The Psychosocial History: An Interview for Pregnant and Parenting Women in Substance Abuse Treatment and Research

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INTRODUCTION

Psychosocial evaluations are commonly required of individuals at enrollment in substance abuse treatment and research programs. The purpose of these assessment procedures is to describe the demographics, personal characteristics, pertinent history, and current biopsychosocial status of those seeking admission to treatment. The information can be used to determine eligibility for a treatment program or research project or to route clients to the services that best suit their needs. In addition, intake data can be used to establish a baseline description of client for treatment planning and review or of the treatment population for program accountability and evaluation.

Several instruments have been developed to document the psychosocial characteristics of clients (Haller and Ingersoll, this volume), including the extent of alcohol or other drug use. Many assessment tools that measure substance use were based primarily on male subjects, who represented the predominant treatment population at the time the tools were developed (Selzer et al. 1975; Skinner and Horn 1984; Wanberg and Horn 1983). One of the most widely used instruments, the Addiction Severity Index (ASI) (McLellan et al. 1980), was tested initially with a population of male armed services veterans. The ASI was designed to use a minimal set of items across repeated assessments to provide information for clinical treatment planning and treatment evaluation. These two purposes necessitated measurement of a wide range of baseline data and potential outcomes in six areas of personal functioning that might be influenced by substance abuse treatment. The comprehensive nature of the ASI and its capacity for followup assessment make it an attractive instrument for treatment and research settings that are concerned with the multiple problems experienced by individuals who abuse substances.

The most recent edition of the ASI (McLellan et al. 1992) includes new items about important life outcomes, such as physical and sexual abuse and long-term personal relationships. It has been tested with several special populations, including pregnant women, drug-dependent inmates,

and dually diagnosed substance abusers. The ASI has been used widely in substance abuse treatment studies with various populations (McLellan et al. 1992). It was adopted as a measurement instrument by community demonstration projects funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1988, which served homeless alcohol- or other drug-dependent men and women (Argeriou and McCarty 1990). Several Perinatal-20 research demonstration projects, funded by the National Institute on Drug Abuse (NIDA) in 1989 and 1990, adapted the ASI as a measurement instrument for pregnant and parenting drug-dependent women. Before incorporating the ASI into their protocols, a few of these projects added supplementary questions that broadened the scope of the instrument to address more fully the special needs of women (Comfort et al. 1991; Ridlen et al. 1990, pp. 99-109; Brown 1990). This chapter describes the development of the supplemented version of the ASI for women, the Psychosocial History (PSH), developed at the Family Center at Thomas Jefferson University in Philadelphia.

RATIONALE FOR DEVELOPING THE PSYCHOSOCIAL HISTORY

During the past 15 years numerous conferences and publications have addressed the special needs and characteristics of drug-dependent women of childbearing age who are undergoing substance abuse treatment (Beschner et al. 1981; Blepko 1991; Kilbey and Asghar 1992; Mathias 1995; Reed et al. 1982). Reed and Leibson (1981) studied the differences in finances, criminal activity, social support, and living situations between black and white women who attended women's demonstration treatment programs and mixed-gender programs. Subsequently, Reed (1987) investigated the reasons for the limited progress in offering gender-sensitive treatment programs for drug-dependent women who demonstrate behavioral patterns and coping styles different from those of men. Treasure and Liao (1982, pp. 137-212) concluded that substance-abusing women need to focus on self-management, self-development, self-esteem, and self-confidence. These personal improvements are fundamental to the development of functional lifestyles that require new tasks and activities in daily living, improvement of interpersonal skills, and examination of gender-role expectations. Hagan and colleagues (1994) discussed the cycle of dependence faced by urban women of low socioeconomic status. The realities and frustrations associated with basic survival for these women and their families may contribute to self-medicating escape by means of substance abuse.

Assessment of women's personal histories may reveal the presence of dysfunctional family relationships during childhood that can interrupt

healthy personal and family development and lead to aberrant patterns of daily adult functioning. Woodhouse (1992, p. 262) noted common "themes of violence, male dominance, dependence, motherhood issues and depression" throughout life history interviews, focus groups, "life line" drawings, and written exercises she conducted with women in substance abuse treatment. Root (1989) proposed the role of sexual victimization and the use of substances in mitigating posttraumatic stress disorder. Treatment failures may reflect a lack of understanding of the long-lasting sequelae of symptoms following such traumatic experiences. Regan and coworkers (1987) suggested that the history of violence and abuse associated with the lifestyles of female substance abusers, their family, and social environments, and heightened depression place these women and their children at risk for parenting problems, child abuse or neglect, and foster placement.

In a report on drug-exposed infants, the U.S. General Accounting Office (1990) enumerated barriers to women's substance abuse treatment based on information obtained from drug treatment, health, and social service providers. The findings focused on external social and systemic barriers, such as gender and cultural insensitivity, negative community and professional attitudes, fear of prosecution for child abuse, limitations in insurance coverage, and lack of transportation and child care. In a qualitative study of women's perceptions of treatment effectiveness (Nelson-Zlupko et al., in press), women in recovery identified the particular needs that influenced their engagement and outcomes in treatment. These included child care; parenting support; information on and discussion of concerns regarding sexuality, victimization, and gender roles; and assistance with interpersonal relationships.

As part of a NIDA research demonstration project, women in treatment for cocaine dependence were filmed as they described their personal stories of addiction, treatment, and recovery (Kaltenbach et al. 1994). These life story videotapes revealed personal barriers to treatment, with common themes related to addiction and female socialization. Addiction issues such as denial, medication of feelings, control and responsibility, the need for informal support, and the view of relapse as failure recurred as focal points throughout the treatment process. They were accompanied by issues concerning female socialization, such as dependence; expression of feelings; the viewing of a woman's needs as secondary; management of personal, interpersonal, and family responsibilities; and the seeking of treatment for the benefit of others.

To engage women successfully in substance abuse treatment, programs must elicit individual client perspectives, acknowledge their value, and facilitate resolution of needs and issues voiced by clients. Women's

characteristics and the circumstances they face in daily life must be addressed concurrently with addiction in substance abuse treatment programs. To address women's special needs and strengths, substance abuse treatment programs must assess women comprehensively as they enter and proceed through the programs.

CONTEXT FOR DEVELOPMENT OF THE PSYCHOSOCIAL HISTORY

Family Center is a treatment program that offers comprehensive medical and psychosocial services for pregnant and parenting drug-dependent women and their children. Services are provided at both an intensive outpatient program and a long-term residential treatment program, with parent-child centers at both facilities. Family Center uses a multidisciplinary approach, with a team that includes an obstetrician, psychiatrists, nurses, therapists, certified addiction counselors, case managers, and early childhood specialists.

At Family Center psychosocial evaluation is part of a multidisciplinary assessment process conducted at enrollment for treatment and research. Each woman is introduced to the program services, participates in a psychosocial interview, and signs consents for treatment and research with an intake counselor. She also receives a prenatal nursing assessment and a physical examination by an obstetrician. A psychiatric interview is scheduled for each outpatient and residential applicant. A woman who requests entry to the residential program attends an interview with the program staff, during which she visits the residence and is screened for abilities to care for herself and her children and to accept the responsibilities of living in a community environment. Followup psychosocial interviews are conducted with women who participate in research studies at Family Center.

Family Center's outpatient and residential programs together maintain an average monthly census of 100 clients. The women are pregnant (typically early in the second trimester) or parenting at enrollment. The majority reside in the Philadelphia metropolitan area. Approximately 45 percent of the women are African-American, 40 percent are Caucasian, 10 percent are Hispanic, and 5 percent are biracial. They range in age from 19 years to the early forties, with the majority in the 25- to 34-year-old range. Most of the women have completed 11 years of education, and nearly 90 percent have had job experience. The majority of the women receive public and medical assistance and are single heads of households with two or three children per family. Typically, half the children are living with their mothers.

Approximately 70 percent of the clients at Family Center have abused opiates in addition to alcohol and other drugs (e.g., barbiturates, benzodiazepines, amphetamines, propoxyphenes, cocaine, marijuana, nicotine) and are currently maintained on methadone. The primary drug of choice for nearly 25 percent of the clients is cocaine, often used with alcohol, marijuana, and/or tobacco. The other 75 percent are being treated for abuse of opiates or alcohol. At enrollment in Family Center, 87 percent of the women report previous episodes of alcohol or other drug treatment. The majority share living accommodations with family members or partners and their children. Intake interviews with cocaine-dependent clients indicate that 78 percent of the women have been victims of violence during their lifetimes. Rape (50 percent) and domestic violence (48 percent) are the leading types of violence reported.

The average length of time in outpatient treatment for clients at Family Center is 9 months for opiate-dependent women maintained on methadone (range=1 week to 42 months) and 5.8 months for cocaine-dependent women (range=3 weeks to 22 months). Average retention time for cocaine-dependent women in the residential program is 6.3 months (range=2 weeks to 16 months).

STEPS IN DEVELOPING THE PSYCHOSOCIAL HISTORY

The developers of the ASI have emphasized that their semistructured interview can be adapted to the informational needs of programs and to the styles of individual interviewers and clients (McLellan 1992; National Institute on Drug Abuse 1993). They also have encouraged development of supplemental questions that meet the needs of specific populations (A.T. McLellan, personal communication, June 1990; McLellan 1992). With the knowledge and support of the ASI creators, the PSH was designed to meet the clinical requirements of a comprehensive drug treatment program for pregnant and parenting women as well as comply with the research purposes of the NIDA Perinatal-20 research demonstration project. Both the treatment program and the research project required a baseline description of the pregnant woman, her history, current status, and individual needs as she enrolled for services.

Although the ASI tapped all the fundamental areas of life functioning, it seemed to stop short of asking many essential questions concerning women, such as pregnancy status and history, housing and caregiving for children, status of intimate relationships, and history of violence and victimization. Family Center clinical and research staff members developed an instrument that retains the fundamental structure, administrative procedures, and original items of the ASI but expands

on the measure by probing areas relevant to barriers to treatment, women's needs and strengths, and substance abuse treatment outcomes. Examples of supplemental areas of interest include family history and relationships, relationship with partner, responsibilities for children, current health problems, pregnancy history, drug use during pregnancy, previous treatment experiences, history of violence and victimization, and family legal issues.

The development of the PSH required several steps. Initially, instruments were gathered from other research projects that had used the ASI, in adapted form, to assess women entering substance abuse treatment. The Families of Recovering Mothers (FORM) project, funded by NIAAA in Philadelphia (Comfort et al. 1991), and the Family Life Program, a NIDA Perinatal-20 project in Boston, had created substantive modifications that were relevant to the Family Center population. The FORM project integrated new items into the ASI and administered a separate housing and family interview (Comfort et al. 1991), whereas the Family Life Program supplemented primarily the medical and drug sections of the ASI to include pregnancy information (E. Brown, personal communication, July 1990). Items adapted from each of these instruments were woven into the appropriate sections of the PSH to create a logical conversational flow during the interview. The format of the PSH is considerably longer than the ASI because, in addition to extra items, coding instructions and space to record the responses to open-ended narrative questions were incorporated into the instrument. New patient and severity ratings are created to represent the additional areas of life functioning that are included in the PSH.

The original version of the PSH was first administered in November 1990 to pregnant women entering the Cocaine, Pregnancy and Progeny (CPP) project at Family Center, a member of the Perinatal-20 project. This research demonstration project compared the characteristics and outcomes of pregnant cocaine-dependent women and their infants participating in residential or outpatient treatment. The ASI administration manual (McLellan et al. 1985) and training videotape formed the basis of training for the PSH administration. The videotape prepared for the third edition of the ASI (McLellan et al. 1985) was used initially, accompanied by discussion of the manual and role-play activities involving the supplementary PSH items for women. After training was completed, the PSH was integrated into the Family Center intake process for cocaine-dependent women involved with the CPP project. Ongoing discussion continued among the intake specialist, counselors, and the research coordinator to clarify the intent of ASI items and supplementary PSH items and to refine coding details.

The next step in the development of the PSH began when Family Center clinical staff members expressed an interest in extending administration of the PSH to all clients who enrolled at Family Center as a step toward quantifying intake information for the total program. Research and clinical staff members agreed to collaborate in revising the PSH for joint use. It was necessary to retain the items essential to describe the heterogeneity and multiple needs specific to pregnant cocaine-abusing women, as proposed for the research demonstration project. At the same time, information had to be incorporated that had been collected by means of referral forms and a narrative psychosocial interview to create treatment plans and to fulfill the State licensing requirements of the Pennsylvania State Office of Drug and Alcohol Programs (ODAP). The feedback from extensive review and negotiation of PSH versions within Family Center were coupled with outside reviews by an ASI consultant (D. Zanis, personal communication, March 1992), the Philadelphia City Office of Drug and Alcohol Programs, and the Pennsylvania State ODAP (J. Peterson, personal communication, January 1991) to create a revised PSH in 1992. The Family Center intake specialist began administering the revised PSH to all women who enrolled at Family Center in March 1992.

The change in psychosocial assessment procedures from a narrative to a semistructured, coded interview presented advantages and disadvantages for the staff, clients, and program. The PSH provided extensive quantitative and qualitative information for research and clinical use about each woman's personal characteristics, needs, substance use, and life situation as well as descriptive data on the service population in general. It also established a standard set of questions on which data were collected at intake. Unfortunately, the PSH required double the usual psychosocial assessment time from clinical staff members and clients, which in turn decreased the potential number of intake interviews per month. In addition, the increased length of the instrument necessitated many hours of data entry and analysis to obtain meaningful information for client description, program evaluation, and research. Weighing the advantages against the disadvantages, the investigators decided to allocate resources by administering the PSH to all women at Family Center yet entering data in computerized databases only for women enrolled in the CPP project so that both clinical and research commitments were met. Meanwhile, use was made of the experience gained from PSH interviews to refine the instrument by gleaning feedback from intake and research staff members and from data entry personnel and counselors as they gathered information from clients, coded responses, and developed treatment plans. Minor additions, clarifications, and reformatting of the PSH have continued periodically to incorporate new items from the fifth edition of the ASI and suggestions from clinical and research staff members as program evaluation requirements have evolved.

TRAINING FOR THE PSYCHOSOCIAL HISTORY ADMINISTRATION

Family Center was invited to introduce the women's supplements to the ASI on a training videotape developed by NIDA as part of a technical training package (National Institute on Drug Abuse 1993). The module offers two videotapes of simulated ASI interviews and a step-by-step resource manual that details administration and scoring procedures. The ASI training videotapes provide an introduction and comments interspersed with role-plays of ASI interviews by male and female interviewers and clients of various cultural backgrounds, life histories, and interpersonal styles. Excerpts from a PSH interview demonstrate the assessment of the client's pregnancy history, relationship with the father of the baby, current housing arrangements, and responsibilities for children. A brief discussion of the PSH modifications underscores the need to assess the multifaceted problems and strengths of women who participate in substance abuse treatment and research.

Training for PSH interviewers at Family Center begins with the ASI training videotapes. These are viewed along with careful study of the ASI administration manual (McLellan et al. 1990). In addition, specialized training includes discussion of how to organize and ensure the flexibility of the PSH interview to respond to the personal styles and individual capabilities of clients. This session also includes instructions for developing interviewer severity ratings and coding PSH items. Staff members are paired with experienced PSH administrators to observe a PSH interview in process.

PSYCHOSOCIAL HISTORY/ADDICTION SEVERITY INDEX RELIABILITY AND VALIDITY STUDY

Family Center has made the PSH available in its preliminary versions to interested treatment programs and research projects across the country, including the NIDA Perinatal-20 projects and several projects funded by the Center for Substance Abuse Prevention. Before distributing the PSH more widely, Family Center has initiated a collaborative study with the authors of the ASI at the Center for Studies of Addiction, University of Pennsylvania/Philadelphia Department of Veterans' Affairs Medical Center. The study examines the reliability and validity of the PSH in relation to the ASI and tries to determine whether the supplementary items for women provide more complete information about women's treatment needs. In preparation for this study, the authors designed a more focused version of the PSH based on the data and experience gathered during 3 years of development and use of the instrument. This version of the PSH was

based on the recommendations of a committee of Family Center clinicians and researchers who had at least 2 years of experience in using the PSH and on suggestions from another researcher who had used portions of the instrument in a neighboring Philadelphia perinatal addiction program (S. Course, personal communication, January 1994). The revisions take into consideration the content of the ASI, significance of information for clinical or research purposes, ease of item administration and recording of responses, clients' responses to questions, and clarity for data entry, analysis, and interpretation of results.

EXCERPTS FROM THE PSYCHOSOCIAL HISTORY

The PSH supplements to the ASI pertain to substance use during pregnancy, family legal issues, history of violence and victimization, budgeting needs, employment history, perinatal medical status, family history, partner relationships, child care, and current housing arrangements. For most of these topics, additional questions were integrated into each section of the ASI. When several additions were required for a specific topic, such as pregnancy history, child care, and housing arrangements, separate PSH sections were created and interspersed with sections of the ASI to ensure a logical flow in the psychosocial interview. The PSH includes open-ended questions as well as categorical items. As they do with the ASI, interviewers are encouraged to rephrase items, probe the client's responses, and comment freely on the record form to ensure that the intent of the questions and the responses are clearly understood. Excerpts from supplementary PSH items are listed in appendices 1, 2, and 3 at the end of the chapter.

ILLUSTRATIONS OF SELECTED PSYCHOSOCIAL HISTORY DATA

The following data were collected during PSH interviews with 64 pregnant cocaine-dependent women as part of intake appointments at Family Center. They have been selected to illustrate PSH information that supplements that of the ASI. Distinctions are made between data gathered with ASI and PSH items.

Analysis of ASI demographic data showed that the women had a mean age of 28 years and were 89 percent African-American, 9.5 percent Caucasian, and 1.5 percent Hispanic. The women reported an average of 11.3 years of education, and 43 percent had received job or technical training. PSH items showed that 86 percent had been employed at some point in their lives, but 83 percent currently were receiving public assistance. The usual

employment patterns in the past 3 years, according to a combination of ASI and PSH data, were 42 percent unemployed, 32 percent employed full time, and 24 percent employed part time; 2 percent were in a controlled environment with no opportunity to work. PSH responses indicated that 30 percent of those unemployed chose not to look for work because of pregnancy, child-rearing responsibilities, or other reasons. With regard to current marital status, the ASI indicated that 4.9 percent were married, 67.2 percent were never married, and the remainder were separated, divorced, or as coded on the PSH, in a long-term relationship (longer than 1 year) with a partner.

Responses to ASI questions concerning substance use and treatment indicated that during their lifetimes women had used, on average, alcohol for 7.7 years, cocaine for 6.2 years, and marijuana for 5.3 years. In addition, the PSH supplements showed that, at the time of the interview, 73 percent of the women admitted to smoking cigarettes and had done so for an average of 12 years. The women had experienced an average of 2.4 previous episodes of treatment, with 83 percent reporting at least 1 episode. Substance use during pregnancy is of particular interest to maternal addiction treatment programs because of the potential effects on the fetus. In response to PSH items, women reported days of use during pregnancy as 73.5 for tobacco, 43.4 for cocaine, 16.9 for alcohol, and 5.3 for marijuana.

The living arrangements of substance-abusing women tend to be transitory or dependent and may involve domestic crises or violence. Therefore, it is important to understand both past living situations, as documented in the ASI, and current living arrangements that are probed in the PSH. At intake, ASI data indicated that 64 percent of the women had been dissatisfied with their living arrangements during the past 3 years. With the addition of several PSH response codes, the data showed that the women usually had lived with partners (10 percent), parents or other family members (8 percent), alone (8 percent), or in several of these living arrangements over the 3-year period (75 percent). Responses to PSH questions regarding current housing demonstrated that 59 percent of the women were dissatisfied with their current housing situations. These living arrangements were more varied than the 3-year patterns—46 percent lived with parents, other family, or friends; 19 percent lived with partners; 19 percent lived in shelters or residential programs; 7 percent had no stable housing; and the remainder reported several of the aforementioned or other living situations.

The legal status section of the PSH includes questions regarding victimization to assess the history of violence experienced by drug-dependent women, in addition to the history of charges and arrests

queried by the ASI. ASI data from cocaine-dependent women at Family Center revealed that 28 percent reported ever having been charged or arrested and 16 percent having been incarcerated. Supplemental information from the PSH indicated that the women had experienced an average of two types of victimization in their lifetimes. These women represented 81 percent of the respondents. The most frequent types of victimization reported include domestic violence (55 percent), rape (49 percent), child abuse/neglect (36 percent), sexual exploitation (30 percent), assault (22 percent), and robbery (21 percent). Thirty-eight percent of the women reported having family-related legal problems.

For pregnant and parenting women, the PSH devotes a section of the interview to questions regarding pregnancy, prenatal care, and history of complications. Cocaine-dependent women at Family Center reported being an average of 19 weeks into pregnancy at enrollment. Their responses showed mean values of gravida to be 4.9, parity 2.4, therapeutic abortions 0.94, and spontaneous abortions 0.60, and they recalled an average of 1.3 previous pregnancies with complications. Of the 42 women who responded to this item, 61 percent had received some prenatal care prior to enrollment at Family Center. When asked how they felt about the current pregnancy, most women discussed assorted ambivalent feelings. Fifty-nine percent were happy to be having a baby, 48 percent felt that this baby would provide a chance to make their lives worthwhile, and 42 percent were happy to be pregnant. On the other hand, 22 percent did not want another baby, 22 percent disliked being pregnant, 28 percent were upset about the conception circumstances, 71 percent felt guilty about using drugs during the pregnancy, and 69 percent worried about the baby having problems.

CONCLUSION

The PSH data presented in this chapter illustrate the breadth of information available during an initial interview through administration of this supplemented version of the ASI. Substance abuse is usually only one of numerous problems that exist in the lives of alcohol- or other drug-dependent women. Their strengths are equally important to identify as treatment begins. A comprehensive assessment is essential to promote treatment and research tailored to the individual needs and strengths of women and their children. The PSH was developed to serve both clinical and research purposes. For clinical use it organizes information on current and historical psychosocial and health status into a single instrument and provides abundant material to aid in the understanding of a woman's history and needs. The PSH thereby facilitates identification of strengths, problem areas, and goals for treatment.

At the most elementary level, PSH data provide researchers with detailed descriptive information about individual women that can be aggregated as needed for program evaluation and research investigations in conjunction with other assessments. These client data also may identify psychosocial and economic realities related to enrollment, use of services, and retention of women in treatment and their ability to achieve and maintain recovery. Although the PSH requires an investment of staff time in training, client interviews, and data entry and analysis, in return it provides a detailed portrait of the characteristics, history, and needs within multiple areas of the lives of drug-dependent women seeking substance abuse treatment.

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APPENDIX 1. *Excerpts from psychosocial history family: Housing and children*

4a. How many adults (including client) live in your current household? _____

4b. How many children? _____

4c. Total number of people in household: _____

5. What type of housing do you presently live in? _____
   a. apartment
   b. house
   c. condominium
   d. room
   e. shelter
   f. supervised group living
   g. no stable living arrangements
   h. other, specify _____

6. How large is the current place where you live?
   a. Total # rooms: _____
      (Count kitchen, dining & living rooms, bedrooms, NOT baths)
   b. Total # of bedrooms: _____

6.1. Do you pay the full cost of your current housing and utilities?
(Check applicable levels of payment and assistance below.
Also explain source of housing assistance.)

_____ NA, no current housing

_____ NA, no housing payments required, explain _____

	a. Level of Housing Payments	**b. Level of Utility Payments**	**c. Comments on Source and Type of Assistance (Note person, organization; type of voucher, subsidy or grant)**
Full	_____	_____	_____
Partial or Reduced	_____	_____	_____
None	_____	_____	_____

Housing History Matrix
(for items #7 - 12)

Housing Past 3 Years (Begin with most recent housing.)	**Length of Time**	**With Whom?**
1. _____		
2. _____		
etc.		

7. How many places have you lived in the past 3 years? _____

8. With which other adults have you *usually* lived in the past 3 years? (Circle all that apply.)
   a. alone
   b. with my parents
   c. with other family members (not parents)
   d. with father of this baby
   dd. with the father of (at least) one of my children
   e. with another sexual partner (not FOB, not father of child)
   f. with friends
   g. in a residential program (e.g., jail, hospital), specify _____
   h. no stable arrangements
   i. in shelter(s), specify_____
   j. other, specify _____
   k. several of the above (Circle k. and all that apply.)

9. How long did you live in the longest of these arrangements?
   yrs. _____ mos. _____

10. Have you been satisfied with any of these living arrangements over the past 3 years?
   _____ Yes, explain _____
   _____ No, explain_____
   _____ Indifferent, explain _____

11. Have you been without a place to stay (homeless) in the past 3 years? (Define homeless as having no place to stay for more than 1 month.)
   _____ Yes _____ No

12. Where did you stay during your homeless period? _____ NA (Circle all that apply.)
   a. in shelter(s)
   b. with extended family
   c. with friends
   d. in a car
   e. in a crack house
   f. in a vacant building
   g. outside on the street
   h. other, specify _____

13. If currently homeless, how long has it been since you had a place to live that you consider to be a permanent home?
   yrs. _____ mos. _____ wks. _____ NA _____

SOURCE: Comfort et al. 1995

APPENDIX 2. *Excerpts from the psychosocial history medical status/ pregnancy history*

8. How many times in your life have you been hospitalized for problems with *past* pregnancy(ies)?
   ____ number of times____ NA (if 1st pregnancy)

9. How many pregnancies have you had with complications? _____
   ____ NA (never pregnant)

10. Please tell me about the complications.
    ____ NA (never pregnant)

    (Please specify complications below from first to last pregnancy. Be sure that all pregnancies are accounted for. Please use back of page if there are more than 10 pregnancies.)

	Specify Problem	**No Comp.**	**No Preg.**
a.	Preg. 1 Complication: _____	_____	NA _____
b.	Preg. 2 Complication: _____	_____	NA _____
	etc.		

11. How many of your babies have had serious health problems at birth or later in childhood?
    ____ NA (never pregnant) ____ NA (first pregnancy)
    a. Total at Birth ____ b. Total Later in Childhood ____

12a. Please tell me about your babies' health problems at birth.
    ____ NA (never pregnant)

    (Please specify from oldest child [Child 1] to youngest child. Please be sure that all births, live and stillborn, are accounted for. Use back of page if there are more than 10 children.)

	Specify Problem	**No Comp.**	**No Preg.**
a.	Child 1's problem: _____	_____	NA _____
	_____	_____	(1st Preg.)
b.	Child 2's problem: _____	_____	NA _____
	etc.		

12b. Please tell me about your children's health problems later in childhood.
    ____ NA (never pregnant)

    (Please specify from oldest child [Child 1] to youngest child. Please be sure that all children are accounted for. Use back of page if there are more than 10 children.)

	Specify Problem	**No Comp.**	**No Preg.**
a.	Child 1's problem: _____	_____	NA _____
	_____	_____	(1st Preg.)
b.	Child 2's problem: _____	_____	NA _____
	etc.		

13a. Have you been hospitalized overnight during this pregnancy at all?
    Yes____ No____ NA ____ (not pregnant)

13b. If yes, why? _____ NA ____

14a. Have you had any prenatal care for this pregnancy yet?
    _____ Yes _____No

14b. If yes, where? _____ NA ____

15. How far along in your pregnancy were you when you started receiving prenatal care?
    _____ number of weeks _____ NA (not pregnant)

16. How many prenatal visits have you attended so far for this pregnancy?
    _____ number of visits
    _____ NA (pregnant, but haven't started prenatal care)
    _____ NA (not pregnant)

17. Did you use drugs and/or alcohol during pregnancy with any of your children?

    (Please specify from oldest [Child 1] to youngest child. Be sure that all births, live and stillborn, are accounted for.)

	NA	NR	DK	Yes	No
a. Child 1 ____	____	____	____	____	____
b. Child 2 ____	____	____	____	____	____
etc.					

18. How do you feel about this pregnancy? (Circle letters of all that apply.)
    ____ NA (not pregnant)
    a. don't want (another) baby
    b. feel guilty about using drugs (and alcohol) during my pregnancy
    c. feel worried about the chance of my baby having problems
    d. dislike being pregnant
    e. happy to have baby
    f. upset due to circumstances of conception
    g. feel that this baby is my chance to make my life worthwhile
    h. happy to be pregnant
    i. other, specify: _____
    j. several of above (Circle j. and all letters that apply.)

For the following, ask Client to use the Client Rating Scale (0-4 scale)

19. How concerned have you been about these medical problems related to your pregnancy in the past 30 days? ___ ___ NA (not pregnant)

20. How important to you NOW is treatment for these medical problems related to your pregnancy? ___ ___ NA (not pregnant)

Interviewer Severity Rating (0-9 Scale)
(defined as need for treatment *beyond* what client is currently receiving)

21. How would you rate the client's need for prenatal care?
    _____ _____ NA (not pregnant)

Confidence Ratings

Is the above information significantly distorted by:

22. Client's misrepresentation? Yes ____ No ____

23. Patient's inability to understand? Yes ____ No ____

24. If yes for #22 or 23, please explain: _____

SOURCE: Comfort et al. 1995

APPENDIX 3. *Excerpts from psychosocial history legal status*

2.How many times have you experienced one of the following:
(If impossible to list number of times, note as continuous over extended period and explain)

_____ NA (never experienced any of the following)
a. _____ assault
b. _____ arson
c. _____ rape
d. _____ domestic violence
e. _____ child abuse, neglect
f. _____ robbery
g. _____ sexual exploitation (forced to provide sexual favors)
h. _____ other, specify

3/4. In the past year, how often have you:

3. Provided sex for money _____
   a. _____ never
   b. _____ once
   c. _____ 2-5 times
   d. _____ 6-10 times
   e. _____ once per month
   f. _____ 2-3 times per month
   g. _____ 1-2 times per week
   h. _____ 3-5 times per week
   i. _____ once a day or more

4. Traded sex for drugs _____
   a. _____ never
   b. _____ once
   c. _____ 2-5 times
   d. _____ 6-10 times
   e. _____ once per month
   f. _____ 2-3 times per month
   g. _____ 1-2 times per week
   h. _____ 3-5 times per week
   i. _____ once a day or more

5a.Have you ever gotten an order of protection? _____Yes _____No

5b.If yes, how many have you gotten? _____ _____NA

Comments:

6a. Do you have any legal problems *now* involving your family?
(e.g., Family or Juvenile Court issues, child custody involving DHS, divorce, domestic violence, etc.)
____ Yes, current ____ Yes, past ____ No

6b. Please describe the nature of CURRENT problems and department
(e.g., DHS, Family Court, etc.)
_____ NA

6c. Please describe the nature of PAST problems and department
(e.g., DHS, Family Court, etc.)
_____ NA

SOURCE: Comfort et al. 1995

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