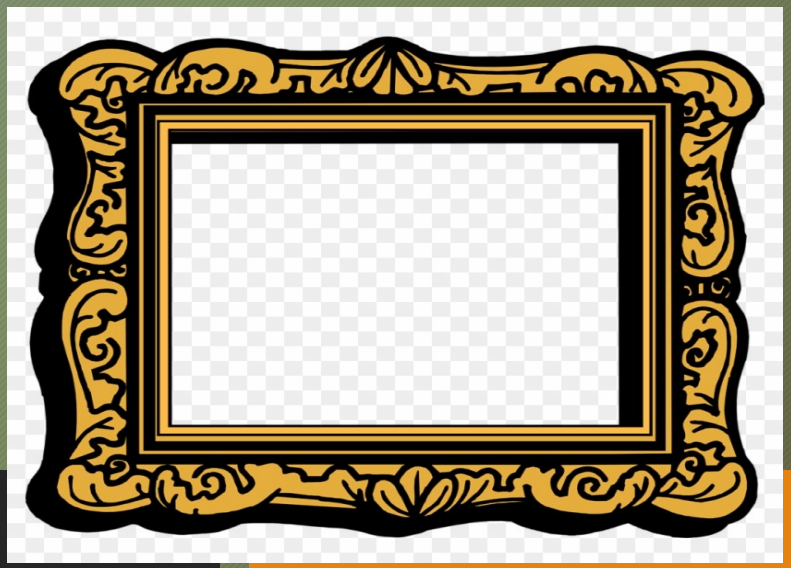


Looking at the bigger picture: Supporting families from trauma informed and health equity approaches

Dr. Lenora Marcellus

Indiana Perinatal Substance Use Conference

August 27, 2019

Disclosure

The content of this presentation does not relate to any product of a commercial entity; therefore, I have no relationships to report.

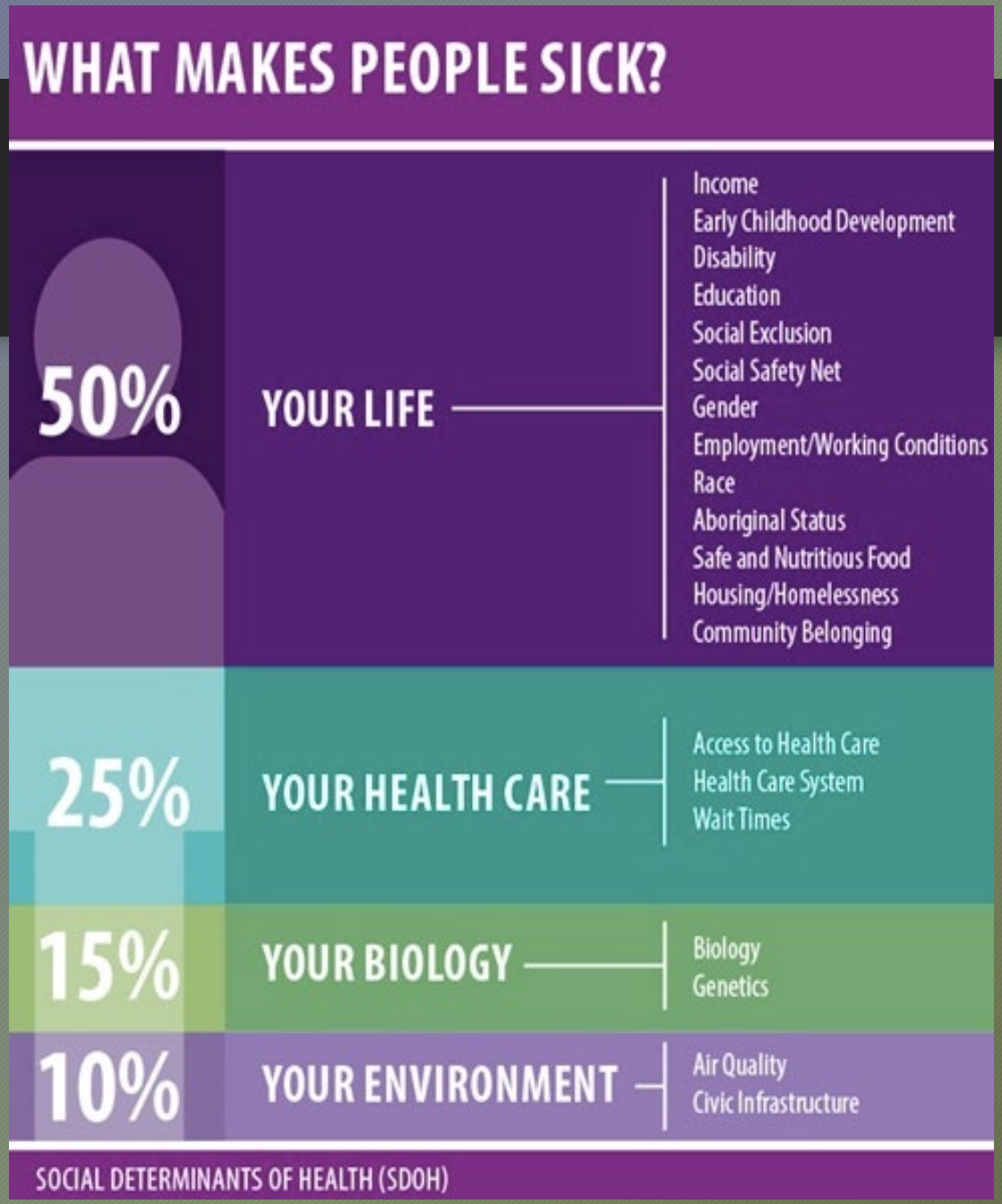
Learning objectives

- Explore the root causes of substance use for women
- Introduce the concepts of trauma informed care, health equity and social determinants of health
- Apply these concepts to supporting women during pregnancy and early parenting
- Provide examples of successful initiatives and lessons learned from programs across Canada to show these concepts “in action”
- Identify two ideas you can take back to your workplace and community

Today's young families

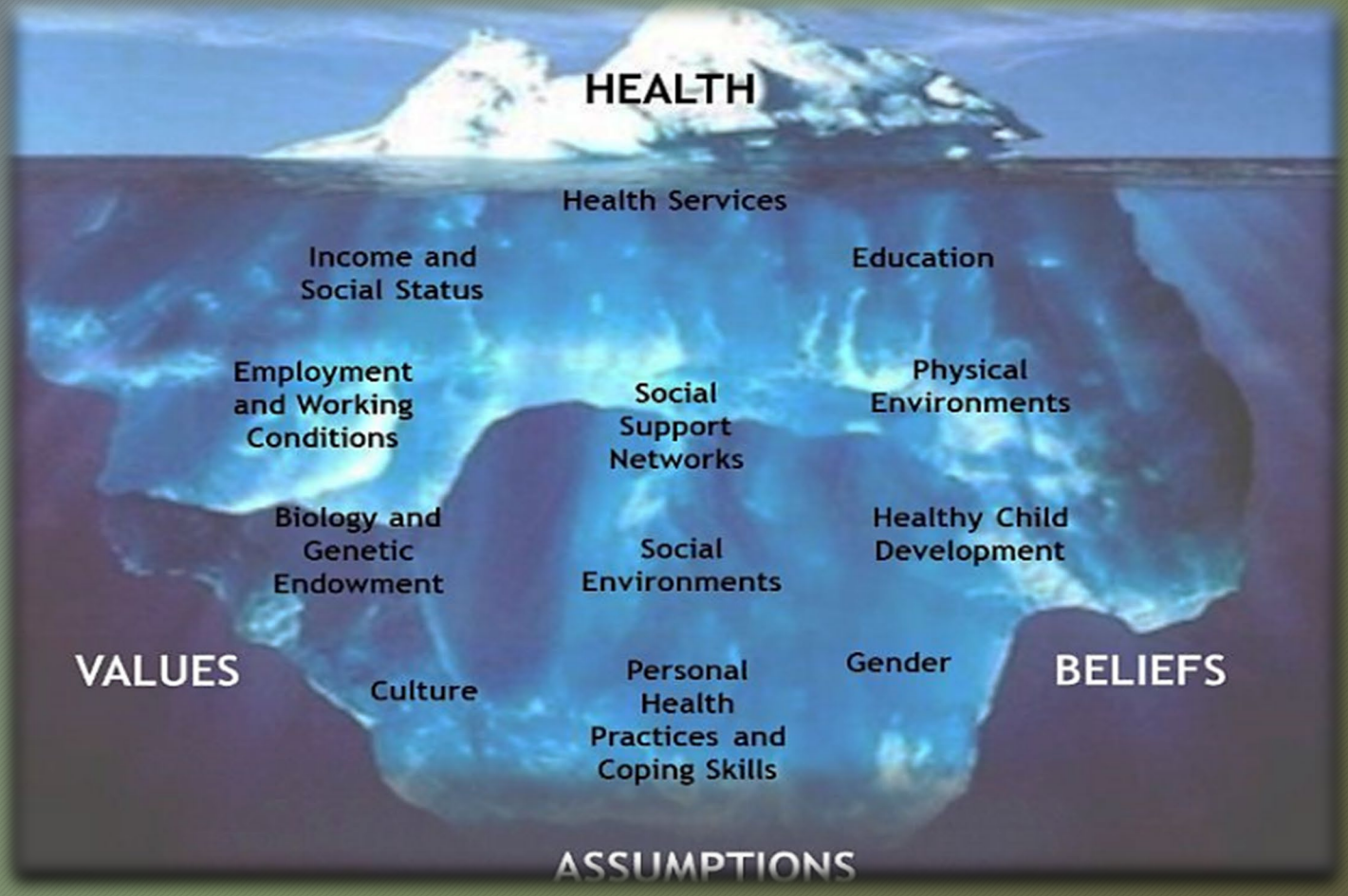
- Growing diversity, complexity and fluidity in family arrangements
  - "No norm is the new norm"
  - Strong link between parent's marital status and likelihood of living in poverty
- Increasing poverty
- More mothers working
- Challenge accessing and affording child care
- Limited maternity leave
- Social challenges

Pew Research Center (December 17, 2015) Parenting in America: Outlook, worries, aspirations are strongly linked to financial situation



http://www.waterloowellingtonlhin.on.ca/forhsps/equity/socialdeterminants.aspx

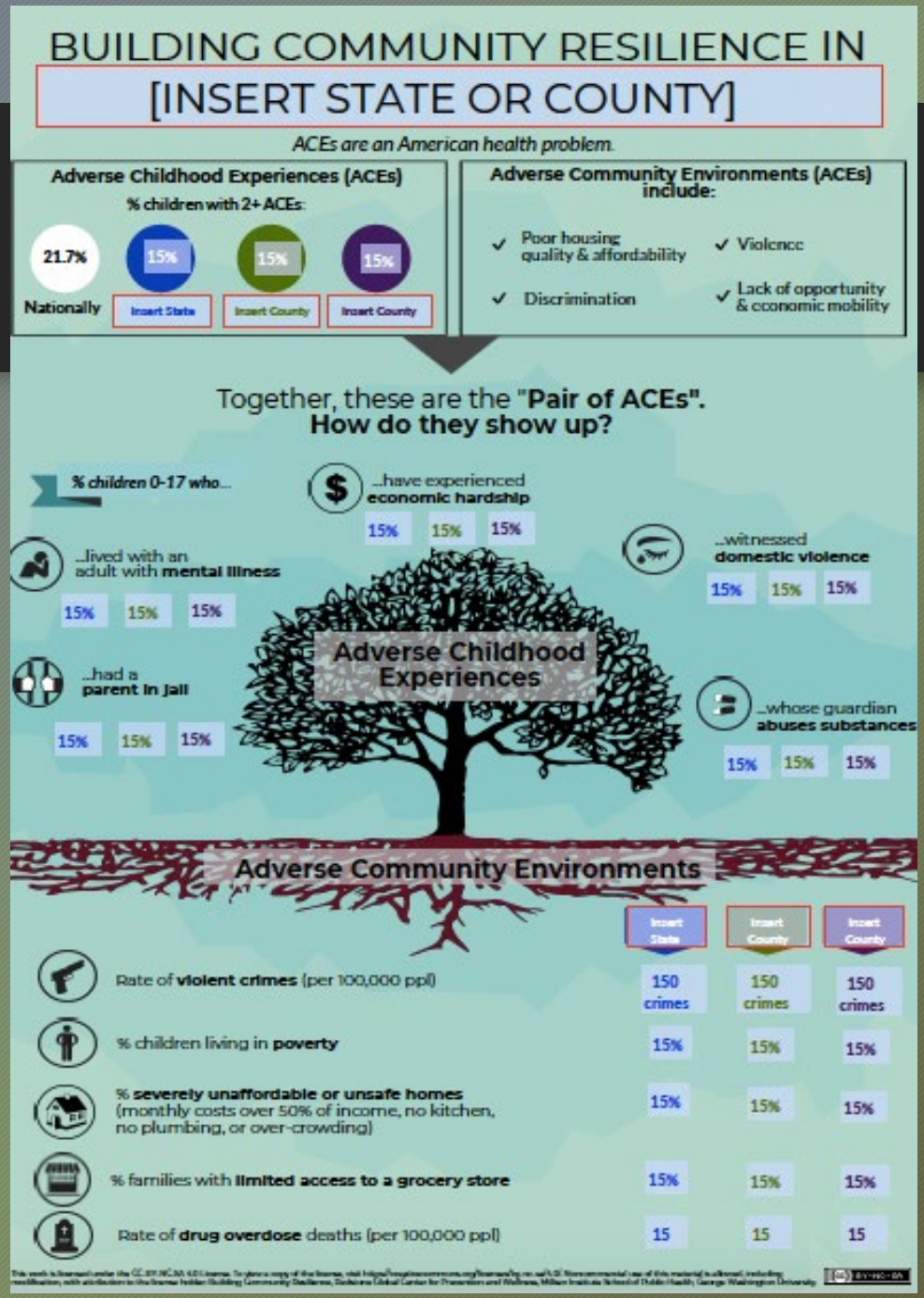
What are social determinants of health (SDoH)?



Glossary of Essential Health Equity Terms: http://nccdh.ca/resources/glossary/

“Pair of ACEs” tree (Ellis & Dietz, 2017)

https://www.google.com/search?q=pair+of+aces&tbm=isch&source=univ&sa=X&ved=2ahUKEwjY-Om664fkAhVRJzQIHfp-BNIQ7Al6BAgIECQ&biw=1045&bih=624#imgrc=RjyNmOfZ2iL3XM:



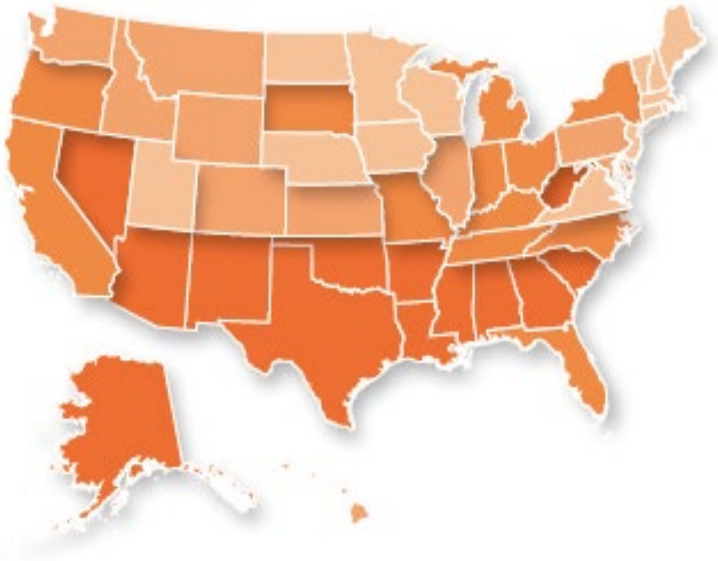
go.gwu.edu/bcrinfographicdata

2019 KIDS COUNT DATA BOOK

STATE TRENDS IN CHILD WELL-BEING

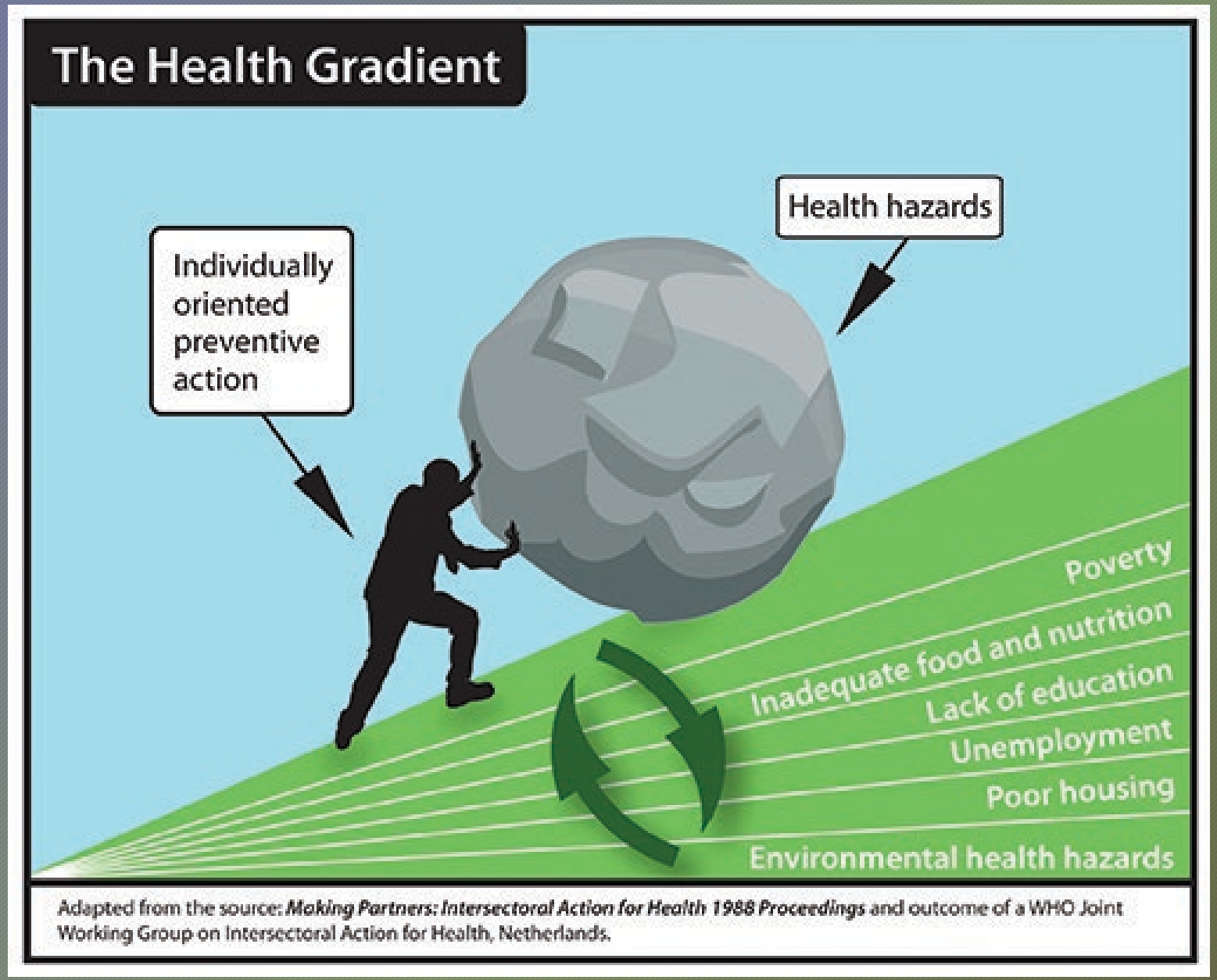
THE ANNIE E. CASEY FOUNDATION

A STATE-TO-STATE COMPARISON OF OVERALL CHILD WELL-BEING: 2019

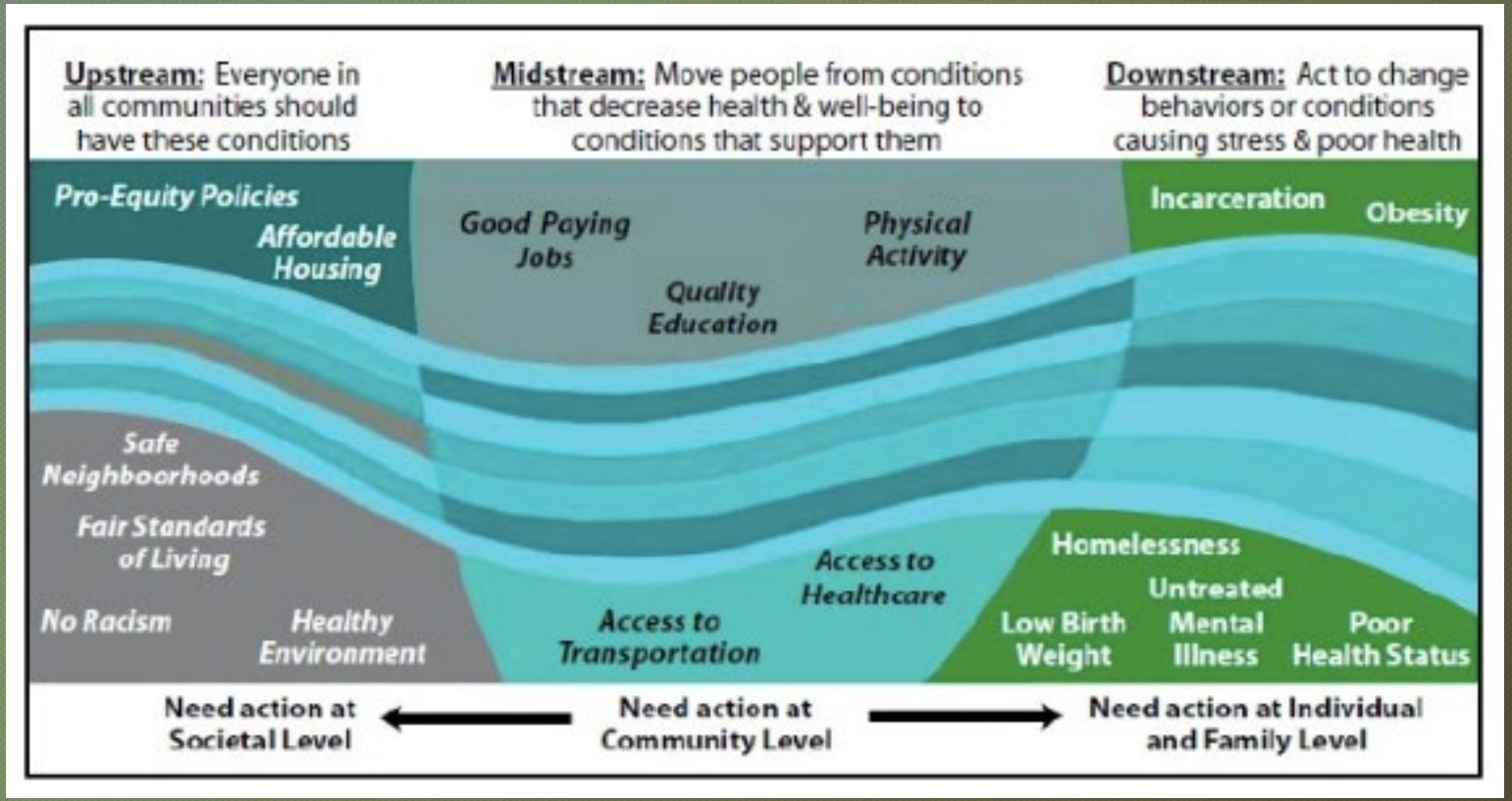


RANKINGS AND KEY

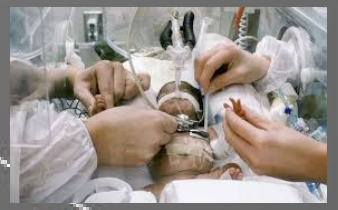
1. New Hampshire
2. Massachusetts
3. Iowa
4. Minnesota
5. New Jersey
6. Vermont
7. Utah
8. Connecticut
9. Maine
10. Virginia
11. North Dakota
12. Nebraska
13. Wisconsin
14. Maryland
15. Kansas
16. Washington
17. Pennsylvania
18. Idaho
19. Rhode Island
20. Colorado
21. Wyoming
22. Montana
23. Illinois
24. Hawaii
25. Delaware
26. South Dakota
27. Ohio
28. Missouri
29. Indiana
30. New York
31. Oregon
32. Michigan
33. North Carolina
34. Kentucky
35. California
36. Tennessee
37. Florida
38. Georgia
39. South Carolina
40. Arkansas
41. Texas
42. Oklahoma
43. West Virginia
44. Alabama
45. Alaska
46. Arizona
47. Nevada
48. Mississippi
49. Louisiana
50. New Mexico


The Health Gradient
Health hazards
Individually oriented preventive action
Poverty
Inadequate food and nutrition
Lack of education
Unemployment
Poor housing
Environmental health hazards
Adapted from the source: Making Partners: Intersectoral Action for Health 1988 Proceedings and outcome of a WHO Joint Working Group on Intersectoral Action for Health, Netherlands.

Classic public health story



Determinants of Population Health



Social determinants of health

Primary prevention

Secondary prevention

Tertiary prevention

From Steven Woolf, MD

What is health equity?

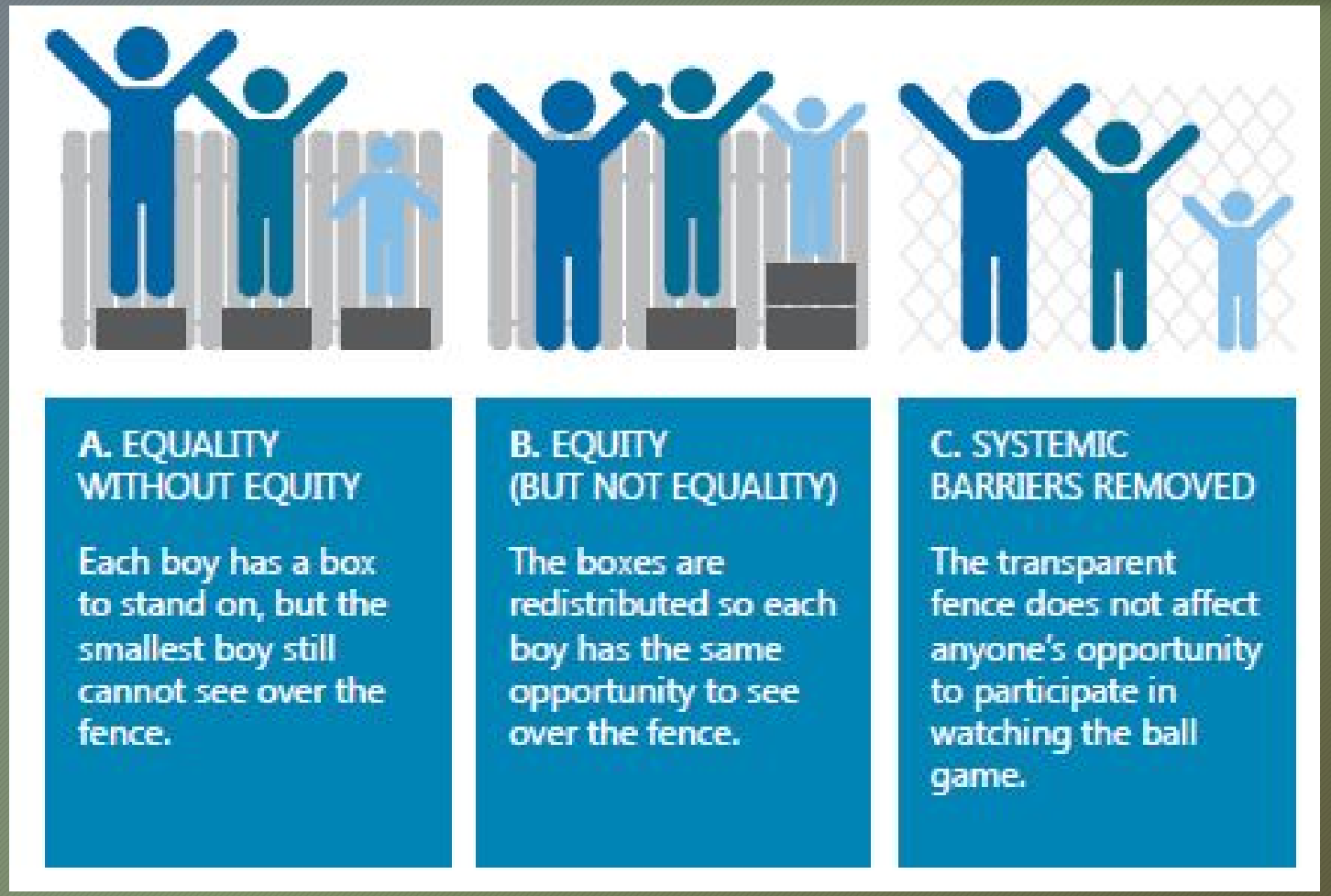
When everyone has a fair opportunity
to reach their full health potential
without disadvantages caused by their
social, economic, or environmental circumstances.

Source:
NCCDH

Health equity does not mean “all the same”

Health inequity	Health inequality
Differences in health associated with social disadvantage that are **modifiable** and considered unfair	Differences in health status between individuals, groups or communities (AKA health disparities) – biological variation, geographical characteristics

We can promote health by supporting individuals and removing barriers



What is an “equity lens”?

“The window is determined by the frames we use to look through. We need a new frame.”

“Life changes the lens you look through.”

Source: NCCDH

Do I see health inequities in my daily practice?

What did I think?

What did I believe?

How did I act?

What might that situation have been like for the individual, family or groups I was working with?

Two potential service pathways

Individuals blamed → Surveillance, risk assessments → *Punishment, child removal*

Holistic approach, SDoH-informed → Community-based, wraparound services → *Greater potential for thriving family life*

We all have a role to play…

HEALTH EQUITY PROMOTION

Winnipeg Regional Health Authority - Health for All. 2016.

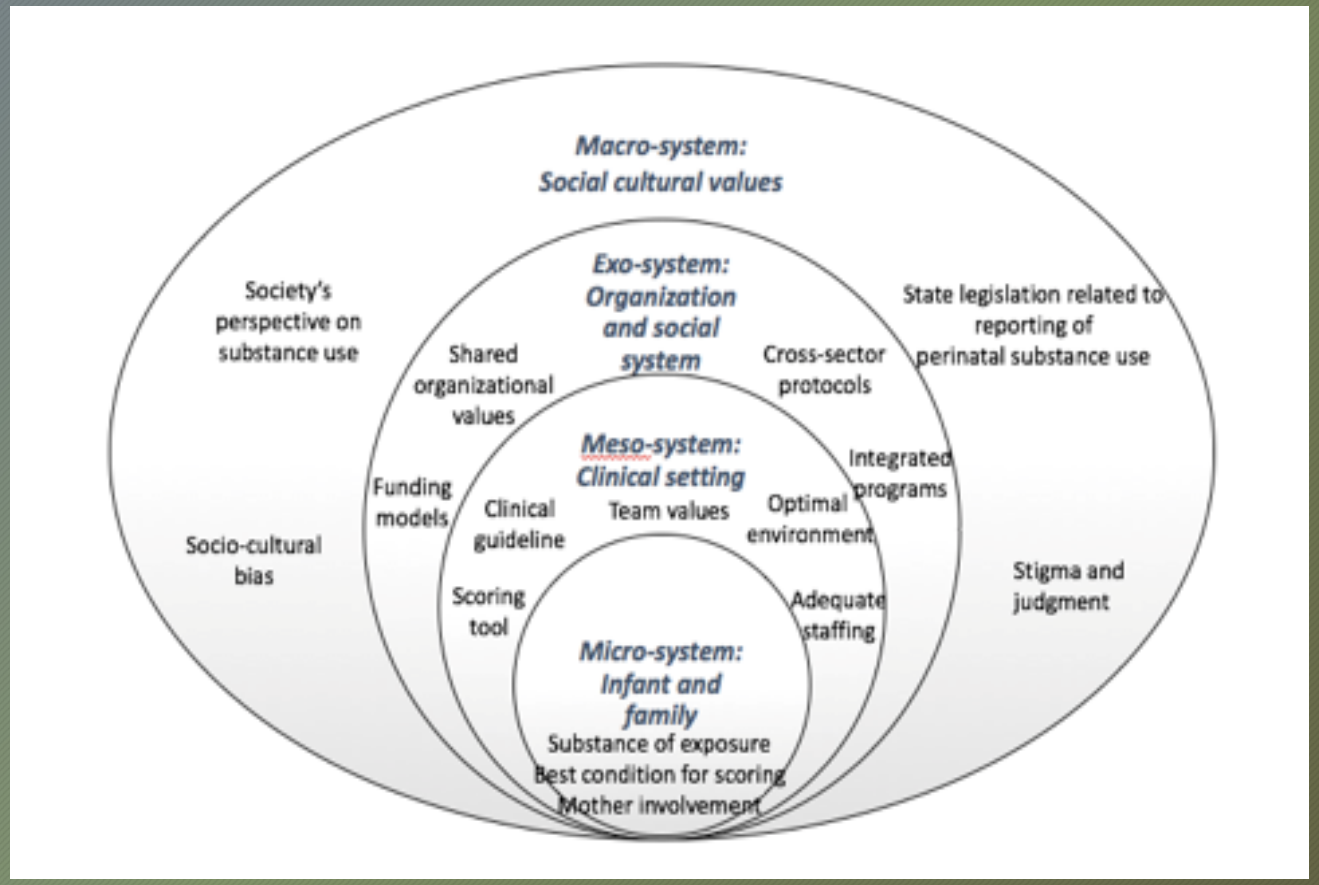
10 THINGS WE CAN REFLECT ON TO PROMOTE HEALTH EQUITY WHEREVER WE WORK…

1. Are our interactions with all people* based on dignity and respect?
2. Do we continually reflect on our assumptions about people and turn them into respectful curiosity?
3. Are we listening genuinely and actively engaging with all people?
4. Do we recognize and respect the strengths of people affected by disadvantage?
5. How can we better align with what is important to people to support empowerment, self-determination and health?
6. What barriers prevent people from accessing and benefiting from our current health services?
7. What can we do better to reach out to people affected by social and economic disadvantage?
8. Are there gaps in services, systems and opportunities? What could we do differently?
9. Who can we partner with to better meet the needs of people affected by social and economic disadvantage?
10. What are my own contributions that support conditions in which all people can achieve their full health potential?

*Patients/clients, families, team members, partners and communities

Learn more: http://www.wrha.mb.ca/about/healthequity/

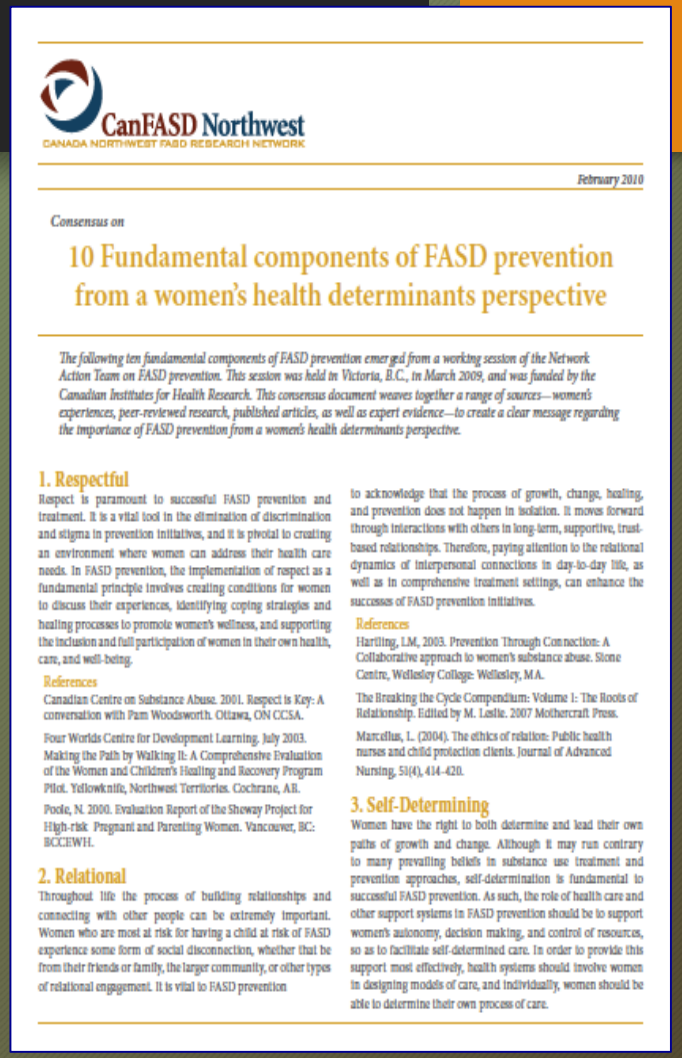
Ecological framework/lens



Marcellus, L. (2018). Social ecological examination of factors that influence the treatment of newborns with Neonatal Abstinence Syndrome. Journal of Obstetric, Gynecologic and Neonatal Nursing, 47(4), 509-519

Canada FASD Research Network Action Team on FASD Prevention

- National
- Funded by provincial, territorial and federal governments
- Four other teams – diagnostics, intervention, child welfare, justice
- Researchers and knowledge users
- Trans-disciplinary
- Virtual and face-to-face
- Consensus document based on evidence, expert advice, women's experiences



CanFASD Northwest
CANADA NORTHWEST FASD RESEARCH NETWORK

February 2010

Consensus on

10 Fundamental components of FASD prevention from a women's health determinants perspective

The following ten fundamental components of FASD prevention emerged from a working session of the Network Action Team on FASD prevention. This session was held in Victoria, B.C., in March 2009, and was funded by the Canadian Institutes for Health Research. This consensus document weaves together a range of sources—women's experiences, peer-reviewed research, published articles, as well as expert evidence—to create a clear message regarding the importance of FASD prevention from a women's health determinants perspective.

1. Respectful

Respect is paramount to successful FASD prevention and treatment. It is a vital tool in the elimination of discrimination and stigma in prevention initiatives, and it is pivotal to creating an environment where women can address their health care needs. In FASD prevention, the implementation of respect as a fundamental principle involves creating conditions for women to discuss their experiences, identifying coping strategies and healing processes to promote women's wellness, and supporting the inclusion and full participation of women in their own health, care, and well-being.

References

Canadian Centre on Substance Abuse. 2001. Respect is Key: A conversation with Pam Woodsworth. Ottawa, ON CCSA.

Four Worlds Centre for Development Learning. July 2003. Making the Path by Walking It: A Comprehensive Evaluation of the Women and Children's Healing and Recovery Program Pilot. Yellowknife, Northwest Territories. Cochrane, AB.

Poole, N. 2000. Evaluation Report of the Sheway Project for High-risk Pregnant and Parenting Women. Vancouver, BC: BCCEWH.

2. Relational

Throughout life the process of building relationships and connecting with other people can be extremely important. Women who are most at risk for having a child at risk of FASD experience some form of social disconnection, whether that be from their friends or family, the larger community, or other types of relational engagement. It is vital to FASD prevention to acknowledge that the process of growth, change, healing, and prevention does not happen in isolation. It moves forward through interactions with others in long-term, supportive, trust-based relationships. Therefore, paying attention to the relational dynamics of interpersonal connections in day-to-day life, as well as in comprehensive treatment settings, can enhance the successes of FASD prevention initiatives.

References

Hartling, LM, 2003. Prevention Through Connection: A Collaborative approach to women's substance abuse. Stone Centre, Wellesley College: Wellesley, MA.

The Breaking the Cycle Compendium: Volume 1: The Roots of Relationship. Edited by M. Leslie. 2007 Mothercraft Press.

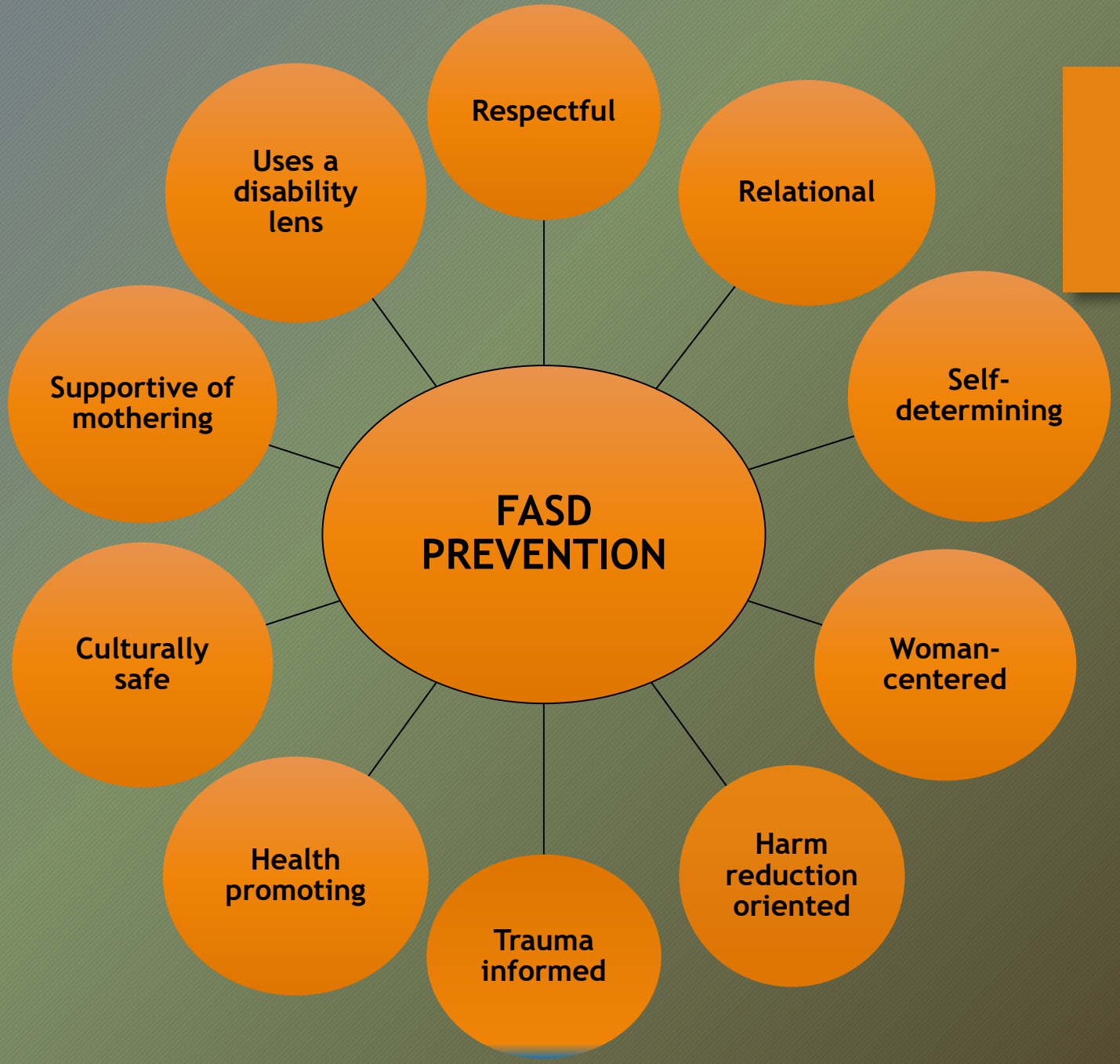
Marcellus, L. (2004). The ethics of relation: Public health nurses and child protection clients. Journal of Advanced Nursing, 51(4), 414-420.

3. Self-Determining

Women have the right to both determine and lead their own paths of growth and change. Although it may run contrary to many prevailing beliefs in substance use treatment and prevention approaches, self-determination is fundamental to successful FASD prevention. As such, the role of health care and other support systems in FASD prevention should be to support women's autonomy, decision making, and control of resources, so as to facilitate self-determined care. In order to provide this support most effectively, health systems should involve women in designing models of care, and individually, women should be able to determine their own process of care.


THE
TOP TEN
LIST

http://www.fasd-evaluation.ca/home/



#1 Respectful

What? How?

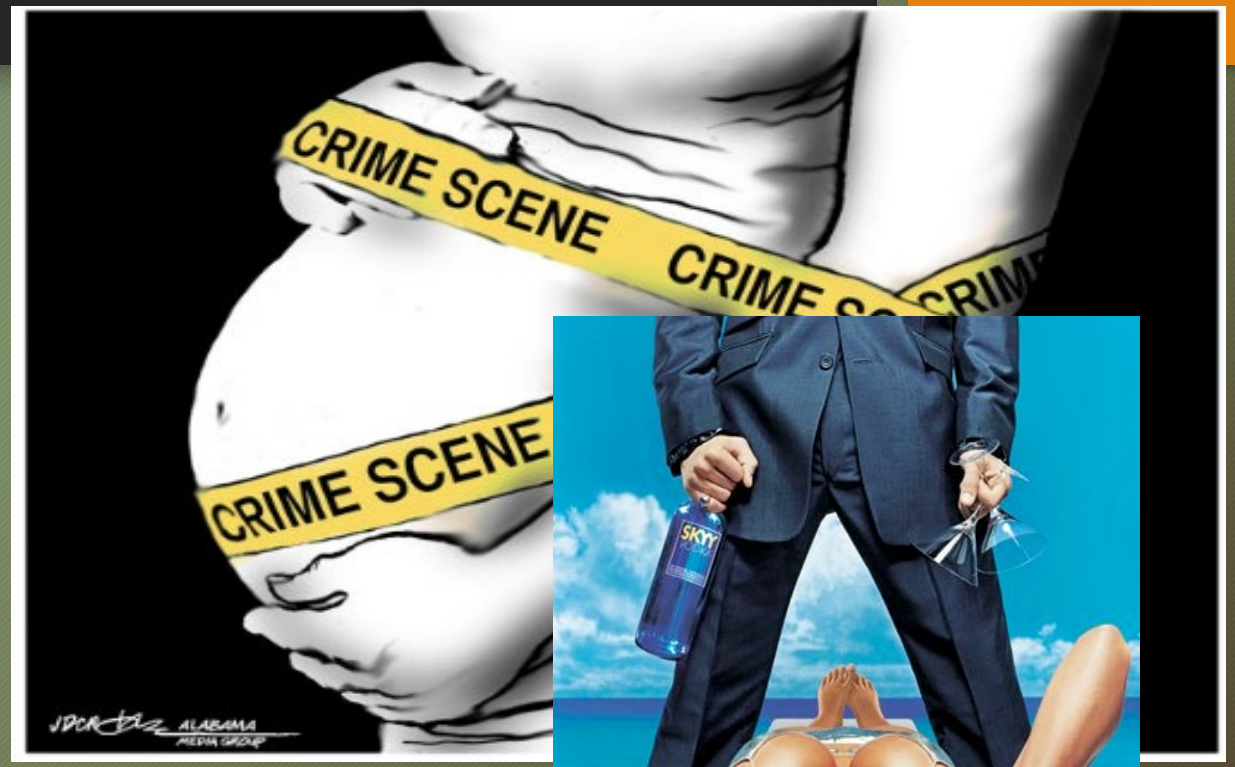
- Fundamental aspect of health care, not add-on, with dignity, compassion
- Ethical and professional imperative
- Link to quality and safety – the case of the Staffordshire Trust
- Health related stigma

- *Reflect on own attitudes and judgments*
- *Language*
- *Contribute to non-judgmental work place*
- *Small things*

Howard, H. (2015). Reducing stigma: Lessons from opioid-dependent women. Journal of Social Work Practice in the Addictions, 15(4), 418-438.

Macro-system: Social-cultural values

- Society's perspective on substance use
- Stigma and judgment
- Socio-cultural bias:
  - Gendered, sexualized
  - Racialized
- Legislation – justice response:
  - Punitive
  - Infant valued more than mother
  - Varies – by state, substance, circumstance (Guttenburg Institute; Paltrow and NAPW)



Springer, K. (2010). The race and class privilege of motherhood: The New York Times presentations of pregnant drug-using women. Sociological Forum, 25(3), 476-499

#2 Relational

What? How?

- Relationship between substance use and social disconnection
- Built on theories of: attachment, development, historical trauma
- Link to trust
- Implications for infant/child brain development

- *Careful admission*
- *Priorize the mother-infant relationship*
- *Provide knowledge on development and parenting – contextualize*

Peplar, D., Motz, M., Leslie, M., jenkins, J., Espinet, S. & Reynolds, W. (2014). The Mother-Child Study: Evaluating treatments for substance-using women – A focus on relationships. Toronto: Breaking the Cycle.

Profile of BTC Families

#3
Self-determining

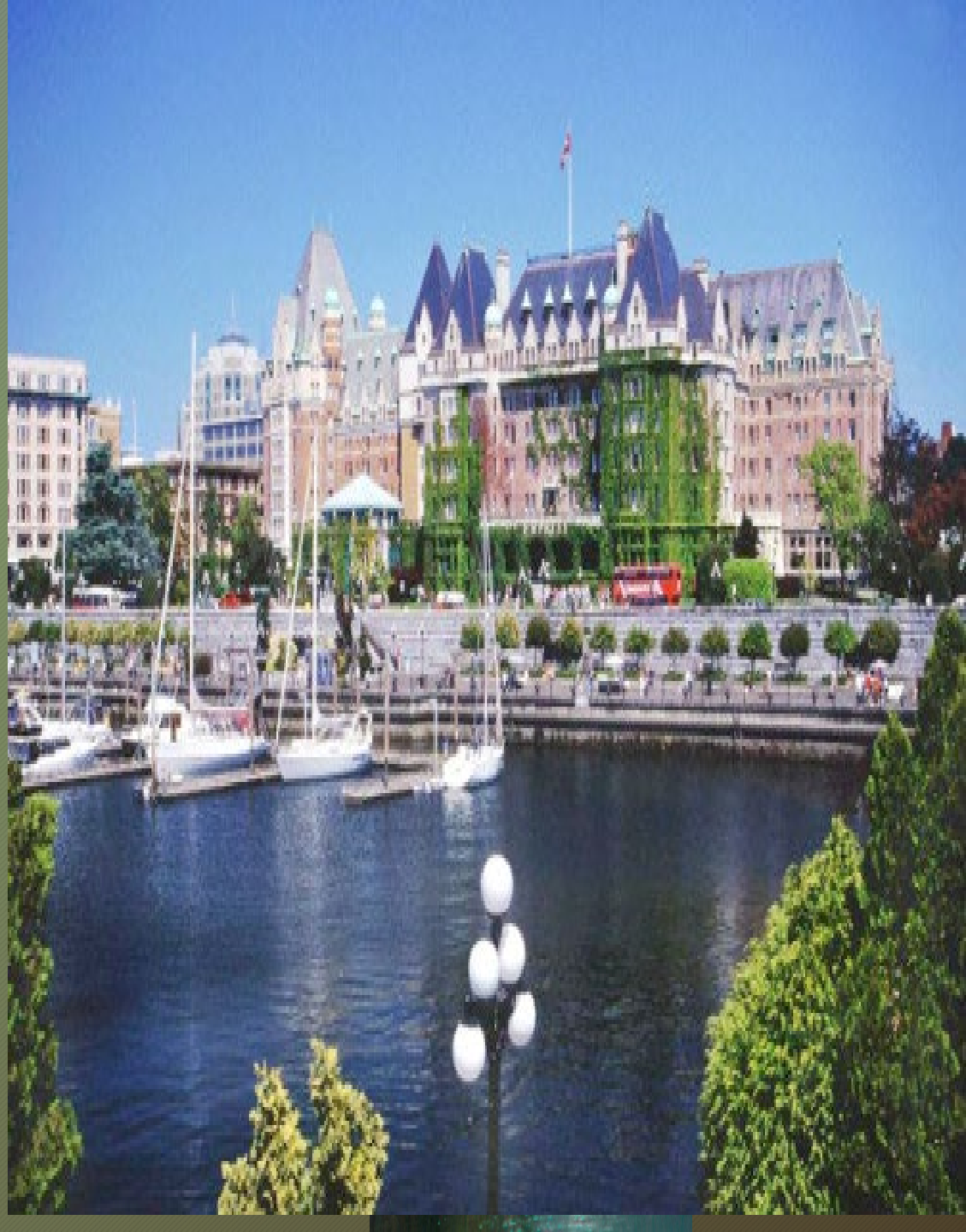
What? How?

- Cardinal principle of modern law and human rights
- Supporting autonomy, decision making, control – intersections, power
- Consider health system – think about those who are marginalized
- Feminist ethics approaches – addressing maternal-fetal rights tension

- *Linked to motivation and behavior change*
- *Involve women in care design*
- *Learn about Stages of Change, Motivational Interviewing and Appreciative Inquiry*

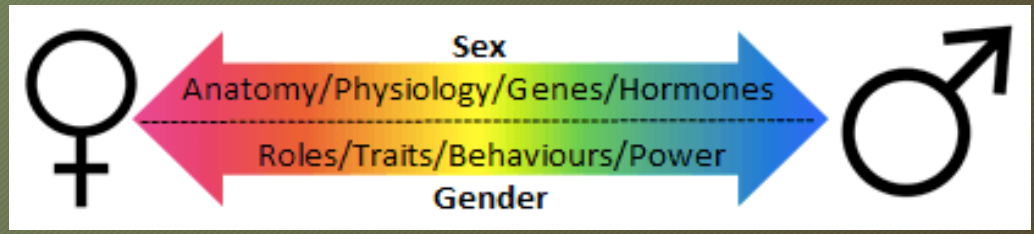
Uberoi, D. & Bruyn, M. (2013). Human rights versus legal control over women's reproductive self-determination. Health and Human Rights Journal, 15(1).

#4
Woman-centered



Example of a woman and family-centered approach

BC WOMEN'S HOSPITAL+ HEALTH CENTRE



What? How?

- Many systems designed without consideration of sex and gender differences
- Holistic and comprehensive approach to health – WHO definition – resource for everyday life
- *Apply sex and gender lens to practices, policies, programs – options, barriers, facilitators*

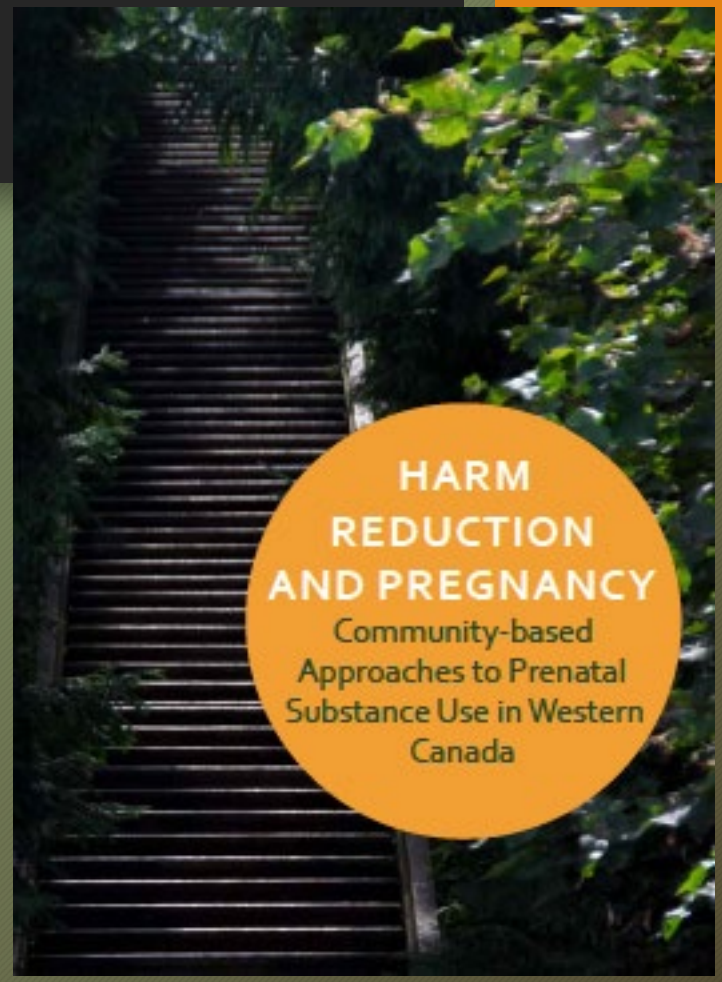
Vancouver Richmond Health Board (2001). *A framework for women-centered health.* Vancouver, BC: Author.

#5
Harm reduction oriented

What? How?

- Not always about the substance use
- Pragmatic – reduce consequences of risky behaviors
- Small steps matter

- *Supporting immediate needs – ie. food, shelter, safety*
- *Think about how the health system might contribute to harm*



Nathoo, T., Marcellus, L., Bryans, M., Clifford, D., Louie, S., Penaloza, D., Seymour, A., Taylor, M. & Poole, N. (2015). *Harm reduction and pregnancy: Community-based approaches to prenatal substance use in Western Canada.* Victoria and Vancouver, BC: University of Victoria School of Nursing and British Columbia Centre of Excellence for Women's Health

http://bccewh.bc.ca/wp-content/uploads/2015/02/Hreduction-and-Preg-Booklet_2015_web.pdf

Lessons learned from a harm-reduction oriented program

- A non-judgmental, relational approach is foundational
- Harm reduction is helping women achieve their goals
- Providing both outreach/one-to-one support and groups is key
- Having excellent staff is critical
- Relationship-building between staff and community partners is essential
- Leadership from multi-sectoral partners is critical

Her Way Home

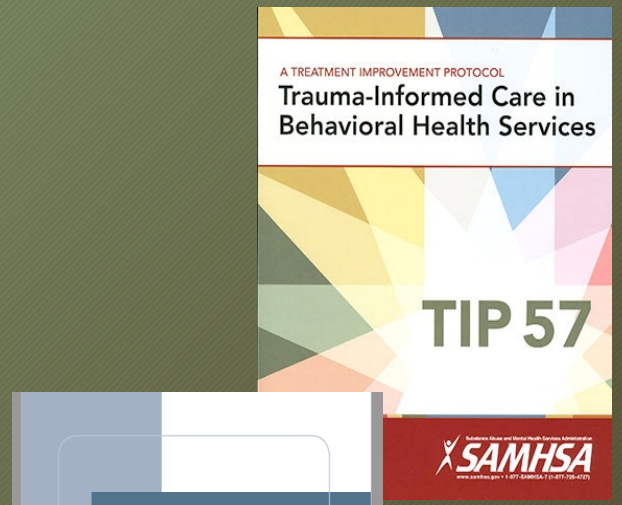
Child Focused • Women Centred • Family Oriented

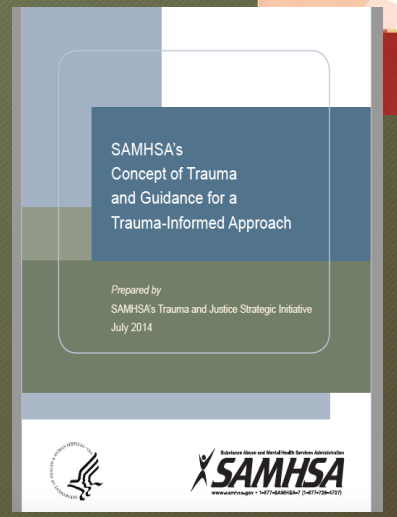
#6
Trauma informed

What? How?

- Trauma is the response that happens when an event, series of events, or set of circumstances is experienced by an individual as physically or emotionally harmful or threatening (SAMHSA, 2014)
- ACE study – physiological links to life course stress
- Considerations from infant, parent and community perspectives - intergenerational
- Many roots to trauma

- *SAMHSA 4 "R" elements: realizing, recognizing, responding, resisting*
- *Universal approach*
- *Recognize trauma symptoms as adaptations*





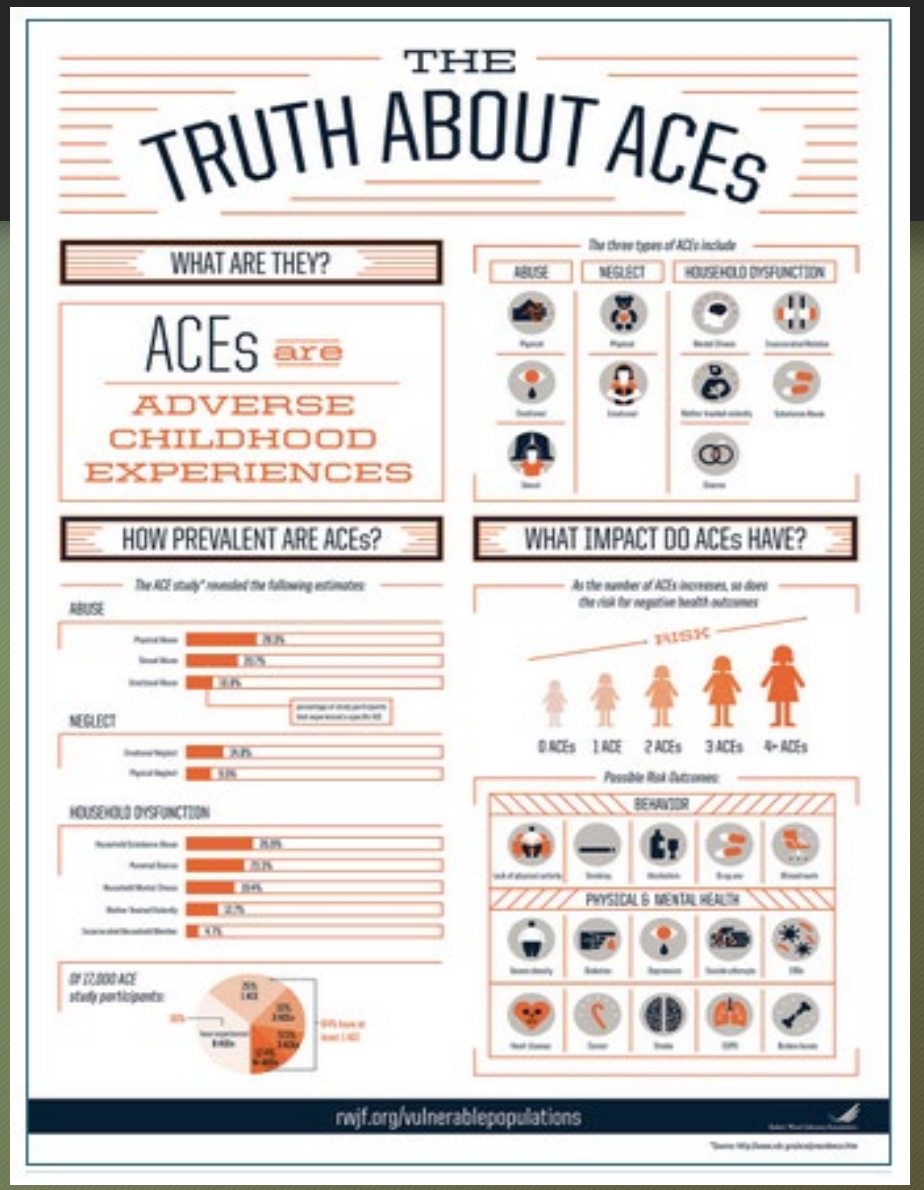
Responding: SAMHSA's 6 Principles of Trauma-Informed Practice

Family Centered Care Core Concepts (IPFCC)	Principles of trauma-informed practice
Respect and dignity	Safety Empowerment Trustworthiness
Information sharing	Transparency
Participation	Voice Peer support
Collaboration	Collaboration and mutuality Choice
	Cultural, historical and gender issues

Realizing:

A program, organization, or system that is trauma-informed **realizes** *the widespread impact of trauma and understands potential paths for recovery;* **recognizes** *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* **responds** *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* **resist re-traumatization.**

https://www.integration.samhsa.gov/clinical-practice/trauma



Recognizing: The effects of trauma

Individual levels

Isolation, shame, anger, self-hatred, fear of authority, low self-esteem, self-destructive behaviors, acting aggressively

Family levels

Unresolved grief, difficulty with parenting effectively, family violence, loss of identity

Community levels and societal levels

Loss of connectedness and collective support, increased suicide rate, communal violence, dependency

This applies to us too..

- Secondary trauma, vicarious trauma, burnout, compassion fatigue
- Multiple contributing factors today..
    - The families that we are caring for
    - Workplace stressors
    - Personal context
- Important link to quality of care and safe care

Best Start (2012). When compassion hurts: Burnout, vicarious trauma and secondary trauma in prenatal and early childhood service providers. Ottawa, ON.

Responding: How can we create a trauma-informed environment?

- Add content about trauma informed care to team orientation
- Provide opportunities for debriefing for team
- Provide opportunities for learning and building of skills
- Set a welcoming tone when women arrive – integrated response from all team members, from unit clerks to direct care workers
- Establish a comforting and welcoming physical environment – emphasize physical and emotional safety
- Use strength-based, person-first language (change language away from "controlling, manipulative, uncooperative, attention seeking, drug seeking, bad mother, etc.)

> *"Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land."*
>
> Sandra Bloom, MD,
> Creator of the Sanctuary Model

Menschner & Maul (2016). Key ingredients for successful trauma-informed care implementation. Center for Health Care Strategies (https://www.chcs.org/)

Resisting re-traumatization: Examples of triggers in the hospital environment

Triggers:

- Feeling lonely, not being listened to, feeling isolated, lack of privacy, being stared at, not having control, being touched, being pressured

Re-traumatizing practices:

- Dark rooms and flashlights, panicked staff, security officers in uniforms, standing over someone while they are sitting, loud/sudden noises, surprises (someone coming up from behind)

#7
Health promoting

What? How?

- Impact of social determinants of health (SDoH) on overall well-being – context for substance use
- Need responses that are cross-sectoral

- *Consider if there are other community partners you need to connect with to address SDOH*
- *Hear from women what steps they want to take first (this is also harm reduction oriented)*

#8
Culturally safe

What? How?

- Based on the principle that the people receiving care decide what is safe or unsafe
- Also applies to vulnerable populations – takes stigma, discrimination, trauma into account
- Going beyond ”the other”

- *The cultural competence journey – awareness, sensitivity, competence, humility*
- *Consider the behaviors and attitudes and policies that support effective work with diverse populations*

Darroch, F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D. & Nosker, R. (2017). The United States does CAIR about cultural safety: Examining cultural safety within Indigenous health contexts in Canada and the United States. Journal of Transcultural Nursing, 28(3), 269-277.


A TREATMENT IMPROVEMENT PROTOCOL
Improving Cultural Competence
TIP 59
SAMHSA


1-2: The Continuum of Cultural Competence
Stage 1
Stage 2
Stage 3
Stage 4
Stage 5
Cultural Destructiveness
Cultural Incapacity
Cultural Blindness
Cultural Precompetence
Cultural Competence & Proficiency

#9
Supportive of mothering

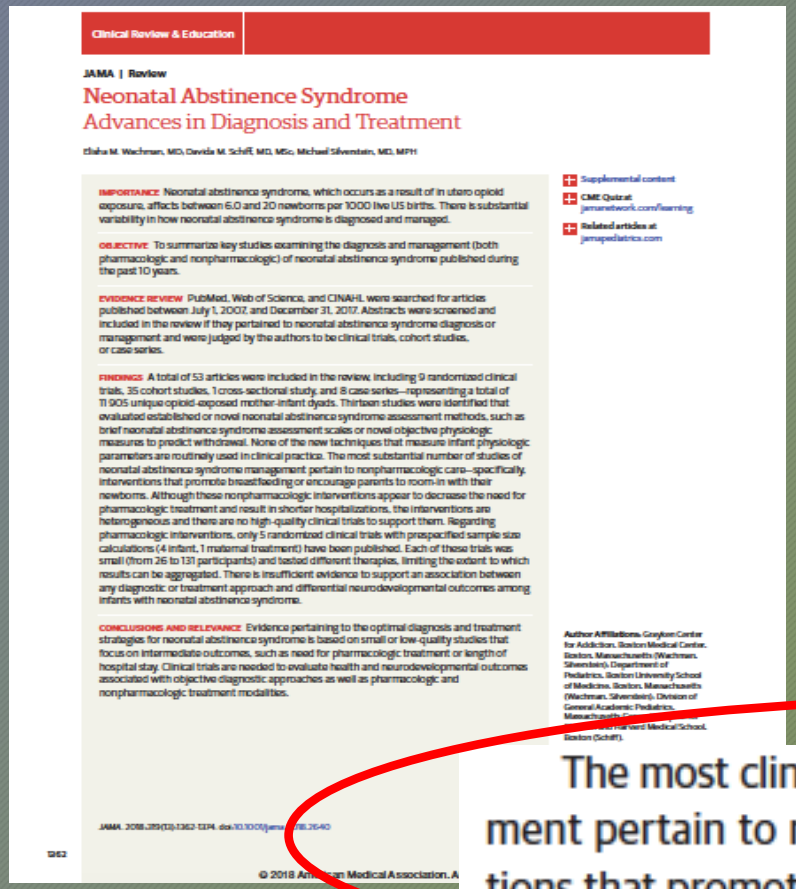
What? How?

- Substance use is often equated with being a bad mother
- Impact of loss of custody on mother, infant, family
- Range of models for mothering is possible

- *Keeping mother and infant together when possible*
- *Supporting parenting, short term in hospital and longer term in community and through treatment*

CBC

Wachman et al. (JAMA April 2018): Key findings



Clinical Review & Education

JAMA | Review

Neonatal Abstinence Syndrome
Advances in Diagnosis and Treatment

Elisha M. Wachman, MD; Davida M. Schiff, MD, MSc; Michael Silverstein, MD, MPH

IMPORTANCE Neonatal abstinence syndrome, which occurs as a result of in utero opioid exposure, affects between 6.0 and 20 newborns per 1000 live US births. There is substantial variability in how neonatal abstinence syndrome is diagnosed and managed.

OBJECTIVE To summarize key studies examining the diagnosis and management (both pharmacologic and nonpharmacologic) of neonatal abstinence syndrome published during the past 10 years.

EVIDENCE REVIEW PubMed, Web of Science, and CINAHL were searched for articles published between July 1, 2007, and December 31, 2017. Abstracts were screened and included in the review if they pertained to neonatal abstinence syndrome diagnosis or management and were judged by the authors to be clinical trials, cohort studies, or case series.

FINDINGS A total of 53 articles were included in the review, including 9 randomized clinical trials, 35 cohort studies, 1 cross-sectional study, and 8 case series—representing a total of 11 905 unique opioid-exposed mother-infant dyads. Thirteen studies were identified that evaluated established or novel neonatal abstinence syndrome assessment methods, such as brief neonatal abstinence syndrome assessment scales or novel objective physiologic measures to predict withdrawal. None of the new techniques that measure infant physiologic parameters are routinely used in clinical practice. The most substantial number of studies of neonatal abstinence syndrome management pertain to nonpharmacologic care—specifically, interventions that promote breastfeeding or encourage parents to room-in with their newborns. Although these nonpharmacologic interventions appear to decrease the need for pharmacologic treatment and result in shorter hospitalizations, the interventions are heterogeneous and there are no high-quality clinical trials to support them. Regarding pharmacologic interventions, only 5 randomized clinical trials with prespecified sample size calculations (4 infant, 1 maternal treatment) have been published. Each of these trials was small (from 26 to 131 participants) and tested different therapies, limiting the extent to which results can be aggregated. There is insufficient evidence to support an association between any diagnostic or treatment approach and differential neurodevelopmental outcomes among infants with neonatal abstinence syndrome.

CONCLUSIONS AND RELEVANCE Evidence pertaining to the optimal diagnosis and treatment strategies for neonatal abstinence syndrome is based on small or low-quality studies that focus on intermediate outcomes, such as need for pharmacologic treatment or length of hospital stay. Clinical trials are needed to evaluate health and neurodevelopmental outcomes associated with objective diagnostic approaches as well as pharmacologic and nonpharmacologic treatment modalities.

Supplemental content
CME Quiz at jamanetwork.com/learning
Related articles at jamapediatrics.com

Author Affiliations: Grayken Center for Addiction, Boston Medical Center, Boston, Massachusetts (Wachman, Silverstein); Department of Pediatrics, Boston University School of Medicine, Boston, Massachusetts (Wachman, Silverstein); Division of General Academic Pediatrics, Massachusetts [illegible] Harvard Medical School, Boston (Schiff).

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The most clinically meaningful interventions in NAS management pertain to nonpharmacologic care—specifically, interventions that promote parental rooming-in and breastfeeding. These

- 53 articles in past 10 years
- 13 related to assessment methods
- 25 related to non-pharmacological care – rooming in; breastfeeding/infant feeding; acupuncture; location of care (inpatient versus outpatient)
- 11 related to infant pharmacological management
- 4 related to maternal pharmacological management

#10
Uses a disability lens

What? How?

- Substance use often intergenerational – consider maternal FASD
- FASD - invisible and permanent physical disability with behavioral symptoms
- Most common developmental disability in the developed world. Conservative estimate to US of $4 billion annually.

- *Learn about the primary and secondary FASD effects framework (Dr. Ann Streissguth) – importance of actions like structure, practice of parenting skills*
- *Avoid making assumptions – "that parent is unmotivated" – may be a need for diagnosis and ongoing support*

http://www.samhsa.gov/fetal-alcohol-spectrum-disorders-fasd-center

Thank You

lenoram@uvic.ca