

The first 10 Years
Integrated Maternal-Child Programs
Practice Based Knowledge Transfer
Partnerships

BTC Compendium

Research Informing Practice

FASD Research

Vol. 1

The Roots of Relationship



Theory Informing Practice

Edited by: Margaret Leslie



Breaking the Cycle

BTCC Compounds

Vol. 1 The Roots of Relationship
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**The Breaking the Cycle
Compendium: Vol. 1**

The Roots of Relationship

Edited by
Margaret Leslie
Director, Early Intervention Programs
Mothercraft



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Margaret Leslie

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INTRODUCTION

Breaking the Cycle is a program of the Canadian Mothercraft Society, a charitable organization which has been a leader in the promotion of healthy child development through support to parents and families since 1931. Breaking the Cycle (BTC) is one of Canada's first prevention and early intervention programs for pregnant women and mothers who are substance-involved, and their young children. Its objective is to reduce risk and enhance the development of substance-exposed children by addressing maternal substance use problems and the mother-child relationship.

Mothercraft delivers BTC through a formal service partnership with the Hospital for Sick Children - Motherisk, Toronto Public Health, St. Joseph's Health Centre, Children's Aid Society of Toronto, Catholic Children's Aid Society, St. Michael's Hospital, the Ministry of Community Safety and Correctional Services, and Toronto Western Hospital - Mental Health and Addictions. With funding support from the Public Health Agency of Canada and Ontario's Ministry of Children and Youth Services, the BTC partners combine to deliver comprehensive, integrated relationship-based services through a single-access model with home visitation and street outreach components.

Since its inception in 1995, BTC has become one of the most extensively documented Canadian programs serving pregnant women and mothers who are substance-involved, and their young children. Careful evaluation of service delivery has yielded rich practice-based lessons that have been shared with others locally, nationally and internationally through:

- **Presentations:** BTC has provided over 250 practice-based workshops and trainings for over 25,000 service providers, policy makers, and researchers across Canada on the issues of substance use, pregnancy, mothering, child development and FASD issues.
- **Publications:** BTC has published three evaluation reports, and over 35 papers, book chapters and articles.
- **Resource Development:** BTC has co-led a number of extensive regional and national projects resulting in the development of resources including videos, training manuals, reports, and web-based tool kits. The aim of these resources has been to transfer practice-based knowledge in the areas of substance use, pregnancy, mothering, child development and FASD issues.

The purpose of the BTC Compendium is to compile an edited collection of publications, papers and resources to describe BTC's experience in developing and evaluating the delivery of an integrated maternal-child response to substance use, pregnancy, mothering, child development and FASD issues. The BTC Compendium is intended to facilitate the dissemination of the program's practice-based knowledge and experience to other communities across Canada. It will also answer frequently-asked questions and provide practice guidance for potential partnerships in other communities wishing to develop a response to pregnancy, mothering and substance use issues.

The papers collected in the BTC Compendium have been written by various authors, and



the voice and style of each author have been retained. There has been an attempt to standardize terminology throughout the BTC Compendium; however, in some cases the terminology that appears in the original papers has been maintained for coherence within the paper. The references cited in the original papers have been listed at the end of the BTC Compendium. In addition, sources which have influenced the development of BTC have been highlighted in the margin of the text. BTC has developed within the context of an environment of active knowledge exchange among practitioners, policy-makers and researchers across Canada, and these influences and sources are cited throughout the BTC Compendium.

The BTC Compendium is directed to service providers and others who have contact with substance-involved pregnant women and mothers, and their young children, including: addictions workers, public health nurses, infant development workers, child welfare workers, psychologists, physicians, trauma counsellors, child development counsellors, early childhood educators, mental health counsellors, justice officials, police, shelter/housing providers, probation and parole officers, and others. This collection of papers will also be relevant to policy-makers, planners and researchers concerned with these issues.

All of the papers in the BTC Compendium explore the theme of relationship as a central construct for understanding and responding to the issues of substance use, pregnancy, mothering, child development, and FASD issues. Relationships are identified as the key concept in understanding the complex issues which bring women to substance use, and which sustain their use of substances. The relationship between mother and child is proposed as the means of intergenerational transmission of patterns of relating and methods of coping. The process of resolution and healing for women and mothers experiencing substance use problems and trauma must necessarily take place within the context of relationships - with service providers, with other mothers, and with their children. The importance of relationships is echoed at the service system level, where an environment of respectful, coordinated, and positive relationships among service providers is described as critical to creating a positive and integrated context for healing, recovery, and new beginnings for substance-involved mothers and their young children.



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Section 1: Developing and Delivering an Integrated Maternal-Child Program

Adapted from the Original Documents:

- Breaking the Cycle: A Project Proposal. Submitted to the Community Action Program for Children, Health and Welfare Canada, February 28, 1994
- Breaking the Cycle: Report of the Development Phase (June 1994 - March 31 1995). Submitted to the Community Action Program for Children, Health And Welfare Canada, 1995
- Moore, TE., Pepler, DJ. & Motz, M. (1998). Breaking the Cycle: The Evaluation Report (1995-1997). Toronto: Breaking the Cycle
- Pepler, DJ., Moore, TE., Motz, M. & Leslie, M. (2002). Breaking the Cycle Evaluation Report: 1995-2000. Toronto: Toronto: Breaking the Cycle
- Motz, M., Leslie, M., Pepler, DJ., Moore, TE., Freeman, PA. (2006). Breaking the Cycle: Measures of Progress 1995-2005. Special Supplement, Journal of FAS International, Toronto: Hospital for Sick Children, 2006;4:e22. www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

Introduction

Reducing the impact on women, mothers and children of prenatal and postnatal exposure to alcohol, tobacco and other substances has prompted the development of specialized programs for pregnant women and mothers with substance use problems, and their children. Participating and engaging with health and social services have been identified as salient protective factors for substance-involved pregnant and parenting women, and their young children (Jeremy et al., 1984; Lief, 1985). Breaking the Cycle (BTC) was launched in 1995 to address barriers to service and enhance outcomes for substance-involved mothers and their young children in Toronto.

This Section will provide an overview of the development of BTC, including the origins of the maternal-child framework for understanding and responding to pregnancy, mothering and substance use issues. This Section will describe the non-traditional partnership between child-serving and adult-serving sectors which resulted in the development of a shared vision and approach, including a definition of both mother and child as clients. Promoting access to services through the development of a comprehensive, integrated program delivered through a “single-access” model with street outreach and home visitation components will be described. Theoretical frameworks and approaches which have influenced program development and delivery - including harm reduction, relational theory, attachment theory -- will be introduced, and the program model and services will be described. Finally, the governance and organizational structure of BTC will be reviewed.

Since the inception of BTC in 1995, the efficacy of comprehensive, integrated models of service delivered through a single-access point for substance-involved pregnant women and mothers, and their young children has been confirmed (McMurtrie et al., 1999; Roberts et al., 2000; Pepler et al., 2002; Health Canada, 2003; United Nations Office on Drugs and Crime, 2004; Brady et al., 2005; Motz et al., 2006). BTC has contributed to the burgeoning practice-based knowledge development in this field, and has developed within the context of an active environment of knowledge exchange among practitioners, researchers and policy-makers since 1995.



1.1 Development of Breaking the Cycle

Founded on cross-sectoral collaboration, including child welfare and addictions treatment

Relationships and common language foundational to the BTC partnership

CADC was launched in 1992 as part of Canada's response to the United Nations Convention of the Rights of the Child.

For more on CADC, visit

www.phac-aspc.gc.ca/hp-ps/dca-dea/program/capc-pace/index-eng.php

The initial impetus for Breaking the Cycle (BTC) grew out of a 1992 conference organized by the Infant Mental Health Promotion Project (IMP) and Metro Toronto Addiction Treatment Services Committee (MTATSC). The conference (*Addressing Addictions Together: Focus on Infants, Parents, Professionals - The Foundation for Collaboration*) represented a unique collaboration between child-serving and adult-serving agencies in Toronto. These sectors had been traditionally isolated in terms of service delivery due to differences in mandate, goals, definition of "client" (adult vs. child), and perceived parameters of responsibility. Recommendations from the conference noted the need to develop an integrated and comprehensive program for pregnant women and substance-involved mothers with young children requiring partnerships among previously fragmented service providers.

A small working group representing health, addictions treatment, withdrawal management, child welfare, and early intervention/infant development services met monthly for the next two years to consider ways in which a service based on relationships between non-traditional service partners could be implemented. In retrospect, these two years were essential in building the foundation of a common language, shared values and principles, and mutual goals; that is, to develop the foundation of the relationships upon which the BTC partnership was built.

Drawing upon their respective service expertise, and a review of the literature, the working group submitted a proposal in February 1994 to the Community Action Program for Children (CAPC) of Health and Welfare Canada¹, as it was then known. Funding was received for BTC in May of 1994 and a 10 month needs analysis phase was undertaken to refine the program model and confirm the service partnership.

Ongoing funding was then received from CAPC and the BTC program was launched in 1995 to address the needs of:

1. Women who are pregnant and/or mothers of young children, and who are also struggling with problems related to substance use or recovery issues; **and**

¹ Now the Public Health Agency of Canada

2. Infants and young children (0-6 years) whose physical, developmental and psychosocial health and well-being are at risk because of their prenatal exposure to substances, or their exposure to postnatal environments in which substances are used.

The BTC partners defined two clients: women *and* children. BTC's priorities, philosophy, and programs were developed in consideration of the maternal-child mandate that was defined from the outset. All aspects of BTC services reflect the fact that both mother and child are affected by maternal substance use and related conditions, that the care of substance-involved mothers and their young children requires attention to each, and to the relationship between them. In fact, the primary focus of all interventions delivered at BTC is the relationship between the mother and child.

BTC was launched with the belief that "there is a relationship between the improvement of the system and the improvement of individuals in that system" (Thurman et al., 1992, p. 37). BTC offered the opportunity for existing services to be re-organized and delivered in an improved manner, recognizing that services should be coordinated so that agencies adapt to families rather than families having to adapt to multiple agencies. The goals were to address existing service system problems such as fragmented services for substance-using pregnant women or mothers, and their young children; multiple intake experiences; poor coordination of services (especially between the adult treatment sectors and the children's service sector); lack of consistency; and multiple locations for service access.

Supplementary funding has been obtained since the inception of BTC and is provided by the Public Health Agency of Canada's (PHAC) Canada Prenatal Nutrition Program (CPNP), and Ontario's Ministry of Children and Youth Services. This core funding has served to leverage significant in-kind service and consultation contributions from BTC partner agencies, including infant development and early intervention services (Mothercraft), the Fetal Alcohol Spectrum Disorder (FASD) Assessment and Diagnostic Clinic (Mothercraft and the Hospital for Sick Children - Motherisk Program) and parenting and nutrition programs (Toronto Public Health and Mothercraft). Special project funding has been acquired to test and develop service responses to identified issues, including housing insecurity and domestic violence (See Section 4 for descriptions of the BTC Pregnancy Outreach Program and the Connections Program.)

Two clients: mother and child

The primary focus of intervention is the relationship between mother and child

Initial goal was coordination of services for substance-involved pregnant and parenting women



1.1.1 Why BTC was needed

A constellation of factors impact on the lives of substance-involved women and their children

For a thorough examination of the context of the lives of substance involved pregnant and parenting women, see Apprehensions
www.bccewh.bc.ca

BTC was established based on a well-identified community need, including the understanding that:

- Substance-involved women bring a host of biological and environmental risk factors to their pregnancy and parenting role, in addition to substance use, including the experience of trauma, loss, and abuse in childhood and in the present. They may be experiencing a number of complex conditions of risk, including violence in intimate relationships, mental health problems, poverty, housing insecurity, lack of medical and prenatal care, food insecurity and inadequate nutrition. Substance-involved pregnant women often have difficulty mobilizing resources and supports essential to their survival because of their life circumstances and the primacy of their addiction. Additionally, they frequently express a pervasive fear and distrust of traditional “helping” organizations, resulting in the avoidance of these services throughout their pregnancies.
- Substance use during pregnancy was being detected with increasing frequency. In the eight years prior to the establishment of BTC, babies born showing the symptoms of their mothers’ drug use increased sevenfold (Metro Toronto Research Group on Drug Use, 1992). The Children’s Aid Society of Metropolitan Toronto also reported admitting more children into care due to substance use problems faced by their mothers (Leslie, 1991). Further, there was increasing public and political attention being directed to substance use among women of childbearing age both in Canada and the U.S.
- Infants of substance-involved mothers are at greater risk for health and developmental problems, impaired attachment relationships, and maltreatment and trauma (Reid et al., 1999; Lester et al., 2000; Mejta et al., 1996)



1.1.2 Key priorities and principles

The founding partners of BTC were committed to developing a comprehensive program designed to respond to the complex issues experienced by women and children who are substance-involved. The partners designed a service delivery model around the following key priorities and principles:

- **Collaborative, cross-sectoral partnerships.** It was recognized that there was no single agency that could address the complex needs and situations of substance-involved women and mothers, and substance-exposed children. Community partnerships were required, and BTC was developed on the basis of a formal service partnership with agencies who all had contact with substance-involved women and/or their children, but who often had very little contact with one another. This was particularly the case with child-focused and adult-focused agencies.
- **Comprehensive, integrated services.** Before BTC, there were no integrated services in Toronto which provided support for substance-involved mothers and infants together, addressing maternal substance use problems, while promoting parenting skills and the developmental needs of the infants. The establishment of BTC meant that women would not necessarily have to make a choice between receiving addiction treatment and caring for their children. The BTC partners believed it was impossible to disentangle the issues of addiction and recovery, trauma, mothering, child care and development, and the complex social stresses experienced by substance-involved mothers and their children. Addressing these issues through an integrated service model that offered a comprehensive range of maternal-child services would more accurately reflect the reality of the lives of substance-involved women and mothers.
- **Consistency.** Historically, information given to substance-involved pregnant and parenting women was not necessarily consistent across various professionals in different agencies with which they had contact. Parenting recovery and addictions recovery approaches were often at odds, leaving a seriously depleted, highly stressed, and unprepared mother to integrate and apply the information. The

*Client-centred, flexible,
respectful, individualized*

*The complex needs of
women and children
require comprehensive,
holistic approaches based
on community partnerships*

*“They had everything
here. Like all the
different aspects of the
program ... not just trying
to help me the addict, but
me the brand new parent-
to-be... Like I had no
idea, I'd never been around
babies or small children
in my life, so I didn't have
a clue about what's going to
happen”*



“BTC is a one-stop shop. Here, they deal with you, your children, parenting, and emotions, all under one roof.”

Women's complex needs require seamless service delivery

BTC model was designed to promote increased contact and communication among the range of service providers working with substance-involved women and their children. This has resulted in opportunities to share and integrate perspectives and approaches, so that service providers communicate with each other to decrease the chances that mothers will be left to reconcile competing approaches and recommendations.

- **“Single Access” model.** There was no existing model to locate the integration, coordination and delivery of the range of services required by substance-involved pregnant and parenting women, and their young children. Services were delivered by a number of different agencies, often working in isolation of one another, and located in different parts of the community. This required substance-involved pregnant and parenting women to travel to tell their story over and over again as they travelled to different agencies for services. The “single access” concept enabled BTC clients to access a broad range of services at one community-based location, and demonstrated how a one-stop model reduces barriers to service for substance-involved pregnant and parenting women. It also demonstrated how intensive case management techniques can be used to promote a seamless system of service for families to access available supports in the broader community. The “single-access” model was important in reducing geographic barriers as well as fragmentation of services. Over the years, the single access model of services at BTC has been augmented with street outreach and home visitation components.
- **Prevention and early identification.** A key priority for BTC was to provide prenatal education, prevention, and intervention strategies for substance-involved mothers who previously may not have been identified at all or at a late stage of problem development for both the women and their children. Recognizing the level of isolation of substance-involved mothers and children, it was a priority of the BTC partners to develop programs and services that provided opportunities for pregnant women to access services early in their pregnancies. It was felt that this would promote maternal, fetal and child health outcomes,



and identify children who may require early interventions to promote development and well-being. Through proactive outreach strategies, BTC strove to provide increased supports for pregnant women to help them engage with community services, and to plan for their infant to come. Early identification has been viewed by BTC as a key prevention strategy, both for the prevention of FASD and for the prevention of well-established addictions problems for women.

- **Early intervention to interrupt cycles of trauma.** It was recognized that maternal substance use problems were often related to trauma and maltreatment that originated in the mother's own childhood. At BTC, the focus is on intervening early in the mother-child relationship in order to help mothers protect their children from the kinds of early experiences that caused their own pain. Often this involves developing relationships with professionals who can assist mothers in promoting safety for their children. Providing supports early in the mother-child relationship is seen as a key to interrupting maladaptive patterns of relating and coping, and establishing strong, healthy relationships patterns between mother and child.

The aim is to help mothers protect their children from the kinds of early experiences that cause their own pain



1.1.3 Values and philosophy

The BTC partners made a commitment to the following program values on which to develop and deliver services:

- Programs and services must be offered in an environment of supportive, encouraging, respectful and non-judgemental regard of all individuals regardless of race, gender, sexual orientation, or religious beliefs.
- All parents have the desire for their children to grow and develop to their full potential.
- All children have the right to have the opportunity to develop into healthy, happy and productive individuals.
- Many children do not have this opportunity for a variety of reasons. These include poverty, parental inexperience and lack of knowledge, emotional or developmental vulnerabilities of the mother, maternal substance use, and maternal isolation.
- The most critical environmental contributor to infant development is the nature and quality of the mother-infant relationship.
- Interventions and supports can enhance parenting skills and developmental gains of 'at-risk' infants if the interventions focus on supporting and strengthening the mother-infant attachment relationship and supporting healthy family functioning.
- Intervention is most effective when it occurs at the earliest possible opportunity in the development of the mother-infant relationship.
- Maternal nurturing styles and responses to infants derive from the mother's past history and nurturing experience, the stressors and supports in her current life situation, and the mother's response to the individual characteristics of her infant.
- Interventions and supports must take a holistic approach which is sensitive to the complexity and diversity of women's lives, particularly with respect



to the impact of trauma such as childhood abuse, adult violence, and violence in intimate relationships.

- Services must be offered in a flexible, responsive manner addressing each woman and child's individual needs and circumstances.
- Woman-centred and child services must protect and respect the integrity of the woman's family as she defines it and acknowledge the impact of significant others in the woman's life.
- By fostering an enhanced sense of self, and the attainment of skills and resources, women will assume mastery of their lives.
- A culturally/racially sensitive, inviting, warm, accessible and non-threatening environment enhances program effectiveness.
- A commitment to supporting and nurturing the emotional well-being of staff, volunteers and students is reflected through opportunities for training, supervision, and consultation.

1.1.4 Building community support

During the development phase of BTC, extensive community consultations were conducted with street-based, community-based, and institutionally-based providers of service to substance-involved pregnant and parenting women, as well as with providers caring for substance-exposed children. Further, a number of interviews were conducted by the lead partners with clients of their agencies who were potential clients of BTC. All potential forums for input and advice were investigated and utilized such as a meeting of the Mayor's Task Force on Drugs, which had widespread attendance by community stakeholders. Service providers and clients were encouraged to provide advice and make input about program development and design. This advice formed the basis of the program design and philosophy of BTC. A one-day program planning session was held by the partners, to which a broad range of community service providers were also invited. The results of the consultations were discussed and conclusions reached about program design with the input of all the stakeholders.

Extensive community consultations developed support and contributed to philosophy and program design ...

... and organizational development



*Partnerships and
collaborations are key
to success*

*“The cooperative
management gives a
richness that wouldn't be
present in single agencies
... It's a holistic approach
because of all the different
perspectives.”*

In addition to wide-ranging consultations regarding program design, the organizational development of BTC was established based on extensive consultation. Upon confirmation of the CAPC funding for BTC, the partners formed the BTC Steering Committee, and a Community Advisory Panel was established to include not only members of the Steering Committee, but also other allied partners and women.

Since 1995, the BTC partnership has evolved and expanded in response to identified community needs and agency priorities. The BTC partner agencies now include: Canadian Mothercraft Society, Hospital for Sick Children - MotherRisk, Children's Aid Society of Toronto, Catholic Children's Aid Society of Toronto, St. Michael's Hospital, Toronto Public Health, St. Joseph's Health Centre, the Ministry of Community Safety and Correctional Services, and Toronto Western Hospital - Mental Health and Addictions.

BTC PARTNERS

Mothercraft

**MotheRisk - Hospital
for Sick Children**

**St. Joseph's
Health Centre**

**Toronto Western
Hospital - Mental
Health and Addiction**

**St. Michael's
Hospital**

Toronto Public Health

**Children's Aid
Society of Toronto**

**Ministry of Community
Safety and Correctional
Services**

**Catholic Children's Aid
Society of Toronto**



Mothercraft

1.1.5 Program evolution

In 1995, the BTC partners identified four core areas of service to be delivered through the single-access model: addiction services, child care, parenting programs, and developmental assessment. The partners recognized that women and children would require additional services that could not be delivered by BTC, and access to these services would be facilitated through the development of strong referral relationships with other community agencies.

Over the years, BTC has increased not only the range of services it offers on-site, but also its methods of service delivery. This has been accomplished through a combination of additional funding, new partnerships, and increased in-kind contributions from existing partners. The development of the BTC model has been an evolving and emergent process that has reflected the voices of the women and children it serves, as well as information collected through evaluation. The following are just a few examples:

- In 1995-1996, there was a recognition of the high level of food insecurity, poor nutrition and poverty experienced by the mothers and children attending BTC. Priority was given to finding ways to deliver a strong component of instrumental supports at BTC, and this was accomplished largely through the development of a relationship with Second Harvest, which allows for the delivery of a breakfast and lunch program, as well for a small food bank capacity. A clothing bank and transportation costs are also offered with the support of private donations as well as funding from the Public Health Agency of Canada. The clinical programs at BTC are bracketed around the delivery of instrumental supports, in particular the food program.
- In 1999, the BTC Pregnancy Outreach Program was developed in response to an emerging understanding of the unique needs of pregnant, substance-using women. With the support of funding from the Canada Prenatal Nutrition Program (CPNP) of the Public Health Agency of Canada, it introduced a street outreach component to augment the single-access model, and to engage and assist homeless, pregnant women using substances to access health, treatment and social support services. (See Section 4.1 for a description of the development of BTC Pregnancy Outreach Program.)

Voices of women and children are reflected in program development

See Second Harvest at
www.secondharvest.ca

Instrumental support as the foundation for clinical programming

Introduction of street outreach

See the original article by Lisa Hicks: Drug Addiction and Pregnant/Parenting Women: Factors Affecting Client Engagement
www.mothercraft.ca



*Introduction of home
visitation*

*To download the
Connections curriculum,
visit: www.mothercraft.ca*

*“They respond to our
needs here. If someone has
an issue that needs to be
dealt with, the staff will
start up a group to cover it.”*

- In 1999, the Mothercraft Parent-Infant Program was dedicated to BTC. The Parent-Infant Program is an infant development program funded by Ontario's Ministry of Children and Youth Services, delivering home-based, early intervention services to parents and young children. This enhanced in-kind contribution by Mothercraft introduced a home visitation component to the service delivery methods available at BTC.
- In 2001, the FASD Assessment/Diagnostic Clinic at BTC was fully established with enhanced in-kind contributions by Mothercraft and the Hospital for Sick Children - Motherisk. The BTC clinic is the first community-based FASD clinic in Canada, and operates in the context of the range of services delivered at BTC. (See Sections 2.4 and 2.5 for an expanded description of the FASD Assessment/Diagnostic Clinic at BTC.)
- In 2005, in response to the pervasive experience of domestic violence in the lives of mothers and children, the Connections group was developed and piloted with the support of Ontario's Ministry of the Attorney General (Ontario Victims Secretariat). Connections is a group program that provides education, information, and a safe opportunity for mothers to explore and process information regarding their experience of violence in intimate relationships, and to explore its impact on their parenting, their recovery, and their children's development. Ontario's Ministry of Children and Youth Services granted ongoing funding for the continued delivery of Connections at BTC and in the community. (For more information on Connections, see Section 4.2.)

The reflection of women's experience in program development is meaningful to women in their process of connection or relationship with programs and service providers.



1.2 Governance

In April 1995, BTC was launched by four founding partners representing child welfare, health/paediatrics, addiction treatment and children's mental health. Since that time, partnership has expanded to include representatives from additional sectors including public health, correctional services, inner-city health, mental health, and hospital-based services. A memorandum of understanding outlines the governance structure of BTC, including the roles and responsibilities of the BTC partners.

*Formalized partnership
model of governance*

BTC Sponsoring Organization - Canadian Mothercraft Society: As the sponsoring organization of BTC, Mothercraft is the financial administration agent, personnel administration agent (including the legal employer of all BTC staff), and owner and manager of all assets of BTC. The Executive Director of Mothercraft regularly reports to the Mothercraft Board of Directors on all aspects of BTC. Mothercraft holds all responsibility and liability for BTC.

*See Appendix 1 for
Memorandum of
Understanding*

BTC Steering Committee: The BTC Steering Committee is comprised of a senior representative of each of the nine partner organizations. Each partner organization makes a commitment to:

- Contribute staff who deliver services at BTC and/or funding and/or space and/or consultation;
- Supervise their staff who provide on-site services at BTC;
- Ensure that an agency representative participates in bi-weekly clinical team meetings;
- Act as a liaison for communications within their agency.

The BTC Steering Committee: 1) discusses and develops program operating policy for BTC; 2) provides input to program management issues as necessary; 3) receives regular reports on operations; 4) receives regular input from the Community Advisory Panel.

BTC Clinical Team: Each of the partner agencies provides a senior clinical consultant who delivers consultation services to BTC staff through the BTC Clinical Team. Clinical team meetings are held on a bi-weekly basis, at which time BTC staff members bring case or clinical questions for review and input by the team. BTC counsellors working with the family are responsible for implementing recom-

*Clinical team meetings
are essential to service
delivery*



*See Appendix 2 for
Consent to Release
Information Among
BTC Partners*

mendations of the BTC Clinical Team, thereby ensuring that treatment plans represent the integrated input of the agencies and sectors represented. Clinical team meetings not only provide the forum for cross-sectoral and transdisciplinary planning, but they have also become an important forum for staff training and development - not only for BTC staff but also for clinical consultants.

Direct Service: Many of the partner agencies also deliver services on-site at BTC.

A Consent To Release Information Among BTC Partners provides the authority for the partners to implement this service model, and allows for the delivery of integrated services through collaboration and communication among providers. It is based on the fundamental assumption that the complex issues faced by mothers and children at BTC (maternal substance use, maternal trauma, domestic violence, and child developmental/mental health problems) are not unrelated, and are most effectively addressed through a comprehensive, integrated and holistic approach that is necessarily based on interagency collaboration, coordination and communication, and that involves the integrated delivery of addictions, parenting, health, and developmental services.



1.3 Direct Service Approaches

1.3.1 Theoretical foundation of service delivery

BTC has drawn on a number of theoretical frameworks in the development and delivery of programs and services, and these are described briefly below. Some of these theories, and their more specific application at BTC, are discussed more fully in Section 3.

Harm Reduction: Harm reduction is a public health alternative to the moral, criminal and disease models of drug use and addiction, and refers to interventions that seek to reduce harms associated with substance use for individuals, families and communities. Although it recognizes abstinence as an ideal outcome, it accepts alternatives that reduce harm (Marlatt, 1998). Implicit in this approach is a shift away from stigma, guilt, confrontation and shame, towards an empowering and strengths-based approach. A respectful, non-judgemental approach accommodates goals of reduced use rather than immediate abstinence. Use of this approach is critical to engaging pregnant women or mothers in treatment, to addressing their shame and guilt around substance use, and to understanding women's use in the context of other complex and interrelated factors in their lives (such as poverty, trauma, homelessness, social isolation, and mental health problems). Use of a harm reduction approach is consistent with Health Canada's best practice statements on successful approaches in preventing FASD and the effects of other substance use which indicate that: "... services employing a respectful, flexible, culturally appropriate and women-centred approach that is open to intermediary harm reduction goals, based on client circumstances, are effective in engaging and retaining women in supportive programming and in improving the quality of their lives" (Roberts et al., 2000, pg.88).

In the integrated maternal-child approach implemented at BTC, harm reduction includes attention to the prevention or remedying the harms of maternal substance use experienced by children (Toronto Drug Strategy, 2005). This includes careful assessment of the impact of substance use on maternal functioning and mothering behaviours, on the individual needs of the infant or child, and on a mother's access to supportive resources, relationships and environments that foster the growth of both the mother and child in the context of safety, health and well-being.

Harm reduction engages women, reduces shame and guilt, and acknowledges the complexity of women's lives

For more information about harm reduction approaches to service delivery, go to:

knowledgex.camh.net/amhspecialists/re-sources_families/pages/harm_reduction.aspx

Harm reduction includes understanding the impacts of substance use on mothering and effects on children



*For more information
about relational theory,
go to:*

[www.centerforgenderandjustice.org/pdf/8.
pdf](http://www.centerforgenderandjustice.org/pdf/8.pdf)

*Positive relationships
are central to recovery*

*Secure attachment
is critical to infant
development*

*Attachment can be
difficult for substance-
involved parents but
can be developed*

*For more information
about implications of
substance use on
attachment, see the
Journal of Zero to Three,
March 2007, vol.27, no. 4
www.zerotothree.org*

Relational Theory

Relational-cultural theory suggests that growth-fostering relationships are a central human necessity and disconnections are the source of psychological problems. It proposes that women's substance use exists within a larger social-cultural, political and economic context, and attends to larger systems changes, including reduction of service fragmentation and access issues as part of the solution. Relational theory is grounded in women's experiences and listening to women's "voices". (For more on the application of Relational Theory at BTC, see Section 3.2.)

Attachment Theory

John Bowlby (1969/82) proposed that attachment occurs in an organized system, the purpose of which is to make individuals feel safe and secure. He further proposed that it was within the dynamic emotional relationship between infant and primary caregiver that the infant's cognitive and affective appraisal of self and others is developed (internal working model) in ways that have a critical influence on the infant's perception of the environment and others, and on later personality development and social functioning. The primary pathway to a secure attachment is parental sensitivity to the infant's cues and signals, as well as an appropriate and consistent response to those signals (Ainsworth, 1978). This focus on the parent-infant relationship is particularly critical for those parents who are burdened and preoccupied with past or present conflicts or stresses that may intrude (knowingly or unknowingly) on the parent-infant relationship. Interventions to enhance the quality of parent-child interactions, therefore, must support and enhance sensitive and responsive caregiving and address the personal and contextual factors that can undermine sensitive care.

Attachment theory suggests that the models established early in life are difficult, but not impossible, to change. Supporting a parent-infant relationship can offer parents a different kind of relationship from other relationships that they have experienced before, and may result in significant shifts in the parent's relationship capacities with the infant (Fraiberg, 1980). Key components of the relationship between parent and interventionist include consistency, predictability, persistence, reliability and caring. (For more on the application of Attachment Theory at BTC, see Section 3.3.)



Developmental Theory

Theories of development have varied in the emphasis they place on contributions made by the characteristics of the child and the characteristics of the environment to later behaviour. In all developmental theories, however, outcomes are never a function of the child taken alone or the experiential context taken alone. Behavioural competencies are a product of the combination of an individual and his or her experience. The transactional model of development (Sameroff & Chandler, 1975) has suggested bi-directional processes of influence, in which the child may have an influence on the environment by virtue of his or her constitutional characteristics or by the history of his/her experiences. In the case of substance-exposed children, developmental theory calls for the consideration of the contributions of neurobiological and psychosocial impacts of the pre- and postnatal environments.

Transtheoretical Model Of The Stages Of Change (usually called the Stages Of Change) (Prochaska et al., 1986). In this model, change happens in cycles, identified as six stages through which people move when they change a problem behaviour. These are:

1. **Pre-contemplation.** The individual is not considering change.
2. **Contemplation.** The individual is thinking about change in the near future.
3. **Preparation.** The individual has decided to change and is seeking information about how to do it.
4. **Action.** The individual makes a plan and changes the problematic behaviour.
5. **Maintenance.** The individual sticks with their new changed behaviour but needs support to maintain it.
6. **Termination.** The individual maintains the new changed behaviour and no longer needs support.

The Stages of Change model acknowledges that all individuals, including pregnant women and mothers using substances, need different kinds of help depending on which stage of change they are in. In the BTC program, the Stages of Change model has been used successfully as a framework for assessing level of readiness to change parenting as well as substance use behaviours. BTC programs and services are mapped against the stages of change so that the services offered to mothers and children match the appropriate stage of change (see Appendix 4).

See The SMART Guide: Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Alcohol: A Training Manual for Service Providers.

Go to

www.aware.on.ca/sites/default/files/Smart-Guide_1.pdf

For more information about the Stages of Change model, go to:

www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html



Motivational approaches are based on understanding the interaction between the woman and counsellor

For more information on motivational interviewing, go to:

www.motivationalinterview.org

Developmental guidance increases comfort and competence in parenting

Women are assisted to reflect on their own early relationships and how these influence their own parenting



Motivational Interviewing: Building Commitment Through Relationship

Motivational interviewing is an approach designed to help build commitment and to reach a decision to change (Miller and Rollnick, 1991). It is a useful strategy for those who have ambivalence about making a behaviour change, and it has been shown to be particularly effective in treatment with women. Removing external barriers to change and providing social support that facilitates change are key factors in the approach. In this approach, motivation is seen not as a trait or personality characteristic, but as something determined by the interaction between the woman and her counsellor. Through an empathic, accepting and non-judgemental relationship with a counsellor, women are offered an opportunity to explore the negative impact of behaviours on their lives, the benefits of changing, and the relationship between problematic behaviours and core values (Mullins et al., 2004). As women identify their benefits, costs, life goals and decisions, costs and benefits, they uncover information about themselves and their counsellor. (For more on the application of stage-based approaches and motivational interviewing at BTC, see Section 3.1.)

Developmental Guidance: Enhancing Knowledge and Understanding of Child Development

Developmental guidance is generally educative, and is designed to enhance parents' knowledge and understanding of child development. Developmental information is provided within the context of a working relationship between the parent and the counsellor, who is able to respond sensitively and with regard to what the parent is ready to hear and able to use (Seitz & Provence, 1990). The assumption is that the enhancement of knowledge and understanding of child development and behaviour will benefit the mother in her ability to function comfortably and competently in the parenting role. This is especially important in understanding the meaning of key behaviours such as separation protest or toddler individuation. Developmental guidance also includes a tradition of anticipatory guidance - looking forward to the next expected events in the infant's development.

Infant-Parent Psychotherapy: Looking Back, Moving Forward

Consistent with attachment theory and research on inter-generational transmission of parenting, infant parent-psychotherapeutic intervention assists mothers in reflecting on what they learned in their own early relationships and how those experiences influence how they respond to their own

children. This approach was described by Fraiberg and her colleagues (1980), who demonstrated that intervening with a parent (typically the mother) who had her infant present during the sessions could generate insights and progress with regard to the development of the child, the development of the mother, and the development of the relationship between the two - all as a positive working relationship between the counsellor and the parent grew over time. This approach is inherently three generational. The interventionist comes to understand the conflicts and expectations that the parent has internalized from her previous caregiving relationship with her own parents, which in turn become activated with her infant. There is an opportunity to use the infant's developmental responsiveness in a positive way to provide new opportunities for the current parent to grow as she improves her current parenting relationship. The influence of internalized experiences across generations has been documented most dramatically in attachment research (Fraiberg, 1980; Benoit & Parker, 1994).

See the seminal article by Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships.

Journal of The American Academy of Child Psychiatry, 29, 387-421.



1.3.2 Overview of programs at Breaking the Cycle

See Appendix 3 for a Weekly Schedule of Programs and Services

See Appendix 4 Programs and Services within the Stages of Change

At BTC, mothers attend addiction services (individual and group), parenting programs (group and dyadic interventions delivered through home visitation and at the clinic), early intervention (home-based and clinic based), developmental follow-up through assessment and through the FASD Diagnostic Clinic, on-site child care, and intensive service coordination and case management. Of critical importance for engaging and supporting women and children is the provision of instrumental supports, including food supplementation, clothing bank, and transportation. Treatment plans and goals for mother and children are individualized, and are confirmed through formal Family Service Plans that are developed with the mother, and which are reviewed and revised, if necessary, every six months.

Many of the programs below are offered on an ongoing basis, while some are offered sessionally. Programs and services are mapped onto the stages of change, and mothers attend programs and services that match their stage of change. (See appendix 4.)

BTC PROGRAMS AND SERVICES

Addictions

- Relapse Prevention Group
- Recovery Group
- Life Skills Group
- Individual Counselling
- Connections Group

Developmental Clinic

- Screening and Assessment
- Developmental and Interactional Guidance
- Parent-Child Psychotherapy
- Home Visiting
- Early Intervention

Mental Health Counselling

Health/Medical Services

- FASD Assessment/Diagnostic Clinic
- Pre-Postnatal Counselling



Child Care

Pregnancy Outreach Program

Probation and Parole Services

Parenting

- New Mom's Support Group
- Nobody's Perfect Parenting Program
- Cooking Healthy Together
- Parent-Child "Mother Goose" Program
- "Learning Through Play" Group
- Hanen "You Make the Difference"
- Make the Connection Program
- Access Visits

**Mothercraft**
Shaping Children's Lives Through Learning

Mothercraft

A. BTC Pregnancy Outreach Program

The BTC Pregnancy Outreach Program is a Canada Prenatal Nutrition Program (CPNP) serving homeless, pregnant women with substance use problems. Through a street outreach model, the program provides information, resources, education and case management support. The BTC Pregnancy Outreach Program also offers the “BTC Satellite Group” at St. Joseph’s Health Centre. Delivered in partnership with Women’s Own Withdrawal Management Centre and the Toronto Centre for Substance Use in Pregnancy (TCUP), this is a combined prenatal/relapse prevention group, with facilitated access to prenatal medical care through the TCUP program (See Section 4.1 for a more detailed description of the BTC Pregnancy Outreach Program.)

B. Addictions

Relapse Prevention Group. This group is offered to women who are in the early stages of their recovery. Behavioural and cognitive-behavioural approaches are used to assist women to develop strategies to manage cravings and other pressures to use substances.

Life Skills. This group offers structured lessons that are developed specifically for women recovering from addiction. They provide an opportunity for women to learn problem solving behaviours or skills in order to be able to manage their lives more effectively while in recovery. Topics covered include: building trust, journaling to express feelings, building self-esteem, recognizing strengths, dealing with anger, creating supports, humour in recovery.

Recovery Group. This group assists women to identify and address the issues and feelings that emerge when they make changes in their use of substances. Women who are eligible for this group are working to consolidate gains made in the earlier stages of their recovery by addressing the underlying issues related to their substance use in order to prevent a return to old behaviours.

“Connections”. The Connections group addresses the impact of domestic violence on child development, parenting and substance use recovery. (See Section 4.2 for an expanded description of “Connections”.)

Individual Addiction Counselling. Addiction counselling is available on an individual basis for all women at BTC. Services

“I like that she’ll meet me, just because it motivates you. For myself, being an addict, sometimes you need someone to come to you and help you.”

“They didn’t force anything upon you like ‘OK you have to go to 12 step meetings, you have to go to detox, you have to look at it this way’. They give you, here’s your five options. Check every one out if you want, or you can choose which one, which path you want to go. But everyone’s an individual and everyone’s different, and one way may work for me that doesn’t work for someone else.”



“I didn’t know how to be a mom. I didn’t know how to play with my daughter, I didn’t know how to breastfeed, I didn’t know how to teach her stuff, how old they have to be before you start feeding them solid food. I didn’t know nothing, absolutely nothing. And to be on my own and try to figure it out, I really didn’t have anybody to turn to.”

For more on Nobody’s Perfect, go to

www.phac-aspc.gc.ca/hp-ps/dca-dea/parent/nobody-personne/index-eng.php

For more on the Parent-Child Mother Goose Program, go to:

www.nald.ca/mothergooseprogram/

offered on an individual basis include assessment, pre-treatment preparation, case management of addictions-related problems, and education and support on addictions-related issues. Many women benefit from a combination of individual and group support for their recovery.

C. Parenting

New Mom’s Support Group. This group is devoted to pre- and post-natal education and support. The group is delivered jointly by Toronto Public Health and Mothercraft. The focus of the group includes preparation for childbirth and parenting, and involves discussion of issues such as prenatal nutrition, breastfeeding, and prenatal attachment. Mothers may attend the group until their infant is 6 months of age. Topics such as breastfeeding, sleeping and feeding issues, infant development and stimulation, and bonding and attachment are discussed.

Nobody’s Perfect Parenting Program. This program is facilitated by a nurse from Toronto Public Health and a BTC counsellor. This parenting program is group-based and is directed to families with children from birth to 5 years of age who have one or more of the following characteristics: young, single, low-income, or poorly educated, and socially, culturally or geographically isolated.

Cooking Healthy Together. The purpose of this program, offered by Toronto Public Health, and co-facilitated by a BTC counsellor, is to increase knowledge regarding the nutritional needs of children, women and pregnant women living with a fixed and limited income. Women gain skills in meal preparation, which increases their self-esteem and sense of self-efficacy. Since meals prepared in this communal cooking environment are shared and taken home by the women who have participated, this program also offers a nutritional supplement.

Parent-Child Mother Goose Program. This is a preventative program designed to assist parents to gain skills and confidence that enable them to create new and positive family patterns during their children’s early years. This group for mothers and their babies and young children focuses on the pleasure and power of using rhymes, songs and stories together. The group is delivered by BTC Child Development Counsellors.

Hanen “You Make the Difference” Group. This is a communication-based prevention program, aimed at helping

parents establish the kinds of interactions with their children that foster self-esteem, the desire to explore and learn, and language development. It makes extensive use of video technology as a powerful teaching tool. This group is co-facilitated by a BTC Parent-Child Counsellor and a therapist with the Mothercraft Parent-Infant Program.

Mothercraft "Learning Through Play" Group. The goal of this facilitated parent-child play group is to support and expand on children's existing skills using didactic approaches combined with opportunities for parents and children to experience play-based activities in a facilitated and supportive environment.

Access Visits. In some situations, access visits for mothers whose children are in foster care may be held at BTC. Mothers and children receive the support of BTC staff and services during their access visits in order to facilitate preparation and planning for the smooth and positive transition of the child from foster care to the mother's care.

D. Developmental Clinic

Developmental Screening and Assessment. As part of the intake process, and at 6-month intervals thereafter, the Battelle Developmental Inventory Screen is administered to all children in order to assess and monitor their developmental status. The child's mother is involved in the screening process and participates in creating a developmental plan, which incorporates the results of the screen, as well as her observations of her child. The developmental plan forms the basis for interventions for the child, and these are jointly implemented by BTC staff and the mother. Full developmental assessments are administered to children annually. Additional resources (e.g., speech and language services, occupational therapy, physiotherapy) are made available to the child and family based on assessed developmental needs.

Parent-Child Counselling. Parent-child counselling is delivered in centre-based and home-based sessions involving the mother and child. Various dyadic interventions are used including developmental guidance, interaction guidance using videotape, and parent-infant psychotherapy. The goal of this work is to enhance the stability and security of the attachment relationship between the mother and child by increasing the awareness of factors (past and present) that influence her parenting,

*For more information on
You Make the Difference,
go to:*

www.hanen.org

*"I mean, can you imagine
being a mom without this
place? Isn't it nice now for
people to say, wow, you're a
really good mom."*

*"My daughter loves the
home visitor. She looks so
forward that she runs and
hugs every time she comes
by, and talks to her on the
phone. That's how close
they are now. And I
thought, who does that, you
know? Who talks on the
phone to your child to tell
her that she'll be back to
see her in one week."*



“These mothers want to help themselves, they want to get help. But how do they get there? And who’s going to watch their kids? There’s so much abuse out there, we want our children in good care. We don’t want to just leave them and go. How can we be there 100% when our minds are back there with our children? We can’t. It’s impossible. Don’t ask us to do these impossible things!”

as well as by increasing her understanding of her child’s developmental and social-emotional needs.

Home Visiting. Home visitation is offered to complement the centre-based activities in which the mother and child participate, and as a vehicle to deliver parent-child counselling services. Home visiting is offered to all BTC participants and is delivered by Mothercraft’s Parent-Infant Therapists.

E. Child Care

Child Care. BTC operates a licensed child care for children of mothers who are attending appointments, groups or other activities at BTC, or in the community. Children are cared for by early childhood educators who provide a nurturing, stimulating and structured environment for children. Individual developmental planning is implemented for each child based on his/her assessed strengths and vulnerabilities.

F. FASD Assessment/Diagnostic Clinic

FASD Diagnostic Clinic. BTC benefits from the service of a paediatrician/toxicologist from the Hospital for Sick Children – Motherisk Program who holds a weekly clinic on site. The paediatrician sees all of the children and records a detailed prenatal exposure history. The children are seen in the clinic every six months for follow-up related to their prenatal substance exposure, or more frequently based on either the assessment of the physician or questions and concerns of the mother. FASD assessments and paediatric follow-up occur for all BTC children who have confirmed prenatal alcohol exposure. When appropriate, additional referrals are made for further assessments and/or diagnoses. Information and education are provided to the mother regarding the effects of her prenatal substance use, and any questions regarding breastfeeding and substance use are addressed.

G. Health/Medical Services

Medical Services. BTC works closely with the Toronto Centre for Substance Use in Pregnancy (TCUP) in the Department of Family and Community Medicine at St. Joseph’s Health Centre. Women who require general medical care, prenatal health care, a medically-managed withdrawal, and/or a methadone maintenance program are referred if they desire. The medical services provided are responsive, respectful, and consistent with BTC’s philosophy of care.

H. Mental Health Services

Individual Trauma Counselling. Women at BTC have access to support from a mental health clinician who provides on-site individual counselling (primarily related to family of origin and trauma-related issues) as well as referral for mental health assessments and more intensive mental health services as required.

H. Basic Needs Support

Breakfast and Lunch program. With the support of the Second Harvest food recovery program, BTC offers a daily breakfast and lunch to participants as a nutritional supplement. The lunch program meets a basic need for food and also relieves some financial stress for families on very limited incomes.

Clothing Bank. Through clothing donations, a supply of children's and adult clothing is maintained and made available to participants.

Transportation. Subway and/or bus tickets are provided to participants to travel to and from BTC.

“There are a lot of things that you have to deal with that you didn't deal with when you were using; the way you treated your children, the things you did for drugs, your childhood, your abusive parents, your alcoholic parents everything.”

SUMMARY of Section 1

The heightened recognition of the impact of maternal substance use on women, on mothering, and on child development prompted the creation of BTC. Because there was not one single agency or sector that could address the complex needs of substance-involved pregnant and parenting women, and their children, a partnership among a number of committed agencies representing child welfare, infant development, child care, addiction services, and health/medical providers was forged. BTC developed a maternal-child relationship-based model to deliver a range of services to substance-involved pregnant and parenting women, and their young children through a single access model, with outreach and home visitation components. The priority was to decrease barriers to services for women and mothers with substance use problems through creative community service partnerships. The primary goal was to engage and retain pregnant women and mothers in services, in order to promote positive maternal, fetal and child health outcomes. A secondary goal was to build community capacity in understanding and serving substance-involved women and children. BTC is based on a unifying set of theoretical approaches and set of principles and values, which provide a framework for the program environment, and program evolution. The use of theoretical approaches drawn from a number of disciplines - public health, child development, addiction treatment, psychology, child welfare - have informed the treatment interventions and programs delivered at BTC, and reinforce the maternal-child focus.

Recent research has supported clinical knowledge about the effectiveness of comprehensive or enhanced treatment for women, including components such as women-only treatment, childcare, prenatal care, parenting interventions and early intervention for children. Services for women must also be aware of the impact of trauma and mental health problems, and develop strategies to address these issues either on site or through referral. Attention to practical issues such as medical care, employment, food, clothing and transportation is also necessary.

Program planning and development should be based on a careful needs assessment, with mechanisms built in to monitor achievement of program and client objectives and outcomes. Program implementation should include ongoing program monitoring and evaluation activities. Because the lives of substance-involved pregnant and parenting women and their children have not been extensively explored, there is a continuing need for quantitative and qualitative research on effective interventions and approaches.



Section 2: Deepening Our Understanding of Substance-Involved Mothers and Their Children

Adapted from the Original Documents:

- Moore, TE., Pepler, DJ. & Motz, M. (1998). *Breaking the Cycle: The Evaluation Report (1995-1997)*. Toronto: Breaking the Cycle
- Pepler, DJ., Moore, TE., Motz, M. & Leslie, M. (2002). *Breaking the Cycle Evaluation Report: 1995-2000*. Toronto: Breaking the Cycle
- Motz, M., Leslie, M., Pepler, DJ., Moore, TE., Freeman, PA. (2006). *Breaking the Cycle: Measures of Progress 1995-2005*. Special Supplement, Journal of FAS International, Toronto: Hospital for Sick Children, 2006;4:e22. www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

Introduction

The success of Breaking the Cycle (BTC) in engaging and retaining substance-involved women and their children in services has provided an opportunity to gain a deeper understanding of the lives of these families. This Section draws on quantitative and qualitative evaluation data, as well as on the testimony of women who describe their past and present experiences.

BTC has been the subject of program evaluation and research since its inception. Three evaluations (Moore et al., 1998; Pepler et al., 2002; Motz et al., 2006) have reported on the efficacy of both the comprehensive, integrated program model and of a pregnancy-outreach model. The evaluations have also reported on enhanced birth and perinatal outcomes for infants of substance-involved mothers engaged earlier in pregnancy, on enhanced developmental outcomes for the children involved, on enhanced parenting confidence and competence, on enhanced treatment outcomes, and on decreased rates of separation of mother and child. The most recent report, *Breaking the Cycle: Measures of Progress 1995-2005* reported on ten years of data on a sample of approximately 770 substance-involved women and their children. We draw on these data to provide the sociodemographic picture of the context of the lives of women and children at BTC.

As women describe their experiences in *The Susan Story* and *Three Voices*, the intergenerational aspects of maternal substance use are clearly described, and provide a rationale for the two-generation, maternal-child approach developed at BTC. The impact of parental substance use on young children has not been extensively explored. The primary source of information about the experiences of children raised by substance-involved caregivers has been adults who were raised in such environments, and who describe them retrospectively. Both *The Susan Story* and *Three Voices* describe experiences that are consistent with the mechanisms of intergenerational transmission of trauma and relationship disturbances as proposed in relational and attachment theories.

Both the evaluation data and the studies by Rouleau et al. and Avner et al. hypothesize that not only are there high rates of prenatal alcohol exposure among the children at BTC, but that mothers at BTC may themselves have been exposed to their mothers' alcohol use during pregnancy. The application of an integrated maternal child perspective on Fetal Alcohol Spectrum Disorder (FASD) at BTC, offering prevention, identification, assessment/diagnosis, and intervention services is described. Of note is the description of the successful engagement of biological mothers in the process of FASD Diagnostic assessment of their children.



2.1 The Context of Women's Lives

For the full report of sociodemographic characteristics, see Breaking the Cycle: Measures of Progress 1995-2005

www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

65% of BTC women have histories of sexual abuse

81% of BTC women have histories of physical abuse

84% of BTC women have histories of emotional abuse



The sociodemographics confirm that BTC is engaging and serving a high risk population of mothers whose substance use problems co-occur with high rates of: early childhood trauma including sexual, physical and emotional abuse; psychological and medical problems; and domestic violence and substance use by spouses or partners in their adult relationships.

Maternal Age

Mothers range in age from 15 to 48; about two thirds are 21 to 35 and the average age is 29 years. Eighty- five percent are Canadian-born and 18% identify as Aboriginal women.

Maternal Maltreatment and Trauma

BTC mothers report high rates of childhood maltreatment. For many, exposure to maltreatment, violence, and exploitation appears to extend into their adult relationships with partners, friends and others.

- **Sexual abuse:** About two thirds of mothers report histories of sexual abuse. The onset of the abuse for three quarters of the women was 16 years and younger. About one third of the time, the perpetrators of the sexual abuse were identified as family members, and about half of the women identified the perpetrators as "various". Women who report "various" perpetrators were often sexually abused early in life by family members, and have continued to become involved in adult relationships with sexually abusive partners, or have engaged in sex trade work.
- **Physical abuse:** Over three quarters of mothers have histories of physical abuse, which most commonly began at the mean age of 14 years. Over one third of the women reveal that the perpetrator was their mother and an equal number of women identify the perpetrator as their partner or ex-partner.
- **Emotional abuse:** Over three quarters of mothers have histories of emotional abuse and most report that the onset of emotional abuse occurred when they were 16 years of age and younger. Their mothers are identified as the perpetrator almost half of the

time and their partner or ex-partner about one third of the time.

Almost half of these mothers report that they had received treatment related to their trauma experiences, and 80% of those who had received treatment report that they had found treatment helpful to them.

Maternal Psychological/Emotional Symptoms

BTC mothers report current mental health symptomatology, which reflects ongoing distress. The women experience flashbacks, amnesia, tension, anxiety, nervousness, depression, and suicide attempts. Self harm behaviours, fears, phobias, violent thoughts and feelings, difficulty eating and sleeping, and eating disorders are also widely experienced by the women.

The severe histories of maltreatment and trauma provide a context for understanding the use of substances by women and mothers. An understanding of the social and psychological context of maternal substance use informs the development of approaches, services and policies designed to support women, mothers and children who are substance-involved.

Maternal Substance Use

The most common substances used by mothers attending BTC are alcohol, crack cocaine and cocaine, cannabis and nicotine.

The average age at which BTC mothers report that they first used their substance of primary addiction was 19 years, it first became a problem at 21 years, and the average length of problematic use of substances was about 10 years. Many women are still using various substances when they initially attend BTC.

Many of the BTC mothers report high rates of substance use in their families of origin; this points to intergenerational transmission of patterns of coping involving substance use. There may be a significant proportion of BTC mothers who were themselves exposed to substances prenatally, and to substance-involved caregiving environments in their childhood.

The women also report very high rates of substance use by their partners. Over two thirds have present partners

Trauma treatment is perceived as beneficial

A wide range of symptoms are experienced by the women

Trauma informed approaches serve to contextualize women's use of substances

Polydrug use is common among the women

Many women were substance exposed prenatally or in their childhood environments



The women's partners have high rates of substance use and are either not supportive or abusive

Substance use and trauma are intertwined

Most of the BTC women are smokers at intake

Often the women choose to quit smoking or cut down

Integrated smoking cessation/reduction programs are part of the BTC menu of services

82% of BTC mothers have previous histories of participation in addiction treatment

Sociodemographic factors compromise the health of the women

who are substance users, and the overwhelming majority of past partners were substance users. Only a third of the women rate their present partner as supportive, while almost half rate their present partner as abusive. The women also report that their past partners were even less supportive and more abusive, all of which illustrates the high rates of abuse and maltreatment in the adult relationships of BTC mothers.

In combination with the trauma data, these substance use findings highlight the complex psychosocial conditions of risk with which BTC mothers present at admission.

It should be noted that over ninety percent of BTC mothers report use of nicotine at admission. The use of nicotine does not usually draw the social and legal sanctions that result from the use of illicit substances and alcohol. At admission, women often have external pressures to address their illicit substance use and/or problematic alcohol use. Because of this, it is often not a priority for women to reduce or stop their nicotine use initially. Nicotine is, however, a substance that mothers choose to address later in their process of recovery. Given the medical and developmental implications of prenatal nicotine use and exposure to second hand smoke, the availability of integrated programs to address smoking reduction or cessation goals is an important item on the menu of services offered to women at BTC (see Section 4.3).

The majority of mothers who participate in BTC programs have previous involvement in substance use treatment programs in an attempt to address their addictions. Most women have attended an average of two previous treatment programs. Although the majority of mothers indicated that previous treatment attempts had been helpful, the reported length of abstinence following treatment was brief and highly variable.

Other Sociodemographic Characteristics

A range of other issues are present in the lives of BTC mothers. These include:

Maternal health and medical status. Substance use and related conditions (including inadequate nutrition, unstable housing and alienation from health and medical services) have compromised the health of many BTC mothers.



Housing status. This is problematic for almost a quarter of the women, who report that they have no permanent residence and who live in either shelter/hostel or other residential settings. Most women report that they have no other adult living with them and only about half of the women have one or more children living with them, which highlights the degree of isolation from personal supports for mothers who attend BTC.

*Inadequate housing
and social isolation
are frequent*

Low-income status. The majority of BTC mothers and their families live in poverty and receive less than \$15,000 per year. The low level of income shapes the programs delivered to women and children at BTC, including a strong component of support for instrumental needs, including food, transportation and clothing. The majority of BTC mothers (92%) are not employed. Women who indicated employment at admission were earning their income through sex trade work or drug trafficking.

*85% of the women live in
poverty*

Educational status. One quarter of BTC mothers have completed less than grade 10 and 18% report that they have learning difficulties.

*Programming reflects and
supports the needs of
low-income women*

Legal status. Many BTC mothers have a history of legal problems, including convictions on various charges including theft, assault, solicitation, possession and trafficking of illegal substances, and weapons offences. About half of the women have current legal problems at admission and one-third are on probation/parole orders.

*Legal problems are
common*



2.2 The Context of Children's Lives: A Chance for New Beginnings

For the full report of sociodemographic characteristics, see Breaking the Cycle: Measures of Progress 1995-2005

www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

72% of BTC mothers reported substance use during pregnancy

Primary drugs of choice were alcohol and crack cocaine, with very high rates of nicotine use



The vulnerable medical, psychosocial, and economic contexts described above impact not only the health and well-being of mothers, but also the health and development of their children. When their mothers live in conditions that include poverty, abuse, homelessness, and isolation, children also experience the effects of these conditions.



In the three evaluations of BTC, numerous prenatal risk factors were identified by the mothers, including limited access to health and prenatal care, and pre-existing or gestational conditions such as low weight gain, anemia, diabetes, high blood pressure, obesity, infections and placental problems. Risk factors related to sociodemographic factors were also reported and these included maternal age, housing insecurity, exposure to violence, maternal stress, isolation, and mental health problems, and exposure to alcohol and other substances.

Age of Children

The average age of children seen at BTC is 1.5 years, with a range from 0 - 6 years.

Prenatal Substance Exposure

Almost three quarters of BTC mothers reported using alcohol and/or other substances during their pregnancy. Alcohol and crack cocaine accounted for the primary substances of choice for almost 80% of the women reporting prenatal substance use. The use of crack cocaine and alcohol places pregnant women and their children at high risk for pre and postnatal difficulties. Ninety percent (90%) of BTC women

also reported that they had smoked cigarettes since the beginning of the pregnancy.

Birth History

Eighty-two percent (82%) of BTC children were born at full term, weighing an average of 6 lbs, 14 oz. Birth complications were reported for over one third of the children, and these included: unplanned Caesarian delivery, placenta previa, induction, infection, meconium stain, low fetal heart rate, and respiratory problems

34% reported birth complications

Perinatal Diagnoses

One quarter of the children were reported to have been diagnosed with postnatal health conditions including: drug withdrawal; Fetal Alcohol Spectrum Disorder; low birth weight; genetic disorder; respiratory difficulties; cardiac complications; birth injuries; congenital birth defects; seizures or tremors.

25% of children had postnatal health conditions

The biological vulnerability created by exposure to substances in utero can be highly modified or exacerbated by social factors. It is important to consider the psychological and social influences that contribute to a woman taking drugs, as well as the nature of the family and community contexts in which a child is being raised, to understand the factors that determine developmental outcomes of prenatally substance-exposed infants. Infants exposed to substances prenatally often continue to live in environments with continued caregiver substance use, domestic violence, conflictual relationships between parents, and poverty, as well as co-existing psychological problems for mother, including depression, anxiety, post-traumatic stress disorder, eating disorders, and suicidality (Brady & Ashley, 2005). Continued postnatal substance use is cumulative on both parental abilities and infant development (Mayes et al., 2003). All of these factors have been associated with increased risk for compromised parenting capacities and child maltreatment (Seifer et al., 2004), resulting in mothers' loss of custody of their children.

The postnatal environment can modify or exacerbate vulnerabilities created by prenatal exposure to substances

Children's Separations from their Mother

About two thirds of mothers reported one or more separations from their children. The average age of the child at first separations was 1.3 years, and the average number of days of first separation was 84 days.

62% of mothers reported one or more separations from children

Custody Status of Children

About one third of BTC children are in the custody of their



Only 32% of BTC children are in their mother's custody

60% of BTC families are involved with child welfare

31% of mothers have concerns about children's development

mother, one third are in the care of another family member, and the remaining third of all children are in non-relative care (i.e., foster care). The high rates of out of home placement of children with substance-involved mothers reflect the impact of substance use on parenting capacity, the impact on child safety, development and well-being, and the lack of available programs and services that could provide treatment and support.

Child Welfare Involvement

Despite the high-risk conditions in which mothers and infants live, child welfare agencies are not involved in 40% of cases when families first arrive at BTC. One of the goals of the BTC program is to identify infants and mothers at-risk as early as possible so that intervention can be expedient and timely, when appropriate.

Mothers' Concerns Regarding their Child/ren's Development

About one third of BTC mothers reported developmental concerns about their children. Their concerns clustered within the following three categories: 1) their children's developmental progress; 2) the effect of prenatal substance exposure on their children's health and development; and 3) the mother-child relationship.



2.3 Intergenerational Impact of Substance Use: SUSAN'S STORY

Originally Published:

Butler, T. & Leslie, M. (2004). Susan's Story. *IMPrint: Newsletter of the Infant Mental Health Promotion Project (IMP)*, Vol. 39, p3-5.

This story is based on the case histories of three clients of Breaking the Cycle, and it represents the stories of the majority of the women and children seen in the program.

Family History

Susan is aged 2 and lives with her mother in a one-bedroom apartment. Her mother drinks alcohol. Her father is in jail on fraud charges. They have little money and Susan is often hungry. Before her father went to jail, he used to hit her mother. This makes Susan feel scared. Sometimes her mother would be lying on the floor and have blood all over her face. Sometimes she would not get up for a long time. Sometimes after her mother was hit, she would hit Susan. There are parties at the house and lots of people come over. They make so much noise that she can't get to sleep. There are often fights at the parties and the police come. They do not notice Susan who is hiding in the closet of the bedroom. After the parties at the house her mother is sick. Susan has to be very quiet or her mother will shout at her.

Susan's mother has a boyfriend. Sometimes late at night he comes into her room and touches her in a way that makes her feel scared and yucky. He gives her candy after and tells her that he loves her, that it is their secret. He tells her that her mother would be very angry with her if she knew about it. Susan has discovered that if she looks at the ceiling she can imagine she is a bird flying high in the sky and this helps her feel better. The boyfriend hits her mother and each day her mother drinks more and more.

Substance Use History

Susan struggles in school. She has difficulty making friends and has trouble paying attention in class. She worries about fitting in. She worries about going home. At 13 she starts to skip school. No one seems to notice. She goes to the arcade in town. She meets others just like her, and they seem to like her. They even let her hang out with them. She enjoys their company and they share their cigarettes with her. When they offer her some glue to sniff, she doesn't hesitate.

In the 10th grade Susan just doesn't go back to school. She

BTC mothers report that:

- 48% of their mothers were substance abusers
- 65% of their fathers were substance abusers
- 82% experienced physical abuse
- 84% experienced emotional abuse (usually by their mother or a partner of either parent)
- 70% were sexually abused
- 50% were abused by more than one perpetrator

BTC mothers report their age of first use (in years) is:

- Nicotine - 13
- Inhalants - 13
- Alcohol - 14
- Cannabis - 15.8
- Cocaine - 19
- Tranquillizers - 20
- Crack - 21
- Heroin - 21
- Antidepressants - 26



30% of BTC mothers have eating disorders

- 32% are bulimic
- 24% are compulsive overeaters
- 12% are anorexic

26.8% of BTC report current or past self-harm behaviours, in particular cutting or slashing

82% of BTC mothers have histories of physical abuse in relationships

40% report that their current partners are physically abusive and 29% are emotionally abusive

69% of their partners are substance abusers



spends more and more time away from home. Eventually she moves out to sleep on a friend's couch. They spend their days on the street asking for spare change. People shout at her, they ignore her, they spit on her, but sometimes she gets lucky and they give her money.

By age 17 Susan is often in trouble with the law. She has been unable to hold down a job. She has to steal food and clothes to get by. She moves from rooming house to friends' couches to other rooming houses. She can't keep up the rent; she is now drinking daily and has been working on the streets for the last year. Her dates pay her more money if she doesn't make them wear a condom. She would rather make the money. She understands the rules of the street, she knows whose territory is whose.

Eating Disorders

Susan has a few bad dates. She is raped but the police won't take a report. She is a known prostitute. She is beaten and robbed. She drinks before and after working. She doesn't eat for days. Although she is underweight, she feels fat and ugly. When she eats she feels disgusted with herself. Her stomach feels bloated and she makes herself vomit. She is afraid of gaining weight. She wants to feel in control.

Self-Harm Behaviours

Susan spends a lot of her time hating herself and feeling afraid but makes sure that people are afraid of her. You can't work the streets if they know you are scared. She feels like she will burst with the anger she feels. She starts to burn herself with cigarettes and cut herself with a razor. She likes the way that feels. Like air coming out of a balloon, relief, and a sense of control. If a date gets out of hand she cuts herself and it really freaks them out.

Partner Abuse

At age 18 Susan has a boyfriend, Gary, who is one of her regular dates. He works in a bar and wants her to move in with him. He tells her that he doesn't like her working and that he will look after her. Susan likes the way that feels. He must really love her. Her welfare is cut off because Gary works. Gary drinks a lot. One day Susan comes home after shopping and he accuses her of working again. He punches her in the face and drags her around the room by her hair; he kicks her in the stomach and leaves. Later he comes back and tells her that he's sorry and it'll never happen again. He says that he's jealous because he loves her so much, and he just loses it when she's late getting home. He makes her promise she'll

call him when she's out. Susan thinks that he must really love her to be that angry. Over the next year Gary hits her a few times every month. He calls her names like "fat ugly bitch" and "whore". He tells her that if she were not so fat and lazy he wouldn't have to hit her. She has no friends, she is afraid to go out, she has no money. Gary brings home the food and alcohol. Gary brings home the crack. Susan starts to smoke it and it feels great. Gary makes her go out and work again to make the money to buy more. He will be her pimp.

Emotional/Psychological Problems

Susan can't sleep, she can't eat, she feels trapped and afraid and out of control. She smokes crack to get high, she smokes crack to escape. She drinks to come down; she takes pills to come down. And when there's no money, she cuts. Susan tries to remember how she got here. There must be a better life, but where? She takes an overdose of pills and alcohol.

After a 3-day admission to a psychiatric unit at her local hospital, Susan is discharged. She doesn't want to go home, and is discharged to a shelter. The social worker at the hospital gives Susan her card and an appointment. She doesn't keep the appointment and loses the card. One night after drinking Susan returns to the shelter and is discharged. They find her a bed in a detoxification centre. She stays with them for 3 weeks. The counsellors are nice. But she experiences alcohol withdrawal. In her second week, she starts to have nightmares about her childhood, feelings of being suffocated. She is scared that Gary will come looking for her. She finds that she is unable to shake these thoughts and, in groups, she floats off. Most of the time her hands are shaking; she feels terrible anxiety. She can't drink or smoke crack so she cuts herself, and she feels better. But a few days later her dreams are back. She can't take it. She leaves to have a drink, and goes back home to Gary.

Over the next 6 months, Susan is assaulted by Gary 10 times and goes to an emergency room three times. She is back working as a prostitute and smoking crack daily. She has been stabbed by a date; she has had one abortion and one miscarriage. She is deaf in one ear from being punched in the head and her nose has been broken. She lives between Gary, the detox centre, hostels and the street. When she can't smoke crack, she drinks; when she can't drink or smoke she cuts herself. She binges and purges on food. Susan takes another overdose of her anti-anxiety medication and alcohol.

BTC mothers experience:

- *tension, anxiety, nervousness (90%)*
- *depression (94%)*
- *fear or phobias (49%)*
- *amnesia (47%)*
- *sleep disturbances (75%)*
- *violent thoughts or feelings (41%)*
- *suicide attempts (47%)*



82% of BTC have previous histories of substance abuse treatment

- 50% in residential treatment
- 45% in self-help
- 44% in detox

86% of BTC families live on less than \$15,000 per year

44% live on less than \$9,999

42% live on \$10,000 to \$14,999

Treatment History

At age 20, Susan is in detox and decides that she has had enough. She has had 14 admissions there in the last year. She stays at the detox until a bed becomes available in a treatment centre. She struggles with her nightmares, and feelings of wanting to cut and use. She completes the program at the treatment centre and moves into a small, furnished room. She is able to remain abstinent for 3 months. She lives in poverty: her rent is \$400 and she struggles on the remaining \$125. She travels to food banks, her aftercare meetings, and she has even joined a self-help group. Finding money to keep her appointments is difficult ... the places are so far apart. She has a few slips and starts to feel like a failure. Susan returns to active drug use.

Pregnancy and Poverty

At age 21 Susan is pregnant by a date. She finds this out in her 5th month. She is smoking crack and drinking. She didn't gain any weight. She hasn't had a period for over a year. Susan has mixed feelings. She can't connect with herself and she doesn't feel pregnant. She sees a doctor three times. She doesn't say that she is drinking or smoking crack. She is afraid that they will take her baby away. So she tries to cut back on her own.

Susan has a 6 lb. baby girl who she calls Emma. She is able to rent a one-bedroom apartment in a low-rent neighbourhood. But she struggles to make ends meet on her welfare cheque and her child tax credit. Her rent is \$550 a month and this leaves her with \$550. It is expensive to buy diapers and to feed herself, pay hydro bills, the telephone bills, the laundromat, and the baby's clothes, bedding, crib and stroller. Her money is soon gone.

Susan has high hopes for this baby, she wants the best for her, and she is filled with love. She is breastfeeding and wants to spend time with Emma. But Emma is so demanding. She cries a lot and Susan never gets a break. She doesn't know anyone she can trust. She feels anxious and alone. She starts to drink a little more each week. She tells herself that it helps her relax with Emma.

Time moves on.

Emma is a 2 year old and she lives with her mother in a one-bedroom apartment. Emma's mother drinks alcohol.



2.4 Nurturing Change: An Integrated Maternal-Child Perspective on Fetal Alcohol Spectrum Disorder (FASD)

Originally Published:

- Leslie, M & Roberts G. (2004). *Nurturing Change: Working Effectively with High Risk Women and Affected Children to Prevent and Reduce Harms Associated with FASD*. Toronto: Mothercraft. www.mothercraft.ca
- Leslie, M. *Nurturing Change Toward an Integrated Maternal-Child Perspective on FASD*. *The Native Journal*. November 2005.
- Motz, M., Leslie, M., Pepler, D.J., Moore, T.E., & Freeman, P. (2006). Breaking the Cycle: Measures of Progress 1995-2005. [Special Supplement, Journal of FAS International, 4:e22. Toronto: Hospital for Sick Children <http://www.motherisk.org/JFAS/index.jsp>]

All BTC evaluations (Moore et al., 1998; Pepler et al., 2002; Motz et al., 2006) have confirmed that alcohol and crack cocaine are the primary drugs of choice of pregnant women in the BTC programs¹. Prevention of FASD involves the care of pregnant women who have significant alcohol problems or addictions, and includes ways to decrease their isolation from the broad determinants of health.

BTC evaluations (Moore et al., 1998; Pepler et al., 2002; Motz et al., 2006) have also confirmed that alcohol and crack cocaine are the primary drugs to which BTC children are exposed prenatally. Consistent with the recommendations of the Centres for Disease Control and Prevention (2005), all BTC children for whom prenatal alcohol exposure is confirmed are referred to the FASD Diagnostic Clinic at BTC for assessment and referral. The confirmed maternal history of prenatal alcohol use, coupled with ongoing contact with children who attend BTC with their biological mothers, offers a unique opportunity for identification, assessment and diagnosis through the FASD Diagnostic Clinic, and for intervention/ treatment with exposed children.

Since 1995 BTC has developed an integrated and comprehensive response to FASD, offering prevention, identification, diagnostic and intervention services in the prenatal and early childhood periods within a maternal-child framework. The elements of the FASD service model at BTC include:

- The **prevention** or reduction of harms associated with alcohol or other substance use in pregnancy. The BTC approach reflects the fact that pregnant

FASD prevention includes substance use treatment and holistic care for women

Substance use is linked to adverse life conditions

¹ There is broad agreement that alcohol and crack cocaine are the drugs of most concern for Toronto (Toronto Drug Strategy 2005)

FASD involves complex issues beyond alcohol use during pregnancy

BTC mothers openly disclose substance use histories in BTC's non-judgemental environment, which leads to timely identification of their children

Mothers are involved in assessment and diagnosis in a supportive and respectful manner



women who use alcohol “are also subject to other adverse conditions that are strongly related to their use, including: poor nutrition, poverty, tobacco use, illicit drug use, violence, history of obstetrical problems, lack of prenatal care, among others. Thus, FAS is not simply an issue of alcohol abuse but a complex issue rooted in the underlying social and economic conditions which influence all aspects of maternal and child health” (Canadian Centre on Substance Abuse, 1994). These root causes comprise the circumstances that not only bring some women to alcohol use, but which also make it difficult for them to stop or decrease their use during pregnancy. The BTC Pregnancy Outreach Program was developed in 1999 as a proactive FASD prevention strategy designed to engage pregnant women using alcohol or other substances as early as possible in pregnancy in order to optimize maternal, fetal and child health outcomes.

- The timely **identification** of children who may have special needs stemming from prenatal alcohol exposure. Because children attend BTC with their biological mothers, we have the advantage of a maternal report on time and doses of intrauterine exposure, as well as all other co-occurring factors. The non-judgemental, friendly and supportive environment facilitates maternal openness regarding prenatal history and, indeed, mothers disclose a full picture of their alcohol and drug use (Avner & Koren, 2004). Access to confirmed maternal prenatal alcohol use history is critical to the confirmation of an FASD diagnosis.
- The **assessment and diagnosis** of children who have been identified with challenges that may be related to prenatal exposure to alcohol. The important role of the biological mother in this process is critical. Respectfully and sensitively engaging pregnant women who use alcohol in the process of information-sharing around their infant-to-come is critical to accurately assessing and understanding the child’s needs – at birth, and throughout his/her life – and, most importantly, to acquiring an accurate diagnosis.
- The provision of appropriate **intervention and treatment** which capitalize on mothers’ and chil-

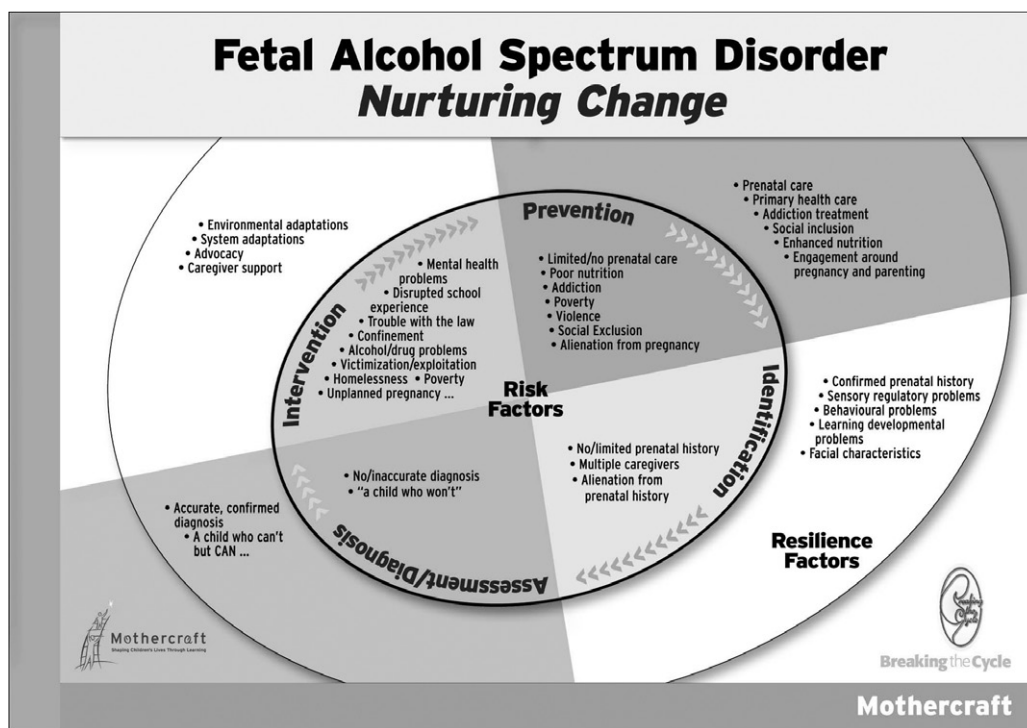
dren's strengths, and support special challenges. Accurate assessment and understanding of the child's strengths and vulnerabilities result in the opportunity to optimize outcomes through early intervention, treatment and parenting support, and to prevent the development of secondary disabilities in children who are inaccurately understood and responded to throughout their lives. Because virtually all of the child participants at BTC have been exposed to alcohol prenatally, the child developmental and parenting programs provide an opportunity for early intervention and support.

When the continuum of caring is interrupted or fragmented, there is an increased likelihood that affected children will not be identified, assessed, and receive appropriate intervention. This, in turn, increases the risk for the development of secondary disabilities, which include mental health problems, substance use, victimization, criminality, trauma and unplanned pregnancy (Streissguth et al., 1996; Institute of Medicine, 1996). The intergenerational transmission of FASD cannot be ignored (Rouleau et al., 2003). Delivering compassionate programs to address the issues of alcohol use in pregnancy and FASD in an integrated and comprehensive way provides opportunities to interrupt intergenerational transmission of FASD and related conditions.

A strengths-based approach is taken with mothers and children

Accurate assessment of strengths and vulnerabilities optimizes outcomes and prevents development of secondary disabilities

Integrated and comprehensive two-generation programs can break the cycle of intergenerational transmission of FASD



2.5 Mothers Affected by FASD

2.5.1 Mothers Affected by FASD: A BTC Research Study

Adapted from the Original Publication:

Rouleau, M., Levichek, Z., & Koren, G. (2003). *Are Mothers Who Drink Heavily in Pregnancy Victims of FAS?* In J FAS Int 2003;1:e4 April 2003

The high rates of reported substance use by the mothers of the BTC women, coupled with the range of sociodemographic difficulties, suggest that BTC mothers may be at higher risk for having been impacted by the prenatal alcohol and substance use of their own mothers. The following study was undertaken to further examine this hypothesis:

A wide range of sociodemographic information about BTC mothers was collected

33% of BTC women were raised by mothers who were problem drinkers

These participants had very high rates of alcohol related disabilities ...

... such as learning disabilities, criminality, and mental health issues



The objective of the study was to examine the possibility that women drinking in pregnancy were also affected by alcohol use in their mothers. In other words, the study was established to discover if women who gave birth to FASD affected children were FASD affected themselves. A cohort study was conducted at BTC that involved 173 women who had been program participants between the program's inception in 1995 until July 2001. The research team reviewed participants' intake forms and extracted relevant data, including mother's age, mother's alcohol and other drug use in pregnancy, highest school grades completed, post-secondary education, learning difficulties, mother's alcohol and drug abuse history, medical and psychological problems, rehabilitation and detoxification treatment history, family history including alcohol and other drug abuse, as well as significant medical and psychological problems such as suicide attempts and mother's criminal record.

The research study revealed that at least one third of the women who were BTC participants during the study period were reared by problem drinking mothers. It is likely that the true figure is higher, due to poor recall, and the fact that some of these women were adopted. When compared to the general population, the women had very high rates of learning disabilities, conflict with the law, depression, suicide attempts, and shorter education. These characteristics are very typical of the secondary disabilities that often co-exist with FASD.

Various degrees of learning disability are hallmarks of FASD, resulting in substantially shorter education. High rates of conflict with the law have been described among individuals with FASD, and it is estimated that a large number of

incarcerated individuals in Canada are affected by FASD. Psychiatric morbidity, including depression and suicide attempts, occur in the vast majority of FASD cases.

These figures strongly support the hypothesis that many of the mothers giving birth to children with FASD are themselves affected by the same condition.

Any strategy to diagnose and manage FASD should include assessment of the natural mother for the same diagnosis. Such diagnosis is important to address the serious problems of the by the mother with fetal alcohol damage, as prerequisite to ensure optimal management of the baby by the mother with fetal alcohol damage.

Both mothers and infants should be assessed for FASD to ensure optimal care for both

2.5.2 Mothers Affected by FASD: A BTC Research Study

Adapted from the Original Publication:

Avner, M. & Koren, G. (2004). *Breaking the Cycle: A Unique Model for FASD Research*. Journal of FAS International;2:e3, Toronto: Hospital for Sick Children <http://www.motherrisk.org/JFAS/index.jsp>

At BTC, children exposed in utero to alcohol and a variety of drugs of abuse are assessed and followed up. Because all children attend BTC with their biological mothers, BTC has the advantage of a full report on time and doses of intrauterine exposure, as well as all other confounders, from poverty to depression. Full physical and neurobehavioural follow-up allows optimal study of FASD and determinants affecting it.

Biological proofs are now available to corroborate the self reports of mothers

To date, a variety of methodologies have been used to study the effects and dose response relationships of ethanol in pregnancy. Because of the shame, guilt and fears associated with alcohol use in pregnancy, there is always a cloud of doubt about the extent and quality of maternal disclosure. The information regarding maternal exposure is often second hand (e.g., family members), third hand (e.g., Children's Aid), or plain hearsay.

Maternal disclosure of alcohol use has historically been treated with suspicion by researchers

BTC has created a unique research paradigm for the complex challenge of identifying the effects of ethanol on the developing brain in the context of all other confounders, and offers a number of significant advantages.

First, per definition, the mother-child dyad is the client/patient. Hence, at BTC the biological mothers are met re-



*A respectful relationship
with mothers is the best
way to learn of maternal
alcohol use*

*The accepting atmosphere
at BTC encourages full
disclosure by women*

*BTC's approach also
helps differentiate between
pre and postnatal damage
seen in FASD*

peatedly in the clinic. The mothers disclose a very full picture of their alcohol and other drug use. This is the strength of the culture in BTC, which is non-judgemental, friendly, and supportive.

For cynical readers who may raise an eyebrow thinking “it is still just mom’s word”, there is now biological proof of the accuracy and completeness of maternal reports of BTC clients. In three recent cases, mothers reported using cocaine only in the first half of pregnancy. Hair analysis of the mothers and babies verified their stories.

BTC clients are also highly motivated women, who despite troubling personal histories are very committed to quitting drugs and making positive changes, focusing on their children. This greatly improved postnatal environment is critical in sorting out how much of the damage seen in FASD is pre-natal and how much is postnatal.

Working with BTC clients also allows for continuous follow-up to detect emerging or disappearing physical, neurological, and neurobehavioural symptoms. About one third of the women report that their own mothers were alcoholics, and quite a few of them have symptoms consistent with FASD. Much more research is needed on the multi-generational transmission of FASD.



2.6 Breaking the Cycle: An Essay in Three Voices

Originally Published:

Leslie, M., DeMarchi, G., Motz, M. (2007). Breaking the Cycle: An Essay in Three Voices, in Susan Boyd & Lenora Marcellus (Eds.). *With Child - Substance Use During Pregnancy: A Woman-Centred Approach* (pp. 91-104) Peterborough: Fernwood Publishing.

Introduction

The complex contexts of women's substance use while pregnant or mothering have been well documented (Boyd, 1999; Poole, 2000; Rutman et al., 2000; Tait, 2000; Poole and Isaac, 2001; Pepler et al., 2002; Jessup et al., 2003; United Nations Office on Drugs and Crime, 2004; Alberta Alcohol and Drug Abuse Commission, 2006). Recent findings based on a sample of 770 substance-using women and mothers attending BTC confirm high rates of maternal maltreatment and trauma beginning in early childhood, a significant history of substance use in the women's family of origin, discontinuities of relationships starting at an early age - including multiple caregivers and foster care placements - high rates of maternal psychological symptoms including depression, suicide attempts, and eating disorders, compromised health status, low levels of educational attainment, high rates of domestic violence, high rates of obstetrical losses, and loss of custody of children (Motz et al., 2006).

This paper examines the experiences of three substance-using women from infancy to motherhood and explores the pathway for the transmission of substance use across generations. Attachment and relational theory will be used to provide a context for understanding the impact of relationships in the lives of pregnant women and mothers with substance-use problems. The testimony of three mothers attending BTC will deepen our understanding of the intergenerational transmission of relationship disturbances that begin in early childhood and figure so prominently in the lives of substance-using women. Their stories also describe mechanisms for change through the development of relational capacity.

Background

Three evaluations (Moore et al., 1998; Pepler et al., 2002; Motz et al., 2006) have reported on the efficacy of both the comprehensive, integrated program model and of a pregnancy-outreach model. The evaluations have also reported on enhanced birth and perinatal outcomes for infants of substance-involved mothers engaged earlier in pregnancy,

Women's stories recount the intergenerational impacts of substance use on mothering



Attachment and relational theory are paramount in comprehensive interventions

The BTC model is based on a “two-generation” response

Relational images are based on past experiences and determine expectations about relationships

Relational images can repeat and re-enact in a mother’s relationship with her children

Corrective therapeutic relationships are therefore essential

on enhanced developmental outcomes for the children involved, on enhanced parenting confidence and competence, on enhanced treatment outcomes, and on decreased rates of separation of mother and child.

BTC uses a mother-child, relationship-based model to deliver a range of integrated programs to serve substance-using pregnant and/or parenting women and their young children. Consistent with attachment theory and research on intergenerational transmission of parenting skills, comprehensive interventions help mothers reflect on what they learned in their own early relationships and how that knowledge influences their interactions with their own children. The opportunity to deliver a “two-generation” response to relational problems involving substance use and trauma has created an opportunity to generate insight into the development of mother and child, as well as the development of the relationship between the two (Fraiberg et al., 1975).

Through our work in supporting substance-using pregnant women and mothers move from disconnection to connection, we have come to a deeper understanding of the experiences that have shaped the development of their “inner working models,” or “relational images.” Relational images are derived from past experiences with others and determine, to a large extent, our beliefs and expectations about relationships: who we are, how we believe others regard us, and what we can expect and deserve to receive in relationships (Miller and Stiver, 1997). Relational theory works to uncover the link between the individual’s “inner working model” and the outer workings of the broader culture.

The relational images mothers carry may trigger repetition and re-enactments in new relationships, including those with children. They are the processes through which intergenerational patterns of relating are transmitted (Fraiberg, 1980; Benoit and Parker, 1994). When women enter motherhood with unhealed emotional wounds, their injuries often trigger re-enactment of their relational images when they relate to their own children (Mejta and Lavin, 1996). Corrective therapeutic relationships with mothers that introduce them to experiences of safety, acceptance, reliability, consistency, structure, and caring have been demonstrated (Lieberman and Zeanah, 1999). For substance-using women, participating in a growth-promoting “therapeutic” relationship that includes respect, mutuality and empathy can facilitate an enhanced capacity for relating within the mother-child rela-



tionship. In this way, mothers are supported to create different inner working models or relational images for their infants than were created for them, and to break the cycle of intergenerational transmission of relational disturbances and related problems, including substance abuse.

Three Voices

In-depth, semi-structured interviews were conducted with three mothers attending BTC to deepen our understanding of the qualitative aspects of demographic data that indicated long histories of maltreatment, trauma, domestic violence, psychological symptoms, disrupted family relationships, and loss of child custody (Motz et al., 2006). The interviews were designed to elicit information regarding the mothers' early childhood and childhood experiences, the onset of their substance abuse, pregnancy and substance abuse, factors that made a difference to them in their healing and recovery, and their experiences of mothering. An independent female consultant not known to the mothers, and not associated with BTC, conducted the interviews. The interviews ranged in length from one to two-and-a half hours, and were audio and video taped. Brief histories of the three mothers interviewed are provided below:

Hannah is a forty-two-year-old woman who is in recovery from a twenty-year history of crack-cocaine and alcohol use. She has been abstinent for three years and continues to participate in addiction treatment, mental-health, and parent-child counselling. Hannah's first child was taken into foster care at birth and was adopted; she has parented her second child, now three years old, since birth.

Maria is a twenty-seven-year-old woman who grew up in Eastern Canada and spent much of her teenage years in group homes and her early adulthood on the streets. She is in recovery from a twelve-year history of crack-cocaine and alcohol use. She has been abstinent for two years and continues to participate in addiction treatment. Her son is in child care and Maria works full-time.

Barbara is a thirty-six-year-old Aboriginal woman who grew up on reserve in rural Northern Ontario. She is in recovery from a twelve-year history of poly-substance use and has been abstinent for six years. Currently, Barbara participates in addiction and parent counselling. Barbara and her common-law partner are parenting their two youngest children. Barbara has two older children whom she was unable to parent due to her substance abuse, but she is now beginning to

Three women were interviewed in-depth to give voice both to the sociodemographics of BTC women and to the aspects of successful support



*Early childhood was
marked by disconnection,
violence, and confusion*

reconnect and form relationships with them.

Growing Up: The Roots of Disconnection

Each mother was asked to talk about her early childhood experiences, about her relationships with her parents and other caregivers, and to describe memories of her feelings as a young child growing up in her home. Their memories of early childhood were threaded with prevalent themes of disconnection, displacement, discontinuity, isolation, violence, loss, fear, nervousness, vigilance, unpredictability, instability, confusion, abuse, and hurt.

Barbara: *I don't even know how to begin there. I grew up with alcoholic parents, and every time they would drink, which was nearly all the time, I would feel nervous, wondering how long it was going to last this time before something went bad... I was scared most of the time and I didn't know what to do. All I knew is that I was afraid, and I thought that was life, I guess... Because I grew up on the reserve, in a village, you know, and that's all that happened there, was drinking and I didn't know nothing else, you know, until I started going to foster homes and come back and stuff like that. So I don't know, I know I felt scared most of the time and confused [about] why they took me away and brought me back and took me again and that was my life I guess, you know. I was scared most of the time and I didn't know what to do... I couldn't take care of myself, you know, I couldn't get up in the morning and go to school and I just had to do whatever my siblings [were] doing, you know, following them and I was, I don't know, scared. That's the only word I can think of, "scared."*

Hannah: *Growing up in a family that used substances was very dysfunctional. It was very unpredictable, there was no consistency at all. I was ashamed to bring anybody to my home, and there was no trust or respect for my parents. I never knew what kind of mood they would be in, couldn't believe what they were telling me to be true, and there was a lot of hurt and pain... I turned inward, I trusted no one, I had no role model, anyone to look up to want to be like, and I felt a void that there was something missing. There wasn't a lot of affection, or encouragement, or positive input, so I was constantly trying to fill that void on my own, and from a very early age I remember turning to food and going into fantasy. I was pretty much isolated into myself. I didn't have a lot of respect for adults - I saw a lot of them drunk, and abusing me and hurting me - and I was afraid of adults. I didn't know how to identify my feelings. I didn't feel good about myself, I didn't get a lot of positive feedback that you can do whatever*



you want to, you can be whatever you want to be. I got a lot of negative words like “don’t be stupid” and “shut up” and awful stuff that sticks with you. And I don’t remember a lot of good times as a child ... I remember feeling that I was a burden and that I was in the way and that I was just a problem. A lot of the negative stuff I remember as a child - violence in the home and arguing between my mom and dad and fights between drunken uncles and neighbours. First my mother left - she went to live with a boyfriend and left us with my father, and then she came back and kicked out my father... My mother... moved us around a lot, and then I got sent to live with an aunt and uncle here, and an aunt and uncle in Winnipeg, and in Scarborough and in Mississauga, and in different schools and different neighbourhoods. I just felt like I didn’t belong anywhere and I wasn’t wanted. I just felt like everything was temporary, there [were] no roots, there was no stability, and it was an awful feeling of not knowing how long you’d be staying in one place. And why bother making friends when you’d just have to say goodbye to them anyways?

Maria: My mom was the primary user in my family, and she was kind of an unstrung person. So I can tell you that, being in and out of my household with my mom and then in foster care and then not... One of the things that really strikes me about being around my mom while she was using, and just the family environment, is that I was really witness to lots of bad decisions, and I know I learned from my mom things that I try not to use now, things like lying to get my own way, and just the manipulation of situations to really gain something personal... When I was around six or seven years old, my older sister and I were put in foster care. My mom was very physically abusive - I can see now that that really did have a lot to do with the cycle of addiction within our family unit. So both my sister and I spent some time in foster care, and then at home, and then with other family members, and then at home. Moving back and forth from home to foster care, the best word I can really put on that right now is the feeling of being displaced. It was a terrible feeling to be taken away from everything that was familiar, even if it was bad. It was kind of a scary thing. It was very scary being without my sister, because at several points we were separated, so that was a pretty scary thing. I think, had I stayed with my mom, terrible things could have happened. So I can see how maybe that whole portion of my life kind of saved me some troubles that I didn’t need. I was in a group home for almost three years, and during that time I was able to form a different relationship with my mom, because I knew I wasn’t going



Hyperarousal and negative mood states result from unresolved and chronic stress in children

Most children of substance-involved mothers exhibit disorganized attachment

Relational theory also posits the pathways by which women become substance-involved

home at that point. So I came to understand my own boundaries for that, and it made it easier for me to understand - away from the situation - what was actually happening in my home. Because, for a long time, even though I saw certain patterns, I didn't understand what caused them, and I think being in that group home was really a good experience for me because it taught me a lot about different cycles and different kinds of relationships people can have with their families.

Unresolved and chronic stress in young children, such as that described by the mothers above, affects brain development and can result in a chronic state of hyper-arousal and reactions such as anxiety, depression, withdrawal, helplessness, and dissociation (Perry, 2001). Repeated stress during critical periods in early life reduces one's ability to moderate response to stress later in life (Bradley, 2000). The experience of long periods of unresolved stress, maltreatment, and unpredictability in early childhood, as described by these mothers, predisposes a disorganized pattern of attachment.

Most children of substance-using women demonstrate disorganized attachment (Espinosa et al., 2001). This pattern of attachment is linked to inaccurate, non-contingent, and contradictory responses by the parent, uncertainty about how a parent will react, and fear of the parent (Lyons-Ruth et al., 1987). Infants and children classified as disorganized lack a coherent strategy for dealing with distress. Their dilemma is that their source of safety and comfort is also their source of fear and distress. Disorganized attachment is linked to poor outcomes, including difficulties managing emotional responses, impulsivity, poor self-esteem, impaired empathy, vulnerability to stress, and regulatory problems (Main and Hesse, 1990). It has been suggested that disorganized attachment, in turn, may be a path to the use of external regulators of emotion, such as drugs and alcohol, sexual behaviour, and eating disorders (Hunter & Maunder, 2001).

Pathways to Substance Abuse

Relational theory proposes two paths that lead women to drugs and alcohol: to facilitate connection in response to a natural desire for connection and/or to cope with relational disruptions and violations, including traumatic experiences (Hartling, 2004). In the mothers' descriptions of their experiences, feelings, and relationships during their adolescence, substance use appears to have been entangled with efforts to find authentic relationships to fulfill the desire for



connection. They describe modeling observed behaviour - parental and cultural - as a way of "belonging," and choosing friends whose "drinking and drugging" echoed relationships at home. They also describe their substance use as a way of coping with their enduring feelings of fear, disconnection, and isolation stemming from the traumatic experiences they described in their early childhood and which, as Barbara describes, continued into adulthood. Maria describes the development of maladaptive ways of coping - manipulation, lying, and substance use - as a "re-enactment" of her mother's behaviour and coping style ("following in my mother's footsteps"). Paradoxically, substance use accelerated the progression of disconnection for these mothers - from their own emotions, from authentic relationships, and from their culture - as their primary relationships became those surrounding substance use (Hartling, 2004). For Barbara, the commencement of childbearing at this time resulted in a tension between her relationship with substances and her relationship with her children, which led to her loss of, and disconnection from, her older children.

Hannah: *As I became a teenager, I was still very full of fear, and felt like I didn't belong, that I wasn't the same as the other children, that I was very different and I believe I chose friends, companions to associate with, that did the things that I saw going on in my family, which was drinking and drugging, and that's how I chose my friends at a young age. I didn't have a lot of responsibility or any pressure to do well in school. If I did really well, it didn't matter, if I did really bad, it didn't matter, so I felt like no one cared, so I didn't care, and that's what I carried through my teenage years. I didn't care much about anything, and I didn't have any goals or interest in anything in particular. I just wanted to get drunk and stoned at a very early age. My first drunk, I remember, I was bartending at one of my parents' neighbourhood parties when I was about eleven years old. It was the very first real, like, throwing-up drunk and blacking-out drunk that I remember. I know I was drunk earlier than that. I used to take the beer bottles off the table and drink when my dad had guys over to watch hockey and stuff and, you know, they used to laugh because I'd be staggering around, and, you know, they kind of thought that was cute to see a little kid all drunk.*

Barbara: *Growing up, I thought I had to do what my parents were doing. I thought I had to drink as soon as I got old enough, you know, and I thought I had to do what my parents did, and my culture, because all Natives up there drink, and I thought that that was what I was supposed to do. I guess I*

Often, substance use is a way of coping with trauma and isolation ...

... or is a "re-enactment" of a parent's behaviour and coping style



*Pregnancy is a profound
turning point*

started drinking when I was about twelve, not getting drunk or anything. I just started to taste it, I guess, from my cousins - they were already fooling around with boys and stuff. I guess I wanted to try that too, and so I started drinking and hanging around with them. And then I started having babies when I was seventeen, and then I came to the city at nineteen. I parented two of the children for five years - one for five years and then the other one. I couldn't look after him because [of] the way I was living, drinking, and then I had to give [my son] to my aunt and she took care of him, and I brought the other one here to the city. And then the child-welfare took her and then I lost her for good. And I kept drinking, I started doing drugs, I started trying some new stuff. Some I tried only once, but other stuff I tried more than once, and then I started having babies and getting raped in the city, and I thought that this was all supposed to happen because I was Native and I saw Native people in the city the same way as me and I thought I was supposed to be like that.

Maria: *All of the things I witnessed at home really affected me in my early teenage years. I did a lot of lying because I knew that would work for me if I needed something, or if I wanted anything, whatever. I could manipulate the situation and lie and whatever, to get my own way. That went really bad for me, it went really bad ... and just making really bad life decisions. And at that point I became addicted myself. And so, even though I kind of had a realization that I was following in my mom's footsteps, I wasn't really able to do anything about it, and my own cycle of addiction kind of took over at that point.*

Turning Points: Substance Abuse, Pregnancy, and Opportunity

Pregnancy has often been described as a "window of opportunity" for women to decrease or cease their substance use (Daley et al., 1998; Klee et al., 2002), and it was clearly a profound turning point for these three mothers. All three describe a primary desire to mother as their motivation for making changes during their pregnancies. For Barbara, this also related to not being prepared to lose any more children due to her substance use and related issues. For Maria, her motivation was related to the recognition that if she did not make changes around her substance use, what would happen would be even worse than what had happened between her mother and herself, because she could lose her son altogether.

The mothers recall that their motivation was met with

access to a “helping” system that was able to support them in their intentions to change. Enhanced connections or relationships among service providers offer an important context for growth-promoting relationships between substance-using pregnant women and the helping system. In caring for substance-using mothers and their children, extensive evidence confirms the efficacy of access to comprehensive, integrated, gender-specific models of service delivered through a single access point. These service models embrace pregnancy-outreach programs, timely access to care, non-judgemental and respectful approaches, and the acceptance of harm-reduction goals (McMurtrie et al., 1999; Roberts et al., 2000; Health Canada, 2003; United Nations Office on Drugs and Crime, 2004).

Barbara: *All my children were in child welfare, and when I lost the fifth one, that's when I decided that was enough and I got sober and got clean, and now it's going on six years now, and I thought that I could have no more babies after the fifth one. And I got pregnant again in 2001 and [my son] was born, and then another one. I went into recovery because I had enough of losing children ... I heard about BTC and I decided I'm going to come here and try it. I came here ... thinking maybe it's going to be another failure, but I came anyway and that's when I met [my counsellor] and I still kept coming here and that's when I started to take things really serious, you know. Even though I didn't have my two babies yet, I knew there's got to be another way for me to go on ... because I needed to get better, not just for my children but for me ... and to show my children that there's better stuff than thinking that you have to be like this. You don't have to be, and that's why I'm here.*

Hannah: *I was pregnant and on the street. I was using crack-cocaine and alcohol, and I was not even able to keep curfew at the shelters that I was staying in. I got myself to a detox, and from there the pregnancy-outreach worker that was involved with BTC got me to the hospital. They admitted me for about a week, and then I went back into detox. They kept me there until I went into treatment. I went through treatment, and I went into a transition house. Then I started coming to BTC at least twice or three times a week and got the home visits and counselling and groups... and they helped with food vouchers, and... just how to cook again and how to, you know, domesticate. And all the questions I had about the pregnancy and how to breastfeed, and you know, what to do... how to be a mom.*

*Service relationships
provide the context for
growth-promoting
relationships for women*

*Extensive research evidence
confirms better practices*



*Counsellor characteristics
and the relationships
mothers form with
providers are rated as
even more important
than access to care*

Maria: *I was seven-and-a-half months pregnant, I think, when I got out of jail, and I was terrified that I would lose [my son], and not have a place to live. And I knew at that point being pregnant was a big thing. I really need to change my life now, because if I don't... what will happen will be worse than what happened with my mom and I, because [my son] won't even be here with me.*

My older sister was another huge help. I mean, at that point in my life, my thinking patterns weren't really very clear. I wasn't very good at making good decisions, and I didn't know who was the first person to go to, what the steps were to try to be clean. My sister spoke to some people that she knows, and found me a treatment centre, which was exactly what I needed. [My son] was in care for three-and-a-half or four months, which was pretty terrible, but that whole situation ended up with where we are now, which is amazing. We are together and we have our own home and we are both doing good things.

Reconnection: Caring, Hope, and Empowerment

Even more important than access to care was the nature of the relationships the mothers experienced with providers or counsellors they encountered in the “helping” system. They identified key qualities of counsellors or programs that formed the foundation of the growth-promoting relationships they were able to develop. Growth fostering relationships - characterized by mutual empathy, mutual empowerment, and mutuality - can enhance the resistance and resilience to the adversities that often precipitate the development of substance use-related problems or addictions (Spencer, 2000). If women's substance use is viewed as a progression of disconnection leading to isolation and alienation from self and others, then the experience of relationships that include key qualities identified by the mothers - authenticity, caring, mutual empathy, acceptance, empowerment, and hope - can be a transforming experience that facilitates enhanced capacity for relating to self, to others, and to one's culture. “Inner working models” and “relational images” begin to change through reconnection.

Maria: *The very first person I really spoke to on a serious level about recovery was my lawyer, and I was blessed with somebody who really cared. And he really... I can't really repeat to you what he said to me, but I just got this feeling from him that he really did care about whether or not things changed in my life.*



Barbara: They started telling me that I was a good person, that we didn't have to be this colour, or to be this to be good. We had to find it in ourselves, and talking about it and sharing. That's what they gave me - they gave me hope. They gave me a different outlook, the way they talked to me... Just like they knew where I was coming from. They didn't have to look at my colour. They talked from, I don't know where, themselves, I guess. They were real, I guess.

Hannah: The main message was that they cared about me and my child, and that, no matter what, they would help me and... you know they seemed to like me even though I didn't like myself. They kind of loved me back to life again. And just that I could do it, that I could do it, that I was able and that... even though I had kind of given up on myself, that there was still hope and that it's possible and that I could do it. Basically, that's the main message that they gave me. They gave me hope.

Mothering: Looking Backward, Moving Forward

When women enter motherhood with unhealed emotional wounds, their injuries often resurface when they relate to their own children (Mejta and Lavin, 1996). Mothers who use substances need help, not only with their substance use, but also to understand the effects of their past relationships, both negative and positive, on their interactions and relationships with their children.

Maria describes an emerging understanding of, and empathy with, her mother before she died. She comes to an understanding of the underlying depression that contributed to her mother's substance use, and the lack of personal and professional resources available to her. She recalls that she was able to "understand myself in regard to her," to "see and feel how it must have been a struggle for her," and thereby resolve some of the anger that had hindered her in the development of healthy connections with others. For Barbara, reconnection occurs at both the cultural as well as the relational level. Her previously internalized cultural shame and humiliation was transformed by a greater understanding and pride in her culture. All the mothers expressed pride in the ways - small and large - that their mothering differed from the ways they were mothered. In contrast to their own childhoods, they describe their relationships with their children as honest, consistent, reliable, responsive, structured, patient, trusting, playful, and relationally authentic - all qualities of relationships that result in the development of markedly different "inner

Substance-involved mothers need support to understand effects of past relationships

Resolving past relationships promotes the growth of healthy connections with others

The women express pride in their ability to relate in a different way with their own children



working models" or "relational images" than they formed growing up.

Maria: *I can't say that I reconciled any old feelings with my mom [before she died], but in that week I learned more about my mom than I probably ever have in my life. And I'm older now and I can see... how little joy was in my mom's life... and she didn't have any friends and... just very much alone and the depression... But I do think I came to a better understanding, and I lost a lot of anger toward my mom because I could see how her lack of resources, and her depression and not understanding it - and not understanding what could be done with it - really contributed to the person she had been, and had become, which was very sad to me. Just seeing her and understanding myself in regard to her really helped put a damper on the anger, which has hindered me in my whole life in relationships with people.*

When I look back on my relationship with my mother, I can see and I can feel how it must have been a struggle for her to try and deal with my sister and I, and deal with herself and her addictions, and her relationships with other people, which were not healthy. I think one of the biggest reasons my mom had a problem with drugs and alcohol was that she was very depressed and because nobody really knew how to handle it. They kind of just let her be with it on her own. I can see in my mom's life that there was a lack of resources. Like where I have BTC, and I ended up with some really good people in my life, like my lawyer, and the children's aid worker, and doctors ... I can't even name the list of people. But my mom didn't have those people. So what she did have was drugs and alcohol.

I always kind of judged how I would be as a parent, even before [my son] came, to what my mother was like with me when I was young. And that kind of scared me because ... I couldn't really understand for myself how I was going to change that. And recovery really showed me that, when you start to change patterns in your life, it changes who you are, and who you care to be, and who you are willing to be.

A few days ago, my sister and I were looking through old photo albums and... there were a few pictures there where I was not smiling and it was obvious that I had probably just cried forever. And I was learning some things about how life was in our household when we were little children. And I'm so thankful my son doesn't have to experience the amount of chaos... and the bad feelings and... nobody paying attention



to you, and not listening to you, and not playing with you, and not letting you express yourself or do certain things that other children would be able to do and other children would be able to say. Thank God that my son doesn't have to deal with those feelings of not understanding where he fits, and being unhappy... at such a young age. He's so happy! He makes other people happy too.

Hannah: I never could have dreamed that I would be a good mom and that I would like being a mom, and that a child would be such a beautiful wonderful gift and a joy. I'm able to listen to her needs and her wants and her cues, and I'm able to be consistent and I'm able to be honest with her and keep all my promises, keep my word, be respectable. I can provide a routine for her. I'm able to attend different kinds of fun-play classes, and parenting classes, and infant therapeutic massage, and rhyme-and-relax, and Mother Goose, and the importance of reading to her and the patience that I have that I would never have if I was using any kind of substance. The patience is so important. She trusts me and she knows I'm always there for her, and it's not going to be a question in her mind of what's mommy going to be like today when she wakes up - you know, the things that I went through like trying to wake mommy up... She doesn't have to worry about any of that. I'm aware of all of her needs.

Barbara: I grew up not knowing that I could change, be a better person. Instead of believing that, I had to get beat up, I had to get raped, I had to get drunk, I had to be no good. Because that's how I grew up knowing, because I found my relatives, my parents, my aunts, uncles - you know, all like that - and I never saw one of them get better, you know. I knew there was something more to this when I came to the city, and then I started seeing these pow-wows and these different ... like my culture, living differently you know, they're smudging and all this. And I wanted that but I was so negative towards Native people because of the way I grew up. I didn't want [any] part of it because that's all I knew, but now I know there's more to that than... people laying on the sidewalk. We're doing the same thing as the white people or what the other cultures are doing. We're just doing it different... we have our dances, we have our smudging, we have our circles. It's just like the groups they have [at BTC], exactly the same thing, you know, and I learned this all here.

I never was in a home where there was laughter. As a little girl, I didn't have a chance to play, or just run around and play with my brothers or friends from school. That was something



The opportunity to experience caring, hopeful, and empowering relationships were transformative for the women and enabled authentic relationships with their children

Relational images may act as the mechanism for on-going relational disturbances and substance abuse

I wanted to do. I wanted to run around and play, but instead I had to go out and get water in the bush, chop wood and make fire, do dishes, wash clothes on the scrubbing board, and all this stuff. I learned through the "Learning Through Play" group [at BTC] to play with my children. My children's future looks very different from mine, exactly the opposite from mine. There's laughter in the home, there's playing, there's fooling around, and just shouting, like happy shouting, not getting-mad shouting, no angry voice, you know, just laughter, and crying of course - we laugh so hard we end up crying, and that's what healing is all about for us in our family.

I give to my [older] children. I give them love, I give them honesty, I give them what real life is about, and I share with them what I went through when they come to my house saying what they're going through. What I give to my two youngest children is I give them myself.

Conclusion

The testimony of the three mothers interviewed at BTC enhances our understanding of the relational experiences of substance-using mothers across the lifespan from infancy to motherhood, and indicates a pathway for the transmission of substance use across generations. This qualitative information enriches quantitative data that indicates high rates of maternal maltreatment and trauma beginning in early childhood, significant histories of substance use in families of origin, discontinuities of relationships starting at an early age, multiple caregivers and foster-care placements, and high rates of domestic violence, children taken into custody, obstetrical losses, and maternal psychological symptoms, including depression (Motz et al., 2006).

Attachment and relational theories have been used to provide a context for the understanding of the impact of relationships in the lives of pregnant women and mothers with substance-use problems. In particular, the use of a lifespan perspective provided us with an opportunity to trace the roots of disconnection of these women in the early childhood, the progression of disconnection with the beginning of their substance use problems, the move to reconnection stimulated by pregnancy and motherhood, and the development of a capacity for different relationships with their children than they had themselves experienced. The opportunity to experience transforming relationships that are caring, hopeful, and empowering facilitated reconnection, and allow for the development of authentic relationships with others - particularly their children - which will result in markedly



different “relational images.”

Relational images or “inner working models” are proposed as a possible mechanism for the intergenerational transmission of relational disturbance and related problems, including substance use. Interventions for mothers and children who are substance-involved must, therefore, be delivered through comprehensive approaches, using relationship-based, maternal-child models, and delivered as a “two-generation” response that generates insights and progress in the development of mother and child, as well as the development of the relationship between the two.

*Relationship-based,
maternal child
interventions are
necessary*



SUMMARY of Section 2

This Section has drawn on quantitative and qualitative data to provide a deeper understanding of the lives of substance-involved mothers and children who attend BTC.

The severe histories of maltreatment and trauma reported by BTC mothers provide a context for understanding the use of substances by women and mothers at BTC, and informs the development of approaches and services designed to support women, mothers and children who are substance-involved.

This information leads to a number of program implications: 1) it confirms the importance of reducing barriers to service for pregnant and parenting women using substances, and highlights the importance of harm reduction approaches which do not require abstinence for admission to service; 2) it highlights the importance of an integrated model of care that allows for the careful assessment of the impact of maternal substance use on parenting capacity, in partnership with child welfare; 3) it highlights the need for intensive intervention and treatment for the mother and infant, including addiction treatment, parenting intervention, child developmental monitoring and support, and health/medical care.

Consistent with attachment theory and research on intergenerational transmission of parenting skills, comprehensive interventions help mothers reflect on what they learned in their own early relationships and how that knowledge influences their interactions with their own children. The opportunity to deliver a “two-generation” response to relational problems involving substance use and trauma has created an opportunity to generate insight into the development of mother and child, as well as the development of the relationship between the two.

Higher rates of undiagnosed FASD among BTC mothers have been hypothesized, and adaptations to BTC addictions and parenting services have been implemented. Although a small number of BTC mothers have been diagnosed through the FASD Diagnostic Clinic at BTC, a greater capacity for assessment/diagnosis of BTC mothers is required. This also suggests that further attention must be given to the possibility that undiagnosed FASD may be a barrier to engagement in services. Programs serving women and children who are substance-involved need to adapt, develop and assess engagement and treatment approaches that may be more effective with women with FASD.



Section 3: Theory Informing Practice: Theoretical Underpinnings for a Maternal-Child Approach

Introduction

The previous Section provided a deeper understanding of the complex contexts within which pregnant women and mothers use substances. In particular, the prevalence of maltreatment and trauma in the relationships of substance-involved women (commencing in early childhood) was highlighted as critical to understanding the circumstances which bring women to substance use, and which make it difficult for them to change their substance use patterns, despite their best intentions. The process of resolution and healing for women and mothers experiencing substance use problems and trauma must necessarily take place within the context of relationships.

The papers in Section 3 below build on this information and describe the application of relationship-based theoretical frameworks and approaches to promote the resolution of substance use and related problems, and to develop relational capacity. The transtheoretical stages of change model, motivational counselling approaches, relational theory and attachment theory all have a relationship-based foundation, and support the maternal-child framework within which all programs and services are delivered at BTC.

Implicit in the application of these frameworks is the adoption of a harm reduction approach. A harm reduction approach is critical to engaging pregnant women or mothers in treatment, to addressing their shame and guilt around substance use, and to understanding women's use in the context of the other complex and interrelated factors in their lives, including trauma, social isolation, domestic violence, poverty, and housing instability. A harm reduction approach is necessary for the application of motivational interviewing strategies within the stages of change, and to relational and attachment-based approaches to treatment for women. Harm reduction calls for a shift away from stigma, guilt, confrontation and shame, towards a strengths-based, respectful, and non-judgemental approach that accommodates women's goals for reduced use rather than immediate abstinence.

In the application of a maternal-child approach, harm reduction also includes attention to the prevention or remedying of harms of maternal substance use experienced by children. This includes careful attention to the impact of substance use on maternal functioning and mothering behaviours, on the individual needs of the infant or child, and on mothers' access to supportive resources, relationships and environments that foster the growth of both the mother and child in the context of safety, health and well-being.



3.1 Stage-based Approaches and Their Relationship to Motivational Interviewing

Adapted from the Original Publications:

- AWARE and BTC. (2000). *The SMART Guide: Motivational Approaches Within the Stages of Change for Pregnancy Women Who Use Alcohol: A Training Manual for Service Providers*. Kingston: AWARE Press
- Leslie, M. & Roberts G. (2004). *Nurturing Change: Working Effectively with High Risk Women and Affected Children to Prevent and Reduce Harms Associated with FASD*. Published by the Canadian Mothercraft Society and the Canadian Centre on Substance Abuse.

Respectful and collaborative relationships between the woman and service provider are essential for change

See The SMART Guide: Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Alcohol: A Training Manual for Service Providers
Go to www.aware.on.ca/resources/resources-service-providers

The ability to convey an understanding of the context of a woman's life is a key attribute of empathic service provision

Services and programs need to be as complex and varied as the circumstances of women's lives

The approach taken by the service provider is one of the keys to whether a woman will change. The ability to engage the woman in a supportive relationship can be just as important as the woman's personal characteristics and behaviour. Examining personal strengths and potential biases help to ensure that a respectful and collaborative relationship will be developed with substance-involved pregnant and parenting women.

Understanding women's alcohol and other substance use

The reasons why pregnant and parenting women use substances are varied and interconnected. For many women, substance use helps them contend with difficult life circumstances such as a history of trauma (violence or sexual abuse), current domestic violence, poverty, or feelings of guilt, shame, and inadequacy. Substance use may be a regular part of their environment - their partners, friends, and family may all be substance users. Some women may also be physically dependent on alcohol or other drugs, which makes abstinence more difficult, especially within the short time frame of a pregnancy. Service providers need to address a pregnant and parenting woman's use of alcohol and other drugs. However, as much as possible, the range of issues that contribute to her substance use must also be addressed. Service providers must try to convey to women an understanding of the context of their lives. Service providers need to also try to communicate empathy for the difficult circumstances in which many women live. Mutually determined, small, achievable goals can lead to positive change for many substance-involved pregnant and parenting women.

Pregnant and parenting women who use substances "do not do so because they are unaware of the public health message, or because they are indifferent to the potential harm to their fetuses. Rather, the contributing factors to substance misuse by pregnant women are complex and varied, and therefore call for services and programs which reflect this reality" (Tait, 2000).

There are a variety of circumstances that can impact on the lives of substance-involved pregnant and parenting women, including increased risk of depression, high levels of stress, low levels of social support, greater risk of domestic violence and histories of trauma, a greater likelihood of living in poverty, and partners, friends, and family who are substance users.

1. Understanding Consequences

Substance-involved pregnant and parenting women report that the biggest barriers to getting help are guilt, fear of being judged, and fear of losing their children. A woman might fear disclosing her substance use because she fears the involvement of from child welfare services or having a child removed from her care. These barriers can lead to the woman providing "half-truths" to service providers and physicians, avoidance of prenatal care, and avoidance of addiction treatment. The consequences of these behaviours often result in the woman's worst fear; that is, having her children removed from her care.

She might feel guilt, thinking her substance use has harmed herself and her infant. Guilt can present as defensiveness, hostility, or resistance. It is very important not to increase her guilt, because guilt can lead to increased substance use, especially during pregnancy.

She might fear for her physical safety if she reaches out for help with an alcohol or other drug problem. This is a very realistic fear, as women who live with a violent partner are most at risk of injury or death immediately after they leave the situation.

She may be overwhelmed by feelings of worthlessness and inadequacy, which can produce inertia or low self-efficacy (i.e., she does not believe she is capable of changing her substance use).

She may be using substances as a coping mechanism for dealing with trauma issues. When substances are removed from her life, the woman's underlying issues, such as trauma, abuse, domestic violence, depression, or anxiety, might surface - so she feels overwhelmed or discouraged and continues to use substances to cope.

2. Supportive Steps

Explore the function substance use serves in her life. Be prepared to address her needs if she quits substance use. For example, she might use substances to cope with underlying

See "Nurturing Change: Working Effectively with High Risk Women and Affected Children to Prevent and Reduce Harms Associated with FASD".

www.mothercraft.ca

Barriers to accessing services are guilt, fear of being judged, and fear of losing children

Guilt may manifest as resistance

Abusive domestic lives may prevent access

Feelings of inadequacy can create inertia

Substance use is often used to self-medicate unresolved trauma

Find supports for underlying issues



Substance use has a positive function

Harm reduction is a series of small steps to change use of substances ...

... or other high risk behaviours

Many factors contribute to negative birth outcomes

Help her to make a connection with her infant

Consider the role of trauma



depression. So, before she quits using substances, supports must be in place to help with that.

- **Acknowledge the positive role substance use can play** in the woman's life, such as stress management, support in social interactions, and self-medication of trauma or abuse. Also, this will show the woman you are open and non-judgemental. It will also help her begin to examine her substance use.
- **Emphasize the benefits of any reduction in substance use.** For example, for pregnant women, it's never too late in her pregnancy to make small changes in her substance use. Provide her with ideas about how to make changes or shifts in her use.
- **Encourage any and all small changes** that reduce high-risk behaviours. Feel encouraged by small changes, not hopeless and discouraged in the absence of complete change.
- **Recognize the context of a pregnant woman's life.** Many pregnant women have stressful lives. It's not only substance use that affects the health of pregnant women and their children. Poverty, lack of food security, violence, and lack of opportunity and support all contribute to negative birth outcomes. If we communicate our understanding of her life, she is more likely to respond favourably to us.
- **Talk about both the mother and the baby.** Talk about both substance use *and* pregnancy concerns. Let her know that both she and the baby are important. But help her make a connection to her infant. Substance use can cause her to detach from the baby. A self-protective thought process takes over. She comes to believe that her substance use affects only her own health, not the baby's.
- **Avoid blame.** Many pregnant women who use substances *intend* to change, but lack the necessary skills. Some service providers might misread this as lack of intent. Instead, we need to work with the woman to find the necessary skills.
- **Be sensitive to trauma issues.** Many women with substance use problems have histories of violence and sexual or physical abuse, especially those women who find

it difficult to quit their substance use.

- **Explore the woman's values about change.** We cannot assume a pregnant woman's values about the benefits of change are the same as ours. We might believe change is positive and necessary, especially because of the baby. We must not impose our reasons for change on her.
- **Acknowledge the social context of substance use.** Family, friends, and community norms all have an impact on the way a pregnant woman uses substances. If she changes her substance use, her whole life can potentially be disrupted. It's normal for people to fear change and expect life to be worse afterwards.

There are a variety of reasons why pregnant and parenting women may feel unable to make changes in their substance use behaviour. Many live in very difficult life circumstances with little or no support. The consequences of change can be profound and not necessarily positive. Empathic service providers can take small steps that will have a significant impact on producing change.

Motivational Counselling Strategies

Motivational counselling has been shown to be very effective when dealing with anyone with a substance use problem, including pregnant and parenting women. The technique places the onus for developing the motivation for change equally upon the service provider and the woman herself.

There are a variety of specific strategies that can be used within the framework. The key is understanding three primary concepts:

1. Empathy, not guilt or fear, will provide the appropriate atmosphere in which change will occur;
2. Self-efficacy is the foundation upon which change rests; and
3. Resistance to change is often a creation of the interaction between counsellor and client.

Within motivational strategies, harm reduction (or small steps to change) can be seen as a legitimate option wherein women can be encouraged to make incremental changes that will eventually produce lasting change.

Motivational strategies have been developed primarily by Miller and Rollnick. Within this framework, motivation is not

Social relationships have an enormous impact on substance use

The relationship between counsellor and the woman is critical

Empathy and the development of self-efficacy will create change

Resistance can be a product of the relationship between the counsellor and the woman



Centre for Substance Abuse Treatment. (1999). Enhancing Motivation for Change in Substance Abuse Treatment: Treatment Improvement Protocol (TIP) Series 35. Rockville, MD: US Department of Health and Human Services.

Reflective listening

Gentle strategies



seen as a behaviour trait or personality characteristic of the individual. **Instead, motivation is seen as a product of the interaction between client and service provider.**

Motivational approaches:

- **are interactive** and based on the belief that change takes place within the relationship between the service provider and the woman.
- **are centred on the pregnant woman and are empathic.** The service provider will always avoid shame, blame, scare tactics, or guilt and instead focus on communicating support and understanding.
- **place responsibility for change** on the service provider and the woman.
- **avoid labels**, such as alcoholic or drug addict. Labels can be stigmatizing, shaming, or prejudicial, and, in fact, may not realistically refer to the woman's situation. It is always better to refer to substance use by women or substance-involved women.
- **reduce resistance** by meeting resistance with reflection rather than confrontation.
- **foster a commitment to change** and brings the woman to greater awareness of, and responsibility for, her substance use.
- **emphasize personal choice** regarding substance use, and personal control over decisions, by providing a range of possible alternatives for change.
- **negotiate** goals between the woman and the service provider. A range of options for change is presented to allow her to select the best options for herself.
- **remove barriers to change** by providing child care, transportation, and any other accessibility issues a woman might face.
- **accept relapse** as part of the process of change.

There are several basic principles involved in motivational counselling:

1. **Express empathy** through reflective listening. Use gentle persuasion but understand that the final responsibility for change is up to the woman. Communicate respect for and acceptance of the woman's feelings.
2. **Avoid argument.** Direct confrontation can turn into a power struggle. Instead, work together to negotiate a change plan. Be non-judgemental and supportive. Listen rather than tell.

- 3. Roll with resistance.** Don't oppose it. This leads to argument or defensiveness. Adjust to resistance by changing your strategies. There are many different types of resistance that are sometimes easy to identify, but more difficult to identify at other times. Pregnant women who are resistant might argue, interrupt, deny, or ignore.

*Change your strategies
when resistance occurs*

Try to view resistance as an opportunity - to keep the woman involved, to engage her in the process of change. Resistance is counter-productive. It causes people to feel angry, stop listening, or drop out.

*View resistance as an
opportunity*

Resistance will decrease if the service provider is able to:

- express empathy
- remain non-judgemental and respectful
- encourage the woman to talk and stay involved with you
- emphasize her personal choice and control

- 4. Develop discrepancy** between the woman's goals and her current behaviour. Her ability to recognize this contradiction is a powerful motivator to change. Reflect the contradiction between her goals for the future and her current behaviour. Help her recognize the conflict between where she is now and where she hopes to be.

*Contrast future goals
with current behaviour*

- 5. Support self-efficacy.** Focus on the woman's strengths. Support the hope and optimism needed to make change. Encourage her belief in her ability to change. Encourage any small reduction in high-risk behaviours, such as substance use. Help her take credit for those changes. Emphasize and reinforce any small steps the woman is able to make towards change.

*Help her take credit for
every small step to change*

- 6. Use gentle strategies.** Maintain an empathic and non-judgemental approach to the woman's perception of her situation. Keep her involved with you. Use these strategies:

*Empathy creates the
helping atmosphere*

- express concern
- establish a trusting relationship
- ask permission
- keep the door open

Ask questions about her life in a direct but non-threatening way. Remember: many factors can contribute to negative birth outcomes.



Small steps matter

*Discuss the positive
function of substance use*

*Be neutral and matter
of fact*

Build skills

7. Emphasize the benefits of any reduction in substance use. It's never too late in her pregnancy to make small changes in her substance use. Provide her with ideas about how to make changes or shifts in her substance use.

8. Acknowledge the positive role substance use can play in the woman's life, such as stress management, support in social interactions, and self-medication of trauma or abuse. Also, this will show the woman you are open and non-judgemental. It will also help her begin to examine her substance use.

9. Be straight-forward and matter-of-fact. Don't alarm the woman about her substance use, but provide factual information about the range of effects substances can have. Some statements you can make in a **neutral, non-judgemental tone of voice** are:

- It's up to you what you're going to do about your substance use. No one can decide this for you.
- No one can change your substance use for you. Only you can.
- You can decide to go on using substances or to change.

10. Avoid blame. Many pregnant women who use substances **intend** to change, but lack the skills necessary to make change. Some service providers might misread this as lack of intent. Instead, you need to work with the woman to find the necessary skills.

Additionally, there are the **five basic strategies** to use in motivational approaches:

1. Ask open ended questions. Open-ended questions cannot be answered with a single word or phrase. For example, don't ask, "Do you like to drink?" Instead, ask, "What are some of the things you like about drinking?"

2. Listen reflectively. Show you have heard and understood the woman - repeat in your own words what she has said.

3. Summarize periodically what she has said up to that point. It allows people to hear something three times: the woman says something, you reflect it, and then you



summarize it later. Summarize at various intervals throughout each interaction with women.

4. **Affirm.** Support and comment on the woman's strengths, motivation, intentions, and progress.
5. **Elicit self motivational statements.** The woman herself must make the statements about personal concerns and intentions to change. Don't say it for her. Try to encourage her to make these statements. It's crucial for people to express their motivations in their own words. Many service providers have a tendency to do this for the woman. Remember: people retain what they say, not what you say.

Motivational counselling strategies can be used at each stage of change with substance-involved pregnant and parenting women. The responsibility for change rests jointly with the service provider (and their ability to develop a mutually respectful relationship) and the woman. Your goal is to increase a woman's motivation to make change while reducing her resistance. Expressing empathy and supporting self-efficacy are key elements in the process.

The Stages of Change Model

In early approaches to substance use counselling, people believed that clients display various degrees of denial of their substance use problem or its severity. More recently, a different viewpoint has been developed, in particular through the work of Prochaska and DiClemente in what is known as the Transtheoretical Model of the Stages of Change.

Service providers will come into contact with a substance-involved pregnant and parenting woman in various "stages of change". Depending upon her stage of change, there are implications for her readiness to engage in the helping process. Her stage of change also has obvious implications for the level of motivation she brings to the counselling or helping situation. Contemporary helping approaches do not see the client as "unmotivated", "in denial", or unable to be supported if she is not highly motivated in the initial stages of counselling. In fact, this is commonly the case, so the emphasis is on determining a woman's stage of change, understanding techniques for dealing with women in each stage, and applying motivational counselling skills appropriate to the woman's stage of change.

Overview

The Transtheoretical Model of the Stages of Change (usually

*Prochaska, J. and C.
DiClemente (1984). The
Transtheoretical approach:
Crossing traditional
boundaries of therapy.
Homewood, Ill., Dow
Jones-Irwin.*



Formerly called denial but there are many strategies for service providers to use in this stage of change

The “yes, but” stage



called the Stages of Change) was developed by James Prochaska and Carlo DiClemente. It is based on their observations of many types of problem behaviours, including alcohol and other drug use. In this model, change is seen as a gradual, rather than a sudden, event. People don't just wake up one morning and change their behaviour. The reality is that change happens in stages or cycles. Here are five different stages people go through when they change:

- **precontemplation** - the person is not thinking about change;
- **contemplation** - the person is thinking about change in the next little while;
- **preparation** - the person has decided to change and wants ideas about how to do it;
- **action** - the person makes a plan and changes the behaviour;
- **maintenance** - the person maintains the new behaviour but needs support to maintain it.

In addition to the stages of change, **relapse** can occur. During relapse, the person reverts to their old behaviour. Relapse can happen at any stage and can happen many times.

Precontemplation is the stage in which people are not intending to take action in the foreseeable future. In traditional styles of substance abuse counselling, this stage would be called “denial” and a person in precontemplation would be seen as “unmotivated” and not able to be helped.

However, in the Stages of Change approach, precontemplators may be in this stage because they are uninformed or under-informed about the consequences of their behaviour. Or they may have tried to change a number of times and become demoralized about their ability to change. In either case, precontemplators tend to avoid reading, talking or thinking about their substance use behaviour.

Contemplation is the stage in which people are intending to change in the near future. They are more aware of the benefits (or “pros”) of changing but are also acutely aware of the costs (or “cons”). This balance between the costs and benefits of change can produce profound ambivalence that can keep people stuck in this stage for long periods of time.

Preparation is the stage in which people are intending to take action in the immediate future. They have typically taken some significant action in the past year. These people have a

plan of action and are becoming confident in their ability to make their change.

Action is the stage in which people have made specific overt modifications in their substance use or other high risk behaviours within the past six months. The Action stage is also the stage where vigilance against relapse is critical.

Maintenance is the stage in which people are working to prevent relapse. They are less tempted to relapse and increasingly confident that they can continue their change.

Relapse can occur at any stage; indeed, some substance-involved pregnant and parenting women will go through the Stages of Change many times. It is important to speak to women about their lapses and relapses in terms of normal learning experiences. If a woman is demoralized and ashamed of a lapse, she is more likely to go back to precontemplation and stay there for longer. You must remind her that she still has all the learning she acquired before the relapse, that this learning is not wasted, and the lapse provides more information about what to do next time to prevent a relapse.

Service providers can identify which stage of change a substance-involved pregnant and parenting woman is in based on what she says about herself and her substance use. The first task is to figure out what stage of change the woman is in. The second task is to choose an intervention that might move the woman to the next stage of change.

Confidence in the ability to change is developing

Vigilance against relapse is critical at this stage

Relapse prevention continues

Relapse is a learning opportunity and a normal part of recovery



3.2 Applying Relational Theory: The importance of relationships

Adapted from the Original Publications:

- Leslie, M. (2007). *Engaging Pregnant Women and Mothers in Services: A Relational Approach*, in Nancy Poole & Lorraine Greaves (Eds.) *Highs and Lows: Canadian Perspectives on Women and Substance Use* Toronto: Centre for Addiction and Mental Health
- Motz, M., Leslie, M., Pepler, DJ., Moore, TE., Freeman, PA. (2006). *Breaking the Cycle: Measures of Progress 1995-2005*. Special Supplement, Journal of FAS International, Toronto: Hospital for Sick Children, 2006;4:e22. www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

Enhanced relationships among service providers offer an important context for growth-promoting relationships between substance-involved pregnant women and the helping system

A central principle of relational theory is that people, institutions and systems grow through relationships with others (Jordan et al., 2004; Walker et al., 2004). Enhanced connections or relationships among service providers offer an important context for growth-promoting relationships between substance-using pregnant and parenting women and the helping system. At BTC, we have learned the importance of relationships and connections between previously disconnected service sectors and providers to create environments that facilitate engagement of pregnant substance-using women in services. In addition, when substance-using women experience a “therapeutic” or helping relationship or program that is congruent with their needs and experiences, it can be a transformative experience that facilitates enhanced capacity for relating within the mother-child relationship.

In this paper, women and mothers at BTC describe their experiences of participating in a program which is based around a core of relationships among community service providers, relationships between service providers and women, and relationships between mothers and their children.

Breaking the Cycle: From Service Fragmentation to Cross-Sectoral Relationships

BTC was launched in 1995 with the belief that “there is a relationship between the improvement of the system and the improvement of the individuals in that system (Thurman et al., 1992, p. 37). BTC mothers have described the importance to them of attending a program that, through service relationships, is integrated, comprehensive and reflective of the reality of their lives as women and mothers. In addition to program qualities, they have identified aspects of the program’s philosophy and approach, including aspects of their relationship with BTC service providers and other mothers, which have enhanced their relational capacity.

The basis of BTC is the belief that there is a relationship between the improvement of the system and the improvement of individuals in that system”



Program qualities

Many have described aspects of the program structure or service delivery method which have facilitated their growth in relationship with the program:

1. Comprehensive, integrated services

Women have described the importance of being fully known as a whole person, and not just “an addict”, and of receiving services addressing and supporting their various roles, including that of mother or mother-to-be. The maternal-child focus was also identified as important.

I find that the focus isn't entirely on your addiction, it's you and your child ... I mean the addiction is part of it as well, but it's mostly about you and your child. And, you know, how you go through with it at the same time. You're going through ... the aftermath of your addiction...which is a hard enough thing to do, without a child ... but then you have a child, and you have to cope with both at the same time. So they focus on both. You have to be there for your child, and what to do when there's stress, so you don't return back to addiction.

We learn how to break the cycle with our children too. They deal with real life here—and they care of me, which has never happened for me before (Moore et al., 1998).

2. Single-access model

Women have confirmed the importance of a single-access model to facilitate their access to services that respond to a range of needs:

Addicts sometimes have a hard time getting their act together and controlling their lives. BTC is a one-stop shop. A lot of places will help you with one thing, but you have to go across town to get something else you need. Here, they deal with you, your children, parenting and emotions all under one roof (Moore et al., 1998).

3. Outreach

For some women, the outreach model contributed to the development of her relationship with the pregnancy outreach worker.

I like that she'll meet me, just because it motivates you ... For myself, being an addict, sometimes you need somebody to come to you, and help you, because maybe - I don't know if I'm making sense or not - but being an addict, sometimes you'll make appointments and cancel. And I'm fresh into

BTC mothers speak of the importance of this approach

The maternal-child focus is critical

Real and protective

One-stop approach facilitates access to a range of services

Outreach is key to relationship development



*Outreach enhances both
engagement and motivation*

*Social and emotional
isolation are common and
pervasive*

*Mutuality, affiliation,
safety ...*

*... lead to deepened rela-
tionships and shared expe-
riences...*

*...and a shared history of
substance involvement*

recovery, and can't wait to meet her there, it's like she's going to be there, she's going to be there, which is really helpful because it's motivating. And then you feel more like she's a friend also, somebody to talk to, so it's nice to meet outside, not like "Oh I have a doctor's appointment, it's going to last half an hour". It's friendly, it's nice ... talking to her, she really does care, right?

4. Specialized program

BTC clearly meets a need for affiliation and relationships among women in similar situations, and is critical to decreasing feelings of isolation and disconnection.

And I'm so alone, and being pregnant, and having a baby, and it's very natural and all that jazz, but it's really huge, but again I'm alone, right, so it's like really hard. I'm not the only one, women are having babies everywhere. Yeah, it's really nice, you know?

Just that I'm not alone, out there, walking around, alone. Because when I leave here, I'm going to walk out there, alone. But now I have the women here, and I'm happy with that.

The specialized groups directed to pregnant and parenting substance-using women create a safe environment for women to feel understood and to provide support to each other.

The flexibility of this group is that we all get to learn things but also, there are times when women come in here and they're up to here, ready to cry, and if it's another group, there's no way everyone would stop for them, they wouldn't just stop for that one person, they would keep going. But here you can stop, just for that one person ... each person is understanding. Like that's the whole thing about being an addict and understanding that, not just as pregnant women but as addicts you need to come in here and express yourself when you need to, you know.

You can go to a group where people are pregnant but when they're addicts, it's far better to come here where others have your problem, and it's nice to have another addict to talk to.

5. Small size

Some women identified the small size of BTC as a factor in facilitating the development of relationships with both counsellors and other mothers:



I really like that even though Toronto is huge, BTC is so small actually, and...I was really given a lot of individual attention, and the groups are so small, you know each other and it's not...it's never been uncomfortable to talk, you know? And it's been small, and you really get to know the people that you work with, and the people who are in your group.

*Small group size
is important ...*

I went to try and go to one other group, and the thing is there were so many women that there was no way I would have gotten what I get out of this one. Because the other thing with this group too, is that it's flexible enough that need be, if I need to talk, I have the opportunity to talk and I get the one-on-one. I do a lot of it. But I do listen too...because everybody does need to talk.

6. Structure

Some women described the importance of a structured program with facilitation rather than the "drop-in" format of other programs they have attended.

*... as is structured
facilitation*

Yeah, you go there and they give you a couple of tokens, a blue voucher and you just sit, hoping someone's going to come in and go "okay, ladies! Today we're going to ..." But nobody ever came in for that. So I only went to three of those meetings.

7. Women-specific programs

All women identified the importance of a woman-only program, recognizing that this aspect of the program contributed to their feelings of safety and security in the BTC environment. It offers an opportunity to talk to other women in similar circumstances, and it facilitates honesty.

Even the fact that they don't allow (men) to come in the door is a comfort. I mean at first I used to get upset because I was still with my daughter's father, and he used to want to wait here, and I know he'd be out of trouble if he could stick around on the couch and wait for me to finish. But no, they changed that because there was obviously problems with women not wanting them to come in because they don't feel safe with this big, big huge guy sitting there with his long dreadlocks and six-foot-two and scary face. Of course, I wouldn't want to come in either if I didn't know him.

*Group programming is
gender specific*

Some programs have men there, their partners too. I don't like that. I prefer just the women, because men are trouble.

Women have problems ... that needs women.



The relationship BTC mothers develop with the program is as important to them as the program structure

Hopeful and honest

Caring and accepting

Respect, understanding, authenticity, mutual empathy, and reciprocity are key

The Importance of Relationships: Transforming Relational Capacities

As important as the program structure for women and mothers with substance use problems is the nature of the relationships women develop with the program. BTC mothers identified key elements of program culture or philosophy that formed the foundation of the growth-promoting relationships they were able to develop. Key elements included acceptance, empathic understanding, honour, respect, empowerment, caring, love and hope.

At Breaking the Cycle, they started telling me that I was a good person; that every race was different, you know, we didn't have to be this colour or be this to be good, you know. We had to find it in ourselves, and talking about it and sharing, you know. That's what they gave me - they gave me hope; they gave me, I don't know, they gave me a different outlook, the way they talked to me, the way they, I don't know, just like they knew where I was coming from. They didn't have to look at my colour just to start talking you know; they talked from, I don't know where, themselves, I guess.

The messages that I got from Breaking the Cycle that stuck with me and helped me through? The main message was that they cared about me and my child and that, no matter what, they would help me and ... you know they seemed to like me even though I didn't like myself. They kinda loved me back to life again. And just that I could do it, that I could do it, I was able and that, you know, even though I had kind of given up on myself, that there was still hope, and that it's possible and that I could do it. Basically that was the main message that they gave me. They gave me hope ... yeah.

Counsellor Qualities

Women described characteristics of their relationship with BTC service providers that they felt were facilitative for them. These characteristics included respect, understanding, authenticity, mutual empathy and reciprocity.

Mutual empathy in relationships enables women to know that they can have an impact on the world, specifically on the people with whom they have relationships, and that relationships may be negotiated. Because this sense of impact may have been missing in relationships they have had in the past, it is seen as an important corrective or transformative experience in that it contributes to women's sense of empowerment and to the counsellor's capacity for new learning. It is important to note that, while the relationship



provides a safe and respectful environment within which to experience emerging connections, it does not guarantee comfort. Safety in relationship allows differences to emerge; and it is how these are negotiated and resolved that provide a template for the development of a corrective “relational image” in relationships.

If there is something that makes you feel uncomfortable, you can just tell her straight up. You know how some people can get defensive and all aggressive? She won't, like literally, she won't ... I'm the kind of person that does need to be challenged to express my feelings and so I would get upset and she said, you know, ... “tell me to fuck off whenever you need to”, you know? And she's like, “I totally don't mind”. Because she knows that I need to be challenged but also, you know, if I don't tell her where my point is, she doesn't know where it is either...She'll do what I like her doing, which is challenging me, but sometimes I can't handle it, and I just say “You know what, I've got to drop this for now” and she'll drop it, and we're on to another subject right away.

Well you know the thing with (the BTC Pregnancy Outreach Worker) too, is that she was very patient. Because like I wasn't a treatment person, I was a person who was not going to go to treatment. Because I had quit many times - not many times, but enough times that I could do it without treatment. But the thing is, you know, she would subtly bring it up. She wouldn't question it, but she would bring it up. So, and the fact that she didn't question it, and was more suggestive of it, eventually I ended up going into treatment.

They didn't force anything upon you like “Okay you have to go to twelve step meetings, or you have to go to (detox), or you have to look at it this way”. They give you, here's your five options, check every one out if you want, or you can choose which one, which path you want to go, but everyone's an individual and everyone's different, and one way may work for me that doesn't work for (another client). Or you know, everybody's an individual, it's not like “Here's how you've got to do it, and everyone's got to do it this way, and if you don't do it this way you're going to fail, or ...” or they didn't ever put it that way. It was always, “here's your options, and try which ways you would like to do it in”, not someone telling you “You have to do this”, you know?

And they were just so gentle, even though you know I was just so scared, and still had that edge on. (The intake counsellor) ... took her time and did it in a slow, gradual process, she

Workers do not rush women to the action stage

Women are presented with a menu of options and personal choice/control are emphasized

Gentle, flexible strategies are emphasized



Respect, recognition, and acknowledgement are identified as meaningful

Workers understand the impacts of isolation and disconnection, leading to stronger therapeutic relationships

Relapse is accepted as part of the recovery process ...

... leading to a feeling of acceptance and encouragement ...

...and a reduction in stigma and guilt

Acceptance is a key element

Workers show genuine caring, concern, and interest



didn't make me tell her everything in one session.

Women also identified respect, recognition and acknowledgement as meaningful components of the growth-promoting relationship they experienced at BTC. Respect is the foundation of mutual empathy, and movement out of isolation into growth-fostering relationship. Mutual empathy is at the core of relational resilience, and is responsible for movement from disconnection to connection.

Women noted the importance of feeling truly known by another person in a relationship - and to be known as a whole person, and not just as a substance user. To be known in a compassionate, caring way, in which difficulties and perceived failings can be known and understood ("nobody's perfect") was important. And, for the respondent below, the capacity of the BTC staff to understand the impact of isolation and disconnection deepened their relationship.

I've been with her when I was clean, when I relapsed, when I went through treatment ... she's loving, she's caring, she's compassionate, she's understanding, she's patient, she's challenging when need be. She has no bias, she has no judgement, she has resources. As a person, you know she just has respect. Not only understanding the respect, but when you go further ... she's understanding of human nature and how people are regardless of whether they have addictions or not... That you know, nobody's perfect .. and then you throw in isolation, and the fact that she understands that category just takes it into depth.

The women speak eloquently of the importance of gentle, motivational strategies used by BTC staff which includes acceptance of relapse as a normal part of the recovery process.

You can't do any wrong, you know what I mean? So you feel comfortable. They all know we have problems, and the fact that we're making an effort they think is a very positive thing.

For me, I had no self-esteem, no self-worth, I felt like the worst person on the face of the earth, because how could you get much lower than what I was. They kind of nursed me back to health again, with words of encouragement, and not just the words but the actions to follow through with the words like "Yeah, we will be here for you, no matter what. And you don't have to be afraid of saying I use, or I had a relapse..." and I don't know, they never kick you out, they never say, you know, you can't come here anymore because you've used too

many times or you've quit too many times, there's no really right or wrong way to do it, it's just like "Okay keep coming, just keep coming, and we'll do what we can to try to make it work, if one way's not working we'll try another way".

They're interested to hear about my daughter, they're interested to hear about me. You know you'll say one thing and next week they'll surprise you with it. I mean I imagine it must be overwhelming; you're talking to all these women with their children ... I mean I talk about my daughter all the time. I could go on and on. But no, they're actually interested in hearing what we do, to get the boring things that we do, and it's like oh! They get excited about certain things, and they're actually happy for me.

Mothering and learning from other mothers

Women identified the importance of learning from other mothers and spoke of the impact of BTC programs on their mothering role.

I didn't know how to be a mom. I didn't know how to play with my daughter, I didn't know how to breastfeed, I didn't know how to teach her stuff, how old they have to be before you start feeding them solid food, I didn't know nothing, absolutely nothing. And to be on my own and try to figure it out, I really didn't have anybody to turn to.

I know ... and you're like, wow, I was crawling around the street four years ago. I got my sanity back. I have a kid and I'm a good mom, and you know it's sort of neat when people say, you've got a really good relationship with your daughter.

When I came here, I always thought that I was not a good mother and then they encouraged me, they kind of showed me the ways that I am a good mother. The fact that I'm here. And because of that, I was able to say to myself, "Yeah I'm a good mother" and so my view of my children is definitely different.

They also spoke of the importance of learning through affiliation with other mothers and their children.

So .. when they have the ... kid group, you'd watch a woman before you have her child a month or two before you do and you learn by them talking about their experiences, like "Now my child is crawling, now my child is doing this, now my child can say a word" so you kind of know, "Okay this is when it's sort of going to happen, within this time this is what she'll be

Learning about mothering is powerful, whether from BTC programs ...

... or from other mothers



Shared experiences with other mothers normalizes and reassures

Observation of difficult experiences can motivate and retain women in their program involvement

Often, an understanding of the child welfare mandate is developed

able to do". And also wondering, what if there's something wrong with my child, because of my using at the beginning, that might not come out right away, but later on down the road, so Dr. Koren checking, and doing those check-ups ...

My heart went out to the women who was still coming to the groups, and had their children apprehended, and was fighting to get them back, and I was like, you know, really looked up to those women, because I could see myself with a crack dealer somewhere, not sitting here, just going nuts, nuts and going out there and using because I felt that way. But no, they came and they did anything they had to do to get their children back. And I saw some of them didn't make it, and they'd be here with their children, and the next thing you know, they're gone, they didn't make it, they went back out and their child is somewhere in a foster home ... and you know that would keep me going, that would keep me coming back here, even through freezing cold winter days.

Women described a range of impacts based on BTC's partnership with child welfare. Some women indicated that the partnership is a barrier for disclosing "something you think you've done bad". Others acknowledged the power of child welfare workers and worried about "mistakes" and "slip ups", but also recognized their mandate and ways in which they could be helpful. Often, BTC mothers learned about safety for themselves and their children, and ways to ensure safe environments and relationships - environments that were not, for the most part, provided to BTC mothers when they were children (see Section 2.6).

It's about the child ... it's about the child's protection, and their best interest. And I'm sure if anyone - if you or me or somebody whose child is being hurt or neglected in some way, I'm sure you guys wouldn't hesitate to call, or even think twice to make that phone call. Because if something should happen to that child, and you knew about it, that's going to be on your conscience for the rest of your life. I mean, you know, give or take, they're not all bad.

Beyond Engagement: Understanding the Processes Underlying Relational Healing

While BTC reaches and engages the high-risk, vulnerable and isolated population of substance-using women for whom it was designed, it is through the process of relationship with substance-using pregnant women and mothers at BTC that we have come to understand the reality of the women's lives, including the contexts within which they use substances.



Engagement is merely the first step in the process of connection within which the possibility of important relational shifts (for women as well as counsellors, programs, systems) may occur. It is the contribution of women's personal testimony through relationship that has guided - and continues to guide - the evolution of BTC. And it is the response by the counsellor and by the program to her experience and testimony that demonstrates that the relationship with this woman matters to the therapist and to the program. Perhaps the most important accomplishment of pregnant women and mothers using substances is that, through corrective relationships, they develop the capacity for different kinds of relationships with others, and especially with their children.



3.3 Establishing Regulation and Attachment

Adapted from the Original Publications:

- Leslie, M. (2004). Parenting and Substance Use: The Significance of Relationships. IMPrint: Newsletter of the Infant Mental Health Promotion Project (IMP). Vol 39, Spring
- Motz, M., Leslie, M., DeMarchi, G. (March 2007). Breaking the Cycle: Using a Relational Approach to Address the Impact of Maternal Substance Use on Regulation and Attachment in Children. Zero to Three, Journal of the National Center for Infants, Toddlers and Families. Vol. 27 No. 4. pp 19-25.

These mothers are aware of the impacts of substance use and feel guilt and shame about "bad" mothering

This paper draws on attachment and relational theories for a framework for understanding the ways in which substance abuse may affect parenting processes; in particular, the development of regulation and attachment in infants and young children. The sociodemographic factors that characterize the lives of substance-involved pregnant and parenting women suggest intergenerational repetition of relational contexts, including significant histories of substance use in families of origin, high rates of maternal maltreatment and trauma commencing in early childhood, discontinuities of relationships commencing at an early age (including multiple caregivers and foster care placements), all of which may have affected the regulation and attachment process of substance-involved pregnant and parenting women (Motz, et al., 2006). The re-enactment of relational images is proposed as the process through which intergenerational patterns of relating are transmitted across generations, calling for a two-generation response to mothering and substance abuse.

Substance abuse and parenting

Mothers who experience problematic substance use acknowledge that substance use and parenting are not compatible (Boyd, 1999; Greaves et al., 2002; Tait, 2000), especially when they reflect on their own lives and childhood memories of how they were parented. Often mothers are more concerned out the impact of their substance use on their children than are service providers about the impact of their substance abuse on their children (Tait, 2000). Women desire to shield their children from harm related to substance use. When they are not successful, they experience tremendous guilt and shame related to their lifestyle and think of themselves as a "bad mother" (Boyd, 1999).

This negative self-evaluation often perpetuates unhealthy thoughts and behaviours, which further negatively affect their infants and very young children. Many women recognize the need for intervention for themselves and their



children; the intergenerational history of substance use in their own families leads mothers to know how it feels to be parented by a substance-involved family. Helping mothers make linkages with their own experiences in childhood generates the empathy and motivation required for mothers to make difficult and important changes in their lives for themselves and their children.

Substance abuse and child maltreatment

Eighty percent of mothers attending BTC report childhood maltreatment (physical, sexual and emotional abuse) in their families of origin, the majority substance-related (Pepler et al., 2002). In the study by Tait (2000), most women reported that they experienced ongoing physical and/or emotional abuse or neglect by one or both of their parents as a direct result of their parents' substance use, and that they had been removed from their parents' care on at least one or more occasions. They linked their parents' substance use to several negative childhood experiences, often involving violence, and believe that this contributed substantially to their own dependency on substances (Tait, 2000).

A strong connection between substance abuse and child maltreatment has been found both in child welfare populations and in community-based samples (Famularo et al., 1992; Kelleher et al., 1994; Reid et al., 1999; Ammerman et al., 1999; Chaffin et al., 1996). Children whose parents abuse drugs and alcohol are almost three times likelier to be abused and more than four times likelier to be neglected than children whose parents are not substance abusers.

Most cases of abuse and neglect by substance-using parents involve children under five (Reid et al., 1999), and several studies indicate that children exposed prenatally to substances are at increased risk for child maltreatment after birth (Kelley, 2002).

An association found between a past (but not current) history of substance use and child abuse potential in both parents (Ammerman et al., 1999; Milner, 1995) belies a common belief that if substance-using parents become "clean and sober," the risk of child maltreatment ceases.

Substance abuse and attachment

Many life experiences of a mother who abuses substances will also influence the mother-child relationship even in the absence of drug use (Pawl, 1992). When women enter motherhood with unhealed emotional wounds, their injuries often



*Substance abuse and
disorganized attachment
are consequences of
childhood maltreatment*

resurface when they relate to their own children (Mejta & Lavin, 1996). Mothers who use substances need help not only with their substance use, but also to understand the effects of their past relationships, both negative and positive, on their interactions and relationship with their child. Unresolved loss and trauma in mothers has been shown to be associated with disorganized attachment in children, and there is stability of attachment across generations (Main & Hesse, 1990).

John Bowlby (1969/1982) proposed that attachment occurs in an organized system in order to make people feel safe and secure. It is within the dynamic emotional relationship between infant and primary caregiver that infants develop their cognitive and affective appraisal of self and others. These "internal working models" have a critical influence on the infant's perceptions of the environment and of others, and on later personality development and social functioning. The primary pathway to a secure attachment is parental sensitivity to the infant's cues and signals, as well as an appropriate and consistent response to those signals (Ainsworth, 1978).

Attachment develops out of patterns of early interactions between the infant and her primary caregiver. As the attachment relationship develops over the first 6 months of life, it serves four major functions: (a) providing a sense of security; (b) regulating affect and arousal; (c) promoting the expression of feelings and communication; and (d) serving as a base for exploration. A sensitive, responsive caregiver is fundamental to the development of a secure attachment bond during the early years of life. Consistency, sensitivity, and contingent responsiveness on the part of the primary caregivers are essential to the baby's psychological development (Davies, 1999).

Three major factors that affect the caregiver's capacity for responsiveness are:

1. The caregiver's internal working models of caregiving, assumed to be derived from her own early experiences of being cared for;
2. Parental risk factors such as substance use or mental illness; and
3. Whether the caregiver is receiving outside support from other adults (Davies, 1999).

The majority of children of substance-using women demonstrate a disorganized attachment type (Espinosa, Beckwith,



Howard, Tyler & Swanson, 2001). Disorganized attachment is linked to a child's fear of the parent, her uncertainty about how a parent will react, and a history of contradictory responses by the parent ranging from inviting closeness to angry rejection (Lyons-Ruth, Connell, Zoll, & Stahl, 1987). Infants classified as disorganized lack a coherent and organized strategy for dealing with distress. Their dilemma is that their source of safety and comfort is also their source of fear and distress. Disorganized attachment is linked to poor children outcomes, including difficulties managing affective responses, impulsivity, poor self-esteem, impaired empathy, vulnerability to stress, and regulatory problems.

Substance abuse and regulation

The first task of the newborn infant is to learn to regulate himself in the face of internal and external stimulation so that he can engage the world of people and things in an active way. This development depends on both the child's capacities to control his own states and the mother's capacity to facilitate the child's ability to self-regulate. In early infancy, parental help is required to maintain alertness and engage with the world for sustained periods. A sensitive caregiver is able to help the infant by modifying the environment and/or supplementing the child's own regulatory efforts in response to cues from the infant's face, voice and body, and other behavioural and physiologic changes. This means that the exchange of subtle information between infant and parent is a critical component of the child's regulatory system. Chronic failure to repair regulatory errors may have long-term negative developmental and mental health consequences. If they have been exposed to substances prenatally, infants may require extraordinarily sensitive adaptations by their caregiving environment. Mothers who are using drugs, or mothers in early recovery, may have impaired ability to read and regulate their own behaviour, much less promote their children's development toward self-regulation. Both the exposed newborn and the substance-involved mother are likely to be difficult regulatory partners.

Neurobehavioural research has demonstrated the importance of early regulation in the development of areas of the brain responsible for emotion regulation, arousal, appetite control and sleep. The quality of the early environment sets patterns for response to stress that become embedded in our physiological and neurological systems (Bradley, 2000). Animal and human studies show that adults who were poorly nurtured in early life tend to retain sustained levels of stress hormones long after the cause of arousal has gone. Initial

"I grew up with alcoholic parents, and every time they would drink, which was nearly all the time, I would feel nervous, wondering how long it was going to last this time before something went bad, and that was how I felt ... I was scared most of the time and I didn't know what to do."

Prenatal exposure to substances affects an infant's ability to regulate

Substance-involved mothers have difficulty supporting their own and their infant's regulation



The quality of the early environment sets lifelong patterns for response to stress

Insecure attachment may predispose use of external regulators, such as substance use

Relational images can repeat and re-enact in a mother's relationship with her children

Corrective therapeutic relationships are therefore essential

response to stress releases chemicals that heighten infants' sensitivity to sensory stimulation and improve memory. Sustained or chronic stress has the opposite effect; it reduces the capacity to process new sensory stimulation and has a negative impact on memory. Thus repeated stress during critical periods in early life reduces ability to moderate response to stress later in life (Bradley, 2000).

It has been suggested that insecure attachment (especially the disorganized pattern) predisposes the use of external regulators of affect, in particular psychoactive drugs, alcohol, sexual behaviour, and eating (Hunter & Maunder, 2001). Their conclusion suggests that one possible reason for transmission of substance use across generation is dysregulation in early caregiving relationships.

Healing through relationships

In the context of our work to support pregnant women and mothers using substances by building and strengthening their relationships, we have developed a richer understanding of the experiences that have shaped the development of their relational images, and how these experiences are passed down to their children. Relational images are derived from past experiences with others and determine, to a large extent, our beliefs and expectations about relationships: who we are, how we are regarded by others, and what we can expect and deserve to receive in relationships (Miller & Stiver, 1997).

Relational images that mothers carry may trigger repetition and reenactments in new relationships, including those with children. Reenactment of relational images is the process through which intergenerational patterns of relating are transmitted across generations (Fraiberg, 1980; Benoit & Parker, 1994). When women enter motherhood with unhealed emotional wounds, their injuries often trigger reenactment of relational images when they relate to their own children (Mejta & Lavin, 1996).

Corrective therapeutic relationships with mothers, modeled through facilitated interactions with clinicians, can introduce them to the experience of safety, acceptance, reliability, consistency, structure and caring in relationship (Lieberman & Zeanah, 1999). Corrective therapeutic relationships with service providers or others help mothers to create different inner working models or relational images for their infants than were created for them, and to break the cycle of intergenerational transmission of relationship disturbance and



related problems - including substance use. Providing women with supportive relationships has led to an increased capacity by the mothers at BTC to form secure relationships with their own children and to experience positive mother-child interactions.

SUMMARY of Section 3

Section 2 highlighted the fact that women's substance use problems develop in relationships that often originate in their families of origin and/or with other caregivers, and that are sustained in relationships with peers, friends, and intimate partners. In particular, the prevalence of trauma and maltreatment in the relationships of substance-involved women (commencing in early childhood) was highlighted as critical to understanding the circumstances which bring women to substance use, and which make it difficult for them to change their substance use patterns, despite their best intentions. The process of resolution and healing for women and mothers experiencing substance use problems and trauma must necessarily take place within the context of relationships.

Section 3 has detailed the application of relationship-based theoretical frameworks and approaches to promote resolution of substance use problems, and to promote relational capacity. The transtheoretical stages of change model, motivational counselling approaches, relational theory and attachment theory all have a relationship-based foundation, and support the maternal-child framework within which all programs and services are delivered at BTC.

Implicit in the application of these frameworks is the adoption of a harm reduction approach. A harm reduction approach is critical to understanding women's use in the context of the other complex and interrelated factors in their lives, including trauma, social isolation, domestic violence, poverty, and housing instability. Harm reduction is also necessary for the application of motivational interviewing strategies within the stages of change, and to relational and attachment-based approaches to treatment for women. In the application of a maternal-child approach, harm reduction also includes attention to the prevention or remedying of harms of maternal substance use experienced by children. This includes careful attention to the impact of substance use on maternal functioning and mothering behaviours, on the individual needs of the infant or child, and on mothers' access to supportive resources, relationships and environments that foster the growth of both the mother and child in the context of safety, health and well-being.

Section 3 confirmed that the contribution of program philosophy and counsellor qualities to the progress of mothers and children who are substance-involved cannot be underestimated. Within therapeutic relationships that provide consistency, reliability, sensitivity, acceptance, mutual empathy and non-judgemental positive regard, mothers are able to explore their past experiences and make shifts that improve their relationship with their infant.



Finally, this Section proposes that the reenactment of relational images is the process through which intergenerational patterns are transmitted across generations. When substance-involved women enter motherhood with unhealed emotional wounds, these injuries can trigger reenactment of relational images in interactions with their own children. Corrective therapeutic relationships with service providers help mothers create different inner working models or relational images for their infants than were created for them, and to break the cycle of intergenerational transmission of relationship disturbance and related problems - including substance use.

Sometimes, supporting a mother's relationship with her infant means helping her protect her child from the kinds of experiences that caused her pain, and this may involve a relationship with child welfare services who can assist mothers in protecting and promoting their infants' safety. Providing supports early in the mother-child relationship is seen as a key to preventing or interrupting maladaptive patterns of relating and coping, and establishing strong, healthy relationships patterns between mother and child.



Section 4: Research Informing Practice

Since 1995, BTC has used research and evaluation as the basis for program development and evolution. In this Section, we describe three program initiatives that resulted from qualitative and quantitative research activities at BTC. The development of the BTC Pregnancy Outreach Program is described in the context of the findings of a study by Hicks (1997) that examined barriers to service for pregnant, substance-involved women attending BTC. A recognition of the high rates of domestic violence experienced by mothers at BTC led to a qualitative examination of their experiences, and the development of the Connections pilot project. A review of that project is described in 4.2 below. And finally, an examination of co-existing tobacco use among BTC women and mothers, and an investigation of their service needs in this area, is the premise of Dr. Singh's paper on smoking reduction. The implementation of the STARSS program, and the relationship with PREGNETS, have combined to introduce smoking reduction/cessation interventions into the range of services offered at BTC. This section concludes with a summary of the most recent evaluation of BTC - *Breaking the Cycle: Measures of Progress 1995-2005* - which reports on data from a sample of 770 substance-involved women and their children at BTC, and describes outcomes including engagement, level of isolation, treatment maintenance, child custody, child development, parenting, attachment, and levels of social support.



4.1 Engaging substance-involved pregnant and parenting women: BTC's pregnancy outreach experience

Adapted from the Original Publications:

- Hicks L. (1997). Drug Addiction and Pregnant/Parenting Women: Factors Affecting Client Engagement. Toronto: Mothercraft Press. www.mothercraft.ca
- Leslie, M. & DeMarchi, G. (2004). Engaging Pregnant Women Using Substances: A Review of the Breaking the Cycle Pregnancy Outreach Program. *IMPrint: Newsletter of the Infant Mental Health Promotion Project (IMP)*. Vol. 39, Spring.
- Pepler, D.J., Moore, T.E., Motz, M., Leslie, M., (2002) Breaking the Cycle: The Evaluation Report (1995-2000). Toronto: Breaking the Cycle.
- Sarkar, M, Santiago, S., Leslie, M., Burgoyne, W., (2006). Moving Systems to Improve Women's Health and Prevent FASD: A Policy Forum. Summary of Proceedings and Recommendations. Toronto: The Hospital for Sick Children. Published on-line @ <http://www.motherisk.org/JFAS/index.jsp>
- Motz, M, Leslie, M., Pepler, D.J., Moore, T.E., Freeman, P. (2006). Breaking the Cycle: Measures of Progress 1995-2005. Special Supplement, Journal of FAS International, Toronto: Hospital for Sick Children, 2006;4:e22

Due to multiple barriers to effective care, most substance-involved pregnant women do not access addiction treatment during pregnancy

Better engagement of pregnant women became a program concern

See the article by Lisa Hicks - Drug Addiction and Pregnant/Parenting Women: Factors Affecting Client Engagement

www.mothercraft.ca



Although pregnancy has often been described as a “window of opportunity” for women to decrease or cease their substance use (Daley et al., 1998; Klee et al., 2002), pregnant women who use substances do not typically seek or access addiction treatment during pregnancy. Barriers to effective care for pregnant substance-using women have been extensively described, and include: stigmatizing, judgemental and blaming public attitudes towards pregnant substance users (Greaves, et al., 2002); negative attitudes and treatment of pregnant substance users by service providers (Finkelstein, 1993; National Institute on Drug Abuse, 1993; Harrington, et al., 1999; Tait, 2000); women's fear of criminal prosecution, mandatory treatment, and removal of custody of their children (Chavkin, 1990; Tait, 2000; Poole et al., 2001; Lester, 2004); and lack of gender-specific programs designed to address both the complexity of needs and experiences of pregnant substance-using women as well as the needs and experiences of their child(ren) together (Jessup et al., 2003; Haller et al., 2004; Lester, 2004). Indeed, the needs of women drug users have been neglected in the past by service providers. The majority of them are of child-bearing age and yet relatively few present to services.

Early evaluation data (Moore et al., 1998) indicated that BTC was engaging a higher proportion of women who were parenting (78%) than those who were pregnant (22%). The 22% engagement rate of pregnant women was consistent with the findings of similar programs in the U.S., and was higher than the rates of pregnant women attending more traditional treatment programs in Toronto. Nevertheless, the engagement rate of pregnant women remained an area of attention for program development.

The BTC study “Drug Addiction & Pregnant/Parenting Women: Factors Affecting Client Engagement” (Hicks, 1997) increased the understanding of the implications of the often co-existing homeless status of pregnant women who are using substances to their capacity to access health and effective treatment services. Their pregnant, homeless status was identified as a significant barrier to engagement in programs, and to “treatment maintenance”. Indeed, the study concluded that, because of their higher incidence of homelessness, pregnant women who are using substances represent a higher-risk sub-population of drug-using women whose barriers to health and effective treatment are even greater than within the larger population of substance-using pregnant or parenting women.

The development of the BTC Pregnancy Outreach Program was a proactive response to these findings, with the aim of engaging women in services as early as possible during their pregnancies in order to positively influence fetal and maternal health outcomes.

The Pilot Phase of the BTC Pregnancy Outreach Program: 1999-2001

In 1999, pilot funding from the United Way of Greater Toronto supported the development and evaluation of the impact of Ontario's first pregnancy outreach program to support homeless, pregnant who were substance-involved.

Project Goals and Objectives

The BTC Pregnancy Outreach Program was designed to evaluate the impact of a pregnancy outreach program on:

- a. the engagement rates of pregnant, substance-using women in services
- b. the community of service providers who works with this population of women

The project **objectives** were:

- To consult with networks and agencies who have contact with pregnant, substance-using women in order to promote the BTC Pregnancy Outreach Program, to receive input regarding the project, and to enhance efforts to build an integrated and responsive community referral network.
- To provide education and training to others that provide services to pregnant substance users

Homelessness was identified as more prevalent among pregnant women

These women have even greater barriers to health care and effective treatment

The Pregnancy Outreach Program was a proactive response

Its goal was to evaluate impacts on both pregnant women and service providers

Build an integrated and responsive network

Provide education and training



Decrease isolation and marginalization

Increase knowledge about and promote use of necessary services

Build relationships between mother and infant

Increase and enhance BTC's engagement of pregnant women

Community consultations provided program promotion, in addition to its design refinement based on input from women and service providers

- To decrease the isolation and marginalization experienced by pregnant women using substances.
- To increase the knowledge of pregnant women using substances regarding community resources available to them.
- To promote the use of services such as primary health care, prenatal care, medically managed withdrawal
- To increase maternal involvement in planning for herself and her expected infant
- To establish a fluid and mobile outreach link to/from Breaking the Cycle and the community, increasing the engagement rate for pregnant women at Breaking the Cycle.
- To study and research techniques that are effective in engaging substance-involved pregnant women in services

BTC Pregnancy Outreach Program Pilot Project Evaluation (Leslie, 2001³)

In the developmental phase of BTC's Pregnancy Outreach Program, community consultation was undertaken with over 35 community providers who have contact with pregnant women who are using substances. In addition to promoting the program, the community consultation resulted in the refinement of the design and implementation of the program based on input from service providers and women. The response to the introduction of the BTC Pregnancy Outreach Program was overwhelmingly positive, with some providers identifying the need for a more intensive service than the 2-day per week initiative that was possible in this pilot phase.

The evaluation examined data collected during the period May 2000 - May 2001. The data confirmed that the project was:

a. Reaching the target population

Demographic data confirmed that the BTC Pregnancy Outreach Program was effective in reaching its target population of homeless, pregnant women who are substance-involved:

- Over two thirds of the women engaged reported

³ Leslie, M. (2001) *Breaking the Cycle Pregnancy Outreach Program: Advance Funding Program Evaluation Report*. Toronto: United Way of Greater Toronto



that they were living in conditions of “visible homelessness”, i.e. “those who stay in emergency hostels and shelters and those who sleep rough in places considered unfit for human habitation, such as parks and ravines, doorways, vehicles, and abandoned buildings”⁴. The remaining one third reported that they were living in an apartment or house. This finding does not take into account those who are living in shared accommodation, and may under report the degree of transience involved in these often short-term and unstable housing situations. It is significant to note that only one respondent indicated that they had been able to access subsidized housing, which indicates that the majority of those who were living in apartments or houses were paying market-level rents. These women are living in conditions of “hidden homelessness”, which includes “... situations where women are paying so much of their income for housing that they cannot afford the other necessities of life such as food; those who are at risk of eviction; and those living in illegal or physically unsafe buildings or overcrowded households.”

- Poverty was identified as a salient co-existing factor. Half of the women reported no income; 43% reported that they were receiving social assistance/ PNA/ ODSP, and 8.8% reported that they were employed. Of those women who reported that they were employed, all reported that they were employed in the sex trade.
- All of the women reported that they were actively using substances, and over two thirds identified crack cocaine as their primary drug of choice. This confirms the research of Hicks (1997), which found that the use of crack cocaine is a more significant barrier than the use of other substances to engagement of women using substances during pregnancy, and results in increased marginalization from health and social support services in pregnancy.
- The treatment histories of the women seen further emphasized their marginalized status. Over half of the women reported that they had had no previous

70% of women were visibly homeless

30% lived in potentially unstable housing situations of “hidden homelessness”

Living in poverty was identified by over 90% of the women

70% reported using crack cocaine as their drug of choice

⁴ Kappel Ramji Consulting Group (2002) Common Occurrence: The Impact of Homelessness on Women's Health. Phase II: Community Based Action Research - FINAL REPORT. Toronto: Sistering. vii



57% of women had no previous treatment history

Reduced isolation leads to improved birth outcomes

Good referral rates in and out of the program demonstrate decreased isolation

Over half of the referrals made to support services resulted in successful engagement by the women

treatment experiences. This is in contrast to treatment history data of pregnant and/or parenting women using substances engaged at Breaking the Cycle, 78.3% of whom report between one and three previous treatment attempts (Moore et al., 1998).

b. Decreasing isolation

The isolation of women from supportive health and treatment services during pregnancy exacerbates the risk for poor fetal and maternal outcomes, and results in inadequate planning and preparation for parenting.

The number and source of referrals of women to the BTC Pregnancy Outreach Program, as well as from the Pregnancy Outreach Program to the community, provided a measure of the decrease in isolation of pregnant women using substances. The primary source of referrals into the BTC Pregnancy Outreach Program was from women themselves (33.3%), and the numbers of self-referrals increased consistently over the course of the pilot phase. Other referrals came through the health, treatment and hostel/shelter sectors. Referrals from the BTC Pregnancy Outreach Program to other services in the community further represent a decrease in isolation. In accessing supportive health, treatment and social support services the women demonstrate an effort to make changes in their lifestyle as they begin to plan for themselves and their expected infants. Referrals from the Outreach Program to the community were primarily to health, treatment and housing providers. There were an average of 3 referrals made per woman, and over 50% of the referrals resulted in women successfully engaging with the providers to whom they were referred, with an additional 18% having made appointments with the referred provider. Only 8.5% of the women refused information and assistance regarding supportive services.

The introduction of the BTC Pregnancy Outreach Program resulted in a 70% increase in engagement rates of pregnant women in the Breaking the Cycle, confirming the effectiveness of this model in supporting this vulnerable population of pregnant women using substances.

c. Engaging women at earlier stages of their pregnancies

Approximately 45% of the women engaged in the BTC Pregnancy Outreach Program were in the first trimester of their pregnancies; 29% were in their second trimester and 26% were in their third trimester. The percentage of women engaged in their first trimester represents a higher proportion than those engaged in Breaking the Cycle during their first



trimester (32%). Contact with women occurs at an earlier stage of their pregnancy, offering earlier opportunities for the introduction of information and education about resources in the community, for the earlier introduction of health and treatment interventions, and for support to assist women to plan and prepare for parenting.

In their evaluation of BTC, Pepler et al. (2002) found that earlier engagement of pregnant women using substances in health and social support services results positive perinatal outcomes for infants. A comparison of the differences between infants who were born from early-identified pregnancies (i.e. within the first 2 trimesters) versus those born from late-identified pregnancies (i.e. in the last trimester) indicated that early engagement is related to:

- Higher birth weight
- Fewer prenatal risk factors (including placenta previa, low weight gain, minimal prenatal care, infections, anemia, high blood pressure, diabetes, Hepatitis C)
- Reduced prenatal substance exposure
- Fewer birth complications
- Better post-natal health
- Reduced length of hospital stay
- Fewer mother-child separations

Enhancing the BTC Pregnancy Outreach Program: The BTC Satellite Group

In April 2001, Health Canada approved funding through its Canada Prenatal Nutrition Program to expand and enhance the BTC Pregnancy Outreach Program, thereby ensuring its sustainability and stability. The funding support from Health Canada resulted in the expansion of the program from a 2-day a week to 5-day a week program as well as the development of the BTC Satellite Group at St. Joseph's Health Centre.

The BTC Satellite Program expanded the services of Breaking the Cycle and the BTC Pregnancy Outreach Program in order to accommodate a 70% increase in the number of pregnant women engaged at Breaking the Cycle since the inception of the BTC Pregnancy Outreach Program.

The BTC Satellite Program provides a supportive group for women seen through the BTC Pregnancy Outreach Program, combining relapse prevention and prenatal health and attachment goals. It is offered weekly, and is located at the St. Joseph's Health Centre. It integrates community and hospital-based supports, and provides a holistic and compre-

Earlier contact with mothers creates more opportunities for treatment and support

Earlier contact may also result in improved birth outcomes, including higher birth weight babies

*Program expansion:
CNP funding received*

*BTC Satellite Program
established*



BTC Satellite Group is a unique integration of community-based and hospital-based supports

Collaborations benefit both mothers and service providers

Early engagement with pregnant women has lasting impacts on many aspects of their lives

Women are more likely to complete their treatment plans

They are more likely to maintain recovery from substance use

hensive service. It includes the provision of a lunch meal, and childcare for those women who have other children.

The Toronto Centre for Substance Use in Pregnancy at St. Joseph's Health Centre offers a prenatal clinic on the afternoon of the BTC Satellite group, so that women can access their health and social supports in a hospital-based single-access model in one day. The hospital's pharmacy also agreed to carry and dispense methadone in order that the women in the BTC Satellite group who are on methadone maintenance programs can pick up their methadone when they are there. The program has become a unique hospital/community collaboration between two CPNP projects—collaborations that have been of benefit to all partners but, in particular, to the participants in the program.

The BTC Pregnancy Outreach Program: Enduring Impacts

In Motz et al. (2006), the findings of the pilot evaluation were confirmed with respect to the outcomes on early engagement and decreased isolation. Notably, this more recent evaluation also demonstrated that the impact of early engagement through the BTC Pregnancy Outreach Program endures well beyond the perinatal period, and includes impacts on completion of treatment/intervention plans, custody of children at discharge from BTC, and maintenance of recovery:

1. Completion of treatment/intervention plans

In comparison to pregnant women entering BTC pre-2001, there were trends for pregnant women who entered through the BTC Pregnancy Outreach Program to be more likely to complete treatment/intervention plans. For most pregnancy outreach clients, treatment plans included three components: accessing addiction services (detox or treatment); accessing prenatal care; and securing housing. These findings confirm the efficacy of a proactive outreach model in engaging and intervening with pregnant women using substances, and helping them access social determinants of health.

2. Maintenance of recovery

In comparison to pregnant women entering BTC prior to 2001, there was a trend for pregnant women who entered through the BTC Pregnancy Outreach Program to be maintaining their recovery from substance use at discharge from BTC.

3. Custody of children

In comparison to pregnant women entering BTC pre-2001, there were trends for pregnant women who entered through the BTC Pregnancy Outreach Program to be more likely to



have custody of their children at discharge from BTC. Earlier engagement in services, coupled with higher rates of completion of treatment/intervention plans, combine to result in mothers being significantly better prepared for their mothering role by attending to their own health, by accessing appropriate housing and by addressing their substance use. This is an important outcome that signifies the enduring impacts of the BTC Pregnancy Outreach Program into the early childhood period.

There were also trends for mothers who entered BTC through the Pregnancy Outreach Program to be more likely to have contact with their children at discharge, whether or not they had custody of the child.

Conclusion

Because the majority of pregnant women using substances do not typically seek addiction treatment due to the social, psychological, economic and legal barriers described above, outreach activities are required to identify and intervene with those women who are disconnected or marginalized from health and social services because of these barriers. The goal of the BTC Pregnancy Outreach Program is to facilitate engagement with women earlier in pregnancy in order to promote maternal, fetal and child health outcomes, and to facilitate the development of service relationships among providers who have contact with pregnant women using substances. Pregnancy outreach programs recognize that the circumstances that bring women to use of alcohol or other substances, and that make it difficult for them to stop using during pregnancy, also affect a woman's ability to access resources. Evaluations of pregnancy outreach programs that have been studied generally confirm that pregnancy outreach programs are "a powerful support mechanism that provide opportunities for meaningful interactions with caring service providers and other women in similar situations" (Tait, 2000), and that demonstrate significant perinatal and enduring outcomes for mothers and infants.

Pregnancy outreach programs are effective to the extent that they facilitate the engagement of women in relationships that decrease their isolation, increase their knowledge of the resources that are available to them, facilitate their connection with those resources, and promote their involvement in planning and decision-making for themselves and their expected infants. Their true power is in their capacity to foster a foundation for sustaining relationships with service providers, other mothers, friends, and family members after

They are more likely to have either custody of, or contact with, their children

Pregnancy outreach has the dual goal of early engagement of pregnant women and stronger service relationships

The program is a powerful support mechanism with enduring outcomes for mothers and children

Beyond its clinical utility, pregnancy outreach serves a deeper function

It fosters a sustained service and personal relationship that is the foundation for relational shifts for substance-involved pregnant women



the birth of their baby. Engagement in relationship through outreach is the first step in the process of healing through relationship. It is through their experiences in this relationship that the possibility of important relational shifts and capacity for relationships may occur for pregnant women using substances.



4.2 Substance Use, Violence, and Mothering: BTC's Connections Project

Adapted from the Original Publications:

- Connections: A Project Proposal. Submitted to the Ministry of the Attorney General - Ontario Victims Services Secretariat, May 13, 2005.
- Connections: Final Report of the Pilot Project (June 2005 - June 2006). Submitted to the Ministry of the Attorney General - Ontario Victims Services Secretariat, June 26, 2006.

The majority of BTC mothers report histories of violent relationships with partners who are also substance abusers and who often exert physical, financial and emotional control over their lives (Pepler et al., 2002; Motz et al., 2006). Substance use, mental health problems (especially depression, anxiety, trauma) and domestic violence are often considered individual problems but, in fact, often co-exist. These risk factors affect parenting processes, child development and substance use recovery.

There is a growing body of knowledge about the impact of parental substance use on children, and on the impact on children living with domestic violence. There is some research available on the impact of substance use on the capacity to enter into and maintain healthy, positive relationships and partnerships. There is little or no research on the relationship between all four:

- Substance use
- Healthy child development
- Domestic violence
- Child maltreatment

Given the evidence that substance use interferes with the capacity for healthy, positive relationships and that exposure to violent relationships may create significant long-term harm to positive parenting, creating an opportunity for BTC clients to explore these issues was seen as a key component of the healing and recovery process for the mothers. And given the focus on supporting parenting at BTC, supporting mothers to consider the potential impact of violent relationships on their own process of healing and recovery, as well as the impact on their children, was seen as critical.

For mothers struggling with substance use problems, parenting their children presents many challenges. When these mothers are involved in violent domestic relationships, these challenges are magnified and the potentially negative

The majority of BTC women have histories of violent relationships with substance abusing partners

Little research is available on interconnections

Exploring these issues is a key component of healing and recovery for women and for healthy child development

Violence magnifies the challenges for substance-involved women of both mothering and their own recovery process



Domestic violence increases the likelihood of child maltreatment and neurological damage

Impacts of violence are more profound for very young children

80% of BTC women report histories of childhood maltreatment; mothering can trigger dormant issues

impacts on themselves and on their children are dramatically increased.

There is a relationship between domestic violence and substance abuse and recovery. There is also a relationship between substance abuse and domestic violence. Women in violent relationships face additional challenges to their recovery process. Dulling both the literal and figurative pain of living with violence is one reason that women may abuse substances (Butler et al., 2004).

There is a further relationship between healthy child development, domestic violence and child maltreatment (Butler et al., 2005). Not only does exposure to domestic violence increase the likelihood of child maltreatment, children who experience domestic violence may experience neurological impacts (Perry, 2001). Furthermore, women coping with the trauma of domestic violence may also find it much more difficult to effectively parent their children. More than 50% of clients of the BTC program report that their current relationships are abusive (Pepler et al., 2002).

The young age of the children served at BTC is of particular significance with respect to the impact of experiencing domestic violence on children. "... The effects of violence in the home are magnified for young children, who depend on adults for all aspects of their care. Infants are highly vulnerable to injury and cannot defend themselves or run away. Infants, toddlers and pre-schoolers have fewer innate coping strategies and adults must help them deal with overpowering emotions associated with violence at home" (Baker et al., 2005).

What is particularly significant for the clients of BTC is that more than 80% of the women report a history of experiencing domestic violence and child maltreatment themselves (Pepler et al., 2002). As these women become mothers, they are often still coping with unhealed emotional wounds from their own childhoods. Parenting their own children may trigger long dormant issues particularly if they are working on their own recovery from substance abuse and no longer have drugs or alcohol to manage the emotions that are generated. Substance abuse may also be a coping strategy used to manage domestic violence (Baker et al., 2005).

One consequence of living with abuse as a child is disorganized attachment. For many of the clients of BTC the Cycle, this is their reality. As is confirmed in the focus group data



below, they have normalized chaos, confusion and low expectations of others in their lives. It is not uncommon for adults who have disorganized attachment patterns to have the expectation that troubled, unhappy and potentially dangerous relationships are safe because this is what they have experienced. For these women, a supportive, loving relationship may be so unfamiliar that it feels unsafe and uncomfortable, and results in a state of hyper-vigilance. For the children of women in this situation, this may become their norm as well. There is considerable research that demonstrates the critical importance of breaking this cycle of troubled attachment. As infants and young children require the active engagement of an involved adult to regulate their emotions and to develop a belief that the world is a safe place to be, it is critical to develop and implement programs that support vulnerable mothers to develop these skills (Sroufe et al., 1999).

In 2005, Ontario's Ministry of the Attorney General (Ontario Victims Service Secretariat) provided pilot funding for BTC to develop, deliver, evaluate and disseminate the results of a "two-generation" approach that simultaneously addresses the needs of BTC mothers and their children for whom domestic violence co-exists with substance use and related issues.

Because the problems of domestic violence, substance abuse, child development and maltreatment, and parenting co-exist and are interrelated for the majority of the women and children at BTC, failure to address them in an integrated and comprehensive way interferes with and fragments processes of change in each of these areas. Providing a group or program addressing domestic violence issues in the context of the existing integrated services at BTC acknowledges the experiences of women's lives and the interrelationship of these problem areas. The pilot was developed in consideration of the following:

- i) The relationship between domestic violence and substance abuse and recovery. There is a connection between substance abuse, victimization and domestic violence. Failure to address these issues in an integrated manner interferes with substance abuse treatment effectiveness and contributes to relapse.
- ii) The relationship between domestic violence, child development and child maltreatment. Exposure to

Substance abuse and disorganized attachment are consequences of childhood maltreatment

Women are enabled to explore past/present victimization and its impact on parenting, recovery, and child development



BTC women had a strong understanding of the interconnections

domestic violence increases the risk of child maltreatment, and affects normal developmental trajectories. Failure to address the impact of domestic violence on child development and child maltreatment interferes with the promotion of safe and appropriate environments and relationships for children.

- iii) The relationship between domestic violence and parenting. Parenting may be a special challenge for women who have or continue to experience violence in relationships. The parenting relationship is the mechanism through which interpersonal patterns of relating and solving problems in relationships are transmitted across generations. Failure to address the impact of domestic violence on parenting processes interferes with efforts to break cycles of abusive patterns of relating.

The primary activities of this pilot project included: 1) a needs assessment, including literature review and focus group interviews with BTC mothers; 2) the development of a Connections group curriculum; 3) the delivery of the Connections group; 4) revision of the curriculum based on feedback from participants.

1) Needs assessment/focus group interviews

A focus group was held with approximately 15 current clients of BTC to solicit information regarding the level of, and gaps in, knowledge in this topic area. Participants in the focus group were all experienced with BTC and involved in the program for a considerable period of time. A facilitator supported the focus group using a pre-determined series of questions. The intent was to gather information about how much women knew and understood about the relationship between substance use, recovery, domestic violence and healthy child development. The information gathered informed the development of the content of the group curriculum. The women were extraordinarily open about their experiences and demonstrated a considerable depth of theoretical knowledge about the relationships between healthy relationships and recovery. The participants also articulated a strong understanding about how their history and experiences may create challenges in developing and sustaining healthy relationships. It is important to note that the responses to the questions confirmed the information gathered through the literature review.



The following questions were posed to focus group participants. Highlights of the responses are listed below each question.

Can you tell us about any connections between your recovery process and the way your relationship with the baby's father (or your current partner) is going?

The fact that with all the resources we have here and maintaining a clean lifestyle, that our partner does not necessarily have access to the same resources, may not even have the same desire to stay clean. This could be either the partner or the baby's father, and whatever cycle in recovery they're in, if they're in, can definitely affect, number one your home life, can affect your baby's life, can affect your own recoveries, because being around a using individual when you're in recovery and not using is incredibly dangerous.

I need to work on my recovery right now, and I really think he needs to work on his...

...And you know, to establish trust in relationships and recovery, and how to re-establish trust in ourselves. Because being with a partner can jeopardize our trust in ourselves.

What can you tell us about any connections between drinking, drugs, and healthy and/or unhealthy relationships? (The intent was to identify whether the women think that there is more violence in their homes when either they or their partners are drinking or doing drugs.)

... We were smoking when we got married, and drinking buddies and, you know. That's all it was. You know, now that I am clean, I just ... I don't have anything in common. That was the only common thing we had going on.

... You're more likely to find what you're looking for when you're high. And ... you know, your perception is clouded and it can't be trusted.

I think of sex, like, as an option for money ... it's a different thing, because you just kind of get this thing, just get him and get him off thing ... that gets you to where you got to be, next time or whatever. I don't know, I found that I carried that out in my marriage, too. ... Other than that ... that is just, it's ... cash.



I think it's a reflection of how they viewed you, and how you were used, in a way. They dehumanize you and in effect we in return dehumanize them. And what do you expect? We can't look at them as heroes now ... If a knight in shining armour rode into my life right now, I'd shoot his bloody horse.

What can you tell us about what happens to babies and little children who see or hear their mom being hit or yelled and screamed at? (The intent was to find out how much focus group participants know about the physiological impact of domestic violence on infants and children.)

They won't trust anymore. Whatever you model, that's what they do. They mimic you. They copy what you do, or their father.

Or if they see there's no respect in our relationships, so how can they learn respect?

... There was all this violence in our house, and I thought that was normal, and I thought that's what I was supposed to be growing up. And I was receiving violence from whomever, and I just let that happen, until I came here to Breaking the Cycle. That's when I realized I didn't have to live like that. ... I never want my kids to ever go through that. There is no way I will let anyone hit my kids. I'd die for them you know, to protect them. There is no way I'm going to let my kids feel like that ...

I'm wondering if it's not the abusive part that brings unhealthy relationships ... I base a lot of my net worth on whether or not I have a man around me, a lot and I'm wondering if that has, like could that have an effect, like, maybe it's not just going after, but just saying I'm worth something if you want to be with me.

How would you define a peaceful environment for your children? If you talk to your partner(s) about making peaceful environments for your child(ren) do they listen? What kind of information might help make these conversations easier?

There is peace at home, but when the kids go to school, that's when we have it out. Even though the kids probably sense it when they come home, there's tension between us.



Also information, like to help with the conversation would be good, because like you said before, if you wouldn't have known certain things about children's reaction to heated discussions or even violence, like without that knowledge that conversation wouldn't have taken place, so probably its good to...

Sometimes having something in black and white, on paper. Say, Here, read this, if you don't believe.

Do you remember violence in your family when you were little? How do you think it might have changed you?

I think it de-sensitizes you a little bit, but the big thing for me that I've learned is that because my parents were so abusive towards each other, there was no respect or love or affection, and there was always turmoil, turmoil, turmoil - we were moving, there was fighting, there was police, there was violence -that I found out even as an adult, because that was so normal for me, if my life was going along smoothly and calmly, it's like unfamiliar so I create this chaos, this craziness, because that feels more comfortable to me.

Would it be helpful to you as a mom to know more about drugs, alcohol, family violence and your children? What kind of things would you like to know?

I just crave knowledge...Teach me because I have an open mind and I want to be different than what my parents were, and you know, not having a clue about, you know, being in a healthy relationship, because I never had one in my life, I need to learn how to, so any information on how to communicate, like I didn't even know that verbal abuse was abuse. I mean I really didn't have a clue.

To recognize what's been done...Because bruises heal, right, but it's the verbal abuse - that's the voice in my head that's not my own - that always goes: You're stupid, you're an idiot, you'll never make it...you deserve this; all this...that's not my voice.

Yeah, not to look for happiness outside from someone else, or some job, or some money, or some relationship. That we are comfortable with who we are and we love ourselves, then we might not necessarily have to go seeking for any kind of substance or relationship or anything



to make us feel better.

It's just making the link between healthy moms and healthy children, but primarily it's something we all need to learn. I like to learn.

As we develop this group to be delivered at Breaking the Cycle, are there topics or areas of discussion that we should sure to include?

Like self-esteem absolutely.

For me it was all about balance and I had no idea that you are body, mind and spirit...so if you maintain your health, you know, eating and exercise, then your positive affirmations or whatever...and, you know, just all three aspects, because if you have two going really great for you, but you don't have the other one... if you're not really balanced, then that can cause a want to relapse.

Self-caring is a very good thing to learn.

2) Development of pilot curriculum and delivery of the "Connections" group

The literature synopsis, focus group data, and additional background information were used to develop a pilot curriculum, which was delivered as 6 week group series for mothers at BTC in the spring of 2006. Approximately 6 mothers attended each weekly session regularly, and participated in ongoing evaluation of the sessions. The focus groups were co-facilitated by a psychologist and an addiction counsellor at BTC. These clinicians were known to most of the participants, and accelerated the level of trust and comfort in discussing some of the sensitive and difficult material that this group covered. Since all of the mothers were active clients at BTC, they had access to individual counsellors regarding any residual feelings stemming from the discussions in the group. Child care was provided by trained early childhood educators who were known to the children. The project consultant was an "observer" of the group sessions. Modifications to the pilot curriculum content were made on a week-by-week basis in response to the needs of the women participating in the group and the feedback participants provided on a weekly basis.

3) Participant feedback and curriculum revision

As a pilot project, it was important to gather feedback from

A pilot curriculum was developed based on the research literature and focus group data



the participants on a weekly basis. In response to direct feedback from participants, changes were made in the curriculum for the following week. Participants were asked for specific feedback about what was interesting and/or helpful, what was uninteresting or not helpful and what, if anything, they would change. The Group Facilitators identified that this was a pilot and that all feedback was extremely important. Participants commented about being “guinea pigs” but were pleased to be asked and to provide feedback. At the conclusion of the Week 6 additional time was devoted to an evaluation of the series.

The overall response to the series was extremely positive. Participants stated that the information was valuable and that they perceived that their ability to recognize healthy, supportive relationships has increased. All participants identified that they had a better understanding of the potentially negative impact of unhealthy relationships on their young children. All participants confirmed that the information discussed in the group was relevant and applicable to their own relationships. When participants were asked what topics or areas could have been more emphasized the responses were as follows:

- More information about how to make changes in their own behaviour
- More information about how we relate to others because “this sends messages to our children”
- More handouts and written material

All the participants were unequivocal about their interest in participating in this group again and all asked if it would be offered again soon.

Development of Final “Connections” Curriculum

The Connections curriculum was revised based on the participant feedback and following reflection by the group facilitators.

Key Messages

The key messages build upon each other supporting the development of increased understanding about positive relationships and their importance to positive mothering and healthy child development. Participants in the focus group session articulated the need to focus on the development of self-esteem both for themselves and for their children. This theme repeats throughout the sessions.

*To download the final
Connections group
curriculum, go to:*

www.mothercraft.ca



Week One:

- No relationship is perfect but everyone has the right to a relationship that is nurturing and supportive
- Domestic violence comes in many forms
- There are clues that a relationship may be moving from healthy to unhealthy
- Unhealthy relationships may have an impact on your substance use and recovery

Week Two:

- Everyone has the right to a relationship that is nurturing and supportive
- Witnessing or experiencing violent, unhealthy relationships as children may have created distortions in how we view adult relationships and our expectations of acceptable/appropriate behaviour
- Unhealthy relationships may have an impact on substance use and recovery
- Witnessing unhealthy, violent relationships may have a negative impact on infants and children

Week Three:

- No matter what happened in your past, it is possible to move beyond this and create healthy, happy relationships for yourself and your children
- Children are dependent on the environments that their mothers create

Week Four:

- Positive brain development depends on healthy, happy environments
- The way we interact with our children when they are infants and toddlers will make a difference for the rest of their lives

Conclusion

The Connections program was developed in response to the high rates of domestic violence reported by mothers attending BTC. The purpose of the Connections pilot project was to develop, deliver and evaluate the impact of a group that addresses the impact of domestic violence on child development, parenting and substance use recovery. The program was delivered within the context of the existing substance use treatment, parenting and child development programs offered at BTC. It provided education, informa-

tion, and a safe opportunity for women to explore and process information regarding their past and present victimization, and to explore its impact on their parenting, their recovery, and their children's development through a holistic and integrated approach. The development and revision of the curriculum relied heavily on the input of participants, both in the needs assessment and evaluation phases of the pilot. It is anticipated that the curriculum will continue to be revised and modified as the group is delivered in the future based on the particular needs of participants.

Following the successful completion of the pilot, Connections was funded by the Ministry of Children and Youth Services Community Capacity Building Fund. Connections continues to be delivered as a domestic violence intervention delivered within the context of Mothercraft's Breaking the Cycle program.



Final Curriculum Outline

Week One	Learning about Healthy Relationships • Healthy relationships/unhealthy relationships: When does a healthy relationship become unhealthy? • What is domestic violence? • The impact of domestic violence on substance use and recovery
Week Two	When we were growing up, how might domestic violence have affected us? • Witnessing violent, unhealthy relationships as children may have created distortions in how we view adult relationships • Talk about self-esteem, fear, stress, anxiety, becoming familiar with chaos; seeing chaos as normal • What is the impact of domestic violence and experiencing unhealthy relationships on children
Week Three	Recovering from my past; Building healthy relationships for me and my child • What is your vision of a healthy relationship? • How do we create healthy relationships for ourselves? • What is my role in creating and sustaining healthy relationships? • What does a healthy relationship look like?
Week Four	Child Development and Behaviour • Brain development • How experience shapes development • Mother/child interactions • The importance of routines: consistency and stability • The importance of social support
Week Five	Building Self-Esteem • High self-esteem is critical to creating and sustaining healthy relationships • Developing strategies to build self-esteem • The relationship between competence and self-esteem • Relapse prevention strategies • Incorporate recovery discussion here (substance use as a management strategy)
Week Six	Positive Parenting: Building Self-Esteem in Children • When we feel good about ourselves it is easier to help our children feel good about themselves • Children with high self-esteem are more likely to succeed at school and in their own relationships • Helping children become competent



4.3 Rethinking Smoking Cessation Strategies for Women and Their Families

Adapted from the Original Publication:

- Singh, Christine (2004). Rethinking Smoking Cessation Strategies for Women and their Families. Toronto: Unpublished manuscript completed as a residency project, Dept. of Medicine, University of Toronto.

Introduction

Treatment of women's substance use problems improves pregnancy and child outcomes. The research is clear that the use of substances exists in the context of other serious conditions including maternal psychopathology, trauma, poverty, abuse and neglect, domestic violence, and homelessness.

Each substance has its own associated risk to the mother and child secondary to the pharmacology of the drug and because of the biopsychosocial factors surrounding use. Cigarette smoking often accompanies other drug use and continues once women are recovering from alcohol, cocaine, heroin, and other substances. There is significant risk from cigarettes towards the health of mother and child. Maternally, risks of cancer, heart and lung disease are among the consequences of smoking. For the fetus in the antenatal period, smoking is associated with lower birth weight, increase of miscarriage, preterm labour, and placental abruption. In childhood, there is an increase in behavioural and learning problems such as hyperactivity and inattention associated with maternal smoking in pregnancy (Kronstadt, 1991) and health consequences for children living with smoking adults include increased incidence of asthma, otitis media, and SIDS.

Background

At BTC, intervention strategies have focused on mothers' use of alcohol and illicit substances. While nicotine addiction may be addressed with mothers individually, no formal group or intervention existed at the time of this study. This study was designed to find out from women and staff at BTC what an ideal smoking reduction or cessation program would look like, considering the life circumstances and barriers faced by mothers attending BTC.

The study used qualitative methods including two client focus groups. One focus group was comprised of women who had been involved at BTC for an extended period of time and had made significant changes to their substance

Many substance-involved pregnant and parenting women also smoke cigarettes

This poses additional risks to both mother and child



BTC women identified many barriers to quitting including lack of social support and addiction to nicotine

Many women who smoke are surrounded by other smokers

use, and the second group consisted of mothers who had more recently joined BTC and were in the early stages of considering changes to their substance use.

Focus Group Responses

The focus groups led to many points of discussion around nicotine. Discussion themes included barriers to quitting smoking, previous attempts to quit smoking, personal motivations, and ideas for a future program.

Barriers to quitting smoking

Barriers to quitting smoking included social support, stress, addiction, costs of medications, and fear of gaining weight. When women enter BTC, they focus on decreasing substance use and learning life and parenting skills. As one participant explained, she was unable to stop smoking because:

It helped me manage through the other quitting of doing either drugs or drinking. It's a new life coming to you.

The incredible life changes that these mothers were making in order to change their substance use were profound. The changes occurred in many spheres of their lives, particularly in the area of social relationships. Because mothers often made decisions to end previous relationships and friendships that involved substance use, social isolation became an issue for women who want to change.

Current social settings and supports further complicate the ability to quit smoking for many clients. Women felt less likely to quit when significant people in their lives still smoked; for example, one woman stressed that:

Both my partner and I need to quit smoking.

Another woman stated that living in a transition house made it difficult because of the prevalence of smoking:

The house I live in, I mean a lot of the girls smoke.

The use of cigarettes to deal with stress was a common theme for all the women in the group. One woman explained:

Now, like, I'm really stressed out, so I'm not ready yet.

Another woman who had successfully quit during her current pregnancy expressed concern for managing post partum without cigarettes.



It's my biggest fear after the baby's born.

She had been able to stop smoking during her pregnancy because it made her feel nauseated but was anticipating the stress of the baby's birth. She was unsure if she could successfully remain a non-smoker once the stresses of parenting set in.

The addictive nature of smoking also proved to be a great concern among both groups of women. As one woman explained:

It was easier to quit drinking.

Women had tried a variety of methods to quit, including nicotine replacement therapy, alternative methods such as acupuncture, and quitting cold turkey. The length of previous quit times varied from hours to months with relapse related to stress. One woman pointed out that, unlike the other substances people used, there was a social acceptability to cigarettes:

You are not going to lose your kid because you smoke cigarettes.

Unlike other substances women had been using, cigarettes are legal and permissible.

Weight gain with quitting smoking was a concern echoed among many women in the focus groups. One participant stated:

If I quit smoking, I would gain a lot of weight because I have before in my life experienced weight problems. And if I quit smoking, I would eat myself into a heart attack.

Issues of self esteem, as one staff pointed out, were intrinsic to these women and their recovery. Often, using drugs kept them thin and the fear of gaining weight was very real. Over 30% of women participating in BTC report a problem with an eating disorder. Low self esteem is pervasive among the clients and body image issues are prevalent and require consideration.

Many women acknowledged that medical aids in helping cessation could be useful. Several women cited cost of nicotine patches as a barrier; for example, one woman said:

Some women fear post partum relapse

Many identified nicotine dependence as more powerful than their drug of choice

The relative social acceptability of cigarettes was also noted

Weight gain is a common concern



*Smoking cessation aids
are highly rated by women
but are not affordable*

*All women had made
previous quit attempts*

*Concern for their own
health and the health of
their children is a strong
motivator ...*

It's a big chunk of money in one shot, you know what I mean? They're really expensive.

Previous attempts to quit

Of the women who participated in the smoking cessation focus groups, virtually all had attempted to quit smoking previously. The following are some excerpts from their experiences:

I used to have a summer job - this was about six years ago - I've been smoking for about 13 years and I would quit for two months in the summer. The last five summers I couldn't quit if you gave me a million bucks.

I tried quitting once in the last three years and I tried to quit cold turkey. It didn't last a long time, only a couple of weeks. I tried the patch a long time ago, like a long time ago.

It's part of my life, period ... it's just part of me. It's never crossed my mind to quit. Only when people talk about it, that's the only time, and I don't even think - I know I'm not going to quit, so why bother myself.

I've thought of quitting when I can't afford them [cigarettes]. I've got bronchitis and asthma, so I really shouldn't smoke. I've never really tried to quit, but I have gone without them and it's pure hell.

I tried Zyban [off and on] for a few years and I found it didn't work.

It is clear that smoking cessation is of interest to women but the challenges of overcoming the addiction are considerable.

Motivations to quit

Reasons for quitting revealed the women's concerns regarding both their children's and their own health. Some women were very cognizant of the effect of smoking on their children and this was a prime concern. One woman said:

I don't really like smoking around my kid, because my oldest daughter, she's 15, almost 16 years old, she's taken up smoking. So I'm trying and trying. I told her if I was willing to give it a shot after 20 years of smoking, she would quit with me. She said, yeah, so I'm really thinking about quitting because I don't want my kid smoking.

This sentiment was echoed many times. As another woman



stated:

Let's just say you see your kid with a cigarette hanging out of her mouth ... oh, it's the worst.

Being a good role model for their children was important. As one woman said:

The whole thing is not a good influence on my child.

Regarding personal health, women said:

I think I should quit because it's expensive and I don't have as much lung power as I used to.

Other women, who were earlier in their stage of recovery from other substances, were less able to articulate the dangers of smoking to themselves and their children. Interestingly, the discussion among women in the early stages of recovery did not reveal knowledge of the specific risks of smoking during pregnancy.

Future smoking cessation programs at BTC

The women were asked to consider at what point in their involvement with BTC they would have been receptive to discussing smoking cessation options. Most of the women explained that, on initial entrance to the program, discussion of smoking cessation would have been too overwhelming.

Some of the comments included:

I had this great sense of urgency to quit drinking when I was pregnant. But it's only really now, you know, eight months later that I would even consider quitting smoking. But you know, like of course, they suggest that you don't quit everything at once. Like you're going to lose your fucking mind.

Cigarettes were my saviour.

She [the BTC staff] knows not only that she's seen, or whatever, but she knows the ... the many steps that we took to change so many other things. But I think, you know, I don't think in a million years she would have ever said to me, OK, you've been clean like ten days now, quit smoking. You know, like, and I respect her for that.

... as is the imperative of providing a good role model for children

Knowledge of risks of smoking can be correlated to stage of recovery

Some women would prefer smoking cessation interventions at a later point in their involvement at BTC ...



... while others would have benefited from an earlier intervention

Women further along in recovery had broader insights into both motivations for quitting smoking and possibilities for programming ...

... which included accessible NRTs, support, and stress management

A few women described that they felt they may have been able to quit smoking at the same time as they began to quit using other substances and would have appreciated an earlier intervention:

I was at BTC for about ten months and I was surprised that there was nothing directly with smoking cigarettes.

Interestingly, as the focus groups consisted of women at different stages of their recovery, the discussion of program ideas was very different. Women who were more stable in abstaining from their drug of choice, whether alcohol, cocaine, or heroin had already accomplished significant work in recovery from their addiction. Their insight into what would be useful in a program for a broader group of women was much greater than women who were earlier in their recovery, as was their personal motivation for quitting smoking. The women at an earlier stage of recovery were less able to reflect on a broader scope of conceptualizing a program for other women. Their focus and reflections were more personally based.

Ideas for a future program came from both the focus groups of women and the BTC staff. The ideas put forth included having the availability of medical aids [nicotine replacement therapy], individual and group counselling sessions, increased educational materials, seminars and workshops promoting alternative substitutions for dealing with stress, and making lifestyle changes. A supportive, non-judgemental atmosphere is critical:

What I needed most to quit smoking was moral support.

I need someone to be gentle with me. It's the hardest thing.

Discussion

The focus groups and staff questionnaires reveal that smoking cessation is important to both the woman and the staff at BTC. Many of the findings from the focus groups correlate with the literature looking at smoking cessation during pregnancy from many research groups in North America and Europe.

The barriers to smoking cessation elicited by the focus groups correlate with those reported in other studies of perinatal smoking in women (Howell et al, 1998). The ability to overcome these barriers will have to do with improving social support, economic status, access to smoking cessation



aids, and lifestyle changes. The influence of nicotine addiction level, smoking by members of the household, lack of social support, stress, and weight gain on relapse and cessation was revealed in an American study of inner city women (Hymowitz, 2003). McCleod et al. (2003) showed that current employment and nausea secondary to smoking increase the likelihood of cessation while socioeconomic deprivation in women increases the likelihood of continuation of use.

Malchodi et al. (2003) showed that peer counselling had the effect of reducing the number of cigarettes smoked and improving birth weight of infants, but did not increase the rate of abstinence. A Danish study showed a multimodal intervention program including counselling, groups, and nicotine replacement therapy improved cessation rates during pregnancy (Hegarrd, 2003). Moran suggested that there are many missed opportunities in the care of pregnant women to address smoking cessation (2003) and that the discussion should be brought up more frequently. Several studies suggest that pharmacotherapy such as nicotine replacement would be helpful in smoking cessation and that its acceptability to women was high (Schroeder, 2002); however, data on safety may be lacking at this point in time and the decision of risk benefit should be discussed individually.

Most of the studies available on pregnancy and smoking did not address the specific high risk group of women served by BTC who have co-existing addictions. One study of women on methadone treatment found lower quit rates than general pregnant smokers and advocated innovative harm reduction strategies and nicotine replacement therapies (Haug, 2001).

Implications for Program Development:

This study allowed the clients at BTC to provide their input on the issue of programs to address smoking. Results of this study and others confirm that interventions to address smoking reduction among pregnant women and mothers must be delivered in the context of a range of multi-faceted supports, and must be delivered in consideration of the woman's stage of readiness for change. BTC is strong in its gender-specific outreach, treatment, and comprehensive service for high risk women. Expanding this theme to include specific smoking cessation strategies with the following components:

Research also indicates that women's ability to overcome barriers to quitting smoking include improved social supports and economic status ...

... including improved employment opportunities ...

... and multimodal intervention programs

Service providers miss opportunities to intervene with pregnant smokers and need to discuss smoking more often

BTC and similar kinds of programs are the ideal locations for smoking cessation programming



Program components should include interventions at intake and beyond, long term counselling, accessible NRTs, self-education, peer support groups, and seminars on related topics

- Offering smoking cessation along with other drug treatment methods at the initial intake with minimal pressure and then a re-introduction of the topic at later times for those women who do not participate earlier.
- Regular long term smoking cessation counselling with health care professionals.
- Ready and monitored accessibility to nicotine replacement therapy.
- Learning centre with videos and written information for self-education about smoking.
- A smoking cessation group meeting with peer support and educational seminars.
- Weekly seminars on topics such as nutrition, stress management, and lifestyle alternatives such as exercise.

In response to these recommendations, these initiatives were adopted:

STARSS (Start Thinking About Reducing Second-hand Smoke)

The **STARSS** program is a non-judgemental, non-blaming approach based on harm reduction and aims to help low income mothers identify ways to protect their children from second-hand smoke. This strength-based program emphasizes the mother's positive actions (e.g. smoking outside) and encourages self confidence in her ability to quit. BTC confirmed its commitment to continue to deliver the **STARSS** program beyond its pilot phase, and to consider expanding the current individualized delivery of the program to group format. BTC was a pilot site for the development of the **STARSS** program developed by AWARE (Action on Women's Addictions - Research & Education) and continues to offer it to all participants on an individualized basis through the home visitation.

PREGNETS

The overall objective of the PREGNETS program is to decrease the negative consequences of smoking and environmental tobacco smoke on the woman, fetus, and child by encouraging healthcare providers to include minimal contact interventions into routine assessments and healthcare. BTC has developed a strong referral and service relationship with the PREGNETS. This has resulted in seamless access to specialized clinical support (including access to NRT) for pregnant women who desire to reduce

For more information about STARSS, go to www.aware.on.ca/starss



or cease their tobacco use. Pregnant women who desire to reduce or stop their smoking during pregnancy are referred to PREGNETS for assessment and treatment (Centre for Addiction and Mental Health, 2005)

It should be noted that both **STARSS** and PREGNETS were adopted because they espouse a harm reduction approach to changing smoking behaviour that is consistent with the findings of the study by Dr. Singh, as well as the overall approach of BTC. Both **STARSS** and PREGNETS recognize cessation as the ideal goal for pregnant women and mothers with young children; however, they recognize and acknowledge the reality of the lives of women with substance use problems as they make changes in their smoking behaviour.

*For more information,
go to: www.pregnets.org*



4.4 Breaking the Cycle: Measures of Progress 1995 - 2005

Original Publications:

- Motz, M., Leslie, M., Pepler, DJ., Moore, TE., Freeman, PA. (2006). *Breaking the Cycle: Measures of Progress 1995-2005*. Special Supplement, Journal of FAS International, Toronto: Hospital for Sick Children, 2006;4:e22.
www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf

*Ten years of research
and evaluation of BTC
are collected in Measures
of Progress*

*Even though mothers who
are engaged in the BTC
Pregnancy Outreach
Program have a greater
degree of problems than
national comparisons ...*

*... many significant
successes are attained by the
women including enhanced
perinatal outcomes and
decreased isolation ...*

*... and a greater likelihood
of having custody of their
children upon discharge
from BTC*



Breaking the Cycle: Measures of Progress 1995-2005 reports on 10 years of data on a sample of approximately 770 substance-involved women and their children. The report presents the results of the evaluation of the BTC Pregnancy Outreach Program (CPNP) as well the evaluation of Breaking the Cycle (CAPC), and provides evidence for the efficacy of this comprehensive, integrated model to engage and treat substance-involved women and their children. *Measures of Progress* reflects ten years of research and evaluation, and the combined efforts and commitments of researchers, evaluators, service providers, community partners, and service recipients, all of whom have played a role in improving services for substance-involved mothers and children.

The results of the evaluation of the BTC Pregnancy Outreach Program (CPNP) confirm that BTC is reaching and engaging this high risk and marginalized population of homeless, pregnant and substance-using women. The data also confirm that, compared to CPNP participants nationally and regionally, the women engaged through the BTC Pregnancy Outreach Program report significantly higher rates of alcohol and tobacco use, significantly higher rates of poverty that affected food security and nutrition, significantly lower levels of educational attainment, and significantly higher rates of social isolation.

Clinical outcome data confirm the success of the BTC Pregnancy Outreach Program in: 1) engaging women earlier in pregnancy, which has been related in previous BTC evaluations with enhanced perinatal outcomes (including higher birth weights, fewer postnatal diagnoses, reduced length of hospital stay, and decreased mother-infant separations at birth); and 2) decreased isolation through positive referrals to health and social services. Further, engagement in BTC during pregnancy was significantly related to higher rates of completion of treatment/intervention plans (including accessing addiction treatment, prenatal care and securing housing). Finally, women who entered BTC in pregnancy were significantly more likely to have custody of their children at discharge from BTC.

Evaluation of the Breaking the Cycle program confirms the high risk factors that characterize the mothers and children who attend BTC, including: high rates of maternal maltreatment and trauma (sexual, physical and emotional abuse); high rates of maternal psychological symptoms including depression, suicide attempts, eating disorders; significant history of substance use in family of origin and in adult relationships; lengthy history of substance use; compromised health status; low levels of educational attainment; high rates of domestic violence; high rates of obstetrical losses, and loss of custody of children. These factors compromise the health and well-being of mothers, and pose risks to the health and development of children. The children at BTC are exposed to multiple risk factors both prenatally, including exposure to alcohol and other substances, and in the postnatal environment (including high rates of separations from their mothers). These risk factors place BTC children at risk for health and neurodevelopmental problems, for child maltreatment, and for disorders of attachment and regulation.

However, clinical outcome data indicated that: 1) BTC children are functioning within the normal range of development, and that they are developing along a trajectory that is consistent with their age over time; 2) there was a significant decrease in parenting stress for BTC mothers over time, and the slope of change is significantly more profound for those mothers who were engaged during pregnancy (highlighting the enduring impacts of early engagement through the BTC Pregnancy Outreach Program); 3) there was significant improvement on mothers' sense of parenting competence; 4) there were significant increases on measures of postnatal attachment and quality of attachment. BTC mothers consistently reported increased knowledge and confidence regarding services in the community at discharge, as well as a significant increase in social support from family and friends.

With the support of the Canadian Institutes of Health Research, BTC will build on its 10 year history of evaluation with a study that will include a comparison with a traditional substance-use treatment program to provide insights into the outcomes and underlying processes of the BTC approach with a focus on mothering and child development.

Similarly, women and children involved in the general BTC program face many high risk factors in their lives

Evaluation revealed many improvements in children's functioning, mothers' parenting ability, and attachment ...

... showing that, with good postnatal supports, substance affected children can function within the normal range of development

Evaluating Treatments for Substance-Using Women: A Focus on Relationships

Study Investigators:

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SUMMARY of Section 4

This Section described the ways in which research and evaluation has influenced practice and program development at Breaking the Cycle. It further described quantitative outcomes which confirm the efficacy of a comprehensive, integrated approach for serving substance-involved women, mothers and children along a number of dimensions, including engagement, maternal substance use recovery, child custody, mothering, attachment, child development and social support. Positive findings on all of these outcomes support the use of relationship-based maternal-child approaches that acknowledge the complexities of the lives of substance-involved pregnant women, mothers and children, and the powerful opportunity for change during pregnancy and early motherhood that occurs within the context of corrective healing relationships with service providers and others. This, in turn, offers an opportunity for mothers to break the cycle of intergenerational transmission of relationship disturbance and related problems, including trauma. Ongoing research will provide additional insights into the outcomes and underlying processes of the BTC approach with a focus on mothering and child development.



CONCLUSION

The *BTC Compendium: The Roots of Relationship* has offered a collection of publications, papers and resources describing the development, delivery and evaluation of BTC since 1995. The *Compendium* explored the central theme of *relationships* - among service providers, between service providers and women, and between mothers and their infants - as the key mechanism for understanding and responding to the complex issues of pregnancy, mothering, substance use, child development, and FASD issues.

Section 1 outlined the context for the development of an integrated maternal-child relationship-based model for substance-involved women and their young children. The development of BTC was grounded in the hypothesis that enhanced connections or relationships among service providers offer an important context for growth-promoting relationships between substance-involved pregnant women and mothers, and the helping system. The importance of relationships between previously disconnected service sectors and providers to create environments that facilitate engagement of substance-involved women and their young children with services was a central theme of this Section. The development of BTC's non-traditional cross-sectoral partnership between adult services and children's services was described, as were fundamental decisions regarding program philosophy and design, including the definition of both mother and child as clients. The unifying set of theoretical approaches that form the foundation of all programs, services and approaches were summarized, and reinforced the maternal-child focus. Section 1 suggested that an integrated, comprehensive and caring service model which attends to the importance of relationships at a number of difference levels and that is congruent with the needs and experiences of substance-involved women can facilitate enhance capacity for relating within the mother-child relationship.

Section 2 drew on quantitative and qualitative data to provide a deeper understanding of the lives of substance-involved mothers and children who attend BTC. The cumulative impact of psychosocial and neurobehavioural influences on the lives of mothers and children at BTC were explored. First, sociodemographic information confirmed the circumstances of risk experienced by substance-involved mothers and children; in particular, the severe histories of maltreatment and trauma reported by BTC mothers provided an important context for understanding the use of substances by women and mothers. Second, higher rates of undiagnosed FASD among BTC mothers were hypothesized, suggesting the importance of considering a neurobehavioural context. This information has informed the development of approaches and services designed to support women, mothers and children who are substance-involved and who may be affected by prenatal substance exposure. In particular, the opportunity to deliver a "two-generation" response to these intergenerational problems created an opportunity to generate insight into the development of mother and child, as well as the development of the relationship between the two.

Section 3 detailed the application of relationship-based theoretical frameworks and approaches to promote resolution of substance use problems, and to promote relational capacity. The transtheoretical stages of change model, motivational counselling



approaches, relational theory and attachment theory were described as the foundation of the maternal-child framework within which all programs and services are delivered at BTC. Implicit in the application of these theories is the adoption of a harm reduction approach, which is necessary for the application of motivational interviewing strategies within the stages of change, and to relational and attachment-based approaches to treatment for mothers and children. In the application of a maternal-child approach, harm reduction also includes attention to the prevention or remedying of harms of maternal substance use experienced by children. This includes careful attention to the impact of substance use on maternal functioning and mothering behaviours, on the individual needs of the infant or child, and on mothers' access to supportive resources, relationships and environments that foster the growth of both the mother and child in the context of safety, health and well-being. The provision of supports early in the mother-child relationship were identified as a key to establishing strong, healthy relationship patterns between mother and child; however, it was acknowledged that, sometimes, supporting a mother's relationship with her infant means helping her protect her child from the kinds of experiences that caused *her* pain. This may involve a relationship with child welfare services who can assist mothers in protecting and promoting their infants' safety.

Section 4 provided research evidence for the efficacy of a comprehensive, integrated approach for serving substance-involved women, mothers and children along a number of dimensions, including engagement, maternal substance use recovery, child custody, mothering, attachment, child development and social support. Positive findings on all of these outcomes support the use of relationship-based maternal-child approaches that acknowledge the complexities of the lives of substance-involved pregnant women, mothers and children, and the powerful opportunity for change during pregnancy and early motherhood that occurs within the context of corrective healing relationships with service providers and others.

Ongoing research will provide additional insights into the outcomes and underlying processes of the BTC approach with a focus on mothering and child development.



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Appendix 1: Memorandum of Understanding

Between

Canadian Mothercraft Society, hereinafter referred to as the “Sponsoring Organization”

and

Motherisk Program, Hospital for Sick Children
Children's Aid Society of Toronto
Catholic Children's Aid Society of Toronto
Toronto Public Health
St. Joseph's Health Centre
St. Michael's Hospital
Toronto Western Hospital - Mental Health and Addictions
Ministry of Community Safety and Correctional Services

Any other organizations that may join as members from time to time

hereinafter referred to as the “Partner Organizations”

THE PURPOSE of this Memorandum of Understanding is to confirm a shared commitment between the Sponsoring Organization and the Partner Organizations (hereinafter collectively referred to as the “Parties”) to collaborate in the management and delivery of the Breaking the Cycle program, coordinating and integrating services to pregnant and//or parenting women experiencing substance use problems and their young children through a single-access model with pregnancy outreach and home visitation components.

Breaking the Cycle was developed as a response to recommendations from the 1992 conference *Addressing Addictions Together* that identified the urgent need to develop an integrated and comprehensive program for pregnant women and substance-involved mothers with young children involving partnerships among previously fragmented service providers.

The complex problems experienced by substance-involved mothers and their young children (maternal substance use, maternal mental health problems, domestic violence, and child developmental/mental health problems, prenatal substance exposure, neurodevelopmental and psychosocial risk to child outcomes) are not unrelated, and are most effectively addressed through a comprehensive, integrated and holistic approach that is necessarily based on interagency collaboration, coordination and communication, and that involves the integrated delivery of addictions, parenting, health, and developmental services;

Breaking the Cycle was launched in 1995 to address the needs of:

- a) Women who are pregnant or mothers of young children, and who are also struggling with problems related to substance use or recovery issues; and

- b) Infants and young children (0-6 years) whose physical, developmental and psychosocial health and well-being are at risk - prenatally, at birth, in infancy, in early childhood - because of their prenatal exposure to drugs, or their exposure to postnatal environments in which substances are used.

The goals of Breaking the Cycle are:

- a) Early identification and engagement of pregnant and/or parenting women experiencing substance use problems to break the cycle of intergenerational patterns of addiction and related problems, and to enhance outcomes in the areas of maternal and child health, child development, and parenting.;
- b) Develop and implement, through an innovative inter-agency partnership, a single access, transdisciplinary model program to collaboratively integrate services to pregnant and/or parenting women experiencing substance use problems and their young children, addressing maternal addiction and recovery issues, infant and child development issues, the mother-child relationship, and larger family issues;
- c) Design and conduct an evaluation to assess the short and long-term outcomes of an early identification, prevention, and intervention program targeted at this high-risk population of mothers and children; and the effectiveness of a cross-sectoral partnership in implementing a single access, transdisciplinary model program integrating maternal-child services for a high-risk population. To document and widely disseminate the evaluation assessment to assist other communities in replication this model approach elsewhere.

Since 1995, Breaking the Cycle has developed an integrated maternal-child model delivering a range of services to serve substance-using pregnant and/or parenting women and their children through a single-access model which offers individual and group addiction treatment, parenting programmes, child care, child developmental services (including screening, assessment and intervention), health/medical services (including paediatric clinic and addiction medicine), mental health counselling, domestic violence programming, case management/service coordination; parent-infant counselling, home visitation, street outreach, and support around instrumental needs (including food, clothing and transportation).

The evaluation of Breaking the Cycle confirms that the model is effective in engaging and serving pregnant and parenting mothers with substance use problem, and their young children (0-6 years) with the following outcomes:

- enhanced perinatal outcomes (including higher birth weights, fewer postnatal diagnoses, reduced length of hospital stay, and decreased mother-infant separations at birth)
- higher rates of completion of treatment/intervention plans by mothers (including accessing addiction treatment, prenatal care and securing housing)
- decreased the levels of isolation in these women's lives through positive referrals to health and social services

- increased likelihood that women have custody of their children at discharge from BTC
- BTC children are functioning within the normal range of development, and developing along a trajectory that is consistent with their age over time
- decreased parenting stress for BTC mothers over time improvement of mothers' sense of parenting competence
- increases on measures of postnatal attachment and quality of attachment
- increased knowledge and confidence regarding services in the community at discharge
- better social support from family and friends

THE PARTIES therefore agree to continue to collaborate in the management and delivery of the Breaking the Cycle Program as follows:

1. Roles and Responsibilities of the Sponsoring Organization

1. Mothercraft manages Breaking the Cycle in accordance with:
 - a) The goals and objectives of Breaking the Cycle as described in the project proposal to Health Canada dated February 28, 1994
 - b) The terms and conditions of the current contribution agreements with the Public Health Agency of Canada's Community Action Program for Children (CAPC), Canada Prenatal Nutrition Program (CPNP), and Ontario's Ministry of Children and Youth Services
 - c) The annual operating budgets and workplans for Breaking the Cycle as approved by the Public Health Agency of Canada's CAPC and CPNP programs Community Action Program for Children, and Ontario's Ministry of Children and Youth Services
 - d) The workplan as approved by the BTC Steering Committee.
2. Mothercraft prepares and submits to the Public Health Agency of Canada, the Ministry of Child and Youth Services, and the Partner Organizations:
 - a) An annual operating plan and budget request.
 - b) Quarterly financial statements and, following the end of each fiscal year, an annual audited financial statement;
 - c) Quarterly progress reports, statistics, evaluations and any other reports as may be required from time to time by the Public Health Agency of Canada, and any other funders
3. Mothercraft is the financial administration agent for Breaking the Cycle. This responsibility includes:

- Maintaining an appropriate set of auditable accounts
 - Monitoring in-year expenditures against the budget
 - Receiving grant funds from the Public Health Agency of Canada, and other funders
 - Receiving any other monies, such as donations
 - Pursuing additional grant funding as appropriate
4. Mothercraft is the personnel administration agent for Breaking the Cycle. This responsibility includes:
- Acting as the legal employer of Breaking the Cycle staff,
 - Providing payroll services
 - Developing position specifications
 - Recruitment of staff
 - Supervision of the Director, Early Intervention Programs
5. Mothercraft is the manager of all assets on behalf of Breaking the Cycle. This responsibility includes, but is not limited to:
- Ensuring appropriate insurance coverage
 - Undertaking of leases or rental agreements
 - Acting as the purchasing agent for Breaking the Cycle furniture, equipment, software and other capital assets
 - Disposal of obsolete and/or redundant items
6. The Executive Director of Mothercraft reports to the Mothercraft Board of Directors on a regular basis on all aspects of Breaking the Cycle

2. Roles and Responsibilities of the Partner Organizations

1. Each Partner Organization will contribute a senior representative who will sit on the Steering Committee of Breaking the Cycle:
2. Each Partner Organization will:
 - Contribute staff who deliver services at Breaking the Cycle, and/or funding, and/or space, and/or consultation
 - Supervise their staff who provide services on-site at Breaking the Cycle
 - Ensure that an appropriate agency representative participates in bi-weekly clinical team meetings
 - Act as the liaison for communications within their agency and in the community on matters related to Breaking to Cycle
 - Identify potential conflict of interest situations such as funding, service and research opportunities as they arise
 - Provide acknowledgement of Breaking the Cycle in publications and research activities

- Maintain confidentiality on Breaking the Cycle matters and discussion as identified.
 - Ensure adequate insurance coverage of all staff while on site at Breaking the Cycle
3. The Steering Committee will:
 - Discuss and develop program operating policy for Breaking the Cycle for final approval by Mothercraft
 - Provide input into program management issues as necessary;
 - Receive quarterly reports on operations;
 - Receive input from the Community Advisory Panel.
 - Promote Breaking the Cycle and act as an ambassador of goodwill in the community.
 4. The Steering Committee will normally meet quarterly or at the call of the Chair.
 5. The Chair of the Steering Committee will be selected from among its members, excluding the Executive Director of Mothercraft. The Chair will serve for a minimum of two years.
 6. The BTC Program Manager and Director, Early Intervention Programs of Mothercraft will:
 - Provide staff support for the Steering Committee
 - Represent staff on the Steering Committee
 7. The Steering Committee will annually include on its agenda a discussion of the functioning and effectiveness of the BTC partnership with a view to continuous improvement of the relationship and the mutual benefit for all Partner Agencies.
 8. Mothercraft will develop and implement an orientation process for new members to the Steering Committee, including background information, values, program directions, and the expectations, benefits, costs and rewards, of active participation.

3. Limitations

This Memorandum of Understanding is not legally binding nor imposes legal obligations on the Parties.

4. Duration

This Memorandum of Understanding will come into effect when duly signed by all parties, and shall remain in effect for a period of five years. Any Party may withdraw from this agreement by providing thirty (30) days notice in writing.

This Memorandum of Understanding may be amended only by a written agreement signed by the Parties.

Each of the undersigned parties represents the full authority to sign this Memorandum of Understanding on behalf of the institution that each represents:

AGREED:

_____	_____
Date:	For: Canadian Mothercraft Society

_____	_____
Date:	For: Toronto Public Health

_____	_____
Date:	For: Children's Aid Society of Toronto

_____	_____
Date:	For: Catholic Children's Aid Society

_____	_____
Date:	For: Motherisk - Hospital for Sick Children

_____	_____
Date:	For: St. Joseph's Health Centre

_____	_____
Date:	For: Ministry of Community Safety and Correctional Services

_____	_____
Date:	For: St. Michael's Hospital

_____	_____
Date:	For: Toronto Western Hospital

Appendix 2: Consent to Release Information Among BTC Partners

BREAKING the CYCLE

Consent to Release Information among BTC Partners

I, _____ of
(PRINT FULL NAME)

(PRINT FULL ADDRESS)

Authorize the partners of Breaking the Cycle, namely:

Canadian Mothercraft Society	Toronto Public Health
Children's Aid Society of Toronto	Hospital for Sick Children - Motherisk
Catholic Children's Aid Society	St. Michael's Hospital
St. Joseph's Health Centre	
Ministry of Community Safety and Correctional Services	
Toronto Western Hospital, University Health Network	

To release/exchange confidential information, both written and verbal, related to the services received at Breaking the Cycle which include:

Addiction Services	Child Development Services
Health and Medical Services	Parenting Services

About me and my children:

Me	Date of birth: _____
My children	Name: _____ Date of birth: _____
	Name: _____ Date of birth: _____
	Name: _____ Date of birth: _____
	Name: _____ Date of birth: _____

For the purpose of coordination of services.

This consent shall remain in effect from _____ to _____

Signature

Witness

Date

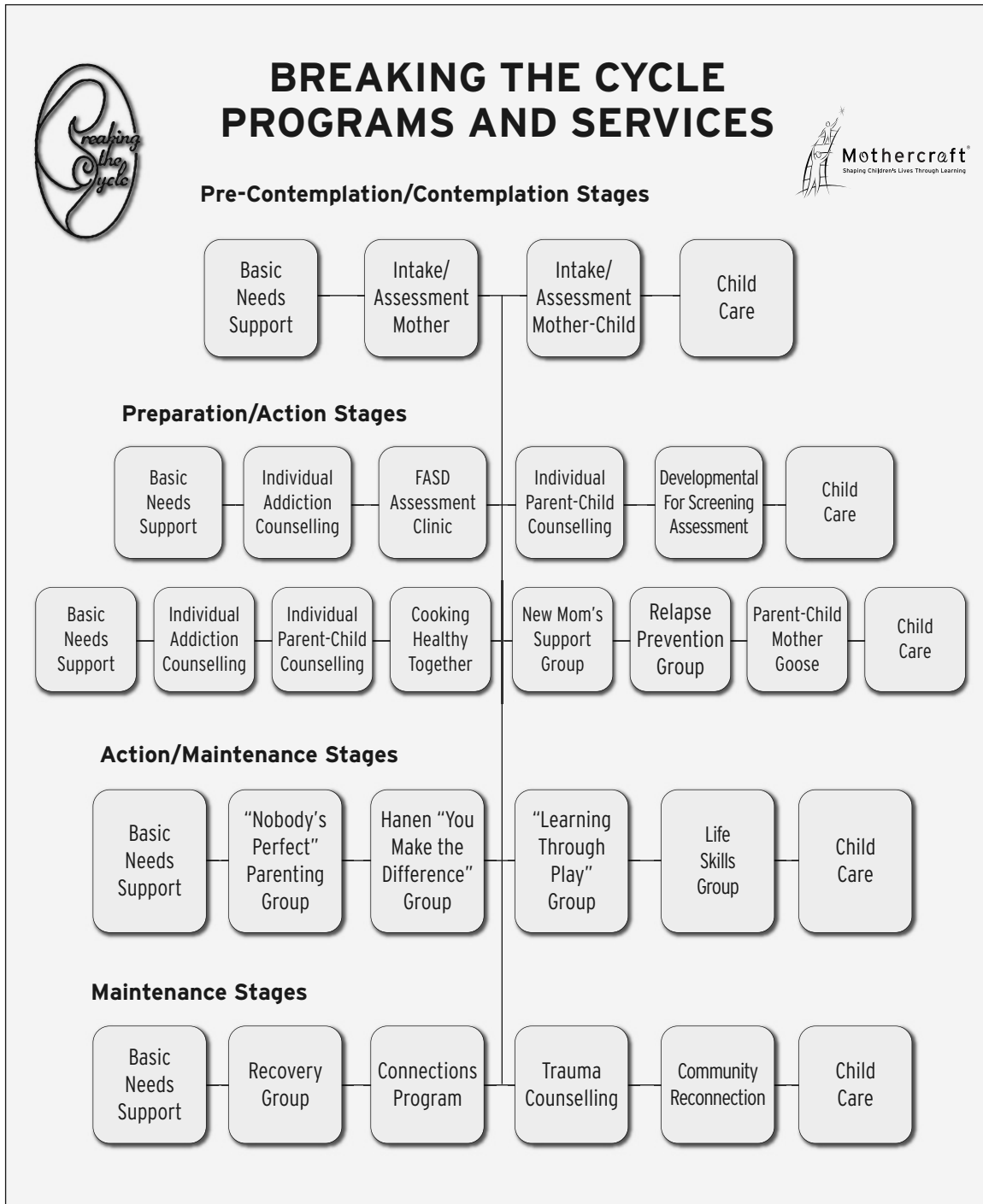
NOTICE With Respect to the Collection, Use and Disclosure of Information: Personal information will be gathered by the partners of Breaking the Cycle and will be shared among staff of the partner agencies. Any personal information collected by Mothercraft is collected under the authority of the Child and Family Services Act and the Personal Health Information Act (PHIPA, 2004). It will be shared only among staff of the partner agencies for the purposes of the program Breaking the Cycle. Questions about this collection should be directed to Beverley Koven, CEO, Mothercraft (416-483-0511).

June 2011

Appendix 3: WEEKLY PROGRAM/SERVICE SCHEDULE (2007)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	
Individual Addiction Counselling Individual Parent-Child Counselling Early Childhood Intervention Services Pregnancy Outreach Child Care Home Visits	Individual Addiction Counselling Individual Parent-Child Counselling Learning Through Play Parent-Child Group Early Childhood Intervention Services Pregnancy Outreach Child care Home Visits	Mother Goose Parent-Child Program Life Skills or Recovery Group or "Connections" Individual Addiction Counselling Early Childhood Intervention Services Pregnancy Outreach Child Care Home Visits	New Mom's Support Group BTC Satellite Group at St. Joseph's Health Centre FASD Diagnostic Clinic Individual Addiction Counselling Trauma Counselling Early Childhood Intervention Services Child Care Home Visits	BTC Clinical Team Meeting (bi-monthly) or Staff Meeting (bi-monthly) Or Clinical Seminar (monthly)
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
Mother Goose Parent-Child Group Relapse Prevention Group Individual Addiction Counselling Early Childhood Intervention Services Pregnancy Outreach Child Care Home Visits	Individual Addiction Counselling Early Childhood Intervention Services Pregnancy Outreach Home Visits Child Care	Individual Addiction Counselling Individual Parent-Child Counselling Early Childhood Intervention Services Pregnancy Outreach Home Visits	Individual Addiction Counselling Child Care Early Childhood Intervention Services Trauma Counselling Pregnancy Outreach Probation/Parole Reporting Home Visits	Individual Addiction Counselling Child Care Individual Parent-Child Counselling Early Childhood Intervention Services Pregnancy Outreach Home Visits

Appendix 4: BTC Programs and the Stages of Change Model





YOUR TURN - RESPONSES TO THE BREAKING THE CYCLE (BTC) COMPENDIUM

Since the inception of Breaking the Cycle, we have learned from the experiences of families, practitioners, and researchers. We invite you to offer your responses to the Breaking the Cycle Compendium by completing this survey online at www.mothercraft.ca.

Please check which of the following sectors best describes your service sector(s):

- | | | |
|---|--|---|
| ☐ Aboriginal community | ☐ Addictions | ☐ CAP-C; CPNP Projects |
| ☐ Child Development | ☐ Child Welfare | ☐ Early Years |
| ☐ Health | ☐ Research | |

Please indicate in which Canadian province or territory your services are offered:

- | | | |
|--|--|---------------------------------------|
| ☐ British Columbia | ☐ Alberta | ☐ Saskatchewan |
| ☐ Manitoba | ☐ Ontario | ☐ Quebec |
| ☐ Newfoundland & Labrador | ☐ New Brunswick | ☐ Nova Scotia |
| ☐ Prince Edward Island | ☐ Nunavut | ☐ Yukon |
| ☐ Northwest Territories | | |

Please circle the number that best describes your level of agreement with each statement listed below. Please consider each section of the Compendium in your responses.

STATEMENT	STRONGLY DISAGREE	1	2	3	4	5	STRONGLY AGREE
SECTION I: DEVELOPING AND DELIVERING AN INTEGRATED MATERNAL-CHILD PROGRAM							
1. The section provided me with new knowledge.	1	2	3	4	5		
2. The section informed me of new practices.	1	2	3	4	5		
3. The articles published in the section are relevant to my work.	1	2	3	4	5		
4. I can apply the information to my work.	1	2	3	4	5		
5. The information contained in the section will influence my practice.	1	2	3	4	5		
SECTION II: DEEPENING OUR UNDERSTANDING OF WOMEN AND CHILDREN							
1. The section provided me with new knowledge.	1	2	3	4	5		
2. The section informed me of new practices.	1	2	3	4	5		
3. The articles published in the section are relevant to my work.	1	2	3	4	5		
4. I can apply the information to my work.	1	2	3	4	5		
5. The information contained in the section will influence my practice.	1	2	3	4	5		

STATEMENT	STRONGLY DISAGREE	1	2	3	4	5	STRONGLY AGREE
SECTION III: THEORY INFORMING PRACTICE							
1. The section provided me with new knowledge.	1	2	3	4	5		
2. The section informed me of new practices.	1	2	3	4	5		
3. The articles published in the section are relevant to my work.	1	2	3	4	5		
4. I can apply the information to my work.	1	2	3	4	5		
5. The information contained in the section will influence my practice.	1	2	3	4	5		
SECTION IV: RESEARCH INFORMING PRACTICE							
1. The section provided me with new knowledge.	1	2	3	4	5		
2. The section informed me of new practices.	1	2	3	4	5		
3. The articles published in the section are relevant to my work.	1	2	3	4	5		
4. I can apply the information to my work.	1	2	3	4	5		
5. The information contained in the section will influence my practice.	1	2	3	4	5		
OVERALL THE BREAKING THE CYCLE COMPENDIUM...							
1. Fills a gap in the literature in my sector.	1	2	3	4	5		
2. Makes a strong contribution to Canada's Drug Strategy.	1	2	3	4	5		
Please provide us with your thoughts on the impact and influence on the Breaking the Cycle Compendium on: a. RESEARCH b. PROFESSIONAL DEVELOPMENT c. PROGRAM DEVELOPMENT d. POLICY							

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