A DESCRIPTIVE STUDY

OF

PERINATAL SUBSTANCE ABUSE PROGRAMS IN OREGON

By

Mary L. Lyon

A Master's Research Project

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment of
the requirements for the degree of
Master of Science

May 19, 1994

APPROVED:

[redacted]

Donna B. Jensen, RN, PhD, Associate Professor, Community Health Care Systems, Research Advisor

[redacted]

Jill Nathman, RN, MS, Perinatal Substance Abuse Coordinator, Oregon Health Division, Maternal and Child Health Section, Committee Member

[redacted]

Margaret Imle, RN, PhD, Associate Professor, Family Nursing, Committee Member

[redacted]

Carol A. Lindeman, RN, PhD, FAAN, Dean, School of Nursing

Acknowledgments

A special thank you to my informants, who so graciously shared their insights.

ABSTRACT

TITLE: A Descriptive Study of Perinatal Substance Abuse Programs in Oregon

AUTHOR: Mary L. Lyon

APPROVED:

[redacted]

Donna B. Jensen, RN, PhD

Perinatal substance abuse, the use of drugs during and after pregnancy, has become a national health concern due to the risk of multiple adverse consequences: negative effects on the health of the mother and the fetus, long term effects on the health of the child, and interference with the ability of the mother to parent. In response to 1990 estimates that between 5.2% and 11% of pregnant women in Oregon used illicit drugs, self reports of almost 9% using alcohol, and self reports of 24% using tobacco, the state designated Drug-free Babies as a lead Benchmark, an urgent problem that must be addressed in order to maintain and enhance quality of life in this state. To address the issue, eight agencies around the state implemented 3 to 5 year comprehensive perinatal substance abuse demonstration projects with U. S. Center for Substance Abuse Prevention funding. In order for agencies and policy makers to benefit from the experiences of these programs, as well as those of two additional programs, a descriptive study was undertaken using qualitative and quantitative methodology based on Guba and Lincoln's constructivist paradigm. Face-to-face interviews were conducted with the program managers regarding client characteristics, effective and ineffective aspects of their programs in decreasing substance abuse and improving outcomes, integration of services, and visions for an ideal program. Interview data were compiled and analyzed according to themes emerging from the data. A second tele-

phone interview with the managers was conducted to validate and further develop consensus regarding those themes across programs.

Analysis suggested that these comprehensive perinatal substance abuse programs accessed or provided multiple services to clients with multiple needs related to childbearing, risk factors for or actual substance abuse, and frequently, poverty and disturbed family systems, within a service environment comprised, primarily, of single service agencies. The broader goal involved replacing the intergenerational cycle of destructive living with constructive behavior patterns in order to improve quality of life for the mother and her family. Establishment of a trust relationship with the provider, detoxification, and letting go of denial were beginning steps toward lifestyle changes, although not necessarily in that order. In general, managers found interventions to be most effective when they capitalized on the woman's motivation of wanting a better life for a healthy baby. The use of policy incentives and restrictions helped to recruit and retain women in supportive and structured programs that utilized case managers to assist clients in identifying and prioritizing needs and accessing services. Development of self esteem, as well as a sense of capability and the power to change were also important factors in decreasing feelings of hopelessness and powerlessness that often led to relapse. In addition to supportive relationships within the program, the development of healthy long term support within the community was also key, with the growing recognition of the need to involve other family members in the recovery process. Integral to supporting behavior changes to end addiction were the availability and accessibility of: (a) assistance with basic needs that were barriers to change, such as housing, financial assistance, child care, and transportation; (b) treatment services, including health and dental care, appropriate alcohol and drug treatment, and mental health counseling, as

needed, to address underlying problems; (c) skill development in the areas of living, relationships, parenting, and health; and (d) general educational and job training programs in tandem with available job opportunities.

Managers focused, primarily, on the many initial and intermediate steps in recovery, with both the implicit and explicit acknowledgment that their programs were a valuable, yet circumscribed, response to these multi-dimensional problems. Program participation generally helped to reduce perinatal substance abuse and improve birth outcomes. The programs experienced moderate success in recruiting clients into alcohol and drug treatment programs, and in helping their clients to redirect their lives. Little was known about long term outcomes for the clients. Factors that hindered effectiveness were the limited knowledge in regard to promoting behavior change within this population, and the limited availability and accessibility of appropriate services. The resource limitations that managers most frequently identified were safe and drug-free housing, appropriate alcohol and drug treatment, services for partners and children, education and job training, and interagency case planning and coordination.

Perinatal substance abuse programs which served this population were found to be most effective when they had comprehensive strategies in place and a wide array of services available, as needed, over time to assist clients to make lifestyle changes and to end substance abuse. Such comprehensiveness may be beyond the scope of any one coordinating agency in the current service environment. Given the multiple problems of these clients and the difficulties of changing addictive behavior, it would also seem expedient to increase interventions in the concomitant areas of social policy, intergenerational poverty and abusive family relationships, as well as in primary and secondary prevention of alcohol and drug abuse.

Pertinent areas for further research include the study of, (a) the perspective of the clients in regard to their needs and the effectiveness of perinatal substance abuse programs to provide primary data from the women themselves; (b) the long term outcomes for program participants, measuring variables such as the former clients' level of sobriety, health status, parenting status, stability of living situation, quality of mother-child relationship, quality of social support system, employment status, and status with the criminal justice system; (c) cost analysis, including both psychosocial and monetary costs, in untreated perinatal addiction verses primary, secondary, and tertiary prevention; and, (d) the characteristics of women in other socioeconomic groups who have risk factors for or actual alcohol and drug abuse problems.

Table of Contents

Table of Contents

List of Tables

Introduction

Alcohol and drug abuse continues to be a major health problem in our society. Perinatal substance abuse, the use of drugs during and after pregnancy, may have multiple adverse consequences: negative effects on the health of mother and fetus, long term effects on the health of the child, and interference with the ability of the mother to parent (Khalsa & Gfroerer, 1991; United States General Accounting Office [GAO], 1990). Women, particularly those who are pregnant or who have children, have had limited access to drug treatment (Department of Human Resources Advisory Committee, 1991; Finkelstein, 1990). The U. S. Center for Substance Abuse Prevention has funded eight comprehensive perinatal substance abuse demonstration projects in Oregon. In order for state agencies to benefit from the experiences of these eight programs as well as two additional programs with ongoing funding, a descriptive study using qualitative and quantitative methodology was conducted to determine characteristics of the women clients and effective strategies for reducing substance abuse. Data are reported from the perspective of the ten program managers.

Statement of Problem

In 1989, a survey by the Oregon Health Division, using both urine toxicology and self report at delivery, indicated that 5.2 % of women used illegal drugs during pregnancy in both urban and rural counties across the state. Because self reports are typically low, a 1991 Oregon Department of Human Resources Advisory Committee Report concluded the actual rate may approach the national estimate of 11% (Chasnoff, 1989). In 1989, more than 700 babies in Oregon (less than 2%) were identified clinically as affected by alcohol or drugs. From 1986 to 1889, the Oregon Children's Services Division had a 400% increase in the referral of drug exposed infants. Additionally, 78% of

children in foster care came from substance abusing families (Department of Human Resources Advisory Committee, 1991).

In response to these problems, Oregon has designated Drug-Free Babies as a lead Benchmark, an urgent problem that must be addressed before the year 2000 in order to maintain and enhance the quality of life in this state (Oregon Benchmarks, 1991). The Benchmarks estimated, based on state and national reports, that in 1990, 11% of pregnant women used illicit drugs. Additionally, almost 9% of Oregon women reported using alcohol and 24% reported using tobacco during pregnancy. The goal for 1995 is to reduce illicit drug use to 5%, alcohol use to 3% and tobacco use to 10% among pregnant women (Office of Alcohol and Drug Abuse Programs, 1993).

The Department of Human Services Advisory Committee Report (1991) recommended both a prevalence study of prenatal substance abuse, which is currently underway, and the development of comprehensive programs for pregnant substance abusers and their young children. These programs would be designed specifically for pregnant women in a culturally sensitive manner with recognition that many women substance abusers have been victimized. Programs would include case management services, prenatal and postpartum health care, child care, substance abuse treatment, mental health services, as well as addressing other needs, such as transportation, job training, life skills and education.

Various agencies throughout Oregon have implemented eight comprehensive perinatal substance abuse demonstration programs. These 3 to 5 year grants are funded by the Center for Substance Abuse Prevention (CSAP), U. S. Department of Health and Human Services. There are also two additional perinatal substance abuse programs in Oregon that have ongoing funding from other sources. In order for state agencies and policy makers to bene-

fit from the experiences of these programs when determining future approaches to perinatal substance abuse, the Coordinator for Alcohol and Other Drug Abuse at the Oregon Health Division, requested a descriptive study of specific aspects of these programs. Priorities for this study were to increase understanding of (a) the characteristics of the women clients, (b) effective and ineffective aspects of the programs in reducing perinatal substance abuse and improving perinatal outcomes, (c) dimensions of integrated service delivery systems in publicly funded programs, and, (d) visions for future programs. The purpose of this project was to develop an understanding of each program in its own context and to develop areas of consensus that apply across programs. Through the process of joint case construction, it is hoped that program managers will come to a more sophisticated understanding of their clients, as well as effective perinatal substance abuse strategies. It is further anticipated that they will be empowered by the consideration of their views and the opportunity to respond to the views of others. The report will serve also to inform other states of the experiences in Oregon.

The study is relevant to the field of nursing through its contribution to the knowledge base regarding perinatal substance abuse. Nurses plan, direct, and provide services for women who abuse substances and their families in the community, in clinics and in hospitals.

As a graduate nursing student with a background in perinatal nursing and a current focus on health care policy and program planning, conducting a descriptive study of perinatal substance abuse programs seemed both valuable and appropriate. Previous related experiences of this investigator include teaching family planning, providing abortion counseling, coordinating high risk perinatal education for practicing health care providers for the Oregon Regional Perinatal Project, and assessing the needs of grandparents who were

raising their grandchildren (primarily as a result of parental drug and alcohol abuse).

Review of Related Literature

Literature relating to the characteristics of women who abuse alcohol and other drugs and the characteristics of effective intervention programs are the foci of this review. Perinatal substance abuse involves complex biological, psychological, medical, sociological, and behavioral components which act as confounding variables in research (Finnegan, 1991). Studies have been spotty, lacking in systematic methodology, and limited in size. Most of the literature is comprised of opinion articles, and the majority of the research has involved factor identification and description, and relationship description. The bulk of the inquiries have focused on low income women, even though Chasnoff, Landress, and Barrett (1990) found that the incidence of illicit drug abuse was similar across socioeconomic classes. Davis (1989) asserted that while social problems are symptomatic of an entire culture, they are first visible among the most vulnerable. Published reports of the characteristics of identified women substance abusers, therefore, cannot be construed to be reflective of the majority of women who abuse substances.

Women Who Abuse Substances

Finnegan reported that there has been a women's drug epidemic for over a quarter of a century, with a lack of research, treatment, education, and interest by professionals (1991). Finkelstein (1990) attributed the neglect of this issue to our male oriented society and traced the historical roots of attitudes of anger and blame toward women who abuse drugs. Women addicts have been seen as immoral and as bad mothers. Women have internalized feelings of shame, low self esteem, and are often plagued by social isolation. There is a high degree of denial among women, their families and friends, as

well as among the professionals who treat them. Beckman and Amaro (1986) have confirmed that women were less likely to be identified and referred to treatment than men.

Preliminary demographic information from 20 Center for Substance Abuse Prevention demonstration programs across the nation indicated that the average client age was 27 to 28 years, 80% to 90% were single, 75% had an 11th grade education or less, and 70% were unemployed. Cocaine was the drug of choice, with polydrug use, including alcohol and tobacco (Rahdert, 1993). Other studies have indicated that about 70% of substance abusing woman were sexually abused as children, and 83% came from homes with drug or alcohol addiction present (Regan, Erlich, & Finnegan, 1987). Over 50% of women in treatment were currently in physically or sexually abusive relationships (Brown, 1992). According to the Family Center experience in Philadelphia, most abusers started using drugs in their teens and may be developmentally arrested at the point of first use (Finnegan, Hagen, & Kaltenbach, 1991). Their clients had a higher rate of HIV infections, other infectious diseases and suffered from poor nutrition. They had difficulty obtaining adequate housing, food, clothing, transportation and child care. Many also lacked parenting skills and had unrealistic expectations of their children due to lack of knowledge of age-appropriate behavior as well as the special needs of drug affected children. Additionally, women abusing drugs were more likely to have men in their lives that were substance abusers, and they were more frequently involved in prostitution or drug dealing (Bays, 1990). Many had few life skills and needed habilitation as opposed to rehabilitation.

Almost 60% of women abusing drugs suffered from moderate to severe psychiatric problems, the most common being depression (Finnegan, 1991). Root (1989) reported the use of drugs by certain women as a response to post

traumatic stress syndrome, characterized by intrusive recall of trauma, use of drugs to numb these intrusions, and increased anxiety, sleep disturbance, or irritability.

Patterns of drug use varied. Chasnoff et al. (1990) found that African American women were more likely to use cocaine (7.5%) while European American women were more likely to use marijuana (14%). Although the rates of drug use were similar, African Americans were several times more likely to be reported by professionals for drug use. Polydrug use was frequent, with alcohol and tobacco most often accompanying other drugs (Center for Perinatal Substance Abuse Treatment, 1993; Khalsa & Gfroerer, 1991). Studies have yet to quantify the frequency and intensity of drug use or the relationship of the frequency and intensity to perinatal outcomes.

Intervention Programs

There seemed to be a consensus among experts in the field that a more comprehensive approach to treating perinatal substance abuse is needed (Brown, 1992; Center for Substance Abuse Treatment, 1993; Finnegan, 1991; US GAO, 1990) . The authors have suggested various models that include individual and family outreach, case management, health care (prenatal, perinatal, child, mental, ongoing), drug treatment, children's services, parenting, education, job training and basic needs management (housing, food, clothing, child care). As in Oregon, comprehensive demonstration programs throughout the country are currently collecting and analyzing primarily quantitative data for the Center for Substance Abuse Prevention, and the results are in process.

In order to encompass both individual and environmental contexts, Gilchrist and Gillmore (1992) called for an integration of the two competing philosophies of the clinical-developmental approach, which is sensitive and

specific to the individual, with the population-based public health approach which, the authors argue, demonstrates more efficiency and generalizability. In addition, these authors stressed that influencing values and beliefs is central in changing behavior. They identified 3 key factors that need to be addressed in designing effective perinatal substance abuse treatment as (a) gender and gender role socialization, (b) culture and ethnicity, and (c) developmental maturity.

Case management was a frequently cited solution for dealing with the fragmentation of services for low income women and their families. Each family may interface with multiple case workers and agencies, resulting in conflicting priorities and difficulty obtaining services. One suggested approach was the one-stop shopping or family center where services would be in close proximity and easily accessible (Rahdert, 1993).

There is a significant gap in the knowledge of what is effective drug treatment for women. In the past, drug treatment programs have been oriented toward men, using male treatment models, and most have not accepted pregnant women or women with children (Brown, 1992; US GAO, 1990). Nationally, Chasnoff et al. found that, in 1990, only 11% of an estimated 280,000 pregnant drug users received drug treatment. Massachusetts had only 15 residential treatment slots for pregnant women (US GAO, 1990). Oregon has 31 residential treatment slots for pregnant alcohol abusers and 52 for pregnant drug abusers (Office of Drug and Alcohol Programs, 1993). Drug treatment programs traditionally have not included child care, prenatal care or educational guidance. Beckman and Amaro (1986) found that alcohol treatment centers that offered child care and children's services attracted more women into treatment. In preliminary findings, PAR Village, an 18 month residential treatment program in Pinellas County, Florida, indicated that

women who had their children with them were staying in treatment longer (Coletti et al, 1992). A US GAO study (1990), found that of the 450 calls from women in Boston who were seeking detoxification, about 50% never called back when services were not immediately available, emphasizing the importance of being able to respond to women when they seek help. At the Family Center in Philadelphia, Kaltenbach and Finnegan (1992) have found that when their clients consistently had shelter, food, and clothing, there was a dramatic increase in those who responded to drug treatment.

The relationship between drug use and prenatal care is difficult to sort out, in part because clinical studies have not quantified the intensity of substance abuse or accounted for socioeconomic variables. Finnegan (1990) noted a drop in the incidence of low birth weight infants from 50% to 18% in a program providing drug treatment and prenatal care. Broekhuizen, Utrie, and Van Mullem (1992), in an 8 year study in Milwaukee, Wisconsin found that the drug use of patients who had 5 or more prenatal visits had minimal negative effects on perinatal outcome, while those with 5 or less prenatal visits had 3 times the perinatal death rate and low birth weight. They postulated that number of visits was associated with the degree of chaos in the users' lives and the severity of drug use. Feldman, Minkoff, McCalla, and Salwen in New York City (1992), after adjusting for multiple risk factors, attributed a 2 to 3 fold drop in prematurity and low birth weight among substance abusers to prenatal care. However, the report did not elaborate on what constituted prenatal care and conceded that clients with no prenatal care were probably heavier drug users in more desperate circumstances.

In the past, society in general, as well as the health care professions, has viewed drug addiction as a problem for the criminal justice system, thus discouraging women from seeking treatment for fear of prosecution and loss of

custody of their children (Finnegan, 1991; US GAO, 1990). Many authors agree that incarceration or civil penalties do not improve perinatal outcomes (Center for Drug Abuse Treatment, 1993; Connolly & Marshall, 1991; Department of Human Resources Advisory Committee, 1991). Physicians and nurses may also lack training in the identification of persons who abuse substances. Health care providers more frequently identify women of color and women who have low incomes as substance abusers. Those in private practice may be more reluctant to broach this sensitive subject with patients out of fear of losing them (Department of Human Resources Advisory Committee, 1991).

There is a need for further research in every area of perinatal substance abuse. It is important for future research efforts to encompass fewer isolated studies and more joint efforts to increase numbers and continuity in research. All confounding variables of perinatal substance abuse need to be considered when evaluating a given variable. An important area of research from the author's perspective, is further development of Gilchrist's and Gillmore's community based concept of combining clinical developmental measures with a public health focus.

Theoretical Framework

Guba and Lincoln's Fourth Generation Evaluation (1989) constructivist paradigm is well suited to the complexities of the behavioral sciences. In their relativist ontology, realities are multiple, socially constructed, and are not governed by natural laws, as opposed to the ontology of the positivist scientific paradigm. Truth is the best informed and most sophisticated construction on which there is consensus. The epistemology is both monistic and subjectivist, in that the inquirer and the evaluand are not separable, and that the findings are a creation of the inquiry process. A hermeneutic, or interpre-

tive, methodology is utilized with a continuing dialectic of iteration, analysis, critique, reiteration and re-analysis until a joint case is constructed among stakeholders. Stakeholders are broadly defined to include all who interface with the program to be evaluated: agents (funders, providers, decision makers), beneficiaries (clients, their families, suppliers), or victims (ineligibles, those who suffer negative effects, programs that aren't funded). In the hermeneutic/dialectic circles of each stakeholder group, claims (favorable assertions), concerns (unfavorable assertions), and issues (items over which there is no agreement) are constructed. Claims, concerns, and issues from other circles, literature analects, and inquirer constructions are also introduced. The process occurs through individual interviews and group negotiation. Fourth generation evaluation is a grounded theory in which theory is imbedded within the data and reasoning is inductive in nature. The aim is to promote a higher level of understanding through creation of the most sophisticated constructions for a specific context and time, employing thick description to make the implicit explicit, and allowing others to vicariously experience the stakeholders' reality. These constructions are not context free or generalizable as in the positivist paradigm, but the constructions may be transferable across similar contexts. The conceptual design emerges from the research.

Research Questions

The research questions for this study are,

From the perspective of Oregon comprehensive perinatal substance abuse program managers,

(a) what are the characteristics of the women clients?

(b) what are the effective and ineffective aspects of the programs in reducing perinatal substance abuse and improving outcomes?

(c) what are the dimensions of integrated service delivery systems in publicly funded programs?, and

(d) what are the visions for future programs?

Methodology

Design

A combined qualitative and quantitative methodology based on Guba and Lincoln's (1985, 1989) constructivist paradigm was used to interview managers from these 10 comprehensive perinatal substance abuse programs in Oregon. Because of concerns for confidentiality for the clients, as well as resource limitations, the study was restricted to the managerial perspective, thus making a complete evaluation representing all stakeholder groups impossible. Additionally, because of resource constraints and distance, group negotiation was not utilized. Previous report materials were requested from all programs to provide background material to enhance understanding and construct a matrix revealing demographic characteristics of each program and their clients for the case report. Face-to-face interviews with program managers were conducted using the Interview Schedule (Appendix A) and follow-up phone interviews were utilized to respond to claims, concerns, and issues from other managers and other sources. The data were analyzed using the constant comparative method with the assistance of the Microsoft Word processing and Microsoft Excel spreadsheet software programs, peer debriefing and advisor review. The case report focuses on program description, joint case constructions where there is consensus, and limited exploration of contextual differences where there is variation. Examples from individual substance abuse programs illustrate in greater detail the perspective of the program manager in regard to the study questions.

The Evaluands

Comprehensive perinatal substance abuse demonstration projects were programs that played varying roles in accessing or providing services to women who were at risk or actively abusing alcohol and/or other drugs during pregnancy, postpartum, or while parenting young children. Services provided or accessed by the programs themselves, or by affiliated programs within their service network, included case management, education related to pregnancy, parenting, and substance abuse; health and dental services; alcohol and drug treatment; support for recovery, mental health counseling, financial assistance, housing, child care, transportation, general education and job training. The ten perinatal substance abuse programs studied were located throughout Oregon in Portland (5), Hillsboro, Oregon City, Eugene, Medford, Madras, and Bend. The programs were:

Teen Parent Connections Project, Tri-County Youth Services Consortium, Portland.

Pre/Postnatal Case Management Program for Women and Infants, Jefferson County Health Department, Madras.

Vital Links, Jackson County Health and Human Services, Medford.

START (Support, Treatment, and Rehabilitation Team), Oregon Health Division Projects in Multnomah and Deschutes Counties, Portland and Bend.

New Start: Drug Free Beginnings for Moms and Babies, Sacred Heart Hospital, Eugene.

ADAPT (Alcohol and Drug Abuse Prenatal Treatment), Multnomah County Department of Community Corrections, Portland.

Project Cradle, Washington County Health Department, Hillsboro.

Model Project for Drug Free Mother and Infants, Clackamas County Mental Health, Oregon City.

SAFE (Substance Abuse Family Evaluation), OHSU, Portland.

Project Network, Emanuel Hospital, Portland.

These programs served many diverse clients, including European Americans, intercity African Americans (Project Network), Native Americans (Jefferson County), incarcerated women (ADAPT), and adolescents (Teen Parent Connections Project). Two projects, SAFE and Vital Links, have ongoing non-Federal funding while the rest are Center for Substance Abuse Prevention (CSAP) demonstration grants. Two of the grants ended in 1993 with the programs continuing within the sponsoring agencies, while the remaining 6 will end in 1994, 1995, or 1996. Because of the wide diversity of the programs and the 5 year limitation of the CSAP funding, the investigator elected to interview all 10 managers instead of selecting a sample of programs to study hoping to represent that diversity. The CSAP programs sent semi-annual reports to their federal funding agency, while SAFE and Vital Links had their own evaluation processes, and were accountable to their respective funding agencies.

Data Collection and Management Procedures

An introductory letter was sent to each program from the Health Division's Coordinator for Alcohol and Other Drug Abuse introducing the student researcher and explaining the purpose and plan for the study. Evaluation reports for the previous year were requested from each program to provide background material for identifying service system characteristics, program components, staffing, and demographic characteristics of clients such as age, race, income, housing, drug use, and pregnancy outcome. For the CSAP grantees, requested materials included the semi-annual reports that

contain (a) a narrative summary describing program highlights, accomplishments and changes, (b) a management plan identifying goals, objectives, activities, milestones, and (c) the Management Information Format providing a quantitative summary of demographic characteristics of the clients. The letter was followed by a telephone call from the researcher to schedule interviews.

Two interviews were conducted with each program manager, the first in person and the second by telephone. The initial interview was a 2 hour face-to-face interview with each program manager to clarify previously described evaluation materials and to address the four research questions in an open-ended question format. The interview schedule (Appendix A) was developed from discussions with the Coordinator for Alcohol and Other Drug Abuse, responses to a survey conducted by her about programmatic strengths and weaknesses (Nathman, 1992), and a review of the literature.
Interviewing techniques as described by Spradley (1979) were utilized to facilitate topic exploration using descriptive questions. The initial broad, grand tour question and more focused questions, respectively, were,

(a) Describe to me the women that you serve.

and the more focused questions,

(b) Tell me about how your program has been effective and how it has not been effective in reducing perinatal substance abuse and improving perinatal outcomes.

(c) Describe how the delivery of client services are integrated within your resource environment.

(d) Describe your vision of an ideal perinatal substance abuse program. Imagine that the resources you want are available.

Exploration of subtopics continued with mini-tour questions, (Tell me about your clients' backgrounds), example questions (Give me an example of

stigmatization), experience questions (Have you experienced conflict among the staff because of differences in philosophy?), and questions encouraging the use of "native" language in the discipline, (Tell me more about "talking the talk"). Their categorized first interview responses and the second interview questions were mailed to each informant (Appendix D). Interviewees were contacted by telephone for a second 30 to 45 minute interview to respond to selected claims, concerns, issues and questions raised by other managers, the investigator, and her advisor, thus forming the beginnings of a hermeneutic circle as described by Guba and Lincoln (1989). The telephone interview was also used as a member check to verify researcher constructions and program characteristics.

The proposal was reviewed by the OHSU Human Subjects Committee to ensure that participant rights were protected. Each respondent signed a consent form (Appendix B) giving permission to use the interview content in the final case report. The interview data were used anonymously, and interview field notes and reconstructions were identified by program and code number only. However, since managers were acting in their official capacity in contributing to a report for the Health Division, no attempt was made to disguise program data.

Previous program evaluations were collected in November and December of 1993 and January of 1994. The initial interviews and ongoing data analysis began in December of 1993 and were completed in February of 1994. The categorized interview responses and questions for the second interview were mailed in March, and the second interviews were conducted in March and April, 1994. One informant, due to scheduling difficulties, responded in writing to the second interview materials.

Analysis

The data were recorded as field notes, and reconstructed, categorized and analyzed with the assistance of the word processing and spreadsheet software programs, Microsoft Word and Microsoft Excel. Analysis, as described by Lincoln and Guba (1985), involved (a) encoding units of data into categories, (b) comparing new data applicable to each category, and (c) defining properties of and reorganizing categories. Microsoft Word was used to categorize the units of data from each interview. A paper copy was color coded and divided by categories. Categories were compiled and reorganized across interviews. Microsoft Excel was used to create a matrix for each category which identified summarized data by program. Member checks, the testing of categorizations and interpretations with the interviewees, were employed to enhance credibility, which is parallel to internal validity in the positivist paradigm. Periodic peer debriefing, the testing of categories and interpretations by a colleague not involved in the study, as well as advisor review, also enhanced credibility. Dependability, which is parallel to the positivist criterion of reliability, was documented with an audit trail that included organizing and maintaining 6 types of information (Lincoln and Guba, 1985), (a) raw data (field notes, documents, program evaluation materials), (b) data reduction and analysis (write ups of field notes, summaries, theoretical notes), (c) data construction and synthesis (categories, matrices), (d) process notes (methodological, trustworthiness), (e) intentions and disposition (proposal, personal notes, expectations, and (e) instrument development (drafts of the interview schedule and the demographic and program information format).

Results

The case report of perinatal substance abuse programs is organized according to

(a) program characteristics,

(b) informant characteristics,

(c) client characteristics and manager claims and concerns regarding clients, and

(d) claims, concerns, issues, and visions regarding program implementation, influencing client behavior, availability and accessibility of resources, integration of services, and further visions for future programs.

The analysis of the interview data comprises the main body of the report. The analysis focuses on joint case constructions where there is consensus and an exploration of contextual differences among programs where there is variation. Included is background material from semi-annual program reports for CSAP grantees and the available evaluation reports from the two other programs and CSAP grantees (Appendix C). Information gathered from the Management Information Formats on client characteristics was found to include too few clients to be representative, and was, therefore, not used. Matrices identifying program characteristics were developed and explained. Data from individual substance abuse programs, chosen to illustrate scope and saliency, present in greater detail the perspective of the individual program manager.

The perinatal substance abuse programs were diverse in character, with the majority of clients sharing the commonalties of childbearing, risk factors for or actual substance abuse, poverty, and disturbed family systems. Additional themes emerged around the topics of reaching women of color, program development, staff, team collaboration, burnout, introducing and sustaining recovery, housing, child care, transportation, alcohol and drug treatment, mental health counseling, family treatment, educational opportu-

nities and job training, smoking cessation, and other services. Integration of services was accomplished through case management, networking, and education of service providers, a time intensive, and sometimes, frustrating process in the fragmented resource environment. Visions for the future centered around building on current programs to facilitate the provision of services. There were decreased perinatal substance abuse and improved outcomes among most program participants. Less than half of the women referred who were determined to need alcohol and drug treatment actually enrolled in treatment programs. With intensive services, some of the program participants were able to redirect their lives. Long term outcomes were unknown.

Program Characteristics

All of the programs were involved in the provision of services and assistance in accessing services for women who were at risk or actively abusing alcohol and other drugs during pregnancy, postpartum or while parenting young children. There was considerable variation among programs, making it difficult to categorize them by more than one variable at a time. One of the programs, Teen Parent Connections, was unique in that it was primarily an alcohol and drug education and assessment resource for all women served by a group of teen parenting agencies. The program had additionally implemented 2 pilot treatment groups. With the exception of Teen Parent Connections, perhaps the most significant distinguishing factor was the presence or absence of alcohol and drug treatment within the program.

Programs ranged from 2 1/2 to 5 years in duration with one half of them in their fourth year of operation (Table 1). One half were urban, three had characteristics of both urban and rural, one classified itself as suburban and rural, and one was rural. The rural Jefferson County program was char-

acterized by a smaller, less complex, and more informal service environment, in which not all resources, such as residential alcohol and drug treatment, were present locally. Four programs enrolled only pregnant women, while six enrolled both pregnant and postpartum or parenting women with young children (Table 2). Half of the programs served both women with risk factors for substance abuse as well as those with active abuse problems. Risk factors varied and included single parenting, low income, low educational level, occasional alcohol or drug use or family history of substance abuse. In three of the programs that served women with both risk factors and active abuse, the majority of the clients were substance abusers. Program capacity ranged from 15 to 60 client families for each program, with six of the programs being at capacity at the time of the first interview. In three programs, services extended from pregnancy through one year postpartum or post treatment. Four were more open-ended in length, such as "until stable," and the rest were of varying duration. The average length of services mentioned ranged from 5 months to 28 months. Infants were often tracked developmentally for one year postpartum, which served as the end point of program involvement for some of the families.

Table 1

Perinatal Substance Abuse Program Characteristics:
CSAP Funding, Duration, Sponsor, Location and Urban/Rural

Program	CSAP	Start Date	End Date	Sponsor	Location	Urban/Rural
Teen Parent	Yes	3/1/91	2/28/96	Tri-Co. Youth Ser. Consortium	Portland	Urban
Jefferson Co.	Yes	7/1/90	6/30/93	Jefferson Co. Health Dept.	Madras	Rural
Vital Links	No	6/91	Ongoing	Jackson Co. Health Dept.	Medford	Urban/ Rural
START	Yes	2/1/90	1/31/95	Oregon Health Division	Portland Bend	Urban/ Rural
New Start	Yes	2/1/90	1/31/95	Sacred Heart Hospital	Eugene	Urban
ADAPT	Yes	9/30/89	11/30/93	Mult. Co. Comm. Corrections	Portland	Urban
Project Cradle	Yes	2/1/90	1/31/95	Washington Co. Health Dept.	Hillsboro	Suburban/ Urban
Clackamas Co.	Yes	3/1/91	4/30/96	Clack. Co. Mental Health	Oregon City	Urban/ Rural
SAFE	No	12/88	Ongoing	Oreg. Health Sciences Univ.	Portland	Urban
Project Network	Yes	9/30/89	5/31/94	Emanuel Hospital	Portland	Urban

Table 2

Perinatal Substance Abuse Program Characteristics: Eligibility, Capacity and Length

Program	Eligibility Characteristics					Capacity	Length
	Pregnant	Postpartum Parenting	At Risk	Abusing	Other Criteria		
Teen Parent	Yes	Yes	Yes	Yes	In teen parent program	Not Applicable	Duration of Program
Jefferson County	Yes	Yes	Yes	Yes		20 - 25	Pregnancy - Treatment
Vital Links	Yes	Yes	No	Yes		50/year	Until child age 5 as needed
START	Yes	No	No	Yes	Illicit drugs only	No Data	1 year post-partum
New Start	Yes	No	Yes	Yes		25	1 year post-partum
ADAPT	Yes	No	No	Yes	In corrections No psychoses	60	Until stable
Project Cradle	Yes	Yes	Yes	Yes		20 treatment plus 25 case managed	Until Stable Infant 1 year
Clackamas County	Yes	Yes	Yes	Yes		15 treatment plus 30 case managed	1 year post-treatment
SAFE	Yes	No	No	Yes		25	Until stable
Project Network	Yes	Yes	No	Yes		30	2 years post - partum

Case management was a part of nine of the perinatal substance abuse programs, with the exception of Teen Parent Connections, where the teen parenting agencies provided ongoing case management (Table 3). Case management is a method of maximizing services while minimizing costs when

multiple providers and agencies are involved with a client. The case manager develops an integrated service plan with the client and monitors progress toward mutually set goals. The manager provides emotional support and assists the client in accessing health care, alcohol and drug treatment, counseling, social services, housing, transportation, education, employment and other services as needed. Four programs used community health nurses (CHNs) for case management, two employed case manager-CHN teams, two used treatment counselors for case management, and one employed a case manager. Client caseloads were most frequently 15 women and their families per full time case manager. Larger numbers of clients were served by the Jefferson County and the Vital Links health department programs, where there was greater variation in the intensity of services.

All programs had individual or group educational components covering topics such as health care, parenting, substance abuse, and family relationships within the programs or as referral services. Community health nursing was provided by six programs, and was a referral service for all clients of the others. One half of the programs provided some form of alcohol and drug treatment, including outpatient, intensive day treatment, and after care; and two programs had funds for treatment. A variety of treatments were mentioned: 12 step, biopsychosocial, and various psychotherapies, ranging in intensity from outpatient to intensive day treatment to residential treatment and after care programs. Some managers viewed Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups as treatment, while others considered them to be support groups. Four programs provided some level of individual mental health counseling within the program, and one had funds for referrals to counseling. Seven provided child care for various aspects of the program, and one had funds for child care. Two programs had their own

housing resources, and two had improved access to housing. Most programs provided clients with bus passes or vouchers, three had vans to transport clients, and one had a car for client transport.

Table 3

Perinatal Substance Abuse Program Components

Program	Case Management	CHN Nursing	Alcohol/Drug Treatment	Mental Health	Housing	Transport
Teen Parent	Teen Agency	Refer	2 Pilot Groups	Refer	HUD Grant 25 Teen Apts.	No Data
Jefferson Co.	Yes	Yes	Refer	Refer	No	Car
Vital Links	Yes	Yes	Refer	Refer	Vouchers	No Data
START	Yes	Yes	Refer/Funds	Refer	No	Bus Tickets Taxi
New Start	Yes	Yes	Refer	Yes	No	Bus Tickets Taxi
ADAPT	Yes	Yes	Refer/Funds	Funds	Transitional	Bus Tickets
Project Cradle	Yes	Yes	Outpatient	Yes	Emergency Incentives	Van
Clackamas Co.	Yes	Yes	Day Treatment	Yes	No	Bus, Taxi Van
SAFE	Yes	Refer	Outpatient	Yes	No	Bus, Taxi Bus Tickets
Project Network	Yes	Refer	Day Treatment	Refer	Assisted Living Transitional	Van

Seven of the ten programs accepted clients who were mandated (required to participate) by the court as a condition of parole or as a condition for custody of their children. Program managers' estimates of the numbers of clients who were mandated ranged from less than 10% to over 90%. Seven of the programs offered case management services to clients regardless of

whether or not they participated in alcohol and drug treatment. The referral processes varied considerably making comparison difficult. However, the majority of the clients referred to programs that had case management apart from alcohol and drug treatment were willing to accept case management services. With the exception of one program with high rate of acceptance of treatment, less than half of the clients who were assessed to need alcohol and drug treatment actually enrolled in treatment. Criteria for completion of treatment also varied, as did the completion rates. In most programs, the majority of women completed at least the first level of treatment, which might be defined as remaining in treatment until after delivery, completing 4 months of outpatient treatment, or completing 90 days of residential treatment.

Informant Characteristics

Eight of the informants were program managers, while one other was the clinical coordinator and the tenth was the case manager. Backgrounds varied. All had bachelor's or master's degrees in counseling/mental health (3); nursing (3); social work (1); psychology and social work (1); management (1); and public policy, planning, and management (1). Two of the managers who were nurses were also direct care providers, and 3 other managers indicated that they had some direct client contact. These dual roles enlarged the perspective of the study to include both that of managers and care providers. Without exception, the informants were found to be cooperative, knowledgeable, committed, caring, and proud of what their specific programs had accomplished. In addition, they all alluded to the job stresses of providers resulting from the complex needs of their clients and the limitations of their resource environments. Each appeared to have invested much time and effort

in shaping the individual program and in forging alliances with other agencies or community groups.

Client Characteristics and Manager Claims and Concerns

The clients of the perinatal substance abuse programs could not be considered representative of pregnant and parenting women in Oregon who are at risk for or have substance abuse problems. These predominately publicly funded programs served primarily low income women who were "in the system," even when higher income women were eligible. There was a further bias toward women who were identified through the criminal justice system, since the courts could provide leverage for program participation. As individuals, the women varied considerably, with not all women encountering the same difficulties. Given the individual differences, there was a surprising degree of similarity in the managers' descriptions of their clients throughout the state.

General Characteristics, Claims, and Concerns

The range of ages extended through the childbearing years, with most women in their mid twenties in the majority of the programs. In the Jefferson County program and Vital Links, the women were typically in their early twenties, while Teen Parent Connections women's average age was 18. The majority of the clients in 9 of the programs were European American, while the clients of Project Network, located in NE Portland, were predominately African American. The other four Portland programs also had a sizable African American minority. Native Americans comprised 40% of the Jefferson County program, reflective of the location of the Warm Springs Indian Reservation within that county. Hispanic and Asian women were present in small numbers across programs. Most of the women were single, and many had another child or children. Sometimes the other children were

in their custody, and sometimes they were not. The Children's Services Division (CSD) was involved with some of the families. The educational level of clients ranged from grade school through college across the programs, with clients, on the average, having dropped out of high school after completing the 10th grade. Project Network clients had more typically completed the 8th grade. Two managers mentioned that the women represented the range of intelligence levels,

> Our clients are really bright in many cases. We have a whole spectrum of IQs. Heroin users are some of the most adept people I've met. Some are developmentally delayed and have major difficulties in functioning. They are very fragile. They are easily influenced by the folks around them.

Another manager suspected that many of the women had undiagnosed learning disabilities. Most did not have job skills and those that had worked had histories of limited employment. Incomes of the majority were below the Federal Poverty Level and many were on public assistance. One informant asserted, "Most are really poor and can't afford to live at more than the subsistence level."

Their families of origin varied, also, but with recurring intergenerational themes emerging. In the majority of families, there was a history of alcohol and/or drug abuse by one or both of the women's parents. Another theme for many was the childhood occurrence of emotional, physical, and "sexual abuse since childhood by their family: father, stepfather, [or] their mother's boyfriend." The ADAPT program, serving women in Multnomah County Community Corrections, was at the high end of the range, with 90% of women reporting parental substance abuse as well as childhood abuse. ADAPT also had many clients who had been raised in the foster care system.

Several managers reported criminal activity in some of the families of origin. Two reported that, generally, the women's families were not supportive and that most had given up on them.

The women had histories of early alcohol and drug use. "Their parents give them alcohol or marijuana, let them drink off the top of their beer, usually in pre- or early teens," stated one manager. Another related, "One woman told me she didn't care that her parents were fighting when she was drinking." Indeed, eight managers described much of the substance abuse in terms of self medication. Women used alcohol and other drugs to "numb physical and sexual abuse [and] poverty. Their families use, so they see it as an option. . . . It's a family-based coping mechanism that they've learned." Another related, "It would be amazing to me if they weren't using drugs. It's a logical step given their circumstances. I think that I would." Drug use also took on social significance and was often a means of affiliating with a sexual partner. One informant added that clients may have had an idealized view of the drug culture, that some sought excitement and viewed drug dealing as an good source of income. At some point, many of these women became addicted. One manager explained that, initially, users experienced euphoria, and, over time, they used just to feel normal again,

> After a while, with heavy users, they don't get very high any more and feel mostly pain. They use drugs to feel normal, non-pain, to be back up where they used to be. They are not having a good time. They are just trying to escape pain. . . . People don't understand this, why they continue to use when their lives are disintegrating. They think that having a good time is more important to them. But that is not it.

The most frequently mentioned drugs of choice, or preferred drugs, were crack cocaine, alcohol and methamphetamines. Alcohol, marijuana, and co-

caine were described as the most frequently used drugs. Cigarette smoking was also common among the women. Several pointed out the varying effects of drugs, "They might use heroin to escape, cocaine to feel sexy, [and] marijuana to 'check out'." Polydrug use was common. In describing the routines of her clients, one manager reported, "They snort meth and then they clean house. Isn't that like women? . . . Then it's 1:00 a.m. and they can't get to sleep, so they use alcohol." Polydrug users may use alcohol as a back up,

> You may have a cocaine user who's not tricking on the streets to get money for cocaine, but she may very well be getting Jack Daniel's at the local liquor store because it's cheaper. It's the most harmful to the unborn baby.

Some women reported that they decreased substance use on their own during pregnancy. "It's not unusual to find that women quit using drugs when they are pregnant. Then our role becomes that of convincing them that they are still at risk," offered one manager. Another related, "Some don't want to stop nursing their babies because they're afraid that they will go back to using drugs." Additionally, managers estimated that from 20% to 75% of their clients had participated in a variety of previous alcohol and drug treatments, with estimates of 50% or more of clients in the Portland programs having received previous treatment (excluding Teen Parent Connections).

Managers described their clients' various strengths as being loving, courageous, wanting to be good mothers, and as being survivors. One manager said, "They are extremely caring, loving people. . . . They send us pictures of their kids, thank you cards, and the looks in their eyes. They try to be soft in their words with us." Another related,

> I see our moms as incredibly courageous. It seems easy when you're looking at it from the outside. What it takes for them to come up here

> on Monday morning: bus pass, baby, baby carrier, food, diapers. Maybe they didn't have any breakfast. The courage it takes to be clean from week to week.

Another stated, "These women are survivors or they wouldn't be alive. They are not often seen that way. Our society thinks of them more in terms of damaged children. They are very strong women, and they have the ability to change."

On the down side, managers described their clients' lives as "crisis oriented", "chaotic", and "out of control." They related that clients expressed various feelings of grief, fear, depression, anger, guilt, shame, desperation, helplessness, and hopelessness. Self esteem was low. Many demonstrated poor social, parenting, and coping skills. They were more likely to respond either passively or aggressively in encounters with people, rather than attempting to problem-solve. One manager related, "Say they paid a bill and the person at the counter says that their records show that they haven't. They'll just say "Oh," instead of producing a receipt. Or else they will get very angry." Many had troubled relationships with men. Some had significant mental illness as well as addiction with which to contend. Many neglected themselves, with resultant health, dental, and nutritional problems. Many also lacked adequate housing, transportation, and child care. Eight managers mentioned that many of their clients had been involved in criminal activities, primarily as a result of illicit drug use and as a way to support their drug habits. Crimes were usually nonviolent, such as theft, shoplifting, forgery, writing bad checks, prostitution; and possession, distribution, and manufacturing of drugs. Teens tended to have the same general characteristics; but, as one manager explained, their "problems are not as great as a 25 year old's that's

done jail time, had several abusive partners, and has health problems." Another reported,

> They come in pregnant and they have used. They are fearful for the outcome of their babies. They have feelings of having no control that are awesome. . . . There is a lot of sadness early in recovery. There is a sense that they have lost all those years of life that they can't recover. Most have been addicts for years. A big loss is the loss of the drugs. Loss of other children to CSD. Loss of family. Loss of worth.

In describing the chaos, the manager further related,

> It is not uncommon for a client to say something like, "Well, Joe was drunk and I couldn't go home. It's happened again. I have no food. I can't go to Mom's. I think I'm going to use." Joe determines her life. Joe has maybe acted out 30 times but she can't seem to get herself out of the situation. She doesn't kick him out. The house usually belongs to the woman, because she has the Section 8 [housing]. Then, if everything is going along okay, she creates chaos because that's the norm. Every day living, such as we might do, is uncomfortable to her. Chaos is comfortable.

"What stands out is the severity of the trauma," another manager related. "And the grief. Dead babies left and right. Miscarriages left and right. Dead gang members. Many had boyfriends who were in gangs when they were using. It's a huge problem. So much grief." Other women experienced anger. One informant said,

> There is a lot of anger at the system for demeaning them. All the hoops it makes them jump through. They are angry at significant others and family for not supporting them when they needed them. They are angry at abusers, particularly sexual abusers. They are angry at los-

> ing their sense of selves, at losing their souls, at themselves. . . . They feel trapped. They have low impulse control, low tolerance for pain. The irritations of daily living that seem normal to us, a grumpy clerk in the grocery store, may infuriate them.

In regard to relationships with men, a manager related, "They define their worth through men," and they were further described as dependent in many cases. Many of the men were also substance abusers. "Out of 150 women, there are maybe 10 that have men that are functional with them," stated another. Many changed partners frequently. Partners may lead the women into criminal activity, and many partners were reported to be violent and abusive to both the woman and her children,

> Women are making desperate decisions. They are choosing partners over the well being of the babies. . . . It happens over and over again. They have a feeling of hopelessness. A feeling that they have to depend on someone to take care of them. They seem to need highly destructive men in their lives.

The most frequently mentioned mental health needs were counseling for sexual abuse and treatment for major depression. Two programs managers also mentioned clients with problems such as personality disorders, schizophrenia, bipolar disorder, multiple personalities, and high anxiety. One manager thought that some clients identified as mentally ill were probably developmentally delayed. The informant from the Jefferson County program encountered mental illness infrequently but was uncertain if this was due to a lower prevalence or the lack of detection.

Parenting was another area of concern. "They have histories of inability to parent, or poor parenting skills," reported one informant. Three manager alluded to this as a parenting deficit resulting from lack of positive par-

enting as children. The women were sometimes neglectful of their children, "With drug use in a disturbed environment, the mother can't be there for the child." Many wanted families. One manager related, "When their kids are taken away from them, I've heard them say, 'I will keep getting pregnant until I can keep my child.'"

Managers acknowledged, but generally did not elaborate on, health problems beyond family planning needs, sexually transmitted diseases, and HIV concerns. This may have been because health services were more accessible than many other services. Additionally, this investigator did not pursue the topic of health due to her own previous knowledge regarding maternal and child health concerns.

Three managers commented on poor nutrition due to appetite suppression by drugs, poverty, lack of knowledge, and the desire to be thin. "Nutrition is a much bigger part of substance abuse than has been acknowledged," commented one manager. "They say, 'I'm too fat, I'm too fat.' Pregnancy reinforces their body issues. They may have eating disorders. They live on cigarettes and Coca Cola. They come in carrying their Big Gulps. They may drink 100 ounces a day." Three managers reported that some women had dental problems related to poor nutrition, teeth being damaged by drugs, and the lack of access to dental care.

Many clients were in transient living situations, particularly in urban areas where adequate housing was the most limited. "They live on the streets, with friends, neighbors, in drug houses, with pimps, [or] jail," stated one informant. Another related,

> The majority are homeless. This is not the same definition as living under a bridge but of not having their own residence. . . . When some of the women come here, they often have a plastic or paper bag of be-

> longings. Some have lost or sold most of their belongings. . . . Some have been evicted. They can have astronomical phone bills and other bills they are running from. . . . They have tapped out their resource system.

Most depended on public transportation, except where it was not available (Madras). In Washington County, clients may not live on the bus lines. Resources were not all easily accessible by bus. Additionally, one manager related, "if you are pregnant with small children, it is so stressful to ride a bus. My clients tell me that it is the most stressful thing they do in a day."

The women did not have resources for child care. One informant said, "When Mom is in treatment, she has to make arrangements for her children. Often, she has sole care for them, no car, no job, no babysitter. She has to handle it all herself." Another related, "They don't have the skills to be with kids 24 hours a day."

African American Women

Three managers mentioned that there was a proportionally higher number of African American women identified as abusing alcohol and drugs due to societal bias against them. Extended kinship was often more important to these women than for their other clients in general. Two informants related that Black women more frequently displayed anger to hide their feelings of hurt and pain. One related that they were often "kicked out" of residential treatment very quickly because they "go off."

Native American Women

In Jefferson County, the case manager found that Native Americans preferred to be treated within their culture, with day treatment and support groups at Warm Springs, as well as a Native American Rehabilitation Association residential treatment facility in Portland. High numbers of

Native Americans in the CSAP substance abuse program initially were due to an unsuccessful attempt at establishing a dual program with Warm Springs during the first year of the grant. The manager indicated that loss of culture, alcohol and drug use, and family breakdown were sources of concern at Warm Springs. Currently, the tribal government was trying to revive tribal ways of parenting in a program called Indian Parent. Native American women seen by the Jefferson County program usually lived off the reservation with Hispanic or European American partners and, because of no transportation, had trouble getting to Warm Springs for services. The manager also related that patterns of substance use seemed to be more related to age among the clients than to cultural background.

Hispanic American Women

Three managers whose programs had links with prenatal clinics that served Hispanic women, alluded to the absence of alcohol, drug, or tobacco use among first generation Hispanic women. While they had no experience to confirm this, they speculated that there might be increased use among younger, more acculturated Hispanic women who had grown up in the United States.

Greatest Needs

Manager responses were varied in regard to their clients' greatest needs. They related that client needs varied according to how the women presented. Although dental care may not be the first priority for most clients, related one manager, it is a priority for a woman with an abscessed tooth. Needs also varied depending on whether the focus was the facilitation of behavior changes, the behavior changes themselves, or the desired long term outcomes. Managers variously identified the greatest client needs as developing a trust relationship, "breaking through denial," "getting off [alcohol and]

drugs," advocacy, counseling to address underlying problems, child care, housing, transportation, parenting resources, increasing self esteem and empowerment, "getting their lives together," developing a long term support system, and education and job training combined with job opportunities.

Program Claims, Concerns, Issues, and Visions

From the first interview on, it became apparent that reducing perinatal substance abuse and improving perinatal outcomes was too narrow a focus with which to address program effectiveness. While maternal alcohol and drug use may significantly harm the fetus, interfere with the woman's ability to care for herself during pregnancy, and, also, with her ability to parent, the broader vision was to replace the intergenerational cycle of destructive living with constructive behavior patterns in order to improve the quality of life for the mother and her family. As one manager put it,

> Pregnancy is a little blip in the reproductive life of women. If we are going to be effective, we need to have long lasting effects. We can do that by broadening the picture to serve the needs of women and families better. Developing parenting and other skills is dependent on their having support systems available. We need more emphasis on GEDs.

Indeed, all informants commented on parts of their programs that extended beyond the perinatal period, pregnancy through 28 days postpartum. Additionally, not all clients were enrolled prenatally, and involvement in most programs, ideally, extended through at least the first year postpartum.

Visions of the managers about ideal perinatal substance abuse programs were generally pragmatic and centered around retention of and building on their current programs to facilitate the provision of more comprehensive services. As one manager expressed it, "What we have is a nice start." In general, managers focused on safe and drug-free housing; availability and

access to appropriate alcohol and drug treatment; services for partners and children; education and job training; transportation; addition of specific categories of staff; and increased interagency case planning and coordination.

Program Implementation

In the area of program implementation, managers commented most frequently on program development, staff, and collaboration claims, concerns and issues. Each will be described in the sections that follow.

Program development. One characteristic of the programs had been a "learn as you go" approach with ongoing change. Eight of the programs were demonstration projects and all were in at the ground level of perinatal substance abuse program development. One manager commented that 4 years ago, there were hardly any programs around, thus providing few models to follow. Program changes had been client driven. In regard to the process, one manager related, "When I focus on the women, then it comes. If I try to control [the direction of program development], then. . . I'm wrong." Many of these changes had involved an increase in the intensity of services. Several examples follow. ADAPT initially made arrangements to refer to day treatment, but found that most of their clients needed residential treatment. New Start targeted women at risk for substance abuse, the recreational user, but found that the referrals they received were for long term addicts who happened to be pregnant. Project Network started out with case management and progressed to providing day treatment. Changes in programs caused difficulties despite their positive intent. The Clackamas County manager indicated that changes were stressful to staff as well as clients. Across programs, staff disagreement frequently resulted from differences of opinion as to the best approach to increase program effectiveness.

Program staff. Programs were implemented with various configurations of professional and lay staff, both paid and unpaid, who contributed in several ways. Six managers identified their staff as a strength. "We have a highly qualified, caring, professional staff. It makes a world of difference," was a typical response. Even so, a manager related,

> One mistake we've made is we didn't have people who knew drug and alcohol. We thought that we could take good CHNs and case managers and that they could learn quickly. There was way too much enabling going on that first year. Addiction is so seductive. You need to be on the same wave length.

Project Network had difficulty finding qualified African American staff. Part of the informant's vision was to have Portland establish itself nationally as a place where professionally trained people of color would want to come. They would like to see the day when their clients would not have to "face the barriers of [both] classism and racism."

One program had been successful in developing volunteer services in the community after not receiving major grant support. This manager came to believe that the use of local community resources was a more effective and efficient way of addressing substance abuse than hiring expensive specialists, such as the alcohol and drug assessment counselor that they had once employed.

Team collaboration. Collaboration with other providers was the key to effective working relationships, both within each program and across agencies. Four of the managers commented that the multidisciplinary team approach increased their effectiveness. "There is both a medical and a social component working together in our program. We come from different disciplines but we all work for the cause." In the rural service environment of

Jefferson County, the concept of team extended across agencies to include all providers involved with a client.

Managers commented on the importance of administrative support, shared goals, development of relationships, communication, open-mindedness, flexibility, and clear expectations as helpful in promoting collaboration. "We have support from the top down," offered one. "There was a common goal right from the beginning." When there were differences, the manager continued, "we have to go back to remember, what is our mission, what are our goals? Then it becomes clear." Another was fortunate to have high level support, but lamented, "We have 5 supervisors. It's difficult to work for that many bosses. . . .The supervisors didn't ever meet. The steering committee members are above them, but the direct line of communication for our staff is to the supervisors." In regard to relationships among staff, a manager commented, "This is really a group of supportive, committed people." One added, "We function like a family." But, as in a family, communication was not always easy, according to another, "We work hard to communicate. It doesn't just happen. We meet every Monday morning and have weekly case updates." One manager stated, "The whole team staffs each and every case. We don't always agree. It can be tiring, but it is necessary." In a program that was attempting to improve communication, the manager thought it could be enhanced by locating all staff at one site.

Many program staff had struggled with developing an open-mindedness and a valuing of each others' perspectives. All seven programs that had teams acknowledged that differing backgrounds had been a source of conflict as well as a strength. Two thought that ego and power issues were involved in conflicts. One manager related,

> One of our counselors is in recovery and has a strong AA 12 step focus. Our parent counselor is a child development specialist by background and has learned the recovery aspect. The drug counselor is more tuned into games and client manipulation. The child development specialist has more of a "never give up" attitude. Community health nurses are more into helping, being non-judgmental. They provide the tools, information for the client to take advantage of. Working through all this has been healthy for our program. It forces us to look at the program. . . .We have to revisit our differences each time we have a change in staff.

Another manager echoed, "Not enabling while helping to decrease use is not real clear. . . . The case manager will say, 'Let's work with this client,' and the nurse will say, 'Let's call CSD'." In another program there was lack of trust between the case managers and the alcohol and drug counselors. To resolve the difficulties, an outside mediator provided education on the varying treatment perspectives and goals. At the same time, the counselors were better integrated into the agencies and began to participate as part of the staff. In another program, a staff member traced the history of each discipline and its philosophy, helping staff to better understand and value each other.

Flexibility was important, also, as one said, "I'm the supervisor, but I jump into the clinical where needed." In another program, "The staff all know each client, and they provide back up for one another if some staff are not there."

All managers affirmed the need for clear expectations. One manager had experienced problems with misunderstandings over roles which decreased their effectiveness in working with clients. Another offered, "We became a team, like a family, with consistency."

Staff burnout. Several programs agreed that staff burnout was a very real problem. Reasons cited were the constant change in the programs, lack of consistent policy, and working with a difficult population. "I feel so alone," offered the manager of a small program. "I belong to a group for the care of the soul. Most of us are providers and we find that we don't take good care of ourselves." Another offered, "We grieve with the clients as they come and go, when they relapse. . . . The staff may be divided, torn. Some may be closer to the child, while others are closer to the mother. It is hard on everyone." Two programs had outside counselors who came in to work with the staff, and a third manager wanted to hire a consultant to counsel the staff. The START program manager related that using a mental health specialist had been "extraordinarily helpful" to staff in handling the stress of working with the client population.

Influencing Client Behavior

"We make a difference by connecting with people when they are vulnerable, finding resources that they need, establishing a relationship, and being there for them in recovery," related one manager. Other program managers would, most likely, include provision of services, such as alcohol and drug treatment. Many times, these tasks were difficult. A manager of a treatment program related, "The overall referrals to the program are what we projected, but we have not been as successful in capturing the women. It is harder than we thought." Indeed, of the women referred to the perinatal substance abuse programs who were identified as needing treatment, less than half participated in treatment. Part of the problem, which was mentioned by several respondents, was the lack of knowledge in the field of perinatal substance abuse in regard to factors that motivate women to use drugs or to end drug use, factors that enable some people to change more easily than others,

the most effective forms of treatment, realistic goals for long term addicts, and the long term outcomes for treatment.

Introducing recovery. Recovery was described by the managers as a process of letting go of denial, maintaining sobriety, and dealing constructively with their life circumstances. Program staff may be the ones to introduce the process of recovery. For women that participated in the programs, getting off alcohol and drugs was suggested to not be the clients' primary motivation for involvement. Several managers considered pregnancy as a "therapeutic window," a time when women felt more vulnerable and motivated to change. Women were concerned about having healthy babies, and they saw hopefulness in a better life for their children. Prenatal care was more readily accepted than alcohol and drug treatment, and the SAFE manager related that clients initially became involved with their drug treatment program because it was part of the prenatal care package in which they were expected to participate. The Project Cradle manager mentioned that being co-located with a prenatal clinic improved their image to that of a helping program. In the same program, women who had declined alcohol and drug treatment were more willing to accept CHN case management when it was not identified as a part of the substance abuse program.

Denial of substance abuse problems interfered with acceptance of services. One manager related, "addiction teaches you to hide. They say you are as sick as the secrets you keep. Admitting to addiction leads to a full confession, that is, sexual abuse, the family history you're hiding. It takes a lot to be ready for that." Toxicological urinalysis was found to be helpful in documenting substance use and cutting through client denial. The same informant related she had an advantage in being able to tell women in denial that no amount of alcohol and drug use was safe during pregnancy. Some women

maintained that they hadn't used during pregnancy and were hard to convince that they needed treatment. In general, managers thought that use did decrease during pregnancy, but that relapse was common postpartum.

Over half of the informants commented that the stigma against pregnant women who use drugs impeded disclosure and treatment, with women being held to a higher level of responsibility than men. One manager called perinatal substance abuse the "witch hunt of the 90's." Another lamented,

> We do not accept women as humans with needs. . . . You don't hear men being called barflies and sluts. . . . Almost all families are affected by alcohol and other substance abuse. Sometimes, it is very difficult to get into an objective mode when you are in denial about the drug use around you. Caregivers need to take care of their own issues first.

Three managers commented on the attitudes of hospital nurses, such as making negative remarks, not allowing the mother to breast feed or care for the infant even when she had been abstinent during pregnancy. For this reason, being identified as a participant in a perinatal substance abuse program at delivery had been very stressful for some clients.

One of the key issues in the effective recruiting of clients was establishment of a trust relationship with each client as a means of engaging them in the program. One manager pointed out that trust and disclosure may be quite difficult for women if they have used isolation as a coping mechanism. "We don't take a wheel chair from a cripple, but we expect these women to give up their isolation." Managers identified the most important factors in establishing an effective client provider relationship as valuing, listening, nurturing, finding resources, advocacy, as well as clear and consistent expectations and limit setting, to foster client accountability and responsibility. As one manager explained, "Our women haven't gotten nurturing and atten-

tion. They've been given money, but no one has helped them deal with the pain." Another reported, "You have to be out there, you can't hide behind your professional face and [yet] get involved. They need warmth and realness, real caring." In describing home visiting, a manager related,

> When I see a client, I focus on being present with this woman, within this moment, keep presence. . . . My question is, "What do you need?" I look around at the awful walls, the concrete floor, and she says, "What I'd really like to have is a blanket to hold to make the baby seem real." Now, I can help her with that. I ask her, "Where do you get your strength?" Not, "How can I empower her?" They are surprised by the question. One woman tells me she likes poetry. I never would have guessed. I bring her poems to read. They like to do for others. I ask "What brings you joy?" Maybe it's helping out a friend. I encourage to them to volunteer where they can. I ask, "Are you safe in your home?" I get responses like, "Are you kidding?", "Oh?", "Safer than I used to be." I ask how? "My old boyfriend used to hit me in the gut and this one only hits me in the face." I tell them, "You are a wonderful mother and you are doing your best." They really light up. No one tells them that. Some say, "Thank you." [On the other hand,] I don't tell them how strong they are because they need permission to be weak, to be needy. No one values them. I point out what they have done. I tell them that I look forward to seeing them again. The message I am trying to convey is one of "you are not alone." That is the first stepping stone out.

Finding resources was a particularly important part of recruitment and retention in that the client's multiple problems needed to be addressed to facilitate participation. The woman's living situation was often a barrier to re-

ducing substance abuse, and child care and transportation were often barriers to program participation. Additionally, clients needed various health care, alcohol and drug treatment, counseling, and educational services in order to begin and sustain lifestyle changes.

Several managers also mentioned the importance of their role as advocates against discrimination based on substance abuse, sex, race, parenting status, and sexual orientation within their agencies, across agencies, and in the community.

Clear expectations and limit setting also contributed to establishing trust and safety in a group setting, as one manager experienced,

> We thought we needed to do whatever it takes to keep these women in treatment. . . .We weren't holding the women accountable. They would miss groups, fail to do homework and there were no consequences. We compromised the integrity of the treatment groups. There was a shift in thinking. The counselors wrestled with rules and what would be required so that the expectations would be clear and consistent, with the intended long term impact to be that [when] the groups encourage follow through, safety, [and] trust, . . . more work will be done.

The majority of the programs cited education as an area of success that was perhaps difficult to measure in terms of outcomes. The Teen Parent Connections program, which is primarily a prevention program for at risk teen mothers, increased the mothers' knowledge of alcohol, drugs, and family relationships. The START manager identified health, nutrition and drug education as a successful component of their program in helping clients make decisions. New Start had been successful in it's individualized approach to education that included videos and games. ADAPT and Vital Links had

comprehensive educational programs in the jail. ADAPT had made presentations to 3,000 women on health, parenting, and getting off drugs. All programs had access to parenting instruction or classes (see Family Treatment).

Several managers also found that clients who were mandated to treatment through the courts as a term of release, or in order to have custody of their child, were more motivated to begin and continue in the programs. "What we know is that when they don't have much choice, they stay in the program," related one manager. "When Corrections, CSD, Juvenile Detention are involved, we have higher hopes. We have more success stories. The moms get cleaned up," asserted another.

ADAPT, who had completed their grant, came to several conclusions regarding recruitment and retention within their program. They found that clients who spent a longer time in the stable environment of the jail had a higher alcohol and drug treatment completion rate. "This containment combined with the pregnancy, detoxing process and confrontation of their disease, created, more often than not, a highly motivated individual" (Multnomah County Department of Community Corrections, 1993, p. 5). All woman within the jail received a health screen that addressed pregnancy status and were given a pregnancy test within the first 2 weeks, which detected an additional 20% of pregnancies. The alcohol and drug interventionist performed intakes and assessments on all consenting women who were pregnant with a history of or current substance abuse. Clients received prenatal and pre-treatment counseling while in jail. Clients were hand delivered to residential treatment and were under constant supervision in an emergency shelter if a treatment bed was not immediately available. They attributed retention success to discharge planning before release from jail and again, before release from treatment, addressing these vulnerable times for relapse. They found

that having all the staff use the language and tools of recovery with clients, such as the 12 steps, questioning clients as to their plan and their excuses, helped create consistency and foster trust. Additionally, involving all ADAPT staff in case planning helped to create cohesion and support for one another, preventing clients from dividing the staff. Three other program managers also stressed the importance of including all staff in case planning.

Programs used various incentives to recruit and retain clients in their programs. Involvement in substance abuse treatment worked as a housing incentive in Washington County by "bouncing clients to the top of the list" for Section 8, thus decreasing a 2 year wait for a certificate to 6 months. The Clackamas County program picked up clients for the intake interview and presented them with a basket of items for the woman and the child. New Start gave gift certificates for the clients and their babies at 3 and 6 months, delivery, and graduation. ADAPT and Project Cradle had discretionary funds to assist with personal or family needs, which one manager asserted, "may make the difference with some clients in sticking to the program or returning to criminal behavior."

The Project Network coordinator cited several factors that contributed to their effectiveness with African American clients in a day treatment setting. They employed a staff that was 60% African American that helped to serve as role models. Network staff included women in recovery from the area who had "turned their lives around." Project Network allowed for the women's anger and found ways to confront it, without tolerating abuse. They also worked to replace racism with self-awareness, sensitivity, and respect for cultural diversity among their staff and women clients. A part of this effort was the Rainbow Group, an ongoing part of the treatment modality which celebrated cultural diversity, and explored origins of cultural values, behav-

iors, and racism from historical, political, and social perspectives. The African American clients also responded to the expression of their culture in the treatment setting through means such as the including of familiar foods (barbecue, greens, "Red Hot" Louisiana hot sauce, for example) and music; supplying grooming aids, such as hair grease and picks; the celebrating of culturally affirming holidays, such as Martin Luther King Day and Kwanzaa; and allowing women to adjust the thermostat upwards.

Sustaining recovery. Policy makers have focused on pregnancy because of concern for developing babies, one manager related, but "the big picture is, how can we keep families in recovery?" Two of the managers reported that the longer clients remained in treatment and after care, the more likely they were to remain in recovery. One conjectured that effective treatment really takes about 2 years. Another related, "The staff work with multiple needs. Treatment has to be the priority. Clients make excuses. We have to remind them that treatment comes first, finish your treatment." Several managers mentioned that urine toxicologies have been effective in keeping women accountable and in recovery.

After the baby is born, it may be more difficult to sustain recovery. Two managers focused on parenting as a motivation. "We tell them that they need to stay clean and sober to be involved in parenting, stimulating their babies' growth." Three managers referred to a parenting deficit that many clients have. They can't parent themselves or their children because they haven't received positive parenting. Through reparenting, they developed a wellness program for themselves that may include affirmations, meditation, and learning how to take good care of themselves.

Additionally, clients were able to progress when they were able to develop a sense of there own power and capability. As one manager described it,

> they deal with the painful issues in their lives and realize that they are capable of going beyond the past. They make choices to deal with the abuse and realize that they don't need to continue the cycle. There is an attitude shift. . . . Something clicks for them. It's a part of their development.

Programs fostered empowerment and a sense of capability by providing positive reinforcement for small successes, such as getting up in the morning, getting the children ready, or keeping an appointment book. They supported the women in making decisions and following through. They served as role models for the women, and worked with them on building cognitive skills in areas such as problem-solving, strategizing, and parenting.

Most managers mentioned the importance of personal support groups in the development of an ongoing system of contacts to sustain the recovery process and either required or encouraged client attendance. These included Alcoholics Anonymous, Narcotics Anonymous and anger management groups. The groups helped clients establish a link with the community that remained after drug or alcohol treatment had ended. "The single most important thing is that you can't do it alone. . . . I ask everyone if they have a sponsor," related one manager. "They can't depend on me. I'm not available 24 hours a day. Sponsors care." In Jefferson County, there was no women's support group that was available to most of the clients. The manager hoped to start such a group using the feminist 12 step model.

Another related, "They can learn from [persons] other than agency people, a clean friend, a mentorship program. . . . Someone who can watch

the kids. Someone who can tell them to 'knock it off,' stuff that good friends do. These women have never had a good friend." Although New Start was involved in a Parent Friend program that matched up parent mentors with new mothers, it did not work with their clients, the manager concluded, because of their greater need for recovery support and the presence of the social worker and CHN as support people in the women's lives. In the future, the manager wanted to recruit Parent Friends who were also in recovery to work with the clients when they transitioned out of the New Start program. An area coalition of family service providers was also applying for a Healthy Start grant to dovetail with their program and others, which would use paraprofessionals to work with at risk first time parents until the child was 5 years old. Currently, the manager found that "clients receive intensive services, and then it drops away."

Several programs asserted that substance addiction was a often a chronically relapsing disease and that their programs were effective by providing support to get women back in recovery and by helping them learn from relapse. Getting off drugs and alcohol and making lifestyle changes occurs in stages, related one manager, "2 steps forward, 1 and 1/2 steps back." Relapse was often related to a sense of hopelessness and the feeling that their lives were not going to change. It might have been preceded by irresponsible behavior characteristic of when they were abusing, such as not paying the bills. Relapse was more likely to occur after delivery when the motivation for staying clean and sober was reduced. Other triggers included problems with relationships with the men in their lives, their partner's using behavior, and memories of sexual abuse. Transition times such as weekends and release from residential treatment are also times of increased vulnerability. There was a growing recognition of the need to applaud small successes. "If they've

used every day since they were 12, then 3 months of clean time is 'success'," stated one informant. Relapse is traumatic to people who have been in recovery. Programs were effective in helping women to identify relapse triggers and barriers in their lives to remaining clean and sober. They taught or reinforced other methods of reducing stress and helped clients identify plans for dealing with stress.

Data collection and analysis. The majority of the programs had not yet analyzed their data, and those that were CSAP grantees would do so at the end of their funding. Six of the programs employed urine toxicologies to monitor drug use, and eight were tracking birth outcomes. The majority of the programs also tracked the growth and development of the babies for 1 or 2 years. The START program was using an experimental design with random assignment of referrals to either a control or treatment group.

ADAPT, who had analyzed their data (Finigan, 1993), divided clients into 3 groups, (a) a comparison group that received some services but less than the basic services, (b) a basic services group that completed alcohol and drug treatment intake, and had at least 2 CHN visits, and 2 case manager visits, and (c), an intensive services group that had basic services plus at least 1 intensive service. Intensive services included program graduation, a specified number of CHN or case manager visits, and completion of the initial alcohol/drug treatment program. Analysis found an increase in birth weight, an increase in gestational age, and a decrease in positive infant urine screens at birth as the intensity of services increased (Table 4). Also, in the comparison group, 14% of the infants were both under 2500 gms. (low birth weight) and less than 38 weeks gestation (pre-term), as opposed to 6.7% in the combined basic and intensive services groups.

Additionally, women in the intensive services group, at termination, had fewer new arrests and parole violations; had fewer unmet needs for food, shelter, and income; were more likely to be in stable living situations; were more likely to have custody of their infants; and were less likely to be involved with CSD.

Table 4

ADAPT Program Birth Outcomes by Service Group (Ending 11/93)

Groups	No.	Average Birth Weight	Gestation	Positive Infant Urine
Comparison	129	3042 gm.	38.7 wks	45.7 %
Basic Services	69	3227 gm.	39.2 wks	23.3 %
Intensive Services	99	3310 gm.	39.3 wks	13.0 %

The ADAPT manager expressed concern regarding lower birth weights among African American women in their program and how to better reach them. In the final program evaluation, when they controlled for the number of CHN visits, case manager visits, and prenatal appointments, the difference in birth weights between African Americans and European Americans disappeared, emphasizing the importance of prenatal client contact. African American women averaged 6 fewer CHN visits, 6 fewer case manager visits, and 2 fewer prenatal appointments than European Americans.

Initial findings in the SAFE program suggested that half of the women were abstinent after entering the program, one fourth significantly reduced their use of alcohol and other drugs and, in one fourth of the clients, there was no change in usage. Their perinatal outcomes have been equal to that of the general population. In initial findings of 50 infants born in the Project

Cradle program, 88% were born drug free, and the average birth weight was 3455 gms. Four other managers concurred that their clients had significantly decreased substance use, and that birth outcomes were better than what could be expected for this population without intervention. Three programs received the majority of their client referrals postpartum, too late to reduce the impact of maternal drug use on the developing fetus.

Availability and Accessibility of Resources

The availability and accessibility of needed resources and appropriate services was central to decreasing alcohol and drug abuse. The resource limitations that managers most frequently identified were safe and drug-free housing, appropriate alcohol and drug treatment, services for partners and children, education and job training, and interagency case planning and coordination. Lack of adequate housing, child care, and transportation were barriers to program participation. Housing, alcohol and drug treatment, and mental health counseling were central to behavior change. Without addressing family issues, as well as offering education and job training opportunities, it was unlikely that lifestyle changes and recovery would be sustained.

Housing. Problems with housing, spontaneously mentioned by everyone interviewed, were considered to be one of the most important unmet needs, with the exception of Jefferson County. Safe, drug-free housing was described as "tight," at a "crisis level," or "almost impossible to find" in all areas. As one informant described it, "You can't stay clean and sober without a roof over your head." Publicly subsidized housing in Portland and Washington County had at least a 2 year waiting list, Eugene had at least a 6 month waiting list, and Madras, where 60 new units had recently been built, had a waiting period of a month to 6 weeks.

Programs addressed the housing issue in a number of ways. Where there had been no teen parent housing before, the Tri-County Youth Services Consortium obtained a HUD grant for 25 apartments to start in February of 1994. The Vital Links manager in Medford convinced the local housing authority to give the program 15 vouchers. "They have a hard time with drug addicts, too. I told them that you deal with them anyway. Wouldn't you rather deal with those in recovery?" This program also had FEMA grants for emergency housing. Two Portland area programs, ADAPT and Project Network, had transitional housing that they case managed. Additionally, ADAPT had emergency housing at the YWCA, and Project Network had a supervised living component with their treatment program. In Washington County, Project Cradle qualified as a self improvement program that "bounced" participants to the top of the housing list, where they could expect to receive a Section 8 certificate in 6 months.

One manager of a program with transitional housing, stated that, while it had made a huge difference for some of their clients, it was "just a drop in the bucket."

> Every single day, 5 of our 60 clients are in the streets, housed at the Y or kept in treatment too long because they have no place to go. Every day I get calls to "Please help me," from clients who have inadequate housing in drug houses, gang affiliated houses where there are shots at night, [and] domestic violence situations.

In Multnomah County, since most women who were in transient living situations were not on the street, they didn't qualify for the Homeless Families Program. Section 8 housing in Multnomah County was not necessarily safe or drug free, according to another informant. If the client requested another location, neighborhood violence was not usually taken into account.

She had the choice of remaining where she was for 2 years while on a waiting list to move or moving and losing her Section 8 certificate.

One program's experience highlighted the need for structured living situations for women in treatment and newly in recovery. The program arranged to place their clients in an apartment complex without on site case management, only to find that the women used drugs, didn't keep the apartments up, and didn't pay the rent.

Eight of the ten program informants included housing in their vision of an ideal program. Four wanted more access to housing, with most wanting access, specifically, to transitional housing where women could remain until stabilized. Three of the five programs with treatment wanted to develop their own housing or to expand their existing housing. One nontreatment program manager wanted to expand to a continuum of housing (residential, transitional, assisted, own apartment, home ownership), as well as to become a treatment program. This manager also wanted emergency housing that was open around the clock where clients could come in if they were tempted to use, for counseling or for sleep.

Child care. Many managers mentioned the need for child care. Single mothers with young children needed affordable child care for most programs, if they were to participate. This included child care for treatment, meetings, after care, probation officer visits, appointments, community service, education, and job training. Most, but not all, of the drug and alcohol treatment settings described, did have child care. Most of the substance abuse programs either funded or provided child care for specific activities in their programs. A few also mentioned the need for respite care, since the women "don't have the skills to be with kids 24 hours a day." One manager would like to use

volunteers for child care. In Madras, child care for young children was reported to be particularly difficult to find.

Transportation. All managers alluded to the transportation needs of their clients, half ranked it as one of the most important needs and half ranked it as moderately important. Most of the programs assisted clients with bus tickets or vouchers. While 3 managers related that taking the bus was stressful, another reported that their clients had learned to use the bus and felt more independent. This program was located close to a transit station. In Washington County, resources were spread out; and even if there were bus service, the clients may not have lived on the bus route. The teen drug treatment facility in Portland was not very accessible by bus, limiting the teen parents' use of that resource. Three of the perinatal substance abuse programs that provided alcohol and drug treatment had vans that could pick up clients for treatment and other appointments. The Jefferson County program had a car and public health nurses transported clients. People living in town walked. They also had a volunteer program through Adult and Family Services that assisted with transportation for specialist appointments in Bend.

Ideally, Jefferson County would like to have a van, the START program would like to have volunteers for transportation, and Project Network, with their planned expansion, would like to have more vans.

Alcohol and drug treatment. Getting off alcohol and drugs was considered by managers to be one of the clients' greatest needs, and improved access to appropriate and effective treatment was a vision of many of them. One half of the programs had their own drug treatment, and at least two others had funds for treatment. According to managers, there was not enough drug treatment in Oregon for all who wanted it. In the past, it was easier for men to get treatment than women. Recently, Oregon laws have changed to give

priority to pregnant women. Access varied according to program and location. Access continued to be an issue for programs with a treatment component since they were "part of a continuum of care in treatment programs," and some clients needed treatment other than what they could provide. Teen Parent Connections found that the 2 teen treatment programs in the Portland area had no child care and had poor access by bus, while some of the other programs had age restrictions. In response to the need, Teen Parent Connections added 2 pilot treatment groups to their program. Jefferson County had no inpatient treatment. Clients had to go to Baker, Bend, Pendleton or the Portland area for residential treatment, depending on their insurance status or CSD involvement. Part of the manager's vision was to develop closer residential treatment, possibly in Prineville. Both Washington and Lane Counties presently had access to what they considered woman-appropriate treatment for pregnant women. ADAPT ensured access by paying enhanced rates for its clients and had not generally had an access problem.

One area of concern voiced by three managers was the need for residential treatment of women on methadone. They reported that most treatment facilities will not take clients on methadone or psychotropic drugs, and the few that do, did not have programs developed for their care. One manager related, "We have only outpatient treatment for them, no residential. . . .They continue to use and chip on the side [do heroin]." Because of the methadone treatment gap, Project Network preferred to detox women on heroin and get them directly into residential treatment.

Several other programs voiced concerns about various aspects of treatment programs. One manager thought that treatment programs needed to do a better job of adapting their programs for women and integrating access

to medical, social, and economic services. Another manager thought that the residential treatment available to her clients was inadequate and could be improved by the development of standards for treatment.

Increased access for pregnant women had resulted in decreased access for others. Women with small children did not have increased access. The ADAPT manager had encountered the unwanted effect of having women call and say, "If I have to get pregnant to get treatment, then I will." Another manager was concerned that the clients' partners did not have access to treatment, an important adjunct to women staying clean and sober.

Mental health counseling. A certain percentage of the women also had mental health problems, or dual diagnoses, that also needed treatment if they were to stabilize their lives. Three of the programs, Clackamas County, Project Cradle and SAFE, employed mental health counselors and were able to provide certain types of counseling. SAFE employed counselors with training in dual diagnosis. Other substance abuse programs had struggled with finding and providing resources for their clients. START reported that public assistance would pay for only 1 counselor, either for drug treatment or mental illness. ADAPT had a limited number of scholarships for counseling, but because of the limited number of Title 19 counselors, they had to force the fit of client to therapy. Because of a lack of mental health services in Lane County, New Start drug counselors were also doing mental health counseling with their clients.

Due to a high percentage of reports about abuse within their families of origin, there was also a need for sexual abuse counseling. Memories of abuse could be a trigger for relapse. Residential alcohol and drug treatment providers were reported to have been reluctant to do abuse counseling, wanting to deal solely with the addiction issues in the first year. Some program

managers related that abuse issues also needed to be addressed earlier. A manager in Portland related that some of the treatment programs were starting to provide sexual abuse counseling. The New Start program manager in Eugene said that most treatment programs in that locality were now addressing abuse issues. She thought that part of the problem had been staffing. Staff that were qualified to do abuse counseling were more expensive to employ. Part of the vision of the ADAPT manager was to have counseling available as needed.

Family treatment. The primary focus of the perinatal substance abuse programs had been women and their young children. Male partners were mentioned primarily in regard to domestic violence and their role in involving women in substance abuse and criminal behavior. Women were supported across programs to end unhealthy relationships with men. "One thing across the board. For those women who have significant others who are using, those who are able to break that link are better able to move on," was the experience of more than one informant. Five managers, however, thought that treatment needed to be more family focused. Two of them related concern that men had been disenfranchised in our social service system, in the way Medicaid was administered. The Clackamas County program wanted a family group which might include partners, parents, friends and teenage children. Project Cradle currently had a monthly family group and, additionally, wanted a weekly treatment group for the male partners. In response to their clients' requests, Project Network was allowing male partners who participated in their couples group to live with women in their transitional housing. The group had helped to legitimize couple relationships, to empower the women, and to involve men in the recovery process. The group was facilitated by the program's treatment coordinator and a probation officer,

who also case managed the men. In the group, they stressed couples' negotiation, the male role, family responsibility, and communication styles. The probation officer involved the men in alcohol and drug treatment and finding employment as needed.

Access to, or provision of, parenting education was considered to be an effective component in all of the programs. The Clackamas County program had a concurrent children's intervention program for children from infancy to 4 years that included hands-on parenting. Three child development specialists worked with the children and a child psychologist saw consults 2 days a week. The manager related,

> The mother and child have an opportunity to play together. They don't know how to play with their children. . . .There is educational time to reinforce positive parenting. . . . Transitions are hard for drug affected children. Mealtime and bedtimes are the most stressful and increase the possibility of child abuse. We use lunch time and nap time to model parenting.

Two of the other treatment programs wanted to expand to do children's intervention. Two Portland area programs reported that services for older children were harder to find.

Education and job training. In addressing education and job training one manager said, "the most useful in the long run would be the ability to earn family living wages so that they could get out of the system and stay out. . . . Women could find hope, if they had access to better jobs and wages. Now they have a sense of futility, like there is no way out." Indeed, managers viewed education and job training as one of their clients' greatest needs but not as the priority, until they were stabilized in regard to recovery, living situations, and parenting. Case managers assisted clients with accessing educa-

tional, life skills and job skills programs. However, one manager suggested, for many clients, staying clean and sober the first year postpartum was probably job enough. One program wanted to have a work prep classes as part of their program which would address self sufficiency, self esteem, work interests, and job education and training requirements. Another manager wanted treatment programs to include habilitation classes. In Jefferson County, a community college branch as well as Youth Conservation Corps job training were available, but the manager wanted more professional training to be available locally. Another program wanted to form a liaison with the community college and bring in mentoring from persons in business. Project Network was developing a mentorship program with Emanuel Hospital, where clients would get on the job training, in such places as the laboratory. Clients and their partners would have to be at least 12 months into treatment before mentoring.

Smoking cessation. Programs with data showed high rates of cigarette smoking among clients, a known factor in the increased incidence of low birth weight infants. There seemed to be an ambivalence among managers regarding this issue. While acknowledging that smoking was a problem, it was not a priority. "We tend not to focus on it," related one manager, and "smoking is one thing that they feel they can hold onto, . . . smoking is part of the treatment ambiance," offered another. The Clackamas County program had added a smoking cessation program and was going to eliminate smoke breaks. They stocked decaffeinated beverages, popcorn, and puzzles, and had started an aerobics class to help with stopping. The Teen Parent Connections and the New Start managers both wanted more emphasis on smoking cessation.

Other services. Vital Links had relied upon volunteer resources developed in the community to increase effectiveness in helping clients to make lifestyle changes, as well as educating and involving the community in addressing the social issues of substance abuse and recovery. Mom's Hope Chest was a free clothing and supply bank for Vital Links referrals that was run by a Jesuit volunteer, with space provided by a local realtor, and the utilities paid by the local Kiwanis. The manager related that her clients tell her that,

> They don't have anything, clothing, furniture, so we've started the Hope Chest. That has done more to decrease abuse than anything. It's safe, warm, quiet, no forms to fill out, free. A safe place. It's not clinical, no nurse practitioners or interventions. There's coffee, something to eat, people who care and are interested in you. Like the neighbor next door. Intimacy. Our community doesn't know much about that. . . . They know that we are there for them, we can help them with money and finding jobs.

The manager further related that the majority of the support came from people who wanted to make a difference. It involved networking with people with resources. Churches played a big part in providing volunteers. They also had volunteer labor coaches who went to the women's homes and coached them when they were in labor, because clients found regular Lamaze classes with "happy" couples "too depressing." The manager involved Southern Oregon State College nursing students in education for women in the jail, and in working on the production of a video project involving interviews with women in recovery to be shown to women inmates. An effective communication tool had been a newsletter, which included writings from

people in recovery, that helped to educate the service community and to provide recovery support for women. The manager related,

> The feedback is amazing, "All my children were just taken away because my urine was drug positive and I'm sitting here reading and rereading this prayer from your newsletter.". . . It goes to the jail. One inmate tore out my name and called. Another found part of the newsletter used as a bookmark and called. It speaks to people.

As an alternative approach, Project Network was participating in a pilot study of the effectiveness of acupuncture in decreasing cravings and withdrawal symptoms. It was a randomized experimental study, with a control group utilizing sham acupuncture points.

Integration of Services

Integration of services was central to the mission of perinatal substance abuse programs. Programs sought to increase cooperation and coordination, facilitate access for clients, smooth transitions, decrease agency barriers in accessing services, and eliminate duplication of services and conflicting treatment plans.

Referrals to the programs. Success with the generation of referrals varied. New Start had effectively educated area physicians and nurses to refer clients. Project Cradle was successfully using WIC screeners to identify those at risk for substance abuse. Some managers, however, mentioned difficulties with referrals of potential clients. One manager of a program that received the majority of its clients postpartum, explained that part of the problem was that physician referrals, which had initially been good, were "down to a trickle." Part of her vision was a more proactive stance and advocacy by physicians. Another informant wanted a more effective program of outreach,

> I have this gut feeling, I don't think substance abuse numbers have dropped. There are other providers, more education on the street to not use when pregnant, or at least 24 hours before seeing a doctor. They show up positive at the hospital, but they have not been in our system.

Part of her vision was to have outreach workers who were trained to do the streets, including low income housing and crack houses. She also wanted to use a van staffed for prenatal care and substance abuse counseling, and stocked with blankets, food, and condoms, to connect with women in the community at scheduled times and locations.

Because of its experimental design, the START program could not recruit, and eventually added a Program Development Specialist to their staff to facilitate coordination of referrals from prenatal clinics.

The manager of Washington County's Project Cradle expressed concern regarding the low number of referrals of Hispanic women. The referring Hispanic health clinic would not screen Hispanic women for substance abuse because the use of alcohol and drugs was culturally unacceptable to women who were new to this country. The manager was concerned that the more Americanized youth might be using, and not be identified. Two managers mentioned that the language barrier and the use of interpreters probably restricted candid communication with Hispanic women. Project Cradle had unsuccessfully tried to recruit a bilingual community health nurse.

Case management. All of the programs used case managers to integrate services. In the case of Teen Parent Connections, the individual teen parenting programs provided the case management. The case managers had frequent contact with their clients, developing plans with them, providing support, advocacy, and finding and facilitating access to services. The major-

ity used some level of home visiting as a tool to increase contact with the client, to aid in the development of the relationship, and to better evaluate family dynamics. The women's lives were chaotic and both the women and their families had a multitude of needs that often crossed jurisdictions of several agencies. Compounding the problem was the fragmentation of the service system. As one manager commented, "women who are not on drugs have many problems trying to function in this system." Case managers and other program staff expended a lot of time and energy trying to develop and implement comprehensive, consistent and individualized plans without gaps and holes that were needed to support recovery in a population that is difficult to retain. This was a source of stress that was apparent in most of the interviews. As one frustrated manager put it, "Who's crazy? Is it us? Or the system? . . . So many people come and go. Sometimes, I think we create more havoc than we heal."

Collaboration and networking. Overriding the frustration was the sense of accomplishment regarding the resource network that the programs have been able to construct. Three managers alluded to high level agency support as a part of their success. To many, another key to success was the task forces and steering committees that had been able to bring together agency representatives to identify common goals, formalize agreements and make policy to facilitate collaboration. The Tri-County Youth Services Consortium was a coordinating organization for youth services that received the Teen Parent Connections grant to place drug and alcohol counselors in teen parenting programs. New Start was involved in a coalition of providers (CSD, AFS, WIC, public health, alcohol and drug treatment programs, parenting education, and a relief nursery) that was writing a grant for a Healthy Start program to work with first time parents who have risk factors. The manager

related, "In the past, we have been in competition with other organizations for money. Now we are working with these organizations to fund bigger projects so there are no big gaps where families can fall through."

Networking had also been essential, with one manager stressing the importance of the case managers having contacts inside each of the many service agencies. Similarly, another manager made a point of identifying one person in each agency, not usually an administrator, who was willing to maintain a relationship and effect the necessary internal changes to facilitate collaboration. Programs had participated in liaison staffings, and had helped to educate the social service environment by holding workshops, networking breakfasts, and sponsoring conferences. Programs also gave community presentations.

Another aspect of integration was sharing resources and expertise. Project Cradle provided CHN follow up for AYUDA, a Hispanic drug treatment center and referral source. The program also funded half of a WIC position, because screening applicants for substance abuse required more of their time. While Head Start provided parenting education for SAFE, both shared a physical therapist, and SAFE acted as a consultant for Head Start, and held workshops for them.

Despite great strides that had been made, communications and coordination were still a problem. One manager lamented that one agency had the client do one thing while another agency required them do another thing. "We don't talk well with other agencies, CSD, even if we work on it." The manager further related,

> [Clients] need a well planned reunification strategy, not just dumping the kids back. All the people involved with the family should discuss it and reunification should be phased in. We have a woman in transi-

> tional housing right now who hasn't parented for years. She has been clean and sober for 1 year. She has 2 of her children with her right now. She knows that she is not ready to reunited with the other 2 yet. CSD wants her to take them in March. She feels it will put her recovery in jeopardy, that she needs to attend more after care meetings, that she will be ready in June. The reunification is set for March.

Another manager complained of territoriality of some agencies and an unwillingness to work together. As a part of their vision, both of these managers wanted multidisciplinary case conferencing and coordinated case management among agencies. Along similar lines, 2 others wanted more overall planning and more agency collaboration.

Integration of services occurred both within and across agencies as some programs provide more services than others. In Jefferson County, efforts supported by the CSAP grant led to a pooling of community resources and the development of a willingness to share. As an example, at a CSD multiagency staffing for a runaway teen with a new baby, the father of the baby's probation officer was contacted at the beginning of the meeting, and was there in 3 minutes. They were able to set up a meeting with the judge for the following week. In contrast, ADAPT within Multnomah County Corrections, had a much more formalized procedure for contact at release from jail or release from treatment to ensure plans for transition were in place.

Three programs alluded to the importance of the presence of their program in the jail in helping the corrections system to address women's issues. The need has been relatively recent, as one manager reported, because there had been an 110% increase of women in the criminal justice system in the last 8 years, primarily due to drug related crimes.

Location. Location also influenced integration of services. Integration was facilitated by several services located together. Project Cradle was co-located with a prenatal clinic where they could provide a cluster of services. SAFE originally referred their clients to alcohol and drug treatment at a different site; but in the 6 months that this program was in effect, not one client showed up for treatment. When treatment services were moved on site there was a dramatic change. As part of their vision, 2 managers wanted one-stop shopping, having the main components of the program located together, while several more described the vision of having their own comprehensive program.

Further Visions for Future Programs

Two of the more comprehensive visions were related by informants from the ADAPT and Project Network programs. The ADAPT manager offered,

> I'd run my own treatment program, with some part of it in the jail. It would be a program that truly "gets" women's issues, and there would be support for the children available, good parenting stuff. Staff would be paid well enough to stay. Counseling would be called in as needed, such as for sex abuse treatment. The care would be ethnically and culturally sensitive. We would have excellent coordinated case management on which there would be agreement. We would use the empowerment model. There would be some safe and secure beds. We have no locked beds unless the client is in prison. Some of our clients tell us that they need that. There would be excellent transitional planning with family and significant others' involvement. We would have a coordinated services worker in lieu of a case manager, they are not cases we are managing. There would be a true continuum of housing,

> from residential treatment to transitional housing, to assisted living, to an apartment, to a house that they own. The program would be supportive of women and children and their relationships. There would be emergency housing 24 hours a day to come to when they feel pressure to use, a place to sleep, or get counseling that would be more than a 12 step meeting. This would be a way to let women in so they don't use and end up in jail. There would be health care on demand, dental care on demand. . . . Then, when a woman is ready to transition, it will be smooth. There will be job skills and self-sufficiency skills available to her. And then there would be no agency involvement.

The Project Network coordinator related,

> Our vision is becoming a reality. We are building a large apartment [and treatment] complex. . . for 21 women and children. We are going to . . . have a developmentally appropriate children's program. We will have several vans. We will have a much stronger outreach with 2 workers that will really be aware of how to access the women. . . . I would like to have an OB-GYN office on site at our complex with a nurse midwife or physician available there to do evaluations. I would like to have a detox bed in the facility, which is part of the plan, with nursing staff, that detox clients could transfer to from the hospital. . . . We need a nurse or health educator that is sensitive to the infant mortality among African Americans, who will be sensitive to their health issues. We project that 75% of our clients will be African Americans. [Another] apartment complex. . . is trying on site management for transitional housing. I would really like Portland to nationally establish themselves as a place where professionally trained people of color want to come.

Last, two managers wanted more emphasis on prevention. One related, "It is harder working with hard core addicts. It takes a long time to make a large difference. . . .We prioritize the most damaged. In order to turn the tide, we have to focus on prevention." Another manager suggested a mentoring program for girls that would focus on valuing and empowering them, asserting, "You can [identify] the girls at risk in the first grade."

Implications and Conclusions

Because of the risk of adverse consequences for both the mother and infant, perinatal substance abuse has become a national health concern. In 1991, a state report estimated that between 5.2% and 11% of women in Oregon used illicit drugs during pregnancy, with additional self reports of almost 9% using alcohol and 24% using tobacco. To address the problem, eight agencies around the state have received Center for Substance Abuse Prevention funding for 3 to 5 year comprehensive perinatal substance abuse demonstration projects. In order for other agencies and policy makers to benefit from the experiences of these programs, as well as those of two additional programs with other funding sources, a descriptive study was undertaken using qualitative and quantitative methodology based on Guba and Lincoln's (1989) constructivist paradigm. Face-to-face interviews were conducted with the program managers to ascertain claims and concerns regarding client characteristics, effective and ineffective aspects of the programs in regard to decreasing substance abuse and improving outcomes, integration of services, and visions for an ideal program. Interview data were compiled and analyzed to develop themes emerging from the data. A second telephone interview with the managers was conducted to validate and further develop these themes across programs.

The analysis suggested that these comprehensive perinatal substance abuse programs accessed or provided multiple services for clients with multiple needs related to childbearing, risk factors for or actual substance abuse, and, frequently, poverty and disturbed family systems within a service environment comprised, primarily, of single service agencies. Establishment of a trust relationship with the provider, detoxification, and letting go of denial were beginning steps toward lifestyle changes, although not necessarily in that order. In general, managers found interventions to be most effective in reducing substance abuse and improving outcomes when they capitalized on the woman's motivation of wanting a better life for a healthy baby. The use of policy incentives and restrictions helped to recruit and retain women in supportive and structured programs that utilized case managers to assist clients in identifying and prioritizing their needs and in accessing services. Development of self esteem, as well as a sense of capability and the power to change were also important factors in decreasing feelings of hopelessness and powerlessness that often led to relapse. In addition to supportive relationships within the program, the development of healthy long term support within the community was also a key factor in sustaining recovery. There was a growing recognition of the need to involve other family members in the recovery process. Integral to supporting behavior changes to end addiction were the availability and accessibility of: (a) assistance with basic needs that were barriers to change, such as housing, financial assistance, child care, and transportation; (b) treatment services, including health and dental care, appropriate alcohol and drug treatment, and mental health counseling as needed to address underlying emotional problems; (c) skill develop in the areas of living, relationships, parenting, and health; and (d) general educational and job training programs in tandem with available job opportunities. The

ultimate goals of self-sufficiency and improved quality of life for their clients were seen as the result of long term sobriety, caring for themselves and their children, dealing constructively with their life circumstances, maintaining healthy support systems, and employment in a meaningful, family wage job.

Managers focused, primarily, on the many initial and intermediate steps leading toward these goals, with both the implicit and explicit acknowledgment that their programs were a valuable, yet circumscribed, response to these multidimensional problems. Program participation generally helped to reduce perinatal substance abuse and improve birth outcomes. The programs experienced moderate success in recruiting clients into alcohol and drug treatment programs, and in helping their clients to redirect their lives. Little was known about the long term outcomes for the clients. Factors that hindered effectiveness were the limited knowledge in regard to promoting behavior change within this population, and the limited availability and accessibility of appropriate services. The resource limitations that managers most frequently identified were safe and drug-free housing, appropriate alcohol and drug treatment, services for partners and children, education and job training, and interagency case planning and coordination.

Perinatal substance abuse programs that served this population were found to be most effective when they had comprehensive strategies in place and a wide array of services available, as needed, over time to assist clients to make lifestyle changes and end substance abuse. Such comprehensiveness may be beyond the scope of any one coordinating agency in the current service environment. Given the multiple problems of these clients and the difficulties of changing addictive behavior, it would also seem expedient to increase interventions in the concomitant areas of social policy, intergenera-

tional poverty and abusive family relationships, as well as in primary and secondary prevention of alcohol and drug abuse.

The depth of this study was limited by time factors, the knowledge level of the researcher in regard to alcohol and drug abuse treatment, and the perspective of program managers, and, in some instances, care providers, as respondents. Pertinent areas for further research include the study of, (a) the perspective of the clients in regard to their needs and the effectiveness of perinatal substance abuse programs to provide primary data from the women themselves; (b) the long term outcomes for program participants, measuring variables such as the former clients' level of sobriety, health status, parenting status, stability of living situation, quality of mother-child relationship, quality of social support system, employment status, and status with the criminal justice system; (c) cost analysis, including both psychosocial and monetary costs, in untreated perinatal addiction verses primary, secondary, and tertiary prevention; and, (d) the characteristics of women in other socioeconomic groups who have risk factors for or actual alcohol and drug abuse problems.

References

Bays, J., (1990). Substance abuse and child abuse, impact of addiction on the child. Pediatrics of North America, 37, (4), 881-902.

Beckman, L., & Amaro, H., (1986). Personal and social differences faced by females and males entering alcoholism treatment. Journal of Studies on Alcoholism, 45, 135-145.

Broekhuizen, F., Utrie, J., & Van Mullem, C., (1992). Drug use or inadequate prenatal care? adverse pregnancy outcome in an urban setting. The American Journal of Obstetrics and Gynecology, 168, (6), 1747-1756.

Brown, E., (1992). Program and staff characteristics in successful treatment. In M. M. Kilbey & K. Asghar (Eds.), Methodological issues in epidemiological, prevention, and treatment research on drug-exposed women and their children, NIDA Research Monograph 117 (pp 395-313). Washington, DC: U.S. Government Printing Office.

Chasnoff, I., (1989). Drug use and women: establishing a standard of care. In D. E. Hutchings (Ed.), Prenatal use of licit and illicit drugs, Annals of the New York Academy of Sciences, 562, (pp 208-210).

Chasnoff, I., Landress, H., & Barrett, M., (1990). The prevalence of illicit drug use or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. The New England Journal of Medicine 322, 1202-1206.

Center for Substance Abuse Treatment, (1993). Pregnant, substance-using women, treatment improvement protocol 2, Rockville, MD: U.S. Department of Health and Human Services.

Coletti, S., Hughes, P., Landress, H., Neri, R., Sician, D., Williams, K., Urmann, C., & Anthony, J., (1992). PAR village, specialized intervention for cocaine abusing women and their children. Journal of the Florida Medical Association, 79, (10), 701-705.

Connolly, W., & Marshall, J., (1991). Drug addiction, pregnancy, and childbirth: legal issues for the medical and social services communities. Clinics in Perinatology, 18, (1), 147-185.

Davis, R., (1989). Teenage pregnancy: a theoretical analysis of a social problem. Adolescence ,24, (93), 19-28.

Department of Human Resources Advisory Committee, (1991). A report of the Department of Human Resources Advisory Committee on alcohol and drug treatment for pregnant users. Salem, OR: Oregon Department of Human Resources.

Feldman, J., Minkoff, H., McCalla, S., & Salwen, M., (1992). A cohort study of the impact of perinatal drug use on prematurity in an inner-city population. American Journal of Public Health, 82, (5), 726-728.

Finkelstein, N., (1990). Treatment issues: women and substance abuse. Cambridge, MA: presentation for the National Coalition on Alcohol and Drug Dependent Women and Their Children.

Finigan, M., (1993). Evaluation of the Multnomah County, Oregon ADAPT Program. Portland, OR: Multnomah County Department of Community Corrections.

Finnegan, L., (1991). Perinatal substance abuse: comments and perspectives. Seminars in Perinatalogy, 15, (4), 331-339.

Finnegan, L., (February 5, 1990). Testimony before the Subcommittee on Children, Family, Drugs, and Alcoholism, Committee on Labor and Human Resources, United States Senate. Washington, DC: Author.

Finnegan, L., Hagan, T., & Kaltenbach, K., (1991). Scientific foundation of clinical practice: opiate use in pregnant women. Bulletin of the New York Academy of Medicine, 67, (3), 223-239.

Gilchrist, L., & Gillmore, M., (1992). Methodological issues in prevention research on drug use and pregnancy. In M. M. Kilbey & K. Asghar, (Eds.), Methodological issues in epidemiological, prevention, and treatment research on drug-exposed women and their children, NIDA Research Monograph 117 (pp 1-17). Washington, DC: U.S. Government Printing Office.

Guba, E., & Lincoln, Y., (1989). Fourth generation evaluation. Newbury Park, CA: Sage Publications.

Kaltenbach, K., & Finnegan, L., (1992). Studies of prenatal drug exposure and environmental research issues: the benefits of integrating research within a treatment program. In M. M. Kilbey, & K. Asghar (Eds.), Methodological issues in epidemiological, prevention, and treatment research on drug-exposed women and their children, NIDA Research Monograph 117 (pp 259-270). Washington, DC: U.S. Governmental Printing Office.

Khalsa, J., & Gfroerer, J., (1991). Epidemiology and health consequences of drug abuse among pregnant women. Seminars in Perinatology, 15, (4), 265-270.

Lincoln, Y., & Guba, E., (1985). Naturalistic inquiry. Newbury Park, CA: Sage Publications.

Multnomah County Department of Community Corrections, (1993). Final report, ADAPT program. Portland, Oregon: Author.

Nathman, J., (1992). Responses to survey on programmatic strengths and weaknesses. Unpublished report.

Office of Alcohol & Drug Abuse Programs, (1993). Presentation to the Sub-committee on Human Resources Joint Committee on Ways and Means. Salem, OR: Author.

Oregon Progress Board, (1991). Oregon benchmarks. Salem, OR: Author.

Rahdert, E., (1993). Case management systems represented in the NIDA-supported "perinatal-20" treatment research demonstration projects. In R. Ashery (Ed), Progress and issues in case management, NIDA Research Monograph 127 (pp 251-260). Washington, DC: U.S. Government Printing Office.

Regan, D., Ehrlich, S., & Finnegan, L., (1987). Infants of drug addicts: at risk for child abuse, neglect, and placement in foster care. Neurotoxicological Teratology, 4, 315-319.

Root, M., (1989). Treatment failures: the role of sexual victimization in women's addictive behavior. American Journal of Orthopsychiatry, 59, (4), 542-549.

Spradley, J., (1979). The ethnographic interview. New York, NY: Holt, Rinehart and Winston.

United States General Accounting Office, (March, 1990). Drug-exposed infants, a generation at risk. Washington, DC: Author.

Appendix A

Interview Schedule

Perinatal Substance Abuse Programs

INTERVIEW SCHEDULE

PERINATAL SUBSTANCE ABUSE PROGRAMS

1. Describe to me the women that you serve.

   Additional questions as needed:

   Tell me about their backgrounds.

   What are their lives like?

   What are their greatest needs?

   Why do you think they are using drugs?

   Some people think they are victims, others think they are immoral. How do you view these women?

2. Tell me about how your program has been effective and how it has not been effective in reducing perinatal substance abuse and improving perinatal outcomes.

   Additional questions as needed:

   Which of the following have been particular strengths or weaknesses in your program:

   funding, other resources, staffing, program implementation, case management, forming supportive relationships, referrals in, referrals to other agencies, A & D assessment, prenatal care, drug treatment, support groups, counseling, education, family treatment, client support system, after care, housing, transportation, child care, job training, financial aid, client attitudes, community attitudes, domestic violence, criminal activity?

3. Describe how the delivery of client services are integrated within your resource environment.

   Additional questions as needed:

   Tell me about how you communicate with other agencies.

   Tell me about what your case managers do.

   How does the location of services influence integration?

   What about access to services?

4. Describe your vision of an ideal perinatal substance abuse program. Imagine that the resources you want are available.

   Additional questions as needed:

   Some people think that there is a need to . . . . . , what do you think?

   (increase funding for pregnant women with children, end dis crimination against pregnant women with children in drug treatment, simplify the system, have family service centers, have family centered treatment, have more child services, have more after care, increase culturally appropriate care, better address socioeconomic needs, increase staff, have more A & D treatment, have more teen treatment, include nicotine addiction in treatment, have CSD be more supportive of families and less an investigative agency).

5. Is there anything else you would like to tell me about the program that I haven't asked?

Appendix B

Consent Form

CONSENT FORM

Mary Lyon, RN, BSN, Graduate Student
Oregon Health Sciences University School of Nursing
24747 NE Prairie View Drive
Aurora, OR 97002
1-503-678-2648

Jill Nathman, RN, MS, Perinatal Substance Abuse Coordinator
Oregon Health Division, Maternal & Child Health Section
800 NE Oregon Street #21
Portland, OR 97232
1-503-731-4684

I give my consent to Mary Lyon to use the contents of this interview and any related communication for the purpose of conducting a descriptive study of Oregon perinatal substance abuse programs for the Oregon Health Division, and as a Masters Research Project for the Oregon Health Sciences University School of Nursing. My participation is voluntary, and I have the right to withdraw at any time without harm or loss. I can withdraw from the study by contacting Mary Lyon or Jill Nathman.

Name_____Date_____

Appendix C

Demographic and Program Information

Perinatal Substance Abuse Programs

DEMOGRAPHIC AND PROGRAM INFORMATION
PERINATAL SUBSTANCE ABUSE PROGRAMS

Code No____Date_____Report period_____

Sponsor(s)_____
Funding_____Start date_____Location_____
Area Served_____Urban/Rural_____
CLIENTS
Eligibility_____
Total caseload_____New clients_____

Pregnancy Status		Stable Employment		Significant Others	
Non-pregnant	___	Yes	___	Yes	___
First trimester	___	No	___	No	___
Second trimester	___	Unknown	___		
Postpartum	___				

Current Employment		Living Situation		Income (all sources)	
Full-time	___	No other adults	___	Below FPL	___
Part-time	___	Adult partner	___	100-200% FPL	___
Unemployed	___	Adult family	___	Over 200% FPL	___
Disabled	___	Adult friends	___	Unknown	___
Homemaker	___	Other Adults	___		
Student	___	Unknown	___		
Unknown	___				

Single heads of households		Medical Coverage	
Yes	___	Medicaid	___
No	___	Other Insurance	___
Unknown	___	Unknown	___
Not applic.	___	None	___

Drugs frequently used					
Alcohol	___	Inhalants	___	Prescription	___
Tobacco	___	Marijuana	___	Other_____	___
Cocaine/crack	___	Methamphetamine	___	_____	___
Heroin/opiates	___	Barbiturates	___	_____	___

Primary language spoken		Children<18 w client		Children <18 not w client	
English	___	None	___	None	___
Spanish-related	___	One	___	One	___
Asian-related	___	Two	___	Two	___
Other_____	___	Three	___	Three	___
		Four or more	___	Four or more	___
		Unknown	___	Unknown	___

Race/ethnicity_____
Age_____
Housing_____
Infant
Complications_____
Other_____

STAFF (title and FTE)_____
_____
_____
Services in other languages_____
Staff from cultures served_____

SERVICES
Service System Characteristics_____
_____
Length of Services_____
Case Management Approach_____

TYPE	DIRECT SERVICE	REFERRAL SOURCES	COMBINED
Case Management			
SUBSTANCE ABUSE			
Prevention			
Early Intervention			
S1-Outpatient			
S2-Inpatient			
S3-Residential			
Rehab/follow-up			
S4-Other sub. abuse			
HEALTH SERVICES			
S5-Perinatal			
S6-Infant/ped.			
S7-Mental Health			
S8-HIV related			
S9-Other health			
SOCIAL SERVICES			
S10-Welfare			
S11-Housing			
S12-Emergency			
S13-Child welfare			
S14-Other social			
S15-Parenting			
S16-Child care			
S17-Skills building			
S18-HIV Services			
S19-Mental health			
S20-Transportation			
S21-Referral Services			
S22-Ed/Vocational			
S23-Employment			
S24-Support services			

Appendix D

Second Interview Forms

Code No.___ Sample Categories Outline

1. Woman
    a. Demographic Characteristics
    b. Backgrounds
    c. Current Lives
    e. Why Using
2. Contexts
    a. Knowledge-Effective Treatment
    b. Resource Environment-Sponsoring Hospital, Housing
    c. Social Attitudes-Middle Class Ignored, Acceptability of Alcohol, African American Bias.
3. Program
    a. Background
    b. Claims and Concerns-Referrals, Motivation, Ethnic Diversity, Treatment: Decrease in Drug Use, Improved Perinatal Outcome, Longer Treatment, Non-punitive, On site, Postpartum Dropouts, Transitioning Out, AA/NA, Tobacco; Multidisciplinary Team: History, Collaboration, Conflict; Housing, Evaluation, Service Integration: Case Management, Comprehensive Services
4. Vision-Comprehensive, Babysitting, Job Training, Access to Residential Treatment, Transitional Housing, Methadone Treatment.

Code No____ Second Interview Questions

1. Clients' Greatest Needs:

Rate each as a **1** (most important), **2** (moderately important), or **3** (least important).

___Get Life Together
___Get Off Drugs
___Increase Self Esteem
___Empowerment
___Counseling
___Child Care
___Parenting issues
___Develop Long Term Support System
___Dental Care
___Housing
___Job Training
___Education
___Transportation
___Other_____

2. What are key factors in establishing effective client-provider relationships?

Y N Gentleness
Y N Nurturing
Y N Valuing
Y N Listening
Y N Mutual Sharing
Y N Finding Resources
Y N Advocacy
Y N Clear and Consistent Expectations
Y N Limit Setting
Y N Accountability
Y N Responsibility
Y N Other_____

3. What percentage of your clients come into your program with entitlement thinking (I deserve to be taken care of because I've been abused and because I am inadequate)? _____

4. What helps these clients develop a sense of capability?

5. What is an example of enabling in your program?

6. What is an example of rigidity in your program?

7. In relationship to the basic components of perinatal substance abuse programs (health care, drug treatment, basic needs assistance, case management, etc.), how important is it to offer the following:
1 (as important), **2** (less important), **3** (not important).

1	**2**	**3**	Children's Intervention Program
1	**2**	**3**	Family Groups
1	**2**	**3**	Couples' Groups
1	**2**	**3**	Partners' Groups
1	**2**	**3**	Sexual Abuse Counseling
1	**2**	**3**	Dual Diagnosis Counseling
1	**2**	**3**	After Care (with counselor)

8. Which of these characteristics have you found to be effective in promoting collaboration both within your agency and across agencies:

___Administration support.
___Shared goals.
___Free communication-the opportunity and responsibility to discuss significant issues.
___Impartiality-recognition that there are many valid perspectives and many useful solutions.
___Cooperation.
___Assertiveness.
___Development of relationship-trust, respect, caring, commitment, support.
___Consensual decision making.
___Recognition of areas of individual competence and shared expertise.
___Division of tasks according to abilities and interests within the framework of the positions.
___Balance between set roles and flexibility.
___Clear expectations.
___Consequences for non-collaborative behavior.
___Revisiting the process as the membership changes.
___Other_____

Program Facesheet

Code No.:
Title of Informant:
Background:
Name:
Sponsor:
Funding:
Start Date:
End Date:
Location:
Area Served:
Urban/Rural:
Eligibility:
Length of Services:

Program Characteristics:

Client Characteristics:
- At Risk/Abusing:
- Pregnant/Not Pregnant when enrolled:
- Voluntary/Mandated:
- Services to those not in treatment/recovery:

Program capacity:
Program at Capacity?
Percentage of referrals that accept case management:
Percentage of clients who need treatment that accept treatment:
Percentage of those who start treatment that complete treatment: