Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Technical report

AADAC
Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

RESEARCH SERVICES

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Alberta Alcohol and Drug Abuse Commission (AADAC)

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Executive summary

In 2004, AADAC carried out a qualitative research project to determine the outcomes that are experienced by women involved in its Enhanced Services for Women (ESW) program. ESW receives funding from the Early Childhood Development Strategy of the Alberta Children and Youth Initiative as a fetal alcohol spectrum disorder (FASD) prevention program. ESW's mandate is to provide an enhanced level of addiction services to women. Services are intended primarily for pregnant women, women who are at risk of becoming pregnant while using substances, and women who are postpartum and using substances.

It is important to document the outcomes, or changes, women have made in their lives after engaging in ESW services. Not only is this information vital to AADAC and its programming, but it is important information for the field of women's issues in addiction services.

AADAC's standard method for determining client outcomes via telephone survey was ineffective with the difficult-to-reach population that ESW serves. As a result, researchers undertook a qualitative study to discover what outcomes clients in ESW were achieving. Researchers collected data from the following sources:

1. Face-to-face interviews with current and past ESW clients
2. Group interviews with the service providers in each of the communities ESW serves (Calgary, Edmonton and Grande Prairie)[1]
3. One group interview with the team of AADAC counsellors that work on the ESW initiative (the ESW service co-ordinators from Calgary, Edmonton and Grande Prairie)[2]

Women involved in ESW services typically represent a marginalized population within society as a whole. As this report will describe, women with substance use issues lead complex lives and substance abuse is only one factor in their lives. Previous research about women seeking or obtaining treatment for addiction has found that women who seek treatment for their substance use are likely to be more marginalized in society than are their male counterparts. They also encounter many barriers that may prevent them from getting treatment.

[1] These service providers, those that serve the community but are not AADAC counsellors or ESW service co-ordinators , are referred to in this report as "community service providers."

[2] This group of service providers are referred to as "ESW service co-ordinators " throughout this report.

Key findings: Challenges

The women who participated in this research project described their lives before coming to ESW. The challenges women described in this research are outlined below.

Substance use

The substance use patterns of the women interviewed are varied. Each has experienced fluctuations in their substance use patterns, including periods of abstinence, relapse or substance substitution. These women have a wide variety of treatment experiences and have sought out treatment for many reasons: to improve their own lives, to improve the lives of their children, or in response to pressure from external agencies.

Parenting

Women's parenting challenges included the following: the potential for intervention from child protection agencies, a lack of positive parenting role models, and dealing with the effect their substance use may have on their ability to parent.

Physical health

Physical health challenges reported by some include positive hepatitis C or HIV status, diabetes, and suspected fetal alcohol syndrome. When women experience physical health concerns, the need to manage those concerns adds to the complexity of substance use treatment.

Emotional health

Women often report trauma, depression, anxiety and feelings of hopelessness. It is common for the women interviewed to report they use substances to deal with their emotional health concerns.

Relationships

Each woman interviewed for this research project has partner, family and other significant relationships, either past or present, that help shape the actions and course of her life. These relationships affect the choices she makes about substance use.

Social environment

The environment in which some women live, either now or in the past, influences their substance use and other aspects of their lives. Some women describe living transiently or even experiencing homelessness and most have a family of origin with a history of substance use.

Key findings: Outcomes

The women interviewed for this research project also described the changes they had made—what outcomes they had achieved—since beginning their interactions with ESW services. The outcomes they describe are summarized below.

Substance use

Women report they have been successful in positively changing their substance use in a variety of ways. Most report they have achieved abstinence at some point in their substance use history and were abstinent at the time of their research interview. The women interviewed were actively employing relapse prevention strategies. If they do relapse, these women report shorter periods of substance use, reporting and reconnecting to their service providers after relapse and engaging in addictions treatment. Research participants report that if they do use, they employ harm reduction strategies such as substituting their main substance of abuse with a substance they consider less harmful or reducing how much or how often they use.

Parenting

The women interviewed report a number of changes they are making as parents including capitalizing on their pregnancy and using it as an opportunity to change their substance use behaviour. They are motivated to keeping or regaining custody of their children and believe they are becoming more effective parents by working on their parenting skills, developing connections with their children, dealing with the negative effects their substance use may have had on their children and breaking the cycle of substance use or violence in their children's lives.

Physical health

Women report successfully making changes to their physical health. They are changing their basic self-care habits (e.g., better eating and sleeping habits), regularly and appropriately using prescription medications and understanding and recognizing the need to maintain their reproductive health.

Emotional health

The women interviewed discussed a multitude of changes in their emotional health. They describe having enhanced self-esteem and improved ability to manage anger and deal with trauma issues, feeling more hopeful and happy, being able to overcome their emotional numbness and being more assertive about their needs.

Relationships

During their interviews, women spoke at length about changes they had made in their primary relationships, with parents, family, friends, and helping professionals. They continue to work on recognizing and avoiding unhealthy relationships, being aware of and nurturing healthy relationships and learning to develop trust in relationships.

Social environment

Women receiving services from ESW have often been homeless or transient at some point in their lives. Therefore, it is a significant outcome that these women are off the streets and most are living in safe and stable housing. They also report that they are incorporating routine into their lives, which has added to feelings of normalcy and assists in decreasing social isolation. Some of the women involved in ESW have returned to schooling or employment.

Network of support

Engagement in addictions treatment is only one piece of a vast network of support that is mobilized with and for women in ESW services. As a result of their involvement with ESW, women have engaged in a vast and varied support network that includes dozens of individuals and agencies. The support network, previously limited to personal supports and crisis services, now includes services that have the potential to change lives in the long term.

Women involved in ESW report using new skills to secure and advocate for the services they need when they do not have someone to advocate on their behalf.

The network that supports women has become more cohesive—a subset of the specialized services that work with women at highest risk is working collaboratively to serve the clients they share.

The role of ESW in clients' lives

What became clear from this research is the importance of the role that ESW service co-ordinators play in their clients' lives and in the communities in which they work.

Linking clients to addiction services and a support network

Through a variety of means designed to increase accessibility to AADAC for pregnant and at-risk women, ESW service co-ordinators are effectively linking women to addiction services. And through advocacy, referrals, and working closely with community service providers, ESW service co-ordinators are linking women to a cohesive support network—acting as a hub in the network of community supports.

Building relationships with clients

By engaging a harm reduction philosophy, using motivational interviewing techniques, and being profoundly non-judgmental, ESW service co-ordinators are listening to women, their experiences, and their needs in ways that the women have rarely experienced. While service co-ordinators have made accessibility their first priority, service recipients—the women themselves—valued their relationship with the ESW service co-ordinator above all.

Implications

Messages aimed at women, community service providers and the general public regarding the successes, the best practices, and the services of ESW are needed.

So much of the "good news" gained through this study could be disseminated to diverse audiences to the benefit of the whole community. Various resources could be developed to disseminate that information.

Expanding and enhancing the community service network may lead to improved outcomes and improved access to services for women who are in need of support for the prevention of FASD and other harm caused by substance use.

This research project strongly suggests that there is a relationship between women's connection to a comprehensive service network and their successful outcomes. The women and community service providers interviewed for this project identified these as areas to consider for further expansion and enhancement of the service network:

- Addressing the need for more subsidized and supported housing
- Developing innovative models of addiction services that incorporate childcare into residential treatment and build on the service network model

Developing common understandings and sensitivities between addiction services and child protection services leads to improved outcomes for women.

Women involved in the child protection system felt supported if their assigned workers were flexible, rewarded them for their attempts and successes, respected their choices, and facilitated access to all available services and supports. These women also voiced concerns about the child protection system's limited concept of substance use treatment and what sometimes appears to be a punitive orientation toward parents attempting to regain custody of their children.

This research project points to different ways of measuring outcomes, particularly for hard-to-reach populations.

This research project has clearly demonstrated that, with an appropriate method, it is possible to discover the outcomes of service provided to difficult-to-reach populations. A qualitative approach to outcome measurement has been shown to be effective in working with this population.

Consideration could be given to expanding ESW services in order to reach women in more diverse geographic areas.

At present, only clients in Grande Prairie, Edmonton or Calgary have access to ESW services. ESW clients who relocate away from the ESW current service area and other clients not in Edmonton, Calgary or Grande Prairie may benefit from this type of service being offered in other locations in the province.

Substance use is not the only concern that ESW clients must manage.

The results of this research describe the complex nature of the lives of women involved in ESW and other addiction services. The ESW program demonstrates that services for women must recognize that substance use does not occur in isolation.

ESW demonstrates an effective model for working with special populations.

As indicated from interviews with women involved in ESW and with community service providers, traditional means of service delivery may not reach or meet the needs of all persons who are harmfully using substances. Specialized services that reach these and other special populations in creative and non-traditional ways are needed and could incorporate these program elements:

- outreach
- recognizing complexity
- case management
- harm reduction
- focusing on the counselling relationship

Current best practice provides the basis for an effective model for working with women.

At its most basic, this research project has demonstrated that pregnant and at-risk women who use substances can and do make significant changes in their lives given support tailored to suit their needs—a finding which is consistent with best practices literature. ESW is an example of a program that follows these best practices:

- taking a holistic view of clients
- inviting collaboration with other service providers and agencies
- offering flexible service delivery rather than "standardized" treatment approaches
- presenting harm reduction as an alternative for those unable or unwilling to consider abstinence
- motivational interviewing as an effective technique in counselling this population of clients

Recommendations

Disseminate the findings of this research project.

This research project describes methods for working effectively with special populations. Disseminating the findings to health and social service providers, planners, and policy makers may assist those who work directly or indirectly with these populations.

Continue training and support to community service providers.

AADAC continues to gather valuable information about working with marginalized populations through research and by consulting staff whose knowledge is based on practical experience. By supporting and training other service providers, AADAC can help its own staff and that of other organizations to offer the best possible service to the clients that are most difficult to reach.

Maintain and possibly expand ESW service.

At present, ESW services are only offered in Calgary, Edmonton and Grande Prairie. The effectiveness of the service in these major centres indicates the need to maintain ESW's current framework for service delivery in these cities. Because this type of service may be beneficial to clients outside the cities ESW currently serves, expansion could be considered to other locations in the province.

Expand the service network to which ESW connects.

The current support network consists mainly of services that offer more planned, longer-term support. What appear to be missing from this network are the more crisis-oriented services or services that have the potential to act as filters into the service network, such as food banks, emergency units, the mental health system, or legal services.

Exchange information between teams that work with marginalized populations.

Within AADAC, there are teams of service providers that work with marginalized populations and have developed an understanding of effective practice. These teams could discuss what they have learned and collaborate to develop a promising practice document for service providers who work with marginalized populations.

Continue to support gender-specific programming.

Substance use treatment programming that recognizes the effect of sex and gender differences on client needs is part of the flexible service delivery that has shown to be effective in this population of women.

Collaborate with community partners on housing issues.

Clients and service providers noted a deficiency of suitable housing options in Edmonton, Calgary, Grande Prairie and surrounding communities. Because some AADAC clients are among those who would benefit from these housing opportunities, AADAC could help community partners in their development of appropriate housing alternatives by offering its expertise in supporting people who have substance use problems.

Collaborate with partners to develop innovative models of addiction services.

This research demonstrates that innovative approaches with a focus on issues particular to women are highly effective in helping ESW clients achieve positive outcomes. Two potential projects that might build on these innovative ideas include residential treatment incorporating childcare, and the creation of specialized addiction services.

Collaborate on policy and programming with child protection agencies.

Because ESW clients have high rates of involvement with child protection agencies, there is a need to develop a common understanding of the needs of each organization (AADAC and the child protection agencies) with regard to the outcomes their clients should achieve and how they should achieve them.

Plan for and implement ongoing outcome monitoring for ESW.

Analysis of the research suggests that outcome monitoring with ESW clients will be most effective if it

- relies on close involvement with ESW service co-ordinators
- reaches clients through face-to-face contact and uses verbal consent
- maintains flexibility of method
- asks questions based on findings from this research study

Plan for flexible service delivery by other AADAC staff.

Given the success of ready access to service for ESW clients, consideration could be given to offering this type of access to other AADAC clients. Specifically, clients praised the access provided when service providers carry cell phones and have the capacity to meet with them offsite, in non-AADAC locations.

Areas for further research

Methods for working with marginalized populations

Researchers struggled with locating and measuring the outcomes of clients who are easily lost to service. Future research projects need to focus on how to find these clients and develop relationships with them in order to garner valuable research information.

Further research regarding ESW and other service providers

Because this was an outcomes research project rather than an evaluation, researchers did not focus on what direct effects ESW had on the outcomes achieved by clients or what possibilities lie ahead for program expansion. A program evaluation and needs assessment are required to make these determinations.

Understanding the attitude and practice of other service providers

Another client that is served by ESW is the network of service providers in their community. A research project that discovers the outcomes related to practice or attitude changes among these service providers might prove useful in future.

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Introduction

The Alberta Alcohol and Drug Abuse Commission (AADAC) introduced the Enhanced Services for Women (ESW) program in 2002. There are three sites within AADAC offering ESW services: Edmonton Adult Counselling and Prevention Services, Calgary Adult Counselling and Prevention Services and the Northern Addictions Centre in Grande Prairie. A total of five AADAC counsellors (two in both Calgary and Edmonton and one in Grande Prairie) provide ESW services. These counsellors are called ESW service co-ordinators.

The priority of ESW is to deliver AADAC treatment services on an outreach basis to pregnant and at-risk women (see definition, next paragraph) who face barriers to obtaining AADAC services in the traditional way. Outreach is defined as any service delivered to clients off AADAC sites. These services are delivered at the sites of other community services, such as health units or inner city agencies.

Background

ESW receives funding from the Early Childhood Development Strategy of the Alberta Children and Youth Initiative as a fetal alcohol spectrum disorder (FASD) prevention program. ESW's mandate is to provide an enhanced level of addiction services to women to reduce the number of children born in Alberta who are affected by prenatal exposure to alcohol or other substances. Services are intended primarily for pregnant women and women who are "at risk." Women who are at risk are those who may become pregnant while using substances or women who are postpartum and using substances.

The goal of ESW services is two-fold:

- enhancing AADAC treatment outreach into the community to better provide addiction service to pregnant/at-risk substance-using women and increase their access to other support services in the community; and
- strengthening the service network to better meet the needs of at-risk/pregnant women through training, case management and advocacy.

Because women served by the ESW program often have complex lives and have many needs, ESW service co-ordinators provide short-term interventions. Their priority is to link clients to the services they need to stabilize and improve their lives and to support recovery. More specifically, the role of the ESW service co-ordinator includes

- providing short-term assessment, crisis intervention, counselling, and referral services to pregnant/at-risk women who face barriers to obtaining AADAC services in the traditional way
- bridging clients to AADAC's network of services (detox, outpatient counselling, group programming, residential treatment) as appropriate

- maintaining familiarity with, and have referral processes in place with, key agencies that provide other services clients may require, and referring clients to these agencies
- consulting with other community service providers to assist them in meeting the needs of the target population
- establishing their role within AADAC as experts on working with pregnant/at-risk women with substance use problems
- connecting with pregnant/at-risk detox clients to provide support and link them to other AADAC services and community services as required
- providing consultation and support to AADAC staff to assist them in supporting pregnant clients
- providing information and training to community service providers to increase their ability to screen, intervene on behalf of, and refer pregnant/at-risk women who use substances
- encouraging and supporting staff in other AADAC programs to incorporate information on the risks of substance use during pregnancy into routine practice with clients

ESW service co-ordinators also provide prevention and education services to staff, community professionals, and clients. Service co-ordinators share their expertise to increase awareness of the issues faced by at-risk and pregnant women with substance use problems, and to help others enhance their ability to meet the needs of this population.

ESW is committed to supporting realistic goals set by the client and recognizes that abstinence may not be the goal for all women who receive ESW services. ESW also works to reduce other risk factors (such as providing information and referrals to foster improvements in nutrition, prenatal care, relationships and housing) in an effort to reduce risk to mother and child.

Project objectives

Because of its funding relationship with the federal and provincial governments, ESW has its own performance measures and is required to report separately on the services provided through this initiative. Service statistics (e.g., numbers of clients served) are tracked using AADAC's information management system (ASIST). However, using AADAC's standard telephone follow-up approach for determining client *outcomes* yielded an inadequate response rate from ESW clients largely because ESW serves a difficult-to-reach client population.

Therefore, AADAC used an alternative, qualitative research approach that builds on the existing ESW outreach service to

- determine the short-term outcomes achieved by the target group of the ESW program
- investigate a more effective and efficient method of tracking ESW outcomes in the future
- gather rich information about women, substance use, treatment and the prevention of FASD that is useful for others working with at-risk/pregnant women who use substances

Research method

Research theory

This research project was guided by a qualitative research methodology known as "phenomenology." Phenomenology refers to the in-depth study of a human experience, or phenomenon. "Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Phenomenology asks, 'What is this or that kind of experience like?' " (van Manen, 1990),. 9) While there are several techniques for conducting phenomenological inquiry (van Manen, 2000a), Patton (2002) asserts that the techniques used require "…methodologically, carefully, and thoroughly capturing and describing how people experience some phenomenon—how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (Patton, 2002, p. 104).

A useful means of obtaining such in-depth information about an experience is to conduct interviews. Phenomenological interviews

> …serve the very specific purpose of exploring and gathering experiential narrative material, stories or anecdotes, that may serve as a resource for developing a richer and deeper understanding of a human phenomenon" (van Manen, 2000b ¶1).

An assumption within phenomenology is that, despite individual uniqueness, there are elements in the phenomenon under study that are common among individuals and that could be understood as the "essence" of that shared phenomenon (Patton, 2002). It is the researcher's task to rigorously analyze the individual experiences to determine those commonalities. The description of this common experience is the end product of phenomenological inquiry, rather than theories or explanations (Swanson, 2001).

In this research project, interviews were conducted with a variety of people who could illuminate the experience being studied, that is, the change, or outcomes, experienced by clients in the ESW program. This report describes the various components that comprise the "essence" of the shared experience of making changes in the lives of clients in the ESW program.

Data collection

Two methods of data collection were used in this qualitative research project: in-depth one-on-one interviews and group interviews. Data were collected from three sources: ESW clients, community service providers and ESW service co-ordinators. ESW clients were interviewed individually, while community service providers and ESW service co-ordinators were interviewed in groups. Supplemental information was gathered from AADAC's client information system and addictions literature related to the target population.

In-depth interviews

A total of 14 interviews were conducted with 12 current and past ESW clients. Three interviews were conducted in Grande Prairie, eight in Edmonton (including two pilot interviews and re-interviews) and three in Calgary from September to December 2004. For details about the administrative tasks undertaken for each individual interview, please see Appendix 1.

In-depth interviewing allows for a fuller exploration of topics and does not limit the respondent to a prescribed pattern of discussion. Rather than establishing a set of specific questions, researchers followed the general interview guide approach that "involves outlining a set of issues that are to be explored with each respondent before the interview begins. The guide serves as a basic checklist during the interview to make sure that all relevant topics are covered" (Patton, 2002, p. 342).

Researchers developed the first draft of the interview guide and then conducted pilot interviews with two project participants. After each pilot interview, participants provided feedback about the tone, quality and effectiveness of the interview. This feedback was reviewed in consultation with an external consultant and project advisory group (see the Consultation section of this report for more information on the role of the consultant and project advisory group). Based on this extensive feedback, the remaining interviews were modified to focus more specifically on outcome information. After an initial open-ended question asking participants to consider the changes they had made since participating in ESW, they were asked to focus specifically on substance use and service network and changes. The two pilot interviewees were re-interviewed with the adjusted interview guide.

In the majority of individual interviews, researchers conducted an exercise with participants to identify the services used before and after intervention with ESW. Participants completed "sociograms" that visually document interactions among individuals and services in the community. These were valuable tools in showing both the researcher and participants the changes that occurred over time. An example of a sociogram is found on page 93 of this report.

Interviews were conducted one-on-one with participants, except in the pilot interviews where, with the permission of the interviewee, both researchers attended. Researchers met clients at their local AADAC office or in their home, depending on what was most convenient for the client while considering the safety of both client and researcher.[3]

Participant selection and recruitment • To develop a sample of potential research participants, researchers developed a spreadsheet to compare the key characteristics in the lives of ESW clients. These characteristics included location, lead ESW service co-ordinator, history of street involvement, mental health issues, sexual orientation, ethnicity, income source, age, substance of concern, marital status, number of children/pregnancies, agency involvement, previous treatment experiences, occupation, educational obtainment, issues with the family of origin, physical abuse experiences, housing issues, length of involvement with ESW, legal and health issues. Case notes and AADAC client information from current and past ESW clients were used to compile information on these key characteristics. Researchers then examined the spreadsheet to identify diversity among the population to garner the widest variety of experiences possible to form the potential sample population.

Researchers relied on ESW service co-ordinators to recruit potential research participants. This method of third party contact was used because researchers realized that the population served by ESW may be wary of strangers inquiring about their lives and potential participants may have been inclined to immediately decline an offer to participate from an unfamiliar person. Because ESW service co-ordinators already have a relationship with their clients, they contacted potential research participants to introduce the project, provide some background information about the research, and ask if they would be interested in participating in the research project. Service co-ordinators then either arranged a research interview appointment on behalf of the researchers or got permission for the researcher to contact the client directly. When clients expressed interest in participating in the project and gave permission to the ESW service co-ordinator, researchers contacted the client to confirm (or arrange) the interview time and location and answer any questions the participant had. Participants were also given the researcher's contact information.

Researchers and ESW service co-ordinators attempted to contact 26 potential participants. When clients could not be contacted, were not appropriate to be interviewed, or were not interested in participating, researchers provided service co-ordinators with alternate client names, while still attempting to maintain adequate diversity within the sample.

[3] Researchers followed AADAC protocol for conducting home visits.

Group interviews

To get another perspective on the outcomes that women in ESW were achieving, researchers sought out the knowledge of the service providers that women are connected to within their communities.

Community service providers • Group interviews were conducted for each of the three ESW community sites, one for each location for a total of three group interviews. Participants for these interviews were selected by the ESW service co-ordinators based on the service providers' knowledge of ESW services, of ESW clients, and of the changes that those clients said they had made.[4]

ESW service co-ordinators contacted the service providers in their community to invite them to participate in a group interview. Researchers then followed up with potential group interview participants by sending formal invitations and background information about the research project.

The group interview in Edmonton consisted of five participants from four community agencies. In Calgary, the six participants represented four community agencies. The Grande Prairie group interview was conducted via teleconference—a total of two community service providers were able to participate from two different agencies.

Group interviews were conducted between October and December 2004. For details about the administrative tasks undertaken for each group interview, please see Appendix 1.

ESW service co-ordinators • Researchers also wanted to tap into the expertise of the ESW service co-ordinators who work with ESW clients and have direct knowledge of the outcomes achieved by women involved in ESW services. One group interview for the five ESW service co-ordinators was arranged in Edmonton.[5]

All ESW service co-ordinators were able to attend.

The service co-ordinator group interview took place in December of 2004. For details about the administrative tasks undertaken for this group interview, please see Appendix 1.

Client information

Background and demographic information about ESW clients was obtained through AADAC's client monitoring system (ASIST) and from ESW service co-ordinators.

ASIST provided basic information about the women who participated in the research project as well as an aggregate statistical description of all ESW clients.

[4] These service providers, those that serve the community but are not AADAC counsellors or ESW service co-ordinators , are referred to in this report as "community service providers."

[5] This group of service providers is referred to as "ESW service co-ordinators" throughout this report.

After completion of all client interviews, researchers asked ESW service co-ordinators to provide information that may not have been recorded in AADAC's client information system, such as more detailed information about clients' relationships with child protection agencies, housing and income sources (see Appendix 2 to view the interview guides and questionnaires used in this research project).

Data analysis

Researchers used qualitative software (Atlas.ti version 4.2) to organize and assist in the analysis of the data gathered from interviews.

The two primary researchers on the project solicited the assistance of a third to independently review and code a sample of interview transcripts. This exercise resulted in similar codes and themes developing across the data analyzed by three separate researchers and gave the primary researchers confidence that they had achieved inter-rater reliability in their data analysis.

Internal validity—the answer to the question "did we get the story right?" (Mayan, 2001)—was achieved through validation among the population being interviewed. Researchers reviewed findings with interview participants and asked if the information "rang true" according to their experiences. Responses were positive.

Data was peer reviewed by two other researchers (one internal, one external) in a process that included extensive discussion of findings, conclusions and data analysis.

Consultation

Two AADAC researchers were assigned to this project. In addition, the researchers formed a project advisory group at the outset of this research study. The advisory group consisted of an internal research colleague, an ESW service co-ordinator and a member of the target population for the research. A research consultant specializing in women's addiction issues was also contracted for this project. This group of individuals was consulted at various times throughout the research project and their insight was used within the research project over time. Their experience provided AADAC researchers with views on the process, methods, data collection and analysis.

Ethical considerations

The ethical considerations of this research project were peer reviewed by experienced AADAC research and clinical staff. This review sought to protect the safety and privacy of the ESW clients and service providers who agreed to participate in the research project.

As stated earlier, researchers met interview participants at participants' local AADAC office or in participants' homes. When researchers met women in

their homes, safety precautions in the interest of both participant and researcher, were observed:

- when the client and researcher had not met prior to the interview, the ESW service co-ordinator who arranged the interview escorted the researcher to the participant's home to facilitate introductions and gauge the participant's willingness and ability to participate in the interview; and,
- researchers attending a client's home carried cell phones on their person and made their immediate supervisors aware of their location and the expected arrival and departure times from the home

ESW clients who agreed to become project participants were provided with a letter informing them of the purpose and process of the research, the ways in which their information would be used, their right to withdraw from the project, and the people they should contact if they are concerned about the research project itself or about their own welfare before, during or after their interview with researchers (see Appendix 3 to view Information Letters). At the beginning of each group or individual interview, researchers reviewed the content of the information letter with the participant, answered any questions the participant may have had, and got consent to proceed with and record the interview (see Appendix 2 to view Interview Guides).

The community service providers and ESW service co-ordinators who were interviewed in a group setting were also provided with information about the purpose and processes of the research project (see Appendix 3) and were asked to provide their consent for the group interview to be recorded (see Appendix 2).

For data collection, analysis and reporting, researchers assigned pseudonyms to research participants in an effort to ensure the anonymity of participants. Prior to their research interviews, participants were told that their information might be used in whole or in part, but that every effort would be made to alter any information that may identify them.

Limitations

Qualitative research offers great benefit in that it can report more in-depth information than what may be available from a quantitative study. However, the number of people interviewed is small in comparison to the number surveyed in a quantitative study, which means that the results of this research cannot and should not be generalized to an entire population—in this case, all women who use substances or all women involved in ESW services.

The findings of this study may be affected by the organization that conducted the study. It was well known to research participants that this research was being conducted on behalf of AADAC, an organization whose mandate is to offer treatment, information and prevention regarding gambling and the use

of alcohol, tobacco, and other drugs. This may have affected participants' willingness to freely speak their minds on all topics discussed in the interview and therefore may have altered research findings. However, participants were assured that researchers were bound by the same confidentiality requirements as ESW service co-ordinators and therefore the information participants provided would be used for research purposes only, with their consent, and with great attempts to maintain confidentiality. This was done in an effort to assure participants that they could speak openly without repercussion. Participants were reminded, however, that any information they provided that would indicate a threat of harm to themselves or others would be reported according to the Alberta Alcohol and Drug Abuse Act.

The sampling method had the potential to limit the scope, and therefore findings, of the research. Only those participants whom ESW service co-ordinators could contact were interviewed, even though great effort was made to reach a wide variety of current ESW clients and former clients who no longer have contact with their ESW service co-ordinator or indeed other service providers in the community. Researchers note that their expectations of meeting certain "types" of clients were not met because ESW service co-ordinators were unable to locate them. These are clients who are transient, homeless, irregularly attend appointments, or are otherwise on the fringe of society in general and community services specifically.

This research project is not a formal program evaluation. The purpose of this research project is not to determine the direct effects ESW has on its clients. Therefore, the findings reported here regarding the outcomes that women involved in ESW achieve should not be directly attributed to their interactions with ESW services.

Supporting literature review and background information

Women accessing substance abuse treatment: Supporting literature and background information

The information outlined in this section provides descriptive information gleaned from literature related to women and substance use issues, project participants, and AADAC client information systems about the lives of women before they became involved in ESW. The descriptions show the layers, subtleties and complexities of the circumstances under which women began and continued their substance use. There are a number of themes discussed here, including: substance use, parenting issues, physical health, emotional health, relationships and social environment.

Supporting literature

A review of literature regarding women and substance use issues reflects this project's findings—that the history and life circumstances of women with substance use issues influence their substance use, their ability to manage their substance use, and their ability to manage other aspects of their lives.

Women who seek treatment services have different issues from their male counterparts

A United Nations review of substance use treatment and care for women cites research from a number of countries that women who seek treatment for substance use are more likely than men to be younger, less educated, of lower economic circumstances, unemployed, have children in their custody, have a partner that uses substances, have been introduced to substance use and injecting-drug use by a partner, have a sex partner who is also an injecting-drug user with whom they inject, have employment and family or social problems, have health problems, have a family history of alcohol or other drug problems, have a drug-only diagnosis as opposed to alcohol and drug diagnoses, and have a shorter period of time between onset of substance use and treatment entry (United Nations Office on Drugs and Crime, 2004).

Women experience barriers when seeking treatment services

Systemic barriers

The United Nations Office on Drugs and Crime notes several systemic barriers that "impede the development of services that respond to women's needs" (United Nations Office on Drugs and Crime, 2004, p. 17). The barriers discussed include: (United Nations Office on Drugs and Crime, 2004)

- Women are underrepresented in positions of power and as a result have less power to influence policy development and resource allocation.

- There is a lack of appropriate gender-responsive and low-cost, evidence-based treatment models.
- There is a lack of knowledge about women with substance issues and their treatment needs and the information that does exist focuses on the experience of women in developed countries.
- Treatment programs generally do not address the multitude of concerns that women have beyond their substance use.

Structural barriers

Child custody and childcare issues • In conjunction with their substance use concerns, many women face custody issues concerning their children, including the possibility of losing custody. Child protection agencies have equated substance use with abuse or neglect of children, making women wary of disclosing their substance use for fear of intervention or loss of custody (United Nations Office on Drugs and Crime, 2004).

> …child welfare authorities may equate substance use problems with abuse or neglect. An unintended consequence of this policy is that women who have substance use problems may be less likely to seek prenatal care in the course of their pregnancy, with serious health consequences to the mother, foetus and society. Clinical experience also indicates that women who lose custody of their children may become pregnancy again. This can result in a cycle of further pregnancies each time a woman loses custody of her child (United Nations Office on Drugs and Crime, 2004, p. 19).

Many women have lost custody of their children and have used the hope of reunification as their motivation for recovery. Some women may be mandated by child protection agencies to attend treatment. So while women are working toward addiction treatment goals, they also feel the pressures of their child custody concerns. As a result, child protection agencies are often important forces in their lives (Moses, Huntington, and D'Ambrosio, 2004; Alberta Alcohol and Drug Abuse Commission, 2004b).

Clinicians working with women who use substances report those women who lose custody of their children sometimes attempt to become pregnant again to fill the void left by the loss of previous children. The result is a cycle of further pregnancies each time a woman loses custody of her child (United Nations Office on Drugs and Crime, 2004).

Women consistently report lack of childcare as a factor that limits their access to treatment. Because women are more likely than men to be living with a substance-using partner or have families of origin with substance use problems, they are less likely to have the familial sources of childcare support that others can rely on (United Nations Office on Drugs and Crime, 2004). In cases where they have no “natural” source of childcare (i.e., family or friends), women face the alternative of placing their children in the custody of child protection agencies. This prospect causes some to fear that

once their children are in custody of the state, they will not be returned to their mother's care (Poole and Isaac, 2001; Health Canada, 2001a; Health Canada 2001b).

Just being separated from their children acts as a deterrent to seeking treatment. Poole and Isaac note in their research that "[w]omen who lived with their children repeatedly cited separation anxiety as a major barrier [to attending treatment]" (Poole et al., 2001, p. 18).

Women who have children may be prevented from attending treatment services (either residential or outpatient) because of childcare concerns. Treatment services that do not offer a childcare component, lack of resources to pay for childcare, or the lack of support from her social or familial environment can prevent a woman from seeking substance use treatment (Poole, 2003).

Financial barriers • Lack of resources is a fundamental barrier to service. Some programming requires payment and as discussed above, a woman with children must cover the cost of childcare when there is no cost-free alternative. Transportation to and from programming is an added expense.

Lack of suitable programming • Addiction treatment goals focused only on abstinence do not suit the needs of all women. Some may not be ready to pursue abstinence treatment goals or may not see reducing their substance use as a priority (United Nations Office on Drugs and Crime, 2004), and instead choose harm reduction: they continue to use, but try to reduce the harmful effects of their use. Harm reduction approaches encourage

> clients to set achievable goals to improve their health, even if they do not give initial priority to their substance use. It also allows women to maintain contact with helping services and experience successful change. In the longer term, women may be ready to consider working toward abstinence goals (United Nations Office on Drugs and Crime, 2004).

Women who identify themselves as belonging to non-dominant ethnic backgrounds may be hesitant to seek services from programs that do not support or reflect their experiences, values, and beliefs (Moses et al., 2004). Language barriers may also prevent some from fully participating in treatment services.

Social and personal barriers

Stigma and shame • Stigma and shame act as barriers to women seeking treatment services. In most societies, women's substance use is more stigmatized than men's, making women less prone to admit their substance use and seek treatment (United Nations Office on Drugs and Crime, 2004). In treatment or other professional "helping" settings (social welfare agencies, physical and mental health facilities or even substance use treatment organizations), a woman may be made to feel ashamed of her circumstances. This shame may prevent her from seeking out services that may provide assistance (Poole et al., 2001; Health Canada; 2001a; Health Canada, 2001b).

Lack of partner support in recovery • A woman living with a substance-using partner may be deterred from seeking treatment because she fears her partner may disapprove or directly or indirectly discourage her efforts (United Nations Office on Drugs and Crime, 2004; Poole et al., 2001). The fear of losing the partner relationship acts as a serious deterrent to women who may otherwise seek treatment for their substance use.

Using substances to deal with trauma • As noted above, women with substance issues are more likely to have experienced traumatic events in their lives, leaving lingering stress-related and mental health problems. A common method of relieving the effects of these issues is self-medication, where an individual uses substances to manage the physical or emotional pain of past events (United Nations Office on Drugs and Crime, 2004). In these instances, the fear of addressing trauma and substance use issues may prevent individuals from seeking treatment.

Distrust of service providers • Past trauma experiences make it difficult for women to trust other people. Their history of feeling guilt and shame when seeking assistance from professionals adds to this distrust and can lead to a fear of authority, making it difficult for them to seek help and participate in services (Moses et al., 2004).

Reservations about the effectiveness of treatment • Women with a history of substance use have either prior experience in treatment or have second-hand knowledge of treatment experiences. Either their own poor treatment experience, or the knowledge of others, can make women cautious in attempting treatment (Moses et al., 2004; United Nations Office on Drugs and Crime, 2004).

Women with substance use issues lead complex lives

Women attending substance use treatment frequently have other challenges that require assistance and treatment. Supports beyond addiction treatment are often required to manage the sometimes chaotic lives of women with substance use issues.

> Women face an array of mental health struggles, substance abuse, and physical health problems. Many are poor and do not have access to adequate food, safe housing, stable income, education, job training/vocational rehabilitation, or employment opportunities. Many women living with mental health challenges, substance abuse, and the repercussions of trauma are mothers. Some live with their children; others do not; some are involved in the criminal justice and child protection systems. But their identities as mothers are primary to them, and many want to reunite with their children. Many of these women are extremely isolated and lack stable, positive supports and safe, anchoring relationships. Some may presently be in dangerous domestic situations. Many of the burdens women face require substantial time and resources

> to address, and the involvement of multiple programs and service systems (Moses et al., 2004, p. 33).

Past trauma experiences and mental health issues

Women with substance use issues are more likely than their male counterparts to have experienced physical or sexual abuse. Trauma experiences can lead to the development of post-traumatic stress disorder (PTSD), or other mental health problems (United Nations Office on Drugs and Crime, 2004). The effects of trauma are substantial and wide-ranging, affecting many life areas, including physical, mental, emotional, spiritual, social, and economic well-being (Moses et al., 2004; Alberta Alcohol and Drug Abuse Commission, 2004b).

Treatment and recovery are difficult

Recovery from substance use can be a long and arduous journey that often entails individuals experiencing relapse over the course of the process. While dealing with substance use issues, past traumas and issues may be revisited that cause distress and strengthen the desire to use substances to mask the negative feelings that come to the surface. The process can be daunting and unpleasant.

Demographic information

A review of the demographic statistics on all women who received ESW services in 2004 suggests that ESW clients are generally 18 to 34 years of age, are single, are unemployed, have not finished high school, and are users of multiple substances. Cocaine is most often identified as the primary substance of concern, followed by alcohol and tobacco use, with a range of other drugs also named as concerns. A total of 115 clients were admitted to ESW services with notes on their files indicating they were pregnant at the time of admission.

A comparative review of statistics of all women in AADAC services in the 2004 calendar year finds that the majority of women are between 25 and 44 years of age, are single, unemployed, and have not finished high school. Detailed comparisons between the women in ESW services and women in AADAC services in general follow.

Age and marital status

The vast majority (83%) of women in ESW in 2004 were between ages 18 and 34 with equal numbers in the 18- to 24-year range and the 25- to 34-year range. Of all the women in AADAC services in 2004, over one-third (40%) were between 18 and 34 years of age.

Almost three quarters of ESW clients (69%) were single; the majority (56%) were never married. Over one quarter (31%) were with partners. For the

same time period, almost three-quarters of all women in AADAC services (72%) were single, with a slight majority (52%) of all women having never been married. Over one-quarter (28%) were married or with partners.

	Age 18 to 34	Single	Single, Never Married	Married or with a Partner
Women in ESW services	83%	69%	56%	31%
All women in AADAC services	40%	72%	52%	28%

Education and employment

The majority of women in ESW have limited educational attainment. Two thirds (67%) had not completed high school, 62% were unemployed and not looking for paid work, and 23% were looking for employment. Just over half of all women in AADAC services in 2004 had not completed high school (56%), 43% were unemployed and not looking for paid work while 22% were looking for employment.

	Not completed high school	Unemployed & not looking for paid work	Unemployed & looking for paid work
Women in ESW services	67%	62%	23%
All women in AADAC services	56%	43%	22%

Substances used

Women in ESW name the following as the most used substances in the past 12 months: smoking tobacco (75%), alcohol (73%), cocaine (73%), marijuana (56%) and opioids (31%). Statistics from all women in AADAC services shows the most commonly used substances as: alcohol (86%), tobacco (76%), marijuana (54%), cocaine (41%) and antidepressants (30%).

Women in ESW services	Smoking 75%	Alcohol 73%	Cocaine 73%	Marijuana 56%	Opioids 31%
All women in AADAC services	Alcohol 86%	Smoking 76%	Marijuana 54%	Cocoaine 41%	Antidepressants 30%

Substance of concern

ESW participants list the following substances as those they consider to be of concern in past 12 months: cocaine (63%), alcohol (36%), smoking tobacco (36%), marijuana (20%) and opioids (14%). Almost one in five women in ESW (19%) injected drugs in the past 12 months.

Women in AADAC services list alcohol (42%), tobacco (33%), cocaine (32%), marijuana (18%), and opioids (14%) as their substances of concern over the past 12 months. Approximately one in 10 of all women in AADAC services (9%) report injecting substances in the past 12 months.

Women in ESW services	Cocaine 63%	Alcohol 36%	Smoking 36%	Marijuana 20%	Opioids 14%
All women in AADAC services	Alcohol 42%	Smoking 33%	Cocaine 32%	Marijuana 18%	Opiods 14%

The women entering ESW services: Describing their lives before ESW

The women interviewed for this research project provided candid descriptions of their life circumstances before their interaction with Enhanced Services for Women (ESW) at AADAC. Several issues were common among the women: substance use, parenting, physical health, emotional health, relationships and social environment.

The topics discussed by research participants generally reflect those that are well-supported in the literature. Not all topics discussed in the literature were mentioned by interviewees, but their descriptions are a reflection of their lives and the manner in which they related the stories of their lives to interviewers.

Substance use

The women interviewed shared a similar history related to their substance use. Most started using substances at an early age and often with family members. Alcohol, cocaine, and tobacco were the most commonly used substances along with experimentation with a wide range of other drugs. The pattern included a progressively increasing amount and frequency of substance use, often interrupted by periods of abstinence, to a point when they considered themselves to be "out of control" or "the worst." Their narratives suggest that their use had become a perceived life*line*—using substances was a way of surviving the pains and stresses of their lives. Women also described negative previous treatment experiences with a variety of service organizations that made it difficult for them to seek help for their substance use.

Early Onset

Many women began experimenting with substances, typically alcohol, in childhood, some as early as the preschool years. "When I was four, I was drinking," reported one woman. "I got drunk at [a family event] when I was five," said another. Others started in grade school. More commonly, the women started using substances in their early adolescence, often progressing in a few years from alcohol to cocaine or other drugs. For example: "Alcohol since I was nine years old…Pot I started when I was 12 and crack I started when I was 18," "I started using pot and drinking when I was 12. I started cocaine when I was 14. [Q: And your needle use started?] When I first did cocaine." In a group interview, the director of a service agency concurred, "The overwhelming majority—something like 95% in our stats—of the women we work with started using at 12 or 13." One woman interviewed in the research project had already "overdosed on alcohol quite a few times" by age 12. A young woman in her early twenties, who had "been drinking quite a bit off and on since I was seven," had already suffered liver damage.

Less common among the women interviewed were those who started as young adults.

> When I was 22, I experimented a little bit. I used powder cocaine for at least six months, but then it was just here and there after that. I've had ecstasy, mushrooms, acid, all that stuff. In that one year kind of thing. And then at 25 I tried crack and now I'm here.

Several women related stories of how family members, such as parents, siblings, or in-laws, played a part in their introduction to substance use. In some instances, family members directly contributed to women starting to use.

> My older sister first started me or introduced me to [coke] when I was 17. I was living with her and her boyfriend and my two nephews. And I didn't know she did it. And so one night, I just went over to her boyfriend's place and we were all, you know, waiting for her to get off work and stuff, and they pulled it out and I was just like "oh, you know, OK." So, I did one and then the next thing you know, it was constant.

In other situations, the fact that family members used made it easier and more accessible for the women to use themselves:

> Mom and dad, when they were together, were serious alcoholics. Like I mean, they didn't notice beer going missing. I was drinking at the age of 12, and they never noticed it missing. I'd get them one, get me one, put it underneath my pillow. They never knew.

This early exposure leads to a normalized perception of substance use. "That's all I knew," stated one woman. She expanded:

> I never thought ever in my life I'd ever quit drugs. I thought it was the way to live. I thought this is what you did. Since I was 14, I done needles. So after a week of that you think that's how it is, right? You forget about the way life really is.

With such an early beginning, some women have "had a 15-year [substance use] history generally when they get to us," reported a director of a mentoring agency. While the research project included women who had been using for shorter periods of time, some confirmed they had lengthy substance use histories, "I've been an addict for 14, no, 15 years now," stated one woman. For others, the duration was even longer.

> I grew up around alcohol and drugs since I was a kid and I've used since I was like a teenager. Well, eight was when I first started using. And I'm 33 now so that was like a long [time], a lot of years abusing.

Harmful substance use patterns

This discussion about substance use patterns includes information from interviews about the variety, amount, and frequency of substance use. It also covers the progressive increase in substance use and the way it permeated women's lives.

Experimentation

In addition to alcohol and tobacco, the women had experimented with a vast variety of substances including: opioids, prescription medication, cannabis, mushrooms, methamphetamines, and cocaine in various forms. Usually the women had one or two drugs of choice, coupled with tobacco, and might occasionally have experimented with others. A few women, such as this young mother of two, had experimented with many substances: "We've had cocaine, we've had crack, we've had weed, we've had ecstasy, acid, mushrooms [and] I used to be addicted to pills at one point." "I did everything a little bit but not lots," claimed another woman.

Frequency and amount used

During the interviews, women described the amount and frequency of their use in terminology familiar to them; no standard definition of heavy or binge use was used to frame their descriptions, but their descriptions indicate heavy, binge and habitual substance use patterns at some time in their history. Moreover, women were often frustrated in their attempts to remember details about their substance patterns. Despite these limitations, there is overwhelming evidence in the interviews of heavy and frequent use. "Daily" was the typical adjective used to describe the frequency of use prior to seeking help, lasting from a few months to a couple of years. One woman said, "I was on crack 24/7." Words used to describe the amount of substance(s) consumed varied according to the substance. "Minimum two 'six' a day," "probably close to 5 grams [of crack] in the day," "I'd probably go through about three 'eight-balls' [of cocaine] a night."[6]

An ESW team member noted that women can build tolerance to larger amounts of substances when "the daily use has been [consistent] for quite a long time."

Substance substitution and efforts to quit

Some women recognized a pattern of replacing one drug for another. For health reasons, a couple of women had quit using alcohol but, as one woman stated, "I replaced one addiction with another, so like I knew I had to quit drinking and I went to crack." Another woman did the reverse. While "off crack" for two years, she "was using weed, and drinking—kind of substituting drugs." Although she tended to avoid alcohol because of witnessing the ill effects in members of her family, "at some stupid level, I thought that if I did other drugs, I'd be OK. Like, if I just smoked weed, then I wasn't going to end up like these people that are drinking."

Some women had attempted to quit their substance use "on my own." Two or three had attempted to quit cold turkey but, without adequate supports, "fell flat on my face" or "ended up in the hospital" and then did the "same drugs, more often and more of it."

[6] A "six" is a six-pack of beer. An "eight-ball" is 3.5 grams of cocaine.

Pattern of use

A striking history of progressively increasing use, punctuated by periods of abstinence and relapse, is apparent throughout the interviews. Women often initially perceived their substance use as innocuous or under control until it spiralled out of control over time. "I figured just this once won't hurt me. Nine months later, I was strung out." Another woman describes this progression in the following quote.

> Actually, it wasn't bad. Like, for the first four months, it was every other weekend, once a month, here and there. And then, all of a sudden, it became every weekend and then the weekends were four, five days long and then it was completely out of control." [Q: And then when it was out of control, how much were you using and how often were you using?] "Oh, every day basically. This last time that it got really out of control—because I quit for three months while I was pregnant, and then just after I had the baby, I relapsed—it was probably $500 to $1000 a day [spent on cocaine]…For three to seven days [I would use], sleep for two, and then do it again.

Eventually, the women's daily existence was framed by their substance use.

> I just started drinking heavily. Like, there wasn't a day I didn't have beer. There wasn't a day I wasn't drunk. I was working at [a diner], and I got off work at about 11, would drink till three or four in the morning, go home, go to sleep, get up, have a shower, go to work, get off at 11, head straight for the bar till three or four in the morning. And I lived like that for about two, three months.

Using substances to deal with negative emotions

Substance use figures prominently as a method of managing negative emotions. Using increasing levels of substances to cope with the pains and stresses of their lives was a common theme among the women interviewed. Women fell into heavy and frequent substance use when problems seemed insurmountable, when partners came in or out of their lives or, more commonly, when their children were apprehended. "If I had a problem, I went and got a drink or went and got a hoot or something," "I was drinking pretty heavily until I settled down with my first baby's daddy…Then when me and him split, I just started hammering," "Once I lost [my daughter] completely to my parents, I just went completely out of control." In the following excerpt, a woman describes a convergence of numerous stressors that led to a relapse.

> [After my son was born,] I just got so stressed out. I was having boyfriend problems. I was having family problems. I was having baby problems. I was constantly depressed. Like, the whole time from when [a traumatic event happened] to any time, I was always depressed. Like, nothing would pick me up unless I was drinking. So, I started drinking

> again and I put my son into care because I was just so physically, you know, broken down, I couldn't handle him.

Perhaps most importantly, then, heavy and frequent substance use becomes associated with basic survival, when some women cannot function in daily life, let alone deal with any other difficulties they may encounter, without using substances.

> I was drinking a lot and doing drugs quite a bit. Every day it got to be…like it was bad. I had to do it just to stay awake, or just to function. Just so I wasn't sick…I was either drunk, high, or sick or tired. And to be not sick and not tired, I had to use…[I'd drink during the day] just enough to keep me going…just enough to keep me from getting sick…[And I'd smoke crack at night] enough to just, you know, either stay awake or sober me up.

> I'd wake up in the morning, and it's the last thing I did before I went to bed. I used weed to escape life more than anything else.

> Like I didn't get out of bed without using. And if somebody didn't have a drink for me or a hoot I wasn't getting up.

Women frequently described the period just prior to the point of seeking help in dramatic terms such as "really bad," "the worst time ever," "the worst of the bad," "knocking on death's door," "kinda like your own suicide," or "nothing but torture." In describing their feelings about themselves during this period, they sometimes used phrases that articulated the depths of their despair and pain: "I was just a junkie," "I felt gross…I couldn't stand myself. I couldn't stand being in my own skin," "I hated myself," "I felt like I wasn't good enough; I felt like my kids deserved somebody better." "Every time I would get high, I would hope I would overdose," admitted one woman about the time after her children were apprehended.

Treatment experiences

Research project participants reported a wide range of treatment experiences. Some had never sought treatment before their experience with ESW while others had experienced a variety of substance use treatment environments, from outpatient therapy to residential treatment to medical detoxification. Some had attempted to engage with these treatment options repeatedly. Several had been exposed to the service system as adolescents.

There were many reasons why women had a history of repeated treatment attempts. Here, a woman with a history of street involvement identifies her difficulty in dealing with substance use issues amidst the complexity of other problems.

> I've been to treatment probably 10 times in the past. I've been to AA and I just never found it helpful at all because I was just, I'm not sure if I was ready or if I just didn't have the right tools to deal with everything that was going on.

The treatment histories related by project participants also reflect the shaming and re-victimization discussed previously, demonstrating why some women have difficulty making themselves vulnerable to these situations again. “I know that [in] some of the other counselling I tried to get, they thought I was crazy or they didn't seem really interested in helping me or it didn't really feel like I was important or whatever,” remembered one young woman with a long history of substance use. In the following excerpt, a woman first describes the intake process she experienced as an adolescent seeking treatment.

> I'd come in and they'd be like “OK, yeah well, sit here, get in line with everybody else.” And so I did. And then, when I'd finally get around to seeing somebody, they'd be like, “OK, so what do you take and what do you do, and how much do you do? OK, yeah, we'll call you when we've found somebody [to counsel you].” And that's the type—basically that's how it was.
>
> [Q: And how many times did you have that kind of an experience?] I had that quite a few times, three times…I remember coming and talking to one person, tell that person whatever, and then they kind of pass you on to somebody else, or whatever. And I'd tell them, you know, I don't work well in groups. And I don't. I really, really don't. And I'm sure there's a lot of people like that…They actually kind of scolded me, you know and I told them, “Can't I just see you alone?” I mean, I asked them if I could just talk with [one counsellor] because that probably would've worked with me. But [the counsellor] felt that I wasn't participating.

Poor service experiences were not only found in the addictions treatment system. As discussed in the literature earlier, any poor experiences from helping professionals at any time in a woman’s life affect her determination to seek professional assistance in the future. For example, a young mother of three described a counselling experience she had had as a teen that affected her trust of professionals well into adulthood.

> After so many years of getting hurt, I wanted to finally deal with that hurt. And we went to one counselling session, and that's all it was, was one, because I didn't see any sincerity in [the counsellor’s] eyes. I didn't feel that she had very good feedback from me or my mother. All she did, really, was feed into my anger. And I just didn't think it was very professional of her. So, I let her know. I was only 14 years old. And then I didn't get help ever since. I always believed that “I will not express my feelings to counsellors, ever, because I don't know them and they don't know me. They'll judge me, you know.” And that's just from that one experience.

Not all experiences in treatment are negative. A pregnant woman with a history of a transient lifestyle describes a positive treatment experience she encountered before her interactions with ESW services:

> I went through an awesome program which…really helped out. Yeah, I did six weeks. They kept me there a little bit longer. It was amazing though, it helped out with, you know, housing and it helped out with stuff like that. So it actually worked out for more than just my addiction part.

What made this experience a positive one is the ability of the treatment program to address the many complexities of the woman's life, not simply treat her addiction in isolation from other concerns. This holistic approach can engage the woman in services and see her achieve positive outcomes.

The descriptions of poor treatment experiences demonstrate why some women have difficulty making themselves open to these situations again. These experiences can be very demoralizing and discourage someone who has taken the first step from pursuing the treatment process any further.

Parenting

This research project gathered information from a variety of women in different stages of parenting—currently pregnant, currently parenting, and mothers whose children are in the care of others. Those who no longer have custody of their children have their children placed with other family members (maternal grandparents, biological father, etc.); others have children in foster care.

In most interviews, women described their feelings and perceptions, abilities and skills related to parenting. This section discusses parenting strengths, parental role models, parenting challenges, and pregnancy.

Parenting strengths

Many women were motivated by and proud of their parenting strengths. Before meeting her current partner, one woman declared, "I was always strong, especially when I had [my first child]. I kept it together. I was always able to maintain a home. I had food in the fridge all the time. I paid my bills. I was very responsible in that way."

Some research participants report that while conditions may not have been optimal, they feel they were able to manage other aspects of their lives, like parenting, while using. In the excerpt below, one woman describes her efforts to keep a "balance" for her children during her substance use. Only when her children were away for two weeks did she break all the rules she had set for herself regarding her substance use:

> There's a lot of years where I didn't drink all the time, but I would have, like, a girls' night out every Thursday, right? Once a week. That's a lot to me now, but back then, that was just my, you know, because then the rest of the week I would be stable for my kids. And everything was all good for a lot of years. That's how I worked it. I used to balance it somehow. I'd balance it some way or another just so the kids were OK. I'd never do

> it at home, because that was one rule I used to have.…I kept the balance for them. Like they didn't see nothing or I'd wait till they went to bed before I would get high. And I don't know, I'd have a few beers during the day but they wouldn't see it type of thing, you know, just enough to keep me going…So three years basically, as long as the kids were OK and they were safe and they were whatever, I was out just binging…I'd be home for the kids after school and then they'd go to bed and then I'd go out. They'd be at school all day. I'd sleep. Then, I'd get up for them and clean and cook and make sure they had supper, and then they'd go to bed and then I'd go out, you know…[Then,] while my kids were gone for two weeks, I really lost it. I was—it was bad [for] the whole two weeks they were gone.

Parental role models

In relation to their own journey as parents, some women reflected on how they were parented as children. Their reports suggest their own parents experienced difficulty in parenting or that they themselves were apprehended as children. As introduced elsewhere, in several families, parents normalized substance use or violence.

> I thought everything was normal, because [of] the way I was brought up. I was brought up watching my mom go through a lot of bad stuff. So, it was like, you know, what I thought or whatever I went through is nothing compared to my mom.

Some women had experience with child protection authorities in their childhood and youth. A community service provider described the situation she sees with her clients:

> What so many women lack is parenting themselves. They have no idea what to do. So without someone parenting them, how are they going to know what to do? They need nurturing themselves…So many of the women [at our agency] that have the little babies—they themselves were apprehended [by child protection] when they were young…They're foster kids or they're permanent wards of the courts themselves at a very young age.[7]

Parenting challenges

The effect of substance use on the ability to parent

Several women considered that they were less able to be good parents because of their substance use and the circumstances that surrounded their use. Their mental state was poorer because of their use and their decision-making ability and parenting skills declined as a result. A mother of three

[7] Different speakers in the same group interview contributed to this quote.

whose children were eventually apprehended by a child protection agency described how substance use affected her ability to parent.

> I started pushing away my children. It was the neglect that was happening with them, and they were feeling very hurt. They were feeling angry inside. I wasn't there for them at all…I started getting heavily into [crack use]. That's when [my husband] had joined the gang and had his friends over. We had a hooker live with us and everything. It was horrible. It was a horrible life.
>
> [Q: You still had your kids then?] Yeah, and I wish they were taken from me then. I really do. I wanted my kids looked after. I knew I had to do something but I didn't know how present it. I didn't know how to ask for help. So I kept neglecting them.

Resources that would generally be used to provide for the needs of the children were sometimes diverted to cover the cost of substance use. The cost, the chaos, and how that affected parenting, is evident in the following story from a mother of four.

> I used [crack] for about a year. Every night, yeah. Got 20 bucks, we went and bought crack. Because down [where we lived] it's pretty cheap now. But we settled down in [one city], because I tested positive for cocaine in [another city] when I had my daughter. And they don't like that. So [a child protection agency] apprehended her for awhile, but then once I promised to go back to [the city I came from] and quit using and all of this they said, "OK, fine." They flew us out of there and I stayed with my husband's family where they don't drink, they don't use drugs, nothing. So it was kind of sobering up. We ended up moving into an apartment, and then [my husband's] brother-in-law came around. [My daughter] would have been almost a year. And he came around and I didn't know he was a crack-head user, and my husband at the time was real easy. All you had to do is just boom and he's off to the dealer's, right? And we weren't rich. We spent our whole income tax return on crack cocaine inside two weeks. $3,000 gone. You know, here we have a kid [and] nothing to show for that money.

Intervention from the child protection system

Research participants have a high rate of involvement with the child protection system, where their children have at some point been taken into custody by government authorities or there has been some intervention by the system. For many, the intervention of child protection agencies eventually precipitated a crisis in their lives. One participant in a meeting with community service providers speculated, "[It] doesn't make sense. They just lose them (custody of their kids) and then they have another child. It's almost like a self-sabotage, punishing kind of thing that they do to themselves." Several women interviewed had had children apprehended, some temporarily, others permanently. In the latter instance, they might have lost touch with their children completely.

> I found on my last day of [substance use] treatment actually that [the child protection system] went [for permanent guardianship of my child]. They subpoenaed me under my door. I figured now I have the guts to call the lady [at the child protection service] because I've done something [about my addiction]. I've made a step, and she said, "Well, he's gone [for permanent guardianship] two and a half months ago." I only had a month to appeal. So that was really hard for me to take, really hard, and I went back to court to try and fight it and then there was nothing I can do. They just brought up the past 15 years of my life. They didn't look at what I'm doing now, and at the time I only had five months' sobriety.

Alternate custody arrangements

Sometimes children were placed in the care of grandparents. Some women considered themselves "lucky" in this circumstance because it meant their children could avoid foster care. However, it sometimes sets up other stresses related to the children such as uncertainty, power struggles, and relationship conflicts with the grandparents.

> Like can you imagine staying with your baby, and at your parents' house, and they're the ones that make the rules. It's their house. I can't even—there was a bed in the room with the bassinet. I could have slept there. No. They didn't want me upstairs. They'd rather get up…she (my mom) would rather get up in the middle of the night and go in there and—oh, it was terrible. It did nothing but cause a lot of problems, and hurt feelings, and arguments, and oh, God…

This mother goes on to describe how the conflict with her parents continued after she had met all the custody requirements set out by a child protection agency:

> So I did everything they'd (the child protection system) asked of me in that service plan, and they extended it. We got to take her home luckily. My mom sat there saying, "No, you can't take her home." She said this right in front of…like my whole family was there.

Pregnancy

A number of women had earlier pregnancies in addition to a more recent pregnancy. The discovery of a pregnancy often led women into a roller coaster of feelings.

> I was so in shock and I was so hurt and depressed and angry at myself. I was a big mess because I didn't know what the heck I was doing, because I didn't know I was 19 and a half weeks [pregnant]. I was expecting to be able to terminate and at least maybe then I wouldn't have to ruin another life, right? Because I thought maybe I had.

As in this story told by a mother of three, often women did not know they were pregnant until well into the pregnancy. One woman whose previous children had not been in her care for many years, was “so happy” to learn of her latest pregnancy at the point when “I went to a treatment centre just cause I wanted to straighten myself out.” Another, in contrast, “took it so hard” to find out she was pregnant just as she was “coming off the coke” so that she “started drinking and drinking, hoping that I wouldn’t have it [hoping to cause a miscarriage].” One woman “went through that denial stage,” insisting that the pregnancy test be done again. In the midst of heavy substance use, homelessness, and a recent break-up with her partner, one woman claimed “I didn't give a shit about the pregnancy at the time.”

A child born to a mother who uses substances during pregnancy may experience mental or physical difficulties as a result of the mother’s use. While some women quit using when they found out they were pregnant, others continued to use substances through pregnancy. One woman miscarried at 26 weeks—

> —because of health and drugs. Because I was very unhealthy and then the fact that I went and didn't stop using drugs probably didn't help it at all. I carried for 26 weeks [and then miscarried]…[the baby’s] lungs didn't develop, but because of my lifestyle I wasn't resting properly, I wasn't eating, I wasn't doing anything.

Some women had experienced previous success in quitting substance use during pregnancy (although they often relapsed afterwards). “To be totally clean and not use?” reported one woman, “I’ve done it, like, twice before but only when I was pregnant with my other two kids.”

Women typically experienced uncertainty and fear for the health of the baby, sometimes hoping that their child would be one of those “cases where the baby doesn’t get affected” yet fearful of the worst.

While research participants report they had successes as parents, they also struggled with a variety of parenting issues, including the parenting role models in their lives, how substance use interfered with their ability to parent, interventions from child protection agencies, alternate custody arrangements and how substance use affected their pregnancy.

Physical health

Project participants reported varying levels of physical health, with several reporting a variety of physical health problems. Women interviewed mentioned hepatitis C from needle use, untreated HIV infection, liver damage from early alcoholism, and diabetes. Irregular sleeping, eating, and hygiene were also noted. Further, women had occasionally suffered physical health concerns as a result of overdoses and from trying to quit using substances “cold turkey.” When women experienced problems with their health, the management of those problems added to the complexity of their substance use and addictions treatment.

The following quotes demonstrate the relationship of substance use to physical health.

> I was drinking a lot and doing drugs quite a bit. Every day it got to be, like it was bad. I had to do it just to stay awake, or just to function. Just so I wasn't sick. Yeah, and then with [other serious health concerns] that's even stupider. Like, hello? Yeah I guess that's kinda like your own suicide.

> There was times where I would use needles throughout the years just because of this one person. I have hep C because of him. I don't even know how to do it (inject myself). He did it all. So that's where I got hep C from.

Some women experience brain damage and have to manage the effects of that. One woman had been diagnosed with fetal alcohol syndrome and was receiving financial assistance and supportive housing. A young woman described the brain damage and after-effects she experienced as a result of her experimentation with crystal meth.

> We had smoked, you know, a couple of bowls of weed and then my buddy pulled out this orange crystal stuff and filled it up. And I woke up in the morgue after that. They kept me in the psych ward for six months, and they told me that I'd never regain my memory, and I was lucky if I was ever going to live a normal life compared to what was normal at that time. I mean, I had a job. I had, you know, things going for me. But because I was under so long they said that there was damage done to my brain. But they said—like, even the psychological testing that they'd done—my brain works at like an eight-year-old level…I didn't know how to read. I didn't know how to write. I didn't know who I was. I didn't know people around me. And I didn't know where I was. I was, you know, pretty much trying to learn the skills that you learned as a kid all over again. It was extremely difficult.

Cognitive challenges add an important dimension to some women's lives. In a group interview with community service providers, one noted that with women "who are in some way intellectually or neurologically challenged, we are not seeing that they are making any kind of long-term progress."

Some women who participated in this research had minor health concerns, others experienced major illnesses. All require some form of medical treatment that they may not have pursued while under the cloud of their substance use. Concerns they had about their health could have been masked by substance use.

Emotional health

The women interviewed for this research project were open about their emotional and mental health concerns and how these concerns interacted

with their substance use. Community service providers and ESW service co-ordinators also recognized this as a key issue for most of their clients. They described the self-esteem and trauma issues that initially led them into substance use, the isolation and anxiety that kept them using, and the growing inability to cope with the stresses and strains of complex and difficult lives.

Self-esteem

Women typically recognized that poor self-esteem "was part of why I started using originally." One woman recalled feeling "like I wasn't good enough." Another began to make a connection between the feelings of worthlessness that had been sown in childhood and then intensified in her current partner relationship. Some women suggested that looking at the past might help them in their recovery.

Dealing with trauma

As suggested by all sources, women receiving support from ESW had experienced trauma in their lives that had lingering effects on both their physical and emotional health. Having experienced abuse in childhood and adulthood severely damaged the women's sense of self-worth and inflicted emotional trauma that lingers. A former sex-trade worker provided a vivid example of such a consequence.

> Because of working the streets and stuff [to support] my habit, I was really uncomfortable around men. I just tell them, "Go away." And so, like, in an elevator or something, I'd stop and get out on the floor, and I wouldn't get back in the elevator till nobody was on there.

Another woman described how the anxiety she experienced as a result of an abusive relationship led to harmful use of prescription medications.

> And he (the doctor) gave me Xanex…and since then I kept wanting to be numb. I didn't want to—I thought, "Oh, this is neat. I don't feel… I don't feel joy, I don't feel sad either." So I started taking more of them, and more of them. But you know what, when I took the pills to stay numb that was the only way I could live, the only way I could survive. I was mentally breaking down.

Anxiety and emotional turmoil

"I spent three years of very, very unhappy," said one woman. And another recalled, "When I lost my kids, I lost my mind." References to anxiety, hurt, depression, "panic attacks," grief, guilt, and "mental breakdown" are interjected throughout the interviews. According to community service providers, "Some of these girls have way more issues than addiction, you know. They have grief, they have losses in their life that they've never dealt with properly." One woman listed a series of losses in her family due to

death, abandonment, and relocation. Another talked about the "consequences from using [such as] other people I've hurt, all the hurt that I've done to myself and everything."

In the next quote, the woman pinpoints the link between her substance use and emotional health.

> I went through a mental breakdown. I didn't know how to deal with my emotions, and being a single parent and stuff like that. I ended up in hospital for a week, and it was like, "What do I do?" I wanted to go use so bad because I didn't know how to cope.

Anger

Anger, leading to destruction and violence, seemed to be the only emotional outlet for some women. One woman described her reaction when her daughter was apprehended at six weeks of age. In her rage, she broke furniture and beat a neighbour who made disparaging remarks about her ability to parent. In the following excerpt, she recounts how she attempted to vent her anger on her daughter's belongings.

> The first time that [a child protection agency] actually [apprehended her], my world collapsed. They apprehended her on a Tuesday. We had to go to court [the next] Thursday or Friday. And that left me with the weekend to ponder my world. I destroyed her baby furniture, the change tables, rocking chairs, everything. They took her when she was a month and a half. So that does a lot of crap to you mentally…I had the shakes, I was so mad.

The community service providers and ESW service co-ordinators recognized that some of their clients needed to develop socially appropriate behaviour: "[Y]elling, swearing, getting physical…have really helped [our clients] to survive [living on the streets]"; such actions may be appropriate in those circumstances, but in the general population, violent outbursts often did not achieve the same result.

Hopelessness and helplessness

As is described earlier, a downward spiral of emotional pain and substance use often led to deep despair and hopelessness. This mother of four expressed the desperation she felt at her lowest point, "I didn't care about anybody, nobody. [Q: How about yourself?] No, no, no, oh God, no. I was (pause), the more I would use (pause). Every time I would get high, I would hope I would overdose."

The mother of an infant daughter explains how she experienced a rollercoaster of emotions over the course of her pregnancy and how her substance use manifested itself over that time:

> I mean things were really bad before I went to treatment, and then I went to treatment in [another community], and then there were two weeks after I got out of treatment I relapsed and I got worse and worse and worse from there until [a few months later], and then the father [of my daughter] came back into the picture, 'cuz at that point I was ready to kill myself and I called him and I said, “I really, really need help.” I was just hating life. If I hadn't been pregnant I probably would have [killed myself], and then so he came out and I cleaned up for three months and things were great. Then we got home with the baby and…“well let's just get a 40 piece,” and I was like yeah, I can control that. We'll just do a 40 piece, and it was a six day binge.

Several of the women who participated in this research project described how their desperation brought them to the point of contemplating suicide, or at least to believe that others, particularly their children, would be better off without them. These thoughts in combination with their substance use, in the wrong circumstances, could have been lethal.

Relationships

The relationships within which a woman is embedded—with families, friends, partners, and other significant people—have a strong influence on the circumstances of her life. The association, for women, between substance use and personal relationships is well-documented here and in the literature (See supporting literature and background information section). As the discussion in this section attests, other aspects of the women’s lives were also affected by their significant relationships.

Family relationships

As discussed earlier, family members introduced some project participants to substance use. Not all women had these experiences with their families of origin, but most do experience the some difficulties in their familial relationships. Women typically described stresses in their relationships with family members—most often parents and occasionally siblings—and sometimes mentioned feeling misunderstood by their parents, such as this young woman who left home at an early age.

> [My parents] just figured I just decided to stay out there [on the streets]. They figured that anybody could quit [using alcohol] anytime. I had absolutely no relationship with them. I left home when I was 12, and I'd just float [back] into town every few years, say, “Hi, I'm here,” and then take off.

Relationships between daughters and their mothers seemed particularly difficult for some of the women interviewed. One woman who shared a home with her mother described their unpredictable relationship.

> It's just a pattern I tend to follow with my mother. You know, I mean she drives me absolutely insane but yet I like the abuse or something, I don't know. I don't know what it is. My mom can play [me], she knows [how to]. I can play my mom, but my mom can play me better, you know? She can sit there, and when she needs me she knows I'm gonna be there for her, but when I really need her she will be there for me but it just depends, you know. Just depends with her.

Some women mentioned that their mothers had reported them to the police or child protection agencies. Usually, this further strained what was an already difficult relationship. One mother of four, who had regained custody of all her children, described her initial reaction to her mother's action: "I was like, 'I can't believe you called the cops on my friends.' I was so mad at her. I said so many mean things to her." For another mother of four, who has custody of only her youngest child, her mother's contact with a child protection agency signalled the end of her relationship with her mother: "She called Child Welfare on me. So, that's a lot to do with why I don't deal with my mom anymore. As far as I'm concerned, she's six feet under."

Women whose parents had custody of their children struggled with the power issues, confusion between dependence and independence, and role conflicts that emerged in such situations. As a community service provider noted, "There's all that control and there may be a negative relationship between the mom and daughter in the first place, and then for [the woman's mother] to have the baby…" A mother of an infant daughter described her struggles to define the boundaries of her relationship with her parents.

> They're going to help me out. But if I slip up, I'm on the streets. After they had to start looking after my daughter and I was still screwing up, they kind of said that they weren't enabling me anymore. While I was pregnant, they didn't want to throw me out on the streets because I was pregnant. I think, after [I had the baby], they kind of said, "you know what? We're not going to put a roof over your head and food in the fridge, if you're still going to be using." So, at that point, I think they kind of had enough that way. But they said, "If you want treatment, we'll pay for it, we'll get you there, we'll help you out after."

Partner relationships

As they described the changes they have made in partner relationships, women sometimes offered a glimpse into the instability, violence, and trauma of earlier relationships. This mother of a young daughter describes a relationship that started in her teens and led her to seek out prescription medications to deal with the anxiety she felt in trying to keep her abusive partner from getting angry with her:

> I was with him for eight years. I was his punching bag and so were the walls. We had lots of holes in our walls in our apartment…No, he did

> not treat me well at all. He had an obsession with guns…and he was really demented. He held a gun to my head, he told me that because I was wanting to leave again he told me that he was going to…if he couldn't have me nobody would, and everyone was scared of him because he was a very good street fighter...

One woman discussed her relationship at length with the researcher because, at the time of her second research interview, she was struggling to define the future of her relationship with her husband of five years. She related her feelings of guilt and blame, the far reaching effects of the relationship on other life areas, and her belief that the relationship had altered her path in life.

> I have never gone through so much hurt in my life as I have with him. I think this was even worse than the abuse that I went through as a child. It feels horrible. And I can't believe that I let myself go like that…It would never have crossed my mind [to do some things]. And even when the situation would arise I would just shut it down immediately. I would be like "yeah, right, as if I'm going to do crack. Yeah, right." You know? Because all my life I have been abused and sexually abused and whatever, right? But I was always able to, you know, I did have a hard time with responsibility but I was always a very independent woman. I never dragged myself down to the point where I didn't feel that I could do anything. And with [my husband], it was completely different. He turned that around. He helped me be weak. I've never felt so degraded as he made me feel. I lost my independence. I lost my strength… When I met [him], everything went down the drain…My bills were neglected. I never moved so much in my life. I mean, I moved a lot in my time, but I have not moved so much in my life as I have in the last five years. And I've gotten evicted from so many homes. I have bad credit up the wazoo now. I lost my children. I lost a lot of things. I lost myself…And, my God, before, I would never let myself go like that. I would never consider it. I was always independent. I was good. I still am a good person, but during the time with [him] I never felt that I was worth it. I felt helpless. I felt controlled. I felt manipulated. I felt abused. I felt used.

Like the woman above, other women and service providers identified numerous instances wherein the involvement or re-involvement of a male partner would lead to relapses, child protection apprehensions, and other social problems. "The guy, more often than not, is sort of the key that will bring them right back (pause) to everything."

In one situation, a woman described how her husband has been a positive resource for financial, emotional, and child care support. To comply with the service plan dictated by the child protection agency, her husband, who works out of town to support his family, came home to assist in caring for his daughter.

> [He] came home from work, he took parental leave, and we told them (at the child protection agency) basically that. That he is going to be with me because their whole problem was leaving her alone with me. And they made him totally responsible. Like yeah, if anything happened to [our daughter]…he's held responsible, and they told him that, so you know luckily he has a lot of faith in me, but if it wasn't for [my husband] then I probably wouldn't have [custody of our daughter] right now. [Our file at the child protection agency] was going to be a potential closure because [my husband] has to go back to work. We're a one-income family and he's it.

Each woman's life involves a host of other people—partners, families and other significant relationships. Each of these relationships helped shape the actions and course of her life.

Social environment

Information obtained during the interviews on family history, social issues, and services are reviewed in this section that examines the social environment women are ensconced in prior to entering ESW services.

Family history

Among the women interviewed, some reported a family history of addictions, often coupled with violence. Others disclosed emotional and sexual abuse. The woman in the following quote had just such a history and discusses how her relationship with her father was shaped by substance use.

> My mom was like that. She was a vicious drunk. Apparently my real grandfather wasn't a vicious drunk but he died of alcohol, something to do with alcohol. My step-grandfather, he was an alcoholic too, so it's in the family, you know. My mom and dad, when they were together, were serious alcoholics…Me and my dad always drank together. That's all we ever did together. We didn't go on picnics or father-daughter shopping trips or anything. He'd take me out for dinner and buy me drinks for Christmas. I never got anything good, except a hangover, for Christmas.

Another woman described a similar situation: her father abused alcohol and would buy drugs for her. Even an entire community could be implicated in a woman's substance use, as in the case of one woman who had come from a small Alberta community. In thinking about the social histories of the women she works with, one community service provider reflects,

> They're not self-inflicted problems. They're problems that were inflicted generations ago and it's an ongoing thing. That's their reality. It's not self-inflicted. It's the circumstances that inflicted it.

In contrast, a few women identified mentor-like figures within their families. For example, one woman's father is a "straight influence" and taught her the

skill of talking things out. Another said that when she makes decisions she is still inspired by what she learned from her grandmother, although that grandmother has long since died.

Social issues

Throughout the interviews, researchers gained clues about the complex, chaotic, and stressful social environment within which women existed. The women and service providers interviewed discussed the issues of housing, the law, finances, social isolation, and education that help to shape social environment. These aspects of women's social environment contributed to their substance use and vice versa. Here, a pregnant woman discusses how substance use contributed to the legal and educational troubles she has faced in her life.

> My whole life I've used drugs, like since I was 12, and it got me into a lot of trouble, you know, with the law. I mean I had numerous charges. Well theft charges, assault charges, stuff like that. I could never do school. I always got kicked out of one school or the other 'cause I'd skip school. And then I'd just end up being expelled just because of the fact that I couldn't function because I was using.

Furthermore, crises in these life areas affect how and when a woman might be able to seek assistance for her substance use. For example, a community service provider noticed that "a number of [women] say, 'Well, I can't come to the appointment because I'm going to court that day.' " Of necessity, women will put basic living needs and more urgent events, such as housing or a court appearance, ahead of attending to substance use issues.

Housing

The women interviewed had experienced numerous housing crises. They were typically highly transient and often homeless. They might have lived with parents or friends on an irregular basis. "I didn't have a home, I didn't have nothing of my own," recalled one woman, "I was staying in other people's houses." They may have spent time in shelters or at other short-term crisis housing like the YWCA. As seen in the quotes below, when women had nowhere to live, some were forced, by lack of safer options, into dangerous living situations and/or prostitution. Several women worked in the sex trade and had been arrested and jailed for their involvement.

> I was on the streets. I was trying to find any place to sleep. I eventually stayed with this guy that I'd known previously. He was really bad into pills, so it was convenient. If I supplied the crack, he'd supply the pills. So it was just horrible. I smoked every day.

> When I was pregnant with my son, I came back from [another country], had two suitcases and $20. My family wasn't talking to me so, I ended up going out and working [on the streets] when I was five months

> pregnant. Basically, I just furnished my apartment, moved in, and went on welfare from that point on. You know, you can't obtain those services (welfare) until you have a place to live so I had to do what I had to do.

Not only do these stories reflect the housing concerns these women had in common, but also the general chaos and uncertainty of their lives. This chaos often prevented them from carrying on the "routine" of life that is normalized in the rest of society. "I would never be home even," recollected one woman of the two-year period before regaining custody of her children, "There was no organization in my life." She then went on to explain that not only had she rarely experienced much routine in her life, but she had never before spent several months at a time living in the same place.

Finances

Most of the women interviewed were receiving some form of social assistance and none had paid employment at the time of their interview. This financial situation is common among this population—a community service provider expands on why this may be the case based on the information they have gathered at their agency:

> …these women are not necessarily part of the mainstream competitive work environment. And that's pretty huge because, if that were the case, (a) [it] would be wonderful for their self-esteem and (b) it would address some of the issues like poverty and how to structure your day. And what we know from our research is that something like 98% of these women haven't even passed Grade 9, that they have never had a driver's license, or they have never had a job. They have really not very much hope of competitive employment, which keeps them pretty marginalized for a long time. So that, too is notably absent. We have a lot of stuff at play but there's a few striking gaps which keep them forever kind of at the outskirts of mainstream society.

Social stigma

In addition to the pragmatic social difficulties identified thus far, women also faced the social stigma directed at women who use substances in our society. "I've been in professional offices where these women are screamed at and yelled at…They're so used to being just like dirt on the floor," claimed a community service provider. The director of a service agency for pregnant women using substances summed it up as follows:

> They're a population of women that, I think, have been studied, vilified, detested. A lot of negative energy is directed at these women. I think, they're very, very misunderstood…They're society's most at-risk. So, we really have those women who have been overlooked and ignored by society really. So, along the way, they have become bitter and hardened and have lost their way and they don't know how to get their needs met.

Their experiences with society in general, and with service providers in particular, have resulted in distrust and wariness of others, making it difficult for them to seek or accept help.

Services

The sociograms completed by research participants clearly depicted the scarcity of services obtained and the crisis nature of the services used before involvement with ESW. Typically, in addition to a family member or friend, the women identified some combination of the following as comprising their support network: parole or probation officer, hospital emergency rooms, food bank, a child protection agency, emergency shelters, and financial assistance. Community service providers had similarly noted,

> Our women don't have any connections…They're all on welfare. Prior to us, the only medical service they would get would be in an emergency, at the emergency [unit] for a crisis…They only would go to the emerg for an OD or something. It's the only medical care they got.

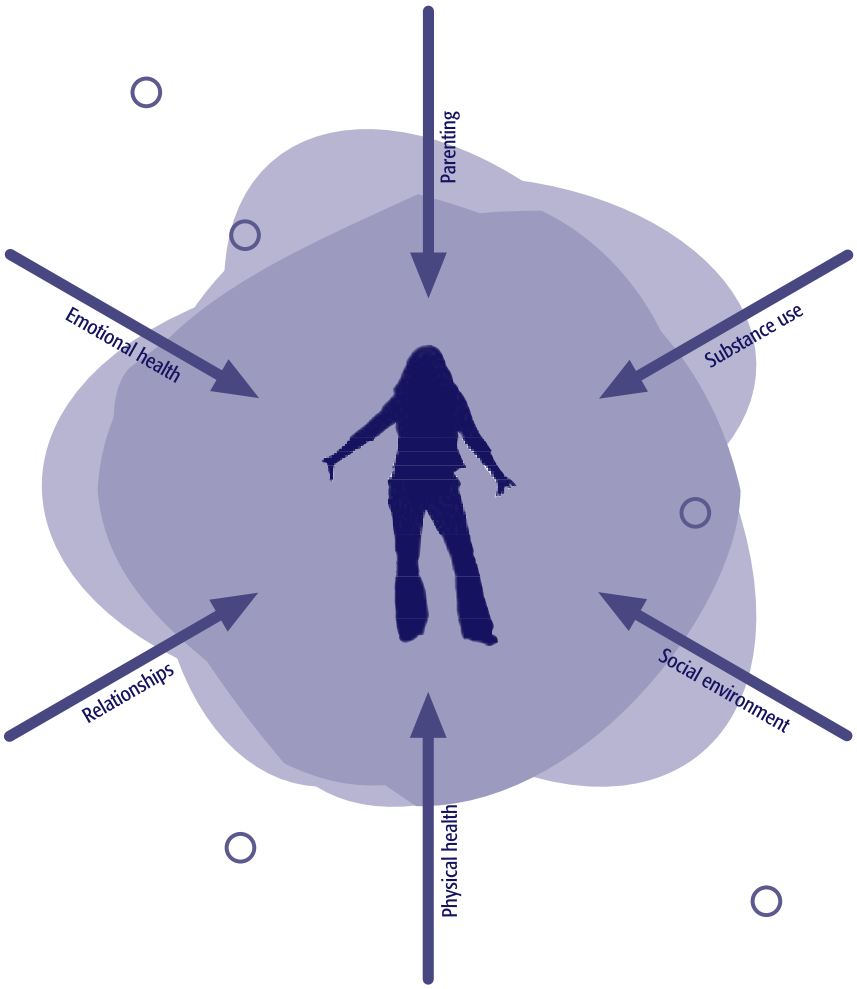
The connections, or lack of connections, these women have in their social environment are telling. Family issues, housing, finances, their lack of access to non-crisis services and the social stigma they face all maintain these women in marginalized roles in society.

Summary

Through the stories told in the interviews, women painted a picture of a complex set of issues that interacted with their substance use prior to their involvement with ESW. Early onset, frequent, heavy use, and escalating substance use occurred in a context of many disadvantages in terms of parenting, health, relationships and other social issues, and in the absence of a supportive service network. Amidst all of this pain and chaos, however, the women identified strengths and occasional supports.

The following model is a visual representation of the lives of women before their interaction with ESW services. Their lives are being impinged upon by the factors discussed earlier (substance use, parenting, physical health, emotional health, relationships and social environment) with women having little influence in changing the circumstances of each factor in their lives. These women have very few supports in their lives that could help them make changes. What supports they have are few and crisis-oriented, meaning that they are generally managing only short-term issues. For example, a woman might go to the emergency room when she has broken her arm or even if she has the flu, but she has no ongoing contact with a health-care provider that could offer continuity of care over time and decrease the burden of non-emergency use of emergency rooms.

What is going on in women's lives when they come to ESW?



Outcomes

This section addresses the main objective of the research project—identifying the outcomes achieved by women receiving ESW services. Because there was no systematic outcome information available prior to the research project, the researchers had few preconceptions about the outcomes the women were achieving, if any. No assumptions were made about what kinds of goals the women had, how they were working towards them, or how effectively they were reaching them.

While ESW's mandate is to provide enhanced addiction services to women to reduce the number of children born in Alberta affected by prenatal exposure to alcohol or other substances, it became evident through this research that women also made changes in other aspects of their lives in conjunction with their substance use changes. Data analysis led researchers to group this information about the changes women were making, or the outcomes they were achieving, into seven categories:

1. Substance use
2. Parenting
3. Physical health
4. Emotional health
5. Relationships
6. Social environment
7. Network of support

Categorizing can result in an artificially static, linear and disconnected portrayal of any outcomes achieved. In reality, these changes are far more complex.

- The change process is holistic. Women seek and make change in all dimensions of their lives.
- Changes among the categories are interrelated and interconnected.
- Changes in substance use behaviour are not possible or sustainable without attention to, and changes in, other major life areas.

1. Substance use

Because AADAC's mandate is to provide addiction services to Albertans, and the mandate of the ESW program is to reduce the use of alcohol and other drugs during pregnancy thereby reducing the risk of negative birth outcomes, substance use changes were identified as one important aspect of women's lives to investigate in the study.

The study participants used a variety of words to describe substance use changes. By far the most frequently used term to connote abstinence, among both clients and service providers, was "clean."[8]

Other words included "quit," "stopped," and "not used/using." Clients occasionally used the word "sober" while service providers added "sobriety" and "recovery." Women who used substances also "cut down" or "reduced" and sometimes "relapsed," "crashed," or "slipped." One ESW service co-ordinator coined the term "recycle" (which was picked up by other service providers) to invoke the positive concept of reconnecting to services after a relapse.

Findings related to substance use changes are grouped into the following themes:

- Achieving abstinence
- Changing relapse patterns
- Reporting and reconnecting to services
- Implementing harm reduction strategies
- Using relapse prevention strategies
- Engaging in addictions treatment
- Changing tobacco use

Some women had begun to change their substance use patterns before they connected with ESW. However, it was a struggle that was difficult to sustain in the absence of information and support. Some women described quitting "cold turkey" on their own and ending up sick or in hospital. After such an unhealthy and distressing experience, some returned to using again. Once involved with ESW and other services, women found support in managing difficult phases in recovery, resulting in greater success.

Achieving abstinence

Abstinence was an important goal and outcome for the women interviewed. It was often the first outcome cited by both clients and service providers in their discussions with researchers about what outcomes are being achieved. Many clients started their interview by simply stating that they had been abstinent for some period of time. Most kept track of the days or months of abstinence and/or their cessation anniversary date. The current period of abstinence from their substance(s) of concern ranged from days to years, depending on where they were in their treatment and recovery cycle.

> I don't touch alcohol, I don't touch weed, I don't touch crack, and [now] I can remember what I did the day before.

[8] Some professionals in the addictions field discourage the use of the term "clean" because if one who does not use substances is "clean," then a person who uses substances could be considered "dirty." Nonetheless, it is a term in frequent use among the population studied and so appears in many quotes in this section.

> As far as my goals go, my number one is [to] stay clean and sober. So far I'm 11 months.

The community service providers participating in the group interviews work with the women at greatest risk who, it could be assumed, would have the most difficulty achieving and maintaining abstinence due to the multiple stressors prevalent in their lives. Yet all service providers could identify clients who had maintained a sustained period of abstinence. ESW service co-ordinators agreed, "A lot of clients have maintained abstinence for quite a length of time. I would say almost more [quit] than reduce." A community service provider recalled, "I worked with one girl that never…had one relapse in the three-year period that I worked with [her]." Another community service provider made the remarkable claim, "I have two [pregnant] clients that I would classify as like real hardcore alcoholics, and one did not drink throughout her pregnancy. She was able to stop, and the other one has binged drank a few times. The last time being…well I think she's been clean about three months where she hasn't drank." Service providers all agreed that most women have some periods of "sobriety," periods of "recovery," or "clean and sober [time]."

There was consensus among service providers that their clients could often maintain abstinence during their pregnancy, especially if they connected to services early in their pregnancy.

Changing relapse patterns

As described earlier, some women involved in ESW have been using substances heavily for a long time and are immersed in complex and difficult life situations that support their use. For most women, periods of abstinence are interspersed with slips (isolated events of use) or relapses (a return to the former pattern of use with the potential of increased frequency or quantity consumed).[9]

Based on their experience in working with women who have substance use issues, service providers in this study view slips and relapses as events that are "going to happen [and as a result we] make a plan for it."

With the support provided by ESW and other service agencies, a notable outcome is that "in those relapses, what's so great is that they're shorter." "Relapses are less and less, and longer in duration of clean time between relapses." For example, a client's relapse time went "from five days to one day [or] two days."

> I've been clean for about five months I think now. One [relapse]. [Q: "And how long did [the relapse] last for?] Just a weekend.

[9] Research participants did not delineate between a slip or a relapse. The term relapse was generally used to describe a return to substance use, regardless of the extent of that use.

Furthermore, the relapses seem less severe. According to one service provider, “It's not like a total relapse where they spend everything, lose everything, sell everything. It doesn't get as bad as it would have before.” An ESW service co-ordinator added “there’s a lot less to clean up when you have a lot less relapse time.” Among service providers there was an explicit recognition that the women “may be relapsing but they're in a different place. They're not as much, you know, [in the] pre-contemplative [stage of change]. They've moved more into trying to maintain abstinence…[and] you notice also a difference in how they feel about their relapse.”[10]

One woman’s story describes how her earlier learning was used to her advantage after a relapse. After being abstinent for a year with the help of ESW and other services, she relapsed when she moved out of the city and lost her support network. In a rapid downward spiral, her child was apprehended, she lost her home, and she returned to prostitution. Within two weeks, one of her previous service providers saw her on the street and “ ‘guilted’ me back [into services].” Since then, she has diligently been working on accomplishing the goals set out in her treatment plan. She says, “I knew what I had to do. I knew what worked for me before and I had to learn it again. Because it worked so well before.”

Reporting and reconnecting to services

“One of the single biggest successes,” according to service providers, is that the women “call and they want to come back [into services]” after they slip or relapse. That women report their relapses and reconnect with ESW and other service providers was a clear outcome achieved by this population. Community service providers and ESW service co-ordinators repeatedly mentioned this outcome as a measure of success. Furthermore, the women interviewees provided examples of this outcome as well, such as this woman who said, “I've had a few slips, and when I did, I told [my ESW service co-ordinator], and I got help.” Service providers provided specific examples such as the woman who “went out on a binge and then she came back and saw us” or another who called from another province when she relapsed “to book an appointment [with her ESW service co-ordinator] for herself before she came back [to Alberta].” The ESW service co-ordinator team summarized that even when, for example, there is a “major, huge” relapse after a woman’s child has been apprehended by a child protection agency, “they stay connected and they're working through their use.”

The experience of the service providers interviewed generally showed that a woman’s recovery process often involves numerous attempts with small successes. Therefore this outcome was especially significant in the context of previous experience with this population. “In the past, they’ve just fled [services],” observed one community service provider. The ESW service

[10] The speaker is referring to the model of change proposed by Prochaska, Norcross, and DiClemente. See Appendix 5 for more information about this model of change.

co-ordinators noticed that the women "relapse and then reconnect much sooner than what would have happened before" and a community service provider noted,

> They [the clients we share with ESW] do keep in touch with us a lot more than a lot of our other clients. So, they'll call and they'll know they can come back. I think we really have reduced, through all of these services, the shame and allowed them to feel that they can call us no matter what. And they do that.

In further noting that the women might also reconnect with ESW, she added another dimension to this outcome.

> Or even if they get discharged from treatment, they don't make it through, then they still don't feel like they're totally just abandoned. They will call [their ESW service co-ordinator].

Fundamental to this reconnection is having establishing a solid connection with services in the first place. This reconnection is simpler because, as noted above, these women have experienced a non-judgmental environment, and "because they were already in the system, when they relapse and then come back to us, we have a place to get them help right now…It's almost immediate." A service provider reiterated "if things are getting stressful in their situation, and they're having a hard time, we've had a number of them come back even when they're not pregnant so [they're] maintaining the link." This experience was echoed among other service providers: "Even those who have recycled back are connected to programs, so that when they're ready, they know where to go for support."

Implementing harm reduction strategies

Most women do want to quit or cut down their use when they find out they are pregnant. Even if a woman continues to use substances during her pregnancy, any improvements she can make to her overall mental and physical health will improve the well-being of both mother and fetus. These improvements can range from eating regular meals to reducing substance use to stabilizing on methadone to implementing safe injection practices. It is important that women are able to obtain addictions services, nutritional support, health care, counselling, and so forth, even when they continue to use. This is called a harm reduction approach.

The service providers interviewed recognized that total or immediate abstinence is not always a realistic or pressing goal for the women they work with and recognize that harm reduction is a viable option for those women. For many of the women, modifying rather than abstaining is a more realistic option, at least initially. After achieving their harm reduction goals, some women may then consider working toward abstinence-based goals.

Substituting substance of choice

One harm reduction strategy, changing to what may be perceived as a less harmful substance, was commonly mentioned. Clients may opt to eliminate the most harmful drug of choice from their use regime and substitute the use of a substance they believe has less associated harm. There are several examples of women using substances other than the substance they consider to be their primary substance of choice, with marijuana mentioned frequently as the drug used for substitution. There remain concerns about the effects that any substance can have on its user, even those substances that may be perceived to be safe—like marijuana. Any substance ingested prenatally has the potential to cause harm to the fetus.

Community service providers observed, "[Clients] go from crack every day to smoking pot once in a while" or "they'll maybe change to a safer [drug] or from I.V. [drug use] to crack or whatever, so it won't be such a harmful [thing]." ESW service co-ordinators offered a similar example of incremental change in drug use, "a lot of them…use pot to come off of the crack…"

The same outcome is embedded in this exchange between community service providers.

> I've noticed that sometimes through the process of the AADAC programs and all the other supports they are able to get off their major drug of choice. But they often substitute something else…So I guess it's a slow process of decreasing the risk at least, and some of them then might give up that and then go to the marijuana…So there is some harm reduction. Even if they haven't quit completely there's definitely harm reduction.

Implied in the preceding quote is that, once the women get a handle on their drug of concern, they begin to consider cutting down on their use of other substances as well. Service providers often identified that marijuana use was perceived to be safer and, thus, was sometimes effectively used as a stepping-stone to other substance use changes. "My observation would be that marijuana is the last to go, because there's a lot of normalcy around that…A few clients have decided, on their own, to eliminate that as well." One of the ESW service co-ordinators related an anecdote about one of her clients that demonstrates how difficult and impressive such a change can be for the women.

> She used to be a regular crack user but now it's only occasionally and she really tries hard to stay away from the crack. But she also smokes pot and she also drinks. And, you know, for the last year or so it was almost every day, sometimes one joint, sometimes two or three or four. But now just the other day she was telling me it's been eleven days that she's been off the pot. That's just awesome for her. And it had been a month since she drank. She says "it's been like forever since I had a drink," and it was about a month…for her, you know, that's a huge, huge thing for her because she hasn't been clean for years. You know,

> maybe a day here or there when she didn't have access to [drugs], or didn't have money [to buy drugs] or whatever, but not intentionally.

Controlled consumption of substances

Another woman interviewed, who has been abstinent from crack cocaine for three years, also abstained from alcohol use for three months at the request of a child protection agency as a condition of her daughter's return to her custody. After that, she resumed drinking in what might be called a controlled fashion, by decreasing the quantity and frequency of her alcohol consumption.

> [My] drinking is not nearly as bad. Before, I'd actually take the beer cans and just actually get beer, more beer. And now it's like I couldn't even care less if there's beer in the house or not. If I want one I'll have one. But if I don't, it's not a demand anymore…If it's not here, it's not here. There's coffee, there's soda, there's water. I just don't need it…Alcohol is just my choice. I used to need it. It seemed like I needed it. Now, it's if I want one, I'll have one. But it's not a need, it's not a desire. I don't have to stay up till three in the morning to drink every last beer in that fridge. I can go to bed and there'll be eight or nine beer in the fridge, so it's just different, and I enjoy it more.

While she had achieved stabilization in one area of her substance use (she no longer uses crack), she found a level of alcohol use that she believed was acceptable and not harmful.

Although the risks may be reduced, there is always risk in continuing to use substances, especially for a woman who is pregnant. Consuming substances during pregnancy may put the health of the fetus at risk.

Relapse prevention strategies

The ESW clients, community service providers, and ESW service co-ordinators described numerous strategies that aided the women in their attempts to avoid relapse. Typically, these were ways to manage their cravings or avoid situations that trigger their desire to use substances. In their interviews with researchers, ESW clients discussed how, through their interactions with service providers, they learned ways to cope with these episodes.

One of the women described a striking example of a strategy she used when she "almost relapsed." On this occasion, the client had decided that she wanted to give in to her craving. She surrounded herself with all the paraphernalia that she needed to pursue this decision and then made a different choice.

> It was [all] there. I was ready to [use]. But then something stopped me. I'm not quite sure what it was or why…Something just came over me and it took everything away. I went to sleep. What stopped me was maybe going, "Well, I have been clean for this long. Do I really, really

> want to do this?" And, at the time, I knew I was upset. I was mad about something that just happened. And then really tired [too] 'cause I didn't really sleep the night before. I just thought, "Well, maybe if I just put this aside for now and maybe try and relax," maybe my mind thought whether or not I want to do [it].

Although she claimed "I don't even know what made me think of [doing] that," she could articulate what it is that people could do when faced with a potential relapse situation: "Put it aside and do something else for a little bit and see if their minds will still want [it]."

In the above example, this pregnant young woman also identified some of her own triggers: lack of sleep and emotional upset. Her trigger management strategy was profoundly simple: Get some sleep. Other women related other triggers and strategies for managing them. Among them, "staying away from people that are triggers" was frequently cited. "There's one guy I don't talk to too much because he's using once in awhile…[and] I would like to call [a support group] but, on that same note, I'm scared to call them because a lot of them were coke users."

"Picking new friends, doing new things" and spending more time with family were strategies used to fill the spare time or the boredom that might lead to "phoning up old friends that you shouldn't be."

In the words of another woman, if you are exposed to substance use, "it's like turning on a light switch—you see it, you want to do it." So for her, "it's not there, I don't see it, I don't hear about it…When I first quit [cocaine], I couldn't even watch [the reality show] Cops on TV. I'm like [shivering], 'I need it.' " Another admitted, "I'm still vulnerable to the drugs. I know that if it was in front of me, there is a good possibility that I would use. So I stay away from it as much as possible…If I know that this person is going to be using I don't hang around with that person."

Just as the woman quoted earlier used sleep as a strategy to deal with the emotions that were triggering a craving and thus prevent a relapse, other women had also learned to monitor their emotional state to see how it affects their desire to use.

> I know that's going to be something I have to watch for, you know. I'll relapse in times when I'm really depressed but I can also relapse when I'm feeling great and in control. So those are both times that I have to watch for.

According to this young mom, "feeling great" is also a trigger emotion because she might let her guard down and convince herself that she is "in control" of her substance use.

One woman was emotionally torn between wanting to be with her daughter who was in the care of her parents and knowing that an uneasy relationship with her parents could trigger a relapse. "So, I'm trying to decide what's going to be safer for me," she mused, "living with them or living on my own."

Women also recognized that "isolation and boredom" were potential triggers and used various strategies to keep busy, such as getting involved in leisure and recreational activities and building more routine into their day so there are fewer down times when one might be vulnerable to giving in to a craving.

Several women recognized alcohol as a potential trigger for using other drugs because "one thing leads to another." One woman, who has "a drink occasionally," acknowledged "I've never had problems with [alcohol] but I know I probably shouldn't drink just because, if I got drunk, I could see myself wanting to use again." Another woman, who still drank and sometimes went to the bar said, "every time I go there, it's like I run into the same people and they're like, 'Let's go do a line.' " Instead of joining them, she recently made a different choice:

> Last Saturday, I was at [a bar] and I was like "I'm going home." Ten minutes later, after I paid $12 to get in the door, I was like, "See ya." That was the first time I'd ever pulled myself out of a bad situation… So, yeah, that was the first time I ever actually said no and left, instead of saying no and staying around and getting teased about it.

"That's why I want to quit drinking…'cuz it's going to set me off to doing the other thing [cocaine]," she concluded.

Service providers also provided examples of avoiding trigger situations. Staying out of the inner city area is one such example.

> [Our clients] really can't come around the area. For a lot of people, there just too many triggers for them. So we just don't see them in that way…They usually say, "You know, I don't want to come down there and see you. Can you come see me?" Because there's just too many people they'll run into, too many triggers, too much stuff…They're being smart about not coming down there.

A client, who wanted to tell her message of recovery to other people from her community, concurred. She knew that she could not yet "go on the street downtown there [because] I can't put myself in jeopardy." Another, feeling threatened by "people out there that I know would love to see me get high one more time," tried to "stay inside more than anything," especially since her roommates were supportive non-users.

Another important, but not surprising, finding is the importance of taking "one step at a time." One woman who had recently reconnected with ESW articulated her belief that making too many changes at once had precipitated a relapse. "We came into the city again and we got a place…like ever since we came back it's been one problem after another, which triggered a relapse for me."

The woman quoted below was working hard to "stay sober so I can pass those tests for [the child protection agency]" so that she could see her daughter. She was pleased with her incremental progress…

> Last time I got a drug test it was at 30%. So that's way less than what it was when I first started to stop doing drugs. Like, it was into the 80s, 90s, now it's into the 30s. So next time I go for my drug test I should hopefully pass with flying colours.

Another woman who relapsed after a year of sobriety, stated, "I'm slowly making the changes again and I know I can't make it too fast, because if you change too much, too fast then it's not going to stick, more or less."

Other trigger situation and craving management strategies mentioned were

- putting a child's picture throughout the house as a reminder of why not to give in to the craving
- choosing AA instead of NA meetings to avoid discussions of a drug that could trigger cravings
- going to self-help meetings twice daily
- staying away from situations where it is hard to say no
- not going to the bar or "go with a sober friend"
- learning from past experiences of what worked in similar situations

Engaging in addictions treatment

Once an individual makes the decision to seek substance use treatment, access to that treatment becomes essential. The decision is not an easy one to make, and being able to get treatment with little difficulty makes the decision easier to follow through on. In other words, the woman is not dissuaded from her decision as long as she does not run into obstacles in getting treatment.

A mother of two describes the dire need she felt when she decided she needed to get into treatment:

> I got very upset and phoned around and said, "you know, this isn't right that I'm not in treatment right now…" They were telling me four weeks I had to wait, and I was like, "No, this is life or death for me. If I don't get in now, I'm going to be dead."

In this instance, the ESW service co-ordinator was able to find a treatment space available within the next 10 days.

Another significant finding is that these women, sometimes for the first time in their lives or in spite of previous unsuccessful or unpleasant experiences, are taking advantage of a range of addictions treatment services that address a variety of different needs.

All of the women interviewed had received regular addictions counselling and support from ESW service co-ordinators. Most had past experience in residential treatment at a variety of treatment centres in Alberta. Some had been in more than one treatment facility, often participating in the gender-specific treatment program at Aventa in Calgary and other treatment programs

that included both men and women. Many had entered day treatment programs. Some women had participated in medical detoxification services.

In a period of six months, one woman in the study had connected with a vast array of AADAC programs. In the month between the end of her outpatient addictions treatment program and the start of residential treatment, she participated in "seven extra programs" including a self-esteem workshop and a series of information sessions offered weekly. Another woman had "been through two phases [at a residential treatment facility] and plus I'm going to go through this next phase [too]."

However, structured treatment programming is not appropriate for all. "We really recognize that lots of the women aren't ready for group [sessions] and [a] four-week program and jumping right into all of that" and "It's a specific format that some of my women can't follow through on," proclaimed the service providers. These women benefit from the flexibility of ESW services or from drop-in group sessions. These less-structured services are necessary for women who require individualized counselling or need to develop a strong trust relationship with their service providers that might not otherwise develop in structured settings.

Not only are women entering treatment, service providers believed that women are "staying longer in programs." Women who were interviewed also knew that, if they could not complete a program, they could return because "it doesn't matter how many times you go, it's not like you're not going to learn something."

Women identified various benefits from their treatment experiences, such as

- learning techniques for trigger management and relapse prevention
- making schedules for building routine
- obtaining information about drugs and their effects
- building self-esteem and confidence
- connecting with other services

Changing tobacco use

There were different perceptions about changes in tobacco use among study participants. Some women included cigarette smoking in their abstinence whereas others gave themselves "permission" to continue smoking after having quit everything else. One woman identified a growing concern about her tobacco use:

> And now, see, I'm even starting to get worried about smoking, which never in my life, never worried me. I'm reading the packages now and like, "Oh, my God, look at that. That's going to happen to me," you know. I'm reading the pack and I'm reading the things on how to stop the smoking thing.

Service providers were equally divided in their view on this issue. One service provider believed that "their smoking creeps up a little bit when they stop using other substances." Others felt that they try to "reduce a bit in pregnancy." The ESW service co-ordinator team perceived that "they're still not willing to give up the tobacco." From these differing perceptions of what women are doing with their tobacco use in pregnancy, it is apparent that tobacco use change is not well integrated into the larger move to stop using substances.

In contrast, there was a consensus among other service providers that their clients had "reduced dramatically," quit, stopped "smoking in the house," and/or increased their awareness of the problems with smoking. Although clients may have "relapsed while they were pregnant," observed one as the others agreed, "I have a number of women who have not smoked during their pregnancies which I've never seen before." Another followed up with an example of "three [women who] quit throughout their pregnancy. From the time that they found out, they weren't smoking, and two have continued to not smoke after delivery." She then added that "even if they continue to smoke, I'm finding that a lot of women are not smoking around their babies which is just wonderful." She provided the following statistic to support her claim: of the 17 women on her caseload, only "one was smoking around her child." The service providers attributed these changes to increased awareness on the part of the women of the dangers of smoking during pregnancy.

> A lot of them really know that it's not good. Like I think a lot of myths around "oh, it's just smoking, I can keep smoking," you know, that's kind of not the norm anymore. And a lot of them will say "I want to quit" and they'll join [a smoking cessation group] and, you know, talk to their doctor and see if it's safe to have the patch and that kind of stuff if they can get that…I think they all have a real focus on knowing that it's not good and wanting to [change]. Like, their attitudes have really changed where they don't think it's not a big deal anymore, that they really see that "OK, this could harm my baby. I want to do everything I can. I don't even want to take aspirin." You know, and they'll quit smoking.

Women are making a variety of changes regarding their substance use and generally demonstrate more conscious thought around why they use. They are using tools like trigger management and harm reduction strategies and are engaging in treatment services, each tool helping them to quit, decrease use or reduce the harm of their substance use.

2. Parenting

For the women interviewed, parenting was identified as a main priority. In this category, there are two interrelated outcome themes:

- Pregnancy and parenting as opportunities for changing substance use behaviour
- Changes specific to parenting status, skills, and goals

A window of opportunity for change

As seen in the literature and through practice wisdom, it is well recognized that pregnancy often acts as an opportunity for women to change their substance use behaviour (Alberta Alcohol and Drug Abuse Commission, 2004b). According to service providers, many women use pregnancy as "a time to get clean" or as "the incentive they need to change their lifestyle." Furthermore, "just the fact of being pregnant, that's such a huge motivator to keep coming back [to services]." One ESW service co-ordinators was unequivocal.

> I would say that 100% of my clients have wanted to make a change in their use during their pregnancy. They've made comments that they're concerned about the impact of their use on their pregnancy and that they want to decrease or cut down or stop. Most of them want to stop.

The women interviewed also recognize this motivation. One young woman in her first pregnancy affirmed that "[my partner and I] tried to eat and we tried to sleep, we were looking for a place [to live]—all [this] came from the fact that I was pregnant…I'm not sure if I wasn't pregnant if I would've bothered trying as hard." Another "had to clean up quick" once she learned she was pregnant and she "made it clean just for the sake of my child for four months."

Women who had negative outcomes in previous pregnancies made different choices in subsequent pregnancies in hopes of avoiding the pain they experienced in those past pregnancies. One woman described her pain and guilt when her first baby died in infancy "because of health and drugs."

> I had like guilt because I feel like it's my fault because I didn't do these things, and I didn't want that guilt this time. [During this pregnancy,] the baby that's not born is really helping [keep me on track], because every time I get kicked, [I remember,] "Oh yeah, I can't [use]."

Another woman who had previously "lost three [children] to social services" believed her last pregnancy as a chance for a different outcome. "And [with] this one, I just said "I'm not losing her." And I didn't." Here she described her connection with the baby from birth.

> You know this time I got to see my baby, I got to feed her, and I stayed there for 19 days with her before I went to treatment. I stayed in the hospital with her. I fed her every day, every night. I'd change her diaper.

The experience of being with her baby after birth acted as a powerful motivator for this woman to get help and to remain abstinent beyond the pregnancy. These experiences can act as a cue for maternity care providers to seek or provide substance use services for women in their care. For example, the Fir Square Combined Care Unit at the British Columbia Women's Hospital and Health Centre fosters these experiences among mothers who use substances. The program's goals are

> [to reduce] substance use and other risky behaviour that could be harmful to the woman and her baby; improve perinatal outcomes related to birthweight, fetal alcohol and drug effects, HIV, and sudden infant death syndrome; improve parenting skills so that more women may safely retain custody of their babies; and increase access to medical services for women who are using substances (Anonymous, n.d.).

Many women were motivated to address their substance use issues by their children. An example of this was embedded in an interview excerpt about a trigger management technique taught to a woman by her ESW service co-ordinator.

> I keep [my child's] picture right above the phone, by the door, and in my purse. So those are the three places I'm going to go if I'm going to [buy drugs and] go use. So if I go for my purse, I go for the door, and I go for the phone—That's one thing [the ESW service co-ordinator] said to do is keep him everywhere that you're going to look. That if you're triggered that will help you, that will keep you in check. [Q: And has that happened? Has it kept you in check?] Oh yeah. Because I couldn't. You know, I've got this big picture of [him], just big grin, and every time I go reach for the phone I have to see that picture. [So] if I phone somebody, I'll phone my dad.

Mothering was important to the women interviewed—they wanted to maintain custody of their children or regain custody if they had been apprehended by a child protection agency. They knew that "if I go back to actively using, like even after the baby's born, I'm going to lose my kid." Or, according to service providers, "they still want to have contact with the baby, even though they may not have the baby. So they want to get clean to have a relationship." Women sometimes verbalized that "it's not worth [it] to lose my kids" over drugs.

Another mother of three, struggling with a chronic illness, wanted to deal with her substance use and other health problems in order to "try to be around longer with the kids." As shown in several ways here, these women often identified their children, even those still in utero, as a support for them in their recovery process and their pursuit of a better life in general.

Not all women are motivated to change their substance use for the sake of the pregnancy or their children. This young mother describes the circumstances of her life when she was pregnant and her husband was sent to prison:

> When he left, we were already really deep into the drugs. I had already lost [our home] when he left. I had already been bad into drugs when he left. So he left me hanging. I wasn't clean at all. I wasn't keeping up on my hygiene. I didn't give a shit about the pregnancy at the time. It was just horrible. I'd smoke every day. As much as I could, as long as I could get it, no matter how I got it I would do it. And I'd get it. I smoked all the time. Like say one day, three grams…tried to smoke three grams in a day, but if not, half a gram.

Some women find internal motivation to make changes. Rather than external motivation like making changes for the sake of the baby or being pressured to make changes by external forces (e.g., child protection agencies), it is internal motivation that is important for them to making lasting changes. Here, a pregnant woman tells of changes she made in her substance use for her own health

> I get to points in my life where if I don't like something I'm not going to do it. You know, like when I cleaned up off crack it was because of the fact that I got to a point where I didn't like what the drug was doing to me. I hated myself. I mean, half the time you don't even sleep and you're a wreck. And then it was, "OK, I've had enough." So I kicked everybody out of my house and I cleaned up. You know because I got to a point within myself, and I think that's a good thing that I…like a good quality that I had, because if I didn't like something, I knew how to change it.

A young mom of three describes how her motivation to change came in its own time, after she had already lost custody of her children.

> I felt really bad about [using while I still had my kids and not being able to attend to their needs] because I knew what they wanted, and I knew how I should have been but I just couldn't. I couldn't reach that point where I wanted to be done with [the drugs] now, you know? And I put [the kids] through a lot. And you know I'm almost thankful. Actually I am thankful that my kids were taken away from me at that time because they weren't being properly attended to. I wasn't interacting with them as much as I should have been. I was using around them and that just wasn't right, and I knew it. I love them and I miss them, and I will get them again, but from then it just wasn't right.

Intervention from child protection agencies can influence a mother's substance use, either positively or negatively. If women are ready to make changes in their substance use behaviour, either for themselves or for the sake of keeping custody of their children, the intervention of children's protection services can act as motivation. As discussed by the same young woman above, when a woman is not ready to address her substance use or any other issues, like housing or partner relationships, in the manner mandated by children's protective services, she is more likely to lose custody of her children and her substance use remains the same or gets worse.

> You know, my kids are gone now so I have nothing to live for. So I just kept using. I didn't care anymore. My kids were gone, my heart's ripped out of my chest. What do I need now? So I kept using, on and on and on. Child Welfare [said], "if you do this…you can have your kids back. If you stay clean…you can have your kids back. If you just go through this you can have your kids back." Well I just kept hearing all this and I started to get clean, and I'd be overwhelmed with you know, meetings, programs, urinalysis tests, you know and even the visits with my

> children and whatnot, it was just all so overwhelming and I gave up once again and I started using once again.

Another mother of an infant daughter describes what happened to her substance use after a child protection agency gave custody of her daughter to her parents:

> Like, I kinda cleaned up and it was on and off, on and off. But then once I lost [my daughter] completely to my parents I just went completely out of control. I would say the last month was definitely the worst.

For these women, external motivators were not sufficient to induce behaviour change. It was when they decided they were ready that they began to change their substance use. This is supported by observations made by Prochaska, DiClemente and Norcross that in part led to the development of their transtheoretical model of change (Prochaska, Norcross and DiClemente, 1994).[11]

Parenting improvements

All the women interviewed had achieved positive outcomes and were making progress towards their parenting goals in the following areas:

- keeping and/or regaining custody of children
- adopting strategies to become more effective parents
- breaking the cycle of violence and substance use

Keeping or regaining custody of children

Many women identified that keeping or regaining custody of their children was a primary objective. For some women, just being a "mom," being with—or having the hope of being with—their children in a home they share was the greatest achievement. According to a parent of four children who is no longer involved with ESW, "I got my kids back, that's the main thing that I was trying to do."

This mother of an infant daughter describes what she needed to do so that a child protection agency would return her daughter to her custody:

> The only way I could get rid of them [a child protection agency], and that is to…was to—I didn't know this then, but I figured it out just a few weeks ago, that they wanted to see a big change in me.

She took this knowledge to heart and made the changes the child protection agency was looking for, all because she wanted her child returned to her custody.

[11] See Appendix 5 for more information about the transtheoretical model of change.

The service network that supports the women in achieving these goals echoed this outcome. There was consensus that when women "got connected up to other programs, they don't usually lose their babies," that the percentage of babies apprehended at the hospital is "very low," and that together they are helping to "keep mothers and babies together." They are confident that, through their collaborative interventions with women and other service providers, they have "been able to break the cycle of apprehension and then pregnancy."

Service providers concurred that women who want their children back "have motivation to be a better parent" and ESW service co-ordinators have noted among their clients "more confidence in the ability to be a parent."

More effective parenting

Working on parenting skills

Women often said that their most immediate objective was to "just work on being a good mom." A woman working towards having her children returned to her custody described what being a "good mother" means to her and how important it is to her.

> I know that I can be a strong, independent, great mother and have a good life…My desire is so much to be having a stable life, be with my kids, be a working mom, teach my kids responsibility, teach my kids good morals and values and just live my life.

Women recognized the responsibility and challenges in achieving this outcome. As one woman jokingly told her ESW service co-ordinator, "What was I thinking? I must be crazy wanting my four babies back. I love them but, geez, you know, I'm like losing my mind." And she told the researcher, "I'm still losing my mind but I love them. They're worth it."

Women gave examples of using a variety of parenting skills:

- regulating bedtimes and developing a routine
- encouraging exercise and enrolling children in developmental and recreational activities
- providing necessities like having diapers on hand, but also non-essentials, like toys
- making healthy and regular meals
- getting children to school and teaching and helping them at home
- educating children about drugs and alcohol
- protecting their children by removing them from abusive or uncaring situations
- sharing "quality time"
- keeping promises

Some mothers also recognized the importance of taking care of themselves, to be "happy and healthy for my kids so that they are" or to "stay healthy and energetic because my kids are very much that way, and I want to be able to keep up with them." Another mother believed that communicating her own experience with her older children would help them to understand "why they should never do drugs." Women were also learning how to cope with the frustrations of parenting without using alcohol or other drugs.

Developing a connection with the child

Among the women interviewed, the majority had children apprehended at one time. Rebuilding relationships with children that had been placed in someone else's care was an important parenting task for these women. As one woman with three children in care proclaimed, "I want to make things better between me and my children. That's the one priority that I will have for the rest of my life, are me and my kids."

Several women had older children who might be living with relatives or foster parents. Along with regaining or retaining custody of the youngest child during their involvement with ESW and other services, "another thing that we've seen is when people get other kids back. Or [have] contacts with [their] other kids." Three women with teenage children in alternative care arrangements identified improved relationships and increased contact with their children. One noted, "We spend a lot more time together, and she likes hanging out at my place, and she comes to church with me on Sundays. Another was pleased that she and her daughter had "gotten really close now too again…[and to be] really good friends."

Dealing with guilt and shame

Another indication of their commitment and concern as parents was their guilt and worry that their substance use during pregnancy had harmed the health and development of their children. Service providers noted that this change often occurred when the women started to bond with the fetus in the last trimester, "when it hits them [that] they're actually pregnant."

> Then suddenly she was very bonded with that child. And then the shame and guilt was just huge for her, and she's been trying to make up for that ever since.

Service providers reported that often women did not know they were pregnant "until they're showing or they're feeling the baby." Some women planned to abort or even "almost try and cause [a miscarriage]" with excessive drug or alcohol use. "Then they make a decision to keep the child, and then they have heavy-duty guilt from that."

At that point, when they feel this guilt, ESW service co-ordinators have observed that their clients become very "focused on their pregnancy" in an attempt to "make up for the last six months and so they try to fit everything in, in that last three months."

As they await the birth of the child and after, “women start looking at what was wrong with using” and may become “overwhelmed by guilt.” They “worried” and were “scared” about the birth outcomes. Some prayed or tried to stay positive and hopeful with ESW support during this time. Most reported, with relief, that their children were doing fine. A mother infected with HIV was “blessed” with a baby whose tests “were all negative.” Another was amazed that, according to all the tests, her son’s brain was functioning normally. She still worried, though, about “what happens down the road.”

Even women who are not pregnant feel this guilt and shame around the impact their use has had on their children. This young mother of three describes how her children reacted to her substance use and the shame she experienced as a result:

> But when I was using you could see the changes that were being made [in my kids] very fast, and that really upset me, and I could see it, and I felt the guilt and shame, and I didn't do anything about it. I didn't necessarily do the drugs in front of them but I was still high around them and that still makes an effect on the kids. They know and kids don't get as much credit as they should. Kids are smart and they know when Mom is different. They didn't feel comfortable around me, they were angry at me, they tried to get my attention as much as possible and they didn't get it.

Breaking the cycle

Some women verbalized their desire that their children experience a different life from theirs, one free of drugs and abuse or violence. For one woman, this was an overarching goal during her pregnancy.

> I don't want my kid brought up in the environment where using is OK, because if I have an addiction, you know, it's going to be very easy for my kid to have an addiction. Because I know my mom and dad both had addictions before I came along…Considering the pattern, now, as a parent, I have to change that. And I want to change that because I don't want my kid to be, you know…Like when I was four, I was drinking. I don't want my kid to be able to just grab a beer container off the table and start drinking it…I want my kid to grow up in a normal, stable environment so that when he's older he'll understand the word addiction, what it means, and how badly your life…I'm going to be a mom. That's my biggest reason [for quitting drugs], because I want to (pause) and I want to (pause)—I'm determined to break the cycle in my family, and I'm the only kid now that can do it. My sister is right into the alcohol, and my brother, you know, three assault charges on his girlfriend, at least. And then it's just like, OK, I'm the only one now out of my siblings that [has] a chance to break the cycle with my kid, you know. And my sister doesn't have kids but my brother has two. So I'm determined, in that sense, to be a responsible parent. You know, I don't want to lose my kid to the system.

Here a woman describes an abusive situation in which she was able to put many of her newfound skills into practice. Her concern for her son and her desire that he not be exposed to violence determined her course of action.

> And then [a friend] came over and like starting yelling at us. Like you heard him in the kitchen. And like an inch from my face and [he] started yelling at me and I'm like "No, OK?" My son's down the hall and I don't want him to know this kind of life, I don't want him to have any abuse in the house at all. So we moved like that night. We packed up the car and whoosh, [we're] gone.

Another woman wished she could return to the community where she grew up so she could relate her experiences and talk about the success she has had in overcoming an addiction—a problem she believes is rampant in her hometown.

> Well from where I came from, the girls out there I wish could go and see some of them, because if I could change then they could, because I was just as bad as all of them out there. You know, and my friends are out there. I never thought ever in my life I'd ever quit drugs. I thought it was the way to live. I thought this is what you did, and I thought—since I was 14 I done needles, so after a week of that you think that's how it is, right? You forget about the way life really is.

There is evidence that women who are connected to ESW and other services confront the challenges they have with parenting and make changes to overcome those challenges. Not only do they deal with their substance use issues which may cause concern among child protection agencies, they also develop the skills and deal with the issues that they believe will make them better parents.

3. Physical health

"They're looking after their health," said one service provider about the clients she has in common with ESW. Ample evidence of this was supplied in the individual and group interviews.

Basic self-care

In particular, improved eating and sleeping were repeatedly mentioned as health improvements made by ESW clients. A radical difference in sleeping patterns was reported by one interviewee: "I sleep normal now. Well, not quite. But I sleep now. Not pass out or not stay up for 15 days at a time."

Another woman reported improved eating: "I eat more. When I came in here, I used to not eat." Another woman was happy to have achieved a healthy weight gain,

> …it baffled me what physical things, unhealthy choices, that I made for my body, and how deteriorated it was. I couldn't believe what I was

> doing to my body. It was sick. 160 pounds and in a month I went down to 115. That was a drastic change. I looked like death. I had sunk-in eyes, you know, I was bones, and that is not [me].

Service co-ordinators were especially pleased to see pregnant women gain weight appropriately. One woman was particularly attentive to outcomes related to proper nutrition for the management of her chronic illnesses such as "trying to cut [out] a lot of the fat and stuff."

Furthermore, in the opinion of an ESW service co-ordinator, "the ability to think clearly and to be able to incorporate concepts improves dramatically once [clients] start eating and sleeping"—a good example of how achieving one outcome affects one's ability to achieve others.

One woman was pleased to report, "It feels good to know that basically my body is back to normal, like my brain and everything," reflecting on the fact her mind and body function differently when she is not using. Furthermore, service co-ordinators report witnessing more energy among the women they work with.

Staff from community service agencies emphasized the importance of the "basic things…that a lot of people take for granted" such as getting sleep and eating healthy food, attending to personal hygiene like regular showers, and having adequate clothing. One counsellor concluded that the health significance of this goes beyond meeting immediate physical needs.

> [Our clients are] getting support. Even if they're just in there for a month, that's a month of, of a sense that there's caring for that month. Even if they relapse, they remember what that was like.

Regular use of prescription medications

For women living with HIV, hepatitis C, diabetes, and/or mental health problems, regular administration of their medications is a life-saving outcome. One woman who was HIV-positive had been diagnosed 11 years earlier but had only recently started taking medication. First, though, came the difficult task of facing her illness.

> I was really scared. Like in my mind I was dying. And [the ESW service co-ordinator] got me to talk about it. Like before I wouldn't talk about it. I'd just say "oh, just never mind" in my mind. Before I started [taking meds], she said "we have to talk about it before you do start," and I had to sit there and think about it and I talked to her for a while. And then I left and I was thinking about it. If I want to prolong my life, I have to take my meds, right? I'm not just going to die if I take 'em.

The ESW service co-ordinators had likewise observed that clients had come to accept their medical conditions and were "doing the drug management with it, or whatever they need to do, that wasn't happening before." Another service co-ordinator related an example of a woman who stabilized on

methadone and decreased her prescription drug use. Then, “because of her stability, she’s not having to have as much of her anti-anxiety medication.”

Reproductive health

A primary goal of many of the service providers working with women who use substances in their childbearing years is to prevent the birth of babies affected by their mother’s substance use. This focus on preventing substance use during pregnancy prompts an “emphasis on reproductive health” that is common to public health agencies, ESW and other community service agencies that work with women who use substances.

Service providers noticed that many women knew very little about the reproductive aspects of their own bodies, even if they had given birth. So, “the biggest thing we see is just them learning about…their physical health” from “teaching around pregnancy.” “Actually having those conversations and looking at their sexual health and other alternatives” is very important, according to an ESW service co-ordinator.

Consideration of reproductive health also prompts thoughts about contraceptive use. Service providers saw many examples of clients using contraceptives, a definite shift in their previous thinking around pregnancy prevention. Clients are now seeking out tubal ligation, the Depo Provera® hormone injection (medroxyprogesterone), IUD (intrauterine device), and the morning-after pill (levonorgestrel) as contraceptive alternatives. A health professional was pleased when women came to the clinic for the morning-after pill because “it means they're actually initiating, you know, some responsibility” and describes how their clinical team uses any opportunity they have to perform “Well Woman Checks.”

> They've come in for the morning-after pill…and then what we do is we use it as a chance to—I had one girl come in who had been in and out of the programs, and [she] lost her baby, but she came in and I went, "Come with me." We had her pap test…and stuff like that. So it is allowing us to continue the contact.

Some women identified their awareness of their reproductive health as an outcome they had achieved. One woman identified it as a primary goal for herself and her partner: “The only goal we're trying to not reach is getting pregnant again. Yeah, we decided we don't want no more.” Another woman interviewed decided to terminate her pregnancy: “It’s probably a good idea that I didn’t keep it because I was doing a lot of drugs” indicating her awareness of both her own health and the health of her fetus.

Women are achieving several physical health-related outcomes. Some outcomes seem like small achievements, like eating regularly, but afford women a great deal of benefit as a result. Other changes they are making to their physical health have the potential to extend their lives and indicate their acceptance of responsibility for their own health.

4. Emotional health

Emotional health refers to changes identified in a variety of areas. The emotionally-related outcomes most often discussed in the interviews were increased self-esteem and anger management. Other important changes noted were being more hopeful, feeling emotions rather than numbing them through substance use, dealing with trauma issues, and having clearer thought processes.

Improved self-esteem

The team of ESW service co-ordinators mentioned increased self-esteem and confidence as the emotional health outcomes they most often see. Examples included more confidence in clients' ability to make decisions and to be good parents. Furthermore, the service co-ordinators believe there is a causal or predictive relationship between self-esteem and substance use. "More self-esteem leads to more confidence that [clients] can maintain abstinence," said one, while another concurred that the chances of maintaining abstinence after childbirth is better if the new mothers have "started to feel good about themselves, [and] increased their self-esteem."

Here, the mother of one with a previous history of street involvement refers to the self-respect she has gained.

> I have respect in my life. Before, I didn't care about nothing. You know, I didn't care about myself, I didn't care about nothing. I didn't care about who I hurt, what I did, or what I said. And now, now that I have everything that I have, you know, I'm a much better person.

Increased self-esteem also gives women the strength they need to re-think their partner relationships. ESW service co-ordinators work at "building [a client's] self-esteem so that she's beginning to believe that she can make it on her own without this fellow." Research participants provided similar examples, such as this woman who spoke about self-worth and strength.

> During the time with [my husband], I never felt that I was worth it… And now I feel strong enough because of the help that I have had in the last four months. I feel strong enough that I still can hold on to that hope for myself.

In the words of a community service provider that refers street workers to ESW,

> Thinking in terms of outcomes, I would think that…women who have been participating in this program begin to experience themselves as having more confidence and to know that they can ask for help.

Related to self-esteem is also increased assertiveness and "self-advocacy" in expressing their needs with service providers, especially with child protection agencies. "The relationship with [child protection agencies] is

clearly a different one, then to now," asserted an ESW service co-ordinator. The women may be "more assertive about what their treatment plan is and what they can and can't do," about "asking for more access," or "even request[ing] a different worker." They insist that case conferences and drug testing be conducted at the required intervals. They may contact a supervisor or even a local politician. In this regard, they are "showing the empowerment, they feel confident enough to do that." In general, women are better advocates because they "know who to ask if I have a question" and "are more in tune with what's going on with the process."

The sense of pride women felt by the women in accomplishing their goals was clearly evident in the research interviews. Women were proud of the tangible evidence of their success such as their home, their "stuff," and their children. After permanently losing three children, one woman tearfully spoke about "her pride and joy"—her last-born child who has remained in her care. Getting involved in advocacy on behalf of marginalized populations at a national level was a source of great pride for one woman.

> A lot of the ladies that were [at the national conference] run their own organizations now, or have PhD's and they've been activists for quite some time. I'm just the newcomer, but I'm learning a lot. And it was interesting [that] the last day, when they did their speeches, a lot of the issues that I brought up were mentioned. So it felt really good.

For another woman, it was the more intangible aspects of her life that made her most proud.

> It's the beginning of a new and improved [me]. It's the beginning of a new and improved life. I am more happy with what I've achieved in the last few months than I have [been] in my whole life, because I'm finally reaching a point where I am touching base with my biggest fears.

Anger management

A major outcome area for all the women interviewed and many other ESW clients is effectively managing anger. "I'm not actually punching people out anymore when I do drink," confirmed one woman. Another woman who claimed to have had "very bad aggression," credited ESW with helping to "keep me calm with my landlords so I didn't move out." When confronted with a "very bad landlord" recently, she "didn't move out or trash the place" as she might have done earlier. A similar change is revealed in the following quote.

> I've gotten enough help that I cannot be violent anymore. I don't have to yell. I can just express it the way I feel, and maybe find different ways of expressing it and not in the way that it will hurt the person deliberately. But just find a way to express it so that they understand what you're feeling exactly.

Women identified a number of skills-in-practice that aided in maintaining calm, "coping with anger," and being more appropriately assertive. These included "learning to communicate," "talk it out more rationally," "just ignore it because it's not worth my time anymore," "don't let it get to me," "stay busy; keep working towards what I want and what I need," and keeping a journal. The following excerpt is reproduced in its entirety as an excellent example of this crucial outcome.

> For months before, our toilet had been backing up. Christmas Eve we had the toilet backing up. It went right into my bedroom. I had a nine-day-old baby, and my dad was coming the next day and [the landlady] goes, "No, I'm not fixing it until after the beginning of next week." I'm like "excuse me, I have a nine-day-old baby and my sewer is backing up here." And she told me I was acting childish. So I walked outside and after I cooled down from there, I went down and phoned her again. I said, "Look, I'm going to get this fixed. I will pay the bill and you will pay it [after]. Otherwise I will withhold my rent." Because I went outside and I thought about it. I just hung up the phone…I was told that if you're faced with a situation where you can't, if you're going to blow up at somebody, just stop. Stop right there. Take some time, think about it. The words that came to my mind were swear words. Yeah. [So I thought,] "I better just bite my tongue and hang up right now." [Q: Oh wow, and you wouldn't have done that earlier?] No, I would have flipped out.

A renewed sense of hope

Women repeatedly discussed the sense of hope they had gained or regained after connecting with ESW and other services. For some women, this is the hope of getting their children back or of maintaining sobriety. For others, hope is connected with a re-emergence of their desire to live. One woman who was HIV-positive affirmed, "It's not a death sentence; it's a life sentence." The quote below represents a similarly profound change experienced by some of the women interviewed:

> I think compared to like where I was in the last month, I have some hope again. I kind of gave up and went "there's no point." I just, you know, I hated myself…And so the difference now is I have some hope. I know there's a lot of consequences to face, but I know I can still get my life back and I'm, you know, still here and I'm happy to be here. You know, I don't want to die anymore so I guess that's a big change in just two weeks.

Feeling more emotions

Just as in the quote above, the word "happy" came up in a number of interviews. Service providers noticed women looking "brighter" and clients said "I've actually never been happier," "I feel good inside," or "I enjoy my life; I'm not miserable." One woman made a particularly passionate appeal for happiness: "I believe there is a purpose for me to live out my life and fulfill it happily. Soulfully happily not just worldly happily, but soulfully happy."

For one woman, being less depressed was a significant outcome and a challenge that demanded her ongoing attention.

> Making sure I don't get slipping into depression…Just working on keeping myself going so that I don't fall back into those old routines and those old bad habits…[But] I'm not used to all these feelings. Like I was numb for so many years that it's hard to sort out how to deal with the feelings that get involved when you get upset or disappointed.

Many women reported that they had spent several years using substances in an effort to remain emotionally numb. While they may not have experienced happiness during that time, more importantly to them, they did not feel physical or emotional pain or distress. A woman who had completed her contact with ESW was just now experiencing a whirlwind of emotions after feeling numb for some time.

> When I was talking with [the ESW service co-ordinator], I was really; I was so really numb from everything. I was just really, really numb, and I'm only kind of now really starting to feel things…Now I'm just more or less just starting to feel things again…You know, and that wasn't happening for a long time.

Similarly, several women spoke of being overwhelmed with feelings in stark contrast to the emotional numbness they had experienced previously. For those women, an important outcome was the newfound ability to manage their emotions more effectively. After her four children were removed from her custody, one woman got high in order to stop "crying constantly." After talking with the ESW service co-ordinator, she "just learned how to deal with it in a different way." Another woman talked at length about the differences in her ability to cope with emotions. Notably, she also made a connection to improved self-esteem.

> I'm overwhelmed with [emotions] right now so I'm just trying to do little bits and pieces. But I am kind of learning that it's easier to face them and deal with them than run away and cover them up and make them 10 times worse…Well, at least I'm getting a little more of my self-esteem back so I think it'll be easier to face all this stuff…Rather than, you know, three weeks ago, I would have just ran away again…I like to isolate and run away from everything…You know, stuff happens, and I kind of locked myself in the bathroom and cried for 10 minutes and then said "OK, I'm going to go out," and it actually felt better. You know, I went out and I got back into doing stuff with people and I felt better. And, you know, that's a much better way of dealing with it rather than staying in the bathroom crying and feeling miserable for two days. So I'm learning to, I guess, deal with stuff.

ESW service co-ordinators concurred with these women's perceptions. "I have clients that would say that they're not having to use substances as much to deal with emotions or crisis situations, because they have an outlet to talk about what they're feeling." A specific example is provided in the next quote.

> She talked to [her relative] about how she felt about him [living with her] and not working, and not paying for the food, and not paying rent. And how that was affecting her and also how that affected [her family] because she's got three children of her own. Financially and emotionally, how that was affecting her. So where she never would have done that before—she would just, you know, swallow it all and then go get drunk, and then, of course, let it all out.

Dealing with trauma issues

Many women who use substances have been physically, emotionally, and sexually traumatized. For some, substance use is an attempt to self-medicate in order to manage the feelings evoked by trauma. In the process of dealing with all the areas related to substance use, women receiving ESW services may also begin to deal with issues that arise from trauma. Service providers describe the process that brings women to the point of working through their trauma:

> You look at their physical health, their mental, emotional, and spiritual [health], because it is a process. And with a lot of them, they're getting to the point where they're looking at all of that, and they get to the point to deal with the trauma, and to heal long-term…They get to a place where they've, you know, tackled each quadrant and got to a part where they're able to deal with the trauma.

Women also learn to make the connections between their trauma and their substance use. One woman who was in a treatment facility when she was interviewed for this research project, described the process:

> I'm starting to deal with some of the stuff, I think, that was part of why I started using originally. So, I've got to look way back at stuff, and it's going to take more than the [length of the program] here obviously to deal with all the issues, but I'm starting to figure some stuff out.

In addition to the counselling and support provided by ESW, some women were also getting professional assistance from psychologists or psychiatrists to deal more specifically with mental health issues. For women who felt that they had in the past been poorly served by the mental health system, this was an especially significant outcome. An ESW service co-ordinator provided the following example:

> [The client] is actually open to seeing a psychiatrist now, which she wasn't before…because she had a lot of trauma around counselling when she was a child. Because they told her she was crazy. And so after that, she was like, "I'm never going to see another psychiatrist." But now she's at a place and we have an appointment with [the psychiatrist] and she's ready to go. And she's really comfortable and she knows that I'm going to be there on the first visit to introduce her, and she feels really safe about that.

Thought process changes

ESW service co-ordinators perceived that their clients were "thinking more clearly" and had "an increased ability to make decisions." Clients and service providers used words like "realize," "understand," "recognize," "self-awareness"—all exemplifying changes in the ways that women were thinking about their substance use and their lives.

One young woman, pregnant for the first time after over 10 years of living on the street, articulated it well when she said, "There [was] something in my brain saying that you had to try [to]…if not quit, at least cut down." She goes on to talk about how she felt while recently living at a shelter: "And I didn't like that being homeless feeling. Like, even though I've been through that before and it didn't bother me before, it bothered me now." She was beginning to recognize that her own thoughts could change.

There were numerous examples of the ways women had changed their minds about their substance use, about what is important in their lives, and about seeking help. In the next quote, not only is there evidence of a thinking change, but also of the incremental nature of such changes. Having first decided to "get better," this woman initially chose a harm reduction strategy of decreased use with limited use of supports. Then, based on her self-evaluation of her choice, she later made a different set of choices.

> I wanted to get better but I still wanted to use. And I thought "oh, I can still kind of control it." So I had a lot of supports at that time, I just didn't use them well, and I wasn't really ready to accept that I couldn't do it on my own. So I think now with all the supports and with me being willing to, you know, ask for help and knowing that I can't just use on weekends or just, you know, it's going to make the big difference… [Now] I know I can't touch any substances. I would go out of control and it really showed me [the last time when it] ended up being such a big relapse…So I'm back to the realization I came to. And I know that I can't pick up no matter what, you know, 'cuz I can't stop.

She further explained, "I still have the addict in my brain…but that's just part of recovery. I think that'll be there for a long time probably. But I'm learning to quiet it, and not entertain those thoughts so much." Another woman who now recognized that her angry outbursts have "scared so many people," reported that "I [wasn't] listening to nobody. Now I can [recognize it] because I see and hear more better than I did when I was using a lot more."

Readiness to change, as was discussed earlier, might be another example of a shift in thinking. In other words, women changed their minds about wanting to change. One woman declared, "I didn't want [support services] so they didn't [work for me]. When I wanted them to, like it just opened everything up."

Women also recognized their ability to make different or new choices. "I didn't have to [finish treatment], I just chose to because I wanted it," declared one woman. After four days in a shelter, another woman "realized

that I needed treatment…I mean, I saw people in there, you know, with heroin problems and stuff like that. It was like "OK, I want help now." You know, like I came to that decision. So I phoned [the ESW service co-ordinators]." Or, in the determined words of another woman, "I want to be clean because I want to be clean. Internally and out. I don't want to live that life anymore."

Holding a changed view of right and wrong was another example of thought changes that appeared in the interviews. One inner city service provider observed this change in clients.

> They've got a different thought process. They're seeing things are wrong that they would have never sensed before and making choices that you thought they would never make. You know, giving up friends or doing different things, and just having a different attitude. They just seem like they're, you know, you can see that they're moving forward in their thoughts. They're getting less "street" I guess.

One woman, who described how she provided accommodation and food for a young prostitute in return for drugs to "supply my habit," now has a different way of thinking about this. "When I think back, it's just like my morals knew that that was wrong, but I didn't care." Another woman described the process of changing from a victim to taking "ownership" and "responsibility for what I'd done." Another acknowledged having "consequences to face" and yet another of feeling "remorse because of what I had done" in anger while drinking. A woman who used substances in her last pregnancy, was now "in the right frame of mind" to "handle admitting what I've done before" in order to help her son.

In this sense, guilt is perceived to be indicative of healthy progress as is demonstrated in the following discussion among service providers in a group interview.

> What happens too is when they make a conscious effort to not use and drink, and start looking at the kind of life they live while they're using and drinking, then they start feeling really guilty about having been a prostitute or having robbed places or pick pocket people. You know they start thinking of all the bad things, the bad things they think they've done, and then it can cause them to use again. And then if they use again they feel guilt for the first time, because when they used before they didn't feel guilty. So when they started looking at what was wrong with using now they're overwhelmed by guilt…I know it sounds awful but without guilt there's not even an awareness that you've strayed. When women say, "I feel so guilty…" we say "well, that's OK, I mean it's OK to look at where you'd like to do things differently. That's all right."

ESW service co-ordinators further observed the potential for movement beyond guilt and shame when women learned to "externalize the problem, and not keep it internal" in situations where there has been sexual or other abuse.

> It's quite magnificent to see because it goes from that guilt/shame to "hey, you know this is why I've been using, for God's sake. This has happened [to me]." It's not only "poor me" [but] really acknowledging that [this happened] and looking at it and then starting to get, instead of "poor me," more angry at it. And they'll just start to say, "hey, that wasn't mine, and that's why I've been [using drugs]…It's kind of like [a] shift too…It's differentiating between what I own and what somebody else owns. So, instead of having to take the whole thing, well, then they pass on the piece that belongs to somebody else.

Other outcomes included proper use of prescribed medication, a general sense of "feeling better," and becoming less paranoid or anxious. Once this woman "discovered the root" of her anxiety, she states, "I didn't get my anxiety attacks again. That's been one very nice relief not to have." A woman with "very bad anxiety" about leaving the house and being in public has discovered "since I've been clean and sober, it's a lot easier than you think to get out and about." Instead of "hyperventilating" during an anxiety attack, another woman was taught "to walk around, to walk away from the situation, but not to do that every time. Just slowly like walk a little less further each time. Slowly [getting] more comfortable with the situation."

Women demonstrate increased emotional health in a variety of ways. They feel better about themselves, they manage negative emotions more effectively, they "feel" more, and think and deal with trauma differently. Each of these changes can dramatically change a woman's emotional health, but also assist her in achieving outcomes in other aspects of her life.

5. Relationships

During interviews, women spoke a great deal about their relationships and about changes they had made in their primary relationships—with parents, family, friends, and helping professionals. Their comments are grouped into three main themes:

- recognition and avoidance of unhealthy relationships
- awareness and emergence of healthy relationships
- selective trust in relationships

Recognition and avoidance of unhealthy relationships

As indicated earlier, the women in this study had been embedded in unhealthy, and in some cases unsafe, family, partner, and social relationships. Helping women learn to recognize and avoid abusive relationships is often a key goal for those working with this population. The women interviewed here provided a number of examples of the skills they learned that helped them accomplish this. This often led to them trying to create distance from previous relationships through less, different, or no contact with unsafe or

unhealthy relationships, especially those that might trigger substance use. Changes to more than just relationships are evident here, as women tell of how these changes precipitate the need or desire to make other changes.

Women noted that old friends were "out of the picture," that they "cut off" friends that encourage their substance use and "stay away from people that are triggers, that I know would easily lead me astray." Even parents that are negative influences were avoided. According to one woman, "[my mom] is not a healthy person for me to be in contact with right now" and another confided, "me and my dad aren't actively on speaking terms just because he's playing with crack."

Service providers noticed that women might start "giving up their friends," or having different thoughts or attitudes about friends and friendship. "You see them changing that social, the social thing that keeps a lot of people in the drug world," said one inner-city service provider.

What seems to be particularly difficult for women is disconnecting from abusive or substance-using partners even when they began to realize that "he is more harm than good." Here, a service provider comments on the changes she witnesses in her clients when they start to consider their partner relationships: "Something that happens, too, when they start changing is maybe looking at the relationships with the guys and [asking themselves], "How is that abusive?""

Service providers provided specific examples that demonstrate the interconnectedness of the many changes women undertake. Here we learn about a woman who is now abstinent, but has also changed her living situation and her relationship with her partner:

> [One woman], who had been through the system and stuff and is now clean, came back to us actually (and the baby is now eight months) because she was having trouble because the boyfriend had been in jail and he has a real abuse issue. First she had to go in the shelter and now she has to move. Of course, it's her that has to move and go into hiding and everything like this. But she also, you know, basically has realized this guy is no good for her. [So she] has broken the ties. And that's a real, that's a real move of strength in these women because it's probably the only person that they've had, even if it's abusive, [it's the only] sort of consistent relationship that they've had.

The women interviewed offered their own examples of relationship changes. This mother of three stated that an important goal for her was "not to be dependent on a man." After "falling off" (i.e., relapsing) because of being "all mixed up inside" about the father of her child, she "got rid of him" and decided to stay away from relationships for at least a year.

> …he had abuse problems with alcohol and drug abuse problems himself. And that's what kind of (pause), because he lied to me about it and said

> he had quit [using] but then he never, and [he] tried hiding it. No, we can't hide it. Especially when you spend all the money that you said you had…If I'm [taking care of everything] myself at least I know the baby's going to have clean diapers…But if he tells me he's going to buy them and then doesn't buy them because he spent all his money on crack it's like, oh yeah, he lied. That was bad…I'm the one that has to go out and find how to do stuff, yeah…I'm getting help but not in that, not with a guy, not one guy.

Over time, as women gained strength and confidence, they sometimes reassessed the partner relationships they previously thought to be supportive. For example, in the time that elapsed between their first and second interview with researchers, two women had second thoughts about the relationships they were in. From the first to their second interview, there was a vast change in their descriptions of their partner relationships.

In her initial interview, one woman was pleased with the improved communication between herself and her husband and with his efforts to get substance use treatment while incarcerated. In the following excerpt from her second interview, she discusses her primary goal of regaining custody of her children and how it is affected by her partner's abusiveness.

> I can get myself back together and be strong for my kids, and get my kids back without him. Because what I've realized is that when he's in jail, I do good. Without him, I am free. Emotionally, I am not controlled. I can talk to whoever I want. I can hang around [with] whoever I want…Respect is very low for him from me [right now]. And what I've realized now is that "throughout your whole life, can you just hang on to this? Because you only have one more chance to get your kids back and get yourself back. And if you don't do it this time, that's it. Your kids are gone forever. And with that happening, you will lose yourself."…I believe that I can have a good life with my kids, you know, and just wake up every day, and just [think], "Oh, my kids are here. Let's go out to the park and just have a good [time]." You know, start some good quality time together and just enjoy life the way it is and not, you know, live in fear. And not worry about being cheated on and being manipulated every day.

Awareness and emergence of healthy relationships

Research participants found the vacuum created by the loss of their previous relationships was filled, not by other unhealthy relationships, but by the emergence of healthier and safer relationships. Often, this meant reconnecting, repairing, or improving relationships with family and friends and, for some women, getting closer to her partner. Women noticed that their circle of friends had gotten smaller once they let go of unhealthy connections. In some cases, their contact with family increased and had become more "respectful."

Healthy family relationships

This woman describes her increased contact and improved relationship with her father and his partner:

> I handle my relationship different, and my family relationships too. I phone my family a little more often than when I was using. Like the only time I ever phoned my family when I was using was when I need money. So now I phone them and tell them like "yeah I'm still good, I'm still clean…" I can phone them with good news, not like, "I need 50 bucks."…And a lot of times before, they would just hang up on me. Because they knew, I think, "[She] is high again." Now they'll sit there and talk to me for like an hour, two hours.

With more contact and improved communication, women observed their parents becoming more "interested," and "supportive," "less judgmental" and "learning a lot about what I've been going through." One woman who hadn't had contact with her parents since age 12 now sees her father "for lunch at least twice a week."

ESW service co-ordinators also noted better and more respectful relationships between clients and their parents. One described these changing relationships:

> I've heard clients talk about improved relationships with parents. And understanding more why the parents are reacting in the way they are, and [why their parents] made some of the choices that they had to make to set boundaries with them, and that kind of thing. And so, yes, they're gaining more perspective on the whole picture and that helps them to work towards healing the relationship.

Several research participants were, or had previously been, living with their parents. For some, this could be a trying experience, fraught with difficulties. Others found this situation to be supportive. One woman who lived with her mother states, "Yeah, she drove me crazy, but she was there for me when I got my kids back."

Attributing her revitalized relationship with her mother to the counselling support she received from ESW (including one session that included her mother), one woman confronted her mother about past abusiveness, told her mother that she doesn't blame her anymore for it, and now "we do have the best relationship ever, you know, I can tell things to her, even deep secrets to her, and really confide in her and trust her, and I love it, and that's because of [the ESW service co-ordinator]."

Women often got practical support from their parents and siblings that assisted them in meeting their substance use goals. Women often spoke of how family helped pay for treatment, drove them to treatment centres, kept them involved with the family, and supported them to not use substances.

One woman tells of an incident where her mother called the police when friends with drugs stopped by for a visit. Initially angry with her mother, she later realized that "she did me a favour…There was drugs and I probably would've used them if [those friends] would've been around a little bit longer."

If they wished to maintain relationships with family members who continued to use substances, some women learned to set safety boundaries. In one situation, a woman appreciated that her mother was "trying to get clean." She said, "I went to my mom's house and there was no drugs or alcohol there so I was OK." Here, another woman describes how her brother remains involved in her daughter's life even though he is using:

> My older brother is…the one who baby knows the most, her uncle, because he lives with us. And he uses. When he uses, he goes to his friend's over here where we live, but every morning baby goes and finds her uncle. Yeah, he's been there since she's been [born].

She has developed boundaries in this relationship that she believes keep both her and her daughter safe—her brother uses, but not in the home they share.

Other family members were also mentioned. After not seeing "these people for like 15 years," one woman recently attended a family event and now has daily contact with her aunt. She explained that these were relationships she "didn't really care to have" while she was using "because they always look down at me, I thought. Now I find out that none of them are any better than me, so that's a better thing." For another woman, an uncle who was a "recovering alcoholic" and his wife were supportive family members. Yet another had a nephew living with her that "helps a lot, too…It's another support that I've set up."

Healthy friendships

As with family members, reconnecting with old friends was a common theme. One woman reported that during a recent visit with a friend that she hadn't seen for four years, "my friend respected the fact that I wasn't using so she didn't drink either so that was kinda cool." Other women also mentioned having friends who don't use, who "[were] there for me when I felt like doing [drugs]," or who "won't [drink] around me anyways just out of respect." A revitalized source of support for some was friends who had always been there for them but with whom the relationship had improved once the substance use issues had been dealt with:

> With [one friend], when I got money from him before, it was just for drugs, which he didn't like to [do] but I always conned him into it…And with [another friend], she helps me more now than before. Like before she would always be there to listen but never give me money. And now if I need something she'll help me out. She'll go put money in my account.

A few women found new non-using friends to help in their recovery. Here, a young mother of two describes how she has used what she learned about what triggers her use and made changes to her living arrangements accordingly:

> I kinda got smart. I moved in with a bunch of people who don't do drugs. They only drink once in awhile and they don't really do it at home. So if there's no drugs around me, I won't do them. So I basically got myself out of an old cycle and just moved into a new one where it's not there. So if it's not there I'm not going to do it.

Healthy partner relationships

Women involved in partner relationships sometimes report that their partners were also in substance use treatment, but the most common outcome reported was a generally less argumentative relationship. Here a woman discusses her relationship with her husband, who is also in recovery:

> We don't fight anymore. Not like we used to. Oh man, did we ever fight before, when we were doing drugs…And now we're still together and we're not fighting as much. Like not nearly. And we're [fighting about] more realistic things if we do fight...

One woman who had discontinued her involvement with ESW was now at a point in her life where she might become involved in a new relationship. In contemplating the situation, she recognized a pattern of getting involved with men before she was ready and decided to reconnect with her ESW service co-ordinator to help her through this new challenge.

Selective trust in relationships

There was evidence of other newfound relationship skills, such as the need to be selectively trusting in relationships and realizing that not everyone, friends, family and service providers included, has their best interests at heart:

> Because I have been betrayed enough that I have no reason at all to trust anybody. Trust is to be earned not given away. I believe that very much. So it's going to take a long time for people to trust me because of my mistakes, but it's going to take a long time for me to trust a lot of people too.

From the initial experience of a respectful and caring relationship with the ESW service co-ordinators (or other philosophically like-minded service providers), research participants experienced a profound change in their relationships with other service providers. The select few service agencies that work closely with this population recognize the importance of this outcome. According to the co-ordinator of a mentoring agency, “the single biggest victory, I think, is that if she has a good experience with one professional, she’ll usually be persuaded to go see yet another one.” Yet, in their estimation, women are wisely cautious as they explore new relationships with service professionals:

> Well, their trust is carefully placed. I mean they choose who they trust. There's no question in my mind that they're still not terribly trusting but they have figured out that, here and there, you can kind of land [safely].

> You know, that your name is safe in the mouth of that person and that you can kind of land a little more safely with whatever information you choose to bring. And so what they're getting is some sort of intermittent trust experiences, which can be very powerful. Intermittent is as good as reliable in the sense that, you know, if the nurse was nice and if the mentor was nice, and if you, you know, you interacted with the [mobile outreach services] van and nobody yelled at you, then maybe it's safe to try it again. So it's not a bad outcome.

Service providers were in agreement that "what is really key to this [ESW] service is that there's a supportive and a trusting relationship that lots of them have never ever had." One young mother explained the significance of the trust she has in her ESW service co-ordinator and how her ESW worker trusts her. "I'm trying to find a way to trust myself again. And as long as somebody else does, I know I have hope in loving myself."

The experience of being helped when previous experiences have not been as successful, contributes to better relationships with service providers. One ESW client describes how her relationship with her ESW service co-ordinator changed over time:

> When I first met [the ESW service co-ordinator], I just thought, "Oh yeah right, she's not going to help me." Right? And then what happened?…I went and seen her when I got out [of treatment three months later]. And then we actually started our bond just about [then] because [before that], I didn't let her in. I'd just go [to my appointments] because I thought, "Oh, I have to go." Now I come on my own. No one's making me. It was hard for me to trust anybody. I went because it looked good in the beginning, but now I come because it does help. She just helped me.

The good experiences women have with service providers make them more likely to pursue further help from others. These women are aware that there are people who they can trust to help them and act in their best interest, but they are still wary of placing trust in new relationships.

What is evident is how women are learning to act in their own best interest in relationships. They are realizing what is safe, unsafe and trustworthy and make decisions about their participation in relationships based on these factors.

6. Social environment

The category of social environment encompasses a number of outcomes that relate to building social stability.

- finding safe and stable housing
- establishing a routine
- obtaining education and employment

Safe and stable housing

As has been described earlier, some women receiving ESW services have been homeless, transient, or prostituting at some point in their lives. Therefore it is a significant outcome for them to get off the streets and move into safe and stable housing. In the opinion of one community service provider, "The people that I've seen that have been successful also were able to access…a safe place to live." Such was the case for all the women interviewed. In collaboration with other community agencies, the ESW service co-ordinators frequently work toward this outcome, as confirmed by an ESW client: "One big trouble we were working on is how to get me out of that place into a safer place where there was no drugs and stuff."

Having a home was a source of pride for the women; conversely, the possibility of not having one was a source of anxiety. One pregnant woman, previously accustomed to street life, was discharged from hospital to a shelter for three weeks. "If I didn't get a place in that three weeks I would have nowhere to go. And I didn't like that homeless feeling…[So] I was not even there quite a week when I found this place." As this woman describes, a stable housing situation is not often the norm, making what might appear to be a short period of time in a home, a major change. "I stayed in one spot for nine months. I lived in one place. That has never happened for me," asserted another pregnant woman.

Some women returned to their parental home during their recovery process. Although they sometimes found the situation challenging, they also found it supportive. One woman got her four children back when she moved in with her mother. "She drove me crazy, but she was there for me when I [got] my kids back. And…I live in the basement suite again [with my four kids] and my mother upstairs."

Many women got their "own place" and were pleased with the independence this afforded. For some, it was a condition of their agreement with child protection services for regaining custody of their children. Although this enhanced their motivation to settle in a home, it was also a very difficult task in view of the significant gap in getting safe, independent, and affordable housing. When achieved, however, having a stable home with the "normal" accoutrements was linked with being a good parent. As a previously street-involved woman proudly stated, "I have a home. I have a TV. I have a couch. I have a table. I have my daughter's playpen full of all her expensive toys…I'm a mom. I have a home. Baby has everything she wants and needs." She added, "I don't have to worry about anybody taking my little girl. And I can just live."

Moving off the streets, or "getting less street" as one service provider called it, includes "making different kinds of choices" about the street lifestyle. "You see them changing that social thing which keeps a lot of people in the drug world…[and] that's hard to quit for a lot of people…[When the street life is] not that important to them anymore, yeah, it's a big thing," After her

parents kicked her out, one young woman had merely “tested out the waters on the street a little bit” before deciding, “This is not the life I want…I’ve got to go to treatment. I don’t want this lifestyle.” Another woman credited her pregnancy with getting her off the streets. Although she relapsed between her previous and current pregnancies, she contended,

> I still had a place. I haven’t been homeless at all. Like, that's always my priority now is to make sure that there's a home. Even when I did relapse, I made sure my boy had clothes, food, diapers. You know, I still kept my priorities straight…I made sure I maintained my family and my home.

Establishing a routine

The idea of developing a routine or schedule was frequently mentioned in the interviews and was often linked to the women’s concept of normalcy. These ideas are clearly exemplified in the following quote:

> Just getting things to, I don't know, to a normal life…Doing everything the way other people, the way I thought other people did them. So…I started a routine, which is something I never had before. It was very cool. It's very normal. Like I woke up, and I make breakfast, and then I took my nap, and then I started playing with baby stuff, and I had lunch, and then I'd clean up the house a little bit, and then I'd wait for [my husband] to come home, and maybe do a little laundry, then I'd have an hour of quiet time…[After recently moving to a new place], I'm back to my old routine. Well, kinda because I'm still unpacking. So, I'm trying to put that in my routine, an hour of unpacking a day…I’ve had such a good schedule and I keep things in my day planner.

Other women added example of routines of keeping house, exercising, eating and sleeping regularly, and looking after children. In the following example, a woman had established a bedtime routine for her daughter:

> I needed stability in my life where I was sleeping when I was supposed to sleep; my daughter was sleeping when she was supposed to sleep. Because she was up all night. Like she'd stay up till three, you know, just watching TV, just being a little bugger. And I knew that had to change…I needed the routine.

Service providers noted that clients not only benefit from routine in their daily lives, but also from treatment programs that offer this sense of structure. These programs model routine and demonstrate how structure can support recovery.

Although they desired structure in their lives, women who had previously experienced “living on the edge” through substance use and street life were often bored by the discipline of a strict routine. These women knew that “being bored is a bad thing” because it could trigger a relapse. A busy and stimulating routine was favoured such as one that included “being active” and “doing more things outside the house.”

Added benefits that result from achieving this outcome also include decreased social isolation and increased social contact. An ESW service co-ordinator related this example: "[The client] tends to isolate herself. And now she's in this women's circle and she's going to [nutrition and support programming] and just being out more and being more social." An interviewee articulated the importance of having "contact with people" so as not to fall into "old bad habits." Another was intent that "I'm not going to be like before…where I'm just going to be isolating myself completely, hiding out from people, and shutting down completely." Instead, she is involved in numerous recreational and healthy activities.

Education and employment

Many of the women involved in ESW are clearly focused on their primary job of parenting. Some, however, have returned to schooling or employment. Community service providers that have clients in common with ESW reported examples of women in nursing training, university programs, college courses, upgrading, and certificate programs. One young woman, who had used substances since age 12 and was now abstinent for two years, "is about to get her papers as a welder."

The positive effect on self-esteem was noted when women were placed in local work experience programs such as teaching English to immigrants, helping in a day care, or doing secretarial or retail work. Those few "who have found jobs, they've really turned their lives around."

7. Network of support

Engagement in addictions treatment is covered in the substance use section of this report, but it is only one piece of a vast network of support that is mobilized with and for women involved in ESW services.

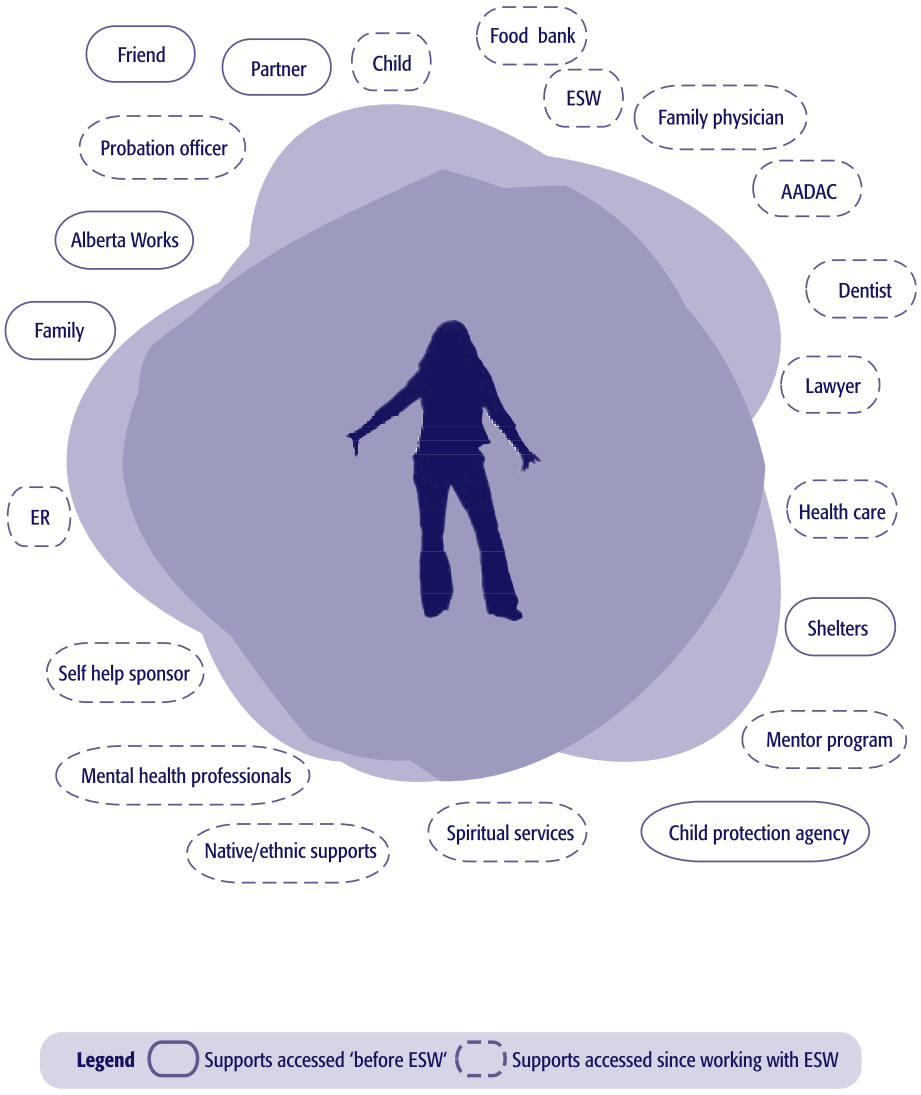
> In your early recovery, you need as much support as you possibly can get…People have to be there to support you as much as [they] can…

In the majority of individual and all of the group interviews, the researchers incorporated the construction of a sociogram to specifically investigate the support network services that are used by this population. Research participants were first asked to identify all the services and supports currently in their network. They were then asked to circle those services that were part of their network prior to their engagement with ESW. The difference in this "before" and "after" snapshot of service access was demonstrable. Referring to the difference between the few circles representing the support she had "before ESW" and the overall size of her sociogram, one woman commented

> Well, you stick those four little things I had before and you see what else came [after] that, that's pretty elaborate. Like, how much I've accessed. You don't realize how much you have behind you until (pause)…

Yeah, it's like quite a bit more than I ever thought there was. You don't realize what you have until you actually take the time to think about it and put it all down.

Example Sociogram



Outcomes related to enhancing the service network are

> **Connecting and reconnecting •** As a result of their involvement with ESW, women have engaged in a vast and varied support network that includes dozens of supports. The support network, previously limited to personal supports and crisis services, now includes services that have the potential to change lives.
>
> **Obtaining and advocating •** Women learn and use skills in obtaining and advocating for relevant services.
>
> **Collaborating •** Some of the specialized services that are working with women at highest risk collaborate to serve the clients they have in common.

Even though expanding the number of services and supports clients access is an impressive outcome, the greater significance lies in how this contributes to other outcomes. The community service providers interviewed are acutely aware of this significant finding. According to the service providers, "doing really, really well" is correlated with being "hooked up with lots of different supports." An inner city service provider declared, "[our] program would not work at all without all of the community partners." And from one of the mentoring services,

> The single biggest factor that we're absolutely convinced of after five years [of operation] is that there is no way in the world our service could survive or could be helpful to these women if it wasn't for other services. And we really do mean that.

"Healthier supports are replacing the role that the drug played in the past," observed an ESW service co-ordinator. Likewise, the women clearly attributed their effectiveness in reaching their goals and achieving positive outcomes to their connection with their network of support. In various ways, they acknowledged the centrality of supports to their recovery process. "I guess my main focus is just on how to, you know, stay clean and have the resources which [are] really helpful," said one. "I've got a lot of supports; it's just a matter of keeping it all and not getting lazy about it…So, I want to make sure that I keep active in programs and stuff," pledged another. In the following excerpt, a woman addresses the consequences of the loss of her support network:

> Well, I've pretty much been through this twice already. With my first pregnancy, I did really, really well. But then I moved out of town and I lost contact with my workers, all my supports, and everything. So that was my fault and now I'm back again…I had too much stress and I relapsed, because I didn't have my workers, by [my own] choice. I know I should have reached for them before but [I didn't]…All my workers know my other workers. So I signed releases for them all to talk to each other, to make sure that I'm doing what I'm supposed to be doing.

Another woman succinctly made her point about the importance of the services she uses: “Well, having all those other things in my life is what helps me [stay away from substances].”

The importance of connecting and reconnecting

Women involved in ESW are connected to a vast variety of services, as the sample sociogram above depicts (for more detailed review of services, please see Table 1 in Appendix 4). During the interviews, women provided many examples of supports and descriptions of how those services were helpful, including this mother: “I used to have lots [of supports]. I used to have so many that every day I was doing something with someone.”

This pregnant woman gives an excellent example of the far-reaching effect of the supports in her life, including how the staff at one agency have become her friends and act as her surrogate parents:

> A lot of my friends actually work at the [service agency]. And it's helped me out over the years…it's helped me out a little bit financially…And if I need baby stuff or whatever, I can go there and get that. I mean, [like] when I was in trouble in [another city]—they actually paid my Greyhound ticket from [there] to here. And then when I got here, they put me in the housing program because I needed help. Because I was on my own with a baby and stuff like that. And they're like, “Well, come here and we'll help you.” So what they've done is they've actually helped hook up resources for me. Like they helped me connect with [financial assistance] and Social Services and stuff like that, because I was in transitional housing before I went into the hospital, and [residential treatment] and stuff. So, I mean, they've helped me out quite a bit. You know, if I get into trouble, it's almost like, you know, most kids have the option of going home, whereas if I get into trouble I run to the [service agency]. Instead of having like one parent, I have like 20. You know, it comes in handy.

Service providers work effectively to connect women to a vast array of services that address a variety and range of needs. A community service provider gave the following example:

> I usually find that whoever connects them up usually connects them up with a whole bunch of different people, so they have more than just the one support, you know. It's usually they've got a counsellor here and they've got this person there. So, usually it works out really well that they have not just one support in their life. So you know if [the ESW service co-ordinator] takes them, then she connects them up with other people and so they have connections everywhere. So, it really helps to have that kind of thing. And some of them are going to meetings and doing things like that too, like still attending AA or CA or NA or whatever…But they still have a lot of support, that the places that they

> have connected up with still connect them further down the road. A lot of times that I've seen them, they haven't quite yet made it to their own apartment kind of thing, but for a lot of these women that long-term situation of being connected still is a good thing.

Thus, a key outcome is this: When women get connected to one service, their support network expands beyond that service. There are obvious benefits to address women's needs in a holistic fashion, but there is another reason for the effectiveness of the enhanced support network: "Women come to experience that 'Hey, there's all these people out here who want to walk with me, and I get to know them.' So, I think that would be one of the outcomes." Furthermore, once connected, the women's positive experiences and new knowledge and confidence increase the probability that they will reconnect to services.

This mother of three affirms her confidence in the network of supports:

> Because just knowing that there's something out there [that] you can always [use] to help some things, if there's a problem. There's always a way to get help for it. No matter what it is.

Women and service providers often discussed the cycle of substance use and how it changes over time if a woman has access to supportive services. Even a woman who has some success finding and using those services and makes some changes in her substance use may relapse in her substance use. But if she has had success in services before, she is more likely to reconnect to services after a shorter period of time. She spends less time in relapse and relapses occur further and further apart.

Obtaining and advocating

Once they know that help is available, the next step for many women is to use that help and advocate for themselves at those agencies. ESW service co-ordinators have noted increased "self-advocacy" among their clients as demonstrated in the following research participant's declaration: "I need help, and I'm asking for it, and I'm going to get it."

Women sometimes noted that it is easier to participate when the service makes it "so much easier" by offering child care and transportation assistance such as one mother's support program: "It helps—well, it just helps."

Women also recognized their own strengths in creating the network of support in their lives. "I went and asked for the help…If you're not going to ask for it, who's going to be willing to give it?"

Interaction with child protection agencies

As is the case with many ESW clients, the majority of women interviewed had some involvement with child protection agencies, which appeared to be a great source of stress in their lives. The quality and affability of their contact

with the system appears to vary depending on the social workers assigned to each individual case. Regardless of initial (or ongoing) tension, however, many women found ways to meet the conditions of their service plan and sustain a working relationship with their social workers and the child protection system in order to regain or keep custody of their children. A mother of four whose children were apprehended and then returned, discusses many themes in this area that were common among the women interviewed:

> I just kept fighting them and kept fighting them and kept fighting them. I was going about it the wrong way, though. I kept trying, I kept telling them [that] I didn't think they could do that, that they could just walk into your life and just take your whole life away from you like that. But, see the way I was approaching them was not great either because I was mad.
>
> Later on, I realized "OK, well you know, I gotta go about this a different way. 'Cause this isn't working." I was throwing the workers out and…[then] I got another worker and I tried to work with her and this worker wouldn't give me the time of day. There was no way. She would tell me straight out, you know, basically that there was no hope, that I'm never going to get my children back so I shouldn't even try and, you know, everything. And I just told her I'd keep fighting her and fighting her until I did. And I wasn't getting anywhere…
>
> I didn't know exactly what I was going to do but I just came [to AADAC], and then I got [into ESW services] and somehow it just kind of all kind of worked out from there on…And [the new social worker at the child protection agency], I mean, he had an open mind. And I was willing to do whatever they wanted, you know. I went in and I said, "You know, I'm not gonna fight with you guys. I'll be whatever you guys want. Whatever. Just tell me what it is…" [Then] they gave me my kids back like so quickly. I had no time to do anything…I mean, they put this big fight up with me and then when I do it all right and tell them, "OK man, you know, bring it on. I'm here, I'll do it." And I did it and I was like "oh my God."…Now I had a social worker who actually listened to me.

ESW service co-ordinators also provided examples of clients who "started out being very adversarial with the child welfare worker, and she's to the point now where she can understand why the child welfare worker would maybe have some concerns." The ESW service co-ordinator concludes, "The relationship with child welfare then to now is clearly a different one."

Once engaged in the child protection system, women "worked hard" for their children. They made substance use changes, entered treatment services, and took drug tests. Also, with the advocacy skills, self-confidence, and knowledge gained through their work with ESW, women were advocating for their own rights within the system (e.g., monthly case conferences, communication log book, regular drug tests). Having a professional, such as their ESW service co-ordinator, participating in the case conferences also "helps them to be able to vocalize."

Collaborating

The outcomes uncovered in this research project not only relate to women connecting with services, but also to service providers connecting more effectively with each other, developing a more synergistic service network. In the next quotation, an ESW service co-ordinator identifies a link between collaboration among service providers and the quality of the support network.

> Quality does increase because, like, if I'm working with [a mentoring program] and a [prenatal program] nurse, and a [child protection agency] worker, we always meet together, we're always on the same page. So, you know, we're all connected, and so [our client] doesn't have five workers telling her five different things so [that] she's running all over the place. We're all on the same page. And we take pieces. Like, you know, we'll take the pieces of what each needs to work on and share that responsibility. And [the client] says, "this is what's working for me, this is not working for me, this is what I want to change with this worker, this is what I want to keep with this worker." And we've done that. And so, it's a shared collaboration. And, I think, that really increases [the benefit to the clients] when we're all on the [same] page together.

The service providers interviewed reported that effective collaboration leads to quicker access to other services. Even though supportive and subsidized housing was repeatedly mentioned as being seriously deficient, service providers noted that their advocacy for a client could expedite access to housing.

> Housing on the other hand is a huge major problem. But we have been really successful in advocating. You know, a lot of women go down to [the subsidized housing program] on their own. They're told, "two year waiting list, forget it"…And if I write a letter of advocacy and make a phone call, they're often in within a week.

Another aspect of collaboration is the noticeable goodwill among the small group of service providers interviewed in each city. Within this "nice little circle," they work closely together, refer clients to one another, share a philosophical framework for working with this population, and trust one another.

> Some of our women [are] calling back [after they leave our services]. And rather than having to connect them to a whole other array of services, we just reconnect them to, you know, to the ones that they had when they left…Rather than having to start that cycle all over again, you know, having the same people involved is really comforting for the women. I think that's why they come back.

Collaboration efforts extend beyond this circle of community service providers. Service providers have found increased collaboration with AADAC services (using ESW as a conduit to other AADAC services) and medical services. "One of the things we're most grateful for is some of the really fine

medical support we're finally getting," reported a community service provider. Clients also remarked on the support they are getting from medical professionals. One woman credited her doctor for "setting up everything for me" including assistance from a mentoring service, AADAC, and housing. "She put me on the right path because I didn't know what to do."

While there have been some successes in developing collaborative relationships with agencies, community service providers often mentioned the difficulties they experience in collaborating with the child protection system and other service agencies. They admit that not all service providers share this philosophy of collaboration.

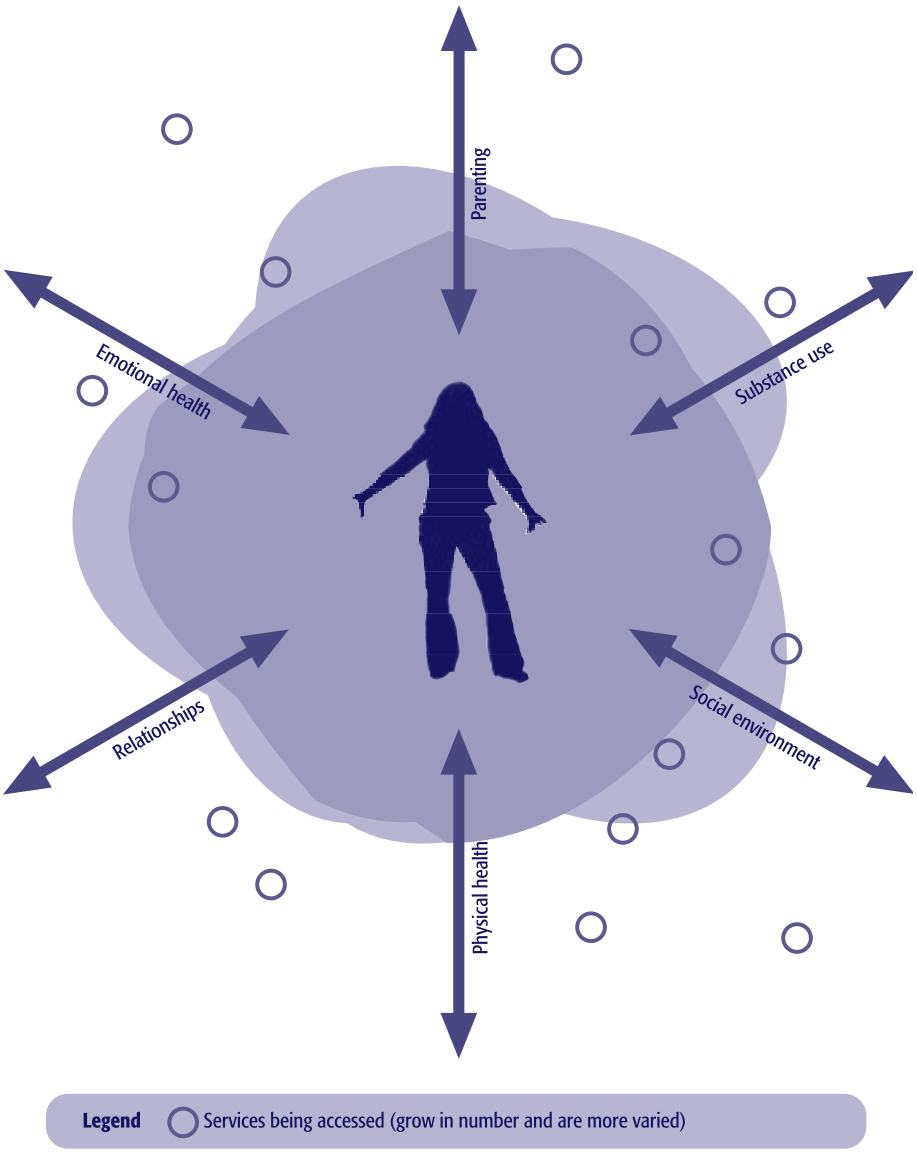
Summary of outcomes

The support women receive with the assistance of ESW and other community service providers includes more long-term, forward-looking services, like employment, financial, childcare, and mental health agencies. These services look beyond immediate needs and help women examine and achieve their long-term goals.

The model that follows depicts the lives of women during and after their interaction with ESW services. While their lives are still affected by substance use, parenting, physical health, emotional health, relationships and social environment concerns, they are now having some influence in making positive changes regarding those concerns.

They are experiencing change in the number and nature of the supports in their lives. Women now use a multitude of services for a variety of purposes. They may still use crisis-oriented services, but they now also have more stability-oriented support, such as financial aid, family doctor, self-help groups, and spiritual support.

What outcomes have women achieved?



The Role of ESW

In addition to documenting an impressive list of outcomes achieved by the ESW clients interviewed, researchers analyzed the role ESW played in achieving these outcomes.[12]

Interpretation of the findings yielded three major categories that succinctly describe the role of the ESW service co-ordinator in facilitating the outcomes achieved:

Linking to addiction services
Through a variety of means designed to increase accessibility to AADAC for this population, ESW service co-ordinators are effectively linking women to addiction services.

Building relationships
By accepting a harm reduction philosophy, employing motivational interviewing techniques, and being non-judgmental, ESW service co-ordinators are listening to women, their experiences, and their needs in ways that the women have rarely experienced. While service co-ordinators prioritized the importance of accessibility, service recipients—the women themselves—valued their relationship with the ESW service co-ordinator above all.

Linking to the community
Through advocacy, referrals, and working closely with community service providers, ESW service co-ordinators are linking women to a cohesive support network—acting as a hub in the network of community supports.

Linking to addiction services

When asked how the ESW service has been helpful to women in achieving their outcomes, community service providers and ESW service co-ordinators repeatedly identified various accessibility factors that made the difference. Women, too, frequently echoed the following comment, "[The ESW service co-ordinator] was there whenever I needed her. Whenever. There wasn't one time, I don't think, that I even called her that she was not there."

The ESW program was specifically designed to provide better access to addiction services for pregnant women who use substances. Therefore, a number of strategies were put into place from the outset of the program to

[12] This research project was not an evaluation of the ESW service, so the information obtained is specifically related to the role of the service in achieving the outcomes, as perceived by research participants.

facilitate this goal. Many of these strategies were mentioned in the interviews with ESW clients, the community service providers, and the ESW team. Some examples are

- prompt responsiveness
- flexible service delivery
- community outreach
- intensive support

Prompt responsiveness

Availability

There is no question that access to the ESW service co-ordinators is enhanced through the addition of cell phones. Numerous examples were provided in the interviews that attest to the effectiveness of this tool. This client describes how the ESW service co-ordinator has "…got her cell phone on all the time. She doesn't care when you call her. She always gets back to you really quick." ESW service co-ordinators spoke of clients calling co-ordinators ' cell phones, wherever and whenever they needed. One client identified "the fact that you could call pretty much anytime" as the most helpful aspect about ESW.

This service co-ordinator gave a vivid account of how a client needed her at a crucial moment and called to get help:

> I had a client that called me when she was at a crack house, and [during the conversation, we coached her to get herself] out of the crack house. We [said] "put your shoes on, walk out the door, walk down the street, get to your home" [while she was on the phone].

Some clients seemed to prefer telephone contact over office appointments such as one woman that "calls me three or four times a day [but] you can't get her to have an appointment to save your life," or another that has never engaged in treatment, but "she phones every three months."

Priority access

As is foreshadowed in the previous quotes, there is a strong perception among all those interviewed that ESW service co-ordinators can and do respond promptly to service requests. Community service providers report, "She's readily available," the client can get "immediate support—I could get [ESW] tomorrow," "It's a quick service," and "They can get help right away."

Likewise, all the women interviewed talked about getting help "right away, right now." "Anytime I needed help, she's been right there." One woman, who'd had previous experience with AADAC services, was astonished to find just how quickly the service was provided to pregnant women.

> When I came in [to the AADAC office] when I was pregnant, I got [the ESW service co-ordinator] within a half an hour. All I wrote down [on the sign-in sheet] was "pregnant." I walked away from the desk for two minutes and they said, "No, no, no, come back."…I came in and like that [snapping fingers], I got her…. Because I know how hard it is to try and get in here sometimes and it's really, really hard, especially when you want help and you can't get it. I mean, when you want it, you kind of have to get it when you're there. When you're there asking for it, you basically kind of have to have it right then. I didn't think being pregnant was going to make a difference. I really didn't. But all I did was do the same thing as I did before [but] I had written "two weeks pregnant" down…I didn't even get to sit down. They called me back. I felt special.

In addition to a quick response to new clients, clients and community service providers also commented that ESW service co-ordinators were willing and able to accommodate urgent requests by "clearing their schedule." An example was provided by a community service provider whose agency has "a special procedure so, if anyone ever just leaves or is discharged [from our services], we'll always try to phone ESW." In one situation, the ESW service co-ordinator "just changed her things (appointments) and it was like, bam, right there, and she stayed with the client" all day while they waited together for the mobile response team. In her opinion, without this support, the client "would've taken off, I'm sure."

Such remarkable availability is facilitated by the priority access accorded to pregnant women by most service agencies and to the way the ESW caseload is managed. The service co-ordinators themselves are aware of these factors. "When they call and you're able to see them fairly quickly, it can make a huge difference because they can count on you then." ESW service co-ordinators recognized the value of their unique ability to keep their schedule flexible so they can accommodate emerging issues or crisis for their clients, which is in stark contrast to the caseload of other addictions counsellors at AADAC.

Furthermore, service co-ordinators facilitate the clients' prompt entry into other AADAC programs or other community services. One community service provider reported, "I see the [ESW] program as being very helpful in the initial stages in fast-tracking women into treatment." According to one service provider, when women "couldn't stay" in her program, the ESW service co-ordinator was "a lifeline for [the women, because] she's always there and quick to initiate paperwork and programs and find [treatment] alternatives for them." An ESW client also recalled, "She did everything she could to get me [into residential treatment]. They were telling me like four weeks I had to wait…So, she really pulled for me [and] I think it was about 10 days [before I got into treatment]."

Flexible service delivery

Individualized treatment planning

Service flexibility was evident in many ways. While it is a component of all other issues addressed in this section, one additional aspect often mentioned, particularly by the women who used the service, was the flexibility in treatment planning. In other words, ESW is not a 'one size fits all' kind of service; it is individualized to meet the varied needs of the women it serves. As the ESW team acknowledged,

> It doesn't work that way a lot of the time…There are certain programs [where] they need to fit into these particular slots to go through the process. We have more flexibility, more resources that we work with, and more options…We're allowed to be creative.

Women were pleased that they were "not pushed" into a particular treatment regimen, that they could choose the option that would work best for them from the range of addiction services available through AADAC and its funded services and programs. As mentioned earlier, some women preferred telephone contact, whereas others enjoyed the face-to-face interaction. Some eschewed groups ("I didn't want to work in any groups") while others thrived in the group counselling setting. ESW has the flexibility to provide treatment or find programs that suit each woman's needs.

Community service providers also appreciated the flexibility of the ESW program. For one service provider, the most important characteristic of the service is, "Individualized services…The women don't have to fit into a particular treatment plan. One is designed for them." Another made a similar comment.

> [The service co-ordinators] can see [the clients] one-to-one [but] it doesn't have to be [like that]. They can be creative about what type of treatment the women will receive, and if she's not suitable for group, I know [the service co-ordinator] has been able to see some of my clients one-to-one regularly.

Administrative tasks are secondary

Because of the outreach nature of the service, ESW service co-ordinators make every effort to connect in a meaningful way with their clients upon first contact. To expedite access, ESW delays the administration of conventional admission and intake procedures in order to immediately engage and support their clients. As one ESW service co-ordinator put it, "We're not coming in [to meet clients] with our suitcase of paperwork."

Community outreach

Regular site visits

ESW service co-ordinators work in the community to reach clients who would not normally use AADAC services, that is, a population that is more marginalized and harder to reach. This often involves establishing a regular (e.g., weekly) schedule for site visits in locations throughout the community. Examples of outreach to community sites include:

- Health units in the high-risk, low-income areas
- Detox or residential treatment centres
- Shelters
- Visits to client's home or to locations near client's home (e.g., coffee shop)
- Hospitals
- Outlying communities (from the Grande Prairie office)

The following passage is from one of the group interviews with community service providers. It is a thorough description and analysis of the outreach component of the service as it is enacted within her service agency.

> [The ESW service co-ordinator] tries to come over to our program on a pretty regular basis. She usually comes on a Thursday and spends a few hours in the office. So, then her face is shown there and people know her there. And it also is always a good reminder for people that, you know, that she is there and she's out there and that we can connect up with her. So, it's really good that way. What we usually do with a lot of the women is, we'll give her [the ESW service co-ordinator's] phone number and her cell number. And, if she possibly can, she tries to come over if they're there, and meet [the clients] right there instead of going to the [AADAC] office. So, that works out really well because sometimes you give a number and they don't always follow through. So [the ESW service co-ordinator is] so close to us, it's really good that way. If she's around and available, she'll come right over and meet with the client right there. And then they set up something from there.

As can be ascertained in the passage above, community service providers are especially appreciative of this way of working with AADAC. Acknowledging that this type of service "was a real departure for AADAC," one service provider proclaimed that the fact that ESW service co-ordinators will "come to you [is] the single biggest ingredient and we'd even like to see more of it." Another in the same group interview concurred, "To whatever degree you've been able to go to the street or to our shop, that is particularly noteworthy, I think, and we want more of it." These service co-ordinators believed that such a program is "an affirmation…[that] AADAC cared enough to create something special for [these women]."

ESW service co-ordinators also provided many of their own examples of outreach-in-action. This description exemplifies the persistence and presence of ESW at other community agencies:

> The doctor introduced me [to the woman] at [an inner city agency] and she's like "fuck you," gives me the bird, and she's flinging physically. She's like, "Get away from me."…Anyways, she had nothing to do with me at all. She was looking me up and down. So, that's fine…This took weeks and weeks. Seriously. Then she'd walk by—and it had to be about five times, so five weeks, you know. And one of the times she was walking by, I said "hi." And then—she had walked past the room already—and then kind of backed up and looked at me and said "hi." And I was so shocked. It was great. I sat there. I didn't know what to do. Anyways, so she walked, she kept walking, but she gave me a smile and said "hi." And from then on, we just [snapped fingers]. Like, she came in and talked and she started crying. But it took [a long time].

In another situation, the ESW service co-ordinator waited about "eight or nine" months for a woman to show up at an outreach site. Even though "she comes here all the time, she would avoid the place on the days that I was there."

Because clients see ESW service providers at outreach sites, they view ESW service co-ordinators as human beings, not only as parts of a larger organization.

> It's just so extremely valuable, because we would never see any of our clients…Other professionals would refer, but them coming in would never happen unless you're there. They see your face, they can see that you're human. You're not this organization. Right? Because that's what they see you as at the beginning.

Reaching clients who might not otherwise seek AADAC services

Beyond facilitating the initial connection with women, ESW outreach also includes providing ongoing services to women in environments that are familiar and comfortable to them when appointments in the AADAC offices are not the most effective option. One community service provider felt that women were better supported "in working towards their treatment goals by the counsellors meeting them [at our facility] where their comfort level is enhanced by their family surroundings."

A preferred treatment option, according to some clients and community service providers, is to have ESW service co-ordinators meet with clients in the clients' homes, a practice that occurs more regularly at the Grande Prairie ESW site and is only occasionally provided by Calgary or Edmonton ESW services.

> I think the most beneficial thing that I get now is that she's able to come [to my home], you know. And that helps me out quite a bit because it's

> hard for me to go to the office. Whereas, I'm still getting the help that I need, that one-on-one counselling for the week, you know, which is really beneficial at this point.

ESW service co-ordinators are also in a position to provide follow-up to women who have been lost to ESW and other community services—where clients lose contact with their support network. One inner city service provider found it very helpful that the ESW service co-ordinator "knows where they might be…if we lose track of them."

Why is community outreach so important? According to ESW service co-ordinators, the outreach aspect of the service reduces barriers such as child care and transportation. It also enhances continuity of service, the ESW service co-ordinator can see a side of the client that may never be evident in an office setting, and "women who are guilt and shame-based, don't have to go to a place that has AADAC on the front of the door," furthering their feelings of shame.

Nonetheless, it seems that as clients become more trusting of their ESW service co-ordinator, they can make the transition into eventually meeting that service co-ordinators at AADAC offices. One ESW co-ordinator told of how she initially met with a client while she was in hospital, then when she was released, met her at a restaurant close to her home and, eventually, they were able to meet at the AADAC office.

Intensive support

Regular, frequent face-to-face contact

Most women interviewed for this research project had received an intensive level of support from the ESW service co-ordinator. This often meant that face-to-face appointments were scheduled regularly or often. One woman observed, "My [substance] usage was going down every time I saw her, and then when I don't see her, [it goes] back up again. So, I just try to get in to see her as much as possible." Yet, she also recognized that her needs were changing.

> I used to see her twice a week. I used to see her almost every day at one point in time because I was so bad that I had to see her every day. Like, if I didn't, I was going to go nuts. But it's getting better where I can see her at least once a week and say, you know, "OK, I'm fine for the week. I'm OK."

ESW service co-ordinators theorize that many women need this type of regular and frequent contact to "give [clients] a time of trust-building" and "strengthen our relationships." The flexibility of this service offers clients the time they need to feel comfortable seeking addiction and other services.

Responding to changing needs

This level of commitment to clients' treatment reflects the client-centred nature of ESW services and the service co-ordinators ability to meet the clients where they are, both in terms of their physical location and in terms of their recovery process. Some ESW clients had weekly appointments with their service co-ordinator, some were only going as needs arose, others used only referrals to other services. They also varied in the length of time they attended ESW, with one woman "working with [the ESW service co-ordinator] for two years." In whatever the situation, ESW services adapt to provide treatment that meets the changing needs of the women they serve.

> We (ESW) don't have an agenda that we're only seeing [a client] three times…There's no timeframe that we have to [follow]. We can see them (clients) tomorrow. We can see them for days in a row if we need to.

Building relationships

The goal of ESW is to provide an enhanced level of addiction services to women with substance use problems who are pregnant or who may become pregnant. The woman quoted below states what was repeatedly mentioned during interviews with other ESW clients and illustrates one of the important aspects of ESW services—ESW service co-ordinators are caring professionals who treat their clients with respect and dignity.

> She treats me like a human, like a person. She respects me. She honours my choices. She doesn't pressure me in any way. She listens to me, and not many people do…It felt so good to be able to express my feelings and be acknowledged for it…Through my most difficult times, she's always been there…I trust her with my life. I confide in her and I know I can trust her. She has not betrayed my trust, not once…To be able to trust that one person is an outcome in itself.

While service providers emphasized the importance of client accessibility to ESW services, service recipients—the women themselves—valued their relationship with the ESW service co-ordinator above all. By far, their most poignant and frequent comments about the role of ESW concerned the perception of the service co-ordinators as caring professionals. Two intricately interrelated themes form this category: caring and counselling approach.

Caring

Building relationships

The women who participated in this research project are closely connected to their ESW service co-ordinators. "She was a friend; she wasn't my enemy," said one women. Another itemized all the qualities that she appreciated in the ESW service co-ordinator and then summarized, "I love her…We have a good relationship. She's a very good woman and I'm glad I got to meet her."

Women reported feeling "comfortable" and "safe," that they were working with a "good person."

Several of the women interviewed used some variation of the expression "being there." This seemed to signify the accessibility of the service co-ordinator at a deeply caring level, "When I'm with her, I have her undivided attention." "When I say she was there, I mean, she was there for me. Like, all the way. And she was completely what I needed."

Community service providers also respected the individual ESW service co-ordinators both for their skills and for their approachability. They have observed "clients gravitating towards" and "establishing lasting connections" with the ESW service co-ordinators. They perceived that counselling is effective, in part, because ESW works to build relationships and develops rapport with their clients.

Staying non-judgmental

Most service providers would likely claim to be non-judgmental of the clients they work with. As the clients have experienced, however, maintaining a non-judgmental stance can be a struggle for service providers when dealing with women who use substances. "I get a lot of judgment being on the streets and stuff" and "the counsellors or whomever were judging you right from the jump" are comments that reflect common experiences for the women interviewed for this project. Yet, they described ESW service co-ordinators as profoundly non-judgmental. One woman appreciated that, no matter how many times she didn't show up or follow through,

> Nobody's closed the door on me even though I've kind of screwed up time and time again…Nobody's criticized me for any of it…Even though I was embarrassed that I screwed up, I still knew that I could go back to her and she wouldn't kind of give me a lecture on it or anything.

An ESW service co-ordinator echoed this sentiment from her perspective: "I never close the door on anybody. I never make comment about [not coming in]…I just go, 'Well, it's really good to hear from you.' "

From having the new experience of not being judged, women could then reframe their own perception of themselves. "She makes you feel important," declared one woman and another affirmed, "She didn't look at me like I was a bad parent. She didn't look at me like I was a bad person. She looked at me as a human being that had problems."

Integrating learning opportunities

ESW counselling techniques are used within a particular philosophy and practice method. Grounded in a harm reduction philosophy and a holistic view of the women they serve, the ESW service co-ordinators use the motivational interviewing method to facilitate the change process. They also integrate learning opportunities into counselling session to help clients develop important, and often missing, skills.

Research participants discussed the numerous useful techniques they learned from their service providers. They learned techniques to stay calm and grounded (e.g., meditation), manage their anger and anxiety, establish schedules, recognize their progress, gain insight into the root causes of their behaviour (e.g., keeping a journal), deal with child protection agencies (e.g., preparing questions for case conferences), and set boundaries (e.g., how to say no). ESW service co-ordinators also provide resources and information, such as booklets, handouts, workbooks, Internet sources, and books.

By integrating learning opportunities into their counselling relationship with the client, ESW service co-ordinators help keep women focused on their goals, and one woman noted of her ESW service co-ordinator, "She's one of the best workers that I've ever met, and I've met lots…I don't know if she knows how really good she is. Her little counselling techniques, she's wicked. She really is."

Counselling approach

Harm reduction philosophy

Harm reduction recognizes that abstinence may not be the goal for all those who have substance use issues so instead focuses on reducing the risks associated with substance use. For some women, achieving harm reduction goals can lead to a willingness to then work towards abstinence goals.

The community service providers who work most closely with the ESW service co-ordinators all share a harm reduction philosophy. That ESW also operates from this philosophical framework is considered a welcome and necessary addition to the delivery of addictions services.

> Because it's a harm reduction kind of model from AADAC that's been [put in place through ESW]—where the girl or woman that comes there feels more comfortable [because] it's not so abstinence based—[the clients] can kind of at least handle that.

Perusal of the outcomes section of this report provides evidence of the harm reduction philosophy in action. First, with the assistance of ESW, women have achieved outcomes in several different life areas, including substance use, parenting, physical health, emotional health, relationships, social environment, and network of support. Second, outcomes within the substance use realm include reduction in frequency and quantity of use, substituting substances they believe to be less harmful, shorter and less frequent relapses, reporting relapses and reconnecting with services, and acknowledging that lasting change occurs "one step at a time."

Holistic view of women

ESW service co-ordinators use a holistic approach—one that "looks at the woman as a whole person as opposed to just…[a woman] with an addiction."

As one service co-ordinator clarified, "We will get [at] so many different areas of their life. We don't just work on addiction, I mean that's a sliver of it, but we're holistic in our approach." This often means, "we won't even go into the depth of their addiction issues at all [at first]. That may come down the road." Instead, other pressing issues, such as housing or physical health, might be addressed first. From this, women get the message that "taking care of yourself now is what matters."

Motivational interviewing and the stages of change

The complexity and social trauma of the women's lives before entering ESW means that their experience of change is multi-faceted and highly complex. To navigate the stages of change that clients experience, AADAC practitioners use motivational interviewing techniques.

Several women involved in this study described their movement through the stages of change (from precontemplation to contemplation to action, as outlined by Prochaska, DiClemente and Norcross) and how they believe they came to the point where they were ready to start their process of change.[13]

> You know if somebody tells you to go [for help] or, you know, hopes that you go, you go and it really has no effect…It just doesn't work until you're ready yourself. That's what I believe.

In looking back on their life while using substances, women often said things like "I just don't want to be like that." One woman offered a description of the change process as she experienced it:

> It got to the point where I was so sick of it. I was so sick of living my days like that every day. I couldn't stand myself. I couldn't stand being in my own skin. I was just like, "Wake the hell up, get out of this life, get out of the house, get away from these people, and start living your life the way you should be. This cannot go on anymore." [Q: Where does that come from?] From my strength from before I started it [the drug use]. I know me. I know that I'm better than that. I know that I can be a strong, independent, great mother and have a good life. I don't have to be in this. What the hell's wrong with me? I have been clean ever since.

As an ESW service co-ordinator said of their work, "It's their (the clients') choice and they are experts in their lives, and we really say, 'You are.' And I think that plays a role in helping them make changes in the goals that they want. Because we're their cheerleaders."

Some key strategies such as listening, guiding, and presenting options were well represented in interview transcripts. For example, many women referred to their experience of being actively listened to, such as in the descriptive statements, "She's got great ears," and "All her heart and her ears are all

[13] See Appendix 5 for a discussion of motivational interviewing and the transtheoretical model of change.

there." Through the process of "gabber[ing] her ear off for an hour," the women found a space where they could reflect on their experiences, be guided to consider options, and then make their own decisions, "When I am expressing my feelings, the feedback is what helps me. It's what makes me realize what I want in my life, what I need in my life, what I have to do about my life."

In motivational interviewing, the counsellor respects the client's autonomy and freedom of choice (and consequences) regarding her own behaviour. Many examples of this were provided in relation to options for treatment, such as the woman who did not want to go into residential treatment or another that "right off told [the service co-ordinator] I didn't want to work in groups. She said, 'If that's what you want to do, you can start with that and see how it goes.'…She didn't try and push me."

The service co-ordinator uses a motivational interviewing approach and tailors her efforts to the client's readiness to change. Thus, resistance and denial are reframed and strengths are highlighted. The ESW service co-ordinators explicitly addressed this.

> I think what we really push on is their strengths, and other people see negatives. Wherever we go all people do is talk about negative, negative, negative. You know, and we really push the strength and we really push the strength base, because we do see the strengths in them, and because we're not focused on, you know, making all these changes in our agenda—it's theirs, and we really take that step back…and I think that plays a huge role too.

A strength-based approach also helps clients to feel that they can create positive change in their lives and builds their self-efficacy. "She helps me see brighter points…[and] to keep my mind open for positive things…just knowing there's hope, there's always hope," reflected one woman.

Linking to the community

Through enhanced outreach into the community, a critical goal of the ESW program is to increase access and linkages for this population of women to existing AADAC services, services funded by AADAC, and other support services in the community. The success in achieving this goal has already been addressed in the outcomes section of this report. This section focuses on ESW's role in accomplishing these outcomes.

Analysis of the data from all sources indicates that ESW service co-ordinators increase access and linkages to services by being at the "hub" of a broad network of services and supports. The role of the ESW service co-ordinators in the centre of the service network is two-fold:

- Linking women to the community support network
- Building the network

Linking women to the community support network

Connecting women to other service providers and services in their community is an essential role for ESW service co-ordinators, as this community service provider and client attest:

> If [the ESW service co-ordinator] takes [clients], then she connects them up with other people and so they have connections everywhere.

> [My ESW service co-ordinator] was kind of like an out branch for me, right? Because, I mean, [she] works at AADAC so that's just one but then [she] also has been able to hook me up with other stuff.

ESW has expert knowledge of community services

To make these connections in the community, ESW service co-ordinators have become familiar with dozens of community services and other programs within AADAC and the services it funds. Because ESW co-ordinators take a holistic view of the women they work with, they refer clients to a range of services that deal with more than addictions (e.g., child-/family-related, physical/mental health, education/employment, cultural/recreational/spiritual, housing, other professional, crisis-related, and community-based supports). An ESW service co-ordinator explains how working in ESW has changed her perspective on addictions counselling:

> We look at the woman as a whole, and not just the sliver [of her addiction]. And, I think, that's where I've really grown within AADAC, is that I look at her as a whole and [needing] a collaboration of other services.

An ESW client who has a private addictions counsellor contrasts ESW's role in the community with the role her other addictions counsellor plays:

> It will probably be [the ESW service co-ordinator that I would go see] for programs and stuff because my other counsellor is just an addictions counsellor. She's really not that connected with programs in the community and whatnot.

Establishing connections is accomplished through the specific task of making referrals to other services in the community. All the women interviewed acknowledged that ESW service co-ordinators provided this kind of help. "She refers me to lots of stuff," reported one woman. This woman makes a similar point:

> She tried to get me connected with as many programs as possible. But she wants to start getting me connected to the outside community resources instead of at AADAC all the time because I very much depend on AADAC, right, to help me. So she's getting me connected with other community resources and she basically is just there for me.

Women recognized that ESW service co-ordinators make the most of these connections because they are well informed about other services in

the community. As one woman confidently asserted, "she's got a lot of information about everything." Moreover, women credited ESW service co-ordinators with getting them into other services, "[she] actually helped me get in [the woman's shelter]…[and] she put me in [residential treatment]," "she referred me to several different places for counselling for grief and loss…[and] she referred me to programs that are [in AADAC]," reported two women. In another woman's experience, "if there is something they can't help you with, they give you referrals; she's given me quite a few referrals." Being connected to many services taught one woman that "there's always a way to get help for [a problem], no matter what it is."

ESW encourages efficient and effective referrals

Community service providers identified three ways that ESW works to maintain an efficient and effective referral system for the community support network.

- Direct referrals to AADAC
- Two-way referrals
- Taking the lead in getting appropriate referrals for clients

First, those in the community appreciated "the ability to refer people directly to AADAC" through one person. For one service whose mandate is to work intensively with pregnant women who use substances, referring to ESW and AADAC is a significant piece of their work. According to one service provider, "in the pilot program period of two years, 45% of the women accessed AADAC services because addiction [is] a pretty main issue." And from a different city, another service provider explained: "Well, all of our women are addicted [and] part of our mandate is to connect women to addiction services. So, if they would agree to it, pretty much everybody would be connected."

Second, phrases such as "referrals go both ways," "we do lot of referring back and forth," and "two-way referral system" provide evidence of the mutual nature of the referral process between ESW and community services. Community service providers explain, "if we have anybody who we identify as potentially benefiting from AADAC services, then we would give them [the ESW service co-ordinator's] card or introduce them. And the same thing as [she] brings women to us for prenatal care." Further, "when [the ESW service co-ordinators] has a client…who has that history of sexual exploitation, she's called us…and we have covered counselling for [her] clients." In the case of a residential treatment program, ESW service co-ordinators "may actually physically come with the client [and] bring them for assessment to get them right in. So we work really closely." Furthermore, "if ESW calls us, we react immediately; the clients get in there that day."

Third, community service providers count on the ESW service co-ordinators to make appropriate referrals and take the lead in getting clients referred to

other services. This means that other service providers can focus more on their own service area rather than engaging in the often complex and time-consuming process of making referrals for women who need an integrated array of services—ESW service co-ordinators are viewed as experts who "make those referrals." Echoing the consensus of her fellow service providers in one group interview, a public health nurse stated: "I can focus now more on the nursing part because I know that there are experts out there who will help them. I don't have to make the referral and connect them, and I don't have to worry about that piece of it as much." Another service provider concluded: "I really do leave a lot of that up to [the ESW service co-ordinators]—to meet with the woman, decide what's going to work best for her, and then for them to make the appropriate referrals."

ESW service co-ordinators also acknowledged the importance of this task in their dealings with their clients. They make a point of staying current with what is offered in the community so that "we can better refer them to [what they need] because we have a broader idea of what they (services in the community) offer." Once a woman is connected to ESW, the service co-ordinators ensure that the whole service network is engaged for her as appropriate: "When they get connected to our services, their isolation kind of pitters away, and they're really connected with a team."

ESW advocates for women in other services

Women also appreciated the advocacy that the ESW service co-ordinators provided. One woman recognized that her ESW service co-ordinator "helped me get into treatment a couple of times." Another attested, "If she has to write a letter to your [social] worker, she will."

Of the many advocacy efforts made by ESW service co-ordinators , the women were especially appreciative of their assistance with child protection agencies. This has a number of dimensions.

For example, women explained that service co-ordinators demystify the system and help them understand their rights within the system:

> It's just explaining what's going on because I didn't understand any of this and I guess she's dealt with this before. So again she's keeping me calm…Yeah, she helps me with [the child protection agency]. She explains the process to me, [and] the system. Because I'm sitting there and I'm just crying, and I don't know what to do. I don't know what they're doing or what's going on or what's normal. So, she tells me, "This is normal, this isn't."

Service co-ordinators also help the women prepare for case conferences and accompany them for support. "I'm there to answer questions if [the social workers] have any concerns." ESW clients perceived that the service co-ordinators's presence as an advocate facilitated better communication between herself and the child protection agency social worker and resulted

in a better outcome. “When you’re there and you’re pushing it…they (the child protection agency) get [things] going because there’s another person with the client, and so they kind of have to.” Referring to the strength of such advocacy, a woman who regained custody of her four children while receiving support from ESW exclaimed, “She was like a lawyer, she was better than my lawyer!”

Another task assumed by the service co-ordinators is to ensure follow-through of the service plan that the child protection agency develops as a condition of regaining or keeping custody. “She makes sure that social services kept up to what they said they were gonna do…[and] helped to make sure that they did follow up.” A community service provider concluded: “It’s all really helpful to the client. They make so much more progress with child welfare because of it.”

In the process of making referrals and advocating, women learn important skills from the ESW service co-ordinators “so they can act on [their service needs] much sooner or they can seek out services.” This modelling of behaviour assists women in their future endeavours to do the same on their own behalf.

Building the network

All that the ESW service co-ordinators are able to accomplish in linking clients to the service network is dependent on what one service provider called “partnership work.” Or, more colloquially, “They are so open to working together with us. Like, it’s amazing. They’re so dedicated.” The role of ESW service co-ordinators in building a network of community service partners entails:

- establishing relationships with a range of community services
- providing consultation, coaching, and training to other service providers
- collaborating and co-ordinating with community service providers

First, to build a helpful, safe and sustainable service network for their clients, ESW service co-ordinators must establish relationships with a range of community services. This point was made by one of the ESW service co-ordinators:

> I think our relationships with all the community partners plays a really big role in getting [the clients] connected and staying connected, 'cause you don't just refer to some agency and say, “phone this place.” You say, “I know [that service provider], let's call her, let's book an appointment,” you know, that connectedness that way.

One community service provider reiterated the vital importance of establishing relationships, especially with like-minded service providers:

> [The ESW service co-ordinators] are connected up with so many other good agencies out there that have that same kind of attitude…They know who to phone to hook up these people. And they know who they're sending [the clients] to and they know what kind of care they're going to get. And that's why the girls are being a little more successful because they're feeling safe with every place that they're sending them to, you know. Because a lot of times you can send somebody to some place and, if you don't know what it's about, you might be just setting them up for disaster. So, I think that connection with everybody out there that does this kind of work is really awesome.

From their perspective on the other side of the referral process, community service providers also felt more confident making referrals to ESW. "It's the establishing of a relationship so that [I] can say 'phone [ESW],' with a name." ESW service co-ordinators speculated that, ultimately, "another outcome is that there's a better relationship in the service provider network, too."

Second, ESW service co-ordinators provide consultation, coaching, and training to assist other service providers in using evidence-based practices for working with women who use substances. In the following quotations, service providers offer specific examples from their own practice.

> A notable achievement, also, is that sometimes I see [the ESW service co-ordinator] just talking to [a community service provider] for half an hour or a period of time…The [worker] needs some comfort and support, and that too wasn't as [available] before, that kind of access. And I think that's also noteworthy that [what we do] is really hard work, and it's very, very discouraging. And to have someone else, another colleague, to talk to about that…and a little bit more support to the [worker], is very critical…

> Sometimes [the ESW service co-ordinator] and I are on the phone or just in a short meeting together. Like, "what can we do together? What can we do for this woman? What do you think we should try?" So somebody else to bounce some ideas off of and share ideas with…It's a piece of the pie that's very necessary.

Training of community service co-ordinators was also occasionally mentioned. In one situation, the ESW service co-ordinator "invited us to come and do some training with [AADAC] staff…and then similarly, we've invited [her] to train [our volunteers]. So, [she] is now one of our trainers."

A third, and critical, piece of building the service network is collaboration and co-ordination. In this regard, community service providers sometimes voiced their views about the positive impact of the ESW service co-ordinators by making comparisons. According to one: "[Before] you didn't know who to refer who to. [Now] it's one person and they know who to go to." Another added,

> [ESW] has kind of pulled everybody together so that we're working in the same direction. It used to be very scattered. You didn't know who to refer who to…And it's pulled everybody else together too, I think, so that they talk more about the mutual clients.

A service provider from an outreach service for street workers reported that some "nice little spin-offs" of the improved collaboration with AADAC, through ESW, included ESW participation in a "resource circle," "back and forth training," and joint presentations. Service providers listed a variety of ways that ESW service co-ordinators are "working together with us," including facilitating admission processes for agencies other than AADAC, conducting one-on-one or group sessions with women in pre-treatment groups, attending case conferences, and working together to develop discharge plans for mutual clients. Community service providers are aware that the ESW service co-ordinators "will follow the client even when they're done our program…and really bridge them to a lot of services." In sum, ESW service co-ordinators play a key role in the service system for women who use substances.

In the opinion of one ESW service co-ordinator, as a result of the collaboration and co-ordination they have facilitated, "accessing service is more efficient, too, and, I think, the transition between services is easier." ESW service co-ordinators are certain that their "shared collaboration" with other services has increased the quality of the service for women because "we're all on the same page and we take pieces…and share that responsibility."

Summary

ESW services have a three-fold function: to link clients to addiction services, to listen to and support clients, and to link clients to the support services in their community. The model below graphically depicts these functions.

1. ESW service co-ordinators effectively 'link' their clients to addiction treatment services in the community.
2. ESW service co-ordinators successfully build relationships with clients by listening to and providing support and understanding to the women they work with. These factors allow clients to feel confident in the guidance they receive and believe they can rely on these service professionals.
3. ESW service co-ordinators link clients to other services in their community and link the community of service providers together.

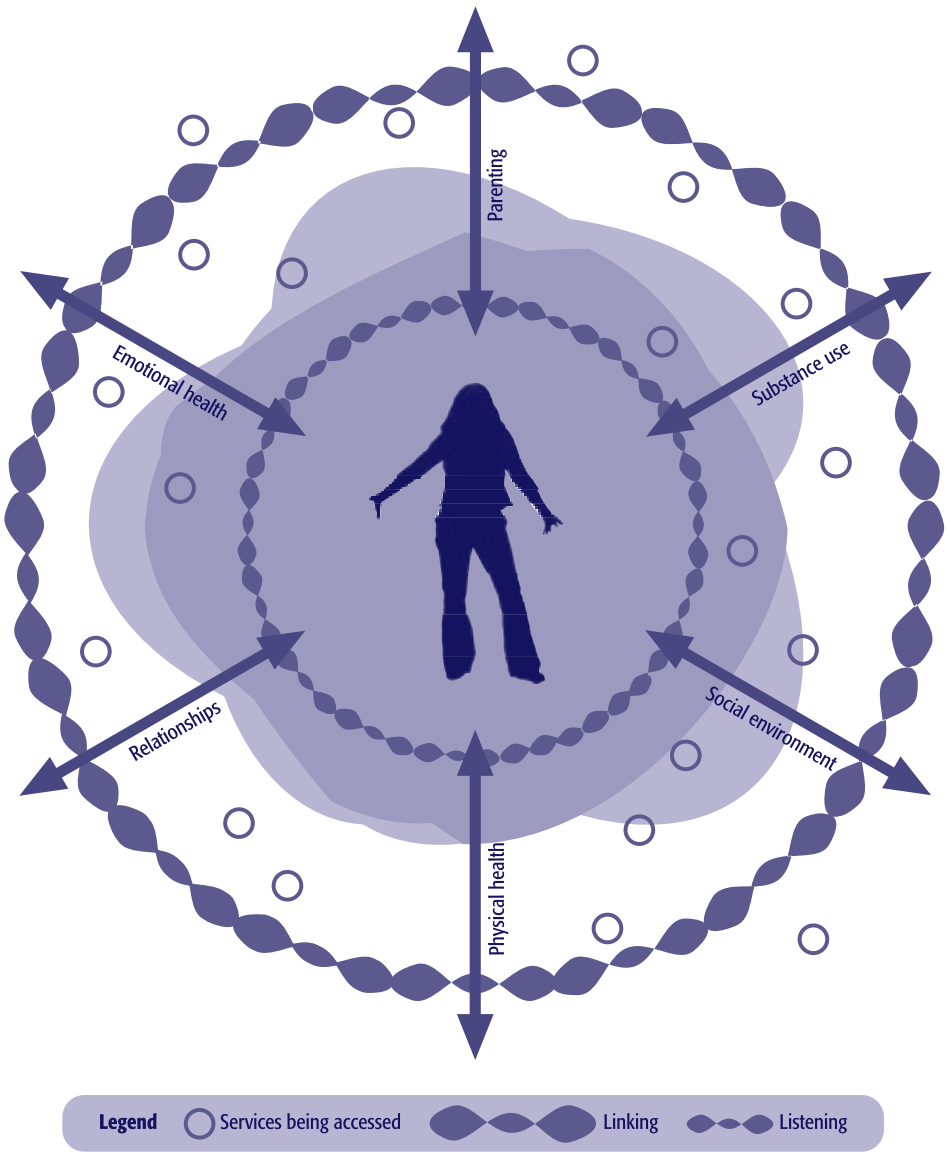
ESW serves as a hub in the service network. ESW service co-ordinators play an important role in linking women to a comprehensive service network and maintaining relationships with their clients while they assist them in negotiating their way through the many services that are available to meet their needs.

As well, ESW service co-ordinators serve as a support to the broad service network. Through ongoing relationships with other community service providers, they help others to serve women in a caring and effective manner.

By working with the women and other service providers, ESW pulls together a cohesive service network that supports women to stay free of substance use.

The challenges clients faced before their interaction with ESW remain, but they are beginning to make changes that help them deal with those challenges. They are better able to deal with their challenges themselves, and they also are now connected to a range of services in the community that can assist them.

What is the role of ESW in women's lives?



Summary

A major theme crossing all aspects of this research project is relationship building—it is a necessity for all people and organizations that work with marginalized populations. These are some examples of building relationships that became evident from this research project:

- ESW service co-ordinators strive to build relationships with their clients and the network of service providers in their communities.
- The community service providers that make up the service network build connections with other providers and work to make the operation of the network efficient and effective.
- Across AADAC itself, relationships are being built as a result of exchanging what has been learned from working with this marginalized population.
- Stakeholders that are responsible for policy and programming related to addictions and other life areas are building better relationships with other stakeholders as well as with the clients they serve.
- The researchers recognized the importance of relationship building early in the development of this research project. It was imperative that researchers develop relationships with the people they interviewed and the introduction, through ESW service co-ordinators, helped researchers gain the trust of clients and community service providers.
- Clients are also building relationships. They are developing trusting relationships with service providers as well as striving to maintain safe and healthy relationships in their personal lives.

Implications

Messages aimed at women, community service providers and the general public regarding the successes, the best practices, and the services of ESW are needed

So much of the "good news" gained through this study could be communicated to diverse audiences to the benefit of the whole community. Various resources could be developed to disseminate that information. Potential resource messages for clients, community service providers, or the general public suggested by this research are

- Women who use substances can and do make changes in their substance use and other aspects of their lives
- Best practice guidelines apply to and are effective in working with this population as demonstrated in the ESW program
- ESW can help women improve their lives
- ESW services are effective, non-judgmental, and follow a client-centred approach

Resources aimed at potential ESW clients are best placed in places that women are likely to see them—for example, malls, doctors' offices, shelters, transit stops and shelters, convenience stores.

Expanding and enhancing the community service network may lead to improved outcomes and improved access to services for women who are in need of support for the prevention of FASD and other harm caused by substance use

This research project strongly suggests that there is a relationship between women's connection to a comprehensive service network and their successful outcomes. While the collaborative work of the multitude of service agencies and providers who work effectively with (pregnant) women who use substances is considerable, areas for further expansion and enhancement are identified here.

Collaborate with the service network to address the need for more subsidised and supported housing

Despite a vast and diverse network of services available in Alberta, gaps remain. The gap most frequently cited by participants in this research project was housing. Stable housing is a critical factor in relieving stress and affects a client's ability to engage in further treatment options. Without a safe, stable, supportive, and affordable place to live, women are less likely to able to make progress in their substance use and other goal areas. They may be in

abusive, transient, or substance use-supportive environments with no solid footing from which to start the change process. As has been indicated, women face a range of challenges in their daily lives that require supportive and available services. Stable housing allows women to undergo their process of change in a safe environment and enables them to fully partake in the services offered to them without the worry of an unsafe or unstable home environment. While there are numerous agencies that provide supportive and subsidized housing in Alberta, there is need for more.

Collaborate with community partners to develop innovative models of addiction services

This research demonstrates that innovative approaches with a focus on issues particular to women are highly effective in helping ESW clients achieve positive outcomes. Two potential future projects that might build on these innovative ideas include residential treatment incorporating childcare and developing community service network models.

Incorporate childcare into residential treatment

Accommodating and making provision for the child care needs of women requiring intensive addiction treatment programming is critical and has been identified as one of the key concerns women face. While women are in treatment, their housing option is often a residential treatment facility, either short- or long-term. This research suggests a need for the review and development of alternative residential treatment models, including those that take into consideration the childcare needs of women in treatment.

Develop community service network models

This research demonstrates that women find the multifaceted approach of the ESW program to be beneficial in addressing their substance use and other concerns. By focusing on women and all of their concerns, ESW service co-ordinators and other community service providers help women develop stability in some facets of their life, thereby creating a foundation for changing their substance use habits.

The service network, with AADAC and other service providers and agencies involved, offers clients many services as well as many points at which to seek support. Clients benefit from accessing a variety of services in a variety of ways.

Developing common understandings and sensitivities between addiction services and child protection services leads to improved outcomes for women

As was identified in this research project, many women who use substances are involved with child protection agencies. Women described various ways in which the system helped and hindered their change process. Women felt

supported in the process when child protection workers were flexible, rewarded them for their attempts and successes, respected their choices, and facilitated access to all available services and supports.

The two concerns most frequently voiced by women and service providers about the child protection system was their sometimes limited view of what constitutes acceptable substance use treatment and what sometimes appears to be the system's punitive orientation toward parents attempting to regain custody of their children. Another concern was how to support women who are devastated and likely to relapse when their children are apprehended or made permanent wards.

The findings from this research project are consistent with research and policy documents from other provinces that call for more diversity and sensitivity in the policies, procedures, and delivery of child protection services (Tait, 2000; Poole, 2003; Pepler, Moore, Motz, and Leslie, 2002).

It falls to addiction service providers, child protection service providers and the policy makers in each to build relationships and a common understanding and sensitivity of the program necessities of each service.

This research project points to different ways of measuring outcomes, particularly for hard-to-reach populations

This research project has clearly demonstrated that, with an appropriate method, it is possible to determine the outcomes of difficult-to-reach populations. Utilizing a qualitative approach to outcome measurement has been shown to be effective in working with this marginalized population.

Based on experience to date in attempting to determine the outcomes achieved by women participating in ESW, two things are evident:

1. It is difficult to obtain outcome information for this population using the standard telephone follow-up method of monitoring outcomes at AADAC.
2. It is possible to gather rich and detailed outcome information through interviews with women who are recruited by ESW service co-ordinators, and by using tools like the sociogram exercise in this research project.

This research was conducted using accepted and rigorous research methods for collecting and analyzing data. From a research perspective, there is no need to replicate this study in the near future. Similar research might be conducted in coming years, especially if there are any modifications to the program structure, target group, policies, or other programs aimed at the target group.

Consideration could be given to expanding ESW services in order to reach women in more diverse geographic areas

This research project points to the success of the ESW initiative and the clients it serves. At present, only clients in Grande Prairie, Edmonton or Calgary have access to ESW services. Not only would women in other areas benefit from this service opportunity, ESW clients who relocate away from these centres are without ESW in their new location. Clients interviewed for this project described how they had moved away from the city where they had the support of ESW and their service network, and were unable to maintain or develop similar connections in their new location. As a result, they lost the momentum they gained while in treatment with ESW.

Substance use is not the only concern that ESW clients must manage

The results of this research describe the complex nature of the lives of women involved in ESW and other addiction services. Their concerns are not only about changing their substance use, but also about their children, housing situation, mental or physical health, finances, family or legal concerns or any of a multitude of other circumstances.

The ESW program demonstrates that services for women must recognize that substance use does not occur in isolation. Effective service providers have taken on a case management role that recognizes the need to deal with the other aspects of life that often affect a client's ability to effectively work on her substance use issues. Service providers working with this population also understand the necessity to take a holistic approach—recognizing that clients' lives are complex and that treatment must reflect this reality.

ESW demonstrates an effective model for working with special populations

Despite the existence of a variety of treatment models and programs, it is recognized that certain populations (women, at-risk youth, individuals with concurrent disorders, and people from varying cultural backgrounds for example) remain underserved. Traditional service delivery models may not reach or meet the needs of all persons who are harmfully using substances. Specialized services that reach these and other special populations in creative and non-traditional ways are needed. These services could incorporate the following elements into their programming, each of which has proven successful in the ESW service model:

> **Outreach •** Moving treatment out into the community improves the access of difficult-to-reach populations and the community service providers who work with them.

Recognition of complexity • Substance use is not the only concern of clients who present with substance use issues.

Case management • Clients often require assistance with non-substance use issues. As a result, service providers are called upon to help clients manage these issues so they can more effectively deal with their substance use issues.

Harm reduction • Not all clients wish to pursue abstinence as their treatment goal and instead would like support in reducing harm if they continue to use.

Focus on the counselling relationship • Building relationships is a key component of working with marginalized populations as clients are typically wary of placing their trust in service providers.

Current best practice provides the basis for an effective model for working with women

At its most basic, this research project has demonstrated that pregnant and at-risk women who use substances can and do make significant changes in their lives given support tailored to suit their needs—a finding which is consistent with best practices literature. It follows, then, that the best practices literature provides an effective guide for working with this group of women.

ESW is an example of a program that follows these best practices. Five key service components used in ESW demonstrated their effectiveness in working with this group of women. What is evident from the discussion of each of these components is that their effectiveness is tied to individualized, client-centred support.

Holistic

As has been reported in the literature (Health Canada, 2001a; United Nations Office on Drugs and Crime, 2004; Moses et al., 2004) the complexity and trauma experienced by women in all major life areas must be taken into account in any addictions treatment and prevention initiative. The stories of these research participants (clients, community service providers, and ESW service co-ordinators) compellingly demonstrate that no one area can be tackled in isolation, or apart from substance use issues.

Collaboration

A holistic approach to the treatment and prevention of substance use among pregnant and at-risk women necessitates collaboration among service providers. There are numerous social and health agencies addressing a vast array of needs and issues in Alberta communities and particular skills and support are needed to navigate this overwhelming system. Once connected to skillful and supportive service providers, women who use substances can and do take advantage of many of these services.

The ESW program has evolved to include collaboration across several health and social service agencies, recognizing that women face a myriad of complex issues in addition to their substance use issues. This research provides evidence that women's chances for successful treatment outcomes are enhanced when collaborative support is provided.

Flexible service delivery

In working with pregnant and at-risk women who use substances, "one size" clearly does not "fit all." The "standard" approach to substance use treatment (which often includes residential treatment followed by outpatient programming) is not a viable or effective option for some women. While some in the research project did follow that path, successful outcomes sometimes required alternative methods of treatment delivery. By working closely with the women and the community service providers that support them, as is done in ESW, individualized treatment planning that incorporates a variety of service options is possible. Offering clients the option of treatment in an outreach location, by telephone, or in a one-on-one office appointment allows them to feel comfortable in their treatment plan and potentially be more successful in achieving their treatment goals.

Conventional service delivery models do not effectively meet the needs of this target group. This population requires individualized and flexible treatment components that address the health and social determinants that are known to be linked to the prevention of fetal alcohol spectrum disorder (FASD) and other harm caused by substance use.

Being flexible in delivering service also means acknowledging the specific sex and gender differences of clients. Outreach, outpatient and residential treatment services that recognize the different ways that sex (biological) and gender (social) differences influence substance use onset, consequences and recovery, assist clients of both sexes in effectively working with their own substance use issues.

Harm reduction

While abstinence is generally the preferred goal for substance users, some may not be ready or willing to commit to that goal. Some may want to try a harm reduction approach in their substance use, where they continue to use but try to reduce the harm related to using.

The harm reduction approach assists clients in reducing the risks associated with substance use if they choose to continue using. Harm reduction typically includes a non-judgmental approach, takes one step at a time, celebrates a variety of successes on a broad continuum of possibilities, and is connected to the holistic approach addressed earlier. Service providers who subscribe to the harm reduction philosophy demonstrate their commitment to allowing clients to set their own goals regarding their addiction and accept that achieving harm reduction goals may lead clients to consider long term abstinence goals.

Motivational interviewing

ESW service co-ordinators work with clients at whatever stage they are in in their recovery process and use motivational interviewing in those interactions with clients. Findings from this research project demonstrate that motivational interviewing (Miller and Rollnick, 2002) is an effective method for providing services to this population of women. Here again we find that clients respond well to treatment approaches that are centred on where they are in the moment, not what is expected of them either now or in the future. For further explanation of motivational interviewing (and the stages of change) please see Appendix 5.

Recommendations

Disseminate the findings of this research project

This research project describes effective service methods for working effectively with special populations. Broadly disseminating the findings to health and social service providers, planners, and policy makers will assist those who work directly or indirectly with these populations.

Continue training and support to community service providers

AADAC continues to gather valuable information about working with marginalized populations through research and by consulting staff whose knowledge is acquired in their work with clients. By supporting and training other service providers, AADAC can help its own staff and that of other organizations to offer the best possible service to the clients that are most difficult to reach.

At present, ESW service co-ordinators provide this training and support in addition to their work with clients. They provide training regarding AADAC's Help Kit and offer training to other service providers who work with women who use substances. To address the gap in service felt by women leaving ESW service and the need to develop a common sensitivity among all service providers, training and support could be offered to non-ESW service providers in AADAC (in both urban and rural locations) and other service providers who work with women with substance use issues, including health-care providers and child protection agency workers.[14]

Maintain and possibly expand ESW service

At present, ESW services are only offered in Calgary, Edmonton and Grande Prairie. The effectiveness of the service in these major centres indicates the need to maintain ESW's current framework for service delivery in these cities. Because this type of service may be beneficial to clients outside the cities ESW currently services, expansion could be considered to other locations in the province.

Expand the service network that ESW connects to

The service network that ESW service co-ordinators link together offers a multitude of services to women in their communities. The description of this network indicates that it consists of services that offer more planned, more

[14] The Help Kit is an AADAC resource package designed to help community professionals to better screen, intervene and refer pregnant women to treatment programs. It includes a guide, a video, posters, information on services for women at AADAC, and information on substance use and pregnancy.

long-term support. What appears to be missing from this network are the more crisis-oriented services or services that have the potential to act as filters into the service network such as food banks, emergency units, mental health system, or legal services.

Exchange knowledge between teams that work with marginalized populations

Within AADAC, there are teams of service providers that work with marginalized populations and have developed an understanding of effective practice. These teams could discuss what they have learned and collaborate to develop a promising practice document for service providers who work with marginalized populations.

Continue to support gender-specific programming

As noted previously, implementing substance use treatment programming that recognizes the sex and gender differences of clients is part of the flexible service delivery that has been shown to be effective in this marginalized population. Men and women function differently in treatment settings and their function can sometimes be altered by the presence of the opposite sex. By recognizing that this can occur, and that men and women may have different issues and means of expressing their issues, each is more supported in receiving effective addictions treatment.

Collaborate with community partners on housing issues

Clients and service providers noted a deficiency of suitable housing options in Edmonton, Calgary, Grande Prairie and surrounding communities. Not only is there a lack of low-cost or subsidized housing, they also commented on the lack of supportive housing. Because some of AADAC's clients are among those who require these housing opportunities, AADAC could support community partners in their development of appropriate housing alternatives by offering its expertise in supporting individuals who have substance use issues.

Collaborate with partners to develop innovative models of addiction services

This research demonstrates that innovative approaches with a focus on issues particular to women are highly effective in helping ESW clients achieve positive outcomes. Two potential future projects that might build on these innovative ideas include residential treatment incorporating childcare, and the creation of specialized addiction services.

Residential treatment incorporating childcare

This research suggests a need for the review and development of alternative residential treatment models, including those that take into consideration the childcare needs of women in treatment. Aventa, a residential treatment facility for women in Calgary and an agency funded by AADAC, could offer its expertise and practice wisdom in discussions regarding any change to residential treatment principles. AADAC, in collaboration with other residential treatment services, is in a good position to take the leadership role in reviewing and developing alternative residential treatment models, including those that incorporate children.

The creation of specialized addiction services

Future addiction health services could follow a model similar to the British Columbia Women's Hospital and Health Centre in Vancouver, which offers national leadership in meeting the complex health needs of women who use substances. From clinics for women's general health to prenatal care to a specialized birthing unit, B.C. Women's Hospital is sensitive to, and knowledgeable about, the unique requirements of women who use substances.

In collaboration with Aventa in Calgary, AADAC is a recognized leader in substance use treatment for women in Alberta. It would be valuable if AADAC were represented in the program planning process for the Lois Hole Hospital for Women in order to ensure that the complex and specialized needs of all women, including pregnant women who use substances, are addressed from the outset.

Collaborate on policy and programming with child protection agencies

Because ESW clients have high rates of involvement with child protection agencies, there is a need to develop a common understanding of the needs of each organization (AADAC and the child protection agencies) with regard to the outcomes their clients should achieve and how they should achieve them. Working collaboratively at the policy and program development levels with child protection agencies in Alberta can ensure that areas of mutual concern are addressed.

To foster understanding among service providers, ongoing AADAC Help Kit training to front line and administrative personnel in Alberta's child protection agencies could prove valuable in light of the need to continue to train new staff. This is one way to encourage the understanding by the child protection system of the best practices for working with women who use substances.

Another method of disseminating this information is for ESW service co-ordinators to continue to develop and maintain collaborative working relationships with individual child protection workers and local offices.

Plan for and implement ongoing outcome monitoring for ESW

This research project has clearly demonstrated that, with an appropriate method, it is possible to determine the outcomes achieved by difficult-to-reach populations. The research suggests outcome monitoring with ESW clients will be most effective if the following principles are observed:

- ESW service co-ordinators are closely involved in the outcome monitoring process.
- Clients are interviewed face-to-face during their regular appointments or visits to outreach sites.
- Clients give verbal, rather than written, consent after a period of relationship building with the researcher or service co-ordinator.
- The method used is flexible, and that flexibility extends to the way in which questions are asked and at what intervals they are asked.
- The questions used are based on findings from this research study—for example, the administration of a sociogram exercise with research participants to gather information about the services women were using before and after connecting with ESW.

Outcome monitoring for 2005–2006 is underway, based on the above considerations.

Plan for flexible service delivery by other AADAC staff

The service that ESW clients receive is lost to them if they leave Calgary, Edmonton or Grande Prairie. While there is potential to maintain telephone contact with their ESW service co-ordinator, local services do not have the same mandate and therefore may not be as flexible in supporting clients as ESW service co-ordinators are. If other service providers could carry cell phones or make offsite client visits, for example, access for all AADAC clients, not just current or former ESW clients, would be improved.

Further research

Examine how to work with marginalized populations

Researchers struggled with locating and measuring the outcomes of clients who are easily lost to service. As was noted in the Introduction section of this report, researchers expected to meet with a wide variety of clients, including those who were transient, homeless, irregularly attended appointments, or were otherwise "on the fringe," but the best efforts of ESW service co-ordinators to locate these clients were unsuccessful.

Future research projects need to focus on finding these clients and developing the relationships with those clients in order to garner valuable research information. A fluid research project with long timelines is required to meet these goals.

Further research regarding ESW and other service providers

Because this was an outcomes research project rather than an evaluation, researchers did not focus on what direct effects ESW had on the outcomes achieved by clients. While it is likely that the assistance of ESW as well as community service providers contributed to the outcomes achieved, a formal evaluation is required to ascertain that information.

Program evaluation and needs assessment

Because this was an outcomes research project rather than an evaluation, researchers did not focus on what direct effects ESW had on the outcomes achieved by clients or what possibilities lie ahead for program expansion. A program evaluation and needs assessment are required to make these determinations.

Understanding the attitude and practice of other service providers

Another client that is served by ESW is the network of service providers in their community. A research project that determines the outcomes regarding any practice or attitude changes among these service providers might prove useful in future.

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Appendix 1: The Interview Process

In-depth interviews

Researchers began each in-depth interview with the following procedure:

- review of the purpose and process of the interview
- review of information letter
- discussion of consent to participate in the project, be audio-recorded and be contacted for follow-up if necessary

The participant was then asked if she would like a copy of the research report when it is available. If she wanted a copy, she was told that her service co-ordinator would contact her when the report was available and arrange for delivery.

Interviews generally lasted one to two hours. Participants received a $30 cash honorarium in compensation for their time. Participants were compensated $5 for transportation costs (return bus fare) and $10 to cover childcare costs as required.

Each individual interview was digitally or tape-recorded and transcribed into text documents for analysis.

Group interviews

Researchers began each group interview with the following procedure:

- review of the purpose and process of the interview
- review of information letter
- discussion of consent to participate in the project, be audio-recorded and be contacted for follow-up if necessary
- offer of copies of the research report when available

After an initial open-ended question asking participants to consider the changes clients had made since participating in ESW, they were asked to focus specifically on substance use and service network and changes.

In all group interviews, researchers conducted an exercise with participants to identify the services used before and after intervention with ESW. In this research project, “sociograms” were used as a diagrammatic display of interactions among individuals and services in the community. An example of a sociogram is found on page 93 of this report.

Appendix 2: Interview Guides

Research Project

Individual Interview Guide

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Interview Code[1]_____

Date _____

Location _____

Interviewer _____

Introduction _____

First of all, I want to thank you for agreeing to participate in this interview. The information you share with us will be helpful to AADAC in improving services for future clients of the Enhanced Services for Women program and across AADAC.

Second, I would like to review the purpose and process of the interview and formally obtain your consent to participate. Review information letter verbally with participant.

- ❍ Interviewee has reviewed information letter and consents to the following:
  (Check all that apply)
- ❍ Agrees to participate in the project
- ❍ Agrees to be contacted for a follow-up interview if necessary
- ❍ Agrees to audio taping the interview

Note any client questions or concerns about the research project.

- ❍ Interviewee would like to receive a copy of the report.

Interview Questions

*For this project, we are especially interested in how you are working towards your **goals (hopes for the future)** and what changes, if any, you have experienced over the time that you've had contact with the ESW counsellors.*

[1]Code protocol: interview # (in sequence), pseudonym, interview # (1 or 2). Eg., #35 Mentor 2

1. **Elicit an open-ended response first.**
   What can you tell me about your goals and changes?

   - Prompts: *Can you tell me what's different now compared to then? Can you give me a 'before' and 'after' description of yourself?*
   - Explore in greater depth any cues that participant has given about outcomes. Use participant's own words and ask them to expand and provide examples. Especially clarify words/phrases related to changes in substance use. E.g.,

     You seem pleased with the parenting changes you have made. For example, you said "I am happy that I have more time to listen to my daughter." Can you tell me more about this?

     You mentioned that "I can say NO to my friends now." How does that feel for you?

     I noticed that you seem to have cut back the number of times you go to the bar. For example, at the beginning of the interview, you mentioned that you went every day and just now you said "the last time I went was last week." Is that right?

     You told me that, when you came to ESW, you wanted to stop using cocaine. How are you doing with this goal?

     When you say that "you don't drink so much any more," what does "not so much" mean?

2. **Introduce questions specific to ESW objectives** (e.g., social supports and substance use):

   Now I'd like to ask you some specific questions that relate to the objectives of the ESW program.

   a) First, I'd like you to think about your social support system/network. We're going to do this by drawing a picture. What services are you linked up with, connected to today?

   Sociogram exercise. Encourage the participant to identify any sources of social support (offer participant choice of writing herself or researcher writing). Once participant has identified all that she can think of, use prompts.

   - health (mental and physical, including addictions and/or pregnancy services)
   - financial assistance
   - child welfare
   - violence and other women's services
   - education and employment

- housing
- corrections/justice system/legal
- cultural/ethnic services (Do you identify with any ethnic origin? Do you have any supports for this?)
- leisure
- spiritual

When did you first meet your counsellor at the ESW program? Think back to the time before this. Let's circle the supports that you had in place at that time?

Prompt: *Compare the quality of those supports between then and now.*

b) Now I'd like to ask you some questions about your substance use.

How long have you been using substances? Which ones? How much? How often?

What, if anything, is different about your substance use today?

We'd also like to understand how the ESW program has helped you reach these goals or make these changes.

1. Elicit an open-ended response first.
   What kind of help have you received from your ESW counsellor? What kind of help did you ask her for?
2. Introduce prompts specific to ESW services.
3. Of all the ways that ESW has helped you, what was the MOST helpful?

Research Project

Group Interview Guide

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Interview Code _____

Date _____

Location _____

Interviewer _____

Participants _____

_____

Introduction

- *Appreciation*: First of all, I want to thank you for agreeing to participate in this interview. The information you share with us will be helpful to AADAC in improving services for future clients of the Enhanced Services for Women program and across AADAC.
- *Introductions*
- *Purpose and process*. Review invitation and information letters. Reiterate that:
    - Not evaluating service co-ordinators or other services
    - Cannot infer that ESW caused the outcomes achieved by women
    - Cannot isolate ESW from the network of other services within or outside AADAC
    - We will list your own name, title, and agency name in the report but not identify what you actually said. However, you may be identifiable by your peers/colleagues by what you say.
- *Consent*:
- Group interviewees have reviewed invitation/information letter and consent to audio recording the interview

Interview Questions

1. Determine what kind of **contact** the participants have had with ESW service co-ordinators and ESW clients. (Round Robin)
2. Determine what kinds of **outcomes** the participants have noticed in their mutual clients during the time the client has had contact with the ESW

service co-ordinators . Solicit specific examples (caution re: confidentiality). Note: this should be from their direct experience of the clients. Three parts: (a) open (b) specific to ESW objective of increasing social supports and (c) specific to ESW objective of decreasing substance use.

(a) Open to all. Record responses on flipchart. Prompts.

Health determinants are:

- Income and social status
- Social support networks
- Social environments
- Education
- Employment and working conditions
- Physical environment
- Gender
- Culture
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment

(b) Elicit more specific information on changes to social **support systems/networks** during the time the client has had contact with the ESW service co-ordinators . Use large paper to draw socio-gram, including all support systems typically accessed by mutual clients. Use prompts as needed.

- health (mental and physical, including addictions and/or pregnancy services)
- financial assistance
- child welfare
- violence and other women's services
- education and employment
- housing
- corrections/justice system/legal
- cultural/ethnic services
- leisure
- spiritual

Using a coloured marker, ask participants to identify those that mutual clients are typically involved with *before* their involvement with ESW and compare the quality of those supports between then and now.

(c) Elicit more specific information about the **substance use patterns** of the mutual clients. What, if anything, is different about their substance use patterns, since they have been involved with the ESW service co-ordinators . Ask about changes in:

- Amount/duration/frequency
- Relapse pattern
- Access to treatment/support
- Drug choices
- How they talk about their substance use
- Alcohol/tobacco/other drugs

3. Determine how the ESW program has been **helpful**

   a. How has it helped clients to achieve these outcomes.

   b. How has it helped the participants to help the women more effectively.

   c. What is the *most* helpful aspect of the service? (write it down first, then report in a round robin)

Research Project

ESW Service Co-ordinators team Interview Guide

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Interview Code _____

Date _____

Location _____

Interviewer _____

Participants _____

_____

Introduction

- *Appreciation:* First of all, I want to thank you for agreeing to participate in this interview. The information you share with us will be helpful to AADAC in improving services for future clients of the Enhanced Services for Women program and across AADAC.
- *Review purpose and process. Reiterate that:*
  - *Not evaluating service co-ordinators or the service*
  - *Cannot infer that ESW caused the outcomes achieved by women*
  - *Cannot isolate ESW from the network of other services within or outside AADAC*
  - *We may list your own name in the report but not identify what you actually said. However, you may be identifiable by your peers/colleagues by what you say.*
  - *Consent:*
  - *Group interviewees have reviewed invitation/information letter and consent to audio recording the interview*

Interview Questions

1) Determine what kinds of **outcomes** the participants have noticed in their clients during the time the client has had contact with the ESW service co-ordinators . Solicit specific examples (caution re: confidentiality). Note: this should be from their direct experience of the clients. Three parts: (a) open (b) specific to ESW objective of increasing social supports and (c) specific to ESW objective of decreasing substance use.

(a) Open to all. Record responses on flipchart. Prompts.

Health determinantsare:

- Income and social status
- Social support networks
- Social environments
- Education
- Employmentand working conditions
- Physical environment
- Gender
- Culture
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment

(b) Elicit more specific information on changes to **social support systems/networks** during the time the client has had contact with the ESW service co-ordinators . Use large paper to draw sociogram, including all support systems typically accessed by mutual clients. Use prompts as needed.

- health (mental and physical, including addictions and/or pregnancy services)
- financial assistance
- child welfare
- violence and other women's services
- education and employment
- housing
- corrections/justice system/legal
- cultural/ethnic services
- leisure
- spiritual

Using a coloured marker, ask participants to identify those that clients are typically involved with before their involvement with ESW and compare the quality of those supports between then and now.

(c) Elicit more specific information about the **substance use patterns** of the clients. What, if anything, is different about their substance use patterns, since they have been involved with the ESW service co-ordinators . Ask about changes in:

- Amount/duration/frequency
- Relapse pattern
- Access to treatment/support
- Drug choices
- How they talk about their substance use
- Alcohol/tobacco/other drugs

2) Determine how the ESW program has been **helpful**.

a. How has it helped clients to achieve these outcomes.

b. How has it helped the participants to help the women more effectively.

c. What is the *most* helpful aspect of the service? (write it down first, then report in a round robin)

If time allows…

3) Elicit a **description** of the ESW service.

a. Who are you serving? For example, how many/what kind of clients are being reached, how many are being retained in the service, how many have difficulty connecting?

b. How are you serving them? For example, what services are provided/offered?

c. How is it shifting? How does it need to evolve?

Research Project

ESW Service Co-ordinators Additional Information Guide

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Date _____

Service Co-ordinators _____

ASIST ID# _____

Please answer these questions to the best of your knowledge. Use ASIST to review case notes if you would find it helpful.

1. Client's children (how many? age? gender?)
2. Previous pregnancies (any that did not go to full term?)
3. Placement of children/Children's Services involvement of any/all children (who has custody?)
4. To your knowledge, have any of the client's previous children been affected by her substance use (e.g., FAS/FASD)?
5. What is the client's substance use history? (what substances do you know she used? when and how long did she use each substance? how much did she use?)

Substance	When used (e.g., since 10 yrs old)	How long used (or does it continue?)	How much used (e.g., using every day?)

6. Does this client have any mental health issues?
7. What is the client's primary source of income?
8. Does the client identify herself as belonging to a particular ethnic background? If yes, which one?
9. What is the client's current housing situation?
10. What do you know about the client's previous accommodations and living arrangements?
11. To your knowledge, has the client had any street involvement? If yes, what did it entail (e.g., homeless, prostitution, etc.)?
12. What has been the client's involvement in the legal system (e.g., charges, incarceration, involvement with a parole officer, etc.)?

Appendix 3: Information Letters

Research Project

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Participant Information Letter

What is this research project all about?

We want to talk to women who have had contact with the counsellor's at AADAC Enhanced Services for Women (ESW). We want to understand your experiences with the program and especially, how you are working toward your treatment goals. We are NOT evaluating individual ESW counsellors.

Why is AADAC doing this research project?

We want to know how we're doing in ESW and to improve the services for other women.

How does it work?

We are doing one-to-one interviews with several women in the ESW program. We will have one interview session with each research participant. Each interview session will be scheduled for one hour. We may want to contact some participants again at a later time to continue the discussion or to check out some ideas that have come up.

With your permission, the interviews will be recorded so that we can capture all the information you tell us. If at any point you are uncomfortable with the recording or the interviewing, it will be stopped. If you do not want the information to be used, it will be destroyed.

To thank you for participating, we will give you $30 at the end of your interview. We may also be able to help you with the cost of childcare or transportation.

What kind of questions will I be asked?

For this project, we are especially interested in how you are working towards your goals and what changes, if any, you have experienced over the time that you've had contact with the ESW counsellors.

First, we will listen to you tell us whatever is most important to you about your goals and changes. Along the way, we will ask you questions to get a better picture of what you are telling us and to be sure that we are understanding you. Then, we will ask you some specific questions related to the objectives of the ESW program.

After that, we will ask you to share your experiences with the ESW program and what you found most helpful about the services.

Who is going to ask me these questions?

Donna Chovanec (780-427-8009) and Michele Watkins (780-644-4882) do research about women's issues at AADAC. They will be leading the project and interviewing you.

Will anyone know who told you the information?

No. We are legally bound by confidentiality agreements not to reveal any information about you. We will NOT give any information about what you said to your ESW counsellor or to anyone else. Your name or any other information that could identify you will NOT be included in written materials or on the audio recording. Only the project researchers (Donna and Michele) and the person who transcribes the interviews will hear the interviews and see the transcripts.

However, we are required by law to report abuse or risk of abuse to children, or if you or someone else is in imminent danger.

How is my information going to be used?

You will never be identified in the study. However, your words may be used as quotations in the written report. We will also report on general themes that we hear from all the participants.

We would be happy to send you a copy of the final report when the project is complete.

What if I change my mind about participating?

We respect any choice you make about your participation in the project. Even if you agree to participate in the research project, you can withdraw at any time. You can also refuse to answer any question that makes you feel uncomfortable. Your decision of whether or not to participate will not affect your access to services at AADAC or in ESW. We hope you continue to use the AADAC and ESW services that are helpful to you.

What if talking about this makes me upset?

We encourage you to contact your ESW counsellor if you want to talk about any feelings or concerns that might come up as a result of the interview.

What if I have more questions? How do I get more information?

You can contact your ESW counsellor or her manager.

You can contact the researchers directly.

Donna Chovanec (780-427-8009) or Michele Watkins (780-644-4882)
You can contact the research manager.
Susan Hart (780-422-1249)

Thanks for your interest in this research project.

Research Project

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Invitation to an interview with Community Partners

Date _____

Time _____

What is the purpose of the group interview?

Building on the existing AADAC Enhanced Services for Women (ESW) outreach service, we are conducting a qualitative research project. For this project, we are especially interested in the outcomes women are achieving. For example, how women are working towards their goals and what changes, if any, they have made over the time that they've had contact with the ESW service providers.

You have been invited to this group interview because your work in a community agency brings you into direct and sustained contact with the ESW service providers and your mutual clients. We want to talk to you about your perceptions about how the women served by ESW are achieving their goals and in what ways you feel that ESW has facilitated these changes.

We are not evaluating individual ESW service co-ordinators . Nor are we evaluating any other AADAC or community services.

Who else is invited?

We have invited a small number of community agencies that serve at-risk/pregnant women who use substances, and that have ongoing contact with the ESW service providers and their mutual clients. We have specifically invited people who can confidently describe the outcomes achieved by the women served by ESW.

How do I get more information?

Please see *Information for AADAC Staff and Community Partners* (attached) for more detailed information about the project.

As well, you may contact the project researchers, Donna Chovanec (780-427-8009) or Michele Watkins (780-644-4882), the AADAC Research Manager Susan Hart (780-422-1249), or the ESW service co-ordinators .

We will be happy to send you a copy of the final report when the project is complete.

Thank you for your interest in this research project.

Research Project

Women working toward their goals through AADAC Enhanced Services for Women (ESW)

Information for AADAC Staff and Community Partners

What is ESW?

Through the Enhanced Services for Women (ESW) initiative, AADAC provides enhanced treatment services to at-risk/pregnant women using substances. The service is delivered by ESW service co-ordinators in Edmonton, Calgary, and Grande Prairie.

The program goals are:

1) To enhance AADAC outreach into the community in order to
    - better reach and provide addiction service to at-risk/pregnant women who use substances.
    - increase access and linkages for these women to existing AADAC and Funded Agency services as well as to other support services in the community.
2) To strengthen the AADAC and Funded Agency service system to better meet the needs of at-risk/pregnant women entering the treatment system, while in the system, and following discharge.

What is this research project all about?

Building on the existing ESW outreach service, we are conducting a qualitative research project with the following objectives:

- Determine the short-term outcomes of the ESW program for the target group.
- Investigate a more effective and efficient method of tracking ESW outcomes in the future.
- Enhance programming.
- Contribute rich information about women, substance use, and treatment that will be useful for others working with at-risk/pregnant women who use substances.

We are talking to women who have had contact with the counsellor's at AADAC Enhanced Services for Women (ESW) in order to understand their experiences with the program and especially, how they are working toward their treatment goals. We are not evaluating individual ESW counsellors. Nor are we evaluating any other AADAC or community services.

We are also conducting group interviews with our community partners—other community agencies that serve at-risk/pregnant women who use substances, that refer women to AADAC, and to which ESW refers women. We may also do a group interview (teleconference) with some AADAC staff.

How does it work?

During October and November, we will be doing one-to-one interviews with several women who are current or former clients of the ESW program. We will have one interview session with each research participant. Each interview session will be scheduled for one hour. We may want to contact some participants again at a later time to continue the discussion or to check out some ideas that have come up. With the participant's permission, the interviews will be recorded. The participant will receive a $30 honorarium at the end of the interview. We may also be able to assist with the cost of childcare or transportation.

What kind of questions will be asked?

For this project, we are especially interested in the outcomes women are achieving. For example, how women are working towards their goals and what changes, if any, they have made over the time that they've had contact with the ESW counsellors. First, we will ask the participant to share whatever is most important to her about her goals and changes. Then we will ask some specific questions about the primary objectives of the ESW program. Finally, we will ask her to share her experiences with the ESW program and what she found most helpful about the service.

Who is going to ask these questions?

Donna Chovanec (780-427-8009) and Michele Watkins (780-644-4882) do research about women's issues at AADAC. They will be leading the project and conducting the interviews.

Will anyone know who told us the information?

No. We are legally bound by confidentiality agreements not to reveal any information about the participant to anyone. Only the project researchers (Donna and Michele) and the person who transcribes the interviews will hear the interviews and see the transcripts. Participants' words may be used as quotations in the written report. We will also report on general themes that we hear from all the participants. However, we are required by law to report abuse or risk of abuse to children, or if the participant or someone else is in imminent danger.

What if she changes her mind about participating?

We respect any choice the participant makes about her participation in the project. Even if she agrees to participate in the research project, she can

withdraw at any time. She can also refuse to answer any question that makes her feel uncomfortable. Her decision of whether or not to participate will not affect her access to services at AADAC or in ESW.

What if I have more questions? How do I get more information?

You can contact the researchers: Donna Chovanec (780-427-8009) or Michele Watkins (780-644-4882)
You can contact the research manager: Susan Hart (780-422-1249)

Appendix 4: Network of Support

Table 1

Addictions	Child-related	Education/ employment	Physical/ mental health	Cultural/ recreational/spiritual
detox	day care		public health units	immigrant services
treatment	family/child		doctors/dentist	Native services
self-help	prenatal		hospitals	church groups
mentoring programs			reproductive health	recreation centres
			counselling	

Housing	Other professional	Personal	Crisis-related	Community
subsidized	financial	parents/ relatives	Abuse/ violence	inner-city & street-based services
supported	legal	children	shelters	Grassroots/ community-based
		unborn child	phone lines	
		non-using friends		

Appendix 5: Motivational Interviewing and the Stages of Change

Motivational interviewing and the stages of change

By Nancy Poole

Counselling methods described by the clients, community service providers, and the ESW team in this research project clearly reflected the practice of "motivational interviewing." Furthermore, the participants reported numerous benefits of using the motivational interviewing approach and clients were satisfied that this counselling approach contributed to their outcomes. This section contains a description of the method and the theory behind it.

In recent years, research on effective approaches to working with those with substance use and related problems has found support for a "change-based" approach (Prochaska, Diclemente and Norcross, 1994). Understanding the process of change and how to discuss change with clients can be the foundation of a practical, women-centred and empowering approach to engaging and counselling women such as the ESW clients.

In the past, counsellors assumed that the woman was ready to take action on the behaviour(s) she needed to change. However, research shows that the majority of those who need to change high-risk behaviour are not yet prepared to take action. A *model of change* first developed by Prochaska, DiClemente and Norcross (Prochaska et al., 1994) provides a useful framework for working both with women who are ready to change, and those who are not. Rather than focus on the problem (such as the substance use) and all the factors that reinforce it, this model focuses on the change process itself.

Following up on this model, Miller, Rollnick, DiClemente and others developed counselling strategies to support intrinsic motivation for change, which lead clients to initiate and persist in their efforts to change (Miller et al., 2002). Miller and Rollnick define motivational interviewing as "a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller et al., 2002, p. 25).

In motivational interviewing, motivation to change is *elicited from the client*, not imposed from without. The counsellor's stance supports exploration of the client's views and ambivalence. This involves providing space for clients to reflect on their experience and to be listened to. As well as an active listening stance, in some instances, the counsellor takes the role of interested teacher/guide who supports clients in learning about their options and strategies for change.

In motivational interviewing practice, direct persuasion and proscribing of a course of action is understood to have the impact of increasing client resistance. It is tempting in the context of substance use and pregnancy to see persuasion about the urgency of the problem and about the benefits of change as helpful. This approach not only may increase client resistance, but in turn may reduce the probability of change or push clients to make changes for which they are not ready. Resistance and "denial" are seen not as client traits, but as a signal that the counsellor is assuming greater readiness to change than is the case, and it is a cue that the therapist needs to modify their approach.

In motivational interviewing practice, the therapeutic relationship is more like *a partnership or companionship* than expert/recipient roles. The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behaviour.

Supporting *self-efficacy* is a key principle of motivational interviewing. It is important to support clients to believe that they can create positive change in their lives and, specifically, that they have the capacity to change their alcohol/drug-related and other behaviour. This principle is about the importance of hope. An individual is more likely to engage in a process of change if they believe it is possible and if they can envision positive outcomes in their lives.

In sum, the change orientation and motivational interviewing practice help counsellors to:

- focus on supporting *self change* versus asking a woman to rely on a prescribed plan of change by "experts"
- really “allow” the woman her own decisions about her life and the space to make these decisions in her own time framework.
- focus on *making change* versus on the problem (e.g., the alcohol and drug use)
- focus on the stage *where the woman currently* is, leading to successful action in the long term, rather than using a uniform, action-oriented approach which doesn’t support lasting change from a firm foundation
- tailor the approach to be most effective with the stage the woman is in, which helps both the woman be successful and for counsellors to feel more effective
- not “lose” women through pushing for change for which they are not ready

Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

For more information, contact your local AADAC office,
call 1-866-33AADAC or visit our website at www.aadac.com

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