

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Voices from the community: Developing effective community programs to support pregnant and early parenting women who use alcohol and other substances

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Abstract

Since the 1990s, many communities in Canada have worked to develop specialized programs to meet the needs of pregnant and early parenting women who use alcohol and other substances. These programs provide a range of services under one roof (a "single-access" or "one-stop shop" model), address women's needs from a holistic perspective, provide practical and emotional support, and strive to reduce barriers to accessing care and support. Over the years, these programs have trialed new approaches to working with indigenous and non-indigenous women, their families, and their communities. In this paper, we describe the development of single-access programs in four different communities in Canada, discuss some of the elements of what makes these programs successful, and share our "lessons learned" over the years. We use examples from four different programs, including the Maxxine Wright Place Project in Surrey, BC; the Healthy, Empowered, Resilient (H.E.R) Pregnancy Program in Edmonton, AB; HerWay Home in Victoria, BC; and Manito Ikwe Kagiiuwe in Winnipeg, MB. All four programs are based upon the "best practices" elements of: (1) engagement and outreach, (2) harm reduction, (3) cultural safety (4) supporting mother and child, and (5) partnerships. In addition to serving First Nations, Métis, Inuit and other indigenous women and their families, these programs have drawn upon indigenous knowledge in their program design, values, and philosophy and have collaborated with indigenous women in evaluation and research to track the successes of these programs and to improve service delivery.

Introduction

Fetal Alcohol Spectrum Disorder (FASD) is a condition “unparalleled in its complexity” as a public health issue (Salmon, 2011). Although a key focus of federal FASD-related funding over the past two decades has been primary prevention campaigns, research strongly suggests that the women most likely to have a child with FASD are those who will be least likely be able to respond to awareness messages about the potential harms of consuming alcohol during pregnancy because of the overwhelming social conditions within which they live (BCCEWH, 2008; Poole, 2008).

In the early 1990s, several communities began to develop integrated responses to addressing the needs of pregnant and early parenting women with substance use issues. These early programs included *Sheway* in Vancouver’s Downtown Eastside and *Breaking the Cycle* in Toronto. These programs were designed to address the multiple barriers to accessing prenatal services that exist for many indigenous and non-indigenous women who use substances (Motz et al., 2006; Poole & Isaac, 2001; Poole, 2000; Racine, Motz, Leslie & Peplar, 2009). These barriers include fear of losing custody of children; fear of forced treatment or criminal prosecution; lack of treatment readiness; coexisting mental illness; guilt, denial and/or embarrassment regarding their substance use; previous negative experiences with health care and social service providers; and lack of transportation and/or child care. These programs were developed with an awareness of how substance use is often intertwined with other issues such as poverty, homelessness, gender-based violence, trauma, involvement with the law, loss of cultural and community connectedness, and food insecurity. These programs were considered innovative in that they trialed new approaches to addressing substance use and developed strategies to overcome system-level barriers to care such as negative attitudes of health care providers towards pregnant women who use substances and the traditional separation of prenatal care and substance use treatment and support within primarily a biomedical service model. In addition to serving First Nations, Métis, Inuit and other indigenous women and their families, these programs have drawn upon Indigenous knowledge in their program design, values, and philosophy; have collaborated with Indigenous women in evaluation and research to track the successes of these programs and to improve service delivery; and have been grounded in grassroots and activist movements to rebuild healthy indigenous communities.

Since the 1990s, other communities in Canada have learned from these pioneer programs and begun to develop specialized programs to meet the needs of pregnant and early parenting women who use alcohol and other substances. These newer programs have evolved within a context of greater awareness of issues like FASD, harm reduction approaches, cultural safety, and violence and trauma-informed care. The authors of this paper have been involved with developing, coordinating, and evaluating these programs for over 20 years. These programs include the Maxxine Wright Place Project in Surrey, BC; Healthy, Empowered, Resilient (H.E.R) Pregnancy Program in Edmonton, AB; HerWay Home in Victoria, BC; and Manito Ikwe Kagikwe in Winnipeg, MB. In this paper, we draw upon some of our experiences to describe the development of single-access programs in four different communities, discuss some of the elements of what makes these programs successful, and share our “lessons learned” over the years.

The single-access program model: An overview

While all four of the programs described below are different from each other in terms of funding, service delivery model, philosophies, and mandates, they share common elements that evaluation studies show work. Research evidence clearly shows that the single-access program model is an effective way of addressing the needs of pregnant and parenting women who use substances (Poole, 2006; Poole, 2008; Sword et al., 2009; United Nations Office on Drugs and Crime, 2008). Early engagement of pregnant women who use substances has been shown to positively affect a range of outcomes related to maternal, fetal, and child health and well-being (Cortis et al. 2009, Health Canada, 2006). Women who participate in these programs are more likely to keep custody of their child and have higher rates of accessing addictions treatment (Sword et al. 2009, Racine et al. 2009). Infants whose mothers have been supported during pregnancy demonstrate improved birth weight and reduced neonatal withdrawal effects (Marshall et al., 2005). Children who are involved with their mothers in a comprehensive early childhood program of support have demonstrated enhanced developmental outcomes (Motz et al., 2006).

All four programs started as unique networks of cross-sectoral partnerships that developed a common vision, values, and goals. The impetus for the programs varied in a number of ways. In one case, the program evolved from a meeting of concerned health care and social service providers. In another, it was a response to a specific community health crisis. Overall, people were observing the challenges that many women were facing and the poor outcomes for both mother and child, including high rates of child removal. All four programs provide a range of services under one roof (a “single-access” or “one-stop shop” model), address women’s needs from a holistic perspective, provide practical and emotional support, and strive to reduce barriers to accessing care and support. Each program also has developed unique strategies and innovations in program delivery. We briefly describe several “best practices” elements of the single-access program model below with examples from different programs and communities. The components described are: (1) engagement and outreach, (2) harm reduction, (3) cultural safety (4) supporting mother *and* child, and (5) partnerships.

Table 1: Examples of integrated community programs that support pregnant and parenting women who use substances across Canada

- HerWay Home, Victoria, BC
- Sheway, Vancouver, BC
- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women, Surrey, BC
- H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program (Streetworks Program), Edmonton, AB
- Manito Ikwe Kagiikwe (Spirit Woman Teachings), Winnipeg, MB
- New Choices, Hamilton, ON
- Breaking the Cycle, Toronto, ON

Engagement and outreach

When the Women in Shadows program started in Edmonton, AB in 2008, the program staff had to first figure out why so many women in inner city Edmonton were not accessing prenatal care. (The Women in Shadows program was a joint initiative between the Streetworks program and the STI Centre and ran from 2008-2010. This program was the foundation for the H.E.R. Pregnancy program, now based at Streetworks that started in 2011). They found that many women did not trust service providers, were ashamed of their substance use, or were frightened and hiding. For many First Nations, Inuit, and Metis women, this lack of trust was rooted in a history of residential schools and colonization and the intergenerational effects of this experience. For other women a history of trauma and violence, or past negative experiences with service providers were also factors. In response, the program hired two pregnancy support workers who had similar backgrounds as the women the program was trying to reach.

The two support workers worked closely with a nurse. They were trained in how to conduct some basic prenatal assessment skills, such as auscultating fetal heart rates, measuring fundal heights and maternal weights, and conducting kick counts. These skills were not used for diagnostic purposes. Instead, the support workers used them as a tool for engaging with pregnant women who were living on the streets. The outreach workers connected with women on the streets, built trusting relationships, and when women were ready, connected them to the program nurse and/or a physician in the community. In the first year, 78 women accessed the program and only one had an underweight baby.

Like the H.E.R. Pregnancy program, all single-access programs have been innovative in developing strategies to engage women. Outreach services have been a key component of all programs. Outreach services work with women where they are - on the streets, in their homes, in the hospital - and are not confined to providing services in one location. This provides service providers with flexibility in how they work with women. They can accompany women to appointments, share information informally, provide advocacy, and help overcome barriers like lack of transportation and distrust of formal settings.

Two of the programs, the Maxxine Wright Place Project in Surrey, BC and Manito Ikwe Kagiikwe in Winnipeg, MB started to provide outreach support to women while the rest of the program components were being developed. In Surrey, staff offered "wraparound" facilitation and support to women. The wraparound process is inherently responsive to women's need for collaborative support in response to challenging life circumstances. It works to coordinate and enhance a woman's existing supports and services and to develop an ongoing community of support and a plan of care tailored to her specific needs. The process "wraps" services "around" women rather than expecting them to conform to existing services (Cailleaux & Dechief, 2007). Providing outreach and wraparound support was a way for these organizations to strike a balance between meeting the immediate needs of women who were struggling with various issues now and developing a well thought out and multi-component program over a period of time. It also provided an opportunity to build relationships with other community partners and to demonstrate how a specialized program can make a difference in outcomes for women and their children.

Other strategies for engagement have included developing an intake process that involves minimal paper work and intake requirements and a program model where women could refer themselves to the program without requiring a formal referral from a physician or other service provider. All the programs have been developed so that women can choose which aspects of the program they are interested in and ready for. Initially, some women might be interested in accessing shelter or a hot meal; other women might be interested in seeing a nurse for prenatal care or talking with an addictions counsellor.

All of the programs have a strong emphasis on practical support. At Sheway and Maxxine Wright Place, the daily hot lunches have always been popular and one of the key reasons that many women attend the programs in the beginning - not only for the nutritional support but also for beginning to develop relationships and a sense of community. The single-access program model recognizes that without practical support, women cannot succeed in meeting other goals like reducing or stopping their substance use or learning parenting skills. Food vouchers, free prenatal vitamins, socks, bus tickets, and support in finding housing are just a few of the practical items that meet women's immediate needs.

Harm reduction

At HerWay Home in Victoria, BC, the program developers found that many of the women they were serving had previously had difficulties accessing the services they needed. Many women described having to travel around the city to attend multiple programs to get their needs met. Often, in this process, they described feeling vulnerable and judged negatively. One of the key goals in the development of HerWay Home was to bring together community partners (such as the regional health authority, pregnancy outreach programs, midwifery and nurse practitioner programs, mental health and addictions counselling, anti-violence services, parenting supports, and child welfare organizations) to create a collaborative "one stop shop" where women could access services in a respectful and non-judgmental environment.

The philosophy of harm reduction has been an important part of creating a respectful and non-judgmental environment (Boyd & Marcellus, 2007). Harm reduction recognizes that "success" does not always require abstinence from alcohol and drug use. A harm reduction approach means that abstinence is just one possible goal for women, and that care and support do not require women to address their substance use issues until they are ready. Harm reduction allows for flexible, respectful, and non-judgmental approaches to engaging with and caring for women and their children. It takes a "bird's eye" view of the issue of substance use by looking at a range of strategies to minimize drug-related harm to both the individual and society. Success might mean a woman reducing her substance use gradually throughout her pregnancy or building a relationship with an addictions counsellor that continues beyond the perinatal period. It might mean supporting a woman in leaving an abusive relationship and finding a new home and creating an environment in which stopping substance use is possible for her. It might mean focusing on other ways that a woman can take care of herself and her child other than quitting substance use, such as eating nutritious meals, attending regular medical appointments, and learning parenting skills.

While harm reduction is an effective method of working with women who use substances, it is not the only way of working with women. Many single-access programs collaborate with other organizations that have different philosophies and approaches, and even different understandings of problematic substance use (Benoit et al., in press). In some situations, this has created challenges in understanding how to best care for women and in fact may set up a tension between the approaches of women-focused and child-focused programs (Marcellus, 2004). With persistence, education, and a commitment to meeting the needs of women and their children, program staff have found ways to help other agencies and community stakeholders understand that women are best served when a continuum of options are available to them and that no one approach is better than another. Some of these discussions have highlighted how addictions issues remain poorly understood across society and how this is reflected in service delivery. There are also additional culturally based negative constructions of First Nations, Inuit and Metis women who are pregnant and experiencing addictions; Aboriginal women continue to be positioned as specific targets for FASD prevention (Salmon, 2011; Tait, 2000). In response, several programs have taken the initiative in providing training for health professionals on substance use and pregnancy. Others have had to overcome resource constraints such as there being only one physician in the community who can prescribe methadone, a drug used to support women with heroin and other opioid addictions.

Cultural safety

The development of the Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women in Surrey, BC was spearheaded by Atira Women's Resource Society, an anti-violence women's organization, in collaboration with representatives from Fraser Health, the Ministry of Child and Family Development, and ten other non-profit community agencies (Surrey High Risk Planning Committee, 2003). Atira Women's Resource Society provides a range of services for women ranging from housing and shelter programs to self-employment initiatives to 16 Step empowerment groups and outreach support. Because Atira is committed to supporting all women who are experiencing the impact of violence, the interconnections between gender-based violence and substance use has always been clearly elucidated in the program model. Maxxine Wright Place supports women who are pregnant (or who have very young children) who are also impacted by substance use and/or violence and abuse. Program statistics from 2007-2009 clearly show how these two areas overlap: 35% of women in the program had substance use issues; 14% had experienced violence/abuse in their lives; and 51% of the women experienced both substance use issues and violence/abuse in their relationships.

All of the single-access programs have found that substance use is often tied to women's experiences of violence and trauma. For many women, these experiences are linked to histories of colonization, residential schools, and migration. As a result, attention to issues of empowerment, trust and safety, cultural awareness, and social justice have shaped the development and success of these programs. At Maxxine Wright Place, this has meant offering specific programming for First Nations, Inuit, and Metis women, including outreach, a Re-Discover Parenting Program, and 16 Step Empowerment Group. When the program expanded and moved into a purpose-built three-story building, the clinic space was placed on the main floor and 12 units of emergency housing were built above. Women can access the shelter at any point during their pregnancy and potentially stay until their baby is 6 months old.

Other programs collaborate with Aboriginal organizations in a number of different ways ranging from program delivery on-site to involving women with first-hand experience of these issues in the development and evaluation of services to training health professionals in cultural awareness. Most of these programs are constantly reviewing and revising their approaches in response to emerging evidence on cultural safety and trauma-informed care. Cultural safety recognizes how a lack of trust and understanding between health care providers and patients and power imbalances can affect care and treatment and that the conditions that First Peoples experience today are a result of a history of colonization, residential schools, and other practices of cultural and social assimilation (Browne et al., 2009). Violence and trauma-informed care is committed to understanding the impact of trauma and violence on women's lives and takes this into account in all aspects of service delivery, with an emphasis on safety, choice, and control. While services are far from perfect, ongoing efforts to minimize re-traumatization and to create an environment in which issues of historical redress can be discussed are important to healing and support.

Many community-based perinatal programs also draw from the practice-based research conducted with First Nations women and treatment providers in Canadian addiction treatment programs (Acoose, Blunderfield, Dell, & Desjarlais, 2009). In a study that was concerned with how identity and stigma impact the healing journeys of Aboriginal women, the participants identified principles for culturally safe practice they wished treatment providers to embody: Recognition, Empathy, Communication, care, Link to spirituality, Acceptance, Inspiration, and Momentum (RECLAIM) (Dell, 2009, 2012a). These seven guiding values for practice are linked to the seven sacred teachings (respect, love, courage, wisdom, truth, humility and honesty) (Benton Banai, 1979; Dell, 2012b). Programs such as Manito Ikwe Kagiikwe find these holistic program values and traditional teachings a gentle and helpful approach to integrating cultural safety in their work. The combination of traditional approaches to care (holistic, community involvement, extended family, learning by doing, sharing circles, seven sacred teachings), ceremony, and a strong understanding of the impact of residential schools and colonization all interact to create a program that is culturally safe. Further, the program name "Manito Ikwe Kagiikwe" is an Ojibway word which means "Spirit Woman Teachings." This name refers to the idea that women carry all the teachings that they need within them and that the role of the program is to help women remember those teachings. Rather than attempting to "fix" or impose solutions on women, the philosophy of the program focuses on support and collaboration and relationship-building.

Honoring the experience, resilience and teachings of Aboriginal peoples, and especially Aboriginal women, has been the foundation for the development of meaningful services for Indigenous women. While many Aboriginal women who participate in these programs may not follow traditional practices or have different beliefs, using an Aboriginal worldview in program design and values appears to have benefits for women from diverse cultural/spiritual backgrounds.

Supporting mother and child

Often, when people think about women who use substances during pregnancy, there is overwhelming concern about potential harms to the fetus. However, this concern can often create barriers to care by viewing women's needs and children's needs as opposed to each other (Marcellus, 2004). Several of the single-access programs are finding ways to overcome this misconception by creating program models that view women's health and child health as inextricably linked. At Manito Ikwe Kagiikwe in Winnipeg, MB, the advisory group that worked to develop a model for the program considered these issues early in the development process. Manito Ikwe Kagiikwe, located at Mount Carmel Clinic, connected with the Anne Ross Day Nursery program which also runs out of the same organization. As the daycare program continues its own renewal and renovation process, Manito Ikwe Kagiikwe is co-evolving so that both programs will expand to include infants. As well, the advisory group decided that the program would support not only mothers whose children live with them, but also mothers whose children have been placed in care. All of the single-access programs avoid viewing a pregnant woman as "case" that requires assessment and management. Instead, staff attempt to work collaboratively with women, build partnerships with other service providers and agencies, and advocate for women to have a voice in their own support and care.

The single-access model views women's substance use outcomes, child development outcomes, and parenting outcomes as integrally linked. Many of these programs grew out of a recognition that high rates of child removal for women with substance use issues did not lead to success for either women or her children. The programs work to connect with women as early in pregnancy as possible so that relationships can be built and options can be explored. The programs have found that, with timely support, many women can successfully care for their children (Marshall et al., 2005) or safely make decisions to not continue with the pregnancy. Women can be supported in choosing other models of mothering such as part-time parenting, open adoption, kinship and elder support, and extended family. Some programs, such as Maxxine Wright Place and Manito Ikwe Kagiikwe, are integrated with daycare services. Other programs offer parenting support through a family support worker, parenting skills classes, or parenting drop-in. Several programs are providing support for women who are unable to care for their children or who choose to terminate their pregnancies and would benefit from support around grief and loss. This is an area of innovation as these are groups that historically have been overlooked in program delivery. In Victoria, BC, the Queen Alexandra Foundation for Children's Health, a children's philanthropic organization, recognized how mothers and babies' needs are linked and became a core fundraiser for HerWay Home. Gradually, individuals and organizations have been finding ways to overcome traditional barriers between adult services and child services and to look for solutions that benefit all.

Table 2: Examples of services and programs provided in a single-access model

- Pregnancy outreach workers
- Nursing support
- Family support worker
- Aboriginal outreach worker and/or cultural programming
- Drop-in program for pregnant women and new mothers
- Family doctors (including physicians who are able to prescribe methadone or have specialized training in addictions)
- Housing worker and/or supportive housing program
- Mental health and addictions counselling
- Early childhood development programming
- Availability of practical support, e.g., daily hot lunch, access to food bank hampers, provision of bus tickets and other help with transportation, free clothing, diapers and other baby items
- Advocacy and support in accessing additional services and programs

Partnerships

Studies have shown that women who use substances have difficulties accessing services that meet their needs. An integrated “one stop shop” model recognizes that no single service provider or agency can meet the often complex needs of women and that formal and non-traditional partnerships are required (e.g., between child-focused and adult-focused services). The single-access model requires innovative partnerships at all levels of service delivery and considers the needs of both mother and child.

One of the most important areas of collaboration has been with child welfare services. At Maxxine Wright Place (Surrey, BC), the social worker position was deliberately created to be “non-delegated” so that she did not have the authority to remove children. The program created a policy that child removals would not happen on-site, a policy that was essential to women feeling safe in accessing the program as a whole. It also created the opportunity for women to connect with child welfare services without the threat of their children being taken away and to build a relationship with a social worker so that solutions that worked for all parties involved could be explored. Thus, social workers are able to focus on women's immediate needs such as housing and income support and to begin to develop a longer-term care plan in collaboration with women. If child removals are likely or a possibility, women are involved in the removal process and receive support throughout and following the removal of the child by program staff.

At the H.E.R. Pregnancy Program (Edmonton, AB), one of the challenges the program has had to deal with is that, technically, Alberta Children & Youth Services cannot be involved with a fetus until the moment of birth. In the past, this has meant that women did not have an opportunity to learn about what they might need to have in place to be able to parent successfully. Working with a social worker located at the Boyle Street Community Services office, support workers have been able to connect pregnant women to a social worker prior to birth. The social worker has been able to act as a "consultant" so that women have a clearer understanding of what they might need to do to avoid having her child removed and to make plans to care for their child. It has also meant that women are able to have an opportunity to build a positive relationship with an individual in Children's Services and that social workers are able to learn more about individual women and their life circumstances apart from what their file might say. This earlier involvement with Children's Services has resulted in many more children going home with their mothers following birth. While the issue of supports and services during pregnancy technically do not fall within the mandate of child welfare services, the fact exists that vulnerable women with substance use problems do need such support services prior to giving birth.

Because all of these programs represent cross-sectoral partnerships, ongoing communication between involved parties has been critical. For example, HerWay Home has a community advisory council that includes representatives from the founding organizations (primarily women- and child-serving agencies) that work to ensure that the program remains true to the original philosophy over time. It also ensures that the program aligns with other community services so that duplicating or creating further gaps in service can be avoided. At the HerWay Home Program and Manito Ikwe Kagiikwe, "women's councils" comprised of women who have had personal experience with the issue of substance use while they were pregnant or new mothers are informing development of the programs.

Challenges and lessons learned

Single-access program models can lead to many successes for mothers and their children. However, there are always challenges in these programs and the complexity of issues such as multiple partnerships, governance models and funding structures for these programs can create obstacles and unforeseen difficulties (Bradshaw, 2007; Machold, Ahmed & Farquhar, 2007; Provan & Kenis, 2007). Flexibility in service delivery and in negotiating relationships is a requisite component of all these programs.

In many of these programs, there is an overwhelming demand for services and there have been challenges with providing adequate services with available staff and funding. For example, at Maxxine Wright Place, the program had to narrow its mandate by only accepting women who are pregnant or have a baby less than six months old and then providing services to women until their youngest child is four years old. Originally, women who had a child under two years of age were accepted and services were provided until the youngest child was six years old.

Many of our programs have been challenged in a number of areas such as shifts in funding and broader concerns of system fragmentation. This has meant that it is important to recognize the importance of working with available resources and building upon natural partnerships that already exist. Cross-sectoral partnerships have required all stakeholders involved to learn to work across different sectors, including community non-profit organizations, government, health care and with interested community members. Differences in values and priorities can sometimes create challenges in ensuring that all voices are equally valued and considered. Women with substance use issues offer a critical and compelling voice and this work represents a commitment to advocating for and ensuring that their experiences inform and shape program delivery.

Stigma and misconceptions about addictions and women who use substances while pregnant continue to create challenges. While attitudes are changing, there continues to be resistance to programs that use a harm reduction approach and a persistent view that women who use substances cannot care for their children. While there is already a strong body of evidence to support these programs, several programs have built partnerships with researchers and evaluators at local universities and with provincial and national research groups and centers so that national research funding can be accessed. This is one way that programs are seeking to build their profile in their communities and to contribute to the growing evidence based chronicling the success of these programs.

All of these emerging programs also have representation on the Canada FASD Research Network, in particular the network action team on FASD prevention from a woman's social determinants of health perspective. The benefits of the networking opportunities generated by this team have been immeasurable in contributing to this evidence base and in supporting community teams to move forward on developing these innovative programs. Recently, a research team has been focusing on developing principles and practices for evaluation of community-based prevention programs serving pregnant women and mothers. This evaluation framework includes an Aboriginal lens that helps to examine a range of outcomes: program philosophy, activities, formative outcomes, and participant, community, and systemic outcomes. This framework helps service providers in their local contexts remain aware of the interconnectedness of the range of factors that contribute to FASD in Aboriginal communities.

Acknowledgements

We acknowledge the financial support of the Canada FASD Research Network in the development of this paper.

Table 3: Online Resources

If you are interested in learning more about the philosophy, development, and outcomes of this type of program in other communities in Canada, the resources below are available for free and on-line.

Best Start. (2002). *Reducing the Impact: working with pregnant women who live in difficult life situations*. Toronto, ON: Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre.

Download from <http://www.beststart.org>

FASD Network Action Team on FASD Prevention from a Women's Health Determinants Perspective. (2010). *10 Fundamental components of FASD prevention from a women's health determinants perspective*.

Download from <http://www.canfasd.ca>

FASD Network Action Team on FASD Prevention from a Women's Health Determinants Perspective.

(2009). *Taking a relational approach: the importance of timely and supportive connections for women*.

Download from <http://www.canfasd.ca>

Leslie, M. (ed) (2007). *BTC Compendium, Vol. 1, The Roots of Relationship*. Toronto: The Mothercraft Press. http://www.mothercraft.ca/resource-library/publications/BTC_Compendium_2007.pdf.

Motz, M., Leslie, M., Pepler, D. J., Moore, T. E. & Freeman, P.A. (2006). *Breaking the Cycle: Measures of Progress 1995-2005*. JFAS; 4:e22 Nov. 10, 2006 © The Hospital for Sick Children 2006.

http://www.mothercraft.ca/resource-library/publications/BTC_JFAS_ReportFINAL.pdf.

Poole, N. (2000). *Evaluation Report of the Sheway Project for High-Risk, Pregnant and Parenting Women*. Vancouver: British Columbia Centre of Excellence for Women's Health.

<http://www.bcccewh.bc.ca/publications-resources/documents/shewayreport.pdf>.

Racine, N., Motz, M., Leslie, M. and Pepler, D. (2009). Breaking the Cycle Pregnancy Outreach Program: Reaching out to improve the health and well-being of pregnant substance involved mothers. *Journal of the Association for Research on Mothering*, 11 (1): 279-290. Download from

<http://pi.library.yorku.ca/ojs/index.php/jarm/article/view/22525/21005>

Streetworks Program website. Resources for clients and service providers, including the book *Oh Shit, I'm Pregnant: Your Guide to Being Pregnant on the Street*. Boyle Street Community Services, Edmonton, Alberta. Download from <http://www.streetworks.ca>

Surrey High Risk Pregnancy and Early Parenting Planning Committee. (2003). *Maxxine Wright Place Project For High Risk Pregnant And Early Parenting Women: Executive summary and Program Model*. Download from http://www.hss.gov.yk.ca/cnfp2010symposium/handouts_29/b2_am_maxx_wright_executive_summary.pdf

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2789048/>

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC420243>

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