FASD Prevention: Supporting Marginalized Women who Live with FASD

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Background

- Recognizing FASD behaviours as prevalent among participants
- Evident need to adjust practice to fit for FASD
- Includes adjustments to:
    - Orientation and training
    - Supervision
    - Agency policies

Program Participant Profile

- Poverty
- Unemployment
- Lack of transportation
- Low education
- Crowded/unstable living
- Childhood trauma
- Domestic violence
- Depression/low self esteem
- Dependency issues
- Justice system involvement
  (Child protection/criminal)

Secondary Disabilities Study

- Unemployment
- Early School Drop Out (Low Education)
- Dependent Living
- Mental Health Issues
- Alcohol Drug Problems
- Trouble with the Law
- Inappropriate Sexual Behaviour
- Confinement

Striessguth, A., Barr, H., Kogan, J., & Bookstein, F. (1996)

The Challenge

Whether we know it or not, as community service providers, we are often working with people who have FASD.

Prevalence rates of FASD are estimated at 1 in 100, making this disorder "epidemic."

Dr. Sterling Clarren

Barriers to FASD Informed Practice

- Stigma around women and alcohol
- Lack of diagnosis/awareness
- Perception that the challenges associated with FASD are insurmountable
- Potential for FASD training to trigger a personal response
- Inflexible policies/practice

FASD Informed - Agency Culture

- Collaborative practice and team work
- Ongoing internal FASD training education
- Curiosity and genuine regard
- Fosters a culture of:
    - Acceptance
    - Reflective Practice - understanding/willingness to learn from participants
    - Trauma informed
    - Harm reduction approach
    - Creativity (think outside the box)

Agency Culture Continued

Create a fit for participants rather than expecting participants to fit within the agency.

Allow for individualized service rather than a "one size fits all approach".

No limits to service based on:

- Missed appointments
- Discomfort with formal institutions
- Lack of transportation
- Location of residence
- Inability to understand expectations
- Inability to follow through
- Literacy issues

Strategies/Supports

Recognize/support basic needs

Ensure services are participant driven. Initially, common issues include the need for:

- Food
- Housing
- Transportation
- Medical care

Practical supports/strategies

- Check for understanding
- Simplify information
- Advocacy/support for contraception
- Use concrete learning tools
- Provide reminders and repetition (cell phones)
- Have fun!

History of Aboriginal People

- 1670 legislation to "protect" Indians from "evil" and prevent “fraudulent trading practices.”
- 1886-87 compulsory school attendance for children
- Anti Potlatching Laws 1884-1951
- Loss of Culture and Language:
  - community structure,
  - oral histories,
  - family crests,
  - traditions

History of Aboriginal People

Residential Schools - 1800s to 1986

- Severely underfunded until 1950's,
- Children subjected to physical, mental, emotional, sexual and spiritual abuse, as well as sexual abuse

Sixties Scoop

- Adoption of First Nations/Metis children between 1960 and mid 1980's .
- Children literally scooped from home/community
- 11,132 Status Indians - adopted out from 1960 to1990
- 70% adopted to non-aboriginal families

http://www.aborignalsocialwork.ca/speical_topic/60s_scoop

Current Reality

- More Aboriginal children in care than during the 60’s scoop
- Three times as many Aboriginal children in care today than were in Residential Schools

(Cindy Blackstock 2003)

Lack of understanding of Aboriginal history causes judgment/assumptions and creates barriers and lack of trust

Trauma Informed Practice

- Pre-contact
- Residential schools
- Colonization
- Sixties Scoop
- Domestic violence
- Abuse (Childhood/current)

Self medication through alcohol/substance use can lead to addiction and FASD.

Creating Safe Places

- Educate all staff including receptionist on FASD and trauma informed practices
- Look at the person not the behaviours
- Allow clients to have a voice
- Trust takes time- limit expectations
- Healing takes time

Connecting with Marginalized Women who Live with FASD

- Trust/Relationship building
- Modify communication based on the participant's communication style
- Address priorities that are relevant for the individual
- Ensure a good fit between the worker and participant
- Be aware of triggers – provide adequate support and supervision
- Learn about the community and culture
- Learn about extended family, informal leaders etc..

Substance Using Women with FASD & FASD Prevention Project

Rationale

Research tells us women with FASD are at high risk of having a baby with FASD

Practice wisdom tells us that women with FASD who have substance use problems:

- don’t do well in traditional substance use treatment programs
- are “very challenging” & have “poorer outcomes”

Purpose

- To expand knowledge regarding promising substance use treatment approaches for women living with FASD.

Research Methodology

Project had 3 inter-related components:

1. Comprehensive review of literature and practice knowledge
2. Interviews with service providers in British Columbia
   - 40 interviews (from 12 BC communities)
3. Interviews with substance-using women with (suspected) FASD
   - 13 women (from 4 communities)

Women's Lives
Situating Substance Use & FASD

12 of the 13 women were mothers.

- All mothers had involvement with child welfare
- The majority reported being survivors of violence, abuse or trauma, and all reported serious mental ill-health issues.
- 10 of the 13 women shared information about their mother drinking in pregnancy; four self-identified as having FASD; ***none reported having been diagnosed***.

Overarching theme in women's self-description:

- Women don't compartmentalize their substance use from other areas of life
- Most likely, they won't disclose having FASD.

Findings from interviews with women

What Works:

- **Focus on women's readiness for change**
- **Relational approach** - *wherein women feel respected and safe, and not judged, blamed or shamed*
- **Wholistic, women-centred, integrated programs**
- **One-to-one care** from a skilled professional ***combined with*** **women-centred, group-based support**
- **Linkages with FASD-related programs**
- **FASD-informed supportive housing**
- **Flexibility in extending program's duration**

Findings from interviews with care providers

Promising approaches:

- Ongoing FASD training, supervision & mentoring
- FASD-informed accommodations to format, content, and physical space; Use of clear and plain language
- FASD-informed ***and*** women-centred theoretical frameworks
- **Practice tips** - Working with Women with FASD

What does an FASD-informed approach look like?

- **Program and Environmental Accommodations**
  - ✓ Reminder calls and transportation assistance
  - ✓ Consistency in program timing
  - ✓ Flexibility for late arrivals or missed appointments
  - ✓ Extended timeframes
  - ✓ Reducing noise level or visual clutter
- **Wholistic, Collaborative Programming & Advocacy**
  - ✓ Individualized support & Intensive case management
  - ✓ Supportive housing
  - ✓ Family-accessible treatment programs or child care resources
  - ✓ Collaborating with child welfare to address child protection issues
- **Ongoing FASD Training & Service Provider Support**
  - ✓ Skilled supervision; Smaller case loads; Additional staffing

Key Message across project components

It is the braiding together of the FASD-lens and the gender-lens that gives rise to promising approaches for women who have FASD.

FASD Effects, FASD-informed Approaches Considered Wholistically

Applying Promising Practices in your Work

Two questions to consider:

- In what ways do you ***already*** provide support based on these promising principles?

- In what ways could you **move further** toward providing FASD-informed supports?