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Pregnant and Homeless

PHOTO CREDIT: George Cecilia and The Better Homes Fund

In this issue of *Healing Hands*, we examine health risks and barriers to reducing them experienced by homeless women and their children, during and following pregnancy. The lead article addresses the greatest challenge reported by Health Care for the Homeless clinicians in caring for these women: alleviating substance abuse problems, to protect maternal and fetal health and foster normal child development. Subsequent pieces list other barriers to healthy pregnancies that are disproportionately experienced by homeless women and points to ways in which HCH providers are endeavoring to overcome them.

How prevalent is pregnancy among homeless women, and what risks does homelessness exacerbate for these mothers and their offspring? According to the recent literature,

- 8% of surveyed homeless women under age 50 report that they are pregnant.
- Homeless women have low birth weight babies at higher rates than other women. Low birth weight is associated with respiratory problems in children including asthma.
- Infants of homeless mothers need special care immediately after birth four times as often as other children.
- Homeless babies show significantly slower development than other children.
- 12% of homeless children are placed in foster care, compared to 1% of other children. Placement in foster care is a predictor of adult homelessness.
- 70% of homeless mothers placed in foster care as children have had at least one of their own children in foster care. ■

Risk Reduction for Substance Abusing Mothers

The University of Washington's Parent-Child Assistance Program (P-CAP) is a drug and alcohol abuse intervention for new and expectant mothers. Its primary aim is to help these women obtain substance abuse treatment, stay in recovery, and address such complex problems as lack of housing, domestic violence, child custody, and other legal issues. In addition, the intervention is designed to assure a safe home environment and regular health care for their children. Begun as a federal research demonstration project in 1991, P-CAP is now funded by the Washington State Legislature. Formerly known as the Birth to 3 Project, the model was developed by Therese Grant, PhD, Ann Streissguth, PhD, and colleagues to ameliorate the horrible effects of alcohol and cocaine on the lives of mothers and newborns, reports Nancy Whitney, MS, clinical supervisor of the Seattle program.

In response to this clinical and ethical challenge, researchers investigated best practices used to help difficult-to-reach, new and expectant mothers with long-established patterns of substance abuse. Drawing from the strengths of existing programs, they developed an innovative model of paraprofessional advocacy. "We focus on women who, unable to make effective use of available services, are falling through the cracks," says Whitney.

PARAPROFESSIONAL ADVOCACY

Trained and supervised paraprofessional advocates work with each mother for three years following her enrollment in the program. Caseloads do not exceed 15 clients apiece. Advocates are chosen for their expe-

rience with high-risk populations through past work in social service agencies, and for life circumstances that bear some similarity to those of their clients.

Paraprofessional advocates help clients identify personal goals and take steps necessary to attain them. They connect women with appropriate services, agencies, and professionals in the area. They provide transportation to appointments, assist in resolving service access barriers, and help to solve problems related to housing, domestic violence and child custody. In short, they keep clients on track through guidance, ongoing support, and a watchful eye. The model features home visiting for domiciled clients and three years of case management for newborns, regardless of who has custody.

"Mothers won't be kicked out of the program if they relapse; we work with them unconditionally. If they disappear, we go out and find them," says Whitney. The intervention presupposes that advocacy must be provided over a long enough period of time to allow for the process of realistic and gradual change, she explains. In some cases, three years may not be long enough.

P-CAP has achieved promising outcomes that are well documented. "Evaluation has shown that program participants are more likely to get clean, use effective family planning, avoid incarceration, and remain housed," says Whitney. "As an ongoing research project, the P-CAP model hasn't changed. It is still considered a best practice," she adds.

Currently, four sites in Washington — Seattle, Tacoma, Yakima and Spokane — have implemented the program, and it is being implemented in Minnesota, Alaska and Canada.

P-CAP staff are available to help those who wish to replicate the model, which is considered to be very cost-effective at an annual cost of $3,800 per client. To learn more, contact P-CAP program director Dr. Therese Grant at 206/543-7155 or granttm@u.washington.edu.

INTENSIVE CASE MANAGEMENT

Broadlawns Medical Center in Des Moines operates a program called Person-to-Person for pregnant women who are chemically dependent. Funded by a grant from the Iowa Department of Public Health, the program goal is "healthy moms, healthy babies," according to Lori Baker, BA, Maternal and Child Health Program Coordinator.

"The mother is referred to our program if her baby has tested positive for drugs — crack, methamphetamine, marijuana, heroin — we see them all." Approximately 75% of women participating in the program at any given time are homeless, according to Baker. Person-to-Person, which works with the mother for a year, employs an intensive case management approach and stresses medical care for the client.

In Iowa, once the baby has tested positive for drugs, the court becomes involved. The baby is placed in foster care or with a family member whom the court deems able to provide a safe, stable environment. The case manager goes to court and attends meetings with the client's probation officer so that all are working toward the same goals, explains Baker. Case managers, who usually handle about 20 cases, get the client into drug rehab and see that she gets her postpartum OB-GYN visits.

The program either provides or links clients to parenting classes, job readiness, job training and GED courses. "We have computers onsite and can assist women with their resumes," Baker adds. Peer-to-Peer refers those who are homeless and chemically dependent, or mentally ill, or living with HIV/AIDS to the Shelter Plus Care program funded by the U. S. Department of Housing and Urban Development.

Even with these important support services, other barriers may remain. "Often women are afraid to put their children into day care because they fear it's not safe," Baker reports. "This interferes with their ability to keep a job."

A relapse prevention group helps these women stay clean and sober, and a pediatrician works with foster parents to rehabilitate drug-addicted infants. "Remain optimistic," Baker advises, "and don't give up on the client or close the door on her. Your agency may be the only safe place she has. You'll have to earn her trust. Many times I've lost a client during the first pregnancy, but she returned for help during her second pregnancy and successfully completed the program." ■

Words to the Wise:

- Establish rapport with the mother and gain her trust. She needs to know that you aren't out to steal her baby. The greater the trust, the better the outcome, especially for homeless women in recovery.
- When discussing substance abuse, emphasize concern for the baby's health instead of condemning the mother's behavior.
- Don't be judgmental; have compassion and show empathy.
- Be honest. Let your client know when you are obligated to involve other agencies or the law.
- Provide information a little at a time, repeating key points during the visit.
- Face-to-face discussions on the dangers of substance abuse during pregnancy are more effective than brochures.
- Adjust your attitude. Don't look down on your client for all the things she doesn't have — a stroller, a phone, a car. Don't ask why she didn't come in earlier. Accept where she is, and be happy that she's here now.

Fetal Alcohol Syndrome (FAS) and Other Prenatal Alcohol Effects: Clinical Implications

curriculum developed by Ann Streissguth, PhD, University of Washington Medical School, January 2001

Described by Lemoine in French in 1968; identified and named as a syndrome by Jones and Smith, University of Washington, 1973

I. Diagnostic features of FAS in the young child:
- Growth deficiency, prenatal origin
- Pattern of dysmorphic features including distinctive faces
- CNS damage and/or dysfunction including: neurological hard or soft signs; impaired fine or gross motor skills; neurosensory hearing loss; learning (especially arithmetic), memory, or attention deficits; poor impulse control; problems with language, abstraction and judgment.
- Maternal alcohol abuse

Partial syndromes are more prevalent than the full FAS: variously named as: Atypical FAS, Partial FAS, Fetal Alcohol Effects (FAE), Static encephalopathy, alcohol exposed, and Alcohol-Related Neurodevelopmental Disabilities (ARND).

Fetal Alcohol Spectrum Disorders (FAS) is an umbrella term used for all of the above.

IQ scores of children with FAS range broadly from severely mentally retarded to above average; most are in the "borderline" range, mildly retarded, or low-normal range.

Primary Disabilities (birth defects):
- Organic brain damage & dysfunction
- Cardiac problem (35%), vision problems, central auditory problems
- Increased rates of many other physical malformations

Secondary Disabilities:
- Disrupted school experiences (60% of adolescents & adults)
- Trouble with the law (60% of adolescents & adults)
- Confinement (~ 50% of adolescents & adults)
- Inappropriate sexual behavior (~ 40-50% all ages)
- Alcohol and drug problems

Life Span Problems:
- Mental health problems (> 90% all ages): attention deficits, depression, alcohol/drug abuse and dependence, anxiety, panic disorder, suicidal ideation/attempts, psychotic episodes, conduct disorders
- Major problems with employment (~ 80% of Adults)
- Difficulty living independently (~ 80% of Adults)

Protective Factors significantly associated with decreased secondary disabilities:
- Early diagnosis of FAS, FAE, ARND
- Living mostly in a stable and nurturing home
- Never experiencing physical or sexual abuse

II. The Teratogenic Effects of Alcohol

Teratogens can cause 4 types of effects (alcohol causes all 4):
- Death (miscarriages, stillbirths, perinatal mortality)
- Malformations
- Growth deficiency
- Functional deficits

Brain malformations include microcephaly, cerebellum, basal ganglia, hippocampus, and/or corpus callosum.

Brain damage from alcohol is caused by:
- Excessive cell death
- Reduced cell proliferation
- Migrational errors in brain development
- Inhibition of nerve growth factor
- Disruption of neurotransmitters

Teratogenic effects depend on:
- Agent, dose, timing and
- Individual factors in mother and child

Teratogenic effects of alcohol have been confirmed in:
- Laboratory animal and clinical studies
- Epidemiologic studies of large groups of children and adolescents

III. Societal Implications:
- Since FAS identification: decreased alcohol use during and prior to pregnancy
- Surgeon General Warning, 1981: "Abstain from alcohol during pregnancy and when planning a pregnancy."
- Avoid alcohol when breast-feeding, as alcohol passes readily through breast milk.
- Alcohol is a unique teratogen because:
  – It also produces dysfunctional families.
  – 80% of children with FAS/ARND are not raised by biological families.
  – Although the primary mode of intergenerational transmission is not genetic, the unusual social / familial context and resulting secondary disabilities (especially alcohol problems) can result in mothers and children who are both fetal alcohol affected.
  – Both prevention and intervention efforts are necessary.

IV. What Clinicians Can Do

In providing medical care:
- Recognize that both child and adult patients can be fetal alcohol affected and may require some accommodations to facilitate treatment.
- Recognize that parents, care givers or supporting relatives and friends are often important to be in contact with, even with adult patients, to facilitate medical care.
- In recognizing which patients might be fetal alcohol affected, facial features and growth deficiency in prepubertal children, observations of behavior, and/or history of learning or attention problems may

be useful. Asking whether or not the biological mother had an alcohol problem, an early demise, or was somehow separated from the child can provide another good clue.
- When a positive history is obtained, talking with patients about maternal alcohol abuse as a possible causative factor in learning and attention problems can be helpful and facilitate the patient's getting appropriate help and support.

In providing gynecologic, obstetric, or family practice care:
1. Talk with patients about alcohol and pregnancy; avoid judgmental remarks; encourage understanding and help if needed.
2. Ask patients how much they drink on a drinking occasion and how often they drink.
3. Advise patients not to drink when planning to have a baby or when pregnant or breast-feeding. If they can't stop, help them cut down. Particularly bad patterns are drinking to get drunk or taking 4–5 drinks at a time — even once in a while.
4. It's best to stop drinking as soon as possible during pregnancy, but stopping anytime is better than not stopping at all.
5. Advise women who can't stop drinking or significantly cut down during pregnancy to get help.

Summary:
- Understanding FAS/FAE is about facilitating healthy babies and helping those babies born with FAS/FAE to grow to their best potential.
- Mothers can be helped to stop or significantly decrease drinking during pregnancy.
- Mothers in recovery from alcoholism can have perfectly healthy babies even after having a baby with FAS.
- Doctors and nurses can make a difference.

Source: University of Washington Web site, *http://courses.washington.edu/hubio516/Streissguthnotes.htm*. Accessed on 8/20/01.

South Carolina's position on drug abuse by pregnant women is the toughest in the nation. In 1997, a South Carolina court ruled that expectant mothers who use drugs can be convicted of child abuse or other crimes, and dozens of women in that state have faced criminal charges after they or their babies tested positive for drugs. South Carolina is the only state where a jury has convicted a woman of homicide for delivering a stillborn baby while using crack cocaine. Prosecutors say tough measures are needed to protect children both before and after birth, but opponents argue that the law scares those women who are chemically dependent away from seeking drug treatment or prenatal care.

In March 2001, the U. S. Supreme Court ruled that public hospitals cannot test pregnant women for drugs without their consent and turn the results over to police. The justices ruled 6-3 that a public hospital operated by the Medical University of South Carolina, which serves indigent and minority patients, violated the U.S. Constitution by testing patients and turning them in to the authorities. Several women, who were taken from their beds and jailed under the state's child-endangerment law, sued the state. The high court decided that the state had violated the patients' Fourth Amendment rights by helping the police obtain evidence for prosecution. *Performing a diagnostic test to obtain evidence of criminal conduct is an unreasonable search if there is not a warrant or if the patient has not consented to the procedure and been fully informed of her constitutional rights.*

— Legal Information Institute, Ferguson v. Charleston: *http://supct.law.cornell.edu/supct/html/99-936.ZS.html*.
— National Public Radio, All Things Considered, Nina Totenberg, reporter, March 21, 2001.
Online audio available at: *www.npr.org/ramfiles/atc/20010321.atc.11.ram*.

SOURCES & RESOURCES

1. The Better Homes Fund. *Homeless Children: America's New Outcasts*, 1999. To order, call the Policy Department at 617/964-3834, ext. 35; cost: $14.95.
2. Burt, Martha R., et al. *Homelessness: Programs and the People They Serve* – Findings of the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC). Technical Report, December 1999: *www.huduser.org/publications/homeless/homeless_tech.html.*
3. Grant, T.M.; Ernst, C.C. and Streissguth, A.P. Intervention with high-risk alcohol and drug abusing mothers: I. Administrative strategies of the Seattle Model of Paraprofessional Advocacy. *Journal of Community Psychology*, 1999; 27(1): 1–18.
4. Ernst, C.C.; Grant, T.M.; Streissguth, A.P., and Sampson, P.D. Intervention with high-risk alcohol and drug abusing mothers: II. Three-year findings from the Seattle Model of Paraprofessional Advocacy. *Journal of Community Psychology*, 1999; 27(1): 19–38.
5. Grant,T.M.; Ernst, C.C.; McAuliff, S. and Streissguth, A.P. The difference game: Facilitating change in high-risk clients. *Families in Society*, 1997: 78, 429–432.
6. Grant, T.M.; Ernst, C.C. and Streissguth, A.P. An intervention with high-risk mothers who abuse alcohol and drugs: The Seattle advocacy model. *American Journal of Public Health*, 1996; 86: 1816–17.
7. Grant, T.M.; Ernst, C.C.; Streissguth, A.P.; Phipps, P. and Gendler, B. When case management isn't enough: A model of paraprofessional advocacy for drug- and alcohol-abusing mothers. *Journal of Case Management*, 1996; 5(1): 3–11.
8. Streissguth, A.P. *Understanding Fetal Alcohol Syndrome* and *Fetal Alcohol Syndrome: A Guide for Families and Communities*. Baltimore: Paul H. Brookes Publishing Company, 1997.
9. Streissguth, A.P. and Kanter, J. (eds.) *The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities.* Seattle: University of Washington Press, 1997.
10. Stein, J.A.; Lu, M.C. and Gelberg, L. Severity of homelessness and adverse birth outcomes; *Health Psychology*, 2000; 19: 524–534.
11. Datta-Bhutada, S; Johnson, HL and Rosen, TS. Intrauterine cocaine and crack exposure: Neonatal outcome. *Journal of Perinatology*, 1998; 18(3): 183–188.
12. National Perinatal Association. *Transcultural Aspects of Perinatal Health Care: A Resource Guide*, 2001. To order: *wwwnationalperinatal.org*; cost: $69.
13. Handel, M.H. and Levine, G.S. Pregnancy and substance abuse. *Professional Medical Assisting*, July/August 2001: 20–23.

Barriers to Healthy Pregnancies for Homeless Women

"Pregnant women comprise a segment of the homeless population that is often overlooked," remarks Christine Reller, MSN, RN, Manager of the Hennepin County Community Health Department's Health Care for the Homeless Project in Minneapolis. "For years we recognized the need to deliver services to pregnant homeless women, and we were able to get a position funded. We focus on maternal and child health outreach, and our goal is getting homeless clients into prenatal care and improving their health status and pregnancy outcomes. We provide an initial health assessment, coordinate linkages to appropriate prenatal care, keep statistics, track program results, and monitor birth outcomes."

LACK OF PRENATAL CARE "Although the HCH Project does not provide prenatal care, we educate about the importance of prenatal care and good nutrition as well as the effects of chemical and other substance use during pregnancy," explains Reller. "We teach the signs and symptoms of early labor and pregnancy complications. During clinic visits at the shelter, our objective is to clarify and reinforce medical recommendations. As part of a county health system, we are able to link clients to a variety of services such as substance abuse treatment or mental health services."

According to Reller, a recent audit revealed that over 90% of the pregnant women seen in 2000 by the maternal child health worker needed access to prenatal care. Almost all were connected to an appointment for prenatal care before they left shelter. Clinic staff check blood pressure, hemoglobin levels, weight gain, and for sexually transmitted diseases. The health assessment includes asking the client if she has access to a stroller, transportation, or a telephone.

Community health specialist Stephanie Abel, BPH, RN, is responsible for coordinating these outreach services at three homeless shelters. One of Abel's strategies for getting clients seen quickly by a health care provider is to do outreach during clinic hours. "We provide a safety net for these women," she says. "Clinic staff provide prenatal vitamins and make sure that they have transportation to prenatal care visits."

"Our biggest obstacle is getting homeless women into prenatal care," says Sharon Brammer, FNP, Director of the H. E. Savage Health Care for the Homeless in Mobile, Alabama. "Lack of transportation is a barrier, and their primary focus is on finding housing, clothing and meals. If a woman is chemically dependent, she is looking for drugs, and she's especially afraid that her children will be taken from her. When you're pregnant and not feeling well, getting prenatal care isn't a priority."

Brammer thinks that her project may be the only HCH located within a recovery center. "H. E. Savage HCH has a contract for two beds in the Home of Grace for Women, an alcohol and drug recovery program. There women are allowed to keep their children with them following delivery, as long as they are in recovery."

PHOTO CREDIT: George Ceolla and The Better Homes Fund

Brammer provides primary care to women residing at the Home of Grace. Those who are pregnant are referred to Franklin Primary Health Center for monthly prenatal visits. She also coaches new moms on parenting skills, and monitors mother/child bonding to assure that the recovery process is not negatively affecting this relationship.

Women are typically at the recovery center for six months. During that time they may continue their education, and many receive their GED. Job training is also available, and a transitional program provides ongoing counseling and support.

LACK OF CHILDCARE Homeless women have complex problems and competing priorities, including finding food and shelter, getting to appointments, and caring for their other children. Sometimes they even forget they are pregnant, observes Stephanie Abel. A major barrier to prenatal care for homeless mothers is the lack of childcare. "It's hard to focus on caring for yourself when you have very young children without access to child care, and you must take them with you to your doctors' appointments," she explains.

NO PLACE TO CALL HOME In Minneapolis, homeless women are fortunate to be able to bring their newborns back with them to the shelter following delivery, which is uncommon. Nevertheless, most mothers are reluctant to bring their babies back to the shelter because it is not their home and seems depressing.

One client received extra cash from a relative to buy cleaning supplies that she used to scour her shelter room before her delivery, reports Abel. Unfortunately, when she returned with her baby, the shelter had given the room to another client.

HISTORY OF ABUSE & SUBSTANCE ABUSE "Homeless women, especially those who are chemically dependent, often avoid seeing providers for fear of being perceived as bad or unfit mothers," notes Abel. "For the most part, the mothers I work with are incredibly loving," she attests. "They're great moms, especially considering the extremely abusive backgrounds some of them come from." The following case study illustrates the reluctance many women with substance abuse problems feel about seeking prenatal care:

In 2000, Abel saw a homeless woman who had been assaulted and had come into the HCH Project to have stitches removed. During the visit, she mentioned that she was pregnant and that she had been using cocaine. She assumed that the baby was dead, and she wasn't getting prenatal care. Abel had her listen to the baby's heart beat, and assured her that the baby was indeed alive and most likely healthy based on her medical history. She had been staying in a shelter for single adult women, but after this visit she disappeared. She went into substance abuse treatment, and called Abel from the hospital to say that her baby was healthy and that she'd been sober for four months. Abel reports that the client is still doing well.

When a homeless woman learns that she is pregnant, she may be ambivalent about the pregnancy. Even if she has decided to keep her baby, she may be worried about caring for the child while she is homeless, with little money. "We try to encourage early bonding by getting the mom excited about her pregnancy. We have access to a Doppler machine so she can listen to the fetal heart beat," says Abel. "These babies can save their mothers' lives. Having a life inside them can really motivate these women to change when nothing else has." ■

The Hennepin County Community Health Department Health Care for the Homeless Project has offered to share the following MCH assessment tools with HCH clinicians, at no charge: the HCH Social Services/Outreach assessment tool, the Prenatal Intake and Prenatal Program Follow-up Visit forms, and the Minneapolis Pregnancy Assessment Form. *To order these forms, which can be adapted to fit your practice setting, call Pat Petty at 615/226-2292 or write her at network@nhchc.org.*

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