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Supporting Families at Sheway and Beyond

Self, Recovery, Family, Home

PREPARED BY:
Dr. Lenora Marcellus

For more information on this research please contact:

Dr. Lenora Marcellus, School of Nursing

University of Victoria

lenoram@uvic.ca

Acknowledgements:

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Background

Housing trends in BC indicate that options for safe, adequate and affordable housing are decreasing while complex housing barriers, such as the stigma and discrimination associated with mental health and addiction and the lack of integration of harm reduction into housing initiatives, are increasing (BC Non-Profit Housing Association, 2007). Researchers have found that unsafe and unstable housing is connected to many adverse effects for women, their children, and our society as a whole.

Affordable and appropriate housing, adequate income, and healthy nutritious food are basic components of health. Women who are pregnant or newly parenting and negotiating substance use and other challenges face overwhelming barriers to obtaining and maintaining housing and a sense of home for themselves and their children. A lack of secure and safe housing severely compromises women's health and also increases the likelihood of losing custody of children.

For over 20 years, the Sheway Program has been providing services and supports to pregnant and newly parenting women with substance use challenges and their families in Vancouver's Downtown Eastside. Sheway aims to support healthy pregnancies and positive early parenting experiences using a service model which is woman-centered, trauma informed, harm reduction focused, and culturally responsive. Sheway provide access to a multidisciplinary team and responds to a wide and complex array of health, social and economic issues that can impact negatively on the well-being of women and their families.

While it is clear that providing supports such as rental housing supplements, nutritional supports, and infant care supplies (such as diapers, strollers, or baby equipment) may provide immediate benefits to vulnerable mothers and infants in the short term, very little research (in particular Canadian research) has examined whether providing such targeted supports during the perinatal period can yield positive long term gains in health and well being. This longitudinal evaluation was developed to follow a previous evaluation of the impact of targeted funding received from the BC Ministry of Employment and Income Assistance (MEIA) to enhance housing specific and non-housing specific supports for Sheway clients and their children (Salmon & Ham, 2008).

Research Approach

This longitudinal mixed-method followed 18 women who were current or former clients of Sheway for a three year period. They were interviewed and completed demographic questionnaires at 6 to 12 month intervals during this time. 6 women were still participating at the time of the final interview. The average age of participants was 32 years (range 22 to 44) and the average number of children was two (range 1 to 6).

Findings

Overall the basic process over time that women experienced was that of *holding it together*. Three key themes were interwoven: (1) restoring their sense of self during recovery, (2), becoming a strong center for their family, and (3) creating a sense of home no matter the circumstances. There were a number of key concepts identified within these three themes. Women, despite multiple adversities and limited resources, were managing to make daily life work. They demonstrated resilience and creativity in how they were able to pull together supports to keep their family going. They were also frustrated with how it was hard to see a way out of their current set of circumstances to improve living conditions for themselves and their children.

Recommendations

There are a number of recommendations for action at the levels of program, health and social service system, and provincial and federal policy. Recommendations are included that address supporting recovery, family development and well-being, and addressing the circumstances of daily living including income support and housing.

Level 1: For programs
- *Extend the period of time that women and families are able to access Sheway services.* Women who access services at Sheway and other post-partum and community support programs consistently identify that shorter maximum limitations on program participation (often from 6 to 18 months postpartum) are distressing. Because one of the key elements of success for retaining women in programs is the development of a trusting, respectful relationship, women are reluctant to leave the program. This recommendation was also in the 2008 evaluation.
- *Expand the scope of services and/or the referral sources from a pregnancy and early parenting focus to one that acknowledges that many clients will have "ages and stages" needs for children who are older than toddlers.* Integrated community maternity programs are usually designed to focus on the current situation which is pregnancy or new parenting. Women in this study required supports and services also for their older children through to young adults.
- *Provide programming options that can be either individualized or in groups.* At different moments in their pregnancy, parenting and recovery, women may feel more safe receiving services for some issues in different ways. This may also change over time.
- *Develop a more intentional transition process for women who are ending their Sheway participation.* Women shared that they felt abandoned with a sudden shift from experiencing "wrap around" support to them being required to take full responsibility for finding the resources that they needed. This process may be modeled on principles of the development of self-efficacy, mentorship, and transition support.

Level 2: For health and social service systems
- *Integrate a housing focus as a core component of intensive integrated maternity programs for women who are coping with multiple health and social issues.* Women shared that over time,

their housing needs shifted related to issues such as location and size. Programs may need to develop a "menu" of housing options and consider how housing can be accessed in a more anticipatory and preventive way. Innovative co-housing and co-parenting models are also needed for women with FASD and other disabilities where full time parenting may be difficult.

- *Strengthen opportunities for resources to be immediate and individualized.* Most funding sources are significantly limited related to flexibility, immediacy of funding, and range of options. A key element of programs like Sheway is inclusion of an unrestricted funding component (like the MEIA funding) where program personnel can immediately meet very specific needs of families. Early investment in emergent needs is preventative and can be more cost effective than funding more expensive downstream interventions.
- *Strengthen services related to behavioral and mental health issues, for both parents and children.* There was a significant need for parenting support, respite, counseling, therapy, and educational support for families. These issues arise from not only the impact of substance use but also from multiple intergenerational determinants and from systemic structural barriers.

Level 3: Provincial and federal policy
- *Ensure that sex and gender analyses are conducted on provincial and federal policies related to housing, social support and income support.* Many policies continue to be universal and do not take into account the gendered pathways that are created for women related to accessing housing, education, income and employment.
- *Develop a range of housing related supports.* In addition to expanding core housing capacity, develop alternate strategies such as housing top up programs that can support stability in housing for families. Build greater flexibility into policies to accommodate the wide range of family structures and circumstances and continuous changes in their needs, including children moving between home and foster care.
- *Engage multiple sectors in developing housing capacity.* Partnerships between housing, health, social services and income support may contribute to the development of creative community-specific housing models.
- *Invest in programs that support women to balance caring for their children with accessing education and employment.* Early investment in supporting women and their partners to complete schooling and find employment that is more stable will have a long term significant benefit for governments. During the early years it is important to build in flexibility for women who would like to maintain a primary parenting role.

In conclusion…

Pathways followed by women in the early years of recovery and parenting often set in play a lifelong set of circumstances that present as barriers to security and well-being. This longitudinal evaluation provides insight into experiences over time for women/mothers living within highly complex social circumstances and identifies elements of transition success for mothers and their children that are more achievable over a longer period of time. This information will assist service providers and government planners in identifying future funding and program planning needs of this population.

CHAPTER 1
Introduction

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> *"The strength of a woman is not measured by the impact that all her hardships in life have had on her; but the strength of a woman is measured by the extent of her refusal to allow those hardships to dictate her and who she becomes."*
>
> *C. Joybell..*

Adequate, safe and secure housing is a fundamental human right and a recognized social determinant of health. Inadequate housing and homelessness have been identified as growing concerns across Canada. While there are some bodies of literature that address the housing needs of women affected by factors such low income and intimate partner violence, there is a specific gap in knowledge that addresses housing and homelessness as they intersect with pregnancy, early parenting and substance use. Pregnant and early parenting women affected by substance disproportionately include those affected by systemic marginalization, trauma and violence, mental health challenges, Fetal Alcohol Spectrum Disorder (FASD) and other disabilities.

The importance of this research gap concerning housing for pregnant and early parenting women affected by substance use is underscored by the literature on the impact of early development on health and well-being across the life course. Poor housing conditions, such as overcrowding, poor repair, and frequent moves, have been linked to a range of adverse health outcomes, including higher rates of maternal stress, prematurity, low birth weight, infant mortality, asthma, environmental toxin exposure, obesity, and mental health concerns (Cooper, 2001; CWHN, 2010; Frankish, Hwang, & Quantz, 2005). Inequities emerge in a systematic way through the early years and the gradient in developmental risk increases, affected by variables including housing security, neighborhood safety, and community cohesion (NSCDC, 2010; Raphael, 2010; Shonkoff et al., 2012). There is also growing recognition of the link between housing problems and children in the child welfare system with homelessness itself to some extent a trigger for child protection referrals and the loss of custody of children (Courtney, McMurtry & Inn, 2004; Shdaimah, 2009; Trocme et al., 2009).

A growing number of integrated primary maternity health care initiatives have emerged in recent decades across Canada, including the Sheway program in Vancouver, BC (Burglehaus & Stokl, 2005; Nathoo et al., Poole, 2000; Sword et al., 2009). Evidence from participants in these models of service and the health and social providers working within the programs suggests that the availability of a range of housing supports is central to the effectiveness of this model of service and to the long-term well being of women and their families.

Background to the Evaluation

The Sheway Program

Sheway is a community-based pregnancy outreach and parenting program offering practical support, health care and counselling for high-risk pregnant women and mothers who have drug or alcohol issues and are involved in Vancouver's Downtown Eastside (Burglehaus & Stokl, 2005; Poole, 2000; Salmon, 2008). Sheway serves women and their infants up to 18 months postpartum, and aims to support healthy pregnancies and positive early parenting experiences using a model that is women-centred, trauma informed, harm reduction focused and culturally responsive.

Operating as a partnership between Vancouver Native Health Society, Vancouver Coastal Health Authority, the Ministry for Children and Family Development, and the YWCA of Greater Vancouver, Sheway provides clients with access to a multidisciplinary team, which includes social workers, family support and outreach workers, infant development consultants, a dietician, a cook, an addictions counsellor, nurses, and three physicians. Staff work collaboratively using a team-based, women-centred model for service delivery to address and respond to a complex array of social, economic, and medical issues which can impact negatively on the health and well-being of women, infants, and families impacted by poverty, problematic substance use, and other forms of marginalization.

In 2006, the BC Ministry for Employment and Income Assistance (MEIA) provided one time funding to the Sheway program to assist Sheway clients in creating more stable living environments for their families. The intent of this funding was to assist low-income mothers and pregnant women with current or previous substance use problems in "finding a more stable environment" through housing, health/nutrition and community supports. Specific areas for which funding could be provided to Sheway clients and their families were through:

- A housing top-up for women to allow them to secure suitable housing during pregnancy;
- Nutritional counseling and the extension of the food program to include formula and other supplements, homemaking services and baby equipment; and
- Transportation, community engagement and the provision of social outings.

There were direct positive impacts of MEIA-funded supports on client outcomes and on Sheway's capacity to respond to their most urgent needs. The supports provided with MEIA funds filled critical gaps which were presenting substantial challenges for women and families working to improve their health, housing, and community engagement, and to secure or retain custody of their children (Salmon, 2008). For example, the following were noted:

- Improved access to safe, stable, and appropriate housing, baby equipment, and food and nutrition supports helped women regain custody of children who were in foster care, and, in some instances, prevented children from being apprehended;
- For some women, the receipt of a housing top-up made the difference between being housed and being homeless. Women who had been experiencing health and safety problems due to living in dangerous and substandard housing identified receipt of rent top-ups as critical to enhancing their health and well-being by facilitating their move to a new apartment in safer surroundings;
- Housing top-ups assisted women in leaving an abusive partner or violent environment, caring for children with special needs, and in maintaining their housing when their relationship with their partner ended;
- Grocery vouchers provide practical support; and
- Access to communications supports helped women to build better relationships with children in care, an important step toward regaining custody.

The majority of infants born to women who received MEIA-funded supports had birth weights within a range of 2500-4250 grams. This represented an 8% incidence of low birth weight babies within the sample, which is comparable to that found in the general Canadian population (CIHI, 2007). MEIA-funded supports appeared to contribute to a foundation for achieving long-term improvements in maternal and child health and well being. A strong parent-child relationship was seen by mothers who received MEIA-funded supports as prevention against future harm, by decreasing their risk of problematic substance use, and by decreasing the likelihood that their children might also turn to substance use when they are older. MEIA-funded supports were found to alleviate stress and worry, which women identified as supporting them to enjoy and focus more on their children, thus facilitating stronger attachment. Clients and staff identified that the provision of MEIA-funded supports, particularly those related to housing and food security, also provided women with stability to think beyond their immediate survival needs to identify long-term goals and plans for their families.

Following completion of this evaluation, further funding was received from the Vancouver Native Health Society to continue to investigate the impact of housing supports over a longer period of time on outcomes for Sheway clients. In this report, the findings of this next phase of evaluation are presented. Many of the goals specified by Sheway and MEIA for the 2008 evaluation related to individual client outcomes that are typically achieved over a period of years, not months. This is especially true among populations of "high risk" women and families experiencing multiple barriers to achieving increased levels of health, income security, housing and family stability, and community engagement. A longitudinal evaluation is able to focus on those aspects of transition success that may be more achievable over a longer period of time, such as those related to transitions in recovery, housing, child custody, and income security.

What does Research tell us About Housing, Women, Children, and Health?

Housing

Adequate, safe and secure housing is linked to improved population health, and precarious housing contributes to poorer health for many, leading to health inequities (Dunn et al., 2006; Frankish, Hwang & Quantz, 2005; Wellsley Institute, 2010). There has been erosion in Canada in the foundations that create stability in living conditions. With the gradual withdrawal over the past 40 years of government investment in affordable housing, there has been a reduction in affordable housing stock for rental and purchase and rising market rents (Gaetz, Gulliver & Richter, 2014). Connelly et al. (2003) estimate that by 2033 approximately $30 billion of federal funds will have been withdrawn from housing capacity building in Canada.

At the same time, social demographics and policies have shifted that are impacting community circumstances and the resources that are available within society to support well-being, including welfare reform, minimum wage erosion, employment trends toward casual and part time work, deinstitutionalization of individuals with mental health issues without adequate community supports, and increasing numbers of lone parent families, in particular headed by women (Beujot, 2003, Vanier Institute of the Family, 2010). In Vancouver, the geographical context for this research, there is currently an even greater stress on affordable housing due to population growth, real estate speculation and overseas investment (City of Vancouver, 2011). Owning housing and renting at market value are increasingly out of reach for many families, even those with middle class resources.

The Canada Mortgage and Housing Corporation (CMHC) defines adequate, affordable and suitable housing as follows:
• Adequate housing – not requiring any major repairs
• Affordable dwellings – costs less than 30% of total before tax household income
• Suitable housing – has enough bedrooms for household residents

In Canada, over 1.5 million households are in core housing need (an incidence of 12.5%), defined as falling below at least one of the above standards. In BC the incidence rises to 15.4% and in Vancouver it is 17.7% (CMHC, 2015). Additionally, the CMHC states that core housing need is even greater for lone parent, Aboriginal and immigrant families (CMHC, 2009). Approximately 25 to 30% of lone women households in Canada live in unacceptable housing conditions (CMHC 2009 in Jategaonkar & Ponic, 2011). Jategaonkar and Ponic (2011) suggest that mothers who are

homeless or live in poverty are faced with a "policy paradox" in that secure housing is often a condition of maintaining custody, but having custody is a requirement for obtaining social housing. The presence of additional complex social issues such as substance use, mental health problems, violence and trauma and the stigma and marginalization created by these issues create even more challenges related to securing safe and adequate housing (Clough et al., 2014; Somers, Drucker, Frankish & Rush, 2007).

A recent Cochrane review (Thompson, Thomas, Sellstrom & Petticrew, 2013) suggests that the best available evidence indicates that housing which is an appropriate size for the household and is affordable to heat is linked to improved health, improved social relationships within and beyond the household, and may reduce absences from school or work. They summarize that "*poor housing is associated with poor health*" (p. 3).

Women, housing and health

Many services and supports for people experiencing unstable housing or homelessness have been developed without sufficient attention to gender differences, creating further barriers for women, in particular for homeless pregnant and newly parenting women and their children (CWHN, 2010). As research shows that the pathways to homelessness are strongly gendered, there is increased recognition of the need for different types of housing strategies that address how gender intersects with other factors which affect homelessness (age, race, health, etc.) (Bryant, 2009; Hwang, 2004; Rude & Thompson, 2001). Poor access to safe and secure housing is an increasingly serious issue for disadvantaged women, and with escalating poverty in BC and Canada there are growing numbers of women who are, if not homeless, precariously housed (BCNPHA, 2007; Jategaonkar & Ponic, 2011). In addition to physical and material housing concerns, women may also experience the loss a sense of home from a social and psychological sense, which confers privacy, safety and personal control (Shaw, 2004).

The health problems that result from lack of stable housing are many and severe, with poor housing and homelessness placing individuals at risk for chronic illnesses, infections, mental health issues, abuse, and premature death. A study conducted in Toronto found that homeless women 18 to 44 years old (primarily of reproductive age) are ten times more likely to die than women of the same age group in the general population (Hwang, 2004). To ensure their children are not removed by child welfare agencies, women often conceal their homelessness, ironically increasing their invisibility (Courtney, McMurtry & Inn, 2004).

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Services for homeless population are typically designed for men, for individuals, and in circumstances where it is more visible (for example sleeping on the street or in parks). Women and women with children who experience housing challenges are more hidden. Women use more informal strategies (staying with friends, becoming involved with men who have homes, staying in unsafe housing). There is a strong interconnection for women between family

violence, poverty and homelessness (Clough et al, 2014; Jategaonkar & Ponic et al, 2011; Skobba, 2016). For example women report returning to abusive partners because of a lack of affordable housing and inadequate financial resources.

A literature review of evaluations of housing interventions in Canada conducted by Pauly, Carlson and Perkin for the Canadian Homelessness Research Network (2012) found that the focus of most of the research on permanent independent housing has been single adults with mental health illness, with or without problematic substance use. Out of 66 papers, five studied homeless families and four studied homeless women. This review illuminated the lack of focus on problematic substance use as the primary concern in housing programs for homeless people, and highlighted the need to better understand the housing requirements of people with substance use problems, the role that substance use plays in re-housing, and substance use policies in a range of housing settings. The review also highlighted that there is a lack of a gendered analysis in housing interventions, and a further lack of focus on Aboriginal peoples, including women, children and families, in research on homelessness interventions.

Children, families, housing and health

Inequities in child development, including health outcome, emerge early over the first five years of life (Hertzman et al., 2001; NSCDC, 2012; Shonkoff et al., 2012). Significant adversity in critical life stages (including during pregnancy and early life) can disrupt development of the nervous, cardiovascular, immune, stress, and metabolic regulatory systems of the fetus and infant (NSCDC, 2012). We now clearly know that an excellent mechanism for improving the overall health of children is by investing in strengthening the foundations of health in the prenatal and early childhood periods. Housing and housing policies are part of this foundation.

Housing conditions, especially overcrowding, poor repair and sanitation are important components of socioeconomic conditions and have been linked historically to adverse health and social outcomes for children and families (Courtney at el, 2004; Gewitz et al, 2008; Zlotnick, 2009; Chau et al., 2001). Economically disadvantaged children and their families often tend to live in housing that is crowded, noisy, and characterized by structural defects such as leaky roofs, rodent infestation, and inadequate heating, and they are exposed to greater air pollution from traffic, industrial emissions and caregiver smoking. Indigenous families on reserve are at risk of additional negative effects (Stout & Harp, 2009).

Children come into foster care for a number of reasons, including when a parent is unable to

provide a safe home for the child. There is growing recognition of the link between housing problems and children in the child welfare system. Children in families experiencing housing problems have been reported to be at increased risk of child welfare involvement and out-of-home placement (Courtney at el, 2004; Gewitz et al, 2008; Zlotnick, 2009). In one study in Ontario, housing was identified as a factor in one out of five cases of child apprehension (Chau et al , 2001). Trocme et al. (2009) have included a housing indicator in the Canadian National Child Welfare Outcomes Indicator Matrix (NOM, the percentage of families receiving services during a fiscal year that move at least once during that period. To some extent homelessness itself is a trigger for child protection referrals. Parents who lose custody of their children are faced with a dilemma; the loss of children triggers reduction or termination of housing subsidies and they are even less likely then to provide a home that meets the expectations of child protection policies.

A review of infant deaths in BC by the Representative for Children and Youth (2011) found that many of the 21 families who experienced an infant death struggled with adverse circumstances, including serious poverty, inadequate housing and fragmented systems of support. A significant proportion of these families were of Indigenous backgrounds from Vancouver Island. In this review, governments, the health and social service system, and community organizations were urged to increase supportive housing options and pursue strategies that address poor housing for expectant economically disadvantaged parents and families, especially those of Aboriginal background.

> *Housing and demographic trends in BC indicate that options for safe, adequate and affordable housing are decreasing while complex housing barriers, such as mental health and substance use issues, are increasing.*

However, housing has not historically been part of deliberations on child policy or a key feature of children's policy initiatives at any level - national, provincial or municipal. A discussion paper from the Canadian Policy Research Network (Cooper, 2001) was developed to bridge the gap that existed between children's policy and housing policy, document the multiple ways in which the quality of housing influences the health and well-being of children, and describe the unintended consequences in Canada of shifting housing markets and the withdrawal of federal and most provincial governments from social housing development. The CPRN considers housing to be a vital component of any strategy for investment in the future of Canada's children.

Housing for women and families impacted by substance use

In summary, housing is considered a fundamental human right and a key health determinant. Housing and demographic trends in BC indicate that options for safe, adequate and affordable housing are decreasing while complex housing barriers, such as mental health and substance use issues, are increasing. Although there is a small body of literature addressing the housing needs of women affected by factors such as single parenting, low income and intimate partner violence, there is a specific gap in knowledge addressing housing as it intersects with pregnancy, early parenting and substance use (Skobba, 2016).

CHAPTER 2
Methodology

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Our Research Question

The question at the outcome of this longitudinal evaluation was*: What aspects of transition were experienced over a longer period of time for Sheway clients from when they were in the program to after they left the program?*

A related question was to explore if there were differences in transition experience pathways for women who received additional financial support from MEIA supplements compared to those who did not.

How we Conducted this Evaluation

The evaluation approach was designed to follow the pathways that women and their families took through the early years during and after receiving services through the Sheway program. In particular we were interested in identifying key elements or strategies that supported or hindered transition and growth during this period of time.

The research approach

This was a longitudinal mixed method evaluation, guided by grounded theory analytic approaches. Grounded theory is a qualitative research method used for exploring, identifying and analyzing complex processes over time (Glaser & Strauss, 1967; Morse & Richards, 2002). It is particularly useful for situations that have not been previously studied and where existing research has left gaps (Schreiber & Stern, 2001). The central objectives of grounded theory are to identify the trajectory of a basic social process (the central theme that explains the data) to which people must adapt and to advance development of a theory with respect to that social process. We used a constructivist approach in this study to acknowledge the mutual creation of knowledge by the researcher and the participants (Charmaz, 2013).

Our theoretical perspective

The theoretical framework for this evaluation was a critical feminist perspective. Social justice as seen from critical and feminist perspectives highlights the importance of including both the experiences of those impacted by homelessness and the structural conditions and processes that give rise to structural injustices and subsequent inequities in health (Chasey, Pederson & Duff, 2009; Pauly, MacKinnon & Varcoe, 2009).

Our population focus

The target population for this study was women who were current or former clients of Sheway and who either: (a) received targeted supports (housing or non-housing specific) from funding provided by the Ministry of Employment and Income Assistance (MEIA) in addition to Sheway supports, or (b) received only general supports through Sheway (for example nutrition support). This group of women was chosen for their ability to describe experiences of transitioning from pregnancy to parenthood, recovering from substance use, coping with multiple complex social challenges, and describe the impact of different community and government services on these experiences over time.

Recruitment:

Sheway personnel identified all potential participants based on their records of supports for clients who received MEIA funds. An invitation to participate was mailed to each woman identified. Sheway personnel made no additional direct communication to potential participants regarding this study. Women who received an invitation and who were interested in participating contacted the researcher directly by phone. Sheway personnel did not have knowledge of who chose to respond to the invitation or who were subsequently enrolled.

If women remained interested in participating and if they met the inclusion criteria, they were mailed or emailed a consent form to examine in their own time. They were provided with at least 24 hours to examine the consent form before being contacted again. Women who wished to continue the process met with the researcher or a research assistant to discuss the study to ensure that they understood the full implications of participating before the consent was signed. Participants were made aware that they were free to withdraw from the study at any time without jeopardizing any service they may receive from Sheway at that time or in the future.

The number of participants for this study was projected to be small (N=20) due to the fact that this was qualitative study and a limited number of mothers and infants received the housing supplement. For the initial interview, 18 women were recruited.

Ethical approval

Ethical approval was received through Human Research Ethics Boards at the University of British Columbia and the University of Victoria. Participants were informed that their participation in the study was entirely voluntary. They were informed that they did not have to answer questions that they were not comfortable with and that they could withdraw from the study at any time without affecting any of the supports they received from Sheway or other agencies.

On enrolment to the study a unique non-identifying code number was assigned to each participant and all study documentation, both paper and electronic, contained only this code number. Details necessary to contact the participant for each interview (ie. name, telephone

number) were kept separately to all other documents. All paper documents were kept in a locked filing cabinet, and all electronic material, including recordings and transcripts of interviews, were password protected and available only to the researcher, research assistant, and transcriptionist. If the researcher or the research assistant had reason to believe that an infant/child may be abused, neglected, or was for any other reason in need of protection they were required by the Child, Family and Community Act of BC to report to the Director or a designated social worker (Ministry of Children and Family Development). All participants were made aware of this exception during the consent process.

How we gathered and analyzed the data

We utilized both quantitative and qualitative approaches to collecting data. A questionnaire was administered at each point of contact. While the participant was a client of Sheway the research assistant examined the participant's confidential file to extract data. This provided information that the participant was unlikely to know (such as the exact date, cost or number of MEIA-funded supports they have received), as well as reduced the interview burden for participants by extracting information provided more expediently through chart review (such as infant health data). Once the participant was no longer a Sheway client, all information was obtained during the interview process and file review was no longer conducted.

The participant and the researcher or the research assistant initially met for a semi-structured interview, which took approximately an hour in a location chosen by the participant, and asked about the woman's housing, child custody, community engagement, income source and her health and the health of her children. The participant was then contacted at approximately 6 to 12 month intervals over a three-year period. Four interview waves were completed during this time. Ongoing consent was obtained prior to each subsequent interview. Childcare and transportation costs were reimbursed and participants received a small honorarium with each interview. 18 women completed the first interview, 11 the second, 10 the third, and 7 the fourth, over a total time frame of three years, for a total of 46 completed interviews (Table 1). One participant moved from BC after the initial interview. Eight of the initial 18 participants received additional housing funding through the MEIA program. This did not correlate with completing more interviews. Overall, six women completed all four interviews, two that received housing top ups and two that did not.

Table 1: Summary of completed interviews by participant

Participant #	1*	2	3	4	5	6	7	8*	9*	10	11*	12	13*	14*	15*	16*	17	18
Interview #																		
1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2	X		X	X	X	X					X	X		X			X	X
3	X			X		X	X				X	X				X	X	X
4	X			X		X					X	X				X		

* Received MEIA top up funding

Recorded interviews were transcribed and the data was analyzed using grounded theory approaches. The quantitative data was entered into Statistical Package for Social Sciences (SPSS) and descriptive statistics were produced.

Description of participants

Demographic data was collected from participants including age, number of children, level of education, income and employment status, relationship status, current legal issues, and housing stability and quality. The demographics reported were similar to previous Sheway service reports and reports from other integrated maternity care programs with a shared model. Because women may be identifiable if individual profiles were presented, all demographic data is presented in an aggregated form. Demographics were noted to be consistent between those who received a housing top up and those who did not and those who completed all four interviews and those who did not.

Based on the first point of data collection, the average age of women was 32 years, with a range from 22 to 44. The number of children in each family ranged from one to six, with an average of two. Ages of the children ranged from under 1 to 19. Seven women self-identified as Aboriginal. Education levels ranged from not having completed high school to one participant having completed some college. Over half of the participants reported completing some high school or less than Grade 8. Related to employment, two participants were in school, five were working full time, two were unemployed and ten were not in the labour force for other reasons, including parenting, disability and illness. The primary sources of income were disability support and social assistance. Of the three women who reported employment, two women shared that this was from sex work. One participant was relying on savings. Ten participants felt that they were experiencing significant financial challenges.

Relationship status varied, with seven women being single, seven living with a partner (not married), and four in the other category. Four women reported current legal challenges (including custody issues, supervision orders, assault, owing money for court fines, and having a partner in probation). Seven women reported that they felt their housing was currently stable. Most participants indicated that they felt they had adequate social support. Sources of this support frequently included family, friends, Sheway personnel, and care providers such as their physician, a public health nurse or a counselor.

Because the full series of four interviews was partially completed by 12 women, there are only limited observations that can be drawn about how women's circumstances changed over time. However, there were some themes that were noted. In general, over the four waves of interviews, some women moved in and out of relationships, often in response to substance use and violence. They remained relatively stable in their housing settings with a total of 4 moves reported in the 46 interviews. The two participants who were in school were not able to complete their programs because of financial issues. Sources of income and the degree of significant financial hardship reported remained significant across all waves of the interviews.

From a health perspective, initially 5 women reported excellent health, 11 reported average health and 3 reported poor health. Some pregnancy complications were experienced, including

miscarriages (1), gestational diabetes (1), cesarean birth (2), premature birth (4), and bleeding (1). Nine participants reported the presence of chronic health issues, including asthma (3), HIV (1), Hepatitis C (4), and diabetes (1). Women reported a number of health issues for their children over the three years. These issues primarily reflect common health issues for infants and young children, including respiratory tract infections (7), asthma (2), ear infections (2), allergies (1), diarrhea (1), abnormal growth (1), rashes (1), strep throat (1), tonsillitis (1), and anxiety (1). Overall women rated the health of their children as average or excellent. No one reported poor health for their children.
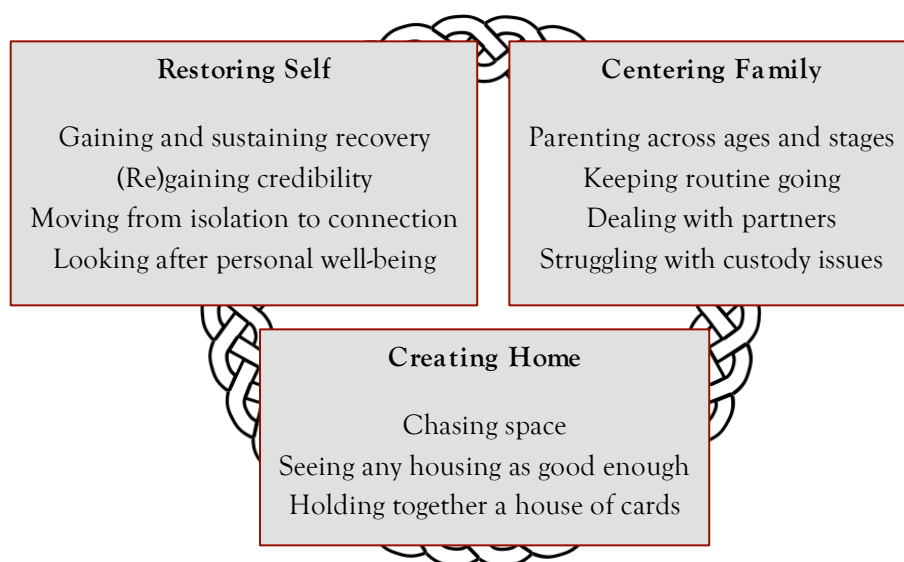
CHAPTER 3
Key Findings
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The overall basic process (or central theme) that was experienced over time by women was that of "*holding it together*". The three core themes that were interwoven in women's daily lives were that of: (1) restoring their sense of self during recovery, (2) becoming a strong center for their family and (3) creating a sense of home no matter the circumstances. These three themes are represented visually as a circle to show the ongoing day-to-day work of maintaining self, family and home. These themes are interwoven as a braid to highlight the interconnectedness of this work and reflect the renewed cultural engagement of many of the Indigenous participants, who are a key population of the Sheway Program. There are a number of key concepts within each of these core themes. The figure below shows the relationships between these themes and concepts (Figure 1).

The overall process - *holding it together* – represents that women, despite multiple adversities and limited reserves, manage to make daily life work. They demonstrate resilience in their determination to be a good mother for their children. In the next section, the core themes and their sub concepts are described and quotes from participants are provided to demonstrate these themes and concepts.

Figure 1: Basic social process - Holding it together

Restoring Self

Gaining and sustaining recovery
(Re)gaining credibility
Moving from isolation to connection
Looking after personal well-being

Centering Family

Parenting across ages and stages
Keeping routine going
Dealing with partners
Struggling with custody issues

Creating Home

Chasing space
Seeing any housing as good enough
Holding together a house of cards

THEME 1:
Restoring Self

This theme reflects the long-term work for women associated with restoring their sense of self during recovery. Within this theme, there are four key concepts: (1) (re)gaining credibility; (2) moving from isolation to connection; (3) gaining and sustaining recovery, and (4) looking after personal well-being.

Concept 1: (Re)gaining credibility

Credibility emerged as the quality of being trusted and believed. Because of their substance use and other life experiences, women shared that they needed to work hard to regain the trust of those around them and those who they interacted with in their daily lives, including family members, friends, landlords, employers, social workers, foster parents and childcare providers. Depending on the age that they became involved with substance use, this trust and credibility may have been built for the first time. Women were required to have positive references for work and renting, rebuild poor credit ratings for managing banking, and gather identification to support residency. Because all markets in the community (such as housing, employment, child care) were stretched, in demand, and highly competitive, these were of critical importance for obtaining housing and moving forward. Many of these requirements had interconnections. For example, one participant reported that in her apartment she needed to use a credit card to use the washing machine. Without a credit card, she was required to walk to the nearest laundromat with her children to do the laundry.

I get through it. I found out that there's a smart card you can use for the washing machines, it's just like a credit card. And you bring it to the gas station and there's a machine and you can put the card in the machine and put cash on the car. And that's what I go through to do laundry at my building. It really stresses me out, even just the laundry thing. It's massive.

Everybody's out, looking for a place, it's a tough competitional thing looking for a good place for a family, you know, with children.

Almost any place you look, you have to go through an interview with the manager, and they want a credit check, they want to know everything about your financial history. And mine's not so great, there isn't anything I can do, but like, I'm sitting here with the baby and I want to be in a good neighborhood. The lady that let me in this building let anybody in. there was no credit check, nothing. So I'm really really grateful and I know it helped establish my residency. So now when I go to get another place I'll have confidence.

Women reported that often building credibility required some resources, which they did not have, and it felt like a "chicken and an egg" process. For example, women who wanted to return to school reported many system level challenges. They needed to meet entrance requirements to access financial support, but there was no support to meet the entrance requirements. Student loans were also often not available for part time courses, and with family responsibilities part time was often the only logistical option. Many of the courses that women expressed an interest in taking (such as home care, child care, esthetics) were also only available during the week full time, which was a challenge without childcare. Related to employment, women expressed a need to secure stable predictable jobs to facilitate family routine and ongoing capacity to meet financial commitments, but the jobs that were available were usually minimum wage, part time and with irregular hours.

> *It is frustrating when you have a plan but just can't execute it as of barriers such because time, money and other resources. You know what you wanna do and it's right there.*

Gaining credibility for employment was a challenge for women who had never been in the mainstream workforce, or who had spent limited time in the workforce. It also meant meeting expectations for workplaces, such as taking out piercings, not wearing high heels, and covering tattoos. Women did not "feel like themselves".

> *It's so difficult because we have no education, we have no history of like, you know, resumes and things like that. If you are a bit older and have not worked, a lot of people don't want to hire you.*

> *I have to get my own job. And I don't know how to get a job per se because I've never really had to get a job. So it's kind of daunting because I'm like, what the heck am I supposed to be doing... it's my own fault for being a drug addict for that long. I should have been looking for jobs.*

Women shared how they connected building this sense of credibility and responsibility to their capacity to provide future opportunities for their children. For example, despite extremely limited finances, some participants were already beginning to save for their children's education. They saw their personal goals also being about their children.

> *My goals are never mine they're my children's. As I'm a loner I don't have a life, I have my children's life, that's it. Just getting my kids on an even keel, that's my goal.*

Finally, women shared that over time, they came to know themselves in a new and different, positive way.

> *I am proud of myself because I have learned how to be more confident in myself because a women instead of as somebody in the world who is not sure of herself.*

Concept 2: Moving from isolation to connection

Women were often in the place of disengaging from family and friends who they saw as pulling them back into their previous way of life. They felt isolated and were seeking ways of rebuilding the social support that they needed to move forward with their children.

There were some differences reported in the kinds of social support that were felt to meet their needs. In relation to connecting to other women who were parenting, some women stated that they would like to be with other moms who could be more like role models.

> *I want to be around normal people who like, no mother's perfect but like, like I'm trying here. I think I need something that I'm around other parents who are not like, messed up ex drug addicts... that's why I, when I was at Sheway I didn't make a lot of friends with the girls there as I don't wanna be their friend. I don't wanna deal with their like, relapse and crap like that, right?"*

Alternatively, other women felt that they experienced stigma and judgment in mainstream parenting groups and that they could not openly share some of their unique challenges.

> *When you are in a group of women who know what you're talking about, it's so much easier to sit there and go, I would, you wouldn't believe how bad my day was... as all of us mothers that go down there have to deal with social workers, we have to deal with drug and alcohol counselors, we have to deal with schools. At least you have someone else that can be your backbone sometimes.*

This diversity in preference also was shown related to whether women preferred to interact with individuals, or in groups.

> *I was attending the groups and there were a lot of people talking a lot about negative things in the groups, and some of the stuff I just didn't want to hear. I don't know how that's gonna help me. For some people it might help but for me, I didn't feel like it was going to help me. So I stopped, and I talked to the worker and said I don't feel comfortable going. I told her that I would rather go through her and deal with my problems, and that's working out good.*

> *It's nice to hang out with women who have children the same age.*

Women shared many ways in which they were starting to build healthy and positive connections for themselves. They looked for friends and family who would be good to them and good to their children. They sought activities for themselves to help them get out of the house, including volunteering at local organizations like churches and friendship centers. Many

Indigenous participants shared that they were exploring and reengaging with their cultural traditions.

> *I do these activities (volunteering) to get beyond myself, to get away from my problems for like two seconds and like think about somebody else for a change, cause otherwise you'll go nuts.*

> *Church is really meaningful to me, it's keeping me sane.*

> *It keeps me on this side instead of that side. I was on that side for so many years so keeping me on this side and letting other women know that I know what it's like as I've been there, done that. It makes me feel empowered as a woman instead of disempowered as a sex trade worker.*

Sheway was identified as a key support during these transitional periods of time. The relationships that they had developed with team members at with Sheway were important parts of every participant's life. These relationships still continued for many of them, even after their file was closed.

> *If it weren't for Sheway she wouldn't even be alive and I wouldn't probably be alive. As we never would have heard about the hospital at FIR Square and that's the only reason I'm alive and the only reason she's alive, because we were both dying.*

> *They still love and support me. And they'll never shut the door on me. They acknowledge me because I am now, just I was then. It means everything to me.*

For some women who continued to access supports at Sheway, they started to see themselves as in a different place from the "usual" clientele. This could be a form of affirmation of their progress also, not just social support and accessing resources.

> *I'm not like the other clients or cases that go there crying for stuff, right, as they're on drugs, in the closet users.*

Women suggested that it would be helpful to have programs like Sheway but for families with older children. They noted that parenting actually became more expensive as their children got older, and they needed more food for growing children, required resources for children's activities and sports, clothing, and larger living spaces.

> *Eighteen months is not really that long, especially when you are not used to having the baby and I wish it could go for until they're at least three or maybe even, until they start kindergarten.*

Another participant shared that she did not go to Sheway for a subsequent pregnancy as a way of demonstrating and maintaining her independence.

I tried to stay away so that I did not become too dependent on them, like I did the last time. I found this almost like a liberating feeling, being able to walk away and actually know that those supports were there should I need them, like surviving on my own.

Many women shared that they found it difficult to have to leave the program when the time came. They felt that like their children, the program was embedded in their lives and it was a loss to them of a supportive network and touch point for respectful care. They suggested that it was not fair to be in a program where team members tried to help them with everything that they were working on, and then have to leave and not have anything. They felt that there should be a more structured visible transition plan for families so they did not feel this sense of all or nothing.

It was heart breaking. I was disappointed, I didn't want to. I forced myself to stop coming around for a month, I'm like, ok, Now I am ok. Like, but no, I'm not, actually. I miss em'. Nothing has really taken their place since.

I went downhill quickly when my file was closed at Sheway. Out in the real world, what am I supposed to do? They need to teach you that this isn't going to be for the rest of your life. We're not going to be here for you to lean on.. for other resources or for older children and stuff like that. I don't know, just don't put us out on our butts.. give us everything and then there you go as it's really hard in the real world compared to the Sheway world.

Concept 3: Gaining and sustaining recovery

Over the course of the sequential interviews, women demonstrated that they moved between different stages along the recovery continuum, including relapse. They reflected that over time they were developing skills in knowing and addressing their triggers, and advocating for themselves related to knowing when they were experiencing challenges in their ongoing recovery.

I've always had a really really good relationship with the Ministry. Always from the beginning. Actually my file was reopened a few weeks ago as I was drinking one night and some stuff happened, their dad was here. I want to start seeing a drug and alcohol counselor. Even before that I had called them up and said I wanted to reopen my file with them. I haven't done counseling in a very long time. It's been like years. But I think I am at that place where, when I drank that weekend that, it would be something to actually explore again. You know, because I don't want to go back to that. It would be something for myself, you know. Just to get things back in perspective.

Even though I'm having those difficulties I'm also learning, more and more because I live day to day and, and the creator wakes me up and allows me to keep learning. And I choose not to close the door on that. As the more I learn from the creator the wiser I get. I just keep on not going back to the things that make me unhappy. I look for things and search for things that will make me happier. And I think that's the best thing to do.

Relapse remained an ongoing concern for themselves and also when applicable, their partner.

> It's just that feeling I get that tries to pull me in. I get all sick to my stomach. I hate feeling that way. Cause I get choked up here, choked up here, get that sick feeling in my stomach where I want to go out again. But I don't wanna go back. I don't wanna be there anymore. It's too hard. Hard on me, hard on my kids. It's just, it's all been hard.

> I did a relapse prevention program, I've been clean for three years and then I relapsed and now I've been about three years clean again. Actually, you know, now that I think about it I should probably get connected with them again. They need to reopen my file. I don't know what caused my three year trigger, something happened, I think now that I cam coming up to my three years again I should be mindful of that.

Concept 4: Looking after personal well-being

As women moved through their recovery process, they looked for opportunities to connect to activities, services and supports that supported their ongoing physical, mental, social and spiritual health and wellness. They tried to develop more healthy eating patterns (such as becoming vegetarian, not eating dairy, trying to eat more vegetables) for themselves and also their children. Some women were trying to quit smoking. They shared that they wanted to be around for their children over the long run, and that they needed to look after their own health to do that.

> As I get older I do worry. I've got little children. There's a lot of health things that run through our family and it's kind of scary.

Women also revealed that that they felt the lives they had led to date had already contributed to some of their health issues, like Hepatitis C or HIV.

> We have both led such rough lives that like, um, my back's already getting sore, you know? He's got, all his bones have been broken before so they get sore. So you know, things like that. I've done so many drugs I'm scared I'm not going to be able to learn anything if I do back to school. I don't know if I'll be able to retain it or remember it. And then I have such little education that I'm concerned that it's gonna be, you know, really hard for me.

I just gotta make sure I keep myself hydrated all the time, you know? As you start, like, focusing all on your children, right? And not eating and drinking enough water and stuff. So I try to keep on top of that so that I'm fully energetic and ready to keep up to the kids.

Although they were determined to look after their health, it was challenging with limited resources.

I find myself eating a lot of cheap junk food, you know? Just something, anything to fill my stomach you know. And even if it's not, I know, right for me, I do, like try to eat healthy.

Women identified a number of personal goals that they had for themselves moving forward in a positive way. These goals primarily centered around family and work. They wanted to improve relationships with their children and family, and visualize and achieve goals for their children. A key goal identified for many participants was for their children to be able to do things that they were never able to do, like graduate from high school. If their children were in foster care, a goal was to regain custody. Some participants were realistic about their current capacity for parenting, but still had goals for their children, such as ensuring that they were in a caring stable foster home. For work, they hoped to finish high school and find meaningful employment, particularly employment that allowed them to balance with family commitments.

I'm just happy that I am alive. That I'm not an addict any more. I can't complain, really. 'Cause there's people out there that are far off in worse places than I am right now.

Even with their progress in their recovery, women continued to have to deal with continued stigma in the community related to their previous substance use or current substance use, including methadone maintenance treatment.

I was really sick and the doctor couldn't give a flying fuck. He went me away saying that I was on methadone. I hadn't even asked for any prescription. Automatically... he took it for granted I was drug seeking and sent me away, told me there was nothing wrong with me. Meanwhile they took me away in an ambulance and said I was lucky I didn't die.

THEME 2:
Centering the Family

This theme reflects how women saw themselves as becoming a strong center for their family. There are four key concepts within this theme: (1) parenting across ages and stages; (2) struggling with custody issues; (3) keeping routine going; and (4) dealing with partners.

Concept 1: Parenting across ages and stages

Participants indicated that they want the same things that any parent would like for their children, for them to be healthy and happy, and to have opportunities in their lives to be successful and have a better future than they did themselves. They were all parenting within

multiple constraints of limited financial resources, sometimes limited social supports, and stressful personal and social circumstances. Women shared that in addition to parenting within these constraints they also had to deal with the societal stigma that was applied to them as women and parents specifically related to substance use and the common implication that substance use is equated with child abuse and poor capacity for parenting.

Because Sheway was developed to support pregnant and newly parenting women and their families, services and supports were usually targeted toward parents of infants and young children. However, many participants had children across multiple ages and stages, from infancy through to young adulthood. Some women were also grandmothers. When asked about what have been high points in the past six months related to parenting, many participants identified that it was when their children reached significant developmental milestones. A key goal they held as parents was to see their children meet their milestones and achieve the things that other children do at each age and stage.

Stage of development:	Reported milestones:	Exemplar quotes:
Infants	• Sitting up, rolling over • Sleeping through the night	*I was so excited when he finally slept through most of the night. I knew he was growing well, but it was great for me to get more sleep too.*
Toddlers	• Potty training • Off bottles • Dealing with setting limits and challenging behaviors • Appropriate speech development	*They push the limits, they want to see how far they can go, and um, and what you are going to do. Some days, I wanna hang them out the window by their toes, man I mean.. My boy especially has a really bad temper. I need some advice on discipline. I just don't know what to do with him. The time out isn't working and I mean obviously you can't throw him over your knee and spank his ass. I mean what do you do, right? I'm hoping to find some parents in the same situation and see if they have got any helpful hints.*
School age	• Helping around the house • Reading and doing well in school • Making friends • Managing sibling relationships	*It's a bit of a struggle at school .. I've collected a bunch of stuff for us to do together over the summer, to help her keep up on spelling, and reading and stuff like that, because they forget so much over the summer.* *I worry about him going to school because he's special needs, and special needs kids get picked on a lot.*
Adolescents and young adults	• Seeing children through to graduation • Becoming more independent	*I have a 17 year old who is learning independent living. She decided to go on her own because she and I butt heads. So we found her a suitable place and they gave her independent living.*

Overall, women focused on doing whatever it took for their children to have what they needed to develop and thrive.

> *Just as long as my kids are happy and benefitting from it then I am alright. Most of the stuff I do isn't for me, and I could care less personally. I mean that may sound really rude but I wouldn't do it but they need it and they enjoy it so I do. So that's what I get out of it: them, happy.*

In addition to the parenting and child development milestones that women identified as important, there were also unique concerns related to their challenging social situations. For example, managing sibling relationships was a common parenting concern, particularly when the children in the family cross a broad range of ages. For this group of participants, many women were managing sibling relationships within the context of children coming and going from other settings of care, including with the other parent, with kinship caregivers, foster caregivers, or for some older children, visits from group homes.

> *She had been gone almost seven months. And the attention was all about one, and then it went to both of them. And they both struggled with getting along again. And then I had to make sure I equalized my time with both of them so that they weren't feeling left out, and that's hard. One of them wants to be loved up and cuddled, and one of them wants to be, but doesn't know how to go about it, so she gets mean and ugly about it.*

Several participants had children who were diagnosed with special needs, including ADHD, FASD, learning disabilities, and anxiety. They required a significant investment of time and resources to manage these additional needs, such as going to doctor's appointments and attending therapy sessions. This work of supporting children with special needs also impacted their capacity for employment and income generation. Staff members at Sheway were usually able to keep service files open longer so that women could continue to access the services that were available.

> *Then I run around like a chicken with my head cut off, getting to all these appointments, doing everything I need to do, making sure everything is checked, making sure he gets to appointments, going here, going there. Holy. It's like a full time job just trying to keep on top of everything you've supposed to be doing with him. It gets really overwhelming. I went to school and was working, but then my kid went in the hospital a lot and he needed all my attention so I quit my job.*

> *I got a counselor for support with my oldest son. It's craziness. Like you don't think, you don't think, and it's just like so much to put in your head. And I have anxiety so, just to deal with a kid who has ADHD and you have anxiety? It just doesn't work. And it's so hard as I try to make it work and then I blow up, and then I realize, oh, I shouldn't have done that because that's what he does too, you know?*

Although some of these conditions can be influenced by early life adversities such as poverty, some women indicated that they blamed themselves fully for these conditions.

Four of my kids have disabilities 'cause I drink. They are all ADHD. Uhm, my 20 year old is a lot like me, the alcoholism...

In addition to parenting, women were also managing their relationships with their own parents. Some were positive and supportive and some were negative and stressful. Because some participants were in their 30s and 40s they were also dealing with intergenerational issues. For example, their own parents may have been sick and needed their support. Grandparents often provided childcare and when they were sick this was an added stressor on participants. There were also many intergenerational issues reported related to substance use, mental health issues, violence and trauma reported by women.

A frequently reported parenting concern was that their children were exhibiting aggressive behavior, either at home with family members or at school. Many participants shared that they did not know how to manage these behaviors and were actively seeking advice. Again, they wondered about the contributory impact of their substance use on this behavior. They recounted thinking about how their own parents disciplined them, which was usually punitive and sometimes abusive, and wanting to be effective and do the right thing for their children. For example, some participants shared that they were trying to avoid spanking if possible and were trying strategies like time outs and taking away privileges. In addition to wanting to use appropriate strategies, women who were involved with MCFD also worked hard to not do anything that would risk their child staying with them. Some women who had their children in care and had their children come home for visits reported that sometimes they needed to reduce visits as they could not manage the behaviors.

He's too aggressive with little kids sometimes. He'll throw sand at them in the park. He'll hit and the time outs aren't really working. So I'm at my wits end. I don't want to spank him, that's going to just reinforce violence. And I'm scared that if I hit him once what's going to stop me from going overboard. I have to go in and talk to one of the ladies that does the parenting program and see what else I can do because I can't figure anything out. I mean, with me it was a smack in the mouth, soap in the mouth, hot sauce in the mouth. I used to get beat by my step dad. I don't want to do that to him. I think it's just because I was disciplined so much that I don't want to do it to him.

For women with children who were adolescents and young adults, seeing children through to their graduation from high school was a significant achievement for them as a mother, for their child and for their extended family. Some of the mothers themselves had not graduated. In other cases, the older children were no longer in the picture because they had been adopted, were in permanent placements with no visitation, or did not want to have anything to do with their mother.

Concept 2: Struggling with custody issues

Custody issues were identified in relation to the other parent or family, and in relation to MCFD. All participants reported an ongoing involvement with MCFD in some way. Relationships with MCFD were usually framed in a negative and adversarial way. A frequently reported sign of success was to not need to be in contact with MCFD. The reluctance for connecting with MCFD was out of a fear of having children taken away, and also related to an overall mistrust of government agencies.

> You always feel like if you reach out and ask for help they are going to say you are a bad parent. That you can't deal with it and probably should not have children in the first place. Big stigma if you ask for help. I don't like my social worker, or the Ministry. They took one kid from me a long time ago, so. I never trust them, they are very sneaky people.

> I'm too scared of authority figures. It's really hard for me to talk to them and explain to them what's going on. I try not to phone them unless it's absolutely necessary.

Women identified some of the strategies that they incorporated to manage their relationship with MCFD. They indicated that they "did whatever it took" to meet the requirements set out by MCFD so that they could retain custody, such as taking any mandated parenting courses. Sheway staff also provided advice, such as staying visible in the community with the children so people would be able to say that they looked like they were doing well, and to cultivate community relationships so that there were people would could vouch for their parenting capacity. Sheway staff also often acted as advocates and character referees.

> Someone phoned welfare and said I was leaving my kids alone which was total crap. I had no life and didn't go anywhere. But, uhm, then they wanted drug testing and some outrageous crap. The doctor here [Sheway] and the drug counselor stepped in and said, like, "slow down". Called the meeting, I mean, if I hadn't had the support I probably would have lost my kids.

The process of being accused of neglecting children and being reported not only impacted the possibility of children being removed from their mother. There were also other child specific impacts, such as the trauma that could arise from having police come to your home.

> My children are old enough now, they know. You have these people coming to the house and they feel your stress to the point that for the longest time they thought cops were not

good people. They're always under the constant impression that the police are coming to take them away.

There were also some reports of having personally shifted to a perspective where MCFD could be seen as a source of support and resources.

I've got good workers and I'm lucky you know as they're working with me, right? And, they helped pay for her to go to camp, and my son to go to daycare. So, you know, I wanted to go to this parenting program. They've been really supportive. So in the long run it was better, being involved. But it's just very invasive, right?

I am lucky to have supportive workers. So that if someone phones on you, I know they still have to investigate, but it's still very upsetting. At least when shit like this happens it can be dealt with a lot quicker and easier than it used to be.

One participant noted that over her years of involvement with MCFD she had noted a shift in how they worked with her.

I think the ministry has gotten a lot better with their communication skills. They're not so much pointing the finger because in saying can we help you. What van we do here, here, here. They're pointing somewhere else and not just saying now, now. So I think they're getting much better now.

In those cases when women were not able to actively parent their children on a full time basis, they wanted to see their children be placed with good foster parents. Some of the characteristics of good foster parents that were identified included being a constant and consistent presence in their children's lives, talking to children positively about their birth parents, being clear about the importance of birth parents in their lives, helping them develop their parenting skills, sharing strategies that work with their children, not denying access, and being non-judgmental.

I would like good foster parents. My daughter has been going to the same ones since she was born 15 years ago. My oldest was able to go to a specialized foster home who could deal with his problems. He's doing very good. He's graduated high school. He's got a job so I mean he's doing good where he is. I told him "but when you age out and you have no where to go, mum's door is always open". Even though we were away from each other for so long, it doesn't take long to reach back in.

With my other child we don't kind of, connect very well. I'm still trying but it's not easy. They probably feel I abandoned them for my addiction which in a way I did. I did choose it over that but in a way I didn't. I was asking for help but didn't get it.

Women spoke of how having access to their children if they were in foster was an important influence in maintaining their sobriety.

I got to see him, and it was the first time I'd seen him in a long time, I think at least eighteen months went by. And it was, really really exciting and it made me feel great and I just, I, it makes me just want to stay sober, like forever, like longer, just to see him. It made me feel good, it made me want to do good more.

Although it was a heartbreaking choice for them, some women also chose to keep their children in care as they could not financially or emotionally manage the costs and energy required of daily life, particularly if they had larger numbers of children.

Financially I'm not ready… I can't handle them all at home. I just couldn't do it. It's hard to clothe and feed even the one I have at home on the income I get now. I get decent money every month but I'm still broke like five days later.

Concept 3: Keeping routine going

Because they had often experienced overwhelming chaos throughout their lives, participants valued gaining some sense of routine and stability for themselves and their children. Routine and consistency are also important for individuals in recovery. They were also often aware through their parenting classes that routine and stability were key strategies to support the development of their children. Routine was of particular importance for those women whose children were dealing with behavioral or emotional issues.

I've got my routine going now. Usually my life is up and down, up and down, so it's nice.

I feel like I am on a good level now in life. So as long as that stays level, and nothing, comes upon, I don't want to go back down. I just want to keep going up.

Things are going a bit better because things are more structured. His behavior is getting better.

Women often shared that although it was hard to sustain this sense of structure throughout the many changes they were dealing with, they continued to try in different ways to get back to this sense of routine. Some women indicted that they equated this routine and a sense of settling down with being a "normal family". They also saw establishment of routine as a way then to integrate other things into their life that were meaningful for them, such as volunteering. Women experienced a particular sense of pride and success in maintaining this stability, under very difficult circumstances.

Concept 4: Dealing with partners

The majority of women reported that they were coping with their partner's substance use, illness, and legal issues. In some cases, this meant that they needed to ask their partners to leave, placing the safety of their children ahead of maintaining the relationship.

> *I had to make the decision that he had to leave. You know, the kids have to come first and it wasn't appropriate and it was too stressful and things were becoming violent and um, someone reported it.*

> *Their dad relapsed and he was gone for a while. It really hurt the kids because they couldn't have him around. My oldest is kind of used to it 'cause it's been a part of her life. He's here and then he's not, he's here and then he's not. But for my youngest it was really hard as for a good two years he was clean and sober. And then he relapsed, right? It's been up and down for him and it's been like a rollercoaster.*

The issue of intimate partner violence was frequently shared. There was a "catch 22" situation for women between it being helpful to have a partner in their life (related to emotional and financial support) but also continually expecting violence.

> *Having a man in my life is good but also, at the same time, I'm expecting him to hit me. All my relationships, all my relationships I've been beaten. He's the only one that hasn't hit me. He even says any man that hits a women needs to be beat down.*

> *I have nothing to do with my baby's father. I have a restraining order against him and he has a restraining order against me.*

As women were usually sharing rent with partners this was a hardship when partners came and went. Because monthly income and budgets were limited and mostly allocated, taking on a partner's share of the rent was highly destabilizing and created a significant risk of not being able to maintain the residence and be evicted. Income diversion from other necessities such as adequate food and paying bills for heating were hardships for the family. Women often chose to stay in a violent or unsatisfactory relationship to maintain the stability of their finances and living arrangements.

> *Because my rent is so high, if things don't work out with my partner, if he has to move out for any reason, I'm stuck with the other part of the rent. One month I had to cover the*

rent all by myself, I had to go through all the resources I could for food and do whatever I could for groceries.

I've had to rely on my partner. And I had to like, even if we're arguing and I've had to just deal with it. I still need to get through it because I need him there financially. If it was up me I'd kick him out right now, you know? But as I need him, I've put up with, you know, a lot of craziness. Just for his money for the rent.

It's been hard when her dad was in rehab. That was tough. But once he's back, he's a really hard worker, so that helps a lot. He's just really been in and out. And that's been really hard. It's been hard emotionally, and financially. But we still seem to get by.

The familiar cycle of good days and bad days in relationships with intimate partner violence made it hard for women to let a partner go. Women often "put up" with their partner's substance use as they felt they were good men when they were sober.

Oh god he's an amazing man when he's clean and sober, I always gotta say that as he's totally different. Two years ago I knew he was the one for me when I first met him. Best man you could ask for when he's clean and sober. I hate when he's on that shit. He goes cuckoo for crack.

When partners were in and out of the relationships, it was challenging for children and their fathers to develop a sustained positive relationship. This particularly held true if fathers come from family backgrounds that were also not optimal. There were also frequently different fathers for different children, which meant negotiating connections and parenting norms with different families under different circumstances. Not having partners physically in the home setting meant that women were parenting on their own and having to manage the full workload of maintaining a family and home.

Now I truly, honestly get why there should be a father. Honestly, when there is a man in the house you're able to get up and leave. You can't do that as a single parent. If the father was here I could take a breather and jut walk out the door.

They don't get along as well as I think she has just, he's just been gone and back and gone and back. I think it has something to do with that. So he's been taking parenting courses and trying to learn how to like, you know, be a good dad. I at least had a good childhood, but he didn't. He had none, none at all, nothing. So he's trying so hard to be a parent.

I can't keep stretching myself so thin that there's nothing left for me. It's been five years since I've been with him. And he's been in and out of jail, and I've spent most of the time in jail with him. And then for him to sit there and try and say "well you don't know what it's like". I come home to four walls, two kids and bed. It's not the same. I said, you're on your own. You're alone. And I said you can laugh and joke around in there, I come home to four walls, two kids and bed.

In some cases, women made the decision to leave their partner for their own well-being and for the stability of the children.

> It was a bad situation, a very bad situation, and I left him. And I don't feel bad about it, I don't talk to him. I'm like, just peaceful in my life, I guess. I grew up in the past six months quite a bit. Like I don't argue with people any more. Drama, there's no drama, cause I'm, I've moved on.

> The big thing for me is that I don't want my kids to thing that what we are in our relationship and what their dad is like as a man is normal. No, no, no. Hell no, no, over my dead body and hopefully even then not.

In two cases, the partner experienced significant illness or had died during the time of this study. This was sometimes related to their high-risk behaviors and ongoing substance use.

THEME 3:
Creating a sense of home

This theme reflected the priority that women placed on creating a sense of home no matter what the circumstances. There were three key concepts: (1) chasing space; (2) seeing any housing as good enough; and (3) holding together a house of cards.

Concept 1: Chasing space

A trajectory of housing acquisition steps were identified by women, from getting a foot into the rental market, to deciding whether or not to have roommates, to envisioning being able to own a home. Finding an initial residence was seen as one of the biggest barriers, particularly during a period of time when they were coping with pregnancy or post-partum challenges and dealing with treatment and recovery issues. Some women were already in an apartment or alternative living arrangement (such as staying with a friend), but were going to need additional space with a new baby. Women reported that the only space that was affordable was often a long distance away from downtown (supportive health and social services), family, and friends.

There was a significant level of work associated with accessing housing – knowing which subsidies they are eligible for, continuing to check for their placement on waiting lists – and there were many compounding challenges that impeded this work

such as trying to make contact without a phone or internet, or while managing health, social service, and education appointment and program requirements. For each potential move, they also needed to find out the details of what was available in the neighborhood to support them like food banks and parenting support programs. Participants also were keenly aware that in their city affordable housing stock was vulnerable and being torn down to make way for gentrification.

> *That's my biggest problem is my housing. And I don't know how to fix it. You need internet to find rental stuff and you've gotta be there to go, to see it straight away*

> *Getting a place was really hard. I was pregnant in the hospital at the time and coming off drugs. So, um, nobody wanted to rent to me. But my mom actually had a friend and she gave me a chance. And so, that's how it worked.*

Women knew that sometimes the shortest route to housing was by going through a shelter. This option placed them in a greater position of vulnerability as they were made more visible to the child welfare system.

> *It's almost to the point where I may have to check into a shelter in order to be able to get that help. That's the only way you can get in real quick unfortunately.*

Women and their partners faced tremendous stigma and judgment from potential landlords. Many did not want to rent to people who are on welfare, and were highly reluctant to rent to people that they suspected may be using substances.

Once they had managed to secure a residence, they often had to start from scratch to gather the household items that they needed. They reported using a wide range of creative strategies such as going to thrift stores or looking on the side of streets, and were overwhelmed and highly appreciative of the generosity of people in the new communities that they joined, such as church congregations.

When I first came here, like first moved in here, there was nothing, it was a blank room, nothing. I just came from the hospital and I had nothing! And for the first few months my parents gave me couches, and that was it. And then, I met the church and they started coming over with food and bringing things and they gave me showers. And it's like, I just can't explain how blessed we are because, I don't know, we have everything we need.

Concept 2: Seeing any housing as good enough

Although women reported that they were satisfied with their housing and thought it was adequate, it was revealing to hear about the issues that they experienced related to the quality of the living environment. Common themes were limited landlord response to fix broken items (like stoves, toilets, or windows) or maintain the general state of the apartment, living in unsafe neighborhoods for walking or playing, and being in a space that was too small for the size of the family. Overall there were low expectations for any improvements and a sense of resignation to the current state of their housing. A key concern was the impact of housing on the health of their children.

> *The building should be condemned. The building is bed bug infested. Cockroach infested, mold infested. Cause I'd always wake up and my face would be swollen from mold and all that. Cause I'm allergic to it.*

> *I recarpeted my living room.. when I tore it up and looked at the underlay I was like, oh my goodness, black mold. I should have taken pictures. It took me four hours of scraping to get all of that stuff off the cement. I am also concerned about mold within the walls and the windowsills. If my kids were to stand on it, I kid you not it would probably fall.*

> *But what do you do? It is what it is. It's low income housing. I mean, I'm not saying we should have to live like that, but I mean it sucks.*

A key enabling factor related to success in maintaining housing was the relationship that they were able to cultivate with the building manager. Women shared that this relationship could be either can be positive/supportive or negative/stressful individually for themselves, and that the role of the building manager also had a significant impact on the quality of the building and living culture on a whole related to who they let rent in the building. They knew that they walked a fine line when they were advocating for apartment or building improvements, and thought that that if they argued too much, they would place themselves at risk of being evicted.

> *I've been in this building for three years and had every intention of it being our permanent residence right? Subsidized, across from the hospital, a block from school. But then we got a new manager and he just started letting whoever move in. They are in the process of kicking people out and stuff but they are really lazy, it's not getting done and I you know there's things wrong with my apartment that have been wrong since I moved in that have not got fixed. Now we find needles in the laundry room and stuff like that. So definitely trying to move.*

The location of housing in relation to other activities in their life (like family support, work, child care, church, shopping, and health care) had a significant impact on the work of their daily routine, how much time they could spend with their children, the kind of employment they could manage, and transportation resources.

> *When my oldest boy was small and I was working, I worked at a daycare but they wouldn't let me have him at my daycare where I work so I go all the way across town and drop him off and by the time I finish work and picked him up it's like fucking seven o'clock man. And then he needs to go to bed! Like you have no time with your kids, and yea, it's just an existing day, like, get up, go, come back, go to bed. Oh wow, that was so much fun wasn't it!! Did you enjoy being with your mom today? Do you even know me anymore?*

Many participants reported that their current living arrangements were not adequate from a *space* perspective. Some women shared that they slept in their living room so that their children could have their own bedrooms.

> *We need another bedroom. They're opposite sex kids and getting older and I'm sleeping in the living room. I had to give them.. I mean they need their own rooms, right? So, I'm sleeping in the living room. It sucks. When I need time out I have nowhere to go.*

Their housing priorities also changed over time, but it was challenging to realign where they lived with these shifts because housing was so hard to access. They were also concerned about the impact of moving on children and did not want to move unless they had to.

> *Moving's a big deal for kids. It's a really big deal for anybody but, um, kids don't do well with change. And yes, my daughter's concerned about moving schools. She's only just started school so it's scary for her. But to sooner we get it done the better right? I just want to move and stay, where we can be permanent.*

> *I opted for this one as I didn't know anyone out here. It was really really far away, nobody would come out here to visit because it was so far away, even on the train and stuff like that. So I found it great. But now that, I'm kind of over that in my life, I kind of want to get back in to where I'm closer to my friends and family out in Vancouver.*

Many women reported poor quality and inadequate maintenance of the physical space. They often waited for extended periods of time to get key household elements fixed, and in some cases, they were not fixed at all. Some women recruited friends to come and do the repairs that were needed.

> *The ventilation systems in my apartment are totally clogged. Yea, there are a lot of people here smoking, still, they should be up there cleaning the ducts out. So now, six months later, they're wondering, why are people getting sick, why are people getting headaches, why are people, you know, like sleeping all of the time. Well, as we're not having enough air coming in, you know? Hello!*

The quality of the housing was not just seen as an environmental health and safety issue. It also linked to the capacity of women to retain custody of their children.

> *A piece of glass fell out of the window so there's a hole in the window. So that's a pretty big thing, which I consider an emergency to hurry up and get done. And then, of course, I had welfare coming and doing home visits and looking at it and going "Why is this broken window here when you have a small child?" Like, what am I going to do? I don't have $50 to put in a new window. I had to get someone from the community to do it.*

Many women lived in neighborhoods where they did not feel safe. In addition to physical risks, they were concerned about being in neighborhoods where there was drug dealing and triggers for their own substance use.

> *With drug dealers being in there and, and not being able to feel safe to come out of your room. The other day someone got hit in the face with rebar, and someone got bear sprayed, and I had an asthma attack, and the fireman and the ambulance had to come and then put oxygen on me and crap. And you know, that's the sort of stuff I deal with. Yea, I'm concerned for my safety, I'd say 55, 60% of the time that I live here.*

Poor housing was also identified as a potential trigger for women in recovery to relapse. They shared that they felt an overwhelming sense of hopelessness about their life circumstances and could often not see a way out. This was compounded by other factors such as not having social supports and employment and being at home alone with children for long periods of time.

> *They don't seem to want to move me as I'm addicted. But if they moved me, I wouldn't want to be addicted. So, you know, like, I don't understand how to, ok, I have to become unaddicted to move to unaddicted housing. Well, move me first as because soon because you move me I'm not gonna want to use these drugs as I'm not gonna be pent up in this little room.*

> *With the depression comes the oh a crack hoot will fix this. Oh, gotta go to work, then I'll get some crack, and it'll start again. So you know, like, I'm caught in that, um, poverty stricken, low income housing, not able to move cycle. When we don't have those things like a decent place to live it doesn't give us the motivation to go out and get a job, because, what do we have to look forward to when we come home?*

A frequently reported challenge was the struggle to maintain current housing when children were moving in and out of foster care. Funding reductions when children were not with their parents impacted their ability to meet rent requirements. Some women lost their housing and their belongings, placing them at greater risk of not being able to get their children back because of inadequate housing.

When my kids got taken away, the social worker was all difficult and said that she was going to write a letter to say that my kids are in care now and to lower the rent level and stuff. But she didn't do that, she was just being really difficult and didn't try to help me in any way whatsoever. Their caseloads are so high and they only seem to look at past records. When I got the eviction notice that was when she said "oh, do you need that letter from me?" but it was too late. I had already lost the place. And I had nowhere to go. No-one would help me move my stuff and I just recently bought new beds for me and all of my kids and stuff. I have to leave everything, the tables, the chairs and that. The new beds, the couches, the TVs. I had to just take whatever I could. And that wasn't much. Now when I get a new place I'm going to have to start all over again, with nothing. All she had to do was write a letter…

Some women had insight into the level of housing support that was needed. One participant with cognitive and learning challenges described her process of accessing supportive housing through a family housing organization. She was aware that this additional support would weigh in her favor for maintaining custody of her baby.

I just wanted to make sure that I was in housing that sort of watches you in a way, not babysit type. I just didn't want them taking this baby away. I would like to get into some kind of second stage housing so that I can get my other children back.

The option of having roommates was not seen as positive by some participants, depending on their previous experiences with roommates.

I don't trust roommates. I've been messed around by roommates too much before. I ended up with a bad credit because of having roommates, of having the bills in my name and not being paid.

The move from renting to owning was seen as unachievable by most participants, especially within the current housing marked in the city. However, one participant reported being able to buy her own suite in a house. This process required an extended period of time locate the suite, a partner to contribute to payments, and a trade off between the benefit of home ownership with a reduction in social support by moving farther away from family members.

Overall women saw any housing as good housing ("at least we have a space, some people have no space"). A common sentiment was that the housing situation in general "sucks shit". Important to note for this population was the strong link between adequate housing and maintaining sobriety.

If I lost my housing I would have been right back down in the heart of it. I would have been lost again.

Concept 3: Holding together a house of cards

The capacity to create and sustain a physical residence and a sense of home for a family requires significant emotional, social, economic and logistical resources. Women often reported a tenuous hold on ensuring that they were able to access and align these resources. One participant referred to this hold as "a shaky house of cards", where one small unexpected change (such as a five week month, a child's birthday, or being sick) could create a domino effect and disrupt the precarious nature of household planning.

Women were highly creative in how they worked to gather the money or resources they needed to make ends meet. They accessed as much public funding as possible and were diligent in managing the limited resources that they had. Overall, they were very familiar with the rules and regulations of public funding.

> *Saving money is always hard especially when you're on disability as they don't let you save too much money, which really, really sucks. You have make up an extra $500 and after that they pretty much cut you off.*

They picked up small paying jobs around their children's schedules (including hairdressing, esthetics, sex work, after school care, watering gardens for friends, making items such as bannock to sell at community markets, participating in research studies), bartered (such as cleaning in their apartment building in exchange for reduced rent), and attended food banks or programs where food and other supports were included. They counted on some of this additional income for "fall back shit", to cover unexpected costs like fixing a car.

> *I budget really well, with what I have. I always almost always have money left over. My bills are caught up to date. But now things might get a little tight as the brakes on my car need doing. It's ok month to month but then if there's an added thing, then I'd kind of be in trouble, and I'd be tight the next month.*

> *I was lucky a friend of mine gave me her freezer. Now I can buy the big family packs.*

They usually placed themselves last on the list of priorities, after making sure their children had what they needed and maintaining their household.

> *I remember plenty of days where it's like, ok, there's food for you but there's no food for me right? So yeah, it's hard. I just do without, right?*

> *I've been going to school. I want to work with people with addictions, they helped me get to where I am today so I want to be one of them people for someone else. I got a grant from Sheway to help pay for it. I've just got to pay my own little piece for the practicum. But I can't go back until I have that $500, and it's already been three months since I*

finished the book stuff. Saving up money is hard when there's things that need to be done.

I worry. Am I going to be able to feed my kids this month? Am I going to be able to get this or that, my daughter needs hair ties you know, and then she's going to need money for school to attend certain things. I know end of story everything's going to work out, but it's just the initial stressing out you know.

If it was just me I wouldn't really care, you know what I mean. There's places I could go crash, with my mom, with my friends. I'm not worried about that. But to have to drag a little child out of his own home, and being told that you can't go into your own home, like how can you do that. I would love to be able to get rid of all of my other debts, but unfortunately my rent comes first. And that leaves hardly anything.

Women reported that it was challenging to manage their budget when they were paid only once per month. This did not provide much space for accommodating the ebbs and flows of what happens over the course of a month with a family. Even the impact of the occasional five-week month was hard as it interrupted a tightly planned budget. The constant worrying about finances was an ongoing stressor for women, feeling it as an ongoing pit in their stomach. Women were aware that this ongoing chronic stress had many impacts for them, including impacting their overall health, particularly if they were already coping with a chronic illness, and creating a potential trigger for relapse.

So my health goes up and down, like I said, stress is a big factor so, but I'm lucky I have a lot of support, just got to take it one day at a time.

CHAPTER 4
Limitations, Conclusions and Recommendations
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Limitations of this Evaluation

While the findings presented in this evaluation were gathered and analyzed using a range of methods to ensure results are accurate, valid, and reliable, no evaluation is without limitations. Specifically, we note three key limitations that suggest a need for caution in interpreting some of the results presented in this report.

First, there was a change in principal investigator part way through the study. This shift required development of an updated memorandum of understanding between the funders and the researcher and approval of study ethics through another university human research ethics board. This gap in the timeline may have contributed to some loss of participants. To compensate, considerable time was invested by the research assistant to reestablish contact and sustain involvement of participants in the study through the overall three-year period of time.

Second, only six women participated in all four waves of interviews. Seven women participated in the first and the last waves. Those who participated may have had more resources of daily living that allowed them to participate. The research assistant adapted the interview guides and questionnaires to address the period of time between the last and the current interviews.

Third, although the primary purpose of this study was to compare the housing experiences of women who had received additional top up funding with those women who had not, the number of participants with longitudinal data was too small to make any significant claims about different outcomes.

Conclusions and Recommendations for
Practice and Policy

Housing is central to the daily well being of women and their families (Bryant, 2009;Gultekin, Brush, Baiardi & VanMaldegham, 2014; Kennett & Chan, 2011; Mulroy & Lane, 2015; Reitma Street et al., 2005). There is a growing body of research on women's experiences of obtaining and retaining safe, affordable and acceptable housing, in particular recently within the context of substance use, mental health, violence and trauma.

This longitudinal evaluation has provided insight into experiences over time of recovery and growth for women/mothers living within highly complex social circumstances. Overall, women demonstrated resilience, perseverance and persistence in the face of overwhelming barriers to

be what they hoped were good mothers and contributing members of their families and communities. Despite this effort in resilience and optimism, for many women there was also an underlying sense of despair and hopelessness that there were limited opportunities to find their way out of their current situations. A step forward was often followed by a step back. Barriers presented in multiple compounding ways, at individual, family, community, and policy levels. These barriers often presented as double binds or contradictions. For example, women managed tensions between:

1. Self/Family
2. Working and school/Parenting
3. Affordable housing but far from supports/Expensive housing but near to supports
4. Asking for help/Exposing self to scrutiny
5. Staying in unsafe relationship/Losing housing

Self/family

The work and resources required to focus on recovery are significant, particularly for individuals with challenges related to having adequate resources for daily living. The work of recovery usually involves improving self care (eating better, sleeping, addressing health conditions), attending multiple counseling, group and therapy sessions, and reconstructing one's identity as an individual who uses less or no substances (Mackintosh & Knight, 2012; Silva et al., 2012). Kearney (1998) identified a basic social process of recovery for women as that of truthful self-nurturing, as compared to the self-destructive self-nurturing of addiction. This process involves recovery or abstinence work, self work, and connection work.

Mackintosh and Knight (2012) suggest that a fundamental task of recovery is the construction of a self-identity that does not include substance use. The first theme identified in this study – (re)storing self – is consistent with this phase of a life course trajectory of substance use. A life course perspective includes concepts such as transitions and turning points (Hser, Longshore & Anglin, 2007). Other studies have framed this process as normalization, or a state of being free from a preoccupation with substances (Kruk & Sandberg, 2013). Pregnancy, birth and early parenting are often seen as transitions or turning points for women for recognizing that their substance use was going to continue to be harmful for themselves and their children.

Becoming a new parent also requires resources related to self care, parenting, and home work. These tasks become more challenging for women in the context of challenges such as relationship status and financial status, and also within a society that is stigmatizing and criticizing of mothers who use substances (Gueta & Addad, 2013). To do the work of recovery while taking on or continuing the role of parent can be overwhelming, even more so when often women are also managing concurrent mental health issues and a context of violence and trauma (Torchalla et al., 2015). One often takes priority over the other, and part of the journey is for women to come to the place where they are able to reconcile that in order to be an effective parent, their own health, well being and recovery is a priority. Research has found that women who identify with the parenting role are more likely to be associated with successful recovery (Carten, 1996; Lander, Howsare & Byrne, 2013).

Granfield and Cloud (1999) have described the concept of "recovery capital". Recovery capital is defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from substance use problems" (White & Cloud, 2008, p. 1). There are three types of recovery capital: (1) personal (including physical and human, (2) family/social, and (3) community (which includes cultural). Increases in recovery capital can spark and/or support transitions and turning points and lead to increased coping abilities and enhanced quality of life. Individuals who have been historically disempowered (including women) may lack assets that contribute to recovery capital. In this case, the interventions that may have more to do with recovery are those that are family and community based rather than individual based. Women and their families will benefit from access to sustained resources to support both recovery and taking on a parenting role.

Working and school/parenting

Many women expressed a desire to continue with or return to school and be involved in meaningful employment. This desire may be linked also to their processes of reconstructing themselves in a new way. Research has found that reintegrating activities such as working, attending school and parenting lowers the risk of developing alcohol and drug problems and is a major factor in enhancing recovery stability and quality of life in long-term recovery (Henkel,

2011). Some gender specific research also supports this finding (Kruk & Sandberg, 2013; VanDeMark, 2007). Threats of unemployment to recovery stability can include boredom, anxiety and depression, social isolation, a lack of meaning and purpose, and a progressive depletion of recovery capital. These conditions may be altered by the simultaneous role and work of mothering.

A common challenge for all mothers, not just participants in this study, is the continuing structural paradox of being expected to be an attentive hands-on/stay-at-home mother but also a contributing member of society (Greaves et al, 2002; Kinser, 2010; O'Reilly, 2008). Some women were receiving social assistance because they made the deliberate choice to do so, despite judgments they may feel, for the early years of their child's life. The growing body of science on attachment and its translation for parents may have influenced this perspective; this decision may also have some coercive elements to it "for the good of the child" rather than being truly a personal decision. Many stated that the work they chose was deliberately part time so that they could structure it around the needs and activities of their family. This reflects the second theme of centering the family. Some women and their partners were interested in continuing with school but found it challenging due to a lack of child care and financial resources. Participants expressed a sense of frustration and despair at not being able to see a way out of their circumstances.

Affordable housing but far from supports/expensive housing but near to supports

Vancouver, which is the context for this study, is one of the most expensive cities in Canada. Families with much greater social means also report experiencing challenges related to locating affordable housing (City of Vancouver, 2011). Many of the services provided in Vancouver related to mental health and addiction, in particular related to pregnancy and early parenting, are clustered in the downtown region. Interestingly, inner urban locations have been identified by women in recovery as a barrier to recovery (Kruk & Sandberg, 2013). In order to be near these specialized supports (which are provided in ways that are women-centered, harm reduction, trauma informed and culturally safe) women are faced with making a choice to live somewhere that is more expensive and often long distances from where supportive friends and families live.

Some participants made the decision to move to more suburban regions, where housing is slightly more affordable and where their family and friends may live. They then experienced challenges accessing recovery services where providers had a good understanding of the unique needs of women who are pregnant/newly parenting and also dealing with issues of substance use, mental health problems, violence and trauma, and practiced in a non-stigmatizing way. Other factors that came into play related to geographical location were access to transportation (many used public transportation), proximity to day cares and schools, securing apartments with more than two bedrooms, and finding neighborhoods that felt safe and inclusive. Research has shown that living in neighborhoods that are perceived by women to be safe has a significant long term impact on recovery success (Evans, Li, Buicristiani & Hser, 2014).

Asking for help/exposing self to scrutiny

Despite significant efforts provincially and in many health authorities and social service programs to take strength based, family oriented, trauma informed approaches to service delivery, many women continue to stay silent about the issues they are experiencing because they fear having their children taken away from them (Courtney & McMurtry, 2004, Greaves et al., 2002; Poole & Isaac, 2001).

Women experience numerous challenges related to parenting, sustaining their own recovery, and having inadequate resources such as housing and income assistance. However, drawing the attention of the child welfare system to these conditions places both women and systems providers in untenable positions. Asking for help theoretically should be seen as an indicator of strength in that individuals know their limits and resources and are able to communicate that. Instead, self-disclosure of these issues for women can be self-shaming, contribute to continued feelings of inadequacy, and reduce the opportunity for women to regain their credibility (Sutherland, 2010). Child welfare providers are responsible for enacting legislation that is essentially child first despite family oriented value statements. Some women with

longer experiences in these systems shared that they can see some improvements over time in how social workers are able to work with them and keep their families together, but this continues to be inconsistent across workers, offices and regions.

An additional layer of scrutiny may also be present for mothers who are Aboriginal. Currently in Canada, although only 7% of children are Aboriginal, they account for 48% of all foster children (Statistics Canada, 2016). A 2008 study in Manitoba examined the experiences and reflections of Aboriginal mothers involved with child welfare and found that successive generations of colonial and assimilative policies have resulted in feelings of powerlessness and denial of motherhood (Bennett, 2008). Women described the feeling of having to "jump through hoops" to love their children. They experienced racism, false accusations, systemic scrutiny and a lack of rights during involvement with legal system.

Staying in unsafe relationship/losing housing

The capacity for families to sustain stable housing in the Vancouver housing market usually is dependent on having at least two wage earners contributing consistently to the rent. Many women were in precarious relationships related to partner factors including unemployment, continued substance use, family violence and incarceration. Some women had made the choice to stay with a violent partner rather than lose housing and create uncertainty for their children. Jategaonkar and Ponic (2011) suggest that as the crisis in Canada in affordable housing and homelessness continues to grow, attention is needed to the relationships between housing, health and violence.

A related tension was that of trying to maintain stable housing when children came in and out of care. Policies require reduction in social assistance funding when children leave the home, leaving women in the position of often having to give up their apartment, lose their carefully collected belongings, and having to start over again when children come back.

In conclusion, many women who participated in this study were managing to maintain their own health and the health of their children. The challenges that they identified were common to early childhood and emerging families (such as dealing with children's behaviors, making ends meet) but most likely amplified within the context of substance use and recovery, and even more limited resources for daily living. Overall they were able to maintain fairly consistent housing over this period of the early years after the birth of their most recent child, both women who received MEIA top up funding and the other women who were receiving usual supports through Sheway. This integrated program model with a focus on social determinants of health may have provided a period of focused support and resources to provide a stronger foundation for recovery, family and housing stability.
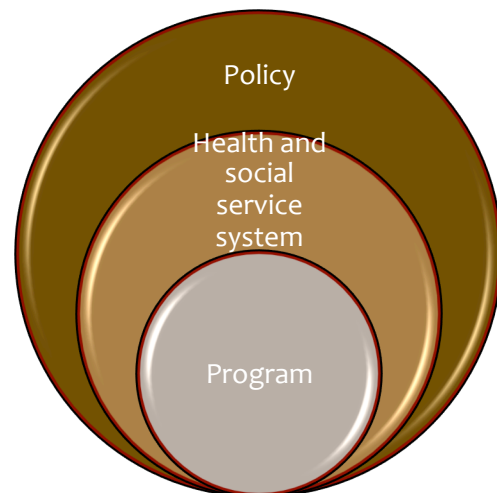
> *Women often continue to experience multiple barriers to security and well-being, and these barriers often become intergenerational. This life course pathway highlights the importance of early health, social, economic, educational, and employment support for women and families.*

The pathways that women follow during these early years set in play a lifelong set of circumstances that will often keep them in poverty and continue to constrain them from achieving economic self-sufficiency (Singh-Manoux, Ferrie, Chandola & Marmot, 2004). A report from Australia has identified that women often "accumulate poverty circumstances" over their lifetime (Cerise, 2009). The gender gap in retirement income and savings is not the result of a single event or experience. Rather, it is the cumulative product of inequitable decisions, events and experiences over the lifecycle. For example, for many women gendered educational choices, sequential work decisions, continued inequity in pay, difficulties balancing care work with paid employment, and experiences of violence, divorce and separation intersect and create poverty rather than wealth. Women often continue to experience multiple barriers to security and well-being, and these barriers can often become intergenerational. This life course pathway highlights the importance of early health, social, economic, housing, educational, and employment support for women and families.

Based on this analysis, there are a number of recommendations for action at the levels of program, health and social service system, and provincial and federal policy. Recommendations are included that address supporting recovery, family development and well-being, and addressing the circumstances of daily living in particular housing.

Level 1: For programs.

- *Extend the period of time that women and families are able to access Sheway services.* Women who access services at Sheway and other post-partum and community support programs consistently identify that shorter maximum limitations on program participation (often from 6 to 18 months postpartum) are distressing. Because one of the key elements of success for retaining women in programs is the development of a trusting, respectful relationship, women are reluctant to leave the program. This recommendation was also in the 2008 evaluation.
- *Expand the scope of services and/or the referral sources from a pregnancy and early parenting focus to one that acknowledges that many clients will have "ages and stages" needs for children who are older than toddlers.* Integrated community maternity programs are usually designed to focus on the current situation which is pregnancy or new parenting. Women in this study required supports and services also for their older children through to young adults.
- *Provide programming options that can be either individualized or in groups.* At different moments in their pregnancy, parenting and recovery, women may feel more safe receiving services for some issues in different ways. This may also change over time.

- *Develop a more intentional transition process for women who are ending their Sheway participation.* Women shared that they felt abandoned with a sudden shift from experiencing "wrap around" support to them being required to take full responsibility for finding the resources that they needed. This process may be modeled on principles of the development of self-efficacy, mentorship, and transition support.

Level 2: For health and social service systems

- *Integrate a housing focus as a core component of intensive integrated maternity programs for women who are coping with multiple health and social issues.* Women shared that over time, their housing needs shifted related to issues such as location and size. Programs may need to develop a "menu" of housing options and consider how housing can be accessed in a more anticipatory and preventive way. Innovative co-housing and co-parenting models are also needed for women with FASD and other disabilities where full time parenting may be difficult.
- *Strengthen opportunities for resources to be immediate and individualized.* Most funding sources are significantly limited related to flexibility, immediacy of funding, and range of options. A key element of programs like Sheway is inclusion of an unrestricted funding component (like the MEIA funding) where program personnel can immediately meet very specific needs of families. Early investment in emergent needs is preventative and can be more cost effective than funding more expensive downstream interventions.
- *Strengthen services related to behavioral and mental health issues, for both parents and children.* There was a significant need for parenting support, respite, counseling, therapy, and educational support for families. These issues arise from not only the impact of substance use but also from multiple intergenerational determinants and from systemic structural barriers.

Level 3: Provincial and federal policy

- *Ensure that sex and gender analyses are conducted on provincial and federal policies related to housing, social support and income support.* Many policies continue to be universal and do not take into account the gendered pathways that are created for women related to accessing housing, education, income and employment.
- *Develop a range of housing related supports.* In addition to expanding core housing capacity, develop alternate strategies such as housing top up programs that can support stability in housing for families. Build greater flexibility into policies to accommodate the wide range of family structures and circumstances and continuous changes in their needs, including children moving between home and foster care.
- *Engage multiple sectors in developing housing capacity.* Partnerships between housing, health, social services and income support may contribute to the development of creative community-specific housing models.
- *Invest in programs that support women to balance caring for their children with accessing education and employment.* Early investment in supporting women and their partners to complete schooling and find employment that is more stable will have a long term significant

benefit for governments. During the early years it is important to build in flexibility for women who would like to maintain a primary parenting role.

Summary

Most research in this area focuses on pregnancy, postpartum, and immediate needs related to health and social care. This longitudinal evaluation provides further knowledge of elements of transition experiences and processes for mothers and their children that are more achievable over a longer period of time. This information will assist service providers and government planners in identifying future funding and program planning priorities for this population. Housing is a key possible point of intervention to mitigate the negative effects of substance use, mental health, violence and trauma. Both the physical aspects of housing (such as location, safety, maintenance and adequate space) and the qualities that provide a sense of home for families (stability, routine, familiarity) are important considerations when developing housing policies.

However, poverty and other accumulating stressors are key factors that restrict access to safe affordable housing. In this study we found that factors such as age, family status, lack of knowledge of the housing system, physical and mental disability and health problems affected housing access. Despite commitment to priorizing housing assistance for women and children in BC, there are still many challenges.

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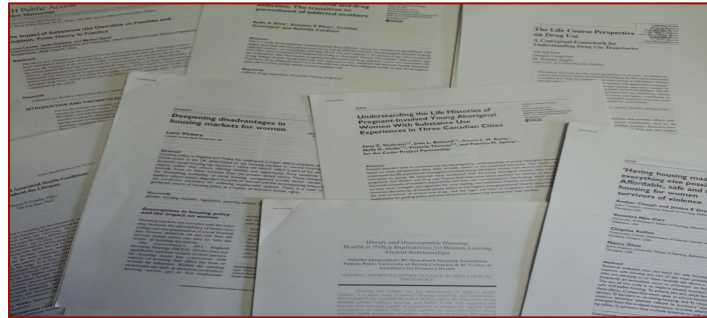
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