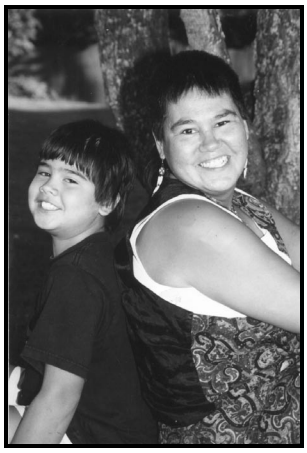
MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN

November, 2003

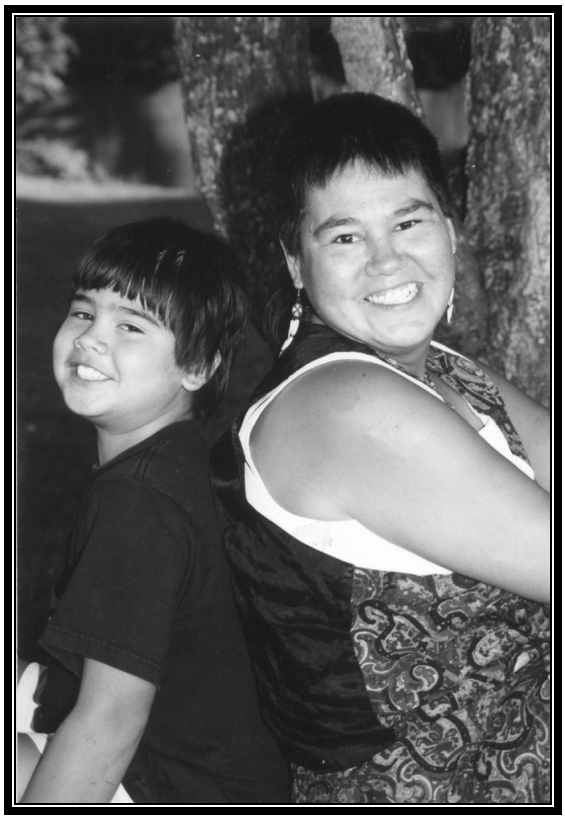


MAXXINE WRIGHT PLACE PROJECT
FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN

DEDICATION

This project, and the program which will follow from it, is dedicated to Maxxine Wright.

Maxx first came to Durrant Transition House, run by Atira Women's Resource Society in White Rock, British Columbia, in 1992, when her son was just three months old. Over the course of the next ten years, Maxx was involved with Atira Women's Resource Society as a resident, volunteer and for a short time as a member of the staff. For all of her life she struggled with issues of grief and loss related to the death of her mother when she was just a child and her subsequent separation from her biological family, a process that took place over the course of her childhood. Maxx died on July 27th, 2002, at the age of 39 after a brief battle with an aggressive form of breast cancer. She left behind her son who turned ten on the day Maxx died. Maxx's son is living in his ancestral territory with his maternal uncle, Herb Wright, and his auntie and two cousins – a reunification Maxx longed for herself all her life.



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This project would not have been possible without the tremendous interest, involvement and support from the Surrey High Risk Pregnancy and Early Parenting Planning Committee. These members are:

Janice Abbott, Atira Women's Resource Society
Zoe Ayre, Ministry of Children and Family Development
Lisa Chu, Fraser Health Authority
Shannon Courchene, Kla-how-eya (formerly Surrey Aboriginal Cultural Society)
Linda Djadidi, Atira Women's Resource Society, Koomseh Second-Stage Housing
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Jan Radford, Fraser Health Authority
Linda Syssoloff, South Fraser Community Services Society
Barb Wong, OPTIONS – Healthiest Babies Possible
Ping Yee, Surrey Memorial Hospital

Our sincere thanks to Lynda Dechief, the hard working Project Coordinator, for ideas, support and collaboration.

We appreciate all those Surrey community stakeholders who gave freely of their time to contribute ideas, thoughts and critical perspectives about the development of the program.

Most importantly, our gratitude and appreciation goes to the 25 women who agreed to participate in the project who are potentially the "proposed" target population. We hope that the project findings and the program that will be developed, provide real opportunities to improve and change "the way things are done".

Finally, we wish to thank the Status of Women Canada for their support of this research.

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EXECUTIVE SUMMARY

Surrey is the second largest city, in terms of population, in British Columbia, and is one of the fastest growing cities in Canada. It faces many major social issues, especially in North Surrey, including poverty, homelessness, lack of affordable housing, at-risk youth, single parent families, drug and alcohol use, absence of treatment facilities, visible sex trade and violence. The live birth rate in Surrey is 35% higher than the provincial average, and there is a disproportionately high population of children. Low birth weights in Surrey are 15% higher than the provincial average, and infant mortality rates are almost twice the provincial average and higher than the Downtown Eastside of Vancouver. High risk pregnant and early parenting women face enormous barriers to getting the care they need.

Responding to these issues, the beginnings of "an idea" for a high risk pregnant and early parenting women's program in Surrey emerged in the fall of 2002 with discussions among staff from Atira Women's Resource Society (Atira), Ministry of Children and Family Development (MCFD), and BC Centre of Excellence for Women's Health. A meeting was scheduled and a number of identified stakeholders with an interest in this area were invited to attend. The group became the Surrey High Risk Pregnant and Early Parenting Committee, a subcommittee of the Surrey Child and Youth Committee. Concurrent to the formation of this group, a high risk pregnancy program was identified as one service priority named at the Surrey Making Children First community consultation process. Subsequently, and on behalf of the Committee, Atira Women's Resource Society applied for, and received, funding from Status of Women Canada to develop a model for a "women's centred program for high risk, pregnant women". A consultant was hired to research and develop the model; a project coordinator was hired to apply for on-going funding and to ensure continued funding for the program after the model was developed. The project came to be known as the Maxxine Wright Place Project.

The overall work process of the Maxxine Wright Place Project involved:

- Reviewing the literature on high risk pregnant and early parenting women, and early intervention programs
- Developing statistics about Surrey
- Developing ideas about a model, discussing and testing them with key community informants, either individually or in focus groups
- Revising the model based on research findings and further discussions with Committee members who oversaw the project.

All the data was ultimately collected, analyzed and reviewed with the Committee, which accepted the proposed model and which will continue to oversee program implementation.

THE LITERATURE REVIEW

The Committee made a decision very early on that the program will include children up to the age of six and/or school entry, whichever came first. Therefore, we took a "best

practices" approach to explore what key principles and services might "fit" a Surrey program. We explored the literature about the lives of high risk women. And we looked at a range of existing programs to see what they might tell us about what works and what doesn't.

THE STATISTICS IN SURREY

We developed a picture of Surrey, through the lens of its statistics, in areas related to our major activity – creating a program model to respond to the needs of high risk pregnant and early parenting women and their children up to the age of six and/or school entry.

THE COMMUNITY CONSULTATIONS

The Committee identified a range of community service providers who might be interested in participating in a consultation process about the development of the proposed program model. We followed up with these providers to request their participation. As well, we wanted to obtain information from women who might be the "potential target client group" so a number of agencies requested permission from their clients to provide names to us. Once the women gave their approval to the agency, the researchers followed up directly with them. In total, 90 individuals were consulted through the research project.

The Project Coordinator held informal consultations with an additional 85 individuals.

THE PROPOSED MODEL

The literature review, the statistics review and the community consultations informed the development of the model.

We proposed a two-stage model of partnership: at the governance level are four or five collaborative partners which are the "core" partners; at the service, or program level, are service partners who contribute in kind to the core program.

GOVERNANCE: THE COLLABORATIVE PARTNERS

There are four proposed collaborative partners of the program: Atira Women's Resource Society, Fraser Health Authority, Ministry of Children and Family Development and OPTIONS. These are the four agencies that were commented on most frequently during the community consultations as being partners. There may be provisions for one or two more collaborative partners upon negotiation. The collaborative partners will fund the core of the program by contributing finances and staff.

We recommend the development of a legally binding agreement among the collaborative partners.

The collaborative partnership carries both the "governance" and some "management" functions. Each core partner's staff must work within the framework of the agreement in

order to provide a seamless and coordinated service to the women in the program. In addition, one of the core partners, OPTIONS, runs the Healthiest Babies Possible Program. This program, serving high risk pregnant women and their babies up to six months, is a logical program to co-locate in the same building.

And Surrey Women's Centre, that runs Stopping the Violence, Specialized Victims Assistance Programs, as well as a pro bono law clinic, clothing exchange and community kitchen, has indicated an interest in co-locating.

Both of these co-location possibilities add value to the offerings within the high risk pregnancy and early parenting program.

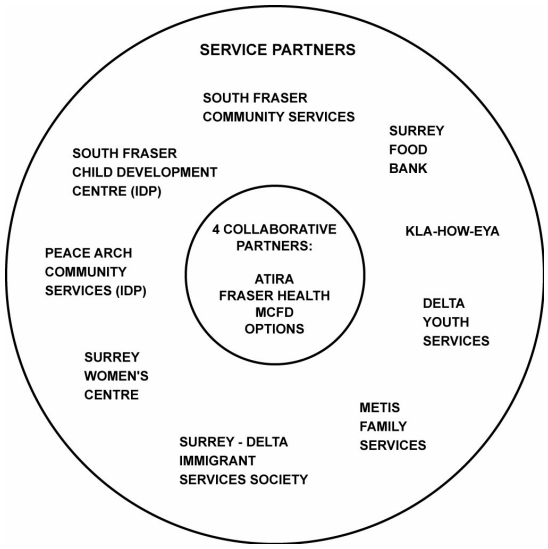
SERVICE PARTNERS

Service partners are envisioned as those agencies that, during the community consultations, indicated an interest in contributing services in kind and on site within Maxxine Wright Place.

The proposed service partners are: Kla-how-eya, Metis Family Services, Surrey Women's Centre, South Fraser Community Services Society, Surrey Food Bank, Peach Arch Community Services (IDP), South Fraser Child Development Centre (IDP), Surrey-Delta Immigrant Services Society and any others that want to contribute services to the program. The actual services they spoke about were: support groups, counselling, outreach, food contributions, etc.

The service partners, in conjunction with the collaborative partners and the Program Coordinator, will draft service agreements, including, but not limited to:

- Types of service to be provided
- Days of the week
- Space requirements



THE PROGRAM - WORKING ASSUMPTIONS

What became very clear in the community consultations is that many agencies and groups are available to provide services to the proposed target population. Yet, almost 50% of women we interviewed are not receiving, or accessing, these services. Thus, **the key focus of the program is not necessarily to provide new services but to provide coordinating and access functions to high risk pregnant women and their children up to school age and/or age six** so they receive a wide range of appropriate and existing services as soon as possible, and for as long as possible. As the program evolves, new programming might be jointly envisioned. Some key features of the program are:

1. The Target Population

"High risk pregnant and early parenting women" is broadly defined. The program will serve "at risk" women/girls who may put their fetuses/young children up to age six at risk due to their struggles with substance use, mental health diagnoses, experience of violence/abuse, reluctance in seeking medical attention/support services and/or socio-economic conditions.

Children up to the age of six and/or school age, whichever comes first, is included to ensure assistance navigating through confusing and multiple services for young children. As well, the literature is clear that early intervention programs offer the best way for children to get a "leg up" in terms of their development.

2. The Goals and Objectives

GOALS

The goal of the high risk pregnancy and early parenting program is to coordinate and provide pre- and post natal care to women who are least likely to access traditional medical resources and to coordinate and provide services to their children from birth to age six and/or school entry, whichever comes first.

OBJECTIVES

- Promote healthy birth outcomes
- Promote healthy early child development, learning and increase in school readiness
- Support women, children and their families
- Coordinate services to women, children and their families
- Build and maintain community partnerships
- Advocate on issues affecting high risk children, pregnant and parenting women.

3. "One-Stop-Shopping"

The program is envisioned as a **gateway** to services for high risk pregnant women and women with children up to the age of six. Women and their children will enter through the gateway where low barrier protocols exist (warm, welcoming environment, food, coffee, and child-friendly space). Core staff, from the four partners, will staff the site and will perform certain core functions.

Core functions of the program will include **relationship building**, an **intake/assessment,** a **"wraparound coordinator"/integration of services coordinator** who will take responsibility to bring together the various service providers with women receiving support in order to develop and monitor plans, and **a medical clinic**. Some of the **services** that could be provided on site are:

- Healthiest Babies Possible (co-location possibilities)
- Surrey Women's Centre services, such as Stopping The Violence, Specialized Victims Assistance, pro bono law clinic, clothing exchange, community kitchen (co-location possibilities)
- Public Health (e.g., pre, post-natal)
- Infant Development Program (outreach services up to age three)
- Medical doctors
- Food Bank (Tiny Bundles)
- Group work and/or counselling support from: Aboriginal Women's Outreach Program, Metis Family Services, Delta Youth Services (PACT), Kla-how-eya, South Fraser Community Services
- Daycare/playground
- Outreach services.

4. Hours of Work

Community consultations noted, without exception, that the hours of work must be flexible: open early, closed late, weekend services. This will be an expectation of both the collaborative partners and service partners.

5. Program Evaluation Framework: Developing an Evaluation Design

An evaluation framework is vital, including a database to be established at the outset of the program in order to collect data regarding the various outcomes. Implementation of a program evaluation framework also needs to mesh with a low barrier protocol for easy access to services. Some examples of expected outcomes to be included are:

- Increase in the number of high risk women receiving prenatal and postnatal care
- Increase in the number of children born with healthy birth weights

- Improvement in the developmental outcomes for high risk children
- Improvement in the nutritional status of high risk children, pregnant and parenting women
- Improvement in the housing situation for high risk children, pregnant and parenting women
- Improving parenting outcomes
- Decrease in rates of child removal by MCFD.

6. Program Location

Community consultations noted that the preferred location is in Surrey Central, near bus and skytrain lines: e.g., between 104th and 72nd; between King George Highway and 144th.

7. Core Staff

Core staff will be contributed by the identified collaborative partners. Although allocations and types of staff may evolve and indeed, grow over time, we recommend the following as the program commences:

1 FTE Administrative Support

- Functions: manages the site, orders supplies, uses computer for database, answers telephones

1 FTE Program Coordinator

- Functions: coordinates various service partners/programs, liaises with community and does community development, fundraising, coordinating staff with appropriate collaborative partners

1 FTE Alcohol and Drug Counsellor

- Functions: facilitates alcohol and drug counselling

1 FTE Social Worker

- Functions: liaises with MCFD social workers, coordinates services, provides individual and group counselling, outreach services
- This social worker will be from MCFD, but will not have delegated authority to remove children under the Child, Family and Community Services Act

1 FTE Nurse

- Functions: coordinates medical clinic, provides nursing services, provides individual and group counselling

8. Wish List

The community consultations highlighted several key components to be built into the program, if at all possible:

- Provisions of bus vouchers/transportation access
- Daycare availability and a playground on site
- More subsidized housing for women
- A van, and/or shuttle service.

CHAPTER I CONTEXT

The beginnings of "an idea" for a high risk pregnancy and early parenting women's program in Surrey emerged in the fall of 2002 with discussions among staff from Atira Women's Resource Society (Atira), Ministry of Children and Family Development (MCFD), and BC Centre of Excellence for Women's Health. Subsequently, a high risk pregnancy program was identified as one service priority named at the Surrey Make Children First community consultation process.

A meeting was organized, with invitees representing a broad range of interests and agencies from across the Surrey community, including Atira, MCFD, OPTIONS, Fraser Health Authority, Kla-how-eya (formerly Surrey Aboriginal Cultural Society), Child and Youth Committee, South Fraser Community Services Society, and Kwantlen College. The working group for the high risk pregnancy and early parenting women's program that came out of that meeting was a sub-committee of the Surrey Child and Youth Committee.

On behalf of the Committee, Atira submitted grant applications to Status of Women Canada and Making Children First, in Surrey, for research funding. Around the same time, the Atira Executive Director met with the Minister of MCFD to request seed money and a capital grant for the project. All these applications were subsequently approved.

The Committee contracted with an action researcher to research and develop a women–centred program model in April, 2003; a month later, the Committee hired a Project Coordinator.

Between April and October, 2003, the researcher focused on the terms of reference of the research component of the project (see below) and completed a literature review, obtained pertinent statistics for the program development, completed community consultations, and worked with the Project Coordinator to develop the program model.

The Project Coordinator initiated a community development process to build support for the project, including meeting with individuals and groups, as well as reviewing building sites for the project, developing of workshops, writing funding proposals and working directly with women with young babies.

In October, 2003, the Committee chose the name of the project to be the Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women.

In November, 2003, the researcher presented a proposed model for discussion and decision by the Committee, which was accepted.

This report summarizes the work performed on the research component of the Maxxine Wright Place Project. It is presented in several parts.

The first chapter, Context, summarizes the history of the project, terms of reference, and methodology.

The second chapter, Literature Review, reports on "best practices" in high risk pregnancy and early parenting and early intervention programs in British Columbia and beyond.

The third chapter, Surrey Statistics, reports on statistics that identified the needs of women and children for this program, and for Surrey generally.

The fourth chapter, Community Consultation, reports on the consultation process undertaken in the Surrey community, about the proposed program.

The fifth chapter, Proposed Model, suggests a model to be implemented in the Surrey Community.

Final sections contain bibliography and interview guidelines.

I. TERMS OF REFERENCE

The Request for Expression of Interest (April 21, 2003) sets out the Consultant's role for the project.

- Conduct a literature review
- Consult with women who might have used or might use the services provided by this new project
- Consult with a variety of professionals, including, but not limited to, doctors, nurses, social workers, nutritionists, etc., working in this or similar areas
- Consult with women working with women who might have used or might use the services provided by this new project
- Liaise with other high risk pregnancy and early parenting programs
- Develop a comprehensive and detailed written program model, based on the results of the literature review, interviews as above and other research.

Added to the terms of reference after discussion between the Committee and the researcher was a review of statistics in Surrey, pertinent to the subject matter, to further inform the development of the program.

II. RESEARCH METHODOLOGY

This project utilized action research methods. Doing action research offers the opportunity to check assumptions and build strategies for action/change based on the perspective and experience of those being interviewed or spoken with.

The overall work process involved:

- Reviewing the literature on high risk pregnant and early parenting women, and early intervention programs
- Developing statistics about Surrey
- Developing ideas about a model, discussing and testing them with key community informants, either individually or in focus groups
- Revising the model based on research findings and further discussions with Committee members who oversaw the project.

All the data was ultimately collected, analyzed and reviewed with the Committee, which accepted the proposed model and will continue to oversee program implementation.

CHAPTER II LITERATURE REVIEW

Since we knew we wanted to have a Surrey program that focused on high risk pregnant and early parenting women, and since we knew we wanted the program to include services for children up to the age of six or school entry, whichever came first, this narrowed our literature review to those areas. We took a "best practices" approach to explore what key principles and services might "fit" a Surrey program. We explored the literature about the lives of high risk women. And we looked at a range of existing programs to see what they might tell us about what works and what doesn't. This literature review, then, is divided into the following sections:

- Service philosophies
- Lives of high risk mothers
- Need for comprehensive services
- Cultural competence
- Fetal alcohol spectrum disorder
- Effects of prenatal drug use
- Drug and alcohol treatment
- Early childhood interventions
- Home visitation programs
- Other programs in British Columbia and across North America and Britain.

I. SERVICE PHILOSOPHIES

Many agencies that provide services to pregnant and parenting substance-using women adopt a feminist, woman-centred, harm reduction approach. A feminist approach: (Abbott, 1994)

- Recognizes and accommodates difference, celebrates diversity.
- Acknowledges oppression and disempowerment of clients.
- Is non-oppressive and encourages client empowerment.
- Eliminates "power over".
- Ensures equal access.
- Recognizes interrelatedness between client, family, community and society.
- Recognizes the power of relationships.
- Acknowledges the role of economic and emotional insecurity in drug use and treatment.

The British Columbia Centre of Excellence for Women's Health recognizes the following aspects of women-centred care: (BCCEWH, 1997, published in BCCEWH, 2002)

- Participatory - women have authority on their own lives.
- Empowering - women have the right to control their own bodies.
- Respectful of diversity.
- Safe - emotionally, physically, spiritually and culturally; takes into consideration the likelihood of women's experience of violence.
- Holistic - avoids unnecessary medicalization.
- Comprehensive - collaboration and partnering across health sectors and professions.
- Individualized - takes into consideration the unique experiences of each woman.
- Focused on social justice.

Additional aspects of women-centred care include: (Buchwitz, 2001, cited in MCFD, 2003)

- Recognizing and building on a woman's existing strengths.
- Recognizing that women use many strategies to keep themselves and their children safe.
- Developing a trusting and respectful relationship.
- Respecting women's ability to make choices within legal limits.
- Empowering women through collaborative decision-making, respecting choices, sharing knowledge and information.
- Providing services that are accessible from the perspective of the woman.
- Respecting cultural diversity and recognizing that all forms of marginalization affect women's experiences and may limit options.
- Countering stereotypes about violence and specific groups.
- Providing interpretation services that allow safe discussion about her experiences.
- Supporting 'solutions' that respect and account for women's cultural and religious values.
- Building resources with women and the larger community.
- Engaging in collaborative approaches to ensure coordinated community responses to end violence against women and their children.

The Children & Women's Health Centre of British Columbia (CWHCBC) lists the following guiding principles in caring for substance-using women and their newborns: (CWHCBC, 1999)

- Harm reduction approaches are encouraged.
- Optimal care is consistent with integrated case management, as outlined by the BC Ministry of Children and Family Development (MCFD).

- Non-judgmental attitudes among treatment staff are essential, as guilt and shame about substance use, along with fear of child apprehension, are the biggest barriers to seeking treatment.
- Referrals to appropriate community resources.
- There is a plan in place to address any child protection concerns.
- Preserving the mother-infant pair whenever possible is valuable.
- Women must be fully informed of their choices and rights at all steps in the process.

CWHCBC advocates early planning and coordination of the woman's health care team, family members, community-based resources, and MCFD. Self-referral to MCFD is encouraged to facilitate service delivery prior to delivery, as well as discharge planning after birth.

Prior to birth, the fetus is not considered a child or person under federal or provincial law. Thus, there is no legal requirement to report risk of harm to MCFD. Rather than "policing", many experienced practitioners believe the best chance of reducing risk for the mother and baby is to work in partnership with the mother, enhancing her capacity to control substance use and access the supports she needs (CWHCBC, 1999).

In working with substance-using mothers, there is often conflict between women-centred interests, and child protection interests. The societal emphasis on prenatal health, as opposed to women's health, leaves women with the message that their reproductive value far outweighs their value as individuals (Greaves et al., 2002).

The result of this conflict are women who do not access available treatments and services, fearing that admission of drug and alcohol use will result in apprehension of their children (Poole & Isaac, 2001; Namyniuk et al., 1997; Finkelstein, 1994). However, fear of child apprehension can also be a major motivating factor for seeking drug and alcohol treatment (Howell & Chasnoff, 1999; Poole & Isaac, 2001). Programs must address the often adversarial relationship between child-focused and mother-focused providers and services. This conflict can be minimized by viewing the mother-child dyad as the client (Howell & Chasnoff, 1999).

Child protection and women-centred approaches need not be seen as oppositional, but rather as common goals: "a child's safety and well-being are, in fact, [usually] dependent on the mother's safety. Creating safety for children requires communities to respond to eliminate the risks which children and their mothers face… Most women care deeply about their children's safety and go to great lengths to protect them from physical assaults, other risks and from the systemic harms of poverty, racism and isolation… [Women] are often very resourceful and have usually attempted to find support for themselves and their children. Unfortunately, the systems are not always in place to support women and their children" (MCFD, 2003). Alcohol and drugs are often used by women as coping mechanisms, in the absence or failure of more constructive supports.

Removing a child from his or her mother may be safer in the short or medium term, but long-term risks must be considered as well. Severing or weakening the maternal-child bond may leave the child with substantial long-term issues to resolve (Greaves et al., 2002).

II. LIVES OF HIGH RISK MOTHERS

A survey of Breaking the Cycle, a program designed for pregnant and parenting substance-abusing women and their young children in Toronto, found that of 120 client families: (Leslie et al., 1999, cited in Roberts & Nanson, 2000)

- More than 25% had no permanent residence.
- The majority of mothers did not have any other adult support available in the home.
- 75% of mothers were single, separated, divorced or widowed.
- The average educational level attained was Grade 10.
- Most women were unemployed and had annual incomes less than $15,000.
- Almost half (43%) reported legal problems.
- The majority reported serious emotional problems.
- Between 10% and 50% of all mothers attending the program were abusing substances at intake.

Similarly, a recent survey of Sheway (an agency serving pregnant and parenting substance-using women in the Downtown Eastside neighbourhood of Vancouver) indicated very high rates of the following client problems: (Marshall et al., 2003)

- Homelessness or inadequate, unsafe housing.
- Poverty.
- Inadequate nutrition.
- Prostitution.
- Sexually transmitted disease, especially Hepatitis C.
- Medical concerns.
- Mental illness.
- Family violence.
- Drug, alcohol and cigarette addiction.
- Apprehension of children by MCFD.

A study of 80 mothers of children with fetal alcohol spectrum disorder (FASD) indicated that 80% of the mothers had major mental illnesses, 100% had been sexually, physically or emotionally abused, 80% lived with men who did not want them to stop drinking, and 60%

had phobias, most commonly agoraphobia, making them afraid to leave home and seek help (Clarren, 1999).

Poor women and women of colour face a greater probability of having their children apprehended if they use drugs or alcohol while pregnant. Women who abuse drugs while pregnant face severe consequences, which include becoming stigmatized as immoral and deficient care givers (Carter, 2002).

Substance-abusing women are very likely to have experienced physical and/or sexual abuse (Howell & Chasnoff, 1999; Janssen et al., 2003). Of women treated at Peardonville House, an addiction treatment centre in Abbotsford, BC, 85% have been in violent relationships and approximately 95% are survivors of sexual abuse (Ellis, 1995). “Intimate partner violence appears to be associated with reduced ability to decrease or discontinue use of substances in pregnancy” (Janssen et al, 2003).

21% of Canadian women who reported being abused by an intimate partner said they were abused during pregnancy (Rodgers, 1994, cited in Janssen et al., 2002). A recent Vancouver study indicated that of women abused before pregnancy, 70% continued to be abused during pregnancy (Janssen et al., 2003). Women abused during pregnancy are more likely to experience antepartum hemorrhages, preterm labour, preterm delivery, intrauterine growth restriction and perinatal death. The rate of perinatal death is 7.3 times greater for abused women than for women who are not physically abused during pregnancy (Janssen et al., 2003).

Substance-using mothers may experience social isolation, physical health problems and serious parenting issues (Covington, 1999; Marcenko and Spence, 1995; Halfon et al., 1993). As a result of their own difficult childhoods, they may have few positive parenting role models (Camp & Finkelstein, 1997). There is evidence that many women who use alcohol and drugs during their pregnancies are themselves victims of FAS (Rouleau et al. 2003), and may exhibit depression, learning disabilities, limited education, and mental health issues.

III. NEED FOR COMPREHENSIVE SERVICES

It is crucial to design programs around the reality that pregnant, substance-using women often have a myriad of risk factors in their lives, and very often do not have the resources or ability to access and coordinate services from several different agencies.

A recent survey of 1250 new mothers in Ontario indicated that many mothers are not fully aware of community-based services available to meet the needs of their newborns and themselves (Sword et al., 2001). As many as 16% of mothers are clinically depressed within four weeks of hospital discharge, highlighting the need for postnatal attention and support, even in cases where a mental health problem is not immediately identified. Post-partum depression is strongly linked with a lack of social resources and adequate income.

Issues associated with infant hospital readmissions, emergency room and walk-in clinic use include poor maternal health, and perceived inadequate help and support at home. Topics identified by new mothers as required post-discharge education include: signs of illness in infant, infant care and behaviour, physical changes and self-care, breastfeeding, emotional changes, community supports and services (Sword et al., 2001).

The Children's and Women's Health Centre of British Columbia identifies the following comprehensive list of interventions: (CWHCBC, 1999)

- Prenatal care.
- Drug rehabilitation training.
- Nutritional support.
- Social services support.
- Prenatal and parenting classes.
- HIV/STD prevention strategies.
- Well baby care.

The Dena A. Coy program in Alaska is based on the philosophy that treatment must consider every facet of a woman's life to be effective in helping her attain her goals. The program includes self esteem classes, anger management programs, parent education, long-term therapy, substance abuse education, counselling and treatment, full medical services, connections and referrals to community social services, life skills classes on topics such as money management, personal care and meal preparation, daycare, transportation, advocacy on legal issues, literacy programs, diploma courses, college preparation courses, and aftercare referrals (Namyniuk et al., 1997).

IV. CULTURAL COMPETENCE

Surrey is an extremely diverse community: 36.7% of Surrey residents are visible minorities. The largest minority populations are South Asian (primarily Indian and Pakistani) (21.9%), Chinese (4.8%), Filipino (3.0%) and Aboriginal (2.0%) (Statistics Canada, 2001).

While there is agreement about the need for culturally competent services, there is little consensus about how to provide such care (Bowen, 2002). The focus has shifted from culturally competent providers to culturally competent systems of care and organizational change.

A recent study of pregnant substance abusers in Massachusetts revealed significant differences in the age range, education, religion, living situation, type of supportive relationships, abuse history, patterns of substance abuse and psychiatric problems between groups of White, Hispanic and African American women (Argeriou and Daley, 1997). While the exact findings of this study have little relevance to the Lower Mainland of BC, they do highlight the need to tailor programs to individual circumstances, which may vary

largely depending on the woman's racial and ethnic identity. Cultural competence depends on understanding the elements of a client's culture, which shape her attitudes and behaviours regarding herself, her partner and children, and her family of origin (Trepper et al., 1997).

First Nations women relate the following invalidating experiences in the Canadian mainstream healthcare system: (Browne et al., 2000)

- Having their health care concerns trivialized or dismissed by health care providers.
- Feeling the need to transform their appearance or behaviour in order to receive good service.
- Being subjected to negative stereotypes about Aboriginal women.
- Feeling marginalized, as an "outsider".
- Feeling vulnerable, ashamed, embarrassed, exposed.
- Lack of consideration for their personal circumstances.

Conversely, First Nations women cited the following affirming health care experiences: (Browne et al., 2000)

- Actively participating in their own health care decisions.
- Feeling genuinely cared for.
- Affirmation of personal and cultural identity.
- Development of a positive, long-term relationship with a health care provider.

Aboriginal residents of Vancouver's Downtown Eastside neighbourhood identify Aboriginal caregivers and traditional Aboriginal healing and health practices as important to them. Lack thereof is a criticism of existing healthcare agencies in this neighbourhood. (Benoit et al., 2003).

For non-Aboriginal ethnic minority women, accessing mainstream services is complicated by issues of language, culture, identity, class, community barriers, immigration issues, lack of awareness of existing services, and the pressures of everyday life (Preisser, 1999). Asian women are much less likely than other racial and ethnic groups to access services (Bauer et al., 2000; Lee & Au, 1998; Rimonte, 1989; cited in Bui, 2003). Unequal access has been attributed to stereotyping and racism from health service staff, lack of understanding of cultural differences, fear that contact with authorities will jeopardize immigration status or child custody, and communication difficulties. Language support has been identified as the single most important issue, since communication difficulties have negative implications for all aspects of care (Bulman & McCourt, 2002). As a result of social isolation, patriarchy, language difficulties, lack of education and immigration status, women may be unaware of resources available to them.

Asian cultural traditions emphasize family privacy, and prohibit any "loss of face" for oneself or one's family. This often prevents women from seeking help outside the family (Dasgupta & Warrier, 1996; Rimonte, 1989; both cited in Bui, 2003; Chew-Graham et al., 2002). The extended family structure of South Asian families ideally serves as stability and support, but may also serve as a barrier to a woman seeking outside help (Preisser, 1999). Family honour is given precedence and preference over the care and happiness of women and children in some families. Women are often coerced into remaining silent about their problems, preventing other community members from listening and getting involved (Chew-Graham et al., 2002). As a result of cultural prohibitions against outside intervention, services may be accessed only at a point of desperation, rather than prior to crisis points. This indicates the need for services to be able to respond rapidly when Asian women do ask for help (Chew-Graham et al., 2002).

South Asian women may feel more secure and comfortable disclosing abuse to individuals of their culture. Women may fear going to mainstream agencies, based on the perception that they would lack understanding of their cultural, ethnic, linguistic and immigrant issues (Preisser, 1999). On the other hand, many South Asian women prefer non-Asian service providers, feeling their personal information and circumstance is less likely to become known in their community. There is tremendous fear of having one's personal problems exposed in tightly-knit South-Asian communities (Chew-Graham et al., 2002). Many South Asian women mistrust all services, fearing familial and community repercussions of breaches of confidentiality.

For many Asians, the Western model of therapy and counselling is problematic and seen as intrusive. The Western model of a counsellor as independent and separate from the client clashes with the Asian understanding of interdependence between the client, counsellor and community (Preisser, 1999).

Suggestions for improving services for Asian women include: (Chew-Graham et al., 2002)

- Explicitly acknowledging the impact of systemic issues on mental distress.
- Recognizing different ways in which Asian women might communicate mental distress (for example, self-harm).
- Being alert to the fact that Asian women may access services at crisis point, and therefore, require a rapid response.
- Providing information and advice to address external pressures; for example, benefits, children's issues, education and employment.
- Gathering good-quality information about domestic violence services targeted at Asian women.
- Emphasizing confidentiality, and providing safe and secure services for Asian women to access one-to-one support.
- Monitoring, evaluating and reviewing interpreter provision in relation to access to health service provision for Asian women.

- Face-to-face promotion of services, in a variety of languages and formats, to Asian individuals, groups and organizations.
- Providing first-language services to Asian women to overcome barriers to interpreter provision.
- Developing facilitated self-help groups for Asian women.
- Effective partnership working with specialist organizations committed to providing support to Asian women (for example, Asian women's refuges).

With all minority clients, service providers need to carefully consider the degree of acculturation that the client has undergone in the mainstream culture, and the type of ethnic identity that the client has developed (Preisser, 1999).

V. FETAL ALCOHOL SPECTRUM DISORDER (FASD)

While there is much unknown about the long-term effects of fetal exposure to drugs and alcohol, the consensus appears to be that exposure to alcohol is much more damaging than in-utero drug exposure.

Initially, [FASD] programs often need to work with caregivers on methods to calm the child and address failure to thrive (Olson & Burgess, 1997, cited in Roberts and Nanson, 2000). Programs are required to help parents come to terms with the FASD diagnosis, make the best use of services, increase parental knowledge of pertinent factors in the growth and development of their child, and learn skills to promote their child's growth (Niccols, 1994, cited in Roberts and Nanson, 2000).

Medical issues that require attention for FASD-affected children include screening for visual, hearing and speech difficulties. Early language stimulation, attention to speech development, and facilitation of fine-motor and perceptual organization have been suggested as useful interventions at the preschool age (Phelps & Grabowski, 1992, cited in Roberts & Nanson, 2000).

FASD-affected children that fare best are those living in a stable, nurturing home, not subjected to frequent changes of household, or victimized by violence. (Streissguth et al. 1996; Wiener and Morse, 1994, both cited in Roberts and Nanson, 2000).

Suggested intervention themes for older preschool alcohol and drug-affected children include attachment security, dealing with transitions, expressing feelings and needs, verbal self-regulation and nutritional, medical and developmental assessment and appropriate therapy (Roberts and Nanson, 2000).

Health Canada advises the following best practices for early childhood intervention of FASD-affected children: (Roberts and Nanson, 2000)

- The use of a professional, multidisciplinary team to address the range of complex health needs of affected children.

- Longer-term, stable living environments contribute to more positive outcomes for children affected by alcohol in utero. This may be facilitated by family-centred substance abuse treatment, respite care and other support services, and FAS-specific information and training for birth, foster and adoptive parents.
- Childcare programs should have a low staff-child ratio, follow structured routines and regulate the amount of stimulation received by the child.
- A single point of access which combines services for the mother with attention to the developmental needs of the child.
- Early educational interventions may contribute to improved outcomes, at least in the short term.

Streissguth et al. (1996) have identified eight main secondary disabilities of FASD. These are problems that may develop if a FASD-affected child does not receive the required supports and interventions. Secondary FASD disabilities include:

- Mental health problems.
- Disrupted school experience.
- Trouble with the law.
- Confinement (in mental hospital, prison or drug & alcohol residential treatment programs).
- Inappropriate sexual behaviour.
- Drug and alcohol problems.
- Dependent living over 21 years.
- Problems with employment.

Protective factors, which are almost universally protective against all FASD secondary disabilities include, in order of strength: (Streissguth et al., 1996)

- Stable and nurturing home.
- Diagnosis before the age of six.
- No exposure to violent abuse.
- Remaining in individual living situations at least 2.8 years.
- Experiencing a good quality home from age eight to 12 years.
- Eligibility for disability services.
- Diagnosis of FAS rather than FAE.
- Having basic needs met.

Adults with FASD tend to have problems with impulsivity, attention, poor judgment, difficulty in recognizing and setting boundaries, social-relationship problems, decision-making and higher-order skills, such as time and money management (LaDue et al., 1992

in Roberts and Nanson, 2000). As a result, frequently required programs, such as substance abuse treatment, employment training, mental health therapy, and parenting classes, need to be tailored accordingly to the capacity of individuals affected by FASD (Roberts & Nanson, 2000).

VI. EFFECTS OF PRENATAL DRUG USE

Children exposed to drugs in-utero are likely to have been exposed to alcohol as well (Roberts & Nanson, 2000). Drug addiction rarely occurs in isolation from additional risk factors such as poverty, abuse, smoking, alcohol and polydrug use, inadequate nutrition and health care, disease, mental illness, stress and homelessness. As a result, it is very difficult to unravel the effects of individual substances, and much remains unknown.

Cocaine use during pregnancy leads to lower birth weight, smaller head size, increased risk of bleeding in the brain, tremors, high-pitched cry, floppiness or stiffness in muscles, irritability, feeding problems, difficulty paying attention, stress, and an increased risk of SIDS (Children's and Women's Health Centre of British Columbia, 2003).

However, early reports may have exaggerated the long-term harm associated with cocaine use during pregnancy (Humphries, 1999, cited in Flavin, 2002). Studies have found small or no effects on physical growth, cognition, language skills, motor skills, behaviour, attention, affect and neurophysiology. However, other reports indicate cocaine-exposed infants are at increased risk of learning and behavioural disabilities (CWHCBC, 1999).

Heroin use during pregnancy may lead to: (Deren, 1986; Doberczak et al. 1988; Hans 1998; all cited in CWHCBC, 1999)

- Intrauterine growth restriction
- Decreased birth weight
- Decreased head circumference
- Increased risk of SIDS.

VII. DRUG & ALCOHOL TREATMENT

Harm reduction at any stage of the pregnancy is effective: "while structural damage resulting from earlier consumption cannot be undone, abstinence or reduction of consumption of alcohol, as late as in the third trimester, has been shown to increase the viability of the fetus" (Jones and Chambers, 1998, cited in Roberts & Nanson, 2000).

Unfortunately, treatment programs are often geared to the needs and experiences of men, and do not accommodate the special needs of women, much less pregnant or parenting women (Namyniuk et al., 1997). For example, 12-step programs which instruct participants to "hand over their power" are often problematic for women (Ellis, 1995) due to their disempowering, anti-feminist stance. In addition, childcare is an enormous barrier; women require childcare while they are attending outpatient services, and they need

residential programs that provide living space and services for their families, not just themselves.

A federal study found the most common reasons women give for not seeking substance abuse treatment include: (Astley et al., 2000, cited in Roberts & Nanson, 2000)

- Did not want to give up alcohol (87%).
- Afraid they would lose their children (42%).
- No childcare available/affordable (40%).
- Partner did not want them to go into treatment (39%).

A Vancouver study found the most common barriers to drug and alcohol treatment cited by women were: (Poole & Isaac, 2001)

- Shame (cited by 66% of study participants).
- Fear of losing children if they identified a need for treatment (62%).
- Fear of prejudicial treatment on the basis of their motherhood/pregnancy status (60%). "…women do not seek prenatal care [or drug and alcohol treatment] in an effort to avoid the judgment and stigma associated with using drugs while pregnant (Flavin, 2002).
- Feelings of depression and low self-esteem (60%).
- Belief that they could handle the problem without treatment (55%).
- Lack of information about what treatment was available (55%).
- Waiting lists for treatment services (53%).

Women cite the following supports that facilitate treatment: (Poole & Isaac, 2001)

- Support provided by wide range of professionals (cited by 77% of study participants).
- Supportive family members (68%).
- Supportive friends and acquaintances in recovery (47%).
- Children as motivation to seek treatment (47%).
- Effective drug and alcohol treatment programs (32%).

Common themes in successful treatment programs for women are: (Roberts & Nanson, 2000)

- Respectful service philosophy, which shifts away from stigma, blame, confrontation and shame, and towards an empowering and strengths-based approach.
- Comprehensive and practical care.

- Interagency collaboration and coordination of services. Barriers that need to be overcome include elements of programming housed in different locations, programs having separate regulations, long wait-lists for services, differing intake procedures and eligibility requirements.
- A broad and flexible continuum of substance abuse services, including outreach, case management, attention to family issues, and continuing care or aftercare.

Heroin-using women have identified a hierarchy of strategies they use to reduce harm to their children: (Richter & Bammer, 2000)

- Stop using completely.
- Go into treatment, especially methadone maintenance treatment for dependent heroin use.
- Maintain a stable small drug habit.
- Shield children from drug-related activities.
- Keep the home environment stable, safe and secure.
- Stay out of jail.
- Place children with a trusted caregiver and maintain as active a parental role as possible.

The relative risk of death is 63 times higher for heroin addicts compared to matched controls. The relative risk drops to eight for methadone users (Grondblah et. al. 1990, cited in CWHCBC, 1999). Advantages of methadone substitution during pregnancy are the following: (Payte & Zweben, 1998; Finnigan, 1991; Kaltenbach et al., 1998, all cited in CWHCBC, 1999; Ward et al, 1998, cited in Roberts and Nanson, 2000).

- Improved prenatal care.
- Improved nutrition.
- Decreased incidence of maternal withdrawal symptoms.
- Engagement of woman into drug and alcohol treatment.
- Decreased criminality and sex trade work.
- Decreased injection drug use, leading to decreased risk of blood born infections such as HIV and Hepatitis C.
- Decreased incidence of prematurity.
- Decreased infant mortality.
- Increased birth weight, and longer gestation.
- Increased infant head circumference.

The disadvantages of methadone use are: (CWHCBC, 1999)

- Neonatal withdrawal (CPS, 1999, p.1289). Methadone may produce more prolonged neo-natal abstinence syndrome (NAS) than heroin. (Finnigan, 1991).
- Though better than heroin, methadone produces a trend toward lower birth weight, smaller head circumference, and minor developmental delays (Hans, 1998; Rosen, 1982).
- Increased risk of SIDS (higher than heroin).
- Methadone is passed to the baby in breast milk, but research indicates there are minimal adverse affects associated with breastfeeding while on methadone maintenance therapy (McCarthy & Posey, 2000).

Alcohol and drug treatment compliance is maximized for mothers who have received previous substance abuse treatment, and whose partner has received previous substance abuse treatment (Clark et al., 2001). Women who live with partners who also use substances are less likely to seek treatment, compared with women whose partners are substance free (Smith, 1992). Women without prior treatment experience may be afraid of what treatment actually entails. Partners with previous treatment experience may be more supportive of a woman's efforts to remain drug-free.

Relationships with male partners may be either supportive or negative; many women involved in the sex trade are encouraged by their male partners to continue to use drugs and earn money through prostitution. Such men use drug dependence as a means of controlling their partners (Howell & Chasnoff, 1999).

Ethnic minorities and women with less education are less likely to remain in treatment; women whose friends have less "deviant" attitudes and behaviours are more likely to complete treatment (Clark et al., 2001; Knight et al., 2001). Women at greatest risk for noncompletion are unmarried, have two or more children with them in residential treatment, have an open child welfare case, are addicted to cocaine, or have psychological problems. This suggests women with few supports and more concerns and challenges are least likely to complete treatment.

A common theme in the literature regarding reasons women do not complete drug treatment is that sober, these women have no social support. They feel rejected by their previous drug-using cohort, but have no non-drug using friends or family to turn to (Howell & Chasnoff, 1999). Social support is a vital substitute when women are trying to give up drugs and alcohol as a coping mechanism. Support groups which give women the opportunity to meet and bond with peers are a crucial element of any treatment program. Forming new relationships with drug-free people may aid women in abstinence, since drug availability and social pressures to use drugs are reduced (Clark et al., 2001).

Focus groups of clients and service providers made the following recommendations for perinatal substance abuse treatment: (Howell & Chasnoff, 1999)

- Comprehensive services for women require collaborative and cooperative efforts at both the provincial and community level.
- Quick responses are important – there is a small window of time after a woman has requested treatment or services. If the wait-list is too long, she may change her mind.
- Programs should use interdisciplinary approaches.
- Services for pregnant substance abusers should be family-centred and address child-care needs.
- Programs should match services to the specific needs of each woman and provide a combination of types of services.
- Substance abuse should be viewed as a long-term, chronic, relapsing condition. Programs should plan for and try to manage relapses.
- Linkages to a variety of programs are critical to program success.
- Programs must address the tension between child-focused and mother-focused providers and services. There is often an adversarial relationship between child welfare proponents and those advocating for the mother. The mother-child dyad should be viewed from the beginning as the client.

The average cost of providing drug and alcohol treatment to a pregnant woman ($6639) plus birth-related costs ($900) is far less than the average cost of intensive care for a drug-affected infant born to an untreated mother ($12,183) (Svikis et al. 1997, cited in Roberts and Nanson, 2000). These cost savings are even greater once the expense of services provided to the child to assist with health issues, learning disabilities and behavioural problems are taken into account.

VIII. EARLY CHILDHOOD INTERVENTION

“As newborns, [substance-exposed babies] are said to display a number of behaviours that not only affect their physical well-being, but interfere with the essential bonding between caregiver and infant so essential to cognitive and emotional development... These behaviours include tremulousness, irritability, rapid mood swings, vomiting, weight loss and diarrhea. Instead of cuddling and returning their caregiver’s gaze, these children avert their eyes and remain rigid. Many of these babies, in other words, are characterized as hard to love” (Franck, 1996).

The rate of developmental delay among drug-exposed babies is not statistically greater than in babies with no known prenatal drug exposure (Franck, 1996). Although infants prenatally exposed to drugs are more likely than others to begin life with some impairments of regulatory and attentional capacities, their early capacity falls within the normal range. However, gaps and lags in performance begin to become apparent in the children’s second year, as language and representational behaviour play an increasingly central role in functioning (Beckwith et al., 1994; Malakoff et al., 1994; Van Baar & De Graaf, 1994; all cited in Johnson et al., 1999).

The effects of prenatal exposure to drugs may be substantially mitigated by well-designed interventions with children and caregivers, enriched environments, and comprehensive services (Zuckerman, 1992, cited in Franck, 1996). "Overall, the care-giving requirements of drug-exposed children are not very different from those of most young children – all need care that is responsive, predictable, consistent, and guided by developmentally appropriate expectations. What is different, however, is that [drug-exposed] children are less likely than most to live in care-giving circumstances that can meet these needs, and to have people and resources available to buffer the consequences of inadequate care" (Johnson et al., 1999). Given the range and severity of risk factors and stresses the substance-using mother may be experiencing, there is a serious mismatch between the mother's limited emotional resources and the infant's intense care-giving needs (Johnson et al., 1984, cited in Johnson, 1999).

Financial concerns are associated with increased harshness in maternal parenting behaviour (Conger et al., 1992, cited in Johnson et al., 1999). Cocaine-abusing mothers have been found to be less attentive and responsive to their infants (Mayes et al., 1997, cited in Johnson et al., 1999). The addicted mother is more likely to have negative perceptions of her child and to view the child as a source of stress (Bernstein & Hans, 1994; Howard et al., 1989; Johnson & Rosen, 1990; all cited in Johnson et al, 1999).

The combination of poverty, addiction and rearing young children, places mothers at a high risk of depression. "A depressed mother engages in less physical and verbal interaction with her infant who, in turn, responds with fewer happy verbal or facial expressions. This reinforces the mother's sense of inadequacy and despair. The stage is then set for a continuing cycle of negative interactions damaging to cognitive and emotional development" (Kaplan-Sanoff et al, 1991, cited in Franck, 1996).

The problem, then, is not so much biological, but environmental. Environmental deprivation has more serious consequences for children than prenatal drug exposure (Ornoy et al., 1996, cited in Johnson et al., 1999). Postnatal factors such as homelessness, poor health care, and inadequate parenting are shown to have tremendous impact on developmental outcomes (Aylward, 1990; Kaplan-Sanoff et al., 1991; Parker et al., 1988; Sameroff et al., 1987; all cited in Franck, 1996), defining the need for postnatal intervention programs.

"Intervention programs vary in a number of dimensions – delivery setting (home, school, centre, clinic), primary target (mother, child, both), timing of onset (prenatal, infant, toddler), intensity (amount of programming per week), extensivity (length of program), curriculum content, staff-child ratios, and staff training. However, all programs focus on enhancing child competence. Programs employ a variety of strategies, including:

- Working directly with the child,
- Helping the mother improve her interactions and teaching skills with the child,
- Teaching the mother about problem-solving abilities,
- Raising the mother's self-esteem and emotional functioning,

- Promoting maternal return to school or the job market, and
- Increasing maternal knowledge about child development or maternal perceptions about child competence.

All but the first strategy assume that altering the mother's behaviour or attitudes will influence the child indirectly through the mother. Indeed, many scholars believe that the long-term success of programs does not depend on their ability to alter directly child cognitive abilities in the preschool years, but on their capacity to alter the environment in which the child lives, in this case, characteristics or circumstances of the mother" (Benasich et al., 1992).

In a review of 27 early intervention programs, Benasich et al. (1992) found the following:

- Mothers involved in an intensive early intervention program are less likely to be on welfare, more likely to be employed, and more likely to have higher rates of educational advancement. The effect is larger for women who receive centre-based care.
- Mothers involved in early intervention programs had fewer children and had increased the spacing between their children.
- Cognitive advances are seen in children immediately following most early intervention programs; centre-based programs are more likely to report sustained results. This is attributed to the quantity of intervention, rather than the quality.

With the exception of Healthy Babies, Healthy Children, the following early intervention programs are offered in BC.

Building Blocks

Building Blocks is an MCFD-referred program which uses lay home visitors to provide support and education to first-time young mothers of high risk children from birth to age five. The home visitors are typically women from similar cultural backgrounds who have successfully raised their own children and can be positive role models and supports (MCFD Connections, 2003).

Infant Development Programs

Funded by MCFD, infant development programs include home visits, assessment and program planning, and referrals for young children at risk for or with developmental delays and disabilities. Activities are selected and practiced to encourage the development of physical, social and intellectual skills. Additional information is made available to parents of children with disabilities (Infant Development Program of BC, 2003).

Pregnancy Outreach Program (POP)

POP is a program intended to decrease the incidence of low birth weight babies and promote positive health practices. Weekly sessions are offered to pregnant women who would not usually access traditional health care services. The program provides education, nutrition counselling, peer support groups, follow-up, vitamins, and food/milk supplements (The 2003 Red Book, 2003; Pregnancy Outreach Practice Guidelines, 2003).

Healthiest Babies Possible

Healthiest Babies Possible is a prenatal outreach program which offers nutrition and prenatal lifestyle counselling, breastfeeding information, food and nutritional supplements, labour and delivery information, and community referrals. Drop-in peer support groups continue until the baby is 12 months of age (The 2003 Red Book, 2003).

Healthy Babies, Healthy Children

The Healthy Babies, Healthy Children program is co-funded by the Ontario government and Health Canada. The program assists children from birth to six years of age who are at risk for poor social, emotional, cognitive and physical health. Lay home visitors provide advice and emotional support to help improve parenting skills. Referrals to the program are made by maternity ward hospital staff (Growing Healthy Kids, 2003).

IX. HOME VISITATION PROGRAMS

Home visitation programs are a popular form of early intervention which aim to prevent child mistreatment, promote effective parenting, improve pregnancy outcomes, and advance the social, emotional and intellectual development of children. Home visitation programs are rooted in the belief that resources should be brought to families, rather than left in the communities for families to seek, although all home visitation programs link families with community resources (Rapoport & O'Brien-Strain, 2001).

Nurse Home Visitation Program (Elmira, NY)

A recent review of five American home visitation programs (Hawaii Healthy Start, Healthy Families America, Nurse Home Visitation Program, Parents as Teachers, and Comprehensive Child Development Program) indicated that the Nurse Home Visitation Program (NHV) was the only program that showed a positive impact in all five evaluation areas: child development, behaviour and health, reducing abuse and neglect, and improving the home environment and maternal life course (Rapoport & O'Brien-Strain, 2001).

The NHV program is the only home visitation discussed in this review which employs nurses as visitors, rather than paraprofessionals. Each NHV nurse has a caseload of 20-25 families, and provides services to both parents and child. Services begin prenatally, and end when the child is two years old. Home visits are weekly, but eventually fade to monthly; visits are typically 60-90 minutes. The client attrition rate for the NHV program

is extremely low, 10 %; the program costs $6600 (US) per family for the entire service period.

Because the NHV program does not stress child development and behaviour, benefits in this area are minimal. Other home visitation programs that place more emphasis on these areas report more positive results in areas of cognitive development. As expected, the NHV program shows impressive reductions in number of child ER visits, injuries, and days in hospital. As well, substantiated reports of child abuse and neglect are reduced. Significant improvements in the mother's health and utilization of other community services have also been measured. Improvements in language stimulation and educational materials, punishment methods, and home quality were measured, as were reductions in home hazards.

The most impressive aspect of the NHV program is the long-term impact, as measured in a 15-year follow-up study (Rapoport & O'Brien-Strain, 2001; Olds et al. 1997; Olds et al. 1998). Fifteen years after exiting the program, youth show a lower incidence of running away, fewer arrests, convictions and probation violations, reduced number of sexual partners, and less alcohol consumption. Substantiated reports of child abuse and neglect are reduced. Mothers have fewer subsequent pregnancies and births, greater time intervals between children, fewer months on social assistance, fewer days in jail, fewer arrests and convictions, and fewer substance use impairments. The long-term impacts are so significant that the overall savings to government and society outweigh the initial cost of the program by a factor of four for higher risk families.

The following list of best practices for home visitation programs are suggested: (Rapoport & O'Brien-Strain, 2001)

- The initial focus should be on family needs and stressors, before the program curriculum.
- The curriculum should have clear objectives, compatible with family's culture, language and needs.
- Services should include frequent assessments of parental drug and alcohol use; appropriate referrals to formal and informal supports should be made.
- Families should be helped to develop an informal support system, including their existing social network, and informal support groups with mothers of similar experience.
- Parental confidence and sense of control should be promoted by acknowledging personal successes and teaching communication and conflict management skills.
- Families must be linked to a medical provider and other services as necessary.
- Program participation should be voluntary.
- The type of visitor (i.e., nurse, social worker, paraprofessional, etc.) must be well matched with the primary goals of the program.

- Intensity is more important than long-term duration; programs initiated prenatally have better outcomes and higher retention rates of clients.
- Programs must be flexible and individualized to clients.
- Services should be two-generational, focusing on parents, child and parent-child interaction.
- Services should be geared toward teaching parents to function in the existing social environment and access community services.

Hawaii Healthy Start (Hawaii)

The Hawaii Healthy Start program is a voluntary program that is initiated at birth and continues until the child is three to five years. Referrals to the program are based on universal medical record screening of all newborn families. Risk is assessed in the following areas: marital status, unemployment, low income, unstable housing, no phone, no high school diploma, inadequate emergency contacts, marital problems, history of abortions, adoptions sought, history of drug use, history of psychiatric care, history of depression, and inadequate prenatal care.

The two-generational program aims to:

- Prevent child abuse and maltreatment.
- Improve family coping and promote positive parenting.
- Help families identify and build on strengths.
- Link families with needed services.
- Use home visitors to role-model problem-solving skills and effective parent-child interactions.

Paraprofessional visitors, chosen for their warmth and good parenting skills, have a caseload of 20-25 families; visits are weekly to quarterly, depending on need. The program has a cost of $3,250 (US) per family. Measured effects include improved parenting efficacy, increased frequency of non-violent discipline, and decreased partner violence. The attrition rate from the program is particularly high: 51% in the first year (Rapoport & O'Brien-Strain, 2001).

The Birth to Three Program (Seattle, WA)

The Seattle Birth to Three program is a home visitation program that uses a case management approach (Ernst et al., 1999). Paraprofessional advocates work with a caseload of 12 to 15 women and their families, from birth until the child is three years old. "Advocates visit homes weekly for the first six weeks, and then biweekly or more often, depending on client needs; they transport clients and their children to important appointments, link clients with appropriate service providers, and work actively within the context of the extended family. Clients are not required to obtain alcohol/drug treatment in

order to participate, and are never asked to leave the program because of relapse or setbacks... Specific program goals include:

- Assist mothers in obtaining treatment, maintaining recovery, and resolving the myriad problems associated with their substance abuse.
- Guarantee that the children are in a safe environment and receiving appropriate health care.
- Effectively link families with community resources.
- Demonstrate successful strategies for working with this population in order to prevent the risk of future drug- and alcohol-affected children.

Advocates work within the context of the close interpersonal relationships they develop with clients" (Ernst et al., 1999).

An evaluation of the program with families who have been in the program for three years and spent more than 95 minutes per week with their advocate, revealed that clients had much higher rates of drug and alcohol treatment and abstinence, birth control use, connection to community services, and custody of their child. While one goal of the intervention is to promote a healthy relationship between the mother and baby and keep the dyad together, another is child safety. Advocates instigate removal of children from homes considered unsafe.

The cost of the Birth to Three program is $3800 (US) per client per year. Each child in foster care costs the state at least $7800 per year. While the program is successful on the most important human terms, it is also a success on financial terms.

After reviewing 31 home visitation programs in Canada (2), the US (23), and worldwide (6), several conclusions were drawn: (Olds & Kitzman, 1993)

- None of the programs reduced overall rates of preterm delivery or low birth weight, although the NHV program did both for mothers who were either smokers or teens.
- For programs to be effective, their designers must be clear about how they expect to improve the outcomes of pregnancy, and they must design home visit protocols based on those expectations.
- Parents and families with particular needs or higher than average risk may benefit more from home visiting than others. The evidence suggests that vulnerable women benefit most: low IQ, low-income, and unmarried teenagers are particularly responsive to these types of programs.
- Programs that employ professionals (especially nurses) and are based on more comprehensive service models stand a greater chance of influencing qualities of parental care-giving...than do narrowly focused programs staffed by paraprofessionals.
- Home visitation programs are remarkably successful in promoting qualities of prenatal care-giving and children's intellectual functioning.

- For services to be effective, parents must believe there is a need for the visits, and that the visitor has something to offer them.
- Programs must be designed flexibly so the frequency of contact can be adjusted to the needs of the family. The frequency of visits in many programs is too low to have any effect. There is a definite correlation between intensity of service and positive outcomes.
- Families at highest risk may need services until the child is enrolled in preschool or public education.

X. OTHER PROGRAMS/RECOMMENDATIONS

A comprehensive listing of programs and services available to substance-using mothers and their children is far beyond the scope of this review. However, noteworthy features and philosophies of a few key programs are highlighted. Sheway is discussed in detail because it is a local program for which evaluative data is available.

Sheway (Vancouver, BC)

The nine key areas of Sheway service are: (Poole, 2000)

- Support to build networks – both friendship and ongoing service support networks.
- Healthy babies, infant/child development.
- Advocacy and support on access, custody and other legal issues.
- Advocacy and support on housing and parenting issues.
- Support in reducing exposure to violence and building supportive relationships.
- Support on HIV, Hepatitis C and STD issues.
- Support/counselling on substance use/misuse issues.
- Nutritional support and services.
- Pre- and postnatal medical care and nursing services.

“On-site professionals include a multi-disciplinary team of two part-time physicians, three community health nurses, two social workers, one outreach worker, a dietician, an infant development program worker, and an alcohol and drug counsellor. Through partnerships with other agencies, the services of an occupational therapist, physiotherapist, pediatrician, nurse clinician, and financial aid worker are also made available. Other services include a daily nutritious hot lunch, food hampers, vitamin supplements, bus tickets, infant formula, baby supplies and other emergency services. For many of the women...poverty was a major issue and these services often meant the difference between feeding and clothing their child or not....research participants identified the value of peer support and appreciated the opportunity to meet with other mothers who shared similar life situations. Sheway provides a space for their children to socialize with other children and to just “hang out“ in a non-

judgmental environment, something not available to them [elsewhere]. For these women, the program provides a safe, encouraging and supportive environment where women can learn problem-solving skills, gain valuable experience in interpersonal relationships and enjoy role modelling and learning from other women... Several participants spoke highly of the midwifery services that were offered at Sheway during 1996-1997 as a pilot project...The women felt midwives had more time for them and were there for them during labour and delivery" (Benoit et al., 2003).

A recent evaluation reveals that higher birth weights are statistically correlated with length of affiliation with Sheway, number of visits and phone calls to Sheway, food bags received from Sheway, and early admission to Sheway. In other words, clients who become members of Sheway early in their pregnancies, visit Sheway regularly, and receive food bags from Sheway, have higher birth weight babies (Marshall et al., 2003).

Although health care is a vital component of Sheway, the clinical aspect of Sheway is subdued; the building facility contains several offices and medical examination rooms, but the living room, dining room, kitchen and childcare areas are emphasized, so that clients feel comfortable and at ease. Non-judgmental, positive relationships with staff are emphasized. The centre is set up with minimal barriers to access; women do not have to make appointments for service. There is no sense that clients have to "do something" while at Sheway; they can feel free to relax (Marshall et al., 2003).

Sheway uses a harm reduction approach, distributing condoms, bad date sheets, and information about unsafe drug supplies at the front door. Women are allowed to access Sheway services while intoxicated, although some clients report they do not feel comfortable exposing their children to drug use while at Sheway.

An essential aspect of all of Sheway's services is that the client is in the driver's seat. The client makes informed choices about the treatments and services that she believes to be appropriate for her (Marshall et al., 2003).

In focus groups, clients have made the following comments and recommendations: (Marshall et al., 2003)

- Parenting and nutritional information, and home visits by the Infant Development Consultants are highly rated.
- Parenting training and support groups should focus on specific stages of children's development and involve the whole family.
- Extended hours are needed. The centre is currently open only from noon to 4:00 pm, Monday to Friday.
- Clients stress high barriers to drug and alcohol rehabilitation services outside Sheway.
- Discontinuation of services at 18 months is problematic and abrupt. Services provided by Sheway are not provided elsewhere, leaving a dangerous gap in services between 18 months and six years, when the child enters school. Many

studies indicate that effects of early intervention programs are lost once the intervention is discontinued (Benasich et al., 1992).

- The establishment of a client advisory council would help direct objectives and programs at Sheway to better meet client need.
- Job training, skill development programs, and referrals to employment opportunities are desired.
- Aboriginal culture at Sheway takes the form of diet and arts and crafts, which are superficial expressions, at best.
- Clients report concerns with the location of Sheway, because their children are exposed to crime and drug paraphernalia outside the building. Clients have stressed safety as a major issue when they are accessing services in areas such as the Downtown Eastside (Benoit et al., 2003).

Key recommendations from the Sheway evaluation: (Marshall, 2003)

- The program should be expanded to cover the child from age 0 to 6. Sheway families need assistance with transferring into the educational system and advocates for educational assistance.
- A non-intrusive tracking system is needed to better evaluate the effect of Sheway services on addictions, FASD, NAS, child outcomes, etc.
- Services should be designed around broad determinants of health, especially those most compromised in the particular service area.
- There must be links with agencies such as the Centre for Ability so children can have disabilities diagnosed as soon as possible, and can be fast-tracked to appropriate services.
- Counselling is essential, to help women address A&D issues as well as violence and trauma.
- Services should have a low-barrier protocol, and should not be cumbersome or rule-bound.
- Very individualized programs are needed to help women with multiple disabilities: FASD, mental illness, histories of abuse, identity loss, etc.

Northern Family Health Society (Prince George, BC)

The Northern Family Health Society seeks to raise awareness of FASD prevention, as well as providing support and community referrals to families affected by FASD (NFHS, 2003). The program is based on harm reduction, not abstinence. The program is based on self-determination -- “we never take the client down a road where they don’t want to go.” The atmosphere is safe, non-judgmental and accepting; clients are treated as partners in the process, and as experts in their own lives (Thio-Watts, 2001).

Breaking the Cycle (Toronto, ON)

Breaking the Cycle is a Toronto-based program which offers addictions counselling and treatment, parenting support and training, life skills, developmental screening and assessment for children, infant development programs, a pediatric clinic, post-natal and mental health counselling, a clothing exchange, daily lunch, and transportation. The program is based on the following service philosophies: (Breaking the Cycle, 2003)

- The most critical environmental contributor to infant development is the nature and quality of the mother-infant relationship.
- Interventions and supports can contribute to enhanced parenting skills and developmental gains of "at-risk" infants if the interventions focus on supporting and strengthening the mother-infant relationship and unifying the family.
- Intervention is most effective when it occurs at the earliest possible opportunity in the development of the mother-infant relationship.
- Services must be offered in a flexible, responsive manner that addresses each woman and child's individual needs and circumstances: “meeting families where they are at".
- Woman-centred and child services must protect and respect the integrity of the woman's family as she defines it and acknowledge the impact of significant others in the woman's life.

Food for Thought (Saskatoon, SK)

This program partners with several other community agencies to encourage optimal health for high risk mothers. “The thing that has been the most critical for us, in terms of successfully reaching some of these women, is providing a safe, comfortable, welcoming environment” (Woodsworth, 2001).

Caring Together (Philadelphia, PA)

“Demographically diverse staff allow participants a wide choice in treatment providers and role models. Treatment plans...are developed around individual client needs.” Childcare, pediatric medical care, pre- and post-natal care, substance abuse treatment, psychiatric evaluation and treatment for dual diagnoses are available (Abbott, 1994). The multidisciplinary team provides supportive, cognitive-behavioural, insight-oriented and psycho-educational approaches with an emphasis on abstinence, relationships, life skills, parenting issues, development trauma and the impact of addiction on the client’s life (Behavioural Health System, 2002).

Program for Maternal Drug Users (Bronx, NY)

The program is based on peer support and outreach, especially that of ex-drug using volunteers. The program highlights the importance of existing community supports,

resources and relationships. This underlying structure is both empowering as well as mending. The atmosphere is one of support, love and respect as opposed to the confrontational format used by many more traditional treatment efforts (Abbott, 1994).

Options for Recovery (California)

While program offerings vary from site to site, they include case management, outpatient and residential drug and alcohol treatment, childcare, parenting education and life skills classes, low-income housing, foster parent training and recruitment, respite care, counselling, methadone maintenance, detox, pediatric care, health care and transportation (Brindis et al., 1997).

A three-year evaluation of the OFR program indicated the following outcomes: (Brindis et al., 1997)

- Of the women who exited OFR, 24% successfully completed the treatment program. Women with more education, with alcohol addiction only, or who had been mandated to treatment through the criminal justice system had the highest rates of completion.
- There was a 27% decrease in involvement with Child Welfare Services between admission and discharge, a 4% increase in the number of children residing with their biological mothers, and increased numbers of children reunited with their biological families after foster placement.
- There was a lower incidence of positive toxicological screens at birth. Birth outcomes were generally normal.

When asked for feedback, clients noted some programs were too strict or structured, clients had no input, transportation was inadequate, and there was a lack of culturally appropriate staff. Evaluation of this program is hindered by the lack of site-specific outcome data. It is not possible to deduce which site-specific aspects of the various OFR programs were most responsible for the positive impacts.

Following a review of programs used in California in the 80's and 90's, (Options for Recovery, Perinatal Treatment Expansion Program, Perinatal Services Network, Federal Substance Abuse Prevention and Treatment) researchers forwarded the following recommendations: (Brindis et al., 1997)

- Efforts need to be made to involve family, friends, and significant others throughout the pregnancy as well as delivery because social support facilitates mother-child bonding.
- Information on how to access alcohol and other drug treatment and recovery services and routine medical and gynecological care should be made available.
- Post-partum follow-up should also include childcare support, parent and health education, and identification of any health or developmental problems with the child.

- Services for children from birth to age three (or older) are vital, since needs may not be evident until children are over 18 months.
- Services that begin immediately after birth may improve parent-child bonding.
- A comprehensive A&D treatment strategy must confront the clients' emotional issues and histories of abuse. Mental health counseling may help chemically dependent women forge positive coping skills and stress management techniques.
- Women generally endorse group counselling over individual therapy.
- Services must recognize the customs, mores and cultural attributes that inevitably influence perceptions of the program.
- Treatment must include safe and sober housing, connection to support groups, and aftercare that emphasizes relapse prevention.
- Aftercare programs are needed during weekend and evening hours to provide a supportive environment and assist women with the task of resuming their lives in the community.
- Without coordination and collaboration, prenatal care, pediatric care, drug user treatment, financial services and social services may be at different locations with separate regulations, intake procedures and eligibility requirements.
- Additional services that support reunification of the family, such as child development education, parenting skills classes, vocational counselling, and assistance with obtaining social services, would enable parenting women to achieve long-term recovery.

First Choice (Fort Worth, TX)

First Choice is a 12-month residential substance abuse treatment facility for women with dependent children. Families live in independent apartments on the facility's grounds. Children attend on-site daycare or school while mothers participate in individual and group counselling, life skills training, case management, parent training, and additional community services. Children are integrated into the treatment program through activities such as play therapy and family therapy (Knight et al., 2001).

Women's Reproductive Health Service (Glasgow, Scotland)

The Women's Reproductive Health Service (WRHS) was established in Glasgow to provide reproductive health care for women with severe social problems. The service cares for approximately 80-100 drug-using women per year (Hepburn, 1993). The service is based on the understanding that women with chaotic lifestyles require services that are easy to access, and that women with low self-esteem and guilt are extremely sensitive to the attitudes and responses of staff members. WRHS is community based, accepts referral by any route including self-referral, incorporates all types of reproductive health care within a single clinic, recognizes that condemnation and moral judgement are not the responsibility of health care services, and strives to deliver a comprehensive, multi-

disciplinary service which is non-judgmental, easily accessible, tailored to individual needs and makes effective use of women's time by providing help with all their problems at a single site. Services include health care, HIV testing, dental care, nutritional counselling, life skills classes and advocacy.

CHAPTER III THE CITY OF SURREY – A REVIEW OF THE STATISTICS

Surrey is the second largest city, in terms of population in British Columbia, and is one of the fastest growing cities in Canada. It faces many major social issues, especially in North Surrey, including poverty, homelessness, lack of affordable housing, at-risk youth, single parent families, drug and alcohol use, absence of treatment facilities, visible sex trade and violence.

This chapter elaborates on the picture of Surrey, through the lens of its statistics, in areas related to our major activity – creating a program model to respond to the needs of high risk pregnant and early parenting women and their children up to the age of six and/or school entry. It is framed as follows:

SECTION I. PROFILE OF SURREY

A. Communities and Population
B. Social Issues
C. Population of Females, Aged 15-44
D. Population of Children
E. Racial / Ethnic Composition
F. Aboriginal Population
G. Religion
H. Families
I. Income
J. Housing and Homelessness
K. Children in Care
L. Crime

SECTION II. BIRTH-RELATED STATISTICS

A. Live Birth Rate
B. Fertility Rate
C. Teenage Mothers
D. Low Birth Weight
E. Pre-term Births
F. Perinatal Complications
G. Maternal Complications
H. Congenital Anomalies and Fetal Alcohol Spectrum Disorder
I. Abortions
J. Still Births
K. Infant Mortality
L. Sudden Infant Death Syndrome
M. Prenatal Health Care

SECTION III. ALCOHOL AND DRUG EPIDEMIOLOGY

A. Alcohol-Related Deaths
B. Drug-Induced Deaths
C. Methadone Treatment
D. Drug-Related Crime

SECTION IV. HEALTH

A. HIV Deaths and New Cases
B. Deaths from Accidents and Violence
C. Deaths from Medically Treatable Diseases

SECTION I. PROFILE OF SURREY

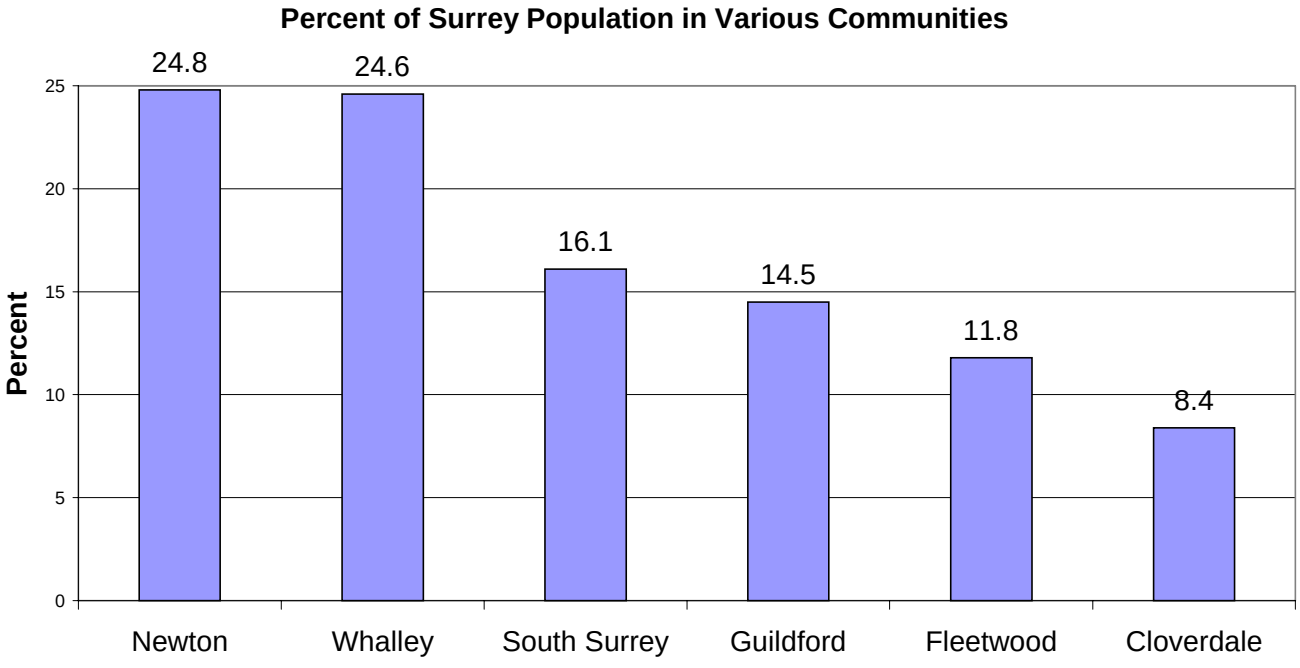
A. COMMUNITIES AND POPULATION

Surrey is composed of six geographic communities: Whalley, Guildford, Newton, Fleetwood, Cloverdale and South Surrey.

The city of Surrey encompasses a very large area (317 square kilometers), which is almost three times the size of Vancouver. As a result, transportation problems within Surrey are significant.

Surrey has the second largest population in BC, and is one of the fastest growing cities in Canada. The population in 2001 was 347,825 (Statistics Canada, 2001). The population has increased 14.2% since the 1996 census, compared with a 4.9% population increase in the province of BC. The fastest growing communities within Surrey are Fleetwood, Newton and Guildford, each with growth in excess of 30% between the years 1991 and 1996 (Talbot, 2000).

The 1996 census indicated the following population distribution among Surrey communities: (Talbot, 2000)



B. SOCIAL ISSUES

The north Surrey communities of Whalley (population 75,000), and to a lesser extent, Guildford (population 40,000), are considered have the greatest incidence of risk factors and service need. Whalley and Guildford have an above average incidence of: (Stubbs, 2001)

- Rental dwellings
- Low income households
- People paying more than 30% of their gross household income on rent
- English as a second language (ESL) enrolments
- High unemployment among Aboriginal people and people with disabilities

Whalley, in particular, has an above average incidence of:

- Female lone parent families
- Visible minorities
- Aboriginal people
- People with disabilities
- People with less than grade nine education
- Crime
- Unemployment

Consequently, major social issues in these north Surrey communities include:

- Poverty
- Homelessness
- Lack of affordable housing
- At-risk youth
- Single parent families
- High number of teenage moms
- Drug and alcohol abuse
- Absence of treatment facilities
- Drug related crime
- Prostitution
- Violence

C. POPULATION OF FEMALES, AGED 15-44

The population of women of child-bearing age (15-44) in Surrey in 2001 was: (Statistics Canada, 2001)

Age	Population
15-19	11,885
20-24	11,615
25-44	54,320

The total population of women aged 15-44 is 77,820, which is 22.5 % of the total Surrey population. This is slightly less than the proportion of women of child-bearing age in the Greater Vancouver Regional District (GVRD), which is 23.3 % (Statistics Canada, 2001).

D. POPULATION OF CHILDREN

Surrey has a disproportionately high population of children, which puts pressure on resources and services for children, such as pediatric health care, schools, and recreational facilities. There are almost equal numbers of children aged 0-4 in Surrey (23,470) and Vancouver (23,690), even though the general population of Vancouver is 1.5 times that of Surrey. Children aged 0-4 make up 6.7% of the Surrey population, compared to 4.3% of the Vancouver population, and 5.3% of the GVRD population (Talbot, 2000; Statistics Canada, 2001).

In 1996, Surrey had the highest percentage (11.2%) of children aged 0-6 in the GVRD. Children aged 0-6 made up 8.5% of the GVRD population. Whalley and Newton had the highest percentages of children in this age range, 12% and 12.7%, respectively (Talbot, 2000; Stubbs, 2001). Almost one-quarter (23%) of Surrey's population is below the age of 15, compared with 13.9% in Vancouver, and 18.4% in the GVRD (Stubbs, 2001).

In 2002, Surrey had the following population of children: (BC Statistics, 2002)

Age	Population
< 1 year	4,823
1-4	20,033
5-9	28,066

E. RACIAL/ETHNIC COMPOSITION

The 2001 census indicated the following racial/ethnic composition of Surrey: (Statistics Canada, 2001)

Racial/Ethnic Composition of Surrey

Racial/Ethnic Identity	Population	Percent of Population
Caucasian	211,875	61.3
South Asian	75,680	21.9
Chinese	16,480	4.8
Filipino	10,235	3.0
Aboriginal	6,895	2.0
Southeast Asian	6,205	1.8
Korean	5,195	1.5
Black	3,810	1.1
Latin American	3,315	1.0
Japanese	1,925	0.6
Multiple Visible Minority	1,325	0.4
West Asian	1,185	0.3
Arab	1,115	0.3
Other Visible Minority	555	0.2

There is considerable variation in the racial/ethnic composition, from community to community within Surrey: (Stubbs, 2001)

Racial/Ethnic Identities of Visible Minorities

	Whalley, %	Guildford, %	Surrey, %
South Asian	62.4	22.4	57.1
Chinese	9.3	31.0	14.7
Filipino	7.3	12.3	7.8
Southeast Asian	5.0	4.9	3.9
Black	3.1	4.9	3.1
Korean	1.3	9.6	2.9
Latin American	3.3	3.0	2.4
Arab / West Asian	1.3	5.3	2.1
Japanese	1.8	2.1	1.7

Whalley and Newton have the highest proportions of visible minorities in Surrey: 35.7% and 41.8 %, respectively (Stubbs, 2001).

Like the rest of the BC Lower Mainland, Surrey is a city of immigrants: 33.2% percent of Surrey residents are foreign-born, compared with 26.1% of BC residents, and 45.9% of Vancouver residents. 30,965 Surrey residents (8.9%) lived in a country other than Canada five years ago. More than one-third (37%) of Surrey residents state a language other than English or French as the language they first learned and still understand (Statistics Canada, 2001).

Immigration status has a substantial detrimental impact on earning ability: (Spigelman, 1999, cited in Stubbs, 2001)

1995 Income for Earners Aged 25-44

	Surrey	Northwest Surrey
Non-immigrants	31,063	27,986
All Immigrants	23,612	21,819
Recent Immigrants	16,726	15,937

F. ABORIGINAL POPULATION

According to the 1996 census, Surrey had the second largest population of Aboriginal people in the GVRD, second only to Vancouver. Whalley (1845), Newton (1345) and Guildford (890) have the highest Aboriginal populations in Surrey (Stubbs, 2001).

G. RELIGION

Surrey residents indicated the following religious affiliations in the 2001 census: (Statistics Canada, 2001)

Religion

Religion	Percent of Population
Protestant	27.0
None	25.8
Sikh	16.3
Catholic	16.3
Christian	5.6
Muslim	2.9
Hindu	2.8
Buddhist	1.9

H. FAMILIES

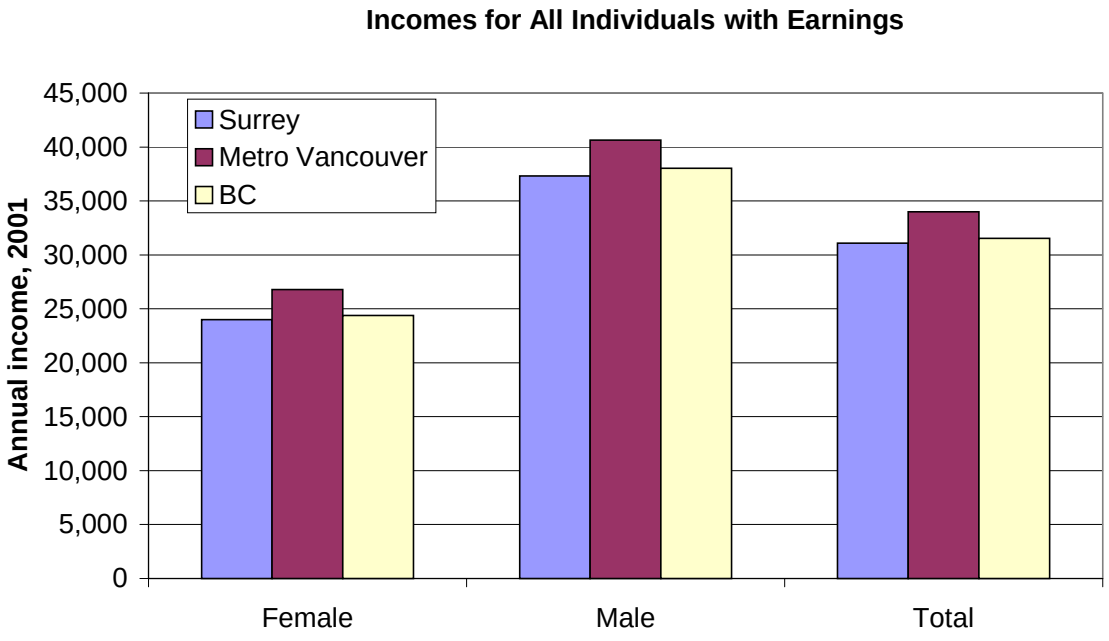
In 1996, Whalley was home to 31.7 % of all of Surrey's lone parent families, which is disproportionately high since Whalley contains only 24.6% of the Surrey population. Guildford contained another 24.3 % of Surrey's lone parent families, but only 14.5 % of the population. The average 1996 income of female lone parent families in Surrey ($25,876) was less than half that of the general population of families ($54,905) (Talbot, 2000).

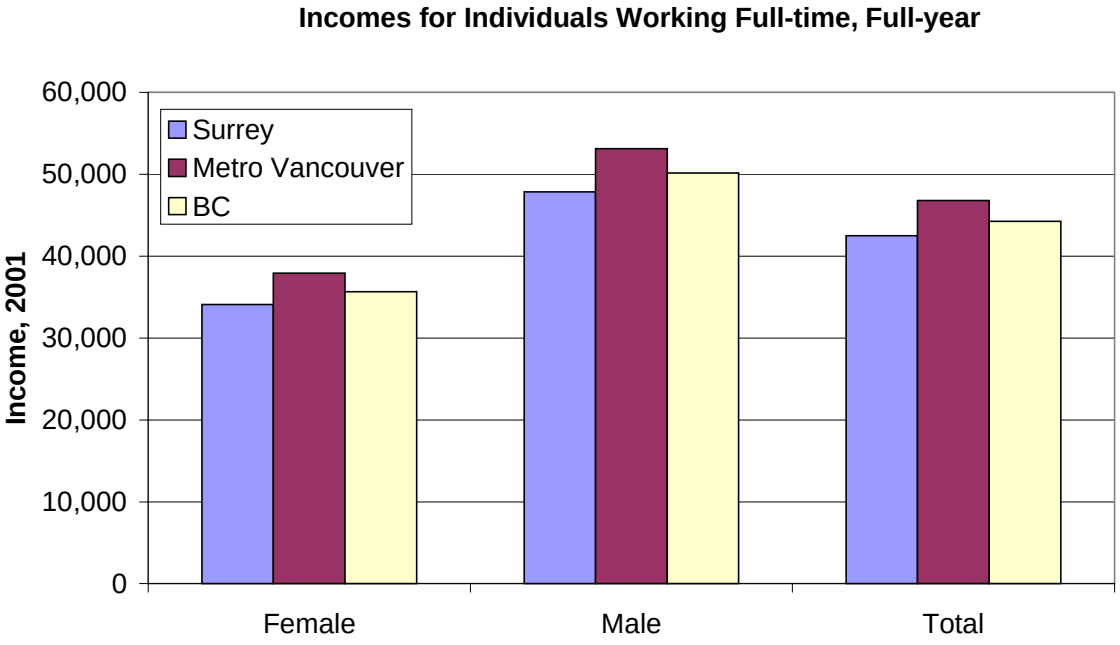
I. INCOME

Incomes in Surrey lag behind both BC and Metro Vancouver (GVRD) incomes: (Statistics Canada, 2001)

2001 Individual Earnings in Surrey, Metro Vancouver and BC, by Gender

Region	Female	Male	Total
For all persons with earnings:			
Surrey	24,009	37,319	31,088
Metro Vancouver	26,793	40,665	34,007
BC	24,401	38,039	31,544
For persons working full-year, full time:			
Surrey	34,108	47,845	42,471
Metro Vancouver	37,932	53,110	46,786
BC	35,636	50,159	44,231

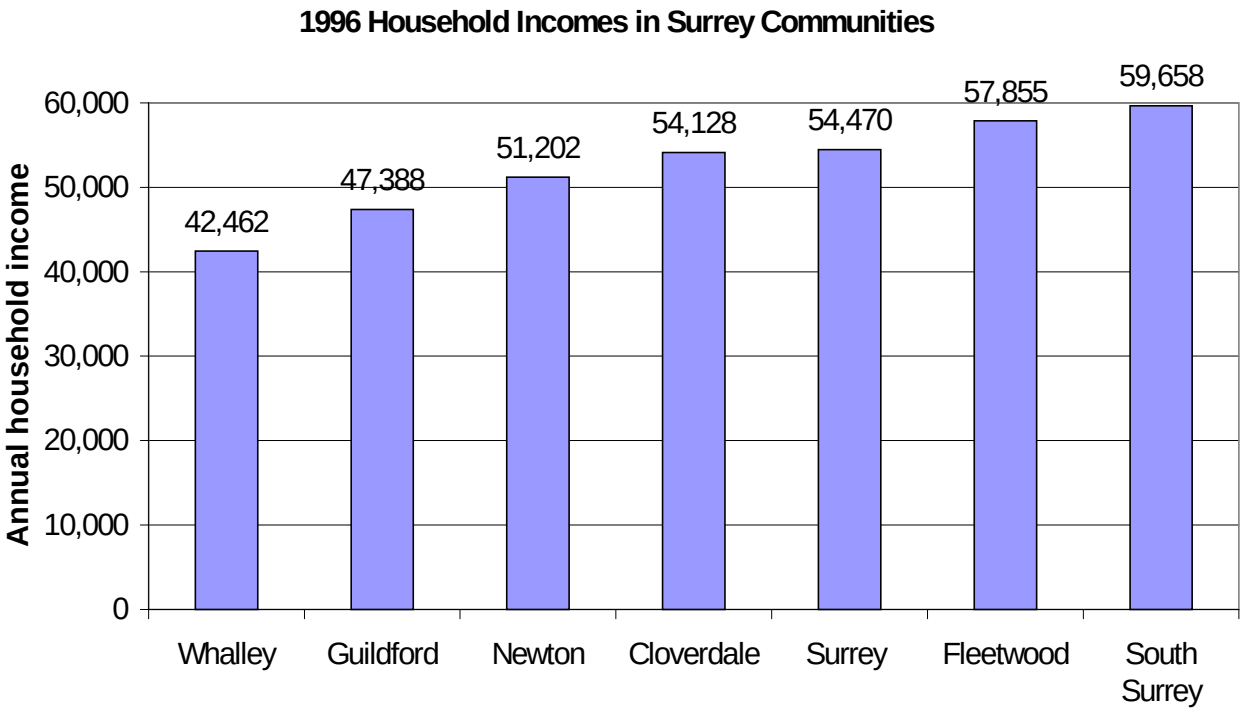




In 1995, 5.9% of Surrey families had household incomes less than $10,000, while another 10.6% had incomes between $10,000 and $20,000 (Stubbs, 2001).

However, the lower cost of living in Surrey partially compensates for lower earnings: in 1995, 18.8% of economic families in Surrey had incomes below the low-income cut-off, compared to 22.9% of families in both Richmond and Burnaby, and 24.6% of families in Vancouver. In 1995, 27.1% of Surrey children 0-14 lived below the low-income cut-off, compared to 26.3% in the GVRD and 36% in Vancouver (Talbot, 2000).

By a considerable margin, Whalley has the lowest household income in Surrey: (Stubbs, 2001).



In 1996, Surrey had the highest unemployment rate, 10.4%, in the GVRD (Talbot, 2000). The unemployment rate for youth (aged 15-24) was 16.4%. Unemployment rates were highest in Whalley and Newton -- 13.9 and 12.2%, respectively (Stubbs, 2001).

In 1996, 61.1% of all females in Surrey, older than 15 years of age, participated in the workforce. This is slightly higher than Burnaby and Richmond (both 57.6%), but approximately the same as Vancouver (60.6%) and the GVRD (61.3%) (Talbot, 2000).

J. HOUSING AND HOMELESSNESS

In 1996, Surrey had a greater percentage of renter households who spent 30 % or more of their gross household income on rent than any other municipality in the GVRD (Talbot, 2000).

Between 1994 and 2000, only 404 non-market housing units were approved for funding in Surrey/White Rock by BC Housing, compared to 978 homes in Burnaby and 2,634 homes in Vancouver (Talbot, 2000).

Surrey is estimated to have 400-500 homeless individuals (Stubbs, 2001). Homeless shelter space is inadequate. There are only 30 permanent shelter beds in Surrey – 20 beds at the OPTIONS Surrey Men's shelter, and 10 beds for women at Sheena's Place. There are an additional 36 beds during the winter at Gateway. In 1999-2000, the men's shelter turned away 230 men for lack of room, while Sheena's place turned away 1,245 women in 2000. From December 1999 to March 2000, Gateway turned away 360 people (Stubbs, 2001).

Transition and second stage housing for women is also inadequate to meet the needs of the Surrey community (Stubbs, 2001). Almost 2000 women and over 1000 children in Surrey alone were turned away from transition houses in the year 2000:

Transition and Second Stage Housing for Women in Surrey

Shelter	Location	Beds	Clients	Numbers Turned Away Due to Lack of Space
Evergreen Transition House	Guildford	10	Women & children	145 women, 121 children, in 2000
Virginia Sam Transition House	Newton	10	Women & children	278 women, 248 children, in 2000
Shimai Specialized Transition House	Whalley	10	Women recovering from violence & addiction	729 women, 138 children
Durrant Transition House	South Surrey	10	Women & children	741 women, 396 children, April 1999 - May 2000
Koomseh Second Stage House	Newton	10	Women	59 women, 134 children, April 1999 - May 2000

K. CHILDREN IN CARE

As of July 2003, there were 388 children under 14 years of age in care in Surrey (MCFD, 2003).

Community	Number of Children in Care
Newton	79
Guildford	105
Surrey North	108
Aboriginal Unit	96

Aboriginal children are over-represented in MCFD removals, both in Surrey and in the province of BC. Twenty-five percent of Surrey children in care are Aboriginal, but only 2% of Surrey residents are Aboriginal. Provincially, 45% of children in care and 8% of the population are Aboriginal (Felgate, 2003).

Thirty-nine percent of children in care under six years of age in BC live in Surrey. Another 21% live in Vancouver.

Drug and alcohol issues are involved in an estimated 50% of cases involving removal of children (Felgate, 2003).

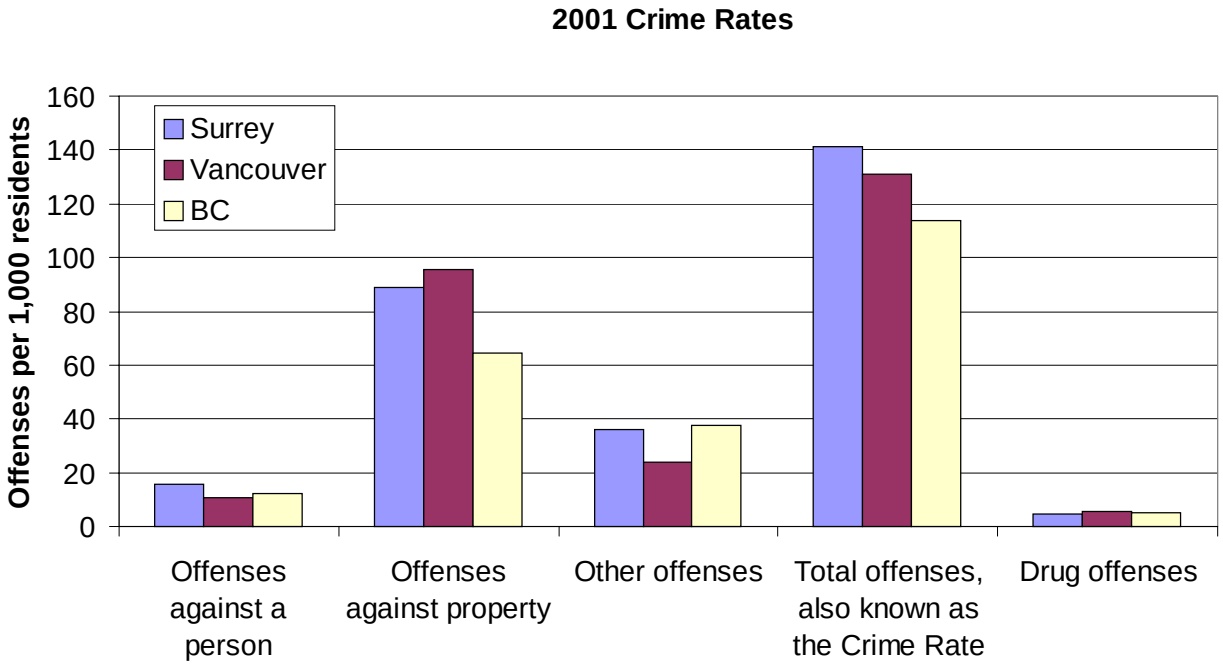
L. CRIME

Contrary to its reputation, the Surrey crime rate has actually decreased over the past ten years (Ministry of Public Safety, 2001, Appendix D, Page 153). Between 1991 and 1998 the crime rate in Surrey fell by almost 20 % (Talbot, 2000).

Despite this improvement, the crime rate in Surrey remains 24% higher than the provincial average, and 8% higher than the crime rate in Vancouver. Drug offenses in Surrey are lower than both the provincial and Vancouver rates (Ministry of Public Safety, 2001, Appendix B, Page 109).

2001 Crime Rates

Criminal Code Offenses, per 1000 Residents	Surrey	Vancouver	BC
Offenses Against a Person	15.7	10.7	12.2
Offenses Against Property	89.1	95.7	64.5
Other Offenses	36.1	24.1	37.6
Total Offenses, Also Known As The Crime Rate	141	131	114
Drug Offenses (Included In “Other”)	4.7	5.5	5.3



The crime rate in Whalley is disproportionately high. The following table indicates the percent of total Surrey offenses by community, for 1999. All else being equal, the percent of crime should equal the percent of population. However, the percent of crime which occurs in Whalley is well in excess of its population (Stubbs, 2001, based on data from the Surrey RCMP Research & Planning Department). In contrast, the Guildford/Fleetwood region experiences significantly less crime than its population would suggest.

Percent Total Surrey Offenses by Community, 1999

Community	% Of Surrey Population	Murder/ Man-Slaughter	All Criminal Code Persons Offenses	All Criminal Code Property Offenses	Procuring/ Prostitution	Heroin/ Cocaine Possession/ Trafficking
Whalley	22.8	66.7	37.1	33.1	84.9	55.8
Guildford/ Fleetwood	25.8	11.1	24.1	25.6	7.8	14.7

The rates of prostitution and drug crimes in 1999 (per 1000 population) were as follows, again indicating the disproportionate amount of crime in Whalley. (Stubbs, 2001).

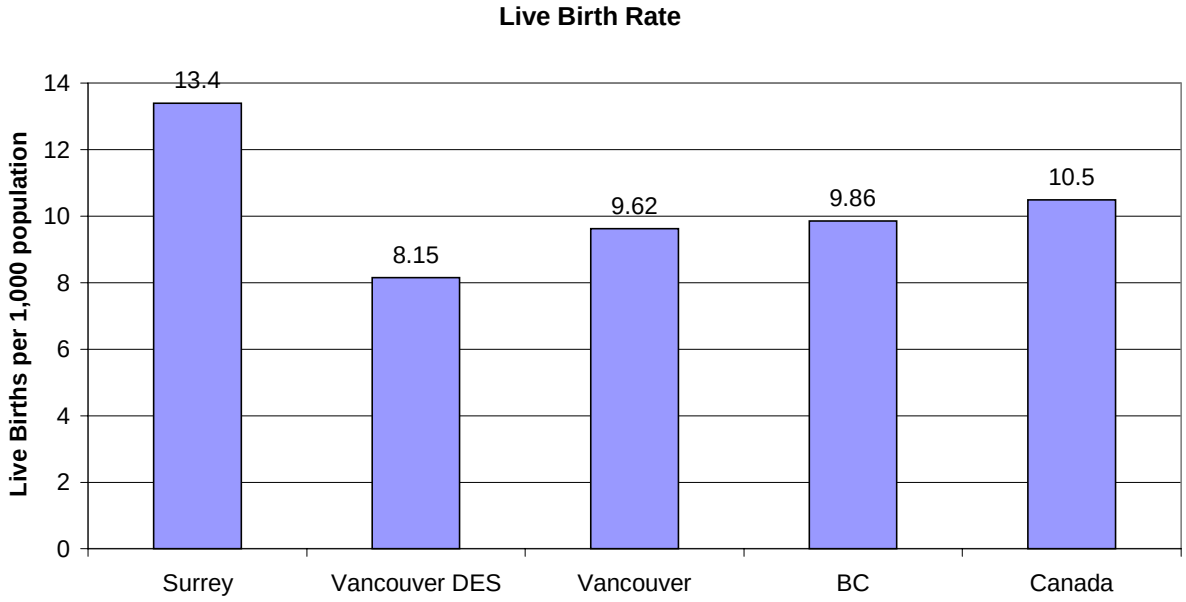
Prostitution and Drug Crimes in Surrey Communities

Community	Procuring/Prostitution	Heroin/Cocaine Possession & Trafficking
Whalley	2.6	1.9
Guildford	0.2	0.5
Surrey	0.7	0.8

SECTION II. BIRTH STATISTICS

A. LIVE BIRTH RATE

The live birth rate in Surrey is very high: 13.4 live births per 1,000 population in 2001, compared with 8.15 in the Vancouver Downtown Eastside community, 9.62 in Vancouver, and 9.86 in BC (BC Vital Statistics, 2001, Table 12). The Canadian average is 10.5 live births per 1,000 population (Statistics Canada, 2003). The Surrey live birth rate has declined 3.8% between 1999 and 2001, but remains 35% higher than the provincial average (BC Ministry of Health, 2002).

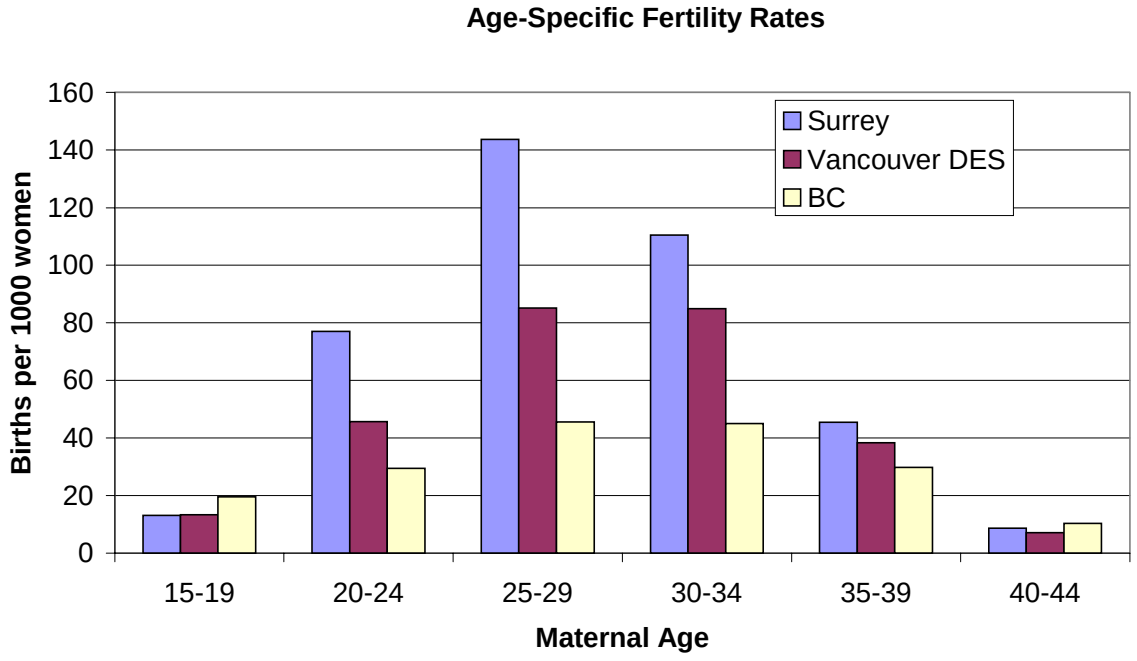


B. FERTILITY RATE

The age-specific fertility rates indicate that the rate of births to mothers under 20 and over 40 are lower in Surrey than the provincial average. The birthrate to mothers in the 20-39 age range is substantially greater than both the provincial average, and the Vancouver Downtown Eastside neighbourhood (BC Vital Statistics, 2001, Table 10).

Age-Specific Fertility Rates, Live Births Per 1000 Women In Specified Age Group

Age Range	Surrey	BC	Vancouver DES
15-19	13.16	19.56	13.28
20-24	77.05	29.49	45.68
25-29	143.66	45.54	85.15
30-34	110.46	45.08	84.84
35-39	45.45	29.81	38.4
40-44	8.67	10.4	7.14



The total fertility rate is calculated by summing all of the age-specific birth rates multiplied by the number of years in the age group. The total fertility rate indicates the number of births that a group of 1,000 women would have if they experienced, during their childbearing years (15 to 44 years), the age-specific birth rates observed in a given calendar year (BC Vital Statistics, 2001, Glossary).

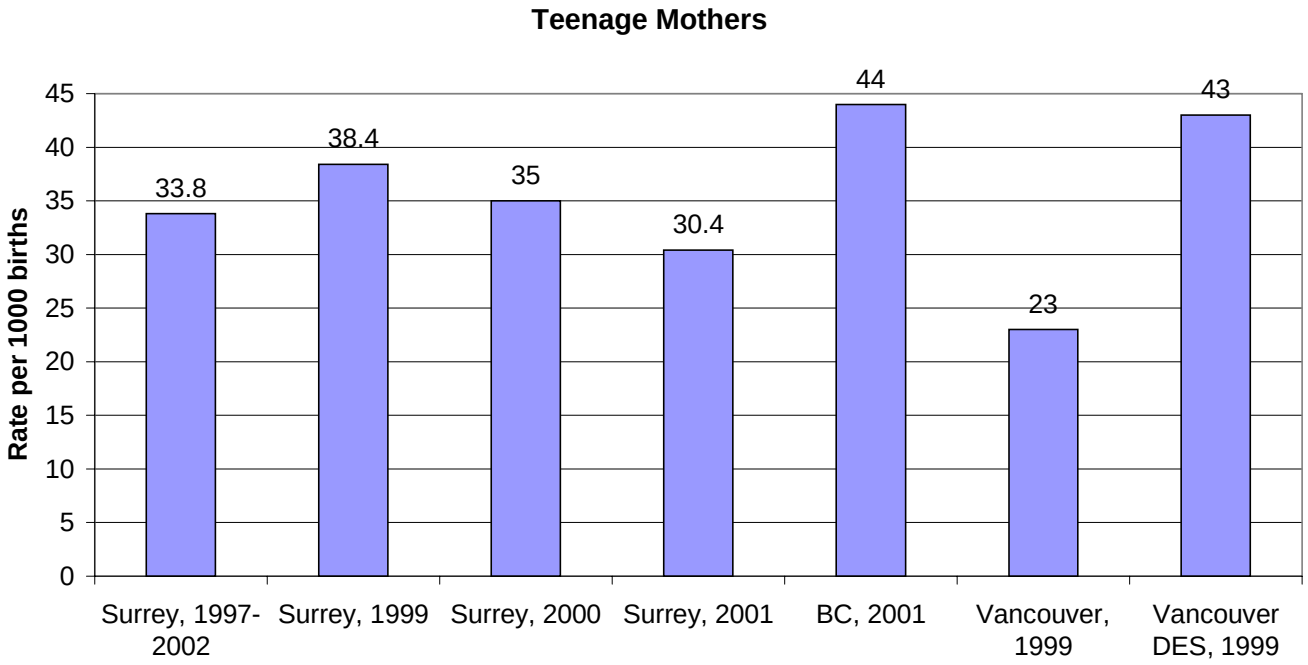
In 2001, Surrey had the third highest total fertility rate in the province of BC. The total fertility rate in Surrey is 1.45 times the provincial average and 2.2 times that of the Vancouver Downtown Eastside community (BC Vital Statistics, 2001, Table 10).

Total Fertility Rate, per 1000 Women	
Surrey	1992
BC	1373
Vancouver	962
Vancouver DES	899

C. TEENAGE MOTHERS

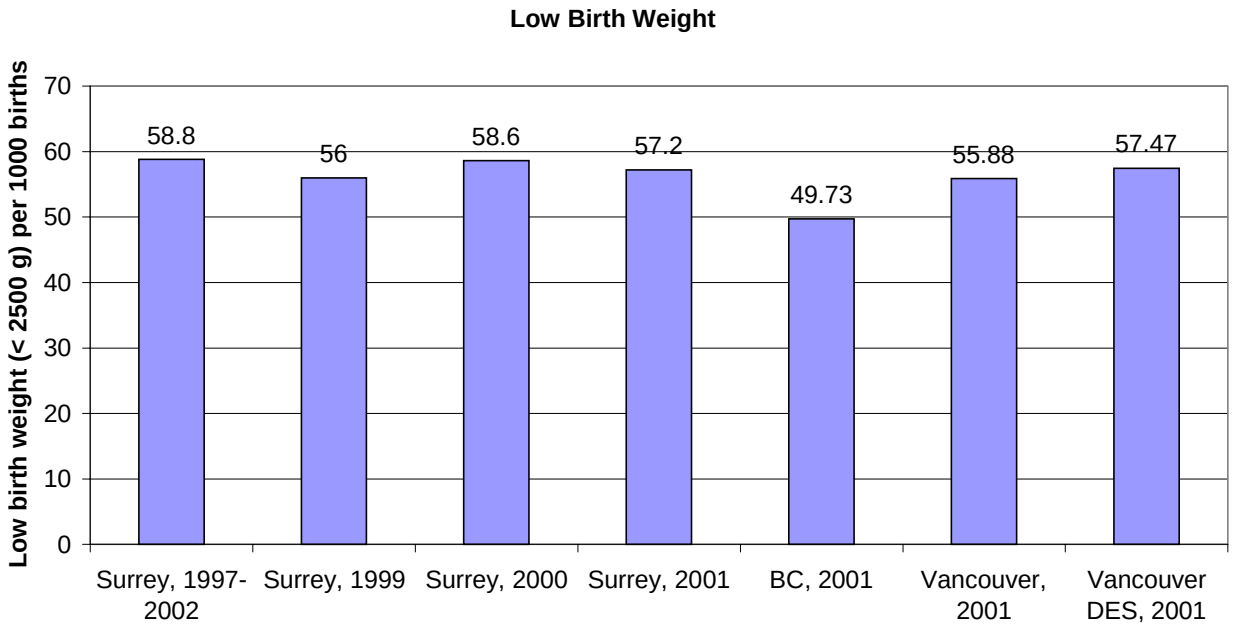
In 2001, the rate of teenage mothers in Surrey was significantly lower (30%) than the provincial average (BC Ministry of Health, 2002; BC Vital Statistics, 2001, Table 9). However, the rate is substantially higher than the rate of teenage mothers in Vancouver. In 1999, Surrey had the highest *number* (not highest rate) of teen mothers in the GVRD. The high number of Surrey teen births has been attributed to: (Stubbs, 2001)

- Increased availability of affordable housing in Surrey, compared to other regions of the Lower Mainland.
- Lack of funding for adolescent birth control. South Fraser is the only health region in the Lower Mainland that does not fund birth control for adolescents.
- Lack of sex education in Surrey schools.



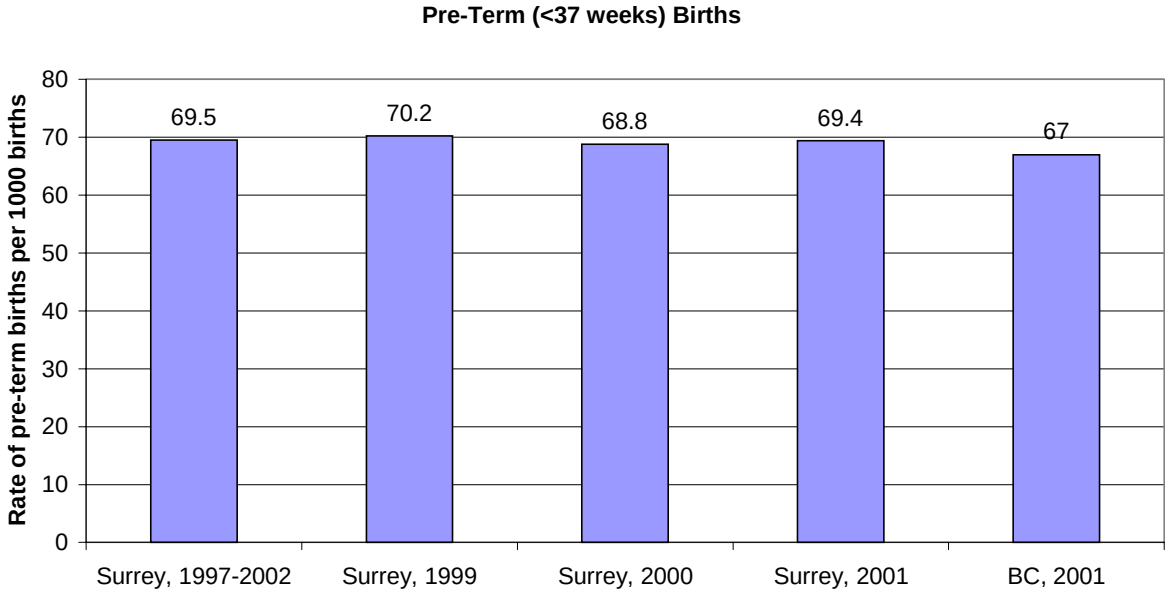
D. LOW BIRTH WEIGHT

For statistical purposes, low birth weight is defined as less than 2,500 grams. The incidence of low birth weight in Surrey is 15% higher than the provincial average (BC Vital Statistics, 2001, Tables 15 and 16). In 1999, 5.6% of Surrey births were low birth weight – slightly higher than the Vancouver Downtown Eastside neighbourhood (Stubbs, 2001).



E. PRE-TERM BIRTHS

The rate of pre-term births (less than 37 weeks gestation) in Surrey is slightly higher than the BC average: 69.4 pre-term births per 1,000 births in Surrey compared to 67 in BC (BC Vital Statistics, 2001, Table 13; Ministry of Health, 2002).



F. PERINATAL COMPLICATIONS

The perinatal period is defined as shortly before, during, and after birth (BC Vital Statistics, 2001, Glossary). The rate of perinatal complications in Surrey is approximately 15% lower than the provincial average (BC Vital Statistics, 2001, Table 20).

Perinatal Complications, Relative to BC Average

Location	1996 - 2000	2001
Surrey	0.84	0.86
Vancouver DES	0.98	0.92
Vancouver	0.91	0.87
BC	1.00	1.00

G. MATERNAL COMPLICATIONS

The rate of maternal complications of pregnancy & delivery are approximately equal to the provincial rate (BC Vital Statistics, 2001, Table 18).

Maternal Complications, Relative to BC Average

Location	1996-2000	2001
Surrey	1.00	1.02
Vancouver DES	0.99	1.10
Vancouver	1.05	1.08
BC	1.00	1.00

H. CONGENITAL ANOMALIES AND FETAL ALCOHOL SPECTRUM DISORDER

Congenital anomalies are physical defects that exist at birth, including fetal alcohol spectrum disorder (FASD) (BC Vital Statistics, 2001, Glossary).

The number of FASD diagnoses have been increasing in the South Fraser HSDA (Health Service Delivery Area), which includes Langley, Surrey and Delta. Estimates of the prevalence of maternal drinking at some point in the pregnancy, range from 7 to 25 percent (Roberts & Nanson, 2000). Alcohol and drug use in pregnancy is higher in some high risk neighbourhoods, and was found to be as high as 46% in Vancouver's Downtown Eastside community (Loock et al., 1993). An estimated forty percent of the women accessing the Surrey Prenatal Clinic use substances during their pregnancy, culminating in approximately 150 births per year (Radford, 2003).

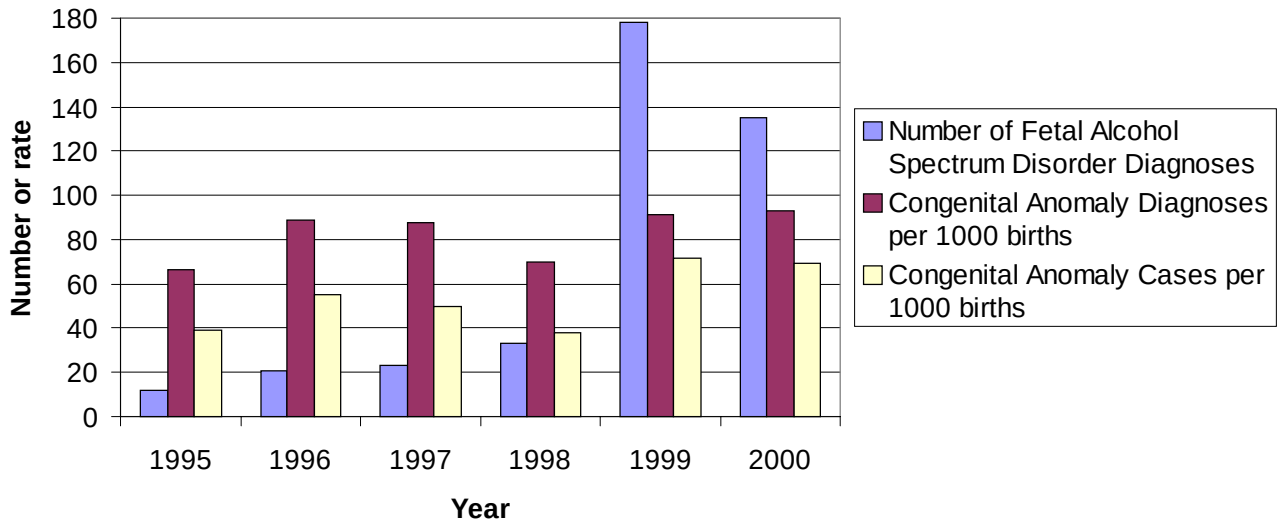
In BC, 50% of live births are unplanned. The risk of alcohol and drug consumption before the mother is aware she is pregnant is very high, and substance exposure during the first trimester is considered the most damaging to the fetus. One in every 50 babies is estimated to exhibit minor effects of FASD, while one in every 500 babies is estimated to exhibit severe FASD-related disabilities (Amos, 2003).

The drastic increase in the number of FASD diagnoses must be interpreted with caution. A major factor leading to this increase is a significantly broadened definition of FASD, and increased emphasis on early diagnosis. Infants currently diagnosed with FASD may not have been similarly diagnosed had they been born a few years earlier.

Congenital Anomalies and FASD in the South Fraser HSDA

Diagnosis	1995	1996	1997	1998	1999	2000
Fetal Alcohol Spectrum Disorder, cases	12	21	23	33	178	135
Congenital Anomaly Diagnoses per 1000 births	66.1	88.9	87.9	69.9	91.3	93.2
Congenital Anomaly Cases per 1000 births	39.0	55.1	49.8	38.0	71.8	69.4

Diagnoses of FASD and Rates of Congental Anomalies in the South Fraser HSDA



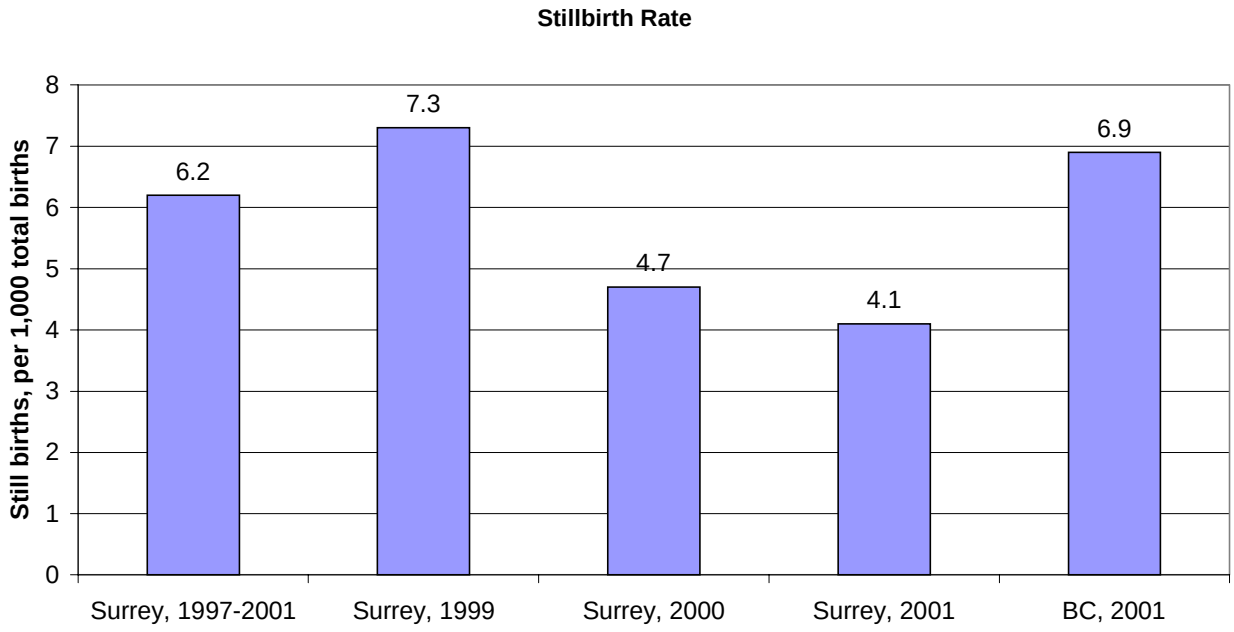
I ABORTIONS

The abortion rate in Surrey, among women aged 15-44, is substantially higher than the provincial average, as well as rates in surrounding communities: (BC Vital Statistics, 2000)

Abortion Rate per 1000 Females Aged 15-44, 1992-2000	
Surrey	20.2
Langley	10.6
Delta	14.1
BC	16.5

J. STILL BIRTHS

The rate of still births in Surrey over the five year period 1997-2001 was 6.2 still births per 1,000 total births. The rate has decreased substantially from 7.3 stillbirths in 1999 to 4.7 in 2000 and 4.1 in 2001 (BC Ministry of Health, 2002). The rate of stillbirths in 2001 in Surrey was substantially (41%) less than the BC rate of 6.9 per 1,000 total births (BC Vital Statistics, 2001, Table 1).

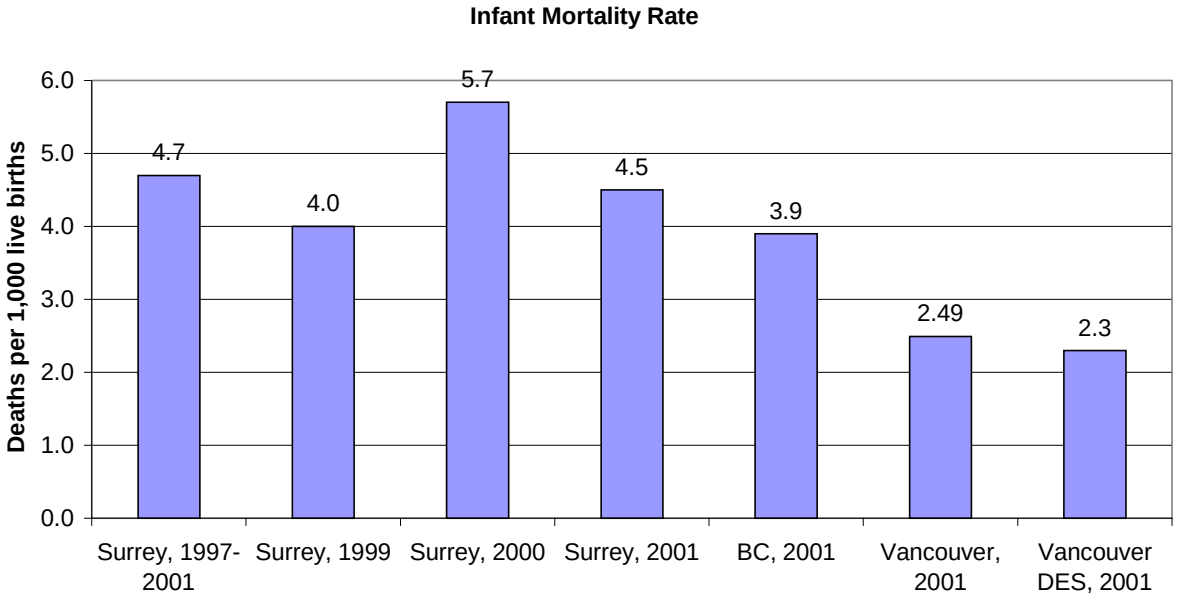


K. INFANT MORTALITY

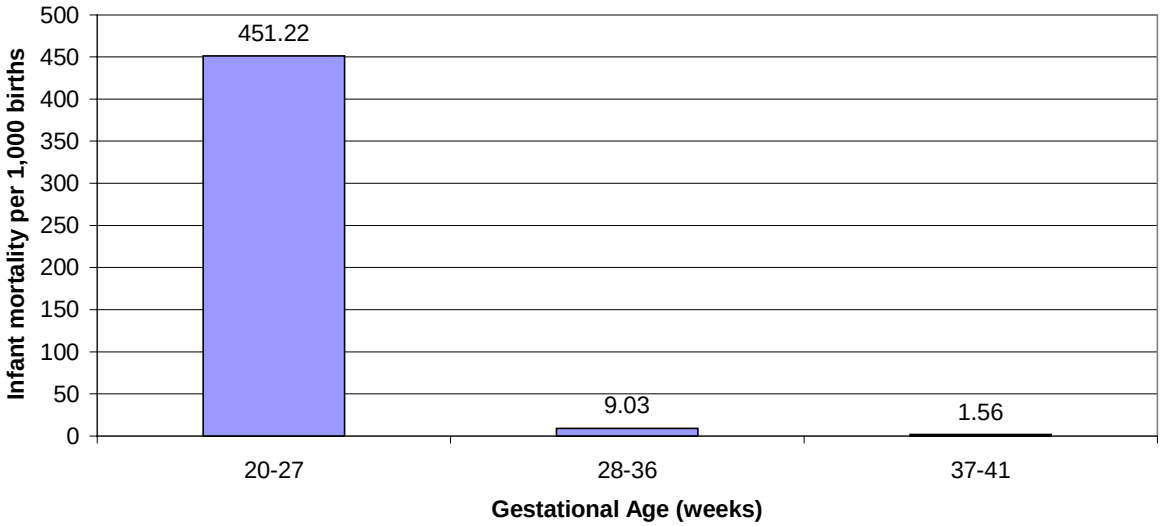
The infant mortality rate in Surrey is higher than the provincial average, and substantially higher than rates in Vancouver and the Vancouver Downtown Eastside community. The five-year average from 1997 to 2001 in Surrey is 4.7 deaths of children less than one year of age per 1,000 births (BC Ministry of Health, 2002). The 2001 rate in Surrey was 4.5 deaths, compared to the provincial average of 3.9 deaths per 1,000 live births. Infant mortality rates in the Vancouver Downtown Eastside community and Vancouver are 2.3 and 2.49, respectively (BC Vital Statistics, 2001, Tables 4 and 26).

In 2001 in Surrey, of the 22 infant mortalities, 14 occurred within 0-4 days of birth, 18 occurred within 0-27 days of birth, and four occurred within 28-364 days of birth (BC Vital Statistics, 2001, Table 26).

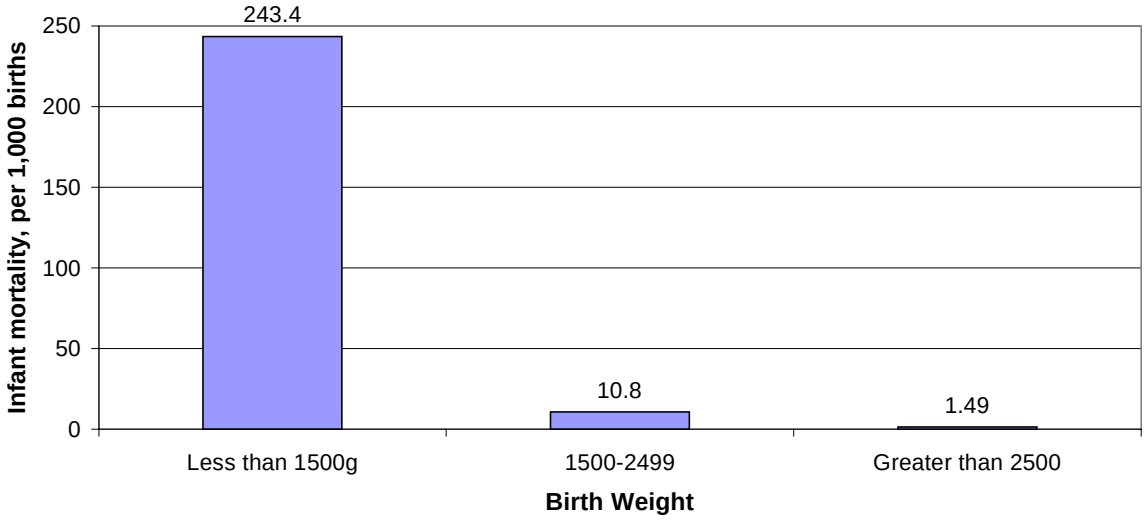
Infant mortality is strongly linked to the baby's gestational age, birth weight, and the mother's age (BC Vital Statistics, 2001, Tables 24 and 25).

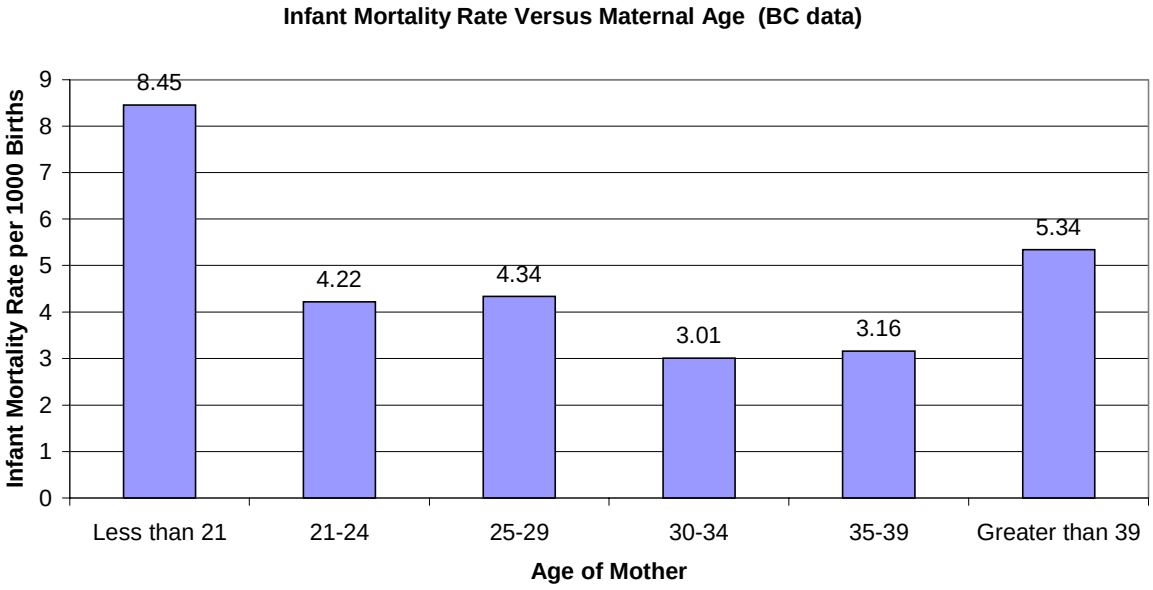


Infant Mortality Rate Versus Gestational Age (BC Data)



Infant Mortality Rate Versus Birthweight (BC data)





Congenital and chromosomal anomalies account for an infant mortality rate of 12.14 deaths and a stillbirth rate of 4.18 per 10,000 births.

Perinatal conditions, including, but not limited to, maternal factors, respiratory, cardiovascular and digestive disorders, infections, hemorrhages, and sudden infant death syndrome (SIDS) account for an infant mortality rate of 39.38 and a stillbirth rate of 69.11 per 10,000 births (BC Vital Statistics, 2001, Table 27). This data emphasizes the importance of good pre- and post-natal care for the mother and baby, since the majority of still births and infant mortalities are caused by factors that can be alleviated or prevented by good quality care.

L. SUDDEN INFANT DEATH SYNDROME

The rate of sudden infant death syndrome (SIDS) in Surrey has decreased from three cases per year in 1999 and 2000 (equivalent to 6.37 cases per 10,000 live births) to one case in each year of 2001 and 2002 (equivalent to a rate of 2.07 cases per 10,000 live births). This compares favourably to a provincial SIDS rate of 2.48 cases per 10,000 live births in 2001 (BC Vital Statistics, 2001, Table 27).

M. PRENATAL HEALTH CARE

The number of women who have received no prenatal care prior to giving birth in Surrey is estimated to be 100 out of 3500 births, approximately 3% (Radford, 2003).

SECTION III. ALCOHOL AND DRUG EPIDEMIOLOGY

A. ALCOHOL-RELATED DEATHS

A standardized mortality ratio (SMR) is the ratio of the number of deaths occurring to residents of a geographic area (for example, a local health area) to the expected number of deaths in that area based on provincial age-specific mortality rates (BC Vital Statistics, 2001, Glossary).

The standardized mortality ratio for alcohol-related deaths in Surrey is comparatively low, 0.80, compared to 1.00 for the province of BC, and 1.05 for Vancouver (BC Vital Statistics, 2001, Table 41).

B. DRUG-INDUCED DEATHS

The relative number of drug-induced deaths in 2001 in Surrey was also substantially lower than the provincial average, and other regions in the Lower Mainland (BC Vital Statistics, 2001, Table 45).

	Deaths	SMR
Surrey	19	0.72
Vancouver DES	31	6.14
Vancouver	72	1.45
BC	312	1.00

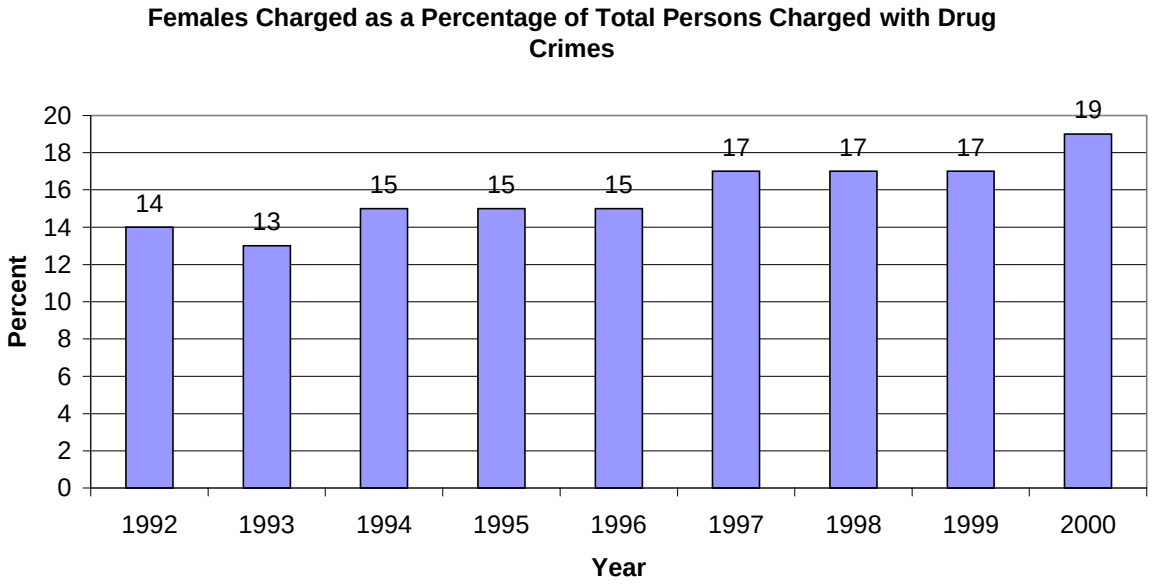
C. METHADONE TREATMENT

Methadone treatment in BC has increased from 2,000 patients in 1998 to 8,600 patients in 2002. In 2002 there were 900-950 individuals undergoing methadone treatment in Surrey (Diakiw, 2002).

D. DRUG-RELATED CRIME

The rate of drug-related crime in BC has increased from 4.08 crimes per 1,000 people in 1992 to 5.64 crimes per 1,000 people in 2001 (Ministry of Public Safety, 2001, Chapter 5, Page 76). In 2001 there were 57 criminal charges laid in Surrey for heroin possession and trafficking, and 304 charges laid for cocaine possession/trafficking (Ministry of Public Safety, Appendix B, Page 109).

The proportion of BC females charged with drug crimes, as a percentage of total persons charged has been increasing over the past decade: (Ministry of Public Safety, 2001, Appendix C, Page 141)



SECTION IV. HEALTH

A. HIV DEATHS AND NEW CASES

The rate of HIV-related fatalities and new cases in Surrey is very low. The following rates of HIV deaths and new cases were recorded, per 100,000 residents: (BC Vital Statistics, 2001, Table 29; Talbot, 2000).

Region	Rate of HIV Deaths, 1987-2001	Rate of New HIV Cases, 1998
South Fraser (Surrey, Langley, Delta, White Rock)	2.04	0.35
Vancouver	20.76	9.58
BC	4.92	2.52

B. DEATHS FROM ACCIDENTS AND VIOLENCE

The age-standardized mortality ratio (ASMR) is a relative measure of mortality which takes into account differences in ages between the populations being compared. The ASMR is the theoretical number of deaths that would occur per 10,000 population, if the specific population had the same age structure as the standard population (BC Vital Statistics, 2001, Glossary).

The age-specific mortality rate due to accidents and violence per 10,000 residents in 2001 was relatively low in Surrey, compared to surrounding communities and the provincial average: (BC Vital Statistics, 2001, Table 31)

	ASMR
Surrey	2.38
Vancouver	2.55
Vancouver DES	8.02
BC	3.19

C. DEATHS FROM MEDICALLY TREATABLE DISEASES

The rate of deaths in Surrey from medically treatable diseases is quite high. The standardized mortality ratio (BC average = 1.00) in Surrey is 1.47. This compares to a SMR of 0.78 in Vancouver and 1.7 in the Vancouver Downtown Eastside community (BC Vital Statistics, 2001, Table 38).

CHAPTER IV COMMUNITY CONSULTATIONS

The Committee identified a range of community service providers who might be interested in participating in a consultation process about the development of the proposed program model. We followed up with these providers to request their participation. As well, we wanted to obtain information from women who might be the "potential target client group" so a number of agencies requested permission from their clients to provide names to us. Once the women gave their approval to the agency, the researchers followed up directly with them. A list of the community respondents is found in the Appendix.

Though every effort was made to be as comprehensive as possible within time and budgetary constraints, it should be noted that there some limitations. Not everyone contacted chose to participate in the community consultations. And we were not able to interview everyone who might have been interested in having a voice in the formulation of the program model.

The previous two sections of the report informed the development of interview guides and focus group guides (see Appendix).

I. VIEWS OF WOMEN FROM THE POTENTIAL TARGET GROUP OF THE PROGRAM

The community consultation process had several components:

- 19 individual interviews with women from the potential target group, drawn from 6 community agency programs
- 1 focus group with 6 women from the potential target group from one community program, Healthiest Babies Possible
- 28 individual interviews with various community stakeholders
- 5 focus groups with 37 additional community stakeholders.

In total, we interviewed 90 individuals.

Each of the components of the community consultation process (i.e., individual interviews and focus group with women from the potential target group, individual interviews with community stakeholders, and focus groups with community stakeholders) is presented in turn in this section of the report.

The first section centres on the results from individual interviews with 19 women and a focus group interview with an additional six women from one program, Healthiest Babies Possible. (This program offers services to the proposed target population, except their services end when the child is six months old). The topics covered include the demographics of respondents, services received while pregnant, services received after childbirth, services currently received, and ideas for the proposed program. In each case,

the results are presented separately for the interview program and the focus group interview and then the conclusions are summarized.

A. DEMOGRAPHICS OF THE RESPONDING WOMEN

The potential target group, defined as "high risk women" were drawn from transition houses, an Aboriginal agency, and several community agencies. These agencies offer a range of programs, including shelter, programs to women who are using substances, medical care, alcohol and drug counselling, among others. Thus, we inferred that women respondents would be able to comment on their experiences of receiving services during and after pregnancy, as well as "ideal services" and other thoughts about a high risk pregnancy and early parenting program.

1. Size of Component - Women Who Are Potential Target Population

- 19 interviews
- 1 focus group with 6 women (participating in the Healthiest Babies Possible (HBP) Program)

2. Ethnicity

a) Interview Program

- 8 First Nations, mainly from Surrey Aboriginal Cultural Society (SACS) (44%)
- 1 Indo Canadian (6%)
- 9 White / Caucasian (50%)
- 1 Unknown

b) Focus Group

- 4 White / Caucasian (66.7%)
- 1 First Nations (16.7%)
- 1 Filipino (16.7%)

3. Age

a) Interview Program

- 9 in their 20's (50%)
- 4 in their 30's (22%)
- 4 in their 40's (22%)
- 1 in their 50's (6%)
- 1 no age information

b) Focus Group

- 4 in their 20's (66.7%)
- 2 in their 30's (33.3%)

4. Family

a) Interview Program

- 18 had children (95%)
- 16 had children under the age of 7 (84%)
- 4 had had children removed by the Ministry of Children and Family Development; all were First Nations (21%)

b) Focus Group

- All 6 had children
- All 6 had a child under 1 year of age
- 2 had had children removed by the Ministry of Children and Family Development

5. Other Population Characteristics

a) Interview Program

- 6 mentioned A&D issues or use of A&D counseling
- 3 were pregnant at time of interview

b) Focus Group

- 1 mentioned A&D issues
- 1 was pregnant at the time of the group interview

Conclusion:
The women in both the individual and group interviews are from the intended target population for the proposed program. As such, their experiences and needs should provide a voice to the expectations of this group for the proposed program.

B. QUESTION RESPONSES

1. Services Received While Pregnant

a) Interview Program

The women were asked what services they received when they were pregnant. The results for the interview program were:

Services Received During Pregnancy	#	%
Services From HBP	8	42%
Services From Other Programs (And No Services From HBP)	2	11%
No Services Received	9	47%
Total Responses	19	100%

In addition, five of the eight women who participated in HBP also received other services during pregnancy. Taken together with the two women who received other services but did not participate in HBP, a total of seven women (37%) received a variety of other services during pregnancy. These other services included:

- Positively Pregnant
- South Surrey/White Rock Women's Place
- Mother Goose
- Time out for Moms and Tots
- Best Babies of Langley
- Family life skills
- Health unit
- Pregnancy crisis center
- Prenatal care
- Special needs daycare.

Those who received services said they were helpful. The main benefits mentioned were:

- Information on how to prepare for birth
- Information on how to live with addiction and a baby
- Information on breastfeeding
- Emotional and nutritional support
- Food gift certificates
- Lunches provided.

The ideal services mentioned (in addition to those received) were:

- A&D counselling daily
- Childcare for other children
- Financial aid to buy vitamins
- Support for young mothers to reduce feelings of isolation
- Opportunity to talk to other mothers
- Information on prenatal care.

b) Focus Group

Given that the focus group participants were involved with HBP, it is not surprising that HBP was mentioned as a service received during pregnancy. In addition, the food bank and medical care from a doctor were other services mentioned as being received during pregnancy.

Like the interview participants, the services received by the women in the group interview were considered to be helpful. The main benefits mentioned by this group were:

- Improved preparation to parent
- Personal and professional support
- Improved nutrition
- Connections made and new friends.

The group participants mentioned the following as part of their ideal services:

- Exercise or stretching
- Clothing
- Money
- Field trips which offer something fun to do.

Conclusions:

- HBP is the most common service used by this high risk group during pregnancy (42% of the interview sample).
- A significant proportion of these women (47% of the interview sample) did not receive any services during pregnancy.
- The services received were helpful and provided a variety of benefits including information and preparation for childbirth, food and nutritional support, emotional support, and making a connection to other women.
- The suggestions for ideal services during pregnancy (in addition to those already received) varied among respondents. The main ones seemed to be A&D counseling, childcare, financial aid, clothing, and support for young mothers.

2. Services Received After Childbirth

a) Interview Program

The women from the interview program were asked what services they needed or wanted post birth up to the child's age six. Half of the women received services as the following results show:

Services Received After Childbirth	#	%
Received Some Services After Childbirth	10	53%
Wanted Help, But Did Not Receive The Desired Assistance	4	21%
Did Not Feel The Need For Any Assistance (And Received No Services)	5	26%
Total Responses	19	100%

The main services mentioned as needed or wanted after childbirth were:

- HBP
- Mother Goose
- Visiting nurse or someone to come in and help as needed
- Emotional support
- Information on breastfeeding.

All those who received services felt that they were helpful. The main benefits mentioned from these services were:

- Information and improved understanding about feeding
- Dietician support
- Assistance with the baby that allowed the mom to go out and meet other women
- Community kitchen
- Food coupons
- Learning about parenting and information on caring for babies.

The ideal services for post childbirth that participants mentioned (in addition to those already stated) were:

- In-house access to A&D counselling
- Information on FAS
- Support groups for young mothers
- Daycare
- Information on proper health and food for mothers

- In-home service visits
- Assistance finding low income housing
- Life skills program
- Employment skills training and job search assistance
- Help getting baby things – clothing, diapers, formula, etc.
- Low cost activities for mothers and children
- Opportunity to network with other mothers.

The services mentioned that might have helped the mother keep a child (in situation where a child was removed by the Ministry of Children and Family Development) were:

- Nurse or home health care support to help with the baby when problems arise
- Support to provide a break for mom and help with cooking/shopping
- A&D counselling
- One-on-one counselling.

b) Focus Group

Given that the focus group participants came from the HBP program, the services needed or wanted after childbirth likely included HBP. However, those mentioned were described in generic terms and were somewhat different than those mentioned by women from the interview program. The services mentioned were:

- Babysitting
- More money
- Family preservation services, including baby supplies and clothes.

Focus group interview participants indicated that they received these desired services and that like those in the interview program, they felt the services were helpful. Group participants felt that the most helpful thing was the provision of baby supplies, which they considered to be expensive.

The ideal post childbirth services listed by the focus group interview participants were again generally different that those mentioned during the individual interviews. The group's perception of their ideal services was:

- Transportation assistance
- Child relief (to allow the mother some time to herself)
- Home nurse support
- Food bank
- A&D treatment information in pamphlet form.

For the focus group interview, the services mentioned that might have helped a mother keep a child (in situation where a child was removed by Ministry) were:

- Better health care to help deal with health problems, stress and depression
- Advocacy and better information about what was going on at the Ministry.

Conclusions:

- A significant proportion of the women (47% of the interview sample) did not receive services after childbirth.
- The services received were helpful and provided a variety of benefits, including information about feeding and caring for babies, food or food coupons, emotional support, baby supplies, and childcare relief or babysitting.
- The suggestions for ideal services after childbirth varied among respondents. The main ones were A&D counselling or pamphlets on treatment, food bank, in-home service visits, daycare, support groups for young mothers, information on proper health, life skills, and assistance finding low income housing.
- The main services mentioned that might have helped a mother keep a child were assistance with A&D or health issues, support to help with the baby when problems arise, and better information on what to expect from the Ministry of Children and Family Development.

3. Current Services Received

a) Interview Program

The women were asked what services they were currently receiving. Interview respondents mentioned the following services as being currently used:

- HBP
- SACS
- PACT
- Mother Goose
- Surrey Women's Centre
- Services at their transition house
- A&D counselling/outreach
- Life skills and parenting skills
- Employment services and Job Wave
- Family support worker
- Community Center programs and services.

The strengths of the current services mentioned by respondents were:

- Gift and food certificates
- Someone to talk to about problems
- One-on-one counselling
- Emotional support
- Opportunity to talk with other mothers
- Access to information and resources
- Supports for finding a job
- Bus pass
- Community kitchen
- Increased knowledge about all aspects of pregnancy and parenting
- Childcare providing a break for mothers.

As for limitations of the currently used services, not many limitations were mentioned because respondents were generally happy with current services. Those that were noted included: long wait lists for services, awkwardness in traveling with children to services, and a need for better information on the services for mothers which are available in Surrey.

b) Focus Group

The services that group participants mentioned as being currently received were:

- HBP
- Surrey Addictions
- Project Parent
- Family Preservation
- Food bank
- Pre-school
- Daycare
- Surrey Community Services.

The strengths of these current services were described as:

- A great atmosphere and support (HBP)
- Immediacy of getting services.

The only limitations mentioned were:

- Family Preservation services needs to be longer
- There is a need for food vouchers.

Conclusions:

- The services currently received varied among respondents. The most commonly mentioned services included HBP, SACS, services from their transition house, A&D counselling/outreach, life skills and parenting, and employment skills and Job Wave. (In the case of SACS and services from their transition house, these services tend to reflect where the sample of individual women was drawn from).
- The most commonly mentioned strengths of these services included an opportunity to talk to other moms, someone to talk to about problems, one-on-one counselling, childcare, gift and food certificates, and supports for finding a job.
- Few service limitations were mentioned. Respondents were generally happy with the current services.

4. Ideas for Proposed Program

a) Interview Program

Women from the interview program were asked what is the best geographic location in Surrey for the proposed program. Respondents generally felt that women with children in Surrey should have easy access to the service. It should be located close to a skytrain station or on a bus route.

From a strict location perspective, examples of the most common responses were:

- *"It should be located in a central area, possibly near Surrey Central skytrain station."*
- *"It should be located between Whalley and Newton – there is nothing between these two areas."*
- *"I would like to see it in Newton – it is central, has easy access by bus and is a safer environment."*

While one respondent felt that it should be in Whalley because that is where the other services are, other respondents said that Whalley should be avoided because "it is not a safe area".

All respondents were in favour of implementing a "one-stop-shop" concept in service delivery. The point was made that lots of single mothers do not have a vehicle and rely on public transportation. Several respondents stated that it would reduce the need to travel "all over the place" to access needed services. A few also said that they found it difficult to travel around Surrey in order to access different services, particularly when traveling with children.

When asked about other aspects that the Committee should consider when designing the proposed program, the following responses were provided:

- *"I would like to see A&D counselling available on a daily basis."*
- *"There is a need to provide support groups for single moms, particularly for those with addictions or those who are battered or abused."*
- *"There is a need for access to counsellors."*
- *"I would like to see information on infant development, FAS, and how to deal with addictions."*
- *"I would like to see information on health, nutrition issues and vitamins."*
- *"I would like to see more focus on the needs of young moms."*
- *"I would like to see assistance with job training for single moms."*
- *"I would like to see outreach workers delivering some services to the home where moms are in need and cannot access the centre."*
- *"There is a need for supervised childcare."*
- *"The program should empower women."*
- *"There must be an opportunity for women to develop a long-term trusting relationship with staff and this requires staff stability."*

b) Focus Group

Like the interview respondents, the focus group participants felt that the best location for the proposed program would be somewhere that is easy to get to if you take the bus or skytrain. No other specific views on location were provided.

Also like the views of the interview program respondents, the focus group interview participants were in favour of the "one-stop-shop" concept because "it would be easier to get to."

Finally, the group felt that the Committee should also consider the following:

- In-home visits for women who are sick and don't get out.
- Those with A&D issues should be in an area away from women with children.
- Employment supports are needed, like resume preparation and job search.

Conclusions:

- The proposed program should be in a central location with easy access by bus or skytrain. Concerns were raised about the safety of the Whalley area, but no consensus was voiced about where the program should be based.
- All respondents supported the "one-stop-shop" concept of service delivery.
- The most commonly mentioned additional aspects that the Committee should consider were A&D counselling, childcare, support groups for single mothers, more focus on the needs of young mothers, employment supports and assistance with job training, an outreach service to deliver some services to the

home, and staff stability, which supports development of a long-term, trusting relationship for the women.

II. VIEWS OF COMMUNITY STAKEHOLDERS

The second component of the research involved 28 interviews with community stakeholders representing service agencies, transition houses, and public health services. Participants were asked to comment on the intended population, the types of services needed, key principles, the partnership model, and the location for the proposed program. This section presents community stakeholder views on these topics.

1. Target Population

Community stakeholders were asked for their comment on the target population for the proposed project (high risk pregnant women and women with children up to six). The majority of the respondents felt that this was the right population. However, a few raised a concern that the project was creating a new program that may duplicate an existing service or would be serving a population that is already covered (by HBP, PACT and IDA). The responses were as follows:

Response About Target Population	#	%
This Is The Right Target Population	22	78%
Concerned That This Project Would Be Serving A Population That Is Already Covered	4	14%
A Different Age Might Be More Appropriate (e.g., Up To Three Years)	1	4%
Not Sure	1	4%
Total Responses	28	100%

Those who supported the concept often made associated comments about the idea and the need for the service. The following comments illustrate their views:

- *"There are lots of women who are visibly pregnant and working the streets in Surrey and we see lots of high risk women using drugs while pregnant. There are no services for them in the community."*
- *"We see lots of high risk pregnant women with drug or mental illness issues. This is a vulnerable population with high needs and the least resources."*
- *"We just surveyed our clients about where they go for support if pregnant. 38% said HBP, but the rest said nothing. Most did not know about HBP."*
- *"Tiny Bundles stops at one and diapers at two years. There is nothing for families to go to after."*
- *"Up to age six is good. Our HBP program has a component of support for kids, but not up to age six. That part is missing."*

- *"Our agency service begins after the child is born, but it makes sense to link to the pregnancy stage."*

2. Types of Services Needed in the Program

Community stakeholders were asked to describe the types of services needed in the proposed program. The 26 stakeholders who offered useable responses suggested a wide variety of possible services with food (58%), daycare (38%), baby supplies (27%), and a safe environment (27%) being mentioned most frequently. Those suggested by at least three respondents are listed below:

Suggested Service	#	%
Free Food / Healthy Snacks / Hot Lunches / Community Kitchen	15	58%
Food Bank	5	19%
Baby Basics (e.g., Baby Food, Formula, Vitamins, Diaper, Toy Bank)	7	27%
Daycare / Childcare	10	38%
Facility For Kids / Playground	3	12%
Clothing Bank With Clothes For Pregnant Women	4	15%
Transportation Assistance / Bus Tickets	4	15%
Shelter / Beds / Safe Housing	4	15%
Safe Environment	7	27%
Supportive, Non-Judgmental Place	3	12%
Life Skills And Parenting Skills Programs	5	19%
A&D Services	4	15%
Counselling	4	15%
Access To Public Health, Medical Services, And A Women-Friendly Doctor	4	15%
Education And Information On Health And Eating Healthy, Raising Babies, And Risky Behaviour And Consequences	4	15%
Support Groups	4	15%
Drop-In Centre For Women / Someone To Talk To	3	12%
Opportunity To Network With Peers / To Talk With Other Moms	3	12%
Crisis And Long-term / Ongoing Support	3	12%
Support Workers / Advisors (To Explain Things, Help Mothers Deal With Stress, And Point Women In The Right Direction)	3	12%
Outreach Workers	3	12%
Pamphlets And Literature (Including Community Resources Information) Printed In Several Languages	3	12%

Few respondents provided a view on what incentives might bring the high risk women through the door. Those who did comment felt that poverty is a huge obstacle for this population's ability to meet the most basic of needs, so that free food and a food voucher program would likely help.

When discussing the services needed, respondents also commented on how the services should be delivered. The following comments illustrate some of the different perspectives provided:

Cultural Diversity

- *"40% of the women in Surrey are from visible minorities or First Nations. This program needs to be culturally diverse and must cater to the multi-cultural nature of the community."*
- *"The staff need to be ethno-specific and reflect the demographics of the area."*
- *"The staff need to be culturally sensitive, be multi-lingual and have multi-cultural training."*

Long-term Relationships

- *"There is a need to build trust with program staff. It is important to have one location that engages women and families for six years. In contrast, there is often a strong relationship established between families and HBP staff, but it ends when the baby is six months old. It can be difficult for parents to make the transition to another service provider at that stage."*
- *"A long-term relationship is important to establish. Some of these kids will need long-term assistance since they are starting from a situation of high risk."*
- *"Staff will also need training to enable them to identify problems in the development of kids. Some will be slow and we need to monitor their development closely."*

Responsive to Needs

- *"The service must be responsive and respectful of the needs of women in this population. Flexibility will be needed to provide what the individual requires and not simply a set program of services. Learning from the experience of Sheway, the individual's services should be planned with them after identifying their needs."*
- *"There may need to be differentiation between services intended for really young pregnant girls and older ones. The needs are different."*
- *"One of the problems is that the young moms often do not qualify for services so the proposed services need to be more inclusive."*

Communication and Outreach

- *"It has been our experience that it is hard to get clients to participate in the services offered. The women here are not at the stage that they can decide what supports they want and then take advantage of them. Clear communication will be needed – too much information is overwhelming for these women."*
- *"Outreach will be needed on a regular basis to keep awareness up and to build trust and respect. It takes courage to walk through the door."*

Use Existing Resources in the Community

- *"The program should be open and flexible in the way the services are delivered. Everyone working there does not have to be employed by the same organization. We should be able to make use of existing resources in the community with the service provider coming in as needed."*

One-Stop-Shop

- *"The services need to be user friendly and accessible. It would be nice if the needed services could be offered in one place and one building – a one-stop-shop approach."*

3. Key Principles for the Program

Community stakeholders were asked to comment on the key principles for the program involving women-centred care, harm reduction, and the interconnectedness of oppressions. Respondents tended to comment on all principles together or they commented on individual principles but not necessarily on all principles. The results are shown below:

Comment on the Key Principles	#	%
Liked All The Principles / Fully Supported These Principles	11	39%
Liked All The Principles, But Were Not Clear on How They Will Be Implemented In Practice	3	11%
Liked Women-Centred Care and Harm Reduction, But Did Not Support the Interconnectedness of Oppressions	1	4%
Liked Women-Centred Care And Harm Reduction, But Gave No View on The Interconnectedness of Oppressions	6	21%
Liked Harm Reduction, But Gave No View on Either Women-Centred Care or on The Interconnectedness of Oppressions	2	7%
Did Not Support These Principles	2	7%
Did Not Have a Clear Opinion on These Principles	3	11%
Total Respondents	28	100%

Taken together, 14 respondents (50%) supported all of the principles, 21 respondents (75%) supported the women-centred care principle, and 23 respondents (82%) supported the harm reduction principle. At a general level, the results indicate that the principles of women-centred care and harm reduction are viewed as being well suited to the target population. The following stakeholder comments illustrate support for these two principles:

- *"Being women-centred should be the main goal and it will be successful. Women need to be able to work on what they want and need."*
- *"Women-centered care will increase their sense of self and belief in their own value and capability."*
- *"This approach does stigmatize women because of their needs and this stigma is in itself marginalizing. However, we need the project to serve marginalized women and these principles offer a best practice for marginalized women."*
- *"Harm reduction is good because high risk pregnant women tend to be addicted and may not have access to the program without harm reduction."*
- *"Harm reduction is appropriate because it will not exclude women who are using and women will not have to lie or hide where they are at."*

Support for the third principle is less solid. A few off topic comments from stakeholders and the fact that eight respondents (29%) did not provide a view on the interconnectedness of oppressions suggest that this principle may not be well understood by all respondents. In addition, one stakeholder said that adopting this principle "might prevent minorities from feeling comfortable because it is not a neutral statement." In fact, defining how each of these principles would affect service delivery would likely help to clarify the opinions of support or non-support on these principles.

4. Tensions Between Women-Centred Care and Child Protection

Community stakeholders were asked to comment on the perspective that in programs like this, there can be tensions between women-centred care and the protection of children. All respondents commented that sometimes there is a gap between the high risk women's decisions and personal needs and her provision of an appropriate level of child care and parenting. However, the stakeholders expressed several different views on the subject of women-centred care and child protection. The basic results are summarized below and then the different perspectives are presented.

Comment on Women-centred Care vs. Child Protection	#	%
This Is a Potential Issue / Often a Difficult Situation	21	75%
Do Not See This as a Problem or Conflict	5	18%
Do Not Know	2	7%
Total Respondents	28	100%

The majority of stakeholders (75%) considered the situation to be complex and, in their experience, often presented a dilemma. This involves finding a balance between respecting the woman's decisions, maintaining her trust and confidence in stressful times, helping to close the gap between the needs of the child and what the mother can give, assessing the risk to the child, and an obligation to report when the child is in danger. The following stakeholder comments illustrate some different views on this subject:

- *"It is hard supporting pregnant women to not infect their body with unsafe needles. And, it is a hard balance to support a mother in harm reduction when children are involved. We need to work with the women and respect their decisions, but we are also bound by law to report problems."*
- *"It is a difficult situation, but child protection is critical. If a mom is not able to protect and do her best for the child or if a child is in danger or neglected, then the child needs to be removed until the mom cleans up or takes care of what needs to be taken care of."*
- *"We are all mandated to report child abuse, but not all issues that these women have are connected to child protection. We need to be sensitive to this, find a balance and gain the women's confidentiality."*
- *"I try to bridge the gap with my work. I try and respect the woman's decisions, but the problem is that sometimes the mom's best is not good enough. If I have to make a call, I worry that my action will drive a wedge between the woman and me."*
- *"Another factor is that the reporting situation is handled differently in different agencies. At one Vancouver agency, it is always about the woman and they never report to the Ministry. But, our staff are always required to call because of accountability issues related to funding."*
- *"Often these high risk women are being flagged by Ministry staff when they go to the hospital and they have their babies removed once they give birth. As such, they do not trust anyone or talk to their social worker. It can be very difficult for these women to be comfortable and honest with our service staff."*
- *"Part of the tension is caused by the way Ministry workers go about it – it is always a threat. With harm reduction, the moms are still using and, as for lots of the Ministry workers, taking the kids is all they know. It is a problem."*

As a follow-up to this question, the community stakeholders made a few suggestions on how the proposed project could help to deal with this issue. These suggestions were:

- *"We need staff that will help women deal effectively with the child protection system. We need one-on-one casework to ensure that mom and baby have a good chance of staying together."*
- *"The key is to keep the women informed and supported then they feel they know what is in the best interest of themselves and the child."*

- *"There is a huge fear of the social worker or the Ministry workers. They are also afraid of Boundary Health Unit. We need to support discussion about the fear of removal of kids."*
- *"Child protection workers should not be on site. I think that it would prevent women from using the program. While a program like this may reduce the need for protection intervention, MCFD social workers in Child Protection need to feel comfortable too. There will need to be adequate supports in place and protocols set up before the program is implemented."*
- *"MCFD does not always respond appropriately. There needs to be protocols established so that staff responses are clear and so women know what to expect when they come through the door."*
- *"Child protection workers need to be educated about the new A&D practices."*

5. The Partnership Model

The community stakeholders were asked for their comments on the idea that those organizations who serve in one way or another the proposed target population, should work in partnership on this project. There was strong support for a partnership and collaborative approach -- 27 respondents (96%) were in favour of this idea. However, three supporting stakeholders (11%) suggested that more work is needed to define what the partnership means, what a structure might look like and how collaboration could work.

The following summarized comments from stakeholders indicate what they felt were important aspects of the proposed partnership:

- *"We need to set up an organization that is easy for the Ministry to deal with, where common goals are defined, and where the roles of each partner are clearly laid out."*
- *"There is a need for strong leadership (probably one agency) for the model to work and the individual involved would have to have the necessary time to take on the project. Also, problems will occur if the staff are transient."*
- *"The partnership will need to have an open environment and respect for the women."*
- *"We will need to develop the most efficient and effective way to serve marginalized women while avoiding overlap of existing services or wastage of money."*
- *"There should be an integrated case management approach used on this project."*
- *"It is important to keep barriers to using services low for these women. If there is a limitation within the service programming, we may want to consider outsourcing resources to other programs with access to the target population."*

In terms of the selection of partners, there were at least two different perspectives on this topic. Some respondents cautioned that the mandates and end goals of the partners need to be compatible. In contrast, others felt that the partnership should be very broad, making allowances for partners with different value statements but who are supportive of the concept. This approach could include the city and the corporate sector. Finally, the stakeholders offered a wide variety of organizations that might be considered as key partners. Those mentioned by at least three respondents are listed below. (Note: Specific organizations that were mentioned frequently are listed separately. In other cases, specific organizations are grouped together):

- Atira Women's Resource Society
- Women-centred organizations such as Newton Advocacy Group, Surrey Women's Centre
- Immigrant serving agencies such as Surrey-Delta Immigrant Services Society
- Healthiest Babies Possible run by OPTIONS and other OPTIONS programs
- Pregnancy outreach and infant development programs: PACT, Infant Development Program, Nobody's Perfect, South Fraser Child Development Centre
- Parenting programs/Family Preservation: Children's Foundation
- Food Bank
- Daycare and Childcare
- Transition houses
- Aboriginal organizations: Metis Family Services, Kla-how-eya (formerly Surrey Aboriginal Cultural Society)
- A&D counselling/Health Authority (addiction services)
- Public Health Authority/public health nurses
- Surrey Memorial Hospital (Youth Clinic)/doctors
- City of Surrey
- MCFD/social workers.

6. Location

Community stakeholders were asked for their views on where in Surrey the proposed program should be located. The responses were as follows:

Suggested Location for SHRP Program	#	%
Whalley	8	29%
North Surrey Along the Whalley–Guildford Corridor	4	14%
Whalley or Newton	5	18%
Newton	2	7%
Guildford or Kennedy Heights	1	3%
No Preferred Location – Need Multiple Locations to Cover the Large Geographic Area	5	18%
No Location Specified – But Must Be Central With Easy Bus or Skytrain Access	3	11%
Total Respondents	28	100%

Whalley was the most popular choice primarily because:

- It has a large proportion of high risk families and women living in poverty.
- Most of the services for this population are located in Whalley and it is important to keep services centralized.
- The high risk women in Whalley will not go elsewhere for service.
- It is serviced by the skytrain and bus routes.

However, other stakeholders felt that Whalley was not the best choice and that Newton or the Guildford area should be considered. Their reasoning is summarized through their comments as follows:

- *"Whalley is not the safest area and where-ever the program goes, it must be safe."*
- *"It should not be in downtown Whalley because of the poor image and it is overloaded with problems at this time."*
- *"Whalley is a high need area, but the city does not want more services there."*
- *"The Whalley–Guildford corridor house the highest risk families so Guildford may be reasonable option. Also, HBP is located at Guildford."*
- *"A good location would be near or at a major activity node like a shopping centre (Guildford Town Centre and Surrey Centre) or a skytrain station."*
- *"There are some pockets of high risk families in Newton as well and Newton is easily assessable by skytrain or bus for lots of clients."*

While there was no clear consensus on the best location, it was generally agreed that the program needs to be easy for high risk women to access by walking, bus or skytrain. Some stakeholders also made the point that bus service is poor and transportation in general is a critical barrier in Surrey. "Anything further away than your local elementary school is going to be too far for marginalized women, especially those with young children and who are facing further cuts from MHR." And, "Women do not have much money for travel to services." Finally, four respondents suggested that with Surrey's large geographic area and the transportation issue, any one single location will not serve all of this population equitably. "Women in North Surrey will not want to go to Newton and women in Newton will not want to go to North Surrey for service." "We need to look at providing service from a number of locations."

7. Closing Stakeholder Remarks

Community stakeholders were asked for any other comments. Of the 18 who responded, 14 (78%) stated that the project sounds exciting, that it is an important and needed service, that they felt this was a good way to create a continuum of service, that they support the concept, and/or that they are looking forward to having the service in place. Two stakeholders (11%) noted that services already existing like PACT and HBP should be involved and consulted, as their services were at least in part focused on the same population as imagined for the High Risk Pregnancy and Early Parenting Program.

III. PERSPECTIVES FROM STAKEHOLDER FOCUS GROUPS

This section documents the results of the third component of the community consultation. Five focus groups were undertaken, one for each of the following:

- Ministry of Children and Family Development
- Healthiest Babies Possible Staff
- Healthiest Babies Possible Advisory Committee
- Public Health Nurses and PACT
- Surrey Transition Houses and South Fraser Women's Services Society.

The focus groups' views are presented below on the target population, type of services need in the program, key principles, women-centred care verses child protection, partners, and location. For each topic, the general themes are noted, but not individual responses for a specific focus group.

1. Target Population

The focus groups were asked to comment on the position that the proposed program should be for high risk pregnant women and women with children up to age six. The consensus was that this target population is appropriate. (Although one group felt that there was a need to develop a clear definition of what constituted high risk). All groups supported the concept of providing service for children up to age six and with the intention of a one-stop-

shop approach, they felt it would provide improved continuity of services and relationships with the family. Some also said that it would lead to fewer clients falling between the cracks in making a transition from one service to another.

The following summarized comments illustrate the perspectives on this topic:

- *"Research shows that ages 0 to five are very important for parenting. With Grade one starting at six years old, there is more visibility for vulnerable children."*
- *"Where moms are involved with substance abuse, the outcomes for children are poor nutrition, the challenges begin in the early years, and they do not have the support they need. With this population, a child of three can be as vulnerable as a baby. Extending service to age six is a good approach."*
- *"There are currently pockets of service with limited time involvement and often the challenge is to make the transition from one service to the next. It would be good to have one program and a one-stop-shop approach rather than pockets. It would mean less fragmentation of relationships with clients."*
- *"For HBP, the service stops at six months, but sometimes the clients get lost going to the next step."*
- *"One-stop-shopping is ideal because many do not have transportation."*
- *"Our clients do not have the social skills to get through the existing programs. Longer-term interventions in the same place would help. Also, going to one place where they feel connected is good."*

2. Types of Services Needed in the Program

The focus groups were asked to describe the types of services needed in the proposed program and as may be expected, a wide range of services was suggested. The services that were mentioned most frequently are listed below.

Needed Service	# Of Focus Groups That Identified the Service as Needed
Food	4
Medical Care – Doctors, Nurses and Public Health Nurses	4
Outreach	4
Transportation and Bus Tickets	4
A&D Counselling	3
Counseling – For Post Partum Support, Depression, Suicidal Tendencies, Abuse, Etc.	3
Daycare, Childcare, Child Minding	3
Drop-Ins	3
Services Delivered In Different Languages as Needed	3
Clothing Exchange – For Pregnant Women, Children, Babies	2
Life Skills Training	2
Nutritional Counselling	2
Practical Information on Pregnancy, Childbirth and Parenting	2
Vitamins and Milk	2

Focus group participants also commented on aspects of how the program should be operated. The following summarized comments illustrate some of their views:

- *"The program should have flexible hours so women can access it in evenings and on weekends."*
- *"The high risk target population does not tend to make appointments. Where possible, key services should be available on a drop-in basis."*
- *"Staff need to establish a friendly, positive environment. Judgments and negative views should be avoided with the emphasis placed on positive change."*
- *"A holistic approach to support should be adopted."*
- *"The program needs to be culturally sensitive and culturally appropriate."*

3. Key Principles for the Program

The focus groups were asked to comment on the program principles of women-centred care, harm reduction, and the interconnectedness of oppressions. In each group, most of the discussion revolved around aspects of women-centred care with some time also spent on the use of harm reduction. There were no significant discussions on the interconnectedness of oppressions. At a general level, all focus groups supported the women-centred care approach and the harm reduction model. However, there were some different perspectives on how they needed to be implemented. The following summarized comments illustrate some different views on these two principles:

- *"We need to focus on the woman, who she is, what she wants, and accept what she wants with out being judgmental. Even if she does not want the baby or cannot parent the child, we must respect her decision."*
- *"We need to recognize the inherent dignity and value of each individual and help them to realize their strengths."*
- *"While women-centred care is important, we have to avoid getting so focused on the woman that the needs of the baby get lost in favour of the best interests of the woman."*
- *"The service focus should be on women, but we cannot ignore the support network immediately around the woman (e.g., father of child, mother of woman). The women must be able to define her key people. If family connections can be built, then we need to look at that too."*
- *"Women-centred sometimes means "women only" and we need to be careful with that. We need safety, but "no men allowed" can be a barrier and pregnant women are lonely. Often partners want to be there and she may want them there. We may want to look at what Sheway does on this topic."*
- *"Harm reduction is critical. Women are often well into their pregnancy before they find out. At that point can they simply stop using?"*
- *"The harm reduction model is appropriate for the target population. However, drug use is a child protection concern for MCFD."*

4. Tensions Between Women-Centred Care and Child Protection

The focus groups were asked to provide their comments on the potential tension between women-centred care and the protection of children. All groups felt that there can be a conflict, but where child safety is an issue, it must be addressed. There were varying views on the situations requiring reporting and how it is handled. The following summarized comments illustrate some different perspectives:

- *"There is a huge fear for women of having their children taken away by the Ministry. This program needs to be about working with women and not about snatching their kids or about spying on them."*

- *"There is a need to work in partnership with the Ministry, but we cannot have them onsite. There needs to be cooperation and a protocol in place."*
- *"Women-centred care and child protection for this population is like oil and water. We know that drugs and parenting do not go together and that some moms cannot parent. We need to be as supportive as possible and focus on help, not fear. But if child safety is an issue, we need to help the women recognize the problem and address it by reporting."*
- *"The guidelines need to be explained right at the start for the woman and partner and they need to be told what to expect. Then they are more prepared to meet the expectations."*
- *"There is a need for more education about addictions for Ministry workers and other workers in the community."*
- *"We need a program that is geared towards helping the woman while working within the legalities of Child Protection."*

5. Partners

Four focus groups were asked who they thought would be key partners for the program. Each group made a list of possible partners and three groups identified a few key ones. While these partner lists were not intended to be comprehensive, a considerable number of organizations (40) were identified in this process and 21 appear on multiple lists. It is likely that most of the key partners for this project would be found among these 21 organizations. The organizations what were suggested by more than two focus groups appear below along with their frequency of appearance.

Organization	# of Focus Groups That Identified the Organization as a Potential Partner
IDP	4
MCFD	4
Public Health	4
A&D	3
Doulas Services Association	3
HBP	3
Options	3
PACT	3
SACS	3
Surrey Memorial Hospital (Youth Clinic)	3
Surrey Food Bank	3

Organization	# of Focus Groups That Identified the Organization as a Potential Partner
Atira	2
BC Midwives	2
Mental Health	2
MFS	2
Newton Advocacy Group	2
Police	2
SDISS	2
Support for Parents of Young Children	2
Surrey Women's Centre	2
Tiny Bundles Program	2

6. Location

Each of the focus groups were asked for their views on where in Surrey the program should be located. All groups felt that the location had to have easy access for clients; walking in, on a public transit route, or near a skytrain station. Four of the groups said that a one-stop-shop approach should be situated in a central location close to a high risk population. One group also stated that Whalley and Newton had the highest number of child removals and as such, this was one indicator of need. Each group mentioned one or two areas that they considered suitable. The different comments and suggested locations were:

Focus Group	Location Comments and Suggestions
A	▪ Guildford ▪ Near Surrey Memorial Hospital
B	▪ Whalley close to the skytrain station
C	▪ Whalley ▪ The area between 135A and King George Highway near the skytrain station
D	▪ Newton. It is a "nicer area" than North Surrey and clients get triggered when they go back (to North Surrey) ▪ A store front approach with high visibility along King George Highway
E	▪ Walking distance from Surrey Central skytrain station ▪ There is a trade off. Everything is in Whalley, but Newton is more central, also has a high risk population, is on a bus route, and there are not a lot of services there.

Four of the groups also suggested that the geography of Surrey was broad and that this situation may require considering a central location with satellites or partnership arrangements to extend service to other areas around Surrey. As an example, "White Rock has problems too and needs service."

OTHER CONSULTATIONS

Surrey City Council and other provincial politicians were invited to a focus group. The focus group ultimately was not held, but the project received letters of support from three politicians and the Project Coordinator did a presentation at the Surrey Social Planning Council, where a number of Councillors were in attendance.

IV. PROJECT COORDINATOR'S CONSULTATIONS WITH OTHER GROUPS

The Project Coordinator held informal meetings in the community during the period of the research project. Although not technically a component of the research, these meetings also informed the development of the program model. The Project Coordinator's (PC) role was different from the researchers', in that the researcher was working to establish *what* the proposed model should include. The PC, on the other hand, spoke with stakeholders regarding *how* to implement the model, once proposed, and to foster community support for the project. Thus, this section presents the views of additional stakeholders that did not participate in the formal research process, as well as other comments from a number of stakeholders previously included in the research.

A. STAKEHOLDERS

The PC's consultation process involved 28 meetings with community stakeholders (including three focus groups), approximately 15% of which also participated in the research process. For those stakeholders participating in both processes, all efforts were made to ensure that they spoke first with the researcher. The PC also met with representatives from five other programs from across Canada (located in Vancouver, Windsor, Toronto, and York) that also support high risk pregnant and early parenting women. The process was also informed by the PC's outreach work with pregnant and early women facing many of the issues this program is meant to address. In total, the views of an additional 85 stakeholders are reported in this section.

B. INPUT INTO THE MODEL

As in the formal research process, stakeholders consulted by the PC supported the key principles for the program: women-centred, harm reduction, a partnership model, comprehensive services provided under one roof, and service providers working collaboratively to support women and their children together. Fewer people used the term interconnectedness of oppressions. However, support for this idea was expressed as the need for services to incorporate an understanding that women dealing with a number of intersecting issues (such as poverty, violence, substance use, mental health issues, sex

trade work, etc.) may not feel comfortable accessing services predominantly used by more "mainstream" women or families. As well, stakeholders expressed the importance of including mental health professionals and/or providing all services with an understanding of how experiences of trauma are intricately related to issues such as substance use and mental health.

Ideas around the types of services needed in the program, and the need for them to be available for extended hours, were similar to those expressed through the research. As well, respondents articulated in a number of meetings and focus groups that the medical services component needs to include a team of physicians, so that one physician does not become overwhelmed. The need for the physicians to have methadone-prescribing privileges was also stressed. Comments on the need for housing arose often as an important component to be included in the services offered. Respondents also suggested that having a financial aid worker linked to the program and on-site on a regular basis would be beneficial.

Support for providing services to high risk pregnant women and their children, the target population, was unequivocal. A few stakeholders expressed the wish to expand services to include children of school age and pre-parenting women but others argued against the idea in order to keep the program manageable.

As found through the research process, there was no consensus on location. Service providers in South Surrey cautioned against the program being located too far north, such as in Guildford, as it would no longer be accessible to their clients. Newton was most frequently mentioned as a central, accessible location.

As in the research, concerns about having child protection workers on-site were raised. Respondents expressed that fears of children being removed may make it more difficult for women to be open about all of the issues they face and to thus get appropriate supports. It was suggested by a number of stakeholders that, if there were MCFD social workers on-site, they should be non-delegated.

C. ADDITIONAL STAKEHOLDER REMARKS: THE NEED FOR TRAINING IN HIGH RISK PREGNANCY AND EARLY PARENTING ISSUES

The need for workshops to be developed and delivered in the community was voiced frequently throughout the PC's consultations. Stakeholders expressed the need for more information on high risk pregnancy and early parenting, including strategies for working with high risk women and their children that are effective.

SUMMARY CONCLUSIONS

In conclusion, all respondents, whether through the research or through the informal consultations, commented favourably upon developing a partnership-based, high risk pregnancy and early intervention program, and gave both general and specific information about ways to do that. They supported the principles of women-centred care, harm reduction and the interconnectedness of oppressions. They thought a "one-stop-shopping" model is the preferred option, where there are both ongoing services and services that are provided on a daily, weekly, and/or or occasional basis. All thought the program should be somewhere central in Surrey, especially on bus and skytrain lines. Many organizations indicated interest in being involved in the continuum of services possible for high risk pregnant women and their children up to age six.

CHAPTER V PROPOSED MODEL

The Committee identified three initial principles about the proposed program. These were: women-centred, harm reduction, and interconnectedness of oppressions. Identifying these principles at the beginning of the project provided a framework for obtaining funding, the literature review and the community consultations. During the community consultations, another principle, that of partnership, emerged. Thus the proposed model contains the four principles outlined below, with their suggested definitions.

A. PRINCIPLES

1. Women-Centred

An empowering, feminist-based approach requires service providers to take a collaborative stance with women coming for services, rather than an expert stance. It involves honouring and facilitating women to learn from, and with, each other. It involves being culturally respectful, including valuing the traditions and beliefs of women. The goal of such care is to help women release fear, shame-built, and self-deprecation and move towards healing, transformation, wholeness and self-determination.

2. Harm Reduction

A harm reduction approach takes into consideration individual choice about substance use and different kinds of use and tailors the support provided to these decisions about kinds and levels of use.

3. Interconnectedness of Oppressions

There is a strong connection between various oppressions and substance use and as such requires service providers to see and work with a multiplicity of issues as identified by the women served. For example, certain women (Aboriginal, women of colour, lesbians, poor women, young women, women who are disabled) face additional barriers to accessing fair and relevant information and support in the face of stereotypes, customs and norms.

4. Partnerships

Partnerships are an undertaking to do something together, a relationship that consists of shared and/or compatible objectives and an acknowledged distribution of specific roles and responsibilities among the participants, which can be formal, contractual or voluntary, between two or more parties.

B. THE MODEL

While "partnership" in its broadest sense is a principle, and also a practice advocated in communities and by government, there has been little clarity developed about what might partnerships look like in practice. Discussion among the key informants during the community consultations, and subsequent Committee meetings, centred on how to make a partnership model for this project work.

A review of the literature on partnership found that a continuum of partnership is elaborated on. A useful model is found below describing partnerships along a continuum of: donation, sponsorship, cooperation, coordination, and collaboration.

Table 1: Models of Partnerships[1]

DONATION - one-time financial or non-financial contribution to support program or service. Donor's expectations may include public recognition or tax credits. An example of this would be a service club donating $1000 to a local family literacy program, or donating a set of books or a computer.

SPONSORSHIP - providing financial support for a specific time period or cycle of program, or providing contribution in kind for the purpose of supporting a program or service. For example, the local college might provide office space or equipment, or the library might make meeting space available, or provide memberships for family literacy participants. Again, the sponsor might expect public recognition in return for the support.

COOPERATION - two or more agencies share general information about their mandates, objectives, and services. They may work together informally to achieve their organizations' day-to-day goals, for example, through support or referrals. It is a relatively superficial level of agency interaction, as in inter-agency meetings and informal networking.

Agency procedures, policies, and activities remain distinct and separate and are determined without reference to the procedures and policies of the other agencies. The agencies are autonomous, function independently in parallel fashion, and work toward the identified goals of their respective programs. It demonstrates a peaceful co-existence, but is neither genuinely interactive nor interdependent (Swan and Morgan [1993] in Government of Saskatchewan: 71).

COORDINATION - a multi-disciplinary approach where professionals from different agencies confer, share decision-making, and coordinate their service delivery for the purpose of achieving shared goals and improving interventions.

Coordination is characterized by deliberate joint and often formalized relations for achieving shared or compatible goals. It involves establishing a common understanding of the services committed to and provided by each agency and by determining each agency's accountability and responsibility to specific groups… Interagency coordination differs slightly from cooperation, but represents a more sophisticated level of interagency interaction. It is a process of engaging in various efforts that alter or smooth the relationships of independent organizations, staffs, or resources (Swan and Morgan [1993] in Government of Saskatchewan). For example, public health, social services, mental health, and school staff might hold case conferences to coordinate services for at-risk school children.

COLLABORATION - Unlike any of the other models of partnership, collaboration requires two or more agencies working together in all stages of program or service development; in other words, "joint planning, joint implementation, and joint evaluation" (New England Program in Teacher Education [1973] in Hord [1986]). There is a cooperative investment of resources, (time, funding, material) and therefore joint risk-taking, sharing of authority, and benefits for all partners (Government of Canada 1995).

The term collaboration has been used to describe integrations that result from blending provider disciplines and usually involves several organizations working together in a unified structure (Mawhinney 1993 37).

[1] http://www.nald.ca/CLR/partner/page19.htm:
Table 1: Models of Partnerships

We propose a two-stage model of partnership for the project, using the ideas from the continuum of partnerships: collaborative partners, and service partners.

GOVERNANCE: THE COLLABORATIVE PARTNERS

There are four proposed collaborative partners of the program: Atira Women's Resource Society, Fraser Health Authority, Ministry of Children and Family Development and OPTIONS. These are the four agencies that were commented on most frequently during the community consultations as being partners. There may be provisions for one or two more collaborative partners upon negotiation. The collaborative partners will bring "joint planning, joint implementation, and joint evaluation skills to the partnership. (New England Program in Teacher Education [1973] in Hord [1986]). There will be a cooperative investment of resources, (time, funding, material) and, therefore, joint risk-taking, sharing of authority, and benefits for all partners (Government of Canada 1995)." In other words, these four partners will fund the core of the program by contributing finances and staff to the endeavour.

We recommend the development of a legally binding agreement among the collaborative partners, including, but not limited to, the following content.

Partnership Agreements Must Ensure That: [2]

- Terms of reference, objectives, procedures, roles, authorities and timelines are clear, detailed enough to guide the process, written in clear language, and available to all stakeholders
- Any administrative questions are addressed in relation to financial records, reporting, etc.
- Mechanisms are in place to detect early signs of problems, and corrective measures are identified
- Expected services are identified
- Eligibility criteria are identified
- Financial, human resource, communication/information management, and accountability needs and commitments are established
- Evaluation requirements, performance measures and reporting arrangements are established
- Flexibility is built into the agreement to allow it to be adapted to changing external/internal circumstances.

[2] http://www.nald.ca/CLR/partner/page50.htm

The partnership agreement should also include policy on how membership in the collaborative partnership will be determined in the future.

The collaborative partnership carries both the "governance" and some "management" functions as noted above. Each core partner's staff must work within the framework of the agreement in order to provide a seamless and coordinated service to the women in the program. In addition, one of the core partners, OPTIONS, runs the Healthiest Babies Possible Program. This program, serving high risk pregnant women and their babies up to six months, is a logical program to co-locate in the same building.

And Surrey Women's Centre, that runs Stopping the Violence, Specialized Victims Assistance Programs, as well as a pro bono law clinic, clothing exchange and community kitchen, has indicated an interest in co-locating.

Both of these co-location possibilities add value to the offerings within the high risk pregnancy and early parenting program.

SERVICE PARTNERS

Service partners are envisioned as those agencies that, during the community consultations, indicated an interest in contributing services in kind and on site within the Maxxine Wright Place.

The proposed service partners are: Kla-how-eya, Metis Family Services, Surrey Women's Centre, South Fraser Community Services Society, Surrey Food Bank, Peach Arch Community Services (IDP), South Fraser Child Development Centre (IDP), Surrey-Delta Immigrant Services Society and any others that want to contribute services to the program. The actual services they spoke about were: support groups, counselling, outreach, food contributions, etc.

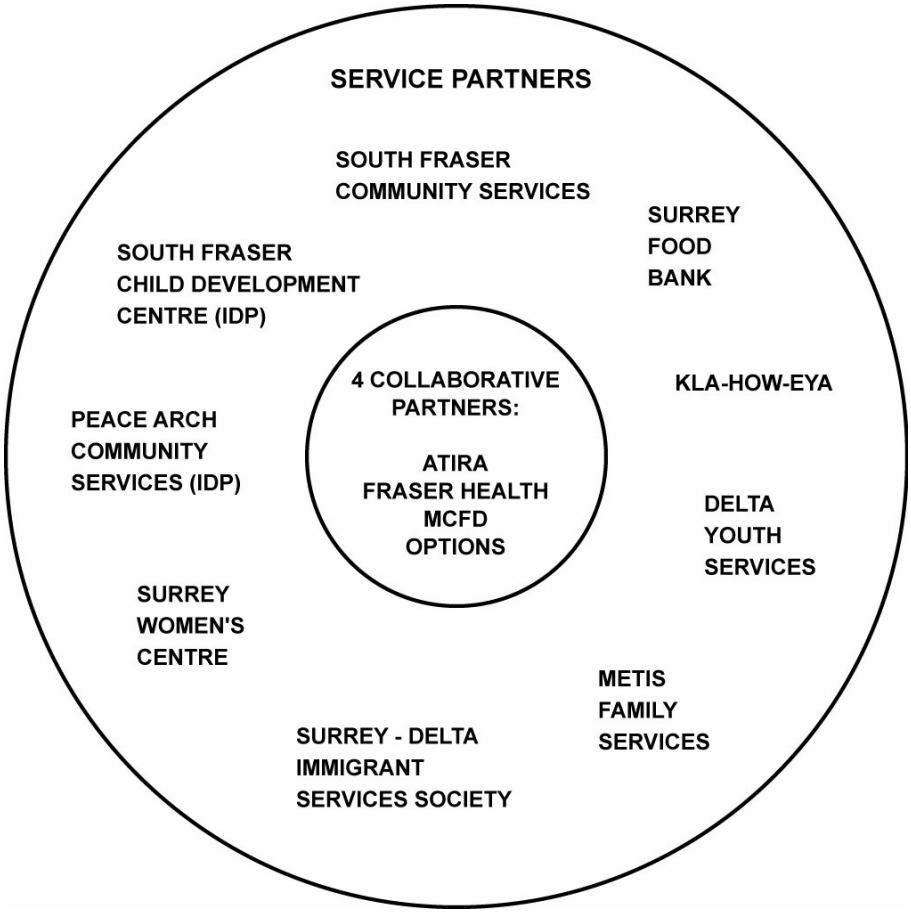
The service partners, in conjunction with the collaborative partners and the Program Coordinator, will draft service agreements, including, but not limited to:

- Types of service to be provided
- Days of the week
- Space requirements

What follows in the text are:

- Pictorial representation of the partnership model
- An example of a partnership agreement.

PICTORIAL REPRESENTATION OF THE PARTNERSHIP MODEL



PARTNERSHIP AGREEMENT

between Community Literacy Organization and Agency A
Date: March 1, 1996

Re: Anytown's 1996-97 Family Literacy Project

ROLES AND RESPONSIBILITIES OF PARTNERS

Community Literacy Organization and Agency A agree to the following roles and responsibilities regarding the management of the Anytown's 1996-97 Family Literacy Project.

Community Literacy Organization agrees to:

- provide training for the project facilitator, materials and other college services as required
- provide office furniture for the project
- advertise for the project facilitator
- liaise between the national funding agency and Agency A
- work with the project facilitator to develop the program model and to write the final project reports
- assist with the purchasing of books and materials

Agency A agrees to:

- provide photocopy and fax services to the project
- provide secretarial and administrative support to the project facilitator
- provide office space and classroom space for the project
- recruit participants into the project
- manage project funds and prepare the interim and final financial reports

A joint committee of the Community Literacy Organization and Agency A will:

- interview and hire a facilitator for the project
- supervise the quality and conduct of the project
- act as a steering committee for the project
- evaluate the project
- complete and file the necessary reports

An administration fee of $2000.00 per project partner will be charged to the project.

The following activities will be shared by the two groups in exchange for the $4000.00 administration fee:

- hiring of the project facilitator
- accounting
- filing of interim reports
- expertise contributed through the steering committee
- access to resources and expertise of both organizations' meeting space

John Doe,
Executive Director, Community Literacy Organization

Jane Smith,
Executive Director, Agency A

C. THE PROGRAM - WORKING ASSUMPTIONS

What became very clear in the community consultations is that many agencies and groups are available to provide services to the proposed target population. Yet, almost 50% of women we interviewed are not receiving, or accessing, these services. Thus, **the key focus of the program is not necessarily to provide new services but to provide coordinating and access functions to high risk pregnant women and their children up to school age and/or age six** so they receive a wide range of appropriate and existing services as soon as possible, and for as long as possible. As the program evolves, new programming might be jointly envisioned. Some key features of the program are:

1. The Target Population

"High risk pregnant women" is broadly defined. The program will serve "at risk" women/girls who may put their fetuses/young children up to age six at risk due to their struggles with substance use, mental health diagnoses, experience of violence/abuse, reluctance in seeking medical attention/support services and/or socio-economic conditions.

Children up to the age of six and/or school age, whichever comes first, is included to ensure assistance navigating through confusing and multiple services for young children. As well, the literature is clear that early intervention programs offer the best way for children to get a "leg up" in terms of their development.

2. The Goals and Objectives

GOALS

The goal of the high risk pregnancy and early parenting program is to coordinate and provide pre- and post natal care to women who are least likely to access traditional medical resources and to coordinate and provide services to their children from birth to age six and/or school entry, whichever comes first.

OBJECTIVES

- Promote healthy birth outcomes
- Promote healthy early child development, learning and increase in school readiness
- Support women, children and their families
- Coordinate services to women, children and their families
- Build and maintain community partnerships
- Advocate on issues affecting high risk children, pregnant and parenting women.

3. "One-Stop-Shopping"

The program is envisioned as a **gateway** to services for high risk pregnant women and women with children up to the age of six. Women and their children will enter through the gateway where low barrier protocols exist (warm, welcoming environment, food, coffee, and child friendly space). Core staff, from the four partners, will staff the site and will perform certain core functions.

Core functions of the program will include **relationship building**, an **intake/assessment,** a **"wraparound coordinator"/integration of services coordinator** who will take responsibility to bring together the various service providers with women receiving support in order to develop and monitor plans, and **a medical clinic**. Some of the **services** that could be provided on site are:

- Healthiest Babies Possible (co-location possibilities)
- Surrey Women's Centre services, such as Stopping The Violence, Specialized Victims Assistance, pro bono law clinic, clothing exchange, community kitchen (co-location possibilities)
- Public Health (e.g., pre, post-natal)
- Infant Development Program (outreach services up to age three)
- Medical doctors
- Food Bank (Tiny Bundles)
- Group work and/or counselling support from: Aboriginal Women's Outreach Program, Metis Family Services, Delta Youth Services (PACT), Kla-how-eya, South Fraser Community Services
- Daycare/playground
- Outreach services.

4. Hours of Work

Community consultations noted, without exception, that the hours of work must be flexible: open early, closed late, weekend services.

5. Program Evaluation Framework: Developing an Evaluation Design

An evaluation framework is vital, including a database to be established at the outset of the program in order to collect data regarding the various outcomes. Implementation of a program evaluation framework also needs to mesh with a low barrier protocol for easy access to services. Some examples of expected outcomes to be included are:

- Increase in the number of high risk women receiving prenatal and postnatal care
- Increase in the number of children born with healthy birth weights

- Improvement in the developmental outcomes for high risk children
- Improvement in the nutritional status of high risk children, pregnant and parenting women
- Improvement in the housing situation for high risk children, pregnant and parenting women
- Improving parenting outcomes
- Decrease in rates of child removal by MCFD.

6. Program Location

Community consultations noted that the preferred location is in Surrey Central, near bus and skytrain lines: e.g., between 104th and 72nd; between King George Highway and 144th.

7. Core Staff

Core staff will be contributed by the identified collaborative partners. Although allocations and types of staff may evolve and indeed, grow over time, we recommend the following as the program commences:

1 FTE Administrative Support

- Functions: manages the site, orders supplies, uses computer for database, answers telephones

1 FTE Program Coordinator

- Functions: coordinates various service partners/programs, liaises with community and does community development, fundraising, coordinating staff with appropriate collaborative partners

1 FTE Alcohol and Drug Counsellor

- Functions: facilitates alcohol and drug counselling

1 FTE Social Worker

- Functions: liaises with MCFD social workers, coordinates services, provides individual and group counselling, outreach services
- This social worker will be from MCFD, but will not have delegated authority to remove children under the Child, Family and Community Services Act

1 FTE Nurse

- Functions: coordinates medical clinic, provides nursing services, provides individual and group counselling

8. Wish List

The community consultations highlighted several key components to be built into the program, if at all possible:

- Provisions of bus vouchers/transportation access
- Daycare availability and a playground on site
- More subsidized housing for women
- A van, and/or shuttle service.

D. CONTINUING THE WORK

Until the collaborative partners have been established, the Committee will continue to develop the program. Once the collaborative partners have been determined, the oversight function then moves to them and the current Working Committee will disband. Future work entails:

- Drafting a mission statement
- Developing a policies and practices manual for the program, and within the collaborative and service partnerships
- Developing job descriptions for the program staff
- Continuing to develop the community's knowledge of the program and services
- Obtaining a facility
- Negotiating co-location possibilities.

IN CONCLUSION

Within a very short period of time, the Committee has moved the dream of a program for high risk pregnant women and their children to a reality. They are to be commended for their interest, their passion and their commitment. As the project now becomes a program, and as the program becomes located in a centre, the reality of providing an integrated service to marginalized women in Surrey offers a unique opportunity for creativity, innovation and best practices.

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APPENDIX

- **List of Community Members Interviewed for the Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women**

- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women: **Interview Guide**

- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women: **Client Focus Group Guide**

- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women: **Community Stakeholders Individual Interview**

- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women: **Community Stakeholders Focus Group**

LIST OF COMMUNITY MEMBERS INTERVIEWED FOR THE MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN

Judith Adelman	Ministry of Children and Family Development
Martha Baldwin	Ministry of Children and Family Development
Suzanne Barton	Surrey Social Futures
Connie Bonsteel	Evergreen Transition House – Options
Zarah Burgess	Virginia Sam Transition House – Options
Lisa Chapeski	Parenting Programs - Options
Julia Chapman	Reconnect - South Fraser Community Services Society
Margaret Duncan	South Fraser Child Development Centre
Tammy Dyer	Growing Together Daycare - Options
Bruce Hardy	OPTIONS
Shannon Hastings	Reconnect - South Fraser Community Services Society
Allison Hawkey	Koomseh Second Stage Transition House - Atira
Tara Jarvis	Virginia Sam Transition House - Options
Val Joseph	Shimai Transition House - Atira
Nav Kang	Koomseh Second Stage Transition House - Atira
Susan Keeping	Newton Advocacy Group - Bridging Programs
Delores Kelly	Aboriginal Women’s Outreach Program - Atira
Pam Kheong	Fraser Health Authority
Gita Kualarachi	Children’s Foundation - Family Preservation
Serena Kullar	Virginia Sam Transition House - Options
Alex Marin	Surrey Aboriginal Cultural Society
Annie McKitrick	Surrey Social Futures
Barb Mcleod	Guilford Park Secondary School

Erin Mullett	Surrey Food Bank
Judi Mussenden	Fraser Health Authority
Rob Rai	Reconnect - South Fraser Community Services Society
Tess Reardon	Shimai Transition House - Atira
Jane Scott	Peace Arch Community Services
Melanie Sheard	Reconnect - South Fraser Community Services Society
Pam Sidhu	Surrey Immigrant Services Society
Lynda Syssoloff	South Fraser Community Services Society
Joy Ward	Metis Family Services

Focus Group #1	Staff from Surrey Transition Houses and South Fraser Women's Services Society
Focus Group #2	Staff from Healthiest Babies Possible (OPTIONS)
Focus Group #3	Healthiest Babies Possible Advisory Committee
Focus Group #4	Public Health Nurses and PACT
Focus Group #5	Team Leaders, Ministry of Children and Family Development

MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN - *INTERVIEW GUIDE*

First Name of Person Being Interviewed:
Date of Interview:

Introduce the Project:

- Purpose of interview - need your feedback as someone who might use (might have used) a program for high risk pregnant women and their children up to age six
- Description of project - high risk pregnant women and their children up to age six. A Steering Committee made up of various organizations is developing this program
- Confidential interview, will not use the information provided except for the research. Don't have to tell story
- Interested in your opinions about the development of this particular program
- The interview will take about 10 – 15 minutes.

THE QUESTIONS

1. Do you have children? How old are they? If yes, use the following questions:

When you were pregnant, what services did you receive?

Were they helpful?

What made them helpful/not helpful?

What would have been the "ideal service" for you while you were pregnant?

What services did you need/want post birth to child's age six?

Did you receive them?

Were they helpful?

What made them helpful/not helpful?

What is the "ideal service" for you and your child(ren) age 0 – six?

If the children have been removed by MCFD, ask what services could have helped to maintain the child(ren) with them.

2. Do you have children? If no, then ask them to imagine.

If you become pregnant, what kind of "ideal service" would you like to receive? ("If you could have your dream support program, what would it look like….")

At birth?

Post birth?

With the child(ren)?

3. For both sets of respondents:

What services are you currently receiving in Surrey?

What are the strengths of these services?

What are the limitations of these services?

What is the best geographic location in Surrey for this program?

Would having "one-stop-shopping" (one central place) to receive all your services for yourself and your children be a good idea? Why or why not?

Is there anything else the committee needs to consider when designing the program?

THANK YOU FOR YOUR TIME IN COMPLETING THIS INTERVIEW WITH ME!

FOCUS GROUP QUESTIONS

The Steering Committee has indicated (as has the research) that the program could be for high risk pregnant women, and women with children up to six. Could you please comment on this.

Describe the types of services needed in the program, keeping in mind the target population. (Probe: What key incentives will bring women through the door?)

Several of the key principles for this program are women-centred care, harm reduction, and the interconnectedness of oppressions. Please comment.

In programs such as this, there can be tensions between women-centred care and the protection of children. Please comment on this perspective.

Who are the key partners for this program?

Where in Surrey should the program be located?

Any final comments to make?

THANKS FOR TAKING THE TIME TO PARTICIPATE TODAY!

MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN - *CLIENT FOCUS GROUP GUIDE*

First Name of Person(s) Being Interviewed:
Date of Interview:
Location of Interview:

Introduce the Project:

- Purpose of interview - need your feedback as someone who might use (might have used) a program for high risk pregnant women and their children up to age six
- Who the interviewers are (names, researchers therefore neutral, etc.)
- Description of project - high risk pregnant women and their children up to age six. A Steering Committee made up of various organizations is developing this program
- Confidential focus group, will not use the information provided except for the research. Don't have to tell story, don't need their last names, etc.
- Interested in your opinions about the development of this particular program
- The group will take about 30 minutes (depending on time allotted and # of women).

THE QUESTIONS

1. Do you have children? How old are they? If yes, use the following questions:

When you were pregnant, what services did you receive?

Were they helpful?

What made them helpful/not helpful?

What would have been the "ideal service" for you while you were pregnant?

What services did you need/want post birth to child's age 6?

Did you receive them?

Were they helpful?

What made them helpful/not helpful?

What is the "ideal service" for you and your child(ren) age 0 – six? What do you need to support you and your family?

If the children have been removed by MCFD, ask what services could have helped to maintain the child(ren) with them.

2. Do you have children? If no, then ask them to imagine.

If you become pregnant, what kind of "ideal service" would you like to receive? ("If you could have your dream support program, what would it look like….")

At birth?

Post birth?

With the child(ren)?

3. For both sets of respondents:

What services are you currently receiving in Surrey?

What are the strengths of these services?

What are the limitations of these services?

What is the best geographic location in Surrey for this program?

Would having "one-stop-shopping" (one central place) to receive all your services for yourself and your children be a good idea? Why or why not?

Is there anything else the committee needs to consider when designing the program?

THANK YOU FOR YOUR TIME IN COMPLETING THIS INTERVIEW WITH ME!

FOCUS GROUP QUESTIONS

The Steering Committee has indicated (as has the research) that the program could be for high risk pregnant women, and women with children up to six. Could you please comment on this.

Describe the types of services needed in the program, keeping in mind the target population. (Probe: What key incentives will bring women through the door?)

Several of the key principles for this program are women-centred care, harm reduction, and the interconnectedness of oppressions. Please comment.

In programs such as this, there can be tensions between women-centred care and the protection of children. Please comment on this perspective.

Who are the key partners for this program?

Where in Surrey should the program be located?

Any final comments to make?

THANKS FOR TAKING THE TIME TO PARTICIPATE TODAY!

MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN - *COMMUNITY STAKEHOLDERS INDIVIDUAL INTERVIEW*

Name of Respondent:
Organization:
Telephone #:
Date of Interview:

OPENING

- Give orientation to the program
- Purpose of the interview
- Confidentiality
- Outcomes: program model based on (1) literature review (2) community consultation and report delivered to the Steering Committee by October 15, 2003.

THE QUESTIONS

The Steering Committee has indicated (as has the research) that the program could be for high risk pregnant women, and women with children up to six. Could you please comment on this proposed target population.

Describe the types of services needed in the program, keeping in mind the target population. (Probe: What key incentives will bring women through the door?)

Several of the key principles for this program are women-centred care, harm reduction, and the interconnectedness of oppressions. Please comment.

In programs such as this, there can be tensions between women-centred care and the protection of children. Please comment on this perspective.

One of the ideas for this program is that those organizations who serve in one way or another the proposed target population should work in partnership. Who are the key partners for this program? And what is your reaction to the partnership model?

Where in Surrey should the program be located?

Any final comments to make?

THANKS FOR TAKING THE TIME TO PARTICIPATE TODAY!

MAXXINE WRIGHT PLACE PROJECT FOR HIGH RISK PREGNANT AND EARLY PARENTING WOMEN - *COMMUNITY STAKEHOLDERS FOCUS GROUP*

Introductions of everyone present:

Introduce the Project and the Program

- Steering Committee
- SWC money for development for the research project
- Lynda Dechief and Liz Robinson's roles

The purposes of this focus group are:

To consult with you as you have knowledge which is useful/helpful

To obtain your feedback on what you think are the crucial elements of the program

To use your information to inform recommendations for the program model

Ground Rules to Working Together

- Two hours only
- Give freely of your thoughts, feelings and experiences
- Speak only for yourself and let others do the same
- Appreciate the other's point of view - we are here to generate an extensive number of ideas and create new ideas by building upon each other's suggestions
- Confine your discussion to the topic
- Give everyone "air time"
- Keep confidences and assume others will
- There are no right or wrong answers

THE QUESTIONS

The Steering Committee has indicated (as has the research) that the program could be for high risk pregnant women, and women with children up to six. Could you please comment on this.

Describe the types of services needed in the program, keeping in mind the target population. (Probe: What key incentives will bring women through the door?)

Several of the key principles for this program are women-centred care, harm reduction, and the interconnectedness of oppressions. Please comment.

In programs such as this, there can be tensions between women-centred care and the protection of children. Please comment on this perspective.

Who are the key partners for this program?

Where in Surrey should the program be located?

Any final comments to make?

THANKS FOR TAKING THE TIME TO PARTICIPATE TODAY!