Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop

June 1, 2018

REPORT OF PROCEEDINGS

Provincial Health Services Authority
Province-wide solutions. Better health.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Perinatal Services BC
An agency of the Provincial Health Services Authority

Acknowledgements

The *Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop* was hosted and sponsored by the Provincial Health Services Authority (BC Women's Hospital + Health Centre and Perinatal Services BC).

Many individuals and organizations made the workshop possible, with significant thanks offered to members of the organizing committee:

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

Tamil Kendall, Interim Provincial Executive Director, Perinatal Services BC (PSBC)

Joanne Wooldridge, Program Director, BC Women's Hospital + Health Centre

Zoë Miller-Vedam, Project Coordinator & Acting Executive Assistant, PSBC

Leona Graham, Executive Assistant, BC Women's Hospital + Health Centre

Additional support and thanks are extended to Elder Roberta Price for opening the workshop with a traditional First Nations prayer, Vicki Farrally for facilitation, Sam Bradd for live graphic recording, and Penelope Hutchison for report writing.

The organizers would like to thank the more than 90 health care professionals, health administrators, and health system leaders who attended from across B.C. Their thoughtful insight and input resulted in innovative recommendations for improvement and action to realize better care and better outcomes for pregnant and newly parenting women with opioid use challenges.

Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop

Executive Summary

On June 1, 2018, the Provincial Health Services Authority (BC Women's Hospital + Health Centre (BCW) and Perinatal Services British Columbia (PSBC)) brought together more than 90 health professionals, health administrators and health system leaders from across B.C. for the *Ensuring Best Care and Supports to Pregnant and Parenting Women with Opioid Use Challenges Visioning Workshop*. The objective was to review new provincial and national perinatal substance use treatment guidelines, shine a light on exemplary models and practices in B.C., identify gaps and areas for improvement at the regional and provincial levels, and build a common vision for action across the province. From the workshop, it is clear there is a strong provincial consensus on the importance of implementing evidence-based, woman-centred, harm reduction, trauma-informed and culturally-safe care for women who experience problematic substance use and their children. This meeting identified shared principles and some key action areas for moving forward.

Principles of Care

The newly released guideline, *Treating Opioid Use Disorder During Pregnancy: Guideline Supplement*, developed by PSBC and the BC Centre on Substance Use (BCCSU), provides recommendations to enable health professionals to break down barriers and establish a standard of care to ensure both mother and child have the best possible health outcomes. The key recommended care principles are for health professionals to:

1. Establish a trusting and collaborative patient-provider relationship;
2. Apply the principles of trauma-informed and culturally safe practice;
3. Provide integrated and individualized care management;
4. Assess each patient's basic medical and psychosocial needs and make appropriate referrals to secure social determinants of health; and
5. Offer the full scope of harm reduction supplies and services.

Principles in Practice

B.C. is home to exemplary models of care for pregnant and newly parenting women and their infants that go beyond a focus on managing withdrawal and treatment to include collaboration with supports and resources to improve women's and families' social determinants of health, such as adequate nutrition, safe housing, and other psychosocial supports.

The B.C. experience shows both that these wrap-around supports are critical, and that the core elements of the services can be offered in both urban and rural settings. Common elements include provision of or connection to low barrier primary medical care, one-on-one and group counselling and meeting basic needs like food and clothing. All models offer outreach assistance to help women navigate different systems from child welfare to income assistance, housing to legal advice, and many programs offer the cultural support of an Indigenous Elder.

For in-hospital care, rooming-in is evidence-based practice and the standard of care. Programs like FIR Square Combined Care Unit at BC Women's Hospital + Health Centre and other sites across the province where mothers and babies are kept together on the ward have demonstrated the benefits and safety of mother-baby care in acute settings. FIR Square's multidisciplinary team helps women and infants stabilize safely. When needed, extended stays support linkages to psychosocial resources to help families transition back to the community.

A central tenet of the programs, from community to acute care, is the provision of woman-centred, harm reduction, trauma-informed and culturally-safe care with low barrier services where women determine at what level they will engage with the program. All service models are adaptable to individual settings, and a repeated message was that new programs do not need to have all elements in place to begin.

Recommendations for Improvement + Action

Visioning Workshop participants identified opportunities for improvement consistent with the recommended care principles and evidence-based practices. Common themes emerged from within community and acute care, and between regions, with some innovative actions proposed to foster better care and support for pregnant and newly parenting women with substance use issues and their infants. Key recommendations included:

1. Call for Executive Level Attention to Perinatal Substance Use

Garner executive attention from within the highest levels of the health system and health authorities to the issue of perinatal substance use and make the issue a priority with concomitant support, funding and resources to implement evidence-based practices and recommended care standards across the province.

2. Make Rooming-in the Standard of Care Across the Province

Make rooming-in the standard of care at all hospitals, promoting mother and baby togetherness across all regions and at all levels of care. Create and share guidelines for rooming-in practices with hospitals across B.C. so there can be "no more excuses" to continue practices of separating mothers and babies or discharging mothers but keeping infants in hospital.

3. Educate, Train and Support Health Professionals and Others in Evidence-Based Practices

a. Standardize interdisciplinary health provider education and training to incorporate recommended treatment guidelines and care principles in treating pregnant and newly parenting women with opioid use challenges. Educate and support providers to provide evidence-based care through mentorship and ongoing supervision-type relationships. Creating support networks to include rural and remote providers, and ensuring access to experienced practitioners across the province are critical and technology can be leveraged to support such networks.

b. Build communities of practice of multidisciplinary providers through community round tables to foster interprofessional collaboration, including the Ministry of Children and Family Development (MCFD), to share best practices and include Indigenous Elders and women with lived experience to incorporate their knowledge.

c. Develop a strategy with the Ministry of Children and Family Development to train and educate social workers in trauma-informed practice to engender a culture shift within MCFD. Standardize MCFD practices across regions to allow opportunities for early bonding and attachment and better informed and supported decision-making for women and families.

4. Support Expansion of Integrated Service Models

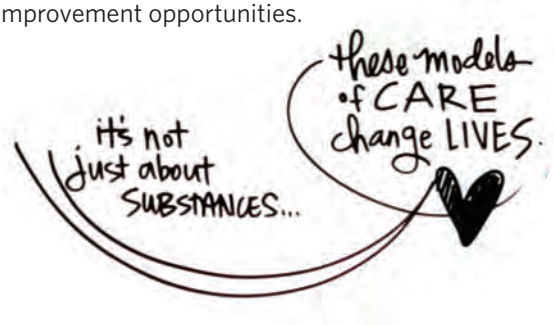
a. Provide funding to communities to establish or enhance integrated service models for pregnant and newly parenting women and infants with substance use issues and integrate Primary Care Networks in the delivery of evidence-based care to this population. Provide women with 1:1 supports to navigate systems and to provide a seamless continuum of care.

b. Create a provincial best practice framework and standardized approach to care based on the key elements of the exemplary service models that can be adapted by different communities.

c. Create opportunities for mother-baby and family foster care by expanding the concept of rooming-in beyond the hospital to create mother-baby and family foster care with wrap-around community supports. Train and establish a network of family foster care coaches and mentors and move away from the model of infant-only foster care provision. Work to keep foster care in the local community by funding local people (e.g., Indigenous grandmothers) to foster mothers and babies.

Next Steps

PHSA is committed to exploring opportunities for investment and support to realize key recommendations for improvement proposed by Visioning Workshop participants. A central focus of our efforts will be to support ongoing networking among workshop participants and the cross-pollination of the ideas for action highlighted during the day's discussions. This report of the proceedings will be shared among all participants to distribute within their organizations and networks towards the aim of facilitating further dialogue, support and improvement opportunities.



Contents

PART 1:
Setting the Context

Pregnancy and parenting can be a positive turning point for women with substance use issues. In British Columbia (B.C.), experience shows that providing trauma-informed, culturally safe and harm reduction-oriented care across the care continuum can change lives. Innovative models of care can improve breastfeeding outcomes, reduce the need for medication for neonatal withdrawal, increase maternal custody in both the short- and long-term, support access to safe housing, and improve health outcomes for women and their infants. There are numerous gaps in the current system that do not foster best health outcomes and actually present barriers, and there are a number of leading exemplars that challenge the status quo with demonstrated outcomes that show that we can be supporting women better and have more positive intergenerational impacts.

On June 1, 2018, the Provincial Health Services Authority (BC Women's Hospital + Health Centre (BCW) and Perinatal Services of BC (PSBC)) brought together more than 90 health care professionals, health administrators, and health system leaders and others from British Columbia's (B.C.'s) perinatal and mental health and addictions sectors for the *Ensuring Best Care and Supports for Pregnant and Parenting Women with Opioid Use Challenges Visioning Workshop*. The objectives were to profile new provincial clinical guidelines for the treatment and care of women with opioid use disorder and their infants, shine a light on care principles, best models and practices in B.C., and build a common vision for action across the province.

The morning presentations detailed new provincial and national guidance that establish a comprehensive framework for best care, while the subsequent presentations from service agencies demonstrated how the guidelines and principles could be implemented in primary care, community, and acute care settings. The objectives of the morning plenary were to:

- envision a future in which women experiencing substance use challenges and their infants reliably and consistently receive evidence-based care in a context of respect and safety;
- review provincial and national principles, guidelines and good practices for pharmacological and non-pharmacological interventions for best care of women with opioid use problems and their infants during the perinatal period;
- share exemplary B.C. models of care from urban and rural areas and across the continuum of care; and
- understand the implications for women, their newborns and families of the First Nations Health Authority's (FNHA) policy statement on Cultural Safety and Humility.

The afternoon centered on small group discussions among participants, first within similar sectors (community-based and acute care) and then within the same health region. The afternoon's objectives were to:

- discuss the application of provincial and national principles, guidelines, and good practices within the primary, community, and acute care sectors across B.C.'s regional health authorities;
- provide a context for stakeholders working in the same sector (e.g., community or acute care) to discuss and explore sector-specific practices, models, and areas for improvement;
- provide a context for regional leaders and clinicians to discuss, assess, and explore their own current local service responses, including successes, gaps, and opportunities for improvement; and
- support regional leaders and clinicians to envision and initiate planning for priority service improvements based on recommended care principles, guidelines, and good practices.

Keynote Address: The Evolution of Care

Dr Lenora Marcellus, PhD, Associate Professor in the University of Victoria's School of Nursing, delivered the keynote address, providing a historical overview of the health system's treatment of women with opioid issues and their infants.

Opioids have been used for centuries to deal with everyday symptoms, especially for women and infants. Opium and cocaine were once ingredients in "infant preservatives" for excessive crying, colic, and sickly babies.

Practitioners first started recognizing the symptoms of substance use in pregnancy in the later part of the 20th Century. Key landmark dates include:

- **1960s**: Thalidomide, a drug prescribed to women to treat morning sickness, resulted in infants born with malformed limbs.
- **1970s**: The terms Fetal Alcohol Spectrum Disorder (FASD) and Neonatal Abstinence Syndrome (NAS) were coined as health care providers defined the symptoms and developmental delays they saw in exposed infants. However, a gap in training and education left providers without adequate knowledge of how to treat women and infants.
- **1980s**: The first specialized program for infants with NAS was created at Sunnybrook Hospital in Toronto. The recommended treatment was to reduce all infant stimulation and babies were removed from their mothers and cared for in dark, quiet areas.
- **1990s**: B.C. led the way in developing new models of care with the establishment of Sheway in 1993, the first pregnancy outreach program for substance-using pregnant and newly parenting women based on harm reduction principles. In 1999, the BC Reproductive Health Program (now Perinatal Services BC), released the first care and treatment guidelines for women with substance use issues and their infants.
- **2000s**: In 2003, the Families In Recovery (FIR) Square Combined Care Unit opened at BC Women's Hospital, Canada's first inpatient program treating pregnant substance-addicted women and their infants based on trauma-informed, harm reduction principles.

Sheway and FIR Square have since become leading-edge models of care that other health systems nationally and internationally seek to emulate. Research on their care models found that separating mothers and babies does more harm than good, and that the biggest impacts on health outcomes are not pharmacological but in promoting the practice of rooming-in. Marcellus said care practices once considered disruptive, such as keeping mothers and babies together, are now promoted as standard of practice. She said B.C. needs to continue to raise the bar when it comes to leading-edge care, for example by incorporating recommended practices such as rooming-in into quality improvement efforts across the province.

> "The biggest impact on health outcomes are not pharmacological but in promoting the practice of rooming-in." – *Dr Lenora Marcellus*

PART 2: Principles and Guidelines

Appropriate care for opioid use disorder during pregnancy, intrapartum, and the postpartum period has been shown to significantly improve pregnancy outcomes for women and infants. Yet stigma surrounding opioid use during pregnancy and lack of knowledge regarding appropriate treatment options and approaches to care among health care providers and by women themselves present barriers to this population seeking treatment. Recently released provincial and national care principles and clinical guidelines outline available care and treatment options, and underscore the essential role of non-judgemental, women-centered and trauma-informed care.

Cultural Safety and Humility

Dr Cornelia (Nel) Wieman, MD, Senior Medical Officer, Mental Health and Wellness with First Nations Health Authority (FNHA), highlighted the health authority's policy statement on *Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in British Columbia.*

Wieman said many First Nations people have had or witnessed harmful experiences in health care settings—ranging from not being accurately diagnosed when presenting at hospital emergency departments to having their health concerns discounted, assumptions made about their behaviour, their rights undermined, or their cultural beliefs and practices shunned. FNHA is working to combat the racial biases, stereotypes, and discriminatory ideas that still exist today by advancing cultural humility and safety across the B.C. health system.

- **Cultural safety** is defined as respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. Its implementation results in an environment where people feel safe when receiving health care.
- **Cultural humility** is a process of self-reflection to encourage people to understand personal and systemic biases, with the aim to develop and maintain respectful relationships based on mutual trust. Cultural humility involves seeing oneself as a learner when it comes to understanding another's experience.

In July 2015, the Ministry of Health and all B.C. health authorities signed a Declaration of Commitment to Advancing Cultural Safety and Cultural Humility within Health Services. Since then, more than 650 individuals have signed pledges on "my commitment to cultural safety and humility". Wieman encouraged participants to visit the FNHA website to access multiple resources from webinars to cultural safety training modules to improve their understanding and champion cultural safety and humility. (http://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf)

Principles of Trauma-Informed and Gender-Responsive Care

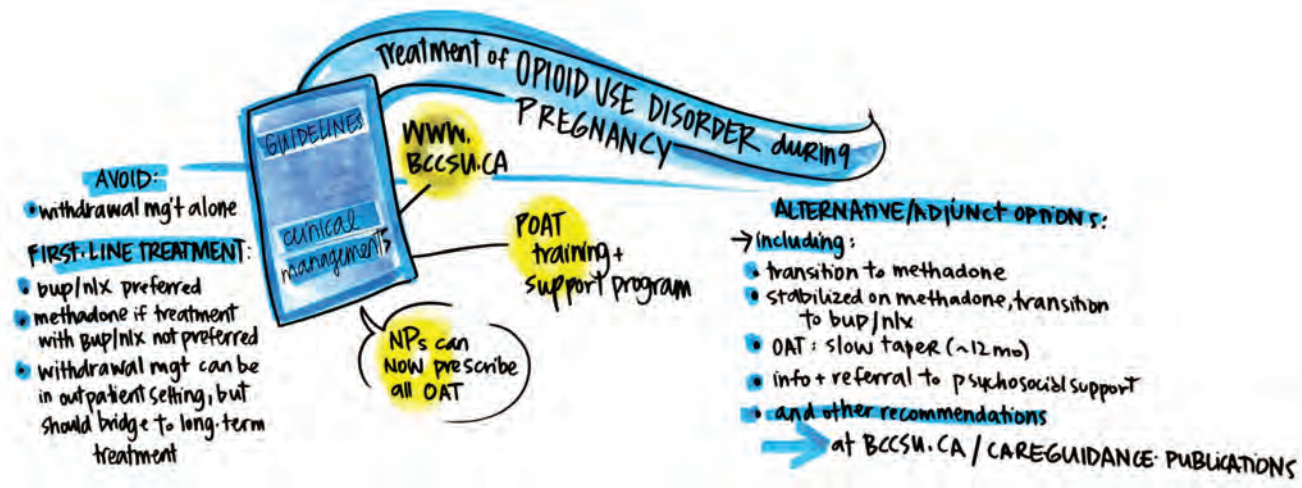
Dr Nancy Poole, PhD, Director of the Centre of Excellence for Women's Health (CEWH), has led several national projects on gender and trauma-informed practices in the substance use field. Her work has informed the development of four principles for the delivery of responsive care for women and girls. The principles are:

1. **Trauma-informed**: This approach recognizes that trauma and violence are common in the lives of girls and women and identifies their need for physical and emotional safety, as well as choice and control in decision-making. Disclosure of trauma is not required in trauma-informed services, but services should be provided in a way that supports safety and empowerment and avoids re-traumatization.
2. **Harm reduction**: This concept is about recognizing the importance of providing support to women who do not have immediate goals for cessation. Harm reducing approaches are non-judgmental and non-coercive; help women to reduce harm to their health, and to have agency in the type and extent of change they make in their substance use and overall health and wellness.
3. **Cultural safety**: The aim with cultural safety is to build respectful and reciprocal relationships that acknowledge differences and create safe ways to interact. Key aspects of culturally safe pregnancy care include assessing cultural biases and understanding historical health disparities.
4. **Women-centred**: An approach that recognizes sex and gender-related influences on substance use and offers interventions to address these influences and women's preferences for action. Women-centred approaches build a person's sense of value, confidence and self efficacy, and support their priorities and ability to improve their own health and the health of their families.

"We need to recognize how common trauma and violence are in the lives of girls and women and recognize their need for physical and emotional safety." – *Dr Nancy Poole*

Care principles for the treatment of opioid use disorder during pregnancy are:

1. Establish a trusting, collaborative and empowering relationship with patients at intake.
2. Apply principles of trauma-informed and culturally safe practices.
3. Assess each patient's basic medical and psychosocial needs and make referrals to secure social determinants of health.
4. Offer integrated and individualized care programs to foster stability and improve treatment and pregnancy outcomes.
5. Provide access to the full range of harm reduction supplies and services.



Guidelines for Pharmacological Treatment of Opioid Use Disorder during the Perinatal Period

Cheyenne Johnson is the Director of Clinical Activities and Development with the BC Centre on Substance Use (BCCSU) and the Canadian Research Initiative in Substance Misuse and is also the Director of the BCCSU Addiction Nursing Fellowship. She provided an overview of the new provincial guidelines for the Treatment of Opioid Use Disorder During Pregnancy. (http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/OUD-Pregnancy.pdf).

The guidelines offer healthcare professionals recommended treatment options and principles for the care of pregnant and newly parenting women with opioid use issues and their infants. Building on the BCCSU's *Guideline for the Clinical Management of Opioid Use Disorder*, (http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf) the supplement, developed with perinatal addictions experts and in collaboration with Perinatal Services BC, provides evidence-based treatment recommendations to address a lack of knowledge as well as to reduce stigma towards pregnant women who use substances.

Johnson also provided an overview of the screening and assessment recommendations, pharmacological treatment recommendations, and postpartum considerations for the treatment of pregnant women with opioid use disorder. These included the need to screen all women who are or may become pregnant for substance use.

The guideline offers postpartum considerations for practitioners and recommends rooming-in as the standard of care for mothers and babies. In addition, mothers who are stable are encouraged to breastfeed their infants to support best health outcomes.

Additional resources are available for providers online through the BCCSU website (www.bccsu.ca), including an online addiction medicine diploma program and OAT training course. Providers can also access support through the new perinatal Rapid Access to Consultative Expertise (RACE) line (www.raceconnect.ca), a provincial initiative to facilitate timely access to specialists so that patients can get their issues dealt with by their primary healthcare provider.

Pharmacological treatment recommendations:

1. Withdrawal management alone is NOT recommended.
2. Opioid Agonist Treatment (OAT) should be offered for all women.
3. Type of OAT initiated should be selected based on a patient's individual circumstances and with consideration of access and availability.
4. Transitioning between different kinds of OAT during pregnancy is not recommended.

Guidelines for Non-Pharmacological Management of Opioid-Exposed Infants

Jola Berkman, Neonatal Care Coordinator for Perinatal Services BC (PSBC), summarized the recently released Canadian Pediatric Society's (CPS) guideline for *Management of Infants born to Mothers who have used Opioids during Pregnancy* (https://www.cps.ca/en/documents/position/opioids-during-pregnancy). Berkman focused on the guideline's non-pharmaceutical practices to improve health outcomes of substance-using women and their infants. The guideline has a number of key recommendations, including:

- Initial treatment for neonatal withdrawal should be primarily non-pharmacological and focus on supportive and responsive care, such as skin-to-skin contact, safe swaddling, gentle waking, quiet environment, and minimal stimulation. Medical interventions, which can prolong hospitalization, disrupt mother-infant attachment and subject an infant to medications, may not be necessary.
- Rooming-in is the ideal model of postpartum care. Evidence is clear that when mothers and babies are kept together, there are greater positive health benefits for both mothers and babies including:
  - infants need less medication and experience reduced withdrawal symptoms;
  - infants have higher rates of breastfeeding (which benefits both women and children);
  - attachment between mother and baby is fostered; and
  - long-term developmental outcomes are improved.

> "Rooming-in is the preferred model of care. When mothers and babies are kept together, babies need less medication and have shorter lengths of stay."– *Jola Berkman*

- Breastfeeding is recommended and safe for infants while a mother is on methadone. Breastfeeding not only supports bonding but human milk reduces abdominal discomfort resulting from neonatal opioid withdrawal symptoms (NOWS). When a mother's own breastmilk is unavailable, donor milk should be provided.

Berkman suggested practitioners should aim to identify mothers using opioids early on in their pregnancy and support them in their own recovery paths as well as prepare mothers to meet their infant's emotional and physiological needs with specific practices — everything from safe sleeping and swaddling to attending to their own medical and emotional needs as women.

According to Berkman, providers need to work collaboratively across the province to change care practices. She suggested health care professionals need to be more supportive and responsive in the care and treatment of substance-exposed infants and their mothers. One concrete and evidence-based way of providing this support is by adopting rooming-in practices as the standard, first line of response—doing so can significantly reduce the perceived need to medicate infants and the consequent separation from their mothers.

PART 3: Principles in Practice

B.C. is home to exemplary programs with models of perinatal care in which the recommended principles and guidelines for the care and treatment of women with substance use challenges and their infants are realized in practice. From urban to rural areas and across the continuum of primary to community to acute care, there are a number of hallmark services providing low-barrier, evidence-based care that are supporting better health outcomes for women and infants and their families.

Various service providers, from rural to urban settings, highlighted the key elements of their program models. Common service components included drop-in medical care to one-on-one and group counselling along with a focus on meeting patients' basic needs like food and clothing through daily drop-ins and hot lunches. Outreach assistance was another central aspect of these services with many programs providing advocacy and support around issues of housing, child welfare, income assistance, legal advice, and employment. Presenters stressed that their models were adaptable to different settings and that new services for pregnant and parenting women with substance use challenges do not need to have all components in place to start providing care and support.

Opportunities in General Primary Care

Dr Sharon Vipler, MD, a physician with St. Paul's Hospital's Addiction Medicine Consult Team and Fraser Health Substance Use Services, spoke about the multiple opportunities health care providers have to identify and refer pregnant women with opioid use disorder in the general primary care setting. The need for greater identification and support for this population is more critical than ever given the increasing focus on substance use within primary care, the introduction of primary care addictions leads in each regional health authority, and the development of Primary Care Homes and Primary Care Networks offering team-based care.

> "As providers, we need to partner with our patients. We know we can have good outcomes with good care so we need to ensure we get good care for our patients." – *Dr Sharon Vipler*

Vipler said the cornerstone to good primary care practice is to establish trusting, collaborative, and empowering relationships with patients. Before referring patients to a maternity care provider, she recommended primary care providers ask about substance use. She said it is important to understand the stigma that exists for patients and providers in relation to substance use but highlighted the need for primary care providers to become comfortable asking questions about substance use with a goal to normalize such inquiry. As example, Vipler said instead of asking a woman "Do you drink...how many drinks a day...", ask her "A number of women I care for have used substances/alcohol....do you identify with this?"

There is no typical look or presentation of an opioid user and Vipler suggested practitioners should "ask once, ask again". The objective is to approach patients

from a place of curiosity, not accusation or judgment. Trauma-informed training and PHSA's and FNHA's cultural safety trainings are good reference points for providers to learn and integrate these care principles into their practice.

The biggest role primary care providers can play for this patient population is that of advocate, to partner with their patients, and ensure they have access to good care and are able to maintain such access. She said providers need to help their patients access the right care and supports to meet their specific individual needs. It is also important for primary care providers to ensure follow-up care takes place as stigma and shame result in a low level of self-advocacy among this population.

Resources for primary care providers:

- RACE lines on addiction medicine; perinatal addictions; and perinatal psychiatry (for patients with concurrent disorders).
- Addiction Medicine Leads within each regional health authority.
- Local withdrawal management facilities.
- Rapid access addiction clinics (e.g., St. Paul's, Surrey, Victoria RAAC).
- Local specialized perinatal substance use programs (e.g., Sheway, Maxxine Wright).

Sheway

Dr Janine Hardial, MD, Medical Coordinator at Sheway, described how B.C.'s first pregnancy outreach program based in Vancouver's Downtown Eastside (DTES) first started providing health and social support for women with substance use issues who are pregnant or parenting young families. Hardial said Sheway got its start after the 1993 Targeting High Risk Families study showed that 40% of babies born in the Downtown Eastside were substance exposed (not including alcohol exposed), there was a high incidence of low birth weight (33% in exposed infants), and 100% of these children were apprehended into child welfare care.

Today, the program has had an immense impact on the lives of women and children. Currently 260 women and 329 children access primary care at Sheway; most were not connected to any primary care upon intake. Evaluation showed the services and supports provided by Sheway have resulted in:

- 86% of families having improved food security,
- 85% of women gave birth to infants weighing over 2500g; and
- 60% of women left the hospital with their babies in their care.

Moreover, evaluation results revealed that Sheway clients felt the program provided them with a safe space where they felt respected and heard, gave them the opportunity to connect with other parents, and increased their self-esteem.

The program's focus is on healthy pregnancies and positive early parenting experiences. Services provided are low-barrier and range from primary medical care to drop-in support to nutritional

counselling to meeting basic needs like food, clothing, and housing. The aim is to have as many resources under one roof as possible while giving women control over the level of interaction they have with the program. Staff are multidisciplinary and many are funded through different collaborative partnerships. As an example, the Sheway social worker is funded by the Ministry of Children and Family Development (MCFD) and is embedded in the program.

Sheway's philosophy of care is that the health of women and children is linked to the condition of their lives. "It's not about the drug use but about all the things women experience in their lives," Hardial said, "from current or repeated childhood trauma, violence, inadequate or unstable housing to guilt, shame, and most of all, the stigma of substance use, especially for pregnant women."

At Sheway, harm reduction is more holistic than it has been defined traditionally, focusing not only on harm reduction supplies and mitigating harms of drug use, but rather on how to broadly prevent harm to families. This includes safety planning in times of relapse and helping parents maintain ongoing relationships with their children. Sheway is also an overdose prevention site and clients can request to use substances in the clinic under the supervision of nurses.

"Women know their own reality best and our job is to listen to that and respect that." – *Dr Janine Hardial*

HerWay Home

Amanda Seymour, HerWay Home Program Coordinator, described the philosophy of care and services provided by the Vancouver Island Health Authority program. Opened in Victoria in 2013, HerWay Home provides non-judgmental health care and social supports for pregnant and parenting women who have a history of substance use and may also be affected by mental health issues, violence, and trauma.

HerWay Home serves 114 women and 112 infants on average a year, with five core staff and two counsellors/case management workers. Four beds are reserved for clients in Victoria General Hospital. The program echoes the philosophical pillars of Sheway with a focus on trauma-informed, culturally safe, harm reduction-based care. Services range from primary care to substance use counselling and, parenting support, to a strong focus on advocacy and outreach assistance for housing, child welfare, food, income assistance, legal advice, and employment. The program emphasizes both one-on-one support and counselling as well as the opportunity to participate in support groups if women wish, giving women control over their health care journey.

"We fulfill a unique role in the community. We help to prevent apprehensions and help return children." – *Amanda Seymour*

Program evaluation found:

- 59% of HerWay Home clients entered the program in their first or second trimester;
- 25% were engaged in substance use;
- 30% were new to recovery; and
- the majority of clients lived in inadequate housing and had had negative experiences with the health system.

The impact of HerWay Home services on women's lives was also assessed in the program evaluation. Between 96% - 100% of clients reported feeling safe, respected, and trusting of program staff, and 100% said their needs were met through the program. What women said they liked most were the support groups and opportunities to connect with other women. The evaluation also showed that the most significant changes women experienced were feeling stronger, regaining custody of their children, stopping drug use, having increased confidence, and developing better connections to resources.

Seymour offered Visioning Workshop participants some of the key lessons learned by HerWay Home providers to date, including that it has been critical to:

- have relational, non-judgmental and harm reduction approaches to the provision of care and treatment;
- provide outreach supports and services to meet clients' psychosocial needs; and
- build relationships between staff and community partners to provide for seamless care and transitions.

Maxxine Wright Community Health Centre

Denise Penaloza, Program Coordinator at the Maxxine Wright Community Health Centre, talked about the program's services and philosophical foundations. Established in 2005, the mandate of the Centre is to provide low barrier support for pregnant women or women who have had a baby in the last six months. The Centre provides women-only services and serves as a place for women to connect — "because the opposite of addiction is connection" says Penaloza.

The program provides drop-in medical appointments, one-on-one counselling, support groups, nutrition care, outreach assistance for child welfare and other social supports, as well as on-site cultural support provided by an Indigenous Elder. Unlike similar community and primary care programs, the Maxxine Wright Centre also provides on-site housing. There are 12 beds for pregnant women within the Centre while second-stage housing is available in a building located behind the Centre, provided in partnership with Atira Women's Resource Society.

The focus of care is on addressing social determinants of health, and the Centre staff works to build trusting relationships and walk alongside women on a harm reduction path. Penaloza said the key is to be transparent and pro-active with women, having early discussions about parenting and helping women determine if they want to parent, as well as encouraging pro-active relations with the Ministry of Children and Family Development.

The Centre recently introduced doula services and is considering new models of care with midwives and an extended scope of practice for its nurse practitioners. A research study is also underway looking at Adverse Childhood Experiences (ACEs) and how the traumatic events in a woman's life affect them and their parenting.

> "We empower our clients to take part in the planning for themselves and their baby. It promotes honest and transparent interactions and helps them come up with a care plan." – *Denise Penaloza*

Pathways to Healing Partnership

Jan Ference is the Director of Pathways to Healing Partnership, part of the Comox Valley Child Development Association. Since 2016, she has been leading Pathways to Healing, a specialized early intervention program for children under the age of twelve, including clients who are pregnant women with histories of addiction. The program serves the Comox Valley and Port Hardy, and offers consultation to Ledger House, Campbell River and Parksville on Vancouver Island.

Pathways to Healing provides services to a small caseload of complex families, and women are typically referred in their second or third trimester by primary care providers, community agencies or MCFD. Pathways to Healing helps women to improve their health and well-being in much the same way as the other programs but in a rural setting by offering:

- system navigation and advocacy (buffering client/family when accessing services that have judgement about substance use);
- therapeutic support (one-on-one and family work);
- housing and food security;
- transportation to appointments, family visits (when necessary);
- assistance building support network/ therapeutic webs for families before discharge
- attendance of birth when requested;
- trauma assessment;
- training and in-service for community partners; and
- consultation for complex families on Vancouver Island (Ledger House, Anscomb Program, Victoria General).

All of the program's clients are assessed and treated through the methodology of Dr Bruce Perry's Neurosequential Model of Therapeutics (NMT). Pathways to Healing is one of the few community-based programs in B.C. using a neuro-developmental, culturally-sensitive lens to help families heal from trauma. The team regularly consults with First Nation's Elders to ensure their work is culturally respectful and to better understand traditional healing practices.

Another feature of this program is that it works with the entire family system (both children and caregivers) in educating a lay support network to better understand their current functioning and needs. This work is done through a neuro-developmental perspective as opposed to a behavioural perspective, whereby addiction is viewed empathically, as an outcome of brain function based on developmental history. Program staff also work to change the systems around them because the more that community and health systems understand how trauma and neglect impact the brain, the more likely they will be to support lasting changes for the most vulnerable members of the community.

FIR Square

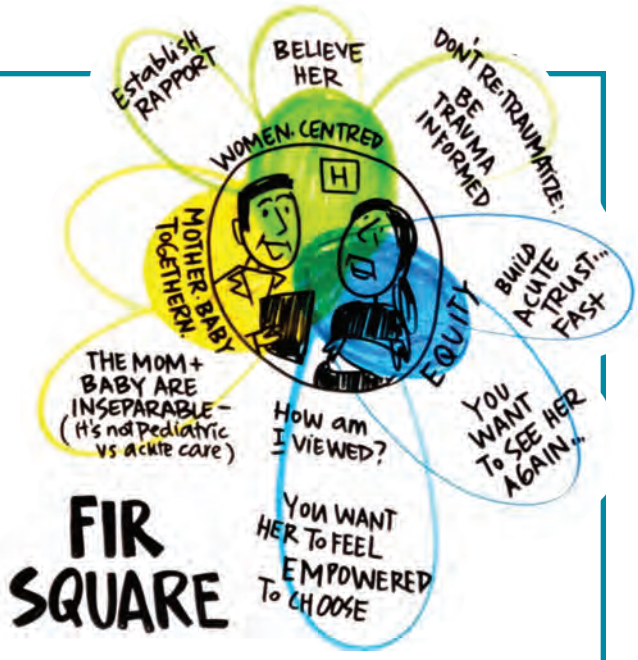
Dr Eric Cattoni, MD, Medical Co-Lead of FIR Square, and **Dr Rob Everett, MD**, Medical Lead of Pediatrics and Mother-Baby Care at BC Women's, talked about the management of women and infants at BC Women's Hospital + Health Centre's FIR Square Combined Care Unit program, Canada's first inpatient hospital program.

Opening its doors in 2003, the acute care program has five antepartum and six postpartum beds for women wishing to stabilize or withdraw from drug use during pregnancy. There is also a centralized nursery for babies in need of specialized treatment.

The program's philosophy of care is women-centred, trauma-informed, culturally safe and harm reduction-oriented. The focus of the program is on mother and baby togetherness with rooming-in being a mainstay of that approach. Baby and mother are seen as an inseparable dyad and medical providers, from family physicians to pediatricians, care for the whole family as one unit.

The majority of care at FIR Square is provided by family physicians, alongside a multidisciplinary team that includes pediatricians, nurses, social workers, counsellors, and other allied care providers. The team assists substance-using pregnant and early-postpartum women and their infants to stabilize safely and achieve optimum health to minimize the effects of alcohol, drugs, malnutrition, and neglect on themselves and their infants.

Women at FIR Square have access to counseling and support to enhance critical life skills, and to learn parenting techniques and coping mechanisms. The program also provides alcohol and drug counseling, recreational and art therapy, Indigenous cultural support through a First Nations advocate, and outreach support



and advocacy for housing, income, and other social needs. FIR Square has also developed a Memorandum of Understanding with MCFD to support early dialogue and planning around parenting.

Cattoni said the aim of providers is to establish a meaningful therapeutic rapport within the hospital setting as many patients have had unpleasant encounters in acute care. He said being trauma-informed does not mean knowing every aspect of a patient's trauma but rather recognizing that most women have experienced trauma in their lives and appreciating that they often use substances to block out the trauma and hurt.

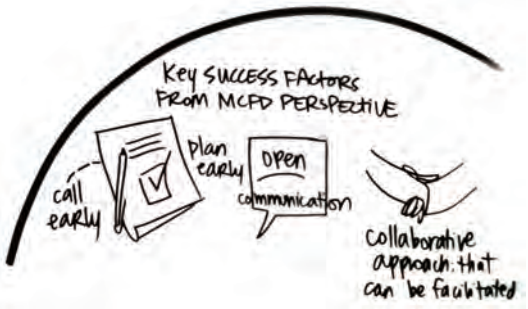
FIR is a leading model of inpatient care, and as a teaching hospital, BC Women's is educating young physicians and trainees about trauma-informed, harm reduction, and culturally safe care delivery for these populations. Everett said currently, physicians' understanding of such practices is variable, and to build a province where such an approach is standard care, more professional development and consultation support are needed.

Ministry of Children and Family Development

Shirin Jangi, Vancouver North Director of Operations, and **Nicole Maharj**, Acting Director of Operations, Vancouver South, Ministry of Children and Family Development (MCFD) spoke about the role of MCFD in working with programs and families to ensure the best outcomes for children.

MCFD's aim is to work with pregnant women on a voluntary basis with the parent's consent. By starting early, the Ministry's social workers can help clients access housing, or if a mother is deep in addiction, find out if there is family the woman and infant can stay with until the mother is stabilized. For women who choose not to parent, MCFD can engage in conversations about adoption or other options the mother wishes to explore.

Jangi said for MCFD, an important element of the relationship with women and with program staff is to establish open and transparent communications. She said challenges arise when information is not shared with MCFD and organizations work in silos. The Child, Family and Community Services Act allows social workers to share critical information that is needed with community partners to develop meaningful plans for women and infants.



> "Early intervention is key. Poverty, trauma, violence and many others issues are behind addiction and the sooner MCFD is called and gets involved, the better they are able to plan with families." – *Shirin Jangi*

"What is crucial in planning is collaboration," said Jangi. "To have facilitators and social workers bring families together. When we have adequate time and enter a collaborative process where planning is family driven, the outcomes are very successful."

Maharj said that community partners are essential in helping to bridge relationships. She said MCFD is fortunate to have programs in Vancouver like FIR Square and Sheway with which the Ministry works hard to build trusting relationships. MCFD has a Memorandum of Understanding (MOU) with FIR Square to guide practices around how to share information with child protection, to plan better, and when a parent has to have a discussion about child not going home, to minimize the trauma to the mother.

"I know there is a lot of intergenerational trauma and that means women have fear around the Ministry so our aim is to align people with those who they can trust," said Maharj. The key take-away both MCFD representatives wanted participants to leave the Visioning Workshop with was that the earlier MCFD is involved and has time to work together to plan and mitigate safety risks, the more likely it is that mother and baby can remain together.

PART 4: Sector-Specific Opportunities for Improvement

The Visioning Workshop shifted into small working group discussions in the afternoon as participants gathered in sector-specific groups – hospital and community care – to consider the implications of the morning's presentations within the context in which they work.

Participants were encouraged to identify opportunities for improvements in services and provider skills consistent with the principles, guidelines, and good practices highlighted in the morning plenary.

The eight sector-specific working group participants were asked to consider the following questions:

Where are we already doing a good job?

What are the opportunities to improve existing or develop new services that align with the principles, guidelines, and good practices discussed this morning?

Each working group was asked to report on the three most important improvements required to better support pregnant women and/or newly parenting women with opioid use challenges and their newborns. The following summarizes the key themes and messages from the working groups by sector.

Improvements Identified for Community & Primary Care

There was general agreement that the model of care needs to:

- offer individualized woman-centred care;
- give women choices about their care and ensure there are 'no surprises';
- provide a trauma-informed, women-centred, harm reduction focus and support and resource educational resources to help achieve this shift; and
- embrace rooming-in and mother-baby togetherness as core principles of practice.

Other suggestions included offering standardized education, awareness-raising and training to support practice improvements and offer support and mentorship to learners while supporting interprofessional practice. A number of audiences were identified as likely to benefit from additional training including MCFD (not just health sector).

Topics might include:

- providing culturally safe care;
- trauma-informed principles and practice; and
- fostering attitudinal shifts by supporting principles of care at all levels.

It was agreed that it is critical to document evidence-based models and exemplary practices. This might involve:

- creating a guide to provincial best practices with standardized evidence and evaluation;
- creating a provincial best practice framework and standardized approach to care that is adaptable across various communities;

- investing in additional implementation and evaluation of evidence-based models of care; and
- engaging women with lived experience in service redesign and planning.

Participants called for bolstering linkages across the care continuum and support for improved communication between health providers and across sectors, including the new Primary Care Networks. This involves:

- clarifying a role for the primary care networks with regard to supporting perinatal substance users;
- expanding midwives scope of practice and engagement within PCN;
- wnsuring every woman has a primary care home;
- integrating women with opioid use challenges within the networks;
- champion collaboration; and
- providing 1:1 outreach and navigation support for all women that spans prenatal to postpartum, with interprofessional and cross-sector collaboration and appropriate government funding (e.g., Nurse Family Partnership; Pathways to Healing).

Participants emphasized that services must strive to achieve provincial best practice standards.

This will require funding for smaller and rural and remote communities to establish and offer integrated, wrap-around care models tailored to their context, and:

- supporting birthing closer to home with funded salaried care teams, and;
- working with FNHA and regional health authorities to establish mobile support services in rural and remote areas. This includes embracing the wisdom of Indigenous elders.

There needs to be investment in supportive, sanctuary-style housing for women and families across the province.

The foster care system should be revamped to include a model of family foster care, like "rooming-in" on the outside.

Improvements Identified for Acute Care Sector

Create a provincial care pathway that addresses standard guidelines, and a philosophy of care that includes:

- a paradigm shift to mother-baby togetherness in care;
- guidelines for rooming-in practices with hospitals across B.C. to facilitate mother-baby togetherness; a standardized approach;
- rooming-in a standard of care;
- organizational capacity to support best practices;
- support for interprofessional practice;
- wrap-around care determined by the specific needs of a particular mother and baby; and
- recognizes the need for flexibility, such as in length of stay.

Support all health authorities to develop expertise to provide support re: perinatal substance use by:

- creating additional mother-baby units; and
- adopting consultation model such as is used at FIR square.

Enhance linkages between hospital and community care sectors, and:

- ensure information follows a woman and her baby, especially after birth;
- overcome service fragmentation and collaborate across sectors (e.g., perinatal, mental health and addictions) and along the continuum of care to create seamless transitions in pathways of care, and ensure women and families contribute to what works best to meet their needs;
- integrate acute, mental health and substance use service, and;
- work across the continuum of sectors.

Nurture champions at all levels (from executive to the front lines).

Ensure standards of practice are identified and there is education and clinical supervision to train health providers in them. For example:

- standardize provider training and care practices in treating pregnant and newly parenting women with opioid use challenges; and
- provide support to further educate and enhance healthcare provider skills in evidence-based care for these populations.

The acute sector must create responsive care with functional assessment for infants, by adapting a model such as Eat, Sleep, Console. It is also important to allow flexibility to allow women supervised visits in hospital and look to establish appropriate assignments to meet the needs of infants for skin to skin care if no parent is present.

Ensure standardization of MCFD practices throughout the province — ensure there is a shared aim of keeping mother and baby together.

Although the discussions were deliberately held separately among representatives of the acute, community, and primary care sectors, participants identified a number of similar opportunities for improvements. Both urged greater coordination and communication across the continuum of care and between health care sectors, and between health care and the Ministry of Children and Family Development. There was a consensus on the importance of "rooming -in" as a core element of the model of care and of the value of trauma-informed, culturally safe, harm reduction-oriented services. Indeed, there was agreement that a standardized provincial model of care needed to be articulated and shared and that learners across all sectors and disciplines would benefit from education on the elements of the model of care. There was also agreement that the model could be adopted and adapted in settings across the province while maintaining a provincial standard of care.

Creating new services should involve women with lived experience, Indigenous elders, and interprofessional providers in order to support the development of locally appropriate services and supports. Doing this will require champions at various levels and across the care continuum, as well as additional investment and discussions with key stakeholders.

PART 5: Region-Specific Opportunities for Improvement

The final discussions of the day involved workshop participants gathering into regional groupings to discuss how they could collectively improve or develop services. Regional groups included health care providers from different disciplines (e.g., physicians, midwives, nurses), sectors (primary care, community, and acute) and specializations (perinatal health, mental health, women's health, and addictions), representatives of regional health authorities, community-based and women serving organizations, First Nations Health Authority and other Indigenous organizations, the Provincial Health Services Authority, and the provincial government (Ministry of Children and Family Development, Ministry of Health, Ministry of Mental Health and Addictions).

Regional groups were asked to consider the following questions:

What are some opportunities for improvements in our region?

What is the top priority for action and/or a quick win?

Who do we need at the table and what resources do we need?

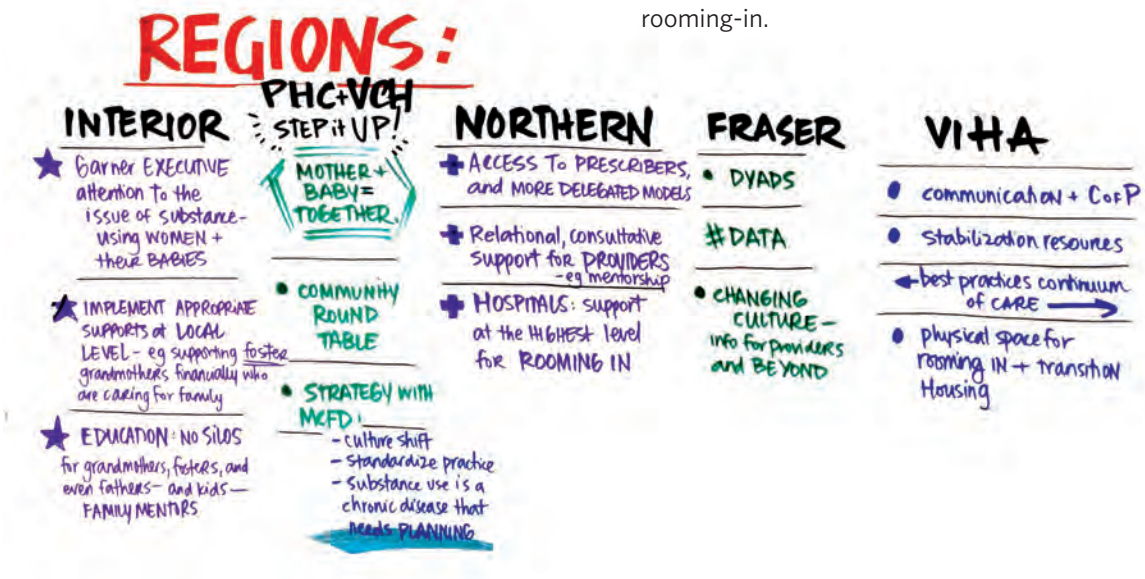
Participants were asked to report out from their region's perspective, what they thought were the three most important actions that could be taken to improve the system of care.

Northern Region

Workshop participants at the Northern Region table proposed a number of opportunities for improvements to support better care for pregnant and newly parenting women and their infants. Participants articulated a need to enhance the work of interprofessional teams with improved linkages to primary care physicians. The group talked about expanding health provider roles and improving support to enhance access to evidence-based care across the North. For example, enhancement of the scope of practice for midwives and collaborative care with Nurse Practitioners was proposed. As well, they recommended the development of relational, consultative support for remote providers beyond the RACE line, and increased access to health practitioners who can prescribe methadone and other OAT's in smaller communities.

The current First Nations Health Authority and Northern Health Authority partnership committee on maternal-child health also needs to continue. Participants noted that it is important to continue discussions on how to address birthing away from home and how to fill in the gaps in the need for housing supports in these situations.

Finally, this group wanted to see continued reflection on cultural safety and the meaning of trauma-informed, harm reduced care, along with a significant push and attention paid at the highest levels of health administration in acute care settings to support rooming-in.



Northern Region: Top Three Improvement Ideas

1. Increase access to health practitioners who can prescribe methadone and other OATs in smaller communities to improve rural and remote communities access to evidence-based treatment.
2. Establish relational and consultative support for rural providers above and beyond the RACE line. For example, a mentorship or ongoing supervision-type relationship where remote providers can reach out to practitioners with expertise (e.g., Sheway providers) and receive guidance in their delivery of services.
3. Obtain hospital support at the highest executive levels for rooming-in and be creative about making rooming-in possible. Eliminate practices that discharge mothers but keep baby in hospital.

Fraser Region

A number of service exemplars were identified by participants at the Fraser Region table, like the Maxxine Wright Community Health Centre in Surrey, as an example of how Fraser has identified gaps and collaborated across sectors to meet the needs of women, infants, and families with opioid use challenges. The group talked about how the Fraser Region has worked to achieve more seamless perinatal care and effective care planning for women and infants.

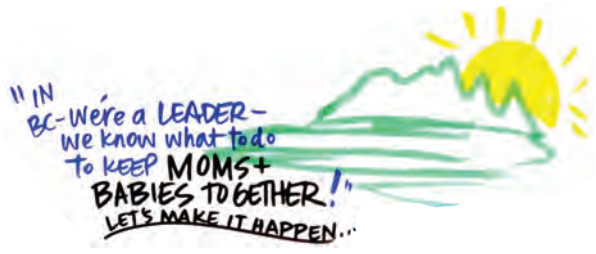
Participants identified a number of opportunities for improvement. They said the overarching philosophy of care for the region should be to keep mothers and babies together. This should be reflected in the architecture of health care services with mother-baby units developed and concomitant staffing to support mental health and addictions services. These mother-baby units could have 'in-reach' services that connect women and families with services in the community to provide for better continuity of care upon discharge.

This group also saw data collection as critical to better understanding the size and composition of the perinatal opioid-using population and to better define the problem. It was suggested Perinatal Services BC was the best organization to lead data collection and participants said opioid use should be added to the antenatal record and perinatal data registry similar to way that information is collected on smoking.

Finally, the group discussed the idea of having a mandatory course on substance use required for physician credentialing or nurse registration, as part of a broader emphasis on improved education and training resources. Access to training should include online and in-person venues, and there should be train-the-trainer models to support the spread of perinatal substance use care education across the province.

Fraser Region: Top Three Improvement Ideas

1. Promote mother-baby dyad care ('togetherness') with mother-baby units created throughout the region. Ensure the predominant philosophy of care is to keep mothers and infants together, and encourage the development of better linkages to community to support the continuum of care when mother and baby are discharged.
2. Improve data collection by adding opioids to the antenatal record and perinatal data registry to better understand the size and scope of the issue of perinatal populations and substance use.
3. Create mandatory education and training for all health care professionals on substance use to support a cultural shift in the care and treatment of women and infants with opioid use challenges.



Interior Region

Discussion among Interior Region participants centred on both current services and supports for women and infants with opioid use challenges as well as opportunities to build on existing strengths and improve care delivery.

Current strengths included acute care facilities like the Royal Inland Hospital in Kamloops allocating beds and supporting rooming-in with a "FIR Square" type model for pregnant women. The Karis Village apartments and the Karis Support Society in Kelowna provides at-risk, substance-using women and their children with early intervention, housing and follow-up for up to seven years through a partnership between public health, MCFD, and others. This was highlighted as an example of continuous, supportive, trauma-informed care that could be replicated in other communities.

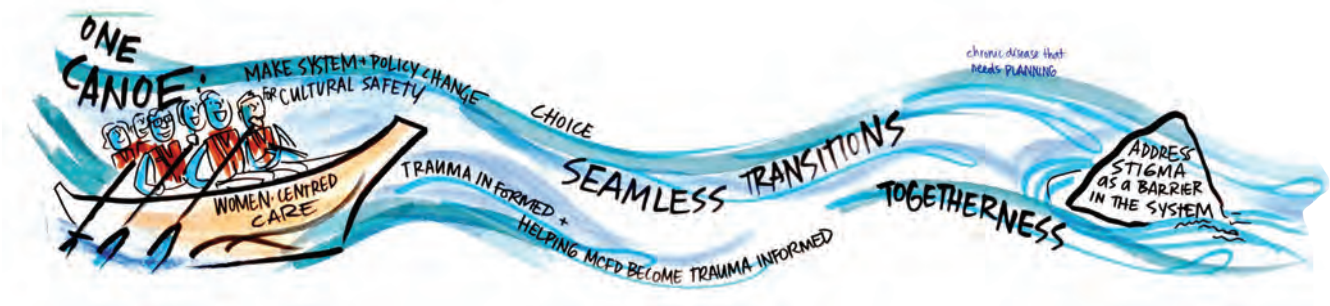
Participants cited other exemplar services in the region such as the Nurse-Family Partnership (NFP) with a two-year home visitation program by public health nurses. Through the Partnership, nurses are incorporating telehealth and reaching out to Indigenous communities to improve access to services and support for women and children.

Opportunities for improvement raised by this group included the need to educate the whole system, not just health providers, about the mother-baby care dyad to embed the principle that "mother-baby being kept together is best". Questions were also raised about how to support care for women and infants in smaller communities, and the need for hospital beds and staff dedicated to this population. One suggestion was to have a refreshed Perinatal, Child and Youth Network of senior leaders to champion evidence-based care and the mother-baby care dyad.

As well, participants called for executive attention at the highest level of health authorities to the issue of substance-use challenges among perinatal populations and the need to make their care a regional priority.

Interior Region: Top Three Improvement Ideas

1. Garner executive attention at the highest level to the issue of substance-using women and their infants and make their care a priority for the region with publicly-funded community program and acute care resource.
2. Create family foster care by implementing appropriate supports in each local community and examining what skills and resources can be brought together to support women, infants and families. For example:
   a. Keep care in the local community – use money for foster care to pay First Nations and Indigenous grandmothers to foster mothers and babies so people can take care of their own people; and
   b. Create family care coaches and mentors and see the family as a whole unit, instead of just focusing on the infants' care and well-being.
3. Educate everyone — society, doctors, caregivers, patients — about how to effect change in care practices and how to work together to deal with and stop the opioid crisis in this province.



Vancouver Island Region

Participants at the Vancouver Island table talked about the barriers to care for these populations being a lack of resources to support providers in smaller communities, the fragmentation of care on the Island, and poor communication between community and acute care sectors in caring for this perinatal population.

This group suggested a treatment unit on Vancouver Island, replicating the BCMHSUS Heartwood Program model, would begin to fill in the gap in substance use beds and treatment options for mothers and babies. Hospital policies also need to change with more education on the benefits of rooming-in especially in smaller communities. In fact, participants wanted to see rooming-in become standard practice for all Vancouver Island hospital maternity units and to see more cross-island consistency in the delivery of care to these populations.

Capacity-building was a theme in this group's discussions, with the need to improve education and training amongst health care providers and administrators, with better sharing of information on evidence-based best practices, and having more health care professionals use of the RACE line. Overall service capacity also needs to improve with more models like Sheway and HerWay Home established across the Island to realize better health outcomes for women and infants.

Supportive housing was identified as a significant need and participants wanted to see the creation of homes where mothers and infants could go after birth that foster families as a whole unit and provide transitional support incorporating Indigenous Elder knowledge.

Vancouver Island Region: Top Three Improvement Ideas

1. Establish women-only substance use treatment beds and allied stabilization resources and services on Vancouver Island to better support women and infants.
2. Establish mother and baby units in every hospital for opioid using perinatal populations and provide the necessary resources to ensure rooming-in is available to women and infants across the region.
3. Provide supportive transition housing and champion innovative models of "family" or "mother-baby" foster care to keep women and their infants together after they leave the hospital setting.

Vancouver Coastal Region

Participants from Vancouver Coastal Region called themselves "Team Step It Up" for women and babies, discussing a host of existing strengths and opportunities to improve the system of care for this population.

Some of the region's current strengths include the availability of harm reduction education and 24-hour consultation for providers to support evidence-based care. There was also strong support for the provision of trauma-informed practice in the region, along with good community capacity and support for mother-baby togetherness. Participants noted that improved relationships with the Ministry of Children and Family Development have also helped to improve the postpartum period for women and infants with better communication and planning in place.

This group talked about the opportunities available to improve care, like the need for extended length of stays and increased supports for women with complex mental health needs. As well, participants said there needs to be support for smoother transitions from acute to community and to build capacity to better consult within the community.

Participants at this table said there can no longer be any excuse for not having rooming-in as it is evidence-based care. Rooming-in should be implemented in all Vancouver Coastal Region facilities to ensure mother-baby togetherness. Another idea was to expand the Nurse-Family Partnership, a public health program for women having their first baby, to meet the needs of parenting women with substance use challenges being discharged back into the community.

Vancouver Coastal Region: Top Three Improvement Ideas

1. Rooming-in becomes the standard of care and occurs in all facilities; "no more excuses" that it can't happen as keeping mom and baby together is evidence-based and best practice and it should happen in all facilities.
2. Initiate a community round table of acute and community sector representatives to build resources and use the collective power to influence change, including building relationships between programs and resources to better serve patient.
3. Develop a strategy with MCFD that includes:
    a. Helping train and educate MCFD to support a culture shift within the Ministry that makes the default position mothers and babies staying together;
    b. Strengthening relationships with MCFD;
    c. Supporting MCFD to standardize their practices (currently unpredictable and uneven across regions); and
    d. Strategizing with MCFD to prevent precipitous removal of infants/children during the ups and downs of substance use where relapse is common.

PART 6: Summary + Next Steps

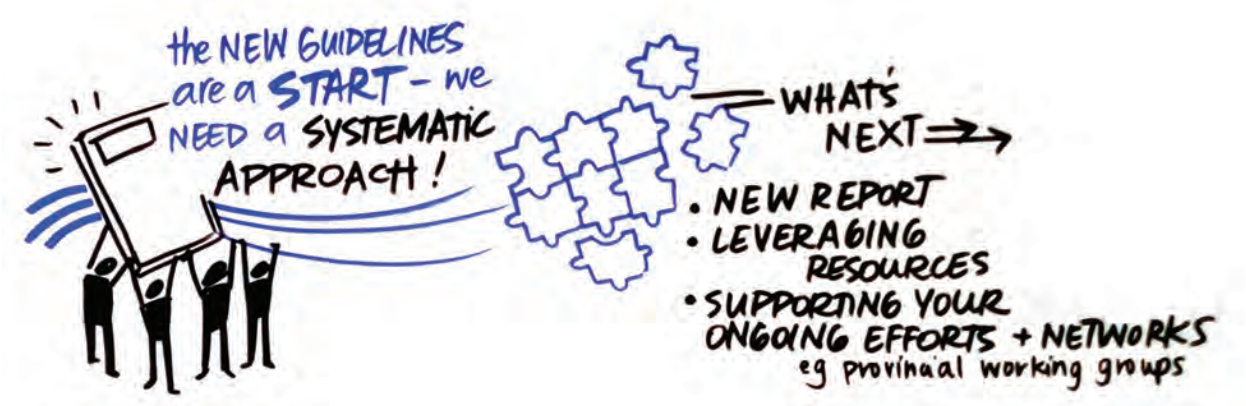
Workshop sponsors and organizers **Tamil Kendall**, Interim Provincial Executive Director, Perinatal Services BC and **Cheryl Davies**, Chief Operating Officer, BC Women's Hospital + Health Centre, closed the day by applauding participants in their demonstrated commitment to serving these populations. They invited all participants to work together as a network to make change and improve the system of care for women and their infants across the province.

In summarizing the day's learnings, the workshop sponsors encouraged workshop participants attendees to prioritize this population within their conversations on perinatal health and in mental health and addictions, as well as across sectors and disciplines. Through strengthening their shared understanding and support for the key principles of best practices – trauma informed, harm reduction, women-centered and culturally safe care – workshop participants are well-positioned to advocate for these principles and their associated practices to be embedded in health care delivery across British Columbia.

The release of the *Treatment of Opioid Use Disorder during Pregnancy Guideline Supplement* is a step forward for B.C. but there needs to be continued leverage of resources, advocacy for change and the creation of a more systematic approach to evidence-based models of care for substance-using women, infants and their families. There is also a need to overcome silos, support more training of health care providers and administrators, and provide more structured mentoring of care providers. Opportunities exist to change mind-sets and the culture of care for opioid-using women and their infants, and create systems that foster supportive, non-judgemental relationships to promote mother and baby togetherness for the best possible health outcomes.

Cheryl Davies and Tamil Kendall said PHSA will continue to explore opportunities for investment and support for perinatal populations with opioid use challenges. A key focus will be to support ongoing networking among Visioning Workshop participants and support the cross-pollination of the ideas and opportunities for improvements highlighted during the day's discussions.

Cheryl Davies closed the event by thanking all participants and encouraging people to keep this perinatal population front of mind in their own networks and to use this report to continue the conversation across all sectors and at all levels of care.



Appendix A: Agenda

Ensuring Best Care and Supports to Pregnant and Newly Parenting Women With Opioid Use Challenges Visioning Workshop

June 1, 2018 | Hilton Vancouver Airport
8:30 am – 4:30 pm

Background/Strategic Context:

Women with substance use problems during the perinatal period require appropriate harm reduction and treatment services, for themselves, their newborns and their other family members. This usually includes early identification (usually through primary care/family physicians, midwives, or community services), expedited low-threshold access to community based substance treatment and support services, management of child protection issues, and support for mother-newborn bonding and maintaining relationships with their children and families.

Today's Objectives:

Morning Sessions:

- Vision a future in which women experiencing substance use challenges, including opioid use problems, and their infants reliably and consistently receive evidence-based care in a context of respect and safety.
- Review provincial and national principles, guidelines and good practices for pharmacological and non-pharmacological interventions for best care of women with opioid use problems and their infants during the perinatal period.
- Share B.C. exemplars of models of care from urban and rural areas and across the continuum of care.
- Understand the implications of FNHA's Policy Statement on Cultural Safety and Humility (http://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf) for First Nations women and their newborns and families.

Afternoon Sessions:

- Discuss the application of provincial and national principles, guidelines and good practices within the primary care, community and hospital sectors across all regional health authorities.
- Provide a context for regional leaders and clinicians to discuss, assess and explore their own current local service responses – including successes, gaps and opportunities for improvement.
- Support regional leaders and clinicians to vision and/or plan future service improvements based on the principles, guidelines and good practices discussed (depending upon their individual starting point).
- Explore a more formalized "provincial networking" support system to encourage and support universal adoption of principles, guidelines and good practices.
- Determine additional opportunities for PHSA to support regional HAs and their communities in achieving improvement.

Time	Presentation
07:00 - 09:00	**Breakfast**
07:30 - 09:00	**Registration Open**
09:00 - 09:15	**Opening by First Nations Elder & Executive Welcome** Tamil Kendall, Perinatal Services BC, Cheryl Davies BC Women's Hospital + Health Centre, Elder Roberta Price, Snuneymuxw and Cowichan First Nations
09:15 - 09:20	**Government Welcome** Carolyn Davison, Ministry of Mental Health and Addictions
09:25 – 10:00	**Visioning the Future** *"Setting the stage: The evolution of practice in B.C. in caring for pregnant and newly parenting women with opioid use challenges and their infants. Where to next?"* Lenora Marcellus, University of Victoria *"Working with Cultural Safety and Humility"* Nel Wieman, First Nations Health Authority
10:00 - 10:45	**Session 1: Principles and Evidence Base and Guidelines for Support and Treatment:** ▪ **Principles of Trauma Informed and Gender Responsive Care** *Bringing Principles to Practice and Policy: Women-centred, Trauma-informed, Harm-reduction, Equity-informed Approaches* (15 min) Nancy Poole, Centre of Excellence for Women's Health ▪ **Current Guidelines for Pharmacological and Non-Pharmacological Treatment for Opioid Use Disorder During the Perinatal Period and Infant Care** *"An overview of the new provincial guideline for the treatment of opioid use disorder during pregnancy"* (15 min) Cheyenne Johnson, BC Centre for Substance Use "*Non-pharmacological management of the infant exposed to opioids - an overview of best* practices" (15 min) Jola Berkman, Perinatal Services BC
10:45 - 11:00	**Coffee and Tea and Stretch Break**

11:00 - 12:10	**Session 2: Applying Principles, Guidelines and Good Practices across the Continuum of Care:** **• Primary Care: case identification and referral and the context of family practice and primary care homes and networks; providing primary care to women with substance use challenges and their children** *"Opportunities for identification and referral in primary maternity care"* (10 min) Sharon Vipler, Fraser Health Substance Use Services *"A day in the life at Sheway"* (10 min) Janine Hardial, SHEWAY **• Acute Care/Hospital: providing hospital based services and supports** "Inpatient Management of Mothers and their Infants – The FIR Square Philosophy" (15 min) Eric Cattoni and Rob Everett, BCW – FIR Square **• Community: providing community based services and supports** *"This time I had help and support and that has made all the difference" – how HerWayHome works with women in need."* (10 min) Amanda Seymour, HerWayHome *"Maxxine Wright Community Health Centre – Our lived experience."* (10 min) Denise Penaloza, Maxxine Wright *"Pathways to Healing; Breaking the Cycle of Intergeneration Trauma Through Attachment."* (10 min) Jan Ference, Pathways to Healing **Discussion and Questions from the floor** (5 min)
12:10 - 12:30	**Session Three: Coordinating and Collaborating across systems to Support Perinatal Substance Using Women and their Families** Shirin Jangi and Nicole Maharaj, Ministry of Children and Family Development **Discussion and Questions from the floor** (5 min)
12:30 - 13:30	**Lunch and Networking**
13:30 - 14:15	**Session Four: What is Working now in My Sector?** **Sector Specific Groups (PC/Community, Acute Care)** (45 min) • Where are we already doing a good job? • Where are some opportunities to improve existing or develop new services that align with the principles, guidelines and good practices discussed this morning?
14:15 - 14:30	**Report out and Discussion** (15 min)
14:30 - 14:45	**Coffee and Tea and Stretch Break**
14:45 - 15:45	**Session Five: Improving My Region's Services** **Regional Specific Groups** (60 min) • What are some opportunities for improvements in our region/community? • What is our top priority for action and /or a quick win? • Who do we need at the table/what resources do we need?
15:45 - 16:15	**Report Out and Discussion (30 Min)**
16:15 - 16:30	**Summary and Next Steps: Identifying the Path Forward** **Closing Comments** Thank you and safe journey

Appendix B: Presenter Bios

Dr Tamil Kendall, PhD

Tamil joined PSBC as Interim Provincial Executive Director in 2017. Tamil has a strong track record in perinatal and women's health, with over 20 years of provincial, national, and international experience in strategic planning, program/policy development, research, knowledge translation, and health care provider education. She has led and co-chaired a number of cross-ministry and provincial working groups, engaging stakeholders across the system of care in B.C. to advance improvements in safe vaginal birth, breastfeeding, perinatal mental health and substance use, gender-based violence and sexual and reproductive health. Tamil is passionate about promoting maternal and newborn health by improving quality because this critical period lays the foundation for individual and population health and well-being across the lifespan.

Cheryl Davies, RN, BA, MEd

Cheryl is the Chief Operating Officer at BC Women's Hospital + Health Centre, one of the largest maternity hospitals in Canada and the only facility in B.C. devoted primarily to the health of women, newborns and their families. With a background in nursing and adult education, she has over 20 years of experience in women's health leadership from community to hospital settings. She is a passionate advocate for women's health, reproductive rights and social justice and is an active international health volunteer in her spare time. She believes firmly in the strength of servant leadership and the importance of honouring women's values and voices in health care planning and system improvement.

Elder Roberta Price

Elder Roberta Price from the Snuneymuxw and Cowichan First Nations has worked tirelessly over the past three decades to educate and raise awareness about issues affecting First Nations people in a positive, informative, and productive manner. She does this by working as a First Nations educator, sharing her traditional knowledge in schools, within the community, and with First Nations people. She is the 'Elder in Residence' on FIR Square at BC Women's Hospital.

Carolyn Davison, BSc, MA

Carolyn is the A/Executive Director of Mental Health and Substance Use Policy at the Ministry of Mental Health and Addictions working with a dynamic team and in partnership across sectors with a focus on overdose emergency. Carolyn has been working in the fields of substance use, gambling, and mental health for more than 20 years and has co-led a number of national and Federal/Provincial/Territorial working and advisory groups including the First Do No Harm Advisory Committee and National Alcohol Strategy Advisory Committee. She holds a Master's Degree from Dalhousie University with a focus on health promotion, population health, and measurement and evaluation.

Dr Lenora Marcellus, RN, BSN, MN, PhD

Dr Lenora Marcellus is an Associate Professor and the Associate Director of Undergraduate Programs and Partnerships with the School of Nursing, University of Victoria. In this role she supports undergraduate program operations and curriculum development and liaises with the college and practice partners. She has over fifteen years of clinical experience in perinatal and neonatal intensive care nursing. Dr Marcellus is on the Community Advisory Council for HerWay Home, a community partnership program that provides care and support for pregnant women and new mothers with problematic substance use.

Dr Cornelia [Nel] Wieman, MD, FRCPC

Dr Nel Wieman is the Senior Medical Officer, Mental Health and Wellness, First Nations Health Authority. She is Canada's first female Aboriginal psychiatrist (Anishnawbe – Little Grand Rapids First Nation, Manitoba). She brings her extensive background in addictions and treatment, mental health and wellness to the First Nations Health Authority.

Dr Nancy Poole, PhD

Nancy is the Director of the Centre of Excellence for Women's Health and the Prevention Lead for the CanFASD Research Network. In these roles, Nancy leads knowledge translation, network development, and research related to improving health policy and service provision for girls and women with a range of health and social justice concerns, including substance use. With financial support from Health Canada and the Public Health Agency of Canada, Nancy is currently leading three national projects on how we incorporate trauma informed and gender informed approaches in substance use systems of care.

Cheyenne Johnson, MPH, RN, CCRP

Cheyenne is the Director of Clinical Activities and Development with the BC Centre on Substance Use [BCCSU] and the Canadian Research Initiative in Substance Misuse. She is also the Director of the BCCSU Addiction Nursing Fellowship. Cheyenne oversees the development of BCCSU's interdisciplinary program, clinical trial operations, as well as provincial clinical care guidance documents and dissemination, including evidence-based clinical guidelines, practice support tools and policy briefs.

Jola Berkman, RN, BScN, BSc (med) Hons

Jola Berkman is the Provincial Neonatal Care Coordinator for PSBC. She received her nursing degree from the University of Pretoria in South Africa and completed Neonatal Nursing Specialty training at Johannesburg General Hospital. After moving to Canada in 1990, Jola worked as a bedside RN and NICU Nurse Clinician at NRGH. In 2017 Jola assumed her new role at PSBC and became an NRP Instructor Trainer. She feels privileged and honoured to be in the position where she works with wonderful colleagues and positively influence the care of newborns across British Columbia. Improving the care of the opioid using pregnant mother and the opioid exposed infant lies close to her heart and continues to work to improve the outcome of this population.

Dr Sharon Vipler, MD, CCFP, dipl.ABAM

Dr Sharon Vipler is a board certified Addiction Medicine physician as a diplomat in the American Board of Addiction Medicine. She serves as Addictions Lead at the Creekside Withdrawal Management Centre. In addition, Dr Vipler works at the Surrey Substance Use Service Opioid Agonist Therapy Clinic, is a member of the Addiction Medicine Consult service at Surrey Memorial Hospital and the Addiction Medicine Consult Team at St. Paul's Hospital. Dr Vipler is also an Expert Clinician with the BC Centre on Substance Use.

Dr Janine Hardial, MD, CCFP

Dr Janine Hardial is a full-scope family physician in Vancouver, consultant for the Perinatal Addiction Service at BC Women's Hospital including providing intrapartum maternity care. She also practices at the *Sheway Clinic in Vancouver's Downtown Eastside and is its Medical Coordinator.

**Sheway is a Pregnancy Outreach Program*

Dr Eric Cattoni, MD, CCFP

Dr Eric Cattoni is a general practitioner in Vancouver, B.C. He is currently the Medical Co-Lead of FIR Square at BC Women's Hospital. He completed his medical training and residency at the University of Alberta. In addition to his work on FIR Square, he is a consultant physician for the Perinatal Addiction Service at BC Women's Hospital, a member of Birth Docs for on-call deliveries, and a physician at the Sheway Clinic.

Dr Robert Everett, MD, FRCPC

Dr Robert Everett is a general pediatrician in Vancouver, B.C. and is currently the Medical Lead of Pediatrics and Mother Baby Care at BC Women's Hospital. He received his medical training at the University of British Columbia, and completed his pediatric residency at Montreal Children's Hospital and BC Children's Hospital in 1998. In addition to his hospital work, he shares a consulting community pediatric practice with his Fairmont Pediatrics partners. His areas of particular interest include newborn care and management of the medically and socially complex child.

Amanda Seymour, BA Hons, BSW, MPA

Amanda Seymour is the Coordinator of the HerWay Home Program located in Victoria. Previously she worked for B.C.'s Ministry of Health in the Mental Health and Substance Use Branch (MHSU) where she led the development of the BC Trauma Informed Practice Guide and the Service Model and Provincial Standards for Residential Substance Use Services (Adults and Youth). Her work in the non-profit sector includes counselling and program leadership working with street involved youth and with women in the Downtown Eastside.

Denise Penaloza, RN, BSN

Denise Penaloza is the Supervisor at the Maxxine Wright Community Health Centre located in Surrey. She has been with Maxxine Wright since it opened in 2005. Denise spent 15 years as a Labour & Delivery nurse prior to her 14 years in Public Health. Maxxine Wright is the culmination of her passion for women's health, babies and the power of change. Her time is shared between day-to-day operations of the clinic, direct care for clients and administrative duties that include teaching and advocacy.

Jan Ference, BEd, M.S in Counselling, IPMHF (Infant-Parent Mental Health Fellow)

Jan Ference is the Director, Pathways to Healing Partnership, with the Comox Valley Child Development Association. Since April 2016, she has been leading a specialized, early intervention, trauma team. This team has had inspiring outcomes working intensely with women in the perinatal period who have Opioid Use challenges. It has been able to facilitate community system change based on the rich learnings gained from the perinatal work. Jan reports that the completion of an Infant-Parent Mental Health Fellowship through the University of California has been life changing as the knowledge and understanding of early care giving experiences is the key to understanding all life experiences that follow.

Shirin Jangi and Nicole Maharaj, Ministry of Children and Family Development [MCFD]

Both Shirin and Nicole hold the positions of Director of Operations with the Ministry of Children and Family Development serving the Vancouver region. They each have a BA with a specialty in Child and Youth Care. They have worked in MCFD for over 19 years in various capacities in the child protection field with over 10 years in leadership roles. Shirin and Nicole are committed to serving the vulnerable children and families in the community and working in partnership.

Appendix C: Resources

1. Evaluation Report of the Sheway Project for High-Risk Pregnant and Parenting Women (http://bccewh.bc.ca/wp-content/uploads/2012/05/2000_Evaluation-Report-of-the-Sheway-Project.pdf)
2. Harm Reduction in Pregnancy (http://bccewh.bc.ca/wp-content/uploads/2015/02/HReduction-and-Preg-Booklet.2015_web.pdf)
3. FNHA Harm Reduction Principles and Practices. (http://www.fnha.ca/wellnessContent/Wellness/FNHA-Indigenous-Harm-Reduction-Principles-and-Practices-Fact-Sheet.pdf)
4. FNHA Cultural Safety and Cultural Humility Policy Statement (http://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf)
5. Provincial Guidelines for the Treatment of Opioid Use Disorder During Pregnancy. (http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf)
6. Provincial Guidelines for the Clinical Management of Opioid Use Disorder. (http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf
7. BCCSU website (www.bccsu.ca), including an online addiction medicine diploma program and OAT training course.
8. RACE line (Rapid Access to Consultative Expertise) speciality areas include perinatal addictions and perinatal psychiatry (www.raceconnect.ca)
9. Canadian Pediatric Society's (CPS) guideline for Management of Infants born to Mothers who have used Opioids during Pregnancy. (https://www.cps.ca/en/documents/position/opioids-during-pregnancy)

Appendix D: Workshop Participants

BACON, Alixandra, Midwives Association of BC

BAKER, Jodi, Island Health Authority

BARCLAY, Karen, Island Health Authority

BARIBEAU, Isabelle, Vancouver Coastal Health Authority/Providence Health

BECU, Annalies, BC Centre for Disease Control/ Provincial Health Services Authority

BELL, Sarah, BC Children's/Provincial Health Services Authority

BERKMAN, Jola, Perinatal Services BC/Provincial Health Services Authority

BODKIN, Dr Kate, BC Women's/Provincial Health Services Authority

BOULTON, Dr Jill, Interior Health Authority

BRADSHAW, Denise, Provincial Health Services Authority

CARRUTHERS, Adrienne, Midwifery/Island Health Authority

CATTONI, Dr Eric, BC Women's/Provincial Health Services Authority

CHAPLAIN, Deborah, Island Health Authority

COMPTON, Miranda, Vancouver Coastal Health Authority

DAVIES, Cheryl, BC Women's/Provincial Health Services Authority

DAVISON, Carolyn, Ministry of Mental Health and Addictions

DE SALABERRY, Julie, BC Women's/Provincial Health Services Authority

DE ZWAGER, Marijke, Midwifery/Island Health Authority

DELANY, Michelle, Interior Health Authority

DODDS, Justine, BC Mental Health and Substance Use Services/Provincial Health Services Authority

EVERETT, Dr Rob, BC Women's/Provincial Health Services Authority

FERENCE, Jan, Pathways to Healing

GABRIEL, Teila, Vancouver Coastal Health Authority

GAUNT, Janet, Island Health Authority

HAMILTON, Danica, BC Women's/Provincial Health Services Authority

HARDIAL, Dr Janine, Sheway

HUNT, Dr Georgia, Sheway

JANG-HUGDAHL, Karen, Vancouver Coastal Health Authority/Providence Health

JANGI, Shirin , Ministry of Children and Family Development

JEBAMANI, Laurel, Vancouver Coastal Health Authority

JENKINS, Loraine, Fraser Health Authority

JEPSEN, Donna , Ministry of Health

JOHNSON, Cheyenne, BC Centre on Substance Use

KASK, Dr Jennifer, Island Health Authority

KAUFMAN, Sarah, Fraser Health Authority

KENDALL, Dr Tamil, Perinatal Services BC/Provincial Health Services Authority

KETCH, Dr James, Interior Health Authority

KOUWENBERG, Dr Jennifer, Island Health Authority

LIAO-LUSSIER, Penny, Island Health Authority

MacKILLOP, Mary, Children's and Women's/Provincial Health Services Authority

MAHARAJ, Nicole, Ministry of Children and Family Development

MAHUNGU, Dr Pascaline, Maxxine Wright Community Health Centre

MALLETTE, Christine, Sheway

MARCELLUS, Dr Lenora, University of Victoria, School of Nursing

McLEAN, Alison, Island Health Authority

MILLER-VEDAM, Zoë , Perinatal Services BC/

Provincial Health Services Authority

MOREAU, Emilie, First Nations Health Authority

MORGAN, Jenny, BC Women's/Provincial Health Services Authority

MUNDEL, Erika , First Nations Health Authority

MURPHY, Lisa, Island Health Authority

O'BRIAIN, Warren, BC Centre on Substance Use

O'SULLIVAN, Erin, Island Health Authority

PALMER, Dr Becky, First Nations Health Authority

PALMER, Lynne, Fraser Health Authority

PARSONAGE, Juanita, Island Health Authority

PATRICELLI, Dr Charissa, Fraser Health Authority

PAWAR, Deborah, Ministry of Children and Family Development

PAWLAK, Anna, Vancouver Coastal Health Authority/ Providence Health

PEDERSON, Dr Ann, BC Women's/Provincial Health Services Authority

PENALOZA, Denise, Maxxine Wright Community Health Centre

POLLOCK, Dr Sue, Interior Health Authority

POOLE, Dr Nancy, BC Centre of Excellence for Women's Health

PRICE, Roberta, Elder

RANGER, Jillian, Island Health Authority

ROBINSON, Samantha, BC Centre on Substance Use

ROGERS, Julie, Island Health Authority

RUDDICK, Kristen, BC Women's/Provincial Health Services Authority

RYAN, Dr Deirdre, BC Women's/Provincial Health Services Authority

SALMONS, Vanessa, Northern Health Authority

SAMSON, Rae, Interior Health Authority

SCARR, Jennifer, Child Health BC

SCHEMENAUER, Katherine , Northern Health Authority

SCRIVENS, Hanna, First Nations Health Authority

SEELEY, Terri-Lee, BC Mental Health and Substance Use Services/Provincial Health Services Authority

SEYMOUR, Amanda, Island Health Authority

SHRESTHA, Hema, Fraser Health Authority

STAVEL, Dr Miroslav, Fraser Health Authority

TAIT, Karla, First Nations Health Authority

THOMAS-PETER, Kate, BC Children's/Provincial Health Services Authority

THUMATH, Meaghan, Ministry of Mental Health and Addictions

TONNELA, Christina, Perinatal Services BC/Provincial Health Services Authority

TURNER, Ashley, Métis Nation BC

VIPLER, Dr Sharon , Providence Health

WALKER, Janet, Vancouver Coastal Health Authority

WEBSTER, Dr Glenys , Ministry of Health

WEICH, Stacie, Northern Health Authority

WHITE, Joanne, Ministry of Children and Family Development

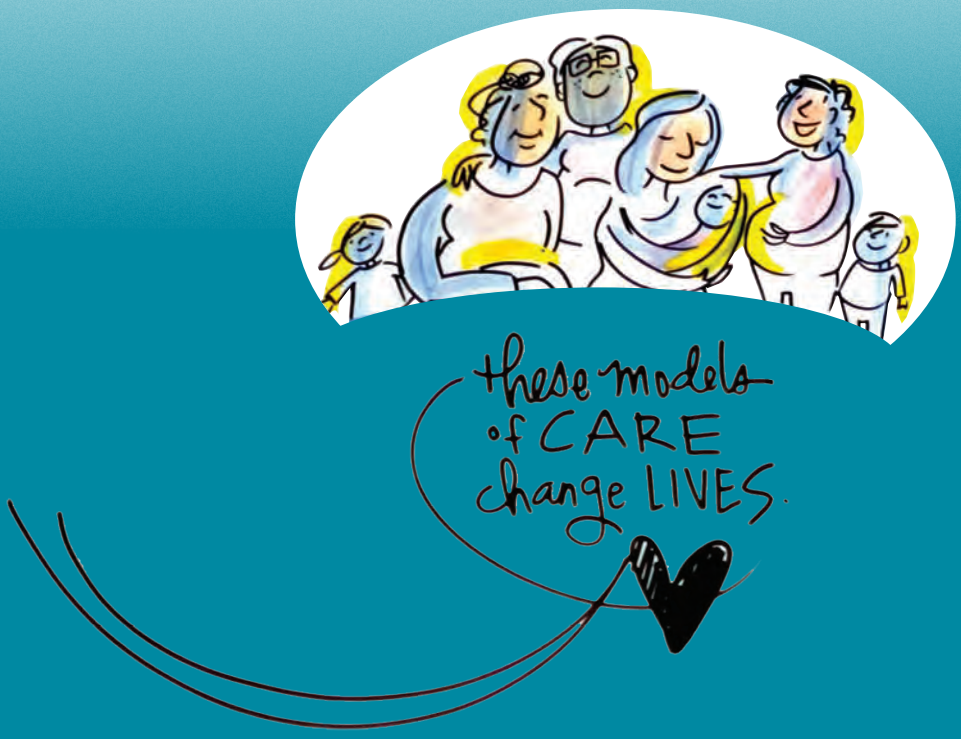
WIEMAN, Dr Cornelia [Nel] , First Nations Health Authority

WILKIE, Bonnie, Interior Health Authority

WITTMANN, Lani, BC Women's/Provincial Health Services Authority

WONG, Michelle, Ministry of Mental Health and Addictions

WYWROT, Michelle, Ministry of Children and Family Development



Provincial Health Services Authority
Province-wide solutions. Better health.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Perinatal Services BC
An agency of the Provincial Health Services Authority