# Supporting the Care of the Mother-Child Dyad in Substance Use Disorder Treatment
# March 16, 2021
# Webinar Questions and Answers

*Disclaimer: We have asked our webinar panelists to address questions from the webinar and are providing responses below, to the best of our current knowledge, given the rapidly evolving circumstances. These answers are informational in nature and are not intended as legal or medical advice.*

## QUESTIONS:

### General:

1. **What percentage of women stay for 9 months and do you have longitudinal data?**
   *We are in the process of collecting systematic data on the outcomes of all women and children who enrolled in Horizons' care and will be able to answer such longitudinal data more completely in the future. With regard to completion rates, last fiscal year 72.5% of families left after receiving the "dose" of residential treatment that met their needs. While the average length of stay is 9 months, some families opt for shorter or somewhat longer stays, depending on their housing, relationship and employment needs.*

2. **Can you recommend any assessment or scale that is adequate in assessing for postnatal depression?**
   *Postpartum Support International (PSI) recommends universal screening with an evidence-based tool such as the Edinburgh Postnatal Depression Screen (EPDS) or Patient Health Questionnaire (PHQ-9). Other scales that may also be considered are Postpartum Depression Screening Scale and the Beck Depression Inventory. The EPDS is the most widely used tool because it assesses for anxiety which is often the presenting symptom of postpartum mood disorders. While many providers focus on the often singular postpartum visit, it is recommended that women be screened during each trimester, at the first post-partum visit (commonly at 6 weeks) and 2 to three additional times in the year after delivery. These additional postpartum screenings may occur in primary care or pediatric setting.*

   *Screenings need to be provided in private setting using a caring and informative approach that normalizes mental health needs. Additionally, screening must be combined with a system that is responsive to all women and protocols to insure appropriate follow up. It is also critical for screening to be universal. It has been estimated that 38% of new mothers of color experience perinatal depression or anxiety however 60% do not receive any treatment or support services. There are numerous reasons for this including barriers to treatment, a lack of culturally appropriate care and structural racism within healthcare. The Perinatal Mental Health Alliance for People of Color is a group within Postpartum Support International that is working to expand access to culturally appropriate care for all families of color. There are additional organizations such a Black Mamas Matter Alliance https://blackmamasmatter.org/ who are also working to expand awareness about and access to culturally appropriate care.*

3. **Can Dr. Horton speak more on "circle of security parenting?"**

   *The Circle of Security-Parenting (COSP) refers to an eight session, manualized, DVD guided, parent education program grounded in attachment theory that UNC Horizons uses as part of our parent education curricula (see Horton E, Murray C. A quantitative exploratory evaluation of the circle of security-parenting program with mothers in residential substance-abuse treatment. Infant Ment Health J. 2015 May-Jun;36(3):320-36.). The program resonates with the families we serve and helps support their relationships with their children as they enter recovery. See https://www.circleofsecurityinternational.com/ for multiple resources, trainings, and research.*

4. **Are there experiences with longer term support to the dyad for example, beyond primary school years?**

   *Due to our state regulations for residential care, UNC Horizons serves children ages birth through of 11, so many of our examples and parent education curricula focus on this age group. However, many of our patients have older children as well who are not with them in residential treatment. The attachment relationship is life-long and concepts from the Circle of Security Parenting (COSP) program can be applied to all dyadic relationships. Family therapy can also be very supportive to families looking to repair relationships with older children.*

   *Of note, two randomized clinical trials support 'Mothering from the Inside Out's' (MIO) efficacy in improving the parent's capacity for making sense of her own emotional stress, considering her child's emotional needs, exhibiting more responsive caregiving behavior, improving child attachment, and decreasing substance use. This intervention was tested with parents of children up to 60 months of age and holds promise for older children as well (Suchman NE. Mothering from the Inside Out: A mentalization-based therapy for mothers in treatment for drug addiction. Int J Birth Parent Educ. 2016;3(4):19-24; Suchman NE, DeCoste C, Borelli JL, McMahon TJ. Does improvement in maternal attachment representations predict greater maternal sensitivity, child attachment security and lower rates of relapse to substance use? A second test of Mothering from the Inside Out treatment mechanisms. J Subst Abuse Treat. 2018;85:21-30). Further, a trauma-informed mindfulness-based parenting intervention was also found to improve the quality of parenting behaviors of mothers with opioid use disorders (Gannon M, Mackenzie M, Kaltenbach K, Abatemarco D. Impact of Mindfulness-Based Parenting on Women in Treatment for Opioid Use Disorder. J Addict Med. 2017 Sep/Oct;11(5):368-376).*

   *Another example of an evidence-based intervention to reduce child maltreatment is the Strengthening Families Program (SFP; Alvarado R, Kumpfer KL. Strengthening America's families. Juvenile Justice 2000;7:8–18; Kumpfer KL. Selective preventive interventions: The strengthening families program. In: Ashery RS, Robertson EB, Kumpfer KL. Drug Abuse Prevention Through Family Interventions. Rockville: National Institute on Drug Abuse, 1998; Kumpfer KL, Whiteside HO, Greene JA, Allen KC. Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites. Group Dyn: Theor Res Pract 2010;14:211–29; Hurwich-Reiss E, Rindlaub LA, Wadsworth ME, Markman HJ. Cultural adaptation of a family strengthening intervention for low-income Spanish-speaking families. J Lat Psychol 2014;2:21–36; https://strengtheningfamiliesprogram.org/) in different variations provides parenting skills for substance-involved parents of children ages 6-11 or 7-17.*

5. **How do you support parents who wish to continue using drugs?**
*It is important to meet individuals where they are without judgment. Motivational Interviewing is an evidence-based modality that helps with navigating ambivalence in a supportive way. One approach to help a provider with strengthening MI-informed skills is to state to oneself, "this person might be experiencing a significant amount of pain, discomfort, or trauma." Acknowledging that substance use could be a coping skill to escape or managing an underlying concern (grief, mood, anxiety, trauma, etc.), can help with rapport building and trust and ultimately lead to behavior modification. Additionally, recognizing that success looks different for everyone, and validating the treatment process (decrease in polysubstance, decrease in frequency, commitment to trying something new, returning for visits, etc.) is essential. Another important tool is working on collaborative safety planning and ensuring that they have access to Narcan, fentanyl test strips, clean needles and syringes and education on how to use all aforementioned tools, providing the number and location to their local mobile crisis unit, and connection with the national harm reduction organization https://harmreduction.org/ and local harm reduction organizations and resources to strengthen support. An example of an important resource in this area is https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/*

6. **What about the stigma related to the mother's use?**
*Many women who come to Horizons have shared that being a person who uses substances and is pregnant is the most stigmatized and discriminated group of people within the population who uses drugs. Stigma and discrimination shows up in numerous ways. It can be found in the language providers use with each other when discussing patients they care for and this stigmatizing language is often internalized by patients based on what they hear, how they are treated by community, society, family/friends and what they see in the media about how people who use drugs are portrayed. Once internalized, patients sometimes use such negative language to describe themselves and such self-stigma can create a barrier to seeing perinatal and/or substance use disorder treatment care (e.g., Frazer Z, McConnell K, Jansson LM. Treatment for substance use disorders in pregnant women: Motivators and barriers. Drug Alcohol Depend. 2019 Dec 1;205:107652). Sarah Roberts and her team have shown that stigma and discrimination is found in state policies regarding alcohol use during pregnancy (alcohol/pregnancy policies) and that some of these policies increase adverse birth outcomes and decrease prenatal care utilization (e.g., Roberts SCM, Berglas NF, Subbaraman MS, Mericle A, Thomas S, Kerr WC. Racial differences in the relationship between alcohol/pregnancy policies and birth outcomes and prenatal care utilization: A legal epidemiology study. Drug Alcohol Depend. 2019 Aug 1;201:244-252; Roberts SCM, Thomas S, Treffers R, Drabble L. Forty Years of State Alcohol and Pregnancy Policies in the USA: Best Practices for Public Health or Efforts to Restrict Women's Reproductive Rights? Alcohol. 2017 Nov 1;52(6):715-721). Unfortunately, even some members of the recovery community stigmatize and discriminate against those who take medications as a part of their recovery journey. Stigma and discrimination in any form must be called out and eliminated. All individuals, regardless of pregnancy status, deserve honor, dignity, care, compassion and support.*

7. **I hear different things from different providers about the best medication assisted treatment for pregnant people — some providers say Subutex, and some say Methadone. What is the gold standard, if any?**
   *Thanks to the seminal PROMISE and MOTHER studies as well as other supportive studies, the field now has data documenting the relative safety and efficacy of multiple formulations of opioid agonist medications for treating opioid use disorder during the perinatal period. Based on the collective literature prestigious entities such as SAMHSA, ACOG, ASAM, the World Health Organization and the United Nations all endorse both methadone and buprenorphine as medications that are standards of care for the treatment of opioid use disorder during the perinatal period. Most recently ASAM updated 2020 guidelines includes the specific discussion of the buprenorphine+naloxone formulation (naloxone is added to buprenorphine to deter its misuse) stating that it is frequently used and considered relatively safe and effective for use in perinatal patients and urge the need for continued research (https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2)*
   *Due to the number of references provided in this response we moved them to the end for clarity of message.*
   *Jones HE, Johnson RE, Jasinski DR, O'Grady KE, Chisholm CA, Choo RE, Crocetti M, Dudas R, Harrow C, Huestis MA, Jansson LM, Lantz M, Lester BM, Milio L. Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: effects on the neonatal abstinence syndrome. Drug Alcohol Depend. 2005 Jul;79(1):1-10.*
   *Jones HE, Kaltenbach K, Heil SH, Stine SM, Coyle MG, Arria AM, O'Grady KE, Selby P, Martin PR, Fischer G. Neonatal abstinence syndrome after methadone or buprenorphine exposure. N Engl J Med. 2010 Dec 9;363(24):2320-31*
   *Kakko J, Heilig M, Sarman I. Buprenorphine and methadone treatment of opiate dependence during pregnancy: comparison of fetal growth and neonatal outcomes in two consecutive case series. Drug Alcohol Depend. 2008 Jul 1;96(1-2):69-78*
   *Binder T, Vavrinková B. Prospective randomised comparative study of the effect of buprenorphine, methadone and heroin on the course of pregnancy, birthweight of newborns, early postpartum adaptation and course of the neonatal abstinence syndrome (NAS) in women followed up in the outpatient department. Neuro Endocrinol Lett. 2008 Feb;29(1):80-6*
   *https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf*
   *https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy*
   *https://30qkon2q8eif8wrj03zeh041-wpengine.netdna-ssl.com/wp-content/uploads/2013/10/WAGBrochure-Opioid-Pregnancy_Final.pdf*
   *https://30qkon2q8eif8wrj03zeh041-wpengine.netdna-ssl.com/wp-content/uploads/2013/10/ASAM-WAGBrochure-Opioid-Labor_Final.pdf*
   *https://www.who.int/publications/i/item/9789241548731*
   *https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf*

8. **How do you recommend social workers/advocates support parents with SUD who are told they have "lost the right" to breastfeed by medical staff?**
   *Most healthcare systems follow the protocols created by The Academy of Breastfeeding Medicine (ABM). Challenges arise when implicit bias, stigma and discrimination influence the decision-making process. This is especially true when related to the assessment of use/return to use in the 30 to 90 days prior to delivery when a parent entered treatment during that time*

*period. If a parent/s is/are in treatment, advocates can encourage parents to allow for communication between healthcare providers and SUD providers. If patients are not involved in treatment, discussing available resources can be helpful because Academy of Breastfeeding Medicine asserts that having a specific plan for postpartum treatment plays an important role in determining safety. In addition to supporting parents, ongoing education on substance use disorders for medical staff can be helpful. It is also critical to encourage ongoing discussions about the structural and emotional barriers that exist for women with substance use disorders that impact engagement with prenatal care services and treatment services. A helpful resource for advocacy for breast/chest feeding is https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/*

9. **What about social and welfare support services to the dyad beyond psychosocial?**
   *We are committed to addressing health-related social problems, social determinants of health and the individual issues dyads face due to ways their circumstances have made them vulnerable and marginalized. We work to provide social needs-informed care and social needs-targeted care through intensive case management services and group therapy. We have case managers, some who have lived recovery experience, embedded at each location. We ensure that individuals have transportation to access adequate prenatal, physical, and pediatric care, equipped with formal and informal childcare services, address nutrition and food insecurity, provide a validating apartment-style home while in residential services and housing referrals post-treatment, host vocational training and financial empowerment groups, life skills group, coordinate with local officials to assist with legal matters, and parenting support groups that are exclusive to child protective services (Care Coordination 4 Children, Nurse Family Partnership, Doulas). Additionally, we encourage social groups that support recovery efforts (AA/NA, Women For Sobriety, Religious or Spiritual gatherings, Peer Support Groups).*

10. **What extra supports do you offer to BIPOC parents considering the maternal mortality crisis and how it disproportionately affects black birthing people?**
    *We provide education to staff about the importance of cultural-responsive care including, community-centered and family-centered practices based on the needs of the dyad. We utilize our Diversity, Equity, and Inclusion Taskforce to discuss conversations such as implicit bias and honoring the patient's needs, intersectionality training, and learning from community stakeholders and guest speakers. We encourage and financially support our BIPOC clinicians, if interested, to receive antepartum, birthing, postpartum doula training, and certifications and/or engage in other cultural-specific conferences to meet the community-centered standards of care. Our patients also have opportunities to receive support to overcome barriers to education and employment that are supported from donors in our community committed to DEI and support of BIPOC. Our outpatient behavioral health teams engage in outreach efforts - during the pandemic also - to work closely in settings where BIPOC individuals, uninsured, and resource-limited are more likely to enter care. Our clinics work with individuals and enroll them in financial assistance programs to ensure access to medications, as BIPOC individuals are more likely not to have insurance compared to White women. However, we are aware that direct care is only one navigation point and interventions on multiple levels must occur to address the maternal mortality epidemic. On a systemic level, we have conversations within our department and divisions about racial and health inequities during provider meetings as well as structural and systemic racism and discrimination. We have a pledge that highlights our commitment to patient care that is advertised throughout our clinics and worksites. Our clinics extend postpartum care up to one-year post-delivery, as the postpartum period also comes with challenges despite*

*insurance status. Albeit confidential in nature, we have leadership members that actively participate in local and state Maternal Mortality taskforce conversations to help facilitate resolutions on a state-level and there is a specific and intentional focus on how discrimination occurs and what can be done to eliminate it.*

11. **Do you have resources or advice for people working with mothers and children beyond infancy?**
*There are multiple evidence based mental health interventions for dyads past infancy, such as Parent Child Interaction Therapy, Child Parent Psychotherapy, Triple P, etc. Look for providers trained in these models in your area (see https://childparentpsychotherapy.com/resources/roster/; https://www.ncchildtreatmentprogram.org/program-roster/?pg=29; http://www.pcit.org/find-a-provider.html)*

12. **Particularly mothers of children that have already been placed in foster care and are trying to regain custody?**
*This is a common situation with our patients at UNC Horizons who are entering a long-term recovery program after a serious spiral of their disease and requires a series of responses from our integrated care team. First, due to the frequent stigmatization of maternal substance use, we have found that in most instances our patients need case management and advocacy to address their current legal situations. Our patients connect with free legal consultation services in our community to learn how to best proceed in their cases. Second, we educate the patients on how to become an advocate for themselves and educate others (including social workers, lawyers, judges, etc.) about their disease. Next, we teach the patients about the dyadic attachment relationship and how to support their relationship with their children. Many of the evidence-based models we've mentioned above are useful in this context. We support them during visitations with their children and write letters on their behalf. Last, we are fortunate to have support funds and community agencies to help our patients with any barriers to connecting with their children, such as transportation, regaining of drivers' licenses, court fees, etc. This is a process that can take the entirety of our 9 month residential program.*

**Criminal Justice Involvement:**

13. **Is there advocacy on state or national levels to support continued mother/child contact after delivery? Ie: child welfare rights to maintain contact with their parent during incarceration (pre-trial detention or post-sentencing/prison) - specifically during the postpartum/postnatal phase and during breast feeding episode?**

*There are currently 9 states that have prison-nursery programs. These states are California, Illinois, Indiana, Nebraska, New York, Ohio, South Dakota, Washington, and West Virginia. The results of these programs are mixed (see* for more information*http://www.bu.edu/writingprogram/journal/past-issues/issue-9/johnson/). There are efforts on the state and national level to promote more support of the dyad during incarceration. In North Carolina, we have the Mothers and Their Children (M.A.T.C.H) Program embedded at a Correctional Institute for Women. This program works with women who have been sentenced to prison to maintain family attachment and positive parenting techniques. For individuals that have not been sentenced but transitioned to prison primarily to receive prenatal care and manage their substance use need a different type of advocacy. We have witnessed positive outcomes when county and community advocates implement jail-based medication-*

*assisted treatment and Family-Drug Treatment Court, Pre-trial programs, and/or Diversion programs to avoid incarceration and promote treatment efforts. We encourage individuals to identify or create justice-involved taskforces or coalitions in their area to highlight the need for such programs in every county of the state. With the majority of women in jail and prison incarcerated for non-violent offenses (most related to substance use or property crime) a broader approach to advocacy may be more effective. There are multiple state and national efforts to end the mass incarceration.*

**<u>Child Protective Services</u>:**

14. **I live in a state where any indication of substance use during pregnancy (sometimes racist/prejudice lenses) will trigger intensive toxicology reports at birth. A positive test will automatically result in DSS involvement /and/ criminal charges--sometimes felony child endangerment. How can we support parents in an environment like this?**
*This is a horrific and sad environment for parents and does not take into consideration that those with substance use disorders can be treated and need support and help from community. All of the suggestions above (see question 11) may apply, but may be inadequate in such a punitive, discriminatory environment. Sometimes the best we can do is provide collective advocacy on a state level against these policies while also acknowledging to the parent how discriminatory these policies are and have no reflection on their caregiving ability or love for their child/children. Visitation policies should reflect the importance of the extended family and capitalize on the many providers of care, affection, and role modeling.*

15. **Regarding cultural safety; how do you practice trauma informed practice toward aboriginal / indigenous mom, baby, family as a whole, who have experienced intergenerational trauma. With a focus on equitable access to supports and services.**
*We work to practice cultural humility and see the indigenous families, like all families, who chose us as their care partner as the experts in their own lives and we seek to find a balance between having them educate us without burdening them with such education demands. Our indigenous families have shared a number of important aspects for their care and we recognize that each family is unique as are the customs, traditions and practices of the indigenous communities. First, women play an important role in health care and decision making given that many tribes are matrilineal. Our practice and education strategies include identifying beliefs and practices specific to the community and working closely with those individuals the patient identifies as important to her. Second, we offer opportunities to incorporate traditional healers, storytelling, talking circles, rituals involving sacred foods or herbs, prayer meetings, and sweat lodges may be incorporated into the care plan and practices for the family. Third, given the historical trauma of how written agreements have been misused, we recognize that a great deal of trust must be established before entering into such agreements. To establish and maintain a trusting relationship, we recognize and honor the need for repeated conversations and the time it takes for the family to consult with a tribal elder or matriarch before the written signature can be obtained.*

16. **"After many years of working in mental health and addiction programs I am doing consulting now for child welfare and foster care providers.. and what I am seeing is shocking. Welfare system workers viewing moms as interfering with permanency planning...Case workers placing kids in schools and housing without involving the child or even visiting the proposed school or apartment. Policy changes that are dogma based not reality/evidence based. What is your take on this?"**
"I play a role in child welfare cases when removal has occurred. It is mind blowing to me to see how little support parents receive and are supposed to do it on their own.

In my community and state, I hope to see change where the DHHR and CPS workers are more involved with other agencies to help parents facing substance use instead of throwing them out to figure it out on their own."

*Yes, we agree. We feel that there needs to be significant changes at both the federal and state levels in how child welfare in conceptualized, implemented and held accountable for child outcomes. The foster care industry has largely gone unchecked with little accountability. Please see https://nccpr.org/ for an excellent talk on the current child welfare system in this country.*

*We have found it helpful for our families in keeping them together to provide regular education about substance use disorders, trauma and recovery from substance use disorders to as many child welfare audiences as we can in our state. Over time, our local child welfare community has seen how a long term residential program for women and children can be extremely beneficial to their current case load and supports long term reduction in their cases.*