

FASD Prevention

Taking a relational approach: the importance of timely and supportive connections for women

This information sheet has been prepared for decision makers, health system planners and service providers interested in improving care for women at risk of having a child affected by Fetal Alcohol Spectrum Disorder. It has been prepared by members of the CanNorthwest FASD Research Network's Action Team on FASD Prevention from a Women's Health Determinants Perspective. This sheet describes the rationale for multi-faceted relational approaches, and extended timeframes for engagement and support, and finishes with ten recommendations for improved care that have implications for policy, system planning and practice.

Background

Pregnancy is often described as an opportune time for service providers to support women in improving their health, including efforts to decrease or stop substance use. However, a number of factors prevent pregnant women, particularly those most marginalized, from seeking out support and treatment. For marginalized women who do access care, entry into treatment is often delayed and attrition rates are high.

The lives of women with substance use problems are often very difficult, requiring attention to myriad interrelated issues, such as: current and/or historic experiences of violence and trauma, poverty, mental ill health, polydrug use, malnutrition, housing difficulties, and physical health problems. Underlying these issues is often a lack of connection to an established support system that can help women respond to existing and presenting challenges. Additionally, multiple barriers to care often influence women's abilities and desires to access support [1-3]. Given the depth and scope of these interconnected barriers and challenges, Fetal Alcohol Spectrum Disorder (FASD) prevention cannot be accomplished using reductive approaches that focus solely on achieving abstinence from alcohol. Rather, FASD prevention requires multifaceted responses focused on addressing the many interrelated issues and barriers to care that directly influence women's and children's health [1, 4-10].

Literature concerning the effectiveness of various interventions related to maternal substance use remains scarce. However, some Canadian service models are garnering attention for their successes. These programs are successfully engaging pregnant women, improving women's health, and reducing adverse outcomes and risks associated with prenatal alcohol and other drug exposure [11-16]. The common themes among these successful interventions is their focus on the nature of the therapeutic relationship between a woman and her service provider, and that they provide multiple opportunities for early engagement and intervention. The success of these programs highlights promising directions for women's care and treatment.

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Engagement with services is most likely to occur in an environment that is welcoming, respectful, and non-judgmental. Women consistently report that they need a supportive service environment that responds to their critical and emergent needs in a timely manner; this is what encourages women to return to services and make positive changes in their lives [8, 11, 16-20]. Service settings that

attend to women's culture, and environments where staff share some characteristics of the women they serve (such as language, ethnicity, culture, or age), also encourage women to engage with the services.

Offering women assistance with their basic needs—such as food, nutritional supplements, a safe place off the streets, bus tickets, and childcare—creates a foundation for building a relationship, thereby initiating the process of engagement [4, 19, 20].

Relational Opportunities

A wide range of relationships have been identified as significant in influencing a woman's engagement and retention in services, as well as in improving health and related social outcomes for women and their child/ren.

Relationship between a woman and a service provider

It is commonly believed that it is a woman's initiative, desire, and perseverance that most strongly influence her engagement, retention, and success in recovery. While this is in part true, women reveal that the support of a caring, respectful, accepting, patient, encouraging, inspiring, and empathetic service provider is pivotal in determining the course of their treatment choices [3, 8, 19, 21-23]. Honouring women's self-determination and capacity for change; building on strengths; and supporting women to address shame and guilt, the loss of control over their lives, and their mistrust of systems, are all beneficial in establishing a trust-based connection [4, 8, 15, 24]. For women who have been influenced by violence and trauma, building trust with services providers takes time. Growth-promoting relationships such as these allow women to regain or establish trust in service providers, and ultimately results in positive engagement with services. A recent study of outcomes associated with attendance at a mother mentoring program demonstrated that it takes an average of 9–12 months for women to build trusting relationships with service providers [25]. In residential treatment, studies reveal that the first two days of engagement are critical in determining whether women will complete treatment [26]. Clearly, the initial encounter with service providers, and service providers' ability to establish rapport, is critical in determining a woman's engagement in care [27-29].

FASD prevention is often fetus-centred: focusing primarily or solely on reducing the fetal risks associated with prenatal alcohol exposure [1]. For many women, such an approach implies that their health is only important when they are pregnant. When a service provider shows a commitment to working with a woman to improve her health and well-being, rather than focusing solely on the pregnancy, the provider sends a powerful message that the woman herself matters. In fact, research shows that a woman's perceptions of her counsellor's concern with her well-being are

closely associated with improved engagement, and increased length in stay, in both residential and outpatient treatment settings [2, 9, 16, 19, 22, 27, 30, 31].

Relationships between service providers

Whether it is a multidisciplinary team working out of one location, or a network of providers working in partnership across agencies, evidence indicates that a collaborative approach results in improved client retention and outcomes, as well as improved program effectiveness [5, 11, 20]. Programs that support a multidisciplinary approach allow a variety of providers and strategies to be available to women. This increases chances that women will successfully engage with a provider and/or facility from which to access services. Service providers observe that interagency partnerships reduce the chances of a woman experiencing disconnection in the referral process. Furthermore, recognizing and respecting that readiness to change is a dynamic state, a broad and flexible continuum of care can support women entering, re-entering, and completing treatment.

Interagency collaboration between prenatal care, addictions services, and child protection services are crucial in supporting positive outcomes for both women who use substances and their

children. Pregnancy is taken by some to be an important opportunity for women to enter treatment. But it is also a time when many women will be most reluctant to access supports, due to their fears that if they disclose they use substances their child/ren will be apprehended. As such, opportunities to encourage and support women's health and well-being are lost because women do not feel they can trust service providers. Women are encouraged to stay connected to services that employ a collaborative and strengths-based approach to supporting pregnant women who use substances. In so doing, women can benefit from the interagency collaboration of services, ideally with a care provider brokering relationships that can minimize the risk for child apprehension [28].

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Relationships between a woman and her peers

Programs that offer opportunities for women to form new relationships can reduce their feelings of isolation. This is particularly important for women who are in recovery and are seeking to make new friendships that are not associated with their previous lifestyle [32]. Women remain in treatment for longer periods of time when they stay in residential drug treatment programs where they are encouraged to foster relationships with other women [32, 33]. In addition, services that offer opportunities for ongoing female peer support following

treatment find that women transition more successfully out of treatment and maintain continued focus on their goals [28].

Relationships between a woman and her child(ren)

Women who have substance use problems as well as parenting challenges are frequently motivated to access services out of a desire to enhance their parenting capacity and improve their relationship with their children. Treatment approaches based on strengthening the mother–child bond and developing parenting skills have been found to engage, retain, and improve treatment outcomes for pregnant and parenting women [3, 7]. When mothers and infants are supported to stay together postpartum, in a way that is safe and supportive of both, developmental gains for “at risk” infants and developmentally appropriate progress for children result [9].

The Timing of Care

Positive outcomes are also associated with timing of care: timing of initial contact, duration of engagement, and length of stays are all connected to positive outcomes consistent with a relational approach to care. Early engagement (i.e., connecting with a woman within the first two trimesters of pregnancy), length of contact with services, and longer stays (in residential treatment settings) are all associated with successful outcomes, including stabilization, reduction in frequency and quantity of substance use, reductions in prenatal substance exposure, longer periods of abstinence, and shorter and less frequent relapses.[3, 14-16, 20, 31, 33, 34]. Longer contact with services has also been shown to enhance parenting capacity, improve maternal physical and mental health, and reduce criminal behaviours [9, 16, 20, 22, 26].

A woman’s early engagement and retention in services is also associated with improved outcomes for her child/ren. Improved outcomes include things such as: lower rates of infant mortality, fewer birth complications, higher birth weight, greater likelihood of full term babies, fewer infant health problems, fewer separations from mothers, fewer developmental delays, and decreased incidence of FASD diagnosis [3, 4, 10, 14, 18, 26, 34-36]. These outcomes are further improved in situations where a woman’s health and social conditions enable her to create a safe and supportive home environment for herself, her child/ren, and her family.

Service mandates differ in that some provide a continuum of care throughout various stages of a woman’s life, while others are shorter-term in nature. It is important to recognize that opportunities exist for making connections at all stages of a

woman’s life. The following periods have been identified as opportune to support women and reduce the harms associated with problematic substance use.

Preconception

Investing in women’s health and well-being, whether or not a woman intends to become pregnant, sends a message that women are deserving of care. Maintaining an open, respectful, and ongoing relationship with women in the preconception period provides the opportunity for education and meaningful discussion. Physicians, community health nurses, outreach workers, campus-based health centres, and pharmacists can serve an important role in starting these conversations. For example, discussing and providing options for birth control can reduce the incidence of unintended and unwanted pregnancies—an essential strategy for preventing alcohol exposed pregnancies [1, 37, 38].

Prenatal

For some women pregnancy is a time of optimism; for others it is a time of increased stress and difficulty. For pregnant women who use substances engagement in prenatal care is often delayed, especially for those women whose pregnancies were unplanned. Even when women who use substances do access prenatal care, they are typically not ready to immediately address their substance use. Moreover, some women may feel ambivalent about their pregnancy, particularly early on.

Therefore, it is recommended that health care providers focus primarily on the woman’s health and well-being. Women at this stage of pregnancy may be challenged to come to terms with the effects that substance use may have on the fetus. Reinforcement of the benefits that overall improved health can have on the health of a fetus can be helpful and motivating to women.

Employing a flexible and harm reduction approach when supporting a woman who is pregnant and using substances is essential to retaining her in care. Also critical to success are flexible policies related to access, respect for women’s presenting and emerging needs, accommodation of absences, and not requiring abstinence as a condition of services.

Outreach provided by mentoring programs and home visit programs, has demonstrated success in reducing internal and external barriers, engaging women, and improving outcomes [2, 13-16, 21, 34, 36, 39, 40]. In these programs, regular and frequent contact provides opportunities to build trust and strengthen the relationship between the woman and service provider. Pregnancy outreach programs have been successful in engaging

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traditionally underserved women in services at earlier stages of pregnancy [35]. The positive impact of early engagement and intervention, where providers can begin to build a relationship with women, introduce information on health and resources in the community, and provide nutritional supplements, is well established [4, 8, 14, 15, 19, 23, 41].

Post-partum/Early mothering

To assist in preventing relapse, or escalated use, it is essential to support new mothers in maintaining the positive changes they made during their pregnancy. This is also a time when women who were not able to make changes to their substance use become disconnected from services, resulting in missed opportunities for care [27, 42, 43]. It is important to continue to support women whose children were apprehended at birth, as they are more likely than women who retain custody of their children to relapse or escalate their use. Research shows that ongoing engagement and comprehensive support for at least three years postpartum are crucial for mothers who continue to use substances, and for birth mothers of children affected by FASD [44]. Also vital in this period are discussions of birth control—to reduce the risk of prenatal alcohol exposure in another child—and practical support for parenting, early childhood development, and positive attachment between a woman and her child/ren.

Outreach during the postpartum and early mothering period can also provide opportunities for the service provider to ensure that the woman's and child/ren's basic needs are being met. For some women the postpartum period is also a time when they may be more willing to enter and remain in treatment—their newborn baby and custody of other children being key incentives for wanting to make positive changes [2, 44].

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FASD diagnosis and intervention

Whether children are living with their birth mother, or in foster care, long-term stability reduces the risk of adverse outcomes and tends to result in fewer psychological problems [19]. Early diagnosis can also help reduce stresses and potential problems within families by increasing understanding of a child's needs and bringing a disability-informed approach to supportive care. Providing a safe, welcoming, and respectful environment where women can bring their children who have had prenatal alcohol exposure to see a clinician can result in earlier FASD diagnosis and intervention. When a diagnosis of FASD is made, every

effort should also be made to reach out to the birth mother to ensure that she has access to supportive care that will decrease the likelihood of future substance-exposed pregnancies.

Post treatment aftercare

To maintain the changes made in treatment, continued support is critical, particularly in the development of new social networks, addressing experiences of violence and family role changes, and practicing relapse prevention strategies [4]. Insufficient aftercare is one of the main reasons for relapse. While literature is limited, what is available indicates that with integrated aftercare, including paraprofessional support and advocacy, many women are able to sustain recovery and decrease the number of subsequent alcohol exposed pregnancies [7, 36]. Ongoing contact with providers, and referrals to community agencies, can help women stay focused on their goals.

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Recommendations

1. Take a relational approach to service delivery in services for pregnant and parenting women whose children are at risk of FASD. Model relationships based on equality, empowerment, and respect.
2. Offer flexible, individualized timelines for program completion, because short timelines are usually not compatible with women-centred and relationship-based approaches to care, and may undermine gains made by women during their engagement with services.
3. Offer comprehensive services reflective of the complexity and diversity of women's lives and the social context of women's substance use. Cross-sectoral, interagency, and intra-agency collaborations can better meet the needs of women and their families. Consider assisting women with meaningful options for meeting basic needs (such as safety, housing, and food security) before expecting changes in substance use.
4. Employ strengths-based approaches to care in prenatal care, addictions treatment and child protection services, approaches that demonstrate belief in women's potential to mother. Offer opportunities for collaboration between service providers and women around safety, treatment planning, and goal setting, and be transparent in addressing child protection concerns.

5. Foster growth-promoting and caring relationships with service providers. This can increase a woman's capacity to form secure relationships with her child/ren and with other people, strengthen the mother-infant relationship, and encourage developmental gains for at risk infants and child/ren.

6. Provide opportunities for peer support to reduce women's isolation and to encourage positive client engagement and successful transition post-treatment.

7. Focus on the initial encounter and the early days of connection and intervention in order to positively influence the degree to which a woman will engage with, and return to, a program or service.

8. Be aware that the preconception, prenatal, and postpartum periods are all important times for service providers to connect with women and build the foundation for trusting relationships. During each of these periods ensure regular and frequent contact with women who use substances, so as to increase engagement and retention in services, and thus improve maternal and fetal/infant outcomes.

9. Create more aftercare programs, and an increased understanding of the importance of post-treatment supports, to help women prevent relapse and maintain positive changes.

10. Encourage women with child/ren with prenatal alcohol and drug exposure to engage in early and regular contact with a range of services. This will facilitate early diagnosis and support as necessary. Supporting long-term family stability for children can improve outcomes and decrease the risk of secondary disabilities.

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The Network Action Team on **FASD Prevention from a Women's Health Determinants Perspective** links researchers, service providers, and policy advisors to build upon the current knowledge base of Fetal Alcohol Spectrum Disorder prevention.

We welcome new members in this Network. *For more information on the work of this team please contact coordinator, Shannon Pederson, spederson@cw.bc.ca or go to www.canfasd.ca*

