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By

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Improving parental support through education for Neonatal Abstinence Syndrome (NAS)

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Abstract

My Master's of Social Work (MSW) advanced practicum took place at Health Sciences North (HSN) in Sudbury Ontario, in the in the neonatal intensive care unit, pediatrics, and birthing centre at HSN. Although limited due to the COVID-19 pandemic that occurred part way through my field work. My main role at HSN for my advanced practicum project was directed at implementing supports and education to families of babies with neonatal abstinence syndrome (NAS). I chose to examine addiction, problematic substance use/abuse and parenting, and the stigma that surrounds mothers who use substances problematically or have addictions. Through examining different theories, I began with the goal of being able to address the gap in support and education for mothers experiencing the process of having a baby with NAS from birth to after discharge from the hospital. From this goal, I was able to create a support system through conversations with mothers and reviewing research that could be followed through any professional work as a part of the families' care teams while I was still placed in the hospital. As the pandemic changed regulations and my work, I was unable to continue this work in the hospital setting and I shifted focus to work with Michelle Buckner and created a training package on peer support in the NICU.

Through my placement at HSN, I set out to help educate families through an antioppressive practice lens by identifying their child's needs through the NAS process and what they should expect. Anti-oppressive practice lenses was used when creating and implementing the NAS information package along with when working with mothers and discussing cases with other professionals involved in particular cases. However, it became apparent that there was also a need to educate medical professionals and care team members on stigma and how their own

personal biases were, and are, having a direct effect on the educational shortcomings and support deficits for these families. I, along with my supervisor were able to begin to help bring awareness to the problem of stigma with medical professionals and social workers by sharing the NAS information package with them and the importance of education on this subject. The learning goals I had going into this work were to gain an understanding of NAS support, benefits to family centered approaches, attachment and anti-oppressive practice theory within the hospital setting and working with interdisciplinary teams in order to address problems within this system and begin to create change for social work practice with NAS care. I was able to begin to meet these goals by providing an information guide to better help support mothers and create a nonoppressive, and the importance of establishing a judgmental relationship between practitioners and mothers who have addictions or use substances problematically.

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Chapter 1: Introduction

The impact of problematic substance use on pregnant women can have profound effects, not only on the immediate health of the mother, but also the health and wellbeing of the newborn infant. One of these outcomes being neonatal abstinence syndrome. The Provincial Council for Maternal and Child Health classifies neonatal abstinence syndrome (NAS) as neonatal withdrawal symptoms from maternal use of drugs from addiction or problematic substance use. The use of drugs while pregnant puts the child at increased risk for a pre-term birth, low birth weight, and intrauterine growth restrictions. The incidence of reported NAS in Canada tripled between 2003 and 2014, with an average annual increase of 0.33 cases per 1000 live births. The incidence of NAS is increasing in Canada with an associated rise in healthcare recourse utilization (Filteau & Coo, 2018). As a result, there is little support for education for caregivers, both during the hospital stay and after care.

The following document outlines the different aspects of my advanced practicum and the work that took place. Through what worked well to what was more challenging during my time at Health Sciences North. In order to continue to raise awareness on the impact of stigma and oppression on mothers that use problematic substances and have children. The NAS information package that was created can continue to be implemented within the hospital setting to help mothers feeling more knowledgeable, prepared and less alone when they have a baby born with NAS.

In chapter 1 of my thesis report, I provide an overview of the advanced practicum at Health Sciences North. I further outline my learning goals that were established before starting my advanced practicum and were specific to working in the hospital setting.

In chapter 2, I will discuss a review of the literature related to the advanced practicum subject. The subjects reviewed are local context; stigma and NAS; current state of practice in Canadian hospitals; improving care; and mothering and substance use. The literature reviewed helped to provide a grounded understanding of noted above subjects in order to fully grasp the impact of stigma in the health care setting and further giving me a background in the information I would be seeking to understand moving forward within my practicum and thesis report.

In chapter 3 of the thesis report, I will provide further detail on the practicum experience, creating and implementing the NAS care package for families, and discuss my passion behind the project. The rapid change to my practicum during the pandemic will be explored along with how I was able to continue through a new realm of work that was still contributing to my overall thesis project

In chapter 4, I reflect on my learning outcomes and what I was able to learn from these goals and further implications for social work from my thesis project. I will cover how we can do better as professionals to begin to provide knowledge and information on NAS education where it is missing and begin to eliminate professional stigma towards mothers who use substances.

Overview of the Practicum Requirements

The primary goal of my 450-hour advanced practicum was to develop an understanding of NAS and how it is treated in Neonatal Intensive Care Units (NICUs) Additionally, I worked with families who had infants going through the existing NAS scoring known as the Finnegan scoring system. I met with parents in the birthing centre and followed them throughout their admission because they would move from the birthing center, to the NICU, and finally to Pediatrics through discharge. I worked with families who were admitted anywhere from 1 week to approximately 3 months depending on the severity of their infant's withdrawal and

improvement over time. Creating an information package with Health Sciences North (HSN) took place by going through approved information on the HSN website, and further talking with mothers about their experiences, were some of the first steps in implementing proper education and support that they needed to receive during their admission to the hospital with their infant. The goal of having the information shared with families who are affected by NAS and beginning to support and minimize the educational gap that currently exists in this area were subsequent goals. The objective was to then address the supports that are missing for parents with a child with NAS when they were going through the admission process.

I created a training PowerPoint on peer support in the NICU that could be used to train volunteers before going into peer support volunteer work in the NICU. The slides outlined best practices and effective ways of participating in peer support in the NICU setting. Additionally, I created a list of the ten most important takeaways in NAS care that were to be turned into a comic strip in order to create another form of education and understanding on NAS care and support.

Rationale

My advanced practicum was influenced by the experiences I had while working with a family who fostered infants. At the time in 2014/2015, they were caring for many infants over the years who experienced drug exposure which created challenges when there was a lack of education provided to them on the special needs of a drug-exposed infant. There were little to no educational materials available on how to properly care for infants who experienced drug exposure, even though their needs are very specific and little support from workers or programming. At this moment, my passion for wanting to minimize harm and provide

information for NAS care became my passion. It was not until I visited the NICU to see one of the foster babies that I began to notice the potentially harmful scenarios that were taking place in the hospital setting towards mothers who used substances. In past placement experiences, I was exposed to societal "mother blame" and related stigma towards mothers for many different reasons, which is a concept I wanted to explore within the hospital setting. I wanted to explore where the stigma was originating and how, and if, stigma and bias were affecting the care these mothers and their infants were receiving while admitted to the hospital. Further, I wanted to determine if these factors played a role in infant recovery and outcomes.

As a social worker, I value an anti-oppressive practice lens which challenges oppression in our everyday lives, and I wished to explore how structural oppression was affecting families who were admitted to the hospital. Having the understanding of an effective anti-oppressive practice was beneficial to further exploring the oppression and stigma that impacts mothers who use substances in a healthcare setting. Healthcare should be a safe environment for them to receive care and support. Being able to address where and how this oppression was affecting these families, not only at HSN but in hospitals globally, was important to addressing a way to close the gap in education and support surrounding NAS care support. Over the years, through life and practicum experience, I have witnessed many different forms of attachment between infant/child and parent. I further wanted to understand attachment theories in general and how, and if, attachment was being fostered in the hospital setting during an admission. Understanding how attachment impacts infant outcomes was an important aspect to further investigate for my practicum. Further, I was interested at better understanding NAS outcomes, and if mother-infant attachment was being fostered and supported within the hospital setting. After reviewing different forms of attachment this theory made the most sense and was the most compelling

given the environment and circumstances I would be working in to help advance the idea that attachment can be affected in the NICU setting and why it is important to foster a securer attachment in order to better infant outcomes when they are recovering My advanced practicum gave me the opportunity to explore the impact oppression and stigma can have on a mother who uses substances and how these factors impact the education and care she receives while admitted to hospital with her infant. My practicum gave me the opportunity to explore different concepts as they play out in health care settings, such as mother blame, the dominance of the medical model, exploration of attachment theories in the hospital setting, anti-oppressive social work practice, and mother-centered approaches to care in the hospital setting.

Learning Goals

For my practicum at Health Sciences North in the birthing centre, NICU and pediatric unit the following learning goals were established:

1) To gain a social work understanding of how NAS effects infants, and how to properly support families and caregivers who are involved in the infant's life.
2) To gain social work experience using mother centred care in a healthcare setting.
3) To understand attachment theory and how attachment directly or indirectly affects the infant with NAS and parental bond during the admission to the hospital.
4) To make use of Anti-Oppressive practice theory throughout practicum.
5) To work effectively with an interdisciplinary team, understand how the different care team member roles interact and influence one another, and how this benefits the clients.
6) To make effective use of clinical supervision.

Key Terms

The section below will introduce key terms that are used throughout my thesis report. The following terms became relevant to clearly identify as they appear often throughout this advanced practicum paper.

Addressing the root cause of problematic substance abuse and addiction is important in improving NAS outcomes. Withingtom and Monnat (2019) discussed how people often view NAS as a result of a voluntary drug habit of an irresponsible parent; however, this view ignores the social and physiological realities of addiction. The language professionals use around problematic substance use and addiction can be perceived to reflect our attitudes towards people who struggle with problematic substance use and addiction. Kelly et al. (2016) explained how the language we use is especially important when it comes to "threatening" or "stigmatized" conditions in someone's life (e.g., drugs or alcohol). Addiction is not an individual choice; it is the language and terminology we use as a society that determines how addiction is perceived (Kelly et al., 2016).

The world health organization (WHO) describes substance abuse as a harmful use of substances that range from illicit drugs or alcohol that with continuous use can lead to difficulties controlling and managing usage which later can develop into a reliance known as addiction (WHO, 2020). When defining addiction Canadian Mental Health Association (CMHA) adopted the *4C's* approach to understanding addiction: loss of control; compulsion to use; cravings; and continued use despite possible consequences. In contrast, NAS definitions do not specifically outline the concept of problematic substance use and addiction. I chose to use WHO and CMHA's definitions to guide my practicum because these are two reputable organization and my practicum location, HSN, works with CMHA.

It is important to look at both problematic substance use and addiction though defined differently. The DSM-V (2013) makes the distinction that not all people who deal with problematic substance use have an addiction. Through an anti-oppressive lens because it encourages social workers to be more accepting and empathetic by understanding how people's oppressions have affected where they are in their lives today. Csiernik and Rowe (2003) discussed how we as Canadians view addiction through a clinical perspective instead of a multidisciplinary holistic perspective of addiction. We need to consider an individual who uses substances from a person-centered approach by looking at how structural, personal, societal, and environmental factors contribute to the use of drugs. Csiernik and Rowe (2003) further discussed the idea that professionals should be looking at addiction as a form of oppression because oppression encompasses unjust reactions such as psychological, political, economic, and social marginalization and exploitation. Csiernik and Rowe (2003) discussed the idea of labeling people with the word *addiction* or *addict* and how that specific labeling takes away from their healing process. They asserted that removing labels is one of the first steps. Instead of using the word *addiction*, the term *drug dependency* should be adopted. Canadians and social workers need to shy away from stigmatizing labels and adopt positive labels when addressing problematic substance use (Csiernik & Rowe, 2003). I chose to embrace the less stigmatizing label because it influenced how I would be interacting with families and other professionals during my practicum and in my future career.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome is defined by the National Library of Medicine (2018) as a collection of symptoms that occurs after antenatal opioid exposure. Symptoms range from excessive crying, poor sleep patterns, hyperactive motor reflex, tremors, excoriation, skin read or

broken, seizures, grater temperature, frequent yawning, sweats, poor feeding, vomiting, rapid weight loss, and excessive irritability. An infant with NAS is scored on each of the above symptoms each day until discharge.

Mother-Centered Care or Family-Centered Care

Mother-centred care, or family-centred care, is defined by the Government of Canada (2017) as an approach to care where the emotional, physical, spiritual, and psychosocial needs of the parent(s) and their infant are the priority. Mother-centered care fosters mother-infant attachment from early on.

Ethical Responsibilities

Throughout my practicum, I was aligned with the code of ethics put in place by the Ontario College of Social Workers and Social Service Workers. My pre-determined learning goals ensured that the principles within the Ontario College of Social Works code of ethics were met, and the standards of practice were met throughout each learning goal I had set and later accomplished. I pursued only the best interests of the client throughout my practicum by remaining an advocate for the population I was working with and carried out my professional duties as a social work student throughout the entire practicum.

Personal Reflexivity

Identifying my own privilege and social location in relation to the mothers I was working with was another important part of self-reflection and discussion during supervision. Not sharing many of the lived experiences that these mothers had was something I needed to be aware of when working with these mothers to ensure I was not further oppressing or being naïve to the experiences of parents. Having this perspective allowed me to practice sensitively and ethically

by recognizing my potential for causing harm and acknowledging the power differences between the mother and myself. For example, recognizing that my age, my gender, not being a mother, and having no personal experience with substances and pregnancy was important. It was important to recognize within myself that I did not go into this work truly objective and I needed to recognize the bias I already did have about problematic substance use and mothering and reflect and learn about why I had these biases and where they came from. It would be wrong for me to say I was perfect and had no preconceived bias and misunderstanding before beginning this work. Exposing myself to different situations and reading as much literature as I was able to was helpful in being able to avoid not only bias but change even my way of thinking before I began this work by engaging in the understanding of why people become dependent on substances and the different life circumstances that lead people to turn to drugs or illicit substances. Such as trauma, abuse, poverty, family history, chronic pain, etc. Further, being in the social work role and how it can influence mother and infant outcomes were important aspects that I needed to work through in order to provide the best services and to effectively help each individual mother during my advanced practicum.

As a student working within the hospital setting, with privileges to work with families and have access to their patient information and medical histories in the hospital, I recognized the opportunity I had to further understand how ethical dilemmas can arise and how they are deeply rooted structural issues within the clinical setting and medical hierarchy. When beginning practicum I did not even cross my mind that I would witness oppression and personal bias from medical professionals and that oppression and structural issues within the hospital would have to be something I would further need to explore within the literature and the work that I was doing for NAS support. When issues arose, I was able to discuss them further in supervision or with

my supervisor for self, and professional, reflection. I was able to align with my professional and personal core values by reflecting on the CASW professional standards. Being able to further explore the ethical dilemmas that arose in the advanced practicum allowed me to gain knowledge and respect from other professionals, and I learned from their set of standards while staying honest to mine.

Theoretical Framework

The focus of my practicum was working with families that were admitted to the NICU and pediatrics at HSN while their infant was going through NAS. After completing a review of the literature and conducting further research, it was apparent that there was a large education and communication gap between medical staff, such as nurses and doctors, and birth parents of infants with NAS. Research shows that parental presence at the bedside in the NICU is associated with better infant outcomes and a shortened hospital stay (Knopf, 2017). Parental presence is especially vital for a baby experiencing withdrawal, yet often mothers are not being welcomed to the bedside of their own infant in the NICU or pediatrics for many different reasons surrounding judgement and stigma (Cleveland et al., 2014).

My aim throughout my practicum was to explore parents' feelings and how social workers can begin to bridge gaps and create support for them during their stay. I will note the differences in mothers who are by their infant's bedside compared to those who are absent. Providing parents with the knowledge, support, and communication they need to accomplish being the main caregiver even while in the hospital will bring out the most positive outcomes for mom and baby. It is important to help remove this barrier by understanding firsthand, and through the literature, why there has been such a large gap in education, support, and best practice for mothers who use substances and infants with NAS.

In the following section, I will explore *attachment theory* and *anti-oppressive practice theory* to advance my practice and contextualize my document.

Attachment Theory

According to Bowlby (1973), attachment theory is described as a bond that emotionally connects one person to another. Attachment theory is derived from the joint work of Ainsworth

and Bowlby (1973). Beginning with the original emphasis of attachment from Bowlby in (1958), he proposed that attachment is to be explained and looked at in context of having a caregiver provide security and safety for their child. Bowlby notes that attachment is adaptive because attachment enhances the infant's survival chances (Bowlby, 1958). Bowlby further discussed in his early study of attachment that attachment should be looked at in an evolutionary context. He asserted that infants are biologically programed to come into the world and form attachments with other people because it essential for their survival (Bowlby, 1958). Attachment is noted at the secure base for how an infant explores the work and acts as a 'prototype' for future relationships. Bowlby's theory of attachment suggests that the critical time for being able to develop a secure attachment is between the ages of birth to five years of age and if the child is unable to form a positive attachment in those years there will be developmental consequences such as aggression or reduction of intelligence (Bowlby,1958).

Following Bowlby's work Mary Ainsworth (1970) identified three main styles of attachment an infant can have' secure attachment, insecure avoidant attachment and insecure ambivalent/resistant attachment (Ainsworth, 1970). Later Main and Solomon (1990), recognized a fourth form of attachment which they identified as disorganized attachment. Ainsworth further identifies that idea of maternal sensitive which argues that a child's attachment is fully dependent on the behavior the mother or primary caregiver shows them in early life. According to the work of Bowlby and Ainsworth (1980) an infant that experiences a secure attachment is the most likely to have the best outcomes in later life which fosters the idea of supporting attachment and bonding within the hospital setting. The later work of Jacobsen and Hoffman (1997) also contributed to the idea that children with secure attachments later develop a positive working

model for themselves and see themselves as worth of respect from others in relationships. Thus, the need the make attachment between mother and infant a priority from the very beginning of life to enhance healthy relationships and development in the future. Across the board of theorist that describe attachment theory there is a general understanding that maternal sensitivity is critical when explaining the different types of attachment, a child has. Fostering maternal sensitivity from the start and providing support for mothers to create a secure attachment is critical in situations where a mother may need some extra support and or guidance. Attachment theory as a theoretical framework looks at a large range of human experiences and how that experience impacts attachment, which further impacts the rest of your life. For this particular paper this means observing the attachment that occurs between mother and infant and how this impacts the infant outcomes with NAS recovery. Further looking at how or if attachment is being fostered and or supporting within the hospital setting by the medical care teams and if attachment is seen as a value in the hospital setting.

The theory of attachment is prevalent in the social work field because it provides an understanding of relationships and how we develop them throughout our lives (Wang & Stalker, 2016). Attachment theory supports the need for having physical closeness to the infant after birth, with the caregiver, which most often is the birth mother.

Having the parent physically present after birth fosters the ability to form a bond and build a secure attachment from the beginning of life. Bowlby (1973) discussed how attachment does not have to be reciprocal, and most promptly examines mother-child relationships.

Attachment Theory, Substance use and Hospital Supports

Attachment theory provides the lens of examining ‘substance use’ as a symptom of an underlying problem or trauma that has impacted someone’s life. It is crucial to understand the cause and effect, rather than treating addiction as a ‘disease with no cure’ that is brought on my personal choices (Reading, 2002).

Fletcher et al. (2014) discussed how problematic substance use is often linked to various social issues such as crime, violence, and poverty, which impacts how a parent using substances is viewed related to stigma and judgment. The theory of attachment has been integrated into different clinical models used in practice including attachment-informed therapy, attachment focused family therapy, emotion-focused therapy, and attachment-focused therapy (Fletcher et al., 2014). These different approaches can help to advance the importance of relationships and how these relationships are formed in the first year of life, which further helps people to understand development that contributes to specific problems in the future. In the 1970s, Edward Khantzian became one of the first theorists to study the relationship that existed between problematic substance use and attachment. He looked at addiction as self-medicating because of a person’s inability to understand their own trauma or emotions and concluded that addiction was about seeking comfort. It was postulated that due to their inability to recognize their emotions, people who have addiction sometimes are unable to have meaningful interpersonal relationships. Addiction creates barriers to attachment and substances may be used as an alternative measure to build attachments (Khantzian, 1970). Schindler (2019) further expands on attachment and substance in her review of attachment differences due to substance abuse and the severities. Schindler (2019) concluded that there is a link between insecure attachment and substance abuse disorder and found that insecure attachment is also a risk factor to substance abuse. She notes

that substance abuse impairs people's ability to be able to form close relationships and need extra support in doing so.

Due to stigma, and possible CAS involvement after a baby with NAS is born, the role of the mother-infant bond is often affected (Kondili & Duryea, 2019). Attachment theory has been utilized to understand NAS and inform interventions for NAS symptom management, with or without the use of pharmacotherapy (Kondili & Duryea, 2019). It is indicated and further stressed that skin to skin attachment is particularly crucial for a baby that is not thriving in the NICU. Findings suggest NAS management should involve prolonged and multidisciplinary interventions focused on the mother (or caregiver). Such interventions could involve nurses, social workers, and counselors, and should incorporate education for mothers. Often the focus is on the infant, rather than the parent-infant bond and connection (Kondili & Duryea, 2019).

Attachment theory reviewed in general offered me the lens which I could develop through a framework to analyze how attachment is affected in neonatal abstinence cases, and the contributing internal and external factors. In addition, I strived to devise successful approaches in developing a more secure and positive bond and attachment in these medical encounters, which are not typically ideal starts to life for baby and parent in regard to bonding and attachment. Attachment theory provides the lens to look at patterns of attachment throughout a child's life and how that initial attachment can foster qualities or behaviours they may have as they go through the stages of life (Van Horn et al., 2011). Further, the systematic links between patterns of attachment and caregiving that are looked at through attachment theory can help us begin to understand how forms of attachment are linked to an infant's emotional health along with the mother's mental health (Van Horn et al., 2011). Understanding attachment and emotional health

can signify how failing to foster a mother centered approach to care in the NICU can affect the baby's outcomes over their lifespan (Van Horn et al., 2011).

The NICU is a complex environment where technology, medicine, and a high stress environment may overpower meaningful relationships and bonds that are critical to develop between infant and parent (Hopwood, 2010).The literature identified that medical professionals tend to focus on meeting medical needs rather than involving or building relationships with the parents of the baby (Hopwood, 2010). The attachment and bond between the parent and the infant are critical to foster an optimal outcome that needs to be understood by all the members of the healthcare system in order to best support these families (Hopwood, 2010).

Parents reported feelings of guilt and inadequacy while in the NICU setting (Cleveland et al., 2014 Understanding how labeling and stigma can occur by medical professionals towards mothers who use substances, will help the understanding of the initial attitudes and how we can best educate staff regarding addiction to create change. Investigation into what internal and external factors lead to a person becoming dependent on substances would assist in patient-worker relationships and ensure the best treatment for both the mother and baby. This would in turn would foster a safe, supportive environment which will encourage a mother to be involved in treatment and recovery in order to foster a strong attachment with their infant. These goals were especially important in my practicum. Attachment theory offered a promising framework for the evaluation of the infant-mother bonds while providing the ability to focus on the barriers such as lack of knowledge, support, and education about their potential addictions. At the same time, attachment theory provided room to open an understanding and eliminate barriers that impact attachment at this stage.

Limitations of Attachment Perspectives

There are limitations of using an attachment perspective to inform social work with mothers who use substances. Bowlby and Ainsworth's (1973), perspectives are rooted in Western, White, colonial and middle-class understandings of mothering and child rearing, where the mother-infant relationship is the sole focus of creating an attachment without considering external supports or factors. Carriere and Richardson (2009) describe that Western, White, colonial and middle-class understandings of mothering directly has an influence on the Canadian child welfare system has been infused through the surveillance of Indigenous families and used as an argument for child removal. They offer an expanded notion of the concept of attachment and explain how Indigenous world views emphasize the value of not only the connection between mother and infant, but also the role in which the community members connect and work together. Carriere and Richardson (2009) discussed the term connectedness in Indigenous communities as a sense of belonging and importance. This feeling of connectedness is important for those who are adopted because longing for a connection can bring suffering to Indigenous children and family communities. People can feel a connection to individuals they do not know as attachment is an emotional bond (Carriere & Richardson, 2009). Carriere and Richardson (2009) discussed how humans require our needs, such as security and safety, to be fulfilled during our lifespan. Human dignity is important and is too often overlooked in child welfare interventions; failing to acknowledge human dignity interferes with connections and bonds. Thus, indicating the importance of dignity to an infant through voices, contact, food, familiarity, cleanliness, safety, and community environment is critical (Carriere & Richardson, 2009). For example, in Inuit communities, family and familial connection is often seen as more important than food itself. Mothering and attachment are seen through various degrees including emotional

and physical support from families and communities as a unit (Carriere & Richardson, 2009). Carriere & Richardson (2009) suggested that we need a more complete understanding of how human dignity and connection can have positive outcomes for people.

Attachment Theory and the Idea of the Ideal Mother

Bowlby and Ainsworth's attachment theory has an emphasis on the mother-infant bond. If a child is viewed as "insecurely attached", blame falls on the mother for taking action or inaction that somehow failed to nurture a secure connection. An 'ideal mother' in this view, is one who facilitates a secure connection, through the mother being the sole care provider, dependable, joyful, sensitive to signals, soothing the infant, and quick to respond to their child's needs (Ainsworth, 1970). The ideology of what it is to be an 'ideal mother' is a socially constructed concept that dates to early ages of the concept of an ideal mother. However, depending on culture, this ideal changes. In Western society there is set beliefs about what an 'ideal mother' consists of. According to Bezanson and Luxton (2006), the ideology stresses that mothering involves devoting all emotional and physical energy to the infant under the assumption that the infant requires nurturing from one primary caregiver, in this case the mother. O'Reilly (2006) further discussed how motherhood in a Western culture is looked at as an apolitical enterprise. The mother must put all the child's needs before her own and must be self-sacrificing and 'ever-giving' to their child. This ideology of the intensive mother is seen as 'proper' in Western society.

Rock (2015) described a society where there is an idealization around motherhood and being a 'good' mother is romanticized. She discussed how the discourse of the good mother is someone who is heterosexual, has traditional family values, is predominantly white, married, middle or upper class, law abiding, and far from deviant. An important point to address is how

the discourse of being a good mother, and having your child be a direct reflection on how you raise them, is upheld and reinforced by educators, doctors, and lawyers (Rock, 2015).

O'Reilly (2010) further advanced the idea that these ideals and practices of patriarchal Western society can be oppressive because these ideals are impossible standards to be constantly met. She noted how mothers associate the construct of ideal motherhood with feelings of guilt, anxiety, boredom, and loneliness while they are constantly striving and failing to meet societal standards.

The universal standard of mothering in the Western society ignores structural, environmental and systemic circumstances. No two mothers will have the same experience. Mothering differs day-to-day and is influenced by the countless situations that happen. Different determinates such as class, race, trauma, education, and economic location, can all impact each individual and their way of mothering. Having an ideology specific to western society of an 'ideal mother' is damaging to society because it fosters oppression and judgement against parents who do not fit the sociocultural norm that society tells women they need to fit into to be a good parent.

Attachment theory provides a strong lens for understanding how attachment can be impacted in a hospital setting in cases of addiction and babies with NAS, and it provides a useful lens for validating specific issues. There are however limitations to attachment theory and the ways it can impact families. Having knowledge of the limitations of attachment theory is critical in understanding how it will advance our understanding of barriers to closing the educational gap in families with NAS. Attachment theory has failed to recognize the diversity among families such as ethnicity, social class, gender, and culture, and how different economic or social factors

can impact the 'ideal' attachment practices. Attachment theory has been critiqued for outlining what the ideal connection or attachment should be without acknowledging non-Western cultures. Carriere and Richardson (2009) discussed how within Canada a sense of ‘longing’ for a connection has been known to bring emotions of feeling in complete or suffering to Indigenous children.

Overall the societal pressure to be an ‘ideal mother’ may impact the bonding process by not allowing mothers who do not meet this *perfect* socially constructed idea of a ‘mother’ to have the opportunity to bond and create an attachment to their child in the first year of life. By not allowing her to be present, whether through the welfare system or in a hospital setting where medical professionals take over the mother role based on their own judgments or stigmas towards the person, can cause significant harm to both the mother and her child with NAS.

Attachment theory encompasses many different perspectives and possible situations for families who are admitted to the hospital with NAS. Complementary to Attachment theories it is important to then work through an anti-oppressive practice lens in social work in order to make sure social workers and other health care professionals are not further oppressing the people that they work with.

Anti-Oppressive Social Work Practice

Anti-oppressive practice theory is based on critical and structural feminist theories that have in the past challenged the social work profession, the way we work within the profession, and practice needs at the political level (Baines, 2007). Looking at practice through an antioppressive lens provides context to the complexity of working with marginalized populations within the realm of social work practice. As social workers, we are faced with the ethical responsibility, according to our social worth ethics and standards lined out by CASW to address

and challenge the inequalities that are occurring in different areas of people's lives. People who use substances are often marginalized, stigmatized, and judged in society, often due to the notion that problematic substance use and or addiction is often viewed as a person's choice with the ability to choose to stop at any time (Room,2005).

Historically, the social work profession has attempted to explain and understand these disadvantages and offer solutions through working with individuals and groups. Anti-oppressive practice is an interdisciplinary approach with the aim of eliminating socioeconomic oppression (Burke & Harrison, 1998). Many different principles are outlined within anti-oppressive practice work. These principles include recognizing social differences, power as a social concept, reflexivity and involvement, linking the personal with the political, and addressing historical and geographical location of the marginalized populations (Burke & Harrison, 1998). According to Dominelli (1996), anti-oppressive practice embodies a person-centered philosophy. The approach emphasizes a concern with structural inequalities. Anti-oppressive practice in social work is a practice that has been extensively discussed throughout the literature and has been the subject of considerable debate over the years (Darlrymple & Burke, 1995; Dominelli, 1996; Fawcett, 1995; Thompson, 1993). Although there is a range of definitions that differ in complexity, anti-oppressive practice is considered to be a dynamic process that acknowledges, social patterns and the complexity of social relations, in order to effectively address inequalities and begin to challenge people who do not understand interconnections (Burke & Harrison, 1998)

The Ontario College of Social Workers (2019) presents anti-oppressive practice as a transformational tool. The college acknowledges that social work is a multidimensional and complex field that is constantly changing. However, it is our duty in the profession to ensure in our practice that oppressive behaviour does not occur. Anti-oppressive practice enables workers

to reframe thoughts, navigate environments, create strategies for practice, alter negative behaviours, and evaluate experiences (OCSWSW, 2019).

In order to begin to see that social change regarding anti-oppressive practice is evident, we have to transform our attitudes and behaviours as professionals first. Baines (2007) argued that social change is necessary and must be one of the key components of social work practice. In order to best serve our clients and advance the practice, we must follow our ethical responsibilities through anti-oppressive practice. This practice allows us as social workers to uphold social justices in society by addressing a person as a whole and relating to the client in social context.

Noted ethical dilemmas did arise during the advanced practicum when looking through an AOP lenses because I faced new challenges within the population and setting. Working within the clinical setting where the medical model is highly valued for the standard of care, it was very difficult at times to work with the interdisciplinary teams. Working with interdisciplinary teams, although optimal to the learning process, brought on ethical dilemmas within the placement. Approaching the practicum from an anti-oppressive model of care among mothers who use substances posed challenges because medical staff often had a pre-determined bias towards mothers with drug dependency. Often, medical staff would automatically defer their duty to report to the social workers, even if the social worker had not yet met the client, which could create tension because there was not always an understanding from other healthcare professionals on what a social worker is and is not able to do.

Addiction, Substance use and Mothering

Oppression typically occurs at three different levels: structural; personal; and cultural (Mullaly, 2002). Looking at oppression in terms of marginalization, exploitation, discrimination, or dominant behaviour in relation to social, political, or economic related aspects in a person's life is something many groups of people face every day. People who struggle with problematic substance use are no exception to oppression from other groups or professionals in their daily lives (Csiernik & Rowe, 2003). Having an understanding of addiction in relation to external factors and seeing the word itself as a complex phenomenon that has been stigmatized, is critical in conducting ethical, anti-oppressive work with clients who have substance dependencies. Csiernik and Rowe (2003) discussed that in Ontario, it took over a decade of time before the province moved to include addiction as a challenge in people's lives that could qualify for a form of social assistance .As of October 2018 in Ontario persons participating in treatment program for addiction ma receive assistance for basic needs. Supports and assistance will vary based on needs, documentation, benefit and circumstance of the person (Ontario Works, 2018).

Understanding that there are many layers of complexity to any form of addiction and problematic substance use is critical in working through an anti-oppressive practice lens with mothers who use substances. As social workers, it is critical to have the understanding that the misuse of substances or addiction is not a simple issue and that substance use will vary depending on the person for a vast number of reasons.

Mullaly (2002), discussed how oppression will continue to happen if we as individuals do not retreat from blocking self-development and move away from the idea that certain groups of people should not have the same rights as others due to misconceptions of their challenges in life. The language used can be oppressive in and of itself. Labeling a person and suggesting that a person is only identifiable by their addiction or problematic substance use, creates significant

stigma. For example, from my readings and my observation in the hospital environment, parents with addictions or those who use substances were often referred to as ‘addicts’ or ‘junkies’, instead of identifying them as a person with an addiction or a dependency. By labeling individuals, their entire being becomes an attribute to their challenge (Csiernik & Rowe, 2003).

The medical model is understood to be set practices that are carried out by medical professionals for treatment and diagnosing purposes (Farre & Rapley, 2017). The medical model has been the primary model followed within the healthcare setting and, although practiced with the best intentions, the power dynamic and imbalance in the ways in which the medical model is practiced can cause harm or oppression to people receiving professional healthcare (Sullivan, 1991). The view in which the medical model can contribute to social oppression is something I witnessed while working in the hospital setting. Power relations and taking social considerations out of medical treatment or discussion, encourages us to view patients as lesser and fosters an environment that contributes to stigma and underlying judgements which leads to an oppressive environment. This conclusion was reinforced for me during my practice. Farre & Rapley, 2017 discuss how the medical model is still used today (2017) and according to the medical model framework each level of the hierarchy needs to acknowledge the system and work within it accordingly. When speaking to mothers in the NICU, they described feeling completely left out of healthcare decisions being made for their baby with NAS or feeling judged by healthcare professionals.

Although anti-oppressive practice is becoming more widely accepted, and a ‘popular’ theory to use within the realm of social work practice, there are still limitations to the theory

itself. Anti-oppressive practice guides us to look through a person-centered lens, but one of the main limitations to this perspective is that the theory has a lack of focus on the micro level of the service user themselves, and focuses more on the larger cultural, social, and economic experiences of a group of people (Sakamoto & Pitner, 2005). Also recognized is the power dynamic that still inevitably exists between a professional worker and a client. These power dynamics may create an oppressive social work environment regardless of the theoretical practices and call for a more expansive integration of critical consciousness when working within an anti-oppressive practice lens (Sakamoto & Pitner, 2005). This limitation could be due to the fact that anti-oppressive practice is an organized theory, which is practiced in professional work and creates power imbalances before the work even begins (Dominelli, 1996). Critiquing anti-oppressive theory, and the values in which it sets out to guide practice, It is important to reflect if anti-oppressive environments are really being fostered or are we continuing to perpetrate oppressive systems that still create power imbalances and place the focus on the wrong systems and aspects of people's lives.

Working through both attachment and anti-oppressive theory lenses will advance the ability for social workers to educate, prevent, and intervene among healthcare professionals when addressing their own personal stigma and bias towards particular populations of people. This positive outcome will be obtained by reflecting on their own actions and coming to understand different reasonings for addictions and substance use, thus creating a more inclusive client centered environment in healthcare. Pescosolido et. al. (2008) discussed how stigma most often leads to negative stereotypes and beliefs that are directed towards groups of people. Stigma is very apparent in healthcare which can impact the experience or healthcare treatment among

certain groups of people. Pescosolido et. al. (2008) also discussed the importance of understanding theoretical and empirical origins and the roots of stigma.

Attachment theory and anti-oppressive practice theory have shaped and guided my practicum in understanding how attachment is affected during a NICU or Pediatrics admission; I also analyzed oppression, stigma, and stereotyping within the healthcare system through an antioppressive lens. My understanding of attachment theory and anti-oppressive theory helped me to examine the role conflict that occurs between medical staff and parents who use problematic substances while pregnant, and why there is missing support around informing parents about NAS. Anti-oppressive practice demands workers to recognize their own privilege and own social status, and how that may impact how they are working with a patient. Understanding the history of oppression, the concept of the ideal mother, and judgement surrounding problematic substance use in a healthcare and societal setting, will assist me to further address the missing support in the hospital setting, work to address it further, and foster attachment between the mother and her baby as one unit instead of two separate units (Schmidt et al., 2019). I aimed and was able to throughout placement to create a positive, personable, and empathetic experience for a mother during the admission of her child to the NICU or pediatrics and will continue to use my understanding to see problematic substance use in a different way.

Chapter 2: Literature Review

The review of the literature examines the various factors contributing to the lack of support that mothers of babies with NAS receive on education, guidance and reassurance about parenting and NAS care while in the hospital setting and how social workers can begin to address this growing problem. There will be a focus on the prevalence of NAS in Canada, local context and statistics, stigma related to NAS, the current state of practice in the hospital setting, how social work can improve care, and the phenomenon of mothering and substance use in general. The insufficiency of treatment and supports that surround assistance with NAS within the family system and in the hospital, setting will be explored. Within this section, I will review strengths and weaknesses encompassing supports and begin to address the gap in the structural context surrounding support for parental figures. The prevalence of NAS will also be addressed because NAS has been increasing globally every year and represents a growing concern in the medical setting.

Specifically how NAS cases have tripled between 2003-2014, the large impact stigma has on NAS care, addressing the impact of the parental presence at the infant's bedside and how this presence affects infant outcomes, the concept of 'mother blaming' and how mother blaming is embedded in our society, the 14 recommended clinical practice guidelines for NAS in the province and the evidence there is to inform protocols of best practice including a mothercentered care.

Databases such as the Laurentian Library database and Google scholar, PsycInfo, Scholars portal, Worldcat, etc. Were searched for scholarly, peer reviewed literature, both qualitative and quantitative data was reviewed, along with journal articles and websites. The

main research focus was peer-reviewed articles; however, reports from grey literature are included as well. Key search terms used were NAS, NAS-scoring, feminist theory, addiction and mental health, northern Ontario, attachment, and pregnancy.

Prevalence of NAS

NAS is a multisystem disorder characterized by disturbances in the central and autonomic nervous systems. If left untreated or treated improperly, NAS can cause death resulting from seizures, fluid loss, and respiratory instability, and may also result in auditory and visual impairments (Kocherlakota, 2014). The prevalence of Neonatal Abstinence is increasing globally as a result substance use and the opioid crisis in Canada. Due to the increased incidence of problematic substance use resulting in NAS there becomes an impact on health costs, resulting in less support and guidance for family's caretaking for a baby with NAS (Kelly & Jansson, 2016). Evidence regarding the effectiveness of NAS prevention and management strategies is very weak, and further research is crucial in addressing this gap. Kelly and Jansson (2016) discussed how in the last decade the opioid epidemic in Canada have impacted many people, including pregnant women. The rise in opioid use during pregnancy has caused a dramatic increase in the number of infants impacted by NAS. The Canadian Institute for Health Information (CIHI) reported that in Ontario newborns with NAS used an average of 23.4 hospital beds per day, up from 5.6 beds per day, from 2003-2004 (CIHI, 2004). Following this a study was completed on the incidence of NAS in Canada and the associated healthcare resources between 2003 and 2014 (Filteu, et, al., 2017). Researchers used a secondary analysis method with data from hospitals across Canada for incidence of; length of stay, occupied per day, demographic features and hospital costs. The study concluded that the total hospital costs for NAS infants in Canada was

1.7 times greater in 2014 then 2010 and all provinces studied had an overall increase in patient costs in that time frame. Further noted was how other provinces had less of a substantial increase whereas Ontario alone demonstrated a six-fold increase (Filteu, et, al., 2017).

Concluding that between 2003-2014 incidence of NAS tripled in Canada alone. Further, there was a rise in the healthcare burden with NAS. Stating that there is a consistent increase in opioid use in Canada which is a direct correlation to the increase of NAS over the years (Filteu, et, al., 2017).

Northern Context

A study from Sioux Lookout Health Centre in Northwestern Ontario documented the incidence of NAS and narcotic use during the time of pregnancy. The design used was a retrospective chart review that took place between January 2009 to June 2010. The study found that narcotic use during pregnancy increased from 8.4% when the study began to 17.2% by the time the study concluded, resulting in 29% of the time the infant experienced NAS. An option discussed in the paper to respond to the increased need for supports was the idea of a healthy infant room. This is a room where parents can stay and bond with their baby after birth. An infant born with NAS, however, typically has a prolonged stay in a NICU anywhere from 5-50 days. This stay is most often away from the birth parent(s) because of the severity of the withdrawal and CAS involvement. The study discusses how having the birth parent-baby connection in these health infant rooms can begin to decrease withdrawal symptoms and speed up a recovery for a baby going through withdrawal (Kelly et al., 2011).

In Sudbury, the site of my practicum, CBC news reported that babies with NAS were showing up once a week in Sudbury's hospital (Dunn, 2017). Dr. Sean Murray, the medical director with NEO Kids at Health Sciences North, stated that he noticed an increase in babies

with an opioid addiction during the past four to six years. He discusses how he used to see one or less baby with NAS a month, but now it was at least once a week (Dunn, 2017). To me, not only does this suggest that NAS is on the rise, but the financial burden on the healthcare system is only increasing to a point that may be impossible to keep up with if it continues to increase overtime.

Current State of Practice in Canadian Hospitals

Medical management of the infant with NAS has emerged in recent years as a major challenge to healthcare professionals (Marcellus & Lenora, 2002). Marcellus and Lenora (2002) demonstrated that there is limited support for birth parents and caretakers for a baby with NAS. Most of the research surrounding NAS is focused on screening and scoring for NAS such as the numerical testing designed to decide the severity of NAS symptoms. There is very little information surrounding the supports that are put into place for the birth parents, foster parents, or caregivers taking home a baby being released from the hospital that is diagnosed with NAS. Many practices related to the care of infants exposed to drugs during the prenatal period have been developed on an anecdotal basis. There are few available research studies to validate these interventions.

Marcellus and Lenora (2002) reviewed a survey of Canadian hospitals with annual birth rates of greater than 500 described current practices used in daily care, discharge planning, community support for drug exposed infants and their families. The implications included: assessment and scoring of drug exposed infants; screening and testing prior to giving birth; pharmacology management; set discharge planning; being able to breastfeed; staff training and proper education on NAS; and working with community partners (Marcellus & Lenora, 2002).

Marcellus (2008) examined the context of foster parents providing loving families for infants that have been pre-exposed to substance use. The results demonstrated that fostering a child requires sustaining an emotional, physical, and positive environment. Further, it was demonstrated that there are three main phases in the process of administering love and guidance to families with infants of different needs: determining the families' determinations and readiness to become a foster parent; being able to foster the skills and experiences that are different according to needs; and the process of moving on (Marcellus, 2008).

Looking at discharge planning from the same study in Canada in 2002, a written discharge protocol specific to infants with NAS is in place in only 6% of hospitals country wide. A further 26% have a discharge protocol in place that applies to any infant in the NICU. Results show that although there are discharge protocols in place in some hospitals, they lack discharge support across many Canadian hospitals for babies and families dealing with NAS. Discharge protocols allow people to have further support and understanding of the medical condition and supports needed before taking an infant home. These protocols also allow the parent to have face to face time with one of the infant's care team members before leaving to hospital.

A study describing the current practice for NAS management across hospitals in Canada (Murphy, et, al., 2017) used a questionnaire to collect information on antenatal referrals, education and treatment for women who use opioids during their pregnancies. The researchers contacted 106 hospitals. Out of the 106, 103 confirmed that they provided care for NAS. Surprisingly only 77.4% had a minimum period of in hospital observation for an infant with NAS. 53.8% encouraged breastfeeding while 44.6% did not support breast feeding if the mother was using illicit drugs (Murphy, et, al., 2017). No significant differences in protocols were reported across hospitals in Canada in regard to treatment and diagnosis. The majority, 89.5%,

used the modified Finnegan scoring tool for NAS infant scoring. All hospitals sites reported the use non-pharmacological interventions first, before implementing pharmacological interventions for a baby with NAS. These interventions included swaddling, kangaroo care, dim lighting, etc. (Murphy, et, al., 2017). Many hospital sites had similar discharge protocols but varied in post discharge follow up measures. Post discharge referrals varied from pediatricians, family physician, developmental clinics and public health unities (Murphy, et, al., 2017). The study concluded that even though high percentages of hospitals have similar protocols and treatments for NAS, there were still notable differences across the settings. Researchers concluded that a national guideline for NAS care needs to be developed given that NAS is only been increasing over the last decade and continues to be on the rise (Murphy, et, al., 2017).

In 2018, Lacaze discussed discharge planning for infants born with NAS. Lacaze stated that for there to be a successful discharge, there needs to be continued care from an interdisciplinary and professional team. This plan should outline a weaning and medication schedule in order to best inform the parent who is caring for the infant after discharge (Lacaze, 2018). More successful outcomes arise when parents feel informed and educated by a care team, even after discharge (Lacaze, 2018).

Stigma and NAS

Stigma related to parenting and problematic substance use or addiction creates barriers to accessing health and social services for problematic substance use and it often makes people feel ashamed, which prevents them from receiving help. Hill (2010), from the Department of Medicine in California, discussed that, as a physician, one must acknowledge that it is more difficult to work with clients who have been affected by moral judgments, and he further emphasized the importance of reiterating a client's personal and social worth.

It is important to address the physician's perspective in order to address where stigma is arising from and be able to then eliminate these stigma barriers to health care with mothers who use substances or have an addiction and because the social worker typically works with the primary physicians on each case. Suggestions for improving the client-doctor relationship include education, communication, professionalism, and empathy (Hill, 2010). In turn, stigma can also effect supports that are put in place by healthcare professionals, based on their own biases towards a group of people in society. Structural stigma refers to a form of stigma where healthcare providers or first responders ignore, or do not take seriously, people with problematic substance use (Fonti et al., 2016). In their study of the attitudes and behaviours that healthcare professions used with women they were treating who used substances in the maternity setting, Fonti et al. (2016) found that among the studied healthcare professionals, a more negative or neutral view towards women who use substances during their pregnancies was found over positive and encouraging views.

In their qualitative study, Freazer et al. (2019) discussed treatment for problematic substance use disorders in pregnant women and found barriers to treatment that included: not wanting to be away from their partner or infant; concern for the loss of custody; concern of privacy and or stigma; and lack of transportation. The results revealed several major themes in motivators to seek treatment: readiness to stop using, concern for the baby's health, concern about custody of the baby or other children, wanting to escape violent environments or homelessness, and seeking structure. These barriers can have a profound impact on a mother's readiness to seek support and or treatment (Frazer et al., 2019). For women struggling with addiction, Frazer et al. (2019) described their pregnancies and after birth as times of high

vulnerability. Accessing proper treatment can be affected due to social or structural stigma, resulting in healthcare support not being available to parents during this time. Changing stigma and attitudes is complex, and there is a lack of research regarding interventions, training, and education in this area. However, it is important to address stigma as we see it as social workers on a regular basis. Therefore, we need to examine our own biases and attitudes when working in the field. Stigma often comes from ignorance and lack of education (Richter & Foster, 2013). Stigma can have harmful effects that can affect how people receive support or care; researchers have recognized that healthcare for mothers who use substances is highly stigmatized, and that these mothers face multiple social and health issues because of this stigma (Marcellus et al., 2015). A re-evaluation of our stigma toward pregnant women who use drugs during pregnancy will be necessary for any type of lasting impact on NAS support and good treatment. There is value in understanding the origins of stigma and the different theoretical definitions of stigma for this advanced this practicum thesis in order to address and explain where the stigma towards parents from which is it originates. After much review and time in the field, it is evident to me that stigma and professional attitudes and behaviours effect parents who use substances. Stigma can create an unhealthy environment and encourage oppression through the mistreatment of people (Marcellus et al., 2015). Further observing and connecting with stigma approaches and theories is beneficial in addressing the existence of stigma within the healthcare setting.

Emile Durkheim was one of the first theorists to explore stigma from a social phenomenon perspective in 1895. He addressed stigma as a power in society that judged and punished deviant acts and people's faults (Liamputtong & Kitisriworapan, 2012). Further advancing stigma theories was Erving Goffman, who quickly became one of the most influential sociologists that worked in the 20th century. Goffman's approach to stigma is particularly

impactful, as he defined stigma as a ‘gap’ that existed between an ‘actual’ social identity and a ‘virtual’ social identity that sought to classify groups of people as undesirable (Bos et al., 2013). In particular, structural stigma, and the way that this particular form of stigma idolizes institutions and portrays a societal ideology, contributes to stigmatization of people (Corrigan & Lam, 2007).

Goffman (2009) acknowledged that although there are various forms and types of stigma. Stigma is described as something that society has established in order to ‘other’ those who do not fit into the set ideas and attributes in social settings. He noted how there is an issue between how we look at actual social identity versus this virtual social identity ideal that is created from stigma. Goffman stated that we need to think critically about our judgements, and we must remember that not all undesirable attributes which stigma is created upon are actually societal issues. When stigma is present, it forces people to feel uncertain about how others view them and creates a sense of humiliation that can have many negative effects on one’s life (Goffman, 2009). He further discussed how the language we use can stigmatize those around us.

Bos et al. (2013) suggested that an approach to working against stigma requires an interdisciplinary team. Thus, developing approaches to foster collaboration between professions, which will allow for a better understanding of where stigma is arising from, and how to end stigma in each work setting. I believe interdisciplinary teams are critical when working with parents of babies with NAS. Working together to overcome obstacles and working from a person-centered approach is critical for best outcomes from both mom, baby, and the care team. Often, from my own observations of completing a practicum within the hospital setting, it is apparent that typically these mothers are being treated as undesirable parents and are made to feel shame, guilt, and blame, even indirectly. Stigma can be very much buried and remain an

underlying deficit in the medical field. As little as a medical professional not informing a parent about how their infant with NAS was scored during testing creates perpetual stigma between the parent and the medical professional or person holding power in that particular setting.

Stigma can play a large role in how mothers who use substances can be affected and treated. Further addressed will be ways in which professionals can begin to eliminate stigma and improve the care that mothers who use substance or have addiction receive.

Improving care for Women and Infants Affected by NAS

Despite the growing problem of increasing cases of NAS, there is limited data on the inter-observer reliability of NAS assessment tools, which is due to lack of a standardized approach. Most scales that have been used were developed prior to the prevalent use of prescribed prenatal concomitant medications, which can make the NAS assessment process more complex (Bagley et al., 2014).

Howard et al. (2017) looked at the impact of parental presence at the infant's bedside and its association with NAS. The study looked at this variable through a retrospective, single-center cohort study of these infants. It is apparent that despite the increased incidences of NAS occurring over the past decade, there is minimal data that exists on the benefits of parental presence at the bedside and NAS outcomes. The study showed that parental presence remained significantly vital with relation to reduced NAS scores and the number of opioid treatment days that the infant required. The study concluded that substantial time spent by parents at the infant' s bedside was associated with decreased severity of NAS symptoms (Howard et al., 2017).

Addressing the initial and root cause of addiction is important in improving NAS outcomes. Many people in our society view NAS as a result of voluntary drug addiction from irresponsible parents who would rather do drugs then care for themselves or their infants. This

stigmatizing view ignores the social and physiological realities of addiction and mental health, and societal factors that impact why people become addicted to substances in the first place (Withingtom & Monnat, 2019).

Ontario's clinical practice guidelines for NAS provide evidence-based recommendations that begin to access and address the needs of pregnant women who use substances and women who have newborns at risk for being born with NAS. According to the Provincial Council for Maternal health there are 14 recommended clinical practice guidelines for NAS. This document was revised on March 30th, 2012. The guidelines are as follows:

1.	Health care professionals should screen women of childbearing age for use of substances including opioids and alcohol
2.	Contraception counselling is an essential part of preventing unplanned pregnancies – whenever a woman is switching to longer term opioids such as methadone
3.	Have a neonatal care and maternal care plan
4.	Create circumstances for success, but when necessary access social risk and anticipate the future needs
5.	Discharge planning
6.	Toxicology testing can be done on all known and suspected cases of NAS
7.	Toxicology screening is to be done though urine and meconium testing
8.	Patient psychosocial screening upon suspicion of substances abuse can be done and may include social work, child protection or spiritual care services.

9.	The Modified Finnegan Scoring tool is the respected tool to be used to asses NAS
10.	Encourage parent's involvement while baby is in hospital
11.	Child protection is to be called if a parent tries to discharge their infant against medical advice
12.	Non- Pharmacological interventions should be used before pharmacological interventions begin
13.	Medications should be considered when supportive care measures fail to help withdrawal
14.	Morphine is to be considered the first pharmacological treatment when supportive measures fail

(Pcmch 2016).

These guidelines further suggest that reducing the incidence and impact of NAS will require immediate action from all levels in order to begin to see an improvement to the care of affected women and their infants (Dow, 2012). Suggestions for change include optimizing and standardizing treatment strategies, assessing and managing social risk, better monitoring of prescribing practices, and facilitating the implementation of better treatment and prevention strategies as they become available. It is intended that the clinical practice guidelines will provide the necessary framework to not only inform, but also support, the required development of a coordinated strategy that will address this important issue and, in turn, promote safe and effective care for these women and infants (Dow, 2012).

Mother Centered Care

When searching 'best practice for NAS care in hospital', often mother-centered or holistic measures are not what typically come up. This may be due to the bias and stigma that still very much exists around birth parents of a baby with NAS. With the rapid increase of the use of opioids, and an increased number of babies being born with NAS each year, it is very important to find resources and methods to reduce hospital stays, and costs that are detrimental to the medical and pharmaceutical systems.

The evidence is there to inform protocols of best practice including a mother-centered approach, encouraging breastfeeding, using the mother as the primary caregiver to treatment in hospital, and allowing rooming-in for mother and baby while in the hospital.

In a retrospective cohort study that took place between January 2004 to May 2011 that looked at infant drug withdrawal and rooming-in. The study looked at 73 mothers who had an infant admitted to the hospital for drug withdrawal. Of this number only 31.2% were rooming in with their infant. The study noted that 79% of infants had to be treated still with drug intervention vs. 88.7% of infants without rooming-in who had to be treated with drug intervention (Hunseler, et, at., 2013). Although there isn't a significant change in outcomes with rooming-vs not rooming in there is enough of a percentage in this study to indicate that supporting rooming-in contributes to better outcomes for NAS infants (Hunseler, et, at., 2013). The documentary The Milky way directed is a documentary that further looks at effective interventions in other places around the world which focus on mother centred care in the hospital setting. In Berlin at St. Joseph's hospital they had some of the highest breastfeeding rates in the world. They had adopted as a 'baby friendly hospital'. Baby friendly hospitals were launched by UNICED and World Health Organization in 1992 as a way to increase breastfeeding rates around

the world. These hospitals have a variety of maternity services that enable attachment and best strategies for both the mother and baby. Some of these services include having the mother be the primary care giver in the hospital 24 hours a day, having a place for her and the father to sleep over night at the bed side, and having the staff always available to help support and encourage parent with empowerment techniques (Fitzgerald, 2014)

O'Reilly (2006), through a feminist approach, discussed the value of mothers by recognizing maternal power and value. By lobbying for social and political change, feminists challenged the patriarchal definition of motherhood and looked further at the individual experiences of mothers and women centered practices of empowering mothers. Change begins with challenging attitudes and confronting bias that goes along with a birth mother being the primary caregiver to their infant. A more standardized, mother-centered approach to care has statistically been shown through extensive article searches to not only be beneficial to the healthcare system, but to the mother and her infant (Jasson & Velez, 2012). Further, Gooding et, al., (2011) discusses how family centered cared has been emphasised as an important element of infant care in the NICU setting. Family or mother centered care contributes to the belief that family members play an active role in infant recovery on social, developmental and social levels and roots in the belief that best outcomes are achieved when a family member is present.

The National Institute for Children's Health Quality (NICH) further solidifies that the mother centered approach is optimal for both mother and infant. By stating there are proven advantages to keeping the mother and baby together for as long as possible when a baby is going through withdrawal. Such as the scientific facts of benefits of skin-skin or breastfeeding. The Hospital of Pediatrics in New Haven published findings in 2018 that stated that the mother centred care approach for NAS reduced the length of stay in the hospital due to improved

withdrawal symptoms resulting in less need for drug treatment such a morphine for the infant (Hospital Pediatrics, 2018). Further the NICH discusses how the mother centered approach to care empowers mothers as care givers (NICH, 2019). Noted is how many hospitals may not have the space to support rooming in of mother and baby, but solutions need to be made in hospitals to support the togetherness of mother and baby. Empowering mothers as caregivers allows them to feel supported and empowered to be a parent, by providing the mother the space she needs to tend to her baby's needs to get to bond and know her baby even while admitted to the hospital. Empowering mothers allows health care workers to remove judgment and focus on the bond that needs to be built between the mother and baby, thus making the hospital stay an easier, healthier and comfortable time (NICH,2019).

Benefits to a Mother-Centered Care in the Hospital Setting

When looking at best practices for treating a baby with NAS, a mother-centered approach is beneficial to the baby. This approach can have an effect on the duration a baby stays admitted to the hospital. Babies suffer from many different withdrawal symptoms when they are born with NAS, such as sleeping issues, tremors, inability to be soothed, trouble gaining weight, high fevers, sweats, seizures, irritability, and sometimes death (Jansson & Velez, 2012). Throughout my advanced practicum, it became evident through discussions with the families, personal observations, and my literature review that often parents are made to feel stigmatized about parenting when caring for their own infant, especially moms because of gendered ideas of what a good and socially acceptable mother is. Mothers often disclosed feeling separated from the mother role or blocked from caring for their infant. The more common forms of treatment for NAS include medications such as morphine, which are prescribed to the infant (Mangat, Schmölzer & Kraft, 2019). However, in contrast to the medical model, there are many holistic

strategies available which focus on supportive care and are shown to help an infant with NAS thrive. For example, beneficial strategies include a dark and quiet, low stimulation environment, tight swaddling, on demand feedings, breastfeeding, and encouraging skin to skin contact with the mother to help promote comfort and attachment (NCPOEP, 2017).

Dr. Louise Dumas has done extensive research on skin to skin care and separation of babies from moms immediately after birth (Dumas et al., 2013) Unfortunately, in my experience it was uncommon for medical professionals to promote these mother-centered approaches to NAS care. A study done by Yang, et, al., in 2018 discussed professionals' attitudes towards breastfeeding in the hospital. The study concluded that although there is an emphasis on the importance of breastfeeding improved knowledge and attitudes on breastfeeding will help guide mothers in feeling more supported and confident to breastfeed (Yang, et, al., 2018). Further Marks and O'Conner (2015) discuss how often breastfeeding isn't supported in the hospital setting. They completed a study where the results indicated that there was a lack of promotion in breastfeeding and professionals felt as though their role was to inform about breastfeeding but not to promote or support the act of breastfeeding with mothers (Mars & O'Conner, 2015).

Mothering and Problematic Substance Use

Mother blame is a socially constructed concept where society blames a mother for any behaviour that is not seen as "proper", "normal", or "appropriate" (Carlson & Dermer, 2017). Throughout history, mothers have been held accountable for any behaviour that is viewed as atypical by society such as how many children a mother has, if she works, her age, what she wears, if she breasts feeds, or if she co-sleeps. Further, Richardson (2014) discusses the concept of 'mother blaming' and how mothering blaming is imbedded in our society, but society is also to blame for the construction of this concept over centuries. There is a long history of what we

call ‘mother blaming’, which refers to something a mother has done and how that impacts poor outcomes for the child (Richardson et al., 2014). Mothers were blamed over the decades for various things. One example was ‘refrigerator mothers’ which referred to a parent that was not emotionally warm to their child, and it was believed to cause autism (Richardson et al., 2014). More recently, a 2013 story that appeared on the health information website which claimed that if a mother had the flu during pregnancy, it could cause bipolar disorder (Richardson et al., 2014). Mothers are made to feel that good isn’t even good enough when it comes to parenting and these constant perceptions on mother from those who are not involved in her day to day life create feelings of shame and guilt that take away from the parenting process (Richardson et al., 2014).

Morton and Konrad (2009) discussed various theories within an interdisciplinary framework that would foster relationships with mothers who use substances in a healthcare setting. For example, having the ability to embrace a non-judgmental and caring relationship will assist in developing an effective relationship with this population. Through their interviews with mothers with addictions in the health care setting. Jackson and Mannix (2004) illustrated how mother blame can deeply affect a mother’s self-esteem during an already vulnerable and complex time. Themes that materialized from the narratives of mothers were mothers felt like terrible parents, keeping problems they may have to themselves in order to avoid being blamed labeled as a bad parent, feelings of never being a ‘good enough’ parent, and feelings of loneliness (Jackson & Mannix, 2004). Lefebrve et al., (2010) found that it is important to offer a non-judgmental space to allow for disclosure of their substance use. Participants felt more comfortable with healthcare providers who had a more accepting attitude towards their problematic substance use (Lefebvre et al., 2010). Support groups and doctor-patient

communication were other points that arose during this study (Lefebvre et al., 2010). People's attitudes in the supporting professions have a profound impact on people that use these services. Studies like these are of value to understand the impact these external factors have on a mother who is struggling with substances. professionals can support more families *productively* when they understand the issue from the group that is being affected.

Conclusion

After reviewing the current literature, it is evident that there is limited research and resources supporting NAS and mothers in general. However, particularly researched was almost non-existent when it came to social work and NAS care. When I would begin my searches for social work and related terms such as NAS parental support or education my searches would automatically change from social work to health care. I believe this speaks volumes to the reason I decided to address the missing information in health care and in social work and find out why it was happening and how it can be addressed. Due to the limited social work resources related to NAS supportive care for parents I had to rely on cues from other professions that I was working with in interdisciplinary teams, as well as sources that those professions have conducted through research on the topic. These other sources helped me be prepared for my role as a social worker coming into the hospital by having some understanding of what was going to be going on around me and how different views impact the information and supportive care mothers of babies with NAS receive. Further I was able to see how a social worker would be needed to help address some of these problems and stigmas that are occurring by providing social work services to the parent and then having discussions with medical professionals about what was needed by the parents. The paucity of research in general but particular to social work reflects the lack of resources applied in hospitals around the world for parents and caregivers taking home a baby

with NAS, and NAS is not made a priority due to the above challenges and stigmas. Evidently, foster care is a significant factor for this issue, yet a large portion of the research studies lack a recognition of this. The needs of the infant exposed to drugs are multiple, complex, and costly, both to the healthcare system and to society. The management of infants with NAS is controversial and hampered by the lack of evidence from properly conducted trials, and acceptance that problematic substance use is another aspect of mental health versus personal choice continues to be a struggle. Most studies investigate the management of NAS but neglect to take into consideration early interventions to improve mother and infant attachment, particularly in underserved and vulnerable populations. The prevalence of NAS only appears to be increasing and reviewing the above literature has provided me with an insight in what needs to begin to take place to start to better the support and care for mothering and problematic substance use or addiction.

Chapter 3: Overview and Reflection

The following chapter consists of an overall reflection of my practicum experience during my MSW. Discussed further will be the impact of my social location, reflection on different behaviours and treatments I observed while working within the hospital setting, and a reflection of my learning goals. My learning goals were to gain an understanding of NAS support, benefits to family centered approaches, attachment and anti-oppressive practice theory within the hospital setting and working with interdisciplinary teams in order to address problems within this system and begin to create change.

Social Location

It is important to recognize my social location in relation to anti-oppressive practice in social work and understand how one's social location can impact practice. As one's privilege of life circumstances and professional role can further oppressive people that social workers work with. Social location refers to a person being able to locate themselves within the different structures of society and is associated with structural social work practice (Heron, 2005). I am a white female in my early 20s who has the privilege of attending university and comes from a middle-class family and grew up with privilege. Throughout my placement I worked with mothers that came from many different backgrounds where it was important for me to reflect on my background when working with them as to not further oppress or say anything that would be insensitive to their social location and or beliefs. I found that I needed to focus on mom and baby and the issue of substance use. There is an idea in society that a mom is intentionally harming her baby by using problematic substances or if she has an addiction. Many people believe that a good mom would stop using as soon as she became pregnant as to not harm her own baby. I have never experienced being a parent or having gone through a pregnancy while using substances.

Having to reflect on this when working with families was important because I truly am unaware of how they would feel or what they have had to go through in their lives. Working from an antioppressive practice lens with mothers who experience a lot of mother blame and stigma within the hospital and continuing to recognizing social differences, power as a social concept, and practice reflexivity in the hospital setting is vastly important in ensuring that they not only are receiving the best possible care but that they are also comfortable being in the hospital with their infant as much as they possibly can be.

Kondrat (1999), discusses that self-awareness should be considered a necessity in being a competent social worker and that the reflection that you will then contribute to the work you can then do with the people that you work with. Reflecting on these points and dating back to starting the BSW program, I recognize that I wasn't always self-aware of my social location and experiences when working with people and the acknowledgement of how I grew up being a contributing factor to oppression in some situations as a social worker. As I went through my education and through this practicum, I was able to do a lot of self- reflection which built my general self-awareness. In particular, awareness on how your social location can impact the people you work with. For example, when entering this form of social work for my practicum I was aware I wanted to work within the NICU hospital setting but I wasn't sure what that meant entirely. After much discussion with my Supervisor in the hospital Alana before the start date of my placement we discussed what was needed in the hospital in the birthing centre, NICU and Pediatrics unit. The discussion led to the large need for focus to be on NAS babies and their parents. This all seemed to algin well for me because of my previous experience working around NAS babies in the foster care setting. However, it would be wrong for me to say that I did not

have my own thoughts and feelings around the use of substances while pregnant. Truthfully before trying to understand I would have said it was selfish to follow through with a pregnancy if you were dependant on substances because of the outcomes the baby would suffer with. Further, my initial thoughts were that these babies would all be going into foster care no questions asked because of the experience I have previously had with the foster system. When I began my work with Alana one of my comments was that we would be going through the NAS package with a foster or kinship parent mostly and she told me how rarely a NAS baby goes into foster care in the Sudbury hospital. That was a turning point for me, when I realized I was making assumptions and being oppressive without understanding a full situation that a person using substances who becomes pregnant is going through. Those assumptions were directly correlated with the experience I had with babies addicted to drugs in foster care and the privileges I had growing up, for example having a supportive family, having a safe place to live, not growing up in chronic pain where I was prescribed pain killers at a young age and having support with my university education from family, etc.

This was a particularly important awareness to learn especially when working through an anti-oppressive practice lens as a social worker in order to reflect on how you yourself can be oppressing the people you work with without awareness. I just assumed I wouldn't be working with a birth parent because of the thoughts I initially had of mothering and substance use and I began to realize the work I needed to do to not only understand but begin to un learn thoughts and pre-conceived bias and stigmas I had. Reflecting on these learned thoughts and behaviours were particularly important when beginning the work on the NAS care package that I would begin using with mothers and caregivers of babies with NAS.

Creating the NAS Care Package

Part of my learning plan was to develop an educational information package to be reviewed with caregivers of babies with NAS. The focus was to create an educational package that would be distributed and discussed with the parental figure who would take the infant with NAS home after discharge. Whether that caregiver is a birth parent, a family member, or a foster parent is less crucial because the care required for an infant with NAS is different than the care required for a healthy infant.

This information package and personal support given to the caregiver was developed to begin to bridge the informational gap and support given to the caregiver, resulting in less fear, anxiety, stressors, and safety for the infant with NAS. Subsequently the information was intended to be shared with families who were affected by NAS and begin to support and minimize the lack of support that currently exists in this area. The objective was to address the support that is missing for parents and caregivers going through the admission of a baby with NAS in healthcare through research and working directly with these families during my practicum to create the most optimal, beneficial package possible through evidence-based practice and direct contact. Most of the work was done with biological mothers something the biological father would be present and sometimes but rarely the work would be done with a foster or grandparent of the infant.

After doing some literature research and review, having conversations with parents who have had multiple children admitted for NAS, I was able to discern the best information that was needed for this package while being guided by the parents. I spent some time with a mother who had previous infants with NAS before her current infant admission. After spending time getting to know her and building a rapport with her, she was able to explain to me what was lacking about the care and the information, and what would have been beneficial to have known, or been

included in, during her other children's admissions. From these conversions and my synthesis of the current research, the NAS care package was then outlined to provide helpful guidance and information for parents and healthcare professionals in the hospital setting (see Appendix A).

The mothers that I had the opportunity to work and speak with reported feeling uninvolved in the care of their babies and often heard nursing staff refer to the mothers' babies as their own. Mothers stated a desire to know about the Modified Finnegan scoring system. This is a scoring tool that is used during the treatment of a NAS infant. Infants that show signs of withdrawal are put on treatment plans that are focused on supportive care and medications, such as morphine, to help manage NAS symptom withdrawals. Slowly, an infant is then weaned from the morphine as their NAS score improves. The NAS scoring sheet provided in the appendix is a standard score sheet used in most hospitals for scoring NAS, the scoring system looks at a range of different symptoms. It is recommended that each infant is scored every three to four hours while admitted to the hospital, but infants should undergo continuous monitoring of symptoms regardless (Marcellus, 2002). The evaluated scores indicate the significance of the withdrawal. It is noted in the literature that the Finnegan scale is an easy and reliable system (Marcellus, 2002). However, there is potential for subjectivity in scoring due to the amount of people nurses or care team members work with in a given shift (North Carolina Pregnancy & Opioid Exposure Project [NCPOEP], 2017). Many Mothers wished to have a healthcare professional physically explain and show them what this scoring system looked like. Subjects that were to be addressed in the informational package included: how to identify withdrawal, looking at scoring on withdrawal, signs and symptoms to look for in the event your infant is declining and becoming more sick, more affordable options when a person has a baby admitted to the NICU, how to manage staying in the hospital for a period of time, the proper technique to help soothe a baby with NAS

according to evidence based practices, what to expect when you are discharged from the hospital, and parking information and parking passes for the parents time in the hospital.

Unfortunately, this is where I began to run into bureaucratic red tape. In the hospital setting, I quickly learned that it is near impossible for administration to accept and approve any documents that were not already in use by the hospital and it was noted that they would not be approving of any document I created on my own for liability reasons of me being only a student at HSN. Which then quickly became a roadblock to my entire advanced practicum. Thankfully, my supervisor Alana and I were able to brainstorm a solution to this problem that would allow me to proceed with creating the information package and use it with families in a way that would be approved by the hospital itself.

The approach I took was collecting documents from the HSN website that had already been pre-approved information to share with patients. The documents on their own are hard to locate on the website if a person did not specifically know what they were looking for. I pulled pages directly from the hospital's NAS care guidelines, the parking information, prices and maps, information on the food options and WIFI, and a NAS scoring sheet. Further, I had information on an addictions program through HSN for those parents who wanted it, Northern travel grant information, and Healthcare connect information when needed.

I then created a check list to be attached to each package for facilitators. This facilitator checklist was important, especially for weekends when there is no social work coverage for nurses to be able to review before going through the package with these families, to ensure everything important was being discussed. The checklist read:

1. Went through the NAS package
2. If no family doctor-provide Healthcare connects information;

3. Present Northern Ontario travel Grant information if necessary;
4. Parking/Parking pass information
5. CAS information (when you would need to report);
6. Information on the length of hospital admission
7. How NAS is scored and how this can be subjective- provide scoring sheet
8. Conversation about addiction services through HSN (if person is open to this);
9. Mental Health and addiction services consult (If applicable);
10. Having a conversation about talking to their doctor about readjustment of suboxone or methadone after birth.

After the NAS care package and checklist was finalized, I was then able to begin to use the package in direct practice with families that had babies with NAS in the HSN hospital.

The direct and indirect practice I was able to ultimately engage in throughout the duration of this advanced practicum was ultimately beneficial in creating supports and addressing the gaps that are present in the current healthcare system. To further help families with child(ren) with NAS, information and support for parents and their infants would be provided by having printed, ready to use packages to be covered upon each new admission, as early as possible. When social workers would receive a new referral for a family with a baby with NAS, they would typically have an initial introductory conversation with the family in the NICU and, shortly after, they would be transferred over to the pediatric unit. The goal was to meet with the parent(s) as soon as possible and ask for consent to talk with a social worker regarding the NAS package

The package was distributed to each family upon admission to the hospital. During my time in the hospital, I only had one family not interested in a conversation or information on NAS from a social worker, but they still took the package to review on their own. After introducing myself and my role and receiving consent I would then sit down with the family in a quiet, private place and we would go through the care package. Beginning with describing what

NAS is, the family was shown the NAS score sheet and how it can be a soothing process. By the end, the family was informed on what to expect when they left the hospital. If it felt like it would be too overwhelming for the parent to sit and go through the entire package at once, I would break it up and go through the main points about being in the hospital and the supports, and then review the second half which involved what to expect when you leave the hospital closest to the time they were able to leave. After, we would go through the entire package, fill out any information, and go through any questions they had. I would leave them with the information package to keep so they would always be able to refer back to the information quickly if they ever needed to at any point, whether in hospital or home.

Professional Behaviours Observed

Often, nursing staff would hold the infant in the loud, bright nursing station even when the parents were present. Too often, I witnessed nursing staff not allow on-demand feedings, discourage breastfeeding, and tell the mother they should just go back home for the night without rationale. During the advanced practicum, I witnessed a parent not being present, not participating in breastfeeding, not experiencing skin-to-skin contact or bonding with the infant, and generally being encouraged not to be present. The infant from this case was admitted to hospital for almost three full months. On the other hand, parents I witnessed who were present at the bedside, participated in the above measures, and succeeded in creating an attachment with the infant resulted in the infant being discharged almost directly after the minimum required admission time for NAS. Teaching techniques to caregivers on specific needs of their NAS infant, including detailed demonstrations and help when needed with infant care and support, is an important factor in the supportive care approach to NAS care (Marcellus, 2002). Thus, education is another important factor in the NAS package which I created for families as a step

by-step way to review these practices with each family due to the fact that these aspects of care were not being modeled by medical staff it was important to include it in the package for families to physically have to be able to refer to when they needed it.

Evidence based practice is talked about widely in literature yet so much of health practice seems to be about more about what is convenient than other considerations for best practice. I witnessed derogatory statements made by medical professionals who described breastfeeding as 'gross' or 'disgusting', and they did not allow the mother to do on demand breastfeeding regularly. Breastfeeding was supplemented with formula against parental wishes. A mother I was working with was a strong advocate for herself and her child in wanting to breastfeed; this mother often reported to social work that the nurses would substitute her breast milk for formula when she was not around even after being clear that she only wanted her baby to be fed with breast milk. One specific time I came into the hospital, this particular mother was very upset because somehow a nurse had thrown out all of her pumped bottles of breast milk. She was devastated, and the solution given by the nursing staff was to substitute formula. This is just one of many examples that reflects how often in the healthcare system medical professionals value convenience over valuing the mothers wishes of using her own milk and connecting with her baby .After witnessing many concerns around breast feeding and observing different attitudes from medical professionals towards breastfeeding felt this was an important aspect to further investigate.

An empowering documentary titled *The Milky Way* (Fitzgerald, 2014) follows two lactation specialists and pediatric nurses, Chantal Molnar and Jennifer Davidson, as they endeavoured to uncover formula marketing, the many challenges of motherhood, and how this had changed their perception of motherhood and breastfeeding in the US. Together, they sought

to normalize breastfeeding in America, began to see a cultural shift, and restored the breastfeeding mother to a place of honour. Molnar and Davidson (2014) discussed how only 15% of babies were breastfed in the United States, and that, by the 1950s, the predominant attitude was that breastfeeding was disgusting and was openly discouraged by doctors. Stating that much of this conception came from the shift where breasts became sexualized features of the body versus multipurpose for feeding an infant. The lack of support and knowledge given to these moms also came from something called 'whose baby syndrome'. This phenomenon occurs when medical professionals experience ownership over an infant admitted to the hospital. Healthcare professionals are often the one doing the changing, feeding, and holding, but this is to the detriment, and exclusion of, the parent from this process because they are ignored, asked to leave, or simply not provided a room with their infant. Routinely, nurses are taking responsibility away from mothers and fathers which is detrimental to a baby's recovery and attachment to their mother. A study completed by Aagaard and Hall in 2010 look at mothers' experiences of having a baby in the NICU setting. The study results revealed that mothers often had the experience of feeling like an outsider or a stranger when they were with their baby (Aagaard & Hall, 2010). Mothers often reported that nurses act as "gatekeepers" and are constantly present in the NICU when they would enter the NICU to visit their baby and were made to feel as though they didn't belong. Reflecting upon this documentary and further source's it allowed me to connect how 'whose baby syndrome' was something I was witnessing often in the hospital setting and was having a direct effect on mothers breastfeeding their baby. Instead of allowing the mother to feed the baby as she wished to the medical professionals were constantly stepping in and deciding feeding schedules or replacing breastmilk with formula instead of encouraging mothers who wanted to breastfeed to do just that. Given what is known from research about the benefits of

breastfeeding, it was difficult to see breastfeeding not being encouraged especially when mothers preferred to engage in breastfeeding and on demand feedings over set scheduled formula feedings.

Babies in NICU or pediatric units are often seen as a product line versus a human being attached to its parent (Molnar & Davidson, 2015). Molnar and Davidson (2015) discussed how the separation of the baby from the mother is one of the most damaging interventions that professional medicine has come up with. When a mother has a baby in the hospital, the way that she is treated and encouraged makes a big difference on whether or not she will be able to breastfeed that infant. Noted is the importance of skin to skin, mother at the bedside and breastfeeding for better outcomes for babies within the NICU care setting. However often people do not witness hospitals encouraging parents to be at the bedside. During my time at HSN I witnessed on multiple occasions female nurses telling parents to go spend at night at home. I recall one situation in particular where both parents were in fact always present at the bedside of their baby and nursing staff were constantly telling them what they were doing wrong in terms of how she wished to feed and hold the baby. The staff would consistently encourage them to go spend nights away from the hospital and would always take the baby away from them and bring the baby into the nursing station away from them. Given what we know about parental presence at the bedside and what external factors irritate a baby with NAS I felt it was extremely inappropriate to remove the baby from the parents and bring the baby into a bright light loud area for what appeared to be no reason other than stigma towards the parents. Unfortunately, my placement at HSN ended before I was able to witness the discharge of this particular family to reflect on how their presence at the bedside impacted their baby and his health outcomes.

Peer Support in the NICU

Unfortunately, around the halfway point of the advanced practicum the pandemic had reached the hospital and I was no longer able to go into the HSN to attend my practicum. As protocols changed, Canadian Association for social work education (CASWE) released their protocols going forward for student placements during COVID-19. New protocols stated that I was to come up with a remote learning plan with my supervisor and my readers if possible. After getter the final word that I would not be going back to HSN to work directly with parents, I worked closely with Dr. Sandra Hoy to come up with a way to finish my required practicum hours and still do work related to in hospital supports. Discussed further will be creating a training guide for peer support in the NICU and working alongside a comic artist to provide information about NAS in order for them to create and educational comic that would explain best practice for NAS.

Dr. Sandra Hoy connected me with Michelle Buckner who is a breastfeeding buddies coordinator at KDCHC in Kitchener, Ontario. Michelle needed me to create a training forum that she could use to train her volunteers on peer support in the NICU setting. Being able to create this power point for training purposes fit perfectly with work I had been doing in the NICU and the literature I had read on peer support. (See Appendix C)

Peer support can be delivered through hospital or community-based programs and offer one on one, in-person or telephone matches, or support groups that meet in-person or via the internet. Peer support is a way to supplement or complement support but cannot replace services provided by medical professionals.

Engaging in this project was connected to my work in the hospital as peer support has been shown to improve outcomes for parents in their abilities and willingness to try certain things such as; breastfeeding, skin to skin, and rooming-in (Hall et al., 2015). Support for a mom

who has a baby in the NICU can help normalize the difficult emotions she is feeling and can decrease their sense of isolation. Peer support has been shown to help people in aspects such as depression, stress, emotional support, and isolation by first and foremost listening (Hall et al., 2015). Critically, peer support can be beneficial to parents of infants with NAS. The prevalence of NAS is increasing globally which resulted in an increased incidence of adverse neonatal outcomes, health costs, and less support and guidance for family's caretaking for a baby with NAS (Kelly & Jansson, 2016). Thus, peer support can be beneficial in encouraging parents who often feel alone, judged, lost, and stigmatized. Peer support can help moms with infant(s) with NAS to achieve long-term goals, maintain sobriety, and have non-judgmental support (Patrick et al., 2016).

The peer support model is rarely available in hospitals in the NICU care setting. However, there is a growing body of evidence on the benefits that peer support provides to parents of infants admitted to the NICU (Oza-Frank et al., 2014). Parents who have had peer support have reported increased well-being, confidence, coping skills, perception of support, acceptance, problem-solving skills, and overall empowerment. Parents reported decreases in stress, depression, and anxiety, and increases in their confidence in caring for their infants and better breastfeeding outcomes through support. Studies have shown that women were more likely to breastfeed if they received some form of peer support or peer-counseling as opposed to only professional care (Oza-Frank et al., 2014). Further peer support is known to help define and foster the 'mother' role within the NICU care setting, and simply being able to make meaningful supportive connections during what can be a very difficult time for many parents is beneficial (Meier et al., 2013). After completing the work for Michelle Buckner on peer support in the NICU care setting I was still a few hours short of completing my required hours for my

placement. I then was connected through Dr. Hoy to someone who creates educational comic strips on different topics. The purpose of the comic strip work was to reflect upon the main leaning outcomes for NAS for mothers and provide the information in an easy to understand and different way that would intrigue people to want to read and learn about.

NAS Comic Strips

For the second part of placement as part of the continued remote learning I then provided ten main learning outcomes on NAS supports for parents that were in the hospital to Dr. Sandra Hoy who them presented them to a planning group. The comic strip artist creates comic strips on educational issues as another resource of education. The ten outcomes came directly from speaking to parents at Health Sciences North during my practicum. The learning outcomes were set out with the goal to provide the comic artist with the main take always for NAS care support that I learned to help better education on what a parent needs and desires. This information, along with the NAS care package used at HSN, was sent to a planning group who are in the process of reviewing and making recommendations to a comic artist to make a comic strip on NAS.

Learning Outcomes Provided for NAS for Comic Strips

My practicum and extensive reading have allowed me to explore the question of best supports for parents of infants with NAS, to address what could be better, how they felt, and what was important for them. Although my time working on the pediatric, birthing center, and NICU units of the hospital for my master's practicum was limited, I was able to learn a lot through conversations and spending time with the moms of babies with NAS. When an infant is diagnosed with NAS after birth, they were automatically admitted to the hospital for a minimum of five days; however, most often they were admitted for weeks or sometimes even months. Throughout my placement, I was able to communicate with a lot of different families and complete readings and research on what is most important when working with a family who has a baby with NAS. The following are the ten significant learning outcomes I achieved after my time at HSN and completing my research.

The learning outcomes on NAS care from my time spent at HSN were written out and then they were provided to the comic artist. The learning outcomes were developed from conversations I had with parents while working in the hospital and the literature that I then reviewed. The following ten points were provided to the comic artist:

1.***Information about CAS***

After conversations with many different parents with babies with NAS a common theme that emerged was for parents to have the worry that as soon as their baby is presenting with NAS symptoms that CAS will be called. This fear often arose from the misconceptions surrounding CAS that they are put in place to strictly take babies away from parents. Many parents felt that because they have a history with problematic substance use or addiction that CAS was probably already watching them and would be ready to remove the baby from their care as soon as it was born and diagnosed with NAS. However, in most NAS cases, CAS does not need to be notified at all from what I witnessed in the hospital. It is critical from the beginning to eliminate some of the fear, although justifiable, around an automatic CAS call. As well, be as transparent as possible about CAS with parents and let them know reasons why CAS would be notified and possibly become involved.

2.Information about how NAS Scoring can be Subjective

The higher the NAS score, the longer a baby is admitted in the hospital. Mothers often noted they wish they were told that scoring can be subjective. Many different doctors and nurses score their babies throughout the day, which can lead to subjective scoring. The Finnegan Scoring tool for NAS is often discussed as having several factors that could impact scoring and is subjective by nature. This is because the scoring tool relies strictly on nurses' interpretations of

the infant's symptoms (Oei & Wouldes, 2020). Many parents I spoke with felt certain healthcare professionals treated them differently than others, which they felt lead the scoring to be influenced by their personal feelings or opinions. Mothers felt it would be beneficial to them if someone went through the scoring sheet with them so they understood exactly how their infant should be scored. This would allow them to speak up during scoring if they felt they were being treated unfairly.

3. Remove Stigma as a Barrier to NAS Education in the Hospital

Through my practicum I observed that in hospitals stigma, negative attitudes, and conflicts are occurring between medical professionals and mothers who use problematic substances. It is important as a health worker/social worker or medical professional to educate yourself on how professional's preconceived judgments related to stigma can affect patient care and the impact that may have on the patient. Often, professionals do not even know they have these judgments or that they are projecting them to the patient. It is important to be aware of yourself. The research suggests that stigma is one of the largest barriers to parents of babies with NAS getting further support, along with feeling safe in the hospital during their admission with their newborn.

4. ***Compassion***

Parents discussed with me feeling a lack of compassion, or lack of caring, from staff about their situation. They discussed how difficult it was to be living in the hospital for weeks and often were made to feel bad if they had to stay at their homes with their other children or were unable to make it into the hospital every day. Compassion can help us as professionals to understand someone else's situation and provide better patient care.

5. Use Mother-Centered Care in NAS care

From my observation and discussion with mothers in the hospital they often report feeling 'left out' of the mothering role when their infant is admitted to the hospital. Teaching the mother how to do certain things instead of doing them yourself as a medical professional is vastly important in engaging the mothers to feel like they are the primary caregiver of their infant. This is vital because even while being in the hospital for the first few days or weeks of their infant's life it is still critical for the mother-infant bond to take place and for the mother to feel as though this is her baby. Best practice includes a mother-centered approach, such as skin to skin, encouraging breastfeeding, using the mother as the primary caregiver to treatment in hospital, and allowing rooming in for mother and baby while in the hospital as these are all means of improving NAS scores.

6. Encourage Skin to Skin between Mother and Baby

Health care providers should follow best practice and inform parents on the benefits of skin to skin contact. As summarized in my literature review, NAS scores tend to improve when a parent is at the bedside and doing the primary caregiving and doing skin to skin with their baby as often as they can. After having conversations with the mothers, myself, many of them felt that there is not a lot of privacy for them to feel comfortable with skin to skin while in the Hospitals. Hospitals should allow for privacy, space and encourage them to use the curtains to feel more comfortable if this is a barrier for them.

7. Communication is Key

Often, mothers stated to me through conversations that there was a lack of communication between the healthcare professionals and themselves. They felt as though a lot of different aspects of their child's health, the scoring, or the test's that were being done were not

being communicated to them as the parent. Which is why it is important for social workers and other healthcare professionals to remember and reflect on how communication with the parents every step of the way is critical, as communication is important to achieve goals and foster a positive relationship between the parent and the healthcare workers. Further, social workers and healthcare professionals needs to remember first that the parent is, and should be, treated as the primary caregiver while their infant is admitted in the hospital.

8. Respect the Mother's Role as Primary Caregiver in the Hospital Setting

Supporting parents in taking care of their infants and being the primary caregiver is critical to the mother role and feeling involved in their infant's care (Sullivan, et.,al, 2011). It would be challenging for any parent to spend the first few weeks of their infant's life in a hospital. Often, mothers felt that they were treated differently than other NICU or Pediatric parents because their baby had NAS. They felt as though they were given no role and were treated as 'unworthy' of their baby. Again, removing that stigma and supporting a family/mother-centered approach is critical in improving the parent role in the NICU.

9. Education on Addiction and Substance use and Pregnancy

Substance use in pregnancy can be a very complex issue. Many external factors can contribute to problematic substance use and eliminating stigma, judgement, and negative attitudes towards families who use problematic substances is vital for optimal patient care. Social workers and medical professionals working with people who use substances or have addictions need to be educated on substance use addiction and be able to take a person-centered approach to care in order to continue to eliminate stigma and treat every person as an equal. The findings from the literature I reviewed from this thesis project and placement indicate that more training

for nursing staff needs to be implemented around substance use, environmental trauma, and social factors which influence the use of drugs. This knowledge would strengthen the relationship between the nursing staff and mothers and enable them to work more harmoniously in-patient care.

10.Provide Education on what NAS will Look like Through the Lifespan to Mothers

Although there is limited research on how NAS effects a child as they age, almost all NAS literature just describes symptoms during infancy and what causes NAS. It is important to provide the parent with NAS education from the birth of their baby in order to help them understand the special needs of their infant. Often, parents talked about not understanding what NAS looked like in their infant and what signs and symptoms they should be looking for. This is why our education package became so helpful to go through with parents from the beginning. The package discusses symptoms and signs, how to sooth a baby with NAS, what triggers a baby with NAS, and what to look for when you are no longer in the hospital refer to appendix. This is a package they can keep and take with them, so they can always refer back to it. Providing as much information as possible to the parent at their own pace is the best way to ensure optimal recovery and shorter hospital time for the infant. Additionally, this allows the parent to fully understand their baby's healthcare needs and for them to provide the best care. The goal is to help them learn to recognize their baby's signs, and what triggers or soothes their baby with NAS, because the behaviours of an infant with NAS differ from the behaviours of a healthy baby at birth.

The above ten learning outcomes that were passed on to the comic artist were all important outcomes that I needed to learn and understand to provide the best care I could for these mothers while I was working at HSN in a social work position. Although challenging to

learn these outcomes and fully understand their importance I was thankful to be able to discuss the different outcomes that I felt were most important during my supervision sessions with my supervisor.

Supervision/Group Supervision

At HSN, I was fortunate enough to have the opportunity to participate in one-to-one supervision along with group supervision. Informal supervision would occur multiple times per day. Working closely with Alana, we were able to share experiences, debrief, and discuss at almost any opportunity throughout the day. Supervision with Alana enabled me to review cases and referrals that I was doing on my own, as well as techniques and approaches I was utilizing when meeting with parents. I had my own HSN email and account for the program *Meditech*, which is where all the case notes are uploaded, and patient information is held. When I began writing my own case notes on *Meditech*, they would be reviewed and signed by Alana. Having Alana monitor my documentation was beneficial for us when discussing my cases; we could ask question back and forth that helped foster my learning and ability to write effective case notes. Alana was very effective in understanding how attachment was effective in the hospital setting with babies with NAS, along with working from an Anti-oppressive practice (AOP) theory lens in her practice. Having a supervisor with these experiences and knowledge was impactful in supervision when discussing the types of oppression, I was seeing, and becoming frustrated with, in the hospital setting and environment.

Clinical supervision with Alana was not only consistent with what I needed in supervision by being a safe space and place to expand on my knowledge but also encouraged me to consider the gaps in information and support that occur consistently in hospitals, especially with groups of people who are oppressed. At times, it became very frustrating to be the constant witness to medical professionals ignoring best practice and mother-centered approaches to NAS care, even though all the literature suggests those techniques are best for recovery. At times, I

became very overwhelmed and consumed when hearing the things medical professionals would say about some parents, like the persistent comments about how these mothers do not deserve their babies. I can recall one situation where an employee was calling someone's baby by a different name that the employee had given to the baby because she felt ownership over the baby and would constantly speak negatively about that baby's mother. I became very conflicted being a person in a student role with little power and I was unsure how to engage in these types of conversations or deal with things I was overhearing on a daily basis. Supervision with Alana was especially helpful in situations such as the one above as Alana had experience hearing such things and is working on educating, not only others, but herself. The hierarchy in a hospital setting can also affect these types of feelings, as I was witness to on multiple occasions to social work being treated as lesser then the job of a nurse or other medical professional. This fact makes it difficult to be taken seriously by individuals in any one of those professions and they do not often believe that what you have to say is accurate. Throughout supervision learning, many aspects of our discussion's where woven into AOP in terms of what I was witnessing where medical staff appeared to not reflect an AOP lens when working with mothers. Further as we discussed different situations or circumstances I was working within while in the hospital Alana and I would discuss how to continue to work from AOP and not further oppress the mothers we were working with even if the situations or circumstances were difficult to work within.

Through the time I spent as an MSW student in the hospital it became clear that there are many challenges that can arise for a social worker in this environment. Being witness to the comments and/or degrading attitudes regarding mothers who use substances became a very challenging aspect of the practicum. Being a student, I felt like I was unable to directly address things I would overhear or see. Gregorian (2005) writes about social work in health care and how

hospitals can be challenging environments for social workers to thrive in because of the complex challenges that can arise. One particular point in this paper that stood out to me was how he mentions that hospitals can be extremely old-fashioned in the way that they organize and are male dominated, and he further reflects on how social workers often struggle with authority in the hospital setting. This is something I observed in my practicum not necessarily on a gender basis but on a power dynamic level. Often times, the social work department was made to feel lesser than any other profession. Social work was expected to do any little job that another profession didn't want to do. Such as calling CAS even if social work wasn't present during the incident, handing out parking passes and being told to 'babysit' children on the pediatric unit when the nursing staff had many students of their own on shift that day. Gregorian (2005) refers to this feeling as other professions imposing their own definition of what they feel social workers do. This was something I discussed in supervision often. Further, Gregorian (2005) reflects on how social workers who work in the hospital need to develop strong professional boundaries while learning to manage their own emotions as a lot of the work they do involves struggle and loss (Gregorian, 2005). At HSN, there were many different cases I witnessed that involved grief and heartache. I imagine, that if I were to work in that environment too long, I believe would lead to compassion fatigue. Being able to fully engage in these conversations with my supervisor and have her to debrief with through the more difficult situations were critical in me developing personal and professional skills and boundaries that I will be able to take with me into the field of social work and future practice.

I also engaged in supervision debriefing to process how hard it can be at times to recognize our own biases when working from a client or mother-centred approach, especially when surrounded by interdisciplinary teams who are not considering these factors, biases, and

approaches when working with mothers who use problematic substances. It can be easy to get caught up in the attitudes and perceptions that we are surrounded by in a work environment, but being able to understand biases and recognizing these biases, were helpful to me for making logic-based, educational decisions on instincts or opinions forming around me all day, every day as a social worker in the hospital environment.

Once a month, all the social workers from each department at HSN meet for group supervision. Group supervision can be helpful in realizing you are not alone in the struggles you face as a social worker in the clinical hospital setting. Unfortunately, with my placement being cut short at HSN, I only attended a couple of these meetings; but they were beneficial overall. I felt it was important engaging in these group supervision sessions because there was a lot of support around the table and understanding of social work as a profession. Which came as relief considering social workers are only able to interact with other professionals who often do not understand exactly what social workers do. During the monthly sessions, each department could raise issues and talk through strategies and interventions together, which I found to be very insightful and was able to use them to enhance my social work knowledge. Talking through antioppressive practice strategies in this setting and expanding our knowledge to other professions was often discussed during these sessions. One limitation I noted during group supervision that I was able to discuss with Alana was how every other department social worker mainly worked with adults. There were many instances when they could not relate to what we were dealing with in the birthing centre, NICU or pediatrics. Often, we would be almost excluded from the conversation because many of the issues raised would be about forms or referrals that did not relate to our department.

Overall, during supervision, Alana encouraged me to critically think about each aspect of the job, and to reflect on my goals professionally and personally throughout the advanced practicum. Through supervision, I was able to gain more insight on AOP, critical reflection, case notes, and professional growth. Being able to take time to be frustrated, debrief, and address how my bias or feelings toward something could unintentionally oppress or create conflict between myself and a client, or myself and another worker, was important to learn. It was beneficial to discuss our biases and feelings in an open setting and to learn ways to express our concerns with coworkers in a professional manner. Supervision was important in helping me meet my learning goals and to have an optimal learning and growing experience professionally and personally in the field of social work.

Having the opportunity to engage in clinical supervision and have constant access to my supervisor Alana when I needed to discuss or debrief situations was extremely beneficial in helping me meet my set-out learning goals and further my learning and education and be able to apply the theory into practice as a professional.

Applying Theory in Practice

Social workers can contribute to social oppression when choosing to not resist it, or when they do not acknowledge our own biases and stigmas that evidently exist by not continuing to educate themselves. Social workers have the duty of questioning and challenging these oppressions and stigmas that are happening in the places that we work. Social work gives us the opportunity to empower those we work with by listening to lived experiences and to then create suggestions and recommendations for bettering the lives of the people social workers work with.

Working through the lens of attachment theory and anti-oppressive practice theory have enabled me to see aspects that effect education and support for families of babies with NAS.

Working through an AOP lens enabled me to look at parents who use substances within their social context and help to not only identify but begin to address the structural patterns of oppression and stigma that were leading to inequalities and negative attitudes in the hospital setting. AOP enabled me as a social worker to view the complexity of oppression and understand my moral and ethical responsibility of challenging these oppressions. Being able to apply AOP when engaging with mothers of babies with NAS through challenging at times was beneficial to the care these mothers received but also to my own personal reflection and growth as a social worker. It was critical to my practice to look at the complexity of the oppression that was occurring within the hospital setting and seek to treat everyone I worked with as an equal. As anti-oppressive practice in social work seeks to explain and understand the disadvantages and try and create solutions. Anti-oppressive practice to me is critical to use in progressive social work in order to help social workers identify issues that are arising through an intersectional lens and how social workers can help to address these issues. As I became more confident in the engaging in AOP and addressing my own personal stigmas and bias towards mothering and substance use I was able to address when medical professionals were not engaging in AOP with these mothers and where problem behaviours were coming from and how implementing this care package could help not only parents but medical professionals begin to understand the importance of creating that relationship with the parent in order to ensure that everyone is being treated ethically and is valued as a person in that system. When deciding what information needed to go into the NAS package it was important to look through an AOP lens in order to ensure I wasn't being belittling and was including all the aspects that would be important to not only their infants care but the care of the parent while they were in the hospital as well. During my conversations with parents I was really able to understand ways in which they were feeling

oppressed or treated unfairly because of their use of substances or addictions while mothering. Taking the time to understand a person's situation from a person-centered approach through looking at their life through personal, social, structural and environmental context helped me in unlearning the thoughts and bias I had towards mothers who used substances as well. AOP helped me to work to empower these mothers by supporting them in knowing that they are capable of being a good parent, through conversations and going through the information with them by encouraging them to know that they already are equipped with all of the skills they need to care for their infant. Often times in the hospital I witnessed parents and mothers second guessing their abilities after discussion with a medical professional, these would be times that it became critical for social work to have discussions with these parents about how they were feeling and why. Being able to understand AOP as a transformative tool in improving not only the work that social workers do but engaging in changing our own attitude and the attitudes around us was a very valuable aspect to my learning and growing as a social worker.

Furthermore, attachment theory provided me with a strong lens for understanding the impact that can be made on attachment within the hospital setting. It became very evident to me how this was happening and how attachment can and was being affected in the hospital during an infant's admission and how this situation can, in turn, effect outcomes for infants with NAS. Experiences of the NICU or pediatrics unit may interfere with attachment by not fostering the mother-infant bond, when medical professionals take over all infant care and refer to a baby as their own, excluding the parent or telling them to go home. I have read in the literature how attachment can be affected by not having a strong parental presence at the bedside. However, this advanced practicum enabled me to witness first-hand how exactly this attachment was happening in the hospital, seeing the different outcomes between parents who were present all the time

compared to those who were not, therefore, witnessing the differences in their baby's outcomes. Too often I witnessed nurses ignore a mother's wish, whether it was about breastfeeding, on demand feeding, or baths. Having an understanding of attachment theory helped me reflect on those type of situations and see how the ideology of what an ideal mother is, is still very prominent today within the hospital setting. Attachment theory enlightened me about the work that needs to be done on encouraging mothers to be having normal parenting experience while in the hospital. When a baby is admitted to the hospital the parenting role should not change by taking away the mother's opportunity to care for her baby in ways that she would choose to if she were home. These decisions directly can have an impact on not only the type of attachment that is formed but also on the infant's medical outcome and recovery. The medical treatment of the baby is the job of the medical professionals not the individual parenting decisions. Advancing mother-centered practice and AOP in the hospitals is critical in hospital environments in order to continue to have optimal care and support for both mother and baby. In doing so, professionals are able to provide better outcomes for not only mother and baby, but also institutionally and financially in hospitals as there will be shorter hospital stays and medical intervention needed by simply fostering the attachment and working though mother-centered care.

Chapter 4: Conclusion

The following chapter will engage in final thoughts, reflections and implications for social work that came from my overall experience while working at Health Sciences North in NAS care with mothers who use problematic substances and or have addictions.

Information Gaps and Anti-Stigma Education in NAS Care

Pregnant women and mothers who use(d) substances such as opioids are commonly stigmatized and judged for using these substances, which can have a direct effect on how they feel about themselves as parents, as well as how they are treated by society and within medicine (Stone, 2015). The gap in supporting and educating parents about NAS through the process of having a baby with NAS in a hospital setting and being admitted was apparent when working in the hospital and reviewing the literature. It became clear when beginning my practicum that there was a need for education regarding personal biases and stigma from medical professionals towards parents who use substances in order to provide the much-needed support that these families require while in the hospital.

With the goal of putting together the NAS care package and using it in the hospital setting, I was able to begin to educate medical staff and social workers on specifically what parents need from us during this difficult process. Ultimately, the goal was to have information that can be shared with families who are affected by NAS and to begin to support and minimize the missing support and information that currently exists in this area. The objective is to address the support that is lacking for parents going through the admission process of a baby with NAS in healthcare. Understanding how professional healthcare providers' stigmatizing views effect patient care an important area for further investigation in the field of social work is. This stigma is why I set out to create a support system through conversations with parents and research that

could be followed through my professional experience working as a part of the families' care team.

Stigma, prejudice, and oppression are apparent in the lives of mothers who use substances which directly affects how these mothers feel about themselves as well as their ability to parent in the hospital setting. Problematic substance use in pregnancy can be a very complex issue and, as predicted, there are many external factors that can contribute to this problematic substance use that are not taken into consideration by professionals in the field. Having discussions with parents about how they felt and what they needed was very important during this advanced practicum. When beginning to address the lack of support and information I had begun implementing the package and was set to bring it to the morning team huddle to show and explain it to the medical staff when I was no longer able to go back into the hospital. While a difficult experience, this opportunity was important for creating more awareness and education in this area; however, Alana continues to implement and hand out the care package with families who have babies with NAS to continue the supportive role in social work.

Outcomes and Implications for Social Work

Substance use in pregnancy is a complex social and health issue. Many external factors contribute to substance use and eliminating stigma, judgement, and negative attitudes towards families who use substances is vital for optimal patient care. The advanced practicum helped me to strengthen my professional skills as a social worker by working alongside an experienced social worker in this particular field of work. By being able to provide social work skills, such as critical thinking, empathy, active listening, and responding, I was able to communicate and support families throughout their admission.

I was able to address the missing support in hospitals regarding NAS care in supporting

families with NAS and begin this conversation within the hospital. However, when I first started this advanced practicum, I predicted that reducing this lack of support and information would happen through education on what was needed in direct support for NAS. It quickly became clear that this gap was more about the medical model and the lack of education that creates bias, stigma, and oppression to parents who use problematic substances. Education is a key intervention for those who work in the medical care setting, whether that be doctors, nurses or social workers. Education on NAS care and how to better support these families is critical in seeing improved outcomes and support for these families. As previously mentioned, patient outcomes can be a direct indication of how the medical team exercises their care. In this case, a baby with NAS thrives and recovers much slower when not using the mother-centered approach, by ignoring the attachment needs of that infant to its mother, and by not following proper guidelines for NAS protocols in recovery. By mutual learning, education on problematic substance use and the mother-centered approach are the main ways of addressing these stigmas in healthcare. The well-established evidence-based practice behind the mother-centered approach has been suggested as the most optimal in infant mother care and recovery, thus creating social change. We have a duty as professionals to remain sensitive to people's experiences and to educate ourselves on how to improve support and care for the people with whom we work. Further implications for social work in the hospital setting from this advanced practicum suggest the explicit need to establish the role of the social worker within the hospital setting and not succumbing to the assumptions made by other professionals about a social workers duty. Further having the NAS care package and the information about professional bias and stigma an helping to educate the interdisciplinary teams in which social workers work with in order to advocate not only for these babies but for their mothers as well, thus creating a more positive and

beneficial hospital stay for everyone involved. As the opioid crisis continues to rise and hospitals continue to see the rise in NAS social workers must begin educating themselves on NAS and work within the best practice recommendations to begin to provide positive support and information to these families. By also helping begin to eliminate medical professional stigma through problematic substance use and addiction education and understanding. As hospitals continue to see a rise in NAS cases social workers must begin to educate themselves on problematic substance use, addiction and pregnancy. By following the best practice guidelines for NAS care and ultimately improving outcomes for both mother and baby`

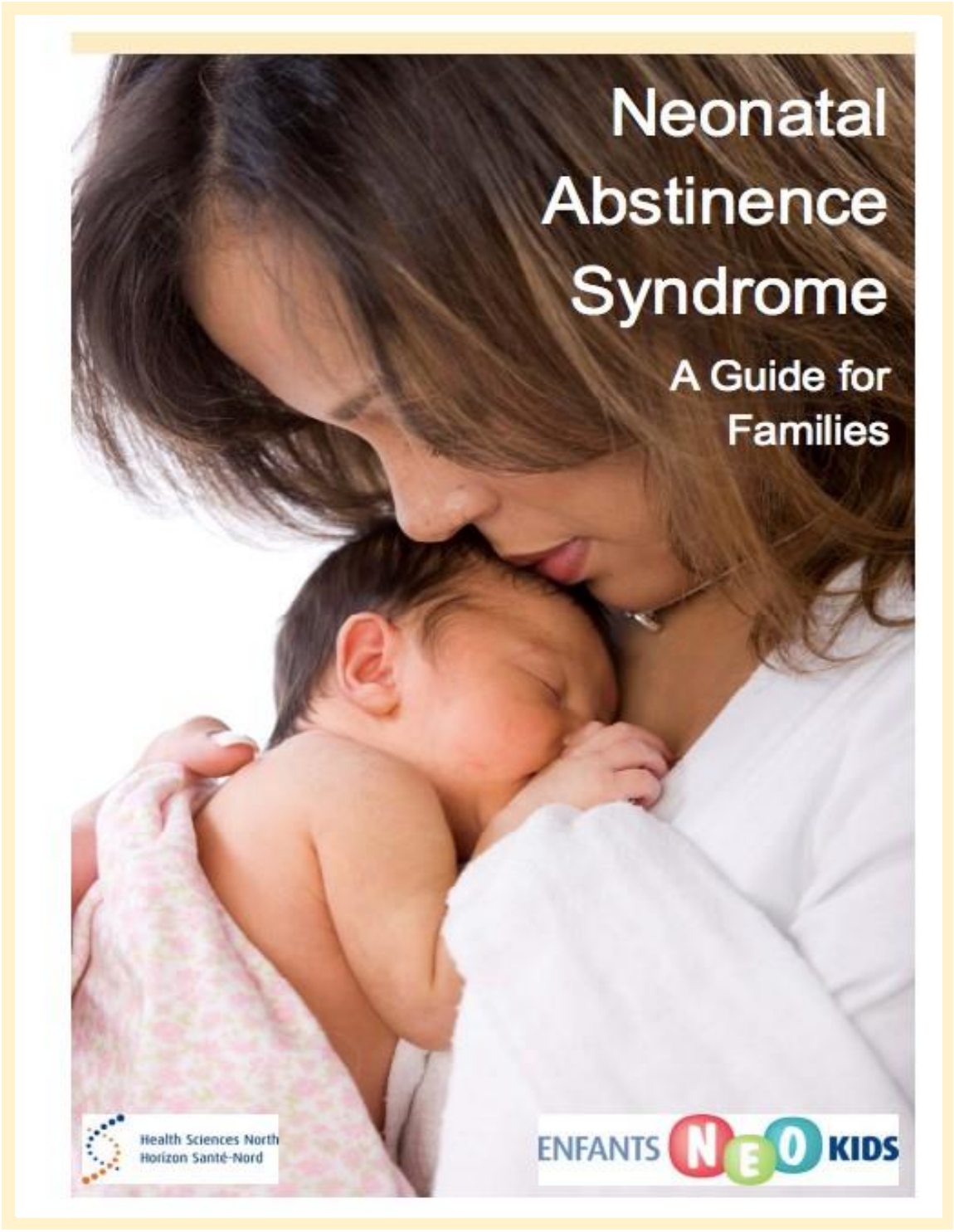
Concluding Remarks

Understanding mothers' experiences when being in the hospital with their baby with NAS is critical to improving practice and integrating education and approaches to help better their experiences while in the hospital and after they are discharged. Having these conversations and hearing about the firsthand experience and perspectives from mothers facing the stigma, oppression, and negative attitudes was extremely beneficial in creating the needed resources for HSN using their pre-approved sources. Mothers want to succeed so it is important that we take away the stigma of the assumption that because they use problematic substances, they are not a good person or worthy of being a parent. Education about stigma and discrimination is highly needed in the medical profession on addiction and parenting. My hope is that the care package continues to be used in the hospital at HSN, not only by social workers, but also by all medical staff who work with mothers who use(d) substances in order to continue to create an environment of support, eliminate stigma, and provide a better environment for recovery for both infant and mother. People often think of mother and baby as separate, when in fact considering attachment and optimal healing is necessary for considering the mother and infant as one unit

that needs one another. Fostering and encouraging this relationship is most important when addressing best practice in care for infants with NAS.

Appendices

Appendix A: NAS Care Package



What is Neonatal Abstinence Syndrome (NAS)?

When will my baby show signs of NAS?

Most babies show signs of withdrawal, or NAS, between 1 and 5 days after birth. The time it takes for signs to show can depend on how much and what kind of medicine or drug the baby's mother took and for how long. It can also depend on whether or not the baby's mother used other kinds of substances as well, such as alcohol, tobacco, or additional medicines.

It is very important to tell your nurse and your baby's doctors about all medicines and drugs used during your pregnancy. This will help them treat your baby.

What will happen if my baby is in withdrawal?

Beginning soon after your baby's birth, nurses will check for certain signs in your baby and give him or her a "score" depending on which NAS signs are present or not. Your baby will be scored every few hours until he or she is ready to go home. The scoring helps doctors decide which types of treatment your baby needs to get better. The nurses will explain the scoring to you. If something is not clear, please ask for more information until your questions are answered.

What are the signs of NAS?

- High-pitched cries or crankiness
- Stiff arms, legs and back
- Trouble sleeping
- Shaking, jitters or lots of sucking
- Not eating well or problems sucking
- Vomiting due to overeating or crankiness
- Fast breathing and/or stuffy nose
- Sneezing or yawning a lot
- Irritation on diaper area due to loose, watery stools
- Irritation on face, back of head, arms and/or legs due to restlessness
- Poor weight gain after a few days of life
- Seizures (These are hard to spot and can last seconds or minutes. Your baby may suddenly start jerking his or her arms and legs or may go stiff. You may also see eye rolling, staring, lip smacking, sucking or a change in skin colour. Seizures are a late sign of NAS.)

Treatment for Babies with NAS - Love, Hugs and Care

If your baby is showing signs of withdrawal, loving and caring may be some of the best medicine. The combination of loving, hugging, holding your baby close and, in some cases, medicine can help your baby.

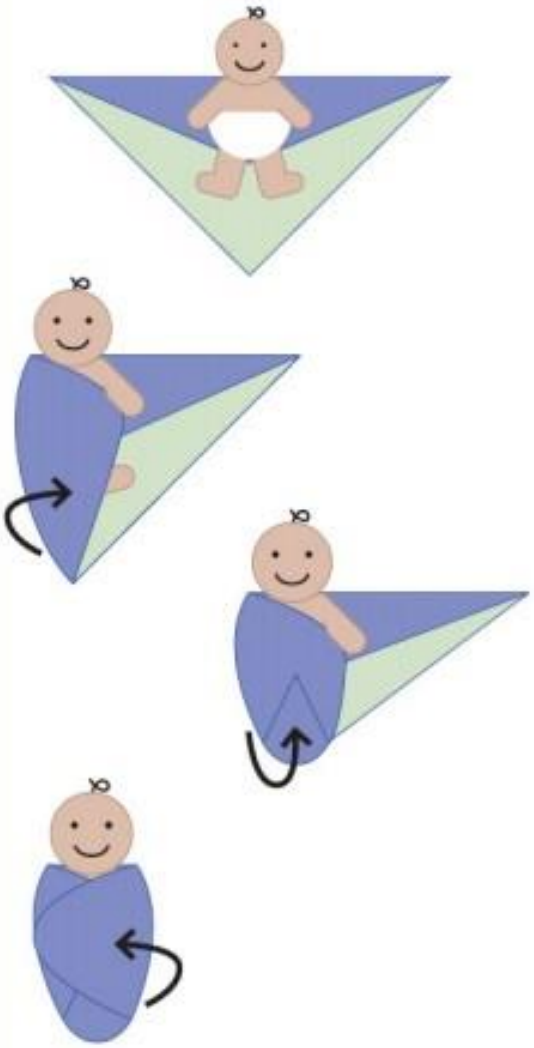
How can I help my baby?

Whether or not your baby needs medicine, you can help your baby by:

- Staying close to your baby
- Continually holding and swaddling your baby
- Making skin-to-skin contact with your baby
- Feeding your baby whenever he or she looks hungry
- Keeping things quiet and calm around your baby (few visitors, no noise, no bright lights)
- Breastfeeding

Your nurse can help you learn how to swaddle your baby if you want to practice or do not know how. If you have any questions, please ask.

How to swaddle your baby



Does my baby need medicine to get better?

If your baby has many strong signs of withdrawal, your doctor may give him or her medicine to help. The medicine that babies with NAS are given most often is morphine. Sometimes other medicines may be added to help your baby during this time. Your doctor or nurse can explain your baby's medication in more detail.

What happens if my baby is given medicine for NAS?

- Medicine like morphine will help your baby be calm and comfortable.
- Medicine will reduce your baby's risk of having seizures.
- As your baby starts to get better, the dose of medicine will slowly be lowered, and then stopped.

How long will my baby need treatment?

NAS can last from one week up to many weeks. It is hard to know how long it will last. The length of withdrawal depends on the medicines or drugs – and the amounts – your baby was exposed to during pregnancy.

If advised by your physician, breastfeeding may help your baby. It is generally safe for mothers to breastfeed if they are in a stable treatment program, even if you are taking medicine given to you by a doctor or nurse – and even if the medicine is for drug withdrawal. Breastfeeding is not safe for mothers who are not in a treatment program, or who are using alcohol or illegal drugs. Talk to your doctor about breastfeeding and the medicines you may be taking. Talk to your doctor about treatment options for opiate addiction.

When can my baby leave the hospital?

Babies who do not need medication to control NAS may stay in the hospital for up to a week. Many babies who need medication for NAS stay in the hospital up to 3-4 weeks, and rarely some may stay longer. It all depends on how your baby responds to treatment.

During your baby's hospital stay, the NAS signs will lessen. Your baby will be discharged when there is little risk for serious problems.

When baby comes home, the journey continues

Remember, babies cry a lot and babies with NAS tend to cry more often and easily. Helping yourself and managing your stress will help you care for your baby.

- Settle into a quiet, low-lit room to feed your baby.
- Gently rock or sway your baby to calm him or her. Do not walk or sway your baby while feeding.
- If you feel upset, walk away and take deep breaths for a few minutes.
- Never shake your baby or put anything over your baby's face to quiet your baby.
- Call a family member, friend, or your baby's doctor or nurse if you feel upset, angry, scared, or just need help. Everyone needs help sometimes.

What to Expect When Your Baby Leaves the Hospital

Parent and family support can make a big difference in how fast a baby with NAS gets better. Babies can continue to have mild symptoms of withdrawal for up to 6 months after leaving the hospital.

Once at home, your baby may continue to experience the following:

- Problems feeding
- Slow weight gain
- Crankiness
- Sleep problems
- Sneezing, stuffy nose and trouble breathing

Your baby's doctor and nurse will teach you ways to take care of your baby. They also will show you how you can help your baby if he or she is having any of the problems listed. Practice caring for your baby while you are in the hospital so you are more comfortable at home.

Asking questions helps you help your baby

If you have any questions or concerns about your baby when you are at home, or if something just does not seem right, talk to your baby's doctor or nurse. It is important to feel comfortable taking care of your baby, and asking questions – any questions helps you help your baby.

Ways to Support and Care for Your Baby

Parents and caregivers of a baby with NAS can help the baby get better. Here are some things you can do:

- Make your baby comfortable by setting up a routine, letting few people visit, talking softly, keeping the room quiet and dim (turn off the TV or radio, turn your phone down or off, and turn down the lights).
- Let your baby sleep as long as needed and without being woken up suddenly.
- Make feeding time quiet and calm, and burp your baby often.
- Learn to spot your baby's "I am upset" signs, whether he or she is yawning, sneezing, shaking, crying, or frowning. Also know the signs that say your baby is happy, hungry, or relaxed.
- When your baby is upset, stop what you are doing, hold your baby skin-to-skin or gently swaddle him or her in a blanket on your chest. Let your baby calm down before trying anything new, or gently sway or rock your baby.
- Gently and slowly introduce new things to your baby one at a time.
- As your baby becomes calmer for longer periods of time, start checking to see if he or she might like to have the blanket wrapped more loosely or taken off sometimes.

You play an important role in helping your baby get better.
Pay attention to your baby's needs. Helping your baby stay calm and comfortable is some of the best medicine he or she will ever receive.
If you have any questions, ask your doctor or nurse.

Tips for Caring for Babies Going Through Withdrawal

- Loving and learning to spot your baby's needs goes a long way.
- Take care of yourself – take breaks, ask others for help sometimes – so you can be there when your baby really needs you.
- Follow all of the doctor's directions for taking care of your baby and yourself.
- If you are in a drug treatment program, stay as long as your doctor says. If your doctor says you need to be in one, go.
- Keep things calm and quiet around your baby.
- Swaddle, gently rock or sway, or use skin-to-skin contact with your baby.
- Talk to your baby softly and gently.

Key Contacts

My doctor's name and contact information:

_____

_____

_____

_____

My nurse's name and contact information:

_____

_____

_____

_____

Other contacts:

_____

_____

_____

_____

_____

Taking care of your baby also means taking care of yourself,
from following your doctor's orders to keeping up your treatment plan.
Please remember, we are here to help you and your family!

Notes

Babies use their bodies and voices to communicate all the time. Write down the things that seem to make your baby happy and unhappy. Also, note the best ways to calm your baby.

How do I know when my baby is unhappy?

_____

_____

_____

How do I know when my baby is happy?

_____

_____

_____

What seems to relax my baby?

_____

_____

_____

How else can I help my baby?

_____

_____

_____

NAS Scoring Tool

MRN NAME DOB

SIGNS
Observations from past 3–4 hours.
Start new scoring sheet each calendar day.

Birth Weight: _____ grams (x 90% = _____ grams)
Daily Weight: _____ grams

DATE:	SCORE	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
High pitched cry: inconsolable >15 sec. OR intermittently for <5 min.	2								
High pitched cry: inconsolable >15 sec. AND intermittently for ≥5 min.	3								
Sleeps <1 hour after feeding	3								
Sleeps <2 hours after feeding	2								
Sleeps <3 hours after feeding	1								
Hyperactive Moro	1								
Markedly hyperactive Moro	2								
Mild tremors: disturbed	1								
Moderate–severe tremors: disturbed	2								
Mild tremors: undisturbed	1								
Moderate–severe tremors: undisturbed	2								
Increased muscle tone	1–2								
Excoriation (indicate specific area): _____	1–2								
Generalized seizure	8								
Fever ≥37.2°C (99°F)	1								
Frequent yawning (≥4 in an interval)	1								
Sweating	1								
Nasal stuffiness	1								
Sneezing (≥4 in an interval)	1								
Tachypnea (rate >60/min.)	2								
Poor feeding	2								
Vomiting (or regurgitation)	2								
Loose stools	2								
≤90% of birth weight	2								
Excessive irritability	1–3								
Total score									
Initials of scorer									

Printed Name	Signature/Title	Initials	Printed Name	Signature/Title	Initials

HSN's Parking System

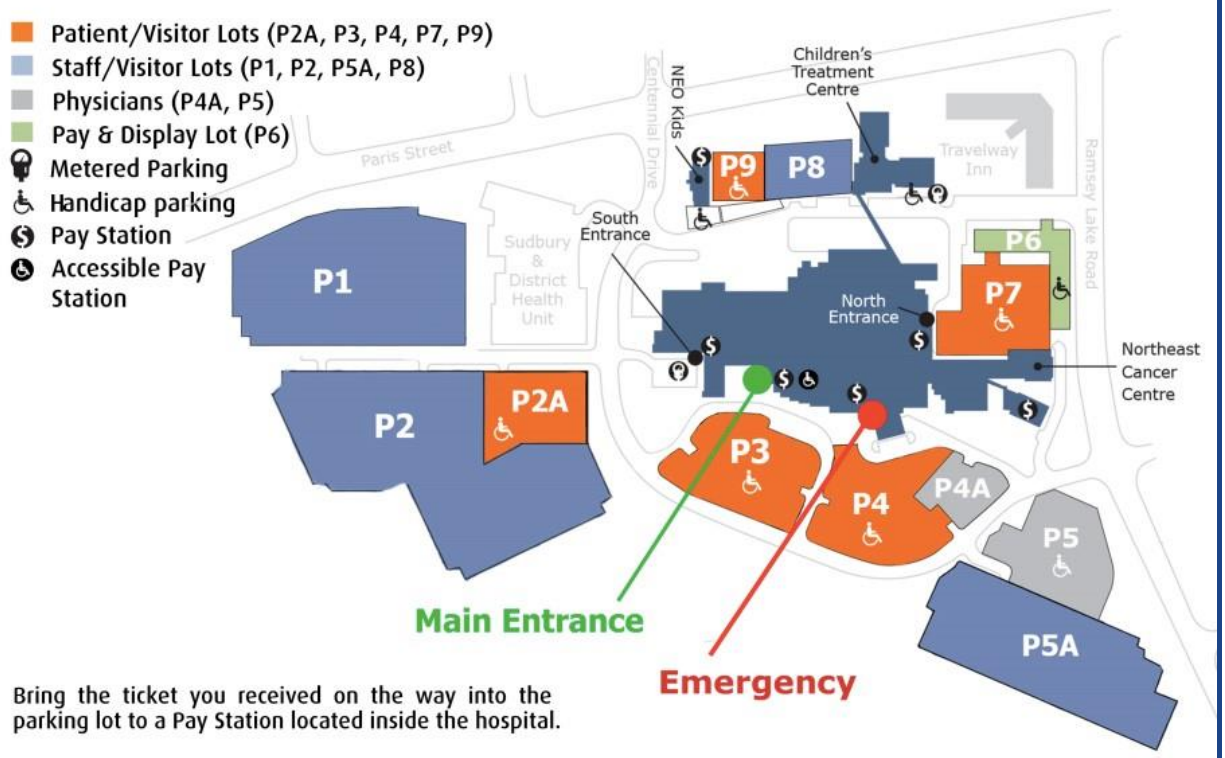
Patient/Visitor Lots – Ramsey Lake Health Centre (P2A, P3, P4, P7, P9)	
1st hour	$3
2nd hour	$2
3rd hour	$1
Extra hour to a maximum of $10/day	$1
1- Day Pass *(unlimited in/out for 24 hours to all parking lots except Pay & Display)*	$10

Patient/Visitor Lots – Sudbury Outpatient Centre (ACU entrance)	
1st hour	$3
2nd hour	$2
3rd hour	$1
Extra hour to a maximum of $10/exit	$1
1- Day Pass	$10

Staff/Visitor Lots – Ramsey Lake Health Centre (P1, P2, and P5A)	
Flat Rate Per Exit	$6
1- Day Pass (unlimited in/out for 24 hours to all parking lots except Pay & Display)	$10
Weekly Pass	$30
Monthly pass*: Ramsey Lake Health Centre or Sudbury Outpatient Centre	$80

Staff / Visitor Lots - Ramsey Lake Health Centre (P8) and Sudbury Outpatient Centre (front lot)	
1st hour	$3
2nd hour	$2
3rd hour	$1
Daily maximum exit fee	$6
1- Day Pass (unlimited in/out for 24 hours to all parking lots except Pay & Display)	$10
Weekly Pass	$30
Monthly pass*: Ramsey Lake Health Centre or Sudbury Outpatient Centre	$80

* Note: a $20 deposit is required when purchasing a parking pass which will be refunded once the card is returned. Please visit the Finance office on Level 1 South Tower at the Ramsey Lake Health Centre for passes. The Finance office is open Monday to Friday 8 a.m. to 4 p.m.



Bring the ticket you received on the way into the parking lot to a Pay Station located inside the hospital.

Please pay for parking: (1) after your appointment or visit and (2) before you return to your vehicle.

Cafeteria / Tim Hortons

Cafeteria services for staff and visitors:

Cafeteria services features beverages, sandwiches, hot meals and baked goods. Vending machines containing pop, juice and snacks are also available. The cafeteria is located on the 2nd floor of the Ramsey Lake Health Centre.

Tim Hortons

The hospital has two full service Tim Hortons located near the main entrance and Northeast Cancer Centre.

Free Public WiFi

Health Sciences North is pleased to offer free public WiFi for patients and visitors in the following locations of the hospital:

- Ramsey Lake Health Centre Cafeteria (by Rock Garden Café)
- Main Entrance of Ramsey Lake Health Centre (by Tim Hortons)
- Main Entrance of the Northeast Cancer Centre (by Tim Hortons)
- Pediatric Chemotherapy Suites in the Northeast Cancer Centre
- Main Entrance of the Daffodil Lodge in the Northeast Cancer Centre

AMCT

ADDICTION MEDICINE CONSULT TEAM

Interdisciplinary addictions team providing capacity building through education and consultation with hospital staff and brief intervention with patients.

Our experienced team can provide rapid access for patients to a variety of long-term addictions support services as well as other local community support services.

REFERRAL PROCESS

We are accepting referrals via Order Entry under the **AMT** category (Addiction Medicine Team)

Health Sciences North
Horizon Santé-Nord

AMCT PROVIDES ASSISTANCE WITH

- Complicated withdrawal
- Opiate replacement therapy
- Treatment planning for complex patients
- Brief motivational counselling for patients
- Involved with discharge planning
- Harm reduction education

CONTACT

CLINICAL TEAM

Monique Marquis (RN)
Jamie Grimshaw (RSW)
Dr. Bradley Long
Dr. Sastry Bhagavatula

PHONE
(705) 523-7100 x3543

FAX
(705) 671-5261

HOURS
Monday-Friday
8:00 AM-4:00 PM

Health Care Connect

Helping you find a family doctor or nurse practitioner

ontario.ca/healthcareconnect

Health Care Connect helps people who are without a family health care provider to find one.

How does Health Care Connect support your search for a family health care provider?

Health Care Connect is a program that will help people without a regular health care provider find one in their community. The program identifies doctors or nurse practitioners who are accepting patients and links them with people who are in need of a family health care provider.

How to join the program

Registering for Health Care Connect is easy. When you call 1-800-445-1822 you will speak to someone who will ask you a short series of questions and sign you up for the program. You can also sign up online at **ontario.ca/healthcareconnect**

Health Care Connect gives priority to those most in need of a family health care provider

Priority is given to individuals with greater health needs.

You will be referred to a family doctor or nurse practitioner in your community once one is found.

Health Care Connect is here to assist you. But you should keep looking for a health care provider on your own as well.

What you need to know about Health Care Connect

- Health Care Connect assists you in your search for a family doctor or nurse practitioner
- It does not guarantee that one will be found, so you should also continue looking on your own
- You should have an OHIP number.

A Care Connector supports your search for a family health care provider

Once you've joined Health Care Connect, a nurse, called a Care Connector, will be assigned to help you find a health care provider in your area.

Your Care Connector and You

Be sure to get in touch with your Care Connector if your contact information or health changes.

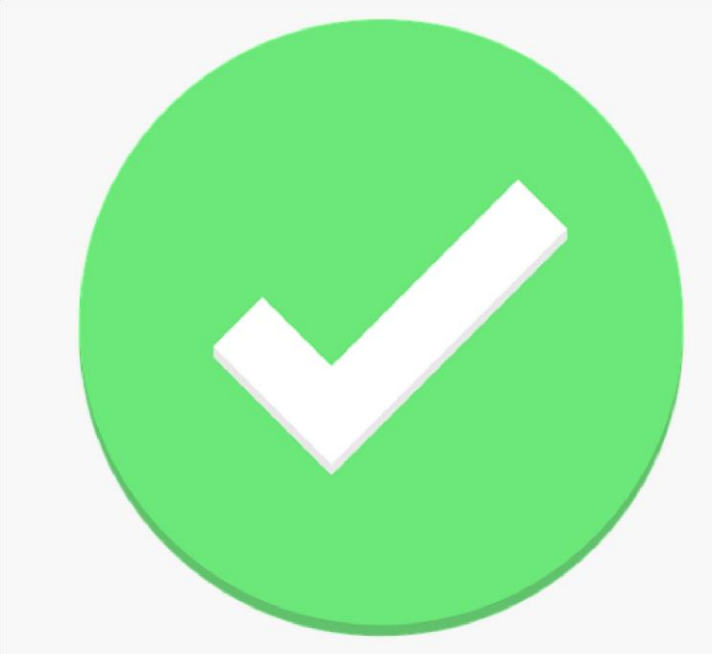
Do you need a family doctor or nurse practitioner? Call 1-800-445-1822 or visit ontario.ca/healthcareconnect

Health Care Connect Cat#011E86 Revised 11/10 ISBN 978-1-4435-5464-0 (PDF) © 2010 Queen's Printer for Ontario

Ontario

Appendix B: Facilitator Check List

Facilitators Package to review before and after NAS package Review with Families



Facilitator checklist

- Went through the pamphlet
- If no family doctor - provide Healthcare connects information
- Present Northern Ontario travel Grant information
- Parking/ parking pass information
- CAS information (When you would need to report)
- Information on length of hospital stay (minimum 5 days with a baby with NAS)-baby needs to be gaining weight typically during that time
- How NAS is scored/ provided scoring sheet
- Conversation about addictions services through HSN
- Mental Health and addictions services consult (if applicable)
- Talk to your doctor after baby is born about readjustment of methadone or suboxone

Appendix C: Peer Support Slides

Peer Support in the Neonatal Intensive Care Unit (NICU)

Supporting Mom's in the NICU

Overview

- What is Peer Support?
- Types of NICU Peer Support
- Maternal Identity
- Neonatal Abstinence Syndrome (NAS)
- Best Practice in Peer Support
- Breastfeeding Support
- Impact of Peer Support: Mom's experiences

Peer Support

→ Peer support is often given through volunteers who have been through similar experiences in their lives. (exp.Past experience with a child in the NICU now providing support to a parent in the NICU with her infant).

→ Peer support can be delivered through hospital- or community-based programs that offer one-to-one in-person or telephone matches, or support groups that meet in-person or via the internet.

→ Peer support is a way to supplement or complement support but cannot replace services provided by medical professionals

→ Peer support has been shown to improve outcomes for parents in abilities and willingness to try certain things. Exp. breastfeeding, skin-skin, rooming-in.

(Hall, Ryan, Beatty & Grubbs, 2015)

Types of Peer Support

- Peer support can be unique to families in the NICU. There are a variety of models for providing peer support in a hospital setting. (Hall, Ryan, Beatty & Grubbs, 2015)

- It is important to note that each individual will experience peer-support differently and have differing needs. The models of peer support can be modified specific to who you are supporting and their family's individual needs or wants.

- In hospital peer support can continue once the parent has left the hospital if both parties wish to continue with this form of support

Types of Peer Support con't

In person Support→ In this model volunteers are closely matched with a parent in the NICU based on language, culture, baby's diagnosis, family makeup etc. The volunteer will then arrange times with their match and meet in person to then provide support and encouragement through experience and just being physically there to listen, mentor, provide advice and form a trusting relationship.

Telephone Support→ Providing peer support by telephone, instead of in-person, can offer many benefits to NICU parents who may not have time to meet in person for various reasons. Connections can occur with more flexibility or spontaneously.Telephone support can be more easily accessible to all moms regardless of geographic location and or socioeconomic status.

Parent Support Groups→ These groups can be run by a veteran parent in collaboration with a NICU medical team for space and time.These groups typically have goals and information regarding mutual topics or concerns and provide parents normalization to what they are experiencing with their child in the NICU.

Internet/Web Support Groups→ Sites or chat rooms can be monitored and created by veteran parents or by health-care providers. Collective knowledge is available at all times regardless of participation. This method is beneficial because parents can access support at anytime from anywhere.

(Hall, Ryan, Beatty & Grubbs, 2015), ("Peer Support | Support 4 NICU Parents", 2019)

Maternal Identity

Maternal identity speaks to the maternal role mothers have once giving birth and being discharged home. It can often be a struggle for moms to find their maternal identity when their infant is in the NICU for a long period of time. Peer support can help the mothers throughout every stage of their infant's hospitalizations, through helping them begin to develop maternal identity, through positive reinforcement and encouragement, personal stories, providing anticipatory guidance, etc. (Rossman, Greene & Meier, 2015)

What is Neonatal Abstinence Syndrome (NAS)?

→ It is important to understand NAS when conducting peer support in the NICU as the incidence of NAS is rising rapidly each year

→ The provincial council for maternal and child health classifies Neonatal Abstinence Syndrome (NAS) as neonatal withdrawal symptoms from maternal use of drugs from addiction. This puts the infant at an increased risk of preterm birth, low birth weight, and intrauterine growth restrictions. The incidence of reported NAS in Canada tripled between 2003 and 2014, with an average annual increase of 0.33 cases per 1000 live births. The incidence of NAS is increasing in Canada with associated rise in healthcare resource utilization (Filteau & Coo, 2018).

→ The prevalence of Neonatal Abstinence Syndrome (NAS) is increasing globally resulting in an increased incidence of adverse neonatal outcomes, health costs and less support and guidance for families caretaking for a baby with NAS (Kelly & Jansson, 2016).

→ Peer support can be beneficial in encouraging parents who often feel alone, judged, lost and stigmatized. Peer support can help NAS moms to achieve long-term goals, maintain sobriety and have non-judgmental support. With NAS peer support it is important to maintain ongoing support (Patrick et al., 2016)

Best Practice in Peer-Support

Planning and Preparation→ identifying needs of the target population

Articulated Policies→ role boundaries and confidentiality.

Leverage Benefits→ social support, leadership, improved self-confidence and experiential learning

Enable Continued Learning→ Communicate with other people engaging in peer support in order to improve/learn new skills and support each other through a similar experience

(Daniels et al., 2013)

How To Best Support Moms In The NICU

-Support for a mom who has a baby in the NICU can help normalize the difficult emotions she is feeling and can decrease their sense of isolation. Peer support has been shown to help people, in aspects such as depression, stress, emotional support and isolation by first and foremost listening.

-Remember that these parents have doctors and nurses day in and day out telling them what they need to do, it is important to know as peer support you are not there as another professional in their life.

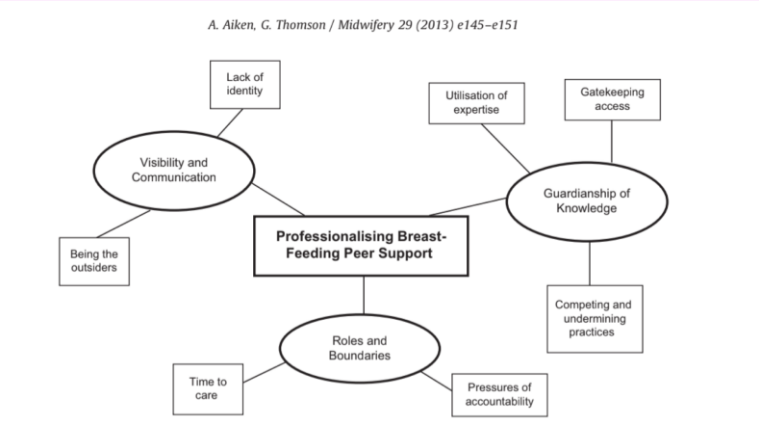
-Ask what they need out of the relationship, let them know you are a non-judgmental support

1. Normalize
2. Listen
3. Respect
4. Non-Judgement
5. Engage (Ask)

Breastfeeding specific Peer -support in NICU

→ Some hospitals have introduced peer support programs for breastfeeding as an additional level of service to be provided to support new breastfeeding mothers

→ Provide non-clinical one -on-one breastfeeding peer support to women who have babies in the NICU



(Aiken & Thomson, 2013)

Breastfeeding Support: Outcomes

→ Studies have shown that women were more likely to breastfeed if they received some form of peer support or peercounseling opposed to only professional care

→ Peer support breast feeding programs provide quality, cost-effective lactation care

→ Studies have concluded that expanding NICU lactation staff, and adding peer support has concluded in increased breastfeeding support and improved outcomes for NICU moms feeling more confident and supported to breastfeed

→ Peer support had been the most effective in improving breastfeeding outcomes and duration

→ There is limited data on breastfeeding peer support after discharge and further research is recommended to focus on ways to improve breastfeeding rates after discharge to sustain breastfeeding and the support

(Meier, Engstrom & Rossman, 2013), (Oza-Frank, Bhatia & Smith, 2014)

Mom's Experiences (Feedback)

'I know now that pumping struggle is common.'

'This is amazing to me and I'm feeling so blessed to be somewhere that I can be a part of something so wonderful'.

'Truly one of a kind support and brings tears to my eyes

that i'm not alone in this' 'I felt less alone'

'I was empowered in my role as a mother. Being in the NICU with my son I didn't know my role'

'Being able to have support without judgment, stigma or medical terms really helped me during the month my baby was in the NICU'

('Best Start', 2016)

Mom's Experiences con't

One study completed by the Best Start program presented research at the 2016 Best Start conference, and concluded that out of their 34 moms studied after peer-support:

22/34 felt less isolated

25/34 felt they had more support

21/34 felt less anxious

19/34 feel better about being at hospital with their infant

('Best Start', 2016)

Overall Outcomes

⟶ There is a growing body of evidence of the benefits that peer support provides to parents of NICU infants. Parents who have had peer support have reported increased well -being, confidence, coping skills, perception of support, acceptance, problem -solving skills and overall empowerment.

→ Parents report decreases in stress, depression, anxiety and increases in their confidence in caring for their infants

→ Better breastfeeding outcomes and support

→ Helping to define the 'mother' role within the NICU

→ Making meaningful connections

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