# Co-Creating Evidence Evaluation Report:

## Stories and Outcomes of Wraparound Programs Reaching Pregnant and Parenting Women at Risk

Prepared by Nota Bene Consulting Group
in partnership with the Centre of Excellence
for Women's Health | 2021

Co-Creating Evidence

National Evaluation of Multi-service Programs Reaching Pregnant Women at Risk

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- Tammy Rowan; Mallory Thomson; Hayley Thomas (Mothering Project, Winnipeg, MB)
- Mary Motz (Breaking the Cycle, Toronto, ON)
- Michelle Ward (Kids First, New Glasgow, NS)

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# Co-Creating Evidence Evaluation Report Executive Summary

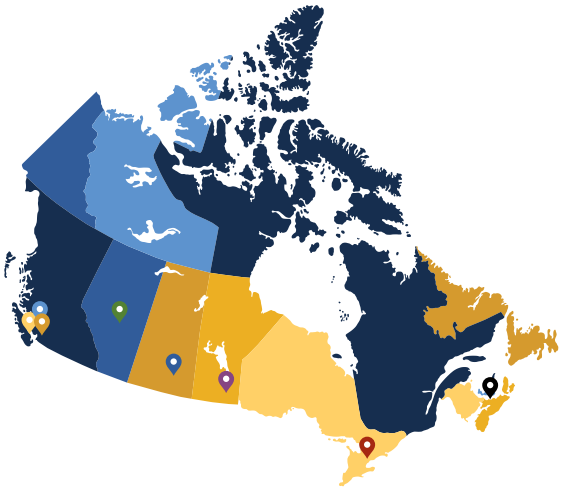
The *Co-Creating Evidence* (CCE) project was a first-of-its-kind-in-Canada national evaluation involving eight multi-service programs serving women at high risk of having an infant who has been prenatally exposed to alcohol or other substances. The eight programs taking part in the study are all different, and all were developed in response to local influences and issues.

**Victoria**
HerWay Home

**Vancouver**
Sheway

**Surrey**
Maxxine Wright

**Edmonton**
H.E.R. Pregnancy Program



**Regina**
Raising Hope

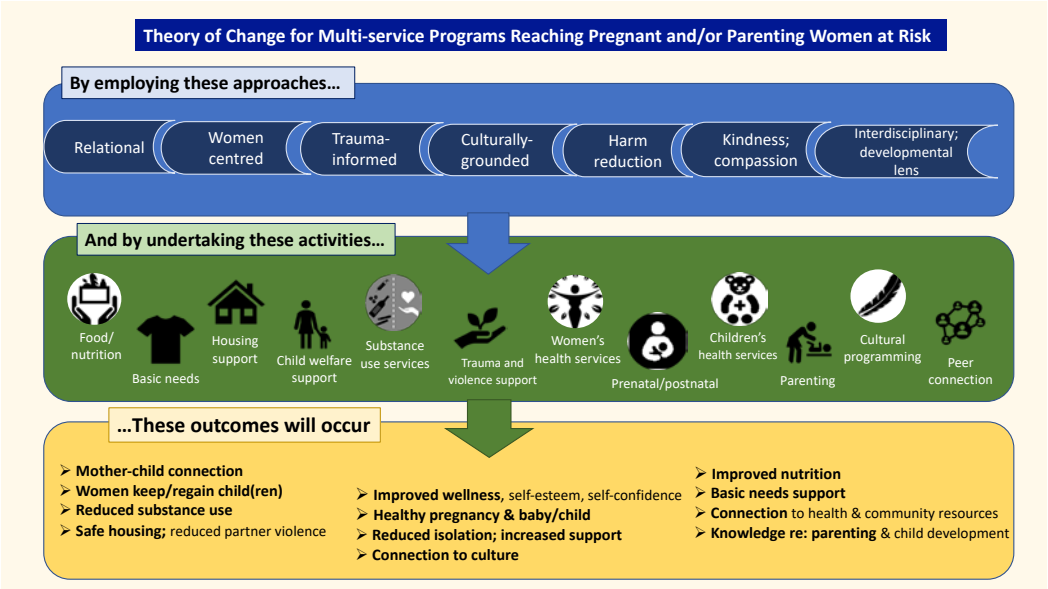
**Winnipeg**
Mothering Project

**Toronto**
Breaking the Cycle

**New Glasgow**
Baby Basics

## Theory of Change

As part of the developmental phase of this project, the project team and the Program Leads of the eight participating sites collaboratively developed a Theory of Change to guide the rest of the evaluation activities. The Theory of Change shows the interconnections between the programs' activities, anticipated outcomes and longer-term impacts.




## Research Process

The project team visited each program twice, at least one year apart, to interview clients, staff, and service partners. The team conducted a total of **424** interviews: **256** with clients, **108** with program staff, and **60** with partners. The programs also submitted de-identified client and output data quarterly for 18 months.

## Story of the Programs

The eight programs were guided by a similar set of theoretical approaches, including being trauma-informed, relationship-based, women-centred, culturally-grounded, and harm-reducing.

A multi-dimensional model was developed that highlights the unique and common characteristics of the eight programs. Dimensions that were most often central to programs' models were:

- one-stop;
- outreach focus;
- peer mentoring focus; and
- cultural focus.

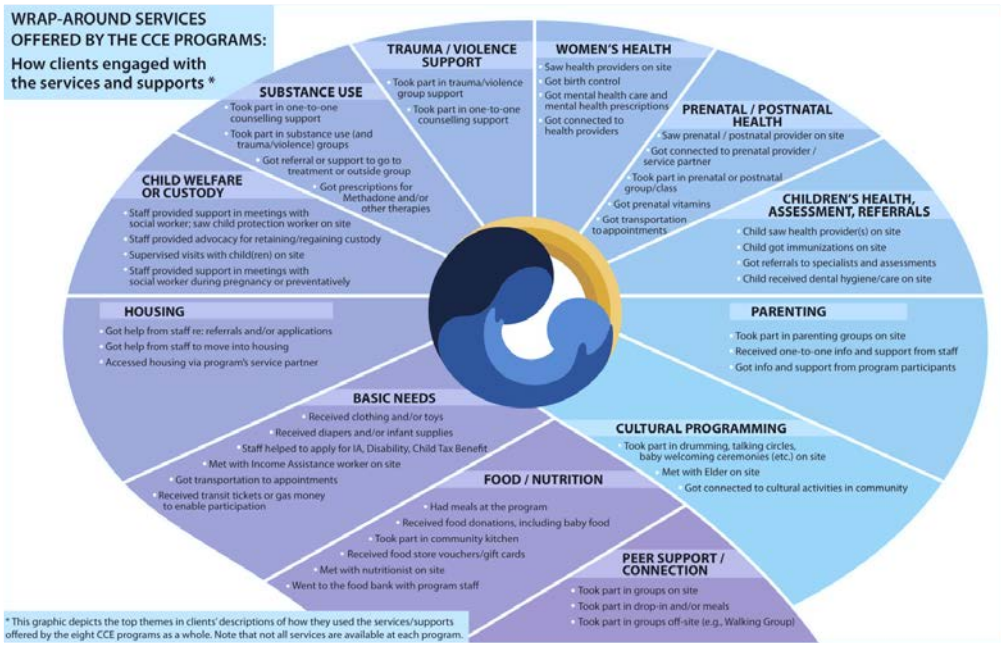
Less common dimensions of the models were: dual client focus (i.e., mother and child) and residential.

Formal and informal partnerships and partner relationships with other sectors and disciplines were key to the delivery of wraparound services. Programs' common partners included: child welfare services; prenatal and postnatal services; specialized health services; and addictions and mental health services. Equally as important, though less commonly occurring partnerships were with housing services; detox; Indigenous wellness services, infant development, income assistance, probation services, and legal services.

Key strengths of the programs included: their philosophical approaches; knowledgeable staff; one-stop/wraparound services that included medical and health services; strong partnerships with other service providers; flexibility and responsiveness to client needs.

## Story of Wraparound Services through an Indigenous Cultural Lens

There are parallels between the wraparound approaches employed by the programs in the Co-Creating Evidence study and the holistic health philosophies found in Indigenous societies. All programs in the CCE study have worked to forge connections and partnerships with Elders, knowledge keepers, and community-based, Indigenous-led programs and services so that they can incorporate culture as a part of women's healing and health. Cultural programming is both a healing and intervention resource.



## Story of the Clients and their Program Experience

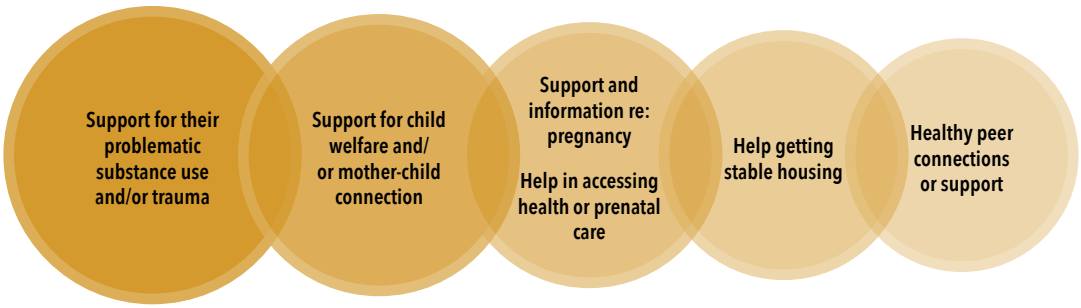
Between April 2018 and September 2019, 1004 clients participated in the eight programs; the majority (55%) were Indigenous, though that varied markedly across programs (from 1% to 93%). At the time of intake to their program, the majority of women were contending with a number of interconnected issues including problematic substance use, violence and trauma, unsafe or inadequate housing, health concerns and/or maternal-child separations.

Overwhelmingly, clients reported positive experiences at their program. They felt physically and emotionally safe, they trusted staff, they had lots of choice about services they received, and they believed that their needs had been met by their program. Clients also valued their program's non-judgemental, welcoming environment and family-like community.

## Key Findings: Outcomes and Evidence

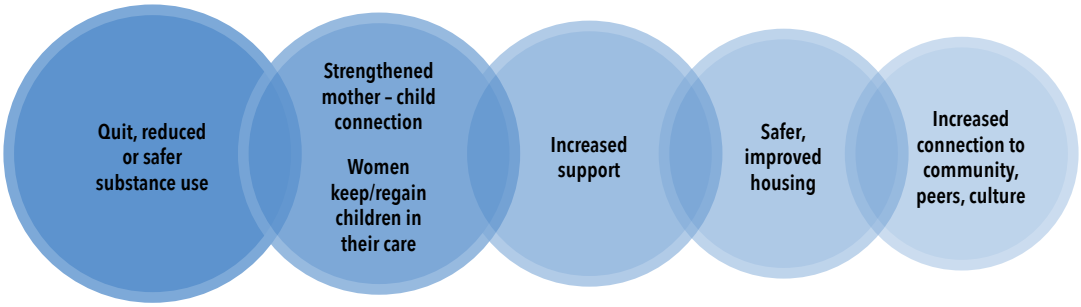
Clients' top reasons for participating in their program were to get help with substance use, child welfare, health care and/or housing. Paralleling this, from clients' perspectives, the most significant changes for them since becoming involved with their program were quitting or reducing their substance use, having a strong connection with their children and/or keeping their baby in their care.

### What women hoped to get from participating in their program – Top themes




*[I wanted] better housing, support to keep me away from drugs and alcohol, and help with nutrition. [I wanted] to keep my baby.*

### Women's 'Most Significant Change' since participating in their program – Top themes




*If I hadn't been at this program, it would have been hard to stay sober, and my baby would have gone to live with my mom.*

Notable improvements in terms of clients' substance use and housing occurred over time; as well, a large percentage of clients kept their infants in their care. These findings were stronger amongst clients who were engaged with their program for a longer duration and/or more regularly, such that their situation could be tracked for more points in time.

Programs' staff – and the approaches staff employed, including being non-judgemental and fostering safety and trusting relationships – was identified as both the most important facet of the program and the driver of significant changes in women's lives.

The programs also had important outcomes for service partners, resulting in gains in knowledge and collaboration for care providers working in a variety of service areas and sectors.

## Discussion

The findings from the Co-Creating Evidence study demonstrated that the participating programs benefitted women and their families in significant ways. Clients reduced or quit their problematic substance use, improved their physical and mental health and access to health services, kept custody of their infant and/or had a stronger connection with their children, improved their housing, and had healthier pregnancies and birth outcomes. That clients identified reduced substance use or recovery as their most significant change is all the more noteworthy given that these are not programs with substance use treatment as the focal service.

The study demonstrated that pregnant and early parenting women experiencing problematic substance use and other complex issues benefit from programs that included the following:

- Wraparound services
- Knowledgeable and empathetic program staff
- Indigenous cultural (re)connection
- Opportunities for community/peer support

Further, the following elements are important characteristics that contributed to the programs' success:

- Well conceptualized, evidence-based approaches
- Strong partnership relationships
- Flexible, multi-dimensional models
- Keeping clients engaged over time

In summary, when the above elements are combined, they indicate that an ideal multi-service program for pregnant and parenting women with substance use and other concerns would be grounded in best practice approaches (e.g., trauma-informed, culturally safe, relationship-based, harm reduction, client-centred) and would offer a 'one-stop' or wraparound experience. Services offered would include a range of primary, prenatal, postnatal health, substance use, trauma, outreach, and child welfare services along with cultural programming and/or supports that address social determinants of health factors in a manner that reflects and respects local/regional influences. As well, it would be ideal for the program to have a connection to on-site housing, either as a core component or through a partnership with another organization. Lastly, ideally, clients would be able to participate in the program for 18 months or longer so that there is time for relationship-building with staff and peers and so that clients are able to fully realize their goals.

## Implications for practice, program development, policy and funding

### Implications for practice

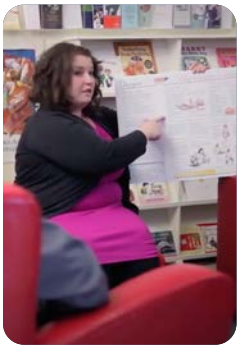
- It is imperative that multi-service programs and their sponsors and partners continue to build on their work of offering wraparound care and employing their key approaches in response to local context.
- Listening closely to what women say they need and are ready for at the time of engagement, and how this readiness evolves as their connection to the program deepens, is paramount.
- Given the strong substance use recovery outcomes achieved by the women in this study, substance use service providers and managers are urged to prioritize partnering with wraparound programs.
- For programs offering group interventions, creating opportunities for peer leadership, co-learning and support is highly important.
- For programs designed to engage pregnant women and new mothers, using a relational approach is essential best practice. For child welfare workers, developing collaborative relationships with wraparound services that support the mother-child unit may be viewed as a top priority.
- Harm reduction is a best practice; however, finding the right balance between a harm reduction approach and women's and children's safety can be challenging. Making time for ongoing practice discussions regarding harm reduction is essential, including with child welfare partners.

### Implications for health system planners/leaders

- Strong linkages between maternal/child health and substance use services are crucial. Activating, supporting and enhancing these linkages must be a top priority for health systems planners.
- Ongoing learning opportunities, focusing on integrated, culturally grounded, trauma informed, relational practice, are important to practitioners in all fields and need to be actively supported.
- Applying a 'sex, gender, equity, inclusion' (SGBA+) analysis in all health planning needs to be implemented as standard practice.
- It is important that care models involving pregnant women and new mothers and their children be structured so that programming covers the period from birth to at least two years. This also means that linkages amongst pregnancy, early parenting and preschool services must be actively promoted.
- For women with substance use and other issues, housing is imperative. It is vitally important that all levels of government invest in making Housing First and supported housing a priority and a reality.

## Implications for government policy makers and funders

- Given the contribution of wraparound programs to a wide range of strategic goals held by governments, it behooves all levels of government to provide adequate funding for the development of wraparound programs in many more communities across Canada.
- This study demonstrated that wraparound programs contribute to making care accessible and that women's health needs are becoming increasingly complex. In view of this, policy makers and finders should make increased funding for additional trauma-informed services a high priority.
- The disconnect between the child welfare and substance use fields urgently needs to be addressed. Systems alignment should include non-judgemental, trauma-informed support for women to reduce or stop their substance use, to develop parenting capacity and commitment to preventing child removals by enhancing availability and access to parenting supports.
- The needs of pregnant and parenting women with addiction concerns are unique and cut across multiple systems of care. In view of this, governments are encouraged to commit to SGBA+ analyses and to gender equitable treatment, harm reduction, health promotion and prevention services in all substance use systems of care.
- Wraparound programs, especially those with a cultural focus, make an important contribution to addressing the health and child welfare-related Calls to Action identified by the Truth and Reconciliation Commission. Leaders wanting to act to combat racism and support the Calls to Action would do well to ensure both that wraparound programs are funded and that programs have the resources necessary to enable cultural connection positions to be put into place.
- Finally, stable funding for community-based, wraparound programs is a must. The programs involved in this study have worked to weave together funding so that a wide range of services "wraps around" women and children. Governments can do their part by creating holistic funding mechanisms that reduce the burden of securing and reporting on funding for services that work in holistic ways.




# 1 Introduction

**Introduction:** Key points

- The Co-Creating Evidence project was a first-of-its-kind-in-Canada national evaluation involving eight multi-service programs serving women at high risk of having an infant who has been prenatally exposed to alcohol or other substances.
- The eight programs taking part in the study are all different, and all were developed in response to local influences and issues.
- Early on in the project, a Theory of Change was developed, describing the connection between the programs' theoretical foundations, activities, and anticipated outcomes.

## Project goals

The Co-Creating Evidence project was a first-of-its-kind-in-Canada multi-site evaluation of eight different programs. Although each program serves women at high risk of having an infant with prenatal exposure to alcohol or other substances, the programs vary in a number of ways because they were developed based on local priorities, needs, partnerships and collaborations.

The overall project goals were to:

- Bring together many of Canada's holistic[1] Fetal Alcohol Spectrum Disorder (FASD) prevention programs to share promising approaches and practices;
- Undertake a prospective, multi-site evaluation study on the effectiveness of FASD prevention programming serving women with substance use and complex issues; and
- Identify characteristics that make these programs successful.

The following evaluation report summarizes key findings from the Co-Creating Evidence (CCE) project. The report draws on and synthesizes presentation materials and journal articles published to date (Hubberstey et al., 2019; Rutman & Hubberstey, 2019; Rutman et al., 2020); for links to these materials, please see www.fasd-evaluation.ca/communitysystem-outcomes. The report concludes with a brief discussion of the implications of the project for policy, programming and practice.

[1] 'Holistic' is characterized as encompassing a combination of activities, services, and interventions designed to address clients' health, social, mental health, emotional, and material well-being, with services delivered through outreach, on-site services and/or via connections to a network of community-based services (Poole et al., 2016). 'Holistic' can also be described as 'wraparound' services.

## Key points from the literature

- Substance use during pregnancy is often intertwined with a host of issues including intimate partner violence, trauma and intergenerational trauma, unsafe/inadequate housing, poverty, food insecurity, mental health issues, mother-child separation, racism, and colonization (Boyd & Marcellus, 2007; Network Action Team on FASD Prevention from a Women's Health Determinants Perspective, 2010; Ordean & Kahan, 2011). Women who struggle with substance use are often isolated, have lower levels of social support and/or live with someone who is also experiencing problematic substance use (Finnegan, 2013; Sword et al., 2004). Consequently, programs and providers need to consider the full context of women's lives, especially when pregnancy and/or parenting is a factor (Pepler et al., 2014).

- Women who use substances while pregnant are often polysubstance users, hence, prevention programs need to consider the possibility of a combination of prenatal alcohol and/or other substance exposure (Latuskie et al., 2018). In addition, pregnant and parenting women who use substances typically encounter social condemnation, stigma, and a strong likelihood of involvement with child welfare authorities (Fonti et al., 2016). These factors contribute to women's reluctance to reveal to service providers the full extent of their use of substances (Latuskie et al., 2018). Indigenous and Black women carry the extra burden of systemic racism within the health care system (Boyer, 2017).

- Services that employ non-judgemental, relationship-based, trauma-informed and harm reduction approaches and that also understand and seek to remove social environmental barriers to participation (e.g., transportation, child care, meals, stigma, and fear of child removal) are most effective and are increasingly recognized as best practice (BC Centre of Excellence for Women's Health, n.d; Motz et al., 2006; Nathoo et al., 2013; Pepler et al., 2014). These approaches recognize and accept the pace and type of change women are able to make and the strategies women use to cope with difficult life circumstances (Motz et al., 2006). Earlier engagement and longer retention with services are also associated with more favourable outcomes (Andrews et al., 2018).

- In Ontario, a multi-site evaluation of integrated addiction treatment programs for pregnant and parenting women has shown that a key component of effective service delivery is coordination across what are typically distinct and not generally well-aligned services, including mental health and substance use services, child protection services, prenatal care, and medical and primary care services (Urbanoski et al., 2018).

- Many national commissions and reports highlight the damaging impact of residential schools on Indigenous families (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Tait, 2003; Truth and Reconciliation Commission, 2015) while emphasizing the need for cultural healing programs based on wholeness, balance and harmony that are consistent with Indigenous worldviews (Castellano, 2006).

- Intergenerational impacts of residential schools have fractured families and communities, meaning that Indigenous women who are pregnant and/or parenting and seeking help for substance use issues often bear the additional burden of having been historically cut off or dispossessed from their culture (Tait, 2003). While some Indigenous women may have grown up firmly ensconced in their culture, others won't have had those ties. Services to Indigenous people that employ a cultural lens and programming can serve as intervention and healing (Christian, 2010; Dell & Acoose, 2015; McCormick, 2000).

A number of communities across Canada have developed low-barrier "one-stop" programs that provide pregnant and early parenting women and their children with a variety of health, wellness, basic needs-related, cultural and social supports. While some of these multi-service programs have been evaluated, others have not or have not been evaluated since their initial years[2].

The Co-Creating Evidence project aimed to address this gap by undertaking a prospective, multi-site evaluation on the effectiveness of eight programs in Canada serving women with substance use and complex issues.

## Program sites and brief descriptions

The programs involved with the Co-Creating Evidence evaluation project were located in six jurisdictions across Canada (**Figure 1**). A brief description of each program is presented in **Figure 2.**

**Figure 1:** Locations of program sites


[2] Notable exceptions are evaluations of Sheway (Poole, 2000), Breaking the Cycle (Pepler et al., 2002; Motz et al., 2006; Pepler et al., 2014), Healthy, Empowered and Resilient (H.E.R.) Pregnancy Program (Wodinski, Wanke & Khan, 2013); and HerWay Home (Nota Bene Consulting Group, 2017).

**Figure 2:** Capsule descriptions of the programs participating the CCE project
Core, in-kind, contracted and/or co-located services offered by/via CCE programs as of March 2020

**HERWAY HOME** • Victoria, British Columbia • Opened in 2013 after 5 years of planning.
Funded and operated by Island Health, with additional funding from Children's Health Foundation of Vancouver Island.

**Core services/ programming**
- Outreach
- Drop-in/wellness groups
- Substance use and trauma support groups & counselling
- One to one support in variety of life areas
- Prenatal/postnatal group
- Food/nutrition & basic needs support

**In-kind services on-site**
**Primary health:** Primary care physician; physicians specializing in addictions & maternity care; public health nurse (PHN); nurse practitioner
**Health & wellness:** Community nutritionist; dental hygienist
**Children's health:** PHN, immunizations, well baby checks

**Contracted services**
**Housing:** Rent supplements; 4 care home beds for women age 16-24

**Co-located services**
n/a

**SHEWAY** • Vancouver, British Columbia • Opened in 1993 – 1st program of its kind in Canada.
Funded and operated by Vancouver Coastal Health, with additional resources from BC Ministry for Children and Family Development, Vancouver Native Health Society, BC Ministry for Social Development and Poverty Reduction & YWCA.

**Core services/ programming**
- Outreach; Drop-in, parenting skills groups
- Substance use groups & counselling
- One to one support in variety of life areas
- Primary health: Primary care physicians; addictions & maternity care physician; nurses; psychiatrist
- Child welfare: BC government child welfare social worker
- Cultural programming
- Food/nutrition & basic needs support

**In-kind services on-site**
**Health & wellness:** Dental hygienist; occupational therapist; physiotherapist
**Income support:** Community Intervention Specialist
**Children's health:** Paediatrician; speech & language therapist

**Contracted services**
**Health & wellness:** Music therapist
**Legal:** Lawyer

**Co-located services**
**Housing:** YWCA supportive housing
**Daycare:** YWCA day care

**MAXXINE WRIGHT** • Surrey, British Columbia • Opened in 2005 after extensive community planning.
Funded and operated by Fraser Health, with additional in-kind support from the BC Ministry for Children and Family Development and the BC Ministry of Social Development and Poverty Reduction.

**Core services/ programming**
- Primary health: Public health nurse; nurse practitioner; prescriptions; opioid agonist therapy
- Substance use counselling
- Prenatal/postnatal services
- Children's health: Immunizations, baby weight, well baby checks

**In-kind services on-site**
**Primary health:** Physician specializing in obstetrics; maternal-fetal medicine
**Health & wellness:** Psychiatrist/ reproductive psychiatry
**Income support:** BC government income assistance worker
**Children's health:** Paediatrician; infant development worker
**Child welfare:** BC government child welfare social worker

**Contracted services**
**Health & wellness:**
Doulas; Midwives

**Co-located services: Atira Women's Resource Society**
Food support; parenting: drop-in groups; daily meal
**Prenatal/postnatal:**
Pregnancy outreach worker
**Housing:** Supportive housing
**Daycare:** Atira Daycare
**Cultural:** Elder services

**H.E.R. Pregnancy Program** • Edmonton, Alberta • Opened in 2011.
Funded primarily by Alberta Health and operated by Streetworks, a non-profit community-based organization.

**Core services/ programming**
- Outreach; weekly drop-in group
- One to one support in variety of life areas
- Prenatal/postnatal: on-site STI and pregnancy testing
- Child welfare support
- Food/nutrition & basic needs support; transportation and accompaniment

**In-kind services on-site**
n/a

**Co-located services: Boyle Street Community Services**
**Health & wellness:** Wellness
**Children's health:** 'Health for 2'
**Child welfare:** AB government child welfare social worker
**Cultural:** Elder services

**RAISING HOPE** • Regina, Saskatchewan • Opened in 2013; the only fully residential program in the CCE study. Funded by the Ministry of Social Services, Sask. Health Authority and the Department of Justice, Canada; operated by SWAP, a community-based agency with an Indigenous housing organization as a partner.

**Core services/ programming**
- Supported housing (18-unit apt building)
- Mental health/trauma counselling
- Cultural programming
- Food/nutrition & basic needs support
- Child care
- Drop-in /peer connections

**In-kind services on-site**
**Primary health:** Primary care physician
**Health and wellness:** Addictions counsellor; wellness therapist
**Child welfare:** SK government child welfare social worker
**Parenting:** Regina Early Learning Centre – Triple P Parenting

**Contracted services**
**Health & wellness:** Psychologist; art therapist; life skills & healing

**Co-located services**
n/a

**MOTHERING PROJECT** • Winnipeg, Manitoba • Opened in 2013, program of Mt Carmel Clinic. Funded by Healthy Child Manitoba and Winnipeg Regional Health Authority.

**Core services/ programming**
- Outreach; transportation and accompaniment; Drop-in groups
- Substance use counselling
- Life skills & mental health/trauma groups
- One to one support in variety of life areas
- Cultural programming
- Food/nutrition & basic needs support

**In-kind services on-site**
**Primary health:** Nurse; public health nurse
**Health & wellness:** Trauma counsellor; speech therapist
**Childcare:** Family Worker – Daycare Inclusion Specialist
**Parenting:** Parent Student Support Program; Families First

**Contracted services**
n/a

**Co-located services:**
**Mt Carmel Clinic**
**Primary health:** Primary care physician, nurse practitioner, public health nurse, midwifery

**BREAKING THE CYCLE** • Toronto, Ontario • Opened in 1995, operated by Mothercraft (non-profit society) and funded by the Public Health Agency of Canada and the Ontario Ministry of Child, Family and Community Services.

**Core services/ programming**
- Pregnancy outreach support
- Substance use counselling; relapse prevention groups
- Life skills & mental health/trauma groups
- Food/nutrition & basic needs support
- Child care
- Parenting/support groups
- In-home visits weekly re: parenting
- Early intervention services for children

**In-kind services on-site**
**Primary health:** Public health nurse
**Health & wellness:** Addictions worker
**Children's health:** Developmental pediatrician (& FASD assessment); speech language services; infant development
**Child welfare:** ON government child welfare social worker participates in bi-weekly team meetings
**Correctional services:** Probation officer

**Contracted services**
**Health & wellness:** Psychological associate; clinical child psychologist

**Co-located services**
n/a

**BABY BASICS** • New Glasgow, Nova Scotia • Opened in 1999; program of Kids First, a community agency and funded primarily by Public Health Agency of Canada's CPNP and CAP-C programs.

**Core services/ programming**
- Drop-in prenatal/postnatal groups and peer connection
- Food/nutrition & basic needs support; transportation support to access program
- Child care
- In-home support when needed

**In-kind services on-site**
**Primary health:** Public health nurse
**Health & wellness:** Trauma-Informed Parenting Support program; groups re: intimate partner violence and healthy relationships

**Contracted services**
n/a

**Co-located services**
n/a

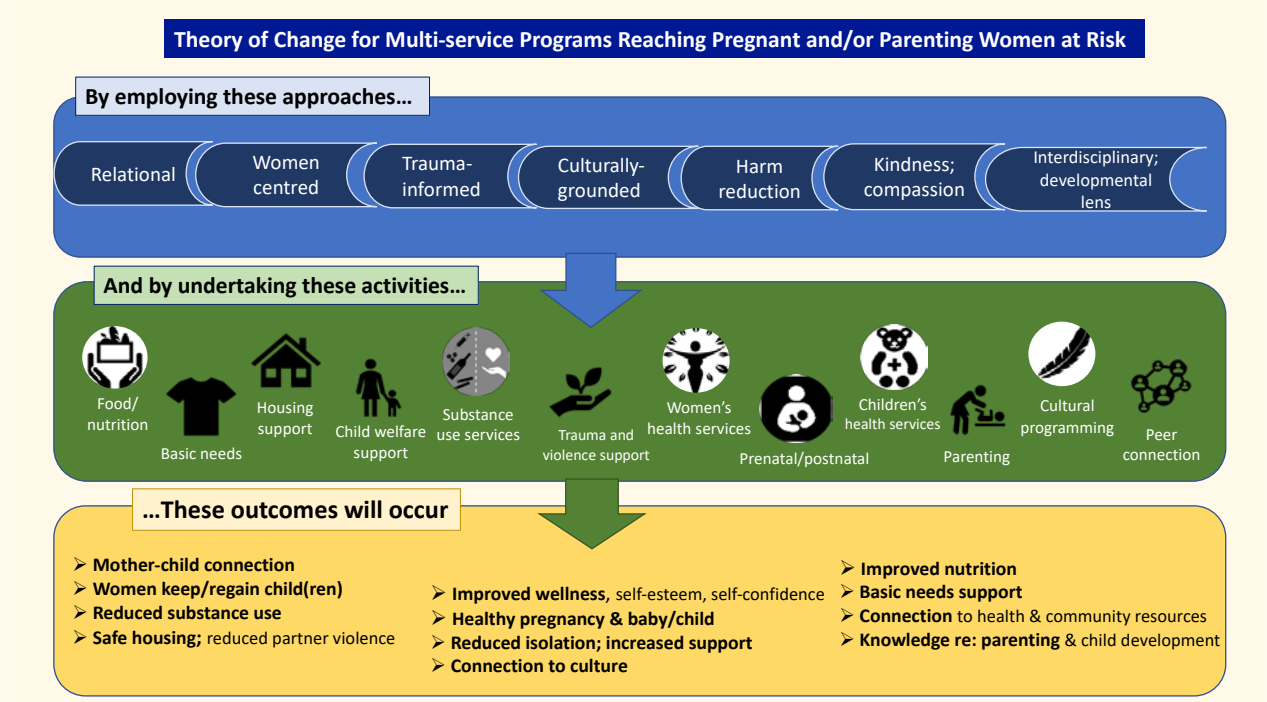
## Theory of change

In program evaluation, a Theory of Change is often developed to show the interconnections between the program's context (current situation for clients/participants), inputs, activities, and anticipated short-term and medium-term outcomes, and longer-term impacts.

As part of the developmental phase of this project, the project team and the Program Coordinators/Managers (Program Leads) of the eight participating sites collaboratively developed a Theory of Change to guide the rest of the evaluation activities. As an important part of these discussions, the Program Leads also identified a number of key issues and challenges for women at the time of intake. These included substance use, unsafe and/or inadequate housing, poverty, experiences of violence or trauma, poor physical health, isolation, maternal-child separations, impacts of colonization and residential schools, and lack of access to health and social care.

The Co-Creating Evidence Project's Theory of Change is presented in **Figure 3**.

**Figure 3:** Co-Creating Evidence project's Theory of Change



# 2 Research Process

**Research Process:** Key points

- The project team visited each program twice between spring 2018 and fall 2019, to interview clients, staff, and program partners.
- A total of 424 interviews were conducted: 256 with clients, 108 with program staff, and 60 with service partners.
- The programs also submitted de-identified client and output data quarterly for 18 months.

## Overview and research questions

The study employed a mixed-methods design involving qualitative and quantitative data and was guided by a collaborative approach. A national Advisory Committee met 1-2 times a year to provide guidance on key facets of the project.

The project's research questions were:

- What are common elements of these diverse, multi-service programs?
- How do these programs reflect their community's context?
- What program components are most helpful from women's perspectives?
- What outcomes are being achieved and what are good measures to demonstrate outcomes?

## Data collection methods

Data were collected in two ways:

1. The project team visited all eight programs in Spring 2018 and Fall 2019 and conducted interviews and questionnaires with clients, and interviews with program staff and service partners; and

2. Staff at the program sites collected quantitative output data and client-based intake and 'snapshot' data quarterly from April 2018 through September 2019. The Client Database contained de-identified demographic and high-level outcome data for each woman attending the program during the quarter, i.e., 'snapshots' related to housing, substance use, and child welfare outcomes.

Additional information about the study's methods and data analysis is provided in **Appendix A.**

## Interview participants

As shown in **Table 1**, a total of **424** interviews were conducted.

**Table 1:** Number of interviews conducted, by time period and participant group

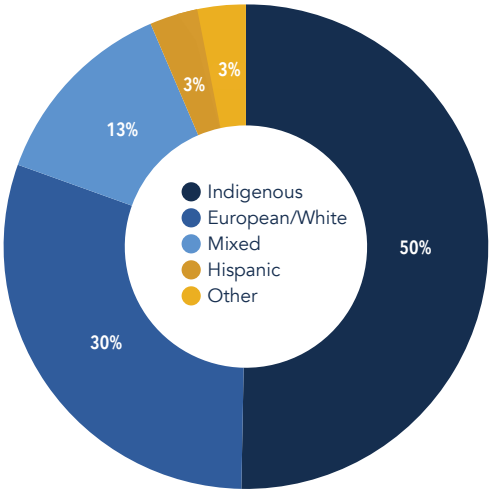
| | Time 1 (April – July 2018) | Time 2 (Sept – Dec 2019) | Total |
|---|---|---|---|
| Client interviews & questionnaires | 125 | 131 | 256* |
| Staff interviews | 61 | 47 | 108 |
| Service partner interviews | 42 | 18 | 60 |

* Twenty-nine clients were interviewed and completed the Client Questionnaire both at Time 1 and Time 2; their Time 2 responses on the Client Questionnaire were used for data analyses.

## Client socio-demographic information

Following is demographic information for the 226 clients who participated in face-to-face interviews and who completed the Client Questionnaire.

Gender: The majority (225) of participants identified their gender as female, and one person identified as 'gender-non-conforming.'

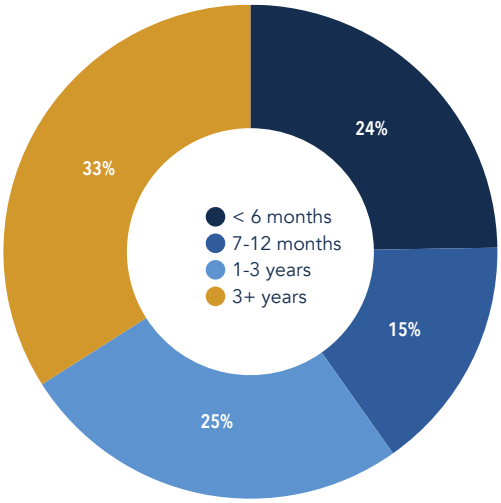



Ethnicity: The majority of interview participants (50%) identified their cultural background as Indigenous, though this varied from 94% at the Indigenous-focused program in downtown Winnipeg to 7% at the program in rural Nova Scotia.

**Figure 4:** Ethnicity of clients participating in interviews

Age: The majority of clients participating in interviews was over age 30; 20% were 16-24, 26% were 25-30, and 55% were over 31 years old.

Length of time in program: The length of time clients had participated in their program varied from <1 month to 3+ years.




In part, this difference can be attributed to the policies of the individual programs; for example, in several programs clients can participate until their child is school-aged, whereas at other programs, clients end their formal involvement at 6- or 12-months post-partum.

**Figure 5:** Clients' length of time in their program

## Program staff participating in interviews or focus groups

Across the eight CCE programs, the 108 staff who participated in an interview or a focus group came from diverse professional backgrounds, and included:

- Program managers
- Nurse practitioners
- Counsellors
- Client engagement workers
- Peer support workers
- Executive directors
- Midwives
- Elders
- Indigenous liaison workers
- Aboriginal family support workers
- Physicians
- Social workers
- Outreach workers
- Infant development workers
- Childcare workers

# 3 Story of the Programs

## What are the programs' origins and approaches?

As noted in the Introduction, the eight programs taking part in the CCE study were developed in response to local influences and issues. Seven of the programs were developed with the recognition that holistic approaches to issues of problematic substance use among pregnant and parenting women were needed in their communities. A Consensus Statement on 10 fundamental components for FASD prevention, prepared by a Canadian network of researchers and practitioners, emphasized the importance of these approaches (Network Action Team on FASD Prevention from a Women's Health Determinants Perspective, 2010). For these programs, access to specialized health and social services is a central feature, and program developers sought to address the fragmentation of services within health care, as well as between the health and social services sectors. The eighth program was developed in response to a group of low-income women who wanted a safe environment and resource for families. Over time, the program evolved to include issues of substance use as part of its overall focus on young, parenting women facing challenges associated with poverty, isolation, and difficulties with various systems and compounded by a dearth of relevant resources in the region. Several of the programs are located in urban areas with a high percentage of Indigenous women and families, and thus these programs prioritize Indigenous cultural safety and programming.

Despite being developed at different times and in different regions in Canada, as noted in the Theory of Change, the programs are guided by a similar set of philosophical/theoretical approaches to their work. During a face-to-face meeting involving the project team and all Program Leads in June 2017, this set of philosophical/theoretical approaches was collaboratively defined as follows: 1) relational; 2) women-centered; 3) harm reduction; 4) trauma-informed; 5) culturally grounded; 6) kindness and compassion; and 7) inter-disciplinary with a developmental lens. Two additional approaches were identified based on qualitative interviews with clients and program staff: **1) non-judgmental, safe, and strengths-based; and 2) community-focused**. These philosophical approaches were found to be at the heart of how the programs operated, as well as what clients valued about the programs.

**Table 2** provides a brief definition of each of the approaches and illustrates how clients and staff experienced these in practice.

**Table 2:** Philosophical/theoretical approaches employed by the programs

| Approach | Definition based on June 2017 meeting | Clients' perspectives | Staff's perspectives |
|---|---|---|---|
| Non-judgemental; safe; strengths-based | N/A | *The people that work there, they aren't judgmental. I feel like a person at [the program], not a nobody.* | *Providing a safe environment where women are in a non-judgemental place and they can get the help they need or want.* |
| Relational | Focussing on safe, respectful, positive and trusting relationships with service providers | *Being able to trust. There's no judgement. But there is judgement when it's needed. [Program Manager] and Dr A., they'd call me on my shit. They'd say things to me how I needed to hear it.* | *The relationships we build are key; they are the intervention. Our relational approach – that is key to success and to achievement of our outcomes. Women are scared when they first come in, so building the relationship is important.* |
| Women-centred | Women set their own goals for service | *The staff; I wouldn't have had the same recovery that I had without them. …They understand how far to go with me and when I need a break.* | *Women choose whatever aspects of the program they want. We give suggestions, but we are really focused on the women's own goals and directions.* |
| Harm reduction | Focussing on minimizing harm and promoting safety | *The staff – they make it so that I can come forward with my own questions or concerns safely, without fear of being judged or reported.* | *We meet the women where they are and support in a safe way. We understand that women may relapse and that is okay.* |
| Trauma-informed | Understanding that many women have experienced serious trauma | *The staff are incredible – consistent and trustworthy in their approach. It is very safe at [the program].* | *Being trauma informed is not asking 'what's wrong with the woman' but 'what happened to her'. Being respectful, focusing on the behavior and not the person.* |
| Culturally-grounded | Employing Indigenous cultural programming and approaches & appreciating the multi-generational impacts of colonization | *The cultural and the drumming. When I started here, I started singing again. …This program helped me get back into my culture, and that's been important.* | *Spirit is an approach. Sacredness influences the way we talk here. Give the message "you are sacred". It is a key piece to healing.* |
| Kindness; compassion | Using person-first language and de-stigmatizing language; minimizing shame and guilt | *You are not stigmatized here. It doesn't matter where you come from, you are treated with respect and warmth. You are not just a statistic.* | *Being kind, welcoming. Women feel as though they can trust. So many women have so much stigma in their life. They can be here and not be judged.* |
| Inter-disciplinary; developmental lens | Addressing women's and children's needs holistically | *Everything I have to do in a week is all at [the program]: health care, Income Assistance, housing support, day care, counselling – all in one place.* | *Women have different relationships with different staff. They rely on the seamless communication that they know exists between the staff.* |
| Community-focused | N/A | *There's a sense of community; the community is really good there.* | *Connection. They have a place to go. Women are giving back to the community.* |

## What are the programs' models?

While the eight programs are grounded in the same set of approaches, the way that programming and services are delivered varies across the programs. This is understandable given that each program was conceived and implemented out of a particular set of community circumstances. The CCE project team developed a multi-dimensional approach to describing each program's model (**Figure 6**) that also reflects its unique characteristics. **Figure 7** provides visual depiction of two of the programs' models; the other programs' models are presented in **Appendix B**. This is followed by examples of how programs put into practice the central dimensions of their model.

**Figure 6:** Mapping the Co-Creating Evidence programs' models: A Multi-dimensional approach

**Dimension 1:** "One stop": Wraparound health and social care and material/ basic needs support under one roof

| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| HWH, BTC, MW, SW, RH, MP | HER, BB | |

**Dimension 2:** Outreach focus

| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| HWH, HER, SW, MP, BTC | MW, BB | RH |

**Dimension 3:** Peer mentoring focus

| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| HER, RH, MP, BB | SW, MW, MP | HWH, BTC |

**Dimension 4: Cultural focus** Indigenous cultural programming/services as core wellness support for clients and staff

| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| HER, RH, MP, SW | MW | BTC, HWH, BB |

**Dimension 5: Dual client focus** Wraparound services to mother and to infant/ child, to strengthen mother-child connection

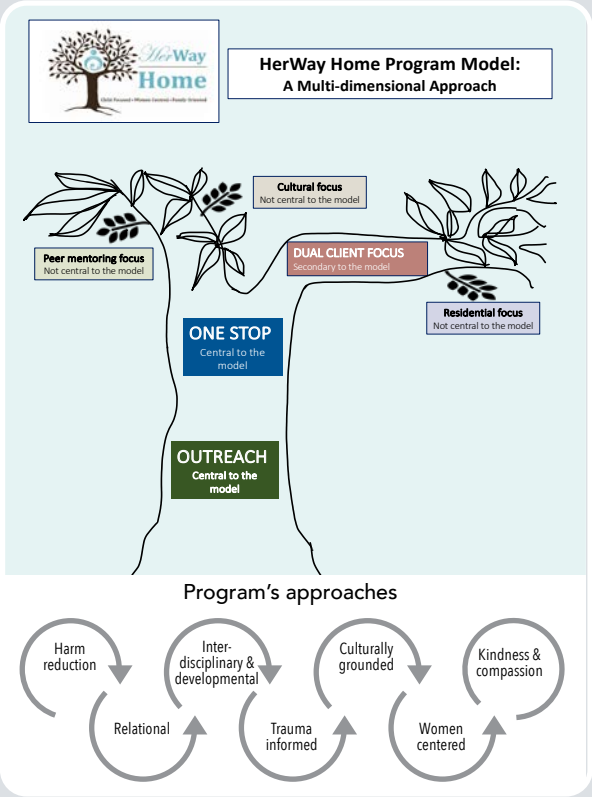
| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| BTC, SW | HWH, RH, BB, MP, MW | HER |

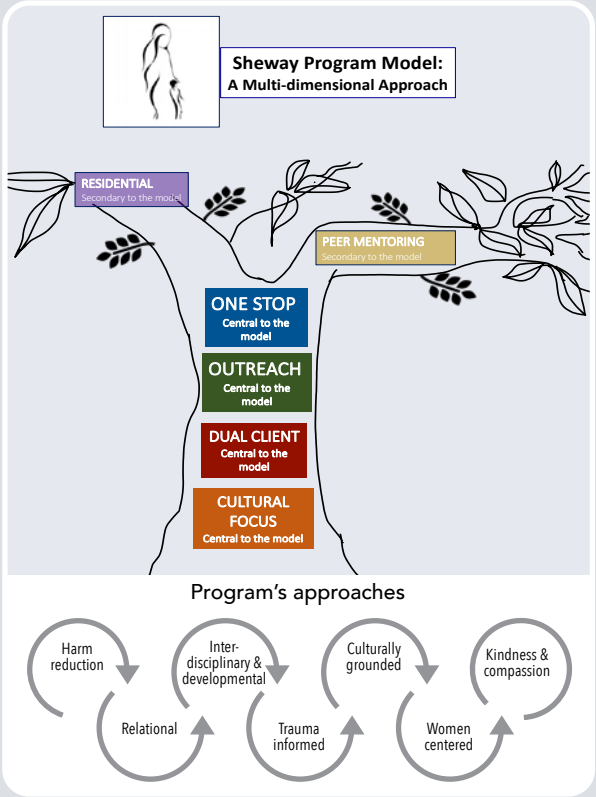
**Dimension 6: Residential** On-site/co-located housing for some/all clients

| Central/Primary to model | Secondary to model | Not (as) central to model |
|---|---|---|
| RH, MW | SW | HWH, MP, BB, HER, BTC |

**LEGEND:**
**HWH** ►HerWay Home
**HER** ►H.E.R. Pregnancy Program
**BTC** ►Breaking The Cycle
**SW** ►Sheway
**RH** ►Raising Hope
**BB** ►Baby Basics
**MW** ►Maxxine Wright
**MP** ►Mothering Project

**Figure 7:** Program models for HerWay Home and Sheway




**One stop:** For six of the programs, providing a one stop experience for clients – having multiple services accessible at in one location – is central to their operation. For example, ***Sheway***, the largest program taking part in the study, is located in the Downtown Eastside of Vancouver, British Columbia; the program is street level, with health services located on the third floor and the YWCA's Crabtree Corner Housing located on the fourth and fifth floors. Sheway clients can drop in daily to have the hot meal that is made in the on-site kitchen, to attend appointments with various staff, or to attend group programming. ***Herway Home***, which has space in a community health centre in Victoria, British Columbia, similarly provides a range of services at one location. For example, primary care physicians, addictions physicians, nurse practitioners, public health nurses, a nutritionist and a dental hygienist all have regularly scheduled hours on-site, and the program also offers a drop-in wellness group, prenatal group and substance use and trauma recovery group.

**Outreach focus:** Five programs have a strong outreach focus. For example, the ***Mothering Project***, situated in the north end of Winnipeg, Manitoba, is in its own space yet is attached to Mt Carmel clinic. The program has two to three Outreach Workers who are assigned a caseload of up to 15 women each, with whom they meet on a one-to-one basis in the community. The Outreach Workers' general focus is to keep in touch with clients, drive them to appointments, meet informally over coffee to build relationships, check in, and ensure that clients are getting the help they need.

**Peer mentoring:** Four programs have peer mentoring as central to their model. To illustrate, ***Baby Basics*** is a small program in Nova Scotia, which is nested within Kids First, a family resource centre. Kids First has a street-front space on a main street of New Glasgow, Nova Scotia. An open space in the front of the building is a group meeting area set up with comfortable couches in a semi-circle. Women meet once a week to talk about issues that are important to them; the groups are facilitated by the Baby Basics Coordinator who is viewed as a role model since she was at one time also a participant at Kids First. At ***H.E.R.,*** in Edmonton, Alberta, outreach staff have lived experiences similar to clients, such as poverty, intimate partner violence, trauma, and problematic substance use. This provides a foundation for trusting relationships and engagement of clients.

**Cultural focus:** Four programs have Indigenous cultural programming as a central feature. The integration of cultural activities and approaches reflects the Indigenous population served by these four programs. For example, the ***Mothering Project*** has a healing room where women can participate in ceremonial activities such as smudging, circle discussions, and traditional teachings. Indigenous staff offer counselling and supports to women through a cultural lens. In the drop-in space, craft activities such as skirt-making and art projects are offered. At ***Sheway,*** the Indigenous Family Support Worker alongside visiting Elders offer traditional parenting, Baby Welcoming ceremonies and activities in both group and one-to-one sessions. Traditional foods such as salmon and bannock are served regularly with the hot lunch program. In addition to supporting program participants, the presence of Elders provides a unique way of supporting members of Sheway staff during the trauma and grief of the opioid overdose crisis.

**Dual client focus:** Two programs, ***Breaking the Cycle*** and ***Sheway,*** have delivery of services to the mother-child unit as a central focus. ***Breaking the Cycle*** is intentionally structured to include both the mother and child, with each having a dedicated staff and programming. Women are connected to an addiction counsellor, and a Parent Infant Therapist meets with the woman-infant/child dyad weekly to help with parenting goals and development of a healthy mother-child dynamic. Childcare is provided on-site by qualified child development workers who also work with the children on healthy development. A developmental pediatrician is on-site bi-weekly for regular developmental check-ups, one-year-old health assessments, and to address the child's routine health care needs.

**Housing focus:** Two programs have housing as a central feature: ***Raising Hope*** and ***Maxxine Wright*** *(also known as Maxx Wright).* ***Raising Hope*** is located in an 18-unit apartment in Regina, Saskatchewan. The main floor houses program offices, a common meeting space and kitchen, and a dedicated child care space. The women and their families are assigned one- or two-bedroom apartments on the second and third floors. Women accepted into the program have substance use issues, housing insecurity, possible intimate partner violence, and are either pregnant or recently post-natal. Most women also are involved with the provincial child welfare authorities. A requirement of being at ***Raising Hope*** is that all residents must take part in a daily structured program that consists of individual appointments and groups focusing on health, addictions, culture, parenting, and mental health. Transportation assistance is provided to help residents get to services in the community. At ***Maxx Wright***, the housing component is available through the program's partner, Atira Women's Resource Society. Maxx Wright and Atira are co-located, offering services together on the same floor. In addition, Atira operates transition housing and second stage housing, both located on the same property.

## Who are the programs' funders?

The programs have a wide array of funders, which can change over time. Generally speaking, funding partners include or have included federal and provincial organizations such as Public Health Agency of Canada, Community Action Program for Children, Department of Justice Canada, provincial and regional health authorities, provincial child welfare ministries, Indigenous health and social services agencies, public health, and community-based organizations and foundations. Local funding sources help fill in gaps, connect the programs to community, allow for creative programming/activities and generally enable the programs to round out their services.

## What services are offered and how are the programs' services delivered?

Half of the programs are operated by a health authority and half are operated by a community-based agency (i.e., non-profit organization). **Table 3** depicts the array of services provided on-site at each program. Taken together, these services comprised key elements of the one-stop approach.

**Table 3:** Services and activities offered on-site by program staff, co-located services, or in-kind or contracted services

| Operated by | Health Authority | | | | Community-based agency | | | |
|---|---|---|---|---|---|---|---|---|
| Program | HWH | SW | MW | MP | HER | RH | BTC | BB |
| Focus on at-risk pregnant and early parenting women | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × |
| **Services Provided** | | | | | | | | |
| Food, nutrition | ★ | ★ | ⊙ | ★ | ★ | ★ | ★ | ★ |
| Basic needs, including transportation | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Housing | ♦ | ♦⊙ | ⊙ | ♦ | ♦ | ★ | ♦ | ♦ |
| Child welfare support | ★ | ⊙ | ⊙ | ★ | ★ | ⊙ | ♦ | |
| Substance use – individual or group | ★ | ★ | ★⊙ | ★ | ★⊙ | ⊙ | ★ | ♦ |
| Mental health/violence and trauma support | ★ | ★ | ♦★ | ★ | ♦★ | ★ | ★ | ★⊙ |
| Primary care | ★ | ★ | ★ | ⊙ | ♦ | ♦★ | ♦ | ♦ |
| Prenatal/post-natal | ★ | ★ | ★ | ★ | ♦★ | ♦⊙ | ♦ | ♦★ |
| Child health | ★ | ★ | ★ | ★ | ♦ | ★ | ★ | ♦ |
| Child assessment/early intervention | ♦⊙ | ★⊙ | ⊙ | ★ | ♦ | ♦★ | ★ | ♦ |
| Childcare on site | ★ | ★ | ⊙ | ★ | | ★ | ★ | ★ |
| Parenting programming | ♦★ | ★ | ★⊙ | ★ | ♦ | ⊙ | ★ | ★ |
| Cultural programming | ♦ | ★ | ⊙ | ★ | ⊙ | ★ | ♦ | |
| Drop-in/peer connections | ★ | ★ | ★⊙ | ★ | ★ | ★ | ★ | ★ |

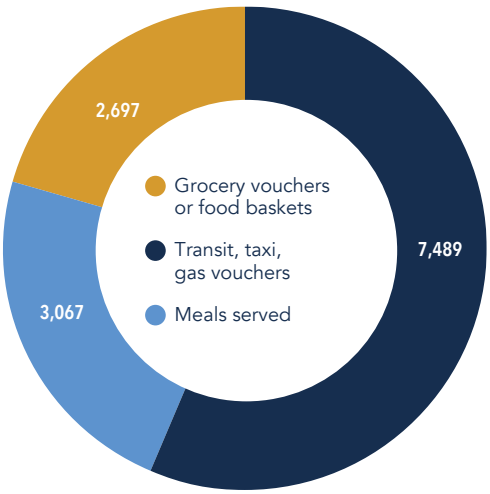
× Young pregnant/parenting women aged 16-24 years of age
★ Services provided on site by staff/program
♦ Services accessed in community via formal or informal partnership
⊙ Services provided on site through a combination of in-kind contribution by the program funder or partner, paid contract and/or as a co-located service

From April 2018 to September 2019, output data were gathered at all eight programs in relation to the number of women who accessed the following services: housing, basic needs, health and wellness, substance use, violence and trauma, and social support activities. The information gave an indication of how each program was structured.

Although all eight programs offered groups, their focus and degree of intensity varied; some primarily offered drop-in groups while others had a combination of drop-in and topic-specific or time limited groups. To illustrate, in keeping with being a housing-based program with an expectation that clients participate in programming daily, ***Raising Hope*** offered daily groups. ***Sheway*** also provided a significant number of groups, the majority being drop-in wellness groups. The types of groups offered varied in accordance with client needs and program resources; for example, prenatal/postnatal groups were not offered at ***Sheway*** because clients accessed their prenatal/postnatal services via one-to-one appointments with staff or with health professionals on-site. By contrast, ***HerWay Home's*** prenatal/postnatal groups represented 70% of its group programming delivered during the evaluation period.

Similarly, although all programs offered basic needs support, the type and level varied, in particular in terms of transportation (e.g., rides, transportation tickets/vouchers) and food (e.g., meals, grocery vouchers) (Figure 8). ***Sheway***, ***Maxx Wright***, the ***Mothering Project***, and ***Breaking the Cycle*** provided a hot meal daily, while others did so only during group programming. ***HerWay Home*** provided hot meals two to three times per week and both ***H.E.R.*** and ***Baby Basics*** provided a hot meal weekly. ***Raising Hope*** has a communal kitchen, and staff and clients organized regular meals, although women mainly ate in their apartments with their families. Similar variety existed in terms of transportation support. ***Baby Basics***, which serves a large geographic area with limited public transit, provided taxi vouchers, which was essential to help women attend the program. Other programs such as ***HerWay Home*** and ***H.E.R.*** routinely drove and accompanied women to appointments and services in the community.

**Figure 8:** Total number of meals, grocery vouchers or food baskets, and transportation-related vouchers, across the CCE study's eight programs, 2018 – 2019

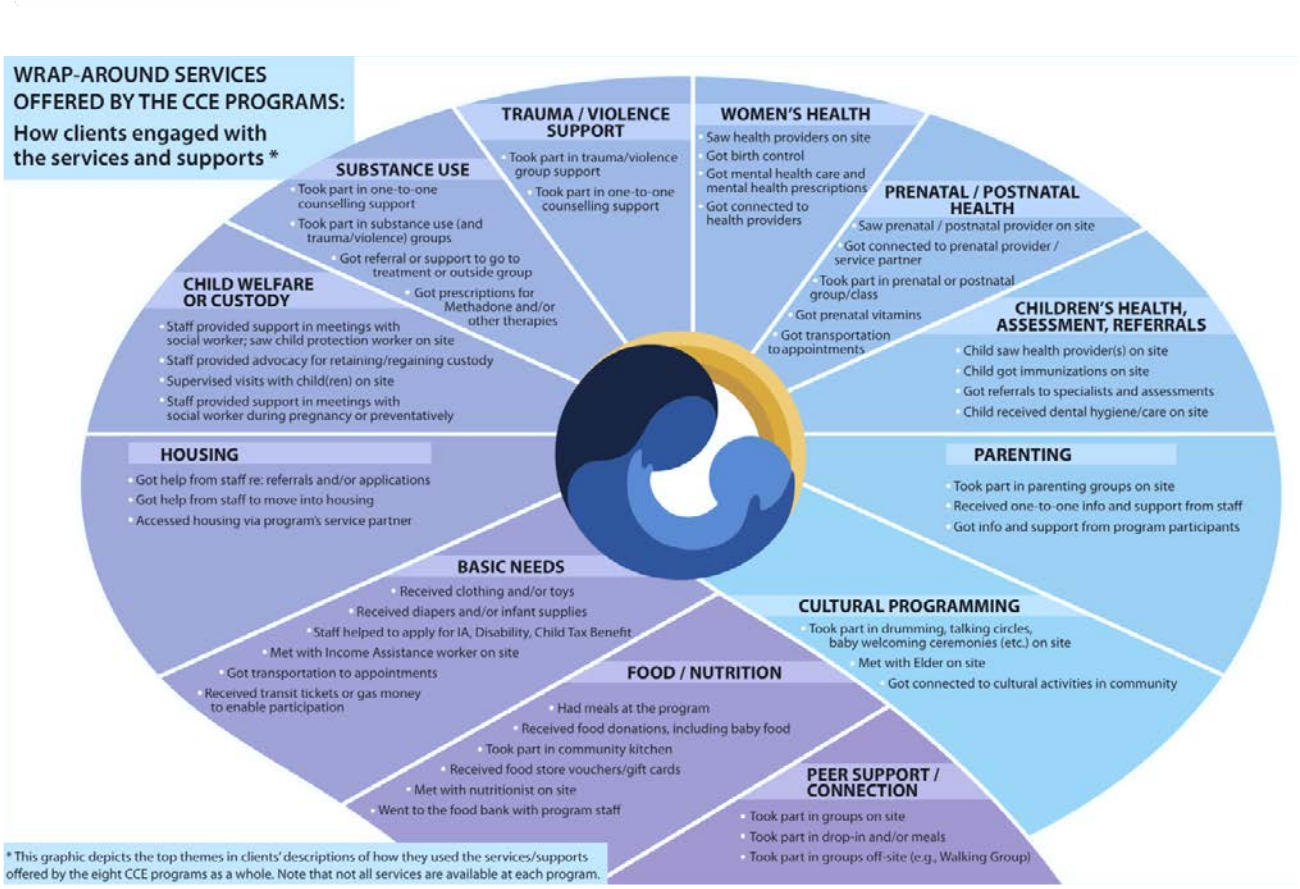



Between April 2018 and September 2019:

- **$26,000** worth of meals, grocery vouchers or food baskets were distributed by 6 programs (2 programs didn't collect the information).
- **$18,100** worth of transit, taxi, gas vouchers were distributed by 7 programs (1 program didn't collect the information).

Regardless of how services were structured or delivered, across the programs, the intent was to ensure that clients had a seamless experience and encountered few barriers to services. **Figure 9** depicts the array of wraparound[3] services offered collectively by the programs, using clients' words to tell the story of how they engaged with the various supports and services offered.

**Figure 9:** The array of wraparound services offered by the programs in the CCE study




## Service partnerships

Formal and informal partnerships as well as partner relationships with other sectors and disciplines were key to the delivery of wraparound services. Formal agreements helped define roles, limits of confidentiality and facilitate information sharing. Informal partnerships or collaborative arrangements were guided by mutual goals, shared clientele, and were built on trust and common purpose. **Textbox 1** depicts the partnership relationships and partnership activities that were common across the eight programs, as well as those that were less common. The variations were reflective of the programs' unique characteristics.

[3] A wraparound approach to service delivery has been defined as a comprehensive, flexible, client-directed way of responding that puts the client's self-identified needs and goals at the centre (National Wraparound Initiative, no date). Central to wraparound is being holistic, team-based and collaborative (Homelessness Hub, 2019).

In general, programs operated by health authorities formed partner relationships with social service programs, whereas programs operated by community-based agencies tended to form partner relationships with primary care and maternal health services. Five programs co-located with other agencies and services (e.g., housing; primary health care), which complemented their core services. The integration of staff from other organizations (e.g. child protection; income assistance; infant development; Indigenous elders) within a program was a strategy that was employed by four programs.

## **Textbox 1:** Partnerships and common partnership activities

### Common partners

- Child welfare/child protection services
- Prenatal/postnatal health care services, e.g. public health, midwifery, primary care physicians
- Specialized health services – e.g. maternal fetal medicine; pregnancy & substance use; Opioid Agonist Therapy
- Addictions and mental health services

### Less common partners

- Housing related services
- Detox
- Health services related to Indigenous health
- Infant development/ child health
- Income assistance
- Legal services
- Probation services

### Most common activities of the partnership relationship

- Resource sharing, i.e. staffing, knowledge, information
- Reciprocal referrals
- Exchange /share program and client information
- Case conference or joint case planning meetings
- Provide services on-site of the program

### Less common activities of the partnership relationship

- Training or information sessions sponsored by the program
- Inter-agency /community based committees and/or advisory committees
- Cultural support
- Research support and/or other expertise to program staff
- Joint development and delivery of programming
- Systemic advocacy

## Partnership examples

The following quotes demonstrate examples of external partnerships that extended the services offered by the programs:

> *The Y[MCA] assists us with giving families a membership. We tell the Y who qualifies based on income and they provide a pass. It gives families a low-cost membership that they can use at the pool.*

> *A new partnership began in 2017 with the Farmers Market. For seven months, women receive $100/month Farmers Market 'Bucks'. They can spend this however they want at the market.*

> *On Thursdays a probation officer is on-site to meet with women who have an active probation order. This approach has made a world of difference, enabling women to have safety while meeting their probation requirements, thereby significantly reducing the likelihood of running into more problems with the criminal justice system by breaching their probation order.*

## What are the programs' strengths from staff's and partners' perspectives?

Strong common themes emerged during interviews with program staff and service partners as to what they viewed as the main strengths of their program:

- The program's philosophical approaches;
- Characteristics of the program staff including being knowledgeable, committed, relational, 'walking the talk', and using a team approach;
- The 'one-stop' or wraparound delivery of services, including medical and health care providers on-site;
- Strong relationships with service partners, e.g., child welfare and health care; and
- Flexibility and responsiveness of service delivery.

Additionally, service partners noted that another strength was that the programs were reaching and providing support to women with complex challenges and needs who were typically underserved by other services.

## What are the programs' challenges from staffs' and partners' perspectives?

Staff and partners were also asked what they viewed as the challenges faced by the programs. As with the strengths, there was consistency in their responses in that both groups saw the need for:

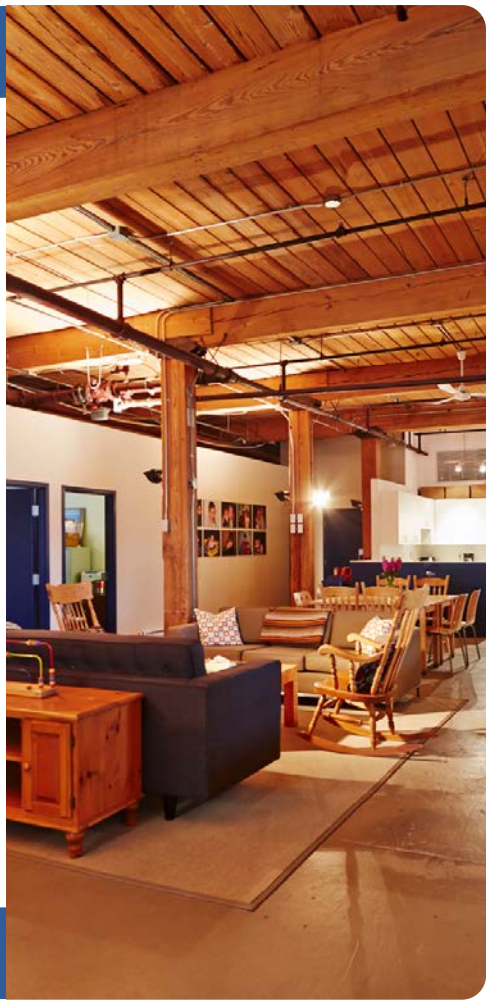
- Stable and adequate program funding;
- More staff; and,
- Better physical space commensurate with program needs.

Both groups also noted the challenges associated with working across systems and disciplines, including barriers to information sharing and differing mandates, timelines, and/or approaches by various systems of care. These challenges affected clients' ability to navigate services.

Staff and partners also highlighted systemic challenges, i.e., issues that were beyond the scope of individual programs to resolve. Both groups noted that the multiple issues facing clients, e.g. trauma, addictions, opioid crisis, added complexity that was further compounded by a lack of safe, affordable housing and limited longer term supports available for women and families.

### **Story of the Programs** - Key takeaways

- The eight programs were guided by a similar set of theoretical approaches, including being trauma-informed, relationship-based, women-centred, culturally-grounded, and harm-reducing.
- A multi-dimensional model highlights the unique and common characteristics of the eight programs.
- Dimensions most central to programs' models were: one-stop; outreach focus; peer mentoring focus; cultural focus. Less common dimensions of the model were: dual client focus (i.e., mother and child focus); and residential.
- Formal and informal partnerships and partner relationships with other sectors and disciplines were key to the delivery of wraparound services.
- Strengths of the programs included: their philosophical approaches; knowledgeable staff; one-stop/ wraparound services that included medical and health services; strong partnerships with other service providers; flexibility and responsiveness to client needs.



# 4 Story of Wraparound Services through an Indigenous Cultural Lens

## How do Indigenous approaches to well-being align with wraparound programming?

All the programs taking part in the Co-Creating Evidence study employed a holistic social determinants approach to supporting women in which multiple services are accessed to meet the various aspects of a woman's life situation. This approach parallels worldviews found amongst Indigenous societies wherein the whole person is considered in context of family, community, and nation, and balance is sought to achieve well-being (Bartlett, 2005).

Indigenous societies in Canada have ancient teachings that consider the whole person in relation to each other, the land, the air, the water, the animals and the plants, and the spirit world. All are interconnected. For example, the Nuu Chah Nulth on the western region of Vancouver Island describe their world perspective as "Heshook-ish Tsawalk", meaning everything is one and that all reality exists in relatedness to each other, both in the physical and metaphysical worlds (Atleo, 2004). Similarly, Anishinaabe use the circle and the medicine wheel in teaching new mothers that each individual is born with sacred gifts. The circle symbolizes completeness and interdependency. It is a resource that allows life to be viewed in a holistic manner, and its teachings guide prospective mothers toward good health and harmony in life (Van Bibber, 1997).

The The Federation of Saskatchewan Indigenous Nations' (n.d.) Culturally Responsive Framework was developed from an Indigenous lens with the aim of ensuring that the health care system in Saskatchewan respects the cultures of First Nations peoples and recognizes community-based Indigenous healing systems as fundamental to good health and wellness (Sasakamoose et al., 2017). It recognizes that healing is achieved through restoring balance in the realms of spiritual, emotional, mental, and physical health. Bringing to life this vision requires the ethical space wherein diverse partners and governments can work together in respect, understanding and equity to achieve health and well-being based on the recognition of the inherent rights of Indigenous Peoples (Sasakamoose et al., 2017)

## How are Elders, knowledge keepers, staff, mentors and women a resource?

Cultural programming includes cultural ceremony, traditional teachings and activities that reflect a worldview where "wholeness, balance, harmony, relationship, connection to land and environment" is a lifelong process of healing (Castellano, 2006, 115). Participating in activities such as Baby Welcoming Ceremony, time with Elders, traditional foods, crafts,

art, songs, and drumming creates good feelings and connects Indigenous women to their identity and sense of self-worth. The philosophical approach of 'culturally grounded' is mostly strongly expressed in programs in which the majority of the participants are Indigenous; of the eight programs involved with the Co-Creating Evidence study, these programs were ***Raising Hope***, ***H.E.R.***, ***Mothering Project*** and ***Sheway***. Within these four programs, the culturally grounded approach is integrated with trauma-informed, harm reduction and client-centred approaches rather than being a stand-alone approach. Indigenous cultural approaches reinforce a positive sense of identity as a resource for healing past and present experiences of traumas.

Cultural programming varied at each program to reflect local and regional cultures. For example, ***Raising Hope*** highlights the sacredness of the women and babies through ceremony and traditional teaching. The cultural and spiritual approaches focus on building a safe space, a place where, in the words of staff, "women can be loved until they can love themselves". ***Raising Hope*** sees the spiritual approach as foundational to healing. At ***H.E.R.***, most of the Outreach Workers are Indigenous and share similar lived experiences as the women coming into the program. These workers engage women by accompanying them to cultural activities and events such as sewing, sweats or medicine picking. Given the small space at ***H.E.R.***, most of the cultural programming is in the community or on the land. The healing room at the ***Mothering Project*** is a sacred space where participants can smudge and take part in ceremony. It is also a safe space where counselling can happen or where staff can recharge and connect through ceremony. At ***Sheway***, staffs' understanding of the historic and immediate challenges facing Indigenous women, along with their respectful relationships and support, have been part of the program's foundation. As well, ***Sheway's*** integrated team approach provides supports to women without getting stuck or siloed in their roles. The staff member who has a relationship with the woman helps to connect her to services within ***Sheway*** and the wider community.

At five programs, Elders play a key role in cultural programming through traditional teachings, ceremony, crafts, and one to one support for participants as well as staff. The presence of Elders is most often available through the collaboration of partner organizations.

## Wraparound programming and reconciliation

Culturally grounded care embraces trauma-informed, strength-based, and spiritually grounded, thus respecting and restoring Indigenous ways of being. Wraparound programs, especially those with a cultural focus, offer positive examples in addressing the gap between the health of Indigenous Peoples and the broader Canadian population.

In this study, cultural safety in health and social services is being embraced by the program staff and their partners, through working together as well as cultural training opportunities. Circle discussions bring women and staff together into an atmosphere of relationship and equity. Cultural programming builds pride, self-esteem, and stronger Indigenous identity amongst women (Rowan et al., 2014). As well, traditional protocols to ceremony are merging with a harm reduction low barrier approach in which women are welcome even though they may be using substances.

There are many reports and commissions in Canada that recommend culture as a path forward in healing past and intergenerational traumas, including the Truth and Reconciliation Commission's (2015) Call to Action #5 that calls for *culturally appropriate parenting programs for Aboriginal families*, Call to Action #20, to *recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders*, and Call to Action #33, regarding prevention of FASD through *programs that can be delivered in a culturally appropriate manner.*

Connecting Indigenous women to culture is one way of addressing the legacies of the sixties scoop and the over-representation of Indigenous children in care. Reconnecting Indigenous families through cultural teachings is a path forward in rebuilding Indigenous families and communities (Christian, 2010).

## **Story of Wraparound Services** through an Indigenous Cultural Lens - Key takeaways

- Indigenous societies have long taught that the people, plants, animals, land, and spirit worlds are interconnected and that well-being is about being in balance.
- There are parallels between the wraparound approaches employed by the programs in the Co-Creating Evidence study and the holistic health philosophies found in Indigenous societies. As well, trauma-informed and harm reduction approaches intertwine with culturally safe practice.
- All programs in the CCE study have worked to forge connections and partnerships with Elders, knowledge keepers, and community-based, Indigenous-led programs and services so that they can incorporate culture as a part of women's healing and health. Cultural programming is both a healing and intervention resource.

# 5 Story of the Clients and their Program Experience

## What were clients' demographic, pregnancy, housing, and substance use status at intake?

Based on the study's client database, between April 2018 and September 2019:

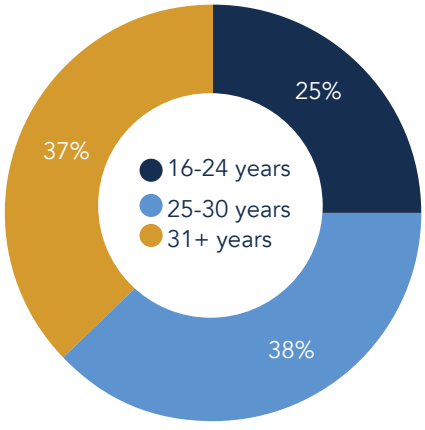
**1,004** clients participated, in total, in the eight programs.

On average, **649** clients participated in the eight programs per quarter.

**55%** of clients were Indigenous. Across the programs, the percentage of clients who were Indigenous ranged from **93%** to **1%**.

***Age at intake:*** Overall, the majority of the clients in the programs (**75%**) were age 25 or older (Baby Basics, the program for women under age 25, was the exception to this). Across the eight programs, clients' age at intake was as follows:

**Figure 10:** Clients' age at intake, across the eight programs




- **25%** were age 16-24
- **38%** were age 25-30
- **37%** were over age 31[4]

***Pregnancy, housing and substance use at intake:***

Based on findings from the client database:

- **85%** of clients were pregnant at intake; the range across programs was from 98% to 57%.
- **58%** of clients had unsafe or insecure housing at intake; the range across programs was from 78% to 29%.
- **64%** of clients had problematic substance use or were new to recovery at intake; however, there was a considerable range across programs, from 85% to 6%.

[4] These findings show that age and ethnicity breakdown of the clients interviewed for the study roughly paralleled the demographics of the programs' clients overall.

## What were clients' key issues at intake?

In the qualitative interviews conducted with clients (*n*=256), women were asked to describe their situation prior to becoming involved with their program. Paralleling the findings from the client database, the two most frequently emerging themes from the interviews with clients were:

- Unsafe and/or inadequate housing or homeless; and
- Struggling with substance use, yet (working toward) readiness for change

Additional top themes were:

- Limited social support/isolation;
- Physical, maternal and/or mental health concerns;
- Maternal-child separations and/or child welfare involvement; and
- Violence, trauma, intimate partner violence

*Substance use and addictions are complex issues, often intertwined with current and/or historic experiences of violence, trauma, poor housing, homelessness, intimate partner violence, racism, poverty, and child welfare involvement.*

For the majority of clients, a number of these issues were intertwined, most notably their having inadequate housing, substance use, mental health issues, violence and trauma, isolation, and maternal-child separations. At all programs, women disclosed that they had experienced some form of violence, abuse and/or trauma, either historically or recently.

> *I was pregnant. I quit using during the summer, but I was struggling with abuse, depression, anxiety and co-dependency.*
>
> *I was fleeing an abusive relationship. My mental health was poor. I was addicted and not taking care of myself.*
>
> *I was living in [supportive housing]; I was pregnant and then gave birth. I was depressed and wanted to address my drug and alcohol use. My son was apprehended at birth.*

Across the programs, women also expressed a strong desire to make changes in their life in order to improve their health, safety, birth outcome and/or connection with their child(ren). Moreover, women came to their program with many strengths and resiliencies, inner resources that they employed in their journeys to wellness and parenting.

## What were clients' experiences participating in their program?

The overwhelming majority of clients who completed the Client Questionnaire reported feeling physically and emotionally safe, that they trusted staff, and that their needs had been met by their program (see **Figure 11**). These are all dimensions of trauma-informed practice (Fallot & Harris, 2009), an approach viewed as being foundational at all programs in the study.

**Figure 11:** Clients' experience of their program, based on Client Questionnaire findings

| | |
|---|---|
| Safety | **96%** feel physically safe at their program.<br>**91%** feel emotionally safe at their program.<br>**91%** feel safe talking with staff about substance use, violence or trauma. |
| Respectful, Strengths-based | **96%** believe staff recognize they have strengths as well as challenges.<br>**94%** believe staff are sensitive when asking about difficult experiences.<br>**94%** believe that the team really listens to what they have to say. |
| Trustworthy | **96%** trust the people who work at their program.<br>**90%** trust that staff will do what they say they'll do. |
| Cultural safety | **92%** believe they have opportunities to tell about their beliefs and traditions. |
| Choice & Client-directed | **92%** believe that their program offers lots of choice about services.<br>**91%** feel like they are a partner in deciding what services to receive and that staff listen to what they want to accomplish. |
| Needs Met | **93%** believe that their needs are met at their program. |

Fleshing out these questionnaire findings, in speaking about what they liked and valued about their program, clients provided insight into what gave rise to their sense of safety, feeling respected, and staff's trustworthiness. A few of their comments, grouped into themes, follows.

## What creates safety, trustworthiness and sense of respect:

- Non-judgemental people - staff and program participants

  *The staff. They're compassionate, non-judgemental and they're true advocates. Here you are human. I can be honest. I can expose myself.*

  *The moms who are recovering from something and are there for their sobriety. There is a shared knowledge and experience of what it is like to give up substances, how hard it can be.*

  *It's really good to have groups and places to go to get food, diapers, produce, baby clothes, without judgement.*

- Feeling cared for and cared about

  *I feel safe here. They are so inclusive and non-judgemental. The staff are very caring. It feels personal here, not at all clinical.*

  *Knowing that there are people who care about you, that there's a community. That helps me to make positive choices. It makes me want to do better.*

- Comfortable, welcoming environment and family-like community

  *This is a safe, supportive environment. I don't feel isolated and alone when I'm here.*

  *It feels very comfortable and family-ish. You can sit down and have lunch and talk with staff. If you're having a crisis, you can go in and talk. I'm never dreading coming here. That's different than how I feel about other programs and places.*

  *They are all like family to me. [Program worker] is like a grandma to my baby. Staff are like aunties. There's heart behind the program.*

- Staff go 'above and beyond' their job

  *The people. The fact that they're not judgemental and they're understanding. They go beyond their job. They really do care. I have no supports outside of [the program].*

## **Story of the Clients and their Program Experience** - Key takeaways

- Based on the client database, between April 2018 and September 2019, 1004 clients participated in the eight programs; the majority (55%) were Indigenous, though that varied markedly across programs (from 1% to 93%).
- At the time of intake to their program, the majority of women were contending with multiple, interconnected issues including problematic substance use, violence and trauma, unsafe or inadequate housing, health concerns and/or maternal-child separations.
- Overwhelmingly, clients reported positive experiences at their program. In particular, they felt physically and emotionally safe, they trusted staff, they had lots of choice about the services they received, they felt as though staff cared about them, and they believed that their needs had been met by their program.
- Clients also valued their program's non-judgemental, welcoming environment and family-like community.

# 6 Key Findings: Outcomes and Evidence

This section presents key findings related to the outcomes of the programs for women and their children, from clients', staff's and program partners' perspectives. Evidence of outcomes was derived from both qualitative data (interviews with clients, staff and service partners) and quantitative data (client questionnaires, along with client intake and 'snap-shot' data over time from the client database).

## What did clients hope to get from participating in their program?

Clients were asked what they had hoped to gain from participating in their program. The themes were often interconnected, as women generally provided several reasons for program involvement. Their comments also helped to illustrate the close relationship between women's situation at intake and the outcomes of the programs.

For example, the most frequently emerging theme—voiced by nearly half of the clients interviewed—was that women sought help in addressing their substance use. However, for many women, this was intertwined with wanting help to deal with effects of trauma as a result of experiences of violence or abuse.

Hand in hand with women's desire for support in relation to substance use was their interest in getting help in relation to keeping or regaining their child(ren) in their care and/or in having a strong mother–child connection. In addition, women voiced their desire for assistance with accessing safe and stable housing, as they recognized the inextricable connection between housing and child welfare authorities' safety concerns.

The top themes in response to the question 'What did you hope to get from participating in the program' (in order of frequency) were that women wanted help or support with:

- Problematic substance use and/or trauma
- Child welfare issues
- Pregnancy (e.g., information, support and/or connections to prenatal care)
- Housing
- Health care (e.g., getting connected to providers)
- Making healthy peer connections

A sample of clients' comments illustrating these themes is presented in **Textbox 2**.

**Textbox 2:** Top themes and sample of clients' comments for question: "What did you hope to get from participating in your program?"

| Theme | In clients' words: |
|---|---|
| Wanted help with substance use and/or trauma | *I wanted to get sober. I wanted my children back, my family back. …. I was using drugs and alcohol. I was going through a rough time–breaking up with my partner who was abusive mentally and emotionally.* |
| Wanted help with child welfare or mother-child connection | *I wanted to get support and bring my child home and parent in a healthy lifestyle for her and for me.*<br>*I wanted sobriety and to learn to parent my kids; I had lost custody.* |
| Wanted support and information about pregnancy | *Initially, I didn't know where or how I'd go with the pregnancy. I needed guidance and support.* |
| Wanted help with housing | *I was in a really shitty situation. I was living with a friend. She was using drugs. I ended up in a shelter. I needed resources to help me with my pregnancy and with raising my baby. And I wanted help getting into different housing.* |
| Wanted help in getting connected to health care or prenatal care | *My family doctor set me up with a maternity doctor who specialized in working with women with addictions. She suggested that I network with someone. I was afraid that the nurses at the hospital would see my medical history, see that I was on suboxone, and be judgmental and call child welfare.* |
| Wanted healthy peer connections | *I wanted connections with other mothers and wanted to know that there were groups I could do that would help me with being a mother with trauma and addiction.* |

## What outcomes are being achieved? What difference did the program make, from clients' perspectives?

### 'Most significant change(s)' that women experienced: Clients' perspectives

As a key component of the qualitative interview, clients were asked what had been the most significant change(s) that had taken place for them and their family since they started participating in their program. As was the case with other open-ended interview questions, women's responses often contained multiple themes, and the themes were intertwined.

## Three key takeaways:

1. The most frequently emerging theme of 'Most Significant Change' was that women had quit or reduced their substance use, and many clients attributed their program with helping them to quit using substances.

2. The second top theme, voiced by nearly as many clients, was that women had a stronger connection with their child(ren). This theme focused on the preservation of the mother–child relationship.

3. The third top theme was that women had kept and/or regained their children in their care. As reflected in clients' comments, this nearly always occurred in tandem with other pivotal life changes, such as reducing or ending their substance use, accessing stable housing, and breaking away from a high-risk living situation.

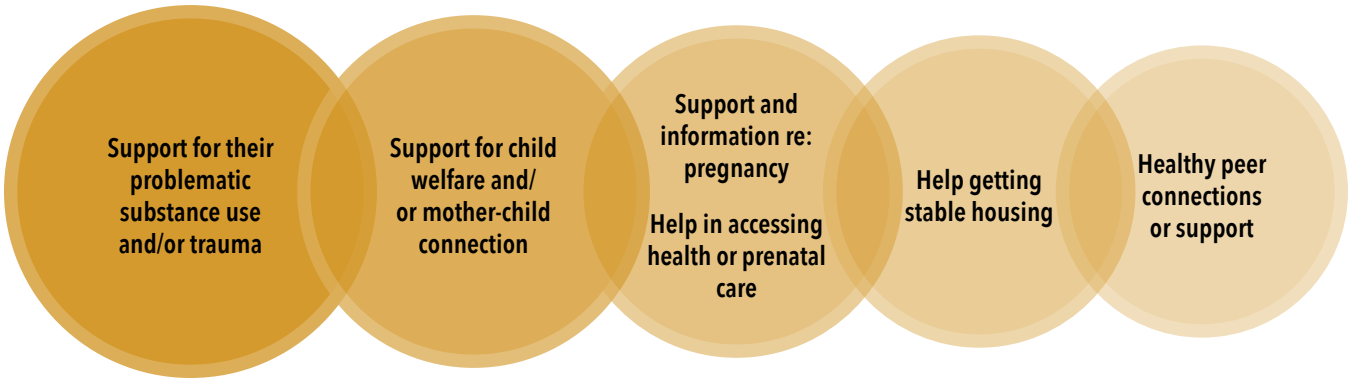
Additional themes related to clients' 'Most Significant Change' were (in order of frequency):

- Increased support
- Safer, improved housing
- Reduced isolation; increased connection to peers, culture
- Improved wellness, mental health and/or health

As shown in **Figure 12**, there was a clear connection between what women hoped to get from participation in their program and the most significant change(s) for themselves and their child(ren) since becoming involved.

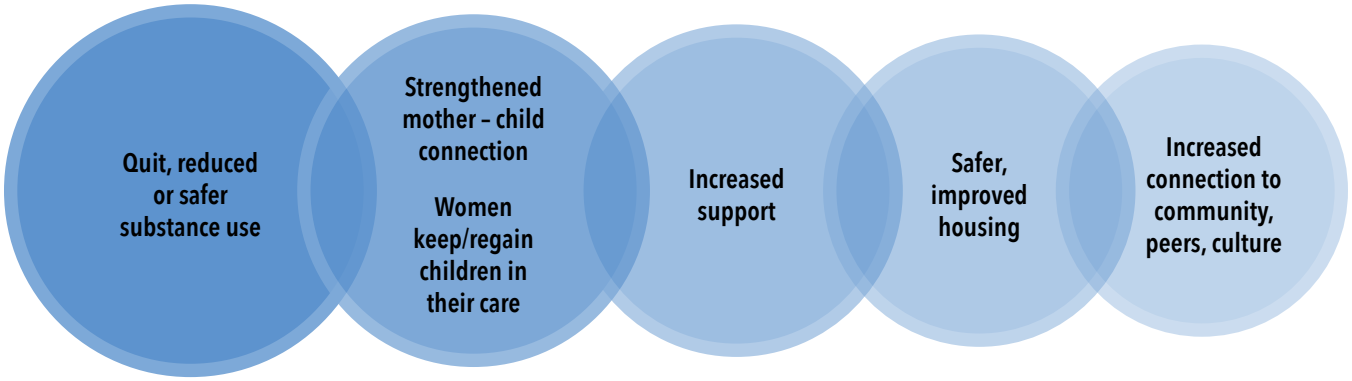
**Figure 12:** Top themes of 'What women hoped to get from participating in their program' and clients' 'Most Significant Change' since participating in their program

What women hoped to get from participating in their program – Top themes




*[I wanted] better housing, support to keep me away from drugs and alcohol, and help with nutrition. [I wanted] to keep my baby.*

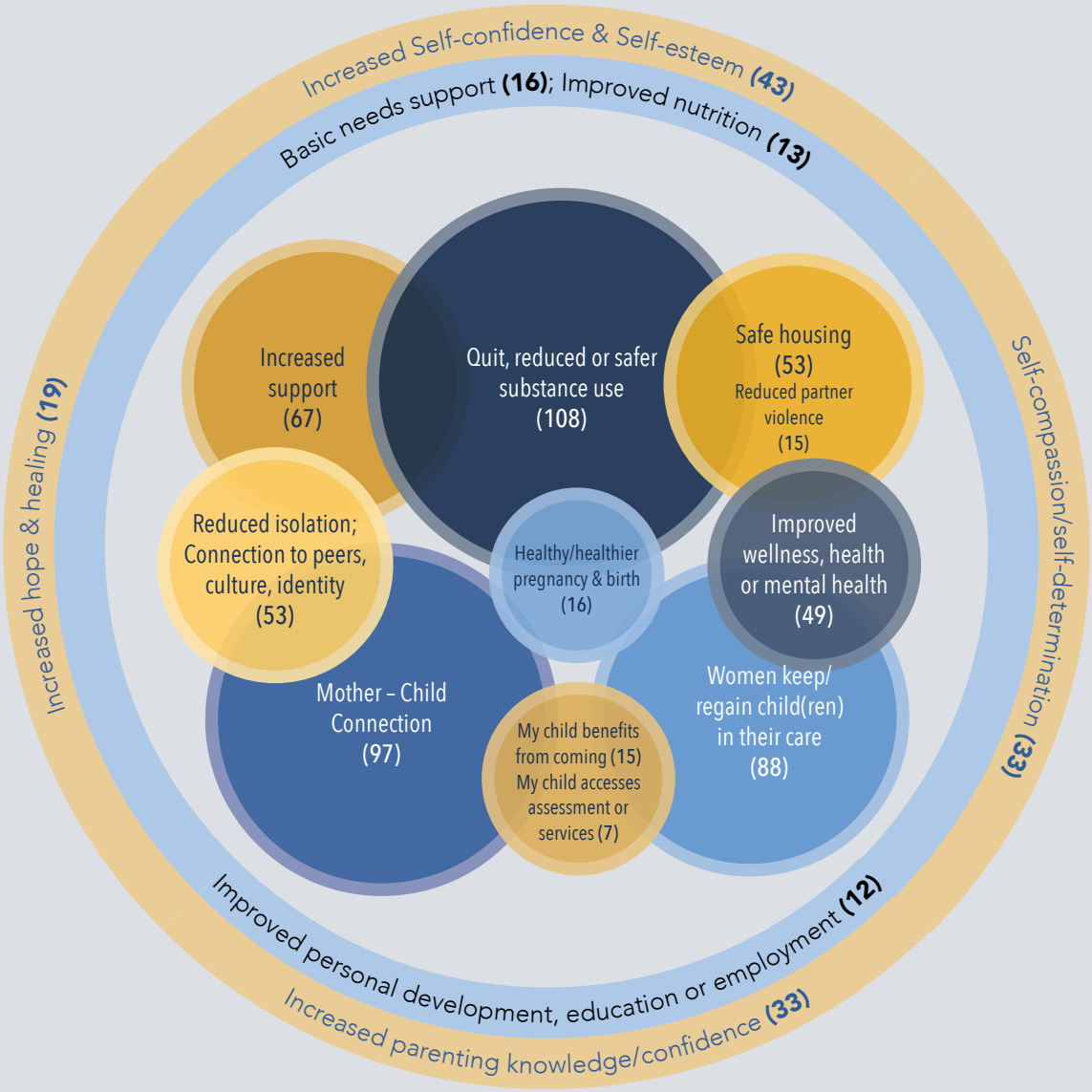
Women's 'Most Significant Change' since participating in their program – Top themes




*If I hadn't been at this program, it would have been hard to stay sober, and my baby would have gone to live with my mom.*

In addition to the top themes of clients' 'most significant change', several other important themes emerged; these aligned closely with the anticipated outcomes in the project's Theory of Change. **Figure 13** presents a visual representation of the full 'most significant change' findings, with, overall, themes that were voiced more frequently being depicted by larger 'bubbles' (numbers represent the number of women who voiced the theme).

**Figure 13:** Graphic depiction of themes emerging from question: 'What has been the most significant change for you and your family since becoming involved with your program?'




## Client Questionnaire findings related to program outcomes and helpfulness

Evidence from the Client Questionnaire reinforced the findings from interviews with clients.

**Key takeaways**, as shown in **Table 4,** include:

- A high percentage of clients agreed/strongly agreed that key outcomes and/or positive life changes had taken place since they became involved with their program, and moreover, that their program was helpful in supporting them in achieving the outcome.
- Notably, for each outcome, a very high percentage of clients reported that their program was helpful to them, even if the specific outcome had not been achieved.

Table 5 similarly presents key Client Questionnaire findings related to skill development, self-confidence, hope, social support and connection to community. Additional findings from the Client Questionnaire are provided in **Appendix C.**

**Table 4:** Key Client Questionnaire findings re: outcomes for clients and their families[5]

| "Since becoming involved with this program… | % who 'agreed' or 'strongly agreed' | % who said program was 'helpful' or 'very helpful' re: outcome[6] |
|---|---|---|
| **SUBSTANCE USE:** | | |
| I have quit, reduced or safer substance use | 81% | 95% |
| I have accessed substance use services or supports | 78% | 93% |
| **MOTHER-CHILD CONNECTION:** | | |
| I have improved connection to my child(ren) | 73% | 91% |
| My child(ren) are now living with me or my family | 72% | 90% |
| **INCREASED SUPPORT:** | | |
| I feel supported and less isolated; I have social support | 93% | 96% |
| **HEALTH, WELLNESS, ACCESS TO HEALTH SERVICES:** | | |
| I have improved access to health services | 88% | 96% |
| I have made progress relative to my health goals | 89% | 91% |
| I've accessed support related to trauma or violence | 67% | 87% |
| **HOUSING:** | | |
| I have improved housing | 78% | 82% |
| **PRE- & POSTNATAL CARE; HEALTHY BIRTH:** | | |
| I accessed prenatal and post-natal care | 86% | 97% |
| My pregnancy was healthy; baby was healthy at birth | 79% | 93% |
| **CHILD HEALTH; PARENTING INFO & CONFIDENCE:** | | |
| My child has developmental assessments via PHN | 82% | 96% |
| I have more info on child development and parenting | 90% | 94% |
| My child has opportunities for positive socialization | 82% | 91% |
| **FOOD, NUTRITION:** | | |
| I know where to get affordable, good food | 91% | 92% |
| My family and I have improved nutrition | 81% | 86% |
| **CULTURAL (RE)CONNECTION:** | | |
| I'm involved in cultural activities, if desired | 59% | 71% |

[5] The *n* was 224. Missing data varied from item to item but, for all questionnaire items, was less than 4%.

[6] In this column, the N/A responses were removed from the denominator in the calculations of percentages.

| **Table 5:** Client Questionnaire findings re: skill development, support & connection to community[7] | |
|---|---|
| "Since becoming involved with this program… | % who 'agreed' or 'strongly agreed' |
| **Skill development, self-confidence and hope** | |
| I feel more hopeful. | **94%** |
| I have developed skills to use in parenting and/or in my personal life. | **93%** |
| I have increased my confidence in my own capabilities. | **91%** |
| I have improved self-esteem. | **84%** |
| **Social support and connection to community resources** | |
| I have met people I trust and whom I would turn to if I were having problems. | **96%** |
| I have met people I can count on in an emergency. | **86%** |
| I am more connected to community resources. | **84%** |
| I have improved practical and/or material supports, including transportation. | **84%** |

## What are infant birth outcomes?

Based on analyses of the client data from April 2018 to September 2019 involving clients whose infant's birth outcome was known (*n*=408), the majority of women had healthy birth outcomes. Specifically, across the eight programs involved in the study:

- **73%** of infants had a healthy birthweight, and
- **76%** of infants had healthy gestation.

In addition, approximately half of clients' infants (51%) did not require the Neonatal Intensive Care Unit (NICU). In terms of prenatal substance exposure:

- **33%** of infants were not substance-exposed
- **51%** of infants were substance-exposed, and
- **17%** of infants' prenatal substance exposure was unknown.

These infant birth outcomes are congruent with findings reported in previous evaluation studies of wraparound programs for pregnant women with substance use and complex concerns, specifically Breaking the Cycle (Pepler et al., 2002) and Sheway (Poole, 2000).

[7] For these questionnaire items, clients were not asked about the perceived helpfulness of their program.

## How did clients' housing, substance use and child welfare status change over time?

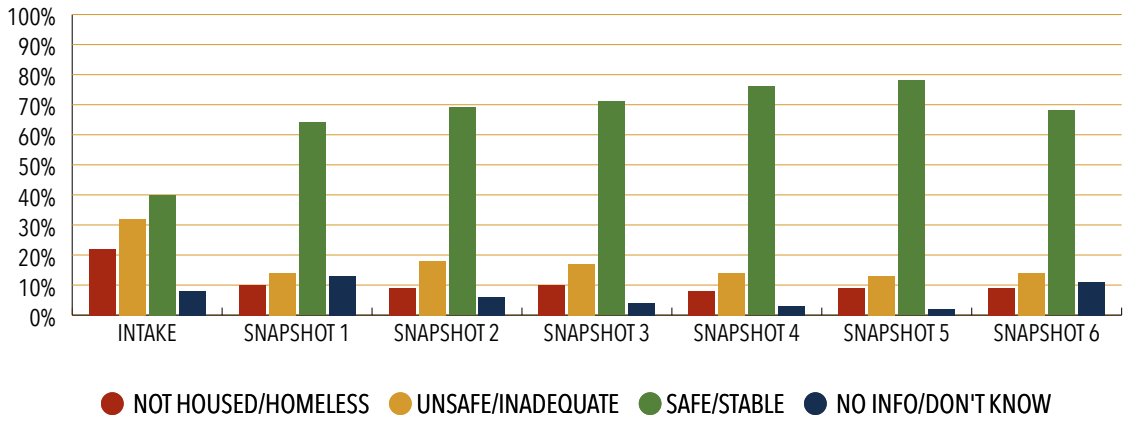
### First, a few caveats about the analyses…

- The findings presented at the beginning of this section are based on clients for whom there were at least ***four*** data points (intake plus at least three subsequent 'snapshots').
- There weren't sufficient data at two of the programs (H.E.R. and Raising Hope) to perform these analyses; consequently, these programs were excluded from the analyses where indicated. Because H.E.R. and Raising Hope are both smaller and shorter-term programs, it is likely that there were few clients for whom there were 3+ quarters of 'snapshot' data.
- As a means to include all programs in the analyses, the data were analyzed again. This time, clients for whom there were intake and at least ***one*** additional snapshot of data were included. These findings thus include clients who may have had more intermittent involvement with their program – that is, they may have not participated for a number of months and then they reengaged.

### Changes in clients' housing situation over time

Overall, based on analyses of data from six programs[8] involving clients for whom there were at least four 'snapshots' of client data, there were substantial improvements in clients' housing status over time, most notably between intake and the first snapshot (**Figure 14**). As shown in **Appendix C,** improvements in clients' housing were more striking at certain programs (e.g., HerWay Home, Sheway and Maxx Wright); nevertheless, positive changes in housing occurred at all six programs.

**Figure 14:** Clients' housing over time,
based on clients with 4 data points (6 programs combined, *n*=321)



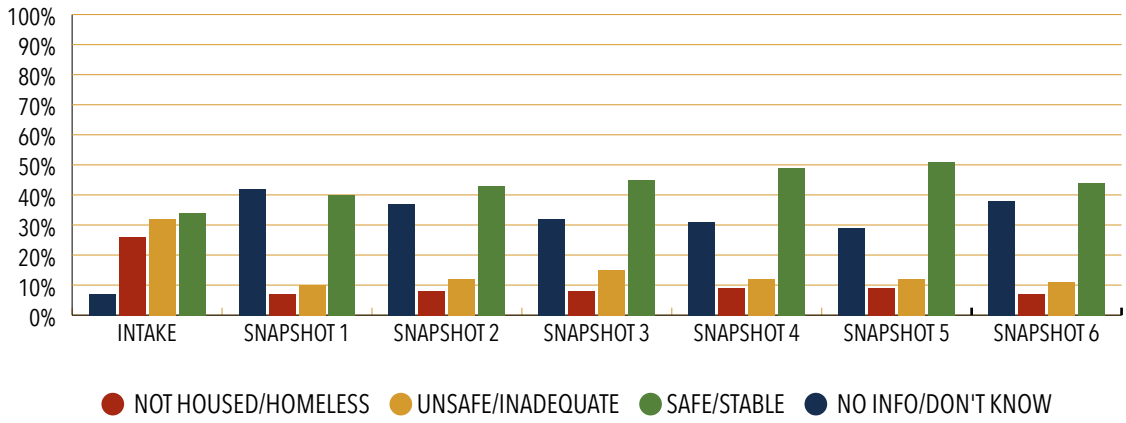

[8] These findings are based on the six programs for which there were a sufficient number of clients for whom there were at least four client data snapshots; H.E.R. and Raising Hope could not be included in these analyses based on 4+ points of data.

Re-analysis of the housing snapshot data - to include clients for whom there were at least two data points rather than four or more data points - revealed a similar pattern as that presented in **Figure 14**: after becoming involved with their program, more clients were in safe/stable housing and fewer were in unsafe/inadequate housing or were unhoused; moreover, these results continued over time. **Figure 15** shows clients' housing over time, based on clients at all eight programs for whom there were two or more points of data.

There were two important differences between the findings involving clients with at least four data points (*n*=321) and the findings involving clients with at least two data points (*n*=749):

- For most programs and across all three variables (housing, substance use and infant's child welfare status) for which these 'snapshots-over-time' analyses were undertaken, the positive findings were substantially stronger in the analyses involving clients with four or more points of data; and
- In the analyses involving clients with only two or more data points, there was a higher percentage of clients whose housing (or substance use or child welfare) status was unknown.

**Figure 15:** Clients' housing over time,
based on clients with 2 data points (8 programs combined, *n*=749)




## Changes in clients' substance use over time

Similar to the findings for housing, client intake and snapshot data showed that there were notable changes in substance use – specifically, fewer clients had problematic substance use and more clients were in recovery/abstaining – over time (especially at HerWay Home, Sheway, Breaking the Cycle and Maxx Wright). As with housing, changes in clients' substance use status were most pronounced in the time period between intake and the first snapshot.

**Figure 16** presents these findings for clients at the six programs for whom there were four or more points of data, and **Figure 17** presents findings for clients at all eight programs for whom there were at least two points of data. As with housing, the pattern of results was similar, although in the analysis involving clients with four or more points of data:

- More clients (i.e., a higher percentage) had reduced or quit their substance use relative to the group of clients involved in the analysis with only two or more data points, and
- Information regarding clients' substance use was much more likely to be known to staff.

Additional program-specific findings are provided in **Appendix C**.

**Figure 16:** Clients' substance use over time, based on clients with 4 data points (6 programs combined, *n*=321)

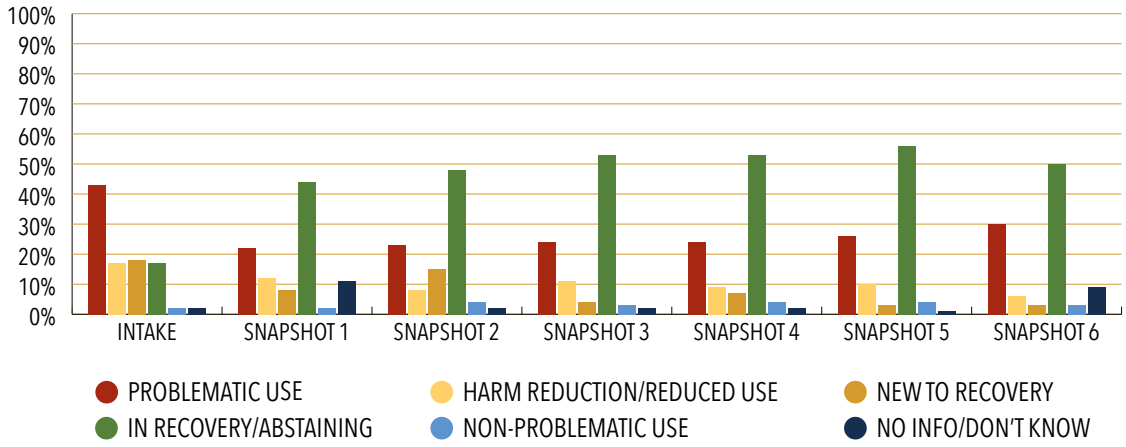
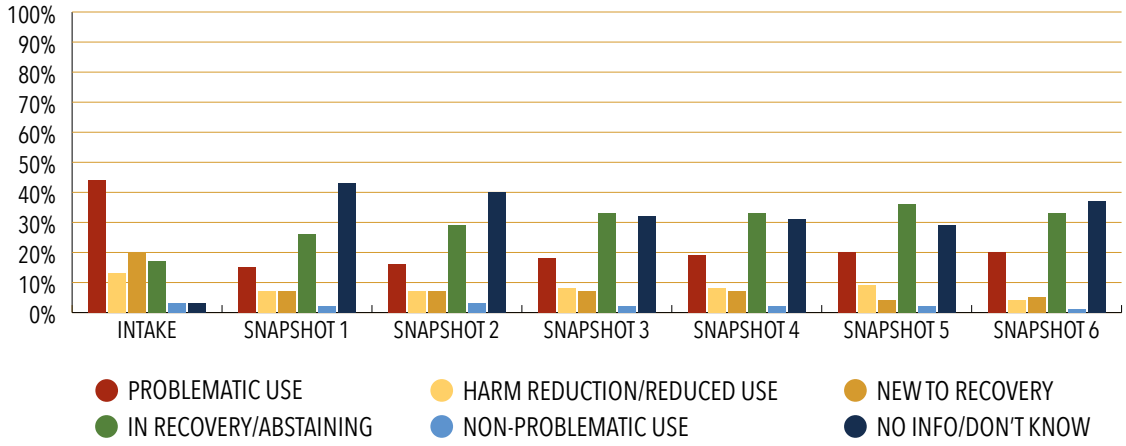



**Figure 17:** Clients' substance use over time, based on clients with 2 data points (8 programs combined, *n*=749)



## Changes in clients' child welfare situation over time

Client intake and snapshot data showed that between intake and subsequent snapshots, there was a substantial increase in the number of infants who were in their mother's care (see **Figure 18 and Figure 19**; program-specific findings are provided in **Appendix C**).

As with the preceding analyses, the pattern of findings was stronger amongst clients with four or more data points (**Figure 18**): a higher percentage of these infants were in their mother's care and staff knew of their care status relative to the group of clients with two or more data snapshots (**Figure 19**).

**Figure 18:** Child welfare status for focal infant over time, based on clients with 4 data points (6 programs combined, *n*=321)

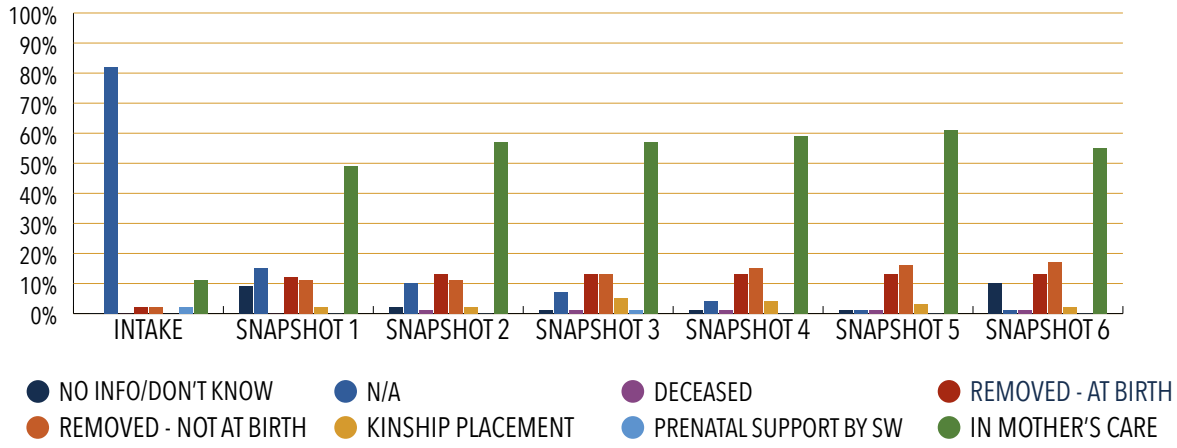
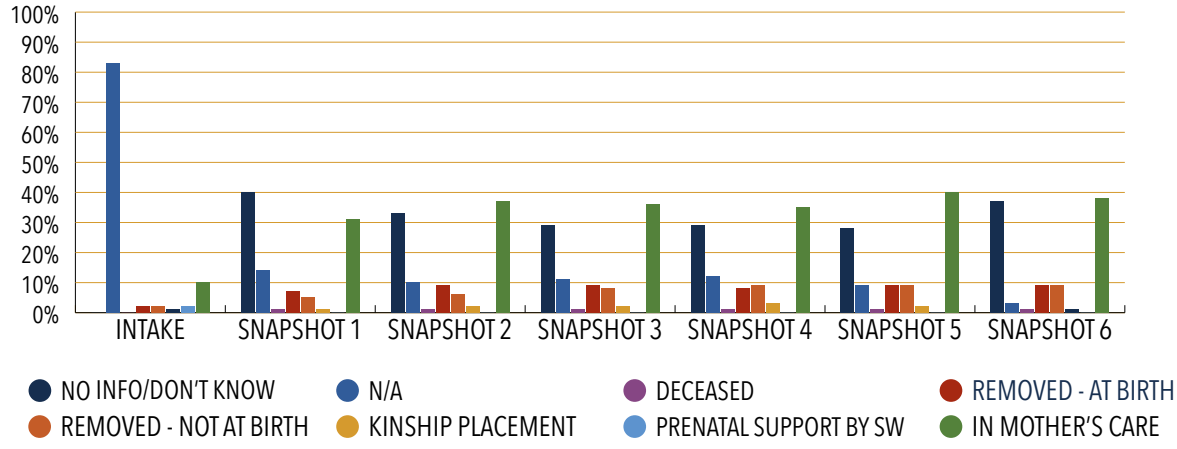



**Figure 19:** Child welfare status for focal infant over time based on clients with 2 data points (8 programs combined, *n*=749)



## What difference did programs make for clients, from staff's and partners' perspectives?

During the interviews and focus groups, program staff and service partners at all programs were asked what difference they believed the program made for women and their families.

As shown in **Textbox 3**, the top themes of outcomes voiced by staff were highly similar to those identified by service partners and were also congruent with the 'most significant change' themes identified by clients. In particular, clients, staff and partners all viewed child welfare-related outcomes as key impacts of the program.

**Textbox 3:** Top themes of outcomes for clients from staff's and partners' perspectives (with themes listed in order of frequency)

| Staff's perspectives (*n*=108) | Service partners' perspectives (*n*=60) |
|---|---|
| Women keep/regain their child(ren) in their care | Women keep/regain their child(ren) in their care |
| Mother-child connection | Mother-child connection |
| Women have improved access to health care and/or community services | Women feel supported; have increased support |
| Women have healthy/healthier pregnancies and births | Women have improved access to health care and/or community services |
| Women develop trusting relationships | Women increase their self-confidence & self-esteem |
| Women have improved personal development, education & employment | Women quit, reduce or have safer substance use |
| Women quit, reduce or have safer substance use | Women have healthy/healthier pregnancies and births |
| Women have improved housing | Women have increased parenting knowledge and/or confidence |
| Women feel supported; have increased support | Children access developmental assessment & services |
| Women have increased parenting knowledge and/or confidence | Women have improved housing |

At the same time, as can be seen by comparing **Textbox 3** and **Figure 13 (page 32)**, there were a few important themes that were voiced by program staff and service partners that were not identified by clients as their 'most significant change', and certain outcomes were voiced more strongly or frequently by clients than by staff or partners.

### Slightly different perspectives

- While staff and service partners focused on child welfare outcomes and women's access/connection to services and care, for clients, the strongest theme of 'most significant change' was 'quitting, reduced or safer substance use'.
- Staff and service partners identified 'women have improved access to health care and/or community services' as a top outcome, and staff identified 'women develop trusting relationships' as a key outcome, one that was often a lynchpin to achievement of other positive changes in women's lives. Clients did not identify these as top themes, though they did identify a parallel theme, having 'increased support'.
- Staff and service partners identified healthy/healthier births as a top outcome more frequently than clients. This may reflect clients' assumption that they would have a healthy birth, and thus it did not come to mind as a 'most significant change'.

## What program components are (most) helpful from clients' perspectives?

In the interviews, clients were asked two questions that related to this important research question. These questions were:

- Who – or what – was involved in making the (most significant) change happen?
- What is most important to you about your program?

**Figures 20** and **Figure 21** present the top themes that emerged for these questions.

**Figure 20:** Graphic depiction of top themes emerging from the question: *'Who or what was involved in making the most significant change happen for you?' – Clients' perspectives*

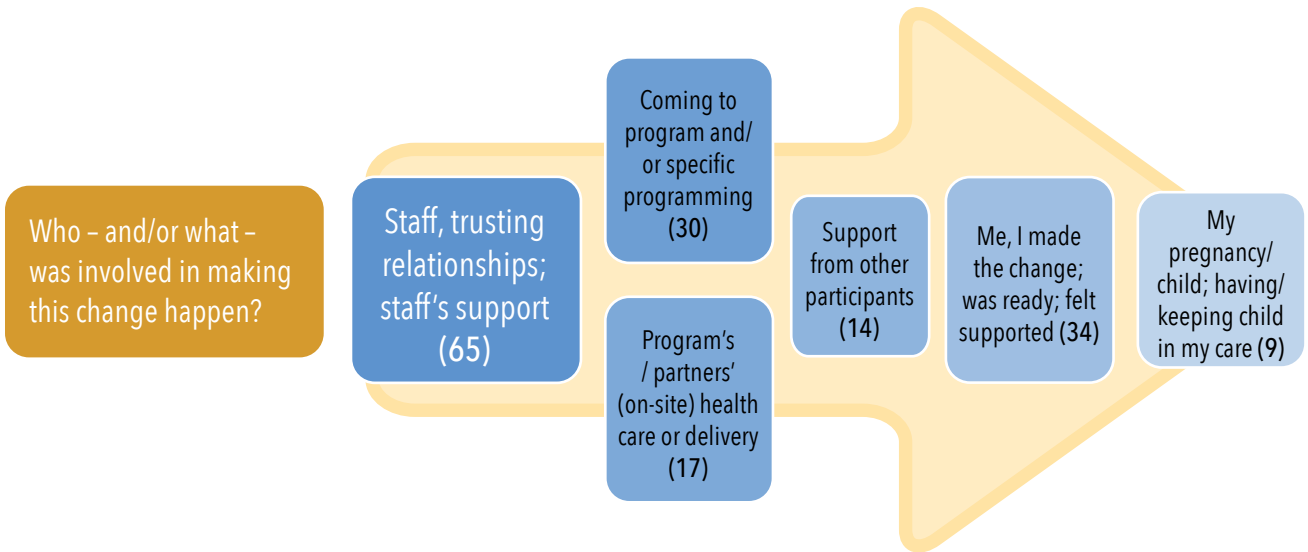
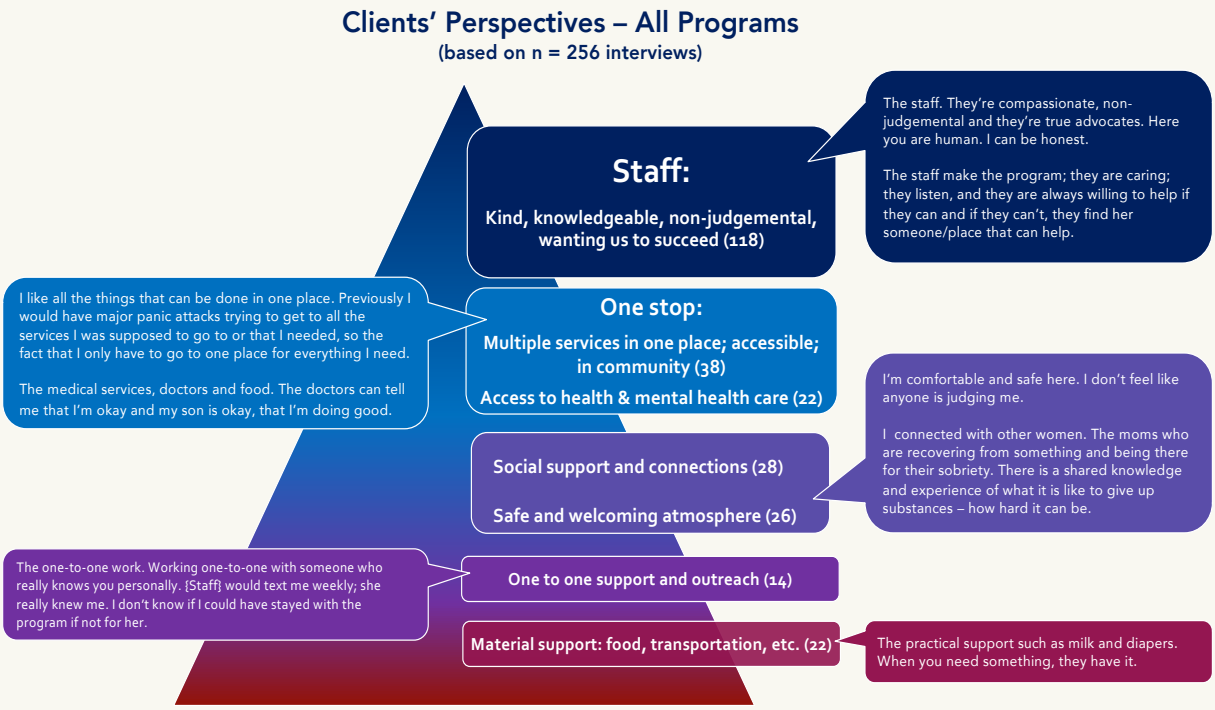


**Figure 21:** Graphic depiction of top themes emerging from the question: *'What is most important to you about your program?' – Clients' perspectives*




As can be seen, the strongest themes for the two questions were similar. First and foremost, programs' staff – and, specifically, the approaches staff employed, including being non-judgemental and caring, and fostering safety and trusting relationships – was identified as both the most important facet of the program and the driver of significant changes in women's lives. Hand in hand with this, the second most frequent theme for both questions was that the program was community-based, accessible, and had multiple services and supports in one place, including on-site health and mental health care and other programming that addressed women's needs. Another key theme of both 'what was involved in making the change happen' and 'what was most important about their program' was the connection with, and support from, other participants. Notably, many clients also stated that their own readiness and/or their experience of having support was what had enabled their life change(s) to happen.

## What are outcomes/impacts of the programs for partners and partner organizations?

In the interviews, staff and partners at all programs were asked about the benefits of working together and what difference they believed the program had made for service partners and the partners' organizations. Staff's and partners' perspectives were highly congruent, and both participant groups focused on partners' gains in knowledge and increased intersectoral collaboration as a result of their involvement and relationship with the program. The combined themes included:

- Shared goals and vision across disciplines
- Increased collaboration re: service planning and coordination across sectors – e.g., health providers, child welfare
- Increased knowledge/ shared learning about:
  - Each other's roles or programs
  - Systemic issues, barriers and advocacy opportunities
  - Women's substance use and social determinants of health
  - Best practice approaches in working with women who use substances
- Increased sense of support; improved peace of mind and broadened reach of partner services
- Reduced barriers to service

*One of the great things is that I feel like our goals are the same: to support these women in the best way we can and get them connected to resources, to avoid having their babies removed. We have the same vision for that, even though we come from different places.*

*The partnership means better case management to jointly identify gaps. They see it through housing lens, and we see it through a health lens, and put together, we can identify more quickly when a woman is struggling or if there is a risk for the children. We can be the expert in health, and they can do the social side. It is more efficient.*

A sample of staff's and partners' comments illustrating these themes follows.

*[The program] is a resource that we can access for the women who can be difficult to find or to support. To know that these women can be supported out there – even if they aren't interested in meeting with me as a hospital social worker – that supports me.* – Program staff

*Our workers are less blaming; they are recognizing that what we are seeing is a result of trauma rather than intentional non-compliance.* – Service partner

*It has helped me to understand more about some of the nuances in terms of child welfare, child protection, and how to work with [child welfare authorities] at a systemic level.* – Program staff

*I think that we are making a more conscious effort to collaborate. We are increasingly recognizing that more heads are better around the table, and that having everyone there is a benefit to women and their families.* – Service partner

## **Key Findings:** Outcomes and Evidence – Key takeaways

- Clients' top reasons for participating in their program were to get help with substance use, child welfare, health care and/or housing.
- Paralleling this, from clients' perspective, the most significant changes since becoming involved with their program were quitting or reducing their substance use, having a strong connection with their children and/or keeping their baby in their care.
- Based on client 'snapshot' data, notable improvements in terms of clients' substance use and housing occurred over time; as well, a large percentage of clients kept their infants in their care. Moreover, these findings were stronger amongst clients who were engaged with their program for a longer duration and/or more regularly, such that their situation could be tracked for more points in time.
- Programs' staff – and the approaches staff employed, including being non-judgemental and fostering safety and trusting relationships – was identified as both the most important facet of the program and the driver of significant changes in women's lives.
- The programs had important outcomes for service partners, resulting in gains in knowledge and collaboration for care providers working in a variety of service areas and sectors.

# 7 Discussion

The findings from the Co-Creating Evidence study demonstrated that the participating programs benefitted women and their families in significant ways. Clients reduced or quit their problematic substance use, improved their physical and mental health and access to health services, kept custody of their infant and/or had a stronger connection with their children, improved their housing, and had healthier pregnancies and birth outcomes. That clients identified reduced substance use or recovery as their most significant change is all the more noteworthy given that these are not programs with substance use treatment as the entry point or focal service.

## The study demonstrated that pregnant and early parenting women experiencing problematic substance use and other complex issues benefit from programs that included the following:

1. **Wraparound services** that acknowledge the wide range of clients' needs and the importance of the social determinants of health by incorporating medical and health services along with child welfare and other crucial social services under one roof and/or by facilitating access to the same in community. In view of the study's findings and echoing existing research, a wraparound approach can be viewed as best practice (Greaves et al., 2015; Nathoo et al., 2013). At the same time, the study also identified challenges, most notably with respect to working across sectors with differing mandates and legislative authorities. The success of the eight programs in developing and augmenting, whenever possible, their wraparound services is testament to their efforts to forge and sustain their partnerships and relationships.

2. **Knowledgeable and empathetic program staff** who exuded deep understanding about clients' circumstances and who 'walked the talk' in terms of putting the programs' theoretical approaches into practice. Staffs' kindness, compassion, depth and breadth of knowledge, skills, and focus on fostering safety and trusting relationships were highly valued. Women learned from their interactions with staff and each other and from being given a voice regarding the kind of programming they wanted. Clients consistently viewed staff as the most important reason for their continued engagement as well as what they liked most about their program. These findings amplify the literature demonstrating the importance of a relational, client/women-centred approach (Motz et al., 2020).

3. **Indigenous cultural (re)connection**, either as a standalone component or within the context of program activities. The inclusion of cultural practices and programming and Indigenous staff or resources such as Elders helped to acknowledge the value and importance of culture as a healing intervention. Indeed, the wraparound, relationship-based, trauma-informed and harm reduction approaches employed by the programs are aligned with the health philosophies of Indigenous societies and considered wise practice when working with Indigenous clients (Christian, 2010; Dell & Acoose, 2015; McCormick, 2000).

4. **Opportunities for community/peer support**, so that women could connect with each other in a welcoming and non-judgmental atmosphere and build healthy social support networks for themselves and their children. Women appreciated the opportunity to connect with peers who understood them and whose own lives mirrored their journeys. As a result, many felt less isolated and more connected to their communities. This too is another area in which the study has made a unique contribution, particularly insofar as emphasizing the importance of peer relationships in a safe and healthy environment. Research regarding what types of peer opportunities have the most impact would be useful to help programs identify more fully how positive peer connections can be best created and sustained.

The findings of the Co-Creating Evidence project also demonstrated that the following elements are important characteristics that contributed to the programs' success:

5. **Well conceptualized, evidence-based approaches**, beginning with a theoretical foundation, for all eight programs, that included being relationship-based, women- or client-centred, trauma-informed, harm reducing, and culturally-informed. All of these approaches are considered part of best practices (BC Centre of Excellence for Women's Health, n.d; Motz et al., 2006; Nathoo et al., 2013; Pepler et al., 2014). A key to success was that staffs' ways of working reflected their program's core values. At the same time, it is important to recognize that putting these approaches into day to day practice can be challenging and requires ongoing reflection, especially given the complexity and diversity of women's situations. For example, working from a harm reduction perspective while also respecting that some clients did not want to engage in services with women who were actively using substances had the potential to impact service delivery, client engagement and retention. Similarly, the intersection of harm reduction, substance use and safety concerns could be difficult to navigate, particularly for women who were actively parenting. Nevertheless, clients reported overwhelmingly that their program offered a safe and compassionate environment, and because of this, they developed trusting relationships with staff that led them to share their experiences, ask questions, decide on their goals, get help in multiple domains, and ultimately make significant changes in their lives. These reflect nuances of practice that could benefit from further research and discussion.

6. **Strong partnership relationships** that enabled multiple services to coalesce around a common purpose and mutual clients. Without these partner relationships and cross-sectoral collaborations, the wraparound approach would have been far more difficult to achieve. Indeed, the programs' capacity to effectively pull together various components of social/child welfare services, health services and substance use services in order to

meet clients' needs was a significant achievement. The partner relationships were also mutually beneficial, in that that all parties improved their understanding of each other's roles and responsibilities. Documenting the programs' partnerships and their outcomes was a unique contribution of the study, as previous studies have largely been from the perspective of treatment programs or addressed the need for addictions services and child welfare to work together to support women (Drabble & Poole, 2011; Urbanoski et al., 2018).

7 **Flexible, multi-dimensional models** that allowed for unique elements in terms of programmatic focus to match community needs, including a focus on outreach, housing, culture and/or dual focus and service streams for the woman and her infant/children. The flexible model reflected factors relevant to each program's history and community including availability of resources and partners while also allowing for shifts in programs' services over time, as needs and opportunities arose. To the authors' knowledge, this is the first time that such multi-dimensional, flexible models have been conceived for programs working with this clientele. Moreover, the dimensions of the models may be useful for research, program development and evaluation, with modifications as needed, for other integrated programs working with specialized populations such as youth with complex needs.

8 **Keeping clients engaged over time**, which was associated with positive trends in three key client outcome areas: reduced substance use, improved housing, and women keeping their infant in their care. These findings support existing literature (Andrews et al., 2018) that found that clients experience better outcomes when they are engaged with their program for a longer period and/or more have more contact with service providers. The findings also indicate that there may be benefits to having a longer horizon for working with clients, to having an 'open-door' approach that fosters clients' re-engagement after a lapse in service and/or to having comparable levels of service pre- and postnatally.


In summary, when the above elements are combined, they indicate that an ideal multi-service program for pregnant and parenting women with substance use and other concerns would be grounded in the aforementioned best practice approaches (e.g., trauma-informed, culturally safe, relationship-based, harm reduction, client-centred) and would offer a 'one-stop' or wraparound experience. Services offered would include a range of primary, prenatal, postnatal health, substance use, trauma, outreach, and child welfare services along with cultural programming and/or supports that address social determinants of health factors in a manner that reflects and respects local/regional influences. As well, it would be ideal for the program to have a connection to on-site housing, either as a core component or through a partnership with another organization. Lastly, ideally, clients would be able to participate in the program for 18 months or longer so that there is time for relationship-building with staff and peers and so that clients are able to fully realize their goals.


# 8 Implications for practice, program development, policy and funding

The Co-Creating Evidence study has provided compelling evidence that wraparound programs benefit pregnant and parenting women who use substances and have other complex concerns. By way of concluding this report, the following are put forward as implications for practice, program development, policy and funding.

## Implications for practice

1. It is imperative that multi-service programs such as those involved in this study and their sponsoring organizations and partners continue to build on their important work of providing **wraparound care and supports**, integrating their services, and employing their foundational approaches in a way that is responsive to local and regional context.

2. In this study, women were interested in and ready for steps to substance use recovery in ways that can inform further integrated service development. Stemming from this, a key practice implication for existing and emerging services that work with pregnant women and new mothers is that **listening closely to women is paramount**, particularly in terms of: what women say they need and are ready for at the time of engagement; how this readiness evolves as their connection to the program deepens; and what do they see as being their most significant change for themselves and their family.

3. Given the strong substance use recovery outcomes achieved by the women in this study, a practice implication for substance use services is to **prioritise partnering with wraparound programs**, in order to enhance these achievements.

4. Women's participation in **peer support and mentoring was a key contributor** to their own and their peers' growth and change; thus, for programs offering group interventions, creating opportunities for peer leadership, co-learning and support is highly important.

5. Wraparound programs can serve as an accessible means to strengthen relational capacity on the part of mothers who have experienced trauma and other daunting life challenges; further, women's relationships with their children and others can lead to changes in substance use and other areas of their lives. For programs designed to engage pregnant women and new mothers, **using a relational approach is essential best**

**practice**. As an extension of this point, for child welfare workers, developing partnerships or collaborative relationships with wraparound services that support and strengthen the mother-child unit may be viewed as a top practice and policy priority.

6 While the study confirmed that harm reduction is a best practice, it also demonstrated that finding the right balance between a harm reduction approach and women's and children's safety can be challenging, especially for programs with co-located housing. Making time for **ongoing practice discussions regarding harm reduction** is therefore critical, including with child welfare partners.

7 A final practice implication is the importance of recognising and honouring wraparound services for their **transdisciplinary and multi-sectoral approaches**, and their ongoing work to integrate theoretical and practice wisdom from Indigenous, medical, fetal/child development, women's health, and social and economic justice fields.

## Implications for health system planners/leaders

1 **Strong linkages between maternal/child health and substance use services** are crucial. Activating, supporting and enhancing these linkages must be a top priority for health systems planners so that maternal/child health services become more adept at serving women with substance use concerns, and substance use services become more adept at serving pregnant women and new mothers.

2 **Ongoing learning opportunities, focusing on integrated, culturally grounded, trauma informed, relational practice, are important** to practitioners in all fields and therefore need to be actively supported. Providers who have deep knowledge about putting these approaches into practice, such as those involved in this study, would be well-situated to teach and mentor other practitioners throughout the health system.

3 Similarly, **creating opportunities to learn from women with substance use concerns** about their needs and how they can be engaged safely and effectively is foundational to good planning. Extending this point, applying a 'sex, gender, equity, inclusion' (SGBA+) analysis in all health planning needs to be implemented as standard practice.

4 It is important that care models involving pregnant women and new mothers and their children be structured so that **programming covers the period from birth to at least two years**. This will allow trust building, early attachment, health and recovery gains, and parenting knowledge and confidence to be solidified prior to clients transitioning to other levels of community support. By implication, this also means that linkages amongst pregnancy, early parenting and preschool services must be actively promoted in order to ensure a seamless continuum of supports for new mothers and their children.

5 For pregnant and parenting women with substance use and other issues, housing is imperative; without safe housing women are at risk of having their children removed and of continued substance use. It is vitally important that **all levels of government invest in making Housing First and supported housing a priority and a reality**.

## Implications for government policy makers and funders

1. Given the contribution of wraparound programs to a wide range of strategic goals held by governments (e.g., related to public health, child welfare, addiction, stigma reduction, mental health, homelessness, primary care, and Indigenous wellness), it behooves all levels of government to provide **adequate funding** for the development of wraparound programs in many more communities across Canada.

2. The increasing complexity of women's health needs, specifically the intersection of mental health, substance use and trauma/violence concerns, must be recognized by funders and policy makers. Given that wraparound programs contribute to making care accessible to women with complex needs, **increased funding for additional trauma-informed services** should be prioritised.

3. **The longstanding, unresolved disconnect between the child welfare and substance use fields urgently needs to be addressed**. Alignment between the two systems should include: non-judgemental, proactive, and realistically tailored support for women to reduce or stop their substance use; support for developing parenting capacity that is informed by an understanding of trauma as a root factor in addiction; and renewed commitment to preventing child removals by enhancing availability and access to parenting supports. As a related point, addressing the disconnect between the maternal health and substance use service systems is similarly important. One key step is to recognize and support positive advances, such as rooming-in models, so that women who use substances are able to have positive birthing experiences, be supported in early attachment with their infant, and make smooth transitions to the support provided in wraparound community-based services.

4. The needs of pregnant and parenting women with addiction concerns are unique and cut across multiple systems of care. In view of this, governments are encouraged to commit to SGBA+ analyses and to **gender equitable treatment**, harm reduction, health promotion and prevention services in all substance use systems of care.

5. Wraparound programs, especially those with a cultural focus, make an important contribution to addressing the health and child welfare-related Calls to Action identified by the Truth and Reconciliation Commission. At the same time, programs typically rely upon Indigenous Elders' or knowledge keepers' part time engagement to provide cultural teachings, ceremonies and other means of connection. While this is invaluable and must continue, there is also merit in having ongoing, full time positions tasked with helping women to (re)connect, if desired, with Indigenous culture and traditions. Leaders wanting to take action to **combat racism and support the Calls to Action** would do well to ensure both that wraparound programs are funded and that programs have the resources necessary to enable these cultural connection positions to be put into place.

6. Finally, **stable funding for community-based, wraparound programs is a must**. As noted throughout this report, delivering wraparound services is challenging and time-consuming work. Staff must be skilled in many domains; partnerships take time and continual nurturing. Nevertheless, the programs involved in this study have worked with governments and other services to weave together funding so that a wide range of services is made accessible to and "wraps around" women and children. Governments can do their part by creating holistic funding mechanisms that reduce the burden of securing and reporting on funding for services that work in holistic ways.

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## About the authors

### Deborah Rutman, PhD

Deborah is a co-Founder and Principal with Nota Bene Consulting Group. She has extensive experience conducting research and program evaluation focusing on: the support needs of people with FASD, particularly in relation to parenting, the legal system, and substance use; supporting youth in/from care; Indigenous child welfare; and evaluating programs serving pregnant and parenting women with substance use, trauma and complex concerns. Deborah is adjunct faculty with the University of Victoria School of Social Work and is a member of the CanFASD Research Network. She lives in Victoria, BC.

### Carol Hubberstey, MA

Carol is a Co-Founder and Principal with Nota Bene Consulting Group. Carol has been engaged in qualitative and quantitative research and evaluation as well as project management for over 25 years. Her focus has been on the needs of youth transitioning from care; evaluation of programs related to Fetal Alcohol Spectrum Disorder; Indigenous child welfare; mentoring practices within Indigenous non-profits; and evaluation of initiatives to strengthen services and supports for women who have experienced violence and trauma. Carol lives in Victoria, BC.

### Marilyn Van Bibber

Marilyn is a Principal with Nota Bene Consulting Group and a community-based researcher with extensive experience working with First Nations in Yukon and BC. Marilyn's work has focused on the areas of community-based health, treaty rights, ethics, FASD, cultural safety, and climate change adaptation. She is currently a member of the Canada FASD Research Network and a founding member of the Aboriginal Nurses Association of Canada. Marilyn belongs to the wolf clan of the Northern Tutchone people and lives in Qualicum Beach, BC.

### Nancy Poole, PhD

Nancy is the Prevention Lead for the CanFASD Research Network, guiding a pan-Canadian network of researchers, service providers, policy analysts and community-based advocates working on FASD prevention. Nancy is also the Director of the Centre of Excellence for Women's Health (CEWH), a virtual, non-profit research centre known internationally for its leadership in gender and health. In her role as Director of CEWH, Nancy leads knowledge translation, network development, and research related to improving policy and service provision for girls and women with a range of health and social concerns, including substance use problems. Nancy lives in Victoria, BC.

### Rose Schmidt, MPH

Rose is a Research Coordinator and PhD student at the Dalla Lana School of Public Health, University of Toronto. Her mixed-methods research focuses on harm reduction and trauma-informed approaches to perinatal substance use. She addresses gender-based determents of health inequity and integrates social epidemiological methodology into applied policy research. Rose lives in Toronto, Ontario.

# 10 Appendices

## Appendix A: Additional information about the study's methodology

### Collaborative approach

As an initial project activity, in June 2017 the project team convened a day-long in-person meeting in Victoria, BC with the eight program leaders. A main focus of the meeting was to collaboratively identify a Theory of Change and to collectively articulate the theoretical foundations, approaches, key activities, and anticipated outcomes of the programs.

Throughout the project, virtual teleconferences were held with program sites to discuss key issues related to data collection and analysis and to solicit the programs' feedback regarding emerging project findings and knowledge translation. Virtual meetings with Program Leads were also an opportunity for the programs to exchange information regarding promising practices, programming, emerging challenges and contextual issues of significance (e.g., current opioid crisis and its impact on clients, staff and program delivery).

### Ethics approvals

The study received ethics approval from the University of British Columbia Office of Research Ethics (H17-02168), Vancouver Costal Health Authority, Island Health Authority, Fraser Health Authority, and York University. All participants gave informed written consent to take part in the study; all were over age 18 and were competent to give their own consent.

### Data Collection Methods and Tools

#### On-site data collection by the project team

The project team visited each site twice during the study, once in spring 2018 and a second time in fall 2019. Interviews were conducted in person with clients, staff and program partners. The arrangements for the site visits were made collaboratively by the project team and the program staff. Staff put up a poster and informed clients about the opportunity to participate in a face-to-face interview approximately one month in advance of the research team's site visit. The recruitment material included information about confidentiality and anonymity.

The interview guides were developed for this study. The Interview Guide for Clients contained open-ended questions focusing on: how the woman first learned about the program and what she hoped to gain from involvement with it; her life situation at the point that she first engaged with the program; whether and how she utilized the different services offered by her program; her satisfaction with the program; and what had been the most significant change for her and/or her family since involvement with her program. The research team conducted individual interviews and questionnaires with clients in a private, comfortable office at each program site. The qualitative interviews were conducted using a "guided conversation approach", which enabled and encouraged women to speak freely about issues and experiences of significance to them.

Immediately following the interview, women were invited to complete the Client Questionnaire, which was most often administered verbally by the researcher. While the Client Questionnaire was created specifically for this study, it also included standardized questionnaire items that have been used in evaluations of trauma-informed and/or harm reduction focused programs.

All clients participating in the study were provided an honorarium for completing the interview and questionnaire, which together took approximately 30–40 minutes. As well, program staff were available afterwards to address any concerns that clients had about the interview.

Interviews and focus groups with program staff focused on staffs' and managers' perspectives on program goals, foundational principles and approaches, program operational issues (e.g., staffing, training, supervision, funding), program partnerships, and the program's impacts for clients, families and community partners. Interviews with program partners focused on partners' perspectives on the partnership and impacts of the partnership, as well as partners' perspectives on the program's strengths, challenges, and outcomes.

## Interview participants

Eligibility criteria for client participation in the interview/ questionnaire were as follows:

- The client had to be accessing services from the program in the month of data collection;
- The client had to be 16 years or older; and;
- The client had to be English-speaking.

The number of interviews with clients varied across sites, from $n = 39$ at one of the large sites to $n = 6$ at a smaller site. The variation in the number of interviews conducted per site reflected the size and scale of the programs and was roughly proportional to the number of clients per site. Events outside of the program, including crises in the community and/ or in clients' lives also impacted response to the invitation to take part in the study.

## Prospective client and outcome databases

Quantitative outcome and client data were collected prospectively over an 18-month period beginning in April 2018. Project sites collected program and output data in relation to the women/clients who attend their program during the data collection period; a designated staff person then sent the encrypted data to the project team every three months (as quarterly "snapshots"). Data collected in the Client Database were irreversibly anonymized and did not contain identifying information such as name, address, health card number or date of birth. A unique code was created for each client to facilitate data analysis over time.

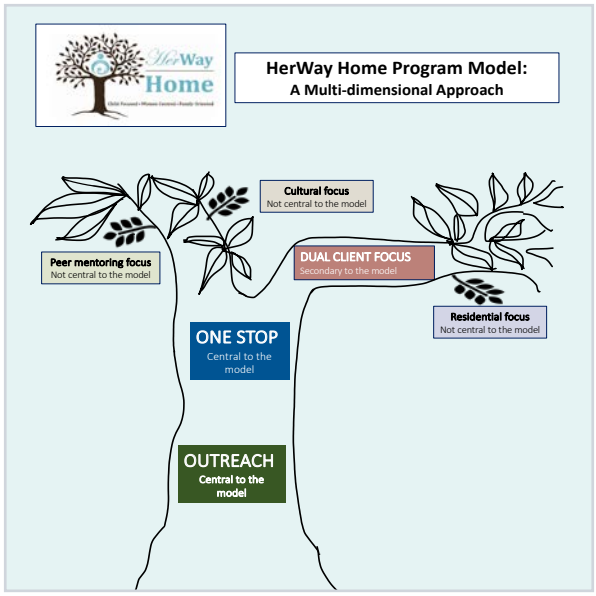
## Data Analysis

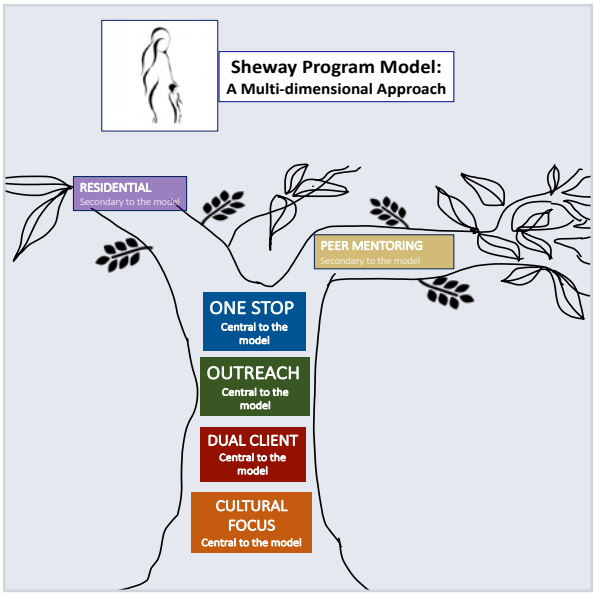
As the interviews with clients, staff, and service partners involved open-ended questions, qualitative data analysis techniques were used, and NVivo 12 qualitative data analysis software was utilized to facilitate the analyses. For the quantitative Client Questionnaire data, and the client and output data, frequency analyses were conducted to describe the program activities and outputs, the client's pregnancy, substance use, child welfare and housing status at intake into each program, and at each subsequent quarter (i.e., 'snap-shot'). These analyses were conducted in IBM SPSS 26.

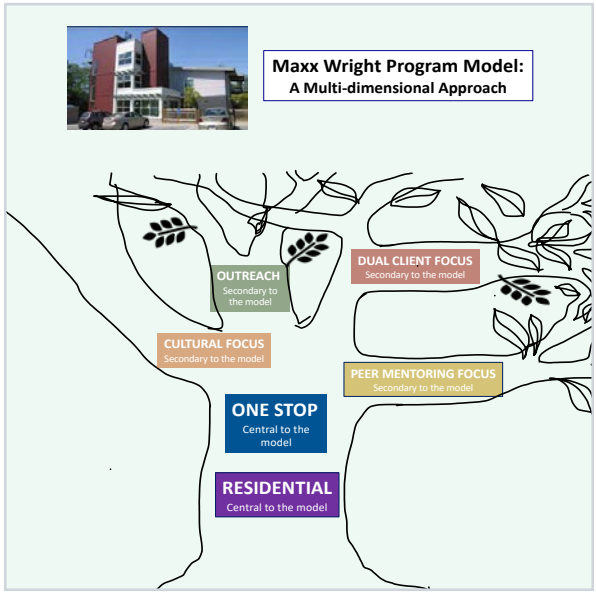
## Methodological Limitations

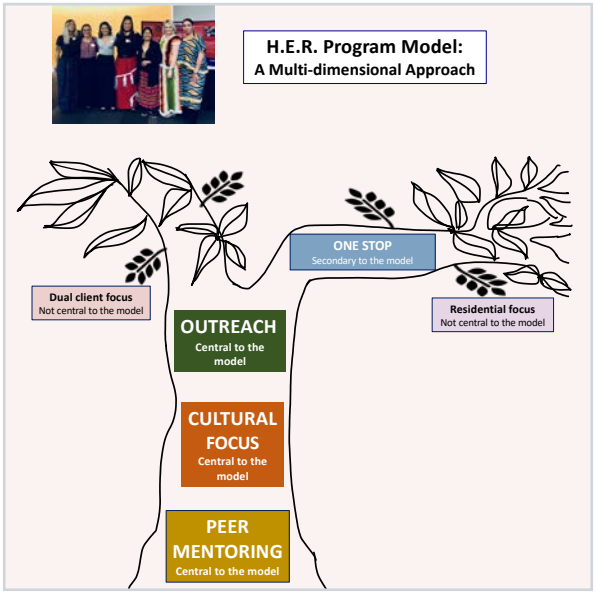
This multi-site evaluation study employed a volunteer sampling approach for the on-site client-related data collection (i.e., interviews with clients). We recognize that that approach could have resulted in bias, in that clients with more positive views about their program could have been disproportionately inclined to take part in the evaluation study. Further, with a circumscribed number of days for each site visit, clients had a narrow window of opportunity to take part. Nonetheless, we have no reason to believe that clients who held less positive perspectives were disinclined to participate in the study. Moreover, the confidential, conversational approach to interviewing also facilitated participants sharing their diverse experiences and perspectives.

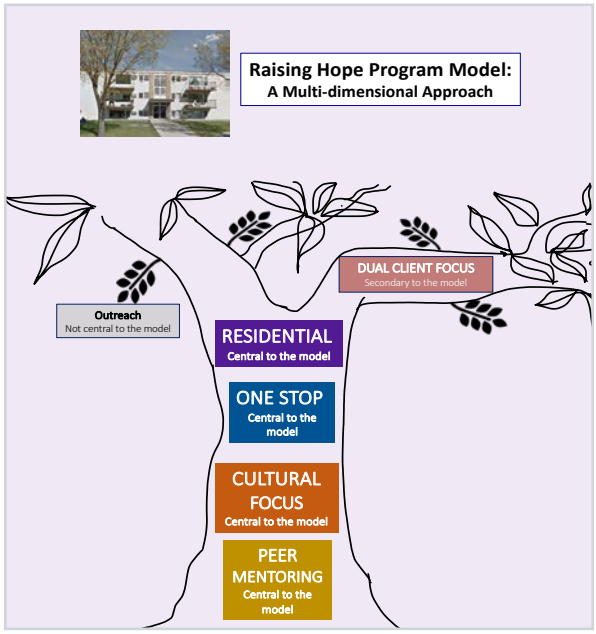
## **Appendix B:** Visual depictions of the each of the eight CCE programs' models

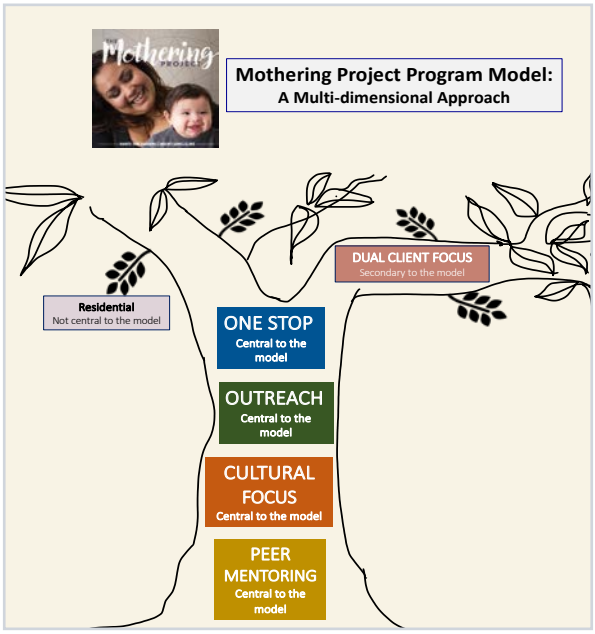


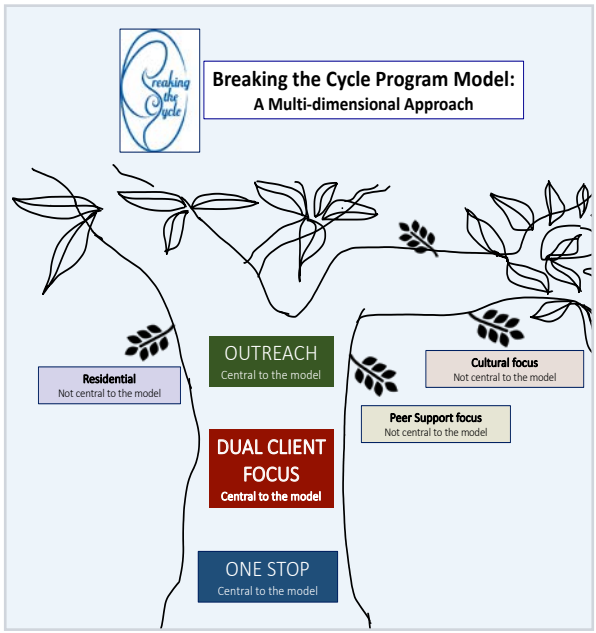



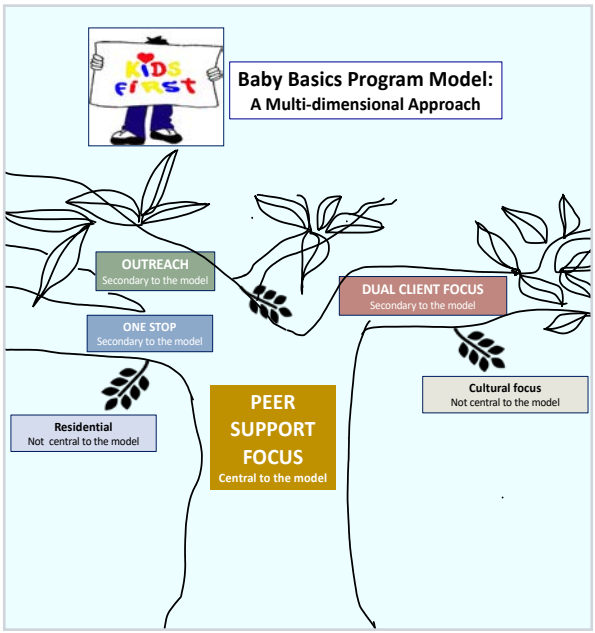




Raising Hope Program Model:
A Multi-dimensional Approach
Outreach
Not central to the model
DUAL CLIENT FOCUS
Secondary to the model
RESIDENTIAL
Central to the model
ONE STOP
Central to the model
CULTURAL FOCUS
Central to the model
PEER MENTORING
Central to the model


Mothering Project Program Model:
A Multi-dimensional Approach
Residential
Not central to the model
DUAL CLIENT FOCUS
Secondary to the model
ONE STOP
Central to the model
OUTREACH
Central to the model
CULTURAL FOCUS
Central to the model
PEER MENTORING
Central to the model


Breaking the Cycle Program Model:
A Multi-dimensional Approach
Residential
Not central to the model
OUTREACH
Central to the model
Cultural focus
Not central to the model
Peer Support focus
Not central to the model
DUAL CLIENT FOCUS
Central to the model
ONE STOP
Central to the model


Baby Basics Program Model:
A Multi-dimensional Approach
OUTREACH
Secondary to the model
ONE STOP
Secondary to the model
DUAL CLIENT FOCUS
Secondary to the model
Residential
Not central to the model
PEER SUPPORT FOCUS
Central to the model
Cultural focus
Not central to the model

## **Appendix C:** Additional information about the study's key findings

**Table 1:** Key Client Questionnaire findings re: outcomes for clients and their families

| "Since becoming involved with this program… | 'Agree' or 'Strongly agree' | 'Neutral' | 'Disagree' or 'Strongly disagree' | 'N/A' | % who said program was 'helpful' or 'very helpful' re: outcome[1] |
|---|---|---|---|---|---|
| I have improved housing | 78% | 9% | 5% | 9% | 82% |
| I accessed prenatal and post-natal care | 86% | 2% | 0% | 13% | 97% |
| My pregnancy was healthy; my baby was healthy at birth | 79% | 7% | 5% | 9% | 93% |
| I have improved access to health services | 88% | 5% | 0% | 7% | 96% |
| I have made progress relative to my health goals | 89% | 3% | 2% | 6% | 91% |
| My child has had regular developmental assessments via public health | 82% | 3% | 1% | 14% | 96% |
| My child has opportunities for positive socialization and is developing socially | 82% | 5% | 1% | 13% | 91% |
| I have more info on child development and parenting | 90% | 5% | 1% | 5% | 94% |
| My child(ren) are now living with me or my family | 72% | 3% | 8% | 16% | 90% |
| I have had a voice in decisions regarding my child's custody or in safety planning | 80% | 6% | 2% | 13% | 90% |
| I have improved connection to my child(ren) | 73% | 3% | 8% | 16% | 91% |
| I've accessed support related to trauma or violence | 67% | 12% | 7% | 14% | 87% |
| I have accessed substance use services or supports | 78% | 4% | 3% | 15% | 93% |
| I have quit, reduced or safer substance use | 81% | 2% | 2% | 16% | 95% |
| I am involved in cultural activities and/or feel connected to culture (if desired) | 59% | 15% | 5% | 21% | 71% |
| I feel supported and less isolated; I have social support | 93% | 4% | 2% | 1% | 96% |
| I know where to get affordable, good food | 91% | 8% | 0% | 1% | 92% |
| My family and I have improved nutrition | 81% | 13% | 3% | 3% | 86% |

[1] In this column, the N/A responses were removed from the denominator in the calculations of percentages.

**Table 2:** Key Client Questionnaire findings re: Programs' helpfulness in achieving outcomes

| To what degree has the program helped you in this area of your life | 'Helpful' or 'Very helpful' | 'Neutral' | 'Helpful' or 'Very helpful' | 'N/A' | 'Helpful' or 'Very helpful' with N/A removed |
|---|---|---|---|---|---|
| I have improved housing | 64% | 12% | 2% | 22% | 82% |
| I accessed prenatal and post-natal care | 82% | 3% | 0% | 16% | 97% |
| My pregnancy was healthy; my baby was healthy at birth | 74% | 3% | 2% | 20% | 93% |
| I have improved access to health services | 86% | 3% | 1% | 10% | 96% |
| I have made progress relative to my health goals | 84% | 7% | 1% | 7% | 91% |
| My child has had regular developmental assessments via public health | 74% | 2% | 1% | 23% | 96% |
| My child has opportunities for positive socialization and is developing socially | 77% | 8% | 0% | 15% | 91% |
| I have more info on child development and parenting | 87% | 5% | 0% | 8% | 94% |
| I have had a voice in decisions regarding my child's custody or in safety planning | 80% | 6% | 2% | 13% | 91% |
| My child(ren) are now living with me or my family | 62% | 3% | 4% | 31% | 90% |
| I have improved connection to my child(ren) | 76% | 5% | 2% | 17% | 91% |
| I've accessed support related to trauma or violence | 71% | 8% | 2% | 19% | 87% |
| I have accessed substance use services or supports | 72% | 4% | 2% | 22% | 93% |
| I have quit, reduced or safer substance use | 78% | 4% | 0% | 18% | 95% |
| I am involved in cultural activities and/or feel connected to culture (if desired) | 50% | 16% | 5% | 29% | 71% |
| I feel supported and less isolated; I have social support | 93% | 4% | 0% | 2% | 96% |
| I know where to get affordable, good food | 86% | 7% | 1% | 6% | 92% |
| My family and I have improved nutrition | 78% | 10% | 2% | 10% | 86% |

## Women's Substance use and Housing status over time

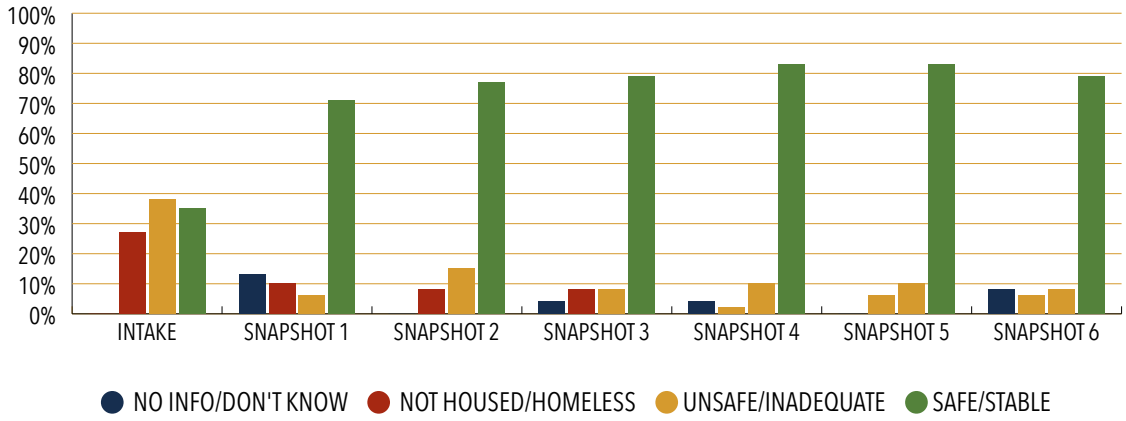
### Housing

Based on statistical analyses involving clients for whom there were at least ***four*** data points (intake plus at least ***three*** subsequent 'snapshots'), the findings showed that there were substantial improvements in housing over time at several programs (especially at HerWay Home, Sheway and Maxx Wright), most notably between intake and the first snapshot.

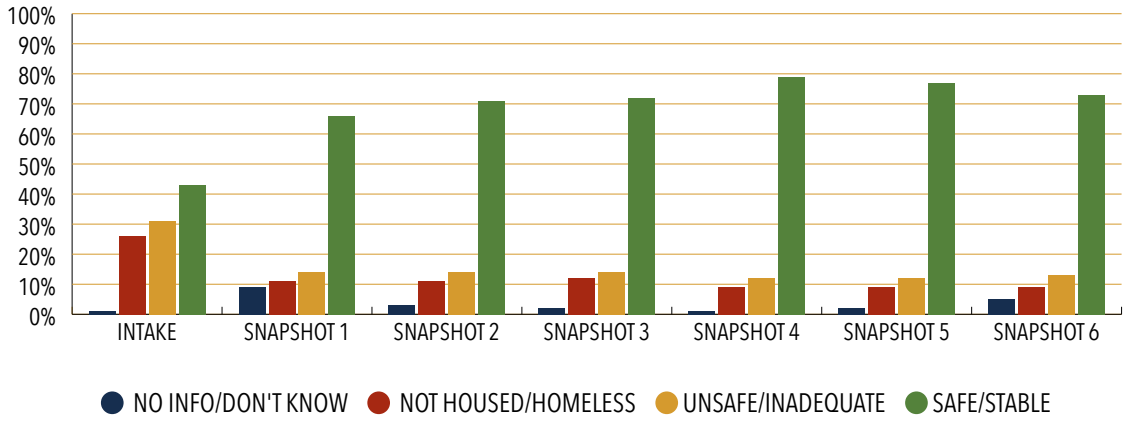
**Table 3:** Clients' housing status time over time, based on clients for whom there were four or more points of data (*n*=321) (six programs)

| | Intake | SNAP 1 June 2018 | SNAP 2 Sept 2018 | SNAP 3 Dec 2018 | SNAP 4 Mar 2019 | SNAP 5 June 2019 | SNAP 6 Sept 2019 |
|---|---|---|---|---|---|---|---|
| **HerWay Home (*n*=48)** | | | | | | | |
| Not housed/homeless | 27% | 10% | 8% | 8% | 2% | 6% | 6% |
| Unsafe/inadequate | 38% | 6% | 15% | 8% | 10% | 10% | 8% |
| Safe/stable | 35% | 71% | 77% | 79% | 83% | 83% | 79% |
| No info/don't know | 0% | 13% | 0% | 4% | 4% | 0% | 8% |
| **Sheway (*n*=196)** | | | | | | | |
| Not housed/homeless | 26% | 11% | 11% | 12% | 9% | 9% | 9% |
| Unsafe/inadequate | 31% | 14% | 14% | 14% | 12% | 12% | 13% |
| Safe/stable | 43% | 66% | 71% | 72% | 79% | 77% | 73% |
| No info/don't know | 1% | 9% | 3% | 2% | 1% | 2% | 5% |
| **Maxx Wright (*n*=24)** | | | | | | | |
| Not housed/homeless | 0% | 0% | 0% | 4% | 4% | 0% | 4% |
| Unsafe/inadequate | 0% | 8% | 17% | 13% | 17% | 8% | 13% |
| Safe/stable | 21% | 83% | 58% | 63% | 67% | 88% | 50% |
| No info/don't know | 79% | 8% | 25% | 21% | 13% | 4% | 33% |
| **Mothering project (*n*=29)** | | | | | | | |
| Not housed/homeless | 14% | 17% | 14% | 7% | 24% | 31% | 28% |
| Unsafe/inadequate | 59% | 31% | 41% | 38% | 24% | 21% | 17% |
| Safe/stable | 24% | 45% | 34% | 55% | 52% | 48% | 41% |
| No info/don't know | 3% | 7% | 10% | 0% | 0% | 0% | 14% |
| **Breaking the Cycle (*n*=14)** | | | | | | | |
| Not housed/homeless | 14% | 0% | 0% | 14% | 0% | 0% | 0% |
| Unsafe/inadequate | 21% | 7% | 21% | 29% | 29% | 14% | 36% |
| Safe/stable | 43% | 50% | 71% | 57% | 64% | 86% | 36% |
| No info/don't know | 21% | 43% | 7% | 0% | 7% | 0% | 29% |
| **Baby Basics (*n*=10)** | | | | | | | |
| Not housed/homeless | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Unsafe/inadequate | 60% | 40% | 30% | 30% | 20% | 20% | 20% |
| Safe/stable | 30% | 20% | 50% | 50% | 70% | 70% | 40% |
| No info/don't know | 10% | 40% | 20% | 20% | 10% | 10% | 40% |
| **All six programs** | | | | | | | |
| Not housed/homeless | 22% | 10% | 9% | 10% | 8% | 9% | 9% |
| Unsafe/inadequate | 32% | 14% | 18% | 17% | 14% | 13% | 14% |
| Safe/stable | 40% | 64% | 69% | 71% | 76% | 78% | 68% |
| No info/don't know | 8% | 13% | 6% | 4% | 3% | 2% | 11% |

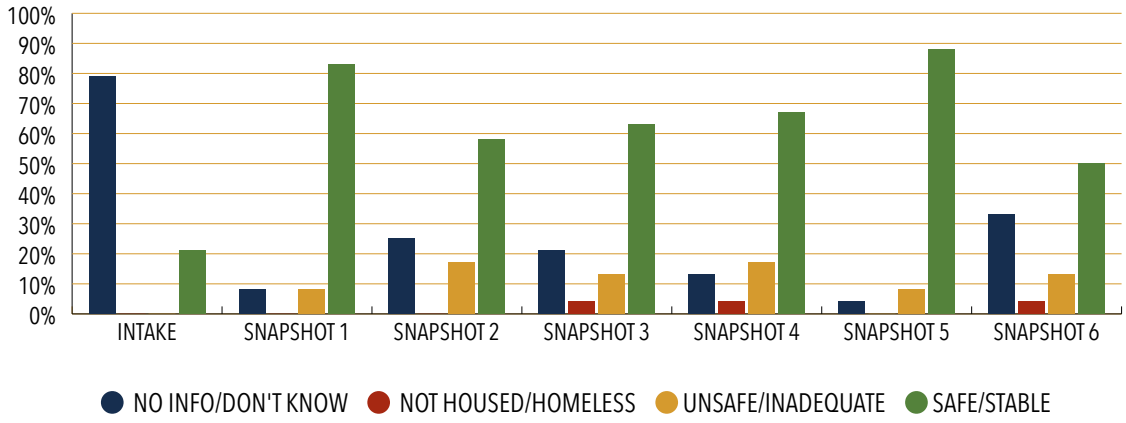
Housing over time, based on clients with 4 data points -
**HerWay Home (*n*=48)**



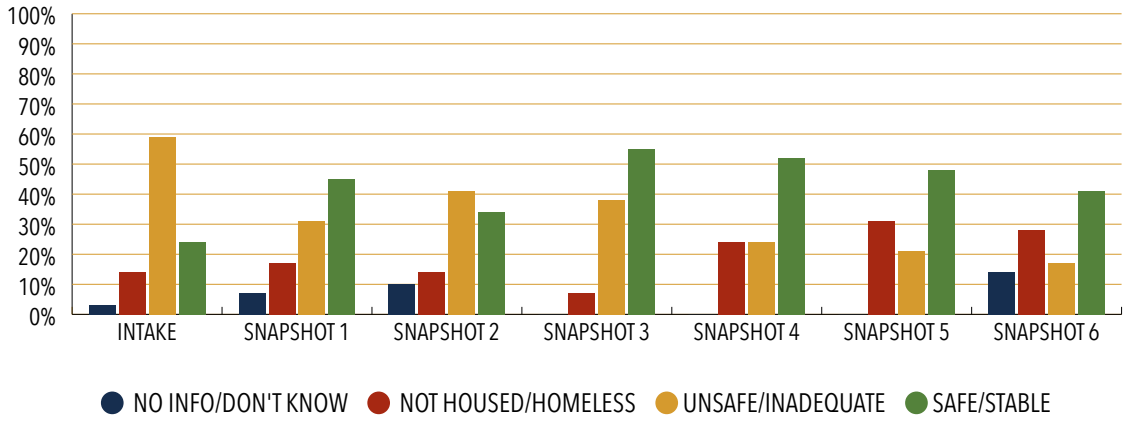

Housing over time, based on clients with 4 data points -
**Sheway (*n*=196)**



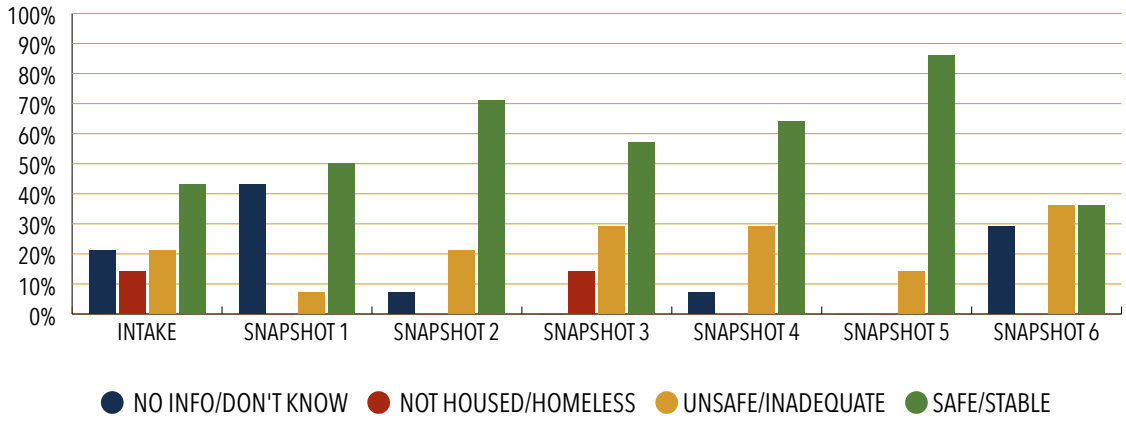
Housing over time, based on clients with 4 data points -
**Maxx Wright (*n*=24)**



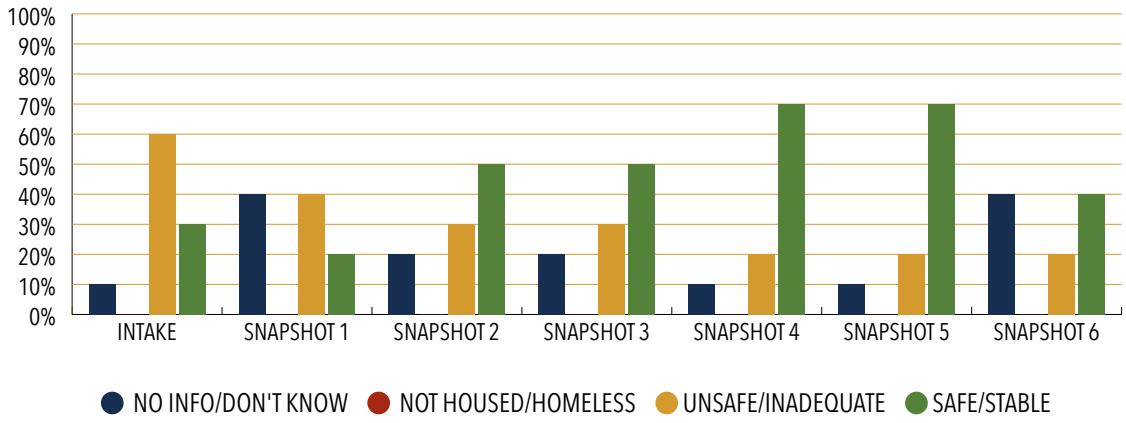

Housing over time, based on clients with 4 data points -
**Mothering Project (*n*=29)**



Housing over time, based on clients with 4 data points -
**Breaking the Cycle (*n*=14)**

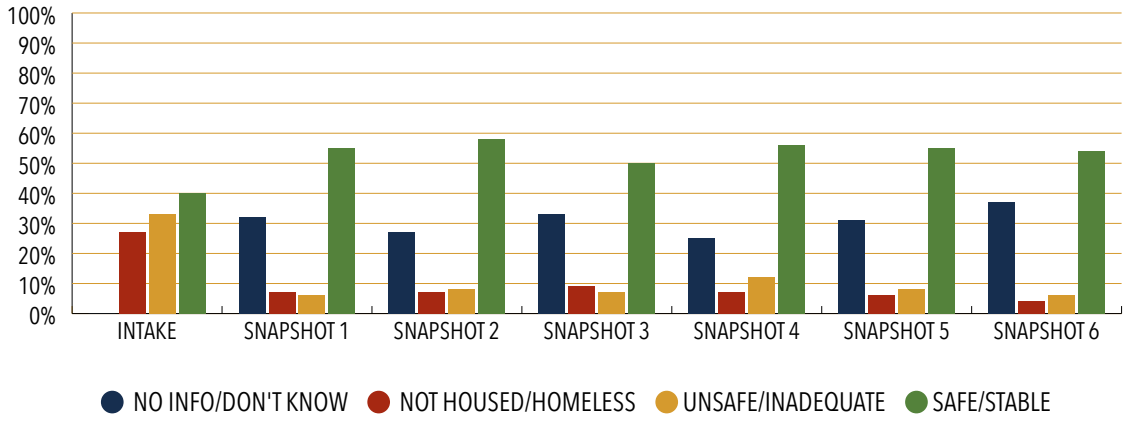



Housing over time, based on clients with 4 data points -
**Baby Basics (*n*=10)**

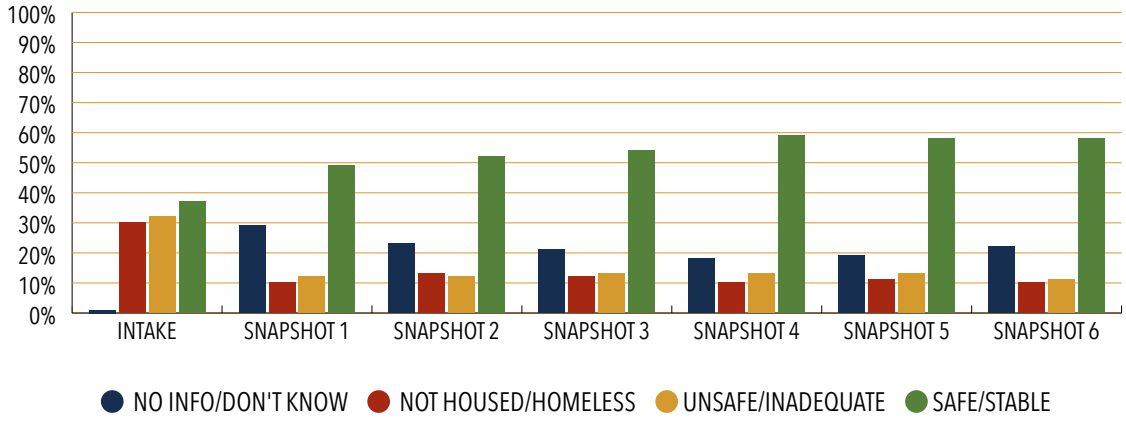


Based on statistical analyses involving clients for whom there were at least two data points (intake plus at least one subsequent 'snapshot'), the findings showed a similar pattern – that is, improvements in housing over time at several programs, most notably between women's situation at intake and at the first snapshot. However, these findings also showed that there was a substantial number of clients whose housing status was unknown to program staff.

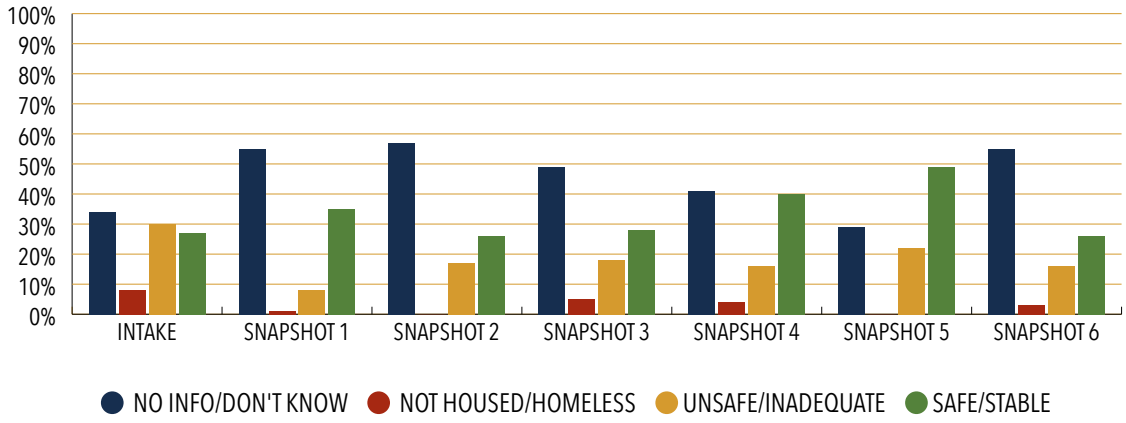
Housing over time, based on clients with 2 data points -
**HerWay Home (*n*=109)**



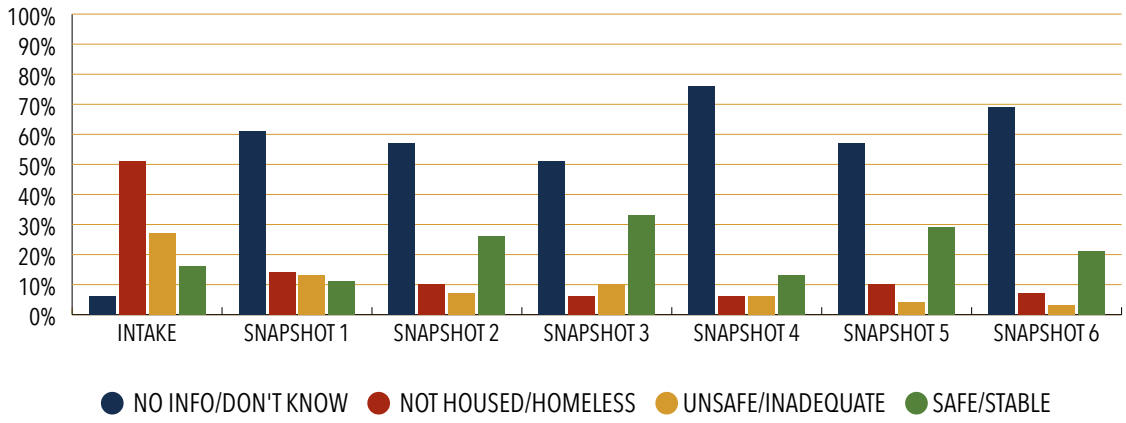

Housing over time, based on clients with 2 data points -
**Sheway (*n*=307)**



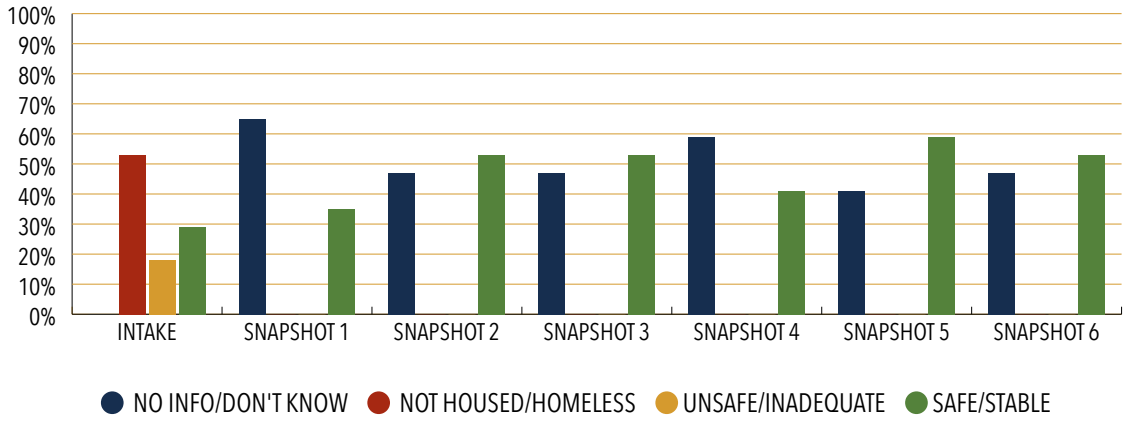
Housing over time, based on clients with 2 data points -
**Maxx Wright (*n*=96)**



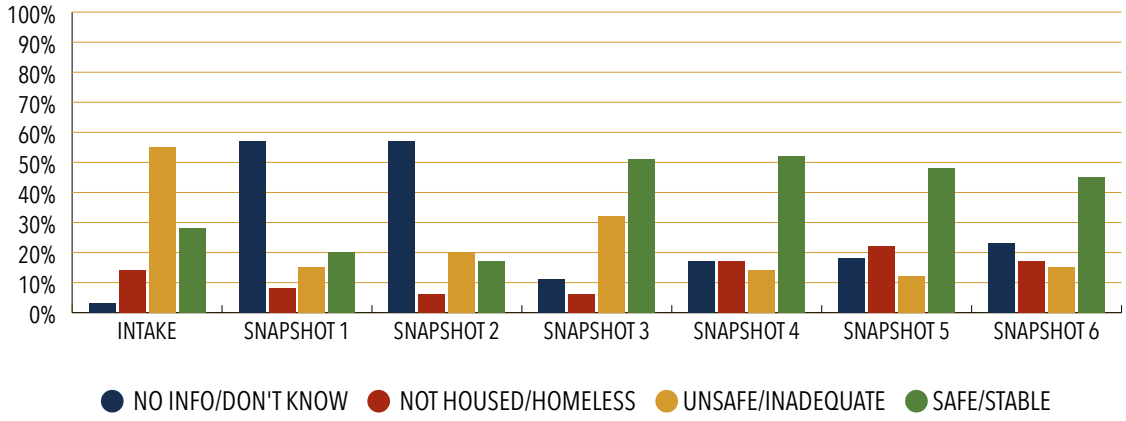

Housing over time, based on clients with 2 data points -
**H.E.R. (*n*=70)**



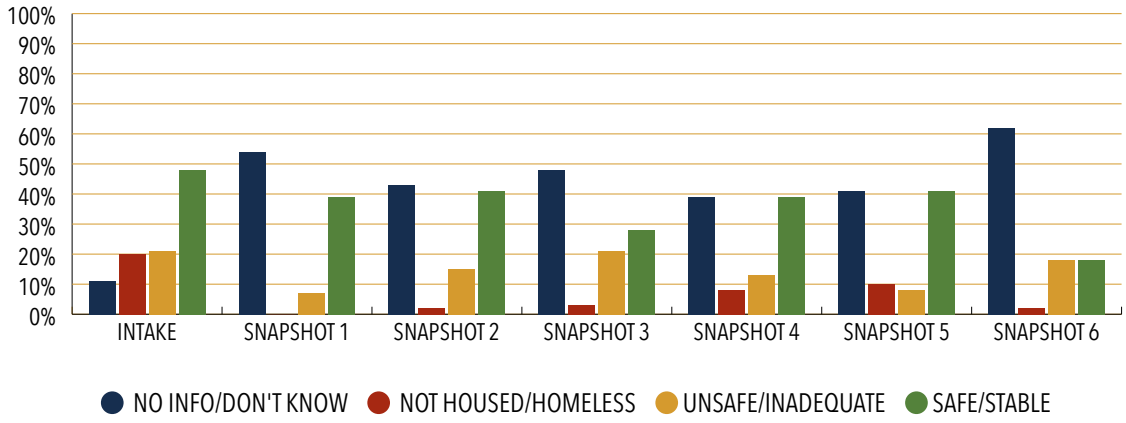
Housing over time, based on clients with 2 data points -
**Raising Hope (*n*=17)**



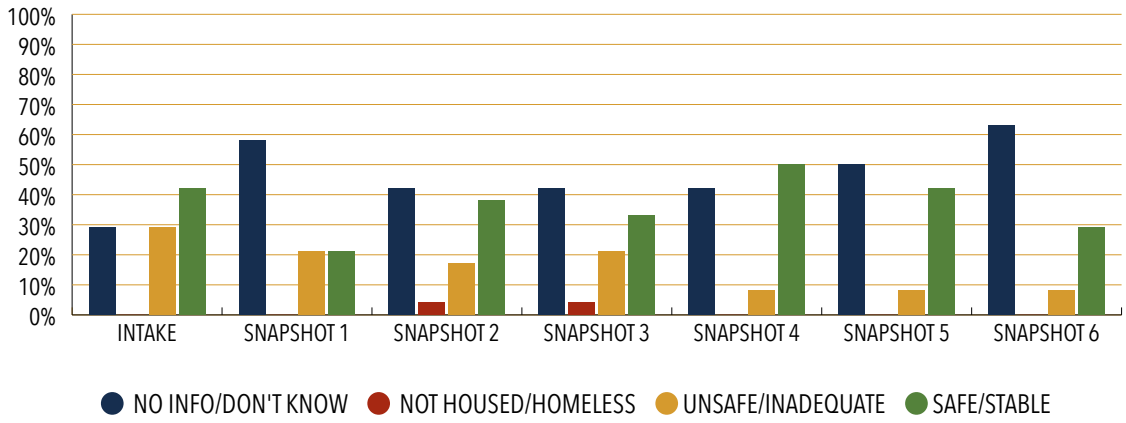

Housing over time, based on clients with 2 data points -
**Mothering Project (*n*=65)**



Housing over time, based on clients with 2 data points -
**Breaking the Cycle (*n*=61)**




Housing over time, based on clients with 2 data points -
**Baby Basics (*n*=24)**




## Substance use

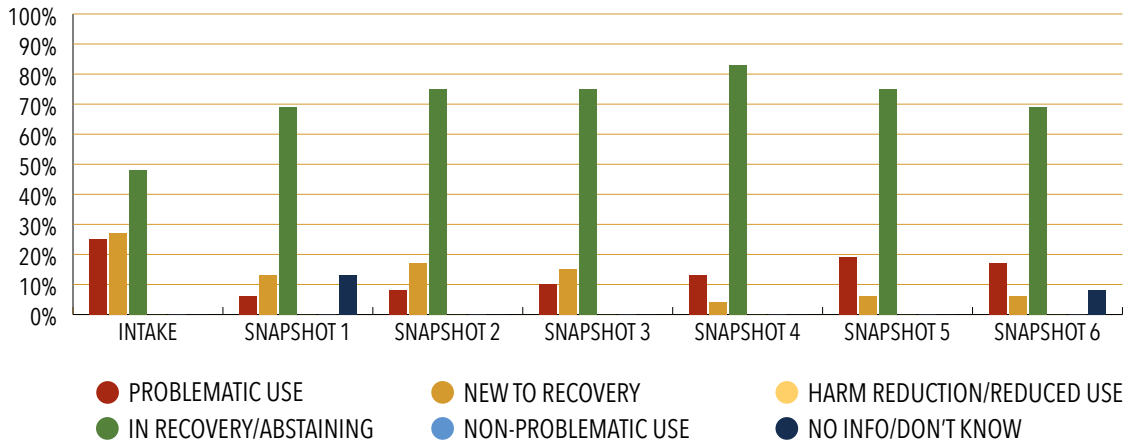
Client intake and snapshot data showed that, for clients with at least four points of data, there were substantial changes over time at several programs (especially at HerWay Home, Sheway, Breaking the Cycle and Maxx Wright), most notably between women's situation at intake and at the first snapshot.

**Table 4:** Clients' substance use over time, based on clients for whom there were four or more points of data (*n*=321) (six programs)

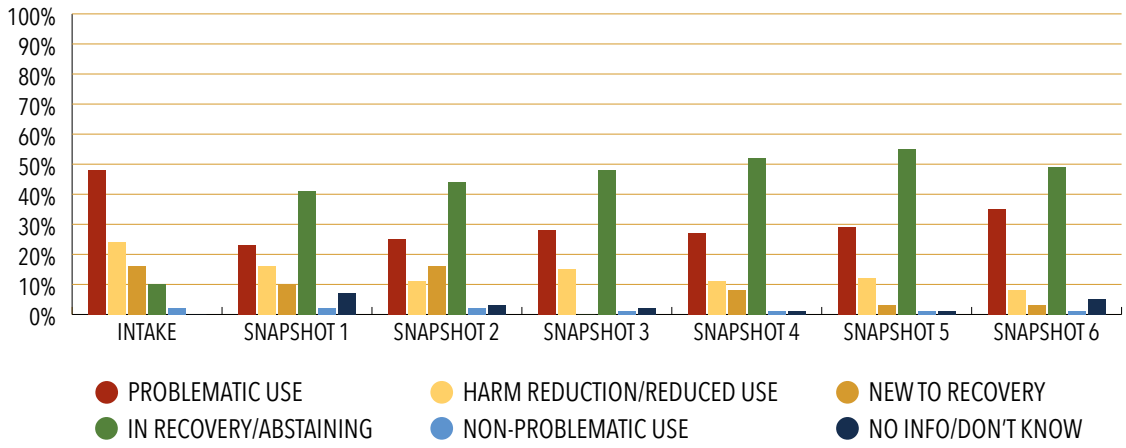
| | Intake | SNAP 1 June 2018 | SNAP 2 Sept 2018 | SNAP 3 Dec 2018 | SNAP 4 Mar 2019 | SNAP 5 June 2019 | SNAP 6 Sept 2019 |
|---|---|---|---|---|---|---|---|
| **HerWay Home (*n*=48)** | | | | | | | |
| Problematic use | 25% | 6% | 8% | 10% | 13% | 19% | 17% |
| In recovery/abstaining | 48% | 69% | 75% | 75% | 83% | 75% | 69% |
| New to recovery | 27% | 13% | 17% | 15% | 4% | 6% | 6% |
| HR/reduced use | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Non-problematic use | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| No info/don't know | 0% | 13% | 0% | 0% | 0% | 0% | 8% |
| **Sheway (*n*=196)** | | | | | | | |
| Problematic use | 48% | 23% | 25% | 28% | 27% | 29% | 35% |
| In recovery/abstaining | 10% | 41% | 44% | 48% | 52% | 55% | 49% |
| New to recovery | 16% | 10% | 16% | 0% | 8% | 3% | 3% |
| HR/reduced use | 24% | 16% | 11% | 15% | 11% | 12% | 8% |
| Non-problematic use | 2% | 2% | 2% | 1% | 1% | 1% | 1% |
| No info/don't know | 0% | 7% | 3% | 2% | 1% | 1% | 5% |
| **Maxx Wright (*n*=24)** | | | | | | | |
| Problematic use | 21% | 17% | 13% | 8% | 8% | 0% | 4% |
| In recovery/abstaining | 50% | 67% | 63% | 75% | 63% | 88% | 63% |
| New to recovery | 21% | 4% | 21% | 17% | 13% | 4% | 4% |
| HR/reduced use | 0% | 0% | 0% | 0% | 0% | 0% | 8% |
| Non-problematic use | 4% | 4% | 0% | 0% | 0% | 4% | 0% |
| No info/don't know | 4% | 8% | 0% | 0% | 17% | 4% | 21% |
| **Mothering project (*n*=29)** | | | | | | | |
| Problematic use | 79% | 62% | 62% | 52% | 55% | 48% | 59% |
| In recovery/abstaining | 0% | 10% | 21% | 24% | 10% | 24% | 21% |
| New to recovery | 3% | 0% | 3% | 3% | 0% | 0% | 3% |
| HR/reduced use | 17% | 14% | 10% | 14% | 21% | 21% | 0% |
| Non-problematic use | 0% | 7% | 0% | 3% | 14% | 7% | 0% |
| No info/don't know | 0% | 7% | 0% | 3% | 0% | 0% | 17% |
| **Breaking the Cycle project (*n*=14)** | | | | | | | |
| Problematic use | 14% | 0% | 0% | 7% | 7% | 7% | 7% |
| In recovery/abstaining | 14% | 64% | 79% | 93% | 71% | 71% | 57% |
| New to recovery | 50% | 0% | 21% | 0% | 7% | 0% | 0% |
| HR/reduced use | 21% | 7% | 0% | 0% | 7% | 21% | 7% |
| Non-problematic use | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| No info/don't know | 0% | 29% | 0% | 0% | 7% | 0% | 29% |

| | Intake | SNAP 1 June 2018 | SNAP 2 Sept 2018 | SNAP 3 Dec 2018 | SNAP 4 Mar 2019 | SNAP 5 June 2019 | SNAP 6 Sept 2019 |
|---|---|---|---|---|---|---|---|
| **Baby Basics (*n*=10)** | | | | | | | |
| Problematic use | 0% | 0% | 0% | 0% | 10% | 10% | 0% |
| In recovery/abstaining | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| New to recovery | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| HR/reduced use | 10% | 0% | 10% | 10% | 0% | 0% | 0% |
| Non-problematic use | 30% | 10% | 90% | 90% | 70% | 80% | 70% |
| No info/don't know | 60% | 90% | 0% | 0% | 10% | 10% | 40% |
| **All six programs (*n*=321)** | | | | | | | |
| Problematic use | 43% | 22% | 23% | 24% | 24% | 26% | 30% |
| In recovery/abstaining | 17% | 44% | 48% | 53% | 53% | 56% | 50% |
| New to recovery | 18% | 8% | 15% | 4% | 7% | 3% | 3% |
| HR/reduced use | 17% | 12% | 8% | 11% | 9% | 10% | 6% |
| Non-problematic use | 2% | 2% | 4% | 3% | 4% | 4% | 3% |
| No info/don't know | 2% | 11% | 2% | 2% | 2% | 1% | 9% |

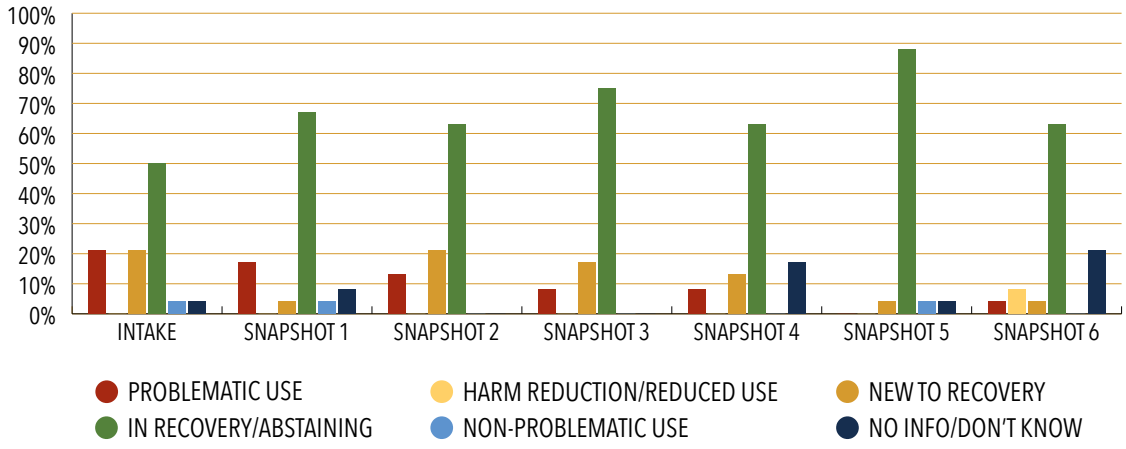
Substance use over time, based on clients with 4 data points -
**HerWay Home (*n*=48)**



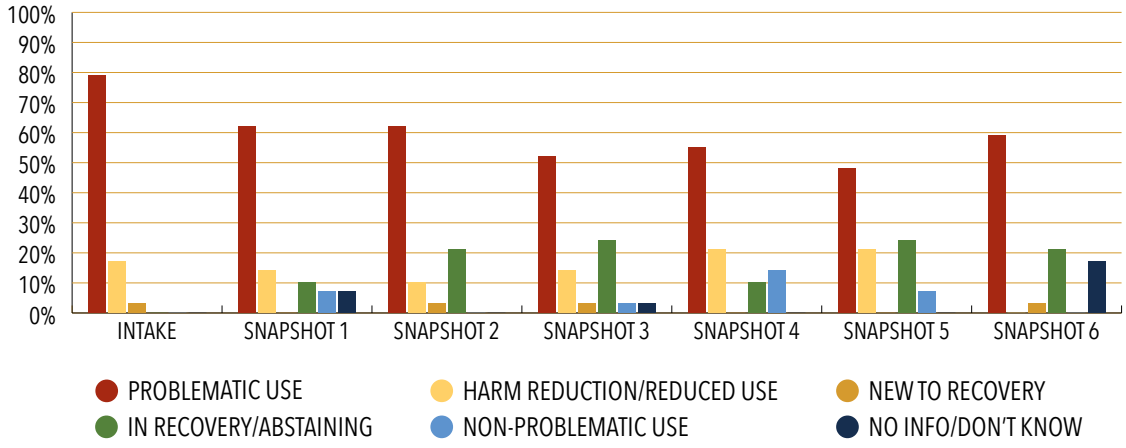
Substance use over time, based on clients with 4 data points -
**Sheway (*n*=196)**



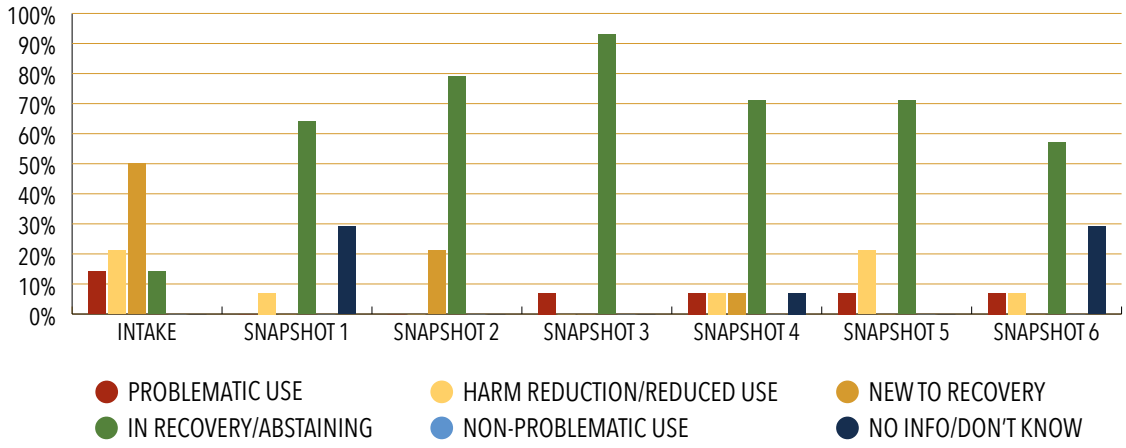

Substance use over time, based on clients with 4 data points -
**Maxx Wright (*n*=24)**



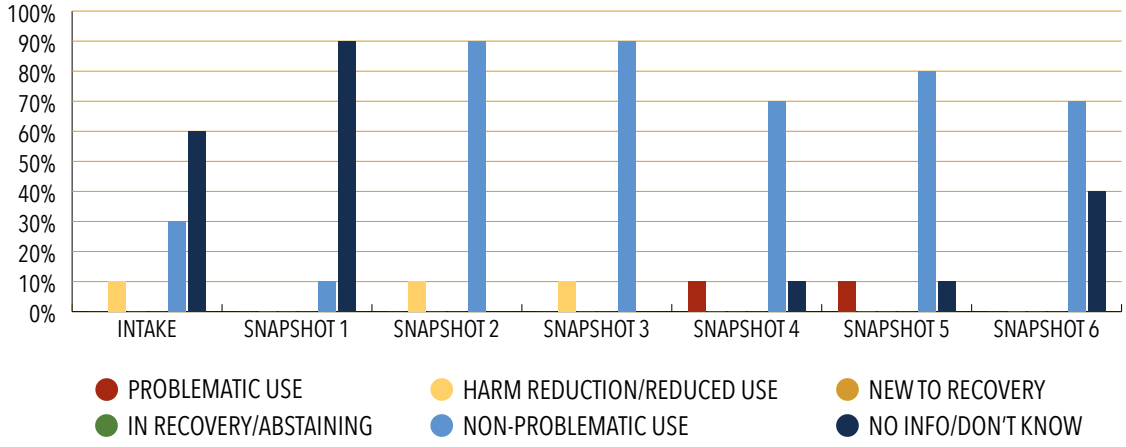

Substance use over time, based on clients with 4 data points -
**Mothering Project (*n*=29)**



Substance use over time, based on clients with 4 data points -
**Breaking the Cycle (*n*=14)**

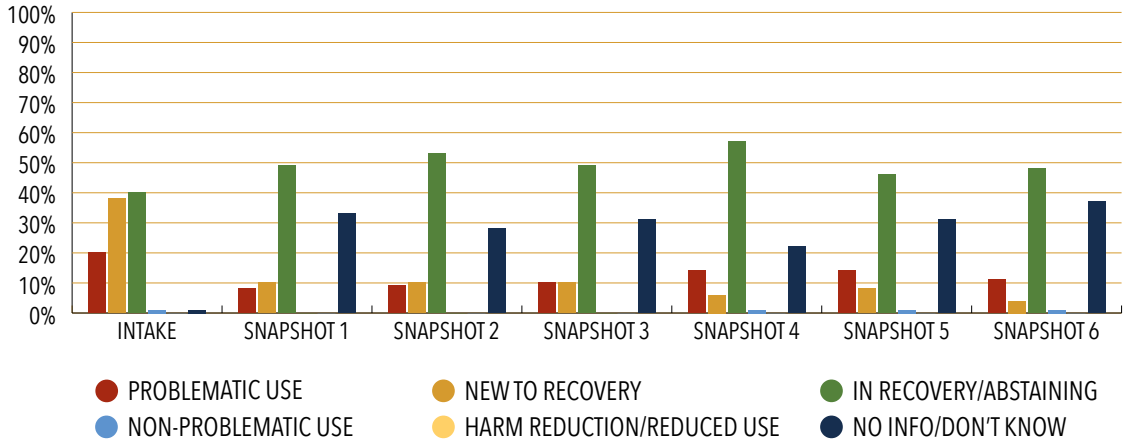



Substance use over time, based on clients with 4 data points -
**Baby Basics (*n*=10)**

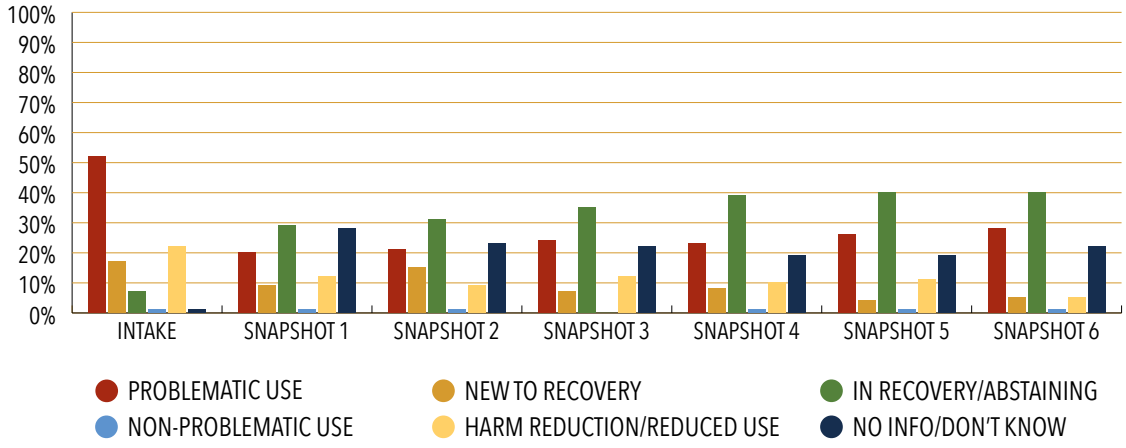


Based on statistical analyses involving clients for whom there were at least two data points (intake plus at least ***one*** subsequent 'snapshot'), the findings generally showed a similar pattern – that is, improvements in substance use over time at several programs, most notably between women's situation at intake and at the first snapshot. However, these findings also showed that there was a substantial number of women whose substance use was unknown to program staff.

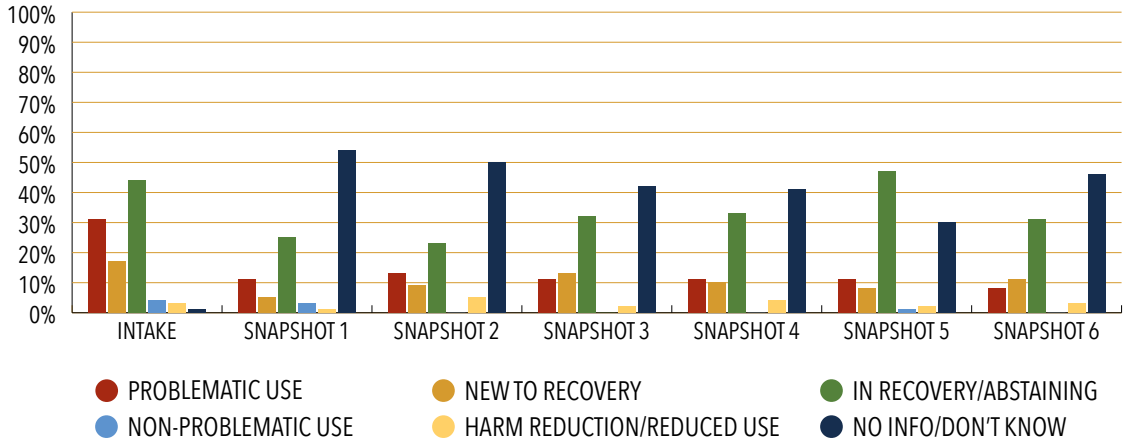
Substance use over time, based on clients with 2 data points -
**HerWay Home (*n*=109)**



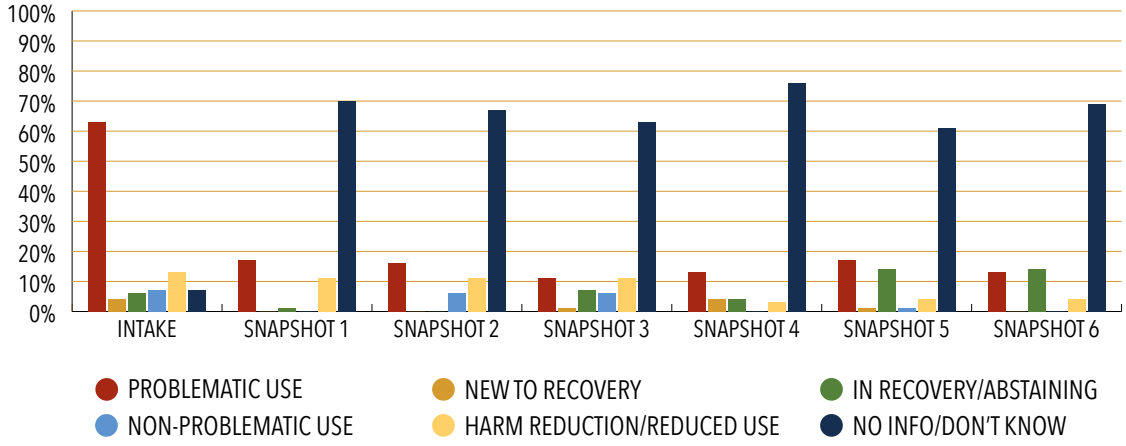

Substance use over time, based on clients with 2 data points -
**Sheway (*n*=307)**



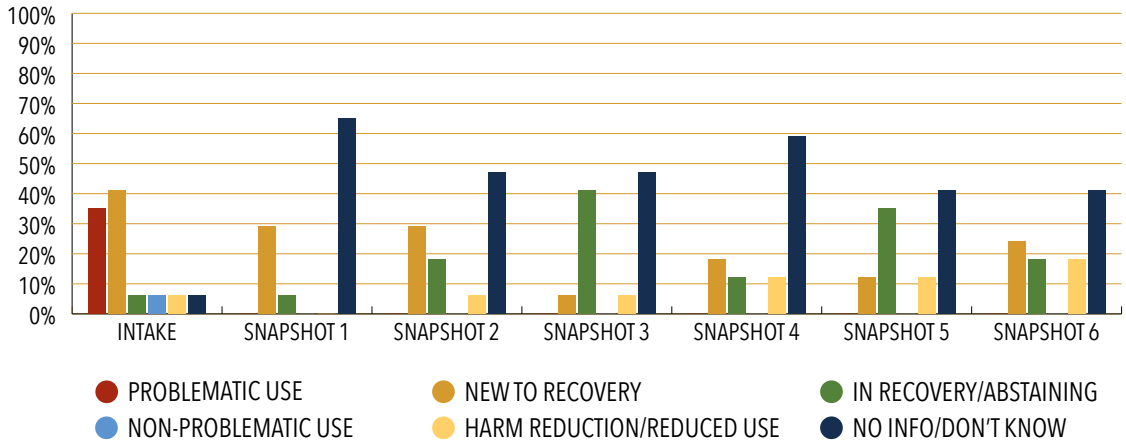
Substance use over time, based on clients with 2 data points -
**Maxx Wright (*n*=96)**



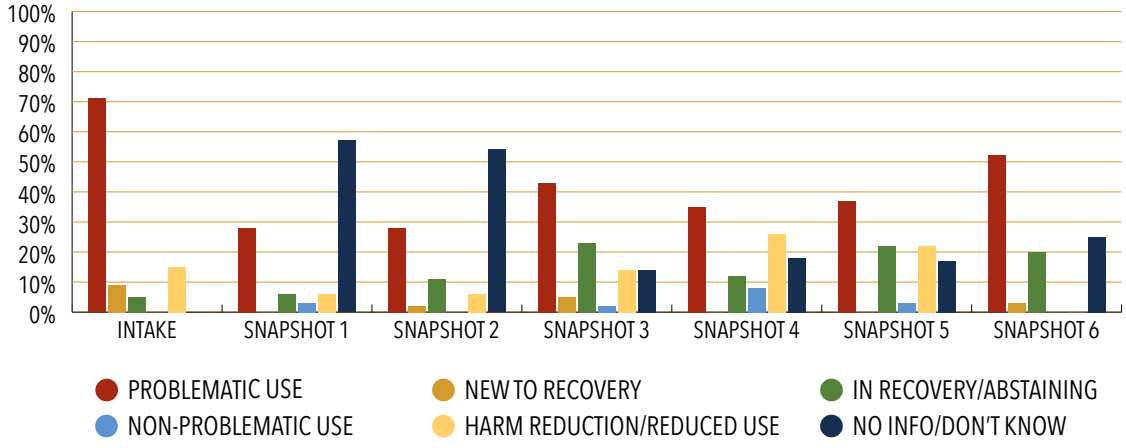

Substance use over time, based on clients with 2 data points -
**H.E.R. (*n*=70)**



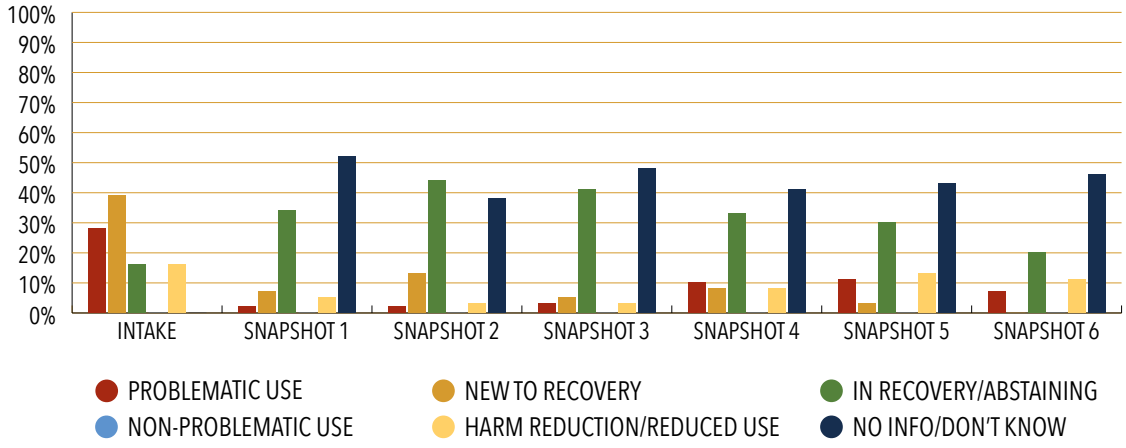
Substance use over time, based on clients with 2 data points -
**Raising Hope (*n*=17)**



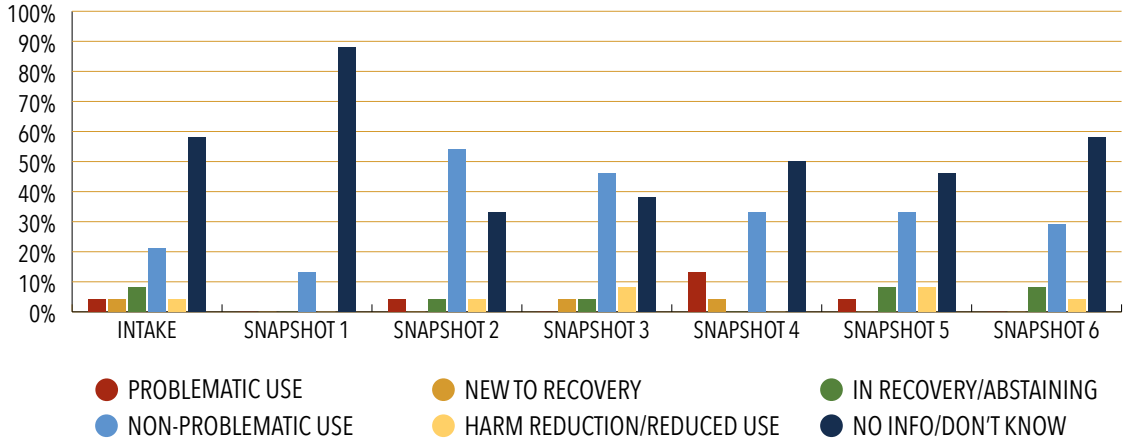

Substance use over time, based on clients with 2 data points -
**Mothering Project (*n*=65)**



Substance use over time, based on clients with 2 data points -
**Breaking the Cycle (*n*=61)**




Housing over time, based on clients with 2 data points -
**Baby Basics (*n*=24)**

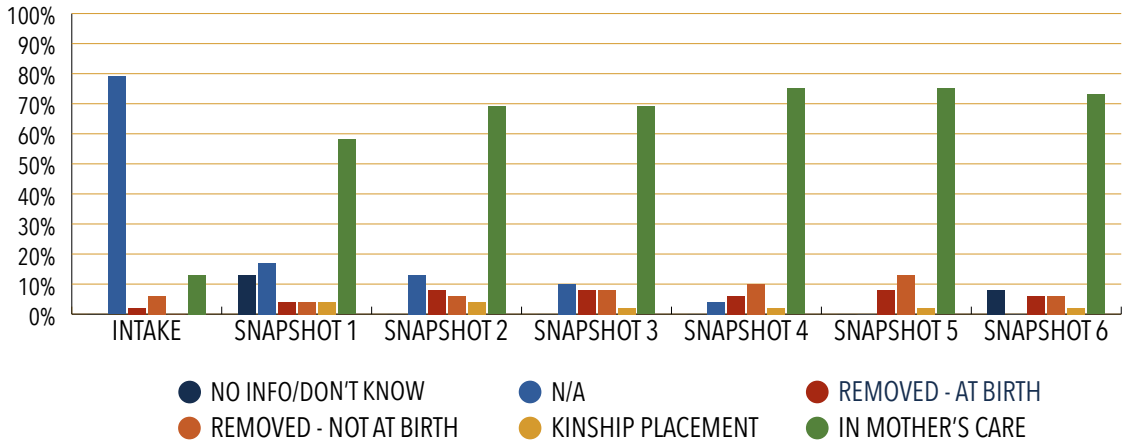


## Child welfare status for focal infant

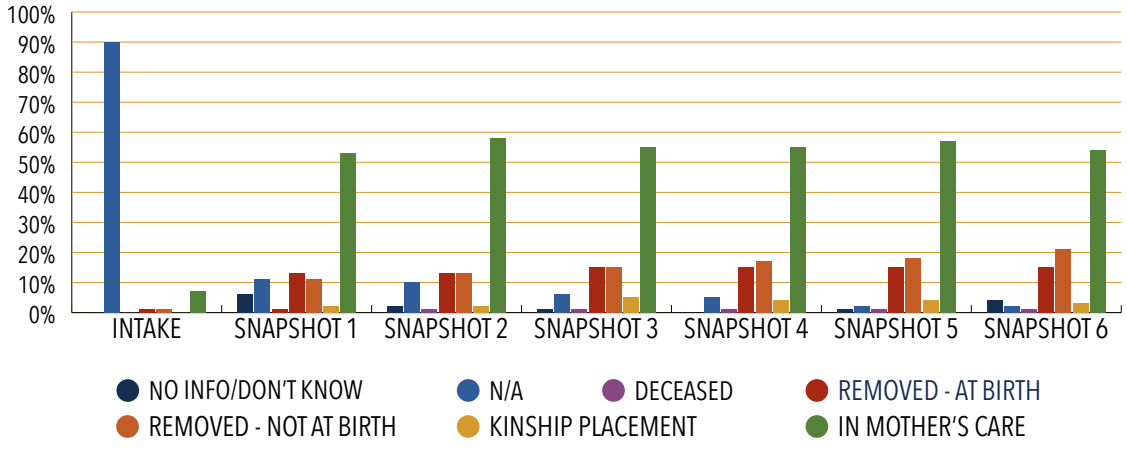
Based on analyses involving clients with Intake plus at least four "snapshot" points of data, the findings showed that between intake and subsequent snapshots, there was a substantial increase in the number of infants who were in their mother's care. This pattern of findings was more evident at some programs (notably HerWay Home, Sheway, Breaking the Cycle and Maxx Wright), than others.

Nevertheless, it is important to bear in mind that for nearly all programs, even small increases in the number of clients who were able to keep their infant in their care is an important outcome, given that the women participating in these programs generally are at high risk of having their infant removed due to their substance use, unsafe housing and other factors.

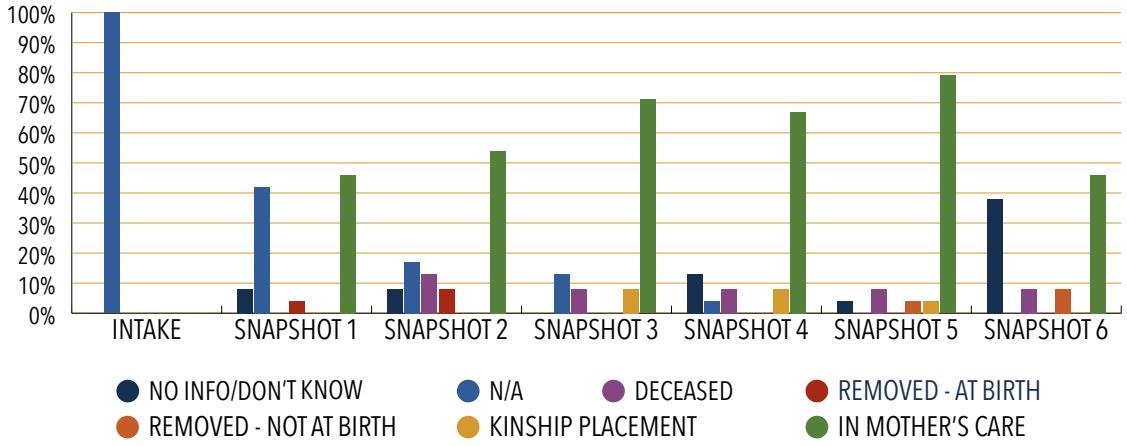
Child welfare status of focal infant over time, based on clients with 4 data points - **HerWay Home (*n*=48)**



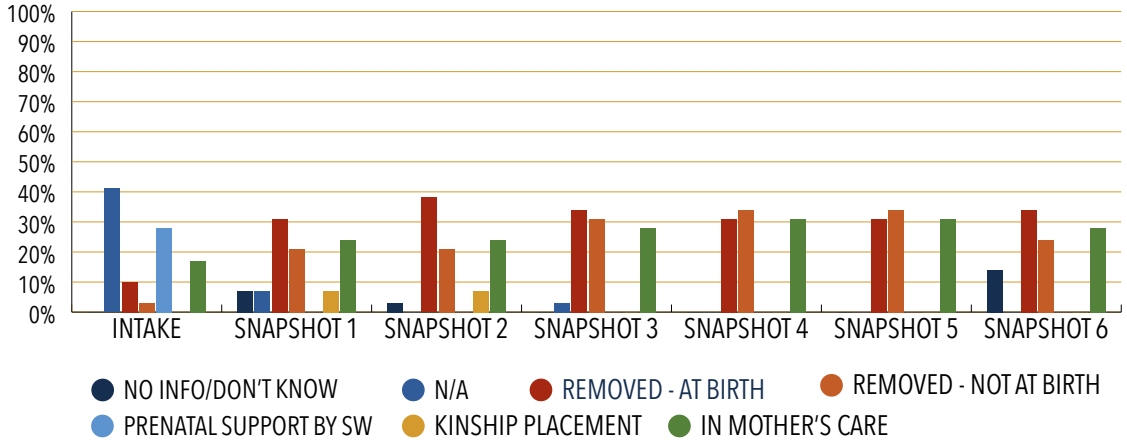

Child welfare status of focal infant over time, based on clients with 4 data points - **Sheway (*n*=196)**



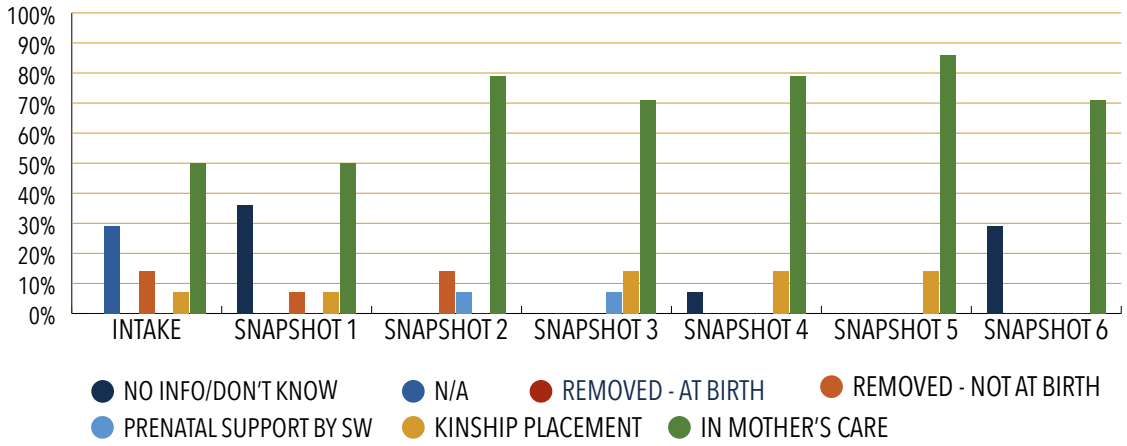
Child welfare status of focal infant over time, based on clients with 4 data points -
**Maxx Wright (*n*=24)**



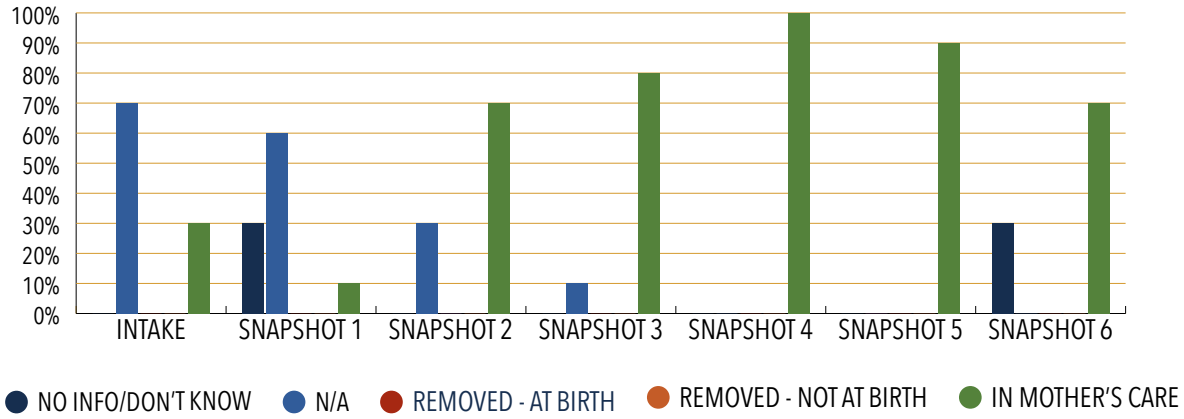

Child welfare status of focal infant over time, based on clients with 4 data points -
**Mothering Project (*n*=29)**



Child welfare status of focal infant over time, based on clients with 4 data points - **Breaking the Cycle (*n*=14)**



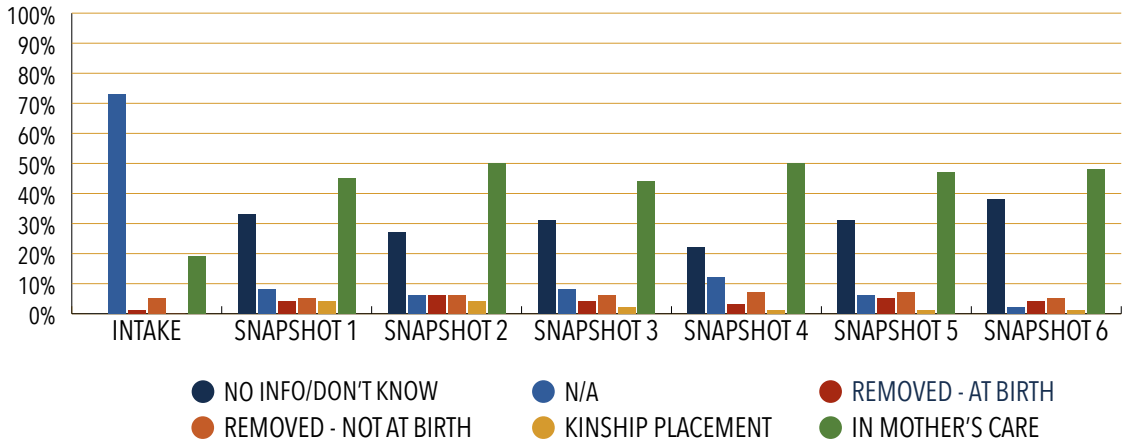

Child welfare status of focal infant over time, based on clients with 4 data points - **Baby Basics (*n*=10)**



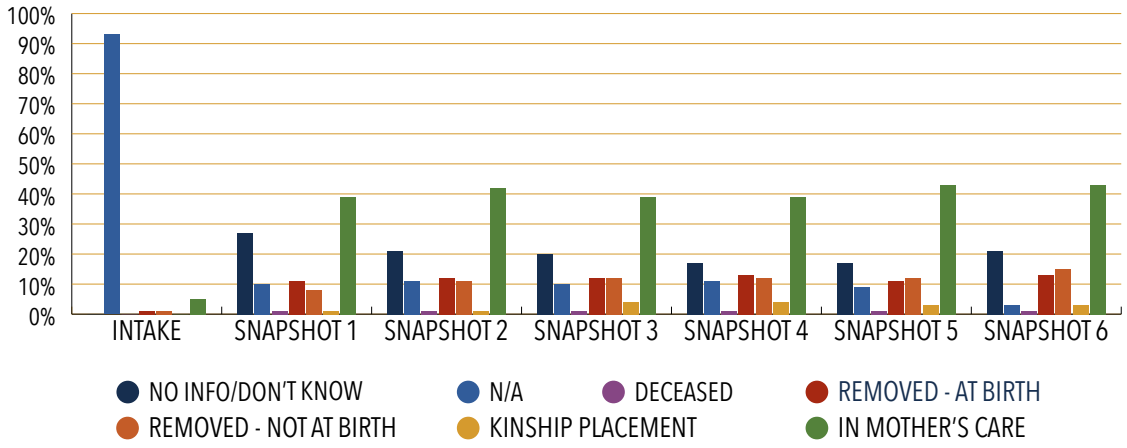
As with the other analyses, findings involving clients for whom there were at least two points of data (rather than four) generally showed a similar pattern – that is, increases in the number of infants in their mother's care, although the patterns of findings was not as strong as the findings involving clients with four or more data points, and in addition, there was a high percentage of clients wherein the infant's child welfare status was unknown.

In addition, as with the analyses based on four points of data, the pattern of findings was more evident at some programs (notably HerWay Home, Sheway, Breaking the Cycle and Maxx Wright), than others.

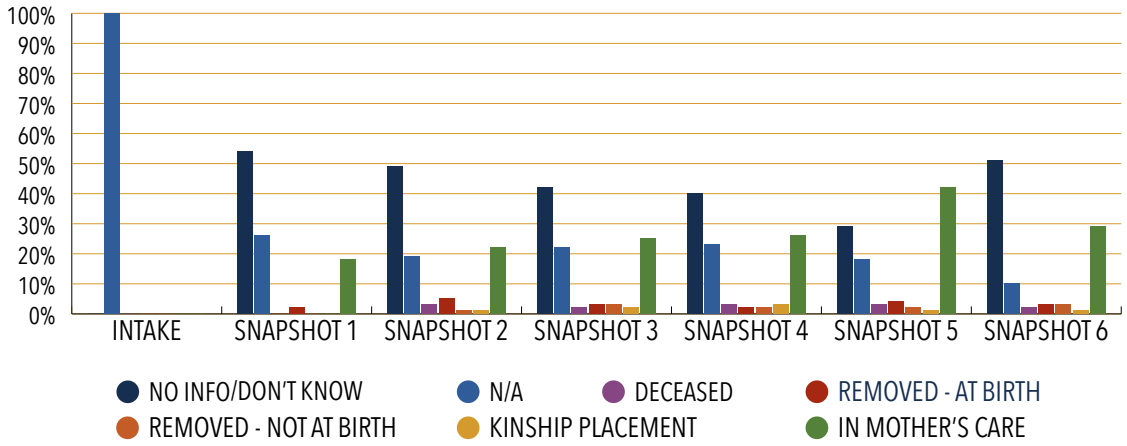
Child welfare status of focal infant over time, based on clients with 2 data points - **HerWay Home (*n*=109)**



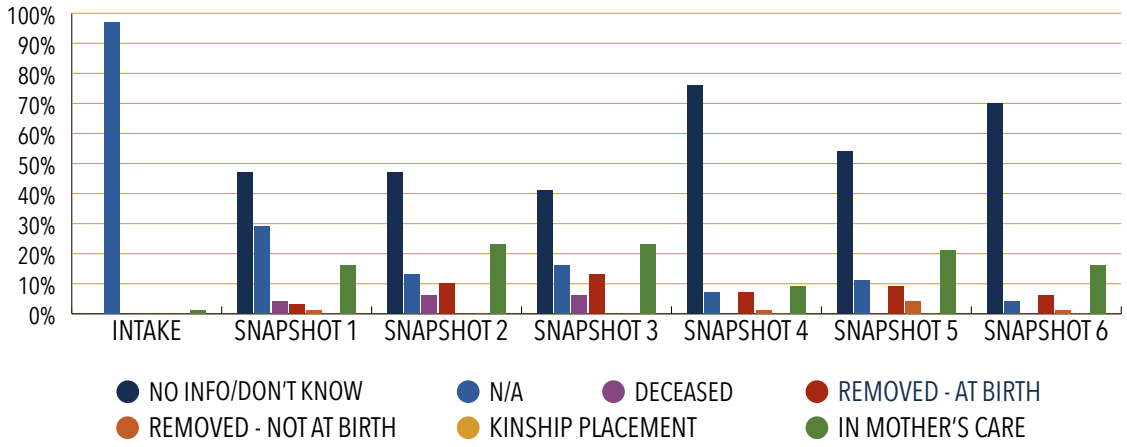

Child welfare status of focal infant over time, based on clients with 2 data points - **Sheway (*n*=307)**



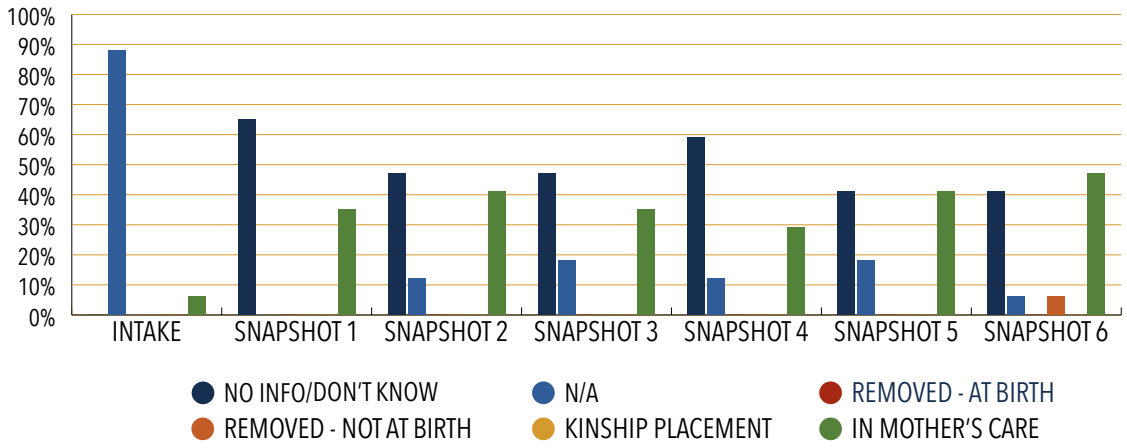
Child welfare status of focal infant over time, based on clients with 2 data points - **Maxx Wright (*n*=96)**



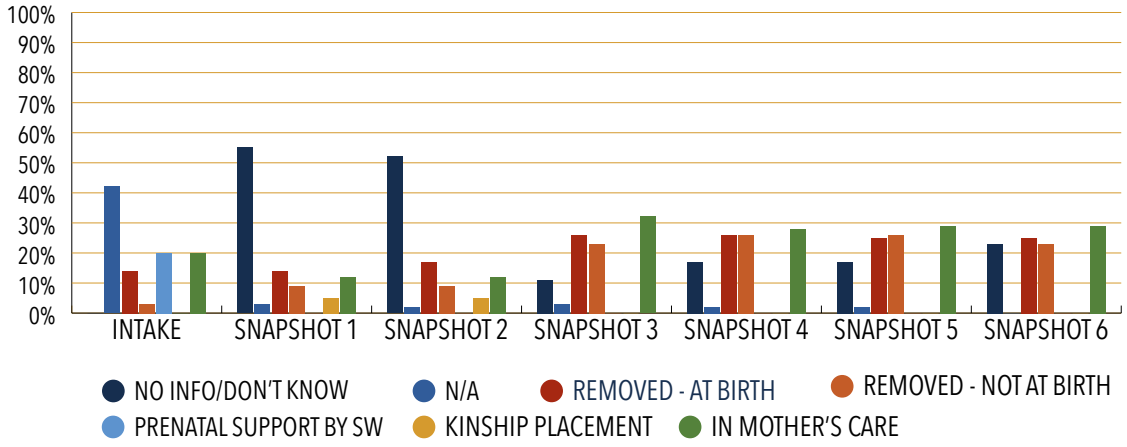

Child welfare status of focal infant over time, based on clients with 2 data points - **H.E.R. (*n*=70)**



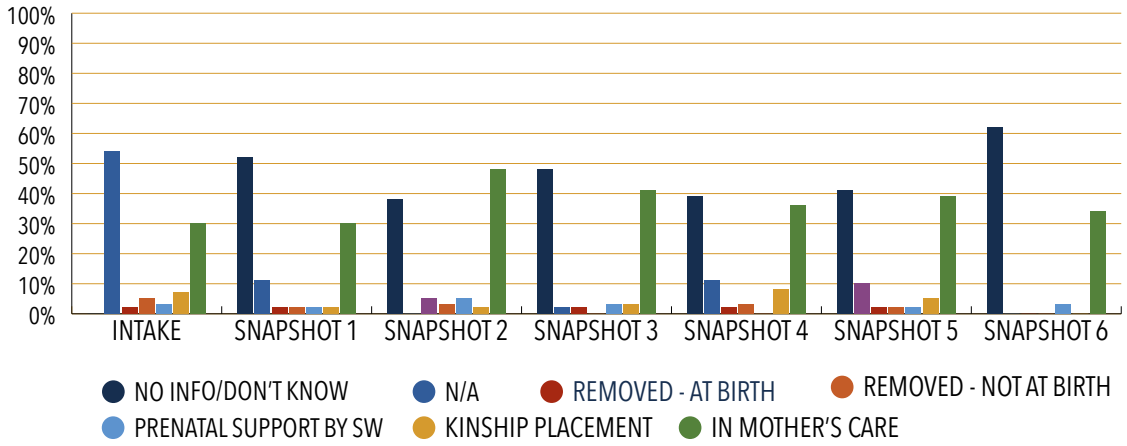
Child welfare status of focal infant over time, based on clients with 2 data points - **Raising Hope (*n*=17)**



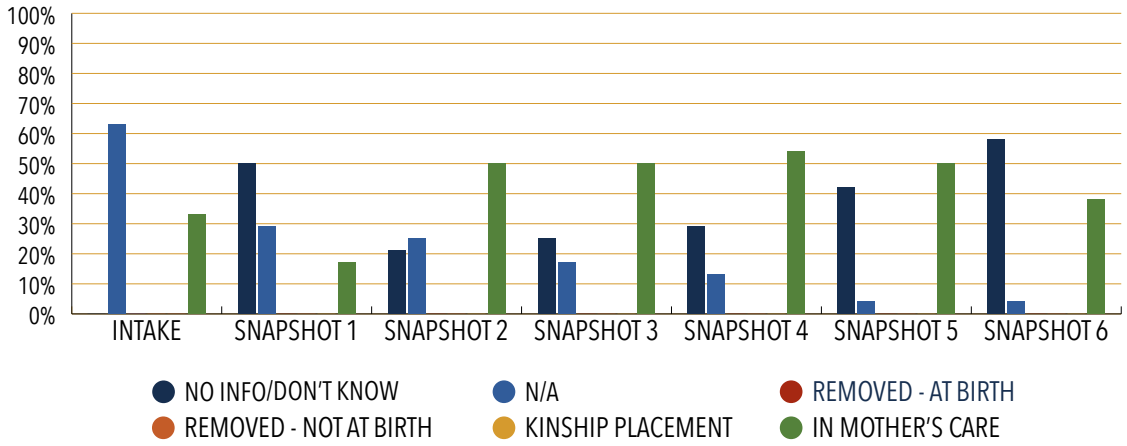

Child welfare status of focal infant over time, based on clients with 2 data points - **Mothering Project (*n*=65)**



Child welfare status of focal infant over time, based on clients with 2 data points - **Breaking the Cycle (*n*=61)**




Child welfare status of focal infant over time, based on clients with 2 data points - **Baby Basics (*n*=24)**



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Co-Creating Evidence

National Evaluation of Multi-service Programs Reaching Pregnant Women at Risk