Oklahoma Infants Assistance Program
Final Project Report
October 1, 1996 to September 30, 2000

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The goals of the Oklahoma Infants Assistance Program (OIA P) were to:

1) Prevent the abandonment of infants and young children by providing coordinated, culturally sensitive, and comprehensive services to families of children at risk of being abandoned, primarily those prenatally exposed to controlled substances or testing positive for HIV.
2) Provide empirical data to support the formation of policy, in Oklahoma and nationwide, regarding how to allocate limited resources for such families, and how to make better treatment decisions.

The objectives were as follows:

1) To implement a community-based, comprehensive, single-site treatment program for infants at risk of being abandoned and their families. A minimum of 7 disciplines and 4 community organizations were to be actively and cooperatively involved in the evaluation and treatment of these families on a weekly basis at a single site.
2) To provide services of varying levels, using a triage approach, to 90 high-risk families (primarily those with drug-exposed or HIV-positive children below age 4) during fiscal year 1996. To provide services to 40 new families each successive year for a total of 210 families served.
3) To provide culturally appropriate services, so that every participating family has at least one key person on the treatment team who is of similar cultural and ethnic background, and so that at least 10% of families involved are of primarily Native American descent.
4) To utilize home-based services with each family, such that every family enrolled in the OIA P receives a minimum of one contact per month, with families needing intensive services receiving a minimum of 8 contacts per month.
5) To insure that access to transportation is in place for at least 90% of all appointments.
6) To provide at least 4 specific training seminars during fiscal year 1996, to relevant professionals in counties other than Oklahoma County, on working with infants at risk of being abandoned and their families. To also be available to public schools, hospitals, scout groups, major state conferences for child welfare, Child Protective Services, and prenatal care agencies as a resource for speaking about the dangers of substance abuse during pregnancy and/or the availability of resources for affected families. At least 4 public service talks to agencies such as the above will be given during fiscal year 1996.
7) To gather comprehensive data regarding the functioning of these families across a wide range of areas, including substance use, child development, parenting skills, parent-child interaction, hospitalizations, child maltreatment, and client satisfaction; families participating in the OIA P will be compared to families dropping out of the program in as many of these areas as possible, especially hospitalizations and reports of suspected child maltreatment.
8) To establish, for purposes of long-term evaluation, baseline measures of the average number of abandoned infants and abandoned infant hospital days in Oklahoma County during fiscal year 1996.
9) To conduct process and outcome evaluation of these services with empirically validated assessment techniques. To provide pilot data regarding the use, effectiveness, and cost-
effectiveness of applying a specific theory to decisions regarding the nature and intensity of services provided.

10) To work towards the establishment of a family mediation and voluntary relinquishment protocol by meeting at least twice during fiscal year 1996 with representatives from Child Protective Services and the Juvenile Court of Oklahoma County to discuss this issue.

The goals and objectives were implemented using the following treatment initiatives:

1) **To efficiently hire a full staff of professionals and fully orient that staff to the OIAP.**
   A culturally diverse staff was hired in a timely fashion. Staff members were oriented via information packets, discussions, and relevant readings. Trainings for staff have continued to be held on a regular basis. Trainers have been brought in specifically for the OIAP staff and staff have attended conferences and workshops sponsored by outside agencies. Trainings have included topics such as identifying and meeting the needs of children with prenatal drug exposure, working effectively with high-risk families, and issues related to substance abuse and substance abuse treatment.

2) **To obtain referrals by alerting and educating the community.**
   This was an on-going process. A family friendly brochure was created detailing the OIAP and how to contact OIAP staff. Please see Appendix A for a copy of the brochure. This brochure was used to provide families, agencies, and referral sources with information. While the majority of referrals were obtained via Oklahoma Department of Human Services (DHS) Child Welfare, presentations were also made at area hospitals, substance abuse treatment centers, Native American tribal court, and Indian Child Welfare in attempts to increase referrals. In addition, information about the OIAP was shared at a variety of state conferences to professionals working in the field of substance abuse and mental health. Thus, a wide range of referral sources was reached. Finally, offers were extended to hospital staff, and at times accepted, to meet directly with women in the hospital to discuss their potential involvement in the OIAP. Many referrals were received and families were scheduled for intakes. While 24% of clients scheduled for an intake never followed through and completed the intake, 191 intakes were completed (4 of these intakes were completed on returning clients).

3) **Comprehensive and collaborative services will be provided to infants and children at risk of being abandoned and their biological families.**
   **Interdisciplinary Evaluations:** Evaluations were completed on all parents entering the OIAP. Evaluations consisted of interviews by a substance abuse counselor, a case manager/in-home specialist, a mental health worker, a domestic violence counselor, and a family planning educator. In addition, parents completed a variety of paper and pencil measures assessing a range of constructs including level of substance dependence, parental stress, risk of physical child maltreatment, child development knowledge, level of depression, amount of perceived family support, and stage of change in relation to parenting and substance abuse. Full reports were written on each family and were shared with the courts and with DHS when relevant (i.e., when there was DHS and court involvement).
In addition, the infant and any sibling who also was prenatally drug exposed was provided the opportunity for a complete developmental evaluation through Dr. Robin Gurwitch’s A Better Chance (ABC) Clinic. This evaluation included a cognitive and motor developmental evaluation provided by a clinical psychologist. Some of the infants and children also were evaluated by a physician, a speech therapist, and/or a physical therapist. Some challenges were noted with regard to completing evaluations on all identified children. Often children were placed in foster care. While they were still eligible for these services, some foster parents were not willing to bring the child to the clinic for the evaluation. Other times DHS workers were unwilling to provide the foster parent’s contact information to the ABC clinic or reported that they would pass information between the clinic and the foster parents but then did not. Thus, some foster parents were not aware of the services available. This was more likely to occur with those DHS workers who did not work regularly with the OIAP. Attempts were made to educate workers and foster care parents with regard to the services the ABC Clinic offered.

**Medical Services:** Some medical services were provided by OIAP staff. Paul Toubas, M.D. and Loy Markland, M.D. (of the ABC Clinic) both provided services to some of the infants. In particular, Dr. Toubas was available to treat medically complex children at his neonatal high-risk follow-up clinic. In addition to this access to medical care, case managers worked on assisting families with negotiating Medicaid eligibility requirements, Title X clinics, and accessing other free or low cost health care. Case managers helped families complete Medicaid insurance applications and schedule appointments, as well as provided transportation to medical appointments. Assistance also was provided in finding appropriate low cost dental care for both children and parents and low cost or free prescriptions. Finally, Gary Borrell, M.D. provided free psychiatric services to any parent who requested psychiatric help or was referred for evaluation/treatment. Dr. Borrell also worked with the OIAP staff in providing free samples of psychiatric medication to OIAP clients.

**Substance Abuse Services:** Two community agencies, Drug Recovery, Inc. (DRI) and Turning Point/Community Action Agency, provided Substance abuse services. DRI provided services for approximately the first two years of the project period and Turning Point provided services for the final two years. This change in agencies was made in order to ensure a more cohesive, team oriented approach to service provision.

With regard to specific services, screenings were provided at the intake evaluation conducted at the OIAP office. At a minimum, these substance abuse screenings included an interview with a substance abuse counselor and the completion of the Substance Abuse Subtle Screening Inventory (SASSI). With regard to treatment, group therapy was provided, with two groups that were restricted to OIAP participants. These groups were at times provided at the OIAP office and at times at the agencies’ offices. The groups included a focus on substance abuse education and on relapse prevention. Groups were run in an open format, allowing OIAP participants to begin attending the groups as soon as they enrolled in the OIAP. Thus, there was never a delay in beginning treatment. Individual sessions with a substance abuse counselor also were provided. These individual sessions were held at the OIAP office, the substance abuse agencies’ offices, the home of the client, or other mutually agreed upon locations. This flexibility allowed for easier access to services.
In addition to direct services, consultation with OIAP staff and DHS child welfare workers also was completed on an on-going basis. The substance abuse counselor(s) were present at the initial team staffing following the intake and assisted in determining the client's treatment plan. Substance abuse counselors also attended the staffings held with DHS workers to discuss the progress and needs of individual clients, and attended the client-based staffings to provide feedback with the OIAP team to the client with regard to progress and needs.

Residential substance abuse services were provided by a variety of treatment centers across the state of Oklahoma. These services were not paid for by the OIAP, but OIAP staff typically facilitated entry into the centers. Centers that provided treatment to indigent clients were identified and relationships were developed with these centers. Treatment centers were divided into adult only centers and women and children centers. The adult only centers were those treatment centers were women were accepted for treatment, but had to enter treatment without their children. All centers varied greatly in terms of length of treatment (ranging from 1 week detox to 12 months). Depending on the needs of the client, and whether or not they had physical custody of their children, a recommendation was made for a treatment center and assistance was provided in contacting that center for admittance. Given that these centers were located across the state of Oklahoma, with some requiring up to a four hour drive to get there, assistance with transportation to get to the center also was provided.

Finally, 12-step groups were heavily utilized including Narcotics Anonymous, Alcoholics Anonymous, Cocaine Anonymous, and at times Alanon. For those clients who had not attended a 12-step group previously and were hesitant to do so, the case manager/in-home visitor would offer to accompany them. Given the different style of each home group, OIAP participants were encouraged to sample different groups until they felt comfortable. Assistance was provided to find groups that met at convenient times, locations, and those that would allow infants/children to attend. As these groups are free to participants and are found throughout the Oklahoma City metro area, this was a relatively easy avenue for clients to begin developing sober contacts and support.

**Specialized Parent Training:** All participants were offered specialized parent training. This came in several forms including a variety of parenting groups, individual parenting sessions, and in-home services focusing on parent training. Several parenting groups were offered including a baby bonding group, a play group, a Parent-Child Interaction Therapy (PCIT) group, and a sober parenting group.

In the baby bonding group participants were taught infant massage and other soothing and positive nurturance skills. The focus of this group was to improve bonding and attachment and to further develop the skills of parents to calm, soothe, comfort and nurture their infants. A positive effect of this group was the increase in confidence experienced by the group participants. This was particularly meaningful for those clients whose infants were still in DHS custody and who were continuing to have supervised visits. Feeling more comfortable caring for their infant allowed some mothers to feel more comfortable caring for their infants in front of a DHS worker. For those parents who had physical custody of their infant, attending group was usually a matter of obtaining transportation. For those parents whose infant remained in DHS physical custody but were ready to attend the group, attempts were made to coordinate with DHS to transport the infant to the group and allow the OIAP group leaders to serve as the
“supervisors” (if the parent was only allowed to have supervised visits). This was effective in some cases. However, when DHS did not have access to a case aide or someone who could regularly transport the infant, or if the infant was in a placement that was not in the county, this was difficult to accomplish.

The play group was designed for those parents with children in the age range of 18 months to 5 years. This was a short-term group focusing on teaching parents how to play age-appropriate games with their children. The goal was to increase positive interactions between the parent and their child and was developed in response to the observation that many of the parents did not have the knowledge or skills needed to simply play with their children.

The PCIT group was available for parents with children aged 2-8 years. This group focused both on improving the positive interactions between the parent and child and on teaching the parent positive discipline techniques (e.g., giving effective commands, using time-out effectively). The benefits of PCIT have been well documented and include improved communication between child and parent, improved self-esteem and social skills for the child, improved frustration tolerance, improved attention and organization, and improved minding and listening.

Finally, the sober parenting group was designed to address issues relating to parenting children of a variety of ages. This helped to ensure that the needs of all of the children in the home were addressed. Issues in this group included but were not limited to basic infant and child care, appropriate developmental expectations, child safety, talking to children about the parent's drug use, and school and education issues.

Individual parenting sessions were conducted with those families who needed individualized services or who requested such services. Parenting issues also were addressed via the in-home visitation component of the program.

In-home Visitation: In-home visitation was an integral part of the OIAP. All OIAP participants were assigned an in-home visitor at intake. The in-home visitor coordinated the intake session and was the first person the client met. This allowed for rapport building and the development of a working alliance. In-home visits typically occurred in whatever home the client was living in. However, if the client was initially uncomfortable with a person visiting them, or was living with other people who were not willing to have a visitor, visits would occur in other locations such as the home visitor's car, a neighborhood park, or a local fast food restaurant. Initially, the goal was to have the home visitor focus on parenting issues. It quickly became clear that other needs often had to take precedence. For example, many of the clients were continuing to use drugs and alcohol, thus sobriety was an important need. Other basic needs often needed to be addressed such as finding housing, getting food, and keeping utilities turned on. In addition, for those parents whose children were in DHS custody, it was difficult for the home visitors to focus on tangible parenting skills when there was no child in the home. Thus, it was helpful to focus on other needs in addition to the parenting skills. Finally, it made conceptual sense to include the client in the home visit treatment planning, and often the client's identified needs were geared towards basic life needs and not necessarily parenting. Focusing on what the client identified as his or her needs was done to help increase motivation for the client to participate in the home visits, to increase the level of investment by the client, and to ensure that the needs of the client were in fact addressed. For all of these reasons, the focus on home visits was fairly broad. Although
child development, safety, care and other parenting issues were often central, many other needs were also addressed. In-home visitors served as case managers and became very adept at finding appropriate referrals for job training and education, day care services, food banks, prescription drug, medical, and dental assistance, furniture, housing, etc.

A home visitation manual was created by the first OIAP Director (Dr. Steve Ondersma) and the in-home visitors. Please see Appendix B for a copy of the home visitation manual. This manual focused on home visitor safety, goal setting with clients, and assessing knowledge relating to infant and child development, nurturance, sleeping, feeding, medical needs, safety, toilet training, and discipline. Exercises that could be completed with clients in regard to each of these areas were included. (Given the number of exercises and brochures that are referenced in the manual, these were not copied and included in Appendix B, but are available upon request). Authorization to photocopy the copyrighted material was obtained, allowing the OIAP to make a predetermined number of copies of each set of materials.

**Domestic Violence/Family Planning Services:** With regard to domestic violence (DV) services, both evaluations and counseling services were provided. A counselor from the YWCA who had training in dealing with women who had experienced domestic violence was present at the intakes. This DV counselor would meet with the client during the intake (held at the OIAP office), assess the reported level of violence in both present and past relationships, tell the client about DV services available, and share with the team perceptions on the client’s treatment needs. Treatment options included individual sessions with the DV counselor (to be held at OIAP or at the YWCA), participation in a DV education group (some groups were held at the OIAP offices, others at the YWCA), and access to the Oklahoma City’s DV women’s shelter. In addition, male partners involved in violent relationships were given a referral for the “male batterers” group held at the YWCA in Oklahoma City.

With regard to family planning services, an educator from Planned Parenthood of Oklahoma City provided a variety of services. He was present at the intakes and would meet with each client, assess the client’s needs related to family planning, sexually transmitted infections, HIV testing/education/services, and other related issues, and would share with the OIAP team perceptions on the client’s needs in these areas. The educator also would share with the client and OIAP team where the client might access services for each need (e.g., title X clinic versus other agencies). All clients were made aware that they could meet individually with the educator at any time during their involvement with the OIAP (either at Planned Parenthood or at the OIAP offices). In addition to meeting individually with the clients, the educator also presented regularly at the OIAP groups and shared additional information with the clients. Free condoms were supplied to the OIAP by Planned Parenthood and were distributed at intake and at groups. In addition to free condoms, arrangements were made to provide ten free tubal ligations to those clients who desired permanent birth control but did not have insurance or the financial ability to pay for the procedure. This was possible through a grant that had been awarded to Planned Parenthood, where ten of their free slots were held open for OIAP clients. Finally, the educator also provided training to the OIAP staff on a variety of issues including HIV and hepatitis, birth control options, and prescription payment options.
HIV/AIDS Risk Reduction: Throughout the course of the grant period, only one parent reported being positive for HIV. This was consistent with the relatively low HIV rate found within the state of Oklahoma. However, given the high-risk behaviors of the clients enrolled in the OIAP, all clients were encouraged to receive HIV testing. This testing and counseling was offered at the same location as the substance abuse counselors, thus, the testing was very accessible. As mentioned previously, groups led by the family planning educator were held to discuss HIV including testing and prevention.

Medical/Social Services Case Management: As mentioned in the in-home visitation section, the home visitors also served as case managers and assisted with both medical and social service needs. Many referrals sources were cultivated, allowing a variety of assistance for OIAP clients.

Psychological Services: Mental health services were provided by a variety of mental health professionals including licensed psychologists, psychology pre-doctoral interns, psychology graduate students, and social workers. In addition, a psychiatrist was available to see those clients who requested or were referred for these services.

4.) Services will be provided in a prescriptive and purposeful manner, maximizing cost-effectiveness.

Theoretical approach to dealing with resistance to parent behavior change: Motivational Interviewing (MI) techniques were used to enhance change. For the majority of the grant program a two-staged group process was utilized. The first group focused specifically on motivation and helping clients move forward in their readiness for change. This involved a variety of interventions including using testimonials from others of similar backgrounds, helping to examine advantages and disadvantages of behavior change using “environmental reanalysis”, and other MI techniques. This group was initially called the Responsibility Group as the focus was on helping the client both accept responsibility for their behavior and begin to take responsibility for changing their behavior. The group was later changed to the Introductory Group, as it was an introduction to the OIAP. Once clients successfully completed this first group, they were eligible for participating in the other groups (e.g., sober parenting group, PCIT group). The rationale was that if clients were not sober, attendance at other groups would be lacking, learning parenting skills would not be the most pressing need, and sobriety and substance abuse treatment needed to be held up as being of high importance. The criteria for successfully completing the first group were regular attendance, clean urine analysis, attendance at substance abuse treatment, and the completion of a personal statement. The personal statement was written in response to questions regarding the client’s drug use, the effect it had on her, her children, family, and friends. Please see Appendix C for a copy of the personal statement. The personal statement was presented to the other group members and all members were encouraged to ask questions. This had the potential for being very powerful and eliciting strong feelings and reactions from all members. After the questions were answered, the group members voted on the statement based on a set of criteria (please see Appendix C for the criteria). If the group did not vote to pass the statement, the client was given feedback on areas to look at further and asked to re-present it to the group. Individual help with the statement was offered with either the group leaders or with the client’s in-home visitor. The clients developed a very strong ethic about the level of thought and commitment that needed to go into the statement.
One client would tell the other women, "If it doesn't take you a long time and you don't cry when you're doing it, then you aren't doing it right. You have to look really hard at yourself and dig down deep and get honest."

There were challenges with this group. Utilizing motivational enhancement techniques (designed for use in individual sessions) in a group format was at times unwieldy. Given the wide range of motivation levels among clients, and the varying reasons for low motivation, it was sometimes difficult to effectively impact all group members with a particular exercise. This was in part due to the fact that the group operated on an open system, meaning anyone could begin the group on any given week. Thus, clients could range from a new member, very angry at DHS for taking her infant, often blaming the hospital or DHS for her predicament, and not ready or interested in looking at changing her behavior, to a client close to being promoted to the next group who has been working on sobriety and changing her behaviors.

**Triage Approach:** Allocation of funds and services was based on an assessment of need and on the family's ability to utilize and benefit from services, always with the welfare of the children being the primary factor in any decisions. Intake evaluation data were used to determine both need and risk. The Child Abuse Potential Inventory (CAP Inventory) was used to determine risk of child physical abuse, the Parenting Stress Index (PSI) was used to assess degree of parental stress, as well as the parent's perceptions of the child(ren), the Beck Depression Inventory (BDI) was used to assess depressive symptoms, the Knowledge of Child Development Inventory (KCDI) was used to assess developmental expectations, and the Substance Abuse Subtle Screening Inventory (SASSI) was used to assess level of substance abuse and dependence. In addition to these paper and pencil questionnaires, a clinical interview was done to further assess psychiatric symptoms, substance abuse history and current use, social support, other risk factors as well as the client's readiness for change. Based on the information obtained at the intake session, an initial risk category was assigned (minimal, moderate, significant, and severe). As additional information was learned, and as the client progressed through the program, the risk category was reassessed. Readiness to change and willingness to work with the program were considered when determining how able the family would be to utilize and benefit from the services. Readiness to change was based on the Transtheoretical Model of Behavior Change (Prochaska, DiClemente, & Norcross, 1992) which posits various stages of change each with specific behavioral characteristics. For example, a person in the precontemplation stage has not started looking at the behavior as a problem and is likely to become angry and appear defensive if it is suggested to him or her that the behavior is a problem. Someone in this stage is not likely to begin attending services with good participation because he or she does not believe that any change is needed. Other stages include contemplation (where the person is beginning to consider making changes), preparation (where the person is looking for ways to make change), action (where the person is actively trying to change), and maintenance (where the person has made changes and is working to maintain those changes).

Despite their stage, all families were offered services and attempts were made to draw reluctant families into treatment. However, it was those families with the higher need and the higher likelihood of utilizing the services that received the most resources. This typically was those clients in the contemplation, preparation, and action stages.
5.) **Services will minimize cultural or financial barriers.**

**Use of Culturally Similar Home Visitors:** The OIAP maintained three home visitors of similar racial backgrounds. One visitor was Caucasian, one was African-American, and the third was Native American. When the home visitor of Native American descent resigned, she was replaced with another person of Native American descent. Thus, the cultural and racial similarity continued. In addition to racial similarity, three of the home visitors had a history of severe drug and alcohol abuse. Their significant amount of clean time, understanding and familiarity with 12-step groups, and personal understanding of drug addiction was incredibly helpful in both building rapport with clients and in assisting them in making changes.

**Use of Peer Volunteers:** Several peer volunteers have been utilized with the OIAP including both graduates of the OIAP, NA or AA members who are willing to come and share their story with the groups, or other parents who have achieved sobriety. In addition, an OIAP graduate was hired to be a peer counselor. Her role was to meet with the clients at their intake, attend group and get to know the clients, and offer to talk with clients confidentially outside of the group. The use of peer volunteers appeared to be helpful as clients typically felt comfortable quickly with peers and were able to relate well and benefit from their input.

**Use of Transportation Teams:** Throughout the grant period, attempts were made to encourage those OIAP clients with cars, to provide transportation for other OIAP clients. Low cost incentives such as McDonald’s gift certificates, baby supplies (diapers, bottles, etc.), lotion, nail polish, and other small items were given to those participants willing to help. Many of the OIAP clients with cars were willing to assist others with transportation to groups without these incentives. Unfortunately, not many of the clients had cars, and of those who did, many of the cars were not reliable. The OIAP was able to provide clients with bus passes. While this was very helpful for some clients, due to the limited routes and hours of the public transportation system, this was not effective for all clients. Thus, the OIAP also provided occasional cab rides and often the in-home team would provide transportation using their own cars.

6.) **To work toward timely, informed, and child-centered placement decisions and to closely monitor the development and welfare of children in the program.**

**Collaboration with CPS and Juvenile Court:** Close collaboration with Oklahoma DHS CPS workers was possible for the duration of this grant. A specially trained team of CPS caseworkers worked with the program completing both intakes and treatment. These caseworkers attended regular staffings with OIAP staff and substance abuse counselors to discuss client progress, they coordinated visits and treatment plan decisions with OIAP staff, and also attended staffings scheduled with OIAP staff and the client. The juvenile court also was involved with the OIAP. Intake reports and updates were provided on a regular basis to the court for those clients with court involvement. Collaboration also was done with the district attorney’s office. This allowed for the sharing of information regarding client progress and child safety. As a result of close communication and recommendations by OIAP, family reunification could occur in a timelier manner. DHS and the courts felt more comfortable in doing so given the increased number of professional contacts with the family. That is, they did not have to rely on only one CPS worker.
worker to make visits with the family as the OIAP was doing weekly home visits and multiple group contacts as well.

**Family Mediation and Voluntary Relinquishment:** Attempts were made to assist in the creation of a program in which independent third parties could help to broker a non-coercive solution to complex custody and parental right situations. Although several meetings were held, DHS was not comfortable with initiating a voluntary relinquishment protocol. However, voluntary relinquishment and voluntary guardianship are discussed with parents by DHS, and all acceptable options are discussed with parents by OIAP staff. Several of the mothers within the OIAP voluntarily relinquished their rights, and several others gave guardianship to another adult.

7.) **To further both basic and applied knowledge regarding children at risk of being abandoned, and to use knowledge gained through the program to provide community leadership and education regarding this population.**

**Data Collection:** A survey of hospitals in the Oklahoma City Metro Area indicated an absence of abandoned infant hospital days. This appears to be due to the quick placement by DHS of infants in need of a foster care home. Infants are typically placed in an emergency foster care home and are rarely placed in the shelter. Given the quick response by DHS, the issue of abandoned infants *in the hospital* is less of a financial issue for the hospital (as the baby is discharged to DHS), but remains a significant social issue and financial issue for the state of Oklahoma (who is paying for the foster care).

**Training and Education:** Multiple training seminars on working with at-risk children and their families were provided, mostly by Dr. Robin Gurwitch, Dr. Steve Ondersma, and Dr. Sharon Simpson. Almost 70 presentations and training seminars were conducted during the grant period to a variety of agencies, organizations, conferences, and groups across the state, country, and even internationally.
Appendix A
Brochure
Helping families with high-risk infants

The Infant Parenting Program (IPP) was designed to help families with infants or young children who were prenatally exposed to drugs or alcohol, or who are HIV positive. This program was developed because caring for such infants and children can be extremely difficult, as they may have special needs. They might not sleep or eat well, they may cry a lot, they may have behavior problems, and they may need extra time and medical attention.

Such infants and young children would be difficult for anyone. They are especially difficult for families that have substance abuse problems, financial problems, or other stressors. They are also difficult for most foster, adoptive, and relative care families. The IPP can help.

Goals of the IPP:
The IPP has many goals. It will attempt to:

- Help high-risk infants and children develop to their full potential.
- Help high-risk infants and children to remain with their natural parents or in the best placement possible.
- Keep children out of the hospital as much as possible.
- Provide the many services a family might need, including: (1) substance abuse treatment, (2) developmental evaluations, (3) parenting classes, (4) in-home services, (5) domestic violence counseling, (6) family planning, (7) medical evaluations of the infant, (8) psychiatric evaluations, and (9) case management.
- Provide these services in one place to make it as easy as possible to use all needed services.
- Coordinate with other services and agencies in the community to increase what we can offer to families.
- Be accessible and sensitive to all cultures, including and especially families of Native American heritage.

Who Can Participate and What to Expect

Families of children between birth and 6 years of age whose mothers used drugs during pregnancy can be in the program. All services are free, and can be provided to biological parents, relative caregivers, foster parents, or adoptive parents.

Services to Biological Parents

Biological parents who are involved with DHS and the court will have 9 months to graduate from the program. In order to graduate, they will be expected to participate in all recommended services and to test clean from drugs. We will do all we can to help parents graduate and retain custody of their child.

Parents may also volunteer to be involved in the IPP in order to help them learn to avoid drugs and to provide better care for their children. The court is not involved in any way with parents who volunteer for the IPP.

Services to Foster / Adoptive Parents

Foster parents, adoptive parents, and relative caregivers all may receive help in dealing with the special needs of prenatally exposed children. These services will continue until the child reaches school age.

Services to Children

All children involved in the IPP receive regular developmental and medical evaluations in order to monitor and enhance their growth.

For more information, contact the IPP office at (405) 271-1292, Ext. 42119.
The Infant Parenting Program is a consortium of three programs within the Department of Pediatrics of the University of Oklahoma Health Sciences Center:

- The Oklahoma Infants Assistance Program (OIAP) is part of the Center on Child Abuse and Neglect, and is funded by a grant from the Children’s Bureau, a division of the Department of Health and Human Services.
- The Oklahoma Parenting Project (OPP) is also part of the Center on Child Abuse and Neglect, and is funded by the Oklahoma Department of Human Services.
- The A Better Chance program (ABC) is part of the Child Study Center, and is funded by the Department of Mental Health and Substance Abuse Services.

THE INFANT PARENTING PROGRAM:

A Better Chance
Oklahoma Parenting Project
Oklahoma Infants Assistance Program

SERVICES FOR HIGH-RISK CHILDREN AND THEIR FAMILIES

The University of Oklahoma is an Equal Opportunity Institution.
Appendix B
Home Visitation Manual
The Infant Parenting Program was made possible by a grant from the Children's Bureau (ACYF/U.S. Department of Health and Human Services) to Dr. Ondersma and the OUHSC.
HOME VISITOR SAFETY

Staying safe is one of the most important aspects of home visiting. A home visitor should never, ever take risks or underestimate any potential danger. Factors to keep in mind include the following:

♦ Make certain your car is in good working condition.
♦ Post a sign in your car that identifies the program.
♦ Call the office before and after a visit that could involve danger.
♦ Make a home visit with a colleague rather than being alone.
♦ In dangerous neighborhoods, make home visits in the morning.
♦ Call the parents just before a home visit so they can watch for you.
♦ Carry a cellular phone (make sure the battery is charged!).
♦ If a situation does not feel right, do not leave your car.
♦ Be organized with materials that are beside you so that you do not have to hunt for them.
♦ Be respectful and professional.
♦ When you leave the home visited, have your car keys in hand.

INFANT PARENTING PROGRAM

HOME VISITOR INTRODUCTORY SESSION OUTLINE

It's crucial that clients get a sense, right off the bat, of what your role is and what they'll be doing with you. It's also important that you set the correct tone right away—the first session with a client, in many ways, determines what all of the subsequent sessions will be like. Ideally, we want clients to learn right away that home visits are about:

1. Being listened to, understood, and respected
2. Discovering that they can do more than they thought they could
3. Focusing on techniques for maximizing their children's physical and emotional health
4. Focusing on their treatment plan
5. Actively coping with difficult problems
6. Finding support in the community

A first session, then, might go something like this:

1. "As you know, part of the IPP is having a home visitor. Have you wondered what exactly home visits are for?" Listen reflectively, looking out for indications that they think your role is to "spy" on them and their home. Affirm any correct ideas, and explain that your job is to help them reach their goals, and to help them raise the healthiest baby possible. Note that for most clients, getting custody of their baby, staying clean, and raising the most healthy baby possible are their biggest goals.

2. "Well, home visitors are people who help parents in any way they can..." Define your role for them in general. "A big part of what home visits are for is to go over information about babies (or "children") together. This isn't because anyone thinks you don't know enough—it's because you can never know enough when it comes to helping children be their best!" Show them the checklist and their folder and explain how it will work.

3. "However, home visits are also about specific things that you're interested in. We need you to tell us what you want more or less of, and what your goals are. Take a look at this sheet and mark your five most important goals. You can also add any that aren't there."

4. Next, add their goals to the treatment plan and ask them for specific steps that will help them reach that goal. You probably will need to help them with this.

5. Ask for their reactions, questions, etc. Explain how often you were thinking about visiting, and ask for their reactions to this.
INFANT PARENTING PROGRAM

Home Visiting Worksheet #1

What are my goals?

Different people have different goals. Home visiting is about helping you to reach those goals. Please mark the five goals that are most important to you. You can add any that aren't here.

- Getting custody of my baby by:
  - Staying clean
  - Getting safe housing
  - Working on baby skills
  - Making it to all my groups

- Raising the healthiest baby possible

- Staying clean (for me)

- Getting a job

- Getting financial help

- Finding a safe place to live

- Being the best parent I can be

- Finding only safe people to be with/talk to

- Being safe from a partner or ex-partner

- Beating my depression or other emotional difficulties

- Feeling less stressed when dealing with my children

- Family planning (only having another baby when I'm ready to)

- Permanent birth control (making sure I don't have more children)

- Accepting that I want my children raised by someone else
**THE HOME TEAM EVALUATION INTERVIEW**

The Home Team Evaluation Interview (or "HOMETEI") is an interviewer-administered measure of specific infant caregiver knowledge in eight domains.

### Home Team Evaluation Interview

**NURTURING**

(1 = target area; 2 = average; 3 = good to excellent)

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Why do babies cry?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. What are some ways to soothe a crying baby?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. Is it best to pick up a crying baby right away or to let them cry?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. How do you show a baby you love him or her?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. Can babies try to help their parents feel better?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### FEEDING

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are signs that a baby is hungry?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. What are some important things to remember when bottle feeding a baby?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. How does a baby tell you he is finished eating?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. What can happen if a baby gets solid food too soon?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. What does it mean when a baby less than 18 months old throws or plays with her food?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### SLEEPING

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Why is it important to have a sleep routine?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. How can you help a baby go to sleep?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. What are some problems with a baby sleeping in mom's bed?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. What should you do if a baby wakes up in the middle of the night?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. What position should babies sleep in?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### HYGIENE AND TOILET TRAINING

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In general, how often does a baby need his or her diaper changed?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. What causes diaper rash?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. What should you do if you're bathing your baby and the phone or doorbell rings?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. How do you know when your child is ready for toilet training?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. What should you do if a child does not seem to want to be toilet trained?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### SAFETY

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How long can babies be left alone?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. What are some things around the house that can be dangerous to a baby?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. What are the best ways to prevent SIDS? (crib death)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. What should you look for in a babysitter?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. How can you prevent accidents?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### MEDICAL

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do you know if a baby is sick?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. How do you know when you should call the doctor?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. Why does your child need regular checkups?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. What are some reasons why babies should have one doctor who they always use?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. What should you do if you are suddenly worried about your baby's health?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### DEVELOPMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What does it mean when a baby less than 9 months or so hits?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>2. What can you do to help your baby learn to talk?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>3. At what age range are most children ready for toilet training?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>4. In general, what are the best ways to enhance a baby's growth and learning?</td>
<td>1 2 3</td>
</tr>
<tr>
<td>5. What are some good games you can play with a baby?</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### TOTALS

**NURTURING TOTAL:**

**FEEDING TOTAL:**

**SLEEPING TOTAL:**

**HYGIENE TOTAL:**

**SAFETY TOTAL:**

**MEDICAL TOTAL:**

**DEVELOPMENT TOTAL:**
DISCIPLINE

1. Can a baby less than 6 months old misbehave?  
2. What is the best way to change a young baby’s behavior?  
3. What are some advantages of time-out compared to spanking?  
4. What should you do when your child has a temper tantrum?  
5. Do parents ever need a time-out?

DISCIPLINE TOTAL: ___
OVERALL TOTAL: ___
NURTURING

1. Babies cry for several different reasons. Here are some examples. First, crying helps get air into the baby's lungs. Second, your baby has many feelings and cries to show his/her feelings and needs. Third, baby's cries can give parents information about the baby such as: wet diaper, hot, cold, need to burp, need to suck, not enough happening, too tired, thirsty, hungry, tummy hurts, etc. Fourth, a baby can tell how parents feel. A baby may cry when parents feel tired, sick, angry, sad, rushed, or very excited.

2. Parents can comfort a baby by holding the baby, rocking the baby, walking the baby, rubbing the baby's neck, talking softly, and singing to the baby.

3. Doctors think that it is ok to comfort a baby when he or she cries. Doctors think parents can not spoil a baby by comforting his or her cries.

4. You can show a baby that you love him or her in several ways: play with your baby, touch your baby, and hold your baby.

5. No. While a baby may be able to tell that you are upset, your baby is not able to comfort you. Babies are only able to try to comfort themselves, they are not capable of trying to comfort you. They can only do this when they get older.

FEEDING

1. A child can express hunger by crying, sucking, chewing, and being irritable, restless, or fussy.

2. Use formula for a baby less than 1 year old. Do not use regular cow's milk until the baby is 1 year old because it can cause an upset tummy and internal bleeding. Formula is cow's milk that is made special for a baby. It is important to make the formula the right way, because if is not, the baby will not get the right amount of food. Do not add more water than the can says to for powder or concentrate formula. Do not add any water to ready-to-feed formula. Do not add sugar or salt to the formula. Sometimes the water added to formula needs to be boiled to make it sterile. Make sure the bottles are cleaned thoroughly after each feeding. When feeding your baby it is important to hold them the proper way. First make sure that the baby is being held while being bottle-fed. The reasons for this include: your baby needs to and enjoys touching you, your baby gets to know you better, and propping the bottle may cause her to choke.

3. A baby can tell you he or she is finished eating by turning his or her head away from food, spitting out food, keeping mouth closed, throwing food on the floor, wiggling, and moving a lot.

4. If a baby gets solid food too soon, food sensitivity is more likely to occur. A baby's body is not ready to properly digest solid food until 6 months old. Some solid foods can make a baby's tummy upset or cause the baby to have gas. In addition, a baby may be so full from eating solid food that he or she will not drink enough breast milk or formula. This can result in the baby not getting the proper vitamins and minerals he or she needs.

5. There is no need to worry if a baby less than 18 months old plays or throws food. Mealtimes are no longer just for nourishment, but for exploration and discovering as well. The baby is finding out about cause and effect, about textures, and about temperature differences. Mealtime is a fun and learning experience.

SLEEPING

1. A sleep routine is important. Here are some reasons why: your baby will know when it is time to sleep, know what is going to happen, get relaxed, feel safe, enjoy bedtime, get adequate amount of sleep, and trust parents and others in the family. In addition, the parents and other family members will learn what helps the baby go to sleep, have time to do their things, enjoy baby's bedtime, and know how to tell other people taking care of the baby how to help the baby to go to sleep.

2. You can help a baby go to sleep by reading the baby a bedtime story, giving the baby a warm bath, gently rubbing the baby's back, infant massage, rocking the baby in a rocking chair, or giving the baby a special toy or blanket.

3. There are some problems that can occur if baby shares bed with mom. First, sharing a bed with mom is a cause of sleep disorders and deprives children of the chance to learn how to fall asleep on their own. Second, chronic nighttime feeding can encourage dental problems. Third, it may interfere with the child developing a strong sense of self, a feeling of independence, and a sense of privacy. Fourth, sharing a bed with the baby can cause marital problems (sexual relationship). Fifth, smothering and rolling onto the baby can also occur when sharing a big bed with more than one occupant. Lastly, how do you teach a child who has slept with you to suddenly sleep in her own bed.

4. If a baby wakes up in the middle of the night he or she may need special help. Reasons for waking up include: wet diaper, thirsty, too cold or too warm, too noisy, getting new teeth, sick, cannot relax, afraid, and not tired. Babies who are not tired at bedtime may not need an afternoon nap, or may need to go to bed at a later time. You can tell if a baby is tired if he or she: rubs eyes, rubs ears, sucks thumb, or cries. It is a good idea to rub your baby's back, rock your baby, or take your baby for a walk to get him or her calm and soothed.

5. The best position for a baby to sleep is on his or her back. This is the best way to prevent SIDS (Sudden Infant Death Syndrome)
SAFETY

1. Babies can never be left alone. They need constant supervision.

2. There are many items around the house that can be of danger to a child. Various small things such as buttons, rubber bands, tacks, pins, paper clips, and coins can choke a child. Cords, ropes, and string, that are common to telephones, necklaces, and toys, can also choke a child. Plastic bags such as grocery sacks, broken balloons and plastic wrap can choke or suffocate a child. There are also things that touch your child that can harm your child such as hot water, hot food, or a hot car seat. Matches, cigarette lighters, and lit candles can also be of harm. Another danger is the kitchen. Make sure when cooking to put pan on the back burner and turn pan handles to the middle of the stove so your child cannot grab handle and spill hot food. Make sure never to hold your child when cooking on the stove because the child’s clothes could catch fire, and the hot food can burn the child. Never let your child near space heaters. If your child crawls, she can get close to the heater and could be burned. Keep sharp items such as hangers, pins, tacks, safety pins, and scissors away from your child because if your child grabs them he or she could get hurt. Keep poisons away from your child. Some examples of poisons include many medicines, cigarettes or ashtrays, drugs or alcohol, things to clean with, animal and insect poisons, dog and cat food, and gasoline and paints. Plants can also be poisonous, so be sure to put them up high and away from a child’s reach. Also be sure to keep your child away from plants when outside. There are several other things to be cautious of around the house, but here are a few more examples: never let crib bars be more than three fingers apart, cover all steps and electric outlets, and use safe high chairs and playpens.

3. The best way to prevent SIDS (crib death) is to make sure that your baby is sleeping on his or her back or side. Babies can never be left alone. They need constant supervision.

4. Things to look for in a babysitter include someone who is: old enough to watch your child, likes children, pays attention to your child, follows your directions, helps when your child is in trouble, and has experience with children's age. Here are some other ideas about what a good babysitter will do with your child: play with your child, talk to your child, be gentle with your child, feed your child when he or she is hungry, put your child to bed when he or she is tired, check your child’s diapers, comfort and calm your child, and take away dangerous things. A good babysitter will not do things that make it hard for her to watch your child carefully. She will not have visitors, talk on the phone, watch TV when child is awake, and do unsafe things.

5. There are numerous ways to prevent accidents. First, watch your child at all times. For example watch your child when you are alone with your child, having visitors, at church, watching TV, shopping, and reading. Second, make places where you live safe by child proofing. Third, try to think like your child thinks so that you can predict what he or she will do next. Fourth, never think like this: “he knows better”, “I already told her about this”, “he does not know how to do that yet”, and “she will not think about doing that”. Fifth, always have important numbers available for anyone caring for your child. Good numbers to have include: fire station, police, poison control center, doctor’s office, emergency room, friends and family who can help, drug store, taxi, and child abuse prevention.

HYGIENE AND TOILET TRAINING

1. How often a baby needs his or her diaper changed is largely dependent on the age of the baby. Babies 0 - 3 months old need 6 - 10 diapers per day, 3 - 6 months old need 5 - 8 diapers per day, and 6 - 24 months old need 4 - 6 diapers per day. The main point here though is to check your baby’s diaper often and change it as soon as there is a mess.

2. Wet diapers can cause a diaper rash. That is why it is important to not let your baby stay in wet diapers. Wet wipes, lotion, baby powder, and baby oil can also cause a diaper rash.

3. If the doorbell or telephone rings while you are giving your baby a bath do not answer it, or wrap the baby in a towel and take your baby with you.

4. There are some helpful things to look for when a parent is deciding whether their child is ready for toilet training. Here are some things to look for: diaper stays dry for 2 or 3 hours, and when a diaper gets wet, it really gets wet; watch the child’s face and body; and the child likes clean hands and clothes. Here are some other things to look for: when a child is told to “sit down” and “point to your noise, eyes, mouth, or hair”, and the child can do these things; when a child can tell his parents what he wants; when a child wants to do things alone and does not want help from anyone; when a child can dress and undress himself or herself; can pretend to use the toilet like mom and dad do; and when a child wants to make parents or other family members happy. If your child can do 4 or 5 of these things your child is ready for toilet training.

5. If a child does not seem to want to be toilet trained, first refer to question number 1 above. Regardless, be patient. Present your toddler with the option of using the toilet or the potty chair, with no pressure to use it. The thing to keep in mind is that success must ultimately come from your toddler’s efforts, not from yours.

MEDICAL

1. A parent can find out if a baby is sick by watching for these signs in their baby: feels hot, has a fever, in a bad mood, feels mad, is fussy, cries a lot, sleeps a lot more, does not play as much, and eats a lot less than before. If your baby acts in these ways, he or she may be sick.

2. Call the doctor’s office or clinic when: your child’s auxiliary temperature (under arm) is 100 degrees or higher, for
more than 24 hours, your child has a fever with diarrhea and vomiting, your child is sick for two days, your child has a cold for 2 weeks, will not eat for two days, coughs for more than 1 week, sleeps more, or does not want to play. When your child is sick you want to call the doctor’s office or clinic during regular office hours because: doctors and nurses are not as nice at night, you may not be as calm if you do not wait, you cannot get medicine as easy at night, it is not as easy to get help from relatives, neighbors, or friends at night. If you are too worried to wait until the doctor’s office or clinic opens, here is what to do: call doctor’s office and use the number for after hours or weekends, and if you can not reach your doctor, call the emergency room at the hospital. Tell them what is wrong with your child and ask them if you should bring your child to the emergency room.

3. It is important that your child get regular checkups. Checkups are important because they help you take good care of your child, they help your child stay healthy and children grow best when they are healthy. Regular checkups can find problems with children that parents cannot see, show parents new things their children can do, and give parents answers to the questions they may have about their children. They can also tell parents about the best food for their children, new ways to play with their children, and how to keep their children safe.

4. It is a good idea that your child has one doctor who they always go to for checkups. First, the doctor or nurse will get to know you and your child. Second, he will be able to help your child better and be able to find problems more quickly. Third, you will get to know the doctor or nurse. Fourth, you will feel more comfortable asking questions and talking about your child’s health.

5. If you are suddenly worried about your baby’s health first refer to question numbers 1 and 2 above. Feel free to call your doctor, IPP worker, or the ABC clinic. It may be a good idea to talk to a doctor or nurse over the phone to see if an appointment or checkup is needed.

**DEVELOPMENT**

1. If a baby less than 9 months old hits there is nothing to worry about. This is just another way in which the baby is exploring, playing, and using his or her body. It is ok to calmly and gently say “don’t hit”. It is also good to distract the baby with something that will take his or her attention away from the act of hitting.

2. An important aspect in helping a child learn to speak is talking. Babies of all ages like to hear mom, dad, and others in the family talk to each other and to him or her. Babies also benefit when the family copies the sounds the babies make. The more interaction and speech available, the more the child is going to soak up and learn. Other ways to help a child learn to talk is reading to him or her and playing music with easy to follow lyrics.

3. Most children are not ready for toilet training until between 2 and 3 years old.

4. In general, a good way to enhance a child’s growth and learning is through play. Play is how children learn about everything. When your child plays, he or she learns about himself or herself, about others, and about how things work in the world. Other ways to help a child grow and learn is through playing games, singing songs, talking, and reading.

5. Children love to play games. There are many games you can play with your child. Here are just a few ideas. Our first suggestion is Peek-a-boo. The second suggestion is So-big. This game is good for babies 3 months old and older. To play the game first put your child on her back. Second, gently lift her arms ups. Third, smile and say: Mary is sooo big.” As your child grows, play So-big while she is sitting up. Our third suggestion is Find The Toy. This game is appropriate for babies 8 months old and older. Sit with your child on the floor and put a toy on the floor in front of your child. Then, cover the toy with a paper towel or diaper and say, “Where’s the toy?” letting your child find the toy. Our fourth suggestion is Pick Up. This game is appropriate for babies 8 months old and older. Drop a toy in front of your child, point to the toy and say, “Can you get the toy?” Then, smile and clap your hands for your child as he or she picks it up. Our last suggestion is Pat-a-cake. This game is appropriate for 10 months old and older.

**DISCIPLINE**

1. Babies who are 6 months old or younger can not misbehave! Younger babies do not know what is OK or what is not OK. They can not remember what mom or dad tells them. They do not understand about rules. They do not do things to make mom or dad mad or upset.

2. Young babies do not misbehave, but they may do things that you do not want them to do. The best ways to change a young baby’s behavior is to distract the baby and childproof the area for the baby.

3. Time-out has many advantages over spanking. Here are some of them: helps the parents stay in control, teaches children to stay in control, reduces anger in child, teaches self-discipline, less damaging on self esteem, less guilt felt by parent, consistent md predictable, does not teach that hitting is OK, no chance for injury (child abuse), and there is no risk of shaking a baby or child which is a NO NO!!!

4. If your child has a temper tantrum ignore the child. If the child has a temper tantrum in a dangerous or public place, remove the child to a safe place and then ignore the child.

5. Even parents need time-outs. For example, when you are very mad and feel like you want to hit, slap, or shake your baby you need a time-out. Try some of these ideas. 1. Stop where you are, step back, and sit down. 2. Take 5 deep breaths slowly. 3. Count to 10 or say the alphabet out loud. 4. Hug a pillow or chew on an apple. 5. Lie down on the floor or just put your feet up.
# HOME VISITATION TREATMENT PLAN

<table>
<thead>
<tr>
<th>GOAL</th>
<th>SPECIFIC GOALS</th>
<th>DATE COMPLETED/COASTING</th>
</tr>
</thead>
</table>
| 1.   | a. Complete assessment  
      | b. Complete first three "primary" areas  
      | c. Complete all remaining areas  
      | | a.  
      | b.  
      | c.  
      | d.  
      | e.  |
| 2.   | a.  
      | b.  
      | c.  
      | d.  
      | e.  | a.  
      | b.  
      | c.  
      | d.  
      | e.  |
| 3.   | a.  
      | b.  
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| 4.   | a.  
      | b.  
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      | e.  |
TRIAGE

Based on an initial evaluation and a 1 to 4 week trial period, clients will be placed into one of three groups:

1. **Low Risk Group.** These parents appear to be at relatively lower risk than others, and appear more likely than others to function reasonably well as parents without intensive services.

2. **High Risk, High Preparedness Group.** These parents appear to be at high risk for parenting difficulties, but also show evidence of being able to effectively use available services.

3. **High Risk, Low Preparedness Group.** These clients appear to be at high risk for parenting difficulties, but consistently fail to show willingness or ability to use available services and make changes.

TRIAGE WITHIN THE HOME-VISITING COMPONENT

Clients in Group 2 are most likely to benefit from a high level of home visiting team contacts, with clients in Groups 1 and 3 not benefiting as much. However, this is not necessarily the case. For example, a family in Group 1 might be at relatively low risk for child maltreatment or substance abuse, but could be very isolated or lacking in living skills. Thus, families will be assigned to three broad types of home-visiting approaches:

1. **Level 1, Low Intensity.** Families assigned to this level of in-home services will be those that seem to require minimal support regarding parenting skills, living skills, or case management. They may not have a child in the home, or they may have been able to retain very good parenting and living skills despite moderate substance abuse. Visits for this group will focus on learning specific skills such as infant massage, as well as on addressing isolated difficulties such as poor social support. Visits will occur at least monthly.

2. **Level 2, Moderate to High Intensity.** Families in this level are those that require a higher level of home-based services. Most of these families will have been triaged into the High-Risk, High-Preparedness Group. Visits will occur approximately weekly, with some families receiving less and some receiving two visits per week.

3. **Level 3, Motivational Intensity.** While the frequency of visits may vary widely in this group, infrequent visits will be most common. The goal of visits will be to build willingness and ability to utilize available services. The goal will not be to teach specific skills, since the client is seen as not ready to do such work. Rather, the home visitor will attempt to engage the client via support, trust-building, decisional balance interventions, and encouragement. If clients respond, they will be moved into one of the above levels. If they do not respond after a certain period of time, visits will be reduced greatly in frequency until the client either responds or is dismissed from the program.
INFANT PARENTING PROGRAM

Exercise Checklist

Nurturing

- Help for Crying- (Meld, Book 1, pg. 59-73)
- All Babies are Different- (Meld, Book 5, pg. 11-15)
- Having Fun with Baby- (Meld, Book 1, pg. 93-103)
- Infant and Child Massage- (Nurturing Book for Babies and Children, pg. 26-44)
- Happy Time/Sad Time Changes- (Meld, Book 5, pg. 19)
- Infant Behavior (stiffness or rigidity, trembling, inability to sleep, hyperactivity, prolonged or high pitched cry, attention deficit, excessive sleepiness)-(IDCFS, pg. 2, 12, 14, 13, 15, 4)

Feeding

- How to Feed Baby- (Meld, Book 1, pg. 1-6)
- Bottle Feeding- (Meld, Book 1, pg. 20-33)
- Feeding a 9-12 month old- (Meld, Book 2, pg. 33-37)
- How Toddlers Eat- (Meld, Book 2, pg. 39-50)
- Finger Foods- (Meld, Book 2, pg. 51-56)
- Nurturing Feeding Time Routine- (Nurturing Program Parent Handbook, pg. 85)
- Eating Changes- (Meld, Book 5, pg. 16)
- Questions and Answers about a Baby’s Nutrition (0-6 months)- (Meld, “Hands on Help” handout)
- Feeding Your Child, Things to Know First- (Meld, Book 2, pg. 1-10)
- Infant Behavior (poor feeding, poor sucking, spitting up, vomiting, projectile vomiting, frantic sucking of fists)-(IDCFS, pg. 3, 8, 10, 11)

Sleeping

- Naptime/Bedtime (routines)- (Meld, Book 5, pg. 47-55)
- Sleeping Changes- (Meld, Book 5, pg. 17)
- Reasons for Bedtime Blues- (Meld, “Hands on Help” handout)
- Bedtime Routines- (Meld, “Hands on Help” handout)

Hygiene and Toilet Training

- Diapering- (Meld, Book 1, pg. 43-45)
- Sponge Baths- (Meld, Book 1, pg. 46-52)
- Tub Baths- (Meld, Book 1, pg. 53-56)
- Toilet Training, Is your Child Ready?- (Meld, Book 5, pg. 44-46)
- Diapering Changes- (Meld, Book 5, pg. 18)

Safety

- Babysitter Sheet- (Meld, Book 4, pg. 25-26)
- Emergency Numbers- (Meld, Book 4, pg. 12)
- When Accidents Happen- (Meld, Book 4, pg. 55-74)
- Keeping a Baby Safe: 20 Rules- (Meld, Book 1, pg. 75-92)

Medical

- When Accidents Happen- (Meld, Book 4, pg. 55-74)
- Middle ear Inflammation (Otitis Media)- (What to Expect the First Year, pg. 423, 425, 426)
- Check-ups and Shots- (Meld, Book 3, pg. 1-20)
- Hearing and Seeing- (Meld, Book 3, pg. 21-24)
- How to be Ready for Illness- (Meld, Book 3, pg. 25-45)
- How to Give Medicine and Love to a Sick Child- (Meld, Book 3, pg. 46-53)
- Flu Bug Blues (Basic Illness and Safety Overview)- (Nurturing Book for Babies and Children, pg. 120-127)
- Caring for a Sick Child (colds, ear infections, vomiting, diarrhea, teething,
diaper rash, allergies)- (Meld, Book 3, pg. 55-84)

- Infant Behavior (diarrhea, fever 101 or higher, respiratory distress, apnea, sneezing, nasal stuffiness)-(IDCFS, pg. 5-9 & 16)

**Development**

- Playing with your Baby (0-3 months)- (Meld, Book 6, pg. 6-9)
- Playing with your Baby (3-6 months)- (Meld, Book 6, pg. 10-12)
- Playing with your Baby (6-12 months)- (Meld, Book 6, pg. 13-16)
- Playing with your Baby (12-18 months)- (Meld, Book 6, pg. 17-20)
- Playing with your Baby (18-24 months)- (Meld, Book 6, pg. 21-25)
- Activities for Infants- (Nurturing Book for Babies and Children, pg. 45-58)
- Activities for Toddlers- (Nurturing Book for Babies and Children, pg. 59-75)
- Body Changes- (Meld, Book 5, pg. 23-28)
- Playing Changes- (Meld, Book 5, pg. 20)
- Talking Changes (Meld, Book 5, pg. 21-22)
- Playing to Learn (0-6 months)- (Meld brochure)
- Playing to Learn (6-12 months)- (Meld brochure)
- Playing to Learn (1-3 years)- (Meld brochure)

**Discipline**

- Basic Handout for 0-6 months and 7-24 months- (Meld, Book 5, pg. 29-43)
- Basic Handout for 0-6 months only- (Meld, Book 5, pg. 29-32 & 36)

**ABC Appointments**

- 3 month
- 6 month
- 12 month

**Triage**

- Group one: low intensity (low to moderate risk); weekly visits or less
- Group two: high intensity (moderate to high risk, moderate to high readiness); twice weekly visits
- Group three: motivational intensity (moderate to high risk, low readiness); monthly visits
SUGGESTIONS FOR HELPING INFANTS WITH PRENATAL EXPOSURE TO DRUG OR ALCOHOL ABUSE TO SELF-CALM

- Hold and swaddle the infant. Wrapping the infant tightly in a soft, snug blanket can give the infant a sense of security. These infants usually like to be held fairly tightly. Softly speaking to, gently touching, or massaging the infant while holding him or her can assist in calming. Using the same routine helps the infant become accustomed to the process.
- The infant may be sensitive to stimulation. Thus, bright lights, fast movements, or loud noises should be avoided.
- Keep the infant in a position so that he or she is facing the caregiver directly. It may take a few weeks of practice before the infant naturally makes eye contact with the caregiver.
- The infant often enjoys soothing by sucking, even when not feeding.
- A gentle foot, ankle, or back massage can help tense infants relax.
- Because diaper changing can be stressful, use of diapers with tape is easier. It is easiest for the infant if the diapers are changed when he or she is sleepy. Speaking softly and massaging helps ease the process.
- Infants prenatally exposed to drug or alcohol may have uncoordinated suck and swallow reflexes. They may have difficulty keeping food down. Given these difficulties, caregivers need to take ample time for feeding and to be as relaxed as possible. Several short meals may be easier for the infant than only a few longer meals. These infants need their caregivers to hold their bottle.
- Solid foods need to be introduced gradually in small amounts.
- Sleep can be very problematic for infants prenatally exposed to drug or alcohol abuse. They may not be able to wake-up gradually, and they often move quickly from a deep sleep to intense crying and screaming. Because most infants feel sleepy after feeding, feeding just before bedtime can help promote sleep. Speaking softly, giving soft massages, and using a night-light can be reassuring.
- Infants ages 6-9 months can have a predictable bedtime. A bedtime ritual can assist in calming the infant before sleep.
- Infants prenatally exposed to drugs and alcohol sleep more restlessly and wake more than other infants. When such infants awaken in the night, caregivers can speak softly to them. Bottles or food should not be given during the night.
- The infant needs help in being comfortable with touch. Caregivers should gently touch the infant frequently for brief periods.
- Caregivers should speak frequently throughout the day to the infant.
- In some cases, nothing a caregiver does stops the infant from crying. Infants prenatally exposed to drug or alcohol abuse can experience discomforts that cannot be relieved. In these situations, caregivers need a helper to provide them with a break.


**Technique Reminder List (p. 20-23; 39-54)**

- Shared delight in the child
- Building on strengths
- Observation and descriptive affirmation
- Modeling
- Sharing developmental information
- Making developmental interpretations
- Offering suggestions
- Questioning
- Problem Solving
- Role-playing
- Linking with group activities
- Linking with ABC suggestions
- Giving "menu" of technique options
- Networking:
  - Infant Crisis Center
  - Vocational centers
  - 12-step groups
  - Sober Living
- CDI skills from PCIT
- Brainstorming
- Bringing to just visit an agency
- Relationship building with parent:
  - Reflective listening
  - Rolling with resistance
  - Labeled praises
IPP Responsibility Group

Personal Statement

Making big changes in our own beliefs and behaviors is very hard to do. This Personal Statement is to help you become ready to make important changes. Please answer the following questions as honestly as you can. The rest of the group and the group leaders will ask questions and give you feedback.

1. Why are you in this program?

2. How has your drug use affected your baby?

3. How could drug use now affect your baby?

4. While you were using, how did your drug use and behavior affect your other children (if you have other children)?

5. Describe specific times that you made poor parenting decisions because of drugs.

6. How has your drug use affected you?
7. How did you try to fool others while you were using?

8. What specific things would you like to stay the same about your parenting?

9. What specific things would you like to change about your parenting?

10. In what ways have you changed since starting the program?

11. What kinds of changes do you think you still need to make?

12. What makes you think that if you decided to make a change, you could do it?

13. Describe what your life might be like if you were able to make a lasting change.
Rating Criteria for Personal Statements

A good personal statement takes a lot of hard work. A good statement:

1. Shows acceptance of responsibility.
2. Shows awareness of the specific effects of past behavior on yourself and on others.
3. Is detailed and gives a lot of specifics about why the person thinks or feels a certain way about their drug use or parenting.
4. Is said to the group and not just read from paper.
5. Seems to have taken real effort; is from the heart.

A statement is **not good just because:**

1. It is long.
2. The person is upset while they talk.
3. The person makes general statements like “I need to change,” “I want to change,” “I should not have done that,” or “Things are better now.”
4. The person talks about bad things that have happened to them.

It is important that we help others move forward in the program by giving them good feedback and honest ratings. **After** everyone asks questions about each statement, please use this rating system to decide what score to give. Use the statements by each rating to help you decide which number mostly fits that personal statement. Which set of statements best describes how this person did?

1 = Not taking responsibility for drug use and parenting difficulties
   Denying and/or blaming other people or situations
   Leaving out a lot of information or details
   Not answering questions

2 = Saying some of the right things, but mostly not taking responsibility for drug use and parenting difficulties
   Some denying and/or blaming
   Giving a little information or a few details
   Giving answers that don’t answer the question asked

3 = Taking some responsibility for drug use and parenting difficulties
   Almost no denying and/or blaming
   Giving some information or details

4 = Taking a lot of responsibility for drug use and parenting difficulties
   No denying and/or blaming
   Some new information, but some important information or details missing
   Answering most questions but leaving out important details or information

5 = Taking lots of responsibility for drug use and parenting difficulties
   No denying or blaming
   Giving all relevant detail, along with a lot of new information
   Answering all questions, not leaving out any important information
Appendix D
Process Evaluation Findings
FINAL PROCESS EVALUATION FINDINGS:
OKLAHOMA INFANTS ASSISTANCE PROGRAM

For Period: October 1, 1996 through September 30, 2000

Prepared by: Robert E. Aronson, Dr.P.H.
OIAP Evaluator
Total Client Contacts
During the entire program period from October 1, 1996 through September 30, 2000, the Oklahoma Infants Assistance Program (OIAP) provided services and counseling to a total of 191 clients. Table 1 shows the number of clients per year and the total for the entire project. The number of clients for the entire project is less than the sum of the number of clients each year, because many clients received services in more than one year.

Table 1: Client and Contacts Per Fiscal Year

<table>
<thead>
<tr>
<th>Project Fiscal Year</th>
<th>Total # of Clients</th>
<th>Total # of Contacts</th>
<th>Mean # Contacts per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1996</td>
<td>25</td>
<td>194</td>
<td>7.8</td>
</tr>
<tr>
<td>FY 1997</td>
<td>83</td>
<td>1368</td>
<td>16.5</td>
</tr>
<tr>
<td>FY 1998</td>
<td>85</td>
<td>1467</td>
<td>17.3</td>
</tr>
<tr>
<td>FY 1999</td>
<td>77</td>
<td>1353</td>
<td>17.6</td>
</tr>
<tr>
<td>Entire Project Period</td>
<td>191</td>
<td>4382</td>
<td>22.9</td>
</tr>
</tbody>
</table>

The in-house and extended staff completed 4,382 contacts with these clients (Table 2), resulting in an average of 22.9 contacts per client for the four year period. Since some of the clients received services for more than one year, this figure is skewed by these clients. A more accurate reflection of the intensity of services received by clients would be the mean number of contacts per client per year. A slight increase in this intensity is observed between fiscal years 1997 and 1999. The level is greatly less in fiscal year 1996, since services were not being provided the entire year. The majority of contacts were through group sessions (N=1,644), clinic visits (N=1,225) and home visits (N=1,019). In fiscal year 1999 we see that home visits exceeded clinic visits for the first time, and phone calls became much more frequent.

Table 2. Types of Contact by Fiscal Year

<table>
<thead>
<tr>
<th>Type of Contact</th>
<th>FY 1996</th>
<th>FY 1997</th>
<th>FY 1998</th>
<th>FY 1999</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Session</td>
<td>73</td>
<td>594</td>
<td>540</td>
<td>437</td>
<td>1644</td>
</tr>
<tr>
<td>Clinic Visit</td>
<td>63</td>
<td>448</td>
<td>393</td>
<td>321</td>
<td>1225</td>
</tr>
<tr>
<td>Home Visit</td>
<td>50</td>
<td>227</td>
<td>356</td>
<td>386</td>
<td>1019</td>
</tr>
<tr>
<td>Phone Call</td>
<td>8</td>
<td>99</td>
<td>178</td>
<td>209</td>
<td>494</td>
</tr>
<tr>
<td>TOTAL</td>
<td>194</td>
<td>1368</td>
<td>1467</td>
<td>1353</td>
<td>4382</td>
</tr>
</tbody>
</table>
Case management activities were conducted daily by the home visitation team. Home visitation staff spent 226,430 minutes, ranging from 350 to 101,880 minutes per year (see Table 3), conducting additional case management activities including brief phone calls, paperwork, consultations with other professionals, and travel time. Time spent conducting case management activities increased considerably over the life of the project.

Table 3: Time Spent on Case Management Activities

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Time Spent in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1996</td>
<td>350</td>
</tr>
<tr>
<td>FY 1997</td>
<td>34,940</td>
</tr>
<tr>
<td>FY 1998</td>
<td>89,260</td>
</tr>
<tr>
<td>FY 1999</td>
<td>101,880</td>
</tr>
<tr>
<td>Total Project</td>
<td>226,430</td>
</tr>
</tbody>
</table>

Group Sessions

A total of 354 separate group sessions, attended by 130 different clients, were conducted during the four year project period. Table 4 shows the number of groups and participants by fiscal year.

Table 4: Group Sessions and Participation by Fiscal Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th># of Groups</th>
<th># clients participating</th>
<th>Total # of group visits</th>
<th>Total # of group no-shows</th>
<th>Total # of group visit cancellations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>20</td>
<td>15</td>
<td>73</td>
<td>43</td>
<td>14</td>
</tr>
<tr>
<td>1997</td>
<td>127</td>
<td>51</td>
<td>594</td>
<td>296</td>
<td>100</td>
</tr>
<tr>
<td>1998</td>
<td>120</td>
<td>56</td>
<td>540</td>
<td>296</td>
<td>127</td>
</tr>
<tr>
<td>1999</td>
<td>87</td>
<td>51</td>
<td>437</td>
<td>347</td>
<td>131</td>
</tr>
<tr>
<td>Total</td>
<td>354</td>
<td>130</td>
<td>1644</td>
<td>982</td>
<td>372</td>
</tr>
</tbody>
</table>

Groups averaged 90 minutes in length, with the most common primary focus being on motivation (35%) and didactic parent training (20%). Over 50% of the groups described their primary, secondary or tertiary focus as group building, and nearly 40% of the groups described their primary, secondary or tertiary focus as problem solving.
There were 1,354 cancellations or no shows for scheduled group sessions. Nearly all clients (94%) who attended groups (N=130) had at least one no show or cancellation. A total of 52 clients had 10 or more no shows/cancellations, accounting for 40% of the total no shows/cancellations for group sessions.

**Individual Counseling/Services**

OIAP provided multiple types of individual counseling and other services during the four year project period (Table 5). A total of 2,738 visits provided one-on-one support to clients, 303 provided individualized counseling on substance abuse, and 168 provided parenting guidance. The majority of home and clinic visits covered more than one topic per session. For example, an average of 2.5 substantive topics were covered in each home visit.

<table>
<thead>
<tr>
<th>Counseling / Service Provided</th>
<th>Type of Contact</th>
<th>Home Visit</th>
<th>Clinic Visit</th>
<th>Phone Call</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td>859</td>
<td>84.3%</td>
<td>390</td>
<td>31.8%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td>476</td>
<td>46.7%</td>
<td>415</td>
<td>33.9%</td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td>551</td>
<td>54.1%</td>
<td>200</td>
<td>16.3%</td>
</tr>
<tr>
<td>Parenting Guidance</td>
<td></td>
<td>329</td>
<td>32.3%</td>
<td>133</td>
<td>10.9%</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td>25</td>
<td>2.5%</td>
<td>122</td>
<td>9.9%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
<td>11</td>
<td>1.1%</td>
<td>171</td>
<td>13.9%</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td>42</td>
<td>4.1%</td>
<td>97</td>
<td>7.9%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>90</td>
<td>8.8%</td>
<td>438</td>
<td>35.8%</td>
</tr>
</tbody>
</table>

* Column totals do not sum to total number of contacts shown in Table 2 since most visits counseled more than one topic.
+ Percent of all home visits (N=1019).
‡ Percent of all clinic visits (N=1225).
n Percent of all substantive phone calls (N=494).

The primary types of counseling provided varied by the setting of the visit (Table 5). The majority of home visits (84.3%) provided support to clients. Over half of home visits provided case management (54.1%), and nearly half of home visits provided counseling on substance abuse. 32.3% of home visits also provided parenting guidance. In contrast, the majority (69.6%) of substantive phone calls concerned case management and/or support to clients (50.8%). Domestic violence counseling, family planning, and medical services were primarily provided through clinic visits.
Appendix E
Reports of Focus Group Findings
REPORT of OIAP FOCUS GROUP FINDINGS

October 25, 1999

Prepared by
Lorraine Halinka Malcoe, Ph.D., M.P.H.
OIAP Evaluator

and

Catherine J. Shaw, Psy.D.
Administrative Director, Substance Abuse Treatment Center
Oklahoma City VA Medical Center
Background
The Oklahoma Infants Assistance Program (OIAP) is directed by Sharon M. Simpson, Ph.D. (formerly Steven J. Ondersma, Ph.D.), in the Department of Pediatrics at the University of Oklahoma Health Sciences Center. The aims of the Program are to provide coordinated, culturally sensitive, and comprehensive services to families of children at risk of being abandoned, primarily those prenatally exposed to drugs and/or testing positive for HIV. Many participants are involved with the Department of Human Services, the legal system, and have dual diagnoses (substance abuse and psychiatric disorders).

The proposed evaluation for OIAP called for semi-structured interviews to be conducted with selected clients in order to identify barriers to case management and service delivery, to identify helpful changes that have already been made to service delivery, and to generate suggestions for improvement of services. When the Evaluator asked clients, as part of a Client Satisfaction Survey, whether they would be willing to participate in semi-structured interviews, many declined to participate. Thus, in discussions with the OIAP Director, the Evaluator decided to conduct focus groups with clients currently participating in one of two OIAP weekly group sessions.

Goals of OIAP Focus Groups
The main purpose of the focus groups with OIAP clients was to obtain client feedback on barriers to utilization of OIAP services, ways OIAP helps clients achieve their substance abuse and parenting goals, and recommendations for Program improvements. In addition, the OIAP Director requested feedback on the extent to which OIAP was meeting the multidimensional needs of their clients, especially with regards to specialized substance abuse treatment.

Methods
Focus groups with OIAP clients were facilitated by Catherine J. Shaw, Psy.D., Administrative Director of the Substance Abuse Treatment Center at the Oklahoma City Veterans Administration Medical Center, and Lorraine Halinka Malcoe, Ph.D., the OIAP Evaluator. No OIAP staff were present during the focus group sessions. The focus groups were conducted on June 17, 1999 and August 6, 1999, and detailed notes were taken of each session. The two groups differed in composition and were mutually exclusive. The Introductory group was comprised of three clients who were relatively new to the Program, and the Growth group included eight clients who had graduated from the Introductory group and were now building problem solving skills. Each focus group lasted approximately 90 minutes.

A draft focus group guide was developed by Drs. Malcoe and Shaw, and was reviewed by Steven J. Ondersma, Ph.D. and Sharon Simpson, Ph.D., the OIAP Directors (please see Appendix for copy of guide). Most questions focused on two broad areas: substance abuse treatment and parenting. Questions covered personal goals in each of these areas; helpful aspects of OIAP staff and services; ways in which OIAP makes it harder to achieve their goals; pressures or life circumstances that make staying clean and sober, or parenting, difficult; and suggestions for improvement of OIAP. The guide also included questions on transportation issues, Program staff, and types of services offered.

Prior to the start of each group, the facilitators explained to participating clients the primary intent of the focus group. In addition, clients were assured that staff would only see a summary written report, and that strict client confidentiality would be maintained. It was requested that all participants maintain the confidentiality of other participants. The focus groups began with the facilitators introducing themselves, and then asking each group member to identify herself and share her main reason for joining the Program.
Findings

Program Goals
Focus group participants identified primary Program goals as the following: i) stay clean and sober; ii) address personal recovery issues; iii) improve parenting skills; and iv) provide supports. The Introductory group did not articulate these goals as clearly as the Growth group.

Personal Goals
Clients’ personal goals were generally in agreement with the identified goals of the Program. However, many clients, especially those in the Introductory group, also emphasized regaining custody of their children as a primary goal of completing OIAP. In addition, participants’ personal goals included increasing their problem solving abilities and available resources regarding finances, employment, housing, etc.; and self improvement, e.g., “getting myself together”, “get head back together”, increasing self-esteem, and developing drug-free social supports.

Substance Abuse Treatment
As mentioned previously, substance abuse treatment goals centered around maintaining sobriety and a drug-free lifestyle. Several clients verbalized the importance of obtaining sobriety “first” so they could work on other problem areas - “it’s like climbing a ladder step by step”. Most participants, particularly those in the Growth group, saw they were making progress in this area by establishing drug-free supports, usually within a 12-step recovery program and/or with a sponsor. Most saw that developing drug-free coping skills was essential to avoiding relapse and learning to deal with others. Most of the clients expressed they were learning self-acceptance, patience, and were changing “old habits” (i.e., less manipulation, dishonesty), and were learning the importance of self-disclosure and sharing painful “secrets”. The OIAP appeared to be doing an excellent job of providing outpatient substance abuse treatment services, such as Turning Point and 12-step programs, to OIAP clients.

Several participants stated that others had observed changes in their behavior regarding having better relationships with parents, improved appearances, e.g., looking “healthier” and gaining respect from their older children. A few shared that their bosses were supportive.

The Growth group considered OIAP very helpful toward achieving their substance abuse treatment goals. This group discussed how OIAP staff were available to address problems that had the potential of triggering drug use. In addition, they stated that OIAP staff, especially home visitation staff, provided advice, referrals, and emotional and instrumental support such as help with filling out applications, moving, providing bus tokens, etc. The strengths of the OIAP staff were their availability to talk and show understanding, problem solve, and advocate on behalf of the clients - “they’d break their neck to help me”. In particular, the OIAP home visitation staff were evaluated as flexible and helpful in making sure basics were met in terms of housing and parenting. The OIAP counselors were seen as able to deal with “any problem at any time”. The OIAP Growth group was considered a strong source of support, “friendship”, and advice. The OIAP staff who are in recovery were strong role models and considered an important part of the program.

The Introductory group found Turning Point groups, and especially one-on-one counseling, to be most helpful in achieving their substance abuse treatment goals. The participants identified distance to Turning Point as a barrier and stated that they spend a lot of gas money trying to get to OIAP and Turning Point services. This group had not developed strong relationships with home visitation staff, and thus did not find them to be as helpful and supportive as did the Growth group participants.
There were three main substance abuse treatment programs discussed in the focus groups: Eagle Ridge, which was described as a long-term residential treatment program; Turning Point, which was considered an outpatient treatment program; and Drug Recovery Inc (DRI), which is another residential program. All drug treatment programs were evaluated as helpful toward achieving recovery although DRI was described as using more confrontational treatment approaches. Positive aspects of Eagle Ridge related to dealing with family of origin and “inner child” issues which were seen to help address negative consequences of drug abuse on self and family. Turning Point was seen to offer helpful groups and individual counseling. On the other hand, DRI focused on a more reality oriented approach, “kicking you down until there’s nothing and then building you up to what they want.” Some participants found that as long as “you take what you want and leave the rest” that DRI was helpful to their recovery, especially related to addressing denial, honesty, and changing the “old crowd”. Other therapeutic supports to substance abuse treatment were the OIAP parenting classes and 12-step meetings. However, some clients, especially the Introductory group, did not appear to regularly participate in AA, CA, and NA meetings. Some clients saw strength in a “higher power” as an important part of their recovery.

Barriers to substance abuse treatment included scheduling conflicts between treatment, OIAP, and work, and the LINK part of the program which is responsible for drug screen urinalysis testing. Transportation and financial problems exacerbated these pressures, particularly for the Introductory group. Participants described that the location of the drug screening site was inconvenient, which made it difficult to get there when contacted to submit a DSUA sample, thereby increasing the stress of the experience. Some participants felt very discouraged by “false positive” urine results, and discussed how this produced trust issues with the OIAP staff. Participants said it would be helpful to get more information regarding DSUA results, such as the effects of over-the-counter medications, contact exposure, etc. A few clients stated that there was a lack of specific OIAP rules regarding the definition of being “late” to group and what the consequences would be. It was felt that knowing specific rules up front, such as “if arriving more than 15 minutes late to a group session, you will not be allowed to participate” would help them better decide whether they should spend limited gas money rushing to a group meeting if they were running late.

Social pressure, stress, frustration, and parenting problems were identified as triggers to use drugs along with lack of money and getting a false positive DSUA (“I might as well use”). Some clients have different trust levels with different OIAP staff so there is variability in what they will disclose to whom. Even when direct OIAP services were not identified as particularly helpful, the fact that OIAP provided referral and the impetus to utilize other drug treatment programs, was seen as a positive aspect of the overall Program.

Parenting
Clients reported two primary goals regarding parenting: 1) to regain custody of their babies or younger children; and 2) to improve relationships with their children. Several clients had lost custody of their babies in the hospital post-delivery, and especially for these women, regaining custody was a primary motivation for them to initially enter the OIAP. Clients reported frustration with the length of time it takes to regain custody, and with the process of drug testing (see substance abuse section). Some clients felt that OIAP staff were very understanding and helpful with custody issues. These clients reported that OIAP staff understood how hard it is for a mother to lose custody of her baby, and that some home visitation staff have helped by calling child welfare workers and encouraging clients to be patient.

Several clients reported problems with their children stemming from the children’s anger and resentment towards them as mothers. One client reported that her adolescent son does not
respect her and prefers to stay with his grandmother. Another client talked about her child saying “I hate you” to her. Overall, clients seemed very happy with the help they are receiving from OIAP regarding development of parenting skills, and they saw this as one of the primary strengths of the Program. Clients reported that the ABC clinic has anger groups for children, and that OIAP offers a pre-school group where mothers and children work together. This latter group helps the mothers to learn to better handle their children’s anger. Some clients did not appear to have access to these groups and expressed a strong interest in attending such a group. Clients also reported seeing progress in their relationships with their children.

Transportation
There were strong differences in discussions of transportation issues for the Growth and Introductory groups. For clients in the Introductory group, transportation was a recurring problem and source of stress and frustration. These clients felt there were too many demands and “constant time conflicts” between treatment, work, and family responsibilities. Locations of LINK and some treatment programs were not convenient and were considered expensive to get to without reliable transportation. In addition, Introductory group participants stated that there needed to be more options for scheduling treatment appointments to meet working schedules. OIAP was seen as helpful in assuring court appointments were kept, which was appreciated, but the need for broader support was expressed by the Introductory group.

Growth group participants also experienced difficulties with transportation, particularly in getting to their appointments for urine drug screens, but were generally very happy with the support OIAP provides them in this area. They stated that home visitation staff often gave them bus tokens and were even willing to pick them up for important appointments. One client discussed how one of the home visitors actually rode the bus with her to help her feel comfortable with riding the bus.

Recommendations
The following recommendations are based on the analysis of the focus group findings, as well as those recommendations identified specifically by focus group participants. It is understood that some of the recommendations may not be feasible given current OIAP funding and staff load.

Regarding Relapse and Drug Recovery
- Help clients identify at least one sponsor as early in the Program as possible
- Help clients develop more specific strategies for managing cravings and relapse prevention
- Consider having staffing meetings with OIAP staff and outpatient treatment staff to reassess treatment plan when positive (“dirty”) drug screens occur to help avoid client relapse

Regarding Urine Drug Screens
- Provide more explanation and information to clients regarding variables (aside from drug use) that can influence positive and fluctuating positive/clean urine drug screens
- If possible, consider identifying alternative locations where clients can obtain drug screens to decrease the stress associated with getting to the appointments on time

Regarding Services
- Increase flexibility of treatment services and group sessions to accommodate clients’ work and family obligations
- Provide financial and legal counseling
- Provide clearer rules regarding tardiness to OIAP services
- Increase visibility of OIAP in prenatal care clinics, Ob/gyn clinics, and hospitals to promote the Program to greater numbers of prospective clients
Regarding Case Management
< Provide more intensive case management upon entry into OIAP to help clients cope with feeling overwhelmed by lack of money, housing and subsistence needs, child care, transportation, etc.
< Ensure that each client has at least one member of the treatment team who is of similar cultural and ethnic background
< Have intensive case management and intensive drug treatment available for clients in times of crisis
< If not already done, treatment team meetings should include representation from external treatment programs being utilized by clients

Regarding Trust/Confidentiality
Since trust is key to treatment success:
< Provide more information to clients regarding confidentiality and disclosure of client information among OIAP staff, and between OIAP staff and outpatient treatment staff (some clients believe that what is told to home visitation staff is not shared with other OIAP staff)
< Have OIAP staff meeting(s) to discuss trust, confidentiality, and disclosure issues

Regarding Parenting
< Increase opportunities for clients to interact more with their children in groups
OKLAHOMA INFANTS ASSISTANCE PROGRAM

REPORT ON FOCUS GROUP

Submitted by:
The Oklahoma Infants Assistance Program Evaluation Team

Kelly Plunkett-Juniper
Robert E. Aronson, Dr.P.H., Evaluation Coordinator

November 2, 2000
Purpose of this Report

This report provides input from clients who participated in a focus group about their involvement in the Infant Parenting Program. The Oklahoma Infant Assistance Program has used focus groups to gain a perspective from client members describing the experience of and issues relating to having their children removed from their care due to drug use during and/or after pregnancy. The data collected will be provided to the operations staff of the Oklahoma Infant Assistance Program, in order to develop culturally appropriate counseling and infant health curricula and interventions, and to help the program make mid-course corrections.

Suggestions for Interpreting Focus Group Results

- The focus group does not represent a random sample of program members, and the small number of focus group participants does not permit us to make generalizations.
- Opinions presented in the focus group can help us to grasp the range of possible viewpoints held by participants of the program.
- When themes are mentioned repeatedly by different participants, it can mean that the theme represents a shared cultural idea, at least by a subset of the program participants.
- The way participants discuss issues that emerge in a focus group can give us clues to the meaning these issues have to their lives. Their personal stories can help us to understand in a more holistic way how this topic fits into their lives.
- What we learn from focus groups can help us to create more standardized instruments that can be administered to a random sample of people, thereby allowing us to make more generalized conclusions.

Focus Group Analysis

The focus group was transcribed verbatim for analysis. For each question of interest, the responses were summarized for the group. This summary represents the basic findings of the focus group. This summary attempts to preserve, as much as possible, the language and meaning intended by the participants, which is done by using direct quotations. Once again, the responses and quotations listed in this summary do not necessarily represent the norms of the program clients, but represent themes that emerged and/or ranges of responses that arose in the discussions. The summary should be read with this in mind, and the reader should look upon the summary as a way to generate new ideas or questions, or to help explain what is already known through more quantitative research.
Summary of Findings

Three major issues were brought up during the focus group session. The first issue was regarding confidentiality. The clients strongly felt that they were dishonestly told that their information would be kept confidential, only to find out later that the information was passed on to social services and used against them. The second issue was regarding the foster care system, which the clients felt was not being strict enough on the foster parents. The clients were very aware of media stories involving foster parent neglect and were concerned about the foster parents caring for their own children. The final issue was the clients’ positive attitudes regarding the program as a whole. Although the clients had several complaints, overall they agreed that it has helped them improve their lives, and look forward to raising their children as drug-free parents.

Question by Question Summary of Responses

Describe how you first became enrolled in the project, how were you referred to the project, how were you treated by project staff, how did the intake process make you feel?

The majority of women mentioned being referred to the program by Social Services after their children tested positive for illegal drugs following birth. A couple of women volunteered themselves after testing positive for drugs, despite the fact that their children did not test positive.

All of the women discussed miscommunication in the enrollment process between Social Services, the project staff and themselves. Many said that the project staff led them to believe their information would be kept confidential, but would pass it on to Social Services. Most felt that Social Services had a goal to break up their families. While the program staff are all trained to explain the obligation of the program to report to DHS, clients appear to have misunderstood or did not have the information adequately explained.

“When I came in here, I didn’t realize that they were so linked up with DHS, you know, first time here. I didn’t also know that if I had just tested positive for weed, I could have taken my kid home.”

“They discussed it with DHS and blew my deal out of the water and stuck my baby with strangers, and we wanted him with family.”

“They didn’t tell me crap. I’ve been scared to say hardly anything ever since. I don’t trust anybody in here anymore and they both kind of ruined it for me.”

“There ain’t one person that walks through here that don’t know everything about me.”
Describe for me your thoughts on what this project is all about, what is it trying to achieve, what services and activities it offers, what is working or not working, what services and activities you feel are missing?

The clients all felt that the program was necessary in order to get custody of their children. Although some had a negative perception of the process, it seemed to help them to talk to someone else in a similar situation to lend and receive support. Some services and activities mentioned were sessions with Planned Parenthood, baby group, and treatment program assistance, although not all of the women seemed aware of some of the other programs offered. Perceptions of the process women were expected to go through varied, and in some instances were confused.

"Some people that I know that was in this group that’s going on now, whatever, they, you know, just seem like if you go in treatment, you get your baby back faster."

"They said that they want to place the kids back with me, right? They said that’s their whole purpose, is to get the kids back with the parents. That’s not true."

"So, if there could be a little more information given that, okay, your partner has to participate; otherwise, you’re going to put your case just that much further behind."

"And they change, you know, I mean, you get start getting a feel for these people and you start working good in your program, they just change and expect you to start all over."

Describe for me what goes on in group meetings, what kinds of group meetings there are, what types of things you have learned, how regularly you attend, give some of the reasons people have for missing group sessions, what you like or dislike about group meetings?

During group meetings the women discuss setting and reaching goals, lending support and receiving counseling. Some women mentioned attending only one session a week, others attend several sessions a week. One in particular said she attends meetings for a total of thirty hours a week. The women agreed that they enjoyed group meetings, some seemed to have built friendships with each other and the facilitators of the meetings. A few reasons given for missed sessions were court appearances, enrolling other children in school and attendance at other treatment programs, others did not mention why they missed meetings. The women like the meetings, but feel that the program should be more up front about what information will be kept confidential and what they must tell Social Services.

"Let me tell you what I learned, that I’m not the only one that’s doing, that’s having problems."
"It does help in a lot of ways. It feels like a bitch session to me. That’s what I told my mom. It’s just a bitch session, really, and we need that. I mean, that’s how you get everything out of our brains so we don’t go back out here and we’re going to blow up on somebody, we’re going to use or whatever."

"Be honest about it. They need to tell you up front, they didn’t tell me, I’m gonna call DHS, I’m gonna tell them this."

Describe for me what goes on in home visits, what do you like or dislike about home visits?

The women had mixed feelings about home visits. The negative responses were directed at insensitive questions asked by workers, however they seem to agree that the purpose of home visits is to see how they are doing and to have one on one time.

"We got my DHS worker on the phone and they were able to talk with me right there. And, so, it’s like, ask him this cause he won’t answer this question for me and so, I don’t know, we got a lot more accomplished."

"How many classes you missed, you comfortable and all like that, I think that’s really what this is about. Just trying to see if you attending your NA, your AA...."

"We laughs when we can and I wasn’t – she didn’t point her finger at me. She simply asked me what you gonna do about it?"

What do you like or dislike about other services related to the project (visits with staff psychiatrist, monitoring drug/alcohol use, dealing with social services, etc.)

Unfortunately, all mentions of DHS were negative, however outside of social services the women seem to find the other services related to the project helpful. Several women mentioned Infant Parenting Program workers by name and said how much they enjoyed their visits with them. They seemed particularly dissatisfied with the care given by the foster parents.

"I do not like the (DHS) woman, she upsets me ‘cause soon as I get, she don’t have a child in the world. Here she is 40 some, 50 some years old, ain’t got a baby in the world, how is she gonna say, you going for (custody) of my child. You know how it feel to be a momma?"

"How you gonna terminate something? Don’t come and tell me my damn problem, you can get up and leave. That’s what I told her. Get up and leave out of my house. And I told the judge, when I went to court, I told the judge I told him that she wasn’t going to tell me."
“No, these foster parents, they need to check out these folks just as they check out us.”

*How can you tell when you or other clients are making progress? (In terms of addictions, parenting skills, personal issues, etc.)*

All the women mentioned the importance of attending meetings in order to stay focused on their goals. Some seem to have developed more strength to avoid their drug habits and the people who influence those habits and one even mentioned turning to physical exercise. The women also mentioned how regular drug tests influence them to stay clean.

“They set us goals every week. We sit and talk about, they just ask, you know, what we accomplished last week, ourselves, and then what we plan on accomplishing this week.”

“Stay away from the places, call your sponsor, get to a meeting.”

“If you’re good and you do everything you’re supposed to, - if you’re not, there’s some how they’re gonna keep you”

*What are some of the things in your life and in your community that make it difficult to make the progress you desire?*

The most difficult problem the clients stated was transportation to meetings. Another difficulty mentioned was the community or relatives who were also involved in drugs, which made them harder to avoid.

“I don’t drive, and where I live, there’s no buses, so you have to arrange transportation up here. It’s at some very inconvenient times.”

“Can’t even be around your relatives.”

“Everything in my town – everybody’s an addict.”

*In what ways has this project helped you?*

Most of the women feel the project has made them feel accepted by showing them that there are others with similar problems. All of them feel that without the project they would not be making the progress they have made. A couple of clients also mentioned the counselors who have impacted their lives.

“It’s just changed me a lot, talking to these women. I didn’t have one girlfriend, now I’ve got all kinds of sisters that are real close to me; I can call anytime and talk to ‘em about
anything. Before I didn’t have anybody. I had to hold all this shit inside and that’s basically, you know, my whole life. I’ve been myself. It’s changed my attitude. It’s changed the way I dress, the way I look, you know, what I think.”

“This program put me on the right track. If it wasn’t for this program, I’d probably still be smoking, you know.”

“Wasn’t for them, I wouldn’t have went back the second time, wouldn’t have no kids, by now DHS would have terminated my rights.”

*In what ways can the project be improved?*

Most clients mentioned that it was difficult for them to make several classes a week in different locations while holding a job or being a full time parent. They also mentioned that they would like to see more programs for men, and a few clients did not seem aware of some of the other projects offered, like the baby group.

“You have to go to a class on Monday, and to go to class Thursday, and you have to go to AA meetings, and be at these other places.”

“And she’s got a son with medical problems, she’s got to take all this and take him to the doctor.”

“Yeah, I work all night long. I bring my husband. He can’t drive without a license. I bring him. I’m sleeping on the couch up here, trying to get me an hour’s sleep before I got to get up and go all over again. I mean, two hours of sleep a day is all I’m allowed. Pretty much.”
Appendix F
Sampling of Publications
Participation in Perinatal Substance Abuse Treatment: The Utility of Stage of Change Assessment

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Introduction

Treatment of mothers with a history of substance abuse is a significant challenge for treatment professionals. Participation in substance abuse treatment programs overall is often limited, with dropout rates sometimes nearing 50% (Blood & Cornwall, 1994). Women who abuse substances have multiple risk factors that may contribute to the challenge of providing effective treatment. These risk factors include violence and abuse during childhood, exposure to substance abusing caretakers, and adult relationships characterized by domestic violence (Amaro, Fried, Cabral, & Zucker, 1990; Black & Mayer, 1980; Hagan, 1988; Ladwig & Anderson, 1989). Other factors such as a history of child abuse and neglect, physical/mental illness, and poverty have also been noted (Bays, 1990; Chaffin, Kelleher, & Hollenberg, 1996).

The challenge and significance of treating these women becomes even greater when the children of these substance abusing women are considered. Approximately 675,000 children are seriously maltreated by a caretaker with a substance abusing problem each year (National Committee for Prevention of Child Abuse, 1989). However, over 20% of high-risk parents enrolled in parent-training interventions (typically one of the treatments of choice for high-risk mothers) often show inadequate participation (Webster-Stratton, 1998). Research regarding participation rates in programs for substance-abusing mothers in the child welfare system is limited, as is information about factors that predict participation.

In general, traditional unidimensional assessments and treatments with this high-risk population have had low success rates (both in treatment participation and completion and in treatment effectiveness). In an effort to address these issues, a demonstration project was developed at the University of Oklahoma Health Sciences Center. The Infant Parenting Program (IPP) is a nine-month multisystemic program for women who used substances during pregnancy. The IPP includes traditional substance abuse treatment, parent education and life skill building groups, domestic violence counseling, family planning services, home visiting, and psychiatric consultations as needed. One of the core features of the IPP is the use of the Transtheoretical Model of Behavior Change (TTM; Prochaska & DiClemente, 1982; 1986) to develop treatment planning.

The TTM is a well-validated theoretical model that is being applied to a wide range of behavior problems. The TTM describes five specific motivational stages people progress through as they begin to change an identified behavior. These stages include Precontemplation, Contemplation, Preparation for Action, Action, and Maintenance.

- Precontemplation exists when the person does not believe that there is a problem and is not considering change
- The Contemplation stage is entered as individuals consider both that they have a problem and the pros and cons of behavior change
- The Preparation stage is entered as the person decides to change and begins to prepare to do so
- The Action stage is entered when behavior change is actually taking place
- The Maintenance stage begins six months after behavior change has been maintained consistently, and primarily involves attempts to maintain that change.

The current study examined the ability of specific risk factors, scores on depression, parenting stress, and abuse potential questionnaires, and self-reported readiness to change both substance abuse and parenting to predict involvement in treatment at three months. It was hypothesized that women in the more advanced stages of change (i.e., Action) would be more likely to remain involved in the IPP, while women with multiple risk factors and high levels of depression, parenting stress, and abuse potential would be less likely to remain involved.

Methods

Participants: 64 women (47% Caucasian; 37% African-American, 1% Hispanic, 13% Native American) with young children who were enrolled in the IPP served as the study sample. Women were between the ages of 15-40 years (X = 27.7). All women used alcohol and/or drugs during pregnancy and most (88%) had involvement with Child Protective Services. The majority of women were polysubstance abusers, all used tobacco products, and most had received limited prenatal care. Forty-five percent had a history of criminal conviction. Among the risk factors assessed via self-report, 29% had a history of physical abuse, 29% had a history of neglect, and 27% had a history of sexual abuse. Over 37% reported witnessing domestic violence between caregivers, and almost 58% reported being involved in domestic violence as an adult. In addition to domestic violence, 20% of the women had experienced physical assaults as adults and 22% reported sexual assaults.
**Procedures:** As part of the program intake, demographic information was obtained via a structured interview. Several standardized measures were also administered including the Beck Depression Inventory (BDI; Beck & Steer, 1987), the Parenting Stress Index, Short Form (PSI; Abidin, 1990), and the Child Abuse Potential Index (CAP; Milner, 1986). To assess mother's reported stage of change relative to their substance use, the Change Assessment Questionnaire (CAQ; Rossi, Rosenbloom, Monti, & Prochaska, 1992) was administered. To assess stage of change relative to their parenting, the Parent Readiness for Change Scale (PRFCS; Bresten, Ondersma, Simpson, & Gutch, 1999) was given.

The outcome variable, initial participation in the IPP, was determined through chart review at three-months post-intake. This variable was defined as the average number of weeks the mother was drug free (assessed via random urine analysis tests) and the number of weeks she attended the required weekly introduction/orientation substance abuse group.

**Results**

Means, standard deviations, and ranges for standardized tests are presented in Table 1.

<table>
<thead>
<tr>
<th>Test</th>
<th>X</th>
<th>SD</th>
<th>Range</th>
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<tbody>
<tr>
<td>Child Abuse Potential Inventory</td>
<td>210.02</td>
<td>89.80</td>
<td>18-379</td>
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<tr>
<td>Parenting Stress Index, Short Form</td>
<td>80.27</td>
<td>17.43</td>
<td>49-123</td>
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<tr>
<td>Beck Depression Inventory</td>
<td>16.79</td>
<td>10.47</td>
<td>0-48</td>
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Zero-order correlations were computed between test data, stage of change, demographic risk factors, and participation (See Table 2). As can be seen by examining these correlations, the only intake variables significantly related to participation at three months were the Contemplation scale of the CAQ, the Precontemplation scale of the PRFCS, and a positive history of domestic violence.

In order to follow up on these potential relationships, an hierarchical multiple regression was conducted in which history of domestic violence was entered first, followed by each subscale/stage of the CAQ, and then each subscale/stage of the PRFCS (see Table 3). Results indicated that a history of domestic violence significantly predicted program participation at three months, as did self-reported stage of change with regard to parenting. Stage of change with regard to substance abuse was not significant. Thus, the parenting stage of change significantly predicted participation above and beyond the domestic violence variable and the substance abuse stages of change.

<table>
<thead>
<tr>
<th>Variable</th>
<th>F Change</th>
<th>ΔR²</th>
<th>Standardized β</th>
</tr>
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<tbody>
<tr>
<td>Domestic Violence</td>
<td>3.856**</td>
<td>.06</td>
<td>-.196*</td>
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<tr>
<td>Precontemplation (CAQ)</td>
<td>2.174</td>
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</tr>
<tr>
<td>Contemplation (CAQ)</td>
<td>2.484</td>
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<tr>
<td>Action (CAQ)</td>
<td>0.003</td>
<td>.00</td>
<td>-.001</td>
</tr>
<tr>
<td>Precontemplation (PRFCS)</td>
<td>5.457**</td>
<td>.07</td>
<td>.578***</td>
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<tr>
<td>Contemplation (PRFCS)</td>
<td>3.777**</td>
<td>.05</td>
<td>.932***</td>
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<tr>
<td>Action (PRFCS)</td>
<td>5.462**</td>
<td>.07</td>
<td>-.641**</td>
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</table>

Note. *** denotes p < .01, ** denotes p < .05, * denotes p < .10.

In order to more clearly conceptualize what stage of change these participants reported, please refer to Figures 1 and 2. When stage of change was assessed for substance abuse (via the CAQ), 7% of the women reported they were in Precontemplation, 57% reported they were in Contemplation, and 36% reported they were in the Action stage (see Figure 1). When stage of change was assessed for parenting (via the PRFCS), 75% reported being in Precontemplation, 8% in Contemplation, and 16% in the Action stage (see Figure 2). As can be seen by these numbers, many more women reported problems with their substance use and motivation to change their drug use behavior than problems with or motivation to change their parenting.

**Discussion**

Contrary to what was predicted, only one of the more traditional risk factors (domestic violence) predicted program involvement at three months. However, the result was in the opposite direction of what was expected. That is, a positive history of domestic violence predicted continued participation in the program. It is possible that when multiple treatment needs are addressed, women with these multiple treatment needs are more likely to remain in treatment. However, this finding is counterintuitive and needs to be replicated with additional samples.

The finding that additional risk factors (such as history of neglect or abuse, physical or sexual trauma as an adult, stress as a parent, depression, or risk of physical child maltreatment) were not related to treatment compliance at three months is consistent with substance abuse treatment literature that acknowledges the difficulty in predicting
treatment outcome (e.g., Araujo, et al., 1996; Ball, Lange, Myers, & Friedman, 1988; Stark, 1992). However, stage of change emerged as an important potential predictor of compliance with treatment. What was particularly interesting was that it appears to be readiness to change parenting practices and not motivation to change substance abuse that predicts treatment compliance. This may be a result of the coerced nature of the current population. The vast majority of these women were involved with Child Welfare specifically because of their drug use and many were court ordered into treatment. Some questions on the CAQ may be considered face valid (e.g., "I have a drug problem and I really think I should work on it") and are likely to pull for socially desirable responses. The potential benefit for these mothers of convincing Child Welfare personnel and family court judges that they are in the action stage and are actively abstaining from drug use is obvious. Questions relating to parenting stage of change may have fewer overt implications and may allow for more forthright answers.

Additionally, the IPP is both a parenting program and a substance abuse treatment program. It is possible that parenting stage of change was an effective predictor of treatment compliance because of the parenting nature of the program. Substance abuse stage of change may be more efficient in predicting compliance with more straightforward, unidimensional substance abuse treatment programs.

While it may be possible to use evaluations of motivation to change parenting to predict who may be more likely to take advantage of available services, there are several limitations of this study that must be considered. First, the size of the sample was relatively small. A second limitation was the prediction of treatment involvement at three months of a nine-month program. It is possible that evaluation further into the program might clarify the relationship between risk factors, stage of change, and success. However, the attrition rate for this program is rather high (60% complete less than half of the program; 25% drop out after the initial intake) and follow up evaluation would yield an even smaller sample size. One way to provide follow-up evaluations of treatment success would be to evaluate the IPP participants' future involvement with the Child Welfare system. A final limitation is the insufficiency of this data to account for all the factors that are contributing to the persistent drug use in the chaotic lifestyles of these participants. As such, another area for future research would be continued investigation into the complex interactions between substance abuse, history of domestic violence, resiliency, and treatment success.

References
Rockville, MD: National Institute on Drug Abuse.
Table 2. Correlation matrix of study variables

<table>
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<th>Variables</th>
<th>V1</th>
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<td>V1. Participation</td>
<td>—</td>
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<td>—</td>
<td>—</td>
<td>—</td>
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Note. CPA = Child Physical Abuse, CSA = Child Sexual Abuse, DV = Domestic Violence, PSI = Parenting Stress Index, Short Form, CAP = Child Abuse Potential Inventory, BDI = Beck Depression Inventory, CAQ = Change Assessment Questionnaire, PC = Precontemplation, Cont = Contemplation. The PRFCS PC was reversed scored, thus a low score reflects a high level of precontemplation.

** denotes p < .01, * denotes p < .05.

Figure 1. Stage of Change Substance Abuse Change Assessment Questionnaire (CAQ)

Figure 2. Stage of Change Parenting Parent Readiness For Change Scale (PRFCS)
ABSTRACT

The Parent Readiness for Change Scale (PRFCS), a modified version of a standard measure of stage of change (URICA; McConnaughey, Prochaska, & Velicer, 1983), was developed to assess readiness to change parenting behavior. The factor structure, internal consistency, and initial validity of the PRFCS were explored in a sample of substance-abusing mothers referred to a parenting program by child welfare services (N = 115). Exploratory principal components analysis (varimax rotation) yielded five factors accounting for 61% of the total questionnaire variance. However, it was difficult to identify distinctive features of factors, as factors 1-3 all included items tapping contemplation, preparation, and action, and factors 4 and 5 both appeared to tap precontemplation variance. Thus, subscales based on the URICA scoring rules were explored. These factors correlated highly (Pearson coefficients ranging from .69 to .93) with derived factors. Internal consistency for the URICA-based scales was good: alpha was .82 for Precontemplation and Contemplation, and .80 for Action. All three PRFCS subscales were unrelated to either the Beck Depression Inventory (Beck, 1961), the Child Abuse Potential Inventory (Milner, 1986), or the Parenting Stress Index--Short Form (Abidin, 1990) total scores. Negative Affectivity, as measured by the PANAS (Watson, Clark, & Tellegen, 1988), was negatively related to Precontemplation (r = -.28, p < .01), Contemplation (r = -.26, p < .05), and Action (r = -.21, p < .05). Some evidence of external correlates consistent with stage of change theory was noted (e.g., interview-based ratings of readiness to change negatively correlated with Precontemplation, r = -.39, p < .01). Most notably, however, Precontemplation was negatively associated with number of groups attended (r = -.23, p < .05) and number of clean urine drug tests (r = -.25, p < .05) at 3 months; no other variable was linked to 3 month outcome. It appears that the PRFCS may meet basic reliability requirements and tap unique variance as compared to standard measures, and that it may be of some utility in predicting 3-month participation. Further work should examine the validity of the PRFCS, as well as the clinical utility of assessing readiness to change parenting behavior.

INTRODUCTION

The Transtheoretical Model of Behavior Change (TTM) developed by Prochaska and DiClemente (1982, 1986) hypothesizes that behavior change occurs when people progress through a series of five sequential stages. Each stage has unique challenges and processes of change associated with it, and it is believed that individuals cycle through the various stages several times before maintenance of change and termination of the cycle is obtained:

• Precontemplation exists when the person does not believe that there is a problem and is not considering change.

• The Contemplation stage is entered as individuals consider both that they have a problem and the pros and cons of behavior change.

• The Preparation stage is entered as the person decides to change and begins to prepare to do so.

• The Action stage is entered when behavior change is actually taking place.

• The Maintenance stage begins 6 months after behavior change has been maintained consistently, and primarily involves attempts to maintain that change.

Although the TTM has been successfully applied to addictive behaviors such as smoking and alcohol use, and health behaviors such as condom use and dieting, there are currently no empirical studies of motivation to change parenting behavior. Much like individuals with addictive behavior problems, lack of motivation, resistance to therapeutic techniques, and defensiveness can contribute to poor treatment outcome for parent training. Parents who are referred for parent training may not have a full appreciation for the extent to which their own behavior and choices have led to the need for services for their children. In particular, a parent in the Precontemplation stage would have no intention of changing his or her parenting in the near future. Prochaska et al. (1992) report that individuals in this stage typically do not realize or believe that they have a problem and often present for psychotherapy only after an outside agent pressures them to change their behavior. According to the TTM, individuals in the Precontemplation stage are likely to continue to make changes in their behavior only while an outside agent demands a change. Unless the person progresses to another stage, they are likely to return to their former behavior pattern once this external pressure is released. This suggests that any gains made during treatment would be short-lived. Awareness of the parent's current stage would allow the clinician to tailor interventions toward the motivational level of the person and potentially create longer lasting change.

Information regarding an individual's motivation to begin therapy provided by a stage of change measure would be especially valuable in the process of developing "stage matched" interventions selected based on the parent's stage of readiness. There are several such measures in existence for addictive behaviors and research evidence suggests that accurate, pre-treatment identification of an individual's stage of change can help the therapist and client set realistic goals and prevent early treatment dropout for the treatment of addictive behaviors (DiClemente & Prochaska, 1998).
the PRFCS is linked to important indices of treatment participation and future study should address the predictive value of the PRFCS for treatment outcome.

The PRFCS also appears to provide a measure of parental motivation for treatment. Assessment of parental motivation for treatment is the first step in developing “stage matched” interventions for parents and their children. State of the art measurement is needed in order for clinicians to tailor their treatment approaches to best suit the motivation level of the parent. Once “stage matched” interventions have been developed, treatment efficacy research can then compare the traditional model of parent training with “stage matched” therapy regarding important process variables such as progression through treatment (e.g., missed sessions, early drop out), as well as with outcome variables (e.g., maintenance of parenting skills, improved parent-child interactions). It is hoped that the use of stage matched interventions will facilitate parent engagement and compliance with behavioral parent training.

REFERENCES


Table 1

Precontemplation Items
As far as I’m concerned, I don’t need to change how I take care of my child.
I take perfect care of my child. It doesn’t make sense for me to change.
Being here is pretty much a waste of time for me because I already know how to take care of my child.
I guess my parenting isn’t perfect, but there’s nothing I really need to change.
I may need to change how I am as a parent, but I don’t think so.

Contemplation Items
I think I may be ready to improve how I take care of my child.
I’ve been thinking that I might want to learn the best ways to help my child.
I’m hoping to learn to better understand my interactions with my child.
My parenting needs changing and I really think I should work on it.
I wish I had more ideas on how to take care of my child better.
Maybe parenting classes will help me handle my child better.

Action Items
I am trying to learn how to take care of my child better.
At times it’s hard to be a good parent, but I’m working on it.
I am really working hard to change how I take care of my child.
Even though I’m not always successful in changing how I interact with my child, I am at least working on it.
Anyone can talk about changing how they are as a parent; I’m actually doing something about it.
I’m actively trying to change how I take care of my child.
Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response

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Elizabeth V. Brestan
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University of Oklahoma Health Sciences Center

Prenatal drug exposure continues to be a controversial topic. Views of what constitutes an appropriate response to drug-exposed infants vary, in large part due to the many complex issues endemic to perinatal substance use. The purpose of this article is to review the controversy surrounding prenatal drug exposure, outline the policy dilemmas that complicate attempts to respond appropriately, review current practice in this area and the effectiveness of those practices, and offer specific recommendations as a starting point for debate. It is suggested that earlier controversy regarding the sequela of prenatal drug exposure may be decreasing as research identifies specific and subtle deficits in some affected infants. It is also suggested that the postnatal effects of parental substance abuse (e.g., in terms of abuse/neglect, attachment, and development) are the more appropriate focus of child protection efforts, and that different disciplines must collaborate to reach a consensus regarding the nature of these efforts.

Awareness of the relationship between substance abuse and child maltreatment is growing, with at least two books (Hampton, Senatore, & Gullotta, 1998; Young, Gardner, & Dennis, 1998) and two major reports (National Center on Addiction and Substance Abuse, 1999; U.S. Department of Health and Human Services [DHHS], 1999) on the subject being published in the past year. It has been estimated that substance abuse is involved in 40% or more of the 1.2 million annual confirmed cases of child maltreatment (Prevent Child Abuse America, 1996), and that the presence of substance abuse disorders in parents increases the risk of child maltreatment threefold or more (Chaffin, Kelleher, & Hollenberg, 1996; National Center on Addiction and Substance Abuse, 1999). Data from the 1996 Household Survey on Drug Abuse suggest that nearly 7.5 million children have a parent who is dependent on illicit drugs and/or alcohol (Huang, Cerbone, & Grofroer, 1998).

Prenatal drug exposure, one aspect of the relationship between substance abuse and child maltreatment, has been the source of particular controversy. The number of women abusing illegal drugs during pregnancy in the United States is currently estimated at between 100,000 and 375,000, with the number of infants prenatally exposed to illicit drugs ranging from 13 to 181 per 1,000 births (U.S. General Accounting Office [GAO], 1990). These numbers appear conservative, however, in light of a report...
from the Substance Abuse and Mental Health Services Administration (1997) that estimated that in 1996, nearly 7 million females of childbearing age used illicit drugs. A study done at a Detroit hospital using near-universal screening and meconium analysis (a much more sensitive test than urinalysis) found prenatal drug use in 44% of 3,010 births (Ostrea, Brady, Gause, Raymundo, & Stevens, 1992). Universal screening using urinalysis of women with mixed socioeconomic status (SES) backgrounds arriving for a first prenatal visit yielded an illicit exposure rate of 13.8% (Chasnoff, Landress, & Barrett, 1990). A recent nationwide survey of county child protective services (CPS) agencies revealed that 90% of all such agencies, and 100% of all urban CPS agencies, have received one or more referrals of infants with prenatal drug exposure (Ondersma, Simpson, Malcoe, & O'Steen, 1999).

However, there is significant controversy regarding the effects of prenatal drug exposure, and whether and how to respond to this issue (Franck, 1996). This is true for at least four reasons. First, a chasm that first appeared in the late 1980s between public opinion and scientific data continues largely unaffected, such that many continue to assume that prenatal drug exposure is highly damaging if not devastating to most infants. Available research does not support this assumption (see below).

Second, whether to regard persons with addictive behaviors as criminals in need of punishment or patients in need of treatment is an ongoing debate that is heightened when the emotionally arousing issue of infants and their well-being is considered. This controversy is largely a reflection of the greater debate between liberal and conservative perspectives on personal responsibility and civil rights. From one perspective, drug use during pregnancy is seen as a public health problem like any other; a strong response is considered unconstitutional, ineffective, misogynous, uncalled for given the actual risks, and akin to punishing persons suffering from depression or other mental illness. Policy makers are particularly blamed for mandating treatment without providing adequate access to it (e.g., Chavkin, Breibart, Elman, & Wise, 1998). From another perspective, drug use during pregnancy is a voluntary and illegal act that requires significant neglect of the rights of the fetus. From this perspective, substance abusers are seen as more likely to avoid available treatment than to seek treatment and not be able to find it. Drug use, from this perspective, is more akin to a criminal act than depression, making public health approaches a dangerous assault on public moral standards. Political agendas and beliefs are thus another factor lending to the controversy in this area.

A third reason for the continuing controversy is the nature of the problem itself. The issue of prenatal drug exposure sits squarely at the intersection of behavioral teratology, jurisprudence, mental health, medicine, child protection, chemical dependency, and civil rights in a way that few other controversies have. This confluence of often-conflicting perspectives has given rise to a number of specific dilemmas that have exacerbated the controversy in this area. (These dilemmas will be reviewed below.) A final reason for the difficulty in finding clear solutions in this area is the lack of controlled research that could illuminate and guide the search for appropriate policy.

The purpose of this article is to put the controversy surrounding prenatal drug exposure into perspective, in the hope of facilitating the formation of consistent and appropriate policy. In doing so, we will articulate a number of specific policy dilemmas that have made the formation of appropriate responses difficult. We will review the controversy over the actual effects of prenatal drug exposure, and will describe the range, nature, and effectiveness of current responses. Finally, specific recommendations—though difficult to make in the absence of better data—will be offered as a starting point for further discussions.


effects of prenatal drug exposure: the core of the controversy

history of research into effects of prenatal substance exposure

Research regarding the effects of prenatal substance exposure dates back to the 1970s. Research of opiates, cannabinoids, amphetamines, alcohol, and other drugs of abuse has seldom received significant public attention, however. Public concern regarding drug use during pregnancy did not become widespread until the mid- to late 1980s, when cocaine use burgeoned. Studies during that time of the effects of prenatal cocaine exposure suggested that these infants were at increased risk of Sudden Infant Death Syndrome (SIDS), spontaneous abortion, intrauterine growth retardation, reduced head circumference, and a range of neurobehavioral abnormalities (as reviewed by Hutchings, 1993). The popular media responded to these early suggestions with frequent and inflammatory reports of an epidemic of devastated crack babies, reports that resulted in the pan-
icked production of programs, laws, and policies to address the new challenge.

The popular furor regarding the supposedly devastating effects of prenatal cocaine exposure led to a similar (if more reasoned) debate in the scientific community—many members of which felt that the risks of prenatal cocaine exposure were being greatly overstated (e.g., Mayes, Granger, Bornstein, & Zuckerman, 1992). Although contradictory findings were common, by 1993, many contributors to a special section in the journal *Neurotoxicology and Teratology* (e.g., Coles, 1993; Day & Richardson, 1993; Hutchings, 1993) appeared to believe that few (if any) direct effects of cocaine exposure could be proved with existing data. In 1996, the introduction to a major National Institute on Drug Abuse Research Monograph summarized the state of prenatal substance exposure research as follows:

For several years the use of drugs during pregnancy, particularly cocaine, has been a major public health issue because of the concern about possible adverse behavioral effects on the neonate and the developing child. Although many popular press publications have warned of the severe adverse effects of prenatal drug exposure, the scientific literature has been less clear on this issue, in part because of complex methodological issues that confront research in this field. (Wetherington, Smeriglio, & Finnegan, 1996, p. 1)

Methodological issues facing researchers in this area have included the frequency of polysubstance abuse (making it difficult to isolate the effects of one drug or abuse from those of another), and the moderating effects of prenatal care, prenatal nutrition, prematurity, and postnatal environment. Furthermore, multiple shortcomings of most research in this area (e.g., the failure of most investigators to use blinded examiners, or the use of self-report of drug use) have led some to assert that few if any conclusions can be made (Lester, LaGasse, Freier, & Brunner, 1996). These cautions, however—as well as the more moderate views of even the most concerned researchers—have gone largely unheeded by the media, lay public, and many policy makers. Thus, the image of cocaine (and other drugs, although cocaine has come to embody perinatal drug use in the public consciousness) as devastating to the developing fetus appears to have continued to a great degree.

*Current Status of Research Regarding the Effects of Prenatal Drug Exposure*

What exactly does current research suggest regarding the negative effects of prenatal drug exposure? In answering this question, it is important to distinguish between short- and long-term effects of exposure. Although inconsistently present after exposure to some drugs of abuse, the presence of short-term effects in some exposed infants is relatively well supported by the literature. Reduced head circumference is reliably associated with cocaine, opiate, and heavy alcohol exposure; neurobehavioral abnormalities, including jitteriness, problems with state regulation, and irritability are commonly found in infants exposed to opiates and inconsistently found in infants exposed to cocaine and alcohol (Zuckerman & Brown, 1993). Recent research suggests that the inconsistency in short-term neurobehavioral effects may be dose-dependent, with infants exposed to heavy doses of cocaine prenatally showing greater effects (Schuler & Nair, 1999). Cocaine appears to be uniquely associated with genitourinary tract malformations (Lutiger, Graham, Einarson, & Koren, 1991), and low birth weight is also a commonly reported result of prenatal exposure to many drugs of abuse (Hutchings, 1993). In contrast, although some have suggested higher rates of infant mortality due to prenatal drug exposure, no evidence of this was found in a recent large, well-controlled study (Ostrea, Ostrea, & Simpson, 1997). However, regardless of the short-term effects, whether such effects translate into long-term dysfunction is of most concern and has been the source of great controversy. The long-term effects associated with each of the major classes of drugs of abuse are presented below.

With regard to cocaine, consensus appears to be building for the belief that although it does not have broad or devastating effects, it may lead to deficits in the ability to habituate or self-regulate, especially under stressful conditions. For example, Zuckerman’s (1996) summary in the *National Institute on Drug Abuse Research Monograph Series: 164* suggests that “If there is any agreement in these data, it might be in the early impairment of habituation” (p. 279). Zuckerman also highlights the fact that both animal and human investigations suggest that “prenatal cocaine exposure may result in a decreased adaptability that may not be evident under . . . minimal stress, low-distracting testing conditions” (p. 278).

Although the literature is inconsistent, other subtle but meaningful long-term deficits have also been reported. Chasnoff et al. (1998), in an evaluation of cocaine-exposed infants at 4 to 6 years of age, found that though IQ was not directly affected, a range of internalizing and externalizing behavior problems were more likely in children who had been prenatally exposed. Lester, LaGasse, and Seifer (1998), in a meta-analysis, report very small but statistically significant decrements in IQ (3.26 points) and language...
abilities associated with prenatal exposure to cocaine. With even these very subtle differences, these authors predicted a yearly increase of 1,688 to 14,062 additional children who will fall within the mentally retarded range on IQ tests (based on a predicted number of infants born drug exposed). Similarly, they predicted an increase of approximately 4,000 to more than 30,000 children yearly who experience receptive language problems, and a similar increase in children experiencing expressive language problems. Bender et al. (1995) found that children between 4 and 6 years of age who had been prenatally exposed to cocaine performed worse than a control group on receptive language and visual motor tests, even after controlling for relevant variables.

Data regarding the long-term effects of prenatal exposure to other drugs of abuse, with the exception of alcohol, is not as current or extensive as that for cocaine. However, results appear to be similar in many ways. With regard to opiates, despite reliably showing intrauterine growth retardation (Kaltenbach, 1996) and early neurobehavioral effects, long-term developmental effects in infants exposed to opiates prenatally have not been shown (Zuckerman & Brown, 1993). The literature regarding other drugs is sparse and inconsistent, with intrauterine growth retardation being the most commonly reported negative outcome of prenatal marijuana exposure (Zuckerman & Brown, 1993) and amphetamine exposure (Plessinger, 1998). Suggestions that attentional difficulties may prove to be a key outcome in marijuana-exposed infants are common (e.g., Fried, 1996).

The literature regarding alcohol use during pregnancy, however, is a departure from that regarding other drugs of abuse. Of all drugs, only alcohol has been proven to have the potential for clear and irreversible negative effects, including mental retardation, neurological deficits, facial malformations, and growth retardation (Streissguth, 1997). These effects are commonly known as Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE) (used when negative effects are present but not meeting full FAS criteria).

A diagnosis of FAS requires evidence of growth retardation, central nervous system involvement (such as developmental delay or hyperactivity), and at least two specific forms of facial malformations. Although only 10 to 20 of 1,000 alcoholic women will have offspring who meet criteria for FAS (Abel & Sokol, 1987), there is evidence of long-term IQ, attentional, and learning deficits even in children of moderate drinkers (Streissguth, Barr, & Sampson, 1990). Thus, although very few children exposed to alcohol in utero will demonstrate the profound deficits that are present in some children of very heavy drinkers, attentional and information-processing capacities may still be significantly affected (Mattson, Riley, Gramling, Delis, & Jones, 1998; Streissguth, Barr, Sampson, & Bookstein, 1994). Controversy continues as to the magnitude of effects when pregnant mothers drink minimally to moderately, and regarding whether there is a threshold of drinking that produces negative effects (Zuckerman & Brown, 1993).

Postnatal Effects of Parental Drug Use

Despite transient hints at consensus regarding the direct effects of prenatal drug or alcohol exposure, the inconsistency and small magnitude of findings has led some to view CPS and social policy responses based solely on substance use during pregnancy as inappropriate (e.g., Lester, Freier, Boukydis, Affleck, & Boris, 1997). The risk of substance abuse during the postnatal period is often seen as a more appropriate focus, especially given the relatively clear evidence that having a substance-abusing parent can be a potent correlate of poor child outcomes.

Such evidence is present in a number of areas of research. For example, Chaffin et al. (1996), prospectively studying a sample of more than 7,000, found that the presence of a diagnosable substance abuse disorder in a caretaker increased the relative risk of neglect by 3.2 and of physical abuse by 2.9. Neither sociodemographic variables nor depression were as strongly related to abuse outcomes as substance abuse. Black and Mayer (1980) reported that in families of 200 parents with addictions to alcohol or opiates, 41% showed evidence of physical abuse, sexual abuse, or severe neglect, and at least mild neglect was noted in all families. Observing the issue from the opposite direction, other researchers have suggested that chemical dependence exists in approximately 50% (Curtis & McCullough, 1993; Murphy et al., 1991) of families that have come to the attention of the CPS system. A recent study, using multiple sources of information and strict definitions of substance abuse, found evidence of substance abuse problems in 79% of caregivers whose children were in out-of-home care (Besinger, Garland, Litrownik, & Landsverk, 1999). Substance abuse has also been shown to be associated with re-reports in parents already known to CPS, indirectly (via compromised parenting) as well as directly (Wolock & Magura, 1996).

Child maltreatment does not appear to be the only risk for prenatally exposed children who are raised by a substance-abusing caregiver. For example, a study of drug-exposed children of heroin addicts conducted by Ornoy, Michailevskaya, Lukashov, Bar-Hamburger,
and Harcl (1996) found that those children raised by their birth parents had significantly lower IQs and exhibited problem levels of hyperactivity more often than did those children raised in adoptive homes. Chasnoff et al. (1998) report that prenatal drug exposure had an indirect effect on child IQ at age 6, a relationship that was mediated by home environment. In a study of attachment in substance-exposed infants, Rodning, Beckwith, and Howard (1991) report that exposed infants showed an 18% rate of secure attachment to their biological parents at 15 months. A matched sample of infants of parents who did not abuse drugs showed a 64% rate of secure attachment. A later report by Howard and colleagues (Tyler, Howard, Espinosa, & Simpson-Doakes, 1997) indicated that drug-exposed infants raised by biological mothers showed better cognitive development at age 6 months than exposed infants in the care of relatives. However, there were three deaths (SIDS) among infants in the care of their mothers, and no deaths among infants in a relative's care.

In addition to the risks to children presented by drug use alone, the many factors associated with substance use are also important to consider. Depression, criminality, poverty, prior abuse, and family violence are all more common in homes where illicit substances are used (Bays, 1990; Jones-Harden, 1998; Nair et al., 1997). These factors present additional risks above and beyond those associated with prenatal drug exposure. Given the frequency of such risk factors in homes where substance abuse is an issue, somewhat less controversy exists in regard to the risks to children raised by substance abusing caregivers than in regard to the risks of prenatal substance use. However, most agree that any special needs or deficits in children with prenatal substance exposure will likely interact negatively when manifested in a compromised environment (Dore, Doris, & Wright, 1995; Jones-Harden, 1998; Kelley, 1992).

Financial Ramifications of Prenatal Drug Exposure

The GAO (1990) reported that postpartum hospital charges for infants with prenatal drug exposure were $4,100 higher (in 1989 dollars) than for infants without drug exposure. Another agency subsequently reported that the financial cost of substance use during pregnancy, resulting primarily from extended hospital stays, is between $22.3 million and $125 million per year (James Bell Associates, 1993). An analysis by Phibbs (1991) suggested that the cost of perinatal cocaine exposure alone is between $83 million and $650 million. The cost to the CPS system of substance abuse, without consideration of medical and legal costs, has been estimated at $10 billion (National Center on Addiction and Substance Abuse, 1999). The cost to the educational system to service children to the age of 18 years with prenatal exposure who have significant impairment has been estimated at $750,000 per child (GAO, 1990). Other more conservative estimates report that upwards of $354 million will be needed annually to provide the additional special educational services needed due to the slight but reliable effects that cocaine exposure has on IQ and learning (Lester et al., 1998).

Summary of Prenatal Drug Exposure Effects

Despite controversy regarding the severity of the effects of prenatal drug exposure, there appears to be agreement that at least some subtle but meaningful long-term behavioral and cognitive deficits may result from prenatal drug exposure, especially in the area of attention and habitation. Significant added financial burden to society also appears to be present through additional hospital, school, and CPS costs. Regardless of prenatal effects, the added risk of child behavior, emotional, and attentional problems; unsafe or inadequate home environments; and child maltreatment that are presented by postnatal caretaker substance use appear to merit some form of societal response. The details of this response, however, are by no means agreed on. This is due in part to a number of complex policy dilemmas that confront those attempting to respond to the issue of prenatal drug exposure.

POLICY DILEMMAS

Perinatal Drug Screening

Screening of pregnant mothers for drug use and neonates for drug exposure is the first policy question to be considered. Whether to test—and who to test—is an issue that raises profound questions about civil rights, societal biases, and child protection. Universally testing all neonates insures fairness and maximizes the chances that an exposed infant will receive any needed services. Testing appears to be the best way at present to reliably identify prenatal exposure. In one study, only 29% of cocaine positive mothers gave a history of such use (Schulman, Mec, Karmen, & Chazotte, 1993). Ostrea et al. (1992) found that although only 11% of more than 3,000 mothers giving birth admitted to having used drugs during pregnancy, 44% of all infants showed evidence of prenatal exposure.
The practice of universally testing neonates, however, may place hospitals in a role that conflicts with their traditionally nonjudgmental and confidential approach to treatment. In addition, such a policy may be seen as having an investigative rather than a medical basis, and implies that such testing could occur without the patient's consent. Furthermore, screening procedures at birth usually involve urine analysis, which is only able to detect drug use over the previous few days, at best (Casanova et al., 1994). Drug screening via urine analysis thus has good specificity but minimal sensitivity in detecting use during pregnancy (Ryan et al., 1994), a fact that may result in identification of only a subset of prenatally exposed infants despite universal testing. (Testing of newborn meconium or hair, though offering a much longer window of detection, is more expensive and thus rarely performed; Callahan et al., 1992.) Finally, universal screening may increase the chances that parents will choose to avoid the hospital altogether rather than risk criminal or CPS charges. For these reasons and due to fears regarding the long-term implications of labeling infants as drug exposed, the committee on substance abuse of the American Academy of Pediatrics (AAP) (1995) has expressed opposition to universal testing.

Targeted testing avoids many of the above difficulties. It leaves decisions regarding testing up to individual hospitals and physicians, reduces costs, and reduces chances that patients will avoid the hospital. However, it introduces the possibility of significant bias in decision making (a suspicion with some basis; see Chasnoff et al., 1990; Hans, 1999), and further reduces the chances that at-risk infants will be accurately identified. Tremendous inconsistency is inevitable with such an approach, in that identification can be more a function of area of residence, hospital philosophy, physician prerogative, and timing of last drug use rather than severity of prenatal drug use.

A third option is to simply not test at all, relying instead on self-report of drug use. This option has the advantage of greatly reducing infractions of civil rights, treatment avoidance, and biased use of child welfare/criminal involvement (because such involvement typically requires medical evidence of prenatal exposure). It would end any investigative role that health care workers may find themselves in, and may thus facilitate voluntary admission of use and acceptance of treatment. However, it would also end any ability of medical professionals to sensitively identify infants at risk due to caretaker substance abuse. The number of high-risk infants unidentified could increase, and opportunities for prevention of negative outcomes could be lost.

This issue appears to be handled very differently in some states than in others. A national survey of state policy directors (Chavkin et al., 1998) regarding perinatal substance abuse revealed that 12% of respondents' states in 1995 had mandatory drug testing policies for pregnant women (up from 2% in 1992), and 7% indicated that their state also required testing of all neonates (up from 0% in 1992). Previously, Adirim and Gupta (1991) had reported that drug testing was at the discretion of the health care provider in all states. Hospitals and health care providers appear to use this discretion very differently: In one major metropolitan area, a survey of 49 hospitals revealed that 10% of labor units always screen, whereas 90% screen sometimes (Birchfield, Scully, & Handler, 1995). Thus, it appears that individual states, hospitals, and even specific hospital units all handle this issue very differently.

Overall, there is not at present a fair and adequate means of identifying infants at risk due to prenatal drug exposure. Although some states have sought to achieve fairness and better child protection through universal screening, this practice has the potential to lead to avoidance of hospitals, politicization of medical care, and serious infractions of civil rights. However, failing to have clear standards for testing creates ample opportunity for bias and may further impair an already inefficient method of identifying children at risk.

CPS and Court Involvement

How, then, should society respond when an infant testing positive for drugs is identified? Whether to involve CPS and/or the court system is a major source of controversy in this area (Garrity-Rokous, 1994). Views of substance abuse as a disease meriting support and treatment conflict with those of substance abuse as a crime that is appropriately dealt with via sanctions and/or court-ordered treatment (Lester et al., 1997). The primary argument offered for involving CPS and the court system is that parents with substance abuse problems are unlikely to enter treatment without a court mandate. The available research seems to provide moderate support for this belief, in that persons court-ordered into substance abuse treatment appear to succeed as often as those not so ordered (Farabee, Prendergast, & Anglin, 1998). Furthermore, the multiple problems faced by many families affected by substance abuse is typically seen as necessitating intensive and nonvoluntary monitoring to assure child safety. Finally, some see court involvement as necessary from a justice perspective. That is, abusing drugs while pregnant is seen by some as an illegal and immoral act that requires a vigorous response to prevent further
such behavior and to satisfy the requirements of justice.

However, parents who abuse substances are less likely to comply with child protection treatment plans than parents who do not abuse substances, even when a court order is in place (Famularo, Kinscherff, Bunshaft, Spivak, & Fenton, 1989). In addition, bringing high levels of coercion to bear on parents increases the likelihood that contact with outside agencies and hospitals will be avoided by pregnant mothers. In this manner, vigorous use of court interventions in an attempt to protect infants with prenatal exposure may result in harm to later-born infants. Furthermore, although most CPS and child mental health professionals believe that adequate child protection requires some level of mandated services for abusive or neglectful parents, trust and openness from parents is affected when treatment is mandatory and progress is monitored. Many believe that drug and alcohol addiction is more a disease than a criminal act, and that to treat them as the latter is an ineffective and punitive approach akin to criminalizing mental illness (Lester et al., 1997; Paltrow, 1998).

Perhaps of even more concern regarding the use of court responses to prenatal exposure is the fact that alcohol, and perhaps even tobacco (Slotkin, 1998), can have equal or greater negative effects than illicit drugs. Hans (1999) emphasizes that substance abuse is largely equivalent across socioeconomic groups, with only the drug of choice varying; higher SES mothers tend to use alcohol and marijuana at rates similar to those at which lower SES women use cocaine and other illicit drugs (Chasnoff et al., 1990). Thus, interventions predicated on damage done to the infant are inconsistent from the outset. CPS referrals based on nicotine or alcohol exposure are clearly not taking place, and cocaine use—more prevalent among lower SES groups—appears to result in a stronger reaction than marijuana, despite the absence of clear data that marijuana use is less harmful. Those advocating for court involvement with drug-exposed infants must show that this response is based on clear evidence of unique environmental risk associated with illicit drug use in the home (or unique risk associated with use of a specific illicit drug) and not on damage due to exposure alone.

As with screening neonates for drug exposure, there is a wide range of responses to this issue. As of 1995, 35% of respondents in a nationwide survey sampling two policy directors in each state reported that positive neonatal toxicology is legally defined as child abuse or neglect in their state; 65% reported that their CPS agency informally considered it to be abuse or neglect (Chavkin et al., 1998). A more recent survey of urban and rural counties in each state found that whereas 21% of counties receiving referrals of drug-exposed infants stated that they never file juvenile/deprived court charges, 46% of respondents reported filing such charges in at least 41% of cases (Ondersma et al., 1999).

Removal of the Infant

Once CPS becomes involved following reports of prenatal substance exposure, they face an immediate and complicated challenge: Should such infants be taken into state custody? CPS agencies are alternately blamed for "unwarranted interference in private life" when a child is removed from their home and for "irresponsible inaction" when a child is not removed and subsequently hurt in their caregiver's custody (Larner, Stevenson, & Behrman, 1998).

Failing to take a drug-exposed child into protective custody means sending a potentially at-risk infant into a home where substance use is known to occur. Furthermore, it means doing so where drug use is known to have occurred in spite of a societal taboo (often present even within drug-using subcultures) against drug use during pregnancy, suggesting that casual drug use or experimentation is unlikely. Finally, if identified via urinalysis, it also means that drug use has occurred within days of delivery, despite the common fear of pregnant drug users that use near delivery places them at risk of testing positive and facing subsequent consequences.

Failing to take initial custody also means allowing an infant to be cared for by a parent who is likely to have a wide range of associated risk factors, including domestic violence, poverty, criminality, depression, and others (Bays, 1990; Jones-Harden, 1998, Nair et al., 1997). Furthermore, such parents are typically also being asked to engage in the stressful and difficult task of entering substance abuse treatment. Initial removal allows parents to focus on substance abuse treatment while simultaneously providing relative assurance of the infant's safety.

However, taking immediate custody of newborn infants is a dramatic societal response that must be carefully evaluated. First, it introduces clear disruption in the very relationship in which inadequate bonding is feared (Mundal, VanDerWeele, Berger, & Fitisimmons, 1991). Attachment is a dyadic process, and either the mother's or the infant's ability to bond can be affected by such action, especially when both members of the dyad are particularly vulnerable. Further exacerbating this problem, visits with infants in state custody are dependent on the overloaded CPS system, are typically brief, and are legally mandated in some states to occur only 1 hour per month. Removal
of the infant can result in extreme distress to parents, which although motivating some toward entry into treatment, is often overwhelming for others who have little ability to respond adaptively to emotional upheaval. Some service providers have also expressed concerns that parents who are separated from their infants for long periods may be more likely to simply give up.

Finally, it is not clear that current research supports such an action. Additional risk pre- and postnatally clearly exists, but this risk may or may not be greater than that present, for example, when a premature infant is born to a low-SES depressed woman, or when a new mother fails to obtain prenatal care and has a partner who is frequently violent. Although erring on the side of child protection is a defensible approach to questions of custody removal, responding more strongly to some risks (i.e., substance use) than others (i.e., low SES, depression, and domestic violence) is not. Empirical evidence of maternal substance use during or after pregnancy as a greater risk than depression or domestic violence may be important if prenatally exposed infants are to be singled out for more frequent custody removal. Furthermore, it is clear that some but not all children of substance-abusing mothers will be maltreated, but clear research and assessment tools to guide risk assessment are lacking. This lack of research-informed guidance, combined with the dearth of time and information available to a worker doing an evaluation in a hospital, makes decisions regarding removal of custody even more difficult.

The Ondersma et al. (1999) survey found near-complete variation in county-level responding on this issue as well. Among supervisors from rural and urban counties in all 50 states, 13% indicated that their county never removes custody of cocaine-exposed infants that are brought to their attention, but 29% said that their county takes custody of such infants more than 75% of the time. (It should be noted that this survey did not clarify whether cocaine-exposed infants were taken into custody for other reasons, such as failure to thrive, focusing instead on frequency of removal where substance exposure at birth was the primary basis of referral.)

Competing Timelines

The infant's need for stability is often in direct conflict with the parent's need for time in which to make lasting changes in addictive behaviors (DHHS, 1999). The National Center on Addiction and Substance Abuse (1999) uses a "two clocks" metaphor to explain this dilemma, in which the "clock of child development" reflects the infant's immediate need for permanence, while at the same time the "clock of recovery" reminds policy makers of the long-term and chronically relapsing nature of addictions (p. 30). An infant's long-term development is greatly enhanced by the immediate presence of an effective and stable caregiver, be that a biological parent or an adoptive parent. Enforcing strict time restrictions can limit the amount of time an infant stays in foster care and can increase the likelihood that the infant will be quickly placed with, and thus more likely to bond with, a permanent caregiver.

However, chemical dependency can easily require years of treatment and is characterized by repeated relapses. Although strict time limits may shorten the amount of time an infant remains in foster care, these limits typically do not allow parents adequate time to achieve stable sobriety. Furthermore, the CPS system itself has not demonstrated the ability to effectively provide permanence and stability. There is at present no guarantee that a permanent home will be available for the infant after strict time limits are enforced.

The amount of time allowed for parents of drug-exposed infants to complete CPS treatment plans, like policies regarding screening, use of court involvement, and custody removal, also appears to vary. Although time is not an issue in counties that respond minimally to prenatal drug exposure, many parents appear to remain involved with the system for as many as 3 years (Ondersma et al., 1999). The Adoption and Safe Families Act (ASFA) (PL 105-89), signed into law on November 19, 1997, was designed to provide clear guidance on this issue, mandating limits on the time in which a child can be out of parental custody before permanency is established. The extent to which PL 105-89 will result in actual changes in the time that children spend in foster care or other impermanent placements due to parental maltreatment remains to be seen.

Complexity and Intensity of Services

The multineeds nature of many parents with substance abuse disorders is well documented. Higher levels of joblessness, poverty, domestic violence, medical and psychiatric problems, prior maltreatment, and criminality are all present (e.g., Bays, 1990; GAO, 1990; National Center on Addiction and Substance Abuse, 1999) and indicate a need for treatment in a wide range of areas. However, intensive treatment in multiple areas can quickly become logistically impossible and emotionally overwhelming for parents. Furthermore, individuals experiencing such difficulties
are often minimally able to seek, obtain transportation to, pay for, and benefit from multiple services. Finally, services themselves may be limited with long waiting lists or availability only at sites that are great distances from the client. How to manage multiple needs, and whether to focus first on substance abuse (as a primary risk factor) or parenting (using a harm-reduction model, assuming that substance use is likely to continue to some degree), is currently not known.

Financial Restrictions

As with all significant social problems, the issue of prenatal drug exposure represents a dilemma between nearly infinite financial need and very finite actual resources. The needs of this population are tremendous. For example, recommendations for program design in working with women who abuse alcohol and other drugs often call for interventions that (a) provide transportation, child care, and housing assistance; (b) include medical, developmental, substance abuse, case-management, HIV, mental health, and vocational services; and (c) provide long-term care by highly trained staff (e.g., Center for Substance Abuse Treatment, 1994; Resnik, Gardner, & Rogers, 1998). However, treatment programs that even approximate all of the above requirements are expensive to maintain, rare, and able to offer services to only a small number of women. Even greatly increased governmental spending could be very poorly used were it devoted exclusively to expensive programs that only serve a small group of highly motivated clients. There is at present no clear policy to guide decision making regarding how to most effectively allocate limited resources to the nearly limitless range of families in need.

Legal Issues

Many questions raised in the previous sections are of a legal nature and must be resolved in the courts themselves. For example, whether specific consent is required before a hospital can test a mother or her infant for illicit drugs, and whether universal or targeted testing violates civil rights, are issues that must be decided in court. A similar dilemma to be resolved is the legality of applying child abuse statutes to the prenatal period. Prosecuting mothers under child abuse statutes (thus defining the fetus as a person with certain rights) may be legally inconsistent when abortion, another action concerning fetuses, is currently legal (thus defining the fetus as something other than a person with rights independent of the parent). In addition, policies created to protect the fetus may infringe on the reproductive privacy rights of the mother (Tomkins & Kepfield, 1992).

CURRENT PRACTICE AND FINDINGS

Thus, a great number of complex and controversial issues face those seeking to respond appropriately to infants with prenatal drug exposure. As a result, as noted above, public policy appears to vary tremendously. However, a great number of treatment programs specific to drug-exposed infants have begun to emerge. Clear success on the part of any of these programs might offer guidance regarding policy. To what extent can current outcome literature provide such guidance? A great number of novel service demonstration projects have been implemented, most of which are primarily home-based, use an interdisciplinary approach, and seek to build positive relationships between staff and clients. Most are based on ecological theory, self-efficacy enhancement, and attachment facilitation (both between staff and client and between client and infant), and attempt to connect clients with services available in the community. However, few have been empirically evaluated, and even fewer have used a control or comparison group.

Perhaps the largest initiative for parents of infants at risk due to substance abuse is the Abandoned Infants Assistance Act, passed by Congress in 1988 (Public Law 100-505) and funded through the DHHS Children's Bureau. This program currently funds 29 service demonstration projects nationwide, 22 of which work with families of drug-exposed infants. Maza (1999) reports that Abandoned Infants Assistance programs have been successful at providing services to a large number of at-risk infants, including prenatally drug-exposed infants, using a collaborative interagency approach, interdisciplinary teams, peer staff, and home-based services. However, evaluations of most individual programs are not available, and no controlled studies of treatment effectiveness have taken place.

A wide range of other new initiatives is reviewed by Young et al. (1998). Most programs attempt to bring CPS and substance abuse services together, either by pairing substance abuse counselors with CPS workers, by increasing the amount of training workers receive in substance abuse issues, or by forming multidisciplinary teams that review cases jointly. For example, a project initiated by the New Jersey Division of Youth and Family Services (DYFS) created contracts with two local agencies to have certified drug and alcohol counselors, together with paraprofessional home visitors with personal experience with addiction, provide services to families. The substance abuse professional accompanies DYFS intake workers to clients' homes following initial reports of suspected abuse or neglect, and continues to work alongside DYFS treat-
ment workers in those cases where parents are identified as in need of substance abuse services.

A second initiative reviewed by Young et al. (1998) has arisen directly from the juvenile/civil court, and is modeled after the criminal drug court model. Family Drug Court programs arrange for immediate assessment and entry into treatment, treatment plans are promptly devised and closely monitored, and parents are provided with significant rewards or consequences for behavior (i.e., a parent fully involved in treatment may get her child back faster, whereas a parent who fails to comply may be detained in jail or expelled from the drug court program). Although some promising results have been reported (National Center on Addiction and Substance Abuse, 1999), no formal evaluation has been done.

Three home visiting programs specifically designed for mothers of substance-exposed infants have reported the results of controlled clinical trials. Although much more controlled research needs to be done, the results of these programs appear to mirror the mixed findings regarding the larger home visitation movement (Comby, Culross, & Behrman, 1999). As a review of these studies will show, results often vary, positive outcomes found are not of great magnitude, and engagement and retention of clients is a major issue.

One of the first controlled trials of in-home work with substance-abusing parents of young children is reported by Howard (1994), who used a multidisciplinary home-based model with parents of substance-exposed infants, and included a non-drug-using comparison group of women of similar socioeconomic status. Despite what were described as great efforts at developing strong relationships with clients, Howard reported that home visitors had trouble engaging clients in child-centered work. At 15 months, 64% of comparison infants demonstrated positive attachment to their caregivers, yet no substance-exposed infants living with a nonabstinent mother showed positive attachment to their caregiver. This was in spite of the fact that a majority of infants (75%) in this latter group did not experience a change in custody. (Among substance-exposed children living with mothers who had been sober at least 6 months, fully 50% demonstrated secure attachments.)

A controlled trial by Black et al. (1994), though also reporting mixed results, was methodologically rigorous and offered reason for cautious optimism. A total of 60 inner-city, low-income mothers with substance abuse histories were randomly assigned to treatment (n = 31) and control (n = 29) groups. Public health nurses sought to provide biweekly home visits prior to delivery and throughout the first 18 months of the infant’s life. Again, engagement appears to have been an issue; a mean of 12 (out of 36) home visits per client were actually provided, with a range of 0 to 32. At 18 months, no differences between treated and control children were found on cognitive or mental development (as measured by the Bayley scales), total home environment (as measured by the Home Observation for Measurement of the Environment [HOME] scales), or self-reported drug use (controlling for social desirability). However, there were significant differences between treated and control groups on measures of physical abuse potential and parenting stress (Child Abuse Potential Inventory and Parenting Stress Index-Child Domain scores, respectively), and maternal emotional and verbal responsivity (a subscale of the HOME scales) favoring the treatment group. Furthermore, differences on total HOME scales score and self-reported substance use approached significance. It is thus possible that sample size (with only 31 and 29 cases per condition) limited statistical significance.

Streissguth and colleagues (Ernst, Grant, Streissguth, & Sampson, 1999) report data from the Seattle Birth to 3 Program, which involved intensive paraprofessional advocacy with 65 mothers who abused drugs and/or alcohol heavily during pregnancy. A comparison group of 31 women was also studied, but use of matching criteria was not reported. Differences between treated and comparison groups were not significant on any of the five individual domains studied (participation in substance abuse treatment, abstinence, use of family planning, target child’s custody and use of health care, and connection with services). However, a global endpoint score representing the combination of all of the above domains did show significant differences favoring the treated group. As with other controlled studies, engagement may have been an issue. Fully 51% of clients were involved for between 9 and 31 months of the 36-month program, and 11% participated for a total of 8 months or less. Clients who participated more frequently appeared to show more improvement on most outcomes, but significant values were not reported. Ernst et al. did not report how involvement in a given month was defined, nor do they report any data regarding child outcomes.

RECOMMENDATIONS

The lack of even a loose national consensus in responding to infants with prenatal drug exposure is clear, and the treatment outcome literature has not
yet provided a conclusively successful model to guide policy decisions. Although the dilemmas identified are complex and not easily resolved, it is possible—and perhaps necessary—to begin developing specific guidelines toward the development of a national response. Though such guidelines should ideally be based on solid research and should emanate from a multidisciplinary advisory committee with expertise in substance abuse, child maltreatment, parenting, law, and child development, the following recommendations are offered as early steps toward such a goal. It is assumed that any practice and policy guidelines must be continually reviewed in light of new knowledge. It is also acknowledged that many of the following suggestions are ideals that although impossible to meet completely, should be approximated to the extent possible. Rather than restrict ourselves to suggestions that can be implemented with minimal effort, we have chosen to provide a comprehensive list of actions that we believe could improve outcomes for drug-exposed infants. Recommendations are arranged under headings representing the major dilemmas discussed earlier.

**Significance of Prenatal Drug Exposure**

Consider prenatal drug exposure a real but not devastating risk factor. A set of suggested working assumptions that appear to be supported by current research include (a) prenatal exposure to alcohol and illicit drugs places infants at increased risk of subtly but important attentional, self-regulatory, and cognitive difficulties; (b) the presence of substance abuse in a primary caretaker places children at additional risk of maltreatment and impaired attachment; (c) the financial cost of such added risk appears to be significant; and (d) there is great variability in harm to exposed infants, ranging from no detectable negative consequences to the relatively rare outcome of severe harm (e.g., infants with FAS or those exclusively dependent on a severely addicted caretaker).

Conduct a campaign to educate the public, professionals, and policy makers. As noted earlier, the most pervasive belief at present appears to be that prenatal drug exposure is usually devastating to infants. There are many potential negative consequences of this belief. For example, at-risk parents may learn to disregard warnings altogether when seeing that their and others' children appear normal, exposed children may be seen as damaged goods or lost causes, and the importance of postnatal substance use may get overlooked. The dissemination of more moderate and empirically based information emphasizing the potential of drug-exposed infants, the subtlety of effects, and the risks of postnatal substance use could facilitate movement toward a more appropriate response.

**Screening**

Screen for tobacco and alcohol exposure, as well as for illicit drug exposure. Grouping all such risks together is logical, given their roughly equivalent risks in most cases, and could facilitate a more reasoned and equitable response to the risk present in a given infant. Such a practice could only take place if responses are predicated on risk rather than illegality.

Do not rule out universal screening. The problems with such a policy are significant, leading it to be widely criticized (e.g., AAP, 1995; Center for the Future of Children, 1991). We agree that such a policy would be controversial and has great limitations. However, targeted testing is predicated on two assumptions that may not be true—first, that persons likely to be substance abusers can be reliably and fairly targeted for testing, and second, that any bias or ineffectiveness present is less costly from a financial or a civil rights perspective than universal testing. The decision to test universally is presumably a function of the potential harm from a given risk factor, the preventability of harm with early identification, cost per detected case, and the feasibility of targeted testing as an alternative. Although not proven currently, there appears to be great potential for preventing negative outcomes if substance-exposed infants are identified early. Furthermore, such screening would greatly facilitate progress toward a consistent policy, and would eliminate the tremendous potential for racial or socioeconomic discrimination that is present when only some women are targeted for testing (Chasnoff et al., 1990; Hans, 1999). Finally, universal screening could force a more appropriate approach to CPS involvement, in that the large numbers of infants identified in this manner would demand that intervention occur with only the highest risk cases. The cost-effectiveness of such a policy, as well as the relative risk of factors other than substance exposure (that perhaps are better targets of universal screening), would have to be carefully considered.

Follow an objective protocol when using targeted testing. If targeted testing is to be an ongoing policy, there must be an objective protocol to guide health care professionals in making testing decisions. However, identifying risk factors that are not confounded with poverty (e.g., limited use of prenatal care, poor self-care) may be a challenge.
CPS/Court Involvement and Custody Removal

Base decisions to become involved primarily on the need to prevent poor infant outcomes due to environmental risk, not primarily on damage due to prenatal exposure. Damage due to exposure alone is often subtle, is not inevitable, and may not be apparent for some time. Furthermore, to respond on this basis to illicit drugs but not alcohol is fundamentally inconsistent. Children with prenatal exposure to alcohol or other drugs have tremendous potential for a good outcome in many cases (with a notable exception being those with FAS), but are at increased risk secondary to substance abuse in their postnatal environment and may be additionally vulnerable to a negative environment due to their exposure.

Use juvenile/civil court only, and only for the higher risk cases. Based on the available evidence, we believe that child protection, on one hand, and family preservation, civil rights, and treatment avoidance, on the other hand, are best balanced via selective use of juvenile/civil court intervention. Doing so in nearly every case would never be sustainable and could have significant negative consequences in terms of treatment avoidance, lost opportunity for voluntary involvement, and civil rights violations. To do so in no (or very few) cases would be to ignore the realities of addiction and the needs of infants.

Develop universal guidelines for comprehensive initial risk assessments. Initial decisions should be based on careful evaluations of a family's substance use history, home adequacy, history of violence, willingness to enter treatment, CPS history, and other factors. Responding to all new cases in the same way, as many counties now appear to do, suggests that a priori assumptions rather than data are guiding decisions. As noted, the emphasis in such assessments should be on the environmental risk rather than the prenatal effects of maternal substance use.

Develop an empirically based hierarchy of risk conditions. Cases of prenatal drug exposure can only be appropriately handled if they are viewed as one of a large number of risk conditions in which children are placed. Factors such as harm (current and future), prevalence, intent, pervasiveness, and variation from normative parenting behavior could be considered in ordering the range of maltreatment to which children are exposed. Such a hierarchy, if settled on by an appropriate multidisciplinary task force, could aid CPS agencies in prioritizing responses to prenatal drug exposure and other risks.

Use actuarial rather than subjective decision making. The potential for bias and inconsistency is clear when decisions to take custody or file court petitions are based on subjective judgment. Furthermore, research has consistently demonstrated the superiority of actuarial (quantitative, based on empirically derived weighting of factors) risk assessment in correctly classifying at-risk and not at-risk cases. Finally, actuarial assessment can potentially be more time efficient, an advantage for workers attempting to make key decisions before an infant is discharged from the hospital.

Competing Timelines

Strictly adhere to a reasonable time limit. The ASFA provides a range of new guidelines for CPS agencies. Among these is its stand on the issue of competing timelines, requiring permanence if a child has been in foster care for 15 of the most recent 22 months. This limit is consistent with the 12- to 18-month time limit recommended by the Center for the Future of Children (1991). Adhering to this or similar requirements will necessitate that which has been so difficult in the past—making binding decisions in cases that are less than clear. Juvenile and civil courts have traditionally had little relative difficulty moving toward permanence in cases of excellent progress or abject failure to progress. It is simply very difficult to make final decisions with the many cases where parents are fulfilling part but not all of a treatment plan. This difficulty has led to the temptation to continue cases until the parent either finally succeeds or finally gives up. The determinant of the child’s best interest requires an outside limit on permanence, which in turn demands clear decisions in less than clear cases. It is hoped that the flexibility built into the ASFA will not be abused to avoid difficult decisions.

Strictly adhere to ASFA concurrent planning requirements. The ASFA dictates that permanency planning begins the moment a child enters foster care. Strict adherence to this requirement could significantly decrease the amount of time vulnerable infants spend waiting for permanency.

Mean what you say and say what you mean. It is crucial that CPS and the court (a) only place demands on parents when it is essential to do so; (b) only place demands on parents that, if not met, will result in termination of parental rights; (c) communicate desires as recommendations or suggestions if termination is not a viable consequence; and (d) hold fast to all treatment plan requirements that are made. Failure to do so clouds the question of when a parent has or has not adequately fulfilled a treatment plan, and seriously compromises the relationship between clients and the CPS system. As with employees and business partners, lack of clarity in expectations increases
the likelihood of failure, and inhibits the ability to fairly evaluate their performance. Dialogue between service providers, CPS, and the court could be helpful in limiting requirements that cannot or will not be enforced.

**Improve access to treatment.** Parents facing shortened timelines will have much greater difficulty succeeding without access to adequate services. Those shortened timelines are also impossible to enforce ethically if adequate access to treatment is not provided. Although there are clear financial obstacles to improving access to treatment, a range of actions may be possible to both increase funds and use available funds optimally (see financial limitations below).

**Seek to maintain extended follow-up.** The sudden freedom of no longer having to meet the demands of a treatment plan is a challenging time for parents with addictive behavior problems. Extended follow-up can also allow placement decisions under strict timelines to be made more comfortably. Random drug screening and home visits for extended periods after the removal of formal requirements can do much to ensure long-term child safety and parental success.

**Intensity and Complexity**

**Strive to close the gap between multiple agencies, especially CPS and substance abuse programs.** Most parents currently must navigate between distinct—and often conflicting—requirements from social service agencies, CPS agencies, substance abuse treatment programs, parenting programs, domestic violence counselors, vocational rehabilitation programs, and so forth. Coordination of such programs is possible with little or no additional expenditures, requiring only a close dialogue between agencies and willingness to compromise on a unified treatment plan. For example, mutual awareness of the requirements and meeting times of each program or service delivery agency, compromise on the intensity of requirements, and discussion among professionals regarding individual cases can do much to make treatment plans more workable for clients.

**Financial Limitations**

**Place a premium on prevention.** The above complexities only serve to underscore the need for an emphasis on substance abuse prevention in pregnant women and in children. Some primary prevention programs have shown good results in preventing later substance abuse by children (Kumpfer, Molgaard, & Spoth, 1996), and brief interventions in substance use have been remarkably effective in reducing substance use in adults (Miller, Andrews, Wilbourne, & Bennett, 1998). As with tobacco use, large-scale reductions in the impact of perinatal substance abuse are far more likely to result from societal shifts in drug use patterns than from targeting those with already well-established patterns of use.

**Advocate for reorientation of government spending priorities.** Current federal and state funding priorities continue to place a disproportionate emphasis on interdiction and prosecution, both of which have failed to show a practical impact on the prevalence of substance use (Nicholson, 1992; Wisotsky, 1990). At the same time, treatment services are neither available nor accessible for far too many persons needing such interventions. Significant changes in society's attitudes toward addiction as a public health rather than a moral problem (Schuster, 1994) may be necessary before elected officials will agree to spend more on treatment than on interdiction and prosecution.

**Use a triage approach.** A triage approach should be considered, in which readiness to change substance abuse and improve parenting skills are considered and decisions are not based solely on need. A military medic, who (like social service programs) often represents a limited resource facing nearly unlimited need, is taught to save more lives by not devoting limited time and supplies only to the most severely wounded, who are less likely to benefit from those investments. Similarly, cost effectiveness could be enhanced if readiness to make use of limited resources is taken into account when working with substance-abusing parents.

**Improving Outcome**

**Provide better training to CPS workers.** CPS workers often lack appropriate training in working with addictive behaviors. Without appropriate training, workers may respond to chemically dependent clients with extremes of either mistrustful confrontation or accommodating sympathy, neither of which are helpful (Miller & Rollnick, 1991). Training is necessary to help CPS workers learn to maintain strict limits, communicate empathy and acceptance, and base decisions on objective risk factors (e.g., attendance at treatment) rather than subjective intuition (e.g., how convincing or likeable a client is). Many CPS workers do receive training in substance abuse, but this education often serves only to improve their knowledge and not their skills in working with substance-abusing clients.

**Consider motivation in treatment planning.** The work of Prochaska and DiClemente (e.g., DiClemente & Prochaska, 1998; Prochaska, DiClemente, & Norcross, 1992) and Miller (e.g., Miller & Rollnick, 1991)
has highlighted the great differences between persons with addictive behaviors in terms of readiness to change and the ability of therapists to influence readiness to change. Furthermore, the work of Silverman and others (see Silverman, Preston, Stitzer, & Schuster, 1999) in contingency management with illicit drug abusers has demonstrated the effectiveness of operant reinforcement systems in enhancing treatment response. Programs that skillfully acknowledge and work with ambivalence, possess a range of stage-of-readiness-for-change-based methods for interacting with clients, offer a range of treatment options, and provide response-contingent reinforcement are likely to be more successful than those not considering motivation.

CONCLUSION

Again, it is hoped that the above can function as a starting point for practical debate regarding the nation’s prenatal substance abuse policies. Only with a commitment to empiricism, willingness to compromise, acknowledgment of various disciplines’ perspectives, awareness of financial limitations, and communication can progress toward a consistent, moderate, and empirically based national policy regarding prenatal substance exposure be made.

REFERENCES


Steven J. Ondersma graduated from Wayne State University in Detroit with a Ph.D. in Clinical Psychology, and went on to receive training in child maltreatment at the University of Oklahoma Health Sciences Center. He is currently an assistant professor of research at the Merrill-Palmer Institute of Wayne State University. His current research interests are in motivational interventions with high-risk parents, especially parents at risk due to substance abuse, and the relationship between substance abuse and child maltreatment, especially in relation to prenatal substance exposure. He is co-director of two programs for parents of infants with prenatal drug exposure.

Sharon M. Simpson is a faculty member at the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center. She serves as the director of the Infant Parenting Program, a program designed to provide comprehensive services to mothers who used substances while pregnant and to their children. She received her Ph.D. in Clinical Psychology from Florida State University in 1997.

Elizabeth V. Brestan received her Ph.D. in Clinical and Health Psychology, with a specialization in Clinical Child Psychology, from the University of Florida. After completing an internship in pediatric psychology at the University of Miami School of Medicine, she completed a postdoctoral fellowship at the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center. Currently, she is an assistant professor at the Auburn University Department of Psychology.

Martin Ward received his Ph.D. in Clinical Psychology from the University of Florida in 1996. From January 1997 until July 1998 he was a postdoctoral fellow with the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center. Currently, he is an outpatient therapist with Pamee Mental Health Services in Concordia, Kansas. He is a coauthor of five articles in peer-reviewed journals.
Appendix G
Inventory List and Match Table with Supporting Letters
Inventory List

With regard to inventory (those items costing more than $500), five computers were purchased during this grant period. All computers were used by OIAP staff for OIAP related work. The following list indicates the serial number of each computer purchased. All computers remain at the Center on Child Abuse and Neglect and are being used by staff working on the renewal grant. Although some office furniture was purchased, none of the furniture cost over $500 and no other large financial purchases were made. Thus, the following is the extent of the inventory list:

<table>
<thead>
<tr>
<th>Items purchased</th>
<th>Serial Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer</td>
<td>3-3828-1347-00</td>
</tr>
<tr>
<td>Computer</td>
<td>3-3828-1348-00</td>
</tr>
<tr>
<td>Computer</td>
<td>3-3828-5680-00</td>
</tr>
<tr>
<td>Computer</td>
<td>3-3828-5681-00</td>
</tr>
<tr>
<td>Computer</td>
<td>3-3828-5682-00</td>
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</table>
OKLAHOMA INFANTS ASSISTANCE PROGRAM
MATCHING FUNDS


<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>HRS</th>
<th>METHOD OF MATCH</th>
<th>HRLY RATE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intakes</td>
<td>6 hrs/ intake</td>
<td>188 clients at 6 hours each</td>
<td>$16.77</td>
<td>$18,917</td>
</tr>
<tr>
<td>Formal Staffings</td>
<td>4 hrs/ mo per worker</td>
<td>Two hours twice monthly for two years – two treatment workers, one intake worker</td>
<td>$16.77</td>
<td>$20,124</td>
</tr>
<tr>
<td>Formal Staffings</td>
<td>2 hrs/ mo per worker</td>
<td>Two hours once monthly for one year – two treatment workers, one intake worker</td>
<td>$16.77</td>
<td>$6,708</td>
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<tr>
<td>Informal Staffings/ consultation</td>
<td>3 hrs/ wk per worker</td>
<td>Three hours per week for two years</td>
<td>$16.77</td>
<td>$5,031</td>
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<td>Treatment</td>
<td>20 hrs/ wk per worker</td>
<td>3 workers at 20 hours per week for two years</td>
<td>$16.77</td>
<td>$50,310</td>
</tr>
<tr>
<td>Treatment</td>
<td>30 hrs/ wk per worker</td>
<td>2 workers at 30 hours per week for two years</td>
<td>$16.77</td>
<td>$50,310</td>
</tr>
<tr>
<td>Treatment</td>
<td>30 hrs/ wk</td>
<td>1 supervisor at 30 hours per week for 100 weeks</td>
<td>$16.77</td>
<td>$25,155</td>
</tr>
</tbody>
</table>

Total FY97-01 $183,263
Less state share (78.25%) $137,905

The University Hospitals – 9/30/96 to 9/29/97

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>MATCH</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Costs for OIAP waived by The University Hospitals</td>
<td>650 square feet of space @ $19.79 per square feet</td>
<td>$12,863.50</td>
</tr>
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</table>
## PLANNED PARENTHOOD MATCHING FUNDS

<table>
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<tr>
<th>FY</th>
<th>HRS</th>
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<th>HRLY RATE</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>1997</td>
<td>74hrs</td>
<td>$18 discount from $30 over 74 total hours</td>
<td>$12</td>
<td>$1,332</td>
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<tr>
<td>1998</td>
<td>63.5hrs</td>
<td>$15 discount from $35 over 63.5 total hours</td>
<td>$20</td>
<td>$952</td>
</tr>
<tr>
<td>1999</td>
<td>40.5hrs</td>
<td>$15 discount from $35 over 40.5 total hours</td>
<td>$20</td>
<td>$607.50</td>
</tr>
<tr>
<td>2000</td>
<td>73.5</td>
<td>$15 discount from $35 over 73.5 total hours</td>
<td>$20</td>
<td>$1,102.50</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>$3,994.00</td>
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## TOTAL MATCH FOR PROJECT PERIOD (FY97-01)

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>MATCH TOTAL</th>
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</thead>
<tbody>
<tr>
<td>Oklahoma DHS</td>
<td>$137,905.00</td>
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<tr>
<td>The University Hospitals</td>
<td>$12,863.50</td>
</tr>
<tr>
<td>Planned Parenthood</td>
<td>$3,994.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$154,762.50</td>
</tr>
</tbody>
</table>
December 13, 2000

Sharon M. Simpson, Ph.D.
Assistant Professor of Research
Department of Pediatrics, OUHSC
CHO 3B-3406
940 NE 13th Street
Oklahoma City, OK 73104

Dear Dr. Simpson:

Please accept this letter as confirmation that the Department of Human Services has been providing services to the Oklahoma Infants Assistance Program for fiscal years 1997 to 2001 (October 1997-September 2000). Services include conducting and providing intakes, participation in formal and informal staffings with OIAP staff, substance abuse counselors, and clients, providing treatment services to clients, and continual collaboration and consultation regarding cases. The Department of Human Services fully supports your efforts to meet the need of families affected by prenatal drug exposure and substance abuse and have provided Child Welfare workers designated to work specifically with your program. The cost for services for the fiscal years 1997-2001 serve as a total in-kind match of approximately $137,905.

Our agency has a long, positive history of close coordination with the Center on Child Abuse and Neglect and with the OIAP in particular. We continue to believe that close communication between agencies is essential for the successful preservation of families.

Sincerely,

Kathy Simms, MSW
Child Protective Services Programs Administrator
Division of Children and Family Services
October 28, 1997

Barbara L. Bonner, Ph.D.
Steven J. Ondersma, Ph.D.
Children’s Hospital of Oklahoma
Department of Pediatrics
940 N.E. 13th, Room 2308
Oklahoma City, OK 73104

Dear Drs. Bonner and Ondersma:

This letter will confirm The University Hospitals’ (TUH) intention of the cooperative use of approximately 650 square feet of space at the Child Study Center for the period September 30, 1996 to September 29, 1997. The space will be used by the Oklahoma Infants Assistance Program (OIAP), a program of the Center on Child Abuse and Neglect of the University of Oklahoma Health Sciences Center (OUHSC).

As you are aware, TUH is a separate administrative entity from OUHSC. Support of research is part of TUH’s recognized mission. In this light, TUH will waive billing facility costs for the 650 square feet of space in the amount of $19.79 per square foot or a total of $12,863.50 to OUHSC/OIAP for the period mentioned above.

Sincerely,

Gene M. Kozikoski
Executive Vice President and
Chief Financial Officer

/skt
f:csespace
Dear Dr. Simpson:

This letter is to confirm that Planned Parenthood of Central Oklahoma (PPCO) has been providing consultation and educational services to the Oklahoma Infants Assistance Program staff and clients for fiscal years 1997 to 2001 (October, 1997 - September, 2000). Services include one-on-one client consultations, client group educational sessions, and specialty support to the project staff. PPCO has also provided free latex condoms and educational materials to program clients and staff, and when appropriate and requested, provided a limited number of tubal ligations at no charge to clients who qualified. Discounts for the fiscal years are as follows.

During fiscal year 1997, PPCO provided an $18.00 discount per hour from the usual $30.00 per hour fee for educational and consulting services. We thus provided 74 hours of service for a total discount of $1,332.00 in fiscal 1997.

During the fiscal year 1998, PPCO provided a $15.00 discount per hour from the usual $35.00 per hour fee for educational and consulting services. We thus provided 63.5 hours of service for a total discount of $952.00 in fiscal 1998.

During the fiscal year 1999, PPCO provided a $15.00 discount per hour from the usual $35.00 per hour fee for educational and consulting services. We thus provided 40.5 hour of services for a total discount of $607.50 in fiscal 1999.

During the fiscal year 2000, PPCO provided a $15.00 discount per hour from the usual $35.00 per hour fee for educational and consulting services. We thus provided 73.5 hours of service for a total discount of $1,102.50 in fiscal 2000.
Combined, these discounts reflect PPCO’s match of $3,994.00, excluding waived fees for educational materials, latex condoms, and the limited number of tubal ligations for program clients.

We have valued our collaboration with you and with the program partners. This collaboration has helped to ensure that families in crisis receive the services they need. We look forward to continuing these relationships.

Sincerely,

Terry Dennison
Director of Educational Services