Respect is key to helping pregnant women with substance use problems

A conversation with Pam Woodsworth

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Based on an interview conducted by Margaret Leslie of Breaking the Cycle (Toronto).

About our project

We are funded through Health Canada's Canada Prenatal Nutrition Program (CPNP). We're administered through our District Health Board, Public Health Services, and we're very much a community-based project, delivered in partnership with other community agencies. We partner with Westside Community Clinic (an inner-city health clinic), Saskatoon Tribal Council, Family Support Centre (an agency of Saskatchewan Social Services), Healthy Mother Healthy Baby (a pregnancy outreach program), Saskatoon Open Door Society (an agency providing support and services to immigrants and refugees), and Addiction Services.

We started in August, 1995.

The project goal is fairly broad, and that is to assist low income, high-risk pre- and post-natal women to achieve an optimal level of health. We encourage women to join in the project during the prenatal period and they are welcome to participate up until their infants are six months of age. We have a couple of permanent community sites where we have afternoon sessions that are typically about 2 to 2½ hours in length and we provide on-site child care and transportation to and from the sessions, either by city bus or by cab, depending on the circumstances of the woman.

During the sessions, we cook together and talk about affordable, nutritious food for the women and their families. We serve a nutritious snack and the participants take home any food that they've prepared during the session.

I'm the project coordinator, and a registered nurse. I've been with the project since it started. Project staff also includes a nutritionist, a health aide and peer leaders – women who are "graduates" of the project.

Respect and dignity

When you're trying to pass on to others what makes your work successful, to me it boils down to our fundamental beliefs in how we treat other human beings. That sounds sort of simple, but it's not really, because not everybody comes from the same place in terms of respect and dignity. It's really easy, as in the Manitoba case (Ms. G.), to blame the woman who was using and say that the fetus has rights and she needs to be incarcerated and we need to force her into sobriety. We know that's just going to push underground all the other women who are using. And there are lots of them, folks. There are lots and lots of women who continue to use drugs and alcohol in their pregnancy. Unless we can somehow support them to deal with the poverty, the racism, the domestic violence, the childhood sexual abuse, all those issues that they are now medicating themselves against, we're

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never going to come to terms with this.

Women's addiction and substance use is different from men's, and we don't deal with it very well or understand the dynamics of it. When I approach the subject of FAS with the women in my group, and I do on a regular basis, I try to eliminate any of the elements of blaming and shaming because I want them to come back. I want them to be connected and to feel some hope in their lives. We reckon that about 80% of the women we see continue to use alcohol and drugs in their pregnancy. I don't think that's atypical. I think we would probably find the same thing across Canada.

Harm reduction approach

Early on, I had a sense that I did my best work when I was able to understand where individual women were coming from and what factors in their life were having an impact on how they lived. More than anything these women needed someone to sit and listen and to not be judgmental and to not try and pressure them into making changes in their lives that they had absolutely no confidence they could make.

What I felt we needed was some work around empowerment and self-esteem. We needed to assist folks in recognizing and celebrating small successes. You can't do that work if you're judgmental.

If a woman discloses that she's drinking during her pregnancy – and this happens all the time – I want to make sure she understands how that's affecting her health and how it might affect her baby. But I also want to really understand what she feels she wants to do about it. We need to make connections with people so they feel they can disclose what they're struggling with in their lives.

It can be very overwhelming if we take personally the fact that we aren't successful in getting women to stop drinking. I knew that for my own self-preservation, I couldn't do that and continue to do this work. I needed to see the positives in the work we were doing and how successful we were, in supporting women when they were saying they wanted to make some changes in their lives.

When someone was with us for 2½ hours in an afternoon, I knew for a fact that they didn't drink during that period, and they had fun ... they had an opportunity to talk to another woman who was struggling with some of the same issues in her life. When they left at the end of the day, they felt really good about their afternoon, and they felt a sense of belonging and a sense of connectedness to other people.

Women have said to me, "I'm going to come back next week because when I'm here I don't drink."

We all make changes in our life at our own pace. I don't have a crystal ball to know exactly what might make a difference in your life ultimately, but I know that if you can come someplace where you feel a sense of welcoming and a sense of belonging, that's going to support you to get there.

If nothing else, if we can improve the nutritional status of a woman, the baby that she's carrying is likely to be less affected. When they come to the sessions, they learn good basic life skills about providing nutritious, affordable food for themselves and their families.

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One of the struggles for us continues to be a lack of diverse treatment programs for women with children. Probably one of the biggest barriers for women to go into treatment is that their children often have to go into foster care. If women have to decide between their children and anything, usually they decide in favour of their children, even though it might be in their kids' best interests for them to go through treatment. There is such distrust of family services that they feel that perhaps they're going to be tricked into something and they'll lose their kids forever.

One-on-one support

When we started, there were so many women coming to this group and only this group. Some of them weren't seeing their doctors, some weren't regularly seeing their pregnancy outreach worker. I knew if I didn't open the door to women approaching us one-on-one, we were missing opportunities. So I have really pushed over the years to increase our staffing in sessions and to implement a peer leader model to increase the availability of staff that women can speak to one-on-one.

The health aide does all the grocery shopping and the organizational stuff in terms of forms and getting things ready for the sessions – all of the stuff I once did. The peer leaders also do a lot of the work, like cleaning up in the kitchen. So, if there's someone who really needs to talk after the group is over, I can go to a room and meet with them for an hour, knowing that someone is cleaning up the kitchen afterwards.

Women also know that they can call me; they know what my office hours are and that if they need to see me, I'll make arrangements to see them one-on-one. It has worked really well in terms of women feeling safe and comfortable in starting to talk about some of this stuff.

I remember one woman who was coming to our group: it was her third child, second pregnancy since she'd been involved with Food For Thought. One day, we had a small group and she and I were preparing something together and just sort of chatting about fairly benign things. She looked me in the face and said, "How do you get rid of somebody who's bothering you?" That was the first time she had ever told me about her partner's violence towards her, and she'd been coming off and on for two years. It took a very long time for her to feel safe about talking to me about that. You just never know when it's going to happen.

I think the one-on-one component is critical, but it isn't effective at supporting women to be less socially isolated. When family violence is a factor, meeting them in their own home doesn't cut it because the partner's there. You might have a gut feeling that this is going on because of the things you've seen, but you can't really get to the meat of the matter when the abusive partner is sitting across the kitchen table from you.

So, I think we need a hybrid approach. A group program cannot take the place of a one-on-one approach, but a one-on-one approach doesn't provide everything that a woman might need to be healthy.

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Talking about substance abuse

When I talk about alcohol use and pregnancy, I always preface it with a discussion about where I'm coming from and that I don't have the expectation that people are going to stop, even if they come to me and tell me that they are. I tell them I don't see that as my job. My job is to help women understand what impact their use has on their health and on the health of the baby they're carrying.

We go through all the facts and people will ask questions, and when I end, I always say, "If you are drinking alcohol in your pregnancy, every time you decide not to have a drink is a gift that you give to yourself and your baby." And I say, "If coming to this group supports you to give that gift to yourself and your baby, then that's wonderful. If coming twice a week would help you twice a week to do that, let me know and we can accommodate you." By putting it that way, women are saying, "Boy, I have the power to do something really kind for me and for my baby by making the decision to have one less drink today, or maybe not drinking at all today." It was wonderful to see the look on the faces of

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some of these women because finally that made sense to them. They want more than anything to have a healthy baby.

The thing that has been the most critical for us, in terms of successfully reaching some of these women, is providing a safe, comfortable, welcoming environment. That never changes, no matter what's gone on in their life, no matter how much they've had to drink. This is something they can absolutely be certain of. When they walk in the door, they know what's going to happen, how they're going to feel, what the quality of the interaction is going to be.

We have an addictions worker in the project. We sat down and talked prior to her joining us and decided we would not make it a big deal, just to say that this is Jamie and she was going to be with us – end of story. She spent some time building relationships with the women. It was several months before she did an educational component where she talked about the work she does. They felt really comfortable with her because she's the person that last week had chopped onions. Someone might come to me and ask me a question around their use or their partner's or their best friend's and we'll deal with it, but I'll also remind them that if they're comfortable, Jamie has a lot of information and expertise she's willing to share.

Peer support

One of the real motivations for me to implement a peer leader component was that our personnel did not reflect the cultural mix of the group. All of us working within the project are Caucasians, and the majority of the women we saw were Aboriginal. Also, I saw some really natural leadership skills in our participants. I felt we could really strengthen the atmosphere of welcoming and belonging by having women use their leadership skills to enhance the project work. It would foster more of a sense of ownership of the group if they saw that women who were sitting across the table from them for several months had taken on more duties and were getting paid for their time. It acknowledged and celebrated those natural leadership skills and that willingness to roll up your sleeves and be an active participant.

When women express an interest in becoming peer leaders, we ask them to make a commitment for three months. We provide them with some training in a variety of areas that will build on skills they already have. We've certainly lost women, but for legitimate reasons, like going back to school, getting a full-time job somewhere, or moving. It has been a very positive experience for us. Some of our peer leaders have been with us for a year and a half or more.

We spend a lot of time on individual support of these women because their life circumstances have not changed significantly. A couple of peer leaders have gone into treatment for alcohol and drugs, and speak quite openly about that with other participants. It's been valuable for participants to see that despite this woman's struggles with alcohol, we recognize her value and celebrate her contribution.

There are lots of merits in supporting group programs, but we can never get away from the fact that it costs a lot of money to support high-risk individuals to make changes. I really believe we're going to look back in 10 or 15 or 25 years and say, "There was so much we gained by taking a risk, providing the funds to do that, and what we've learned has really benefited the women we worked with." □

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