Overview: Treating SUD among pregnant and post partum women

FMRS Health Systems, Inc.

Jaime Cantley, MHA, ADC-S, CCM, NCAC2
Karen Dominick, PRC

Learning objectives:

- Review epidemiology and scope of opioid use among pregnant and post partum women (PPW) in Appalachia
- Explore stigma and barriers to treatment for substance use disorders (SUD)
- Review three-pronged approach to treatment
- Review guiding practices published by American Society of Addiction Medicine (ASAM)
- Explore the role of Peer Recovery Coaches (PRC)

Introduction:

- Pregnancy is hard. The post-partum period is hard. Period.
- Maternal opioid use can have long-lasting and severe impact on both the mother and the developing fetus [1]
- Treatment should be evidence-based and comprehensive [3, 5, 7]
- Women are still left untreated due to stigma [6]

Epidemiology: Substance use

- 27 million people in the US reported current use of an illicit drug or misuse of Rx drugs in the past 30 days [4]
- Women of childbearing age, ages 15–44, who reported heroin use in the last 30 days increased 31 percent from 2011–2012 [4]
- The prevalence of opioid use disorder (OUD) during pregnancy more than doubled between 1998 and 2011 [14]

Epidemiology: West Virginia

- Appalachia faces unique challenges in the treatment of SUD in both general population and the PPW population [12, 17]
- WV has a exceptional need for prenatal public health drug treatment and prevention resources, specifically targeting the southeastern region [17]
- The effects are felt throughout the entire state; cost is high [12, 17]
- Rural areas are less likely to offer treatment resources specific to the needs of women [2,12, 17]

Drug-exposed infants and NAS:

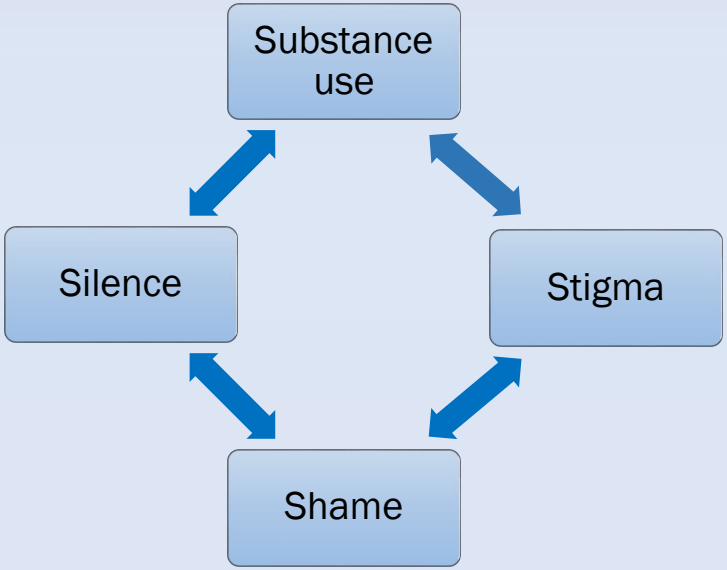
- 30% of pregnancies complicated by opioid use disorders result in preterm birth [17]
- NAS has both short and long-term effects [1, 17]
- An “expected and treatable” condition [15]
- Sometimes requires extended hospitalization
- Financial cost is great ($3,500 per day for an average length of stay of 30 days) [10]

Barriers to Treatment:

- Social [2,6, 16]
  - Community attitude
  - Limited support
  - Sigma surrounding MAT
- Personal [2,6, 16]
  - Sense of self-efficacy
  - Shame, fear
  - Comorbid psychiatric diagnoses
- Familial [6, 12, 16]
  - Family members with active SUD
  - Family bias/secrets
- Logistical [6, 12, 14, 16]
  - Transportation
  - Lack of child care
- Medical [2,6, 12, 16]
  - Fear of judgment
  - Staff attitudes
  - Limited access to services
- Legal [6, 16]
  - Fear of losing rights
  - Criminalization of substance use during pregnancy
  - Ongoing involvement of illegal activity

Consequences to Barriers:

- Prevents women from accessing SUD and mental health services in both prenatal and postpartum periods [2,6,11]
- Increased risk of NAS [1,17]
- Increased risks of preterm delivery, low infant birth weight, and transmitting HIV to their infants [1,2,6,10,11]



Guiding principles of treatment:

- PPW SUD treatment is a challenging and complex process that requires a multidisciplinary approach of evidence-based interventions [13]
- Though the mother is the primary client at this point, the health of the fetus is considered in all treatment decisions [2, 6,7,10, 11, 13]
- Goal is to engage client, not punish
- As a treatment provider or a peer recovery coach, check and challenge your own personal biases and worldview

Three pronged treatment approach:

- Screening and assessment:
  - Discover and identify substance use or disorders in PPW
  - Develop a plan for treatment in collaboration with client
- Initiating pharmacology:
  - Introduce appropriate medication to stabilize client and reduce risk to fetus
  - Monitor and maintain appropriate pharmacological intervention
- Behavioral and psychosocial interventions:
  - Address psychosocial issues that may compromise recovery efforts
  - Develop skills necessary for developing and maintaining recovery

Screening and assessment:

- Screening should include a variety of items that may impact the healthcare of the PPW and fetus/infant
  - Substance use and SUD
  - Mental health
  - Unsafe behaviors
  - Communicable diseases
  - Use of state-based prescription drug monitoring programs (PDMP)
  - Toxicology screening

Pharmacotherapy:

- Medication assisted treatment (MAT) is recommended for pregnant women who are diagnosed with an Opioid use disorder
- Medically monitored conversion from illicit opioid use to opioid maintenance is indicated
  - Decreases maternal and neonatal morbidity
  - Minimizes withdrawal and risk of complications
  - Reduces risk-taking behavior associated with illicit use
  - Decreasing the spread of HCV and HIV
  - Is associated with the improved utilization of health care services such as prenatal care
- NAS may occur, but the severity is much less severe than without treatment

Pharmacotherapy cont.:

- Methadone
- Gold standard of treatment for PPW
- Approved for pregnant and breastfeeding women
- There is no correlation between dosage, severity, and length of NAS
- Used to treat the physiological symptoms of associated with opioid dependency in infants

- Buprenorphine
- 10% lower incidence of NAS [13]
- decreased neonatal treatment time by 8.46 days
- less morphine needed for NAS treatment by 3.6mg [13]
- Insufficient evidence to establish superiority of either drug [2]

Psychosocial treatment guidelines:

- Primary objective is to assist pregnant woman in stabilization/harm reduction
- Evidence-based interventions employed across all levels of care
    - Create and foster engagement
    - Maintain motivation
    - Move from one level of care to the next
    - Culturally appropriate
    - Women-centered
- Treat comorbid psychiatric issues concurrently
    - High prevalence (56%-73%) of comorbid SUD and mood, psychotic, and anxiety disorders.

Psychosocial treatment strategies:

Intervention	Definition	Examples
Harm reduction:	Aim to reduce risk associated with substance use and ancillary behaviors	• Education and outreach • Small reduction in illicit drug use per day - limiting frequency of use, • Needle exchanges • -MAT
Cognitive behavioral therapy (CBT):	Identification and restructuring or replacement of maladaptive but functional beliefs that contribute to substance use	• Challenging beliefs to change behaviors • "Examining the evidence" • Skill building
Motivational interviewing (MI):	Client-centered approach that increases a client's internal readiness and motivation to make a change	• Increase sense of self-efficacy • Facilitate change talk • Decisional balance • OARS
Contingency management:	Use of positive reinforcement (adding a desirable thing) for healthy behavior, and the use of undesirable consequences for unhealthy behavior	• Giving vouchers of monetary value for licit drug screens • Providing needed items for participation in programming

(Brandon, 2014; Bishop, Borkowski, Couillard, Allina, Barcuh, and Wood, 2017).

Additional services:

- Medical services
  - Gynecological services
  - Prenatal care
  - Pediatric care
  - Infectious disease
- Health promotion
  - Nutritional counseling
  - Psychoeducation on diet, exercise, hygiene, etc.
  - Wellness programs
- Psychoeducation:
  - Sexuality education
  - Assertiveness skills training
  - Prenatal education
- Peer Recovery Coaching
  - *Recovery planning*
  - *Aftercare assistance*
  - *Peer support through lived experience*
  - *Community integration*
- Life skills
  - Money management
  - Stress reduction
- Comprehensive case management
  - Linkage and referring to appropriate agencies
- Mental health services
  - Trauma-informed providers
  - Eating disorder and nutritional services
  - Co-occurring disorder treatment (Bishop, et al., 2017).

Guiding practices:

- Psychosocial support is critical in developing and maintaining recovery, however it is defined by the client
- Linkage and referral to early intervention services if necessary.
- Follow the ASAM guidelines for proper placement in the next level of care
- Treatment/therapy is warranted regardless of the medication.
- Aftercare planning must begin from day one
- PRC to transition through all levels of care
- Family and social supports
- Assessment is ongoing, needs change

ASAM Recommendations:

- Deterring women from seeking care is detrimental to women and infants. Seeking care should not expose a woman to civil or criminal proceedings
- Treatment not criminalization
- High quality, affordable, and culturally competent SUD treatment should be made readily available to pregnant and parenting women and their families
- MAT should be available
- Detox of PPW not recommended
- Adequate and appropriate facilities for all levels of care
- Collaborative, interdisciplinary relationships and consultation among all treatment providers

ASAM Recommendations:

- Pregnant women and their partners should be given priority for admission into available slots
  - Family-centered treatment and education should be available
  - Evaluation and case management should be available for substance-exposed children
  - Childcare and transportation should be made available
  - Perinatal care that is non-judgmental and sensitive to special needs
  - Facilitate and maintain mother-child unity if possible
  - Refer to CPS if safe adult within family is not available

PRC Core Competencies

- Recovery Oriented
  - Help identify and build on strengths
- Person Centered
  - Respond and identify specific goals, hopes, and preferences
- Voluntary
  - Partner with peer to provide choices/elements of recovery plan
- Relationship focused
  - PRC and peer relationship is the foundation
  - Built on trust, empathy and is mutually earned and supported

PRC Core Competencies cont.

- Trauma informed
  - Provides psychological, physical and emotional safety
  - Creates opportunities to rebuild peers sense of empowerment and control

PRC primary job functions

- Aftercare planning
  - Family planning assistance
    - WIC, DHHR, etc.
  - Employment and Education
    - Job skills, GED classes
  - Housing
    - Safe, healthy, sober environment
- Community integration
  - Support network
- Recovery plan
  - Medication management
  - Primary care and Therapeutic services
  - Relapse prevention

PRC Support Services

- Emotional
  - Demonstrate empathy and help peer regain confidence and empowerment
- Informational
  - Share and provide knowledge of resources and life skills
- Instrumental
  - Provide assistance to help peer achieve goals and accomplish tasks
- Affiliational
  - Arrange and organize community contacts and support

PRC supportive roles

- Support through lived experience
- Offer resources for multiple recovery pathways
- Learn coping skills
  - Assist peer with utilizing coping skills
  - Provide information on different types of coping skills
- Stigma reduction
- Promote autonomy
  - Housing and job resources
  - Rebuilding relationships
  - Growth and development
- Compliance with CPS and treatment guidelines

PRC role differences w/ PPW

- Asking for and accepting help
  - PPW struggle more to receive help due to stigma
    - PRC support must be more aggressive and more understanding
- Emotions runs higher
- Encouragement of CPS
  - PRC guidance in perception of CPS involvement is crucial
- Support of parental pathways
  - PRC provides more hands on and direct resources of parental choices to PPW
- Prenatal/Postnatal care

PRC valuable characteristics

- Recovery first
  - PRC dedication and effort in personal recovery
- Empathetic and Hopeful
  - PRC is understanding, encouraging, genuine, respectful
- Autonomy and Self care
  - PRC behaviors and actions
- Healthy boundaries and discretion
  - PRC practices and values confidentiality and limits
- Responsible and competent
  - PRC is reliable, resilient, attentive, honest, open
- Cultural diversity
  - PRC understands importance of peers background

PRC detrimental traits

- Anti MAT and harm reduction
  - Judgement of MAT and harm reduction
- One way recovery path
  - Only 12 steps or abstinence is effective
- Misleading resources
  - Not offering full range of services
- Blurring boundaries
  - Being unclear about relationship, roles, and limits
- Lack of dedication and interest in job and peer
- Simplifying confidentiality
  - Applying NA “what’s said here, stays here” as confidentiality practice

Questions?

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