

Harm Reduction and Pregnancy: Best and Promising Practices for Supporting Pregnant Women and New Mothers Who Use Substances

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**2nd Biennial Healthy Mothers and Healthy Babies Conference: Advances in
Clinical Practice and Research Across the Continuum**

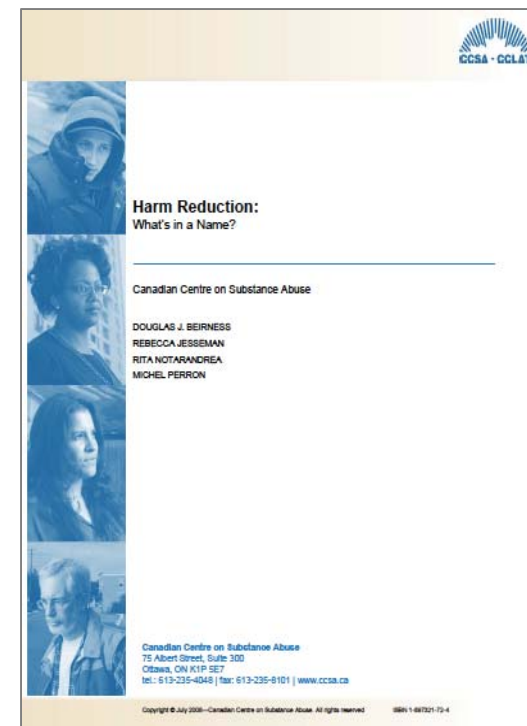
Friday, March 11 - Saturday, March 12, 2016

Learning objectives

- Provide an introduction to harm reduction approaches during pregnancy
- Review the evidence base for a range of harm reduction based interventions
- Use examples from integrated maternity care or “one-stop shop” programs across Canada to illustrate harm reduction “in action”

What is harm reduction?

- A “contentious issue” in drug policy
- Emotion/ethics laden
- Many misperceptions



What is harm reduction?

Source:
*Canadian Harm
Reduction Network*

- **Harm Reduction** refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are *public health, human rights and social justice*. It benefits people who use drugs, families and communities.
- **Harm Reduction** is underpinned with the knowledge that many drug-related problems are not the result of the drugs themselves; rather they are the *consequences* of the unregulated manufacture and trade of drugs and the enduring commitment to failed policies and ill-thought-out and inequitably applied laws.
- Finally, **Harm Reduction** ensures that people who use psychoactive substances are treated *with respect and without stigma*, and that substance-related problems and issues are addressed *systemically*.

The short CNA
version..

Harm reduction is a pragmatic
public health approach to reducing
the negative consequences of risky
behaviors

Key principles of harm reduction

Source:

*International Harm
Reduction
Association, 2010*

- Pragmatism
- Humanistic values – emphasis on human rights
- Reducing risks and harms of drug use
- Evidence of costs and benefits
- Priority of immediate goals
- Acknowledging incremental change
- Challenging policies and practices that maximize harm
- Meaningful participation of those who use drugs in policy-making and program development

Well known examples of harm reduction

- Related to substance use:
 - Nicotine patches, e-cigarettes
 - Needle exchange programs
 - Supervised injection sites
 - Methadone maintenance
 - Drug substitution
 - Peer administered Naloxone
 - Street outreach programs
 - Safer crack pipe programs
- In other areas:
 - Seat belts, helmets
 - Interventions related to chronic disease
 - *What about harm from the health care system?*

Historical development of concept..

- Netherlands
- Commissions established to pragmatically determine how to balance interpretation of the law and the best interests of individuals in the context of minor drug offences
- “Balance of harms” approach



Historical development - Liverpool

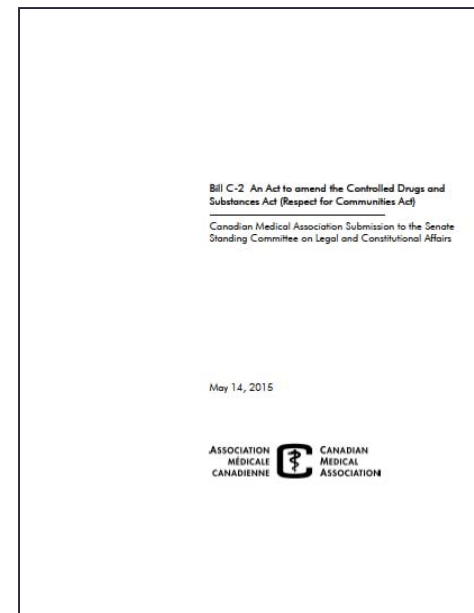
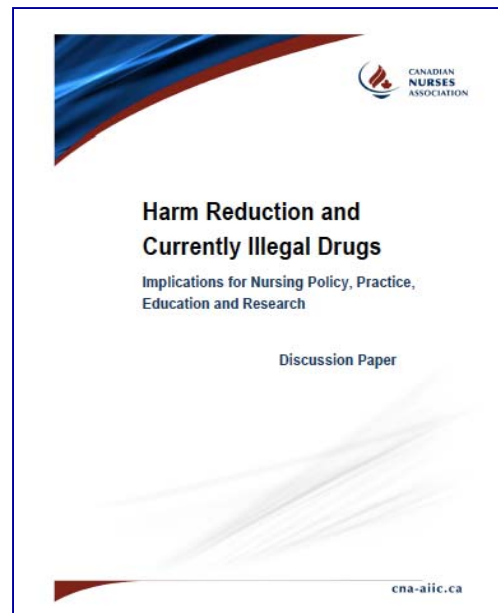


In Canada..

- 1990s – needle exchanges emerged
- 2003 - InSite – Vancouver's safe injection site – opened
- HIV/AIDS public health officials and policy makers engaged
- City of Vancouver – 4 pillar approach
- “Unlikely coalitions” of public health authorities and activists



For health
professionals,
two examples



Some critiques..

- Concept has been “medicalized” and can pull attention away from root societal and political causes
- Limited analysis from theoretical perspectives:
 - Sex and gender
 - Cultural
 - Other social determinants of health
- Is an “enabling” approach
- Yet another form of social control, normalizing deviance
- Still primarily professional-led approaches


What about girls and women?

Women-Centred Harm Reduction

In 2009 a national virtual Community of Practice (vCoP) provided the opportunity for a "virtual discussion" of issues, research, and programming related to girls' and women's substance use in Canada. The goal of the vCoP was to serve as a mechanism for "gendering" the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada. Participants included planners, decision-makers, direct service providers, educators, NGO leaders, policy analysts, researchers, and interested women. The project was sponsored by the British Columbia Centre of Excellence for Women's Health (BCCWEH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

This discussion guide highlights one of the topics explored in the vCoP: its purpose is to stimulate further conversation on gendered approaches to harm reduction.

Gendering the National Framework



- Broader determinants of health not well enough accounted for in the design of harm reduction strategies
- IE. Poverty, mothering, violence, social policies, sex work, HIV/AIDS, criminalization, housing
- Need a sex and gender lens to address intersection of multiple determinants

What about
pregnancy
and
parenting?

Pregnancy and Harm Reduction in Canada

Five key areas:

1. Women and harm reduction: New models of care
2. Women's rights and maternal advocacy
3. Supporting mother and child
4. Different communities, different approaches
5. New issues: Early parenting and attachment, caring for babies with prenatal substance exposure, women and opiates

1. New models of care



History of Harm Reduction and Pregnancy in Canada

- Harm reduction in Canada just beginning – women's health advocates looked to the UK and Netherlands
- Recognition that the consequences of drug use are not the same for all women: poor women, Aboriginal women, and women of colour the most vulnerable to arrest, child apprehension, and poor health outcomes
- Sheway (Vancouver) and Breaking the Cycle (Toronto) in the 1990s – earliest programs in Canada to use harm reduction approaches during pregnancy
- BCRCP 1999 guidelines

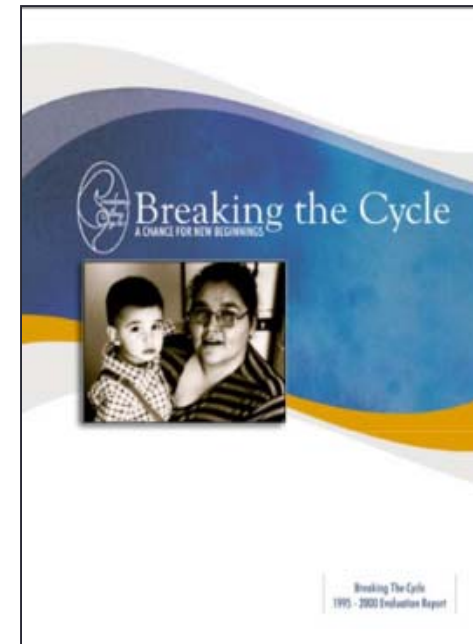
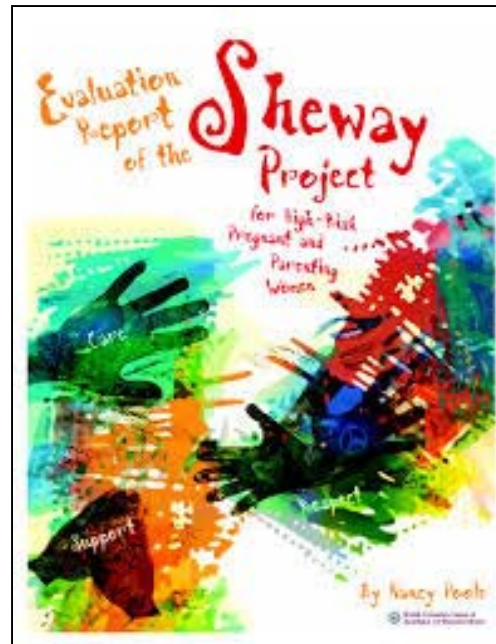


Sheway, Vancouver's Downtown Eastside

- Sheway was established in **1993** in response to a growing understanding of the needs of pregnant and parenting women living in the Downtown Eastside
 - Approximately 40 per cent of infants born over a two year period to mothers living in this area of Vancouver were exposed to alcohol or other drugs in utero.
 - The rate of low birth weight was 33 per cent in the exposed infants, all of whom were apprehended by child protection authorities.
 - Hospital health care providers seeing women arriving at their emergency departments ready to deliver and with no history of prenatal care.

Impact of early evaluation findings

From radical and invisible to international best practice



In 2004, 'Breaking the Cycle' was **recognized by the United Nations Office on Drugs and Crime as an exemplary program** serving pregnant and parenting women with substance use problems and their young children.

2. Women's rights and maternal advocacy

The Story of Ms. G – setting a precedent

- In 1996, "Ms G," a 23-year-old First Nations woman from Winnipeg, was ordered into treatment by the court when five months pregnant with her fourth child due to concerns about glue sniffing.
- Although the original ruling was overturned by the Manitoba Court of Appeal and "Ms G" decided to get treatment of her own accord, Winnipeg Child and Family Services took the case to the **Supreme Court**.
- **Question: Does a woman legally owe a 'duty of care' to her fetus? Should addictions treatment be mandatory for pregnant women?**

What is good public health policy?

Compulsory Treatment for Pregnant Women?

Issues:

1. Research showing the ineffectiveness of forced treatment
2. Women at-risk avoid health care services due to fear they and their children will be apprehended – thus, they are driven underground, deprived of necessary care.
3. Forced treatment laws may be applied unfairly, i.e., to women are poor and/or members of racial minorities.
4. A legal response does not address the systemic and social causes of substance use including violence, sexual abuse, poverty, etc.
5. If fetuses are granted a legal right to care, the court could extend the power to institute control over *any behaviour* of all women of child-bearing age.

Outcome of the Ms. G case: 7 out of 9 Supreme Court Judges said that the court does not have the right to force pregnant substance users into treatment programs.

Recognizing systemic barriers to care



Breaking Barriers

Barriers to effective treatment for pregnant women using substances include:

- Stigma and judgment (substance use as a “lifestyle choice”, “bad mothers”)
- Fear of child welfare involvement
- Lack of support to decrease or cease their substance use
- Lack of availability of appropriate treatment options
- Waiting lists for treatment
- Abstinence as a requirement for admission to treatment
- Unsupportive attitudes of practitioners

Maternal
advocacy ,
social policy,
and ethics

Creating a supportive policy environment

- Legislation, social policy and health care and child welfare practices critical to reducing barriers to care
- Background – key policy areas: (1) addiction treatment (2) health care services (3) child welfare



Download from www.bccewh.bc.ca

SUBSTANCE USE DURING PREGNANCY AN OVERVIEW OF KEY CANADIAN POLICY AND PRACTICE AREAS

BACKGROUND

In Canada, many people are asking questions about how best to support pregnant women who use alcohol and drugs during pregnancy so that they and their babies can have a healthy and safe start in life.

Accessing health care and social supports prenatally is an important factor in improving maternal and infant outcomes. Without prenatal care, women who struggle to abstain from using substances during pregnancy are more likely to miscarry, give birth prematurely and have infants with low birth weights, with symptoms of withdrawal or with alcohol and drug related birth defects and developmental disabilities (1). They are also more likely to have their children removed from their care (1-2). Thus, it is in the best interests of both women and their infants if they are able to access appropriate care and treatment during pregnancy.

Legislation, social policy and health care and child welfare practices can contribute significantly to effective care and support for women who use substances during pregnancy. This background document provides a brief overview of several important areas of policy-making and discusses how policy can contribute to developing supportive health and social services to effectively address substance use during pregnancy.

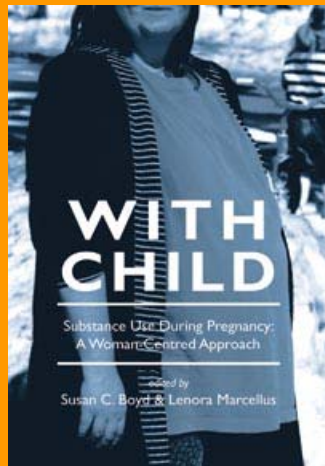
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- ▶ Child Welfare Policy and Practice
- ▶ Moving Ahead: Improving Policy & Practice
- ▶ Resources
- ▶ References

Canada F100 Research Team's Action Team on Prevention from A Woman's Health Determinants Perspective • www.cdrf.ca

3. Supporting mother AND child





Mother AND Child = SUCCESS

Countering the tendency for programs and policy to be “fetal-centric”

- FASD prevention/prenatal substance use seen as a child health and welfare issue
- Focus on Aboriginal women
- Focus on substance use itself – emphasis on abstinence as indicator of success
- Consequences of drug use are mediated by a woman’s social environment, as is her pregnancy

Advocating for the “mother and child unit”, not one or the other, leads to better outcomes

Challenging 'standards of care'

FIR Square: Rooming In Study

- FIR Square - unit at BC Women's Hospital in Vancouver that provides care for women before and after birth and whose pregnancies are complicated by substance use.
- A study of 952 moms and babies at FIR Square found that babies who were kept with their moms after birth (rather than separated and observed in a quiet room) had fewer admissions to the neonatal intensive care unit, a shorter hospital stay, were more likely to be breastfed while in the hospital, and were more likely to go home with their mothers.

Abrahams RR, MacKay-Dunn MH, Nevmerjitskaia V, MacRae GS, Payne SP, Hodgson ZG. An Evaluation of Rooming-in Among Substance-exposed Newborns in British Columbia. *Journal of Obstetricians and Gynaecologists of Canada* ; 2010; 32(9):866-71.

Challenging 'good motherhood'

Drug Use Does Not Equal Poor Parenting

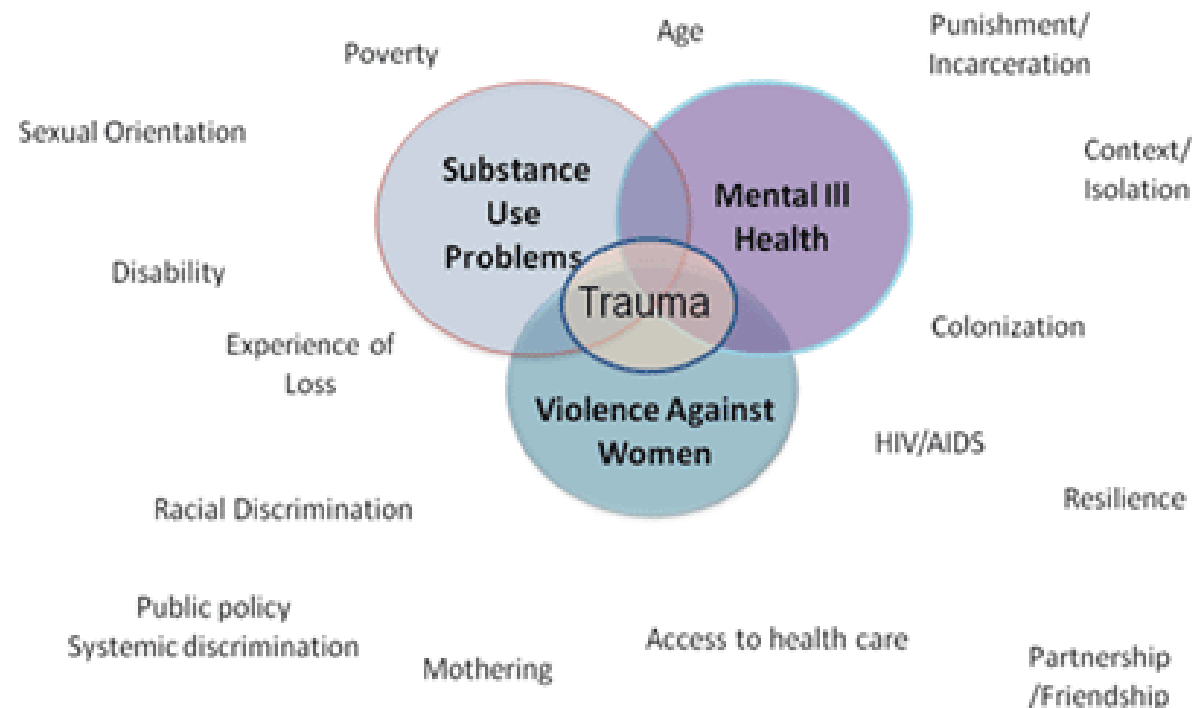
- Fear of child apprehension and custody loss as a barrier to accessing prenatal care and support for many pregnant women who use substances
- With timely support, many women can successfully care for their children.
- Other women can be supported in choosing other models of mothering such as part-time parenting, open adoption, kinship and elder support, and extended family.

Shift: In 1990s, 0% of infants born to moms in the Downtown Eastside went home with their moms; in 2010s, 70% of infants are going home with their moms

The
complexity of
substance use
problems

Promoting women's health – success 'beyond
abstinence'

Making the Links



4. Different communities, different approaches



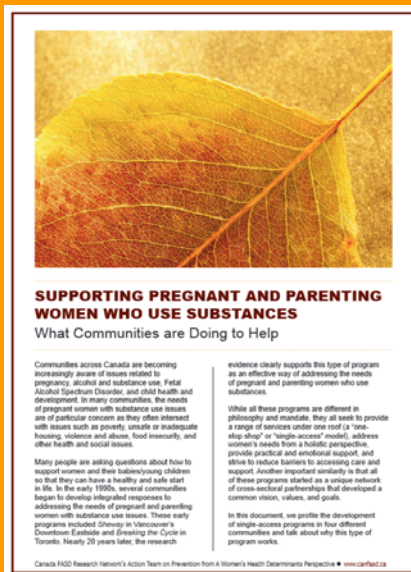
The 'one-stop shop' model

Growth of harm reduction-oriented pregnancy programs

Examples:

- **2000s:** New Choices (Hamilton, ON)
- **2005:** Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women (Surrey, BC)
- **2008:** H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program (Streetworks Program) (Edmonton, AB)
- **2012:** HerWay Home (Victoria, BC)
- **2013:** Manito Ikwe Kagiikwe/The Mothering Project (Winnipeg, MB)
- **2013:** Raising Hope Moving Families Forward (Regina Qu' Appelle Health Region)

Common issues, local solutions



Different Starting Places for Different Communities

Three examples:

- Maxxine Wright Place Project for High Risk Pregnant and Early Parenting Women (Surrey, BC) – collaboration between an anti-violence organization and local health authority
- H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program (Streetworks Program) (Edmonton, AB) – awareness stemming from increased rates of syphilis in newborns
- Manito Ikwe Kagiikwe/The Mothering Project (Winnipeg, MB) – grew out of a community clinic providing primary care and early childhood services

Download “What Communities Are Doing to Help” from www.bccewh.bc.ca

Why do these programs work?

While all of these programs are different from each other in terms of funding, service delivery model, philosophies, and mandates, they share common elements that evaluation studies show work.

OUTREACH	PRACTICAL SUPPORT	HARM REDUCTION	INTEGRATED	MOTHER + CHILD = SUCCESS	TRAUMA + SAFETY
Outreach services work with women where they are - on the streets, in their homes, in the hospital. Outreach provides flexibility for service providers in how they work with women. They can accompany women to appointments, share information informally, and help overcome barriers like lack of transportation and distrust of formal settings.	Without practical support, women cannot succeed in meeting other goals like reducing or stopping their substance use or learning parenting skills. Food vouchers, free prenatal vitamins, socks, bus tickets, and support in finding housing are just a few things that meet women's immediate needs.	A harm reduction approach means that abstinence is just one possible goal for women and that care and support do not require women to address their substance use issues until they are ready. Harm reduction allows for flexible, respectful, and non-judgmental approaches to engaging with and caring for women and their children.	Studies have shown that women who use substances have difficulties accessing services that meet their needs. An integrated "one stop shop" model recognizes that no single service provider or agency can meet the often complex needs of women and that formal and non-traditional partnerships are required (e.g., between child-focused and adult-focused services).	All these programs view the needs of women and the needs of fetus/children as being linked. Programs that focus only on women's health or only on child health miss a big part of the picture. Approaches that view women's substance use outcomes, child development outcomes, and parenting outcomes as linked lead to success.	Substance use is often tied to women's experiences of violence and trauma as well as histories of colonization and migration. Attention to issues of empowerment, trust and safety, cultural awareness, and social justice have shaped the development and success of these programs.

Common elements

Different but effective program models

Marjorie Rosensweig, after visiting 147 of the Pregnant and Postpartum Women and their Infants Programs in the USA in the 1990s, commented:

I have seen time and time again proof that program effectiveness is not dependent on adherence to a single program model. Instead, a set of core concepts and competencies undergirds very different – yet effective – programs.

She summarizes these concepts and competencies as:

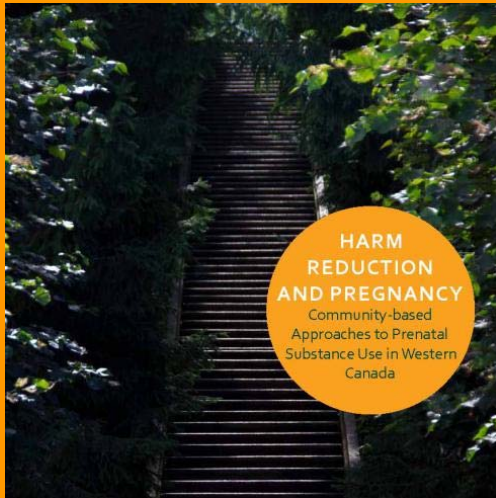
- “Women-focused, taking into account women’s families and relationships”
- “Based on a philosophy of mutual trust and respect”
- “Staffed by people who believe that the glass is generally half full, not half empty”
- “Responsive to clients’ real and pressing needs and concerns, not experts’ concepts of the nature of these needs”

(Rosenzweig, 1998, p.206)

Interventions
to promote a
healthy
pregnancy
and reduce
the harms of
substance use

What does harm reduction during pregnancy look like?

1. Prenatal care
2. Primary health care
3. Dental care
4. Mental health treatment and support
5. Food vouchers (e.g., milk, eggs)
6. Hot meals
7. Prenatal vitamins
8. STI testing
9. Promoting condom use (to prevent STIs)
10. Antiretroviral therapy
11. Buprenorphine and methadone maintenance treatment
12. Nicotine replacement therapy
13. Support with cutting back or quitting smoking
14. Withdrawal management
15. Addiction counselling & treatment
16. Education (e.g., alcohol and tobacco are more likely to have long-term effects on fetus)
17. Promoting safer substance use (e.g., providing clean needles)
18. Rooming in
19. Help with attending appointments (reminders, transportation, advocacy)
20. Stable housing
21. Legal advice and advocacy (e.g., child protection, family, and criminal matters)
22. Financial aid



Evidence for harm reduction during pregnancy

Research shows that harm reduction activities and approaches during pregnancy can:

- Increase engagement and retention in prenatal services and addiction treatment
- Increase referrals to other health and social services and increase engagement in services following birth
- Reduce alcohol and drug use and improve nutrition
- Reduce health care costs
- Improve health outcomes for women and their babies, including fewer preterm births and babies born with low birth weight
- Increase the number of babies discharged home with their mothers following birth
- Encourage breastfeeding, early attachment and improve early childhood development outcomes

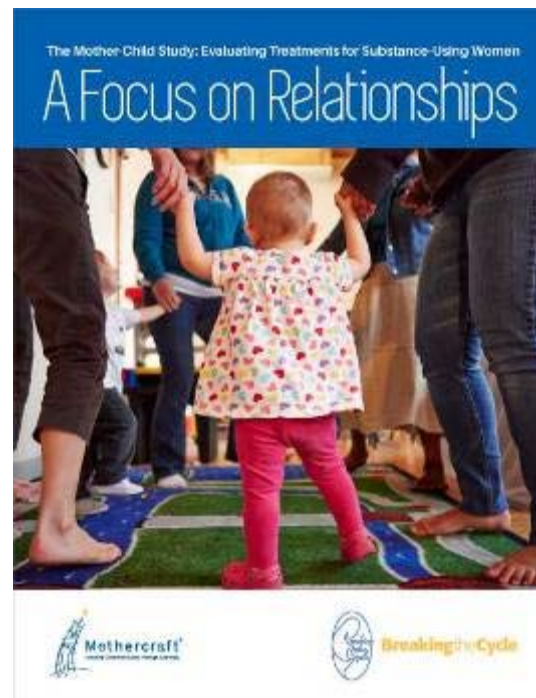
References in *Harm Reduction and Pregnancy: Community-based Approaches to Prenatal Substance Use in Western Canada*. Download from www.bccewh.bc.ca

5. New issues



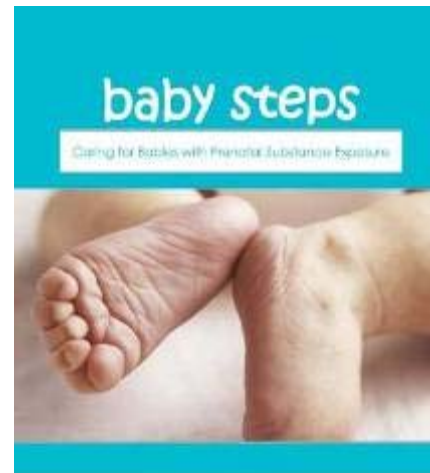
Women as mothers

- Supporting women in their parenting roles – fostering attachment, parenting support, addressing intergenerational trauma, providing culturally safe care



Caring for babies with prenatal substance exposure

- Practices and policies in neonatal intensive care units – training for nurses and other health professionals
- Rooming-in as a standard of care
- Training for caregivers and foster parents
- Advocacy and ethical issues related to meconium testing



Prescription opiates and marijuana use

Challenging the licit/illicit divide and the class divide

- Women from all social and economic groups use substances while pregnant, and,
- Overall, alcohol and tobacco are the most commonly used drugs during pregnancy
- **How do we move beyond a narrow focus on certain groups of women and certain substances as problematic?**
- Prescription medication misuse (especially opioids like morphine and oxycodone) is increasing in Canada
- **Are there opportunities for promoting women's health before and during pregnancy?**
- Legalization/acceptance of marijuana – little know about prenatal effects
- Example: Colorado – Ob/gyns reported women using marijuana to treat morning sickness
- **How do we give women the information they need to make choices about their health?**

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