PROVINCIAL BLUEPRINT

for a Perinatal Substance Use Continuum of Care

NOVEMBER 2021

PROVINCIAL PERINATAL SUBSTANCE USE PROJECT TEAM

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

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

Land Acknowledgement

We respectfully acknowledge that the *Provincial Blueprint for a Perinatal Substance Use Continuum of Care* was developed on the the unceded, traditional and ancestral territories of the Coast Salish People, specifically the xʷməθkʷəy̓əm (Musqueam), S wx wú7mesh (Squamish) and səlí lwətaʔɬ (Tsleil-waututh) Nations. Further, this acknowledgement, gratitude and respect extends to the diversity of all Indigenous contributions including First Nations, Métis, Inuit and non-status Indigenous identities and communities on whose traditional territories we have the privilege to build relationships and provide services.

Acknowledgements

The *Provincial Blueprint for a Perinatal Substance Use Continuum of Care* developed by the Provincial Perinatal Substance Use Project is funded by the BC Ministry of Health and BC Ministry of Mental Health and Addictions.

We dedicate this work to Denise Bradshaw, Director, Provincial Health Initiatives, BCWH who inspired systems transformation in substance use services throughout her formidable 30-year career in the mental health and substance use services sector. Denise was a true champion and tireless advocate for women and people using substances. This document reflects her visionary leadership and passion for trauma and violence-informed, culturally safe, equitable, gender-responsive and high-quality care.

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BC Association of Pregnancy Outreach Programs

Carrier Sekani Family Services

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Fraser Regional Aboriginal Friendship Centre Association

Hiiye'yu Lelum House of Friendship

Harmony House

HerWay Home

Karis Support Society

Kermode Friendship Centre

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

Led by the Provincial Perinatal Substance Use Project, the Provincial Blueprint for a Perinatal Substance Use Continuum of Care has taken several years to develop. The Blueprint compiles the knowledge base surrounding perinatal substance use services and integrates the best evidence, leading practice, Indigenous ways of being and knowing and wise practice. It is truly a provincial effort that highlights shared learning over the past years about how to provide excellent and high-quality care for pregnant and parenting women and people using substances. The Provincial Project team, regional health and community partners, Indigenous Elders, Indigenous-led organizations, Aboriginal Friendship Centres and government partners have been instrumental in establishing the Blueprint. The Blueprint places principle-based practice at the forefront of this work and ensures that our care for women is culturally safe, trauma and violence-informed, gender-responsive and oriented toward harm reduction and recovery. In short, the Blueprint reflects a new and transformative vision for perinatal substance use services for the women and people we serve.

In June 2021, the entire province was saddened by the sudden and unexpected passing of Denise Bradshaw, Director, Provincial Health Initiatives, BC Women's Hospital + Health Centre. Denise had a remarkable 30-year career in the substance use field and was dedicated to developing and implementing innovative services for people using substances, especially women. The Provincial Perinatal Substance Use Project was the culmination of her extraordinary drive, passion and commitment to supporting women using substances on their recovery journey. Her leadership on the Project served to ensure a clear vision for inclusive, non-stigmatizing, compassionate and culturally safe perinatal substance use services.

Denise placed relationships at the centre of her work. As part of the Project, she created safe and meaningful processes to engage Indigenous Elders, Indigenous Leaders and women with lived and living experience at all levels. Throughout these processes, Denise touched the lives of countless people and walked shoulder to shoulder with people using substances. Denise believed we are better when we work together and that our collective commitment and dedication to women and people using substances "could move mountains." Indeed, she was right. The positive changes happening across the province – and now, the Blueprint – will serve to guide us as we move forward… together.

Denise always acknowledged and empowered the Project team and was extremely proud of their collective efforts. She assembled an extraordinary group of people who share her dedication and drive for change. The Provincial Perinatal Substance Use Project Team dedicates the Blueprint to Denise and continues this important, transformative work in her honour and as her legacy. Denise would have expected no less.

Sincerely,

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

Message from Elder Glida Morgan, Tla'amin Nation & Elder Roberta Price, Coast Salish Snuneymuxw and Cowichan Nations

O Siem, thank you.

As Coast Salish and Tla'amin Matriarchs and Elders with the Provincial Perinatal Substance Use Project Team, we raise our hands up to honour all the beautiful Indigenous lifegivers, including First Nations, Métis, Inuit and non-status Indigenous identities impacted by substance use across British Columbia.

As Elders, our vision for the future is that all Indigenous women, children and families are happy, healthy and thriving; that Indigenous people are strong in their lives, jobs and families; that Indigenous people are listened to and heard and that women and matriarchs are held in the highest respect and honour. By listening to the voices of Indigenous Elders, leaders and women, health care and social systems can change for the better. The Project's Blueprint aligns to this vision of the future and shares how to achieve it.

The Blueprint also recognizes the role of colonization in the fracturing of Indigenous families, culture, ceremonies and ways. We are all still affected by trauma that happened 60 years ago and is still happening today. As Elders, we have taken on the very important and sacred roles of sharing our teachings to ensure they continue through the generations to address this trauma. As Elders, we bring our stories, learnings, teachings, wisdom, wise practices and guidance to inform care for Indigenous women and people, children and families in a good way. We draw upon our strength and the strength of our ancestors to guide us and help us share our strength with everyone.

The Project acknowledges our important roles as Elders in this work by respecting us, respecting our leadership and taking direction on how to care for Indigenous people. This is also demonstrated in the Elders Visioning Toolkit for Perinatal Substance Use led by Elders throughout the province. It is our hope that these examples have taken root and that we have planted the seeds for Elders across the province to be more connected to Indigenous women, children and families. We hold our hands up to health care providers supporting pregnant and parenting people using substances for opening your hearts and minds to the experience of Indigenous lifegivers and families and creating space to honour and learn from Elders. We look forward to hearing the stories about these beautiful relationships with Elders and what they have achieved both now and in the years to come.

Warmest blessings. O Siem.

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Message from the Director, Provincial Health Initiatives, BC Women's Hospital + Health Centre

Dear Partners,

It is with the greatest pleasure that I write this message regarding the Provincial Perinatal Substance Use Project's primary deliverable – A Provincial Blueprint for a Perinatal Substance Use Continuum of Care for women and people who are pregnant and/or parenting and affected by substance use. Since the Project's inception, we have worked with a myriad of diverse partners to bring this Blueprint to fruition. The Blueprint would not have been possible without the many collaborators who have given of their time, wisdom, experience and subject matter expertise to guide us on this journey. The Provincial Perinatal Substance Use Project Team applauds all of you.

The content of this Blueprint and its recommendations are a result of collaboration between Indigenous Elders, Indigenous Leaders, women with lived and living experience, peers, clinicians, educators, researchers, child welfare representatives, housing representatives, health system leaders and government leaders from a number of sectors. The recommendations provide us with a pathway to a robust continuum of care where no woman, family or community will fall through the cracks of a system that has been traditionally fragmented. The layers of fragmentation exist largely due to colonialism, racism and stigma towards people who are pregnant or early parenting and using substances.

The journey that has culminated in this Blueprint began in 2018 with the Visioning Workshop – Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges. As a result of this workshop, funding was provided to PHSA by the BC Ministry of Health and the BC Ministry of Mental Health and Addictions. Both Ministries have continued to be strong partners in our work to achieve our goals for the Project. As the Project has evolved, we have had the honour of providing funding to 19 community agencies – 10 of which are Indigenous-led health organizations and Aboriginal Friendship Centres.

As the collaborations across BC unfolded, cross-cutting themes emerged that provided a focus and foundation for our work. We committed to an Indigenous Cultural Safety journey to ensure that all points in the continuum of care reflect safety and that only Indigenous people can define this and determine whether we have achieved it. Indigenous Elders must be included at all dialogues that relate to their communities. We engaged women with lived and living experience and learned from their wisdom, voices and experiences.

As we move forward to implement the Blueprint, we will all need to reflect and focus on the priorities. We look forward to working with all our partners in a truly collaborative, good way!

Sincerely,

Denise Bradshaw, Director, Provincial Health Initiatives, BC Women's Hospital + Health Centre

Executive Summary

Led by the Provincial Perinatal Substance Use Project, BC Women's Hospital + Health Centre, the Provincial Blueprint for a Perinatal Substance Use Continuum of Care is the culmination of several years of collaboration among perinatal substance use services and sectors. The Blueprint shares the lessons learned through the Provincial Perinatal Substance Use Project, which aimed to initiate, expand, and improve acute and community-based services supporting pregnant and parenting people who use substances. The Project has been the crucible for envisioning and developing care centred on mother-baby dyads in a continuum that spans the journey from community to hospital and back to community. The Project has served as a linchpin for regional and local initiatives to transform perinatal substance use services. Together, Indigenous Elders, Indigenous Leaders, women and people with lived and living experiences of substance use, peers, clinicians, educators, researchers, child welfare representatives, housing representatives, health system leaders and government leaders have generated a new, transformative vision for perinatal substance use services for British Columbia.

Visionary leadership is essential to overcome the societal conditions that contribute to perinatal substance use. Pregnant and parenting women using substances face tremendous stigma, judgment, blame from the health care system, and are often fearful of having their children removed. Substance use among Indigenous women and people, in particular, can be attributed to a complex interplay of factors including Indigenous-specific racism, historical and ongoing colonization, intergenerational trauma, and barriers to accessing services. The removal of children, notably Indigenous children, into foster care contributes to traumatizing a new generation, recreating the experiences of those removed in earlier generations from Indigenous families and communities. This cycle continues to disproportionately affect Indigenous children and ironically contributes to further intergenerational trauma, substance use, and disrupted parenting. The Blueprint offers an opportunity to change direction and decolonize such systemic practices through the articulation of principles to guide system redesign, highlighting evidence-informed and leading practices, wise practices, and identifying tools for change.

Though much work still remains to generate contextual understanding of the needs and experiences of pregnant and parenting people using substances, data from the Perinatal Data Registry suggest that five percent of pregnancies in BC involved some form of illicit/other drug use in 2019/20—likely an underestimate. To advance understanding and support knowledge of interventions that work, the Blueprint calls for the development of perinatal substance use data infrastructure that adopts a life-course perspective and contextualizes substance use with data on preconception health, maternal health, child development, and family context, balancing administrative data with qualitative findings, stories, and narratives informed by Indigenous ways of knowing and being.

The Blueprint places principle-based practice at the forefront of this vision to ensure that care is culturally safe, trauma and violence-informed, equitable, gender-responsive, and oriented toward harm reduction and recovery. The Blueprint outlines system design elements and considerations for planning and implementing perinatal substance use services and supports. Building on evidence, leading practices, promising practices, wise practices, and the voices of those with lived and living experience, the Blueprint describes the foundational, clinical, and cross-sectoral components of the perinatal substance use continuum of care.

The Blueprint traces a pathway of system transformation and provides descriptive recommendations on how the perinatal substance use continuum of care can be improved at local, regional and provincial levels. Each chapter shares evidence and experiences regarding a key aspect of a supportive continuum of care. A set of 38 recommendations build a rendering of a continuum of care in which no woman, family or community will fall through the cracks of a system that has been traditionally fragmented due to colonialism, racism, and stigma towards people who are pregnant or early parenting and using substances. The recommendations, taken together, amount to a comprehensive, aspirational yet attainable approach to transforming the system of perinatal substance use services and supports for pregnant and parenting women using substances.

Indigenous Cultural Safety is the process of making spaces, services, and organizations safer and more equitable for Indigenous people by considering colonial history and responding to structural racism and discrimination. The Blueprint recognizes that all aspects of the perinatal substance use system of care must work toward Indigenous Cultural Safety in order to eliminate the pervasive gendered colonial violence related to pregnancy, birth, and parenting in health and social systems of care. Supported by Indigenous Elders, Knowledge Keepers, and Leaders, the Project team and partners have undertaken an extensive journey toward Indigenous Cultural Safety. Indigenous Cultural Safety is therefore the most important guiding principle of the Project and informs all aspects of the Blueprint, from service planning and design to education and training.

The Blueprint advances a holistic, wrap-around approach to caring for people who are pregnant and parenting and using substances. This approach shapes acute care design and systems of referral, admission, and transition using Families in Recovery (FIR) program at BC Women's Hospital + Health Centre as a model program. The Blueprint also is informed the services provided by community-based organizations funded by the Project, including Aboriginal Friendship Centres, Indigenous Health Organizations, and the First Nations Health Authority.

The Project supported Elders across each region in British Columbia involved in substance use services and perinatal health to share their diverse knowledge and wisdom as Knowledge Keepers and storytellers in their communities in an Elders Visioning for Perinatal Substance Use Toolkit. In the virtual toolkit, Elders outline how to support First Nations, Inuit and Métis women, children, and families impacted by substance use in a good way. In addition, the Project has developed an array of education and training offerings for health care providers, as well as guidelines to support practices such as rooming-in, withdrawal management, and injectable opioid agonist therapy and follow-up. In partnership with the BC Association for Pregnancy Outreach Programs, the Project has

established a Healthy Care Pregnancy Program to provide hospital-based in-reach at 10 sites in the province. The Project has conducted an environmental scan of housing for pregnant and parenting women using substances and in early recovery. Together, these diverse and intersecting initiatives form the scaffolding for a robust continuum of care.

The Provincial Perinatal Substance Use Project embraced the experiences of those with lived and living experience of substance use, pregnancy and parenting. Supported by their stories and wisdom, and guided by Indigenous Elders, Knowledge Keepers, and Leaders, the Blueprint documents the reality that women and people who are pregnant and parenting and using substances have immeasurable strengths, gifts, and resiliency. As a system of care, we must honour those gifts by creating and fostering the supportive conditions that enable mothers and babies to be together. By doing so, we will help women, children, families and communities forge ahead on their unique journeys and paths of healing and wellness.

Summary of Recommendations

The following list of 38 recommendations reflect each chapter of the Blueprint. Implementing the recommendations will result in a positive transformation of perinatal services and suppports across the province.

CHAPTER 2 Perinatal Substance Use in BC:

Recommendation 2.1: *Continue to work with Regional Health Authorities, community organizations, Indigenous health organizations, Aboriginal Friendship Centres, researchers, evaluators, women and people with lived experience and cross-sectoral partners to attain a better contextual understanding of the needs and experiences of pregnant and parenting people using substances*

CHAPTER 3 Guiding Principles:

Recommendation 3.1: *Prioritize and embed nine guiding principles including specifically Indigenous Cultural Safety, trauma and violence-informed practice, harm reduction and recovery-oriented practice into training, learning and substance use-related service delivery*

CHAPTER 4 Indigenous Cultural Safety:

Recommendation 4.1: *Create relationships with Indigenous people in culturally safe ways that are respectful, reciprocal, responsible and relevant*

Recommendation 4.2: *Centre and formalize opportunities led by Indigenous Elders, Indigenous Leaders, Indigenous doulas and midwives, birth workers and birth keepers in perinatal substance use work, and create time and space for story-telling, voices, perspectives and world views*

Recommendation 4.3: *Create space for Indigenous midwives, doulas, birth workers and birth keepers in perinatal services and hospital settings and support the development of birth work communities of practice and/or networks*

Recommendation 4.4: *Ensure access and provide culturally safe programming and ceremony that includes involvement of Elders, Knowledge Keepers, and the land across settings and sectors*

CHAPTER 5 Women with Lived and Living Experience:

Recommendation 5.1: *Commit to understanding and addressing stigma that pregnant and parenting women and people using substances experience including accessing resources and tools that help with addressing stigma and building a speak-up culture*

Recommendation 5.2: *Prioritize the engagement of women and people with lived and living experience in program planning and service delivery*

Recommendation 5.3: *Formalize peer support roles and hire peer support workers in acute and community settings*

Recommendation 5.4: *Establish and/or foster existing and emerging peer support networks*

CHAPTER 6 Interdisciplinary Practice:

Recommendation 6.1: *Develop an interdisciplinary team that aligns to a bio-psychosocial-spiritual philosophy of care that supports women. The team should include leadership, allied health, Indigenous staff and leaders, Indigenous Elders, and clinical team members and should clarify roles and responsibilities of each interdisciplinary team member*

Recommendation 6.2: *Implement trauma and violence-informed practice, Indigenous Cultural Safety (including anti-racism and anti-oppression approaches) and harm reduction as the cornerstones of interdisciplinary teamwork*

Recommendation 6.3: *Implement multi-level communication mechanisms to bring interdisciplinary teams together and support consistency, collaboration and planning of activities including care coordination and transitions*

Recommendation 6.4: *Use a strengths-based lens when documenting the assessment, progress and care planning of each person's health care journey*

CHAPTER 7 Engagement and Stabilization:

Recommendation 7.1: *Build trust and relationships first, and expect women and people to engage at "the speed of trust"*

Recommendation 7.2: *Establish a model for stabilization in which one discipline leads while other disciplines remain engaged as consult services*

Recommendation 7.3: *As the health, medical and social concerns of pregnant and parenting women and people are complex, implement a broad range of assessment tools and document thoroughly*

Recommendation 7.4: *Provide pregnant and parenting women and people using substances with access to the full range of harm reduction and treatment options for the clinical management of substance use disorders*

CHAPTER 8 Acute and Community Programming:

Recommendation 8.1: *Implement substance use services and treatment in community and acute care settings as a priority*

Recommendation 8.2: *Prioritize holistic, wrap-around programming in both acute care and community settings across a range of domains*

CHAPTER 9 Transitions:

Recommendation 9.1: *To ensure continuity of care, provide women and people with one-on-one or structured system navigation support in hospital and/or community settings*

Recommendation 9.2: *To support and empower pregnant and parenting people using substances, every community or acute care organization must have a clear and detailed approach to addressing all aspects of transitions systemically*

CHAPTER 10 Knowledge Exchange, Training and Education:

Recommendation 10.1: *Use a learning campaign approach to education and training and build in multiple activities over time*

Recommendation 10.2: *Emphasize learning by integrating performance supports into education and training*

Recommendation 10.3: *Utilize provincial courses, core education offerings and resources to support education, training, capacity building and alignment to principle-based practices among health care providers*

CHAPTER 11 Primary Care:

Recommendation 11.1: *Support the implementation of respectful discussion and collaborative tools for assessment and engaging in brief intervention/support for perinatal substance use in primary care*

Recommendation 11.2: *Support the implementation of substance use-specific guidelines (alcohol, tobacco, opioid use disorders, cannabis) in primary care*

Recommendation 11.3: *Encourage physicians working in the perinatal substance use field to enhance their addiction medicine skills*

Recommendation 11.4: *Include emergency departments in transition protocols and processes*

Recommendation 11.5: *Provide postpartum supports – including substance use-related education, partner support, mental health support and infant development support – for women and people after labour and delivery in primary care settings*

CHAPTER 12 Child Welfare Engagement:

Recommendation 12.1: *Acknowledge and understand the historic and ongoing colonial context of child welfare services and their impact on Indigenous women, children, families and communities and non-Indigenous women*

Recommendation 12.2: *Pursue every option and alternative to child removals and keep mothers and babies together*

Recommendation 12.3: *When a child removal occurs, child welfare staff need to provide a comprehensive and documented assessment, cause for child removal or supervision orders and plans for reunification of family* **before** *a child's removal. A person must have a circle of support present that may include a partner, family members, Indigenous Elders and community members. A safety plan must be in place before child removal*

Recommendation 12.4: *Ensure that a pregnant or parenting person using substances has given documented consent to communicate their personal information with MCFD/DAA. To make this decision, women and people must be aware of what information is being requested and what information will be shared. Consent should be treated as an ongoing process where health care providers check in regularly regarding whether the consent to share information has changed*

Recommendation 12.5: *Foster collaborative relationships with MCFD/DAA to ensure that a pregnant or parenting person using substances has access to community supports and resources*

CHAPTER 13 Housing:

Recommendation 13.1: *Develop and support the implementation of a non-linear, flexible and person-centred housing services model for parenting women and people using substances and in early recovery. Within this model, ensure that transitions between housing types are seamless and well supported and that abstinence-based and stable active use housing is included, so that women have access to appropriate supports wherever they may be on the recovery spectrum*

Recommendation 13.2: *Target immediate and ongoing investments to increase the supply of family housing inclusive of partners and children that is women-centred, culturally safe and supports family unity; ensure that housing units are high quality and located in neighbourhoods conducive to family safety and well-being*

Recommendation 13.3: *Integrate substance use treatment, psychosocial supports and peer support into family housing for pregnant and parenting people using substances, their children and families*

Vision for a Perinatal Substance Use Continuum of Care

CHAPTER 1:

Background and Context

A Vision for Pregnant and Parenting Women and People Using Substances

Led by BC Women's Hospital + Health Centre, PHSA, the Provincial Perinatal Substance Use Project was established to advance provincial capacity and enhance services for pregnant and early parenting women[1] using substances and their infants, families and communities. The goal of the Project is to establish a provincial 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 supports capacity-building across acute and community services to integrate best evidence and wise practice for improving the perinatal substance use continuum of care and foster optimal health outcomes, including keeping the mother-baby dyad together. The Project is leading the establishment of principle-based care approaches (including trauma and violence-informed practice; Indigenous Cultural Safety; harm reduction in the context of recovery-oriented systems of care) throughout BC.

The Project is funded by the BC Ministry of Health (MoH) and the BC Ministry of Mental Health and Addictions (MMHA). The Project is linked to the MMHA's *Pathways to Hope* strategy, which places a priority on improving wellness for children, youth and young adults by supporting pregnant individuals and parents with substance use challenges. The Project also supports the MoH's goals and objectives to improve health outcomes and reduce hospitalizations of those with

1 A note about gender and sexual orientation terminology: In this document the terms: **woman, individual and women and people** are used throughout. This is to acknowledge health inequities that exist for both women and people who do not identify with gender binary terms. These different terms, in particular gender additive terms such as "women and people", are meant to be inclusive of transgender individuals who are pregnant, and to respect those who wish to continue to be identified as pregnant women or mothers. We encourage all providers not to assume binary genders, gender identity or sexual orientation of the pregnant person (or their partner) and to respectfully and non-judgmentally ask all pregnant people about their preference for how they wish to be addressed

mental health and substance use issues. The Project is also aligned to PHSA's service plan to augment evidence-informed perinatal substance use services in the province.

The Project has provided centralized, core leadership for system-wide planning and implementation of perinatal substance use-related enhancements in collaboration with over 300+ provincial stakeholders. This work has involved extensive partnerships with community organizations including Indigenous-led health organizations and Aboriginal Friendship Centres to enhance direct care for pregnant and parenting people using substances. All Project partnerships and collaborations are intended to contribute to a new vision for perinatal substance use services and supports.

Imagine that an individual who is pregnant, postpartum or parenting and using substances approaches any part of the health care system and is supported to embark on a health care journey free of racism, discrimination, stigma, judgement, blame, shame and fear of child removal. Imagine the system responding in a caring, compassionate, trauma and violence-informed way by saying "Welcome. We understand that you're on a journey and will support you in every way possible. What can we do for you right now?" Imagine that, regardless of whether the woman is striving to address an obstetric, prenatal, pediatric, medical or substance use issue, every person in the health care system feels responsible and accountable for addressing her needs in a positive way. This is the experience and journey for pregnant and parenting people this Project hopes to realize.

Provincial Visioning Forums

In June 2018, Perinatal Services BC and BC Women's Hospital + Health Centre co-led the *Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop*. The workshop engaged 90 health care leaders and professionals from across BC to review new provincial and national perinatal substance use treatment guidelines, highlight exemplary models and practices in BC, identify gaps and areas for improvement, and build a common vision for action across the province. The Visioning Workshop culminated in five recommendations, along with specific regional priorities to improve the care of pregnant and newly parenting people using substances. The findings of this workshop were leveraged to develop the Project.

In June 2019, the Project hosted the *From Visioning to Reality Forum: Caring for Pregnant and Newly Parenting Women Using Substances*. The Forum brought together more than 130 health care leaders and professionals, Indigenous Elders and women with lived and living experience to learn about the various initiatives underway since June 2018, highlight the importance of the Indigenous Cultural Safety journey and provide expertise and input into the development of a blueprint for a provincial perinatal substance use continuum of care.

Building on the success of both forums, the Project's work involves more than 300 stakeholders including Regional Health Authorities (acute care, mental health & substance use, perinatal care); Indigenous Leaders; Indigenous Elders; Métis Nation; women and people with lived and living experience; BC Association of Aboriginal Friendship Centres; First Nations Health Authority; Métis Commission for Children and Families of BC; community-based organizations serving the perinatal substance use population; BC Housing; BC Centre for Substance Use; BC Centre of Excellence for Women's Health; Perinatal Services BC; BC Centre for Disease Control; BC Mental Health & Substance Use Services; BC Children's Hospital; BC Women's Hospital + Health Centre; and government partners from MCFD, MoH and MMHA.

The Project includes the following evolving committees and working groups:

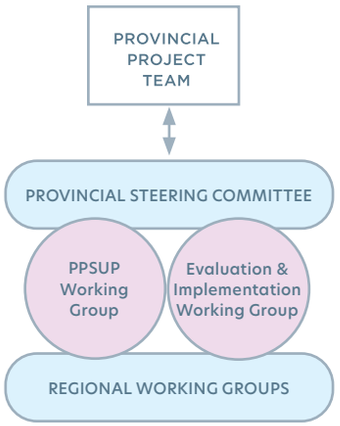
Provincial Steering Committee provides leadership, guidance and oversight of progress on Project goals and the ultimate project deliverable, the Blueprint.

Provincial Perinatal Substance Use Project Working Group comprises a multidisciplinary membership that shares evidence-informed practices, key education and training initiatives, and discusses issues and opportunities to improve the journey of women and people with lived and living experience.

Evaluation and Implementation Working Group oversees the evaluation of the Project's contributions to system-wide transformation in terms of project-, service- and system-level outcomes. The Working Group draws on data, research, Indigenous knowledge and wise practices, Indigenous Cultural Safety and lived and living experiences to inform the Project's evaluation approach.

Regional Working Groups are co-led by Regional Health Authority Leaders in perinatal health. Each Regional Working Group is responsible for informing and developing regional services and supports for pregnant and parenting people using substances, ensuring equitable access to services and supporting system improvements/implementation. The Regional Working Groups include representatives from Regional Health Authorities, community organizations, Indigenous health organizations and people with lived and living experience. The Regional Working Groups play a key role in ensuring that systems transformation in perinatal substance use is sustained over time.

Figure 2: Project Structure



Blueprint

Blueprints align to systems planning and design approaches that are reflexive, flexible, and account for the inherent complexity of systems change and transformation. Blueprints provide both strategic and operational direction for the components of complex system initiatives that must be in place to ensure success. They also identify the current context, necessary conditions and cumulative actions that work together to achieve system change.

The Blueprint for a perinatal substance use continuum of care incorporates all the project learnings from regions, communities, the Indigenous Cultural Safety journey, women with lived and living experience and education and training.

The Blueprint outlines system design elements and considerations for planning and implementing perinatal substance use services and supports. It also describes the foundational, clinical and cross-sectoral components of the perinatal substance use continuum of care and harvests evidence, leading practices, promising practices, wise practices and voices of women and people with lived and living experience.

The Blueprint can be used to address specific parts of the perinatal substance use continuum of care that require improvement, or read in its entirety for direction on transforming the overall system of care. The Blueprint's audience includes health care planners, operational leaders, clinicians, physicians, health care providers, community service providers, project teams, educators and practice leaders.

Table 1. Components of a Provincial Blueprint for a Perinatal Substance Use Continuum

Foundational	Clinical	Cross Sectoral
• Principles of care • Engaging peers, women and people with lived and living experience • Engaging Indigenous Elders • Indigenous Cultural Safety	• Interdisciplinary approaches • Engagement and stabilization • Acute and community programming • Transition planning • Knowledge exchange, training and education	• Primary care • Child welfare • Housing

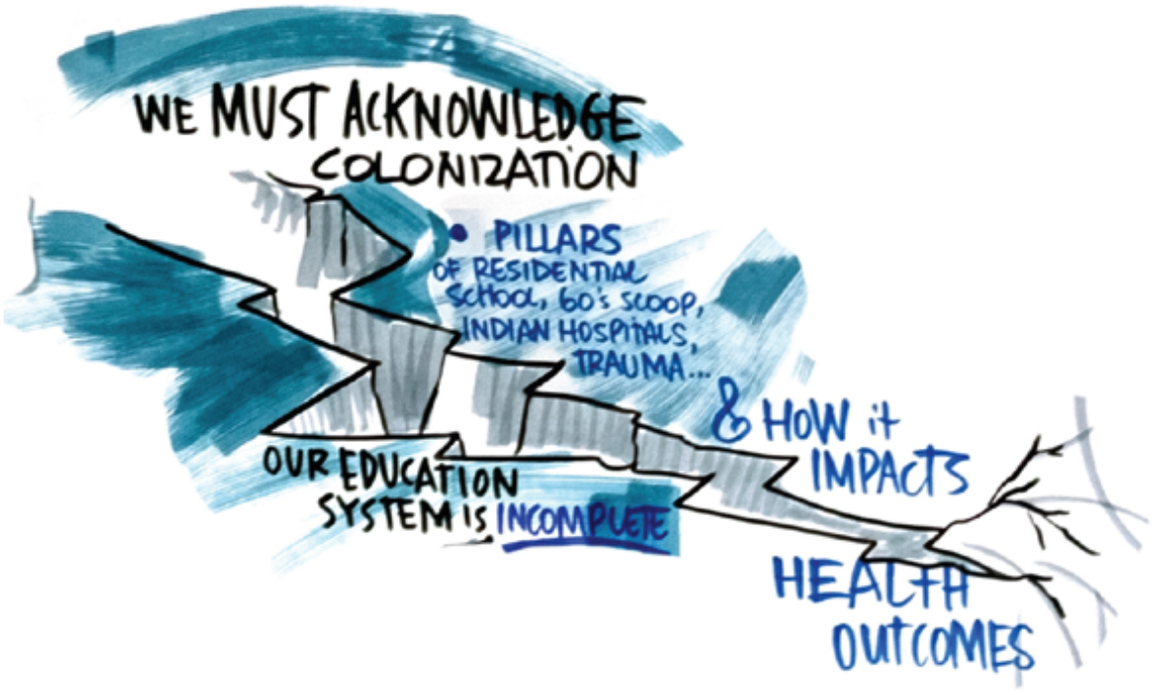
Indigenous Cultural Safety Journey

The Project is on an Indigenous Cultural Safety (ICS) journey to decolonize perinatal substance use services for Indigenous women, children and families in BC. ICS is the process of making spaces, services and organizations safer and more equitable for Indigenous people by considering colonial history and responding to structural racism and discrimination. ICS occurs when Indigenous people determine the system is safe for Indigenous people. Indigenous-specific racism is part of the daily reality for Indigenous people and part of the reason why services and supports must engage in real, tangible daily actions to address it. Indigenous-specific racism refers to the unique nature of stereotyping, bias and prejudice about Indigenous Peoples in Canada that is rooted in the history of settler colonialism (Turpel-Lafond, 2020). Colonial policies and practices are the source of ongoing race-based discrimination, negative stereotyping, power imbalances, systemic discrimination, and inequitable outcomes experienced by Indigenous Peoples (Turpel-Lafond, 2020).

A recent inquiry – *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care* – surveyed the health experiences of 2,780 Indigenous people. Eighty-four percent of the respondents indicated they had experienced racism within the health care system (Turpel-Lafond, 2020). The inquiry found that for Indigenous women, systemic racism, past and present gendered colonial violence and intergenerational trauma related to birth and mothering are pervasive experiences. As a consequence, far too many Indigenous women and children are receiving child

welfare services and/or having children taken into care. Indigenous women are overrepresented in the justice system and disproportionately affected by substance use. The harms that Indigenous women and people have experienced and continue to experience in the health care system and other systems are unacceptable. Each individual that plans, designs and delivers health care services must acknowledge this disparity and their role in combatting anti-Indigenous racism.

Adding to the layers of complex intergenerational trauma experienced by Indigenous Peoples, in May 2021, the Tk'emlúps te Secwépemc Nation made the devastating and tragic discovery of unmarked graves and burial sites on the grounds of the former Kamloops Indian Residential School. The remains of 215 Indigenous children were found via ground-penetrating radar, confirming the known truths and oral histories documented by Residential School Survivors and Elders. As this report was being writtten, additional burial sites were found at the Residential Schools located on the lands of the Cowessess First Nation, Sioux Valley Dakota Nation, Lower Kootenay Band and Penelakut Tribe. Many further investigations are pending and Indigenous Elders and Leaders caution that there will be more discoveries to come. Canadian authorities established residential schools to force Indigenous Peoples to assimilate. They separated children from their families and communities and outlawed their languages, sacred ceremonies, and important traditions (FNHA, 2021). In essence, the federal government declared Indigenous Peoples to be unfit parents who were indifferent to the future of their children (FNHA, 2021) This judgment is contradicted by the fact that parents tried to keep their children out of residential schools because they saw them, correctly, as dangerous and harsh institutions that raised their children in alien ways (FNHA, 2021). Residential schools also created an opportunity to gain access to and control Indigenous land. The trauma from the burial site discoveries has reverberated throughout the entire country, with demands for accountability on the part of the government for the residential school system. In addition, calls for action demand that each individual take responsiblity to learn about residential schools and colonization and adopt an anti-racist and anti-oppresion stance in the name of truth and reconcilation. For Indigenous Peoples, apologies are not enough, and must be followed by action (Dr. Elder Roberta Price & Elder Glida Morgan).



The Project's ICS journey involves having Indigenous voices across the province inform all aspects of this work, from service planning and design, to education and training. The ICS journey describes an overarching approach to decolonizing perinatal substance use services and aligns to empowerment and self-determination approaches described in the following reports: *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care* (2020), *Truth and Reconciliation: Calls to Action* and the *United Nations Declaration on the Rights of Indigenous Peoples* – national and provincial declarations and the PHSA commitment to Indigenous Cultural Safety. From a gendered perspective, the Project aims to align to *Reclaiming Power and Place: Recommendations from the National Inquiry into Missing and Murdered Indigenous Women and Girls* (2021); *Sacred and Strong: Upholding Our Matriarchal Roles* (FNHA, 2021) and *Honouring Indigenous Women's and Families' Pregnancy Journeys* (PSBC, 2021).

The ICS journey also emphasizes the importance of the voices of Elders and Knowledge Keepers in the process of decolonizing perinatal health care approaches. Jeane Riley, Fort Nelson First Nation, is the Project's Indigenous Healing and Wellness Lead. Dr. Elder Roberta Price, Snuneymuxw and Cowichan First Nations and Elder Glida Morgan, Tla'Min First Nation are members of the Project team who provide guidance and consult on progress toward outcomes. Dr. Elder Roberta Price and Elder Glida Morgan are leading the development of an Elders Visioning Toolkit, which compiles the knowledge, wisdom and practices of Elders across the province involved in substance use services and perinatal health. The ICS journey also centres on raising the voices of Indigenous Elders, Knowledge Keepers, Indigenous Leaders, Indigenous midwives, doulas, birth workers and birth keepers and Indigenous women and children and honouring Indigenous ways of being and knowing.

Project Evaluation

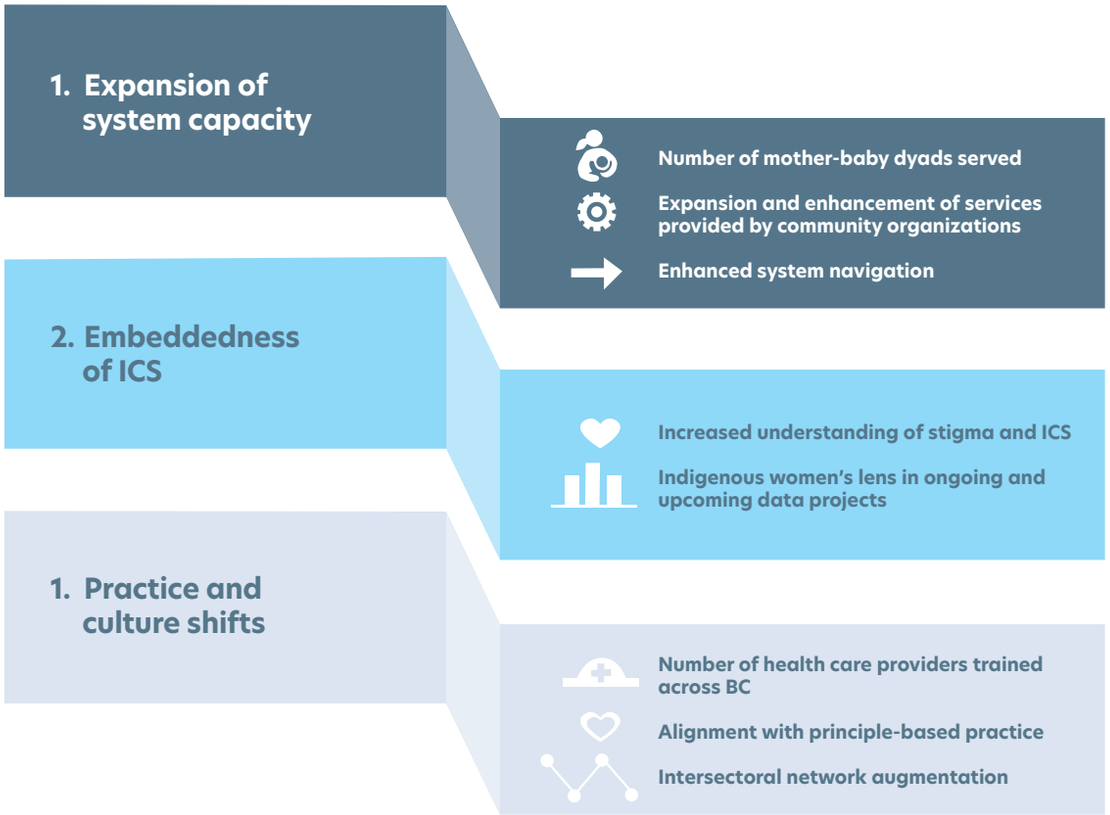
To assess the Project's short-, medium- and long-term contributions to system transformation, a mixed-method, complexity-informed evaluation has been designed. The underlying framework components of the evaluation are:

- **A developmental evaluation approach:** This type of evaluation is especially well suited to system transformation initiatives in complex and uncertain environments. Its characteristics include real-time feedback about innovative programs, iterative feedback loops, promotion of organizational learning and allowing room for program and systems change (Quinn Patton 2006; 2010).
- **A contribution lens:** A linear understanding of cause and effect does not reflect the complex nature of this Project's work and the multiple, interactive and additive effects of systems transformation. The Project works in collaboration with multiple disciplines, services and sectors to advance a holistic, wrap-around approach to caring for women and people who are pregnant and newly parenting and using substances. A robust understanding of the enablers and constraints of this approach makes it possible to adjust the Project's activities to yield results that advance system transformation.

- **Indigenous Cultural Safety:** Working alongside the Indigenous Healing and Wellness Lead for the Project and with guidance from Elders, the Project evaluation aims to generate and mobilize knowledge that will benefit and support Indigenous women, families and their communities. The evaluation incorporates stories and experiences throughout. The Project also upholds Ownership, Control, Access and Possession (OCAP) principles and that the "ability to design, direct, and benefit from evaluation practice is an inherent right" of Indigenous Peoples.

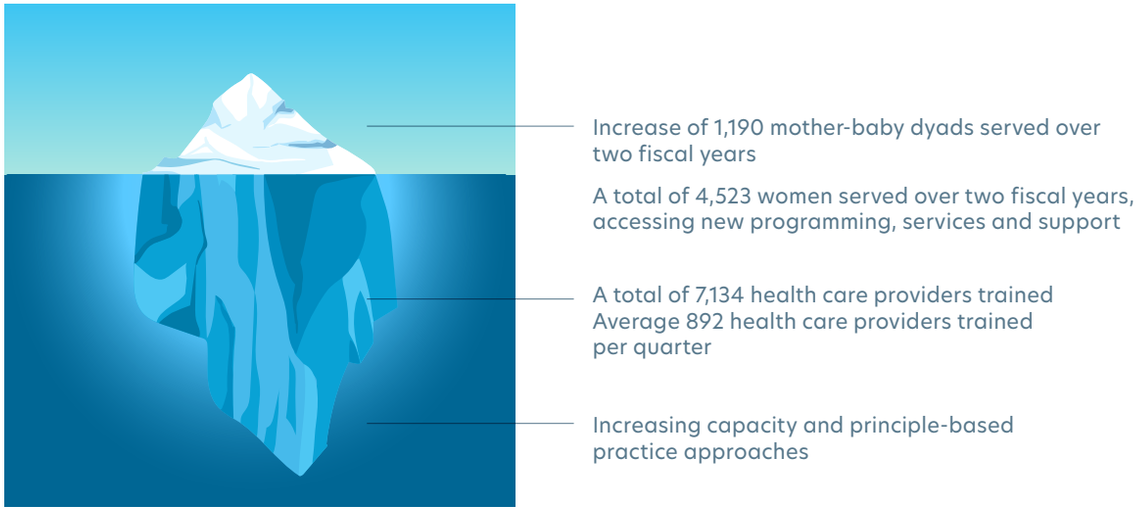
- **Focus on women and people with lived and living experience:** Given the fundamental role that lived experience plays in effective service planning and delivery, the Project evaluation incorporates the voices of people with lived and living experience, and includes Indigenous women's perspectives.

Figure 3. Project Evaluation Domains and Areas of Measurement



The Project evaluation addresses two key metrics: The increase of mother-baby dyads provided with direct care through community organizations, and the number of health care providers trained through community- and project-led training opportunities. These metrics can be conceptualized as the tip of an iceberg, with an increase in mother-baby dyads served being a reflection of broader system-wide changes in the perinatal substance use continuum of care.

Figure 4. Project Metrics in Summary — FY 2019/20 - 2020/21

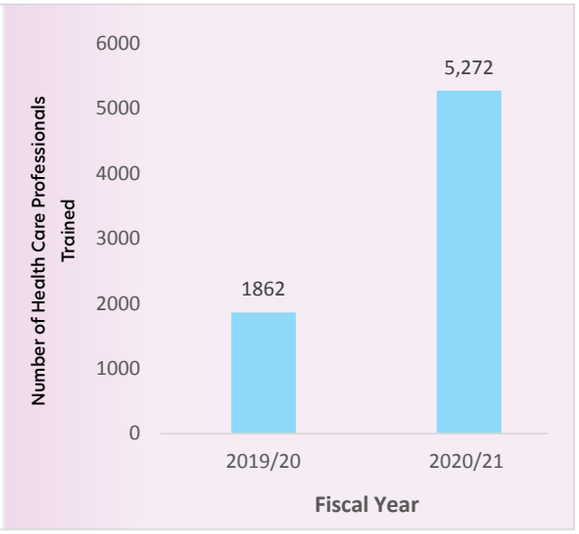


Increases in mother-baby dyads are a proxy measure of enhanced access to perinatal services and supports. This metric has been achieved through the funding of community organizations that provide direct care services, expanding capacity and implementing principle-based practices. There was an increase of 1,190 mother-baby dyads served new to receiving perinatal substance use services from the period April 1, 2019 to March 31, 2021. These increases in mother-baby dyads exceeded all annual targets set by the government at the start of the Project. In addition to increasing the number of mother-baby dyads served, 4,523 women overall were served by community organizations over the same period.

Lastly, 7,134 health care providers were trained from April 1, 2019 to March 31, 2021, averaging 892 health care providers per quarter. The emphasis on training reflects a deep commitment across the province to enhancing the skills of health care providers and supporting the implementation of principle-based practice.

Figure 5. Increases in Mother-Baby Dyads, FY 2019/20 - 2020/21

Figure 6. Increases in Health Care Providers Trained in Perinatal Substance Use and Principle-Based Practice Areas, FY 2019/20 - 2020/21



The Project has achieved many additional milestones articulated and referenced throughout the Blueprint, including:

- **Acute Care Design:** The Project has engaged in collaborative renewal of the Families in Recovery (FIR) Model of Care at BC Women's Hospital + Health Centre. The Model of Care Renewal informs acute care design elements referenced throughout the Blueprint. The Project has been supporting implementation of the Model of Care and has developed a FIR Triage Protocol defining referral, admission and transition processes for FIR.

- **Community Design:** The Project has provided community funding for up to 19 organizations across the province including Aboriginal Friendship Centres, Indigenous Health Organizations and the First Nations Health Authority.

- **Elders Visioning: Perinatal Substance Use Toolkit:** The Project has supported Elders to lead and develop a unique resource in which Elders across each region in BC involved in substance use services and perinatal health share their diverse knowledge, wisdom and practices about how to support First Nations, Inuit and Métis women, children and families impacted by substance use in a good way.

- **Provincial Healthy Care Pregnancy Program:** In partnership with the BC Association for Pregnancy Outreach Programs, the Project has established a Healthy Care Pregnancy Program providing hospital-based in-reach at 10 sites in the province.

- **Project-Related Education:** The Project has created specific training opportunities aligned to principled practice in Perinatal Substance Use including Perinatal Substance Use/Eat Sleep Console training; ACTOC/BCCSU Perinatal Substance Use Modules; Motivational Interviewing; SafeCare; Acute Care Social Work Training; and Prescriber Training.

- **Guidelines:** The Project has developed the Provincial Guideline for Rooming-in for Pregnant and Parenting Women using Substances and a draft Guideline for injectable opioid agonist therapy (iOAT) in hospital settings.

- **Housing Framework:** The Project has conducted an environmental scan of housing for pregnant and parenting women using substances and women in early recovery across the province.

CHAPTER 2:

Perinatal Substance Use in BC

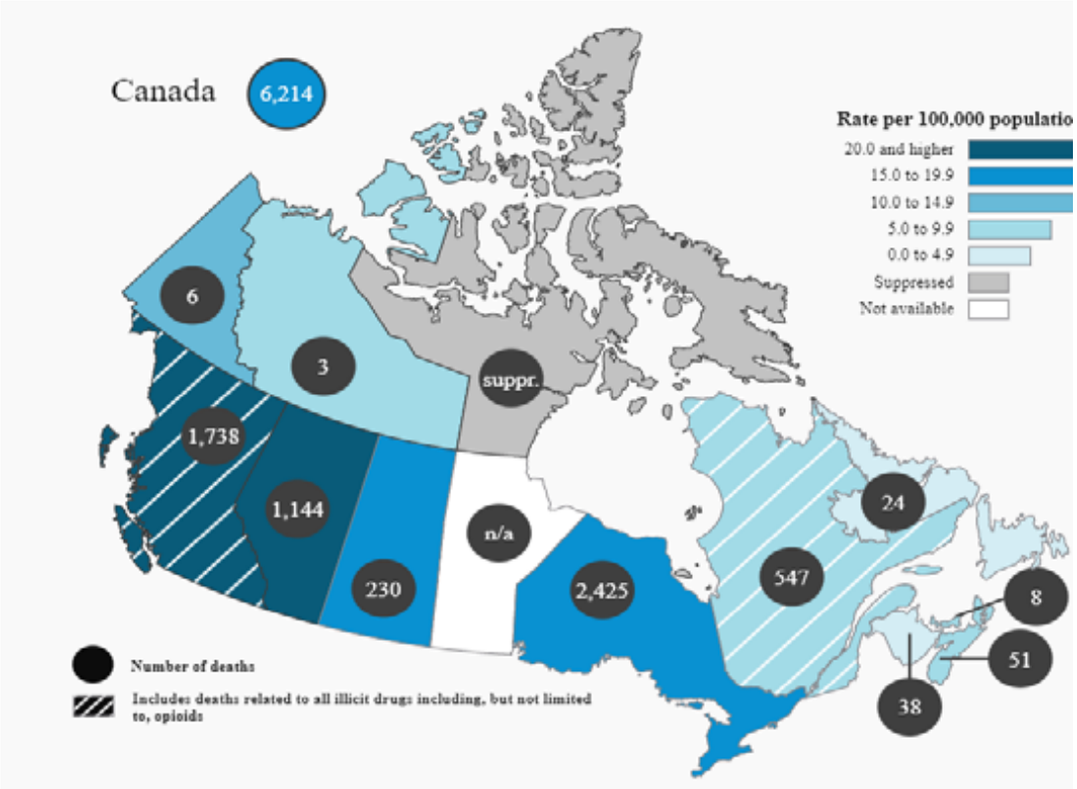
Substance Use in Canada

The opioid epidemic is one of the most complex public health and safety issues in Canada. More than 21,174 apparent opioid-related deaths occurred between January 2016 and December 2020 (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020). BC was the province with the highest rate of death during that time (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020). Opioids such as fentanyl, morphine, oxycodone, hydromorphone and increasingly methamphetamines, or a combination of these different substances, in both licit and illicit forms, were involved in most opioid-related overdose deaths.

While the overdose epidemic and public health emergency continues, a number of global factors are contributing to the impact of substance use on individuals and families. On March 11, 2020, the World Health Organization declared the spread of the novel coronavirus (COVID-19) to be a global pandemic.

In addition to the COVID-19 pandemic, there have been global efforts since June 2020 to acknowledge the widespread and ongoing systemic racism experienced by Black, Indigenous and People of Colour (BIPOC) every day. Movements such as Black Lives Matter and National Day for Truth and Reconciliation in Canada (September 30, 2021) are a start towards recognizing the harms of colonial systems, institutions and practices. BIPOC peoples experience racism, discrimination and significant health inequities and disparities in terms of accessing health care services including substance use services, supports and treatment and maternal/perinatal health services. All of the data presented in this section should be interpreted through this lens.

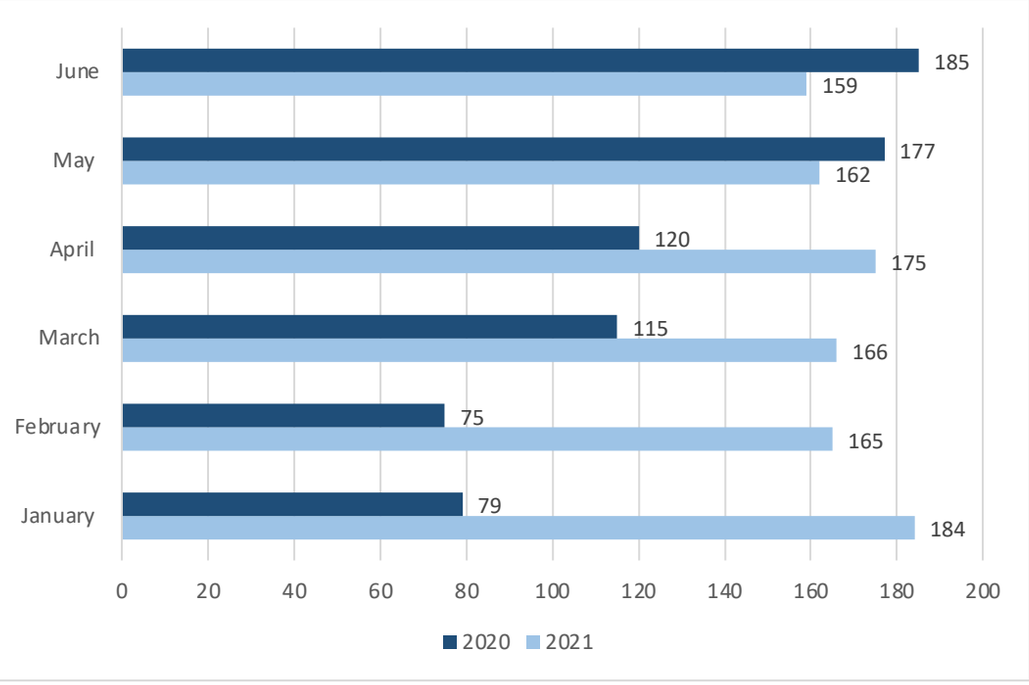
Figure 7. Number and of Opioid Toxicity Deaths in Canada by Province/Territory, 2020



Substance Use in BC

On April 16, 2016, BC declared a provincial public health emergency in response to the opioid overdose crisis. Since then, more than 6,000 British Columbians have died from opioid overdoses. People in every BC region have been impacted, regardless of their age, education, profession and income (BC Coroner's Service, 2020). In 2019, there were 984 illicit drug toxicity deaths, the first annual decrease since the declaration of the public health emergency. In 2020, 1,716 illicit drug toxicity deaths occured, a marked increase of 74 percent from 2019 (BC Coroner's Service, 2021). Between January 2021 and June 2021, BC saw 1,011 overdose-related deaths, a significant increase from the same period in the previous year.

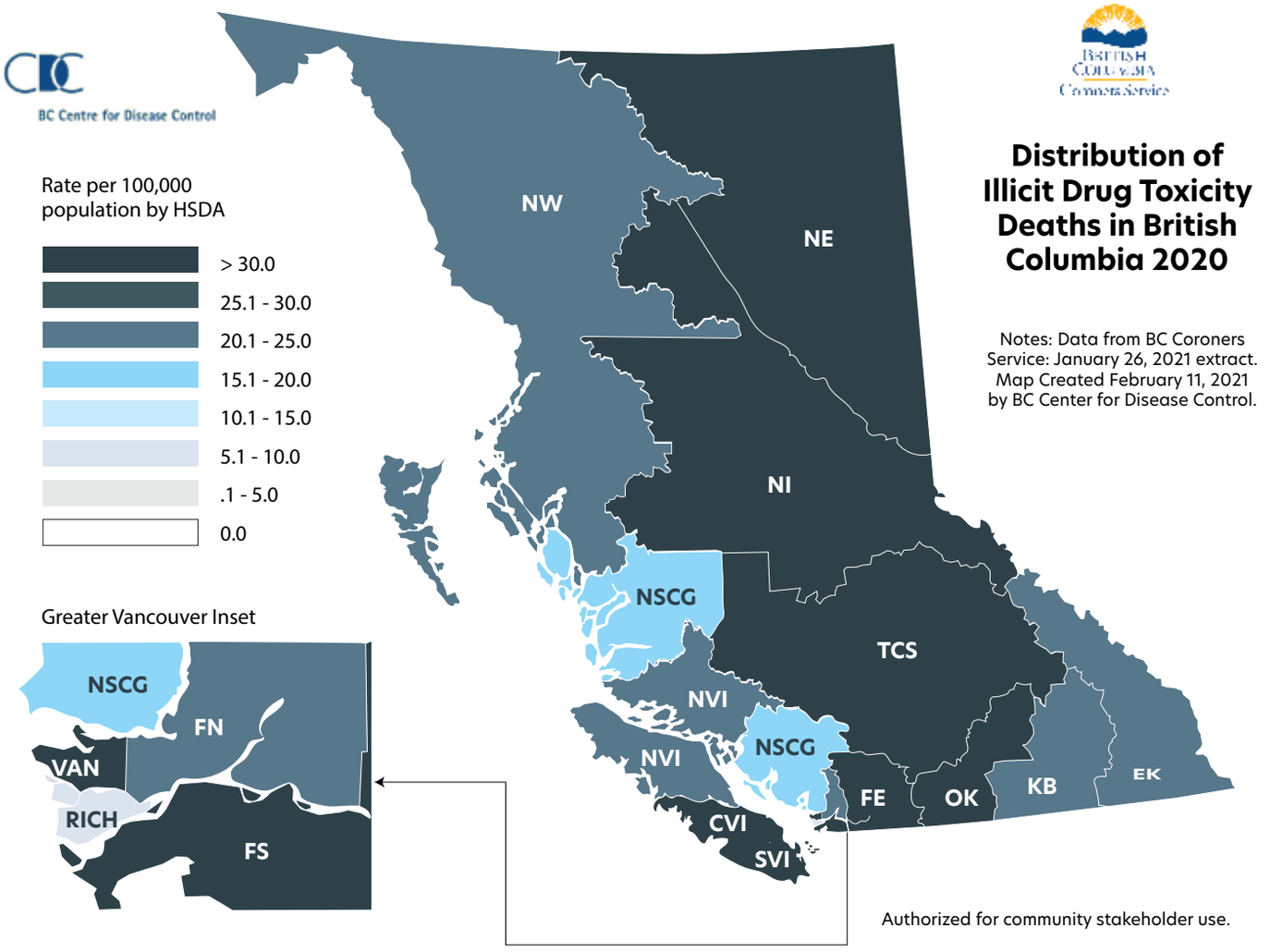
Figure 8. Comparison of Overdose-Related Deaths in BC in 2020 and 2021



Increases in illicit drug toxicity deaths can be largely attributed to the considerable harms created by the dual pandemic of both COVID-19 and the overdose crisis. Key challenges associated with COVID-19 for people using substances include increased social isolation and substance use, increased violence against women, downsizing of services and lack of access to harm-reduction services due to physical distancing and/or pandemic-related restrictions on availability.

From a geographic perspective, the Health Service Delivery Areas experiencing the highest rates of overdose deaths during 2020 are Northeast, Northern Interior, Thompson Cariboo Shushwap, Okanagan, Fraser East, Fraser South, Vancouver Coastal and Central Vancouver Island, and South Vancouver Island.

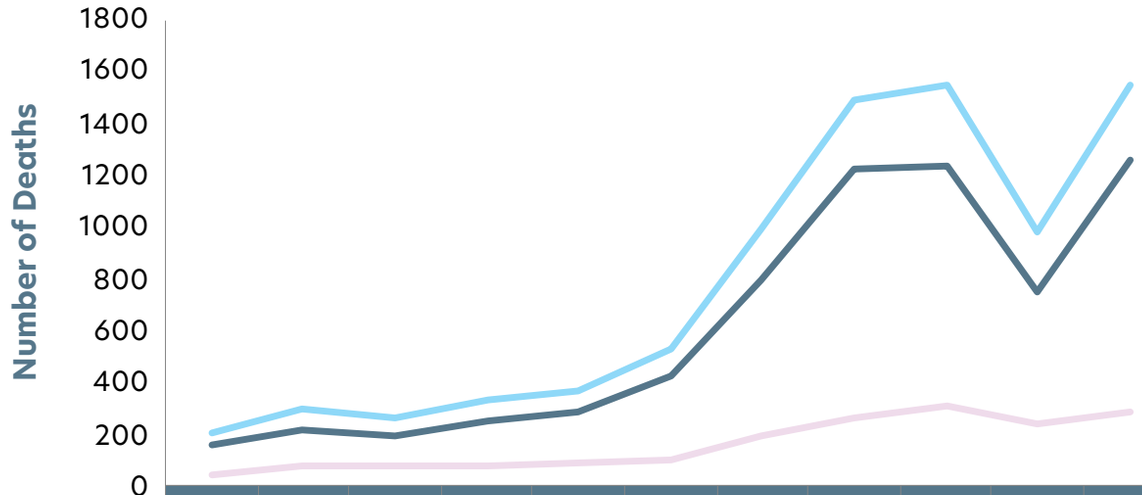
Figure 9. Geographic Distribution of illicit Drug Overdose Deaths by Health Service Delivery Area, 2020



Gendered Lens on Substance Use

While opioid-related deaths are most common among men, women account for approximately 19 percent of illicit drug toxicity deaths.

Figure 10. Number of Deaths due to Illicit Opioid Use in BC, By Sex, 2010-2020



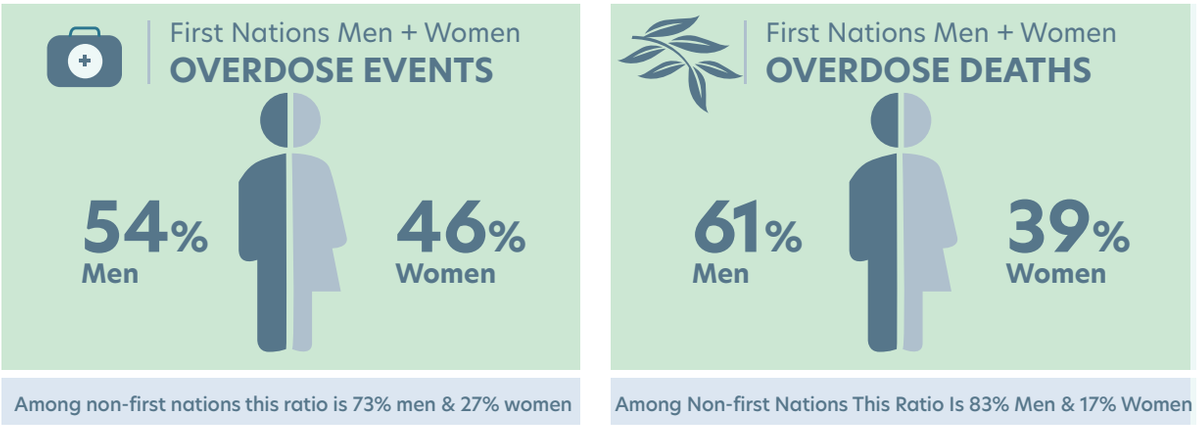
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Female	49	82	76	79	86	106	199	269	313	238	293
Male	162	213	194	255	283	423	792	1223	1236	746	1255
Total	211	295	270	334	369	529	991	1492	1549	984	1548

The percentages of women and men dying from prescription drug overdoses are similar (45 percent of deaths in women and 55 percent of deaths in men) (BC Coroners Service, 2020). Women's risk for overdose death involving prescribed pharmaceutical opioids is significantly higher than their risk for overdose death involving illicit opioid use (BC Coroners Service, 2017). Women are more likely than men to visit health care providers to seek medical attention, providing them more opportunity to receive prescription opioid medications and increasing the risk of opioid dependence. Women also suffer from chronic pain more significantly than men (CIHR, 2016). There is evidence that, compared to men, women with opioid use dependence demonstrate a more severe clinical profile in the Addiction Severity Index composite scores, significantly higher opioid cravings and more past and active medical conditions such as chronic physical pain and psychiatric symptoms, including depression and suicide attempts (Back et al., 2011).

Indigenous Lens on Substance Use and Maternal Care

Substance use among Indigenous people can be attributed to a complex interplay of factors including Indigenous-specific racism; historical and ongoing colonization; intergenerational trauma; and barriers to accessing services. *Sacred and Strong* (FNHA, 2021) notes that for Indigenous people, substance use may provide a way to cope with the pain, trauma, loss, and intergenerational impacts they have experienced as a result of racism and colonialist systems, the residential school system and the Sixties Scoop.

Figure 11. First Nations Overdose Events and Overdose Deaths, By Sex, 2019



The effects of BC's two public health emergencies are magnified among Indigenous populations. There were 254 First Nations illicit-drug overdose deaths in 2020 (FNHA, 2021). That year, First Nations people died from overdoses at 5.3 times the rate of other BC residents (FNHA 2021). As Indigenous people represent only 5 percent of BC's population, a single overdose or overdose-related death is devastating for a community.

From a gendered lens, First Nations women experience eight times more overdose events (46 percent vs 27 percent) and five times more deaths than non-First Nations women (39 percent vs 17 percent). In 2019, First Nations women died from overdose at 9.9 times the rate of non-Indigenous women in BC (FNHA 2021). These data refer to First Nations with status who are living on reserve. Urban populations, Metis populations and off-reserve populations are not reflected in these data.

In terms of perinatal health, Indigenous women, black women and people of colour experience significant inequities in maternal care. A recent US study by Vedam et al. (2019) of the lived experience of 2,700 women found that Indigenous women were the most likely to report at least one form of mistreatment they had experienced from health care providers (32.8 percent), followed by Hispanic (25.0 percent) and Black women (22.5 percent) when compared to white women. Mistreatment included being shouted at or scolded by health care providers, violations of privacy and threats of withholding treatment or using coercion to make a patient accept it. Vedam et al. (2019) noted that rates of mistreatment were consistently higher for Indigenous women and women of colour compared to white women. For Black women and people, there are limited Canadian race-based studies on maternal health experiences; however, it is believed that these trends are similar to those described in US studies.

Among Indigenous women, historical and ongoing mistreatment, violence and harms inflicted by colonial institutions during and around childbirth have resulted in deep, complex and intergenerational trauma (PSBC, 2021). Forced sterilizations, which stopped only in the recent past, violated the reproductive rights of Indigenous women and were often performed without consent (PSBC, 2021). The findings of *In Plain Sight* (2020) describe a contemporary and distressing reality for Indigenous women and their interactions with the health care system. Indigenous women experienced:

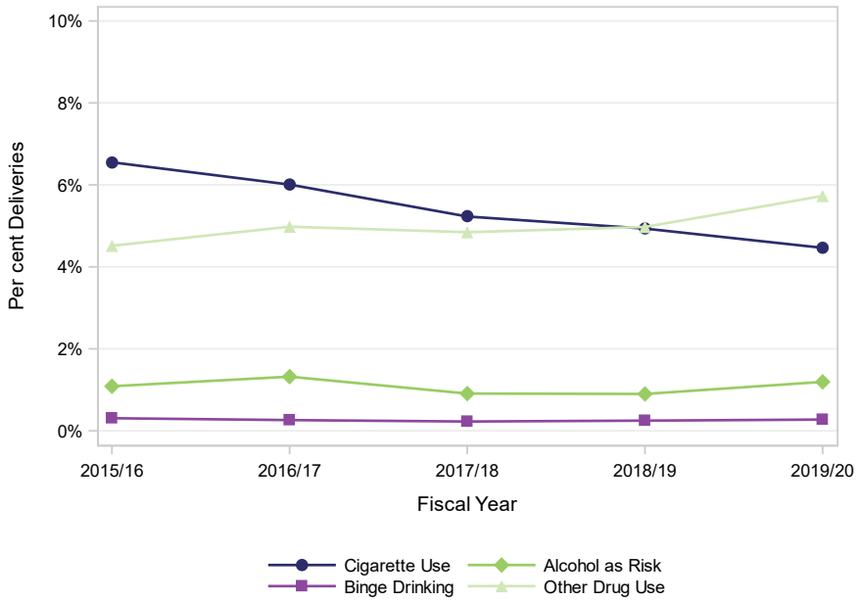
- Unique forms of racism within the health care system, including virulent misogynistic stereotypes specific to Indigenous women
- Unique traumas, including forced sterilization
- Impacts of child welfare policies that separate and disrupt Indigenous families
- A high feeling of unsafety when interacting with the health care system
- A higher need for health care services (compared to Indigenous men) and
- A need to interface with health care services in more intimate ways than men, especially in relation to maternal and reproductive health

Data on health care utilization of First Nations expectant women also indicated that, compared to non-First Nations women, First Nations women received fewer antenatal visits, were less likely to access midwifery care, have an obstetrician present during delivery, or deliver at home (Turpel-Lafond, 2020). These findings, taken together, present a picture of health care services that are much needed yet inaccessible/unavailable for Indigenous women, or services that are risky, unsafe and traumatizing. Health care providers in perinatal health have the responsibility to not only understand and address how racism impacts BIPOC women, but also to understand that racism can be overt or covert. The response from health care providers must be zero tolerance for racist language, imagery, behaviours or gestures (PSBC, 2021) and immediate "stop the line" interventions to address racism and discrimination.

Substance Use During Pregnancy in BC

Data from the Perinatal Data Registry provide insight into the different types of substances pregnant women used in BC between 2015 and 2020. These data show increases in other drug use and relatively stable levels of binge drinking and risky alcohol use over time (PSBC, 2021). In terms of substance use, the data show that five percent of pregnancies in BC involved some form of illicit/other drug use in 2019/20 (PSBC, 2021). "Other drug use" refers to health care provider-documented use of heroin/opiates, methadone, cannabinoids, stimulants or solvents at any time during the pregnancy as disclosed by a pregnant woman, or a provider's indication that a prescription, other, or unknown other drug was used during pregnancy. The data also include substance use by women who used a substance before learning they were pregnant (PSBC, 2021). The data likely under-represent the true picture, as they rely on self-reported substance use. Such disclosures can only occur when a woman feels safe and/or a health care provider has asked her specifically about her substance use.

Figure 12. Substance Use in Pregnancy, By Substance, 2015/16 - 2019/20



Further data on perinatal women who have been diagnosed with a substance use disorder are also available. In a BC-based cohort identified between January 1996 to September 2018, perinatal women accounted for 8,112 (8.8 percent) of 92,305 people diagnosed with opioid use disorder (OUD) identified through a case-finding algorithm (Noysk et al., 2020). Among this group, 52.9 percent were diagnosed with OUD prior to labour and delivery and/or within the first six weeks postpartum; 60.7 percent were diagnosed with OUD after the first six weeks postpartum.

The data provided in this section are drawn largely from administrative and secondary health data sets and from the perspective of health services and health system utilization. These types of data are limited and lack contextual information surrounding health system use. For Indigenous Peoples, the data only provide some inferences regarding ICS experiences. The data inherently privilege the health care system and health care providers by not acknowledging the health inequities and disparities that are the by-product and outcome of Indigenous-specific racism, discrimination

and stigma. *In Plain Sight* (2020) recommends that the BC government establish a system-wide measurement framework on Indigenous Cultural Safety, Indigenous rights to health and Indigenous-specific racism. It also recommends working with First Nations governing bodies and representative organizations, Métis Nation BC, the Indigenous Health Officer, and the Indigenous Health Representative and Advocate to ensure appropriate Indigenous data governance processes are followed during the required data acquisition, access, analysis and reporting.

Recommendation 2.1:

Continue to work with Regional Health Authorities, community organizations, Indigenous-led health organizations, Aboriginal Friendship Centres, researchers, women and people with lived experience and cross-sectoral partners to attain a better contextual understanding of the needs and experiences of pregnant and parenting people using substances

In a provincial consultation regarding perinatal substance use infrastructure, several key considerations emerged regarding what data are collected, how they are collected and how to include multiple lenses and perspectives. To effectively establish perinatal substance use data infrastructure, it was recommended that a life-course perspective is adopted and data are collected on maternal health, child development and adulthood (pre-conception) and family context. Data should focus on discrete individual-level indicators (e.g., length of stay in acute care or access to opioid agonist therapy), socio-economic determinants of health (e.g., poverty, homelessness, race and ethnicity) and indicators of system-level functioning (e.g., census and regional data on availability of care, community health data). Lived and living experience is particularly important to inform local context and service improvements and should be sought carefully, with the intent to balance the risks that women and people may feel in disclosing substance use.

Key data elements for perinatal substance use from systems, clinical, community and lived and living experience are described in Table 2.

Figure 13. Provincial Consultation on Perinatal Substance Use Data Infrastructure

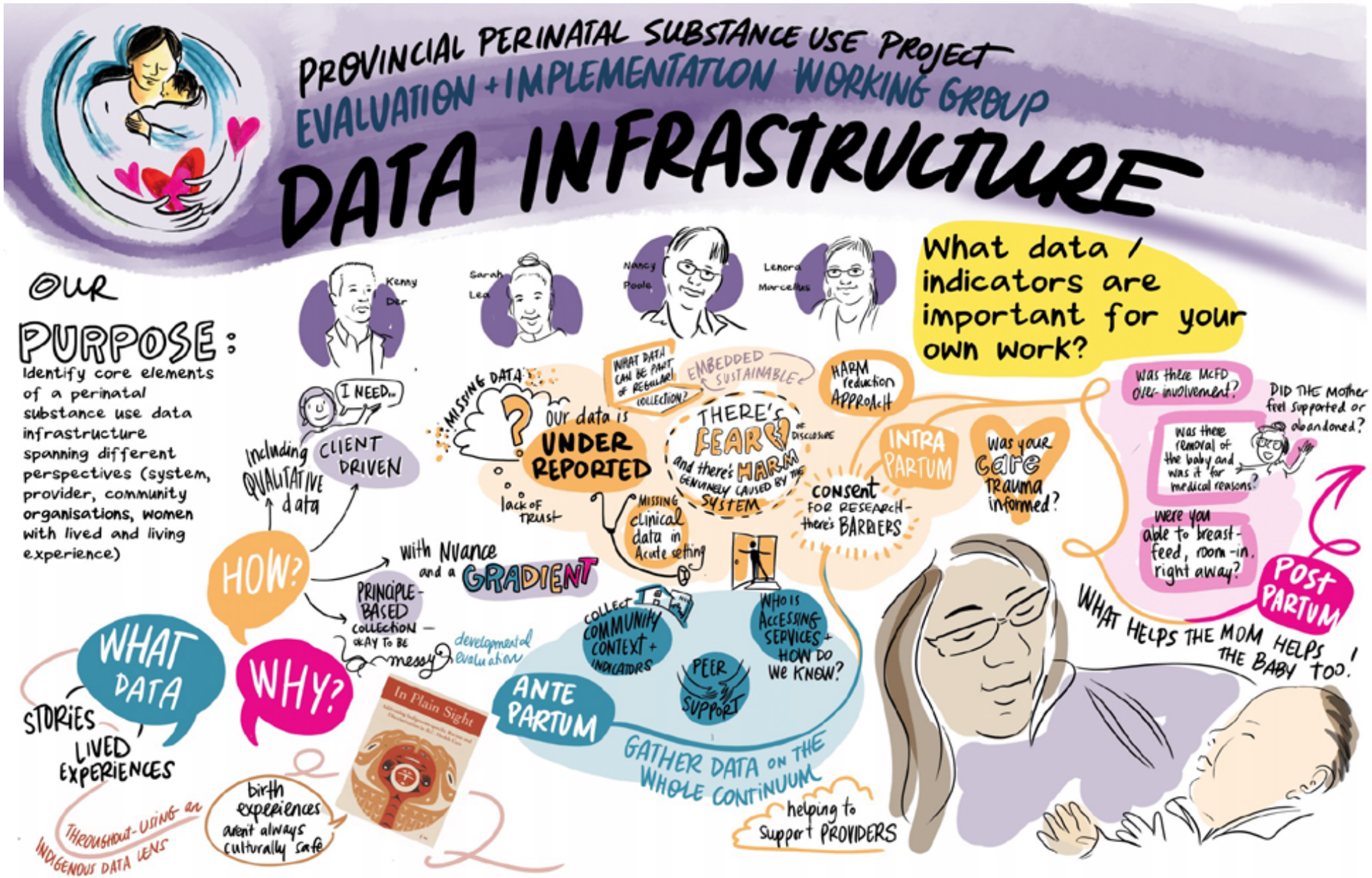


Table 2. Preliminary Core Data Elements for Provincial Perinatal Substance Use Data Infrastructure

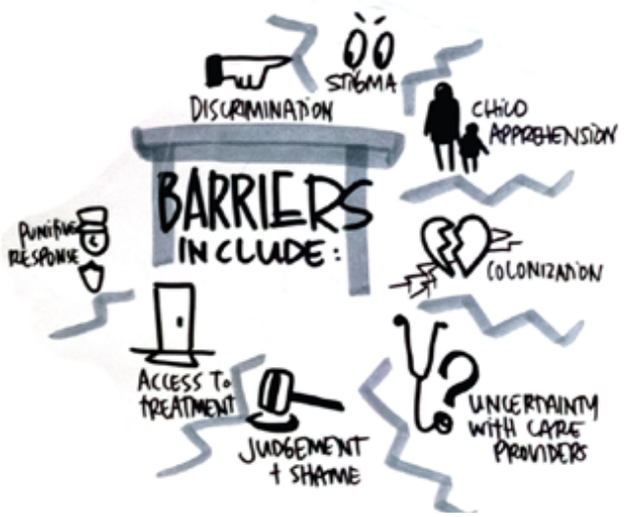
Data Categories	Data Elements
Systems	• Social determinants of health (socioeconomic status, race & ethnicity, community health indicators) • Child guardianship and parenting arrangements • Indigenous, Métis, First Nations identity • Continuity of MH&SU care and supports • Aggregate measures of non-health-enhancing aspects of the health system (e.g., social support, dignity, confidentiality, autonomy) • Gender and sex – disaggregated data, factors and influences • Equity measures • Policy and legislation impacts and changes
Clinical	• Numbers of hospital and emergency department admissions • Referrals and discharges including community and housing • Length of stay associated with perinatal substance use • Access to OAT treatment and stabilization, OAT dispensations • Obstetrical history and assessment • Medical co-morbidities • Substance use diagnosis and/or concurrent mental health diagnosis • Types of substances/effects of substances • Treatment matching, treatment planning • Neonatal health (Neonatal Abstinence Syndrome) • Postpartum care • MCFD/DAA child welfare involvement • Discharge plan components • Effects of interventions on practice change
Community	• Connection to prenatal and postpartum care • Referrals and access to housing • Purpose of intake to community services • Access to inter-professional health care supports • Infant development plan • Child welfare services involvement
Patient Centred Data	• Patient-Reported Outcome Measures (PREMS), Patient-Reported Experience Measures (PROMS) and Client-Reported Experience Measures (CREMS) • Lived experience stories, narratives • Patient journey maps • Studies/data driven by the insight of women and people with lived and living experience

CHAPTER 3:
Guiding Principles

Supporting pregnant and parenting people using substances requires developing and putting relational practice at the centre of health care service delivery. Meaningful relationships take time and energy to develop, maintain and sustain. Relational practice is defined as a way of being that includes collaboration, trust, respect, compassion and empowerment and the willingness to engage in a relationship that acknowledges limitations, strengths and emotions (Greenwood, 2016). This kind of authentic engagement from health care providers and allied health professionals is essential in providing care for people using substances, especially considering that stigma is one of the major barriers to accessing services and supports for people who are pregnant and newly parenting and using substances.

Recommendation 3.1:

Prioritize and embed nine guiding principles including specifically Indigenous Cultural Safety, trauma and violence-informed practice, harm reduction and recovery-oriented practice into training, learning and substance use-related service delivery



The Project's nine guiding principles reflect deeply-held values, foundational and core beliefs and aspirations for the health care system. The principles help orient Project partners, health care providers and stakeholders to what matters most when caring for pregnant and parenting women and people using substances. As such, the guiding principles permeate the Project's approach to strategy, education, knowledge exchange, training and clinical practice change.

Figure 14. Guiding Principles

The Project's foundational and guiding principles for the design and delivery of health care services for pregnant and parenting people using substances are:

1. **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. ICS is also an outcome that occurs when Indigenous people determine the system is safe for Indigenous people.
2. **Trauma and violence-informed practice:** Trauma and violence are common experiences in the lives of women and people using substances. Intergenerational cumulative trauma in relation to colonialism, residential schools, and child removal may also factor into the complex experiences of the lives of women and people affected by substance use. In addition, trauma, substance use and intimate partner violence have complex intersections. Trauma and violence-informed practice provides a person with choice, collaboration, control and autonomous decision-making. Services are provided in a way that supports safety and empowerment and avoids re-traumatization. Work is done at the systems level to prevent the structural forces that create trauma.

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 and support all women and people throughout the treatment and recovery continuum. These approaches help people 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 psychoactive substances, without necessarily reducing substance use itself.

4. **Women Centred and Women's Voices:** A women-centred approach recognizes sex and gender-related influences on substance use and interventions to address these influences and women's preferences for action. It builds a person's sense of value, confidence and self-efficacy and supports their priorities and abilities to improve their own health and the health of their families. Women's voices ensure that women with lived and living experience are empowered and contribute to the design and development of health care services.

5. **Recovery-Oriented:** 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. Being recovery-oriented means supporting pregnant and parenting women and people 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." Recovery-oriented care involves health care 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. This includes a broad range of activities that are person-centred and promote resilience. Kelly (2020) describes multiple pathways to recovery including:

    - Clinical pathways supported by a clinician or other medical health professionals involving bio-psycho-social-spiritual interventions
    - Non-clinical pathways and services involving programs such as 12-step, Narcotics Anonymous & Alcoholics Anonymous and SMART Recovery
    - Self-management pathways and recovery change processes that do not involve formal services, sometimes referred to as natural recovery

6. **Mother-Baby Togetherness:** Keeping mother and baby together in close proximity by rooming-in to enhance physical/emotional interactions and bonding through skin-to-skin touch, sight, hearing, smell and taste. Mother-baby togetherness is foundational to Eat, Sleep, Console strategies for the non-pharmacological management of Neonatal Abstinence Syndrome.

7. **Interdisciplinary:** Working with interdisciplinary teams acknowledges how health care professionals from different disciplines and peers can collaborate with a common purpose to set goals, make decisions, share resources and responsibilities. Interdisciplinary approaches can be a precursor toward a trans-disciplinary team work.

8. **Evidence-informed:** Evidence-informed refers to being guided by quality research evidence, clinical practice guidelines, leading practices, wise practices and Indigenous ways of knowing.

9. **Equitable Access:** Equity involves fair distribution of care according to population need, and providing access to health care services to people regardless of their gender, socioeconomic status, ethnicity, sexual orientation, or where they live. Equitable access includes involving women and people with lived and living experience in the planning, delivery and evaluation of services. There is a primacy on providing equitable and culturally safe care for Indigenous people, in particular.

CHAPTER 4:
Indigenous Cultural Safety

Acknowledging the need to address colonization, racism and discrimination in the health care system at large, the Project has been engaged in an Indigenous Cultural Safety (ICS) journey since its inception.

Training and education are an integral part of the ICS journey. Foundational ICS learning can take place through provincial or regional online training throughout BC. San'yas Indigenous Cultural Safety Training (PHSA) is designed to enhance self-awareness, develop understanding and promote positive relationships when working with Indigenous Peoples.

Further to ICS training, many Regional Health Authorities have developed approaches that support continuous engagement and learning on an ICS journey. For example, Vancouver Coastal Health offers a primer to ICS through the Introduction to ICS in Health Care training followed by in-person foundational ICS training. An ICS Book Club, regular ICS webinars, an annual ICS summit and a Matriarch and Knowledge Keeper Advisory Circle have also been implemented at Vancouver Coastal Health. These kinds of layered opportunities for authentic connections are essential for ongoing self-reflection, dialogue and learning and reinforce anti-racism efforts.

Historical and ongoing mistreatment, violence and harms inflicted by colonial institutions on Indigenous women in and around childbirth have resulted in deep, complex and intergenerational trauma (PSBC, 2021). Recognizing that colonial behaviours, institutions and policies are pervasive and impact the lives of Indigenous women and people every day, the Project places highest priority on ICS. The Project's ICS journey aims to align to *Truth and Reconciliation – Calls to Action; The United Nations Declaration on the Rights of Indigenous Peoples* — national and provincial declarations; The PHSA commitment to Indigenous Cultural Safety; *In Plain Sight* recommendations (Turpel-Lafond, 2021); *Reclaiming Power and Place: Recommendations from the National Inquiry into Missing and Murdered Indigenous Women and Girls (2021); Sacred and Strong: Upholding Our Matriarchal Roles (FNHA, 2021) and Honouring Indigenous Women's and Families' Pregnancy Journeys* (PSBC, 2021).

"What is working in a good way? It means many things; for me, it means knowing that I have lots of levels of accountability as a health care provider, and ensuring there's reciprocity."

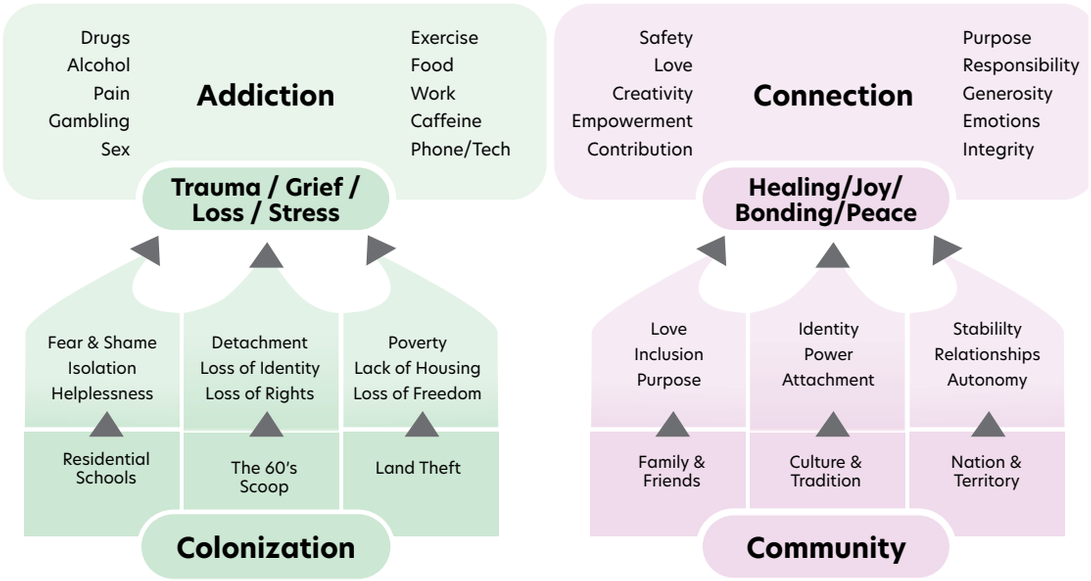
— Jeane Riley,
Indigenous Health & Wellness Lead,
Provincial Perinatal Substance Use Project;
Social Worker, FIR, BC Women's Hospital + Health Centre

Important Concepts in the Indigenous Cultural Safety Journey

Decolonizing Addiction & Resisting Colonization

The First Nations Health Authority (Pierre, 2018) has developed a model describing addiction as rooted in historical, ongoing and current colonialism. In this model, the opposite of addiction is connection, where community, including family and friends, culture and tradition and nation and territory, leads to feelings and experiences associated with healing/joy/bonding and peace.

Figure 15. First Nations Health Authority Model for Decolonizing Addiction (Pierre, 2018)



Decolonizing substance use involves understanding the concept of resisting colonization. Resisting colonization can be seen as a way to cope with painful experiences and lack of safety or even resisting pain. Resisting colonization can be misinterpreted as a lack of engagement or lack of involvement of women and people in their care and treatment. In practice, honouring that resistance comes from a place of strength and can lead to a dialogue that starts with: "Yes, we're honouring that this is your current strategy to really get through the day, and when you're open to it, how do we move to a space to talk about other strategies that might work to help you cope with what's happening in your life right now?"

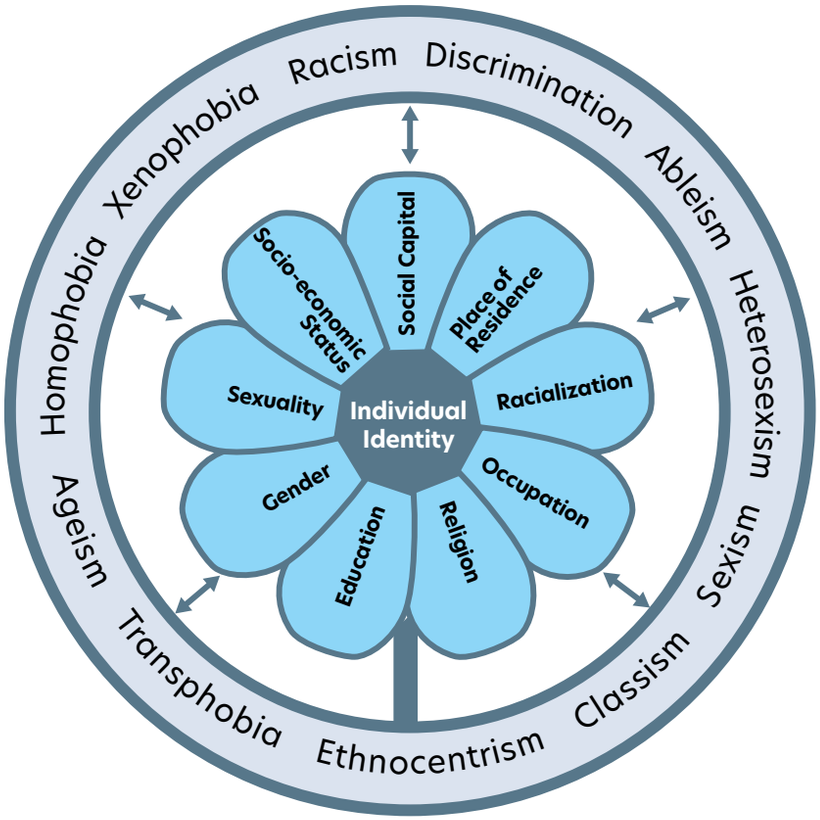
Witnessing

Witnessing is a diverse practice among First Nations, Inuit and Métis Peoples. In the health care context, providing the space for women and families to name what is happening in a situation, acknowledging colonization, distress, discomfort and feelings are examples of witnessing and naming. It is important to create safe spaces for naming and witnessing for Indigenous women, people and families who are experiencing anxiety and stress or are triggered by trauma and feeling unsafe about sharing their truth. For example, when social workers identify the colonial context of their work and share the intentionality of wanting to honour the family and their goals with humility, it can help build a relationship and create space for engagement.

Intersectionality

Intersectionality involves looking at how a person's experiences and identity (race, gender, sexual orientation) intersect with how they experience the health care system or institutions generally. For Indigenous people, intersectionality is relational and acknowledges that a woman or person may identify their kinship ties as a daughter, sister, mother, auntie and grandmother and their roles in the Indigenous community.

Figure 16. Visual Depiction of Intersectionality (St. Michael's Hospital, 2019)



Clark (2016) has established the term Red Intersectionality to refer to the importance of local and traditional tribal/nation teachings and the intergenerational connection between the past and the present, while also recognizing the emergent diversity of Indigenous girlhood and the geographic movement off and on reserve, and the construction of Indigenous girls through *The Indian Act*. A Red Intersectionality perspective of Indigenous girls and violence does not centre the colonizer, nor replicate the erasure of Two-Spirit and trans peoples but, instead, attends to many intersecting factors including gender, sexuality, and a commitment to activism and Indigenous sovereignty (Clark, 2016). Recognizing Red Intersectionality can create shifts in practice and foster the conditions necessary for cultural safety.

Land as Healing

Reconnection to land is an important aspect of Indigenous healing and well-being.

> *Land-based treatment and healing can take place when Indigenous people return or reconnect to the land while utilizing supports to relearn, revitalize, and reclaim our traditional wellness practices. This is because the land is foundational to our Indigenous identity, but over generations of colonization, we have been disconnected and dispossessed from our traditional territories (FNHA).*

This story about moose-hide tanning from Jeane Riley, Indigenous Healing and Wellness Lead, beautifully illustrates that there is no magical formula for transformation, and that healing from the land takes place in multiple ways and forms.

> *Having the opportunity to tan moose-hide was really vital in my journey and connection to culture. As a Dené person, it's very important and means a lot to my practice when I'm able to speak about moose-hide tanning and how it connects to the way I see my work and how healing it was for me as a social worker to be able to, at the time, when this opportunity came up, to go tan moose-hide. So, when I was able to go and do this experience, the impacts it's had since then, really re-learning this experience is important to me. I learned my great grandma Maha was a Moose-Hide Tanner — the healing and the wellness that came from that. In this experience, my twin sister described tanning moose-hide as an experience of really radically softening because you go from this raw hide, and you're going through this transformational experience with the hide, and there's relationship with the hide. Then the hide does become hard after certain processes of working with it. Then you have to soften it, and you're ultimately really trying to soften it and get it to a point where it's ready for smoking and then softening and then a final smoke. I remember asking one of the Sahtú Dené Elders — I believe it was Elder Lucy - and just thinking, "Well, how many times are we going to do this process of soaking it and smoking it?" What the teaching was for me was that in my mind I thought, "Okay, how many times do we do this? Is there a number? What's the formula?" Then it was, "No, the hide tells you when it's ready to be smoked for the last time." Ultimately, as a group, as we were all learners and we needed the Elders' approval to do the final smoke — we didn't know if we were going to get to it as a group — and we worked really hard, and the Elders said, "You know what? We do approve that this can go for a final smoke."*

Recommendation 4.1:

Create relationships with Indigenous people in culturally safe ways that are respectful, reciprocal, responsible and relevant

The 4Rs framework can be used as the foundation for building relationships with Indigenous people (Kirkland & Barnhardt, 1991). The 4Rs are:

- **Respecting** Indigenous people for who they are
- Providing Indigenous people with information that is **relevant** to and respectful of their world views
- Encouraging **reciprocity** in health care relationships; and
- Enabling Indigenous people to exercise **responsibility** and agency over their health

This section builds on the 4Rs framework and summarizes perspectives of the Visioning Forum 2019 Indigenous Cultural Safety Panel led by Dr. Elder Roberta Price with panelists Stacey Turcotte, Aboriginal Safety Educator, Interior Health; Brooke Bobb-Reid, Maternal Child Health Lead, Seabird Island Health Services; and Toni Winteroff, Healthy Children's Specialist, First Nations Health Authority. Their leadership, direction and insights are provided in their entirety in the Visioning Forum 2019 Report: http://www.bcwomens.ca/Professional-Resources-site/Documents/Visioning%20forum%20June%202019%20Update.pdf

Their insights during the panel have been arranged thematically here in terms of advancing ICS practice in perinatal and maternity care but can also be applied more generally:

1. ICS starts with Indigenous people leading how they move within and across every level of care. The recipient of care defines whether their care is culturally safe and decides how and when to bring culture into care.
2. ICS is about situating person to place and understanding how culture is different from person to person, family to family and nation to nation. There is no one teaching to give or know and we must move gently within the teachings.
3. ICS involves examining and identifying personal biases, cultural lenses and being aware that we all have a story we carry with us. It is also about acknowledging the history of colonization and understanding where health outcomes and inequities for Indigenous people come from.

4. ICS is about creating genuine relationships first, asking questions second. It is about acting in a respectful way by introducing yourself, asking permission to be in a person's space, finding out who they are as people first, meeting a person where they are at and not pushing until they are ready.

Recommendation 4.2:

Centre and formalize opportunities led by Indigenous Elders, Indigenous Leaders, Indigenous doulas and midwives, birth workers and birth keepers in perinatal substance use work, and create time and space for story-telling, voices, perspectives and world views

Indigenous Elders, Matriarchs and Knowledge Keepers have roles in maintaining Indigenous traditions of health and wellness and resisting colonization and these roles have been an intense struggle to maintain over time (Turpel-Lafond, 2020). The ICS journey of the Project recognizes that reconciliation involves raising and centring the voices of Indigenous people and supporting the leadership and direction of Indigenous Peoples. This involves learning more about the resurgence, reclaiming and relearning of Indigenous women, families and communities. Reclaiming First Nations teachings and protocols around birth, pregnancy and mothering helps to strengthen vital connections to land, culture and community (PSBC, 2021). These connections, which are the roots of wellness at all phases of life, help to nurture the holistic wellness of women during the transition to motherhood while also establishing a strong foundation for infant health (PSBC, 2021).

Centring Indigenous voices is about creating spaces and opportunities for building relationships, listening with a whole heart and taking direction from Indigenous Peoples. In the health care context, it involves putting a primacy on Indigenous leadership inclusion and involvement in service design, planning, delivery and evaluation at all levels. By working in this way, non-Indigenous people can learn how perinatal and birth work is deeply impacted by colonialism and resolve to take action and make changes. Centring Indigenous voices demonstrates a commitment to anti-oppression and anti-racism. Taking this one step further, health care providers must address the power dynamics, inequalities and anti-Indigenous racism that currently exist in the colonial health care system.

Elders' Voices

Bringing Elders into health care services involves creating relationships with Elders in a safe, respectful way and being mindful of their cultural safety. Elders have many teachings and approaches that look different for each Elder. From our Project learnings, Elders work in pairs support each other, bring forth diverse practices, witness each other's practices and complement each other's strengths. Elders working in tandem align to the Indigenous belief and way of thinking that we are not alone – there is always connection to ancestral knowledge and ancestral strength. It also provides Elders with support when they feel triggered by colonization in the health care system.

Honouring Indigenous Women's and Families' Pregnancy Journeys: A Practice Resource to Support Improved Perinatal Care provides significant direction on how to work with Indigenous women in families in culturally safe ways. This resource was coordinated and led by Lucy Barney, Titqet Nation & Indigenous Lead, Perinatal Services BC, with input from Indigenous Leaders and aunties, mothers, grandmothers, daughters, and sisters across the province.

http://www.perinatalservicesbc.ca/Documents/Resources/Honouring_Indigenous_Womens_and_Families_Pregnancy_Journeys.pdf

A key aspect of the ICS journey is the Elder leadership and involvement in the Project. Dr. Elder Roberta Price and Elder Glida Morgan are members of the Project team. They provide guidance, wisdom and contribute to key project deliverables designed to strengthen services for women, children and families. The vast contributions of both Elders include stories of healing and intergenerational experiences, witnessing, aligning culture and ceremony to local protocols and teachings and wise practices when caring for pregnant and parenting women and people using substances.

Some Indigenous women, children and families, due to colonialism or displacement from community or intergenerational trauma, may have never had an opportunity to connect with an Elder. Elders have an innate way of holding space that creates accountability on the part of health care providers and creates safety for Indigenous women and families by addressing power imbalances in the health care system. For some Elders, holding space may look like bringing ceremony (welcoming, traditional birthing practices) into their interactions with a family, offering blessing and a prayer or bringing healing and wellness to an Indigenous family. Elders can be involved in acute care settings in a variety of ways, including care planning, rounds and child welfare discussions. Elders also bring healing and wellness into health care settings, impacting health care providers as well as the family. There is a gentleness and a strength to Elders' practice that is not paralleled anywhere else in the health care system. These teachings are all highlighted in the Project-developed *Elders Visioning: Perinatal Substance Use Toolkit.*

> "Our Elders are our cultural keystones. They provide connections to our Ancestors, teach us our history and help light our path forward in a good way. If the legends fall silent, who will teach the children our ways."
>
> ***Chief Dan George***

Recommendation 4.3:

Create space for Indigenous midwives, doulas, birth workers and birth keepers in perinatal services and hospital settings and support the development of birth work communities of practice and/or networks

The Project's ICS journey has also involved learning about Indigenous midwifery, doula work and birth work and how to support Indigenous Peoples in reclaiming birth work. Each of the specific disciplines has different scopes of practice and roles in honouring Indigenous Peoples, languages, oral traditions, culture and traditions while providing holistic (emotional-mental-spiritual-physical) support to Indigenous women and families during pregnancy, labour and delivery and postpartum. Historically, at some point, all First Nations communities had a traditional midwife who assisted with the ceremonial and physical aspects of births and passed on these skills and vital knowledge to younger generations (PSBC, 2021). Over time, the Western medicalization of birth led to Indigenous midwifery being banned, which caused a decline and disruption of Indigenous birth knowledge (PSBC, 2021). Indigenous midwives remain resilient however, and there is a resurgence of midwifery and birth work throughout Indigenous communities today.

In December 2020, the Project Steering Committee held a Listening Session led by Indigenous Elders, Dr. Elder Roberta Price and Elder Glida Morgan and Indigenous Leaders. The session identified the following areas of action for better supporting Indigenous women, children and families:

1. Open your hearts and minds to the experiences of Indigenous women and families and accept their experiences as the truth.
2. Support the reclamation of the role of women in society as lifegivers.
3. Create spaces to honour and learn from Matriarchs.
4. Change practices and policies to do what Indigenous Elders, women, children and families need.
5. Honour Indigenous teachings and ways of knowing.

Indigenous doulas and midwives share similar beliefs, values, and practices, and are informed by an understanding of Indigenous ways of being (PSBC, 2021). These roles honour birthing traditions, Indigenous women as lifegivers and strengthening Indigenous traditional and ceremonial practices and protocols related to birth and new life that have been negatively been impacted by colonization (BCAAFC, 2020). Having an Indigenous midwife, doula, birth worker or birth keeper can ensure culturally safe birth and postpartum experiences. These providers can bridge the cultural gap and provide community-based support for families—support that is culturally respectful and integrates traditional values and beliefs into the birthing process (PSBC, 2021).

The is great need for Indigenous midwives, doulas, birth workers and birth keepers throughout the province, as is the need for a sustainable, well-funded model and approach to birth work that ensures that there is capacity and support across disciplines. Longer-term support for Indigenous families during the postpartum period is also needed.

Given the relatively small numbers of Indigenous midwives, doulas, birth workers and birth keepers, circles, communities of practice and networks can provide culturally safe spaces for birth workers to build relationships, feel connected and share their practices, teachings and learnings.

The Project has provided support to the BC Association of Aboriginal Friendship Centres for the Circle of Birth Keepers project. Circle of Birth Keepers is actively addressing the needs and gaps in birth work by training more Indigenous birth keepers and providing access to wrap-around care for Indigenous birthers to access support, programs, services, information and supplies. The Circle of Birth Keepers project is also increasing capacity for Indigenous birth workers and Knowledge Keepers to mentor newly trained Indigenous doulas.

The Circle of Birth Keepers Project focuses on:

- Providing networking, training and learning opportunities for Indigenous doulas
- Supporting Indigenous culture in birth
- Connecting Indigenous families to Indigenous doulas
- Organizing gatherings for Indigenous birth workers
- Providing funding for birth ceremonies
- Offering ICS training to non-Indigenous doulas
- Building connections to culturally relevant supports

Recommendation 4.4:

Ensure access and provide culturally safe programming and ceremony that includes involvement of Elders, Knowledge Keepers, and the land across settings and sectors

The *In Plain Sight* report (2020) identified the importance of Indigenous knowledge, Elders, cultural healing practices, Indigenous cultural spaces in health care settings and traditional medicines to Indigenous Peoples. There is a need for trauma and violence-informed, sustainable, permanent, no-barrier, preventative, accessible, holistic, wrap-around services that meet the health and wellness needs of Indigenous women and girls (Turpel-Lafond, 2020).

For community and acute care programs, culturally safe programming in the context of perinatal substance use programming can include:

- Elder teachings
- Drumming/making drums
- Celebrating the birth of the baby
- Cultural practices for birth and women's wellness
- Tobacco ceremony
- Access to land-based healing and ceremony
- Elders on staff to support women and families (at least two Elders working in partnership)
- Welcome-to-the-world ceremonies and end-of-life ceremonies
- Indigenous doulas
- Aunties to support women and families
- Supporting families with ceremony
- Indigenous wellness gardens with Indigenous healing medicines

Chapter 5

Women with Lived and Living Experience

Working from a women-centred approach with women's voices is one of the Project's nine guiding principles. Lived and living experience refers to the firsthand experience of people in recovery who may be actively using substances or on an abstinence-based journey and everything in between.

Recommendation 5.1:

Commit to understanding and addressing stigma that pregnant and parenting women and people using substances experience including accessing resources and tools that help with addressing stigma and building a speak-up culture

Stigma can be defined as a set of negative attitudes or beliefs about a person or group of people (Schmidt et al., 2019). Stigma reinforces unequal power dynamics and has a direct impact on the quality of life of the person(s) or groups these attitudes are directed towards (Schmidt et al., 2019). For pregnant and parenting people using substances, stigma, judgement and blame are significant barriers to accessing prenatal and postpartum care. Societal discourses and expectations about mothering and parenting contribute to stigma.

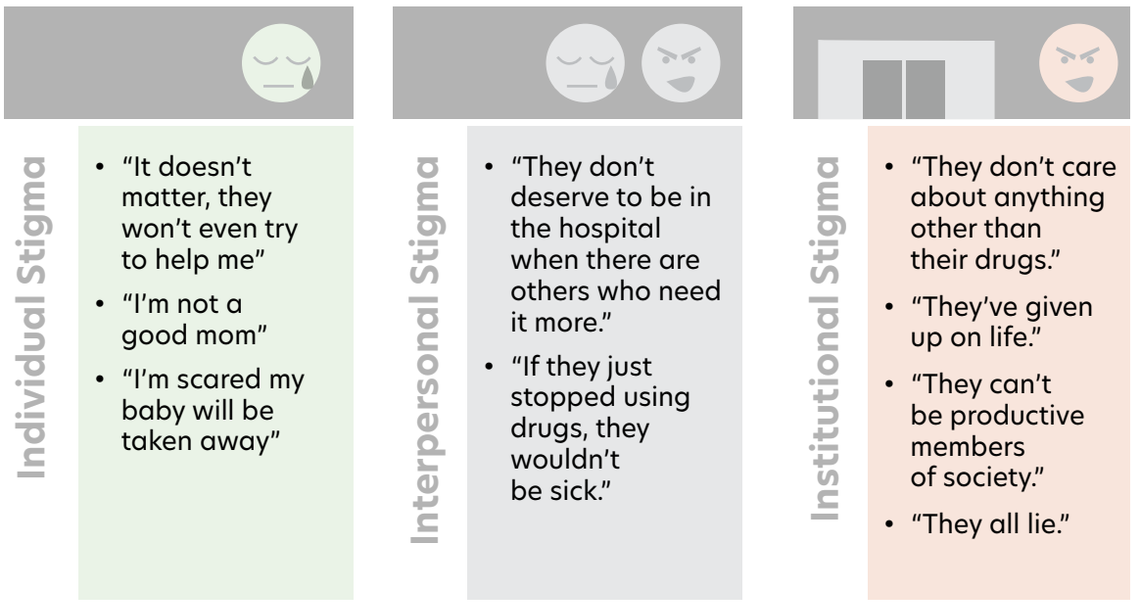
In a comprehensive evidence review of stigma among pregnant and parenting women using substances, Wolfson et al (2021) illustrated how stigma operates at individual, interpersonal, institutional and population levels. At the individual or internalized level, pregnant and parenting women and people using substances may (Howard, 2015; Wolfson et al, 2021):

- Experience loss of self worth
- Question their ability to parent
- Feel shame or self blame
- Experience stigma from child welfare, health and justice systems and
- Have concerns about not being able to reduce substance use

At the interpersonal level, women and people can experience the effects of stigma in their relationships with their partners as a barrier to accessing treatment (Wolfson et al., 2021). Health care providers may hold biases or lack awareness of trauma, harm reduction and treatment options (Wolfson et al., 2021).

Wolfson et al. (2021) suggest institutional barriers include lack of coordination among service providers, lack of outreach, lack of harm reduction and treatment programs, lack of family-centred programs and lack of control over visitation and reunification. In addition, at the population level, the social determiants of health (e.g., poverty, geography, transportation, socioeconomic status) can also contribute to stigma. Substance use may even be an exclusionary criterion for accessing some prenatal services and supports. The health consequences of stigma on pregnant and parenting people using substances are significant in terms of reducing timely access to prenatal services and supports, increasing their stress response and re-traumatization, and putting people at high risks of harms related to substance use disclosures.

Figure 17. Stigma Experiences of Women with Lived and Living Experience



Pregnancy and childbirth may present a time when many individuals experience significant motivation and desire to make changes with regard to their substance use. In a multi-site evaluation of eight community-based programs serving pregnant and parenting people using substances, substance use-related treatment and readiness for change were among the top reasons for engaging in the programs, followed by housing, maternal child/welfare involvement, violence, trauma and intimate partner violence (Rutman & Hubberstey, 2019). Indeed, pregnancy may be an opportunity to identify treatment options and supports in both community and acute care.

To meaningfully address stigma, the way health care providers engage with pregnant and parenting women and people using substances matters. Commonly used words such as "addict" or "drug abusers" are dehumanizing and harmful (CPHA, 2019). Changing the way we talk about substance use can not only help reduce the negative impacts of stigma but can also be essential to the healing journey of women who use substances. Language matters, and using person-first language takes the complex associations between substance use and physiological, genetic, psychological, sociocultural and spiritual factors into account.

In the acute care/neonatal intensive care setting, the Acknowledge-Create Circumstance for Reflection-Teach-Support (ACTS) script supports effective team communication and aims to shift health care providers' language to become less judgemental and more compassionate when talking about people who use substances (Marcellus & Poag, 2016). *The Mothering & Opioids Toolkit* provides examples of how health care providers can use the ACTS script to address stigmatizing conversations about pregnancy and substance use in a constructive and respectful manner. The ACTS script outlines how health care providers can encourage their peers to reflect on stigma and address patients in a more compassionate way (Schmidt et al., 2019).

Recommendation 5.2:

Prioritize the engagement of women and people with lived and living experience in program planning and service delivery

The Project team includes women with lived and living experience who provide expert guidance and input into system design and key project deliverables. In addition, women and people with lived and living experience challenge concepts such as stigma, recovery, capacity for parenting, and active substance use while parenting. To better illustrate these concepts, the Project developed a video titled: *Women Together, Conquer Stigma. Perinatal Substance Use* http://www.bcwomens.ca/health-professionals/professional-resources/perinatal-substance-use

The video describes how intersecting and foundational principles of ICS, women-centered care, trauma and violence-informed practice and harm reduction can support and empower people who are pregnant and parenting and using substances and address stigma across supports, services and sectors of the health care system.

10 Things Pregnant and Parenting Women who use Substances Would Like Practitioners to Know (Schmidt et al., 2019)

1. Mothers want to succeed. Don't assume we are not trying or that we chose the challenges we face.
2. Language matters. Say things like "I've seen this help others, maybe this will work for you" not "You should."
3. Show empathy, not pity.
4. Show more compassion, less condescension.
5. Be a support – get behind us.
6. Listen – be curious about what might work for each of us.
7. Be educated. There are a lot of things that play into substance use.
8. Just because a person is still using, it doesn't make them a bad mother.
9. Not everyone takes the same path to recovery. Listen to where each woman is at in her journey and what will work for her.
10. Don't judge us – care about us.

Involving women and people with lived and living experience requires organizational commitments to support and understand their unique stories and life experiences of recovery. It also involves ensuring that when they are asked for input and feedback, it is honoured and integrated into system design and change initiatives.

Recommendation 5.3:

Formalize peer support roles and hire peer support workers in acute and community settings

Peer-based programs and initiatives are ideal for highly stigmatized people facing multiple and significant barriers to accessing support, including people using substances (Eddie et al., 2019). Peers can often provide one-with-one support for a person using substances, help foster communication, build trust, and support access to health care services (Marshall et al., 2015).

Research evidence suggests that when peers are part of programs for women using substances, they are often viewed as helpful and often increase engagement (Olding et al., 2020; Rutman & Hubberstey, 2019; Kruk & Banga, 2011). Peers connect well with others who can relate to their experiences which provides a sense of community (Olding et al., 2020). For women and people using substances who have experienced a child removal, peer-based programs can be a vital support (Kenny & Barrington, 2018; Kruk and Banga, 2011).

In a recent study, Olding et al. (2020) conducted three focus groups with organizations in the Lower Mainland serving pregnant and parenting women using substances. These groups discussed the experiences and benefits of having peers in their programs, and expressed their concerns about peer-based approaches. Twenty women participated in the focus groups, and more than half (55 percent) were Indigenous. Themes emerging from this work included the importance of mothers having connections and non-judgemental acceptance. Sub-themes included safety, love and trust (Olding et al., 2020). Peers were viewed as an essential part of support systems for women. Participants also shared that interacting with a peer made them feel hopeful, especially about their chances of parenting their children. Peers kept urging them on and encouraged them to not lose hope, despite the overwhelming barriers they faced surrounding parenting and child protection, substance use, colonization, poverty, trauma, shame, etc. This encouragement was a key element in many participants' stories, and often their successes. Women also expressed that Indigenous peers and supports are much needed, specifically in perinatal services.

Consistent with the findings of Olding et al. (2020), in a sample of nine community organizations funded by the Project, evaluation results found that peers were seen as making significant contributions in terms of modeling behaviours, enhancing access and connection to services and increasing women's overall sense of well-being.

Table 3. Community Organization Survey Results on Peer's Contributions to Their Programs (N =9)

Peers' Contributions	Number of Community Organizations
Modelling what principle-based practice looks like	●●●●●●●●●
Modelling the operationalization of ICS	●●●●
Enhancing outreach	●●●●●●
Enhancing connection with primary care	●●●●●
Supporting transitions to and from acute care	●●●●●●
Improving access to services	●●●●●●
Increasing wellness	●●●●●●
Increasing hopefulness	●●●●●●●
Increasing sense of being connected	●●●●●●●●●
Helping people feel understood	●●●●●●●●
Providing a sense of community	●●●●●●●●●

Recommendation 5.4:
Establish and/or foster existing and emerging peer support networks

In partnership with the Community Action Initiative and BC Centre for Disease Control, the Project has helped fund the development of the Provincial Advocacy Network of Women Supporting Women. The network provides peer support for women and people who use substances, including coordinated efforts to address harmful policy and practices that affect the women in the network and the people they represent. These kinds of peer-based networks provide important sources of support for people with lived and living experience and a stronger and unified voice on systemic issues related to substance use, child removals and advocacy for mother-baby togetherness.

CHAPTER 6

Interdisciplinary Practice

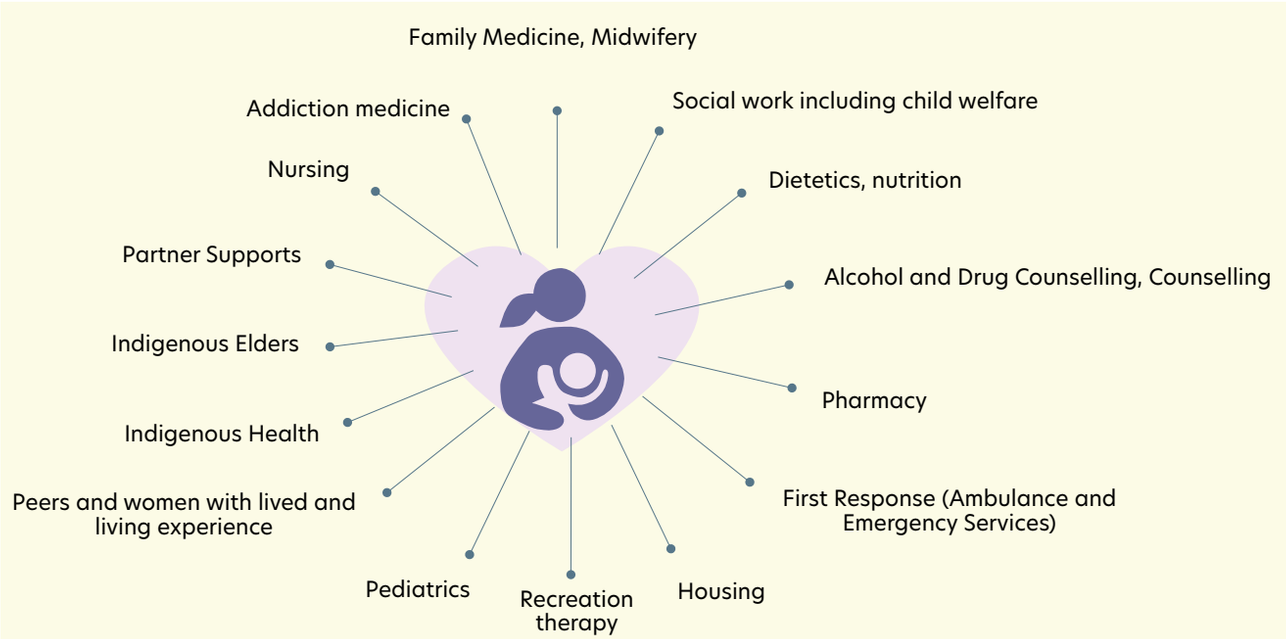
Interdisciplinary approaches are foundational to perinatal substance use-related practices, services and supports. Interdisciplinary practice happens when health care professionals from different disciplines and peers work together collaboratively and with a common purpose to set goals, make decisions, share resources and responsibilities and aspire towards a trans-disciplinary approach.

Recommendation 6.1:

Develop an interdisciplinary team that aligns to a bio-psychosocial-spiritual philosophy of care that supports women. The team should include leadership, allied health, Indigenous staff and leaders, Indigenous Elders, and clinical team members and should clarify roles and responsibilities of each interdisciplinary team member

Working in an interdisciplinary team acknowledges the scope and breadth of expertise needed to best support pregnant and parenting women using substances and their infants, families and communities while addressing their medical, health and social needs and well-being. Interdisciplinary team members should represent a broad range of disciplines and include Indigenous health care providers, Elders and peers.

Figure 18. Disciplines Involved in Caring for Pregnant and Newly Parenting People Using Substances



To provide comprehensive, interdisciplinary team-based care, the bio-psycho-social-spirtual model is a well-accepted approach to substance in BC (BC Ministry of Health, 2011). This holistic approach to healing and wellness, especially the spiritual component, aligns well with and complements Indigenous perspectives that recognize the continuous interaction of physical, emotional, mental, and spiritual realities (BC Ministry of Health, 2011; Pathway to Hope, 2019). The medicine wheel approach is another example of a holistic approach to health and well-being that considers mental, emotional, physical and spirtual aspects of life.

Recommendation 6.2:

Implement trauma and violence-informed practice, Indigenous Cultural Safety (including anti-racism and anti-oppression approaches) and harm reduction as the cornerstones of interdisciplinary teamwork

Each interdisciplinary team member brings highly specialized skills, knowledge and practices to their work when caring for pregnant and parenting women using substances. Evidence suggests that the key attributes of interdisciplinary teams working in a trauma and violence-informed way are:

- Being trauma and violence-informed while having difficult conversations and giving clear and honest answers
- Using a harm reduction approach to substance use
- Engaging in reflective practice and regularly discussing practice-related issues
- Facilitating access and eliminating barriers to services (e.g., housing, legal, child welfare services) to best meet a woman's needs
- Supporting women through complex interactions with child welfare services

To address Indigenous-specific racism, interdisciplinary teams members also have a responsibility to address racist language, gestures and actions as they occur in real time. These acts of allyship create the foundation for culturally safe care. Reporting racism is also part of the foundation to identify locations, patterns, and trends in how racism and discrimination unfold in the health care setting.

The BC Association of Aboriginal Friendship Centres has recently partnered with SafeSpace Networks to develop the SafeSpace App (https://safespace.healthcare/bcaafc). Safespace provides a safe and anonymous way to share personal health care experiences and/or experiences that one has witnessed or heard about from friends, family and community members. SafeSpace aims to identify patterns and trends in racism and health care. In addition to SafeSpace, Regional Health Authority-specific racism reporting mechanisms can be accessed as well.

Recommendation 6.3:

Implement multi-level communication mechanisms to bring interdisciplinary teams together and support consistency, collaboration and planning of activities including care coordination and transitions

Consistent and regular communication among interdisciplinary team members is essential to address the evolving needs of a pregnant or parenting individual using substances and their infant, family and community. Communication structures that can support this include interdisciplinary rounds centering on the patient's experience, and daily huddles/handovers across interdisciplinary team members.

Recently, for the Renewed Model of Care implementation at FIR, the FIR team engaged in a process to restructure rounds to:

- Support representation from all aspects of the program (medical, nursing, allied health, Indigenous health)
- Add ICS components (acknowledgement of the land and Indigenous, First Nations and Métis identities and heritage of a person, infant and family)
- Address power dynamics and power differentials and
- Place the patient's bio-psycho-social-spiritual goals in the foreground of the planning

All of these elements reflect a holistic approach to integrating the bio-psycho-social-spiritual aspects of care.

Recommendation 6.4:

Use a strengths-based lens when documenting the assessment, progress and care planning of each person's health care journey

For interdisciplinary teams, careful documentation ensures that an accurate picture of a person's health and wellness is conveyed across acute care, community and other sectors. Well-documented, clear assessments, progress notes, and care planning help convey the story of an individual's journey, clarify where a person is at and can prevent the retraumatization of being asked and re-asked questions about their health and journey. Noting the progression of a person's engagement with health services impacts other services and supports, including child welfare services. Communicating strengths and sharing positives about how a recovery journey is unfolding within documentation is essential.

Core practices include:

- Creating concise and accessible documentation
- Providing documentation that meets the standard of each discipline
- Documenting assessments, progress towards goals and transition plans clearly

> *"Saying that a woman is failure because of a relapse and she feels really bad about it, is not only unhelpful, it is really damaging. When her relapse is unpacked, reframed and documented in strengths-based way, it communicates that she had a goal not to use substances, experienced a setback, has a lot of emotions around it and that we are going to use this opportunity to explore triggers for relapse and engage in relapse prevention. This is so much more powerful than reducing her experience to a single event."*
>
> **Health Care Provider, Acute Care**

CHAPTER 7
Engagement & Stabilization

Engaging pregnant and parenting people using substances in prenatal care and/or postpartum services requires an inherent understanding of the context of their lives. This knowledge can be gleaned only through establishing trusting relationships. Pregnant and parenting women and people experience tremendous barriers to care overall and require consistent encouragement and support to engage.

Table 4. Barriers to Engagement and Stabilization for Pregnant and Parenting Woman and People Using Substances

Barriers to Engagement	Barriers to Stabilization
• Traumatizing health care experiences • Experiences of racism/discrimination in the health care system • Colonization in health care • Intense stigma and judgment regarding substance use by health care providers • Lack of social supports and stable housing • Poverty • Impact of a controlling partner/possibility of intimate partner violence	• Co-occurring mental health concerns • Significant medical complexity/chronic health conditions that may or may not be well managed • Limitations of available treatments to address high tolerance to substances. • Severity of substance use disorder

Cameron, Hardial & Mead, 2020

Recommendation 7.1:

Build trust and relationships first, and expect women and people to engage at "the speed of trust"

Evidence suggests that pregnancy is a time when a person using substances may be highly motivated to change (Rutman & Hubberstey, 2019; BCCSU, 2018). When a person is having difficulty engaging, it is important to pause and think about their needs, the barriers they might be facing and what additional approaches may work (BCAPOP, 2019). It is also important to understand from an ICS perspective that a woman or person may be showing their resistance to colonization and/or colonial practices. Informed consent can help start a process of engagement and create the foundation for a relationship. With informed consent, continued repeated attempts at engagement are important and worthwhile (BCAPOP, 2019). This process involves focusing on building trusting relationships from the very first interactions, meeting a person where they are at and not pushing faster than they may be ready for. It is also important to be available to provide support once they are ready.

Recommendation 7.2:

Establish a model for stabilization in which one discipline leads while other disciplines remain engaged as consult services

Triaging and intake of a pregnant or parenting woman or person using substances can follow standardized admission and assessment processes. These processes involve welcoming a person into the care setting and addressing their immediate needs for comfort and safety, obtaining informed consent and then working to build a meaningful and trusting relationship to support engagement. Approaches to assessment and medical stabilization of pregnant and parenting women and people using substances in the hospital setting can involve obstetrics, family medicine, midwifery, psychiatry and addiction medicine working collaboratively. The pregnant and/or parenting person would then be admitted under the service/discipline that best aligns to their health care concern, with other services acting as consult services. For telephone consult services, the Rapid Access to Consultative Expertise (RACE line) via telephone or www.raceapp.ca or the 24/7 Addiction Medicine Clinical Support Line can be used.

Sound evidence supports the use of an addiction medicine consult service model in perinatal settings. For example, St. Paul's Hospital has established an service in which addiction medicine physicians assess and treat hospitalized patients with substance use disorders (SUDs), medical or psychiatric complications of substance use, or who require maintenance treatment (Braithwaite et al., 2020). A study of the impacts of the service found that over a five-year period, the number of consultations increased by 228 percent. More than half of the consult requests originated from the emergency department, predominantly for the assessment and management of opioid, stimulant or alcohol use (Braithwaite et al., 2020).

Recommendation 7.3:

As the health, medical and social concerns of pregnant and parenting women using substances are complex, implement a broad range of assessment tools and document thoroughly

All assessments, care plans and programs should be developed within the framework of trauma and violence-informed practice, ICS, harm reduction principles and recovery-oriented practice.

The assessments undertaken by the different disciplines across settings can include (but should not be limited to):

- Medical and obstetric assessment, treatment and follow-up
- Suicide risk assessment and plan
- Substance use assessment and treatment (e.g., withdrawal management, OAT including iOAT and follow-up)
- Individual nursing assessment and care plan
- Chronic disease management plan
- Functional cognitive health assessment (as indicated)
- Reproductive mental health assessment (as indicated)
- Assessment and management of NAS/NOWS through consultative care with pediatricians, midwives, nurse practitioners and nurses
- Feeding and lactation consultant assessments and supports
- Nutrition assessment and plan
- Psycho-social-spiritual assessment and plan
- Recreation and community orientation assessment and plan
- Transition plan

Recommendation 7.4:

Provide pregnant and parenting women and people using substances with access to the full range of harm reduction and treatment options for the clinical management of substance use disorders

For pregnant and parenting women and people using substances, the full range of evidence-informed substance use treatments for opioids, stimulants, nicotine and alcohol available to the general population should be available (Mead, Hardial & Cameron, 2020). These include pharmacological treatments, anti-craving medications, psychosocial treatment interventions, recovery-oriented services and bed-based treatment facilities.

In alignment with the *BCCSU Opioid Use Disorder in Pregnancy Guidelines*, withdrawal management should be approached cautiously and with informed consent that ensures a person is aware of the high risks of relapse and associated harms. Slow withdrawal management (e.g., prolonged OAT taper) combined with intensive long-term monitoring and psychosocial interventions is generally recommended (BCCSU, 2018). In alignment with the *BCCSU Pregnancy Supplement to the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use,* withdrawal from alcohol should be managed carefully and is best managed in an inpatient setting.

Chapter 8
Acute and Community Programming

Acute care for perinatal substance use consists of services and supports typically provided at labour and delivery and in the immediate postpartum period. However, for a subset of pregnant and parenting people using substances, labour and delivery may be their first encounter with pregnancy-related services and supports. As such, women and people need to be engaged in a compassionate, empathetic and non-judgemental manner. Individuals who are pregnant and parenting and using substances may have complex medical health issues in addition to pregnancy- related concerns and complexities. During labour and delivery and immediately postpartum, acute care can offer support and encourage engagement in maternity care and provide some degree of programming. Acute care services are contingent upon length of stay and available resources and supports. However, for the most part, pregnant and parenting women and people using substances will spend most of their journey in community care. For this reason, the Project has focused on enhancing community services, building capacity and implementing principle-based practice in community settings. The Project funded 19 community organizations from FY 2018/19 to FY 2021/22.

Funded Community Organizations

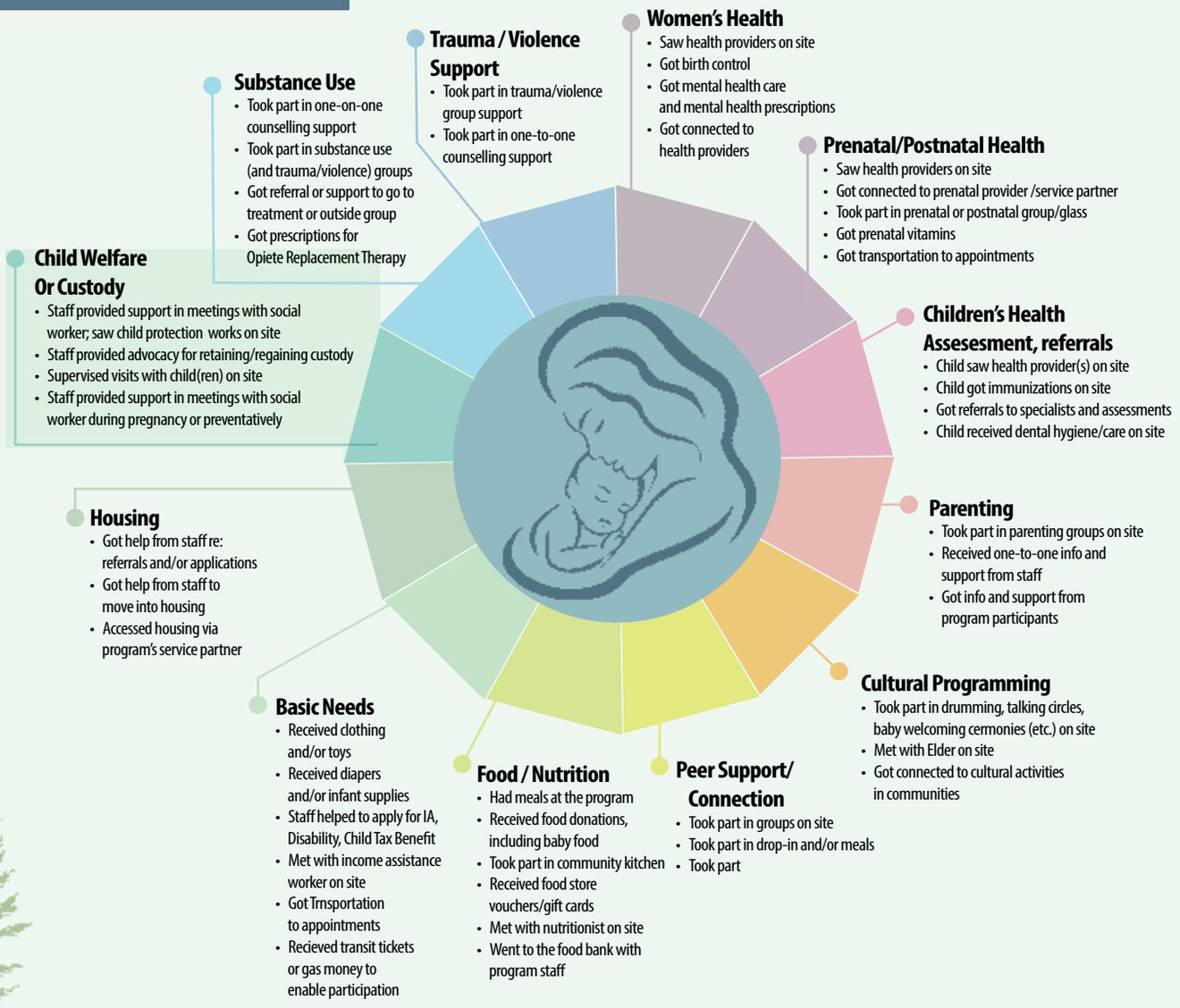
Aboriginal Mother Centre Society
BC Association of Aboriginal Friendship Centres
BC Association of Pregnancy Outreach Programs
Carrier Sekani Family Services
Family Tree Family Centre
First Nations Health Authority
Fraser Regional Aboriginal Friendship Centre Association
Hiiye'yu Lelum House of Friendship
Harmony House
HerWay Home
Karis Support Society
Kermode Friendship Centre
Kilala Lelum Health Centre
Ki-Low-Na Friendship Centre
Maxxine Wright Community Health Centre
Seabird Island Health Services
Sheway
Together We Can
Turning Point Recovery Society
Union Gospel Mission, Sanctuary Program

Evidence indicates that wrap-around services, predominantly offered in community settings, are highly effective for pregnant and parenting people affected by substance use (Tarasoff et al., 2018; Hubberstey & Rutman, 2019; Poole, 2021). The Co-Creating Evidence Project (2019) provides a comprehensive national evaluation of eight community-based programs for pregnant and parenting women using substances and emphasizes the voices of people with lived and living experience. They shared that their key reasons for engaging with a program were to address substance use issues, address unstable/unsafe housing and get assistance with child welfare involvement. These issues were often intertwined (Rutman & Hubberstey, 2019). Women tended to engage with wrap-around services to holistically address medical, health and social concerns (Rutman & Hubberstey, 2019).

Figure 19. Components of Wraparound Community Programs from the Co-Creating Evidence Project (Rutman & Hubberstey, 2019)

Wrap-around services offered by the Co-Creating Evidence Programs (2019)

How clients engage with services and supports



As part of the Project, the FIR interdisciplinary team engaged in a process to renew the FIR Model of Care to address the evolving needs of pregnant and parenting women and people using substances, align to evidence-informed practice and provide the overarching acute care design elements/approach for the Blueprint. At the community level, in a parallel process, the team at Sheway engaged women with lived and living experience to update the *Sheway Model of Care*. Both programs provide insight into acute and community services for pregnant and parenting individuals with the caveat they are located in the Lower Mainland, where there is a high density of wrap-around substance use services and supports. This section highlights wrap-around programming options applicable to remote, rural and urban contexts and unique program delivery options in community for pregnant and parenting people using substances.

In general, programming for pregnant and parenting women and people using substances is often effective when provided in a group setting (Wolfson et al., 2021). Individuals should be encouraged to participate in programming as soon as they are able. Efforts to balance engagement and routine are important in both community and acute contexts. Wrap-around programming options are provided in Table 6, recognizing that acute care and community settings will adapt options and innovate to best support the needs of women and people, their infants, children, families and community.

Recommendation 8.1:

Implement substance use services and treatment in community and acute care settings as a priority

Substance use-related programming, services, treatment and education have been identified as a gap in community (Rutman & Hubberstey, 2019) and acute care settings. In acute care, the integration of addiction medicine into maternity services can support women and people with substance use challenges and provide substance use-related practice support to family physicians, obstetrician-gynecologists and midwives. Opportunities for addiction medicine certification are available for physicians.

Access to alcohol and drug counselling is imperative in acute care as it provides a unique opportunity to engage antepartum and postpartum individuals in dialogue regarding their substance use. Acute care staff across disciplines can take the BCCSU Addiction Care Training Online Certificate. Group-based substance use-specific programming such as Seeking Safety, Relapse Prevention, Dialectical Behavioural Skills Training, Mindfulness, Smoking Cessation and Contingency Management are evidence-informed approaches to addressing substance use that can be implemented in acute care, provided that staffing and resources are available to provide consistent programming.

In community settings, evidence suggests one-with-one counselling support, substance use group programming, opiate replacement therapy and referral and support for treatment are important supports for women (Rutman & Hubberstey, 2019). However, the evidence also shows that community-based offerings may not fully address people's substance use-related treatment needs. Areas for substance use treatment identified as important included withdrawal management and relapse prevention. Mothers in Recovery group-based programming is another option for scalability and implementation that has been trialed in a number of programs throughout the province. Mothers in Recovery consists of peer-based groups in which people with lived and living experience support women in parenting and recovery (Cameron, 2008). This kind of recovery coaching can fill gaps in community-based programs that may be unable to provide formalized substance use treatment. Day treatment programs have also shown some effectiveness in supporting women and people with substance use disorders.

Engaging Partners into Recovery

At FIR, partners are encouraged to be actively involved in care planning and supporting mothers and infants, whenever possible. The Together We Can Addiction, Recovery & Education Society (TWC) and FIR are collaborating to encourage men who have partners at FIR to consider recovery options by: 1) Fast-tracking access to TWC services and treatment and 2) Engaging men at FIR in TWC's All My Relations program provided onsite. The TWC/FIR partnership has been extremely successful, as the current demand for men's programming and treatment is outpacing availability.

Recommendation 8.2:

Prioritize holistic, wrap-around programming in both acute care and community settings across a range of domains

Through partnerships with community organizations, the Project has learned what aspects of programming work well for pregnant and parenting people using substances and what areas can be prioritized for programming in acute care and community settings. Using a true community development approach, organizations funded by the Project determined what service improvements/enhancements would be funded in alignment with the needs of women and people with lived and living experience, local contexts and current service gaps. Using Project funding, community organizations providing direct care services developed new services such as treatment, outreach, parent programming, cultural programming and recovery programming. They also worked to improve access to housing and primary care, provide practical supports, enhance substance use training and provide local, regional and provincial trainings.

Figure 20. Access Improvements, Service Improvements and New Services Established by Community Organizations (N = 9)

Access Improvements, Service Improvements and New Services	Number of Community Organizations
Practical supports	●●●●●
New outreach services	●●●●
New parenting programs	●●●●●
New food security programming	●●●●
New cultural programming	●●●
Enhanced substance use focus	●●●●●
New treatment services	●●●●
New recovery programming	●●●●●
Offered local, regional or provincial education and training	●●●●
Improved access to housing	●●●●
Improved access to primary care	●●●●●

Project funding also enabled Indigenous-led organizations and Aboriginal Friendship Centres to make direct care service enhancements and improvements. Many Indigenous-led organizations and Aboriginal Friendship Centres improved access to Elders and Knowledge Keepers, Indigenous midwives, doulas and birth workers. Several organizations directed funding to support housing for Indigenous women and children. Enhanced programming refers to providing ceremony and teachings and/or structured groups (e.g., postpartum groups, parenting groups).

Figure 21. Increased Staffing, Programming and Services at Indigenous-led organizations and Aboriginal Friendship Centres (N = 10)

Increasing Staffing, Programming and New Services	Number of Indigenous-led Organizations
Provided practical and transition supports	●●●
Enhanced programming	●●●●
Honouring Knowledge Keepers (Elders & Aunties)	●●●
Access to Indigenous midwives, doulas, birth workers	●●●
Collaborative care planning	●●
One-with-one Clinician support/programming	●●
Housing for Indigenous women	●●●

Based on the learnings across 19 community organizations, research evidence related to wrap-around service models and the FIR model of care renewal findings, the Project proposes that wrap-around service models be applied in both community and acute care contexts. The elements of wrap-around services are described below and can be adapted/integrated in either setting.

Table 5. Acute and Community Wrap-around Program Components

Program Component	Community	Acute
Access	Drop-in, low barrier	Linkage with community programs, Indigenous-led Organizations and Aboriginal Friendship Centres Opportunity for women to self-refer
Practical and material support	Infant supplies, diapers, clothes, toys Assistance with Disability, Income Assistance and Child Care Tax Benefit applications Transportation assistance to support program participation	Tools and guides about pregnancy, parenting and prenatal care (e.g., Baby's Best Chance, etc.) Support with Disability, Income Assistance and Child Care Tax Benefit applications
Indigenous health and wellness programming	Elder teachings Drumming/making drums Celebrating the birth of the baby Cultural practices for birth and women's wellness Tobacco ceremony Access to land-based healing and ceremony Access to First Nations Health Benefits Elders on staff to support women and families (at least two Elders working in partnership) Indigenous peer support Welcome-to-the-world ceremonies and end-of-life ceremonies Indigenous midwives, doulas and birth workers Aunties to support women and families Indigenous wellness garden with Indigenous medicines and Indigenous facilitator for medicines	
Food and nutrition support	Meal programs Food donations including baby food Community kitchen Food vouchers Nutritional counselling Facilitated food bank access	Nutritional counselling, support on infant/child feeding and nutrition Lactation support

Program Component	Community	Acute
Housing	Referrals and/or applications for housing Access to housing through service partnerships Access to housing via program's service partner	Connecting to housing immediately upon entry into acute care to support care coordination
Trauma education and support	Trauma and violence-informed approach to work Group support One-with-one counselling support	Trauma and violence-informed practice orientation Trauma awareness and trauma wellness
Parenting support	Onsite parenting groups One-with-one parenting support Prenatal classes Infant care classes Safe sleeping	Eat Sleep Console Prenatal education Safe sleep education and plans Infant first aid and CPR Infant care – diapering, sleeping, consoling, infant massage Parenting classes Coping skills
Recreation therapy	Connection to community centres and resources and baby support services	One-with-one and group outings to support leisure without substances Connection to community resources
Peer support	Peer-led peer support groups One-with-one relationship building and coaching Drop-in groups Drop-in meals	Peer Support Worker providing support at child welfare meetings, transition planning, navigating the health system and accessing recovery-oriented supports

Program Component	Community	Acute
Outreach	Outreach through telephone, text, email, home visits Transportation where available	Link to overdose prevention-related outreach
Children's health services	Onsite child health services Infant development programs Referrals to specialists	Support from pediatrics on child health Referrals and linkage to family physician, community provider
Women's health	Onsite physicians supporting prenatal and postpartum health, primary care, chronic disease supports, contraception, mental health Women's wellness group, reproductive mental health	Women's wellness group (e.g., contraception, postpartum concerns including mental well-being)
Child welfare support	Support meetings with social worker Onsite support to work with child welfare services – MCFD/DAA Advocacy for mother-baby togetherness and reunification Supervised onsite visits with children	Working collaboratively with MCFD/DAA by having regular leadership meetings and social worker meetings Trauma and violence-informed and Indigenous Culturally Safe approach Focus on keeping mother-baby dyad together When a child supervision order or child removal occurs, ensuring a trauma and violence-informed approach involving the mother in every step
Legal support	Providing access to legal aid onsite where possible	Providing "Know your rights" information Facilitating access to legal aid

Program Component	Community	Acute
Partner and family support	Partner and family groups Parenting together classes Partner recovery supports where possible	Partner and family involvement Partner groups where possible
Additional therapies	Facilitating access to dental services, physical therapies (physiotherapy, RMT), complementary alternative therapies (acupuncture, yoga)	Facilitating access to physical therapies (RMT, physiotherapy) Spiritual wellness Expressive art therapy, music therapy Therapeutic healing garden

Chapter 9
Transitions

Transitions refer to the movement of patients between health care settings and home as their condition and care needs change (The Joint Commission, 2012). Transitions happen throughout the journey of a pregnant and parenting individual using substances and involve multiple sectors and services that all collaborate to ensure the best possible outcomes. Transitions require supports for a person and their children throughout their journey across systems, services and sectors.

Research has shown that transitions can be challenging and anxiety-inducing. Among the challenges are:

- Leaving a known or safe environment for an unknown environment
- Experiencing a transition when a child has been removed
- Increased risk of relapse or overdose
- Lack of availability of community or wrap-around supports
- Lack of housing availability
- Risk of traumatization or re-traumatization

Recommendation 9.1:

To ensure continuity of care, provide people with one-on-one or structured system navigation support in hospital and/or community settings

When a person uses a service, regardless of the setting, transition planning starts with discovering their goals, needs and desires and creating safety. It is important for the person and/or the family to lead their transition planning and process. People must be able to have whomever they trust supporting their transition planning. This may be a specific person on a care team or community team with whom they have a connection, relationship and feeling of safety. Many programs have shared that having a dedicated person, whether it is a health care professional or peer, caring for a person and their family is key to improving transitions. Building and maintaining those therapeutic professional and personal connections is essential.

HCPP Hospital and BCAPOP Member Program Partnerships

Burnaby/New Westminster – Royal Columbian Hospital/ Burnaby Family Life

Duncan – Cowichan District Hospital/Hiiye'yu Lelum House of Friendship

Kamloops – Royal Inland Hospital/The Tree

Port Alberni – West Coast General Hospital/Port Alberni Friendship Centre

Powell River – Powell River General Hospital/LIFT Community Services

Prince George – University Hospital of Northern BC/ PG & Area Elizabeth Fry Society

Richmond – Richmond Hospital/Elizabeth Fry Society of Greater Vancouver

Smithers – Bulkley Valley District Hospital/ Dze L K'Ant Friendship Centre

Surrey – Surrey Memorial Hospital/Options Community Services

100 Mile House/Williams Lake – Cariboo Memorial Hospital/Cariboo Family Enrichment Centre

The Project has partnered with the BC Association for Pregnancy Outreach Programs (BCAPOP) to pilot the Provincial Healthy Care Pregnancy Program (HCPP). Led by BCAPOP, the HCPP provides community-based in-reach to other community agency/ acute care settings to support pregnant and newly parenting women and people who use substances and are experiencing social, medical and health risks. The HCPP in-reach worker walks one-with-one alongside any individual who is pregnant or up to seven months postpartum to help meet their most basic needs physically, emotionally and spiritually. The HCPP in-reach worker has a unique role in advocating and supporting women and people during transitions in and out of acute settings, including hospitals, detoxification facilities, mental health facilities and bed-based programs and travelling from/back to their communities.

Key learnings from the program's preliminary evaluation are that HCPP in-reach workers address a vital gap in transitions. When an individual starts the program, the in-reach worker helps address pragmatic and practical issues. These early connections build a relationship with a person where they are at. The program also offers a high degree of flexibility to engage with women and people whenever and however needed, during business off-hours and weekends. An in-reach worker's activities include accompanying a woman to appointments, supporting them in the hospital, setting up the Healthy Care Pregnancy Meetings with the person and family at the centre and with hospital-based and community partners.

Since its inception in 2020, 133 people agreed to participate in the program. In-reach workers have facilitated 277 Healthy Care Pregnancy Meetings bringing together community and acute care professionals to provide wrap-around services that meet the person's goals. Forty-one individuals were connected to traditional and/or culturally focused supports such as their community or nation, band office, Elders, traditional healing practices, Aboriginal Patient Navigators, and land/community supports. Through the program, in-reach workers:

- Accompanied participants to 683 appointments, intakes and support sessions, including prenatal care appointments with physicians and midwives, counsellors and bed-based programs
- Provided hospital tours
- Helped women access food supports
- Provided referrals and linkages to community-based programming and
- Attended appointments with child welfare workers or family court

A strength of the HCPP is the support of mother-baby togetherness in every way possible. This starts with working with a person's strengths and recognizing that pregnancy is a hopeful time in their life. Treating a woman like a mother is key: she should be supported to experience regular perinatal practices such as the golden hour after birth, celebrating the birth of the baby, skin-to-skin contact and rooming-in wherever possible.

Another program strength lies in how the in-reach worker supports the person's parenting wishes and advocates for alternatives to child removals. When a child removal occurs, the in-reach worker supports supervised visitations and access to treatment with the baby. With the support of an in-reach worker, 32 individuals have voluntarily accessed services from MCFD or a child welfare agency either during their pregnancy or postpartum. In-reach workers have supported participants during 109 meetings with child protection workers and helped to coordinate 74 supervised visits between participants and their infants and/or other children.

Women and people transition or "graduate" from the program once they are well connected to other services they identify as helpful and positive. Further development of the program will involve expanding the HCPP model to include peers in the community and implementing ICS training.

Recommendation 9.2:

To support and empower pregnant and parenting people using substances, every community or acute care organization must have a clear and detailed approach to addressing all aspects of transitions systemically

To ensure pregnant and parenting women and people using substances have trauma and violence-informed, compassionate and well-coordinated transitions, it is important to be explicit regarding what will happen during the transition process. Transition plans should be well documented and encompass all aspects of a person's journey.

Table 6. Key Clusters of Tools and Connections Required During Transitions in a Pregnant and Parenting Person's Journey

Part of the journey	Key Tools and Connections
Supporting a person from a recovery-oriented and harm reduction perspective	Safe use/Safer substance use plan Relapse prevention plan Connection to an OAT provider in the community OAT-specific support plan Substance use supports in community Follow-up with a GP who may oversee OAT Recovery supports and recovery-oriented programs
Keeping a person connected to continuous supports	Primary health care/GP documentation regarding who will assume responsibility of a person's care Support for accessing pediatric care Support from Indigenous-led Organizations including access to Knowledge Keepers and Elders Public health nursing follow-up Sexual health support including contraception and pregnancy tests Key Worker Parent Support Program Mentors and other community-based paraprofessional mentors
Maintaining community connections	Community health services Community programs (drop-in, flexible, low barrier) Home-based support Outreach
Ensuring safe housing and food security	Safe, supportive housing Access to income assistance, rental supplements Access to food banks, community kitchens, community programming
Supporting access to appointments	Transportation supports (access to infant car seat, stroller, transit access/passes/vouchers) Child minding
Advocating for family preservation and family reunification	Planning with MCFDD/DAA Holding meetings with child welfare where and when a woman feels comfortable Access to Indigenous Elders Ensuring that a social worker has conducted a comprehensive documented assessment before placing a child in care and provided plans for access, visitation Clarifying access to an infant/children and interpreting supervision orders Support for family reunification Access to legal aid

Chapter 10

Knowledge Exchange, Training and Education

The Project has actively engaged in needs assessment, planning and implementation throughout the province to address education-related gaps when caring for pregnant and parenting people using substances. The most oft-repeated, overarching, and unifying single theme in terms of education and training emphasizes the importance of relationship, or way of being with clients. This way of being is characterized by compassion, collaboration, non-judgement, safety, choice, and trustworthiness. Needs assessments have yielded other fundamental education and training needs including:

- Perinatal substance use
- Harm reduction
- Trauma and violence-informed care
- Motivational Interviewing
- Cultural safety and humility
- Employee self-care (vicarious trauma, compassion fatigue)
- Eat, Sleep, Console (ESC)
- Rooming-in
- Parenting supports

Many of these identified needs (trauma and violence-informed care, Motivational Interviewing, ESC, harm reduction, and ICS) are tightly aligned with, or necessary for, that desirable “way of being” that enables caring and collaborative relationships with pregnant and parenting women and people using substances.

Recommendation 10.1:

Use a learning campaign approach to education and training and build in multiple activities over time

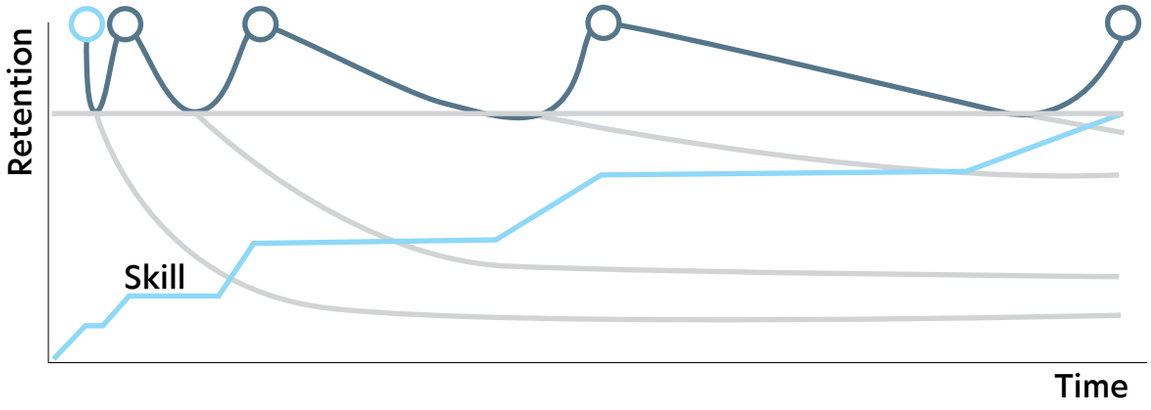
Traditional learning programs often consist of a formal training event or classroom education with no follow-up sessions. This approach is expensive, difficult to sustain and largely ineffective (Arets et al., 2016). After formal training events, learners tend to forget what has been taught within 48 hours if they have no other opportunities for knowledge transfer, retention and sustainment. Thus, spaced, relevant, and regular reinforcement in a learning campaign approach is required to connect the dots between formal training events and day-to-day work.

Perinatal substance use services span Regional Health Authorities, community organizations, Indigenous-led organizations and clinical education teams and are provided by people in clinical, non-clinical, supportive, and leadership roles in various geographic and service settings. Knowledge, experience and education levels of service providers vary, as do their skills and attitudes towards caring for pregnant and parenting people using substances. In terms of planning for education and training, the Project has been cognizant that a given training or education opportunity requires a learning campaign, rather than "courses" approach.

Figure 22. Comparison of New Knowledge Acquisition and Retention Over Time With and Without Learning Reinforcement (Arets et al., 2016)

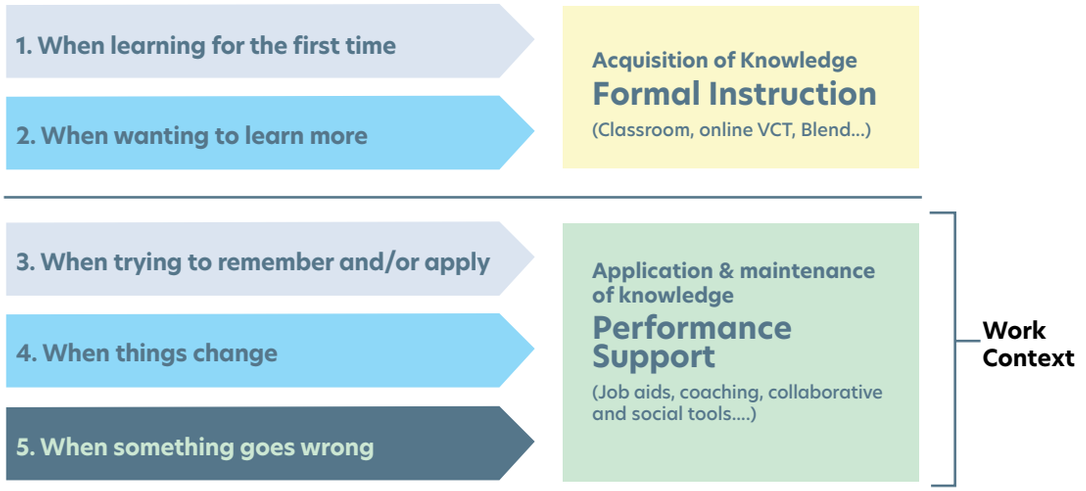
Without Learning Reinforcement

With Learning Reinforcement



A learning campaign draws on social marketing principles to target attitude and behaviour change. Formal education may be part of a broader learning campaign that reinforces key messages through multiple methods and points of contact over time. It may also involve adapting messages and methods for different target audience groups (e.g., nurses and leaders) and locations. A multiple-activities approach also allows for an extremely high level of localization and customization, which is important for such a diverse and broad audiences (Van Dam, 2018).

Figure 23. 5 Moments of Need Methodology to Determine When to Apply Formal Instruction or Performance Support



Recommendation 10.2:
Emphasize learning by integrating performance supports into education and training

Performance support activities can foster the link between formal education and on-the-job learning and sustain and reinforce practice change. While formal learning events are most appropriate when the audience is learning something new, performance support is best used when something changes, when something has to be applied (e.g., relationship skills), or when troubleshooting is required. It is also better suited for an audience that is not learning something entirely new and has enough contextual experience to immediately apply the skills in practice. Performance support can be achieved through any of the following activities:

- On-the-job learning
- Coaching and mentoring
- Demonstration, simulation, and role play
- Team discussion, team meetings, and daily huddles
- Clinical supervision
- Peer involvement/peer-led education
- Debriefings
- Job aids (FAQs, algorithms, reference sheets, protocols)
- Access to resources and policies through existing organizational content management systems
- Email distribution lists, newsletters, posters and other media

Recommendation 10.3:

Utilize provincial courses, core education offerings and resources to support education, training, capacity building and alignment to principle-based practices among health care providers

Core perinatal substance use-related education and training offerings have been developed by the Project to ensure alignment to principle-based practices across sectors and settings. Given that the Project is time-limited and the audience is broad and diverse, it was important to align strategies and approaches and scale and share them throughout the province using existing resources wherever possible, reducing duplication of efforts, and allowing for localization and customization. Education and training have been implemented and adopted for use in different settings and regions. Delivery models include a range of virtual, in-person, self-paced online work and content management strategies to curate resources that health care professionals can access from anywhere. Virtual education became central to delivery when COVID-19 limitations on gathering and travelling made classroom-based training impractical. Key Project developed/supported education and training offerings include:

Perinatal Substance Use Repository

A curated list of free courses, toolkits, and other resources that cover all key education areas, such as harm reduction, Indigenous Cultural Safety, perinatal substance use and substance use, and Motivational Interviewing. The repository is available at: http://www.bcwomens.ca/health-professionals/professional-resources/perinatal-substance-use

Perinatal Substance Use Webinars

The Project calls for an active approach to embedding ICS into training and learning and acknowledges that everyone in health care is on an ICS journey. To this end, the Project hosted a webinar series entitled Sitting with Cedar that explores approaches to decolonizing perinatal substance use services and supports. Topics include historical and ongoing impacts of colonization on Indigenous women's health and practice-related considerations for those who care for pregnant and parenting people using substances. Evaluation results showed that the series helped viewers increase their knowledge of the impacts of colonization and intergenerational trauma. Recordings of the webinar series is available on the PHSA LearningHub at https://learninghub.phsa.ca/Courses/23460/ppsup-webinar-sitting-with-cedar-laying-the-foundation

Learning & Acting Together – Perinatal Substance Use Webinar Series

In collaboration with the Centre of Excellence for Women's Health, the Project supported the development of a webinar series on perinatal substance use practice. This four-part series discusses current, new and emerging evidence-informed work in the perinatal substance use field and how the voices of women with lived and living experience are paramount in supporting pregnant and parenting women and people using substances. The webinar series is available at: https://bccewh.bc.ca/webinars-and-courses/webinars/

Trauma and Violence-informed Practice Through "SafeCare" Education

The Project has supported access to trauma and violence-informed practice training offered by the Sanctuary Institute. The training describes the Sanctuary Model, and how to create trauma and violence-informed teams and organizations. A preliminary evaluation found that approximately four out of five health care providers (83 percent) who took the training intended to apply the skills they learned. Sanctuary Institute training offerings have been provided at provincial and regional/local levels.

Building on work at Providence Health Care to enhance the Sanctuary Institute model, the Project has adapted and expanded SafeCare training. SafeCare is blended, facilitated psychoeducation for health professionals on trauma and violence-informed practice, substance use, harm reduction, Indigenous Cultural Safety and self-care. The delivery model is a combination of self-paced online modules and a facilitated session. In-person and virtual options are available on the PHSA LearningHub at https://learninghub.phsa.ca/Courses/25045/safecare-provincial-perinatal-substance-use

Motivational Interviewing

The Project has developed a significant strategy to support provincial uptake of Motivational Interviewing (MI). MI is a strengths-based approach to conversations that helps draw out people's motivation and commitment to change. MI helps people work through ambivalence or complex situations so they can move towards the changes that are important to them.

The Project has supported train-the-trainer sessions to expand MI across the province and provided provincial/regional access to training on the Foundations of MI, Spirit of MI, Brief Action Planning, Communicating with Clarity and Compassion and Beyond the Fundamentals of MI. Information about MI provided by the Centre of Collaboration, Motivation and Innovation is available at https://centrecmi.ca/motivational-interviewing/

Rooming-in Guideline

The Rooming-in Guideline for Perinatal Women Using Substances was developed through consultation with health care providers and women with lived and living experience throughout the province. The guideline offers strategies on how to keep mother and baby together via rooming-in in the physical space, addresses breastfeeding and substance use, skin-to-skin contact and safer sleep. The Rooming-in Guideline is available at: http://www.bcwomens.ca/health-professionals/professional-resources/perinatal-substance-use

Perinatal Substance Use Online Modules/Eat, Sleep, Console (ESC)

Perinatal Substance Use Online Modules provide education on evidence-informed, gender-responsive, trauma and violence-informed and culturally safe care for women and people using substances and infants exposed to substances during pregnancy.

The course focuses specifically on Eat, Sleep, Console (ESC), a model for the non-pharmacological treatment of neonatal abstinence syndrome (NAS). ESC emphasizes the involvement of family, keeping birthing parent and baby together, sees the parent as the first line of treatment and attachment and provides 10 reinforcing strategies to support the mother-baby dyad. The CME-accredited, self-paced course has been designed for family physicians, obstetricians, nurse practitioners, midwives, neonatologists, registered nurses, and pediatricians.

The course is divided into four modules:

1. Principles of Care (2 hours)
2. Care during Pregnancy and Labour (2 hours)
3. Care of the Newborn Exposed to Substance Use during Pregnancy (2 hours)
4. Discharge Planning and Transition to Community (1 hour)

Preliminary evaluation results show that the modules support principle-based practice approaches and uptake of technical skills for the non-pharmacological management of NAS. The Perinatal Substance Use Online Modules are available through UBC Continuing Professional Development at: https://ubccpd.ca/course/perinatal-substance-use

Addiction Care and Treatment Online Certificate – Perinatal Substance Use Module

The Addiction Care and Treatment Online Course (ACTOC) is a comprehensive online course developed by BCCSU for health care professionals. It describes how to manage substance use disorders and provide evidence-informed treatments along a continuum of care. The Project supported the development of a module focused on perinatal substance use that includes opioid use disorder in pregnancy, treatment pathways and possible interventions. The module also discusses clinical considerations, screening, brief intervention approaches and treatment options for women and people who are pregnant and parenting and using substances. ACTOC is available at: https://ubccpd.ca/course/addiction-care-and-treatment

Acute Care Social Work Training

The Project developed a webinar series for acute care social workers and others who have similar responsibilities to support immediate practice changes and address new legislation such as the end-of-birth alerts and the "Act Respecting First Nations, Inuit and Métis children, youth and families." The four-part webinar series explores the following topics:

- New Child Welfare Legislation: Clarity on Roles & Responsibilities for Acute Care Social Workers
- Breastfeeding & Substance Use: Harm Reduction Supports Acute Care Social Workers Can Provide
- Collaborative Care Planning with Mothers Using Substances: Support from Acute Care Social Workers
- Leading from Within the Team: Skills for Acute Care Social Workers

MCFD/Delegated Aboriginal Agencies Training

On a trial basis, the FIR team leadership have been providing training to MCFD/VACFSS on perinatal substance use to practice leads, team leads and case workers in the Vancouver-Richmond health service delivery area. This model is being evaluated for potential gradual expansion into other MCFD health service delivery areas. Preliminary evaluation results have determined that the format, structure and content align to MCFD/VAFSS training needs and expectations. The training covers:

- Substance use and addiction medicine fundamentals
- Harm reduction
- Stigma reduction
- Bio-psycho-social-spiritual treatment
- Breastfeeding and substance use considerations

Prescribing Workshop

This physician-led workshop explores the medical management of perinatal substance use in a trauma and violence-informed, culturally safe way that is inclusive of lived experience. The workshop uses a case-based approach that enables physicians, nurse practitioners, midwives and pharmacists to explore scenarios and evidence-informed options for prescribing medications and OAT to support pregnant and parenting women using substances. Evaluation results indicate that the workshop is highly rated (4.7 out of 5) for its presentation of practical and relevant information, enhancing knowledge and providing opportunities for interaction.

Elders Visioning: Perinatal Substance Use Toolkit

This toolkit is a unique resource in which Elders from each region in BC involved in substance use services and perinatal health care draw on their decades of experience as Knowledge Keepers and storytellers. The Elders share their diverse knowledge, wisdom and practices about how they support Indigenous women, children and families impacted by substance use in a good way. The toolkit includes essential knowledge, wise practices, cultural teachings, stories and practical tools about how to support and work with Elders.

CHAPTER 11

Primary Care

Prenatal and postpartum care are opportunities to engage pregnant and parenting people using substances in meaningful and non-stigmatizing ways. Family physicians, nurse practitioners and midwives play a crucial role in providing perinatal services and supports for pregnant and parenting people using substances. During initial visits to health care providers, the priority is to build relationship and rapport in ways that are trauma and violence-informed, non-judgmental and culturally appropriate. It is important to acknowledge that a full prenatal and health assessment need not be completed at once, and important junctures for engaging in conversation about perinatal substance use may present themselves over time.

Recommendation 11.1:

Support the implementation of respectful discussion and collaborative tools for assessment and engaging in brief intervention/support for perinatal substance use in primary care

Research indicates that, during pregnancy, a woman using substances may be highly motivated to address their substance use and minimize potential harms. In the prenatal stage, family physicians, nurse practitioners and midwives are well positioned to discuss and offer substance use education. Collaborative discussion provides an opportunity for early detection of problematic substance use, helps establish levels of risk associated with substance use and reduces the risk of progression to more severe disease (Mead, Hardial & Cameron, 2020). The Centre of Excellence for Women's Health has developed a number of assessment and brief intervention resources including a comprehensive, principle-focused guide on brief intervention for women and girls using substances. *Doorways to Conversation – Brief Intervention on Substance Use With Girls and Women*

(2019) encourages physicians, nurse practitioners and midwives to discuss the type, frequency and amount of substance use. Topics include:

- Tobacco and harm reduction
- Cannabis and morning sickness, second-hand smoke, safe storage
- Polysubstance use and harm reduction
- Tobacco-related relapse postpartum
- Alcohol, prescription opioids and breastfeeding

In terms of identifying substance use, the Substance Use Risk Profile – Pregnancy (SURP-P) is a three-item scale that asks about alcohol use and alcohol and drug use (Yonkers et al., 2010). It is a simple and flexible scale that can be used to initiate further conversations and assessments related to substance use and support planning and interventions.

Recommendation 11.2:
Support the implementation of substance use-specific guidelines (alcohol, tobacco, opioid use disorders, cannabis) in primary care

Organizations leading family practice physician education should highlight the aforementioned screening and brief intervention resources. At the clinical level, routine or follow-up visits with pregnant and parenting women and people using substances should incorporate counselling on alcohol, cannabis, smoking/vaping and illicit substance use. Prescribing of pharmacotherapies aligned to treatment guidelines for tobacco use (e.g., nicotine replacement therapy), alcohol-related pharmacotherapy and OAT can occur in the family practice setting with appropriate training. In an upstream and public health approach, postpartum people should also have ready access to long-acting contraception if desired.

Recommendation 11.3:
Encourage physicians working in the perinatal substance use field to enhance their addiction medicine skills

Education and training is available to support family practice physicians providing obstetric care for pregnant and parenting women and people using substances. These resources align with addiction medicine best practices and evidence-informed guidelines relating to substance use. Minimum requirements for addiction medicine training are completion of the BCCSU ACTOC training, including the newly developed perinatal substance use module. Given the significant complexity surrounding substance use, medical co-morbidities, and complex health issues that pregnant and parenting people using substances often present with, family practice physicians may want to consider obtaining the Canadian College of Family Practitioners-Certificate of Added Competency in Addiction Medicine. There are also fully funded opportunities through the Enhanced Skills Program at UBC for three- to six- month training (Category 2) or a one-year addiction medicine fellowship (Category 1).

Recommendation 11.4:

Include emergency departments in transition protocols and processes

Pregnant and parenting women and people using substances without established prenatal care may present at emergency departments for episodic care. These visits may occur on weekends, evenings and nights, when specialized resources and supports are less available. The women may present with complex obstetric or medical concerns and complex social health risks/issues. Pregnant and parenting people using substances must feel safe in emergency department settings. However, in BC, there are numerous challenges in the emergency department environment. Recently, emergency departments across the province have been identified as anti-Indigenous racism hotspots (Turpel-Lafond, 2020). No matter what is available in the emergency department in terms of staffing, perinatal substance use expertise, skills and resources, Indigenous women and people will continue to feel unsafe and remain at very high risk of adverse health outcomes until unless racism and discrimination is addressed.

The Project has identified specific challenges in emergency departments related to perinatal care:

- Inadequate withdrawal management
- Focus on the well-being of the fetus above that of the mother
- Environmental restrictions leading to sub-optimal care

To enhance care for pregnant and parenting people using substances, emergency departments should:

1. Address racism in the emergency department
2. Increase education and training about perinatal substance use, including addressing myths and misconceptions
3. Provide practice guidance on withdrawal management in the perinatal period, and
4. Provide clear protocols to support trauma and violence-informed and culturally safe admissions, discharges and transitions either to community care or acute care.

Recommendation 11.5:

Provide postpartum supports including substance use-related education and support, partner support, mental health support and infant development support for women and people after labour and delivery in primary care settings

Support after childbirth for women and people using substances is a known gap in holistic care. There are high rates of relapse and riskier substance use postpartum, due in part to the significant life changes and stressors of parenting an infant. If there is an opportunity, engaging partners in substance use treatment can help create a circle of support for the new mother.

Primary care follow-up on medical conditions, contraception and sexual health advice, screening and treatment for postpartum depression and overdose prevention education all support maternal/child health. Primary care providers can also offer education on breastfeeding, bottle feeding, safer sleep and infant development.

CHAPTER 12

Child Welfare Engagement

Recommendation 12.1:

Acknowledge and understand the historic and ongoing colonial context of child welfare services and their impact on Indigenous women, children, families and communities and non-Indigenous women

There is a historic legacy in Canada of removing Indigenous children from their families and communities, first through the residential schools and later through the Sixties Scop. Indigenous women, people and their families are particularly fearful of interactions with social workers or child welfare workers when visiting hospitals or giving birth due to concerns that their children will be apprehended (Turpel-Lafond, 2020). Pregnant and parenting women and people using substances have a complex relationship with child welfare services. Child welfare workers often assume that a mother who uses substances is an unfit parent, resulting in the removal of a child in her care. Indigenous women, children and families often experience the compounded harms of significant discriminatory and colonial attitudes and practices and child welfare policies, including the perpetuation of stereotypes regarding substance use and capacity for parenting.

These fears are well-corroborated by data indicating that Indigenous children are more likely to be placed in care. In 2019, the rate of all children in care for the general population was 6.3 per 1,000; the rate for Indigenous children in care was 43.8 per 1,000 (MCFD, 2020). An analysis of access to breastfeeding found that 264 out of 448 infants aged 12 months or less were removed from their mother's care in 2017/18 (RCY, 2018). The data indicate that much needs to be done to address ongoing colonization and support mother-baby togetherness for Indigenous women, people and families in culturally safe ways. By naming and understanding the problems and committing to proactively solving them, child welfare services can move toward truth and reconciliation.

Recommendation 12.2:

Pursue every option and alternative to child removals and keep mothers and babies together

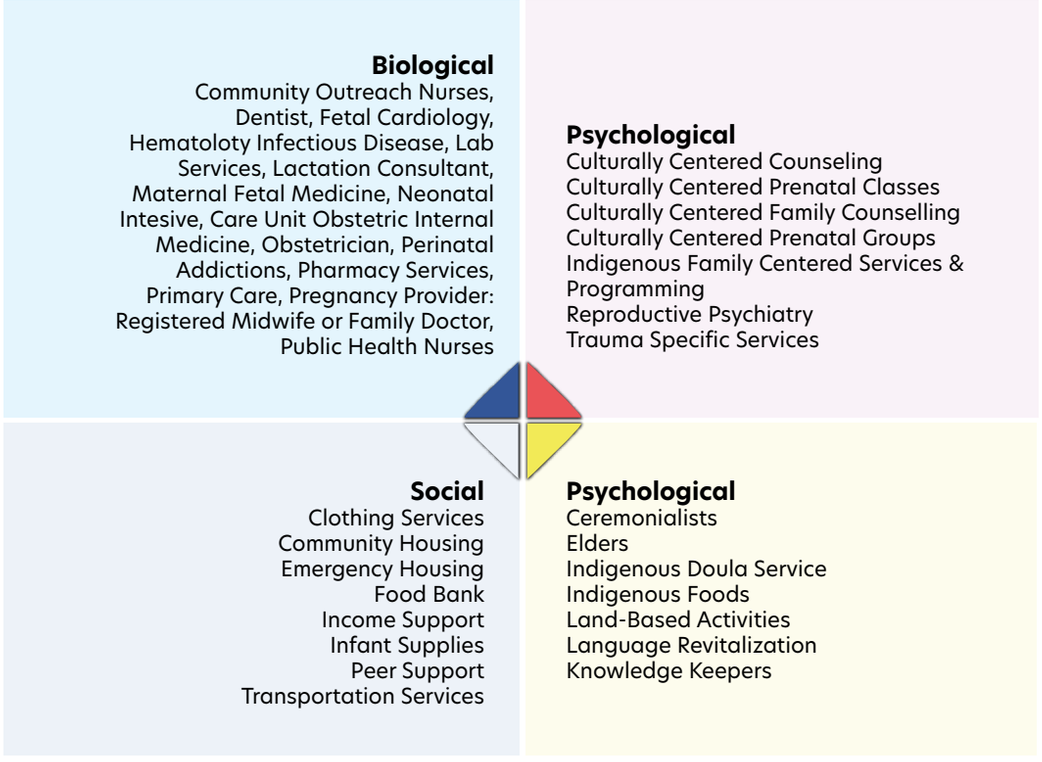
Child removals involve either taking a child into care or developing a written voluntary care agreement with the custodial parent. The *Child, Family and Community Services Act (CFCSA)* governs BC's child welfare system. The CFCSA states:

> *Unless a child or youth is in immediate danger, all measures less disruptive than removal for protecting the child or youth must be fully explored. When removal of a child or youth under Section 30 of the CFCSA is necessary, preference is given to seeking an out-of-care order, which places the child/youth in the custody of an individual other than a parent instead of in the Director's care.*

It is important to clarify that substance use is not reason enough to precipitate a child removal.

In an analysis of the legislation, West Coast Leaf (2019) identified that the law's direction to use less-disruptive measures lacks clarity and accountability. Options to remediate this issue that align to *Bill C-92: An Act respecting First Nations, Inuit and Métis Children, Youth and Families* prioritize placing children with their birth parents, and when that is not possible, having a priority list of adults, beginning with family members and Indigenous community members, with whom the child might be placed. It also recommends that the pursuit of less-disruptive measures be clarified as an ongoing process that does not stop after a child removal occurs.

Figure 24. Essential Prenatal Services and Supports for Indigenous Parents (Wachatowin Law & Governance Lodge, 2020)



For Indigenous Peoples, the concept of family may include extended family members, grandparents, aunties, uncles and cousins. It is important to ensure that the women's interpretation of familial relationships is honoured. Interpretation of Bill C-92 by Wachatowin Law and Governance Lodge has clarified what services are essential for supporting Indigenous families and preventing child removals. Bill C-92 prioritizes the prevention of child removals and indicates that child welfare services must demonstrate they have prioritized and facilitated access to services across sectors, including prenatal care, to prevent child removals at birth.

Both pieces of legislation are designed to keep families intact. Focusing on the assets of the birthing parent, family and community, makes alternatives to child removals possible.

Recommendation 12.3:

When a child removal occurs, child welfare staff need to provide a comprehensive and documented assessment, cause for child removal or supervision orders and plans for reunification of family before a child's removal. A person must have a circle of support present that may include a partner, family members, Indigenous Elders and community members. A safety plan must be in place before the child removal

Child removals are devastating. There is research evidence to suggest that when they occur, mothers are at very high risk of mortality (Wall Weier, 2018; Thumath et al., 2020). For women and people actively using substances, child removal can further entrench their substance use. For a person on an abstinence-based recovery journey, child removal can trigger relapses and put them at high risk for fatal or near-fatal drug overdoses (Westcoast Leaf, 2019; Kruk & Banga, 2011). A recent Canadian study found that child removal was associated with an increases in non-fatal overdoses as well, especially among Indigenous women (Thumath et al. 2020). For Indigenous women, people, families, Elders and Knowledge Keepers, witnessing a child removal can reactivate both current and intergenerational traumas related to residential schools and the Sixties Scoop.

In a comprehensive review of the child welfare system from an Indigenous healing and wellness perspective, healing circles with parents across the province identified significant inconsistencies in practice related to the duty to provide parents and caregivers with written reasons for child removal (Westcoast Leaf, 2019). Many parents noted that they did not receive written reasons.Parents who did receive written reasons perceived them as inconsistent or insufficient to warrant the child's removal or felt the reasons were so general that they found it difficult to apply them to their circumstances (Westcoast Leaf, 2019). *In Plain Sight* (2020) identifies the role of anti-Indigenous racism in child removals by noting that health care workers have reported situations in which they felt mothers were referred to child protection services only because they were Indigenous. They described how normal childhood injuries, parental concerns and parenting experiences were pathologized for Indigenous families in ways that were not extended to non-Indigenous families (Turpel-Lafond, 2020). In light of these findings, written documentation and clear communication of social work assessments, child removal causes and plans for reunification are essential to support women and keep mothers and babies together.

Reunification and visitation are particularly important for women and people who have experienced a child removal. One study describes maintaining in-person contact between mothers and children as "a vital form of social support when facing the aftermath of child custody loss," provided that child welfare services are enabling time and space for authentic interaction with children (Kenny & Barrington, 2018).

Recommendation 12.4:

Ensure that a pregnant or parenting person using substances has given documented consent to communicate their personal information with MCFD/DAA. To make this decision, women and people must be aware of what information is being requested and what information will be shared. Consent should be treated as an ongoing process where health care providers check in regularly regarding whether the consent to share information has changed

Clinicians in Canada do not have a legal obligation to report prenatal substance use during pregnancy, and maternal substance use alone does not constitute sufficient grounds for child removal. While this position is clear, there have been conflicting practices with regards to how and when MCFD/DAA are engaged when a pregnant woman using substances presents in a hospital-based setting. Until recently, hospital staff commonly alerted child welfare workers when they determined a newborn might be at risk for harm, without informing expectant parents. Known as a "birth alert", this practice was eliminated by the BC government in September 2019, with the acknowledgement that birth alerts had been "primarily issued for marginalized women and, disproportionately, Indigenous women (MCFD, 2019)." Eliminating the practice of birth alerts was also a response to calls for action from the National Inquiry into Missing and Murdered Indigenous Women and Girls, the *United Nations Declaration on the Rights of Indigenous People* and the *Truth and Reconciliation Commission Calls to Action.*

The Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director (CFCSA) was updated in light of the elimination of birth alerts and clarifies that written consent must be obtained when communicating between Regional Health Authorities and MCFD/DAA. The process of consent should be clear and well documented for a pregnant and parenting person and revisited over time.

Recommendation 12.5:

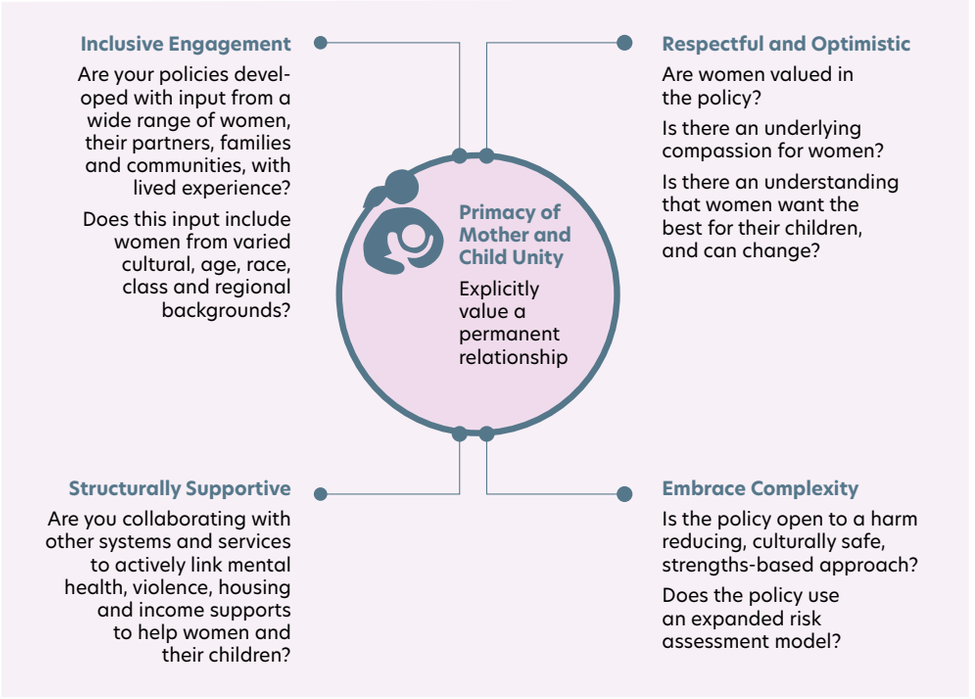
Foster collaborative relationships with MCFD/DAA to ensure that a pregnant or parenting person using substances has access to community supports and resources

There are examples of relationships in which MCFD/DAA can be supportive and shift away from a focus on child protection to providing access to funding, supports and resources for pregnant and parenting people using substances. MCFD/DAAs can augment community services and supports, provided they are oriented towards family preservation.

One mechanism to help envision how MCFD/DAA policy approaches can be more upstream and collaborative is the *Mothering and Opioids Toolkit* – Policy Development Framework, which focuses on mother-baby togetherness. The framework describes key questions and approaches that can be taken during policy development that maintain the primacy of mother-baby togetherness and engage women with lived and living experience in the policy development process.

As part of the FIR Model of Care Renewal, a group of more than 20 health care providers (practice leaders, team leaders, social workers and directors) from MCFD and VACFSS met on a monthly basis over six months with the FIR team to explore collaborative care planning. The outputs of this collaboration included new structures for interdisciplinary collaboration, joint care and transition planning when moving from hospital to community. This partnership has increased mutual understanding of how child welfare priorities can be balanced with principle-based approaches to working with families impacted by substance use. This working model is being assessed for application to other communities and regions to support mother-baby togetherness.

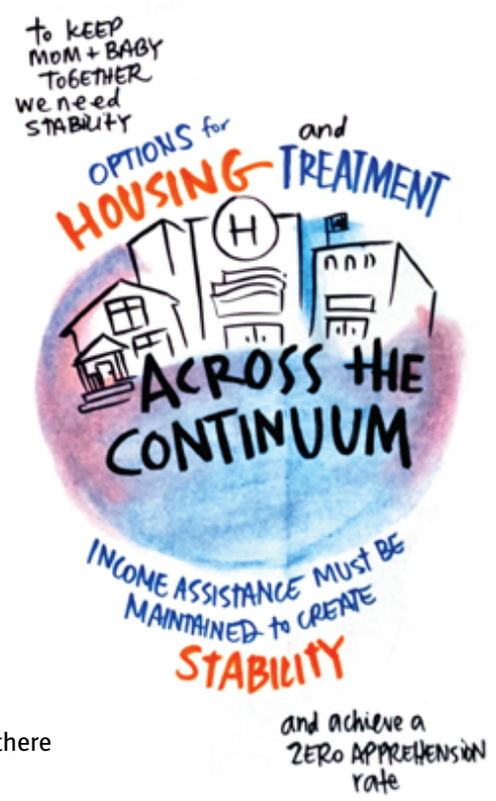
Figure 25. Policy Development Framework Focusing on Mother-baby Togetherness for Child Welfare Policy (Schmidt et al. 2019)



Chapter 13

Housing

Women and people who are pregnant and parenting and using substances or in early recovery often have unstable housing or precarious housing arrangements. They may have low incomes, be receiving income assistance or be living in poverty. Poverty is a key factor in homelessness and housing insecurity for women and families. It significantly impacted by gender inequalities that underpin women's economic exclusion and vulnerability. Gender-based violence is also associated with homelessness among many parenting women, and substance use and intimate partner violence are often linked.



Research from the Co-Creating Evidence Project indicates that over half of the clients (up to 85 percent at some sites) of Canadian organizations serving women using substances had precarious or inadequate housing (Hubberstey & Rutman, 2019). Housing was among the top three concerns of pregnant and parenting women and people using substances and the main reason why they sought support from community organizations. In this evaluative study, women and people highlighted the inextricable connection between housing and the safety concerns of child welfare authorities. They acknowledged that stable, "safe housing" was a determinant of whether or not their children would be removed (Marcellus, 2016). Complicating matters further, child welfare services lack a definition of "safe housing" and what kinds of services and supports need to be in place. More broadly, there

are significant inconsistencies in how "safe housing" is defined. Unstable/unsafe housing can trigger investigations by the child welfare system, precipitate child removals, and delay family reunification (Rog et al., 2017). In turn, the removal of children can lead to the loss of housing subsidies, which places the family in an even more precarious housing situation and makes family reunification more difficult (Rog et al., 2017).

Recommendation 13.1:

Develop and support the implementation of a non-linear, flexible and person-centred housing services model for parenting women and people using substances and in early recovery. Within this model, ensure that transitions between housing types are seamless and well supported and that abstinence-based and stable active use housing is included, so that women have access to appropriate supports wherever they may be on the recovery spectrum

The housing continuum model is a well-established concept used by policymakers and housing advocacy groups to represent the range of responses available to help individuals and families access housing. Typically, it illustrates a linear progression of housing from homelessness to home ownership. The reality is that most housing programs address different parts of the continuum, and those that offer different types of housing appear to operate as discrete entities rather than as part of a supported pathway. While housing has been often conceptualized as a continuum, integrated housing programs that support an individual through all levels of housing are rare.

At present, there is no provincial housing model for women, children and families affected by substance use. Some exemplary wrap-around programs exist, drawing upon evidence-informed, wise and leading practices to support pregnant and parenting women using substances.

To establish a provincial model, it would help to conceptualize housing less as a continuum and more as a housing wheel or housing circle, which would better reflect the diverse and dynamic nature of individual and family housing and recovery needs. Circular models offer optimal flexibility for women, people and their families to move between housing types according to their evolving circumstances. They also mitigate the gaps and barriers to access inherent in a traditional, linear housing continuum.

Recommendation 13.2:

Target immediate and ongoing investments to increase the supply of family housing inclusive of partners and children that is women-centred, culturally safe and supports family unity; ensure that housing units are high quality and located in neighbourhoods conducive to family safety and well-being

The Project conducted a comprehensive and current environmental scan of the provincial housing programs that accept pregnant and parenting women with dependent children. The housing supply is defined and identified in Table 7.

The scan found that the vast majority of housing programs in BC that accept women with dependent children are intended for individuals fleeing domestic violence or who are at risk of violence. Although many women and people who face challenges associated with substance use may also be affected by intimate partner violence – and, therefore, may be eligible to apply – few of these housing programs are specifically positioned and/or suitable to support women using substances. In many cases, programs have substance use as an exclusionary criterion for accessing housing. Working with the violence-against-women housing/shelter sectors could help increase capacity to provide safe emergency shelters for parenting women and people using substances. Ideally, safe shelters ideally would have on-site staff with perinatal substance use training, harm reduction processes in place and be able to accommodate safe active substance use.

The scan identified only one program providing recovery housing and four programs providing live-in treatment for women with dependent children. Recovery housing is defined as short-term temporary housing for women addressing substance use and their children. For parenting women who use substances, housing is an essential platform for recovery, which is nearly impossible when they are homeless or unstably housed (Kawachi et al., 2015). Transitional housing that offers some substance use supports is often used in place of recovery housing; however, the demand for short-term and medium-term transitional housing outpaces the available supply.

Table 7. Stock, Supply and Definitions of Housing across the Province by Type

Type of Housing	Definition	Number of Programs Offering Housing
Specialized perinatal substance use programs with housing	Housing programs that serve pregnant/early parenting women using substances or in early recovery; programs provide some level of psychosocial and/or substance use-specific services and supports; all types of housing are included (e.g., live-in treatment, emergency housing, supportive housing)	18
Live-in bed-based treatment	Live-in substance use treatment programs for women that allow dependent children to remain onsite with the parent while they undergo treatment; includes 'family-based' bed-based treatment programs	4
Emergency shelter	Short-term (max. 30 days) emergency/temporary housing for women with dependent children; note that many emergency shelters are intended for women fleeing domestic violence, and some may not accept women with substance use as their primary challenge	29
Recovery housing	Short-term (max. 30 days) emergency/temporary housing that addresses substance use specifically for women with dependent children	1
Short-term housing (may include transitional housing and supportive and supported housing)	Time-limited housing (up to 1 year) for women with dependent children, who are facing various challenges that put them at risk of homelessness (e.g., domestic violence, mental health issues, substance use, low income); programs provide some level of psychosocial and/or substance use-specific services and supports	11
Medium-term housing (may include transitional housing and supportive and supported housing, and subsidized/ affordable housing)	Time-limited housing (1-3 years) for women with dependent children, who are facing various challenges that put them at risk of homelessness (e.g. domestic violence, mental health issues, substance use, low income); programs provide some level of psychosocial and/or substance-use specific services and supports	14
Long-term Housing with supports (may include transitional housing and supportive and supported housing, subsidized/ affordable housing)	Longer-term housing (3+ years) for women, with dependent children, who are facing various challenges that put them at risk of homelessness (e.g., domestic violence, mental health issues, substance use, low income); programs provide some level of psychosocial and/or substance use-specific services and supports	8
Subsidized housing without supports	Long-term or non-time-limited housing that provides rental subsidies for low-income women/families with dependent children; additional services or supports not typically provided	7

In addition to creating new housing, opportunities exist to expand current specialized housing supports for pregnant and parenting people using substances. These options include: 1) supporting agencies and programs that currently provide integrated housing services to perinatal people affected by substance use to expand their capacity; and 2) rolling out additional services based on this proven approach and/or increasing the capacity of wrap-around perinatal substance use programs to provide housing either onsite or through partnerships with BC Housing.

Recommendation 13.3:

Integrate substance use treatment, psychosocial supports and peer support into family housing for pregnant and parenting people using substances, their children and families

Integrated substance use treatment, other health services and psychosocial supports need to be provided within each type of housing. Peer engagement and supports are effective and should be fostered along each step of recovery/housing provision. These supports should be portable (e.g., attached to the person and family rather than the housing program) and address the needs of the entire family unit.

A family-centred treatment model also warrants further consideration. Evidence from the US suggests that family- and bed-based treatment or recovery is a promising practice that both addresses substance use disorders and improves child welfare outcomes (Casey Family Programs, 2019). The environmental scan found that live-in treatment for women with dependent children was available in only four programs/agencies, indicating this area could be further developed across the province. Being able to participate in live-in treatment is a strong motivator for pregnant and parenting women and people using substances to engage in substance use treatment and recovery (Chou et al., 2020) and remain in treatment over the longer term (Wiegmann, 2016).

Chapter 14
The Path Forward

The Provincial Blueprint for a Perinatal Substance Use Continuum of Care is the culmination of evidence, wise practice, leading practice, the ICS journey, provincial and regional collaborations and key learnings from community organizations. The Blueprint's recommendations, taken together, offer a comprehensive, aspirational yet attainable pathway to transforming the system of perinatal substance use services and supports for pregnant and parenting women using substances. The recommendations call for greater alignment to principle-based practices and approaches when caring for pregnant and parenting women using substances. In this regard, the Project's ICS journey and efforts to decolonize perinatal substance use services and supports are extremely important.

The Project has already made significant progress in transforming perinatal services and supports in the province. By developing core provincial education in principle-based practice, the FIR Model of Care Renewal and extensive strategic community partnerships to directly support women who are pregnant and parenting and using substances, the Project has realized many gains in terms of catalyzing action to address perinatal substance use. The Project has served as a linchpin for regional and local initiatives to transform perinatal substance use services.

In addition to realizing system transformation objectives, the Project has met all the calls to action identified in 2018 at the *Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges Visioning Workshop*.

Table 8. Addressing the 2018 Calls to Action for Ensuring Best Care and Supports to Pregnant and Newly Parenting Women with Opioid Use Challenges

2018 Call to Action	Project Actions
Garnering executive attention to perinatal substance use Expanding integrated service models to ensure the best possible health outcomes for pregnant and newly parenting women and people using substances	Supporting the establishment of five regional working groups including co-leadership by Regional Health Authorities Engaging community in funding/service partnerships to enhance services and provide direct care Integrating addiction medicine across service and supports
Making specific practices the provincial standard of care, such as rooming-in, and principle-based care (including trauma and violence-informed practice, Indigenous Cultural Safety, women centered, harm reduction and evidence-informed)	Developing the provincial Rooming-In Guideline Establishing nine guiding principles for the province and aligning core provincial education offerings to principle-based practice in a robust education/training strategy
Facilitating the uptake of these practices through the education, training and supports for health professionals and others in evidence-informed and wise practices	Training 7,134 health care providers over two fiscal years, 892 per quarter on average Establishment of a complexity-informed evaluation framework assessing principle-based practice across regions and communities

The Project's next phase will focus on implementation of the Blueprint's recommendations, uptake of key provincial education initiatives and futher evaluations of the Project's contributions to the health care system. This phase will require health care planners, providers and leaders and community leaders to consider the Blueprint's recommendations and the gaps and challenges in their local context to determine what they can implement going forward. There are also opportunities for collaborations with researchers and advocates to further advance transformation of perinatal substance use services and supports.

The Project evaluation will continue to assess how education and training are contributing to practice change and how acute and community services are evolving to support the needs of pregnant and parenting women and people using substances.

The Project remains committed to the ICS journey and to working in deep allyship and respectful partnership with Indigenous Elders, Leaders, health care providers and women and families to advance the decolonization of perinatal substance use services.

Above all, the findings and recommendations of the Blueprint reinforce the reality that women and people who are pregnant and parenting and using substances have immeasurable strengths, gifts and resiliency.

As a system of care, we must honour those gifts and create and foster the supportive conditions that enable mothers and babies to be together. By doing so, we will help women, children, families and communities forge ahead on their unique journeys and paths of healing and wellness.

"Women are caregivers, leaders, heads of families and keepers of knowledge.

Women's health is family health, community health, nation health and cultural health."

— In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (2020)

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