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

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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_
WHAT MAKES PEOPLE SICK?

50% YOUR LIFE
- Income
- Early Childhood Development
- Disability
- Education
- Social Exclusion
- Social Safety Net
- Gender
- Employment/Working Conditions
- Race
- Aboriginal Status
- Safe and Nutritious Food
- Housing/Homelessness
- Community Belonging

25% YOUR HEALTH CARE
- Access to Health Care
- Health Care System
- Wait Times

15% YOUR BIOLOGY
- Biology
- Genetics

10% YOUR ENVIRONMENT
- Air Quality
- Civic Infrastructure

SOCIAL DETERMINANTS OF HEALTH (SDOH)

http://www.waterloowellingtonhin.on.ca/forhsps/equity/socialdeterminants.aspx
What are social determinants of health (SDoH)?

Glossary of Essential Health Equity Terms: [http://nccdh.ca/resources/glossary/](http://nccdh.ca/resources/glossary/)
“Pair of ACEs” tree (Ellis & Dietz, 2017)

https://www.google.com/search?q=pair+of+aces
tbtm=isch&source=univsa=X&ved=2ahUKEw17z77tJfXoAhUKEw17z77tJfXoQIwAckEAsA&biw=1045&bih=624#imgrc=RJyNmO7ZzL3XM:
Building Community Resilience in [Insert State or County]

ACEs are an American health problem.

Adverse Childhood Experiences (ACEs)

- 21.7% of children with 2+ ACEs.
- 15% have experienced economic hardship.
- 15% have witnessed domestic violence.
- 15% have experienced adverse childhood experiences.
- 15% have had a parent in jail.
- 15% have had a parent with mental illness.
- 15% have lived in poverty.
- 15% have experienced abuse.
- 15% have experienced lack of safe housing.
- 15% have experienced lack of safety.
- 15% have experienced lack of support.
- 15% have experienced lack of economic mobility.

Adverse Community Environments (ACEs)

- Include:
  - Poor housing quality & affordability
  - Violence
  - Discrimination
  - Lack of opportunity & economic mobility

Together, these are the "Pair of ACEs". How do they show up?

Rate of violent crimes (per 100,000 ppl)
- 150 crimes
- 150 crimes
- 150 crimes

% children living in poverty
- 15%
- 15%
- 16%

% severely unaffordable or unsafe homes (monthly costs over 50% of income, no kitchen, no plumbing, or over-crowding)
- 15%
- 15%
- 15%

% families with limited access to a grocery store
- 15%
- 15%
- 15%

Rate of drug overdose deaths (per 100,000 ppl)
- 15
- 15
- 15
The Health Gradient

Individually oriented preventive action

Health hazards

Poverty
Inadequate food and nutrition
Lack of education
Unemployment
Poor housing
Environmental health hazards

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”

<table>
<thead>
<tr>
<th>Health inequity</th>
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<tbody>
<tr>
<td>Differences in health associated with social disadvantage that are <strong>modifiable</strong> and considered unfair</td>
<td>Differences in health status between individuals, groups or communities (AKA health disparities) - biological variation, geographical characteristics</td>
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</table>
We can promote health by supporting individuals and removing barriers.

A. EQUALITY WITHOUT EQUITY
Each boy has a box to stand on, but the smallest boy still cannot see over the fence.

B. EQUITY (BUT NOT EQUALITY)
The boxes are redistributed so each boy has the same opportunity to see over the fence.

C. SYSTEMIC BARRIERS REMOVED
The transparent fence does not affect anyone's opportunity to participate in watching the ball game.
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
  - Holistic approach, SDoH-informed
  - Community-based, wraparound services
- Punishment, child removal
  - Greater potential for thriving family life
We all have a role to play...

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

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
FASD PREVENTION

- Uses a disability lens
- Respectful
- Relational
- Self-determining
- Woman-centered
- Harm reduction oriented
- Trauma informed
- Health promoting
- Culturally safe
- Supportive of mothering

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

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)

#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

Profile of BTC Families

- History of trauma
- Poverty
- Homelessness
- Parenting difficulties
- Mental health problems
- Maternal-child separations
- Isolation
- Early childhood development/mental health problems
- Polysubstance use
- Family violence
- Conflict with the law
- Family substance use history

Breaking the cycle
#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

#4
Woman-centered
Example of a woman and family-centered approach
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

#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**


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
#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**

<table>
<thead>
<tr>
<th>Family Centered Care Core Concepts (IPFCC)</th>
<th>Principles of trauma-informed practice</th>
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<tbody>
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<td>Respect and dignity</td>
<td>Safety</td>
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<td></td>
<td>Empowerment</td>
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<td>Trustworthiness</td>
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<td>Information sharing</td>
<td>Transparency</td>
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<td>Participation</td>
<td>Voice</td>
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<td>Peer support</td>
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<td>Collaboration</td>
<td>Collaboration and mutuality</td>
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<td>Choice</td>
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<td>Cultural, historical and gender issues</td>
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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.”)

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

1-2: The Continuum of Cultural Competence

Stage 1: Cultural Destructiveness
Stage 2: Cultural Incapacity
Stage 3: Cultural Blindness
Stage 4: Cultural Precompetence
Stage 5: Cultural Competence & Proficiency
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
Wachman et al. (JAMA April 2018): Key findings

- 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

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

Thank You
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