Mountain Plains ATTC (HHS Region 8)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Thank You for Joining us Today!

Please remember to:

- Mute yourself
- Ask questions in the chat box
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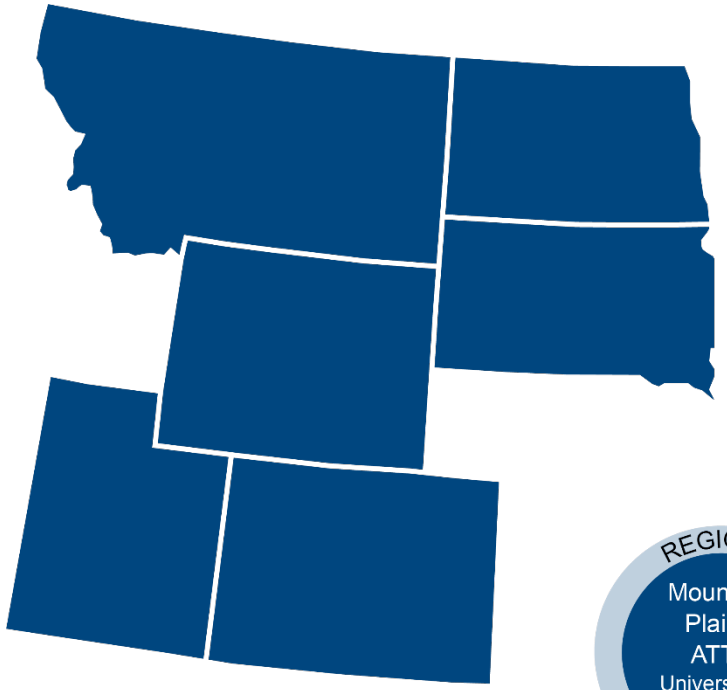
The Mountain Plains Addiction Technology Transfer Center

Provides training and technical assistance on evidence-based practices to providers offering substance use disorder in Region 8 (North Dakota, South Dakota, Montana, Wyoming, Colorado, and Utah). We are funded by the Substance Abuse and Mental Health Service Administration (SAMHSA)

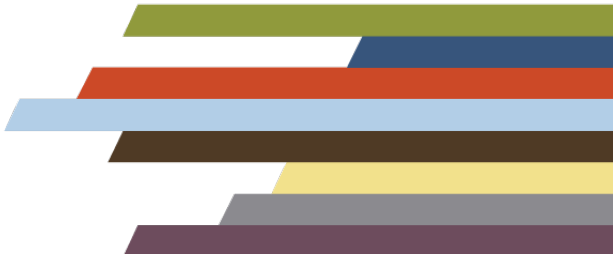


REGION 8
Mountain Plains ATTC
University of North Dakota

How we can continue to offer free training

A SURVEY!

https://ttc-gpra.org/P?s=860917



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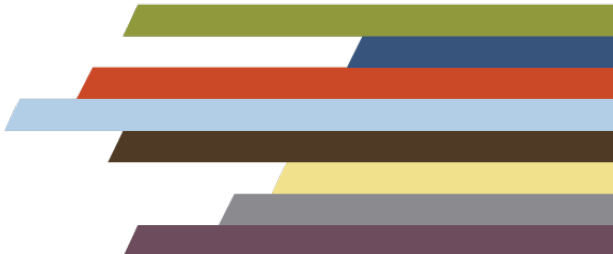

Mountain Plains ATTC (HHS Region 8)

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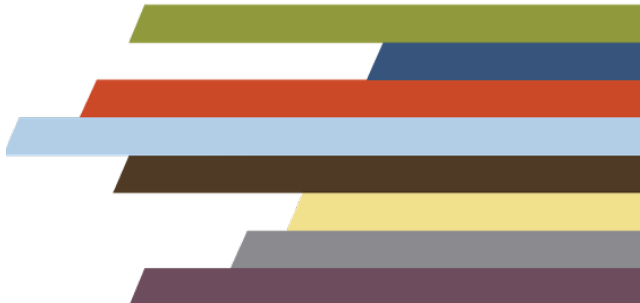
The Stigma is Real
Pregnant and Parenting Women with Substance Use Disorders

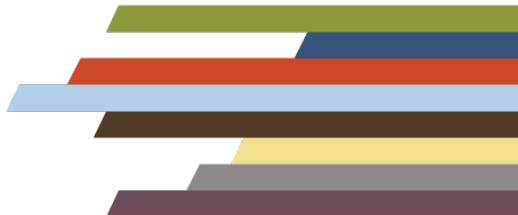
SAMHSA

Substance Abuse and Mental Health Services Administration



Learning Objectives

- **At the end of this presentation, participants will be able to:**
  - Describe the unique differences in adverse stigma encounters experienced by women who are pregnant and parenting
  - Recognize the consequences of stigma related to SUDs in women who are pregnant and parenting
  - Describe opportunities to change stigma

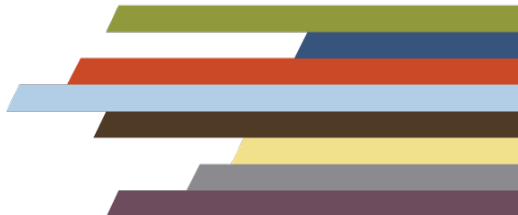


Stigma and Substance Use Disorders Defined

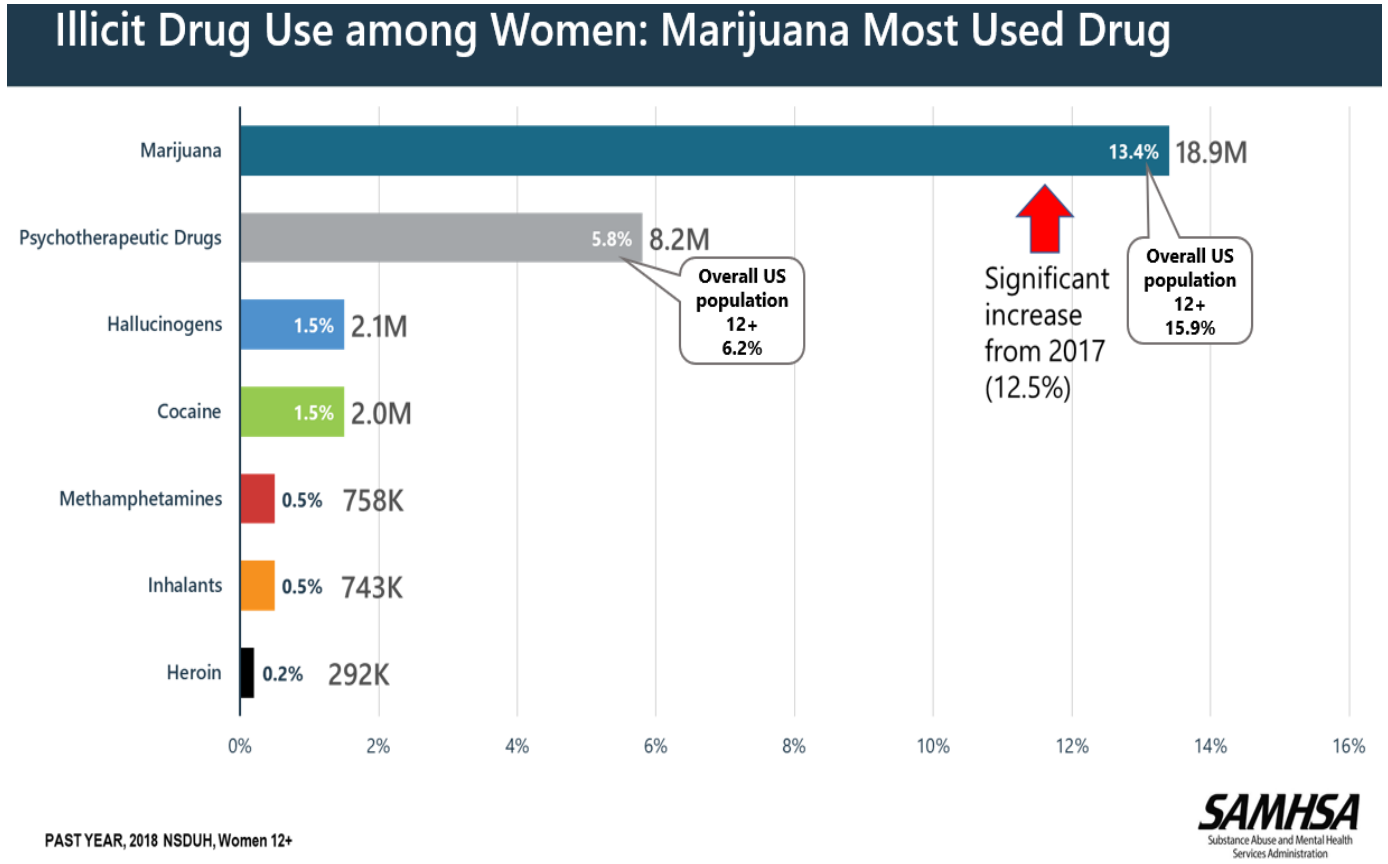
Substance Use Disorders (SUD)

"Chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness"

"Addiction is the most severe form of a full spectrum of substance use disorders, and is a medical illness caused by repeated misuse of a substance or substances." (NIDA, 2018)



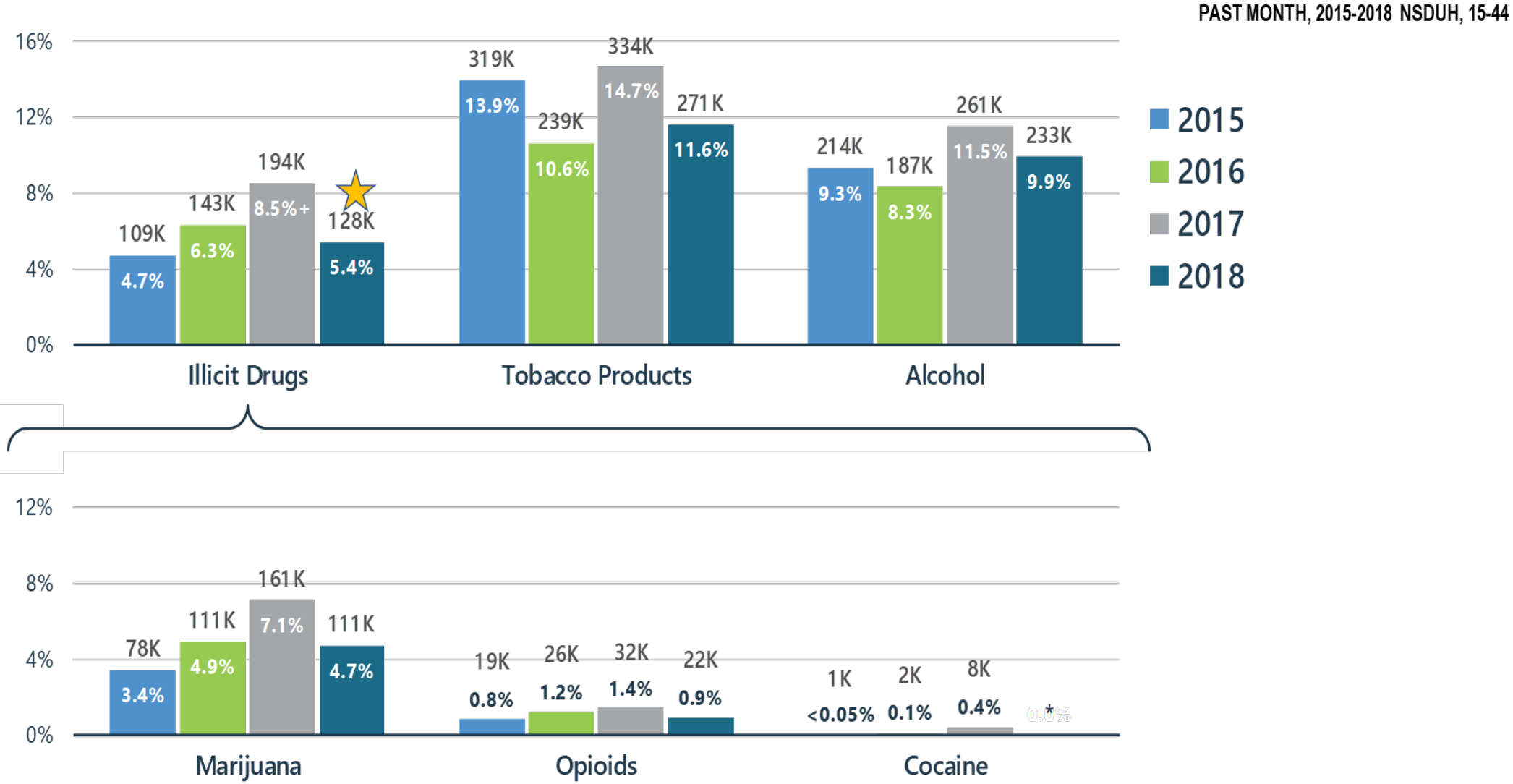
SUDs and Women



(NSDUH, 2018)

- Women are at highest risk for developing SUDs during reproductive years
- Fair to say that polysubstance use during reproductive years is common
- Unintended pregnancy rate among women with SUD is ~80%
- Consequences of SUD in Pregnancy
  - Substance use in pregnancy connected to many complications / negative health outcomes for mom/baby dyad
  - Any substance has potential to cross over to the fetus

Past Month Substance Use Among Pregnant Women



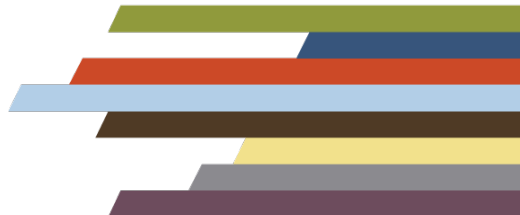
* Estimate not shown due to low precision.

\+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

(NSDUH, 2018)

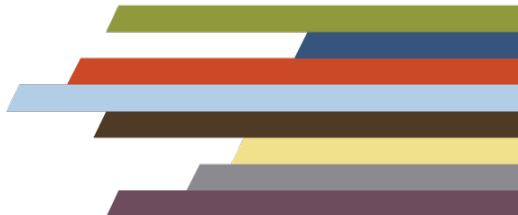
Stigma IS Different for Women with SUDs

- Women face unique and distinct differences in stigma from male counterparts.
  - **Biological**
    - Women experience a faster onset and progression of SUD than men
    - Women more susceptible to cravings and relapse
    - Metabolize alcohol and drugs differently; fewer stomach enzymes and more fatty tissue slow down processing which contributes to higher concentrations of substances longer
  - **Cultural**
    - Greater stigma as a result of traditional societal roles as gatekeepers, mothers, caregivers, and “central organizing factor in family units”
    - Prolonged isolation may be more common among stay-at-home moms
    - Greater impairments in social functioning, such as relationships and employment



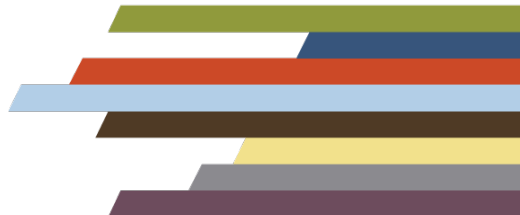
Stigma IS Different for Women with SUD

- **Gender Specific Sensitivities**
  - SUD in women has historically been considered selfish, moral failure
    - Resulting in intentional harm to family, child, and placing burden on society
  - May have more economic barriers to treatment
    - Less income, pay gaps, higher likelihood of living in poverty prior to SUD onset
  - Higher % of women have history of trauma (Research Recovery Institute, n.d.; National Academy for State Health Policy, 2018)



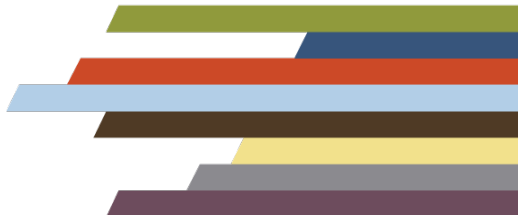
Stigma IS Different for Women with SUD

- **Gender Specific Sensitivities**
  - Women are more prone to co-occurring disorders
    - 2015-2018: Serious mental illness significantly increased in women aged 18-49, especially among women aged 18-25
      - Increased risk for suicidality among women
    - Among women, use of one substance—alcohol or other illicit substances-- is strongly correlated with polysubstance use, major depressive episode, serious mental illness
      - Need to screen for all substances as well as mental health issues, *and* treat all co-occurring disorders
    - The large gap in treatment need continues among women (NSDUH, 2018)
    - Despite these facts, providers tend to miss signs of addiction and mental health concerns, especially in older women and younger females



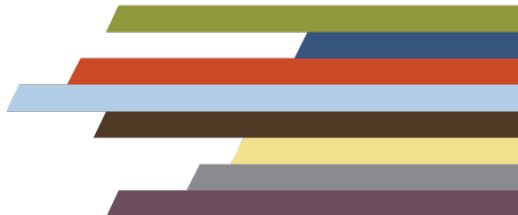
Stigma IS Different for Women with SUD

- **Gender Specific Sensitivities**
  - **Motherhood**
    - Includes pre-conception, pregnancy, postpartum (first year after delivery) and beyond
    - As many as 70% of women entering addiction treatment have children AND primary responsibility for children
    - Family responsibilities can interfere with regular attendance in treatment sessions
    - May be more hesitant to seek treatment for fear of legal action and social service involvement



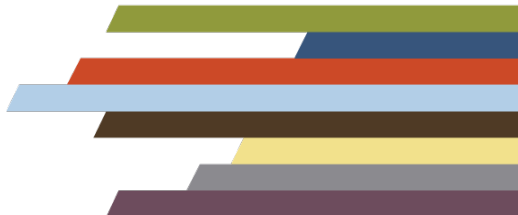
Mothers and Stigma

- Pregnant women with SUD are increasingly stigmatized and prosecuted for their substance use, leading to financial, emotional, and legal consequences in this population
  - Stigma disproportionately noted among poor women and women of color (Chou et al., 2018).
- After pregnancy, mothers with SUD continue to perceive stigma from
  - Healthcare providers
  - General public
  - Loved ones
  - Themselves
  - Addiction community (Frazer, McConnell, Janssen, 2019; Paterno, Low, Gubrium, Sanger, 2019)
- What about preconception period?



Stigma, Cultural Sensitivity and Health Care

- Each health care interaction occurs in context of three cultures
  - Healthcare **provider's** lived experiences
  - Experiences of **person** seeking care
  - Culture of healthcare **system** itself
- Wide variations in attitudes, beliefs, behaviors, exist among all individuals
  - This includes bias
  - This includes stigma



Now Consider This…

If a mother seeks treatment for SUD or discloses her SUD during her pregnancy, she may, at a minimum, have the following perinatal interactions

- Prenatal visits: 9
- Labor and delivery stay: 2 days
- Postpartum visit: 1

AND

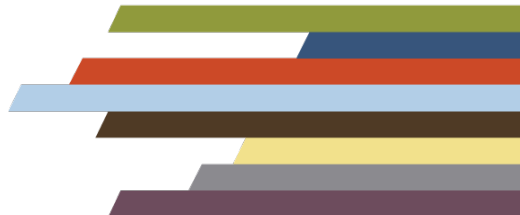
- Remember, each interaction occurs in a context of three cultures

THEREFORE

- She may potentially face at least **36 negative stigmatizing experiences** from routine care **ALONE!**

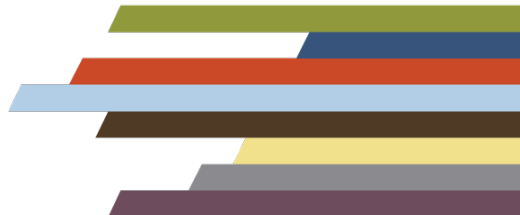
AND

- This doesn't include interactions with family, friends, colleagues, the addiction community, behavioral health professionals AND the subsequent encounters that she may occur over the first year postpartum, i.e. newborn/pediatric appointments, WIC visits, family planning visits



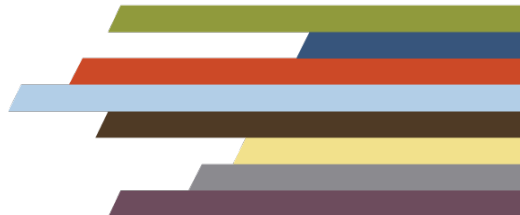
Five Types of Adverse Encounters

- Mothers with SUD may experience the following encounters (Renbarger, Shieh, Moorman, Latham-Mintus, & Draucker, 2019)
  - **Judgmental**
    - Sense providers' disapproval of SUD
    - "Look down on them"
    - Sense blame when infants experience withdrawal symptoms
    - Feelings of shame, frustration, irritation and dismissed during visits
  - **Scrutinizing**
    - Feel closely observed or monitored
    - Identified as "Drug User"
    - Causes mothers to avoid prenatal care, lie about SUD, use other women's urine for drug testing
    - Feel watched for indications they were "high" when holding infants, visiting NICU, breastfeeding
    - Feel questioned about ability to mother
      - Inhibits mother-infant bonding



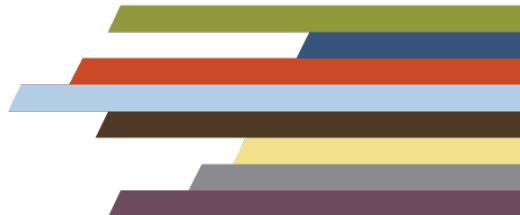
Five Types of Adverse Encounters

- **Disparaging**
  - Overt critical behaviors
  - Experience eye-rolling, name calling “Addict,” “Junkie Mom,” “Methadone Mom” told to “Get their life together”
  - Whispering
  - Results in sense of low self-worth
- **Disempowering**
  - Cause mothers to feel like they have little or no control over own health and infant’s health
  - Don’t feel believed, listened to or feel like health concerns taken seriously
  - “No voice” in healthcare decisions, type of SUD treatment
  - Frustration and anger



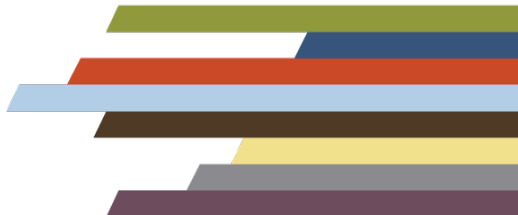
Five Types of Adverse Encounters

- **Deficient care**
  - Mothers often feel they receive lower quality of care because of substance use
  - Feel they are not provided with adequate health information
  - Lack of time during visits secondary to SUD
  - Causes mothers to discontinue care
  - Mothers desire **MORE** information about SUD in pregnancy, SUD treatment options and breastfeeding



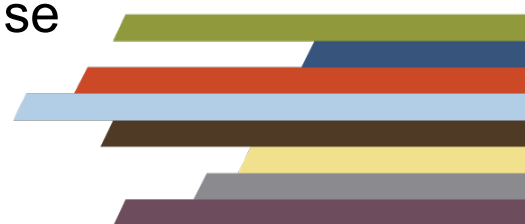
Other Forms of Stigma

- **Mislabeling**
  - “Crack babies” and “Junkie mom”
- **Misinformation**
  - “Babies are born addicted”
    - Infants may experience withdrawal symptoms maternal substance use and abuse, BUT they are not born addicted.
    - American Society of Addiction Medicine describes addiction as a “treatable, chronic medical disease involving complex interaction 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.” (ASAM, 2019)
      - Does a baby really have these experiences?
  - MOUD should not be used during pregnancy/ breastfeeding
    - Our best evidence reports safety of use in the perinatal period



Other Forms of Stigma

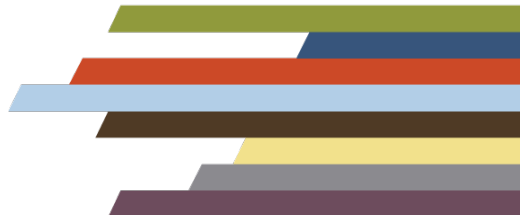
- **Media**(Avery & Avery, 2019)
  - Most Americans get health information from news media, social media, public information campaigns
  - **Agenda setting**
    - Topics receiving high levels of media attention likely perceived by public as priorities for intervention
    - Focuses attention on topics likely to generate/mitigate stigma toward a population
      - Illicit drug use typically receives more media than alcohol/tobacco
      - Stigmatizing attitudes greater toward people who use illicit drugs
  - **Framing**
    - Emphasizes certain aspects of an issue over others; influences how public views that issue
      - Consequence framing: Emphasizes consequence of problem of interest over others
        - FAS/FASD campaigns: Highlight consequences of alcohol use on fetus; rarely mentions maternal impact
        - Drug epidemic: Children left without parents



Other Forms of Stigma

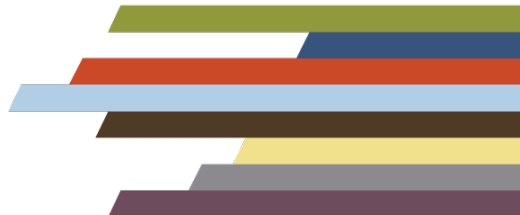
- **Punishment**
  - Forced detoxification from treatment with MOUD
    - Women are already more likely to discontinue MOUD during postpartum period than pregnancy
  - Incarceration during pregnancy
    - Guttmacher Institute: Substance Use During Pregnancy:
    - 23 states and District of Columbia consider substance use in pregnancy child abuse, 3 as grounds for civil commitment (as of 3-1-20)

    https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy
- **Devaluing maternal relationship with child**
  - "Saving" the vulnerable infant from the "harming mother"; restricting participation in initial infant care (Frazer, McConnell, & Janssen, 2019)



Consequences of Stigma on Women Who are Pregnant/Parenting

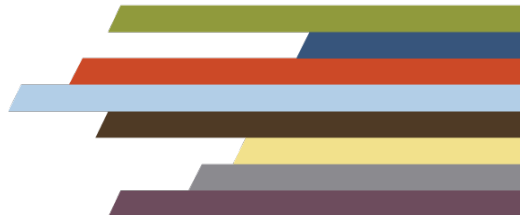
- Poor self-image
- Poor self-esteem
- Shame
- Fear
- Depression/anxiety
- Defensiveness
- Suboptimal prenatal care
  - Direct impact on fetus AND mother
    - Impact growth, miss warning signs for OB complications, lack of emotional support
    - Increased risk of NOT breastfeeding
- Non-treatment seeking
  - NOT engaging in MOUD during pregnancy or breastfeeding; withdrawing early from treatment
- Incarceration
- Death (Frazer, McConnell, & Janssen, 2019)



Access Barriers to SUD Treatment During Pregnancy and Postpartum

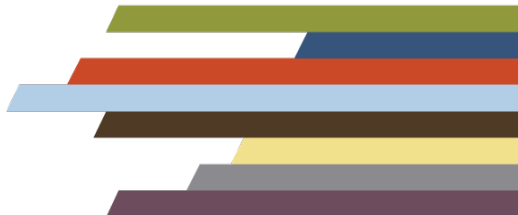
- The act of accessing treatment alone identifies
  - The woman as having a SUD AND
  - Infants/children that are potentially substance-exposed

- In addition to Stigma:
  - Lack of access to gender-specific care
  - Limited child-care availability at treatment facilities
    - Not wanting to leave children or a partner at home
    - Minimal access to transportation or childcare, limited availability on housing units
    - *Attendance and retention best predictors of treatment success
  - Few providers with OB and addiction treatment expertise
  - Fear of criminal or child welfare consequences
  - Perinatal period is actually a very short period of time to receive services
    - Wait times to access



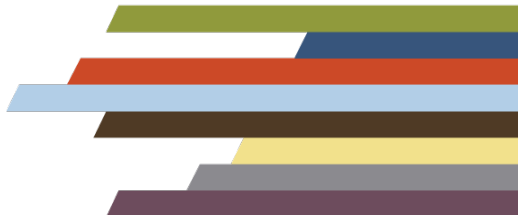
“The way a mother experiencing Perinatal Substance Use Disorder is treated, and her view of herself as being a capable (or incapable) mom, will impact how her relationship and attachment with her baby develops.” (MAIMH, 2017)

We have work to do!



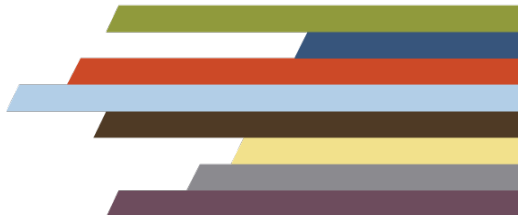
How to Affect Change

- **Language Matters**
  - Terms like “Substance Abuser,” “Addict,” “Alcoholic” and “Opioid Addict” are associated with negative bias and should not be used
  - View addiction as a chronic disease, not a moral shortcoming
  - Terms like “Recurrence of Use” and “Pharmacotherapy” have more positive benefits.
    - MOUD vs MAT
  - Nonbiased language in health care encounters with women with SUDs matters
- **Education**
  - Present factual information
  - Correct MIS-information
    - Rethink Public Service Announcements
  - Increase training for health care professionals (Merrill & Monti, 2015)



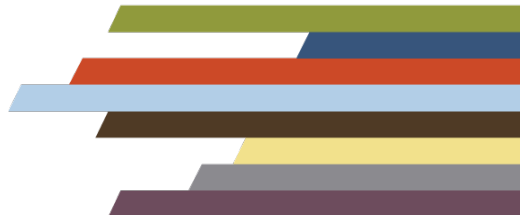
How to Affect Change

- **Improve interprofessional communication**
  - Perinatal health care providers may not be well-informed about addiction and substance use treatment
  - Recovery professionals may not be sensitive to women's unique needs during pregnancy and postpartum
  - Need for health systems to provide well-coordinated integrated care
    - Women with SUDs who participated in integrated care more likely to receive prenatal care, less likely to give birth prematurely
    - Integrated care includes services for pregnancy, parenting, or children in combination with substance use treatment in one setting (Tarasoff et al. 2018)



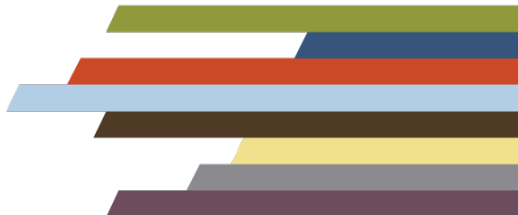
How to Affect Change

- **Pregnancy** provides a **“WINDOW of OPPORTUNITY”** to engage in treatment and recovery (ACOG, 2017;Terplan, McNamara, Chisolm, 2012; Terplan & Minkoff, 2017)
  - Be open and transparent about testing and reporting requirements
  - Universal screening
    - Drug testing done with consent of the pregnant woman; understand right to refuse testing
    - Consider screening for substance use through self-report
  - Consider peer services, group prenatal care programs
    - Peer support can be a counterbalance to discrimination, rejection, isolation that may sustain longer term and more regular treatment utilization



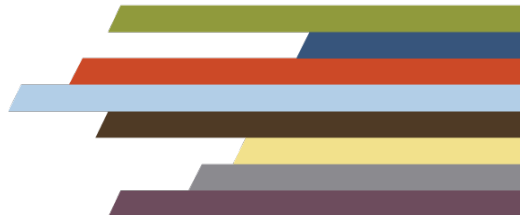
How to Affect Change

- **Need for Gender-Responsive care options**
  - Most treatment and recovery for women has been programmed around pregnancy
  - Also should address gender specific needs outside of pregnancy
    - Trauma history: IPV, sexual trauma and victimization
    - Housing support
    - Income support
    - Contraception
      - Women spend an estimated 5 years of life trying to conceive, pregnant, immediately postpartum BUT 30 years trying not to get pregnant!
      - Include family planning in treatment and recovery!



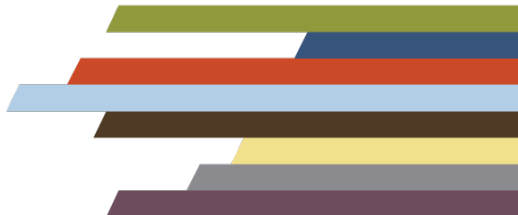
How to Affect Change

- **Legislative and Policy Change**
  - Punitive laws/actions against pregnant women can serve as barriers to trusting patient-provider relationship
  - 19 states have created/funded drug treatment programs specifically targeted to pregnant women
  - 17 states and District of Columbia provide pregnant women with priority access to state-funded drug treatment programs.
  - 10 states prohibit publicly funded drug treatment programs from discriminating against pregnant women (Guttmacher, 2020)
  - Many women lose public health insurance coverage during postpartum period
- **Remember the Impact of Co-Occurring Disorders**
  - Treat co-morbid behavioral health disorders before, during, post-pregnancy
    - ~30% or pregnant women enrolled in SUD treatment screen positive for depression, ~40% report postpartum depression
    - Quality treatment options consider quality of life for mother too



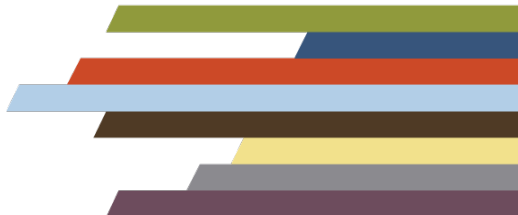
How to Affect Change

- **Promote Health**
  - The World Health Organization has defined health as not merely the absence of disease, but the presence of optimal social, psychologic, and physical well-being
  - “Prevention and treatment interventions should be provided to pregnant and breastfeeding women in a way that will prevent stigmatization, discrimination and marginalization, and promote family, community and social support, as well as social inclusion”
- **Empower Women to be Partners in Healthcare**



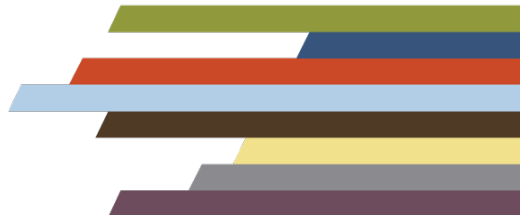
Yes, the Stigma is Real…

But so is the Opportunity to Impart Change and Support Pregnant and Parenting Women with SUD



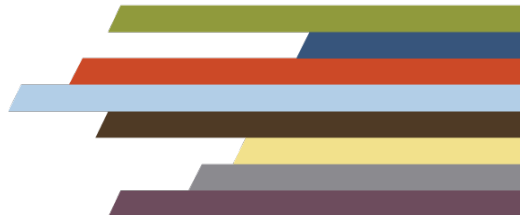
References

- American Society of Addiction Medicine. (2019). Definition of addiction. Retrieved from https://www.asam.org/Quality-Science/definition-of-addiction
- American College of Obstetricians and Gynecologists. (2015). ACOG committee opinion 633: Alcohol abuse and other substance use disorders: Ethical issues in obstetric and gynecologic practice.
- American College of Obstetricians and Gynecologists. (2017, reaffirmed 2019). ACOG Committee opinion 711: Opioid use and opioid use disorder in pregnancy.
- American Society of Addiction Medicine. (2019). Definition of addiction. Retrieved from https://www.asam.org/quality-practice/definition-of-addiction
- Colorado Department of Public Health and Environment.(2017). Marijuana pregnancy & breastfeeding guidance for Colorado healthcare providers prenatal visits. Retrieved from https://www.colorado.gov/pacific/sites/default/files/MJ_RMEP_Pregnancy-Breastfeeding-Clinical-Guidelines.pdf
- Chou, J., Pierce, K., Pennington, L, Seiler, R., Michael, J., McNamara, D., & Zand, D. (2018). Social support, family empowerment, substance use, and perceived parenting. Competency during pregnancy for women with substance use disorders. *Substance Use & Misuse, 53*(13), 2250-2256. doi: 10.1080/10826084.2018.1467456
- Frazer, Z., McConnell, K., Janssen, L. (2019). Treatment for substance use disorders in pregnant women: Motivators and barriers. *Drug and Alcohol Dependence, 205*. doi: 10.1016/j.drugalcep.2019.107652.
- Guttmacher Institute. (2020). Substance use during pregnancy. Retrieved from https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy



- Michigan Association for Infant Mental Health. (2017, April 6). The infant crier. Retrieved from http://infantcrier.mi-aimh.org/perinatal-substance-use-an-update-and-reflection-on-the-importance-of-relationship/#respond
- Merrill, J. & Monti, P. (2015). Influencers of the stigma complex toward substance use and substance use disorders. Retrieved from https://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170043.pdf
- National Academies of Sciences, Engineering, Medicine. (2016). Ending discrimination against people with mental and substance use disorders: The evidence for stigma change. Washington, D.C. The National Academy Press
- Normile, B., Hanlon, C., & Eichner, H. (2018). National academy for state health policy. State options for promoting recovery among pregnant and parenting women with opioid or substance use disorder. Retrieved from https://nashp.org/wp-content/uploads/2018/10/NOSLO-Opioids-and-Women-Final.pdf
- Paterno, M., Low. M., Gubrium, A., Sanger, K. (2019). Mothers and mentors: Exploring perinatal addiction and recovery through digital storytelling. *Qualitative Health Research, 29*(4), 545-556. doi: 10.1177/1049732318777474
- Recovery Research Institute. (n.d.) Special topics and resources: Women in recovery. Retrieved from https://www.recoveryanswers.org/resource/women-in-recovery/
- Renbarger, K., Shieh, C., Moorman, M., Latham-Mintus,K., & Draucker, C. Health care encounters of pregnant and postpartum women with substance use disorders*. Western Journal of Nursing Research*, 1-17. doi: 10.1177/0193945919893372

- Substance Abuse and Mental Health Services Administration. (2019). 2018 national survey on drug use and health: Women. Retrieved from http://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases
- Substance Abuse and Mental Health Services Administration. (2018). Treatment episode data set (TEDS) 2016. Retrieved from https://www.samhsa.gov/data/sites/default/files/2016_Treatment_Episode_Data_Set_Annual_Revised.pdf
- Substance Abuse and Mental Health Services Administration. (2009). Treatment improvement protocol (TIP) series, No. 51. Chapter 7: Substance abuse treatment for women. Addressing the specific needs of women
- Tarasoff, L., Milligan, K., Le, T., Usher, A., Urbanoski, K. (2018). Integrated treatment programs for pregnant and parenting women with problematic substance use: Service descriptions and client perceptions of care. *Journal of Substance Abuse Treatment, 90*, 9-18. doi: 10.1016/j.jsat.2018.04.008
- Terplan, M., McNamara, E., Chisolm, M. (2012). Pregnant and non-pregnant women with substance use disorders: The gap between treatment need and receipt. *Journal of Addictive Diseases 31*, 342-349. doi: 10.1080/10550887.2012.735566-
- Terplan, M. & Minkoff, H. (2017). Neonatal abstinence syndrome and ethical approaches to the identification of pregnant women who use drugs. *Obstetrics & Gynecology, 29*(1), 164-167.



- Worth the Watch
  - YouTube: Dr. Mishka Terplan, MD, MPH -- “Gender & Use, Misuse, Treatment and Recovery” (May 17, 2017)

    Dr. Mishka Terplan talks about how developing addiction to opioids and other drugs vary across gender, and how those expectations impact the conception of treatment and stigma around use. Dr. Terplan is a Professor of Obstetrics and Gynecology and Psychiatry and the Associate Director of Addiction Medicine at Virginia Commonwealth University. The From Research to Recovery Town Hall brings together speakers from across the country to address mental health, substance use and other facets of behavioral and emotional health.

- Investigation
  - Substance Use Stigma Mechanism Scale (SU-SMS)
  - Laramie R. Smith, PhD and Valerie A. Earnshaw, PhD (co-developers)
    - Smith LR, Earnshaw VA, Copenhaver MM, Cunningham C. Substance use stigma: Reliability and validity of a theory-based scale for substance-using populations. (2016). *Drug Alcohol Depend 162*, 34-43. doi: 10.1016/j.drugalcdep.2016.02.019

    https://www.ncbi.nlm.nih.gov/pubmed/26972790