc. from CareNet Door prizes Certificate for program completion Special Events – Foot Spa night, special music, Annual Christmas Party
Safe Babies, Safe Moms TICM (at PTA)	Meal Crafts/Activities – plaster masks Transportation Child care WorkFirst credits (if on IRP) Advocate for client's case; letters of class attendance Certificate for parenting class Mentoring program with Zonta Alumni may attend groups on a space available basis after completing program Special Events – quarterly activities, i.e. pumpkin patch field trip and trick-or-treating
Women's Education Seminars	Snacks Transportation (if on IRP) Child care (if on IRP) WorkFirst credits (if on IRP) Gift card after completing program evaluation Graduation Certificate including recognition for perfect attendance
Young Women's Group	Light meal Craft/Activities – Traditional Button Blanket Transportation, if needed

Several programs have incorporated nutrition and food preparation into their curricula. Bienestar increased the length of each session to allow time for a weekly cooking activity. A nutritionist from the health department coordinated a quick meal that clients prepared and ate together. Providing food at every session can be time-consuming for facilitators. At PTA, clients plan the

menu, create a shopping list, and prepare the meal. Consequently, clients learn important meal preparation skills and facilitators have more time to devote to the curriculum.

Craft activities gave clients a way to express themselves and time to socialize with others. Projects included scrapbooks, masks, and traditional button blankets. Facilitators have integrated crafts into the curriculum through creative experiential projects. At PTA, clients create plaster masks of their faces and decorate the exterior of the mask to identify how they present themselves to others. They decorate the interior of the mask to represent what they do not show to others. The Young Women's Group chose a traditional button blanket project in part to encourage regular attendance, as it would take five months to complete. However, the facilitator identified one challenge to large projects: clients who miss a few sessions may have difficulty keeping up with the project, become discouraged, and quit attending altogether. Bienestar, using a different strategy, began each session with a craft activity so clients arriving late would not miss important educational messages.

Some programs awarded participants certificates upon program completion. Receiving a certificate provided "*a sense of accomplishment*" and documentation that CPS or court-ordered requirements had been fulfilled. Earning a certificate also enhanced clients' self-esteem.

Incentives have changed over time. Long-standing programs, such as CBE, have developed new incentives to meet the changing needs and motivations of their clients. In the 1970s, when support persons could not be present in the delivery room without first completing a childbirth education program, a certificate awarded at the program's conclusion provided an incentive for regular attendance. BTC does not currently award certificates, which are no longer required. One incentive for clients today is additional support during the birth process. Clients appreciate having doula interns provided at no cost. Condensed one- and two-day CBE courses also accommodate clients' busy lifestyles.

Material incentives may work to encourage short term attendance, but not long term. In the past, PTA clients earned points for class attendance and could exchange points for basic household items. PTA found that clients stopped attending once they had received all the items offered. More recently PTA has developed partnerships with programs that require class attendance. Several housing programs offered by Catholic Community Services require residents to attend group classes at PTA. By including class attendance on the clients' WorkFirst IRP, Women's Education Seminars and PTA clients may receive WorkFirst credits.

COMMUNITY PARTNERSHIPS

> *"Our relationships within the community are the motivating factors that keep women engaged."*

Various community partners provide support to the seven group programs featured in this report. One program has 18 partners, while others have 3–6. This variation notwithstanding, all program representatives indicated that collaborative relationships with community partners are essential to the functioning of their programs. As noted by a program representative, "*…great partnerships with other organizations in the community*" contribute to program success. Community connections developed over many years were a necessary component of the grassroots campaign to

implement a group program at another site. According to other program staff, creating partnerships and community linkages allows them to focus their efforts on case management and behavioral health, while ensuring that program participants receive comprehensive services. They reported that community relationships are a distinctive factor that sets their program apart from others in the area. Another program representative said that community partnerships "*are instrumental because they are our primary source of volunteers*." "*We couldn't afford to do this program without their support financially*," one program staff member admitted.

The importance of community collaboration is also illustrated by the efforts of program staff to initiate and maintain linkages with other organizations and individuals. Writing grants and letters of support to organizations like the March of Dimes,[36] and becoming a United Way member agency,[37] were cited as ways to develop partnerships and obtain funding. Other strategies included capitalizing on personal and professional relationships with members of community organizations, recruiting staff from other aligned organizations, and making cold call requests for funding. Program staff members at one site complete Memoranda of Understanding (MOUs) with other programs or agencies. In addition, program staff decided to refer participants to local literacy and mentoring programs rather than develop such programs in-house, thus creating additional community linkages for participants and providing mutual support to the local organizations. Inviting professionals from local agencies to speak or facilitate group sessions also establishes partnerships.

By collaborating with community organizations, group programs are able to secure essential funding, materials, training, services, incentives, referrals, guest speakers, equipment, meeting space, facilities, and other types of support. For instance, two group programs received funding for program implementation from the March of Dimes; one also received money from the United Way to supply participants with workbooks. Collaboration also educates program participants about community organizations and provides a link to services. Community partners include other non-profit organizations, individual service providers, volunteers, faith-based organizations, government agencies and programs, coalitions, local hospitals, for-profit companies, and school districts—even, in some cases, international associations.

Given the various ways in which these seven programs have implemented and sustained group services for pregnant and/or parenting women, it is remarkable that the critical factors for success most frequently cited by each were so similar.

[36] "Every year the March of Dimes provides millions of dollars in grants, scholarships and awards that promote research, education for professionals, and community programs designed to reduce infant mortality and improve the health of babies." http://www.marchofdimes.com/professionals/685.asp
[37] http://www.uwint.org/gppweb/about/about.aspx

CONCLUSIONS

From the American Medical Association to Zonta International and from Alcoholics Anonymous to Weight Watchers, groups are part of everyday life in America. Groups exist in a wide range of contexts and assume a variety of forms, including ad hoc groups, therapy groups, friendship groups and cliques, organizational units, self-help groups, Web-based groups, and learning groups. Patients with common and rare diseases, persons with disabilities, caregivers, and family members meet to share information, experiences, problems, and solutions. Groups offer social support, relief from isolation, and opportunities for personal growth and development. Scientists from many disciplines study groups and report their findings in books, journals, and on the Internet. This report focuses on groups in Washington that serve pregnant and parenting women.

Group services have certain advantages over one-on-one services. Group environments provide a welcoming and flexible forum for diverse participants to share similar experiences, concerns, and form supportive relationships. Craft activities foster creativity and openness allowing individuals to express themselves. Overcoming anxiety or shyness and gaining a sense of confidence, empowerment, and community are other potential benefits. Group sessions may represent the only time some participants are free from the responsibilities of their daily lives. Teens, participants without families or a social support network, and those open to making positive changes in their lives are most likely to benefit from group programs.

Groups enhance learning by providing individuals with access to more information and an opportunity to participate in experiential activities. Individuals gain knowledge from facilitators and other group members. As one facilitator commented on the sharing of information, "*There is a lot of wisdom in the group…. [W]omen can hear things [more easily] from their peers.*" Experiential learning activities help to reinforce new skills. Activities such as role playing, games, and quizzes are also more enjoyable in a group than in one-on-one situations.

Additional benefits of group services include cost-savings, provider satisfaction, linkages to community resources, and family support. For instance, the CenteringPregnancy® program is more cost-effective than individual service delivery. Overall costs are lower when information is presented only once to the group rather than repeatedly throughout the day. Participants ultimately spend more time with their providers, and receive more education and services. A midwife reported, "*It's fun to watch the women grow in a group…. I sometimes bond more with the Centering women because I see them for longer periods of time*." In addition, groups that feature speakers from community organizations provide an opportunity for participants to learn about their organizations and services. Group programs that encourage or permit attendance by family members and/or friends not only educate those individuals, but also enable them to discuss how their partners' pregnancies affect their own psychosocial needs, to discover shared experiences with others in similar circumstances, and to be supportive of the women they accompany.

Program representatives stressed the importance of providing a choice between the two models because some women are not comfortable in groups. In particular, certain topics may be too sensitive to discuss in a group. Groups may be inappropriate for high-risk women or those who have experienced trauma. Requiring everyone to receive services in a group setting may be counterproductive because groups that include unwilling participants do not function well.

Another challenge is meeting every participant's need in a group setting. For example, some women may want more breastfeeding information than others. Furthermore, written materials require a certain level of literacy and may not available in all languages. Special transportation arrangements may be needed to help some women attend regularly.

Some program staff advocated using group services to supplement rather than replace one-on-one care. Initial individualized attention makes subsequent group programs more successful because earlier one-on-one contacts draw participants into the groups. Trust must be established before additional linkages with groups and community resources can be developed. Program representatives said that service provision in groups is an important and necessary transition from individual service delivery because it enables participants to become more productive and successful by bringing more people into their lives and reducing their reliance on individual providers and caseworkers for emotional support.

Program representatives also discussed the importance of offering meals, snacks, or refreshments during the sessions. In one form or another, food is a component of all but one group program. Survey responses by participants in a parenting class indicate that, in addition to the camaraderie, respectful and open atmosphere, and information offered in group settings, they value the food provided. One program representative noted that the "*meal is critical*." Eating together as a group helps to foster social interaction, create a sense of community, and provide a relaxed environment where participants can feel comfortable. Increasing participants' socialization and decreasing their sense of isolation are key goals in many group programs, and communal eating is an appropriate vehicle for achieving success in those areas.

Other benefits derived from providing food to groups include encouraging attendance while meeting physical needs, and learning about nutrition and cooking. Some participants may be insecure about food or have access only to poor quality food, and many are motivated to attend group sessions by the good fare offered and the prospect of taking leftovers home. Group programs that link the food provided to a presentation or group activity include the added benefit of education and life skills development. Although providing food during group sessions is time-consuming for program staff, some programs have met this challenge by engaging group members in the tasks of planning and preparing the group meals or snacks.

The seven groups included in this study are particularly remarkable for their responsiveness to identified community needs. While community needs and target populations differed across the seven sites, similar strategies were developed to meet these needs and serve the clients. Group leaders implemented common strategies to achieve successful groups—groups with regular attendance, relevant and client-centered curricula, and the potential to be self-sustaining. Even more important, successful groups provide benefits of social support to promote and reinforce healthy behaviors, socialization and personal development, education and information.

Group services are becoming more widespread in medical care throughout the U.S. By recognizing basic factors critical to group facilitation, a wide range of providers have the opportunity to improve client services this with cost-effective strategy and to meet unique needs of their community members.

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