

Supporting Families Impacted by Substance Use Disorders

Sangeeta Parikshak: Hello everyone, and welcome to the Head Start Heals Office Hour series. My name is Sangeeta Parikshak, and I'm the behavioral health lead at the Office of Head Start. The focus of Head Start Heals is to discuss how early childhood programs can promote resilience and wellness for children and families.

The office hours we are hosting is to help address questions, staff, and early childhood programs are asking related to addressing specific adversities the children and families that they serve are facing. As we know, the current pandemic is creating even more concern for the welfare of our most vulnerable populations.

One concern that has been raised by many of you is how to address substance use and substance use disorder, particularly during a time when the only connection we may have with our families is a virtual one, and that is what we will be talking about today. I am pleased to be joined by my colleagues from the National Center on Early Childhood Health and Wellness, Neal Horen, and Amy Hunter. The center is jointly administered by the Administration for Children and Families, Office of Head Start, in partnership with the Office of Child Care and the Health Resource Services Administration, Maternal and Child Health Bureau.

We are also very fortunate to have three physicians with us today who are on the frontline working with children and families. We thank you for your service, particularly during this time and are grateful that you could be on with us today. Some of you may already have heard Dr. Stephen Patrick speak. He is an old friend of Head Start Early Head Start, and if you haven't had a chance, please view the webcast he did for us on "Optimizing Outcomes for Pregnant Women and Infants Affected by the Opioid Crisis."

You can find that on the Early Childhood Learning and Knowledge Center website, or the ECLKC. Dr. Patrick is the director of the Vanderbilt Center for Child Health Policy, and associate professor of Pediatrics and Health Policy at Vanderbilt University School of Medicine, and an attending neonatologist. His National Institute on Drug Abuse funded research focuses on improving outcomes for opioid exposed infants and women with opioid use disorder, and evaluating state and federal drug control policies.

He previously served as senior science policy advisor to the White House Office of National Drug Control Policy, and has testified about the impact of the opioid crisis on pregnant women and infants before committees in both the U.S. House of Representatives and the U.S. Senate. Thank you for being on with us today, Dr. Patrick, and for bringing along two of your amazing colleagues. Dr. Jessica Young is an obstetrician, gynecologist, and addiction medicine specialist. She is an associate professor at Vanderbilt University Medical Center in the Department of Obstetrics and Gynecology.

She pioneered the Vanderbilt Maternal Addiction Recovery Program, which is an outpatient addiction treatment program for women that integrates substance use disorder treatment with prenatal postpartum care and primary care. She's the state physician lead for the Tennessee initiative for Perinatal Quality Care Opioid Use Disorder and Pregnancy Project. Board certified

in both obstetrics, gynecology, and addiction medicine, she has spoken regionally and nationally on the issue of substance use disorder and pregnancy, and as an advocate for pregnant women and their families. Thank you so much for joining us today.

Dr. Lauren Jansson is a professor of pediatrics at Johns Hopkins University School of Medicine. She is a developmental pediatrician and has been the director of pediatrics at the Center for Addiction and Pregnancy, a comprehensive treatment program for pregnant and parenting women with substance use disorders since the program's inception in 1991. In that capacity, she provides comprehensive health care and developmental assessment to substance-exposed infants, children, and adolescents in the context of maternal addiction and mental health concerns in the often difficult environment in which the mother and child reside.

Dr. Jansson is also a researcher with a primary focus in exploring the effects of in-utero exposures to opioids and other substances on the developing fetus and infant, neonatal abstinence syndrome, optimizing treatment for women with opioid use disorders, and lactation among women with substance use disorders. We certainly have an all-star cast and we look forward to hearing from you today. Just a few housekeeping tips before we get started today. We really want to hear from you, so please use the "Ask a Question" feature to submit your questions and we will try to answer as many questions as we can.

You can also download a PDF copy of today's presentation by clicking on the "Event Resources" tab at the bottom of your screen. A recording of this webinar will be posted on the Office of Head Start's website, the ECLKC, on the Head Start Heals page. We will provide you with that website at the end of the presentation today.

You can also use the webinar link that you used to join this broadcast to watch the recording again until June 15. Participants will receive a certificate for attending this webinar at the end of either the live or on-demand viewing, so please stay on until the end to receive your certificate. Once again, thank you so much for joining us today for our office hour on "Supporting Families Impacted by Substance Use Disorders." I will now turn it over to Neal Horen to facilitate the discussion for today. Thanks Neal.

Neal Horen: Sure. Thanks, Sangeeta. So, I'm super excited. We've come up with at least some of what we think are the most commonly asked questions. We obviously want you, and encourage you, to put in the Q&A questions that you have. We will do our best to try and sort through, figure out which ones to add to the list here or sort of get to them as they come in.

As we were waiting to come on, we were all chatting, you know, Stephen tells me about people were, "I just came off the unit," and people are talking about, "I was with this," and I was like, "Oh boy, we've got like real doctors; this is serious." And then, they started talking about, "My husband might interrupt us." "I got a dog," and I was like, "Oh OK, we're good." Everyone's going to have the same experiences as I'm having, when somebody's going to walk in here and say, "Can you put my glove on or something?"

So, let's get started. We've got a lot to get to, and, I think folks, as I see in the Q&A are already asking lots of really good questions, but we'll start with these and maybe we'll start, Lauren, with you on the first one and then, Stephen, Jessica, feel free to sort of jump in if you want to add. But, you know, we hear this question a lot about, "How is COVID impacting families who

are already impacted by substance use?" And so maybe, Lauren, you could share some thoughts on what you think about that.

Lauren Jansson: Sure, sure I can. Hi everyone. It's my pleasure to be here, so thank you so much for the invitation. I can certainly tell you how COVID is impacting the families that I see. Remember, I'm a pediatrician and I work in a substance use disorder treatment program, so I can tell you what I see, but I can imagine that some of these things are going to be familiar to the other presenters and to all of you.

So, the first big thing that I'm seeing is that mothers are not in active substance use disorder treatment right now because the programs are closed, so this loss of structure for women, being confined to neighborhoods that they've lived in during their times of active substance use, these can lead to cravings and relapses and increased drug use, especially I'm finding, with THC, which can be a gateway to another drug use. Almost all of the mothers that I see with infants and children are reporting this right now.

Pregnant women who would normally come to my center for care are not accessing treatment for fear of infection, especially when they're pregnant, so these women are continuing to use substances, not getting prenatal care. They're not getting therapy, they're not getting nutrition and other services. Mothers that are not receiving psychiatric care now are not able to get psychiatric medications. This can cause problems with increased psychopathology. No obstetric care means undetected fetal concerns; no contraceptive care means unwanted pregnancy, so this whole lack of care has a big impact.

The other thing that I'm seeing quite a lot of is increased intimate partner violence. I understand you've just had a webinar on this, so I won't belabor it, but I also see mothers becoming abusive partners during confinement. I think this can lead to dangerous situations for mothers, for pregnancy, and for children who might witness this or become inadvertent victims of violence. In addition, families are losing contact with supportive or other healthy context through isolation, or death.

So, we have a lot of grandmothers that provide support for mothers, parenting guidance. They provide food for the family. These families are not in contact with those supportive people right now. This is destabilizing for some women. Isolation can cause lack of supply, [inaudible] unhealthy diets contributing to obesity or malnourishment. I have one mom who's telling me that her daughter's struggling with obesity, is now back on a diet of chicken nuggets and french fries, because she can only go shopping once a month. She can't get vegetables, and this is all that she can get to last the child through the month.

Fathers are out of work; this can trigger substance use. Paternal use can trigger maternal use. Parents working can expose children to the COVID infections, and I will kind of say, as an aside, we used to think this virus didn't affect children very much, but now we know there's actually a very significant pediatric illness related to this infection. Courts are closed; pending legal actions are causing stressors for families. Adoptions are on hold, so children are in foster care for longer than they had been previously.

Moms are not turning in on warrants, leading to problems with prolonged, suspected prolonged incarceration once they leave and do turn in, especially, if they're not able to provide

evidence of treatment right now. And for the children, infants who were opiate-exposed can have neonatal abstinence syndrome, and if we have moms without support, dealing with neonatal abstinence syndrome in the community, moms can make poor decisions and can cause child harm. Children with NAS can still have significant symptoms after the hospital discharge, and now the moms are dealing with this on their own. Homeschooling has provided problems.

Teens are taking risks; no early intervention services right now, so children with developmental disabilities are not having them addressed very well. And I will say, kind of, finally, the problems that I'm seeing aren't really restricted to children and families. We, as providers, are also struggling to find new ways to treat families without the usual support. It's difficult to address all of these many concerns, especially from one angle, like pediatrics or obstetrics, and that can lead to stress and burnout for all of us. And I can tell you with all certainty that I've seen all of these issues, even in the last two weeks in the families that I take care of.

Stephen Patrick: I just want to weigh in, too.

Neal: Go ahead, Stephen.

Stephen: Well, the one thing that I see too, you know, this is sort of jumping off with what Lauren just said, is I think the stress of everything is affecting everyone, and I think, you know, we see that in staff, too. I think we see that in ourselves in the way we approach things, too. I think there are, this is a stressful time for everyone, and I think sometimes giving ourselves a little bit of grace and a little bit of knowledge that this is a hard time on everyone.

And I see that in staff in ways that, you know, I think folks are a little bit more quick to react sometimes, and I think just being mindful of, you know, not only is it affecting our patients, but it's also affecting each one of us; it's affecting the folks that we work with, too, and I certainly see that playing out in our settings as well.

Neal: Well, so to that, and any of you can answer this or just private message me: "Why did you ask me that really hard question?" But one of the questions that's come through here is about, somebody who asked, "I've had several moms who have relapsed during their pregnancy, especially during this — this COVID-19 crisis." Are there ways to perhaps recognize things, the precursors, that, you know, well, we're talking about families impacted this is a very specific way, but I'm wondering if you all have any thoughts about that.

Jessica Lauren Young: Hi, this is ... Sorry, go ahead, Lauren.

Lauren: No, no, go ahead, Jessica.

Jessica: Yeah, so I would say that making, putting it out in the open that, and really normalizing that relapse is common right now, and because what I'm seeing is moms who relapse and then have a lot of guilt about relapsing and then kind of go into this shame spiral. But what we want is we want them to re-engage and to take advantage of the resources that they do have. So, we've been doing a lot of education about relapse and the risk of relapse and prevention before the relapse happens.

But then, if the relapse happens, making a very concrete plan on how to get them re-engaged, helping them to access the virtual meetings that are out there, helping them to access our

virtual services that we have available, making sure that, if they are feeling isolated, that they have peer support. Because although it is very challenging right now to get services, there are services that are available, and so making sure that women are aware of that and helping them to cope and recognize the stress that they're under.

I'm finding a lot of moms and patients are often surprised at their own kind of emotional stress reaction to what's going on right now, and thinking that, "Oh, I'm not directly affected by COVID. This isn't really impacting me." But I think it is impacting all of us, regardless of how direct our exposure is to working with patients or people with COVID or not.

Neal: Thanks Jessica. Lauren, did you want to jump in there?

Lauren: No, I think that was a really comprehensive answer. The only thing I would, might add to that is that I think we can safely assume that all women are having at least cravings right now, so to address that up front to prevent relapse is something that we're working hard to do with a lot of our mothers.

Neal: OK. Great. So, I'm going move us to the next question, and I want to sort of bridge here a little bit, because I think that when we talk about substance use, when we talked about interpersonal violence and some of the issues we've been bringing up, that these are heavy issues. They are, sort of, we can paint a very grim picture and it seems to us, and certainly in the work that we've done with Stephen and others, there's oftentimes more positive or things that you've sort of seen that sort of surprise you in a time like this, and I'm wondering if any of you have, sort of, had some experience that you're like, "You know what all this other stuff going on, what a great thing.

This is the thing I came home and told my — my significant other about, or this is, you know, if I was that, if I was allowed to leave my house, this is what I would tell somebody about." And before somebody answers. I know somebody in the Q&A had asked about NAS, which is neonatal abstinence syndrome, we just wanted to sort of clear it up. I know sometimes we're throwing acronyms out. So, keep asking those questions, folks, if something comes up and you're like, "Well, what did they say? What does that mean?"

We'll try and make sure ... I'll have the real doctors actually answer it, but that one I actually knew. So, but folks, you know, any of you, anything surprised you, anything really positive that you've seen?

Lauren: So for me, this is ... Sorry,

Jessica: We do that a lot. Go ahead.

Neal: I'm going to go Lauren, and then Jessica. Go ahead Lauren.

Lauren: OK, so for me, one really good thing I've found in all of this is that I'm using telemedicine now, which I thought I would really dislike, but I actually really like it and enjoy it. It is a new platform to connect with families. It's easy; I can connect with them more often. I'm seeing families a few times a week now who are really struggling, and it gives kind of a unique access to the home for other family members in natural settings.

So for example, I have one woman who I was seeing with her infant and I noticed her 4 year old, who isn't in my care, was really struggling with some behavioral issues, so we can kind of turn to address his care. He's now coming into care with me and we're addressing his behavioral issues, so it gives you an opportunity to see things in a little bit of a different light, and I can see families with more than one provider.

So, I have a parenting coordinator that I work with and she and I can see families together, and that's often very appreciated by the moms that we see. So, I think that, so staying in contact and being able to kind of seek help for — having parents seek help for issues with parenting and development, seeing them weekly, I think has been a really positive thing that's come out of this.

Neal: Great. That's good.

Jessica: I would echo the telemedicine, increased use of telemedicine just really across the board. I know in my health care system, we, and in particular in our, [inaudible] program, we have really wanted to use more telemedicine and make that a service that's available to people for a while now, and there have just been barriers and all sorts of things, but I think that's the silver lining, too. COVID for us is that it has forced us to really ramp up and move into telemedicine very quickly, and because of some of the changes in DEA restrictions with doing consults for medication-assisted treatment over telemedicine, that's allowed us to give access to people, particularly people who live in a very rural environment and are having a lot of trouble getting in to see us to be able to do that first visit with them in their home. That's been a really great thing.

Also, being able to see patients in their home, virtually, has really given me and my team a real insight into the situations that people are finding themselves in, and we really find that it's helping us get a better understanding and develop better plans of care, just by having that little visual glimpse into their — their living situation. And then we've also found, patients are just doing really surprising things, making masks for each other, doing other projects, really — really kind of coming together and supporting each other, and so that that's been pretty amazing to see, too.

Neal: And Stephen, I know nothing has ever surprised you, but maybe — maybe there's been something super surprising or positive that you've seen.

Stephen: Yeah, you know, I'm a neonatologist, so I spend my time in the NICU unit, and I would just say like, this may not be as like patient-centric, but the, how quickly folks rallied to do things, to set up contingency plans, the teamwork that was involved in that I think has been pretty extraordinary. And then, I've also seen our staff advocate for families in ways that I think, you know, in NICUs oftentimes they're advocates for families, but things like, you know, bucking visitation and stuff like that.

I probably shouldn't say that on a recorded line, but when we, when it needed to happen, it happened. And I'm just also reflecting a little bit on, you know, we had our, one of our meetings yesterday with our team that cares for opioid [Inaudible] in the hospital, and part of what we've been doing is calling families to check in after they go home and, you know, hearing some of the stories of how people have felt empowered, just in general.

I think that continues now, too, families being empowered to, in the hospital, to be engaged in care. When we do things that are, you know, normalizing, trying to fight stigma, trying to engage people, trying to keep moms and babies together, do those things, people respond to it and they feel empowered. And I have to say like yesterday, my most inspiring thing that happened yesterday was our meeting together and hearing some of the family comments, even in the middle of this.

Neal: Yeah, and maybe, in some ways that's, you know, that's obviously part of what we want to get across is that, while there are lots of, you know, scary things here, there's also a lot of hope, a lot of positives, shifts I think that have been made, as you all talked about, in terms of the, sort of, the rapid switch that many folks have made to telemedicine.

How then can our folks, right, this is, you know, our Head Start folks, and for some of you, this may be, you know, something that's not as much in your wheelhouse, but we're interested in your thoughts about how early childhood professionals, all the folks who are working in Head Start and Early Head Start, how can they, sort of, support families, given these increased challenges that families are experiencing and that they're experiencing, that they're trying to figure out a virtual world, that they may also be dealing with some of these issues?

How do we, what can the folks, you know, we've got thousands of folks on the phone and I'm sure my mom will listen to this after, but I'm sure some other folks will listen to this recording after what ... They're going to be interested, "What can we do? So, what are some — some of your thoughts on how early childhood professionals can — can support families?"

Stephen: I wonder, Jessica, if you want to talk about some virtual groups. I mean, I wonder about that, the utility of doing that. I mean, I think for none of us, you know, we are not Head Start experts, and so we just see our own — live through our own lens and own the experience. But I do wonder about virtual groups, like you've done in your clinic, Jessica.

Jessica: Yeah, I think that there is a lot of positive that can come from virtual groups, and it's a big opportunity, and of course, our groups are all very focused on medication-assisted treatment and recovery skills.

But I think that there could be all sorts of different topics and focuses of virtual groups, and we had a lot of concern that the virtual group wouldn't have the same interactive quality that our in-person groups have, and I think what we've found is that — that very quickly patients adapted to the virtual nature, and there were some patients who really seemed to thrive more in the virtual realm than they do when they're with us in person.

And that may have to do with their own, kind of, social anxiety, but that virtually is enough of a barrier and being in their safe space that they're opening up more virtually than they have in the past, and I think that there are all sorts of opportunities, virtually, to keep people engaged, keep connections going, and to do some education. And we've also, with our virtual groups, added a, kind of a slideshow and sometimes a video component, which we don't typically do in our in-person groups, and patients have really liked that, and so that, I think that's been engaging different kinds of learning styles, too.

Neal: Great. Stephen, anything else? I know that you just pulled a "Neal" where you don't really answer. You just tell somebody else to answer, but it seems like you answered it. Anything you'd wanted to add?

Stephen: No, no, I'm not — I'm not particularly smart, so I just like to delegate out to the smart people. That's my sort of take.

Neal: That's great.

Stephen: I think we're in this interesting space where, you know, we're seeing technology move forward in ways that we didn't think were possible. I think with even our own thinking about staff, that I think what we're finding is just more frequent check-ins, because I think that, and I wonder if there's a way to virtually do that. I wonder what does EI look like virtually?

I have no idea, but I'd be curious actually, to hear what folks on the call think. But, you know, how can we, how can we endure over the next few months, but then maybe even expand services in ways that we didn't think were possible before. I think that's what we're seeing in medicine with telemedicine overall, and it does make you wonder how that may, how that may impact early childhood education, too.

Neal: Yeah, and it certainly, Stephen, you know, all joking aside, like we, on one of our previous calls in this series, we did talk about sort of the, very elevated importance of the mental health consultants who are a required component of our Head Start work as being very critical here and helping think through all the sort of emotional mental health sorts of issues that may be happening, the stress that's going on, all those kinds of things.

So, I think there, you know, we've had some discussions about this, but I think what you both laid out are super helpful, sort of beginning thoughts for folks, and so, I wonder if any of you could talk to, sort of, a link the partnering Head Start, I mean, there's many strengths obviously, but one of the strengths is how connected oftentimes our Head Start programs are with local community organizations, and obviously, in particular, local sort of community-based health organizations.

So, can you speak a little bit about how these connections might sort of be, sort of come to bear and maybe be helpful at this point? So, I'll now actually formulate a question as thousands of people listen to my brain work, but can any of you sort of talk a little bit about what's the best way to, sort of, take advantage of the fact that Head Start oftentimes has very strong partnerships in the community, particularly with our health organizations?

Stephen: So, I think some of it is making sure that we do things to try to break down the silos that exist and I can just tell you a little bit about what we're trying to do as we're sort of ramping up a new program here that Jessica is also a co-lead of. We're working to sort of both catalog folks in the community.

How can we leverage folks? Because we realize that yeah, we provide a role in the hospital in outpatient settings, but for our families, what really matters is what's in the community, and so we're going through a process of trying to actively engage with not just Head Start, but also other kinds of other programs within the community and be more intentional. We realized, for example, that, you know, look, I'm a pediatrician and I would suspect that there's a good chunk

of pediatricians that don't really understand EI or don't really understand early childhood education programs, so I think beginning to make those contacts, too, maybe, you're, depending upon where you are in the community, your local, federally qualified health center, or if you have a place like the Center for Addiction and Pregnancy, or like Dr. Young's clinic that focuses on pregnant women with opioid use disorder. I think there's an exceptional partnership, in particular, with Early Head Start that could be fostered.

And I think, oftentimes, it's this sort of natural extension that should — it should seem so obvious, and I think things become so busy sometimes and they're just so naturally silent. Sometimes we forget to do that, so I think, for one that was a long-winded answer to say, I think some of it is intentionality and really trying to think through what the actual needs are and how to build those partnerships.

Neal: Yeah, no, I, much smoother than I did, Stephen. But I do think that that idea that the work that folks like all of you are doing ultimately is going to be passed on, right? A family is going to end up being in their Early Head Start, being in the Head Start program in their community, and those, that intentionality I think is such a — such a great word to describe how are we making these connections in a thoughtful, intentional way, so that's super helpful.

Stephen: So, I would just say this, one of the things just like briefly, sorry to like, but we — so we are starting a program that's going to, it's just locally right now, that has some funding to take care of pregnant women with opioid use disorder from pregnancy to one-year postpartum.

And for us, one of the things that's really been, you know, bringing in where the holes are for families, has been just to draw what a patient experience is like, and, you know, it shows you for example, like how small the amount of care that I deliver in the neonatal ICU, like how little that actually matters compared to the work that happens after discharge and where those things are, and I think that process of understanding those connections, at least for us, has been really helpful.

Neal: Yeah, no, great, that's a great sort of addition there, Stephen. OK. I, you know, I think we've gotten a lot of que — I'm gonna keep us moving. I think we could probably talk about each of these for quite some time. That said, I do think that the issue around stigma is a huge issue and we've gotten lots of questions, and so we'll start with this, and then there may be a couple of follow ups here and, maybe we'll go back to Lauren to start, and I'm assuming all of you have lots of thoughts on this, but strategies that you can share, so hopefully they're as concrete as possible, but are there strategies you can share to reduce stigma related to substance use disorders?

Lauren: Yeah, I can talk about that. So, this is something that we think about literally all the time, about confidentiality and about stigma. These are big issues in the treatment world. Pregnant and postpartum women, especially with substance use disorders, report stigma all of the time, and it's usually founded in negative stereotypes and misinformation in the community.

So, we can feel stigma [Inaudible] ... from friends, from family, from themselves, and this feeling can really drive them away from treatment — them and their children — away from

treatment. So for me, I think the way of dealing with this is understanding addiction, not as a moral failing or anything like that, but as a complex, genetic, neuro-biologic and behavioral disorder, [Inaudible] ... you can deal more effectively with it. We have to move away from the overt or sometimes covert assumption that the mother with a substance use disorder is an innate threat to her child, Withdrawal or neonatal abstinence syndrome — sorry, I should have defined that earlier — in an infant, in half, there isn't a treatment program and perfectly compliant with medical advice and never relapses to any substance.

So, I think it kind of starts with finding it inside yourself to understand pregnant parenting women with substance use disorders, particularly those in recovery, as people with this horrible incurable relapsing disease that will last throughout their lives. [Inaudible] ... or to the pediatrician or to a program are women struggling to take care of themselves as mothers who love their children and want to take care of them.

I get a lot of my education about addiction from the mother. I was very unhappy when I started my job at the center. [Inaudible] ... and understand addiction at all, and when I started to talk to the women and really understand where many of them had come from, what it's like to have to work as a sex worker to make money, what it's like to be prostituted by your mother, what it's like to be shot up with heroin when you're a young child by siblings to keep you quiet about sexual abuse, these are all stories I heard and made me understand the women in a much different context.

You know, we also want to really watch our language; that's a very important part of this. Infants with neonatal abstinence syndrome are normal infants with a medical condition. Don't use terms like "NAS baby," "methadone baby," "crack baby." Babies can't be addicted; addiction is a psychosocial construct, that's not an appropriate label for a child, and don't use terms like "addicts" and "junkies;" these are women, or people with substance use disorders. And lastly, you know, don't separate the interest of the child from the family, you know, really denying the interconnectedness of the mother and the child and the family kind of undermines our public health goals of healthy pregnancies and children and families.

Neal: Well, Lauren as my 4 year old would say, "You crushed it." I mean, I think those are lots of really concrete, like the language piece about understanding, you know, sort of a perspective shift and things like that.

Lauren: It's important, especially the language piece.

Neal: Right, yeah. No, I think that that's a really helpful thing for us to be considering in our Head Start work is how do we even think about this? And then, not just, how do we talk to the family, a caregiver, a child, but how do we just all in general, even when we're behind our closed doors in our staff meeting, are we using the language that sort of fosters understanding, I think is such a helpful strategy to reduce stigma. That's super helpful. I'm going to go to Stephen next. Hopefully. Oh no, he's ready. All right, Stephen.

Stephen: Yeah. So, I was going to just echo on the language piece a little bit and we see it all over the media. We see it so many places, you know, using person first language, people are not defined. You wouldn't go into a room and say, you know, that diabetic or that diabetic baby, and I think that's such an important piece. I just wanted to share something briefly. We,

this has been something that sort of "born addicted" thing is something that just drives me crazy, and as Lauren said, you know, I've never seen a baby that has withdrawal go from nurse to nurse to nurse to get more morphine.

Addiction is a psychological phenomenon. It is not — it's not only just incorrect, but it also is stigmatizing. We put out a poll in Tennessee, it's part of the things that some of the work our centers doing. We randomized people to getting a vignette that had stigmatizing language, so an, "opioid addict and the baby was born addicted," versus seeing "opioid use disorder and the baby had withdrawal," and I really expected to see a big difference, and I actually didn't.

We didn't see a huge difference and we didn't see a huge difference because the stigma was so pervasive. When we gave people an option of, "Should a mom be arrested and the baby be placed in foster care," or "Should the mom not be arrested, but the baby be placed in foster care," or, "Should the mom not be arrested and the baby be allowed to return home." It was about a third, a third, a third, so even if you had the vignette of a mom with opioid use disorder and a baby who had withdrawal, that's kind of like, that could be the person that Lauren was talking about. It could be in long-term recovery for 10 years.

A third of people still thought that woman should be arrested. I mean that's extraordinary, and I think part of the work of the group just collectively is to talk about this and keep it out in the open and to talk about someone not being defined by their disease, that this is a chronic relapsing condition. There are other chronic relapsing conditions, diabetes is one, and I have to tell you, I see far more complicated problems from uncontrolled diabetes in the neonatal ICU, than I see from opioid use disorder, and we just don't frame it the same way. In some ways, we actually celebrate it.

We celebrate the 15-pound baby in the press, and it's almost always an infant of a diabetic mother. And I think we — we really do have to check ourselves and understand what is our role in fighting stigma with the way we treat people, with the way we — we use our language as well.

Neal: That's great, and I think Stephen, before I know Jessica is going to jump in, but I do think this ties in really nicely. This whole campaign Head Start Heals has really been about how do we sort of come at this from a trauma-informed lens? And the idea of asking not what's wrong with you, but what's happened to you.

They obviously, the Office of Head Start has put a huge emphasis on us really moving our Head Start world to thinking like that, and all of what you and Lauren have already laid out has sort of been exactly that, which is: There's not something wrong with somebody, something happened, and if we understand and have a frame of reference, as we've been talking about in this series of Head Start Heals calls, it really changes our perspective and allows us to approach our work with families and staff and children in a very, helpful trauma-informed way. So, I don't want Jessica to lose her thoughts. I'll come to you next, Jessica.

Jessica: Yeah. Thanks. I think along those lines, having some — having women tell their own stories really humanizes addiction, and I think it's harder for people to put people in a box or think of people in a very simplistic, good-versus-bad kind of way, if they hear their story, hear what brought them to this place in their life, hear their triumph, hear their success. And so,

finding women who want to tell their story and are, want to share that part of themselves can be really helpful with that. We use that in our teamwork groups. We use it with our state perinatal quality collaborative in hearing people's stories, because, I think, ultimately what stigma it does is it decreases access to care and services.

Both it decreases the types of care that are available to people. It decreases the resources that society is willing to spend on a particular patient population and also decreases access by internally causing people to feel shame and not want to access care. And ultimately that's discrimination, so I don't think any of us want to perpetuate that. And I think individually we can name it when we see it.

When we see stigma and discrimination, we can name it for what it is. We can call it out in a gentle way, in a teaching way, but help people to reframe and to use language that is supportive and not undermining.

Neal: So, I want to build on this just, 'cause we've seen a lot of comments here in the Q&A, and I love that you all are participating so much today. We have talked a lot. I know, I think Lauren maybe alluded to this once or twice and maybe the others did, too. We talked a lot about moms, and I haven't heard dads talked about a lot, and about, as we're sitting here talking about stigma, I'm wondering, I've seen lots of questions here about, "How do we address the issue that men may also be using? May also have misuse?" What's the impact on, in terms of that?

What's the stigma around that and how do we sort of — sort of come at that? Are there certain things about this where we've — we have, we spent a lot of time, obviously on, you know, women who are pregnant or have just given birth, but anything about how we deal with — with the men. This is Head Start, and we, you know, we have to deal with everyone, but any thoughts on that?

Lauren: Well, from my perspective, this is Lauren, from my perspective, you know, fathers can certainly contribute to the problems of the family, but they can also be really supportive stabilizing factors for women, so it really depends on the individual family. What you're ... We involve fathers, and I am talking about mothers mostly 'cause I work in a maternal treatment program, but we involve fathers in our family therapy programs all the time. In fact, we seek them out, so when they come, mothers come to treatment, we ask about fathers and we ask if they can be involved in treatment.

So, we feel the same way about fathers that we do about mothers. In my pediatric clinic, I often find if a mom [Inaudible] come in and keep the family together. Conversely, the father can, you know, if he relapses to substance use can destabilize the family. So the father, the audience is right, the father is a very important part of this, in both respects and his care and his contribution to the family should always be respected.

Neal: Thanks. Any other thoughts? I do want to get to this last question, because boy, we've got a lot of questions related to it, but I don't want to cut Stephen or, I don't want to cut you guys off. Anything else?

Stephen: No, I thought Lauren's answer was perfect.

Neal: Yeah. Good. OK. So, last question, and in some ways, it's the last question. It was actually the first question out of the box. Somebody asked about this, and so, I have, you know, I have, "question five, sub paragraph A," like we have a lot of questions. So, we've gotten a lot of questions about, "How do you have a conversation? How do you approach somebody?" and I think like, Tamra just laid it out kind of nicely. "How do you start a conversation with a family that you feel may have this kind of issue going on?" That's, "Do you have any tips or strategies when staff are concerned?"

What's sort of, you're thinking? I have lots of other questions that have come in around that, but let's start with sort of the broad ones around, "If somebody suspects that something is going on, what's a way to start the conversation?"

Stephen: So, I would just say starting out and I'm curious what other folks say, too. Part of it is about relationships, empathy, and trust, you know, what is the relationship, and to that point, is it a safe space to begin to share and have those conversations? I would say that, you know, in our world, ideally, we would universally screen for some of these things, but I think so much of this is about relationship.

I mean, if you just walk into a room with somebody that you don't have a relationship with, or haven't fostered trust and say, "Hey, you know, you having trouble with, you know, using drugs," that's not a conversation that, it may, but it's not going to be the same as building trust over a long period of time.

Lauren: Yeah, I think Stephen's right. So, if you have a trusting relationship, ask if the family needs help, but if you ask that question, make sure of two things: A) that you know how to provide the answer. "So yeah, I'm struggling. What do I do?" And then, B) make sure you're doing it in a confidential manner. We haven't really touched on that very much in this conversation, but you know, maternal confidentiality as having a substance use disorder is something that's important to maintain at all times.

Neal: Well, you're talking to the right audience, right? This is a Head Start. This is the relationship-based like center of the early care and education world from our perspective.

Stephen: Can I just say one quick thing about that? Is that if folks are, you know, it's not a perfect system, but the, if you go to findtreatment.gov, you can enter your zip code, this may be something folks know, you can enter your zip code and it'll identify folks who provide treatment, and on the latest update of this, it also has a breakout — if they take pregnant women, you can't search by it, but it is listed under subpopulations that they will care for. So, if folks need that, that resource is there. It's SAMHSA who puts it out.

Neal: Stephen, I just want to make sure, 'cause this happens a lot. You said find, F-I-N-D treatment, T-R-E-A-T-M-E-N-T.gov, correct?

Stephen: You're asking me to spell which I'm not very good at but, yes, that is correct.

Neal: Me neither, and that's why I'm really nervous that I just spelled something that may have been completely way off, and I've just sent people to some god-awful website. So, I apologize if I did. Yeah. Is it findtreatment.gov?

Stephen: Correct.

Neal: OK. Thanks a lot. Both of us will be fired probably by the end of the day, now. So, I have a couple of follow ups to that because a question that's come in several times is about, "What about if we either suspect or know that a parent is using, what, how do we support the children? What is it that we do?"

So, I don't know if folks have thoughts about that; obviously, you know, we talked about this on our mental health [inaudible] I'm giving you guys a little time to formulate some thoughts, but we did talk about this on our mental health consultation office hours that we did a few weeks back about the critical role of your mental health consultant in supporting your programs. But I'm wondering if any of the three of you have any thoughts about strategy, staff when they're concerned about this, and obviously these are folks who are very concerned about children. Any thoughts on that?

Lauren: So, this is Lauren. So, you know, this may sound trite, but the best thing you can do for a child whose mother is struggling with a substance use disorder is find treatment for the mother. So, you know, it's the most important factor that we can provide for the child's overwhelming [Inaudible] really pretty much bar none, and sometimes I will even bend what is the best pediatric care for the child in being able to maintain themselves in the level of treatment that they need. Sometimes it's intense; sometimes it's not intense. So, my advice is it's all about maternal treatment. It's all about maternal access to care because once moms can do well, then the family, the child and the family can do well.

Neal: Great, yeah, I mean, sort of, and I'm not, yeah, I get you when you say it sounds trite, but it really is like, it is sort of a core of, sort of how we can support that child is to make sure that there's somebody who's going to be available to provide as much support as they can ultimately.

Lauren: It is the bedrock. I mean, I've taken care of substance exposed children, like I said, for 30 years; it is the bedrock of everything that happens to that child. The child's development depends on it. That child's health depends on it, that child's safety depends on it, so it is really the single most important thing that you can do is assure that the well-being of the mother or whoever's providing care. It could be the father I'll say that, but ...

Neal: OK. We did have one question. I'm sorry, Stephen, anything or Jessica on that, because I have one other piece here, if not.

Stephen: Again, I really liked Lauren's answer.

Neal: Yeah. Yeah. No, same. So, so one last question for you for you all and in some ways it is this relationship-based piece, which is, "How do we re-engage somebody if they are experiencing a relapse?" How do we, sort of use a relationship or what can folks do? What are some strategies for sort of re-engaging somebody if they have, especially during this time; that's where I think we started today was talking about this is a tough time.

I think Lauren, when you started with that first question, sort of laying out all the kinds of things that are happening in terms of access to treatment and all the other sorts of things, are there ways that you all would suggest folks can re-engage?

Jessica: This is Jessica. I would say, meeting that person without judgment and with empathy, and then also meeting them where they are, probably not physically in this time of COVID, but if, I think sometimes in addiction, treatment and recovery, we have a lot of kind of rules and, which are important and boundaries are important, but keeping someone engaged in care means I'm not turning them away.

So, like an example in my setting would be: She shows up six hours late for her appointment, we still see her because she's been gone for two weeks and I know she needs that appointment, so ways that we can keep people engaged by decreasing those barriers, whatever they are, I think can go a long way in bringing someone back into care and into relationships.

Neal: Thanks Jessica. Yeah. And I, it does sort of builds on a lot of what you all have talked about today in terms of, how do we speak about this, the language we use, our thought process that sort of, you know, that trauma-informed approach that we keep coming back to around what's happened to you, not what's wrong with you kind-of-thing. So any other thoughts that you all have on this? If not, I'm going to sort of go ahead and give it back over to Sangeeta, but just wanted to sort of see if there's any last thoughts that any of the three of you had.

Stephen: Let me just say, thanks to everyone for the work that they do for kids in communities across the U.S., that they serve such a critical role, and I'm just grateful that you guys are there.

Lauren: Especially now.

Neal: Yeah, well, so, I just want to thank the three of you. I know you're actually really busy, but I also think that not only did you come and answer some questions, but you really thought about this in our Head Start context, in our Head Start Heals campaign context. And it was just, you know, if you listen to all of the office hours and calls and things that have been a part of this campaign, this fits so nicely in terms of how much Head Start brings to the table for this. So, I just really appreciate it and I'm sure saying Sangeeta shares that sentiment. So, I'm going to turn it back over to Sangeeta.

Sangeeta: Thanks, so much Neal and Stephen and Lauren and Jessica. I definitely share those sentiments. I think, you know, I think the hour really flew by here and I appreciate you all trying to answer as many of the questions coming in, and Neal, thank you for trying to group a bunch of the questions into different categories so that we could address as many as we can.

We know that you all probably have more questions and things you were hoping to get to, and I wanted to direct you to some resources on substance use and substance use disorder that we have on the ECLKC. If you don't know about that, I'd really encourage you to go and look at it. This first link here, Head Start and the Opioid Crisis video series, it's really, I find it to be very uplifting to look at a lot of these videos, particularly during this time, when we're wondering how we can help, if Head Start is able to make a difference in the area of substance use disorder.

This is stories that we're hearing, not only from staff and programs around what they are doing, but also from parents and from grandparents, so about how Head Start has made a difference, in ways that Head Start staff engaged them so that they felt safe and secure, and can develop that trusting bond. So, really encourage you to look at that to get some more ideas and just feel

good about the work you do, right? Because like Stephen and Neal said, we really just appreciate everything that you're doing, and we know that during this virtual time, it's even more challenging to engage with the families at times that, you know, in the way that you want to. We have a link on Substance Use and Recovery that we encourage you to check out.

There's a lot of great resources in here. We have resources on how to talk with families about substance use disorder, the basics around substance use disorder. I know we had some questions we couldn't answer around how alcohol impacts the developing fetus, how to talk with pregnant women about the impact of different types of substances. So, you can go in there; they're kind of one-pagers.

You can even give them to your families, if that would be useful for them. We have a section on intervening early in substance use disorder during pregnancy, so please look at those resources and see if you can find some things that will be helpful for you and your — and the families you serve. The National Child Traumatic Stress Network here is a great resource. We've been highlighting it throughout the Head Start Heals campaign.

They do have specific resources related to trauma and substance abuse, so please check that out. And SAMHSA always had great resources and I'm really glad that Stephen highlighted the findtreatment.gov. We don't have that up here for you, but we'll definitely include that in future Head Start Heals work that we do, because I think that's a great resource to know about. And then Sesame Street. If you don't know about all of the things that Sesame Street is doing around parental addiction, I think they have great resources there for parents to use with their children, for parents to take care of themselves.

So please check that out. They also have specific resources for providers as well. We have a variety of national hotlines, and again, I just want to remind you all that you can download all of these slides, you don't have to write these down quickly while I'm talking. You can definitely download these slides with the Event Resources tab at the bottom of your page, and these slides will also be available for you on the Head Start Heals website, as well, as well as this recording. So don't worry, we're not expecting you to remember all of this information we're throwing out at you just this second.

But we have a variety of different hotlines that we encourage you to use, if you need it. If you need to give it to your families, we have these related to substance use down at the bottom. And then, if you don't know about MyPeers, please check out MyPeers. It's a collaborative platform for ECE programs to ask questions and share resources. Our National Center regularly posts information in the mental health community, and many other communities on MyPeers.

We have one specifically related to opioid misuse and substance use disorders as well. And if you are not a member of MyPeers, you can set that up on the ECLKC as well on the front page. And then, we have a few more things coming up for Head Start Heals and probably some more. We've extended our campaigns through the end of July to give you as much information as we can around all of the topics related to trauma, trauma-informed practices, and trying to address a lot of the questions more focused on specific topics that you've been asking about.

So, we have one coming up on child welfare on May 28, so please check that out, if that's something that you're interested in. We'll have our National Center for Parent, Family, and

Community Engagement joining us for that one. At the end of June, we're going to be re-airing a webinar on "Behavior has Meaning," that the National Center for Development, Teaching, and Learning did with us before, and we'll hold some office hours with those experts around this topic as well. And then we have another webinar coming up around, "Preparing for Challenging Conversations with Families" in June.

And if you're wondering where all this information is that I've been talking about, so here's our website, eclkc.ohs.acf.hhs.gov. On the front page, you'll see the Head Start Heals campaign. You can click on that to get information that I've been talking about today. All of our webinars and office hours are being posted there and we're posting all the materials and resources that we're trying to highlight for you as well there.

So please, feel free to check that out and don't forget, you're going to get your certificate at the end of this live webinar, and if you're listening to it on demand, you will get it at the end of on demand. So, don't go away until we say goodbye. And with that, I'm going to say goodbye. I hope you have enjoyed our one-hour speed presentation on substance use disorder.

Again, thank you so much to Stephen, Lauren, and Jessica for being on with us today. We know that you have a very busy schedule. You're working on the frontline with children and families every day. Thanks again for all the work that you're doing. Have a good day, everybody.