Evaluation Report of the Sheway Project

for High-Risk Pregnant and Parenting Women

By Nancy Poole

British Columbia Centre of Excellence for Women's Health


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I. Executive Summary

The Sheway Project is a unique outreach program located in the Downtown Eastside (DTES) of Vancouver, providing holistic services to pregnant women with substance use problems, and support to mothers and their families until their children are 18 months of age. Sheway promotes the well-being of pregnant women and their families, taking into consideration the context of living in the Downtown Eastside of Vancouver, one of Canada's poorest neighbourhoods, renowned for its high crime rate, drug and sex trade, violence, substandard housing and high rate of HIV. Sheway takes a woman-centred, harm-reduction, culturally focused approach to providing services.

This evaluation brought together the perspectives of women who had used Sheway's services in 1998, the staff and Council members, and allied service providers in nine health areas connected to the work of Sheway. Statistical information on the health outcomes of women and their children was analyzed, and recommendations arising from research undertaken by other programs serving high-risk pregnant women were also considered.

Similar to other programs serving pregnant women with substance use problems, the women coming for help at Sheway had lives characterized by poverty and hunger, unstable living situations, low levels of social support, histories of violence and sexual exploitation, use/misuse of alcohol and other drugs, unplanned pregnancies, apprehension of previous children, and stress and exhaustion from the care of young children currently living with them.

This evaluation documents the success of the Sheway Project in engaging women in accessing pre- and postnatal care, in making improvements in their housing and nutritional status, and in retaining custody of their children. Also identified are further service developments needed to support women in reducing their substance use during pregnancy and to support the growth, assessment and health of their children.

Also identified in the course of the evaluation were community service needs that would support the work of Sheway, including: substance use treatment and support services; services for children in the age range of eighteen months to five years; services for partners of women accessing care; as well as housing, home support, recreational and parenting services. Interest in a collaborative perinatal network structure was also identified to promote and support communication across services, prevention initiatives, policy development and research efforts.

II. History and Evolution of the Sheway Project

The Downtown Eastside of Vancouver where the Sheway project is located has been identified as the poorest neighbourhood in Vancouver, if not in Canada. It is known for its sex and drug trade, violence and crime, alcohol and drug misuse, substandard housing and high rate of HIV-related illness.

Sheway was established in 1993 in response to a growing understanding of the needs of pregnant and parenting women living in the Downtown Eastside. A report entitled *Targeting High-Risk Families* (Loock, et al., 1993), revealed that approximately 40 per cent of infants born over a two year period to mothers living in this area of Vancouver were exposed to alcohol or other drugs in utero. The rate of low birth weight was 33 per cent in the exposed infants, all of whom were apprehended by child protection authorities. In this same period, hospital health care providers were identifying an increasing number of socially high-risk pregnant women with substance use problems arriving at their emergency departments ready to deliver and with no history of prenatal care. The health outcome for these mothers and their infants was poor.

In response to these concerns, a group of health and social service providers including representatives of BC's Children's Hospital, Vancouver Health Department and the YWCA's Crabtree Corner program prepared a proposal for the development of a community-based integrated service that would meet the complex health and social needs of this population of women and children. In July 1992, funding for the project was approved and the service began operation in March 1993, with the overall goal of reducing the potential harmful effects of prenatal drug and alcohol exposure by providing a community-based continuum of outreach education and service to women at risk.

Initial partners in developing the funding and supporting the Sheway service were the BC Children's Hospital, Vancouver Health Department, the Ministry of Social Services (now incorporated into the Ministry for Children and Families), the YWCA and the Vancouver Native Health Society. The unique funding and management structure of Sheway evolved because of an early decision, whereby government and non-government agencies became full partners in the development and provision of services. (Whynot, August 1993)

Sheway's **mission** since its inception has remained as follows:

> Sheway is a community outreach program for childbearing women and their families who live in the Downtown Eastside of Vancouver. Sheway recognizes that the health of women is linked to the conditions of their lives and to their ability to influence these conditions. Sheway reaches out to women who are pregnant to assist them with meeting their needs for support, safe living conditions, economic security and physical well-being. The staff works with women to help them develop the information, skills and confidence that they will need to care for themselves and their children. Sheway affirms the right of all women to self-determination within their own cultural, spiritual and social context, and endeavours to link the program with those in the community who share these goals. (Sheway Planning Documents, unpublished)

Its **goals** also remain largely unchanged and fall into four core areas:

- **To engage women in accessing prenatal care and a range of other supports during pregnancy.**

  Underlying this goal are the intents of:

  - reducing the isolation of high-risk pregnant women,
  - providing a positive experience with a community service which may serve as a basis for further connections,
  - supporting improved health of mothers, and
  - reducing harm associated with substance use, including reducing the number of infants born with Fetal Alcohol Syndrome or Neonatal Abstinence Syndrome and low birth weight.

- **To provide education, referral and support to women to help them reduce risk behaviours, in particular to reduce or stop use of alcohol and other drugs during pregnancy.**
  In the substance use area, Sheway provides limited alcohol and drug education and counselling, referrals to treatment, and harm-reduction-oriented medical services.

Behind this goal is the intent of reducing the number of infants born with Fetal Alcohol Syndrome and Neonatal Abstinence Syndrome and to create the conditions for women to be able to parent their children after birth.

- **To support mothers in their capacity as parents and caregivers.**
  The intent has been to reduce child apprehensions and to support women to have positive parenting experiences.

- **To promote the health, nutrition and development of children born to women accessing prenatal care at Sheway in the period up to 18 months following birth.**
  Sheway provides "well baby" care and many other supports on site, and places priority on assisting women and their children in getting connected to community-based services.

Like other pioneering services in this area, the program objectives and services have evolved in response to its increasing number of clients and the evolving needs of the community. This evaluation focuses on the services provided to women and their families in 1998. By that point the program had been operating for five years and had expanded considerably. In its first year of operation there were nine staff members, providing prenatal education, advocacy, nutritional counselling and outreach services to 30 to 40 women. Gradually other program components such as the healthy hot lunch program were added. From June 1996 to 1998, three midwives successfully provided comprehensive midwifery services at Sheway through the Safe Passages Program.[*] As of March 2000, Sheway has 16 staff members (a mix of full and part time) and has had to limit its caseload to100 women and their families.

Just as Sheway providers have been building on their services to respond to the needs of pregnant and parenting women, other community service providers have been working to define and address the health and social needs of all those living (and visiting) this community. Research documented in reports such as *Something to eat, a place to sleep and someone who gives a damn – HIV/AIDS and Injection Drug Use in the DTES* (Parry, September 1997) and *The Place to Start, Women's Health Care Priorities in Vancouver's Downtown Eastside* (Core Women Care, 1995) have contributed greatly to the understanding of this community's needs.

Other communities in Canada and the USA have also been developing and delivering services for pregnant and parenting women facing life situations not unlike those in the Downtown Eastside of Vancouver. The work of the *Breaking the Cycle* program in Toronto and other perinatal projects funded in the USA as of the early 1990s will also be considered in this report in relation to the evolving work of the Sheway Project.

[*] See *Maternal Care for Substance Using Women and their Children - Program Evaluation Report*, prepared by Lesley Sherlock for the Vancouver/Richmond Health Board in October 1998 for more information on this phase of Sheway's work. The Safe Passages Program was a short term "Closer to Home" funded project. As a result of the reorganization of the delivery of midwifery in BC, midwives are not able to work within institutional or community agency settings.

III. The Evaluation Process

The evaluation plan was developed through a collaborative process led by the British Columbia Centre of Excellence for Women's Health.

The evaluation brought together the perspectives of women who had used the services in 1998, the staff and Council members, and allied service providers in nine health areas connected to the work of Sheway.

An innovative approach was taken to gather information from women served. Art expression was combined with a focus group to capture women's perspectives on their experience at Sheway. The evaluation was driven by the concern that information gathering be consistent with Sheway's philosophy of providing service in a respectful, non-intrusive and self-determining way to women who have had negative experiences with how information about them has been gathered and used.

Detailed information on the birth and health outcomes of women and their children was gathered through a file review. This information was entered onto a clinical database and compared with information on women served in the two previous years.

Descriptions and recommendations of other programs serving high-risk pregnant women were also considered.

A description of the evaluation questions, principles and methods is included in Appendix 1. Also included in Appendix 1 is a listing of the twenty-one key informants involved in the evaluative research.

IV. Perspectives on the Services Provided

An overview of the services provided, the philosophy of care on which services are based, and the key outcomes sought when providing services to women and their families are included in the "Sheway Program Model" on page 7.

A. Philosophy of Service

Marjorie Rosensweig, after visiting 147 of the *Pregnant and Postpartum Women and their Infants* programs in the USA, summarized the importance of working from a respectful core philosophy as follows:

> I have seen time and time again proof that program effectiveness is not dependent on adherence to a single program model. Instead, a set of core concepts and competencies undergirds very different – yet effective – programs. (Rosensweig, 1998, p.206)

She summarizes these concepts and competencies as:

- "Women-focused, taking into account women's families and relationships"
- "Based on a philosophy of mutual trust and respect"
- "Staffed by people who believe that the glass is generally half full, not half empty"
- "Responsive to clients' real and pressing needs and concerns, not experts' concepts of the nature of these needs" (Rosensweig, 1998, p.206)

At several points over the course of the evaluation, the Sheway staff reviewed their service philosophy and values, and reaffirmed the importance of using these to guide program delivery. The service philosophy and values underlying the program are to:

- provide services in a flexible, non-judgmental, nurturing and accepting way,
- support women's self-determination, choices and empowerment,
- offer respect and understanding of First Nations culture, history and tradition,
- take a harm-reduction approach,
- offer a safe, accessible, welcoming drop-in environment, and
- link women and their families into a network of health-related, social, emotional, cultural and practical support.

The twenty-one key informants interviewed, representing both hospital and community-based services were resounding in their support of this harm-reduction oriented, flexible, non-judgmental approach, saying:

> *If they didn't have that approach then a lot of women wouldn't go there. Women feel safe when allowed to be who they are, even when they are high, and there is no judgment.*
>
> *Their philosophy fits perfectly with their client.*
>
> *Their philosophy is very supportive . . . They are just fantastic at going the mile with women on practical support.*
>
> *With this kind of client it is the only way you can get an effective relationship – if you become more directive they are not going to come back. It's about empowering people and giving them a sense of self.*
>
> *It's fabulous – it's the only way to go as it's so easy to shame mothers about drugs. I think harm reduction and acceptance and being non-judgmental is the only shot we have at reaching them. It would be great if*

abstinence worked, but we know it doesn't – it is shallow to suggest women stop period. When you are un-numbing and then having to deal with what you are un-numbing from, it's not realistic.

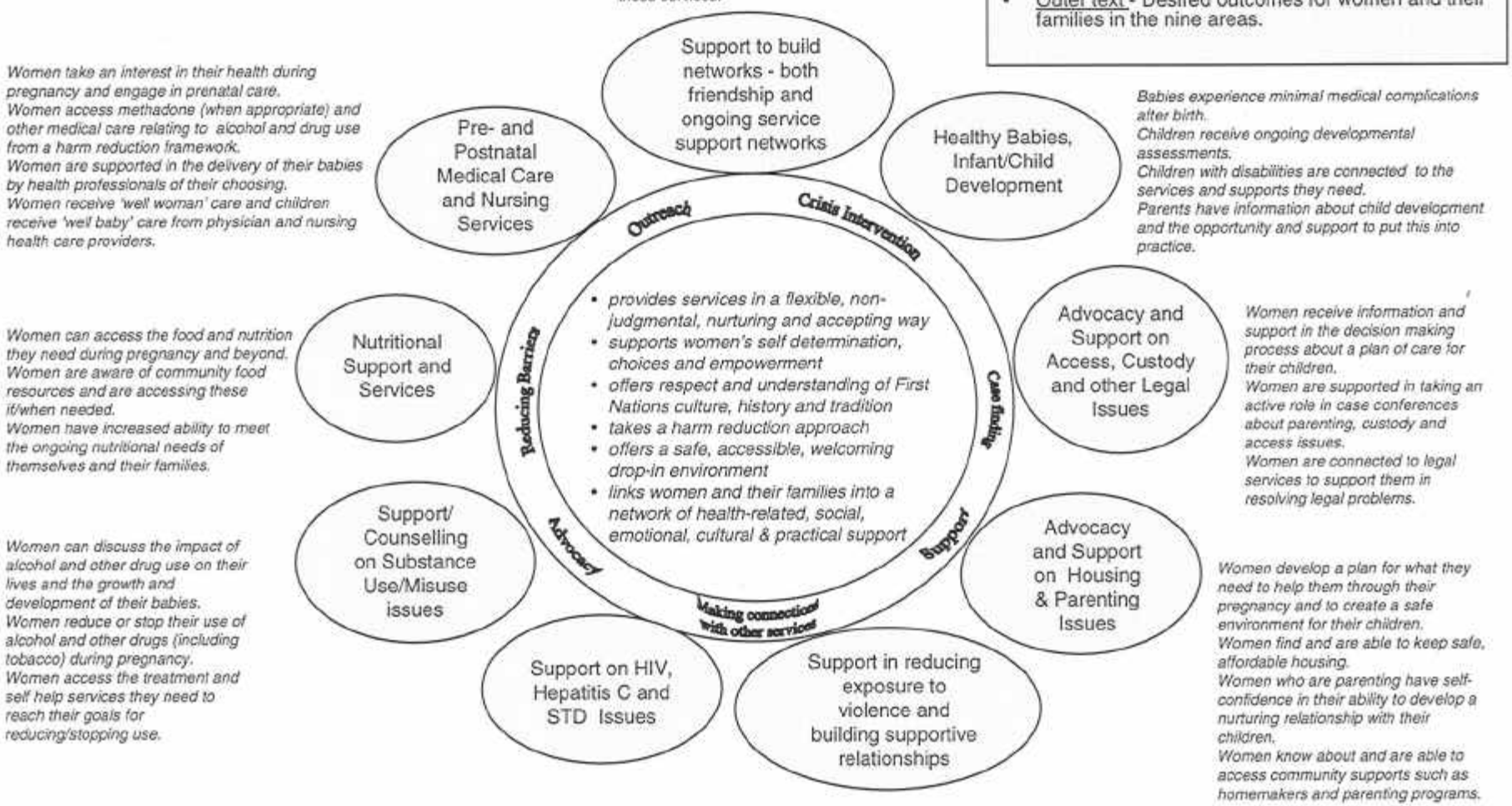
It is the only way to go with this population of women – if we try to shove our agenda down their throats they ain't going to come back, and we don't have the right to do that. Our job is to help them see what they need to see about themselves and support their self-responsibility.

The abstinence model takes away services from women in the DTES and forces them to live with the shame and the blame that they're already experiencing and doesn't offer them services to improve their situation or where they're at. By being non-judgmental and letting them change at the rate they're able, (Sheway's approach) is more empowering.

Sheway Program Model

based on the recognition that the health of women and their children is linked to the conditions of their lives and their ability to influence these conditions

- In the centre - Sheway's philosophy of service.
- Encircling the philosophy - Key approaches to service provision that reduce barriers to care.
- Ovals - Services/supports provided in nine key health areas.
- Outer text - Desired outcomes for women and their families in the nine areas.



B. Practical and Professional Services Provided

Sheway's services are provided on an outreach and drop-in basis from a storefront in the heart of the Downtown Eastside of Vancouver, co-located with the Vancouver Native Health Service clinic. A small reception area brims with donations of clothing and offers a small table space where women can make phone calls. A homey living and dining room area with adjoining kitchen is the focus of service space. In the summer, a back deck serves to expand the drop-in space. Tiny, windowless staff offices line the central drop-in space and an additional room for the provision of medical care is located in the Native Health clinic space. A small, child playroom links the Sheway and Native Health service areas.

Within this setting, an array of services are provided by the multidisciplinary staff, including a Project Coordinator, two Social Workers, an Outreach Worker, an Infant Development Program Worker, a part-time Alcohol and Drug Counsellor, two Community Health Nurses, a Dietitian, two sessional Physicians (available three afternoons per week each), an Office Manager, a part-time Receptionist, a Medical Office Assistant and a part-time Cook.

Other professionals, from outside agencies, provide on-site service to Sheway clients. A Pediatrician and Nurse Clinician from an outreach program associated with Sunny Hill Hospital provide developmental assessment services to substance-affected children and their parents. The Centre for Ability (formerly the Vancouver Neurological Centre) provides an Occupational and Physical Therapist who work closely with Sheway's Infant Development worker and nurses, and the infants and children of Sheway clients. A Financial Aid Worker also meets with women on site regarding financial support.

Practical services

Central to the program delivery and success is provision of basic, practical and nurturing care, including:

- daily hot nutritious lunches,
- drop-in time from noon to 4 p.m. every weekday, when women and their families can drop in to socialize or access services,
- weekly food coupons and food bank hampers for pregnant women,
- emergency food for women in need,
- nutritional supplements for pregnant women and breastfeeding mothers,
- bus fare for transportation to medical and other appointments,
- formula, diapers, shampoo, soap, toothbrushes and toothpaste (rely on donations for these),
- donated clothes, baby cribs, toys, and car seats,
- outreach services. This involves visiting women who have not dropped in with regularity to encourage them to access care, or work with women in their homes to help them improve their capability to provide care for themselves and their children, and
- recreational and creative programming. Special events are celebrated on days such as Mother's Day, Halloween, Christmas and Easter. Picnics, mothers' and children's swimming sessions, and arts and craft sessions are organized/offered.

When asked what brought them to Sheway, clients often mentioned this practical support as critical to their coming for help:

> *It was basically the free food for me. They (other programs) didn't give you enough to live on during the months that you're pregnant, and the milk and stuff really helped out in case you ran out and if you had other children. They don't give you enough to live on, right, so you need that extra support.*
>
> *When I first came to Sheway they told me that it was like a drop-in centre and will help you through your pregnancy with milk and stuff like that, and that was fine. And then all of a sudden they introduced me to*

a social worker for the ministry, and she'd kind of help you out a little bit, instead of like, being a worker when you're in her office. And it was choice, to participate in the program at Sheway, but they also wanted you to do your part of being responsible for yourself too while you're there, instead of always them supporting you all the time. So that's why I came to Sheway.

Professional services

The array of professional services that Sheway's multidisciplinary staff group is able to provide is, as one allied professional described, "very, very impressive."

It involves:

- comprehensive pre- and postnatal medical and nursing care and other medical and nursing care unrelated to pregnancy and parenting status,
- assistance in accessing available social and financial supports,
- nutrition counselling and support,
- alcohol and drug counselling, methadone prescribing and other support in reducing harm from the use of illicit drugs, and referral to treatment services,
- support in developing/improving parenting skills and understanding of child development,
- advocacy on housing and legal issues, and
- referrals to ongoing community supports, and referral and transportation (as necessary) to other specialized services.

These professional services are grounded in positive, collaborative relationships with the women served. In this context women can identify and negotiate the amount and type of services they need.

In the focus group, clients identified the range of services they chose to access. When asked what support or combination of supports they sought out, they responded:

All of it!

The clothes for the kids.

The nurses to get the shots.

The alcohol and drug counsellor to work out your problems with trying to get off drugs.

The social workers, settlement workers, you know.

The nutritionist.

Everything, yeah, all of it.

I took different stuff – I (got referred to) a parenting program, a native awareness one – and for me that's what really helped me, because, like, I didn't even know how to parent. I was too tied in to when I lost my three children, so I had a lot of issues to deal with.

The doctor that came here every Thursday.

Lynn's (the Infant Development Worker) sewing machine.

Lynn has stuff on loan for babies and helps you work through the development stages of the children.

And Sheway lets you use their fax machine and phone.

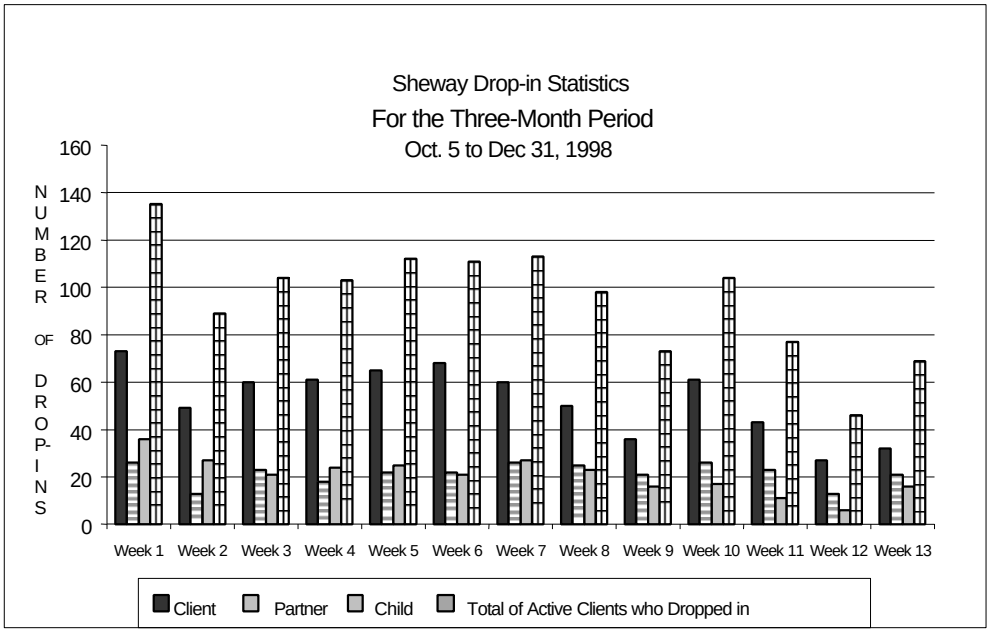
We could come here and not be judged.

C. The Amount of Service Provided

In the 1998 year, Sheway:

- received two to three new referrals per week,
- carried an active client list of 60-70 women and 20-30 children,
- saw 25-35 drop-in clients per day on average between noon and 4 p.m.,
- provided comprehensive 24-hour prenatal medical care to 25-30 women,
- delivered two to four babies per month, and
- answered 40-80 telephone inquires per day.

The chart included below provides a view of the drop-ins by active clients in the three-month period between October 5 and December 30, 1998. Over one thousand (1161) active clients were seen in this period. Of these, 53 per cent were pregnant and parenting women, 24 per cent were partners of these women and 23 per cent were children. A further 317 former clients also dropped in over this time period.



As of January 2000, the active caseload had increased to 100 (maximum capacity), the drop-ins per day to 60-90, the prenatal medical care to 60 women and the telephone calls to approximately 100 per day.

The need to set a maximum number of women and families that can be effectively served arose during the course of the evaluation process. An appropriate upper service level remains an outstanding issue to be monitored and assessed. As comparable perinatal services are developed throughout the Lower Mainland, the pressure on Sheway services may be decreased and this may become less of an issue.

V. Profile of the Women and Families Accessing Sheway Services

In 1991, there was a glaring hole in the literature on pregnancy and drug use. While extensive and sophisticated knowledge concerning fetal outcome was available, there was a paucity of information about the mother herself. We did, however, learn from prior research that, compared with non-drug users, the pregnant addict was less likely to attend prenatal appointments, more likely to live in poor conditions, more likely to have a host of confounding problems such as sexually transmitted diseases, and more likely to experience higher rates of violence. Nevertheless, the details of her social world had not been well mapped out. As a result, it remained difficult to understand how each of the factors in a pregnant drug user's life affected and was affected by her drug use as well as the individual and cumulative effects of these factors. (Sheigla Murphy and Marsha Rosenbaum (1999) describing the rationale for undertaking the Pregnancy and Drugs (PAD) study in *Pregnant Women on Drugs Combating Stereotypes and Stigma*, p.13)

A. Profile from the Literature of Women Who Are Pregnant and Using Substances

There is now extensive literature from cities throughout the USA and Europe that profiles women who are struggling with substance use problems and facing a very complex array of health and social problems when pregnant. In the emerging literature, women using substances during pregnancy have been described both as struggling with the many pressures put on them and demonstrating remarkable strength and resourcefulness.

The profile arising from the literature of women who are pregnant and using substances, is strikingly similar to that of the Sheway clients. And the descriptions of the services that have been developed to address the needs of these women show that the Downtown Eastside of Vancouver is by no means unique in its challenge to assist women and children facing very difficult life situations.

Pregnant, substance-using women have been described in the literature as follows:

- experiencing poverty and hunger, worsened by diversion of resources to drugs,
- living in unstable living situations and frequently relocating,
- doing licit work in menial jobs, illicit work, or on welfare,
- having low levels of social support,
- needing the basics – transportation, housing and food,
- from unstable childhood situations – having experienced disruption in their families, emotional, physical and sexual abuse, divorce and abandonment,
- having histories of violence and sexual exploitation, including violence experienced in the course of the pregnancy,
- exposed to drugs at a young age and continued exposure through partners and environment,
- often affected by cognitive impairments associated with their addiction and affected by their mothers' substance use during pregnancy,
- stressed and exhausted from care of young children, turning to alcohol and illicit drugs to help them cope,
- "embroiled in contradictions about the quality of their mothering practices" (Baker, & Carson, 1999, p.351) – both able to see how their drug use made them unavailable to their children and also how they were able to fulfill their children's practical needs,
- "not passive users," often raising finances for their drug purchases and making the purchases for themselves and for their partners (Taylor, 1998, p.80),
- not "lacking in understanding of their own denial" (Davis, 1999, p.867),

- faced with unplanned pregnancies, “wrestling with the incompatibility of pregnancy and drug use” (Humphries, 1999, p.106),
- experiencing feelings of loss of control over their lives, slowed by depression, anxiety grief and loss, angry and untrusting in the face of the scrutiny of many systems on their lives,
- experiencing shame and guilt, and feeling they have to prove their worth in ways that other parents do not, and
- resourceful, holding "attitudes, hopes and expectations . . . similar to those of many non-drug-using mothers" and in most cases caring for their children "perfectly adequately". (Taylor, 1998, p.83)

In the focus group, the clients described themselves when first arriving at Sheway, as both struggling with many issues and also capable of accessing help:

> *I was having trouble with (Ministry) workers, and trying to get things, like what I was supposed to be getting. The staff here was really helpful and was doing a lot of phoning and being an interpreter in that sense in order for a lot of single women and single parents to get things they deserve. When they were struggling trying to get it for themselves, with their workers, they made you jump through hoops like you wouldn’t believe, but Sheway, they helped interpret, be that medium between the two – and that’s really a good thing to have when you’re just starting off and coming off your drugs and trying to become a parent again. So I think that’s what happened to me. I mean, I was a parent before but I had lost both of my kids through my addiction and stuff. Because of that I was finding it hard, trying to be a mom again and to stay off drugs. The first year, of course, I struggled, I went back out a few times. But eventually I got sick and tired of being sick and tired and they got me in a (alcohol and drug treatment) program.*
>
> *What brought me to Sheway when I was pregnant with my daughter is that three-month thing where you can get on assistance because of the situation, and I came from Kenora. And I’ll never forget the first time I went to Sheway, I thought, “Oh, no, they’re sending me back to Ontario, I have no food.” I was seven months’ pregnant, I was all scared, eh, freaking out. And okay, (Sheway said), “we’ll help you the best we can.” And I ended up staying at the shelter. But I know what really impressed me about them was just, you know, they were willing to help me, they didn’t even know me!*

Table 1: Sheway Client Profile at Intake

	Clients Admitted in 1998 Year n=109*		Clients Admitted 1996 through 1998 n=378	
Average Age (min 15 yr max 42 yr)	26		26	
	# Clients	% Clients	# Clients	% Clients
Income Source at Intake was Social Assistance	80	73.4%	315	83.3%
Had No Income at Intake (needed advocacy)	16	14.7%	51	13.5%
With Health Care Number (PHN)	84	77.1%	251	66.4%
Of Aborginal Descent (as identified by women at intake)	65	59.6%	245	64.8%
Women with Children Living with Them at Intake (Maximum # of children living with was 6)	31	28.4%	105	27.8%
Women with Previous Children in Care at Intake	31	28.4%	169	44.7%
Women with Previously Opened Ministry Files at Intake	42	38.5%	194	51.3%
Community Health Area in which Women Lived at Intake				
(The Downtown Eastside is a neighbourhood of CHA 2 - See Appendices for city map showing CHA's)				
CHA1	1	0.9%	8	2.1%
CHA2	43	39.4%	143	37.8%
CHA3	8	7.3%	21	5.6%
CHA4	2	1.8%	2	0.5%
CHA5	17	15.6%	47	12.4%
CHA6	3	2.8%	8	2.1%
No Postal Code	20	18.3%		
Postal Codes from Other than Vancouver	15	13.8%	149	39.4%
	109	100.0%	378	
Housing Type at Intake				
No Fixed Address	6	5.5%	35	9.3%
Hotel	18	16.5%	74	19.6%
Shelter	5	4.6%	18	4.8%
Apartment or House	74	67.9%	238	63.0%
Unknown	6	5.5%	13	3.4%
	109	100.0%	378	99.0%
Week Gestation at Intake				
Average Week Gestation	17.5		17.4	
In First Trimester	38	40.4%	135	40.1%
In Second Trimester	35	37.2%	125	37.1%
In Third Trimester	21	22.3%	87	25.8%
	94		347	
No Friends or Family Support in Vancouver at Intake	10	8.8%	50	13.2%
No Medical Care at Intake	34	30.1%	107	28.3%
Identified Housing Concerns at Intake	69	64.5%	246	65.1%
Identified Nutritional Concerns at Intake	85	79.4%	319	84.4%
Identified Substance Use at Intake	83	77.6%	178	47.1%
Substance Use Unknown at Intake	11	10.2%		
Identified Violence Concerns at Intake	11	10.2%		
		Max		Max
Average Number of Pregnancies per Client	3.5	10	3.9	15
Average Number of Live Births per Client	2.5	9	2.9	11
Average Number of Abortions per Client	0.2	4	0.6	5
Average Number of Miscarriages per Client	0.8	8	0.4	8
Referred by Self	48	45.3%	170	48.0%
Referred by Family or Friend	13	12.3%	32	9.0%
Referred by Health Professional	31	29.2%	120	33.9%
Referred by Other Professionals and Community Agencies	5	4.7%	20	5.6%
Other	9	8.5%	12	3.4%

* Note: There were an additional 28 women (not included in this 109) who came for service only once. 2 of these women may have found they were not pregnant, 12 were likely connected to other services, 9 may have moved to other cities/provinces or decided Sheway was too far to travel from their homes in Hope, Mission and Surrey.

B. Profile of Women Accessing Sheway's Services in 1998

Table 1 provides a statistical profile of the information provided by women about their lives at the time of coming to Sheway. The women accessing service in 1998 have been highlighted in the statistical profile. Given that women can access Sheway's service over an 18-month period, this group was chosen because at the time of undertaking this evaluation it was possible to see the majority of this group's progress from entry to discharge. The information on the women accessing service in the 1998 year is compared to that of women accessing care between 1996 and 1998.

When reviewing this information, it is important to take into consideration both that Sheway's core service philosophy is to engage women in as welcoming a way as possible, and that the service is an informal drop-in (and outreach) one. As such, women are not asked to fill out formal or informal questionnaires on their lives. Instead they are encouraged to identify what they need and to provide information about themselves in ways that feel comfortable. As a result the data reflects simply what women saw and chose to share about their situation and does not provide a comprehensive view of all the issues that they may have been facing.

Interestingly, given Sheway's mandate to serve women with substance use problems, the issue that women were most reticent to share information on is their use of substances.[*] In the polarized territory of women's substance use and child protection, this reticence to share information on alcohol and drug use is understandable. It underlines how challenging the process of engagement is with women who are pregnant, parenting and using substances. The Sheway staff emphasized how important the building of trust has been in engaging women in accessing care – accordingly at intake they emphasize what the service had to offer women, making the interaction more about women's entitlement to service than about "getting information".

At present, there is no ongoing, dedicated funding for database development and entry of information on clients. With the pressures of provision of care, the planning for the information needed from a database and the regular analysis of information generated, this has not been prioritized. The current database has structural limitations. For example, most fields do not have an "unknown" category, which can result in false positives. (It appeared that 100 per cent of children were immunized at the time of discharge, as there was no indication of those whose immunization status was unknown). It will be important to future evaluative efforts that the needed profile and outcome indicators are refined, the database is strengthened structurally, and that a process for entering and analyzing the information is resourced.

The profile of women accessing care at Sheway in the 1998 year is outlined in Table 1. In summary, the statistical profile for the women who came for service at Sheway in 1998 indicates:

- 15% of women had no source of income at intake and 73% were on social assistance,
- 23% did not have a health care number and 30% had no medical/prenatal care at intake,
- 28% had other children living with them and 28% had previous children who were in care,
- 60% were of Aboriginal descent,
- 39% were living in the core catchment area for the service (CHC2), 28% were living in other parts of Vancouver, 14% were from other communities/provinces, and for 18% no location could be identified due to unknown postal codes,
- 27% had no fixed address or were living in a hotel or shelter at the time of intake. For many of those with housing, there were housing concerns due to the size of the housing, poor location, overcrowding, and/or safety/health/structural problems. In total, 65% of women had identified housing concerns of some type at the time of intake,
- less than half (40%) were in their first trimester at the time of accessing services, 21% were in the third trimester and 35% in the second trimester,

[*] Accordingly, the percentage of women using alcohol and drugs in Table 1 has been adjusted to reflect later identification of use, rather than that identified at intake.

- 9% had no friends or family support in Vancouver,
- 79% had nutritional concerns (less than three meals a day, lack of financial resources to buy adequate food, lack of knowledge of food resources and nutrition, and/or no kitchen facilities),
- 78% were using substances at intake. Of the remaining 22%, many had stopped using very recently or had used in the past and were vulnerable to relapse. There were a few women who did not have substance use issues, yet had significant health, nutritional and social needs which put their health and pregnancies at risk, and
- 45% came to Sheway on their own initiative (as self-referrals) and a further 12% came on the advice of other Sheway clients, friends and family.

The stories of the women who have accessed the Sheway service since its inception in 1993 provide a compelling profile of the complex and desperate "worlds" of women who are struggling with substance use at the time of becoming pregnant. They also demonstrate the strength and resilience of the women served, and the empowerment made possible in this context. The following is a composite story developed by the Sheway staff to give a more descriptive sense of the struggles and strengths of women accessing care.

> *Terry grew up in a community in Northern BC and came to Vancouver with her partner four years ago when she was 17 years of age. She was pregnant with her first child and had no supports "back home." She first came to Sheway while living in a hotel in the Downtown Eastside and in need of food and housing support. She was advanced in her pregnancy and was using intravenous drugs with her partner. While at Sheway for food, she also received prenatal care from the doctors and learned she was HIV positive. The doctors and nurses worked hard with Terry and other related professionals to stabilize her drug use and to begin to manage her HIV. The Sheway team of doctors, nurses and an alcohol and drug counsellor helped her reduce her heroin use through counselling, support and education. They also helped her to get connected to Oak Tree Clinic for support on managing her HIV. As Terry coped with her recent diagnosis of HIV, she returned back to her community to get support from her family. What she found was that she was quickly stigmatized in her small rural community for having HIV and that her family and friends were not supportive. Feeling ostracized, she left. On her return to Vancouver, Terry increased her use of drugs and her relationship fell apart. She got connected back into the sex trade and was arrested. She spent the last part of her pregnancy in jail. Sheway did outreach to her in the jail. She had the baby, was released from jail and looked for drug detoxification and treatment services where she could bring her baby with her. She couldn't find this as there is only one treatment facility for mothers and children in the province and it was full with a long waiting list. At the same time the baby was found to be HIV positive and was apprehended. Several days later Terry learned that her partner had died of AIDS.*
>
> *Terry continued to use heroin and spent most of her time in hangouts in the Downtown Eastside. Despite this she always stayed in contact with Sheway and would drop by on occasion for a talk, or referral to service, or some medical attention when warranted. She began a new relationship and became pregnant again. She connected with the doctors, nurses and social workers at Sheway early in her pregnancy this time and began to get medical services and other supports immediately. When taking the bus was too much for her, the outreach worker drove her to the various appointments she needed to attend. The dietician worked with her on her diet and nutritional needs because of her pregnancy, HIV status and methadone use.*
>
> *Terry started to take her AZT and vitamins regularly, and her HIV is now stable. In addition she is well connected with Oak Tree Clinic, Positive Women's Network and Positive Outlook where she is able to access more support and care. She has come in regularly to Sheway for daily hot lunches and groceries and has gained weight. She has stopped using heroin and the Sheway physicians have helped her stabilize on methadone, and manage her pregnancy and other health-related concerns. She has attended substance use treatment and continues counselling with the A&D counsellor at Sheway. Sheway continues to provide bus tickets for her to get to other services and acts as a co-ordinator of care. She has enjoyed participating in the aboriginal crafts program offered by Sheway. She has started to envision herself as a mother and has begun to discuss with the Ministry the conditions for keeping this child. Terry has built up a relationship of trust with a Sheway physician who will be able to deliver the baby at BC*

Women's Hospital. The doctor and other Sheway staff have helped her devise a supportive birth and after-birth plan. Discussions on birth control have been initiated. Terry has voiced that she is glad to know Sheway staff will visit her at the hospital and she won't be alone for the birth, and that she now has a plan for the birth and after.

C. Reaching Women "at Risk"

The data on women's place of residence at intake by Community Health Area, from Table 1, gives a sense of Sheway's reach. In the 1998 year, Sheway worked with an estimated 75 women with high- risk pregnancies from CHA2 (the Community Health Area where they are located).[*] This count of 75 includes: the 43 women with postal codes from CHA2, the 20 with no postal codes, and an estimated half of the 28 who came for service only once. There were 469 births to women from CHA2 in 1998. Thus Sheway is reaching approximately 15 per cent of women giving birth in this Health Area in a year.

A 1999 study undertaken in Vancouver was designed to estimate the number of pregnant, substance-using women in the Lower Mainland who require medical stabilization in pregnancy (Legare, & Bodnar, 1999). The authors explained the challenges of making such an estimate due to women's frequent reluctance to seek care, physician's failure to identify substance misuse in women, and a general lack of awareness of the effects of alcohol and illicit drugs on the fetus. The authors employed the overall prevalence rate of 5.5 to 6 per cent of pregnancies where significant substance use is a factor, while recognizing that the rate in the Downtown Eastside may be significantly higher. The *Targeting High Risk Families* study (Loock, et al., 1993) found that an average of 16 per cent of infants born to women living in the downtown area of Vancouver as a whole had been exposed to alcohol and drugs in utero (exposure was defined as maternal use of greater than two drinks per day, any illicit drug exposure, or having a diagnosis of FAS or NAS).

Using these indications of the size of the target group, it can be said that Sheway is reaching the majority of women in the target group in the downtown area. This is a very significant accomplishment, given the level of hardship and alienation experienced by the women they seek to serve. It is also significant given that they are also serving many women from other areas of the city, the Lower Mainland, BC communities beyond the Lower Mainland and other provinces, all of whom come to the Downtown Eastside for "community" and supportive services.

There was scant consideration in the literature of the extent to which other programs were able to reach their target population. In the *Evaluation of the Demonstration Projects to Improve Access to Care for Pregnant Substance Abusers* (Howell, et al., 1997), it was estimated that some programs reviewed in that study were identifying only 10 to 50 per cent of pregnant substance users . In the evaluation of the Breaking the Cycle Program in Toronto (Leslie, 1999) it was noted that this program was not reaching many pregnant substance-abusing women, and that further outreach attempts were needed "to engage women who were ready for change, but were not aware of the BTC program"(Leslie, 1999, p.4). Probably related to Sheway's success in reaching women at risk is their policy of not requiring women to be ready for change before accessing service.

Half of those interviewed from services connected to Sheway assumed that there may be women at risk who were being missed, possibly due to: "being too 'whacked out' on drugs, being transient, living in other parts of the Lower Mainland, being immigrant/refugees, being isolated (including being 'holed up' on surrounding reserves), struggling with mental illness, not wanting to travel to the dangerous DTES neighbourhood, the failure of physicians and other workers to refer, the lack of women's detoxification services which could play a role in linking them up, and/or being fearful of Ministry involvement." The barrier identified most often by Sheway staff and allied professionals was the location of Sheway in the dangerous Downtown Eastside area – which may be a deterrent for pregnant and parenting women living in other areas of the city, who are trying to avoid exposure to drug use.

At the same time, **all** key informants saw the Sheway service to be actively and effectively addressing all surmountable barriers through their respectful, empowering approach to service provision and through their outreach efforts. Sheway clients reported to these allied service providers that they saw Sheway as "a very safe

[*] CHAs are the smallest area for which birth data can be aggregated, but the DTES makes up approximately one-third of the total population and 20 per cent of the female population of CHA 2.

place to go where no one was going to dictate the care that they receive," that "they have found Sheway to be tremendously accepting of them – it's where they turn to if they are really bottoming out – if they are back on the street or bingeing they'll end up at Sheway and they will be accepted." Several key informants mentioned the high rate of self-referrals to Sheway (45 per cent self-referred and another 12 per cent referred by family or friends) as a very strong indicator of their ability to address barriers to accessing care. Allied providers emphasized the critical role of outreach activities in supporting access, and of their own role in supporting women's connection to the service.

One key informant summarized the Sheway Project's capacity to reach those in need as follows:

"The whole mandate of the program is to reach out to women who are using, and the reason that it is in difficulty now with respect to its volume is that it has done what the original plan was, which was to penetrate the community and it make itself acceptable to those who need it."

Services comparable to those of Sheway, for pregnant women who use substances are being planned/needed in other areas of the Lower Mainland. The establishment of such services will reduce the pressure on the Sheway Project and address the concern that women living outside the Downtown Eastside have to travel to this dangerous part of the city for service.

VI. Making a Difference in the Lives of Women and Their Families

> Recovery needs to be viewed not only as recovery from drug use itself, but from poverty and homelessness, from abusive relationships and mental disturbance, from criminal behavior, from destructive and negative behaviors that have been reinforced over generations and from resultant or concomitant low self-esteem. The progress of recovery needs to be understood as a lengthy, slow, complex and often unpredictable process of small steps frequently requiring repetition over time. (Brindis, Clayson and Berkowitz, evaluators of the Options for Recovery Perinatal Projects in California, 1997)

A. Defining Success

In the literature and in discussions with Sheway staff, the challenge of "defining success" was repeatedly raised. Indicators utilized in evaluations of programs in the literature varied widely (see Appendix 4).

For indication of improvement in the alcohol and drug use domain, the success indicators ranged from:

- abstinence from all drugs or "clean" urine screens to any period of abstinence
- completion of alcohol and drug treatment programs, to simple attendance at an alcohol and drug treatment program
- a return to treatment after relapse
- keeping alcohol and drug counselling appointments
- stabilizing on methadone, switching to less harmful types of use, and many other indications of reducing harm (even in programming without an ostensible harm-reduction approach)

Other indicators of success which have been utilized in women-centred programming include:

- self-reported increase in self-esteem,
- use of family planning methods,
- any use of condoms in past 30 days,
- decreased involvement with people who use,
- being "substance free" at time of birth,
- having supportive relationships with partners, mothers and siblings, and
- having appropriate connections to community resources.

Indicators of child custody status, which have been identified as indicators of success include:

- low apprehension rates,
- children returned to parent's care after apprehension,
- decreased involvement with child protection agents, and
- positive involvement with child welfare.

Indicators of the health and well-being of the children have been measured by:

- Apgar scores at birth,
- the child having a regular doctor, and
- up-to-date immunizations and well-child healthcare visits.

As this evaluation looked retrospectively at clients who had accessed service in the 1998 year, and in comparison with clients who had accessed care in the previous two years, outcome indicators that had been previously identified and captured on files were used.

However in discussions of the outcomes arising from this evaluation, the current outcome indicators employed were questioned, and suggestions for other outcome indicators which might be used in future evaluation efforts were made. In several cases it was difficult to come to a consensus about indicators of success. For example, when looking for an indicator of possible later disability in children, low need for specialized care nursery at birth and use of Sunny Hill Hospital services was put forth as an indicator. Later concern surfaced about this indicator as most use of specialized nursery care is planned in advance, for children of women who were stabilized on methadone. It was felt that even these uses of specialized nursery care could be avoided if care for these children was provided in the mother's room. No indicator could be identified for determining the number of children who may have been affected by maternal use of alcohol, which has a stronger link to later disability, as Fetal Alcohol Syndrome and related disabilities usually cannot be diagnosed in infants. Clearly the defining of indicators of success is an important area for further investigation to support the work of Sheway, and allow for comparisons of outcomes with comparable programs in other jurisdictions.

Table 2: Sheway Client Birth Outcome

	Clients Admitted in 1998 Year			All Clients Admitted 1996 through 1998		
	n=108			n=378		
	# Clients	% Clients		# Clients	% Clients	
Number of Clients gave Birth While in Program	68			254		
Babies Delivered by Midwife or Physician	62	91%		228	90%	
Number of Women Who Had Miscarriages or Therapeutic Abortions	10	9%				
Number of Babies	69			243		
		Min	Max		Min	Max
Average Birth Weight of Babies Born in the Program (grams)	3236	1280	4660	3150	1100	5280
Average Gestational Age at Birth (weeks)	35.7	28	41	38	20	42
Babies with Low Birth Weight (under 2700 gm)	10 (14%)					
Babies Transferred to Specialized Nursery Care	21	30.4%		97	39.9%	
Babies Placed in Care Voluntarily at Birth	0	0.0%		10	4.1%	
New MCF File Opened at Birth to One Month Postnatal	34	47.2%		164	67.5%	
Babies Supported by Sheway's Infant Development Worker	55	79.7%				
Babies Followed By IDP at 6 mo Postnatal	4	5.7%				
No Ministry Involvement re: Support/Apprehension*	17	22.1%				
Ministry File Opened for Support Only*	29	37.7%				
Babies Apprehended – At Birth (In First 2 Weeks)*	20	26.0%		72	29.6%	
Babies Apprehended – After First 2 Weeks*	12	15.6%				

* Note: Included in data on support and apprehension are 10 additional children whose mothers accessed care at Sheway during the 1998 year, but whose status was not captured on the Sheway database

Babies Returned to Mother or Placed With Family Members	12	37.5%
Children Not Returned Following Apprehension	20	62.5%

Table 3: Outcomes for Women Accessing Sheway Services

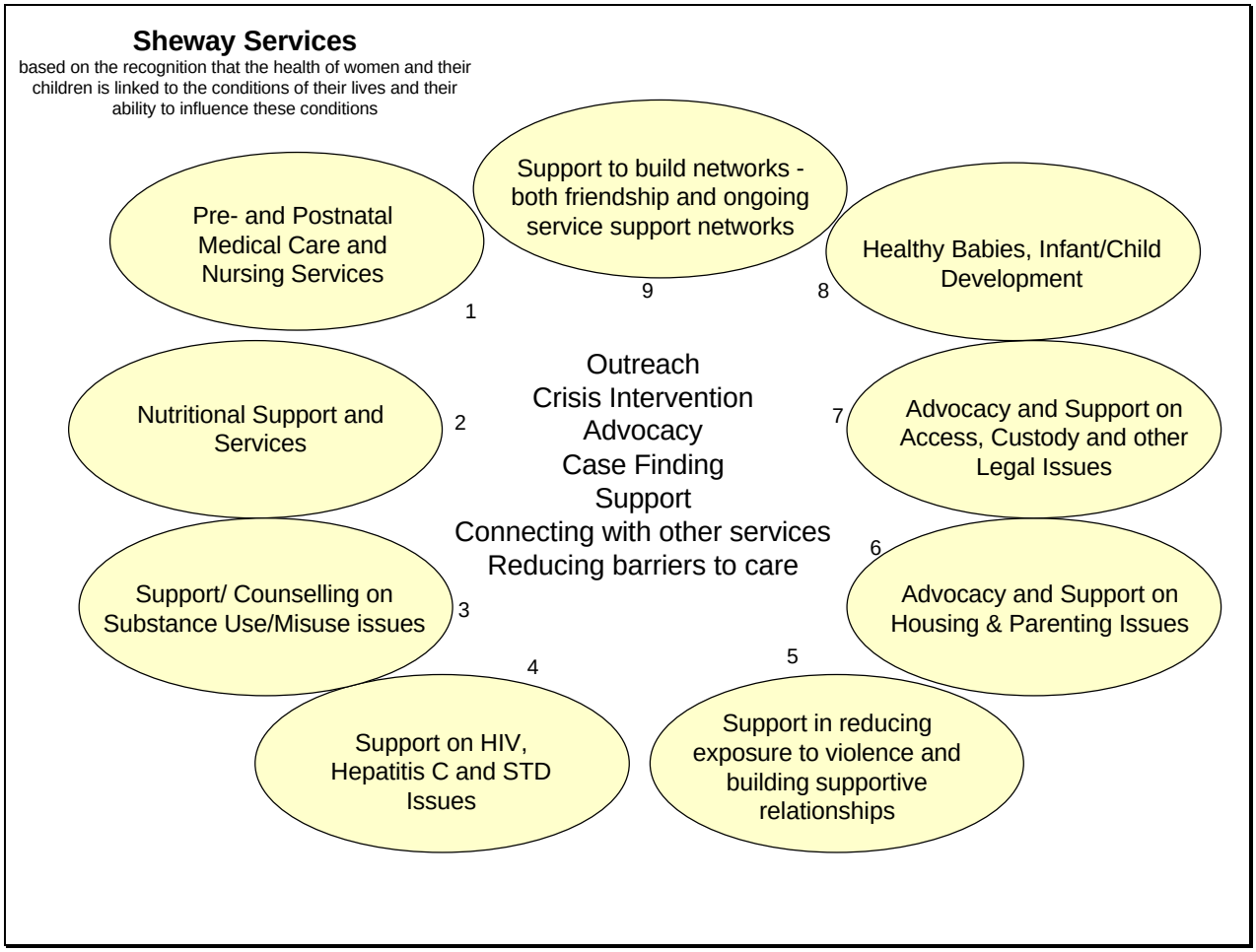
	Clients Admitted in 1998 Year n=108*		All Clients Admitted 1996 through 1998 n=375	
HIV Status	# Clients	% Clients	# Clients	% Clients
Clients Tested for HIV	43	39.8%	152	40.5%
Those identified as HIV+ Amongst Total Clients Tested	6	14.0%	32	20.5%
% Clients HIV+ Amongst Total Clients in Program		5.6%		8.5%
Hepatitis C Status				
Clients Tested for HEP C	47	43.5%	160	42.7%
HEPC+ Amongst Total Clients Tested	29	61.7%	104	63.4%
Clients HEPC+ Amongst Total Clients In Program		26.9%		27.7%
Birth Status				
# of Clients Who Gave Birth While in Program	68	63.0%	254	67.7%
Babies Delivered by Physician or Midwife	62	91.2%	228	89.8%
Women using Sheway Maternity Services	38	55.9%		
New Ministry Files Birth to Discharge	44	40.7%	262	68.6%
Ministry involved at Discharge	36	33.3%	104	27.7%
Child in Ministry Care at Discharge	20	18.5%	53	14.1%
Housing Concerns				
At intake	69	63.9%	246	65.6%
At 1 mo post intake	50	46.3%	194	51.7%
At birth	26	24.1%	106	28.3%
At 6 mo Postnatal	6	5.6%	32	8.5%
Known Suitable Housing at Discharge	29	26.9%	143	38.1%
Nutrition Concerns				
At Intake	85	78.7%	319	85.1%
At 1 mo Post Intake	66	61.1%	260	69.3%
At Birth	20	18.5%	130	34.7%
At 6 mo Postnatal	4	3.7%	37	9.9%
Known Adequate Nutrition at Discharge	14	13.0%	122	32.5%
Substance Use				
Substance Use at Intake	83	76.9%		
Client accessed treatment while at Sheway, identified as not using at discharge and/or stabilized on methadone at discharge	22	24.1%		

Servies Accessed at Discharge		
Still Accessing Service at Time of Report	19	18%
Accessed Services for Less Than 1 mo	22	20%
Of those staying longer than 1 mo # positively connected to services at discharge	28	42%

B. Statistics on Outcome in Key Health Areas for Women and Children

Tables 2 and 3 provide information on the outcomes for women and children in key life areas, gathered from summary information noted by hospital personnel at the time of the birth of the child, and by Sheway staff members at the time the family discontinued accessing the program. In most cases the discharge information is based on direct knowledge of the woman's situation through discussion/planning with her at the time of "discharge", and in some cases the information is based on a "best guess" of the woman's situation at the point she last came for services.

The outcomes for women accessing services in the 1998 year are listed below, organized in nine key life areas related to key areas of service/support provided at Sheway:



1. **Accessing prenatal/delivery care** – 30% of women had no medical/prenatal care at intake and at the time of the birth of their children 91% of women were connected to a physician or midwife to support their deliveries (for the other 9% it was not known). As a comparison, in an evaluation of 26 demonstration programs funded by the US Centre for Substance Abuse Prevention undertaken in 1993, approximately 80% of women received intermediate (43.5%) or adequate (35.8%) levels of prenatal care.

2. **Improvement in nutritional status** – Women's food security improved significantly over the time of accessing services at Sheway. 79% had nutritional concerns at intake and this was reduced to 4% at six months postnatal. (Nutritional concerns were defined as less than three meals a day, lack of financial resources to buy adequate food, lack of knowledge of food resources and nutrition, and/or no kitchen facilities.)

3. **Decrease in substance misuse** – It was not possible to identify with accuracy, how many women reduced or stopped their use of alcohol and other drugs over the period of time they accessed Sheway services. From an in-depth file review, it appeared that 24% of women accessing services in the 1998 year met one of the three indicators of a positive outcome in relation to their substance use: had accessed alcohol and drug treatment services while also accessing services at Sheway; were not using substances at discharge; and/or were stabilized on methadone at discharge.

   As is unfortunately all too common in alcohol- and drug-related services, levels and changes in tobacco smoking were not documented.

   All Sheway discharge assessments now include documentation of women's use of eight levels of alcohol and drug treatment/support/harm-reduction services over the time they were at Sheway, as well as any current use of these levels of care at the time of discharge. Women's use of alcohol and drugs at discharge, if known, is also now clearly noted.

4. **Action on STD and other health concerns** – Approximately 40% of women were tested for HIV and Hepatitis C. The medical/nursing staff at Sheway predict that this number will increase for future years, as the medical and nursing services have expanded since the 1998 year.

5. **Experience of violence** – The extent of women's experience of violence, and how this may have changed over the course of their involvement at Sheway was not consistently recorded for the women accessing care in the 1996-1998 years. Nor was the extent that women were able to build supportive relationships captured as an indicator of success. While Sheway staff provide significant support in this important life area for women, the changes in women's exposure to violence and in development of healthy partnerships have not commonly been considered as indicators of success in perinatal programs. This remains as a challenge for Sheway and most other health related services in further evaluative efforts.

6. **Improvement in housing** – Women made significant gains in accessing housing while at Sheway. 27% had no fixed address and 65% had housing concerns at intake, and by six months after the birth of their child, this was reduced to 6%. Housing concerns were defined as having no housing, or inadequate housing due to the size of the housing, poor location, overcrowding, and/or safety/health/structural problems.

7. **Parenting and custody** – For 22% of mothers, the Ministry did not become involved at all, and for an additional 36% the Ministry was involved for the provision of support only. Thus for over half the mothers (58%) child custody did not become an issue.

   26% of infants born to Sheway mothers in the 1998 year were apprehended at birth and another 16% at later points in time. 37% of these babies were later returned to the birth mother or to immediate family members These parenting outcomes are an indication of significant success for the Sheway Project from the time of its inception in 1993, when virtually all children of mothers identified as high-risk were being apprehended.

   An important area for further study is the closer examination of the appropriateness of the parenting/custody decisions made. Refinement of the simplistic apprehension/lack of apprehension as an indicator of positive parenting outcomes is needed. In the evaluation of the Birth to Three Program in Seattle, "custody of target child in relation to mother's alcohol/drug use" was used as an endpoint assessment variable (Ernst, et al., 1998, p.10). A wider range of indicators of parenting capability, using a harm-reduction framework has been developed and are in use in the United Kingdom (Local Government Association, 1997). A study involving Sheway clients in reviewing and defining criteria for "appropriate" placement of children would be helpful in setting indictors of success for future evaluations and in supporting the work of Sheway social workers as they help mothers define and meet Ministry conditions.

8. **Outcomes for infants of mothers accessing Sheway Services in 1998**:

   Healthy birth weight – 86% of women who had babies while accessing services at Sheway had babies with a birth weight over 2500 grams. This is consistent with the significant nutritional gains made by the Sheway

mothers, and compares very favourably with levels of low birth weights in other areas of the city with lesser levels of poverty (V/RHB data).

Babies needing specialized care – 33% of the babies delivered by women in the 1998 year needed specialized nursery care at birth. Twelve of these 23 babies were transferred to Sunny Hill for longer term care. For eight of the 12 babies transferred to Sunny Hill, their stay was related to opiate withdrawal connected to their mothers' efforts to stabilize on methadone over the course of their pregnancy. The percentage of babies needing specialized nursery care at birth is less than in previous years.

In evaluations of comparable programs, "nursery-care-needed" has not been employed as an outcome measure. Instead the results of drug screening of mother or child has been reported. In an evaluation of 26 perinatal demonstration programs funded by the US Centre for Substance Abuse Prevention undertaken in 1993, 60% of the women had positive drug tests at delivery. In the 1995 evaluation of the California Perinatal Services Network, 29% of infants were not "substance free" at birth. It is of note that the American programs with a stronger abstinence approach have similar or less positive results than the Sheway program, which takes a harm-reduction approach.

An outstanding issue related to the longer term outcomes for children is that the impact of women's alcohol use during pregnancy, while potentially more devastating than that of other drug use, is usually not detectable at the time of delivery. Neither drug screening at the time of birth, nor use of specialized nursery care can serve as indicators of fetal alcohol syndrome (FAS). For FAS and other alcohol-related developmental disabilities to be identified, tracking and assessment of children of women who drink heavily during pregnancy would need to done at a much later point(s) in time (three to six years), rather than through evaluation efforts such as this one. The identification and provision of care for children affected by their mothers' use of alcohol during pregnancy remains a significant challenge.

Babies with up-to-date immunizations – Almost all babies/children had up-to-date immunizations at discharge, but due to structural problems with the database, the exact percentage is unknown.

9. **Connection to social supports** – From the in-depth file review, it appears that close to half of the women who accessed services at Sheway longer than one month were positively connected to services such as parenting programs, health care providers and social workers at discharge.

In summary, the Sheway service has been very successful in their work:

- to engage women in accessing prenatal care and a wide range of other supports during pregnancy,
- to assist women and their families in improving their nutrition and finding adequate, stable housing during pregnancy, and
- to support mothers in their capacity as parents and caregivers.

Assisting women to reduce risk behaviours, in particular to reduce or stop use of alcohol and other drugs during pregnancy, has proven more challenging. It will be important for the program to review the work it does to address its mandate to provide education, referral and support to help women reduce or stop use of alcohol and other drugs during pregnancy. While recovery from substance misuse/addiction often requires years, not months to achieve, and while other more tangible changes such as finding better housing, income and nutrition may be necessary conditions for change in substance use, given the potential negative impact of exposure to substances in utero on the long term health of children, substance use counselling remains a priority in work with women during pregnancy.

The second core area of the Sheway mandate where more moderate success has been achieved is in the promotion of the health, nutrition and development of the children born to women accessing care. While very positive results have been achieved in areas such as birth weight and taking babies to term, Sheway staff have concerns about meeting objectives for early assessment of child development, and for ensuring that successful connections to professional intervention and other supports are made for children in the first two years of life and beyond.

C. Consumer View of Growth and Change Made

In the focus group, clients described the significant positive impact of Sheway on their lives. When asked to talk about the most important change they made while getting help from Sheway, the clients responded:

*The **self-esteem** I guess, like, you know, when you're first coming off the street for the first year, it's kind of rough and Sheway's there to support you and you start getting some of your self-esteem back.*

*Because I know when we were using, did we have **patience**? No. "I want it now and I want it right now and if I can't have it right now, I'm going somewhere else to get it right now." You know, like we didn't have the patience, we didn't have the understanding of calming the baby, you know, instead of getting angry, or just trying to work through, you know, them teething and things like you just needed to learn patience for them, you know, like you just – you needed some patience and if you didn't get them, then it was like, forget it. So for me the most important thing that I've learned around here is patience.*

*And them **talking through things** with you instead of going, "Oh, well, just, don't worry about it and blah blah blah" or something – like they asked me how to work through the situation and they got you to do most of the work on it, you know, like the talking of whatever was going on and how to work through it, rather than just giving you answers. And that helped, right? Because of course by doing that, you keep it inside, right?*

*For me it was listening and **connecting with other parents**, because they put me into ACCESS, they helped me so I would not be alone because I'm younger, so I guess basically they just helped me to realize that I'm not the only young parent there, kind of thing, and I could actually do it, and that basically as long as you show love to yourself and to the baby that it'll come out okay.*

***Being able to talk and be open** with no support, you know, like you're sitting there by yourself and then going to Sheway and then with the other women there and just talking with everyone, you know, you got something in common somewhere.*

***To stop using drugs** was the most important change.*

***To respect yourself**.*

*Remember your spiritual values. **Finding your real beliefs**.*

*And **don't listen to anyone who says that you can't do it** – that's one big thing.*

***I learned to value myself as a person** other than just as an object, an object to go out and use men to get whatever I needed – so that's why being around all these women you know, I realized that's not all there is to life.*

VII. Looking Forward – To Continue to Address Barriers and Improve Service Delivery

A. Consumer Views

All those involved in the evaluation were brimming with ideas for enhancing Sheway's current work. Virtually all of the ideas were dependent on the service securing expanded space for programming.

The clients suggested: a regular art program, more formal child care while they were meeting with staff on health issues, expanded provision of food, emotional support groups, more outings, information groups for new moms and new fathers on care and development of infants and children, a room to view videos and read books on parenting, help on parenting older children and children with special needs, more time to access alcohol and drug counselling, and longer term support.

In their own words:

> *Making it bigger. Yeah, it's so confined. Need a new building. I think it needs bigger facilities and a bigger play area for the kids.*
>
> *Like a day care or something, you know. When you're in there seeing a counsellor or something, someone else can watch over your kids instead of asking one of the staff, they're usually just busy –*
> *I would like to know that one person is taking care of my baby instead of substituting it all the time.*
>
> *I will say something. Could you have a group where you just learn how to deal with each other and stuff? Right now there's a lot of harshness. You're dealing with the harshness out there, and so we come into the centre (and need help in not continuing it).*
>
> *Okay, I think something for some new moms on how do you care for your baby, when do you give them Tempera, how often do you bath them, how do you bath them? When I went and had (my older child), you were in hospital for a week, and during that week they showed you how to hold the baby to wash,*
> *so you don't slip when holding this squirming baby, how to wash a baby, what is the normal temperature, when to give them Tempera – you know, basic health needs and care. Now you're in one day, you're out 24 hours later – if you're lucky, you get to stay a bit longer.*
>
> *Several: More educational classes on parenting newborns. Parenting, like a parenting class for first-time moms. Like, you know, a book doesn't just cut it, you know, you gotta show them because some of them don't know how to hold a baby. The nurse is supposed to show you how to do all that stuff but they don't always have time.*
>
> *So, I think they should have it for fathers too, they should have, because I think some fathers are intimidated, because basically it's just mothers that teach you how to do this stuff in prenatal classes,*
> *I think they should have fathers so the fathers would know, they would not feel so abandoned. And nowadays, a lot of fathers are coming out, being willing to be a father and – but there's not resources there to help them.*
>
> *In the baby book that I had, they didn't tell you exactly what you were going to need for a baby and I think that Sheway should have had a group where parents who were interested to know exactly what a newborn eats, instead of finding out later. Like I had to find out from different people at Sheway, "What does a newborn eat?"*
>
> *I think what would help me, when you have an older child and you're expecting another one, is to have that support on how can I help my oldest child when I'm having another baby. Like in a positive way because, when I ask people I don't find that very helpful. My daughter's three years old, and there's times when she'll pick on her brother. (I need help on things like that), like what you do in a transition to manage two children, because there's nobody to tell you that. And they could have stuff like, to help you with teenagers?*
>
> *Yeah, like if they could have information for special needs, if they could have all the information here to help us so we don't want to have to ask our workers, because sometimes they don't want to reveal the*

information you know. It's hard to ask for that. The Sheway social worker she's helping me through it right now, but like if I asked my own worker, she wouldn't have a clue where to start to help me. Yeah, if it wasn't for Sheway you wouldn't have any idea of where to start or what to do. Like, okay, she gave me a number for somebody out of college so I called right away and I got help to get my daughter on a waiting list, but I need something for her now, you know, because she's just spending her time at home and I don't want her in this area, hanging out, doing nothing, anything like that at all, or doing this shit her mom did, I don't want her getting caught up in that, I want her in the right direction.

I feel I got really dependent on Sheway. I almost went out and got pregnant again, just so I could keep coming here. (Laughter). It made me think it would be good if they gave us an opportunity to come and share this, like gave us one day a week that we could come in and talk to the other clients.

I think that they should have a few older clients volunteer a couple of hours a day, a different one each day, so that people have different views and ideas, to deal with certain issues and stuff that they're going through. You know, like each one of us is individual and unique, that we can each share a different experience with someone, which may help them deal with something that they're going through.

And if you help one person . . . Helping one is like helping the world. For everything they've done for me, to volunteer once or twice a week for a few hours, heck that's nothing. And I've done that, like with the art program, I've come every Thursday and I've helped the ladies with teaching the dream catching. And I also helped start that support group on the Mondays with the D&A counsellor and stuff. So yeah, I've given back for what they've given to me, I mean, that's an awesome feeling inside for most of us, right? Is being able to give back a little bit to what's given us so freely.

B. Combined Perspectives on Program Delivery and Ideas for Moving Forth

1. Continuing to Reach Women at Risk

Sheway has been successful in reaching pregnant women with substance use problems, and inviting them to act on the range of health and social issues they face. Foundational to Sheway's success is the respectful, non-judgmental approach taken that honours women's self-determination and capacity for change, no matter how desperate their current situation.

Program components that were identified as particularly valuable in contributing to Sheway's success reaching and supporting women were:

- **Assistance on practical, basic needs** such as transportation to appointments, nutritional support, and advocacy on housing and medical needs.

- The stance taken by the Sheway social workers **towards helping women face and meet child protection standards of care.** That the social workers and the rest of staff team have been able to find supportive ground for women on child welfare issues, in a way that does not prevent women from accessing care, is impressive. The clients, key informants and the literature all emphasized the complexity, subtlety and challenge of this work.

- **The multidisciplinary, comprehensive services.** The Sheway team has been particularly effective in creating a context where women can choose the assistance they are willing to act on, and where action in any life area can be honoured.

2. Enhancing Sheway's Current Programming

a) Securing more space!
For everyone involved, improved and expanded space for programming was identified as critical to the capacity to achieve the organization's mission. Nowhere were space issues stressed more than in the consideration of improving the intake process. Staff, referral agents and clients all noted how the lack of

space can compromise the ability to create a calm and confidential context for welcoming women to the service. The other services and functions which the lack of space is compromising include: developmental assessments of children, programming such as infant massage and play groups for children, craft program-ming, safe storage of client files, space for women to socialize without children, adequate seating for meals, as well as drop-in space for women who may need a quieter space.

b) Expansion of current work in core service areas

Building on current work is seen as important to help meet the needs of the increasing numbers of women coming for service, to increase options that encourage women to come for care, and to support change by women in key life areas. Many areas for expanded work were identified, including:

- **More alcohol and drug counselling**, including information sessions on alcohol and drug issues, ongoing/regular pretreatment groups, as well as expanded capacity to provide individual and group counselling.

- **More children's and parenting services,** such as

    - on-site parenting groups/circles,
    - group programming for women facing apprehensions,
    - aboriginal programming such as talking circles,
    - infant massage programming,
    - safe space for babies to play, nap and be assessed, and for toddlers' programming,
    - a place for women to breastfeed in private, and
    - improved ability to identify children affected by FAS/NAS and to coordinate their care.

- **Expansion of outreach efforts** was strongly advocated, including having more time to introduce women to other services, more linkages to programs on employment, violence and other issues.

- **Sponsoring of creative programming** such as art therapy, Mother Goose groups, picnics and outings, graduation process and celebrations of "graduating" were all mentioned.

c) Peer support

Within the current Sheway context, client-facilitated drop-in groups, peer counselling programming and mentoring programming were recommended, especially by former clients. The SISTERS program in New York City has successfully developed and evaluated a model for peer support (Sherman, et al., 1998; Sanders, Sherman, & Banks, 1998). There is also experience arising from services other than those for women in the perinatal period, which could support Sheway in implementing programs which involve healthy graduates a range of ways – in "aftercare" support groups, in assisting with outreach and advocacy, and with mentoring of women who are newly accessing services.

d) Expanding Aboriginal programming

While the nurturing, respectful approach taken towards all women who access care serves well as a bridge across cultural differences, many suggestions were provided towards improving program relevance for Aboriginal women. In addition to increasing the number of staff of First Nations descent, ideas were provided regarding co-sponsoring educational and creative programming with First Nations services, and working closely with representatives of local reserves, Aboriginal organizations and Aboriginal women's health advocates. See Appendix 3 for more detail on the suggestions for providing culturally competent care.

e) Planning and evaluation

A recommendation was made by both staff and clients to continue to gather perspectives from clients on their growth and what supports it, through focus groups. A process for capturing statistical information (data entry and database development) also needs to be solidified and funded. Creating forums for discussing success

and indications of success with others who work with women, children and family members is stressed in the literature, as a solid basis for resolving different missions, professional mistrust and lack of expertise.

Sheway has a non-traditional governance structure. Senior managers from each of the four funding agencies meet with the Program Coordinator and a staff representative every three months. The Council straddles uncertain ground between advisory and governing functions. The Council members from the four funding agencies see their role as monitoring the budget, being involved to some extent in planning with the staff, and providing advice on day-to-day issues as requested by the Program Coordinator. Staff and Council members alike identified that functions such as concerted program planning, fundraising, developing a volunteer component, and supervision and support of the Program Coordinator are not being adequately met through this current governance structure. While it was noted there were many benefits to the current administrative model, most also felt that a move needed to be made away from a "reactive, crisis" mode of operating and towards an informed planning process. A key suggestion for building on the organizational structure was to add a committee comprised of former clients, women's health advocates from the community, and professionals working in allied agencies, research institutes and the university, which would provide advice on program development and delivery.

3. Enhancing the Network of Services Surrounding Sheway

a) Expanding access to a broader range of substance use treatment and support services

Critical to building on the success of Sheway's work is having a supportive, accessible constellation of services on the full range of issues affecting pregnant and parenting women with substance use problems. Services identified as gravely needed to support the work of Sheway were:

- accessible detoxification for women, and expanded pretreatment programming,
- tobacco cessation programming tolerant of women with other substance use problems,
- expanded opportunities for women to socialize with and without their children in the DTES when leaving the drug scene, and
- transitional living for women and their families when they are preparing for and following substance use treatment.

b) Services for women and children aged 18 months to five years

Sheway staff find it difficult to discontinue service to women at the 18-month point, as there are few services for children in the 18-month to five-year period. In the words of one of the clients:

> *A suggestion I could give would be that if they could change their age bracket to, like, five. Once a kid gets into school, you've got the resources through the school to be able to help you, but up until they're five years old, you still need help with a lot of development things that are happening.*

Ideas for support of both parents and children in this critical period for early intervention presented in the evaluation process and the literature include:

- therapeutic child care programs,
- housing programs operating as satellites to outreach, withdrawal management, and treatment programs,
- approaches to foster care that involve "fostering" of both mother and child,
- training and respite care for relatives, and
- a "Sheway 2" drop-in model (identified by the clients) that would serve as a base for parents to access ongoing developmental assessment and programming for their children and would meet the changing needs of parents as they progress to a more stable life and parenting style.

c) Serving women's partners

Both Sheway staff and clients acknowledged the importance of the role Native Health plays in providing support for the male partners of women accessing care at Sheway. Concern was expressed about the lack of services for men as parents and partners of women who are pregnant or parenting young children. Involving men in anti-violence, anger management and parenting programming was advocated for promoting their own growth and supporting women's growth, stability and capacity to parent.

d) Other services identified as needed to support the work of Sheway

- expanded provision of homemaking services,
- "kid-friendly" spaces and events in the Downtown Eastside,
- parenting programs with an option for longer support beyond 10-12 weeks,
- transitional living centres for women and their babies right after birth, and
- a mechanism for involving midwives and doulas.

4. Interagency Coordination and Collaboration

Many of the community and hospital-based services interviewed were intrigued by the written version of the Sheway program model, provided as background to the interviews. All providers see it as important to increase their knowledge of each other's work, as a foundation for taking an active role in helping clients get connected to other services that they need. Allied service providers acknowledged how easy it is to fall into a "territorial" style, such as: trying to provide everything rather than to refer on, failing to encourage clients to investigate all the service options available to them, or just not taking the time to think about what might benefit each individual client.

Sheway staff also identified the difficulty/impossibility of staying abreast of available resources in the many areas where their clients may have need for referrals: violence, parenting, housing, alcohol and drug treatment, First Nations support groups, child and day care, infant care groups, mental health services, food bank and community kitchens, etc.

The literature on programs in the US and Europe also stressed the importance of building comprehensive networks of services as foundational to successful work to facilitate referrals, to identify gaps in care, and to collaborate on how these gaps might be addressed. In California these networks were established and supported on the local, regional and state level. They have served to strengthen the response to women in need in many ways. They have facilitated a melding of disciplinary philosophies amongst the medical, social work and alcohol and drug providers, have built understanding of the need for a broader continuum of treatment and ancillary services, and supported community-wide recognition of the complexity and dimensions of the problem of substance misuse by women in the perinatal period (Brindis, et al., 1994).

The Women's and Children's Health Policy Centre at John Hopkins University advocates the building of collaborative networks of "health care providers, policy makers, families, the general public and others, to identify and solve maternal and child health problems" (Grason & Guyer, 1995, p.7). These networks articulate and build on the holistic, women-centred models of care, like that of Sheway, that have proven their effectiveness in communities. They work to "chart a course for the future of women's and perinatal health" (Grason, et al., 1999, Title page*)* by undertaking prevention, mobilizing community partnerships, providing leadership on policy development, and identifying needed research.

Services such as Sheway have made significant and successful efforts to provide "frontline" services to pregnant and parenting women and their families. They have grown in their ability to understand and address the needs of women with substance problems in the perinatal period. Yet they are continually challenged to meet these needs. A collaborative perinatal network structure for Vancouver was seen by Sheway and other service providers to be a welcome, timely support to their efforts to effectively serve women and their families on the broad range of health, economic and social issues affecting them.

VIII. Conclusion

The evaluation found that the following key components contribute to Sheway's success:

- A service philosophy respectful and supportive of women's self-determination in making needed change
- The provision of practical supports, such as hot meals and vitamins, advocacy on housing and other basic needs, bus tickets, clothing, baby equipment, etc.
- Outreach to engage women in prenatal care and to assist women in exploring and connecting to other needed services in the pre- and postnatal periods
- The full range of assistance found in a multidisciplinary team of professionals in an accessible drop-in setting
- Leisure and creative programming for women and their families
- The active approach in assisting women to face and meet child protection standards of care

To build on Sheway's current work and to address the health needs of women and children that are more resistant to change, the evaluation identified the following key areas:

- Finding a larger site for providing current and expanded services
- Expanding the alcohol and drug information and counselling programming
- Expanding programming on parenting and programming that supports the growth, assessment and health of children (infant massage, programming for toddlers)
- Providing more opportunities for "graduates" of the Sheway program to volunteer as leaders and participants in "aftercare" groups, as assistants with leisure/creative programming and as mentors to women who are newly accessing services
- Continuing to seek out staff of First Nations descent, to expand the culturally-based programming provided at Sheway, and to access assistance on providing culturally competent care from others with expertise in providing care to First Nations people

To support this program development, a stronger organizational planning process – including ongoing evaluation, database development, and planning advice from allied experts beyond the small governing Council – was advocated by both Council and staff members.

Also identified in the evaluation were services that are beyond the scope of Sheway's mandate, yet would support the work of Sheway in helping pregnant and parenting women in making needed changes in the many health, economic and social issues they are facing. Needed services identified were substance use treatment and support services, services for children in the age range of eighteen months to five years, services for partners of women accessing care, as well as housing, home support, recreational and parenting services. Interest in a collaborative perinatal network structure was also identified to promote and support communication across services, prevention initiatives, policy development and research efforts.

Appendix 1 – The Evaluation Plan

The evaluation plan was developed through a collaborative process led by the British Columbia Centre of Excellence for Women's Health. An Advisory Committee was established to guide the evaluation process over a ten-month period. This committee was comprised of:

- a representative of Sheway staff members,
- representatives of Sheway Council members, both current and historical,
- a representative of former clients,
- a representative of allied service providers,
- an Aboriginal health service planner, and
- experts in women's health research and policy development.

The evaluation questions identified included:

1. Who is being reached by the Sheway service?
    - What is the profile of the women and children who access services?
    - What is the demand for service and is the demand being met?
    - Are all the women in the target group being reached?
2. How does Sheway address the needs of socially high-risk pregnant women and their young children living in the Downtown Eastside of Vancouver?
    - What services are being offered to address the client need?
    - Are the services provided consistent with program intent?
    - How might Sheway further demonstrate cultural competence in the provision of service?
3. Did the Sheway service make a difference in the lives of women and in the community?
    - What improvements are the women who access Sheway services achieving in housing, income, social support, legal involvement, nutrition, prenatal healthcare, postnatal healthcare, substance misuse and parenting?
    - Are barriers to care being addressed?
    - What other changes are taking place for clients?
4. How can Sheway most effectively involve its clients in defining and directing program delivery and what role do women and community agencies associated with Sheway want to play in advocating for services and resources for women and children in the community?

The following principles were followed in determining the evaluation methods:

- Perspectives on the evaluation questions would be collected from clients, staff members, funding agents, and service providers in allied services.
- In keeping with the Sheway model as an informal drop-in service for women, intensive methods of gathering information, such as individual interviews and questionnaires would not be used. A less structured approach to gathering information was seen as suitable with women who have had alienating experiences with service providers and who are mistrustful of how written information may be used against them.

- The evaluation was to be forward looking and identify the future directions and development opportunities for Sheway.

The methods for gathering information were:

- A review of files of women coming for service in the 1998 year.
- Analysis of information from a database of information on clients served over the period from 1996-1998.
- A focus group held in September 1999, with 18 women who had accessed service in the 1998 year. Connected to the focus group was an optional art exercise, guided by an art therapist. Through this art exercise, women contributed to a collage on the theme of the "helping hands of Sheway." Each woman traced her own hands and "decorated" them in a way that indicated how they had been helped/what they had learned while accessing services at Sheway.
- A gathering of perspectives on their needs and gains, from current clients, through eight "art expression" sessions held in July and August of 1999.

  These art expression groups did not serve well as a forum for gathering client perspectives. An art group had not been held at Sheway for some time prior to the evaluation, so there was not an established routine for the group nor a pre-existing rapport with the art therapist. The busy, often chaotic and small setting at Sheway, with limited child care for the children of the women participating did not lend itself to expression in the way that a group in a closed room, with established day care might have. The participants expressed interest in doing crafts with an Aboriginal focus over open-ended art expression activities. In keeping with Sheway's approach of supporting and honouring women's choices, the art expression group transformed itself into "dreamcatcher-making" sessions, and the use of the group as a method of gathering women's stories through art was set aside.

- Tracking of 12 clients who accessed services over the 5-month period between July 1999 and December 1999. This "tracking" was an enhancement of the work done weekly by the staff to plan and coordinate their work with women. The tracking involved documenting life events that affected women's use of services, decisions made by women as to the changes they planned/made for themselves, and the support provided by staff to support women's decision making.

  It was hoped that this tracking would provide further insight into the issues facing women accessing care and their process of empowerment. However in the busy staff meeting context, the staff were challenged to reflect on and document women's needs and choices. As an alternative, two composite "stories" of women who come for care at Sheway were prepared to give a more compelling sense of the women's lives than can be portrayed by statistical means.

- Surveys completed by 10 staff and 3 Council members.

- A survey of 21 key informants, comprised of service providers in the Downtown Eastside, allied professionals working with hospitals, and health clinics serving clients in common with Sheway, as well as several women's health planners and leaders with expertise in early intervention with women in the perinatal period. The key informants were identified to the evaluator by the Sheway staff and Evaluation Advisory Committee as having strong knowledge of Sheway's work through collaborative work in nine key areas: provision of medical and nursing services, nutritional services, substance use services, HIV services, violence-related services, housing services, parenting and custody-related services, infant and child development services, and services to Aboriginal peoples. See list of key informants (p. 35).

- A search of the literature on comparable programming, with the goal of identifying elements of successful programming serving women with alcohol and other drug problems and facing other health and social issues in the perinatal period. Articles were identified though a search of Medline, PychINFO and Sociological Abstracts (formerly Sociofile) databases using the key words: women, mothers, mothering, perinatal, parenting AND alcohol, drugs, substance use, addiction. Articles mentioning programming and evaluation of programs were prioritized for review. Publications were also identified through key Canadian and American

addiction-related sites on the internet and through attendance at the Substance Abuse and Mental Health Services (SAMHSA) conference on women and substance use issues, held in Los Angeles in June 1999.

The focus group and key informant interviews were audio-taped and transcribed for analysis. Key themes and issues were highlighted and categorized from the interviews, focus group and surveys. The aggregated responses are integrated throughout the report. The art created through the focus group exercise and other art expression sessions is also included throughout the report as are the composite stories.

KEY INFORMANTS

Medical and Nursing Services

Catherin Astin, RN
AIDS Prevention Street Nurse Program, V/RHB

Terry Garahan, RN
Downtown Community Health Clinic, V/RHB

Lynn Bruce
Social Worker, BC Women's Hospital

Nutritional Services

Jeannie Dickie
Healthiest Babies Possible, V/RHB

Barb Wong
Pregnancy Outreach Program, Surrey

Substance Use Services

Judy Starr
Pacifica Treatment Center

Karen Hallett
Women's Day Treatment, Family Services Greater Vancouver

Candace PlattorWatari
Downtown Eastside/Strathcona Youth and Family Alcohol and Drug Service

HIV Services

Maria Hudspith
Positive Women's Network, and Oak Tree Clinic

Violence-related Services

Hazel Cardinal
Helping Spirit Lodge Society

Housing Services

Sabrina Driuna
Downtown Eastside Residents' Association (DERA)

Tina Nicholas
Vancouver Native Housing Society

Parenting and Custody-related Services

Nancy Ross
Westcoast Family Resource Society, Vancouver Outreach Program

Nancy Cameron
YWCA Crabtree Corner

Infant and Child Development Services

Nadia Marcinowski
Sunny Hill Health Centre for Children

Misty McAlear
Centre for Ability

Aboriginal Services

Deborah Auroux (Senger)
First Nations Patient Advocate, BC Women's Hospital

Policy and Program Development

Alicia Mercurio
Carnagie Community Centre

Elizabeth Whynot
Children's and Women's Health Centre of BC, and Sheway conception

Janet Amos
Provincial FAS/NAS Early Intervention Consultant, Aurora Centre

Appendix 2 – Community Health Areas

Appendix 3 – Providing Culturally Competent Services

A focus for the evaluation was a consideration of how the service might further demonstrate cultural competence in the provision of service.

In *Healing Ways, An Aboriginal Health and Service Review* prepared by Rhea Joseph for the Vancouver/ Richmond Health Board, culturally appropriate health care is described as "tangible, action oriented and founded on respect for diverse cultural practices. It includes the physical structure and environment, how a program or service is delivered and by whom, and it provides choices relative to how each person experiences culture" (Joseph, October 1999, p.13). The Sheway providers are actively involved in addressing all these elements of culturally competent care.

In the focus group, Sheway clients spoke of how having staff from differing visible minorities can serve to make women more trusting when first accessing services. They also emphasized that, regardless of ethnicity, it has been critical to their participation that the receptionist is approachable and that they are always treated with respect.

The staff too identified the usefulness of a nurturing, respectful approach as a bridge across cultural differences. Staff identified their interest in sponsoring more on-site prenatal groups, parenting circles and talking circles for First Nations women. Staff members also identified the need for a mechanism to stay abreast of all the First Nations groups, programs and projects in the community, that could assist women to get linked up with these services. Council members affirmed the commitment to hire First Nations staff and noted how challenging the recent process was to hire an aboriginal nurse – a process which required both union and Human Rights approval.

The key informants also mentioned having culturally diverse staff as important. One key informant also offered the caveat on staffing as a unidimensional approach to providing culturally competent services: "It can be a drawing card in getting reluctant people in the door, but in the end if we relate as human beings that's more important. Having First Nations staff does not necessarily mean it will work."

The key informants provided the following practices as helpful to their agencies in providing culturally competent care, and possibly relevant in the Sheway context:

- Staff training – One agency with primarily First Nations staff said they found that even the First Nations staff found the Aboriginal Support Worker training informative. Others mentioned the benefits of Healing Circle training provided by a local addictions agency, and training provided through community colleges and the Justice Institute.

- Client education and support – One agency co-sponsors information sessions for clients with the Friendship Centre where speakers, such as Aboriginal Child Protection workers come in to answer questions about apprehension issues. Others mentioned bringing in elders to speak on traditional healing, alternative therapies and spiritual practice. Others use a First Nations Advocate to provide support and ceremony for clients who identify their interest in cultural learning and growth.

- Art, music and video – Several agencies mentioned the importance of having a selection of drumming tapes and videos with First Nations content for women to listen to/view and borrow. Having art celebrating cultural difference on the walls and offering art/craft-making sessions have also been found to serve well to help women connect to cultural traditions and find pride in their status.

- Cross agency meetings – As the Sheway staff identified, other agencies support the strategy of holding inter-agency meetings to identify services, service gaps and areas for working together. One key informant mentioned the value of having a representative of her agency sit on the Vancouver Aboriginal Council. Another agency has a designated volunteer to liaise with other Aboriginal agencies and to accompany First Nations clients to meetings and events on issues affecting First Nations women.

- Connecting through services to children – Several key informants mentioned the importance of linking women and their children to culture though helping the children get connected to Aboriginal Head Start programs and family groups at the Friendship Centre

- Mentoring – Several agencies mentioned mentoring as a strategy that promotes involvement and employment of First Nations people. One agency has developed a policy of assisting clients towards becoming employed though a planned support process which involves mentoring, volunteering, and training in peer support, leading to employment as relief workers.

- Seeking expert advice – Others spoke of involving First Nations leaders in an advisory capacity in their organizational structure, liaising with local Bands, and liaising with local First Nations women's organizations.

Appendix 4 – Summary of Literature on Successful Programming Serving Pregnant Substance-Using Women and Their Families

In the past decade a growing body of literature has documented intervention and treatment strategies with women with substance use problems in the perinatal period. Much of this literature documents the impact of demonstration projects funded by the American government under the Pregnant and Postpartum Women and their Infants (PPWI) and related funding programs. Themes that have arisen in evaluations of these programs as contributing to successfully reaching pregnant substance users and retaining them in care are:

- working from a respectful, empowering service philosophy
- providing comprehensive care and addressing practical needs
- undertaking interagency collaboration and coordination
- providing a broad and flexible continuum of alcohol and drug services

Respectful Service Philosophy

In launching programs designed specifically for pregnant women who were using substances, program planners have identified as foundational to engaging women in treatment, the need to address women's shame and guilt experienced about their use, their feelings of loss of control over their lives, and their mistrust of the systems scrutinizing them. In this context, programs "shifted away from stigma, blame, confrontation and shame" (Creamer, and McMurtrie, 1998, p.242) and made a "paradigm shift" towards an empowering and strengths-based approach.

The mission of the Prototypes program in Los Angeles underlines that "women and children require and deserve a warm, nurturing and safe environment" (Mosley, 1996, p.381). The Prototypes philosophy also includes "an emphasis on the empowerment of the woman and a focus on encouraging and promoting her ability to identify and express her needs in order to determine the direction she wants her life to take" (Mosley, 1996, p.381).

The Birth to Three Program based in Seattle has identified the importance of establishing a relationship with program participants whose "lifelong experiences of abuse and abandonment taught them not to trust anyone" (Grant, et al., 1996, p.6). The Breaking the Cycle Program in Toronto identifies that "women may be fearful about reaching out for help as they feel they may be judged or lose their infants at birth. They are easily lost to the health care system at a time when prenatal care is particularly vital to their health and the health of their fetuses" (Paquet, 1998, p.8). The Sheway Project and all the services surrounding it in the Downtown Eastside of Vancouver see their respectful, empowering approach to service provision as foundational to their work (Garm, 1999, p.25).

Marjorie Rosensweig when reflecting on the work of the 147 CSAP Pregnancy and Postpartum women and their Infants Program saw that "program effectiveness is not dependent on adherence to a single program model. Instead a set of core concepts [including a philosophy of mutual trust and respect] and competencies undergirds very different, yet effective, programs" (Rosensweig, 1998, p.206).

Providing Comprehensive and Practical Care

A second theme regarding the provision of treatment to women with alcohol and other drug problems during pregnancy is the success achieved when programs provide a "comprehensive array of resources that go beyond traditional program offerings" (Brindis, et al., 1994, p.15). Instead of focussing narrowly on change in substance use patterns, programs have found it useful to combine alcohol and drug treatment with other services such as prenatal care, other medical care, parenting education, family planning services, nutritional support, advocacy on housing needs and counseling on violence and relationship issues (Lieberman 1998b; Creamer et al., 1998; Garm, 1999; Grella, 1996; Kerson, 1990; Egelko, et al., 1998; Finkelstein, 1994; Grason et al., 1999; Ryland, et al., 1996; Mosley, 1996; Schumacker, et al., 1996; Brindis, et al., 1997; Namyniuk, et al., 1997; Rivadeneira, et al., 1998; Whiteford, &Vitucci, 1997; Young, & Gardner, 1998). The experience has been that the barriers to substance use treatment were the most formidable, and engaging women in care through other avenues that have the impact of reducing harms related to substance use is effective. Several programs have specifically

described the utility of a change-oriented and motivation approach whereby women are actively engaged in choosing the life areas they wish to work on (Grant, 1996, LaFave, & Desportes Echols, 1999).

In some cases this comprehensive programming has been organized into a “one-stop” multidisciplinary clinic setting and in others a network of services have been created and nurtured. The evaluation of the California wide, Options for Recovery programming summarized the challenges when addressing needs of pregnant and parenting women with substance use problems as follows:

1. the difficulty in addressing the special psychological, cultural, medical and social needs of women and their families, and

2. the complex, administrative and organizational barriers which must be overcome in order to develop comprehensive prevention and drug treatment services for women. (Brindis, et al., 1997, p.90).

Related to providing comprehensive care is the provision of practical support such as transportation to appointments and babysitting costs. Numerous studies found the provision of this practical support directly related to success in recruitment and retention of mothers (Ashery, et al., 1997; Robles, Flaherty, & Day, 1994; Rivadeneira, et al., 1998; Ryland et al., 1996; Poland Laken, et al. , 1996; Brindis, et al., 1997; Clayson, et al., 1995; Corse, et. al 1998).

Interagency Collaboration and Coordination of Services

Overwhelmingly, the literature proposes interagency collaboration and coordination as critical both to engage and retain women in treatment, and to assist agencies in providing the needed comprehensive scope of care. (Young & Gardner, 1998; Grason, Hutchins, & Silver, 1999; Poland Laken & Hutchins, 1995; Rivadeneira, et al., 1998). A significant proportion of the literature is dedicated to benefits of working in a collaborative and coordinated fashion to meet the needs of pregnant, substance using women and their families.

The California pilot programs found a “melding of different disciplinary philosophies towards recovery” took place when collaborative efforts were instituted. They found the following:

> A gradual synthesis evolved that drew together the primary social medical and drug treatment models into a hybrid bio-psycho-social model of alcohol and drug abuse treatment. Case management and drug treatment philosophies moved to common ground through cross training and an evolution to a more family-focussed paradigm took place throughout the OFR program as a whole (Clayson, et al., 1995, p.237).

Interagency coordination also serves to alleviate the problems associated with elements of programming being in different locations, programs having separate regulations, long waitlists for services, differing intake procedures and eligibility requirements – all of which serve as significant barriers to treatment (Finkelstein, 1994).

Poland Laken and Hutchins (1995) describe the benefits of building a service-oriented system connected to the 12 PPWI projects in Virginia. Through these coalitions, common understandings of women’s needs were forged, turf issues were easier to address, differences in philosophy and approach were reconciled, and joint training curricula set. These coalitions also had the benefit of promoting the sharing of resources and joint planning, as well as bringing the larger communities into local planning processes.

A key barrier to engaging pregnant women in treatment is the fear of losing custody of their children (Finkelstein, 1994; Poole, 1999). Nancy Young writes compellingly on the importance and benefits to collaboration between the child welfare and alcohol and drug agency fields, particularly in supporting strengths-based assessment and in broadening the lens though which alcohol and other drug problems are viewed (Young, Garner, & Dennis, 1999).

Another useful area of coordination identified in the Options for Recovery evaluation was the foster care component. In these California projects, foster parents were recruited to meet the needs of children who were prenatally exposed to drugs. The programs targeted specific racial populations so that infants could be placed in culturally appropriate homes, provided recruits with respite care for themselves as caregivers and training in caring for substance-exposed infants, and supported involvement of birth mothers in decision making with the foster parents on child care issues (Brindis, Berkowitz, Peterson, Clayson, & Broadnax, 1995).

Providing a Broad and Flexible Continuum of Alcohol and Drug Services

The literature describes the challenges inherent in supporting pregnant women to enter, re-enter and complete alcohol and drug treatment. A broader array of services – including case management, pretreatment programming, harm reduction programming (such as prescribing of methadone), medical detoxification, short term intensive programs (day and residential) as well as sober housing and aftercare – is advocated (Brindis, Berkowitz, Clayson, & Lamb, 1997; Howell, Heiser and Harrington 1999; Poland Laken and Hutchins, 1995). Case management, from a broad, client-centered approach is repeatedly described as a key component of an alcohol and drug system of care responsive to the needs of pregnant women, and is particularly well defined by Marilyn Poland Laken and Ellen Hutchins in Building and Sustaining Systems of Care for Substance-Using Pregnant Women and Their Infants: Lesson Learned (1995).

A significant component of alcohol and drug treatment for this population is outreach. Outreach efforts have served effectively to reduce known barriers such fear, low self-esteem and denial as well as to demystify what is available and what is in involved in the various levels of care (Brindis, Berkowitz, Clayson, & Lamb, 1997; Garm, 1999, Namyniuk, et al., 1997). As well as street outreach targeted directly to women at risk, the Dean Coy program in Alaska has described outreach work as involving collaboration with referral sites, education of community agencies and advertisement of programs (Namyniuk, et al., 1997).

Flexibility in providing access and in accommodating absences while in treatment have been found to be critical to enhancing retention of pregnant and parenting women in care. Egelko et al. (1998, p.257) describes “the daunting array of competing demands on their schedule (e.g. medical appointments, activities related to their older children in protective custody) to be handled while also meeting the official requirement of attendance [in day treatment programming] five days per week”. It is noted that the process through treatment for pregnant and parenting women is not necessarily orderly, but more often takes a complicated cycle of entering treatment, trying different types of treatment, relapse, reunifying with children, completing treatment and maintaining sobriety. Accordingly, programs emphasized the importance of incremental steps rather than completion of treatment or maintenance of sobriety as the indicator of success. Flexibility regarding the response to relapse is another key component of working with women with substance use problems in the perinatal period. The Prototypes program and many others no longer view relapse as automatic grounds for discharge from treatment. The client is assisted to resume her recovery plan and she is invited to measure success by longer periods of abstinence, fewer relapses, and by improvement on other quality of life measures (Mosley, 1996).

Programming that integrates women’s children and partners in their care has often been found to improve treatment outcomes for women in the perinatal period. An almost universal finding was that women were often unwilling or unable to separate themselves from their caregiver role to attend to their treatment needs. In a qualitative study of women’s perceptions of treatment effectiveness, participants indicated that they want and need assistance in obtaining child care, and when child care services were accessible, participants found this to be among the most helpful services in terms of improving attendance in and use of drug treatment (Nelson-Zlupko, et al., 1995).

Many programs have found that even when partner relationships are in turmoil it is critical to support decision making around disconnection or reunification, as a primary task of this period (Egleko, et al., 1998; Rivadeneira 1998). Finkelstein (1994) in her groundbreaking paper on treatment issues for alcohol- and drug-dependent pregnant and parenting women stressed that “to be effective in helping women, treatment programs must help clients develop models for healthy, mutually empowering, non-destructive relationships” (p.11). She goes on to explain how individually oriented treatment approach stemmed from a medical model in which the “illness” was viewed as an individual problem, affecting homeless men or young, unmarried males without family ties.

The result is a treatment system that lacks family-centered comprehensive treatment models in which families in the broad sense of a community or group of persons closely connected to each other are provided services in a coordinated fashion (p.12).

In summary, the needs of women of childbearing age with substance use problems will not be addressed using traditional prevention, intervention and treatment methods. We must provide additional supports for treatment access and success and learn to work in truly collaborative ways.

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