Perinatal Substance Abuse Treatment
Findings From Focus Groups With Clients and Providers

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Abstract—Thirty-three focus groups were conducted with pregnant women in substance abuse treatment and their providers in order to identify factors in women's lives that facilitate and hamper their treatment process and successful program components to address the needs of this high-risk population. The focus groups were conducted as part of a larger evaluation of demonstrations funded by the Health Care Financing Administration. From the 88 women in the focus groups we received a picture of their troubled lives and the events that led to their participation in the programs. The women had difficult childhoods, and currently had weak support networks and difficult relationships with male partners, many of whom were substance abusers. Most had children, which complicated getting into and staying in treatment. However, fear of losing custody of children was a major motivator for treatment. Important components of successful programs included: (a) the development of interorganizational linkages between various governmental agencies, especially child protection systems, prenatal care providers, and substance abuse treatment agencies and providers; (b) outreach and systems for identifying pregnant substance abusers through provider education and routine screening; and (c) intensive case management, necessary to link women to the many services they needed in order to obtain treatment, such as child care, transportation, and housing. Published by Elsevier Science Inc.

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INTRODUCTION
There is a growing body of literature that documents the impact of substance use and abuse by the pregnant woman on the developing fetus (Chasnoff, Burns, Schnoll, & Burns, 1985; Frank et al., 1990). However, in recent years, there is clear evidence that intervention and treatment of the woman's substance abuse problems significantly improves pregnancy and child outcome (Chasnoff, Griffith, MacGregor, Dirkes, & Burns, 1989; National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco and Other Drug Abuse and Mental Illness, 1997). The problem of developing appropriate treatment programs and linking these programs to prenatai care, however, remains.

From 1993 through 1996, the Health Care Financing Administration—the federal agency that administers Medicaid and funds care for poor pregnant women, their infants, and several other low-income groups—funded...
five Demonstrations to Improve Care for Pregnant Sub-
stance Abusers in five states, Maryland, Massachusetts,
New York, South Carolina, and Washington. These
states developed and implemented programs to improve
access to care for pregnant substance abusers by provid-
ing enhanced services and coordinated prenatal and sub-
stance abuse care. The demonstration projects were evalu-
ated by Mathematica Policy Research, Inc. (MPR) and
its subcontractors, the National Association for Families
and Addiction Research and Education (NAFARE) and
Health Systems Research, Inc. (HSR). The purpose of the
evaluation was to assess the outcomes and policy-
relevent lessons of the demonstrations. The evaluation
included both process and outcome analyses.

Data for the process analysis were collected through
site visits that included focus groups with participants
and service providers in each of the five sites. We ana-
lyzed the cross-cutting issues and common themes that
emerged from the diverse state environments and pro-
grams. The purpose of this article is to describe the re-
sults of the focus group discussions and to provide new
insights into program operations and lessons that can
guide the development of improved treatment programs
for substance-abusing pregnant women.

METHODS

Thirty-three focus groups were conducted across five
states and included three types of participants:
1. Program administrators (5 groups)
2. Providers (16 groups)
3. Women participating in the programs (12 groups)

Table 1 shows the number of participants of each type in
the focus groups. There was an average of 8 participants
in each focus group, with a range from 4 to 15 partici-
pants in each group.

The goal of the focus groups was to obtain an inside
view of the characteristics of demonstration participants
and programs. The focus groups were not statistically
representative of the clients or provider staff. For exam-
ple, almost all of the pregnant/postpartum women in the
focus groups were older mothers and were in treatment,
although some of the women in the demonstration pro-
grams were moderate, as well as heavy, substance abu-
users. Thus, although the focus groups provide an under-
standing of the views of selected individuals and
illustrate the range of views in the demonstration, they
may not accurately represent the average view.

The lead demonstration agency in each state assisted in
setting up the focus groups and selecting the adminis-
trative staff and providers. The case managers of the
clinical programs selected the women who would partic-
icipate. The focus groups were conducted as structured
discussions based on a series of open-ended questions.
The focus groups addressed four areas:

1. Client Characteristics. Who are the clients of the
demonstration? How do their characteristics affect
the design and outcomes of the demonstrations?
2. Interorganizational Linkages. What administrative
approaches are instrumental in demonstration success?
3. Outreach, Screening, and Identification. What suc-
cess have the programs had in identifying pregnant
women for the demonstration? What are the key
problems facing the programs in identifying eligible
women?
4. Treatment. What are the treatment interventions?
What is working and what is not working?

The facilitators from NAFARE, led by one of the au-
thors (JJC), guided the sessions through a structured in-
terview format and allowed the interviews to continue
uninterrupted, except to keep the participants on the sub-
ject being discussed. For the focus groups that included
women enrolled in the programs, permission was ver-
bally obtained at the beginning of the session and was
tape-recorded. Assurances of confidentiality and anonym-
ity were provided to all focus group participants. Care
was taken to protect pregnant women from over-
revealing questions or discussion. Each focus group with staff
and with clients lasted from 1 to 2 hours. All sessions
were audio-taped and transcribed. A summary of each
focus group was prepared based on information in the
transcripts and observations of the group facilitators.
Both the summaries and the transcripts provided the ma-
terial for this article.

THE WOMEN

From the 88 women who participated in the focus
groups, we received a picture of their lives and the events
that led to their participation in the programs. Although
not a random sample of substance abusers, the following
background—provided mainly in their own words—
reveals some of the faces behind the statistics on sub-
stance abuse in pregnancy.
Focus Group/Pernicious Substance Abuse Treatment

Substance Abuse History

The women generally had difficult childhoods, which they considered a major factor in their initiation of substance use. They generally began using substances before 10 years of age, the first episode of substance use was accompanied by sexual molestation, the perpetrator providing the alcohol or illicit drug.

My first drug of choice was marijuana, and I was 14. I smoked to fit in with the crowd that I hung with, and it became a habit. I didn't like the after-effects of it, so I looked for something different, and that's when I first tried cocaine. I was sniffing it at first, and then it became a habit. [client]

I started drinking to escape my parents. They were so abusive. The school knew it, but they didn't do anything about it. [client]

I remember being nine years old and thinking everything that was going on in my house was my fault and that the drugs, opium, and lifestyle in my house was OK because that's what my mother did. For so long I thought that lifestyle was OK. [client]

When I was in high school I met this pimp. When I graduated from high school, he took me to New York and put me to work. I got exposed to the life, and I was working the streets. After three or four months of that, I really got scared and called home. My mom sent me a ticket. [client]

Many of the women were struggling with intergenerational issues in which their grandparents, parents, and siblings were ensnared in a substance abuse lifestyle. Incest, rape, and violence were regular components of the women's life histories. The women held low opinions of themselves, and many felt society reinforced their feelings of worthlessness through perpetuating its negative perceptions of drug use in women.

Women go through a lot. They get sexually abused. . . . We do drugs sometimes because of abusive relationships in our past. [client]

It could have been child abuse, it could have been stuff that happened in single-parent homes. Our father not being there. A lot of stuff that we're dwelling on now, you know, that affected our drug use. [client]

A provider described this cycle as typical of the women in their program:

Picture an alcoholic grandmother who has a daughter who is a substance abuser, who gave birth to her daughter who is a substance abuser and alcoholic (our client), who also gave birth to a little girl. . . . There's a possibility that we can break this cycle. [provider]

Significant Others

Many of the participants had weak or nonexistent social support networks. Their families might have been involved, particularly their mothers, in the care of the grandchildren, but by the time the women sought help those relationships had become strained. Their "peer group" consisted of women with drug-using companions. Once in treatment, they often felt rejected by this peer group and at the same time stigmatized by the more stable community groups, such as churches.

The relationships between participants, their male partners, and significant others were complex. In some cases, the significant others were supportive of the woman's seeking help from the program and may have been a motivating influence. More commonly, the significant others were negative influence. Because many women had been involved in prostitution, their male companions often preferred to have them continue to use drugs and earn money through prostitution. In many cases, the women lived in fear of threats from the men, because the men needed them to stay drug-involved in order to control them.

I relapsed three times this summer because I couldn't get away from this man. I think I'm doing the right thing with my drug addiction and my alcohol addiction, but I'm not doing anything with my addiction to him. There needs to be some more education on that. I'm finding this out through trial and error, learning that the best thing for me is to stay away from him. It's hard when your heart's involved. You think it's love, but it's not. It's just another sick addiction. [client]

My baby's father is an addict. He's been in and out of detox seven times since I've been here, and I've been here two months. And my mom drinks, but not when I'm around. I say she's an addict, but she doesn't agree. My father, he's in jail in New York. He's an addict. [client]

After I was sober for a year, I went to a bar. My boyfriend's friend kept saying, "Oh, it's so good, just taste it. Taste it." And I was drinking again from that day on. You need new friends, a new environment. [client]

The minute you go into recovery you are an outlaw. You are no longer down in the crew. You are somehow different, which presents a problem because you lose a support system there. I mean, not that they were the most positive people in the world, but they helped you get high, but you lose a little bit of the neighborhood camaraderie that you used to have. So, it's really important that you have another kind of support system to back you up. [client]

In some cases, people are positive influences.

My doctor told me that my baby was doped. . . . And believe it or not, my ex, the drug dealer, was telling me, "Don't get high, because you don't know for sure. Do not do this, don't let it affect you." Well, you know, if he would have given me the OK, I would have gotten high. They took me to the hospital, and my baby was fine. [client]

Most of the participants in the focus groups had young children, but very often they had lost custody of those children. Keeping custody of the baby from the current pregnancy, as well as regaining custody of other
children, was a major motivating factor for seeking help. At the same time, caring for their children was very time-consuming and often a deterrent to seeking help or stay-
ing in treatment. The guilt that women felt about their substance use and its affect on their children complicated their recovery.

I used, I was afraid, scared. I used to ask God for help be-
cause I knew I was a crack addict and an alcoholic, and I'd say, "God, please help me." I felt really powerless over these drugs and out of control. And it wasn't what I wanted to do. I decided I wanted to have a happy life, but I was so scared about what would happen to my kids. Where would they be? Are they go-
ing to be treated OK? And just the thought of them not being with me kept me out there. [client]

I was in active addiction for the past two years. One of [my children] was born with fetal alcohol syndrome, and the other tested positive for cocaine. I went to the last time to treatment to stay away from child protective services (CPS) so I could keep my kids. My water broke early, several weeks too early. So, I was in the hospital all that time, and they took me to fam-
ily court because this baby was clean but they attributed my early break of the water to cocaine abuse. [client]

I used with both my sons. The oldest one didn't come out positive, but my youngest did, because I used to smoke with him every day. My son was born two pounds, two ounces, half a heart, couldn't breathe. Then I went into a rehab. I was like, "I'm leaving this rehab, because I have to get me another hit." I still didn't want to go visit him because I knew I was at fault. But my mother told me, "Stop blaming yourself, he's going to get better. He is a miracle child for you." [client]

Courts and Child Protective Services

Most of the women in treatment were involved with the court system or child protective services, or both. Often their treatment had been mandated. Indeed, the threat of losing custody of their children or of incarceration were incentives for many of the women to go into treatment programs.

Normally we don’t see the children until after she has deliv-
ered. Pregnant women come to us for eligibility determination for Medicaid, and then we don’t see them again until the baby is born. The hospital then notifies us that we have an addicted baby. Then protective custody normally comes into play, and then we deal with the child after the fact. [provider]

Our involvement usually comes from the hospital if the baby is born with a positive test, when the hotline report is made. Then the social worker will contact my office, and de-
pending on the circumstances—but most of the time—we ask to come in and facilitate a meeting with the staff at the hospital. [provider]

The role of "mandated" treatment by either child pro-
tective services or the court system was a controversial topic among program administrators and providers. Some administrators and providers believed that this punitive approach could be effective in getting women to face their addictions.

When a pregnant substance-abusing mother, no matter what her age is, sees another woman's children being taken away from her because she was using, that flips a switch: "I might lose this child; I'd better do something about this." Most of the time if this person needs to be hospitalized for any reason, whether it's depression or diabetes or some other cause of control, that's usually when the client will say, "Wait a minute, people are checking me out, people are looking at me. Maybe I should go into treatment." [provider]

We can involve Department of Social Services (DSS) in try-
ing to work with the family, to make that person take control of their life and do something. The threat of losing benefits is a very motivating factor in the addictive personality. So it's a very good tool for us to use because it gets them to take control and get involved in treatment. [provider]

Pregnant women also expressed varying points of view.

I have to say this. Mandating is a key to get the women in here. Mandate them. If they're using during pregnancy, and CPS is threatening to take your kids, that's mandating! [client]

Court order helped me to be here. I wasn't grateful that day. How could they do this to me and all that. But after a few days, I became grateful. [client]

I have a sister. I'll get a buck every time CPS came to her house, well, if I was still using crack, I'd have enough to get me a dime [of crack]. They don't scare her. She probably scares them. Her life is work to get high. CPS don't scare her. Mandating don't scare her. I mean, you have to want to do it. [client]

Several program staff stated that stories of the prosecu-
tion of a pregnant woman for substance abuse instilled a fear of discovery of addiction in pregnant women, ham-
pering outreach efforts. Indeed, providers found that the majority of women who did enter a treatment program, entered late in pregnancy. They attributed this late entry to this fear of "being found out," the stigma in the com-
unity against addicted pregnant women, and strong de-
nial on the part of the women, many of whom were not ready for treatment. The extent of these interventions may be exaggerated in the community's mind because of adverse publicity. Staff in some treatment programs found a lack of leadership at the state level for these complex issues. Issues of advocacy and "who is the pa-
tient?" often clouded decision-making.

Both providers and clients indicated that women were reluctant to come for prenatal care if they feared being reported to child protective services (CPS).

I'm sorry, but the down side is that when the word gets out in the community that's going to happen, why bother? Why come to the health center? [provider]

I wanted the baby to have prenatal care, but they get [write checks] all the time. Most mothers that are using don't have pre-
natal care. [client]
If a woman is here today, I can pretty much get her an appointment by the end of the week or sometime next week. The question will be, can we find her between now and then? [provider]

The process can be very time-consuming. It took us a good two days, and by the time the two days were over, it was a Friday. After going through all of that I found out that she couldn’t even go there on Friday, because they didn’t have intake time on Friday. Friday is like a party day for a substance abuser. [provider]

Several program administrators explained that state regulations and paperwork interfere with the delivery of services to pregnant women. The states’ lack of treatment guidelines and the absence of a system of quality control led to a wide variation in the quality of the services being delivered to pregnant women, mothers, and their children.

At the same time, many of the administrative staff and providers saw substantial progress, based on the demonstration effort to improve interorganizational linkages.

We’re working closer with the provider agencies to try to work out a lot of problems that we’ve been encountering in the past. We’ve been visiting them, trying to see how we can be of assistance to make the relationship work a lot better. [administrator]

The entire system is becoming more integrated. I think we’ll see more outreach, more public education, and I expect we’ll see more impact on the system as a whole. [provider]

I think that these kinds of forums, with folks sitting down and saying, “How can we approach a pervasive problem?”—that’s very positive. It may not be happening as fast as the design of the grant says it should happen, but I see this as a major milestone. [provider]

The development of managed care programs also has stimulated the development of linkages.

The environment is shifting very quickly, and so we are actively talking with hospitals and health centers about linkages and how do we build networks and relationships that maintain the value of the recovery spirit. [administrator]

Outreach

Perhaps the most troublesome problem encountered by the demonstration programs was their difficulty in developing effective methods of outreach to pregnant substance-abusing women. Although no program was completely successful in this effort, the insights of several focus group participants helped to identify problems and issues.

Traditional media approaches were tried by the demonstration programs but were generally not effective in reaching the substance-abusing population. Media strategies usually relied on public messages, but these did not reach the target groups because of high levels of denial and a wide range of literacy capabilities in the population.
Anybody that’s been in treatment realizes that [programs] advertise for the noose or the family member. Very few ad- dicted people see advertisements and say, “Gosh, I think that’s me.” [client]

Some programs used prenatal care outreach workers to recruit substance-abusing pregnant women. Though a theoretically workable process, medically trained out- reach staff (who often did not have specialized substance abuse training) did not always have the substance abuse training needed for recruiting women into the demonstration programs. Knowing that a clinic-based outreach strategy missed many women who did not come for pre- natal care, projects also used indigenous outreach work- ers in nontraditional settings. However, these workers confronted many logistical and safety issues while trying to conduct “street” outreach among drug-using women.

The women are out there, and they’re drinking and drugging all through the evening. From eight o’clock to five o’clock they just don’t work, and that’s my hours. [provider]

Using indigenous workers also raised concerns regarding confidentiality and the sensitivity of asking women to disclose their substance use to their neighbors.

I’ll give you an example of one [outreach worker]. The per- son that she was dealing with from the community didn’t want to talk to her, because she felt that her business would be spread about the community. On the other hand, there were some con- nections because this person knew her Aunt Mary. [provider]

Indigenous workers were fearful that if they went into the sensitive issues, that they were going to jeopardize the trust re- lationship that they were trying to build. They felt that trust was paramount to getting them into prenatal care. Although they may have viewed alcohol and drug abuse as a problem, I don’t think that they put it at the top of the list of priorities. [administra- tor]

. Family members may provide this outreach function.

I had initially gotten into a detox because of my mother. She told me I had a problem. She told me she would get me help, and she told me I needed to go into an inpatient program. That’s how I first found out about detox. In my mind my mother had the problem. Having my children taken away from me—that’s when I realized that I did have a problem. [client]

My parents put their foot down, they got to the point where they said, “These are your kids and we don’t mind helping you out, but if you don’t get your act together don’t come here any- more. You ain’t gonna see your kids until you get your life to- gether.” So that was really serious. [client]

A successful program was advertised within the com- munity by those it had helped. Many providers thought the most effective outreach strategy was through word- of-mouth from a substance abuser, who succeeded in treatment, to another substance abuser.

One of the women who was in the program initially re- cruited someone who is in the program now. And that’s grow- ing. You’re beginning to have clients who have gone through the process of giving a clean birth and are now doing some of the outreach just by word of mouth. [provider]

They need to see that a member of their group has gone through your process and has been successful and drug-free. [provider]

Listening to me say how good it is and how beneficial might sound good to us, but we are not substance abusers. So, it sounds better to another substance abuser to hear how you got over these hurdles. [provider]

I think the billboards will help a bit, but I also think that ex- perience is the best way to help another person. . . . a person that has been through it, that’s received the help, an apparent total change, you know. [provider]

Since I’ve been here, I feel a little bit of hope and I see other people that used to be out there using. I see them coming in for treatment. And they look good. [client]

Screening and Identification in Prenatal Care Settings

One of the major goals of the demonstrations was to identify pregnant substance abusers early in their preg- nancies. Two types of screening were used. The most common method was urine toxicology either during pre- natal care or at delivery. Most of the pregnant substance abusers participating in the focus groups were identified through such urine screens. The demonstrations also attempted to identify women through verbal screening. Providers spoke to the difficulty of doing verbal (and potentially subjective) screening.

Sometimes it’s a human characteristic not to want to ask a question to get information if you are helpless to do anything or you have no resources available. [provider]

I have worked with women for the full nine months and never suspected that they were using any kind of substance. I have one in particular—I can remember right now—that I worked with. She came in the second time and we did not sus- pect at all until the baby was born. We saw the weight, and the doctors said there was crack cocaine, and she was caught. And we still did not suspect it. You just cannot tell by the way women act. Maybe some of you can tell, but I cannot, and I have worked with them. [provider]

Women admitted to having avoided identifying them- selves as substance abusers.

I don’t look like the jail type. The doctors believed every- thing I said, even though it was all a lie. They didn’t want to know, and I didn’t want to tell. It’s a simple agreement that protects both of us. [client]

The identification and referral process was more suc- cessful on an Indian reservation in one project area. Three factors were cited as key to this success:

? The Indian Health Service was relatively aggressive in identifying substance abuse, with mandatory on-site
classes for pregnant women discussing the impact of substance abuse on pregnancy.

- The Indian community supported these efforts of the clinics to identify substance-abusing women and get them into treatment services.
- A "wellness evaluation," which included answering questions about alcohol and other drug use, was a necessary step in receiving some services.

Program administrators expressed frustration with the knowledge that physicians had regarding the process and treatment of addiction. Physician training—particularly for the obstetricians who are most likely to identify women early in their pregnancies—was critical but lacking. For example, in one focus group, a participant reported that a recent obstetrics grand rounds portrayed fetal alcohol syndrome simplistically and gave doctors the impression that identification should be the responsibility of the nurse.

Private obstetricians come from private services or are recently out of training. I can tell you right now, it's not up there on top of their mind. They're not very conscious of it. [provider]

I don't know that the obstetricians in the community are sufficiently aware of the problems among all their populations. [administrator]

They say that the younger the physician, the more open that physician is. The older the physician, the less likely it is, because they were not trained or oriented. [provider]

Physicians often were reluctant to refer women to substance abuse treatment programs because they were not in close communication with treatment providers and did not have confidence in the results of treatment.

There's a gap between making the referral and actually seeing the outcome of that referral. [provider]

You don't really have a personal feeling of what the treatment service is. [provider]

However, training for physicians in one site improved identification and referrals, although very few referrals to the program came from prenatal care providers early in the demonstration. This active provider training effort, combined with the use of a standard screening form, increased referrals from prenatal care providers. In that system, mobile outreach workers also provided immediate access to treatment for the women who were identified, increasing providers' confidence that women would receive help once they were identified.

In some settings, there was a high level of frustration and anger directed at substance-abusing women by their doctors. Once physicians identified a pregnant substance-abusing woman, the relationship could quickly become strained. There especially was anger when a woman relapsed. The sheer numbers and demands of this population also often led to feelings of overload. The

women participating in the focus groups substantiated the comments of the staff on the reluctance of physicians to become involved.

...Some doctors treat us funny. We can't be tired, we can't have a down day. They judge us and think we're doing drugs again just because we're not Mary Sunshine that day. [client]

I relapsed, and my doctor told me my baby was dead because I had used. I wasn't, but he was just trying to get me to stop. Of course, it made me go out and find some coke right away. [client]

In summary, the gaps and deficiencies in knowledge about substance abuse affected identification and participation of women in the demonstrations. The demonstration health-care communities generally were not yet fully prepared to actively identify and treat pregnant substance abusers. Mistrust of the substance abuse treatment system, and resistance to becoming involved in patient's substance abuse issues, impeded developing a seamless continuum of care between prenatal care and substance abuse treatment providers. In spite of these problems, program staff noted that linkages to obstetrical providers, once established, were beneficial.

Substance Abuse Treatment

The focus groups revealed both successes and problems with providing effective substance abuse treatment for pregnant women. Ideally, a range of treatment options should be available for pregnant substance abusers in each community. The demonstration highlighted the lack of such a range of alternatives. This lack of a continuum of treatment alternatives made it difficult to match appropriate treatments to women's individual needs. For example, in New York there were no licensed short-term residential drug treatment programs, although there were short-term alcohol treatment programs. In that state also there was a geographic imbalance between the types of programs available. Short-term alcohol treatment programs were readily available statewide, but there were more licensed drug programs downstate.

The states varied substantially as to how they defined various levels of care and there were no clear standards for who should receive each level of care. For example, some referred to detoxes as very short-term (5 days) medical treatment, while others used a definition that in other states would fall into a short-term treatment category.

Over time I've learned the word detox means various things depending upon which state you're talking to. [provider]

States, and individuals within states, also varied in the length of stay that they considered the norm for residential treatment. The following was one person's definition:

- Residential means that you take people away from the community and you put them in a house and you run their life for
them for six to nine months. And then you discharge them to outpatient status. They need to learn how to walk past the liqour store, past the drug dealer, how to manage having money in their pocket and not buy drugs. A residential program allows people to test those things but gives them a safe environment, because the one they were in was violent, abusive, or battering.

Representatives from long-term residential programs thought they were more successful in reaching treatment goals, but the number of beds for this type of treatment was extremely limited. The preference for residential treatment was prevalent, even when its success was not necessarily demonstrated.

It's the client's tendency to want a magic bullet. So they say, OK, do the worst, give me the biggest, give me your best shot. [provider]

Residential programs had several limitations for pregnant women, a major one being the issue of who will care for a woman's children while she is in treatment. Many of the women in the focus groups expressed anxiety about entering a residential program because it meant separation from family, relationships, and children. Few programs allowed women to bring their children, especially if they had several children. Also, historically in many areas, women on methadone could not be admitted to residential treatment.

Some intensive outpatient programs were available to provide some of the benefits of residential treatment. It's a 28-day program where you don't have to stay in the hospital if you don't want to and you get the same benefits as if you were inpatient. [provider]

Right now we have an intensive outpatient program where they come every day from nine to two, two-thirty, or three o'clock. They are placed in services such as group counseling and individual counseling. [provider]

There was disagreement on appropriate criteria for placing women in residential versus outpatient treatment. Most program staff agreed that the decision about whether a woman needs outpatient or residential treatment must be made on an individual basis and with the woman's agreement. However, there usually were no objective criteria on which to base this decision. For example, program administrators in Massachusetts reported that their guideline was always to allow people to sequentially fall at the least restrictive level of care. They generally started at an intensive outpatient level, with provision of comprehensive services. If the woman failed in her attempts at sobriety, residential treatment was available.

Preventing relapse in all programs was a major factor in successful long-term outcomes for mother and infant. Aftercare following completion of the initial outpatient or residential intervention was generally reported to be extremely important, but often unavailable. For women in the focus groups, most of whom were in residential treatment, relapse had been part of their recent experiencing. A provider and then a woman discuss the period after delivery as being a time of high risk for relapse:

Postpartum depression occurs, and she may then go right back. You know that women smoke cigarettes up until they get pregnant, and then stop. After they deliver they're back smoking again. So, that same thing happens with substance-abusing women. [provider]

Two weeks after I had my kids [twins], I went out and I bought crack. It kept me up for nine hours, completely pared out, heart racing, feeling like I was going to have a heart attack in front of my babies. When I first started smoking it, it felt so good, but after 20 minutes, it kicked in, and it was a sleighhammer on my mind. [client]

A variety of support services were needed to help women during and after treatment to avoid relapse and become established in a drug-free lifestyle. Staff members often found themselves dealing with a variety of issues for which they were unprepared: domestic violence, AIDS, syphilis, medical complications of pregnancy, newborn irritability, child development difficulties, dysfunctional parenting, and child abuse. Intensive case management was used in many programs to address these complex needs.

While it's extremely important to help them to deal with their substance-abusing behavior, if you don't deal with those other core issues they will either live minimal lives or they will relapse. [provider]

They have been in a system where they've been able to focus on themselves. The children have been separated, and they haven't had to worry about the money and food. Now, they're discharged and have got to reconnect with public assistance, and the children are coming back. They're under all this stress, and you've got a high percentage of relapse. So, I think that intensive case management has really got to come into play when they're being discharged, to help them refocus. [provider]

Such intensive case management requires very low case loads.

We have three case managers for 25 women, and we've found that the kinds of issues that are being dealt with even overwhelm that kind of caseload. [provider]

There was controversy over the amount and type of social and emotional support that should be provided to pregnant substance abusers and the degree to which such support could become "enabling." One woman expressed her appreciation for the support she received from program staff, but another expressed her own need for a sterner approach.

They help you to realize your problem. They don't tell you what your problem is. They try to give you opportunities to sit and think and understand what's going on, what caused you to do what you're doing, and what you need to do about it. You don't have to duck, dodge, or hide. You can crawl, you can cry, you can jump, scream, or do whatsoever. And they're always there to tell you that "we are there for you." [client]
Focus Groups/Perinatal Substance Abuse Treatment

They were too nice, too loving, too caring, and I didn’t know how to accept that. I needed somebody to be stern with me. Sometimes, the loving and caring part is OK, but some of us come in here and we take that and roll with it. Everybody doesn’t need that loving and caring stuff, I didn’t. I needed somebody to be firm with me. [Client]

Mental health issues were pervasive among the women served by treatment programs.

Our treatment incorporates treatment of sexual abuse and codependency issues. On an outpatient basis, it is difficult to do more than help people understand that they have these issues and help them connect with a mental health program. [Provider]

Other programs have incorporated job readiness and life skills components. As one client described:

This is a good program. I had never thought about school when I was out there drugging. Today, I’m getting ready to go for my GED. I’m getting ready to go to work. I have never worked, never, and I am 27 years old. Now I have an opportunity to do these things. [Client]

Child care is a need in both residential and outpatient programs. Massachusetts developed several model child-care approaches.

We’re making great strides in child care, but some of the child care issues still exist. I say that guardedly because we’ve come a long way in the past year and now have six model child care programs attached to day treatment programs. We’re experimenting with two different models. One is based in family day care, the other we call “have toys will travel.” [Administrator]

One of the reasons that residential treatment is considered desirable is that it provides safe housing. Some programs have begun providing outpatient treatment in housing developments.

We’re working with local housing authorities to identify space within developments where we can provide outpatient counseling. We’ve been less successful at creating (but it is still an idea) alcohol and drug-free sections of their developments. [Administrator]

Programs have attempted to increase the diversity of their treatment staff to address the needs of pregnant substance abusers and to provide more culturally sensitive care.

We now have five obstetricians. One is Black and one is Puerto Rican, so we have a Spanish-speaking obstetrician. We also have two outreach workers, and one is Spanish-speaking. So I think the outreach workers are diversified, as far as their ability to speak Spanish and their color. [Provider]

Diversity is a value in a system as complete as ours. In Massachusetts 50% are in recovery and 50% are not in recovery. Fifty percent have graduate education, 50% don’t. Fifty percent are men. I think we want to maintain that diversity. I don’t think we want to limit it to the professionally trained individual. [Administrator]

Recovering substance abusers also work in the programs and provide role models for those in treatment.

We have a lady that comes in here on Thursdays and teaches a life skills course. She’s a recovering addict for 17 or 18 years. I mean, I get such a charge out of her, she really motivates me. [Client]

In the course of the focus group discussions many interesting ideas about program features were raised by women in treatment and providers. One woman summarized her view of an “ideal” treatment program as follows:

There is this great facility, and me and my children can come in and live in one little apartment, with a bathroom and small kitchen area. As a requirement I am to go to Narcotics Anonymous (NA) meetings and I’m to go to group therapy. Meanwhile, while I’m going there, I have a school bus that’s picking up my six-year-old and taking him to school and coming back and dropping him off. And I have a day care provider that’s there down in room B, or whatever. Afterwards I’m told that I’m to go into a life skills group that’s down the hall in this room. Let’s just say this is an 18-month term facility. [Client]

POLICY IMPLICATIONS

The information gathered from these focus groups underscores the need for gender-specific outreach, treatment, and service integration. Traditional models of substance abuse treatment, based on programs developed for men, do not address the needs and life styles of the women encountered through these demonstration projects. Since 1975, when Public Law 94-371 was passed mandating the development of specialized treatment programs for women, there has been a steady but sporadic increase in the number and quality of programs serving women. However, women continue to be underserved in both prevention and treatment programs, and states continue to struggle in their efforts to serve the special population of pregnant women. Some common lessons for states and communities can be gleaned from the clients, providers, and program administrators who participated in our focus groups include the following:

- Comprehensive services for women require collaborative and cooperative efforts at both the state and community level. Efforts at cooperation imply allowing multiple agencies to participate in a needs assessment that facilitates coordinating existing services while collaboration requires joint decision-making on policies, programs, and funding (Jones & Hutchins, 1993). Without both cooperation and collaboration, the target population gets caught in the crossfire of turf battles and administrative delays.

- States should start small and then expand. Programs need time to establish assessment and treatment systems and to change attitudes about pregnant substance abusers and treatment. This is especially impor-
Outreach should be broad-based and encompass many "satellite" sites. The programs had more outreach success when they performed outreach using highly trained workers in a diversity of outreach sites. The key to successful outreach lay in knowing the community and how it would respond to a variety of strategies.

Quick responses are important. There is a narrow window of time in which the women are willing and able to respond to identification and outreach efforts. Once a woman has been identified as a potential pregnant substance abuser, a full assessment should be done within 24 hours. Furthermore, there should be the capacity to make arrangements for child care and supply treatment within 24 hours of a woman's decision to seek treatment. The ability of case managers to allocate treatment resources without administrative delays is key to program success.

Physicians should be involved in efforts to change physician knowledge level, attitudes, and behavior. The states' experiences suggest that physicians seemed to respond favorably to training and information, particularly when it was provided by another physician. However, the bias against substance abusers, especially pregnant women, must be addressed in any training programs, for it is this aspect that contributes most greatly to physician reluctance to become involved in the problem and promotes punitive attitudes among physicians.

Programs should use interdisciplinary approaches. Staff and community providers must have expertise in prenatal care, chemical dependency, child protection, family preservation, treatment, and ancillary services, such as child care and transportation. Communication strategies among the multiple disciplines must be established and agreed to prior to instituting any program; otherwise, turf battles over "who is in charge" will disrupt all treatment efforts.

Services for pregnant substance abusers should be family-centered. Women's primary and traditional relationships are based on giving care to others. Thus, interventions must address the woman's ability to continue in her role of mother, daughter, and spouse or partner. On a practical level, this can mean providing child-care services for the woman in treatment and providing services for a spouse (or significant other) at the same time the woman receives treatment. Parenting training is a key program component.

Programs should match services to the specific needs of each woman and provide a combination of types of services. Matching treatment needs to treatment strategies requires a comprehensive intake assessment that examines all aspects of the woman's life, seeking an understanding of the strengths she brings to the treatment forum as well as her weaknesses. This is a key concept in developing gender specific treatment programs.

Substance abuse should be viewed as a long-term, chronic, relapsing condition. Short-term treatment interventions are unlikely to be effective, and no matter what type of treatment program a woman participates in, she will relapse. Success should be measured from a variety of perspectives, including the time between relapses, the duration of sobriety or drug abstinence, her success in caring for her children, her interactions with the criminal justice system, and her appropriate use of health-care services. Programs should plan for and try to manage relapses and recoveries long after the woman's pregnancy has ended.

Linkages to a wide variety of programs and systems are critical to program success. Connections with mental health services, the child protection system, employment and training services, and housing are particularly important and should be considered in every treatment plan.

Programs must address the tension between child-focused and mother-focused providers and services. This tension is illustrated by the often adversarial relationships between child welfare agencies that seek to protect the children and substance abuse treatment providers who advocate for the mothers. As programs are developed, the mother-child dyad should be viewed from the beginning as the target unit to be served. This avoids later questions of "Who is the client?"

Although the Health Care Financing Administration demonstrations have addressed some of these components, none developed a model program that incorporated all of them. However, the efforts of the demonstrations provide a base of experience that will be valuable to those who are developing such programs in other states and in a variety of settings.

REFERENCES