



ROOMING-IN GUIDELINE

**for Perinatal Women
Using Substances**

OCTOBER 2020

i. Acknowledgements

We acknowledge that the *Provincial Rooming-in Guideline for Perinatal Women Using Substances* was created on the unceded traditional and ancestral homelands of the Esquimalt and Songhees Nations.

We dedicate this Guideline to all of the women and families who inspire us with their courage, strength, resilience and kindness, and we thank the many individuals whose work, input and expertise have contributed to its development.

We acknowledge that the Rooming in Guideline was developed through the overarching Provincial Perinatal Substance use Project which is funded by the BC Ministry of Health and BC Ministry of Mental Health & Addictions.

ii. Contributors

Elders

Input from the Elders has supported and strengthened the development of this Guideline. Special thanks goes to:

Glida Morgan, Tla'amin Nation

Roberta Price, Coast Salish Snuneymuxw and Cowichan Nations

Provincial Perinatal Substance Use Project Leads

Denise Bradshaw, Director, Provincial Health Initiatives, BCWH

Pamela Joshi, Project Manager, BCWH

Stacey Boon, Senior Provincial Education Lead, BCWH

Researchers / Writers

Tracy Byrne, InsideOut Policy Research

Michele Mundy, Indigovation Consulting, Inc.

Jenny Weston, InsideOut Policy Research

Research support by Samantha Morris, Jenneka Janzen, and Chelsea Gladstone

Reviewers

Lucy Barney, Indigenous Lead, Perinatal Services BC, PHSA

Amelia Doran, Registered Midwife, Seabird Island Health Centre

Dr. Robert Fox, Family Physician and Addiction Medicine Specialist, Seabird Island Health Centre

Dr. Annabel Mead, Clinical Assistant Professor, UBC; Director, BCCSU Addiction Medicine Fellowship Program; Addiction Medicine Consultant; Medical Lead, Provincial Perinatal Substance Use Service

Jenny Morgan, Director, Indigenous Health, Women and Families, BCWH

Dr. Charissa Patricelli, Medical Director, FIR BCWH; Family Medicine Lead, Prevention and Primary Care, Perinatal Services BC

Hawkfeather Peterson, Person with Lived Experience and Substance User Advocate

Erin Price Lindstrom, Manager, Women and Maternal Health, BC Ministry of Health

Kenneth Tupper, Director, Substance Use Prevention and Harm Reduction, BC Ministry of Health

Glenys Webster, Director, Women's, Maternal and Early Childhood Health, BC Ministry of Health

Zachary White, Policy Analyst, BC Ministry of Health

Key Informants and Reviewers

Dr. Ron Abrahams, Founding Director, FIR, BCWH; Consultant Physician, Sheway Program; Physician, Perinatal Addiction Service; Clinical Professor, UBC

Jola Berkman, Neonatal Care Coordinator, Perinatal Services BC

Sarah Coutts, Coordinator, Kangaroo Care, Perinatal Services BC

Tania Dick, First Nations Council

Lea Geiger, Provincial Coordinator, Baby Friendly Initiative, Perinatal Services BC

Dr. Jennifer Kouwenberg, Pediatrician, Nanaimo Regional General Hospital (*also a Regional Champion*)

Jeane Riley, Indigenous Health & Wellness Lead, Provincial Perinatal Substance Use Project; FIR Social Worker, BCWH

Lani Wittmann, Senior Practice Leader – Perinatal, BCWH

Provincial Consultations – Regional Champions / Leads

Maria Brouwer, Coordinator, Harmony House, Prince George BC

Robert Finch, Director, Maternal, Newborn, Child & Youth Network, Interior Health

Sarah Kaufman, Clinical Nurse Specialist – Perinatal Health, Fraser Health

Dr. Bill Kingston, Medical Lead, Perinatal Program, Northern Health

Deborah Klassen, Co-Executive Director, Karis Support Society, Kelowna BC

Jeanette Lequiere-Tough, Gaia Program, Aboriginal Family Services, Dawson Creek, BC

Rebecca Mabee, Program Manager, Victoria Native Friendship Centre

Tara MacDonald, Program Manager, Sanctuary, Union Gospel Mission, Vancouver BC

Denise Penaloza, Program Coordinator, Maxxine Wright Community Health Centre, Surrey BC

Sarah Rourke, Clinical Nurse Specialist – Neonatal, Maternal, Infant, Child & Youth Program, Fraser Health

Vanessa Salmons, Executive Lead, Perinatal Program, Northern Health

Amanda Seymour, Director, Provincial Support Office at Ministry of Mental Health and Addictions (formerly Regional Manager of HerWay Home Program, Island Health)

Focus Groups

Thank you to all of the women with lived and living experience, as well as direct care service providers who participated in focus group sessions across the province



iii. Message from the Chief Operating Officer, BC Women's Hospital + Health Centre and Chief Medical Officer, BC Children's Hospital & BC Women's Hospital + Health Centre, Provincial Health Services Authority

Rooming-in is a practice that originated at the BC Women's Hospital + Health Centre Families in Recovery (FIR) unit during its inception in 2003. Under the leadership of its Founding Medical Director, Dr. Ron Abrahams, FIR was one of the first units of its kind in Canada not only to address the acute stabilization of pregnant women using substances, but also to put the principle of mother-baby togetherness in the foreground. Over the years, Dr. Abrahams has contributed extensively to developing a body of evidence that supports Rooming-in as a standard practice of care for pregnant women using substances.

During the Visioning Forum 2018 – *Ensuring Best Care for Pregnant and Parenting Women Using Opioids* – a call to action to establish Rooming-in as a provincial standard of care was identified as a high priority for the province. This call to action, along with other priorities for system-wide transformation of services for pregnant and parenting women using substances, allowed the Provincial Health Services Authority to strategically leverage the initial forum to establish the *Provincial Perinatal Substance Use Project*.

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

The evidence related to the effectiveness of Rooming-in is undeniable. Some of the demonstrable benefits of Rooming-in include decreasing Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal symptoms among infants increasing efficacy, confidence, and attachment between mother and baby, and contributing to decreased costs to the healthcare system. Intuitively and scientifically, we know that mothers and babies do well together. With all of this evidence and knowledge, we have invested in the development of a comprehensive *Rooming-in Guideline* for the province.

The *Rooming-in Guideline* has been informed by extensive provincial consultations, including key informant interviews, focus groups across the province with direct care service providers, focus groups with women with lived and living experience, input and feedback from Elders and Indigenous Health Leaders. As a result, this Guideline identifies how to engage in Rooming-in as an ethos. Furthermore, it illustrates what the practice can look like across the maternity care landscape, even when the physical spaces (e.g. private rooms) do not exist. In addition, guidance is provided on reinforcing Rooming-in practices such as breastfeeding and substance use, skin-to-skin contact, and safer sleep. The Guideline also weaves Indigenous Cultural Safety as a core component of Rooming-in. Knowing Indigenous Cultural Safety is an outcome, we are committed to implementing evidence-informed and safe measurement tools, to uphold accountability and to learning about how culturally safe our services are. This approach will involve reciprocal relationships with Indigenous peoples, communities, and leaders on evaluating our services.

It is our sincere hope that the *Rooming-in Guideline* will describe a clear path for this best practice – what it looks like, who is involved, and how it can be implemented across acute care settings as a collective province-wide approach to improving our services for pregnant and parenting women using substances.

Sincerely,

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

Dr. Jana Davidson
Chief Medical Officer, BC Children's Hospital &
BC Women's Hospital + Health Centre

A Note on Key Terminology

Gender and Language

In order to acknowledge and be inclusive of individuals who have given birth to a baby but do not identify as female, and to respect those who do identify as women and mothers, this Guideline uses the terms ‘woman,’ ‘person,’ ‘mother,’ ‘birthing parent’ and ‘parent.’ In the introductory content, these terms are used interchangeably. In the sections of the Guideline that set out the components and practice elements of the Rooming-in model, the terms ‘mother’ and ‘woman’ are predominantly used, in the interests of clarity and consistency.

The *Provincial Perinatal Substance Use Project* uses the terms ‘mother-baby dyad’ and ‘mother-baby togetherness,’ and they are also used in the Guideline to align with the broader work of that Project.

All healthcare providers are encouraged not to make assumptions about the gender identity of the pregnant or newly parenting person (or their partner), but to respectfully and non-judgmentally ask them how they want to be addressed. In addition, not every person who is lactating will be comfortable with the term ‘breastfeeding.’ It is important for healthcare providers to ask people which term they prefer to use when discussing the act of feeding their baby. Other options include ‘chestfeeding’ or ‘nursing.’

Indigenous Peoples

‘Indigenous Peoples’ refers to the original inhabitants of the land and, in Canada, includes First Nations, Métis, and Inuit Peoples. The first letters are capitalized to recognize nationhood, and the term is plural to recognize the multiplicity of Indigenous nations that exist across the country. In Canada, the term ‘Aboriginal’ is sometimes used interchangeably with ‘Indigenous.’ However, ‘Indigenous’ is increasingly recognized as the preferred term due, in part, to its association with the *United Nations Declaration on the Rights of Indigenous Peoples*.

TABLE OF CONTENTS

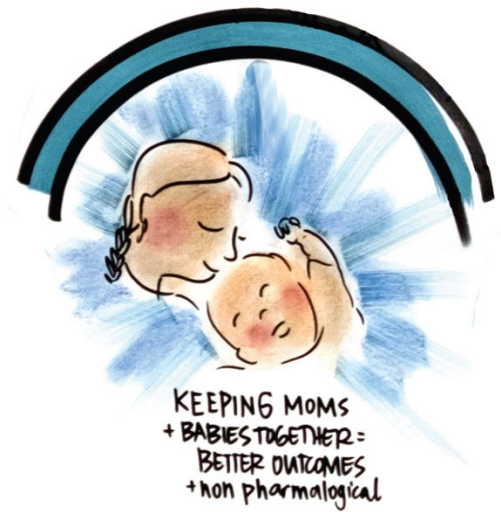
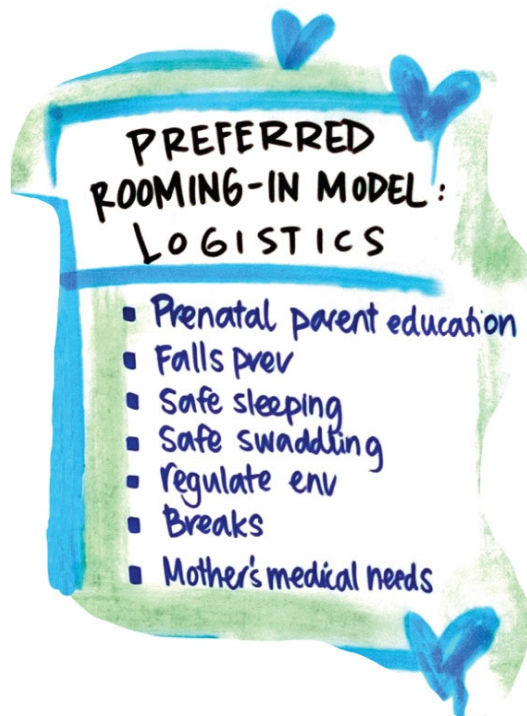
Introduction.....	1
<i>What is Rooming-in?</i>	<i>1</i>
<i>The Provincial Perinatal Substance Use Project</i>	<i>1</i>
<i>Rooming-in for Perinatal Women Using Substances</i>	<i>1</i>
<i>Indigenous Women, Colonization, Substance Use and Perinatal Care</i>	<i>2</i>
<i>The Current Landscape</i>	<i>3</i>
<i>The Provincial Rooming-in Guideline for Perinatal Women Using Substances</i>	<i>9</i>
Guiding Principles in Practice	11
Rooming-in Components	16
1. <i>The Physical Space</i>	<i>17</i>
2. <i>Breastfeeding</i>	<i>21</i>
3. <i>Skin-to-Skin</i>	<i>27</i>
4. <i>Safer Sleeping</i>	<i>31</i>
Foundations for Implementing Rooming-in	35
Looking Forward	36
Appendix A: Organizational Self-Assessment Tool	37
Appendix B: Definitions of Guiding Principles	40
References	41

Introduction

What is Rooming-in?

Rooming-in is the practice of keeping a mother/birthing parent and baby together in the same room for the duration of their hospital stay with the key goal of promoting mother-baby togetherness. The Rooming-in model of care encompasses support for breastfeeding, skin-to-skin contact and safer sleeping. It may also include the active involvement of fathers, whole family support, and other caregivers to help the mother look after their baby. Rooming-in may be offered on the maternity unit, pediatric unit or in the NICU. As well as the hospital, Rooming-in can also be provided in a community setting.

Rooming-in is an evidence-informed model of care that prioritizes the mother-baby dyad, fosters trust between parents and healthcare providers, and facilitates healthy bonding and attachment between mother and baby. It is the standard of care for the general postpartum population. However, it has been a challenge to implement, due to system, organizational, and staffing-level issues, many of which are addressed throughout the *Rooming-in Guideline*.



The Provincial Perinatal Substance Use Project

The *Provincial Rooming-in Guideline for Perinatal Women Using Substances* (the Guideline) has been developed as part of the *Provincial Perinatal Substance Use Project*. The Project is led by BC Women's Hospital + Health Centre, Provincial Health Services Authority, to build capacity within acute and community-based services for pregnant and early parenting women using substances and their infants. The goal of the Project is to establish a blueprint for a provincial perinatal substance use continuum of care. One of the nine guiding principles of the Project refers to keeping the mother-baby dyad together.

The *Provincial Perinatal Substance Use Project* is funded by the BC Ministry of Health and the BC Ministry of Mental Health and Addictions.

Rooming-in for Perinatal Women Using Substances

There is abundant evidence to support Rooming-in as the standard of care for both women, who have used substances during their pregnancy, and their babies. In the research literature, Rooming-in is associated with a range of medical and psychosocial benefits. These benefits include higher levels of maternal satisfaction with birthing and hospital experiences, more hands-on involvement in infant care, increased bonding and attachment, and improvement in symptoms of neonatal abstinence syndrome (NAS) in infants.

Systematic reviews have found that Rooming-in is consistently connected to higher rates of breastfeeding, lower rates of pharmacological treatment for NAS, reduced treatment length, and shorter hospital stays.¹ Additional benefits include faster response to infant hunger or discomfort cues, increased privacy for birthing parents to provide skin-to-skin contact and breastfeed, more opportunities for fathers and family members to participate in day-to-day infant care, and increased family unity (where child welfare agencies are involved).²

Rooming-in is also associated with significantly reducing health care costs and reducing health care utilization. For example, modeled after the practices at FIR at BC Women's Hospital + Health Centre, Kingston Hospital in Ontario undertook a pilot project to explore providing Rooming-in among 21 mothers in 2013. An analysis estimates that implementing Rooming-in with that cohort of mothers saved the hospital approximately \$400,000 from reducing the need for pharmacological treatment and decreasing NICU and maternity unit hospital stays.³ Rooming-in has now become a standard of care at the Kingston Hospital.

As a standard of care, Rooming-in is associated with non-judgmental, compassionate, trauma-informed, and culturally safe practice. It is well-documented that pregnant and parenting women who use substances face stigma and discrimination in the healthcare system, as well as poor outcomes with respect to their health, the health of their babies, and the preservation of their families.⁴ It is crucial, therefore, to promote the nurturing environment of Rooming-in for pregnant and parenting women at every possible juncture in the perinatal journey.⁵

Indigenous Women, Colonization, Substance Use and Perinatal Care

It is critical for healthcare providers to examine the history of colonization in Canada in order to understand the ongoing impacts for Indigenous Peoples across the country, and in British Columbia specifically. This understanding must underpin changes in healthcare provision that will support improved outcomes for Indigenous Peoples.

Colonial history has created the foundation for racism and discrimination against Indigenous Peoples. This is entrenched throughout society – in legislation, in policy, and in practice. As Senator Murray Sinclair has noted, even if every racist person were removed from systems across the country, there would still be racist institutions because they are founded on racist principles that assume Indigenous inferiority and European superiority.

Colonial legislation, such as the Doctrine of Discovery and the Indian Act, and the establishment of the Residential School system and segregated hospitals, have deliberately disconnected Indigenous Peoples from their lands, traditions and cultural identities. This has led to a range of detrimental outcomes, including poverty, violence, problematic substance use, chronic social and legal persecution, and disenfranchisement. Indigenous women and mothers have been – and continue to be – disproportionately impacted by gendered colonial violence and removal of children which ultimately affects First Nations, Métis and Inuit communities as a whole.

The National Inquiry into Missing and Murdered Indigenous Women and Girls found Canada guilty of genocide against Indigenous Peoples.⁶ This genocide is ongoing. Colonial structures – including healthcare and child welfare systems – have often discriminated against Indigenous women and their children.⁷ Indigenous women have experience forced sterilization in the recent past, and currently experience high rates of family separation, leading to over-representation of Indigenous children in care.

These realities have instilled a deep sense of loss and intergenerational trauma for Indigenous women, families and communities, which must be taken into consideration when providing perinatal care. Indigenous women survivors in Vancouver's Downtown Eastside have cast a spotlight on these acts of colonial violence and ongoing oppression in

the *Red Women Rising Report*.⁸ This recent report makes an urgent plea for radical system change across all sectors, including a focus on culturally safe care and keeping Indigenous families together.

Addressing historical, current and ongoing colonization requires meaningful, consistent action at multiple levels. At the national level, the UN Declaration of Rights of Indigenous Peoples (UNDRIP)⁹ and the Truth and Reconciliation Commission of Canada (TRC) Calls to Action¹⁰ to redress the legacy of residential schools provide frameworks for advancing reconciliation across Canada. There are provincial commitments in BC to both implement the principles of the UNDRIP in 2019 and the TRC in 2016, that acknowledge that words must translate into positive and tangible change for Indigenous communities and the province. At regional levels, Regional Health Authorities also signed off on the Declaration of Commitment on Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal people in BC.

The Rooming-in model, with its inherent focus on mother-baby togetherness, family involvement, and trauma-informed practice, creates a space for culturally safe and supportive perinatal care. The *Provincial Rooming-in Guideline for Perinatal Women Using Substances* has been developed with these crucial considerations firmly in mind and with a concerted effort to translate the principles of trauma-informed care and Indigenous Cultural Safety into practice. The majority of women accessing perinatal substance use services in BC identify as Indigenous.¹¹ Therefore, it is imperative that all perinatal service providers participate in ongoing Indigenous Cultural Safety training. This message is stressed throughout the Guideline. Embedding Indigenous Cultural Safety from a trauma-wellness and trauma-informed lens into perinatal substance use services will support improved access to care for Indigenous women and better outcomes for them, their babies and their families.

Further, it is vital for Indigenous women's voices to inform the design, delivery and evaluation of perinatal programs and services. In the consultations for the Guideline, Indigenous women emphasized the importance of consistency of care, non-judgmental service provision, and a sense of safety in order to build trust and remove power differentials between providers and Indigenous patients and families.



The Current Landscape

The current landscape in British Columbia, with regard to Rooming-in for perinatal women who use substances, is extremely varied. FIR, located in BC Women's Hospital + Health Centre in Vancouver, is the province's highly specialized Rooming-in program for perinatal women who use substances. It was here that Rooming-in for women using substances began, as did foundational work on the *Eat, Sleep, Console* model of care for infants with symptoms of NAS. At the regional health authority level, hospitals are at different stages with regard to Rooming-in: at some sites,

including the University Hospital of Northern BC and Nanaimo Regional General Hospital it is the standard of care, while at others it is not yet being offered.

Nevertheless, across the province there is growing recognition of the benefits of Rooming-in for birthing parents and babies affected by substance use, and increasing commitment to taking steps towards implementing it as the standard of care. For instance, health professionals, administrators and system leaders from across BC who participated in a PHSA led 2018 Visioning Workshop on “Ensuring best care and supports for pregnant and newly parenting women with opioid use challenges” identified stigma as a significant barrier to mother-baby togetherness and agreed that there should be “no more excuses” for continuing to separate mothers and babies, and that Rooming-in should be implemented in all hospitals across the province.¹² The Guideline is a direct response to this call to action. Noted trauma-informed exceptions to this may exist where a woman has requested respite support or breaks from caring for her infant or when a woman has, by choice, indicated that she does not wish to participate in Rooming-in/mother-baby togetherness. The Guideline is a direct response to this call to action.

Challenges and Opportunities

Stigma is a barrier to timely, accessible and quality care for pregnant and parenting women using substances. Stigma is generally defined as a complex social process involving the interplay of many processes, such as labelling, stereotyping, separation, prejudice and status loss, and discrimination and can be felt at multiple levels (self, social and structural).¹³ In addition, stigma is intersectional and compounding, meaning that stigmatization related substance use may be experienced even more severely by people who experience other forms of inequity (e.g. poverty, racism and other forms of discrimination).¹¹

Throughout the development of the Rooming-in Guideline, stories of stigma were shared by women with lived and living experience consulted across the province about Rooming-in. Women with lived and living experience described the importance of bonding with the baby, to have supportive health care providers and access to partners and families while Rooming-in for added support. Women with lived and living experience also shared instances of social stigma with health care professionals in hospitals holding biases and negative judgements towards pregnant and parenting women using substances. Women described being scrutinized and often judged harshly or unfairly – examples included being judged for breastfeeding or conversely being judged for bottle feeding, being judged for taking a break/asking for respite, and most significantly, being judged on their ability to parent.

Service providers across the province identified a number of challenges for implementing Rooming-in and supporting mother-baby togetherness that speak to structural stigma. These challenges include lack of leadership supports, policies or infrastructure in place to support Rooming-in. Many of these issues are covered in this Guideline and are also actively being explored and addressed by hospitals and healthcare workers with input from parents and families, including: lack of appropriate Rooming-in space in the hospital; management of neonatal abstinence syndrome; hospital length of stay; and working with the Ministry of Children and Family Development (MCFD).

Finding or creating appropriate space for Rooming-in within the hospital setting is covered in the first of the four Guideline components, The Non-pharmacological management of NAS, hospital length of stay, and working with MCFD are examined here.

Non-pharmacological Management of Neonatal Abstinence Syndrome (NAS)

Recent BC data indicate that approximately 40% of infants who have been exposed to opioids in utero will develop symptoms of neonatal abstinence syndrome (NAS) or be affected by maternal substance use.¹⁴ Anecdotal evidence suggests this number is higher, ranging from 80 to 90%.

Pharmacological management of NAS has traditionally involved admission to a Neonatal Intensive Care Unit (NICU) for assessment and, if indicated, continuous cardio-respiratory monitoring. Admission of the baby to the NICU for assessment and subsequent treatment of NAS continues to be a common practice in hospitals across BC. However, there is recent emerging evidence from a five-year retrospective chart review at the Families in Recovery (FIR) unit (BC Women's Hospital + Health Centre) that infants did not experience apneic events associated with morphine treatment for NAS.¹⁵ This emerging research suggests that treatment for NAS may not require transfer of care to NICU environments for cardio-respiratory monitoring for pharmacological NAS treatment.

Maintaining mother-baby togetherness in the maternity environment is paramount. When the NICU is an open bay design, the mother-baby dyad may be disrupted as there is often a lack of space for the birthing parent to stay at the baby's side. In addition, the NICU environment, such as bright lights and sound, does not always allow for the regulation of environmental stimulation.

What parents are saying...

"When I first heard about Rooming-in, I was overjoyed to hear it. I think that my baby would have been off morphine quicker if I could have been closer to him. If the baby doesn't need to be in the NICU, they should be with the mom."

What healthcare providers are doing...

- Utilizing morphine when pharmacological treatment for NAS as indicated and in alignment with site specific practices and protocols. There is evidence emerging on the use of buprenorphine and methadone to manage NAS as an alternative to morphine.^{16, 17}
- Promoting *Eat, Sleep, Console*, which is an evidence-based method for managing NAS that preserves the mother-baby dyad in the Rooming-in setting, rather than the baby being removed to the NICU for care. The method maximizes non-pharmacological support using ten reinforcing strategies with the mother as the first line of treatment. Strategies include skin-to-skin, cuddling, swaddling, and frequent feeding. *Eat, Sleep,*

Console places parents (and, potentially, other family members) as primary caregivers, which enhances bonding and attachment, and offers parents an active role in supporting their baby's health.

- In collaboration with Perinatal Services BC, the Provincial Perinatal Substance Use Project has funded and supported the development of *Eat, Sleep, Console*, including online learning modules. The modules are available as foundational interdisciplinary training by UBC Continuing Professional Development [link here](#):



Hospital Length of Stay

Mother-baby togetherness is best supported when mother and baby can room-in at the hospital for as long as they need to establish a bond and to be connected to supportive housing and other community-based supports.

However, hospitals are under pressure to discharge mothers and babies promptly to free up needed space. Mothers and babies may be discharged before essential community supports – especially housing with wraparound supports– are in place, which increases the risk of the baby being removed. Mothers may also be discharged while their babies are in the NICU, which disrupts the mother-baby dyad.

What parents are saying...

“I had to fight to stay in the hospital. I needed more time with my baby.

I had to look really hard to find resources in the community. I had to struggle to find any help at all.”

What healthcare providers are doing...

- Involving all members of the mother and baby’s care team in determining an appropriate length of stay – taking into account the needs of each dyad, and allowing time to connect them to appropriate community-based resources.
- Working with hospital executive administration to explain the benefits of a longer hospital stay for mother and baby – both for the individual mother-baby dyad, longer term outcomes and the healthcare system as a whole.
- Learning about local community services that provide live-in, specialized supports for mothers and babies – building and maintaining relationships with these services and engaging them early in the pregnant person’s care to enable the dyad’s safe transition to a community setting.



“We are allowed to room-in with our baby in the NICU in Prince George. They have double-size beds, sinks, counters, a mini-fridge to put your breastmilk in, and screens that show baby’s vital signs.”

Working with MCFD/DAA

When a pregnant or parenting person is affected by substance use, child welfare services often become involved and there is a significant risk that a new baby will be removed from the birth parent's custody.

Parents report feeling reluctant to engage with the Ministry for Children and Family Development (MCFD)/Delegated Aboriginal Agencies (MCFD/DAA) proactively because of the fear of losing their baby. Healthcare providers may be unsure about the extent to which they can advocate for the mother-baby dyad.

What parents are saying...

"We are scared to death to reach out to MCFD. If my baby had been taken, I don't know where I'd be now. If we can talk to MCFD beforehand, we can make plans, and put things in place. That would be better."

What healthcare providers are doing...

- Supporting parents and their families to navigate child welfare services and engage with MCFD/DAA proactively. This reduces parental anxiety and improves the chances of mother's self determination, wellbeing and baby staying together.
- Finding opportunities to work collaboratively with MCFD/DAA social workers to provide the best and safest care for the mother-baby dyad by, for example:
 - To honour and support the voices of birthing parents, and their advocates, to lead their care in all communication and decision-making with MCFD/DAA.
 - Establishing shared decision-making, protocols and agreements and decision making around infant removal and ensuring that there is a clear assessment in place and safety plan completed prior to any child removal (See, for example, the [Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities](#).) Participating in joint education and training sessions.
 - Holding regular hospital –child welfare meetings to identify and address ongoing issues, challenges and mitigations to supporting mother-baby togetherness.



"Having my partner in the room has been a godsend. It's been a really big help. My exhaustion levels have been minimal."

Rural and Remote Communities

In rural and remote communities, there is often no local access to hospital-based maternity care and pregnant people are required to travel to larger centres (sometimes weeks before their due date) to deliver their babies without the support of their families and communities. They often go through the final weeks of their pregnancy homesick, distressed, alone, and feeling voiceless and powerless. Many of these people are Indigenous, and this forced evacuation to give birth perpetuates trauma and the colonial disruption of Indigenous ways of being.

Through community consultations, women shared stories of the trauma of having to leave their homes at this significant and vulnerable time in their lives. Affordable transportation to needed services was identified as a major issue, with women describing having to hitchhike, or even walk, from their remote communities to the closest hospital. Women also described feelings of loneliness and anxiety during their stay at hospital, with detrimental impacts on their health and wellbeing.

In many remote communities, families, mothers and local not-for-profit organizations (including pregnancy outreach programs) are finding creative solutions, and going above and beyond, to keep mothers and babies together. For example, in Dawson Creek, community members developed a local protocol with provisions for a mother to stay with her baby after she was discharged from hospital, as the baby needed additional care in hospital. The same protocol commits to holding at least 2 integrated case management meetings before a baby is discharged (including safety planning and planning with MCFD). This example highlights how essential it is for hospital staff to build relationships with community-based organizations and with local MCFD/DAA services, and to collaborate on ensuring pregnant and newly parenting people using substances experience safe transitions and continuity of care.

The Provincial Rooming-in Guideline for Perinatal Women Using Substances

What is the Goal of the Guideline?

The Guideline has been developed to improve perinatal care for women using substances, with the specific goal of Rooming-in implementation to keep mothers and babies together in the immediate and longer term. The evidence-informed Guideline reflects the latest published research and is also informed by the experiences and expertise of parents with lived and living experience and service providers throughout BC.

The Guideline is not a “how to” manual; rather, it is a tool to guide best practice and enhance decision making for healthcare providers working with pregnant and parenting women using substances.

Who is the Guideline for?

The Guideline applies primarily to hospital-based perinatal care settings, with some consideration of the role played by community-based services in facilitating mother-baby togetherness beyond the hospital stay. Intended audiences include direct care staff involved in providing perinatal care, educators, practice leaders, hospital executives and administrators, and community organizations that link with hospitals to provide ongoing care for women and their babies.



“Once I had privacy, I felt like I could bond with my baby, and I wasn’t feeling discouraged by what was happening for the other mothers.”

How was the Guideline developed?

Development of the *Provincial Rooming-in Guideline for Perinatal Women Using Substances* was supported by the *Provincial Perinatal Substance Use Project* team. Research, consultation and writing were conducted by a team of Indigenous and non-Indigenous consultants, with input from Elders and Knowledge Keepers, as well as from key informants and experts in Rooming-in and perinatal substance use across the province.

The approach to developing the Guideline was evidence-informed and highly collaborative. Foundational research included reviews of:

- Recent research and grey literature on perinatal substance use and Rooming-in;
- Policy and practice materials from select Canadian and international jurisdictions; and
- Stories of women sharing their health care experiences
- Published sources on the impacts of colonization and approaches to reviving traditional Indigenous birthing practices.

In-person consultations were conducted across BC with 8 sessions occurring among perinatal healthcare providers and community-based service providers and 7 sessions occurring with women with lived and living experience. At FIR, fathers also participated in a consultation session. In addition, interviews were held with Indigenous and non-Indigenous key informants with expertise in specific aspects of perinatal care, including Rooming-in for women who use substances and their babies.

All of the findings, and in particular the insights and experiences shared by direct care providers and women with lived and living experience, have helped to shape this Guideline.

The writing process was iterative. Ongoing input was provided by the *Provincial Perinatal Substance Use Project* team at BC Women's Hospital + Health Centre, and drafts were reviewed by selected subject matter experts and Indigenous health and wellness service providers. Feedback from all of these contributors was used to refine the final version of the Guideline.

How is the Guideline structured?

The Guideline has three parts:

- **Guiding Principles in Practice** – presents concrete examples of how service providers can apply to their practice the nine principles that underpin the work of the *Provincial Perinatal Substance Use Project*.
- **Rooming-in Components** – provides guidance for the four key components of the Rooming-in model of care – the physical space, breastfeeding, skin-to-skin, and safer sleeping. Each component includes essential elements of care, as well as notes and considerations to support practice.
- **Foundations for Implementing Rooming-in** – describes capabilities and resources that are foundational to implementing Rooming-in for women using substances and their babies.

Considerations for Indigenous Cultural Safety are woven into the Guideline, and the voices of direct care service providers and women with lived and living experience are highlighted throughout.

Guiding Principles in Practice

The *Provincial Perinatal Substance Use Project* is guided by a set of nine principles. (See image right.) These principles, which support strong relational practice, underpin the *Rooming-in Guideline*. They also closely align with what women with lived and living experience have said is important to them when receiving perinatal care.

Below are some select examples of what these principles look like in practice when establishing and supporting Rooming-in across sectors, settings and disciplines.

It is important that healthcare providers receive appropriate education and training with respect to these principles, so that they can apply them to their daily practice.



Mother – Baby Togetherness **MOTHER – BABY TOGETHERNESS**



In their practice, healthcare providers are encouraged to...

See the parent and baby as one unit and give care to both parent and baby without separation. This is the overarching principle and intended outcome of Rooming-in, and therefore healthcare providers should strive to implement the *Rooming-in Guideline* into their daily practice.



TRAUMA AND VIOLENCE INFORMED PRACTICE

Trauma and Violence Informed



In their practice, healthcare providers are encouraged to...

- Be as transparent, consistent and predictable as possible
- Be aware of the intersections between trauma, substance use and intimate partner violence
- Use a tone that conveys genuine care and concern
- Ask what physical and emotional safety means to each birthing parent, their partner and family
- Explain what, why and how before doing something
- Be clear about your role as a healthcare provider (e.g. communicate what can and cannot be done)
- Be conscious of balancing power and addressing power dynamics
- Focus on building trust and providing and communicating options and choices to birthing parents, their partners and family
- If a promise is made (e.g. to connect with a family member or to help with an aspect of the baby's care) follow-through in a timely manner

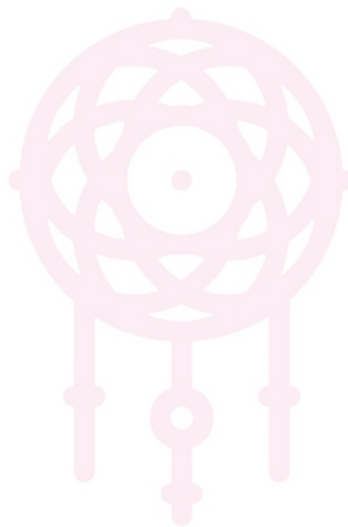
Indigenous Cultural Safety



INDIGENOUS CULTURAL SAFETY

In their practice, healthcare providers are encouraged to...

- Create a welcoming space for Indigenous women and their families – ask the woman and their family, “What do you need to feel safe in this space?”
- Be prepared to share information about yourself to create trust and a movement towards equity, actively reflecting on how your social location affects your practice
- Frequently check-in to ensure that the care plan fits with the mother’s cultural needs and preferences
- Find or create space and opportunities for ceremony
- Engage community-based Elders, Knowledge Keepers and Traditional Healers as a normative part of clinical practice
- Build relationships with Indigenous service providers as a part of care planning
- Learn about the Indigenous communities where you work and participate in community events, if invited
- Participate in ongoing, Indigenous-led Cultural Safety training, cultural events and ceremony provided by Indigenous Elders and leaders
- Learn about and acknowledge the history of colonization – in particular, the ongoing racism and discrimination against Indigenous Peoples within health and child welfare systems, and how practices need to shift to support Indigenous women and families
- Share knowledge instead of telling, and solve problems collaboratively instead of being the expert
- Create opportunities for Indigenous people to safely provide feedback and participate in service evaluations



Harm Reduction Based



HARM REDUCTION BASED

In their practice, healthcare providers are encouraged to...

- View harm reduction in the context of recovery, strengths and resiliency – recognizing that it includes abstinence and active use, and everything in between
- View connection and culture as approaches to decolonizing addiction
- Actively work to address stigma, bias about substance use and harm reduction
- Provide care in a flexible, non-judgmental and nurturing way
- Provide parents with accurate and current information and education about pregnancy, parenting and substance use
- Involve birthing parents in safety and relapse planning, and make harm reduction supplies available
- Collaborate with child welfare services, advocating strongly for mother-baby togetherness
- See each person for their potential, not their limitations in a strengths and resiliency based approach
- Be aware of your own prejudices and work to remove such feelings

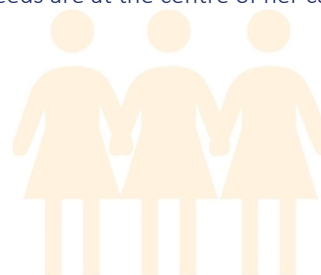


WOMEN CENTRED AND WOMEN'S VOICES

In their practice, healthcare providers are encouraged to...

- Explain the different options for care, and give each woman enough time to carefully consider these options and come to a decision
- Share decision-making power with women, recognizing that they are a partner in their own health and the experts in their own needs
- Ask the mother what they need to know about their care and the care of their baby, and provide the appropriate information, education and practical support
- Support each woman to participate in the care of their baby, as much as they are comfortable, to help them gain skills and confidence as a parent
- Work from a strengths-based perspective, recognizing and drawing on the strengths that each woman brings
- Respect each woman's choices and preferences for their care and the care of their baby
- Work with the woman's advocate and, if needed, support her to connect with an advocate (e.g. a hospital-based worker, social worker, Indigenous liaison), to ensure that her voice and needs are at the centre of her care

Women Centred & Women's Voices



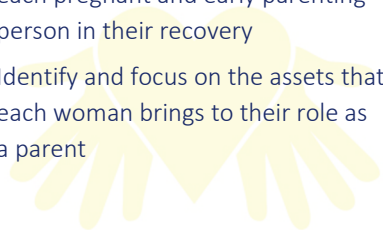
Recovery Oriented



RECOVERY ORIENTED

In their practice, healthcare providers are encouraged to...

- Recognize that recovery is a journey that involves caring for the whole person and working to enhance their physical, mental, spiritual, social and cultural wellbeing
- Use motivational interviewing techniques to support each person to set and make progress towards their own recovery-related goals
- Identify and focus on the sacredness and assets that each woman brings to their role as a parent
- Ask each person who they would like to be involved from their family and community, and welcome and make space for them
- Take time to talk to fathers and family members at each visit – make sure they do not feel like you are rushing them
- Help pregnant and early parenting people to connect with and access substance use and recovery services and supports in their community
- Build linkages and collaborate with community-based health, social and cultural services that can support each pregnant and early parenting person in their recovery
- Identify and focus on the assets that each woman brings to their role as a parent



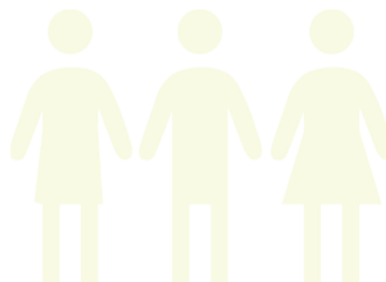
Inter-disciplinary



INTER-DISCIPLINARY

In their practice, healthcare providers are encouraged to...

- Work collaboratively as part of a care team – this calls for strong relationships between, for example, perinatal nurses, physicians, midwives, hospital social workers, doulas, lactation consultants, Aboriginal Patient Liaisons, patient advocates, outreach workers, Elders, peer support workers, first responders, and child welfare workers, as well as connections to community supports
- Provide consistent messaging and care to each mother and baby – for example, consistent messaging around breastfeeding and substance use, and clustering care to minimize disruptions
- Create opportunities to come together regularly as an inter-disciplinary team for updates and planning
- Engage peers and women with lived and living experience in planning and service delivery
- Know when to call in a clinician with expertise in perinatal care and substance use to ensure that each woman receives the best possible advice and support



Evidence Informed



EVIDENCE INFORMED

In their practice, healthcare providers are encouraged to...

- Have the appropriate education, training and experience to provide perinatal and substance use specific care, particularly in hospital
- Make sure that all of the information and education you offer parents and families reflects the latest evidence
- Learn about the traditional birthing practices, wise practices and cultural knowledge that may help you provide better care to people who identify as Indigenous
- Stay up-to-date on the latest data and research evidence on perinatal care and substance use
- Initiate and/or take part in information-sharing sessions with colleagues (such as lunch and learns)
- Take part in knowledge-exchange activities with service providers from other sectors



Equitable Access



EQUITABLE ACCESS

In their practice, healthcare providers are encouraged to...

- Acknowledge the patient-provider power dynamics and make every effort to mitigate them by, for example, providing woman-centred and culturally-safe care
- Treat all people, regardless of their past or current substance use, with a high level of respect
- Use language that reduces stigma related to substance use and other challenges
- Engage peers and women with lived and living experience in planning and service delivery
- Be mindful of the particular needs of women who have had to leave their home communities to give birth – additional supports may include, for example, connecting women with their family virtually, linking Indigenous women to Aboriginal Patient Liaisons and other Indigenous supports, offering opportunities for ceremony
- Where perinatal services for women using substances are limited, work collaboratively with community partners to provide the supports needed to keep mother and baby together



Rooming-in Components

Rooming-in is a care model that incorporates a bundle of practices, including the physical space, breastfeeding, skin-to-skin, and safer sleeping, all with a focus on keeping birthing parent and baby together for the duration of their hospital stay or while they are accessing live-in community-based supports. Rooming-in also represents a fundamental commitment to honouring the mother-baby dyad, rooted in an understanding of the vital importance of early bonding and attachment between birthing parent and baby.

Rooming-In to Support Mother-Baby Togetherness



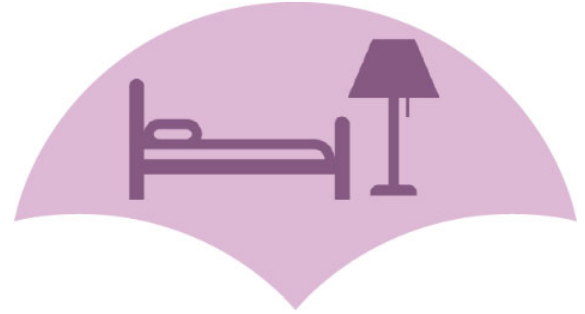
All components of the Rooming-in model are equally important and mutually reinforcing. Depending on local contexts and resources, hospital and community-based sites may already have some (or all) of the components in place, while others may still need to be developed and implemented. The *Rooming-in Guideline* supports service providers to gauge where they are at, and what more they need to do, to provide the best care possible for perinatal women using substances and their babies.

One of the most common barriers to implementing the Rooming-in model in BC is the lack of private rooms in maternity units. However, while providing a private room for parent(s) and baby is the ideal scenario, in settings where this is not yet possible, the majority of Rooming-in practices can still be implemented. Creative solutions can be found for increasing privacy and mother-baby togetherness in shared rooms and spaces.

Therefore, Rooming-in is still possible when a private room is not available.

1. The Physical Space

The Rooming-in space offers privacy, and a sense of safety and comfort for the mother and involved family members, and is an environment that is responsive to the baby's needs.



What the evidence says...



Rooming-in is best facilitated when mothers, their partners and/or involved family members have access to a private room, which makes it easier and more comfortable for them to participate in caring for the baby.¹⁸ Women report that privacy or undisturbed time with their baby helps with establishing a bond.¹⁹ While not all infants exposed to substances will experience neonatal abstinence syndrome (NAS), those that do may have a

heightened sensitivity to their external environment. One of the key components of the non-pharmacological treatment of NAS is to care for the baby in a low-stimulation environment.²⁰ Rooming-in facilitates this as it allows for the physical space to be individualized according to the baby's needs.²¹

Babies receive more direct interaction from caregivers in a Rooming-in setting where the mother, their partner and/or other family members are able to respond immediately to the baby's needs.²²

"I was so happy when I got to sleep with my baby in the room."

ELEMENTS

1.1

Mother and baby stay together in a room that provides sufficient privacy for close contact, establishing breastfeeding, bonding and attachment, and a sense of safety.

1.2

The room is spacious enough for the mother's partner and/or involved family members to participate in the baby's care and for one extra person to stay overnight.

1.3

The room offers a low-stimulation environment that can be adjusted according to the baby's needs.

1.4

Room facilities support the mother's comfort, enable mother-baby closeness in a safe environment, accommodate safer sleeping practices and include all necessary items for the baby's care.

1.5

Healthcare providers cluster care to limit disturbance to the mother and baby.

1.6

The mother is supported and encouraged to take a break when needed and respite options are provided (e.g. nursery).

PRACTICE NOTES AND CONSIDERATIONS

1.1

Ideally, mother and baby have a private room. If this is not possible, efforts must be made to increase privacy in a shared space (such as a shared room or open NICU) by, for example, using curtains or moving equipment or furniture to create a screen.

Privacy is important for a woman's comfort with breastfeeding and skin-to-skin, both of which are components of the non-pharmacological treatment of NAS.

A private room also supports patient confidentiality, which is particularly important in the context of pregnancy/parenting and substance use. If mother and baby are not in a private room, a private area must be used for conversations of a confidential nature, especially when these involve child welfare services.

When a woman is experiencing withdrawal from substances, a private room is preferred.

From an Indigenous Cultural Safety perspective, a private room facilitates the practice of birth traditions and ceremonies.

1.2

The room should contain an extra bed or a reclining chair for the partner or other support person to stay overnight.

To provide culturally-safe care, it is important that there is space for additional seating for visiting family members and for conducting ceremony. If this is not possible, creative solutions must be found to provide an alternative suitable room (such as a meeting room or office) in the hospital.

1.3

NAS heightens sensitivity to the external environment, therefore environmental stimuli must be reduced by: lowering noise levels; dimming the lighting; regulating the room temperature; using slow movements around the baby; and clustering nursing care.

In a shared room, the following may help to **create a low-stimulation environment**:

- Close blinds or curtains;
- Silence alarms promptly;
- Dim lights around the baby's bassinet; and
- Provide a reading lamp to avoid having to light the whole room.

1.4

For the mother's comfort, facilities should include: access to washroom and shower (ideally private); sleeping surface; a reclining chair (ideally with arm rests); a reading lamp; internet access; a TV with remote control; access to a telephone; a stock of baby supplies; a change table; storage for personal items; and a small fridge.

Physical safety features to consider include: a bed that can be lowered close to the floor; a bassinet that facilitates mother-baby closeness (especially at night); and visual sight lines/observation windows to allow checks by healthcare providers without disturbing mother and baby.

Sites are encouraged to conduct an "equity walk through" of the space from an Indigenous perspective. This will prompt staff to consider the extent to which the Rooming-in space feels welcoming, and culturally and emotionally safe for parents and their families. See *Resources* below.

1.5

Clustering care maximizes undisturbed time for mother and baby to bond. When baby is sleeping, non-essential care should be delayed until baby wakes, allowing both mother and baby to rest.

Clustering care is also important when a baby is exhibiting symptoms of NAS, as it reduces exposure to light, noise and movement.

1.6


Building in opportunities for the mother to take some time for self-care, to attend medical appointments or substance use services, or to take care of other responsibilities is crucial.

Women must not be judged for asking to take a break. This is a reasonable request for all new parents.

Some women may be uncomfortable or nervous about asking for help. Staff should pay attention to any signs that a woman is experiencing stress, and proactively support her to take a rest or have some time to herself.

Being able to take a break is especially important when the baby is experiencing symptoms of NAS, which may be very stressful for parents.

When a woman needs a break and a nursery is available, the baby can be temporarily cared for there. If a nursery is not available, arrangements should be made for an alternate caregiver to watch the baby in the Rooming-in space.



“If a mom gets tired and asks for her baby to go to the nursery, there is definitely judgment from staff – like she can’t take care of her baby. Moms need more support around this.”

Resources

Equip Health Care. (n.d.). [Equity Walk Through](#).

2. Breastfeeding

Healthcare providers respect the mother's goals for feeding the baby. If the mother chooses to breastfeed, they are given individualized support to do so safely.

What the evidence says...



The physiological and psychosocial benefits of breastfeeding for mother and baby are well-documented. Breastfeeding supports mother-baby bonding and attachment, alleviates maternal and infant anxiety, and facilitates healthy infant development.²³ Indigenous knowledge recognizes breastfeeding as key to fostering reciprocity, the formation of cultural identity, and reviving traditional mothering

practices.²⁴ The breastfeeding parent has the right to choose and to succeed with breastfeeding, and it is a responsibility of the family and community as a whole to protect, promote and support this right.²⁵ Breastfeeding is a baby's first traditional food.

Breastfeeding is an essential component of the non-pharmacological treatment of NAS. As practised within the *Eat, Sleep, Console* model, breastfeeding supports the mother as the first line of treatment and has been shown to reduce the incidence and severity of NAS symptoms, and the need for pharmacological intervention.²⁶

Substance use is not an absolute contraindication to breastfeeding, although there are some substances that require careful breastfeeding safety plans. All mothers should be encouraged to breastfeed, unless the risks clearly outweigh the benefits. Breastfeeding while stabilized on Opioid Agonist Treatment (OAT) is safe regardless of dose.²⁷ Mothers who are on OAT and who choose to stop breastfeeding must be supported to do so gradually to reduce any potential withdrawal symptoms in the infant.²⁸

"It's hard to be separated from your baby, and told you can't breastfeed either."

ELEMENTS

2.1	Perinatal nurses receive ongoing general education about breastfeeding and substance use so that they can provide accurate and consistent guidance to the mother.
2.2	The mother is provided with education on the benefits of breastfeeding and how to mitigate any risks associated with substance use. As appropriate, the mother is reassured about the safety of breastfeeding while on Opioid Agonist Treatment (OAT).
2.3	Discussions with the mother , her partner, and involved family members about feeding the baby are non-judgmental, trauma-informed and culturally-safe, and prioritize the mother's preferences and goals.
2.4	When the mother chooses to breastfeed , healthcare providers help her to create a breastfeeding safety plan.
2.5	The mother is given the practical and emotional support she needs to feed the baby safely and successfully. Discuss with Knowledge Keepers how she can start her healing journey.
2.6	If the baby is removed by child welfare services while the breastfeeding mother is still an inpatient at the hospital, healthcare providers and child welfare services support her to continue consistently breastfeeding and/or to provide a supply of breastmilk.



“I had to have labels on my breastmilk. It was in bags saying ‘hazardous.’ And it was so uncomfortable.”

PRACTICE NOTES AND CONSIDERATIONS

2.1

All nurses involved in perinatal care must have a basic understanding of breastfeeding and substance use, including which substances are known to be safe and how to reduce any potential harms (e.g. through delaying breastfeeding and/or pumping and discarding).

Because the evidence on breastfeeding and substance use is constantly evolving, education needs to be ongoing to ensure that the information being provided to the mother is as up-to-date as possible.

It is imperative that the woman receives consistent messaging on breastfeeding and substance use from all healthcare providers that she is in contact with, across all units and work rotations (day/night and weekly changes). This is vital to the mother's emotional wellbeing and confidence as a parent.

To support consistent messaging, hospital sites must have an evidence-informed policy that clearly articulates their protocols and practices with regard to breastfeeding and substance use. All staff must be familiar with the policy and be able to communicate it to parents in a way that is respectful and easy to understand. The overarching intent of the policy should be to promote breastfeeding, unless there are clear contraindications (see Practice Note 2.2 below).

Education for nurses must include breastfeeding as a key component of non-pharmacological treatment of NAS, such as the *Eat, Sleep, Console* model.

It is also important for social workers, who may be involved in decisions regarding an infant's care, to have a basic understanding of breastfeeding and substance use.

2.2

The information given to women about breastfeeding and substance use must reflect the most current evidence.

If a pregnant or parenting woman is receiving OAT, this should be seen as a positive step in her recovery journey. Prescription opioids and opioid agonist therapies (methadone, buprenorphine, slow release morphine) are not a contraindication to breastfeeding.

For mothers on OAT, anxiety about transmitting medications to their infant through breastmilk, lack of family support, and concerns of hepatitis C transmission are barriers to breastfeeding. Therefore, education for the mother, father and/or involved family members to dispel these concerns is important.²⁹

2.3

Judgment from healthcare providers about a woman's substance use can be a significant barrier to initiating and sustaining breastfeeding. Women also report feeling judged by nurses when they choose to formula feed.

In conversations with the mother about feeding the baby, healthcare providers must take a mother-centred approach. This includes: addressing the mother's needs first; asking open questions; listening actively; building on what the mother already knows; showing empathy; and remaining neutral.³⁰

Women who have experienced sexual trauma may not feel safe or comfortable breastfeeding. In such cases, it may be helpful to look at alternative feeding options and strategies.

The Public Health Agency of Canada's *Family-Centred Maternity and Newborn Care in Canada* emphasizes the importance of family-centred practice that supports parents as the primary decision makers for the care of their newborn.³¹ It is crucial that care options are offered to parents in an objective and neutral manner. See *Resources* below.

Healthcare providers must be aware of and take into consideration Indigenous experiences and beliefs about breastfeeding when supporting Indigenous mothers. This may include making space for family involvement, including, for example, guidance from Grandmothers and Aunties.

2.4

A breastfeeding safety plan³² is a written document that addresses the following:

- What substances the breastfeeding mother may be affected by;
- The length of time they need to either abstain from breastfeeding or pump and discard after using those substances;
- What feeding option will be used during this time period (e.g. expressed, stored breastmilk, pasteurized donor human milk when available, or infant formula); and
- If a woman chooses to, how to stop breastfeeding / wean the baby gradually.

When a mother wishes – or has been advised for safety reasons – to provide expressed breast milk for her baby, guidelines for the safe handling of expressed breast milk must be followed. See *Resources* below.

Women who choose to stop breastfeeding should be given support to wean the baby gradually to reduce the risk of engorgement and/or, in the case of mothers prescribed OAT, to reduce the potential risk of the baby developing withdrawal symptoms.

Further breastfeeding safety plan guidance can be found in the BC Association of Pregnancy Outreach Programs handbook supplement for healthcare providers on Perinatal Substance. See *Resources* below.

2.5

All perinatal nurses must be able to provide practical support for breastfeeding and know who to consult when additional help is required. A lactation consultant needs to be available to support the mother, as and when needed. Ideally, lactation consultants have an understanding of breastfeeding and substance use.

All breastfeeding women will benefit from some one-to-one support with positioning and attachment, and understanding how continued skin-to-skin contact can help facilitate feeding.³³ Peer support may be particularly helpful in this regard.

Women who bottle feed (expressed breast milk, pasteurized donor human milk, or formula) must receive education and practical help on safe bottle feeding practices.

2.6

If direct breastfeeding is not an option, then healthcare providers must make every effort to support the baby's access to the mother's own milk. This includes advocating for the mother and baby to stay together with child welfare services.

In situations where a mother is not co-located with the baby, she has the right to daily access/visits of a substantial length of time in order to continue breastfeeding, maintain an adequate breastmilk supply, and enable attachment and bonding.

If separated from the baby, the mother should be supported to have access in order to breastfeed in alignment with her goals and wishes



Resources

- Baby-Friendly Initiative Strategy, Ontario, et al. (2019). [Breastfeeding Protocol: Expressing, Collecting, and Storing Human Milk](#).
- BCAPOP. (2019). [BC Pregnancy: Outreach Program Handbook Supplement, Perinatal Substance Use](#).
- BC Women's Hospital + Health Centre. (2019). [Breastfeeding my baby](#).
- Best Start Resource Centre. (2017). [Breastfeeding for the Health and Future of Our Nation: A Booklet for Indigenous Families](#).
- British Columbia Centre of Substance Use. (2018). [Treatment of Opioid Use Disorder During Pregnancy: Guideline Supplement](#).
- Centre of Excellence for Women's Health. (2019). [Mothering and Opioids: Addressing Stigma - Acting Accordingly](#).
- First Nations Health Authority. (n.d.). [Breastfeeding Wellness Teachings for Mothers, Families and Communities](#).
- [Infant Risk Center](#) – an international call centre used by physicians, nurses, lactation consultants and parents, designed to help people have safe pregnancies and safe breastfeeding while using medications.
- La Leche League Canada. (n.d.). [Transgender/Transsexual/Genderfluid Tip Sheet – General Information](#).
- Perinatal Services BC. (2020). [Cannabis Use During Pregnancy and Lactation: A Practice Resource for Health Care Providers](#).
- Perinatal Services BC. (2020). [Breastfeeding Your Early Preterm Baby](#).
- Public Health Agency of Canada. (2014). [Protecting, Promoting and Supporting Breastfeeding: A Practical Workbook for Community-based Programs](#).
- Public Health Agency of Canada. (2017-present). [Family-Centred Maternity and Newborn Care in Canada: National Guidelines](#).
- Representative for Children and Youth. (2018). [Promoting Access to Breastfeeding in Child Welfare Matters](#).
- UNICEF United Kingdom. The Baby Friendly Initiative. (2018). [Guidance for Antenatal and Postnatal Conversations](#).

3. Skin-to-Skin

Healthcare providers support the mother and involve family members to do skin-to-skin in a manner that is safe and responsive to the baby's needs.



What the evidence says...



Skin-to-skin is important and needs to be actively encouraged for perinatal women using substances.³⁴ Kangaroo Care refers to the skin-to-skin holding of a preterm or low-birth weight infant. The term can be used interchangeably with skin-to-skin. It is associated with a wide range of short and longer term benefits for both infant and mother. With respect to short-term benefits for the infant, skin-to-skin has been shown to enhance physiological stability and reduce risk of infection. Skin-to-skin promotes

mother-baby bonding and attachment, helps to establish and prolong breastfeeding, and is associated with reduced infant and maternal anxiety.³⁵ Demonstrated longer-term effects include: improved cognitive functioning and enhanced self-regulation in infants and children; and, for parents, decreased depressive symptoms post-partum, and improved mood and interactive behaviour.³⁶

Skin-to-skin is also a direct care, non-pharmacological treatment for NAS and is a key component of the *Eat, Sleep, Console* model of care. It minimizes signs of pain, promotes better sleeping patterns, and is linked to significantly decreased initiation of pharmacological treatment and decreased length of hospital stay.³⁷ Skin-to-skin allows an infant to hear its mother's heartbeat.

Skin-to-skin relies on parental presence and is best facilitated by Rooming-in.

Those first bonding moments with your baby can be the most precious moments you can have."

ELEMENTS

3.1

Healthcare providers discuss the benefits of skin-to-skin with the mother, her partner, and involved family members, and actively support them to practise skin-to-skin safely.

3.2

Skin-to-skin is initiated immediately after the birth of the baby and is encouraged and supported from that point forward.

3.3

If the health status of the baby and/or mother prevents skin-to-skin, the reason for this is communicated clearly and sensitively to the mother. Other forms of loving touch are facilitated and/or skin-to-skin is initiated with the other parent or a family member.

3.4

The mother and involved family members have access to a private area to do skin-to-skin.

3.5

In situations where challenges exist (e.g. following a C-section or when the baby is placed in the NICU), healthcare providers strive to find solutions to enable skin-to-skin.

PRACTICAL NOTES AND CONSIDERATIONS

3.1

Given the positive outcomes, healthcare providers are encouraged to support all mothers and involved family members, including fathers, to practise skin-to-skin. Women who identify as Indigenous may wish to involve Grandmothers and Aunties, and other extended family.

Women should never be pressured to do skin-to-skin. There are a variety of personal reasons that may make skin-to-skin difficult for some parents, including experiences of trauma.

Healthcare providers must understand the benefits of skin-to-skin and be able to assess any risks that may be present for each mother-baby dyad. Risks include maternal drowsiness (due to, e.g., the effects of OAT, effects of active substance use if that is occurring, sedation following C-section) and symptoms of withdrawal. In such circumstances, women may need additional support for safe skin-to-skin. Conversations with mothers should be candid but sensitive, respectful, and free of judgment.

Whenever possible, education on safe skin-to-skin practice should happen before the birth of the baby. It covers safe positioning of the parent and baby (i.e. parent is upright, baby's face can be seen, their head can move freely, their nose and mouth are uncovered, their head is turned to one side, their neck is straight, their shoulders are flat against the parent, and their back is covered with a blanket).

BC Women's Hospital + Health Centre has a one-page handout on "Doing Skin-to-Skin Safely" (see *Resources* below). Education must include information on how skin-to-skin can be practised safely at home.

To promote safe practice in the hospital and at home, parents should be given a brief and easy-to-read handout on skin-to-skin and a baby wrap. The handout should include information on safe holding with a wrap (i.e. baby is positioned against the parent's chest and is visible at all times, the wrap is tight and secure, and baby has their back supported with their chin away from their chest).

A baby wrap increases stability and comfort, reduces the risk of an infant being dropped should the mother (or other holder) start to feel drowsy, and helps skin-to-skin to be sustained for a longer period of time. See also *Safer Sleep* below.

3.2

Evidence supports immediate, uninterrupted skin-to-skin care after birth for all stable mothers and babies, regardless of feeding preference. The first hour after birth is a particularly important time for mother and baby bonding and attachment. It is often referred to as the "golden hour," and should be respected, protected, and supported.³⁸ In addition, skin-to-skin should be encouraged as much as possible in the first days and weeks of the baby's life.

When a mother or baby requires urgent medical intervention after birth, skin-to-skin must be facilitated as soon as both are stable.

3.3

When skin-to-skin cannot be done safely, parents, Grandmothers and Aunties, and other family members should be encouraged to provide other kinds of loving touch and contact. These include hand holding and singing, reading or talking to the baby.

3.4

Skin-to-skin contact necessitates that the caregiver holding the baby is partially unclothed; privacy may be required for them to feel comfortable and safe. This is especially important for people with a history of trauma, which may exist among women who use substances.³⁹

Where mother and baby are not in a private room, staff must prepare a separate area for skin-to-skin.

Following C-section, the mother may be feeling drowsy and her mobility may be restricted for several days. Additional support for skin-to-skin must therefore be given by staff. This may include setting up skin-to-skin in the mother's hospital bed, helping with transferring the baby, and providing extra supervision.

There may be barriers to doing skin-to-skin in the NICU associated with the lack of privacy in the space and the medical equipment that the baby is connected to. NICU staff must find solutions to mitigate these barriers, including, for example, creating an appropriate level of privacy for the participating adult, and helping with transferring and positioning the baby.⁴⁰



Letting mothers go there, to this natural place, can lead to so many other positive things.

Resources

BC Women's Hospital + Health Centre. (n.d.). [Doing Skin-to-Skin Safely](#).

Perinatal Services BC has developed a variety of resources for parents and families to support skin-to-skin/Kangaroo Care. These can be accessed via their [Kangaroo Care](#) webpage.

UNICEF UK. The Baby Friendly Initiative. (2019). [Skin-to-Skin Contact](#).

4. Safer Sleeping

Healthcare providers work with parents and family members in a culturally-safe and respectful manner to promote safer sleeping practices both in the hospital and at home.

What the evidence says...



Established safer sleeping practices include: putting the baby to sleep on a firm mattress in a crib, or bassinet, that is free of hazards and is in the same room as the parents; minimizing/eliminating exposure to smoke; and taking care to ensure that the baby is warm, but not hot. Swaddling can cause the baby to overheat and increase the risk of sleep-related infant death. Swaddling can be beneficial for babies who are experiencing neonatal abstinence syndrome (NAS) in the first 72-96 hours after birth.⁴¹

Bed-sharing is a common practice in many households.⁴² Some families may choose to bed-share with their baby and others may engage in unplanned bed-sharing. If done unsafely, bed-sharing can pose a serious risk to babies. When a mother, or other caregiver has, for example, used substances that cause drowsiness (including prescription medications), there is an increased risk of accidental smothering or injury to the baby.⁴³ Because of these risks, open discussion between healthcare providers and parents about safer sleeping is crucial.⁴⁴

Research and practice-based evidence suggests that respectful, culturally-safe education on safer sleeping practices is more effective than fear-based or punitive approaches to preventing bed-sharing.⁴⁵

“We try to do a lot of education on safer sleep because we know that parents will sleep with their babies when they get home.”

ELEMENTS

4.1

Healthcare providers have respectful discussions with parents about safer sleeping practices in the hospital and at home. These address the risks of unsafe bed-sharing and swaddling, and what parents can do to keep their baby safe during sleep.

4.2

When the mother is at risk of falling asleep while feeding the baby, doing skin-to-skin or holding the baby, a healthcare provider or family member is present to ensure the baby's safety.

4.3

The mother is given safe options for maximizing mother-baby closeness during sleep.

4.4

Healthcare providers support parents and involved family members to create a plan for safer sleeping at home.

PRACTICAL NOTES AND CONSIDERATIONS

4.1

Ideally, conversations with parents, and other involved family members, about safer sleeping take place prior to the birth of the baby. Parents need to receive clear and consistent messaging about safer sleeping. Education must include how to apply safer sleeping practices to different contexts, e.g. in the hospital and at home.

Healthcare providers must have the skills to create a culturally-safe and respectful space to talk about safer sleep. These skills include:

- Listening carefully;
- Respecting the parents' perspectives;
- Providing time for parents to express themselves fully; and
- Being kind and considerate when explaining safer sleep practices.⁴⁶

First Nations Health Authority has created a *Safe Infant Sleep Toolkit*, which includes practice tools for healthcare providers on how to talk to Indigenous parents about safer sleep in a culturally-safe way. See *Resources* below.

Questions that healthcare providers might ask to open up the conversation include:

- Where will your baby sleep?
- What have you heard about keeping your baby safe while they sleep?
- What would you like to know about keeping your baby safe while they sleep?⁴⁷

Conversations about safer sleeping should also address the potential risks of swaddling and, if parents choose to swaddle, how they can do so more safely. Swaddling is a traditional practice in many cultures. Therefore, conversations should be sensitive, respectful and take a harm-reduction approach. Perinatal Services BC has produced a useful guide for parents on safer sleep, which covers safe swaddling. (See *Resources* below.)

It is important to make sure that parents whose baby has been swaddled as part of the management of NAS understand that swaddling is not necessary after their baby is no longer experiencing withdrawal.

4.2

The mother's care team, partner and involved family members must have a clear understanding, at all times, of who is responsible for monitoring the mother and baby when there is a risk of maternal drowsiness. This is especially important in cases where the mother is experiencing symptoms of withdrawal or is stabilizing on OAT, has experienced a C-Section or is exhausted/tired

4.3


Safe options may include adjusting the placement of beds in the hospital room, or the use of an attachable bedside bassinet or portable sleep space (such as a "baby bed" or "pepi-pod").

4.4

To help ensure the baby's safety at home, a "safer sleep plan" must be created in collaboration with parents and family members.

Healthcare providers should model safer sleep practices prior to the baby going home. In addition, parents should be given an easy-to-read handout, such as the BC Ministry of Health's *Safer Sleep for My Baby* guide for parents. This guide is one of a suite of practice support tools and resources to help service providers engage parents in talking about and creating a plan for safer sleep. See *Resources* below.

It may be helpful for service providers to use the First Nations Health Authority's *Safe Infant Sleep Toolkit – Honouring Our Babies* when working with Indigenous parents and families to create a safer sleep plan. See *Resources* below.



“I want my baby with me. Pepi-pods sound like a good option, or another type of co-sleeper bed in the hospital room.”

Resources

First Nations Health Authority. (2013). [Safe Infant Sleep Toolkit – Honouring Our Babies.](#)

Island Health. (2020). [Baby Bed Program.](#)

Perinatal Services BC. (n.d.). [Safer Infant Sleep: A Practice Support Tool for Healthcare Professionals.](#)

BC Ministry of Health & Perinatal Services BC. (2020). [Safer Sleep for My Baby.](#)

Foundations for Implementing Rooming-in

In conversations with perinatal service providers across BC, the following capabilities and resources were identified as key foundations that support and enable Rooming-in implementation for women using substances and their babies.

Sites do not have to wait to start Rooming-in until all of these factors are in place, but they do need to be working towards them in a thoughtful and intentional way.

These enablers will also require consistent attention and ongoing development to ensure that parents and infants affected by substance use are receiving the best care possible.

- ★ **Support from hospital administration, leadership and executive** – senior leadership is committed to developing policies, infrastructure and other mechanisms to facilitate the implementation of Rooming-in and capacity building for perinatal staff. This includes support for longer-length of hospital stay, when needed.
- ★ **Staff buy-in** – perinatal staff have confidence in the benefits of Rooming-in for women who use substances and their babies, understand the importance of caring for the mother and baby as a dyad, and receive appropriate support from their supervisors and senior leadership to provide the kind of care embedded in the model.
- ★ **An appropriate space** – birthing parent and baby require a low-stimulation environment, physical proximity and sufficient privacy for skin-to-skin and breastfeeding. While a private room is ideal, Rooming-in can also be accommodated in shared rooms that have been adapted to ensure reduced light and noise, and increased privacy.
- ★ **Non-pharmacological management of NAS** – there is site-wide adoption of the evidence-informed *Eat, Sleep, Console* model of care as first line treatment for NAS.
- ★ **Staff training and education** – there are opportunities for staff to participate in regular, ongoing training to develop core competencies for providing care to perinatal women using substances. This includes Indigenous Cultural Safety and trauma- and violence-informed practice, as well as education on substance use and perinatal care.
- ★ **Partnerships and linkages** – there are strong relationships and effective partnerships between community- and hospital-based services to ensure that women are connected to the services they need in a timely fashion, prior to having their baby and after discharge from hospital. It is particularly important that there are good relationships between hospital staff and MCFD workers.
- ★ **Commitment to evaluation** – there is ongoing evaluation and monitoring of Rooming-in implementation through the use of evidence-informed measures that are timely, appropriate, and respectful to the women and families involved. Women and families partner in the design of the

evaluation, as well as Indigenous peoples, communities, and leaders. Processes must be set up in alignment with the OCAP principles (Ownership, Control, Access, and Possession) to assess and measure Indigenous Cultural Safety. These approaches will foster reciprocal respectful engagement and relationships.

An organizational self-assessment tool has been included in the Guideline (Appendix A) to support sites and units to assess and measure their progress against these foundations.

Looking Forward...

This *Rooming-in Guideline* is one of several tools and resources being developed by the *Provincial Perinatal Substance Use Project* to support the provision of safe, effective and respectful care for pregnant and parenting women, using substances, and their babies. It is ultimately the blueprint for a provincial perinatal substance use continuum of care.

The Guideline provides direct care perinatal staff, hospital executives and administrators, and community organizations a roadmap for principled practice that places the wellbeing and unity of the mother-baby dyad at the centre of care. While implementation of the Guideline will necessarily look different from site to site and community to community, a commitment to establishing Rooming-in as a standard of care in perinatal substance use services will help realize better outcomes for parents, babies, families and communities across BC, in both the short and longer term.

Appendix A: Organizational Self-Assessment Tool

This organizational self-assessment tool supports staff members to reflect on and gauge how their site or unit is doing with respect to the six foundations for implementing Rooming-in for perinatal women using substances. It is intended to facilitate discussion and consensus building among staff members, and may be particularly useful as an early step in the planning process for Rooming-in, since it helps to identify current strengths/assets and areas that require development.

The factors listed in the tool are not exhaustive, and staff are encouraged to identify and assess site-specific factors that may support the implementation of Rooming-in.

How to Use this Tool

A two-step process is recommended:

- **Step 1** – Individual staff members complete the tool. For each factor, staff members indicate their rating. The rating can be anywhere along the spectrum (1 – 4). The spaces for notes under each factor should be used to: (a) briefly describe why the particular rating was given; and (b) record ideas for actions that the organization can take in order to make progress.
- **Step 2** – Staff members meet as a group to share and discuss their individual assessments. They engage in a facilitated process to come to a single, consensus rating for each factor and to agree on actions that should be taken next.

The tool can be completed at regular intervals along the road to implementing Rooming-in as a means of evaluating progress and flagging issues.

Self-Assessment Template

Support from Hospital Administration and Executive

Senior leadership is committed to developing policies, infrastructure and other mechanisms to facilitate the implementation of Rooming-in and capacity building for perinatal staff. This includes support for longer-length of hospital stay, where needed.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Staff Buy-In

Perinatal staff have confidence in the benefits of Rooming-in for women who use substances and their babies, understand the importance of caring for the mother and baby as a dyad, and receive appropriate support from their supervisors and senior leadership to provide the kind of care embedded in the model.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

An Appropriate Space

Birth parent and baby are accommodated in a space that allows for a low-stimulation environment, physical proximity and sufficient privacy for skin-to-skin and breastfeeding. When a private room is not available, Rooming-in is facilitated in shared rooms that have been adapted to ensure reduced light and noise and increased privacy.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Non-Pharmacological Management of NAS

There is site-wide adoption of the evidence-informed *Eat, Sleep, Console* model of care as first line treatment for NAS.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Staff Training and Education

There are opportunities for staff to participate in regular, ongoing training to develop core competencies for providing care to perinatal women using substances. This includes Indigenous Cultural Safety and trauma- and violence-informed practice, as well as education on substance use and perinatal care.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Partnerships and Linkages

There are strong relationships and effective partnerships between community- and hospital-based services to ensure that women are connected to the services they need in a timely fashion, prior to having their baby and after discharge from hospital. It is particularly important that there are good relationships between hospital staff and MCFD workers.

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Commitment to Evaluation

There are opportunities for women, families, Indigenous peoples, communities, and leaders to design the approach to evaluation including when and how data and information are collected, accessed and used. Indigenous cultural safety is a particular focus of evaluative efforts as well as measuring how services are performing and opportunities for improvement. Assessing Indigenous cultural safety including supporting Indigenous people to share and determine whether a service is culturally safe

1	2	3	4
Just Started	On the road	Nearly there	We're there
<i>Why I gave this rating:</i>			
<i>What we can / need to do next to make progress:</i>			

Appendix B: Guiding Principles Definitions

- 1) **Trauma and violence informed practice:** Trauma and violence are common experiences in the lives of girls and women using substances. In addition, trauma, substance use and intimate partner violence have complex intersections. Trauma and violence informed practice provides a woman with choice, collaboration, control and autonomous decision making. Services are provided in a way that supports safety and empowerment and avoids re-traumatization.
- 2) **Indigenous Cultural Safety:** Indigenous Cultural Safety (ICS) is about fostering a climate in which the unique history of Indigenous peoples is recognized and respected in order to provide appropriate care and services in an equitable and safe way, without discrimination.⁴⁸ ICS is also an outcome; it is when Indigenous people determine the system is safe for Indigenous people.
- 3) **Harm Reduction:** Harm reduction, in a recovery oriented context, is a spectrum, from active use to abstinence. Harm reduction approaches are non-judgemental and non-coercive, providing support to all women throughout the treatment and recovery continuum. These approaches help women reduce harm to their health and have agency in the type and extent of change they make in their substance use and overall wellness. Harm reduction is founded on kindness, compassion, and caring. A harm reduction approach includes policies, programs, and practices that aim to reduce the negative consequences of using psychoactive substances, without necessarily reducing substance use itself.
- 4) **Women Centred and Women's Voices:** Recognizes sex and gender related influences on substance use and offers interventions to address these influences and women's preferences for action. Approaches build a person's sense of value, confidence and self-efficacy and support their priorities and abilities to improve their own health and the health of their families. Women's voices ensure that women with lived experience are empowered and contribute to the design and development of health care services.
- 5) **Recovery Oriented:** Supporting pregnant and parenting women using substances through "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential"⁴⁹. In this context, recovery is a unique individual journey that involves living a satisfying, hopeful and contributing life even when one may be experiencing ongoing mental health or substance use challenges. Recovery may not necessarily mean abstaining from substance use. Recovery oriented care involve healthcare providers working with individuals and their families to reach their chosen recovery goals by building on personal strengths and skills to enhance health outcomes and quality of life.⁵⁰ This includes a broad range of activities that are person-centred and promote resilience.
- 6) **Mother and Baby Togetherness:** Keeping mother and baby together in skin-to-skin and close proximity by Rooming-in to enhance physical/emotional interactions and bonding through touch, sight, hearing, smell and taste.
- 7) **Interdisciplinary:** Involves and includes health care professionals from different disciplines and peers working together collaboratively, with a common purpose to set goals, make decisions, share resources and responsibilities and aspiring towards a trans-disciplinary approach.
- 8) **Evidence Informed:** Guided by quality research evidence, clinical practice guidelines, leading practices, wise practices and Indigenous ways of knowing.
- 9) **Equitable Access:** Fair distribution of care according to population need with attention to accessing health care services regardless of gender, socioeconomic status, ethnicity, or where one lives. There is a primacy on providing equitable and culturally safe care for Indigenous people, Community partnerships and Indigenous health, Indigenous led partnerships. Equitable access includes involving women with lived and living experience in the planning, delivery and evaluating services.

REFERENCES

- ¹ E.g. Whalen, B. L., Holmes, A. V., and Blythe, S. (2019). "Models of Care for Neonatal Abstinence Syndrome: What Works?" *Seminars in Fetal and Neonatal Medicine*, 24: 121-132, at p. 123.
- ² Ryan, G. et al. (2019). "Nonpharmacological Management of Neonatal Abstinence Syndrome: A Review of the Literature." *Journal of Maternal-Fetal & Neonatal Medicine*, 32(10): 1735-1740, at p. 1738; and Whalen, Holmes, and Blythe, (2019), pp. 122-23.
- ³ Canadian Broadcasting Corporation. (2019). "White Coat, Black Art - A cuddle from mum instead of morphine: How rooming in helps opioid-dependent newborns combat withdrawal."
- ⁴ See, for example: Livingston, J. D. et al. (2011). "The Effectiveness of Interventions for Reducing Stigma Related to Substance Use Disorders: A Systematic Review." *Addiction*, 107: 39-50, at p. 40; Benoit, C. et al. (2013). "Providers' Constructions of Pregnant and Early Parenting Women Who Use Substances." *Sociology of Health and Illness*, 36(2): 252-263, at pp. 253, 260; Grisham, L. M. et al. (2019). "Eat, Sleep, Console Approach: A Family-centered Model for the Treatment of Neonatal Abstinence Syndrome." *Advances in Neonatal Care*, 19(2): 138-144, at p. 139; Vogel, L. (2018). "Newborns Exposed to Opioids Need Mothers More than NICU, say Pediatricians." *CMAJ*, 190(4): E123, at p. e123; MacMillan, K. D. L. et al. (2018). "Association of Rooming-in with Outcomes for Neonatal Abstinence Syndrome: A Systematic Review and Meta-Analysis." *JAMA Pediatrics*, 172(4): 345-351; and Cleveland, L. M. and Bonugli, R. (2014). "Experiences of Mothers of Infants with Neonatal Abstinence Syndrome in the Neonatal Intensive Care Unit." *JOGNN*, 43: 318-329.
- ⁵ Abrahams, R. R. et al., (2010), p. 871.
- ⁶ National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*; Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*.
- ⁷ Gary Geddes. (2017). *Medicine Unbundled: A Journey Through the Minefields of Indigenous Health Care*; see also the work of Janet Smylie, Annette Browne and Colleen Varcoe on health inequities affecting Indigenous Peoples.
- ⁸ Downtown Eastside Women's Centre. (2019). *Red Women Rising: Indigenous Women Survivors in Vancouver's Downtown Eastside*.
- ⁹ United Nations Declaration on the Rights of Indigenous People. (2010). Canada's Statement of Support on UNDRIP
- ¹⁰ Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*.
- ¹¹ Consultation with women with lived experience and service providers.
- ¹² PHSA, BC Women's Hospital + Health Centre, Perinatal Services BC. (June 1, 2018). *Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop*.
- ¹³ Mental Health Commission of Canada. (YEAR). Stigma.
- ¹⁴ Nosyk, B. Homayra, F. and Piske, M. (2020). "A Brief and Preliminary Summary of Perinatal Services BC Data." PowerPoint Presentation. *Health Canada Substance Use and Addictions Program*.
- ¹⁵ Doerksen, J.S., Everett, R. (2020). Infants Diagnosed with Neonatal Opioid Withdrawal Syndrome Receiving Morphine Oral Solution: A 5-Year Retrospective Chart Review Evaluating Safety in a Non-NICU Setting. [Powerpoint slides].
- ¹⁶ Frazier, L.M, et al. (2020). "Emerging therapies for the treatment of neonatal abstinence syndrome." *Journal of Maternal- Fetal and Neonatal Medicine*, 1-9.

¹⁷ Lee et al. (2019). “Comparative effectiveness of opioid replacement agents for neonatal opioid withdrawal syndrome: a systematic review and meta-analysis.” *Journal of Perinatology*, 39(11):1535-1545.

¹⁸ Grisham et al., (2019), p. 142.

¹⁹ Consultation with women with lived experience.

²⁰ Whalen, Holmes, and Blythe, (2019), pp. 122-23; Ryan, G. et al. (2019). “Nonpharmacological Management of Neonatal Abstinence Syndrome: A Review of the Literature.” *Journal of Maternal-Fetal & Neonatal Medicine*, 32(10): 1735-1740, at pp. 1737-38. Mangata, A. K., Schmölzer, G. M., and Kraft, W. K. (2019). “Pharmacological and Non-pharmacological Treatments for the Neonatal Abstinence Syndrome (NAS).” *Seminars in Fetal and Neonatal Medicine*, 24: 133-141, at pp. 134-135; Vogel, (2018), p. e123; Murphy, K., et al. (2017). “Variations and Similarities in Clinical Management of Neonatal Abstinence Syndrome: Findings of a Canadian Survey.” *Paediatrics & Child Health*, 22(3): 148-152, at p. 150; Grossman, M. R. et al. (2017). “An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome.” *Pediatrics*, 139(6): e1-e10, at pp. e2-e3; Holmes, A. V. et al. (2016). “Rooming-in to Treat Neonatal Abstinence Syndrome: Improved Family-centered Care at Lower Cost.” *Pediatrics*, 137(6): e1-e11, at pp. e2-e3; Substance Abuse and Mental Health Services Administration. (2018). *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants*; New Zealand, Starship Child Health. (2018). *Clinical Guideline: Infants Born to Drug Dependent Mothers [on Tamaki Ward, Auckland City Hospital]*, p. 4; Queensland Government, Queensland Maternity and Neonatal Clinical Guidelines Program. (2016). *Perinatal Substance Use: Neonatal*, pp. 14 and 29.

²¹ Hudak, M.L, Tan, R.C. Committee on Drugs, and the Committee on Fetus and Newborn & American Academy of Pediatrics. (2012). “Neonatal Drug Withdrawal.” *Pediatrics*, 129(2): e540-560, at p. e547.

²² Substance Abuse and Mental Health Services Administration. (2018). *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants*.

²³ Yonke, N., Maston, R., Weitzen, S., and Leeman, L. (2019). “Breastfeeding Intention Compared with Breastfeeding Postpartum among Women Receiving Medication-assisted Treatment.” *Journal of Human Lactation*, 35(1): 71-79, at p. 72; MacVicar, S., Humphrey, T., and Forbes-McKay, K. E. (2017). “Breastfeeding Support and Opiate Dependence: A Think Aloud Study.” *Midwifery*, 50: 239-245, at p. 240; Holmes, A. P., Schmidlin, H. N., and Kurzum, E. N. (2017). “Breastfeeding Considerations for Mothers of Infants with Neonatal Abstinence Syndrome.” *Pharmacotherapy*, 37(7): 861-869, at p. 862.

²⁴ Exner-Pirot, H., B. Norbye and L. Butler, (eds.). (2018). *Northern and Indigenous Health and Health Care – Chapter 21: Infant Feeding Teachings from Indigenous Grandmothers: Generating Knowledge through Sharing Circles*. University of Saskatchewan.

²⁵ The right to breastfeed is supported by two international conventions – *The Convention of the Rights of the Child* (1989) and the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979). Breastfeeding is also a human right protected by the BC Human Rights Code.

²⁶ Yonke et al. (2019), pp. 71-72; Bogena, D. L. and Whalen, B. L. (2019). “Breastmilk Feeding for Mothers and Infants with Opioid Exposure: What is Best?” *Seminars in Fetal and Neonatal Medicine*, 24: 95-104, at pp. 95, 102; Ryan et al., (2019), p. 1737; Holmes, Schmidlin, and Kurzum, (2017), p. 862; MacVicar et al., (2017), p. 239.

²⁷ Jansson L.M. et al. (2008). “Methadone Maintenance and Breastfeeding in the Neonatal Period.” *Pediatrics*, 121(1): 106-114; Wilbourne P., et al. (2001). “Clinical Management of Methadone Dependence During Pregnancy.” *The Journal of Perinatal & Neonatal Nursing*, 14(4): 26-45; Lindemalm S. et al. (2009). “Transfer of Buprenorphine into Breast Milk and Calculation of Infant Drug Dose.” *Journal of Human Lactation: Official Journal of International Lactation Consultant Association*, 25(2): 199-205; BCPAPOP. (2019). *BC Pregnancy: Outreach Program Handbook Supplement, Perinatal Substance Use*, p. 27.

²⁸ Drugs and Lactation Database. Bethesda (MD): National Library of Medicine (US); 2006-, “Methadone” and “Buprenorphine.”

²⁹ Yonke et al., (2019), pp. 71-75; Holmes, Schmidlin, and Kurzum, (2017), p. 867.

-
- ³⁰ UNICEF UK. (2018). The Baby Friendly Initiative. *Having Meaningful Conversations with Mothers*, p. 5.
- ³¹ Public Health Agency of Canada. (2017-present). *Family-Centred Maternity and Newborn Care in Canada: National Guidelines*.
- ³² BCAPOP. (2019). *BC Pregnancy: Outreach Program Handbook Supplement, Perinatal Substance Use*.
- ³³ *Ibid.*, p. 9.
- ³⁴ WHO. (2014). *Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*, p. 15; and consultation with service providers.
- ³⁵ Ryan et al., (2019), p. 1738; and consultation with service providers.
- ³⁶ Consultation with service providers; Feldman, R., Rosenthal, Z., and Eidelman, A. I. (2014). "Maternal-preterm Skin-to-skin Contact Enhances Child Physiologic Organization and Cognitive Control across the First 10 Years of Life." *Biological psychiatry*, 75(1): 56-64; Bystrova K. et al. (2009). "Early Contact Versus Separation: Effects on Mother-infant Interaction One Year Later." *Birth*, 36: 97-109; Scatliffe, N. et al. (2019). "Oxytocin and Early Parent-infant Interactions: A Systematic Review." *International Journal of Nursing Sciences*, 6(4): 445-453; Bigelow, A. et al. (2012). "Effect of Mother/Infant Skin-to-skin Contact on Postpartum Depressive Symptoms and Maternal Physiological Stress." *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 41(3): 369-382; and Aghdas, K., Talat, K., and Sepideh, B. (2014). "Effect of Immediate and Continuous Mother-infant Skin-to-skin Contact on Breastfeeding Self-efficacy of Primiparous Women: A Randomised Control Trial. *Women and birth*, 27(1): 37-40.
- ³⁷ *Ibid.*
- ³⁸ Crenshaw, J.T. (2014). "Healthy Birth Practice #6: Keep Mother and Baby Together – It's Best for Mother, Baby, and Breastfeeding." *J Perinat Educ.*, 23(4): 211-217.
- ³⁹ Whalen, Holmes, and Blythe, (2019), p. 123; Shahram, S. Z. et al. (2017). "Understanding the Life Histories of Pregnant-involved Young Aboriginal Women with Substance Use Experiences in Three Canadian Cities." *Qualitative Health Research*, 27(2): 249-259, at pp. 252-54.
- ⁴⁰ Whalen, Holmes, and Blythe, (2019), p. 128; Lee, Martin-Anderson, and Dudley. (2012). "Clinician Perspectives on Barriers to and Opportunities for Skin-to-skin Contact for Premature Infants in Neonatal Intensive Care Units." *Breastfeed Med.*, 7(2): 79-84.
- ⁴¹ BC Ministry of Health and Perinatal Services BC. (n.d.). *Safer Infant Sleep: A Practice Support Tool for Healthcare Professionals*; Perinatal Services BC and BC Ministry of Health. (2020). *Safer Sleep for My Baby*.
- ⁴² UNICEF UK. (2019). The Baby Friendly Initiative. *Co-sleeping and SIDS: A Guide for Health Professionals*; and consultation with women with lived experience and service providers.
- ⁴³ NSW Government, Ministry of Health. (2014). *Clinical Guidelines for the Management of Substance Use during Pregnancy, Birth, and the Postnatal Period*, p. 29.
- ⁴⁴ *Ibid.*
- ⁴⁵ *Ibid.*; Eni, R., Phillips-Beck, W., Mehta, P. (2014). "At the Edges of Embodiment: Determinants of Breastfeeding for First Nations Women." *Breastfeeding Medicine*, 9(4): 203-214, at p. 207; First Nations Health Authority (FHHA). (2013). *Honouring our Babies: Facilitator's Guide*; and consultation with service providers and women with lived experience.
- ⁴⁶ FHNA. (2013). *Honouring our Babies*.
- ⁴⁷ BC Ministry of Health & Perinatal Services BC. (n.d.). *Safer Infant Sleep: A Practice Support Tool for Healthcare Professionals*
- ⁴⁸ San'yas Indigenous Cultural Safety Training. (n.d.)
- ⁴⁹ SAMHSA (2013). *Definition of recovery*
- ⁵⁰ Alberta Health Services (2019). *Harm Reduction. Recovery Oriented Care*