TOOLKIT

Mothering and Opioids

Addressing Stigma – Acting Collaboratively

Centre of Excellence for Women's Health

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Contents

Introduction

Much is changing in the substance use and child welfare fields to bring forth approaches that are culturally safe, trauma informed, harm reduction-oriented and participant-driven. This toolkit highlights these advances and invites people working in both systems to think about how we can continue to improve our work, in partnership with the women who use these services.

How to use this toolkit

This toolkit is designed primarily for substance use and child welfare practitioners, as well as other service providers and health system planners who offer services to, or design services with, pregnant women and new mothers who use substances. The toolkit is organized into four sections.

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1. **Addressing Stigma in Practice**
2. **Improving Programming and Services**
3. **Cross-system Collaboration and Joint Action**
4. **Policy Values**

- **The first section** examines how women who use opioids experience stigma and includes tools for assessing potentially stigmatizing practices. This section also includes a script for responding constructively to coworkers' stigmatizing behaviour, as well as a factsheet developed for practitioners by women with lived experience.
- **The second section** describes how stigma relates to the barriers that women face. It identifies promising practice and policy responses that address stigma and health, substance use, and child protection concerns. Tools are provided to facilitate integrating promising approaches into our responses, and to identify ways in which barriers can be overcome.
- **The third section** includes information and tools to facilitate cross-system collaboration. Featured in this section are tools that help identify how the substance use and child welfare fields can effectively collaborate, while responding to their respective mandates and roles in supporting women and children. In this way, care is wrapped around families.
- **The final section** discusses policy matters, and how defining and affirming policy values can clarify our work in both systems of care. This section emphasizes viewing mothers and children as a unit when developing policy and programming to facilitate the goal of keeping mothers and children together.

Where We Have Been

Stigma, fear of incarceration, and loss of child custody have worked as very strong barriers to women disclosing substance use and accessing help.

For Indigenous women, discrimination, racism, structural and colonial violence, and intergenerational trauma continue to be additional barriers to discussing substance use and seeking support for problematic substance use.

As systems in general:

- We have viewed the needs of mothers and children as conflicting, as opposed to connected
- We have separated children and mothers when there is parental substance use
- We have not worked together as fields to support the wellbeing of both parents and children
- We have stigmatized and retraumatized mothers for their substance use problems
- We have focused on services for substance use, over other concerns for which support is needed
- We have focused on abstinence from substance use by mothers over supporting harm reducing approaches

Where We Are Now

Promising approaches by each field, and collaborative practice approaches between the child welfare and substance use fields are essential. In Canada, these approaches **are** being enacted and evaluated, but there is more work to do.

Projects such as the *Provincial Perinatal Substance Use* project at BC Women's Hospital + Health Centre are involving women with lived experience, service providers, health system planners and researchers in co-creating a blueprint for a continuum of respectful, trauma informed and culturally safe harm reduction and recovery-oriented services for pregnant women and new mothers who use substances. Promising research is being done in projects such as the *Co-Creating Evidence* project (see **www.fasd-evaluation.ca**) to identify both substance use and child welfare issues facing women.

Yet there remains much to be done to advance evidence based and promising practices. We need more research on harm reduction and substance use treatment practice, and on decolonizing approaches to harm reduction that can be enacted by both substance use and child welfare fields. We need to continue to create opportunities for involving women with lived experience in defining what works for them.

Many women are prescribed or use opioids before they become pregnant and will use opioids during pregnancy.

Opioids can increase the chance that a baby will be born prematurely or experience symptoms of withdrawal. But babies who experience symptoms of withdrawal will not necessarily have long-term effects on their health and development.

This toolkit highlights some of these advances and promotes practice and policy changes to better respond to the needs of pregnant women and new mothers who use opioids.

Centring Women's Needs and Perspectives

Understanding women's experiences when navigating child welfare and substance use services is critical to improving practice and integrating promising approaches. Journey maps are one way that practitioners are coming to understand how stigma and other barriers affect women and families.

Another way to include the experiences of women with lived experience is through the development of digital narratives and videos by women who use substances. These videos can help people who work in systems of care better understand how practice and policy can support women who use opioids and their families.

> "... they treated you like garbage. It didn't matter, prescribed or not... And it's like, you guys are the ones who put us on this... they treated me almost like I wasn't her mom."

(Howard, 2015, p. 431)

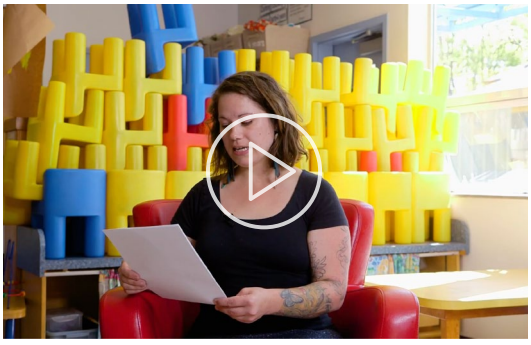
Example of Digital Narratives

Mothering project in Winnipeg:
Video of how a community program meets women with addictions where they are at on their journey of self-discovery, healing and belonging.

https://youtu.be/c2YBbOgF7TA

A Letter from Jane:
The voices of women who have participated in the Herway Home Program in Victoria are captured in the reading of letters they have prepared, describing their experience.

https://youtu.be/wXC6LmNXrDE?t=129



Glossary

Care coordination, also known as case management, refers to approaches where case workers connect with women on a one-to-one basis to facilitate meeting their needs. By working with women and families through every aspect of connecting to services and support, care coordination can offer a seamless experience through transitions such as from hospital to community.

Cultural safety has the goal for people to feel respected when they access the health system through minimizing power imbalances between clients and care providers. Cultural safety means that service providers are aware of the cultural history of those who access services, and people are supported to integrate their identity, culture, and community into their care decisions and interactions.

Decolonization is the process of critically examining how colonial practices have oppressed Indigenous peoples and divesting from these practices where they continue to operate, while honouring resiliency of peoples, culture and traditional Indigenous practices in the process.

Harm reduction refers to policies, programs and practices that aim to reduce the negative consequences of substance use and its associated harms. Harm reduction refers to the full range of supports and strategies that help women reduce harm, support wellness and address determinants of health without requiring abstinence. The term is also used to refer to pharmacological treatments that support stabilization (e.g. methadone) and supervised consumption sites to facilitate safer use.

Living/lived experience is the firsthand perspective of living as a member of a group. In this toolkit living/lived experience refers to the experience of women who use substances and are accessing substance use services and/or are involved with child welfare services.

Live-in treatment is one type of substance use treatment where people live communally, often in hospital settings, while accessing counselling and other treatments. This type of treatment is often abstinence-focused and for people with serious substance use concerns who have undergone withdrawal management and need to recover from serious health, financial, family and other concerns connected to their use. This type of treatment is often referred to as "residential" treatment; however, given the association with residential schools, "live-in treatment" is a preferred term

Opioids are a type of pain reliever. Opioid medications like oxycodone and morphine are prescribed to treat acute and chronic pain. Some illegal drugs like heroin are also opioids. Methadone and buprenorphine are prescribed to help people with opioid use disorders to reduce harm and can be part of addiction treatment and recovery.

Screening refers to direct questioning by health professionals about quantity, frequency and type of substance use. Screening is often accompanied by a **brief intervention**, where substance use and related health issues are discussed in a safe and respectful way, and where risks and benefits of substance use and options for health enhancement can be discussed. Referred to as Screening, Brief Intervention and Referral to Treatment (SBIRT), brief interventions can occur both before and after screening, and can be followed by referral to treatment and supports.

Recovery-oriented approaches to mental health and substance use support recognize each person's right to determine their own unique path to health, and focus on strengths, hope, dignity, resilience, social connection and holistic wellness.

Rooming-in is an interdisciplinary model of care that supports mothers and newborns to stay together in the same room immediately following childbirth. This arrangement results in higher rates of attachment and breastfeeding, and results in less intensive withdrawal for the baby. Additionally, infants are more likely to go home with their mothers, have fewer admissions to the neonatal intensive care unit, and a shorter hospital stay.

Stigma is a negative view about a group of people based on a particular quality, behaviour or circumstance, such as seeing women who use substances as "bad mothers." **Discrimination** is the unfair treatment directed to people based on labelling. These concepts are further explored in Section 1.

Trauma informed practice is an approach to service delivery where an understanding of the prevalence and effects of trauma is taken into account in all aspects of service delivery, and priority is placed on the individual's safety, choice collaboration, connection, and empowerment.

Addressing Stigma in Practice

1 2 3 4

Understanding Stigma

Stigma is a set of negative attitudes or beliefs about a person or group of people.[1] 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.[2]

Pregnant women who use opioids are often judged and stigmatized for using substances.[3] Discrimination is the unjust treatment people face due to stigma.[4] Pregnant women are often discriminated against when seeking care.[1,5-7] For example, as a result of their substance use, women may have their infants unnecessarily separated from them at birth, or they may not be provided the holistic treatment they require (i.e. substance use care, child support, housing and economic support resources).[8] Further, women can be denied housing, economic support, and employment opportunity due to their substance use. Evidence shows that the public and the media often blame for women for their substance use disorders, yet show more compassion for women with mental illness.[9]

See Tool: Self-Assessment – Practitioner Behaviours and Attitudes pg. 11

Women can internalize these negative attitudes. Pregnant women and mothers who use opioids have described experiences of judgement, surveillance, threats of losing their child, and restricted decision-making agency in interactions with service providers. This in turn can lead to self-consciousness, guilt and self-blame. These feelings can affect women's confidence in their ability to parent, and can also stop women from attempting to seek treatment at all.[1, 5-7, 10-14]

> "My sister is always calling me an unfit parent. Because I never raised any of my kids... But I didn't understand how can you judge me when you drink alcohol everyday as I got high. But by me doing heroin and losing my kids they think mine was worse, more out of control."
>
> (Gunn & Canada, 2015, p. 285)

Engaging in Non-Stigmatizing Practices

Judgement from service providers is a significant barrier to accessing services for women.[13, 14] Service providers are often unaware that their own behaviours and attitudes can contribute to stigmatization. Some service providers may lack knowledge about addiction, leading to stereotypes, stigmatizing, and judgmental attitudes that can create an unsafe environment for some women.

See Tool: Examining Our Use of Language About Pregnant and Parenting Women Who Use Substances Pg. 13
and Tool: ACTS Script to Address Stigmatizing Behaviours by Coworkers Towards Pregnant and Parenting Women Who Use Substances, Pg. 14

The stigma associated with substance use during pregnancy has led some practitioners to take punitive approaches to working with women.[1, 7, 13] Historically in Canada, Indigenous women, other racialized women and women with disabilities have been particularly stigmatized by the reproductive health and child welfare fields resulting in coerced sterilization, mother, child, family and community separation, increased surveillance, and requirements for stricter levels of compliance.[15]

Service providers have an opportunity through their practice to remain sensitive to women's experiences and support self-esteem, self-efficacy, self-determination and recovery.

See Factsheet: 10 Things Pregnant and Parenting Women Who Use Substances Would Like Practitioners to Know. Pg. 16
and Factsheet: The Role Of The Treatment Provider In Indigenous Women's Healing, Pg. 17

> "...she got it into my head, you're a mum, it's no different being on methadone. She dealt more with my problems than my baby's and saying, 'You're a mother, you're doing a great job.' It's just that reinforcement, it can just be those words that really help you."
>
> (Harvey, Schmeid, Nicholls & Dahlen, 2015, p. 295)

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8. Laudet, A. B. P. D. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment,* 33(3), 243-256.
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14. Kenny, K. S., & Barrington, C. (2018). 'People just don't look at you the same way': Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children And Youth Services Review, 86,* 209-216.
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Self-Assessment

Practitioner Behaviours and Attitudes

Judgement from health professionals is a significant barrier to accessing services for women. Service providers are sometimes unaware of how their own behaviours and attitudes can contribute to stigmatization. The statements below are to be used as a self-reflective exercise to help service providers become aware of how they may contribute to stigma.

To what degree do you agree with the following statements?

1. I believe that women who use opioids can be good mothers.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

2. I believe that women who use opioids during pregnancy are responsible for the negative parts of their lives.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

3. I think that women using medication for treating opioid use disorders (e.g. methadone or buprenorphine) should try to cut down their dosage during their pregnancy.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

4. I feel that pregnancy or the birth of a child should be reason enough to stop substance use.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

5. I believe that relapse is a normal part of the recovery process.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

6. I believe that a relapse indicates a lack of commitment to recovery and parenting.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

7. I can tell by looking at a woman if she has a history of substance use.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

8. I am aware of the effects of opioid, alcohol, and other substance use on a fetus during pregnancy.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

9. I know what harm reduction in pregnancy looks like.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

10. I am comfortable supporting harm reduction practices during pregnancy and parenting.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

11. I feel comfortable asking a woman about her history of substance use.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

12. I am confident I can provide the same care to people who do and don't use opioids.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

13. I feel comfortable working with a woman who is using opioids.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

14. I would feel comfortable talking to a mother about concerns I have about her attachment to her baby.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

15. I know how to find substance use resources for a pregnant woman or a mother.

1	2	3	4	5	6	7	8	9	10
STRONGLY DISAGREE									STRONGLY AGREE

After you have reflected on the statements above, consider:

- How did it feel to think about the statements?
- Were there any statements that you got stuck on, or had a harder time with?
- How might your attitude, awareness, assumptions or approach impact the way you work with women who use opioids?

Adapted from:

- "Comfort Scales" (ND). BC Association of Pregnancy Outreach Program.
- Winkelstein, E. (2012). *Understanding Drug-Related Stigma Tools for Better Practice and Social Change: Curriculum Outline for Trainers*. New York, NY: Harm Reduction Coalition for the New York State Department of Health AIDS Institute.

Resources:

- Harm Reduction and Pregnancy: Community-based Approaches to Prenatal Substance Use in Western Canada: http://bccewh.bc.ca/2015/02/harm-reduction-and-pregnancy-community-based-approached-to-prenatal-substance-use-in-western-canada/
- Doorways to Conversation: Brief Intervention on Substance Use with Girls and Women: http://bccewh.bc.ca/2018/06/doorways-to-conversation-brief-intervention-on-substance-use-with-girls-and-women/

Examining Our Use of Language

About Pregnant and Parenting Women Who Use Substances

As service providers and policy makers, we have a responsibility to use accurate and non-judgemental language. The language we use can contribute to or reduce stigmatization, and can influence public opinion. What terms are currently used in your workplace? Check the columns where you use the recommended language and notice where there may be room for improving your use of language.

Instead of...	Recommendation	✓	Why this helps
Drug habit, drug addiction	Regular substance use, problematic substance use, or ask women what term they feel comfortable with	○	Describes substance use as health related and changeable, not as a habit or intractable. This recognizes that substance use is influenced by many factors and does not reinforce a deficit view that addiction is a moral failure, personality problem, or narrow mental health disorder.
Addict, junkie, former/reformed addict	Person who uses substances, person in recovery/long-term recovery	○	*Person first language* focuses on the person before their condition or behaviour. This recognizes that a person's condition, illness, or behaviour is only one aspect of who they are and not a defining characteristic.
Clean	Person in recovery	○	Terms such as clean and dirty reinforce negative stereotypes of people who use drugs. Terms like 'clean' put a focus on abstinence only, and do not recognize the benefits of pharmacological treatments and harm reduction efforts.
Suffering from..., Victim of...	Has a history of..., Working to recover from..., Living with... or Experiences of...	○	*Recovery-oriented language* expresses hope, optimism, supports recovery and shifts away from the view that substance use is only negative and has no benefits.
Replacement or substitution therapy	Opioid-Maintenance Therapy (OMT), Opioid Agonist Therapy (OAT), treatment or medication for Opioid Use Disorders	○	Accurate medical terms recognize these protocols as treatment, or a component of treatment, and avoid the implication that this use of medication is in some way enabling or replacing 'one addiction with another.'
Unmotivated, non-compliant, resistant	Not in agreement with the treatment plan, opted not to...	○	Emphasizes strengths, agency, autonomy, self-determination, and preferences in treatment, rather than focusing on compliance with a prescribed treatment plan that may not have been co-created.
Born addicted to heroin, addicted babies, drug babies	Experienced withdrawal symptoms at birth, exposed to substances in utero, neonatal withdrawal	○	Newborns can be physically dependent on opioids but are not capable of showing the signs of addiction/substance use disorder. Most babies who experience withdrawal will have no long-term effects on their health and development. Inaccurate labels like 'addict' can follow women and babies lifelong, increase stigma, and deter or not acknowledge positive change.

Adapted from:

- Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A. et al. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: A Recognition and response. *Substance Abuse, 35*(3), 217-221.
- Government of Canada. (2019). *Changing How We Talk About Substance Use.* Ottawa, ON: Government of Canada.
- PHSA, BCCDC, & Toward the Heart. (2017). *Respectful Language and Stigma: Regarding People Who Use Substances.* Vancouver, BC: PHSA.

ACTS Script to Address Stigmatizing Behaviours by Coworkers

Towards Pregnant and Parenting Women Who Use Substances

Scripts or structured communication frameworks can help teams have difficult conversations.

The **ACTS** (Acknowledge Create Circumstance for Reflection-Teach Support) script was developed to address peer attitudes and stigma related to substance use during pregnancy. A script can help you respond respectfully and constructively to situations where you see your coworkers stigmatizing or judging clients. For example, you might hear a peer say, "How can she do that to her baby?" or "If she really cared about her baby, she would… (stop using, leave the guy)."

The following examples show how conversations may be redirected to encourage exploration of underlying assumptions, positive possibilities, and build capacity, thus incorporating a more compassionate view of the woman.

ACKNOWLEDGE

Create safety by not directly criticizing. Rather, create an opportunity to open a dialogue:

- "I know, I used to feel the same way, then I got to know one of the mothers and…"
- "I find it really difficult too, but I keep thinking about her circumstances and what has happened in her life."

CREATE CIRCUMSTANCE

It is hard to challenge a coworker's values or judgments about a client. Instead of creating a confrontational situation, provide a comment that may help the other person to reflect on his or her practice:

- Ask questions or think out loud —
  "I wonder if she has experienced violence in her life? I wonder what may have happened to her if this is the choice that she made?"
- "We probably need to think about some different ways of talking about this woman/mother as I am feeling uncomfortable with how this is being talked about."
- "It is difficult, I know. On the one hand, I feel frustrated and confused at her substance use/staying with her abuser, and, on the other hand, she is so gentle with her baby and trying to learn how to care for her baby… she asks all the same questions as any other mother."

TEACH

There are many opportunities for sharing this information with your team:

- Choose a high-quality, practical article about substance use and pregnancy that addresses attitudes and stigma. Leave it in multiple places around the unit.
- Ask permission by saying "Can I share something with you that I learned in a workshop?" (Share a little piece of information at a time).
- "I heard something that made me think about mothers a little differently, and about what I could do differently that would make them and me feel better."
- "I have learned that lots of women have experienced a lot of life before I have met them and learned to cope in ways that I don't necessarily approve of or agree with. I try to keep that in mind when I am working with them, and it helps me to take it slowly and try to build bridges rather than set up walls between us."
- Use a recent clinical scenario to "unpack" what happened, what worked, and what didn't work. For example, you may discuss how a woman may have used substances as a way to cope with past or present abuse and violence… it may have been a rational decision for her to start with… and that by supporting the woman and the baby without judgment leads to improved outcomes for both.

SUPPORT

Provide immediate and continuing support to your coworkers as they try out some new approaches:

- Help them debrief: "how did that work for you compared to what you were doing before?"
- Point out what you saw in the client — what the response of the client was to the new approach and also what you saw in your co-worker: "I saw her smiling a lot when she was talking to you, that is new… she looked a lot more relaxed, and I saw her asking you questions about her baby… you looked more relaxed when you were with her."
- Share at staff meetings how you are seeing positive changes; ask how can we do this as a whole team?
- Identify and celebrate success. What worked? How can we do this more?

Adapted from:
- Marcellus, L. & Poag, E. (2016) Adding to our practice toolkit: Using the ACTS script to address stigmatizing peer behaviors in the context of maternal substance use. *Neonatal Network*, 35(5).

10 Things Pregnant and Parenting Women Who Use Substances Would Like Practitioners to Know

HerWay Home, in Victoria BC, provides non-judgmental health and social supports for pregnant and parenting women who have used substances and face other health and social concerns. The HerWay Home Women's Advisory Council reviewed a draft section of the Toolkit in September 2019, and suggested we go back to the drawing board! As a result of this feedback, we returned to a drop-in in October 2019 and more informally asked for their thoughts on "what would you like social workers to know that would help them understand how to improve their practice?" Here are the 10 ideas the women offered:

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 have 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 addiction.
8. Just because you are still using does not make you 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. Instead care.

Thank you to The HerWay Home Women's Advisory Committee for their help in developing this Fact Sheet

The Role Of The Treatment Provider In Indigenous Women's Healing

These **RE-CLAIM** practices were identified by addiction treatment providers and women with lived experience in a community-based collaborative research project. The project examined the role that identity and stigma have in the healing journeys of Indigenous women in treatment for illicit drug use at treatment centres across Canada. The RE-CLAIM practices are the skills and traits that are important for treatment providers to offer when working with women in treatment. The study was funded by the Canadian Institutes of Health Research and led by Dr. Colleen Dell of the University of Saskatchewan, and representatives of the Thunderbird Partnership Foundation and the Canadian Centre on Substance Use and Addiction.

R

Recognition

Recognize the impact of **trauma** in women's healing (ranging from the intergenerational effects of colonialism through to the disproportionate rates of inter-personal violence faced by Aboriginal women).

E

Empathy

Relay **empathy** for the struggles that women face due to their problematic substance use (e.g., loss of custody of their children).

–

Communication

Open lines of **communication** for two-way, non-hierarchical dialogue with the women.

C

Care

Show **care** for the women and passion for your own role as a treatment provider.

L

Link to spirituality

Support the **link to spirituality** in women's healing through Indegenous culture as well as any other traditions and teachings with which the women identify.

A

Acceptance / non-judgemental attitude

Be **accepting and non-judgemental** about women's past behaviours (e.g., women's involvement in sex work for survival).

I

Inspiration

Provide **inspiration** by acting as a role model (e.g., when appropriate share parts of your own healing journey to show it is possible to gain further education as an adult and secure meaningful employment).

M

Momentum

Promote **momentum** in the women's healing journeys; that is, assist the women in **moving toward the future** after **acknowledging the past** (promoting accountability). For example, assist the women in developing healthier relationships and parenting skills. Fostering the women's ties to their communities will help break generational cycles.

Adapted from:

- Dell, C. (2005). *The Role of the Treatment Provider in Aboriginal Women's Healing from Illicit Drug use.* Retrieved from: http://www.addictionresearchchair.ca/creating-knowledge/national/aboriginal-women-drug-users-in-conflict-with-the-law/view-our-findings-through-posters/

Improving Programming and Services

1 2 3 4

Understanding Barriers to Programs and Services

Stigma is related to many barriers to substance use and child welfare services.

Women's very real concerns over child apprehension can prevent them from accessing services during pregnancy and while parenting. Fear of judgment and discrimination can impact women's comfort in using substance use treatment, counselling, or other services that can improve their outcomes with the child welfare system.[1,2]

Both substance use treatment and child welfare services often place high expectations on women.[3,4] These requirements from multiple systems and services can prevent women from fully focusing on their substance use treatment and can decrease their confidence in their parenting. Despite the expectation that women who are engaged with child welfare and who use substances access treatment, most substance use programs do not have childcare or family programs.[3,5] As a result, many women are unable to find services that will accept them as clients. It is critical to address the significant barriers to engagement with both child welfare and substance use treatment in order to support women, children, and their families.

See Tool: Reflecting on Barriers and What We Can Do to Reduce Them, Pg. 22

In addition to concerns related to substance use and child welfare, women who use substances while pregnant often have a complex set of related health and social factors that may also require support (e.g. housing, violence etc.).

See Tool: Women Who Used Opioids During Pregnancy – Three Scenarios for Discussion, Pg. 24

"I was treated like crap at that hospital... and I'd get to the point where I just wouldn't show up. It was too much."

(Howard, 2011, p. 431)

[Child protective services] "felt like I was just an addict and that I could not be a mother to my child... every time they came over that stigma seemed to elaborate itself into something that was always hanging around our conversations."

(Kenny & Barrington, 2018, p. 214)

Opportunities for Improved Programs and Services

A continuum of responses for mothers with substance use concerns recognizes that there is no one approach that will work for everyone, and that each woman may need or be ready to access different services at different points in time.

See Tool: Bringing Evidence-based and Values-based Approaches into our Work with Pregnant and Parenting Women who Use Substances, Pg. 26
and Tool: Examples of Promising Approaches for Service Delivery to Support Pregnant and Parenting Women Who Use Substances, Pg. 30

A promising approach from the substance use sector is family-centred treatment. Family-centred treatment provides services to each member of the family and can include live-in treatment for mothers and children together.[6,7] These programs address the barriers of childcare and fear of child apprehension, and recognize the importance of parenting in the process of healing and recovery.

Child welfare practices and policies are also evolving to better respond to families affected by parental substance use. There is an important shift happening — to understanding that it is not parental substance use itself that is potentially problematic, but rather the impact of substance use on the ability to parent that requires consideration. There is also increased appreciation for how issues such as social isolation, poverty, unstable housing, and gender-based violence might contribute to both the need for child welfare involvement and to parental substance use itself. An example of a promising approach in the child welfare sector is shared family care. In shared family care, parents and children are placed together in the home of a host family. The host family is trained to mentor and support the parents as they develop the skills and supports necessary to care for their children independently. Mentors and families work with relevant service providers to help parents develop the skills and supports necessary to prevent out-of-home placement and/or to provide a safe environment for reunification with their children.[8]

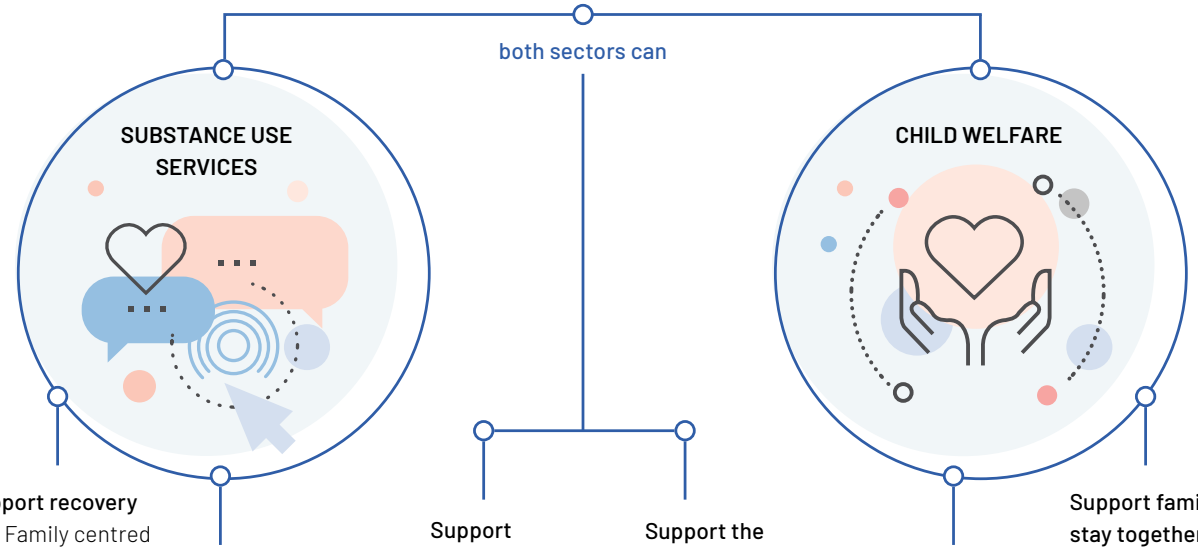
In both fields there is increasing recognition of promising approaches to improve services and programs for both mothers and their children. Principles such as viewing the mother and child together as a unit, and providing holistic, wraparound and trauma and violence-informed services can ground service delivery in both substance use and child welfare fields.[9]

See Tool: Bringing Trauma Informed Principles into our Work with Pregnant and Parenting Women who Use Substances, Pg. 28

There are also innovative approaches to service delivery that are applicable to both sectors, such as holistic 'wraparound' services and peer mentoring.[9] The relationship between substance use, child welfare, and Indigenous peoples is deeply complex. In the last few years, there has been a shift to Indigenous approaches to wellness and healing that recognize the influence of historical and intergenerational trauma, colonial policies and practices, and institutional and systemic racism in child welfare involvement and parental substance use.[10]

See Factsheet: A Focus on Indigenous Approaches to Child Welfare and Substance Use, Pg. 32

COLLABORATION



Shared Approaches

- Mother/child togetherness/family centred
- Involvement of mothers
- Harm reduction oriented
- Collaborative
- Trauma and violence informed
- Holistic approaches
- Culturally safe
- Optimistic and appreciative approach
- Concerned with access, engagement and retention

References:

1. Kenny, K. S., & Barrington, C. (2018). 'People just don't look at you the same way': Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children And Youth Services Review, 86*, 209-216.
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7. Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare: Journal of Policy, Practice, and Program, 80*(2), 179-198.
8. Price, A., & Wichterman, L. (2003). Shared Family Care: Fostering the whole family to promote safety and stability. *Journal of Family Social Work, 7*(2), 35-54.
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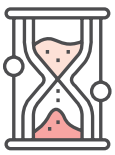
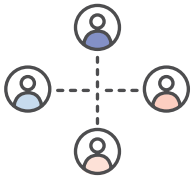
10. Wolfson, L., Poole, N., Morton Ninomiya, M., Rutman, D., Letendre, S., Winterhoff, T. et al. (2019). Collaborative action on Fetal Alcohol Spectrum Disorder prevention: Principles for enacting the Truth and Reconciliation Commission Call to Action #33. *International Journal of Environmental Research and Public Health, 16*(9).
11. Howard, H. (2015). Reducing stigma: Lessons from opioid-dependent women. *Journal of Social Work Practice in the Addictions, 15*(4), 418-438.

Reflecting on Barriers and What We Can Do to Reduce Them

There are significant barriers that prevent women from accessing substance use services or engaging with child welfare when pregnant and while parenting.

The following tool lists several key barriers, offers ideas about how they can be addressed in programming, and how services could help. The third column provides an opportunity to reflect on how these barriers may be addressed where we work.

Key Barriers	How can programs address these barriers? (Examples)	What services or approaches are available to address these barriers?
 **Stigma** • Prevents women from accessing prenatal care or substance use treatment • Increases surveillance and discrimination from providers	Employ non-judgemental, trauma informed, and harm-reduction oriented approaches	
 **Fear of Child Apprehension** • Paralyzes women from seeking substance use treatment • Exacerbates trauma histories • Can increase substance use due to limited healthy coping mechanisms	Engage in early identification and planning during the pregnancy to better support women to ultimately care for their babies or be involved in planning their care	
 **Lack of Women and Family Centred Programs** • Prevents women from staying in treatment due to fear of child apprehension or lack of available childcare • Less able to respond to gender-specific issues or concerns	Integrate parenting or opportunities for childminding into existing substance use treatment programs	
 **Mistrust** • Limits capacity to build a client-provider relationship • Prevents women from discussing issues relating to their substance use and child welfare involvement	Develop transparency and confidentiality guidelines that are clear to women who enter the program	
 **Reunification Timelines** • Increases pressure to build/restore relationships in a mandated period of time • Forces readiness to parent	Review and update reunification policies that dictate how long children can be in care	

Key Barriers	How can programs address these barriers? (Examples)	What services or approaches are available to address these barriers?
 **High Expectations on Women** • Increases women's stress to perform as a 'good' mother • Encourages women to meet an unrealistic number of tasks including proof of treatment completion, employment, and of safe housing • Demonstrates lack of coordination when tasks are dictated from multiple sources that may be in conflict	Work with women to identify and prioritize expectations that meet their goals	
 **Lack of Coordination** • Limits communication, cross-training, and awareness across substance use and child welfare fields • Forces women to act as intermediaries and having to meet all of the providers' needs	Cross-train child welfare and substance use workers to build an understanding of each other's systems, goals, approaches, and shared interests	

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Women Who Used Opioids During Pregnancy

Three Scenarios for Discussion

The following scenarios describe three women who used opioids during pregnancy. Read each scenario and consider the reflection questions.

SCENARIO 1:

Kimberly

Kimberly is in her early twenties. She began working as a cashier at a local grocery store after dropping out of high school. Last year Kimberly was hit by a car and injured her back, requiring surgery. She still had severe pain after the surgery, so her doctor prescribed her an opioid pain medication. Three months later she was still in a lot of pain, so her doctor prescribed her a higher dose of medication. To control the pain, Kimberly began taking more pills and started to run out before her next refill. When she ran out, she felt anxious, became sweaty and nauseous, and had trouble sleeping. Her doctor refused to further increase her dose, so Kimberly sometimes took the bus to other parts of town to get pills from dealers on the street. Her family and friends noticed her behaviour had changed, and that she was borrowing money that she didn't repay. When Kimberly's family found out that she was pregnant, they urged her to get help. Kimberly took the concerns of her family to heart, and her doctor recommended that she begin taking methadone, a medical treatment for opioid addiction, on a daily basis. Kimberly enrolled in a methadone program near her home, and with the help of this program and working with a counselor, she had a healthy pregnancy. Her treatment has continued successfully and she hasn't used prescription pain medications in over two years.

Reflection Questions:

- Do you think Kimberly was to blame for her opioid addiction?
- If Kimberly walked into your office while she was pregnant, how might you be able to help her?
- In addition to services for her opioid addiction, what other kinds of supports might she need?

SCENARIO 2:

Michelle

Michelle is in her mid-thirties. She began working as a regional manager of a local grocery store chain after completing a master's degree in business administration. Last year Michelle was hit by a car and injured her back, requiring surgery. She still had severe pain after the surgery, so her doctor prescribed her an opioid pain medication. Three months later she was still in a lot of pain so her doctor prescribed her a higher dose of medication. To control the pain, Michelle began taking more pills and started to run out before her next refill. When she ran out, she felt anxious, became sweaty and nauseous, and had trouble sleeping. Her doctor refused to further increase her dose, so Michelle sometimes drove to other parts of town to get pills from different doctors. Her family and friends noticed her behaviour had changed, and that she was borrowing money that she didn't repay. When Michelle's family found out that she was pregnant, they urged her to get help. Michelle took the concerns of her family to heart, and her doctor recommended that she begin taking methadone, a medical treatment for opioid addiction, on a daily basis. Michelle enrolled in a methadone program near her home, and with the help of this program and working with a counselor, she had a healthy pregnancy. Her treatment has continued successfully and she hasn't used prescription pain medications in over two years.

Reflection Questions:

- Do you think Michelle was to blame for her opioid addiction?
- If Michelle walked into your office while she was pregnant, how might you be able to help her?
- In addition to services for her opioid addiction, what other kinds of supports might she need?

SCENARIO 3:

Sarah

Sarah is in her early twenties. She began working as a cashier at a local grocery store after dropping out of high school. Sarah experienced childhood sexual abuse, and last year she was sexually assaulted on her way home from work. After this incident, she has experienced depression and recurring thoughts about the assault. At a party, a friend offered her heroin to smoke, to help her 'zone out'. Three months later she was still in a lot of emotional pain, and she began using heroin on her own. Sarah felt weighted down by negative emotions and began using often. When she ran out, she felt anxious, became sweaty and nauseous, and had trouble sleeping. Sarah often had to take the bus to other parts of town to get drugs from dealers on the street. Her family and friends noticed her behaviour had changed, and that she was borrowing money that she didn't repay. When Sarah's family found out that she was pregnant, they urged her to get help. Sarah took the concerns of her family to heart, and her doctor recommended that she begin taking methadone, a medical treatment for opioid addiction, on a daily basis. Sarah enrolled in a methadone program near her home, and with the help of this program and working with a counselor, she had a healthy pregnancy. Her treatment for substance use and trauma issues has continued successfully and she hasn't used heroin in over two years.

Reflection Questions:

- Do you think Sarah was to blame for her opioid addiction?
- If Sarah walked into your office while she was pregnant, how might you be able to help her?
- In addition to services for her opioid addiction, what other kinds of supports might she need?

Did you answer any of the questions differently for Kimberly, Michelle or Sarah?

Adapted from:

- Kennedy-Hendricks, A., McGinty, E. E., & Barry, C. L. (2016). Effects of competing narratives on public perceptions of opioid pain reliever addiction during pregnancy. *Journal of Health Politics, Policy and Law, 41*(5), 873-916.

Bringing Evidence-based and Values-based Approaches into our Work
With Pregnant and Parenting Women Who Use Substances

This tool describes common evidence-based and values-based approaches that have been studied in the substance use and child welfare fields. Use the tool to reflect on how your agency currently incorporates these approaches, and how they might be further integrated into your work.

Value	Description	How are agency brings in these approaches?	In what ways can we further these approaches in our agency?
Mother-child togetherness	Values keeping families together, not only in relation to child custody but also through rooming-in maternity care, integrated addictions treatment, and community outreach.		
Involvement of mothers	Recognizes women's strengths, rights, autonomy, and self-determination, and includes co-planning processes with women where these strengths and rights are amplified.		
Collaboration	Aims to support both child(ren)'s and mother's wellness, resilience and recovery through cross-sectoral and interdisciplinary work. Includes collaboration between service providers and families as well as across systems.		
Harm reduction oriented	Does not require abstinence from substances and provides a continuum of care that includes abstinence-oriented treatment and holistic wellness support, to meet varied recovery needs.		
Holistic, wraparound approach	Provides support for parenting and the range of needs that are associated with all social determinants of health (i.e. housing, education, economic support). Does not have a sole focus on changing substance use.		

Value	Description	How are agency brings in these approaches?	In what ways can we further these approaches in our agency?
Trauma and violence informed	Approaches to service provision that take experiences of trauma and violence into consideration and avoid re-traumatization are recognized as important. Offers programming that supports early attachment and aims to prevent adverse childhood experiences.		
Access, engagement and retention	Facilitates access to treatment through outreach, day treatment, and mentoring services, and welcoming intake processes. This supports engagement and ongoing service use. Transitions between various levels of support are encouraged and supported. Extended families are honoured as sources of support.		
Concerned with Indigenous wellness and cultural safety	Addresses the over-representation of Indigenous women and children in substance use and child welfare systems through reconciliatory, wellness-oriented, culturally-specific and culturally safe practices.		
Optimistic and appreciative approach	Asks questions such as 'what is working well?' in service planning to avoid a sole focus on problems and deficits.		

Bringing Trauma Informed Principles into our Work

With Pregnant and Parenting Women Who Use Substances

Substance use and child welfare practitioners often work in partnership with maternity care providers. This practice sheet illustrates how the principles of trauma informed approaches can be enacted, using the maternity care environment as an example of how to support women who use opioids.

Pregnant women who have experienced trauma have heightened susceptibility of being re-traumatized throughout labour and delivery.[1-3] This can impact their own health and affect attachment with their baby.[1-4] Within the child welfare, mental health, and substance use fields, there are evidence informed approaches that avoid re-traumatization. When these approaches are applied to perinatal and prenatal healthcare, they can help ensure women and their babies have positive health care experiences.[4]

Both the substance use[5] and the child welfare[6] fields in British Columba have developed guidelines on implementing trauma informed practice, using the principles of safety and trustworthiness, choice and collaboration, connection, and skill building. The table below offers ideas for how these key principles of trauma informed practice can be enacted in the maternity care environment.

SAFETY AND TRUSTWORTHINESS

- Discuss ahead of labour and birth what safety means to each woman, including options the birthing team can offer to address any safety concerns.
- Discuss in advance what women's signs of feeling overwhelmed are (do they get agitated or numb); what they find helpful to re-center (e.g. mindfulness exercises, walking, saying affirmations, having an Elder present); and help them use these strategies in the labour and birthing process, as necessary.
- Explain all procedures beforehand, and with continuous consent as you go along, so women can see you as trustworthy, and the process as predictable as possible.

CHOICE AND COLLABORATION

- Listen and enlist women's ideas of how they can have choice and control to the degree possible, in birthing, breastfeeding, and rooming-in processes.
- Provide choices where possible — about birth plans or pain control; breast or bottle feeding; gender of practitioner; and labour and birth positions — so that women have agency, self-determination, and feel empowered within parameters of the maternity care experience.
- Listen for ambivalence about connecting with infants. Assure women that this is common after having experienced trauma, and collaboratively identity how best to help.

CONNECTION

- Trauma informed practice is a relational practice, intended to repair memories of unsafe, overwhelming experiences. Facilitate connection through creating a respectful and safe environment for women.
- Plan for support during labour and birth that will feel comfortable for women, including family members, friends or doulas as appropriate.
- The maternity care unit can be a positive one, modelling respectful relationships among maternity care providers, between maternity care providers, with other professionals, and with mothers. This has been referred to as organization-wide emotional intelligence.

SKILL BUILDING

- Offer opportunities to learn self calming and self soothing skills on the unit.
- Encourage women to connect with community services that offer walking groups, mindfulness practice, yoga, drumming and other wellness-oriented practices post-delivery.
- Encourage women to visit local anti-violence services and support groups so they can connect to these services as needed.
- Affirm women's strengths and resilience, the survival skills they possess, and the skills waiting to be developed.
- Remind women that they do not have to be perfect mothers — mothering is a process of learning over time. Encourage them to connect with services or groups related to parenting that feel comfortable and supportive for them.

Reflection question

Are trauma informed practice principles being integrated into your work?

Consider to what extent your program or service is already applying trauma-informed principles and practice, and note them in the second column. The third column is for ideas that might be the focus of further action.

Principles	We are already...	Commitments going forward...
Providing safety (physical, emotional, and social)		
Offering opportunities for choice ad collaboration		
Offering opportunities for connection		
Offering opportunities for skill building, self-regulation, and grounding		

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Examples of Promising Approaches for Service Delivery
to Support Pregnant and Parenting Women Who Use Substances

This factsheet provides an overview of three examples of promising service delivery models for supporting pregnant and parenting women who use substances. These delivery models incorporate elements of evidence-based and values-based approaches including mother-child togetherness and collaboration.

See Tool: Bringing Promising Approaches into Agency Work, Pg 28

Program examples are provided to demonstrate how these approaches can work in practice.

Holistic Multi-Service Programming

Community based, harm reduction oriented holistic multi-service models for pregnant women and new mothers and their children offer easy access to prenatal care, health care, social support, advocacy, and childcare.[1] By co-locating services, this model reduces barriers and increases access to services for women. Across Canada, some low barrier holistic services have been developed to meet the unique needs of pregnant or parenting women who have substance use issues.[2]

EXAMPLE:
Sheway in Vancouver BC, offers a broad range of on-site health, medical and social services and supports for women who are either pregnant or parenting young children and who are experiencing current or previous issues with substance use. Services are provided through its program staff and via partnerships. Housing in the building is available to clients, which is operated by the YWCA through its Crabtree program.[2] Sheway also has a health clinic. Voluntary child welfare services are provided on-site through a partnership agreement with the provincial Ministry. The length of time that women can participate in Sheway is flexible and not set by the child's age.[2]

Learn more

Harm Reduction and Pregnancy Community-based Approaches to Prenatal Substance Use in Western Canada **bccewh.bc.ca/2015/02/harm-reduction-and-pregnancy-community-based-approached-to-prenatal-substance-use-in-western-canada/**

Co-Creating Evidence Evaluation Project of 8 Canadian services **www.fasd-evaluation.ca/**

Mentoring and Peer Support Models

Mentoring and peer-support models are offered by paraprofessionals or peers who connect with women through shared understanding of their recovery path[3] and knowledge of community supports. The central aspect of mentoring programs is to connect women with community-based resources and to co-develop individualized goals.[4,5]

EXAMPLE:
The **Parent-Child Assistance Program** (PCAP) is a voluntary program for women who are pregnant or who have recently had a baby and who are using substances. Mentors support women over a 3 year period in connecting with/building upon personal support systems as well as community services.[6] Some of the skills women develop include budgeting, parenting, family planning, social skills, and maintaining a recovery plan. The PCAP model has been replicated and evaluated across North America and has been found to be effective in numerous ways, including preventing substance exposed pregnancies and reducing the number of children going into care. The program has been successfully adapted for/with Indigenous communities in urban and rural contexts, both on- and off-reserve.

Learn more

Alberta Parent-Child Assistance Program Council **www.alberta-pcap.ca**

Parent-Child Assistance Program **www.depts.washington.edu/pcapuw**

EXAMPLE:

InSight Mentoring Program in Winnipeg, Manitoba is an outreach mentoring program that focuses on long term one-to-one relationship building with women and their families for up to three years. The program supports health and wellness through trauma informed and harm reduction practices. This can include a family planning method, connection to community and substance treatment services, transportation support, and addressing domestic violence concerns. Women are not asked to leave the program if they relapse or experience setbacks. Mentors support both the woman and child regardless of custody arrangements.

Learn more

InSight Mentoring Program
www.gov.mb.ca/healthychild/fasd/insight.html

Care coordination

Care coordination may be offered in a variety of environments and with differing intensity.[8-10] Care coordination allows for the unique needs of mothers and infants to be identified and met by available services. Care coordination can link acute and community care to facilitate support for mothers and newborns transitioning from the hospital to the community.[11-13] Current approaches to care coordination intentionally move away from traditional notions of "case management" and involve mothers and community-based providers, as well as substance use and child welfare workers, in discussing options for service connection that fit the individualized needs of women and their families, while positioning women at the center of the planning.

EXAMPLE:

Vulnerable Infants Program of Rhode Island (VIP-RI) is a care-coordination program that works closely with parents and social service agencies, such as child welfare, courts, and substance use treatment providers.[11] The goal of the program is to optimize parents' opportunities for reunification and increase the efficiency of social service systems involved with families affected by perinatal substance use. One year after birth, the majority of infants (>70%) are placed with biological parents or relatives.[13] At discharge from the program, 76% of women reported no recent substance use, and 98% had sustained abstinence for at least six months prior to discharge.[12]

Learn more

In Canada, care coordination is discussed in, and achieved through, the participation of community-based providers in Family Centred Conferencing sessions
https://www.torontocas.ca/index.php/media/family-centered-conferencing-fcc

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A Focus on Indigenous Approaches to Child Welfare and Substance Use

As a result of colonial and structural violence, Indigenous children continue to be disproportionally separated from their parents, extended families, and cultures.

Indigenous approaches to child welfare and substance use treatment incorporate the ideas of *land, lineage,* and *language* to give individuals and their families a sense of Hope, Meaning, Purpose, and Belonging — all of which are integral to Indigenous wellness.

Life Course Approach

Life course approaches recognize the significant historical roles of pregnancy, childbirth, and child rearing as sacred components of the life cycle.[1] Adopting a life course approach promotes positive parenting. It also reinforces familial and community roles in raising children in ways informed by individual and community cultural identities. This can disrupt trauma arising from structural violence, colonization, and dislocation.

Community-Led

Indigenous peoples are distinct and diverse with unique histories, languages, cultural practices, and spiritual beliefs. Service delivery should be based on and driven by nations and communities' strengths and needs. This ensures that local concepts of health, wellness, and healing are central to service delivery, and that supports and services respond to the local geography, infrastructure, language, culture, and resource capacity.[2]

Culture-Driven

Centering service delivery around land, lineage, and language can support individuals and families in achieving a balance of the body, mind, spirit, and emotion. Efforts to re-centre Indigenous knowledge supports self-determination and can give individuals Hope, a sense of Belonging, and a greater understanding of the Meaning of life, grounded in a sense of Purpose - all integral to Indigenous wellness.[3,4]

Learn more

First Nations Mental Wellness Continuum Framework

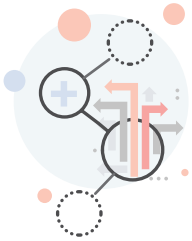
thunderbirdpf.org

Strengths-Based

Strengths-based approaches that recognize Indigenous culture as foundational. These approaches champion Indigenous women and their families' wellness and self-determination, avoid deficit-based and stigmatizing attitudes and behaviours.[5] Strengths-based approaches support women and their extended families' rights to parent, the mother-child unit, and encourage families to see their own strengths and resources.[1,6]

Wraparound Support for Women, Families, and Communities

Wraparound support for women, families, and communities coordinates professional and community services to meet physical, emotional, mental, and spiritual needs. Care is wrapped around women, families, and communities through using existing services and natural supports that exist through culture and extended family.[6]



Social and Structural Determinants of Health

Service delivery models must explore the social and structural influences on substance use engagement, including but not limited to ongoing impacts of colonial violence and structural inequities that continue to impact Indigenous peoples. Offering services that address the social and structural determinants of health shifts from individual stigma and blame and reframes conversations around substance use to better support mothers, families, and communities.[7,8]

Adapted from:

- Wolfson, L., Poole, N., Morton Ninomiya, M., Rutman, D., Letendre, S., Winterhoff, T., et al. (2019). Collaborative action on Fetal Alcohol Spectrum Disorder Prevention: Principles for Enacting the Truth and Reconciliation Commission Call to Action #33. *International Journal of Environmental Research and Public Health, 16*(9).

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Cross System Collaboration and Joint Action

1 2 3 4

Opportunities for Cross System Collaboration and Joint Action

Cross-system collaboration is an opportunity for the child welfare and substance use fields to work together, and to work with women and families in developing services that wrap around women, children and families within their communities.

Supporting pregnant and parenting women who use substances also goes beyond engaging with child welfare and substance use treatment services, to involve cross system collaboration that includes housing, health care and anti-violence services, among others.

See Tool: Identifying Available Services in Your Community to Support Mothers, Children, and the Mother-Child Unit, Pg. 36

Collaborative models can lead to: higher referrals to, and receipt of substance use services among child welfare clients; greater attainment of substance use treatment goals; and increased custody retention and greater reunification if custody has been previously lost.[1,8-10] Collaborative practices and services can be supported through strong leadership, relationship building, integrative protocols, and cross-training.[1,2]

See Tool: Principles and Approaches for Cross-System Collaboration, Pg. 37
and Tool: Tips for Cross-System Collaboration, Pg. 38

Within the substance use and child welfare fields, stigma can influence how service providers interact with women and the quality of service they offer. Providing substance use and child welfare services collaboratively and with women can allow for cross-sector education and the development of peer-to-peer relationships between people with lived experience and service providers.[3-6] Improved collaboration across fields, and with pregnant and parenting women who use substances, can increase empathy and understanding among services providers of the issues impacting women's lives. This greater understanding of women's experiences can reduce stigma,[3-7] assist with addressing barriers and is key to women's empowerment and self-determination.[3-5]

See Tool: Checklist for Joint Safety and Treatment Planning with Families, Pg. 39

Co-location is one model for collaboration in which child welfare and substance use service providers work in the same location or as a team. Co-location can foster better communication and improve the shared understanding of what is required for successful holistic treatment approaches between the child welfare and substance use fields[11,12]

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Identifying Available Services in Your Community
to Support Mothers, Children, and the Mother-Child Unit

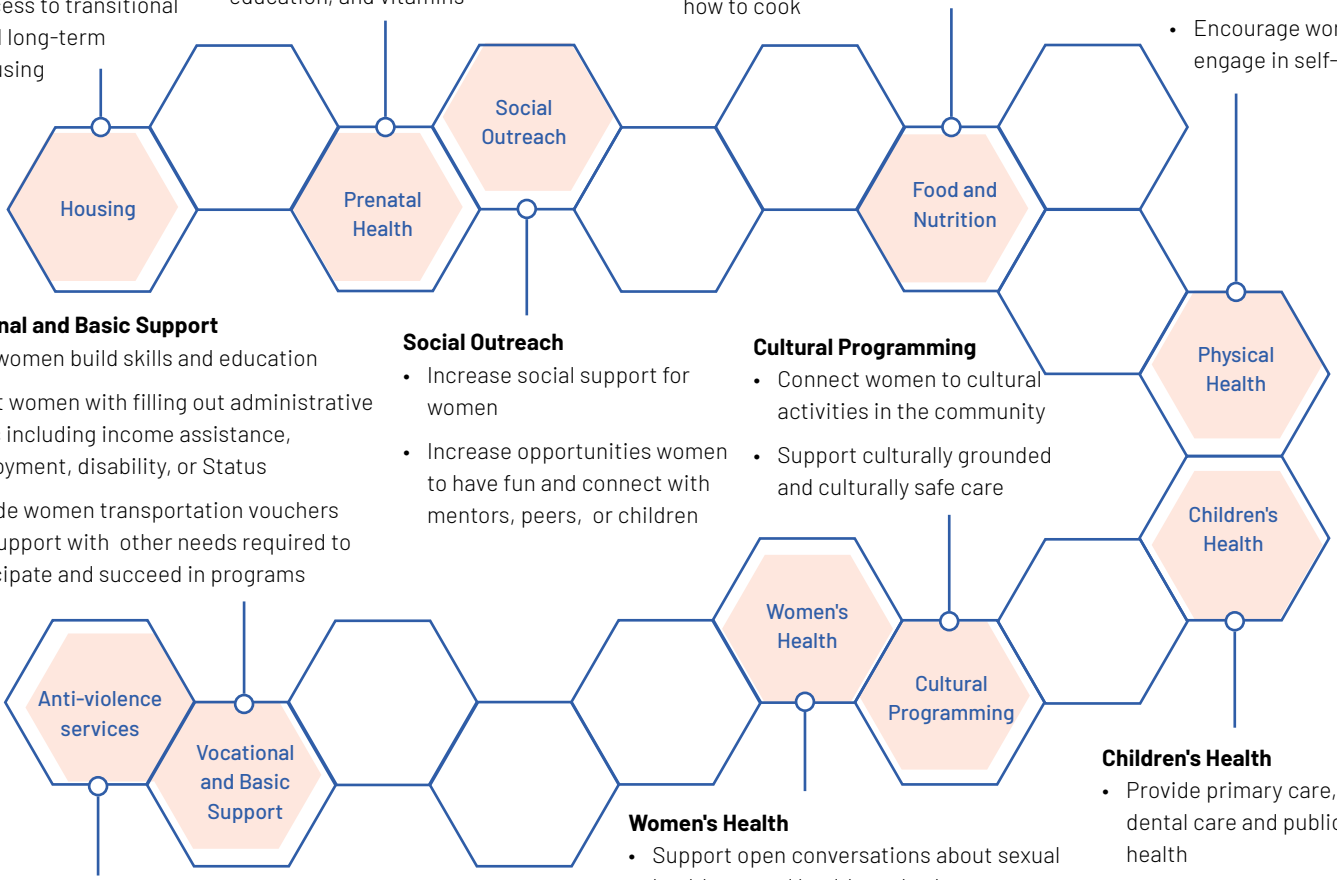
Supporting pregnant and parenting women who use substances goes beyond engaging with child welfare and substance use treatment services. This tool identifies additional types of services and providers that can support mothers, children, and mother-child togetherness. Use this tool to brainstorm the range of services providers that may be available in your community – recognizing your unique geographic context and human resource capacity.

Housing
- Increase women's access to transitional and long-term housing

Prenatal Health
- Connect women with prenatal provider and resources
- Offer prenatal classes, health education, and vitamins

Food/Nutrition
- Increase access to dietician/nutritionist
- Provide healthy/culturally-appropriate meals, food vouchers, or gift cards
- Support ways that teach women how to cook

Physical Health
- Help women respond to chronic pain that may have prompted opioid initiation
- Encourage women to engage in self-care



Vocational and Basic Support
- Help women build skills and education
- Assist women with filling out administrative forms including income assistance, employment, disability, or Status
- Provide women transportation vouchers and support with other needs required to participate and succeed in programs

Social Outreach
- Increase social support for women
- Increase opportunities women to have fun and connect with mentors, peers, or children

Cultural Programming
- Connect women to cultural activities in the community
- Support culturally grounded and culturally safe care

Anti-violence services
- Provide safe spaces for women to discuss substance use and create safety plans
- Help women navigate complex health systems

Women's Health
- Support open conversations about sexual health, mental health, and substance use
- Provide referrals to other health and social service providers including: primary care, physiotherapy, dental care, or a nutritionist

Children's Health
- Provide primary care, dental care and public health
- Connect women to children's specialists and assessments

Resources:
- Hubberstey, C., Rutman, D., Schmidt, R. A., Van Bibber, M., Poole, N. (2019). Multiservice programs for pregnant and parenting women with substance use concerns: Women's perspective on why they seek help and their significant changes. *International Journal of Environmental Research and Public Health*, 16(18).
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Principles and Approaches for Cross-System Collaboration

The following nine principles and approaches have been identified as supportive of collaborative practice. Discuss one or more of these principles and approaches to collaboration at a staff meeting. Use the prompting questions to jump start your discussion.

1

Mutual respect, understanding and trust of each other's roles and responsibilities

2

Common goals and expectations, developed in collaboration with women, their families and support networks

3

Understanding that different values and mandates do not prevent collaboration

4

Awareness that a "one-size-fits-all" approach to maternal substance use is unlikely to be effective

5

Open and frequent communication, with attention to confidentiality, consent, and transparency for families

6

View of the mother-child dyad or family as one "client"

(instead of two clients with opposing interests where service providers have to "take sides")

7

Support from leadership

8

Sharing of resources and infrastructure

9

Willingness to try things in a new way

Prompting Questions:

1. How does my agency or unit practice each of these principles/ approaches when working with other services, agencies or sectors?
2. Where could we enhance our work towards collaboration?

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Tips for Cross-System Collaboration

Collaboration between the child welfare and substance use fields provides an opportunity to improve child safety and support the recovery of parents. Cohesive working relationships between these sectors can foster advocacy, consultation, system navigation, safety planning, and streamlined referrals.

Presented below is a summary of evidence-based cross-system collaboration that may be relevant to your practice. These actions do not need to be taken as one-directional steps, but it is always important to keep in mind how we are empowering women and families to co-identify their treatment goals.

1. Develop a list of substance use and child welfare services available in your community, including wraparound services.

   See Factsheet: Examples of Promising Approaches for Service Delivery to Support Pregnant and Parenting Women who Use Substances, Pg. 30

2. Create a list of services that could be potential partners. Build relationships with the workers in these services, and encourage everyone to work from a harm reduction and trauma informed way.

   See Tool: Identifying Available Services in Your Community to Support Mothers, Children, and the Mother-Child Unit, Pg. 36

3. Share information about your roles and responsibilities and invite exchange when in meetings with people working in other fields.

4. Learn about policies and protocols used in collaborative practice by the child welfare and substance use fields. Even if they are not active in your area, they can inspire discussion.

5. Work together when identifying treatment goals with women and families.

6. Discuss how you can be trustworthy as you provide information about each other's practice. Work together to identify how you present limitations to confidentiality and consent protocols to women and families.

7. Look for cross-training opportunities or advocate for them if there are none.

8. Find opportunities to co-locate services, either part- or full-time.

9. Find opportunities for cross-sectoral job shadowing, which can be an effective tool for training, co-learning, and relationship-building.

Checklist for Joint Safety and Treatment Planning with Families

This list can support safety and treatment plans for families where parental substance use is an issue so that both child welfare and substance use service workers can share ownership.

- ☐ **Coordination of comprehensive assessment and planning related to parents' and child's needs, including assessment of substance use and related co-occurring concerns**
  (e.g., mental health, domestic violence, physical health).
- ☐ **Identification of services to be provided if there is a waitlist for substance use treatment**
  (e.g., child visits with parent, brief intervention and support with parent, outreach or drop-in support)
- ☐ **Determine interest/need for other holistic/wraparound supports related to substance use**
  (e.g., Indigenous cultural supports, community or online support groups, access to nicotine replacement therapy for smoking cessation)
- ☐ **Provide counselling or support for the child, including support with understanding parental substance use, child's own substance use**
- ☐ **Plan for updates on treatment progress, sharing of information, discussion of duty to report, limits to confidentiality**
- ☐ **Discuss joint approach(es) to supporting a parent who misses appointments, who drops out of treatment, etc.**
- ☐ **Discuss how to handle "slips" and possibility of relapse. Discuss if relapse can be seen as an opportunity for intervention and/or enhancing recovery, and how child safety can be addressed if relapse occurs**
  (e.g., child stays with friend or family member)
- ☐ **Plan how parenting be included in an aftercare plan if the parent is attending a live-in treatment program**
  (e.g., family support worker, drop-in parenting group, regular child visits, peer mentoring program)

Policy Values

1 2 3 4

Policy Values

Developing policies that meet the needs of substance affected families can pose challenges.

When reviewing or developing new policies, it is useful to consider, "What values underpin these policies?" Stigma has often shaped how health topics are discussed, treated and researched, and how policy is developed.[1-3] Stigma connected to substance use during pregnancy and motherhood elicits little public support, and often incites blame and shame.[1-7] This can be reversed through values-based policy development, along with changes in practice and programming.

See Tool: Rethinking Policy Values that Impact Pregnant and Parenting Women who Use Substances. Pg. 42

The child welfare and substance use fields have traditionally had different responsibilities and operate from different paradigms. For example, in the substance use field, recovery is understood as a non-linear process, with relapse a common occurrence. However, in the child welfare field, relapse is often viewed as an indication that mothers are unable to change and that children require protection.

It is clear that there is a dire need for change, collaboration, and mutual planning. Policies for collaborative practice and integrated systems require attention to dual interests: both for child protection concerns, and in providing support to substance using mothers. Typically, the interests of infants and children have been disconnected from the interests of women and mothers who use substances.[5,8-11] This disconnection has frequently resulted in mother-child separation, often with lifelong consequences for both women and children. [5,8-10] Mother-child separation also disrupts those surrounding the mother-child unit including fathers, siblings, grandparents, extended families, communities, and in many cases, cultures. These lifelong impacts contribute to ongoing trauma, and often contribute to further substance use.

A collaborative approach recognizes that policies are built on values, and values can be made explicit. Values can, and do, change as societies and cultures evolve.[12] Instead of separating policy and practice responsibilities, a promising shift in policies values is to focus on the mother-child unit together as the "client." It is clear that policies, strategies and practice guidance can support the interaction of multiple interconnecting systems and use models that balance the emotional, developmental and physical needs of children with strengths-based support of mothers and their circles of support.

These policies do not exist in a vacuum.[12] In addition to changing child welfare and substance use policies, it is essential to examine the social determinants of health that surround maternal substance use and revise related policies accordingly. In addition to increasing access to comprehensive integrated collaborative care, health care, housing, support for intimate partner violence, and income support must also be considered in order to meet the needs of substance using women and their children.

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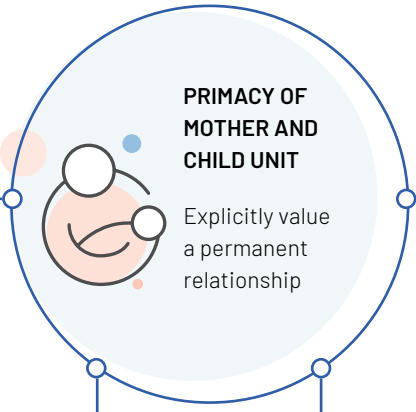
Rethinking Policy Values that Impact Pregnant and Parenting Women Who Use Substances

Significant strides forward are required in policy, as well as practice, to improve the response to mothers who use opioids or other drugs and their children. Policy can be made at many levels-organizational — municipal, regional, provincial, territorial or federal.

A version of the diagram below was first published in 2002 in *A Motherhood Issue: Discourses On Mothering Under Duress.* The diagram depicts four values that can be explicitly adopted to help develop and implement mothering-related policy. It is useful to review these values when redesigning policy, assessing policy or developing agency or interagency protocols.

Discuss these values one by one, at a staff meeting, or during strategic planning sessions.

1. Which values could you and your team aspire to?
2. How you could make these values come alive in written policies and protocols?



PRIMACY OF MOTHER AND CHILD UNIT

Explicitly value a permanent relationship

Inclusive Engagement

Are your policies developed with input from a wide range of women, their partners, families and communities, with lived experience?

Does this input include women from varied cultural, age, race, class and regional backgrounds?

Respectful and Optimistic

Are women valued in the policy?

Is there an underlying compassion for women?

Is there an understanding that women want the best for their children, and can change?

Structurally Supportive

Are you collaborating with other systems and services to actively link mental health, violence, housing and income supports to help women and their children progress?

Embrace Complexity

Is the policy open to a harm reducing, culturally safe, strengths-based approach?

Does the policy use an expanded risk assessment model?

Adapted from:

- Greaves, L.. Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., & Irwin, L. (2002). *A Motherhood Issue: Discourses On Mothering Under Duress.* Ottawa, ON: Status of Women Canada. Retrieved from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.200.1563&rep=rep1&type=pdf

Conclusion

The Centre of Excellence for Women's Health (CEWH) is a research and knowledge exchange centre focused on linking research on gender and women's health to policy and practice. Since the 1990s, researchers at CEWH have conducted research on topics such as the barriers pregnant women and new mothers face when accessing substance use treatment and support. Since the 2000s, CEWH has invited researchers, service providers, women with lived experience and policy analysts to think critically together as members of virtual communities about how we can improve practice and policy. This project, with a focus on mothers, opioids, stigma, harm reduction and child welfare interactions builds on this work.

As researchers, we started this project with a scoping review using the research question "How do women who use opioids (and other substances) experience stigma, pregnancy, parenting and child welfare concerns, and how can this inform harm reduction responses?" We then took a synthesis of the findings to the wise women listed as partners and collaborators on the title page. Through their feedback and generosity in sharing their own work, we translated this information into useful, practical and forward-looking tools. We hope that the tools and approaches offered in this toolkit will support practice improvement and policy development for the reader.

We have tremendous respect for the work of the substance use and child welfare workers whom we are hoping to reach with this toolkit, and hope that the self-reflection and action-oriented tools in this toolkit will have an immediate and important impact on current policy and practice to reduce the harms associated with women's opioid use. The tools are designed to help us continue to build on our capabilities to make mothers' needs and voices central in our work, and to offer mother-child centred, trauma informed, culturally safe and harm reduction-oriented services and policies.


Centre of Excellence
for Women's Health