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## **Breaking the Cycle Pregnancy Outreach Program**

*Reaching Out to Improve the  
Health and Well-being of Pregnant  
Substance-Involved Mothers*

*Substance-use during pregnancy is a significant health issue in Canada that can have a serious impact on the mother, the unborn child, and the community. The risks associated with substance-use during pregnancy include poor maternal health, increased maternal mortality rate, limited access to prenatal care, inadequate nutrition, violence, and poverty. Despite the evidence that substance-use during pregnancy is a major health concern, programs and services for this population have been historically under-funded and fragmented. Few substance abuse programs have been specifically designed to meet the needs of female clients, particularly women who were pregnant or parenting. This continues to be particularly problematic as pregnant and parenting women with substance-use problems have complex health and social issues that require an extensive range of services. Mothercraft's Breaking the Cycle (BTC) is a comprehensive, integrated, early intervention program designed to reduce the risk and enhance the development of substance-exposed children by addressing maternal substance use issues and the mother-child relationship. BTC's priorities, philosophy, and programs reflect the fact that both mother and child are affected by maternal substance use and related conditions, that the care of substance-involved mothers and their young children requires attention to each, and to the relationship between them. Using rich practice-based knowledge and the stories of women who have been engaged in the Pregnancy Outreach Program at BTC, this paper discusses the importance of a woman-focused approach to support and treatment, and highlights the particular importance of relationships to engage, treat, and maintain recovery for substance-using pregnant women.*

*I found out about this place because my drug of choice was ecstasy and cocaine, and I like to drink with the two of them, and I ended up doing a bad batch of E, and I ended up waking up to a police officer and being*

*restrained in a hospital gurney. And...after they pumped my stomach, and God knows whatever else they did... they told me I was pregnant. And at first I thought the doctor was a lunatic and... you know, crazy, and "What do you mean? I'm not pregnant! You're trying to take my drug life away from me? You're crazy bud!" And I sat there and just sort of lived with the fact that "Okay you're pregnant, now you've got to do something." And one of the police officers mentioned about [Breaking the Cycle] and gave me [the Pregnancy Outreach Worker's] name. (Former Pregnancy Outreach Client, 2005)*

Substance-use during pregnancy is a significant health issue in Canada that can have a serious impact on the mother, the unborn child, and the community. The risks associated with substance-use during pregnancy include poor maternal health, increased maternal mortality rate, limited access to prenatal care, inadequate nutrition, violence, and poverty (Hepburn, 2007). According to a Canadian Community Health survey conducted in 2001, approximately 9.6 percent of Canadian women who were pregnant at the time of the survey drank alcohol during the past week and over 14 percent of mothers reported that they drank alcohol during their last pregnancy. Furthermore, these data were most likely considerable underestimates since most surveys are not likely to capture information from high-risk and transient populations and due to potential under-reporting as a result of the stigma associated with substance-use during pregnancy (Greaves and Poole, 2004).

Despite the evidence that substance-use during pregnancy is a major health concern, programs and services for this population have been historically under-funded and fragmented. Up until the early 1980s, few substance abuse programs were specifically designed to meet the needs of female clients, particularly women who were pregnant or parenting (Finkelstein, 1993). This was and continues to be particularly problematic as pregnant and parenting women with substance-use problems have complex health and social issues that require an extensive range of services (Greaves and Poole, 2004). Women-specific and women-centered alcohol and drug services are particularly important in being able to support and address the needs of pregnant women with substance-use problems, as well as to promote good perinatal health (Greaves and Poole, 2004). In the following paragraphs, we will demonstrate the importance of a women-focused approach to support and treatment, and highlight the particular importance of relationships to engage, treat, and maintain recovery for substance-using pregnant women. Through the use of rich practiced-based knowledge and the voices of the women themselves, we will discuss the barriers to substance-use treatment for pregnant women, the specific needs of substance-involved pregnant women and how these barriers have shaped and influenced the development of the Breaking the Cycle Pregnancy Outreach Program. Lastly, we will discuss the evaluation and outcomes of the program and the characteristics of the relationships, the pregnancy outreach worker,

and of the program that have resulted in it being successful in engaging such a high-risk population.

### **Barriers to substance-use treatment for pregnant women**

Although pregnancy has often been described as a “window of opportunity” for women to decrease or cease their substance use (Daley, Argerious and McCarty, 1998; Klee, Jackson, and Lewis, 2002: 165-175), pregnant women who misuse substances do not typically seek or access addiction treatment. Barriers to effective care for pregnant substance-using women have been extensively described and include: stigmatizing, judgmental and blaming public attitudes towards pregnant substance users (Greaves, Varcoe, Poole, Morrow, Johnson, Pederson and Irwin, 2002); negative attitudes and treatment of pregnant substance users by service providers (Finkelstein, 1993; National Institute on Drug Abuse, 1993; Harrington, Heiser, and Howell, 1999; Tait, 2000: 61-73); women’s fear of criminal prosecution, mandatory treatment, removal of custody of their children (Chavkin, 1990; Tait, 2000: 61-73; Poole and Isaac, 2001: 1-146; Lester, Andreozzi and Appiah, 2004); and lack of gender-specific programs designed to address both the complexity of needs and experiences of pregnant substance-using women, as well as the needs and experiences of mothers and their child(ren) together (Jessup, Janice, Humphreys and Brdinis, 2003; Haller and Miles, 2004; Lester, Andreozzi and Appiah, 2004). Indeed, the needs of women substance users have been neglected in the past by service providers. The majority of substance-using women are of child-bearing age and, yet, relatively few present themselves to services. With increasing research outlining that non-judgmental prenatal care and social and economic supports lead to improved maternal outcomes for substance-involved women, the need to address these barriers and develop programs to meet the needs of substance-using women has become increasingly evident (Boyd, 2007).

### **Breaking the cycle: Model and theoretical foundations**

*But they had everything here. Like all the different aspects of the ... not just trying to help me the addict, but me the brand new parent-to-be.... Like I had no idea, I'd never been around babies or small children in my life, so I didn't have a clue about what was going to happen. (Former BTC client, 2005)*

Mothercraft’s Breaking the Cycle (BTC) is a comprehensive, integrated, early intervention program designed to reduce the risk and enhance the development of substance-exposed children by addressing maternal substance use issues and the mother-child relationship. BTC is delivered through a formal service partnership with Toronto Public Health, the Hospital for Sick Children—Motherisk, St. Joseph’s Health Centre, the Children’s Aid Society of Toronto, the Catholic Children’s Aid Society, St. Michael’s Hospital and

the Ministry of Community Safety and Corrections. Programs are delivered through a collaborative cross-systemic service model and serve women who are pregnant and /or parenting children under the age of six. BTC provides service through a “single-access” model so that clients (women and children) can access a broad range of services at one community-based location in order to reduce barriers to service usage.

BTC’s priorities, philosophy, and programs reflect the fact that both mother and child are affected by maternal substance use and related conditions, that the care of substance-involved mothers and their young children requires attention to each, and to the relationship between them. In fact, the primary focus of all interventions delivered at BTC is the relationship between mother and child. BTC has drawn on a number of theoretical frameworks in the development and delivery of programs and services including: attachment theory, relational theory, feminist theory, harm reduction theory, developmental theory, the transtheoretical model of the stages of change, and motivational interviewing. All of these frameworks have culminated in the formation of the larger women-focused approach employed in the program.

Since its inception in 1995, BTC has become one of the most extensively documented Canadian programs serving pregnant women and mothers who are substance-involved, and their young children. Careful quantitative and qualitative evaluation of service delivery has yielded rich practice-based lessons that have resulted in significant knowledge transfer activities with others locally, nationally and internationally. One of the most valued sources of information for and about the program comes from the mothers themselves, as they generously share their stories and experiences with BTC clinicians and researchers. The stories and feedback of the women involved at BTC, such as those included in this article, have been monumental in providing insight towards further developing and enhancing the program.

### **Recognizing the need to reach out to pregnant substance-involved women**

*Women have problems ... that need women.* (Former BTC Client, 2005)

Along with continuously seeking feedback from clients, Breaking the Cycle has conducted three evaluations where research has been used to inform practice. Early evaluation data (Moore, Pepler, and Motz, 1998) indicated that BTC was engaging a higher proportion of women who were parenting (78 percent) than those who were pregnant (22 percent). At that time, the rate of engagement of pregnant women attending BTC was consistent with the findings of similar programs in the United States of America; additionally, it was a higher rate of pregnant women than those who were attending traditional treatment programs in Toronto. Nevertheless, the engagement rate of pregnant women at BTC remained an area of attention for program development.

A research study conducted at BTC (Hicks, 1997) was particularly important in explaining the discrepancy in engaging substance-involved pregnant mothers. The study highlighted the relationship between the often co-existing homeless status of pregnant women who are misusing substances and their capacity to access health and effective treatment services. Pregnant women who were using substances represented a high-risk sub-population of drug-using women whose barriers to health and effective treatment were greater than those of the larger population of substance-using women (Hicks, 1997). The development of the BTC Pregnancy Outreach Program was a proactive response to these findings, with the aim of engaging women in services as early as possible during their pregnancies in order to positively influence fetal and maternal health outcomes. The BTC Pregnancy Outreach Program was designed as a two-day per week pilot project, which was initially funded by the United Way of Greater Toronto, to operate for a period of one year. The pilot phase of the program was designed to identify and evaluate the impact of a pregnancy outreach program on: the engagement rates of pregnant, substance-using women in services; and the community of service providers who work with this population of women. The community response to the introduction of the BTC Pregnancy Outreach Program was overwhelmingly positive, with some providers identifying the need for a more intensive service than the pilot phase.

### **BTC pregnancy outreach program evaluation and outcomes**

*Well, they were here to help me when I was in pretty rough shape. Like I was down to the ground, I had nothing, I had no one, and I came and asked for help, and now today I can say that I am very grateful. Without them I wouldn't be here... They don't judge you. (Former Client, 2005)*

The evaluation of the pilot phase confirmed that the project was, first, reaching the target population of pregnant, homeless, and substance involved women. Specifically over two-thirds of the women were living in conditions of “visual homelessness” (emergency hostels, shelter, abandoned buildings, etc), and the other one-third were living in conditions of “hidden homelessness” (unsafe, overcrowded, or unaffordable housing, etc). All of the women were actively using substances, living in salient poverty, and only half had ever accessed substance treatment in the past. Second, the project was successful in decreasing the isolation of substance-involved women by providing referrals and access to supportive health and treatment services. There were an average of three referrals made per woman and over 50 percent of the referrals resulted in women successfully engaging with the providers to whom they were referred. The introduction of the BTC Pregnancy Outreach Program also resulted in a 70 percent increase in engagement rates of pregnant women seen at BTC. Third, the evaluation confirmed that the BTC Pregnancy Out-

reach Program model was successful at engaging women at an earlier stage in pregnancy (almost two-thirds in the first and second trimester) as opposed to the engagement rates of pregnant women seen at BTC prior to the development of the Pregnancy Outreach Program. These outcomes confirmed the effectiveness of the model in supporting this vulnerable population of pregnant substance-involved women from the social determinants of health through early engagement, decreasing social isolation, and developing practical and realistic treatment/intervention plans.

*Well, you know the thing with (the Pregnancy Outreach Worker) too, is that she was very patient. Because, like, I wasn't a treatment person, I was not going to go to treatment. Because I had quit many times – not many times, but enough times that I could do it without treatment. But the thing is, you know, she would subtly bring it up. She wouldn't question it, but she would bring it up. So, and the fact that she didn't question it, and was more suggestive of it, eventually, I ended up going to treatment. (Former Client, 2005)*

In 2001, the Public Health Agency of Canada (formerly Health Canada) approved funding through its Canada Prenatal Nutrition Program to expand and enhance the BTC Pregnancy Outreach Program, thereby ensuring its sustainability and stability. The funding support resulted in the expansion of the program from a two-day per week to a five-day per week program, as well as the development of the BTC Satellite Group, at a local inner-city hospital which is also a BTC partner (St. Joseph's Health Centre in Toronto). The BTC Satellite Program allowed for increased capacity to accommodate women in the BTC Pregnancy Outreach Program by seventy percent through the provision of a support group that combines relapse prevention, prenatal health, and attachment goals. The group is offered in the hospital setting, integrates community and hospital-based supports, and provides a holistic and comprehensive service, including a lunch meal and childcare for those women who have older children.

*The flexibility of the group is that we all get to learn things but also, there are times when women come in here and they're up to here ready to cry, and if it's another group, there's no way everyone would stop for them, they wouldn't just stop for that one person, they would keep going. But here you can stop, just for that one person, and people will stop; each person is understanding, that's the whole thing about being an addict and understanding that, not just as pregnant women, but as addicts, they need to come in here and express themselves when they need to. (Former Client, 2005)*

### **Outcomes of the pregnancy outreach program**

In an evaluation of the BTC Pregnancy Outreach Program in 2002,

Debra Pepler, Timothy Moore, Mary Motz, and Margaret Leslie found that earlier engagement of substance-misusing pregnant women in health and social support services resulted in positive perinatal outcomes for both mothers and infants (2-83). A comparison of the differences between infants who were born from earlier-identified pregnancies (i.e., within the first two trimesters) versus those born from later-identified pregnancies (i.e., in the third trimester) indicated that earlier engagement is related to fewer prenatal risk factors for the mother (e.g., maternal infections, anemia, high blood pressure, Gestational Diabetes, minimal prenatal care, low weight gain, placenta previa), reduced maternal substance use, fewer birth complications and reduced hospital stay for mother and baby, better infant post-natal health, and fewer mother-infant separations. All of these outcomes pointed to the benefit and effectiveness of the women-centered approach of the BTC Pregnancy Outreach Program.

Five years after its inception in 2001, the BTC Pregnancy Outreach Program was further evaluated to determine the enduring impact of the model, beyond the perinatal period (Motz, Leslie, Pepler, Moore and Freeman, 2006). These positive outcomes included impacts on completion of treatment/intervention plans, custody of children at discharge from BTC, and maintenance of recovery. In comparison to pregnant women entering BTC prior to 2001, pregnant women who entered through the BTC Pregnancy Outreach Program were more likely to complete treatment and follow-through with intervention plans such as accessing addiction services, accessing prenatal care, and securing stable housing, were more likely to be maintaining their recovery from substance use upon their discharge from BTC, and were more likely to have custody of their children upon their discharge from BTC or to have contact with their children if they did not have custody. Earlier engagement in services, coupled with higher rates of completion of treatment/intervention plans, combine to result in mothers being significantly better prepared for their mothering role by attending to their own health, by accessing appropriate housing and by addressing their substance use. These important outcomes confirm the efficacy of a proactive outreach model in engaging and intervening with pregnant women using substances, and in helping women access social determinants of health. They also demonstrate the enduring impacts of the women-centered BTC Pregnancy Outcome Program beyond the perinatal period (Motz et al., 2006).

### **Why the program works: The voices of the women**

As an ongoing component of the program, Breaking the Cycle research staff regularly conduct focus groups of clients to evaluate the success of the program and to provide feedback to clinical staff. Input from women has resulted in many important program changes and refinements over the years. Through these focus groups, women from the BTC Pregnancy Outreach Program have provided information regarding factors related to their satisfaction

and progress in the program. Specific program aspects that have been consistently highlighted include: qualities of the relationships they have developed with the BTC Pregnancy Outreach Worker; specific counselor characteristics; and characteristics of the program that they felt made a difference to them. Through the BTC women-centered framework, these three aspects are what seem to make the program effective and the aspects the women like most about the program.

### Promoting relational capacity

Given a history of unhealthy relationships as well as a difficulty with establishing and maintaining new relationships (Cosden and Crotez-Ison, 1999), a healthy and supportive relationship with the pregnancy outreach worker is an important aspect of a women-centered pregnancy outreach program since this relationship often serves as a model for future relationships.

*If there is something that makes you feel uncomfortable, you can just tell her straight up. You know how some people can get defensive and all aggressive? She won't, like literally, she won't . . . I'm the kind of person that does need to be challenged to express my feelings and so I would get upset and she said, you know . . . "Tell me to fuck off whenever you need to," you know? And she's like, "I totally don't mind." Because she knows that I need to be challenged but also, you know, if I don't tell her where my point is, she doesn't know where it is either. She'll do what I like her doing, which is challenging me, but sometimes I can't handle it, and I just say, "You know what? I've got to drop this for now" and she'll drop it, and we're on to another subject right away. (Former Client, 2005)*

Clients identified characteristics of their relationship with the BTC Pregnancy Outreach Worker that they felt were facilitative for them. These included respect, understanding, authenticity, mutual empathy and reciprocity. Mutual empathy in a relationship enables women to know that they can have an impact on the world, specifically on the people with whom they have relationships, and that relationships may be negotiated. Due to the fact that a sense of impact may have been missing in relationships they have had in the past, this new relationship is seen as an important corrective or transformative experience in that it contributes to women's sense of empowerment and to the counselor's capacity for new learning (Walker and Rosen, 2004).

*For me, I've been seeing [Pregnancy Outreach Worker] since the beginning of my pregnancy and she's been my backbone. I relapsed at the beginning of my pregnancy and I didn't feel judged or anything by her. So to be able to meet her for support was a big thing for me. When I went on my relapse, I started coming here, and it gave me that support, it just made it easier. And yah, she kept coming to meet me, every week and even—it didn't matter.*



*And that was a big deal for me, because I was never a person who seeks other people, I was never a person who asked for help from other people.*  
(Former Client, 2005)

### **Characteristics of the pregnancy outreach worker**

Along with qualities of the relationship developed with the pregnancy outreach worker, specific characteristics of the worker were outlined as important for the women throughout the treatment process. Women identified respect, recognition, acknowledgement and a lack of judgment as meaningful components of the growth-promoting relationship they experienced in the BTC Pregnancy Outreach Program. Respect is the foundation of mutual empathy, and is involved in the movement out of isolation into being able to grow a fostering relationship. Establishing relational resilience with the pregnancy outreach worker seems to be of particular importance for the women involved in the program.

*I've been with her when I was clean, when I relapsed, when I went through treatment ... she's loving, she's caring, she's compassionate, she's understanding, she's patient, she's challenging when need be. She has no bias, she has no judgment, she has resources. As a person you know she just has respect. Not only understanding the respect, but when you go further... she's understanding of human nature and how people are regardless or whether they have addictions or not... That, you know, nobodies perfect ... and then you throw in isolation, and the fact that she understands that category just takes it into depth.* (Former Client, 2005)

Some of the most important qualities of a pregnancy outreach worker outlined by clients in the Pregnancy Outreach Program at BTC are the capacity to be non-judgmental, caring, and an active listener. One woman commented the following about the pregnancy outreach worker:

*Like, she really does listen to you. She listens to what you say. And she remembers. And I assume that she probably talks to all of us, but when she comes to talk to you, she remembers what you said last week and it's not written down in a book. She knows you as a person.* (Former Client, 2005)

### **Aspects of the BTC pregnancy outreach program**

Other aspects of the program that were identified by women as important in their ability to successfully engage in service included: a need for affiliation with other women in similar circumstances; a structured as opposed to open-ended group; a small group where they did not feel like their stories were overlooked or lost; and a specialized program with relapse prevention and prenatal components. In a focus group three women shared their opinion on what specific characteristics of the program they found most useful in engaging them: "You

almost feel like there's no other place for addicted women, who really need each other" (Former Client, 2005). Another woman highlighted that: "...Just that I'm not alone, out there, walking around, alone. Because when I leave here I'm going to walk out there, alone. But now I have the women here, and I'm happy with that" (Former Client, 2005). A third woman said: "You can go to a group where people are pregnant but when they're addicts, it's far better to come here where others have your problem, and it's nice to have another addict to talk to..." (Former Client, 2005).

### **Healing through the power of relationships**

The majority of pregnant women using substances do not typically seek addiction treatment because of the social, psychological, economic and legal barriers described earlier. For this reason, outreach activities are required to identify and intervene with women who are disconnected or marginalized from health and social services as a result of these barriers. The goal of the BTC Pregnancy Outreach Program is to facilitate engagement with women earlier in pregnancy in order to promote maternal, fetal and child outcomes. Pregnancy outreach programs recognize that the circumstances that bring women to use alcohol or other substances, not only make it difficult for them to stop misusing them during pregnancy, but prevent them from accessing resources and being successful in treatment in order to improve their health and well-being (Comfort and Kaltenbach, 2000). Evaluations of pregnancy outreach programs that have been conducted generally confirm that pregnancy outreach programs are supportive mechanisms that provide opportunities for meaningful interactions with caring service providers and other women who are also using substances (Tait, 2000: 78), and demonstrate that they promote significant and enduring outcomes for mothers and their infants-to-be.

Pregnancy outreach programs are effective to the extent that they facilitate the engagement of women in relationships that decrease their isolation, increase their knowledge of the resources that are available to them, facilitate their connection with resources that are available to them, facilitate their connection with those resources, and promote their involvement in planning and decision-making for themselves and their expected infants. Women-centered, harm reductions programs not only offer non-judgment compassionate care, but result in better health outcomes for both mothers and the unborn infants (Boyd, 2007). The true power of these programs lies in their capacity to foster a foundation to support mothers in sustaining relationships with service providers, other mothers, friends, and family members. Engagement in relationships through outreach is the first step in the process of healing through relationships and in supporting the relationship capacity for pregnant women using substances.

The idea of the "window of opportunity" for substance-involved pregnant women as a time to make positive changes with regards to their substance-use has been criticized as a societal expectation of the mother in order to protect

the fetus with little regard for the pregnant woman's health (Greaves and Poole, 2004). However, changes made in pregnancy by substance-using women are not only changes made for the unborn baby but can also be positive and hopeful changes that the pregnant woman desires for herself. By emphasizing the health of the woman, having a warm and non-judgmental approach, and emphasizing the role of material conditions and context on women's health, we can foster the woman's own desire for health and well-being for her unborn child, and most importantly for herself. Effective approaches to supporting substance-using pregnant women are women-centered, emphasize the context and social factors that lead women to use substances and use a relational approach to successfully engage pregnant women in substance-use treatment. Overall these approaches emphasize the importance of healing through relationships that promotes the health of both the mother and the unborn baby.

Research and evaluation of BTC's Pregnancy Outreach Program, as well as the stories of the women who we serve have supported the need for specialized women-centered services for pregnant-substance using women. It has also demonstrated that when substance-involved pregnant women are successfully engaged in a Pregnancy Outreach Program, they show better maternal health outcomes and trends toward long-term reduction in substance use (Motz et al., 2006). Lastly, the women have emphasized the importance and effectiveness of engaging and treating substance-using women through a relational capacity. As one former BTC client simply stated: "They loved me back to life. They did" (Former BTC Client, 2005).

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