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Practice Summary & Implementation Guidance

Mothers on the Rise

Mothers on the Rise is an individualized, coordinated system of care to provide instrumental, emotional, and resource connection support for mothers and their babies transitioning from the Indiana Women's Prison Nursery Unit into community.

Cutting-Edge | **Emerging** | Promising | Best

Location	Topic Area	Setting
Indiana	Care Coordination, Health Promotion & Communication, Mental Health & Substance Use	Community, Women's Prison

Population Focus	Date Added
Infant, Women & Maternal	Fall 2024

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The Grassroots Maternal and Child Health Initiative has worked to build the capacity of individuals and organizations to bring about systems change to improve maternal and child health (MCH) outcomes. Since its inception, one Grassroots MCH leader, Nina Porter, has emphasized the challenges mothers face leaving incarceration. Academic research aligns with Ms. Porter's emphasis on the need to support mothers transitioning into community. Incarceration is a growing discussion in the United States; however, Indiana has a disproportionate incarceration rate of 764 per 100,000 people, meaning that it locks up a higher percentage of its people than any democracy (Widra, 2024). About 58% of females in state prison are parents of minor children, compared to 46% of males (Maruschak & Bronson, 2021). Studies show that women in the justice system have high rates of substance use disorder, poor mental health, and trauma (Edwards et al., 2022). To compound these factors, the social network many women are released to may demonstrate domestic violence tendencies and promote criminal behavior (Govena et al., 2022).

The key population Mothers on the Rise (MOR) impacts is mother-baby pairs transitioning from the Indiana Women's Prison Nursery to their home community. With funding from the Indiana Department of Health and Riley Children's Foundation, MOR is the first program of its kind in the United States, providing an individualized coordinated system of care for mother-baby pairs transiting from the Leath Nursery Unit to community. Although we work with the mother-baby pairs directly, our comprehensive, coordinated system of care works to promote the whole family system and encourage the women to integrate into their home communities. MOR meets each mother's immediate needs after release, by supplying her with clothing, hygiene products, and infant supplies. Additionally, our social support team works with participants to navigate any barriers they face in community by providing support from our interdisciplinary team of professionals and community members near the mother's home neighborhood. The social support team includes the program manager, social work navigator, lead community navigator (Nina Porter, a mother who was formerly incarcerated), nurse navigator, and community navigator when applicable. Mother-baby pairs can stay engaged with the team as long as they desire (mean time is 13 months). Throughout our time with them we work to support the mothers to promote independence, stability, and access to resources for sustainable success. With ongoing support from our social support team, mothers can maintain support in times of stability (maintenance status) or have increased engagement in times of stress (crisis status). These two categories allow us to individualize our level of support to maintain rapport and anticipate and address crises as they arise.

CORE COMPONENTS & PRACTICE ACTIVITES

The goal of our program is to support mother-baby pairs as they transition from the Indiana Women's Prison Leath Nursery Unit into their home community. We provide an individualized, coordinated system of care for each mother through an interdisciplinary team. The core components of this program include the mother completing a needs assessment, MOR social support team preparing for her release, providing immediate material needs upon release, continuous engagement with each social support member, ongoing team coordination and crisis management, and constant data collection and tracking by the program manager.

Core Components & Practice Activities		
Core Component	**Activities**	**Operational Details**
Assessment/Connection	Assessment of mother-baby pairs needs and introduction to social support team.	The basic demographic and contact information for the mother-baby pair is collected. She self-identifies her needs and goals she anticipates addressing upon released. She is introduced to her social support team before release to build rapport and the social support team can prepare individualized resources and referrals.
Immediate Needs and Referrals	Immediate material needs are met, and relevant referrals are made to provide support during transition.	Order items for the mother-baby pair once she is released, including clothing, hygiene products, and infant supplies to relieve immediate material stress. The program manager makes referrals, with the consent of the mother, to programs such as Community Partners and Healthy Families to provide complimentary support.
Continuous Engagement	Consistent weekly contact from each social support member	Continuous engagement with the mother from each social support member to build rapport, provide emotional support, and help navigate crises. The nurse navigator follows up on self-identified health goals and the social work navigator provides an individualized curricula. Referrals as needed are provided to legal aid services, or to Reform Alliance to help address ongoing legal issues (i.e. paying off fines and fees.)
Team Coordination and Crisis Management	Coordinate care and make referrals when applicable.	Weekly team meetings with the social support team members allow coordination to meet the self-identified goals of the mothers and overcome barriers in times of crisis. Team members refer mothers to each other when necessary, such as to the social work navigator when there is concern involving an intimate partner.

Data Collection	Weekly qualitative and quantitative data collection from social support team members.	Collect data to update social network analysis tool, including weekly data from MOR team members and qualitative notes on the status of each participant.

HEALTH EQUITY

Women in the justice system suffer from disparities in health, education, and employment. We address this through our coordinated system of care, whichh facilitates easy access to services accompanied by advocacy. To improve access to education, we collaborate with local organizations and partners to support their individualized education and professional goals, such as pursing a degree, completing peer-recovery traning, or working towards a promotion. Our social support team ensures each mother-baby pair receives adequate mental and physical healthcare. For example, our nurse navigator works with each mom to ensure she not have difficulty scheduling appointments. Our social work navigator helps the moms advocate for themselves and their babies to heatlhcare providers. The community navigators ensure that the moms have access to, and are able to utilize, local community resouces.

EVIDENCE OF EFFECTIVENESS

To monitor and evaluate the impact of our program, the Program Manager continually collects and evaluates data. To track the outcomes and level of crisis and maintenance management, the team uses a social network analysis tracking system, developed by the Program Manager, to measure the duration of the number of contacts, frequency, mode, topic of discussion, and who initiated the contact. Since the first participant was released in February of 2021, MOR has engaged 39 mother-baby pairs, 67% of the total mother-baby pairs released from the unit.

We analyzed crisis and maintenance status data collected over a fifteen-month period. Crisis periods were characterized by a housing or mental health crisis. Across the time of our program, our team has facilitated in-patient substance use or mental health care for four women. During a mental health crisis, average engagements of the program manager occur twice weekly, with a mean duration of 17 minutes. Throughout our program, our team has prevented five mother-baby pairs from experiencing homelessness. During a housing crisis, the mean frequency of engagements of the program manager increases to an average of twice weekly, with a mean duration of 21 minutes. During the maintenance period, the program manager conducts weekly engagements with a mean duration of 11 minutes. Providing increased engagement during a mental health or housing crisis allows the mother-baby pair to receive support to successfully navigate the crisis.

One MOR participant has returned to the justice system since being released, resulting in a 2.56% recidivism rate thus far. Three non-MOR participants have returned to the justice system, resulting in a 15.79% recidivism rate for those not involved with MOR. By addressing crises as they arise, MOR plays a partial role in reducing recidivism, which reduces state spending. Compared to mother-baby pairs who did not engage with MOR, participants have had an 84% reduction in recidivism.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Mothers on the Rise requires ongoing collaboration with Indiana Department of Corrections (IDOC) to assist with connecting with the mothers before release, works with the Program Manager to collect participant needs assessments, and provides data regarding mothers on the Nursery Unit.

To ensure Mothers on the Rise is valuable to the mothers, partnership with a Grassroots Maternal and Child Health Leader who has personal experience leaving the nursery unit is crucial. The Grassroots MCH Leader provides her expertise during project planning, implementation, and evaluation. She also works directly with the mothers to provide a peer perspective to our coordinated system of care.

The Mothers on the Rise Social Support Team provides direct feedback to improve the program. The Social Support Team also uses their interactions with the mothers to advise what resources need to be added to best serve the participants.

Additional partnerships are used to provide a diverse set of resources. The Program Manager works directly with DCS Prevention Services to refer mothers to services. Additionally, the Program Manager works with legal aid agencies to resolve remaining court cases. Partnership with AHEC has funded participants to complete peer-recovery training. Partnership with Reform Alliance connects mothers with funders to relieve remaining court fees and fines.

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
Indiana Dept. of Corrections (IDOC)	IDOC staff members and leadership are informed of any implementation or program changes, and their insight is used to inform program quality control measures.	IDOC is actively engaged in program implementation and meets with MOR team monthly as well as weekly contact with program manager.	Yes, IDOC works directly with the mothers impacted and tracks the success or failures of reentry.
Grassroots MCH Leader	A Grassroots MCH Leader, is the co-founder and is	The Grassroots MCH Leader is actively	Yes, the Grassroots MCH Leader has first-hand

	included in any discussions of changes or additions to program implementation.	engaged in program implantation and evaluation and meets with the project director on a weekly basis. She is the lead community navigator and works to support the community navigators who live in communities with the women, and she also provides direct support to the mothers as needed in their community journey.	experience being released from the Indiana Women's Prison Leath Unit into community.
MOR Social Support Team	The MOR social support team provides insights on how the program components and implementation could be improved.	The MOR social support team is actively engaged in program implantation, data collection, and evaluation through weekly meetings.	No, however, the MOR social support team works directly with participants and can provide useful insight into how we can best serve the population.

REPLICATION

As of Fall 2024, Mothers on the Rise has not been replicated.

INTERNAL CAPACITY

PI, who secures the funding through government, nonprofit and private philanthropists, oversees the reporting to the funders along with the direction and the vision of the program. The Program Manager provides daily management, data collection and evaluation, individualized support to participants, and leads team members during weekly meetings. The Community Navigators, Social Work Navigator, Nurse Navigator, and Lead Community Navigator work with mothers directly to provide individualized support and care. We utilize all forms of communication to best serve the mothers, utilizing texting, phone calls, personal visits, video calls, and social media platforms – especially Facebook. Critical partnerships include DCS Prevention Services to refer mothers to services, legal aid agencies, and connections with Reform Alliance to address remaining court fees and fines.

PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Partner collaboration, secure funding	Ongoing Process	PI
Hire personnel	1-2 Months, ongoing as needed to fill in team members to meet the needs of the women	PI
Train Community Navigators	6 weeks	Program Manager

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Met with collaborators to develop the implementation plan	4 months	PI, Program Manager, Peer Navigator, and DOC partners
Connect with mothers Pre-Release	Ongoing	Program Manager
Regular mentoring with mothers	Ongoing	Program Manager, Social Work Navigator, Nurse Navigator, Community Navigators, and Lead Community Navigator
Social Support Team Weekly Collaboration	Ongoing	Program Manager

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Data Collection and Evaluation	Ongoing	Program Manager
Collect Feedback from Participants and Peer Navigator	Ongoing	Program Manager, Social Work Navigator, Nurse Navigator, Lead Community Navigator, and Community Navigators
Meet with IDOC Regularly	1 hour monthly	PI, Program Manager, IDOC

PRACTICE COST

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Community Navigators	Community Navigators are crucial to provide support for the mothers in their home community.	6	$21,600
Social Work and Nurse Navigator	The Social Work Navigator provides an individualized curriculum with topics ranging from healthy relationships to budgeting. The Nurse Navigator provides support with scheduling healthcare appointments and establishes personal health goals.	2	$36,000
Program Manager	The Program Manager coordinates the social support team, works with the mothers	1	$66,903

	on a weekly basis, and collects and analyzes data to evaluate the impact.		
Lead Community Navigator	The Lead Community Navigator utilizes her personal experience to advise the social support team and Program Manager to best serve the mothers.	1	$18,000
Material Items (clothing, hygiene products)	To assist with the material needs once released, clothing, hygiene products, and infant supplies ensure the mother/baby pair have necessary items.	N/A	$6,825.60
		Total Amount:	**$149,328.60**

LESSONS LEARNED

We have learned the importance of having a strong relationship with Department of Corrections staff members and leadership, as our ability to understand the population being released and gather necessary assessment information on each mother-baby pair is dependent on their support. Additionally, we learned it is important to be flexible in terms of who is a part of the social support team, as we did not originally design the program to include a nurse navigator or partner with a legal aid agency. Once we implanted the program, we realized the remaining legal issues mothers had and the importance of having a trusted nurse to engage with the women to review their self-identified health goals and follow up on recommended standards of care.

The participants continue to face challenges with unstable housing, unhealthy relationships, and a lack of public transportation in community. Our social work navigator continues to address individualized needs through her curriculum, including healthy relationships. Our program manager continues to look for local resources and is in contact with organizations such as Reform Alliance to expand her resource knowledge. Our leadership team continues to meet with IDOC leadership monthly to better serve the moms.

We have had the privilege of adding components of care, when necessary, given the flexibility of our funders. However, with additional funding we would add components to our programming and/or expand the demographic we serve, by adding women in the general prison population, since many of them parent minor children in community.

NEXT STEPS

We will continue applying to receive funding from Indiana Department of Health Title V Grant as well as additional funding sources. We will continue to serve eligible mother-baby pairs being released from the Leath Nursery Unit.

We will soon be implementing Legal Informational Sessions based on feedback from mothers on the Leath Nursery Unit. Lastly, we are in the planning stage to further address recognizing antisocial relationships.

RESOURCES PROVIDED

- Grassroots Maternal and Child Health Initiative: Mothers on the Rise website: https://medicine.iu.edu/pediatrics/specialties/health-services/grassroots-maternal-child-health/mothers-on-the-rise