Best Practices: Services and Supports For Street-Involved Pregnant And Parenting Women

A Review of the Literature

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Alberta Government

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Street Works

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Background

The Healthy, Empowered, Resilient (H.E.R.) Pregnancy program uses professional staff and peer support workers to reach at-risk, pregnant and parenting women in inner-city Edmonton. The program, developed by Streetworks, supports street-involved women to access healthcare services before and throughout their pregnancy and address issues such as addiction, poverty, and family violence to ultimately support healthy births leading to safer and healthier lives for women and their children.

Funded by Safe Communities, Alberta Justice and Solicitor General, the H.E.R. program closely aligns with Premier Redford's Early Childhood Development (ECD) priority initiative. This literature review is a component of a larger evaluation of the program, and was made possible through funding provided by Alberta Health. The evaluation is contracted to Charis Management Consulting by the Alberta Centre for Child, Family and Community Research (ACCFCR).

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Key words: Maternal-infant health; street-involved women; pregnant; at-risk pregnant women; parenting women; single-access models; outreach; harm reduction models; peer support models; homeless; community-based outreach programs.

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Introduction and Methodology

As a component of the Healthy, Empowered, Resilient (H.E.R.) Pregnancy Program Year One process evaluation, a literature review was conducted. The purpose was to identify elements of successful programming and models similar to the work of the H.E.R. Program. The review was designed to capture information on what similar programs are operating both in Canada and internationally to support street-involved pregnant women and youth. The review provides information on key questions and information sought about service delivery models for street-involved pregnant women. It summarizes and provides details on similar programming offered for street-involved pregnant women that align with the H.E.R. Program goals and principles. The search strategy components include questions, scope, search strategy and reporting details as outlined, below. This information is followed by the results from the literature review, presented in narrative form.

Literature Review Questions

The literature review focused on programs developed and operated with goals and outcomes similar to those of the H.E.R. Pregnancy Program. General focus was on recent programs (from 2002) and information on larger concepts, such as: facilitation of better maternal and newborn health outcomes for street-involved women; enhancing skills, knowledge, resources for street-involved women to live safer lives; and, utilization of harm reduction models and principles.[1]

Focus was placed on those documents that included the following outcomes, impact and effectiveness indicators or discussions:

- **Outcomes:** a reduction of client risk factors; strengthening of protective factors; decrease in incidences of victimization; and, an increase in wellness (e.g., health births, decrease of sexually transmitted infections (STI's) and trust and support services).
- **Impact:** what difference has the program made on the social, environmental, family health and well-being statuses? Specification of knowledge gained; behavioural changes; and, situational changes (e.g., homeless to transitional to secure housing, child in temporary or permanent guardianship to full client custody).
- **Effectiveness:** recommendations for effectiveness and addressing barriers and challenges.

[1] H.E.R. Program Goals; Streetworks. (2012). *Publications*. Retrieved 04 19, 2012, from Streetworks: http://www.streetworks.ca/pro/publications.html

The specific questions that the literature review addressed included:

- In what ways have established programs reduced risk factors for the target population?
- What impact did the programs make on health outcomes and birth outcomes of clients?
- What were the measureable impacts of the program on knowledge, behaviour and lifestyle of the target population?
- What types of partnerships were established among both service providers and street-involved women? Did established partnerships enhance service delivery for homeless pregnant women?
- How effective were the strategies employed by the programs?
- What can be learned from other models for successful delivery of programming for street-involved pregnant women?
- What challenges still need to be addressed from other models for successful delivery of programming for street-involved pregnant women?

Scope

The scope of the strategy was in place to ensure that the review targeted the best and most appropriate resources. The review was guided by the following principles:

- Quality over quantity; and,
- Grey and published literature.

The following outlines the inclusion criteria (programming, target population, jurisdictions) as well as the search parameters (search field, acceptable document types, time frame, language and population) that were used for the literature search.

Inclusion Criteria

Chart 1. Inclusion criteria for literature review

Category	Inclusion Criteria
Programming	Programming *primarily* for street-involved pregnant women (but can include programming for non-pregnant women). ▪ Programs that offer empowerment services similar to HER in the context of street-involved pregnant women (e.g., use peer support models of service delivery); ▪ Focus on programs that utilize harm reduction models of service delivery; ▪ Minimum 1 year length for program; ▪ English language programming; and, ▪ Grey and published literature from 2002 – present (10 years).
Target population of program	Programs targeted for street-involved pregnant women and may include programming for those: ▪ who are youth and/or adult women of childbearing age; ▪ who are of Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority; ▪ who are homeless or street-involved; ▪ who are in transitional or unstable housing; ▪ who are involved in addiction and/or substance use; ▪ who have unstable family structures; ▪ who are employed and unemployed and/or chronically under-employed; and, ▪ who are involved in prostitution or other at-risk behaviours.
Jurisdictions	Focus on Programs delivered in Canada to accurately describe the unique subset of street-involved pregnant women. ▪ Targeted search may potentially include high quality program reviews from Australia and the United States of America.

Search Parameters

Chart 2. Search parameters for literature review

Category	Parameter
Search Field	The search will target both published and grey literature. All literature retrieved should be produced by a recognized and reputable organization or author in the field.
Acceptable Document Types	Literature can be in the form of program evaluation reports; academic articles; program descriptions and outcomes; technical reports; strategy and policy documents; and/or, other reports or informative materials that speak to the literature review questions outlined above.
Time Frame	Only documents published in 2002 or later will be included.
Language	English-language documents only.
Population	Street-involved pregnant women; homeless pregnant women; high-risk or at-risk pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.

Search Strategy

Considering the unique programming and population sought for the literature review, the search strategy involved two phases and two types of literature.

Phase One

The first phase involved a brief search using Google and the main keywords to provide a scan of Canadian programming offered for street-involved pregnant women. The resulting programs and literature were examined for additional citations and information on similar programming. The initial search in Google primarily included grey literature but did not exclude published literature. The first search phase provided more information to successfully target programming that met the inclusion criteria and search parameters, above (e.g., additional search terminology, programs, or organizations).

Phase Two

After the initial literature review, the search protocol was expanded to include additional programs, organizations, or search terminology noted in the first group of literature. The terminology provided additional keywords that were used to better target similar programming. Both published literature databases and grey literature databases and sources were utilized in the second phase to exhaust the listing of search terminology. The search protocol, including the databases and sources examined, along with the listing of key words used are displayed below.

Search Protocol

Chart 3. Sources of information searched

Published Literature Databases	Grey Literature Databases/Sources
PubMed	Google/Google Scholar
PsycINFO (Ovid)	Professional associations, societies, groups, centers, non-profits, medical facilities offering pregnancy programs (*e.g., Sheway, HerWay Home, Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women, St. Michael's Hospital, Homeless At-Risk Prenatal Program, and others*)
NEOS (Central AB Library Consortium)	Websites focused on programming for street-involved pregnant women/youth, homeless pregnant women/youth, at-risk pregnant women/youth as well as at-risk non-pregnant women and low socio-economic status populations.
Web of Science	Government websites (*Canada, Australia, USA*)
MEDLINE	Provincial/National Medical Society websites (*e.g., Alberta Health Services, Alberta Health and Wellness, Medicare Australia*)
EMBASE	Health Quality Council, Alberta
CINAHL	Alberta Public Health Association
Native Health Databases	Public Health Agency of Canada
	WHO website
	Charis Library
	Canadian Evaluation Society

Key Words

Street-involved pregnant women/youth, *OR* Homeless pregnant women/youth, *OR* High risk pregnant women/youth,

AND

Maternal care, *OR* mother/infant model programs, *OR* health promotion, *OR* Community-based outreach programs, *OR* peer support models*, OR* healthy public policy, *OR* health clinics, *OR* support systems, *OR* harm reduction models, *OR* parenting options, *OR* Interventions [for: HIV; family violence; substance abuse], *OR* Self-sufficiency/Independence skills

AND/OR

Aboriginal populations, *OR* 'ethnic' populations, *OR* Native populations, *OR* Native American/ Indian American populations *OR* substance abuse, *OR* drug abuse, *OR* addiction, *OR* family violence, *OR* spousal violence, *OR* HIV

Review Process

Upon completion of phase two of the literature search, the articles and reports were reviewed to ensure they matched the search inclusion criteria. A checklist was completed for the search inclusion criteria for each article/document. In exceptional circumstances, articles/documents that are missing criteria were included if they were of exceptional quality, added to knowledge about a particular program, included innovative programming, foundational/seminal knowledge or relevant models of service delivery.

Reporting

Once screened, the information from the articles/documents was summarized in a modified table of the inclusion criteria and literature review questions for each respective program. The tables were then used to summarize further similar programming/models of service delivery in the field. It should be noted that although extensive use of the key words were used in a multitude of journal databases, limited published articles were located. The majority of the literature reviewed was grey literature. However, it was well-focused and provided valuable information on current programming. Due to resource allocation and context of the H.E.R Program, primarily Canadian programs were reviewed.

General Literature Review Findings

Challenges Street-Involved Pregnant Women Encounter

Street-involved women encounter a variety of challenges and risks in their day to day life (e.g., Frankish, Hwang, & Quantz, 2005; Hwang, 2001; Wright, Schuetter, Fombonne, Stephenson, & Haning III, 2012). They may live in hunger, have limited access to suitable housing, and have difficulty obtaining basic amenities to provide for themselves (Burglehaus & Stokl, 2005). Safety is often a concern and many women are unable to obtain secure housing or accommodation (2005). In many cases, the women have encountered a wealth of adverse experiences including family violence or sexual abuse and lack of positive parenting experiences and become pregnant at a rate twice that of the general population (Robrecht & Anderson, 1998). If they become pregnant, the women's risks can intensify and present unique challenges to both health care providers and the women themselves (Beal & Redlener, 1995). The risks can include limited access to both prenatal care and health care in general (Frankish, Hwang, & Quantz, 2005); undernourishment and poor nutrition; unsafe or limited housing (Little, Shah, Vermeulen, Gorman, Dzendoletas, & Ray, 2005); mental health and addiction (Crawford, Trotter, Sittner Hartshorn, & Whitbeck, 2011); abuse or family violence (Robrecht & Anderson, 1998); and, continued use of street drugs or alcohol during pregnancy (Beal & Redlener, 1995).

Street-involved pregnant women are less likely to access health services as a result of experiencing negative attitudes of stigma, rejection and blame (Currie, Janet C.; Focus Consultants, 2001). Other barriers to accessing services as noted by participants in Poole & Isaac (1999) included: shame; fear of losing their children; feelings of depression and low self-esteem; belief they could handle the issue without treatment; lack of information as to what was available; and, waiting lists for treatment services. In addition to experiencing barriers to treatment during pregnancy, street-involved women often experience poorer birth outcomes including: preterm delivery; low infant birth weight; and, higher rates of infant mortality (Beal & Redlener, 1995). Drug and alcohol abuse during pregnancy contributes to the adverse risks on infant health outcomes and can affect the woman's ability to care for her child (Marshall, Hare, Ponzetti, & Stokl, 2005). Further, risks experienced in all pregnancies are often amplified as a result of limited access to healthcare and the high-risk lifestyle led by street-involved women (Robrecht & Anderson, 1998).

Harm Reduction Approach

An important component of many programs focused on street-involved or at-risk pregnant and parenting women recognize and utilize a harm reduction approach to the services they offer to clients. Harm reduction models focus on reducing the risks or consequences of a behaviour instead of requiring abstinence from the behaviour (Marshall, Hare, Ponzetti, & Stokl, 2005). They accept alternatives that reduce harm but recognize abstinence as an ideal outcome (Motz, Leslie, Pepler, Moore, & Freeman, 2006). Harm reduction emerged as a model of service delivery in the 1980's as an alternative approach to working with substance users and those who engage in high risk sexual behaviours (Ravinsky, 2009).

Harm reduction is a practical approach to substance use and key components include: community-based services, client-driven services, non-judgmental attitudes and service delivery and a broad-based system that reduces isolation, alienation and marginalization (Streetworks, 2012). The approach encourages the reduction of stigma, guilt, shame and confrontation and instead advocates empowerment or strengths-based approaches (i.e., identifying progress or willingness to accept services as a success rather than abstinence) (Motz, Leslie, Pepler, Moore, & Freeman, 2006).

Harm reduction strategies can include needle exchange programs; safer sex campaigns; safe injection facilities; prescription heroin or morphine, among others (Streetworks, 2012). They address the needs of substance users, including issues of physical and mental health, the justice system, income support, food security, and homelessness (Streetworks, 2012). Proponents of harm reduction approaches believe the creation of an environment where vulnerable communities or individuals feel accepted and in charge of their own decisions and change are paramount to success (Ravinsky, 2009). Continuums or degrees of descriptors or progress are used to destigmatize the population (e.g., avoiding the use of good/bad terminology) (Ravinsky, 2009). The use of continuums, as opposed to polarities, result in steps and series of changes that may or may not fall in a linear direction (Ravinsky, 2009). By providing services and support that assist in the series of changes or places the individual or community may be at one particular time is seen as a more flexible and successful model than encouraging complete absitinence from a behaviour to be provided services (Ravinsky, 2009).

The utilization of harm reduction approaches has been found to enhance pregnant and parenting women's retention in and entry into programming (Pepler, Moore, Motz, & Leslie, 2002). Specifically, engaging women in treatment, addressing their shame and guilt around substance use and understanding their context of complex factors (e.g., trauma, poverty, mental health concerns) is critical to success (Motz, Leslie, Pepler, Moore, & Freeman, 2006).

H.E.R. Program

The risks for street-involved pregnant women and their fetuses demonstrates compelling need to create protective factors using service provision focused at improving health outcomes, access to services and reduction of stigma. Utilizing harm-reduction models addressing the social determinants of health, the Healthy, Empowered, & Resilient (H.E.R.) Pregnancy Program developed by Streetworks provides much needed support for street-involved women in Edmonton, Alberta. The goal of the program is to enhance street-involved women's knowledge, skills and resources and support them to facilitate better health outcomes for themselves and their children. The H.E.R. Program, funded by the Ministry of Justice and Solicitor General and led by Streetworks, utilizes individuals with street experience to help provide basic needs, support and care for street-involved pregnant women (Streetworks, 2012). They also employ health professionals who work as team with the outreach workers. The outreach workers are women who were formerly street involved and provide peer support to clients. The workers provide women with information on overall maternal and prenatal health (e.g., Oh Sh*t, I'm Pregnant… – Your Guide to Being Pregnant on the Street) and provide resources, options and supports for women regardless of

their decision to complete their pregnancies (Streetworks, 2012). The three year outcomes for the program are to reduce street-involved pregnant women's risk factors, strengthen protective factors, decrease the level of victimization and increase their level of wellness.

The purpose of the literature review was to examine similar programs operating in the context of street-involved pregnant women to determine successes and strengths of their programming models. In the review, overarching models and values were discovered for successful programming with the population in question. The types of models operating in Canada and internationally are briefly detailed and following that, the results of the literature review questions are discussed. It should be noted that there has been little published literature on the topic, and in addition, minimal grey literature documents available to the public. Thus, the review has attempted to capture as many programs and documents as possible but is likely not all-encompassing.

Review of Programming for At-Risk Pregnant and Parenting Women

In reviewing the literature on programming for street-involved or at-risk pregnant or parenting women, a variety of different models of programming were examined. The review primarily focused on programs similar to the H.E.R Program in order to make parallels and comments about the model of programming. However, other types of models were included in the review if their goals and outcomes were similar. The programs that were examined for the literature review included:

1. Sheway;
2. Breaking the Cycle;
3. Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women;
4. HerWay Home[2];
5. The Mothering Project[3];
6. St. Michael's My Baby and Me Infant Passport Program;
7. First Steps Housing Project Inc.;
8. Homeless At-Risk Prenatal Program;
9. KidsFirst;
10. Supportive Housing for Young Mothers;
11. Villa Rosa;
12. First Steps Fetal Alcohol Spectrum Disorder (FASD) program;
13. Toronto Centre for Substance Use in Pregnancy;
14. New Choices;
15. Homeless Prenatal Program (USA); and,
16. Parent-Child Assistance Program (USA).

[2] Program in early stages but based off a similar model to H.E.R and relevant to provide information on.
[3] Program in early stages but based off a similar model to H.E.R and relevant to provide information on.

The programs had slightly different mandates and visions but similar goals to assist at-risk pregnant or parenting women. As mentioned, in many cases limited information was available on programming for street-involved pregnant women; the above programs had information that was readily available.

Chart 4. The location and model of service delivery of programming reviewed

Program Name	Location	Model of Service Delivery
Sheway	Vancouver, Canada	"One-stop" or single access model
Breaking the Cycle	Toronto, Canada	"One-stop" or single access model
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	Surrey, Canada	"One-stop" or single access model
HerWay Home	Victoria, Canada	"One-stop" or single access model
The Mothering Project	Winnipeg, Canada	"One-stop" or single access model
New Choices	Hamilton, Canada	"One-stop" or single access model
Homeless Prenatal Program	Seattle, USA	"One-stop" or single access model
Toronto Centre for Substance Use in Pregnancy	Toronto, Canada	"One-stop" or single access model/ Hospital comprehensive care
Homeless At-Risk Prenatal Program	Toronto	Home visitation/mobile outreach
KidsFirst	Saskatchewan, Canada	Home visitation/mobile outreach
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	Edmonton, Canada	Home visitation/mobile outreach
Parent-Child Assistance Program	Washington, USA	Home visitation/mobile outreach
St. Michael's My Baby and Me Infant Passport Program	Toronto, Canada	Hospital comprehensive care
First Steps Housing Project Inc.	Saint John, Canada	Residential
Supportive Housing for Young Mothers	Halifax, Canada	Residential
Villa Rosa	Winnipeg, Canada	Residential

Prior to the discussion of these programming models in the context of the H.E.R. Program, a description of other types of programs and organizations that provide services to at-risk pregnant and parenting women are briefly delineated.

Resource Centres and Community Centres

Resource centres and/or community centres provide information and programming to men, women and children. Services tend to focus on prevention and wellness rather than intervention. Resources and supports are available to those who attend the centres (Ravinsky, 2009). Limitations to these centres in the context of street-involved pregnant or parenting women include the ability for women to know or access these types of supports. In addition, the gravity of their life situations are often beyond the scope of the resources the centres could provide.

Healthy Baby Programs

Healthy baby programs are neighbourhood drop-in centres with mandates to support the health of women and their infants both during and post- pregnancy. Programming typically utilizes peer support and discussion groups and the focus is often on the nutritional needs of mothers and babies (Ravinsky, 2009). An example of such a program is the Canadian Prenatal Nutrition Program (CPNP) which is a community-based program delivered through the Public Health Agency of Canada (PHAC) (Public Health Agency of Canada, 2011). There are 330 sites operating across Canada and they provide support "to improve the health and well-being of pregnant women, new mothers and babies facing challenging life circumstances" (2011, p1). Although the programs are focused on an important component of maternal and infant health outcomes, they often are unable to provide the complex interdisciplinary and integrated services that street-involved pregnant or parenting women need.

Residential Programs

Residential homes and programs provide services to pregnant and parenting women and offer them residency servicers prior to and after their pregnancy. Many of these models provide programming and services aimed to increase knowledge and enhance maternal and infant birth outcomes. For example, Villa Rosa in Winnipeg and First Steps Housing Inc. in Saint John were both reviewed as a component of the literature search. Both organizations offer residency for pregnant and parenting women of childbearing age that have had complex life experiences (e.g., abuse, substance use, homelessness) (Evaluation Designs Ltd., 2006). Programming offered can include nutritional counseling, pre-natal classes and exercises, career counseling, referrals to community resources, support groups, among others (2006). A limitation to residential homes and programming discovered as a result of reviewing relevant literature is the inability to access or provide services to women who are more transient or street-involved than others (measured by years in this lifestyle). These women are more difficult to access and typically less able to adhere to guidelines set by residential programs.

Home Visitation or Mobile Outreach Programs

Home visitation or mobile outreach programs provide healthcare and social services to the client in their home or location of residence. These models were developed to provide care to clients who require support during or after their pregnancies and may be geographically isolated or part of a hard-to reach population that may not otherwise access services (Saskatchewan Population Health and Evaluation Research Unit, 2010). Providing services in the home can offer a sense of comfort to pregnant or parenting women and allow greater flexibility in programming and meeting individual needs (2010). Home visitation programs for at-risk mothers such as KidsFirst (Saskatchewan) have been modeled after the Hawaii Healthy Start model called Healthy Families America (HFA) (2010). Currently HFA exists in over 440 communities in the U.S. and Canada (Gates, Nickel, & Muhajarine, 2010). A literature review conducted specifically for home visitation programs for at-risk pregnant and parenting women by KidsFirst noted benefits and positive outcomes from home visitation models that included:

breastfeeding; parental knowledge of abuse; parental self-reports of abuse; parental self-efficacy; and, prevention of abuse and neglect (2010). However, the review did not find a benefit in the following areas: preterm births or low birth weight; children's health status; use of community resources; substance use; and, health of subsequent pregnancies (2010). This model appears to reach at-risk pregnant and parenting women and provide benefit to them in terms of knowledge and support but does not seem to address health concerns such as low birth weight, maternal and child health and substance use.

"One-stop" or Single Access Models

A "one-stop" or single access model seeks to address the limitations of other models by providing services in one location for at-risk pregnant and parenting women. These models are most similar to the H.E.R. Program model; in fact, the H.E.R. model is a single access, integrated care model. These "one-stop shop" or "single access" model programs are different in their mandates and goals, but they attempt to provide services in one location to address the women's' needs (Canada's FASD Research Network, 2012). Important components of the model include reduction of barriers to accessing healthcare and support services and the inclusion of multidisciplinary teams and services (2012). Single access models include the provision of basic needs, healthcare, mental health support services, substance use services, maternal and infant care services, social services support, pregnancy and parenting support among others (Poole, 2000).

Literature Review Findings from Programming Reviewed

The focus of the literature review was to examine programming most similar to that of the H.E.R program, including having a Canadian context. As discussed, programs that operated under a residential, home visitation or mobile outreach, hospital setting comprehensive care or "one-stop" / single access models were reviewed. The differences allowed an in-depth examination of what components of the models contributed to their success. Although the method of care and service delivery varied depending on the program, there were commonalities and key components that could be learned from. The following summarizes and provides information and supporting evidence from all programs reviewed in relation to the literature review questions. The summarized information is from program documents and evaluations that contained data or statements of results from the programming. For more specific information please reference the Appendices.

In what ways have the program(s) reduced risk factors for the target population?

The vision and goal of almost all the programs included reducing risk and improving life outcomes of the street-involved or at-risk pregnant and parenting women. Commonalities in the reduction of risk from the programs reviewed included the following, below.

Improved maternal and infant health

A component of all programs is the health and well-being of the mother and her infant. The programs noted that maternal and infant health was improved by increasing the women's nutritional status. The provision of lunches, food coupons and hampers, and nutritional supplements and vitamins assisted in this task. In addition, primary medical care was provided to improve both maternal and infant health outcomes. Simply by providing easier access to healthcare and reducing barriers and stigma surrounding pregnancy for the women resulted in an improvement in overall health. Women were more likely to access services and maintain pre- and post-natal healthcare appointments. Pre- and post-natal medical care, as well as ongoing primary healthcare was provided to women and included ultrasounds, obstetric and gynecological appointments, blood tests and other services to improve the healthcare of the women and their babies.

Reduction of harm associated with substance use

Most models utilized a harm reduction approach, and thus were able to provide care and supports to women covering the spectrum of substance use. The following were provided to women if and when they required them: information and education on substance use; referrals to treatment centres or other organizations focused on detoxification or rehabilitation; methadone prescriptions to manage substance use; social supports to connect with others who struggle with substance use issues; and, an overall reduction of harm associated with substance use. These were all components that were noted as successful. In addition, some programs reported a reduction in alcohol and drug use and clients were more likely to have received treatment as a result of the program.

Increased social support networks

Almost all programs noted that there was an improvement in the women's social supports and social connections; as a result the women's sense of isolation was reduced. The social supports were provided by the program and service providers themselves; the other women accessing programming; and, through other agencies or programs in partnership with the original service provider. Of the programs under review only the Homeless Prenatal Program (USA) was designed to include the employment of peer support women to work with their clients. This impacted their capacity to provide social support networks for their clients.

Improved parenting knowledge and skills

Programs noted that clients improved their knowledge and skill about infant care and parenting. Providing parenting support groups, parenting education, and information on infant care was reported as contributing to increased knowledge and skills that resulted in improved parenting outcomes. In addition, some programs observed that by providing extensive education and programming fewer removals of children from their mothers and increased movement toward family reunification resulted.

Improved career, vocational or educational status

Programs noted that improved career, vocational or educational status reduced the risk for the women. Some programs provided career counselling support, job placement services, computer training, or skill training support for the women. In addition, some programs were connected with the local school board and were able to provide onsite school or course provision for the women to complete. These components contributed to an increased opportunity for employment or future employment.

Other methods

Other methods of reducing risk for the target population were not common among most programs, but important to mention. Some programs specified that increased confidence and self-esteem were important and resulted in attitudinal and behavioural changes among the pregnant and parenting women. Others observed that improvement in the women's housing status or living conditions were an important factor in reducing risk for the women. Similarly, enhancing the whole family's health and well-being contributed to the success and reduction of risk for the pregnant and parenting women. Some programs noted that increasing knowledge surrounding family planning methods resulted in increased likelihood of use of birth control and reduction of additional pregnancies. Finally, others reported that by utilizing standardized measures, they were able to demonstrate a reduction of overall risk factors over time.

What impact did the program(s) make on health outcomes and birth outcomes of clients?

All programs indicated in their vision, mission or purpose that the ultimate goal was to increase the health and birth outcomes for the women and children. The following indicators were common among the reviewed programs, in relation to maternal and infant health.

Improved access to pre- and post-natal care

Most programs noted that increased access and reduction of barriers to obtain medical care for the women was substantial in improving their health outcomes. By accessing primary medical care and attending pre- and post-natal appointments, the mothers and infants were healthier. In addition, increasing the information and knowledge about pregnancy to the women at their medical appointments impacted the subsequent health of the women and their babies. This access to medical care also reduced the postnatal risk factors and diagnoses of the infants born.

Reduction or abstinence from substance use

A reduction in or abstinence from substance use was reported as a program impact on the health and birth outcomes of their clients. Reducing maternal substance use decreased the likelihood of medical complications or situations for both the mother and her child. Some programs reported that there was reduced pre-natal substance exposure and thus more infants born were drug-free.

Reduction in low birth weight and pre-term infants

One of the most critical components of infant health identified is the delivery of a baby who has a healthy birth weight (Beal & Redlener, 1995). In many cases, poor nutrition, substance use and lack of pre-natal care can result in low birth weight babies or pre-term babies. Most programs described that the vast majority of their clients ended up delivering babies that had a healthy birth weight (more than 2,500 grams). Some noted that the higher birth weight was associated with pre-natal care and increased nutritional status of the women. Most observed a reduction in preterm infants and infants requiring specialized care after birth. In addition, fewer birth complications were reported as a result of the programming offered by the organizations.

Improvement in child development and care

Programs noted that infants born had healthier APGAR scores and were functioning within the normal range of development. APGAR is a test performed on a baby at 1 and 5 minutes after birth (Medline Plus, 2012). The 1-minute score determines how well the baby tolerated the birthing process (Medline Plus, 2012). The 5-minute score tells the doctor how well the baby is doing outside the mother's womb (Medline Plus, 2012). The medical team will examine the baby's: breathing effort, heart rate, muscle tone, reflexes and skin color and each category is scored with a zero, one or two. The APGAR rating is based on a total score of 1 to 10 (Medline Plus, 2012). The higher the score, the better the baby is doing after birth (Medline Plus, 2012). In addition to healthier APGAR scores, there was the ability for early intervention and identification of risk factors or child health problems. Specifically, some later noted an improvement in children's motor skills, social skills and language skills.

Other impacts

Other impacts on infant and maternal health for the target population were not common among most programs, but important to mention. Some programs identified an increase in up-to-date immunizations for babies; a reduction in the length of hospital stay for mothers; and, a decrease in mother-infant separations at birth. Some programs further observed that more infants were discharged in the care of their mothers. In addition, some programs indicated there was a decrease in parenting stress and an improvement in measure of post-natal attachment as a result of the programming.

What were the measureable impacts of the program(s) on knowledge, behaviour and lifestyle of the target population?

Another shared goal among the reviewed programs was to build the knowledge, behaviour and lifestyle capacity of the pregnant or parenting women. Common to the programs detailing impacts on knowledge, behaviour and lifestyle included the following:

Enhanced connection to social supports

The majority of programs noted that the program provided enhanced connection to social supports, including: better social support from family and friends; access to social supports at the program site;

connection to staff and caseworkers; and, connection to other pregnant and parenting women. The connections provided increased knowledge of those with similar situations, increased education on supports available, and reduced isolation.[4]

Reduction in substance use and harm associated with substance use behaviours

Most programs noted a reduction in substance use or harmful substance using behaviours from their clientele. They also noted an increase in overall health and wellness as a result of reducing substance use and an increased connection to treatment programming or supports. In general, the increased knowledge of substance use on infant development resulted in a reduction of substance use or harmful behaviour (e.g., use of a prescribed substance instead of a substance obtained from the street; utilization of clean needles; use of birth control or condoms).

Increased knowledge of fetal development and parenting skills

Programs noted that the pregnant or parenting women were more educated on fetal and infant development and were able to make better choices for care and parenting skills for their children. For example, education on substance use reduced the harm associated with the use of substances. In addition, there was an increase in learned parenting strategies and the classes and education on parenting skills and infant development resulted in women who were more likely to retain custody of their child after birth or to start the process of reuniting themselves with their child.

Improvements in attitude and behaviour towards parenting

As a result of education and knowledge transfer, some programs reported the pregnant or parenting women had a better attitude towards parenting and made small but significant behavioural changes, such as: better eating habits and more time spent playing with their children. In addition, there was an improvement in mothers parenting competence and with their overall confidence in being a mother.

Better outlook on the future (hope)

Education, information, knowledge and support from the programs seemed to result in improvements in attitude towards the future. Programs noted women seemed more confident in their ability to continue to parent and retain custody of their child. The women had increased self-confidence and positive outlooks on the future. Likely a contributing factor, some programs offered the women school or training for career development while being involved with the program. The access to education supported the small but significant changes in attitude and confidence towards the future, including the development of increased hope.

[4] The report on the Homeless Prenatal Program did not include information on measured impacts of utilizing peers to provide support to clients.

Other improvements in knowledge, behaviour or lifestyle

Some programs reported additional improvements in knowledge, behaviour or lifestyle of their clientele: reduction of barriers to access care; improvement in nutritional status; improvement in housing or living situations; better attitudes towards child welfare services and other support agencies; achievement of client goals; improved family interaction; decrease in welfare use; reduction in additional pregnancies; increased trust between women and their caregivers (e.g., doctor, psychologist); and, greater stability.

What types of partnerships were established among both service providers and street-involved women? Did established partnerships enhance service delivery for homeless pregnant women?

All programs developed single or multiple partnerships with government, healthcare organizations or hospitals, and other service organizations. The linking of multiple organizations and service agencies allowed the opportunity to provide diverse service delivery to assist pregnant and parenting women who may have more complex needs. Typically, the more partners identified by the program, the more programs and services they were able to offer on a variety of different topics of concern. In addition, the programs noted that the partnerships created with the women enhanced their ability to provide services to them that would fit their needs. In many cases, the women commented on the value of comprehensive, centralized, and relational service delivery that encouraged support and change.

How effective were the strategies employed by the program(s)?

To some degree, every program was successful and effective in contributing to the achievement of their mandate and goals. In general, however, programs seemed to have some similar measures of success and effectiveness. These common measures of effectiveness included:

- Ability to access marginalized populations of street-involved or at-risk pregnant or parenting women[5];
- Ability to engage and provide services to street-involved or at-risk pregnant or parenting women;
- Ability to increase social network supports and reduce isolation of at-risk pregnant and parenting women;
- Provision of services and supports to women involved in substance use and helping women achieve a reduction in substance use or a reduction in harm behaviours associated with substance use;
- Provision of supports and services to increase overall health and wellbeing of the pregnant or parenting women including nutrition, primary medical care and pre-natal care;

[5] The report on the Homeless Prenatal Program did not include specific information on measured impacts of utilizing peers to provide support to clients.

- Enhancement of perinatal outcomes including higher birth weights, fewer post-natal diagnoses, reduced length of hospital stays, and reduction of mother-infant separations; and,
- Increased education, knowledge, competence and confidence of women accessing services.

What can be learned for successful delivery of programming for street-involved pregnant women?

All programs designed measures and indicators of success. In the context of street-involved pregnant and parenting women there were some strategies that emerged as more effective than others. These results offer learnings or best practice for other programs or continued program development.

Common elements among programs directly focused on street-involved pregnant and parenting women included:

- *Drop-in or mobile outreach models* for the women to access care when they are willing and able to;
- *Centralized or integrated models of care* so the women can access a variety of services in a location that is easy to access for them. Please note only one program reviewed (Homeless Prenatal Program) indicated they utilized a peer supported model of delivery that employed peers to provide support to the clientele;
- *Multidisciplinary and comprehensive services* to address complex needs of women who may all require varying supports or levels of intervention;
- *Provision of basic and practical needs* for the women to fulfill their more basic concerns prior to addressing more complex concerns they may have;
- *Provision of primary healthcare* to provide basic medical care support, pre- and post-natal support, as well as medical advice and guidance;
- *Client-driven programming* to allow the women to decide which services and supports they are willing and able to access and how the staff can best accommodate their needs and support their goals;
- *Non-judgmental and harm reduction approaches* to issues of substance use, family violence and mental health;
- *Focus on both maternal and infant health outcomes* to support healthy women and healthy children; and,
- *Support systems and advocacy* to provide resources, information, education and social support to women who may feel marginalized.

What challenges still need to be addressed for successful delivery of programming for street-involved pregnant women?

Programs noted that the population of street-involved or at-risk pregnant and parenting women encompass a variety of complex health and social concerns that cannot be addressed by traditional

models of service delivery. Even with innovative or diverse programming, there are still challenges that impede the successful delivery of programming for street-involved or at-risk pregnant and parenting women. Many of the challenges described in the introduction of this literature review continue to encapsulate the challenges of providing services to street-involved or at-risk pregnant women.

The women tend to have had traumatic life experiences such as abuse that have contributed to their current situation. In addition, they may be involved with substance use, or have mental health concerns that infringe on their ability to access medical or psychological care. Many women continue to report barriers to accessing care and programming, and this can continue to be a challenge to programs. The women may not trust the service providers and practitioners and then are less likely to obtain and retain appointments. In addition, they may continue to feel marginalized, stigmatized and isolated as a result of their life experiences or their pregnancy.

In reviewing the programs, some specific concerns related to their programming were noted by organizations including:

- *Securing more space* to be able to provide care for pregnant or parenting women;
- *Broader substance use treatment and support services* to address the use of multiple substances, pregnant women's substance use or post-natal substance use support;
- *Expanding outreach programming* to reach more women;
- *Including more creative and unique programming* such as art therapy;
- *Including more Aboriginal programming* that include traditional therapies like smudging;
- *Provision of services for women and children to five years of age;*
- *Increased programming to support education or employment;*
- *Increased peer-support* or mentoring from former clients;
- *Funding concerns; and,*
- *Continuity of service after the women have completed their pregnancy.*

Common Elements among "One-Stop" or Single Access Models Reviewed

The majority of programming reviewed were those that were a "one-stop" or single access model of service delivery. As found in the literature review, the single access models seem to contain more comprehensive and integrated models of care that are better suited to addressing street-involved or at-risk pregnant and parenting women's needs. A brief discussion of the commonalities and successes of "one-stop" models will expand the literature results into the context of programming similar to H.E.R. Programs cited as most similar in Canada were: Sheway; Maxxine Wright; Breaking the Cycle; HerWay Home; and, The Mothering Project (Ravinsky, 2009). These programs have similar structures and goals to one another and assist a similar type of population of street-involved pregnant or parenting women of childbearing age. Chart 5 outlines the similarities between the program in the context of the Program Review Checklist that was developed to screen programs for the literature review.

All of the single access models provide programming similar to H.E.R in the context of street-involved or at-risk pregnant and parenting women. They all utilize harm reduction and integrated models of service delivery. In addition, they all provide English language programming and had grey literature available for review. A minority had published literature available for review in addition to the grey literature. Most of the literature reviewed was recent (last 10 years); however, some seminal program documents that were published in the late 90's or early 2000's were also included. Most programs were located in Canada, with the exception of the Homeless Prenatal Program and the Parent-Child Assistance Program (located in Seattle and Washington). It is important to note that H.E.R was the only program in Canada (of those found and reviewed) that utilizes peer-supported models of service delivery.

Chart 5. "One-stop" or single access model comparisons

Category	Inclusion Criteria	H.E.R.	Sheway	Breaking the Cycle	Maxxine Wright	HerWay Home	The Mothering Project	New Choices (USA)	Homeless Prenatal Program (USA)
Programming	▪ Programming similar to H.E.R.	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Peer-supported models of service delivery	✓	-	-	-	-	-	-	✓
	▪ Minimum 1 year length	✓	✓	✓	✓	-	-	✓	✓
	▪ English language	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Grey literature	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Published literature	-	✓	✓	-	-	-	✓	-
	▪ Literature from 2002 – 2012	✓	✓	✓	✓	✓	✓	✓	✓
Target Population	▪ Youth	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Adult women	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Aboriginal descent/recognized minority	✓	✓	✓	Unknown	✓	✓	✓	✓
	▪ Homeless/street-involved	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Transitional/unstable housing	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Substance use	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Unstable family structures	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Employed/unemployed	✓	✓	✓	✓	✓	✓	✓	✓
	▪ Prostitution/other at-risk behaviours	✓	✓	✓	Unknown	✓	✓	Unknown	Unknown
Jurisdictions	▪ Canada	✓	✓	✓	✓	✓	✓	-	-
	▪ USA	-	-	-	-	-	-	✓	✓

Key similarities between "one-stop" or single access models

The "one-stop" or single access models encapsulate all the methods of success discussed in this review, including:

- drop-in or mobile outreach models;
- centralized or integrated models of care;
- multidisciplinary and comprehensive services;
- provision of basic and practical needs;
- provision of primary healthcare;
- client-driven programming;
- non-judgmental and harm reduction approaches;
- focus on both maternal and infant health outcomes; and,
- support systems and advocacy.

Yet, these models seem to have additional other or enhanced key features that contribute to their success. Supporters of single access models and the results from the literature review note several key principles of the models as to why they are successful, and why they are preferred over other approaches when possible (e.g., Burglehaus & Stokl, 2005; Cailleaux & Dechief; Marshall, Hare, Ponzetti, & Stokl, 2005; Motz, Leslie, Pepler, Moore, & Freeman, 2006; Ravinsky, 2009).

Outreach and access

The most visible difference between "one-stop" or single access models is that they provide access to their services not only through outreach and word of mouth, but from one easily accessible location. One location to access services ensures pregnant and parenting women a simplified access process and easy accessibility (once the location is known) through walking or public transit. The model allows service providers to provide care that aligns with where the women are situated; this facilitates access to and following through with appointments. In addition, the single access models reviewed also included specific street outreach services and case management support (e.g., Motz, Leslie, Pepler, Moore, & Freeman, 2006). These outreach services ensured that women were continually provided care, even if they were unwilling to maintain or access supports at the organization's location. In addition, utilizing single access and street outreach models offered reach and access to and for street-involved or at-risk pregnant and parenting women that likely could not be accessed by other models. The "one-stop" models seemed to be much more successful in locating and providing services to marginalized women who needed support most.

Integration, collaborative partnership and multidisciplinary service delivery

As described, single access models utilize one location to provide diverse programming that meets the needs of street-involved or at-risk pregnant and parenting women. Through partnerships/collaboration with other service providers in the area, they are able to both provide a wide range of appropriate programming through the location but also to refer to service providers who may be better able to handle a particular woman's concerns (e.g., a doctor providing a methadone prescription). In all of the single access models reviewed, there were multiple partnerships and a team of multidisciplinary service providers on staff at the location to provide services (e.g., a social worker, nurse, psychologist, nurse practitioner, life coach). Street-involved pregnant or parenting women experience adverse challenges and complex concerns that can often not be solved by traditional methods of service delivery (Burglehaus & Stokl, 2005). A model with one location addresses the complex needs of women by utilizing one single service provider team to coordinate care. In addition, the multidisciplinary care provided at the one location can address multiple concerns the women may have concerning their pregnancy, parenting or other immediate needs like nutrition.

Harm reduction

Harm reduction was discussed in general terms at the beginning of the literature review. Through the program review, not only did all single access models note they utilize harm reduction approaches, but that these philosophies were embedded in the principles of their organization (e.g., Motz, Leslie, Pepler, Moore, & Freeman, 2006; Poole, 2000). A harm reduction model where flexible, non-judgmental approaches are used recognizes that abstinence of a harmful or risky behaviour is one goal of many (Streetworks, 2012). The model that has been embedded into the core goals of single access models supports street-involved or at-risk pregnant or parenting women and their children by providing care and services, regardless of lifestyle choices. In many cases women may feel marginalized or stigmatized for the choices they have made in their lives and experience this as a barrier to accessing services (Beal & Redlener, 1995). Single access models have embedded non-judgment and harm reduction strategies into their mandates and thus are better equipped to provide care to pregnant and parenting women who may feel ostracized from other systems of care.

Women- centred/Mother-child success

Another common indicator shared among single access models that were reviewed is their stance on the type of supports provided and definition of "success". All programs had common goals to increase both maternal and infant health outcomes while being woman-centred (e.g., Poole, 2000). Woman-centred care recognizes the power imbalances that a woman may face and also acknowledges the differing experiences women have in the world, in comparison to men (Ravinsky, 2009). Women-centred care usually encompasses the following characteristics: a protected space where women can access services without intimidation from men; a welcome and respectful space that recognizes women's needs and differences; a community where women support one another; use of collaborative approaches to care; provision of opportunities for women to gain new perspectives and skills; opportunity to reflect on their own personal growth and learning goals; and, service delivery that

minimizes women's barriers to access (Ravinsky, 2009). The "one-stop" models reviewed all focused on the creation and maintenance of a welcome, non-judgmental and respectful place for women to access service and forge bonds with other women, service providers and their children. In addition, by providing care for the pregnant or parenting women, the focus was on both maternal and infant health outcomes and supports. The primary focus or overall goal for the single access models reviewed was to support the best possible maternal and infant health outcomes and promote increased health of women and their children.

Cultural Safety and Culture-based Approaches

Finally, the last common principle among single access models that will be discussed is that of cultural safety and culture-based approaches. In Canada, a large proportion of street-involved pregnant or parenting women identified by single access models are of Aboriginal descent (e.g., 60% at Sheway, 2000), it is important to offer culturally relevant programming and support. Identifying with and understanding the differences in cultural context and cultural past allows for cultural considerations when providing support to pregnant or parenting women. A culture-based approach encourages the recognition of one's own culture while being cognizant of others cultures (Ravinsky, 2009). A culture-based approach does not entail targeting programming for one particular "group", as the term "Aboriginal" or "South-Asian" does not describe a homogeneous group that will require all the same information and supports (Ravinsky, 2009). Rather, approaching culture with curiosity and openness where service providers and program participants can utilize their own background or others' backgrounds to inform their perceptions are preferred (Ravinsky, 2009). In the single access models reviewed, most included a component of cultural safety practices to ensure that women feel more at ease and less stigmatized as a result of their cultural background. In many cases, programming was offered that may be appropriate to certain groups (e.g., traditional Aboriginal therapies like smudging) but this was not forced upon or restricted to those of Aboriginal descent. Rather, the programming offered was just that, available to those that would like to take part or would benefit from aspects of culture in their service delivery.

Summary of Literature Review Findings

In summary, street-involved or at-risk pregnant or parenting women encounter many challenges and untraditional life experiences (Beal & Redlener, 1995). They are a population that is difficult to access and they experience many barriers to service delivery that include stigmatization, marginalization and shame (Currie, Janet C.; Focus Consultants, 2001). The challenges they experience, do not undermine the strengths and resilience these women demonstrate in the face of adversity (Crawford, Trotter, Sittner Hartshorn, & Whitbeck, 2011). Providing care that removes barriers to access and is inclusive, integrated, multidisciplinary and relevant is of paramount importance for this population.

The programs and literature reviewed addressed the literature review questions that were created at the outset of the project. Specifically, the following factors of the programs reviewed contributed to the literature review questions.

Factors that reduced risk factors for the target population included:

- improved maternal and infant health;
- reduction of harm association with substance use;
- increased social support networks;
- improved parenting knowledge and skills; and,
- improved career, vocational or educational status.

Factors of the programs that impacted health and birth outcomes of clients included:

- improved access to pre- and post-natal care;
- reduction or abstinence from substance use;
- reduction in low birth weight and preterm infants; and,
- improvement in child development and care.

Factors of the programs that impacted knowledge, behaviour and lifestyle of the clients included:

- enhanced connection to social supports;
- reduction in substance use and harm associated with substance use behaviours;
- increased knowledge of fetal development and parenting skills;
- improvement in attitude and behaviour towards parenting; and,
- better outlook on the future (hope).

The program models reviewed were all similar in that the target for their programming was street-involved or at-risk pregnant or parenting women. In addition, key facets of their programming accounted for the successful delivery of services and supports by using:

- drop-in or mobile outreach models;
- centralized or integrated models of care;
- multidisciplinary and comprehensive services;
- provision of basic and practical needs;
- provision of primary healthcare;
- client-driven programming;
- non-judgmental and harm reduction approaches;
- focus on both maternal and infant health outcomes; and,
- support systems and advocacy.

Challenges that were noted by service providers and programs included:

- the continued barriers to access that the women faced;
- missed appointments or difficulty attending appointments;
- complex health, social and psychosocial concerns; and,
- stigmatization, marginalization and isolation of the target population.

Finally, "one-stop" or single access models operating in Canada were the primary target of the literature review and provided a wealth of information on the successful delivery of services to street-involved or at-risk pregnant or parenting women. The models included design models of success as noted by all programs together, but also included principles that were both unique and critical to their programming. Specifically, the following principles and components were identified as being key to the success of the single access models reviewed:

- outreach and access;
- integration, collaborative partnership and multidisciplinary service delivery;
- harm reduction;
- woman-centred/mother-child success; and,
- cultural safety and culture-based approaches.

In addition, an approach that is utilized by the H.E.R. Program and only one other single access model review (Homeless Prenatal Program), is that of peer-support service delivery. In both programs, women who have been in similar situations or actual clients of the program help to deliver services by acting as an outreach worker or support to those currently involved in the program. For example, the Homeless

Prenatal Program provides a course for women to become outreach workers for their organization or other organizations (Homeless Prenatal Program, 2011). Utilizing peer-support models demonstrates to the women that there are others who have been in their situation and are willing to help. It helps to remove the "us-versus-them" mentality and allows for another diverse perspective of care to be included (Solomon, 2004). In this way, it is seen as strength and identified by this literature review as a critical facet of success, although currently not a component of any other single access model in Canada outside of the H.E.R. Program.

The approaches and common goals utilized by these models help to ensure that they are reaching their target population and providing services that are both relevant and appropriate for the pregnant or parenting women. They further ensure the best possible maternal and infant health outcomes. Recommendations and learnings from the single access models include the provision of non-judgmental, inclusive, integrated and multidisciplinary care that is better able to provide the unique supports to women with more complex or untraditional concerns.

In many ways, the programs reviewed are all operating to accomplish similar goals, but their mandates and visions may vary. In addition, the single access models reviewed seemed to be more comparable and cohesive in their structure and principles and thus are models that can be learned from and replicated for other service delivery programs being offered, or under development, for street-involved pregnant or parenting women. Similarly, after reviewing the literature, it can be stated that the H.E.R. Program is delivering programming that is aligned with best practices and encompasses successful components of the other models. The program provides access and the delivery of services in similar ways as other successful programs and is unique and at the forefront of innovative service delivery in Canada by providing peer-supported methods of service delivery, among other models of care.

In completing the literature review, the author notes a recommendation for enhanced knowledge sharing. It would be beneficial to develop systems of knowledge transfer (specifically among the single access models operating in Canada) so that service providers can share information and learnings with each other more easily. In some ways, information was not always readily available or able to be shared with the reviewer. Encouraging a community of shared practice would assist all service providers in learning what is working well and what unique strategies can be utilized to enhance service delivery to street-involved or at-risk pregnant or parenting women in Canada.

Appendix A – Program Review Literature Review Questions

Literature Review Questions	
In what ways has the program reduced risk factors for the target population?	
Sheway	▪ Reducing isolation of high-risk pregnant women (socialization and service access, recreational and creative programming, referrals to other supports); ▪ Improving health of mothers and babies (provision of lunches, food coupons and hampers, emergency food, nutritional supplements, medical care, nutritional counselling); and, ▪ Reducing harm associated with substance use (providing information and treatment referral, methadone prescriptions, reduction of harm from use of drugs).
Breaking the Cycle	▪ Increased social connections; ▪ Increased knowledge and support surrounding substance-use; ▪ Increased maternal and infant health; ▪ Provision of supports and treatment; ▪ Improvement in sobriety and parenting; and, ▪ Knowledge, attitudinal and behavioural changes.
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	▪ Improvements in access to health care; ▪ Improvements of birth outcomes; ▪ Improvements in families' health and well-being; ▪ Improvement in housing status; ▪ Improvement in nutritional status; ▪ Reduced risk from the use of substances; ▪ Improved parenting outcomes; ▪ Fewer removals of children; and, ▪ Increasing move towards family reunification.
HerWay Home	N/A
The Mothering Project	N/A
New Choices	▪ Decreased substance use; ▪ Improved maternal health;

	▪ Enhanced opportunity for employment; ▪ Increased access to resources; ▪ Increased confidence; ▪ Enhanced social support; ▪ Enhanced parenting skills; and, ▪ Improved child behaviour and development.
Homeless Prenatal Program (USA)	▪ Since 1992, of 2,680 babies born to HPP, 2,412 (90%) were of normal weight and 2,559 (95.5%) were drug-free. ▪ Since 1995, 164 women have entered the Community Health Worker (CHW) Training Program; 132 (82.9%) graduated the program and 124 of the graduates (93.9%) found jobs or pursued educational opportunities within 30 days of graduation. [Many at the HPP] ▪ Prenatal education and support groups; ▪ Increased social support network; ▪ Medical and mental health support; ▪ Substance use support; ▪ Vocational training and assistance; and, ▪ Basic needs supplied.
Toronto Centre for Substance Use in Pregnancy	▪ Provision of prenatal/postnatal medical care; ▪ Provision of addiction counselling and other complex psychosocial needs; ▪ High compliance rate with prenatal care attendance; ▪ More women living in stable housing and fewer had no fixed address; ▪ Reduction in living with substance-using household members; ▪ Decrease in maternal drug use; and, ▪ Increased connection to addiction treatment programs.
Homeless At-Risk Prenatal Program (USA)	▪ Provision of primary health care services; ▪ Provision of support and intervention; and, ▪ Provision of information.
KidsFirst	▪ Percentage of women who enrolled during the prenatal period grew from 15% to 40% in the most recent year (Program evaluation summary, 2010);

	▪ Addresses mental health and addiction issues; ▪ Significant improvement in risk scores (Program evaluation summary, 2010); and, ▪ Improved social supports, housing, food security, education, employment and income (Program evaluation summary, 2010).
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	▪ Increased use of family planning methods; ▪ Decrease in welfare use; ▪ Some reduction in unemployment and in unstable housing; ▪ Reduction in additional pregnancies; ▪ Reduction in alcohol and drug use; ▪ Reduction in overall needs (e.g., independence and financial issues, community resources, addictions problems, health issues); ▪ Increase in goals; and, ▪ Increased social support networks.
Parent-Child Assistance Program (USA)	▪ A comparison of the original demonstration treatment group and the control group at 36 months showed that the treatment resulted in significantly higher endpoint scores. ▪ At a 36-month follow-up women in PCAP were more likely to have received alcohol/drug treatment than the control group (85% vs. 76%). ▪ Alcohol and drug abstinence rates at 36 months were higher among the treatment group than the control group (37% vs. 32%). ▪ The treatment group was also more likely to use birth control than the control groups (73% vs. 52%) and have the appropriate custody of their child (69% vs. 29%). ▪ The program has been replicated at two other sites in Seattle and Tacoma. Compared to the original demonstration, positive outcomes at the replication site were maintained for contraception use (72%), use of reliable contraceptives (51%) and number of subsequent deliveries (27%). Outcomes improved for completed alcohol/drug treatment (74%), alcohol/drug abstinence (53%), and subsequent delivery unexposed to alcohol/drugs (36%).
St. Michael's My Baby and Me Infant Passport Program	▪ 85% retained passport through to the birth of the infant or last prenatal program; ▪ Education on health outcomes for the women and their children; and,

	▪ Fluidity of health care provision by staff who are able to look at the passport and know what next needs to be done, reducing the instances of multiple tests and distrust.
First Steps Housing Project Inc.	▪ Creation of social supports; ▪ Provision of information and education on drug and alcohol; ▪ Provision of educational and career services; and, ▪ Provision of nutrition and prenatal care.
Supportive Housing for Young Mothers	▪ Provision of a supportive housing structure; ▪ Promotion of health, safety and stability; and, ▪ Provided emotional and physical support.
Villa Rosa	▪ Healthy pregnant women give birth to healthy babies; ▪ Offer the opportunity to break the cycle of poverty and abuse ▪ Young mothers stay in school; ▪ Breastfeeding rates at Villa Rosa higher than the national average ▪ Prevention of Fetal Alcohol Spectrum Disorder; ▪ Improved social support network ▪ Significant improvement in risk scores over time; ▪ Fewer problems caused by drinking and drugs; and, ▪ Provision of education and information.
What impact did the program make on health outcomes and birth outcomes of clients?	
Sheway	▪ Increase in ability to access prenatal/delivery care; ▪ Improvement in nutritional status; ▪ Decrease in substance use; ▪ Healthy birth weight (in updated Burglehaus & Stokl (2005) document, described as 86% had babies with a birth weight more than 2,500 grams); ▪ Higher infant birth weight significantly associated with longer prenatal care and reception of food bags from Sheway (Marshall et. al, 2005); ▪ Low Apgar scores have reduced over the years of Sheway's operation (Marshall et. al, 2005); ▪ Reduction of babies needing specialized care and preterm infants; and,

	▪ Up-to-date immunizations for babies.
Breaking the Cycle	▪ Higher birth weights; ▪ Fewer postnatal risk factors and diagnoses; ▪ Reduced prenatal substance exposure; ▪ Fewer birth complications; ▪ Reduced length of hospital stay; ▪ Decreased mother-infant separations at birth; ▪ BTC children functioning within the normal range of development; ▪ Decrease in parenting stress for mothers over time; and, ▪ Increase on measures of postnatal attachment and quality of attachment.
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	▪ Improvements of birth outcomes (unspecified to what extent).
HerWay Home	N/A
The Mothering Project	N/A
New Choices	▪ Improved maternal health; and, ▪ Improvement in children's motor skills, social skills and language skills.
Homeless Prenatal Program (USA)	▪ Since 1992, of 2,680 babies born to HPP, 2,412 (90%) were of normal weight and 2,559 (95.5%) were drug-free.
Toronto Centre for Substance Use in Pregnancy	▪ Decrease in maternal drug use; ▪ Decreased birth complications; ▪ Increased breastfeeding; and, ▪ 75% of infants discharged home in the care of their mothers, the longer the client received care at T-CUP the more likely she was to retain custody of her child.
Homeless At-Risk Prenatal Program (USA)	Unspecified
KidsFirst	▪ Early intervention and identification of child health problems; and, ▪ Children developing normally (Program evaluation quantitative, 2010).
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	▪ Increased use of family planning methods; and, ▪ Reduction in alcohol and drug use.

Parent-Child Assistance Program (USA)	▪ Reduction in alcohol and drug use; and, ▪ Increased use of birth control.
St. Michael's My Baby and Me Infant Passport Program	▪ 94% of passport users gave birth to full term infants; ▪ 90% of women gave birth to healthy weight infants; and, ▪ Rate of premature infants was less than national average.
First Steps Housing Project Inc.	▪ All clients who have delivered babies while in the program have all delivered babies with health birth weights
Supportive Housing for Young Mothers	▪ Increased positive levels of overall health.
Villa Rosa	▪ Over 90% of Villa Rosa babies weigh over the recommended healthy birth weight —the best indicator of future health and wellness. ▪ Healthy pregnant women give birth to healthy babies; ▪ Breastfeeding rates at Villa Rosa higher than the national average; and, ▪ Prevention of Fetal Alcohol Spectrum Disorder.
What were the measureable impacts of the program on knowledge, behaviour and lifestyle of the target population?	
Sheway	▪ Increase in ability to access prenatal/delivery care; ▪ Improvement in nutritional status; ▪ Decrease in substance use; ▪ Improvement in housing; ▪ Increase in parental skills and retaining custody; and, ▪ Increased connection to social supports.
Breaking the Cycle	▪ Increased confidence in services in the community; ▪ Better social support from family and friends; ▪ Better attitude towards parenting; ▪ Better attitude towards child welfare services and other support agencies; ▪ Small but significant behavioural changes (e.g., better eating, more time spent playing with children); and, ▪ Improvement in mothers parenting competence.
Maxxine Wright Place Project for High Risk Pregnant and	▪ Improvements in families' health and well-being;

Early Parenting Women	▪ Improvement in housing status; ▪ Improvement in nutritional status; ▪ Reduced risk from the use of substances; ▪ Improved parenting outcomes; and, ▪ Fewer removals of children.
HerWay Home	N/A
The Mothering Project	N/A
New Choices	▪ Decrease substance use; ▪ Increased health; ▪ Increased confidence; ▪ Enhanced social support; and, ▪ Increase in learned parenting strategies.
Homeless Prenatal Program (USA)	▪ Training for career development; ▪ Access to community technology centre to search for employment; ▪ Increased prenatal education; and, ▪ Increase substance use education.
Toronto Centre for Substance Use in Pregnancy	▪ High compliance rate with prenatal care attendance; ▪ More women living in stable housing and fewer had no fixed address; ▪ Reduction in living with substance-using household members; ▪ Decrease in maternal drug use; and, ▪ Increased connection to addiction treatment programs.
Homeless At-Risk Prenatal Program (USA)	▪ Achievement of client goals.
KidsFirst	▪ Increased knowledge surrounding issues of child health; ▪ Improved social supports, housing, food security, education, employment and income (Program evaluation summary, 2010); and, ▪ Improved family interaction (Program evaluation summary, 2010).
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	▪ Increased use of family planning methods; ▪ Decrease in welfare use;

	▪ Some reduction in unemployment and in unstable housing; ▪ Reduction in additional pregnancies; ▪ Reduction in alcohol and drug use; ▪ Reduction in overall needs (e.g., independence and financial issues, community resources, addictions problems, health issues); ▪ Increase in goals; and, ▪ Increased social support networks.
Parent-Child Assistance Program (USA)	▪ Increased knowledge of drugs and alcohol; ▪ Increased knowledge on birth information and child development; and, ▪ Prevention of FASD.
St. Michael's My Baby and Me Infant Passport Program	▪ Passport increase mother/infant attachment; ▪ Helped foster trust between patients and caregivers; and, ▪ Reduced barriers to care.
First Steps Housing Project Inc.	▪ Increased knowledge of drug use and alcohol use; ▪ Increase in self-confidence; and, ▪ Increase in education and goal setting.
Supportive Housing for Young Mothers	▪ Higher quality of life rating; ▪ Greater stability and wellness; ▪ Receiving educational services; and, ▪ More positive outlook.
Villa Rosa	▪ Comfort in plan to parent; ▪ Confidence in the future; ▪ Improved social support network; ▪ Higher self-esteem; and, ▪ Women are better equipped to parent upon leaving Villa Rosa.
What types of partnerships were established among both service providers and street-involved women? Did established partnerships enhance service delivery for homeless pregnant women?	
Sheway	Partnerships (*from website*): Ministry of Children and Family Development; The Vancouver

	Coastal Health Authority; YWCA of Vancouver; Children's and Women's Hospital; Health Canada - Canadian Prenatal Nutrition Program; UBC's Trek Volunteer Program; United Way - Success by Six. The evaluation report details the linking of service provision and partnerships strengthened the organization and the ability to continue to provide appropriate and sufficient services.
Breaking the Cycle	"BTC operates through the efforts of a unique, collaborative partnership including Mothercraft, the Jean Tweed Centre, Motherisk-Hospital for Sick Children, Children's Aid Society of Toronto, Catholic Children's Aid Society, Toronto Public Health and St. Joseph's Health Centre" (Summary Report, 2006). Partnership model was working well, had synergistic impacts and continuing to evolve with changing needs of clients (Program evaluation report 1995-2000).
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	Partnership with Fraser Health and the Ministry for Children and Family Development.
HerWay Home	N/A
The Mothering Project	N/A
New Choices	Women value comprehensive and centralized approach to service delivery.
Homeless Prenatal Program (USA)	Comprehensive work with women and families to determine goals and outcomes of success; and, Utilization of training for employment in community organizations.
Toronto Centre for Substance Use in Pregnancy	Unspecified
Homeless At-Risk Prenatal Program (USA)	Unspecified
KidsFirst	Shared accountability and community development.
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	Partnership between women and mentor, long-term.
Parent-Child Assistance Program (USA)	Long term connection between case worker and client (3 year period); and, Establishment of relationship to encourage change.
St. Michael's My Baby and Me Infant Passport Program	Partnership between women and health care providers to share information – seemed to be effective.

First Steps Housing Project Inc.	Partnership between Victorian Order of Nurses and counselling groups to provide integrated programming.
Supportive Housing for Young Mothers	Unspecified
Villa Rosa	Provision of information and support for the women that seemed to work while staying at Villa Rosa. Noted that once the woman left, supports diminished.
How effective were the strategies employed by the program?	
Sheway	▪ Program evaluation reports noted successes in utilizing a drop-in format to reach at-risk pregnant and parenting women and provide service delivery.
Breaking the Cycle	Ten year evaluation demonstrated: ▪ Reaching and engaging high risk and marginalized population of homeless, pregnant and substance-using women; ▪ Enhanced perinatal outcomes (higher birth weights, fewer postnatal diagnoses, reduced length of hospital stay, decreased mother-infant separations at birth); ▪ Helping women achieve higher rates of completion of treatment/intervention plans; ▪ Decreased levels of isolation; and, ▪ Increased likelihood women have custody of their children at discharge.
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	▪ Appears the program is effective but does not specify to what extent. Limited information in publicly released documents.
HerWay Home	N/A
The Mothering Project	N/A
New Choices	▪ Centralized model of care; and, ▪ One-stop model of care.
Homeless Prenatal Program (USA)	▪ Healthy women and babies; ▪ Healthier families; ▪ Reduction in risk behaviours; and, ▪ Increased employment.
Toronto Centre for Substance Use in Pregnancy	▪ Increase in positive maternal and infant health outcomes; and, ▪ Increased social support networks.

Homeless At-Risk Prenatal Program (USA)	▪ Pregnant substance-using women can have positive maternal and infant health outcomes when they receive comprehensive care in a family medicine setting
KidsFirst	Unspecified
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	▪ Long-term relationship between mentor and client were established; ▪ Building of trusting relationships; and, ▪ Effective in reducing risk factors.
Parent-Child Assistance Program (USA)	▪ Effective reduction of alcohol and drug use; ▪ Increase in birth control mechanisms; and, ▪ Relationship building between caseworker and client.
St. Michael's My Baby and Me Infant Passport Program	▪ Effective in that women attended the majority of their appointments, improved their knowledge and nutritional status and 90% had babies who were a health birth weight.
First Steps Housing Project Inc.	▪ All babies born were health birth weight; and, ▪ Women noted increased self-esteem and knowledge.
Supportive Housing for Young Mothers	▪ Generally successful, however, limited information on children's birth outcomes and mothers' health outcomes.
Villa Rosa	▪ Healthy birth weight babies; ▪ Healthier mothers; and, ▪ More educated and knowledgeable.
What can be learned for successful delivery of programming for street-involved pregnant women?	
Sheway	▪ Assistance on practical, basic needs; ▪ Perspective of Sheway staff and outreach workers; ▪ Multidisciplinary, comprehensive services provided on a drop-in basis (no appointment necessary); and, ▪ Clients choose and decide which services and supports they will access through pregnancy and prenatal period. They determine their priorities and how the staff can best accommodate their needs and support their self-determination; ▪ The association between service utilization and infant well-being is seen as a combined influence of clients' motivation and self-understanding of their needs, ability to access

	services and the agency's service delivery. This speaks to the resiliency and resourcefulness of the client population (Marshall et. al, 2005).
Breaking the Cycle	▪ Prevention through early identification; ▪ Improved child and health functioning; ▪ Improved parenting skills; ▪ Improved child development outcomes; ▪ "one-stop" and integrated service model proved to be advantageous to clients and deemed effective by partner agencies and other referral sources (Program evaluation report 1995-2000); ▪ Access to onsite programming and child care; ▪ Non-judgmental staff; ▪ Quality of and access to a wide range of programs; and, ▪ Building capacity through service, research and teaching.
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	Unspecified
HerWay Home	N/A
The Mothering Project	N/A
New Choices	▪ Centralized model of care; and, ▪ One-stop model of care.
Homeless Prenatal Program (USA)	▪ Comprehensive service delivery; ▪ Harm reduction and client driven approach; and, ▪ Training and employment for women (over half of staff were former clients).
Toronto Centre for Substance Use in Pregnancy	▪ Pregnant substance-using women can have positive maternal and infant health outcomes when they receive comprehensive care in a family medicine setting
Homeless At-Risk Prenatal Program (USA)	▪ Client-centred programming; ▪ Client-driven goals and interventions; and, ▪ Flexibility and community care.
KidsFirst	▪ Utilizing untraditional methods for mental health and addictions supports (e.g.,

	counsellors go where family is most comfortable); ▪ Program staff building relationships with multiple stakeholders (Program evaluation summary, 2010); ▪ Voluntary participation; ▪ Strengths-based approach; and, ▪ Community integration.
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	▪ Long-term connection with clients; and, ▪ Demonstrated pre-post analysis and reduction of risk factors.
Parent-Child Assistance Program (USA)	▪ Long-term relationship between client and caseworker; and, ▪ Home visitation model.
St. Michael's My Baby and Me Infant Passport Program	▪ Utilizing an infant passport appears to be a good way to engage women and allow them to be involved and in charge of their health and their babies health; and, ▪ The passport serves as a memory document for women who may not have other means of obtaining or tracking that information.
First Steps Housing Project Inc.	▪ Residential program to provide services and shelter for pregnant and parenting teens; and, ▪ Transition to independent living through mentoring, training and assistance.
Supportive Housing for Young Mothers	▪ One on one coaching was successful; and, ▪ Offering school programming.
Villa Rosa	▪ Residence supported learning and education; and, ▪ The environment supported health mothers and the development of healthy babies.
What challenges still need to be addressed for successful delivery of programming for street-involved pregnant women?	
Sheway	Evaluation report from 2000 details: ▪ Securing more space; ▪ More alcohol and drug counselling and broader substance use treatment and support services; ▪ More children's and parenting services; ▪ Expansion of outreach efforts;

	▪ Sponsoring of creative programming (e.g., art therapy) (in updated Burglehaus & Stokl (2005) document, the program has been updated to include music and energy therapies); ▪ Peer support (in updated Burglehaus & Stokl (2005) document, the program has been updated to include peer counselling); ▪ Expand Aboriginal programming (in updated Burglehaus & Stokl (2005) document, the program has been updated to include traditional therapies like smudging); and, ▪ Services for women and children aged 18 months to five years.
Breaking the Cycle	▪ Integration of domestic violence programming; ▪ Integration of programming to support employment; and, ▪ Extending interventions to children with FASD in foster care.
Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women	Unspecified
HerWay Home	N/A
The Mothering Project	N/A
New Choices	Unspecified
Homeless Prenatal Program (USA)	Unspecified
Toronto Centre for Substance Use in Pregnancy	▪ Increased peer support, mentoring from former clients and an onsite parenting group.
Homeless At-Risk Prenatal Program (USA)	▪ Improving strategies to reach target population; and, ▪ Streamlining interventions and services.
KidsFirst	▪ Difficulty recruiting women prenatally (Program evaluation summary, 2010); ▪ Some families, particularly those with complex needs have not benefited as quickly as those with less complex needs (Program evaluation summary, 2010).
First Steps Fetal Alcohol Spectrum Disorder (FASD) program	Unspecified.
Parent-Child Assistance Program (USA)	Unspecified
St. Michael's My Baby and Me Infant Passport Program	▪ Need for more HR and support services; ▪ Inability to follow-up with clients post-partum; and, ▪ Time taken from other duties for passport program.
First Steps Housing Project Inc.	Unspecified

Supportive Housing for Young Mothers	▪ Struggle with interpersonal relationships at a residence; ▪ Difficulty balancing the constraint of independence and involvement of voice and choice; and, ▪ Funding frustrations.
Villa Rosa	▪ Continuity of service after women leave; and, ▪ Continual support and ongoing communication.

Appendix B – Program Review Charts

Canadian Programs

Document Summary Table: Sheway

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but	▪ Canada	✓

may include Australia, USA)	▪ Australia	
	▪ USA	
Description of Programming/Article		
Document type	Program Evaluation: Poole, 1998; Article: Burglehaus & Stokl, 2005; Article: Marshall, Charles, Hare, Ponzetti & Stokl, 2005. Program Website : http://www.vnhs.net/programs-services/sheway	
Description of target population	Childbearing women and their families who live in the Downtown Eastside of Vancouver. [identified as the poorest neighbourhood in Vancouver. Known for its sex and drug-trade, violence and crime, alcohol and drug misuse, substandard housing and high rate of HIV-related illness].	
Jurisdiction	Canada	
Summary of Programming/Article		
Summary and/or abstract	▪ outreach program located in the downtown eastside of Vancouver, BC ▪ Established in 1993 in response to growing need of pregnant and parenting women in the downtown east side ▪ Active caseload of approximately 100 women at any given time **Mission:** "Sheway is a community outreach program for childbearing women and their families who live in the Downtown Eastside of Vancouver. Sheway recognizes that the health of women is linked to the conditions of their lives and to their ability to influence these conditions. Sheway reaches out to women who are pregnant to assist them with meeting their needs for support, safe living conditions, economic security and physical well-being. The staff works with women to help them develop the information, skills and confidence that they will need to care for themselves and their children. Sheway affirms the right of all women to self-determination within their own cultural, spiritual and social context, and endeavors to link he program with those in the community who share these goals." (Poole, 1998) "Sheway's program model is based on the recognition that the health of women and their	

	children is linked to the conditions of their lives and their ability to influence these conditions" (Burglehaus & Stokl, 2005). **Goals:** To engage women in accessing prenatal care and a range of other supports during pregnancy. ▪ Reducing the isolation of high-risk pregnant women; ▪ Providing a positive experience with a community service which may serve as a basis for further connections; ▪ Supporting improved health of mothers; and, ▪ Reducing harm associated with substance abuse, including reducing the number of infants born with Fetal Alcohol Syndrome or Neonatal Abstinence Syndrome and low birth weight To provide education, referral and support to women to help them reduce risk behaviours, in particular to reduce or stop use of alcohol and other drugs during pregnancy ▪ Sheway provides limited alcohol and drug education and counselling, referrals to treatment, and harm-reduction-orientated medical services To support mothers in their capacity as parents and caregivers To promote health, nutrition and development of children born to women accessing prenatal care at Sheway in the period up to 18 months following birth. **Services:** ▪ outreach and drop-in basis; ▪ Multidisciplinary staff ; and, ▪ Outside agencies provide on-site service to clients. **Services offered:** ▪ Daily hot lunches; ▪ Drop-in tie from noon to 4pm when women and their families can socialize or access services; ▪ Weekly food coupons and food bank hampers for pregnant women; ▪ Emergency food for women in need;

	▪ Nutritional supplements for pregnant women and breastfeeding mothers; ▪ Bus fare for transportation to medical and other appointments; ▪ Formula, diapers, shampoo, soap, toothbrushes and toothpaste; ▪ Donated clothes, baby cribs, toys and car seats; ▪ Outreach services; and, ▪ Recreational and creative programming. **Professional services:** ▪ Pre and postnatal medical and nursing care and other medical and nursing care; ▪ Infant development support; ▪ Peer counselling; ▪ Assistance in accessing available social and financial supports; ▪ Nutrition counselling and support; ▪ Alcohol and drug counselling, methadone prescribing and other support in reducing harm from the use of illicit drugs, referral to treatment services; ▪ Support in developing/improving parenting skills; ▪ Advocacy on housing and legal issues; and, ▪ Referrals to ongoing community supports. **Main successes:** ▪ A service philosophy respectful and supportive of women's self-determination in making needed change; ▪ The provision of practical supports (e.g., hot meals), advocacy on housing and other basic needs; ▪ Outreach to engage women in prenatal care and to assist women in exploring and connecting to other needed services; ▪ The full range of assistance found in a multidisciplinary team of professionals in an accessible drop-in setting; ▪ Leisure and creative programming for women and their families; and, ▪ The active approach in assisting women to face and meet child protection standards of care.

Document Summary Table: Breaking the Cycle

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	
Description of Programming/Article		
Document type	Breaking the Cycle: Measures of progress 1995-2005, Motz, Leslie, Pepler, Moore & Freeman (2006); Breaking the cycle: Measures of Progress 1995-2005 Summary Report, Motz, Leslie,	

	Pepler, Moore & Freeman (2006); Breaking the cycle 1995-2000 evaluation report, Pepler, Moore, Motz & Leslie (2002); Engaging Pregnant women using substances: a review of the breaking the cycle pregnancy outreach program (Leslie & DeMarchi); Breaking the Cycle: Reflections on the first Nine Years (Koren, 2004);Program Website, 2012 Program Website: http://www.mothercraft.ca/index.php?q=breaking-the-cycle
Description of target population	Pregnant women and mothers who are using alcohol or other substances and their children
Jurisdiction	Canada: Toronto
Summary of Programming/Article	
Summary and/or abstract	Created in 1995 to address the needs of: ▪ Women who are pregnant or mothers of young children and who are also struggling with problems related to substance use or recovery issues; and, ▪ Infants and young children (0-6 years) whose physical, developmental and psychosocial health and well-being are at-risk prenatally, at birth, in infancy, in early childhood because of their prenatal exposure to drugs, or their exposure to postnatal environments in which substances are used. Breaking the Cycle serves women: ▪ Who are pregnant and/or parenting at least one child under the age of 6 years and ▪ Who are experiencing problems of substance use or recovery ▪ Who desire support around their substance use or recovery Program Model: ▪ A collaborative, community-based response; ▪ A comprehensive, integrated cross-sectorial system response; ▪ Prevention through early identification; ▪ Improved parenting skills and prevention of maltreatment; ▪ “single access” and “one-stop” model, with pregnancy outreach and home visitation components; and,

	▪ Rigorous evaluation. **The BTC Pregnancy Outreach Program** is a Canada Prenatal Nutrition Program (CPNP) serving homeless, pregnant women with substance use problems. Through a street outreach model, the program provides information, resources, education and case management support. The BTC Pregnancy Outreach Program also offers the "BTC Satellite Group" at St. Joseph's Health Centre. Delivered in partnership with Women's Own Withdrawal Management Centre and the Toronto Centre for Substance Use in Pregnancy (TCUP), this is a combined prenatal/relapse prevention group, with facilitated access to prenatal medical care through the TCUP program. ▪ Relapse Prevention Group ▪ Life Skills ▪ Recovery Group ▪ Individual Addiction Counselling ▪ The Connections Program ▪ New Mom's Support Group ▪ Nobody's Perfect Parenting Program ▪ Cooking Healthy Together ▪ Parent-Child Mother Goose Program ▪ Hanen "You Make the Difference" Group ▪ Mothercraft "Learning Through Play" Group ▪ Access Visits ▪ Make the Connection Group ▪ Developmental/psychological screening and assessment ▪ Parent-Child Counselling ▪ Home Visitation ▪ Parent Relief-Child Care ▪ FASD Diagnostic Clinic ▪ Medical Services ▪ Individual Trauma Counselling

	▪ Breakfast and Lunch program ▪ Clothing Exchange ▪ Transportation

Document Summary Table: Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	**unknown**
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but	▪ Canada	✓

may include Australia, USA)	▪ USA	
Description of Programming/Article		
Document type	Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women Report, 2003; "I've found my voice": Wraparound as a promising strength-based team process for high-risk pregnant and early parenting women (Callieaux & Dechief); Program website, 2012 Program Website: http://www.atira.bc.ca/maxxine-wright-community-health-centre	
Description of target population	women who are pregnant or who have very young children at the time of intake **who are also** impacted by substance use and/ or violence and abuse.	
Jurisdiction	Canada: Surrey	
Summary of Programming/Article		
Summary and/or abstract	The Maxxine Wright Community Health Centre supports women who are pregnant or who have very young children at the time of intake **who are also** impacted by substance use and/ or violence and abuse. Women do not need to have their children in their care to receive support provided there is an ongoing relationship with the child. Note: our current mandate is women who are pregnant or have a child under six months old at the time of intake. Once a woman has completed intake, we can potentially work with her up to her youngest child turns 4 years old. We provide a wide range of women-centred health and social supports, all under one roof. Services are provided in partnership with Fraser Health and the Ministry for Children and Family Development. Offers drop-in programming. **Supports currently offered include:** ▪ Daily hot lunch program ▪ Non-judgmental emotional and practical support ▪ Medical and nursing care ▪ Dental hygienist	

	▪ Alcohol and drug counseling ▪ Donations of clothing, household, food, and baby items ▪ Assistance with housing, income assistance, forms ▪ Access to a social worker ▪ "Re-Discover Parenting" Program ▪ Information and resource referral ▪ 16 Step Empowerment Group (open to all women in the community) ▪ Outreach ▪ "Wraparound" support and facilitation (team based support focused on your strengths) ▪ Advocacy ▪ Safe, welcoming drop-in space and opportunity to socialize with other women and kids ▪ Various other groups may be offered throughout the year **Goals:** ▪ Promote healthy birth outcomes; ▪ Promote healthy early child development, learning and increase school readiness; ▪ Support women, children and their families; ▪ Coordinate services to women, children and their families; ▪ Build and maintain community partnership; and, ▪ Advocate on issues affecting high-risk children, pregnant and parenting women.

Document Summary Table: HerWay Home (In Early Stages)

* Program in early development stages but chart filled out for service demographic and information for the future for the H.E.R Program.

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	Business Case proposal, HerWay Home, 2009; HerWay Home Program: Comprehensive Programming for Women and Children in Victoria (Davoren & Poag).
Description of target population	Pregnant women and new mothers with substance use problems and their babies
Jurisdiction	Canada: Victoria
Summary of Programming/Article	
Summary and/or abstract	▪ Focus on engaging and strengthening relationships with pregnant women and new mothers with substance use problems and their babies; ▪ 'one-stop' comprehensive drop-in centre; ▪ Detox and stabilizing component; ▪ Housing component for women and children Potential to serve up to 270 women each year; and, Modelled after Sheway; Breaking the cycle and Maxxine Wright Community Health. Services HerWay Home will include: ▪ Primary health care; ▪ Perinatal care; ▪ Infant and child services; ▪ Drug and alcohol counseling; ▪ Woman abuse response services; ▪ Parenting support and advocacy; ▪ Nutrition; ▪ Pragmatic supports; ▪ Detox and stabilization services; ▪ Long-term transitional housing

Document Summary Table: The Mothering Project (In Early Stages)

Documents utilized: The Mothering Project: A Template for a Pregnancy and Parenting Support Project for Substance-Involved Women, Ravinsky (2009)

* Program launching in 2013 but chart filled out for service demographic and information for the future for the H.E.R Program.

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but	▪ Canada	✓

may include Australia, USA)	▪ USA	
Description of Programming/Article		
Document type	The Mothering Project: A Template for a Pregnancy and Parenting Support Project for Substance-Involved Women, Ravinsky (2009).	
Description of target population	Pregnant and parenting for substance-involved women	
Jurisdiction	Canada: Winnipeg	
Summary of Programming/Article		
Summary and/or abstract	Modelled after: Breaking the Cycle, Sheway, and Portland Hotel. Five Key program areas: ▪ Obstetric support; ▪ Nutrition; ▪ Parenting/mothering support; and, ▪ Therapy services. Guiding principles: ▪ Attachment Theory; ▪ Harm Reduction; ▪ Women-centred Practice; ▪ Culture-based Approaches; and, ▪ Experiential and Participatory Learning. Services HerWay Home will include: ▪ Primary health care; ▪ Perinatal care; ▪ Infant and child services; ▪ Nutrition program; ▪ Vitamin supplements; ▪ Nutritional awareness;	

	▪ Community kitchen; ▪ Community garden; ▪ Acupuncture; ▪ Yoga; ▪ Parenting support and advocacy; ▪ Parent-child groups; ▪ Toy lending library; ▪ Language and literacy program; ▪ Sharing circles; ▪ Arts-based activities;

Document Summary Table: St. Michael's My Baby and Me Infant Passport Program

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	**Somewhat**
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	**unknown**
	▪ Homeless or street-involved	✓

	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	**Unknown**
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	
Description of Programming/Article		
Document type	Evaluation of "My Baby and Me" Infant Passport, St Michael's Hospital (Wellesley Institute, 2009); Adverse perinatal outcomes associated with homelessness and substance use in pregnancy (Little, Shah, Vermeulen, Gorman, Dzendoletas & Ray, 2005); Project website, 2012 Program Website: http://www.stmichaelshospital.com/partners/caps/wac-cap.php	
Description of target population	young, homeless moms and their babies	
Jurisdiction	Canada: Toronto	
Summary of Programming/Article		
Summary and/or abstract	My Baby and Me that helps to reduce risks for young, homeless moms and their babies by creating a portable health record to help keep track of appointments and health information. The program also includes practical supports and incentives such as TTC fare and grocery vouchers. It also incorporates measures to protect the privacy of the young women who participate. **Goal:** The passport and incentive program were developed to improve maternal and child health outcomes by motivating youth to attend regular prenatal appointments and improve communication and coordination of patient care among health care providers.	

	Purposes: ▪ Functions as a diary for young pregnant homeless women who along with their health care providers record tests performed, test results, progress of the pregnancy, appointments and other information; ▪ Serves as an education resource containing valuable information about pregnancy, labour and baby care; ▪ Documents milestones during pregnancy and early infancy to promote early maternal-infant attachment; and, ▪ Decreases barriers to health care through the incentive program (transportation tokes, food coupons and department store vouchers which are given out at all prenatal and post-partum visits.

Document Summary Table: First Steps Housing Project Inc.

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	✓
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	**unknown**

	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	
Description of Programming/Article		
Document type	Proposal to the Minister of Family and Community Services, 2006; Literature review on homelessness and teenage pregnancy, 2006; Program website, 2012 Program Website: http://www.firststepshousing.com/index.html	
Description of target population	homeless pregnant and parenting youth.	
Jurisdiction	Canada: Saint John	
Summary of Programming/Article		
Summary and/or abstract	First Steps Housing Project Inc. (First Steps) was developed in Saint John because of the high teen pregnancy rate and the lack of support facilities for young women and their babies. These mothers and their children are in jeopardy of poverty, illness and abuse. First Steps provides a supportive environment where young mothers can continue their education, further their personal development and gain the skills required to thrive as individuals and as parents. To create a better community for us to live and offer long-term solutions in breaking the cycle of poverty, criminal activity, violence, abuse and dependence on the public system. In Saint John New Brunswick, on May 22, 2002, First Steps Housing Project Inc. opened its doors to homeless pregnant and parenting youth.	

	The aim of First Steps is to provide a supportive transitional housing facility for homeless pregnant youth and their infants. First Steps strives to ensure that homeless pregnant young women will have a healthy pregnancy and a healthy baby; and through partnering with existing community services will assist these young women in moving from homelessness to self-sufficiency and a better quality of life. Services: ▪ Access to prenatal care; ▪ Provision of proper nutrition; ▪ Education on child care and child development; ▪ On-site education program; ▪ Assisting parents make the transition to stable housing; ▪ Second-stage housing program; ▪ Counselling; ▪ Drug and alcohol information; ▪ Social network support from other pregnant and parenting young women

Document Summary Table: Homeless At-Risk Prenatal Program

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓

	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	**unknown**
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	**Unknown**
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	Homeless At-Risk Prenatal Program: A Formative Program Evaluation, 2010; Nursing interventions to support homeless pregnant women: lessons from the Homeless At-Risk Prenatal Program (Miss, Gorman, Fordham & Murphy, 2010)
Description of target population	Homeless pregnant women
Jurisdiction	Canada: Toronto and Scarborough
Summary of Programming/Article	
Summary and/or abstract	**HBHC Prenatal and Homeless At-Risk Prenatal (HARP) Programs** Public Health Nurses provide one-to-one visits to pregnant women who are adolescents (19 years and under) or are 20 – 24 years old with developmental delays, and/or are homeless or at-risk of becoming homeless. The goal of this program is to increase accessibility to prenatal

	care and community resources. Client needs influence the overall goals for service and how interventions are delivered. Ultimate HARP goals are to support a healthy pregnancy. Services are delivered in the community (e.g., in shelters/coffee shops) and services are provided city wide. Client-centred and non-judgmental model. Interventions offered: ▪ Supportive listening/counselling; ▪ Outreach nursing assessment; ▪ Prenatal house assessments; ▪ Housing assessment; ▪ Social support assessment; ▪ Mental health assessment; ▪ Health teaching and literature; ▪ Supportive accompaniment; ▪ Advocacy; ▪ Service coordination; and, ▪ Referrals.

Document Summary Table: KidsFirst

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	**Somewhat**
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	

	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	Saskatchewan KidsFirst Program Evaluation: Report of the Qualitative Study (2010); Saskatchewan KidsFirst Program Evaluation: Report of the Quantitative Study (2010);The Effectiveness of Home Visitation Interventions similar to KidsFirst, Saskatchewan: A Focused Literature Review (2010); Saskatchewan KidsFirst Program Evaluation: Summary of Findings and Recommendations (2010); KidsFirst program website (2012) Program Website: http://www.education.gov.sk.ca/KidsFirst
Description of target population	*"KidsFirst* is a voluntary program that helps vulnerable families to become the best parents they can be and to have the healthiest children possible. The program enhances knowledge,

	provides support and builds on family strengths" (website, 2012).
Jurisdiction	Canada: Saskatchewan
Summary of Programming/Article	
Summary and/or abstract	*KidsFirst* is a voluntary program that helps vulnerable families to become the best parents they can be and to have the healthiest children possible. The program enhances knowledge, provides support and builds on family strengths. *home visitation program The *KidsFirst* program is not designed to replace existing services, but to enhance existing programs in the community. Parents and their children under five years of age who live off-reserve in the targeted areas are assessed for program eligibility. The in-home assessment looks at family strengths. Those who can best benefit from *KidsFirst* services are eligible for the program. **Vision:** "Children living in very vulnerable circumstances enjoy a good start in life and are nurtured and supported by caring families and communities. In targeted high-needs communities, supports and services are provided through partnerships between families, communities, service organizations and governments". (Program evaluation summary, 2010). **Goals:** ▪ Children in very vulnerable situations are born and remain healthy; ▪ Children living in very vulnerable circumstances are supported and nurtured by healthy, well-functioning families; ▪ Children living in very vulnerable situations are supported to maximize their ability to learn, thrive and problem-solve within their inherent capacity; and, ▪ Children living in very vulnerable situations are appropriately served by the KidsFirst program and support (Program evaluation summary, 2010).

	***Services*:** ▪ Support from a home visitor who provides assistance regarding child development, parenting and connecting to the community; ▪ Help to access services such as childcare and parent support groups; ▪ Early learning opportunities for children; ▪ Help regarding literacy, nutrition, transportation and specialized counseling services; ▪ Prenatal Referral and Support; ▪ In-hospital Questionnaire; ▪ Assessment; ▪ Home Visiting Services; ▪ Mental Health and Addiction Services; ▪ Early Learning and Childcare ; ▪ Family Support Opportunities ; ▪ Cooking activities and nutrition programs; ▪ Milk vouchers, food boxes and referrals to food banks;

Document Summary Table: Supportive Housing for Young Mothers

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓

Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	**unknown**
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	Building Community: The Story of Supportive Housing for Young Mothers (SHYM) Final Report (Karabanow, Hughes & Hadley, 2008); Program website (2012) Program Website: http://www.shym.ca/
Description of target population	Young women, ages 16 to 24, who are pregnant or parenting, and who have no safe place to live.
Jurisdiction	Canada: Halifax
Summary of Programming/Article	
Summary and/or abstract	Supportive Housing for Young Mothers (SHYM) began in January 2002 when a group of concerned community members met to address the problems that young, single mothers face when trying to make a safe and suitable home for themselves and their child(ren). Some of us were once young mothers, and some of us worked with young mothers.

Mission

Supportive Housing for Young Mothers (SHYM) helps young moms and their children develop the skills they need to build strong families in a safe, encouraging environment.

Our priority is young women, ages 16 to 24, who are pregnant or parenting, and who have no safe place to live.

Objectives

- Reduce the risk of violence, addictions, inadequate prenatal and postnatal nutrition and care, child development delays and social isolation for young mothers and their children;
- Provide safe and secure housing where residents can acquire the life management and parenting skills essential to independent living;
- To provide a safe and nurturing environment for the children involved in the program;
- To provide individually tailored action plans that address the specific needs of residents; and,
- To provide a supportive and nurturing environment that includes individual counseling, the development of support networks and access to training and educational supports.

The SHYM program is housed in one building, a former elementary school in Woodside (341 Pleasant Street). SHYM is staffed by a wonderful group of professionals. Direct support is offered by Family support workers, Program staff, child-minding staff and a live-in staff so that there is support available to SHYM families 24 hours per day. Live-in support staff are on duty weekends and evenings. Individual support is provided on an as-needed basis. We also help young mothers to make use of other services in the community, and to keep any ties that you already have with family, friends, teachers, counselors, etc., who are supportive of you.

Group programming, aimed at health promotion, independent living/household management skills, parenting skills, and building knowledge in the areas of child development, woman

	abuse, healthy relationships, self-advocacy, poverty, and racism. Support, education, referrals, and advocacy will be provided to assist tenants in returning to school and/or work and pursuing their goals. Tenants are able to live in the SHYM program for up to 24 months, with assistance provided for women preparing to graduate from SHYM. **Programs:** ▪ Physical Wellness ▪ Parenting Education ▪ Cooking & Nutrition ▪ Career Planning & Education Support ▪ Budgeting ▪ Household Management

Document Summary Table: Villa Rosa

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓

	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	Villa Rosa Annual Report 2011-2012; Supporting the bruised reed: a longitudinal study of young single moms (1985-1995) (Currie & Zimmer, 2002); Program website, 2012 Program Website: http://www.villarosa.mb.ca/
Description of target population	single, pregnant woman or new mother
Jurisdiction	Canada: Winnipeg
Summary of Programming/Article	
Summary and/or abstract	Villa Rosa is a prenatal and postnatal residence offering a wide variety of programs in a safe and nurturing environment. Any single, pregnant woman or new mother may access our services. Villa Rosa was founded over a century ago by the Misericordia Sisters, who created a respectful place where young women could find shelter during their pregnancies.

Mission:
To provide educational, health and social services to young single women and their families during and after pregnancy, in the Province of Manitoba. Programs are offered in a safe, nurturing environment that encourages personal growth, and carried out in a fiscally responsible, culturally competent manner.

Our clients are often our society's most vulnerable women who come from lives of abuse, addiction, and violence who are seeking a safe and healthy environment to prepare for their future. At Villa Rosa they are offered support, education, information and the opportunity to live in an alcohol and drug-free environment.

Since its inception Villa Rosa has served over 14,000 women and their children.

- Provide a safe place to live during and after pregnancy;
- Counselling and life skills training;
- Opportunities to learn a healthy lifestyle;
- Offer an education program to get back to or stay in school; and,
- Provide access to community services such as midwives, the medical system, and elders.
- Mothers live in an alcohol- and drug-free environment
- Good nutrition
- 24-hour breastfeeding support
- On-site school with three teachers
- Counselling and programming available in a supportive, non-judgmental environment
- On site pre-natal classes

Villa Rosa's Services:
- Post Natal House;
- Parent-child centre;
- Toddler room;

	▪ Breast feeding support; ▪ Medical care; ▪ Follow-up program; ▪ School; ▪ Moms group; ▪ Early literacy; ▪ Aqua size and yoga; ▪ Smoking awareness; ▪ Speakers; ▪ Decision making; ▪ Adoption support group; ▪ Anger management; ▪ Parenting the newborn; ▪ Nobody's perfect and being a parent; ▪ Budgeting and nutrition; ▪ Cooking program; ▪ Saving circle program; and, ▪ Spirituality.

Document Summary Table: First Steps

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓

	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	✓
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	

Description of Programming/Article	
Document type	The effectiveness of a community-based intervention program for women at-risk giving birth to a child with fetal alcohol spectrum disorder (Rasmussen, Martens, Denys, Badry, Henneveld, Wyper & Grant, 2010); Program website, 2012 Program Website: http://www.catholicsocialservices.ab.ca/CSSFindServicesbyCategory/childrenfamilyandcommunity.aspx?id=143
Description of target population	women who are pregnant or who have recently given birth and have used drugs or alcohol during the pregnancy
Jurisdiction	Canada: Edmonton
Summary of Programming/Article	

Summary and/or abstract	The First Steps Program offers mentorship to women who are at high risk of giving birth to a child with FASD (Fetal Alcohol Spectrum Disorder). This includes women who are pregnant or who have recently given birth and have used drugs or alcohol during the pregnancy. Mentors work with women for 3 years. First Steps is intended for women who are pregnant or up to six months postpartum, who have used drugs or alcohol during pregnancy. They wish to make a change in their lives and lack connections to other community services. Service is also provided in the community, with home visits and transportation support as needed (e.g., doctor's appointments and addiction counselling appointments). The program was modelled on the Parent-Child Assistance Program which began at the University of Washington. Case managers develop a positive, empathetic relationship with their clients, help mothers identify person goals and the explicit steps to achieve them and monitor progress. **Program Outcomes** ▪ Clients will identify personal goals and work together with their mentor to meet those goals. Goals might include: finding housing, establishing an income, addressing family violence issues, learning about parenting, and addressing addiction issues; and, ▪ To reduce the number of children who are pre-natally exposed to alcohol and/or other drugs . **Services:** ▪ Provision of support; ▪ Development of goals and outcome supports; ▪ Coordination of multidisciplinary care; and, ▪ Drug and alcohol treatment referrals.

Document Summary Table: Toronto Centre for Substance Use in Pregnancy

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	
Description of Programming/Article		
Document type	Comprehensive treatment program for pregnant substance users in a family medicine clinic (Ordean & Kahan, 2011); Program website, 2012	

	Program Website: http://www.stjoe.on.ca/programs/family/tcup.php
Description of target population	mothers who abuse alcohol or drugs during pregnancy
Jurisdiction	Canada: Toronto
Summary of Programming/Article	
Summary and/or abstract	The Toronto Centre for Substance Use in Pregnancy (T-CUP) is a comprehensive substance use program for pregnant women. Based within the Family Medicine Centre, we offer "one-stop" access to multidisciplinary addiction, obstetric and neonatal care in an empathic and non-judgmental environment. We provide both substance abuse counselling and medical care for you and your baby. We will follow you during your pregnancy and deliver your baby, or we can work with your existing family doctor to “share your care.” We will also give you honest information about the known risks to your baby due to substances used during pregnancy. T-CUP will also connect you with other important services, such as inpatient treatment or other substance use programs. We also have experience with methadone maintenance therapy in pregnancy and how to prescribe in a way that is safe for you and your baby. We are a team consisting of family doctors, a nurse clinician and a social worker. We also have access to obstetricians, paediatricians, psychiatrists and other specialists at SJHC. The T-CUP program is part of the Family Medicine Centre, located on the Ground Floor of St. Joseph’s Health Centre. All appointments are booked in advance, but when our patients have urgent concerns, they can phone the Family Medicine Centre at 416-530-6860 to speak to a nurse. The nurse will then provide you either with instructions or with an urgent care appointment with one of our physicians. ▪ One-stop model ▪ Utilization of harm reduction and women centred philosophy of care

Document Summary Table: New Choices

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	✓
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	✓
	▪ USA	
Description of Programming/Article		
Document type	"New Choices" for women with addictions: perceptions of program participants (Sword, Niccols & Fan, 2004); Program website, 2012	

	Program Website: http://www.inform.hamilton.ca/record/HAM1987?UseCICVw=38
Description of target population	women with substance use issues who are pregnant and/or parenting young children
Jurisdiction	Canada: Hamilton
Summary of Programming/Article	
Summary and/or abstract	The New Choices program is an example of a "one-stop shopping" model for women with substance use issues who are pregnant and/or parenting young children. The program components include addiction groups and counselling, nutrition counselling and skill development, parenting education, peer support, and an enriched children's program. In addition, it provides linkages with prenatal services, a family physician, a perinatal home visiting program, and other services as needed. The program is not set in terms of a specific structure or length of time which allows services to be tailored to meet the needs of individual women. Attendance at New Choices ranges from 1 to 12 months, with the average length of involvement being 4 months. Sometimes clients will be involved for a few months, leave, and then return to the program at a later date. New Choices offers a one-stop setting for pregnant and parenting women/teens with substance use concerns, and their children ages 0-6. Services for women include assessment, treatment and referral and both individual and group counselling concerning substance use. Outreach services are also provided to mothers and children. Services for women also include prenatal and postnatal education, and general wellness. Parenting education and support is provided both individually and in group format as well as through interactive play between mother and child. Services for children include individualized therapeutic play programs that promote physical, social, and emotional development, developmental screening and assessment, and speech and language services. Children have access to early identification, assessment and intervention services. By locating a team of staff from a range of services at one site, a

	woman/teen can receive assessment of her own needs and those of her children and support in her parenting efforts. Bus tickets and food vouchers are available.

International Programs

Document Summary Table: Homeless Prenatal Program

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	✓
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓

	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**
Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	
	▪ USA	✓

Description of Programming/Article	
Document type	Intervention with high-risk alcohol and drug-abusing mothers: II. Three year findings from the Seattle model of paraprofessional advocacy (Ernst, Grant, Streissguth & Sampson, 1999) Program website, 2012 Program Website: http://depts.washington.edu/pcapuw/
Description of target population	mothers who abuse alcohol or drugs during pregnancy
Jurisdiction	USA: Seattle
Summary of Programming/Article	
Summary and/or abstract	The Homeless Prenatal Program (HPP) is an award-winning San Francisco Family Resource Center. For more than 20 years, HPP has provided poor and homeless families the ability to end childhood poverty. Built on a foundation of supportive, nonjudgmental case management, we empower families, particularly mothers motivated by pregnancy and parenthood, to recognize their strengths and trust in their own capacity to transform their lives. **Mission:** In partnership with our families, break the cycle of childhood poverty **Purpose & Philosophy:** By seizing the motivational opportunity created by pregnancy and parenthood, HPP joins with families to help them recognize their strengths and trust in their capacity to transform their lives. **Organizational Values for Working with Clients:**

- We believe that people can change and they want a better life for themselves and their children.
- Every mother wants to deliver a healthy baby and become a good parent.
- We are committed to providing a non-judgmental, motivating and empowering environment that builds trust and strengthens the family.
- We show respect to every client and treat them with empathy and compassion.
- We are committed to providing a culturally sensitive environment and services to all families.
- We recognize that people have strengths and do not need to depend on us or any other agency or system.
- We never give up on anyone; they are always welcome to come back.
- We believe in the importance of building a sense of community among families who have no other source of support.
- HPP honors diversity and respects the culture and dignity of each family.

As the first agency in San Francisco to hire former clients as program and case managers, the agency's growth and evolution have been guided by those we serve. Because case managers share some of the same life experiences as the women they help, they are able to create a relationship of trust and credibility with clients. They partner with clients to design a plan for health and self-sufficiency; they serve as role models for clients who want to turn their lives around, and they have been instrumental in expanding our services when they see the need in their clients. Today, more than half of HPP's program staff are former clients.

HPP has three major goals:
Healthy Babies: ensure that parents give birth to healthy babies and successfully bond with their infants
Safe, Nurturing Families Where Children Thrive: ensure that parents are knowledgeable, motivated and empowered to support their children's success and healthy development
Economically Stable Families: ensure that families have access to information and resources that move them towards permanent, stable housing and economic self-sufficiency.

	Over the past 20 years, HPP evolved from focusing solely on prenatal care for mothers into a Family Resource Center with a broader, more holistic mission – breaking the cycle of childhood poverty. More than 3,000 families access HPP's services each year, with nearly 200 families coming to HPP for the first time every month. Today, HPP offers services focused on housing, prenatal and parenting support, child development, family finances and stability, access to technology, domestic violence and substance abuse, family unification, and emergency support of basic needs. By combining critical prenatal education and parenting classes, HPP's Wellness Center increases healthy birth outcomes, promotes maternal and infant health and well-being, improves strong parent-child bonding, and teaches effective parenting skills. The Wellness Center: ▪ Teaches prenatal classes and offers on-site group prenatal care ("Centering Pregnancy") in English and Spanish. ▪ Conducts post-partum services, including home visits to promote parent-child bonding, assessing basic household needs (e.g., food, clothing, furniture, baby supplies, etc.), evaluating babies' development, ensuring follow through on medical appointments and supporting new parents through the stress of raising babies. ▪ Offers health services including yoga, massage, acupuncture and doula (birth coach) support. ▪ Provides activities to bring new mothers together, form lasting friendships, and build a community. Since 1995, 164 women have entered the Community Health Worker (CHW) Training Program; 132 (82.9%) graduated the program and 124 of the graduates (93.9%) found jobs or pursued educational opportunities within 30 days of graduation. The CHW Training Program is an intensive, 12-month paid job training program that prepares up to eight women at a time (most of whom are former HPP clients) for meaningful employment in career fields that provide a path to financial security. Community Health

	Workers: ▪ Fulfill important HPP functions, such as managing the reception desk, client intakes, client records in the database, and community outreach. ▪ Participate in weekly trainings with HPP staff. ▪ Build office, computer, language, and writing skills. ▪ Attend classes and continuing education programs at City College of San Francisco. ▪ Participate in an outside internship with a collaborating CBO (community-based organization) for additional work experience and exposure to potential employers. Since January 2011, clients utilized the community technology center over 3,000 times. Of those, more than 1,000 performed housing searches and more than 1,200 performed job searches. The Community Technology Center (CTC) is open daily for clients to learn how to use computers, set up an email account, create resumes, conduct job and housing searches on the Internet and research health questions (such as those related to substance abuse and mental illness). In addition to the practical skills and resources gained from the CTC, clients – many of whom have never touched a computer before – overcome their fear of technology and are empowered to accomplish their goals. The CTC is staffed by trained and experienced volunteers who tutor clients on a one-on-one or group basis on basic computer and online job search skills. These sessions are offered to clients in both English and Spanish. HPP believes that building a strong foundation of stable support for families requires addressing issues related to mental health, domestic violence, and substance abuse in our clients' lives, in addition to basic emergency needs and child care. Along with our case management and prenatal and parenting programs, HPP offers these critical support services: ▪ Mental Health Wellness ▪ Domestic Violence Services and Referrals ▪ Child Welfare, Family Unification and Substance Abuse ▪ Childcare Services for Clients

	▪ Emergency Needs Mental health services and resources include: ▪ One full-time and two part-time therapists onsite that offer private, one-on-one counseling for clients, including mother and child counseling, to help them evaluate themselves, their histories, and their environments to identify behavioral patterns or events that may influence the clients' present situations. ▪ A partnership with UCSF's Child Trauma Research Project to support families healing from trauma. ▪ Parent/peer support groups and parent/child playgroups ▪ Through staff and volunteers, HPP offers ESL (English as Second Language), art, gardening, quilting and sewing classes which are both practical and therapeutic to clients. HPP offers critical services to families affected by domestic violence, starting with safe shelter. HPP then offers: ▪ Support to file a police report, obtain a restraining order and connection with pro-bono legal services. ▪ Crisis therapy for parents and children. ▪ Ongoing, intensive group therapy sessions led by our Mental Health Program Supervisor and victim support groups. ▪ Referrals to appropriate domestic violence providers (e.g., La Casa de las Madres, Riley Center and W.O.M.E.N. Inc.). Since July 6, 2007, HPP provided case management for over 300 women seeking to reunify with their children. HPP case management and advocacy helps parents with substance abuse issues work to reunite their families. By partnering with City and County of San Francisco Human Services Agency, Child Protective Services, the courts, attorneys, hospitals, clinics, substance abuse

	treatment programs and other community-based organizations, HPP helps parents overcome addictions through three programs: ▪ **Drug Dependency Court** – for parents in recovery who are reunifying with their children through the San Francisco Superior Court. ▪ **New Beginnings** – for pregnant women who are currently abusing substances or have abused drugs in the past 12 months. ▪ **Keeping Families Together** – for parents who are alleged to have neglected or abused their children with substance abuse as a factor. ▪ These programs guide and support parents to take the necessary steps (e.g., entering treatment programs, counseling, parenting classes, Narcotics Anonymous meetings) to reunite with their children who have been placed in foster care and/or avoid losing their children to foster care because of substance abuse. While parents received onsite services, trained child development staff cared for almost 900 children in HPP's Childcare Center last year. Staff also helped the families of 180 children apply for subsidized childcare, pre-school and after-school programs. Childcare services include: ▪ A drop-in childcare center is staffed by bilingual caregivers trained in child development that consult with Family Case Managers on children's' development ▪ Weekly playgroups for parents and their children to strengthen parent/child bonds. ▪ Assistance in applying for subsidized childcare programs and registering for free high-quality preschool. HPP offers critical resources for families, helping them get through times of crisis. Services include: ▪ Emergency food vouchers for groceries and meals including food bags supplied by the San Francisco Food Bank. ▪ Vouchers for temporary housing in SROs (single room occupancy hotels) while families wait to get into shelters or housing. ▪ Fees for IDs, licenses, birth certificates; school supplies, and clothing for children and

	bus/cab fare to appointments, classes, job interviews, and for emergency medical situations. ▪ Diapers, cribs, strollers and car seats.

Document Summary Table: Parent-Child Assistance Program

Inclusion Criteria Checklist		
Category	**Inclusion Criteria**	**Criteria Met? (✓/ X)**
Programming	▪ Offers programming similar to H.E.R. in the context of street-involved pregnant women as well as at-risk non-pregnant women and low socio-economic status populations.	✓
	▪ Utilize peer-supported and harm reduction models of service delivery (NR)	
	▪ Minimum 1 year length for program	✓
	▪ English language programming	✓
	▪ Grey literature	✓
	▪ Published literature	
	▪ Literature from 2002 – present (10 years)	✓
Target Population of Program (focus on street-involved pregnant women/youth AND/OR other characteristics)	▪ Youth (aged 12-17 years)	✓
	▪ Adult women (aged 18 years or older)	✓
	▪ Aboriginal descent (including American Indian, Native American and other Aboriginal populations) or recognized minority (NR)	✓
	▪ Homeless or street-involved	✓
	▪ Transitional or unstable housing (NR)	✓
	▪ Addiction and/or substance abuse (NR)	✓
	▪ Unstable family structures (NR)	✓
	▪ Employed and unemployed (NR)	✓
	▪ Prostitution or other at-risk behaviours (NR)	**Unknown**

Jurisdictions (focus on Canada but may include Australia, USA)	▪ Canada	
	▪ USA	✓
Description of Programming/Article		
Document type	Intervention with high-risk alcohol and drug-abusing mothers: II. Three year findings from the Seattle model of paraprofessional advocacy (Ernst, Grant, Streissguth & Sampson, 1999) Program website, 2012 Program Website: http://depts.washington.edu/pcapuw/	
Description of target population	mothers who abuse alcohol or drugs during pregnancy	
Jurisdiction	USA: Washington	
Summary of Programming/Article		
Summary and/or abstract	The Parent-Child Assistance Program (PCAP) is a home visitation intervention program that works with women who abuse alcohol or drugs during pregnancy, with the aim of preventing future alcohol- and drug-exposed births among these mothers. PCAP supports mothers in achieving this goal by helping them complete substance abuse treatment and stay in recovery and by motivating them to choose effective family planning methods. Case-managers address the health and social well-being of mothers and their children and help participants reduce alcohol and drug use. Advocates are paraprofessionals who have personal experience with many of the same adverse circumstances as their clients and can therefore serve as positive role models. PCAP does not provide direct alcohol treatment, drug treatment, or clinical services. Advocates visit client homes, transport clients and their children to important appointments, and link clients with appropriate service providers. The intervention lasts 36 months. Advocates visit client homes weekly for the first 6 weeks, then at least once every 2 weeks, depending on client needs, for the duration of the program. The goals of the program are to (1) assist mothers in obtaining treatment, maintaining recovery, and resolving the complex problems associated with their substance abuse; (2) guarantee that the children are in a safe environment and receiving appropriate health care;	

	(3) effectively link families with community resources; and (4) demonstrate successful strategies for working with this population to prevent the risk of future drug- and alcohol-affected children. PCAP provides trained and supervised case managers who work with a caseload of 16 mothers and their families for three years, beginning during pregnancy or up to six months postpartum. The case managers offer regular home visitation and link women and their families with a comprehensive array of existing community resources to address health care, housing, child welfare, and other issues. Case managers help mothers identify personal goals and the steps necessary to achieve them; they monitor progress, facilitate case conferencing and integrated service delivery among providers, transport clients and children to important appointments, and work actively with the extended family. **PCAP's primary aims are:** ▪ to assist substance-abusing pregnant and parenting mothers in obtaining alcohol and drug treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse; ▪ to assure that the children are in safe, stable home environments and receiving appropriate health care; ▪ to link mothers to community resources that will help them build and maintain healthy, independent family lives; ▪ to prevent the future births of alcohol and drug-affected children. **Core components include the following:** ▪ PCAP is a three-year home visitation model, implemented by highly trained, clinically supervised case managers. ▪ Caseload recommendation is no more than 16 active client families per case manager. ▪ Case managers maintain frequent contact with client families through home visits; recommended minimum is two home visits per month. ▪ Case managers conduct initial needs assessment, help clients define personal goals

	and identify the incremental steps necessary to meet those goals, help clients work toward those goals, and evaluate and re-establish goals every four months. ▪ Case managers develop a network of contacts and relationships with client's family and friends, and provide advocacy for other family members as needed. ▪ Case managers link clients with substance abuse treatment, provide support for treatment completion and recovery, and help clients develop relapse prevention strategies. ▪ Case managers develop and maintain professional relationships with community service providers and link clients with appropriate and available services, including, but not limited to, family planning, safe housing, health care, domestic violence services, parenting skills, and mental health services. ▪ Case managers offer transportation for client's important appointments. ▪ Case managers work with both the mother and the target child throughout custody placement changes. ▪ Clients are not asked to leave the program because of relapse or setbacks. ▪ Clinical supervisors meet with case managers for individual supervision and group staffing at least twice monthly. ▪ Case managers monitor client progress and outcomes according to PCAP protocols.

Appendix C – References

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