



Sharing the Journey:
The Sheway Model of Care

Sheway: A community program

- “*SHEWAY*” is a Coast Salish word meaning “growth”
- Since 1993 this program has provided health and social service support to pregnant and parenting women surviving circumstances such as trauma & substance use, poverty, violence, homelessness, legal and mental health issues and who are living in the DTES (Salmon, 2013)
- Sheway is one of the longest running programs in Canada supporting pregnant and parenting women with current or former substance use

The promise of the *Sheway* Approach

- Substance use and addiction are complex, hard to solve problems
- When a woman is pregnant or parenting, the child is undeniably part of the the equation
- This can provide significant motivation for change (Kuo, et al., 2013; Slater, 2015)
- There are also potential negative effects on the child(ren), from exposure, from risks to safety, from impaired dynamics with mother

*Therefore, the stakes can feel especially high, because this is not an individual but a **dyad**, and healthcare providers have to navigate obligations to both mother and child*

The promise of the *Sheway* Approach

- Substance use, mental health, inequity, and trauma are often co-occurring
- Not just a “correlative curiosity” – this pattern is indicative of entrenched systemic issues
- The response must be integrated and multidimensional, including the perspectives of multiple disciplines and sectors, along with mothers’ voices, in a coordinated response around a shared vision: *stabilization of the mother/infant dyad to allow the possibility of change*

Marked social disparities in the perinatal period represent a magnifying glass of pre-existing disadvantage, and a forecast for continued adult inequity and ill health.

de Graf, Steegers, & Bonsel, 2013

Epigenetics . . . reason to think upstream

Genetic expression, ie. what genes are “turned on” or “off”, are influenced by prenatal and postnatal environment. Genes are responsible for cellular programming.

- It is now well accepted that exposure to early life stressors, such as violence, neglect, and malnutrition, are risk factors for developing mental and physical ill health later in life
- Now it is further understood that stress *preconception* can be transmitted epigenetically
- Both malnutrition and trauma have been shown to have transgenerational effects in humans (Provencal & Binder, 2015)

This represents
a critical period
in which to make a
difference to the life course of
the mother and the child



Eligibility Criteria

- Significant history or present substance use
 - Vancouver or no fixed address
- Pregnant or postpartum within 6 months

“While maternal drug use does contribute to adverse pregnancy outcomes - largely indirectly through its social effects - adverse outcomes among babies of drug-using women are primarily due to underlying socioeconomic deprivation”

Hepburn, 2007

Methodological Issues in the Literature

- Reporting of exposure(s)
 - Self-report – accurate remembering of substances, frequency, amounts, etc . . .
 - Standardization of exposure – how to measure consistently and compare?
 - Patterns, chronic v.s. binge use

Significant limitations in determining causality given the co-occurrence of other factors that effect outcomes, such as poverty, mental health, violence.

For example, see the work of Singer, et al., where the neurodevelopmental effects of prenatal cocaine exposure was significantly ameliorated when an infant was adopted at birth, thus family environment and resources are influential factors.

Neonatal & Obstetric Outcomes for Dyads Not Receiving *Sheway*-type Care

- 6 fold increase in obstetrical outcomes, such as low birth weight, toxemia, third trimester bleeding, malpresentation, puerperal morbidity, fetal distress and meconium aspiration
- Neonatal risks include narcotic withdrawal, postnatal growth deficiency, microcephaly

Minnozi, et al., 2013, Cochrane Review

Demographics

Sheway client

- Cigarette use: at first contact 94%; at delivery 83%
- Alcohol use: at first contact 19%; at delivery 6%
- Cocaine/crack: first contact 75%; at delivery 28%
- Heroin: 1st contact 81%; at delivery 22%
- Homeless: 1st contact 19%; at delivery 3%

B.C. Statistics

- Cigarette use 7.4%
- Alcohol use 1.1%
- This data not collected provincially

(Sheway data from:
Ordean, et al., 2013)

Neonatal & obstetrical outcomes

Sheway Outcomes

- Average GA 38 weeks
- Mean B.W. 2856 g.
- Caesarean section 17%
- Preterm delivery 28%
- Need for resuscitation 20%

Ordean, A., Kahan, M., Graves, L., Abrahams, R., & Kim, T. (2015). Obstetrical and Neonatal Outcomes of Methadone-maintained Pregnant Women: A Canadian Multisite Cohort Study. JOGC.

B.C. Data

- 80% of births are 37-40 wks
- Average B.W. 3169-3290
- Caesarean section 31.7%
- Preterm delivery 10.5%
- Need for resuscitation 8%

Perinatal Services B.C., Perinatal Health Report 2009-10 to 2013-2014, Retrieved from:
http://www.perinatalservicesbc.ca/Documents/Data-Surveillance/Reports/PHR/PHR_BC_Deliveries_201314.pdf

3 integrated care sites for substance using pregnant women in Vancouver, Montreal, and Toronto. Vancouver (Fir Square, many of whom are from Sheway) clients had higher rates of homelessness, hepatitis C, HIV, *and yet obstetric and neonatal outcomes between the three groups were similar and acceptable.*

Ordean, et al., 2013, 2015

What (might be) different about the Sheway/Fir Model?

- Rooming in
- Community integrated/wraparound services
 - Addressing social determinants of health, for example housing, food security
 - A spectrum of services to meet a women where she is at, eg. peer support at drop-in to addiction and/or trauma counseling
- Commitment to caring for the dyad, as determined by the mother's goals

The cost of separating & removing children

- Historically the response to substance using mothers has been to remove children from the home
- Short term gain of “safety” has been offset by the long-term consequences of trauma, ie. toxic stress & epigenetics
- Adults with a history of childhood foster care, compared with those without, consistently report lower socioeconomic status (e.g., being unmarried, less educated, living in poverty)
- Foster care history is associated with 1.5 increased risk of poorer physical and mental health

Zlotnick, et al., 2012

Child Protection Outcomes

Sheway data as reported in the *Vancouver Native Health Society Annual Report (2012/13)*:

- 74% of children are in the care of their mothers or both parents
- 24% are in foster care
- 2% are being cared for by their father or other extended family

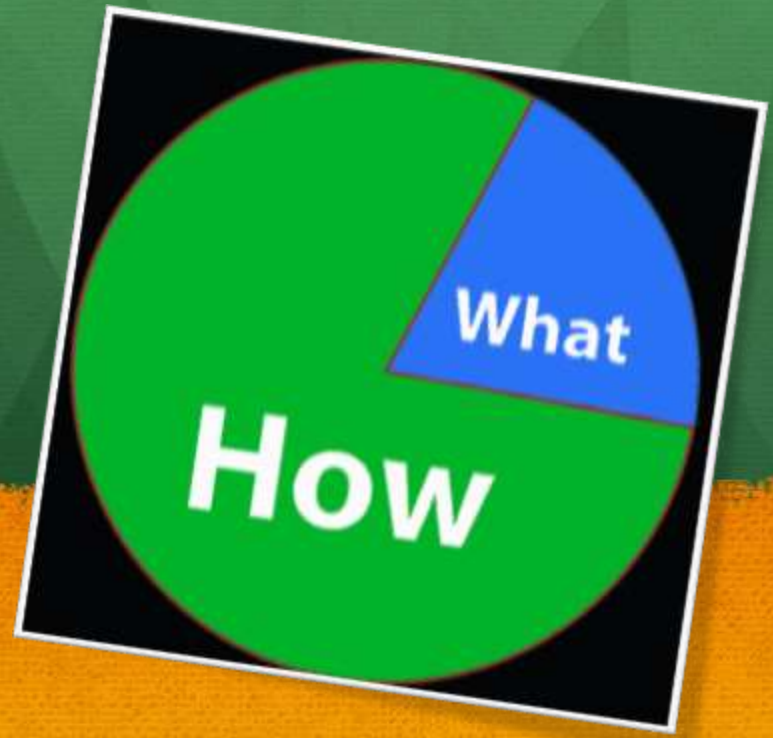
Compare with 1993 data, where *Targeting High-Risk Families* reported that 100% of infants born to substance using mothers were apprehended.

Social Worker on staff without delegation duties with the role of liaising between agencies such as MCFD and VACFSS, building relationship, and supporting mothers to parent as desired, within capacity

Standard of Care

Increasingly integrated/interdisciplinary
and combined community/acute care is
recognized as the best practices for
substance using pregnant and parenting
women

Greaves, et al, 2015; Nikoo, et al, 2015



Once it is accepted that integrated care of mothers and infants in this context makes a difference, the next question is how do people come together to set up a program that promotes conditions to achieve this?

Shared Values Igniting Action

Social Justice
Feminism
Interconnectedness

Social Justice

- Differences in healthcare access related to degree of disadvantage (Brause & Bausch, 2010)
- Poverty is associated with greater exposure to violence (Krug, et al., 2002); inadequate nutrition (Drewnowski, 2009); significantly poorer mental health (Macmillan, et al., 2004) and physical health (WHO, n.d.)

Common to groups that experience health inequities is lack of political, social or economic power. Thus, to be effective and sustainable, interventions that aim to redress inequities must go beyond remedying a particular health inequality and help empower the group in question through systemic changes (WHO)

Injustice anywhere is a threat to justice everywhere
Martin Luther King Jr.

It is Aboriginal women who bear the brunt of racism in Canada. In addition to experiencing three-to-four times more interpersonal violence than non-Aboriginal women, Aboriginal women are at higher risk for harassment by authorities.

Aboriginal women also face a phenomenon best described as 'racialized misogyny' (the hatred of racialized women), which fosters and legitimizes physical and social violence perpetrated against them by virtue of their exponentially diminished social status (i.e. being a woman and being Aboriginal).

Loppie, Reading, & de Leeuw, 2011

Feminism

- Various and intersecting oppressions operate for women living on the DTES
- Recognizing the barriers to women's agency in the face of sexism, racism, violence, and poverty
- Violence or fear of violence constrain women from real choice in regards to sexual safety (Messing, 2014)

Interconnection

- Receiving teachings from those served by the program: rejecting a position of charity, to working across difference with an understanding of shared humanity
- A central tenet of many First Nations, Metis, and Inuit worldviews: *nə c'a?mat ct* (Musqueam), *Mitakuye-oyasin* (Cree), *He-shookish-tsawalk* (Nuu Chah Nulth), *Namwuyat* (Kwak'wala), “all my relations”



Experience and “muddling through” gives way to a sophisticated process of theorizing, that is always refining itself.

Newman & White, 2012



Harm Reduction
Trauma-informed
Culturally Safe

Theory Lived At Sheway

What is trauma?

there are many *potentially* traumatic, lived experiences:

- ❖ single incident trauma, such as an assault during a robbery
- ❖ repetitive trauma, eg. domestic violence
- ❖ developmental trauma, occurs when the event is experienced early in life and can either be single incident or repetitive
- ❖ intergenerational trauma, results when a family member is a trauma survivor and the coping patterns can be passed from one generation to the next
- ❖ trauma relating to structural violence, such as sexism and racism
- ❖ historical trauma, eg. colonization or war

Trauma experiences are known to be cumulative.

The subjective meaning of the event(s) matters.

What does 'trauma-informed' mean?

All staff recognize that people affected by marginalizing conditions and structural violence, have experienced, and often continue to experience, varying forms of violence with traumatic impact.

It does *not* mean probing for trauma stories; it is about creating a safe environment based on an understanding of the effects of trauma, so that health care encounters are safe and affirming.

(Browne, et al., 2012; Poole & Greaves, 2012)

Trauma-informed

Being trauma-informed is about building trust.

Key elements include:

1. thinking about and removing barriers to engagement
2. attending to a person's immediate needs
3. being as transparent, consistent, and predictable as possible
4. respecting healthy boundaries
5. having clearly communicated program goals
6. obtaining informed consent and explaining confidentiality and limits to confidentiality

(BC Center of Excellence for Women's Health, 2013)



Why trauma-informed care?

In a sample of 33 substance using pregnant and parenting mothers recruited from Sheway and Fir Square, 100% reported experiences of childhood trauma.

Torchalla et al., 2015

Harm reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Abstinence is just one possible goal for women.

Framing the concept of success together: for example, reducing substances gradually, stabilization on methadone or suboxone, or maintaining connection with addictions, mental health, or trauma services.

Marcellus, et al., 2015; Nathoo, et al., 2013

Harm reduction

Meeting women where they're at

Focusing on maternal stability, recognizing that for many women, substance use offers a means of coping with trauma, such as childhood abuse, partner violence, and, for Aboriginal women, the intergenerational effects of colonization.

Niccols, et al., 2010; Slater, 2015

What is cultural safety?

- A call for healthcare providers to respond to the colonizing histories and experiences of Indigenous People (Ramsden, 2000)
- Cultural safety is attending to and recalibrating power differences between (primarily) non-Aboriginal healthcare providers and Aboriginal healthcare service users

The key concept is that it is the client who determines whether a person, situation, or service is culturally safe

Why culturally safe care?

- **60-65% of women at Sheway self-identify as Aboriginal** (Poole, 2000)
- **Health inequities are disproportionately represented in Aboriginal people, this especially true for Aboriginal infants, children and women** (Eni, 2009)
- **Recognition that Aboriginal women's multiple experiences of abuse arise from a context of ongoing colonialism and racism** (Varcoe, et al., 2013)
- **Women using services in the DTES are looking for care that "endorses a philosophy that promotes preventive health and incorporates traditional Aboriginal medicine into modern health care practices"** (Benoit, Carroll, & Chaudhry, 2003)



Praxis is, “reflection and action upon the world in order to transform it”
Paolo Friere

Program Processes

Interdisciplinary

Responsive

Integrated

Emergent

Interdisciplinary & Collaborative

Sheway Staff

- Alcohol & Drug Counselor
- Community Health Nurses
- Aboriginal Family Support Worker
- Family Physicians
- Psychiatrist
- Social Worker
- Registered Dietitian
- Kitchen Staff
- Housing Support Worker
- Reception/client engagement
- IDP Workers
- Medical Office Assistant
- Office Assistant

Working in Partnership

- Pediatricians, Speech & Language Therapist, Music Therapist, Dental Hygienist, Lawyer, Residents, Students

Interdisciplinary

- Acknowledging interdependence
 - Respect for each member and role in the team
 - Flexibility in boundaries
- **Protected time** for team meetings requires organizational support and commitment
- Working together in ways that flatten hierarchies
- *Recognizing that reception staff are key players on the team as they often have the most frequent contact*

Browne, et al., . (2012)

Integrated & Responsive

- Women have control over the services they receive
- Strengths and needs of the woman are foregrounded
- Always persisting in partnering with her regarding her care; plans/expectations are revised as needed rather than “discharging” from the service
- Care is comprehensive, coordinated, and individualized to the woman’s unique circumstances (Niccols, et al., 2010)

Emergent & Co-evolving

- Ongoing connections and program processes emerge as stakeholders evolve together within and as part of the whole system, over time
- Deep commitment to program philosophy; tweaking program processes to fit that
- Making change is a process of unfolding – *it takes time*, dialogue, and listening to one another and the program participants

Patton, 2011

Program Goals

- To establish relationship
- To address client goals
- To improve social stability, including:
 - Food security
 - Housing
 - Connections to community
 - Practical support to access medical and social benefits
- To facilitate bonding & attachment between mother and baby
- To decrease the potential impacts of substance use
- To facilitate mothers to parent as desired, within capacity

Mothers' Voices

- Relationship with baby is often significant motivation
- The majority of mothers value the opportunity for group or peer interactions
- A safe environment to share feelings, that includes partners
- Family members are not always viewed as facilitators of recovery

Kuo, et al., 2013

Feedback specific to *Sheway*

- Sheway staff were praised for being easy to talk to and for meeting the women's diverse emotional and psychological needs.
- "I like talking to the workers up there and I find that it's a good place for me right now, where I'm at, to be around the people."
- "It's [Sheway] a safe place; instead of being out there I'm lucky this place is here, otherwise I'd probably be six feet under long ago."
- Practical support especially appreciated, for example, the hot lunches, nutritional snacks, diapers

Benoit, et al., 2003

Opportunities for growth

Client Perspectives on Improving Healthcare in the Downtown Eastside, a VCH initiative in 2012/13

- Many new mothers in the DTES reported struggle in successfully keeping their babies, and they are reluctant to access services because they do not want to have their babies taken away
- Clients at Sheway reported positive support to interrupt a cycle of hopelessness
- The willingness to share stories and bring complaints forward also indicated an interest in, and even an enthusiasm for participating in a process to improve health care services.

Retrieved from: http://dtes.vch.ca/wp-content/uploads/sites/6/2014/01/DTES_Discussion_Paper-3-Final.pdf



“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

Margaret Mead

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“Cooperation is the thorough conviction that nobody can get there unless everybody gets there”. ~ Virginia Burden