

SW 811

# Substance Use during Pregnancy and a Women Centered Harm Reduction Approach:

challenging the mother and baby divide  
to support family well-being and the  
prevention of child maltreatment

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## **Substance Use during Pregnancy and a Women Centered Harm Reduction Approach: challenging the mother and baby divide to support family well-being and the prevention of child maltreatment**

### **Abstract**

Treatment programs that meet the needs of women during pregnancy and after delivery are not well addressed by existing policies and programs (Applegate et al 2001, Boyd 2007, Hepburn 2007, Payne 2007, Tait 2000). Over the past year Yorkton Tribal Council Child and Family Services (YTCCFS) report the agency apprehended nine babies from the hospital after delivery due to problematic maternal substance use during pregnancy. Researchers indicate that First Nations women are often overrepresented in groups of substance using women (Boyd, 2007; Tait, 2000) Additionally women who use substances during pregnancy face a number of systemic barriers and due to this they do not seek health care, treatment or other services. One of the noted barriers is fear of apprehension of their baby from social services. Associated to the fear of apprehension and other barriers to access care, are many poor health outcomes and risks for the mother and child. Researchers indicate that mothers who have their babies apprehended at the hospital are discharged to the streets where the cycle of poverty and homelessness begins again (Payne, 2007). In turn substance use continues and women can “re-cycle” via another subsequent pregnancy and child apprehension (Appendix A). Further exacerbating the issue is the problem that even when women want to enter treatment there are no existing woman centred treatment services available for mothers and babies.

In an attempt to address the issues outlined YTCCFS is partnering with White Bear First Nation to review the feasibility of developing a women centered harm reduction program for women and babies. To accomplish this task a consultant hired from White Bear First Nation, and YTCCFS are working on a business plan and program description to support the development of a program. This paper will support the business plan via a literature review on substance use during pregnancy, and the recommendations and best practice approaches for women centred treatment programs. An environmental scan will summarize three national programs that work with pregnant women who use substances, and one local woman centred treatment program from Regina. A program description for the White Bear program will be offered and the paper concludes with broader recommendations for the proposed program and broad policy and social work practice. The development of a woman centred treatment program for women who use substances during pregnancy will be a step towards keeping mothers and babies together vs. ongoing systemic outcomes that foster a mother and baby divide and put a number of other pressures on research, policy, practice, and education.

## **Literature Review**

**The review of academic journals and literature on this topic area offers a historical context of substance use, women and pregnancy. The literature review provides rationale for the need of a woman centred harm reduction program as well as an outline of what a woman centred program harm reduction program looks like. The two areas of literature reviewed are “substance use and pregnancy”, and “the treatment needs of women”.**

### **I. Substance use and pregnancy:**

Women who use substances during pregnancy are not well served by existing treatment programs or related health and social services and many barriers to accessing services exist (Applegate et al, 2001; Bang et al, 2007; Carten et al, 1996; Tait, 2000; Goldberg, M.E., 1995). Beginning in the mid 1970s increased attention and advocacy has prompted researchers to look at women as a separate category of substance user (Abbott, 1994; Drabble, L. 1996; Yaffe, Jenson, & Howard, 1995). Since then researchers have made a considerable effort toward the analysis and consideration of how to best work with women who use substances. Some of the research in this area has included exploring barriers, prenatal care, perinatal care, gender issues, treatment issues, women’s needs, women and co-occurring disorders, parenting, culture groups, feminist perspectives, family or support systems and children (Jessup, M.A., Humphreys, J.C., Brindis, C.D., & Lee, K.A. 2003; Alexander, M.J. 1996; Bang, D., Irwin-Seguin, K., & Bradley, N. 2007; Carten, A. J. 1996; Dodge, K. & Potocky-Tripodi, M. 2001; Drabble, L. 1996; Finkelstein, N. 1994; Russell, M., & Gockel, A. 2005; Boyd, S. 2001).

Despite the amount of research completed some of the basic tenants to working with pregnant women who use substances remain a challenge. Women who use drugs or alcohol during pregnancy are often stereotyped, for example the literature references to stigmatization include the following: being viewed as villains who are immoral; sexually promiscuous; weak willed; negligent to their children;

tramps who deserve to be taken advantage of sexually; are more disgusting than male addicts, and are the enemy to a fetus (Finkelstein, N. 1994; Goldberg, M.E. 1995; Applegate, D., Bradley, C., Rhodes, R., & Saulnier, C.F. 2001). These stereotypes fuel the argument that drug-using women should not be allowed to have children, which in practical terms aside to being inappropriate would be impossible to reinforce and would only aid to further punish the disadvantaged (Hepburn, M. 2007). In considering the social construction of these stereotypes is the role and influence of drug laws on shaping policy and attitudes both in the present and the past (Boyd, 2001).

There has been a long history of misinformation on illicit drugs and drug use. Beginning in the early 1900s drug legislation in Canada was fuelled by morality, racism and economic concern (Boyd, 2001). This was evidenced via the writings of the acclaimed Emily Murphy who won the right for women to be appointed to the Senate and linked opium use to Chinese Canadians and cocaine and marijuana use to southern Blacks (Donovan, 2006; Boyd, 2001). In the February 15, 1920 issue of MacLean's Magazine, Murphy wrote an article entitled "The Grave Drug Menace". She stated her intent was to write about drug addiction and to discuss its relation to insanity, crime, racial deterioration and social wastage. While the statement is outdated and questionable by current research, it holds relevance in that similar assertions have been presented since then through to this day.

Current day references to drug addiction in terms of "insanity" are now more often discussed as mental health disorders which are classified in the DSM. The DSM provides clinical criteria for categories of chemical abuse and dependency (Goldberg, 1995). Modern connection to "crime" is evident in the laws and legislation in Canada that continue to deal with drug use from a criminal position (Boyd, 2007). The insanity and crime perspectives have also aided in the construction of drug use and addiction as a medical and legal problem (Boyd, 2001).

In consideration of Murphy's reference to "racial deterioration and social wastage" and modern assertions, one only has to review the literature and research that has been compiled on alcohol and drug use. A lot of the research focuses on the social downfalls that are often attributed to drug and use, or to other harms associated with problematic use and do not clearly establish that poverty itself is not an indicator for substance misuse (Tait, 2000). A considerable amount of the literature and research on alcohol and drug use also focuses in on specific racial groups and this can create bias or misleading information. For example while Kaskutas (2000) stated the highest published rates of FASD are among American Indians and African Americans, other researchers note the significance of the unpublished rates and the potential bias (Donovan, 2006). Substance use during pregnancy and drug addiction in the United States is less visible among middle and upper income women because they usually give birth in private hospitals that often do not screen for illicit chemicals thus much of the research has been with low income women only (Carten, 1996). Added to this is the fact that most of the research on maternal drug use is from the United States, where there is no universal medical insurance and poverty is extreme (Donovan, 2006). Despite the potential for biases based on race and class the issue continues to be framed as more significant to American Indians and African Americans. Other research directly opposes this and finds that contrary to the stereotypes substance use and abuse among women occurs at similar rates among poor and nonpoor people and among white people and people of color (Goldberg, 1995).

In further analysis of the literature on both drug and alcohol use during pregnancy it is clear there are two distinct bodies of literature that can be found in this area. One is on women who use substances during pregnancy and the second focuses specifically on alcohol use during pregnancy and is on fetal alcohol spectrum disorder (FASD). It is interesting to note the effect of drug use during pregnancy on the fetus is not found in the literature as predominantly as alcohol use. While it is recognised that there are two persons involved, a mother and a child, the division of the literature and

focus on alcohol use while perhaps more functional than intentional could add to the needs of the mothers and their children not being met. In the case of alcohol use during pregnancy, when a FASD diagnosis is applied to children it directly implicates the mother as responsible (Schellenberg, 2007) and it is the only disorder that is named in such a way (Badry, 2008). In addition putting focus on the fetus/child can lead to an effort to protect the fetus/child, which further implies the mother is an enemy (Applegate, Bradley, Rhodes & Saulnier, 2001). Women who have used substances during pregnancy and were interviewed reveal a predominant theme where the wellbeing, care and treatment of the mother and the baby are divided and the division is evident from pre-conception through to delivery. (Hunter, Donovan, Crowe-Salazar & Pedersen, 2008)

After delivery a woman's fears are realised when her child is apprehended. Women who use substances are said to make up 80% of those in the child welfare system (Smith, 2006). Child protection workers have identified denial, rationalization, minimizing and blaming as some of the most frequent challenges they work with. However given that pregnant women who admit to substance often have their children apprehended, pregnant women who use substances are not in a position to admit to substance use. The adversarial framework of the child protection social worker – mother relationship creates denial (Weaver, 2007) and results in women not accessing prenatal care.

The present systems that deal with substance use and pregnancy are enforced by laws and policies and these in turn influence public attitudes and opinion (Boyd). It is imperative that health professionals, doctors, nurses, social workers, child protection workers, and addiction counsellors consider the historical foundations on which we have developed these laws, policies, attitudes and opinions and that we clearly examine the way we actively oppress mothers and children who are already marginalized. As professionals we need to consider how through efforts that purport helping we have developed a myriad of ways where mothers who use illicit drugs are regulated via legal, medical and social professions competing, and overlapping in social control (Boyd, 2001).

To engage women who use substances during pregnancy it is essential that service providers create a continuum of services and a practice framework which is based upon current findings of the needs of women in treatment. Service providers need to know that women are likely more at risk from the social aspects of the use and the environment they live in than from the substances themselves, added to this pregnancy offers women a life event that can foster motivation to change (Wright & Walker, 2007).

## **II. The treatment needs of women:**

In 1991 Susan Boyd helped create one of the first women-centred, harm reduction programs for women in Vancouver. The group called Drug and Alcohol Meeting Support (DAMS) was dedicated to harm reduction, stabilization and self empowerment, family reunification was also a component of the program because most women had at least one child apprehended from social services. The needs for the DAMS program were identified by what a woman prioritized. Stabilization versus abstinence was the goal, and support was diverse. The group was predominantly First Nations women, who were mothers. Boyd notes that First Nations women are often over represented in groups of substance using women and they are the most vulnerable to arrest, child apprehension and poor health outcomes.

Drug and alcohol use is shaped by gender, class, race / ethnicity, sexuality and culture and because it is mediated by these factors the consequences of drug use are not the same for all women (Boyd, 2007). Poverty and social conditions are correlated to outcomes in pregnancy, for example in one study mothers who used heroin were matched for social factors and had comparable birth outcomes to similarly vulnerable non-drug using mothers (Wright & Walker, 2007). However, poverty and related factors do play a role in why some women misuse substances during pregnancy, and services need to address ways women can be meaningfully supported to improve their day to day life (Tait, 2000)

Substance use programs for women must meet women's diverse needs and include programming which reflects they are women and they are pregnant (Tait, 2000; Applegate et al, 2001; Bang et al,

2007; Carten, 1996; Drabble, 1996; Sun, 2004). Pregnant women who use substances need to be regarded as pregnant versus substance users who happen to be pregnant, and this ensures women will receive necessary prenatal and health care as well as treatment services (Hepburn, 2002). Gender specific treatment has been found to be more effective than mixed gender approaches (Fitzgerald, Hiram, Lester, Barry, Zuckerman & Barry 2006). Criticisms against mixed gender treatment state that pregnant women do not get services related to their pregnancy nor do they show positive outcomes from traditional, predominantly male-based programming and these programs have been found to exacerbate women's depression and also do not address the violence that is often linked to substance use (Russell & Gockel, 2005; Fitzgerald et al 2006).

The treatment components for women discussed in the literature are diverse, and offer a range of services for women and often their children and partners, and some researchers have referred to the array of resources as a "complex constellation of interdependent bio-psycho-social factors" (Nina, Uziel-Miller & Lyons, 2000). More specifically these components include: services delivered by multidisciplinary teams; services delivered via a multi-agency framework; antenatal / prenatal management; trauma counselling; peer role models; vocational and educational components; reproductive health care; infant- child needs; child protection needs; obstetrician needs, methadone maintenance; role of partners; considerations for domestic violence counselling; FASD; mothering, tobacco cessation; therapy needs; life skills; culture; health, and child care (Carten, 1996; Drabble, 1996; Marchenko & Spence, 1995; Russell & Gockel, 2005; Nina, Uziel-Miller & Lyons, 2000; Nicola, Connors, Grant, Crone & Whiteside-Mansel, 2006; Martin, S., Beaumont, J. & Kupper, L., 2003; Poole, 2007; Sowards, K., O'Boyle, K. & Weissman, M., 2006; Dempsey Marr, D., Wenner, A., 1996; Hepburn, M., 1993; Hepburn, M., Wright, A. & Walker, J., 2007; Roberts, A. 2007; Olson, B. 2007; Bailey, J., Hill, K., Hawkins, D., Catalano, R. & Abbott, R., 2008) This list is neither exhaustive or in any relational order

and treatment for women requires flexibility in delivery providing women a wide range of options suited to their lives and families.

While there has been a lot of research and support in the area of women and substance use, a gap remains between what is known and what is done (Poole, 2007). The diagnoses of FASD has been out for a number of years, regardless of this, in Saskatchewan there has been no revision or establishment of treatment services that are specific to prevention and reflective of women's needs (Tait, 2008). As previously stated, women are often motivated to change their substance use during pregnancy and as outlined in the stages of change (Appendix B) during pregnancy women are at a point of action where they are ready to establish and practice a change in their substance use. In consideration of the needs and services that could be offered in a women centred treatment program it must be recognised the treatment needs of women are complex and require many levels of intervention and treatment including but not limited to socioeconomic, clinical and systemic (Finkelstein). Service providers need to be aware of the larger picture and continually increase their knowledge of special factors affecting substance use by women (Goldberg, 1995), particularly during pregnancy.

The Centre for Substance Abuse Treatment outlines a bio-psycho-social intervention model which includes:

- “Medical interventions and Health Services (including general, gynaecological, and obstetrical health services; infant and child primary and acute care; health education, prevention, and treatment regarding sexuality, HIV, AIDS, and STDs).
- Substance Abuse and Psychological Counselling (including substance-related counselling, as well as counselling based on the relational model in which issues such as low self-esteem, violence, interpersonal relationships, loss and shame are discussed).

- Life Skills Training (including vocational, educational, and parent training).
- Other Social Services (a comprehensive case management approach is recommended including child care, transportation, legal services, and housing).” (p.356, Uziel-Miller & Lyons, 2001)

Pregnancy is an event in a woman’s life that often offers the opportunity and motivation for a mother to change her lifestyle benefiting both herself and her children (Hepburn, 2007). Interventions for mothers and children must be delivered through broad approaches using relationship based, mother-child models inspiring insights and progress in the development of mother and child and , including the development of the relationship between the two (Leslie, DeMarchi & Motz, 2007). The treatment needs of women will be further discussed in the program description via connecting the core program components to what the literature states as needs for woman centred treatment services. This gives further validation to the program design and concepts of delivery of treatment services for woman who use substances during pregnancy.

## **Environmental Scan - review of existing programs and services for women who use substances during pregnancy:**

The environmental scan provides an overview of existing programs for women who use substances during pregnancy. The programs reviewed offer a diverse range of services and supports, and offer them via women centered harm reduction models of care. Currently in Saskatchewan there are a variety of stakeholders that have expressed an interest in the care of women who use substances during pregnancy and many of these groups and individuals have been to the two programs outlined in Vancouver. The information outlined in this section is derived from available information on the programs and personal site visits at Sheway and Fir Square from the author. The author reflects that the services outlined are thorough and meet the needs of the community they are in, however, because of specific community make-up and need these programs can not be exactly duplicated to represent a local model of need and care. The environmental scan of the national programs offers a good model of how to work with women who use substances during pregnancy and how to become women centred in service delivery. The section concludes with demonstrating how one local organization developed a community specific women centred program in Regina. The program is offered by KidsFirst Regina, and is called Mothers First.

### **I. Sheway, Vancouver**

Sheway is a Coast Salish word meaning “Growth”. Sheway is a partnership initiative governed by the Vancouver Coastal Health Authority, Ministry for Children and Family Development, the Vancouver Native Health Society and the YWCA of Vancouver. The program provides comprehensive health and social services to women who are either pregnant or parenting children less than 18 months old and who are experiencing current or previous issues with substance use.

Sheway operates in a client centered, women focused environment and offers highly specialized services to pregnant women who use substances who have highly complex needs. Sheway gives recognition that the health of women and their children is linked to the conditions of their lives and their ability to influence these conditions. All staff work in partnership with a woman as she makes decisions regarding her health and the health of her child. The program provides health and social service supports to pregnant women and women with infants less than eighteen months who are dealing with drug and alcohol issues. The focus of the program is to help the women have healthy pregnancies and positive early parenting experiences.

Sheway is located in the Downtown Eastside of Vancouver, in a two story building shared with the YWCA. The YWCA is on the main floor as well as Sheway's community activities and programs. On the main floor there is a common area with couches and a few small offices surrounding it, a kitchen and a small eating area. There is a cook at Sheway and at noon they provide lunch. Moms can come and eat and participate in any of the weekly activities that are offered. The second floor space has examination rooms for the physicians, offices for counsellors and other services, as well as an open area waiting room. Women who are in the program can have all of their prenatal exams done at Sheway. A Doctor is available and there are nurses.

In addition to the medical aspects of care there is also an early childhood intervention worker, a drug and alcohol counsellor, social workers, an Aboriginal/First Nations liaison worker, community liaison outreach worker, a nutritionist, cooks, infant development consultants, and other program staff. In addition to this Sheway also works directly with: A Pediatrician from Children's and Women's Hospital specializing in developmental assessments and substance exposed infants and children; An Occupational Therapist; Physiotherapist; Speech/Language Pathologist from the Centre for Ability; Music Therapists from Vancouver Native Health Society, and Fir Square.

The Sheway pamphlet states the following services:

**We provide:**

- Daily hot lunches
- Weekly Food Bags
- Nutrition counseling and prenatal vitamins
- Grocery store food/milk coupons
- Practical support for securing medical care, housing, advocacy and social benefits
- Prenatal and postnatal care
- Well baby care, child and adult immunizations
- Parenting support
- Referral and access to support groups and community resources
- Alcohol and drug counseling
- Contraception counseling and provision
- STD/HIV counseling and testing
- Baby food, formula, toys, diapers and baby clothes, when available.

Sheway works with a woman for a specified amount of time during and after pregnancy and then relies on referrals to other community services and supports. Women come into the program via referral from other sources. They fill out an application form which has health information and related information that health systems often require. Staff at Sheway state this is the only program of this type in North America, and attributes this to the fact that in most other locations pregnant mothers using substances would not enter a program known to be for pregnant women who use substances due to the stigma associated and fears of having their children apprehended.

The following excerpt is taken from a descriptive summary of a visit to Sheway by the author in 2008:

At the side of the building there is a playground that is affiliated with the YWCA program, it is treed and has play structures. The playground is fully fenced in and from the street you would not even imagine it is there. The building inside is nicely furnished and again offers a stark contrast to the street outside. Beside the common area and couches there is a bulletin board for the women. A letter from a former participant is on the bulletin board, she writes a letter from eastern Canada where she now lives and works. She addresses the letter to current women and families at Sheway. She goes on to tell about her life on the streets in Vancouver several years earlier and how Sheway helped her start to change her life. It is a nice summary of the good service the program offers. Sheway does not track former clients or long term outcomes. One of the program's challenges includes the inability to follow up with the families on a longer term, or to provide intensive home visiting portion to the program.

After hearing about the program, and reading about it a few years ago, going there was almost anticlimactic. While they offer a good program for their community I see challenges in Sheway being a program that would readily fit other communities. For example as Pam indicated for

most communities the program mandate would be a barrier that would be insurmountable to most pregnant women who use substances. From other reading on the topic and clinical practice, I professionally would recommend and favour long term programs that provide services for a number of years after delivery. Long term services provide the amount of support and duration that women often require on the continuum to change. This being said, Sheway is a great program for the community it is in, however, if given the opportunity to provide longer term programming and support it could be more effective in breaking the cycle that the staff referred to often as being their barrier to getting work done – children being apprehended.

## **II. Fir Square Unit – BC Women’s Hospital, Vancouver**

The web site for this program offers the following information on services:

Fir Square Combined Care Unit program is the first in Canada to care for substance-using women and substance-exposed newborns in a single unit. The program helps women and their newborns stabilize and withdraw from substances, keeping mothers and babies together whenever possible and continuing to provide care from antepartum to postpartum and between hospital and community.

Women at Fir Square have access to counselling and instruction to enhance critical life skills, parenting techniques, and coping mechanisms. Babies receive specialized care that meets their needs if withdrawing from prenatal substance exposure to ensure the healthiest possible start. Babies room in with their mothers on the ward. Women and their babies are kept together on the ward, and women learn to care for their baby if the baby is withdrawing. The philosophy of care is one of harm reduction. The aim is to help reduce substance use and risky behaviours that can cause harm to mothers and their babies. Mothers and their babies are supported to safely stay together after they leave hospital, and help them to gain confidence with parenting. Alcohol and drug counselling, assessment and support as well as a referral service is offered as needed.

The multidisciplinary team of physicians, a senior practice leader, nurses, a social worker, an addictions counsellor, a nutritionist and a life skills/parenting counsellor provide the care. This team assists substance-using pregnant and early-postpartum women achieve an optimum health to minimize

the effects of alcohol, drugs, malnutrition, and neglect on themselves and their infants.

BC Women's Fir Square Combined Care Unit has five antepartum and six postpartum beds for women wishing to stabilize or withdraw from drug use during pregnancy. There is also a centralized nursery for babies in need of specialized treatment.

Fir Square offers the following services:

- Caring, non-judgmental support
- Advocate
- Assistance with finding housing
- Referrals to community services as needed
- Access to medical care
- Parenting groups
- Recreational and music therapy
- A First Nations Advocate available
- Spiritual Care

Working within a model of woman centered care, women participate and guide every aspect of their care and discharge planning ([www.bcwomens.ca](http://www.bcwomens.ca)).

The following excerpt is taken from a descriptive summary of a visit to Fir Square by the author in 2008:

We meet with a nurse, her name is Pat. This is not the nurse we were scheduled to meet with. Initially we were to meet with Sara Payne, who has written on the topic and is included in "With Child" by Susan Boyd. Sara we learn has left to work for a one year contract with the UN. We have a very informal meeting with a nurse who has worked on the unit since it opened. Due to her frankness her real name is being omitted.

Pat provided a tour of the unit. It is a part of the hospital and is set up in that fashion. There are 11 beds. We tour the unit and see many of the moms on the unit and one mother, her partner and their baby. Fir Square provides two primary services detox to pregnant moms, and delivery. After pregnant women detox they cannot stay at Fir Square and only return for delivery. After delivery they stay for as long as they can until both mom and baby are ready to be released, often this is dependent on baby and withdrawal, weight gain, health, and on the Ministry if baby is able to go home with mom.

Pat showed us their wall of photographs of moms and babies. She pointed out many who "made it" and many who returned to the streets and their children are in foster care. She ended the facility tour with the nursery. There were two babies, one baby was two weeks and had just come off of morphine and the other one month old. Morphine is used to detox babies after they

are born. Both babies had been abandoned by their moms, the two week old the day before. Her name (baby) was Strawberry. Strawberry was very small and basically just fit into the two hands of the nurse. Pat shared the mom tried her best and had actually delivered Strawberry at home alone, she could not feed her due to some aspect of her own drug use versus the inability to breastfeed, and as such she gave her baby a can of ensure from the fridge, it was strawberry and the baby smelled like a strawberry. Due to this her mom named her “Strawberry”. Pat discussed the mom with much empathy and discussed how the pull back to the streets is very difficult to overcome.

The one month old baby had been abandoned two weeks before and had been waiting for a foster home. This baby was swaddled and sleeping she looked to have gained weight and was the average size of a one month old. Pat talked about how this further hinders the outcomes for this baby because the hospital cannot provide the environment or needs that a baby who is born addicted requires. Pat spoke about “THE ministry” with a lot of frustration. From her own work on the unit she shared how she sees firsthand the babies do better with withdrawal and weight gain, health improvements when they are allowed to stay with their moms. While what she shared is anecdotal, she did identified Fir Square has preliminary research that also suggests this as a beneficial practice and outcome to the baby.

We go to their coffee room and Pat talks about nursing on the unit and how she came to work there. She shared she was never a conventional nurse and always viewed hospital policy and rules as “guidelines” only. Pat shared many of the barriers that the women experienced prior to Fir Square unit opening and some ongoing challenges they have with other units and staff in the hospital. A lot of the problems were associated to the stigma of using drugs during pregnancy, and lack of understanding the continuum of coming to abstinence, and harm reduction.

Most outstanding about the tour was Pat’s perspective and focus on the positives of keeping mom and baby together for the babies health and development. Regardless of her peers and the challenges she maintains a focus on the positives of working with the mom and her frustration related to women leaving the hospital and going back to the streets, the men involved in their lives, and child protection. Pat spoke frankly about these issues and talked specifically about certain women and the circumstances in their lives.

Some of the challenges to the program from Pat’s perspective sounded to be stemmed in the philosophical and ideological beliefs and differences from the work they do at Fir Square from child protection workers.

### **How can Sheway and Firsquare be the only programs of their kind?**

#### Community and Systemic reasons:

The social conditions on East Vancouver as indicated by staff at the programs allow for their programs to be successful in that community. Most people would not be up to admitting to substance use during pregnancy. The visibility of the programs in other communities could be a barrier. In addition to this societal beliefs and values lean toward abstinence based approaches or “war on drugs” beliefs via media campaigns.

Added to this is the history of villainization of drug use and in particular women drug users. Some of the related literature talks about drug use and pregnancy, a lot of women smoke without the same alienation as other drug use and many take controlled substances such as anti-depressants without any stigma associated. Our society has a twist on what is acceptable and what is not, and this is not necessarily based on evidence. Another societal issue is the rift between women's' issues and children's, rather than recognising the benefits of keeping mother and child together.

The medical model and barriers imposed, and "patient" focus offer a narrow view point to adequately address the needs and better health outcomes. This also applies to other systems and can be seen via program designs, e.g. high threshold programs and services. Another impact is the move away from social reform and the state's involvement in social issues has lead to a reduction in budgets and the services that can be provided. This could be a part of the problem as identified with the need for child protection to be more in support and alignment with services to maintain the family unit.

### **III. Breaking the Cycle, Toronto**

**Unless otherwise noted this information was taken from "With Child", Breaking the Cycle: an essay in three voices by Margaret Leslie, Gina DeMarchi, and Mary Motz.**

Breaking the Cycle is an early identification and intervention program for women and their children, pregnant women with substance use problems and mothers who have substance use problems with children under age six (Van Den Broek, 2007). Breaking the Cycle is supported by Mothercraft, which has been a leader in supporting healthy child development since 1931. Breaking the Cycle was designed to enhance the development of substance-exposed children by addressing maternal addiction problems and the mother-child relationship through a comprehensive, integrated, cross-sectoral, community model. The program offered the opportunity for existing services to be reorganized and delivered in an improved manner, recognizing that services should be coordinated so agencies can adapt to families rather than families having to adapt to multiple agencies. Goals identified were to address existing service-system problems and fragmented services for substance using pregnant women or mothers and their young children. Problems included multiple intake experiences, lack of consistency, multiple service-access locations, and poor conditions of services, particularly between adult and child service sectors.

Breaking the Cycle is funded by the Public Health Agency of Canada's Community Action Program for Children and the Canada Prenatal Nutrition Program. The program operates through the efforts of seven partner agencies representing a non-traditional collaboration among child welfare, substance use treatment, health, and child service sectors to address the complex problems of mothering and substance abuse. A single access model offers integrated addiction counselling, parenting intervention, health and medical services. External evaluations have taken place since the program began in 1995 and it has been the focus of many research initiatives. Evaluations have reported on the efficacy of both the comprehensive, integrated program model and of a pregnancy-outreach model. The evaluations have also reported on enhanced birth and perinatal outcomes for infants of substance-involved mothers engaged earlier in pregnancy, on enhanced developmental outcomes for the children involved, on enhanced parenting confidence and competence, on enhanced treatment outcomes, and on decreased rates of separation of mother and child.

In 2004 Breaking the Cycle was recognized by the United Nations Office on Drugs and Crime as an exemplary program serving pregnant and parenting women with substance-use problems.

#### **IV. MotherFirst, KidsFirst Regina**

KidsFirst Regina is a program that assists families in becoming the best parents they can be, by providing support, enhancing knowledge and building on family strengths. KidsFirst offers a home-visiting component via home visitors who work out of five community agencies in Regina. Participation in the program is voluntary. KidsFirst accepts expectant mothers or those with a child up to the age of one. Families interested in participating in KidsFirst will receive a visit by an assessor to determine if they are eligible for the program. A special team made up of a variety of mental health and addictions professionals provides support and training for Kids First Regina programs, including the home visitors. KidsFirst is a unique program that provides support to vulnerable expectant and

new mothers in Regina.

The MotherFirst component to KidsFirst was established in 2007. The specialized team that offered mental health and addictions services were already providing various programs that would fit with the recovery base for the women in the program. The idea of integrating those programs into one stream of service was reflected in the literature as a best practice, via adjusting services to meet the needs of the moms in the program and not having them register for multiple groups or components to access mental health and addiction care. To solidify this transformation a working group was struck that consisted of internal KidsFirst program staff and external partnerships. The additional partners also brought expertise and specialized services to the women on the stages of change. External partners included public health, the social worker from the Mother Baby Unit at Regina General Hospital, and addiction services.

The initial group was scheduled to be run over eight weeks with women attending three days per week. This schedule allowed the women, as mothers, to have time during the week to care for their families. The group was designed to meet the needs of women who are involved in treatment for problematic substance use and who want to participate in parenting and general lifestyle groups. Priority was given to pregnant women. As evidenced in the literature barriers for women entering treatment programs have included cost, childcare, transportation and meals. All of these associated costs are covered by the KidsFirst Regina program. Transporting other children to school was also accounted for and arranged.

Program Outline:

*You Make the Difference* is a program designed to support parents of children from birth to five years old, who would like to learn more about enriching their child's early language, social and literacy

development. The program can also provide support to vulnerable families whose children's learning may be at risk due to environmental or social factors.

*Reclaiming our Lives, Creating our Tipis Parenting Program*, is a parenting approach that supports grassroots issues, concerns and celebrations. The structure of the program is based on the 15 traditional values representing the 15 poles held together to form a tipi. Each session relates to a traditional value to the journey of becoming a parent. The main objective is for the women to allow themselves to listen and take care of their own self as a parent.

*Stress Management Group* helps individuals recognize when stress starts causing problems in the women's health and relationships. Women are taught alternative responses to stress through a holistic approach that promotes balance in the participant's life and relationships. The group focuses on skill building.

*Self-Esteem Program* is designed to enhance the self-esteem and communication skills of group members. Facilitator's assist in the discovery of what self esteem is and how it affects beliefs, feelings and self perceptions which motivate our attitudes and behaviours on a day to day basis. Communication skills are incorporated to develop or enhance positive and effective interactions with confidence, building upon self-esteem.

*Recovery Group- Addiction Services* objectives are to assist women in learning the factual information about chemical dependency; to connect motivating problems with chemical use; to examine denial patterns which block processes to recovery; to learn about recovery processes; to recognize the need to change and where to access help and support. Stages of change are a component as well as relapse prevention.

Additional *open sessions* are also provided which include guest speakers in the areas of healthy relationships and domestic violence, community kitchens, self-care, budgeting, nutrition in recovery, and the importance of physical fitness. At intake measures of a women's well being are taken and the pre and post test measure assist in the ongoing program evaluation and assessment. The program is currently in the second run and some components have changed based upon feedback of participants, one of the changes was to increase the amount of time spent with services from Addiction Services.

The programs reviewed offer necessary care for women allowing women to work through their stages of change (Appendix B), often allowing women to rotate back to the streets several times during their pregnancy. Sara Payne (2007) writes the following on Fir Square:

“We have learned about resiliency, of the will to live life with dignity. We have learned about the transformative power of birth. We have learned that with life there is hope. We have learned to laugh and cry with women in the face of huge challenges. We have learned that we can make a difference step by step as we walk with women. Fir Square is premised on taking risks with women and believing that, with support and encouragement, women’s lives can change....,There is more to be learned about applying harm reduction and women centred care within an acute-care setting, and about ourselves. We took the risk of believing women with problematic substance use can be good, caring mothers and can care for their babies from birth, despite active substance use during pregnancy. It is incumbent on all of us who care for pregnant women with problematic substance use to insist on a women-centred, harm-reduction approach, and to practice it. The lives of many women and children depend on it.” (Payne, 2007 pp.68-69)

**Program Description:  
For a Woman Centred Harm Reduction Treatment Program at White Bear First Nation**

**I. History: The needs via the case summaries of nine women who had their children apprehended after delivery due to problematic substance use:**

Between the dates of November 1, 2007 through to October 31, 2008 Yorkton Tribal Council Child and Family Services apprehended nine babies from the hospital shortly after delivery due to problematic substance use by the mother during pregnancy.

In a file review of the nine cases cited by YTCCFS, all babies went into foster care after discharge from the hospital and they have remained in care. The mothers each had limited or no extended support systems or a venue where they could address their substance use during pregnancy or following delivery.

Not all files specified what drugs were used other than polysubstance use, which is often referenced in association to polysubstance dependence as listed as a substance disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. The *DSM-IV* is used by mental health and addiction professionals to diagnose disorders related to mental health and addiction. To meet the criteria for dependence on a group of substances (at least three different types used in the same 12-month period) an individual is given the diagnosis of polysubstance dependence. The individual uses the three different classes of substances indiscriminately and does not have a favorite drug that qualifies for dependence on its own.

Given this definition all of the mothers' drug use, from the files reviewed would fall under polysubstance use and / or dependence. The drugs stated on the files included the following: dilaudid, morphine, painkillers, Ritalin, cocaine, and kadiann. Four of the mothers were at one point currently or past on a methadone maintenance program.

Three of the babies are the only child, and the remaining babies have at least one and up to six siblings each. The baby born on November 2007 is a long term ward, along with the sibling group due to

their parent's unwillingness to address their problematic substance use. The babies had varying degrees of withdrawal symptoms to no symptoms experienced. Babies in withdrawal are often given medication for a period of time to lessen symptoms and wean the drug from the system.

From this broad overview of the files reviewed, the issues for consideration include the aspect that the babies have not returned to the care of the parent and the gap in existing treatment services for mothers. The aspect that infants do not return to the care of their mother within the first year of life is concerning because infants who remain in care form their primary attachments to the foster caregiver and not the parent. The majority of child development and bonding occur within the first year of life, any subsequent plans to reunite children after primary bonds have been established are within the realm of creating further duress and developmental impacts to the child. To lessen this occurrence the proposed program would fill a large gap in services between child welfare system and health care / hospitals. In addition the files show that finding adequate treatment and supports for the mother's has remained also presented a significant gap in treatment services that meet the needs of pregnant and parenting women. Aside to these two broad considerations that will support a woman centred treatment program are issues such as methadone maintenance and this will be considered within the *special consideration* section of the program description.

## **II. Community overview, community asset exercise summary**

To give the context of the community the proposed program will be delivered in, the local Child and Family Service office dedicated time and resources to complete a community asset exercise. This section briefly summarizes the work that was completed and is taken directly from that work (Ewak, 2008).

The White Bear First Nation reserve and community is located in the south east corner of Saskatchewan. The Four Nations Care Lodge is located within the White Bear Lake Resort. The on-

reserve population is approximately 800-900 residents. According to information provided from community members there are 15 elders, 8 persons living with a disability, 80 children under the age of six and a yet to be determined number of young mothers and families. The community consists of Cree, Nakota, Lakota and Saulteaux people. The faiths that are practised are Traditional Spirituality, Catholic, Protestant and Van Johnson Christianity.

The community has a number of strong individual and organizational assets. The following list is not exclusive or exhaustive and is offered only as a summary of the people, skills and programs available in the community that can be drawn on to enhance the proposed woman centred program:

- Life Skills facilitators,
- Cultural helpers,
- Income Assistance Program and staff,
- Child Care Initiatives
- Aboriginal Head Start
- Home & Community Care
- Medical Transportation Program
- Community Addictions Program
- Mental Health Services
- Brighter Futures
- Solvent Abuse Initiatives
- Aboriginal Diabetes Initiatives
- Prenatal Nutrition
- Tobacco Control Strategy
- Fetal Alcohol Spectrum Disorder
- Four Nations Care Lodge Board of Directors,
- Community health representatives,
- Workshops in the following areas: Diabetes, AIDS, Family Education, nutrition.
- Home-visits with clients,
- Interpreter of health services to members,
- Baby clinics –weigh-ins, pre-natal care, post-natal care, assists with immunizations,
- Flu vaccines,
- Home nursing care,
- NNADAP program,
- Community Health Nurse,
- Health promotion,
- Health prevention,
- Immunization,
- Communicable disease control,
- Health teachings,
- Home-visits,
- School health, adult health, chronic disease and long term care.
- Healing through our Ancient Teachings provides services and support to community members

- Parenting services and elders programming,
- Traditional parenting teachings,
- Medicine wheel teachings,
- Suicide prevention certificate,
- First Aid/CPR,
- Post Secondary Co-ordinator, Post Secondary Education,
- White Bear Home Care Co-ordinator,
- The White Bear Education Centre
- The Kakakaway Learning Centre
- The Four Nations Care Lodge
- The White Bear Administration Band Office
- The Carlyle Medical Clinic
- L'il Bear Paws Day Care
- The Yorkton Tribal Council Child & Family Services Inc.
- Healing Through Our Ancient Teachings Office
- The White Bear Political Office of the Chief and Council
- The Arcola Hospital

### **III. Service Philosophy**

#### **a) The program:**

- The guiding mandate of the program is to provide treatment services to women who have had problematic substance use during pregnancy, and have an infant that is at risk of apprehension.
- Provides services in a flexible, non-judgmental, nurturing and accepting way.
- Offers respect and understanding of First Nations culture, history and tradition.
- All services will flow from a woman centred and harm reduction philosophy.
- A woman centered approach supports women's self-determination, choices and empowerment.
- A harm reduction approach is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence.
- To support mothers in their capacity as parents and caregivers.
- Women who have experienced problematic substance use during pregnancy and their infants (up to 12 months age maximum at entry) can enter the program.
- The women centred program will run over 3 to 6 months in duration. An assessment at 10 weeks will be completed to determine if the woman will graduate at the end of 3 months or stay in the program up to 6 months. This is to offer flexibility to women and their families who can not reside at the facility.
- Core staff at the initialization of the program includes an RN who will function as administrator and work both sides of the Lodge, A clinical social worker MSW or a MA psychologist and an addiction counsellor. The three will function as a multidisciplinary team and function in a collaborative process when working with the women.
- Program elements have a foundational link to the determinants of health, as indicated in text boxes.

### **b) What is a woman centred philosophy?**

- Women are central and have a choice in their decision making.
- Women define their family as whomever they choose rather than traditional bloodlines.
- Caregivers have the role of facilitator for the woman's pregnancy and birth experience.
- Strategies put women's safety first, focus on empowerment; minimize risks, recognize diversity and complexity of women's lives.
- Respect a woman's choices.
- Strategies include honesty, advocacy, given information to assist in making choices, support her decisions, maintain confidentiality, always obtaining consent, and partnering with community support services (Payne 2009).

### **c) What is a harm reduction philosophy?**

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use. (reproduced from Shewey)

## **IV. Program Description for Phase One:**

Phase one is the initialization of the program. It will include key elements necessary, however there are additional elements that will be built upon as the staff builds a strong team environment and implements a program based upon a woman centred harm reduction philosophy. Clients in phase one are post delivery mother and baby under one year of age. The program will run for 3 months, or 6 months depending upon a woman's needs. At six weeks all women will have an assessment completed

with them to determine if they will continue in the program or graduate. Women who graduate will need to have their external team of support integrated for aftercare planning.

Other program phases will include the following:

#### Phase Two

Mother and baby, expanded funding, expanded program, training needs, community support, expanded policy development

#### Phase Three

Expanded program components to include prenatal mother, and mother and baby, NNADAP funding, expanded program, expanded training needs, community supporting, and policy development completed

#### Phase Four

Expanded program and facility to extend to the women's family, and include family living units.

This program description is related to the phase one level of the program and the initialization of the program. All elements in this paper while they are foundational to other phases for program development, the focus of this program description is primarily on the initialization of the program and all recommendations are for the first phase of the program delivered.

### **a) Intake**

Procedures for intake need to be completed on a case by case basis and will vary depending on the women and babies that are in the program at any given time. Assessments must consider at all times the existing client population and needs, balancing that with the women and children's needs, as well as with the other residents at the facility. As previously stated the guiding mandate of the program is *to provide treatment services to women who have had problematic substance use during pregnancy, and have an infant that is at risk of apprehension*. To adequately speak to the intake process and procedures it is first necessary to speak to the client population.

**Client Population:**

- Mother and baby up to maximum of 18 months old (12 months old at Intake)
- Mother has had problematic substance use during pregnancy
- Mother and baby are detoxified
- Baby is at risk of being apprehended
- Mother has not had a significant history of violence
- Mother does not have a pervasive mental health disorder
- Post partum depression is to be considered for each mother

Clients referred to the treatment program will be women who have recently delivered a baby and the baby is up to a maximum of 18 months old, specifically the baby is 12 months maximum at intake. The age limit of babies must stay within the specifications with each intake consideration given to the age of the babies that are currently residing at the treatment centre. Babies that are not yet crawling and under the age of 6 months old will be the better candidates and this is due to their limited mobility and ease of care, as well as the overall impact on the child via establishing a bond with their mother from an early age. Babies who are experiencing withdrawal show better results and outcomes from rooming in with their mothers and from breastfeeding as early as possible. Breastfeeding has been found to reduce the severity of neonatal withdrawal symptoms, and the only time breastfeeding should not be considered is when the mother is HIV positive (Hepburn, 2004). There are varying recommendations on the transmission of hepatitis C and it is recommended that staff consult with resourced and knowledgeable physicians on this aspect.

Aside to these client population specifics for the baby, mothers and babies will both be detoxified before entering the program. The staff needs to work closely with the CFS and Ministry staff that are making referrals as well as other referral sources, including the hospital where the mother delivered to ensure that mom and baby have detoxified prior to coming to White Bear First Nation. Baby must also be at risk of apprehension due to associated risk assessments completed from the associated child welfare authority, or come under the recommendation of that body and referral source. However, the

treatment program is not an alternative to foster care and women without problematic substance use will not be given priority.

Other considerations for intake include the existence of a history of violence, mental health disorders, and post partum depression. In no manner are these three factors linked or associated they are only other considerations that need to be made with each intake.

Any woman who has experienced significant violence in her life, either where she has been the perpetrator or the abused needs further assessment and exploration regarding the violence during the intake process. This is to ensure safety of the woman and child entering the program and the safety of the other mothers and children, and other residents. An assessment tool that can be utilised to assess this is the *Conflict Tactics Scale* which is a useful tool to open discussion on violence a woman may have encountered. It is a clinical tool and requires skilled application from an authorized and registered clinical social worker or psychologist.

Pervasive mental health disorders such as schizophrenia may be outside of the scope that a program of this nature could offer. The Phoenix Residential Society in Regina specialises in co-occurring, concurrent or dual diagnoses disorders, meaning a substance use addiction problem and a mental health disorder. Should any referral indicate presence of a pervasive mental health disorder or suspect of these criteria, linking to the Phoenix program for consultation on the intake could occur to determine the most suitable program for the woman and child.

Service providers indicate that First Nation women are often suspect to post partum depression. In determining if a woman may have post partum depression intake personnel for the treatment program can consult with hospital staff and the delivering physician (or other professional) who can use a depression screen such as the *Beck*. If post partum depression is suspect the mother needs to be referred to a physician for full assessment and diagnoses. The outcome of the depression screen needs

to be considered in the intake process to determine if the woman has mental health care needs. In the event a woman does have symptoms associated and / or a diagnoses of post partum depression this does not rule the woman out from entry to the program. It will mean the clinical staff will need to be prepared to work with the woman regarding the depression and know the related clinical criteria and best practice measures for treatment which can include cognitive behavioural approaches and medication if determined by the physician as necessary.

Intake interviews must also explore the factors associated to the problematic substance use. This information and discussion can include a detailed drug history, details of drugs used, amounts used, routes of use, financing of use, social aspects of the use (functional assessment), readiness for change (assessment tool), domestic situation and any violence, partner's drug use, history of parenting and previous problems with parenting, and other possible medical consequences related to substance use (Hepburn2004).

Summary of intake considerations:

- guided via woman centred care philosophy
- exploring any history of violence – *Conflict Tactics Scale*
- considering pervasive mental health disorders - *consult with other specialized programs*
- depression screen, post partum depression – *Beck, or Happiness Scale*
- a detailed drug history,
- details of drugs used, amounts used, routes of use, financing of use,
- social aspects of the use (behavioural assessment),
- readiness for change (assessment tool),
- domestic situation and any violence,
- partner's drug use,
- history of parenting and previous problems with parenting,
- and other possible medical consequences related to substance use

The intake process is the most important first step in engaging a woman and it should be considered as the meeting whereby the intake assessor, who is actively engaged in the delivery of the clinical program, is welcoming a potential new member to the treatment family. Within that realm it also needs

to be understood that not all intake meetings will result in an intake. Once the intake meeting is completed the treatment team will meet and review the intake and as a team discuss the intake process established and the intake information. To ensure a woman centred approach is taken, it is necessary to state the intake process is not the job of one person to determine who enters the program, however, all intake information is confidential and is not to be shared. Procedures for safe storage of files, treatment program information will need to be established along with guidelines on how long files are kept before they are destroyed.

Another aspect to consider in the overall client representation is the fact that there are two groups of women who use substances during pregnancy. One group is the chronic addicted and the second group, noted as being the more prevalent, have problematic use of substances but are not addicted (Tait, 2008). The problems associated to the use however are of significance to the mother and child and overall outcomes. In completing intakes it must be considered that both groups, due to being mothers with children are within the criteria to enter the program and chemical or substance dependence is not an absolute criterion.

The elements discussed are not exhaustive and upon initialization of the program the core staff needs to sit down together and decide what other elements of intake need to be considered. It is recommended that the core staff meet with the staff from the Phoenix Residential Society in Regina. This program includes the identical core staff that is being recommended for the White Bear program, a Registered Nurse, Registered Clinical Social Worker (MSW) or Registered Psychologist (MA) and an Addiction Counsellor.

## **b) Program Model (see Appendix C.)**

The program is built upon the social determinants of health, and a skilled clinical team who will offer weekly individual counselling on issues related to substance misuse and overall emotional, spiritual,

mental and physical well being for every woman and child in the program. Other core program elements are based upon the needs of women in treatment as identified by women and researchers who work with women who use substances problematically. The program model is illustrated in Appendix C. In addition to the elements discussed the model takes the form of a house, the foundation of the house is the local community of White Bear First Nation and a women centred and harm reduction philosophy, the house then is built upward on the social determinants of health as related to perinatal substance use, a skilled clinical team and the roof of the house are the needs of women in treatment.

**i) The Social Determinants of Health:**

Adapted from “With Child” (Marcellus, L., & Kerns, K. 2007)

Social support networks:

Substance abuse is related to impairments in social functioning. Intergenerational effects lead to children being apprehended and children placed in foster care.

A women centred treatment program will allow mothers and babies to enter treatment together and offer programs that will build skills in developing support networks. In turn this will reduce the impact of intergenerational effects and break down in the family system via children being raised in foster care.

Personal health practices and coping skills:

Substance use interferes with the ability of an individual to practice health skills, including comfort in accessing and advocating for resources that enhance health.

Self esteem and stress management training and associated programming will foster personal life choices and skills which allow women to seek resources for them and their family and build on health practice and coping skills. All aspects of the daily program will seek to improve the personal health practices and coping skills for the women and children in the program.

Health services:

Women with substance use issues are more likely to use episodic emergency care, leading to decreased availability of follow up for health issues.

A women centred program linked to the new White Bear Health Authority will have access to additional health supports that can build on a women’s confidence with consistently accessing regular health care for themselves and their families.

### Gender:

There are gender differences in the way alcohol and drugs are socially used and accepted. Existing recovery programs are based on models that are male focused.

A woman centred program offers all aspects of programming that are reflective of a woman's needs and experience as mother's and partners.

### Culture:

Data on the prevalence of FASD is inadequate in both Aboriginal and general populations. However, Aboriginal women experience a disproportionate burden of health problems and Aboriginal people are a high risk group for substance use, and substance use during pregnancy.

All aspects of programming will assist in reducing risk and outcomes associated. The location on White Bear First Nation will allow all participants the ability to easily access traditional healing components of the program.

### Education:

Health status improves with education level. Maternal education level is a key predictor of health for both women and their families.

Programming will link with existing White Bear educational programs and assist women with initial steps towards attaining educational goals. Weekly programming will be implemented to achieve this goal, including linkage to follow up or transfer when the women leaves the treatment program.

### Income and social status:

Poverty is often a factor affecting the development of children with a history of prenatal substance exposure. Poverty compromises and strains a families' ability to provide a consistent nurturing environment.

Working on the development of monthly budget skills, including grocery shopping and meal preparation will build upon overall health and overall family wellness. To support mechanisms to build on income, programming will include a vocational component and women will connect to local resources on White Bear First Nation, to plan their goals towards employment.

### Working conditions:

People with addictions are often unemployed, underemployed or experience stressful or unsafe working conditions and experience poor health.

Establishing educational and vocational goals will give concrete skills that will allow women to seek better opportunities for employment and work. The second wing of the existing facility for the proposed program is also the home to elders and is operated as a care home. Women who enter the program and who wish to develop skills associated to home care could be mentored a few hours per

week by the nursing home staff to work with the elders. Women who choose to do this would then leave the program with practical job experience and a work reference.

#### Physical environments:

Due to lack of financial and social resources, people with addictions often live in sub standard housing.

The time a woman and child spend at the treatment program will help the family develop the personal resources to establish social networks and ultimately financial resources needed to attain better housing. Linking women to external supports while they are in the treatment program will help women to build the links they will need when they leave treatment. Inclusion of the prevention workers from child and family service agencies and off reserve early intervention programs, such as KidsFirst, will also support this goal and outcome.

#### ii) **Skilled Clinical Team:**

Multidisciplinary health teams are found in many health settings. A multidisciplinary team takes a collaborative approach and disciplines consider the work from a collective frame of each profession.

Multidisciplinary teams require a lot of work in developing a framework for practice and the team make-up changes as the team progresses e.g. builds rapport, and as team members change. Due to the multifaceted needs of women in treatment, a multidisciplinary approach that meets women's needs in a single service is being recommended. (Hepburn, 2004). The core professionals on the team will include:

- A Registered Nurse, who will function as the overall facility administrator for both programs at the facility (the women centred treatment program, and the care home program), and offer leadership.
- A Registered Social Worker (MSW), or Registered Psychologist (MA), who will function as the program lead / Director of the women centred treatment program, and offer leadership.
- An Addiction Counsellor who will function to ensure that all aspects of the program consider the problematic substance use, such as parenting within the context of being a parent when you have problematic substance use, and offer leadership.

- Licensed practical nurses and care aides as required based on total of clientele (on both programs) who will function in providing care and support as required.

The skilled clinical team will function in a team environment versus a hierarchical frame. The social worker/or psychologist and the addiction counsellor will each have weekly counselling sessions with each woman in the program. The weekly individual sessions will be specialized to meet the need of each woman in the program and will be foundational to other elements of the program that the woman participates in. The development of positive quality relationships with women in treatment has been linked as critical to a women's success (Carten, 1996), and clinical staff must always strive to establish and maintain these relationships with women in the program. The goal of the team is develop a strong team who has specialised capacity in delivering a women centred harm reduction program. To achieve this, the team will require team building and training on an ongoing basis. Recommended training could include the following philosophical practice frameworks, resources and programs:

- Foundational philosophy of woman centred care
- Strengths based model training and learning
- Smart Guide – packaged resource to work with women who use substances, training available through KidsFirst Regina
- Sisters in Spirit Resource Manual: a Harm Reduction Approach for Aboriginal Women Struggling with Addictions during their Childbearing years – a manual which could be used for team building and training.
- Reclaiming our lives, creating our teepees – a program currently delivered in Regina from Four Directions Health Regina
- Kisewatotatowin Traditional Parenting Program – offered from Randal Kinship, Child and Youth Service Regina Qu'Appelle Health Region (RQHR)
- Harm Reduction training – offered from Saskatchewan Registered Nurses Association (SRNA)
- Harm Reduction and methadone maintenance – offered from the Harm Reduction program at RQHR
- Team building/strengths based training
- Fetal Alcohol Spectrum Disorder (FASD) training focusing on working with children and adults based on cognitive level, ability and maturity – offered from a specialist in FASD
- Daily functioning, nutritionist cooking circle / budgeting break down and shopping, living skills – concrete more lasting vs. abstract – lentils, etc how to use nutritionist at WB health
- Robert Miller – Motivational Interviewing, professional training offered from trained trainers
- Living Works – Suicide Intervention Training

- Making the Connection birth to one - Infant Development/Bonding Facilitator Training
- First Nations/Health Canada Midwifery Program
- Community Reinforcement and Family Training (CRAFT) – training to work with family members of persons with problematic substance use
- Centre for Addiction and Mental Health (CAMH) training online with Saskatchewan Health on Mental Health and Addictions co-occurring disorders, etc.
- Postpartum Depression, and other Mental Illnesses
- Site visit to Phoenix Residential Society in Regina
- Site visits to other treatment programs in the province

A final ongoing consideration for the skilled clinical team is to consider that to be fully effective the women who are in the program need to be included in the content of the program and what they need. Programs designed for women need to be women specific and service providers and participants need to take a lead role in framing and creating new directions (Drabble, 1996).

### **iii) The Treatment Needs of Women:**

The following section links to the literature review and what the literature states the needs of women in treatment are. As well some of the sections are supplemented or derived from the clinical experiences of the author. The programming suggested is based upon what women who are in treatment have stated they need and do not get from traditional treatment programs. Each of these aspects can be included in the program from the sources identified and be offered in house and / or via the community services identified in the community asset exercise. The list is not exhaustive and can be built upon and adapted as the program develops, and developed to meet the needs of specific women and infants.

#### Parenting (traditional):

Women who experience problematic substance use face challenges when parenting. A lack of effective parenting has been linked to neglect and subsequent child apprehension and a parenting component in treatment has been associated with reduced parenting stress, increased parenting knowledge and improved attitudes (Conners et al. 2006). Women who can better identify with the parent role are also more successful in change and not using substances (Carten, 1996). The proposed program and inclusion of parenting also brings together child welfare agencies and substance use treatment in a collaborative way linking and harmonizing support to mothers and their children, this solves key

dilemma which has prevented the prevented effective approaches to problematic substance use treatment for women (Poole, 2007).

In order to make the parenting component of the program more culturally reflective a traditional parenting program is recommended. In addition to the traditional parenting program a mainstream parenting program could supplement the traditional program. Traditional parenting models for consideration are recommended and listed in the “skilled clinical team” section of this program description. In addition the author would recommend that the local community be consulted with in regard to existing parenting programs and traditional people who could offer added value to the program.

### Trauma

The association between trauma and substance use in groups of women who experience problematic substance use is an area in which the program will require specialized clinical skill and care. Researchers note there is a well established link between trauma and problematic substance use or mental disorders (Conners et al, 2006). Due to this association women in treatment may experience post traumatic stress disorder, and symptoms of trauma including sleeplessness or flashbacks that may re-occur when a women is maintaining sobriety and is no longer coping from using substances (Roberts, 2007). Addiction services need to integrate with skilled trauma counselling and women who seek help with trauma and mental health issues report misdiagnoses, medication over prescription and re-traumatization through encounters with health care professional lacking sensitivity (Poole, 2007).

There are a number of services and resources that clinical staff can utilize to develop further clinical skills in working with trauma as related to problematic substance use. The *Women, Co-Occurring Disorders and Violence Study* (<http://www.prainc.com/wcdvs/publications/default.asp>) provides resources, and models for the delivery of integrated support women on substance use, mental health and trauma related issues (Poole, 2007). Women in treatment have faced challenges in getting the proper care due to linear treatment models and service, another resource bringing together trauma and problematic substance use is the Seeking Safety program developed by Dr. Lisa Najavits at the Boston University School of Medicine <http://www.seekingsafety.org> (Roberts, 2007).

It is significant to remember that substance use can be secondary to the trauma (Tait, 2008). Programs that link substance use and trauma, such as the Seeking Safety program begin by helping women ground in the here and now and emphasize the importance of finding a place of safety, in the mind, physical space or action. Coping triggers, self talk, compassion, sleep problems, boundaries in relationships, and asking for help while highlighting the importance of safety in one’s self are also emphasized (Roberts, 2007).

### Personal wellness and self care

Women who are dealing with problematic substance use face a variety of challenges and demands. They are often mothers who are single parents, and are underemployed or unemployed. Due to involvement with child welfare authorities and children being in foster care, their children may experience emotional and behaviour difficulties which are a normal part of their experience in being moved. However, this adds back to the other impacts and stressors on the women as parent. In addition to the shame and loss they experience when their children are removed from their care.

As a clinical social worker, working with women with problematic substance use and / or the family members of a loved one with problematic substance use, every woman I worked with could not identify

with how to care for her own needs over others needs in a healthy and non-guilt producing manner. The guilt often related to occasions when the woman had taken on too much stress and made choices that were not safe for herself and her children to relieve the stress, such as binge drinking when the children were home or even leaving her children to do so.

In addition women who use substances problematically during pregnancy are not often socialized to care for themselves. This may be related to the stigma and stereotypes that include being viewed as immoral, negligent to their children, and as the enemy to a fetus (Finkelstein, N. 1994; Goldberg, M.E. 1995; Applegate, D., Bradley, C., Rhodes, R., & Saulnier, C.F. 2001).

To overcome this stigma ongoing daily work on encouraging women to spend time on self-care is essential. Within that is also balancing and learning how and when, or the identification of healthy self care. Working on establishing a routine of exercise, and daily consideration toward answering the question of “how as a mother how do you care for yourself?” are helpful tasks towards helping women develop healthy and appropriate measures of self care.

#### Self esteem and stress management

Associated to a woman’s ability to care for her own personal and mental well-being are self esteem and stress management techniques, and training. There are a number of programs that are available to work on both self esteem and stress management. Clinical staff will need to review a variety of programs and decide upon a model that best meets the needs of the women in the program. Measures of programming reflective to the ongoing development, support and building of self esteem and stress management need to be linked to all other areas of the program, such as self esteem in finding a job or completing education goals.

#### Family

Inclusion of partners and family in the treatment process is important to family well being and healing. In conversations with service providers, professional and from personal clinical experience it is commonly discussed and understood that sending individuals to treatment programs only to send them home to the same family members and environments they came from is not conducive to change in the family system. There are a variety of measures to include family in the treatment process.

Community Reinforcement and Family Training (CRAFT) is a treatment program for family members or loved ones of a person with problematic substance use. The program is offered over eight sessions. The program works to bring the family member into awareness of their loved ones substance using pattern and how they can effectively bring about change in the family system, beginning with their own behaviours and involvement in negative family interactions and coping (Meyers, Miller & Smith, 2001; Meyers, Miller, Smith & Tonigan 2002).

The program was initially developed to train a loved one how to motivate their substance using loved one to enter treatment, and in the context of the treatment continuum available to the original program that was a feasible goal. Current wait lists for persons with problematic substance use to enter treatment put limitations on the ability to duplicate that intent of the program. However, the program has over thirty years of clinical trial and measures and it meets the criteria to be an efficacious treatment. Of particular interest the program in clinical trials has consistently shown significant outcomes for the improvement of the family member’s sense of well-being (Crowe-Salazar, 2003).

The change in the family member well-being is a step towards changing the environment and better preparing the family for a substance using loved one to return home. The CRAFT program could be utilized in the treatment program to also help women change their own patterns of communicating with other family members and loved ones who use substances problematically.

Other consideration for inclusion of family in treatment is the inclusion of partners. Given the recommended time that women will be staying at the White Bear program of three to six months, partners need to be connected to their family. In program discussions the local White Bear community members and health professionals engaged, options for partners becoming involved in the program has been discussed. Involvement could range from visits to inclusion in programming and lodging at other resources at White Bear First Nation. These discussions developed the concept of programming in phase four, where the facility would expand to family treatment.

An earlier establishment for the inclusion of partners would involve the partner during the intake interview and an assessment and screening on the partner would also be completed. This begins the process of actively engaging the partner in the treatment process. It also helps to educate both the father and the mother about the effects of substance use on the family (Baily et al, 2008).

#### Life skills training

Life skills programs offer a diverse range of skill building and development that are reflective of the needs that women who enter treatment have identified. Treatment programs for women that have outlined the design strategies in treatment programs for women include life skills training as a key component (Uziel-Miller & Lyons, 2000). Added to this are also recommendations for inclusion of components that actively lead to completing education and work goals.

The White Bear community asset exercise indicated there are individuals in the community who are trained facilitators in Life Skills. The treatment program could be supportive of the community via contracting facilitators to come into the facility to deliver a program for the women, and / or depending on a woman's individual needs women could attend existing Life Skills programs in the community in the later months of the program.

#### Vocational and educational

Positive future orientation via the support for and inclusion of educational and vocational achievements are associated with mother's successfully maintaining positive change in their lives (Carten, 1996). While there are many vocational programs available, vocational programming in drug and alcohol treatment programs need to include assessment and counselling techniques inclusive to all needs of the individual.

Goals for comprehensive vocational counselling for women who use substances problematically include:

1. Helping women to discover their true abilities and potential.
2. Assisting women in finding and/or sustaining the desire for vocational services.
3. Giving women relevant, operationally defined occupational information.
4. Linking vocational counselling to the other areas of treatment, e.g. anger and feelings of anger in early the stages of not using substances problematically.
5. Assisting women in developing problem solving and goal setting skills.
6. Planning incremental and attainable steps toward achievement with women always based on validating the strengths of the woman.

7. Helping women to acquire the necessary training, education, support services and financial assistance to secure their chosen occupation (Dempsey & Wenner, 1996).

All of these vocational counselling goals help women attain valuable and personally satisfying work experience. The proposed program at White Bear could support women in later stages of the program to be mentored to work a few hours per week in other areas of the care lodge. This would give the women needed work experience, references and the self satisfaction and accomplishment of receiving a pay cheque.

In addition vocational programs that include peer role models, women who have worked through the stages of change and are satisfied with their employment, help women in treatment with achieving success and maintaining motivation towards employment (Dempsey & Wenner, 1996).

#### Peer support and role models

Peer supports and role models have shown to be a powerful component to treatment programs for fostering positive change. Women's ability to recognize the potential for change in their own lives by witnessing that change among their peers offers hope and motivation (Sowards, O'boyle & Weissman, 2006). Holistic programs including a focus on individual support and mentorship from peers are creative approaches that are needed to address the complex problems associated with problematic substance use (Olson, 2007).

During meetings with local health professionals and community members at White Bear several women identified aspects of their own journey towards abstinence. Clinical staff could meet with these women and develop ways their experiences could be added to the daily programming. This use of community skill and knowledge also builds upon an interactive and collaborative mechanism with the local community. If local women are utilized an honorarium will need to be offered, or if they are a regular part of the program compensation and a monthly wage given, depending on hours. Another option would be to hire home care aides with this personal experience and background, to compliment the clinical staff.

#### Reproductive health

Drug misuse during pregnancy and the reproductive health cycle are important elements for education. Women must become active and informed consumers regarding their sexual and reproductive health. Currently women receive misinformation on their reproductive health or it is an area that is not adequately discussed via this women can inadvertently be put at risk. For example women are often prescribed Depo-Provera due to ease of administering versus other oral contraceptives, however, what is not often considered is that this offers no form of protection from sexually transmitted infections (STIs). Women who use substances problematically are also often referred for tubal ligation, and this makes the woman invisible around the issues of substance misuse and addiction (Tait, 2008).

Elements of reproductive health include pre-conception, pregnancy, childbirth and postnatal and parenthood. At each phase the women requires proper issue identification and a specific process or procedure that addresses the issue and meets the needs of that woman. For example in the postnatal and parenthood phase of care, the issue may be parenting support, the specific process or procedure attached to this is the delivery of a multi-disciplinary family support plan (Scottish Executive, 2005).

### Tobacco cessation

Tobacco use is another important issue for parenting and pregnant women. It is also often ignored or overlooked in treatment for women (Connors et al, 2006). There are a number of reasons to include this in treatment programming and numerous resources.

Pregnets is a tobacco cessation program with information accessible over the internet. The mission of the program is to improve the health of mothers, fetuses, babies and children. Goals include the elimination of smoking in pregnant and postpartum women by increasing the capacity to quit and stay quit using a woman centred model of care. The Pregnets website hosts up-to-date information on smoking cessation practices for pregnant and postpartum women, a toolkit for health care professionals, a printer-friendly nicotine dependency test and an anonymous on line discussion board. The Pregnets toolkit has been developed for health care providers, educators and researchers and provides the essential components to address smoking cessation among pregnant and parenting women ([www.pregnets.ca](http://www.pregnets.ca)).

### Baby program

The “baby program” is based on a series of activities that foster the ongoing building of the mother and infant bond to build and support healthy child development. A key component to the baby program will be the *Making the Connection* program.

Resources to support the baby program could include:

- Pre-natal health visits
- Baby wellness clinics
- Breastfeeding support
- Infant books
- Infant videos e.g. a Baby Einstein video library
- Infant toys that can be easily laundered
- Flexible daily routines and program structure that allow mom and baby to participate
- Training for *Making the Connection*

Other considerations for the baby program include medical needs and care of baby for babies in withdrawal. This aspect will be reviewed in the “special considerations” section of the program description. For phase one baby will not have special medical needs or have withdrawal symptoms that cannot be managed outside a hospital setting.

### **c) Special Considerations:**

This section covers other considerations that clinical staff and the facility management and board will need to determine and develop a working knowledge of the scope of inclusion in the program. It is not intended as an overall guide or recommendation component and each section requires additional research and communication. Specifically each section will require consultation and inclusion of specialists in the given area identified. This information needs to be disseminated among staff and

management including the board, so all people have received the same information and have the same understanding.

#### Methadone maintenance

In the case summaries from YTCCFS there were 3 mothers identified as participating in a methadone maintenance program. The women who enter the program, for phase one will be post delivery and it is not feasible to not give consideration in the program on how to continue to assist the women with their choice and access to a methadone maintenance program.

In program implementation meetings with methadone maintenance programs will need to be completed to review the feasibility of partnerships and agreements needed to partner with an existing methadone maintenance program.

#### Withdrawal and infants

Many authors and health care specialists recommend that whenever possible babies should remain with their mothers, and because withdrawal symptoms are not predicable based on maternal drug use, it is not possible to plan for what the specified need or level of care for an infant will be (Hepburn 2002).

This issue was raised in consultation meetings with other service providers. The aspect for consideration lies at the hospital and level of care required. Often mothers are discharged while babies stay in the hospital due to care required for management of withdrawal. Researchers indicate that babies do best when they room in with their mother during the hospital stay and that breastfeeding helps lessen the symptoms and allows for bonding between mother and child (Hepburn, 1993, 2002, 2004, 2007).

During program implementation this will impact the intake of mothers, if they come to the program before their baby or are discharged from the hospital prior to their baby. This requires consultation with a number of other care givers on the service continuum including the hospital, local community programs and social services, to establish an effective continuum of care for mothers and infants.

#### Working with moms who are impacted by FASD

In consultation with other program specialists the aspect of working with mothers who are also impacted by FASD was raised. This requires additional skill and understanding of how to work with persons affected cognitively and all other elements of the program would need to be adapted for women who are impacted by FASD.

#### Traditional healing

It is very significant and self efficacious to have women engaged in culturally relevant and inclusive programming. Given that the proposed program will be on reserve it is even more valid to thoroughly plan this component. In discussions with local member of the White Bear community and Board the plan to develop this component in consultations with local traditional people (lodge keepers, pipe carriers) was discussed. To have a planning circle and have women who have traditional cradleboard teachings would be the starting point towards implementing a cultural component to the program.

### Month 3 Assessment

It is being recommended that the program be three to six months in duration. To plan for the needs of a woman an assessment at eight to ten weeks will be completed in collaboration with the woman and all program staff. The assessment will determine all elements of the woman's life and if she will graduate or continue in the program to six months. During program implementation this will need to be established via the development of an assessment framework.

### Aftercare component to the program description

Most treatment programs offer some level of aftercare, however, distance often makes this a difficult aspect to follow through with. The transition back home is a critical time for people who have been in treatment and away from their families.

To facilitate the needs for a continuum of services for women who use substances problematically during pregnancy, the program will need active engagement throughout the duration of the program from the professionals that will offer support and services after treatment. For the First Nation Child and Family Service agencies prevention workers or other staff directed towards prevention could link to the program and woman they have referred while she is in the program. For urban settings linking to family service workers and to community services that work with prenatal woman and children, such as KidsFirst, will be of benefit.

The external support persons will need to be linked via case meetings and circles throughout the time the woman is in the program. To develop this partnerships and working plans will need to be established with external programs. In addition training of the staff that will work to support the woman they refer will need to occur. The external referring staff and supports will need to understand a woman centred harm reduction approach. To facilitate this the program staff, while they are not solely responsible for the aftercare program they could become mentors to other service providers, offering in-services and training on women centred approaches and harm reduction.

During implementation of the program meetings will be required to fully develop aftercare and a continuum of services with other stakeholders.

## **d) Program Recommendations**

Several recommendations have been given throughout each section of this paper. This concluding section is therefore not exhaustive and does not repeat all previous given recommendations. This section highlights major recommendations regarding the program and implementation of the program.

In addition broader recommendations are made with respect to the child welfare services related to problematic substance use during pregnancy. In addition to this all health care providers who also work with women who use substances problematically during pregnancy need to engage together to create a continuum of services that are sensitive and reflective of the needs of women and children.

### **Staffing (for the program):**

As outlined in the section entitled, *Skilled Clinical Team* the following professionals were recommended:

- A Registered Nurse, who will function as the overall facility administrator for both programs at the facility (the women centred treatment program, and the care home program), and offer leadership.
- A Registered Social Worker (MSW), or Registered Psychologist (MA), who will function as the program lead / Director of the women centred treatment program, and offer leadership.
- An Addiction Counsellor who will function to ensure that all aspects of the program consider the problematic substance use, such as parenting within the context of being a parent when you have problematic substance use, and offer leadership.
- Licensed practical nurses and care aides as required based on total of clientele (on both programs) who will function in providing care and support as required.

In addition to the staff identified for the program, other facility staff will be needed e.g. cooks, maintenance, night staff, security and others as required. Staffing needs can be identified during implementation via existing staff and consultation with previous facility administrators, and consultation with other treatment programs.

### **A multidisciplinary health team:**

Systems that work best are multidisciplinary in nature with specialist input from a variety of professionals and other support agencies with non-judgemental caregivers with boundaries that offer a constructive source of support (Wright, Walker 2007). Further support for implementing a multidisciplinary team were discussed in *Skilled Clinical Team*. It is recommended that the program operate via a multidisciplinary team framework that collaboratively works with the mothers in the program.

**Holiday coverage and considerations related:**

For staff to cover for one another on holidays and weekends, staffing for this will need to be considered. Weekend staff will not require the same level of experience as the full time program staff, however, it would be an asset to have a nurse and social worker on the weekend team. Full consideration of this could look at hospital rotation of staffing and other treatment centres. Consultations with both will be necessary to establish what is the best model given the proposed program, facility and needs. If women and children who enter the program after phase one, require nursing care or have a level of care that needs a nurse on staff at all times, operations and staffing will need to be reflective of this need.

For phase one initialization of the program it has been recommended that the women and infants who enter the program do not have a level of care that would require nursing care. However, to operate the second wing, and overall health related issues of the treatment program an RN has been recommended as useful to function in the administrator role of the facility. This recommendation is supported via the staffing of other programs for women and babies, and was also a recommendation of the previous administrator for the care home currently operating in the facility.

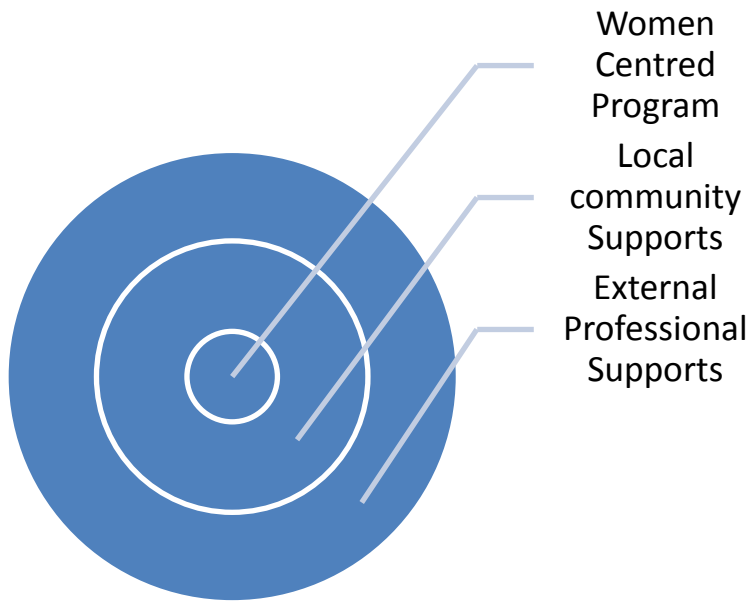
**Length of stay:**

In an analysis of program design of specialized substance abuse treatment for women and their children researchers found that longer treatment leads to better outcomes and several studies indicated that nearly half of all women successfully completed treatment. Women who enter treatment with their children also show better motivation and outcomes (Uziel-Miller & Lyons, 2000; Connors et al, 2006).

It is recommended that women and babies stay in the treatment program for a minimum of three months and with a collaborative assessment with the mother, up to six months. This length of stay is supported by the literature and longer stays show better change, and better outcomes.

**Program implementation:**

Sustainable program framework of support to the program:



The sustainable program framework offers the inner circle, the program, to be an operational entity unto its own direction and function. The second circle of support is via the local White Bear First Nation community and surrounding assets, as identified, and supports for the program. The outer circle is a professional circle of support that will be established among the partnering agencies, FNCFS, Social Services, professional associations and others that are drawn upon for support to the program.

At implementation this aspect of the program will need to be initialized via meetings with external partners on the continuum of services including the agencies making referrals, and others identified.

### **Program Evaluation / Assessment**

It is recommended that from the point of program implementation that a process of collaborative assessment and evaluation be initialized by researchers not employed within the program. This allows for a subjective analysis and opportunity to engage with all relevant members of the program team, staff, mothers and other supporters without any perceived conflict of interest by the assessment begin completed by regular full time employees of the facility / program.

Assessment and evaluation will assist in the program implementation and formation over the first year. Offering ongoing work to consider what is working and what could work better, always in a collaborative context. A completed assessment will also assist in validity of the program and seeking further supports and funding.

### **Recommendations for policy considerations within child welfare**

From a systemic perspective problematic substance use during pregnancy the outcomes associated impact on a number of areas in the child welfare system, not limited to but including the following:

- Children who are returned home to mothers who have not accessed appropriate care due to it not existing, are at risk for maltreatment with ongoing substance use and related neglect;
- the recycling of mothers and babies leads to at least two or more apprehensions from the hospital, once children enter foster care they often do not return home;
- foster care resources are limited and specialized foster care resources that can care for infants in withdrawal are even more limited;
- infants in foster homes that do not return to parents or extended family establish primary bonds with their foster caregivers;
- the development of primary attachments is a significant factor for good health outcomes for children who were born in withdrawal;
- the establishment of primary bonds with foster caregivers puts a strain on needed foster care resources and puts foster care into a long term, lifelong role that it was never intended or developed to deliver;
- as babies grow problematic developmental outcomes associated to the substance use during the pregnancy can impact on breakdown of the foster care placement;
- the breakdown in foster care placements leave children cycling through a number of foster homes and other care resources by the time they reach adulthood.

All of these factors have implications for social work education, practice, research and policy within child welfare, and other family and child programs. The program posed in this paper offers one element in a range of services that can address these outcomes by actively engaging and working with women who use substances problematically during pregnancy. Working towards keeping mothers and babies together presents opportunities for children to not enter the child welfare system and to not encounter the ongoing systemic outcomes that result from children being raised in foster care. In turn this lessens the resultant pressures on research, practice, policy and education.

Child welfare professionals can also seek to consider the following questions when analyzing and evaluating child welfare programs and services with regard to problematic substance use during pregnancy:

- When does a parent's substance misuse pose a conflict of interest with a family?
- When does a parent's substance misuse pose risks for the safety and wellbeing of his or her child?
- How does the ability to parent become impaired in these circumstances?
- What is a child's capacity to tolerate the changed and often detrimental care that he or she might receive?
- How can these risks be assessed and how can they be managed?
- Who decides when the risks become acceptable?
- What services need to be available to meet the needs of both adults and children in these circumstances?
- How do professionals working in these circumstances need to be trained and supported?
- What can be done to bridge the gap between the professional who are trying to meet the respective needs of children and parents?
- How can the different agencies involved ensure consistent practice and good communication with each other? (Macrory & Boyd, 2007)

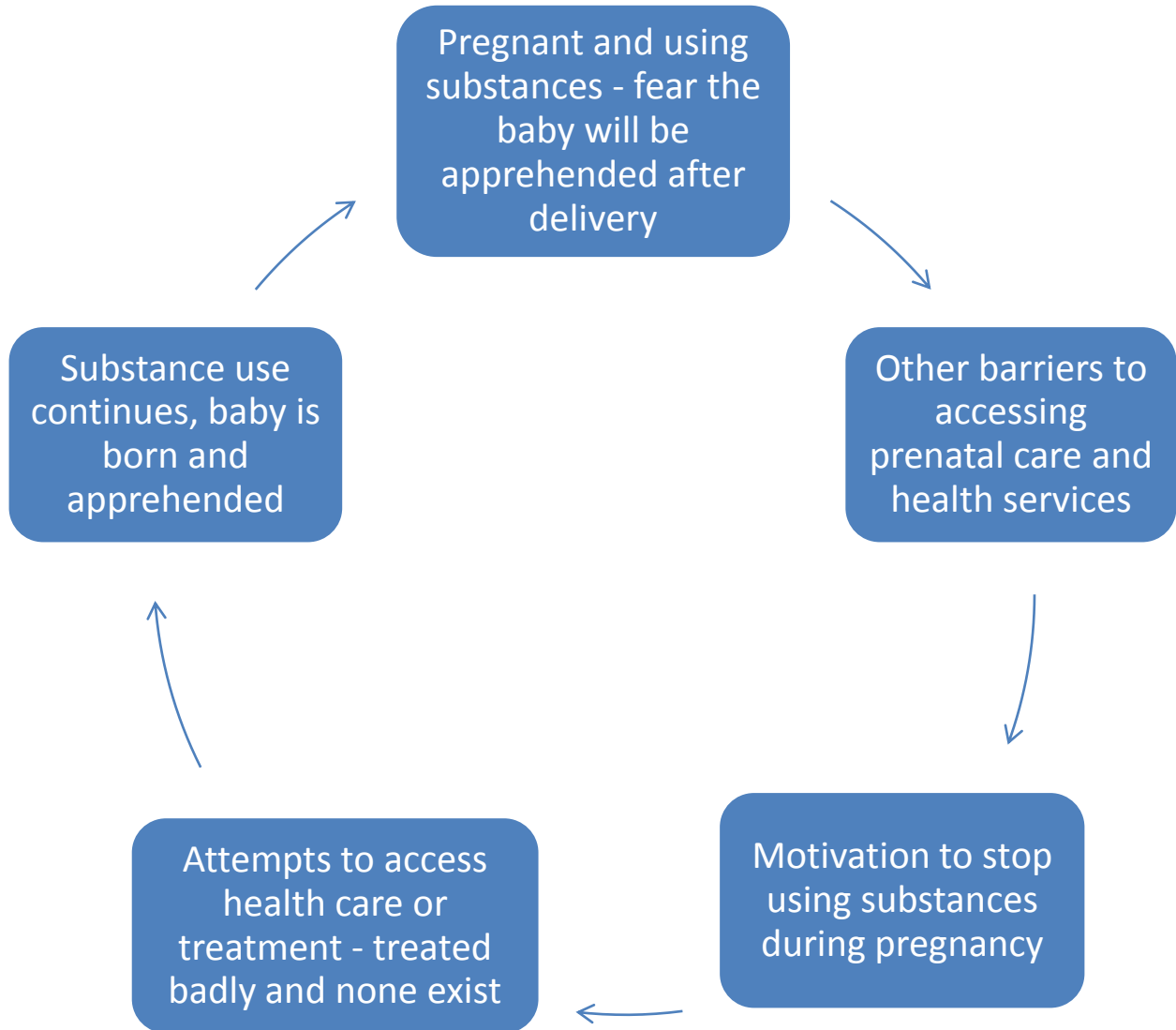
The collaboration between child welfare and addiction services or treatment providers, and other related health care providers will foster and encourage women to view the involvement of social services as supportive and preventative rather than punitive (Hepburn, 2002).

Other resources identified within the First Nation Child and Family Service agencies allow for the development of prevention services. The existing provincial child welfare system in turn could offer

services via intake, and have one worker assigned to work with pre-natal women who problematically use substances during pregnancy. A woman centered harm reduction approach would need to be developed and understood; currently most professionals who work with women who use substances problematically during pregnancy do not come from this approach. We are socialized to be judgemental towards substance use during pregnancy and specialized training needs to be reflective of the unique skill set that workers assigned at an intake level would require development of.

Appendix A.

## Women who use Substances During Pregnancy – Recycle



(Crowe-Salazar unpublished paper)

Appendix B.

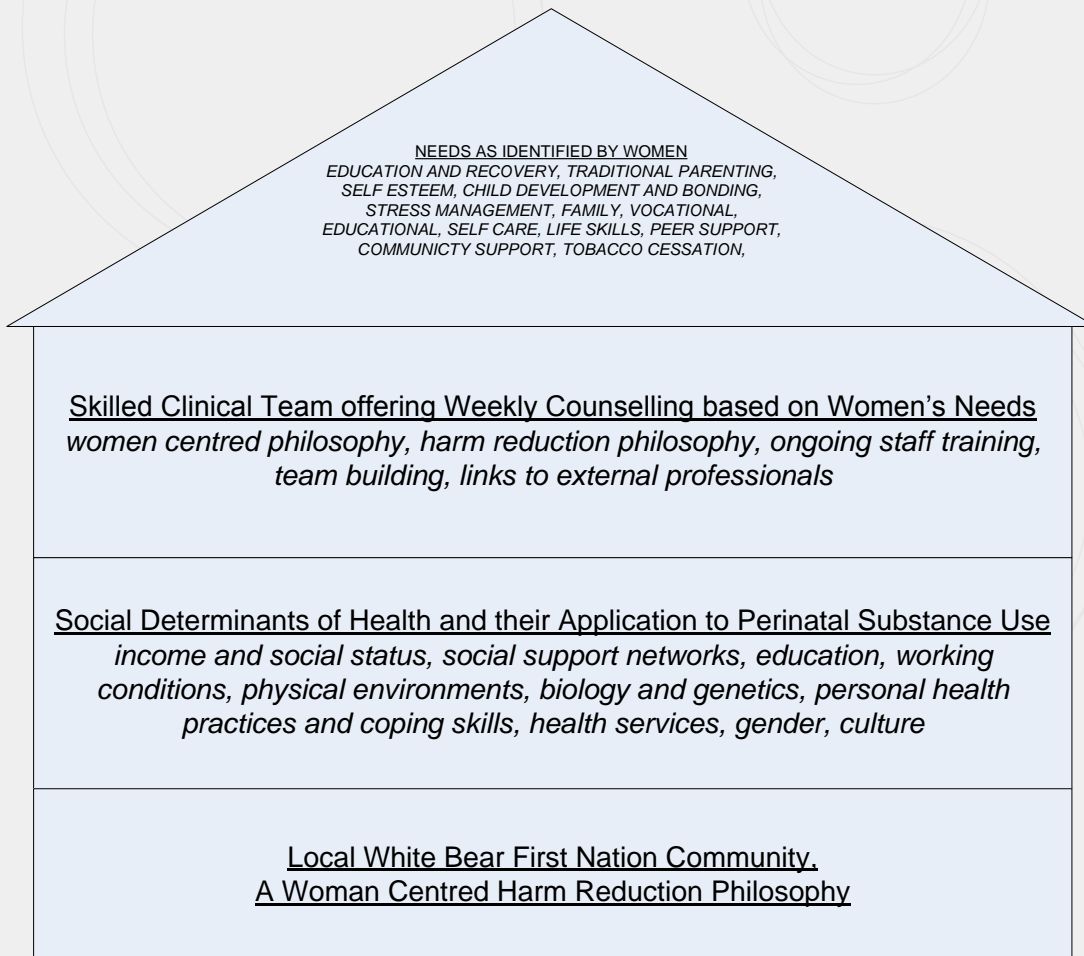
**Prochaska and DiClemente's Stages of Change Model**

<b>Stage of Change</b>	<b>Characteristics</b>	<b>Techniques</b>
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence"  Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters"  Planning to act within 1 month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for  3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior  Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

([http://www.cellinteractive.com/ucla/physician\\_ed/stages\\_change.html](http://www.cellinteractive.com/ucla/physician_ed/stages_change.html))

## Cradleboard Program Model:

Building a Home of Family Wellness



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