Trauma informed care and harm reduction practices

Supporting pregnant women and mothers with substance use disorders

Dr. Lenora Marcellus
National Perinatal Association Conference
March 16, 2018
Loma Linda, California
Learning outcomes:

• Define trauma informed care and harm reduction
• Explore historical origins of these approaches
• Describe what these approaches look like when applied within the context of pregnancy and the early years
• Identify concrete strategies for your practice environment.
Why I am interested..
British Columbia context:

- Over 44,000 births per year
- Estimated that 10% of pregnant women use tobacco, 10% use alcohol, and less than 3% use illicit drugs.
- Perinatal Services-BC database registry: less than 1% of women reported using alcohol and illicit drugs
- Many significant data challenges
B.C. asks Ottawa to declare public health emergency as death toll from overdoses continues to surge

B.C. declares public health emergency after fentanyl overdoses
Overdose Deaths in Vancouver

Annual Overdose Deaths in Vancouver
Jan 1, 2007 - Dec 31, 2017

- BC Coroners Confirmed OD Deaths
- Estimated OD Deaths
- Fentanyl-Detected OD Deaths

Source of Data: BC Coroners Service and VPD
***Deaths in 2017 have yet to be confirmed by BC Coroner Service
2015 overdose deaths per 100,000

U.S. states

British Columbia

U.S. stats: https://www.cdc.gov/drugoverdose/data/statedeaths.html
Join Us!
Want a new Challenge? Join our Board of Directors!
The Canada FASD Research Network is now seeking new Directors for its Board of Directors.
Learn More

En français
Research Library
Our mission is to support Canada’s leadership in addressing the extraordinary complexities of Fetal Alcohol Spectrum Disorder (FASD).
Diagnostics Clinics
Grants and Awards
Organizations
Canada FASD Research Network Action Team on FASD Prevention

• National
• Funded by provincial, territorial and federal government
• Two other teams - diagnosis, intervention
• Researchers and knowledge users
• Trans-disciplinary
• Virtual and face-to-face
• Consensus document based on evidence, expert advice women’s experiences
Determinants, intersections

https://www.colleaga.org/article/what-are-determinants-health
FASD PREVENTION

- Respectful
- Relational
- Self-determining
- Woman-centered
- Culturally safe
- Supportive of mothering
- Uses a disability lens
- Health promoting
- Trauma informed
- Harm reduction oriented
NEAR science - “unified science” of human development - becoming NEAR informed

• Neuroscience of toxic stress (brain and body)
• Epigenetic consequences of toxic stress (passing from parent to child)
• Epidemiology of Adverse Childhood Experiences (ACEs)
• Resilience


At the turn of the (last) century infants seen as:

- Diffusely organized
- Unstructured
- Lacking in sensory capacities and motor abilities
- No examinations because there was “nothing” to evaluate - classed with animals
Classic studies..

- Harlow - monkeys and attachment
- Ainsworth - strange situation
- Tronic - still face
- Thomas & Chess - temperament
Explosion of science..

• Committee on Integrating the Science of Early Childhood Development
• Key message: Development of the brain is highly dependent upon experience
Infant mental health
(Key sources: Zero to Three, Center on the Developing Child at Harvard University)

• The healthy social and emotional development of a child from birth to three years
• An ability to form satisfying relationships with others, to play, communicate, learn, and experience the full spectrum of human emotions
• Is about more than the infant: is also about the relationship of the parent with their child
A parent’s mental health...

- Enhances their capacity to promote healthy practices emotionally and physically for their children
- Creates stability of self and emotional regulation for young children
- Supports strong parent-child attachment critical to behavioral regulation, self-worth and resiliency in children

“The most powerful people for reducing ACE scores in the next generation are parenting adults”

(NEAR@Home, US Dept. of HHS, 2016)
**OUR MISSION**

ZERO TO THREE is a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.

Our mission is to promote the health and development of infants and toddlers.

**SUPPORT US**

ZERO TO THREE is on the move - Our main office has relocated to 1255 23rd Street, NW, Suite 350, Washington, DC 20037. Please begin using this new address immediately.

ZERO TO THREE celebrated the 25th National Training

**NEW VIDEO**

Promoting Early Language and Literacy Development - ZERO TO THREE's Policy Center announces the release of a video and a new policy brief illustrating how early language and literacy development contributes to a child's success throughout life. Play the video right from our website and show it to policymakers, advocates, community partners, and others. For more information, check out the early literacy webinar and our wealth of early literacy resources.

**WHAT'S NEW**

**FEATURED RESOURCES**

Improving the Lives of Infants and Toddlers in Foster Care - The youngest children in the child welfare system face the greatest risks. In this issue’s first article, researchers share new data analysis revealing that the rate of children less than 1 year old entering foster care has increased by 75% since 1995.

**FIND IT FAST**

Select a Key Topic

**BABY BRAIN MAP**

The Baby Brain Map reveals the secrets of how early care enriches development.

**DOWNLOAD OF THE WEEK**

The Magic of Everyday Moments™4 to 6 Months: This resource offers information on how children grow and develop from 4 to 6 Months. You’ll find tips for how parents and children can nurture their children’s healthy development.
Three key actions for healthy social and emotional development

Consistent and sensitive caregiving
Repair
Serve and return
The impact of stress

- **POSITIVE**: Brief increases in heart rate, mild elevations in stress hormone levels.
- **TOLERABLE**: Serious, temporary stress responses, buffered by supportive relationships.
- **TOXIC**: Prolonged activation of stress response systems in the absence of protective relationships.
“Pile up”

Infant and child vulnerabilities such as sensitive temperaments, prematurity, congenital problems, neurodevelopmental or genetic disorders, prenatal exposure to alcohol or other drugs (this may include prescription drugs)

Parent vulnerabilities such as mental illness, problematic substance use, low cognitive ability, a history of unresolved trauma, or a limited understanding of children’s development

Relationship issues such as a mismatch between infant and parent temperaments, family parenting practices or challenges, or attachment/bonding problems

Environmental or contextual issues (adverse life circumstances) such as poverty, insecure housing, social isolation, lack of family/social supports, relationship conflict, family violence, culture and acculturation factors

Accumulation and interaction of multiple risk factors
Building resilience

A class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development.

Ann Masten
*Ordinary magic: Resilience processes in development* (2001)
3 systems for promoting resilience in individuals, families and communities

• Capabilities:
  • Developed sequentially, developmental milestones - including emotional regulation, self-efficacy, self-esteem
  • Affected by adversity and toxic stress

• Attachment and belonging:
  • Affected by trauma

• Community, culture and spirituality:
  • Affected by determinants of health - economics, education, housing, racism
  • Intergenerational influences
  • Impact of stigma, shame

US Dept. of HHS (2016). NEAR@Home: Addressing ACEs in home visiting by asking, listening and accepting. Region X ACE Planning Team.
American Academy of Pediatrics

Eco-Bio-Developmental
Model of Human Health and Disease

Ecology
Biology
Development
The Basic Science of Pediatrics

And together they drive development across the lifespan

WHY YOUR DNA ISN’T YOUR DESTINY

The new science of epigenetics reveals how the choices you make can change your genes — and those of your kids

BY JOHN CLOUD
### Rough history of nature versus nurture (Samaroff, 2010)

<table>
<thead>
<tr>
<th>Historical era</th>
<th>Empirical advance</th>
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<tbody>
<tr>
<td>1880-1940s - Nature</td>
<td>Inherited differences</td>
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<td></td>
<td>Instincts</td>
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<tr>
<td>1920-1950s - Nurture</td>
<td>Reinforcement theory</td>
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<td>Psychoanalytic theory</td>
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<tr>
<td>1960-1970s - Nature</td>
<td>Ethology - species differences</td>
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<td></td>
<td>Behavioral genetics</td>
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<td></td>
<td>Cognitive revolution</td>
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<tr>
<td>1980-1990s - Nurture</td>
<td>Poverty</td>
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<td>Social ecology</td>
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<td>Cultural deconstruction</td>
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<td>2000-2010s - Nature</td>
<td>Molecular biology</td>
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<td>Neuroscience</td>
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<tr>
<td><strong>Now??</strong></td>
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Environmental exposures, stresses, diet, and lifestyle can all induce epigenetic changes that determine whether genes are turned on or off.

Illustration by Jude Buffum

https://harvardmagazine.com/2017/05/is-epigenetics-inherited
History related to development of concept of psychological trauma

- 1800s - development of ideas of neurosis and hysteria
- 1902 - first suicide hotline in San Francisco
- Emerging awareness since World War I - shell shock - treatment was to “get right back to the front”. Symptoms often blamed on “poor moral character”
- Contemporary trauma theory in civilian context - Coconut Grove Fire, Boston, 1942
- 1980 - DSM III - PTSD
Psychological trauma and women

• 1970s - trauma in the lives of women moved “from the private domain of the home to the public arena” with the women’s movement (Ringel et al., 2012)

• Social changes in policies and institutions to address barriers of secrecy, shame and denial

• Emergence of “battered women syndrome” and “battered child syndrome” in legal and health contexts

• 1971 - first rape crisis centre

• 1984 - landmark epidemiological survey (Russell) - 25% of women had been raped, 33% had been sexually abused in childhood
• Judith Herman - psychiatrist - landmark book on trauma and recovery (1997) - essential connections between biological, psychological, social and political dimensions of trauma

• Maxine Harris and Roger Fallot (2001) - pioneered the notion of trauma-informed services for the survivors of violent victimization - book - “Creating Cultures of Trauma-Informed Care”

• Elliot, Bjelajac, Fallot, Markoff & Reed (2005) - described 10 principles for designing trauma-informed services
The “ACE” study..

- Adverse Childhood Event study
- Key finding - childhood experiences are powerful determinants of who we become as adults
- Unaddressed traumatic experiences have a graded effect on future physical, mental and social well-being
- 17,000 HMO participants
- 1 in 4 exposed to 2 categories of ACE; 1 in 16 to 4
- 22% sexually abused as children
- 66% of the women experienced abuse, violence or family strife in childhood
What is trauma?

The response that happens when an event, series of events, or set of circumstances is *experienced* by an individual because physically or emotionally harmful or threatening (SAMHSA, 2014).

- Trauma can result from early experiences in life such as child abuse, neglect, and witnessing violence as well as later experiences such as violence, accidents, natural disasters, war, and sudden unexpected loss.
- Depending on contextual factors this experience can have *lasting effects on the individual’s functioning and well being*
- Trauma results from experiences that *overwhelm an individual’s capacity to cope*
- Post-Traumatic Stress Disorder (PTSD) is a diagnosis used to describe one type of mental health response that can result from trauma/violence. Depression is another common response.
SAMHSA’s informed 6 principles of trauma-practice

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical, and gender issues
# SAMHSA’s elements of trauma informed care (4 “R”)

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
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<tbody>
<tr>
<td>Realizing</td>
<td>the widespread impact of trauma and understands potential paths for recovery</td>
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<tr>
<td>Recognizing</td>
<td>the signs and symptoms of trauma in clients, families, staff, and others involved with the system</td>
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<tr>
<td>Responding</td>
<td>by fully integrating knowledge about trauma into policies, procedures, and practices</td>
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<td>Seeks to actively resist....retraumatization</td>
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Language and assumptions

<table>
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<tr>
<th>Unhelpful Assumption</th>
<th>Helpful Response</th>
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<tbody>
<tr>
<td>This person is sick</td>
<td>This person is a survivor of trauma</td>
</tr>
<tr>
<td>They are weak</td>
<td>They are stronger for having gone through the trauma</td>
</tr>
<tr>
<td>They should be over it already</td>
<td>Recovery from trauma is a process and takes time</td>
</tr>
<tr>
<td>They are making it up</td>
<td>This is hard to hear, and harder to talk about</td>
</tr>
<tr>
<td>They want attention</td>
<td>They are crying our for help</td>
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<tr>
<td>Don’t ask them about it or they will get upset</td>
<td>Talking about the trauma gives people permission to heal</td>
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<tr>
<td>They have poor coping methods</td>
<td>They have survival skills that have got them to where they are now</td>
</tr>
<tr>
<td>They’ll never get over it</td>
<td>People can recover from trauma</td>
</tr>
<tr>
<td>They are permanently damaged</td>
<td>They can change, learn and recover</td>
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Developing a trauma informed perspective: A culture shift

Not everyone needs to know everything about trauma, but everyone needs to know something.

- Shift from: “What is wrong with her?” to “What happened to her?”
- Integrate this knowledge into every aspect of service design and delivery
- Recognize “problem behaviors” as an attempt to cope with past experiences.
- Know that disclosure is not required
“Universal precautions”..

• Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences

• Start with assuming that people are doing the best they can at any given time to cope with the effects of trauma
Family centered care and trauma informed care are complementary.

<table>
<thead>
<tr>
<th>Family Centered Care Core Concepts (IPFCC)</th>
<th>Trauma Informed Care Principles</th>
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<tbody>
<tr>
<td>Respect and dignity</td>
<td>Safety</td>
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<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>Collaboration</td>
<td>Collaboration and mutuality</td>
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<td></td>
<td>Choice</td>
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<td></td>
<td>Cultural, historical and gender issues</td>
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Trauma and pregnancy outcomes

• PTSD has been linked with a number of concerns during pregnancy (Bell & Seng, 2013):
  – high risk behaviors, such as tobacco and alcohol use
  – complications such as miscarriage, ectopic pregnancy, hyperemesis gravidarum
  – preterm contractions that do not lead to preterm delivery
  – the adverse outcomes of lower birth weight, and shorter gestation
Trauma in the NICU

- Emerging studies on prevalence of ASD, PTSD in the NICU context (Lefkowitz, Baxt & Evans, 2010; Peebles-Kleiger, 2000; Shaw et al., 2009)

- For parents and families:
  - Coping with possible death of their child
  - Seeing their child require multiple serious procedures
  - Seeing their child in pain
  - Physical environment is overwhelming

- For team members:
  - Secondary or vicarious trauma
  - Constant critical care nature of work
  - Moral and ethical challenges
Landmark study of birth mothers of 80 children with Fetal Alcohol Syndrome

- **Goal of study** - to generate a profile of birth mothers of children with FAS
- 257 women eligible
- 27 deceased; 97 could not be located
- 80% of children no longer in the custody of their mother
- Of the 80 interviewed:
  - 100% seriously sexually, physically or emotionally abused
  - 80% had a major unaddressed mental illness
  - 80% lived with men who did not want them to quit drinking

“A call to action”

- 3-10 million children witness domestic violence every year
- More than 30% of adolescents 14-17 have seen a parent assaulted
- More than 100 women are murdered every year by their partner
- 1 in 5 women will be sexually assaulted in their lifetime
- More than 8 million days of work are missed every year as of domestic violence
What is harm reduction?

• A “contentious issue” in drug policy
• Emotion/ethics laden
• Many misperceptions
What is harm reduction?

- **Harm Reduction** refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are *public health, human rights and social justice*. It benefits people who use drugs, families and communities.

- **Harm Reduction** is underpinned with the knowledge that many drug-related problems are not the result of the drugs themselves; rather they are the *consequences* of the unregulated manufacture and trade of drugs and the enduring commitment to failed policies and ill-thought-out and inequitably applied laws.

- Finally, **Harm Reduction** ensures that people who use psychoactive substances are treated *with respect and without stigma*, and that substance-related problems and issues are addressed *systemically*.

Source: *Canadian Harm Reduction Network*
Harm reduction is a pragmatic public health approach to reducing the negative consequences of risky behaviors.
Well known examples of harm reduction

- **Related to substance use:**
  - Nicotine patches, e-cigarettes
  - Needle exchange programs
  - Supervised injection sites
  - Methadone maintenance
  - Drug substitution
  - Peer administered Naloxone
  - Street outreach programs
  - Safer crack pipe programs

- **In other areas:**
  - Seat belts, helmets
  - Interventions related to chronic disease
  - *What about harm from the health care system? (and us as care providers)*
Key principles of harm reduction

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

Source: Harm Reduction International
Historical development of concept

- Netherlands, UK

- Commissions established to pragmatically determine how to balance interpretation of the law and the best interests of individuals in the context of minor drug offences

- “Balance of harms” approach
History of harm reduction in the US:

- Moralistic condemnation of intoxication and of dependence on psychoactive drugs
- Stigmatization of racial/ethnic minority groups
- Demonization of the psychoactive drugs used by particular minority groups
- Tradition of science to address health problems


Be Here for The Cure
Get Early Treatment for HIV
San Francisco AIDS Foundation

What Have You Got Against A Condom?

Good boys always wear their rubbers.
In Canada:

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

Four key areas:

1. Women and harm reduction: New models of care
2. Women's rights and maternal advocacy
3. Supporting mother and child
4. Different communities, different approaches
Evidence for harm reduction during pregnancy

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

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

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

- Harm reduction in Canada just beginning - women’s health advocates looked to the UK and Netherlands
- Recognition that the consequences of drug use are not the same for all women: poor women, Aboriginal women, and women of colour the most vulnerable to arrest, child apprehension, and poor health outcomes
- Sheway (Vancouver) and Breaking the Cycle (Toronto) in the 1990s - earliest programs in Canada to use harm reduction approaches during pregnancy
Impact of early evaluation findings: From radical and invisible to international best practice

In 2004, ‘Breaking the Cycle’ was recognized by the United Nations Office on Drugs and Crime as an exemplary program serving pregnant and parenting women with substance use problems and their young children.
Interventions to promote a healthy pregnancy and reduce the harms of substance use: What does harm reduction during pregnancy look like?

- Prenatal care
- Primary health care
- Dental care
- Mental health treatment and support
- Food vouchers (e.g., milk, eggs)
- Hot meals
- Prenatal vitamins
- STI testing
- Promoting condom use (to prevent STIs)
- Antiretroviral therapy
- Buprenorphine and methadone maintenance treatment
- Nicotine replacement therapy
- Support with cutting back or quitting smoking
- Withdrawal management
- Addiction counselling & treatment
- Education (e.g., alcohol and tobacco are more likely to have long-term effects on fetus)
- Promoting safer substance use (e.g., providing clean needles)
- Rooming in
- Help with attending appointments (reminders, transportation, advocacy)
- Stable housing
- Legal advice and advocacy (e.g., child protection, family, and criminal matters)
- Financial aid
Why do these programs work?

- Outreach
- Practical support
- Harm reduction
- Integrated - “one stop shop” model
- Integrity of mother-baby dyad
- Trauma and safety informed
2. Women’s rights and maternal advocacy

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

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

- Countering the tendency for programs and policy to be “fetal-centric”
- FASD prevention/prenatal substance use seen as a child health and welfare issue
- Focus on substance use itself – emphasis on abstinence as indicator of success
- Consequences of drug use are mediated by a woman’s social environment, as is her pregnancy

*Advocating for the “mother and child unit”, not one or the other, leads to better outcomes*
FIR Square - unit at BC Women’s Hospital in Vancouver that provides care for women before and after birth and whose pregnancies are complicated by substance use.

952 moms and babies at FIR Square - babies who were kept with their moms after birth (rather than separated and observed in a quiet room) had fewer admissions to the neonatal intensive care unit, a shorter hospital stay, were more likely to be breastfed while in the hospital, and were more likely to go home with their mothers.

Challenging understandings of ‘good motherhood’

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

*Shift: In 1990s, 0% of infants born to moms in the Downtown Eastside went home with their moms; in 2010s, 70% of infants are going home with their moms*
4. Different communities, different approaches
Attitudes - three components - “ABC’s”

• Affective - feelings, emotional reactions
• Behavioral - how you act
• Cognitive - beliefs, facts, information

Impacted by external factors such as culture, religion, education, past experience, media
Stigma..

This is why
I supported her not to drink
Alcohol during pregnancy can harm a developing baby

www.howtohelp.ca

Alcohol & Pregnancy
What SHOULD the Message Be?

SAY NO TO ALCOHOL WHILE PREGNANT
FETAL ALCOHOL SPECTRUM DISORDER (FASD)

scienceandsensibility.org/pn

https://www.facebook.com/groups/614641739643471
What helped me as a health care provider...

• Learning more about substance use, trauma, violence and mental health within the context of women’s health
• Widening my network of support and resources
• Meeting and caring for more women, mothers and families, both within the NICU setting and out in the community, and hearing their stories

“Slowly, I have come to see that asking, and listening, and accepting are a profound form of doing”

Vincent J. Filletti
What can I do in my everyday practice? In my community?
Thank You

lenoram@uvic.ca