

# Reenvisioning Success for Programs Supporting Pregnant Women With Problematic Substance Use

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## Abstract

Community-based, integrated, primary care maternity programs for pregnant women affected by problematic substance use are emerging as effective models for engaging women affected by multiple health and social issues. Although addictions services have historically been evaluated by individual achievement of abstinence, new definitions of program success are required as addiction comes to be viewed as a chronic illness. We conducted a mixed-methods study to follow the formative development stages of a community-based program, identifying key evaluation indicators and processes related to this program, program team members, and women and families served. As this program model develops, it is critical that providers, community partners, and health system leaders collaborate to frame definitions of success in ways helpful for guiding program development.

## Keywords

addiction / substance use; families, high risk; health care; marginalized populations; perinatal health; pregnancy, high risk; program evaluation; vulnerable populations

The care of women with problematic substance use and their infants continues to be widely recognized as a significant health and social concern in many countries (Gyarmathy et al., 2009; O'Donnell et al., 2009; Patrick et al., 2012; Walker, Al-Sahab, Islam, & Tamim, 2011). Taking the high likelihood of significant underreporting into account, a recent Canadian prevalence survey reported that during pregnancy, 10.5% of women smoked cigarettes occasionally or daily, 10.8% of women drank alcohol frequently and infrequently, and 1% used illicit drugs (Walker et al., 2011). A number of jurisdictions also report significant increases in prescription opioid use during pregnancy (Gyarmathy et al., 2009; Patrick et al., 2012). Although research indicates that substance use during pregnancy cuts across socioeconomic strata, women who face social and economic vulnerabilities likely experience compounded stressors during pregnancy and parenting.

In addition to substance use, many pregnant and early parenting women are affected by cumulative barriers to health, including violence and trauma, mental health conditions, poverty, poor nutrition and food insecurity, and inadequate housing (Greaves & Poole, 2007; Society of Obstetricians and Gynecologists of Canada, 2011). Community-based, integrated, primary care maternity

programs for pregnant women who are affected by problematic substance use are emerging as effective models for engaging women who experience complex forms of marginalization and require multimodal supports for improved health and social outcomes (Canada Fetal Alcohol Spectrum Disorder Research Network Action Team on Prevention From a Women's Health Determinants Perspective, 2012; Goler, Armstrong, Taillac, & Osejo, 2008; Motz, Leslie, Pepler, Moore, & Freeman, 2006; Sword et al., 2009). As this program model continues to develop, program planners within health and social care systems are interested in learning why and how integrated maternity care programs are more successful than traditional models of care.

Consequently, more research is needed concerning how providers and community members view success,

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not only for the programs themselves but also for women, their partners, and their children receiving services and supports, as well as for team members working in integrated interventions. Below, we share the findings from a mixed-methods study of the development and implementation of the HerWay Home (HWH) program, a new multiservice health care site located in the Victoria metropolitan area of British Columbia. We focus specifically on how the concept of success was framed by providers, community partners, and health system leaders during this program's formative stages. Before discussing the study and methods, we examine the relevant literature on measures of success in substance-use treatment programs.

## Background

### *How Is Success Currently Framed?*

Because for the past 30 years, substance-use treatment models have revolved around a simple rehabilitation-oriented model, program evaluation methods have also been traditionally framed this way (McLellan, McKay, Forman, Cacciola, & Kemp, 2005). Treatment outcomes have primarily focused on measurable criteria gathered through standardized client-information assessment procedures, based on care received during the program trajectory and on client status at either end of the program or in the immediate post-intervention period.

There is increasing pressure from governments and funders to define successful substance-use treatment. More than 10 years ago, the Treatment Outcome Working Group, sponsored by the Office of National Drug Control Policy in the United States, began calling for the development of standards and protocols for defining substance-use program effectiveness. Rather than the traditional focus on a single outcome, such as decreased substance use, this group suggested that these standards encompass a wide range of physical, mental, and behavioral variables that affect health outcomes (McNeece, Springer, & Arnold, 2001).

A recent development is to critique whether assessing a program's effectiveness via the concept of success itself is the most appropriate and useful approach (Poulin, Harris, & Jones, 2000; Ruefli & Rogers, 2004). McLellan et al. (2005) explored mechanisms for continuing evaluation of treatment services beyond the hospital-based system into the community. They suggested that the public has been disappointed in outcomes from participation in treatment programs because many individuals relapse following completion of a standard program. Although one interpretation would be that treatment is ineffective, an alternate is to reframe the issue from a chronic disease perspective (a substance use and recovery trajectory)

rather than from a single event (success/fail) perspective. McLellan et al. (2005) introduced the concept of recovery progress, also described as concurrent recovery monitoring, or extended case monitoring, as an alternative to a one-time, post-treatment status measurement.

### *Integrated Care Delivery Models*

Although partly driven by societal discourses of social control and moralization around pregnancy, the birth of a child continues to provide a powerful motive for women affected by problematic substance use to connect with the health and social services sectors for support and treatment. However, many psychological, social, and program barriers, including denial, fear, guilt, stigma, shame, and a lack of access to sensitive treatment options, deter women from seeking the help they need (Benoit, Carroll, & Chaudhry, 2003; Poole & Isaac, 2001).

Societal disapproval and the accompanying stigma of substance use also tend to be disproportionately attached to women of disadvantaged backgrounds (Greaves & Poole, 2007; Lester, Andreozzi, & Appiah, 2004). In an often cited study in the United States, researchers found that African American women and poor women were reported to child protection authorities at a much higher frequency than White women and wealthy women; this was discordant with urinary drug test results (Chasnoff, Landress, & Barrett, 1990). Recent studies continue to document these racial and socioeconomic inequities, including unequal testing for substance use, comparing White populations with ethnic minorities (Kerker, Leventhal, Schlesinger, & Horwitz, 2006), and unequal reporting to child protection services (Roberts & Nuru-Jeter, 2012). Finally, although alcohol and prescription drug misuse during pregnancy is widespread, authorities continue a more punitive focus on illicit substance use, again often bringing attention to women from disadvantaged backgrounds (Benoit et al., 2014; Radcliffe, 2011).

Community-based, integrated, primary maternity care programs have designed their services around the reality that pregnant women who use drugs or alcohol tend to face complex barriers to health. Very often, they do not have the resources to access and coordinate services from several different agencies. Single access or "one-stop-shop" programs are emerging in several Canadian regions as an intervention to support women not effectively served through traditional maternity care models.

Studies demonstrate that these programs effectively reduce maternal substance use, improve access to prenatal care, engage women for significantly longer periods of time, and improve women and children's overall health outcomes (Lefebvre et al., 2010; Marshall, Charles, Hare, Ponzetti, & Stokl, 2005; Milligan et al., 2010; Motz et al., 2006; Poole, 2000; Sword et al., 2009). This evidence

suggests that for the health and well-being of pregnant women and new mothers affected by problematic substance use to be supported, services should address not only this vulnerable population's immediate health issues but also the contextual issues—including poverty, discrimination, and isolation—that limit their chances of a healthy pregnancy and a positive parenting experience (Greaves & Poole, 2007; Lester et al., 2004). As a result of the holistic and contextual nature of these matters, it is important that providers, community partners, and health system leaders frame the concept of success together, in a way that creates a useful framework for evaluating programs from formative through maintenance stages.

## Design and Method

The data below were gathered as part of a larger mixed-method study. In this study, we aimed to clarify factors that promoted full participation of HWH team members in their work and that enhanced client access to other health and social services. We received ethical approval from the Human Research Ethics Board at the University of Victoria.

We conceptualized the findings within a participatory or transformative framework (Mertens, 2007; Sweetman, Badiee, & Cresswell, 2010), drawing on three theoretical perspectives congruent with transformative mixed methods: critical feminism, intersectionality, and health equity (McCall, 2005; Sprague, 2005). These perspectives allowed us to highlight how a myriad of demographic and societal factors, in interaction and intersection with genetic and biological factors, shape the health and well-being of pregnant and early parenting women affected by problematic substance use.

## Setting

We conducted this study in the Victoria metropolitan area, a medium-sized Canadian urban region (current population around 366,000) located on Southern Vancouver Island in British Columbia, Canada. Victoria's comparatively positive standing in provincial indicators, such as residents' overall income, education, and employment, tends to mask the significant population dealing with poverty, homelessness, and problematic substance use. Of Victoria's homeless population, 25% are young women of reproductive age; many have children living with them and report domestic violence and/or unsafe living conditions (Mayor's Task Force, 2007). Many services are available for maternity care, addiction and mental health care, and social support; historically however, these services have not been effectively networked and integrated, resulting in care gaps, overlaps, and discontinuity.

## Participants

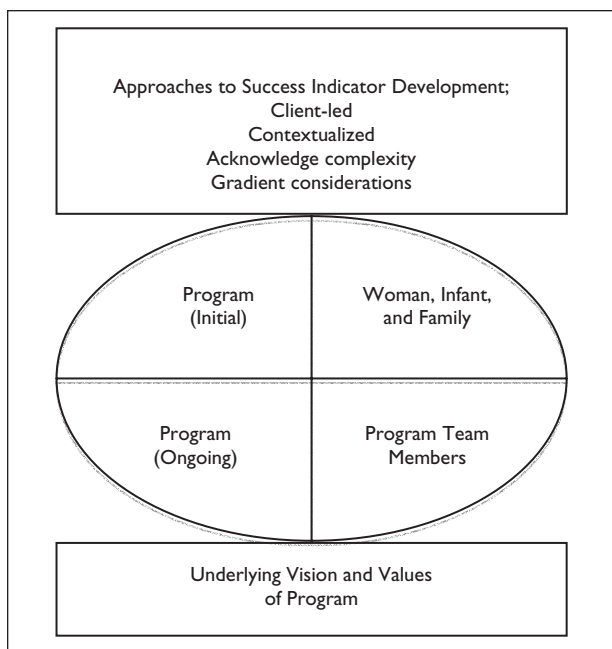
We initially recruited participants for this study from members of the HWH steering committee and community advisory groups, representing the core team of health and social care providers connected with program. We then expanded recruitment using a snowball technique to include a more diverse group of the local community's providers with less knowledge of HWH; these included public health nurses, hospital social workers, and outreach workers who provide services to pregnant and parenting women affected by social and economic marginalization. Repetition of ideas and representation from identified sectors and professional groupings contributed to our assessment that the sample was sufficient.

By email, a research assistant contacted all eligible participants. The research assistant provided those interested in participating with further information, including potential risks. If an eligible individual was interested in participating further, the research assistant obtained contact information and arranged an interview. Prior to the interview, the researchers reviewed informed consent forms with the participants and outlined the study purpose, the participants' rights to anonymity and confidentiality, and their right to withdraw from the study. Finally, we interviewed a broad range of 77 health and social service professionals, including some at leadership and executive levels in health and social services programming (32.4%), some providing services as community-based support providers (28.4%), some performing social work (12.2%), nurses (14.9%), and primary care providers (4.1%). Respondents were predominantly female (97.3%), representing the gendered nature of infant, child, and family care work. The average age of participants was 43 years, their mean income level was \$74,000 (Canadian), and 60.8% had completed some form of post-secondary education. Of the participants, 11% shared that they were Aboriginal.

## Data Collection and Analysis

Methods of data collection were field observations of community team meetings and program planning work sessions, document analysis, and individual semi-structured interviews along with completion of an individual questionnaire. Five members of the research team conducted in-person participant interviews. The interviews ranged from approximately 30 to 90 minutes, and they were audio-recorded and transcribed.

Initially, the first and second authors independently read and reread the data, then independently developed and assigned preliminary broad codes, and next met in person to compare coding. During the next phase of the analysis, we subsumed related codes under broader



**Figure 1.** Development framework for (alternative) indicators of success.

emergent categories to reduce the data into meaningful descriptions, and we developed additional codes and categories as necessary to capture new meanings. Finally, we developed a higher-level theoretical interpretation of the data and a visual map of this interpretation. To promote trustworthiness of the analysis, the fourth author also conducted an initial data analysis and compared it with the emerging theoretical interpretation. We focused our analysis specifically on participants' interview responses to the following question: "What will success look like for HWH (probes: clients, providers, funders)?"

## Findings

We organized our key findings within four core clusters: initial implementation of the program, team members, clients and their families, and the ongoing program (Figure 1). Our findings are presented as a whole because, for the most part, our analysis revealed a convergence in viewpoints, despite differing professional backgrounds and career positions. Overall, for the HWH program's vision as it continues to grow and evolve, the participants identified a fairly consistent set of values as important. These included respect and collaboration, valuing the woman for her own sake, a woman-centered trauma and disability-informed approach, a harm-reduction approach, maintaining belief in the woman, and negotiating individualized goals for her care.

These values may reflect that several members of the community-planning group were involved with a national Fetal Alcohol Spectrum Disorder (FASD) prevention research team and participated in developing consensus principles for integrated programs such as HWH. Because in the study community, many individuals and programs have been networked for more than 6 years, developing and implementing the HWH program in a region widely promoting harm-reduction philosophies, such congruence may reflect earlier relationships and a common purpose. This common purpose might also have contributed to the community's capacity to launch the program. Some differences in viewpoint emerged in the analysis, but these related primarily to governance and power issues and will be highlighted in the core clusters. For anonymity, the quotations presented below are identified only by the participant's career position.

### Initial Indicators of Program Success

*Opening the doors to a safe place.* Many participants defined program success simply as finally opening the doors after many years of planning. However, most of them also recognized the importance of creating a safe, welcoming environment for women with a history of poverty, trauma, and/or substance use:

I think first and foremost that the women feel like it is a safe place where they are accepted and dare I say, loved. The whole of themselves is welcome. They feel that it is a supportive place for them. (Community provider [CP])

Participants saw nurturing and sustaining relationships with women as foundational to the program's immediate and long-term success. The women would be asked for verbal or written feedback about how safe, comfortable, connected, and listened to they felt when they accessed the program; this information would provide formative evaluation and inform the services' continued development. The study participants emphasized that women must first be comfortable accessing services and trust the providers before they will report substance use. They also emphasized that women need to feel safe, supported, and connected before they will return to access the program's services.

*Improved access to care.* Women were seen as voting with their feet, and participants asserted that initial program success would include women showing up (knowing about the program), coming back (feeling safe accessing the program), bringing a friend (recommending positive experience to others), and remaining connected over time (valuing the trustworthy, safe relationships developed).

Perhaps later, the women would volunteer or work as part of the program team (feeling engaged and empowered) to assist other women. HWH becoming a busy hub was seen as an early indicator of success because it would improve access to many services for hard-to-reach, marginalized women:

You're creating more capacity, you know? It's huge, right? That's a success right there; that access piece and turn-around piece. If you are able to have more services under one umbrella, obviously health care improves, consistency is better, all that, you know? (CP)

In addition, participants identified the importance of coordinated care for improving access to women who struggle daily for survival. Feedback from HWH clients about their perceptions of acceptance and safety, and program utilization data could then provide indicators for monitoring the program's initial success.

### *Indicators of Success for Women and Their Families*

*Meeting the immediate needs of women.* Many participants expressed the hope that women who access the program would feel safe, respected, supported, and nourished. They would have their immediate needs met and begin what we interpret as personal development specific to their life experiences and personal goals. The study participants expressed this as being nonjudgmental and meeting women where they are:

Ideally, I think it will be successful if women feel that they were getting all of their needs met, and feeling that they were having positive outcomes, regardless of what that was. [This means] the women are feeling really good about whatever they're choosing. Because I have had women enter into voluntary supervision orders, do open adoptions, choose to parent, and kind of just as long as they're feeling that whatever choice that they made, it was good for them, and that they had everything they needed during that pregnancy. (Social worker [SW])

Participants shared that success needs to be individualized; it should reflect where women are in their pregnancies, substance use, and recovery trajectory when they connect with the program. One indicator of success might be a greater number of women able to maintain primary custody of their infants. Success for other women might be having support to access pregnancy termination services, to place their newborn for adoption, or to design unique co-parenting models within their immediate and extended families or with a foster or adoptive family. Participants stated that women should be comfortable with their own decisions and goals (rather

than preconceived program goals), and program evaluation should reflect this woman-centered approach.

Participants identified a number of strategies to make visible the program's early success as related to clients' experiences. For example, tracking participation and referrals to resources not available on-site were identified as possible evidentiary sources of community connectedness. Overwhelmingly, participants understood the program should focus more on how women came in and how they were helped to find what they needed, rather than on attempting to achieve a certain outcome.

*Experiencing stability and self-respect.* The HWH program was designed to help women experience genuine support and gain personal empowerment and stability. Stability has been proposed as a quality of life improvement for individuals affected by problematic substance use, along with mental health improvements and enhanced social engagement and reliability (Lee & Zerai, 2010). What stability looks like for clients might differ depending on their life circumstances—for example, simply talking to the same people at a program every week for 6 months might feel quite stable to a woman living in an unstable environment with limited access to social support:

It gets a bit complicated if there are different people doing different things. So having somewhere we know that we can trust the people that are there, so again the consistency. 'Cause I'm always reminded of this thing where it's not about the individuals, it's an individual's relationship with our services as a whole. If we practice differently, it becomes difficult for the clients. (CP)

This comment highlights that although treatment for substance use itself was important, it was unlikely the first priority for many women accessing the program.

*Recognizing strength and resilience.* Women sharing their stories and survival skills within a safe, trusting environment provides an opportunity to focus on their strengths and resilience despite experiences of loss and exposure to systemic barriers to health care, such as discriminatory treatment. Some participants spoke about providing a context that fosters personal visions and goal setting as the ultimate goal, whereas other participants envisioned the program as helping women to improve their lives. Focusing on the woman to strengthen her capacity for self-determination, notwithstanding the related need to address structural health barriers such as housing, was understood as one of the most effective ways to promote the health of infants, children, and families.

*Healing in her own time.* Participants felt that avoiding "all-or-nothing" indicators applied to women who would

be accessing HWH services. We developed the terms *success gradient* and *recovery gradient* to represent this shift and to align with a harm-reduction approach. Coming into and remaining in the program for some time were considered early steps of a gradient approach in developing trust of program staff.

I think it is about reaching women, having women actually come in. It might take some time for the woman to actually, especially the more marginalized ones, to come in and get more comfortable and that kind of thing. But yeah, getting the women in, seeing them regularly, having them come back, decreasing their drug use if that is an issue, learning some parenting skills, coping skills. (SW)

In some substance treatment models, these early steps correlate with pre-treatment, a process of invitation, preparation, and voluntary engagement that increases readiness for later effective drug or alcohol treatment (Grantham, 2013).

According to participants, then, possible indicators of success for clients might include any continued or overall movement forward in a recovery trajectory. In addition, self-reports of increasing personal capacity and self-esteem, working toward improving their own health and well-being, making decisions around pregnancy and parenting options, and increasing the ability to plan and/or care for their infants before and after birth should also be considered potential indicators of success.

### *Indicators of Success for the Program Team Members*

**Building a strong team.** Although for care providers, success primarily revolved around adequate time and resources for addressing women's needs, participants also identified the importance of working within a truly collaborative team. Recognizing and supporting others' hard work, respecting differing, individual disciplinary and philosophical approaches, and celebrating everyone's successes were identified as important for preventing burnout and promoting team stability. Respect for everyone's contributions, including acknowledging women as experts in their own lives and trusting other team members that women would be cared for during the professional's breaks, was also identified as foundational:

If you can get a group of people in one place that work really well together, there's a big success. Especially from the varied areas that they are probably going to come from. (Registered nurse [RN])

Besides having adequate time and resources for clients, participants saw these factors as helpful in building and supporting a well-functioning team.

In terms of a comprehensive program evaluation plan, staff development was seen as another strategy that could be documented. One measurable indicator of an effective team was the care providers discovering and addressing individual client needs; the team's capacity to do so could be assessed by feedback from clients and their families. The number of women able to disclose problematic substance use, whether past or present, could also indicate positive teamwork and the women's trust in program staff.

**Safety on multiple levels.** In addition to creating a well-functioning environment for women accessing care, participants also identified safety as a key indicator of success for the HWH team itself. Program providers need to feel safe within their team to collaborate, learn together, and share their reflections, both about clients and about their program experiences. Some participants acknowledged that working across intersectoral boundaries could be complex and could even compromise feelings of personal and professional safety:

What worries me the most is that whole thing of people that are vulnerable being under a pretty tight microscope. I know that not all staff feel the same way I do about supporting families. . . . It's tough, it's really tough, but it's one of those things that will have to be addressed. (CP)

Participants highlighted the importance of role clarity, flexible role boundaries, and respectful nonstigmatizing attitudes toward clients and each other. They noted multiple tensions within these tasks, including that of balancing program goals in supporting both mothers' and infants' health. Many participants actively grappled with these tensions from practical, disciplinary, and ethical perspectives, in particular, those providers subject to regulatory or legal requirements around monitoring and reporting infant safety (Benoit et al., 2014).

**Caring for self and supporting each other.** The participants understood working with a vulnerable group of women as rewarding, yet also filled with formidable challenges. They shared that this work is time-consuming and at times very frustrating:

Knowing that it could be at, like just the most amazing outcome ever or it could be a just a real shit-show and everything in between. And just continue . . . and even after the baby's born, you know, keep walking alongside her. (CP)

They understood success as incremental and sometimes difficult to recognize due to the subtle nature of change over a long period of time. To them, team success meant being able to celebrate subtle steps of accomplishment in each woman's personal development. Participants recognized that when program staff practiced good

self-care and supported each other, they would enhance their capacity for therapeutic relationships with clients:

I think it's really important that your staff is well cared for, and does good self-care and is not overburdened. I think that it is really important that both sides take care of themselves, 'cause if you don't take care of yourself, no one else is. (CP)

Participants also saw caring for each other as a way to enhance trust and respect for the whole team (including off-site community partners). Enhanced staff perceptions of support and fewer experiences of moral distress and/or secondary trauma are possible indicators of success. One primary care provider suggested that it was important to be recognized and respected for working within the complex challenges associated with providing services and supports to address parental substance use.

*Enacting the vision.* Participants described the importance of program staff and partners' willingness to speak up on behalf of women and support for women speaking up for themselves. In addition, the participants identified making visible and celebrating women's successes as an important indicator of success. However, most recognized that they would have to work hard to identify small indicators of success. One participant expressed the program's goal as "We're gonna fan the goodness." We interpreted this as celebrating women's strengths and successes along with the achievements of the HWH program as a whole.

*Being there for as long as it takes.* In addition to a safe, accessible place, housing, and links to other services, participants viewed the right kind of support for the right length of time as critical for program success. Many concurrent programs in the community, for legitimate reasons including resources and program scope, limit their services to specific time frames and subpopulations within their broader potential client population. Clients of integrated maternity care programs often require services for prolonged periods of time, particularly if they develop strong relationships with team members. Study participants were concerned that programs focusing on support for short periods were less likely to be successful. Care providers and community members wanted to ensure they would have the time and the opportunity to enact their collaborative vision prior to opening the program's doors.

### *Indicators of Ongoing Program Success*

*Staying true to the vision.* Participants identified staying true to the vision of a community-based hub and one-stop-shop model as important. The hub model's importance stems from the planning priority of not duplicating existing programs and services, but rather making them

more accessible, either by providing them on-site or by efficiently ensuring transportation and facilitating service connections:

As you build an agency, it can start to lose, possibly lose, that sense of collectivity. And to me, the agency part of it is really only the nugget in the center of this collective effort, which is even more important now than ever, right? So [it is important] to keep everybody philosophically in the networking mode. It is going to be challenging when there has been such a lot of cutbacks in social service funding, people who lost jobs along the way that could really support the work at this point. (CP)

These comments seemed to reflect that most participants, whether administrative or front line, emphasized staying true to the program's original philosophy as a core indicator of success. Participants reaffirmed their values of woman-centered trauma informed care and a community-based, coordinated harm-reduction approach as important for the HWH mission as it grows and evolves.

*Growing the model.* Participants were mindful that the program would need to grow over time in relation to the number of clients served. They expressed the importance of focusing not only on the number of clients but also on how deeply and intensely the team serves clients and their families. Flexible policies and creative approaches to care were identified as broad strategies to actualize these values. Several participants identified these values as important for success, in particular the frontline providers:

I think success will be evident in a program model that evolves and you know, moves, changes, revises itself in order to address the specific concerns of the women who are actually showing up. I think, right now, there's been sort of an imagined client for the program, right? When we actually hit the ground running, we need to be in a position where we can say "Hey, you know what? We thought we were going to need this. In fact, we are going to need something that's really different . . ." I hope that we never arrive at a moment that we say, "Oh, we're there," [rather] that we're always challenging ourselves to grow the model yet a bit more. (RN)

Similarly, another participant stated,

There has been a lot of really good planning that has gone into thinking what women need from a place like HWH, but eventually we have to view all these things as experiments, right? And so when women show up, and they tell us what they need, we are going to have to be flexible and shift what we are doing to be able to really meet our clients where they are at. (SW)

Participants voiced the importance of a new program not having too many of its processes and elements firmly in place, so that it can develop in alignment with client and community needs. Overall, participants were interested in balancing the need to stay true to their vision, yet being flexible in adapting the program as clients share how the program works for them.

*Careful choice of meaningful indicators.* Many participants indicated that caution is required when measuring and analyzing data related to traditional outcomes. They thought that some of the indicators often applied to programs are unrealistic as they fail to consider external or contextual influences. Participants familiar with mental health and addiction services were more likely to identify this limitation to traditional indicator measurement:

Some people consider abstinence being a success, but I think realistically, people know that isn't necessarily . . . true. And if you're . . . going to measure abstinence, and sustained abstinence, as your success factor, you could be in deep trouble. (CP)

Another participant put it this way:

I know we need to have some measurements in place, but I don't think that some of the success factors that I have looked at are realistic. For example, saying that it will be successful if the maternity ward at the hospital has a reduced number of this or that or the other thing. The reality is that there are other factors that are impeding the measurement of that factor, and I've seen that in other programs that I have evaluated. It's the outside factors that aren't really taken into account in the evaluation. So I would be worried about that. (SW)

Although many participants clarified that individualized, contextualized approaches to measuring success were needed, they also identified a number of specific short- and long-term indicators of health and social well-being for women and their families (Figure 2). In the formational stages of a program, carefully identifying achievable indicators and measures is critical: Because program teams will be held accountable for these outcomes, they must accurately select outcomes within the scope of the program's influence.

*Beyond the binary.* The challenges faced by participants in planning measurements of success suggested the need for other possible measures, such as transformative evaluation (Mertens, 2007). Because the program is not just about abstinence or a mother maintaining custody of her baby, participants did not see measuring success as a strictly linear or quantitative process: They understood stories as an important adjunct to numbers:

[Success is] more ambiguous. I think some of those types of measures . . . so like photographs and stories and women coming to services, women who maybe haven't been able to cook meals on their own are now cooking and organizing and taking on roles in the center. I think those kinds of outcomes would be success. (CP)

These comments highlight the limitations of binary or all-or-nothing indicators (e.g., successful or not successful; clean or using; custody or not):

Success will have to be measured in little stages. So you're going to have small successes and large successes. A small success is if a family is able to maybe not be completely healthy but stays connected or is working towards [health]. A long term success [is], wow, we've met our outcomes, we're doing what we said we were going to do. In this area, we are not, but here's some learning and we can tweak this. (System leader)

Another participant elaborated,

Holding this together is tough, but it will all be really worth it, I think, if we can just say, yup, it's so complex we'll never be able to nail it all down. So let's just take a complexity view and be good with it. (CP)

Many participants spoke of the importance of acknowledging and celebrating small changes, or gradients of success, within the complex processes of recovery and healing and within the overall system's expectation and demand for linear, speedy, and measurable progress (Rutman, Callahan, & Swift, 2007).

*Holding on to collective autonomy.* At the time we conducted these interviews, plans were announced to fund the program and the community action group was establishing official connections with larger health and social care systems. Several service providers identified the need to be connected and supported, but not completely subsumed by these systems. The risk was losing autonomy and opportunities to contribute and make decisions as a community partnership. As noted, this community-based program was developed by a small, active group from many local agencies interested in sustaining a clear mission and developing the program's originally envisioned noncore elements. Group members were holding on to their vision within an environment that, during HWH's development, had experienced resource shifts including social service program cutbacks, system reorganization, and leadership turnover:

As you build an agency, it starts to lose, possibly lose, that sense of collectivity. . . . The agency part of it is really only the nugget in the center of this collective effort. So to keep everybody philosophically on, you know, in the network



|   |   |
|---|---|
| <p>Infant</p>   | <p>Providers/Team</p>   |
| <p>Fewer infants with unidentified withdrawal symptoms (earlier identification)<br/>                 Shorter and less intense withdrawal (more infants receive appropriate treatment)<br/>                 More healthy birth-weights and fewer preterm infants<br/>                 Increased breastfeeding initiation and duration<br/>                 More infants remain in care of mother with supports in place<br/>                 Less exposure to drugs, alcohol, and unsafe environments (such as poor quality housing)</p>   | <p>Feeling safe, reduced secondary trauma<br/>                 Having adequate time and resources<br/>                 Caring for self and supporting each other—effective team functioning<br/>                 Respect for and trust in the whole team, including community partners<br/>                 Being respected for working with this challenging population<br/>                 Being able to speak up on behalf of women and support women to speak up for themselves<br/>                 Making visible and celebrating successes<br/>                 Staying with the program—retention</p>  |
| <p>Woman/Mother</p>   | <p>Program</p>  |
| <p>Feeling safe, supported, and connected to the program<br/>                 Engaging with the program by returning and utilizing services (such as housing access, income support, access to contraception, earlier identification of pregnancy, earlier and regular maternity care)<br/>                 Feeling able to voice their concerns and needs for support<br/>                 Feeling safe enough to share that they are using substances<br/>                 Increasing self-esteem and reducing feelings of shame or stigma<br/>                 Increasing personal capacity to work toward improving own health and well-being, including decision-making around pregnancy and parenting options, and an increased ability to plan and/or care for the health of the baby<br/>                 Shorter hospital stays or more mother-baby supported care during hospital stays</p> | <p>Staying true to the values, mission, and purpose of the program<br/>                 Having a program model that evolves along with flexible policies and creative approaches to care<br/>                 Attending to program utilization issues such as low threshold access<br/>                 Being connected to and supported by the larger health and social care system and community at large<br/>                 Not being subsumed by the larger system of health and social care delivery—maintaining ownership of the non-negotiable program components<br/>                 Being sensitized to the need for alternative, appropriate forms of program evaluation<br/>                 Being a touch-point for working toward changing community and societal attitudes about women who use substances during pregnancy<br/>                 Having ripple effects within the larger health and social services systems to enhance care for this population</p> |

**Figure 2.** Indicators of success synthesized from data analysis.

mode? And the collective mode? I think is going to be challenging when there [have] been a lot of cutbacks in social service funding. (Primary care provider [PCP])

Participants were hopeful that, despite economic challenges, once the program opened, a strong team could enact the program’s envisioned philosophy. Through continued collaboration, participants hoped to build on existing strengths within the larger community and to advocate for regaining capacity.

*Being a touch-point for community change.* Participants maintained that program success was related not just to service delivery but also to the program’s image perceived as a touch-point for changing community and societal attitudes about women who use substances during pregnancy and early parenthood. Participants indicated that success was likewise linked to health and social systems’ effectiveness as a whole in supporting and advocating for this population. They envisioned ripple effects such as more accurate media coverage and improved

service planning in other communities. One system leader expressed concerns about lingering societal attitudes that stigmatize women who use substances and individualize personal responsibility for health:

Unless there is a profound change in attitudes towards women with substance use and parenting and pregnancy and so on, I don’t think this kind of service fits within the public health care delivery systems we have today. (SL)

This leader also described tensions that can emerge between grassroots, community-based programs, and the hierarchical corporate structures of large organizations.

Overall, participants expressed confidence in HWH’s value and effectiveness via the hub-program model for supporting this population and for integrating complementary and comprehensive services. They strongly reaffirmed the importance of HWH remaining rooted in the community and staying focused on its original philosophy of care.

## Strengths and Limitations

We used data for this analysis from evaluation-related components in a larger interview schedule. Multiple interviewers from various disciplinary backgrounds conducted the interviews. Our constructivist, emergent design influenced how questions were asked, how prompts were contextualized for different participants, and how information was received. However, data triangulation and prolonged engagement helped address some of these limitations. We focused on how community partners and program team members understood and measured success. Our analysis reflects care providers' considerations of success, which may diverge from how clients and their families perceive success. A second stage of our research program is to explore definitions of success by clients and then compare the definitions of clients and professionals. Although we intended to solicit data about both women and their families, the study participants focused primarily on the women's experiences. Although HWH was conceptualized as a child-focused, woman-centered, family-oriented intervention, the family-oriented focus was limited in the participants' narratives. We expect that in subsequent interviews with women clients and the fathers of their infants, this theme will emerge as an integral part of the narratives.

## Discussion

Overall, the service providers, community partners, and system leaders who we interviewed challenged notions of success as binary, that is, the entire program is considered successful or not. Participants were clearly aware of the myriad personal, programmatic, and sociostructural conditions influencing such health interventions and the related health experiences of clients and intended not to set themselves up for failure.

McLellan, Chalk, and Bartlett (2007) provide definitions of outcome measures, domains, quality indicators, and recovery in addiction treatment that may be helpful to readers responsible for program development and evaluation. They also point out that abstinence is necessary but not sufficient for attaining full recovery. Writing about outcomes and performance indicators for substance-use treatment programs, these authors caution us:

There is a significant difference between holding the treatment system responsible for assuring that individuals "have a life" and holding the treatment system responsible for identifying recovery related problems and providing the supportive services that support clients' abilities to seek a life. (p. 333)

Because most integrated community-based programs' primary purpose is to change risk environments (Rhodes,

2002) linked to harm to a woman and her baby by providing access and links to critical resources such as safe housing, food security and income assistance, and health and social services, focusing only on abstinence from substance use during pregnancy is counter-productive. This perspective resonates with McLellan et al.'s (2005) concept of recovery progress or recovery trajectory.

There is movement toward identifying elements of integrated programs and evaluating these elements individually and also as a whole. Sword et al. (2009) conducted a qualitative meta-analysis of processes and outcomes that contribute to recovery in integrated programs. Outcomes were organized within three areas—maternal, child, and parenting. Recovery was conceptualized as much broader than the process of reducing or abstaining from substance use—as individualized patterns of transformative growth. The process themes identified here provide guidance on practices to enhance women's recovery. They also present measurement challenges because they are not necessarily amenable to evaluation mechanisms that use standardized external validation.

For this study's participants, success in substance-use programs was about more than traditionally understood abstinence and outcome indicators. In the selection of indicators, understanding the possibility of multiple interpretations for each one is critical. For example, the reported incidence of substance use by women in a community may increase after implementation of a single-access program; however, this might not reflect a true increase, but instead, the development of trusting program relationships so that women feel safe disclosing their substance use. Program planners and evaluators must acknowledge the complex, dynamic nature of organizations, of people working there, and of the clients receiving support.

As service programs and systems develop and change, definitions of success must also evolve conceptually. Reliance on single indicators and static measurements conceals complex individual and sociostructural contexts within which health experiences are rooted (Israel & Chui, 2006). Evaluative approaches drawing on a range of outcome measures and using a variety of techniques, both qualitative and quantitative, are more likely to capture this complexity because they allow for consideration of both inductive and deductive findings from various perspectives. Cheatham, Fuller, McIvor, and Petch (1992) suggest that a pluralistic, or situational, evaluation approach has the potential to "bring to centre stage" the multiple, possibly conflicting criteria of success of different stakeholders, including clients, to the process (p. 83). A pluralistic approach potentially embraces complexities and flexes with evolving program development.

This study's participants also identified the importance of changing societal attitudes toward substance use during pregnancy and early parenthood. Flavin and Paltrow (2010) note the unfairness of expecting disadvantaged or marginalized women to access health promoting resources during pregnancy when they cannot meet even the most basic of their own needs. Alternative approaches to program evaluation, such as transformative evaluation, which works collaboratively with clients to promote social change, may be helpful. Transformative evaluation facilitates reciprocal learning to create sustainable social change (Mertens, 2007). Based on the principal value of social justice, transformative evaluation incorporates participative methodologies to create socially inclusive evaluations.

A life-course approach to program development and evaluation, or a program-course approach, offers another broad framework for identifying and organizing assessments. Program development is a continual, iterative process, and definitions of success should also grow as the program matures (Patton, 2011). Application of the standards for a fully operational program to an emerging one is most likely inappropriate, particularly as programs require substantial time (possibly years) and resources to be seen by clients as a safe, helpful place (N. Poole & D. Rutman, personal communication, May 10, 2013). Finally, given the persistent, long-term barriers to health that influence the lives of the HWH program's clients, we need to be mindful from the outset that not all women reach the goals envisioned by the service providers and health and social care planners whom we interviewed.

## Conclusion

There are many theoretical and pragmatic challenges to defining success and what it might look like within the context of pregnancy/early parenting and problematic substance use. Historically, the measurement of success in substance treatment programs has focused on achievement of abstinence and on measuring this achievement by externally verifiable outcomes. Knowledge about the process of substance use and recovery during pregnancy has advanced significantly, and now the notion of defining and measuring success in interventions, particularly programs designed with a harm-reduction approach, challenges this standardization. Outcomes are instead presented as nuanced and incremental; they might include components individually defined by clients themselves (Lee & Zerai, 2010; McLellan et al., 2005). For example, the mere act of engaging in services has come to be seen by many program providers as a measure of success. This leads us to reconceptualize success beyond traditional measures

to appreciate the positive changes that participants experience as a result not only of their treatment but also of their demarginalization and reengagement in social relationships and communities (Lee & Zerai, 2010).

There was a strong consensus among our study participants that they needed to continue to engage with women and empower them to inform the program team about their immediate and long-term needs. Our participants needed this information to help determine indicators and develop a program evaluation strategy. The HWH team has supported a women's advisory council since 2011 to partner in collaborative planning. Similarly, Lee (2006) engaged addiction treatment program clients to identify participant-generated outcome tools. As with our study, the identified outcomes, such as demarginalization, consistent engagement in the program, quality of life, social functioning, changes in use, and articulation of future goals and plans, differed from traditional measures of success (such as abstinence, completion, and recidivism) in substance-use treatment programs (Lee, 2006).

Quantitative cost-benefit evaluation approaches dominate in health care. Emerging movements in quality improvement, patient and public participation, and community-led governance are slowly shifting these approaches from "non-traditional" to "necessary within our increasingly complex practice environments" (Mercado-Martinez, Tejada-Tayabas, & Springett, 2008).

Understanding success as defined from these multiple perspectives is essential for grounding a cohesive approach for teams to assess the quality and impact of care, improve services, and apply this learning to future program development. Evidence continues to build that programs primarily addressing only substance use are not as effective as those mobilizing the sociopolitical capacity and interest of communities in addressing social determinants of health. Evaluation provides a mechanism for leveraging bottom-up program change to address not only specific program-development issues but also issues of social justice and democratization of health and social institutions.

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