DANIELLE SCHROEDER

UBC CPD
Medicine
CONTINUING
PROFESSIONAL
DEVELOPMENT

How Can We Help?

When our perinatal patients are overwhelmed and sad

Danielle Schroeder, RCC, MA yellaschroeder@gmail.com
South Community Birth Program

Goal is to help our overwhelmed and sad patient...

- **To not suffer in silence**
- **Build trust** that we will do what we can medically to keep them safe and the baby safe
- **Strengthen their resilience = Accept** that it is not about getting rid of overwhelm and sadness, but **learning how to live with it**
- **Regain a sense of perceived control =** emotional regulation & mental stability

Self-Efficacy

- **The belief in our own abilities**, specifically our ability to meet the challenges ahead of us (Akhtar, 2008)
- At the heart of RESILIENCE
- Inner capacity to FACE FEAR OF…the unknown, not being able to handle this, making mistake

"I am nervous about caring for a new baby, but I believe that I have what it takes to do it, no matter how difficult or scary it gets"

Th Four S's

(Adapted from 'The Power of Showing Up' by Daniel J. Siegel, M.D. and Tina Payne Bryson, Ph.D.)

SECURE

To feel safe, seen, and soothed we will trust in a feeling of secure connection

SAFE

Open
Grounded
Curious
Competent

We aren't afraid of their emotions/dysregulation

SEEN

Empathy

Attunment

Sensing into what might be happening beyond the surface symptoms, content of the story

SOOTHED

Reassurance
Guidance
Helping access
Resources
Harnessing courage

Being a Safe Harbour means…

Creating a **'relational field'** that is:

1. **Open**- Our body language, our 'vibe', pacing, tone of voice, words we choose.
***Take a moment to pause and ground before patient walks in:** What am I noticing in my body, is it open (calm, easy to breathe)? Or closed (tense, hard to breathe, urgent)? What am I noticing in my mind, is it distracted, present, agitated?

Overwhelmed people feel safer when we can **slow down a sense of urgency

2. **Grounding**- practice of pausing in a moment to notice what's happening. Helps with emotional dysregulation
"I want to pause you for a moment. That's a lot you just said. Let's slow it down, and just notice what's happening in your body?"

Being a Safe Habour means...

3. **Curiosity**- learning to be curious about our thoughts and feelings vs critical helps us not be afraid of them

"I'm curious what your sad/overwhelmed thoughts/feelings are saying to you. Why don't you write them down for me"

Get curious about **your own triggers (that lead to defensiveness and reactivity) What happens for me when I sit with a panicky patient? **What happens in me when I feel helpless?**

Being a Safe Habour means...

4. Competence- having a clear **action plan/roadmap-** Gives a sense that something is being done about specific pregnancy/postpartum concerns. Provides a sense of direction when so much feels out of their control

Being sensitive around **how and when** you share information about more serious mental health concerns (i.e. talking about medication, or addressing future concerns of PPA/PPD)

Your patient feels seen when...

1. Show **empathy by attuning** to their emotions:

"I see that you are feeling scared...sad...helpless. It's OK to feel this way."

"Must be exhausting to live with all that worry. Can you tell me about your fears?....Let's have you write them all down and see how you feel after."

****We have to be careful around saying:** "You don't need to be worried about this..." ***

Your patient feels seen when...

2. You can **'see' the 'bigness'** of what they are going through within **the whole context of their lives**

"I am aware that there's a lot going on in your life beyond the pregnancy and I'm wondering if this might also be contributing to all that you are carrying inside"

Seeing the Mindsets they carry…

3. You can ‘see’ the different mindsets/voices they carry in their head

Anxious Mindsets/Voices

Catastrophizer = Constant worrying “what if…what if…” (future oriented)

Shoulds voice=“I should be able to…have a vaginal birth… produce enough milk… nurse my baby” (external oriented)

Perfectionist voice=“What I am doing and who I am being as a parent is not enough”

Resourceful Mindsets/Voices

Kind voice- “I am doing the best we can” “Pregnancy is hard” “Motherhood is hard”

Trusting voice- “I am strong” “I trust my body can do this”

Courageous voice “I am afraid about the birth, and I trust that I am going to be handle it” “I’ve been through really hard things before, I can get through this”

“The Second Arrow” Metaphor (Pattern of self-blame/shame)

“The Buddha once asked a student, “If a person is struck by an arrow, is it painful?” The student replied , “It is.” The Buddha then asked, “If the person is struck by a second arrow, is that even more painful?” The student replied again, “It is.” The Buddha then explained, “In life, we cannot always control the first arrow. However, the second arrow is our reaction to the first arrow. And with this second arrow comes the possibility of choice.”

The “Second Arrow” Metaphor

1. Recognising the second arrow when you see it in a patient = noticing the pattern of self-blame/shame (“I should have been able to…”)

2. Helping them feel their feelings = shifting from “I am bad” to “this situation feels sad…helpless…hard…out of my control”

3. Helping them learn to be kinder to themselves (ex. “What would you say to your friend if this happened to them?”)

****Shame/self blame** = Results from unrealistic expectations of trying to live up to some idealized fantasy of how a pregnant person/parent *“should be”*

Being a Soothing Presence...

Repeating reassuring words in a **gentle tone of voice:**

"I'm not concerned about anything medically wrong..."
"There is nothing wrong with you. Something happened to you"
"You're doing the best you can right now"
"One day at a time"
"It is a strength to ask and receive help"
"Parenthood is messy"

Being a Soothing Presence…

Offering practical guidance and information, with a **sensitivity to pacing and timing**

"I know this is scary and here is what we are going to do to make sure the baby is safe...."

"I can see that your sadness is making it harder for you to function these days. I would love to tell you about some supports available to help your sadness. Are you open to hearing about them?"

Being a Soothing Presence

Encouraging **DAILY ACTS OF KINDNESS:**

A. Treating themselves to things that are **soothing, pleasurable, comforting, esp, nature**

B. **Prioritize 'self-regulation activities'** like body work (massage), walking, singing, dancing, cooking, gardening, creative projects

Grounding
(Self-Regulating) Practices

The 3-2-6 Breathing Technique

Focus on the following breathing pattern:

1. Empty the lungs of air
2. Breathe in quietly through the nose for 3 seconds
3. Gently suspend the breath for a count of 2 seconds
4. Exhale through the mouth, pursing the lips and making a “whoosh” sound, for 6 seconds
5. Repeat the cycle up to 4 times

Orientation Practice:
Come back to the Present Moment

* **Name five things in the room**. "There's a computer, a chair, a picture of the dog, an old rug, and a coffee mug." It's that simple.

* **Breathe!!!**

* **Use your senses** and think about what they feel. The desk is hard. The blanket is soft. I can feel the breath coming into my nose.

***All of these help remind us that **"right now I am safe, we are safe, we are OK for right now."**

Reassuring Self-Talk

“It won’t be like this forever”
“One day at a time”
“I am OK for now”
“There is no right way to do this”
“It’s OK to feel…sad, angry, ambivalent”
“I can’t do this alone…It’s OK to ask for help”

Write a list of all your specific worries/losses

* Fear of…the birth not going the way I hoped
* Fear of….something happening to the baby
* Fear of…being judged for needing/asking for help
* Fear of…the unknown

Writing down your fears **DOES NOT MEAN THEY ARE GOING TO HAPPEN. **Most of what we are afraid of never happens.**

**** Can write the same kind of list for sadness/losses (loss of/sadness about…not enjoying this)**

P.R.N. Strategy

Pause! = Stop whatever you are doing, especially if you notice you've been triggered

Reset = Take **TWO minutes** and engage in something you find grounding/calming

Nourish = **Acknowledge** that you've **done something good** for you (which benefits everyone else in your life)

Patterned, repetitive rhythmic activity

Walking , Running , Cycling- exercise in general

Dancing

Singing

Repetitive meditative breathing

Knitting

Creative projects

Video games

DR. DEIRDRE RYAN

UBC CPD
Medicine
CONTINUING
PROFESSIONAL
DEVELOPMENT

Safety of Antidepressants in Perinatal Patients

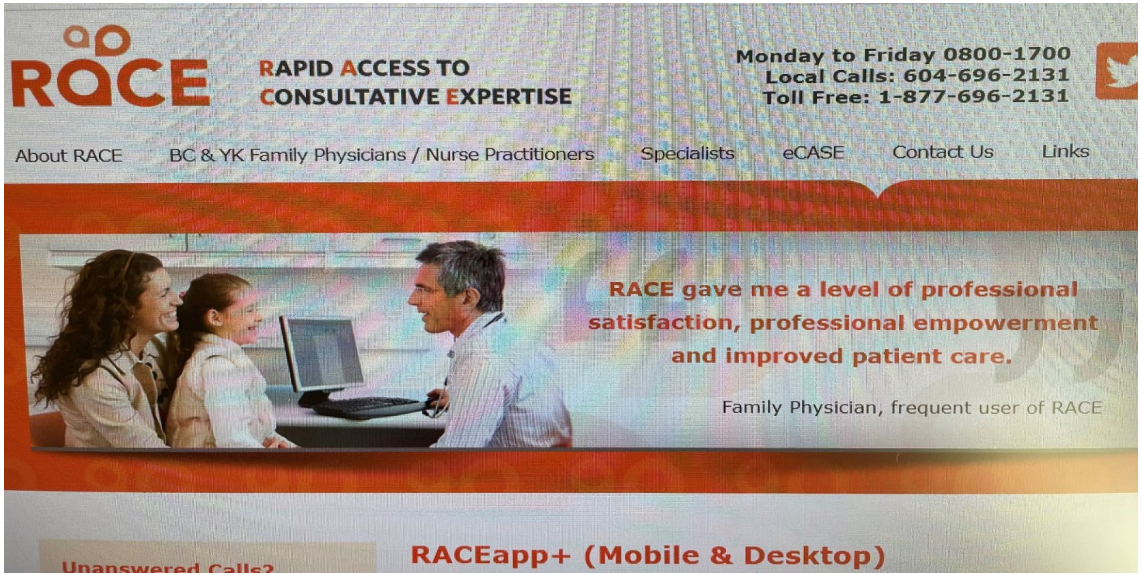
Dr. Deirdre Ryan, MB, FRCPC, Psychiatrist,
Co Medical Director, Provincial Reproductive Mental Health Program,
BC Women's Hospital
Clinical Associate Professor, Dept. of Psychiatry, UBC

BC Provincial Reproductive Mental Health Program

- Over 5,000 patient visits/year
- 80% of referrals for perinatal depression & anxiety
- Treatment is research / evidence based
- Website: www.reproductivementalhealth.ca
- Phone: 604 875 2025

Rapid Access to Consultative Expertise

Search under Psychiatry, Perinatal



When do you consider antidepressant use in Perinatal Patients?

- Inadequate response to Self Care and Psychotherapy
- When risk of relapse is high, especially in women with chronic illness
- Women who are not sleeping, not eating or unable to care for them selves or their children

When do you consider antidepressant use in Perinatal Patients?

- Overwhelming anxiety, including recurrent panic attacks
- Intrusive, distressing thoughts of harm occurring to others
- Risk of harm to self or others (suicide or infanticide)
- Comorbid illnesses, including SUD, eating disorders

Choosing an Antidepressant

- If no previous antidepressant use, consider an SSRI.
- If women has responded to a particular antidepressant in the past, use that one
- Use LOWEST EFFECTIVE DOSE of antidepressant
- Discuss risks on NOT treating the illness and risks of treatment with pregnant or breastfeeding woman prior to prescribing.

Risks of Untreated Depression in the Perinatal Period

- Poor prenatal care
- Risk of medical / obstetrical complications e.g. Hyperemesis Gravidarum and Pre-Eclampsia
- Self-medication / substance use
- Impaired bonding
- Postpartum exacerbation
- Suicide

Risks of Depression in Pregnancy and after birth to the Developing Fetus / Infant

- ↑Risk of preterm birth
- ↑Risk of low birth weight
- ↑Fussiness
- Impaired maternal-infant bonding
- Possible long term emotional, behavioural, and cognitive effects

Bonari, L., Pinto, N., Ahn, E., Einarson, A., Steiner, M., Koren, G. (2004). Can J Psychiatry, 49: 726-735

Antidepressants Used in Perinatal Period

- **First Line: SSRIs**
  - Sertraline (Zoloft) 25-200mg daily
  - Citalopram (Celexa)10-40mg daily
  - Escitalopram (Cipralex) 5-20mg daily
  - Fluoxetine (Prozac)10-80mg daily
  - Fluvoxemine (Luvox) 25- 200mg daily

- **Second Line: SNRIs:**
  - Venlafaxine (Effexor)37.5 – 225mg daily
  - Desvenlafaxine (Pristiq) 25 -100mg mg daily
  - Duloxetine (Cymbalta)30-120mg daily

- **Others:**
  - Bupropion (Wellbutrin SR) 150 – 300mg daily
  - Mirtazapine (Remeron) 15-45mg daily
  - Vortioxetine (Trintellix) 10-20mg daily

What are the concerns of exposure to the baby in utero?

Teratogenicity:

- Majority of studies showed **NO increased risk** above background rate of birth defects: 2%-4%-6%
- Huybrechts 2014 : no increase in cardiovascular defects for SSRIs or other antidepressants.
- Furu 2015: sibling controlled analysis showed no increase in total or cardiovascular malformations.
- Bupropion: majority of studies do not support increased risk

What are the concerns of exposure to the baby in utero?

Obstetrical complications:

- Nordic and Danish studies (2013/2014): NO increased risk for miscarriage, stillbirth, or infant mortality
- Inconsistent findings for late preterm birth, small for gestational age, neonatal complications, and NICU admission.
- SNRI and SSRI use in the 3rd trimester may result in a small increased risk of PPH.

Andersen JT et al. Exposure to Selective Serotonin Reuptake Inhibitors in Early Pregnancy and the Risk of Miscarriage. Obstet Gynecol. 2014

GE Hanley, Obstet Gynecol.

What are the concerns of exposure to the baby in utero?

Neonatal complications:

- Transient Symptoms of Neonatal Adaptation Syndrome in some exposed infants
  - Symptoms may include jitteriness, respiratory distress, temperature instability, feeding difficulties
  - Usually resolve without treatment
  - No evidence of significant long term effects

- Persistent Pulmonary Hypertension of the Newborn slightly elevated <1% (Meta-analysis)

Grigoriadis Sophie [et al.] Prenatal exposure to antidepressants and persistent pulmonary hypertension of the newborn: systematic review and metaanalysis [Online]. - bmj, January 14, 2014. - October 2022. - https://www.bmj.com/content/348/bmj.f6932.

What are the concerns of exposure to the baby in utero?

Neurobehavioral teratogenicity:

Two studies examined SSRI, venlafaxine, and TCAs:

No differences in language, IQ, or behavior (16m – 7y)

SSRIS and Autism Spectrum Disorders:

Causal relationship **not** supported

Harrington et al, Pediatrics. 2014 May; 133(5): e1241–e1248

Antidepressants in breastfeeding:

- Do not change or stop an effective medication; continue whatever was working in pregnancy – exposure is less in breast milk
- Do not “pump and dump”
- If infant is premature, consult with pediatrician
- SSRIs and SNRIs are not contraindicated in breastfeeding parents.

  Sertraline (Zoloft), escitalopram(Cipralex) or citalopram (Celexa) first line options

CANMAT 2016.

Misri S, Kendrick K. *Can J Psychiatry*. 2007;52(8):489-498; Davis et al. JCP. 2009.

Useful Resources About Antidepressant Use in pregnancy and breastfeeding

In Pregnancy:

Mother to Baby https://mothertobaby.org/fact-sheets/

In Breastfeeding:

Drugs and Lactation Database: LactMed
https://www.ncbi.nlm.nih.gov/books/NBK501922/

Creating Comfort in Choice:bit.ly/creatingcomfort

Resources

- RMH Website: www.reproductivementalhealth.ca

- Not Just The Blues: Perinatal Depression and Anxiety: https://ubccpd.ca

Thank You

DR. CHARISSA PATRICELLI

UBC CPD
Medicine
CONTINUING
PROFESSIONAL
DEVELOPMENT

Dyad Care in Substance Using Perinatal Population

June 2023

Community of Practice Webinar

Charissa Patricelli, MD, CCFP(AM), FCFP, DABAM, FASAM

Medical Director Perinatal Substance Use BCWH

Philosophy of Care

FIR
FAMILIES in RECOVERY

PHILOSOPHY OF CARE

The FIR team works together to ensure the most comfortable and safe care for you, your baby and family. We are guided by values, beliefs and practices that have been proven to result in the best outcomes, time and time again.

INDIGENOUS CULTURAL SAFETY

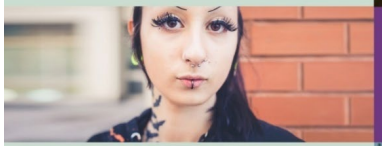
We recognize that health care systems are historically colonizing spaces. We strive to foster a climate where your unique history and culture is recognized and safe care is provided.

EQUITABLE CARE

It is important that we provide adaptable and flexible approaches to care, in order to remove barriers and address any discrimination that you may have experienced in past healthcare settings.

STRENGTH & HEALING BASED

Your natural strengths are important and are meant to be recognized and developed. We seek to empower you to care for yourself and your baby. We seek to understand what healing looks like from your unique perspective.



WOMEN-CENTRED

We strive to engage you with kindness, respect and dignity. We apply a holistic wellness based approach encompassing individual mental, emotional, physical and spiritual well-being. We recognize the importance of your individual story and experience. This is an important factor in how you make your decisions.

MOTHER BABY TOGETHERNESS

A strong connection between mother and baby ensures the best health outcomes for both of you. We believe in keeping mother and baby together and strive to ensure this bond is sustained from hospital to community.

TRAUMA & VIOLENCE INFORMED

Your physical, mental and emotional well-being is of the utmost importance. We believe in ensuring your safety through empowerment, communication, choice, collaboration and trust when planning treatment and care with you.

HARM REDUCTION

We use harm reduction in the context of recovery to help you to know your options and to set individual goals about your substance use. We believe in the practice of truth telling and transparency as we work towards limiting the risk of substance use.

Neonatal Opioid Withdrawal Syndrome (NOWS)

- Constellation of signs caused by dysregulation of CNS and GI
  - Inconsolable crying
  - Tremor
  - Irritability
  - Poor feeding and weight loss
  - Vomiting and diarrhea
  - Seizure

- 48-94% of infants exposed to opioids go through opioid withdrawal
- Onset depends on opioid type (i.e. short acting opioids such as fentanyl occurs earlier, methadone later)
  - Canadian Pediatric Society (CPS) recommends keeping in hospital for up to 7 days

Paediatr Child Health 2020 23(3): 220–226.

ESC: Eat, Sleep, Console

- Non pharmacological management of the substance exposed infant/NAS using 10 reinforcing strategies:
  - Eat
  - Sleep
  - Console
  - Gain weight
- Mother first line of treatment → responsive, newborn centered care
- Consider reasons other than withdrawal for ESC behavior
- Medical management last resort

Perinatal Services BC
Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

Eat Sleep Console Approach

Prior Approaches

- Finnegan Neonatal Abstinence Tool
- Separation of the mother-infant dyad
- High rate of medical management
- ↑ LOS
- Monitoring when on morphine
- MCFD involvement not always positive

ESC Standard of Care

Standardized care and documentation

- ESC Assessment:
- Simple, easy
- ↓ Subjectivity
- ↑ IRR
- Studies (QI) promising results → evidence-based care
- Allow for easy adoption and implementation at other sites in BC

ESC

EATING, SLEEPING, CONSOLING (ESC) CARE TOOL

- Initiate a new ESC Care Tool record every day.
- Review ESC behaviors with parents/caregiver every 3-4 hours, after feedings, using the Newborn Care Diary.
- If not clear if the baby's difficulties with eating, sleeping or consoling is due to substance withdrawal, indicate **Yes** and continue to monitor closely while optimizing all Non-Pharmacological Care Interventions.
- See back of sheet for definition of items and interventions **prior to performing** assessment of ESC-W Care

PATIENT LABEL

Date:								**Daily WEIGHT (grams):**											
Gestational Age:								**Weight: Gain ↑ / Loss ↓**											
Corrected Age: **Age in days:**								**Weight loss** more than 10%: YES/NO											
Birth Weight:								**OR** If using NEWT is weight loss more than 95%? YES/NO											
Time																			
ESC ASSESSMENT **Y = Yes N = No**	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
EATING: Poor eating due to substance withdrawal?																			
SLEEPING: Sleep less than 1 hour due to substance withdrawal?																			
CONSOLING: Unable to console within 10 min due to substance withdrawal?																			
Consoling Support Needed: 1. Able to self console 2. Able to console with caregiver support within 10 min 3. Unable to console with caregiver support within 10 min																			
PARENTAL/CAREGIVER PRESENT FOR:																			
0. More than 3 hours 1. Two – three hours 2. Less than 2 hours 3. Less than one hour 4. No parent present																			
WHO PROVIDED INFANT CARE?																			
1. Mother 2. Partner 3. Support person 4. RN/LPN 5. Other **(describe)**																			
PLAN OF CARE	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Recommend Formal Parent/caregiver Huddle?																			
Recommend Full Care Team Huddle?																			
Management Decision 1. Continue/optimize non-pharm care 2. Initiate medication treatment 3. Continue medication 4. Other **(describe)**																			
NON-PHARMACOLOGICAL CARE INTERVENTIONS	I	R	I	R	I	R	I	R	I	R	I	R	I	R	I	R	I	R	
I = Increased R = Reinforced																			
Rooming – in																			
Parent/caregiver presence																			
Skin-to-skin contact																			
Safe swaddling																			
Optimal feeding at early hunger cues																			
Quiet, low light environment																			
Non-nutritive sucking/pacifier *(If not needed indicate as NN in I column)*																			
Additional help/support in room																			
Limiting number of visitors																			
Cue based responsive care																			
Parent/caregiver self-care and rest																			
Observers Initials																			

EATING, SLEEPING, CONSOLING & WEIGHT (ESC) CARE TOOL

Review definitions of assessment items and interventions prior to assessment. Review ESC Manual for more information.

DEFINITIONS	
WEIGHT	
Weight loss	Weight loss calculated as more than 10% OR more than 95% on NEWT requires a full care team huddle
EATING	
Poor eating due to substance withdrawal?	Answer **YES**, if due to substance withdrawal symptoms (e.g. fussiness, tremors, uncoordinated suck, excessive rooting), any of the following are observed: • Baby is unable to coordinate feeding within 10 minutes of showing hunger cues AND/OR • Baby is unable to sustain feeding for age appropriate duration at breast OR • Baby is unable to take in age and weight appropriate volume by alternate feeding method
	Do not indicate Yes if poor eating is clearly not due to substance withdrawal (e.g. prematurity, transitional sleepiness, excess mucus in first 24 hours, and inability to latch due to infant / maternal anatomical factors).
OPTIMAL FEEDING: • Baby feeding when showing early hunger cues until content, on demand, without any limit placed on duration or volume of feeding. Baby should be offered feedings whenever showing the desire to suck. • Breastfeeding: Baby latching deeply with comfortable latch for mother and sustained active suckling for baby with only brief pauses noted. Staff assist directly with breastfeeding to achieve more optimal latch/position. Express breastmilk and have baby feed on an adult finger first to organize suck prior to latching, as needed. Withhold pacifier use if possible. • Bottle feeding: Baby able to effectively coordinate suck and swallow without gagging or excessive spitting up. If needed modify bottle position, nipple flow rate and provide chin support. • Engage lactation consultant or feeding specialist if feeding difficulties continue despite above optimal feeding measures.	
SLEEPING	
Sleep less than 1 hour due to substance withdrawal?	Answer **YES** if baby is unable to sleep for at least one hour after feeding due to substance withdrawal symptoms (e.g. fussiness, restlessness, increased startle, tremors).
	Do not indicate Yes if sleep less than1 hour is clearly not due to substance withdrawal (e.g. physiologic cluster feeding in first few days of life, interruptions in sleep due to external noise, light and clinical care).
CONSOLING	
Unable to console within 10 min due to substance withdrawal?	Answer **Yes** if baby unable to self console within 10 minutes (due to substance withdrawal symptoms) despite infant caregiver/provider effectively providing any/all the Consoling Support Interventions (CSI's) below.
	Do not indicate Yes if infant's inconsolability is clearly due to other factors (e.g. caregiver non-responsiveness to infant hunger cues, pain).
Consoling Support Needed:	
1. Able to self console	Able to self console without any caregiver support needed.
2. Able to console with support within 10 min	Able to console within 10 minutes with any level of consoling support provided by caregiver/provider.
3. Unable to console with support within 10 min	**Unable to console within 10 minutes despite effective implementation of all levels of consoling support.**
Consoling Support Interventions (CSI's)	
1. Talk softly and slowly to infant, using voice to calm baby. 2. Look for hand-to-mouth movements and facilitates by gently bringing baby's hand to mouth. 3. Continues talking to baby and place hand firmly but gently on baby's abdomen. 4. Continues soft talking to baby and brings baby's arms and legs to the center of body. 5. Pick up baby, hold skin-to-skin or swaddled in blanket, and gently rock or sway baby. 6. Offer a finger or pacifier for infant to suck, or feed if showing hunger cues.	
PARENTAL/CAREGIVER PRESENCE	Time since last assessment that parent, or another caregiver, spent with baby Caregiver can be parent, other family member, designated visitor, cuddler, or healthcare worker that can deliver responsive care in a timely manner.
PLAN OF CARE	
Bedside RN and Parent/ caregiver Huddle	Bedside RN and parent/caregiver meet there is a **Yes for any ESC item** to determine if non-pharmacological care interventions can be optimized further, continue to monitor closely.
Full Care Team Huddle	Bedside RN, parent/caregiver and physician meet if infant has **more than 10% weight loss** (or more than **95% weight loss on Newt Tool), and/or CONTINUED Yes for any ESC item, or 3 for consoling support needed** (or any other significant concerns) **despite** optimal non-pharmacological care. Determine if medication treatment is needed. Continue to optimize all Non-Pharmacological Care Interventions and follow baby closely.

Rooming In BC Provincial Guideline

- Emphasis on Rooming-in even when a private room is not available
- Consists of guidance on:
  - Physical Space including when private rooms are unavailable
  - Breastfeeding and Substance Use
  - Safe Sleeping
  - Skin to Skin Contact

Transition Planning

Planning for transition from inpatient to community is a critical step for women and their families.
This includes:

- Referrals to primary health care, public health and Indigenous led organizations
- Community mental health and substance use services/treatment including OAT specific support plan
- Connection to parenting supports, peer supports
- Relapse prevention plan and safety plan
- Safe/supported housing
- Transportation and financial needs

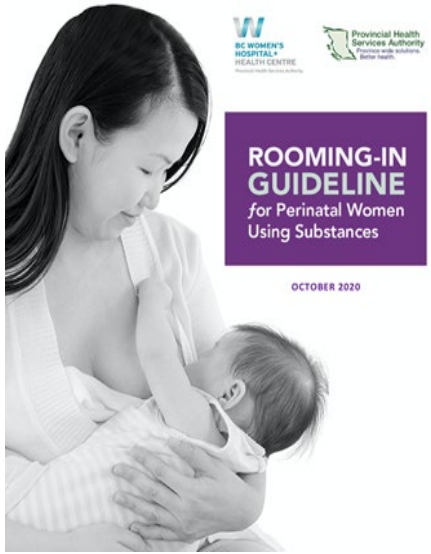
Resources

- Perinatal Substance Use
  - elearning.ubccpd.ca
- Perinatal Addictions RACE Line
  - Vancouver Area: 604-696-2131
  - www.raceconnect.ca
- BCCSU
  - Practice guidelines and support tools
  - ACTOC: Addiction Care and Treatment Online Course
  - POATSP Injectable OAT Stream
- VCH preceptorship training
- OUD Project ECHO
  - Launched June 2019, 12 sessions/cycle
  - Targets primary care providers

Resources

https://bccewh.bc.ca/wp-content/uploads/2019/11/CEWH-01-MO-Toolkit-WEB2.pdf

https://harmreduction.org/wp-content/uploads/2020/10/09.17.20_Pregnancy-and-Substance-Use-2.pdf



http://www.bcwomens.ca/Professional-Resources-site/Documents/Provincial%20Rooming-in%20Guideline%2022Oct2020%20Final%20-%20updated%20hyperlinks.pdf