The Opioid Crisis and Early Intervention

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- Associate Professor of Psychology at Slippery Rock University and the Program Director of the SRU Neuroscience and pre-professional studies programs.
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- Jennifer has worked with the Maternal Health Practices and Child Development project, focusing on research of the effects of prenatal drug exposure on neuropsychological and brain imaging outcomes.
- Her current research interest is in the role of early childhood environments, prenatal exposures, and early caregiving relationships on the development of emotion and behavior regulation systems in at-risk infants.

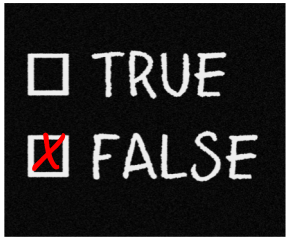
Agenda

- Scope of the problem
  - What are opioids
- What is the impact?
  - Parents
  - Infants
  - Infant-Parent relationship
- Helping and Early Intervention
- Resources

Dispelling the Myths

Opiates prescribed by parents' doctors are the most common risk factor for misuse.

Substance misuse tends to be more likely when someone gets ahold of a family or friends prescription medication.



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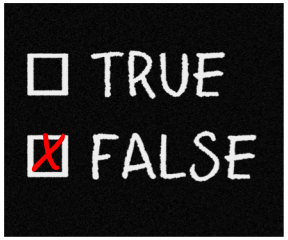
Dispelling the Myths

Parents who are misusing substances have a known history of using illegal drugs.

Many have a history of chronic pain and misuse started with prescribed opioids, and even more likely used prescription pain medications that they acquired from family or friends.



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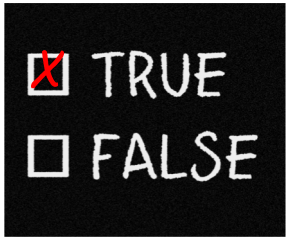
Dispelling the Myths

Prescription pain relief medication misuse is more than 10x more common heroin.



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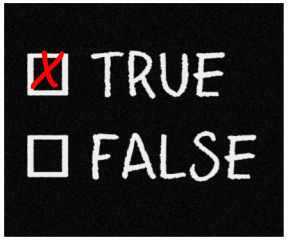
Dispelling the Myths

86% of pregnancies in women who struggle with opioid misuse are unintended.



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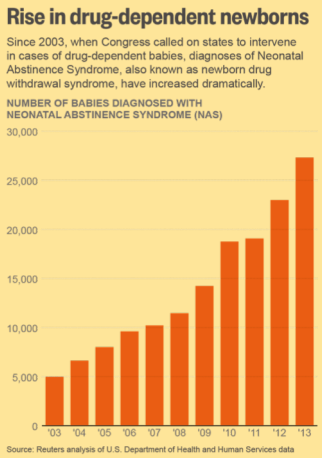
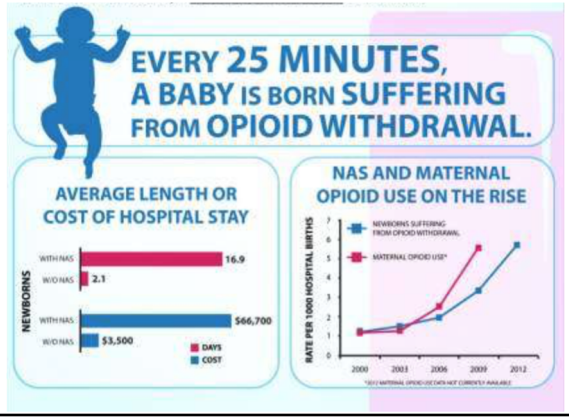
I. What is the scope of the problem?



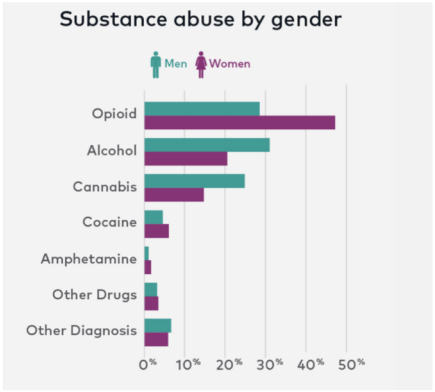
Opioid Misuse During Pregnancy



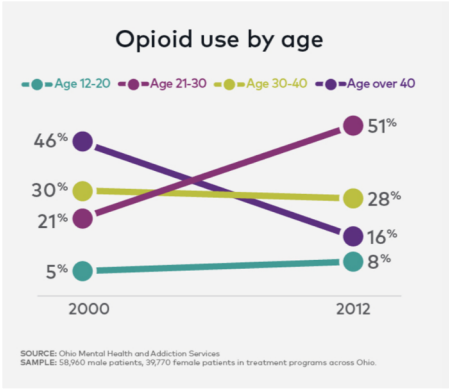
Source: National Institute on Drug Abuse

Ohio's children's services agencies overwhelmed by opioid crisis

In Ohio women abuse opioids more than men.



...and they tend to be child-bearing age



National Perinatal Association

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nationalperinatal.org/position

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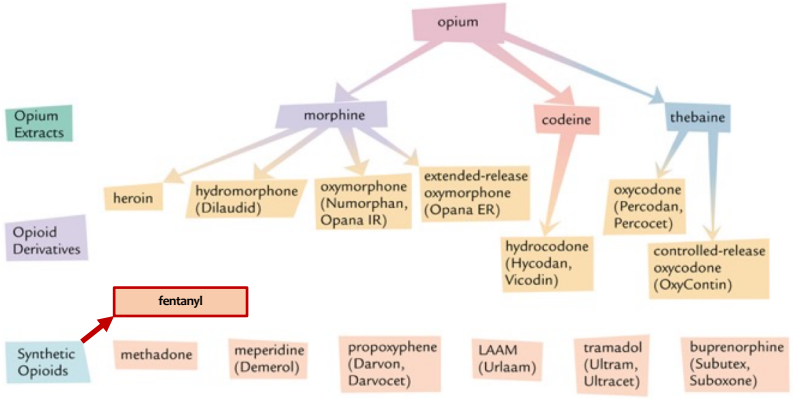
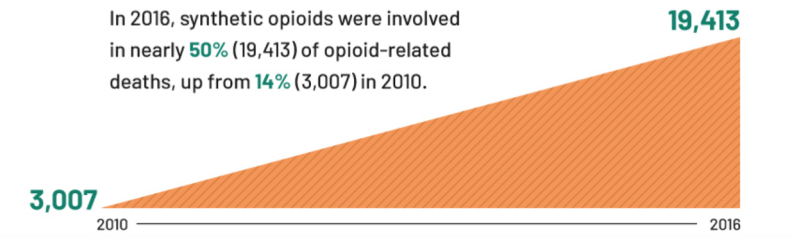
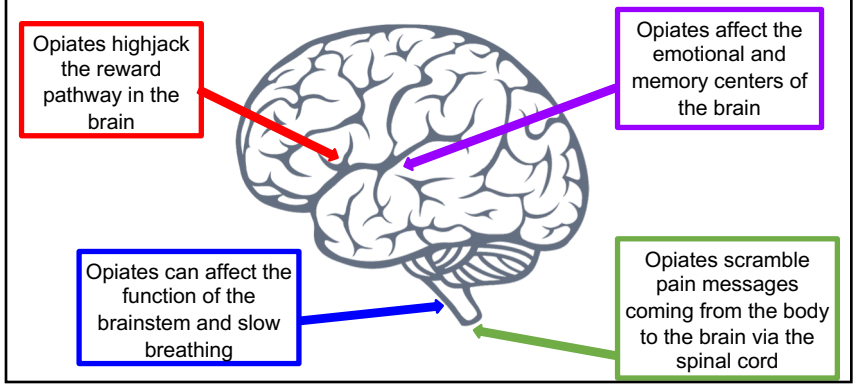
II. Understanding opiates – their power, pathways and risks



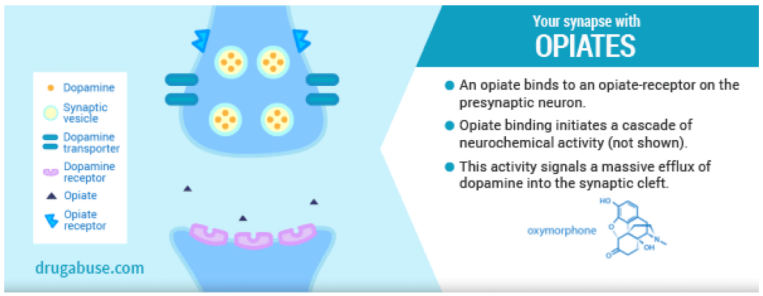
In 2016, synthetic opioids (primarily illegal fentanyl) passed prescription opioids as the most common drugs involved in overdose deaths in the United States.



Opiates and the Brain



Opiates "push" more dopamine into the reward pathway



Pathways to Parent Addiction

Prescription Pain Relievers → **Injection Drug Use**

Physical Pain	Chronic and acute medical conditions
Mental Health	Anxiety and Depression
Trauma	Adverse Childhood Experience

Opiate Misuse During Pregnancy

- Harms to Mom
  - Dependency, physical and psychological
  - Weakened immune system
  - Nausea and Vomiting (reduced appetite)
  - Overdose risk
  - Slow breathing rate
  - Hallucinations
  - Difficulty caring for herself

Opiates and Fetal Exposure

- **Opiates accumulate in amniotic fluid and are able to cross the placenta (within 1 hour of mother's use)**
- **The growing fetus has a difficult time with detox and metabolism of the drug due to immature tissues.**
- **Fluctuations in drug levels cause placental changes → placental insufficiency and IUGR**

Opiates and Obstetric Complications

Women who use opiates during pregnancy have a six-fold increased risk of obstetric complications, with no clear cause. Risks include:

- Spontaneous Abortion
- Low Birthweight
- Intrauterine Growth Retardation
- Preeclampsia
- Placental Abruption
- Premature Birth

Opiates and Birth Complications

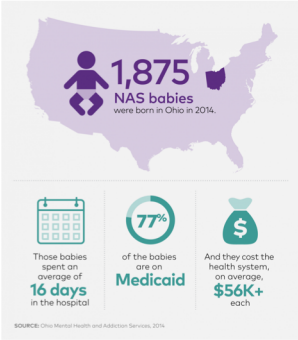
Women who use opiates during pregnancy are also at risk for birth complications. Risks include:

- Fetal distress
- Fetal demise
- Low APGAR scores
- Postpartum hemorrhage
- Meconium aspiration
- Maternal infection that affects the placenta and membranes that surround the baby

Opiates and Newborn Complications

Babies whose mothers used opiates during pregnancy are at risk for

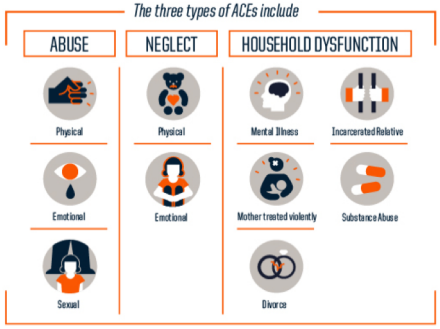
- No consistent pattern of congenital anomalies
- Microcephaly
- Neurobehavioral problems
- Postnatal growth deficiency
- Sudden Infant Death Syndrome
- Neonatal Abstinence Syndrome

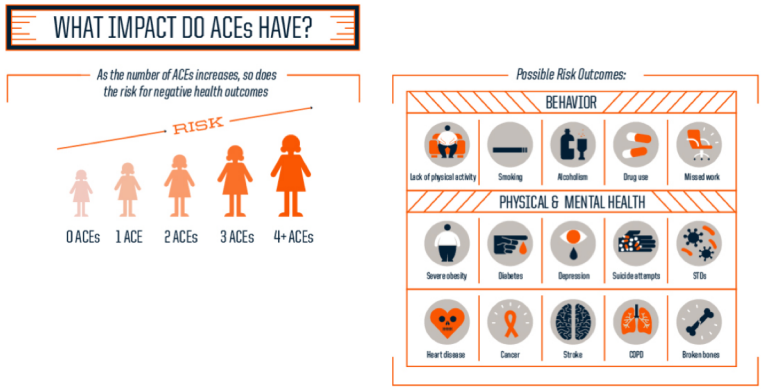


Other Risks

What are the other risks? Trauma

ACEs are ADVERSE CHILDHOOD EXPERIENCES





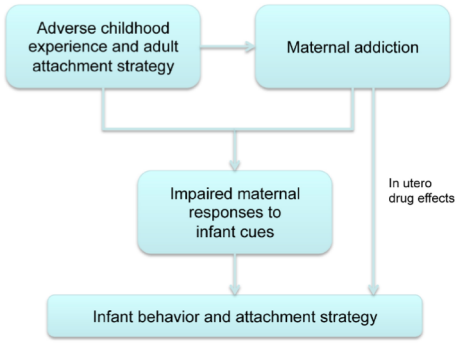
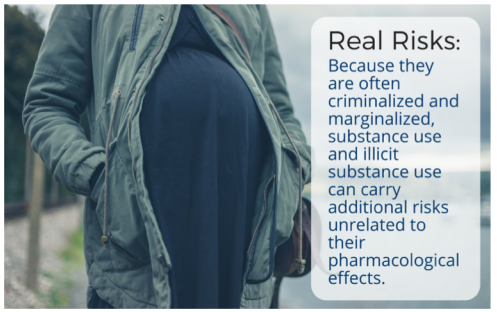


Figure 1: Factors influencing and resulting from maternal addiction. Adapted from Strathearn and Mayes (2010).

What are the other risks? Criminalization

Women who fear criminalization for their drug use during pregnancy are less likely to seek prenatal care.



How can we advise mothers and lower risk for pregnancy related complications?

Get Prenatal Care

Start early. Go to all your visits. Empower yourself with information so you can make smart decisions. Build relationships with providers who understand Substance Use Disorders (SUDs) and know how to help. Partner with them to reach your goals. But remember, you do not need to be abstinent from substance use to get care. Go now.

Use Medication-Assisted Treatment (MAT)

if you are opioid dependent

Methadone and Buprenorphine (Subutex® or Suboxone®) are the "Standard of Care" during pregnancy because they:

- Eliminate the risks of illicit use
- Reduce your risk for relapse
- Can be a positive step towards recovery

Reduce Your Use

There are simple things you can do to limit the harm substances might do.

- Use fewer substances
- Use smaller amounts
- Use less often
- Learn how to use safer

Reducing or quitting smoking is a good place to start. Set your goals, then ask for help. One of the best things you can do is to stop using alcohol. We know that even small amounts are risky. And when combined with benzos and opioids, alcohol can kill.

Take Good Care of Yourself

You deserve a healthy pregnancy & childbirth.

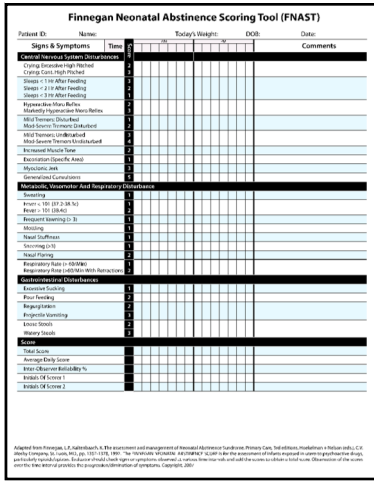
- Eat healthy and take your prenatal vitamins
- Find the right balance of rest and exercise
- Surround yourself with people who care

III. What are the impacts of opiate exposure on the baby? What do we know so far?

What is Neonatal Abstinence Syndrome (NAS)?

Neonatal abstinence syndrome (NAS), is a clinical diagnosis and set of symptoms associated with the abrupt withdrawal of opioids and other drugs when infants are born to mothers who were taking these substances. The symptoms can range from mild to severe and include:

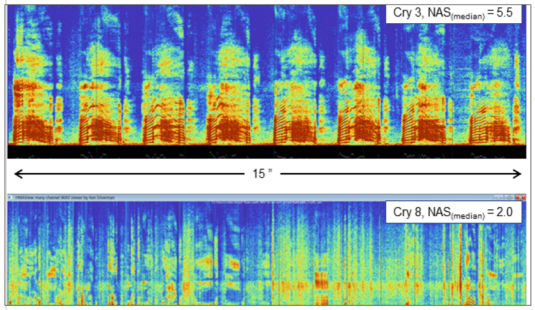
- Low birth weight
- Restricted growth
- Premature delivery
- Breathing problems
- Feeding difficulties
- Tremors (trembling)
- Irritability (excessive crying)
- Alterations in tone and movement (hyperactive primitive reflexes, hypertonicity, tremors, etc.)
- Seizures
- Sleep-wake disturbance
- High-pitched crying
- Yawning, stuffy nose, and sneezing
- Vomiting
- Diarrhea
- Dehydration
- Sweating
- Fever or unstable temperature
- Hypersensitivity to stimulation (light, sound, handling)



NAS Assessment

- Measuring NAS severity helps guide early interventions including initiation and termination of treatments
- The Neonatal Abstinence Scoring System, is the most commonly used scale assessing presence and severity of 31 items
- Scoring performed at 2-4 hour intervals when the infant is awake after feeds
- Modified over time, a commonly accepted score of 8 or more on three consecutive assessments, or 12 on two consecutive assessments, achieves severity cutoff meriting treatment

Spectrograms of Infant Cry Before and After Treatment



Finnegan = 8, high pitched cry, start pharmacological treatment
Pitch = 473 Hz

Finnegan <8, no high pitched cry, discharge day 2
Pitch = 472 Hz

BROWN

Women & Infants

Lester 2017

Health Outcomes in OH (2015)

Table 2: Health outcomes in inpatient settings, NAS infants* vs. all infants, Ohio

Setting:	Inpatient (all)
Location:	Ohio hospitals
People:	Ohio Residents
Age:	<1
Query Codes:	MSDRG 789-795 (Neonates and Newborns)
	ICD-9 [illegible] (NAS) *Could be in primary or 18 secondary dx fields
	*See [illegible] Tab for ICD-9 and ICD-10 Codes (Could be in primary or 18 secondary dx fields.)
	*Divi[illegible] group by the total number of NAS infants to get %

	2015	
Health Outcomes	**NAS infants (%)**	**All Infants (%)**
Feeding Difficulties	16.45	5.36
Low Birth Weight	19.63	9.99
Respiratory Symptoms	21.03	9.46
Seizures and Convulsion	0.79	0.19

NAS Interventions

Pharmacological Treatments

- No good (RCT) studies
- Morphine (1) and Methadone (2) most common
- Buprenorphine associated with 40% reduction in treatment and 24% shorter stay
- Methadone associated with shorter hospital stay than morphine (21 vs. 25 days)

Breastfeeding

- Reduced length of stay
- Less likely to require pharmacological interventions
- Time to treatment longer, and length of treatment shorter

- **Non Pharmacological Treatments**
  - Rooming In
    - Babies in room with mothers vs. NICU less likely to need NAS treatments and more
  - Laser Acupuncture
    - Reduced length of stay (35 vs. 50) and fewer days of morphine (28 vs. 39)
  - Soothing Techniques (e.g., non-nutritive sucking, positioning/swaddling, gentle movement, rocking)
  - Minimize environmental stimuli
  - Massage
  - Respond early to infants signals
  - Demand feeding
  - Avoidance of waking sleeping infant
  - Kangaroo Care
  - Pacifier
  - Maternal participation

Outcome/ Child Effects

"There are no published developmental outcome studies of infants with NAS" (Lester, 2017)

Summary

	Nicotine	Alcohol	Marijuana	Opiates	Cocaine	Meth
Short-term effects /birth outcome						
Fetal growth	+	+++	-	+	+	+
Anomalies	+/-	+++	-	-	-	-
Withdrawal	-	-	-	+++	-	unk
Neuro-behavior	+	+	+	+	+	-
Long-term effects						
Growth	+/-	+++	-	-	+/-	unk
Behavior	+	+++	+	+	+	unk
Cognition	+	+++	+	+/-	+	unk
Language	+	+	-	unk	+	unk
Achievement	+	+++	+	unk	+/-	unk

Strong effect: +++ No consensus about effect: +/-
Effect: + Unknown: unk

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IV. What is the impact of opiates on parenting and the infant/caregiver relationship?

Relationships are the "active ingredients" of the environment's influence on healthy human development

National Scientific Council on the Developing Child: Harvard University (2009)

Parenting and Opioids

- **Previously rewarding** patterns in relationships, parenting, self-efficacy and self-care are **no longer as rewarding**
  - e.g., Close physical contact with infant, enjoying infant's growth and development, feeling connected with infant emotionally, etc.
- Plus, there is reduced tolerance for challenges of parenting
  - e.g., crying, needy infant, sleep deprivation, attunement to infant's needs, etc.

…there are often significant relational concerns

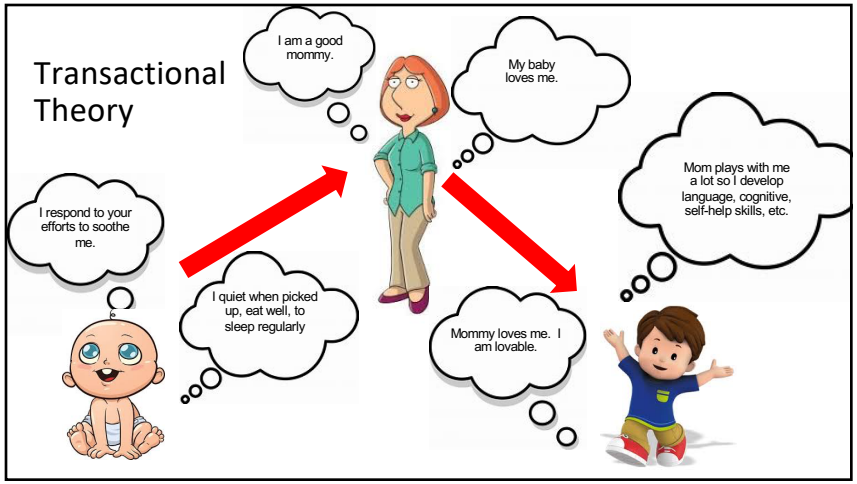
- "The substance-exposed mother and child are *difficult regulatory partners* for each other, as the exposed infant often has an impaired ability to regulate his states … and needs more parental help. At the same time, the mother usually has a reduced capacity to read the child's signals. This combination easily leads to a viciously negative cycle that culminates in withdrawal from interaction and increased risk for child neglect and abuse."
  - (Pajulo et al., 2006)

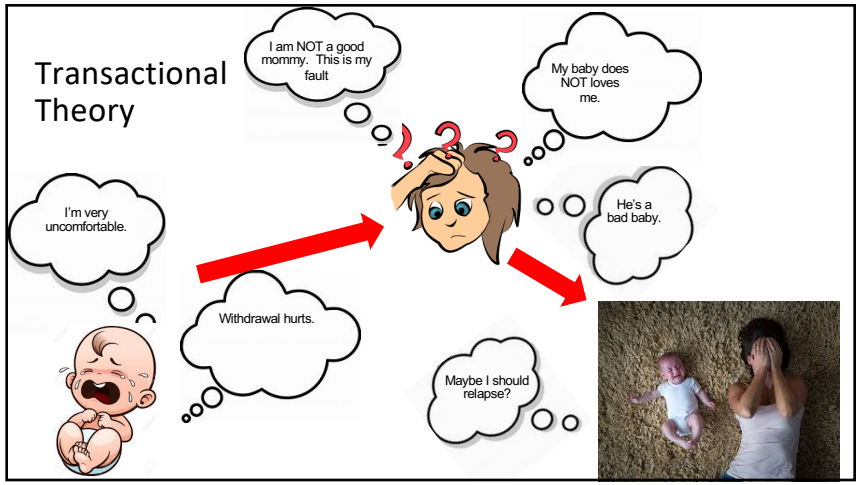
Paris and Sommer (2015)

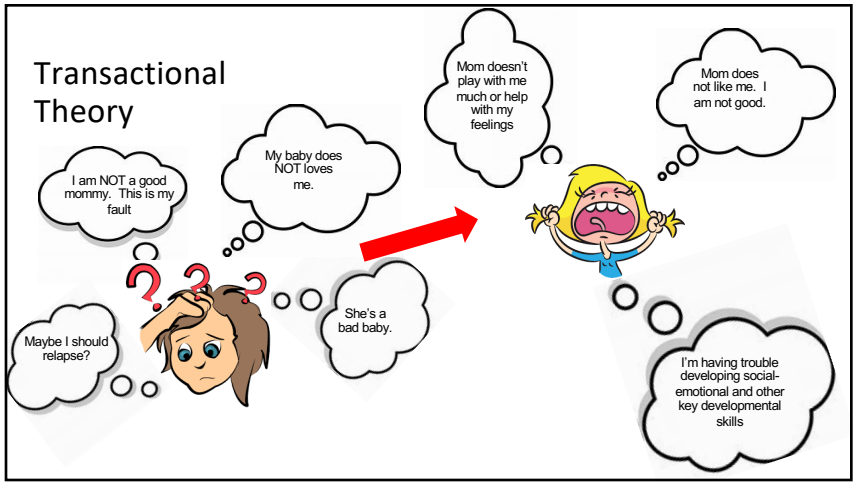
Not all mothers with SUDs histories struggle as parents, but many do…

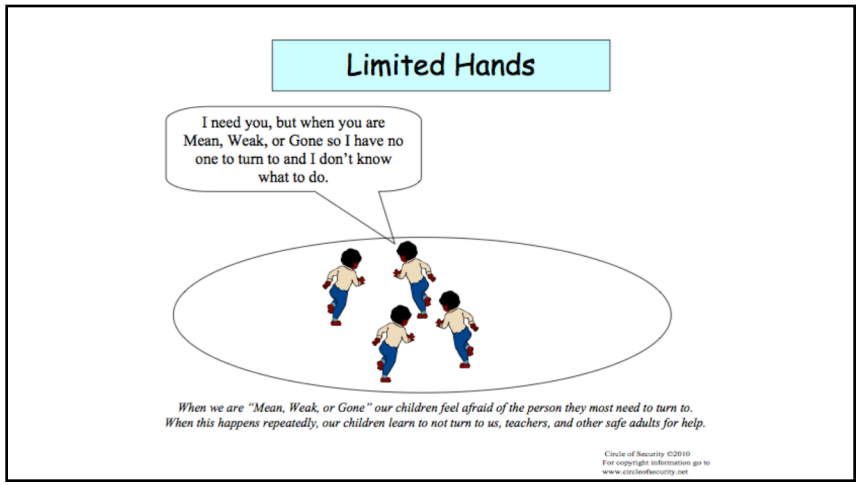
- Mom's with SUDs are more likely to demonstrate
  - Lowered sensitivity & responsiveness to infant emotional cues
  - Difficulty responding to infant distress
  - Difficulty supporting social-emotional and cognitive development
  - Oscillation between intrusive, over-controlling, and passive-withdrawal parenting styles
- Deficits in **reflective function*****
- Unpredictable and chaotic caregiving
- Unmet basic needs such as nutrition, supervision and nurturing
- Child abuse, neglect and foster care placement.
- Other challenges such as mental illness, domestic violence, unemployment, housing instability

Transactional Theory

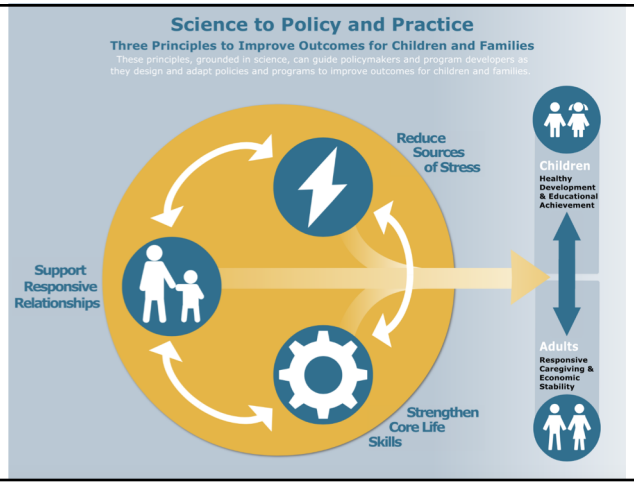








V. What can you do for infant/caregiver relationships?



National Perinatal Association

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Educate. Advocate. Integrate.

Promote infant-parent relationships to enhance outcomes for infants and their caregivers

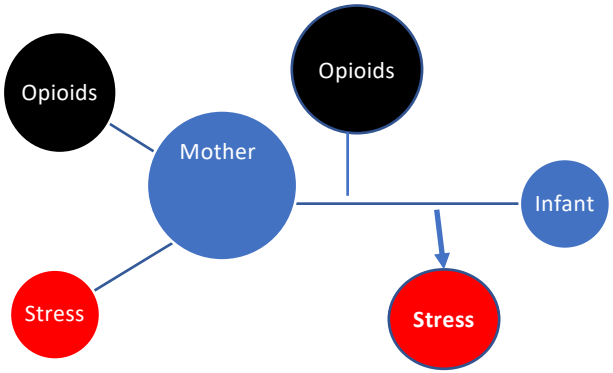
New developments in the treatment of mothers and infants affected by opioid addiction point to the promising effects of interventions that adopt a developmental perspective, occur concurrently with addiction treatment, and target the parent-infant relationship as early as possible.

Suchman and DeCost (2018)

Developmental Perspective

As Early Intervention providers…

- Meet the developmental needs of infants "as usual"
- Provide Developmental Guidance as needed
- Recognize that, as far as we know right now, many of these infants can/will do well… but they are at risk…
- Pay attention to other stressors and risks associated with SUDs
  - neglect
  - poverty
  - mental illness
  - and so on



…Concurrently with Addiction Treatment

- The time for intervention is **now**… babies at risk cannot wait
- Support parent engagement in MAT (these mom's are survivors!) and other services
- Pregnancy and the birth of a child are powerful motivators for change
- Engage maternal motivation here and now
  - Harness this motivation by encouraging parents to take action steps toward recovery couched as taking better care of themselves AND of their families.

  - Suchman and DeCoste (2018)

Target the parent-infant relationship

The parent-infant/young child relationship is the vehicle for repair that can break the cycle of substance use-substance abuse-rehabilitation and relapse.

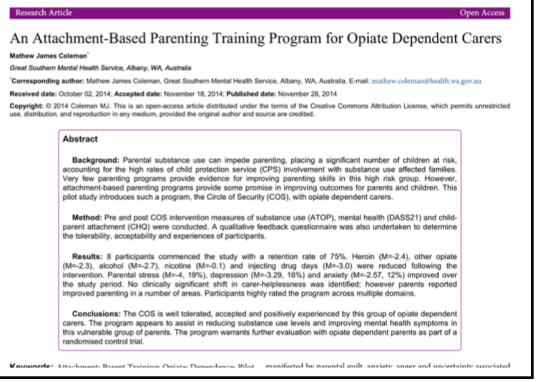
- Addressing the opioid epidemic using a ***relational health approach*** is critical to repairing the disrupted relationship that an infant or toddler has experienced when their parent/caregiver has succumbed to substance use and abuse.

  - Alliance for the Advancement of Infant Mental Health (2017)

Therapy Approaches

Research on **relational and attachment based programs** has shown promise in improving parenting in the opioid use population relative to more traditional cognitive behavioral and psychoeducational approaches.

- (Gannon et al. 2017)


Research Article Open Access

An Attachment-Based Parenting Training Program for Opiate Dependent Carers

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Abstract

Background: Parental substance use can impede parenting, placing a significant number of children at risk, accounting for the high rates of child protection service (CPS) involvement with substance use affected families. Very few parenting programs provide evidence for improving parenting skills in this high risk group. However, attachment-based parenting programs provide some promise in improving outcomes for parents and children. This pilot study introduces such a program, the Circle of Security (COS), with opiate dependent carers.

Method: Pre and post COS intervention measures of substance use (ATOP), mental health (DASS21) and child-parent attachment (CHQ) were conducted. A qualitative feedback questionnaire was also undertaken to determine the tolerability, acceptability and experiences of participants.

Results: 8 participants commenced the study with a retention rate of 75%. Heroin (M=-2.4), other opiate (M=-2.3), alcohol (M=-2.7), nicotine (M=-0.1) and injecting drug days (M=-3.0) were reduced following the intervention. Parental stress (M=-4, 19%), depression (M=-3.29, 16%) and anxiety (M=-2.57, 12%) improved over the study period. No clinically significant shift in carer-helplessness was identified; however parents reported improved parenting in a number of areas. Participants highly rated the program across multiple domains.

Conclusions: The COS is well tolerated, accepted and positively experienced by this group of opiate dependent carers. The program appears to assist in reducing substance use levels and improving mental health symptoms in this vulnerable group of parents. The program warrants further evaluation with opiate dependent parents as part of a randomised control trial.

Infant and Early Childhood Mental Health Approaches

- Focus on the infant-caregiver relationship
  - **Serve and Return Approaches**
  - **Video Interaction Feedback (McDonough; VIP approach)**
  - **Mentalization/Reflective Functioning Approaches**
    - **Mothering Inside Out** (Suchman et al.)
  - Trauma Focused Interventions
    - Circle of Security
    - Child Parent Psychotherapy

Serve and Return

- Ongoing, reliable interaction with trusted adults is essential for the development of healthy brain circuits
- Systems that support the quality of relationships in early care settings, communities, and homes help build brain architecture

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Video Interaction and Guidance

- Use video recordings to capture interactions
- Watch together and discuss positive interactions
- *"Specialists observe interactions of parents and infants together, noticing what is happening "in the moment," inviting parent's comments and reinforcing what is going well. The use of videotape for guided interaction is a particularly useful strategy when supporting overburdened parents in their developing relationships with young children"*
  - McDonough, 1993; Weatherston 2000

Mentalization/ Reflective Functioning Approaches

- Mothering Inside Out (MIO)- Suchman et al.
  - ...psychotherapeutic intervention designed to promote parental "***Reflective Functioning***" in mothers in treatment for SUDs or mental health problems
  - Aim is to increase **Reflective Functioning** so that mothers are better able to manage emotional distress (the infants, and their own) in absence of neural reward related to substance use problems

Suchman (2016)

Helping a mother manage her emotional distress and improving attachment quality may may promote a mother's successful recovery from addiction and her capacity to experience reward and delight in her parenting role.

Mentalization (Fonagy)
Reflective Function (Slade)

- Psychological skills (such as perspective taking) that allow us to make sense of our own and others actions by reference to ***mental states*** such as beliefs, intentions, desires, and feelings.
- "Mentalizing forms the fundamental basis for relating to and thinking about what other people and ourselves feel."
  - Central to recognizing, regulating, and communicating emotions
  - Inversely related to emotional arousal

Reflective Function Examples

EX: If a child is having a tantrum, a parent who senses the toddlers *frustration and anger* may be more likely to help the child manage those strong feelings rather than punishing the child's behavior.

EX: A parent who becomes very angry in response to their child's tantrum behavior may be able to link their own anger back to its original source such as an argument with a friend, lack of sleep etc. rather than directing that anger toward their child.

Reflective Functioning: Listen for Evidence

- Evident in how someone talks about their own and others underlying mental states and feelings
  - **CHILD**: *"My mom was really mad when she saw that I didn't do my homework because she was worried I was going to get in trouble at school, and she thought I was being lazy."*
  - **MOM**: *"He used to cry all the time as a baby, and it used to make me feel so inadequate when I couldn't soothe him, but I think he was just very frustrated."*
- When a parent can think about their child's minds in this way and respond sensitively, they are showing good RF.

Suchman 2018

Impaired Reflective Function

- Impaired mentalization/RF occurs under conditions of high emotional arousal
- RF has been found to be impaired in mothers with SUDs
- When RF improves, the quality of interactions improve

What can you do? Listen for, and Support RF

- Support the parent to engage in conscious and explicit efforts to mentalize about the
  - child
  - parent-child relationship
  - parents own strong reactions to parenting situations

Suchman 2018

Ask Parents to Engage in Reflective Function "Keep the baby in mind"

- Engage in conscious and explicit efforts to mentalize about moments of emotional arousal when RF was momentarily suspended.
- Slow down, consider the event and the individuals mental and emotional reactions the came before the emotional arousal or loss of RF
- Repeat this process to build RF capacity over time

Suchman 2018

Mentalize for the Parent First

- Parents preoccupied by guilt, shame, anger, disappointment have little room to keep the baby in mind
- Help the parent "untangle" their own emotions.. this can help them feel more grounded, connected, and to think about the child's experiences
- Oxygen mask analogy

Suchman 2018

Maintain a Curious, Inquisitive Stance

- "What do you think was going through his mind?"
- "What do you think was going on in your mind"
- "What feelings do you think they (you) had when that happened?"
- "Why do you think they (you) felt that way?"

Suchman 2018

Maintain a Curious, Inquisitive Stance…. and offer alternative interpretations if needed.

Provider: "What do you think was going through his mind?"

Parent: "I don't know. He's too young to think."

Provider: "I was wondering if he might be wanting some physical contact with you, or maybe he wants to hear your voice. What do you think?

Remain curious and inquisitive..

Suchman 2018

Listen for Changes in Reflective Capacity

- "You seem to be noticing more directly how disappointed you were. I'm wondering if you're aware of this?"
- "You're noticing that he wanted to be closer to you. What's that like for you?
- "You're seeing the things you like about him as well as the things you don't like. Sometimes he feels like an angel to you and sometimes like a rascal. Can you tell me more about when your experiences shift like that?"

Suchman 2018

Reflective Function Changes Develop Slowly

- Take the long view. RF changes take time, but when they do occur, they tend to persist.
- Emotional arousal can undermine RF momentarily.
- Several invitations to mentalize may be needed before this ability becomes automatic or spontaneous.

Suchman 2018

MIO Vignette
Theresa (mom) and Anna (2½)

- **Theresa:** My Anna! She's getting attitude. She just doesn't listen to me. This morning I had to get to the clinic before they closed. I tried to dress her but she couldn't have it. She wanted to play with her dolls. So I said "Anna, you're going to get a spanking if you keep this up!" I know she's doing this to annoy me.

Suchman 2016

MIO Vignette

- **Provider:** So I'm wondering what was going through your mind when you were trying to get Anna dressed this morning…
- **Theresa:** If I don't get medicated, my body starts to ache and I begin to sweat! And I don't want to pick up using again.
- **P:** So you were worried that if you didn't make the medication hours, you'd begin going into withdrawal which would make you think about using. Do I have that right?
- **T:** Yes, they don't let you in the door if you're one minute late. They're very strict about it.

Suchman 2016

MIO Vignette

- **Provider:** Oh, I see. What was it like to think about the possibility of going into withdrawal?
- **Theresa:** If I don't get medicated, my body starts to ache and I begin to sweat! And I don't want to pick up using again.
- **P:** So in your body you feel incredible discomfort. How about emotions. Does anything come to mind?
- **T:** No. I just feel sick.
- **P:** I'm wondering if you might have felt scared- and maybe a little mad with Anna? Could that be?
- **T:** Well, no. I wasn't scared, but I was very worried and nervous. I wasn't mad at Anna but I guess I was more than a little annoyed.

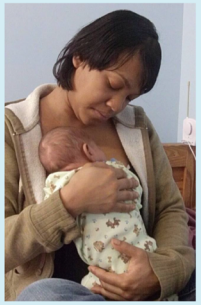
Suchman 2016

MIO Vignette

- **Provider:** That's very understandable. I'm glad you were able to help me understand how you felt. That's very important to me. It sounds like you really wanted Anna to cooperate and understand what was worrying you. Do I have that right?
- **Theresa:** Yeah. It's always a struggle. She's so stubborn.
- **P:** What do you suppose was going through her mind this morning when you were trying to get her dressed and out the door?
- **T:** I don't know. She's just two years old. I never really thought about what she thinks. I guess she just wanted to play. Maybe she doesn't understand.
- **P:** Can you say more about that? What do you think she doesn't understand? And why do you think playing is so meaningful to her right now?

Suchman 2016

Reflective Functioning



"Putting myself into their shoes and figuring out, you know, what they thought about it and how they felt. Everything from them first moving their heads to, you know, emotions. How frustrating it is that they can't move their heads, and they can't tell me what they want. You know, she [clinician] made me realize that babies have it tough."

Caring for Generations JF&CS

BU School of Social Work

Paris and Sommer (2015)

MIO Findings

- More sensitive and responsive caregiving behavior
  - Sustained at 6 week follow-up
- Improved maternal caregiving behavior (1 year)
- Improved dyadic reciprocity (1 year)
- Reduced heroin use (6 months)

- Outcome data indicated that when maternal RF improved, the quality of mother-child interactions improved.
- Evidence-based- at least two RCTs with mothers in treatment for drug addiction

Suchman 2016/2018

Interesting finding.. food for thought

In recent studies, mothers with higher "ACE Burdens" (Mindfulness Based Parenting) or more severe addiction (MIO) showed significant improvements in parenting quality at a greater rate than mothers with lower ACE scores or less severe addiction.

A DOSE response was also identified… more intervention (and practice) with RF skills predicted more improvement

Understanding the science of addiction and parenting helps (providers) avoid the pitfalls of harsh and judgemental attitudes toward parents in addiction recovery

Suchman and DeCoste (2018)

The need for ongoing professional development

National Perinatal Association
PERINATAL SUBSTANCE USE

nationalperinatal.org/position
www.nationalperinatal.org/Substance_Use

Educate. Advocate. Integrate.

You are still working with a baby and a caregiver. Many of the risk factors, needs and stresses are the same. And there is a SUDs problem too. The needs are ***typical and unique.***

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Educate. Advocate. Integrate.

Avoid judgement and stigma. Pay attention to your own biases (implicit and explicit) and work to manage these.

Trusting relationships with providers are crucial

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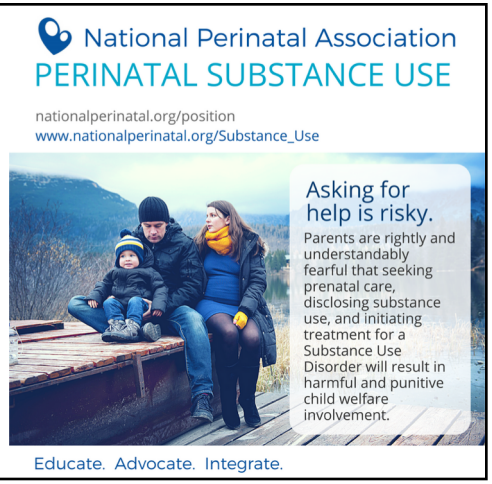
Engaging Families.. as soon as is possible!

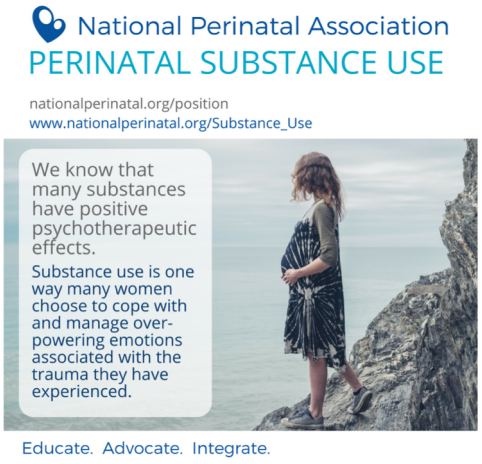
- Often the first indication of substance exposure is when the baby shows signs of NAS
- Stigma and bias may increase mom's distrust of systems as allies (or not).. this is a crucial period to foster alliance and trust
- Moms may feel pushed in directions against her will..possibly reducing engagement in other systems later (such as Early Intervention)

Miriyala (2018)

Take the Caregivers perspective. Fear, shame, remorse etc. can make it hard to ask for or accept help.



Consider the role of trauma. Drugs and alcohol serve a purpose.



"The root cause of the Substance Use Disorder "is probably the most dangerous thing in the household—whether that's mom's history of abuse or neglect or sexual assault or whatever it is. That thing will continue to come back and haunt that caregiver and the child-caregiver relationship for a very long time unless it's addressed."

- Nadine Burke Harris, 2017 (www.motherjones.org)

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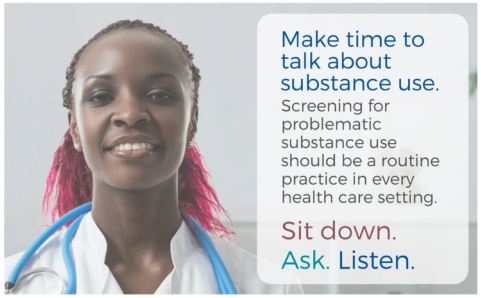

Educate. Advocate. Integrate.

There is a need to ask...

SUDs moms are usually of child-bearing age... knowing about substance use helps us understand the current baby... and maybe save the next one.....

Be the model of mature discussion about SUDs, opioids, and supports.

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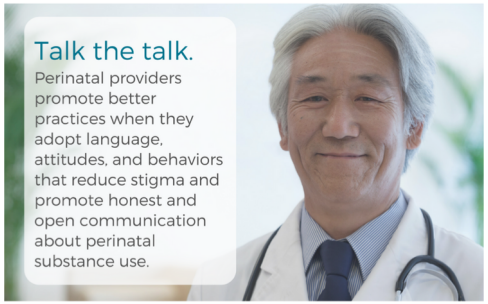

Educate. Advocate. Integrate.

Support goals and desires. Any "positive" change, which can include "change talk," should be supported. Do not abandon parents who still use.

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Educate. Advocate. Integrate.

Support mom's need for other treatments. Being in treatment is ACTION toward health. Acknowledge, encourage, support, help.

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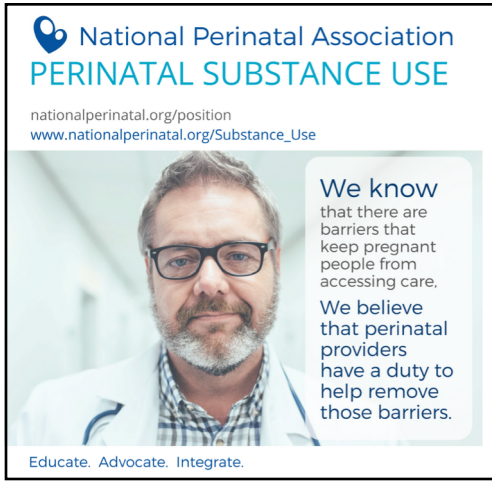
Educate. Advocate. Integrate.

SUDs parents experience many barriers

- Declines in financial, occupational, and relational stability
- Repeated exposure to social stigma (including by providers)
- Legal consequences
- Shame and fear about the impact of substance use on offspring
- Discouragement about treatment by peers and romantic partners



Help remove or overcome barriers when you can. Setbacks for mom are setbacks for the infant.

work with and across systems

"Careful coordination and collaboration is necessary"

- Obtain permission to get history of past events and interventions
- Obtain permission to communicate necessary information with other providers
- Obtain permission to release information to the next provider when transferring care (and if possible talk to them about the case)
- Get comfortable with laws, institutional protocols, guidelines to ensure compliance
- Advocate for the family

Miriyala (2018)

VII. Resources

Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants

SAMHSA has released a new tool to assist health care providers in caring for pregnant women and new mothers with opioid use disorder and their infants. The new publication, Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants, includes 16 fact sheets, with each fact sheet containing four elements:

- clinical scenario
- clinical action steps
- supporting evidence and clinical

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- **SAMHSA TIP 63: Medications for Opioid Use Disorder – Executive Summary** https://store.samhsa.gov/shin/content//SMA18-5063EXSUMM/SMA18-5063EXSUMM.pdf

END

Thank you