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Résumé de l'article

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Improving Substance Use Treatment for First Nations, Métis and Inuit Women: Recommendations Arising From a Virtual Inquiry Project

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Abstract

This article describes the work undertaken by participants in a virtual community, who came together online over a 15-month period to improve supports for First Nations, Métis and Inuit women with substance use problems at risk of having a child affected by Fetal Alcohol Spectrum Disorder (FASD). The project exemplifies a collaborative process, inclusive of people from various geographical locations, cultures and professional sectors, affording participants the opportunity to weave together research, practice wisdom, policy expertise, and Indigenous Knowledge(s) in a voluntary, nonhierarchical context. Such virtual processes have the potential to support the development of nuanced recommendations reflective of the complexities of FASD prevention in Indigenous contexts taking into account multiple influences on women's substance use, and a continuum of treatment responses. The article includes participants' recommendations for improving Canada's substance use system of care to address the treatment and support needs of First Nations, Métis and Inuit women.

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Building the Circle . . .

Between January 2010 and April 2011, a virtual community was created to foster discussion on how to improve the response to First Nations, Métis and Inuit women with alcohol and other substance use problems, who are at risk of having a child affected by Fetal Alcohol Spectrum Disorder (FASD). While past-year drinking among Aboriginal women is actually lower than non-Aboriginal women, concerns have

been identified about the patterns of drinking among First Nations, Métis and Inuit women when they do drink, and when alcohol is used in pregnancy: a survey in Ontario found that First Nations women who drink are heavier drinkers (Macmillan, 2008); and Inuit women in an area of northern Quebec have been found to have high rates of binge drinking in pregnancy (Muckle, 2011). The virtual community was established within the context of the renewal of the federally funded addictions treatment programs in Canada (Health Canada, 2011) and drew on promising new studies of Aboriginal women's substance use (Acoose, Blunderfield, Dell, & Desjarlais, 2009; Chansonneuve, July 2008; Niccols, Dell, & Clarke, 2009), and as such there was an optimistic action-oriented focus. Many of the discussions illuminated how gender, race, culture and geography often interact to increase stigmatization and marginalization as well as resilience and resourcefulness; and how lack of attention to the workings of these factors contributes to service barriers and inaccessibility of effectively tailored treatment options.

Over thirty researchers, service providers, health system planners and Aboriginal health advocates were involved in these small, virtual communities. The participants were from three different geographic locations: 1) Manitoba and Saskatchewan, 2) Ontario, and 3) Yukon, NWT, Nunavut, northern Quebec and Labrador. This broad geographic participation was designed to capture a sense of the rich diversity of the experiences of First Nations, Métis and Inuit women living in urban, rural, and remote settings. Their recommendations for program and policy improvements reflect the rich diversity of experience of First Nations, Métis and Inuit women in remote, rural and urban locations. Group participants included:

- Aboriginal program providers (working in pregnancy outreach, addictions treatment, midwifery and related positions serving women and their families);
- federal employees with responsibilities for managing programs on the above topics;
- leaders/women's advocates working in First Nations, Métis and Inuit organizations; and
- researchers in the substance use treatment field.

The project began and ended with a face-to-face opportunity for participants to meet each other and identify topics and plans for the online discussions. Then, over a period of six months, via online meetings, participants examined treatment and support services and made suggestions for ways to improve responses to women and girls with alcohol problems. The online meetings used a desktop video-conferencing format.

The inquiry was based on Indigenous research methodology and tailored for communicating in the online environment. Indigenous research methodology is community-based and participatory. It places a high value on experiential learning and symbol-based expression and fosters respectful, cross-cultural communications. Most importantly, the methodology takes into account Indigenous experience and ways of knowing, being and doing. Effort was made to evoke respect and integrate knowledge derived from research, practitioner wisdom, policy expertise and Indigenous world views.

One challenge in creating a virtual community of participants from widely dispersed geographical areas relates to the specificity of northern and Inuit women's experience. To avoid a pan-Aboriginal approach and ensure discussions and recommendations addressed unique geographical needs, three sub-communities were created for focused dialogue on regional issues. Recommendations from these three

groups were integrated into discussions of the larger, blended virtual community.

Ideas Arising from the Virtual Discussions

The virtual groups discussed, and came to consensus on five key areas for improving the substance use treatment system. The recommendations reflect the conceptualization in Canada of a tiered system of substance use treatment – from community based supports, through brief intervention to structured treatment (National Treatment Strategy Working Group, 2008). In such a tiered system, it is acknowledged that the majority of treatment takes place outside of intensive residential settings. The work in informal community settings (Tier 1) and in brief primary care encounters (Tier 2) where it is discussed in a non-judgmental way how alcohol and other substance use affects girls' and women's lives can be particularly important to assist girls and women of childbearing age in coming to see their need for treatment. The participants stressed that every nation and each community within nations are as different as the landscape of its location. Accordingly, it is important that treatment approaches be tailored by and for each community.



Figure 1 – Services that might be in a position to discuss substance use with Aboriginal women of childbearing years living in the north of Canada

1. Improving Connections between Community-Based Professionals, Elders, and Others in a Position to Discuss Alcohol Use with Women

In the first meetings, discussions centered on who at the community level is in a position to talk with girls and women about their use of alcohol and other substances. Services and specific people were identified who were in a position to discuss alcohol use and related risks with women of child bearing years and their support networks, and also ways of coping without alcohol, prenatal supports available, and pregnancy planning (Poole, 2008). How well services were linked, or working together was also identified so as to achieve a more systemic commitment on the part of service providers working with girls and women to engage in informed and respectful discussion of drinking and related issues.

Following are a selection of the key themes that emerged from the discussions on the topic of improving connections between community-based professionals, elders, and others in a position to discuss alcohol use with girls and women.

Representatives of northern communities identified a very wide range of service providers who might be in a position to discuss substance use with girls and women and their families: pregnancy outreach program providers, women's shelter counsellors, family support workers, nurses, physicians, midwives, staff at birthing centres, maternity care workers, FASD program providers, social service workers, youth

protection workers, Family Houses, Community Health Centres, Well Baby Clinics, and community mental health workers. In smaller communities in the North these groups are well connected. The range of these identified service providers illustrates how important it is to target all social determinants of health in this work to prevent FASD and support girls' and women's health. All systems offering support to girls and women need to be involved in discussing alcohol use and helping them make the connections between drinking and other issues they may face.

The Inuulitsivik Health Centre is an example of women's leadership to promote community-wide awareness and to link substance-using women and girls with professionals. It has an FASD prevention program delivered through the midwives and birthing centre staff and other community workers. Through one-to-one counselling and community awareness programs (radio talks on prevention and wellness, baby showers, nutrition programming) girls and women receive support, and in turn begin to change voluntarily, as does the community in general. There are measurable reductions in substance use by women who used alcohol during earlier pregnancies, and the message is resonating with young people. Of note is that men have also been reducing their drinking to support women during their pregnancy.



In some southern communities there are doulas and midwives who are potential supports in the postnatal period for girls and women with alcohol problems. While there are some examples of integrated outreach services in the prairies and Ontario, there is more of a sense that the professionals who are in a position to discuss alcohol and other substance use with girls and women are not well connected to each other. What's missing is an effective support net, one that includes perinatal services, violence support services, and substance use services of the type provided by the Minwaashin Lodge Sacred Child program in Ottawa. It is not an impossible task, for in the case of solvent abuse treatment programs, connections across different systems are working and judges, social services or Child and Family Services, community National Native Alcohol and Drug Abuse Program (NNADAP) workers, FASD mentors and the solvent abuse treatment centres help identify those with FASD, and integrate FASD prevention strategies.

Figure 2 – Key service types to be linked to provide a net of support for Aboriginal women with substance use problems.

It was noted that for urban-based girls and women, Friendship Centres could be sites of collaboration, provided that these community-based services come to see brief, strengths-based, culturally based interventions on alcohol use, as part of their responsibility to girls and women. Multi-faceted clinics where women of child bearing years can access nurse-practitioners and midwives for prenatal support, addictions, and personal counselling, as well as cultural supports such as healers and elders can be helpful to girls and women in accessing the care they are most comfortable with, and can also increase their access to other forms of support. The Sheway model in Vancouver and the model at the All Nations Healing Hospital in Fort Qu'Appelle are important examples of this approach. Several treatment

programs serving Aboriginal girls and women, such as Minwaashin Lodge in Ottawa, are involving community members and health care providers in meals and gatherings that both maintain and expand connections between girls and women in treatment and community members. In rural and remote locations, a model that is being tried with some success is to have a counsellor or mentor travel to outlying communities to work with service providers, and to support women with substance use issues. This model of outreach, combined with education of allied professionals, has also been effective in urban centres, as evidenced by the Jean Tweed Centre's Pathways to Healthy Families program in Toronto.

In all three contexts represented by participants (rural, urban and northern/remote), education for service providers on how to discuss substance use was identified as critically important. This is primarily because service providers can lack understanding of the impact of colonization on First Nations, Métis and Inuit girls and women and compassion for those with substance use problems. Training on respectful engagement approaches that allow for women's self-determination and support reduction in women's self-blame is key. Often practices that make it safe to tell someone about drinking, to set realistic goals for reducing drinking, and/or to discuss personal barriers to making changes in drinking may not be in place. As such, it is important for service providers to have opportunities to learn more about how they can be conscious of the process they are using in their discussions with girls and women. Through discussion and education, service providers can learn:

- how they create safety
- how they obtain informed consent
- the implications of how they record women's drinking on perinatal records
- how they can listen and pace their discussions based on women's readiness
- how they can make an interaction empowering and strengths based
- how they can connect girls and women to other services
- how they distinguish between girls and women experiencing some problems related to their alcohol and other substance use (who may find it easier to stop drinking during pregnancy) versus those with a physical dependence
- how they can help avoid extremist prevention approaches that can have the effect of driving the issue of drinking underground, and prevent girls and women from accessing services

2. Improving Access to Holistic Treatment for Alcohol and Other Substance Use Problems

Next the virtual discussions focused on questions about treatment. Participants discussed what alcohol and other substance use treatment is available for First Nations, Métis and Inuit women and how it could be made more accessible and helpful for women of child-bearing years at risk of having a child affected by FASD. Following are a selection of the themes that emerged.

Often we limit our views on treatment, seeing only residential addictions treatment as effective, whereas community-based outpatient models can be just as effective for many pregnant women and mothers.

Access to different types of treatment such as day treatment, outpatient counselling, mobile treatment (Weibe & Hubert, 1996) and land-based treatment has yet to be realised in some communities. In the North, setting up a multi-function mobile treatment team that can go to communities to assess, treat and educate community members may improve access to treatment services, and prevent women from having to leave their children, families and communities in order to seek treatment. In this process, treatment can be designed by communities and the expertise of elders can be drawn in, as can the expertise of other women who can serve as mentors.

In Ontario, a treatment centre (Margaret Smith), a child-focused program (Our Kids Count) and Anishnawbe Care partner to provide community treatment that includes childcare. There are other examples where child protection workers, Aboriginal wellness workers, and treatment staff are working collaboratively to promote and support access. These are useful community models for increasing availability and access to treatment, in ways that are not stigmatizing. Another example is the Auntie (Ninoshe) program developed by Native Child and Family Services of Toronto, a mentoring program that helps young mothers by assigning an auntie to mentor them. This culturally informed model creates a supportive relationship for young mothers, which can be beneficial in engaging them in support services, and assisting them in navigating services. In Ottawa, Minwaashin Lodge also provides mentoring and role models for healthy, traditional parenting through their Sacred Child program.

Taking a holistic approach—addressing vocational, mental health, and physical health needs as well as culture and tradition—can improve interest, engagement and the relevance of treatment for women. This is important in both treatment and community-based wellness programs. Anishnawbe-Mushkiki has offered a 6-week women's program in self-care, self-esteem, coping with stress, and healing through the arts and herbs. This opens up connections between women and assists in mitigating and preventing mental health and substance use problems. Ekweskeet Healing Lodge in Onion Lake, SK and Sakwatamo Lodge on James Smith offer gender-based treatment cycles addressing the aforementioned issues.

Mentoring programs such as those first described by researchers in Washington state regarding the Parent-Child Assistance Program (Grant, Ernst, Streissguth, & Stark, 2005) take a different approach to treatment and support by involving paraprofessionals who help women access the services and supports they need over a three-year period. Similarly, community-based services such as Kids First and Aboriginal Family Services in Regina and Saskatoon support mothers and children; Kids First will work with mothers until their children are 5 years of age.

More focus is needed on pre-treatment readiness, finding ways to involve girls and women in accessing a range of supports while technically on a waitlist. This shift in the understanding of waitlists is seen, for example, in the pre-treatment sessions at the Round Lake Treatment Centre in BC. Waitlists can provide an opportunity to introduce women-specific information and address access issues. Where women do need to leave communities for treatment, a staged process for women and their families may be important (as the Healing Drum Society in Yellowknife has supported). It is critical that community service providers know where to find culturally specific treatment programs for First Nations, Métis and Inuit girls and women who must leave for treatment; and that plans for after-care in communities are developed and implemented.

There is a sense among participants that much more could be done to improve the linkage between

women's shelters/transition houses and addictions treatment programming. Trauma, violence and substance use concerns are experienced by a very high proportion of women who seek a range of services. In some cases it was noted that women's shelters could be places where treatment and support on substance use issues is delivered, including providing shelter for women at risk in the last two weeks of pregnancy. There was strong support for better connections between addictions and non-addictions services that work with girls and women, to support cooperation in healing and wellness, using a determinants of health framework (Poole, Salmon, & Network Action Team on FASD Prevention, 2010). Criminal justice system connections to treatment, as well as child protection, can also be important. In Ottawa, Minwaashin Lodge has taken a leadership role in an initiative of the Ottawa Children's Aid Society to develop a non-colonizing approach to Aboriginal child welfare including a process to reduce apprehension of children for women in recovery (including newborns). Oshki Kizis Lodge, the shelter component of Minwaawshin Lodge, provides a range of supports for pregnant women at risk of substance abuse before, during and after the birth.

A project involving researchers, First Nations women with substance use problems and service providers in six NNADAP treatment programs identified key healing/recovery needs for women, and key attributes needed by treatment providers to support this healing (Dell, 2009). Their focus was not only on alcohol and mothering, but on healing from all types of substance use for women who had been criminalized, yet the findings were felt to be relevant to pregnant women in need of treatment for alcohol problems and at risk of having a child with FASD (Dell, Acoose, Blunderfield, & Desjarlais, 2009). These attributes include relaying empathy, being accepting/having a non-judgmental attitude, being inspirational, recognizing the impact of trauma in women's healing, communicating in open dialogue, showing care, supporting the link to spirituality through cultural teachings and traditions, and promoting momentum in moving toward the future (assisting with parenting and healthy relationships) after acknowledging the past. Together these attributes form the acronym RE-CLAIM. These attributes seem highly relevant to people who are supporting girls and women at the community level as well as in treatment centres—if girls and women knew they would be treated by providers with these attributes, it is likely that more girls and women would feel safe coming forward for assistance.

3. Providing Treatment Supportive of Mothers and Families

Two key questions were discussed related to mothering and healing from alcohol problems: How can we support women with alcohol and other health and social concerns and their children, partners and families, without compromising the needs of each? And how can we reduce the historical tension between substance use treatment for women and child welfare approaches? Following are the key themes that emerged from the responses to these questions.

Often the court and child protection systems take an adversarial, problem-based approach and rely on ordering women into treatment or parenting skills programs, rather than seeking solutions that recognize women's agency, and the complexity of the needs of women who use substances. Many First Nations groups have funded advocates who work on behalf of the mother or family to help them navigate the courts and government ministries, or prepare for treatment. However, band representatives and Aboriginal-led child welfare agencies are not available in the NWT and Nunavut. An overwhelming workload and restrictive timelines for child welfare workers make it difficult for them to carry out comprehensive assessments, and women often say they are "forced" to take treatment or parenting classes

to “get their child back.”

The current practice of birth apprehensions from hospitals (based on women’s histories of addiction and contact with child welfare authorities) targets First Nations, Métis and Inuit children in the North. BC Women’s Hospital in Vancouver has shown that mothers and children can be much more effectively supported through collaboration with child welfare and changes in hospital policies (Payne, 2007). There is a big divide between community actions that support a family support model of intervention versus the child protection system. The community approach, nested in culture and kinship, and acceptance/lack of judgment is the strength of programs like the FASD prevention program in Puvirnituq.

It is crucial for First Nations, Métis and Inuit women to have a self-determining role in planning for the interim care of their children and in choosing supports to prepare for treatment. Mentoring programs based on the evidence-based Parent-Child Assistance Program model to support women post partum, and advocate/mentor type programs for women with FASD themselves have been found to be helpful (CanFASD Research Network, 2012). There are a number of mentoring programs in Aboriginal communities across Canada.

Thunder Bay has a Talking Together Circle program that helps each woman develop a plan to support her to keep her child at home, and to work together to make the treatment plan successful. This is reflective of an Aboriginal alternative dispute resolution approach to child welfare (Metz, 2008). The Ottawa Children’s Aid Society in collaboration with local Aboriginal service providers has implemented a ‘Circle of Care’ program based on the Talking Together model and on the four-phase process for reconciliation in child welfare, *Touchstones of Hope for Indigenous Children, Youth, and Families* (Blackstock, Cross, George, Brown, & Formsma, 2006). In light of the distrust northern families have for the child welfare system and in the absence of formalized supports in remote communities, the Centre for Northern Families in Yellowknife developed a family support model of practice that trains families to provide peer support. First Nations, Métis and Inuit elders responded to the model by describing it as a traditional approach they have always understood. In the model, individual family members including children identify goals and strategies that are subsequently negotiated within the family and community context.

Childcare is often missing from services helping women with addictions. For mothers, it often requires coordinating funding from different agencies in order to allow them to attend day programs or residential treatment. Childcare is a critical piece for treatment centres to address directly, or to be active in helping women arrange.

The grief, loss and trauma related to losing custody of one’s children is a very significant issue for pregnant women and mothers with substance use problems and is made more complex by the “backlog of grief” carried by First Nations, Métis and Inuit women. It is important to note that over half of the children in care in Canada are Aboriginal which is about one third more than the number of children in care during the residential school era (Blackstock et al., 2005). It is critical that we find ways to support mothers and children together; the experience of healthy relationships will, in turn, foster healthy communities.

4. Connecting Support on Substance Use Issues with Support on Trauma and Violence Concerns

Trauma and violence are prevalent in the lives of First Nations, Métis and Inuit women, and the experience of trauma and violence is often connected to women's use of substances. In the virtual discussions, the question frequently emerged: What opportunities are there for integrating our support on substance use and trauma and violence concerns in ways that take into account these connections? Following are the key themes that emerged in discussion of what actions were needed in linking our response on trauma, violence, and substance use concerns for pregnant women and mothers in First Nations, Métis and Inuit communities.

The Women and Children's Healing and Recovery Program, a trauma recovery program for women was designed and piloted in Yellowknife to help women work on trauma and other root causes of addictions. It had strong roots in the community, used a holistic approach, used empowerment as a key strategy for healing and recovery, and was women-centred and family focused (Bopp, July 2003). The Ottawa based Mamisarvik Centre, serving Inuit people, fully integrates trauma and substance use treatment.

On-the-land camps can play a role in helping women reduce trauma flashbacks related to the residential school experience, as women are in a space in nature that is familiar to them and over which they have implicit knowledge and a sense of control. There is widespread need to create spaces where women, families and community members can come together to engage in healthy relationships. If a treatment centre acts as a community hub, their spokes will reach out to violence and cultural supports. Such connection means no one service has to provide it all, but instead simply link to all that is available to help women heal.

The term "trauma-informed" is used to describe the type of approach where every effort is made by service providers to avoid re-traumatization of their clients and to establish safe, non-hierarchical relationships. Trauma informed services do not necessarily actively help people heal from trauma, but at all points of service they take into account the likelihood that clients will have experience of trauma, and create a culture of safety, connection, and trustworthiness, offering and respecting client choice wherever possible (Fallot & Harris, 2009; Poole, 2012).

Women and children need help to understand how trauma is affecting them in the present and child welfare and other service providers need to consider how relapse to substance use, and/or becoming overwhelmed by trauma symptoms can be reframed as a need for "emergency sleepover" and respite care, not removal.

Programming such as the Sacred Child Program at Minwaashin Lodge weaves learning about the effects for children witnessing family violence into culturally-based experiential work with families.

The grief of mothers and families associated with the loss of children to child welfare needs to be acknowledged as a form of trauma, and healing support must be provided. Also, the high mortality rate of mothers of children with FASD needs to be acknowledged, and healing of trauma on the part of children and families when mothers die needs to be supported. There is a profound lack of such support available through services at the community level.

High levels of substance use and deaths within Inuit communities are ongoing challenges. At the Healing

our Spirit Worldwide conference, presentations identified positive ways to move forward related to parenting in Inuit cultures, and cultural adaptation during a time when the direct relationship of Inuit to their landscape is changing.

Cultural identity is central to knowing where you are, where you have been and where you can go, and as such is a central part of healing, recovery, and empowerment. At all levels of services, support is needed that addresses: the shame that people carry regarding the residential school experience and other experiences of trauma, and the need for safe places for working through stress and vicarious traumatization. Combining traditional healing and counselling can be incorporated in every skill development program, community-based supportive service, and treatment service. The need for care for the caregivers, who work with women who come for help with trauma-related issues, is critically important.

5. Awareness Building

It was initially planned that the discussions would focus on treatment for women, however, the groups saw the need to bring particular attention to the learning needs of service providers, health system planners, community members and others in a position to lead, provide, and fund women's treatment. Building awareness of the issues related to treatment for First Nations, Métis and Inuit women not only begins to address the stigma associated with Aboriginal women's substance use, but has the potential to increase confidence and a commitment to work on increasing access and quality of treatment on the part of service providers and decision makers. A wide range of awareness building initiatives were identified and provided in communities, conferences and continuing education sessions at colleges. The potential of technology to support awareness building via webinars, podcasts, DVDs, video clips on YouTube, and other initiatives was also discussed.

Actions Identified

Based on these virtual discussions, recommendations in five key areas have been generated (for a complete list see Table 1):

1. Increasing capacity and coordination of those at the community level who are in a position to **discuss alcohol with girls and women** and help them find the optimal combination of support to make possible their healing, growth and recovery.
2. **Improving access** to treatment and related supports for girls and women through, for example, expansion of treatment and support options on the community level, and careful linkage with treatment outside the community.
3. **Supporting mothers** with alcohol and other substance use problems in their abilities to retain custody of their children, and to heal, grow, and recover within community based treatment programs that have childcare and children's treatment programming.
4. **Integrating support on violence and trauma** with treatment on substance use so that girls and women are able to make the connections among these experiences and are not re-traumatized in services that have a narrow focus on addiction, and/or the use of proscriptive, choice-limiting approaches.

5. **Building awareness** on, and respect for, the treatment and support needs of First Nations, Métis and Inuit women of child-bearing years, who are at risk of having a child affected by FASD.

Summary of Findings and Recommendations

In summary, the virtual community allowed for Identifying services that offer support to girls and women with alcohol problems, and their families, both services specific to substance use treatment, and maternal and child health services that play a role in supporting girls' and women's health and the prevention of FASD. It also allowed for the participants to propose key changes in service provision and policy that may be helpful when addressing alcohol and related health and social issues facing First Nations, Métis and Inuit girls and women, across the diversity of community contexts. Finally it provided the space for diverse participants to co-construct how we might improve and expand treatment and support services for girls and women who are at risk of having a child affected by FASD, honouring the perspectives of elders, service providers, researchers, civil servants, and people working within First Nations, Métis and Inuit organizations.

Our findings confirm those of related projects that make the link between the experience of trauma, substance use, and prevention of FASD, and in turn understand and demonstrate how integrated approaches to support on these issues need to incorporate culture, treat the whole person, take a life cycle approach, have continuity of care, and include ample training for service providers (Council of Yukon First Nations, 2010, revised February 2011).

The findings also expand upon the conceptualization of a continuum of support recommended by participants in an earlier project undertaken in 2008. In the recommended continuum, four key service components were identified to assist women with substance use concerns at risk of having a child affected by FASD. These four service components were grounded in two foundational community-wide practices: awareness building/stigma reduction and community-wide support and change. Both projects have, in summary, emphasized the importance of

- Discussion and brief intervention,
- Outreach and engagement
- Specialized holistic support
- Structured substance use treatment
- Awareness building, and
- Community wide change and support



Figure 3 – Representation of types of supports and services comprising a comprehensive net of support for Aboriginal women with substance use concerns. See www.coalescingvc.org/virtualLearning/community5/documents/Cmty5_InfoSheet1.pdf

Reflections on the Community of Inquiry Process

This project used a participatory action research process based on Indigenous research methodology. Therefore in the sessions we were able to pay attention to context of First Nations, Métis and Inuit girls' and women's health—both the immediate, local and specific, and the broader historical and structural roots of marginalization—and to consider actions to promote change to research, policy and practice. As leading Indigenous women researchers have identified, it created space for First Nations, Métis and Inuit women to be involved in the generation and reporting of information about them (McHugh & Kowalski, 2009), and recognized the central role of culture in healing (Anderson, 2009). One participant affirmed the benefits of this process, via an email communication following the final face-to-face meeting:

I am writing to you to say Thank You! . . . To be honest, I am often critical of research methods and how invasive they can be to communities and individuals. But this method which I guess would be called community based participatory research which created a safe space for people to talk and share openly about their stories, challenges and solutions was refreshing. The fact that people were so open and trusting is testament to the approach that was taken . . . – A Project Participant

Study Limitations

There are limitations to findings arising from cross-sectoral and cross-cultural communities of inquiry such as this. Participants who voluntarily attend such collective exercises are not necessarily representative of all those with expertise in holistic approaches to prevention of FASD with/for First Nations, Métis and Inuit women, who are researchers, service providers, civil servants, community advocates and mothers-at-risk. Pregnant women at risk of having a child affected by FASD were not proactively invited to the community, however several participants mentioned having had that experience at earlier points in their lives, and the perspectives of mothers of children with FASD were frequently brought forth in the discussions. The inclusion of elders could have been more adequately addressed over the duration of the community; yet two elders were formally included in the final face-to-face meeting, and contributed greatly to our understanding and to the recommendations at that point. While the majority of the virtual community participants were of First Nations, Métis or Inuit descent, this does not guarantee that their voices were adequately heard. At the same time all participants had multiple opportunities to add to, and refine the community's findings and recommendations both in the final face-to-face meeting and through multiple rounds of seeking feedback on the final report.

Table 1 - List of Recommendations

Thirteen recommendations were identified:

1. **Improve connections between community-based professionals, elders and others in a position to discuss alcohol use with women.**
 - **Recommendation 1:** Facilitate networking among community-based service providers, elders and others with an interest in women's wellness, health and substance use. In such networks these community-based experts can identify their linked roles in discussing alcohol use with women and their families. Reinforce the value of all members of the support circle, including community members and paraprofessionals. Where practical, facilitate team building at the community level so that holistic service from the most appropriate combination of people is provided.
 - **Recommendation 2:** Provide training to these community-based experts in prevention of FASD, women's substance use issues and options for treatment. In this way they can most effectively design community-based assistance for women and their families, and be aware of treatment options outside of the community where necessary.
 - **Recommendation 3:** Support dissemination of the description of the work of community agencies and networks that are effectively reaching pregnant women to inspire and assist other communities that could improve services to reach women with alcohol problems.
2. **Improve access to holistic treatment for alcohol and other substance use problems.**
 - **Recommendation 4:** Assist communities in the provision of community-based treatment for women and children, including day treatment, mobile treatment and land-based treatment. In addition explore the idea of technology-based supports to increase access for women who are isolated (geographically or psychologically) such as tele-support and online support groups.
 - **Recommendation 5:** Identify cultural- and gender-specific treatment services so that if women do need to leave their communities for treatment, they can be supported to attend services that best meet their needs. Provide pre- and post-treatment support to make the transition as smooth as possible.
 - **Recommendation 6:** Provide options that support women's access treatment by ensuring their children are well supported – such as funding for childcare to be provided in the community, onsite childcare, and onsite treatment for children. Central to women's treatment access and recovery is collaboration on the systems level that is based on the principle of supporting and strengthening the capacity of mothers with alcohol and other substance use problems to maintain custody of their children.
 - **Recommendation 7:** Integrate support for addictions with other supports for health and healing, including culturally-based support from elders and aunties, and trauma-informed approaches. Introduce girls and women to the full range of supportive options in non-threatening

ways that encourage access to treatment, as needed, yet leaves decisions in girls' and women's hands.

- **Recommendations 8:** Help service providers embody the RE-CLAIM attributes, so that girls and women know they will be treated with care and respect.

3. Provide treatment supportive of women and their families/support networks.

- **Recommendation 9:** Assist communities in the provision of community-based treatment that has the full range of childcare options for mothers and fathers, including treatment/support for children of parents with alcohol problems; the wellness of children of mothers who need treatment.
- **Recommendation 10:** Take action on bringing together the child welfare and addictions treatment providers to collaborate in the provision of seamless and respectful support of parents with alcohol problems. There are many models where joint training and collaboration has meant that a continuum of supports and protocols has been implemented successfully.

4. Integrate support on trauma with support on substance use issues.

- **Recommendation 11:** Assist communities and all treatment centres in Canada to braid in supports that address the connections between violence and trauma and substance use problems, in culturally relevant ways and ways that respect the preferences of treatment participants.
- **Recommendation 12:** Make gender-specific healing options available that support healing from trauma and substance use, in holistic and culturally relevant ways, as an option for girls and women whose experience of violence and trauma prevents them from benefitting from mixed-gender mental health and substance use treatment services. Such options need to be linked with healing options for families and communities, as well as with social change on the societal level.

5. Build awareness to reduce stigmatization and marginalisation

- **Recommendation 13:** Multi-directional and multi-audience education is needed to build awareness of and respect for the treatment and support needs of First Nations, Métis and Inuit women of child bearing years who are at risk of having a child affected by FASD. The audiences include women, their partners and families, service providers, evaluators, whole communities and health system planners. The formats can include community radio, community-based training, conferences, webinars, podcasts and many other forms of sharing and linking expertise and knowledge.

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Appendix

The topics of the questions discussed by the online participants in the first three meetings were identified collectively at the initial face-to-face meeting. They included:

- What services do we currently have, that assist women with health and social issues during child bearing years, and which are in a position to help women identify that they may have an alcohol problem?
- How are these services connected to alcohol and drug services?
- What types/levels/qualities of this programming are meeting, or might better meet women's needs?
- What kinds of substance use treatment are available for women and children?
- What recommendations do we have to make treatment more accessible and helpful for First Nations and Inuit women at risk of having a child affected by FASD?
- What opportunities are there for helping women with substance use problems heal and mother?
- How might child welfare and addictions workers collaborate to support First Nations, Métis and Inuit women at risk of having a child affected by FASD?
- What opportunities are there for integrating our support on substance use and trauma and violence concerns in ways that take into account these connections?

From meeting three forward, the questions and discussion topics emerged from the participants' priorities, and covered for example, how healing from trauma could be linked to treatment for substance use concerns; the role of learning about cultural identity in healing from trauma and substance use concerns; and the ongoing learning needs of community based professionals and paraprofessionals in a position to support girls and women with substance use concerns.