2015 Minnesota Summit on Prenatal Substance Use and Infant Exposure

May 21, 2015 | 8:00 AM – 5:00 PM
Kelly Inn Grand Ballroom
St. Cloud, MN

Questions and Answers

Dr. H. Westley Clark, Keynote Speaker

- **Can you email Dr. Clark's slides?**

  The slides for Dr. Clark's presentations, as well as others from the Summit, are posted on the Summit website, http://tinyurl.com/mn-prenatal

- **Will you please comment on this Catch 22? Abortion/mandated report; fetus is not a child. Child Protective Services cannot open, which locks access to social service resources.**

  The distinction between the status of a fetus as a child and the use of psychoactive substances by a woman who is pregnant is an important but technical one   While a woman may opt to terminate a pregnancy is a jurisdiction that permits such a decision, the decision to carry the fetus to term can be seen as a separate legal and medical condition. . If a jurisdiction permits an abortion, that decision is not subject to the reach of Child Protective Services. However, a statute that "protects" the fetus once a woman has decided to carry the fetus to term is currently permissible.

- **Why did Dr. Clark's presentation not cover the topic of contraception?**

  The topic of the Summit was prenatal substance use and infant exposure, contraception is not applicable. A woman using effective contraception would not likely get pregnant. Thus, any discussion of prenatal substance use and/or infant exposure would be moot.

Jessica Schmoll, Plenary Speaker

- **How does your organization enforce the prohibition of contact with men during treatment?**

  We operate with a "therapeutic community" structure, which means that clients are responsible for each other, and if one person breaks a rule, the others are obligated to bring it into the open. Should they not do so, they face the same consequence as the rule-breaker. We have clients nod politely or state that they are in treatment and cannot socialize if they are in an awkward situation with a man that requires some acknowledgement. Clients are also on the buddy-system for a fair amount of their time in treatment, so there is accountability in that way. Of course, we are not a lock-down facility so if someone is determined to break the rule, they probably will regardless!

- **Will you please share information about how to teach clients [in recovery] and families how to socialize in a non-alcohol and drug setting?**

  If I understand the question correctly, we show clients how to engage in "forced fun" in the beginning, or sober fun which may be foreign to them. This might include yoga or other fitness/games/athletics, sharing/preparing meals, playing games and telling stories, shopping at thrift stores, and creating a safe and enjoyable space for themselves at the residences (to name a few). Addiction often lives in isolation so just having other women around to be with can be a start to learning how to socialize and connect in a different way than before. Our family therapist guides family members in how to plan visits and have holidays/occasions that do not include alcohol or drugs in order to learn a "new normal." When occasions arise, later on in recovery that involve alcohol (planned or unplanned), we teach folks how to draw boundaries around what they feel comfortable with and safety plans for when they get triggered or overwhelmed. Teaching women to use their voice in stating what they need is a challenge but a very worthwhile one.

- **How is Post-Traumatic Stress Disorder (PTSD) identified and when is it addressed in treatment? I understand that cognitive therapy doesn't work as well for those experiencing PTSD. Thoughts?**

  PTSD is usually identified pretty quickly by our medical director/psychiatrist, who provides a preliminary diagnosis within 1 week. We do not "unzip" their trauma very early in treatment because they have not yet developed sober coping skills to deal with that yet. We offer a weekly Healing Trauma group that is led by an EMDR therapist, which teaches clients how to contain their trauma and cope effectively without reverting to old behaviors. We also do a Shame Resilience group weekly to address the shame that often surrounds the traumatic event(s) and the negative core beliefs that result from them. We support clients in sharing whatever portion of their experience they feel safe sharing in group therapy to get support and feel less isolated and alone. In Phase II of treatment (6+ weeks in), Ct's are provided with an individual therapist to start addressing their trauma more intensely in individual sessions, as exposing trauma to others who may not have the ego-strength to support it can be detrimental to the client(s) as well. In extreme cases, we offer private EMDR sessions to clients whose trauma prohibits them from moving forward in their recovery process.

Samuel Moose, Plenary Speaker

- **Can the video from Mr. Moose's presentation be available to view later?**

  The video from the presentation is ABC news video "More Babies Born Addicted to Opiates", May 1, 2012; by Kristina Fiore. There are a number of video from creditable news sources on the web. Just type in Opiate Addicted Newborns.

- **How will the proposed Indian Child Welfare Act (ICWA) regulations improve responsiveness to American Indian pregnant women who are addicted?**

  The ICWA regulations provide "Notice provision in case of potential removal of Indian Children", so the provision may not prevent mothers who find themselves addicted to opioids birthing Infant exposed to opioids. However, the regulation of ICWA and "Active Efforts" of the law can help families in the system be linked to high quality treatment programs, mental health & substance

abuse counseling, and other human service/medical interventions. The Child Welfare System could also use the "Notification" procedure in the intake process of a child welfare screening reach out the tribe to coordinate services or social support services (financial assistance, wrap-around services or other tribe specific services). The child welfare system could see better outcomes through more effective partnership/collaborative between tribal and county agencies, with additional state funding/or procedure to require or mandate.

- **In regards to out of home placement, what percentage of babies are with family and what is ICWA doing to ensure this?**

  Unfortunately, I am unsure of the overall State of Minnesota numbers for relative placement of Indian Children. However, the Mille Lacs Band has seen these numbers (according to tribe specific data) increase to nearly 70% of children placed in relative care.

- **Things are not working. Native Americans have access to tribal & county resources – access to more is not working.**

  I can agree and disagree with more is not working, the system of child welfare and "Active Efforts" in its current form (limited to no funding for prevention / crisis response – poor access to resources/active efforts) is not working. In a system that is more concern with short term fiscal models or liabilities and not focused on the long range outcomes of families or system of prevention; then we will continue to see poor outcomes for families of color or disenfranchised. In additional, if the system could focus more resources on prevention or family supportive services – "Active Efforts" or co-occurring models for family counseling/treatment for families in crisis – then we might get somewhere. There definitely needs to be a shift in system culture – proactive vs. reactive … along with a true access of equity across the systems.

- **What changes can be made to change the soil of reservations? The percentages are overwhelming in the Native American population. How can we ignore "the soil"?**
  Assuming in this case that soil refers to attitudes, culture or something more along the lines of social-behavioral factors of American Indian communities, then the soil of the reservation has been poisoned/contaminated by invasive species for hundreds of years… In that a foreign government in crisis with little to no direct based out of fear and oppression – desperately needing to escape their oppressors began a systematic, deceitful and destructive policy in dealing with the indigenous populations of North America. These policies were designed to destroy or break the inhabits spirit (genocide) to free title to the land of America – through a system process of oppressing/eliminating the social, religious, educational and economic institutions of the indigenous community of North American… Therefore, Tribes must maintain and continue to strengthen their identity as Sovereign Nation with all power to govern and develop their own social, religious, educational and economic institutions based out of their indigenous' morals, values and beliefs. Nation to Nation relationships – which the current policy of Tribal Self-Governance as independent sovereign nations – Tribal governments have begun to rebuild all the institutions to self-govern our current indigenous populations way of life – which adds to the beauty and diverse America! Currently, self-governance has increase many of the social structure for American Indian/Alaskan Native populations, for instance – the average life expectancy of an AI/AN has increased to 73 years of age (4 years behind mainstream America) from an average of 55 years in the 40's and 50's – and continue to increase as Tribe's begin to operate and owner their own health care systems… these policies, programs and

services own, operated and cultural constructed by tribes are the only way Indigenous population or tribal people are going to heal the "soil" of the Reservation.

Rashida Fisher, Plenary Speaker

- **What are some examples of cultural activities that are occurring, or could be occurring, for clients and families in programs of recovery?**

There are a number of programs developed to provide culturally specific services. These programs are excellent resources to identifying specific cultural activities. Overall, a program can implement activities that create community. For individual treatment planning activities should include considerations regarding: Client Strengths, Problem Identification and Development of Goals and Objectives, and Modalities of Treatment.

Client's Strengths

A person's culture can provide him or her with much support and strength that he or she brings to the treatment process. A few examples of strengths likely to be revealed include:

- Close, supportive community relations
- Supportive and extended family relations
- Engagement in community activities
- Faith, spiritual and religious beliefs
- Multilingual
- Healing practices and beliefs which support treatment
- Health promoting cultural beliefs (specific family beliefs, principles, and traditions)
- Holiday and other celebrations with family and/or friends
- Participation in rituals and practices (religious, cultural, familial, spiritual, community)
- Dreams and aspirations
- Participation in cultural art events and festivals, preparation and enjoyment of traditional foods

Problems, goals, objectives

It is important to note that a person's culture is not a problem. However, a program that presents organizational barriers for a consumer of a particular culture may very well deter that consumer from following through with needed treatment, and that is a problem. A culturally informed initial treatment plan must address initial engagement that will make the consumer feel safe to explore his/her problems within his/her cultural context.

Modalities of Treatment

Treatment will be most effective when it is consistent with a consumer's culture. When planning treatment, consider, for example, the cultural appropriateness of and ability to implement various treatment modalities:

- Individual vs. group treatment
- Writing, Music, Art, or Cooking Therapy
- Medication, western, traditional and alternative
- Family involvement or not
- Meeting in the park, in the home or at the clinic

Dr. Jeff Schiff, Plenary Speaker

- **What information do you have about prescribing Narcan to people in the community? For a primary care physician?**

  The Minnesota Department of Health has a grant to provide Narcan to emergency providers that is one time appropriated money. In Medicaid, Narcan can be prescribed for an individual getting opioid meds. The Rumler Foundation promotes Narcan use and has information. It is also one of the state strategies, but a plan for further distribution is not yet set.

- **A problem we have is clients will go to urgent care for various reasons - often migraine – and will be given Depecote or other pain killers. Even though clients give the provider a paper to sign (that they have to turn into us), which states they are in chemical dependency treatment and not permitted to have narcotics. Clients do not refuse the drug if "prescribed," even though they know it's against our policy. What can we do to decrease pain medications easily given in emergency and urgent care?**

  The Minnesota Department of Human Services (DHS) has an Opioid Prescribing Improvement Project that was part of the governor's budget and passed last year. It will set protocols for prescribing docs. I'd recommend following this effort at the DHS website. The site page should be up soon.

- **Is there a "new" response to the belief that THC can't be that bad since it's getting legalized?**

  Legalization does not mean it is without risk, similar to alcohol. It will need to be studied. Most al studies are lacking.

- **Along the same line, can you address the "double standard" regarding positive THC toxicology and mandated reporting, child protection involvement, etc.**

  I believe that THC, like alcohol does not need to be reported for exposure in pregnant moms

- **Will all Medicaid plans be asked to represent SOOP? Or only state MA?**

  The SOOP is the internal state government coordinating group. A group to get feedback from the community is in the planning.

- **We need to treat addicted moms. But isn't the starting point to stop the over prescription of opiates? How do we do that?**

  The opioid prescribing improvement and monitoring program was passed this session and will do this.

- **If we treat addiction as a disease, is or will it ever be possible to screen all pregnant moms for substance abuse?**

  We support universal screening.

- **Is it possible to prescribe Narcan to patients or their families – like you would prescribe Epi pens? Or how else is it available?**

  The EpiPen version is about $500 a pen. We are concerned about this cost. An intranasal approach is roughly 1/1oth the price and easier to administer. It can be prescribed for anyone in DHS programs

- **Do you have data around rate of Neonatal Abstinence Syndrome (NAS) in babies with mothers on prescribed methadone/suboxone vs. illicit opiates and do those experiences differ?**

  NAS rates from illicit opiate use have been difficult to ascertain. There is good info about NAS rates from methadone and buprenorphine from a comparative, randomized trial, which is attached. The observed results are as follows:

  "A comparison of the 131 neonates whose mothers were followed to the end of pregnancy according to treatment group (with 58 exposed to buprenorphine and 73 exposed to methadone) showed that the former group required significantly less morphine (mean dose, 1.1 mg vs. 10.4 mg; P<0.0091), had a significantly shorter hospital stay (10.0 days vs. 17.5 days, P<0.0091), and had a significantly shorter duration of treatment for the neonatal abstinence syndrome (4.1 days vs. 9.9 days, P<0.003125)."

  To summarize in comparative terms, it looks like duration of NAS resulting from buprenorphine is about half of NAS duration caused by methadone, and NAS intensity from buprenorphine about a tenth of NAS intensity caused by methadone, based on morphine dose required for treatment of withdrawal symptoms. In table 2 of this article it can be seen that 57% of newborns of methadone treated moms had any NAS symptoms, compared to 47% of newborns of buprenorphine treated moms. Also, in this trial 18% of moms discontinued methadone treatment prior to delivery, compared to 33% of moms discontinuing buprenorphine prior to delivery.

  The question here is asking how all of this compares to NAS from illicit opiates. It's difficult to know what the true rate of NAS is from illicit opiate exposure, because such exposure is often not disclosed. We know that with a large proportion (around 50%)of the NAS births we are seeing in our Medicaid data, there wasn't an associated maternal diagnosis of known opiate dependency. This implies that some fraction of maternal opiate use which doesn't result in NAS may go undetected. Because of the hidden nature of illicit use, it's been difficult for researchers to establish an accurate denominator, and thus derive an accurate rate. In the literature, estimates vary from 50 to 90 percent, but they are estimates. Nevertheless, it seems reasonable to say that the rate of NAS due to illicit opiate use is at least equal to, if not greater than, the rate of NAS due to methadone maintenance treatment.

  NAS is a disturbing outcome, because the newborn can be subject to a lengthy and uncomfortable period of withdrawal. However, there are other, more consequential adverse outcomes associated with illicit opiate use—preterm delivery, intrauterine growth retardation, low birth weight, infant mortality, and fetal demise. Our own data shows that 26% of NAS newborns were born

prematurely. It is known that these adverse outcomes are reduced to normal levels when illicit opiates are replaced by maintenance therapy during pregnancy. The outcomes are normalized because maintenance therapy is highly effective in stabilizing the uterine environment, while in contrast illicit opiate use is very destabilizing. Avoiding these adverse outcomes are the primary reasons that methadone and buprenorphine are recommended during pregnancy. In addition, maintenance therapy is known to greatly reduce maternal mortality due to overdose and to reduce transmission of diseases such as HIV and hepatitis.

In this regard, comparing NAS rates of illicit opiate use with NAS rates of maintenance therapy is perhaps not the best way to weigh the risks and benefits of using maintenance therapy. I don't know whether that was the thinking behind the forwarded question, but I hope not. Even if illicit opiate use had lower rates of NAS than maintenance therapy, the benefit of avoiding high rates of prematurity and fetal demise is the essential reason maintenance therapy is strongly considered to be the standard of care. NAS itself, however unsettling it is as a side effect of maintenance therapy, is wholly treatable and has no known long term consequences.

- **What are the underlying "stories" we know about the disproportionate rate of opioid use among Native American women and the rate of NAS among Native American babies?**

  Some is availability. I do not know all of the stories besides this and concerns about social risk.

- **It has been said that to take an expectant mom off of suboxone (MAT program), it will cause that mom to miscarry the baby. Why has this been said and is there any proof of miscarriage?**

  Bringing babies to term is most effectively done on MAT.

- **How do you screen for ACEs (Adverse Childhood Experiences)?**

  We have no specific process but encourage ACE evaluation and trauma informed therapy in our children's mental health unit.

- **How do "White" chemical support providers best work with American Indian women and men?**

  It is our hope that all providers are culturally sensitive. We encourage support that represents the ethnicity of the population served when possible.

General Questions/Suggestions

- **Could the speakers please recommend some books/articles for us to read that they think would be helpful?**

  Recommended by **Dr. H. Westley Clark:**
  1) TIP 51. Substance Abuse Treatment: Addressing the Specific Needs of Women
  2) Future of Children:
  http://www.princeton.edu/futureofchildren/publications/journals/journal_details/index.xml?journalid=83

3) Methadone Treatment for Pregnant Women: http://store.samhsa.gov/shin/content//SMA14-4124/SMA14-4124.pdf

Recommended by **Jessica Schmoll**:
I enjoyed reading Dr. Louann Brizedine's "The Female Brain." Anything by Dr. Stephanie Covington is amazing – her articles are easy to find online and talk in depth about treating women. Other good staples are Codependent No More (especially for women) and of course, the Big Book of AA.

Recommended by **Samuel Moose**:
Books:
1) In the Realm of Hungry Ghosts. Close Encounters with Addiction by Gabor Mate, MD
2) Healing the Soul Wound. Counseling with American Indians and Other Native Peoples by Eduardo Duran.
Online resources:
1) Karina Walters, University of Washington, Historical Trauma, Micro-aggressions, and Identity: A Framework for Culturally-Based Practice (see video, at Lessons from the Field 12/4/09. https://www.youtube.com/watch?v=7u9GU2ENI0s
2) GSSW Speaker Series: Karina Walters on Embodiment of Historical Trauma and Micro-aggression Distress. https://www.youtube.com/watch?v=WzPNWTD56S8

Recommended by **Dr. Jeff Schiff**:
For medical providers, the Centers for Disease Control and Prevention will soon release prescribing guidelines. The state of Washington has great guidelines.

- **How can we get handouts from presenters?**

  The presenters' slides are posted on the Summit website, http://tinyurl.com/mn-prenatal

- **Suggestion regarding Narcan kits: Valhalla Place in Brooklyn Park and Woodbury offers Narcan kits for $8 to anyone in the public, phone 651-200-6088.**

  Thank you for sharing this information.

- **Suggestion for a future event: A meet and greet of community agencies with booths and/or brief introductions of the services we offer so we have a better idea of other agencies that exist, and so we can partner together.**

  Thank you for this suggestion. We hope to offer more opportunities for networking/information sharing between agencies in the near future.