

Optimizing Care of the Mother-Baby Dyad Affected by Substance Use Disorder:

A Guide for Health Care and Social Service Professionals
Serving Pregnant and Parenting Persons



Mid-America (HHS Region 7)

ATTC

Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Introduction and Summary

Improving health care delivery for maternal and infant populations is a critical priority in Missouri. Substance use disorder is a chronic disease with lasting effects for the mother, infant, family and community. With the global opioid epidemic, there has been a significant increase in maternal SUD rates further impacted by the “pair of ACEs” — the combined effects of adverse traumatic life events and social determinants of health. According to the Missouri Pregnancy-Associated Mortality Review 2018 Annual Report, 54% of pregnancy-related and 43% of pregnancy-associated but unrelated deaths were attributed to SUD. Overall, mental health conditions were the primary underlying cause of pregnancy-related death, with 63% occurring 43 to 365 days postpartum.

Historical models of care delivery focus intense resources on ensuring the infant’s health and safety. At the same time, the birthing person often is faced with stigma, shaming and exclusion from their infant’s care. Parents suffering from SUD lack access to consistent, robust systems of recovery treatment, behavioral health and social support while being stigmatized as moral failures and unfit parents. Early intervention and recovery support in the prenatal period is critical and is supported by implementing universal screening, brief intervention and referral to treatment protocols. Health care and social support providers must take steps to both recognize and mitigate their own stigma and implicit bias against persons with SUD and mental health diagnoses, both chronically referenced in multiple literature sources. The system must turn to a model that supports the mother’s recovery in an individualized manner; supports the mother and family to develop parenting skills, and include them in care of the infant with in-utero substance exposure; and supports the ongoing health and social supports after the baby is born. Optimizing a mother-infant dyad approach for those affected by SUD can improve the health outcomes of both the birthing person and infant. System strategies also must be acted upon to address institutional racism. Decreasing stigma and bias increases acceptability; provides respectful, inclusive and safe environments for patients to disclose misuse; and offers an atmosphere to receive medical care and treatment resources.

Reducing stigma and bias toward people with SUDs and co-occurring mental health diagnoses begins with increasing our individual and collective awareness through education, dialogue and self-reflection. This participant guide supports the on-demand webinars and educational material developed and presented by Sharon Hesseltine, BSW. It is essential to recognize that understanding the science and psychology of SUD prevention, assessment and treatment, and addressing the role stigma and bias play in a health care professional’s effectiveness, are not achieved by participating in one course. Rather, organizations and individuals are encouraged to continue leveraging this guide for ongoing team discussions in an inclusive, respectful manner.

The guide, on-demand recorded webinars and PowerPoint materials cover the following three sections.

- 1) The Brain, SUDs and Parenting: A Health Care Professional’s Guide
- 2) Pregnant and Parenting Families with SUD: Evidence-Based Treatment, Neonatal Opioid Withdrawal and Supporting the Infant-Parent Relationship
- 3) Stigma, Language and Implicit Bias: Moving Toward Becoming a Stigma-Free Provider

Each section includes three presentations that are approximately 30 minutes long, with all presentation materials included in the remainder of this guide.

Acknowledgments

This guide was developed in partnership with the Mid-America Addiction Technology Transfer Center, which is a partnership between University Health Behavioral Health and the University of Missouri-Kansas City School of Nursing and Health Studies. It serves the states of Iowa, Kansas, Missouri and Nebraska (HHS Region 7). The vision of Mid-America ATTC is that all people accessing services for an SUD in Iowa, Kansas, Missouri and Nebraska will receive treatment and recovery support rooted in evidence-based and promising practices. To accomplish this, Mid-America ATTC supports multidisciplinary practitioners, agencies and communities in implementing evidence-based practices.

Author and Presenter



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Sharon Hesseltine is the President and CEO of Intentional Beginnings Consulting & Training of Louisville, Ky., a small nonprofit with the mission to strengthen organizations and individuals serving those who experience SUDs, ACEs and trauma. Hesseltine received her Bachelor of Science in social work from Southern Illinois University in 1981, and in 2011 completed a post-graduate Certificate in Infant and Early Childhood Mental Health from the University of Minnesota. For more than 30 years, Hesseltine has worked in public health and specialized in early childhood development, women's health and addiction. Her career has ranged from providing direct services to women through managing two sober living residences, to designing and facilitating statewide and local collaborative initiatives that call on her skills in public policy, strategic planning, cross-sector collaboration, program assessment and marketing. She is a national trainer, Technology Transfer Specialist and facilitator for multiple organizations, including the Hazelden Betty Ford

Foundation, the Addiction Technology Transfer Centers and the Opioid Response Network. In 2018, Hesseltine developed SUD-specific training for peer support specialists and supervisors for the Commonwealth of Kentucky. She is passionate about reducing the stigma associated with addiction and developing the capacity of communities, organizations and individuals to better meet the needs of individuals with SUDs. In 2020, Hesseltine accepted the position as Chair of the Substance Abuse and Mental Health Services Administrator's Peer Recovery Center of Excellence Steering Committee. She resides in Louisville with her husband, Scott Hesseltine.

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., is the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration. The opinions expressed herein are the views of the authors and do not reflect the official position of HHS or SAMHSA. No official support or endorsement of HHS, SAMHSA for the opinions described in this product is intended or should be inferred. The work of the Mid-America ATTC is supported by SAMHSA grant #1H79TI080208.



Session 1

The Brain, Substance Use Disorders and Parenting: A Health Care Professional's Guide



Recording Links

[Session A](#)

[Session B](#)

[Session C](#)



Learning Objectives

- » recognize addiction as a chronic brain disease
- » understand the connection between ACEs and vulnerability for addiction
- » the role of the reward system in driving parenting behavior

Session Overview

In the first of this three-session series, the focus will be on addiction as a chronic and treatable disease that impacts functioning within the brain. As medical professionals, you've engaged in many hours of education and training focused on the human body and various disease processes. At the same time, many of you have likely had limited opportunity to learn a lot about addiction, the disease course and its impact upon the human body; yet, you encounter its impact on a regular basis when you are in the position of providing care to a mother with an SUD and the newborn who may have been affected as well.

Individuals in the active stage of an SUD can present many challenges to those charged with caring for them. The behavior patterns of those in active addiction are difficult to ignore, and can be challenging and trying. Often, when caring for someone in active addiction, it is almost impossible to recognize that the person is afflicted by a disease that is both progressive and deadly. When it comes to diseases that impact brain functioning, the symptoms are often disguised as choices — something within the control of the person with the disease — when in reality, the inability to choose is reflective of the disease itself.

This session is designed to support our understanding of what science tells us about the disease of addiction. We will have an opportunity to learn how brain functioning is altered during addiction and how these changes are directly responsible for the behaviors often observed among individuals with an SUD. We will explore the factors contributing to addiction vulnerability and discuss why only about 10% of the population ever develops an SUD. There are significant benefits when we take the time to understand the science of addiction, specifically the brain changes that occur and how those brain changes impact behavior, decision-making and problem-solving. These benefits include becoming more patient and less frustrated with those we provide care for and an enhanced ability to support those who struggle with the disease.

We will also discuss parenting specifically and the challenges faced when early recovery from addiction and parenting coincide. Our focus here is again on the brain and how the systems of the brain that early parenting or caregiving behaviors are the same systems impacted by addiction. All in all, this session lays a foundation for understanding the disease of addiction and its impact upon parenting. It brings us all to a common level of understanding that we can leverage in our subsequent sessions to best support parents afflicted with this disease.



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The Brain, Substance Use Disorders and Parenting: A Health Care Professional's Guide – Session A

Presented by

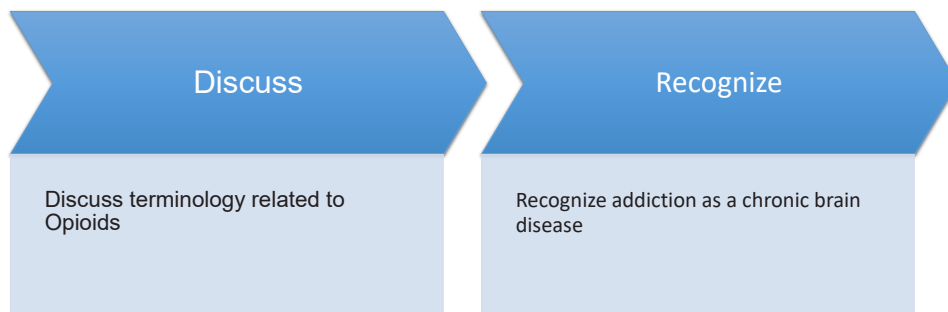
Sharon A. Hesseltine, BSW

Intentional Beginnings/Intentional Development



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Session A Learning Objectives



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Terminology Related to Opioids



Opioid use: Taking an opioid to reduce pain

Broad category includes morphine, codeine, synthetic opioids (e.g., fentanyl or methadone) and semisynthetic opioids (e.g., oxycodone)



Opioid abuse or misuse: Use of prescription drugs without a prescription, or in a manner other than as directed by the prescriber



Opioid dependence: Physiologic adaptation to opioids that produces symptoms of withdrawal when opioids are stopped



Opioid use disorder: Problematic pattern of opioid use leading to clinically significant impairment or distress



Medication Assisted Treatment: Use of specific medication in the treatment of opioid use disorders

Includes methadone, buprenorphine (Subutex, Suboxone) or naltrexone (Vivitrol)

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YES, IT'S IN YOUR HEAD!

The Neurobiology of Addiction

According To ASAM Addiction Is:

“Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases”

ADDICTION IS NOT:

- Caused by another mental illness or trauma
- A moral or ethical problem
- A personality disorder
- A choice
- Caused by lack of social connection or isolation

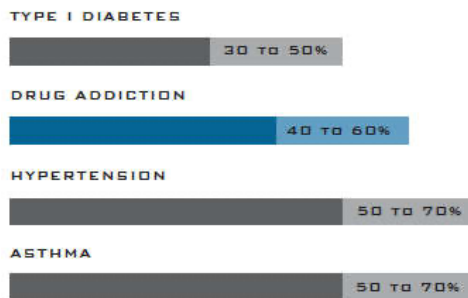
ADDICTION IS:

- Compulsion to seek and take the drug
- Loss of control in limiting intake
- Diminished recognition of significant problems
- Emergence of negative emotional state
- Craving
- Chronicity
- Periods of remission and recurrence

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**Like Other
Chronic
Diseases,
Addiction
Often
Involves
Cycles of
Recurrence
and
Remission**

Percentage of Patients Who Relapse



NIDA, 2020

What is Addiction?

from
The Addiction
Policy Forum

The Old Brain

- Three Main Functions:
 - Regulate physiological functions
 - Experience basic emotions (anger, fear, hunger, thirst, lust, pain and pleasure)
 - Imprint survival memories
- Overrides new brain in times of stress
- Can be thought of as the “go” or reactive part of the brain

~University of Minnesota

The New Brain: Prefrontal Cortex

Executive Functions

(not fully developed until age 25)

- Judgment
- Impulse control
- Self-monitoring

Coping Functions

- Attention span
- Organization
- Learning from experience
- Empathy
- Problem Solving

~University of Minnesota

OLD VS. NEW BRAIN

Old brain is senior partner

Craving resides in the old brain and can override the reasoning that happens in the new brain

Old brain acts 4 -5 x more quickly than new brain

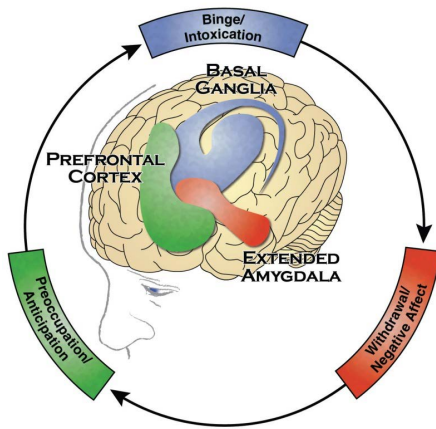
~University of Minnesota

DOPAMINE



- Neurotransmitter
- Signals reward in our brains
- Also increased by stimuli that predict a reward
- Brain itself will drive the repeating of what it perceives as life-sustaining activity
- Over time when the brain is regularly flooded with dopamine (and other neurotransmitters) it will reduce the natural production

Three Stages of the Addiction Cycle



- **Binge/Intoxication**, the stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects
- **Withdrawal/Negative Affect**, the stage at which an individual experiences a negative emotional state in the absence of the substance
- **Preoccupation/Anticipation**, the stage at which one seeks substances again after a period of abstinence

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol,
Drugs, and Health, 2016

The Addiction Cycle

- The three stages are linked to and feed on each other
- A person may go through this three-stage cycle over the course of weeks or months or progress through it several times in a day
- May be variation in how people progress through the cycle and the intensity with which they experience each of the stages
- The addiction cycle tends to intensify over time, leading to greater physical and psychological harm

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

BRAIN CHANGES INHERENT TO ADDICTION

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- Less dopamine produced
- Fewer dopamine receptors
- Ability to experience normal reward – feel joy reduced significantly
- Using no longer pleasurable, but about trying to get dopamine function back to a normal level
- Brain is driven to seek out and use substances compulsively
- Ability to make sound decisions and control impulses is compromised

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NIDA – Drugs, Brains and Behavior: The Science of Addiction

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<https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health/index.shtml>

From the University of Minnesota open library. This is part of an Introduction to Psychology Course. It is from Chapter 3 Brains, Bodies and Behavior and provides an excellent description of the brain and functions of the various parts in an easily understandable manner. Complete with numerous links and illustrations.
<http://open.lib.umn.edu/intropsyc/chapter/3-2-our-brains-control-our-thoughts-feelings-and-behavior/>

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ADDITIONAL NOTES:



The Brain, Substance Use Disorders and Parenting: A Health Care Professional's Guide – Session B

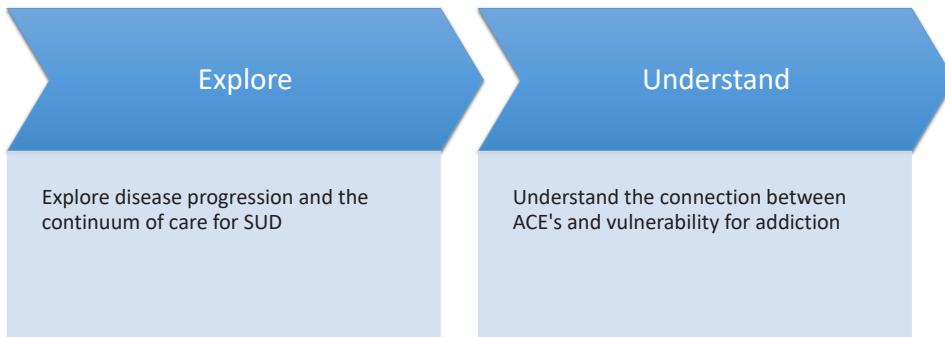
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Session B Learning Objectives



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Substance Use Disorder Disease Progression

Substance Use Status

Positive Physical, Social, and Mental Health	Substance Misuse	Substance Use Disorder
A state of physical, mental, and social well-being, free from substance misuse, in which an individual is able to realize his or her abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to his or her community.	The use of any substance in a manner, situation, amount, or frequency that can cause harm to the user and/or to those around them.	Clinically and functionally significant impairment caused by substance use, including health problems, disability, and failure to meet major responsibilities at work, school, or home; substance use disorders are measured on a continuum from mild, moderate, to severe based on a person's number of symptoms.

Substance Use Status Continuum



Substance Use Care Continuum

Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health communications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at an early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: <ul style="list-style-type: none"> • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services. 	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Substance Use Care Continuum

Continuum of Care

- **Early Intervention**, for addressing substance *misuse problems or mild disorders* and helping to prevent more severe substance use disorders
- **Treatment engagement and harm reduction interventions**, for individuals who have a substance use disorder but who may not be ready to enter treatment, help engage individuals in treatment and reduce the risks and harms associated with substance misuse
- **Substance use disorder treatment**, an individualized set of evidence-based clinical services designed to improve health and function, including medications and behavioral therapies.
- **Emerging treatment technologies** are increasingly being used to support the assessment, treatment, and maintenance of continuing contact with individuals with substance use disorders.

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

Early Intervention

- Can be provided in a variety of settings (e.g., school clinics, primary care offices, mental health clinics) to people who have problematic use or mild substance use disorders
- Goals are to reduce the harms, reduce risk behaviors and prevent progression
- Consists of providing information about substance use risks, safe levels of use, and strategies to quit or cut down on use and use-related risk behaviors
- Structured approach includes screening and brief intervention

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

As individuals continue to misuse alcohol or other substances, progressive changes, called *neuroadaptations*, occur in the structure and function of the brain

These changes compromise brain function and drive the transition from controlled, occasional substance use to chronic misuse, which can be difficult to control

Brain changes endure long after an individual stops using substances

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

According to the Surgeon General . . .

“The good news is that a spectrum of effective strategies and services are available to identify, treat, and manage substance use problems and substance use disorders.

Research shows that the most effective way to help someone with a substance use problem who may be at risk for developing a substance use disorder is to intervene early, before the condition can progress.”

SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health

How Adverse Childhood Experiences Increase Vulnerability for Substance Use Disorders

Why Do Only Some People Become Addicted?

- No single factor
- More risk factors = a more vulnerable brain
- Protective factors decrease chance of brain becoming addicted
- Genetics account for 40% - 60%
- Adolescents & people with mental illness are at greater risk
- In many ways addiction is a disease that originates in adolescence

ACE Questions Focus On Occurrences Before The Age Of 18

ACE Questions

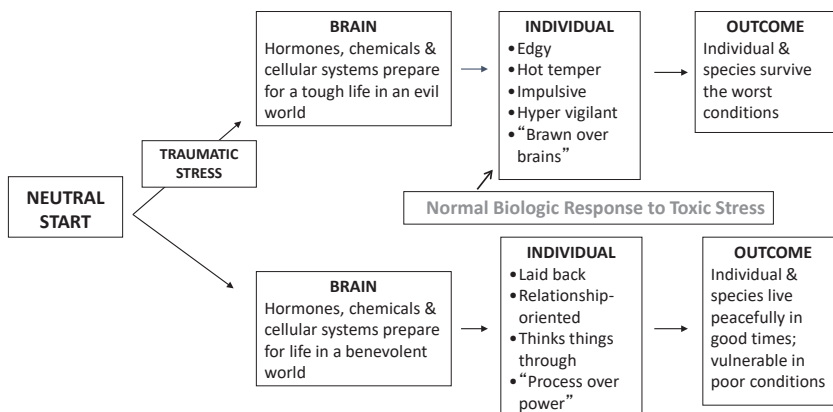
Personal

- Physical abuse
- Verbal abuse
- Sexual abuse
- Physical neglect
- Emotional neglect

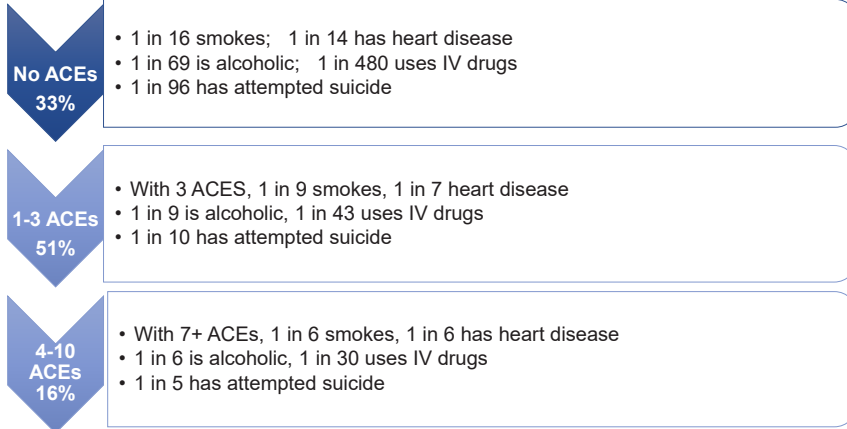
Family Members

- Mother is a victim of domestic violence
- Family member in jail
- Parent with a substance use disorder
- Family member with mental illness
- Disappearance of parent through divorce, death or abandonment

ACEs Influence Via Biologic Impact on Neurodevelopment



ACE's Increase Chronic Disease



13 Felitti et al, 1998



Relationships

Children's earliest interactions within the family are crucial to their healthy development and risk for drug misuse

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Connectedness Is The Key

YOUR HISTORY OF CONNECTEDNESS IS A BETTER PREDICTOR OF YOUR HEALTH THAN YOUR HISTORY OF ADVERSITY

be with each other | celebrate diversity | listen and learn from others | share time, food, work

The "super-power of human-kind is our capacity to connect; it is regulating and the major 'route' by which we can teach, coach, parent, heal and learn"

~Bruce Perry

<https://norasblog.wordpress.com/2020/03/21/advice-from-bruce-perry/>



The Brain, Substance Use Disorders and Parenting: A Health Care Professional's Guide – Session C

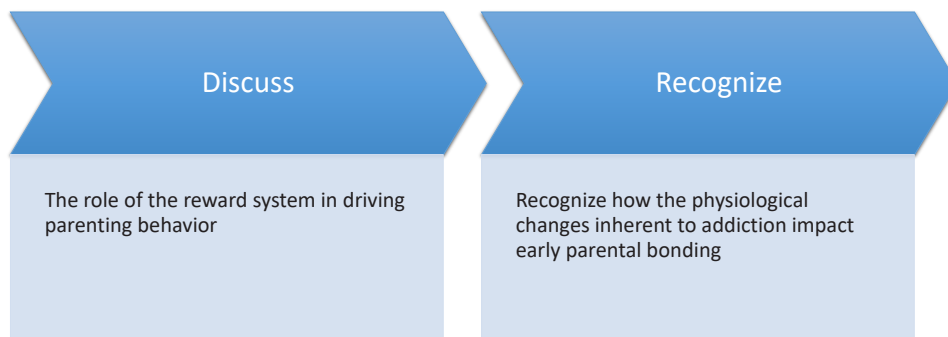
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Session C - Learning Objectives



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The Brain, Addiction & Parenting

The Reward System & Parenting

PAGE 4c

- In chronic active addiction the brain's reward circuits drive drug-seeking behavior
- Key regions of the brain's reward system do not engage among addicted individuals to the same extent as non addicted persons when it comes to non-drug rewards
- Research has shown activation of reward circuits in mothers' brains when viewing their infant's smiling face vs. an unfamiliar infant
- Studies indicate that these reward processing areas of the brain overlap with the areas of the brain involved in processing infant cues in mothers

The Neurobiology of Addiction and Attachment H. Rutherford, M. Potenza and L. Mayes

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The Stress Response System

- Considerable research has shown that stress increases craving in addicted individuals
- These factors could explain increased incidence of relapse during the postpartum period
- Stress may influence the brain to drive drug seeking behaviors that are connected to relief of negative feelings
- Stress-induced cravings have been found to significantly predict relapse in abstinent individuals

Source: The Neurobiology of Addiction and Attachment H. Rutherford, M. Potenza and L. Mayes

PAGE 5c

MORE ON STRESS

PAGE 6c

- Individuals who are more vulnerable to stress may also be impacted more significantly by stressors that are part of parenting
- Stress related to lack of resources also contributes
- Oxytocin an important facilitator of maternal caregiving behavior (and lactation) and may also help reduce the impact of the stress response
- Mothers taking cocaine during pregnancy have lower levels of Oxytocin which were actually decreased by stress – non-using mothers did not show such a decrease

Source: The Neurobiology of Addiction and Attachment H. Rutherford, M. Potenza and L. Mayes

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Brain Pathways Overlap

PAGE 7c

- The brain pathways involved in parenting are also the pathways negatively impacted by addiction
- Reward and stress pathways are of significant importance in both parenting and addiction
- Pathways driving parenting and attachment behaviors seem to be the same pathways negatively impacted or dysregulated by addiction

Source: The Neurobiology of Addiction and Attachment H.Rutherford, M. Potenza and L. Mayes

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Early Recovery & Early Parenting

- Mama & baby are difficult regulatory partners for each other
- Substance-affected baby has hard time regulating sleep/wake cycles, not always a clear signaler, needs more parental help to regulate
- Mothers have a difficult time reading baby's signals –and a reduced tolerance for coping with a distressed baby – very vulnerable combination

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Babies Of Mothers With SUDs

PAGE 9c

- Show less positive emotion during interaction
- More distress from new situations (novelty)
- Slower recovery from interruptions
- Have a harder time maintaining alert attentive state
- Interaction between moms and babies has less enthusiasm and mutual enjoyment, more conflict and less mutual excitement

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Early Recovery & Early Parenting

Women are making several great changes at the same time in multiple areas of their life:

- Make room for child in their mind
- Take responsibility for child
- Give up substances – including smoking
- New social network
- Life & securing services

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Source: M. Pajulo, N. Suchman, M. Kalland and L. Mayes, Enhancing the Effectiveness of Residential Treatment For Substance Abusing Pregnant and Parenting Women: Focus on Maternal Reflective Functioning and Mother-Child Relationship; Infant Mental Health Journal., 2006 Sept 1; 27 (5): 448

Clinical Finding:

The most problematic areas found in parenting among mothers with SUD'S includes inability to keep the baby in mind and stay emotionally connected and present to baby. Moms have difficulty differentiating the child's needs from their own.

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Source: M. Pajulo, N. Suchman, M. Kalland and L. Mayes, Enhancing the Effectiveness of Residential Treatment For Substance Abusing Pregnant and Parenting Women: Focus on Maternal Reflective Functioning and Mother-Child Relationship; Infant Mental Health Journal., 2006 Sept 1; 27 (5): 448

Post Acute Withdrawal Syndrome

Six Major Types of Symptoms

- Sleep disturbances
- Memory problems
- Inability to think clearly/problem solve
- Emotional overreactions or numbness
- Physical coordination difficulties
- Stress sensitivity

Recovery from PAWS usually takes somewhere between six and 24 months

Hazelden Betty Ford Foundation, 2019



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Let's Unpack All This Just a Bit

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- When we talk about “keeping the baby in mind” how does that look to you?
- How do the brain changes involved with SUD impact the capacity to keep the baby in mind from a neurobiological perspective?
- If the capacity to keep the baby in mind is challenging from a neurobiological perspective what are your thoughts around how we support the growth of that capacity?

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ADDITIONAL NOTES:

Key Quotes:

“Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.”

— American Society of Addiction Medicine, definition of addiction, 2019

“Addiction is a chronic neurological disorder and needs to be treated as other chronic conditions are.”

— Sylvia Mathews Burwell,
Secretary, U.S. Department of Health and Human Services, 2016.
Facing Addiction in America, The Surgeon General’s Report on Alcohol, Drugs, and Health

“Decades of scientific research and technological advances have given us a better understanding of the functioning and neurobiology of the brain and how substance use affects brain chemistry and our capacity for self-control.

— Sylvia Mathews Burwell,
Secretary, U.S. Department of Health and Human Services, 2016.
Facing Addiction in America, The Surgeon General’s Report on Alcohol, Drugs, and Health

“Severe substance use disorders, commonly called addictions, were once viewed largely as a moral failing or character flaw but are now understood to be chronic illnesses characterized by clinically significant impairments in health, social function and voluntary control over substance use.”

— *Facing Addiction in America,*
The Surgeon General’s Report on Alcohol, Drugs, and Health

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Session 2

Pregnant and Parenting Families with SUD: Evidence-Based Treatment, Neonatal Opioid Withdrawal and Supporting the Infant-Parent Relationship



Recording Links

[Session A](#)

[Session B](#)

[Session C](#)



Learning Objectives

- » describe evidence-based treatment for pregnant women with an opioid use disorder
- » recognize the impact of parent involvement in the care of newborns experiencing Neonatal Opioid Withdrawal Syndrome
- » develop skills and strategies to positively impact the parent-child relationship among parents with a substance use disorder

Overview

The last session focused on the disease of addiction and how the neuropathways impacted by addiction are the same ones that drive early parenting/caregiving behavior. This session moves our attention to treatment for OUD and strategies you can easily employ to support maternal bonding.

This session begins by drawing our attention to an underutilized process of universal screening for substance use problems using an evidence-based interview tool. Screening is distinctly different from toxicology testing and is recommended by the American College of Obstetricians and Gynecologists, American Society of Addiction Medicine, American Academy of Pediatrics and the Society for Maternal-Fetal Medicine.

According to ACOG (Committee Opinion #711), *“Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.”*

Providers of prenatal/obstetrical care are in a key position to positively impact not only birth outcomes but also life outcomes for families experiencing challenges with substances. Through screening, brief interventions, or referral for assessment and treatment where indicated, there is an opportunity for families to find recovery well ahead of delivery. And finding recovery during the prenatal period means greater stability for the entire family and a lessened chance of out-of-home placement for newborns.

During this session, we will have the opportunity to focus on evidence-based treatment for pregnant women with OUD and discuss addiction medication during pregnancy. We will discuss methadone or buprenorphine as the recommended treatment for a pregnant woman with an OUD. While there is a roughly 50% chance the baby will experience NAS/NOWS, it is a highly treatable condition. What is important to know is that while following a medically managed withdrawal protocol may seem like a wise idea, it won't automatically remove the risk of NAS/NOWS and definitely increases the risk of overdose death for the woman. We know that medications to treat an OUD reduce the risk of OD death by 50%, and unfortunately, pregnancy does not reduce the risk of returning to use if someone goes through a withdrawal protocol.

As noted in the learning objectives above, this session will also include information specific to NAS/NOWS. Still, the most important element of this module is its attention to fostering the parent-infant relationship. We will discuss the powerful benefits of parent involvement in caring for neonates with NOWS and explore concrete strategies to support parent engagement that can be employed with all families. As health care providers, you truly have the opportunity to make a lasting, positive impact upon parental competence and confidence.



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Pregnant and Parenting Families with SUD: Evidence-Based Treatment, Neonatal Opioid Withdrawal and Supporting the Infant-Parent Relationship – Session A

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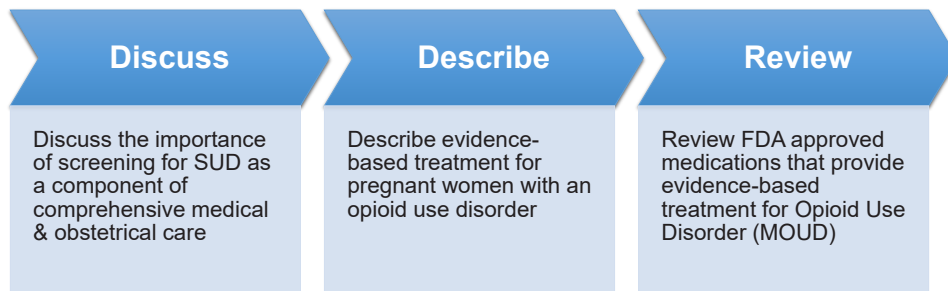
Sharon A. Hesseltine, BSW

Intentional Beginnings/ Intentional Development



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Session A Learning Objectives



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Comprehensive Care Begins with Screening

- Screening should be conducted universally as opposed to being driven by specific risk factors
- Screening based upon risk factors can lead to missed cases and carries the potential for stereotyping and stigma
- The goal of screening during pregnancy is to identify those women with substance use disorders and to help all such women receive treatment if needed
- All women should be routinely asked about their use of alcohol and drugs, including prescription opioid and other medications use for nonmedical reasons
- A caring and non-judgmental approach is essential
- Routine screening should rely on validated screening tools
- ACOG advocates the administration of a brief substance use screening questionnaire to all pregnant women that would trigger a brief behavioral intervention and referral, if warranted
- SBIRT is the acronym that stands for **S**creening, **B**rief **I**ntervention and **R**eferral for **T**reatment – On-line SBIRT training is available at no cost through the Mid-America ATTC - <https://attcnetwork.org/centers/mid-america-attc/online-courses>

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OB Providers

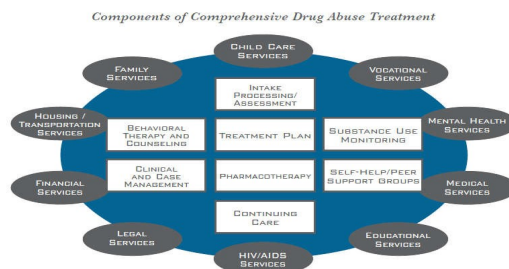
- Play a critical role as a bridge to treatment for opioid use disorder (OUD)
- Prevent dire consequences of untreated OUD (overdose death, fetal loss, and preterm birth) by implementing universal screening for SUD per ACOG recommendations
- Can couple screening with the provision of or referral to treatment that includes MOUD
- Have an opportunity to expand care to include MOUD per new DHHS Practice Guidelines
- Can establish partnerships with local SUD treatment providers to facilitate a "warm" referral process to assure patients with OUD have access to evidence-based treatment that includes MOUD

Evidence Based Treatment for Pregnant Women With an Opioid Use Disorder

Treatment

The National Institute of Drug Abuse (NIDA) emphasizes that treatment of addiction is a long-term process that involves multiple interventions and regular monitoring.

NIDA outlines an approach to comprehensive treatment in the diagram to the right



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

Treatment of OUD

Most effective treatment for OUD involves a combination of several approaches:

Medication for Opioid Use Disorder involves use of medications in combination with intervention to increase adherence to medications

Psychosocial/behavioral approach focused on helping patients develop skills necessary to maintain abstinence

Self Help/Mutual Help support groups form social network supportive of recovery

Recovery-oriented activities help patients develop satisfying lives

SAMHSA, TIP 63, 2020

American College of Obstetricians and Gynecologists (ACOG) Committee Opinion – August 2017

Opioid **agonist pharmacotherapy is the recommended therapy** and preferable to medically supervised withdrawal because:

- Medically supervised withdrawal is associated with higher rates of recurrence
- More research is needed to assess the safety, efficacy, and long-term outcomes of medically supervised withdrawal
- Infants born to women who used opioids during pregnancy should be monitored by a pediatric care provider for neonatal abstinence syndrome
- Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed

Why Medication?

- Current data does not support a reduction in NAS with medically assisted withdrawal (MAW) compared to medication
- Medically assisted withdrawal increases risk of maternal return to use and poor treatment engagement and does not improve newborn health
- Close to half of pregnant women who completed a MAW protocol (48%) returned to active use, significantly increasing risk for OD, HIV, Hep C and infection

Jones et al. Addiction Medicine March/April 2017, HE Jones. Approaches in Women with Substance Use Disorders Who Become Pregnant Opioid Use Disorders in Pregnancy: Management Guidelines for Improving Outcomes- Cambridge University Press 2018 pp 76-77. ACOG Committee Opinion # 711, 2017.

Addiction Medicine During Pregnancy

- Concurrent use of multiple substances during pregnancy coupled with environmental factors during early childhood make it difficult to demonstrate a simple linear cause-and-effect relationship between either NAS diagnosis or prenatal opioid exposure and compromised developmental outcomes
- Advantages of buprenorphine include lower risk of OD, fewer drug interactions, evidence of less severe neonatal abstinence syndrome (NAS) as opposed to methadone
- Pregnant women who stop using opioids and subsequently experience recurrence are at greater risk of overdose death
- Research shows that a combination of medication and behavioral therapies is most successful for substance use disorder treatment

Jones et al, Journal of Addiction Medicine 2019
Source: ACOG Committee Opinion Number 524, May 2012,
SAMHSA - A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders, 2016

Risks of Returning to Use

MAT decreases likelihood of a return to use and its dangers including:

- Rape
- Prostitution
- Assault
- Disease exposure (STI, HIV, Hep C)

Lifestyle associated with active addiction is a bigger risk than fetal exposure (exception is alcohol)

Reducing stress, eating well, exercise and consistent prenatal care are all conducive to a healthy baby and not part of a lifestyle in active opioid addiction

Overdose & death most significant risk following a period of abstinence

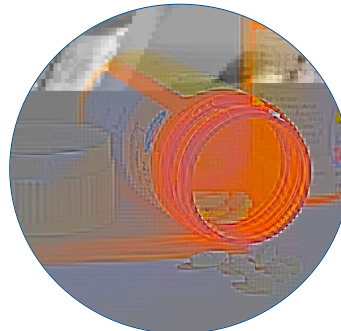
Medication to Treat Opioid Use Disorder (MOUD)

Success rate of IV opioid addiction without MOUD is approximately 10%

MOUD increases the rate of success by 50% and reduces risk of OD by 50%

Helps establish:

- ✓ normal brain functioning after years of substance misuse
- ✓ reduces cravings
- ✓ prevents recurrence
- ✓ reduces HIV, hepatitis C, and other physical health complications related to IV use



National Academies of Sciences, Engineering, and Medicine, 2019

A Word on Medication Dosage

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- Reducing the dose of medication does not reduce NAS expression or severity
- No relationship was found between either methadone or buprenorphine dose and significant infant outcomes, including NAS expression or severity
- Dose of medication should be individualized to suppress withdrawal symptoms, minimize cravings and prevent a return to substance use

SAMHSA. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

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FDA Approved Medications to Treat Opioid Use Disorder

Vivitrol
Methadone
Buprenorphine

PAGE 15a

Vivitrol[®] *(Sole Source)*

- Opioid antagonist obtained by prescription
- Once-monthly injectable
- Requires detox
- Not a narcotic
- Non-addictive
- Helps prevent relapse
- Treatment includes counseling
- **Not FDA approved and should not be prescribed for pregnant women**

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Methadone

- Opioid agonist medication
- Reduces withdrawal symptoms
- Used as a pain reliever for detoxification and maintenance
- Daily dose
- Treatment includes counseling
- Creates physiological dependence
- Requires detox
- Prescription required or registration with a Methadone clinic
- Dosage typically needs to be increased in the 3rd trimester

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Buprenorphine

- Sublingual tablet, sublingual film (Suboxone[®]), extended-release injection (Sublocade[®])
- Used in the induction and maintenance treatment of opioid dependence
- Treatment of opioid dependence
- Reduces withdrawal symptoms
- Daily dose
- Prescription required
- Treatment includes counseling

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Exceptions to Buprenorphine DATA 2000 Waiver – April 28, 2021

- Under certain conditions, new Practice Guidelines exempt eligible practitioners from the certification requirements related to training, counseling and other ancillary services related to the prescribing of buprenorphine
- Practitioners licensed under state law, and who possesses a valid DEA registration under 21 U.S.C. 823(f), may become exempt from the certification requirements related to training, counseling, and other ancillary services
- Needed in order to expand access to buprenorphine for opioid use disorder treatment
- Exemption allows practitioners to treat patients with buprenorphine without certifying as to their capacity to provide counseling and ancillary services
- Practitioners must submit a Notice of Intent (NOI) in accordance with current procedures in order to be covered under this exemption and receive a waiver.
- If a practitioner selects a patient limit of 30 in the NOI, the practitioner will not need to certify as to the training, counseling, or other ancillary services requirements

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<https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder>

Disease Course and Medications



The longer the patient remains on the medication, the better chance of benefiting from treatment:

- It is not known if there is a duration of medications for addiction treatment (MAT) that would eliminate the risk of return to use
- The risk of return to use should always be considered to be greater once the medication is stopped
- A decision to discontinue medications after a period of successful treatment should occur only after a careful discussion of risks between the clinician and the patient

Disease Course and Long-Term Management

Long-term management rather than repeated episodes of acute treatment should be a primary strategy

- Post-stabilization monitoring, education, and linking with community supports
- Medical, psychosocial, and environmental interventions should be utilized over a lifetime with intensity matching the severity of symptoms
- Frequent checkups to monitor stability/adjust medications
- Focus on treating consequences and minimizing risk factors
- Helping patient develop self-monitoring and self-care strategies

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Pregnant and Parenting Families with SUD: Evidence-Based Treatment, Neonatal Opioid Withdrawal and Supporting the Infant-Parent Relationship – Session B

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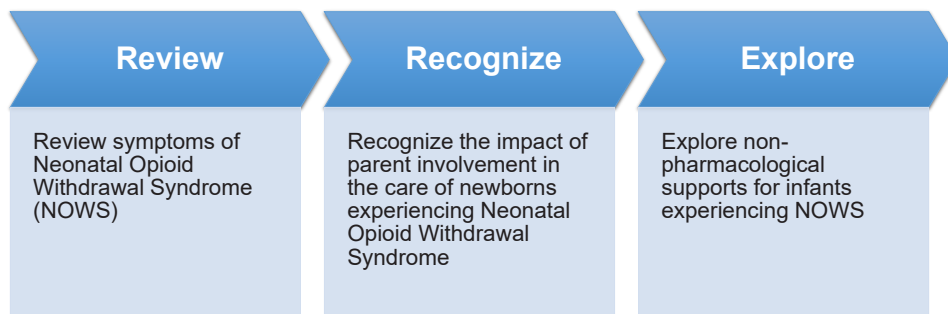
Sharon A. Hesseltine, BSW

Intentional Beginnings/ Intentional Development



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Today's Learning Objectives



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Neonatal Opioid Withdrawal Syndrome, Newborns & Parenting

Neonatal Abstinence Syndrome

PAGE 4b

- Collection of symptoms babies experience as they withdrawal from drugs they were chronically exposed to in utero
- Clinical diagnosis
- There can be symptoms of withdrawal from substances other than opiates – such as nicotine or anti-depressants
- Has not been demonstrated to cause long-term neurodevelopmental deficits
- Is a short period of time in the larger continuum of an infant's life

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SYMPTOMS of NAS/NOWS

Neurological

- Tremors
- Irritability
- Increased wakefulness
- High-pitched crying
- Increased muscle tone
- Hyperactive deep tendon reflexes
- Exaggerated Moro reflex
- Seizures
- Frequent yawning and sneezing

Gastrointestinal

- Poor feeding
- Uncoordinated & constant sucking
- Vomiting
- Diarrhea
- Dehydration
- Poor weight gain
- Increased sweating
- Nasal stuffiness
- Fever
- Mottling
- Temperature instability

Source: Hudak, Pediatrics February 2012

Factors Contributing to Severity of NOWS

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Genetics

Other substances

- Tobacco use
- Benzodiazepines (alprazolam, diazepam, clonazepam)
- SSRIs (i.e., specific types of antidepressants)
- Gabapentin

Birth weight

Hospital Protocols

- NICU setting
- NAS medication choice
- NAS medication and weaning protocols
- Not breastfeeding
- Separation of baby from mother

Jansson and Velez, Curr. Opin. Pediatrics, 2012, Sanlorenzo, Stark and Patrick, Pediatrics 2018

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How Severity of NOWS/ NAS is Determined

- Multiple assessment tools are in use across the country
- Finnegan Neonatal Abstinence Score (FNAS) used most
- Researchers and clinicians have not come to a common agreement on how to best assess NAS/NOWS
- Eat, Sleep, Console (ESC) assessment approach is showing promise for guiding the management of infants exposed to opioids during pregnancy
- Babies whose care was guided by the ESC approach had a shorter length of hospital stay and fewer infants were treated with medication

Westgate & Gomez-Pomar, 2017, Grossman et al, 2018, Spence, 2020

Importance of Parental Involvement

- Full rooming in leads to decreased hospital costs and length of stay
- Parental presence associated with reduced days of opioid medication for newborn (5.7 fewer days)
- Maximal parental presence associated with fewer opioid treatment days for neonate
- Strategies that promote rooming-in and minimize separation of mother and infant benefit both mother and baby
- Priority should be placed on non-pharmacological interventions and effective nonpharmacologic care that engages the mother is an essential foundation to the care of an infant with opioid exposure

Sanlorenzo, Stark and Patrick, Curr Opin. Pediatrics, April 2018. Spence, 2020. AAP October 2020.

What About Breastfeeding?



- Has positive physical and behavioral health results for mother and baby
- Most of the time breastfeeding is encouraged for women on methadone & buprenorphine
- Breastfeeding is not safe if someone is HIV positive or using illicit drugs
- Only very small amounts of methadone &/or buprenorphine get into the baby's system
- Decreases NAS severity, reduces the infant's need for pharmacological treatment, and decreases the length of pharmacological therapy and hospitalization
- Introduce the concept of breastfeeding in the last trimester

Source: ASAM Pamphlet "Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine, SAMHSA. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Infants With NAS Struggle With Regulation

- Behaviors regulate internal states & interactions with environment
- NAS behaviors indicate dysregulation of behavioral repertoire and functioning
- Conceptualize newborn behavior in terms of ability to regulate responses
- Regulation vs. dysregulation
- Responds to typical parental interactions (eye contact, light touch, vocalization) with:
 - Irritability
 - Exaggerated reflex responses
 - Spitting up
 - Loose stools
 - Hiccups

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Nonpharmacologic Care

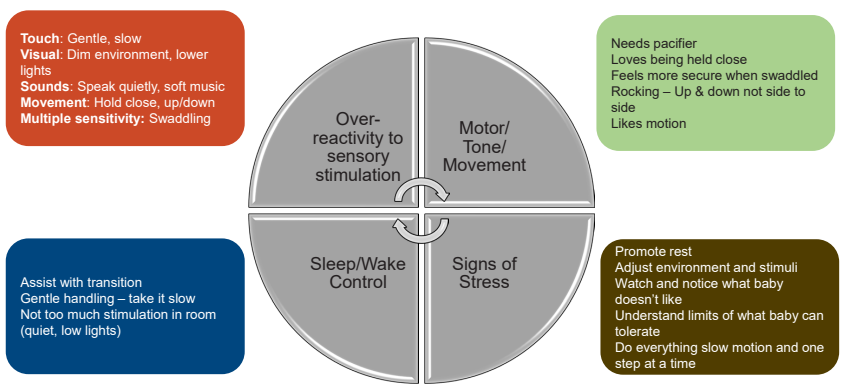
- Effective nonpharmacologic care that engages the mother is an essential foundation to the care of an infant with opioid exposure
- Nonpharmacologic care that is individualized should be applied beginning at birth for all infants with substance exposure and continued throughout hospitalization and beyond, regardless of the need for pharmacotherapeutic intervention
- Engaging and coaching caregivers in nonpharmacologic care promotes bonding and may improve outcomes
- Health Care staff can provide education about the infant-specific signs of NOWS and help the family identify factors that exacerbate and diminish clinical symptoms
- Clinical features of NOWS can be challenging for the new mother and providing encouragement as she responds to these clinical features is important
- Nonpharmacologic care should also include a thorough assessment of the hospital environment

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Patrick et al, Pediatrics, 2020

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Non-Pharmacologic Supports For Infants



Velez, M. and Jansson, L. Journal of Addiction Medicine 2008 September 1; 2(3)

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From Dr. Hendree E. Jones et al, 2019:

“Use of a NAS or Nows diagnosis as a main indicator of adverse developmental outcomes poses potential radiating harm to the child and the family and misses the opportunity to see the complexities of interpersonal, intrapersonal and environmental factors that contribute to the long-term developmental trajectories of children.”

13

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Pregnant and Parenting Families with SUD: Evidence-Based Treatment, Neonatal Opioid Withdrawal and Supporting the Infant-Parent Relationship – Session C

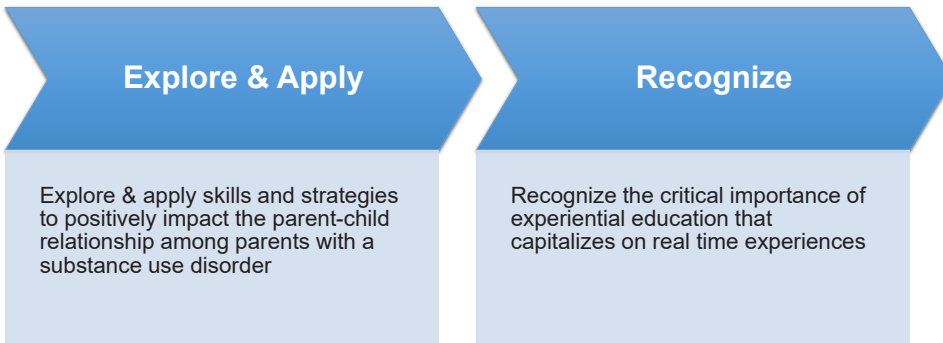
Presented by

Sharon A. Hesseltine, BSW

Intentional Beginnings/ Intentional Development



Session C - Learning Objectives



2

Neonatal Opioid Withdrawal Syndrome, Newborns & Parenting

Recovery & Parenting

PAGE 4c

- Equally relevant
- Worked on simultaneously
- Focus on the parent-child relationship promotes and actually enhances recovery
- Relates to the relationship between the reward pathways in the brain
- Pathways are “competing” between investment in substances or investment in caring for the infant
- As mothers become invested in their infants the focus of the reward system is “reset”

Mentalizing-Based Intervention with Mother-Baby Dyads, M. Pajulo and M. Kalland

4

Cumulative Challenges

- Recognizing and dealing with emotions
- Trauma history
- Mental health issues
- Feelings of shame and guilt
- Poor relationship history (romantic and family)
- Difficulties in social relationships
- Lack of trust and confidence in own maternal abilities
- High expectations for self and children
- Easily disappointed in self and child

PAGE 5c

Supporting Parents with SUD

PAGE 6c



- Begins during pregnancy
- Must build capacity to read and interpret baby’s states
- Also supports mothers in processing and changing own emotional reactions
- Strengthen mother’s ability to soothe infant and build confidence
- Builds ability to manage daily cycles and rhythms of feeding, sleep and play for infants
- Must respect what we know about regulation for mom and baby while also supporting development of co-regulation

6

6

Being A Regulatory Partner

Children need adults to partner with them in order to build their capacity for self-regulation

As human beings we are wired to regulate better when supported by another person

Our capacity for problem solving and other executive thinking is significantly diminished in a state of emotional arousal



7

Wondering About Baby Together



Staff:

- Waits for the parent to comment and then reinforces or expands on the parent's comment;
- Asks open ended questions (What do you think is going on for her right now? What might she be telling us?)
- Wonders out loud about specific infant behaviors (When she saw your face, her eyes brightened, her breathing became steadier, and she kept her focus on you; I wonder what she is telling you right now)
- Serves as a *collaborative* observer who wonders aloud about what the baby may be telling the mother

8

As we watch Hudson jot down two "wondering" questions in that you might pose if watching this IRL (in real life)!



9

Let's Take Another Look at Hudson

As you watch this video, please type your observations in the chat

- What is Hudson trying to tell us?
- What feeling words would you use to describe him?



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Experiential Education

Partner with parents to observe together for early feeding cues such as:

Licking lips or smacking

Fists moving to mouth or sucking on hands/fingers

Becoming more alert and active

Opening and closing the mouth

Sticking the tongue out

Moving the head from side to side as if looking for something - called the rooting reflex



Crying is considered a late cue and waiting until baby begins crying can make successful feeding more challenging



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WIC/USDA

Building Capacity For Parental Empathy

- Think together about the baby's emotional experience
- Support mothers to connect how their actions impact the baby's emotional experience
- Build an environment where parents support each other to recognize and respond to infants
- Regularly ask parents about what infants are experiencing in real time

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Feelings Questions:

What do you think your baby is feeling right now?

What is she doing that is clueing you in to this feeling?

How are you feeling right now, and could your feelings be impacting baby?

What is going on around us right now and could that be impacting baby's feelings?

Because of how he is feeling does he need anything from you right now?

Because of how she is feeling is there anything going on around us that needs to change right now?

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Feeling Words for Young Children

Babies Feel

- Joy
- Excitement
- Frustration
- Discomfort
- Fear
- Boredom
- Contentment
- Pain
- Anger
- Loneliness
- Being Loved
- Curious
- Tired
- Hungry

Toddlers Also Feel

- Fear
- Happiness
- Pride
- Jealousy
- Frustration
- Exhaustion
- Surprise
- Love
- Shame

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Don't just do something – stand there and pay attention

~Sally Provence



Affirmations – With Benefits

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Step 1: Pay attention to what is going well

Step 2: State it out loud & be specific

Step 3: Note how child benefits

“Wow! Your baby is so much calmer when you hold her and gently rock her, she feels so safe and secure in your arms.”

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Do unto others as you would have others do unto others

~Jaree Pawl



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Jones, Hendrée E. PhD; Kaltenbach, Karol PhD; Benjamin, Tara MD; Wachman, Elisha M. MD; O’Grady, Kevin E. PhD Prenatal Opioid Exposure, Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal Syndrome, and Later Child Development Research: Shortcomings and Solutions, *Journal of Addiction Medicine*: March/April 2019 - Volume 13 - Issue 2 - p 90-92 doi: 10.1097/ADM.0000000000000463

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Key Quotes:

“The belief that a substance-using pregnant woman is failing is to protect an innocent other, and thus, deviating from the social norms surrounding motherhood, positions the woman as an adversary of the developing fetus. This attitude assumes that substance use during pregnancy is incompatible with good mothering, and therefore constitutes maternal unfitness. This is a false dichotomy as it denies the integral interconnectedness of the maternal–fetal dyad and undermines the historical reality of women’s role as advocates for the health of their pregnancy and that of their children and family.”

— Mishka Terplan, Alene Kennedy-Hendricks and Margaret S. Chisolm

“Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.”

— ACOG, Committee Opinion #711, August 2017

“The population of substance-exposed infants and their caregivers is a complex and vulnerable group that requires the extension of traditional boundaries by specialty for adequate care. Only through coordinated, comprehensive and compassionate care can the difficulties created by in-utero substance exposure for the mother and the infant be overcome.”

— Lauren M. Jansson and Martha Velez, 2012. *Neonatal Abstinence Syndrome*

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Session 3

Stigma, Language & Implicit Bias: Moving Toward Becoming a Stigma-Free Provider



Recording Links

- [Session A](#)
- [Session B](#)
- [Session C](#)



Learning Objectives

- » recognize data relevant to addiction and recovery in the U.S.
- » define stigma and examine its impact upon individuals experiencing addiction and those in recovery
- » discuss implicit bias and examine strategies to examine and reduce our own unconscious bias
- » illustrate the power of language in relationship to stigma and contrast stigmatizing language with the language of recovery
- » identify actions each member of the health care team can take to reduce the impact of stigma

Overview

I've given a lot of thought to what I want to emphasize in the overview to this session and as I sit to put my thoughts on the screen, I am compelled to write this overview as a letter to you — the health care provider.

Stigma is incredibly powerful and often destructive. With addiction, stigma gets in the way of seeking care and it gets in the way of implementing practices that can save lives, such as screening, early engagement and even prevention efforts such as Narcan distribution. At the core of stigma is the underlying belief that the continued use of substances in the face of a mountain of consequences is somehow a choice that those who are afflicted make. And pregnant women with an SUD are the most stigmatized group out there, followed closely by mothers with an SUD.

We've spent time together learning about this disease and the ways in which the brain is altered as a result. We've learned that when the brain undergoes those alterations inherent to addiction the power of choice is gone, and the individual is driven to continue using substances by the brain's own survival wiring; while at the same time the part of the brain that might support decision-making is compromised. It's confusing to watch and equally (if not more) confusing to experience. Addiction is a disease that most often has its roots in adolescence, and the factors which increase vulnerability for it include childhood trauma and a good dose of genetic predisposition. No one says, "I want to become a heroin addict when I grow up," and certainly no one who experiments with substances as an adolescent has the ability to foresee where that early experimentation will take them.

My hope for all of you who have participated in this series is that you will gain a better understanding of individuals who struggle with substances. And for your increased understanding will inspire you in being better able to care for, support and hold hope for the pregnant and parenting women with SUD you will no doubt care for in the future. As a health care provider caring for women during the perinatal period, you truly have an amazing opportunity to positively impact the most important relationships any of us will ever have — the relationship with our parents.

The biggest barrier to being able to positively impact that relationship is stigma. This session gives us an opportunity to explore stigma and implicit bias. We will tackle it head on, and I challenge each of you to explore your bias, pay attention to your language and honestly reflect upon your feelings toward those you care for who are struggling with addiction. I know that individuals in active addiction are often difficult to care for and even more difficult to feel compassion toward. I know because I am one of those individuals, and when I was in active addiction, I was not easy to be compassionate toward or easy to understand. I also know all too well the feelings of self-loathing, guilt and shame experienced universally by individuals in active addiction. And I've known the stigma those with this disease experience, during active addiction and throughout my 17 years in recovery.

Stigma is exactly what lead me to wrestle with how I was going to write this overview and whether I'll identify myself as a person in long-term recovery when I present these sessions to you. And there's an irony in that. Stigma leads me to wonder if I'd lose credibility by sharing the fact that I am a survivor of this disease, and I wrestle with this decision each and every time I present to groups outside of the addiction and recovery space. And part of the irony is that if I had diabetes I was successfully managing and I came to present on that topic I wouldn't wonder for a minute if it was ok to self-identify. That is the power of stigma and ultimately, I always take the risk of identifying as a person in long-term recovery, because while the active stage of this disease is quite visible, recovery from it is silent — unless those of us in recovery speak up.

I'd like to thank-you for participating in this series of trainings and my hope is that you've heard something within these sessions that you'll take forward into your work so that you too can be a catalyst for change.

All my best,
Sharon Hesseltine, BSW



Mid-America (HHS Region 7)

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Stigma, Language & Implicit Bias: Moving Toward Becoming a Stigma Free Provider – Session A

Presented by

Sharon A. Hesselstine, BSW

Intentional Beginnings/ Intentional Development



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At the Heart of Stigma – We Find the Question of Choice

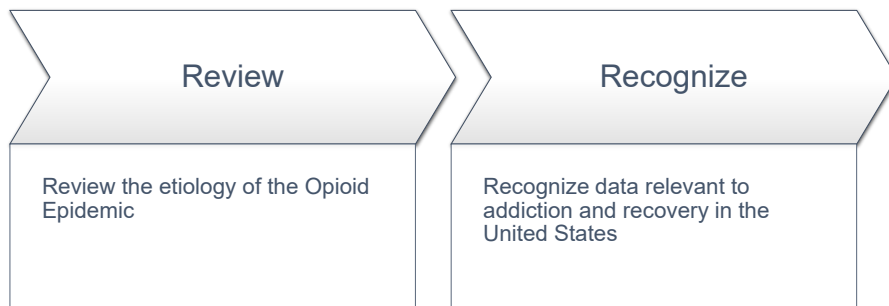
“For decades, the public at large has viewed, and continues to view, addiction as simply a matter of individual choice. This view is largely driven by a lack of scientific understanding of the genetic, environmental and neurobiological aspects of substance use disorders and addiction. Language is perpetuated by the general public, by the media, by the medical community, and even among those in the recovery community. Historically, we have used language to isolate and to treat those affected in a less than compassionate and therapeutic way.”

~Michael Botticelli, Former Director of ONDCP

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Session A - Learning Objectives

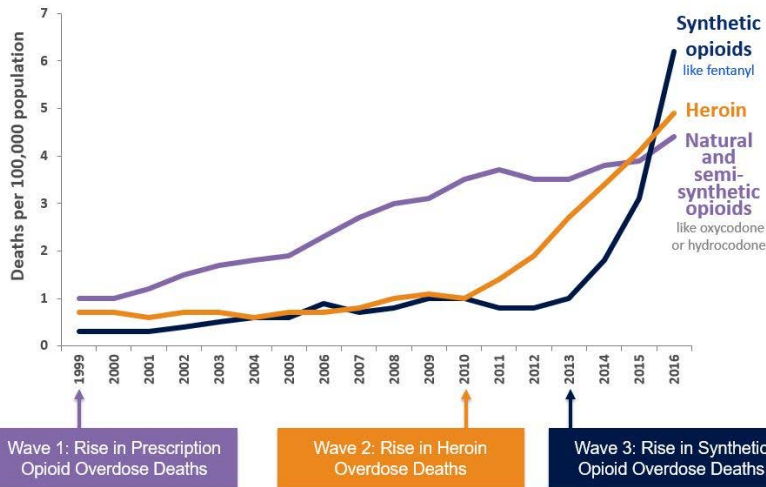


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Addiction & Recovery in the United States

What does the data tell us?

3 Waves of the Rise in Opioid Overdose Deaths



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SOURCE: National Vital Statistics System Mortality File.

Prevalence

Among adults aged 18 or older in 2019, 11.4 percent (or 28.2 million people) perceived that they at one point had a problem with their use of alcohol or other drugs



SAMHSA, 2019

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Addiction Contributes to Mortality

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- Provisional data from CDC indicates that there were an estimated 100,306 drug overdose deaths in the United States during 12-month period ending in April 2021
- This represents an increase of 28.5% from the 78,056 deaths during the same period the year before
- Estimated overdose deaths from opioids increased to 75,673 in the 12-month period ending in April 2021, up from 56,064 the year before
- Overdose deaths from synthetic opioids (primarily fentanyl) and psychostimulants such as methamphetamine also increased in the 12-month period ending in April 2021
- Alcohol misuse contributes to 88,000 deaths in the United States each year

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Surgeon General, 2016; CDC, 2020; CDC 2021

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Substance Use Disorder (SUD) *is* a Disease

- Treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences
- People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences
- Involves cycles of return to use and remission
- 40-60% genetic

Sources: American Society of Addiction Medicine, April 12, 2011, <http://www.asam.org/>
NIDA, August 2010, <http://www.drugabuse.gov/publications/science-addiction>
DSM-5 <http://www.dsm5.org/documents/substance%20use%20disorder%20fact%20sheet.pdf>

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SUD Meets Criteria for Chronic Illness

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Common features with other chronic illnesses:

- Heritability
- Influenced by environment and behavior
- Responds to appropriate treatment
- Without adequate treatment can be progressive and result in substantial morbidity & mortality
- Has a biological/physiological basis, is ongoing and long-term, can involve recurrences

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Source: <https://archives.drugabuse.gov/about/welcome/aboutdrugabuse/chronicdisease/de-long-term-lifestyle-modification> <http://www.asam.org/quality-practice/definition-of-addiction>

SAMHSA Definition of Recovery, 2012

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A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

<https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>

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In ASAM's Definition, Recovery from Addiction is:

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An active process of continual growth that addresses the biological, psychological, social and spiritual disturbances inherent in addiction, and includes the following factors:

1. The aim of improved quality of life and enhanced wellness as identified by the individual
2. An individual's consistent pursuit of abstinence from the substances or behaviors towards which pathological pursuit had been previously directed or which could pose a risk for pathological pursuit in the future
3. Relief of an individual's symptoms including substance craving
4. Improvement of an individual's own behavioral control
5. Enrichment of an individual's relationships, social connectedness, and interpersonal skills
6. Improvement in an individual's emotional self-regulation

https://www.asam.org/docs/default-source/public-policy-statements/2018-statement-on-role-of-recovery-in-addiction-carec806229472bc604ca5b7ff000030b21a.pdf?sfvrsn=4fba42c2_0

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Remission from Substance Use Disorders

- Remission from substance use disorders—the reduction of key symptoms below the diagnostic threshold—is more common than most people realize
- Approximately 50 percent of adults who once met diagnostic criteria for a substance use disorder—or about 25 million people—are currently in stable remission (1 year or longer)

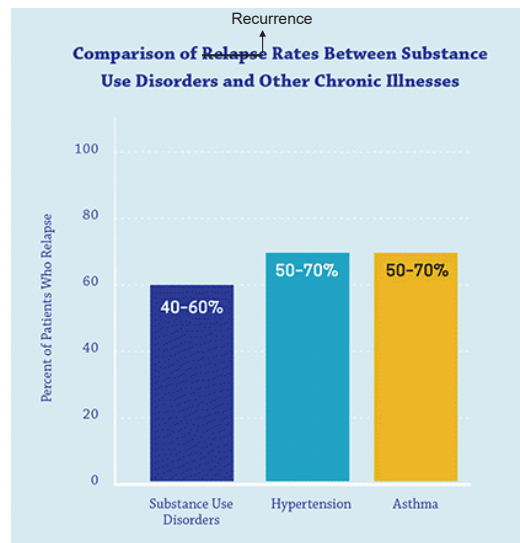
SAMHSA Office of the Surgeon General
Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health

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Addiction in the US – Recovery Data

- Approximately 25 million people in recovery in the US
- Recovery goes beyond the remission of symptoms to include a positive change in the whole person
- “Abstinence,” though often necessary, is not always sufficient to define recovery
- Well-supported scientific evidence demonstrates the effectiveness of 12-step mutual aid groups focused on alcohol and 12-step facilitation interventions
- Evidence for the effectiveness of other recovery supports (educational settings, drug-focused mutual aid groups, and recovery housing) is promising

Recurrence Rates



NIDA, 2020

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Stigma, Language & Implicit Bias: Moving Toward Becoming a Stigma Free Provider – Session B

Presented by

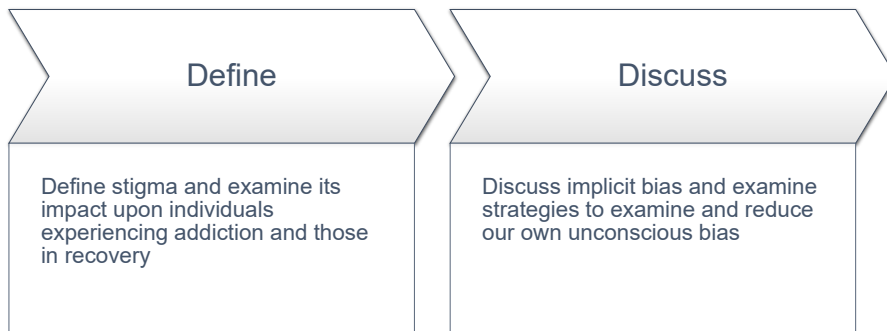
Sharon A. Hesseltine, BSW

Intentional Beginnings/ Intentional Development



Session B - Learning Objectives

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Confronting Stigma & Discrimination

To tame it, we must name it

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Confronting Stigma

“We Can’t Fight This Epidemic Without Removing Stigma”

~President Barack Obama
Charleston, West Virginia
October 21, 2015

Stigma: That Pernicious Mark

“Stigma is a degrading and debasing attitude of the society that discredits a person or a group because of an attribute... Stigma destroys a person’s dignity; marginalizes affected individuals; violates basic human rights; markedly diminishes the chances of a stigmatized person of achieving full potential; and seriously hampers pursuit of happiness and contentment.”



2015 International Conference on Stigma Howard University, Washington, DC

What is Stigma/Explicit Bias?

It is a characteristic or condition that is socially discrediting and is mainly influenced by whether **you think someone is to blame** and whether they have control over the behavior

Two main factors influence stigma:

- Cause
- Controllability

Stigma decreases when:

- “It’s not his fault”
- “She can’t help it”

Why is Stigma so Damaging?



- Stigma depersonalizes people, depriving them of individual or personal qualities and personal identity
- Self-stigma becomes a major determinant in why those with a SUD delay seeking care or avoid care altogether
- Stigma plays a role in continuing to frustrate evidence-based and compassionate public policy
- Stigma continues to have a negative impact upon the quality of care those with an active SUD and those in recovery receive

Stigma Is Everywhere!

Stigma from within

Blame self, feel hopeless

Stigma from recovery community

Medications vs. “abstinence”

Stigma from clinicians

Belief that treatment is ineffective

Stigma from outside

Choice (moral failing) vs. disease

What if....



You go to the hospital with chest pain and are found to be having a heart attack

- Told it’s “your fault” because of your “choices”
- Denied treatment because you “did it to yourself”
- Given a list of cardiologists and cath labs to call
- Only given aspirin if you agree to go to counseling
- Kicked out of the hospital for more chest pain

Stigma Impacts Accessing Treatment

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- Over 21 million individuals aged 12 and older having a diagnosable SUD, fewer than 3.8 million receive treatment each year
- An estimated 28% of those who do not seek treatment (but recognize the need), report reasons related to stigma for not accessing or engaging in care
- Stigma presents as a significant barrier to engaging with SUD treatment, the recommendation of SUD treatment and the quality of care delivered

Ashford, Brown and Curtis, 2018

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Stigma in Healthcare

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- Health professionals (HP) generally had a negative attitude towards patients with substance use disorders
- HP perceived violence, manipulation, and poor motivation as impeding factors in the delivery of care
- HP received inadequate education, training and support structures specific to caring for patients with SUD
- Negative attitudes diminished patients' feelings of empowerment and subsequent treatment outcomes
- Less involved and more task-oriented in the delivery of healthcare, resulting in less personal engagement and diminished empathy

Leonieke et al, 2013

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Stigma Specific to Pregnant Women with SUD

Large body of evidence on the many adverse health effects of prenatal exposure to tobacco and alcohol

- Cigarette smoking is the leading preventable cause of pregnancy-related morbidity and mortality
- Alcohol is the leading preventable cause of developmental and intellectual disabilities

“Linking substance use with maternal unfitness is not supported by the balance of the scientific evidence regarding the actual harms associated with substance use during pregnancy.”

Despite the stronger evidence of harm from pregnant women's use of legal substances, punitive policies focus on pregnant women's use of illegal substances

Terplan et al, 2016

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Impact of Stigma on Prenatal Care & Treatment

- Pregnant person with OUD is often reluctant to seek prenatal care according to recommended guidelines
- Stigma associated with use of MOUD contributes to reluctance to seek prenatal care
- Mandatory notifications or reporting requirements (child welfare) deter pregnant people from seeking prenatal care and/or SUD treatment
- Pregnant women fear losing custody as a result of MOUD
- 23 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and 3 consider it grounds for civil commitment

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Leiner, Cody and Mullins et al, 2021; Guttmacher Institute, April 2021; ACOG 2017

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Fear is a Barrier to Seeking Care

“... I was scared coming here, because I thought it’s gonna be immediate Social Services [involvement]. I [thought I] was never gonna see my child again... I never heard of this program, until the day I admitted I needed help, and that day was terrifying for me, because I’d had no idea what was gonna happen... people had told me [seeking treatment would mean immediate removal]...”

~“Billy”

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Leiner, Cody and Mullins et al, 2021

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Impact of Stigma Around MOUD & Pregnant Women

- Despite the strong body of evidence MOUD remains a highly stigmatized treatment
- In the many U.S. states where Medicaid coverage ends shortly after delivery, OUD treatment is also largely limited to pregnancy and may end abruptly for new parents
- Though recommended for OUD treatment, access to MOUD is uneven and geographically stratified
- Less access to MOUD in the U.S. South, despite higher rates of OUD and the highest national rates of opioid prescribing
- Only 19 states have either created or funded drug treatment programs specifically targeted to pregnant women

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Leiner, Cody and Mullins et al, 2021; Guttmacher Institute, April 2021; ACOG, 2017

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Impact of Stigma

- Justifies Discrimination
- Erodes confidence that substance use disorder is a valid and treatable health condition
- Barrier to jobs, housing, relationships
- Deters public from wanting to pay for treatment, allows insurers to restrict coverage
- Stops people from seeking help
- Impacts clinical care and treatment decisions

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Implicit Bias

The bias we're not conscious of

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What is Implicit Bias?

- Based on the assumption that subconscious associations exist toward the characteristics of individuals
- Implicit bias may be apart from and separate to, the social or ethical values we hold
- Measuring implicit bias has been recently popularized through the Implicit Association Task (Harvard)

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Explicit vs. Implicit Bias

Explicit Bias

- Expressed directly
- We are aware of the bias
- Intentional & Controllable
- Operates consciously
- Reporting impacted by social pressure

Implicit Bias

- Expressed indirectly
- We are unaware of the bias
- Unintentional & difficult to control
- Operates sub/un-consciously
- Not as easily impacted by “how we see ourselves”

Implicit Bias & Addiction

- Addiction stigma may also intersect with other forms of bias, such as racism and sexism
- Individuals with SUDs may be treated less favorably if they also hold other status characteristics that are marginalized
- Minorities are significantly more likely to be arrested and receive harsher sentences for drug-related offenses (although rates of use and selling are similar)
- Men are more likely to be sentenced and receive harsher sentences for drug-related crimes as opposed to women
- In relationship to people who inject drugs data suggests a preference for punishment in an implicit assessment but for help in the explicit assessment

Kulesza et al, 2016

Intersectionality of Addiction, Stigma & Women

- More concern, sympathy, and interest in helping behavior towards women (vs. men) with SUDs
- Women felt they would be looked down upon by others, more than their male counterparts would be, if their identity of a “drug user” was known to others
- Reporting of pregnant women to state authorities (specific to SUD) as well as prosecution and incarceration in the US has disproportionately affected the low-income women of color



Kulesza et al, 2016, Terplan et al, 2015

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ADDITIONAL NOTES:



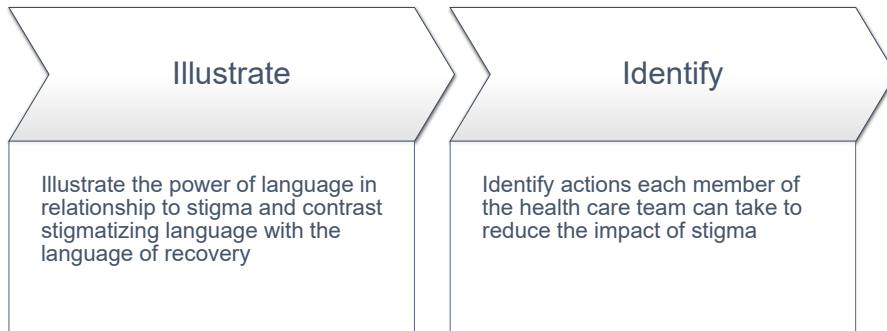
Stigma, Language & Implicit Bias: Moving Toward Becoming a Stigma Free Provider – Session C



Presented by
 Sharon A. Hesselstine, BSW
 Intentional Beginnings/ Intentional Development



Session C - Learning Objectives



2

Language Considerations

Our language impacts our attitudes and our attitudes impact care

The Power of Language

PAGE 4a

**Words are important.
If you want to care for
something, you call it a
flower; if you want to kill
something, you call it a
weed.**



~Don Coyhis

4

The Impact of Language on Implicit Bias

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- The term “addict” inspires more negative attitudes both in isolation and compared to the term “substance use disorder”
- The term “substance use disorder” appears to be a less-stigmatizing term on both explicit and implicit levels
- “Person with a substance use disorder” may be a better alternative than the label of “addict”
- By replacing the word “addict with “person with a substance use disorder” in our communication we may reduce negative bias toward those with SUD or in recovery from an SUD

Ashford, Brown & Curtis, 2019

5

Non-Stigmatizing Language



PAGE 6a

"By using accurate, non-stigmatizing language, we can help break the stigma surrounding this disease so people can more easily access treatment, reach recovery, and live healthier lives."

~Michael Botticelli, Former Director
White House ONDCP

6

2013 Open Letter to the Media

PAGE 7a

Signed by 51 nationally recognized doctors (M.D. & PhD.)

Key Points:

- No newborn is born addicted
- Infants of mothers with an SUD are not “victims”
- NAS, when it occurs, is treatable and has not been associated with long-term adverse consequences
- The media’s misinformation and stigmatizing characterizations discourage appropriate federally recommended treatment



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Things We Can Do



- Put people first: Do say, “a person with a behavioral health condition” or “a person diagnosed with ...”
- Emphasize abilities - focus on what is strong such as the person’s strengths, skills & passions
- Focus on language that is respectful, clear and understandable, free of jargon, confusing data, and speculation
- Focus on language that is non-judgmental and carries a sense of commitment, hope and opportunity

Adapted in 2019 from Wahl, O. (2010). Recovery Language.
Adapted from Burge, M. /Consumer Advocate (2010). Excerpt from speech given at The MHS Conference 2010

8

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Changing the Narrative:

Deficit-Based

- An addict/junkie
- Substance abuser
- Treatment Team
- Relapse
- Not ready/not willing
- Non-compliant

Strengths-Based

- A person diagnosed with an addiction
- Person with an addiction to
- Recovery Team, Recovery Support System
- Return to use/re-emergence of symptoms
- Experiencing ambivalence
- Experience challenges around . . .

Janis Tondora, Psy.D.

9

Changing the Narrative Continued:

PAGE 10a

Deficit-Based

- Drug abuse
- Clean
- Dirty
- MAT
- Former addict
- Drug of Choice

Strengths-Based

- Drug misuse, harmful use
- Abstinent, not actively using, negative for
- Actively using, presence of, positive for
- Medication to treat addiction/OD
- Person in recovery
- Substance of addiction

Janis Tondora, Psy.D.

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Language Guidelines:

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- Respect the worth and dignity of all persons
- Focus on the medical nature of substance use disorders and treatment
- Promote the recovery process
- Avoid perpetuating negative stereotype biases by using slang and idioms

Broyles et al, 2014

11

Towards Becoming a Stigma Free Zone:

Things You Can Do

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The Addictionary

PAGE 13a

If we want addiction destigmatized,
we need a language that's unified

The words we use matter. Caution needs to be
taken, especially when the disorders concerned are
heavily stigmatized as substance use disorders are

<https://www.recoveryanswers.org/addiction-ary/>



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Language Audit

- Perform a “language audit” of existing materials for language that may be stigmatizing, then replace with more inclusive language
- Example: Using the search and replace function for electronic documents, search for “addict” and replace with “person with a substance use disorder,” or search for “abuse” and replace with “use” or “misuse”
- Make sure to review both internal documents (e.g., mission statements, policies) as well as external ones (e.g., brochures, patient forms)

SAMHSA/CAPT, 2017 <https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf>

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Evidence-Based Interventions

Stigma Elimination Through Contact

- Peer storytelling

Stigma Elimination Through Education

- Peers educating on the science of addiction and recovery

Stigma Elimination Through Language

- All of us using non-stigmatizing and recovery-oriented language
- Holding each other accountable by creating teachable moments/ learning opportunities when we use stigmatizing language

Corrigan et al., 2012, Borschmann et al., 2014

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Consider a Perinatal Educator with Specialized Training

- Perinatal substance use exposure education
- Perinatal substance use exposure educator (PSE) working as part of the provider team
- (PSE) teaches perinatal OUD patients what to expect at the time of delivery
- PSE consultation early in the third trimester in preparation for delivery
- PSE covers preparation for delivery, care of newborn with NAS/NOWS, what to expect in relationship to child welfare
- PSE could be a social worker, community health worker, peer support or nurse

Leiner, Cody and Mullins et al, 2021

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Shifting the Paradigm on Medication (MOUD)

- Assess yourself: attitudes, beliefs and practices
- Use non-stigmatizing person-first language
- Educate yourself, be an educator
- Embrace all pathways to recovery
- Challenge institutions, policies, regulations & procedures not aligned with the science & evidence of MOUD



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Words Matter



“If we don't choose our words carefully, we perpetuate bias, cloud understanding and end up distancing ourselves from the people we want to help.”

~Howard Koh, Harvard T.H. Chan School of Public Health

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THANK YOU!

Thank you for all you do to support families in recovery!



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Key Quotes:

“Words are important. If you want to care for something, you call it a flower; if you want to kill something, you call it a weed.”

— Don Coyhis

“Sometimes you honestly don’t realize what you’re doing, and who you’re hurting, until you’re looking back months later. I wish people could understand the suffocating guilt.”

— Kaylee Jane Kominck

“The language used in describing substance use, substance use disorders and other related topics affect the types of explicit and implicit bias that individuals experience.”

— Robert D. Ashford, Austin M. Brown and Brenda Curtis; *Substance use, recovery and linguistics: The impact of word choice on explicit and implicit bias*

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