FIR MODEL of CARE

MARCH 2020

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

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i. Acknowledgements

We would like to acknowledge that the FIR Model of Care was developed on the the unceded, traditional and ancestral homelands of the Coast Salish People, specifically the the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səlílwətaʔɬ (Tsleil-waututh) Nations

We would like to thank the Elders for their support and guidance on the FIR Model of Care. Specific thanks to Elder Roberta Price and Elder Glida Morgan.

We would like to acknowledge the work of the Provincial Perinatal Substance Use Project Team in providing leadership for the development of the FIR model of care with the FIR Interdisciplinary Model of Care Working Group.

We dedicate this work to all the women and families who inspire us with their courage, strength, resilience and kindness.

TABLE OF CONTENTS

1.0 Introduction 4

2.0 History and Context 7

- Substance use in BC 7
- Indigenous Peoples 8
- Indigenous Women & Mothering 9
- Substance use and treatment issues for women 11
- Pregnancy 13
- Rooming-In 14
- Parenting and Child Welfare 14

3.0 FIR 16

- Service Population 16
- Model of Care Renewal 17
- Philosophy of Care 18
- Guiding Principles 19

4.0 Service Components 20

- Assessments & Care Plans 20
- Healing and Wellness Programming 20
- Interdisciplinary Practice 23

5.0 Discharge and Transition Planning 24

6.0 Harm Reduction and Active Use 25

7.0 Child Welfare Engagement 26

8.0 Engaging women with lived and living experience 28

9.0 Connection to BC Women's Hospital & Health Centre Experience 28

10.0 Workforce Development 29

11.0 Staffing Model 30

12.0 Safety and Wellness of Providers 31

13.0 Education and Training 32

14.0 Research and Evaluation 33

Appendices 34

References 36

ii. Message from the Chief Operating Officer, BC Women's Hospital & Chief Medical Officer, BC Children's Hospital, Sunny Hill Health Centre for Children & BC Women's Hospital & Health Care Centre

FIR opened in 2003 as the Families in Recovery program or FIR Square – the first of its kind in Canada to support pregnant women using substances requiring stabilization of substance use and pregnancy. As part of the BC Women's Hospital & Health Centre, FIR provides a safe haven for pregnant women and their families to experience labour and delivery in a compassionate and empathetic, non-judgemental environment.

Over the years, evidence for managing and treating substance use among women including pregnant and parenting women has evolved significantly along with the changes to how women use substances, what substances are used and what supports are available in community and acute care maternity settings. The need to decolonize approaches to addiction, align to the actions of the Truth and Reconciliation Commission and UNDRIP is paramount to Indigenous Cultural Safety and Humility. As well the severity of the Overdose Crisis in BC has added significant complexity and urgency to addressing substance use among women.

These strategic and contextual considerations have supported the development of the Provincial Perinatal Substance Use Project (2018-2021), a comprehensive systems transformation project led by BC Women's Hospital and Health Centre, PHSA. The goal of the project is to establish a blueprint for a perinatal substance use continuum of care that will initiate, expand and improve services from community to acute care and back to community across the province. The project has a focus on integrating best evidence for improving the perinatal substance use continuum of care and fostering optimal health outcomes.

In order to align to evidence and support the aspirations, goals and needs of women with lived and living experience, a group of 19 multidisciplinary team members from FIR and the Provincial Perinatal Substance Use Project Team worked collaboratively to develop a renewed, aspirational model of care for FIR. This renewed model of care will guide how services are delivered in this highly specialized setting. The model of care is also translatable to other acute care settings and provides design components that will inform the provincial blueprint for perinatal substance use.

It is exciting to embark on a journey with the FIR team to implement the service enhancements and improvements outlined in the renewed model of care. By embracing a philosophy of care that puts trauma informed practice, Indigenous cultural safety, harm reduction, recovery oriented practice and women's centred care at the forefront, we will transform how we care for pregnant and parenting women using substances, their infants and families and ensure communities are ready and able to embrace them. FIR aims to become a model program in the province for doing this work in a good way.

Sincerely,

Cheryl Davies, Chief Operating Officer
BC Women's Hospital & Health Centre

Dr. Jana Davidson, Chief Medical Officer
BC Children's Hospital, Sunny Hill Health Centre for Children,
and BC Women's Hospital & Health Care Centre

1.0 INTRODUCTION

Substance use in the perinatal period is a challenge which crosses all socio-economic levels and is intrinsically linked with other societal factors, including poverty, racism, sexism, and economic and political power. Perinatal substance use also has effects on relationships between the mother and infant, family and community.

Early emphasis in perinatal care was on the consequences of illicit drug use, alcohol, and tobacco during pregnancy. The national prevalence rate of fetal alcohol spectrum disorder (FASD) in the general population is estimated to be 4% (CanFASD Research Network, 2018). Over the past decade, there has been a significant increase in the use of opioids during pregnancy. In 2017, the Canadian Institute for Health Information reported an estimated 1,908 hospitalizations were due to Neonatal Opioid Withdrawal Syndrome (CIHI, 2018). In BC, there were 238 cases of Neonatal Abstinence Syndrome (NAS) in 2015/16 and infants with NAS stayed in the hospital an average of 20 days (compared to an average length of stay of 2.1 days for a full-term infant) (Young, 2017).

While the perinatal period presents unique risks for those who are substance dependent and their babies, it is also a time when there are unique opportunities for improving the wellbeing for both women[1] and babies. For maternal health clinicians, mental health and substance use providers, community health care providers, peers, child welfare workers and social workers, it is imperative to understand the nature of perinatal substance use disorders and provide harm reduction, treatment and recovery options, care and supports that acknowledge the inherent strengths of the women, preserve the mother-infant dyad, promote parenting potential, connection to family and community and support the baby's health and development (National Perinatal Association, 2017).

Substance use disorders seldom begin during a pregnancy. Women typically have long histories of problematic substance use and recovery that include periods of abstinence which predate their pregnancy. There is a subset of pregnant women who may continue to use during pregnancy that qualify for being diagnosed with a Substance Use Disorder (National Perinatal Association, 2017).

Among Indigenous people, colonization, oppression, residential school experience and the "60's scoop" have created intergenerational trauma experiences (Medley & Pierre, 2018). Indigenous people continue to experience systemic and institutional racism and discrimination in the health care system today. These negative experiences add further layers of trauma for Indigenous women, their families and communities.

Due to the long-lasting impacts of colonization Indigenous women are impacted by high rates of trauma and hence substance use is at a disproportional rate compared to non-Indigenous women. It is vital to understand the strength and resilience within Indigenous families and communities when considering the historical and current impacts of colonization.

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[1] *A note about gender and sexual orientation terminology: In this document the terms pregnant women and pregnant individual are used. This is to acknowledge and be inclusive of transgender individuals who are pregnant, and to respect those who wish to continue to be identified as pregnant women or mothers. We encourage all providers to not assume the gender identity or sexual orientation of the pregnant person (or their partner) and to respectfully and non-judgmentally ask all pregnant people about their preference for how they wish to be addressed.*

[2] *A note about Aboriginal and Indigenous terminology: In this document the terms Aboriginal and Indigenous are used. These terms are used interchangeably and are inclusive of all peoples of long settlement and connection to specific lands who have been adversely affected by incursions by industrial economies, displacement, and settlement of their traditional territories by others.*

Factors and Experiences Associated with Perinatal Substance Use among Indigenous and Non-Indigenous Women

INDIGENOUS WOMEN	NON-INDIGENOUS* WOMEN
Colonization including colonial violence	Depression
Residential School Experience	Intimate Partner Violence
60's Scoop	Sexual Abuse
Child removal	Childhood trauma
Loss of Indigenous women and girls (Missing and Murdered Indigenous Women and Girls)	*Note that these factors may intersect with the experience of Indigenous women
Culture of Grief	
Indian Hospitals	
Forced Sterilization	

Sources: National Perinatal Association, 2017; Medley & Pierre, 2018, FNHA, 2017; FNHA, 2019; Sany'as Indigenous Cultural Safety, 2010

We know that many substances have positive psychotherapeutic effects. In many cases, women initiate substance use to cope with and manage over-powering emotions associated with trauma. Because they are stigmatized, criminalized and marginalized, substance use can carry additional risks unrelated to their pharmacological effects. Substance use can increase risks of structural violence, imbalance of power in intimate relationships, and involvement with the criminal justice system, all of which can contribute to new and/or compounded experiences of trauma (CEWH, 2012).

Perinatal substance use is a major health care concern for pregnant women, their families and communities, health care providers and advocates. We are grateful for an emerging body of evidence that tells us how to deliver timely and appropriate perinatal care for this population. While we acknowledge that there are barriers that keep pregnant women from accessing this care, we believe that health care and social service providers have a responsibility to eliminate those barriers.

Substance use has significant intersections with the social determinants of health in every domain and adverse social, cultural and economic conditions have a cumulative impact on the health of pregnant and parenting women using substances. Addressing this health concern and public health issue as a criminal matter - or a deficiency in parenting that warrants child welfare intervention - results in pregnant and parenting women who use substances avoiding perinatal care and putting the health of themselves and their infants at increased risk (National Perinatal Association, 2017). Parents are rightly and understandably fearful that disclosing substance use while seeking prenatal care, and initiating treatment for a substance use disorder may result in harmful and punitive child welfare

involvement (RCY, 2018). This, unfortunately, increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants (Finnegan, 2013). It also contributes to higher rates of unmanaged NAS (Finnegan, 2013).

Health care providers require opportunities to educate themselves more fully on the issues that accompany and contribute to substance use and dependence. Understanding trauma and its relationship to substance use is imperative to providing the best care possible to perinatal substance using women (CEWH, 2012). Optimal perinatal care requires a trusting relationship between providers and pregnant and parenting clients that supports open and honest communication about substance use. Screening questions for substance use need to be a routine practice in every health care setting. Perinatal providers have a special responsibility because women are at highest risk for developing a substance use disorder during their reproductive years (18–44), especially ages 18–29. It is also critical that we address the effects of poly-substance use, as it is the norm when we describe perinatal substance exposure and dependence (National Perinatal Association, 2017).

While clearly in the best interests of both women and their infants to access appropriate care and treatment during pregnancy many women report significant barriers to doing so. Engaging pregnant women struggling with substance use in pregnancy requires an understanding of the barriers (stigma, discrimination, fear of loss of child custody) they face in accessing services (Poole & Isaac, 2001). It is important that services take into account this larger social context. The vulnerabilities of this group of women can be largely countered by providing a safe environment where staff is respectful, non-judgemental, supportive and understanding.

Current research and practice has found that when women partner in their prenatal care with supportive and knowledgeable staff, receive coordinated care to address their substance use and are able to room-in with their infant after delivery, the parent-infant bond is preserved and the wellbeing of both is improved (Abrahams et al., 2007; Abrahams et al., 2010; Ordean et al., 2015). Programs where pregnant women with a perinatal substance use disorder can receive both their prenatal care and substance use treatment in the same facility with supportive community partners are an exemplary practice resulting in better health outcomes for both the mother and baby. Programs need to provide spaces in which Indigenous girls and women can address their intersecting and emergent health needs without furthering the discourse and construction of Indigenous girls and women as being at-risk, or further criminalizing and medicalizing children and communities (Clark, 2016).

2.0 HISTORY AND CONTEXT

Substance Use in BC

Opioids including heroin, methadone, morphine, oxycodone and hydrocodone have been commonly used for decades but the introduction of fentanyl and fentanyl analogues has resulted in an unprecedented increase in opioid use disorder since 2011 (Special Advisory Committee, 2019). Fentanyl, an extremely potent synthetic opioid, was first reported in BC and Alberta in 2011 and since then the number of deaths involving fentanyl has risen dramatically (Special Advisory Committee, 2019). In 2016, British Columbia's Provincial Health Officer declared a public health emergency in response to the alarming increase in opioid related harms and deaths. While people have been impacted from every region in BC and from across the continuum of age, education level, profession and income level, some segments of the population have been disproportionately affected.

Canadian & BC Data on the Opioid Emergency/Crisis

BC has the **highest rates** of **opioid** related **deaths** in Canada

Between 2007-2015, **30% increase** in **hospitalizations** due to opioid poisoning in Canada

In 2017, **3,998 deaths** due to Opioids, **72% include fentanyl** or fentanyl analogues

201 illicit **drug overdoses** in 2009 and an increase to at least 1,514 people in 2018. **Women accounted for 20% of deaths**

The rate of fentanyl detected in **deaths increased from 4%** in 2012 to **85%** in 2018

Prescribed pharmaceutical opioids, from 2005-2010, **women accounted for 44.4% prescription** opiate related overdose **deaths**

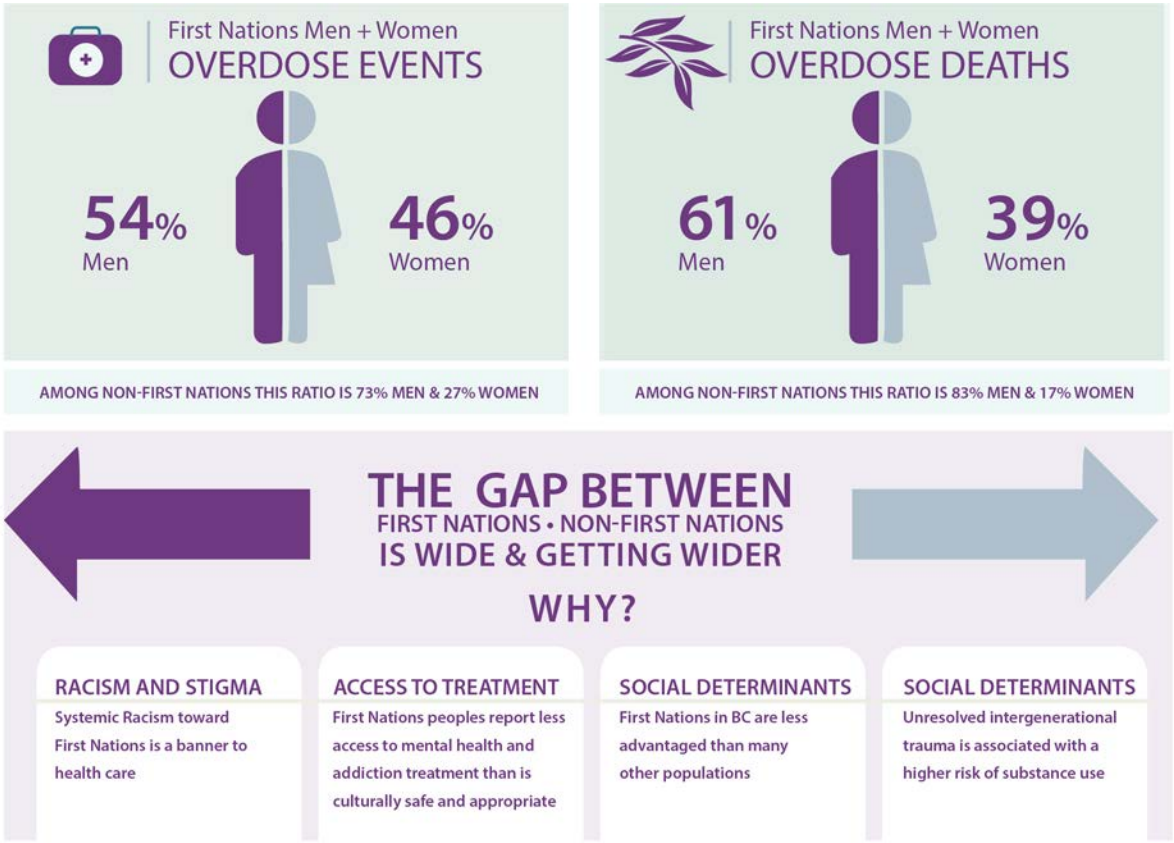
Sources: BC Coroner's Service, 2013; BC Coroner's Service, 2018; BC Coroner's Service, 2018; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019

In addition to opioid use, tobacco, alcohol and other substances also pose a significant concern to the health of women. Data from the Canadian, Tobacco and Drugs Survey (CTADS) estimate that in 2017, 77% of women use alcohol and 14.6% of women use alcohol in ways that exceed low risk drinking guidelines. Smoking prevalence among females is estimated at 13% (2.1 million). It is also estimated that past year drug use (including cannabis use) prevalence among females is 11% (1.7 million). From the data, there is overlap between cannabis use and other substances suggesting that polysubstance use is prevalent among many women who are using substances. In a US study, polysubstance use has been found to be highly prevalent among women of reproductive age using opioids for non-medical purposes (Jarlenski et al., 2017).

Indigenous Peoples

Indigenous peoples are disproportionately impacted by the opioid crisis in BC. Data on the experience of First Nations people in 2019 (FNHA, 2017; FNHA 2019) indicates that:

- First Nations people are five times more likely than non - First Nations people to experience an overdose event and are three times more likely to die from an overdose.
- First Nations women experience eight times more overdose events (46% vs 27%) and five times more deaths than non-First Nations women (39% vs 17%)
- The gap between First Nations and non-First Nations people can be attributed to racism, discrimination, lack of culturally safe treatment, and intergenerational trauma effects from colonization (FNHA, 2019).
- Indigenous peoples experience higher rates of unemployment, poverty, inadequate housing, inequitable access to health care, education and other social services than non-Indigenous Canadians (Government of Canada, 2018).



Sources: FNHA, 2017; FNHA, 2019

The Government of Canada (2018) has recognized that colonization, historical and intergenerational trauma, residential schools and loss of culture and language are significant factors in the increased risk of mental health and substance use issues for Indigenous peoples.

Colonial practices, past and present, often mean that Indigenous people do not have access to culturally safe care or care that integrates cultural practice with Western approaches. As a result, Indigenous peoples and communities experience significantly negative mental health, substance use and perinatal health outcomes. Indigenous people continue to experience stereotyping, racism and discrimination in the broader health care system (A Pathway to Hope, 2019).

Indigenous Women & Mothering

Indigenous women have been targeted by gendered colonial violence. Red Women Rising (2019), a report from the Downtown Eastside Women's Centre is based on the lived experience, leadership and expertise of Indigenous survivors and identifies the importance of keeping women and children together.

> *"We need to keep families together. Colonization and missing and murdered Indigenous Women has broken families. The children left behind by missing and murdered Indigenous women are mostly in foster care and then when they age out, they end up on the street. The violence against missing and murdered Indigenous Women continues when their children are also violated and made vulnerable" (Downtown Eastside Women's Centre, 2019)*

Indigenous mothering involves the lived realities of Indigenous women working to care and parent their children, communities, land and families. According to Anderson (2000),

> *"The Aboriginal ideology of motherhood is not dependant on whether, as individuals, we produce children biologically. Women can be mothers in different ways. I have heard many stories of magnificent "mothers" who have adopted children as well as adults and provided them with the guidance and love that they needed" (p. 171).*

> *"Reconciliation is about forging and maintaining respectful relationships. There are no shortcuts." – Justice Murray Sinclair*

Despite the historical and current impacts of colonization Indigenous communities, families, and women have found ways to resist colonial ways of parenting, mothering and caring for their children and families (National Collaborating Centre on Aboriginal Health, 2012). This resistance can be found in the everyday acts of strength and resilience. Indigenous women strive to navigate health and social systems that have perpetuated western ways of parenting as an outcome of Residential Schools, the 60's scoop and the overrepresentation of Indigenous children in care (Anderson 2000; Lavell-Harvard & Lavell 2006, Lavell-Harvard & Anderson, 2014).

Prior to colonization Indigenous women were deeply respected and recognized as giving and nurturing life for their families and communities and from an Indigenous perspective " producing life and raising children are understood as the creation of a people, a nation and a future" (Anderson, 2000). It is clear that colonization has deeply impacted the mothering experience for Indigenous women and working to support the resurgence of Indigenous ways of mothering and fostering Indigenous women's access to their culture and land are vital to ensuring the overall health and wellbeing of Indigenous children, communities, families and future generations to come (National Collaborating Centre on Aboriginal Health, 2012).

Traditional Indigenous approaches to addressing substance use historically have been different from Western approaches. Indigenous healing traditions view the individual in relational, interdependent terms and Western approaches tend to view the individual as separate and independent (Niccols et al., 2010). It has been suggested that in order to more effectively meet the needs of Indigenous peoples, Western treatment providers need to understand traditional spiritual healing and to incorporate traditional practices and community-based models into programming (Blending Indigenous and Western). By engaging with Indigenous people from a place of cultural humility, health care professionals are better able to create a safer and more effective environment in which to offer care (FNHA, 2016).

The Realities of Indigenous Motherhood

by Andrea Landry Anishinaabe from Pawgwasheeng (Pays Plat First Nation)

My mother's resistance,
is my resistance.

My nokamis' resistance,
is my resistance.

My daughter's resistance
is my resistance.

And that is what will keep me going, every single day that I live, as an Indigenous mother.

Because if my mother survived in the struggle and my mother's mothers survived in the struggle, why would I give up?

Substance Use and Treatment Issues for Women

It is important to recognize and identify gender differences in substance use based on the complex interplay of differences in physiology/biology, sex and gender roles. Women are more likely to experience chronic pain and use prescription opioid medications for longer periods and in higher doses than men. Psychological and emotional distress has also been identified as a risk factor for prescription opioid use among women, but not among men (NIDA, 2018). Research has shown that the following complexities exist for women using substances from the effects of the substance itself to accessing services and supports:

BIOLOGY AND PHYSIOLOGY RELATED	GENDER RELATED
Women tend to have more drug cravings and may be more sensitive than men to the effects of some drugs	Women may experience interpersonal violence that increases risk of substance use
Women experience more physical effects on heart and blood vessels than men	The end of a relationship, loss of child custody, or the death of a loved one can trigger women's substance use, relapse or other mental health disorders
Brain changes that differ from men	Women may be reluctant to get help during or after pregnancy treatment due to stigma and fear of child welfare consequences
Women may be more likely to have panic attacks, anxiety, or depression related to the use of certain substances	Women often need help with child-care, home care and other family responsibilities in order to attend treatment
Woman may use small amounts for less time before becoming dependent	Women entering treatment are more likely than their male counterparts to report relationship problems, social isolation, fewer friends, and having partners who use drugs or alcohol
Among women, substance use tends to progress more quickly from first use to addiction and withdrawal may be more intense	

Sources: NIDA, 2018; Niccols et al., 2010

For some women substance use has been identified as a way to cope with emotional pain, violence and trauma. Childhood and adult sexual abuse are higher among women than men and experiences of violence and/or sexual abuse increase the risk of adverse outcomes from substance use (Bishop et al., 2017). Opioid use is associated with intimate partner violence among women and alcohol abuse can be up to 15 times higher for women who experience interpersonal violence (Niccols et al., 2010). A history of trauma was reportedly found in 55 – 99% of women who misused substances, compared to 36 – 51% in the general population (Bishop et al., 2017). Other adverse childhood experiences such as emotional abuse, neglect, problematic substance use among family members, mental illness, family breakups, incarceration of family members and witnessing violence in the home are known to increase the risk of harmful substance use (Bishop et al., 2017).

Concurrent disorders typically refer to the simultaneous occurrence of a mental health and a substance use disorder (Statistics Canada, 2017). A person with a mental health issue has a higher risk of having a substance use issue, just as a person with a substance use issue has an increased risk of having a mental health issue. The most common combinations are:

- Substance use disorders + anxiety disorders
- Substance use disorders + mood disorders

For perinatal substance using women with childhood trauma, particularly sexual abuse, the physical changes associated with pregnancy and the lack of control during birth can be catalysts for trauma from past abuse to resurface (LoGiudice, 2016). A history of sexual abuse can impact several aspects of a woman's childbirth, thereby affecting her long term physical and emotional wellbeing. This re-triggered trauma can impact a women's relationship with her loved ones, care providers, contribute to fears regarding labour and delivery and affect her ability to attach to her baby. Anxiety related to breastfeeding is not uncommon. Adverse childhood experiences together with the mental health sequelae (posttraumatic stress disorder, depression, dissociation) also contribute to adverse pregnancy outcomes (eg pre-term birth, low birth weight), poor post-partum mental health and impaired or delayed bonding with baby. (Sperlich, 2017).

> *"Shame is the intensely painful feeling or experience of believing we are flawed & therefore unworthy of acceptance or belonging." – Brene Brown*

> *"You cannot shame or belittle people into changing their behaviours." – Brene Brown*

Care providers benefit by recognizing typical indicators of trauma and elements of perinatal care that may become triggers for memories or adverse reactions for survivors of abuse. Universal trauma and violence informed practice is paramount to working with women at risk for re-traumatization. (Klaus, 2010). Demonstrating respect and enabling women to retain control is crucial. Getting to know women is important in the building of trusting relationships that will facilitate the delivery of sensitive care and enable women to feel safe so that the triggering of past memories of abuse is minimized in maternity care.

For women using substances in pregnancy, co-occurring mental health concerns may add complexity to their maternal health and supports needed. Ten to twelve percent of pregnant women are diagnosed with a major depressive episode, often as a postpartum depression, and up to 70% of women report some depressive symptoms during or shortly after their pregnancy (BC Ministry of Health, 2006). The risk of trauma and re-traumatization are magnified during pregnancy (Krausz, 2010). Women who use substances while pregnant face harsh criticism, stigma and discrimination. They also face a realistic fear of losing their children that in turn makes it difficult to reach out for support (Krausz, 2010).

Pregnancy

Substance use during pregnancy can be risky to the woman's health and that of her children in both the short and long term. Health outcomes for women and infants related to perinatal substance use depend on many factors such as the substance itself, substance use patterns, health care supports available and accessible primary care, family networks and community support, environmental factors and safe housing during preconception and during pregnancy. In general, opioid use during pregnancy can increase risks of preterm birth, low birth weight or symptoms of NAS (CEWH, 2018). Scientists are still learning about the overall safety of using long-term opioids during pregnancy. Some research has shown the effects of cannabis use during pregnancy is associated with smaller size at birth, low birth weight, increased risk of preterm labour, and increased risk of stillbirth (Luke, Hutcheon & Kendall, 2019).

Despite the fears and challenges of reaching out, pregnant women who use substances often attempt to reduce or stop their use, and are likely to seek health care for their unborn child. For some pregnant women using substances, reducing or stopping substance use without medical support/supervision can create additional health risks. Pregnancy presents an opportunity to provide medical care as well as to engage women in harm reduction, substance use education and treatment and other community supports (Krausz, 2010). Guidelines developed by the BC Centre on Substance Use (BCCSU) and Perinatal Services BC (PSBC) related to opiate use disorders recommend the following for pregnant women (BCCSU, 2018):

- Ask questions about substance use during prenatal assessment; (including a urine drug screen with consent)
- Offer the full scope of harm reduction supplies and services,
- Make opioid agonist treatment (OAT) available,
- Encourage breastfeeding and end the practice of separating the mother from her newborn child immediately after birth. Rooming-in is recommended as the standard of care for opioid exposed infants and treatment of Neonatal Abstinence Syndrome (NAS) should be conducted in rooming-in settings (BCCSU, 2018; Abrahams et al., 2007; Abrahams et al., 2010; Ordean et al., 2015)

The Centre for Excellence for Women's Health has developed a toolkit bringing together child welfare and substance use practice. Mothering and Opioids: Addressing Stigma- Acting Collaboratively (2019) is a toolkit designed for substance use and child welfare practitioners to work collaboratively with pregnant and parenting women using substances. The toolkit has practical exercises and approaches to:

1) Addressing stigma in practice;

2) Improving programming and services;

3) Cross-system collaboration and joint action; and

4) Policy Values.

http://bccewh.bc.ca/wp-content/uploads/2019/11/CEWH-01-MO-Toolkit-WEB2.pdf

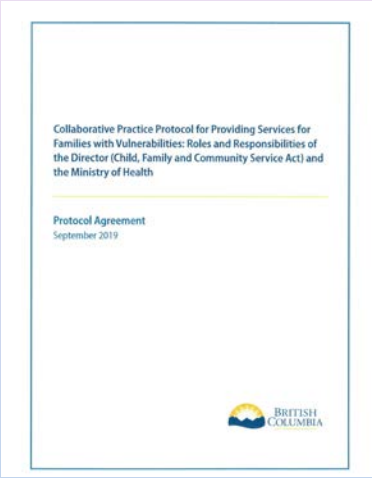
Rooming-In

The separation of women and their newborns including child removals are associated with a range of negative social and health outcomes (BCCSU, 2018), contribute to continued experiences of inter-generational trauma and substance use, and are not effective ways to engage women. The Rooming-In model promoting mother-baby togetherness is indicated as a best practice for substance-using women and newborns (Abrahams et al., 2007; Abrahams et al., 2010; Ordean et al., 2015). This approach treats the mother and the baby as a dyad and consists of "keeping mother and baby together in skin-to-skin and close proximity in order to enhance physical/emotional interactions through touch, sight, hearing, smell and taste" (Abrahams et al., 2007; Abrahams et al., 2010). Mother and baby are kept together in the same room at all times and family support is encouraged and facilitated (BC Women's Hospital, 2018). Evidence indicates, that even when medical therapy for NAS is initiated, rooming-in demonstrates several positive outcomes including improved attachment, communication, maternal self-confidence and stability, maternal emotional well-being, higher likelihood of breastfeeding, improved long term developmental outcomes, and reduced need for pharmacological treatment of NAS (Abrahams et al., 2007; Abrahams et al., 2010; Ordean et al., 2015). The practice of rooming-in is prominently featured in Eat-Sleep- Console (ESC), an evidence-informed approach to the non-pharmacological management of a newborn experiencing NAS (Grisham et al., 2019).

Parenting & Child Welfare

While stigma is experienced by substance users in general, society is particularly judgmental towards women who use substances while pregnant or parenting young children. The child welfare system response is frequently punitive and the assumption that a mother who uses substances is an unfit parent results in the child being removed from her care in a majority of cases. **Clinicians in Canada do not have a legal obligation to report prenatal substance use or other risks to the fetus during the course of pregnancy and maternal substance use alone is not grounds for the apprehension of the infant. The Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director (Child, Family and Community Service Act) and the Ministry of Health states the following regarding information sharing with MCFD/DAA and where the client is pregnant without children in their home:**

The Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director (Child, Family and Community Service Act) and the Ministry of Health



https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/collaborative_practice_relating_to_pregnant_women_protocol_agreement.pdf

"Any information that MCFD/DAA receives about a fetus from any sources cannot legally be considered a child protection report under the CFCSA (as there is no child). MCFD/DAA cannot use s.96 of the CFCSA to require disclosure of information with respect of a fetus (e.g. obtain information about a pregnant person in order to ensure the fetus will be safe when the baby is born). For infants at risk of child protection concerns, under s. 14 of the Child, Family and Community Service Act (CFCSA), health authority staff has a duty to report concerns regarding the safety and well-being of children promptly to an MCFD/DAA delegated worker."

The health and well-being of women and children are not well served by punitive approaches as many women do not access health care services and the outcomes are often poor for children raised in foster care (Kullar, 2009). In addition, a population based administrative cohort study in Manitoba demonstrates there is a significant mental health impact associated with removing a child from a mother by child protection services with complex grief experienced similar to the loss/death of a child (Wall-Wieler et al., 2018a). The period after a child removal presents risk of relapse, overdose, increased substance use and maternal mortality due to avoidable causes (Wall-Wieler et al., 2018b)

In regard to Indigenous families, the Truth and Reconciliation Commission of Canada calls upon all levels of government to "commit to reducing the number of Aboriginal children in care by providing adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and to keep children in culturally appropriate environments, regardless of where they reside" (Truth and Reconciliation Canada, 2015).

Indigenous children are overrepresented in the child welfare system. In 2016, there were 4,300 Indigenous children under the age of four in care (Statistics Canada, 2017). While 7% of children are Aboriginal, Aboriginal children account for nearly half of the children in care across Canada (Statistics Canada, 2017). A recent study in BC found that Indigenous babies are disproportionately removed from their mothers by Ministry of Children and Family Development (MCFD) child protection services (RCY, 2018). Removal of an infant at any point is disruptive to mother and baby bonding/attachment, and breastfeeding. Most removals involve 1) either taking a child into care or 2) developing a written voluntary care agreement with the custodial parent who is unable to take care of the child within the home. In 2017/18, 448 infants were removed under 12 months old and of those infants, 264 (59%) are Indigenous (RCY, 2018). In a review of 110 advocacy files where either MCFD or a Delegated Aboriginal Agency removed an infant and denied access to breastfeeding, social workers had differing and uninformed views on the safety of a mother's own milk when a woman was on opiate agonist therapy or using substances (RCY, 2018). This finding underscores the judgement and stigma that exists in child welfare agencies towards pregnant and newly parenting women using substances.

3.0 FIR

FIR is a provincial specialized perinatal service located in BC Women's Hospital and Health Centre in Vancouver BC. FIR provides care to prenatal and postpartum women who use substances, and to infants exposed to substances in a primary care/interdisciplinary team-based model. FIR opened in 2003 and is a first of its kind program in Canada.

FIR's mandate is to address the needs of antepartum and postpartum women who use substances and their infants exposed to substances in order to improve women's wellness and to ensure a safe labour and delivery. Through the provision of treatment and supports based on principle based practice and integrated programming, the interdisciplinary team at FIR focuses on stabilization and harm reduction within a recovery oriented approach to care..

The acute care program has 12 beds for women wanting to stabilize their substance use and address any pregnancy related concerns and/or withdraw from drug use during pregnancy. There is a centralized nursery for babies in need of specialized nursing care or babysitting however, the focus of the program is on keeping mother and baby together by rooming-in. FIR is a leading model of inpatient care, and as a teaching hospital, BC Women's is educating multi-disciplinary teams and physicians about trauma informed practice, harm reduction, and Indigenous Cultural Safety.

Care at FIR is provided by family physicians, alongside a multidisciplinary team that includes pediatricians, nurses, social workers, Elders, counsellors, dietitians, recreation therapists and other allied care providers. FIR consults with maternal fetal medicine, reproductive mental health, anaesthesia, Oak Tree HIV Clinic and Infectious Diseases at BC Women's Hospital.

FIR provides a recovery program and includes the provision of harm reduction strategies and approaches. Women at FIR have access to social workers to assist with child custody concerns, counselling and support to enhance critical coping and life skills. All disciplines provide education focussed on parenting skills and techniques. The program provides recreation and expressive art therapy, Indigenous cultural support through a First Nations advocate and Indigenous Elder, nutrition assessment and support from a dietitian and advocacy for housing, income, and other social needs.

Service Population

FIR is a provincial resource that provides care to prenatal, and postpartum women, and to infants exposed to substances. Women may be admitted who are actively using substances (poly drug use is common) and may be receiving opioid agonist therapy (OAT). Women often have unstable or precarious housing arrangements and may be low-income/receiving income assistance or living in poverty.

Substance use during pregnancy is often interconnected with issues such as trauma and interpersonal violence, lack of stable housing, social isolation, and racism (Poole & Isaac, 2001). Due to barriers in receiving care women may not have received any prenatal care. They may have complex medical issues related to lack of access to health care (e.g. HIV, Hepatitis C, and sepsis), concurrent mental health concerns, chronic disease and diagnosed or undiagnosed post-traumatic stress disorder (PTSD). Women may also be experiencing complications related to pre-term labour and placental abruption. Women may have partners who use substances. In most cases, there is MCFD

(Ministry of Child and Family Development) or Delegated Aboriginal Agency (DAA) involvement and potential for supervision orders. Many women have had unpleasant or traumatic encounters in acute care in the past and may be wary of trusting service providers. Approximately 70% of women at FIR identify as Indigenous. Some women may be engaged with FIR prior to labour and delivery and others are admitted in labour.

Many women using substances who are pregnant access FIR through *Sheway*, a community-based program located in the Downtown Eastside of Vancouver. Sheway is the Coast Salish word for growth. Sheway provides health and social service supports to pregnant and parenting women with children under age five and who are currently using substances or at high risk of relapse (RCY, 2018). The goal is for women to have choice in their care and to promote healthy pregnancies and positive early parenting. Sheway provides a full medical clinic, a daycare (Crabtree Corner operated by the YWCA), a drug and alcohol counsellor, daily hot lunches, grocery supports, practical support for securing housing and social benefits, parenting support, First Nations Support Workers, Elders in Residence and social workers - all available on site (RCY, 2018).

Model of Care Renewal

The increase in illicit drug related deaths resulted in BC's Provincial Health Officer declaring a public health emergency in 2016, and prompted several provincial initiatives to address this crisis. The BC Centre on Substance Use (BCCSU) and Perinatal Services BC (PSBC) developed new treatment guidelines to support women with opioid addiction (BCCSU, 2018). In 2018, BC Women's Hospital + Health Center launched the Provincial Perinatal Substance Use Project with the aim being to develop a provincial blueprint focussed on a continuum of care and supports for women who are pregnant/early parenting and using substances.

In order to continue providing the best level of care for perinatal women using substances, FIR engaged in a process to renew their model of care to integrate new evidence and to clarify care principles. The resulting aspirational model of care is a strengths-based approach to building on existing practices as well as establishing new practices and approaches as needed.

To renew the FIR model of care, nine weekly facilitated sessions and one-half day session was held from January 24 2019 – April 1, 2019, with the multidisciplinary team. FIR leadership worked alongside the Provincial Perinatal Substance Use Project team to guide the design of the working sessions. Representation across disciplines included Family Physicians, Pediatricians, Nurses, Pharmacist, Social Workers, Alcohol and Drug Counsellor, Dietitian, Recreational Therapist, Indigenous Health, Expressive Arts Therapist and Spiritual Care Practitioner.

Since FIR opened in 2003, the program has experienced increasing complexity in the needs of women and a lack of resources to adequately support women prenatally and postpartum. Feedback from women with lived experience at FIR through an expressive arts therapy project identified the following:

1) Need to address the issue of keeping woman safe when using substances,
2) Need to address programming gaps and keeping the women active and busy,
3) Ensuring patient respect and confidentiality and
4) Increasing safety during transitions and discharges.

Women with lived experience at FIR identified that having a mixed group of women at different stages of their journey can be challenging – some of whom are engaging in a recovery-oriented journey which may include reducing use or not using substances and others who are ambivalent regarding their ongoing substance use.

Philosophy of Care

FIR's mandate is to address the needs of antepartum and postpartum women who use substances and their infants exposed to substances in order to improve women's wellness and to ensure a safe labour and delivery. Through the provision of treatment and supports based on principle based practice and integrated programming, the interdisciplinary team at FIR focuses on stabilization and harm reduction within a recovery oriented approach to care. Programming and treatment are rooted in harm reduction in the context of recovery and the bio-psycho-social-spiritual framework which recognizes that substance use is the result of the complex interactions of biological, psychological, social and spiritual factors.

Recovery-oriented care involves healthcare providers working with individuals, their families (as appropriate) and their communities to reach their chosen recovery goals including healing and wellness. Healthcare providers build on personal strengths and skills to enhance health outcomes and quality of life and work within a trauma informed approach to support choices, build trust and to collaborate. This includes a broad range of activities that are person-centred, promote resilience, healing and wellness. A recovery goal is individually defined. It involves a person living a satisfying, hopeful, and contributing life, even when they may be experiencing ongoing substance use. A person's recovery goal may not include abstinence (Alberta Health Services, 2019). A recovery journey is a process of change on the way to reaching an individual's recovery goals, and healing and wellness. The person has increasing responsibility and control of their life to improve healing and wellness, and move towards hope and a positive identity (Alberta Health Services, 2019).

Recovery oriented care and harm reduction are not mutually exclusive. Neither approach focuses on abstinence. The focus is on the goals of the individual and ensuring that the individual understands the steps to reach their goals and the supports and services available to assist them to support their journey.

In addition, the bio-psycho-social-spiritual model of care is the accepted substance use practice model in British Columbia (BC Ministry of Health, 2011). This holistic approach to healing and wellness aligns well with Indigenous perspectives that recognize the continuous interaction of the physical, emotional, mental, and spiritual realities (BC Ministry of Health, 2011; Pathway to Hope, 2019).

Guiding Principles

4.0 SERVICE COMPONENTS

When a woman arrives at FIR, the team welcomes her and addresses her immediate needs for safety, comfort, support and builds readiness for engagement in stabilization and treatment. Women are supported to consider potential goals for stabilization and treatment. Informed consent is a particularly important process as part of admission and can be paced. Informed consent needs to address treatment, people who can be given information and potential referral opportunities. Initial assessment will focus on stabilization of acute medical and pregnancy related issues while at the same time assessing substance use. Information and documentation from assessments will form the baseline for developing a collaborative care plan with the woman at the centre of the planning. Ongoing assessment is conducted throughout the woman's stay in order to monitor her wellbeing and to address any concerns she may have. All assessments, care plans and programs are developed within the framework of trauma and violence informed practice, Indigenous Cultural Safety and harm reduction principles.

Assessment and Care Plans (not limited to):

- Medical and obstetric assessment, treatment and follow up
- Suicide risk assessment and plan
- Substance use assessment and treatment (e.g. withdrawal management, OAT including Injectable Opioid Agonist Therapy (iOAT) and follow up
- Individual nursing assessment and care plan
- Chronic disease management plan
- Functional cognitive health assessment (as indicated)
- Psychiatric assessment (as indicated)
- Reproductive mental health assessment (as indicated)
- Assessment and Treatment of NAS through consultative care with pediatricians
- Nutrition assessment and plan
- Psycho-social-spiritual assessment and plan
- Recreation/ and community orientation assessment and plan
- Discharge and Transition Plan

Healing and Wellness Programming:

A menu of options for programming is provided for women and their families (as appropriate) and revisited throughout her journey to support her goals within healing and wellness. Women are encouraged to participate consistently in core programs as soon as they are able and efforts are made to find balance between engagement, choice and routine for the women. Programming may be structured/stratified to plan for a woman's increasing capacity to engage post stabilization and while receiving treatment and care. Participation in programming is particularly encouraged on 'cheque day' when woman are especially vulnerable. Expanded programming will include evening and weekend activities.

Substance use group-based programming: (See Appendix for Detailed Summary)

- Seeking Safety: A modified version of Seeking Safety will be offered. Seeking Safety is an evidence informed integrated treatment developed to help those struggling with co-occurring trauma and substance use (Najavits et al., 1997) and has been recognized as a treatment that can integrate well with Indigenous healing practices (Marsh et al., 2016).
- Relapse Prevention: Relapse prevention and development of recovery skills and recovery capital will be taught using a modified version of the Matrix Model (Rawson & McCann, 2015).
- Dialectical Behavior Skills Training: Dialectical behavior therapy (DBT) was originally developed as a treatment for Borderline Personality Disorder (Dimeff & Linehan, 2008) but has been proven to be an effective approach with other issues, including substance dependency (Axelrod et al., 2010).
- Mindfulness: Evidence informed practices to support emotional regulation through focused attention and meditative practices and integrated with cognitive therapy, DBT, relapse prevention, (Sancho et al, 2018; Shi & MacBeth, 2017; Vieten & Astin, 2008).
- Smoking Cessation utilizing a harm reduction and contingency management approach
- Contingency Management: Providing motivational and tangible rewards to support positive behavioural change (McPherson et al., 2018).
- Psychoeducation (e.g. neurobiology, effects of substances, local resources, nutrition on a budget, etc.)

Healing and Wellness Specific:

- Peer Support Program: Women with lived experience provide support for women and their baby on the journey from community to acute and back to community. This support may include support at child welfare meetings, transition planning, navigating the health system and accessing recovery oriented supports and community services in their home community.
- Nutrition: Mother and baby nutrition groups will provide information about how substance use impacts nutrition and the role of nutrition in restoring physical and mental health. Nutrition information will include ideas for low cost healthy meals and infant/child nutrition. Opportunities for cooking healthy meals and snacks will be available.
- Recreation Therapy: Therapeutic Recreation activities such as 1-1 and group outings will be offered in order to model with women how to enjoy recreation and leisure activities without using substances, to enhance mental wellness, to improve social skills, have fun, and enjoy time with their babies. Woman will also be shown how, and encouraged to make use of community centres and other recreation resources post discharge in their home communities. Orientation to baby support services will also be provided in group settings. Activities such as cooking, sewing, beauty night, movie night and other opportunities for constructive “fun” will be provided.
- Women’s Wellness group (e.g, contraception, postpartum concerns including mental wellbeing)
- Legal Education – “Know Your Rights”
- Yoga classes will be facilitated by a trauma informed yoga instructor
- Acupuncture and other forms of complementary medicine
- Access to Registered Massage Therapy and Physiotherapy
- Spiritual Health support that primarily addresses celebration of births, spiritual distress, trauma and bereavement by creating ceremony, ritual, and meditative practices in one-to-one or group settings
- Expressive Arts Therapy in group sessions as well as 1-1 sessions (when indicated)
- Music therapy
- Pet therapy

- Therapeutic Gardening
- Traditional healing, Elder led healing circles

Indigenous Cultural Programming:

Indigenous cultural programming will take the perspective of culture as healing while taking the diversity of Indigenous people, language, cultural practices, and cultural beliefs into consideration during planning and providing the programming. **"**Our Elders are our cultural keystones. They provide connections to our Ancestors, teach us our history and help light our path forward in a good way. If the legends fall silent, Who will teach the children our ways." (Chief Dan George)

A sample of Cultural Programming at FIR:

- Elder teachings (Work to have xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səl̓ílwətaʔɬ (Tsleil-waututh representation)
- Drumming/making drums
- Celebrating the birth of the baby
- Cultural practices for birth and women's wellness
- Tobacco ceremony
- Access to land based healing and ceremony
- Elders on staff to support women and families (at least 2 Elders working in partnership)
- Welcome to the world ceremonies and end of life ceremonies
- Indigenous doulas
- Aunties to support women and families
- Indigenous Wellness garden with Indigenous medicines and Indigenous facilitator for medicines

Prenatal care and Infant development

- Prenatal classes
- Breastfeeding and formula feeding
- Infant first aid and CPR
- Safe sleeping
- Infant care - diapering, sleeping, consoling, infant massage
- Parenting classes
- Coping skills
- Volunteer Cuddling Program

Family Centred Opportunities:

- Monthly Family Days
- Celebrating Fatherhood and Fatherhood Supports
- Celebrating family supports from Grandparents, Aunties
- Parenting Together Classes
- Opportunities for women and families to revisit FIR with their child/children

Let Go

(A Poem from a Woman at FIR)

Let go of toxic relationships,
unhealthy friends, unhealthy choices

Let go of negative thoughts and
environments

Let go of self-harm, self-sabotage
'Old habits, die hard'

Let go of trauma, grief, unhappy memories
hurt from my past

If I Let Go…

I will be at peace within
I will be whole
I will be able to make
better choices

If I Let Go

I will find me again

Interdisciplinary Practice

Inter-disciplinary practice is necessary to achieve the best possible outcomes for patients on FIR. This translates to ongoing dialogue to ensure all disciplines understand the care plan and their role in supporting it. Effective communication among staff is promoted through:

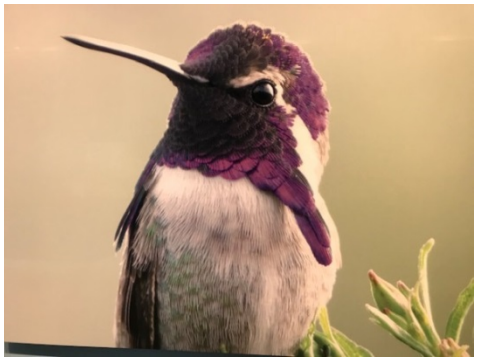
- Regular interdisciplinary team meetings
- Consistent and unified messaging from the leadership, clinical co-ordinator and amongst the team
- Daily huddles focussed on most urgent and challenging patient concerns
- Understanding between the disciplines roles, where there is overlap and how to communicate best with each other regarding who is doing what
- Documentation that is consistent and meets discipline documentation standards
- Regular case consultations and care planning with the women (and when appropriate their families)

5.0 DISCHARGE AND TRANSITION PLANNING

Planning for transition from FIR is a critical step for women and their families. The anticipation of leaving a safe environment often results in women feeling deep anxiety - whether they are leaving with their infant or not. The transition plan is a fluid document that is completed over the course of a women's admission. It may change with circumstances of birth, child custody and family supports however it must at all times reflect the wishes of each woman and the reality of accessible services. Transition planning needs to be led by each woman with the support of the FIR inter-professional team, family, friends, community supports and when appropriate MCFD/DAA. The transition plan must align with the woman's goals in order to be effective. Transition planning ought to begin as soon as a woman is admitted to FIR and stabilized. A key enabler for transitions for the FIR team will be strong awareness of community resources and supports available, how to access them and the ability to support a woman's decision-making to access services and supports. Whenever possible, community supports ought to be invited to meet with women on FIR and to a transition planning meeting with the patient at the centre. Peer support with transition planning is highly effective in ensuring all potential supports are identified and that woman's voices are heard.

A FIR transition plan will include (not limited to) the following elements:

- Primary health care for mother and babies
- Mental health and substance use supports in community and relapse prevention plan
- An OAT specific support plan including access to OAT prescribers in community
- FIR Outpatient support/Sheway/ Maxxine Wright Community Health Centre
- Public health nursing
- Indigenous serving agencies including Aboriginal Friendship Centres, on reserve supports etc.
- Safe/Supported housing
- Financial needs
- Community resources including access to food banks, community kitchens, community based supports for mothers and infants, local community centres etc
- Transportation needs
- MCFD/DAA involvement re: supervision orders etc.
- Opportunities to engage with peer supports



A FIR Discharge Plan includes all tasks that must be completed on or just before day of discharge. A FIR discharge plan (checklist) includes:

- Medications and arrangements for prescriptions including for OAT prescriptions
- Communication and arrangements with housing destination
- Safety Plan
- Relapse Prevention Plan reviewed
- Providing confirmation of discharge to MCFD/DAA
- Arranging transportation including support with car seats
- Notification of primary care provider
- Notification of Public Health Nurse
- Notification of community supports (A & D counsellor, outreach worker, etc.)

6.0 HARM REDUCTION AND ACTIVE USE

Harm reduction at FIR is situated in the context of recovery oriented care. As such, supporting women at any part of the recovery journey and recognizing each woman as an individual poses a challenge of providing safety and support for those actively using substances without compromising women who may be approaching recovery from a reduction or abstinence-based approach. Women who are seeking abstinence or attempting to reduce substance use may require additional support when triggered by evidence of active use by other women.

FIR is located within BC Women's Hospital which currently lacks designation as an overdose prevention site, hence there cannot be active substance use occurring in the rooms, bathrooms or on the unit. As women may be in the process of stabilization or may continue to use substances during pregnancy there is a responsibility to promote safe use and harm reduction approaches. Feedback from women with lived experience at FIR identified the need to address the issue of keeping women safe when using substances, as well as increased safety during transitions and discharges. Women are asked not to use alone and are facilitated with transportation and check-ins while accessing an off-site safe consumption or overdose prevention site. This can be facilitated by a peer support worker or FIR staff.

As active substance use must happen offsite, FIR has processes to support women by keeping the communication open, providing Take Home Naloxone (THN) kits at admission, providing training on their use and replenishing them often, providing THN and training (if needed) at discharge and providing harm reduction supplies. For women with the goal of reducing their substance use, the team can offer options such as the full spectrum of opiate replacement therapies, opiate replacement optimization, symptom management support, or support with newborn care in terms of breaks/breathers as alternatives to active use. Programming is also available to support recovery.

To support safer use, FIR will provide the women with education on safer substance use related to substance dosing, drug testing options, limiting polysubstance use, scheduling sleep breaks, partner's substance use and ensuring child care supports.

7.0 CHILD WELFARE ENGAGEMENT

The FIR team and social workers have an important role in interfacing with MCFD/DAA Social Workers as 95% of the women have some involvement or engagement with MCFD/DAA. In general, across the province, child removals have been increasing for Indigenous children and decreasing for non-Indigenous children over time. Contributing factors may include racial bias, lack of safe housing for pregnant and newly parenting women using substances and poverty. Prior to the opening of FIR, infants were routinely removed from women who used substances (RCY, 2018).

FIR has worked to advocate with women and families and have found certain strategies to support achieving a collaborative relationship:

WORKING WITH WOMEN AND FAMILIES	WORKING WITH MCFD/DAA
Maintaining transparency, honesty and building trust	MCFD/DAA and Fir staff collaborate in accordance to the Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities (2019)
Use a trauma and violence informed practice lens when supporting women and families (e.g traumatic experiences in health care, birth experiences, child welfare)	Ensures MCFD/DAA is aware through documentation of women and families strengths
Providing guidance on supportive parenting	Collaborates with MCFD/DAA to ensure assessments are conducted with a trauma and violence informed lens and practice
Support with income assistance and housing	Clarifying MCFD's concepts regarding safety (safe housing, safe space, safe substance use, etc)
Clarity on the use of urine drug screens and its potential impacts	MCFD/DAA leadership and Fir leadership and social work meet quarterly to ensure communication and collaboration in supporting women and families
Engages legal aid/advocacy for support and providing women with information on their rights	

FIR has articulated a goal of zero child removals in hospital that includes a clear and transparent process around planning, connecting to the mother-baby dyad when a woman has goals to parent, alternate caregivers and communities to support where a woman is unable to parent. When removals do occur or cannot be mitigated, FIR staff will ensure that MCFD/DAA provide a clear assessment prior to removal, clear direction on when and how the family will be reunified and ensure supportive processes are in place for the woman at discharge (BC Ministry for Children & Development Protocol, 2013). FIR and BC Women's Hospital are in the process of renewing a Memorandum of Understanding with MCFD to support early dialogue and planning around parenting. FIR is committed to providing consistent access to legal aid and/or legal advocates to provide information circles on the rights for families, who are involved with MCFD on the unit, sit in on MCFD/DAA meetings in an advocacy approach, interpret legal agreements and provide referrals as needed.

One model program with leading practices that can be applied to this work is the Journey to Zero (J20) project in Toronto where the central vision is that no child will grow up in care. Led by the Children's Aid Society, J20 is an innovative, urban-centered, newly formed child welfare prevention program with the overall aim to strengthen families so as to reduce the numbers of children/youth entering care and remaining in care. Commencing with a child welfare referral, services are delivered by community agencies that partner with child welfare and families to keep children and youth safe within their home, community, and culture. In BC, the percentage of Indigenous children and youth in care as compared to the total number of children and youth in care has increased from 56.4% in 2015 to 63% in 2018 (RCY, 2018). Between 2015 and 2018, the percentage of non-Indigenous children and youth in care at each fiscal year-end decreased by 26.6%, yet the percentage of Indigenous children and youth in care only decreased by 3.3% (RCY, 2018).

Outcomes for children and youth in care in British Columbia are dismal. Fewer than 51% of B.C. students in continuing care graduated within six years of starting Grade 8, compared to about 89% of the rest of the students in the province (RCY, 2018). Disparities are often worse when the student in continuing care is Indigenous or has a special need. As of as of December 2017, the provincial government was faltering in its efforts to find permanent homes for the children and youth in its care – particularly for Indigenous children and youth. The report, BC Adoption and Permanency Option Update (2017), indicates that only 84 B.C. children and youth in care were adopted during the first six months of the fiscal year and, of those, only 16 were Indigenous.

This discouraging data reinforces FIR's focus on eliminating child removals when at all possible. FIR works to develop collaborative relationships with MCFD/DAA by having regular leadership meetings to discuss opportunities to work together to better support women and families at FIR. Regular meetings will need to be extended to MCFD social work staff so that the process to access FIR is on a known schedule with shared, common understandings. In addition, FIR focuses on ensuring that when MCFD/DAA are involved with women and families that Indigenous cultural safety and trauma and violence informed practice is enacted and that MCFD/DAA provide supportive and safe practices. For example, when women are discharged with their baby, FIR requests MCFD/DAA to be present for discharge meetings in order to set the woman up for success upon her discharge from acute care into community. Additionally, if a baby is going into foster care then there is a two day discharge process. Starting day one, the woman and family are given the opportunity and choice to meet with the foster caregivers and provide their discharge teachings with FIR staff present. On day two, baby would be discharged into foster care with MCFD social worker present to answer any questions and provide clarification to the woman and family around questions and visits (set-up prior to discharge). As there is significant risk of relapse and mortality when a child is removed from a woman and her family, safety and safety planning must be a core consideration including ensuring facilitated contact with community resources. Women discharged from FIR will have a follow-up plan in the community that they have created with their care team including Public Health with wrap around services and supports.

8.0 ENGAGING WOMEN WITH LIVED AND LIVING EXPERIENCE

Women with lived and living experience at FIR are recognized as being experts in program design, planning and clinical practice implementation and there is primacy on the voices of women in altering how the program delivers services. Peer engagement in the design, planning and delivery of service and support is best practice. An important contributor to engagement and at times recovery, peer support is a supportive relationship between people who have a lived experience in common. The peer support worker provides emotional and social support to others who share a common experience. Peer support offers a level of acceptance, understanding, and validation not found in many professional relationships (Mead & McNeil, 2006; Tracy & Wallace, 2016). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards helping others to build fulfilling, self-determined lives for themselves. Despite evidence of the benefits, for both individuals and families, peer support programs have yet to receive the focus, funding, and attention needed.

FIR is working to establish regular processes to engage women with lived and living experience for real time program changes that best fit the needs of the women. To this end FIR has engaged women with lived and living experience in recent projects to support planning in the following areas:

- Expressive Arts Therapy Project, Phase 1 and Phase 2
- Implementing regular community meetings where a small staff complement provides a safe space for women to discuss areas for improvement, issues and concerns on FIR and how these concerns could be addressed
- Healing and wellness consultations – what does it look like and mean to women with lived and living experience
- Hire a full time, paid Peer Support Position, providing equitable pay

9.0 CONNECTION TO BC WOMEN'S HOSPITAL AND HEALTH CENTRE

As FIR is situated within BC Women's Hospital, FIR patients will access other services within the hospital when receiving prenatal and postpartum care. There are opportunities to better engage neonatal intensive care units, pediatrics, other maternity units, outpatient services and the Urgent Care Centre in providing care to the pregnant and parenting women using substances in non-judgemental, non-stigmatizing and trauma-informed ways. There are also opportunities to share knowledge regarding substance use and to decrease stigma by educating medical, nursing and allied health staff regarding working with women using substances in terms of principled practice and clinical practice. Mechanisms such as structured training opportunities with significant reach may support increased knowledge and awareness about perinatal substance use on site. Clinical opportunities include warm handovers (informed by the woman's choices, transparent and clear when sharing the woman's information) and transfers between units and huddles to support patient care.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

10.0 WORKFORCE DEVELOPMENT

Caring for women using substances requires commitment and application of principle based practices and approaches. Central to workforce development, how staff are recruited, hired, oriented, supported, trained and clinically supervised will be an area of focus for FIR leadership. Clinical supervision will support staff in enhancing skills and competencies and provide support for compassion fatigue, moral distress and vicarious trauma. Team based approaches will include working in a resilient teams framework – bringing individual, team and systems level resiliency together. FIR staff and leadership will have core knowledge and competencies in the following evidence informed practices:

BUILDING ON THE PHILOSOPHY OF CARE	ENHANCED THERAPEUTIC APPROACHES	MEDICAL MANAGEMENT AND SUPPORT
safeCARE Training	Reflective Practice	OAT/Pregnancy and Opioid Use Disorder Guidelines (BCCSU, 2017)
Indigenous Cultural Safety - It starts with me (FNHA, 2016)	Motivational Interviewing (Ogborne et al. 2005; Rubak et al., 2005)	Withdrawal Management
San'yas Indigenous Cultural Safety (PHSA)	Dialectical Behavioural Therapy (Dimeff & Linehan, 2008)	Eat Sleep Console-Weight for the nonpharmacological management of NAS (Grisham et al., 2019)
Trauma and Violence Informed Practice (CEWH, 2019)	Cognitive Behavioural Therapy	Pharmacological management of NAS
Harm Reduction Foundational Training (Nathoo et al., 2015)	Seeking Safety (Najavits, 2002;	Addiction medicine
Rooming In Guideline	Centre for Substance Abuse Treatment, 2009)	Core competencies for nursing (including perinatal and substance use/concurrent disorders)
	Mindfulness practice (Sancho et al, 2018; Shi & MacBeth, 2017; Vieten & Astin, 2008)	BCCSU Addiction Treatment and Care Online Certificate
	Relapse Prevention (Rawson & McCann, 2015)	Development of a Perinatal Speciality Nursing Pathway for Perinatal Substance Use
	Contingency Management (McPherson et al., 2018)	Obstetrical assessments

11.0 STAFFING MODEL (aspirational)

The aspirational staffing model at FIR will be instrumental to achieving the goals set out in FIR model of care. It is recommended that augmentations occur in medical, nursing and allied health staffing to account for expanded and enhanced assessment, stabilization and treatment practices and expanded programming to provide the best possible care for pregnant and parenting women using substances. Areas that are bold represent augmentation to the existing staffing model.

MEDICAL STAFFING	NURSING STAFFING	ALLIED HEALTH STAFFING
Medical Director 3 Family Physicians (Sessional) **1 Psychiatrist (Sessional)** **1.0 FTE Nurse Practitioner**	**1.0 FTE Patient Care Coordinator** 0.5 FTE Educator 17.0 - 22.0 FTE Nurses including addiction and mental health specialization **1.0 FTE Nurse/Outpatient Staffing Complement**	**2.0 FTE Social Workers** 0.25 FTE Pharmacist **0.5 - 1.0 FTE Dietician** **0.5 - 1.0 FTE Alcohol & Drug Counsellor** **0.5 - 1.0 FTE Recreation Therapist** **0.5 - 1.0 FTE Expressive Arts Therapist** **Doula - Weekly Consultations** **Lactation Consultant - Regular consultations** Indigenous Elders (at least 2 Elders working in partnership) Legal Advocate and/or Legal Aid 0.4 FTE Spiritual Care **1.0 FTE Peer Support** **0.4 FTE Research Manager** Complementary Alternative Medicine RMT/Physiotherapy Volunteers including cuddlers, patient navigation support

12.0 SAFETY AND WELLNESS OF PROVIDERS

Trauma and violence informed organizations apply the same principles of safety, collaboration and empowerment to staff as they do to patients. Providing the best trauma informed services requires an "organizational environment of care for the health, wellbeing and safety of, as well as respect for, it's staff and that the culture of care must permeate the organization from top to bottom" (SAMSHA, 2014). It is important to recognize that the care at FIR will be delivered in a trauma and violence informed approach, and not trauma specific or trauma counselling approach (Bloom & Farragher, 2013). There is an opportunity for FIR to partner with Interprofessional Practice at C&W Health Centre to align to organizational approaches to staff safety and wellness.

Working with patients who have experienced trauma impacts staff members, and many workers may have their own histories of trauma. Additionally, secondary stress reactions and vicarious trauma are normal for staff working with this population. It is paramount that this be viewed as a systemic issue rather than evidence of pathology or weakness of staff members who may experience it.

Trauma informed organizational practices adapted from SAMHSA (2014) and the BC Trauma Informed Practice Guide (CEWH, 2012) suggest the following strategies to consider when striving for a trauma informed organization/department/team:

SAFETY	• Physically safe environment • Regular assessment of safety • Seeking input from staff on safety concerns and actioning feedback • Critical incident debriefings by appropriately trained staff
POLICIES AND PROCEDURES	• Respectful communications • Maintaining confidentiality • Self-care related policies and modelling by leadership • Opportunity to provide input to policies
UNDERSTANDING TRAUMA	• Ongoing training in trauma, mental health, substance use and Indigenous Cultural Safety • Information on signs of vicarious trauma • Support for vicarious trauma • Opportunity to discuss ethical issues, questions and boundaries
STAFFING CONSIDERATIONS	• Clear and well defined roles, responsibilities and expectations • Team building activities • Support for resolving conflict and addressing challenging team dynamics
TEAM-BASED CONSIDERATIONS	• Adequate staffing levels • Manageable allocation of patients to staff • Patient experience review and debriefing processes • KE opportunities, staff development and continuing education • Peer support

13.0 EDUCATION AND TRAINING

Education, training, and performance support for the interdisciplinary team is necessary to implement and sustain the practice changes at FIR. The education approach at FIR includes a combination of formal learning events (online, blended, and classroom) along with performance support activities (e.g. coaching, mentoring, job aides) over time to embed and support key practice shifts. Performance support ensures that transfer and sustainment of practice occurs by reinforcing and consolidating formal training with supportive activities.

As previously identified in this document, the major components of the education and performance support include trauma and violence informed care, Indigenous Cultural Safety, substance use, harm reduction, and the various aspects of mother baby togetherness, such as rooming in, safe sleeping and the use of Eat, Sleep, Console, Weight (ESC) for substance exposed or affected babies and their caregivers. Implementing the five moments of need approach (see below), (Mosher & Gottfredson, 2010) will help distinguish when to employ formal training (online or classroom training) and performance support activities (coaching, mentoring, job shadowing, practice, job aides).

ACQUISITION OF KNOWLEDGE	
1 When Learning for the First Time	Training
2 When Wanting to Learn More	Training
APPLICATION OF KNOWLEDGE	
3 When Trying to Remember and/or Apply	Performance Support
4 When Things Change	Performance Support
5 When Something Goes Wrong	Performance Support

Planned formal, structured education and training offerings for all FIR staff include:

- 2 day classroom training in Motivational Interviewing
- 2 day training in “safeCARE”
- Online learning modules for ESC
- Online learning modules for addiction treatment including perinatal substance use

In addition to these formal events, there are multiple existing self-paced online resources for trauma informed practice, motivational interviewing, harm reduction, and Indigenous cultural safety which can be shared with staff to access as appropriate or as part of a learning plan.

Application of knowledge, or performance support, will be supported through:

- On the job learning
- Coaching and mentoring
- Demonstration, simulation, and role play
- Team discussion and daily huddles
- Clinical supervision
- Peer involvement/peer led education
- Building in time for debriefing
- Job aides (FAQs, algorithms, reference sheets, protocols)
- Access to resources and policies through existing organizational content management systems

A sustainment plan for education and training is necessary to address the onboarding and orientation of new staff following the FIR model of care renewal. All resources and education will be worked into annual goals, reviewed at regular, set intervals to ensure content is current and desired changes in practice are occurring.

14.0 RESEARCH AND EVALUATION

FIR will collaborate with the Women's Health Research Institute to plan and conduct research and evaluation that aligns to the needs of women with lived experience, advances maternal and newborn health, advances clinical practice at FIR and connects with broader research at the BC Women's Hospital. A 0.4 FTE Research Manager will be embedded on the FIR team and work together to explore research opportunities and co-ordinate all research activity. A critical component for research and evaluation will be developing data infrastructure to collect/record information regarding patient characteristics, FIR access and utilization characteristics, and clinical service delivery and treatment related data. Additionally, it will be important to collect and record information on transition planning, MCFD/DAA engagement, community partner and housing supports. Taken together, the information will help us visualize a women's journey from community to acute care to community and assist with identifying leading practices and opportunities for quality improvements and enhancements.

Ongoing engagement of women with lived and living experience through community meetings and other structured and non-structured formats for providing feedback about their experiences at FIR will guide planning and timely quality improvements. The feedback of women with lived and living experience will be documented and used to support service design and improvements.

Appendix 1: Evidence informed programming

Contingency Management (McPherson et 2018).

Contingency management is an effective behavioral treatment approach commonly applied to substance-use treatment. Contingency management involves a structured approach to support, reward and reinforce behavioural change.

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is a structured goal-directed form of psychotherapy in which patients learn how their thought processes contribute to their behaviour (Noorani & Severn, 2010). Increased cognitive awareness is combined with techniques to help patients develop new and adaptive ways of behaving and alter their social environment, which in turn leads to change in thoughts and emotions (Noorani & Severn, 2010). CBT is effective for the treatment of substance use disorders as monotherapy or as part of combination treatment strategies (McHugh et al., 2010).

Dialectical Behavior Skills Training (Linehan, 1990; Dimneff & Linehan, 2008; Axelrod et al., 2011)

Dialectical behavior therapy (DBT) was originally developed as a treatment for Borderline Personality Disorder but has been proven to be an effective approach with other issues, including substance dependency. DBT specifically focuses on providing therapeutic skills in 4 main areas: Mindfulness; Distress tolerance; Emotion regulation; and Interpersonal effectiveness. DBT skills are best learned in a group format as the ability to practice with peers is critical.

Mindfulness (Sancho et al, 2018; Shi & MacBeth, 2017; Vieten & Astin, 2008)

Mindfulness skills have traditionally been used in meditation practices and have recently been proven to be effective when integrated with cognitive therapy, DBT and relapse prevention. Mindfulness practice can: reduce the tendency to act impulsively without thinking of consequences; increase self-awareness and awareness of triggers and cravings; increase awareness of high-risk situations and ability to react skillfully; increase awareness of how thoughts influence behavior. Mindfulness skills will be taught in group format.

Motivational Interviewing (Rollnick & Miller, 1995; Miller & Rollnick, 2012)

Motivational Interviewing (MI) is a collaborative conversation to strengthen a person's own motivation for and commitment to change (Rollnick & Miller, 1995; Miller & Rollnick, 2012). MI is an evidence based practice that has been adapted over time for different roles, contexts, and issues. It may be used to different degrees by a range of health care providers to support behavioural change. MI is more than the use of a set of technical interventions. It is characterized by a particular "spirit" or clinical "way of being". The key elements of the 'spirit of MI' are:

- collaboration (vs. confrontation)
- evocation (drawing out rather than imposing ideas)
- autonomy (vs. authority)

The principles that guide MI are to express empathy, support self-efficacy, to roll with resistance, to develop discrepancy when there is a mismatch between where the person is at and where they want to be and their future goals.

Relapse Prevention (Rawson & McCann, 2015)

Relapse prevention and recovery skills will be taught using a modified version of the Matrix Model of Intensive Outpatient Treatment. This model includes a set of evidence-based practices including cognitive behavioral therapy, psychoeducational information, motivational interviewing strategies, relapse prevention research and encourages self help participation. The Matrix Model recommends sessions to educate family members about substance use, dependency and recovery. This model is offered in group format as peer support is considered to be a critical part of recovery. The Matrix Model also encourages involvement of people with lived experience of addiction and recovery.

Seeking Safety (Najavits, 2002; Najavits et al., 1997)

A modified version of Seeking Safety will be offered in a group format. Seeking Safety is an evidence based, integrated treatment developed to help those struggling with co-occurring trauma and substance use. The Seeking Safety model is positive, strengths-based, respectful, supportive, and collaborative (Niccols et al., 2010). While it addresses the role of trauma in substance use it does not require deep exploration of trauma. Seeking Safety is present focused and teaches coping skills to overcome the past and create a more meaningful life today. Topics address cognitive, behavioural and interpersonal skills and encourages clients to engage in community resources. Similarities have been acknowledged between Seeking Safety and an Aboriginal traditional healing approach (Niccols et al., 2010). The Seeking Safety manual is recognised as culturally sensitive and empowering and incorporates elements that may have been missing from other treatment models that have led to the higher attrition rates with Aboriginal participants (Niccols et al., 2010)

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