

Washington State Home Visiting Needs Assessment Narrative

Revised

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Home Visiting Needs Assessment Narrative

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Introduction

Background: Early Childhood Comprehensive Systems and Home Visiting in Washington

Over the last decade, public and private stakeholders in Washington have worked together to build early childhood comprehensive systems (ECCS). Home visiting is one of several service strategies embedded in an ECCS—to promote maternal, infant, and early childhood health, safety and development and strong parent-child relationships. This home visiting grant, the needs assessment, and subsequent planning process, provides an opportunity for Federal, State, and local collaboration to improve health and well-being of vulnerable populations.

Since 2000, Washington’s Foundation for Early Learning has supported early childhood development from birth to age five. In 2003, the federal Health Resources and Services Administration awarded the Department of Health (DOH) a five year ECCS grant. DOH used the ECCS grant to develop and support Kids Matter, a statewide partnership and strategic framework to build Washington’s early childhood system. Home visiting programs and other service strategies in Kids Matter promote maternal, infant, and early childhood health, safety and development and strong parent-child relationships. In 2006, Washington’s Department of Early Learning was established to support access to safe, healthy and quality early childhood development throughout the state.

In 2007 State Senate Bill 5830 directed the Council for Children & Families¹ to collaborate with other agencies on a plan to consolidate home visiting services for children and families. The Department of Social and Health Services (DSHS), the Department of Health (DOH), the Department of Early Learning (DEL) and the Family Policy Council (FPC) joined the Council to develop the plan. Their product, *Senate Bill 5830: Home Visiting Collaboration and Consolidation—Report to the Washington State Legislature*, identified opportunities for increasing collaboration and included short and long term objectives to implement a statewide plan for home visiting. The state did not implement the workgroup’s plan due to budget constraints.

There continues to be a lot of activity in the area of early childhood systems development in the state. For example, Thrive by Five is a public-private partnership championing positive early learning opportunities for children, birth to five, so they are ready to succeed in school and thrive in life. Thrive currently funds home visiting in two demonstration communities. In 2008 Washington State received a Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) grant from the federal Substance Abuse and Mental Health Services Administration. Home visiting is one of five key strategies of the Project LAUNCH. Project LAUNCH funds help support implementation of Parents as Teachers in Yakima County.

In September 2010, the Department of Early Learning completed the *Washington Early Learning Plan*.² One of the strategies in the plan is making evidence-based and promising pre-natal and child (birth to 5) home visiting services more widely available to at-risk families and caregivers. Home visiting is also related to several other strategies in the Early Learning Plan such as

¹ The Council for Children & Families was formerly known as the Washington Council for Prevention of Child Abuse and Neglect/Children’s Trust of Washington

² Department of Early Learning. *Washington Early Learning Plan*. September 2010. www.del.wa.gov/plan

medical homes, developmental screening, literacy programs, and promoting social-emotional learning in young children.

The Early Learning Plan describes the new Home Visiting Matching Fund³, established by the State Legislature. It will be administered jointly by the Department of Early Learning and Thrive by Five Washington. The Home Visiting Matching Fund will leverage increased state dollars for home visiting by providing private dollars as match. It will also support efforts in areas such as coordinating evaluation and providing training and technical assistance.

Overview of Washington, Its Regions and Population

Regions

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. The Cascade Mountains divide the state into Western and Eastern Washington. These two regions are somewhat distinct in terms of geography, climate, economic resources and health care infrastructure. In 2009, about 75% of Washington's population was concentrated west of the Cascades. Most of this largely urban population is along the I-5 corridor, particularly in counties bordering Puget Sound. Over 90% of population growth between 2000 and 2009 occurred in the state's urban counties. Western Washington includes the state's three most populous counties: King, Pierce, and Snohomish. Together these counties represent 51% of the population and 52% of the births.

In contrast, Eastern Washington has large regions that are rural, sparsely populated and/or chronically economically depressed. Several counties in Southwest Washington which are along the coast and up into the Olympic Peninsula also fit this profile. These rural areas typically have shortages of both primary and specialist care providers. Residents of rural counties in Eastern Washington tend to have lower median household incomes, higher poverty rates, and higher unemployment rates. There is a higher percent of uninsured residents and residents enrolled in Medicaid in rural counties.

Counties with large proportions of Hispanics tend to be located in rural areas of Eastern Washington. Two Eastern Washington counties, Adams County and Franklin County, were majority Hispanic in 2008. In the same year, the majority of births in four Eastern Washington counties were to Hispanics. 2000 Census data showed that while Hispanics make up a large proportion of the population in many Eastern Washington counties, the largest number of the state's Hispanics live in Western Washington in King, Pierce, and Snohomish counties. In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents. Most of the farm workers are Hispanic and live in Eastern Washington. These farm workers are more likely to face language barriers and to have low family incomes and limited transportation options. Most rely on community and migrant health centers for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 54% of Asian/Pacific Islanders and 48% of Blacks resided in King County alone in 2008.

In 2009, the average population density in Washington was 100.3 persons per square mile. The national rate reported in the 2009 Population Estimates Program is 82.6 persons per

³ The Home Visiting Matching Fund is also known as the Home Visiting Services Account.

square mile. Population density estimates for 2009 range from 906 persons per square mile in King County in Western Washington to less than four persons per square mile in Garfield and Ferry counties, both in Eastern Washington.

The Data Report section of this Needs Assessment includes additional information on Washington's overall population and race/ethnicity, with an emphasis on women of child bearing age, infants and children. This information can be found in the text and in Table 1: Population and Births (Count), Washington State 2008 and Table 4: Numbers of Births by Race/ Ethnicity by County and Subcounty, Washington State 2008.

Race/Ethnicity

Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Between 2000 and 2010, the estimated population increase is projected to vary widely by race and ethnicity. The estimated population increase was 12.4% for White, 23.6% for Black, 17.4% for Alaska Native and American Indian, 45.1% for Asian and Pacific Islander, and 38.4% for those of two or more races.

Washington is experiencing a significant growth in its Hispanic population. The estimated population increase for those of Hispanic origin was 47.5% between 2000 and 2010. The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. The estimated Hispanic population in 2010 is 651,027.

Languages

According to the 2006-2008 American Community Survey 3-year estimates, approximately 18.8%, or 209,276, of Washington's children age 5–17 years speak a language other than English at home. Of these children, 55.8% speak Spanish, 21.4% speak Asian and Pacific Islander languages, 17.9% speak other Indo-European languages, and 5.0% speak other languages. A similar figure of 17.1%, or 710,729, of the adult population age 18–64 years does not speak English at home. Of those who speak another language at home, 71.2% of the children and 50.6% of the adults speak English very well. Approximately 10% of the children and 26% of the adults, speak English not well or not at all.

Tribes and Maternal/Infant Health

There are 29 federally recognized American Indian tribes in Washington with varying populations and land areas. Between 2000 and 2010, the estimated population increase for American Indians/Alaska Natives was 17.4%. American Indians/Alaska Natives are about 2% of the overall Washington population. American Indian reservation and trust lands are located in 19 of Washington's 39 counties; 13 in Western Washington and 6 in Eastern Washington. Based on information from the 2000 Censuses, the Urban Indian Health Institute estimates that 81% of the American Indian/Alaska Native population in Washington lives off of reservations. There are two Urban Indian health clinics in Washington. Eight tribes offer evidence-based or other home visiting programs.

The American Indian Health Commission in our state works to improve health status by promoting increased tribal-state collaboration. The commission and tribal delegates at the 2008 Tribal Health Summit identified American Indian/Alaska Native health disparities, particularly in infants and pregnant women as a serious problem. Alaska Native and

American Indian pregnant women are more likely than women in any other racial group to get late or no prenatal care, to smoke or abuse drugs or alcohol, have a mental health diagnosis, or have suffered abuse by a partner. Although Washington State leads the nation with the lowest infant mortality rate (IMR), this is not reflected in the state's American Indian/Alaska Native population. In 2005, the overall state IMR rate was 5.1 per 1000 live births. The rate for the state's American Indian/Alaska Native population was 9.8 per 1000 live births. In addition, Washington's American Indian/Alaska Native infant mortality rate has risen since 1994, the only racial/ethnic group in which that has occurred. The 2010 Title V Needs Assessment identified this increasing racial/ethnic gap in IMR as concerning and requiring more attention. The Department of Health and the American Indian Health Commission are collaborating to focus on infant mortality rates.

Process for Conducting Home Visiting Needs Assessment

At the request of the Governor, a Cross Agency Governance Structure will lead the Washington State Home Visiting program. The group began meeting in mid-June, 2010. Members are the heads of the Department of Early Learning (DEL), the Department of Health (DOH), the Department of Social and Health Services (DSHS), and the Council on Children and Families (CCF) or their delegates. Together these agencies are responsible for administering health, early learning and social and economic programs to promote maternal infant and early childhood health and development in Washington State. The Cross Agency Governance Structure has decision making authority for the Home Visiting Needs Assessment. This includes deciding which key indicators and other factors will be used in the Needs Assessment, making the final identification of which communities are at the highest risk and spending program funds. DOH is the program fiscal agent and is coordinating the needs assessment process. DEL is coordinating the Cross Agency Governance Structure and program planning.

The Governance Group established a Partnership Group of managers from the four agencies and Thrive By Five (a public-private partnership focusing on Early Learning), to recommend strategic direction for the program. This group advises the Cross Agency Governance Structure. DEL is working with the Partnership Group to establish a broader group of stakeholders as an advisory group to the process.

Many organizations across the state have an interest in promoting child health, early learning, and strengthening families through home visiting. Recognizing this, we developed a comprehensive list of potential partners. They include the Family Policy Council, the Office of the Superintendent of Public Instruction (K-12 education), other federal, state, and local government agencies, other governments (tribes), and private organizations like the Washington State Association for Head Start and the Early Childhood Education and Assistance Program, the Home Visiting Coalition, family and community representatives, and others. Their collective knowledge and experience have strengthened the Needs Assessment and will ultimately strengthen home visiting programs across the state.

Early in the Needs Assessment process, we started working with stakeholders to identify potential data indicators, sources, and owners, and to identify the geographic levels for which the data are available. Many of the data sources, including vital statistics, are at DOH. DOH worked with other agencies to access their key data files. Data sharing agreements and other measures to ensure data confidentiality were put in place.

Introduction

DOH is sharing information and gathering comments about the project through a listserv and a project website which are open to the public. We set up a project email-box for input and questions and are responding to emails within two business days. In addition, we are holding weekly webinars when there is new information. The purpose of the webinars is to involve project partners, keep them up-to-date on the project and receive their input. Periodically, we have posted and solicited input on data analyses done for the Needs Assessment and drafts of the Assessment itself.

In addition to coordinating with the MCH Block Grant and Title V Needs Assessment, the Head Start, and Child Abuse Prevention Needs Assessments; the Home Visiting Needs Assessment coordinated with related project evaluations, planning documents, and other needs assessments. These include information from the Early Childhood Comprehensive Systems grant, Project LAUNCH grant, the statewide Early Learning Plan, and the Family Policy Council's assessment of community mobilization.

Data Report

Methods

In order to conduct a needs assessment for home visiting services in Washington State, we followed the guidelines stated in HR 3590, the Patient Protection and Affordable Care Act (also known as the Health Care Reform Act) and the accompanying guidance document (Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment).

First we present the material specified in the guidance document which includes:

1. Completing a statewide data report of risk indicators for at-risk communities as specified in Appendix A of the guidance document;
2. Identifying the units selected as *community* and describing how at-risk communities were selected;
3. Completing a data report for each at-risk community; and
4. Providing information on existing home visiting in the high-risk communities.

Next we describe other information we compiled based on our discussions of home visiting needs, including:

5. Measures of population size, including those used to calculate levels of community risk;
6. Additional approaches to defining community risk;
7. Descriptions of racial/ethnic communities and differences in the risk indicators;
8. Home visiting coverage ratios that we developed to compare the extent of home visiting in the various geographic areas.
9. Comments on the limited information available about quality.
10. Integration of home visiting programs.

More detail on the geographic areas, population figures, risk indicators, and home visiting measures are provided in Appendix B.

Completing a Statewide Data Report

To measure community risk, we worked with other state agency staff and non-governmental stakeholders to identify potential data sources and key indicators for each topic area outlined in the Patient Protection and Affordable Care Act. We included in our analyses the following fifteen dimensions of risk: premature birth, low birthweight infants, infant mortality, poverty, crime, domestic violence, school dropout rates, substance abuse, unemployment, child maltreatment, late or no prenatal care, teen births, youth binge drinking, youth illicit drug use, and 3rd grade reading levels (conceptualized as a measure of readiness for school). The first 10 of these dimensions are specified in the Patient Protection and Affordable Care Act. The additional dimensions were recommended by a stakeholder group as additional indicators of high risk. A description of how the indicators are defined and the years of data used is in Appendix B, Table B-1: Summary—Indicator Data.

Data sources

Specific data sources for each indicator are described in Appendix B, Table B-5: At-Risk Communities. We considered data from Title V, local Head Start Needs Assessments, federal Substance Abuse and Mental Health Services Administration (SAMHSA), and other data

sources. We used the same data sources as Title V for indicators of premature birth, low birthweight infants, infant mortality, poverty, and school drop-out rates. These include birth and death certificate data, census bureau data and data from the Office of Superintendent of Public Instruction. In our state, neither the Child Abuse Prevention and Treatment Act (CAPTA) Title II Needs Assessment nor the local Head Start Needs Assessment contain statewide data on the home visiting needs assessment indicators. For the indicators for crime and domestic violence we used law enforcement data provided by the Washington Association of Sheriffs and Police Chiefs (WASPC). We obtained data on unemployment from the Washington State Department of Employment Security and child maltreatment data from the Washington State Department of Social and Health Services (DSHS) Children's Administration. We used SAMHSA data for the substance abuse indicators in Appendix B, Table B-5: At-Risk Communities, to the extent possible. SAMHSA data are not available at a community level for our definition of communities. In order to choose high-risk communities, we used local data on youth binge drinking and youth drug use from another source (Washington's Healthy Youth Survey). We obtained information for our other additional indicators from birth certificates (prenatal care and teen births) and the Office of the Superintendent of Public Instruction (grade 3 reading scores).

Developing state rates

We developed a rate of each indicator for the state as a whole by dividing the number of occurrences (e.g., the number of premature births) by the appropriate population denominator and if necessary, multiplying by a constant (e.g., to get a percent or a rate per 1,000 population). We then created a statewide average risk score by averaging these risk indicators as described below.

Identifying the Unit Defined As *Community* and Describing How At-Risk Communities Were Selected.

Defining *Community*

We defined communities in two ways: a) geographically and b) based on race/ethnicity. The methods used to identify geographic communities are listed below. We used similar methods to identify at-risk race/ethnic communities. These are described in the Race/Ethnic Disparities in Need section (see page 10).

The geographic units that we defined as communities were counties or for some of the larger counties, subcounty areas used by these counties for health planning. To define the geographic units, we made an inventory of datasets for the indicators that we or our partners had access to and identified the geographic units of measure available (county, city, zip code, etc). Then, we contacted local health department staff at the five largest counties (King, Snohomish, Pierce, Spokane and Clark) and asked if they had subcounty health planning areas that they typically use and for which they had indicator data. We learned that Clark and Spokane Counties do not currently have subcounty areas identified for health planning analysis. For three counties (King, Pierce and Snohomish) we used subcounty rather than county level data. King County provided data on four, Pierce County seven, and Snohomish County ten subcounty areas. This totaled 57 areas, based on 36 counties (not including King, Pierce or Snohomish) plus 21 subcounty areas. More detail about the geographies used in these analyses is provided in Appendix B, Detail on Geographical Groupings.

Although Washington contains tribal areas, we have neither risk measures nor home visiting measures by tribal areas, and were unable to consider these as communities for the purpose of this report. However, some of the at-risk communities include tribal areas or other Native American populations. In addition, American Indians/Alaska Natives were considered as a community as part of the race/ethnic definitions of communities described in the Race/Ethnic Disparities in Need section on page 10).

Selecting At-Risk Communities

The guidance requires that we identify at-risk communities based on where indicators show that the community is at greater risk than the State as a whole. In order to determine which communities were at-risk, we developed rates of each indicator for each county/ subcounty area in the same manner as the state rates (above). Then, for each of these indicators we derived the risk ratio by dividing the community rate by the state rate. Next, we log transformed the rate ratios to put them on an appropriate scale for averaging them. Finally, we developed a summary risk score for each community by averaging the log-transformed risk ratios across indicators. Communities with summary scores greater than 0 were identified as at-risk communities for the first cut. On average, these communities experience greater risk than the state as a whole. The information about these communities will be provided to a stakeholder group to consider whether to reduce the number of at-risk communities to a smaller group.

We grouped several of the indicators by category and re-calculated the summary risk score to explore the impact of different weighting strategies on identifying at-risk communities in response to stakeholder input. We present three different methods for identifying at-risk communities. For Method 1, we did not group the indicators. For Method 2, we grouped the maternal and infant health measures (preterm delivery, low birthweight, infant mortality, teen births and late/no prenatal care) into one item, crime measures (total crime rate and domestic violence) into a second item and the substance use measures (substance use—DSHS, 10th grade illicit drug use and 10th grade binge drinking) into a third item and added the remaining items. For Method 3, we used the grouped maternal and infant health item, the grouped crime item, the grouped substance use item, and created a socioeconomic item (unemployment, poverty, high school dropout rate) and added the remaining items.

Completing a Data Report for Each At-Risk Community

Summary information for the communities selected as at-risk are included as specified in Attachment A of the guidance. For a small number of indicators (substance use and specific type of child maltreatment) we did not have information for some of the communities so we used data from the appropriate SAMHSA region (for substance use) or county (for maltreatment).

We were able to collect sub-county information for all the indicators except unemployment in Snohomish County and juvenile arrests for three of the subcounty areas in King County. In these cases, we assigned the county rate to all the subcounty areas. For three indicators (low birthweight, late or no prenatal care, and infant mortality) and a total of six counties (see Appendix B, Table B-1: Summary—Indicator Data), we developed proxy measures for small counties with sparse data (less than five cases) for a given indicator. The proxy measure combined the county data with data from a neighboring county with similar demographics. We contacted some local health department staff in affected counties to gather their input on

this approach. Proxy measures are indicated on the summary indicators sheet. Data on youth binge drinking was not available for Clallam County and youth illicit drug use was not available for Clallam or Garfield counties and so the average risk scores were based on the remaining indicators for these counties. For three subcounty areas in Snohomish County where youth survey data were not available, we assigned that area the county rate.

Some of the risk indicators based on births (preterm birth, low birthweight, infant mortality, late/no prenatal care, and teen pregnancy) have small numbers and rates are highly variable over time. To minimize this variability and present more stable rates, we have used multiple years of data for some indicators. Years of data used are indicated in Appendix B, Table B-1: Summary—Indicator Data.

Existing Home Visiting in At-Risk Communities

In order to measure the extent of current home visiting, we compiled the number of families served in each home visiting program and the number served with home visiting in programs that provide broader services, for each program that provided data. We were unable to obtain home visiting data for subcounty areas and so for those communities we report county level data. We also attempted to gather home visiting data for race/ethnic communities, however, the data are so inconsistently collected that there was no way to compare these data. However, we noted that the amount of home visiting per at-risk population is low in almost all of the communities in Washington, suggesting that most areas could benefit from additional home visiting capacity.

Population Size/Denominator Data

Population size is important for computing rates of the various risk indicators among the county/subcounty areas (e.g., occurrences per 1,000 population). It is also important as a measure of the potential burden of need since larger counties may have more high-risk individuals even if the rate is lower). Thus, we provide both rates/ratios and population numbers in the accompanying spreadsheets.

We examined several different populations within each of the county/subcounty areas and used several of these to compare risk and home visiting coverage across a variety of measures. These include total population, women of reproductive age (ages 15-44 years), total births, Medicaid births (proxy for low income), first time Medicaid mothers younger than 25 years, total children 1-4 years, and total children 1-8 years. Population figures are presented in the Data Report, Results section (see page 11).

For several of the risk factors (indicators), the population measure (the denominator for rates) is total population. For most of the others it is total live births. See Appendix B, Table B-1: Summary—Indicator Data for more detail.

For the measures of home visiting coverage, the choice of denominator is complicated by the fact that different home visiting programs target different populations. No single population measure is able to measure potential need for all of the home visiting programs. For the combined measures of home visiting coverage (coverage ratios, described below) we chose Medicaid births as the best available proxy for the number of families that might be targeted for home visiting services, because many (though not all) home visiting programs target low-income families with a newborn. More information about the population measure for specific home visiting programs is provided in the section on home visiting, below.

Additional Approaches to Defining Community Risk

To ascertain whether changing the methods for defining at-risk communities dramatically changed the results, we used an alternative method. Initially, we ranked communities. To do this, we used the rates described in Section 2 above to rank the geographic areas on each indicator. We averaged the ranks for a risk score for each county/subcounty area. For example, Adams County ranked 50th out of 57 counties and subcounty areas for preterm birth, 47th for low birthweight, 55th for infant mortality, etc. We summed these ranks and divided by the number of indicators to obtain the overall rank (risk score). We switched to using the ratio method described in Section 2, because the ranking method did not compare the communities to the state as directed by the Supplemental Information Request.

Race/Ethnic Disparities in Need

Although the guidance specifies community as a geographic unit, we compiled information on an additional approach to *communities* by examining racial/ethnic disparities. Disparities by race or ethnicity exist for many of the indicators used in the Home Visiting Needs Assessment. We compiled statewide data on the risk indicators by race/ethnicity to address the concern that some population groups may have higher need within geographic areas. We also compiled birth data by race/ethnicity as home visiting programs mostly target young families, and we felt births were a better proxy for young families than the total population.

We described the disparities in race/ethnicity among the risk indicators for Washington State as a whole. Ideally, we would look at this data within counties and sub-counties as well. Unfortunately, much of the race and ethnic-specific data are either not available or highly variable at the county level due to small numbers. In order to describe the associations between race and the indicators used to develop the county risk ranks, we tested the differences between each race/ethnicity grouping and non-Hispanic Whites on each of these indicators.

We also calculated risk ratios as described in Section 2 above, comparing each racial/ethnic group to the state rate. We compiled summary risk scores using the three methods noted in the Identifying the Unit Defined As *Community* and Describing How At-Risk Communities Were Selected section (see page 7), and identified at-risk race/ethnic communities. This race/ethnicity information will be used to target services with the geographic communities where high risk populations live.

Home Visiting Coverage and Gaps in Coverage

Finally, in order to examine the extent of current home visiting in comparison to need for the various communities, we added the total number of families served by any home visiting program in each county. Few families are served by more than one home visiting program, so adding the numbers served across program should be a valid approach. We did not have detailed enough information to determine the numbers served within the subcounty areas. Most programs target families for services rather than individuals. To determine the coverage of Evidence-Based home visiting programs, we calculated a coverage ratio of the numbers served to the number of Medicaid births. We used the population of Medicaid births as a proxy for high risk families with young children, because many home visiting programs focus on low-income mothers. We feel this measure undercounts the true number of high risk

families proportionately across geographies. Thus, comparing the coverage across counties should not be biased.

We also calculated program-specific coverage ratios for the likely evidence based programs in Washington State: Nurse-Family Partnership, Parents as Teachers, Parent-Child Home Program, and Early Head Start. We used the following as estimates of the targeted families: first time Medicaid mothers for Nurse-Family Partnership; total births for Parents as Teachers; Medicaid births for Parent-Child Home Program and for Early Head Start. For Parent-Child Home Program, which serves primarily two and three year olds, we tried to find the number of low income families with children under five as the best measure of targeted families, but this information was not available for all counties.

Quality of Home Visiting Programs

We have not been able to adequately assess the quality of existing home visiting programs and the extent to which they meet the needs of eligible families due to the short time frame for this assessment and the need for evaluation designed to assess the quality of these programs. Programs which include on-going evaluation including client outcome data and other efforts to incorporate continuous quality improvement are more likely to meet the needs of families. Howard and Brooks-Gunn (2009) reviewed evaluations of 9 home visiting programs. They concluded that a primary factor in determining the impact of home visiting programs is the provider's vigilance in following the guidelines and protocols mandated by the respective programs. They also recommended that high-quality programs use professional staff whose credentials are consistent with program goals, and intervene prenatally with at-risk populations. Although limited information is available about particular programs, the extent to which Washington programs comply with this recommendation is unknown.

State and Local Coordination and Integration Across Home Visiting Programs

Given the short time frame and the need for more evaluation, we have also not been able to adequately assess state and local coordination across home visiting programs. Some key components of a successful early childhood home visitation system include coordination between programs and geographic areas in: strategic planning and integration with other health prevention and education improvement efforts, intake and data collection, common program standards, evaluation, technical assistance, training, communication with stakeholders.

Results

Washington State Population Demographics

The data below provide a framework for understanding the size of the population in Washington State counties and subcounty areas. Geographic differences in population size are an important consideration in identifying target areas for home visiting services.

In 2008, there were an estimated 6.6 million residents, 1.35 million women of child bearing age (ages 15-44) and over 90,000 births. Almost 19,700 births in 2008 were first time births to women covered by Medicaid. There were about 686,000 children ages 1-8. The size of the population varies greatly by county, ranging from 2,300 people and 24 births in Garfield

County to 1,884,324 persons and 25,222 births in King County. Three counties (King, Pierce, and Snohomish) account for 51% of the population and 52% of the births in the state.

Table 1: Population and Births (Count), Washington State 2008

	Total Population*	Women Ages 15-44	Births	Medicaid Births	Medicaid Primips Ages <25	Ages 1-4	Ages 1-8
State Total	6,587,600	1,350,299	90,270	43,163	12,695	347,674	686,181
Adams	17,792	3,372	426	348	103	1,253	2,530
Asotin	21,401	3,978	235	139	50	1,134	2,169
Benton	165,481	32,790	2,444	1,464	490	9,853	19,463
Chelan	72,083	13,277	1,076	789	216	3,964	7,866
Clallam	69,202	10,276	648	415	131	2,759	5,466
Clark	424,211	86,751	5,851	2,488	751	26,240	50,943
Columbia	4,100	638	43	31	15	182	375
Cowlitz	99,000	18,356	1,343	842	262	5,161	10,456
Douglas	36,991	7,016	597	386	118	2,209	4,362
Ferry	7,700	1,268	70	52	16	318	677
Franklin	70,160	13,945	1,656	1,197	259	5,347	10,257
Garfield	2,300	349	24	17	7	77	180
Grant	84,573	16,071	1,635	1,226	345	5,731	11,086
Grays Harbor	70,898	12,522	914	614	199	3,453	6,801
Island	79,305	14,271	959	324	84	4,094	8,150
Jefferson	28,801	3,896	199	122	33	891	1,929
King	1,884,324	410,813	25,222	9,278	2,506	89,668	175,766
<i>East</i>	458,154	93,178	5,817	870	212	23,402	46,158
<i>North</i>	168,385	29,389	1,651	724	189	7,178	14,554
<i>Seattle</i>	556,124	141,909	6,992	2,397	588	19,384	36,482
<i>South</i>	707,678	146,337	10,757	5,284	1,516	40,024	79,193
Kitsap	246,810	47,470	3,053	1,142	363	13,097	26,151
Kittitas	39,399	9,343	384	220	71	1,522	3,049
Klickitat	20,099	3,388	204	149	49	993	2,007
Lewis	74,699	13,074	953	608	198	3,709	7,333
Lincoln	10,400	1,589	106	61	13	456	928
Mason	56,301	9,043	631	385	118	2,339	4,812
Okanogan	40,095	6,958	582	448	133	1,920	4,039
Pacific	21,800	3,003	220	137	35	764	1,586
Pend Oreille	12,801	2,051	129	97	37	542	1,139
Pierce	805,445	169,558	11,537	4,945	1,562	45,340	89,360
<i>County Council District 1</i>	123,184	25,405	1,528	382	116	6,665	13,779
<i>County Council District 2</i>	109,832	22,599	1,559	1,233	421	6,082	11,929
<i>County Council District 3</i>	134,561	29,115	1,929	500	170	8,027	16,405
<i>County Council District 4</i>	98,348	20,791	1,366	557	162	4,575	8,644
<i>County Council District 5</i>	116,049	26,777	2,042	1,238	380	7,436	14,357
<i>County Council District 6</i>	110,647	22,904	1,959	591	169	7,241	13,458
<i>County Council District 7</i>	112,825	21,934	1,121	394	124	5,313	10,782
San Juan	16,101	2,147	93	53	12	470	1,035
Skagit	117,490	21,730	1,628	972	293	6,068	12,153
Skamania	10,700	1,968	113	53	15	526	1,049
Snohomish	696,629	146,536	9,808	4,071	1,136	39,848	78,962
<i>Arlington-Stanwood</i>	63,975	12,615	671	274	137	3,474	7,128
<i>East County</i>	23,037	4,754	291	142	80	1,368	2,825

	Total Population*	Women Ages 15-44	Births	Medicaid Births	Medicaid Primips Ages <25	Ages 1-4	Ages 1-8
<i>Edmonds-Mukilteo</i>	75,125	14,101	648	179	69	3,310	6,789
<i>Lake Stevens</i>	39,961	8,815	573	182	83	2,650	5,413
<i>Lynnwood-Mountlake Terrace-Brier</i>	106,809	23,749	1,643	730	271	5,995	11,489
<i>Marysville-Tulalip</i>	68,452	14,176	1,090	477	248	4,240	8,728
<i>Mill Creek-Bothell</i>	104,985	22,326	1,461	291	122	5,781	11,762
<i>Monroe-Snohomish</i>	61,560	12,293	763	307	158	3,530	7,001
<i>North Everett</i>	65,661	13,393	941	526	250	3,577	6,899
<i>South Everett</i>	87,065	20,315	1,727	942	430	5,923	10,928
Spokane	459,009	93,852	6,156	3,358	1,133	23,663	46,713
Stevens	43,702	7,469	425	294	82	2,073	4,408
Thurston	245,307	49,821	3,074	1,225	336	12,001	24,066
Wahkiakum	4,100	586	33	14	6	165	332
Walla Walla	58,591	11,242	737	445	137	2,924	5,669
Whatcom	190,996	41,545	2,181	1,018	302	9,267	18,342
Whitman	43,000	12,209	442	182	45	1,600	3,089
Yakima	235,805	46,130	4,439	3,554	1,034	16,051	31,479

Sources: Population Estimates for Public Health Assessment, Washington State Department of Health/Krupski Consulting, Dec 2009.

Medicaid Data: Department of Social and Health Services, RDA. Supplied by Laurie Cawthon

Note: * Subcounty totals may not match county totals due to differing sources of population data used.

Geographic At-Risk Communities

Appendix B, Table B-1: Summary—Indicator Data, shows the indicator data for each of the geographic areas identified. Appendix B, Table B-2: Summary—Risk Ratio Data, shows the ratio of the indicator for the geographic area to the state rate and the log transformation of each ratio.

Summary risk scores for each geographic area are listed in the table below. Communities with summary scores greater than 0 were identified as at-risk communities for the first cut. On average, these communities experience greater risk than the state as a whole and are shaded gray in the table. Communities with a risk score greater than 0 for any of the three scoring methods were included as at-risk. Thirty-two of the 57 areas were identified as at-risk communities based on these summary risk scores.

Table 2: Summary Risk Scores for Geographic Communities

	Method 1	Method 2	Method 3
Washington State	0.000	0.000	0.000
Adams	0.029	0.018	0.003
Asotin	0.001	0.037	0.030
Benton	0.005	-0.023	-0.011
Chelan	0.013	0.014	0.004
Clallam*	0.025	0.100	0.057
Clark	-0.036	-0.024	-0.044
Columbia	-0.049	-0.062	-0.031
Cowlitz	0.054	0.069	0.062

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	Method 1	Method 2	Method 3
Douglas	-0.015	-0.036	-0.042
Ferry	-0.005	0.019	-0.028
Franklin	0.074	0.072	0.059
Garfield**	-0.144	-0.145	-0.160
Grant	0.060	0.054	0.046
Grays Harbor	0.078	0.097	0.089
Island	-0.107	-0.110	-0.101
Jefferson	-0.032	-0.024	-0.018
King			
<i>East</i>	-0.212	-0.224	-0.190
<i>North</i>	-0.146	-0.136	-0.109
<i>Seattle</i>	-0.038	-0.045	-0.073
<i>South</i>	-0.008	-0.019	-0.015
Kitsap	-0.048	-0.059	-0.043
Kittitas	-0.018	0.050	0.006
Klickitat	-0.007	0.024	-0.002
Lewis	0.007	0.040	0.019
Lincoln	-0.145	-0.126	-0.124
Mason	0.070	0.076	0.080
Okanogan	0.042	0.055	0.037
Pacific	0.064	0.102	0.064
Pend Oreille	0.020	0.017	0.024
Pierce			
<i>District 1</i>	-0.098	-0.133	-0.137
<i>District 2</i>	0.076	0.093	0.105
<i>District 3</i>	-0.042	-0.053	-0.053
<i>District 4</i>	0.137	0.154	0.147
<i>District 5</i>	0.116	0.128	0.114
<i>District 6</i>	0.071	0.078	0.066
<i>District 7</i>	-0.082	-0.105	-0.090
San Juan	-0.174	-0.166	-0.155
Skagit	0.033	0.044	0.037
Skamania	-0.028	0.046	-0.011
Snohomish			
<i>Arlington-Stanwood</i>	-0.048	-0.070	-0.043
<i>East County</i>	-0.016	-0.026	-0.009
<i>Edmonds-Mukilteo</i>	-0.159	-0.183	-0.126
<i>Lake Stevens</i>	-0.052	-0.017	0.001
<i>Lynnwood-Mountlake Terrace-Brier</i>	-0.114	-0.162	-0.213
<i>Marysville-Tulalip</i>	0.057	0.077	0.090
<i>Mill Creek-Bothell</i>	-0.200	-0.202	-0.147
<i>Monroe-Snohomish</i>	-0.061	-0.045	-0.007
<i>North Everett</i>	0.082	0.097	0.134
<i>South Everett</i>	0.040	0.043	0.048
Spokane	0.018	0.038	0.034
Stevens	-0.015	0.017	-0.012
Thurston	-0.053	-0.061	-0.057

	Method 1	Method 2	Method 3
Wahkiakum	-0.030	-0.043	-0.051
Walla Walla	0.005	-0.014	0.014
Whatcom	-0.018	0.002	-0.002
Whitman	-0.147	-0.111	-0.127
Yakima	0.089	0.086	0.089

Note: * Clallam lacks HYS data for 2 indicators so summary score divided by 14 indicators and Garfield lacks HYS data for 1 indicator so score divided by 15 indicators rather than 16.

** Garfield summary risk score = average of log-transformed risk ratios across indicators.

We also compared the summary risk scores above to an alternative methodology based on ranking the indicators. We identified the average rank of each geographic area and identified the top 32 areas. Twenty-six of (81%) of the top 32 communities by rank were also identified as at-risk by summary risk score.

Race/Ethnicity and At-Risk Communities

Race/ethnicity is a social construct that is often used as a measure for social, economic and political factors that can impact health outcomes. Reducing disparities in health status among racial and ethnic groups is both a national and a state goal. Presenting data by race and ethnicity helps us to understand the magnitude of the disparities and can assist with developing interventions to decrease these gaps.

In 2008, Washington State had a population of about 6.6 million people and 90,270 births. Among non-Hispanic births where race was known, about 62% were White, 8% Asian, 4% Black, 2% American Indian, 1% Pacific Islander and 3% were of multiple races.² Around 19% of Washington’s births were to Hispanic women; this varied greatly by county, ranging from 2% in Stevens to 75% in Adams county. Multiracial persons may be a large percentage of births within communities. For example, the multiracial American Indian/Alaska Native population in King County is larger than this single race population.³

Table 3: Total Number and Percentages of Birth by Race/ Ethnicity by County and Subcounty, Washington State 2008

	Total Births	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
State Total	90,270	62%	4%	2%	8%	1%	3%	19%
Adams	426	24%	<1%	1%	<1%	<1%	<1%	75%
Asotin	235	91%	1%	1%	2%	<1%	<1%	5%
Benton	2,444	62%	1%	1%	2%	<1%	2%	31%
Chelan	1,076	51%	<1%	<1%	1%	0%	1%	46%
Clallam	648	77%	1%	9%	1%	0%	2%	9%
Clark	5,851	77%	2%	<1%	4%	1%	2%	12%
Columbia	43	79%	<1%	2%	2%	<1%	<1%	16%
Cowlitz	1,343	79%	0%	2%	2%	<1%	3%	13%
Douglas	597	52%	<1%	0%	1%	<1%	1%	46%
Ferry	70	67%	<1%	1%	1%	<1%	7%	4%

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	Total Births	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
Franklin	1,656	33%	1%	<1%	1%	<1%	1%	63%
Garfield	24	92%	<1%	<1%	<1%	<1%	4%	4%
Grant	1,635	44%	1%	1%	<1%	<1%	1%	53%
Grays Harbor	914	70%	<1%	5%	2%	<1%	5%	18%
Island	959	74%	3%	1%	6%	1%	3%	11%
Jefferson	199	81%	2%	8%	3%	1%	2%	4%
King	25,222	53%	7%	1%	17%	1%	3%	15%
<i>East</i>	5,817	56%	1%	<1%	27%	<1%	2%	9%
<i>North</i>	1,651	66%	3%	<1%	16%	<1%	2%	11%
<i>Seattle</i>	6,992	60%	9%	<1%	14%	1%	3%	9%
<i>South</i>	10,757	44%	9%	1%	14%	3%	3%	23%
Kitsap	3,053	73%	3%	2%	5%	2%	5%	11%
Kittitas	384	76%	<1%	1%	2%	1%	2%	18%
Klickitat	204	71%	<1%	2%	1%	<1%	1%	23%
Lewis	953	80%	1%	1%	1%	<1%	2%	16%
Lincoln	106	91%	<1%	4%	2%	<1%	1%	3%
Mason	631	68%	<1%	5%	2%	<1%	3%	20%
Okanogan	582	49%	<1%	15%	1%	<1%	2%	31%
Pacific	220	70%	<1%	1%	4%	<1%	4%	20%
Pend Oreille	129	86%	<1%	6%	<1%	2%	3%	3%
Pierce	11,537	63%	7%	1%	6%	2%	5%	14%
<i>District 1</i>	1,508	82%	1%	1%	4%	1%	3%	9%
<i>District 2</i>	1,499	62%	5%	2%	9%	2%	5%	16%
<i>District 3</i>	1,876	71%	4%	1%	6%	2%	5%	11%
<i>District 4</i>	1,277	63%	12%	1%	5%	1%	7%	11%
<i>District 5</i>	2,167	48%	9%	1%	9%	4%	6%	21%
<i>District 6</i>	1,913	59%	9%	2%	6%	3%	5%	16%
<i>District 7</i>	1,134	73%	6%	1%	5%	1%	5%	10%
San Juan	93	73%	<1%	1%	2%	<1%	8%	16%
Skagit	1,628	62%	<1%	2%	1%	<1%	2%	33%
Skamania	113	85%	<1%	1%	1%	<1%	3%	10%
Snohomish	9,808	63%	3%	1%	9%	1%	3%	15%
<i>Arlington-Stanwood</i>	638	80%	1%	2%	3%	<1%	1%	13%
<i>East County</i>	280	81%	<1%	1%	2%	<1%	3%	13%
<i>Edmonds-Mukilteo</i>	625	71%	3%	<1%	14%	1%	2%	8%
<i>Lake Stevens</i>	533	83%	1%	1%	3%	<1%	4%	9%
<i>Lynnwood-Mountlake Terrace-Brier</i>	1,599	56%	6%	<1%	17%	1%	3%	16%
<i>Marysville-Tulalip</i>	1,012	69%	1%	6%	4%	1%	5%	14%
<i>Mill Creek-Bothell</i>	1,350	67%	1%	1%	18%	1%	2%	10%
<i>Monroe-Snohomish</i>	750	75%	<1%	<1%	2%	<1%	2%	21%
<i>North Everett</i>	860	68%	3%	1%	5%	1%	3%	19%
<i>South Everett</i>	1,612	54%	4%	1%	10%	1%	4%	26%
Spokane	6,156	83%	1%	2%	2%	1%	3%	6%
Stevens	425	87%	<1%	8%	0%	<1%	2%	2%
Thurston	3,074	73%	3%	2%	6%	1%	4%	10%

	Total Births	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
Wahkiakum	33	88%	3%	<1%	3%	<1%	3%	3%
Walla Walla	737	62%	1%	1%	2%	<1%	1%	33%
Whatcom	2,181	76%	1%	4%	4%	<1%	3%	12%
Whitman	442	77%	2%	<1%	12%	<1%	2%	5%
Yakima	4,439	31%	0%	5%	1%	<1%	1%	61%

Source: Center for Health Statistics Birth Certificate Data. Numbers by race may not add up to state or county totals due to missing data on race.

While the distribution of the population by race/ethnicity varies greatly across counties, it is important to review the number of births to get a sense of the magnitude of families in need. For example, Clallam County has 9% of births to Non-Hispanic American Indian/Alaska Natives. While this is a high percentage, the actual number of Non-Hispanic American Indian/Alaska Natives births is 61. In comparison, South King County has 1% of births to Non-Hispanic American Indians, but the number of births, 114, is larger than in Clallam County. To illustrate the size of the populations by county, the numbers of births by county/subcounty and race are provided in the following table.

Table 4: Numbers of Births by Race/ Ethnicity by County and Subcounty, Washington State 2008

	Total Number of Births	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
State Total	90,270	55,641	3,319	1,431	7,159	915	2,692	17,348
Adams	426	104	0	3	1	0	0	318
Asotin	235	214	2	3	4	0	1	11
Benton	2,444	1,519	28	13	54	0	43	761
Chelan	1,076	553	3	4	15	1	6	493
Clallam	648	502	6	61	6	1	15	56
Clark	5,851	4,530	93	26	254	59	132	683
Columbia	43	34	0	1	1	0	0	7
Cowlitz	1,343	1,067	5	21	25	2	43	176
Douglas	597	313	0	2	5	0	3	273
Ferry	70	47	0	14	1	0	5	3
Franklin	1,656	539	12	3	20	1	18	1,045
Garfield	24	22	0	0	0	0	1	1
Grant	1,635	721	9	15	8	0	21	860
Grays Harbor	914	640	0	50	17	1	44	160
Island	959	712	33	5	58	6	28	102
Jefferson	199	162	4	15	6	1	4	7
King	25,222	13,243	1,762	159	4,310	367	717	3,822
<i>East</i>	5,817	3,253	64	8	1,576	6	96	542

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	Total Number of Births	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
<i>North</i>	1,651	1,083	47	6	260	8	33	183
<i>Seattle</i>	6,992	4,172	658	31	990	40	233	631
<i>South</i>	10,757	4,731	993	114	1,484	313	355	2,464
Kitsap	3,053	2,228	105	51	150	47	143	324
Kittitas	384	292	1	3	7	2	8	69
Klickitat	204	145	0	5	2	0	3	47
Lewis	953	758	5	8	11	1	18	151
Lincoln	106	96	0	4	2	0	1	3
Mason	631	431	1	32	11	1	18	126
Okanogan	582	286	1	88	4	0	12	180
Pacific	220	154	0	2	8	0	9	45
Pend Oreille	129	111	0	8	0	2	4	4
Pierce	11,537	7,295	763	142	713	265	600	1,599
<i>District 1</i>	1,508	1,236	11	15	53	12	43	138
<i>District 2</i>	1,499	926	74	28	130	28	80	233
<i>District 3</i>	1,876	1,328	77	13	106	44	99	209
<i>District 4</i>	1,277	799	159	16	64	15	85	139
<i>District 5</i>	2,167	1,050	198	30	196	93	140	460
<i>District 6</i>	1,913	1,131	175	33	106	59	98	311
<i>District 7</i>	1,134	823	69	7	57	14	55	109
San Juan	93	68	0	1	2	0	7	15
Skagit	1,628	1,002	8	25	19	2	27	541
Skamania	113	96	0	1	1	0	3	11
Snohomish	9,808	6,201	257	123	913	59	283	1,488
<i>Arlington-Stanwood</i>	638	512	8	10	16	1	9	82
<i>East County</i>	280	227	1	2	5	0	9	36
<i>Edmonds-Mukilteo</i>	625	446	21	2	87	5	12	52
<i>Lake Stevens</i>	533	444	4	4	14	0	19	48
<i>Lynnwood-Mountlake Terrace-Brier</i>	1,599	895	94	6	272	17	54	261
<i>Marysville-Tulalip</i>	1,012	701	13	59	44	6	47	142
<i>Mill Creek-Bothell</i>	1,350	910	19	8	244	7	31	131
<i>Monroe-Snohomish</i>	750	562	2	1	16	2	13	154
<i>North Everett</i>	860	583	29	12	45	7	23	161
<i>South Everett</i>	1,612	870	66	17	166	14	66	413
Spokane	6,156	5,111	86	126	146	57	192	388
Stevens	425	371	0	36	1	1	8	8
Thurston	3,074	2,229	92	64	189	33	137	320
Wahkiakum	33	29	1	0	1	0	1	1
Walla Walla	737	458	4	4	17	1	11	240
Whatcom	2,181	1,659	13	84	90	3	58	266
Whitman	442	341	7	1	55	1	10	23
Yakima	4,439	1,358	18	228	32	1	58	2,721

Source: Center for Health Statistics Birth Certificate Data. Numbers by race may not add up to state or county totals due to missing data on race

Race/Ethnic Disparities in Risk Factors⁴

Below we summarize the findings where other race/ethnic groups had greater risk than Non-Hispanic Whites. We did not include information about groups with lower risks than Non-Hispanic Whites as our purpose was to identify pockets of need. Differences in risk factors not included in the indicators, such as access to health care and low maternal education may also account for some of the racial and ethnic disparity in need for home visiting services.

Compared to non Hispanic Whites:

- Hispanics have significantly higher rates of preterm birth, poverty, rates of children receiving child protective services case management or child welfare case management, late or no prenatal care, youth binge drinking and teen births. Hispanics have the highest rates of teen births in the state.
- Non-Hispanic Blacks have significantly higher rates of preterm birth, low birthweight birth, infant mortality, poverty, rates of children receiving child protective services case management or child welfare case management, high school dropouts, late or no prenatal care, youth illicit drug use, and teen births. Blacks have the highest rates of low birthweight births in the state.
- Non-Hispanic Asians have significantly higher rates of preterm birth, low birthweight births, and late/no prenatal care.
- Non-Hispanic Pacific Islanders have significantly higher rates of preterm birth, poverty, late/no prenatal care, high school dropouts, and teen births. Pacific Islanders have the highest rate of late or no prenatal care.
- Non Hispanic American Indian/Alaska Natives have significantly higher rates of preterm birth, low birthweight, infant mortality, poverty, late/no prenatal care, children receiving child protective services case management or child welfare case management, rates of DSHS women who need substance use treatment, high school dropouts, youth illicit drug use, and teen births compared to non Hispanic Whites. They have the highest rates among all race/ethnic groups for all of these indicators except low birth, late/no prenatal care, youth illicit drug use, and teen births.
- About 3% of the births in the state are to persons indicating more than one race. Depending on the diversity of the county, this population can represent members of any of the other racial and ethnic groups. The number of births in selected race/ethnic groups might actually be quite a bit higher if a large proportion of that group identifies with multiple races as noted above for American Indians in King County. Thus, the rates presented here for individual race/ethnic groups may not represent the total burden of the risk factors. If program planning targets specific racial groups, it might be helpful to recalculate the number of births by counting everyone who identifies with multiple race/ethnic groups as belonging to all the groups they list. Rates could then also be recalculated, and may better reflect community perceptions and needs.

Table 5: Home Visiting Needs Assessment Indicators by Race/ Ethnicity*

	White Non Hispanic	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Asian Non Hispanic	Pac Islander Non Hispanic	Multiple Races Non Hispanic	Hispanic
Preterm Birth Rate	9.8	13.1	17.1	10.5	12.0	11.5	11.3
Low birthweight	6.0%	10.2%	8.3%	7.8%	5.4%	7.1%	6.0%
Infant Mortality Rate	4.2	7.3	11.0	3.3	7.5	7.0	5.2
Poverty	10%	24.5%	27.5%	9.9%	20.6%	N/A	23.6%
Late/ No Prenatal Care	4.3%	8.8%	11.4%	4.8%	16.7%	6.4%	7.6%
CPS/CWS Services Rate**	68.0	121.2	164.0	25.3		274.2	114.1
Needing substance use tx***	11.5	8.9	25.0	2.3		18.2	3.9
Teen Birth Rate	9	16.7	34.1	4.1	22.1	17.8	56.8
Binge drinking- Grade 10	16.8%	22.4%	31.6%	11.7%	17.7%	16.1%	23.7%
Illicit Drug Use- Grade 10	19.6%	31.4%	27.5%	11.1%	14.5%	21.6%	21.6%

The Race Data below was not available for non Hispanics—Hispanics could be included in each category

	White	Black	American Indian/ Alaska Native	Asian	Pac Islander	Hispanic
Unemployment	8.8%	12.9%	N/A	6.2%	N/A	12.3%
High School Dropout Rate	4.5%	7.8%	10.1%	3.0%	6.8%	7.2%
3 rd grade Reading WASL	78.5%	58.6%	54.8%	80.5%	62.9%	51.9%

Notes: Shaded areas indicates significantly higher than Non Hispanic Whites based on z score testing with $p < 0.05$

No race/ethnicity data was available for total crime and domestic violence data.

See indicators summary for definition of these indicators.

*NH=Non-Hispanic

**Rate of unduplicated children who received child protective services case management or child welfare case management per 1000 children 0-17 yrs, 2008

***Percent Substance Use is the percent of women 15-44 who received one or more months of DSHS medical coverage who needed substance use treatment, 2008

We calculated summary risk scores for each race/ethnic group in the same manner that we did for the geographic analyses to identify at-risk communities. These analyses yielded results similar to the table above. Overall, Non Hispanic Whites and Non Hispanic Asians had summary risk scores lower than the state. Non Hispanic American Indian/ Alaska Natives, Non Hispanic Blacks, people reporting multiple races, Non-Hispanic Pacific Islanders and Hispanics had higher scores than the state average.

The table below highlights the summary risk scores for those groups identified as at-risk compared to the state average and the communities in the state with proportions of births that are higher than the state average.

Table 6: Summary Risk Scores

Summary Risk Score	Black Non Hispanic	American Indian/ Alaska Native Non Hispanic	Pacific Islander Non Hispanic	Multiple Races	Hispanic
Method 1	.154	.279	.106	.139	.115
Method 2	.197	.310	.105	.300	.169
Method 3	.186	.303	.082	.300	.155
Areas with % births by race/ethnicity greater than the state average, from highest percent down	King (Seattle) Pierce (District 6) King (South) Pierce (District 5) Snohomish (Lynnwood-Mountlake Terrace-Brier) Pierce (District 7) Pierce (District 2)	Okanogan Clallam Jefferson Stevens Pend Oreille Snohomish (Marysville-Tulalip) Grays Harbor Mason Yakima Lincoln Whatcom	Pierce (District 5) Pierce (District 6) King (South) Pierce (District 2) Pierce (District 3) Kitsap Pend Oreille	San Juan Pierce (District 4) Ferry Pierce (District 5) Grays Harbor Pierce (District 6) Pierce (District 2) Snohomish (Marysville-Tulalip) Pierce (District 3) Kitsap Pierce (District 7) Snohomish (South Everett) Pacific Thurston Snohomish (Lake Stevens) Garfield	Adams Franklin Yakima Grant Douglas Chelan Skagit Walla Walla Okanogan Benton Snohomish (South Everett) Klickitat King (South) Snohomish (Monroe-Snohomish) Pierce (District 5) Pacific Mason

Home Visiting Coverage and Gaps in Coverage

There are four likely evidence based home visiting practices offered in Washington State. These include: Parents as Teachers, Nurse-Family Partnership, Parent-Child Home Program and Early Head Start. Appendix B, Table B-3: Summary—Coverage Data for Likely Evidence Based Practices, shows (by county) the number of families served by each of these programs. We have also estimated the target population for each program and a coverage ratio which divides the number of families served by the estimated target population. Statewide, coverage ratios for these likely evidence based programs ranged from 1.1% to 9.8%. The numbers of families or individuals served ranged from 489 to 1782. County numbers of families served by evidence based home visiting ranged from 0 to 1537. None of the four likely evidence based home visiting programs were available in seventeen counties. We know there will always be families or individuals who will not choose to participate in home visiting programs, so we do not see 100% coverage as the goal. However, even if we assume that 50% coverage is ideal, there still exists considerable unmet need for evidence based home visiting services throughout Washington as well as across counties.

We also looked at all voluntary programs available in Washington with a home visiting component. These programs and the criteria for selecting them are identified in the Home Visiting Programs in Washington State section (see page 26). Appendix B, Table B-4: Summary—Coverage Data for All Home Visiting, shows by county the total number of families receiving a likely evidence-based practice, the total number receiving any home visiting service except First Steps home visiting, and the number receiving First Steps home visiting. We show First Steps services separately because in 2008 most counties offering Nurse-Family Partnership used First Steps as a source of funding and we can't separate these services.

To estimate coverage, we compare the families served to the number of Medicaid births as many of the home visiting programs target low income families. The ratio, though, is not a true rate as the numerator is not a true subset of the denominator. However, the ratio should be sufficient for making county to county comparisons. Statewide, we estimate 4,880 families received any evidence-based home visiting service for a coverage ratio of 11%. Considering all home visiting programs except First Steps, we estimate 18,299 families received some services over the 1-2 year period of 2007-2009.

First Steps home visiting services were provided to 21,247 families in 2008. In the First Steps Maternity Support Services program, a client is counted as receiving a home visit even if she received only one home visit. Beginning in July 2009, the First Steps Maternity Support Services program was redesigned to focus on the highest risk Medicaid births and the budget was reduced 20%. Data for pregnant and parenting women receiving home visits for 2009 are not yet available; however a significant reduction in the number of women receiving home visits is anticipated.

Programs count families served in different ways and use different time periods for estimating services, so this number is our best estimate. Families may receive services from more than one program over time due to differences in eligibility and areas of focus. For example, a family may receive services from First Steps and then be eligible for Early Head Start and receive services there. We currently have no way of knowing how often this happens. We compare the number of families receiving services to Medicaid births to get a sense of whether programs are reaching those in need of services. We found a ratio of 42% statewide for any home visiting except First Steps home visiting. First Steps home visiting services reached an estimated 49% of low income families (estimated by Medicaid births). Because of the differing time periods, it may be that the true target population may be closer to two years of Medicaid births. While a ratio of 42% appears favorable, this is not a true rate. The denominator we used, one year of Medicaid births, is a proxy for the true number of eligible families. Furthermore, the number of eligible families is slightly different depending on the program. The coverage ratio is best used to compare geographic areas rather than as a reflection of the true proportion of eligible families being served. County numbers of families served by any home visiting program, range from 0 to 5,793. Coverage estimates range substantially from 0% to 386%. (Note that some programs provide services to multiple age children so the numbers served may include more than one birth cohort. This can result in coverage estimates greater than 100%).

Note that we totaled families served across programs without information on the length of time services were received, the depth or intensity of services received, whether families

received the totality of services they needed. And, we cannot estimate the impact of the services received on the long term outcomes for children.

Discussion

For the Home Visiting Needs Assessment, Washington State compiled data on the indicators outlined in the Patient Protection and Affordable Care Act and the accompanying guidance document. We considered input from stakeholders in deciding on final indicators and used information from other Needs Assessments when applicable.

We defined communities in two ways: a) geographically and b) based on race/ethnicity. The geographic units defined as communities were primarily counties. For the three largest counties (King, Pierce, Snohomish) we included sub-county areas used by these counties for health planning. We defined race/ethnic communities using seven groups: Hispanics, Non Hispanic (NH) American Indian/Alaska Native; NH Asian; NH Black, NH Pacific Islander, NH White, and Multi-race. We considered the state-wide population for each group. We collected the same information for the geographic communities and for the race/ethnic communities. This race/ethnicity information will be used to target services with the geographic communities where high risk populations live.

In order to determine which communities were at-risk, we first developed rates for each indicator for each county/subcounty area and racial or ethnic group. Then, for each of these indicators we derived the risk ratio by dividing the community rate by the state rate. We developed a summary risk score for each community by averaging the log-transformed risk ratios across indicators. (We log transformed the ratios to stabilize the greater variability which smaller communities experience). A summary score of zero indicates that on average the community has the same risk as the state. Those communities with summary scores above 0 were selected as communities at-risk since their summary risk score was higher than the state as a whole. Thirty-two geographic areas were identified as at-risk communities because they had a summary risk score greater than the state:

- Adams County
- Asotin County
- Benton County
- Chelan County
- Clallam County
- Cowlitz County
- Ferry County
- Franklin County
- Grant County
- Grays Harbor County
- Kittitas County
- Klickitat County
- Lewis County
- Mason County
- Okanogan County
- Pacific County
- Pend Oreille County
- Pierce (District 2)
- Pierce (District 4)
- Pierce (District 5)
- Pierce (District 6)
- Skagit County
- Skamania County
- Snohomish (Lake Stevens)
- Snohomish (Marysville-Tulalip)
- Snohomish (North Everett)
- Snohomish (South Everett)
- Spokane County
- Stevens County
- Walla Walla Cty
- Whatcom County
- Yakima County

In addition, 5 racial/ethnic groups had summary risk scores greater than the state: Non-Hispanic Blacks, Non Hispanic American Indians/Alaska Natives, Non-Hispanic Pacific Islanders, Hispanics, and those who identify with multiple races.

Coverage of Home Visiting Services and Gaps

The available data suggest considerable unmet need for home visiting among Washington families. We identified four likely evidence based home visiting programs and nine other home visiting programs offered in Washington State. Overall 11% of targeted families were estimated to be receiving likely evidence-based home visiting services at some time. Seventeen counties did not have any evidence based home visiting services available. While coverage for at-risk families receiving any home visiting program (except First Steps home visiting) statewide was 42%, there was substantial variability across counties. Further, these coverage ratios indicate that a family received some services, but do not take into account the length of time services were received, intensity of services, or their impact on long term outcomes for children.

Limitations

The analyses presented here are subject to a number of limitations.

Measures of Risk

Ten of the measures of risk used were mandated by the legislation. Some of these are characteristics used to select families for home visiting (e.g., poverty) and/or are targeted outcomes of home visiting programs (e.g., child maltreatment). Most if not all of the measures are related to income and some are closely related to each other (e.g., preterm birth and low birthweight). Some of the risk factors have more than one possible measure (e.g., crime offenses or arrests). A different array of risk factors or specific measures, or a summary score that weighted the individual scores differently, would likely lead to different results. Juvenile arrest data underestimate juvenile arrest rates because not all police departments or sheriff's offices in the state provided data to the Washington Association of Sheriffs and Police Chiefs Uniform Crime Reporting system. These data are included in Appendix B, Table B-5: At-Risk Communities, but were not included in the matrix to identify at-risk communities.

Geographic Areas

The size of the geographic areas varied by more than two orders of magnitude. Total population for the 57 areas ranged from 2,300 in Garfield County to 707,678 in South King County. Total births ranged from 24 to 10,757 in the same areas. Some areas were so small that reliable data were unavailable for a few indicators and synthetic estimates were used, as described in the Methods. Other areas were so large that pockets of high risk might exist within generally moderate or low risk areas (for example, high risk areas within Seattle in King County). Different geographic groupings would likely lead to different results.

Denominators

Providing summary coverage ratios for all evidence-based programs and for all home visiting programs required grouping programs with different target populations. We selected the number of births paid by Medicaid as the comparison population for these coverage ratios because many home visiting programs target low-income mothers. We felt that this is the best available denominator for these analyses. However, not all of the families receiving home visiting are drawn from this population, and some programs provide services over multiple years so these coverage ratios should not be interpreted as rates. For example,

Wahkiakum County's coverage ratio was 3.71 because 52 families received home visiting from the Parents as Teachers Program, which serves children up to age five, and there were only 14 Medicaid births.

Statistical Significance

We explored whether county rates for risk factors are significantly different from the state rate and have this information available in a background spreadsheet. We chose not to present this information to keep the presentation simpler. Part of the concern about statistical significance relates to small areas having highly variable rates over time (statistical significance provides a way to determine whether an apparent difference is likely to actually be due to chance). To minimize this, we used multiple years of data for several health indicators. For other indicators, we present the data our partner agencies felt was most pertinent.

Separate Measures for Risk and Home visiting Coverage

As noted earlier, we identified population size, levels of community risk, and levels of current home visiting provision as contributors to a local area's need for home visiting services. We discussed creating a combined summary measure of need but were concerned about the validity of such a measure in the absence of empirical information as to the optimal formula. For example, the results would be strongly influenced by factors such as scaling (e.g., a simple multiple of the risk ranks and coverage ratios would be dominated by the risk ranks due to their greater variability) and weighting of the various factors. This type of summary measure might be created in the future if a consensus can be reached about the relative importance of the various factors.

Home Visiting Data

The measure of families served by home visiting may be imprecise because of several factors. These include the possibility of families receiving more than one program, differing time periods for determining those served, attrition, and programs reporting the number of people served in a particular year vs. enrolled in a cohort. Some programs such as Child Protective Services do home visits, but are not voluntary (unlike most home visiting programs). We are unable to provide overall coverage estimates by race because this information is not consistently available. However, we believe that non-English speakers may be less adequately served by home visiting programs than English speakers.

Notes

1. See *Guidelines for using Racial and Ethnic Groupings in Data Analyses*, Washington State Department of Health (http://www.doh.wa.gov/Data/Guidelines/REGL2010_1.htm)
2. A multiple race category is difficult to interpret. We include this category in order to match census-based race breakdowns, which either categorize Asians and Pacific Islanders separately, or bridge multiple races to individual race categories while combining Asians and Pacific Islanders.
3. Comment from Eva Wong, PhD, Public Health-Seattle & King County, Seattle, Washington.
4. Significance based on z-score testing with significance at $p < 0.05$. Race data for unemployment is only available for Whites, Hispanics, Blacks and Asians. Significance for unemployment is based on non-overlapping confidence intervals. Race data are not available for total crime and domestic violence data. Across the 60 significance tests that we conducted, we identified 35 higher and three lower significant differences. This is more than the three significant differences we would have expected by chance alone.

Home Visiting Programs in Washington State

The Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program law states that the needs assessment must include information about the quality and capacity of existing programs or initiatives for early childhood home visitation in the State, including the:

- Number and types of individuals and families receiving services.
- Gaps in early childhood home visitation in the State.
- Extent to which such programs or initiatives are meeting the needs of eligible families (pregnant women, expectant fathers, children birth to 8 and their parents – parents includes anyone acting as a parent, including foster parents, grandparents, etc.).

Terms Used

For the purposes of this document, the terms agency or provider agency, model and program are defined below:

- **Agency or Provider Agency** – The name of the organization providing the home visiting program, e.g. Clark County Public Health or Catholic Child and Family Services.
- **Model** – A home visiting model is the components for implementing a specific type of home visiting. A model usually includes the curriculum, training requirements, schedule of visits, and other elements of implementation. Nurse-Family Partnership and Parent-Child Home Program are examples of home visiting models. Models may be evidence-based, promising, or based on professional best practices.
- **Program** – The implementation of a model by an agency, for example Nurse-Family Partnership at Clark County Public Health.

Introduction

Washington State has many home visiting programs and initiatives. Programs are provided by many different agencies, including, local health jurisdictions, school districts, and private organizations. Programs have a variety of funding streams, federal, state, local, tribal, and private. Agencies often use several funding streams to fund the implementation of one model.

In the Home Visiting Needs Assessment, we have attempted to gather information on as many home visiting programs as possible. Though the focus of the funding provided by the federal Maternal, Infant and Early Childhood Home Visiting Programs is on evidence-based and promising models, an understanding of the broader world of home visiting will aid the decision about where to infuse additional services. It will also be useful as state agencies and other stakeholders, state, local, and tribal, work to better coordinate home visiting services and continue to look for ways to maximize home visiting resources. Table C-3 lists home visiting programs and models by county and/or Federally Recognized Tribe (see Appendix C, Table C-3).

Definition of Home Visiting

In the Supplemental Information Request for the Submission of the Statewide needs Assessment, the federal government defines home visiting as:

- Voluntary

Home Visiting Programs

- Serving pregnant women, expectant fathers, children birth to kindergarten entry, parents and caregivers
- Supported by State or Federal government funds
- Programs in which home visiting is a primary intervention strategy
- Excluding programs with few or infrequent visits or where home visiting is supplemental to other services
- Targeting a participant outcome listed in the law (see list below)

Appendix C Tables C-1 and C-2 show how home visiting models implemented in Washington State match the definition of home visiting in the law.

All of the home visiting models that we were gathering information about before the Supplemental Information Request was published meet at least one element of this definition. Since some of these elements are not specific (e.g. How often is few or infrequent?), no models were eliminated from the needs assessment because they did not meet this definition.

Home Visiting Program Outcomes for the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

The following desired program outcomes are listed in the law:

- Improved maternal & child health.
- Prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits.
- Improvements in school readiness and achievement.
- Reduction in crime or domestic violence.
- Improvements in family economic self-sufficiency.
- Improvements in the coordination and referrals for other community resources and supports.
- Improvements in parenting skills related to child development.

Information about Home Visiting Programs

The Supplemental Information Request requires states to include the following information about home visiting programs in the needs assessments:

- Name of program
- Model or approach used
- Specific services provided
- Intended recipient
- Goals/outcomes
- Demographic characteristics of individuals or families served
- Number of individuals or families served
- Geographic area served

The information about home visiting programs is included in this needs assessment as follows:

- **Appendix C, Table C-1: Home Visiting Models Implemented in Washington State & the Definition of Home Visiting for the Needs Assessment & Grant**
- **Appendix C, Table C-2: Home Visiting Models—Participant Outcomes** shows which of the outcomes listed in the law are addressed by each of the home visiting models.
- **Appendix C, Table C-3: Home Visiting Programs and Models by County and/or Federally Recognized Tribe**
- **Appendix C, Tables C-4 through C17: Home Visiting Program Information** (one table for each model) includes: Name of program, number served, demographic characteristics, and geographic area served (county or Tribe).
- **Home Visiting Model Information** including intended recipient of service and specific services provided (below beginning on page 30)

Information Collection Process

The DOH Needs Assessment Team began gathering information about home visiting models and programs in the State several months before the Supplemental Information Request was published. Based on the information in the law, we attempted to anticipate what would be requested in the SIR. As a result of this, we gathered information on home visiting across the state, rather than just in the communities identified as being at risk. Information about home visiting models or programs is not available at a sub county level.

In order to gather this information, DOH started with models implemented in multiple sites in Washington State that regularly show up on state and national lists of evidence-based home visiting (Early Head Start, Nurse-Family Partnership, Parent-Child Home Program, and Parents as Teachers). Each of these models also has a state lead, so one person could be contacted to get information about all the programs implementing that model in Washington State. In some cases, we contacted individual programs, but most communication was with the state leads. One state lead works for a state agency, the others work for private organizations or the national office of the home visiting model. The state leads are listed in the Home Visiting Model Information beginning on page 30.

Next we identified other home visiting models (not necessarily evidence-based) implemented in several sites, with a state lead. State leads were very helpful in providing information about the models, the programs implementing them, and clarifications about the models and data. In several cases we contacted programs directly. The Nurse-Family Partnership feasibility study,⁴ the Council for Children & Families (CAPTA, Title II agency) evidence-based home visiting matrix, and mapping done by the Home Visiting Coalition were also used in gathering this information.

An email message was sent to the Community Health Leadership Forum, local public health leadership, asking about home visiting in local health jurisdictions (a county or group of counties). The home visiting needs assessment team at DOH developed a website, a listserv, and held a series of webinars. These provided additional opportunities to request information. As DOH worked with other state agency staff and stakeholders, we became aware of other models and programs and contacted them as time allowed.

⁴ Judy Ziels. *Nurse-Family Partnership in Washington State: Feasibility Study of Statewide Implementation*. June 2010.

Number of Individuals and Families Receiving Services

Home visiting models count people served in different ways and time periods. The numbers below reflect the numbers served by models, a total from all programs implementing the model, in the format and timeframe that they collect the data. This list includes the models identified to date, that are implemented by more than one program:

- Children with Special Health Care Needs (CSHCN) program served 10,653 children birth to age 9 in 2009. DOH CSHCN staff estimate that 50% of the children birth to age 3 receive home visiting through this program, approximately 4,000 children in 2009.
- Early Family Support Services served 1,406 families in 2009.
- Early Head Start served 976 children in home-based programs during the 2008-2009 program/school year (one year).
- Early Intervention Program (DSHS Children's Administration) served 1,404 children in 2009.
- Early Steps to School Success serves 200 children prenatal to age 3, and over 300 families and caregivers, as of 7/6/10.
- Early Support for Infants and Toddlers, IDEA Part C (formerly Infant Toddler Early Intervention Program) served 5,242 children and families as of December 1, 2009. The program served 9,395 children and families from October 1, 2008 to September 30, 2009.
- First Steps – 21,247 women who gave birth in 2008 received at least one home visit. These visits may have occurred in 2007, 2008 or 2009. They could have occurred during pregnancy or with the delivered infant up to age 1.
- Nurse-Family Partnership served 1,533 clients during 2009.
- Parent Child Assistance Program had 734 slots as of December 31, 2009. DSHS reports that the slots are usually filled.
- Parent-Child Home Program – 256 children and families started the program during the 2007-2009 school years.
- Parents as Teachers served 2,109 children and 1,782 families during 2008-2009 (school year).
- Partnering with Families for Early Learning serves 192 children and families.
- Safe Babies, Safe Moms has 250 slots. DSHS reports that the slots are usually filled.
- Safe Care—Data was requested from 2 programs in Washington State, but not received.

In addition to the models described above, the Parenting Partnership Program is being implemented in one site in Washington State. The Parenting Partnership Program, an adaptation of Steps to Effective, Enjoyable Parenting (STEEP), served 175 children and 60 families. This program provides home visiting and parent support groups for socially vulnerable families of medically fragile infants living in South King County or Pierce County.

Models Not Included At This Point In Time

Data and information about the following models are not included in this needs assessment. This is due to lack of time, information, and/or lack of clarification about the model (whether or not it includes home visiting, what age group is served):

Home Visiting Programs

- Triple P (Positive Parenting Program)—several communities reported implementing this model, information about what components are being implemented is not available at this time.
- Homebuilders – a program of DSHS Children’s Administration
- Family Preservation Services – a program of DSHS Children’s Administration
- Even Start – may include home visiting
- Readiness to Learn – may include some home visiting
- Parent-Child Interaction Therapy – this is sometimes provided in families’ home

Home Visiting Model Information

This section includes the intended recipient of service and specific services provided (as required for each home visiting model). It also includes additional information about the models that we thought would be useful for the home visiting planning process and future coordination efforts.

DOH worked with state leads for models to verify and complete the information. In some cases we were not able to obtain the information. We will continue to work with programs to gather this information.

Children with Special Health Care Needs (CSHCN)

Intended Recipients: Children, birth to age 18, who have serious physical, behavioral or emotional conditions that require health and related services beyond those required by children generally.

Goals for Home Visiting:

- Families of children and youth with special health care needs are partners in decision-making at all levels and are satisfied with the services they receive.
- Families of children with special health care needs have access to needed services, including health insurance.
- Children receive coordinated, ongoing, comprehensive care within a medical home.
- Children are screened early and continuously for special health care needs.
- Services are organized so families can use them easily and are satisfied with the services they receive.

Specific Services Provided: Care coordination, referral to community services and resources, developmental screening

Average Cost: \$250 for the first visit, \$150 for subsequent visits.

Home Visiting as Part of the Model: Some children and families in the Children with Special Health Care Needs program receive home visits from that program, they are prioritized based on need. DOH CSHCN staff estimate that 50% of children birth to 3 received home visits.

Contact: Maria Nardella, Manager, CSHCN Program
Department of Health
maria.nardella@doh.wa.gov
360-236-3573

Model Website: <http://www.doh.wa.gov/cfh/mch/cshcnhome2.htm>

Early Family Support Services (EFSS)

Intended Recipients:

Goals for Home Visiting:

Specific Services Provided:

Average Cost:

Home Visiting as Part of the Model: All services are provided via home visits.

Contact:

Model Website:

Early Head Start

Intended Recipients: Low income, pregnant women and children to age 3

Goals for Home Visiting: Early Head Start was launched in 1995 to provide comprehensive child and family development services for low-income pregnant women and families with infants and toddlers ages birth to three years. Early Head Start (EHS) programs were established to provide early, continuous, intensive and comprehensive child development and family support services on a year-round basis. The purpose of the program is to enhance children's physical, social, emotional, and intellectual development, to support parents' efforts to fulfill their parental roles, and to help parents move toward self-sufficiency.

Specific Services Provided: Home-Based services bring EHS staff into family homes every week to support child development and to nurture the parent-child relationship. Twice per month, the program offers opportunities for parents and children to come together as a group for learning, discussion, and social activity.

Average Cost: The average funding per slot for EHS during the 2009-2010 school year was \$13,571. This is an average of all EHS programs including both home based and center based models.

Home Visiting as Part of the Model: Early Head Start programs may provide center-based, home-based or combination services.

Contact: Jennifer Jennings-Shaffer, Director, Head Start State Collaboration Office
Department of Early Learning
Jennifer.Jennings-Shaffer@del.wa.gov
360-725-4423

Model Websites: EHS National Resource Center
www.ehsnrc.org/
WA Head Start—State Collaboration Office, DEL
<http://www.del.wa.gov/partnerships/head-start/Default.aspx>

Early Intervention Program (DSHS Children's Administration)

Intended Recipients: Accepted referrals to CPS that are low-risk. Families with children birth to age 5. Children have an identified health or developmental need and could benefit from home visitation nurse. Children may also be in relative or foster care.

Goals for Home Visiting: Improve family functioning and improve child safety and well-being.

Specific Services Provided:

Average Cost:

Home Visiting as Part of the Model: All services are provided via home visits.

Contact:

Model Website:

Early Steps to School Success

Intended Recipients: Pregnant women and children birth to age 5. This model targets resource poor, rural communities.

Goals for Home Visiting:

- Children will enter school with the skills necessary for school success
- Parents will have the knowledge and skills to support their children's education
- Home/school connections will be strong
- Early childhood knowledge and skills in communities will be significantly increased

Specific Services Provided: Parent education and support, home visiting and pre-literacy and language development, connecting parents and schools, community collaboration.

Average Cost: \$1,500 per child per year (ESSS is a year-round program)

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Natalie Vega O'Neil, Senior Early Childhood Specialist
Save the Children
noneil@savechildren.org
360-359-2332

Model Website: <http://www.savethechildren.org/newsroom/2010/education-washington-st.html>

Early Support for Infants and Toddlers (formerly Infant Toddler Early Intervention Program)

Intended Recipients: Children, birth to age 3, with developmental disabilities and/or developmental delays and their families (IDEA⁵, Part C eligibility).

Goals for Home Visiting: Children will demonstrate positive social emotional skills, acquire and use knowledge and skills, including early language, communication and early literacy, and use appropriate behaviors to meet their needs. Families will know their rights, effectively communicate their children's needs, and help their children develop and learn.

Specific Services Provided: Family training and parent education, specialized instruction, speech therapy, occupational therapy, physical therapy

Average Cost: Cost specific to each child and families individual needs, billed at local level, average varies from \$2,700 to \$4,000/ per

Home Visiting as Part of the Model: Services may be provided in the child's home, child care, or other settings.

Contact: Karen Walker, ESIT Project Administrator
Department of Early Learning
Karen.walker@del.wa.gov
360-725-3516

Model Website: <http://www.del.wa.gov/development/esit/Default.aspx>

First Steps—Maternity Support Services (MSS) & Infant Case Management (ICM)

Intended Recipients: Low income women and infants. MSS-pregnant women through 2 months post pregnancy. ICM- infants 3 months to age 1

Goals for Home Visiting:

- Improve and promote healthy birth outcomes
- Improve maternal-infant bond and parenting skills
- Improve welfare of infants and their families by providing information and assistance in accessing needed services

Specific Services Provided: Screening, Assessment, Interventions, Care Coordination, Case Management

Average Cost: \$815 total expenditure per MSS women with any home visits; \$352 total expenditure per ICM infant/family with any home visits. A visit can range from 15 minutes to one and one half hours

Home Visiting as Part of the Model: First Steps MSS and ICM may be provided through home visits or at clinic sites.

Contact: June Hershey, First Steps Program Manager
Department of Social and Health Services

⁵ Individuals with Disabilities Education Act (IDEA)

Home Visiting Programs

june.hershey@dshs.wa.gov
360-725-1293

Jan Crayk, MSS Coordinator
Department of Health
janice.crayk@doh.wa.gov
360-236-3967

Model Websites: DSHS First Steps MSS information
<http://hrs.dshs.wa.gov/firststeps/index.htm>
DOH First Steps information
http://www.doh.wa.gov/cfh/mch/maternity_support_services.htm

Nurse-Family Partnership (NFP)

Intended Recipients: Women with low-incomes and pregnant with their first child. The women must enroll and receive first home visit no later than the 28th week of pregnancy. Home visits continue until the child is 2 years old.

Goals for Home Visiting:

- Improve pregnancy outcomes
- Improve child health and development
- Improve families' economic self-sufficiency

Specific Services Provided:

Average Cost: \$5000 per child/family per year

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Kristen Rogers, Regional Manager—West, Program Developer
NFP National Service Office
Kristen.Rogers@nursefamilypartnership.org
253-441-0292

Model Website: www.nursefamilypartnership.org

Parent Child Assistance Program (PCAP)

Intended Recipients: Women who abuse alcohol and/or drugs during pregnancy, from pregnancy until the child is 3 years old.

Goals for Home Visiting:

- Assist mothers in obtaining treatment, maintaining recovery, and resolving the complex problems associated with their substance abuse
- Encourage that the children are in a safe environment and receiving appropriate health care
- Effectively link families with community resources

Home Visiting Programs

- Demonstrate successful strategies for working with this population to prevent the risk of future drug and alcohol affected children

Specific Services Provided: Case management, advocacy, services referral to community resources

Average Cost: \$5,000 per client per year

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Sue Green, Family Services Manager, Prevention and Treatment Services
DSHS, Division of Behavioral Health & Recovery
sue.green@dshs.wa.gov
360-725-3732

Model Websites: UW—Parent Child Assistance Program website
http://depts.washington.edu/chdd/ucedd/ctu_5/parentchildprog_5.html
DSHS Program Profile
<http://www.dshs.wa.gov/pdf/HRSA/DASA/ParentChildAssistance.pdf>

Parent-Child Home Program (PCHP)

Intended Recipients: At-risk parents (single, low-income, teen parents, English not spoken at home, low literacy, multiple risk factor families, etc.). Program begins when a child is age 2 and continues until he/she turns age 4.

Goals for Home Visiting: (1) Increase positive and joyful parent-child verbal interaction, imagination and creativity; build language-rich home environments. (2) Empower parents to become their child's first and most important teacher. (3) Promote early literacy and social-emotional/cognitive skills. (4) School readiness. (5) School success. (6) High school graduation. (7) Family accesses community and educational resources and services.

Specific Services Provided: (1) Intensive, long-term, one-on-one modeling by home visitor increases parent-child verbal interaction and school success. (2) 92 home visits over two years, involving both parent/primary caregiver and the child. (3) Gifts of 23 books and 23 educational toys as permanent learning tools. (4) Referrals for social services, if parent requests assistance.

Average Cost: \$4,000 per year per family, or \$87 per visit

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Nancy Ashley, Parent-Child Home Program Regional Coordinator for Washington and Oregon
nancyashley@heliotropeseattle.com
206-526-5671

Model Website: www.parent-child.org

Parenting Partnership—uses Steps to Effective, Enjoyable Parenting (STEEP)

Intended Recipients: Socially vulnerable families with medically fragile infants from neonatal intensive care unit (NICU) discharge until around the third birthday, or 3 years of service.

Goals for Home Visiting:

- Promote healthy parent-child relationships
- Prevent social-emotional problems in children challenged by risk factors such as poverty and stressful life conditions

Specific Services Provided: home visits, group sessions, videotaping, and guided viewing

Average Cost: approximately \$5,000 per family, per year (average)

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Jody Hawthorne
Manager, Parenting Partnership
Mary Bridge Children’s Hospital
Jody.hawthorne@multicare.org
253-403-1478

Model Websites: <http://www.multicare.org/marybridge/child-abuse-intervention-2/>
<http://www.ccf.wa.gov/funded-programs/parenting-partnership-program>

Parents as Teachers (PAT)

Intended Recipients: Universal—All pregnant women and children birth through 5 (families may enter at any time).

Goals for Home Visiting:

- Increase parent knowledge of early childhood development and improve parenting skills
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Specific Services Provided: Parent-child activity and book sharing, child observation and discussion, problem-solving and goal setting, parenting information sharing and handouts, resource referral and follow-up, developmental screening using a standardized tool, informal health information, hearing and vision screening

Average Cost: \$2,800 per family per year (WA estimate), Parents as Teachers national office estimate is \$2,290 per family per year.

Home Visiting as Part of the Model: Home visits are the primary method of service delivery. The model also includes parent group meetings, at least monthly.

Contact: Kathy Zeisel, Parents as Teachers Coordinator/State Leader
Parent Trust for Washington Children

kzeisel@parenttrust.org
206-233-0156 Ext 228

Model Website: www.parentsasteachers.org

Partnering with Families for Early Learning (Thrive by Five Washington)

Intended Recipients: Low-income pregnant women with a focus on women who already have children and who are experiencing increased levels of physical, social or environmental risk. Clients should be in the 28th week of pregnancy or less at program entry, others considered on case by case basis by agency staff considering client need and interest. Home visits continue until the child turns 2.

Goals for Home Visiting:

- Maintain high percentage of positive birth outcomes
- Maintain high percentage of children who have access to comprehensive health care and medical homes
- Increase positive adult-child interactions that promote social and emotional relationships

Specific Services Provided: Not available

Average Cost:

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: Sangree Froelicher, Deputy Director
Thrive by Five Washington
sangree@thrivebyfivewa.org
206-621-5559

Model Website: <http://www.thrivebyfivewa.org/downloadables/HBEL%20Companion%20Piece%20FINAL%206%209%2010.pdf>

Safe Babies, Safe Moms

Intended Recipients: High-risk substance-abusing women (18 yrs and older) with young children, or women who abuse alcohol and/or other drugs during pregnancy, are low-income and not successfully accessing community resources. Pregnant women and children to age 3.

Goals for Home Visiting:

- Stabilizing women and their young children
- Identifying and providing necessary interventions and making appropriate referrals to community resources
- Assisting women in gaining self-confidence as they transition from public assistance to self-sufficiency

Specific Services Provided: Case management, advocacy, referrals to community resources. Additional services offered (vary by site) may include and is not limited to: parenting classes, self esteem groups, budgeting classes, nutrition classes, and GED preparation.

Home Visiting Programs

Average Cost: \$6,100 per client/per year, each program also receives discretionary funds to assist program participants with basic needs.

Home Visiting as Part of the Model: All services are provided via home visits or in the office of the provider (group type services).

Contact: Sue Green, Family Services Manager, Prevention and Treatment Services
DSHS, Division of Behavioral Health & Recovery
sue.green@dshs.wa.gov
360-725-3732

Model Websites: DSHS Program Profile
<http://www.dshs.wa.gov/pdf/HRSA/DASA/SafeBabiesSafeMoms.pdf>
Safe Babies, Safe Moms in Snohomish County
<http://www.evergreenmanor.org/SafeBabiesSafeMoms.htm>
Safe Babies, Safe Moms in Benton-Franklin Counties
<http://www.bfhd.wa.gov/ph/ticm.php>
Safe Babies, Safe Moms in Whatcom County
<http://www.bridgcollins.org/index.php?display=48&expand=40>

SafeCare

Intended Recipients: Families with children, ages birth through 5 who are at-risk or have been reported for child maltreatment.

Goals for Home Visiting: The child's safety is the center of focus for the delivery of service

- Assist the DSHS Children's Administration social worker to assess the safety of the child and their home environment
- engage the families to reduce the threats of hazards in the home
- Work with parents to increase their safe parenting skills
- Communicate with DSHS any concerns regarding any safety issues regarding the child
- Improve home safety, and address health and safety issues

Specific Services Provided:

Average Cost:

Home Visiting as Part of the Model: All services are provided via home visits.

Contact: State lead not identified

Model Website: <http://chhs.gsu.edu/safecare/>

Other Programs that Include Home Visitation Services

The law asks states to describe other state programs in the state that include home visitation services, including the following:

Maternal and Child Health Block Grant

The Department of Health administers these funds, most of the funding goes to local health jurisdictions and some stays at the state level. Local health jurisdictions may choose to use these funds to do public health nurse home visiting, to support staff salaries in First Steps or Children with Special Health Care Needs, and to support implementation of other home visiting models (e.g., Nurse-Family Partnership, Early Intervention Program, and Early Family Support Services). The home visiting services supported with these funds are included in Appendix C, Table C-3: Home Visiting Programs and Models by County and/or Federally Recognized Tribe, to the extent that we were able to gather the information.

Title II of the Child Abuse Prevention and Treatment Act

The Council for Children & Families administers these funds. These funds are used to support evidence based and capacity building home visiting, as well as other child abuse prevention activities. The home visiting services supported with these funds are included in Appendix C, Table C-3: Home Visiting Programs and Models by County and/or Federally Recognized Tribe.

Section 645A of the Head Start Act (Early Head Start)

Local Early Head Start provider agencies receive funds directly from the Office of Head Start in the federal Administration for Children and Families. Early Head Start programs that serve children in home visiting programs are included in the Home Visiting Programs and Models by County and/or Federally Recognized Tribe table (see Appendix C, Table C-3). The federal Region X Office of Head Start serves Washington, Idaho, Oregon and Alaska. At the state level, there is an Office of Head Start State Collaboration, in the Department of Early Learning that facilitates collaboration between the State and Head Start programs, including Early Head Start. There is also a state-based training and technical assistance network which provides services to grantees in Washington State.

Extent to which Programs are Meeting the Needs of Eligible Families

The Data Report section provides additional information about the extent to which programs are meeting the needs of eligible families.

The information collected shows the numbers of children and families served, the types of children and families served, and the goals and outcomes the programs strive to achieve. From the statewide data report, we know that in every county there are many more children and families experiencing risk factors than are served in home visiting programs. Most of the home visiting models are not available statewide. Many serve a specific population or only for a limited time, rather than being available for all at risk families until their children enter kindergarten. Also due to funding challenges, see discussion of gaps below, programs may come and go depending on funding. Quality is also difficult to assess due to the varying capacity of home visiting programs for data collection and evaluation. It is also difficult to combine data in order to report quality of home visiting across models, due to differences in the models and in the information they collect.

The Council for Children & Families conducted an evaluation of the evidence-based home visiting they funded during the 2009-2010 program year⁶. They funded 11 programs in six communities across the state. These programs served 463 families with 585 children (80% of the children were under four years old). The evaluation included participant characteristics, program characteristics, and program benefits. The evaluation concluded that:

- Programs are reaching the intended clients.
- Programs face a variety of staff, client and resource challenges.
- All programs are working to implement models with fidelity, but success is fragile.
- Return on investment appears to be meaningful, particularly for Nurse-Family Partnership programs.

Gaps or Duplications in Early Childhood Home Visiting Services

The Data Report section provides additional information about gaps or duplications in early childhood home visiting services.

Gaps in early childhood home visiting include data, services, and infrastructure. Even though an incredible amount of information about home visiting programs was gathered, as we learned more about each model, program and community, we realized how much more there was to know.

Service Gaps—Even though there are home visiting programs in every county in Washington State, they are serving only a small portion of the eligible families and children. The *Washington Early Learning Plan* notes that the total capacity of the four evidence-based home visiting programs in Washington is enough to serve only 2 percent of the estimated eligible families who would choose to participate.⁷

Data Gaps—Stakeholders, and mapping done by other groups, suggest other information that would be useful to planning, coordination and infrastructure building efforts:

- Number of slots and number of children and families served
- Enrollment – In some models, families need to enroll by a certain point in time, in others they can enroll anytime during the eligibility period. For example, in Nurse-Family Partnership, mothers must enroll no later than the 28th week of pregnancy. In other models families can enroll any time before the child enters kindergarten.
- Service intensity and duration – How often are home visits (e.g. once a week, every other week)? How long do the visits last (e.g. an hour, 90 minutes)? What is the timeframe for visits (e.g. for a number of weeks or until a child reaches a certain age)?
- Training and supervision requirements of the model
- Qualifications of the home visitors
- Source of funding

⁶ Christopher Blodgett, Myah Houghten, with Joan Sharp. The Council for Children & Families Evidence-Based Home Visiting Program, Program Evaluation Report 2009-2010 Program Year. Council for Children & Families, September 2010.

⁷ *Washington Early Learning Plan*. Department of Early Learning, September 2010. www.del.wa.gov/plan (accessed 9-16-10)

- Referral sources

Infrastructure Gaps—The Council for Children & Families, Children’s Alliance, the Home Visiting Coalition and the *Washington Early Learning Plan* all have made significant efforts to build home visiting infrastructure, including adequate and stable funding, coordination among providers and funders, and increasing capacity to implement evidence-based home visiting models. The Early Learning Plan is an effort to coordinate across state and local, and public and private entities. It was completed in September 2010. Governance strategies and implementation responsibilities are still being developed. The *Washington Early Learning Plan* states that the Home Visiting Matching fund will support efforts to coordinate evaluation, increased technical assistance and training and integrate home visiting with other critical issues identified in the Plan.⁸

Obtaining and maintaining funding is a challenge for most home visiting programs. Programs are often funded with multiple funding streams, with different timeframes and reporting requirements.

Many local communities have early childhood groups, some of which have worked to identify local gaps and needs in home visiting services, or that could be filled with home visiting programs. In some communities, stakeholders have worked together across agencies to identify a home visiting model or models that best match the needs and capacity of their community.

Duplications — For the most part, from the available data, it is not possible to know if children and families are being served by more than one program. Early childhood groups are working in some communities to coordinate services and assure that families are served by the most appropriate model and program. In some cases children and families may be served by more than one model, because models complement each other, or families have multiple needs.

In most counties providing Nurse-Family Partnership, this model braided with First Steps in order to access Medicaid funding.

Some Parents as Teachers and Early Head Start programs are braided. The Early Head Start model does not require a specific curriculum, so some Early Head Start programs have chosen to use the Parents as Teachers curriculum. When they do this, they must meet all the standards of each program, including numbers of visits provided and training of home visitors.

Children with Special Health Care Needs may receive care coordination from that program, while also receiving early intervention services from Early Support for Infants and Toddlers. They might also be in an Early Head Start program in order to participate in a setting with peers with typical development.

Many local communities have early childhood groups, some of which have worked to coordinate home visiting at the local level.

Information from Other Needs Assessments and Plans

The Supplemental Information Request suggests that information from the following inform this section:

- Child Abuse Prevention and Treatment Act (CAPTA), Title II inventory of unmet needs

⁸ Ibid.

- Head Start/Early Head Start community-wide strategic planning and needs assessments
- State Domestic Violence Coalition's statewide needs assessment
- STOP Violence Against Women grant implementation plan

Child Abuse Prevention and Treatment Act, Title II

In Washington State, the Council for Children & Families is the administrator of the Child Abuse Prevention and Treatment Act (CAPTA), Title II Funds. The Department of Health, Department of Social and Health Services, Department of Early Learning, and the Office of the Superintendent of Public Instruction sit on the Council, along with private citizen stakeholders.

Washington's CAPTA Title II Needs Assessment does not contain statewide data on the home visiting needs assessment indicators. The alternate sources we used for data on these indicators are detailed in the Data Report, Methodology section (see page 6). The CAPTA Title II Needs Assessment references several other sources of information on early childhood home visiting in Washington, which we used to obtain background information on home visiting. These sources include the Children's Alliance and the Home Visiting Coalition.

Head Start/Early Head Start

The law requires states to coordinate the home visiting needs assessments with the Head Start community needs assessments and strategic plans. The Department of Health (DOH) has been working with the Head Start State Collaboration Office in the Department of Early Learning to gather copies of these documents. DOH staff also contacted Region X staff at Head Start and Maternal and Child Health, and the federal home visiting grant staff at Health and Human Services seeking assistance in getting these documents, but were told that either they need to be requested directly from the programs or a Freedom of Information Act (FOIA) request would need to be submitted. Information was received from 17 of 49 Head Start programs serving children and families in Washington State, including Head Start, Early Head Start, American Indian-Alaska Native Head Start, and Migrant and Seasonal Head Start. The Head Start State Collaboration Office Director told us that several of the programs were closed for the summer, so would not have responded to email requests sent during that time. We were not able to review all the needs assessments that were received. During the planning phase, we will continue to attempt to gather and review Head Start community needs assessments and plan, especially from the at risk communities.

A list of the Early Head Start programs showing those that provide a home-based option (home visiting programs) is below.

Early Head Start programs serving children and families in Washington State

The Head Start State Collaboration Office in the Department of Early Learning was able to provide copies of the 2008-2009 Head Start Program Information Reports (PIRs). The following information about Early Head Start program options in Washington State is from the PIRs.

Home-based only

Early Head Start staff provide weekly home visits to support child development and nurture the parent-child relationship. Twice a month, the program offers opportunities for

Home Visiting Programs

parents and children to come together as a group for learning, discussion, and social activity.

- Enterprise for Progress in the Community (Yakima county)
- Neighborhood House (King county)
- Snohomish County Early Head Start (Snohomish county)
- United Indians Prenatal to Five Head Start (King county)
- Washington State Migrant Council (Yakima county)

Home-based and combination (combination includes home and center-based services)

- Family Services of Grant County (Grant county)
- Lewis-Clark Early Childhood Program, Lewiston, ID (serves children and families in Asotin County)
- Okanogan County Child Development Association (Okanogan County – the community of Bridgeport in Douglas County)
- Skagit Valley College (Skagit and Island counties)

Home-based and center-based

- Chelan-Douglas County Child Services Association (Chelan county)
- Children’s Home Society of Washington (King county)
- Eastern Washington University Early Head Start (Ferry, Pend Oreille, and Stevens counties)
- Educational Opportunities for Children and Families (Clark county)
- First AME Child Development Center (King county)
- Kitsap Community Resources (Kitsap county)
- Olympia Educational Service District 114 (Kitsap county)
- Olympic Community Action Programs (Clallam and Jefferson counties)
- Puget Sound Educational Service District Early Head Start (King county)
- Spokane County Early Head Start (Spokane county)

Home-based, center-based, and combination (combination includes home and center-based services)

- Mid-Columbia Children’s Council, Hood River, OR (serves children and families in Klickitat County)

Center-based only

Center-based Early Head State provides care and education to children in a private home or family-like setting.

- Confederated Tribe of Chehalis (Thurston county)
- Port Gamble S’Klallam Tribe (Kitsap county)
- Suquamish Tribe (Kitsap county)

New Programs Early Head Start Programs (2010 Expansion Funds)

- Denise Louie Education Center (82 expansion slots)

Home Visiting Programs

- ESD 112 (60 expansion slots)
- Kittitas County Head Start (54 expansion slots)
- Lower Columbia College (60 expansion slots)
- Lower Elwha Klallam Tribe (24 expansion slots)
- Lummi Nation (72 expansion slots)
- Makah Nation (32 expansion slots)
- Quinault Indian Nation (36 expansion slots)

Some Expansion Funds were also used to expand existing programs.

Summary of Information from Head Start Community Needs Assessments and Strategic Plans

The Head Start programs work to prepare children for success with common goals of providing quality and culturally appropriate early childhood education. The Early Head Start programs serve pregnant women and children from birth–3 years. Head Start programs serve children 3–5 year olds. Early Childhood Education and Assistance Program (ECEAP) serves children 3–4 year olds.

Data challenges

The analysis of the Head Start Community Assessments was challenging in that there was no standardized way or format for reporting data and other information contained in the narratives. The data and figures were not consistent across programs. Data was reported for various years going back to 2005 and projecting forward to 2014, which did not allow for a comparison of data or years. Not all data was reported in the same way. Some data was provided in percentages, some were actual numbers and other reports just listed high, low, many, increase, and decline. There were various ways of reporting data even when it came from the same program. Some programs did not have current data to report. Some of the larger assessment area programs indicated that data was approximate while the smaller areas were more exact. Some of the data in the same reports were in conflict.

Strengths of Head Start Needs Assessments

The information provided in the Community Assessments is quite descriptive of local communities in each of the Head Start areas. They provide insight into the geographical, socioeconomic, demographic, medical and dental health, education, climate, population growth, child care resources, housing, basic infrastructure, and economic uniqueness of each community.

The Community Assessments contained health and nutrition information, including access to services; insurance coverage; food and food insecurity; mental health, obesity, domestic violence, and substance abuse issues; disability population and services; health care resources. Most assessments contained the mission, goals, strategies and long range plans for future success of children and the programs.

These assessments may be particularly useful in the planning and implementation of home visiting and other interventions in at risk communities across Washington State. The assessments show a highly developed level of collaboration and openness among

stakeholders within communities, including communities linked across counties and states, in some instances.

Some common themes observed in the Head Start Assessments were:

- All programs analyzed strived for service collaboration with other agencies, including United Way, Children’s Home Society of Washington, substance abuse providers, child care centers and others.
- All programs except one reported a need for increased mental health services.
- High rates of child abuse/maltreatment was identified in the assessments covering:
 - Lewis-Clark Early Childhood Program service area in Asotin and Garfield Counties.
 - Community Colleges of Spokane service area in Spokane County. In 2005 nearly 84% of children services accessed were for Child Protective Services and Child Welfare Services Case Management.
 - Walla Walla County had 89 substantiated Child Protective Service investigations in 2007.
 - The Samish Indian Nation: 106 cases of child abuse were reported to Child Protective Services between July 2006 and June 2007. 8% of the reports related to sexual abuse, 36% physical abuse, and 74% to neglect.
 - Kittitas County: Child Protective Services reported 717 instances of case management in 2007.
 - Kittitas County Head Start/ECEAP reported 17 instances of suspect child abuse for the 2007-2008 program year.
 - Klickitat County social service data for child abuse and neglect in 2007 was 7%.
- Housing: the lack of or difficulty in finding suitable affordable housing was an issue in all assessments reviewed.
- Domestic Violence:
 - There were 372 domestic violence incidents in Chelan County and 142 incidents in Douglas County (Chelan County Sheriff as cited by Chelan-Douglas County Child Services Association Community Assessment, 2009–2012).
 - Kittitas County Head Start/ECEAP reported 6 cases of domestic violence for the 2007-2008 program year.
 - Cowlitz County reported a reduction in women and children involved in domestic violence over the last 5 years.
- High rates of poverty were identified in:
 - 17.2% of children between birth–4 years in Lewis-Clark Early Childhood Program service areas in Asotin and Garfield Counties in 2009
 - 26% of Spokane’s children under the age of 5 lived in poverty in 2005
 - 9,727 families in Clark County lived below the federal poverty level in 2005. This number included 6, 239 (66%) families headed by females with no spouse present
 - 70% of families in Pacific County in 2007 lived in poverty, per WIC data

- 17.3% of families in Walla Walla live below the federal poverty level
- 20% of children under 5 lived in poverty in 2008 in Skamania County
- 13.2% of children under 5 in King County live below the federal poverty level (Denise Louie Education Center Community Assessment for Early Head Start Programming, May 2010)
- 14.5% of families in Cowlitz County lived in poverty in 2008, and at the same time, 27% of children fell below the federal poverty guidelines
- 24% of Skagit County's population lived in poverty in 2009. 21% of Skagit's children lived in poverty in 2009
- 11% of children under 5 years of age in Island County live in poverty.
- Substance Abuse:
 - 14.4 % of adults in Asotin County at or below 200% of the federal poverty level need substance abuse treatment, particularly for methamphetamine use (Lewis-Clark Early Childhood Program Community Assessment, August 2010)
 - Methamphetamine use has increased in Pacific County
 - Methamphetamine issue in Goldendale believed to be affecting the local economy
 - 1,214 individuals were admitted to substance abuse treatment in Chelan and Douglas Counties. (Chelan-Douglas County Child Services Association Community Assessment, 2009-2012)
 - In Cowlitz County, violations for alcohol has increased since 2005 for 10-17 year olds to double the State's rate and triple the national rate. Alcohol and drug induced deaths in Cowlitz County is at 41.0 per 100,000 compared to the State rate of 24.5.
- Eligible Children not served or underserved:
 - 8 children are on the waitlist for the Samish Indian Nation Head Start
 - 25 children are on a waitlist or are not served in Garfield County
 - 318 children are on a waitlist or are not being served in Asotin County
 - 5343-5627 children are not served in Spokane County
 - 33 children are on a waitlist in Clark County
 - 954 children are not served in Pacific County
 - 70 families are on a waitlist in Walla Walla County
 - 7, 758 children are not served in King County (excluding Seattle)
 - 461 children are not served in Grant County (based on U.S. 2000 Census)
 - 2,071 children are not served in Chelan County
 - 402 children are not served in Douglas County
 - 98 children are not served in Klickitat County
 - 21% of eligible children in the Highline School District in 2007 were served leaving 1,499 children unserved
 - An estimated the 13,955 children eligible for Early Head Start were not served in Seattle in 2007
 - 6% of eligible children from Skagit County were served in the Skagit/Islands Head Start program in 2009 with a waitlist of over 595 families for Early Head Start and Head Start

Home Visiting Programs

- 6% of an estimated 400 (0-3 year old) children eligible for Early Head Start, and just over 50% of an estimates 280 eligible ECEAP/Head Start children in Island County were served during the 2008-2009 school year
- Unemployment/Income:
 - Unemployment across the Asotin and Garfield County portion of the Lewis-Clark Early Childhood Program service area was 8.9% for 2009
 - Over 40% of Spokane County families do not make enough money to live above the U.S. Department of Housing and Urban Development living wage level
 - Walla Walla unemployment was at 6.8% in December of 2009
 - Assessment in Pacific, Skamania, Asotin, Klickitat, and Garfield Counties raised the issue of making a living wage
 - Grant County unemployment in 2009 was 9.5%
 - Cowlitz County unemployment in 2009 was above 12% with a loss of 3,400 jobs in the past 2 years
 - Skagit County unemployment rate was 10.7% as of December of 2009
 - Island County's unemployment rate was 10.2% as of February of 2009
 - San Juan Island unemployment rate was at 7.9% as of February of 2009

Asotin and Garfield Counties

The Lewis-Clark Early Childhood Program (LCECP), located in Lewiston, Idaho, provides Head Start, Early Head Start, and Early Childhood Education Assistance Program (ECEAP) services to Asotin and Garfield Counties in Washington State. There are four centers located in Asotin County. Families from Garfield County receive services at the Asotin County locations. During the 2007-2008 school year, transportation was eliminated throughout the LCECP areas, including Asotin and Garfield Counties, which reduced access to Head Start programs for eligible families.

Teachers in the LCECP programs seek to provide a healthy learning environment through exploration, discovery, and experimentation. Parents receive a minimum of two parent/teacher conferences and three home visits per school year, at which time parents are assisted with defining appropriate development goals for their children in both home and preschool settings.

LCECP provides families with information on community resources and referrals to specific agencies. Crisis intervention services are provided as needed. In the Early Head Start program, expectant parents are provided prenatal and post-partum assistance.

Chelan and Douglas Counties

The Chelan Douglas Child Services Association (CSA) provides services at seven locations within the service area. The average monthly enrollment in programs is 100%. In March of 2009, the unemployment rate was 10.1%. In addition to the CSA Head Start, Early Head Start and ECEAP services; Enterprise for Progress in Communities (EPIC) provided 188 slots for Migrant Head Start. ECEAP has 50 slots within the boundaries of Manson and Chelan School Districts. CSA offers a home base program to non-working parents enrolled in the Early Head Start program.

Clark, Cowlitz, and Pacific Counties

The Educational Opportunities for Children and Families (EOCF) service area includes Clark, Cowlitz, and Pacific Counties. In Clark County, the Universal Home Visiting program is available to families with newborn infants as a means of providing early screening and development information and connections with other programs in the community. Universal Home Visiting is funded through the Clark County Early Learning Fund and implemented in partnership with the Children's Home Society of Washington. EOCF Head Start, Early Head Start and ECEAP sites throughout Clark County are affiliated with the school districts. There are 10 programs countywide.

EOCF Programs (Clark, Cowlitz and Pacific Counties) have experienced consistent growth in population and decline in available slots. There are five Head Start, Early Head Start and ECEAP sites in Pacific County. It is listed as one of the sixteen counties distressed for 2007, with a three year average unemployment rate of 7.1% (Washington State Employment Security Department as cited by EOCF Community Assessment—2008–2011).

Pacific County resident's methamphetamine use has become a particular problem, with increases in burglary by 31%, theft by 30%, and shoplifting by 70%. These increases correlate with the increase in methamphetamine use (Washington State Office of the Attorney General: Supporting Law Enforcement: Allied Against Meth/Statistics as cited by EOCF Community Assessment—2008-2011).

Cowlitz County is also served by the Lower Columbia College Head Start and Early Childhood Education and Assistance program (LCCHS/ECEAP). This program expanded between 2007 and 2010 with an additional 77 slots for children. LCCHS/ECEAP received a community development block from the city of Longview to plan for an early childhood education center. The community assessment showed increases in poverty; maternal smoking rates; child and adult obesity; and other indicators (2007–2010).

Grant County

Much of eastern Washington where Grant County is located is rural and is made up of largely farming communities. Head Start, Early Head Start and ECEAP are located at 13 sites in Grant County.

King and Pierce Counties

Puget Sound ESD (PSESD) Head Start service area does not include the city of Seattle. PSESD offers Head Start, Early Head Start and ECEAP. This area's population continues to grow and become more racially and ethnically diverse. The percent of families below the federal poverty level has slightly declined over the past several years. Some of PSESD goals for 2009-2011 are:

- Increase the quality and timeliness of services for children with special needs.
- Increase the knowledge and understanding about the needs of underserved population to assure children's success.
- Provide professional development and support systems for staff, which leads to high quality practices with children and families.
- Enhance collaboration to support seamless services for children birth to 8.

- Promote and support parent-child relationships.

Kittitas County

Services are provided under Kittitas County Head Start/ECEAP. In 2008, Kittitas County unemployment rate was 6.2%, which exceeded the state and federal unemployment rates of 5.7%. Since 1990, Kittitas County has consistently exceeded the state unemployment rate. Birth to Three Program provides transition into Head Start and a potential foundation for Early Head Start.

Klickitat and Skamania Counties

Mid-Columbia Children's Council (MCCC) provides services in three Oregon counties and two Washington Counties (Skamania and Klickitat). The unemployment rate rose in March of 2009 to 13.5% in Klickitat County. MCC notes in its Community Assessment, "Because housing is more affordable in Klickitat County, more low-income families settle on the Washington side of the river (Columbia)" versus the Oregon side. Skamania's County's unemployment rate for 2009 was 14.8%.

Skagit, Island and San Juan Counties.

The Skagit/Islands Head Start serves communities in Skagit, Island, and San Juan Counties.

Island County consist of two main populated islands (Whidbey and Camano Islands) and several small unpopulated islands. The population on these islands increase and decrease, seasonally because of tourism and summer homes. Because Camano Island residents have access to Snohomish, the Skagit/Islands Head Start has not expanded into that area. However, Josephine Sunset Homes manages an ECEAP program in Stanwood and Camano Island providing 36 low-income slots.

San Juan County is comprised of 170 islands and attracts retirees, tourists, wealthy part-time residents, and business owners. The county has a dual economy (a group of very wealthy, full or part time residents; and another group who lives there year-round, but are only seasonally employed).

City of Seattle

The Community Assessment for Seattle Early Childhood Programs (May 2010) reflected that six programs the Seattle Early Childhood Programs. They are the:

- City of Seattle Step Ahead
- First AME. Child & Family Center Early Head Start and Head Start
- Denise Louie Education Center Head Start
- Neighborhood House Early Head Start and Head Start
- Seattle Public Schools Head Start
- United Indians of All Tribes Foundation Early Head Start and Head Start programs

The Community Assessment for Seattle Early Childhood Programs (May 2010) indicated that it was difficult to forecast the eligible population numbers because of the broad estimates of children in Seattle living below the poverty level. Poverty has a

disproportionate impact on minority communities and families with children. In Seattle, there has been a notable decrease in children in Head Start with emotional/behavioral disabilities, speech/language impairments, and multiple diagnoses. For example, no children were diagnosed with learning disabilities in the 2008–2009 enrollment year as compared to 36 reported for 2007–2008 program year.

Denise Louie Education Center goals include preparing children for school and support family self-sufficiency by providing access to resources. Denise Louie is focusing on educating children and teaching them to be a part of a respectful community with a primary teaching goal of helping children use the environment productively and to see themselves as capable learners.

Families with female head of household represent the highest percentage of families living in poverty in Seattle.

In 2007, there were an estimated 14,103 low income children ages birth to 3 in all areas of the county excluding Seattle with only 148 available Early Head Start slots.

Skagit County—Samish Indian Nation Head Start

The Samish Indian Nation Head Start is located in Skagit County and primarily serves Anacortes. There are 38 children eligible to be served by the Samish Indian Nation Head Start. The data reported for abuse and neglect covered children 0–17 years of age.

Spokane County

The Community College of Spokane (CCS) provides service at 21 Head Start, Early Head Start and ECEAP centers (1, 889 slots). CCS has delivery models that include part and full time enrollees, and center and home based services for families. In 2006–2007 the CCS waitlist ranged from 639 to 778 children per month.

The CCS program strives for service collaboration with other agencies.

Walla Walla County

Walla Walla Head Start/ECEAP programs are administered under the Public Schools Head Start/ECEAP programs. Head Start through the Walla Walla Public Schools is the only Head Start in the city of Walla Walla. The Head Start program in Milton-Freewater, Oregon, located 10 miles south of Walla Walla is a seasonal program serving 234 children. The college park Migrant Council has a seasonal Migrant Head Start program that served 177 children in 2009. It had a wait list of 87 children for the program. The ECEAP Services District 123 serves 138 and the Washington Migrant Council ECEAP serves 48 children.

Walla Walla is using community resources to help address its child abuse issues. Walla Walla has high unemployment. This allows more families to qualify for Head Start and ECEAP. This has generated a long wait list of families seeking the available slots.

Gaps in service identified in Head Start Community Needs Assessments:

- There is only one certified substance abuse service provider in Asotin County.
- There is no pregnant and parenting women's program for substance abuse treatment in Grant County.

- More substance abuse services are needed in rural areas of the state such as Asotin, Garfield, and Grant Counties.
- There are not enough slots available across Washington to meet the needs of the Head Start and Early Head Start populations.
- There is a lack of access to medical and dental service to eligible children. This is due in part to a lack of insurance and Medicaid providers in some instances; and a lack of awareness of dental service coverage under Medicaid in other instances.

Head Start Community Needs Assessments and Strategic Plan References

- Chelan-Douglas County Child Services Association Community Assessment 2009-2012 (August 2009)
- Clark, Cowlitz and Pacific Counties Community Assessment (2008–2011)
- Lower Columbia College Head Start and ECEAP Community Assessment (2009-2010) which covers Cowlitz County
- Grant County Community Needs Assessment (2010)
- Kittitas County Community Assessment 2008—Kittitas County Head Start/ECEAP
- Lewis-Clark Early Childhood Program Community Assessment (August 2010)
- Mid—Columbia Children’s Council Community Assessment (Pacific, Skamania and Clark Counties) (2009)
- Puget Sound ESD—ECFS Community Assessment (2008)
- Samish Indian Nation Head Start Community Assessment (2009–2010)
- Skagit/Islands Counties Head Start Community Assessment (2010)
- Community Colleges of Spokane Community Needs Assessment
- Walla Walla Public Schools Head Start/ECEAP—Review of the Community Needs Assessment (March 2010)

Domestic Violence Information

The Supplemental Information Request suggested that information from the State Domestic Violence Coalition’s statewide needs assessment and the Violence STOP Violence Against Women grant implementation plan inform this needs assessment. The Department of Health partners with the State Domestic Violence Coalition through DOH Family Violence Prevention Workgroup, which includes DOH staff from Maternal and Child Health and Injury Prevention. We have received information from the State Domestic Violence Coalition and will continue to work with them through the planning and implementation phases of this grant.

STOP Violence Against Women is a formula grant to states from the US Department of Justice, Office on Violence Against Women.⁹ STOP stands for Services-Training-Officers-Prosecutors. The STOP Program promotes a coordinated, multidisciplinary approach to enhancing advocacy and improving the criminal justice system’s response to violent crimes against women.¹⁰ In Washington State the STOP grant is implemented by the Office of Crime Victims Advocacy in the Department of Commerce. The Implementation Plan for 2007-2009 was reviewed. The 2010-2012 plan has not been formally accepted yet. Funds in

⁹ http://www.ovw.usdoj.gov/stop_grant_desc.htm (accessed 9/13/10)

¹⁰ Ibid.

Washington State are distributed to all 39 counties on a non-competitive formula basis. Funds are used to increase the capacity of the justice system and law enforcement to effectively respond to violence against women, with a focus on responding to underserved and marginalized populations with culturally appropriate supports and services.

Home visiting programs can provide connections to other community resources for women experiencing domestic violence and women re-establishing their lives after leaving domestic violence. Partnerships between local home visiting and domestic violence prevention programs are critical in order for both programs to serve women and children effectively.

Home Visiting Program Summary

Though there are many home visiting models being implemented in Washington State, there continue to be many children and families experiencing risk factors that do not have access to home visiting programs. The small numbers of children and families served, and the difficulty in combining data across models, makes it difficult, if not impossible, to report change or impact at a community or state level. Only a few of the models are implemented statewide, most are in only a few communities.

Home visiting models vary in terms of populations served, goals and outcomes, length of time that visits are provided (number of weeks, years), and the content of the visits. Due to these differences, it is challenging to compare and/or combine data from one model to another. Within one model (e.g., Parents as Teachers) data appears to be gathered in a consistent manner across programs.

We began gathering information about home visiting models and programs before the Supplemental Information Request (SIR) was published, so we were guessing as to what information to gather. Some models collect a lot of data, some collect a limited amount. As we developed our thinking, and again after the SIR was available, most models have been contacted numerous times with requests for additional information and clarifications. As model leads and implementers reviewed initial drafts, some of them suggested different ways to report and describe the data.

Because we tried to gather information about as many home visiting models and programs as possible, not limited to evidence-based models, we have broader information based from which to move into the planning phase of this grant

Substance Abuse Treatment Capacity in Washington State

Introduction

The Patient Protection and Affordable Care Act (Health Care Reform Act H.R. 3590), under Section 2951—Maternal, Infant, and Early Childhood Home Visiting Programs, requires the state to assess its “*capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.*” In addition to discussing substance abuse and counseling services available throughout the state, the following must be addressed:

- Gaps or duplications in service in each community identified as being at risk for substance abuse.
- A summary of findings, specifying, which communities or sub-communities have been identified by the State as particularly at risk and in particular need of improved or expanded home visiting services.
- The state’s plan for addressing these needs.

Capacity for Substance Abuse Treatment and Counseling Services

Substance abuse treatment and counseling services are available to any individual within Washington State, regardless of age, race, gender, religion, or economic status. Outpatient treatment services are available to Washington residents. Residential, inpatient and detoxification services are available to anyone within the boundaries of the state at the time of crisis, and to those in need of treatment who reside in neighboring states.

There are 626 active providers of substance abuse treatment in Washington State, including both private and publicly funded services. The Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) contracts with 51% (360) of these providers. 19% (132) serve any resident within Washington State and are not restricted to county boundaries for services. 39% (275) serve residents within specific county lines. Most county-specific services are outpatient, intensive outpatient, or opiate dependency treatment services, which require short-term or ongoing case management through a single provider. Details are provided in Table 7: Substance Abuse Capacity Services Program and County Breakdown.

At any given period, Washington State’s total capacity for residential, inpatient, and detoxification services is 5,770, but this may change depending on funding. In fiscal year 2009, 9,066 (unduplicated) adults were admitted to intensive inpatient services, 653 (unduplicated) adults were admitted to recovery house services, and 2,443 (unduplicated) adults were admitted to long-term chemical dependency treatment services. In calendar year 2009, a total of 66,538 adults and minors received residential, inpatient, or detoxification substance abuse treatment services.

Table 7: Substance Abuse Capacity Services Program and County Breakdown

County	# of Providers	Outpatient Treatment Services	Intensive Outpatient Treatment Services	Opiate Dependency Treatment Services	Recovery House Services	Long-Term Residential Treatment Services	Sub-acute Detoxification Services	Acute Detoxification Services	Intensive Inpatient Treatment Services	Alcohol and Drug Addiction Treatment Support Act Assessment	Chemical Dependency Involuntary Treatment Act Assessment	Driving Under the Influence Assessment	Alcohol and Drug Information School	Total
Adams	1	1	1	0	0	0	0	0	0	1	1	1	0	5
Asotin	1	1	1	0	0	0	0	0	0	1	1	1	1	6
Benton	13	9	10	0	0	2	0	0	1	1	1	10	7	41
Chelan-Douglas	7	6	6	0	1	1	1	0	2	1	1	6	6	31
Clallam	14	12	10	0	0	1	0	0	0	5	2	10	8	48
Clark	27	24	19	2	0	0	1	1	2	4	1	16	10	80
Columbia	1	1	1	0	0	0	0	0	0	1	1	1	1	6
Cowlitz	14	13	11	0	0	2	0	0	2	3	1	11	5	48
Ferry	4	4	3	0	0	0	0	0	0	1	1	3	1	13
Franklin	10	8	9	0	0	1	1	0	0	0	0	7	5	31
Garfield	1	1	0	0	0	0	0	0	0	1	1	1	1	5
Grant	3	3	3	0	0	0	0	0	0	1	1	3	2	13
Grays Harbor	16	14	14	0	1	1	0	1	2	5	2	13	9	62
Island	7	7	4	0	0	0	0	0	0	1	1	4	4	21
Jefferson	4	4	2	0	1	0	0	0	0	1	1	2	2	13
King	158	135	104	8	4	6	1	7	14	23	1	117	82	502
Kitsap	22	21	17	0	0	0	1	0	2	3	1	16	12	73
Kittitas	5	3	3	0	0	0	0	0	1	1	1	3	3	15
Klickitat	2	2	2	0	0	0	0	0	0	2	1	2	2	11
Lewis	11	8	7	0	1	1	0	0	2	2	1	7	6	35
Lincoln	1	1	1	0	0	0	0	0	0	1	1	1	1	6
Mason	15	12	12	0	1	0	0	0	1	6	0	9	4	45
Okanogan	3	3	3	0	0	0	0	0	0	1	1	3	2	13
Pacific	8	7	4	0	0	0	0	0	0	5	1	3	3	23
Pend Oreille	3	3	1	0	0	0	0	0	0	1	1	1	1	8
Pierce	72	58	52	4	1	0	0	1	5	11	1	47	44	224
San Juan	3	3	3	0	0	0	0	0	0	3	1	3	0	13
Skagit	16	13	10	0	1	1	2	1	0	6	3	12	10	59
Skamania	2	2	2	0	0	0	0	0	0	1	1	2	2	10
Snohomish	49	40	42	4	0	4	1	2	4	11	1	38	29	176
Spokane	48	34	28	1	6	4	2	0	11	4	2	23	19	134
Stevens	6	6	3	0	0	0	0	0	0	4	1	4	3	21
Thurston	20	17	16	1	0	0	0	1	1	1	1	13	9	60
Wahkiakum	1	1	1	0	0	0	0	0	0	1	1	1	1	6
Walla Walla	7	4	4	0	0	0	0	0	1	1	1	4	4	19
Whatcom	17	12	11	0	1	0	1	0	1	5	1	11	9	52
Whitman	2	2	2	0	0	0	0	0	0	1	1	2	2	10
Yakima	33	24	21	2	2	4	3	0	3	1	1	23	16	100
Statewide Total	626	519	443	22	20	28	14	14	55	122	41	434	326	

Accessing Publicly Funded Substance Abuse Treatment Services in Washington State

Individuals seeking treatment for substance abuse, who are not already on public assistance, may seek assistance from a local Community Service Office (CSO). The CSO will determine their eligibility for the following funding sources:

- ADATSA (Alcohol and Drug Addiction Treatment Support Act)
- TANF (Temporary Assistance to Needy Families)
- Disability Lifeline (as of July 1, 2010, formerly known as GA-U)
- Disability Lifeline – Expedited Medical (as of July 1, 2010, formerly known as GA-X)
- SSI (Supplement Security Income)

Priority for services is given to pregnant women (initiation within 15 working days), referrals from Child Protective Services, street youth, youth in the midst of family problems, injection drug users, and people with HIV/AIDS.

If individuals are financially eligible, their treatment assessment is paid for through Medicaid. They are referred to any local certified assessment center for a treatment assessment.

Individuals already on Medicaid may go straight to any local certified assessment center for a treatment assessment. Individuals can self-refer or be referred by a third-party such as a care provider, agency, or family member.

Individuals requiring immediate detoxification services may go directly to a certified detoxification facility without going to a CSO first (see Detoxification Services).

The treatment assessment determines qualifications for services and placement based on the ASAM-LOC (American Society of Addiction Medicine—Level of Care) measurement screening tool.

The assessment counselor makes a treatment recommendation for one of the following treatment modalities:

- Intensive Inpatient (up to 30 days)
- Long Term Residential (up to 180 days, typically 45 to 90 days)
- Recovery House (adults up to 60 days, youth up to 120 days)
- Intensive Outpatient
- Outpatient

These treatment modalities are discussed in more detail below.

Medicaid-eligible individuals who are not ADATSA eligible, can access any publicly funded treatment program for assessment and referral for LOC placement.

There are 122 assessment centers for ADATSA eligible individuals across the state. At least one ADATSA assessment facility is located in each county, except Franklin County, which shares a facility with neighboring Benton County.

After being assigned an LOC, individuals are placed on a waitlist, if services are not immediately available. The waitlists vary depending on location and are managed internally by each facility.

Substance Abuse Treatment Capacity

The Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) monitors these services.

DBHR provides publicly funded treatment and prevention services for chemically dependent individuals and their families. Both drug and alcohol dependencies are addressed. There are a variety of programs targeting substance use among pregnant and post-pregnancy women, as well as affected infants/children. Many of these programs are integrated and include: Fetal Alcohol Syndrome/Fetal Alcohol Effects Services; Parent-Child Assistance Program; Pregnant, Post-Partum, and Parenting Residential Treatment Services; ADATSA (Alcoholism and Drug Treatment and Support Act); Housing Support Services for Pregnant, Post-Partum, & Parenting Women; Safe babies, safe moms (formally known as Comprehensive Program Evaluation Project for Substance Abusing Women and Their Young Children); Crisis Nurseries; and Chemical Using Pregnant detoxification. DBHR collaborates with agencies, non-profit organizations, tribes, and local governments to provide services for individuals and communities.

According to the TARGET data system, the demographics of the adults that received treatment in FY 2009 were as follows:

Gender:	61% male	38% female
Race:	65% Caucasian (Non-Hispanic)	2% Asian/Pacific Islander
	9% African American	3% Multiple Race
	10% Hispanic	2% Other
	8% Native American	
Schooling:	2% enrolled full-time in school	3% dropped out, expelled or suspended from school
	1% enrolled part-time in school	
Substance use history:	10% began using their primary substance by age 11	Alcohol is the most frequently cited drug of abuse in adult admissions (74%)
	44% began using their primary substance before age 16	50% of adults admitted for treatment also reported Marijuana use.
	28% had used needles to inject illicit drugs	
Type of substance abuse treatment services:	The majority of adult admissions were for outpatient services (82%)	9% long-term residential
	30% intensive inpatient	7% opiate treatment
		2% recovery house services
Mental health needs:	25% had a diagnosed mental disability	23% were prescribed psychiatric medications
	17% received mental health services	

Criminal history:	40% were on parole at the time of substance abuse treatment	
Other socioeconomic factors:	36% had been victim of domestic violence	50% used the emergency room for one or more visits in the previous year

Services Available to the General Population

Awareness, Prevention, and Referral Services

The Alcohol/Drug Help Line

The Alcohol and Drug Help Line offers general information, referrals and counseling, maintains listings of bed availability around the state, and maintains a Chemical Dependency Professional's webpage for information on workforce development and employment. They have four departments: Teenline, Washington State Alcohol/Drug Clearinghouse (which provides free print and video resources), Behavioral Health Professional Job Line and Evolution of Chemical Dependency Treatment and Services in Washington State. Volunteers receive extensive training in crisis counseling before they begin providing services on the Help Line. During the 2007–2009 Biennium, the Alcohol/Drug Help Line responded to 43,532 calls from teens and adults, the Clearinghouse distributed over 925,412 educational resources and presented materials at 138 events around the state, and received 20,381 visits to its website.

Alcohol and Drug Information School

Alcohol and Drug Information School is an education program about the use and abuse of alcohol and other drugs. Individuals who do not present a significant chemical dependency problem are referred to this service by the courts and other third party agents. Alcohol and Drug Information School is designed to help individuals make informed decisions about the use of alcohol and other drugs. Alcohol and Drug Information School is offered by 326 providers in Washington State.

Parenting Education Programs

Various community-based parenting education programs are available throughout the state. These programs assist parents to strengthen their own recovery, facilitate recovery within their families, and build a nurturing family lifestyle. Short-term and intermediate outcomes of these programs include increased capacity to parent and to decreased family tension. The long-term outcome is to decrease family conflict. Target populations are parents, caregivers and affected family members of children (birth to age 18), who are in treatment, recovery, or otherwise at risk.

Assessment Services

The ADATSA (Alcohol and Drug Addiction Treatment Support Act) Assessment is an alcohol and other drug assessment which helps determine whether an individual meets criteria for financial assistance from the Washington State Department of Social and Health Services (DSHS) based on the individual's need for chemical dependency treatment. Services included in this assessment are referral, case monitoring, and assistance with employment. As noted earlier, there are 122 providers in Washington State that offer ADATSA

Assessment (see *Assessing Publicly Funded Substance Abuse Treatment Services In Washington State* above).

The DUI (Driving under the Influence) Assessment is a diagnostic service requested by courts to determine a client's involvement with alcohol and other drugs and to recommend a course of action. Washington State has 434 providers that offer DUI Assessment.

Treatment Support Services

Other services offered within the state offer support to individuals receiving treatment. Treatment support services are critical to an individual's ability to successfully complete a substance abuse treatment program. Outpatient treatment support services do not include housing, vocational training, or mental health counseling. They may include transportation to/from outpatient treatment services when no viable alternative exists, and child care services that are necessary to ensure a participant's ability to attend outpatient treatment sessions.

Childcare

Counties and tribes throughout the state provide and/or arrange for childcare for parents in outpatient treatment. The amount of funding by the counties and tribes for regular childcare varies. Some counties and tribes provide funding for childcare for their outpatient patients, while others rely on referrals and arrangements with local childcare providers, with payment coming from other sources such as Children's Administration, self pay, and reduced fee.

Outpatient Treatment Services

Clinics that offer outpatient treatment services to individuals of all ages are located in each of Washington State's 39 counties. Outpatient services provide chemical dependency treatment services less than 24 hours a day. Individual and group treatment services that vary in duration and intensity according to a prescribed plan are available. There are 519 outpatient services providers in Washington State.

Intensive outpatient treatment services

Intensive outpatient treatment services are concentrated programs of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families. There are 443 intensive outpatient services providers within Washington State.

Opiate Dependency Treatment Services

Opiate dependency treatment services address an array of comprehensive medical, vocational, employment, legal, and psychological issues (through referral when appropriate). These services are offered to individuals who are medically diagnosed as being unable to stop using opioids.

Take-home medications are regulated through criteria that take into account: length and participation in treatment, results of urine drug screens, and stability in living environment. To prevent the diversion of take home medication, patients are required to return to a clinic with their take home medication at the clinic's request. All pregnant patients are provided information about how the medication will affect them and their fetus prior to the first dose. Pregnant patients are followed by an OB/GYN and the program physician who regularly evaluates the medication regime.

The Revised Code of Washington (RCW) 70.96A provides for 350 patient slots, but some counties authorize more using non-state funding. In order to qualify for these services, individuals must meet DSM-IV diagnostic criteria for opiate dependence and meet state and federal eligibility requirements for admission (pregnant and intravenous drug users are priority populations). From June 2007 to May 2009, 6,045 patients were served. The state budgeted a total of \$5,282,670 to counties for these treatment services in the 2009–2011 Biennium from general state funds. There are 22 opiate dependency treatment services providers in Washington State.

Inpatient and Residential Treatment Services

Intensive inpatient treatment is a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families. There are 55 intensive inpatient treatment services providers in Washington State that serve both adults and youth.

Long-term residential services

There are two types of long-term residential services in Washington State. The first is for adults and the second for pregnant and parenting women and their young children (see *Services for Pregnant, Post-Partum, and Parenting Women*). There are 28 long-term residential treatment services providers in Washington State; nine of these provide pregnant and parenting women long-term residential treatment. Therapeutic childcare is available within eight of the nine PPW residential programs.

Washington State adult long-term facilities have the following characteristics:

- Length of stay can be up to 180 days at a time.
- Average length of stay is 85 days.

Recovery House

Recovery House offers treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and in job training, employment, or other types of community activities. The length of stay varies: adults can stay up to 60 days and youth up to 120 days. Eligibility criteria are the same as that for Outpatient Services. There are 20 Recovery House services in Washington State with a total of 180 adult beds.

Other Residential Services (Clean and Sober Houses)

Residences designed to help individuals stay substance abuse free are run by churches, community groups, and as extensions of some outpatient and residential treatment programs. These are often called clean and sober houses. We were unable to collect extensive information on this service. Washington State does not require this type of service to be licensed or certified.

Oxford Houses provided us with detailed information, see *Oxford Houses* below. Other clean and sober houses that we are aware of include houses in: Spokane (5), Yakima (8), Seattle (2 houses plus about 50 beds located in the same building as a residential treatment program).

Oxford Houses

Oxford houses provide an affordable, alcohol- and drug-free housing option for individuals in recovery. They are independent and peer run. Residency is voluntary and residents manage their own medications and health care needs through outpatient care services. As of May 2010, Washington State had 215 Oxford Houses with 1,781 beds covering 20 counties.

- Houses operate democratically; elected house officers serve six-month terms.
- Houses are financially self-supporting with members splitting house expenses, which average \$275 to \$450 per person per month.
- Any resident who relapses must be immediately expelled.
- It is recommended, but not required, that individuals complete a treatment program and be alcohol and drug-free for ten days or more (longer is preferred) at the time of application.
- Applicants must be willing to accept the house rules and expectations, and be able to pay their equal share of household expenses.
- Individuals apply directly to the house of their choice. If there are vacancies, they are interviewed by all members of the house. At least 80% must approve of the applicant as a roommate.

Detoxification Services

Detoxification services assist patients in withdrawing from drugs, including alcohol. Washington State offers two levels of service.

Acute Detoxification Services provide medical care and physician supervision for withdrawal from alcohol or other drugs. There are 14 acute detoxification services providers in Washington State. Individuals experiencing acute detoxification may be admitted to any of these facilities regardless of their place of residence. If an individual requires immediate detoxification services, they may go directly to a certified detoxification facility without going to a Community Service Office (CSO) for financial eligibility screening as described under *Accessing publicly funded substance abuse treatment services in Washington State* above.

Sub-Acute Detoxification Services are non-medical detoxification services for patients who may or may not have medications to assist with withdrawal. If medications are taken, the patient self-administers as ordered by a physician. There are 14 sub-acute detoxification services providers in Washington State. As with acute detoxification services individuals may be admitted to any facility in the state.

Crisis Services

Various types of crisis services are made available to the general population in Washington State. For instance, emergency service patrol and crisis intervention services offer response services to persons having substance abuse related crises, by telephone or in person. Crisis nurseries are also made available to children of parents with substance abuse challenges through day and respite childcare services. Parents using chemical dependency services who have children up to age six years are eligible for crisis nursery services. There are two sites

statewide, one in King County and one in Yakima County. Approximately 83 families and 143 children were served from 2003-2005.

Another crisis service made available to the general public is the Chemical Dependency Involuntary Commitment Act (CD-ITA) Assessment. This assessment is conducted under the Revised Code of Washington (RCW) 70.96A.140 for adults and high risk youth. Under this law, a designated county chemical dependency specialist is authorized to investigate and evaluate specific facts alleging that a person (age 13 and older) is incapacitated as a result of chemical dependency. If the chemical dependency specialist determines that the facts are reliable and credible, they may file a petition for commitment of such a person with the superior or district court. Each county has at least one designated chemical dependency specialist to carry out these duties. There are presently 41 providers within the State of Washington which offer the CD-ITA assessment. CD-ITA assessments do not depend on residency.

Services Available to Specific Populations

Services for Pregnant, Post-Partum, and Parenting Women

The Washington State Division of Behavioral Health and Recovery (DBHR) funds treatment based on Medicaid-eligible or low-income standards (220% of federal poverty level). Some women who exceed these income standards, may have treatment service paid for through the Children's Administration's reunification process, The Children's Administration is another division of the Washington State Department of Social and Health Services. Children's Administration funds assessment, treatment, and case management services for women (and men) above the federal poverty level in King, Pierce, Snohomish, Clark, Yakima, Spokane, and Thurston Counties through an agreement with DBHR.

Parent-Child Assistance Program (P-CAP)

P-CAP offer referrals, advocacy, connections to local resources, financial assistance, and continuing care at sites in nine counties (King, Pierce, Yakima, Spokane, Cowlitz, Clallam, Skagit, Kitsap, and Grant) and on the Spokane Indian Reservation.

Services are available to:

- High-risk, substance-abusing pregnant and parenting women and their young children
- Women who may themselves have a diagnosis of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE)
- Women who have given birth to a child diagnosed with FAS or FAE
- Women who do not receive adequate prenatal care
- Women who have not successfully accessed community resources for substance abusing individuals

An estimated 675 women and their children receive services annually. Waiting lists vary by site. The 2009–2011 Biennium budget allocates over \$7.7 million for these services (funded by a combination of Temporary Assistance of Needy Families (TANF) and state dollars).

Services offered include:

- Case management up to the target child's third birthday

Substance Abuse Treatment Capacity

- Assistance in accessing and using local resources such as family planning, safe housing, healthcare, domestic violence services, parent skills training, child welfare, childcare, transportation, and legal services
- Linkage to healthcare and appropriate therapeutic interventions for children
- Financial assistance for food, unmet health needs, other necessities
- Incentives as needed
- Timely advocacy based on client needs

Housing Support Services

Housing support services are available for up to 18 months for pregnant, postpartum (up to one year after delivery), or parenting women who are:

- Living in drug and alcohol free housing
- Currently in treatment for chemical dependency, or have completed treatment within the last 12 months
- At or below 200% of the federal poverty level at the time they enter transitional housing
- Not actively using alcohol or other drugs
- Currently living in or seeking a transitional house.

Services offer recovery support and linkages to community-based services, including an initial needs assessment coordinated with a treatment provider and the woman to determine current need for services. A care plan is developed with the woman to identify community supports to maximize her recovery plan. Services are provided to monitor for substance abuse and participation in outpatient substance abuse treatment, and to facilitate linkages and appointments for prenatal and postnatal medical care, financial assistance, social services, vocational services, childcare needs, and permanent housing.

Washington State presently has 11 sites (149 openings) statewide. Approximately 149 women are served annually (services can be used for up to 18 months). Waitlists vary by site. DBHR has allocated a total of \$1.5 million for housing support services in the 2009–2011 Biennium. These are Substance Abuse Prevention and Treatment (SAPT) funds.

Pregnant and Parenting Women's Outpatient Programs

Pregnant and Parenting Women's (PPW) Programs are designed to provide support and chemical dependency treatment to pregnant women and new mothers. Participants can bring their babies (up to one year of age) to their treatment groups and individual sessions. Mothers learn skills for recovery, and more effective parenting strategies.

In calendar year 2009, 567 (unduplicated) women were admitted to PPW outpatient treatment services. This is a low estimate of the number of pregnant and parenting women served because some women were admitted to outpatient treatment services that were not specifically designated as PPW.

Pregnant and Parenting Women Long-Term Residential Services

There are currently nine long-term residential treatment services providers in Washington State; that provide services to pregnant and parenting women (PPW).

PPW residential services are paid with state funds (for non-Medicaid eligible individuals) and Medicaid match (for Medicaid eligible individuals). In calendar year 2009, 696 (unduplicated) individuals were admitted to PPW residential treatment services.

These services are available to pregnant and parenting women who:

- Are either Medicaid eligible or at or below 200% of the Federal Poverty Level
- Abuse alcohol and/or drugs during pregnancy
- Meet the American Society of Addiction Medicine (ASAM) criteria for chemical dependency

During the state 2007–2009 Biennium, an estimated 1,300 women and their families were served through these programs: 1,108 patients were admitted and counted in completion rates; 602 successfully completed treatment (54%).

There are approximately 2,000 children who need care while their mothers are receiving inpatient services and only 130 slots available.

For the 2009–2011 Biennium, over \$17.3 million in Medicaid matched funds is budgeted for these services: \$14 million for residential treatment services and over \$3.3 million for therapeutic childcare.

The characteristics of PPW Residential Programs are:

- Children up to six years of age may accompany their parents to treatment for up to six months at a time.
- Length of stay varies and is determined by the woman's needs using American Society of Addiction Medicine (ASAM) patient placement criteria.
- Structured clinical services are provided in a planned regimen of patient care in a 24-hour, live-in setting.
- Enhanced curriculum for high-risk women that may include a focus on domestic violence, childhood sexual abuse, mental health issues, employment skills and education, linkages to pre-and postnatal medical care, legal advocacy, and safe affordable housing (see Housing Support Services below).
- 8 of Washington's 9 programs provide therapeutic childcare (a minimum of four hours per day, five days per week), when one or more child accompanies their mother to treatment.

Therapeutic Childcare

Therapeutic Childcare provides a safe and nurturing environment for children when their parent is in treatment. It prevents parent/child separation and encourages family stability. Therapeutic Childcare helps substance abusing parents improve parenting skills during treatment and provides children of substance abusers who are exposed to drugs and/or alcohol during pregnancy with needed remedial assistance to regain normal development.

Therapeutic childcare services include:

- Developmental assessment using recognized/standardized instruments
- Play therapy
- Behavioral management and modification
- Individual counseling and case management (typically referred outside the provider)

Substance Abuse Treatment Capacity

- Self-esteem building
- Crisis and anger management
- Medication and medical emergency management
- Re-entry preparation
- Family intervention to modify parenting behavior (through child care education) and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

Safe Babies, Safe Moms

Safe Babies, Safe Moms is offered in three Washington State county area sites (one in Snohomish County, one in Whatcom County and a shared site in the neighboring counties of Benton and Franklin) Safe Babies, Safe Moms is a comprehensive service based for substance abusing pregnant, postpartum, and parenting women (PPW) and their children (birth–3). It is a collaborative effort of several divisions of the Washington State Department of Social and Health Services (DBHR, Children's Administration, Economic Services Administration, Medical Assistance Administration, and Research and Data Analysis) and the Washington State Department of Health.

There are 250 Safe Babies, Safe Moms slots available each year. Each site manages its own waiting list. DBHR budgeted \$3.2 million for Safe Babies, Safe Moms Targeted Intensive Case Management in the 2009–11 Biennium (a combination of Medicaid and state dollars).

Women are eligible for Safe Babies, Safe Moms if they:

- Are high-risk substance-abusing women with young children or women who abuse alcohol and/or other drugs during pregnancy
- Have income at or below 220% of the federal poverty level or eligible for Medicaid
- Are not successfully accessing community resources

Safe Babies, Safe Moms goals:

- Stabilizing women and their young children
- Identifying and providing necessary interventions
- Assisting women in gaining self-confidence as they transition from public assistance to self-sufficiency.

Safe Babies, Safe Moms:

- Provides a Targeted Intensive Case Management (TICM) multidisciplinary team at each Safe Babies, Safe Moms site
- Offers case management services for up to three years.
- Provides referral, support, and advocacy for substance abuse treatment and continuing care.
 - Collaborates with long-term residential treatment that provides a positive recovery environment with structured clinical services as needed (see Inpatient & Residential Treatment Services above).
- Assists women in accessing and using local resources such as family planning, safe housing, healthcare, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal services.

- Focuses on domestic violence, childhood sexual abuse, linkages to medical care and legal advocacy, mental health issues, employment skills and education, and provision of safe, affordable drug-free housing as appropriate.
- Collaborates with housing support services for women and children, who stay up to 18 months in a transitional house.
- Provides mental health screening, assessment, and treatment (sometimes through referral to appropriate services)
 - Screening and brief intervention services are designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions and make appropriate referral as needed.

Chemical Using Pregnant Detoxification Services

Chemical Using Pregnant (CUP) Detoxification Services are inpatient hospital programs for detoxification and chemical dependency medical treatment for pregnant women. These services are available to pregnant women who are medically approved for this treatment. Since substance-abusing pregnant women present the highest risk, there are no waitlists for this treatment service. They have direct *access to these services, usually within 24 hours of referral. There are five CUP hospital sites statewide.*

Services for Youth

The Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) provides publicly funded treatment and prevention services for chemically dependent adolescents and their families. Both drug and alcohol abuse and dependencies are addressed. DBHR collaborates with agencies, non-profit organizations, tribes, and local government to provide services for individuals and communities. DBHR contracts for and manages a comprehensive continuum of intervention, screening, assessment, and treatment services. These target indigent, low-income, and Medicaid-eligible youth and their families. Funded services include the Alcohol Drug Helpline and the Teenline, school-based intervention services through the Office of Superintendent of Public Instruction (OSPI), contracts with counties for outpatient assessment and treatment services, and direct contracts with public and private agencies for stabilization/detoxification and residential services.

Screening, assessment, and general outpatient services provide assessments and alcohol/drug counseling for youth and families, including outreach, case management, group and individual counseling, and referral to treatment. These services address abuse of alcohol and drugs, aftercare services, and post-residential treatment. Services may include Group Care Enhancement, which provides outpatient services at youth group homes as a way to reduce barriers and increase access to treatment. DBHR sub-contracts with all 39 counties to provide these services. Eligible individuals are youth ages 10-18, whose family incomes are below 220% of the federal poverty level, and who do not have access to treatment through health insurance. In the State of Washington, any person thirteen years of age or older may give consent for him/herself of outpatient treatment by a certified chemical dependency treatment program. Parental authorization is required for any treatment of a minor under the age of thirteen.

Cumulatively, there are 271 services offered for youth in Washington State. Services vary in type and level of care and in target ages. Some providers serve birth–17, while others serve ages 12 or 13–17, and some serve only ages 16–17. There are 59 services available to youth ages 13–17 in Washington State (8% of total services). There are 212 services available to youth of all ages (birth-17) (30% of total services). Together, these youth services make up 38% of the overall services within the state.

This percentage includes known privately-funded services within the state, however not all privately-funded service data was available for this assessment. In addition, some providers were not able to provide a breakdown of their services by age ranges in time for this assessment.

Each DBHR-contracted youth provider is responsible for determining a youth's clinical and financial eligibility for treatment at their facility.

- Youth who have medical coupons are approved for DBHR funding.
- Youth who are low-income may be eligible for DBHR funding
- Families with third party insurance that does not cover the full costs of treatment may be eligible for funding.

Generally, youth are referred to an outpatient treatment program for an initial assessment of chemical dependency. If the need for residential treatment has already been established, youth may be referred directly to a contracted residential facility and arrangements for continuing care made with a local outpatient provider.

Stabilization and Detoxification

Stabilization and detoxification services provide a safe, temporary, protective environment for at-risk/runaway youth experiencing harmful effects of intoxication and/or withdrawal from alcohol and other drugs, in conjunction with emotional and behavioral crisis (including co-existing or undetermined mental health symptoms). These services address the needs of and treatment outcomes for youth (13–17) who need chemical dependency and other treatment services, but may not be able to access them due to acute intoxication and medical, psychological, and behavioral problems associated with their alcohol/drug use. These services are open to all youth (13–17) regardless of income or financial resources.

Approximately 403 youth between ages 13–17 received detoxification services in 2008.

There are seven sites throughout Washington State serving regional populations. Parental consent is recommended, but not required, for these services, since they are not considered treatment services.

DBHR funds youth treatment and detoxification beds that are open to youth regardless of their county of residence. The minor is placed in the closest facility to their home whenever possible. Intensive inpatient treatment is a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families (see Inpatient and Residential Treatment Services, above). There are two treatment modalities to address addiction and other life issues and their severity within youth treatment services. They take into account the type of secure setting required for individuals in treatment.

- Youth Level I treatment is for individuals with the primary diagnosis of chemical dependency and with less complicating mental health, other emotional, and behavioral problems. The length of stay within this level of care varies between 30-45 days.
- Youth Level II treatment is for individuals with the primary diagnosis of chemical dependency and symptoms of mental health diagnosis or problems requiring concurrent management. The length of stay within this level of care varies between 30-90 days.

As noted earlier, there are 55 intensive inpatient treatment services providers in Washington State serving both youth and adults.

Recovery House

Recovery House services are available for youth who need sober supportive homes after residential treatment stay, recovery house services are available. Youth can stay at Recovery House for up to 120 days (the average stay is 90 days). They offer longer term recovery, life skills development, and relapse prevention (see Inpatient and Residential Treatment Services in the General Population section for more detail). Regional statewide providers and services are open to all youth within Washington State. Parental consent is generally required for minors under age 18. A minor may consent for themselves if they meet the definition of Child In Need of Services (CHINS) and the parent is unable or unwilling to provide consent. As noted earlier, there are 20 recovery house services in Washington State with a total of 180 beds. Approximately 3,200 youth receive residential treatment services each biennium.

Teenline

Teenline is a crisis intervention and referral service targeting counseling and support to youth, their families and those that work them. Teenline is a department of *The Alcohol and Drug Help Line*. Teenline is staffed by adult volunteers during normal business hours and into the evening; they are augmented by teen volunteers Monday through Thursday from 3:00–5:00pm. In 2009, Teenline staff responded to 1,658 teen calls and 25 emails. They made 1,349 referrals to youth agencies across the state.

Student Assistance Prevention-Intervention Services (SAPISP)

The Washington State Office of Superintendent of Public Instruction's Student Assistance Prevention-Intervention Services (SAPISP). These services are funded through local, state, and federal funds. SAPISP places prevention and intervention specialists in schools in order to provide comprehensive student assistance programs. Teenline and SAPISP address problems associated with substance use, early prevention and intervention, assistance in referrals to assessment and treatment, and strengthening transition back to school for students who have had problems of alcohol and other drug abuse and dependency.

Strengthening Families Program

The Strengthening Families Program is a family skills training program designed to increase resilience and reduce risk factors for substance abuse, depression, violence and aggression, delinquency, and school failure in high-risk children (6–12) and their parents. The short-term and intermediate outcome is that participating parents/caregivers will report decreased family tension. The long-term outcome is decreased family conflict. This program identifies high

need school districts in Washington State and targets students and their parents and families. Agencies providing this training work directly with school districts to identify schools that have the highest family need. Training is offered at those schools. There are no financial eligibility criteria for these services.

Juvenile Justice Services

Juvenile Justice Services in Washington State are governed by the Juvenile Justice Act of 1977, which establishes a system of accountability and rehabilitative treatment for juvenile offenders. These services consist of vocational, educational, mental health, substance abuse, and behavioral health services for youth (8–21 years old) who have been sentenced to incarceration by a court for criminal offenses. A majority of juvenile offenders are retained in their home counties. Services, such as detention and probation are administered by the juvenile court.

Washington is the only state that uses a determinate sentencing structure in committing juvenile offenders. This structure sets court determined minimum and maximum sentence terms; for example 15 to 36 weeks. Sentencing length is determined using a point system that takes offense seriousness and criminal history into account. A judge or juvenile court commissioner may find that the standard range sentence is too lenient for the seriousness of the offense and order a longer term of confinement (Manifest Injustice Up) or overly punitive and order a sentence less than the standard range (Manifest Injustice Down). Manifest Injustice sentences also have proscribed minimum and maximum sentence terms.

JRA Administered Services

Some youth, typically those that have committed serious crimes or have an extensive criminal history, receive services directly administered by the Washington State Department of Social and Health Services Juvenile Rehabilitation Administration (JRA). Approximately 35% of youth in JRA care are serving Manifest Injustice Up sentences; 5% Manifest Injustice Down. Washington has 33 local juvenile courts that may refer (sentence) youth to JRA.

JRA establishes criteria for release of a youth from residential care and has authority to do so at any point between the minimum and maximum release dates. JRA does not have the authority to retain a youth in residential care beyond his or her maximum release date or authority to return a youth to long term residential care from parole, regardless of poor progress in the community. Post release, youth may be returned to residential care (up to 30 days) for parole violation; this requires the approval of an administrative hearings judge. Youth may be returned to residential care multiple times for parole violations, but for no longer than 30 days per return.

JRA operates three institutions, one youth camp, and one basic training camp. The institutions are located in Snoqualmie, Centralia, and Chehalis. The work camp is located in Naselle, and the Basic Training Camp is in Connell. About 1,000 youth are sentenced annually.

Some youth who leave JRA institutions and facilities receive parole. On parole, JRA staff work with youth and their families to improve communication and set appropriate expectations. JRA staff help youth access substance abuse treatment programs, sex offender treatment, family therapy, and mentoring programs.

Approximately 700 youth are in JRA residential programs on any given day and 450 youth are receiving parole services. Minorities are disproportionately represented: accounting for approximately 45% of JRA's population. This is almost twice the proportion of youth minorities in Washington State as a whole. As of March 30, 2010, 59% of youth involved in residential care were chemically dependent.

County Administered Services

There are 22 detention facilities for juveniles in Washington State. Local Superior Courts administer secure juvenile detention in most counties. Several juvenile detention programs incorporate alternatives to detention including day and evening reporting, electronic home monitoring, group care, and work crew programs.

JRA provides funding to local probation departments for expenses related to some programs and services. Washington State's Community Juvenile Accountability Act (CJAA) provides funding for research-based interventions proven to reduce recidivism among juvenile offenders. These interventions include Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Aggression Replacement Training (ART). Juveniles who have been assessed as moderate to high risk to reoffend are eligible for these programs.

The Case Management Assessment Process (CMAP) determines levels of probation supervision in most counties and its use is mandated by some county governments. CMAP uses of a validated risk assessment instrument (the Washington State Juvenile Court Risk Assessment, which includes the Washington State Juvenile Court Pre-Screen Risk Assessment as a subset). State funds are available to help counties implement CMAP.

According to the TARGET data system, the demographics of the youth that received treatment in FY 2009 were as follows:

Gender:	66% male	34% female
Race:	58% Caucasian (Non-Hispanic)	2% Asian/Pacific Islander
	7% African American	7% Multiple Race
	18% Hispanic	2% Other
	6% Native American	
Age:	70% under the age of 16	19% under the age of 14
	42% under the age of 15	
Schooling:	15% not enrolled in school	18% dropped out, expelled or suspended from school
	7% enrolled part-time in school	
Substance use history:	22% began using their primary substance by age 11	Marijuana is the most frequently cited drug of abuse in youth admissions (89%)
	77% began using their primary	

Substance Abuse Treatment Capacity

	substance before age 16	76% of youth admitted for treatment also reported alcohol use
	4% had used needles to inject illicit drugs	
Type of substance abuse treatment services:	The majority of youth admissions were for outpatient services (91%) 23% intensive inpatient	4% recovery house services
Mental health needs:	11% had a diagnosed mental disability 14% received mental health services	12% were prescribed psychiatric medications
Criminal history:	39% were on parole at the time of substance abuse treatment	
Other socioeconomic factors:	19% had been victim of domestic violence	30% used the emergency room for one or more visits in the previous year

Court Mandated Services

Drug Court Services

Drug Courts are special courts designed with jurisdiction over cases involving drug-using offenders. These courts are treatment-based alternatives to prisons, youth-detention facilities, jails, and probation. Drug courts use comprehensive supervision, drug testing, treatment services, immediate sanctions, and incentives. They help offenders change their lives in order to stop criminal activity, rather than focusing on punishment. Drug courts also help provide consistent responses to drug offenses among the judiciary, and foster coordination between intervention agencies and resources. This increases the cost-effectiveness of drug-intervention programs. Jurisdictions tailor drug courts to meet the specific needs of their communities. Most drug courts are pre-plea courts, but some are post-plea, and others are used as an alternative sentencing method. Approximately 8,000 offenders are served (funded through state Criminal Justice Treatment Account (RCW 70.96A.350)).

Individuals cannot qualify for these services, if they are currently charged with or have been convicted in the past of a sex offense, a serious violent offense, an offense during which a firearm was used, or an offense during which there was substantial or great bodily harm or death to another person.

Successful completion of a drug court's treatment or intervention regimen usually results in dismissal of drug charges and/or shortened or suspended sentences. A recent meta-analysis suggested drug courts reduce recidivism by about 9%. Drug Courts generally:

- Incorporate drug testing into case processing
- Create a non-adversarial relationship between the offender and the court
- Identify offenders who are in need of treatment and refer them to treatment as soon as possible after arrest
- Provide access to a continuum of treatment and rehabilitation services

Substance Abuse Treatment Capacity

- Monitor abstinence through frequent, mandatory drug testing
- Establish a coordinated strategy to govern drug court responses to offenders' compliance
- Maintain judicial interaction with each drug court participant
- Monitor and evaluate program goals and effectiveness
- Provide continuing education to promote effective drug court planning, implementation, and operations
- Promote partnerships among drug courts, public agencies, and community-based organizations in order to generate local support and enhance drug court effectiveness.

Family Treatment Court

Family Treatment Court is also offered in Washington State. This service works parents and children to provide treatment to methamphetamine impacted children.

Department of Corrections Treatment Services

Washington State Department of Corrections (DOC) Treatment Services are available to offenders under the guidance of corrections facilities. More offenders are convicted of drug offenses than any other crime category. Chemical addictions lead to continued cycling of offenders through halfway houses, community mental health agencies, emergency rooms, and in many cases, back to prison. According to Nobles (Substance Abuse Treatment Report from the State of Minnesota) inmates who complete substance abuse treatment programs while in prison have lower overall arrests and conviction rates following release than inmates who complete short education programs, and untreated inmates.

The Washington State Institute for Public Policy (WSIPP) found that drug treatment in prison saves tax payers \$7,835 for each inmate who receives treatment. In Washington State chemical dependency treatment is available at 20 community-based sites, 14 of the state's 15 prisons, 13 work release centers, and two jails. WSIPP identified DOC Chemical Dependency programs as effective in reducing recidivism. Services offered include recovery houses, intensive outpatient treatment, outpatient treatment, community based treatment, drug testing services, and therapeutic community.

Therapeutic Community is a 6–18 month intensive treatment. It is located in a separate living area with a highly structured environment where offenders participate in treatment, right-living skills, work, and education and practice community and personal accountability skills.

Chemical Dependency-Involuntary Commitment Act (CD-ITA) Residences

There are two CD-ITA facilities in Washington State. They offer a total of 150 beds for individuals who meet Washington State CD-ITA residential treatment requirements. These services are only available for adults, who have been involuntarily detained by the superior or district court under the Revised Code of Washington (RCW) 70.96A.140 (see *Crisis Services* above).

Tribal Services

Individuals who wish to receive services from a tribal facility go through the same eligibility process as individuals not affiliated with a tribal facility. There are currently 57 active tribal service providers in Washington State. These services make up approximately 8% of the 626

providers across the state. Supported tribal services include inpatient and outpatient services. Some tribal services receive public funding and some do not.

Public funds for tribal services are made available through the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) (Substance Abuse Prevention and Treatment Block Grant, State grant-in-aid (GIA), and Medicaid). Federally recognized tribes have traditionally used Block Grant funds to support prevention programs and State GIA funds to cover administrative costs. Many chemical dependency patients in federally recognized tribal programs are either Medicaid-eligible or Indian Health Services-eligible. Some tribes use their own funds for tribal members. Tribal members may also possess private insurance. Indian Health Service is the payer of last resort, so private insurance is billed first, then Medicaid (for Medicaid eligible individuals), then Indian Health Service, and finally the tribal program. Individuals, who are low income or indigent, are supported solely by Substance Abuse Prevention and Treatment Block Grant funds. Payment to federally recognized tribes for services for Medicaid-eligible Native Americans is based on an encounter rate, which is a different than the usual and customary fee-for-service rate. Medicaid pays 100% of the encounter rate for Native Americans. They receive the encounter rate once a day for a face-to face service for chemical dependency, mental health, medical, or dental treatment. However, only one encounter is permitted for each type of service per day. So, a tribe could be reimbursed for four encounters for an individual per day. If a tribe chooses to serve Medicaid-eligible *non-natives*, they receive 50% of the encounter rate and the tribe is responsible for the rest of the matched funds. In order to receive the federal portion of these funds, the tribe must first pay the match funds to the State Treasurer.

Funding

The capacity of each provider and the system as a whole is driven almost entirely by funding. As available funding is adjusted, capacity expands or contracts by restricting/increasing the number of beds contracted or hiring/decreasing counselors at outpatient programs. Down-sizing can happen virtually overnight. Increasing capacity can be more challenging since providers have to identify, hire, and train new employees. While the need for substance abuse services is increasing, programs must shrink when funding is limited. When the funding is adequate, programs are able to expand to come closer to meeting the need.

Cost is determined by individualized treatment plans and based on the actual services delivered (fee-for-service). Since individual needs vary widely, calculating the average cost per client by provider would not result in a meaningful figure.

As discussed in *Tribal Services* above, public funds are made available through the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR). Similarly, reimbursement begins with private insurance first, then Medicaid (for Medicaid eligible individuals), and finally state and other funding sources.

Most publicly-funded service providers share a common funding structure that includes a mix of Medicaid, State, and private sources. These private sources may include third-party insurance, sliding fee scale, or cash payment. State funding for criminal justice treatment services may come from the Criminal Justice Treatment Account (CJTA) and Chemical Dependency Disposition Alternative (CDDA). State funds also support Crisis Treatment. Examples of Medicaid funding sources include Alcohol and Drug Addiction Treatment Support Act

(ADATSA), Temporary Assistance to Needy Families (TANF), Disability Lifeline (formerly known as GA-U), Disability Lifeline—Expedited Medical (formerly known as GA-X), and Supplemental Security Income (SSI). However, when accessing outpatient services, individuals using funding sources like Disability Lifeline, Disability Lifeline—Expedited Medical, TANF, or SSI, are not eligible to receive ADATSA funded services or a living stipend. Particular types of funding sources within Washington State are listed and defined below.

Information for the private services sector was not readily available for description in this assessment. Therefore, it is difficult to summarize the overall funding options and sources within the state. State funding sources are listed below:

Chemical Dependency Disposition Alternative (CDDA)

The Chemical Dependency Disposition Alternative was created by the 1997 Washington State Legislature as a sentencing option for juvenile offenders. Its goal was to reduce recidivism by providing treatment for chemically dependent or substance abusing youth. The Juvenile Rehabilitation Administration (JRA) was charged with managing treatment resources and prioritizing expenditures to programs that demonstrate the greatest success.

Criminal Justice Treatment Account (CJTA)

The criminal justice treatment account was created under Revised Code of Washington (RCW) 70.96A.350, to fund substance abuse treatment and support services for offenders with an addiction; or a substance abuse problem that, if not treated, would result in addiction. This account was also created for the provision of drug and alcohol treatment services and support services for nonviolent offenders within a drug court program; the administrative and overhead costs associated with the operation of a drug court; and the operation of the integrated crisis response and intensive case management pilots contracted by the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) during the 2007–2009 Biennium.

While these funds may be used to purchase chemical dependency treatment, child care, and transportation to and from treatment services, they may not be used for housing and medical care. Many individuals entering residential treatment funded by the CJTA funds qualify for ADATSA medical coupons while in residential treatment (State CJTA funds the chemical dependency treatment and federal ADATSA funds provide medical care). ADATSA medical funding ends when individuals enter CJTA-funded outpatient treatment services.

Treatment Expansion

In 2005, the State Legislature approved an increase in funding for chemical dependency treatment. This state funding source is available to Medicaid-eligible individuals who need treatment for alcohol and other drug use disorders. We anticipate that this funding will result in cost savings in acute medical care, prescription drugs, acute psychiatric care, and long-term care.

Needs Assessment Limitations

A number of limitations were identified while conducting this Needs Assessment.

- Information for privately funded services (including privately funded tribal services) was not readily available for this assessment. Some of these resources were available, but we

were unable to collect all of the necessary information in time for this assessment. This made it difficult to summarize the overall services provided within the state.

- It was a challenge to describe the process for accessing private services (again, due to the availability of this information).
- We were unable to obtain quantitative data on providers' waitlists.
- Data may be skewed because only individuals presenting for treatment are reported. Individuals who may need treatment, but are not presenting for treatment are not reported in this assessment.
- We were unable to collect subcounty data for the capacity for substance abuse treatment services section of the assessment.
- We were not able to contact each of the individual 626 providers in Washington State for more specific and/or individualized data in time for this assessment.

Potential Service Gaps

Throughout this assessment, we were able to identify a number of potential service gaps. Overall, the demand exceeds the available resources for drug and alcohol abuse services, preventing those in need from receiving care. Areas in need of attention are criminal justice, alcoholism as a chronic disease, opiate substitution treatment (methadone treatment), substance use and aging, substance abuse and child welfare, treatment for nicotine dependence, and brief interventions within the emergency departments and health care settings.

In addition

- There is an increased need for co-occurring substance use and mental health programs to better treat the symptoms presented by some of individuals entering into treatment services with the limited capacity and funding options available.
- Cross-county service areas pose another potential gap: Individuals may enter residential, inpatient, or detoxification treatment services, with placement that is outside their local area. On discharge back into their community, it is a challenge to ensure that referral for continued outpatient services are followed.
- In order to get the best outcomes for youth, the youth's families and community supports must be actively involved in treatment services. However, not all Juvenile Rehabilitation Administration (JRA) residential programs are located near communities where the families live. DBHR is reviewing the locations of JRA residential programs to identify steps that will allow youth to be served in secure residential programs located closer to their families and home communities.
- There is a need for more Pregnant and Parenting Women Residential Treatment space that incorporate care for children while their mothers are receiving services (approximately 2,000 children need this service and there are 130 slots available: leaving an unmet need of approximately 1,870 slots).
- There is an on-going need for training in techniques to improve engagement, retention, and completion using cognitive behavioral approaches compatible with alcohol and drug addiction treatment.
- Due to capacity, there are waitlists within some treatment programs. This could result in missed windows of opportunity for admitting clients into necessary treatment services.

- As noted earlier, the capacity for programs shift when funding shifts. According to DBHR the need is growing, yet funding is limited. When the funding is adequate, programs are able to expand to come closer to meeting the need. When funding is poor, as it is currently, programs are forced to shrink despite the increased need.
- There is an increased interest and need for secure facilities for youth. Recently, a youth treatment facility was closed because of loss of state funding. This further decreased the capacity of youth inpatient treatment services. In state fiscal year 2007 (July 2006 through June 2007), DBHR provided services to 6,160 out of an estimated 19,591 eligible youth needing and eligible for publicly-funded chemical dependency treatment. The treatment gap (or unserved need) was 68.6% (13,431 of 19,591 eligible individuals were not served).

Sources

1. Washington State Department of Health Maternal & Child Health May 2010 Data Report
2. Washington State Division of Behavioral Health and Recovery Treatment Analyzer/TARGET
3. Washington State Department of Corrections November 2008 Report
4. Washington Administrative Code (WAC) 388-805; 246-337
5. Revised Code of Washington (RCW) 2.28.170; 70.96A.095; 70.96A.097; 70.96A.140; 70.96A.350; 71.12
6. Washington State Division of Behavioral Health and Recovery:
 - Division of Behavioral Health & Recovery: <http://www.dshs.wa.gov/dasa/>
 - Juvenile Rehabilitation: <http://www.dshs.wa.gov/jra/treatment/index.shtml#ITM> and <http://www.dshs.wa.gov/jra/about/justice.shtml>
 - Frequently asked questions about treatment: <http://www.dshs.wa.gov/pdf/HRSA/DASA/FAQaboutTx.pdf>
 - Resource Guide for substance abusing pregnant and parenting women (PPW): <http://www.dshs.wa.gov/pdf/HRSA/DASA/PPW%20Resource%20Guide%202010.pdf>
 - Adolescent Strategic Plan: <http://www.dshs.wa.gov/pdf/hrsa/dasa/Adolescent%2520Strategic%2520Plan%2520Final.pdf>
 - “Tobacco, Alcohol, and other Drug Abuse Trends in Washington State 2004”: <http://www1.dshs.wa.gov/pdf/hrsa/dasa/2004TrendsIssues.pdf>
 - Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State Report 2008: <http://www.dshs.wa.gov/pdf/hrsa/dasa/2008-Trends%20Report.pdf>
 - AOC/DBHR Courts: http://www.courts.wa.gov/court_dir/?fa=court_dir.display&content=problemSolving/index.
7. Department of Health, Facility Investigation and Inspection
8. Snohomish County Health District
9. Whatcom County Health Department
10. Clark County Health Department

Substance Abuse Treatment Capacity

11. Jefferson County Health Department
12. Lewis County Public Health & Social Services
13. Grays Harbor County Public Health
14. Clallam County Health & Human Services
15. Department of Corrections – Chemical Dependency Program
16. Adult Residential Providers Advisory Committee (ARPAC)
17. State of Washington Sentencing Guidelines Commission *Juvenile Disposition Manual 2004* (http://www.sgc.wa.gov/PUBS/Juvenile/Juvenile_Disposition_Manual_2006.pdf)
18. Alcohol Drug Helpline (<http://www.adhl.org/>)
19. Teen Line (<http://www.theteenline.org/>)
20. SAMHSA Co-Occurring Center for Excellence presentation on ASAM (http://coce.samhsa.gov/cod_resources/PDF/ASAMPatientPlacementCriteriaOverview5-05.pdf)
21. Oxford House Association: www.oxfordhouse.us
22. National Center for Juvenile Justice (NCJJ) (<http://70.89.227.250:8080/stateprofiles/profiles/WA06.asp>)

Summary of Findings

Data Report

In order to measure community risk, we worked with other state agency staff and non-governmental stakeholders to identify data sources and key indicators for each topic area outlined in the Patient Protection and Affordable Care Act and the accompanying guidance document. We included the following dimensions of risk in our analyses: premature birth, low birthweight infants, infant mortality, poverty, crime, domestic violence, school dropout rates, substance abuse, unemployment, child maltreatment, late or no prenatal care, teen births, youth binge drinking, youth illicit drug use, and third grade reading levels (conceptualized as a measure of readiness for school). The first 10 of these dimensions are specified in the law. The stakeholder group recommended additional dimensions as indicators of high risk. Overall, the dimensions included 15 specific indicators. A description of how the indicators are defined and the years of data used is located in Appendix B, Table B-1: Summary—Indicator Data. Data sources, including Needs Assessments for Title V, Head Start, Child Abuse Prevention and Treatment Act (CAPTA), Substance Abuse and Mental Health Services Administration (SAMHSA), and sources such as state databases on child maltreatment, crime and domestic violence, are described in the Data Report—Methodology section (see page 6).

Defining Community

For analysis purposes, we defined communities in two ways: a) geographically and b) based on race/ethnicity. The geographic units were primarily counties. For the three largest counties (King, Pierce, Snohomish) we included the subcounty areas they use for health planning. Overall, we considered 57 geographic communities, including 36 counties and 21 subcounty areas.

Although Washington contains tribal areas, we could not present them as communities for the purpose of this report, because we have neither risk measures nor home visiting measures specifically for tribal areas. However, data are available on the indicators of risk for the overall American Indian/Alaska Native (AIAN) population in Washington and for each of Washington's other race/ethnic communities. We defined race/ethnic communities using seven groups: Hispanics, Non Hispanic (NH) American Indian/Alaska Native; NH Asian; NH Black, NH Pacific Islander, NH White, and Multirace. We collected the same indicators for the state as a whole, for the geographic communities, and for the race/ethnic communities.

Defining Communities At-Risk and Preparing a Data Report for Each Community At-Risk

To determine which communities were at-risk, we developed rates for each indicator for each county/subcounty area and race/ethnic group. Then, for each of these indicators we derived the risk ratio by dividing the community rate by the state rate. We developed a summary risk score for each community by averaging the log-transformed risk ratios across indicators. We log transformed the ratios to stabilize the greater variability which smaller communities experience. A summary score of zero indicates that on average the community has the same risk as the state. We identified communities at-risk as those communities with summary

scores above zero, since their summary risk score was higher than the state as a whole, detailed in the Data Report—Methodology section (see page 6)

In response to stakeholder input, we also grouped several of the indicators by category and re-calculated the summary risk score to explore the impact of different weighting strategies on identifying at-risk communities. We present three different methods for identifying at-risk communities. Two methods grouped the indicators. In Washington, at-risk communities are defined as those that were identified using any of the three methods. For more detail, see the Data Report—Methodology section on page 6. We identified 32 geographic areas and 5 racial/ethnic groups as communities at-risk.

Although information was available for most indicators, for all of the geographic and race/ethnic communities, there were some challenges in identifying and compiling the data. In those few instances where data were not available for a specific community, we used the available data most closely associated with that community. For example, we used countywide information when an indicator was unavailable at the subcounty level. The measure of risk is highly dependent on the specific set of risk factors used. Also some of the risk factors have more than one measure (for example crime offenses or arrests). A different array of risk factors, of specific measures used for a risk factor, or a different weighting given to the individual scores would likely lead to different results. Similarly, some geographic communities are so small that reliable data were unavailable for a few indicators. We made estimates based on nearby, comparable communities. Other areas were so large that we could not determine if they contained any small pockets of high risk populations.

The Governance Group for the HVNA has reviewed and concurs with the methodology used to identify communities at-risk.

Existing Programs for Early Childhood Home Visiting (Including Quality and Capacity)

Washington State has many home visiting programs and initiatives. Programs are provided by many agencies, including, local health jurisdictions, school districts, and private organizations. Programs have a variety of funding streams, federal, state, local, tribal, and private. Agencies often use several funding streams to fund the implementation of one model.

In the Home Visiting Needs Assessment, we have attempted to gather information on as many home visiting programs as possible. Though the focus of the funding of the federal Maternal, Infant and Early Childhood Home Visiting Program is on evidence-based and promising models, we realized that an understanding of the broader world of home visiting in our state will aid decisions about where to infuse additional services. It will also be useful as state, local, and tribal stakeholders work to better coordinate home visiting services and continue to look for ways to maximize home visiting resources. Two resources we used were inventories of home visiting programs we obtained from the Council for Children & Families, the state's Child Abuse Prevention and Treatment Act (CAPTA), Title II agency, and the Home Visiting Coalition. In addition, we contacted the state leads for the evidence-based programs: Early Head Start, Nurse-Family Partnership, Parent-Child Home Program and Parents as Teachers; and the Head Start State Collaboration Office in the Department of Early Learning. We also asked Washington's 35 local health jurisdictions for information about home visiting in each of their areas. The Home Visiting Needs Assessment Team

developed and used a dedicated website, listserv, and periodic webinars to communicate with and seek information from stakeholders. To increase the accuracy of information in this Needs Assessment, we use several routes to follow up on the information we received. We also posted drafts of the Needs Assessment on the website and asked stakeholders to comment.

The core of information we collected is contained in Appendix C: Tables C-1, C-2, and C-3. Tables C-1 and C-2 show how home visiting models implemented in Washington State match the definition of home visiting in the law. Table C-3 lists home visiting programs and models by county and/or Federally Recognized Tribe.

As required by the Supplemental Information Request, we include a profile of 15 home visiting models in our state. All but one of these models are implemented by more than one agency or organization in our state. The profiles show the program name, model or approach used, specific services provided, intended recipients, goals/outcomes, demographic characteristics of families served, and geographic area served.

Though there are many home visiting models being implemented in Washington State, there continue to be many children and families experiencing risk factors, who are unable to access home visiting programs. The small numbers of children and families served, and the difficulty in combining data across models, makes it difficult, if not impossible, to report change or impact at a community or state level. Only a few of the models are implemented statewide, most are in only a few communities.

Substance Abuse Treatment and Counseling Services

Substance abuse treatment and counseling services are available to any individual within Washington State, regardless of age, race, gender, religion, or economic status. Outpatient treatment services are available to Washington residents. Residential, inpatient and detoxification services are available to anyone within the boundaries of the state at the time of crisis, and to those in need of treatment who reside in neighboring states.

There are 626 active providers of substance abuse treatment in Washington State, including both private and publicly funded services. The Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR), contracts with 51% (360) of these providers. 19% (132) serve any resident within Washington State and are not restricted to county boundaries for services. 39% (275) serve residents within specific county lines. Most county-specific services are outpatient, intensive outpatient, or opiate dependency treatment services, which require short-term or ongoing case management through a single provider. Details are provided in Table 7: Substance Abuse Capacity Services Program and County Breakdown. At any given period, Washington State's total capacity for residential, inpatient, and detoxification services is 5,770, but this may change depending on funding. In fiscal year 2009, 9,066 (unduplicated) adults were admitted to intensive inpatient services, 653 (unduplicated) adults were admitted to recovery house services, and 2,443 (unduplicated) adults were admitted to long-term chemical dependency treatment services. In calendar year 2009, a total of 66,538 adults and minors received residential, inpatient, or detoxification substance abuse treatment services.

Data limitations make it difficult to summarize the state's overall services. Much information for privately funded services (including privately funded tribal services) was not readily available

Summary of Findings

for this assessment. Describing the process for accessing private services was challenging due to the unavailability of information. We were unable to collect substance abuse treatment capacity data at the subcounty level. Data may be skewed because only individuals presenting for treatment are reported. Individuals who may need treatment, but are not presenting for it, are not reported in this assessment.

We identified a number of potential service gaps. Overall, the demand exceeds the available resources for drug and alcohol abuse services, preventing those in need from receiving care. Areas in need of attention are criminal justice, alcoholism as a chronic disease, opiate substitution treatment (methadone treatment), substance use and aging, substance abuse and child welfare, treatment for nicotine dependence, and brief interventions within the emergency departments and health care settings.

In addition:

- There is increased need for co-occurring substance use and mental health programs to better treat the symptoms presented by some of youth entering into treatment services with the limited capacity and funding options available.
- Cross-county service areas pose another potential gap: Individuals may enter residential, inpatient, or detoxification treatment services, with placement that is outside their local area. On discharge back into their community, it is a challenge to ensure that referral for continued outpatient services are followed.
- In order to get the best outcomes for youth, the youth's families and community supports must be actively involved in treatment services. However, not all Juvenile Rehabilitation Administration (JRA) residential programs are located near communities where the families live. DBHR is reviewing the locations of JRA residential programs to identify steps that will allow youth to be served in secure residential programs located closer to their families and home communities.
- There is an on-going need for training in techniques to improve engagement, retention, and completion using cognitive behavioral approaches compatible with alcohol and drug addiction treatment.
- Due to capacity, there are waitlists within some treatment programs. This could result in missed windows of opportunity for admitting clients into necessary treatment services.
- As noted earlier, the capacity for programs shift when funding shifts. According to DBHR the need is growing, yet funding is limited. When the funding is adequate, programs are able to expand to come closer to meeting the need. When funding is poor, as it is currently, programs are forced to shrink despite the increased need.
- There is an increased interest and need for secure facilities for youth. Recently, a youth treatment facility was closed because of loss of state funding. This further decreased the capacity of youth inpatient treatment services. In state fiscal year 2007 (July 2006 through June 2007), The Washington State Division of Behavioral Health and Recovery (DBHR) provided services to 6,160 out of an estimated 19,591 eligible youth needing and eligible for publicly-funded chemical dependency treatment. The treatment gap (or unserved need) was 68.6% (13,431 of 19,591 eligible individuals were not served).

Communities Identified As Particularly At-Risk

Of the 57 county and subcounty communities on which we collected indicators, there were 32 with summary risk scores higher than the risk score for the state as a whole. These 32 geographic at-risk communities include 24 counties and 8 subcounty areas. Twenty-three of these communities have risk scores higher than the overall state score by all three methods used in this Needs Assessment. Two communities have higher risk scores by two of the methods; and seven communities, by one method.

Nine of the at-risk communities are, or are part of, counties that are among the state's largest by population. They are four at-risk subcounty areas in Pierce County, four at-risk subcounty areas in Snohomish County, and Spokane County as a whole. There are evidence-based home visiting programs in each of these counties. Pierce and Snohomish Counties are in Western Washington. Spokane County is in Eastern Washington and borders on Idaho.

The remaining 23 communities at-risk are counties with large areas that are rural or sparsely populated. Several of these counties have one or more small areas of urban concentration. Fifteen of the 23 counties/communities at-risk are in Eastern Washington. The eight remaining communities/counties are in Western Washington. Twelve of these 23 at-risk communities have evidence-based early childhood home visiting. The remaining 11 have other home visiting programs (see Appendix C, Table C-3: Home Visiting Programs and Models by County and/or Federally Recognized Tribe).

In addition, five racial/ethnic groups had summary risk scores higher than the state and were identified as at-risk communities for Washington State. All five groups had risk scores higher than the overall state score by all three methods used in this Needs Assessment. We described the disparities in race/ethnicity among the risk indicators for Washington State as a whole. Ideally, we would look at these data within counties and subcounties. Unfortunately, much of the race and ethnic-specific data are either not available or highly variable at the county level due to small numbers. We compiled statewide data on births and on the risk indicators by race/ethnicity to address the concern that some population groups may have higher need. Presenting data by race and ethnicity helps us to understand the magnitude of the disparities and can assist with developing interventions to decrease these gaps. We will use this information along with the tables that show where these populations reside as another tool during the planning process.

The guidance for the Patient Protection and Affordable Care Act, requires that states which include American Indian/Alaska Native Tribal areas within their boundaries should include these areas in the state's needs assessment. There are 29 federally recognized American Indian tribes in Washington. We did not have access to data on enough indicators for these tribal areas to calculate tribal area risk scores. Additionally, based on information from the 2000 Census, the Urban Indian Health Institute estimates that 81% of the American Indian/ Alaska Native population in Washington State live off of reservations. Washington's State's approach with tribes will be addressed further in the planning phase.

American Indians/Alaska Natives had the highest risk scores of the five race/ethnic groups with elevated summary risk scores. The risk scores for American Indians/Alaska Natives were also higher than those of any of the geographic at-risk communities identified.

As shown in Appendix C, Table C-3: Home Visiting Programs and Models by County and/or Federally Recognized Tribe, eight of the tribes and United Indians of Washington have evidence-

based early childhood home visiting. Five other tribes have other home visiting programs. Sixteen tribes have no early childhood home visiting. In Washington, many American Indian/Alaska Native families do not reside on tribal lands. This is likely to impact access eligible urban American Indian families have to home visiting programs.

Washington's State's approach with tribes will be addressed further in the planning phase.

Gaps in Home Visiting Services

The available data suggest considerable unmet need for home visiting among Washington families. Based on estimates in the *Washington Early Learning Plan* (September, 2010) developed by the Department of Early Learning and estimates using the methodology described in this Needs Assessment (see Data Report, Methodology section, page 6), between 2% and 11% of the eligible statewide population receive evidence-based early childhood home visiting services. There are no evidence-based home visiting programs in 17 of Washington's 39 counties. While coverage for at-risk families receiving any home visiting program (except First Steps home visiting services) statewide was 42%, there was substantial variability across counties. Further, these coverage ratios indicate that a family received some services, but do not take into account the length of time services were received, intensity of services, or their impact on long term outcomes for children.

The First Steps Maternity Support program also provides a substantial number of home visiting services. In the First Steps Maternity Support Services program, a client is counted as receiving a home visit even if she received only one home visit. Beginning in July 2009, the First Steps Maternity Support Services program was redesigned to focus on the highest risk Medicaid births and the budget was reduced 20%. Data for pregnant and parenting women receiving home visits for 2009 are not yet available; however a significant reduction in the number of women receiving home visits is anticipated.

Home visiting programs collect data in different ways and for different time periods, making it very difficult to make comparisons across programs. The following information is not easily or uniformly available, but would be useful to planning, coordination, and infrastructure building efforts:

- Number of slots and number of children and families served
- Criteria and windows for enrollment
- Service intensity and duration
- Training and supervision requirements of the model
- Qualifications of the home visitors
- Source of funding
- Referral sources

The Council for Children & Families, Children's Alliance, Home Visiting Coalition, and Early Learning Plan have made significant efforts to build home visiting infrastructure, including obtaining funding, coordinating among providers and funders, and increasing capacity to implement evidence-based home visiting models. However, infrastructure gaps remain.

The *Washington Early Learning Plan*, released in September, 2010, is an effort to increase coordination across state and local, and public and private entities. The Plan identifies the following opportunities for strengthening home visiting in Washington State:

- Create an integrated and effective system for evidence-based home visiting, including: evaluation, expansion of quality services, and addition of new promising practices
- State agencies funding home visiting need to better coordinate so programs have shared outcome reporting, cross-program training, and incentives for communication and coordination.

Obtaining and maintaining funding is a challenge for most home visiting programs. Programs are often funded by multiple funding streams, with different timeframes and reporting requirements.

Many local communities have early childhood groups, some of which have worked to identify local gaps and needs in home visiting services. In some communities, these groups have identified home visiting models that best match the needs and capacity of their community.

Plan for Addressing the Need for Early Childhood Home Visiting Programs

One way Washington State plans to address home visiting needs of eligible individuals and families in at-risk communities is to follow through on the third step in the process to receive federal fiscal year 2010 Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Funding. Once the guidance for this third step is issued, Washington plans to prepare and submit an Updated State Plan.

Another important way Washington is addressing early childhood home visiting needs is through a recently released statewide plan. In September, 2010, the Department of Early Learning released the *Washington Early Learning Plan*. The Plan is an effort to increase coordination for the state's Early Childhood Comprehensive Systems across state and local, and public and private entities. Home visiting is one of many strategies laid out in the Plan. All of the agencies concurring with the Home Visiting Needs Assessment were partners in developing the Plan. These agencies are all currently engaged in activities that will further the plan and will be partners in implementing it. Governance strategies and implementation responsibilities for the Plan are still being developed.