BRIDGES AND BARRIERS TO CARE FOR WOMEN STRUGGLING WITH SUBSTANCE-USE DURING PREGNANCY IN NORTHERN BC

INFORMATION DEVELOPMENT COMMONS – BROWN BAG LUNCH
27 APRIL 2017

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DISCLOSURES

Nothing to declare
Acknowledgements

I would like to acknowledge the traditional territories of the Lheidli T’enneh and the Carrier Nation upon which much of this work was undertaken.

Without their welcome this work would not be possible.
In Memory of Margaret Coyle
OBJECTIVES

1. Review the development of research in Northern Health around perinatal substance-use.

2. Describe the creation of supported housing for women struggling with substance-use during pregnancy.

3. Discuss paths forward in addressing gaps in care for women with substance-use in the peripartum period.
TEAM MEMBERS

UNBC

CENTRAL INTERIOR NATIVE HEALTH SOCIETY

UBC

northern health

WOMEN’S HEALTH RESEARCH INSTITUTE
AT BC WOMEN’S
Challenging Geographies

- Remote and dispersed communities
- Aboriginal population is 17%
- Total population 300,000
PERINATAL SUBSTANCE-USE

- Pregnancy as a unique opportunity along the life span
- Women struggling with substance-use during pregnancy and post-partum come with complex needs
- Years of work by dedicated and passionate community members
- Strategic Dialogue – January 2015
- Goal of creating evidence to change practice
  - Specific to northern populations
Research Objective

• Identify perceived gaps in the continuum of care both in community and acute care settings

• Provide evidence-based information to care providers around effective engagement strategies

• Describe differences in rural versus urban northern populations
THE BIGGER PICTURE

1. Retrospective chart review
2. Provider attitudes to women struggling with substance-use
3. Mapping informal communication and disclosure of substance-use across the north
4. Evaluation of integrated supportive housing for women with perinatal substance-use
Scope of the Problem

Gathering accurate information

Prevalence of substance-use in pregnancy data challenging
  ◦ Stigma
  ◦ Fear of child apprehension
  ◦ Care provider record keeping

Providing adequate resources in a vast geographic area

Inpatient antenatal programs based in Vancouver
  ◦ Requires removing a woman from her family and social supports
Are best practices in use?

- Harm reduction
- Options for detox and inpatient care during pregnancy
- Rooming-in to decrease neonatal abstinence syndrome (NAS)
- Continuity of care
STRATEGIC DIALOGUE

- Review best-evidence
  - Experts in the field
    - Dr. Ron Abrahams – Perinatal Addictions at BC Women’s Hospital
    - Pediatrics
  - Local experience
    - Patient’s lived realities
    - First Nations perspective – Dr. Robin Johnson

- Prioritize areas to target moving forward

- Wide-swath of engaged stakeholders
  - Clinicians, social work, addictions, BC Housing, MCFD, Northern Health, acute and community services
PRIORITIES

1. WRAPAROUND CARE

2. CULTURAL COMPETENCY AND TRAUMA-INFORMED CARE

3. DEDICATED SUPPORTED CULTURALLY SAFE HOUSING
Methods

Phase 1: Patient Journey Mapping
- What is the patient experience at the interface with the health care system?

Phase 2: Semi-structured interviews and survey with care providers
- What are frontline care provider attitudes towards women with substance use in pregnancy?

Phase 3: Retrospective clinical chart review
- What is the prevalence of substance-use in pregnancy in northern BC?

Phase 4: Evaluation of culturally safe supported housing
- What model is relevant for northern populations?
I was throwing up alcohol
Went to physician for pregnancy test, was 3.5 – 4 months pregnant
Had a check-up with nurse at CINHS, taking prenatal pills, seeing nurse 1x week
I had some bleeding and called the ambulance and went to UHNBC
ER checked my blood pressure, bleeding was not stopping
Sent upstairs to LDR, told I had gestational diabetes
Had the fetal heartbeat monitor on
I was sent home, still bleeding and in pain
Saw CINHS nurse for prenatal care, bleeding had stopped
I was in a lot of pain, my water broke at 8 months
Called ambulance to go to UHNBC ER
Alone in ER for 2 hours, in a lot of pain
I felt good with the support I received from CINHS nurse
MCFD came to my house about 6 times while I was pregnant
Staff did not want to help me because I was native, they thought I was doing drugs
One of the nurses asked me if I was high
I was scared, thought I was going to lose the baby
MCFD came to my house a couple of days after I got home
Home with my baby and learning to take care of her, breast-feeding, bathing, changing
CINHS nurse got a car seat for the baby and helped me get home
The day I was discharged the nurse told me at 2:30 pm I was going home
My daughter was born with jaundice and had to stay in the hospital for 2 weeks
Don’t like the hospital, they don’t check in on me or teach me how to breastfeed
MCFD showed up at my house
My baby was apprehended at 6 months old
I tried to get my daughter back
My daughter died in care at age 3
I was doing well and just being a mom
Had a home visit from Healthiest Babies
This was a good experience
MCFD thought I was drinking and that my baby was FAS
Patient Journey Mapping
Staff did not want to help me because I was native, they thought I was doing drugs.

One of the nurses asked me if I was high.

I was scared, thought I was going to lose the baby.
Semi-structured interviews and survey with care providers (n=20)

• Included maternity and NICU nurses, pediatrics, midwifery, social work

• Acute care settings and community health center

• Interviews were transcribed, coded and thematically analysed
Results: Barriers

• Lack of provider knowledge
  • Disconnect between attitudes and opinions

• Post-natal/post-partum perceptions

• Lack of follow-up
  ◦ No options for supported housing at discharge

• Clear disconnect between provider perceptions and patient experience

“I think women do get kind of forgotten after baby is born. I don’t even know if they always have follow-up appointments, like for their own medical care or medical needs really, you know, it’s all around baby.”
Results: Bridges

• Harm reduction
• Wraparound care
• Provider education
  • Trauma informed care
  • Culturally competent care

“I think it can if you approach [the patient] with attitude, you’re just another stereotype, you’re totally going to put up a barrier and... I think, [the patient] senses you have a stereotype about them and they usually feel super guilty already, so they’re super sensitive to when you walk in the room.”
Retrospective Clinical Chart Review

- Total Number of charts = 572
- Hospital and two First Nations Health Providers

Key Findings
- Significantly higher incidence of substance use in rural populations
  - 3x higher rate of substance use
  - Significant difference in proportion of aboriginal women in rural population versus urban population

Proportion of records by residential postal code:
- Prince George: 76%
- Other (rural): 24%
Number of charts N=572

Proportion of records by clinical site
- CINHS: 8%
- CSFS: 6%
- Hospital: 86%

Proportion of records by residential postal code
- Prince George: 76%
- Other (rural): 24%
Self-reported substance use during pregnancy (total records N=527)

- Opiod
- Crack/cocaine
- Amphetamine
- Alcohol

Marijuana: 9.8% vs 19.7% p<0.01

Any substance use: 14.8% vs 26.8% p<0.01

No substance use
<table>
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<tr>
<th></th>
<th>Total N=572 N(%)</th>
<th>Prince George (urban) N=435 N(%)</th>
<th>Other (rural) N=137 N(%)</th>
<th>p-value</th>
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<td></td>
<td>Total N=572</td>
<td>Prince George (urban) N=435</td>
<td>Other (rural) N=137</td>
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<td><strong>Gestational age (days)</strong></td>
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<td><strong>Birth weight</strong></td>
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<tr>
<td>Mean (SD)</td>
<td>7.99(1.81)</td>
<td>7.95(1.86)</td>
<td>8.17(1.58)</td>
<td>0.11</td>
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<tr>
<td><strong>APGAR score 5 minute</strong></td>
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<tr>
<td>Mean (SD)</td>
<td>8.84(1.14)</td>
<td>8.83(1.17)</td>
<td>8.88(1.02)</td>
<td>0.34</td>
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<td><strong>MCFD involved</strong></td>
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<td>521(93.0)</td>
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<td>39(7.0)</td>
<td>29(6.7)</td>
<td>10(7.8)</td>
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<tr>
<td><strong>Child apprehended prior to discharge</strong></td>
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Adjusted odds ratio estimates for factors associated with any substance use

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<td>Reference</td>
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<td>1.54</td>
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<td>Rubella titer</td>
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<td>Non-immune (&gt;10)</td>
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<td>1.19</td>
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<td>0.37</td>
<td>0.12-1.13</td>
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</table>
CULTURALLY SAFE HOUSING

- Harmony House opened official January 2017
- Culturally safe holistic housing for women struggling with substance-use during pregnancy and post-partum
- Aboriginal grandmothers
- Harm reduction model
- Art Heals Program
- Multidisciplinary
- Home visit by midwifery!

Province of BC
MEASURING OUTCOMES

- Indigenous methodologies
- Maternal and neonatal outcomes
- Integral role of Aboriginal Grandmothers in mentorship
- Participant-defined outcomes
JOURNEYING WITH WOMEN...
Moving Forward

Changes to the current model of care

• Enhance screening for substance use

• Provide informal opportunities for patients with addictions to access care in a non-judgmental environment

• Increase care provider knowledge

• Wraparound services

• Holistic and culturally relevant housing options – provide evidence for ongoing services
URBAN TO RURAL

- Prevalence of perinatal substance-use up to 3x higher in rural areas
- How can we focus much-needed resources and programming in these areas rather than urban centers?
- Primary care home model in action
- Community driven projects
  - Gaia (Dawson Creek)
LESSONS FROM THE JOURNEY

- Let your research be defined by the voiced needs in front of you
- Focus on sustainable relationships rather than methodology
- Show up....and keep showing up!
ACKNOWLEDGEMENTS

• Maria Brouwer
• Margaret Coyle
• Lucille Duncan
• Vanessa Salmons
• Jane Richie
• Rachael Wells
• Tammy Hoefer
• Lindsay Matthews
• Domnick Manhas
• Kat Harwig
• Carolyn Emon
• Megan Enos
• Heather Pedersen
• Gerrard Prigmore
• Ron Abrahams
• Murry Krause
• Olive Godwin
• Karen Underhill
• Sharon Hurd
• Tarissa Alec
Questions

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