Using the Peer Recovery Model with Mothers of Substance-Exposed Newborns Identified through CAPTA Requirements

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Sophie gives birth to an infant prenatally exposed to opiates and methadone. She struggles with chronic depression and is a trauma survivor. Her baby remains in the hospital, "detoxing" for several weeks. Because of her drug use, Sophie lost custody of her first child seven years ago. Her guilt over her new baby's condition, and her awareness that she may lose this child as well, makes it difficult for her to attach to her baby. While awaiting her baby's discharge, and potential removal, Sophie and her baby's father are evicted from their home. Sophie is afraid. Whom can she trust? Who will understand her? Her child welfare worker refers her to a peer recovery worker.

In 2003, Congress passed the *Keeping Children and Families Safe Act*, an amendment to the *Child Abuse Prevention and Treatment Act* (CAPTA) which requires states to: 1) develop policies and procedures to identify infants affected by prenatal illegal substance use; 2) notify child welfare of such infants; and 3) develop plans of safe care for substance-exposed newborns (SENs) and their families. Two demonstration projects, funded by the U. S. Department of Health and Human Services, Administration for Children and Families to implement these new requirements, have utilized a Peer Recovery Worker Intervention Model. This evidence-informed home visiting practice employs staff, whose backgrounds mirror their clients, to assertively engage and support pregnant women and/or mothers of SEN.

A Helping Hand: Mother to Mother (AHH) is housed in the Massachusetts Department of Public Health, Division for Perinatal, Early Childhood and Special Health Needs, which includes the early intervention system established under Part C of the Individuals with Disabilities Education Act. Early Intervention (EI) provides crucial developmental assessment and intervention services for children from birth to three. AHH, in close collaboration with the state's child welfare agency, aims to provide a comprehensive, coordinated system of care for SENs, their mothers and families, using peers (mothers in recovery) to intervene in the immediate post-partum period.

In Lane County, Oregon, *Project Family Early Advocacy and Treatment* (FEAT) is directed and coordinated by staff at the University of Oregon's Early Intervention Program, a research and graduate training program. FEAT's mission is to implement policies and procedures for identifying and providing safe care for SENs and their families, and for working collaboratively with child welfare during the notification process. FEAT employs peers who engage with both pregnant and postpartum substance using women.

Both AHH and FEAT are collaborative efforts that include state public health and child welfare departments, substance use disorder treatment providers, hospitals and medical providers, community agencies, and EI. Both view peers as a central part of their project mission.

Why Use the Peer Model?

Research demonstrates that peers working with pregnant and postpartum women have promoted the following: positive maternal health outcomes; general infant health

and positive interaction between mother and child; use of perinatal health care; longer breastfeeding; prevention of unplanned repeat pregnancies; and increased use of community resources by pregnant and parenting women (Chapman, Siegel, & Cross, 1990; Flynn, 1999; Perino, 1992; Schafer, Vogel, Viegas, & Hausafus, 1998). Peer workers have been found to have a strong sense of commitment and a positive effect on substance use disorder treatment (Marchant, 2002) through their unique ability to engage and empathize with clients, thereby increasing the use of substance use treatment services and promoting relapse prevention. The peer recovery intervention worker is similar to the community health worker, which is shown to be effective in multiple health care and public health settings (Brownstein et al., 2005; DeFrancesco et al., 2002; Human Resources and Services Administration, 2007).

Similarly, both AHH and FEAT employ peers to engage mothers of SENs during critical perinatal periods to ensure better outcomes for women and their infants. These peers provide emotional support, linkages to resources, and assist women in maintaining or initiating substance use treatment and/or other recovery supports, and treatment for trauma and mental illness.

Sophie benefits from good communication between her child welfare worker and Heidi, her AHH peer. Heidi not only engages with the families of SENs, but provides an added resource to child welfare workers who have limited time to spend with families. Together, they hold case conferences with Sophie to ensure that they are working toward the same goals. With Sophie's permission, Heidi also communicates with EI and Sophie's mother, giving this grandmother support and information about the addiction and recovery process.

What Do Peer Workers Do?

Sophie's life challenges are congruent with the profile of many mothers of SENs: maternal substance use is associated with a range of environmental factors that are risk factors for healthy child development, including poverty, unstable housing, mental health problems, domestic violence, child abuse and neglect, and compromised parenting (Lester, Andreozzi, & Appiah, 2004; The National Abandoned Infants Assistance Resource Center, 2004; Ondersma, Simpson, Brestan, & Ward, 2000). Although prenatal drug exposure can have immediate and latent effects on children, current research indicates that the postpartum environment is a critical factor in child outcomes. Early identification and intervention with mothers, infants, and families improves outcomes and can reduce societal costs, while providing substance-exposed newborns the opportunity to achieve their full potential. Pregnancy provides a unique timeframe to reduce or abstain from substance use. In turn, the postpartum period is when many women resume substance use, even though abstaining during pregnancy. It is also a time when mothers of SENs can feel overwhelmed, ashamed, afraid, and confused. They frequently perceive interactions with child welfare professionals as punitive rather than supportive.

One of the greatest supports a peer can provide a new mother is assistance navigating the "resource maze." Peers might help a woman identify goals; support and empower her in developing her child welfare service plan; advocate for her with child welfare, court systems and treatment providers; and provide service coordination before, during and/or after childbirth. Additionally, peers work to ensure that each SEN and his/her mother are referred to EI.

In addition to such practical assistance, the emotional support provided by peers is essential for women attempting to maintain their sobriety and provide safe care for their infants. A mother from FEAT said that, "Emotional support was my biggest help. The peer made this whole process much more tolerable and easy. I was scared to death until I knew she was going to be around." Julie, a peer from FEAT, describes her most important role as "instilling hopefulness in women who don't already have it...and the willingness to change." This shift in motivation often happens in the context of conversation, when a peer listens without judgment and shares her own experience with her client, as she deems appropriate and helpful. Clients appreciate Julie's perspective. "It was really helpful to know about my peer's personal history with substance abuse," said one, while another commented: "My peer knows what she is doing, and the fact that she has been there too makes a big difference from other people that don't really know how it feels to deal with child welfare. And she helped me take my son home."

To support Sophie's recovery from co-occurring disorders, Heidi referred her for in-depth individual counseling, accompanied Sophie to 12-step meetings and shared recovery readings. After seven months of working with Heidi, Sophie's parenting skills improved considerably. She developed a wonderful, strong bond with her baby. Since Sophie had no access to transportation, Heidi drove her to the welfare office, grocery store, and helped her apply for vocational training. These seemingly simple tasks would have been difficult for Sophie to complete by herself. The "car time" also provided a comfortable setting in which to talk.

Though Sophie was difficult to engage initially, Heidi's ability to share her own background as a parent in recovery was significant in breaking through the resistance and establishing trust. Eventually, Sophie told Heidi that she wanted to be like her, a healthy mother in recovery.

What Kind of Training and Support Do Peers Need?

Besides having a solid personal recovery background, peers need a familiarity with substance use disorder treatment. It is ideal to hire peers with addictions certification/licensure. Training in motivational interviewing, an evidence-based strategy for working with substance use disorders, is extremely helpful. Peers in both demonstration projects are required to have child welfare system knowledge, as well as knowledge of community resources, particularly those most relevant to pregnant women, SENs and their families. Basic understanding of child development, healthy attachment and parenting is exceptionally helpful in supporting women as they experience sober parenting. Finally, it is crucial for peers to be trauma-informed. Many women with substance use disorders have significant trauma histories including physical and sexual abuse. Childbirth often triggers memories of these traumas contributing to intense emotional stress. Trauma-informed services are based on an understanding of the impact of violence on the lives of survivors, and include approaches that help women heal from trauma.

Adequate supervision and personal support are essential to peers' success. Peers need help working with these families to manage and prioritize complex and overwhelming problems. Since a family's trauma history may "trigger" memories of a peer's own experiences of violence and abuse, peers need support to address secondary trauma. FEAT's peers are housed at the Relief Nursery, a local family-support agency focused on reducing child abuse and neglect with high-risk families, while AHH peers are housed in community-based organizations. Both programs provide training and supervision, as well as peer supervision and mentoring.

Heidi's reflections on working with Sophie underscore the importance of supportive supervision. As Heidi found herself connecting deeply with Sophie, the relationship triggered turbulent emotions for her, including guilt stemming from her own past substance abuse. Heidi sometimes called her own sponsor from her car after meeting with Sophie. Despite this, Heidi has not felt roused to use: she attends 12-step meetings regularly, has a solid relationship with her sponsor, and receives excellent supervision. With these support systems in place, Heidi has been able to develop personal and professional boundaries and maintain healthy self-care.

What Are the Challenges and Strengths of the Peer Model?

A major challenge of the peer model has been the maintenance of professional boundaries and appropriate sharing. Peers may over-identify with mothers because of their own experiences with child welfare, incarceration, depression, homelessness, or trauma. Peers need to be clear about their role, and well-informed about issues related to boundaries,

mandated reporting, and primary allegiances and alliances. Peers must remember that child welfare agencies are collaborators in these projects, not "the enemy" that needlessly takes children away from their families. Supportive supervision and comprehensive training can address these issues.

Community and client response to peers has been positive for both projects. Community referrals from prenatal providers, hospital staff, child welfare and other agencies have increased during the three-and-a-half years that FEAT peers have been practicing in the community. Since FEAT peers often work with pregnant women, child welfare may not open a case when a SEN is born if they know that the peer will continue with the mother. Child welfare lawyers and judges have been more willing to allow SEN to accompany their mothers into residential treatment directly from the hospital after delivery, rather than placing them immediately in foster care. In FEAT, court representatives have, in fact, begun to refer women directly to peers themselves. AHH peers also provide support to child welfare, early intervention and other community professionals who recognize the important role they play in the lives of women with substance use issues. One child welfare professional said, "The peer has experienced similar challenges which allow an increased ability to both empathize and respectfully confront. The peer isn't a loaded professional who might be seen by the client as the enemy." An EI professional wrote about the peer model: "Providers and administrators are offered an invaluable perspective on the challenges and recovery processes that are not available through other avenues."

After a number of relapses, loss of custody, and a few days living in a car, Sophie signed herself into an inpatient mental health facility. Heidi sent her a note of encouragement while she was there. After completing that treatment, Sophie moved to a residential program where she received integrated treatment for substance dependence, mental illness, and trauma. Her mother continues to have custody of her child, but child welfare hopes to reunify Sophie and her toddler in treatment. Heidi will work with her until she is stable and has increased resilience.

Alternate Peer Worker Models

This article describes two approaches that incorporate the use of peers in the service mix for pregnant and parenting women who have substance use disorders. A variety of such models exist across the country. For example, the newly emerging role of the recovery coach in the evidenced-based Recovery Management Model (White, Kurtz, & Sanders, 2006) is based on a long history of approaches to recovery that integrate peer support (White, 2004a, 2004b). In this model, peers act as recovery coaches, focusing on engagement and motivation, rather than supportive services or 12-step sponsorship. Services are tailored to support lifestyle change along the pre-treatment, treatment, and post-treatment continuum, with the understanding that for some, recovery is attainable by means other than treatment. Peer recovery workers assist each mother in finding her individual pathway to recovery and working together toward the goals of reduction/elimination of substance use and risky behavior, improved health and social functions, and strengthened parenting skills. Peers build on a mother's strengths, using motivational strategies to address a mother's ambivalence while supporting her personal recovery goals. Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive outcomes, including reduced consumption, increased abstinence rates, and successful referrals (Miller 1999; Miller & Rollnick, 2002).

Recovery coaches are not always in recovery themselves. In Illinois, child welfare has experimented with using social workers as recovery coaches with mothers of SENs to good benefit and reduced costs (Ryan, Choi, Hong, Hernandez, & Larrison, 2008).

Key Programmatic Recommendations

The two projects' experiences in operating peer recovery programs have prompted them to offer the following guidance:

- **Develop collaborative relationships with key agencies, i.e., child welfare, treatment, courts, medical, community parent support.**
  AHH has found that being "housed" in public health has facilitated cross-state agency systems collaboration.
- **Hire peers with recovery experience.**
  FEAT originally hired parents without a recovery history, but found that the peers in recovery were especially effective with pregnant and postpartum substance using women. The peers should have at least two solid years of recovery and, ideally, credentials in addiction treatment.
- **Support peers in practicing good self-care.**
  Overcoming the stigma of being an identified woman in recovery can be challenging. Support the peer in maintaining her own recovery, and allow time for both supervisory and peer-to-peer support.
- **Provide broad training.**
  Topics may include: home visiting protocols and safety, motivational interviewing, CPR, local resources, substance use disorders, trauma-informed services, maintaining personal boundaries, and cultural competence.
- **Provide ongoing supportive and reflective supervision.**
  Crucial in any position, this is particularly important when distinctions between identities as a peer and as a clinician may be blurred.
- **Enjoy and value your peer workers!**
  As associates, they can enrich your shared work and you can provide them another step in their career ladder.

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