

Consensus on

## 10 Fundamental components of FASD prevention from a women's health determinants perspective

*The following ten fundamental components of FASD prevention emerged from a working session of the Network Action Team on FASD prevention. This session was held in Victoria, B.C., in March 2009, and was funded by the Canadian Institutes for Health Research. This consensus document weaves together a range of sources—women's experiences, peer-reviewed research, published articles, as well as expert evidence—to create a clear message regarding the importance of FASD prevention from a women's health determinants perspective.*

### 1. Respectful

Respect is paramount to successful FASD prevention and treatment. It is a vital tool in the elimination of discrimination and stigma in prevention initiatives, and it is pivotal to creating an environment where women can address their health care needs. In FASD prevention, the implementation of respect as a fundamental principle involves creating conditions for women to discuss their experiences, identifying coping strategies and healing processes to promote women's wellness, and supporting the inclusion and full participation of women in their own health, care, and well-being.

#### References

Canadian Centre on Substance Abuse. 2001. *Respect is Key: A conversation with Pam Woodsworth*. Ottawa, ON CCSA.

Four Worlds Centre for Development Learning. July 2003. *Making the Path by Walking It: A Comprehensive Evaluation of the Women and Children's Healing and Recovery Program Pilot*. Yellowknife, Northwest Territories. Cochrane, AB.

Poole, N. 2000. *Evaluation Report of the Sheway Project for High-risk Pregnant and Parenting Women*. Vancouver, BC: BCCEWH.

### 2. Relational

Throughout life the process of building relationships and connecting with other people can be extremely important. Women who are most at risk for having a child at risk of FASD experience some form of social disconnection, whether that be from their friends or family, the larger community, or other types of relational engagement. It is vital to FASD prevention

to acknowledge that the process of growth, change, healing, and prevention does not happen in isolation. It moves forward through interactions with others in long-term, supportive, trust-based relationships. Therefore, paying attention to the relational dynamics of interpersonal connections in day-to-day life, as well as in comprehensive treatment settings, can enhance the successes of FASD prevention initiatives.

#### References

Hartling, LM, 2003. *Prevention Through Connection: A Collaborative approach to women's substance abuse*. Stone Centre, Wellesley College: Wellesley, MA.

*The Breaking the Cycle Compendium: Volume 1: The Roots of Relationship*. Edited by M. Leslie. 2007 Mothercraft Press.

Marcellus, L. (2004). The ethics of relation: Public health nurses and child protection clients. *Journal of Advanced Nursing*, 51(4), 414-420.

### 3. Self-Determining

Women have the right to both determine and lead their own paths of growth and change. Although it may run contrary to many prevailing beliefs in substance use treatment and prevention approaches, self-determination is fundamental to successful FASD prevention. As such, the role of health care and other support systems in FASD prevention should be to support women's autonomy, decision making, and control of resources, so as to facilitate self-determined care. In order to provide this support most effectively, health systems should involve women in designing models of care, and individually, women should be able to determine their own process of care.

## References

Geller, J., K. E. Brown, and S. Srikameswaran. 2007. Motivational Approaches to Assessing and Treating Women with Disordered Eating and Substance Use Problems. In *Highs & Lows: Canadian Perspectives on Women and Substance Use*, eds. N. Poole and L. Greaves, 349–354. Toronto, ON: CAMH Press.

Rutman, D., M. Callahan, et al. 2000. *Substance Use and Pregnancy: Conceiving Women in the Policy Process*. Ottawa, ON: Status of Women Canada.

Cailleaux, M. & Dechief, L. (2007). "I've Found My Voice": Wraparound as a promising strength-based team process for high-risk pregnant and early parenting women. *UCFV Research Review*, 1(2). <<http://journals.ufv.ca/rr/RR12/article-PDFs/found.voice.pdf>>

## 4. Women-Centered

Women-centred FASD prevention and care recognizes that, in addition to being inextricably linked to fetal and child health, family health, and community health, women's health is important in and of itself. Empowerment, safety, and social-justice, are all key considerations to this perspective. Women-centred prevention and care involves women as informed participants in their own health care, and attends to women's overall health and safety. It also acknowledges women's right to control their own reproductive health, avoids unnecessary medicalization, takes into account women's roles as caregivers, and recognizes women's patterns and preferences in obtaining health care.

### References

Covington, S. S., C. Burke, S. M.A. Keaton, and C. Norcott. 2008. Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*. 40(S5): 387–398.

Greaves, L., Poole, N., & Cormier, R. (2002). *Fetal Alcohol Syndrome and Women's Health: Setting a Women-Centred Research Agenda*. Vancouver, BC: BC Centre of Excellence for Women's Health.

Parkes, T., Poole, N., Salmon, A., Greaves, L., and C. Urquhart. 2008. *Double Exposure: A Better Practices Review on Alcohol Interventions During Pregnancy*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

## 5. Harm Reduction Oriented

Preventing FASD involves understanding substance use and addictions, including the full range of patterns of alcohol and other substance use, influences on use, consequences of use, pathways to and from use, and readiness to change. Harm-reduction strategies help to minimize known harms associated with substance use and enable connections and supports to develop between women who use substances and available healing services. A harm-reduction oriented response is pragmatic, it helps women with immediate

goals; provides a variety of options and supports; and focuses not only on attending to the substance use itself, but on reducing the scope of harms that are more broadly associated with use.

### References

Boyd, S., and L. Marcellus. 2007. *With Child, Substance Use During Pregnancy: A Woman-Centred Approach*. Halifax, NS: Fernwood Publishing.

United Nations Office on Drugs and Crime. August 2004. *Substance abuse treatment and care for women: Case studies and lessons learned*. <[www.unodc.org/pdf/report\\_2004-08-30\\_1.pdf](http://www.unodc.org/pdf/report_2004-08-30_1.pdf)>

Smith, D., Edwards, N., Varcoe, C., Martens, P., & Davies, B. 2006. Bringing safety and responsiveness into the forefront of care for pregnant and parenting Aboriginal People. *Advances in Nursing Science*, 29(2), E27-E44.

## 6. Trauma-Informed

Multiple and complex links exist between experiences of violence, experiences of trauma, substance use, addictions, and mental health. It is important to understand that at times, research initiatives, policy approaches, interventions, and general interactions with service providers can in themselves be re-traumatizing for women. When a woman seeks out treatment or support services, practitioners have no way of knowing whether she has a history of trauma. Trauma-informed systems and services take into account the influence of trauma and violence on women's health, understand trauma-related symptoms as attempts to cope, and integrate this knowledge into all aspects of service delivery, policy, and service organization.

### References

Markoff, L. S., B. G. Reed, R. D. Fallot, D. E. Elliott, and P. Bjelajac. 2005. Implementing Trauma-Informed Alcohol and Other Drug and Mental Health Services for Women: Lessons Learned in a Multisite Demonstration Project. *American Journal of Orthopsychiatry* 75(4): 525-539

Harris, M., and R.D. Fallot. 2001. Envisioning a trauma-informed service system: A vital paradigm shift. In M. Harris & R.D. Fallot, (Eds.), *Using Trauma Theory to Design Service Systems* (pp. 3-22). San Francisco, CA: Jossey Bass.

Cory, J. and Dechief, L. 2007. *SHE Framework: A Safety and Health Enhancement Framework for Women Experiencing Abuse*. Vancouver: Woman Abuse Response Program. BC Women's Hospital and Health Sciences Centre. <[www.bcwomens.ca](http://www.bcwomens.ca)>

## 7. Health Promoting

Promoting women's health involves attending to how the social determinants of health affect overall health. In the context of FASD prevention, health promotion approaches draw the lens back so that FASD can be understood in its broader context. Prevention

and care is not simply about alcohol use. Social determinants of health like poverty, experience of violence, stigma and racial discrimination, nutrition, access to prenatal care, physical environment, experiences of loss or stress, social context and isolation, housing, and so forth all come together to holistically influence FASD risk factors, prevention, and care. Accordingly, holistic, multidisciplinary, cross-sectoral, health promoting responses to these complex and interconnected needs are vital to successful FASD prevention.

### References

Poole, N. 2003. *Mother and Child Reunion: Preventing Fetal Alcohol Spectrum Disorder by Promoting Women's Health*. Vancouver, BC: BCCEWH.

Salmon, A. 2007. *Beyond Shame and Blame: Aboriginal Mothers and Barriers to Care*. In *Highs & Lows: Canadian Perspectives on Women and Substance Use*. Eds. N. Poole and L. Greaves, 227 – 235. Toronto, ON: CAMH Press.

Vandiver, V. 2007. Health promotion as brief treatment: strategies for women with co-morbid health and mental health conditions. *Brief Treatment & Crisis Intervention* 7(3): 161-175.

## 8. Culturally Safe

Women who seek help from service agencies need to feel respected, safe, and accepted for who they are, with regard to both their cultural identity and personal behaviours. Recognition of the influence of colonization and migration on a woman's identity is important, as is recognition of the benefits of building on individual and community resilience. Service providers must be aware of their own cultural identity, socio-historical location in relation to service recipients, and pre-commitments to certain beliefs and ways of conceptualizing notions of health, wellness, and parenting. Respect for cultural location and having one's values and preferences taken into account in any service encounter is extremely important, as is respect for and accommodation of a woman's interest in culturally specific healing.

### References

Ball, J., 2008. *Cultural safety in practice with children, families and communities*. School of Child and Youth Care, University of Victoria. <[www.ecdip.org](http://www.ecdip.org)>

Hanson, G. (2009). *A Relational Approach to Cultural Competence*. In *Restoring the Balance: First Nations Women, Community, and Culture*. Eds. G. Guthrie-Valaskakis, M. Dion Stout, and E. Guimond, 237–264. Winnipeg, MB: University of Manitoba Press.

Dell, C. A., & Clark, S. (2009). *The role of the treatment provider in Aboriginal women's healing from illicit substance abuse*. Saskatoon, SK. <[www.coalescing-vc.org/virtualLearning/community5/documents/Cmty5\\_InfoSheet2.pdf](http://www.coalescing-vc.org/virtualLearning/community5/documents/Cmty5_InfoSheet2.pdf)>

## 9. Supportive of Mothering

FASD prevention must recognize the importance of supporting women's choices and roles as mothers, as well as the possible short- and long-term influences that a loss of custody may have on a woman. Prevention and care approaches need to support the range of models for mothering, including part-time parenting, open adoption, kinship and elder support, shared parenting, inclusive fostering, extended and created family, and so forth. Further, successful FASD prevention must attend to the importance of pacing and support in transitions for women as they move between mothering roles.

### References

Abrahams, R. R., Kelly, S.A., Payne, S., et al. 2007. Rooming-in compared with standard care for newborns of mothers using methadone or heroin. *Canadian Family Physician* 53: 1722–1730.

McGuire, M., Zorzi, R., McGuire, M., & Engman, A. (2006). *Early Childhood Development Addiction Initiative: Final Evaluation Report v.2*. Toronto, ON: Ministry of Health and Long Term Care: Mental Health and Addiction Branch.

Watkins, M. and D. Chovanec. 2006. *Women working toward their goals through AADAC Enhanced Services for Women*. Edmonton, AB: AADAC. <[www.aadac.com/documents/women\\_working\\_towards\\_goals\\_summary.pdf](http://www.aadac.com/documents/women_working_towards_goals_summary.pdf)>

## 10. Uses a Disability Lens

Women with substance use and mental health problems may also have disabilities, including FASD. Women need care and prevention responses that fit with what we know about the spectrum of disabilities related to FASD.

### References

Classen, C., Smylie, D & Hapke, E. (2008) *Screening for FASD in women seeking treatment for substance abuse*. Poster presentation at "Gender Matters" Conference, Toronto, Ontario, May 2008.

Dubovsky, D. (2009). *Adapting motivational interviewing for individuals with FASD*. Workshop presentation made at National Fetal Alcohol Spectrum Disorders conference: Addressing social and behavioural issues across the lifespan. Madison Wisconsin, April 30 - May 2, 2009.

The Network Action Team on **FASD Prevention from a Women's Health Determinants Perspective** links researchers, service providers, and policy advisors in Canada's western provinces and northern territories, in order to build upon the current knowledge base of Fetal Alcohol Spectrum Disorder prevention, and bring it into health promotion, prevention, treatment, harm reduction, and policy development, as well as further research. *For more information please contact coordinator, Shannon Pederson, [spederson@cw.bc.ca](mailto:spederson@cw.bc.ca)*