Helping professionals help families affected by drugs and/or HIV

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Intervening with Pregnant and Postpartum Women with Substance Use Disorders

Fall 2010
Volume 20, No. 2
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It is a well-established fact that mothers with substance use disorders and their children are at higher risk for myriad problems that threaten their health and well-being. Exposure of the developing fetus to psychoactive drugs in utero is a leading cause of mental, physical, psychological and sociologic problems in infants and children (Shankaran et al., 2007). In the prenatal period, maternal substance abuse can lead to fetal growth restriction, abnormal fetal neurologic development and increased risk of preterm labor. These complications may result from drug use and/or withdrawal effects along with a higher incidence of sexually transmitted diseases and obstetric consequences from late or inconsistent prenatal care (Shankaran et al., 2007).

Problems around the time of birth include neonatal abstinence syndrome, sometimes requiring treatment in the neonatal intensive care unit, and irritable newborns that are difficult for mothers to interact with or comfort (Shankaran et al., 2007; Dryden, Young, Hepburn & Mactier, 2009). Maternal psychiatric illness and addiction also may serve to hinder the promotion of appropriate secure attachment relationships between the mother-infant dyad. Current research suggests that insecure or disorganized attachment is a risk factor for subsequent psychiatric disorders in children, particularly in an environment with additional risk factors (Sroufe, 2005; Essex et al., 2006; Feng, Shaw, & Silk, 2008; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; Holt, 2008; Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006). Neurologic effects in the developing infant, along with continued problematic attachment can lead to emotional, behavioral and cognitive issues for the child and, indirectly, to the family, educators and other service providers (Shankaran et al., 2007). At the same time, a mother’s inability to effectively attach to her infant can negatively impact her ability to find meaning for compliance with substance use treatment and longer term developmental effects (Seifer et al., 2004).

A Multifaceted Intervention

The Partnering for the Future project, at the University of Michigan Medical School, is based on the belief that the adverse outcomes attributable to an active substance use disorder are modifiable through early identification of pregnant women at risk and provision of a multifaceted intervention to aid mother and baby at this time of expected high motivation. Early childhood is an important window of opportunity for health promotion for both mother and child, and is also a time when mental health interventions can be very effective (Marvin, Cooper, Hoffman & Powell, 2002).

Every pregnant woman assigned to the High Risk OB Clinic at the University of Michigan receives an initial addiction psychiatry evaluation along with obstetrical and nursing evaluations, and a social work needs...
and a specially trained sonographer, is designed to strengthen the relationship between mother and developing fetus and increase mother’s investment in a healthy pregnancy. In addition, it has been shown to promote maternal attachment to the developing fetus as an isolated experience in the low risk patient (Boukydis et al., 2006).

2. Labor & Delivery Tour/Baby Shower. To support the development of a trusting relationship with the postpartum therapists and ease the women’s anxious anticipations regarding the postpartum period, labor tours are co-facilitated by one of their familiar prenatal team members, as well as their future postpartum therapist from the Home of New Vision (HNV). HNV is a local non-profit organization that provides gender specific programs and specialized services to empower, protect, encourage and enrich the lives of women, their families, and communities affected by the disease of addiction. The hospital tour ends with a baby shower, designed to celebrate the women who soon will undergo labor, and to facilitate the first meeting with the postpartum interventionist in a contained, comfortable, and emotionally safe environment.

3. Bridging the Gap between Late Pregnancy, Birth and Early Postpartum. Once the postpartum therapist connects with a mother in late pregnancy, she maintains weekly phone communications with the mothers, and offers informal check-in or supportive counseling. If clinically required, she reports back to the addiction psychiatry/mental health department to facilitate more support. The postnatal therapist tracks the delivery status via close communication with the prenatal team, and continues weekly phone calls in early postpartum. If indicated, for example, with newborns requiring inpatient medical attention, she will serve as therapeutic liaison and maternal ally during the NICU/pediatric inpatient stay.

Early childhood is an important window of opportunity for health promotion for both mother and child, and is also a time when mental health interventions can be very effective.
reunions between mothers and their children. Mothers “graduate” from the program after they attend 12 group sessions. In addition, all women are engaged in on-going psychiatric, medical, and pediatric care while in the group.

Target Population

Every Tuesday afternoon, the clinical team meets in the High Risk OB staff room at University Hospital nearly an hour before the start of clinic to review the women presenting to clinic that day. Among us are a social worker, an RN, a nurse practitioner, an OB staff physician, addiction psychiatrist, child psychiatrist, physician fellows, master’s and doctoral level social scientists, resident physicians and medical students. On a recent afternoon, we saw 21 patients, all publically funded. Two were here for first time care in their third trimester, nine out of ten met DSM criteria for substance abuse or dependence, and three out of four had significant psychiatric co-morbidity. Nearly every woman seen in this clinic has experienced some form of trauma.

Amber is 36 weeks pregnant and on stable methadone maintenance for heroin dependence. She was severely beaten by the father of this baby who has been incarcerated but due to be released in two weeks. She came to us also dependent on high dose Alprazolam, begun by her primary doctor for PTSD. With informed consent about potential risks to the baby, we are maintaining her on Clonazepam because she could not wean from the medication without incapacitating panic. She placidly says she is, “OK with him getting out,” has a protection order, lives with her parents and says her father has bought a gun. She usually asks for an increase in her Clonazepam dose at every visit, accepts our refusal with an explanation, but firmly resists any suggestion or interpretation that she might be angry or scared that her assailant will be back in the community soon.

... national data suggest that nearly 85% of women who needed treatment for a substance use problem during pregnancy or following childbirth between 2004 and 2006 did not receive treatment or perceive the need for it.
Amber enjoyed the added social support provided by enrolling in the research project, as well as seeing clinic and research staff at her OB appointments. She participated in three ultrasound intervention sessions and loved having extra time during the ultrasounds to interact with her son before he was born. She was excited to meet the other moms enrolled in the study at the hospital tour and baby shower. At 38 weeks, she delivered a healthy baby boy. He spent a short time in the NICU due to methadone withdrawal, but was soon discharged home with Amber, her parents and younger sisters. She continues to struggle with anxiety and depression, especially since the release of her abuser from jail shortly before she delivered, but has remained in substance abuse counseling and depends on support from her mother and sisters. When the Mom Power group sessions start next month, Amber is looking forward to connecting with the other moms she met at the baby shower.

**Measuring the Success of the Intervention**

Outcome data for the Partnering for the Future project are not yet available. However, to assess the effectiveness of the postnatal program, we are using pre-and post-group intervention psychometrics measuring maternal psychopathology (depression and anxiety) and mothers’ self-reported assessments of their parenting competence and quality of attachment to their children. In addition we video-tape the group sessions to evaluate fidelity of group facilitator with the curriculum.

Baseline measurements of maternal attachment and psychological distress are obtained using the Maternal-Fetal Attachment scale, Beck Depression Inventory (BDI), a Trauma Scale, and a fidelity tool for standardization of the ultrasound intervention. The Addiction Severity Index is used to compare treatment outcomes and track patient response.

**Conclusion**

Early identification of women at risk, along with interventions to promote bonding to the fetus and the child, healthy lifestyles, and skilled parenting, are crucial to the success of both parent and child. Partnering for the Future project hopes to serve as a model program to provide comprehensive, targeted intervention for this high-risk group of women with the ultimate goals of preventing fetal exposure to toxic substances, enhancing early relationship bonds between mother and child, preventing child abuse or neglect, and preventing situations that lead to involvement with the child welfare system and the termination of parental rights. Potential direct benefits to participants include improved self-care, emotion regulation, anger management, adaptive coping strategies and parenting skills, all of which have the potential to benefit the well-being of the mothers and their children.
Authors all are from the University of Michigan in Ann Arbor, MI, and include:

**Patrick Gibbons, DO, LMSW**
Principal Investigator, Partnering for the Future project
Department of Psychiatry, Addiction Treatment Services
patrgibb@med.umich.edu

**Sheila Marcus, MD**
Co-Principal Investigator, Partnering for the Future project
Associate Professor, Department of Psychiatry,
Section Director, Child and Adolescent Psychiatry

**Maria Muzik, MD**
Co-Principal Investigator, Partnering for the Future project
Assistant Professor, Women’s Perinatal Clinic and Parent-Infant-Program, Depression Center and Trauma, Stress and Anxiety Research Group (TSARG)
Department of Psychiatry

**Susan Eileen Hamilton, MS**
Research Specialist Associate, Partnering for the Future project
Department of Psychiatry

**Susan McDonough, PhD**
Co-Investigator, Partnering for the Future project
Associate Professor, School of Social Work
Associate Research Professor, Center for Human Growth and Development

**Ellen Mozurkewich, MD, MS**
Co-Investigator, Partnering for the Future project
Assistant Professor of Obstetrics and Gynecology
Department of Obstetrics and Gynecology

**Kate Rosenblum, PhD**
Co-Investigator, Partnering for the Future project
Assistant Research Scientist, Human Growth and Development, Adjunct Clinical Assistant Professor of Psychiatry

**Marjorie C. Treadwell, MD**
Co-Investigator, Partnering for the Future project
Professor of Obstetrics and Gynecology,
Department of Obstetrics and Gynecology
Maternal-Fetal Medicine

**REFERENCES**


Many attempts to address alcohol and other drug (AOD) use during pregnancy focus on silver bullet solutions, such as telling women to stop using, instituting universal urine toxicology testing at delivery, and requiring reports to child protective services. However, the problem of AOD use during pregnancy is more complicated—both at the system and individual levels.

Research indicates that changes made in one part of a complex system have the potential to cause reactions elsewhere, leading to unintended consequences (Merton, 1936; Sterman, 2006). For example, in the perinatal services system, messages about damage to the fetus due to maternal use of alcohol or other drugs, creation of a stigma around using substances during pregnancy, urine toxicological testing for AOD in prenatal care, and warnings to parents about child protective services reporting are all intended to decrease AOD use during pregnancy. Quite to the contrary, however, these practices can create barriers to prenatal care, potentially placing the fetus at greater risk (Roberts and Nuru-Jeter, 2010; Roberts and Pies, 2010). This article describes one county’s comprehensive, coordinated, system-wide approach to building a more effective system of care.

The Setting

Contra Costa County is located northeast of San Francisco with approximately one million people (U.S. Census Bureau, 2006). Contra Costa County contains a mixture of rural, urban, and suburban areas and is racially and ethnically diverse. In 2006, the population was 51% White, 22% Hispanic/Latino, 9% Black, and 13% Asian/Pacific Islander (ACS 2006). The county poverty rate is lower than in California or in the United States (7.9%, 13.1% and 13.3% below Federal Policy Level, respectively) (U.S. Census Bureau, 2006), but there are pockets of poverty.

Like many other places, Contra Costa’s response to prenatal AOD use, during and after the crack cocaine epidemic of the 1990s, was characterized by reactionary and punitive approaches. These included prosecutions of mothers (Gomez, 1997), as well as county hospital holds on newborns with positive toxicology results pending intervention by Children & Family Services (CFS), the local child protective services agency. Most of these punitive approaches focused on responding at the time of delivery. The responses resulted in significant racial/ethnic inequities in the child welfare system, and fragmented and unsustainable services. Visionary thinkers in the county pushed for and achieved a handful of innovative programs and some initial cross-agency collaborations emerged. As drug use shifted to methamphetamine in the early 2000’s, agencies and service providers in Contra Costa coalesced to respond to this ongoing problem.

In 2003, the Perinatal Substance Abuse Partnership (PSAP) was created with representatives from Family, Maternal and Child Health Programs (FMCH), Alcohol and Other Drugs Services (AODS), CFS, county hospital and clinic staff, AOD treatment providers, and others. PSAP’s goal was to develop an integrated, coordinated county-wide approach to perinatal substance abuse services (PSAP 2007) to replace the punitive and fragmented responses of the earlier era.

Developing an Integrated, Coordinated, Countywide Approach to Perinatal Alcohol and Other Drugs Services

Sarah C.M. Roberts, Cheri A. Pies, Suzzette C. Johnson, Dorie Klein, Elaine Zahnd, and Rhonda Smith
The Mom and Baby Care Plan is a psychosocial assessment to be completed in the 2nd or 3rd trimester by a health care provider and client. It assists prenatal health care providers to document a pregnant woman’s plans for how she will care for her baby and her formal and informal resources to support her during and after pregnancy. The plan offers guidance to social workers and other medical/nursing personnel at labor & delivery about follow-up referrals and other steps to take at delivery and under what circumstances a report to CFS might be warranted. The plan emerged from concerns about the uneven quality of medical tracking, communication, and outcomes for pregnant women using AOD as they move from prenatal care through labor & delivery. An additional objective was to decrease unnecessary and potentially discriminatory calls to CFS. Over 30 nurses, medical social workers, and community health workers have attended one of the three trainings on the plan, funded by First 5 Contra Costa Children and Families Commission and Contra Costa Health Services.

Ingredients for Success

Four main ingredients have been key to PSAP’s success: 1) building on existing programs and services, 2) developing shared values, 3) using data, and 4) engaging visionary and committed people.

BUILDING ON EXISTING PROGRAMS AND SERVICES

PSAP did not need to create perinatal treatment programs or develop a perinatal AOD screening protocol from scratch. PSAP built upon Contra Costa’s county-wide network of experienced residential and outpatient perinatal AOD treatment programs (AODS, n.d.) and personnel to move different agencies forward. We also built upon the county’s history of screening pregnant women for AOD use in prenatal care.

DEVELOPING SHARED VALUES

Developing shared values among diverse players from multiple disciplines and organizations was challenging, but essential. Consensus ultimately emerged from mutual respect, persistence, and dedication. Shared values include:

- We will engage women in care early in their pregnancies and not wait until the time of delivery to begin responding.

Systems Change Interventions

Following a multi-year planning process with monthly and then quarterly meetings, PSAP developed and implemented three main projects: Bridges to Care; Prenatal Screening, Brief Intervention and Referral to Treatment (Prenatal SBIR); and the Mom and Baby Care Plan. These projects shared a goal of increasing the chance that a woman who uses AOD in pregnancy will be healthy, have a healthy baby, and retain custody of the child if she chooses. One key strategy was to start support early and continue it throughout the perinatal period rather than waiting until the time of delivery to start responding.

Bridges to Care (B2C) is a collaboration between FMCH, AODS, CFS, and clinic and hospital staff with three main objectives: 1) To ensure health care providers have clear, consistent guidelines for reporting to CFS; 2) To ensure providers know where to refer women for support, including treatment; and 3) To provide pregnant women who use AOD with information about what to expect from prenatal care. Funded by the March of Dimes, First 5 Contra Costa Children and Families Commission, and Contra Costa Health Services. B2C provides toolkits and trainings for providers and informational materials for women. As of May 2010, B2C had distributed almost 500 toolkits, trained more than 150 prenatal and labor & delivery health care providers, and distributed materials for women to about 150 agency and community sites. The toolkit and materials for women have also been made available on-line (FMCH, 2008).

Prenatal SBIR places AOD counselors as “prenatal support” at county clinics’ Healthy Start programs. Healthy Start provides psychosocial and educational support as part of the county’s Comprehensive Perinatal Services Program (CDPH, 2008). The SBIR model consists of standardized, self-report screening of women for AOD use followed by several weeks of in-person or telephone sessions with a prenatal support counselor. Sessions focus on whether and how patients can cease or reduce their use. Referrals to AOD treatment programs are made as needed (SAMHSA, 2009). Funded by the AOD Federal Block Grant and First 5 Contra Costa Children and Families Commission, SBIR aims to bridge general prenatal health care and specialized long-term AOD treatment. In its first year, Prenatal SBIR counseled over 125 women.
PSAP presented these data to county departments, community-based providers, and funding agencies. These presentations facilitated collective recognition of problems that some of us had previously refused to acknowledge, such as how disproportionate reporting to CFS contributes to inequities in child welfare and how fear of CFS is a barrier to prenatal care. This collective recognition reduced resistance to collaboration and enhanced belief in a common purpose. Data also helped us obtain outside funding and leverage internal resources to develop and implement the three main systems-change projects.

ENGAGING VISIONARY AND COMMITTED PEOPLE

A small, committed, and diverse group of people that included representatives from key agencies (FMCH, AODS, CFS, as well as county hospital and health services), visionary leadership, and two part-time staff whose time was dedicated to PSAP, worked with other key stakeholders such as doctors, nurses, social workers, community-based treatment providers, and local policy makers to make the system changes. A range of flexible participation options was especially important for agency and department heads, whose attendance at key meetings reinforced shared values and demonstrated that PSAP’s work was consistent with their mission, making PSAP’s work an agency priority.

Lessons Learned

Go after low-hanging fruit.

We had more success when we focused on points of agreement, areas of consensus, and available resources that allowed for immediate progress towards long term goals. For example, for B2C, some advisory committee members had participated in prior multi-year efforts that failed to resolve longstanding debates about targeted versus universal screening and self-report versus toxicology screening (Berger, 2002; Christmas et al, 1992; Hansen, Evans, Gillogley, Hughes, & Krener, 1992; Horn et al, 1993; Horrigan and Piazza, 1999; Miller, Cox, Harbison, & Campbell, 1994). Rather than focusing on these continuing debates, we decided to develop guidelines for how providers should respond to women they have already identified as using AOD. While still controversial and complex, starting with points of agreement made it easier for us to identify and resolve questions that arose without getting bogged down as we created B2C materials.
Spend enough time working together to distinguish between people’s personal values and system constraints.

The Mom and Baby Care Plan work group met almost monthly for three years before finalizing the protocol and form. The time together was necessary to distinguish between members’ personal values and system constraints. When encountering personal attitudes that resisted change, we engaged in dialogue to work through our conflicts. When resistance was due to system constraints, such as labor & delivery not having information from follow-up prenatal assessments, we created systems solutions, such as the Mom and Baby Care Plan.

Talking about racial/ethnic inequities is challenging before a group builds trust.

Addressing the complexities of racial/ethnic inequities is challenging at any time in a group process, but particularly before a group builds trust. Initial Mom and Baby Care Plan work group meetings included conversations about racial/ethnic inequities in CFS reporting, as well as in labor & delivery screening and reporting practices. Some hospital staff were defensive about perceived accusations and resistant to engaging in these initial conversations and, as a result, attended meetings reluctantly. Working on less sensitive issues helped build trust, so hospital staff began to attend meetings more regularly. After meeting for a year, the issue of racial/ethnic inequities emerged again and the group leader facilitated an open, honest, and non-threatening conversation about it, which led to greater understanding on all sides. At the next meeting, the CFS director presented data about racial/ethnic inequities throughout the child welfare system and the role of labor & delivery reports to CFS in contributing to these inequities. The trust from working together for a long period and the open and direct conversation this allowed, coupled with the non-judgmental presentation of data, reduced resistance to working together and enhanced commitment to reducing inequities.

Persistent Challenges

Despite our successes, we face persistent challenges. First, decreasing public sector funding has led to cuts and threatens further reductions, including services within perinatal AOD treatment programs. Second, despite our best efforts, some people in key roles are not willing to change their practices for reasons such as history, inertia, workload, and personal beliefs. We have worked around them and, in some cases, waited for staff turnover. Third, system change requires a long-term commitment to attend meetings. Some direct care providers, overburdened with cases and accustomed to individual clinical practices, do not perceive utility in continually meeting to resolve policy and systems coordination issues. Fourth, whereas PSAP’s consensus against punitive measures has influenced practices among some, we still have only reached a small proportion of providers and staff in the county. We still need to approach other key players such as judges. Finally, racial/ethnic inequities persist. Our efforts to date have focused on improving the system for everyone, including increasing women’s access to services, enhancing cross-site staff communication, and establishing consistent guidelines for AOD screening and CFS reporting. However, reducing inequities also requires specific resource commitments by policymakers; targeted strategies by practitioners; attention to institutionalized biases in screening and reporting policies and practices; and systematic and routine collection of health care data by patient/client race/ethnicity, and feedback of this aggregated data to providers (Crosby and Cordova, 1996; Dominguez, 2008; Frohlich and Potvin, 2008; Keppel, Billeimer, and Gurley, 2007). Although necessary, our work to improve the system for everyone is insufficient to ensure that the system will equitably serve those who have historically born the brunt of punitive approaches.
Conclusion

We are still far from having the comprehensive system to address alcohol and other drug use during pregnancy that truly embodies our shared values. However, by recognizing that changing organizational practices takes time, “going after low-hanging fruit” to create new practices and build momentum, and using a variety of strategies to foster and sustain diverse collaborations and innovations, we have taken some incremental and essential steps to build this system and an environment that fosters change.

Sarah C.M. Roberts, DrPH
Associate Scientist and Postdoctoral Research Fellow, Alcohol Research Group/University of California, Berkeley
Family, Maternal, and Child Health Programs, Contra Costa Health Services (at time of writing)
sroberts@arg.org

Cheri A. Pies, MSW, DrPH
Director
Family, Maternal, and Child Health Programs
Contra Costa Health Services

Dorie Klein, D.Crim
Consultant
Alcohol and Drugs Division
Contra Costa Health Services

Suzzette C. Johnson, MSW, MPA
Public Health Program Manager
Family, Maternal, and Child Health Programs
Contra Costa Health Services

Elaine Zahnd, PhD
Senior Research Scientist
Public Health Institute

Rhonda Smith, MSW
Administrative Services Assistant III
Contra Costa Children and Family Services

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Who Uses When They’re Pregnant? Screening Pregnant Women for Drug and Alcohol Use

Heather B. Howell, Lin Shao, and Kimberly A. Yonkers

This article describes the characteristics and service needs of women participating in a substance use screening and treatment protocol co-located within two hospital-based prenatal primary care clinics. It also offers physical and mental health care providers a framework for identifying at-risk patients and providing health education and related services.

Problem Focus

Women are at the highest risk for developing addictive behaviors between ages 18-29 (Compton, Thomas, Stinson, & Grant, 2007), which are also the peak reproductive years. A recent national survey shows that more than 5% of pregnant women use illicit drugs and more than 11% drink alcohol (Ebrahim & Gfroerer, 2003; Substance Abuse and Mental Health Services Administration (SAMHSA), 2009), yielding over 1,000,000 in-utero exposures annually. Some suggest that surveys underestimate use (Chasnoff, Landress, & Barrett, 1990), although our research indicates that self-report is a reasonably accurate method to screen for marijuana and cocaine use and comparable to more costly urine toxicology tests (Yonkers, Howell, Gotman, & Rounsaville, in press).

Concerns for the impact of substances on one’s baby lead some substance users, particularly those with light to moderate use, to decrease their use of alcohol, cigarettes and illicit substances (Chang, Wilkins-Haug, Berman, & Goetz, 1999; Goldenschmidt, Day, & Richardson, 2000; Higgins, Clough, Frank, & Wallerstedt, 1995), although not all studies support this pattern of behavioral change (Carrington, Loftman, Jones, Williams, & Mitchell, 1998; Corse & Smith, 1998). Ironically, casual users may feel less impetus to change their behaviors, as they may not identify their use as a problem.

Risks of substance use during pregnancy are complicated by associated risks of poverty, poor nutrition, interpersonal violence and nicotine use (Schempf & Strobino, 2008); and myriad barriers exist within the obstetrical healthcare system to identifying at-risk pregnant women and engaging them into needed addiction treatment. Notably, providers report self-imposed barriers, such as their own attitudes toward alcohol/other drug use, their lack of self-efficacy in managing addictions, and their lack of knowledge relative to the field of addiction recovery (Holland, Pringle & Barbetti, 2009). Substance users report barriers such as treatment accessibility, lack of transportation or childcare, lack of readiness to decrease/stop use, and concerns that the treatment will not be relevant for them or meet their unique needs. Often, women withhold reports of their drug use for fear of moral judgment or legal ramifications.

The remainder of this article reviews a screening protocol developed to identify substance users and describes
the sample of volunteers who enrolled in substance abuse treatment integrated into primary care obstetrical clinics. It also illuminates the health care service needs of women with substance abuse receiving prenatal medical care.

Method

Given that women of reproductive age are at high risk for using alcohol and illicit substances, our program elected to administer a health questionnaire to every patient presenting for care at two large inner-city, hospital-based primary care prenatal clinics, both affiliated with the Yale University School of Medicine. We made no assumptions about who might or might not be at risk for problems with alcohol or drugs, but rather left that profile to be informed by our data collection. A recent qualitative study found that, while pregnant women have concerns about the identification and subsequent consequences of their drug use, they are more open to self-disclosure in the setting of an understanding and respectful provider who can offer related treatment resources (Roberts & Nuru-Jeter, 2010). Using a straightforward approach consistent among all pregnant women, our goal was to avoid singling out or targeting those with an identified problem in an effort to promote self-disclosure of use.

Clinic staff (obstetricians, nurses and midwives) and study-specific research personnel (research nurses, social workers and assistants) were extensively trained on the qualities of building rapport, establishing trust, and presenting the message that health care providers collaborate with patients to meet the joint goal of maternal and infant health and well-being. Per our protocol, all women receiving prenatal care at these two hospital-based sites were screened for emotional health risks such as depression, domestic violence, and use of cigarettes, alcohol, and illicit drugs. Screening was followed by the offer of a full psychosocial intake assessment, and finally by the offer of onsite treatment services.

For the screening, we selected validated instruments shown to be effective and reliable in the identification of substance use and health risks (Yonkers, Gotman et al., in press). Instruments included the PRIME-MD Patient Health Questionnaire for depressive symptoms (Spitzer, Williams, Kroenke, Hornyak, & McMurray, 2000); the TWEAK for alcohol use (Russell, 1996); the 4 P’s Plus for drug use (Chasnoff, Wells, McGourty, & Bailey, 2007); and the Addictions Severity Index Alcohol & Drug Module for alcohol and drug use (McLellan, Kushner, & Metzger, 1992). The majority of patients (88%) reported no current alcohol or illicit substance use, but the fact that a conversation with a health care professional occurred validated the importance of the problem. It also reinforced that, if it were relevant for them, this clinic was a safe place to address the topic of substance use and receive support and resources.

We did not include urine toxicology as part of our preliminary screening, both as a cost-saving measure and to avoid the impression that providers were trying to “catch” women at using drugs. We focused our identification methods on establishing provider-patient rapport and using validated screening questionnaires. Women reporting use in the prior 30 days (N=312, 12%), and thus considered at risk for substance abuse during pregnancy, were offered a multi-level clinical intake assessment consisting of computer-administered self-report measures, a daily substance use calendar, and a biological measure (urine toxicology) which tested for marijuana, cocaine and opiates. Instead of penalizing these women, they were offered immediate drug-specific education, relevant targeted services, and/or referrals to adjunct community resources.

Some (59%) of those at-risk women accepted the offer of onsite services, and, as part of the integrated treatment, completed a full psychosocial intake assessment with a behavioral health nursing team. This comprehensive evaluation offered a practical and useful measure of severity of substance use for the obstetrical providers. There was no penalty for declining the offer of in-house treatment; however, in an effort to reinforce the supportive, open-door policy, we attempted several follow-ups with those who refused treatment.

Findings

Between June 2006 and July 2009, 2,660 pregnant women were enrolled for prenatal care in participating clinics and agreed to be screened for behavioral health problems. Of those, 47% had a history of using alcohol or illicit substances, and 12% reported current use. One
hundred eighty-four (59% of those determined to be at risk) enrolled in onsite treatment (Yonkers, et al., 2009).

As illustrated in Table 1, general characteristics of the lifetime versus current substance-using samples do not vary significantly. The average age of substance users was 24.7-26 years, and the average number of prior pregnancies was three with a resulting average of one child apiece. We encountered patients when they commenced prenatal care in their first or second trimester (average 15-18.5 weeks gestation). Current users were slightly less likely to be Hispanic, although this was not statistically significant. Our sample reflected the diversity of the site cities in both race and ethnicity. Level of education was fairly evenly spread, with 29-30% reporting less than a high-school education, 41-42% reporting that they had graduated high school (or obtained a GED equivalent), and slightly more than one quarter (29%) reporting some college or technical training beyond high school. Although we did not ask about marital status of women at screening, current users who enrolled in treatment were evenly split between single and partnered women.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Used Alcohol and/or Drugs Past 30 Days (N=312, 12%)</th>
<th>Used Alcohol and/or Drugs During Lifetime (N=1264, 47%*)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std Dev</td>
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<tr>
<td>Maternal Age</td>
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<td>Black, non-Hispanic</td>
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<td>45%</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>82</td>
<td>26%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>79</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>5%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Above high school</td>
<td>93</td>
<td>29%</td>
</tr>
<tr>
<td>High school</td>
<td>134</td>
<td>42%</td>
</tr>
<tr>
<td>Less than high school</td>
<td>93</td>
<td>29%</td>
</tr>
</tbody>
</table>

* 15% during lifetime used alcohol only, 32% during lifetime used drugs, with or without alcohol.
While stereotypes may exist with regard to women who use illicit substances when pregnant, we encountered significant diversity within that sample in all descriptive demographics. Women tended to be in their mid-20’s, were already mothers (with one child, on average), had engaged in prenatal care at a reasonable gestational age, and had an average range of education; over half reported the presence of a spouse/partner in their lives. It is worth noting here the obvious omission of any data regarding substance-using women who did not engage in any prenatal care, as they are clearly an untreated, high risk group who were missing from our sample.

Our currently-using sample was identified based upon their self-report of current or recent use of illicit substances or alcohol while pregnant. Of the 184 women who chose to enroll in treatment with our group, only 11% had ever attended treatment for alcohol problems, and only 28% had ever attended treatment for drug problems.

Treatment enrollees were not limited to casual users. Of the alcohol users, 60% had a diagnosis of Alcohol Abuse or Dependence. Of the marijuana smokers, 61% had a diagnosis of Marijuana Abuse or Dependence. Of the cocaine users, 75% had a diagnosis of Cocaine Abuse or Dependence. While we were not explicitly recruiting nicotine users, it is noteworthy that 50% of the treatment enrollees were virtually daily cigarette smokers.

Not surprisingly, the currently-using sample was also at risk for co-occurring mental health disorders. A clinical DSM-IV diagnosis of current Major Depressive Disorder (MDD) was confirmed for 20% of treatment enrollees, while 40% had moderate to severe symptoms. As further measured by the MINI Neuropsychiatric Inventory (Sheehan, et al., 1998), over 10% had Agoraphobia and/or Generalized Anxiety Disorder (GAD); 11% were in a current episode of Post Traumatic Stress Disorder (PTSD).

While we were not explicitly recruiting nicotine users, it is noteworthy that 50% of the treatment enrollees were virtually daily cigarette smokers.

Discussion

In spite of advances in obstetrical and behavioral treatment options and medical knowledge, use of alcohol and illicit substance use during pregnancy remains a significant health problem. Yet, our experience demonstrates that, with training and education of care providers, a professional and therapeutic rapport can be established with at-risk pregnant women—one which allows for honest sharing of information about substance use and supportive provision of education and resources. As reported, we found acceptable agreement between the self-report of use and urine toxicology tests (Yonkers, Howell, Gotman, & Rounsaville, in press). Although the toxicologies were conducted on a voluntary sample who were enrolling in treatment, this finding reiterates that accurate information can be gleaned from a quality face-to-face interview with high-risk pregnant women. An additional benefit is that this promotes provider-patient rapport and better engages the mother in measuring her own progress in mother-child health. Based upon detailed analysis of our patient self-report calendars in comparison to toxicology tests, we advise our colleagues to ask patients if they have used a particular substance “within the prior four weeks.” This seems to allow the patient some distance from the recency of use, while still giving her the chance to be honest about drug-using behavior with her doctor.

Ultimately, both the mother and her provider share the mutual goal of healthy outcomes for mother and child. The prenatal care setting offers a window of opportunity for improved physical and behavioral health, enhanced awareness and understanding of health risks, and improved motivation for behavioral change.
Heather B. Howell, MSW  
Social Worker, Yale University, School of Medicine,  
Department of Psychiatry  
heather.howell@yale.edu

Lin Shao, MS  
Research Assistant, Washington University in St. Louis,  
Department of Psychology  
vernal.lyn@gmail.com

Kimberly A. Yonkers, MD  
Professor, Yale University, School of Medicine  
Departments of Psychiatry and Obstetrics, Gynecology & Reproductive Sciences  
kimberly.yonkers@yale.edu

ACKNOWLEDGMENTS

This research was supported by Grant R01 DA 019135 from the National Institute on Drug Abuse to Dr. Yonkers.

REFERENCES


One Woman’s Story

I’m a single mom of 4 children, but I was in a marriage for 11 years that was physically abusive. The pathway to addiction for most mothers (upwards of 97%) is one of physical and sexual violence, and that was my experience. The year I finally got the courage to end the marriage was the same year that my mother died. I became severely depressed and began to self-medicate. First with marijuana and then when the marijuana no longer worked, I began to self-medicate with crack cocaine. Needless to say, I spiraled down in my addiction very quickly. It didn’t take long for me to know that I had a problem and that I was not able to stop using on my own. So I sought help.

I didn’t know anything about treatment other than what I heard on television. The only thing I knew about treatment was places like Betty Ford, and I knew that I couldn’t afford something like that. So, the way that I picked my treatment program was by going through the Yellow Pages and calling every program. I picked my first treatment program because it was the only one that accepted Medicaid. It was a single adult treatment model. There were no gender specific groups. I was in group all day with men and women. I did not feel comfortable talking about the abuse I had suffered. So, my underlying issues of violence and trauma were never addressed. I did not have an individual therapist. It was 28 days in length and I was not able to get clean. So I went back to using at the end of 28 days. I was in and out of this type of treatment for the next couple of years.

In one treatment program, I met a man and thought, “you know, at least economically, things were better when I was married.” So, I got the bright idea of partnering with a man who was as sick as I was. He could not stop using just like I could not. And I got pregnant with my 4th child. I was at least clean for the first trimester while I was still in treatment. I was the model treatment person at this point. It was my 3rd time in treatment, I was about to graduate, and I couldn’t admit that I had gotten pregnant. There wasn’t a women’s group where I could say “I’m pregnant.” So I left the treatment program knowing that I was pregnant, but I had not disclosed it to anyone. In the 2nd trimester I used again and continued to use through the entire 2nd trimester. I was on welfare at the time, and I remember checking the box that said “is there a substance abuse problem?”

I didn’t have the heart to tell the worker that I had a substance abuse problem, but I did check the box. Nothing ever happened. I also told the midwives that I was working with for my prenatal care that I had a substance abuse problem. Of course, in the first trimester, I wasn’t using, so if they were doing urine screenings, they would have come up negative. But by the 2nd trimester I was using, yet they didn’t address my use at all. Another missed opportunity was when I was 7 months pregnant and landed in the hospital because I was having contractions. I was seen by an OB/GYN and I’m not sure if they screened, but I think it was pretty apparent that I was using at that time because I was pretty thin and looked like I was using. Yet nobody asked me about drug use. I also had a primary care physician who I did not tell that I was using. I had a long relationship with her and had been under her care for about 15 years. I used to be a doula, had all my older kids at home, and had been like the model mom when it came to birthing. So, by the time I was using drugs, I just couldn’t admit that I had fallen into this. I don’t know if she ever saw any signs, but she certainly never screened for it or reported it.

Finally, when my son was born, he screened positive for crack cocaine, and I was referred for the first time to a comprehensive, family based treatment program where my son and I both got therapeutic services. He was tested for developmental delays and assigned a developmental psychologist. He was able to stay in their 0-3 program for 3 years. I stayed in the program for 18 months where I got a very comprehensive list of services. My son is now 12 years old, and he’s in the top of his class. When he was in 3rd grade, he tested in the 99th percentile in math and 98th percentile in reading. And I know it was about the comprehensive services he got in the first 3 years of his life. He’s a beautiful child in terms of his spirit and compassion. And I know that the outcomes for him would have been different if we had not accessed comprehensive family services.

Imani Walker is Co-founder and Director of the Rebecca Project for Human Rights in Washington, DC. This testimonial was excerpted from a presentation she made at a national summit, Substance Exposed Newborns: Collaborative Approaches to a Complex Issues, on June 23, 2010, in Alexandria, VA.
Strategies for Retaining Pregnant and Postpartum Substance Abusing Women at SHIELDS for Families, Inc.

Charlene K. Smith and Ronna B. Montgomery

Perinatal substance abuse programs are the cornerstone of the agency. Genesis, the founding program of SHIELDS, was started in 1990 in partnership with Martin Luther King Hospital after physicians there delivered 1,200 infants exposed prenatally to drugs in one year. Offered in both English and Spanish to clients with a moderate level of substance abuse, Genesis serves 45 families in a day treatment model. The Exodus program serves homeless clients with a long history of substance abuse and is the only program in the United States that allows the entire family to live and participate in treatment together. Forty-five families live in an apartment, community owned and managed by SHIELDS. Other perinatal programs are specially designed to serve women leaving the penal system, women with a dual diagnosis, as well as young women ages 13 to 21 who present with co-occurring substance abuse and mental health disorders.

SHIELDS’ Healthy Start Program is a federally funded program aimed at reducing infant mortality and morbidity. Healthy Start annually enrolls 200 substance abusing pregnant and postpartum women with children 0-2 years of age. Participants include clients in our perinatal programs, as well as women with a minor level of substance abuse and women enrolled in other community perinatal substance abuse programs. Healthy Start provides intensive case management services, health education, perinatal depression screening, and inter-conceptional continuity of care to clients. Approximately 25% of Healthy Start clients are pregnant and 75% are postpartum at enrollment. More than three-quarters (77%) of clients have an open case with the Division of Children and Family Services (DCFS).

Strategies for Retaining Perinatal Clients

Retention of participants is achieved through a variety of strategies, including:

- Providing quality outreach and case management services that respond to specific family needs such as housing, transportation, legal services, income support, etc.;
- Enrolling clients in the SHIELDS substance abuse treatment program that meets their particular needs;
- Engaging clients through parenting and child development classes, in-home early childhood education, child development services, health education, and on-site vocational services and high school diploma program;
- Hiring staff members who are indigenous to the community, are former substance abusers and/or SHIELDS alumni, are familiar with the community and the issues facing program participants, and who can serve as role models and encourage participants to realize they can overcome their challenges and be successful in their life goals;
- Providing regularly scheduled family-oriented extracurricular activities and graduation ceremonies; and
- Promoting self-empowerment by encouraging participants to join in program planning by becoming involved in SHIELDS’ Client Council and Consumer Advisory Board.
Community Outreach and Case Management Services

Community outreach is essential to identifying and engaging substance-abusing women. SHIELDS Healthy Start outreach workers conduct street outreach by distributing program literature, conducting door-to-door canvassing, and targeting local areas known to be frequented by substance abusing women (parks, alleys, etc.). Outreach staff also works in partnership with a local health program through their mobile van project, and with existing outreach and maternal and child health programs to ensure that women identified with substance abuse problems are linked to the program. Additionally, SHIELDS outreach staff works in collaboration with other SHIELDS staff located in two local Department of Public Social Services offices, the Los Angeles County Juvenile Dependency Court, and the Compton Superior Court. Finally, outreach staff targets WIC sites, DCFS, medical providers, and other social services organizations, including local hotlines and referral agencies.

Outreach workers conduct initial intakes on all recruited clients, identifying and addressing any barriers and/or urgent needs (e.g., food, shelter) the clients may experience while completing the intake process. The outreach worker then transports the client to the SHIELDS Central Intake and Assessment Center the same day or by scheduled appointment. At the Center, further assessments are conducted and the client is enrolled in Healthy Start as well as other SHIELDs substance abuse and mental health services as indicated.

Intensive case management is another key strategy for retaining program participants. Once successfully assigned to a treatment site and enrolled in the Healthy Start Program, clients are assigned a case manager. Case management staff consists of paraprofessionals with a bachelor’s degree or extensive experience working in the community. Most are indigenous to the community and in recovery from substance abuse.

In addition to the initial assessment done on each client, Healthy Start case managers complete a Family Assessment, as well as other risk screening tools. Based on the results of these assessments, a Family Service Plan is developed in collaboration with the client to identify family goals and the services needed to achieve objectives. It is updated every 90 days as a mechanism to monitor a client’s progress in the program. Case managers provide participants with a minimum of weekly contact and two home visits per month. High risk pregnant clients receive more frequent visitation, and case managers transport and/or accompany clients to doctor visits as needed.

SHIELDS recently partnered with a federally qualified health clinic (FQHC) in the community that provides high-risk perinatal care for substance abusing mothers and provides direct linkages to these services. As other specific needs are identified, case managers provide internal and community referrals for housing, medical, dental care, mental health services, transportation, vocational and adult education, employment, income support, clothing, food assistance, etc.

Case managers also serve as advocates for clients within the child welfare system, communicating with county social workers regarding their clients’ progress, and accompanying clients to court or to team decision-making meetings (TDMs). Clients enroll in mandated parenting and child development classes where they learn essential skills for becoming effective and nurturing parents. Monitored visits can be held on-site, and once women regain custody of their children, they are provided with comprehensive child development services.

On-site child development centers provide quality child care services while the client participates in one of SHIELDS’ treatment programs. In addition to the parenting and child development classes, parents receive center-based parenting training and one-on-one mentoring from on-site child development specialists. Child development specialists also team with case managers to carry out monthly home visits to assist clients and to demonstrate early childhood experiences (ECEs), which ensure practical application of what they are learning in classes. In addition, child development specialists assess the home environment, as well as parenting stress levels. Developmental assessments are performed at enrollment and at a minimum every six months thereafter to identify any potential developmental delays and to make appropriate referrals.
Extracurricular Activities and Advocacy

Finally, SHIELDS offers a multitude of opportunities to engage clients and their families through extracurricular activities and advocacy and leadership training. Annual holiday and multicultural programs include Black History Month, Cinco de Mayo, Family Day Picnic, Al-Impics, and Juneteenth. Quarterly graduation ceremonies are also held, as well as numerous dances, retreats, and outings. Self-empowerment and advocacy is stressed as clients are encouraged to become involved in client councils at each treatment program site and to represent their program at monthly Consumer Advisory Board meetings with SHIELDS administrators to discuss policy and programming issues.

Case Study

“Carla” was homeless, pregnant, and working at a nightclub when she came to SHIELDS through a referral from DCFS. Her three young children under five had been detained due to allegations of general neglect, and she had been smoking marijuana and drinking alcohol. She immediately stopped using when she enrolled in Healthy Start and committed to keeping her baby and regaining custody of her other children. Her significant other was also enrolled in a SHIELDS substance abuse program, and they were able to access housing and live as a family unit. With the support of SHIELDS, “Carla” began monitored visits with her children and later unmonitored overnight visits. Within three months, she had regained custody of her children. She had no medical coverage or medical home at intake, so her case manager assisted her in accessing quality prenatal care. Her children were enrolled in the child development program and are receiving periodic developmental assessments. “Carla” is receiving mental health services through our Healthy Start therapist (weekly therapy) and is attending classes through the Healthy Start program (drug and alcohol education, relapse prevention, health and nutrition, life skills, parenting, and “Mommy, Daddy and Me” instruction). She has been active in Client Council at the Healthy Start program and has plans to finish her high school diploma and enroll in community college upon program completion. She recently gave birth to a healthy, drug-free baby girl.

Conclusion

SHIELDS’ perinatal substance abuse programs have average completion rates of 60-80%, among the highest in the country. This is due in large part to SHIELDS’ belief in families and their ability to acquire the skills needed to accomplish their goals and become nurturing parents and productive members of the community. To support this process, SHIELDS embraces a truly family-centered approach, providing a full range of culturally sensitive services to meet the unique need of each family member, advocating for families within the community, and providing linkages to service providers who are respectful of families’ backgrounds and circumstances. Moreover, SHIELDS strives to build clients’ self-efficacy so they can become their own advocates, and provides myriad opportunities to engage clients in family-centered activities that foster a sense of community and build a lifetime commitment as SHIELDS alumni.

Charlene K. Smith, MA
Director of Child Development and Healthy Start
SHIELDS For Families, Inc.
csmith@shieldsforfamilies.org

Ronna B. Montgomery, MA, MPH
Research Analyst
SHIELDS For Families, Inc.
rmontgomery@shieldsforfamilies.org
Two Perspectives on Use of 4P’s Plus® to Screen Pregnant Women for Alcohol and Other Drugs

Nancy Calvo, Shelli Cannon-DeKreek, Elizabeth Dahms, Suzanne A. Kinkle, Barbara May, and Susan Whalen

In 2007, over 4.3 million babies were born alive in the United States, and far too many were exposed to drugs and alcohol during pregnancy. The 2007-2008 National Survey on Drug Use and Health reported 10.6% of pregnant women used alcohol, 16.4% smoked cigarettes, 5.1% used illicit drugs, and 10.3% engaged in binge drinking in the first trimester of pregnancy (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Pervasive substance use during the prenatal period can contribute to obstetric and pediatric complications, including fetal alcohol syndrome, prematurity, and placental abruption. Multiple studies have demonstrated the benefits to both mothers and their infants when substance abuse treatment is provided during pregnancy (Morse, Gehshan, & Hutchins, 1997; Center for Substance Abuse Treatment, 2001; Nocon, 2010).

4P’s Plus® Screening Tool

The 4P’s Plus® screening tool is an instrument developed by Ira Chasnoff, M.D., pediatrician and founder of the National Training Institute in Chicago. The six question screen is designed to quickly identify obstetric patients at risk for alcohol or other drug use and in need of in-depth assessment or continuous monitoring. The tool allows the provider to ask, in a non-threatening way, about a woman’s use of drugs or alcohol prior to pregnancy and how alcohol may have affected others in her life. Taking less than one minute, it is intended to place screening in the context of primary health care, integrating the questions with the social history during the initial prenatal intake or at other encounters during pregnancy. The 4P’s Plus® screening tool has been implemented in numerous sites across the country and validated across various populations (Chasnoff, Wells, McGourty & Bailey, 2007; NTI Upstream, 2006). This article presents two perspectives on how it can be successfully integrated into individual obstetric practice, local systems of care, and statewide initiatives. The authors examine the successes, challenges and similarities encountered in the state of New Jersey and in Solano County, in the San Francisco Bay Area.

The New Jersey Experience

In New Jersey, there are six regional Maternal and Child Health Consortia (MCHC). Licensed by the New Jersey Department of Health and Senior Services (NJDHSS), the MCHC are responsible for conducting prevention activities, consumer and professional education, total quality management, and data analysis; coordinating perinatal transport systems; and developing comprehensive regional perinatal plans. In 2001, the Southern New Jersey Perinatal Cooperative (SNJPC), one of the MCHC, used federal Healthy Start funds to implement the 4P’s Plus® screening tool in five public prenatal clinics in Camden, New Jersey. In 2002, NJDHSS initiated the statewide Perinatal Addictions Prevention Project (PAPP) with a goal of implementing uniform screening in all public and private prenatal care settings statewide. The
project was and continues to be supported with New Jersey tax dollars collected on beverages classified by the IRS as intoxicating liquors and earmarked in 1992 for alcohol education projects.

In 2003, a three-year, statewide companion initiative, *A Window of Opportunity for Children*, was awarded to Family Health Initiatives (FHI) to coordinate regional PAPP activities related to the 4P’s Plus©. Funded by New Jersey Health Initiatives and The Robert Wood Johnson Foundation, the initiative focused on the development of the following components:

- statewide implementation of the 4P’s Plus© screening tool,
- Toolkit for PAPP staff to train providers about the effects of alcohol and drugs during pregnancy,
- Users Guide to train prenatal providers to use the 4P’s Plus©, and
- 4P’s Plus© database to quantify the problem of substance use in pregnancy and support the need for treatment and supportive services.

**The Camden experience demonstrated that inviting sites to provide input in the development of the form resulted in their ownership and consistent use of it.**

**IMPLEMENTATION**

To begin implementation of the uniform screening process in each MCHC region, PAPP coordinators surveyed their areas for drug and alcohol treatment programs serving pregnant women, identified eligibility criteria for each program, and developed a directory to share with prenatal sites. Each region recruited several prenatal sites, beginning with those they knew, to participate in the pilot phase. They introduced a draft of the screening tool and made plans to train staff about substance use in pregnancy and how to use the 4P’s Plus© tool. The Camden experience demonstrated that inviting sites to provide input in the development of the form resulted in their ownership and consistent use of it. Therefore, during this introductory visit, prenatal care staff were asked to consider what patient information, in addition to the 4P’s Plus© questions, should be included on the screening tool. PAPP coordinators also reviewed the intake process unique to each site and engaged staff in discussions regarding the appropriate time to incorporate screening questions.

PAPP coordinators scheduled a second site visit to train staff when the final version of the form was complete, and this process continues today. Each site is provided with a Users Guide; supplies of 4P’s Plus© forms; pre-paid postage envelopes, in which to mail completed forms back to the MCHC for data entry and analysis; brochures (substance use and pregnancy, domestic violence, and smoking and pregnancy); and a regional treatment provider directory. A site coordinator is identified, typically a social worker or registered nurse. Bi-weekly follow-up calls and visits are made after training to assess progress and resolve problems. Quarterly site visits continue with the site coordinator and staff to review data reports, provide retraining on site-specific issues, and assure that linkages exist for prevention and treatment services.

In 2005, a New Jersey Medicaid quality improvement initiative provided a new opportunity to expand the use of the 4P’s Plus©. A statewide uniform perinatal risk assessment tool was designed by Medicaid Managed Care Plans to evaluate the risk status of pregnant members. This screening tool includes the 4P’s Plus© questions. As a result, more provider doors are open for PAPP coordinators to offer professional education and outreach to identify women at risk.

**OUTCOMES**

The number of women screened and the number of providers who screen their patients has steadily increased since the beginning of the PAPP project. A total of 152,042 screens were collected between July 1, 2004 and December 31, 2009. The majority of these screens were completed in hospital-based clinics and Federally Qualified Health Centers. The 4P’s questions pertaining to “in the month before you [the woman] knew you were pregnant” revealed: 28,622 (18.83%) were positive for tobacco; 23,561 (15.50%) were positive for alcohol; and 8,474 (5.6%) were positive for marijuana. A positive 4P’s Plus© screen results in prevention education, referral for a substance abuse assessment/smoking cessation program, or entry into a treatment program when necessary. Additionally, the SNJPC added four follow-up questions to help providers best determine what level and type of treatment to refer women to. Specifically, the questions ask...
about the frequency of alcohol and other drug (e.g., marijuana, cocaine or opioids) use in “the month before you knew you were pregnant” and “now.” Preliminary data from these questions show that 87% of women who screened positive for using alcohol “the month before you knew you were pregnant” reported using “less than 1 day a week” or “1-2 times per week”; whereas only 21% of the positive responses to illicit drugs indicated this relative infrequency of use. Additionally, there was a 94% reduction in alcohol use for women who had a positive response to alcohol use in the month before knowing they were pregnant and “now,” once they knew they were pregnant. In contrast, there was only a 23% reduction in illicit drug use for women who had a positive response to drugs use (marijuana, cocaine or opioids) in the month before they knew they were pregnant.

CHALLENGES AND NEXT STEPS

The implementation of a universal screening tool, the 4P’s Plus©, has been challenging in New Jersey. Too many private providers throughout the state do not believe their patients use tobacco, alcohol or illicit drugs, and/or are hesitant to discuss alcohol and drug use with their patients. Practitioners believe they know their patients well enough to recognize who might have a problem. PAPP coordinators offer education to these providers about the prevalence of hidden substance use. They also act as a resource to private providers and assist them to locate assessment or treatment services for identified women. However, in this era of managed care and diminishing resources, there is a limited time allotted for each patient visit. When numerous obstetrical examinations must be done; voluntary substance use screening is not seen as a priority.

A next, vital step to expand the use of the 4P’s Plus© in New Jersey would reduce the barrier to physician use by reimbursing them for the time they spend on screening and brief intervention. State officials currently are exploring this possibility and how the use of Medicaid reimbursement codes could demonstrate the effectiveness of this practice.

The Solano County, California Experience

Perinatal substance abuse emerged as a growing community concern in Solano County in northern California over 20 years ago. Although hard numbers were initially difficult to come by, data from the 1992 Statewide Perinatal Study showed that 14% of pregnant women were suspected of using or abusing drugs during pregnancy (Vega, Kolody, Hwang, & Noble, 1993). Findings from the 1999-2001 Solano County Fetal and Infant Mortality Report showed that 17 (37%) of 46 case reviews of fetal or infant death included a history of substance use/abuse (Charron, Calvo, Pearsall, & Booth, 2002). In addition, results from the California Health Information Survey showed rates of tobacco and alcohol use were also high for women in Solano County (California Health Information Survey, 2007).

In 1998, California voters passed Proposition 10, adding a 50-cent tax to each pack of cigarettes sold to create First 5 California, also known as the California Children and Families Commission, dedicated to improving the lives of California’s children age 0-5 and their families. In 2003, in response to concerns about prenatal and perinatal health, First 5 Solano Children and Families Commission funded Solano County Health & Social Services (HSS) as the lead agency to improve access and utilization of prenatal care services for three high-risk populations: teens, African American women, and women abusing, or at risk of abusing, substances, including alcohol, tobacco and other drugs. Additionally, the Commission funded HSS to form an innovative collaborative of public and private agencies to provide a continuum of services to pregnant and postpartum women and newborns. To this end, the Maternal, Child & Adolescent Health Bureau formed the BabyFirst Solano Collaborative, known as BabyFirst Solano, by engaging active participation from non-profits, prenatal clinics, and experts in delivering case management and home visiting services. The collaborative identifies and addresses barriers to care, streamlines services, and coordinates health promotion activities. Multi-agency teams of health professionals and outreach workers provide comprehensive support services, including linkage to medical insurance and prenatal care, case management and care coordination, home visiting, health and parenting education, and substance use services.
Five clinic sites currently participate in the project: the two primary sites, as well as two smaller clinics with a mix of public and private patients, and one smaller private provider. Every woman who enters into prenatal care receives an initial substance use screen for alcohol, tobacco, and marijuana using the 4P's Plus©. Women who report using one or more of these substances are asked a subsequent question about use of other drugs (e.g., Vicodin, Ocycontin, methadone, cocaine, heroin, or methamphetamiens) during the month before they knew they were pregnant.

Women at risk for substance use during pregnancy receive an immediate brief intervention. Those in need of treatment are connected to the substance abuse specialist specifically trained to work with pregnant women. Women who are not ready to accept a referral for substance abuse treatment services are offered case management and follow-up services through the prenatal clinic. A second screen is performed in the third trimester of pregnancy, and a final screen is done postpartum.

In 2008, questions were added to the 4P’s Plus© instrument to screen for depression and domestic violence. Because the standardized screening tool is used by multiple providers, results can be compared across many factors including race, age, language and clinic site. Clinics have access to data analysis that allows them to evaluate their effectiveness. The project has also worked on strengthening referral linkages and building capacity for substance use services. The unique collaborative approach of the project has led to increased cooperation among both funded and unfunded partners, encouraged new partnerships, and generated enthusiasm and support for additional projects to improve maternal and child health, as well as funding for two more years.

**OUTCOMES**

Almost 4,000 women in Solano County have been screened for alcohol, tobacco, and other drug use between June 2006 and March 2010. Overall, 42.2% of the women reported using alcohol, tobacco or other drugs before they knew they were pregnant; 24.1% reported using cigarettes, 30.5% reported using alcohol, and 11.4% said they had used marijuana. Of those who reported using one or more of these substances, 7.5% said that they also used another illegal drug such as methamphetamine, cocaine, or Vicodin. Results show that women who participated in the screening project had a significant reduction in substance use from the month before they knew they were pregnant to the point at which they received a second screen in their third trimester. Only 7% of women who received a 4P’s Plus© screen and brief intervention reported using...
alcohol, tobacco, or other drugs when screened again in their third trimester. One hundred thirty-two women were referred to the substance abuse specialist, and 57 women were linked to other services and received an intake assessment. Based on its success, BabyFirst Solano was awarded the 2007 California State Association of Counties 2007 Challenge Award, and was selected as a Promising Practice for the National Association of County and City Health Officials’ (NACCHO) Model Practice initiative for creating a replicable, innovative public health practice.

CHALLENGES AND NEXT STEPS

As the program moves forward, the next steps for the 4P’s Plus© Project lie in three areas. First, BabyFirst Solano plans to continue to work towards universal screening by adding more private prenatal care providers. Although 4P’s Plus© data gathered thus far suggests that privately insured clients have the highest rates of alcohol use, private providers have been slow to come forward and participate. In the coming year, money has been set aside to provide free health education materials about perinatal substance abuse to participating private practice providers as an incentive to encourage their participation in the 4P’s Plus Program.

A second area involves the need for ongoing evaluation, quality improvement and feedback. Clinic staff turnover continues to be an issue. Consequently, there is a re-occurring need for training, both in technical issues such as filling out forms correctly, and in motivational interviewing techniques to help encourage women to stop substance use. Systems must also be improved to ensure that data is available when needed. For example, the project is working to ensure that the 4P’s Plus© records are available to hospital staff at labor and delivery; however, Solano County hospitals are currently in the process of implementing electronic medical records. This has introduced an element of complexity in integrating the 4P’s Plus© paper form.

Third, BabyFirst Solano is continuing to improve tracking systems to ensure that all women are linked to needed services, and that there is appropriate follow-up to ensure completion of referrals. Protocols for women who refuse referrals are also being refined to clarify how often to schedule visits with women who are not yet ready to enter treatment, and how to train all prenatal care staff in motivational interviewing techniques to assist the client in moving towards readiness to quit. The collaborative partners are also designing systems to identify substance exposed pregnancies to ensure that the babies are referred for developmental assessment and follow up.

As in New Jersey, reimbursing clinicians for the time they spend on screening and brief interventions would be tremendously helpful in expanding the number of providers who perform 4P’s Plus© screens. A bill to this effect (AB 217 Beall, Medi-Cal Alcohol and Drug Screening and Brief Intervention Services) was introduced in California last year, but was vetoed by the governor.

Discussion and Conclusion

The New Jersey and Solano County experiences demonstrate the wide applicability of the 4P’s Plus© screening tool. Although the projects differ in scale and rates of substance use, both found the screen to be a helpful tool in identifying and addressing perinatal substance use. In both cases, implementation happened initially with public clinics with which the local Maternal Child and Adolescent Health agency already had a strong working relationship. Participation by private providers has been more gradual and has presented increased challenges in overcoming resistance to participation, both because private providers may not be aware of the need, and because smaller clinics are more sensitive to the perceived burden of adding paperwork or spending extra time with patients. Smaller clinics may also need more education about services available for clients once substance use is identified. Additionally, both projects found that encouraging feedback on the 4P’s Plus© form and the protocols for using the screen increased buy-in by clinic staff. Regular follow up, by phone and in person, with clinics using the screen was essential for quality assurance and timely resolution of problems. Finally, both projects identified reimbursement for screening and brief intervention as an important tool for reducing barriers to widespread use of the 4P’s Plus© screen. These experiences can serve as encouragement and as a guide for other MCAH jurisdictions seeking to address perinatal substance use in their own communities.
REFERENCES


The 5 P’S Screening Tool was developed by the Institute for Health and Recovery (IHR) to help identify alcohol and other drug use among pregnant and postpartum women. Based in Massachusetts, IHR’s mission is to develop a comprehensive continuum of care for individuals, youth, and families affected by alcohol, tobacco, and other drug use, mental health problems, and violence/trauma. This overview of the IHR 5 P’S Screening Tool describes content design and implementation models in Massachusetts, as well as an innovative use of the 5 P’S via electronic medical records in California, and with Medicaid reimbursement in Virginia.

Development of 5 P’S Behavioral Risk Screening Tool

The IHR 5 P’S is based on Dr. Hope Ewing’s 4 P’s, which was designed to ask a pregnant woman about the alcohol and drug use of her Parents and Partner, as well as her own use in the Past and Present (Ewing, 1990). The 5 P’S expanded the 4 P’s to include questions about “peers” and “smoking” for use by the Alcohol Screening Assessment in Pregnancy (ASAP) projects, funded by the federal Health Resources and Services Administration, Maternal and Child Health Bureau from 1999-2005. IHR further adapted the 5 P’S to include quantity and frequency questions for another prenatal screening project, Fetal Alcohol Screening for Today (Project FAST, 2004-2006), funded by the SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. Additionally, a positive screen was redefined as a single positive answer to either Parents, Partner, or Past use, even with negative responses to the Present and Peers questions. However, providers continue to ask all 5 “P” questions to better assess risk, motivation to change, and relational impacts of abstention from substance use during pregnancy.

As part of the national SBIRT (Screening, Brief Intervention, and Referral for Treatment) initiative to improve screening in health settings, the Massachusetts Department of Public Health contracted with IHR to further adapt the 5 P’S for utilization, training, and technical assistance in 32 community health centers across the state. Questions regarding “Emotional Health” and “Violence” were included, and a preamble was added in an effort to be trauma-informed by letting women know why these questions about their family and friends were being asked. This adaptation of the 5 P’S, the IHR 5 P’S Behavioral Risk Screening Tool, is directed toward women of childbearing age to positively impact pre-conceptional substance use.

The IHR 5 P’S Behavioral Risk Screening Tool is in the public domain and included in the forthcoming Massachusetts Department of Public Health’s FASD Prevention Toolkit to be distributed statewide. Additional information about the utilization, outcomes and implementation of the 5 P’S in prenatal settings can be found in the ASAP curriculum (Watson, Barnes, Brown, Kennedy & Finkelstein, 2003) and in a previously published article (Kennedy, Finkelstein, Hutchins & Mahoney, 2004).

Innovative Use of 5 P’S Behavioral Risk Screening Tool

Although a number of sites across the country are using this new integrated screening tool, two innovations are noteworthy.

SANTA CLARA COUNTY, CALIFORNIA
PERINATAL SCREENING AND ELECTRONIC MEDICAL RECORDS

The Coalition for Alcohol and Drug Free Pregnancies (CADFP) aims to raise the capacity of perinatal service providers in Santa Clara County, located in the Silicon Valley of San Francisco’s Bay Area, to educate, identify risks, and
prevent or treat perinatal substance use. An anonymous survey of 200 providers undertaken by the Santa Clara Public Health Department (2007) found that although 100% of providers asked their patients about tobacco use, only 11% asked about alcohol use, and 67% reported needing assistance to identify which women were using substances. With support from the Santa Clara County Department of Alcohol and Drug Services and technical assistance from IHR, CADFP provided training and technical assistance to providers to implement the IHR 5 P’s tool.

In 2010, the Comprehensive Perinatal Services Program in five Valley Health Center hospital clinics in Santa Clara County incorporated the 5 P’s into their electronic medical records. Patti Bossert, LCSW, of CADFP reports that while this is an exciting development, providers have been confronted with a steep learning curve and are gradually becoming more comfortable with entering data into the computer while conducting face-to-face interviews with women. This is so new that the data are not yet complete. However, over 40% of screened women have been identified as “at risk”; rates of depression are reported at 17%; and over 25% of the women’s partners reportedly have a problem with alcohol or drug use (Coalition for Alcohol and Drug Free Pregnancies, 2010).

**VIRGINIA BEHAVIORAL HEALTH RISK SCREENING AND MEDICAID**

In 2008, as part of the Assuring Better Child Health and Development Initiative Screening Project, the Virginia Department of Health (VDH) and the Virginia Department of Medical Assistance Services (DMAS) developed a subcommittee to address issues of maternal depression and depression’s impact on pregnancy and infant development. Since one of the barriers to depression screening was lack of reimbursement, the subcommittee recommended that Medicaid pay a separate fee for prenatal/postpartum depression screening, allow payment for up to 4 screenings per pregnancy/postpartum, and pay a separate fee for parental depression screening and referral, if indicated, in the child’s medical home.

Concurrently, in 2009, DMAS staff began working with the Department of Behavioral Health and Developmental Services (DBHDS) on recommended tools for substance use screenings. In 2010, DBHDS, in collaboration with VDH, DMAS and IHR, adapted the 5 P’s to include three emotional health questions from the Edinburgh scale (Cox, Holden, & Sagovsky, 1987) to increase sensitivity for depression.
Virginia’s Medicaid BabyCare program is currently working on updating policy to use this integrated tool; screening must be implemented by a physician, nurse practitioner or certified nurse midwife for reimbursement. The Medicaid Community Mental Health program in Virginia will also allow for licensed mental health/substance use disorder treatment providers to bill for substance use screenings using the 5 P’S integrated tool. The target populations to be screened are: (1) fee-for-service Medicaid or CHIP (Children’s Health Insurance Program) enrolled pregnant women and mothers of infants up to age two (billed under the infant’s benefit); and (2) fee-for-service Medicaid or CHIP enrolled women of childbearing age in Community Mental Health Programs.

Summary

Early identification of risky substance use and appropriate intervention can be effective in preventing problem or dependent use, and avoiding substance-exposed births. Co-occurring mental health conditions and violence/trauma are additional risk factors for substance misuse that can be addressed if identified. The integrated IHR 5 P’S Behavioral Risk Screening Tool provides a relationally-based opportunity to identify risk and offer brief interventions and/or referral for specialist assessment. This tool can be used in primary care (pre-conception) or prenatal health settings through self-administered questionnaires or face-to-face interviews. Innovations, such as enabling Medicaid reimbursement or utilizing electronic medical records, further encourage providers to implement this tool and support women to make healthy choices, for themselves and their children.

Enid Watson, M. Div.
Director of Screening and Early Identification Projects,
Institute for Health and Recovery, Cambridge, MA

REFERENCES


The integrated IHR 5 P’S Behavioral Risk Screening Tool provides a relationally based opportunity to identify risk and offer brief interventions and/or referral for specialist assessment.
In 2003, Grand Rapids had the highest black infant mortality of any city in Michigan, with black babies nearly four times more likely to die than their white counterparts (Michigan Department of Community Health, 2008). Strong Beginnings, a federally-funded Healthy Start project, was created in 2004 to address this inequity and eliminate disparities in pregnancy outcomes among African Americans. Strong Beginnings is a partnership of six community agencies, including the local mental health and substance abuse authority. A holistic approach is used to address the multiple needs of high-risk African American women during pregnancy and for two years after delivery, including behavioral health services, home visits, education, social support, wrap-around services, and case management by teams of nurses, social workers, dietitians, and community health workers (CHWs).

The main cause of death among African American infants is prematurity (Matthews & MacDorman, 2010). Lifestyle factors that contribute to preterm delivery include smoking, drinking alcohol, using illegal drugs, and experiencing high levels of stress (March of Dimes, 2010). Moreover, numerous studies have shown that women who have a substance use disorder, more often than not, are also struggling with a mental health disorder including trauma related issues, depression and/or anxiety; some studies have shown a prevalence rate as high as 75% (Lincoln, Liebschutz, Chernoff, Nguyen & Amaro, 2006). In 2006, the local county Fetal Infant Mortality Review (FIMR) conducted a factor analysis and found that the closest associations with infant mortality among African Americans were depression (present in 27% of infant deaths) and multiple stressors (present in 43% of infant deaths reviewed) (Healthy Kent, 2007). In 2008 and 2009, FIMR found illicit drugs had been used prenatally in 24% of African American infant deaths, and alcohol in 15% (Healthy Kent, 2010). Among the 1,650 Strong Beginnings clients enrolled to date, 42% screened positive for depression on the Edinburgh Post-Natal Depression Screen (EPDS), and 25%-33% used drugs and/or alcohol during pregnancy.

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Recruitment and Retention Strategies

Before treatment can be offered, women have to access care. African American women have very low rates of engaging in substance abuse treatment and mental health services for a number of reasons: the stigma associated with addiction and mental illness, mistrust, racism and discrimination within the health care system, lack of transportation or child care, lack of insurance, and difficulty navigating health care systems.

Skilled community health workers (CHWs) can help overcome these barriers. CHWs conduct outreach at...
The MHC receives 99% of her referrals from CHWs. She is notified when a client admits to drug or alcohol use, scores high on the EPDS or if the CHW has concerns about the family. Once the CHW has agreement from the client, the MHC and the CHW make an appointment to meet with the client together. The CHW joins in future sessions until the client is comfortable meeting with the MHC on her own. If clients are not interested in meeting individually with a counselor, the CHWs refer them to a six-week therapeutic support group facilitated by the MHC. Once clients attend a group, they often become interested in individual counseling.

As a care coordinator, the MHC’s goal generally is to provide brief interventions. Some women are assessed and referred to appropriate treatment or counseling services. However, the majority distrusts the system and is not stable enough to follow through with a referral. The MHC then counsels women for repeated sessions as she breaks down barriers to services, assists with stability, and uses motivational interviewing techniques to further the client’s recovery. Throughout this process, clients develop skills to stay clean and sober, reduce life stressors, improve family functioning, and enhance self-esteem.

Once a client is stabilized, she may be referred to outpatient treatment to continue her recovery and access psychiatric services. When a client is referred elsewhere, the MHC accompanies the client to her first appointment. After releases of information are secured, the MHC monitors the clients' involvement and progress in treatment through regular conversations with the primary therapist and monthly meetings with the client. If appointments are missed, and there is no response to telephone calls, the MHC goes to the client’s home to find out what the issues are, resolve them, and ensure that client continues in treatment.

Throughout the entire therapeutic process, there is close coordination between the MHC, CHWs, and case managers. The MHC communicates regularly with CHWs regarding clients’ progress and follow-through with treatment. CHWs participate in case conferences, assist with therapeutic group sessions, and follow-up with client self-care plans during home visits.

**Care Coordination and the Therapeutic Process**

A critical component of Strong Beginnings, the mental health program focuses on enabling pregnant and parenting women to access appropriate services and substance abuse treatment, learn to manage stress, and decrease perinatal depression. A full-time PhD family therapist serves as the mental health coordinator (MHC), providing crisis management, case coordination, therapeutic support groups, and individual counseling to women with co-occurring disorders.

Culturally-appropriate locations (e.g., beauty and nail salons, grocery stores, cell phone companies, day care centers, houses of worship, community centers, dance clubs) and become known as ‘individuals of trust’ within the community. As peer workers, CHWs represent the women they serve. This shared cultural identity is crucial for engaging high-risk women, developing trust and communicating effectively with them.

As members of case management teams, CHWs conduct home visits on average every two weeks with the 30-35 clients they follow from pregnancy through two years after delivery. CHWs administer depression screenings, assess for drug and alcohol use and other risk factors, identify client strengths, advocate for client needs, make referrals, arrange transportation and childcare, and provide supportive relationships.

Once women have engaged, they need to remain in the program long enough to benefit from the services offered and make lasting changes in their lives. This is a challenge with a highly mobile population facing multiple demands on their time and energy. Retention strategies include:

- Utilizing a client-centered approach that empowers women to set goals and develop plans to reach those goals;
- Frequent client contact with CHWs and other team members to strengthen relationships and respond promptly to emerging issues;
- The CHW-client relationship is considered primary and is maintained even if the professional case manager or service provider agency changes;
- Incorporating cultural relevance and socio-cultural styles in all activities and interventions;
- Addressing all issues that impact clients’ well-being, e.g., housing, employment, education, nutrition and access to food, relationships, parenting skills, dental care, family planning or medical care.

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Client surveys show a high level of satisfaction with the program. Scores range between 4.6 and 4.8 on each of the ten items measured, on a Likert scale of 1 – 5, with a mean of 4.75. All clients reported use of new techniques for staying off drugs and managing stress, anger and depression, and improvements in relationships, school or work.

This model successfully engages hard-to-reach pregnant women by building long-term, trusting relationships and taking a holistic, culturally-relevant approach to meeting client needs. It has demonstrated a positive impact on substance use and mental illness among low-income pregnant African American women.

Emmy Ellis, MSW, LMSW
Program Manager
Arbor Circle
eellis@arborcircle.org

Peggy Vander Meulen, MSN, BSN, RN
Program Director
Strong Beginnings (federally-funded Healthy Start Project)
peggy.vandermeulen@spectrum-health.org

REFERENCES


In an effort to prevent Fetal Alcohol Spectrum Disorders (FASD) and provide hope for pregnant and parenting addicted women, the National Organization on Fetal Alcohol Syndrome (NOFAS) piloted three regional Hope for Women in Recovery summits across the United States (2004-2006). The summit model targeted two distinct groups: women receiving addiction treatment; and the providers and policy makers that serve women with addictions. The inclusion of both groups provided a unique opportunity for consumers and providers to learn from each other; attendees from both groups reported a significant gain in knowledge about FASD. The day-long summit experience also increased collaboration among providers and ultimately served as a catalyst for systemic change.

Pregnancy is an opportunity for change and an excellent time to expose pregnant women who used substances during pregnancy to other women who used while they were pregnant and subsequently experienced successful long term recovery.

**You Are Not Alone!**

The theme of hope and empowerment was woven into every aspect of each summit. Women who struggle with addiction often suffer from low self-esteem and have difficulty asking for help. Additionally, women who use substances during pregnancy are likely to have histories of physical and sexual abuse in childhood (Laken & Hutchins, 1996). Pregnancy is an opportunity for change (Tough, Clarke, Hicks, & Clarren, 2004) and an excellent time to expose pregnant women who used substances during pregnancy to other women who used while they were pregnant and subsequently experienced successful long term recovery. Sharing the guilt and shame over substance use while pregnant is a powerful bond for women who typically have trouble connecting with other women. This proved true at the summits as women from various treatment settings came together, and their fear and trepidation began to dissipate.

Each summit opened with a spiritual speaker or song that set the tone that a special gathering was about to take place. The presenters were all women in recovery who had given birth to children diagnosed with FASD.

Hearing stories from women who are “just like me” allowed the participants to have an open mind and heart while learning about FASD. Moreover, teaching women...
how to connect and make friends was a powerful lesson, especially for those in early recovery. This lesson began the process of empowerment, long-term recovery, and true FASD prevention. The term Warrior Mom was used throughout each summit to encourage women to “own their strengths.”

Women heard the message: You are not bad; you are sick. You can and WILL recover if you choose to. You are a Warrior! One summit participant noted, It was a day I’ll never forget! Thank you for giving me an opportunity to know that I do count, that I am somebody. This day made me excited to stay sober, and I know that my kids need me to be sober.

The summits also stimulated sustainable change on many levels. They increased knowledge of and enrollment in the NOFAS Circle of Hope (COH), an international network for birth mothers of children with FASD. Through annual meetings, regional gatherings, email, conference calls, and personal phone calls, the COH offers ongoing support to help reinforce the positive messages of strength and empowerment and sustain the process of change initiated at the summit.

Service Providers Benefit Too

Some providers disclosed that they arrived at one of the summits with an attitude of blame and anger towards pregnant addicted women. Some reported that they had believed women should be punished for use while pregnant. After attending a summit, providers had a greater awareness and became motivated to work for systemic change. Participating substance abuse treatment centers now incorporate sessions on FASD into their programs. Additionally, local FASD coalitions have been established, FASD prevention legislation has passed, and each state that participated now has an FASD state coordinator.

Conclusion

The summits proved to be an effective model for engaging pregnant and parenting women who were enrolled in addiction treatment services at the time. Given the flexible design, however, the model could be adapted to include providers of prenatal care or other ancillary services, and the women who access those services. NOFAS continues to work with a variety of groups across the U.S. to assist in the planning and facilitation of Women in Recovery Summits.

Kathleen T. Mitchell, MHS, LCADS, NOFAS
Mitchell@nofas.oeg, www.nofas.org

REFERENCES


Books, Guides, and Reports

There’s No Place Like Home: Home Visiting Programs Can Support Pregnant Women and New Parents

This review of home visiting programs illustrates what is working and can be built upon to provide meaningful supports to parents. It also examines poverty’s effects on mothers and young children, why home visiting programs are a good investment, and how policy makers and stakeholders can craft effective programs for vulnerable families. Cost: Free online.


Caring for Drug-Exposed Infants

This comprehensive guide for caregivers includes information about the effects of various drugs on newborns, how to recognize symptoms of prenatal drug exposure, and how to care for these newborns. The author shares experiences from running the Pediatric Interim Care Center, a specialized 24-hour nursery for drug-exposed and medically fragile infants. Cost: $30.00.


Substance Abuse and Emotion

This book explores recent, significant field observations, theory construction, rigorous testing, and laboratory research to advance working models for a new research paradigm on substance abuse and comorbidity. It examines various theoretical perspectives on the interrelationship between substance abuse and emotion, such as craving and positive/negative reinforcement; cognitive theories; relapse; and developmental, sociobiological, and evolutionary perspectives. Cost: $69.95 (list price); $49.95 (APA member/affiliate price).


Substance Abuse Treatment: Addressing the Specific Needs of Women

This guide provides clinical and administrative information to assist counselors, clinical supervisors, program administrators, and others on how to best respond to the specific substance abuse treatment needs of female clients. Cost: Free online.


Caring for Drug-Exposed Infants

This comprehensive guide for caregivers includes information about the effects of various drugs on newborns, how to recognize symptoms of prenatal drug exposure, and how to care for these newborns. The author shares experiences from running the Pediatric Interim Care Center, a specialized 24-hour nursery for drug-exposed and medically fragile infants. Cost: $30.00.


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This guide provides clinical and administrative information to assist counselors, clinical supervisors, program administrators, and others on how to best respond to the specific substance abuse treatment needs of female clients. Cost: Free online.

Substance Exposed Infants: State Responses to the Problem

This report analyzes state policies and practices regarding pre-pregnancy prevention efforts, screening and assessment in the prenatal period, testing at birth, notification of child protective services when infants are identified as substance-affected, the provision of services to affected infants and their parents, and the processing of referrals to developmental disabilities agencies. Cost: Free online.


Helping Substance-Abusing Women of Vulnerable Populations

Drawing on empirical research, this volume provides concepts, tools, and techniques for culturally and socially inclusive practice with vulnerable female populations. After a brief history of substance abuse among women in the United States, along with an overview of previous epidemiological studies, the author systematically describes the characteristics and nature of alcohol and other drug problems among pregnant women, teenage girls, older women, and other vulnerable populations. Cost: $65.00.


Concise, focused chapters illuminate how biological and psychosocial factors influence the etiology and epidemiology of substance use disorders in women; their clinical presentation, course, and psychiatric comorbidities; treatment access; and treatment effectiveness. Prevalent substances of abuse are examined, as are issues facing special populations. Cost: $65.00.


Handbook of Infant Mental Health

Widely regarded as the standard reference in the field, this state-of-the-art handbook offers a comprehensive analysis of developmental, clinical, and social aspects of mental health from birth to the preschool years. Leading authorities explore models of development; biological, family, and socio-cultural risk and protective factors; and frequently encountered disorders and disabilities. Cost: $75.00.


Trauma Services for Women in Substance Abuse Treatment: An Integrated Approach

This is a hands-on guide for clinicians seeking to treat women who suffer from both a history of trauma and the effects of substance abuse. The intertwined nature of trauma and addiction is explored through a review of recent research, with a focus on treatment options for PTSD and addiction that together form the basis for many of the recently developed treatments for trauma and addiction co-morbidity. Cost: $49.95 (list price); 39.95 (APA member/affiliate price).


Women, Girls, & Addiction: Celebrating the Feminine in Counseling Treatment and Recovery

This book provides a feminist approach to understanding the experience of addiction. The authors discuss specific research and practice-based treatment and recovery interventions, and closely examine the barriers and strengths of women experiencing addiction. Cost: $32.95.

**Videos and Other Resources**

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**Caring for Drug-Exposed Infants**
This comprehensive training DVD covers everything from the drug withdrawal of a newborn to the drug-exposed child’s first years of life. It is designed as a hands-on manual to help caregivers understand a drug-exposed baby’s needs and how to meet them. In addition, it is a guide to specific drugs, their effects, and what symptoms might be associated with each. Also discussed is overall infant management and techniques to aid in reading the signs and signals of the infant. It details the importance of the caregiver’s role in regards to the success of each child’s long term outcome. Cost: $125.00.


**Why Us? Left Behind and Dying**
This 90-minute documentary is an innovative effort to explore why HIV disproportionately affects Black people. In total, twenty students in Pittsburgh, PA braved the stigma to become researchers, speaking to scientists, public health workers, and people living with HIV/AIDS about the deadly intersection of race, science, and culture. Cost: $275.00.


**Arizona CASA Online Training Modules: Neonatal Substance Exposure / Substance Exposed Newborns (SEN)**
This training module presents information on the effects that intrauterine drug exposure has on children.


**Integrated Treatment for Co-Occurring Disorders**
This evidence-based practice toolkit provides information about a treatment approach that integrates mental health and substance abuse services in one setting for people with co-occurring disorders. Cost: Free online.


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**Methamphetamine Addiction: Biological Foundations, Psychological Factors, and Social Consequences**
The author presents a biopsychosocial perspective on methamphetamine addiction, taking into account the biochemistry of the drug, the predispositions and behavioral patterns of the individual user, and the effects of the drug on immediate and wider social environments of these drug users. He examines its addictive properties and its effects on users, which include a complex synergy with HIV. Cost: $79.95 (list price); $49.95 (APA member/affiliate price).


**With Child: Substance Use During Pregnancy, A Woman-Centered Approach**
This book provides practitioners and researchers with valuable information about maternal drug use, related policy, and best practices for addressing the social and medical problems of pregnant, drug-using women. Cost: $17.18.

Women and Substance Use
http://www.oas.samhsa.gov/women.htm

Find data and reports from the Substance Abuse and Mental Health Services’ Administration Office of Applied Studies regarding trends in substance use among women.

Family Resource Information, Education and Network Development Services
http://www.friendsnrc.org/

This site is dedicated to providing resources to the child abuse prevention community.

Child Information Gateway

Search for state laws that include parental drug use in child abuse definitions. The site also allows searches for numerous other state child welfare laws.

Internet Resources

The Drug Endangered Child Training Network
http://www.drugendangeredchild.org/

This network seeks to increase community and professional awareness of the impact of adult drug involvement on children.

Faces & Voices of Recovery Mutual Aid Resources
http://www.facesandvoicesofrecovery.org/resources/support/index.html

This site provides information about the growing number and scope of volunteer recovery mutual aid groups.

Join Together Blog
http://www.jointogether.org/blog/

This blog delivers valuable news and information for those in the addiction field.

Pregnancy and Substance Abuse
http://health.nih.gov/topic/PregnancyandSubstanceAbuse

This site offers links to important information about the impact of substance abuse during pregnancy.

National Alliance for Drug Endangered Children
http://www.nationaldec.org/

This site supports multi-disciplinary alliances of service providers caring for children who are in danger because their parents or caregivers are manufacturing, dealing or using drugs.

Substance Abuse During Pregnancy
http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf

Check here for a regularly updated summary of state policies regarding substance abuse during pregnancy.
<table>
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<td>2010 National Alliance for Drug Endangered Children Conference</td>
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<td>Dallas, TX</td>
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<td>8th National Harm Reduction Conference</td>
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<td>Austin, TX</td>
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<td>December 9-11, 2010</td>
<td>Phoenix, AZ</td>
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2010 HIV Prevention Leadership Summit
Dates: December 12-15, 2010
Location: Washington, DC
Website: www.nmac.org/index/
hiv-prevention-leadership-summit

SSWR 15th Annual Conference
Dates: January 12-16, 2011
Location: Tampa, FL
Website: www.sswr.org/conferences.php

25th Annual San Diego International Conference on Child and Family Maltreatment
Dates: January 23-28, 2011
Location: San Diego, CA
Website: www.chadwickcenter.org

Strive to Thrive: Building Systems of Care for Birth to Fives
Dates: February 3-4, 2011
Location: Long Beach, CA
Website: www.childrensinstitute.org/events/details/18

2011 AMCHP and Family Voices National Conferences
Dates: February 12-15, 2011
Location: Washington, DC
Website: www.amchp.org/conference

12th Annual National Fatherhood & Families Conference
Dates: March 1-4, 2011
Location: San Francisco, CA
Website: www.azffc.org

Sixth National African American Drug Policy Summit
Dates: March 24-27, 2011
Location: Silver Spring, MD
Website: www.naadpc.org

CWLA’s 2011 National Conference
Dates: March 27-30, 2011
Location: Washington, DC
Website: www.cwla.org/conferences

National Conference on Juvenile and Family Law
Dates: March 27-30, 2011
Location: Reno, NV
Website: www.ncjfcj.org/content/view/285/378

27th National Symposium on Child Abuse
Dates: March 28-31, 2011
Location: Huntsville, AL
Website: www.nationalcac.org/professionals/index.php?option=com_content&task=view&id=179&Itemid=138

HIV/STD Prevention in Rural Communities: Sharing Successful Strategies VII
Dates: April 7, 2011
Location: Bloomington, IN
Website: www.indiana.edu/~aids/conferences.html

29th Annual “Protecting Our Children” National American Indian Conference on Child Abuse and Neglect
Dates: April 17-20, 2011
Location: Anchorage, AK
Website: www.nicwa.org/conference

Third Conference of the International Society on Early Intervention
Dates: May 2-5, 2011
Location: New York, NY
Website: http://depts.washington.edu/isei/ISEI_3rd_conf.html

35th Annual NAPSW Conference: Building Bridges: The Heart of Perinatal Social Work
Dates: May 11-14, 2011
Location: San Francisco, CA
Website: www.NAPSW.org

2011 NAATP Annual Addiction Treatment Leadership Conference
Dates: May 14-17, 2011
Location: Phoenix, AZ
Website: www.naatp.org/conferences/annualconference.php
Visit the National AIA Resource Center at http://aia.berkeley.edu

Website Features

- Numerous monographs, fact sheets, issue briefs, and other publications—most of which are available for free download in PDF format
- Archived issues of *The Source* from 1993—present available for download
- Information about Resource Center trainings and conferences, including our ongoing Teleconference training series
- Archived proceedings from past Resource Center trainings and conferences, including recordings and handouts
- Profiles of federally funded Abandoned Infant Assistance (AIA) projects

The site also features extensive information and resources about families affected by HIV and/or substance abuse, including special topics such as:

- Kinship Care
- Standby Guardianship and Future Care and Custody Planning
- Shared Family Care
- Substance Exposed Newborns
- Child Welfare

Join Our E-List

To receive periodic emails from the Resource Center announcing new publications, conferences, and trainings, and other important information, email aia@berkeley.edu and ask to be added to our email list.
New from the National AIA Resource Center (NAIARC)

SEN SUMMIT ARCHIVE

In June 2010, the NAIARC, along with the Children’s Bureau, National Center on Substance Abuse and Child Welfare, and National Institute on Drug Abuse, convened a national summit on substance exposed newborns (SEN). This summit showcased exemplary policies and practices for identifying pregnant substance users and their newborns; referring them to child welfare, treatment and other community services; and developing plans of safe care for their newborns. Audio recordings, presentation slides, the event program, speaker bios, and handouts from this meeting are available on the AIA website at: http://aia.berkeley.edu/training/SEN2010/

Coming Soon…

REPORTS FROM FOCUS GROUPS ON PARENTING WITH CO-OCCURRING DISORDERS

In June 2010, the NAIARC conducted focus groups to explore parenting challenges and effective interventions with mothers who suffer co-occurring disorders. One focused on parents with substance abuse disorders and mental illness, and the other focused on parents with HIV and mental illness and/or substance abuse disorders. Reports summarizing the findings from these sessions will be posted on the NAIARC website soon.

ONLINE TUTORIALS

The NAIARC is developing 2 online training opportunities for individuals interested in overviews of the fields of perinatal substance abuse or HIV/AIDS. One tutorial addresses the prevalence and impact of substance use during pregnancy, as well as an overview of intervention strategies and related policies. The other explores the prevalence and impact of HIV/AIDS on women and children, along with related challenges and interventions. Continuing Education Credits will be available upon completion of each tutorial. Both will be available soon on the NAIARC website.