Co–Creating Evidence

National Evaluation of Multi-service Programs Reaching Pregnant Women at Risk

Interim Report

Project Leads:
Deborah Rutman, Carol Hubberstey, Marilyn Van Bibber (Nota Bene Consulting Group) & Nancy Poole (Centre of Excellence for Women's Health)

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The views expressed herein do not necessarily represent the view of PHAC.

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Introduction & Methods

Section 1

Introduction:

Project Background, Overview & Research Questions

Background and Overview

Preventing Fetal Alcohol Spectrum Disorder (FASD) requires a range of efforts from general awareness to targeted prevention and treatment services. In the Canadian four-part FASD Prevention Model (Poole, 2008), ***Level 3*** programs work with women at highest risk who have substance use, mental health and/or trauma-related issues and/or related social or financial concerns. These programs provide low barrier services for pregnant or parenting women, offering outreach and "one-stop" services on-site and/or through a network of services.

While some Level 3 programs have been evaluated, others either haven't or their evaluations aren't published.

The *Co-Creating Evidence* project is a first-of-its-kind-in-Canada national evaluation involving 8 holistic, wrap-around programs serving women at high risk of having an infant with FASD.

The overall project goals are to:

- Bring together many of Canada's holistic FASD prevention programs to share promising approaches and practices;
- Undertake a prospective, multi-site evaluation on the effectiveness of FASD prevention programming serving women with substance use and complex issues; and
- Identify characteristics that make these programs successful.

Section 1

Introduction:

Project Background, Overview & Research Questions

Overview (continued)

It is important to note that this project is not an evaluation of one program that has been implemented in multiple communities across Canada. Rather, it is a multi-site evaluation of eight different programs that each emerged based on local priorities, needs, partnerships and collaborations.

A capsule description of each program is provided later in this section.

Research Questions:

- What are common elements of these diverse, multi-service programs?
- How do these programs reflect their community's context?
- What program components are (most) helpful from women's perspectives?
- What outcomes are being achieved and what are good measures to demonstrate outcomes?

Section 1

Introduction:

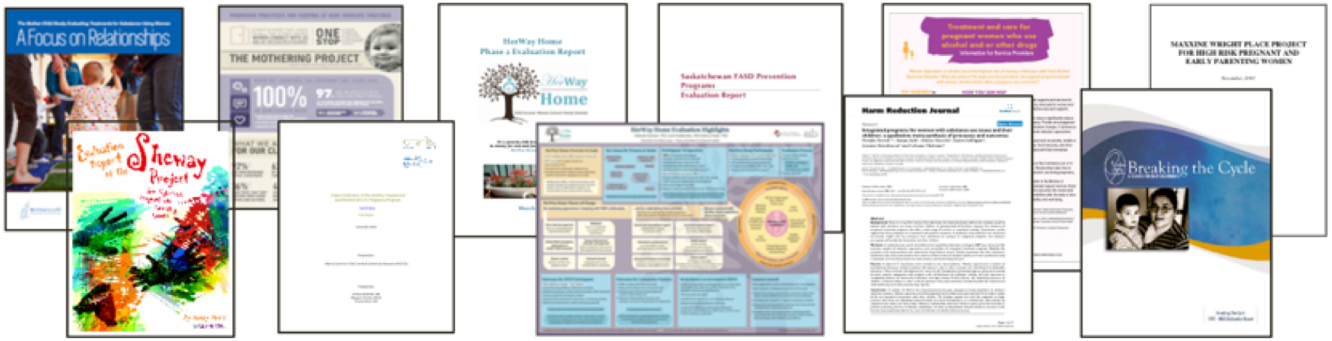
Key points from existing literature

Key points from the literature

- Substance use during pregnancy is often intertwined with a host of issues including intimate partner violence, trauma and intergeneration trauma, unsafe/inadequate housing, poverty, food insecurity, mental health issues, social isolation, mother-child separation, racism, and colonization (Boyd & Marcellus, 2007; Network Action Team on FASD Prevention from a Women's Health Determinants Perspective, 2010). In view of these complex and inter-connected issues, research has shown the importance of wrap-around programs that address women's and children's health and well-being together (BC Centre of Excellence for Women's Health, n.d.).

- Services that employ non-judgemental, relationship-based, trauma-informed and harm reduction approaches and that also understand and seek to remove social environmental barriers to participation (e.g., transportation, child care, meals, stigma, and fear of child removal) are most effective and are increasingly recognized as best practice (BC Centre of Excellence for Women's Health, n.d; Motz et al, 2006; Nathoo et al, 2013; Pepler et al, 2014). These approaches recognize and accept the pace and type of change women are able to make and the strategies women use to cope with difficult life circumstances (Handmaker, Miller & Manicke, 1999; Motz et al, 2006).

Only services that counter the exclusion and marginalization this group of women faces can help them to access the health care they and their infants need. The provision of a safe environment where staff is non-judgmental, respectful, supportive and understanding is integral to women accessing ongoing care (BC Centre of Excellence for Women's Health, n.d., 2).



Section 1

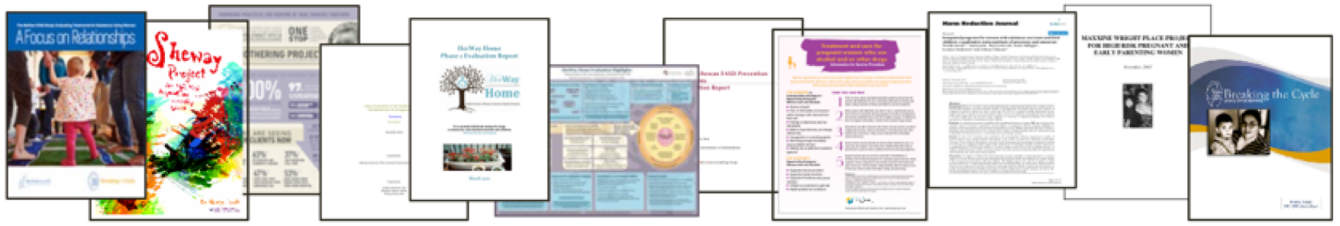
Introduction:

Key points from existing literature

Key points from the literature (continued)

- A number of communities across Canada have developed "one-stop" programs that provide pregnant and early parenting women and their children with a variety of health, wellness, basic-needs-related, cultural and social supports. Each of these programs is unique, yet all aim to address women's needs holistically and employ relational, trauma-informed approaches (BC Centre of Excellence for Women's Health, n.d.; Nathoo et al, 2010). Based on published evaluations and research on Level 3 prevention and/or integrated services for pregnant or parenting women who use substances, key impacts of these programs include:
  - Women engage with prenatal care and support earlier in pregnancy (Racine et al, 2009);
  - Higher rate of women access and complete addictions treatment (Sword et al, 2011); and
  - Higher rate of women retain or regain custody and/or have improved mother-child connection (Pepler et al, 2014)
- Still, as noted previously, while some Level 3 programs have been evaluated, others have not or haven't been since their initial years.* Moreover, evaluation of these programs can be challenging, as the issues they address are complex.

Results of a recent FASD gap analysis found evaluation of Level 3 prevention programs to be a very important priority for research on FASD prevention (Poole et al, 2016). The *Co-Creating Evidence* project aims to address this gap.



* Notable exceptions are evaluations of Sheway (Poole, 2000), Breaking the Cycle (Pepler et al, 2002; Motz et al, 2005; Pepler et al, 2014), H.E.R. (Wodinski, Wanke & Khan, 2013); and HerWay Home (Nota Bene Consulting Group, 2017).

Section 1

Introduction:

Program sites & locations

Program Partners/Sites

Victoria
HerWay Home

Vancouver
Sheway

Surrey
Maxxine Wright Place

Edmonton
H.E.R. Pregnancy Program

Regina
Raising Hope

Winnipeg
The Mothering Project

Toronto
Breaking the Cycle

New Glasgow
Kids First

Program	Year started:
HerWay Home (HWH)	2013
Sheway (SW)	1993
Maxxine Wright (MW)	2005
H.E.R. (HER)	2011
Raising Hope (RH)	2013
Mothering Project (MP)	2013
Breaking the Cycle (BTC)	1995
Baby Basics (Kids First) (BB)	1999

There are two 'generations' of programs participating in the project:

- 1st generation = Sheway, BTC, and Kids First/Baby Basics, launched in the 1990s
- 2nd generation = Maxx Wright, HER, HerWay Home, Mothering Project, and Raising Hope, launched since 2005

Section 1

Introduction:

'Thumbnail' program descriptions

- **HerWay Home (HWH)** opened in 2013 after after five years of planning by over 30 government staff, community agencies and advocates; it is funded and operated by Island Health Authority, with additional (but time limited) funding from Children's Health Foundation of Vancouver Island. Intakes are increasingly annually; in 2017 HWH served 114 women. HWH offers drop-in and outreach support, wellness and prenatal/post-natal groups, and, with in-kind support from partners, an array of on-site health/medical services for women and their children.

- **Sheway,** which opened in 1993**,** is the first program of its kind in Canada and the largest taking part in this study**;** In 2017, Sheway served 331 women. Sheway is located in the Downtown Eastside of Vancouver and is funded and operated by Vancouver Coastal Health, with additional resources from the Ministry for Children and Family Development, Vancouver Native Health Society, Ministry for Housing and Social Development and the YWCA. Through its staffing and partnerships, Sheway offers a broad range of on-site health/medical and social services/supports.

- **Maxxine Wright (MW)** opened in 2005 and also was created through an extended community planning process. It located in Surrey and serves 350 women annually (for the purposes of this study, only women who were pregnant at intake are included). Funded and operated by Fraser Health, MW is co-located with Atira Women's Resource Society; additional in-kind support is provided by the Ministry for Children and Family Development. Consequently, women can access an array of on-site medical/health and social supports, including second stage housing.

- **Healthy, Empowered, and Resilient (H.E.R.)** is a relatively new program (2011). Funded primarily by Alberta Health and operated by the community agency Streetworks, H.E.R. is located within the Boyle Street Community Services, which provides an array of social supports in Edmonton's downtown core. H.E.R. provides outreach to about 90 highly street-involved clients annually. Through its staffing and partnership with Boyle McCauley Health Centre, H.E.R. clients have access to regular prenatal care and post-natal support, as well as social supports/resources.

Section 1

Introduction:

'Thumbnail' program descriptions

- **Raising Hope (RH)** opened in 2013 and is the only residential program in the study. Located in an 18-unit apartment building in Regina, RH serves about 25 women annually. A range of health/medical, social and cultural supports and programming is offered on-site, including child care; residents are required to take part in daily programming. Funded by the Ministry of Social Services, Saskatchewan Health Authority, and the Department of Justice Canada, RH is operated by the community-based agency Street Workers Advocacy Project; Namerind Housing Corporation is a programming partner.

- The **Mothering Project (MP)** opened in 2013 and is a program of Mt Carmel Clinic, which is located in the North End of Winnipeg; both the MP and the Clinic are located in the same building, although they have different entrances. Funded by Healthy Child Manitoba and Winnipeg Regional Health Authority, the MP serves over 100 women annually. Through its staffing and partnerships, the MP offers a broad range of drop-in, outreach and on-site supports and health/medical services, groups, cultural programming including a room/space for ceremony, child care, and access to pre-natal care.

- **Breaking the Cycle (BTC)** opened in 1995 and is one of the first programs of its kind in Canada. The program provides children's developmental assessment and mental health services with wrap-around services for women. BTC is is run by the non-profit organization Mothercraft, is funded by the Public Health Agency of Canada and the Ministry of Child, Family and Community services, and is located in the southwest end of downtown Toronto. The program serves about 100 women annually. Each woman is connected to a counsellor and each child is connected with a Child Development Worker.

- **Baby Basics** is operated by Kids First Family Resource Program in New Glasgow, NS and is a weekly drop-in parenting program for young women under age 25 and their children age 0-6; it opened in 1999. Although not specifically directed at pregnant or parenting women who are using substances, there are very few such options available to women in the community/region. Baby Basics offers a safe place for women to access support and talk about a range of issues, including isolation, housing challenges, substance use and intimate partner violence. Baby Basics serves 45 women annually.

Section 1

Introduction:

Developing the project's visual Theory of Change

In June 2017, the Project Team and Program Site Coordinators held a face-to-face meeting to share information about the programs' theoretical foundations, staffing, and services, and to begin to draft the project's overall **Evaluation Framework** and **Evaluation Plan**.

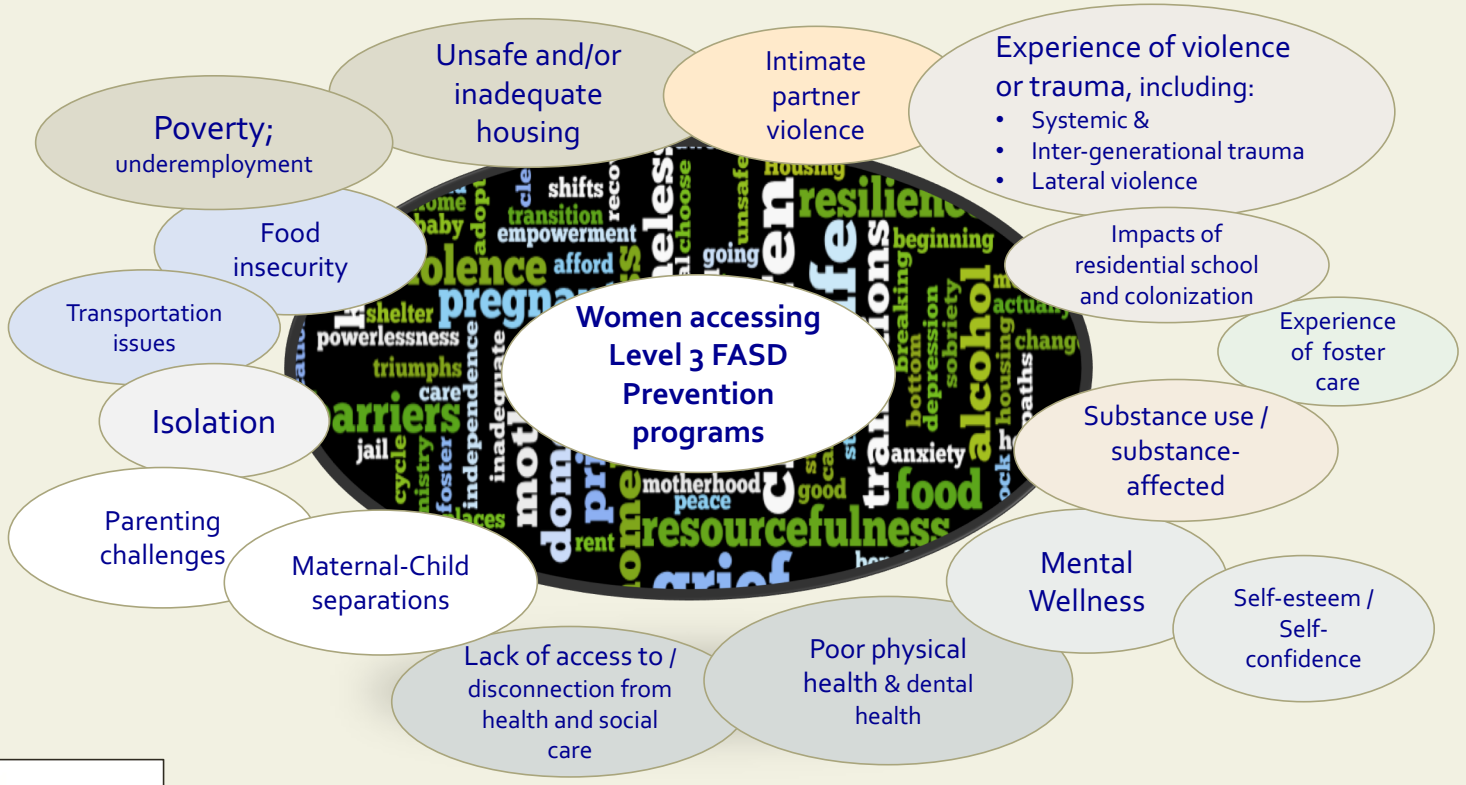
Through this meeting, we developed the project's **Theory of Change**, which included a visual 'map' of key issues for women at program intake.

The **'Theory of Change'** and **'Issues for Women at Intake'** are presented in the following pages.

Co-Creating Evidence Theory of Change

(created summer 2017)

Key Issues for Women at Intake



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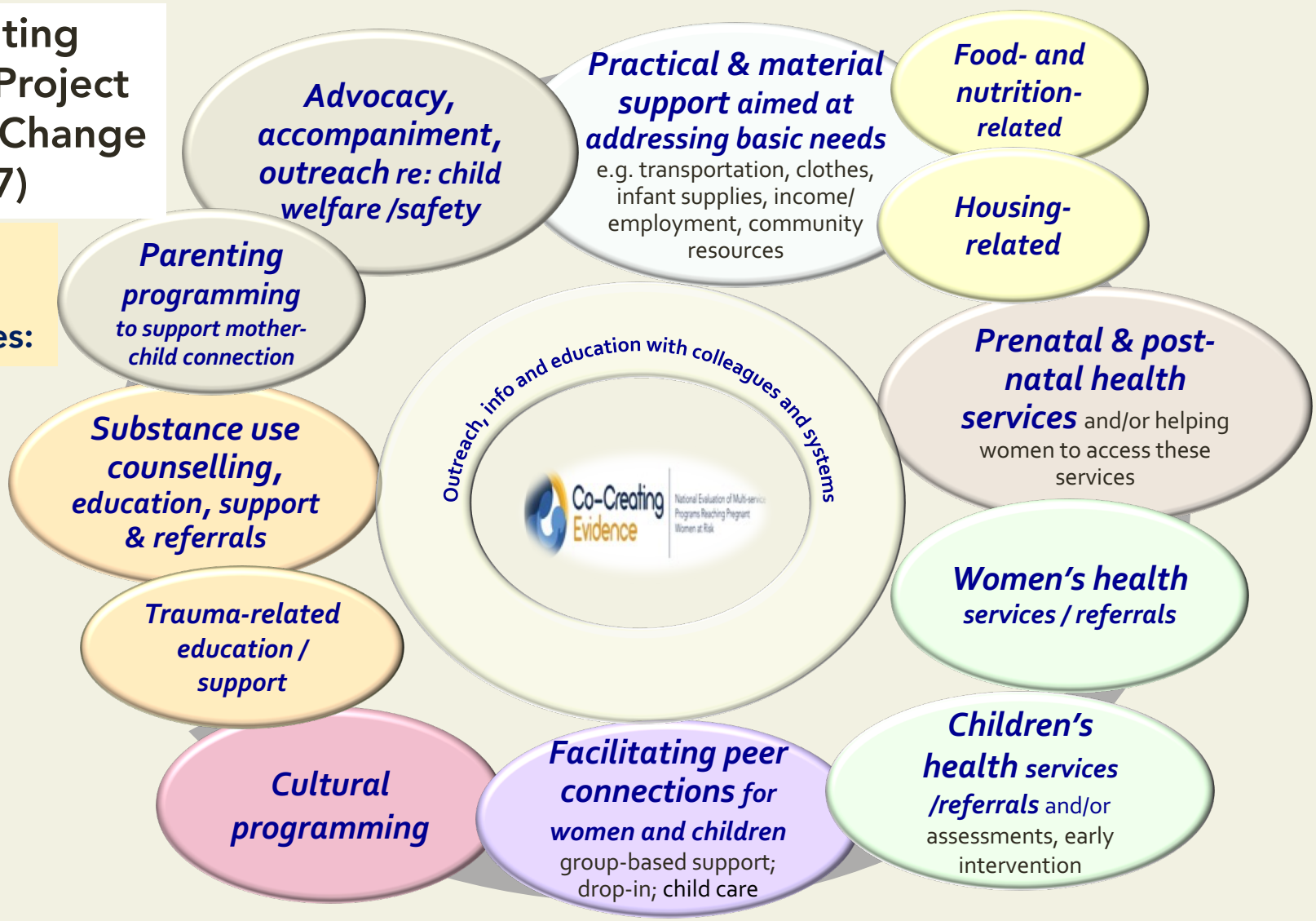
Co-creating Evidence Project Theory of Change* (2017)

By employing these approaches…

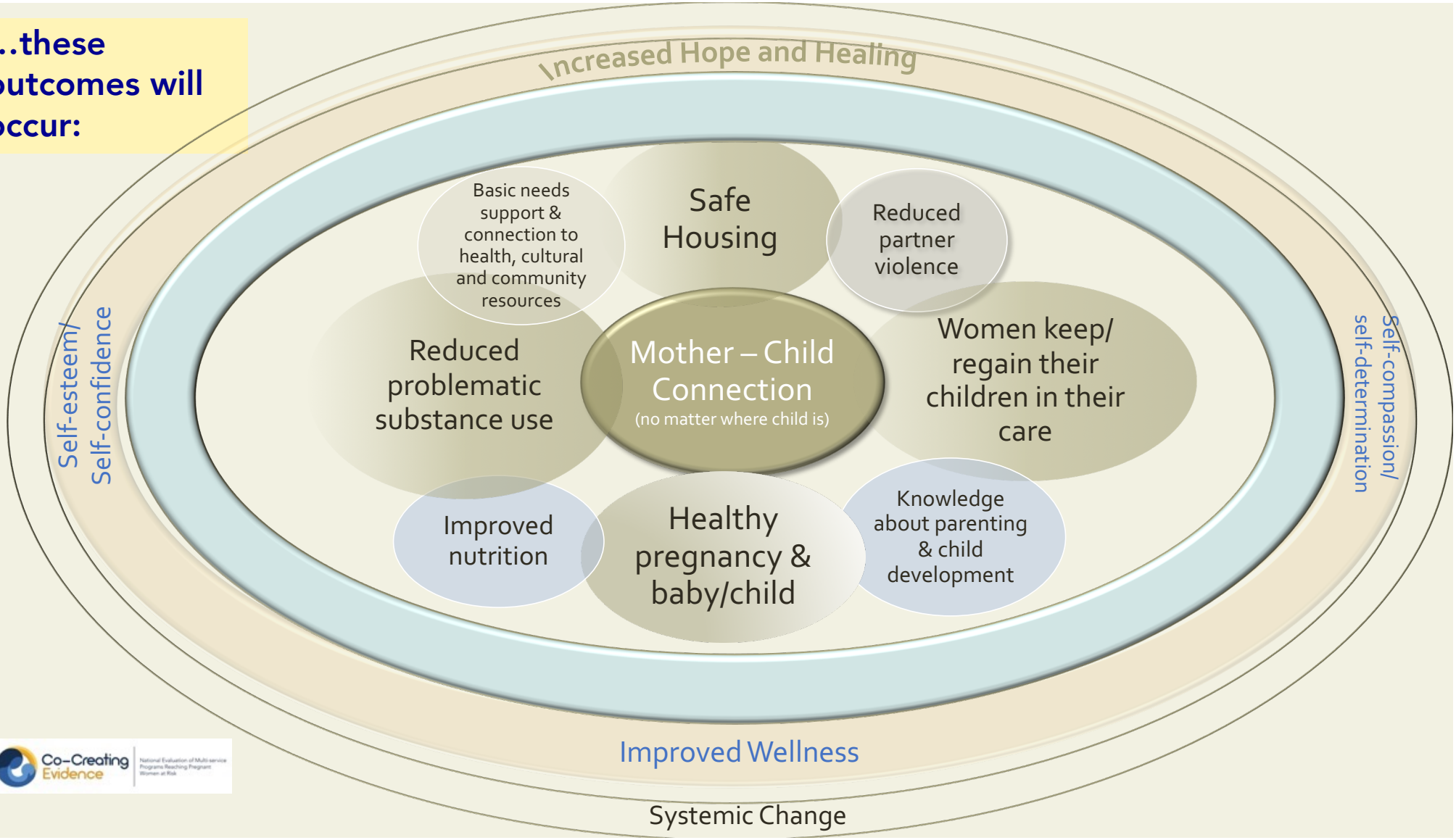
* The approaches comprising this Theory of Change have been informed by the document: ***10 fundamental components of FASD prevention from a women's health determinants perspective.*** (Network Action Team on FASD Prevention from a Women's Health Determinants Perspective, 2010)

Co-creating Evidence Project Theory of Change (2017)

…and by undertaking these activities:



…these outcomes will occur:



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Section 2

Project Process:

Overview of design & Milestones to date

Overview of study design

The evaluation is employing a mixed-methods design involving semi-structured interviews, focus groups, questionnaires, output/program data, and client intake/outcome 'snapshot' data. Both quantitative and qualitative data are being utilized.

Overview of data collection methods

- **Data collected by Project Team** - The team is visiting each program twice (in spring/summer 2018 and fall 2019) to conduct face-to-face: interviews and questionnaires with a sample of clients; interviews and focus groups with program staff; and interviews with programs' service partners.
- **Data collection by Program Sites –** From April 2018 to September 2019, program staff are compiling de-identified client and output data and are electronically sending the data quarterly to the Project Team.

Milestones in the project's processes to date:

- Face-to-face meeting with Program Sites and Project Team to develop Theory of Change and identify outcomes and indicators to collect (June 2017)
- Development of Evaluation Plan and data collection tools (July – September 2017)
- Ethics submissions and approvals (September 2017 – February 2018)
- Review and finalization of Output and Client data bases (September 2017 – January 2018)
- Piloting both in-person data collection and Client and Output data collection (January – March 2018)
- Programs begin compiling and sending quarterly data (April 2018)
- Time 1 interviews with program participants, staff, and service partners (April to July 2018)
- Time 1 data analysis (August – November 2018)

Section 2

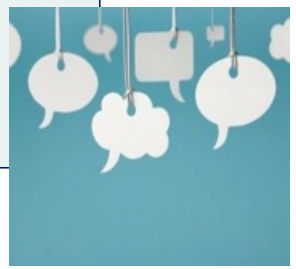
Project Process:

Participants in Time 1 data collection

Time 1 data collected on-site by project team (April – July 2018)

- **125** clients participated in interviews and **123** completed questionnaires
- **61** program staff took part in interviews/focus groups
- **42** service partners took part in interviews

Total # interviews = 228



Number of Interviews by Program Site:

Program Site	# Clients	# Program staff	# Service Partners
HerWay Home	11	4	6
Sheway	32	16	7
Maxx Wright	20	9	3
H.E.R.	9	6	5
Raising Hope	10	7	7
Mothering Project	27	6	2
Breaking the Cycle	8	11	6
Baby Basics (KF)	8	2	6
Total	**125**	**61**	**42**

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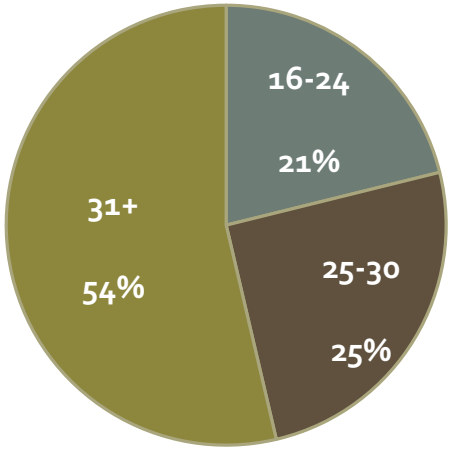
Section 2

Project Process:

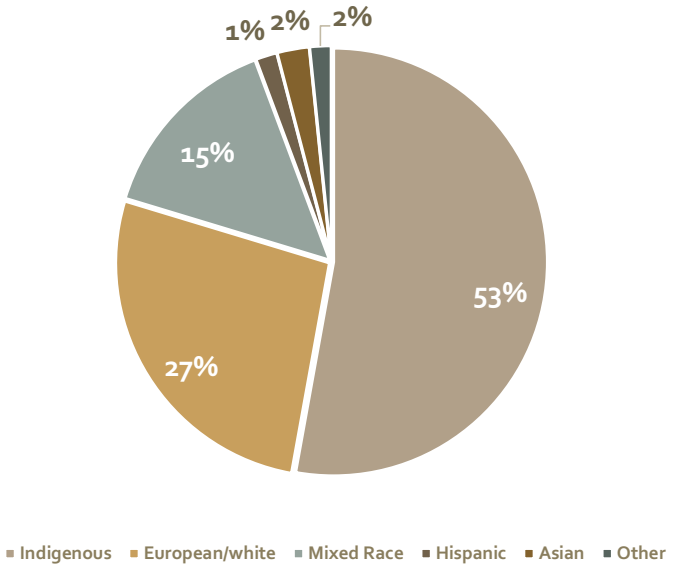
Participants in Time 1 data collection

Client Interview/Questionnaire Participants – Demographic characteristics

All clients interviewed for the project identified as female. Just over one half were age 31 or older (Figure 1).



Slightly over half of the clients interviewed for the evaluation self-identified as being Indigenous; 27% self-identified as being of European/white descent.



Section 2

Project Process:

Output data to be collected

Output Data Collected by Program Sites

Examples of Variables

Intakes & Active Files
active files this quarter
no contact in past 90 days
new intakes this quarter
new intakes who report substance use at intake
clients who had been inactive and who reengaged this quarter
clients who are Indigenous
infants/children this quarter

Variable Categories

- Intakes and Active Files
- Outputs – Group Program Activities
- Client Services – One-to-One Services
- Client Services - Basic Needs Support: Food
- Client Services – Basic Needs Support: Housing, Transportation & Other Supports
- Client Services – Prenatal/post-natal & Women's Health
- Client Services – Substance Use, Trauma & Violence-related Support
- Client Services – Peer Connections/Support
- Client Services – Cultural Programming
- Client Services – Parenting
- Client Services – Children's Health

Interim Findings based on Multi-site Data

Section 3

Client characteristics

Client Characteristics – All programs

Between April – September 2018:

- **708** women participated across the 8 program sites
  - **57%** of women were Indigenous (of the 7 programs reporting data on Indigenous status in the second quarter of data collection)
  - Across the programs, the percentage of clients who were Indigenous ranged from 97% to 0%.
- **Women's age at intake:**
  - **27**% were age 16-24
  - **35**% were age 25-30
  - **37**% were over age 31
- **84%** of program clients were pregnant at intake; the range across programs was from 100% to 49%
- **62%** of program clients had problematic substance use or were new to recovery at intake; however, there was a considerable range across programs, from 92% to 44%
- **60%** of program clients had unsafe or insecure housing at intake; the range across programs was from 74% to 37%

Section 3

Birth outcomes

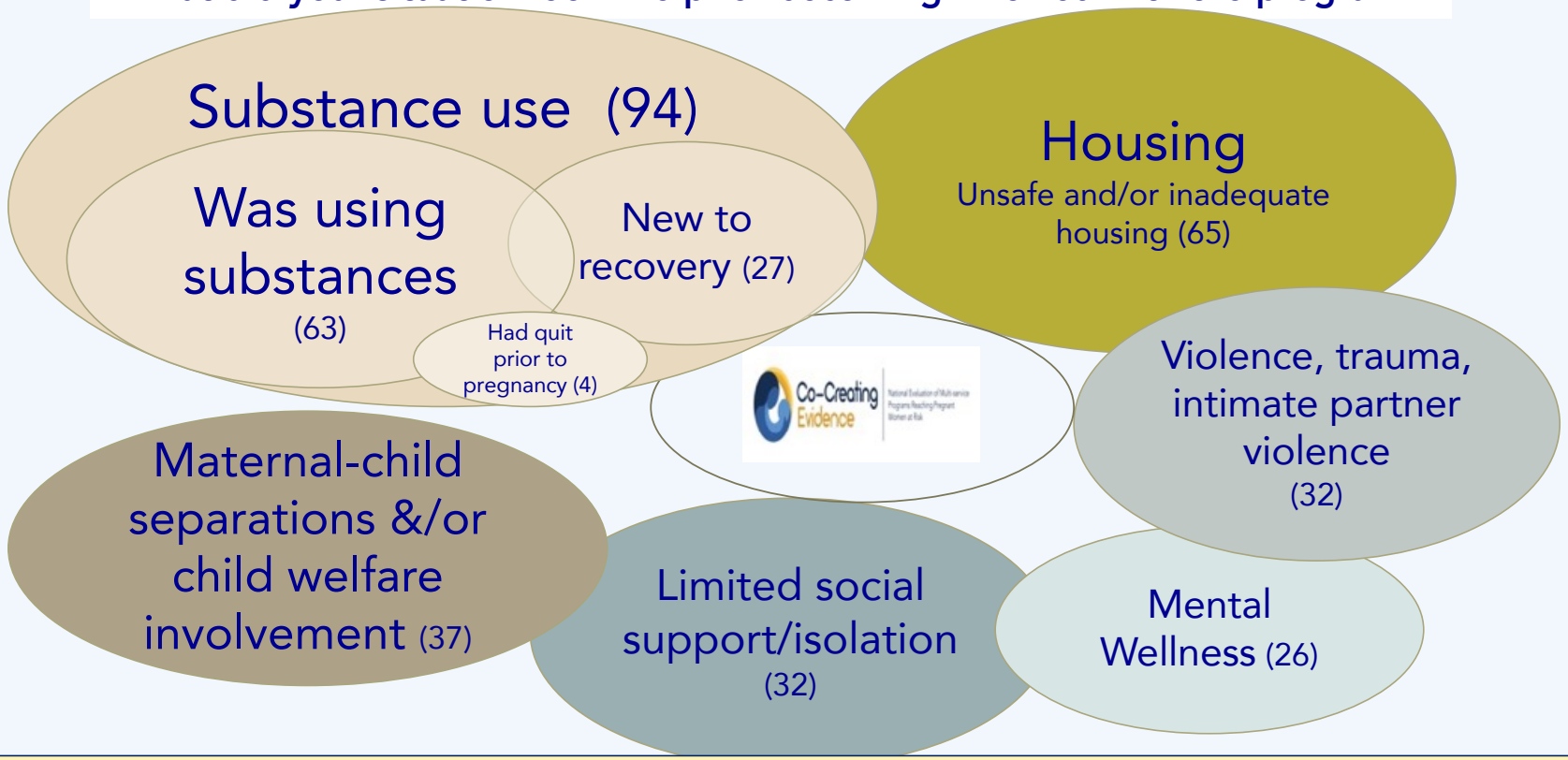
Birth Outcomes – All programs

Between April – September 2018:

- **147** infants were born
  - **80%** were healthy birthweight
  - **85%** were *not* premature
  - **59%** were prenatally exposed to substances
  - **39%** were admitted to the NICU
    - **24%** were admitted to the NICU related to substance exposure

Key Issues for Women Prior to Intake – All programs

Presented here are the themes emerging from clients' responses (**n = 125**) to:
"What did your situation look like prior becoming involved with the program?"



As is evident, these themes are highly congruent with the project's Theory of Change (p. 12).
And, as illustrated by women's own words (following), women's issues at intake are highly intertwined.

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Section 3

Key Issues for Women Prior to Intake

Examples of key issues at intake – In clients' own words:

Substance use

- I was pregnant; my partner had just gone to jail. I was struggling with whether I wanted to be pregnant and whether I could do it – parent my baby – and with urges to use.
- I was living in an SRO. I was using substances at the time. Everyone around here was using, so I used, too. And I was pregnant.
- I was pregnant. I quit using during the summer, but I was struggling with abuse, depression, anxiety and co-dependency.
- I was using heavily till I knew I was pregnant. Then I quit hard drugs and smoked weed. I had to isolate myself to quit.
- I was trying to quit doing drugs, hanging out with people using drugs. They were a bad influence. I was also pregnant with my sixth child; the five older children are all in care.
- I was pregnant but was determined to stay sober. My first daughter was apprehended at birth and was affected by alcohol so I wanted to do it differently this time.

Housing

- I was working on the street and supporting my habit. I was homeless and couch-surfing.
- I was living in a two-bedroom apartment with my mom, sister, two boys, my ex and sometimes my mom's friends. There could be 13 people at a time in the apartment.
- My partner didn't respect my space – there was partying and I was uncomfortable; housing was unsafe. There was domestic violence.
- I was in a really bad situation. I was living with a friend; she was using drugs. I ended up in a shelter. I needed resources to help me with my pregnancy and with raising my baby, and I wanted help getting into different housing.

Violence/Trauma/Intimate Partner Violence

- My partner assaulted me when I was two months pregnant. I have two older children and am a single parent with social anxiety, mental health issues and a long history of trauma.
- I was pregnant, alone, homeless and escaping an abusive relationship in Saskatchewan.
- I was pregnant, and I was living in a women's shelter, getting out of an abusive relationship.

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Section 3

Key Issues for Women Prior to Intake

Examples of key issues at intake – In clients' own words:

Maternal-Child Separation

- Child welfare took my baby for a year. I was addicted to opioids from post-surgery.
- I was seven months pregnant and doing IV cocaine. I had lost custody of my kids.
- I was living in Palmerston House; pregnant and then gave birth. I was depressed and wanted to address my drug and alcohol use. My son was apprehended at birth.
- I had started using again. It wasn't a good time; after I had the baby I dropped her off with CFS – I felt that I wasn't able to care for my daughter and that it was for the baby's own safety.
- I was pregnant; struggling with Percocet substance use. Everything was well hidden. My kids were apprehended after I started doing Percocet.
- I was pregnant. I had just quit using drugs a month before that. I was living with my boyfriend's parents at the time. I knew that I'd be better off here at Raising Hope if I wanted to get my kids back.
- I was struggling, no place to stay, on my own. My children were apprehended by MCFD.

Isolation/Limited Social Support

- I was pretty lonely. I was feeling that I didn't have people to talk to.
- I didn't have a lot of social support. I have no family and was raised in foster care and by my grandmother who is now deceased.
- I was living in an SRO, using crystal meth and heroin every day. I almost never left the SRO. I didn't like to go out. I was very much shut off from other people.
- I was kind of an alcoholic. I wasn't really doing anything. I didn't have anyone for help, expect for the drop-in here.

Mental Wellness

- I was in a youth Mental Health program and relapsed.
- I was fleeing an abusive relationship. My mental health was poor. I was addicted and not taking care of myself.
- I was starting to fall back into drug use. I was depressed and I was scared of my behaviour.
- I spent every day sitting at home. I got super depressed.
- I quit using during the summer, but I was struggling with abuse, depression, anxiety and co-dependency.

Co-Creating Evidence | National Evaluation of Multi-service Programs Reaching Pregnant Women at Risk

Section 3

Overview of programs' governance

Overview of programs' governance model and partnerships

Program Sites	Governance Model		Co-located with other (shared) services	Shared health care staff provided (FT/PT) by funder/partner agencies	Shared social support staff provided (FT/PT) by funder/partner agencies
	Health Authority	Community agency			
HWH	√			√	
SW	√		√	√	
MW	√		√	√	√
H.E.R.		√	√		
RH		√			√
MP	√		√	√	√
BTC		√		√	√
BB		√	√		

Operationally, the programs are either situated within a health authority or a community-based agency. A mix of services and supports are provided via co-location with other services and/or shared services/staff.

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Section 3

Overview of programs' services

At a glance: What services/activities do the programs provide?

Services	HWH	SW	MW	H.E.R.	RH	MP	BTC	BB
Basic Needs Support	√	√	√	√	√	√	√	√
Child Assessment / early intervention	✢ √	√√	√	✢		√	√	✢ √
Child care on site	√	√	√		√	√	√	√
Child health	√	√	√	✢	√	√	√	✢
Child welfare support	√	√	√	√	√	√	√	
Cultural programming	✢	√	√	√	√	√		
Drop in; peer connect	√	√	√√	√	√	√	√	√
Food / nutrition	√	√	√	√	√	√	√	√
Health/medical	√	√	√	✢ √	✢ √	√	✢	✢
Housing	✢ √	✢ √	√	✢	√	✢	✢	✢
Life skills	✢	√		√	√	√	√	√
Mental health /trauma	√	√	✢ √	✢ √	√	√	√	√√
Outreach	√	√	√	√		√	√	
Parent programming	✢ √	√	√√	✢	√	√	√	√
Prenatal /post-natal	√	√	√	√	√	√	✢	√
Substance use counselling	√	√	√√	✢ √	√	√	√	✢

√ = service provided on site either by program core staff or by health/social care staff with dedicated time per week/month at the program (e.g. PHN, MD, NP, midwife, etc.)

√ = service provided (on site) via staff from partner organization (e.g. child protection; infant develop worker; income assistance; etc.), via 'in-kind' contribution or via funding from program

✢ = service facilitated primarily via advocacy, referral, help with applications and/or accompaniment to other programs/services

Through a combination of their own staff or staff from partner organizations providing services on-site, or a strong advocacy and referral network, the programs are able to provide a range of services aimed at meeting clients' health, social, cultural, and material needs.

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Section 3

Examples of clients' use of programs' services/ activities

Examples of clients' use of the programs' services/activities

Food/nutrition

- We have the Food Bank come here every two weeks. They come here; you don't have to go to them.
- I do the Breakfast Club, and we always feel free to use the kitchen – there's a client fridge. They have feasts, and kids have food. They don't serve junk food; it's healthy.
- Breakfast is made by the moms as part of group. That helps to learn new recipes and to try new foods. There are multiple foods that I now include in my diet that I wouldn't have previously.

Housing/basic needs support

- There is lots of practical support, such as a bag of clothes for the baby and items for me, such as a sports bra when I gave birth recently.
- They helped me get into housing when I was pregnant. I had to stay sober for 18 months, and then once I graduated I got to take over the lease.
- They got me into Manitoba Housing with support letters. I'm getting a three-bedroom apartment in two months.

Pre/post-natal health support

- I had help getting to prenatal ultrasound appointments. The doctor from Sheway delivered my baby at Women's Hospital. I was at Fir Square for two months so I wouldn't lose custody of my baby.
- The doctor is on staff. My pregnancies are very high risk and they know how to work with that.
- They got me connected to an OB-GYN, nurses, ultrasound. They drove me to appointments and followed up with me to see if I went. If I missed the appointment, we rebooked.

Women's health services

- I see the Nurse Practitioner or doctor for birth control. It is such a comfort to have someone I know and trust. I have sexual trauma and could not go to a stranger.
- I get Suboxone from the GP on second floor.
- Yes, I see the doctor every two weeks here.

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Section 3

Examples of clients' use of programs' services/ activities

Examples of clients' use of the programs' services/ activities

Children's health, assessments, referrals

- They made a referral to Sunny Hill and introduced me to a dentist for the children. They made sure the kids were up to date for their immunizations, and referred me to an IDP worker.
- The developmental assessment allowed me to see where my oldest daughter is at relative to others – and resulted in speech and language help for my daughter.

Parenting support/programming

- They offer groups such as Ages & Stages, Moms & Tots, Nobody's Perfect.
- I have done lots of programs – e.g. Wellness, Circle of Security, Rediscovering Parenting, etc. All very useful because as my kids age, new problems arise and I retake the program to see how the information applies to my current situation.
- I've done groups and at-home visits with the Parenting Intervention Therapist. The parenting/infant program does home visits. These were the best because they could see me at home and at ease with the children.

Support/advocacy re: child welfare or custody

- When I was pregnant, Sheway helped with my anxiety about meeting with the social worker, and then she closed my file. Without Sheway, they wouldn't have closed my file as soon.
- The HER social worker made the appointment for me to meet with the CFS worker. I had to stay clean/sober and get a restraining order against my partner. Because of that, CFS did not flag me and I had no issues in the hospital.
- My visits with my child have been here; my daughter can come to any visits here, even without CFS staff coming. They see the Mothering Project staff as okay and safe. Or the program staff here will attend CFS meetings with me.
- When I was breast feeding and CPS was concerned about partner violence and baby's safety, Baby Basics advocated for me to take a parenting course on-line about how to avoid conflict and work with the child's best interests and supported me when I went to court for custody and support.

Trauma related support

- I'm learning about healthy relationships.
- I was involved in the group; we talked about the effects of residential school over the generations and how that's affected us. Now I'm seeing why my father didn't know how to be with me.

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Section 3

Examples of clients' use of programs' services/ activities

Examples of clients' use of the programs' services/ activities

Alcohol and drug counselling / education

- Through the counsellor, we're building trust so that we can dig deeper about other issues. It's hard for me to open up.
- I did the 16-step recovery group. I was seeing the counsellor and the psychologist but now am going to Options.
- They've helped me connect with AADAC. They have a parenting class for moms in recovery and how to parent through craving.
- Addiction services comes here. I have been referred for the family treatment program. They provide lots of support for relapse. Raising Hope makes sure our kids are safe no matter what.
- I just signed up for the SWAG (Struggling With Addictions Group) program. I feel grateful.
- I had stopped cocaine in August 2017 and alcohol in September 2017. Breaking the Cycle helps me deal with and address the urges. I have a one-to-one counsellor I was seeing weekly until recently – now it's bi-weekly.

Peer / social connection and groups

- That's huge here. I think that's the main focus for me right now. All the women who did prenatal together, now our children are all the same age.
- Through the Community Kitchen and Mentorship program.
- Definitely – that is what happens with all of the groups and for the kids as well – they get peer and social connections too.

Cultural programming

- I've done the Talking Circle, Dealing with Trauma, drumming, arts and crafts with the Elders.
- There is the First Nations Talking Circle. I have spoken with the Elder about two of my kids who have First Nations ancestors about how to get status for them.
- The Elder comes here weekly. We do smudging, Talking Circle and have lunch.
- I do drumming, singing, medicine picking, sweats.

Section 3

Clients' perspectives about their program

Clients' Perspectives – All Programs

(based on n = 125 interviews)

What do you like most about the program?

5 top responses

- Friendships & social supports
- Multiple services & supports in one place
  - Access to health care
  - Connects me to other programs
  - Cultural programming
  - Practical support
- Staff
  - Feel safe & not judged
  - Having a one to one worker
- Group programming
  - Parenting group & information
  - Substance use group & health info
- Help with child protection

- *Definitely, the friends I've met here. …..the moms are both in recovery and are new moms. It's easy to relate to them and to get along; we have things in common and have the same aspirations and common goals.*
- *I don't have to go far to get to a doctor. There are all kinds of different resources here. There is a welfare worker, a housing worker, the tax lady, as well as food to eat.*
- *They got me connected to specialists, like Alberta Works, so I could get on income assistance, and they connected me to housing.*
- *They have free laundry…..and the support when I had a baby, through that whole time.*
- *The grocery cards help and access to clothes and diapers.*
- *Practical help such as the Donation Room where I can get clothes and baby equipment like a stroller.*
- *It's a safe place to be, and they treat me like a mom first and an addict second. There's no judgement.*

- *I like meeting other women in the same situation. And getting questions answered.*
- *I had a meeting with program social worker who encouraged me to meet with CFS and even inspected my house to give me suggestions for what CFS would be looking for. So when we met with the CFS worker, I was surprised at how well the meeting went.*

- *I like seeing the psychologist here. I think that I've gained the most from working with her; she has given me a lot of tools to deal with stress and anxiety.*
- *I really like the groups and the ability to be open and honest about my drug use. (My family never knew about my drug use.) I like that they taught me self-love.*

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Section 3

Clients' perspectives about their program

Clients' Perspectives – All Programs

(based on n = 125 interviews)

I'm always treated with dignity and respect – the non-judgemental approach.

There's a sense of community; the community is really good there.

What is most important to you about the program?

- Staff
- Staff – caring and compassionate
- One-stop; multi-disciplinary staff
- Getting support
- Staff are non-judgemental
- Sense of community; it's like family

All of the services I need are in one place, under one roof.

I feel a lot of support and love at Sheway. They always help me to stay on top of my appointments. My children feel safe and have relationships at Sheway too.

Wrap-around of medical, mental health, and social services. The health component is critical. No one else brings them all together like this.

Doesn't matter where you come from, you are treated with respect and warmth. You're not just a statistic.

The HER staff bend over backwards for the girls. They are always willing to help.

They're really helping me to get to my appointments. They're willing to come to my delivery.

The way the staff are has made me feel comfortable. It's huge – I don't feel judged by anyone at Breaking the Cycle. No matter what I say, they don't treat me differently. This is different from past experiences.

The staff; everyone is incredible – consistent and trustworthy in their approach. It is very safe.

The staff – they are very helpful. They always give me answers to my questions.

Knowing other women have had similar experiences. Shared experience.

The staff. They are always there. Friendly, open, willing to listen. Caring, very thoughtful, and authentic.

They are all like family to me. Staff are like aunties. There's heart behind the program.

The staff give me a push when I need it. They are kind at heart. They don't give up on you.

The biggest thing has been working with the psychologist. Talking with her, I'm starting to realize why I was using. The one-to-one with her is most important to me.

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Section 3

Clients' perspectives about their program

Findings from Client Questionnaire: What has been your experience with the program?

The overwhelming majority of clients who completed the Client Questionnaire (92-96%) reported feeling physically and emotionally safe; as well, 95% also said they trusted staff and **92% reported that their needs had been met by their program.**

When I come to the program (n = 123):

- 96% • I feel physically safe
- 92% • I feel emotionally safe
- 95% • I trust the people who work here
- 90% • I trust staff to follow through
- 89% • I have a lot of choice about services
- 89% • I feel like I'm a partner with staff in deciding what services to receive
- 94% • Staff recognize that I have strengths and skills as well as challenges and difficulties
- 91% • Staff are as sensitive as possible when they ask me about difficult experiences
- 89% • I feel safe talk with staff about substance use, violence or trauma
- 79% • Staff support me in connecting with cultural programs and activities
- 92% • My needs have been met at the program

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Section 3

Clients' perspectives about their program

Findings from Client Questionnaire:
"What, if anything, has gotten in the way of your participating in the program?"

49% of the women who completed the Client Questionnaire indicated that **nothing prevented them from attending their program**.

Of the six potential barriers included as questionnaire response options, 'lack of time' and 'transportation' were most frequently cited as an impediment to participation:

- 18% • Lack of time/too busy (n=22)
- 18% • Transportation (n=21)
- 8% • Lack of child care (n=9)
- 6% • Program location (n=7)
- 5% • Don't feel safe (n=6)
- 3% • Feel judged by others (n=4)
- 18% Other – please describe (n=22)

My mental health.

People in my past who are here.

My alcoholism, getting sick from drinking, anxiety and feelings of shame. Feeling unsafe walking on Main St.

When group is really noisy and chaotic.

As well, some participants' comments illustrated that the barriers could overlap. For example, two people indicated that transportation challenges were exacerbated by challenges of having to take their children on the bus.

In addition, clients' open-ended comments regarding barriers to program participation could be grouped into several additional themes, including:

- My health or mental health
- My substance use/addictions
- Difficult or 'dramatic' group dynamics
- Lack of energy
- Can't get time off work; other programs/school
- Being in a violent relationship

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Section 3

Client outcomes

Clients' Perspectives – All Programs

(based on n = 125 interviews)

What has been the most significant change for you and your family?

- Quit, reduced or safer substance use
- Mother – child connection
- Women keep/regain children in their care
- Improved wellness/mental health
- Increased support
- Safer, improved housing
- Increased self-confidence/self-esteem
- Reduced isolation
- Self-compassion/self-determination

Coming to HerWay is getting us out of our shells. My daughter and I, we really needed this. It's really made a difference in terms of our health, mental health and well-being.

I'm happy, have lots of friends. I've connected again with family, and I'm sober.

Because the staff care so much, I've gotten clean.

Getting suitable housing and reuniting with my son. We were in the SRO when I had the baby. Then he went into a foster home. Then we got housing and the baby was returned to us.

Our household is more balanced. I know my triggers and deal with anger better. I am more balanced emotionally.

I've been clean and sober for 22 months. Getting clean changed my whole life. I got my son back and I'm about to get the older two children back in September.

I got back into my culture. I'm teaching my daughter how to smudge and do drumming. I'm really glad I'm in this program. If I hadn't, I don't think I'd have my daughter. I'd be doing drugs and messing up my life.

I'm about to reach out for support. I couldn't do that before.

My baby and I have a home. We know we're not alone – both because I can call the HER staff and because of other women. Without HER, I probably wouldn't have had my baby.

My stress level has gone down quite a bit. I know that no matter what, they'll be here. The program helps with everything: prenatal care, housing, CFS advocacy, baby stuff. Before coming into this program I felt hopeless. If I didn't do this program I probably would have had an abortion.

Getting my daughter back from foster care and having my baby come home from the hospital with me. Getting my kids back is the biggest thing. That showed me I'm done with my past lifestyle.

If I hadn't been at this program, it would have been harder to stay sober, and my baby would have gone to live with my mom.

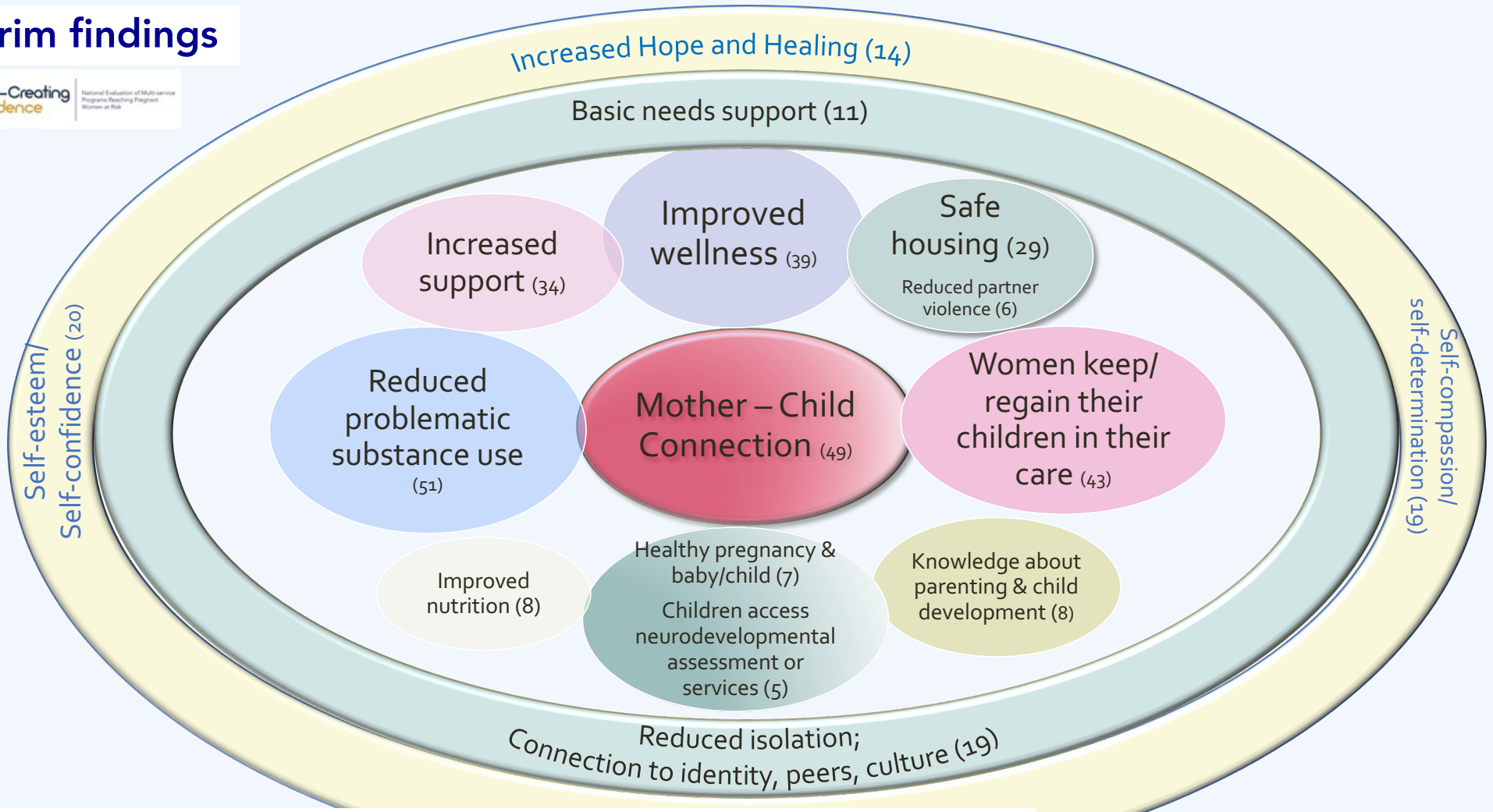
It helped me – the therapy and the groups – to reflect on myself, and I wanted to do that for myself. I have a better understanding of myself. They give us the tools to help ourselves.

My sobriety. I've had a couple of slips, but I've maintained my sobriety since my son was born – which is my goal.

They've helped me open up more. I feel more self-confident and happy. I've opened up a lot more.

A lot has changed. I feel more informed as a parent. It's made it easier for me to transition into different stages with my children.

Interim findings



Presented here are the themes emerging from clients' responses (**n = 125**) to the open-ended question: "**What has been the most significant change for you and your family**?"

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Section 3

Programs' strengths

Programs' Strengths – All Programs

Staff's perspectives (n=61)

- Philosophical approach & program model: relational, trauma-informed, holistic, women / client-centred, harm reducing, culturally informed
- Multi-disciplinary staff with expertise in multiple areas
- 'One-stop' / wrap-around; medical health providers on-site
- Flexibility and outreach
- Strong relationships with service partners

Our philosophy is our strength – especially being trauma-informed and taking a harm reduction approach.

Providing a safe environment where women are in a non-judgmental place where they can get the help they need or want. It's like a one stop shop.

A huge strength is the experience and qualifications of staff.

Having the doctor on-site is very helpful, as it enables women to address longstanding health issues.

When a child is born, they are welcomed to Mother Earth. Recognizing mother and child are on a sacred journey , we love them till they can love themselves.

The partnership means better case management; together we can identify more quickly when a woman is struggling or if there is a risk for the children.

Service partners' perspectives (n=42)

- Philosophical approach & program model: holistic, relational, women / client-centred, trauma-informed, harm reducing
- 'One-stop' / wrap-around
- Strong relationships with service partners (e.g., child welfare; health/medical)
- Committed, multi-disciplinary staff
- Program is flexible and responsive; outreach
- Strong outcomes for women and families

They have the ability to navigate the delicate balance between providing women with support and being attentive to safety concerns.

[The program] is guided by harm reduction: meeting the needs of women where they're at. They'll do so much to engage women. Women come here and feel safe; it's non-judgmental and inclusive.

They are stigma-free; women aren't judged and don't feel judged.

Having everything 'in-house'.

It's giving women the chance to have their families with them. They wouldn't have that chance without [the program].

The women are getting prenatal care earlier in their pregnancy. So the benefit is more medical care and the opportunity to talk about reducing substance use.

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Section 3

Programs' challenges

Programs' Challenges – All Programs

Staff's perspectives (n=61)

- Complexity of challenges facing clients, including trauma, intimate partner violence, addictions, Fentanyl, poverty, racism including systemic racism, housing, being street- entrenched, coming late in pregnancy, low self-esteem
- Program is understaffed to meet demand, especially given complexity of women's issues
- Stable and adequate program funding
- Engaging the hardest-to-reach women
- Need for additional programming for women struggling with addictions
- Differing mandate, timelines and philosophical approaches of other systems of care

With Fentanyl, we are seeing women with more complexity than before – more chaos, more drug induced psychosis, more infections.

The Case Managers are still way too busy; the number of women in their caseloads has gone up, as has the complexity of the issues that they – and the women – are dealing with.

We recently had to cut our food budget by one-third, so now the food is all gone halfway into the drop-in. We also don't have enough money to stock up on formula. It's been hard to say to women, "We can't help you with this."

It's hard to plan a program such as drop in or relapse prevention groups when women's lives aren't stable.

Systems (courts, CAS) can interfere with the progress of women. … . Some can be very judgmental and show little respect to women in our program.

Service partners' perspectives (n=42)

- Program is understaffed to meet demand
- Need for (additional) housing – this is a service gap
- Differing mandate, policies and approaches of other systems of care – can lead to mistrust
- Regularly scheduled communication with service partners initially was a challenge; needs to be ongoing priority
- Need additional substance use services for women

The client load is increasing, yet the number of staff is the same. The Drop-in numbers have increased, maybe tripled in 15 years.

What's been disappointing is that housing hasn't been connected to the program. That continues to be a huge barrier to women taking their babies home from hospital.

I still have to do my work within my home agency's' guidelines and structure, which isn't always easy.

We need a way to access treatment more quickly.

Section 3

Suggestions for program improvement

Suggestions for Improvement – All Programs

Staff's perspectives
based on n=61)

- Increase staffing
- Have additional training/PD opportunities
- Have increased outreach capacity
- Offer (additional) housing
- Offer programming to support men
- Relapse Prevention grp; better access to detox

We'd love to be able to follow up with women longer term and to increase our capacity to have a second Pregnancy Outreach Worker.

It would be good if staff could access advanced courses in trauma or counselling.

It would be good to have a lower barrier Recovery Group for women who are still actively using.

We need to have better supports for men/partners, so that they can get over their trauma.

Service partners' perspectives
(based on n=42)

- Increase staffing
- Increase hours of operation
- Better access to mental health or A&D resources
- (Additional) programming, e.g., re: parenting; cultural activities; programing for men
- More regularly scheduled mtgs with partners

I see the need for more staff to correspond to the increasing number of women.

I'm sure they could use more resources – there's a bit of a baby explosion about now.

We need a way to access treatment more quickly.

Availability of a sacred space for smudges and other ceremonies; additional funding for cultural activities.

Clients' perspectives: What would you change about the program?
(based on n=125)

- Nothing (50)
- More groups or programming (29)
- No substance use on site (10)
- More basic needs support (10)

There are a lot of children with barriers; we could use a group or drop in conversation about how to deal with or raise a child with significant challenges.

Have more groups on trauma. Once a week would be good. Also, parenting support for moms who have lost their children.

More cultural activities such as meeting at a pow wow or sweat, with child care. I want to teach my children about culture because I grew up in care.

People should not be able to get high where there are children.

Discussion and Conclusions

Section 4

Discussion

Discussion: Overview and Key Program Strengths

Overview

The ***Co-Creating Evidence*** **(CCE)** multi-site evaluation involves eight holistic programs across Canada serving pregnant and/or parenting women at high risk of having an infant with FASD. While the programs are grounded in highly similar philosophies, each program is different, and each was created to address local priorities, needs, partnerships and collaborations. The CCE evaluation approach is collaborative in that the project team and program sites have worked together to develop common outcomes and indicators, including program outputs and client 'snapshot' data related to selected client outcomes. Moreover, an important objective of the project is to bring the programs together to share promising practices and approaches.

The findings reported in this Interim Report are based on site visits and face-to-face data collected at all eight programs during spring/summer 2018, as well as program output and client 'snapshot' data. The in-person data collection involved: semi-structured interviews and questionnaires with 125 clients; semi-structured interviews and focus groups with 61 program staff; and semi-structured interviews with 42 service partners. In total, **226** people participated in the Time 1 data collection.

Key program strengths

There was considerable consistency in the themes that staff and service partners identified as program strengths, and these were also very congruent with what clients voiced as being 'most important' to them about their program. Key program strengths included:

- **Well-conceptualized, evidence-based philosophical / theoretical foundation**
  There was tremendous commonalty in the elements of programs' theoretical foundations, including being: relational; women- or client-centred; trauma-informed; harm reducing; holistic; and culturally-informed. Many evaluation participants stated that the program "meets women where they're at" and used that phrase when speaking to several elements of the philosophies.

- **One-stop / wraparound model**
  Staff, partners and clients spoke of the importance of the 'one-stop' approach, wherein women and their children can access an array of health/medical services and social, financial, housing, basic needs, child welfare, and cultural resources and supports under one roof. Also, in most programs, there is a combination of outreach, groups, and one-to-one support, and women have options about the services they receive. All of these were viewed as key dimensions of the wrap-around model.

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Section 4

Discussion

Discussion: Key Program Strengths (continued)

Key program strengths (continued)

- **Program staff**
  Staff have deep knowledge about multiple areas – substance use/use during pregnancy, child welfare practice and legislation, health, housing and social services, and how to access resources. Staff in some programs also have experiential expertise.
- **Staff use best practice approaches in keeping with their program's philosophy; they 'walk the talk'. Consequently:**
  - Women experience the program as safe and welcoming, and staff are viewed as non-judgemental, caring and helpful
  - Programs provide regular opportunities for women to give input/feedback about the services and operation; programs are modified based on women's feedback.
  - There is a strong focus on cultural approaches and activities (five of the eight programs have Elder services on/near-site)
  - While being trauma-informed, staff do not shy away from having 'hard' conversations and giving honest answers.
  - Staff engage in reflective practice; teams regularly reflect on and discuss practice-related issues and challenges.
- **Strong partnerships / collaborations** (e.g., with housing, health/medical, Labour and Delivery, and substance use services)
  Spotlight on child welfare: Five of the eight programs have a child welfare social worker on-site, who specializes in working preventatively/voluntarily with pregnant women who use substances. Program staff, partners and clients believe this has helped prevent infant removals and has enabled more women to keep their infant and child(ren) in their care. The strong partnership with child welfare workers also allows for mutual learning between program staff and social workers (e.g., about harm reduction, trauma, substance use).
- **Sense of community / Peer support**
  In a number of the programs, staff and clients spoke of the sense of community that existed at their program and the peer support that women offered to and received from one another. Some spoke of the program as feeling 'like family'.

As an additional strength, staff and service partners spoke of programs' strong impacts for women and their child(ren):

- Women are accessing better and earlier prenatal care, as well as services for their other health issues
- Healthier birth outcomes
- Women are keeping their infant / child(ren) in their care
- Women are quitting or reducing their substance use; women are improving their well-being
- Women are assisted in accessing safe housing and in getting support, including material/basic needs support

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Section 4

Discussion

Key Program Challenges or Service Gaps

- **Stable and adequate funding**
  All programs grappled with funding issues. Some programs did not have stable funding partners, while others had not received increases in their funding relative to their initial years of operation, despite the multi-fold increases in both the number of women served, the diversity of the client group, and the increasing complexity of many of the women's needs.

- **Increasing complexity and intensity of women's needs**
  This was noted in seven of the eight program sites. Specifically, several Program Coordinators noted that the opioid crisis is profoundly affecting their program and its surrounding community, including resulting in significant grief and loss issues for clients and staff. At the same time, there is tremendous diversity in programs' client composition: many women have quit or substantially reduced their substance use and are seeking to maintain where they're at.

- **Engaging hardest-to-engage women**
  Program staff observed that despite their program's growing number of clients, it was an ongoing challenge to engage the hardest-to-reach women, including those who were younger, most street-entrenched, who had serious mental health issues, who were involved in sex work and/or who had controlling partners.

- **Balancing harm reduction with women's/children's safety and women's desire for no substance use on site**
  While clients were highly appreciative of a harm reduction, low barrier approach, some also expressed concerns, namely feeling triggered by others who were still actively using substances or early in their recovery. This causes some tension in terms of women's and children's safety and women's desire for no substance use on site, especially notable in programs with a housing component. Staff were well aware of these challenges and were grappling with how to practice harm reduction and offer low-barrier services while ensuring safety and honouring women's preferences for a substance-free living/program environment.

- **Length of service**
  Programs vary in terms of how long women can participate in the program. Typically the timeframe has been based on funding issues/limitations, possibly running counter to research evidence. Currently, one of the programs has a 6-month post-natal cut-off; two programs are 18 months post-natal; one is 3 years post-natal; and the others are 4-6 years or no set cut-off in terms of the child's age. Programs currently are being challenged to make decisions regarding length of service that best supports their clients (women and children), while taking into account the program's capacity in terms of staffing and resources.

Co-Creating Evidence | National Evaluation of Multi-service Programs Reaching Pregnant Women at Risk

Section 4

Discussion

Key Program Challenges or Service Gaps

- **Additional programming for women struggling with addictions**
  Many of the programs are offering individual and/or group programming for women who are ready for change and seeking support in relation to their healing/recovery. At the same time, several programs have recently recognized that their existing programming wasn't working optimally for women who are struggling with problematic substance use. The programs are starting new programming or trying to secure resources / community partnerships to offer this programming, complementing their wrap-around approach.

- Service Gap: Housing for women and children
  The programs all provide a range of health/medical and social services. Many included material/basic needs supports as well, which was appreciated by the women in the program. However, access to stable, adequate, affordable, and safe housing remains a major hurdle, not to mention a necessity for women's ongoing well-being and plans for parenting. Two programs have a housing component while the remainder rely on a combination of approaches including advocacy, rent supplements, and/or having Income Assistance staff on site to help ensure that women have an income source and access to all available supports. Program staff at some sites noted that they needed better, more direct access to housing options for their clients, including rent supplements if inclusion of a housing component itself wasn't an option.

- Service Gap: Women's detox & treatment services
  A key service gap noted is the lack of withdrawal management and treatment services that are tailored for pregnant and parenting women. Not all women who access the holistic community based services involved in this study wish to access withdrawal management and/or treatment even when eligible, but they are critical supports to have in place for those women who are ready and in need of day/residential treatment and support. Such addiction services should include programming designed for both pregnant women/mothers and child care/programming for their children, and be closely coordinated with community-based health, housing and other relevant supports.

Section 4

Conclusion

- **Overview**: It bears repeating that in the programs taking part in the CCE study, staff are highly skilled at creating safety and building trusting relationships with the women seeking services, all of whom are pregnant and/or parenting and some of whom are considered 'hardest-to-reach'. This is important; many of the programs' clients have a long history of distrust of service providers and are adept at living outside of health and social service systems due to previous bad experiences. That nearly all clients reported feeling safe participating in the programs was a significant marker of program success.

- **Wrap-round model**: Interim evaluation findings echo the literature, i.e. that high risk pregnant/parenting women have numerous, complex, and intertwined issues. In the face of such complexity, the ability to provide a core cluster of health, medical, and social services under one roof is crucial, regardless of governance model.

- **Engaging clients**: In terms of client demographics, across the eight sites, approximately one quarter of the programs' clients were under age 25, and 60% had unsafe or insecure housing. According to program staff, younger women are often more street entrenched, and for this and other reasons, the programs' inclusion of an outreach component is essential. As well, overall, 57% of clients were Indigenous, emphasizing the importance of the programs offering culturally-grounded programming and approaches.

- **Services are experienced as safe, respectful, welcoming and helpful:** Clients had a very high degree of satisfaction with their program, and their experience of their program was in synch with its philosophy. This indicates that when programs employ best practice approaches (e.g., being relational, trauma-informed, culturally safe), clients are engaged and develop strong positive relationships with staff and other program participants that directly contribute to positive health and social outcomes.

- **Helping clients solidify their gains:** The majority of the women in the programs had lost custody and/or connection to one or more infants/children, and for them the desire not to repeat that experience was a driving factor in their decision to seek support during pregnancy or postnatally. Interim findings of the CCE study suggest that the programs are making an important difference in terms of women's accessing prenatal care and health services, having healthier births, reducing their substance use, improving their mental wellness, having improved housing and basic needs support, and retaining or regaining custody. In the next phase of the CCE study, these impacts will be examined in greater detail, along with exploring factors that help to instill lasting gains, particularly in relation to the women's well-being, mother-child connection, and parenting outcomes.

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