Engaging Pregnant Women Using Substances: A Review of the Breaking the Cycle Pregnancy Outreach Program

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Despite the fact that pregnancy has often been described as a "window of opportunity" for women to decrease or stop their substance use, women using substances typically do not seek or access addiction treatment during pregnancy. Barriers to effective treatment for pregnant women using substances have been described and include: stigma directed toward pregnant women using substances, fear of child welfare involvement, lack of support to decrease or cease their substance use, lack of availability of appropriate treatment options, waiting lists for treatment, abstinence as a requirement for admission to treatment, and unsupportive attitudes of practitioners (Rutman et.al., 2000[1]; Tait, 2000[2])

It has been proposed that the setting for early intervention efforts on behalf of pregnant women with substance use problems lies not within the specialized addictions treatment sector, but within agencies and institutions that provide health and social and other services to women (Poole, 1997)[3]. Within the continuum of care for pregnant women with substance use problems, these services are key to identifying women with problems, disseminating information, providing immediate support and brief therapeutic interventions, and making referrals to health and treatment programs (Tait, 2000).

The following is a review of the development and early findings of the BTC Pregnancy Outreach Program, which introduced a pregnancy outreach model of service for pregnant women with substance use problems in Toronto.

The BTC Pregnancy Outreach Program developed as a result of findings in the Breaking the Cycle program, a Health Canada Community Action Program for Children (CAPC) project serving pregnant and parenting women with substance use problems and their young children. Breaking the Cycle offers a one-stop model in a community-based location in downtown Toronto where women receive integrated assistance with addiction issues, parenting, child development services, health and paediatric services, mental health counselling, and basic needs supports.

Early evaluation data (Moore, et.al, 1998)[4] indicated that Breaking the Cycle was engaging a higher proportion of women who were parenting (78%) than those who were pregnant (22%). The 22% engagement rate of pregnant women was consistent with the findings of similar programs in the U.S., and was higher than the rates of pregnant women attending addiction treatment programs in Toronto. Nevertheless, the lower engagement rate of pregnant women led

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[1] Rutman, D., Callahan, M., Lundquist, A., Jackson, S., & Field, B. (2000). *Substance Use and Pregnancy: Conceiving Women in the Policy-Making Process*. Ottawa: Status of Women Canada.
[2] Tait, C.L. (2000). *A study of the service needs of pregnant addicted women in Manitoba.* Winnipeg: Manitoba Health.
[3] Poole, N. (1997) *Alcohol and Other Drug Problems and BC Women: A Report to the Minister's Advisory Council of Women's Health.* Vancouver: British Columbia Ministry of Health and Ministry Responsible for Seniors.
[4] Moore, T.E., Pepler, D.J., and Motz, M. (1998) *Breaking the Cycle: The Evaluation Report (1995-1997).* Toronto: Health Canada

to an effort to gain a greater understanding of the barriers to engagement of this vulnerable population at Breaking the Cycle.

Through a retrospective file analysis, the BTC study Drug Addiction & Pregnant/parenting Women: Factors Affecting Client Engagement (Hicks, 1997)[5] identified three significant factors which were present among pregnant women who visited, but were unable to remain engaged in, the Breaking the Cycle program. These were:

- Homelessness
- Crack cocaine as primary drug of choice
- Lower level of educational attainment

The study increased the understanding of the implications of the often co-existing homeless status of pregnant women who are using substances for their capacity to access health and effective treatment services. Their pregnant, homeless status was identified as a significant barrier to engagement in programs, and to "treatment maintenance". Indeed, the study concluded that, because of their higher incidence of homelessness, pregnant women who are using substances represent a higher-risk sub-population of drug-using women whose barriers to health and effective treatment are even greater than within the larger population of pregnant women using substances.

The development of the BTC Pregnancy Outreach Program in 1999 was a proactive response to these findings, with the aim of engaging women in services as early as possible during their pregnancies in order to positively influence fetal and maternal health outcomes.

The BTC Pregnancy Outreach Program was designed to examine the impact of a pregnancy outreach program on:

a. the engagement rates of pregnant women using substances
b. the community of service providers who works with this population of women

The project objectives were:

- To consult with networks and agencies who have contact with pregnant women using substances in order to receive input regarding the project, and to enhance efforts to build an integrated and responsive community referral network.

- To provide education and training to other agencies that provide services to pregnant women using substances.

- To decrease the isolation and marginalization experienced by pregnant women using substances.

- To increase the knowledge of pregnant women using substances regarding community resources available to them.

- To promote the use of services such as primary health care, prenatal care, medically managed withdrawal programs, and methadone programs.

[5] Hicks, L. (1997) *Drug Addiction and Pregnant/Parenting Women: Factors Affecting Client Engagement.* Toronto: Breaking the Cycle and University of Toronto (Manuscript submitted for publication).

- To increase maternal involvement in planning for herself and her expected infant.

- To establish a fluid and mobile outreach link to/from Breaking the Cycle and the community, increasing the engagement rate for pregnant women at Breaking the Cycle.

- To study and research techniques that are effective in engaging pregnant women using substances in services.

Early evaluation data[6] confirmed the following outcomes:

a. Reaching the target population

- Almost seventy percent (69.5%) of the women engaged reported that they were living in conditions of "visible homelessness", i.e. "those who stay in emergency hostels and shelters and those who sleep rough in places considered unfit for human habitation, such as parks and ravines, doorways, vehicles, and abandoned buildings"[7]. Thirty percent (31.5%) reported that they were living in an apartment or house. This finding does not take into account those who are living in shared accommodation, and may under-report the degree of transience involved in these often short-term and unstable housing situations. It is significant to note that only 1 respondent indicated that they had been able to access subsidized housing, which indicates that the majority of those who were living in apartments or houses were paying market-level rents. These women are living in conditions of "hidden homelessness", which includes "…situations where women are paying so much of their income for housing that they cannot afford the other necessities of life such as food; those who are at risk of eviction; and those living in illegal or physically unsafe buildings or overcrowded households."[8]

- Poverty was identified as a salient co-existing factor. Half of the women (49.7%) reported no income; 43% reported that they were receiving social assistance/PNA/ODSP, and 8.8% reported that they were employed. Of those women who reported that they were employed, all reported that they were employed in the sex trade.

- All of the women (100%) reported that they were actively using substances, and 70.85% identified crack cocaine as their primary drug of choice. This confirms the research of Hicks (1997), which found that the use of crack cocaine is a more significant barrier than the use of other substances to engagement of women using substances during pregnancy, and results in increased marginalization from health and social support services in pregnancy.

- The treatment histories of the women seen further emphasized their marginalized status. Fifty-seven percent (57.35%) reported that they had had no previous treatment experiences. This is in contrast to treatment history data of pregnant and/or parenting

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[6] Leslie, M. (2001) *Breaking the Cycle Pregnancy Outreach Program: Advance Funding Program Evaluation Report.* Toronto: United Way of Greater Toronto.

[7] Kappel Ramji Consulting Group (2002) Common Occurrence: The Impact of Homelessness on Women's Health. Phase II: Community Based Action Research – FINAL REPORT. Toronto: Sistering. vii

[8] Ibid., vii.

women using substances engaged at Breaking the Cycle, 78.3% of whom report between one and three previous treatment attempts (Moore, et.al. 1998).

b. Decreasing Isolation

The isolation of women from supportive health and treatment services during pregnancy exacerbates the risk for poor fetal and maternal outcomes, and results in inadequate planning and preparation for parenting.

The number and source of referrals of women to the BTC Pregnancy Outreach Program, as well as from the Pregnancy Outreach Program to the community, provided a measure of the decrease in isolation of pregnant women using substances. The primary source of referrals into the BTC Pregnancy Outreach Program was from women themselves (33.3%), and the numbers of self-referrals increased consistently over the course of the pilot phase. Other referrals came through the health, treatment and hostel/shelter sectors. When women were asked what motivated them to accept supports through the Pregnancy Outreach Program, they identified the following in order of importance: a desire to parent and care for their child (73%); to have a healthy pregnancy (43%); to engage in healthier eating (43%); a need for affiliation (42%); to access information regarding breast-feeding (25%); to access food vouchers (23%).

Referrals from the BTC Pregnancy Outreach Program to other services in the community further represent a decrease in their isolation. In accessing supportive health, treatment and social support services the women demonstrate an effort to make changes in their lives, including in their substance use behaviour, as they begin to plan for themselves and their expected infants. Referrals from the BTC Pregnancy Outreach Program to the community were primarily to health, treatment and housing providers. There were an average of 3 referrals made per woman, and over 50% of the referrals resulted in women successfully engaging with the providers to whom they were referred, with an additional 18% having made appointments with the referred provider. Only 8.5% of the women refused information and assistance regarding supportive services.

The engagement rates of pregnant women in the Breaking the Cycle program have increased by 70% since the introduction of the Pregnancy Outreach Program, confirming the effectiveness of this model in supporting this vulnerable population of pregnant women using substances.

c. Engaging women at earlier stages of their pregnancies

Approximately 45% of the women engaged in the BTC Pregnancy Outreach Program were in the first trimester of their pregnancies; 29% were in their second trimester and 26% were in their third trimester. The percentage of women engaged in their first trimester represents a higher proportion than those engaged in Breaking the Cycle during their first trimester (32%). Contact with women occurs at an earlier stage of their pregnancy, offering earlier opportunities for the introduction of information and education about resources in the community, for the earlier introduction of health and treatment interventions, and for support to assist women to plan and prepare for parenting.

Data from Breaking the Cycle (Pepler et.al, 2002)[9], confirms that earlier engagement of pregnant women using substances in health and social support services results in positive outcomes for

[9] Pepler, D.J., Moore, T.E., Motz, M.H. and Leslie, M. (2002) *Breaking the Cycle: The Evaluation Report (1995-2000)* Toronto: Health Canada

mothers and children. A comparison of the differences between infants who were born from early-identified pregnancies (i.e. within the first 2 trimesters) versus those born from late-identified pregnancies (i.e. in the last trimester) indicated that early engagement is related to:

- Higher birth weight
- Fewer prenatal risk factors (incl. placenta previa, low weight gain, minimal prenatal care, infections, anaemia, high blood pressure, diabetes, Hep C)
- Reduced prenatal substance exposure
- Fewer birth complications
- Better post-natal health
- Reduced length of hospital stay
- Fewer mother-child separations at birth

In April 2001, Health Canada approved funding through its Canada Prenatal Nutrition Program (CPNP) to expand and enhance the BTC Pregnancy Outreach Program, thereby ensuring its sustainability and stability.

Pregnant women using substances are marginalized from health and social supports by psychological, structural and systemic barriers which jeopardize their health and the health of the fetus. Pregnancy outreach programs are a powerful support mechanism in the lives of the women they serve, not only as a valuable source of information and support, but also to provide opportunities for meaningful interactions with caring service providers and other women in similar situations (Tait, 2000). The desire for pregnant women using substances for affiliation with others with whom they can discuss their pregnancy cannot be underestimated. "Women have spoken of the importance of someone 'come looking for you' in order to demonstrate caring and concern and to provide the message that 'you matter' to them (Rutman et.al. 2000).

Within the continuum of care for pregnant women with substance use problems, pregnancy outreach programs are key to identifying women who are struggling with substance use, providing information, resources, and brief therapeutic interventions, referring to health, treatment and social support programs, but most importantly, to establishing non-judgemental relationships with women that are respectful, caring, and enduring.