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RELATIONSHIPS BETWEEN CLIENTS USING SUBSTANCES AND HOSPITAL-BASED PERINATAL NURSES: A CRITICAL FEMINIST STUDY

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RELATIONSHIPS BETWEEN CLIENTS USING SUBSTANCES AND HOSPITAL-BASED PERINATAL NURSES: A CRITICAL FEMINIST STUDY

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ABSTRACT

Pregnant women who use illicit substances may avoid routine perinatal care as a result of the stigmatic attitudes of care providers (Irwin, 1995; Kearney, 1995; Levine, 2001). This is detrimental as the time period around the birth of a child may be a time when women who use illicit substances may be motivated to change (Tait, 2000). Client-nurse relationships have been shown to be health promoting (Hartrick & Varcoe, 2007), therefore it is important for vulnerable women to engage in relationships with perinatal nurses. There is little empirical work looking at the relationships between clients who use substances and perinatal nurses. The purpose of this critical feminist study was to examine the relationships between perinatal nurses and clients who used illicit substances or methadone. Focus group interviews were used to collect data from perinatal nurses about caring for clients who used substances while clients who used substances were individually interviewed about their experiences with nurses. Ten nurses and three clients participated in the study. The findings revealed four layered themes. Navigating barriers in a fragmented healthcare system illuminates how limited healthcare resources and hospital policies affected relationship development between nurses and clients who used illicit substances. Reinforcing marginalization and stigma reflects how clients who used substances in pregnancy were judged by healthcare professionals, impeding relationship development on an interpersonal level. Doubting honesty reveals an absence of trust in client-nurse relationships when the client used substances. The fourth and final theme, negotiating relationships as a means to an end, displays how relationships between nurses and clients who used illicit substances were superficial, and developed for the wellbeing of the infant. These findings have implications for nursing practice, health policy, research and nursing education.

Keywords: client-nurse relationships, perinatal care, substance use, relational health promotion, family health promotion

CO-AUTHORSHIP

Angela Wilkinson completed the following work under the supervision of Dr. Catherine Ward-Griffin and Dr. Cheryl Forchuk. Drs. Ward-Griffin and Forchuk will be co-authors of the publication resulting from this work.

DEDICATION

To the women who shared their stories for this research.

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TABLE OF CONTENTS

Certificate of Examination		ii
Abstract and Keywords		iii
Co-Authorship		v
Dedication		vi
Acknowledgements		vii
Table of Contents		viii
List of Appendices		ix
Chapter 1	Introductory Chapter	1
	Background	1
	Summary of Literature Review	2
	Study Purpose	4
	Methodology	4
	Study Significance	7
	References	8
Chapter 2	Manuscript Relationships between Clients Using Substances and Hospital Based Perinatal Nurses: A Critical Feminist Study	13
	Introduction	13
	Literature Review	13
	Statement of Purpose and Research Questions	19
	Methodology and Methods	19
	Data Analysis	22
	Findings	23
	Discussion	34
	Conclusion	38
	References	39
Chapter 3	General Summary and Conclusions	45
	Implications for Nursing Practice	45
	Implications for Nursing Education	48
	Implications for Policy	50
	Implications for Future Research	53
	Conclusion	54
	References	55
Appendices		59
Curriculum Vitae		85

LIST OF APPENDICES

Appendix	Description	Page
A	Ethics Approval	60
B	Letter of Information for Perinatal Nurses	62
C	Recruitment Flyer for Perinatal Nurses	65
D	Letter of Information for Clients	67
E	Recruitment Flyer for Clients	70
F	Consent Form	72
G	Semi-Structured Client Interview Guide for Women	74
H	Semi-Structured Focus Group Interview Guide for Nurses 76	
I	Field Note Guide	78
J	Demographic Questionnaire for Nurse Participants	80
K	Demographic Questionnaire for Client Participants	83

CHAPTER I

Background

Illicit substance use has been shown to increase the risk of physical and psychological complications to the mother and fetus/infant during the perinatal period (Kennare, Heard & Chan, 2005; Little et al., 2005; Quinlivan & Evans, 2002). Therefore pregnant women using illicit substances may need extra support during this critical period. Although perinatal care is structured to provide psychological and emotional support, focusing on the unique needs of the mother (Baker, Choi, Henshaw & Tree, 2005), many women who use illicit substances are not receiving added support. Many do not attend prenatal care and those who do, may not attend the recommended number of visits (Irwin, 1995; Kearney, 1995; Levine, 2001). Since pregnancy is often the only time women using illicit substances may seek healthcare (Dunlap, Sturzenhofecker & Johnson, 2006), it is imperative to gain a better understanding of the relationship between women who use illicit substances during the perinatal period and perinatal nurses. The relationships nurses have with clients can have a positive impact on the health and wellbeing of both mother and child and help foster client choice related to healthcare decisions (Hartrick, 1997).

There is evidence that client-nurse relationships are an important component in healthcare delivery and health promotion, leading to more ethical and effective care for the client (Hartrick & Varcoe, 2007). However, relationship development between nurses and clients using illicit substances may be strained by the demands of the healthcare setting, and the potentially conflicting values, goals and desires that each client and nurse bring to the relationship (Hartrick & Varcoe). This may be especially true when nurses are dealing with situations in which they deem "unfixable" or when the "client creates their own suffering"

(Hartrick & Varcoe). Perinatal nurses and clients who use substances may be less likely to develop relationships as they will often hold differing values on what constitutes a healthy pregnancy and lifestyle. Preconceptions that nurses and clients may have for each other related to personal experiences and public stereotypes may also affect the initiation of relationships, especially if these preconceptions are negative (Forchuk, 1994). Relationships may also be hampered because the healthcare setting may not be structured to meet the needs of perinatal women who use illicit substances or to support nurses in their care for these clients.

Summary of Literature Review

The body of literature that exists around perinatal substance use is primarily focused on the negative outcomes of the use of illicit substances during pregnancy to both the mother and the infant, treatment outcomes and mothering as a substance user. Very little empirical literature was found that focused on the experiences of clients who used substances during pregnancy and the experiences of nurses caring for clients who used illicit substances while pregnant. No literature was found that specifically examined client-nurse relationships, from both nurse and client perspectives, during the perinatal period when substance use was known to the nurse. For the purpose of this study, substances included any illicit substance and methadone.

Substance use during pregnancy has been linked with numerous consequences to both mother and infant. The mother is more likely to suffer placenta abruption and other antenatal hemorrhagic outcomes (Cox, Posner, Athena & Jamieson, 2008; Kennare et al., 2005), threatened preterm labour (Quinlivan & Evans, 2002), premature delivery (Cox et al.), premature rupture of membranes (Cox, et al.) and pre-eclampsia (Finnegan, 1978) or pregnancy induced hypertension (Cox et al.). Their infants are more likely than infants not exposed to substances in utero to suffer from low birth weight (Bada et al., 2005; Kennare et al.; Little et al., 2005; Petitti

& Coleman, 1990; Richardson & Day, 1999) and prematurity (Bada et al.; Kennare et al.; Little et al.; Richardson & Day; Wobie, Eyler, Gervan, Hou & Behnke, 2004). Additionally, when substances are used during pregnancy or postpartum the maternal-infant bond may be difficult to establish (Porter & Porter, 2004).

Treatment experiences and outcomes have been studied with regards to substance use during pregnancy and while parenting (Kelly, Blacksin & Mason, 2001; Pursey-Crotteau & Stern, 1996; Roberts & Nishimoto, 2006). The effects substances may have on mothering have also been studied. Mothers using substances or recovering from substance use considered motherhood a fundamental part of their lives (Baker & Carson, 1999; Hiersteiner, 2001) and placed their children first (Reid, Greaves & Poole, 2008). Motherhood was also found to create normalcy in the lives of women using substances (Kearney, 1996).

There is a gap in the literature related to accessing perinatal care while using substances with only a few studies looking at this experience (Irwin, 1995; Kearney, 1995). Little is known about nurses' encounters of caring for clients who used substances, with only one study found (Raeside, 2003). Understanding client-nurse relationships as they occur is imperative in order to uncover what hinders and what promotes the health of women using substances. Positive relationships between nurses and clients who use substances in the perinatal setting may lead women to access more health care in the future for themselves and their families. Further, having therapeutic relationships with clients may lead to more satisfaction in the work lives of nurses. Understanding how contextual factors shape the relationships between nurses and pregnant substance users may also lead to the identification and development of policies and practices that address deficiencies in this area.

Study Purpose

The purpose of this critical feminist study was to examine the relationships between perinatal nurses and clients who use substances. The study was guided by three research questions: 1) What are the relationship experiences between perinatal nurses and clients who used substances during the perinatal period? 2) What factors strengthen or inhibit the relationships between perinatal nurses and clients who used substances during the perinatal period? 3) How do the relationships between perinatal nurses and clients who used substances during the perinatal period promote client health and wellbeing?

Methodology

A critical feminist methodology was chosen for this study because it looks to uncover social inequities in order to create change (Berman, Ford-Gilboe & Campbell, 1998). A critical feminist lens also examines how gender, age, race, social economic status and other factors have led to power imbalances within social systems (Kushner & Morrow, 2003). The literature reviewed and the nursing experience of the primary researcher suggests there is a power imbalance between perinatal nurses and clients who use substances, with judgmental attitudes (Irwin, 1995; Kearney, 1996) and anger (Raeside, 2003) being prevalent.

Critical feminist principles call for any potential power inequities between participant and researcher to be minimized as critical research is a collaborative, respectful process between the participant and the researcher (Berman et al., 1998; Demarco, Campbell & Wuest, 1993; Hasse-Biber, 2007; Thorne & Varcoe, 1998). To ensure that power inequities were minimized, dialogic qualitative data collection methods were used. For example open-ended questions with client and nurse participants encouraged participants to focus on topics and experiences they felt were most important (Hasse-Biber; Sprague, 2005). This is especially important for client participants

as they have traditionally been marginalized within the healthcare system (Levine, 2001) and participation in this research helped them to voice their ideas and opinions about their experiences within the perinatal system. Nurses conversed openly during their focus groups with the researcher moderating the discussion only when necessary, using probes and new questions (Leavy, 2007).

In critical research it is not only the researcher who gains from the research, but the participants are also expected to gain through their participation (Berman et al., 1998; Demarco et al., 1993; Hall & Stevens, 1991; Thorne & Varcoe, 1998), experience change (Berman et al.) and personal empowerment (Hall & Stevens). Participants also had the opportunity to receive satisfaction in knowing that someone wanted to listen to them and felt their experiences were important. Client participants benefited through sharing their stories with the researcher knowing they would be used to create social change within the healthcare environment. Nurse participants benefited by having the opportunity to discuss their relationships with clients who used substances and reflect on how their own beliefs and values about pregnancy, parenting and substance use may affect their care for these clients.

Feminist research looks to promote social change within the everyday socially accepted lived experience, and therefore it is essential to explore the lived experience from those experiencing it (DeMarco et al., 1993; Hasse-Biber, 2007). The potential influence the participants' voices may have on future health policy and practice is one of the fundamental strengths of using a feminist framework (Hall & Stevens, 1991). To ensure this principle was upheld, policy, practice, education and research recommendations were developed based on nurse and client data.

The focus group interviews with perinatal nurses also created the opportunity for consciousness raising through discussion and reflection, another important principle of feminist research (Wuest, 1995). Consciousness raising is a process in which participants reflect on everyday experiences and begin to realize how these experiences may be unjust to themselves and those around them (Henderson, 1995). Nurses discussed how policies and their current practices maybe unfair to clients who used substances and how women who used substances were viewed as "second class citizens" within the perinatal system. They began to suggest how the system could change to better promote the health of women who used substances. It is also hoped that through reflection perinatal nurses will be more conscious of their practices and look to create positive changes.

In critical feminist research it is important to explicate any preformed assumptions throughout the research process (Berman et al., 1998; Sprague, 2005; Thorne & Varcoe, 1998) because researchers choose areas of interest that they hope to see changed politically (Maxwell-Young, Olshansky & Steele, 1998), such as health inequities (Berman, McKenna, Taylor& Traher, 2000; Ward-Griffin, Schofield, Vos & Coatsworth-Puspoky, 2005). This was particularly important in this study because the primary investigator was a nurse working within the perinatal setting. Being reflexive during the course of the study minimized the primary researcher's influence on the study findings (Berman et al.; Hall & Stevens, 1991; Sprague; Thorne & Varcoe). This was facilitated by the use of a reflexive journal, peer review and through bringing preliminary findings back to the nurse participants for member checking (Hall & Stevens).

Study Significance

Three key areas make this study significant. First, the study design provided an opportunity for a traditionally marginalized population to be heard and possibly empowered through the research process. Secondly, with respect to nurse participants, the study was designed to promote consciousness raising during focus groups. These reflections on practice and client experiences may lead nurses to change their practice in the future when working with clients who use substances during pregnancy. Lastly, this study sought to look at ways in which the healthcare system can be changed to better meet the needs and promote the health of clients who use substances during pregnancy.

Nurses who practice relational health promotion create the opportunity for clients to transform their health and healing experiences and to foster choice and power (Hartrick, 1997), thus improving their health (World Health Organization, 1986). In contrast, relationships that are disempowering can negatively influence the health of clients (Hartrick, 2002); therefore, it is important to examine how relationships between perinatal nurses and clients who use substances during the perinatal period can be therapeutic and empowering.

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CHAPTER II

Introduction

When pregnant women use illicit substances they face stigma and disapproving attitudes from healthcare professionals and therefore may not seek routine perinatal care (Irwin, 1995; Kearney, 1995; Levine, 2001). However, perinatal care might be the only healthcare service accessed by women who use illicit substances (Dunlap, Sturzenhofecker & Johnson, 2006). Since pregnancy is also a time when women who use illicit substances may be motivated to seek treatment (Tait, 2000), it is important that we optimize the healthcare experiences of pregnant women using illicit substances.

Client-nurse relationships in the perinatal setting need to be examined in order to better understand their dynamics and how they can be health promoting. When nurses are able to develop relationships with clients it is more likely that they will take control over their health (Hartrick, 1997). Being with clients is a way to promote their health through relational practice (Falk-Rafael, 2005). At times, however, relationship development between nurses and clients may be hindered as a result of many factors including nurses' focus on medical tasks or differing values (Hartrick & Varcoe, 2007).

Literature Review

A literature review was conducted using online data bases, hand searches of relevant hard copy and electronic journals and through searching the reference lists of retrieved articles. Data bases searched included, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Sage Full Text Collection: Sociology, ProQuest (both nursing and psychology), PubMed and Medline. Keywords included: addictions, women with addictions, pregnancy, postpartum, substance use, substance abuse, perinatal substance use, intrapartum, prenatal care, relationships,

and client-care provider relationships. Due to the lack of literature surrounding perinatal client-nurse relationships when the client used substances, no time limit was placed on the literature search. Twenty eight empirical research articles were eventually included. All literature found on seeking perinatal care as a substance user and providing perinatal care to substance users was included. Other literature was included if it related to perinatal substance use.

Adverse effects of Using Substances during Pregnancy

Using illicit substances during pregnancy has been associated with several complications to the mother including placenta abruption and other antenatal hemorrhagic outcomes (Cox, Posner, Athena & Jamieson, 2008; Kennare, Heard & Chan, 2005), premature rupture of membranes (Cox et al.), an elevated risk of pre-eclampsia (Finnegan, 1978) and pregnancy induced hypertension (Cox et al.). With respect to fetal/infant development prematurity (Bada et al., 2005; Cox et al.; Kennare et al.; Little et al., 2005; Richardson & Day, 1999; Wobie et al., 2004) and low birth weight (Bada et al.; Kennare et al.; Little et al.; Petitti & Coleman, 1990; Richardson & Day) have been identified as the most common adverse outcomes of exposure to illicit substances in-utero. However, Quinlivan and Evans (2002) found routine prenatal care attendance resulted in pregnancies that did not lead to prematurity or low birth weight when the mother used illicit substances.

Cocaine use has been associated with intrauterine growth restriction (Bada et al., 2005; Cox et al., 2008), decreased head circumference and decreased total length of the infant (Wobie et al., 2004). Congenital abnormalities, still birth (Kennare et al., 2005) and fetal death (Cox et al.; Kennare et al.) have also been associated with illicit substance use during pregnancy. Intrauterine exposure to illicit substances may increase infant irritability (Richardson & Day, 1999) and have lasting effects on brain size and volume (Rivkin et al., 2008). As a result of

complications infants are often hospitalized for long periods of time (Finnegan, 1978; Kennare et al.). Research on the adverse effects of illicit substances during pregnancy is important, but research must also examine ways in which healthcare provider relationships with clients who use substances may affect perinatal care attendance and the clients control over their health, subsequently improving the health outcomes of mother and infant.

Health Outcomes of Women Using Substances during Pregnancy

Although many adverse outcomes have been associated with using illicit substances during pregnancy, Richardson and Day (1999) suggest that lifestyle and other health and contextual factors of the lives of women who use substances may lead to the adverse outcomes more than the substance use itself. A sample of women who used illicit substances during pregnancy were more likely to be smokers, have a psychiatric condition, be single, and have a low socio-economic status, which may contribute to the adverse effects seen during the perinatal period (Kennare et al., 2005). Healthier outcomes have been achieved when prenatal care was provided to meet the unique needs of pregnant substance users, along with close supervision of substance intake (Finnegan, 1978). Social determinants of health include social and political factors that may influence one's ability to access and use healthcare resources and are not always freely chosen (Raphael, 2004). The impact of social determinants of health on the health of women who use illicit substances while pregnant and their fetuses/infants needs to be studied. Understanding these factors will assist in developing appropriate health promotion strategies that address the social conditions of women who use substances during pregnancy.

With regards to addiction treatment, pregnant or parenting women using substances completed treatment if they: perceived fewer treatment barriers, including negative staff attitudes (Roberts & Nishimoto, 2006); had less involvement with child protection services; had success

in education and job skills; and experienced less chaos in their lives (Kelly, Blacksin & Mason, 2001). Treatment was seen as an opportunity to create a new life by pregnant women using cocaine (Pursey-Crotteau & Stern, 1996). A study on pregnant aboriginal women who used substances and addiction treatment providers revealed that programs and services did not meet the needs of women who used substances (Tait, 2000). A supportive non-judgmental environment was identified as the most valuable component of a treatment program (Tait). More research on how preconceived judgment is enacted in client-care provider relationships may lead to more successful outcomes during the perinatal period.

Using Substances while Mothering

Maintaining a maternal identity has been found to play a vital role in treatment recovery among women using illicit substances (Baker & Carson, 1999; Hiersteiner, 2001; Kearney, 1996). Mothers who used illicit substances felt they were 'good' mothers if they were committed to their children, fulfilled their children's basic needs, and protected their children from harm (Baker & Carson; Reid Greaves & Poole, 2008). 'Bad' mothers in the Reid et al. study were those who did not protect their children and created poor stereotypes for all mothers who used substances. Adolescent illicit substance users were found to have unrealistic expectations of their children and felt their children misbehaved to annoy them (Spieker et al., 2001). However, the maturity level of adolescent mothers may have impacted this finding. The age of the mother and the maternal-infant bond should be studied further when the mother uses illicit substances.

Perinatal Health Care Experiences of Women Who Use Illicit Substances and Care Providers Experiences of Caring for Women Who Use Illicit Substances

Generally speaking women are subjected to more prejudice than men within the healthcare setting leading to decreased health seeking behaviour (Facione & Facione, 2007). Women do, however, depend on healthcare professionals to treat them with dignity and respect, and involve them in their plan of care (Widang, Fridland & Martensson, 2008). Poor childbirth experiences resulting from a perceived lack of control and negative staff attitudes were found in a study on women's experiences of childbirth (Baker, Choi, Henshaw & Tree, 2005). Negative perinatal experiences have also been identified by women who have used illicit substances during pregnancy.

Women who used crack cocaine, heroin or methamphetamine while pregnant perceived they were receiving less quality prenatal care from healthcare professionals and were judged compared to women who did not use substances, leading to the avoidance of appointments (Irwin, 1995). Pregnant crack cocaine users felt as though they were "damned if they did and damned if they didn't" access prenatal care (Kearney, 1995). They felt judged by healthcare providers when seeking prenatal care because of their substance use, but were also judged for avoiding care. Interactions with healthcare providers led to feelings of guilt and fear. Contrary to the women in Irwin's study, women in Kearney's study sought care because they wanted to increase their chances of retaining custody of their infants following the birth. Women in the first study did show concern for their unborn child and strived for positive pregnancy outcomes as best as they could. Although these studies do look at the experience of being a woman seeking prenatal care while using illicit substances, they are dated 15 years and may not be

relevant today. More research that looks at this experience in the context of today's society must be completed.

Few research studies have been conducted examining obstetrical care providers' experience of caring for clients using substances. Midwives (Chang et al., 2008; Gunn et al., 2006; Raeside, 2003), physicians (Chang et al.; Gunn et al.), nurse practitioners (Chang et al.), nurses (Raeside) and home healthcare visitors (Tandon et al., 2005) were found to have difficulty communicating with and meeting the needs of women who used substances during pregnancy. Providers felt more comfortable dealing with smoking versus drug and alcohol use (Chang et al.) and felt judgmental and angry when caring for women who used substances (Raeside). Educational programs on caring for women who used substances while pregnant have been shown to increase provider confidence levels (Gunn et al.). Healthcare professionals and paraprofessionals do not feel well prepared to deal with important psychosocial issues, such as illicit substance use, during the perinatal period, therefore more research is necessary.

In summary, the majority of literature available on women who use substances during the perinatal period focuses on the adverse effects of substances, motherhood and addiction treatment. Few investigated the experience of seeking healthcare as a perinatal substance user (Irwin, 1995; Kearney, 1995) or providing perinatal care to clients who use substances as a healthcare professional (Chang et al., 2008; Gunn et al., 2006; Raeside, 2003; Tandon et al., 2005). No studies looked exclusively at client-nurse relationships during the perinatal period when the client used illicit substances. More research must be completed that specifically examines the health promoting potential of relationships between nurses and clients who used illicit substances during the perinatal period.

Statement of the Purpose and Research Questions

The purpose of this study was to examine the relationships between perinatal nurses and clients who used substances. Substances were defined as the use of any illicit substance or methadone. Three research questions were addressed: 1. What are the relationship experiences between perinatal nurses and clients who used substances during the perinatal period? 2. What factors strengthen or inhibit the relationships between perinatal nurses and clients who used substances during the perinatal period? 3. How do relationships between perinatal nurses and clients who used substances during the perinatal period promote client health and wellbeing? The perinatal period was defined as conception to six months postpartum.

Methodology and Methods

This study utilized a critical feminist methodology. The aim of critical research is to initiate social change within power imbalanced social systems (Berman, Ford-Gilboe & Campbell, 1998; Hasse-Biber, 2007) while feminist research begins with the assumption that structural and interpersonal conditions oppress women and other marginalized groups (Hall & Stevens, 1991; Hasse-Biber). Feminist inquiry calls for research to be built on the experiences of women in order to challenge the oppressions of the current healthcare system and policies affecting female consumers and female care providers (Hasse-Biber; Stevens, 1993).

Recruitment and Sampling

Registered nurses were eligible to participate in this study if they had: worked within the perinatal setting for at least one year; taken care of at least one client who used substances; and worked at least twenty hours per week. The coordinator of the mother-baby care unit of a local hospital was contacted directly about nurse and client recruitment. Staff nurses were informed of the study through electronic mail with letters of information (see appendix B), posted flyers

(see appendix C) and informal information sessions held by the primary researcher. They were instructed to contact the researcher themselves if they wished to participate.

Eligibility criteria for client participants included: having used at least one substance during the perinatal period; having accessed some form of perinatal nursing care in the hospital setting with the perinatal nurses involved in their care aware of their substance use; were 18 years of age or older; and having the ability to give consent and speak and understand English. Three sites were accessed for client recruitment: two community programs for women involved with substances and the same mother-baby care unit used for nurse recruitment. As the primary researcher was employed at one of the recruitment sites, clients in which she was directly involved in their care were excluded.

Coordinators for community programs were contacted via electronic mail and the letter of information (see appendix D) and a flyer (see appendix E) were provided. The coordinators forwarded this information to their staff counselors to share with clients. Staff nurses contacted for nurse recruitment were also provided with information on recruiting potential client participants. In addition, the unit's social worker and clinical nurse specialist were asked to recruit client participants. Recruitment flyers were posted on the mother-baby care unit. Clients were asked to contact the researcher themselves or provide their contact information to be forwarded to the researcher.

Purposive sampling was used for client and nurse participants. Purposive sampling is when the researcher intentionally selects participants who are experienced with the phenomenon to ensure the collection of information rich data (Morse, 1994). Snowball sampling was also used to gain access to client participants (Morse, 1991).

Data Collection

Written consent was obtained from all participants prior to the qualitative interviews (see appendix F). One in-depth semi-structured interview was conducted (Hasse-Biber, 2007) with each client participant (see appendix G) lasting 25-60 minutes. This method has been used successfully by other researchers studying this population (Baker & Carson, 2003; Hiersteiner, 2004; Irwin, 1995; Kearney, 1995; Masters & Carlson, 2006; Pursley-Crotteau & Stem, 1996). Client recruitment ended when no further client participants were recruited over a seven month period. All participants chose to be interviewed at their recruitment site and one chose to have a support person present.

Two focus group interviews with five participants in each were conducted with nurses (Krueger, 2006; Leavey, 2007) (see appendix H). Focus groups were chosen to collect data on perinatal nurses' perceptions of caring for clients who used substances while pregnant as they created an opportunity for consciousness raising and emancipation among them (Wuest, 1995). The first focus group lasted one hour and was held during the day shift in an empty nursery on the unit. The second lasted one hour fifteen minutes and was held during the night shift in an empty visitor's lounge. A follow up focus group for the purpose of member checking was conducted with seven of the original nurse participants seven months after the completion of the initial focus group interviews. All individual interviews and focus group interviews were audio-taped and transcribed verbatim for data analysis. Open-ended questions during interviews helped the participants shape the outcome of the research (Hasse-Biber, 2007; Sprague, 2005). Field notes were completed using the framework of Lofland, Snow, Anderson and Lofland (2006) following each interview and included as part of the data log (See appendix I).

For their participation all clients received a $15.00 gift certificate to a local grocery store chain. One client was reimbursed with bus tickets for travel expenses. Nurses received food and refreshments during the focus group interviews.

Data Analysis

Data analysis was completed following the framework provided by Lofland et al. (2006). Data analysis began concurrently with data collection with completed interviews shaping subsequent interviews. During preliminary analysis, emerging codes were written in the margins of the transcripts and then grouped together electronically to create memos. Memos explained the meaning behind codes and the possible relationships between codes. Codes and memos were refined as more data was collected leading to the creation of the final themes. Diagramming was also used to illuminate the relationships between and among initial codes and themes.
In qualitative research saturation is not limited to the sample size, but achieved when analysis results in a new understanding of the experience under investigation (Sandelowski, 1995; Sandelowski, 2008). A new understanding of client-nurse relationships during the perinatal period when the client used substances was achieved through the combined analysis of client and nurse data. Five transcripts, totaling 145 pages were analyzed.

Reflexivity is an important component of the researchers' role when conducting critical research (Hasse-Biber, 2007). Here the primary researcher reflected on how her experiences, values and biases affected the research (Hasse-Biber; Sprague, 2005), as well as on how she may have influenced the questions, the data and the conclusions (Thorne & Varcoe, 1998).

Credibility

Credibility was ascertained through member checking and the use of an audit trail. Member checking consisted of bringing the emergent findings back to the perinatal nurses for

validation (Hall & Stevens, 1991; Lofland et al., 2006). They also had the opportunity to review the findings and provide insight into the emerging analysis (Lofland et al.). A similar follow up focus group was not held with client participants due to difficulty with subsequent contact (Heaman, 2001). An audit trail tracking data collection and analysis was kept allowing the researcher to look back to see how certain findings emerged (Lofland et al.). This process helped ensure that all findings were accurate and reflected the data that was collected (Hall & Stevens).

To ensure the findings were credible from a critical feminist perspective, social inequities (Labonte, 2004) were uncovered and recommendations for social change were developed (Lather, 1995). Recommendations arose out of client and nurse interviews and during the final focus group as nurses were able to reflect on the realities of their relationships with clients based on the study findings and reflect on possibilities for change.

Findings

Sample

Demographic data was collected from participants following interviews (see appendices J and K). Three clients participated in the study. All were unemployed at the time of their interview and had incomes of less than $19, 999 per year, one had completed high school. Two clients had just given birth to their second and third child and the third client was pregnant with her third child. None of the clients' children were in their care when interviewed, however one client would regain custody of her children shortly after her interview. One client was married; the others did not have partners. The clients were 20 years to 28 years of age. They described addictions to "pills" or cocaine; one was on a methadone maintenance program.

Ten perinatal nurses with 6 to over 25 years of experience participated in the study. Six worked full time and four worked part time or casual. Two nurses held degrees in nursing. Five had household incomes greater than $100 000 per year. They were 34 to 64 years of age.

Themes

Thematic analysis revealed four layered themes: 'navigating barriers in a fragmented healthcare system', 'reinforcing marginalization and stigma', 'doubting honesty' and 'negotiating relationships as a means to an end'. 'Navigating barriers in a fragmented healthcare system', the outermost layer, depicts how relationships were inhibited on a broad systemic level. The second layer, 'reinforcing marginalization and stigma' reflects how clients who used substances in pregnancy were judged by healthcare professionals, impeding relationship development on an interpersonal level. 'Doubting honesty', the third layer, illustrates the lack of trust between nurses and clients who used substances. At the core of these layers is the final theme, 'negotiating relationships as a means to an end', portraying the superficial nature of relationships between nurses and clients.

Navigating barriers in a fragmented healthcare system

'Navigating barriers in a fragmented healthcare system' illuminates how the perinatal and broader healthcare systems are fragmented and ill-equipped to care for clients who used substances during pregnancy. Clients who used substances during pregnancy needed a different kind of support compared to the "average" perinatal client, which was not provided. Care was described by one nurse as,

> ...very disjointed. People are struggling; they don't have family doctors so they are popping into clinics that don't know them and then they come here and they may not get the doctor they saw, you've got somebody else who is checking in on them here and then you get different nurses everyday and then you go home. And who are you going home to?

The inconsistency of care providers decreased the opportunity for relationship development. One client remarked on the lack of continuity between physicians: "They were all nice, [but] I never had the same doctor more than once".

Policies created barriers to relationship development and sometimes resulted in practices by perinatal nurses that negatively affected relationships. Relationships were also impeded by the lack of addiction support services and consequently nurses' inability to refer clients to these types of services. One nurse commented: "I think it's a weak link in our system though, that things aren't set up for these moms to go from here to a rehab centre, or somewhere to get help". Clients were frustrated by nurses' failure to provide them with appropriate resources. One client remarked: "No, there's enough resources, [but] not enough education on where to find them and how to deal with them". Another client had already been discharged from the perinatal system twice with no discharge plan. "It was a police officer who told me about [community addiction program]. I think they should have it in the hospitals, to people they know who are drug addicted and let them know about these resources and stuff". Nurses in this investigation and one other (Raeside, 2003) admitted to a lack of knowledge on caring for clients who used substances. "Education I think is a big thing. Education for us as to how we can help them more. Where are we going to send them to get resources"? Nurses' inability to assist clients who used substances with resources led them to believe they could do little to help, unfortunately they did not realize the health potential of relationships.

Nurses argued that policy makers devalued clients who used substances when policies were being developed or changed, as stated by this nurse: "I think it's an easy group to disempower 'cause they are already disempowered. So they're an easy group to ignore because they are so disempowered". Because clients who used substances were ignored by policy

makers, policies were designed for conventional families and therefore did not fulfill the unique needs of clients who used substances during pregnancy. As directed by hospital policies, nurses were encouraged to discharge clients as early as possible. The perinatal system was not equipped financially nor staffed adequately to care for clients for more than 60 hours unless they had a recognized postpartum complication such as hypertension. Psychosocial and substance use health concerns were not seen as a valid reason to remain in the acute care system. Early discharges meant there was inadequate time for nurses and clients to build relationships, which was particularly important with clients who used substances. Lack of time with clients and lack of trust (discussed in 'doubting honesty') between nurses and clients were the most commonly mentioned barriers to relationship development by perinatal nurses. This nurse discussed how clients were discharged early from the hospital:

> They discharge early, usually because Children's Aid is involved and they're discharged day one, saying your babies going to be apprehended anyways. Let's get the mom out the door before the baby goes. We'll escort her out. That's happened where we have escorted the mom out.

The differential treatment experienced by clients who used substances was described by another nurse as "pushing them away". Perinatal clients who used substances were also marginalized when in hospital for acute conditions.

Clients were sometimes blamed for poor client-nurse relationships if nurses perceived they did not prioritize interactions with nurses, as explained here: "I think it's time. We don't have enough time with them. Let's be reasonable those are the people that want to get out after 24 hours. Or, they sign themselves out against medical advice. I think the main thing is time". However, no reflective comments were made as to why clients were so eager to leave or why clients would want to stay in a system that treated them so poorly.

Thus the perinatal system was functioning under a medical and behaviourist model of care, which focuses on illness and lifestyle change rather than on developing health promoting relationships between nurses and clients. Consequently, the fragmented policies of the perinatal system and some nurse practices were examples of the health inequities experienced by perinatal women who used substances, which in turn contributed to the ongoing marginalization and stigma of this population.

Reinforcing marginalization and stigma.

'Reinforcing marginalization and stigma' portrays how perinatal nurse actions influenced clients' marginalization within the perinatal setting. Nurses acknowledged that clients who used substances were stigmatized and judged by society and admitted contributing to this judgmental attitude in the perinatal setting. "It's still like that tug of war type of thing, we're very good at hiding it. We don't come across as being judgmental, but in the back of all our minds...". Although nurses felt clients did not perceive being judged, client comments suggested otherwise. "She made me want to go and slice my throat, literally, cause of the way she looked at me. The way she was snapping back and making her little comments. It's just not fair. Thank God my baby's healthy".

Similar to other investigations, the actions of nursing staff made clients feel like undeserving mothers when receiving care (Irwin, 1995; Kearney, 1995), as this client remarked: "Oh, it makes me feel like I'm not as good as everybody else. Like I'm worse, like I shouldn't even be there, or I shouldn't even be having kids and stuff". Nurses perceived clients entered the healthcare setting feeling unworthy, as the next quote demonstrates, but did not consider how these feelings were accentuated by their actions. "I think they feel like they are being judged

when they come in here. They think we're going to think they're not worthy or that we're going to judge them".

Nurses also judged clients based on the origins of their addiction. Clients who experimented with substances and become addicted received less empathy than clients whom nurses viewed as casualties of addiction, as the following nurse quote demonstrates:

> There was a patient who talked about a nurse she knew that got percocets for post op pain, was addicted and lost her husband, lost her family, like terrible addiction versus someone who you know was at a party and tried it for fun. I picture the nurse almost as being sort of a victim in a way.

This was a dangerous scenario, as arguably, it was the client who became addicted through experimentation who needed more support, as another nurse commented:

> Whereas some kid who is just out trying to get crack cause they just want to be high, but then you just have to go another step back and say what was the driving force that they needed to go get high?

Nurses were less judgmental of clients who had made an effort to change and improve their lives through the methadone maintenance program, versus those who had not. "You have more empathy with them if they're really making that effort to change, then the ones that are coming in with four different pills, and crushing them and shooting them up".

Because nurses tended to be older than clients there was a "natural" tendency to be maternal, as displayed by this nurse's remark: "I think I take more of a maternal relationship with them. More of a parent-child, which isn't a good way to be…I just want to smother them more than my other patients". This maternal approach however, may have accentuated the power imbalances between themselves and clients who used substances.

In contrast, other nurses attempted to decrease their authoritative status to appear welcoming to clients. The following nurse quote described a way in which nurses and clients

could relate to each other; however the language and assumptions of nurses with regards to their position over clients ironically reinforced the power imbalance.

> I think it starts with how you walk in the room. If it's a young girl I'm not going to walk in and say "good morning, my name is Tanya, I'll be your nurse today". I'll go in and be like "Hey, how's it going"? You kind of change your approach to them and you use words [so] you don't really talk over their head. It's all just kind of suiting your practice to their needs.

Nurses hypothesized that perhaps it was their middle-class status in society and professional standing that led them to be judgmental. "We are very fortunate with the job that we have how we came to our jobs, maybe our type of family life. We judge because they are different than what we're brought up with. We are very fortunate". Nurses' inability to relate to the everyday lives of clients who used substances affected client-nurse relationships. One client suggested nurses could "educate themselves a little more and learn tolerance in the attitude department. If you agree, disagree, whatever. I'm sorry to say, but everybody's poop smells the same way".

In sum, preconceived judgments about clients using substances were prevalent in the relationships between nurses and clients making them less effective and reinforcing the marginalization of clients within the perinatal system. As much as marginalization and stigma were factors that hindered relationship development in perinatal care, the mistrust between nurses and clients also impeded relationship development.

Doubting honesty.

Doubting honesty was a dialectical process: ironically nurses doubted clients' honesty when clients were truthful and clients felt they were judged even when they were honest, based on what they disclosed. The lack of trust nurses had for clients and their judgmental attitudes made relationship development difficult. Although nurses felt clients who used substances were

manipulative and practiced liars, they did feel it was important for them to try and facilitate trust. As described by this nurse:

> Well what helps it just being open. They can tell when you're not telling them something. They know when people aren't telling them things. They know all the little scams. They've done them themselves. Being as open as you can, but you don't have them for a long time. Just being someone they can trust.

Trust was valued by nurses as they wanted clients to trust them; however trust was not reciprocated as this nurse stated: "Some of them aren't always up front either so it's just like before, they're not always telling the truth so sometimes it can be hard to develop a relationship with someone who's not truthful". Mutual trust is essential for successful relationships.

The physical layout of the hospital impeded relationships as, in some cases, clients had to leave their room to visit their infants on another floor of the hospital. This separation, a policy barrier, decreased opportunities for client-nurse relationships to develop. More importantly, nurses doubted clients' actual whereabouts when visiting their infant, also affecting relationship development, as one nurse explained:

> In some cases when the baby's up on seven, and if they're going outside for several breaks, or they go outside to do something, or cigarettes. Then they're going up to see their baby. They're not on the floor enough to develop a rapport. I find they're off the floor a lot more than they are on.

Nurses solely blamed clients for the lack of trust within the relationship. They did not explore why clients who used substances may not feel comfortable disclosing information.

Nurses knew they should trust clients, but their preconceived assumptions about clients using substances affected their ability to trust, as this nurse stated: "You sometimes have that voice in that back of your head going, what are they trying to pull over on me but you also have to get passed that a bit and give them the benefit of the doubt". Contrary to nurse perceptions, clients insisted they were honest with care providers. "I am honest. I'll go, I'm high right now,

on crack or I have a problem or whatever, I always tell them [healthcare providers] everything when it comes to that".

While clients valued honesty, they knew they could be subjected to additional judgment by healthcare providers based on what they might tell them. One client wished she could be a care provider who encouraged women who used substances in pregnancy to be honest, and not worry about being judged. "A catch 22. Well you know that's when I wish that I was in her shoes for a minute, so I could encourage them". Nurses touched on how clients may withhold information to protect themselves, as one nurse explained: "Judging. They are afraid we'll judge them", but nurses still faulted clients if they thought they were not completely forthcoming. Clients recognized that they were not trusted by care providers even when they were being honest. The frustration in the following client's words was apparent as she was not given the chance to be honest.

> It hurts me inside because at least I am trying to be honest. I don't like that feeling when someone is talking to you, or looking at you like that. It makes me feel like I have a disease or something and no one wants to come around me.

Ultimately, dishonesty and mistrust between nurses and clients who used substances influenced the development of a non-health promoting and superficial relationship.

Negotiating relationships as a means to an end.

Finally, the core theme, "negotiating relationships as a means to an end" describes the ways in which clients using substances and nurses maintained a superficial relationship. Although the time period around the birth of a child has been found to be an optimal time to assist women who used substances with their substance use (Tait, 2000), the client-nurse relationship in this study was developed solely for the wellbeing of the infant. Clients and nurses both placed the infant first. Perinatal nurses stated that clients entered the perinatal setting for

their infant's health. "I think a lot of them want the help, if not for themselves, then for their baby, when they have their baby". However, clients were often blamed for compromising the health of their infants instead of supported by nurses.

> Part of a nurses personality is that caring feature, and some of it is even the mother bear feature, and as soon as there's that baby that you've seen harmed, or in some way compromised because of someone's behaviour, there is judgment there…There is a certain thing as a nurse that you feel like, how could she have subjected her baby to that much risk? And how could she not be putting the baby first, and putting her addiction or her need for drugs ahead of the welfare of that baby. I think every nurse to a certain extent makes a judgment at that point. They are judging that woman's behaviour based on the fact that now we have a baby at risk….We see that baby as an innocent victim and therefore if there is a victim there has to be a culprit.

This nurse quote exemplified how nurses viewed "good" mothers and how mothers were supposed to protect their children.

Clients expected to be judged in the perinatal setting, but were willing to endure scrutiny by healthcare providers for the sake of the infant's health and safety, as explained here by one client:

> Well I never went back ever until I found out I was pregnant with this one. I just do it for the baby even though I don't want to go there [prenatal care]. I'm one who takes offence strongly to being judged, if I think they are negative towards me.

Nurses treated clients differently based on how they responded to their infant's withdrawal. Instead of exploring how clients might be feeling when they perceived clients were not responding appropriately to their infant, nurses judged them. Nurses' judgment of clients ultimately affected how they responded to their needs. One nurse stated:

> I think for me it depends on how the mother is reacting to the baby withdrawing. If the mother is just kind of brushing it off or laughing, or watching T.V, or talking to her friends on the phone well her baby is throwing up and showing all these signs, and she's not showing any interest I'm a little more annoyed then if she seems genuinely concerned.

Clients and nurses entered relationships as a formality and avoided each other as much as possible. Nurses talked about wanting to 'appear' to be caring with these clients, versus wanting to be caring. "It's maybe more a positive experience for them, that they're in a place where they feel not judged, where someone *appears* to be kind to them or *appears* to care about them". Nurses also felt clients were going through the motions in order to navigate the system unnoticed and would say what they felt nurses wanted to hear in order to be discharged from the hospital, as this nurse described: "If they're at a point where they really are concerned, that they really want to make a change, then they're not as manipulative. But if they're just saying it to get through the process …they're really manipulative".

Even though clients felt many nurses treated them well, they questioned their dedication, as represented here:

> A lot of nurses were really good, really nice, but I still had that feeling, it could have been just me. I felt it was how could you do something like that? Some attitude, or nice just because they had to be nice.

Nurses perceived that clients might be skeptical of their intentions, as explained by one nurse: "You want them to feel that you do really care about them, that they can trust you. They are a hard people to trust and I'm sure they doubt our sincerity sometimes too [and] how much we really care about them".

Clients did not seek a deep connection with nurses, but they did seek validation for their attempts to do well for their family, as this client remarked: "I'm trying…it's nice to hear once in a while, it's a good thing that you're trying. Or it's a good thing that you were honest with us. Or it's a good thing that you told someone that you needed help". This client also felt negative remarks about her lifestyle were inappropriate and expected healthcare professionals to provide positive reinforcement for seeking care and being honest.

> If anything, other than maybe a best friend, you would think that when you come here, to the hospital, they are the people that are going to help you. They know what's going on. It's not ok to have an attitude. You are a healthcare professional. I need your help. I know I have a problem. I know it's wrong, especially if I'm pregnant.

Clients also stated they wanted nurses to understand what they go through emotionally, not just physically. "I think they need better understanding [of] what we go through, instead of just what drugs do to people and stuff. I mean emotionally what we go through .... Basically have a better understanding of what people go through emotionally". Nurses talked about furthering their education on substance use, but focused on the physical effects of substances so they could do more policing versus gaining emotional understanding about clients who used substances.

Negotiating relationships as a means to an end summarizes how perinatal nurses and clients who used substances interacted superficially. The priority was the mutual goal of a healthy and safe infant. On some level the client did seek understanding; however this usually did not occur. By not developing relationships with clients who used substances, perinatal nurses were facilitating what they were trying foremost to prevent, a compromised infant, as they did not optimize the health of the whole family.

Discussion

Three key insights emerged from the study findings. First, perinatal nurses tended to prefer caring for "good" mothers who fit the conventional societal standard for parenting over women who used substances during pregnancy. Secondly, perinatal nurses were operating within a behaviourist model of care, with the purpose of changing the clients' addictive behaviour and preventing harm to the infant, versus forming relationships which are health promoting in themselves. Finally, nurses reported that the perinatal system was ill-equipped to care for clients who used substances, but they rarely advocated for change. Even though nursing

purports that social justice is a part of nursing practice (Falk-Rafael, 2005), socio-political health promotion was all but absent.

Perinatal nurses preferred caring for "good" mothers compared to mothers who used substances. This was portrayed through the poor treatment and judgment of clients who used substances during pregnancy and ultimately the lack of relationship development. Nurses tended to value mothers who fit conventional standards of parenting and their own middle-class status. They could relate to typical families who were easier to care for within the standard model of care. They saw substance use as "bad" during pregnancy and subsequently viewed women who used substances as "bad" mothers. Similar to another study, the current study affirms that the practice of healthcare providers reflect middle-class values when working with populations they deem to be 'bad' mothers, such as adolescent mothers (Rutman et al., 2002). In contrast to the assumptions of nurses, pregnant women who used substances tried to do everything they could to ensure the health of their children given their circumstances, which reflects the findings of other investigations (Baker & Carson, 1999; Irwin, 1995; Kearney, 1995; Reid et al., 2008). The disconnect between perinatal nurses' and clients' perspectives as to what constitutes "good" mothering led to unmet perinatal health and psychosocial client needs and to the social exclusion (Galabuzi, 2004) of clients who used substances.

In addition to the preference of "good" mothers, nurses focused their care on the infants even though clients should have mutual and active participation in their care and in their relationship with nurses (Falk-Rafael, 2005). Placing the mother on the outside of the care relationship between nurse and infant did not facilitate her participation in her own and her infant's care. Nurses ought to ensure that they provide clients with an opportunity to be change agents in their lives (Falk-Rafael); therefore it is imperative that they facilitate relationships and

care for mother and infant equally. Nurses are responsible to initiate relationships with clients that ultimately foster health and healing (College of Nurses of Ontario [CNO], 2006). For this reason perinatal nurses should examine how relational practice could better meet the needs of clients who use substances during pregnancy. Moreover, nurses need to be active in the development and implementation of policies in the perinatal system that facilitates relational care practice. Further research is needed to explore how marginalized populations are perceived as parents within the perinatal system and how to foster relational practice.

Secondly, relational health promoting practice rarely occurred between nurses and clients who used substances during pregnancy. Care was provided within a behaviourist model of health promotion, which focuses on changing client behaviour (Vanderplaat, 2002). On the contrary, relational health promotion practice involves the nurse and the client entering into a relationship which fosters and promotes the client's health potential (Hartrick, 2002). Falk–Rafael (2005) describes caring as a relational way of being. Relational practice can be impeded when nurses and clients hold differing values (Hartrick & Varcoe, 2007) and in this study nurses perceived that some clients were unresponsive to the needs of their infants, when in actuality they were both striving for a healthy infant. Nurses in this study were judgmental of clients (Raeside, 2003) and did not trust clients who used substances during pregnancy. These factors impeded relationship development at a time when relational nursing practice may enhance the care of women and their infants.

Relational practice encourages clients to take control over their health (Hartrick, 1997). Marginalized populations often have little control in their lives and the opportunity within the healthcare setting may increase their health as well as impact the control they have in other areas of their lives. For this to occur, nurses must reflect on their values, beliefs and practices and be

prepared to be with and work with clients versus doing for clients. Policy makers should consider relationship development as a valuable part of nurses' time by developing policies and standards of care which support relational practice. The findings of this study demonstrate how marginalizing policies and nurse attitudes affect relationship development. More research on how relational health promotion benefits clients, especially those who are marginalized needs to be completed. Educational programs also need to be developed that enhance nurses' potential to develop relationships with their clients, especially with clients who use illicit substances. Furthermore, nurses also need to be educated on community resources and how to access them.

Lastly, the perinatal system did not adequately meet the needs of women who used substances during pregnancy yet change was not being advocated for by nurses. Several barriers related to policy existed and there were gaps in resource allocation. Nurses displayed a lack of knowledge on substance use and subjected clients to judgment. Nurses are in a position to advocate for social change in their own practice and with health policy (CNO, 2006; Vanderplaat, 2002). Part of client advocacy is political action (Falk-Rafael, 2005). Here nurses can advocate for clients who do not always have a voice. Perinatal nurses have the power to advocate for the development of policies that promote social justice and equity, thereby ensuring each client in the perinatal system is treated fairly (Labonte, 2004). Additionally, women who use substances during pregnancy may need more support and care, or different support and care, than the "average" client of the perinatal system. Clients who use substances may not enter the perinatal system with the same resources and supports as most clients; therefore the perinatal system needs to ensure that *all* clients are well equipped to care for their infants.

No literature was found that directly discussed the perinatal system structure and substance use; however one study suggested that the healthcare system as a whole was not

prepared to meet the needs of women who used substances while mothering or pregnant (Tait, 2000). This gap in literature indicates a need for researchers to study how the perinatal system can be changed to meet the needs to women who use substances. Based on the findings of this study, some examples for future study include examining how health promotion approaches can be effective in acute perinatal care and what specific program resources can be allocated to ensure the needs of perinatal substance users are met.

Conclusion

The findings of this study were significant as they illuminated how the relationships between perinatal nurses and clients who used substances during pregnancy were superficial. No other study was found that examined relationships in this context. However, the study was limited by the small number of clients who participated. Even though rich data was collected with a small sample of clients, more research in this area is required. The absence of a client follow up focus group also limited the study; however because all clients were interviewed after nurse data collection was complete, they were invited to comment on general responses of nurses. Despite these limitations, the present study increases our understanding of client-nurse relationships when the client used substances, but more research needs to be conducted on how contextual and attitudinal factors affect these relationships. Most importantly, as nurses are the frontline deliverers of care, they need to realize the importance of their advocacy role. Finally, because therapeutic relationships between care providers and clients have been shown to improve the health and well-being of the latter (Hartrick &Varcoe, 2007) perinatal nurses, policy makers, researchers and educators need to look at ways in which client-nurse relationships can promote the health of pregnant women who use substances.

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CHAPTER III

The purpose of this critical feminist study was to examine the relationships between perinatal nurses and clients who used substances while pregnant. Substances in this study were defined as any illicit substance use or methadone. Findings revealed four layered themes. "Navigating barriers in a fragmented healthcare system" reveals how the perinatal system was largely unequipped to care for clients who used substances during pregnancy. Barriers related to policy, resource allocation and nursing practices were identified. "Reinforcing marginalization and stigma" illuminates how perinatal nurses were judgmental of clients who used substances during pregnancy. Finally, "doubting honesty" reflects the lack of trust in the relationships between nurses and clients who used substances.

The first three themes collectively uncovered a core theme. "Negotiating relationships as a means to an end" ultimately portrays how relationships between nurses and clients who used substances while pregnant were superficial. Nurses and clients entered the relationship for the infant's wellbeing and only invested what was required to ensure the infant's welfare. Several implications for practice, education, policy and research have arisen from this study.

Implications for Nursing Practice

Study findings indicated that nurses were judgmental of clients who used substances during pregnancy. This preformed judgment adversely affected relationships between nurses and clients. It is important for perinatal nurses to be conscious of how their underlying assumptions and values enter into relationships with clients and ultimately affect the care they provide (College of Nurses of Ontario [CNO], 2006; Registered Nurses Association of Ontario [RNAO], 2006). A discrepancy in values, goals and desires between nurses and clients can jeopardize relationship development (Hartrick & Varcoe, 2007) while judgmental attitudes by care

providers can impede their ability to listen to clients, which is also detrimental to relationships (Centre for Addiction and Mental Health, 2007). Non-judgmental environments were found to be the most important component of treatment programs in other studies (Roberts & Nishimoto, 2006; Tait, 2000).

Perinatal nurses did not perceive clients who used substances as "good" mothers. Nurses tended to prefer mothers who fit within the common ideology of "good" mothers as white, middleclass, married women (Baker & Carson, 1999). Even though clients who use substances may not fit within nurses' perceptions of the "ideal" mother, it is important for nurses to assist clients to realize their strengths so they can provide good care to their infants. Similarly, middleclass social workers working with adolescent mothers, who did not use substances, felt as though teenage pregnancy was wrong and that teenagers often made "bad" mothers (Rutman et al., 2008). Non-supportive, judgmental attitudes (Lester, Andreozzi & Apiah, 2004) and stigma (Irwin, 1995; Kearney, 1995) turn mothers away from prenatal care, decreasing opportunities for help and opportunities for relationships. Clients in this study recommended that nurses consider how their negative attitudes towards them influenced the care they provided.

One way for nurses to prevent their stigmatic attitudes from entering relationships is for them to reflect on their personal beliefs, singularly or collectively as a group, and how they might influence their practice. When entering into relationships with clients, nurses must be aware of how their preconceived assumptions and attitudes about clients may affect their relationships with them (RNAO, 2006). For example, if nurses do not agree with some of the decisions a client has made, and they do not reflect on how their attitudes may affect the relationship, they may not develop a therapeutic relationship with that client. Researchers who investigated stigmatic attitudes toward people with mental illness suggest that stigma could be

decreased through the use of strategies, including protest, education and contact (Corrigan & O'Shaughnessy, 2007). Nurses could assume a leadership role in protest, which involves going up against the untrue. Education includes gaining knowledge on facts and dispelling myths. Finally, nurses have the opportunity to use the strategy of contact within their everyday practice by facilitating interaction between the stigmatized group and the stigmatizing group. Nurses should be working to create environments that support clients' physical, social, political and economic needs (Falk-Rafael, 2005b).

Although, a stronger family focus has also been recommended for substance use treatment (Lester et al., 2004; Salmon, 2006), the current study found judgmental attitudes led nurses to prioritize the care of the infant, the "victim", while seeing the mother as the "villain". This practice was counterproductive as it did not facilitate bonding between mother and infant and did not optimize the health of the whole family, which could ultimately compromise the health of the infant. This study validated the importance of the maternal-infant bond for mothers who used substances. In addition, not including clients who used substances in the care of their infant contributes to their social exclusion (Galabuzi, 2004) within the perinatal system. Clients need to be partners in their care (CNO, 2006) and share power and decisions with care providers (Falk-Rafael, 2005a).

Lack of continuity of care providers, that is having different care providers, inhibited client-nurse relationships in the present study. With trust also emerging as a barrier to relationship development, continuity of care providers may help increase the trust building capacity of relationships. Continuity of care providers should be practiced by nurses (RNAO, 2006) and other healthcare professionals whenever possible in order to aid trust and thus relationship development. Also, clients enter into relationships with nurses in a vulnerable

position so the nurse must create a trusting environment (CNO, 2006). For example, perinatal nurses need to be involved in developing and refining policies that ensure all vulnerable clients of the perinatal system have a primary care nurse to promote continuity of care.

Another important practice implication for nurses is advocacy. Advocating for clients and their families is a central component of nursing practice (CNO, 2006). Perinatal nurses divulged during this study that the perinatal and broader healthcare systems were not equipped to cope with clients who used substances during pregnancy. Nurses also did not tend to support clients who used substances or advocate changes to improve care in spite of their claim that political action (Falk-Rafael, 2005a) and social change advocacy are important aspects of nursing practice (Vanderplaat, 2002). Other nurse researchers have discussed the importance of nurses advocating for victimized populations in their research on violence in the lives of females (Berman, McKenna, Taylor & Traher, 2000) and on families of sufferers of mental illness (Ward-Griffin, Schofield, Vos & Coatsworth-Puspoky, 2005).

Clients who use substances may not always fit within conventional standards of care as they may not enter the perinatal system with the same resources and supports as other families. Therefore, care that can adjust to their individual needs may increase health outcomes. Recommendations such as, facilitating more time between nurses and clients who use substances in pregnancy by decreasing the nurses' remaining patient load or encouraging clients to become actively involved in their care and the care of their infants are relevant to this current study.

Implications for Nursing Education

The findings of this study and other research suggests that healthcare professionals, including nurses, are uncomfortable with and do not feel skilled in dealing with socially vulnerable perinatal patients (Chang et al., 2008; Gunn et al., 2006; Raeside, 2003; Tandon et

al., 2005). Therefore perinatal nurses and other healthcare professionals need further education on caring for vulnerable women, especially those who use substances during pregnancy. Staff education is vital according to Dodge, Brady and Maguire (2006) who successfully initiated a new perinatal program for opiate addicted women. Moreover, educational opportunities for nurses and other providers caring for vulnerable clients need to be a priority of healthcare organizations and educational facilities.

The nurses in this study made the following recommendations for opportunities to expand their knowledge in the care of vulnerable clients: ensuring that all employees receive a comprehensive orientation; supporting nurses in reflective practice scenarios; accessing conference funds and educational in-services on caring for clients using substances; completing self-learning packages; and peer mentoring by skilled professionals. Nurses also stated they would like to hear from a client who had journeyed through the perinatal system as a substance user. Although this is an important suggestion, perinatal nurses have the opportunity to care for and listen to clients who use substances in their everyday practice. Listening to clients who have already journeyed through the perinatal system will do little to help current clients unless nurses begin to value their voices too.

Healthcare providers in general are educated on how social determinants of health affect client populations (Rapheal, 2004). Perinatal nurses, however, should be educated on how social determinants of health may affect perinatal care attendance and pregnancy outcomes (British Columbia Centre of Excellence for Women's Health & BC Women's Hospital and Health Centre, 2008). All perinatal staff should be trained in women centered approaches to sensitive issues such as housing, violence and other determinants of health that may be present in the lives of women who use substances.

Although ongoing education for practising nurses is important, it is equally important to ensure that undergraduate nursing curricula include relationship development with vulnerable populations. The RNAO (2006) recommends that nursing curricula focus on developing therapeutic client-nurse relationships and provide diverse clinical experiences for nursing students. Moreover, experiences in caring for marginalized populations should be included in all nursing programs. Principles of social justice and equity as well as the nurses' role of political activist when clients are subjected to unfair treatment would be addressed.

Nursing education, for both practising and student nurses, should also include teaching the importance of self reflection and understanding one's personal biases, and how these might affect relationships with clients (RNAO, 2006). Nurses must always be aware of how their preconceived attitudes may enter into relationships.

Implications for Policy

Clients who used substances while pregnant were disadvantaged by the perinatal system. This was revealed through the stigma they faced and the focus on "acute" medical conditions. Postpartum stays in hospital were short, with only clients suffering from medical adverse effects of pregnancy staying for longer periods. Even though clients who used substances during pregnancy had an illness, they were still discharged. Arguably, clients who use substances are entitled to equitable care (Labonte, 2004) and it is the moral imperative of nurses to facilitate this fairness (Falk-Raphael, 2005a). Clients who use substances may require more care or a different kind of care than socially advantaged women due to their psychosocial support needs. Social justice perspectives may also draw attention to other intersected injustices that women who use substances may experience, such as poverty and unsafe housing (Corrigan, Watson, Bryne & Davis, 2005). Examples of policy changes include providing longer hospital stays and

decreasing the separation between mother and infant, which would also increase the likelihood of relationship development between nurse and client.

As clients who use substances often have poor social determinants of health, other policy changes for this vulnerable population could include providing transportation to and from prenatal appointments, being flexible with appointment times and having space and toys available for other children to play with if the client has no child care. Findings revealed that clients who use substances in pregnancy are further marginalized by practitioners within the perinatal system. The system needs to change as vulnerable populations cannot move out of their marginalized position unless the social system that is perpetuating this marginalization changes (Vanderplaat, 2002).

Even though professional standards state that client-nurse relationships are vital to nursing practice, this study demonstrated nurses were required to practice within a behaviourist model of care. Within this approach, nurses within the perinatal setting were busy with task orientated medical duties and therefore had little time to relate to clients. A relationship within a behaviourist model of care focuses on changing client behaviour through educational strategies. In addition, when clients do not engage in healthy behaviour they may be blamed by care providers for their health status. In contrast, relational health promotion practice involves nurses assisting clients to take control over their health versus nurses doing it for clients, or simply educating them. Thus client-nurse relationships within a relational approach have a positive impact on the health and wellbeing of the client and help foster client choice related to healthcare decisions (Hartrick, 1997). Focusing on promoting the health of women who use substances and their families through relational practice would be more productive than vilifying them within the system.

Nurturing client-nurse relationships is also an organizational responsibility. Clients have a right to engage in caring relationships with nurses. Organizations therefore must provide the opportunity to enable these relationships (RNAO, 2006), making them a valued part of nurses time. Caring is a relational way of being (Falk-Rafael, 2005a) therefore relationships must develop for clients to experience the full benefit of the healthcare system. In addition to providing the opportunity for relationships to develop, organizations must also provide clinical supervision and coaching related to nurses' preconceived attitudes and relationships (RNAO, 2006). An arena for self reflection and dialogue should always be available to ensure that nurses are able to enter into relationships with clients without bias.

Another policy recommendation is to ensure that all clients are discharged with a discharge plan. The findings of the current study demonstrate clients were discharged with no plan. Policies need to be in place guaranteeing that all perinatal healthcare consumers are discharged with the appropriate follow up. Prior to discharge, nurses need to assist clients who use substances to identify potential support systems in the community as well as help them establish goals. Support systems may include referrals to appropriate community agencies, family and friends of the client and public health. Clients should be assisted to make appointments with services prior to discharge as well as securing safe accommodations. Potential discharge goals that the nurse and client can develop include securing second hand clothing, if needed, or enrolling in a parenting class. In order for discharge planning to be effective, it is imperative that nurses and clients develop a trusting collaborative relationship as a client may not be as receptive to assistance from someone whom they do not trust. Because perinatal nurses tend to be unaware of community resources they also need to be educated on the resources available in the community and how to make referrals to them (Lester et al., 2004).

Implications for Future Research

No other studies examined client-nurse relationships in the perinatal setting when the client used substances. A few studies, although dated, investigated seeking care as a pregnant substance user (Irwin, 1995; Kearney, 1995), and some did examine relationships between care providers and substance users among other vulnerable clients (Chang et al., 2008; Gunn et al, 2008; Raeside, 2003). More research is needed exploring the relationships between perinatal nurses and clients who use substances, as well as how nurses preconceived assumptions of substance users may affect their relationships with this population. Similar studies as this that are able to recruit more client participants would be beneficial as well as studies examining other care providers' relationships with clients who use substances while pregnant. If the perinatal period is considered a time when women who use substances may be motivated to change (Tait, 2000) we need to continue to consider ways in which we can optimize the health promotion potential of perinatal care. A study that may build on this study's findings and improve health outcomes includes investigating how relational models of care may affect perinatal care. Relationships between nurses and clients promote health, reinforcing the need to examine how to ensure these relationships are effective.

More research on the social determinants of health of women who use substances during pregnancy is also needed. Lifestyle and contextual factors in the lives of women who use substances while pregnant may contribute to the adverse effects seen more than the substance use itself (Richardson & Day, 1999). Although substances have been shown to have a negative impact on the health and wellbeing of pregnant women and their fetuses/infants, a broader look at what socio-political factors may also be contributing to these adverse affects would be

beneficial. Healthier pregnancies and infants were the outcome in one study that tailored prenatal care to the needs of pregnant substance users (Finnegan, 1978).

Finally perinatal care is an interdisciplinary area and therefore interdisciplinary research is also vital. A better understanding of the barriers that may prevent collaborative perinatal care is necessary with the ultimate goal of ensuring that the entire perinatal experience is relevant and tailored to the unique needs to clients who use substances.

Conclusion

The findings of this study have provided new insights into the relationships between perinatal nurses and clients who use substances during the perinatal period. Relationships were found to be superficial for several reasons, including lack of trust between nurses and clients, judgmental attitudes toward clients using substances, and perinatal system barriers. Clearly, the care of pregnant women using substances needs to change. Care practices and hospital policies based on the principles of social justice and equity (Falk-Rafael, 2005b; Labonte, 2004) would ensure that every perinatal client, including those women who use substances, is treated fairly. Perinatal nurses also need to recognize the role they play in potentially hindering the healthcare experiences of clients who use substances, but most importantly, they need to advocate for and with clients through the development of a therapeutic client-nurse relationship. Nurses, policy makers, educators and researchers must join forces in order to promote the health of women who use substances and their families.

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APPENDIX A

Ethics Approval

Office of Research Ethics

The University of Western Ontario
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Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. C. Ward-Griffin
Review Number: 15403E **Review Level:** Expedited
Review Date: August 13, 2008

Protocol Title: Relationships Between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study

Department and Institution: Nursing, University of Western Ontario

Sponsor:

Ethics Approval Date: October 9, 2008 **Expiry Date:** December 31, 2009

Documents Reviewed and Approved: UWO Protocol, Letter of Information and Consent for Client Participants. Letter of Information and Consent for Nurse Participants. Advertisement (x2)

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland	☐ Elizabeth Wambolt	☑ Grace Kelly	☐ Denise Grafton

This is an official document. Please retain the original in your files.

cc: ORE File
LHRI

APPENDIX B

Letter of Information for Perinatal Nurses

Relationships Between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study

As a nurse working with the perinatal care setting you are being asked to participate in a study looking the relationships that perinatal nurses have with clients that use substances. Substances include illicit drugs, alcohol, inappropriate use of over the counter or prescription medications and methadone. By participating in this study you will be providing information that may help perinatal nurses like yourself and policy makers create a workplace that supports and strengthens the relationships between perinatal nurses and clients who use substances during the perinatal period. Clients who are currently undergoing perinatal care or have recently had a baby will also be interviewed for this study. This study is being completed by Angela Wilkinson, a graduate nursing student at The University of Western Ontario.

Eligibility

You may not be able to participate if you are not currently working at least 20 hours per week as a nurse within the perinatal program at London Health Sciences Centre. You must have at least one year of experience in perinatal nursing and have cared for at least one perinatal client who has used substances during the perinatal period.

What does participation involve?

If you agree to participate in this study you will be asked to participate in one focus group interview with about 3-10 of your colleagues. It is anticipated that 2-4 focus group interviews will occur. During the focus group interview you will be asked questions about your experiences of caring for clients who have used substances during the perinatal period. Questions relating specifically to the relationships that you have had with these clients will be asked. The focus group interviews will take about an hour to complete and will take place over your lunch period during day and night shifts at London Health Sciences Centre. If you are not working on a day in which a focus group is being held, you may come in if you would like to participate. Food and beverages will be provided. Focus groups will be audio taped and later transcribed verbatim. The researcher will also be taking notes during the interview in order to capture a more in depth analysis. You will be asked to choose a pseudonym in which you will be referred to for the remainder of the study to help ensure your confidentiality. However, the researcher cannot guarantee your confidentiality after the focus group. All participants will be asked to keep everything confidential and to not discuss anything outside of the focus group interview.

Risks/Benefits of Participating

There are no known risks in taking part in this study. You may however benefit from the opportunity to reflect on your practice in caring for clients who use substances. Participation is voluntary. You may refuse to participate, refuse to answer any questions and are free to withdraw from this study at any time with no effect on your employment status. If you withdrawal from the study after your focus group interview has been completed, your data may still be used. Information that you provide will be kept confidential. All information will remain in a secure location and will only be available to the research team. If the results of the study are published or made public no identifying information linking you to the study will be used. You may be provided with a summary of the study findings if you wish.

Questions

This letter if for you to keep. If you have any questions about this study please contact Dr. Catherine Ward-Griffin, Associate Professor, at The University of Western Ontario. If you have any questions about you

rights as a research participant or the conduct of the study you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute or The Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Sincerely,

Angela Wilkinson, RN
MScN Graduate Student
University of Western Ontario
School of Nursing
London, Ontario N6A 5C1
Phone:
Email:

APPENDIX C

Recruitment Flyer for Perinatal Nurses

NURSE-CLIENT RELATIONSHIPS IN PRENATAL, LABOUR & DELIVERY AND POSTPARTUM CARE

Have you been working in obstetrics for at least 2 years and are currently working full time?
Have you experienced working with a woman who has used substances or methadone during her perinatal period?

If you have answered "yes" to both of these questions I would like to invite you to participate in a focus group of yourself and 4-5 other nurses.

Please contact:
Angela Wilkinson
Phone:
Email:

This study is being conducted by a graduate of nursing student at The University of Western Ontario.

APPENDIX D

Letter of Information for Clients

Title: Relationships Between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study

You are being invited to participate in a research study looking at the relationships women who use substances in pregnancy or postpartum have with perinatal nurses. About 10-20 women are being asked to participate. If you take part in this study you will be providing information that could assist nurses and other health professionals as well as hospital policy makers build stronger care relationships with women like yourself. Your contribution may help healthcare professionals meet the unique needs of clients who use substances. Perinatal nurses are also being interviewed for this study. This study is being completed by Angela Wilkinson, a graduate nursing student at The University of Western Ontario.

Eligibility

To participate in this study you must: be at least 18 years of age; speak and understand English, have received or are currently receiving prenatal, labour and delivery or postpartum care at London Health Sciences Centre; and used substances during your perinatal period (from the time of conception until 6 months after the birth of your baby). Substances include illicit drugs, alcohol, inappropriate use of over the counter and prescription medications and methadone. Finally the perinatal nurses were aware of your substance use during this time.

What does participation involve?

If you participate in this study you will take part in one interview with the researcher. Your interview will last about an hour and take place in a location that is convenient for you. At this interview you will be asked questions about your experience of prenatal, labour and delivery and postnatal care, focusing on your relationships with perinatal nurses. A focus group will be held a few months after your initial interview and include other women who have been interviewed for this study. At this time you will be able to hear some of the findings from the interviews, and comment on them to ensure that what is being learned represents what you have said. The findings will be presented in a way that will not identify what you specifically said during your individual interview, but will reflect the findings of the group as a whole. You may choose to discuss your personal experiences with regards to the emerging themes if you wish. The focus group will last about 1 hour. If you take part in the original interview, you do not have to take part in the focus group. If you do not take part in the focus group, your interview data will still be used. Your interview and the focus group will be audio taped and later made into written form so that the researchers can play close attention to everything that you say. To ensure confidentiality, you will be asked to pick a name for yourself in which you will be referred to throughout the course of the study. This name will appear on your interview transcript and be used during the focus group if you choose to participate. Everything you say during your interview will be kept confidential, however confidentiality after the focus group cannot be guaranteed. All participants will be asked to keep everything confidential and to not discuss anything outside of the focus group interview. Additional costs you may incur as a result of your participation, such as parking, transit and childcare will be reimbursed. Food and beverages will be provided at the focus group.

Risks/Benefits of participating

There may be a small risk for emotional harm to you during your interview if negative experiences are discussed. Your interview will be stopped for this reason. If at the conclusion of the research you still would like to talk to someone about your experiences a list of counselors and community resources will be provided to you. You may benefit from this research as sometimes having the opportunity to talk can be helpful. Also, if you choose to participate in the focus group you will have the opportunity to share with other women who have gone through a similar experience to you.

How are you protected?
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdrawal from the study at any time. If you are still undergoing perinatal care, your care will not be affected by your participation in this study. If you withdraw from the study after your interview has been completed, data from it will still be used. Information that you provide will be kept confidential. All information will remain in a secure location and will only be available to the research team. If the results of the study are published, your name will not be used and no information that discloses who you are will be used. If you would like to receive a summary of the results of the study, or your interview transcript, this will be provided to you.

Questions
This letter if for you to keep. If you have any questions about this study please contact Dr. Catherine Ward-Griffin, Associate Professor, at The University of Western Ontario. If you have any questions about you rights as a research participant or the conduct of the study you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute or The Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Sincerely,

Angela Wilkinson, RN
MScN Graduate Student
University of Western Ontario
School of Nursing
London, Ontario N6A 5C1
Phone:
Email:

APPENDIX E

Recruitment Flyer for Clients

Relationships Between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study

Are you pregnant or have had a baby in the past six months? Do you use illegal drugs or alcohol or the methadone maintenance program?

If your answer is "yes" to both of these questions please contact:
Angela Wilkinson:
Phone:
Email:

I would like to talk to you about your experience in accessing and receiving care in the hospital setting.

This study is being conducted by a graduate nursing student at The University of Western Ontario.

APPENDIX F

Consent Form

Consent Form

Relationships between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study

I have read the letter of information, have had the nature of the study explained to me and I agree to participate in the study "Relationships between Hospital Based Perinatal Nurses and Clients Using Substances: A Critical Feminist Study". All questions have been answered to my satisfaction.

Participant name _____
Please print name

Signature_____
Date_____

Name of person obtaining consent _____
Please print name

Signature _____
Date_____

APPENDIX G

Semi-Structured Client Interview Guide and Probes for Women

Semi Structured Interview Guide and Probes for Women

I. Introductions
II. Review of letter of information/consent/demographic data (may be at end)
III. Review procedure for audio taping
IV. Questions before beginning
V. Summary: Before we begin I would like to tell you about myself and why I have undertaken this research project. I have been working as a nurse in postpartum care for a few years and am interested in learning more about what the client feels about their care. I would like to know what health is to you and your family. I would also like to know what it is like to live in your shoes and access healthcare services when you are pregnant, in labour and or postpartum. I would especially like to focus on your interactions with nurses during this time.

1.) Experience of going through care

a. What is it like to access healthcare as a substance user?
b. Where there any factors that lead to more or less care accessed?
c. Have you ever felt judged by your nurses?

2.) Relationships

d. Do you think your nurse understood what you were going through?
e. Did you feel comfortable talking with your nurse
f. Do you feel that you were able to develop a relationship with your nurse that was beneficial to you?
g. Did anyone talk to you about your substance use?
h. Is there anything that you especially remember from your care?

3.) Healthcare setting

i. Do you feel that the healthcare setting was able to meet your individual needs? Are there enough resources for you?
j. Were your nurses knowledgeable about your substance use?
k. Are there any changes that you would like to see take place within the healthcare setting that may lead to better care for future clients?
l. What do you feel would be helpful to you as a substance user?

APPENDIX H

Semi-Structured Focus Group Interview Guide for Nurses

Focus Group Interview Guide for Nurses

VI. Introductions
VII. Review of letter of information/consent
VIII. Review procedure for audio taping/note taking
IX. Questions before beginning
X. Summary: Before we begin I would like to tell you about myself and why I have undertaken this research project. I have been working as a nurse in postpartum care for a few years and am interested in learning more about how nurses and clients interact when the client is using substances. I would especially like to focus on the relationship that you are able to develop with these clients and if you feel these relationships are beneficial. I would also like to discuss changes you would like to see to the perinatal program in order to ensure that you are comfortable in providing high quality care to these women.

1.) Experience of providing care to perinatal substance users

a. What is it like to care for women who use substances in pregnancy? Tell me about your experiences (positive/negative).
b. Describe positive encounters that you have had with these women? Positive outcomes? What made the difference for these encounters?
c. Do you feel as though you have different values than these women? How does this affect the care you provide?
d. Do you feel as though you are judging these women? What about your colleagues? Other healthcare team members?
e. Is it easy/difficult for you to focus on the woman's needs? The infant's needs? Both of their needs together?
f. Is it easier/more difficult/any different to care for a woman who is on methadone versus a woman taking other substances?

2.) Relationships

g. Do you feel you can develop a relationship with them? Compared to other women who are not using substances? What is this like?
h. Do you feel as though the relationships that you are able to develop with these women are beneficial to them? Are they health promoting?
i. What factors might impede relationship development? What factors might help it?

3.) Healthcare setting

j. Are there any changes that could take place within the healthcare setting that would make caring for substance using women and their infants/families easier/better?
k. Do you feel adequately staffed to deal with their health/social issues when they arise?
l. Do you feel as though you have enough education to support and care for substance using women and their families?
m. Do you feel that the healthcare setting as a whole is equipped to deal with these women?
n. Are there any changes within the healthcare setting that you think will help make your job in providing care easier and more effective?

APPENDIX I

Field Note Guide

Field Note Guide

Interview/Focus Group number:

Participant pseudonym(s):

Date/Time:

1. Description of the Setting:

2. Description of the Informant:

3. Description of Emotional Tone:

4. Difficulties encountered:

5. Researcher's Feelings about interview:

6. Emerging Reflections/Insights:

APPENDIX J

Demographic Questionnaire for Nurse Participants

Demographic Data – Nurse Participants

1. Code (participant)

2. Sex (male/female)_____

3. Date of Birth (year/month/day):_____

4. Country Born In: _____

5. Primary language spoken at home: _____

6. Cultural Descent _____

7. Nursing Education: (please circle one)
   a) degree (please specify degree optained)_____ b)diploma

8. Number of years in Nursing:

   a) <5

   b) 6-10

   c) 11-15

   d) 16-20

   e) 21-25

   f) >25

9. Employment Status:

   a) Full time (30 hours or more per week)

   b) Part time

   c) Casual

10. Total Household Income (2007) from all sources before taxes

a) $0-19,999

b) $20,000-39,999

c) $40,000-59,000

d) $60,000-79,000

e) $80,000-99,999

f) over $100,000

g) Choose not to answer

APPENDIX K

Demographic Questionnaire for Client Participants

Demographic Questionnaire – Client Participants

1. Code (participant)
2. Date of Birth (year/month/day):_____
3. Country Born In: _____
4. Primary language spoken at home: _____
5. Cultural Descent _____
6. Marital Status: (circle one)
    a) Single (never married)
    b) Married (or common law)
    c) Separated
    d) Divorced
    e) Widowed
7. Highest level of education: (circle highest level completed)
    a) Primary School 1 2 3 4 5 6 7 8
    b) Secondary School 9 10 11 12 13
    c) Post-Secondary 1 2 3 4 5 6 7 8
8. Employment Status:
    a) Full time (30 hours or more per week)
    b) Part time
    c) Other (e.g. casual, contract) _____
9. If employed, specify occupation_____

10.Total Personal Income (2007) from all sources before taxes

a) $0-19,999

b) $20,000-39,999

c) $40,000-59,000

d) $60,000-79,000

e) $80,000-99,999

f) over $100,000

g) Choose not to answer

11. Substance used during pregnancy: (circle all that apply)

a) Alcohol

b) Methadone

c) Cocaine

d) Methamphetamine

e) Heroine

f) Marijuana

g) Other: _____

12. Number of children: _____

13. Are your children currently in your care?_____