


BC PREGNANCY

OUTREACH PROGRAM HANDBOOK SUPPLEMENT

Perinatal Substance Use



BC Association of Pregnancy Outreach Programs

BCAPOP

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BC Pregnancy Outreach Program Handbook Supplement

Perinatal Substance Use

The development of this handbook supplement included extensive consultation and collaboration with pregnancy outreach program team members, stakeholders and professionals. The original content was created by Heather Cameron, RN, Executive Director of BC Association of Pregnancy Outreach Programs, and her work was directed by a provincial volunteer advisory committee. BCAPOP would like to gratefully acknowledge funding from the PHSA Provincial Perinatal Substance Use Project for supporting the development of this handbook supplement. The entirety of the views expressed herein do not necessarily represent the views of the BCAPOP, the PHSA Provincial Perinatal Substance Use Project, or the Advisory Committee Members.

Acknowledgements

This handbook supplement is dedicated to the pregnant and newly parenting individuals¹ who use substances, the pregnancy outreach workers who work diligently to support them, and the community partners that come together to create best-practice support services. All photos in this handbook have been used with permission.

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¹ A note about gender and sexual orientation terminology: In this document the terms pregnant women and pregnant individual are used. This is to acknowledge and be inclusive of transgender individuals who are pregnant, and to respect those who wish to continue to be called women. We encourage all providers to respectfully and non-judgmentally ask all pregnant people about their preference for how they wish to be addressed and to recognize that a participant's gender identity may differ from their anatomical, physiological or genetic assignment. We also encourage providers to not assume the gender and sexual orientation of the partners of those who are pregnant.



Contents

Acknowledgements.....	1
BC Pregnancy Outreach Program Handbook Supplement <i>Advisory Committee</i>	1
Introduction.....	4
Pregnancy Outreach Worker Role.....	5
Nutritional Support.....	5
Outreach and One-to-One Support	6
Group Sessions	6
People-first Language	6
Working in a Trauma-Informed Way.....	7
Trauma-Informed Principles	7
Applying Trauma Awareness	8
Applying Safety & Trustworthiness.....	8
Applying Choice & Collaboration.....	8
Applying Strengths-Based & Skill Building.....	9
Implementing Trauma-Informed Approaches.....	9
Preparation	9
Engagement.....	9
Connecting with trauma-specific services.....	10
Cultural Safety, Humility & Awareness	10
Cycle of Addiction.....	11
Stages of Change	12
Method for Building Motivation to Change: OARS	13
Cycle of Recovery	13
What “Recovery” Means.....	14
Relapse Prevention Planning	14
Safety Planning.....	14
Harm Reduction Strategies.....	14
Harm Reduction Supplies.....	15
Safer inhalation supplies	15
Safer injection supplies.....	15
Safer sex supplies.....	16
Pregnancy and Substance Use.....	16
Prenatal Care.....	16
Duty to Report to Child Welfare Agencies During Pregnancy	17



Detoxification	17
Substance Specific Detoxification During Pregnancy	18
Residential Treatment and Day Programs	18
Effects of Substance Use During Pregnancy	19
Alcohol and Pregnancy	19
Cannabis and Pregnancy	19
Nicotine and Pregnancy	19
Stimulants and Pregnancy	20
Non-Prescription/Prescription Opioids and Pregnancy	20
Opioid Agonist Treatment	20
Methadone (Methadose)	21
Buprenorphine/Naloxone (Suboxone)	22
Slow-Release Oral Morphine	22
Injectable Opioid Agonist Treatment	22
Naloxone (Narcan)	23
Naloxone and Pregnancy	23
Naloxone Training	23
Labour and Delivery	23
Prenatal Education Prior to Labour	23
Support Persons During Labour and Delivery	24
Pain Management in Labour	24
Postpartum	25
Breastfeeding and Substance Use	25
Breastfeeding Safety Plan	25
Breastfeeding Delay or Pump and Dump Recommendations	26
Breastfeeding and Child Welfare	28
Parenting and Substance Use	28
Child Welfare Concerns	29
Working with MCFD/Delegated Agency	29
Support Families Through Apprehension	30
Summary	30
Resources	30
References	31



Introduction

Pregnancy outreach program workers have a unique opportunity to positively impact the lives of pregnant individuals who use substances, their babies and their families. As part of the BC Association of Pregnancy Outreach Program's (BCAPOPOP) work to support program staff, BCAPOPOP completed a needs assessment survey of 77 pregnancy outreach programs in British Columbia in June 2019. The survey explored substance use in pregnancy supports.

The results indicated:

- An estimated 1224 pregnant women who used substances were served by pregnancy outreach programs in the prior 12-month period;
- 97% of respondents indicated an interest in in-person perinatal substance use training;
- 88% of respondents identified a BCAPOPOP Perinatal Substance Use Handbook as a needed resource;
- The top three resources that would be useful included a webpage with perinatal substance use resource links, quick-reference sheets for staff, and a booklet for new parents on how to care for an infant who has been exposed to substances during pregnancy.

In response to the information collected, BCAPOPOP created an advisory committee to oversee the Substance Use in Pregnancy project, launched a Perinatal Substance Use Resource List webpage on the BCAPOPOP website, planned training in the Fall of 2019, and is creating and distributing resources such as this handbook supplement.



Pregnancy Outreach Worker Role

Pregnancy outreach program workers come from diverse backgrounds and bring their unique personal experiences to the role. Reflecting on one's own values and biases towards substance use prior to working with pregnant and newly parenting individuals who use substances can be informative and helpful. Having differing opinions and thoughts towards the topic is healthy and can be an advantage to a team working with a participant. As with any "helping profession", it is imperative for pregnancy outreach workers to self-reflect on how the actions of the participant affect them personally and identify if personal biases or judgements can be put aside in order to be a healthy support.

Working with pregnant and newly parenting individuals who use substances can be very rewarding. At the same time, it can take a toll on staff emotionally, mentally and physically. Self-care will enable pregnancy outreach program staff to stay healthy, avoid burnout, address vicarious trauma and continue to benefit the participants long term. The importance of de-briefing confidentially with a safe co-worker and/or accessing services that promote wellness is essential. Participants who use substances are often encouraged to implement self-care in their own lives. It's equally important for staff to "walk the talk" and take care of themselves first.

Nutritional Support

Pregnancy outreach programs can have a positive impact on the outcomes for both the pregnant individual who uses substances and their baby through nutritional support. Nutritional support can include connecting the participants with a dietician or offering prenatal vitamins, vitamin/mineral supplementation, infant vitamin D drops, food vouchers, food bags/boxes, nutritious meals and snacks. Activities that can help to improve the health status of pregnant women who use substances include community kitchens, cooking classes and community gardens. Not only can nutritional support improve the health status of the pregnant individual, but activities involving sharing a meal or providing food can lead to opportunities to build rapport and can be a motivating factor for a participant to return to a pregnancy outreach program leading to accessing other services and support.



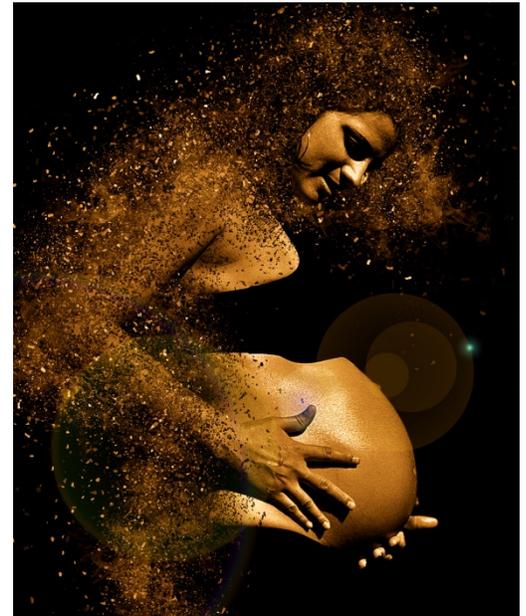
Outreach and One-to-One Support

Pregnancy outreach programs can offer support to pregnant and newly parenting individuals who use substances through outreach, one-to-one appointments and groups. Consistent providers have the advantage of building rapport and working more effectively with participants. Staff are encouraged to use their own judgement when it comes to meeting the needs of each participant and the type of support offered.

Many pregnancy outreach program workers recognize that hard to reach participants require more time and repeated offers of support before it is accepted. This may include leaving a business card on a participant's door weekly, leaving phone messages, or repeatedly extending an invitation to groups. Nobody can predict when a participant will be able to accept the help offered. As such, it's important to persist in offering services.

Group Sessions

Pregnancy outreach programs throughout BC are ideal hosts to provide group sessions specifically for pregnant and newly parenting individuals that struggle with substance use. Providing group sessions such as the 16 Steps of Empowerment, Mothers for Recovery, or Circle of Support provide opportunities for pregnant and newly parenting individuals to address their substance use, create a social support network, and to build rapport with pregnancy outreach program workers. Group guidelines and manuals are readily available online, in bookstores, and through other agencies.



People-first Language

The language used by pregnancy outreach program workers when supporting a participant, or talking about a participant to other staff members, can have a powerful impact on reducing the stigma experienced by pregnant women who use substances.

A way to reduce stigma and work in a trauma-informed way is to use "people-first" language, also called "person-first language". People-first language uses phrases and words that identify the individual as the priority, and only secondly as a person with a trait/characteristic/condition.

Examples of people-first language:

- "Pregnant individual that uses substances" vs. "addicted pregnant individual"
- "Baby exposed to substances" vs. "addicted baby"
- "Families in recovery" vs. "recovery families"
- "Moms prescribed methadone" vs. "methadone moms"

Staff are encouraged to use language that best supports participants and reduces further stigmatization of pregnant women who use substances.

Working in a Trauma-Informed Way²

People start and continue to use substances for a variety of reasons, but substance use can often become a strategy for coping with experiences of trauma. Trauma involves the experience of an event or series of events or circumstances that are overwhelming, and that has lasting negative effects on one's ability to cope in daily life. Trauma experiences can arise from interpersonal violence, sexual assault, sudden loss, accidents, exposure to natural disasters like wildfires, and many other difficult experiences. Historical, intergenerational and complex trauma arise from cumulative experiences such as colonization, residential school experiences, and war. There are a wide range of effects these traumatic experiences can have in physical health, social relationships, emotional health, and spiritual wellness.

All pregnancy outreach program workers need to be aware of how the experience of trauma can affect those accessing services, and to offer services in a trauma-informed way. Working in a trauma-informed way is different than providing trauma-specific services such as sexual assault counselling, residential trauma treatment, or one-to-one counselling. Working in a trauma-informed way means to universally provide safety, choice and collaboration with all participants, and avoiding approaches that may retraumatize (3). It's important to be aware that pregnancy puts individuals at a higher risk of intimate partner violence, especially when the pregnancy is unwanted or unplanned (2). It's not necessary for individuals to disclose a history or current experiences of trauma for pregnancy outreach programs workers to support them in a trauma-informed way. Learning to work in a trauma-informed way requires ongoing education, self-reflection and practice.

Trauma-Informed Principles

Working in a trauma-informed way is not about implementing a rigid set of skills or tasks, but instead is a way of being and working daily with all participants. Pregnancy outreach program workers who work in a



² This section draws on the collaborative work undertaken by many people working in the BC substance use and mental health system of care, and captured in this manual which is available online along with many other resources on trauma informed practice at <http://bcewh.bc.ca/category/post/trauma-violence-mental-health/>. It can also be downloaded from the Ministry website (2).

trauma-informed way integrate the core trauma-informed principles of trauma awareness, safety, trustworthiness, choice, collaboration, and strength-based and skill-building approaches into their daily practice. These principles are summarized below.

<p style="text-align: center;">Trauma Awareness</p> <p>Trauma awareness is the foundation for trauma-informed practice. Being trauma aware means that service providers understand the high prevalence of trauma in society, the wide range of responses, effects, and adaptations that people make to cope with trauma, and how this may influence service delivery (e.g., difficulty building relationships, missing appointments).</p>	<p style="text-align: center;">Safety and Trustworthiness</p> <p>Physical, emotional, spiritual, and cultural safety are important to trauma-informed practice. Safety is a necessary first step for building strong and trustworthy relationships and service engagement and healing.</p> <p>Developing safety within trauma-informed services also requires an awareness of secondary traumatic stress and the promotion of self-care for all staff in an organization.</p>
<p style="text-align: center;">Choice, Collaboration and Connection</p> <p>Trauma-informed services encourage opportunities for working collaboratively with people. They emphasize the fostering of choice and connection within the parameters of services provided. Having the opportunity to establish positive connections with service providers, peers, and the wider community can promote health, and encourage further connection and engagement with services.</p>	<p style="text-align: center;">Strengths-Based and Skill Building</p> <p>Promoting resiliency and coping skills can help individuals manage triggers related to past experiences of trauma and support healing and self-advocacy. A strengths-based approach to service delivery recognizes the abilities and resilience of trauma survivors and fosters empowerment.</p>

Applying Trauma Awareness

In order for program staff to work in a trauma-informed way they must be provided with ongoing educational opportunities that foster awareness of the high occurrence of trauma among pregnant women who use substances, the relationship between substance use in pregnancy and trauma, how this impacts pregnant women’s lives, and the coping skills pregnant women are utilizing to deal with trauma.

Applying Safety & Trustworthiness

Working in a trauma-informed way means creating a sense of safety and trust between staff and participants. Pregnant individuals who both use substances and have a history of trauma have likely experienced relationships where power was abused, and trust was broken. They have also potentially lived or are living in unsafe spaces. When pregnancy outreach programs and their staff provide safe physical spaces and welcoming intake processes, and gain informed consent for all services and referrals, make program expectations clear, and follow through on commitments, they can create a sense of safety and trust for the participant.

Applying Choice & Collaboration

Pregnancy outreach program workers can further work in a trauma-informed way through providing choices in the types of services offered through their program and service agency referrals made for the participant. Participants who have a history of trauma, or who are currently experiencing it, may not identify their experience as traumatic and may not be in a place mentally and emotionally to work through it. Working in

collaboration with participants to identify their needs, and referring them to the appropriate services, will support best outcomes.

Applying Strengths-Based & Skill Building

When working with pregnant women who use substances and have experienced trauma, it is of utmost importance to assist them in identifying the strengths and skills they already possess and build on these. The concept is to focus on doing more of what's working, instead of focusing on doing less of what isn't working. This will increase self-efficacy in the pregnant women and contribute to better outcomes.

Pregnancy outreach program workers can work with pregnant women who use substances to identify triggers and coping skills (both helpful and less helpful). They can also act as role models and offer to teach skills for grounding, centring and staying present. There are a wide variety of simple grounding exercises and ideas for healthy coping skills readily available online to assist pregnancy outreach workers to support participants.

Implementing Trauma-Informed Approaches

In order to successfully implement trauma-informed ways of working in pregnancy outreach programs, we must consider how our policies, procedures and physical spaces reflect the principles. It's often helpful for workers to review these program policies and practices with program participants to get ideas for how to change approaches that may be experienced as traumatizing. Pregnancy outreach program workers may wish to start with the following steps.

Preparation

Pregnancy outreach programs and staff can prepare themselves for implementing trauma-informed approaches by accessing continuing education on trauma-informed practice and through regular self-evaluation. Suggested topics to learn about include effects of trauma and vicarious trauma, and approaches to teaching mindfulness and coping skills. Increasing the knowledge and skill level of program staff is an ongoing process that is paramount to providing trauma-informed pregnancy outreach services. There are numerous online and in-person training programs and modules available in BC.

Engagement

Engagement with pregnant women who use substances can be difficult at the best of times. Pregnancy outreach programs have the unique opportunity to engage with this often hard to reach population and continue the staff-participant relationship over the course of the pregnancy and beyond. Pregnant individuals who struggle with substance use can have a difficult time accessing services for the first time and following up with ongoing appointments due to their experience(s) of trauma that have resulted in a lack of trust, chaotic lifestyle, and mental health issues such as depression. They may also have a current partner/family member who is controlling and not wanting the pregnant woman to access services.

When a participant is difficult to engage it's important to pause and think about what the barriers might be, what approaches may work, and consider how to provide services that meets the needs of the participant. This may look like providing services in a location that is comfortable for the participant, providing on demand-visits when the participant feels safe to engage, or communicating via text messages. Asking the



participant what will work for them and how you can best serve them will contribute to best outcomes for both the pregnant individual and their baby. Pregnant women who have a history of trauma can be quick to cancel appointments, not show up for appointments, and resist ongoing support. This isn't necessarily an indication the participant does not want or need the services provided. Continued repeated attempts at offering collaboration and outreach services is important and worthwhile (3).

Connecting with trauma-specific services

Working in a trauma-informed way does not require a disclosure of trauma from participants. At the same time, it is important that those women who wish/are ready for counselling about trauma are provided with appropriate referrals. The most important task during intake to pregnancy outreach programs is to build relationships. This will allow pregnant women to share what is most important to them, to know they have choice in what services they access, and choice in the pace these services are accessed.

Ideally, pregnancy outreach program workers will share with participants how common the experience of trauma is, and the many ways in which people who access pregnancy outreach services can choose to build resiliency and health. These options include learning self-regulations skills and participating in many other health-promoting activities such as trauma-informed yoga and outdoor walking groups, accessing trauma-specific counselling, and participating in traditional Indigenous healing activities. It will be important to have a list of trauma-informed and trauma-specific services readily available if a participant discloses trauma and wishes to access additional help beyond the pregnancy outreach services.

Cultural Safety, Humility & Awareness

Cultural safety in health practice and care is based on respectful engagement that recognizes and strives to equalize the power imbalances that exist in the health care system. Cultural safety aims to create a culturally safe environment which enables people to receive care in ways supportive of their cultural strength, as opposed to stereotypical thinking, racism and discrimination.

Professionals who provide services to pregnant First Nations women need to take specialized training to learn the skills, attitudes and knowledge to effectively provide care across cultures. First Nations women may have cultural differences, in addition to having a long-imposed history of unresolved trauma, which all too often results in substance use.

Culturally safe health care practices promote self-determination and decolonialization. The western-based healthcare model holds much power and control over expertise knowledge and policy development.

Consequently, the pregnant First Nations woman is in a disparaging position, with the health care provider holding all the power. The western healthcare system



emphasises the values of individualism, empirical evidence, future orientations, and nuclear families—which are very different from the interconnected holistic world view of a traditional First Nations woman. The goal of ensuring cultural safety in service provision is for pregnant First Nations women to feel safe, respected and empowered when they come to seek healthcare services from healthcare providers. Culturally safe services for First Nations women support them in drawing strength from their identity, culture, and community.

Culturally safe services are provided when cultural humility is used to understand our own personal and systemic biases.

Respectful processes grounded in cultural humility include:

- Building authentic and trusting relationships;
- Learning about your own world view and how it was formed, and then strive to learn the world view of the person you are providing services for;
- Developing a curiosity and listening to understand (vs. coming to assumptions or judgements);
- Understanding that not all cultural norms are shared;
- Learning about the local colonial history, including Residential and Day Schools and the present-day impacts on First Nations people, families and communities;
- Learning about intergenerational trauma and the continued impact of Indian Act policies on Canada's First People.

Practicing cultural awareness when supporting pregnant indigenous women will help them, their families, and their communities to become empowered and embrace their healing journeys. Today, there is an increase in health care systems and organizations supporting cultural competency and safety training for their employees. We all must be the change we want to see. Together, we can move mountains and build bridges - to restore wellness and balance to our First Nations people.

Cycle of Addiction

Illicit substance use among girls and women has become an important health, economic and social problem across the globe—sadly remaining mostly invisible. The cycle of addiction is a progressive and powerful path that can either happen over a long period of time or very quickly. Often, individuals will experiment with substances when the opportunity presents itself at a younger age, or in order to deal with the experiences of past or current trauma to relieve emotional or physical pain. Individuals susceptible to addiction may then use substances more often over time due to an increased tolerance to the drug. The rate of the development of tolerance depends on the effects of the drug.

This increased use of substances means a reduction in engaging in healthy activities and using healthy coping skills. Healthy coping skills and habits will then erode and be replaced with habitual substance use to deal with feelings and/or past or current trauma. If there's a sudden cessation of the drug, withdrawal symptoms appear, forcing the individual to resume substance use.

Often, the circumstances of the individual's life will change to accommodate their substance use. These circumstances can include changes in housing, friends and support systems, parenting strategies, daycare use, and modes of income. This does not depict how substance use progresses for everyone but is often the pathway that individuals who use substances have taken who are highest at risk of experiencing addiction. Some of the clinical features of dependence include the neglect of major responsibilities, the continuation of substance use despite the consequences, repeated attempts at abstaining from substance use, developing tolerance, and going into withdrawal and experiencing powerful urges to use (cravings).

Some people can exit the pathway at some point and use substances without losing the ability to function and parent safely. There is controversy over what makes one individual over another able to limit their use of substances. Those who are unable to limit their substance use experience more consequences, stigma, and barriers to accessing services.

Stages of Change

In order to best support pregnant individuals who use substances, it is critical to remember to match the services provided with the goals of the participant. It's easy to jump ahead in stages of change and to the desire for the participant to be in the action stage and "doing" activities that are viewed as beneficial to them. However, it's natural for participants to travel through stages of change at a pace comfortable for them. Some participants may even move forward through the stages, then move back to a previous stage. This is normal and not an indication of their level of commitment to recovery or desire to parent. The importance of understanding these stages is that many women are pre-contemplative when they first become pregnant, but do not want to harm their baby. If they believe they are being given no choice at this time, they will not return for care. These stages are, however, not static.

The Stages of Change:

1. Pre-contemplation: Not aware of/or in denial of a substance use issue/problem. In this stage, ask permission to talk about the problem, discuss the role the drug use plays in her life.
2. Contemplation: Ambivalent, starting to recognize there may be a substance use issue/problem. A conversation starter at this stage might be: "All of us, at one time or another, do things that aren't good for us. Are you doing anything right now that you would put into this category?"
3. Preparation: Getting ready to make changes and talking about solutions to the substance use issue/problem. May commit to a time and plan to change.
4. Action: Doing activities or taking steps towards harm reduction or recovery from substance use. Vulnerable to relapse.
5. Maintenance: Taking long-term actions in attempt to prevent a relapse of substance use and improve overall wellbeing

Method for Building Motivation to Change: OARS³

O = ask Open-ended questions (questions that do not invite short answers (yes/no). "Can you tell me more about that?", "What was that like?", "How did you feel when that happened?".

A = Affirm. Support the person during the process. "Thank you for coming in today, I appreciate it is a long way for you".

R = Reflective listening. Focus on the meaning of what the person is saying. Be a mirror reflecting what was said. "So, what I hear you saying is...."

S= Summarize. Shows you have been listening. Ask if you have missed anything.

Their readiness to change depends on:

Importance: Why should I change? What are my personal values and expectations of the change?

Confidence: Self efficacy. "If you decided right now to stop using, how confident do you feel you would succeed with this?"

Cycle of Recovery

When a pregnant individual has walked down the pathway of addiction to the point where they are unable to limit their use on their own and they require assistance, they will need to transition through the exact opposite steps of the cycle of addiction in order to achieve recovery. Recovery can mean many different things to different individuals and is defined by the individual. The individual may benefit from being supported to practice healthy coping skills and activities. This can take time and repetition to make new ways of being and doing things until it becomes habitual. This will result in less and less time using substances and participating in activities surrounding substance use. Next, lifestyle situations may change to accommodate recovery. This can include changes in housing, friends, support systems, parenting styles, daycare use, and mode of income. Relapses may occur during this transition time.

The focus after a relapse should not be on the relapse itself, but on ways to continue the recovery journey and prevent future relapses. Relapse can be a normal part of the recovery process and does not in itself indicate a lack of desire to parent or to be in recovery. Over time, the individual may need less and less support to implement their new ways of living. Often individuals in recovery will enter a maintenance stage of recovery where they continue to access some type of service(s) long-term to maintain their recovery. Again, recovery is defined by the individual.

³ Adapted from handouts by David Rosengren and from Miller & Rollnick, *Motivational Interviewing, 2nd Edition, 2002.*

What “Recovery” Means

Individuals define what “recovery” means to them. For some, it’s complete abstinence from all substances including drugs and alcohol. For others, recovery may take on a harm reduction approach such as only using cannabis and not opioids, or only using substances when their children are cared for by a safe adult. Others may define recovery as not using their drug of choice but continuing to use alcohol socially. Whatever the individual’s definition of recovery is, it’s important to have a discussion with them so that both the pregnancy outreach worker and the participant are on the same page. This is important for collaborating with the participant to create relapse and safety plans and in order to offer appropriate referrals. Some individuals may change their definition of what recovery means to them over time—through trial and error, or with input from others including family, friends, and professionals.

Relapse Prevention Planning

Relapse prevention plans are a tool used to identify triggers (people, places and things) that put an individual at risk for using substances and strategies to address those triggers. A relapse prevention plan can be as simple as listing triggers, talking about how to avoid those situations, and then listing the strategies to deal with those situations if they arise—as some triggers will be unavoidable. Pregnancy outreach program workers can take time to talk about relapse prevention and creating plan with participants, which can have a positive effect on outcomes. There are many templates available online that pregnancy outreach workers can work through with participants or that they can work through on their own, depending on their preference. Pregnancy outreach program workers can also refer participants to an addiction counsellor or other substance use program to complete relapse prevention planning.

Safety Planning

Pregnancy outreach program workers can create positive impact by assisting in safety planning with participants, identifying who will care for their babies or children if they do use or relapse. This can become part of the relapse prevention plan. Many individuals with a history of substance use who are attempting to live free of substances do not expect to use substances again. A substance use relapse can occur unexpectedly and seem to happen “all of a sudden”. It’s important to plan out safety plans for babies and children well ahead of any potential relapses when the participant is thinking clearly. This should include discussing two or three people who would be safe and reliable to provide childcare, and that the participant can depend on if they are going to use substances. Child welfare social workers may also play a role in relapse prevention plans and safety planning if they are involved with the individual.

Harm Reduction Strategies

“People have the perception that harm reduction happens out there on the street. The fact is that every time you take the time to build a positive relationship with a person, you are practicing harm reduction” (Emergency Room Nurse).

Harm reduction strategies aim to reduce harms, while individuals continue risky behaviours, such as substance use. Pregnant women should have access equal access to harm reduction services and supplies as the general population (2). Harm-reduction services can include supervised consumption sites, take-home naloxone kits, and information about lower-risk use guidelines. Access to food banks or regular meals as nutrition is also an important part in maternal/fetal health.

Harm Reduction Supplies

Harm reduction supplies are items used during substance use or other risky behaviours that reduce the associated risks. Studies show a correlation between harm reduction strategy implementation and reduced risk of infection transmission (HIV/Hepatitis C), decreased risk of death by overdose, and increased opportunities for service providers to provide and promote substance-use related services (2). Harm reduction strategies that are implemented in pregnancy have been shown to have a positive impact on outcomes including a decrease in pre-term birth, healthier birthweights, and an increased probability of the birth parent being safely discharged home with their baby from the hospital (2).

Street outreach nurses, public health units and other agencies may provide individuals who are struggling with substance use a variety of harm reduction supplies that can reduce the risk of infection transmission. It's helpful to be familiar with what these supplies are and how they are used in order to be informed during conversations with participants.



Safer inhalation supplies

- Alcohol swabs
- Personal sharps container
- Crack pipe mouthpiece
- Crack pipe screen
- Crack pipe push stick

Safer injection supplies

- Needles and syringes
- Sterile water
- Acidifier (vitamin C)
- Cooker
- Tourniquet
- Alcohol swabs
- Personal sharps container

Safer sex supplies

- External condoms (sometimes called a male condom)
- Internal condoms (sometimes called a female condom)
- Lubricant

A list of sites around the province that are providing harm reduction supplies can be accessed at: <https://towardtheheart.com/site-finder>.



Pregnancy and Substance Use

Prenatal Care

Pregnancy outreach workers can have a positive impact by referring pregnant individuals who use substances to a prenatal care provider, such as a physician, obstetrician or midwife. Pregnant women who use substances often experience barriers to accessing prenatal care. This can include, but is not limited to, shame, fear of child welfare involvement and/or an abusive or controlling partners/family members. It may be of great worth to connect with a local prenatal healthcare provider to discuss the opportunity to provide on-demand appointments for high-risk pregnant individuals in order to reduce the barriers to care. If possible,

it may also be of great benefit to accompany participants to their appointments until they are comfortable and able to attend on their own. If that's not possible due to limited program staff, then transportation support (bus tickets or taxi vouchers) may be the best next choice. It is important to go to great lengths to support participants who use substances to attend their prenatal appointments as this can have great benefit.

Duty to Report to Child Welfare Agencies During Pregnancy

There is no legal obligation to report the use of substances by pregnant women to the Ministry of Child and Family Development (MCFD) or to delegated agencies. Any contact with MCFD or a delegated agency regarding a pregnant individual who is using substances should be done with explicit consent from the individual (2).

There can be a benefit to connecting with MCFD or a delegated agency if the individual is asking to review assistance to address their substance use and is hoping to parent their baby. The decision to include MCFD or a delegated agency in the support network for a pregnant individual must come from the individual themselves. Some pregnant individuals may already be involved with a child welfare agency if they have had prior involvement with older children. These previous experiences may have been very traumatic for the individual leading to fear and distrust of the child welfare system.

Detoxification

Pregnancy outreach program workers will find it helpful to have knowledge of which substances require medical attention to detoxify from, and which substances can be safely discontinued at home without medical supervision. Sharing this information with participants can help them to make an informed decision



about accessing detoxification services during pregnancy and helps to dispel myths. Pregnant women may feel apprehensive, embarrassed, and shameful about their substance use and this can be a barrier to accessing detoxification services. Stigma can be reduced by normalizing substance use as a part of life and talking about substance use on a regular basis within pregnancy-related services.

In-patient detoxification is not available in every community in BC and those that do exist have different requirements and waitlist times. Become familiar with the local detoxification services. Some communities also have at-home detoxification services that are either publicly funded or private pay.

Substance Specific Detoxification During Pregnancy

- Alcohol: Alcohol withdrawal may require medication, such as lorazepam (Ativan) or phenobarbital to avoid medical complications and/or seizures (8). Alcohol withdrawal can be dangerous and should be addressed under medical supervision and support in order to mitigate fetal distress and pregnancy complications.
- Nicotine: Nicotine withdrawal may be more comfortable and achievable with nicotine replacement therapy (NRT) from a pharmacy, but discontinuing smoking abruptly is considered safe (6).
- Cannabis: Cannabis withdrawal does not require medication to discontinue use abruptly, but pregnant individuals may benefit from professional in or out-patient support (11).
- Stimulants: Stimulant withdrawal does not require medication to discontinue use, but pregnant women may benefit from professional in or out-patient support (11). For some individuals, medications can be used to treat the symptoms of stimulant withdrawal.
- Prescription and non-prescription opioids: Opioid withdrawal may require medication, such as methadone or buprenorphine, to avoid fetal distress and prevent pregnancy complications due to opioid withdrawal (2).

Residential Treatment and Day Programs

If participants are able and willing to attend a residential treatment program to address their substance use, pregnancy outreach workers can be of assistance in connecting them to a referral agent, (usually a mental health and addiction counsellor) or if the treatment centre does self-referrals then pregnancy outreach workers can assist with this process. Often treatment centres that accept self-referrals require forms to be printed, completed, and emailed or faxed back to them.

It's important to become familiar with the local or closest residential treatment centres in order to be prepared to discuss this option with participants if the time is right. There are a growing number of treatment centres in BC that are restricting the intake of pregnant individuals or the trimester they will accept intakes. Also, treatment centres can have waitlists that make it a slower process than what most pregnant women would like to see once they are motivated to attend. Treatment centres may also require that the pregnant individual has attended an in-patient detoxification centre prior to attending residential treatment.

There are a few residential treatment centres that provide treatment to parents and children or families. If an individual is not able to complete treatment during pregnancy, they may be able to attend a program with their child.

Effects of Substance Use During Pregnancy

Pregnancy outreach program workers should be aware of evidence-based information regarding the effects of substances on the pregnant individual, their fetus, and their baby. In order to reduce stigma, it's important to share the truth about the effects of substance use during pregnancy and to also combat myths.

Alcohol and Pregnancy

It is safest not to use alcohol during pregnancy because there is no known safe level of consumption. When a pregnant individual drinks alcohol it's carried to the baby through the bloodstream and the placenta. Alcohol use during pregnancy can cause Fetal Alcohol Spectrum Disorder (FASD) and/or may lead to spontaneous abortion (miscarriage), stillbirth, premature birth, or low birthweight. FASD is a lifelong, irreversible disorder that can include brain damage, vision/hearing problems, slow growth, birth defects and/or heart problems. FASD can lead to learning disabilities, memory problems, and issues with judgement or problem solving (9). It's common in Canada for individuals to consume alcohol prior to becoming aware that they are pregnant. Most pregnant individuals will abstain from alcohol once they find out they are pregnant, but some will have difficulties abstaining because they are dependent on alcohol.

Cannabis and Pregnancy

It is safest to not use cannabis during pregnancy because there is not enough research today to give guidelines on a safe amount of cannabis consumption during pregnancy (9)(10). When a pregnant individual uses cannabis, THC, the active ingredient that creates a "high", is carried through the blood stream and passes through the placenta to the fetus (10)(6). Because THC is stored in fat cells and then is slowly released back into the blood stream, it can stay in the pregnant body and fetal body for up to thirty days after the last use (10)(6). Cannabis use during pregnancy has been related to lower birth weights (6) and could affect the baby's mental health (10). Researchers need more time to produce a larger body of research before anyone can be sure of the effects and outcomes for babies exposed to cannabis during pregnancy (10).

Nicotine and Pregnancy

There is no known safe amount of nicotine consumption during pregnancy (9), therefore, it's safest not to use nicotine during pregnancy. Nicotine can be used through smoking cigarettes/cigars, vaping, through tobacco rolled into a joint of marijuana, and in nicotine patches and gum. Tobacco cigarettes include nicotine, but also over 4000 other toxic chemicals (9). Therefore, nicotine replacement therapy (NRT) including nicotine gum, patches or inhalers are a harm-reduction strategy for pregnant women trying to quit smoking cigarettes. Tobacco use during pregnancy can result in premature birth, stillbirth, or a low birthweight. Children of individuals who smoked cigarettes during pregnancy are more likely to smoke

cigarettes as an adult. Vaping through electronic cigarettes has not been shown to be as safe as nicotine replacement therapy, as the vapour has chemicals that have been linked to birth defects and cancer (9).

Stimulants and Pregnancy

Stimulant use includes cocaine, amphetamines and methamphetamines. Cocaine can be consumed through mucous membranes (snorted nasally, rubbed on gums or other mucous membranes), smoked when in “rock” form, or injected. Amphetamines include prescription drugs such as methylphenidate (Ritalin) that can be useful in the medical treatment of attention deficit hyperactivity disorder (ADHD), but can also be a drug of abuse when used by an individual who does not have a prescription. Methamphetamines are produced and consumed in a variety of forms including those known as speed and crystal meth. Methamphetamines are the only illegal substances produced from legal ingredients, including pseudoephedrine, and are cheaper to purchase and use than other stimulants, such as cocaine. There is no known safe amount of non-prescription stimulant use during pregnancy, so it’s safest not to use non-prescription stimulants during pregnancy (6).

Stimulant use in pregnancy increases the risk of early miscarriage, placental abruption (the placenta separates from the uterine wall ceasing oxygen delivery to the fetus), stillbirth, pre-term rupture of membranes, premature birth, intrauterine growth restriction (IUGR), and low birthweight. Stimulants are also known to decrease appetite, which can result in poor nutrition in pregnancy, and increased pulse and blood pressure (6).

Non-Prescription/Prescription Opioids and Pregnancy

Non-prescription opioids include heroin and non-medical use of opioids such as morphine, hydromorphone and fentanyl. Opioids can be taken orally, snorted nasally, applied trans-dermally (patches applied to the skin), smoked or injected. Often, individuals are not even aware they are using fentanyl as many illicit pills, heroin or cocaine are “cut” with fentanyl without their knowledge. There is no known safe amount of non-prescription opioid use during pregnancy, so it’s safest to not use non-prescription opioids during pregnancy.

Prescription opioids are medications prescribed by a healthcare professional for pain and/or opioid agonist therapy (OAT). Prescription opioids include methadone, buprenorphine, fentanyl, morphine, hydromorphone, and oxycodone (2). See the “Opioid Agonist Treatment” section below for more information.

Untreated non-prescription opioid use in pregnancy may result in fetal distress with repeated episodes of withdrawal, nutritional deficiencies resulting in inadequate weight gain, low birthweights, and can lead to spontaneous abortions (6).

Opioid Agonist Treatment

All pregnant individuals who struggle with non-prescription opioid use should be offered opioid agonist treatment (OAT) by their primary healthcare provider (2). Non-prescription opioid use can include heroin and/or non-prescribed fentanyl, oxycodone, hydromorphone (Dilaudid) and Percocet (4).

OAT is the prescribing of a long-acting opioid that replaces the short-acting opioid and prevents withdrawal symptoms for 24-36 hours (4). OAT medications include methadone (Methadose), buprenorphine/naloxone (Suboxone), slow-release oral morphine or injectable opioid agonist treatment (iOAT).

The goal of OAT in pregnancy is to support individuals to reduce or abstain from non-prescription opioid use and has been shown to improve the outcomes for both the individual and their baby (2). OAT is one tool available to assist pregnant and parenting individuals achieve their goals in pregnancy and/or parenting. It's recommended that OAT be combined with other types of support such as, but not limited to, counselling, in-patient treatment, and/or group sessions in order to be effective (2)(4).

Withdrawal management alone, without OAT, is not recommended for opioid use disorder due to the high risk of relapse that can result in overdose, fetal stress, and infections (2). Individuals that are stable on any type of OAT are not encouraged to switch between OAT medications, because tapering down from one OAT medication and initiating another OAT medication poses a risk of relapse and possible fetal stress (2). If an individual insists on switching or tapering OAT, encourage them to work closely with their physician and have a back-up plan in place to prevent relapse. Pregnancy outreach workers may work more often with pregnant women prescribed methadone or buprenorphine/naloxone (Suboxone) than those prescribed slow-release oral morphine or injectable opioid agonist treatment (iOAT).

Methadone (Methadose)

Methadone (Methadose) is a common type of OAT and is safer for pregnant individuals and their fetuses than continued non-prescription opioid use or withdrawal management alone. This is because methadone provides a consistent level of long-acting opioids in the pregnant body and to the fetus (2). Preventing fluctuations of opioid levels in the body that come with using non-prescription, short-acting opioids is important in improving pregnancy outcomes (2). Methadone has been shown to decrease risk of relapse and provides consistent opioid levels, in turn improving birthweights, rates of live births, increased gestation time, and reduces newborn hospital stay length (2) compared to continued non-prescription opioid use.

During pregnancy, an individual's prescriber may find it necessary to increase their dose of methadone due to the increased blood volume and metabolism that comes with pregnancy. It can be difficult for a pregnant individual to differentiate between opioid withdrawal symptoms and symptoms of pregnancy, hence consistent follow-up appointments with their prescriber will be imperative to being prescribed a safe and effective dose (2).

After giving birth, the methadone dose may be decreased by their prescriber due to the decrease in blood volume and metabolism (2). Without adequate monitoring of their methadone dose it's possible for the parent to experience drowsiness or sedation that could interfere with safe parenting practices. It's also common for new parents to be sleep deprived due to caring for a newborn. Having a conversation with the new parent as to what they believe is causing their drowsiness is very important. If they believe it is from too high a dosage of medication, then encourage them to speak to their prescriber and have the dosage adjusted.

When pregnant women are prescribed methadone, their newborns are at risk of experiencing neonatal opioid withdrawal symptoms (NOWS) just like with use of non-medical opioids during pregnancy. NOWS

due to methadone exposure in-utero may last longer than NOWS due to non-prescription, short-acting opioid exposure in-utero, such as heroin exposure. However, it has been shown that there are fewer risks associated with NOWS from methadone exposure in-utero than the number of risks to the fetus from continued non-prescription opioid use or abrupt withdrawal during pregnancy (2).

Buprenorphine/Naloxone (Suboxone)

Historically, methadone has been prescribed more often for pregnant individuals over other OAT medications. There is building evidence that shows that buprenorphine/naloxone (Suboxone) may be as effective, and possibly safer, than methadone during pregnancy due to a decreased risk of pre-term labour, increased infant head circumference measure, and increased birthweights (2). Buprenorphine/naloxone (Suboxone) may be initiated, instead of methadone, on a case-by-case basis as decided by a pregnant woman and her prescriber (2).

An advantage to pregnant or parenting individuals in taking buprenorphine/naloxone (Suboxone) over methadone often includes the ability to take multiple doses home to self-dispense. Methadone commonly requires daily dispensing at a pharmacy due to its potential for abuse. Pregnant and parenting individuals who are already facing social and economic challenges may find it difficult to attend a pharmacy daily and missing a dose of methadone could put individuals at risk for relapse when they begin to feel withdrawal effects.

Slow-Release Oral Morphine

Slow-release oral morphine has been shown to be as effective, if not more effective, in treating opioid use disorder than methadone (2). The drawback is that there isn't much evidence to support the safety and effectiveness of slow-release oral morphine during pregnancy (2). Pregnant women may be prescribed this medication at the discretion of their prescriber; however, this is more likely to occur only when both methadone and buprenorphine have failed to be effective and/or when they are not available (2).

Injectable Opioid Agonist Treatment

Injectable opioid agonist treatment (iOAT) is not nearly as common as the other OAT medication options. There's limited research regarding iOAT use in pregnancy and other OAT medication options will most likely be offered to pregnant individuals by their prescriber (2). Injectable medications for iOAT include diacetylmorphine or hydromorphone.

It is possible that pregnancy outreach workers will support a pregnant individual that has been prescribed iOAT prior to becoming pregnant. Their prescriber may transition them from iOAT to methadone or slow-release morphine during pregnancy or they may continue with iOAT (2). Their prescriber will likely not transition pregnant women from iOAT to buprenorphine or buprenorphine/naloxone (Suboxone) as this requires a period of detoxification prior to initiation and can put the pregnant individual at risk of relapse and could also cause fetal stress (2). Continuation of iOAT or transition to another OAT medication is a decision made by the prescriber in collaboration with the pregnant individual on a case-by-case basis with parental/fetal wellbeing in mind.

Naloxone (Narcan)

British Columbia lost 1535 individuals to drug toxicity overdoses in 2018, according to the BC Coroners Service (1). Naloxone is the only drug known to reverse the effects of opioids. Pregnancy outreach program workers should be familiar with signs and symptoms of an opioid overdose, when to call for help and the treatment for an opioid overdose.

Naloxone and Pregnancy

Naloxone (Narcan) is considered safe for use in pregnant individuals because of the great risk of death for both the pregnant individual and fetus due to an opioid overdose (12). Naloxone administration may cause withdrawal symptoms in both the pregnant women and the fetus, and this may result in premature labour or fetal stress (12), but it's still more important to save their lives.

Naloxone Training

Naloxone training is readily available throughout BC and all pregnancy outreach program workers are encouraged to complete it. Training is available online and in-person (<https://www.bcapop.ca/Perinatal-Substance-Use-Resources>). Take home naloxone kits are available free to all individuals at high risk of witnessing an overdose and kits are available to agencies to respond to overdoses.

Take-home naloxone training should be encouraged and made available to all pregnant women who are struggling with opioid use. There are ways to collaborate with other community professionals to offer the training within pregnancy outreach programs for pregnant individuals and their support persons. If a pregnancy outreach program is unable to provide the training, then it's recommended to have a list of local naloxone training opportunities to offer. Unfortunately, due to stigma and fear, pregnant and/or parenting individuals are more likely to use alone in their homes putting them at higher risk of overdose.

Labour and Delivery

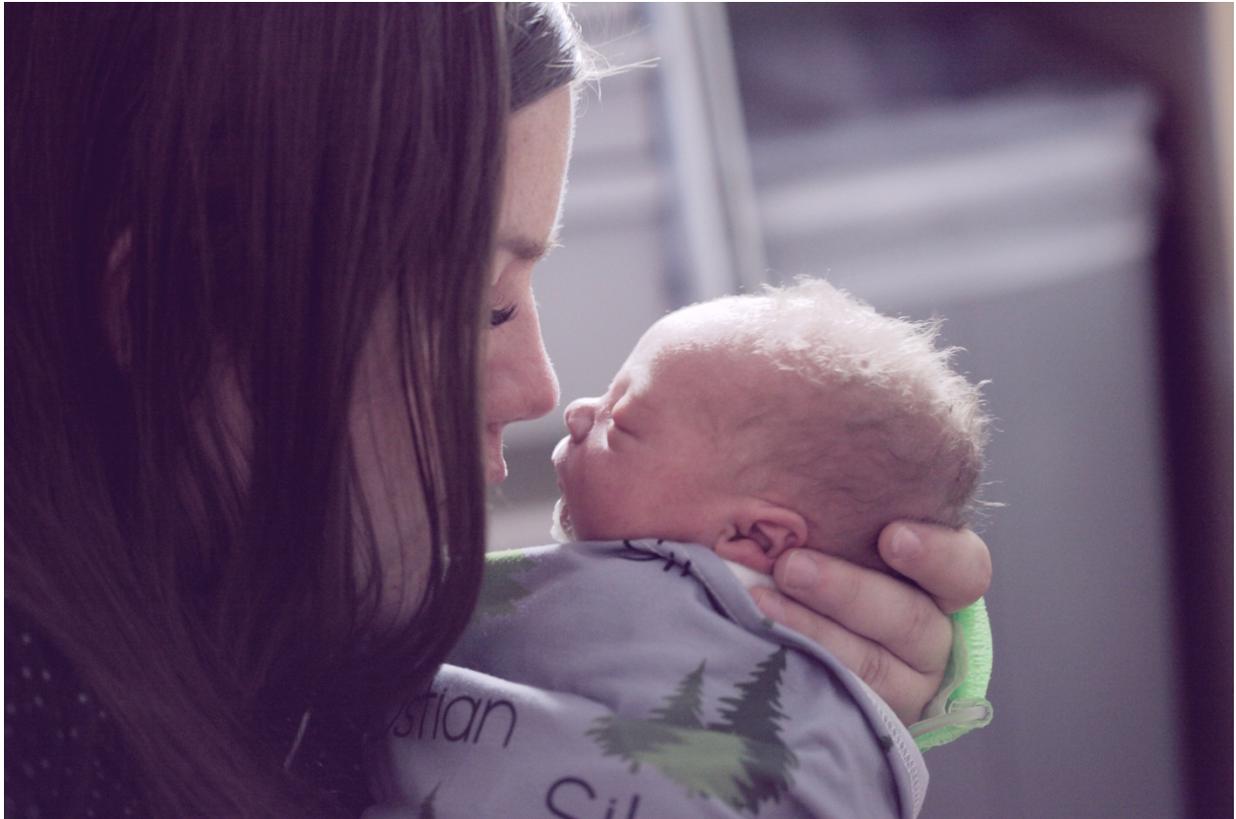
Prenatal Education Prior to Labour

Ideally, all pregnant women receive prenatal education prior to starting labour. This can sometimes be difficult if the pregnant individual is experiencing a chaotic lifestyle due to substance use. Sometimes pregnant individuals arrive in labour at a hospital without any prenatal education and little prenatal care which can lead to increased fear and experience of stigma or judgement from staff.

Pregnancy outreach program workers have the benefit of interacting with pregnant women in pregnancy and creating a staff-participant relationship that can help to prepare them for labour and delivery. Even if the participant is unable to attend prenatal education, pregnancy outreach workers can speak with them about labour and delivery topics they are familiar with over time to prepare them as best as possible. Pregnancy outreach workers can also act as a liaison to a prenatal education professional or try to attend the class as a support person.

Support Persons During Labour and Delivery

Speaking with participants about who will be able to support them once they go into labour can help to create a plan that contributes to positive outcomes. If a participant does not have a support person available, then pregnancy outreach workers can help them to explore the options of a volunteer or funded doula. The First Nations Health Authority (FNHA) and the BC Association for Aboriginal Friendship Centres has a Doulas for Aboriginal Families Grant Program (<https://bcaafc.com/initiatives/doula-support-program/>).



Pain Management in Labour

It's important to help dispel common myths about pregnancy, labour, and delivery for a pregnant individual who uses substances and the community at large. It can be common for healthcare providers to tell a pregnant individual who uses substances that it's best not to use pain management medications during labour and delivery. This could be due to the healthcare provider's natural fears of compounding substance use issues or wanting to reduce the number of substances a fetus is exposed to prior to birth. However, it is unethical to limit the use of pain control during labour and birth due to a history of substance use alone. Pregnant individuals on OAT may require a higher dose than normal or multiple measures to control their pain due to an increased tolerance to opioids (2).

Pregnancy outreach workers can play a role, if within their scope, to identify the menu of pain management options available in the local hospital. This may include massage, counterpressure, coaching support, hot

showers/baths, position changes, Entonox (laughing gas), morphine, fentanyl, and/or epidural. All pregnant women have a right to pain management.

Postpartum

It will be helpful for pregnancy outreach workers to become familiar with the policies and procedures at their local hospital when it comes to postpartum care of parents with a history of substance use, or who are on OAT, and babies who have been exposed to substances. Some hospitals have formal programs to offer parents with a history of substance use or who are on OAT, others do not. Becoming familiar with the local hospital procedures will help pregnancy outreach workers to prepare participants for their experience, especially if they have delivered previously in other hospitals with different policies and procedures.

Pregnant individuals who use substances or are on OAT should be encouraged to have a healthy support person who can stay with them and support them through the postpartum period in the hospital. Having discussions with participants about who is a good fit as a support person may contribute to a more positive experience for the individual and their baby.

Breastfeeding and Substance Use

Substance use, or risk of substance use relapse, are not absolute contraindications to breastfeeding. Breastfeeding women and their primary healthcare provider should discuss the risks and benefits of breastfeeding while using substances or breastfeeding during a relapse in order to make an informed decision about breastfeeding.

Breastfeeding Safety Plan

A breastfeeding safety plan is a written plan that pregnancy outreach program workers can assist pregnant and breastfeeding individuals to create (<https://www.bcapop.ca/Perinatal-Substance-Use-Resources>). The goal of creating a breastfeeding safety plan is to prepare and educate the breastfeeding parent so they can make an informed decision on how to feed their newborn if they use substances that have breastfeeding risks. The key is to provide information and create a breastfeeding safety plan during pregnancy, well before a relapse on substances or substance use during breastfeeding is a risk. Breastfeeding mothers can then implement the plan on their own in a situation where they may be apprehensive about reaching out for professional support. Increasing self-efficacy in pregnant and parenting individuals who have a history of substance use can have a positive impact on outcomes for both the parent and the newborn.

Components of a breastfeeding safety plan include discussing and writing out what substances the breastfeeding parent is at risk for using, the length of time it's recommended they either abstain from breastfeeding or "pump and dump" after using those substances, and what infant nutrition option the infant will receive during this time period. Infant nutrition options could include stored breastmilk that was expressed when they were not using substances and/or infant formula, as well as method used to feed i.e.: bottle, cup, etc. It's important to support the breastfeeding parent to make sure their infant is receiving nutrition in the case of a relapse, even when they report that they don't expect to relapse. Relapse often happens unexpectedly, and commonly there is little time between the decision made to use substances and the actual act of using

substances. Making sure the breastfeeding parent has their chosen infant nutrition option on hand is imperative for a breastfeeding safety plan to be implemented.



Breastfeeding Delay or Pump and Dump Recommendations

Having conversations about the risk of relapse and a breastfeeding safety plan can build rapport between pregnancy outreach workers and program participants. When program participants feel that they're being supported on their journey to parenthood, and program staff understand their challenges and barriers, then it's more likely that they will be open and honest with program staff when they need help. Talking about breastfeeding safety plans is a natural segue to talking about safety plans for baby if the parent(s) relapse on substances.

Alcohol and Breastfeeding

It is safest to not drink alcohol while breastfeeding because the safe amount of alcohol consumption is unknown (7). However, having an alcoholic drink occasionally has not been shown to be harmful to breastfed babies (9). If a breastfeeding mother chooses

to drink alcohol while breastfeeding, then they should time feedings around their alcohol consumption. Breastfeeding parents should be encouraged to delay breastfeeding for 2-3 hours per standard drink consumed from the start of drinking (7)(9). For example, if a breastfeeding parent drinks one standard drink then they can safely breastfeed their baby 2-3 hours later. If a breastfeeding parent consumes five drinks, then they can safely breastfeed 10-15 hours later. Babies should be fed breastmilk that was pumped when the breastfeeding parent was not drinking alcohol or infant formula during this delay time, if they require a feed. The body will remove alcohol from the breastmilk over time (7)(9).

Pumping and dumping breastmilk due to alcohol consumption is only required for the comfort of the parent and to maintain breastmilk supply if the time between feeds is substantial. It's important to be aware that if binge drinking is an issue for the parent that it may be difficult for the individual to recall how many drinks were consumed. It can also be difficult for a breastfeeding mother who is dependent on alcohol to limit the number of alcoholic drinks they consume once they begin to drink.

Nicotine and Breastfeeding

It is safest to abstain from smoking cigarettes while breastfeeding because nicotine passes through breastmilk and the risk of second (7)(9) and third-hand smoke exposure. Infants who are exposed to second and third-hand cigarette smoke have an increased risk of sudden infant death syndrome (SIDS) (9). There isn't enough evidence to clearly show the long-term effects on a baby who receives breastmilk from a smoking parent (9).

If a breastfeeding mother is unable to abstain from cigarette smoking, they should still be encouraged to breastfeed because the benefits outweigh the risks (7).

Harm reduction strategies for breastfeeding parents who smoke include smoking outside, changing out of the clothes they smoke in before breastfeeding the baby, reducing the number of cigarettes smoked, and smoking after breastfeeding instead of right before or during breastfeeding (9), and washing hands after each use. Nicotine replacement therapy (nicotine inhaler, gum or patch) can be used during breastfeeding to assist a breastfeeding parent to quit smoking cigarettes (9).

Cannabis and Breastfeeding

It's safest to abstain from any form of cannabis use while breastfeeding (10)(9). Breastfeeding parents should be informed of the risks of breastfeeding while using cannabis including poor feeding, poor tone and/or drowsiness (10)(9). Breastfeeding mothers should watch for these symptoms in their baby and talk to their primary healthcare provider if their baby experiences them.

It is also possible that using cannabis while breastfeeding could affect the mental health and brain development of the baby and increase the probability that the baby will use cannabis when they are adults, however more research in this area is needed to be sure. THC, the active ingredient in cannabis, can stay in breastmilk up to thirty days after use in heavy users (10), therefore it's not possible to implement "pump and dump" strategies for cannabis use. Breastfeeding parents and their health care provider should discuss the risks and benefits of breastfeeding while using cannabis to make an informed decision about breastfeeding.

Stimulants and Breastfeeding

Few studies have examined the effects on babies of stimulant use during breastfeeding. It's safest to not use non-prescriptions stimulants (e.g. cocaine or methamphetamine) while breastfeeding as there is no known safe consumption amount. It has been shown that using stimulants while breastfeeding can reduce milk supply and increase irritability and agitation in the breastfed infant (6). If a breastfeeding parent does relapse on cocaine or other stimulants, the pump and dump practice is recommended during use and for 24 hours following use, to allow time for the stimulants to clear from the breastmilk (5). Breastfeeding parents and their healthcare professional should discuss the risks and benefits of breastfeeding while using stimulants to make an informed decision about breastfeeding.

Opioids and Breastfeeding

The use of non-prescription, non-medical opioids (e.g. heroin) and breastfeeding has not been systematically reviewed. The effects are unknown currently, therefore it's safest not to breastfeed while using heroin or other non-prescription, non-medical opioids (13). Pregnant and newly parenting individuals should be offered the option to initiate OAT if they are experiencing opioid use disorder. Breastfeeding mothers should be offered the opportunity to initiate OAT and breastfeed, instead of jumping straight to offering infant formula.

If a breastfeeding parent is on OAT (e.g. methadone or suboxone) it is considered safe to breastfeed, regardless of the OAT dose (13), and a baby of an exclusively breastfeeding parent who is prescribed OAT will likely experience a reduction in NOWS compared to babies who are formula fed (2). Breastfeeding mothers and other caregivers should be informed to watch for symptoms of NOWS in a breastfed baby

whose breastfeeding parent is taking OAT. Also, the infant should not be switched back and forth from breastmilk of the mother prescribed OAT and infant formula as this could cause NOWS. This can sometimes occur when the baby is cared for by someone other than the breastfeeding parent for an extended period and is fed infant formula, then returned to the parent to breastfeed. Breastfeeding parents and their healthcare provider should discuss the risks and benefits of breastfeeding while using non-prescription or prescription opioids to make an informed decision about breastfeeding.

Breastfeeding and Child Welfare

Breastfeeding parents who have a newborn apprehended at birth or in the postpartum period should be encouraged and supported to initiate a breastmilk supply, continue breastfeeding and/or provide breastmilk when possible. Breastfeeding can offer a sense of continued attachment to the newborn and the ability to provide for the newborn at a time when the risk of relapse is great. It's important to support attachment development tasks and activities.



Breastfeeding parents in this situation may need to access a lactation professional for help to create a plan that will support their breastfeeding goals. Goals may include, but are not limited to, providing expressed breastmilk to the newborns foster parents/caregiver to feed the newborn, breastfeeding during visitation sessions and pumping when not with the newborn to keep up an adequate supply, or pumping and dumping to create an adequate supply and then initiating breastfeeding once the mother and baby are reunited.

Regardless of the goals, the breastfeeding mother should be offered the necessary support and equipment to attempt to achieve their goals. This may include funding for a breast pump, knowledge on how and when to pump, and how to safely store and transport breastmilk. The support team can also work with the foster family to educate them on their role with expressed breastmilk (EBM), and fostering attachment through infant feeding.

Parenting and Substance Use

Every family is different when it comes to substance use. Pregnancy outreach programs can support families who use substances or are in recovery from substance use in a variety of ways. These situations can be difficult for both service providers and families. As substance use and parenting needs to be supported on a case-by case basis, there is no blanket statement or support plan that applies to all families who use substances. Making sure support plans and approaches are individualized is the first step in promoting the best outcomes for both the parent and the baby. This grey area can be difficult for pregnancy outreach

program workers to work within. Therefore, collaboration with other agencies, self-care, de-briefing, and knowledge exchange are extremely important.

Child Welfare Concerns

A variety of service support staff across the country, including pregnancy outreach program workers, often report confusion surrounding the duty to report substance use during pregnancy. At the same time, pregnant women who are using substances struggle to disclose their use to professionals because of the fear of losing custody of their children (9).

Ongoing changes to the policies and procedures that child welfare workers use to guide their practice has led to the idea that parental substance use is not a child welfare concern on its own. The concern is instead how substance use affects parenting practices (9). This focus leads to better safety planning with parents who struggle with substance use because it focuses on harm reduction strategies such as the child having a competent caregiver when the parent does use substances that may affect their parenting.

Ideal safety plans include relapse prevention and planning strategies that allow for parents to move through the natural and normal recovery process, which may include relapse, while still providing best care for their children. This provides the time required to increase parenting capacity and self-efficacy within the parent and family. The pregnant individual who struggles with substance use will feel pressure from society, family, partners, child welfare organizations, physicians, nurses, and social workers to go down the path of recovery in a short period of time and the stakes are high: the opportunity to parent their children.

Working with MCFD/Delegated Agency

Pregnancy outreach program workers can play a vital role in supporting pregnant individuals and families who are involved with MCFD or an Aboriginal Delegated Agency due to child welfare concerns. MCFD or the delegated agency may set expectations and guidelines for the pregnant person or family to meet in order to continue or regain custody, or to be able to have visitation with their child(ren).

Pregnancy outreach program workers can support the pregnant individual or family through this process in the following ways:

- Attend appointments as a support;
- Clarify expectations and guidelines set by the child welfare agency to make sure the pregnant individual or family understands what is being asked of them;
- Create safety plans for children;
- Create breastfeeding safety plans;
- Create harm reduction plans for pregnant women or families;
- Refer pregnant individuals or families to community resources that will help achieve their goals;
- Advocate for the pregnant individual or family;
- Host pregnancy/family care meetings that support the goals of the pregnant individual or family.

Support Families Through Apprehension

Parents who have a history of substance use and have their newborns apprehended for child welfare concerns are at risk for experiencing relapse, postpartum depression (PPD), and other mental health disorders. Sadly, this is the time that this population also tends to experience a reduction in the number of supports they can access. Parents who lose custody of their children often no longer qualify for programs and services that are parent-baby focused and may lose income support, such as the Child Tax Benefit and rental subsidy. The stress of the loss of a support system and decrease in financial support can be overwhelming for many parents and may lead to further and heavier substance use or harmful behaviours.



Pregnancy outreach programs can support parents through apprehension by:

- Continuing some level of support and program participation;
- Referring parents to other appropriate services that are meant to support reunification;
- Continuing to offer nutritional support as available.

Summary

With a trauma-informed and culturally safe approach toward reducing harm, pregnancy outreach program workers have the honour of supporting one of the most vulnerable populations, contributing to better outcomes for pregnant and newly parenting individuals, and their babies. This handbook supplement is a starting place to ignite conversations, promote self-reflection, and support new ways of working with participants. Pregnancy outreach workers are encouraged to continue their learning journey to implementing best practices in supporting pregnant women and newly parenting individuals who use substances, and their babies.

Resources

For an up to date list of perinatal substance use resources please see BCAPOP's website at <https://www.bcapop.ca/Perinatal-Substance-Use-Resources>.

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