

Network Action Team 4: Evaluation of FASD Mentoring Programs



Experiences of Women Involved with Mentoring: Summary of Activities 2011-12

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The Experiences of Women Involved with Mentoring:

Summary of NAT 4 Research Projects 2011-12

**Canada FASD Research Network
Network Action Team 4**

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Mentoring Programs**

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TABLE OF CONTENTS

1. INTRODUCTION	5
2. NETWORK ACTION TEAM 4 2011-2012 WORKPLAN	6
3. LITERATURE REVIEW	6
FASD Prevention Through Mentoring	6
Women and Alcohol Use: Patterns and Trends	7
Differing Effects of Alcohol on Women and Men	9
Women and Alcohol Use During Pregnancy	10
Contextual Factors for Problematic Alcohol Use During Pregnancy	12
Mentoring Women with High Risk Alcohol Use for Prevention of FASD	21
Over-Representation of Aboriginal Women in Alcohol Misuse Studies	23
4. MENTORING PROGRAMS IN CANADA	25
5. CHARACTERISTICS OF WOMEN WHO HAVE COMPLETED A MENTORING PROGRAM	26
Study Findings	28
Conclusion	31
6. HEARING THEIR VOICES: THE EXPERIENCES OF WOMEN IN MENTORING PROGRAMS	33
Study Findings	35
Phase 1: Engagement with the Program	36
Phase 2: Discoveries Through Mentoring	27
Phase 3: Changes and Transformations	47
Phase 4: Life After Mentoring	49
Discussion and Summary	53
Recommendations	61
7. CONCLUSION	62
8. REFERENCES	63
9. APPENDICES	
Appendix A: Letter of Invitation	72
Appendix B: Consent Form	74
Appendix C: Interview Guide	78

THE EXPERIENCES OF WOMEN INVOLVED WITH MENTORING: SUMMARY OF NAT 4 RESEARCH PROJECTS 2011-12

Canada FASD Research Network Network Action Team 4: Evaluation of FASD Prevention Mentoring Programs

1. Introduction

The Canada FASD Research Network (formerly the Canada Northwest FASD Research Network) is a collaboration of formally and informally connected professionals from a range of research sciences who are currently located across western and northern Canada. The aim of the Research Network is to create and sustain a collaborative partnership that produces research leading to the prevention of Fetal Alcohol Spectrum Disorder (FASD) and significant improvement in the lives of individuals affected by FASD, their families and communities. Known as the CanFASD Research Network, we conduct our work through several Network Action Teams (NATs) under the leadership of Dr. Sterling Clarren, scientific director, and Dr. Jocelyn Cook, Executive Director.

The overall purpose of the CanFASD Research Network is:

- To build a sustainable research network;
- To build research capacity and knowledge across and within all communities;
- To identify priority research questions and themes relating to FASD policy and practice; and
- To develop comprehensive and culturally appropriate prevention, surveillance, diagnosis and intervention research programs to answer research questions in ways that can be understood, utilized and applied.

There are five Network Action Teams, each focusing on a different aspect of the issue of FASD. NAT 1 is centred on research in the area of FASD diagnostics, while NAT 2 is examining interventions to mitigate the impact of FASD. NAT 3 is attending to public health and education campaigns that aim to raise awareness about the effect of prenatal alcohol exposure and prevent incidence of FASD. A second prevention research team, NAT 4, is evaluating the impact of mentoring supports for women with high risk substance use concerns who may be at risk of having a child with FASD. The final group, NAT 5, is examining the social determinants of women's health that affect women's substance use. This report outlines the work of NAT 4, pertaining to the experiences of women involved with mentoring programs to prevent substance use during pregnancy and the risk of giving birth to a child with FASD.

NAT 4 initiated its work in June 2010 and its first year of work was summarized in the report *Establishing a Research Agenda: Summary of NAT 4 Activities 2010-11* (available at: http://www.canfasd.ca/files/PDF/NAT4_EstablishingResearch_Agenda_FinalReport2010-11e.pdf). The main activities of that inaugural year of work included the development of a literature review, a forum with mentor program coordinators mainly from mentoring programs from Manitoba and Alberta styled on the Parent Child Assistance Program (PCAP) originated in Seattle, a survey of PCAP programs in these two provinces, the identification of research themes for future research partnerships with mentoring programs, and the creation of a research program of study for 2011-12. This report summarizes the two main research projects that were undertaken by NAT 4 in the past fiscal year.

2. NAT 4 Workplan 2011–12

The workplan for NAT 4 in the 2011-12 fiscal year consisted of three components. The first was the development of an inventory of mentoring programs for women with high risk substance misuse issues, an ongoing activity that will continue throughout the 2012-13 fiscal year. The second was a small quantitative study examining the characteristics of 100 women who had completed a three-year mentoring program in either Alberta or Manitoba, utilizing existing data collected by mentoring programs, to better understand what data is collected, how it can be used to tell part of the story of the experiences of women in mentoring programs, and how such data collection can inform service delivery. Finally, the third component was a qualitative research project involving interviews with ten women in Manitoba and Alberta who had completed a mentoring program for high risk substance misuse. This report focuses on the results of the quantitative and qualitative studies.

3. Literature Review: FASD Prevention Through Mentoring Women

Fetal Alcohol Spectrum Disorder (FASD) is a condition caused by prenatal exposure to alcohol, and it is considered to be a condition that can be prevented. Mentoring is viewed as one of the most effective interventions to assist women with high risk alcohol misuse issues in altering the life circumstances that create risk to themselves and to their children, who are vulnerable to being born with Fetal Alcohol Spectrum Disorder (FASD). Consequently, mentoring programs have been established in many communities in northwestern Canada in response to the need to more effectively engage women in recognizing the dangers of alcohol use during pregnancy. Many Canadian programs are based on the Parent Child Assistance Program (PCAP) that was developed in Seattle in the 1990s.

The range of physical and developmental problems in children who are exposed to alcohol *in utero* has been a matter of increasing concern to Canadian and global health authorities for over forty years. In the North American literature, the basic features of the syndrome were first described in 1973 by David Smith and his colleagues (Jones, Smith, Ulleland, & Streissguth, 1973). Smith dubbed the condition ‘fetal alcohol syndrome’ (FAS). The more broadly-based umbrella term, Fetal Alcohol Spectrum Disorder (FASD), has become the

accepted term used to generally describe the spectrum of physical, cognitive, and behavioural characteristics seen in children affected by alcohol exposure before birth (Public Health Agency of Canada, 2004), which includes (a) FAS; (b) Partial Fetal Alcohol Syndrome (pFAS); (c) Alcohol-Related Neurodevelopmental Disorder (ARND); and Alcohol-Related Birth Defects (ARBD).

Over the years, much has been learned about the complexity and seriousness of FASD, and it has become clear that symptoms are not uniform but rather vary in severity between individuals on a spectrum. Further, the deficits in brain functioning caused by alcohol exposure before birth are permanent and cannot be reversed. They have lifelong consequences for affected individuals and can require complex care (Chudley, Conry, Cook, Looock, Rosales & LeBlanc, 2005). Impulse control and attention problems act as obstacles to academic success, which can prove to be debilitating to the self-esteem of children, especially when combined with the social difficulties that often accompany FASD. Due to the confluence of these difficulties, individuals with FASD are at increased risk of becoming involved with the law in their adolescence and adulthood (Mitten, 2004). The non-reversible nature of FASD and the debilitating effects of this disorder, as well as the costs of providing supports and services to individuals throughout the lifespan, make it very important to focus efforts on prevention. Often, prevention programs aim to understand the experiences of women who struggle with substance misuse and assist them to refrain from substance use during pregnancy.

Women and Alcohol Use: Patterns and Trends

Alcohol is the most widely used drug in Canada. The 2004 National Canadian Addiction Survey indicates that in the year prior to the survey, 79.3 percent of Canadians reported drinking alcohol (Adlaf, Begin, & Sawka, 2005). Surveillance data on prevalence, frequency, and level of women's use of alcohol in Canada are limited in number and in some cases have methodological weaknesses in that they involve retrospective self-reporting. Different data collection parameters make broad comparative statements difficult. Nevertheless, some large studies do exist and an overview of them in relation to alcohol use patterns by women can be useful in providing a general frame of reference to understand aspects of problematic substance use.

Prevalence and patterns of women's drinking

The *Canadian Addiction Survey (CAS): Focus on Gender* (Ahmad, Flight, Singh, Poole, & Dell, 2008) drew on the 2004 *Canadian Addiction Survey (CAS)*'s database of 8,188 women and 5,721 men over 15 years of age to provide one of the most comprehensive overviews to date of patterns of alcohol consumption by gender in Canada. The CAS gender analysis showed that approximately three quarters (77%) of Canadian females aged 15 and over reported being current drinkers (defined as drinking alcohol in the 12 months prior to the survey). Drinking patterns varied with age, province, education, marital status and income level.

Late adolescence was the peak age level for maximum prevalence of current drinking for women: 91% of 18 and 19 year olds drank in the year prior to the survey, compared to 66% of

15 to 17 year olds. Current drinking levels declined after age 55. As education level increased, so did drinking: women with a university degree had close to twice the odds of currently drinking (82%) than did those who did not complete high school (63%). Women who were divorced, separated or widowed were more likely to drink than those who were married. The province with the highest proportion of women currently drinking was Quebec, while a couple of the maritime provinces were among the lowest. Women in the highest income group were three times more likely to be current drinkers than those in the lowest income group.

CAS: Frequency of drinking alcohol

The most common frequency of drinking for women was one to three times per month (36%), Thirty-one percent of women drank less than once a month (31%), followed by 27% of respondents who drank one to three times per week. Once again, late adolescence is a peak drinking time: young women aged 18 to 19 years of age were five times more likely to drink one to three times a week than those 15 to 17 years of age (28.7% vs. 6.8%). Weekly drinking declines significantly for women 25 to 34 years of age, compared to those aged 20 to 24 (23.4% vs. 32.8%), indicating a more moderate drinking pattern for women during these childbearing years.

CAS: Heavy drinking

On average, 17% of Canadian women reported heavy drinking (defined as five or more drinks per occasion) once per month and 3% reported heavy drinking once per week. Once again, young women aged 18-24 were the most likely to drink heavily on a monthly basis (43%), compared to 28% of 15 to 17 year olds and 19% of 25 to 34 year olds. Similar patterns held for heavy weekly drinking. Marital status was also a predictor: divorced, separated or widowed women and women who were single or never married were more than 1.5 times more likely than married women or women with partners to report heavy monthly drinking.

Heavy drinking decreased in relation to completion of high school and higher education. Women with a university degree had an increased likelihood of drinking fairly lightly (one to two drinks per occasion), when compared to those with less than a secondary education (81.0% vs. 71.4%). Women with a secondary education, some post-secondary education, or a university degree were all significantly less likely to drink five or more drinks per occasion when compared to those with less than a secondary education.

In summary, the CAS gender analysis showed that more than half of women over the age of 15 drank lightly and infrequently (62.0%), almost one third drank lightly and frequently (29.2%), 5.1% drank heavily and infrequently and 3.7% drank heavily and frequently. Age, region, education, and income adequacy were predictors of women's drinking patterns. In general, as age increased in women, there was an increase in the rate of light frequent drinking and a decrease in the rate of heavy frequent drinking and heavy infrequent drinking (Ahmad, Flight, Singh, Poole, & Dell, 2008).

The Canadian Community Health Survey

The Canadian Community Health Survey, Cycle 1.1 (CCHS) reported a similar proportion of women drinkers. Seventy three percent of females 12 years or older said that they had taken alcohol at least once in the previous year and 13.3% reported they had used alcohol during their lifetime but not in the previous year. Frequency of use was variable: of current drinkers, 32.6% drank less than once per month, 13.4% drank once a month, 16.1% drank two to three times per month, 19.7% drank two to six times per week, and 4.8% drank every day (Cormier, Dell, & Poole, 2003). Heavy drinking, defined as five or more drinks per occasion, was reported to occur at least once per month for 8.3% of women. Twice as many Aboriginal women as non-Aboriginal women met this criterion (Cormier, Dell, & Poole, 2003).

Subgroup drinking patterns

Binge drinking is thought to be more harmful to the developing fetus than low-level daily drinking (Stratton, Howe, & Battaglia, 1996). An American study showed that one in eight women of childbearing age reported binge drinking during the past month (Tsai & Floyd, 2004), and Canadian research has shown that one in 10 women reported binge drinking before she knew she was pregnant (Tough, Tofflemire, Clarke, & Newburn-Cook, 2006).

Certain subgroups of women have patterns of drinking that are of particular concern: the 2004 CAS shows that high-income women were most likely to be light frequent drinkers (38.6%) and lowest-income women were most likely to be heavy frequent drinkers (9.3%) (Ahmad, Poole, & Dell, 2007). About ten percent of young women between the ages of 15 and 24 engage in heavy weekly drinking (7.8% of women between 15-19 years and 11.8% of women between 20-24 years).

Binge drinking is a risk factor for unintended pregnancy (Naimi, Lipscomb, Brewer, & Gilbert, 2003) and alcohol exposure to the fetus at an early stage. Unplanned pregnancies account for up to 82% of pregnancies among women 15-19 years old, which is the age group most likely to binge drink (Carson, Cox, Crane, Croteau, Graves, & Kluka, 2010). This conjunction of adolescent and young adult binge drinking and the high rate of unplanned pregnancies for the age group is a concern as it increases the chance of significant prenatal exposure in children of young mothers.

Differing effects of alcohol on women and men

Women are affected by alcohol differently than men. Despite having generally lower levels of alcohol use compared with men (Canadian Centre on Substance Abuse, 2004), women have a greater risk of developing alcohol-related problems (Cormier, Dell, & Poole, 2003). The reasons for this are embedded in a complex interplay of factors, including those that are biological (related to genetics and physiology), as well as those that are social and psychological such as increased risk of victimization and the effects of cultural, relational, and environmental

influences (Cormier, Dell, & Poole, 2003). In relation to physical health effects, for example, women metabolize alcohol more slowly than men so that harmful levels of metabolites remain longer in the body. Women are more likely than men to develop cirrhosis of the liver after consuming lower levels of alcohol over a shorter period of time. These impacts also apply to brain shrinkage and impairment, gastric ulcers, breast cancer, and alcoholic hepatitis (Cormier, Dell, & Poole, 2003; Parkes, Poole, Salmon, Greaves, & Urquhart, 2008).

Not only do women have a different situation from men in terms of physical health, but in mental health as well. Mental health problems intersect with misuse of alcohol and other drugs in complex ways for women, especially for women who have had a history of trauma or maltreatment. As many as two-thirds of women with substance misuse problems have a concurrent mental health problem such as depression, post-traumatic stress disorder (PTSD), panic disorder or an eating disorder (Zilberman, Tavares, Blume, & el-Guebaly, 2003).

Women and alcohol use during pregnancy

The inadequacies of Canadian data, as previously mentioned, are exacerbated when the spotlight is turned to use of alcohol when pregnant. Numerous researchers warn of the difficulty in obtaining accurate information, since data are disparate and limited, sample sizes can be small, and many studies (especially regional studies that look at risk of FASD) are disproportionately focused on Aboriginal women and the regions in which they live (Dell & Roberts, 2006; Gelb & Rutman, 2011). In addition, much of the research is drawn from women's self-reports, and the use of self-report methodologies to gather data on alcohol use in pregnancy is limited by social stigma, feelings of guilt or shame, and fear of repercussions including child welfare involvement (Dell & Roberts, 2006). Pregnant drinkers are very likely to under-report their rate of alcohol consumption (Mengel, Searight, & Cook, 2006).

Rates of drinking during pregnancy on the decline

Various studies suggest that, although heavy drinking may have increased among young women, the rate of drinking alcohol during pregnancy appears to have declined in Canada over the last decade (Canadian Centre on Substance Abuse, 2008). The most recent *Canadian Community Health Survey (CCHS)* results, which surveyed women from 15-55 years of age, showed that the 2007/08 prevalence of drinking alcohol during pregnancy was 5.8% across Canada (Thanh & Jonsson, 2010). In 2005, the Alberta Alcohol and Drug Abuse Commission showed that 9.2% of Alberta women aged 18-44 reported that they drank during their last pregnancy (Alberta Alcohol and Drug Abuse Commission, 2005). In the same year, the *Report on Maternal and Child Health in Canada* reported that "roughly 14% [of mothers] reported drinking alcohol (any amount) during pregnancy" (McCourt, Paquette, Pelletier, & Reyes, 2005, p. 5). Similar rates were reported by the 2000-2001 *CCHS*, which indicated that 13.7% of all women who reported using alcohol during their lifetime also consumed alcohol during their last pregnancy (Statistics Canada, 2009). In the U.S., data indicate that 10.1% of women report

drinking during pregnancy, with 1.9% engaging in heavy drinking and 1.9% engaging in binge drinking (Tsai & Floyd, 2004).

The 1998-99 National Longitudinal Survey of Children and Youth reported that 14.4% of women consumed alcohol at some point during their pregnancy, and 4.9% drank throughout (Dell & Garabedian, 2003). Dell and Roberts (2006) state that several older surveys report even higher rates: the 1994-95 *National Population Health Survey* and the 1994-95 *National Longitudinal Survey of Children and Youth* reported that between 17% and 25% of women reported drinking alcohol at some point during their pregnancy, and between 7% and 9% drank alcohol throughout.

Regional data can show variation from these trends. In Manitoba, one study showed that the percentage of women using alcohol during pregnancy fluctuated from one community to another, ranging from a high of 28% to a low of 9%; on average, 14% of women in each community used some amount of alcohol during pregnancy (Healthy Child Manitoba, 2009). *The Saskatoon Pregnancy and Health Study* (Muhajarine, D'Arcy, & Edouard, 1997) found that 46% of women reported drinking alcohol during the first trimester of their pregnancies, with 75% consuming less than two drinks per week.

Cormier, Dell, and Poole (2003) highlight aspects of the 2000-2001 *CCHS* report that show that the majority of women who reported alcohol use during pregnancy drank infrequently: 75.4% drank less than once per month, 9.7% drank once per month, 6.5% drank two to three times per month, 5.3% drank once per week, and 1.3% drank every day. Pregnancy is a motivator to reduce alcohol consumption for many women (Alberta Alcohol and Drug Abuse Commission, 2005, Dell & Roberts, 2006). Recent research has shown that the majority of Canadian women will cease to drink or will reduce alcohol intake when they learn they are pregnant (Carson, et al., 2010). However, it can take weeks or even months for women to realize that they have conceived, and during this time use of alcohol can be uncurbed by any restraint that knowledge of the pregnancy may impose. Many women do not realize they are pregnant until after the sixth week of pregnancy (Project Choices Research Group, 2002) as borne out by studies showing that approximately 50% of pregnant women in Alberta report drinking alcohol before they realized they were pregnant (Hicks, 2007; Tough, Tofflemire, Clarke, & Newburn-Cook, 2006). Most of these women reported alcohol consumption in amounts that were within the low-risk guidelines for Canada, however 22% reported binge drinking (consuming five or more drinks on one occasion) prior to pregnancy recognition (Tough, et al., 2006).

It is also important to note that women who use alcohol in problematic ways while pregnant often misuse other substances in combination with alcohol, since substance-using women rarely misuse a single substance (Dell & Roberts, 2006; Muhajarine, D'Arcy, & Edouard, 1997), and this misuse can start well before pregnancy (Hayes, Brown, Hofmaster, Davare, Parker, & Raczek, 2002; Rutman, Callahan, Lundquist, Jackson, & Field, 2000). The misuse of substances during pregnancy needs to be understood in relation to a number of contextual issues that will be further discussed in the next section.

Contextual factors for problematic alcohol use during pregnancy

As shown above, surveillance studies show that many women will reduce or stop their use of alcohol once they discover they are pregnant. For some women, however, this is not the case. A study in Alberta showed that 90% of women knew that abstinence from alcohol is best during pregnancy, yet 20% admitted to using alcohol during pregnancy (Tough, et al., 2006). Other Canadian research has shown that 40% of women continue to drink during pregnancy even when they know about the risks. Eighty percent decrease their consumption upon learning of a pregnancy, but only 60% discontinue alcoholic beverages completely (Alberta Centre for Child, Family and Community Research, 2010).

According to Deshpande, et al. (2005), women who drink during pregnancy are influenced by several factors:

1. They may not realize they are pregnant;
2. They may be misinformed about the harmful effects of alcohol, and think that alcohol intake during pregnancy poses less of a risk than it actually does;
3. They may continue to drink for social reasons; for example, it might be common in their circles or communities for women to drink alcohol, pregnant or otherwise;
4. They may drink due to an addiction or use alcohol as a coping mechanism for difficult life circumstances such as isolation, poverty, or violence; and/or
5. They may be influenced by a family history of alcohol or their partner's drinking habits, and may live with partners who do not know about the dangers of alcohol exposure during pregnancy.

A proportion of pregnant women misuse alcohol (and frequently other substances as well) in patterns that put their fetus and themselves at risk of harm. An early study (Smith, et al., 1987) looked at the differences between women who ceased to drink during their second trimester of pregnancy compared to those who continued to drink, and found that the best predictors of drinking through pregnancy were length of drinking history, reported tolerance to alcohol, a history of alcohol-related illness, drinking by siblings, and drinking most often with other family members. Smith concluded that those women who drank throughout pregnancy had more chronic and severe alcohol-related problems than women who ceased to drink.

This early study hints at an ingrained familial pattern of alcohol misuse that research shows can make it difficult for some women to stop or decrease their use when pregnant. Although there are many gaps, the literature now abundantly indicates that women's misuse of alcohol and other substances during pregnancy often takes place within a larger context of antecedent and co-occurring problems, many of which are interrelated and rooted in biological, socioeconomic and relational factors that are gender-specific, complex, and connected to trauma, mental illness, poverty, and a long history of difficult life circumstances (Alberta Alcohol and Drug Abuse Commission, 2006; Astley, Bailey, Talbot, & Clarren, 2000; Boyd, 1999; Boyd & Marcellus, 2007; Gelb & Rutman, 2011; Kearney, 1997; Parkes, Poole, Salmon, Greaves,

& Urquhart, 2008; Peplar, Moore, Motz, & Leslie, 2002; Poole, 2000; Rutman et al., 2000; Tait, 2000; United Nations Office on Drugs and Crime, 2004).

These circumstances not only bring women to the use of alcohol, they make it very difficult for them to decrease or stop their use while pregnant. Poole (2003) points out that the difficulties faced by women who are at risk of giving birth to a child with FASD include malnutrition, stress, use of other drugs besides alcohol, and exposure to violence. The breadth of these factors requires a prevention approach that looks beyond alcohol to focus on the social determinants of health: income and social status, support networks, education, working conditions, physical environments, biology and gender, personal health practices and coping skills, health services, and culture (Marcellus & Kerns, 2007).

[In the past,] prevention messages have tended to oversimplify [the reality of the many factors faced by women abusing substances]. They often focus only on alcohol use and imply that any level of alcohol use is dangerous. More critically, they often imply that it can be a simple matter for women to “just say no” to alcohol and pregnancy, ignoring the dynamics of addiction and the burden of other health and social problems that many women face. (Poole, 2003, p. 5)

Trauma is a recurrent theme

Past trauma, particularly sexual or physical abuse, is a recurrent theme in the lives of women who misuse alcohol and other harmful substances during pregnancy. Evidence shows that a large proportion of women with substance use problems have experienced domestic violence, abuse, sexual exploitation, incest, rape, sexual assault, and child physical abuse (Brema & Namyniuk, 2002; Gelb & Rutman, 2011; Grant, Ernst, Streissguth, & Stark, 2005; Ouimette, Kimerling, Shaw, & Moos, 2000; Tait, 2000) and some studies (National Women’s Health Resource Centre, 2006) indicate that sexual abuse is the single greatest predictor of alcohol abuse in women. As many as 80% of women seeking treatment for substance abuse report a lifetime history of sexual or physical assault, or both (Cohen & Hein, 2006). There are strong correlations between sexual and physical abuse and early onset of alcohol use as well as frequent, heavy drinking by girls and young women (National Centre of Addiction and Substance Use [CASA], 2005).

The service needs faced by women who misuse alcohol during pregnancy should be trauma-informed, given that the issues these women are often dealing with include low self esteem, stigmatization, high incidence of physical and/or sexual abuse as a child, lack of social support, need for social services and child care, need for support and education around parenting, relationship counseling, coping skills training, and vocational and legal assistance. (Kearney, 1997, p. 463)

Substances can be used as a coping mechanism to deal with a range of life problems such as the violence, trauma, and mental health problems that frequently precede or co-occur along with substance use (Gelb & Rutman, 2011; Grant, Ernst, Streissguth, & Stark, 2005; Logan, Walker, Cole, & Leukelfeld, 2003; Najavits, Sonn, Walsh, & Weiss, 2004). The co-occurrence of alcoholism with other mental health disorders has been widely recognized (Kessler et al., 1997; Regier et al., 1990; Sheehan, 1993).

Mental health problems

Up to two-thirds of women who misuse substances also have a concurrent mental health problem such as post-traumatic stress disorder, anxiety, or depression, which is often related to their experiences of physical or sexual abuse as children or adults (Ouimette, Kimerling, Shaw, & Moos, 2000). Gelb and Rutman (2011) note that the sequence in which concurrent disorders develop is different for women compared to men. They indicate that for women, evidence shows that psychiatric disorders such as depression, panic disorder and PTSD are more likely to ***precede*** the onset of a substance use disorder, and that experience of abuse typically happens ahead of women's mental ill health, with the resultant emotional pain leading women to self-medicate with alcohol, licit and illicit drugs.

Table 1: List of Co-existing Conditions Experienced by Pregnant Women Who Use Alcohol
(adapted from Gelb & Rutman, 2006 p. 29)

sole parenting	violence, abuse, sexual exploitation, trauma
child(ren) in custody/changes in custody	involvement in the criminal justice system
low income/socioeconomic status/poverty	low social support
limited access to prenatal/postnatal care services	previous birth of a child with prenatal exposure to alcohol and/or other substances
feeling/experiencing loss of control	low education and literacy levels
menial/low paying employment problems	concurrent physical and mental health problems
cognitive impairments, possibly due to FASD	co-existing use of other substances
unplanned pregnancy/pregnancies	feelings of shame and guilt
low self esteem	depression and other mental health issue(s)
historical and cultural factors	heavy consumption of alcohol prior to pregnancy
older in age	inadequate nutrition
mother's own prenatal exposure to alcohol, tobacco or other drugs	alcohol, tobacco, or other drug exposure at a young age
poor early childhood environment (stress, abuse, neglect)	partner/familial alcohol and drug use during the pregnancy
physical, mental, social and spiritual imbalance	unstable housing and living conditions

Table 1 (above), drawn from Dell and Roberts (2006), summarizes the numerous, often interconnecting and mutually reinforcing factors that are shown in the literature to co-exist in the circumstances of women who misuse substances while pregnant.

Astley et al. (2000) carried out a landmark study in the state of Washington on the profiles of women who had already given birth to an alcohol-affected child, examining factors that helped or hindered a mother's ability to achieve abstinence. Key findings were:

- Mothers were, on average, 21 years of age at the birth of their first child, 27 at the birth of the "index child" (the child identified as affected by prenatal alcohol exposure), and 35 at the time of diagnosis of the index child with FASD.
- The women resembled the racial distribution of the area, being largely Caucasian with a slight overrepresentation of Aboriginal women.
- Average maternal IQ was 90.
- 61% did not complete high school.
- 59% had an annual income of less than \$10,000.
- 95% had been physically or sexually abused at some point.
- 58% had been sexually abused by the age of 17.
- 99% had been emotionally abused as a child; 86% had been emotionally abused as an adult.
- 96% had 1-10 mental health disorders, the most common being PTSD.
- 73% of births had been unplanned.
- The average number of live births for each woman was 3.4; the average number of conceptions was 4.4.
- 80% of women had had their children in foster care.
- Average age of alcohol initiation was 15.
- 47% were drinking daily just before the birth of the index child.
- 84% felt they had a problem with alcohol.
- 94% reported they did not want to reduce their alcohol use because it helped them to cope.
- 72% reported they did not want to reduce their alcohol use because they were in an abusive relationship.
- 79% reported that they were too depressed to do anything about their alcohol use.
- 86% had used illicit drugs; 9% reported current use, most commonly marijuana, amphetamines and cocaine.
- 84% smoked tobacco around the time of the index child's birth.
- The most common reasons for not seeking alcohol treatment were that the women (1) did not want to give up alcohol; (2) were afraid they would lose their children; (3) had no one to take care of the children; and (4) had a partner who did not want them to go into treatment.

The women who were able to achieve abstinence in Astley's study had significantly higher IQs, more satisfactory social networks, and were more likely to report a religious

affiliation than those who were not able to break away from alcohol. Although they were equally likely to have mental illnesses, they were more likely to have received treatment.

Other studies have confirmed this complex profile of women who misuse alcohol while pregnant, and although there are variations in the risk profile (such as age and socioeconomic status), many elements are shared. Meschke, Hellerstedt, Holl and Messelt (2008) found that correlates of prenatal alcohol use included older age, being unmarried, having had fewer pregnancies, greater depressed mood, currently smoking, exposure to interpersonal violence, a history of not remembering things because of alcohol use, and a feeling of needing to reduce alcohol use. Leonardson and Loudensburg (2003) found that women who misused alcohol tended to be younger, less educated, single, and unemployed. Other relevant variables were past sexual abuse, current or past physical abuse, using tobacco, using other drugs, living with substance users, and having partners who were substance users. Badry (2009) conducted interviews with eight birth mothers in Alberta who abused alcohol and other substances while pregnant. These women had complicated and difficult life experiences: single motherhood, histories of sexual abuse, transient relationships, unplanned pregnancies, involvement with child welfare, heavy alcohol use combined with drug use, and family backgrounds of alcoholism and violence.

The Sheway Project in Vancouver confirmed that its clients are strikingly similar to the profile from the literature, in that they are:

- experiencing poverty and hunger, worsened by diversion of funds to drugs;
- living in unstable situations with frequent moves;
- working in menial jobs, working illicitly, or living on welfare;
- having low levels of social support;
- needing the basics, such as transportation, housing, and food;
- coming from unstable childhoods, having experienced disruptions in their families, emotional, physical and sexual abuse, and abandonment;
- having histories of violence and sexual exploitation, including violence during pregnancy;
- exposed to drugs at a young age and continued exposure through partners and their social and physical environment;
- often affected by cognitive impairments associated with their addictions and affected by their own mothers' substance use during pregnancy;
- stress and exhaustion from having to care for young children, and turning to alcohol and drugs to help them cope;
- faced with unplanned pregnancies;
- experiencing feelings of loss of control over their lives, slowed by depression, anxiety, grief, and loss, untrusting of the scrutiny of the many systems in their lives;
- experiencing shame and guilt, and feeling they have to prove their worth; and
- resourcefulness, holding attitudes, hopes and expectations similar to those of all mothers, and in most cases caring for their children quite adequately. (Poole, 2000)

Intersections between child welfare and substance use during pregnancy

The nature of alcohol addiction and the adverse life circumstances associated with maternal drinking (as described above) are strongly associated with children needing child welfare intervention. Studies report that 40% to 80% of families involved with child welfare involve parents who struggle with alcohol abuse (Besinger, Garland, Litrownik, & Landsverk 1999; Curtis & McCullough, 1993; Department of Health and Human Services, 1999; Dore, Doris, & Wright, 1995; McNichol & Tash, 2001; Semidei, Radel, & Nolan, 2001; Young, Gardner, & Dennis, 1998). Several studies have shown that most women entering into substance abuse treatment are mothers of dependent children and about half or more have had contact with child welfare (Conners, et al., 2004; Grella, Hser, & Huang, 2006; Tait, 2000). Usually, fewer than half are living with all of their children at the time of treatment (Knight & Wallace, 2003; Schilling, Mares, & El-Bassel, 2004).

Spohr, Willms, and Steinhausen (1994) report that numerous alcohol-exposed children grow up in child welfare care as a result of parental substance misuse. Besharov (1994) estimated that between 65% and 80% of children with FASD were raised by someone other than their birth parents. The high proportion of children with FASD in child welfare care has also been identified in Manitoba (Fuchs, Burnside, Marchenski, & Mudry, 2005), with 11% of all children in care having been diagnosed with FASD and a further 6% in the process of being tested for the condition. In reviewing the experiences of women in the Seattle PCAP program, Ernst, et al. (1999) found that many of the women's children were in care after three years, either at her request or as a result of child welfare concerns.

However, child welfare services and treatment programs for substance abuse have historically not collaborated well to jointly provide services for substance-abusing mothers and their children in ways that support the mother-child dyad, each focusing instead on their mandate to serve either one or the other (Grella, Hser, & Huang, 2006). Research has repeatedly found that one of the most significant barriers that pregnant women face in asking for help with their substance use problems is the fear of losing their children (Astley, et al., 2000; Poole, 2003; Poole & Salmon, 2007; Tait, 2000). Child welfare workers have a child-centred, risk assessment focus and sometimes resort to child removal if the mother is abusing substances. According to Weaver (2007), a child welfare mandate that is concerned with the protection of the child, exclusive of the mother, may not consider harm reduction as a viable pathway to addiction intervention that also ensures child safety. Consequently, relationships between child welfare practitioners and mothers become adversarial, as mothers who use substances may be labelled as 'bad mothers' (Weaver, 2007).

One study of women in substance treatment programs (Grella, Hser, & Huang, 2006) found that mothers who had been involved with the child welfare system had an overall lower level of addiction severity, were younger, had more children, and had more problems with economic stability, than mothers in treatment who were not involved in child welfare. Those with three or more children were more likely to be referred to child welfare than those with no dependents. With their lower levels of education and lower rates of employment, mothers

who had been involved with the child welfare system relied more on others for economic support. They were more likely to be referred into treatment by the criminal justice system or other service providers, to have a history of physical abuse, and to be treated in outpatient programs rather than residential programs. Analysis showed a positive association between lifetime history of physical abuse and involvement with child welfare, suggesting these women had greater service needs related to their own long exposure to traumatic events and victimization, and these events adversely affected their ability to parent. Both sets of women in substance abuse programs reported high rates of lifetime physical (67-71%) and sexual (48-51%) abuse as well as unstable living conditions (33%), and those with alcohol problems had correlations with a history of mental health problems, history of physical abuse, and history of prior substance abuse treatment (Grella, Hser, & Huang, 2006).

Another aspect of the intersection of child welfare and women who drink during pregnancy is the adverse childhood experiences that these women have had themselves and their own experiences with the child welfare system as children. This is further explored in the following section.

Adverse childhood experiences and intergenerational alcohol misuse

Flynn and Chermack (2008) found that parental alcohol abuse was significantly correlated with alcohol abuse in offspring, echoing a number of other studies that have explored this intergenerational link. Research is emerging to show that genetic as well as complex sociological factors play a role in intergenerational predispositions to alcohol misuse (Basford, Thorpe, William, & Cardwell, 2004). Researchers from the University of Washington found that exposure to alcohol before birth predicts alcohol problems later in life: women who binge drink during pregnancy triple the odds that their children will develop problems with alcohol consumption by age 21 (Baer, Sampson, Barr, Connor, & Streissguth, 2003).

Parental or community patterns of heavy alcohol consumption can also shape a child's perceptions, normalizing the misuse of alcohol and the negative behaviours that accompany it. Fifty-nine per cent of substance-abusing women surveyed by Tait (2000) reported that they had been exposed to a family member or caregiver with an alcohol addiction problem during childhood, and some women spoke about the effect that this had on them. As an example, some saw alcohol abuse, rather than moderate drinking, as the norm during childhood.

Parental alcoholism is thought to be linked to many damaging factors for child development. Flynn and Chermack (2008) found that parental alcohol use was significantly related to childhood physical and sexual abuse, which studies have identified as a correlating factor with alcohol abuse during pregnancy (see Simpson and Miller, 2002, for a review). Children who grow up in homes where alcohol is abused are often subjected to a number of adverse experiences that increase their risk for alcoholism (Johnson & Leff, 1999), not the least of which is the risk of being prenatally exposed to alcohol and affected by FASD (Gelb & Rutman, 2011).

Numerous studies have shown a relationship between various kinds of child abuse and the risk of alcohol misuse as an adult (Kunitz, Levy, McColoskey, & Gabriel, 1998; Langeland & Hartgers, 1998). An emerging body of work is showing the impact of multiple types of childhood abuse and other early adverse experiences simultaneously. Dube, Anda, Felitti, Edwards, and Croft (2002) looked at eight adverse childhood experiences (verbal abuse, physical abuse, sexual abuse, battered mother, household substance abuse, mental illness in household, parental separation or divorce, and incarcerated household member) in relation to the risk of adult alcohol abuse. They found that each of these eight individual adverse childhood experiences (ACEs) was associated with a higher risk of adulthood alcohol abuse. The risk of heavy drinking, alcoholism, and marrying an alcoholic were increased twofold to fourfold by the presence of multiple ACEs, regardless of parental alcoholism. Dube et al. (2002) postulated that ACEs may interact with heritable factors to create a heightened risk of intergenerational cycles of alcohol abuse and traumatic and chaotic childhood experiences. Literature and practice show this intergenerational cycle is often part of the background of women who abuse alcohol while pregnant (Gelb & Rutman, 2011; Grant, 2011; Grant, Ernst, Streissguth, & Stark, 2005; Tait, 2000).

Further, many women with high substance use patterns have themselves been affected by prenatal alcohol exposure, although many have not been diagnosed with FASD due to limited diagnostic services for adults. Researchers at the Hospital for Sick Children's Motherisk Clinic in Toronto hypothesized that "because of the familial trend in problem drinking, it is possible that women drinking heavily in pregnancy were also victims of FAS through their mothers' drinking." (Rouleau, Levichek, & Koren, 2003, p. 1). Results of a cohort study of clients of Toronto's Breaking the Cycle program for women substance abusers showed that a "substantial proportion of women drinking heavily in pregnancy were born to women who drank heavily. Their characteristics, including rates of learning disability, criminality and psychiatric morbidity, suggest that a substantial proportion of them are afflicted by ethanol embryopathy" (Rouleau, Levichek, & Koren, 2003, p. 1). This finding is supported by the results of evaluations of the Washington-based Parent-Child Assistance programs (Grant, Ernst, Streissguth, & Stark, 2005), which showed high levels of parental drinking in the histories of women who have given birth to children with FASD.

Related to the many adverse experiences of growing up in a household where substances are abused is the likelihood that children will become involved with the child welfare system and be taken into care. The literature shows that many women who misuse alcohol while pregnant have had involvement with child welfare and foster care themselves as children (Tait, 2000). This brings its own risks. As Tough (2010) states, "Children who come into contact with child welfare authorities, or children of parents who have had contact with child welfare as a child, are at a higher risk of developing substance abuse issues." Tait (2000) found that more than a third of the substance-using women she interviewed in Manitoba had been in foster care, and for some women the experience of foster care was one of the most negative outcomes of their own parents' misuse of substances, mainly due to multiple placements but also due to some being sexually, physically, and emotionally abused while in care.

Alcohol use before age 13

Early age of first use of alcohol is also a risk factor in the lives of women who misuse alcohol during pregnancy. The average age at first use of alcohol in Canada varies from 11 to 15 years (Dewit, Adlaf, Offord, & Ogborne, 2000; Leatherdale, Hammond, & Ahmed, 2008; Leslie, 2008). In 2000, Dewit, Adlaf, Offord, and Ogborne reported that the highest risk profile for developing lifetime alcohol dependence occurred for people who had taken their first drink at age 11 or 12. Those who started to drink at 11 to 12 years of age were nearly ten times more likely than those who started drinking later (age 19 or older) to become alcohol dependent.

It is now well recognized that early initiation of alcohol use increases the risk of alcohol dependence and other alcohol-related disorders later in life (Dube, et al., 2006). Early drinking has been associated with a number of risky behaviours in later life, including tobacco and illicit drug use, violence, sexually risky behaviours, and suicide ideation (Durant, Smith, Kreiter, & Krowchuk, 1999; Windle, 2003). Grant and Dawson (1997) showed that 40% of individuals who start drinking at age 14 or younger have lifetime dependence on alcohol, compared to roughly 10% among those who start drinking at age 20 or older. Calvert, Bucholz, and Steger-May (2010) found that drinking before 13 years of age is significantly related to risk-taking behaviours such as having multiple sexual partners and unprotected intercourse, which negatively alter life trajectories.

In addition to the impact of adverse childhood experiences noted above (Dube, et al., 2006), the researchers found that adverse childhood experiences have a strong relationship to the onset of alcohol use in early adolescence. Stress and trauma, such as experiencing abuse and witnessing domestic violence in the family, may affect neurodevelopment in ways that lead to early initiation of alcohol use as a means to regulate emotional states and cope with stress.

Early age of alcohol use has been found in some studies to be part of the profile of women who abuse alcohol while pregnant. Tait (2000) found that many of the pregnant, substance-abusing women she interviewed in Manitoba had used alcohol throughout their lives, often starting at an early age. The average age of first use was 14, with the age of first use varying from age 7 to 25. Dell and Roberts (2006) report a personal communication with staff of the Edmonton First Steps FASD program, which offers mentorship to women who are pregnant or have recently given birth after using drugs and alcohol through pregnancy. Of the 96 female program clients interviewed, all had begun to use alcohol and/or drugs prior to age 13.

Lifetime experiences of violence

Many studies show a correlation between substance use and past experiences of violence. Poole (2007) found that 63% of the women in residential treatment in British Columbia for substance abuse had experienced physical violence as adults and 41% had experienced sexual violence. As children, 48% had experienced physical violence and 46% had experienced sexual violence. Covington (2007) noted that complex PTSD, defined as generally

resulting from “multiple incidents of abuse or violence” (p. 3), may be connected to substance abuse, and that the combination of both puts individuals at particular risk for homelessness, mental health problems, and decreased life functioning. Flynn and Chermack (2008) found that while childhood abuse was not significantly related to alcohol use during pregnancy, lifetime partner violence showed a strong and significant correlation. Individuals were asked how many drinks they consumed during pregnancy; of those who reported no alcohol use, nine percent had experienced partner violence; of those who reported 1 to 10 drinks during pregnancy, 21% had experienced partner violence; and of those who reported greater than 10 drinks during pregnancy, half had experienced partner violence (Flynn & Chermack, 2008).

Influence of partners

The connection between substance use, trauma, and domestic violence is becoming clearer as the complex profile of women who are at risk of having a child with FASD increasingly becomes a topic of research focus. As mentioned earlier, partner violence is strongly correlated with increased alcohol usage. An international study by the World Health Organization revealed that up to half of victims of domestic violence believed that their partners had consumed alcohol prior to the assault; a further study found that regular alcohol use acted as a risk factor for domestic violence (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). A nationwide study in the United States revealed similar results: up to 75% of partner violence incidents involved alcohol use by one of the parties (National Abandoned Infants Assistance Resource Center, 2002).

Streissguth, Barr, Kogan, and Bookstein (1996), Tait (2000), and Leonardson and Loudensburg (2003) found that women’s partners’ use of alcohol also served as a risk factor to further substance use, especially if the partner was misusing alcohol. This is supported by the Environics Research Group (2000) and by Wiemann and Bereson (1998), who found that adolescent women’s drinking habits are influenced and predicted by their partner’s use of alcohol. Drug-using male partners are also less likely to offer support for their partners’ efforts to recover from addiction or reduce substance use (Walters, 2003, as cited in Poole & Salmon, 2007). Isolation from support systems is a strategy used by abusive partners to maintain their control over women, and one way that paraprofessionals such as mentors in PCAP programs offer support to women who are victims of domestic violence is to offer connections to community support systems and advocacy for them in ways that build on their natural strengths (Bybee & Sullivan, 2002).

Mentoring Women with High Risk Substance Use to Prevent FASD

Relational theories approach addictions and treatment by emphasizing the importance of relationships in the lives of women; the framework recognizes that interpersonal relationships can play a key role in the maintenance of and the termination of substance use problems (Grant, Ernst, & Streissguth, 1999). Relational approaches emphasize a woman-centred, strengths-based approach that seeks to effectively engage pregnant women with

mentoring relationships and other prenatal supports. They seek to make positive interpersonal relationships a central part of addictions treatment (Grant, et al., 1999). In the context of working with pregnant and parenting women with addictions, interpersonal relationships are used to narrow the gap that frequently exists between high-risk women and the programs and services that they need.

Mentoring programs take a relationship-based approach that also comes from a harm reduction stance and addresses the concerns that may make it difficult for these women to seek or remain in treatment. Mentoring programs provide one-on-one support for women who use substances, helping them improve their health and social support networks, as well as the health of their children (Poole, 2008). The harm reduction philosophy recognizes the incidence of relapse, the value of reduced use or transition to a less harmful substance, and the importance of life changes other than successful abstinence, such as use of birth control and increase in self-esteem (Poole, 2000; Grant et al., 1999). Tait (2003a) notes that harm reduction is a controversial position within the addictions treatment field in general, and in particular for child welfare services, as substance use, even at reduced levels, may still present barriers to appropriate parenting.

Mentoring as a relational intervention to prevent FASD began twenty years ago with the Seattle Birth to 3 Program, a long-term, intensive mentorship program that has received widespread recognition for its effectiveness in reducing the birth of FASD-affected children (Grant et al., 1999). It is a home visitation model in which paraprofessionals (often called mentors) work with extremely high-risk substance-abusing mothers for three years, starting at the birth of a target or index child who may have been exposed to alcohol prenatally.

The Seattle Birth to 3 Program began in 1991 as a federally funded demonstration project based in the state of Washington. The program built on previous studies that had provided evidence for the effectiveness of home visitation programs for at-risk families by nurses and trained laypersons. Over the course of a three-year intensive intervention, these mentors build trusting relationships with women and help them set goals in their lives and connect to services that assist them to stabilize their situations and lead healthy, independent lives so as to prevent the birth of future children who are exposed prenatally to substances. It has since been widely replicated at numerous other locations in the United States and Canada, with the replicate models becoming known as Parent Child Assistance Programs (PCAPs). The model's principles and service standards have been well described in Grant, Ernst, and Streissguth (1999) and Grant, Ernst, Streissguth, and Sampson (1999).

The women who enrol in the PCAP programs are characterized by one of two profiles:

- a) Pregnant or up to six months postpartum and has abused alcohol and/or drugs heavily during the pregnancy and is ineffectively connected to community services, or
- b) Has previously given birth to a child who has been diagnosed with FASD and continues to drink heavily while being capable of further pregnancies.

Overview of findings from Seattle PCAP evaluations

One of the most important features of the University of Washington PCAP program is the rigorous evaluation component, which uses a pre-test/post-test model to interview clients at the start and finish of the program. The profile of the women as they enter these programs echoes the complexity of the lives of women substance abusers:

Mothers who enroll in PCAP exemplify the intergenerational nature of familial substance abuse and dysfunction: they were themselves the neglected and abused children in our communities just a decade ago. For example, among 817 women currently enrolled in the Washington PCAP, the typical client was born to substance-abusing parents (92%), she was physically and sexually abused as a child (71%), ran away from home as a child (67%), and did not complete high school (49%). She is now in her late 20s, and her life circumstances are grim: she is unmarried (91%), and is beaten by her partner (76%), is homeless or lives in temporary housing (24%), has a history of incarcerations (75%), and is on public assistance (69%). She does not use family planning on a regular basis (91%), and now has an average of 2.7 children, half of whom are not in her custody.” (Grant, 2011, p. 194-195, referring to Grant & Ernst, 2009)

The University of Washington research team evaluated the effectiveness of the original demonstration project (OD) along with two replications (Seattle replication, or SR, and Tacoma replication, or TR) in Grant, Ernst, Streissguth, and Stark (2005). The results showed that the well-documented gains in functioning that women achieved in the original project were matched or exceeded by the replications.

In brief, the details of the study showed that baseline characteristics of the women who participated were as follows: most had been physically and/or sexually abused as children, had parents who abused alcohol/drugs, had been incarcerated as adults, and were currently living on welfare; approximately half were living in stable housing, and there were two prior children, most not in the mother’s care. Average age was 28.6. Most were unmarried and approximately half had a diagnosed mental health disorder. All in the OD and 81% in the combined replications were polysubstance abusers (binge alcohol use and cocaine being the most common combination). Tobacco was the substance most commonly used (88% of combined women), with other drugs in order of usage being alcohol, cocaine, marijuana, binge alcohol, methamphetamines, and heroin.

Three year outcomes showed that compared to the OD, which had 45% of subjects complete treatment, the replications had a larger proportion of women complete the program (SR=72%, TR= 49%). The replication subjects also achieved longer duration of abstinence from alcohol and drugs for six months or greater (OD=28%; SR=43%; TR=39%). Regular use of contraceptives were sustained or improved (OD=73%; SR=74%; TR=71%). The rate of subsequent births during a three-year period ranged between sites from 25% to 29%. Among

those who had a subsequent birth during the intervention, the proportion unexposed to alcohol or drugs during the pregnancy doubled at the replications compared to the original (OD=18%; SR=32%; TR=40%). At all three sites, upon exit most subjects were no longer at present risk of having another drug or alcohol exposed pregnancy, either because they were using a reliable contraceptive or had been abstinent from alcohol/drugs for at least six months, or both. The percentage of index children in the custody of their mothers or other family members at exit varied from 70-77%.

In summary, the Seattle PCAP interventions were shown to be effective in reducing harm caused by substance abuse during pregnancy. They successfully prevented alcohol/drug exposed births, either by helping women to avoid alcohol and drug use during pregnancy or by helping them to avoid becoming pregnant if they were using alcohol and drugs. Other findings included increased maternal employment, more permanent child custody placements, and increased connections with services. These outcomes help mothers build healthy and productive lives, improve the quality of the home environment for the children, and reduce the burden on taxpayer-funded social systems (Grant, Ernst, Streissguth, & Stark (2005).

Overrepresentation of Aboriginal women in alcohol misuse studies

In Canada, studies of women's use of alcohol during pregnancy often disproportionately focus on Aboriginal women (Dell & Roberts, 2006). Canadian studies of prevalence rates of FAS/FASD have also tended to focus on Aboriginal communities, especially those where alcohol abuse is known to be high (Tait, 2008). These communities tend also to be areas in which poverty is widespread, services are inadequate, and intergenerational cultural trauma, rooted in residential schools and the other forms of marginalization typical of the colonial history of First Nations people in Canada, is evident. Consequently, the rates of Aboriginal women's substance misuse during pregnancy and the prevalence rates of FASD derived from high risk Aboriginal populations lead to generalizations that are often applied to the entire Aboriginal population, Pacey (2009) asserts.

Wilson (2000), in her unpublished Master's thesis on the hopes and dreams of pregnant Aboriginal women with high risk substance use, described their plight this way:

We are victims – of society, of our history, of our dysfunctional families, and of our abusive partners. Our children, who have been raised in chaotic conditions, face a bleak future. What can possibly save us – education, knowledge, money, better housing, healthy food, healthy relationships? We 'need help'. Equal opportunity, better education, counselling, further understanding, cultural recognition, and respect are some of the things that I have heard from the dominant society that we 'need'. We also 'need' to be heard. (Wilson, 2000, p. 54)

Despite the growing body of research that shows that factors such as poverty, violence, poor health and abuse among marginalized populations contribute to alcohol misuse and are associated with the occurrence of FASD (Schellenburg, 2007), the diagnosis of FAS assumes a

direct causal relationship between maternal alcohol consumption and affected babies. Consequently, Aboriginal women are often personally blamed for their substance use during pregnancy without consideration of the impact of these environmental influences. Wilson (2000) elaborates:

Over the years, Canadian health care providers have sought to educate and support pregnant Aboriginal women in a variety of ways and settings. Still, so many Aboriginal women continue to carry out behaviours which put their children 'at risk'. This continues to be a frustration for health care providers. It is hard not to put the blame on the victim. It is hard to not get frustrated with the women who 'bring the trouble onto themselves'. It is easy to get burnt out as a health care provider. It is easy to become apathetic. The non-Aboriginal health care provider does not see the answer. He or she has tried everything they know to 'help' these women. Some are successful in their ambitions, as some women do change their behaviours, but there are still so many who don't. (p. 55)

As Tait (2003) says, "It is critical to understand that for many Aboriginal women, this history of colonialization and marginalization will play a pivotal role in their path both in and out of substance use" (p. 215b). However, rather than only focusing on the negative influences that lead to problematic substance use, Wilson (2000) asserts that more emphasis needs to be placed on the positive factors that instill motivation in Aboriginal women to change. For the women Wilson interviewed, one of the key positive factors that stimulates change is a relationship with a female role model. In the words of one of the Elders who advised Wilson in her research, "As workers, we must be mother, sister, auntie to these women" (p. 62). The power of relationship, such as the relationships offered by mentors through PCAP and other support programs for women with substance misuse issues, to influence change needs to be better understood. This stance has informed the research projects described in this report.

4. Mentoring Programs in Canada

Mentoring programs for women with high risk substance misuse have been in existence in Canada since 1998, when Manitoba initiated two programs based on the PCAP model. Alberta's first PCAP programs began in 1999, and these two provinces have been the leaders in Canada in the provision of PCAP-modelled mentoring programs. There are now 21 PCAP or PCAP-like mentoring programs operating in Alberta, and seven in Manitoba, in both urban and rural locations (Government of Alberta Fetal Alcohol Spectrum Disorder Cross-Ministry Committee, 2009; Healthy Child Manitoba, 2009; Henneveld & McFarlane, 2009). Other western provinces, such as British Columbia and Saskatchewan, have also established mentoring programs that draw from the work of the PCAP experience as well as other program influences. Health Canada has also supported First Nations communities in responding to the issue of FASD by funding on-reserve mentoring programs and other interventions since 1999. For a full description of the application of mentoring programs in Alberta and Manitoba, please

see our report *Establishing a Research Agenda: Summary of NAT 4 Activities 2010-11* (available at: http://www.canfasd.ca/files/PDF/NAT4_EstablishingResearch_Agenda_FinalReport2010-11e.pdf).

There has been little research into the effectiveness of mentoring programs in Canada, although some of the more established PCAP programs, such as the Insight programs in Manitoba and Catholic Social Services in Alberta, have reported some program outcomes (Healthy Child Manitoba, 2009; Rasmussen, Henneveld, Badry, & Andrew, 2010). Therefore, studies regarding the impact of mentoring programs on women who struggle with high risk substance misuse have been an important priority for the CanFASD Research Network, as assigned to Network Action Team 4 (NAT 4). The next two sections describe the first research projects undertaken by NAT 4, beginning with a small quantitative study of the characteristics of women who had completed a mentoring program in Manitoba or Alberta.

5. Characteristics of Women Who Have Completed a Mentoring Program

As noted earlier, the research agenda for NAT 4 was derived from a meeting with many mentor program coordinators of PCAP-based programs from Alberta and Manitoba (and coordinators from similar mentoring programs in Saskatchewan), held in October 2010. Program coordinators spoke about the data that is collected in a relatively standardized manner for all women who participate in a mentoring program: the Addiction Severity Index (ASI). Developed by the Seattle Parent Child Assistance Program, the ASI focuses on key aspects of a participant's life circumstances and characteristics, measured at intake, every six months through the duration of the program, and at program exit. This detailed assessment tool is utilized by mentors with the women they are working with to help track progress, identify goals, encourage progress, and measure outcomes. Variables that are captured include:

- basic demographic information;
- education/training;
- employment/source of income;
- housing status;
- substance use;
- family history of substance use;
- physical and mental health;
- criminal justice system involvement;
- relationships and sources of support;
- parenting status;
- birth control and family planning;
- substance abuse treatment programs; and
- involvement with/need for community services.

In addition, the Intake ASI also records information about the woman's childhood experiences, such as physical abuse, sexual abuse, adolescent pregnancy, and child welfare involvement, adverse life experiences that are often associated with substance misuse. Finally, details with regard to substance use include type of substances, the age when the woman first began to use substances, use of substances in past 30 days, lifetime use of substances, periods of abstinence, and primary substance.

Given the availability of program data that had already been collected about women who had completed a mentoring program in Manitoba or Alberta, a study was developed by NAT 4 to better understand the characteristics of women at the start of the mentoring program and at the end of the program. The study began in August 2011 and concluded in February 2012. It received research ethics approval from the University of Manitoba in July 2011.

Methodology

The aim of the project was to review the ASIs at intake and exit for 50 women in Manitoba and 50 women in Alberta. The main themes of examination included basic intake characteristics (e.g. education, housing situation, substance use, involvement in community services, marital status, parenting status, domestic violence, mental health status), which were then compared to these same variables at exit. As well, information about adverse childhood experiences (parental substance misuse, childhood physical abuse, sexual abuse, first age of alcohol use) captured at intake were also examined, to gain some insight into characteristics that contributed to high risk substance misuse and may have an impact on the experience of mentoring. Due to many mentoring programs in the two provinces being too new to have women who had graduated from the three-year program, this study focused on the ASIs (or similar documentation) at four programs in Manitoba (50 files) and two programs in Alberta (50 files) who agreed to participate in the study and where there were a sufficient number of program "graduates".

Limitations

A number of challenges were encountered in the collection of data for this study. Despite the volume of information collected about the participants in these mentoring programs, that information was not always uniformly collected nor was it always easily accessible. For example, the ASI has been adapted over time and differs across mentoring programs, leading to some discontinuity in data reliability and availability. Some details of interest are not captured in the Exit ASI but in the final Bi-Annual report, completed six months prior to program completion, leaving some gaps in information. While the Manitoba data is available in electronic format, some details are stored in a different database than the main record of Intake and Exit variables, and the narrative information recorded on the ASI paper form (information that adds depth to the data) is not part of the Manitoba database. A major barrier affecting the Alberta data is the lack of a database to obtain information for this study; data had to be collected manually and transferred into a spreadsheet for data analysis.

Despite these limitations, the information provided by the mentoring programs in Alberta and Manitoba who participated in this study was invaluable in beginning to understand how mentoring makes a difference for women, and points to the strengths and limitations of the current approach to assessment (and therefore, data collection) of the characteristics of women who have completed a mentoring program.

Study Findings

This study examined the characteristics of 100 women (50 from Alberta, 50 from Manitoba) who had completed a mentoring program for women with high risk substance misuse. The majority of women (75) lived in an urban environment, while 25 were from rural communities. The women ranged in age from 18 – 41, with an average age of 26.4 years. The median age was also 26 years.

The majority of women were Aboriginal (73), and 48 were from the Manitoba cohort. In Alberta, 25 women were Aboriginal, and 25 belonged to other ethnic groups. Most women were not listed as being in a relationship with a partner, both at intake and at exit, although there was some missing data for this variable. At the start of the mentoring program, women had on average three children each, although the range was from one to eight children.

Intake Characteristics

At the start of the mentoring program, women's educational attainment ranged from Grade 3 to post-secondary programs, with an average grade attainment of 9.7 years of schooling. Slightly less than half (42%) had a Grade 9 or less education, while 51 had achieved credits from Grade 10 – 12, and 4 had achieved some post-secondary training. The majority of women at intake were in receipt of social assistance (70), but almost half of them (33) had more than one source of financial support, including disability benefits (29), band funding (4) and/or a partner or other person who was providing them with financial support (26). Five women were employed at the start of the mentoring program and four were in receipt of unemployment insurance benefits.

Slightly more than half of the women (55) described themselves as living in a stable housing situation, while 33 were in unstable environments (living temporarily with friends/family, homeless, at an emergency shelter, or in a time-limited facility such as a treatment program or correctional facility). All but three women were involved with some form of community services, most frequently health care services (72), housing services (48), child welfare (41), and food banks (36). Many more women were in need of these kinds of supports, particularly housing assistance (44 women), mental health services (35), and family planning (30). One third of the women (33) were involved with addictions treatment services at the time of intake.

Almost 75% of women had criminal charges of some kind prior to beginning the mentoring program, usually of a minor nature (shoplifting, breaches of probation, failure to appear in court, etc.), but 36 had been charged at least once with a serious offence, such as assault, weapons offenses, arson, homicide or manslaughter. Thirteen of the women who had minor criminal charges had drug-related charges. A quarter of the women (26) had been in jail at least once in their lifetime.

Alcohol use over the lifetime was an issue for 98% of the women, with most (69) beginning to use alcohol between the ages of 11 and 15, with a concerning proportion (11) initiating alcohol use under the age of 10. The average age of first alcohol use was 13.3 years of age. Cocaine had been used by 68 women, beginning on average at age 19. However, for those who started cocaine use in adolescence, the average age of first use was 15 years of age, while the average age of those who did not experiment with cocaine until adulthood was 21.9 years. Marijuana had been used by 75 women, on average beginning at age 13.7.

Alcohol was the main substance used by both Manitoba women (48) and Alberta women (50), while cocaine use was noted at a higher frequency for Alberta women in the sample (46), compared to 22 Manitoba women. Marijuana was used by 76 women (24 Manitoba women; 42 Alberta women). Polysubstance use was noted for almost 60% of women, more so for Alberta women (40) than Manitoba women (18). In the 30 days prior to admission to the mentoring program, almost all women had used alcohol (98), 68 had used cocaine, and 76 had used marijuana.

Prior to admission, 69 women had attended at least one substance abuse treatment program, although only 13 were noted to have completed a program. More than a quarter (28) had never attended a treatment program before.

Further, 42 women were pregnant at point of admission. More than half of all women in the sample reported not using any form of birth control (52, including the 42 who were pregnant) while 27 acknowledged that their use of birth control was sporadic. Where type of birth control utilized was noted, condoms were identified as the most frequent method (18 women used this as their main type of birth control).

Women were asked at intake about experiences of physical, sexual, or emotional abuse that had occurred within their lifetimes. Almost 80% reported having been physically abused at some point in their lives, and 72 women experienced sexual abuse or assault in their lifetime. Almost all described themselves as having experiences of emotional abuse (86). Further, 67 reported having been in a partnered relationship in the past that had been abusive. At the time of intake, 33 women acknowledged that their current relationship involved domestic violence.

The majority of women (92) reported at intake that they struggled with their mental health, with 76 indicating they felt depressed, 70 acknowledging feelings of anxiety, 61 reporting thoughts of suicide, and 55 admitting they had previously made suicide attempts. Almost 40% (37 women) experienced all four of these conditions at intake.

Adverse Childhood Experiences

At intake, women are asked about some childhood experiences that have been identified in the professional literature as being associated with substance abuse. While not as extensive as the eight Adverse Childhood Experiences (ACEs) described by Dube, et al. (2002) above, the ASI does ask women about parental alcohol use, physical abuse, adolescent pregnancy, and spending time in child welfare care. More recent versions of the ASI inquire about childhood sexual abuse, but due to the variations in ASIs available in this study, it was not possible to determine how many of the women in the entire sample had experienced childhood sexual abuse. Information was available, however, for the Alberta women: 24 of the 50 women reported sexual abuse as children.

In this sample of 100 women, 75 reported alcohol/substance abuse by one or both parents during childhood. Additionally, the women were asked if their mother's alcohol use had occurred when she was pregnant with the respondent. About a quarter of women (26) reported that their mother used alcohol during that pregnancy, but many (30) didn't know for sure. More than half of the women (52) reported experiencing physical abuse as children, and more than half spent time in child welfare care (55). A quarter of the women (25) had their first pregnancy as a teenager. Only three women in the sample had none of these adverse life circumstances (physical abuse, parental substance use, child welfare involvement, or adolescent pregnancy) happen in their lives.

Exit Characteristics

Over the course of three years of mentoring, many women experienced significant changes in their lives, captured through the ASI Exit interviews with women as they "graduated" from the program. During the program, 4 women had completed a high school equivalency program and 29 women were currently in school. An additional 16 had returned to school but had dropped out at the time of program completion. Almost a quarter of the women (23) were employed (compared to 5 at the start of the program) – of these, 11 were also in school while working and 2 had completed their schooling while in the mentoring program. About 40% of women were in receipt of social assistance, with half of those (20 women) also receiving income from other benefit programs or financial support from a partner or family member.

Almost three quarters of women (73) now described themselves as living in stable housing, with 21 living in unstable/temporary situations. Almost all women (98) were involved with community services of some kind: health care services (82), food banks (53), housing services (51) and family planning supports (20). With regard to housing, 25 of the women who were now receiving housing supports had not been involved with housing services at intake. A third of the women were involved with addictions treatment supports at exit (15 were women who had no involvement with these kinds of supports at intake). Around 40% of women were involved with child welfare, 21 of whom did not have child welfare involvement at intake.

Since enrollment in the program, 28 women had been charged with a minor offence, including 2 who had drug charges, and 12 had been charged with a major offence. Of the thirteen women who experienced some jail time during the program, four were women who had never been incarcerated prior to intake. Although charges and incarcerations occurred over the duration of the program, it was not clear if the criminal acts had also occurred in this time period. It is possible that women were experiencing the judicial consequences for criminal behaviour that had occurred prior to admission to the program.

At the point of program completion, alcohol was the main substance used by both Manitoba women (38) and Alberta women (24). Fewer Manitoban women reported using cocaine (10) or marijuana (20) compared to intake; similar changes were noted with Alberta women, with 16 continuing to use cocaine and 11 continuing to use marijuana at exit. Only 7 Manitoba women and 6 Alberta women reported polysubstance use at program completion. In the 30 days prior to program completion, 38 women acknowledging having used alcohol, 26 had used cocaine, and 31 had used marijuana. Almost a third (29) had not used any of these substances in the 30 days prior to program completion.

By the end of the mentoring program, 65 women had participated in at least one form of treatment program for substance misuse (20 inpatient only, 15 outpatient only, and 29 in both types of programming), with 36 women completing at least one of her treatment programs. The majority of women who completed a program were enrolled in both inpatient and outpatient programs (19 completed), while 13 who completed a program were only involved in inpatient treatment, and 4 who completed were only involved in outpatient treatment. Of the 36 who had completed a program, 21 had used alcohol in the 30 days prior to program completion. Almost a third (29) women were noted to have participated in no (zero) treatment programs for addictions since enrollment in the mentoring program, and there was no information recorded at all for 7 women.

Birth control practices had also changed by the end of the program, with 44 women reporting that they regularly used birth control: 13 had a tubal ligation, 5 used birth control pills regularly, 7 used condoms, 5 had received a birth control injection, and 4 used the IUD. The method of regular birth control was not noted for the remaining 10 women. Although 34 women still used no form of birth control, five of those women were pregnant, one was not sexually active, and one had had an abortion, leaving 27 with no form of birth control practice. Six women sporadically used condoms as a method of birth control.

Significant changes in mental health functioning were reported at program conclusion. Half of the women (50) no longer reported any concerns with depression, anxiety, suicidal thoughts or attempts of suicide at conclusion of the program. Only 8 women had suicidal thoughts, but only 4 of them had made suicide attempts through the duration of the program. Four of these women were currently in school, with two of them also working while attending school. While 30 women still reported feelings of depression, 22 of whom also experienced anxiety, and an additional 13 had anxiety but no depression, only 2 women reported feeling all

four of these mental health states (depression, anxiety, thoughts of suicide, and suicidal behaviour).

Conclusion

Although there were a number of limitations to accessing, collecting and interpreting the data from the various ASIs utilized by different mentoring programs in Alberta and Manitoba, this study of the characteristics of 100 women who have completed a three-year mentoring program in one of these two programs still demonstrate some important findings that are consistent with the outcomes described in the evaluation literature on PCAP programs. The relevant findings from this study include:

- Women demonstrated a growing capacity for self-sufficiency at the conclusion of the program, with more women employed (almost 25%) and in school or training programs (almost 30%) than at intake.
- 25% more women described themselves as living in a stable environment at program conclusion than at intake.
- There was some evidence of harm reduction, with fewer women reporting the use of substances at program completion compared to intake. However, the available information did not account for the amounts of substances or the frequency of use, additional measures of harm reduction.
- In particular, a third of women had not used any substances in the 30 days prior to the end of their program, where 98% of women had used substances in the 30 days prior to program admission.
- More than a third of women successfully completed a treatment program while enrolled in the mentoring program.
- More women used regular birth control at program exit.
- Significant reductions in mental health distress were reported by women at program conclusion. Half of the women stated they had no concerns about feeling depressed, anxious or suicidal by the time they completed the program. Importantly, only 4 women had made suicide attempt during their three years of involvement in the mentoring program, compared to 55 who admitted to suicide attempts prior to program enrollment.

Additionally, the data collected in the ASIs points to adverse life experiences that likely contributed to these women's struggles with alcohol misuse, such as parental substance abuse (75 women) and experiences of childhood physical abuse (52 women) and childhood sexual abuse (24 of the 50 Alberta women). Half (12) of these women from Alberta who had been sexually abused began to use alcohol prior to age 13, while 7 of those who had not been sexually abused in childhood initiated alcohol use prior to age 13.

Although the findings in this study illustrate some consistency with the outcomes of evaluations of other PCAP programs, the findings must be interpreted with caution. This study

involved a small sample of the files of only 100 women, as mentoring programs are fairly new in Canada and relatively small in size; due to the intensive nature of mentoring, programs often have only one or two mentors who can support only a few women at a time. Consequently, there is not a large pool of “graduates” to include in studies of this nature, although this is rapidly changing with the expansion and longevity of programs in western Canada. Further, the data collection tools (the ASIs) varied somewhat across programs, across provinces, and over time, so it is not always clear if questions were asked and recorded in a consistent manner. Some information that would have helped to understand the experiences of women in mentoring programs was not available due to blank entries in the database or on the paper ASI forms, due to information recorded in the Biannual version of the ASI and not at exit, or due to data entry and/or interpretation error.

The inconsistent ASIs across programs (and over time) and the lack of a centralized database of information present two major barriers to analyzing the entry and exit characteristics of women who have completed a mentoring program in Manitoba or Alberta. However, with increased efforts to examine and understand the data, both in Canada and through the evaluation work of the PCAP programs in Seattle, more understanding is being gained about the variables that are most helpful in capturing the changes that occur in women’s lives over their involvement in mentoring programs. Focused attention on key variables, as well as consistent data collection and use of a centralized database, will aid greatly in demonstrating the kinds of outcomes that can be expected when women engage in mentoring programs, such as those under the PCAP model.

6. Hearing Their Voices: The Experiences of Women in Mentoring Programs

To build on our understanding of women who had completed a PCAP-based mentoring program in either Alberta or Manitoba that was derived from the quantitative study of mentoring program records described above, it was identified as a research priority to try to learn from women themselves about their experiences through qualitative interviews. In recognition of the degree of stigmatization facing women who have used substances while pregnant, and the marginalization many women experience that keeps them from accessing services and supports, it was important to approach this project with a high degree of sensitivity. Additional areas of sensitivity considered by the researchers were that the women may be of Aboriginal heritage (requiring awareness of their experiences of cultural oppression), from small communities (necessitating extra care to ensure confidentiality), and may themselves be affected by FASD (requiring clarity in communication and ensuring comprehension in forming consent to participate in the study). This study was granted approval from the University of Manitoba research ethics board in October 2011.

Methodology

As in the first study, only those mentoring programs in Alberta and Manitoba that had been in existence long enough to have a sufficient number of graduates were asked to

participate in the qualitative study. Women were eligible to participate if they had completed a 3-year mentoring program in the previous 12 months. Mentor programs were asked to recruit prospective participants by a) posting notices in their program waiting rooms, b) distributing letters of invitation to women who met the research project criteria who were involved in the agency's formal after-care supports, and c) making personal contact with women they have mentored who have graduated from the program to provide them with a letter of invitation to participate in the study. A copy of the letter of invitation is included in Appendix A.

Women who expressed an interest to their contact at their former mentoring program were then contacted by one of the researchers for screening to ensure that they met the study participation criteria. Interviews were held at a setting of the woman's choosing: the mentoring program office, a neutral community location, or the woman's home. Each participant was provided with a copy of a detailed letter of consent (Appendix B) that was reviewed with the researcher prior to initiating the interview.

The interview questions consisted of several open –ended questions and focused prompts and were structured around four main themes:

1. life before entry into the mentoring program;
2. experience of being mentored;
3. the context of women's lives; and
4. after the mentoring program.

A copy of the interview guide is provided in Appendix C. Each interview lasted from one to two hours in duration and was recorded on a digital audio recorder. Interviews were then transcribed and analyzed using the qualitative research software Nvivo (Version 9).

Limitations

It was anticipated that only a small number of women would be willing to participate in a study of this nature, due to the fact that mentoring programs are relatively new in Canada. Many mentoring programs have been in existence for less than ten years, and there are fewer than five graduates per year in some programs, due to the small size of programs and the intensive three-year duration of support that mentors provide to women. Given the challenges in developing trust with women who have often experienced distrust with formal helping systems, it was also expected that some women would be reticent to talking about their experiences and decline an invitation to participate in this research. Therefore, in order to attract a sample of 5 – 12 women, no sampling methodology was employed to solicit women from a cross-section of community types (for example, urban or rural based), cultural groups, provinces, or programs. Voluntary participation was the key characteristic that determined participation in the study, in addition to the main eligibility criteria. Consequently, the ten women who agreed to be interviewed for this study cannot be considered a representative sample of the population of women who have completed a mentoring program in Alberta or

Manitoba. However, it must be noted that many qualitative studies involve a small sample population who have shared a similar kind of experience, in this case participation in a mentoring program for women with high risk substance misuse issues, even if there are some differing demographic characteristics.

Demographics

A total of ten women agreed to participate in this qualitative study: six from Manitoba and four from Alberta. They ranged in age from 19 – 42 years of age. In Manitoba, three women completed a rural-based mentoring program and three women completed an urban-based program. In Alberta, all four women completed an urban mentoring program.

At the time of enrollment, seven women were pregnant, and five acknowledged using substances throughout their pregnancies. Seven women were in relationships at admission to the program, although one partner was incarcerated at the time of enrollment. Four of the women described their partners as abusive, and five partners were identified as using substances, with one partner selling drugs in addition to using substances. One woman who was not in a relationship reported having been in an abusive relationship in the past. At the end of the program, five women had partners, with two of these women remaining in the same relationship they had been in at intake. At enrollment, five women had recently had their children apprehended by child welfare, and one woman was at risk of having her children apprehended.

Study Findings

The aim of this qualitative study was to learn about the experiences of women who had completed a PCAP-model mentoring program in Alberta or Manitoba, focusing especially on how the mentoring program had made a difference in their lives. Analysis of the responses of the ten women who were interviewed for this research resulted in the identification of four distinct phases that were common across their experiences:

1. Engagement with the Program (characterized by one participant's quote *"I think I hit rock bottom"*);
2. Discoveries Through Mentoring (or in one participant's words *"I wasn't as broken as I thought I was"*);
3. Changes and Transformations (described by one woman as *"It literally changed my life"*); and
4. Life After Mentoring (captured by one woman's assertion *"I take care of myself now"*).

Each of these phases will be examined in detail, including the sub-themes that emerged from the analysis of the interviews within each of these phases. As much as possible, the words of the women themselves are used to articulate their experience of being mentored. To begin, a fitting definition (and endorsement) of mentoring was inadvertently offered by one participant, which captures in her own words what it was like to meet with a mentor:

You meet with this lady once a week and she gives you rides that you need or takes you to appointments if you need. She's there whenever you need to talk and gives you information on stuff like parenting and FASD and stuff like that and whatever. It's an awesome program and they don't judge you and it's all confidential and it's awesome. I love it.

Phase 1: "I Think I Hit Rock Bottom" – Engagement with the Program

For all of the women, their lives leading up to enrollment in the mentoring program were characterized as the most desperate of times. They used diverse but similar terms to describe the personal challenges they were facing, including having difficulty coping, feeling like giving up, and feeling alone and abandoned. Five women had experienced significant losses just prior to enrollment (such as the death of a partner by suicide, the death of a parent by homicide, the death of a parent by illness, and the death of a friend by overdose). Additionally, five women had their children apprehended just prior to their decision to enroll in the mentoring program and one had been threatened with apprehension as soon as she delivered her child. Four women stated that their substance use was at its highest during this time. The profound losses of their lives had taken a toll and left women with no hope for the future. Comments made by women about this time in their lives included *"I really, just truly, was a shell and just empty"* and *"I was really afraid that I was about to lose everything"* and *"I knew that if I don't get this help, I'm going to die."*

'This help' was the mentoring program. Four women were referred to the mentoring program by their health care practitioners and two were referred by their child welfare workers; in each case, the professional involved with the woman made the referral call on her behalf. These women had never heard of the mentoring program before. Three women knew a little about the program prior to enrollment, as one had picked up a pamphlet in the local mall and two knew of friends who had participated in the program. These women made the call to the mentoring program on their own. One woman could not recall how she learned about the program or how she was referred to the program.

Certainly, their state of desperation was the main factor behind the decision to accept the offer of mentoring supports. Many women recognized that they could no longer cope alone and had no other source of support in their lives, and many women identified their children as a primary motivator for enrolling in the mentoring program. They also liked the practical supports that the program offered, such as transportation, information, and support to attend appointments. However, the most important reason they agreed to enroll in the mentoring program was that the offer of support was immediate. One woman stated:

I think the hardest time was when I first made that phone call and that time, they came right away. The help started right away. These people are going to be here, they are going to be here to help me, and it just got better.

Phase 2: “I Wasn’t as Broken as I Always Thought I Was” – Discoveries Through Mentoring

Once women agreed to participate in the mentoring program, they reported that the development of trust was crucial to their ongoing involvement. Their life experiences had left them unable or unwilling to trust others, but despite their dire circumstances, they needed to know that they could trust their mentors. Mentors frequently told women at the start of the program that their involvement was confidential, which meant a lot to the women. They also talked about how important it was not to be judged, as so many had already judged them in their lives. Respondents described the development of trust this way:

It was just sudden, it was just everything is so beneficial. It was just the talking and somebody hearing my side, and the real side. It wasn’t just someone assuming something and treating me a certain way. They really wanted to know how I was feeling, and I could really open up, whether it was good or bad, and I liked that.

[My mentor] made a commitment to me and she kept it. She said, “I will be here every week and you call me whenever you need”, and she kept that commitment and she was always willing to help. She was always willing to help no matter what I needed, and taking me anywhere. She was always there.

The women identified what mentors did as the most significant part of the developing relationship of trust. Specifically, they mentioned the provision of emotional support, encouragement, compliments, and practical assistance (for example, transportation) to access required services (such as medical care and resources like food banks). Most women had never experienced this kind of support before. For example, one woman stated:

Some people, like I said, in the past they try to give me shit. That didn’t help me and that didn’t change me. It pissed me off. I went and did it even more. But when you have someone like [a mentor] in your life coming to you and saying “Good job, you know you are doing the right thing”, it just takes a whole load off every time you meet that person. Every time you are around that person is positive.

Another said:

She just got access to so many different places that were the best for me. You know, even from the food bank to stay-in-school programs for my boys, like, there is nothing that she didn’t do for me. And sometimes, I even felt that I was taking advantage of her.

Secondly, women identified the characteristics of their mentors that made a difference to them, such as being compassionate, being reliable, and having a big heart. It was these attributes that often led to mentors becoming so close to the women, they were almost like friends. Almost all of the participants described their mentor as being like a friend in many ways, although they were also able to distinguish between personal friends and professionals. However, many women had no personal friends or personal supports – professional supports were all they had.

It got more personal and she was more of a sister almost, but on a professional level. She kept her professionalism, but she also took that one step closer to me. We were friends, almost, and I would tell her things that I would never tell anybody.

She was genuinely concerned...it was more like, not best friends, but listening-wise, which was really good.

The respondents also appreciated the advice that mentors would give to them. In many cases, these words of advice continued to guide the actions of the women after program completion. One woman explained it was like having her mentor's voice in her head, telling her what to do or how to handle things differently. This was particularly helpful guidance when dealing with child welfare agencies, women reported, as they were reminded to stay calm and advocate for themselves. For example:

There was a lot of support for me too, because I would always get upset, and she would be, like "Okay, let's not swear". That type of thing. Kept me grounded, I guess.

Then my meetings with CFS. She would give me some pointers, like "Maybe you should try it this way, instead of this" kind of thing, and try to help me do things differently, in a positive, better way.

She was always saying to me, "You got to learn to say 'no', and you have to learn how to stand up for yourself. Stop letting people walk all over you."

Importantly, once trust was established in the relationship between mentor and participant, women were willing to accept challenges from their mentors. On occasion, mentors had to confront the women and push them to do what they needed to do, interactions that were difficult, as women were faced with realities they preferred to avoid or had to overcome their fear about something they didn't believe they could manage. Still, these confrontations did not damage the trusting relationship. In fact, the high degree of trust, caring and respect were the very things that made such confrontations possible.

Usually, [my mentor] was quite direct in her words. Even though on occasion they could be hurtful, she would tell me before that “This is going to hurt, but I’m going to say it”.

[My mentor] is very opinionated, strong-willed, abrupt, and sometimes ignorant a little bit, but you know, when it comes from a good place and a good heart, you know that she’s only saying it to make a difference for your life. She just changed everything for me.

[My mentor] actually pointed out to me a few times, “Why did you do it last night” or “Why did you do it last week”, and “Say, do you see the same thing that’s happening every time?”

Often, the mentor was the only one in the woman’s circle who could provide her with the support she needed. Two especially poignant examples were raised by respondents of this study. One woman talked about asking her mentor to be with her during her caesarian delivery at the hospital, as there was no one else she could ask, stating:

[I called my mentor]: “I want to ask you something and I’m not sure if you are allowed, but would you like to come with me while I am having my baby today?” Then she stood by my side and I was shaking, and I was scared that I had to have a C-section, and she was holding my hand, like she didn’t have to, but she was holding my hand. I was like, “Okay, thank you, oh my goodness, I am so happy that you are here.”

Another woman described her experience of leaving the province to attend a residential treatment facility, with the support of her mentor:

[My mentor] drove me to the bus, gave me some advice. She hugged me, she was so proud of me and she’s like “Oh, I’m so proud of you, do it, do it.” She encouraged me so much and she was the only one that was at the bus stop, saying “You can do this. You can do this and I will be there once you come home and I will be waiting for you at the bus stop and I will meet you.” And sure enough, when I was done, I finished, and then I came home and she was at the bus stop, and I gave her a big hug and she was all happy.

One of the most important activities of the mentoring program involved the identification and attainment of goals. Many respondents were not accustomed to articulating and working on goals, although some stated that they had goals, but didn’t know how to achieve them. With encouragement from their mentor, women began to identify goals for themselves and develop plans to work toward them. Examples of goals included improved health care (attending medical appointments, healthy eating, etc.), attending parenting courses, engaging in hobbies, going back to school (for training, literacy, or high school credits), searching for housing, and working toward reunification with their children who were in child

welfare care. Many women spoke explicitly about the process of setting goals, which became a skill they still used after completion of the program: writing goals down, taking small steps, evaluating and rating their progress, building confidence in their abilities, and becoming motivated to achieve their goals.

We started setting goals. And I never had those before. I didn't even have hobbies. Like, my hobby was drinking and going out every weekend.

[My mentor] just kind of made that bridge to places that I would have never imagined being able to go to.

Women also expressed their gratitude for the support of their mentors in working with the child welfare system. However, a couple of respondents noted that child welfare workers were not necessarily as pleased to be working with their mentors. Mentors were strong advocates, understood the child welfare system, and were willing to challenge the system on behalf of the women. In some cases, the mentors acted as a second pair of ears to help women remember what was said, and they often helped to interpret technical language and processes for the women.

Child welfare agencies were not generally seen as helpful, the women reported, as their caseworkers just told them to go to addictions treatment, or go to a parenting program, which felt like having to jump through hoops. Women described their mentors as being more purposeful in helping women to see what they needed to do and why. Mentors helped the women have faith that they could be successful in regaining custody of their children from child welfare care.

People are always paranoid about [child welfare], all the time, so to see that [my mentor] came in and she was definitely not on [child welfare's] side was a good thing, and it just opened up all the trust. Because that's a huge thing, especially when you are involved in drugs and you don't trust anybody.

[Child welfare] won't do something like [help families]. They just apprehend your kids and they do their own stuff by the book and everything, and they won't give you any moral support. You have to jump through hoops for them before you can get your kids back.

Long time ago, I never seen my kids for like three months and I was upset. But, I mean, I had [a mentor] to talk to again and thought, okay, just hang in there and things will start coming together, and sure enough, I hung in there and now I'm getting them twice a month, sleepovers and unsupervised visits.

Often, one of child welfare's expectations of the women was completion of a parenting program. The women described needing feedback from their mentors about their parenting skills, needing to know that they were good mothers, as they were often unsure they were doing the right thing as parents. Additionally, all of the women spoke about how they also needed to demonstrate that drug and alcohol abuse was no longer a concern in order to child

welfare to consider reunification. Most of the respondents were parenting by the time they completed the mentoring program, with only one woman still working toward the return of her children, although she had regular contact with them. Overall, they felt positive about their parenting roles and viewed their parenting responsibilities as a priority, which hadn't always been the case when addictions were dominant in their lives.

I loved hearing that I was a good Mom. I loved hearing that I was doing it right. And I really needed to hear that, because I didn't know that.

I showed myself that I didn't want to use anymore and I don't want to hurt my kids anymore, and I don't want to. Especially as they got older, they were starting to, you know, I just couldn't leave them, I couldn't do it. I just made the conscious decision that I am done [with substances].

Many women reported feeling guilty for having failed their children. Once they were reunified, they often wanted to make amends in some way, even apologize to their children for their substance misuse. Some participants began to make connections between their own substance use and the unhealthy role modeling it presented to their children. They were concerned with trying to prevent another generation of substance misuse in their own children.

If you are teaching them positive and they see you being positive, then you are going to have a positive outcome for your kids and your family. But if you are going to sit there and drink in front of your kids and they are 7 or 8 years old, your kids are going to drink in 10 years because they are going to think it's okay, and then they are going to drink in front of their kids.

It doesn't help the family, your family, that if you continue on going on with things like that...because your kids are going to be like that.

I apologized for the things that I did, but [my children] are little, and I have a chance to catch it now before it's too late.

However, parenting was not without its significant challenges. Some of their attempts to compensate for their past mistakes were problematic, such as letting their children get away with things and learning that they needed to set consistent limits.

I felt guilty and now it's been over a year and I have had to start putting my foot down, because I was letting them get away with way too much.

Other challenges included engaging the necessary supports, whether community services or the assistance of a partner, to ease the burden of parenting.

Back to social services, I am basically begging this time for help. Basically, there is nobody to get a hold of when you call the office, nobody is answering. There is nobody to help with anything.

Like, I did everything, the laundry, the bedtimes, the suppers, everything was on me, and I felt so pressured, and I felt “Why can’t anybody else help here?”

[My son] still is very high needs. I don’t have enough support for him. I don’t have nobody else, and I am on 24-7, which puts me on standby on a daily basis for his school, because if his behaviour has escalated, I have to pick him up, which has happened.

Despite these challenges, many women shared stories of feeling competent and strong as parents, surviving circumstances they might not have coped with well in the past.

There have been times, like just a couple of days ago was the worst night I have ever had with my kids. Was the worst by far, and I didn’t know how I was going to get through it, but I got through it. I survived. And then, all of a sudden, the next day was, probably, the best day, it was just ‘wow’.

Women also described their relationships with partners, both before, during, and since completion of the mentoring program. Partner relationships prior to admission to the mentoring program or in existence at the time of program initiation were often characterized by the man’s abusive behaviour, his substance misuse, and his unhelpfulness in parenting or household maintenance. When talking about past relationships with unhealthy partners, the women often referenced how the nature of the relationship affected her self esteem, her self-care and her substance use.

Before, it was like, when I was with him, I didn’t give a shit. I would just put my hair up and I don’t go shower for two or three days, because I am always at home, and he kept me at home. And if I did try to wash up or whatever, “Who are you trying to look good for?” Now I can do whatever I want.

I told my ex, I said, “You know, someday, somebody is going to appreciate me”, and I said “Somebody is going to love me, somebody is going to take me, and somebody is going to accept me and make me feel better and going to appreciate me and take care of me and love me, and not put me down and make me feel like shit and treat me like dirt, and leave me and the kids alone all the time and think about themselves.”

Mentors were instrumental in helping women to recognize the abusive and denigrating characteristics of their relationships, and although they didn’t tell women what to do, for many women, this insight helped them to end destructive relationships.

I realized telling [my mentor] what was happening to me and my partner, and she didn’t make me change my mind or whatever, just made me open my eyes and realize it’s not good for me and my kids to go through that. Like, she gave me resources, like “Okay, go to this and call this and that”. But that’s when I realized, towards the end, like I said, I got to snap out of it for my kids.

Women recognized that they approached new relationships differently, although with hesitation for fear of making the same mistakes again. They were often encouraged by their mentors to use their insights to assess their new relationships. Women were often surprised by how positive relationships with partners could be.

I am already into a year [of the mentoring program] and then I met somebody. So I talked to [my mentor] about that too, because I didn't want to start falling into a relationship again with those signs of abuse, or whatever, and I started talking to her and I would share those things with her, because she would know of those signs. And I would tell her how I felt about the whole situation, and then she's like "Yes, okay, it sounds good. Right on. See, things change, and things will get better." So, I am still with the guy today.

An important area of growth was learning how to deal with and recover from relapses. All ten women involved in this study acknowledged that relapses were part of their recovery process while in the mentoring program. While one woman stated that she only had one or two relapses, most reported having several through the duration of the program. Some women talked about being able to identify their triggers for relapse as a result of being in the program:

- For one woman, it was night time, when she was alone and all the evening parenting and household chores had been done and she was watching television;
- For another, it was whenever she felt alone;
- For another woman, anger was a relapse trigger; and
- For another, it was harder to avoid drinking after her children were apprehended.

Women had enough trust in their mentors to tell them when they had relapsed. They recognized that disclosure about relapses was part of their recovery, that their mentor was not going to judge them, but would challenge them to examine the reasons behind their relapses. Sometimes, the relapse was the incident that helped the woman decide that she needed to go into treatment.

I was really feeling guilty that [my mentor] was probably worried. So I remember calling her and she didn't freak out or nothing. She just said "Do you want me to come and get you? Are you done, are you really done? You don't have to do this alone. We can do this together", so that made it a lot easier. And I just remember my relapses were getting fewer and farther apart because I was happy and I didn't feel like I needed to be sneaky, and I liked the trust that I was getting back in my relationship and stuff. I just liked the person that I was becoming. I just liked it.

[Your mentor] is there for you, like no matter what. Like no matter if you messed up, no matter if you slip, she's still going to help you, and she's not going to abandon you like other people did in your life.

Sometimes, [my mentor] would even relate things back to her own life, so it wasn't always pointing the finger at me. It was saying, "You know what, I've gone down that road and I know how relationships can be", and things like that, and it was so helpful that I wasn't alone.

Although relapses did occur, all ten women talked about ways that they learned to cope with and prevent relapses. In most cases, women used their mentors as initial prevention strategies, contacting them to overcome feelings of isolation, to seek out support, to cope with a bad day, and sometimes just to get over that moment of craving substances. Many talked about how their mentors were immediate in their response to calls about needing support to prevent relapse. They also found that there were others they could rely on for support in preventing relapse, including other professionals, AA sponsors, friends, and family members. For one woman, the positive experiences she was having with her partner and children when they were home with her have kept her motivated to maintain sobriety.

When I had a bad day and had nobody to talk to, [my mentor] was there, she was like a phone call away. And she was just there when I felt angry, when I felt alone, when I felt, you know? And when I was starting, when I was home with the kids alone, I was starting to get bored again, and that's when usually an addict starts up again, because they have nothing to do. She came, and I told her, she came right away and got my mind off of it.

It was overcoming the obstacle of feeling alone, feeling like I had to seek out that help, where it was just one person with the resource in order to help me to stop behaving in that way, or to reach out and say, "It's okay, we are human. Don't be so hard on yourself. Let's do this together and move on."

I would phone [my mentor] and she would phone me and come and pick me up and take me for coffee, because it takes 15 minutes to get off of craving whatever you had. She's the one who told me that.

One of the major changes women had to make in their lives to prevent relapses pertained to limiting their contact with family members and friends who were risky influences for substance misuse. It took considerable courage and strength to place boundaries around these relationships, and there were significant losses experienced as women disengaged from those who had otherwise been included in their support networks, often leaving them feeling isolated.

I kind of kept my distance and I knew that's what I had to do, is to stay away, because [my sister] could have a slip at any time, and it would be such an easy access for us to start doing our thing. And I just knew that was another thing too that you have to stay away from....Like [my mentor] said, you got to stay away and you have to change your friends, and you have to change people in your life, and you have to stay away from things like that. And you will know who your true friends are when they are there going through your healing process.

I am scared to have friends because they might not be suitable to my family. So I am just scared to have people around because if they drink, they are not good, or if they might do drugs. So I keep myself very isolated, and still do. And by having the program, it allowed me not to be isolated, because they were acceptable and they were people I could have in my home, and people we could go to and go to functions with without being judged.

I had to stop letting [my neighbor] come into the house to use the phone, to phone for drugs, and I'm like "no more". I just had to shut my door and shut her out of my life.

Unfortunately, when I got my kids back, I was basically told that those aren't the people that I should surround myself with because I will find myself in the same position again. So unfortunately, the only person that was there to help me and give me a home when I had nothing, I had to walk away from that. So I haven't seen her (that friend). In July, it will be five years.

Throughout their interviews, women talked about changes in their substance use, although some women did not attain (nor were they aiming for) full abstinence. However, there was considerable evidence of harm reduction as a result of changes to women's use of substances. In fact, some talked about harm reduction as being the best strategy toward making changes in their use of substances. Many women attributed mentors and the mentoring program for helping them to make the decision to enter treatment or change their substance use patterns. Given that this is one of the key aims of the mentoring program, numerous quotes about these women's experiences with harm reduction are warranted:

With the amount of drugs that I was doing, it was hard for me to just go cold turkey, so we were just going to work on that really slowly.

[The mentor] helped me do things in a positive way and not turn to alcohol or drugs, that kind of thing, and trying to find positive activities out in the community, like for me and my family.

After leaving the mentorship program, throughout the whole program, I did continue smoking marijuana, but at a lot less rate than what I had for the previous 30 years. But now I have quit that...Well, I guess it would be about 7 months now, completely.

I still continued to use on and off, and then I finally made up my mind in September that I wanted treatment, and I've been sober since, which is good. And I found that probably made a difference from the mentor program, because since I entered the mentor program is when I started thinking about sobriety.

My hobby was drinking and going out every weekend. I mean, I still continue doing some things, but then I started thinking about "Okay, well, I don't have to do these things anymore because I have this person to help me."

I am always going to be an addict. I am always going to use somewhere down the road, get real. You can talk to anybody until you're blue in the face, but the reality is, somewhere in the back of my mind, I had thought "I am still going to use", and we work through it.

Even the days where I felt so ashamed because my alcoholism was really affecting my life, I was a high functioning alcoholic and my alcoholism was affecting my life a great deal. And when it was, I was still able to pick up the phone and still talk to [my mentor], which was very beneficial.

Because of the fact my substance use had decreased and such, I was seeing a little more clearly and actually feeling a little more capable of taking care of myself. And with that kind of help, I was most likely grateful for it because I needed that. I needed that support to make sure that my health was in good condition, because I was basically really malnourished and left with nothing.

Women also commented on the effectiveness of their efforts to address their substance misuse (and many did achieve abstinence) and the profound changes in their lives related to substance use:

Drug use has changed definitely, yes. Did I do programs when I was...no, [my mentor] was always trying to get me to go to AA meetings and stuff and I didn't want to. I felt uncomfortable at the time. I was probably still in denial. I guess I didn't want people to know. But since then, I have completed many programs and I have been clean and sober and off drugs.

I haven't touched anything, any kind of drugs for six months.

And to this day, I don't smoke, I don't drink, and I'm still in my relationship and I still feel good. I still am working on my kids, but I mean, I still know I have the tools that [my mentor] gave me, and the support that, I know that there is always support out there.

Made me think a lot differently about drugs and alcohol and more aware of the consequences, on parenting. Just the effects of drugs and alcohol have made me more aware, plus growing up with drugs and alcohol – not so much drugs, but a lot of alcohol in my surroundings. And maybe I've learned more about how come I turned out the way I did, or the way I talk to my mom, or the way I treated others and stuff. It made me more aware of that, maybe.

And perhaps most profoundly, the reflections of one woman:

I can't believe though, that today, when you see other addicts doing their drugs, I can't believe that I was there one time, and how much it's a waste, it's just a big waste of money and a big waste of life and time.

Phase 3: “It Literally Changed my Whole Life” – Changes and Transformations

The women who participated in this study identified many significant changes that had occurred in their lives, which they attributed to their experience of being mentored. These changes included specific, practical changes, such as:

- Participating in programs they might not have accessed previously, such as literacy programs or addictions programs;
- Developing insight into themselves, their families, and their substance use;
- Learning how to deal with triggers for substance misuse;
- Accessing practical supports, such as emergency food and milk, bus tickets, assistance to get to appointments, and guidance with preparing resumes and conducting a job search; and
- Developing important life skills, such as budgeting, parenting skills, and consistently using birth control.

Many women spoke about the things they had learned about themselves through the experience of being mentored, especially positive changes in their attitudes or perspectives on life. Most significantly, they identified increased self confidence and self esteem, feelings of competence and capability, self-acceptance, and a growing sense of self-worth and maturity.

[My mentor] just helped me realize that little flicker of light inside. As long as you can feel that, then you will glow and people aren't going to see what you think they see, right. They are just going to see that kindness, and that lovingness, and smart and stuff like that. And that was something I always knew, but coming from someone else that also felt like that, it's like, okay then, that must be real, so that was huge.

I was capable, and that I was beautiful, and I was worth it, and that I was worth it and I was smart. I think that feeling that I was smart...Nobody ever really saw that I was smart, but [my mentor] saw I was smart.

I finally became more mature. I kind of became more mature and started putting my responsibilities first, instead of playing around all the time.

I know that I am capable of doing things that I didn't know I did. And I am my own person.

These changes were often directly and indirectly attributed to the women's mentors, leaving many women inspired to want to help other women.

The ability to trust, the ability to move on, the ability to have the strength even when times are really tough, that there's always a way out. There is always somebody there to help you and you just need to find it. Teaching me how to

access communities, teaching me how to ask for help, and I take it with me probably every day, what [my mentor] has taught me.

Knowing that somebody loves you for who you are, and just knowing that someone trusts you and believes in you, and that somebody is there to help you get whatever you need done...To be able to get what you need doesn't come very often.

It kind of inspires me because they help me, and that makes me want to help other women.

Several women characterized the changes they experienced as total transformations, from who they had been to who they are today. They pointed out contrasts from where they had been in their lives previously to where they are today. These changes occurred at a significant internal level, stimulating faith in herself, empowerment, and, most importantly, recognition that it is her right to have a good life. Again, multiple quotes are appropriate to share the voices of women in transformation:

I went from being the suicidal drug user to the college graduate, and everybody is like, "Wow, what a difference."

It literally changed my whole life. They gave me hope again. They gave me a faith in myself that had kind of left and, if up to the rest of the people in the world, I still wouldn't have any of that.

I got presented with an Eagle feather, actually, and there was the whole thing for two hours. It was just for me. Just to say that "You have been coming here for two years and we've watched you grow as a mom, and we've watched you as a person." And to be presented with an Eagle feather is just the biggest honour. And just everything, they made me a medicine bag where there is sage and there is sweetgrass, and it's for me. It was for me, and I have never felt so special, ever, in my life.

I didn't have a lot of faith five years ago, and I watched everybody walk all over me. And within meeting [my mentor], within four months, everything completely turned around and changed, to the point of having my boys back.

If I didn't have [my mentor] or the program, I don't know where the heck I would have been, who knows. To have that somebody there when you are so alone and you are struggling, and all it takes is somebody to come into your life and say "Good job", or "Here, do this" or "Do that", "Here's this way", and "You can do this instead of this, try this instead of that." Like, and you don't know any of the things like that, and nobody teaches you. You don't know. And then somebody comes along and teaches you and tells you, and you are, like, "Wow."

They helped me get my wings together and helped me set off into flight into a good life. That's basically the way I could describe it.

Knowing that there is a wonderful life out there for me and I'm entitled to it. Life is what you make it. From where I came from before to how I am now, it's just, I don't know, it's so different. I am a totally changed person, not the person I used to be. You know, I have changed every single part of my life.

Interestingly, at the start of the interviews, women often downplayed that they had achieved anything remarkable in their lives, and were skeptical that anyone would be interested in their experiences, which they perceived to be quite ordinary. However, as each interview progressed, each woman expressed a new appreciation for her journey and accomplishments, recognizing the magnitude of change she had gone through and the courage it took.

Phase 4: "I Take Care of Myself Now" – Life After Mentoring

The ten women who participated in interviews expressed sadness that the mentoring program had ended for them and that they had "graduated". They wished that the program was longer, or that there were other programs or "after care" services that were available to them. Despite the transformational changes in their lives, they didn't feel ready for the program to end, that their growth was incomplete and their work was unfinished. And, despite the end of their involvement in the program, they still call their mentors on occasion for advice and support.

It was kind of sad. It was like, "Can I go reapply?"

I was kind of disappointed too, because I didn't...like, I know I can still count on them, but I mean, I kind of felt like I was on my own now. And I felt kind of like there was things that I haven't done yet that were my goals, that I didn't get done really.

It really broke my heart when we were finished the program.

At the end of the program, I was sad because I didn't want to get out of it. I didn't want to quit.

It was more than losing a best friend. It was like, I don't even know, like more than a mother. It was kind of like I felt like I was losing everything.

As they elaborated on what the mentoring program meant to them, the women turned to describing the relational dynamics between themselves and their mentors that had been most meaningful. The enduring nature of these relationships, even though the formal aspect of contact had concluded, was poignantly expressed by many women.

[My mentor] still thinks about me. She cares. She is so caring and giving that way, and that, I think, was really beautiful. So I think she could be one of the people that I could depend on if I really needed any support that way.

I know if I really felt bad, I could phone her and talk to her if anything happened, like, ten years down the road.

I still know that she's always going to be there if I ever needed to talk, no matter what. But I think she's at ease too, because she sees me doing the right things and she sees me doing good. So I think she's a little at ease too, and she's like, "Right on, I did something. I helped somebody."

Despite their sadness at leaving the program, the women acknowledged that they had developed some skills to manage their lives more independently. For example, they talked about how they had learned to identify and work toward goals. While some goals had already been attained during the mentoring program, women were also thinking about their long-range goals that now seemed possible. For some, these goals included employment, returning to school, and even becoming mentors to other women. For others, their goals were more about self-care: being able to support themselves and their children or getting their health issues under control. Some women spoke about practical goals, like getting a driver's license, buying a car, or obtaining their own home.

I want to go back to school. I want to help others. I want to be a role model for my children, and I want to have a good home for them.

I'm kind of looking forward to learning more about myself and how I can maintain it.

Well, pretty much, I just want to be happy and sober and be able to live a sober life, and to be positive and have a good job, finish school, and go and take something for a career kind of thing.

I am wanting to have the positive lifestyle I've always wanted. Just to be settled, to have that clean environment, able to work while my kids are in school, come home and be a family.

The women also talked about goals they had for their children, such as getting an education and playing sports. Some also thought they would want their children to know about their struggles with alcohol use and abusive partners, feeling that telling their stories would help their kids avoid these issues in their own lives.

I want them to have a childhood that I had, where they don't know their mom as an addict. I want to be there for all the bake sales, I want to be there for all the field trips, I want that special feeling that I had, and I want them to know that they always know where mom is, that security, right? That's what I want, and that's what I'm going to give them.

School, to finish school, to not smoke, to have hobbies, to know wrong from right and to become something, and to be positive. Just to have a positive lifestyle and to know the signs of danger and abuse in a boyfriend, and to choose and to be proper with their kids when they have kids. And to make sure they make the right decisions, because I want to tell them my experience. I'm not going to be afraid to tell them things, how I used to be, and sometimes when you tell a story of your past and you get them thinking "Wow, I never want to be there, I'm never going to be like that", and that's good, because a lot of people do need to hear people's stories and what a waste it was. And to also see that you can get better, no matter what.

Just to make sure they feel that love. I want them to have big hearts and know right from wrong. And that is not as easy as it may seem, right?

The women also described their current sources of support after completing the mentoring program, and it was evident that mentors continued to play an informal support role for women. Despite the changes they had made, the skills they had developed, the dysfunctional relationships they had left, there were still gaps in their support networks that had not been filled once their mentors left that formal role. Some women could only identify professionals as the current supports in their lives. Other women talked about relationships with family members or partners as becoming more supportive as a result of changes they had made during the mentoring program. In some cases, supports from family members were problematic or conditional, indicative of the lack of support women had experienced throughout their lives in their personal support networks. For example:

My sisters. My mom. She has seen a big change too. She also had started to see a big change, and I guess there was times where I did use to take advantage of her and get her to babysit and borrow money and things like that. And of course, nobody is going to want to deal with anybody who is just going to use you, or they try to give you advice and you shut them out. And you start realizing and saying things to them, and that person doesn't want to even be around you at all. So she came back into my life. And then I told her, and I apologized to her, and I said, "Mom, I am sorry. Now I understand why you were trying to say these things to me, and I was so stubborn."

There is about three or four people in the church who would be there for me, people that bought me my first van, who came to court with me, and I think I have to add my Dad in there. Even though by having my Dad support me, puts him and my Mom at odds, as it has been throughout my whole childhood.

Finally, women were asked if they had any advice for women who might be in similar life circumstances who were considering enrolling in a mentoring program, as well as advice they would give to mentoring programs themselves. For their advice to other women, the respondents were universal in their encouragement for women to join a mentoring program, citing its benefits to women who were in dire circumstances. Many spoke again about the

qualities of mentors that made the experience so meaningful, especially the feeling of not being judged, and the opportunity to make real change in one's life. Their advice to women:

If you really want to make it and you really want to succeed, anything is pretty much possible when you become part of the program. That they don't leave much room for failure, and when you do, you just start again.

If you are a parent who wants to give up and not have your children, don't get a mentor. If you want your children and you want your family, get a mentor.

You can't get better support anywhere else. There is no...your family will never do as much for you as this program has.

Just do it. Just do it and let it happen. Just don't think too much about it, and just know that they are there for us. They are not there to make a report to child welfare. They are not to go and talk behind your back and judge you as a mother. They are there to help you as a mother, and they are there for you and your needs, and anybody who does that as a job has to have a good heart. Just do it and it's so beneficial for everybody in your life, especially for your children, but most importantly, for yourself.

The mentor program worker won't judge you. She will not judge you, she will be there for you, even if you have slipped, even if you think you don't matter, and just to trust them. Let yourself trust them because they are there to help you...I was alone one time, and having her in my life and the program helped me where I am today, if you just allow them to help. Don't be afraid. Don't be afraid – just take it.

There is nothing bad that is going to happen. Nothing bad is going to happen. It's going to help you to be a better mom, a better caregiver, take care of yourself so you can take care of your children. No fear, no fear.

You can trust what I am saying for sure, because I have been there.

When it came to advice for mentoring programs, many women focused on strategies to make the program more known to women in the community, and the need for after care services. In particular, several women noted the critical role that health care providers play in identifying women who may be using substances during pregnancy and making referrals to mentoring programs. They acknowledged the fear that many women might have about child welfare involvement, which might prevent them from acknowledging their substance misuse, but respondents felt that if health care practitioners had a better understanding of addictions and presented with a non-judgmental attitude, they would be in a key position to help women get connected to mentoring programs and reduce, if not prevent, alcohol exposure during pregnancy.

Other strategies that were recommended included television and radio ads, increased availability of pamphlets, presentations in the community, a video or audiotape featuring

women who have completed a mentoring program which could be shown to other women in addictions treatment programs or other social service environments. They also encouraged reaching out to teenagers who might be pregnant. A couple of women also talked about how associating the mentoring program with FASD in its advertising was intimidating. Finally, the women were interested in group mentoring or group support sessions, assuming that the participants were consenting to a group process, as their confidentiality would not be as protected as it is in a one-on-one relationship.

I think [mentoring programs] should be working in collaboration with the prenatal doctors. Start working before the child is even born, before the child is exposed too much, before the damage is already done.

So many women won't say to their obstetrician that they are active users because they are in fear of their child being taken from them. They are inflicted with a disease, and if a lot more practitioners understood the disease of alcoholism and drug addiction, perhaps they would understand that there are programs like this where women can go instead of threatening them with the law.

They should have a group where the girls all meet, because we all know each other in town and whatever. I know it's supposed to be confidential, but I think with [my mentor], it would have been good to meet with a group of girls once in a while, just like an AA meeting. That's how you start things off, you chat and "How are you guys doing?" and what did we do this week, or whatever. Like, something where you can say "hi" to your girls.

Discussion and Summary

The goal of this study was to interview ten women in Alberta and Manitoba who had completed a mentoring program to learn about their experiences, especially how the mentoring program had made a difference in their lives. The experiences of the women in this study revealed four common, distinctive phases:

Phase 1: Entry to the Program: For the majority of women, entering the program occurred at the lowest point in their lives. Often, this was associated with being pregnant (7/10), using substances throughout their pregnancies (5/10), and experiencing significant losses (5) including recently having their children apprehended by child welfare (5) with one at risk of having her child apprehended (1). They characterized this low point in their lives in the following ways:

- *I really, truly was just a shell and just empty.*
- *Mentally, physically emotionally – everything was wrecked*
- *I was basically a mess.*
- *I think I hit rock bottom.*

Phase 2: Process of Discoveries: The women discovered that they won't as broken as they thought they were. Through the process of relationship with their mentors, they discovered a sense of self, self-worth, and identity. The women attributed these discoveries to their mentors:

- *I knew she was on my side.*
- *She made a commitment to me.*
- *Not only was she a mentor, she was a friend.*
- *She just really knew, even though I didn't know what was best and just really wanted to give up. She wasn't quite prepared to let me do that. Not on her time, anyways.*

Phase 3: Process of Transformation: As the program progressed, women described themselves as changing in profound ways, in their relationships, their parenting practices, their substance use, their relationships with partners, and their overall identities:

- *My mentor was the first person in my life that told me that I could do it that I believed, that I really did believe.*
- *It literally changed my whole life.*
- *They helped me get my wings together and helped me set off into flight, into a good life.*
- *There's a wonderful life out there for me and I'm entitled to it.*

Phase 4: Life After Mentoring: All 10 women were sad when the mentoring program ended, not ready for "graduation", but described themselves as feeling somewhat more empowered and independent in their lives. However, they knew that they could still call their mentors for support if necessary, and they continued to maintain contact:

- *It really broke my heart when we were finished the program.*
- *I didn't feel as strong as I would have liked to have been.*
- *I still know that she's always going to be there if I ever needed to talk, no matter what.*
- *My mentor still thinks about me, she cares. I think she could be one of the people that I could depend on if I really needed any kind of support.*

Important insights were derived from the women's experiences, organized according to each phase of their experience in mentoring. In Phase 1, during entry to the program, it is clear that health care professionals are a key point of referral. Therefore, they need to be aware of the mentoring program, aware of the dynamics of addiction, and aware of women's needs regarding their substance misuse. Most women had the referral call made for them, often by a health care practitioners, but they also stated that they would have been more willing to make the call themselves had they known about the program. Raising the profile of mentoring

programs in communities would assist in this regard. However, the most important factors that influenced women's decision to enroll in the program were a) the immediacy of service (often, the mentor immediately came to establish contact with the woman), b) the things that the mentor did that initiated a trusting relationship, and c) the practical support that was offered (transportation, assistance with child welfare, help to set appointments, etc.).

I really needed somebody. I was so depressed and I had nobody there to talk with me, to say, "Oh, everything is going to be okay."

The hardest time was when I first made that phone call and they came right away. The help started right away.

Insights from Phase 2, when women made important discoveries about themselves through the process of mentoring, can be organized around three main themes: a) the role of mentors, b) ways that the mentoring program provided support to women, and c) how to deal with relapses.

a) Role of Mentors

The women identified their relationships with their mentors as the most important reason for why the program was so important to them. The development of trust began at first contact, usually because the mentor did something practical that the woman needed, that was helpful to her. They referenced three areas that contributed to the development of trust:

- the qualities of the mentors as being key factors (non-judgmental, following through on commitments, being compassionate, and having a big heart);
- the provision of emotional supports (compliments, encouragement, positive feedback, being willing to listen); and
- the provision of practical supports (information, access to resources, transportation, taking her to appointments).

Eventually, women found that they were reaching out to their mentors themselves, finding that their mentors were responsive and supportive. Over time, the relationships evolved and mentors became friends, not only to the women herself but also to her partner and extended family members.

It got more personal and she was more of a sister, almost, but on a professional level...I would tell her things I would never tell anybody.

The most important part, I think, was having someone to talk to, and not only were they a mentor, but they were my friend.

So it was a mentoring program, but she was more like a friend to everybody. It kind of became more of a friend, a family member almost.

More importantly, over time, mentors were able to challenge the women around their decisions, around their behaviour, and while these challenges were difficult, they were accepted by the women the resulted in change.

Usually she was quite direct in her words. Even though on occasion they could be hurtful, she would tell me before that "This is going to hurt, but I'm going to say it".

She said some firm things that she was right. It was criticism, but I wasn't good at taking that kind of stuff at that time.

If I had met my mentor at any other place, we probably wouldn't have liked each other. She is opinionated, strong-willed, abrupt, and sometimes ignorant a little bit, but you know, when it comes from a good place and a good heart, you know that she's only saying it to make a difference for your life. She just changed everything for me.

b) Ways of Providing Support

One of the most important things that mentors did was teaching women about goal-setting. This was a key feature of the program, and an area of skill development that women took with them at the conclusion of the program.

We started setting goals. And I never had those before. I didn't even have hobbies. Like, my hobby was drinking and going out every weekend.

She started telling me little steps, how to take it from step one to step whatever. So I tried it and then I noticed I started walking, and less smoking, and healthy eating, and things like that. She had that written down and she kept a record of it and she rated it. Then we reviewed them after, and she's like "Good job!"

Mentors were also very helpful with the women's involvement with child welfare, leading to children being reunified with their mothers in most cases.

We used to go to meetings together to meet with CFS, just first to have an extra set of ears, that kind of thing.

Long time ago, I never seen my kids for like three months and I was upset. But, I mean, I had a mentor to talk to and thought "Okay, just hang in there and things will start coming together", and sure enough, I hung in there and now I'm getting them twice a month, sleepovers and unsupervised visits.

Many women described changes in their parenting as a result of the mentoring

program: having a more positive attitude about parenting, being able to set more consistent limits with their children, modelling more appropriate behaviour. They began to prioritize parenting, and noted connections between their own histories (how they were parented) and their own approach to parenting.

I had had to start putting my foot down because I was letting them get away with too much.

If you are teaching them positive and they see you being positive, then you are going to have a positive outcome for your kids and your family. But if you are going to sit there and drink in front of your kids and they are 7 or 8 years old, your kids are going to drink in 10 years because they are going to think it's okay, and then they are going to drink in front of their kids.

Just a couple of days ago was the worst night I have ever had with my kids. Was the worst by far and I didn't know how I was going to get through it, but I got through it. I survived. And then, all of a sudden, the next day was probably the best day, it was just, "wow".

For the 7 women who were in relationships with partners at the start of the mentoring program, relationships were characterized as unsupportive (3), abusive (4), and marked by substance abuse (5). Three partners were actively against the woman's involvement in the mentoring program. However, relationships at the end of the program were characterized differently, with women attributing the difference in their current relationships as due to insights they gained from their mentors about how to recognize abusive relationships and their newfound sense of self-esteem and self-worth.

I realized telling my mentor what has happening to me and my partner, and she didn't make me change my mind or whatever, just made me open my eyes and realize, it's not good for me and my kids to go through that.

I told my ex, I said, "You know, someday, somebody is going to appreciate me." I met somebody. So I talked to [my mentor] about that too because I didn't want to start falling into a relationship again with those signs of abuse or whatever."

c) Dealing with Relapses

All 10 women experienced relapses during the mentoring program. They found that they could talk about their relapses with their mentors, learning about their triggers and deciding to enter treatment programs.

She's there for you, like no matter what, like no matter if you messed up, no matter if you skip, she's still going to help you and she's not going to abandon you like other people did in your life.

So I remember calling her and she didn't freak out or nothing. She just said, "Do you want me to come and get you? Are you done, are you ready? You don't have to do this alone. We can do this together". So that made it a lot easier.

They also learned how to cope with and prevent relapses, using their mentors as primary prevention strategies. They found that their mentors were immediately responsive to calls about needing support to prevent relapse.

Just knowing that in the worst case scenario, that at least having somebody to talk to even for a few minutes, helped knowing that they were there.

I would phone her and she would phone me and come and pick me up and take me for coffee because it takes 15 minutes to get off craving of whatever you had, and she's the one who told me that.

Women also reported that they had to make changes in their social relationships to prevent relapse, but it was difficult because it made them isolated.

Like my mentor said, you got to stay away and you have to change your friends and you have to change people in your life and you have to stay away from things like that.

I am scared to have friends because they might not be suitable to my family, so I am just scared to have people around because if they drink, they are not good, or if they might do drugs – so I keep myself very isolated and still do, and by having the program, it allowed me not to be so isolated.

There was considerable evidence of harm reduction throughout the women's experience in the mentoring program.

With the amount of drugs that I was doing, it was hard for me to just go cold turkey, so we were just going to work on that really slowly.

I still continued to use on and off and then finally, I made up my mind in September that I wanted treatment, and I've been sober since, which is good.

Since I entered the mentor program is when I started thinking of sobriety. In the last while, I feel good about myself because I'm not abusing as much as I used to and I am focusing on my babies more than I did.

And to this day, I don't smoke, I don't drink, and I'm still in my relationship and I still feel good.

I can't believe though that today, when you see other addicts doing their drugs, I can't believe I was there one time, and how much it's a waste. It's such a big waste of money and a big waste of life and time.

In the third phase, women experienced transformation. Many significant changes were noted by the participants that they attributed to involvement in the mentoring program. The mentoring program assisted women in getting involved in programs (literacy, addictions treatment programs), developing skills, gaining insight, using birth control, and accessing practical supports (food banks, bus tickets, preparing resumes).

Just helping me go in the right directions when it came to finding help for my substance abuse, making sure I would go to my doctor's appointments, help with keeping me healthy and keeping me taken care of, so then that way, I was a bit more healthier for my son.

Maybe learn more about how come I turned out the way I did or the way I talk to my mom or the way I treated others and stuff, it made me more aware of that.

They also described changes in their self confidence and self esteem, independence, self-acceptance, and sense of self-worth and maturity, which they attributed to their mentor.

I had bigger confidence of myself. My self esteem was higher.

I know that I am capable of things that I didn't know I did. And I am my own person.

I found it made me more independent. I found myself getting independent and not relying on other people and finding myself resources that I needed.

Many women described their experience through mentoring as leading to total life transformations: faith in oneself, empowerment, and recognizing her right to have a good life.

I went from being the suicidal drug user to the college graduate and everybody is like, "Wow, what a difference."

It literally changed my whole life. They gave me hope again. They gave me a faith in myself that had kind of left, and, if up to the rest of the people in the world, I still wouldn't have any of that.

Coming from losing your kids and thinking that you are not the best person in the world for them and then seeing that now that you are doing so much better in your life, that your kids need you and love you, and being mother and doing those mother things, and not missing out on the little things that a baby does, and being there to tuck your baby in and to be there to get up to your baby, be there to take your baby to school, and get his first thing and do that first thing – that’s what really keeps me happy today.

I was alone one time and having her in my life and the program helped me where I am today.

Finally, women talked about their lives after mentoring, the fourth and final phase of their journey. All ten participants were sad when the mentoring program ended and did not feel ready for “graduation”. However, women knew that they could still contact their mentors even after the program ended.

The women had goals for the future for themselves (going back to school, gaining employment, finding careers, supporting themselves and their families) and goals for their children (getting a good education, playing sports). They also talked about being good role models for their children, feeling that they should share their struggles with addictions and abusive partners with their children so they would understand and avoid these issues in their own lives. Some women also talked about helping other women in the same situation.

I am wanting to have the positive lifestyle I’ve always wanted. Just to be settled, to have that clean environment, able to work while my kids are in school, come home and be a family.

Well, pretty much, I just want to be happy and sober and be able to live a sober life, and to be positive and have a good job, finish school and go and take something for a career.

There were still gaps in the support networks women needed post-mentoring, and mentors (and other professionals) informally continued to fill those gaps. They still worried about slipping back into addiction, especially in the face of loss – how would they cope with things like their parents’ deaths, or loss of a partner?

The women had important advice for other women who might benefit from a mentoring program, as well as advice for mentoring programs themselves. Universally, they encouraged women to seek out mentoring programs as an opportunity to make real change in their lives. For programs, they advocated for after care programs and strategies to make the programs more known to women, particularly through the health care sector.

If you really want to make it and you really want to succeed, anything is pretty much possible when you become part of the program. They really don't leave much room for failure and when you do, you just start again.

The mentor program worker won't judge you. She will not judge you, she will be there for you even if you have slipped, even if you think you don't matter, and just to trust them.

So many women won't say to their obstetrician that they are active users because they are in fear of their child being taken from them. They are inflicted with a disease, and if a lot more practitioners understood the disease of alcoholism and drug addiction, then perhaps they would understand that there are programs like this where women can go without threatening them with the law.

I think they should be working in collaboration with the prenatal doctors. Start working before the child is even born, before the child is exposed to too much, before the damage is already done.

Recommendations

The voices of the women who participated in this study are strong testaments to the power of mentoring. Relationships are key, and from what these women described, their mentors were successful in developing trusting relationships that allowed for deep and profound change to occur over time, affecting all aspects of their lives. Significant changes were noted in substance use (using a harm reduction lens), parenting skills, having children returned to their mothers, maintaining better boundaries with others, and finding relationships with partners who are not abusive. These outcomes provide clear advocacy for the continuation and expansion of mentoring programs for women with high risk substance misuse.

However, these women did not feel completely ready for termination at the program's conclusion. They identified gaps in their informal support networks, they worry about relapse, and they are still in the process of achieving their goals. After care supports are critically needed, and while they don't necessarily have to involve the same degree of intensity that mentoring provides, a relational model of service delivery is recommended.

Women reported enrolling in a mentoring program when their lives were most in crisis, when they had reached such a low point that they were at risk of losing (or had already lost) everything. While it is promising that mentoring programs can effectively engage women when they are experiencing such desperate circumstances, it does raise the question of how women might be engaged earlier, before they and their children have endured such deleterious experiences. Some strategies were identified by the women themselves, such as raising the profile of mentoring programs in the community and assisting health care practitioners to become more cognizant of addictions and mentoring interventions, so that referrals can be

made more easily. However, the readiness of women to engage in mentoring is a theme that merits further research, to better understand what helps women engage in services and supports before their lives are in such a state of crisis. These insights would also further our efforts to reduce and prevent prenatal alcohol exposure.

It must also be noted that the women who participated in this study volunteered at the encouragement of their former mentors. Being women who had a positive experience with mentoring may have resulted in a one-sided (albeit positive) view of the strengths and benefits of mentoring. Hearing the voices of women who left the program prematurely, or resisted engagement with the mentoring program, or who were dissatisfied with aspects of the program, would add to our knowledge of how mentoring can best meet the needs of vulnerable women who struggle with substance misuse.

7. Conclusion

There is growing evidence that mentoring is a critical approach to helping women with high risk substance misuse, with outcomes that not only lead to changes in substance use during pregnancy to reduce alcohol exposure to the fetus, but transformational changes that impact all aspects of women's lives. This report outlines two studies in Canada, conducted by the Network Action Team 4 (NAT 4) of the Canada FASD Research Network, that contribute to this expanding body of knowledge.

While these studies involved small populations and faced some methodological limitations, the findings are consistent with what other researchers have found when exploring the impact of mentoring on women who abuse substances, particularly the studies based on the evaluations of the Parent Child Assistance Program (PCAP) that originated in Seattle. These two small Canadian studies also point to future research themes that will continue to enhance our understanding of how to best assist this vulnerable population.

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Network Action Team 4: Research Study Letter of

Study Title: Hearing Their Voices: Perspectives of Women who have Completed a Mentoring Program for High Risk Substance Misuse

Dear _____

My name is Linda Burnside and I am the lead researcher of the Network Action Team under the Canada Northwest FASD Research Network. My team and I are conducting a study into the experiences of women who have completed a 3-year mentoring program in Manitoba or Alberta because of concerns about their substance use. This study has been approved by the Research Ethics Board of the University of Manitoba. The study involves interviewing women about what their lives were like before they began the mentoring program, their experience of being mentored, their current lives after completing the mentoring program, and their plans and goals for the future.

In order to find women who would be interested in participating in this study, we have asked the mentoring program in your community to post a notice in the office and to provide a Letter of Invitation to women who they think might be interested in participating.

This letter is being given to you by the mentoring program that you recently completed. Women who have completed a 3-year mentoring program in 2011 in Manitoba or Alberta, like yourself, may be interested in participating in this study. We have not asked the mentoring program to give us your name, or the names of any other women. If you are interested in participating, we want to hear from you!

Let me tell you more about the study. Participating in this study is voluntary. If you decide to participate, you will be asked to meet with one of our team members, a social worker who is also a researcher on the team, for an interview. There may be up to 2 or 3 interviews, to ensure you have enough time to talk about your experience in the mentoring program. Each interview will take about 2 hours. The researcher will have some questions to ask you, but you can choose not to answer any questions that you don't feel comfortable with. You can also change your mind and withdraw from the study at any time.

The researcher will be recording the interviews on a digital recorder. To protect your confidentiality, your name, where you live, the names of people in your family, or any other information that is personal, will not be shared with anyone else. Even if you use names or share personal information that might identify you or other people during the interviews, the researcher will not be keeping that information, so your identity will be kept private.

After the interviews, if you like, the researcher can send you a summary of our conversation to make sure that she understood you correctly, or she can talk with you on the phone to review what she heard you say. If she got anything wrong, you can correct her and she will make the changes.



Sharing your experience about being in the mentoring program might be a positive thing. Sometimes, people like to tell others about what they learned, about what was helpful, or about what might be helpful for other women in similar situations to know. But, you should also know that talking about your experience might also be difficult. Sometimes, when people remember difficult times in their lives, they feel sad, worried, scared, or upset. It isn't the intent of the study to make you feel upset, but you should know that some people do feel upset when they talk about things that have happened in their lives. The researcher will be sensitive to your feelings and your situation, and if you are feeling upset, you can take a break or you can decide you don't want to continue. If you are feeling upset, the researcher will ask you if you need some support, such as from a counselor or doctor.

You should also know that if the researcher is worried about your safety, it is her responsibility to contact the appropriate professional in your community to make sure you are safe. If she is worried about your safety, she will tell you why she is worried and who she will be contacting to help keep you safe.

The study begins in October 2011 and ends in March 2012. The researchers will be interviewing women who are interested in participating from October to January. Every person who decides to be interviewed will get a summary of the study findings in writing, if they want one. After the study ends, all of the interview tapes will be destroyed.

There is no financial compensation for participating in the study. However, if you need assistance with transportation, such as bus tickets, or money to pay for a babysitter, we can help cover those costs. We also will give each person who participates in an interview with a small gift card for a local store to thank you for your time.

Whether you decide to participate or not has no effect on the services that you are currently receiving in your community or that you might need in the future. If you decide to participate in this study, you should do so of your own choice. No one is expecting you to participate if you don't want to. It's up to you.

Do you have any questions? Would you like more information? If you would like to talk about participating in this study, please let us know. You can let us know by filling in your name and contact information below and giving it back to your mentor, who will be in touch with me. Or, you can call me at (204) 619-3148 to let me know you are interested. Or, you can mail this page with your contact information back to me at: Linda Burnside, c/o Canada Northwest FASD Research Network, 14 Sunglow Road, Winnipeg, Manitoba, R3W 1C8

Thank you for your interest!!!

Your Name: _____

Contact Information (telephone): _____

(email, if applicable): _____

Community and Province of Residence: _____

Date: _____

Network Action Team 4: Research Participation Consent

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Study Title: Hearing Their Voices: Perspectives of Women who have Completed a Mentoring Program for High Risk Substance Misuse

Principal Investigator: Linda Burnside, PhD, c/o Canada Northwest FASD Research Network
14 Sunglow Road, Winnipeg, Manitoba, R3W 1C8
Phone (204) 619-3148

Co-Investigators: Amy Reinink, MSW and Sherri Tanchak, MSW

Sponsor: Canada Northwest FASD Research Network

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends, family or (if applicable) your mentor before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of the Study

This study is focused on exploring the experiences of women who have completed a 3-year mentoring program in 2011 in Manitoba or Alberta because of concerns about their substance use. This study has been approved by the Research Ethics Board of the University of Manitoba. The study involves interviewing 5 – 10 women about what their lives were like before they began the mentoring program, their experience of being mentored, their lives after completing the mentoring program, and their plans and goals for the future.

Study Procedures

Participating in this study is voluntary. If you decide to participate, you will meet with one of the researchers for 1 - 3 interviews, to talk about your experience in the mentoring program. The number of interviews will depend upon how much you have to say about your experience. Each interview will take about 2 hours. The researcher will ask you questions about your experience in the mentoring program. You can choose not to answer any questions that you don't feel comfortable with. You can also change your mind and withdraw from the study at any time by telling the researcher you no longer want to participate.

Confidentiality

The researcher will be recording the interviews on a digital recorder. To protect your confidentiality, your name, where you live, the names of people in your family, or any other information that is personal, will not be shared with anyone else. If you use names or share personal information that might identify you or other people during the interviews, the researcher will keep that information confidential, using initials or titles of roles (e.g. mentor, daughter, partner, etc). All interview recordings and transcripts will be kept in a locked cabinet in the researcher's office. Your identity will not be shared with your former mentor, or revealed in any reports or presentations about the results of this study.

Hearing Their Voices: Perspectives of Women who have Completed a
Mentoring Program for High Risk Substance Misuse

Page 1 of 3

Participant's initials/Date: _____



After the interviews, if you like, the researcher will send you a summary of your interview or, if you prefer, talk to you on the phone to make sure that you were understood. You can make any corrections if you were misunderstood at that time. After the study ends, all of the interview tapes will be destroyed.

Timeframe

The study begins in October 2011 and ends in March 2012. Interviews will be held from October 2011 to January 2012. Each person who participates will receive a summary of the study findings in writing at the end of the study, if requested.

Benefits and Risks

Sharing your experience about being in the mentoring program can be a positive thing. Sometimes, people like to tell others about what they learned, about what was helpful, or about what might be helpful for other women in similar situations to know. But, you should also know that talking about your experience can also be difficult. Sometimes, when people remember difficult times in their lives, they feel sad, worried, scared, or upset. It isn't the intent of the study to make you feel upset. The researcher will be sensitive to your feelings and your situation, and if you are feeling upset, she will ask you if you want to take a break, or you can decide you don't want to continue. If you are feeling upset, the researcher will ask you if you need some support, such as from a counselor or doctor.

If the researcher is worried about your safety, it is her responsibility to contact the appropriate professional in your community to make sure you are safe. If she is worried about your safety, the researcher will tell you why she is worried and who she will be contacting to help keep you safe. If the researcher is worried about your safety if you continue in the study, she will let you know that your participation is no longer required or appropriate.

Costs

However, if you need assistance with transportation, such as bus tickets, or money to pay for a babysitter, in order to participate in this research, the project can help to cover these costs. Please discuss your needs with the study staff.

Compensation for Participation

Each person who participates in an interview will be given a small gift card for \$30 for a local department or grocery store to thank you for your time. Each interview, to a maximum of three interviews, is eligible for one \$30 gift card (to a maximum of \$90 in total).

About the Researchers

The researchers are social workers with a Masters level degree, and the study's lead investigator is a social worker with a PhD in social work. The researchers are under contract with University of Manitoba under the sponsorship of the Canada Northwest FASD Research Network. The study is funded by the Canada Northwest FASD Research Network and by Healthy Child Manitoba.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your current or future services from the mentoring program or other services provided by the agency. If the study staff feel that it is in your best interest to withdraw you from the study, they will remove you without your consent. We will tell you about any new information that may affect your health, welfare, or willingness to stay in this study.

Questions

For more information about this project, please contact the project lead, Dr. Linda Burnside, at (204) 619-3148. If you have concerns about this research project at any time, you can contact the Bannatyne Campus Research Ethics Board at the University of Manitoba at (204) 789-3389 to express your concerns.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Linda Burnside, PhD. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study. I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed.

Yes, I would like to participate in this study:

Name of Participant

Signature of Participant

Date

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Name of Researcher

Signature of Researcher

Date

Yes, I wish to review a copy of my transcript:

Signature of Participant

Yes, I wish to receive a summary of the results:

Signature of Participant

HEARING THEIR VOICES: PERSPECTIVES OF WOMEN WHO HAVE COMPLETED A MENTORING PROGRAM FOR HIGH RISK SUBSTANCE MISUSE

Interview Guide

1. Life Before Entry into a Mentoring Program

- What was going on in your life when you got involved with the mentor program (marital status, parenting status, living arrangement, health status, substance use, financial status)?
- How did you decide to become involved in the mentoring program?
- What aspects of the mentoring program appealed to you when you decided to get involved?
- What were you most afraid of when you became involved in the mentoring program?
- How did you know you were ready to become involved in a mentoring program?

2. Experience of Being Mentored

- Tell me about your experience in the mentoring program (when you started the program, at the end of the program).
- What did you find to be helpful?
- What do you wish had been different?
- What impact did the mentoring program have on your life: substance use, parenting, relationships with others, health, self esteem, lifestyle, family planning/birth control, living arrangements, etc.
- What was the most important part of mentoring that you found to be helpful?
- Tell me about the most difficult experience you had while you were involved in the mentoring program. How did that experience affect you?
- Tell me about a time when you learned something important about yourself while you were involved in the mentoring program. How did that experience affect you?
- Did you experience a 'relapse' or 'setback' during your experience of being mentored? What happened? What contributed to that relapse occurring? How did you overcome this setback?
- What is different in your life today that you attribute to your experience of being in the mentor program? How did mentoring help you to make these changes?

3. Context of Your Life

- What is your current situation (marital status, parenting status, living arrangement, health status, substance use, financial status)?
- Who was in your life when you first started in the mentoring program?
- Who supported your involvement in the mentoring program? How did they support you?
- Who was against your involvement? How did they interfere with your program?
- Who currently supports you emotionally?
- What is your relationship like with your partner?
- What is your relationship like with your children?

- What is your relationship like with others in your life (extended family, friends, community supports, etc)

4. After the Mentoring Program

- What kind of life do you want for yourself?
- What kind of future do you want for your child(ren)?
- What are your future plans?
- What goals have you set for yourself? How do you plan to achieve those goals?
- What are you most optimistic about in your life?
- What are you most worried about in your life?
- Who can you count on to help you if you encounter a problem or need help?
- How do you feel about ending your involvement in the mentoring program?
- What advice do you have for a woman who is thinking about enrolling in a mentoring program?
- What advice do you have for mentoring programs on how to approach women about enrolling in a mentoring program?