Perinatal Addiction – The Vancouver Experience

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When talking about drug use in pregnancy, we are immediately conditioned to think of "damaged" babies and inadequate parenting. Over the last generation, the approach to this population by the medical profession and society, has been abstinent based, with the belief that these women were in the most part incapable of parenting unless they were abstinent. Separation of the mother and baby was and still is the norm. We can reverse this trend by decreasing the amount of drug that the mother and baby are exposed to during the pregnancy and improving the socio-economic determinants of health.

In Vancouver we have improved outcomes for these women and families by adopting a harm-reduction philosophy and integrating the community and hospital into a seamless system of care. The foundation for this system of care is the Sheway Maternity Clinic in Vancouver's Downtown East Side and the development of FIR (Families In Recovery) Square at BC Women's Hospital 10 years ago, the first Combined Care Maternity Unit in Canada for pregnant women struggling with addiction.

The goals of this program are:

1. To decrease the amount of drug that the mothers and babies are exposed to (trauma informed care).
2. To facilitate bonding between mother and baby
3. To improve social stability.
4. To reduce withdrawal and the need to treat in the newborn.
5. To prevent apprehensions safely.

Vancouver's downtown east side is an area of 10 city blocks. It is the poorest postal code in Canada. There is a high crime rate with an open drug market. Many of the women are living on the street , and are subjected to repeated and ongoing violence either through involvement in the sex trade and/or abusive partners. "Self medication" with heroin, cocaine, alcohol etc. makes it possible for them to cope in this environment. The Hepatitis C rate is close to 90% and HIV is usually only 1 shared needle away. Being pregnant in this community meant that your baby was inevitably apprehended at birth.

Within this setting the Sheway Maternity Clinic was developed in 1992. It provides holistic services to pregnant women with substance use problems and supports mothers and their children until the children are 18 months of age. It is interprofessional by design and function. Funding is through several partners: BC Women's Hospital, the Vancouver Health Department the Ministry of Social Services, the YWCA and the Vancouver Native Health Society. Its

Mission statement states that “Sheway reaches out to women who are pregnant to assist them with meeting their needs for support, safe living conditions, economic security and physical well-being. The staff work with women to help them develop the information, skills and confidence that they will need to care for themselves and their children.” An evaluation of the Sheway maternity project in 1993 looked at several outcomes. It revealed that there were improvements in accessing prenatal care as well as a demonstrated increase in birth weights, improvements in nutritional status (e.g. hot lunches are served daily), demonstrated decrease in substance use, improved housing, and more mothers going home safely with their babies. These findings were identified as a result of their involvement with the Sheway Program. Sheway delivers approximately 60-70 women per year and at any onetime we have a case load of 115 families.

Any “good” that is done in the community can be quickly nullified if the “institutions” do not provide similar care and support. With this in mind, Fir (Families In Recovery) Square, the first Combined Care Unit of its kind in Canada, was developed at BC Women’s Hospital in 2002. It is a 12 bed in patient dedicated unit that was designed to provide a continuum of in hospital care for maternity patients with addictions within a Harm Reduction context. It is an interprofessional team of physicians, nurses, a social worker, alcohol and drug worker, nutritionist, Infant development worker skilled in teaching parenting, and a Spiritual Care Minister. Staff were hired because they wanted to work in this setting AND because they had the “right” attitude. The staff received additional education and training specific to this population. Women can be admitted anytime during their pregnancy for obstetrical management and/or stabilization of their drug use. There are daily programs to support the women both individually and in groups. In keeping with providing a continuum of care, women deliver from the unit and are brought back to the unit for post partum care. The philosophy of the unit is harm-reduction in nature and based on the premise that outcomes can be improved by rooming in these babies with their mothers. All mothers are given the opportunity to room in with their babies. Over the last 10 years we have delivered approximately 1200 plus women.

The babies room-in with the Mom immediately after birth. Moms are encouraged and taught how to hold and cuddle their babies. Moms are allowed to breastfeed at any maternal dose of methadone and the only medical contra-indication that we use for breastfeeding is HIV positivity in the mom.

In this setting the babies are observed for withdrawal by monitoring the babies’ ability to gain weight. This minimizes observer bias inherent in the use of subjective signs of withdrawal (sneezing, tremors, crying, and not settling) that have been previously used to assess these newborns. As “normal” babies usually take 36-72 hours to gain weight while the breastmilk comes in and breastfeeding is established – we avoid treating with morphine during this period.

Within this context we have been able to decrease the number of babies requiring treatment. In fact, we are finding that most of our methadone babies, as long as they are rooming in with the mothers and being cuddled and held by their mothers, do not require treatment. If the babies require treatment, we are initiating morphine treatment while the babies are still rooming in with the mothers. Using an accelerated protocol we have been able to withdraw the babies off morphine within a period of 10 to 14 days before they are discharged.

We have noticed that the drugs that seem to have the most impact on the newborns ability to thrive in the newborn period, establish breast feeding and gain weight are not necessarily the opiates but are the prescribed medications such as the antidepressants and antipsychotics. With this experience, we now counsel the women about prescribed medications during their

pregnancy. Most of these women suffer from chronic post traumatic stress as a result of their life experiences. Clinical depression is not the diagnosis. Developing cognitive based counselling programs and finding practical solutions for their poverty and housing issues, allows us to minimize the prescribing of anti depressants in this population.. In fact, women coming through this program reported that a 100 percent of the women felt connected to the community, 74 percent reported a decreased use of their problem drug and 89 percent reported a decreased level of anxiety.

Along with these two programs we have developed a Primary Care Physician on call group called the Perinatal Addiction Service. These Family Physicians, have developed a clinical expertise that is unique to British Columbia, if not Canada. This call group provides a 24-7 consulting and referral service for Vancouver and the rest of British Columbia.

Unfortunately in Vancouver we have the distinction of possessing one of the poorest neighborhoods in Canada with a high drug and crime rate which has negatively impacted women and their desire to raise healthy families. As a response to this we have developed a harm-reduction philosophy which does not rely on urine drug screens as a measure of stability, but depends on clinical stability as a monitor for these women. This approach , and the integrated community hospital program described above, have resulted in improved perinatal outcomes for both mother and baby. Less babies are requiring treatment for withdrawal and more babies are going home safely with their mothers. The babies and moms that come through this program are demonstrating to us, through our longterm follow up , that given the opportunity to bond together in the newborn period , they do indeed go on to be healthy and emotionally stable.
" Damaged babies and inadequate parenting is now a phenomenon of the "last generation"

Homelessness is the biggest hurdle for these women . This translates into apprehension of their children after they are stable and ready for discharge from our program. To reverse this social catastrophe we need to develop social housing in the context of it being affordable and supportive. Only then will both these moms and their babies and their families have a chance to "grow" within our community.

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