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## **SUPPORTING PREGNANT AND PARENTING WOMEN WHO USE SUBSTANCES**

### What Communities are Doing to Help

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Communities across Canada are becoming increasingly aware of issues related to pregnancy, alcohol and substance use, Fetal Alcohol Spectrum Disorder, and child health and development. In many communities, the needs of pregnant women with substance use issues are of particular concern as they often intersect with issues such as poverty, unsafe or inadequate housing, violence and abuse, food insecurity, and other health and social issues.

Many people are asking questions about how to support women and their babies/young children so that they can have a healthy and safe start in life. In the early 1990s, several communities began to develop integrated responses to addressing the needs of pregnant and parenting women with substance use issues. These early programs included *Sheway* in Vancouver's Downtown Eastside and *Breaking the Cycle* in Toronto. Nearly 20 years later, the research

evidence clearly supports this type of program as an effective way of addressing the needs of pregnant and parenting women who use substances.

While all these programs are different in philosophy and mandate, they all seek to provide a range of services under one roof (a “one-stop shop” or “single-access” model), address women's needs from a holistic perspective, provide practical and emotional support, and strive to reduce barriers to accessing care and support. Another important similarity is that all of these programs started as a unique network of cross-sectoral partnerships that developed a common vision, values, and goals.

In this document, we profile the development of single-access programs in four different communities and talk about why this type of program works.

# Common Problems, Local Solutions

## How it all began

Often, individuals and groups can see the challenges that women in their communities are facing, but aren't sure where to start in supporting them. In the following profiles, you'll see that the starting place varies - it can be an idea at a meeting of service providers, a health crisis in the community, or people finding that old ways of doing things aren't working anymore.

## Developing a community approach

Each of these programs developed a unique approach to addressing the concerns of their community. Individuals and organizations drew upon the research evidence, talked to women with substance use issues about what they needed, and found ways of bringing together and sharing resources. In each profile, you'll hear about how people got involved and how they decided to shape and organize their program over time.

## Lessons learned

Each of the programs profiled is in different stages of development and has gone in different directions from the program models first developed in the 1990s. But there are also many similarities between programs and suggestions for others who may be thinking about starting a similar program in their community or who are trying to better understand the issues that women who use substances are facing.

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## PROGRAM PROFILES

**Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women** (Surrey, BC)  
▶ Opened in 2005

**HerWay Home** (Victoria, BC)  
▶ Opened in 2012

**H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program (Streetworks Program)** (Edmonton, AB)  
▶ Opened in 2008

**Manito Ikwe Kagiikwe** (Winnipeg, MB)  
▶ Opened in 2013

# MAXXINE WRIGHT PLACE

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## HOW THE PROGRAM BEGAN

Today, the Maxxine Wright Place Project in Surrey, BC includes a community health centre, daycare, emergency shelter, and longer term housing for women and their children. But, the idea for the project came from service providers in the community seeing how many women were facing issues such as violence, abuse, substance use, poverty, racism, HIV/AIDS, unsafe or inadequate housing, food insecurity, and other health and social issues. These women were not getting the support they needed. Not only was the health of both women and their babies/young children being affected, mothers and children were often being separated.

In 2001, a group of health and social service providers started meeting regularly to develop a “Sheway-like” program for Surrey. The meetings were spearheaded by Atira Women’s Resource Society (an anti-violence women’s organization), and included representatives from Fraser Health (FHA), the Ministry of Child and Family Development (MCFD), and ten other non-profit community agencies. Atira also obtained funding for a Project Coordinator, who began to provide support and advocacy for pregnant and early parenting women while the program was being developed.



## A SMALL COMMUNITY HEALTH CENTRE OPENS IN 2005

The program first opened in a small daycare building. The comprehensive, multi-disciplinary community health centre was open for drop-in Monday-Friday afternoons and provided a hot lunch for the first hour. The centre also provided free clothing, baby items, diapers, and food bank hampers for the families.

Staff included a receptionist, family doctor, nurse practitioner, public health nurses, dental hygienist, social worker, Aboriginal women’s outreach worker, Concurrent Disorders Therapist, Wraparound Coordinator, cook, nutritionist,

pregnancy outreach worker, and two Program Coordinators (one from FHA and one from Atira). Most of the staff were part-time. Approximately half of the staff were existing positions from FHA, Atira, or MCFD that were re-located to Maxx Wright. The MCFD social worker position was deliberately created to be “non-delegated” in that she did not have the authority to remove children from their families. The family doctor had one session per week, and was the only doctor in Surrey that could provide both pre-natal care and methadone prescriptions.

In the first year, 59 women and 30 children had open files at Maxx Wright.



## EXPANDING THE PROGRAM

A purpose-built three-story structure was completed in 2010, with a daycare on the ground floor, significantly expanded clinic space on the main floor, and 12 units of emergency housing on the top floor. The 12-unit Maxxine Wright Shelter serves women who are pregnant or have a newborn and need a safe place to stay. Women can access the shelter at any point during their pregnancy, and potentially stay until their baby is 6 months old. The shelter is staffed 24/7 and staff provides a wide range of emotional and practical support, parenting support, advocacy, accompaniments, child-care, information and help connecting with other resources.



While women are typically motivated to reduce their substance use during pregnancy, women who are in abusive relationships may not be able to do so. Stress, physical pain, emotional distress, or the controlling influence of abuse can make reducing or abstaining from substance use more difficult or impossible.

*Maxx Wright Place profile  
contributed by Lynda Dechief*

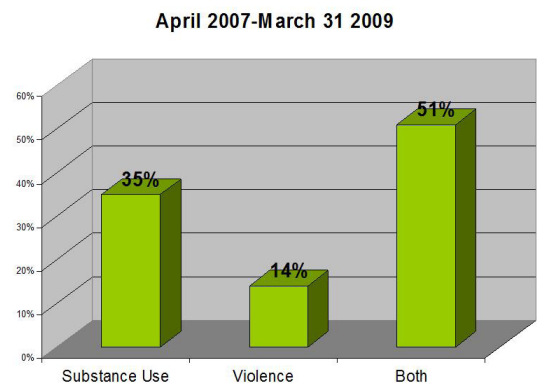
By 2011, approximately 450 women and 300 children were accessing services at Maxx Wright, demonstrating the success of the program in engaging “hard to reach” women and children. There have been challenges, however, in providing adequate services with the available staff. Maxx Wright has narrowed its mandate somewhat to address this, by only accepting women who are pregnant or have a baby less than six months old, and providing services only until their youngest child is four years old (originally, women who had a child less than two years of age were accepted, and services provided until the youngest was six).

## LESSONS LEARNED

- ▶ Involve women in the development of the program model so that it works for them
- ▶ Inform neighbours early in the development process to avoid “NIMBY” (Not In My Back Yard”). When community members understand more about the project and the needs of women and their children, they are likely to give their support.
- ▶ Partnerships can be challenging and ongoing effort is needed to integrate services across different organizations, disciplines and philosophies – e.g., the medical model and feminism, child-centered and women-centered care.
- ▶ Evaluation is important to build in from the beginning
- ▶ Don’t undervalue the importance of “practical” support – outreach workers, transportation, food, diapers, etc.
- ▶ An intake process that is not onerous or intrusive is key to women coming back.
- ▶ Having a non-delegated social worker (i.e., a social worker that cannot apprehend children) and a policy that child removals will not happen on site is essential in women building trust with child welfare services

Maxx Wright provides support to pregnant/parenting women experiencing abuse or violence as well as those struggling with their use of drugs or alcohol.

This two-year snapshot shows how about one third (35%) of the women have only substance use issues; about 14% have only violence/abuse in their lives; 51% of all the women accessing Maxx Wright are experiencing both problematic substance use AND violence/abuse in their relationships.



# H.E.R. (HEALTHY, EMPOWERED, RESILIENT) PREGNANCY PROGRAM

## HOW THE PROGRAM BEGAN

In 2007-2008, Edmonton experienced a sharp rise in overall rates of syphilis. Health professionals noticed an increase in the number of babies being born with congenital syphilis, which is often a life-threatening infection in babies. A physician from the Edmonton STD Centre approached the Streetworks program at Boyle Street Community Services. She was interested in collaborating on a project that would address syphilis infections for street-involved, high-risk pregnant women. Many women in this group were not accessing prenatal care and, as a result, were not getting screened for infectious diseases.

The Streetworks program, at that time, did not specifically work with pregnant women. But, through its regular activities, the program had developed strong relationships with people who were street-involved, worked from a harm reduction perspective, and had a history of hiring employees with a street background who could connect with the population it served. The STD Centre provided funding for the development of a pregnancy-focused component of the Streetworks program. The Women in the Shadows program (which later evolved into the H.E.R. program) started in 2008. The program was initially comprised of two outreach workers (who had

“Little things can make a huge difference. Pregnancy outreach workers are helping street-involved women listen to the heart beat of their babies. This has been a great way for workers to connect with women, but also a tool to support women in staying focused on their goals. We’ve had women run into the office and say, “I feel like using! I need to listen to the baby’s heartbeat!” This provides them with a way to refocus, connect, and avoid using substances. ”

similar backgrounds to the women they were trying to reach) and a nurse.

## STREET OUTREACH

When the program started, staff had to first find out why pregnant women were avoiding prenatal care. They learned that mistrust and fear of child apprehension were the two major challenges. The two Pregnancy Support Workers (PSWs) were trained in how to do some very basic nursing skills, such as measure fetal heart rates, fundal heights, weights, and kick counts, etc. This was not intended to be for the purposes of diagnosis or medical care. It was a tool that the workers used in engaging with pregnant women who were living on the streets. The outreach workers did street outreach, connected moms with the program nurse and a physician who worked one day per week in the Streetworks program. In the first year, 78 women accessed

the program and only one had an underweight baby.

The H.E.R. team works with the Streetworks’ program at the Boyle Street Community Services, a multiservice agency with programs such as mental health, a youth unit, housing, family program, Indian Residential School Survivors program, and others. Children’s Services has an office in the basement of the building. The team also works closely with the Nurse Practitioners at the Boyle McCauley Health Centre.

## LOOKING FOR NEW SOLUTIONS

The program initially ran for two years from 2008-2010 with funds from the STD Centre. In 2011, the Alberta government funded the program for three additional years. The new funding allowed for a larger staff complement and greater access to needed materials and supplies.

The program now consists of 2.4FTE Pregnancy Support Workers, one Social Worker and one Registered Nurse. The PSWs do on-foot and van outreach in an attempt to connect with women who are hiding. The program Social Worker assists women with issues such as income assistance, housing, and child welfare. The nurse provides onsite care and refers women to other service providers who can help meet their individual needs. The Streetworks' physician also sees women and ensures they have the proper testing and referrals. Staff will often connect women with Children's Services workers, so they have a clear understanding of what they need to do to be able to avoid apprehension and to develop a trusted relationship with a worker from the agency they fear the most. The program staff runs a pregnancy drop-in once a week where moms are welcome to come and learn about pregnancy and meet other women in similar circumstances. There is also a focus on healthy activity, healthy recreation, healthy eating and Aboriginal cultural support.

The program is also working to address issues such as: education for health professionals on substance use and pregnancy and cultural competence; helping to provide street-involved women with better access to birth control, if that is what they wish; supporting women around 6-8 weeks post-partum when they are more likely to experience issues leading to Children's Services involvement.

### **LESSONS LEARNED**

- ▶ Women who have “been there, done that” have the best chance of connecting with women who are hiding, ashamed, frightened and afraid to bond with service providers.
- ▶ Having outreach workers accompany women to appointments builds trust and confidence.
- ▶ In Alberta, technically, Children's Services are not to be involved with a fetus until the moment of birth. This means that many women do not have the opportunity to learn about what they need to have in place in order to be able to parent. Having Children's Services workers come into the picture early in a pregnancy means that many more children are going home with their mothers.
- ▶ Street-involved women often have had a traumatic life history and/or have grown up in foster care. This has meant that “trauma-informed” services are very important. Also, supporting women who have had few role models in becoming mothers requires attention to issues like learning how to play or how to find and take advantage of low or no cost recreation.

*H.E.R. Pregnancy Program profile contributed by Marliiss Taylor*

# Why These Programs Work

While all of these programs are different from each other in terms of funding, service delivery model, philosophies, and mandates, they share common elements that evaluation studies show work.

OUTREACH	PRACTICAL SUPPORT	HARM REDUCTION	INTEGRATED	MOTHER + CHILD = SUCCESS	TRAUMA + SAFETY
<p>Outreach services work with women where they are - on the streets, in their homes, in the hospital. Outreach provides flexibility for service providers in how they work with women. They can accompany women to appointments, share information informally, and help overcome barriers like lack of transportation and distrust of formal settings.</p>	<p>Without practical support, women cannot succeed in meeting other goals like reducing or stopping their substance use or learning parenting skills. Food vouchers, free prenatal vitamins, socks, bus tickets, and support in finding housing are just a few things that meet women's immediate needs.</p>	<p>A harm reduction approach means that abstinence is just one possible goal for women and that care and support do not require women to address their substance use issues until they are ready. Harm reduction allows for flexible, respectful, and non-judgmental approaches to engaging with and caring for women and their children.</p>	<p>Studies have shown that women who use substances have difficulties accessing services that meet their needs. An integrated "one stop shop" model recognizes that no single service provider or agency can meet the often complex needs of women and that formal and non-traditional partnerships are required (e.g., between child-focused and adult-focused services).</p>	<p>All these programs view the needs of women and the needs of fetus/children as being linked. Programs that focus only on women's health or only on child health miss a big part of the picture. Approaches that view women's substance use outcomes, child development outcomes, and parenting outcomes as linked lead to success.</p>	<p>Substance use is often tied to women's experiences of violence and trauma as well as histories of colonization and migration. Attention to issues of empowerment, trust and safety, cultural awareness, and social justice have shaped the development and success of these programs.</p>

See the resources section for links to evaluation studies and summaries.

# HERWAY HOME

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Success is not always based on abstinence. Harm reduction approaches offer practical, non-judgmental services that seek to minimize drug-related harm to both the individual and society.

## HOW THE PROGRAM BEGAN

In the 1990s, a group at the Victoria General Hospital, called Together for Education on Addiction and Mothering (TEAM), began meeting to talk about improving how we support pregnant and parenting women with substance use issues. Over the next fifteen years, our community partners noted a gradual increase in the number of women in Victoria who needed services that were more comprehensive and coordinated than what was currently available. Over time we also came to recognize that substance use, mental illness, and violence and trauma are often concurrent challenges in the lives of women.

In 2008, a group of organizations met at the downtown Blanshard Community Centre to begin planning and advocating for a model of service like Sheway in Vancouver or Breaking the Cycle in Toronto. The local children's

foundation, the Queen Alexandra Foundation for Children's Health, expressed interest in contributing to improve the outcomes of this group of mothers and babies and joined our efforts. In 2011, the Queen Alexandra Foundation and a number of community donors committed to funding the first five years of our program and our doors opened in the fall of 2012.

## CREATING A "ONE-STOP SHOP"

Prior to developing our program, pregnant women with addictions had to travel around Victoria to multiple programs to address all of their health and social concerns. Women told us they felt vulnerable, and judged negatively, and were often not able to access the services they needed. HerWay Home was conceptualized as a collaborative "one stop shop" program where community partners (such as our regional health authority, pregnancy outreach programs, midwifery and nurse practitioner programs, mental health and addictions counselling, anti-violence services, parenting supports, and child welfare organizations) agreed to collaborate to support women in one place, in an environment that was respectful and non-judgmental.

Early on in the planning process, several members of our planning team joined the Prevention from a Women's Health Determinants Perspective Network Action Team (part of the Canada FASD Research Network) and gained valuable knowledge about the elements and practices needed to support pregnant and newly parenting women effectively.

The consensus statement "10 Fundamental Components of FASD prevention from a Women's Health Determinants Perspective" developed by this team provided us with the philosophical foundation on which to build our program (including principles such as woman-centered care, harm reduction, trauma informed care, and cultural safety).

## GETTING STARTED

From a governance perspective, program operations are being coordinated through the Vancouver Island Health Authority in partnership with the community. We have a community advisory council that includes representatives from the founding organizations, primarily women and child serving agencies, to ensure that the program stays true to the original philosophy and that it aligns with



other services in Victoria (we want to avoid duplicating services or creating further gaps in services). With funding from the Canadian Institutes of Health Research, we have been able to develop and support a women's advisory council, which is composed of women who have had personal experience with the issue of substance use while they were pregnant or new mothers. Consultation with the women's advisory council provides information with respect to program development, design and delivery. For example, the council has been invaluable in determining the kinds of services that will be beneficial to those accessing the program and where the program should be located.

We also developed a research and evaluation working group right at the beginning of our planning. Working with local researchers and evaluators helped us access national research funding and increase our profile within the community. Over the next five years we hope to develop an evidence base and evaluation profile that confirms the value of this program philosophy and service model. We will be exploring evaluation from

a broad range of perspectives, including developmental, feminist and gender informed, Indigenous, and democratic perspectives, with the intention of learning what women themselves see as meaningful.

### **LESSONS LEARNED**

- ▶ **Patience.** It's hard to be patient when you can see the need for a program like this in your community right away. Continuing to move forward, however slowly, provides time to develop an excellent and well-designed model.
- ▶ **Persistence.** It takes time to make the case in your community that this kind of specialized program will improve the system of care and make a difference in outcomes for mothers and babies. Keep on building relationships and keep reaching out.
- ▶ **Partners.** We had a core group of planners from a number of community agencies that facilitated regular meetings and strategic planning. It is critical to work across sectors, including community non-profit, government, health care and interested community members. Our door was always open to people who were interested

in contributing to this vision. We also consulted frequently with staff at other similar Canadian programs. Team members in these programs were supportive and open to sharing all of their own lessons learned over their years of operation.

- ▶ **Planning.** To get to the point of launching the program required years of sustained relationship building and community development planning.
- ▶ **Power.** We recognized and experienced the challenge of negotiating between sectors, and continue to focus on respecting each others values and priorities and ensuring that all voices are equally valued and considered, keeping our destination always in view.

*HerWay Home profile contributed by Lenora Marcellus and Betty Poag*

## Why Do Women Use Substances During Pregnancy?

Many people struggle with understanding the reasons why a woman would use alcohol and drugs during pregnancy. There are as many answers to this question as there are women. But, it is important to remember that substance use and misuse spans all segments of society.

Some women who have a difficult time stopping substances during pregnancy have a history of complex background factors, including trauma, childhood abuse, mental illness, violence, and poverty. Rarely is information and advice about the harm of substance use the main issue. Programs that shift attention to the underlying causes of why pregnant women use substances and that involve the entire community in finding solutions have been shown to be the most successful.

# MANITO IKWE KAGIIKWE

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## HOW THE PROGRAM BEGAN

The Mount Carmel Clinic (MCC) was established in Winnipeg in 1926 and has evolved into a community health centre whose purpose is to create and promote healthy inner city communities. In the mid-2000s, the Clinic noticed that the needs of pregnant and early parenting street-involved/substance-using women and their children in the neighbourhood of North Point Douglas (the neighbourhood that it primarily serves) were not being met. An idea for a community project to provide pregnancy support and parenting support to women affected by systemic marginalization and substance use and their children from conception to 3 years of age was born.

A Community Advisory Committee was established in September 2011 and includes partners such as the regional health authority, the Addictions Foundation of Manitoba, Child and Family Services representatives, Winnipeg-based community health clinics, and other community agencies. This advisory group has been working to develop a working model for the program and will ultimately serve as an advisory group to the program as a whole. As part of this process, it was decided that the project would support not only mothers whose

children live with them, but also mothers whose children have been placed in care. And, because the demographic of the neighborhood includes a significant population of Aboriginal people, it is believed that many of the program participants are likely to have Aboriginal heritage. As a result, issues of cultural competence and cultural safety are key components of the model. Initially called “The Mothering Project,” the program was formally named Manito Ikwe Kagiikwe in November 2012, an Ojibwe word which means ‘spirit woman teachings.’

## BUILDING ON MCC'S STRENGTHS

Although Mount Carmel Clinic does not have a specific background in delivering addiction-focused programs, it does have a significant commitment to integrating harm reduction principles into program delivery. It also has a strong background in early childhood education and perinatal care and has been involved with delivering teen parenting programs, obstetric and midwifery care, home-based parenting support, and early literacy programs. Over the past few years, the Anne Ross Day Nursery program has been undergoing a huge renewal and renovation and Manito Ikwe Kagiikwe will co-evolve with the changes to this program,

including expanding the population served to include infants.

Additionally Mount Carmel Clinic has been a leader in providing street involved women and sex trade workers with access to low-threshold healthcare and social support through Sage House, a drop-in that has been in operation for approximately 20 years. Mount Carmel Clinic has successfully served a significant homeless population with severe and persistent mental illness using a cultural model in care delivery through the Assertive Community Treatment Team. Manito Ikwe Kagiikwe will rely heavily on the expertise of colleagues in these programs to inform the program development of this project.

## A COMPREHENSIVE DROP-IN PROGRAM

Manito Ikwe Kagiikwe will start by implementing the outreach component of the program as the building renovations will not be completed by the program start date. The Pregnancy Outreach Team will be based out of Mount Carmel Clinic's Community Services building and will be comprised of a clinical team lead, a four member outreach team, a family support worker, nursing staff, and the program manager. The second phase of Manito Ikwe

Kagiikwe will be a drop-in program where pregnant women and mothers can choose from a variety of programs and activities most relevant to their needs and interests.

As the project evolves, we are continuing to gain support from other community agencies and groups and to build new partnerships. In 2011, we received funding from Health Canada to develop a 'women's council.' This group of experiential women are informing the development of the program by drawing upon their lived experience, knowledge of our community, and awareness of how things like gender and culture shape parenting. This group is also involved in the Advisory Committee and in program development. As well, in May 2012, the government of Manitoba announced increased funding support for our project as part of its FASD Strategy.

### **LESSONS LEARNED**

► Rely on experiential women to keep the project on the right path. The Women's Advisory Council has

consistently and gently reminded the program manager of what the key features of this program need to be which has informed how we roll out the program and prioritize what comes first.

► Use the evidence. The work being done by the Canada FASD Network has been invaluable in building community support, gaining government interest and informing the development of our program philosophy and practice model.

► Flexibility. This program is being invented as we go and the key for us in building support has been our willingness to change gears when suggestions are made, to avoid duplication by building strong community partnerships, and our desire to be as effective as possible. This flexibility is possible due to our commitment to evaluate the various aspects of the program and to then act on the results of the evaluation and to not remain stubbornly attached to things that aren't working.

*Manito Ikwe Kagiikwe profile  
contributed by Margaret Bryans*

Fear of child apprehension and custody loss is a barrier to accessing prenatal care and support for many pregnant women who use substances. Connecting with women earlier in a pregnancy gives time for relationships to build and options to be explored. With timely support, many women can successfully care for their children. Other women can be supported in choosing other models of mothering such as part-time parenting, open adoption, kinship and elder support, and extended family.

## The Evidence Is In

Twenty years of evaluation research has shown us that these programs are successful in a lot of ways.

- Early engagement of pregnant women who use substances has been shown to affect a range of outcomes related to maternal, fetal, and child outcomes, including improved infant birth weight. (Low birth weight has been linked to various health problems such as learning disabilities, slower growth rates, respiratory difficulties, and delayed development).
- Women who participate in these programs are more likely to keep custody of their child and have higher rates of accessing and completing addictions treatment.
- Children who are involved with their mothers in a comprehensive program of support have been shown to have enhanced developmental outcomes.

## RESOURCES

Learn more about the philosophy, development, and outcomes of this type of program in other communities in Canada. All the resources listed below are available for free and online.

Best Start. (2002). *Reducing the Impact: working with pregnant women who live in difficult life situations*. Toronto, ON: Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre. Download from <http://www.beststart.org>

FASD Network Action Team on FASD Prevention from a Women's Health Determinants Perspective. (2010). *10 Fundamental components of FASD prevention from a women's health determinants perspective*. Download from <http://www.canfasd.ca>

FASD Network Action Team on FASD Prevention from a Women's Health Determinants Perspective. (2009). *Taking a relational approach: the importance of timely and supportive connections for women*. Download from <http://www.canfasd.ca>

Leslie, M. (ed) (2007). *BTC Compendium, Vol. 1, The Roots of Relationship*. Toronto: The Mothercraft Press. [http://www.mothercraft.ca/resource-library/publications/BTC\\_Compendium\\_2007.pdf](http://www.mothercraft.ca/resource-library/publications/BTC_Compendium_2007.pdf).

Motz, M., Leslie, M., Pepler, D. J., Moore, T. E. & Freeman, P.A. (2006). *Breaking the Cycle: Measures of Progress 1995-2005*. JFAS; 4:e22 Nov. 10, 2006 © The Hospital for Sick Children 2006. [http://www.motherisk.org/JFAS\\_documents/BTC\\_JFAS\\_ReportFINAL.pdf](http://www.motherisk.org/JFAS_documents/BTC_JFAS_ReportFINAL.pdf).

Poole, N. (2000). *Evaluation Report of the Sheway Project for High-Risk, Pregnant and Parenting Women*. Vancouver: British Columbia Centre of Excellence for Women's Health. <http://www.bccewh.bc.ca/publications-resources/documents/shewayreport.pdf>.

Streetworks Program website. Resources for clients and service providers, including the book *Oh Shit, I'm Pregnant: Your Guide to Being Pregnant on the Street*. Boyle Street Community Services, Edmonton, Alberta. Download from <http://www.streetworks.ca>

Surrey High Risk Pregnancy and Early Parenting Planning Committee. (2003). Maxxine Wright Place Project For High Risk Pregnant And Early Parenting Women: Executive summary and Program Model . [http://www.hss.gov.yk.ca/cnfp2010symposium/handouts\\_29/b2\\_am\\_maxx\\_wright\\_executive\\_summary.pdf](http://www.hss.gov.yk.ca/cnfp2010symposium/handouts_29/b2_am_maxx_wright_executive_summary.pdf)

This overview of community programs that support pregnant and parenting women who use substances was developed by members of the Canada FASD Research Network's Action Team on FASD Prevention from a Women's Health Determinants Perspective. To learn more about our work, visit [www.canfasd.ca](http://www.canfasd.ca).

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