KC PERINATAL RECOVERY COLLABORATIVE

Pregnancy and Parenting Periods: Best Practices, Clinical Guidelines and Model Programs

Hendrée E. Jones

Mid-America (HHS Region 7)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Disclosures

- Dr. Jones has no conflicts of interests or disclosures relevant to the content of this presentation.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

FDA Context

- Methadone and buprenorphine have historically been labeled by the US Food and Drug Administration (FDA) as Category C for use in pregnancy for the treatment of maternal opioid dependence: *"Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks"*
- As of May 2016, the FDA requires methadone and buprenorphine safety labeling to include information regarding the risk of neonatal opioid withdrawal syndrome (NOWS)

FDA Context: Part 2

- Pregnant women with opioid use disorders (OUDs) can be effectively treated with methadone or buprenorphine. However, labeling states it should be used only if the potential benefit justifies the potential risk to the fetus

- Pregnant women with opioid use disorders can be effectively treated with methadone or buprenorphine. Both these medications should not be considered "off-label" use in the treatment of pregnant patients with opioid use disorder (Jones et al., *Am J Obstet Gynecol,* 2014).

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Identify at lest three historical and current factors that help explain the current opioid epidemic for women
  - Identify at least three new SAMHSA recommendations to care for pregnant women and their children touched by opioid use disorder
  - Identify at least three elements that are common themes among Model Programs
  - Articulate three ways providers can reduce discrimination and stigma against women with opioids use disorder

Historical Context: Opioid Use and Women

Main Eras of Opioid Use in the USA

1800s: **66–75% of people using opioids were women**

1940-50s: **New York saw large increase in teenage opioid use**

1969-70's: **Opioid use by Vietnam veterans**

1996-now: **Pain as the 5th vital sign and pain medication access**

http://usslave.blogspot.com.br/2012/02/opiate-addiction-and-cocaine-use-in.html; https://pixabay.com/en/vintage-retro-ladies-photo-paper-1303815/

Courtwright D. *J Southern History* 1983; Kandall S *Substance and shadow*, 1996.
Earle, *Medical Standards*, 1888
The Incidental Economist 2014 https://pointsadhsblog.files.wordpress.com/2012/03/08-0620hair20salon20loc20nywt20226b.jpg

Recent History: Opioid Use in the USA

- **80's** — Reports state few receiving narcotic painkillers develop addiction
- **90's** — Purdue Pharma Develops Oxycontin
- **1996** — The Joint Commission "Pain - the 5th Vital Sign"
- **1998** — Federation of State Medical Boards: Model Guidelines for the Use of Controlled Substances for Pain Treatment
- **2003**
  - Tripling of 18-25 year olds abusing opioid pain relievers
  - DEA and FDA task forces to reduce internet opioid sales
- **2007** — George Brothers open first pain clinic in FL. American Pain prescribed almost 20 million pills over two years
- **2009-now** — Drug overdose surpass motor vehicles as the leading cause of injury death

"Our people are dying. More than 175 lives lost every day. If a terrorist organization was killing 175 Americans a day on American soil, what would we do to stop them?"

THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS

Roster of Commissioners

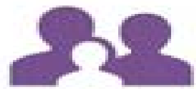
Governor Chris Christie, Chairman
Governor Charlie Baker
Governor Roy Cooper
Congressman Patrick J. Kennedy
Professor Bertha Madras, Ph.D.
Florida Attorney General Pam Bondi

Frakt, A. *NY Times* 12/22/14; CDC *Morbidity and Mortality Weekly Report* (*MMWR*) 1/1/16

Current Scope of the Problem: Opioid Epidemic in the United States

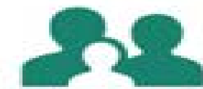
In 2015...

12.5 million
People misused prescription opioids[1]



2.1 million
People misused prescription opioids for the first time[1]

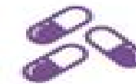
33,091
People died from overdosing on opioids[2]



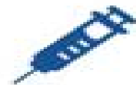
2 million
People had prescription opioid use disorder[1]

15,281
Deaths attributed to overdosing on commonly prescribed opioids[2,3]

828,000
People used heroin[1]



9,580
Deaths attributed to overdosing on synthetic opioids[2,5]

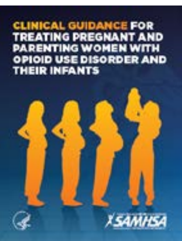


135,000
People used heroin for the first time[1]

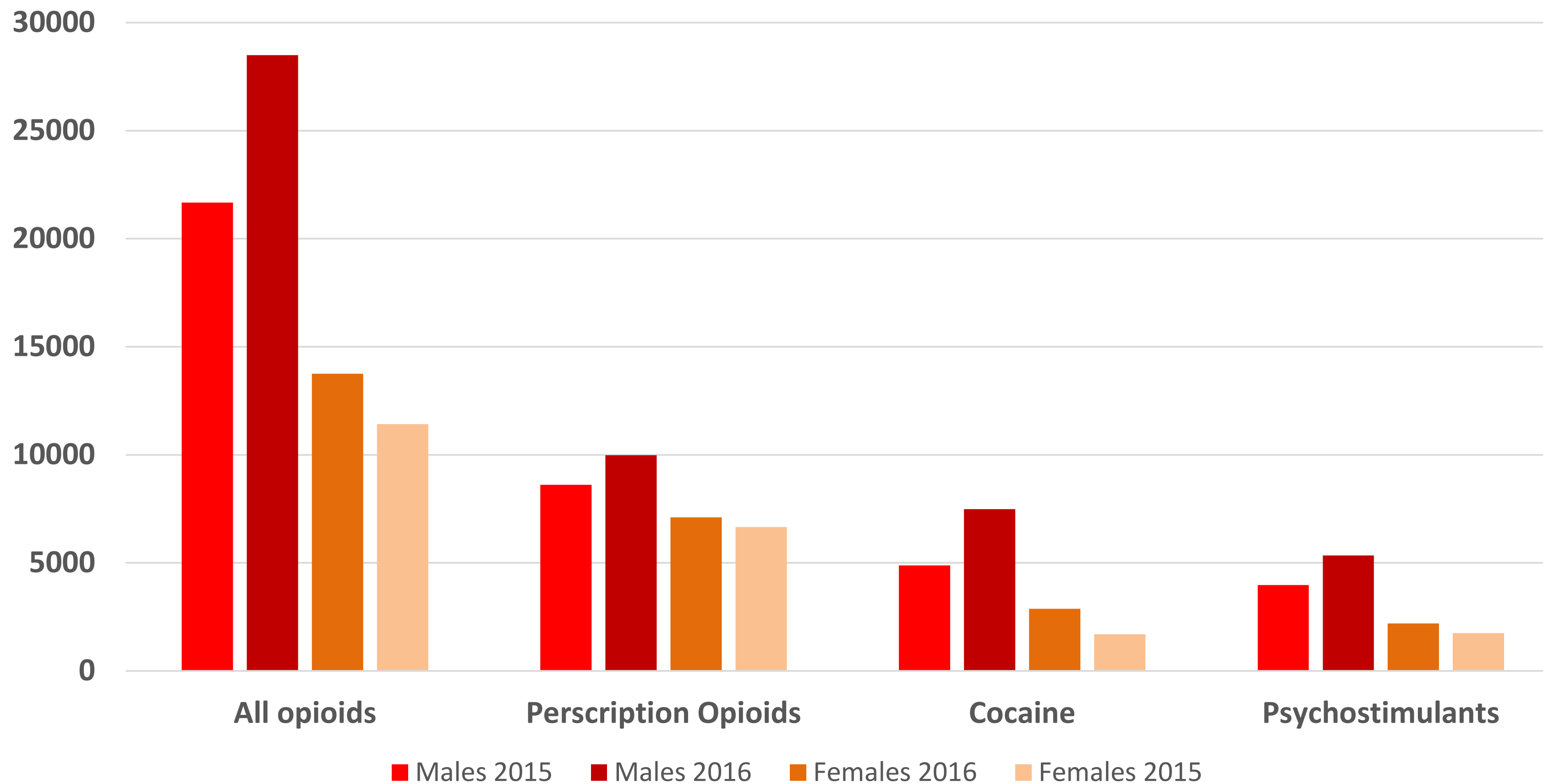
12,989
Deaths attributed to overdosing on heroin[2,4]

$78.5 billion
In economic costs (2013 data)[6]

1. SAMHSA 2016. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf
2. CDC 2016. Retrieved from https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm
3. CDC 2017. Retrieved f rom https://www.cdc.gov/drugoverdose/data/overdose.html
4. CDC 2017. Retrieved from https://www.cdc.gov/drugoverdose/data/heroin.html
5. CDC 2017. Retrieved from https://www.cdc.gov/drugoverdose/data/fentanyl.html
6. Florence C et al., *Medical Care*, 2016



Current Context of Opioid Misuse in the USA for Women



Seth P, et al. MMWR Morb Mortal Wkly Rep 2018;67:349–358.

Current Context: Opioid Use and Women

Compared to men, women are more likely to:

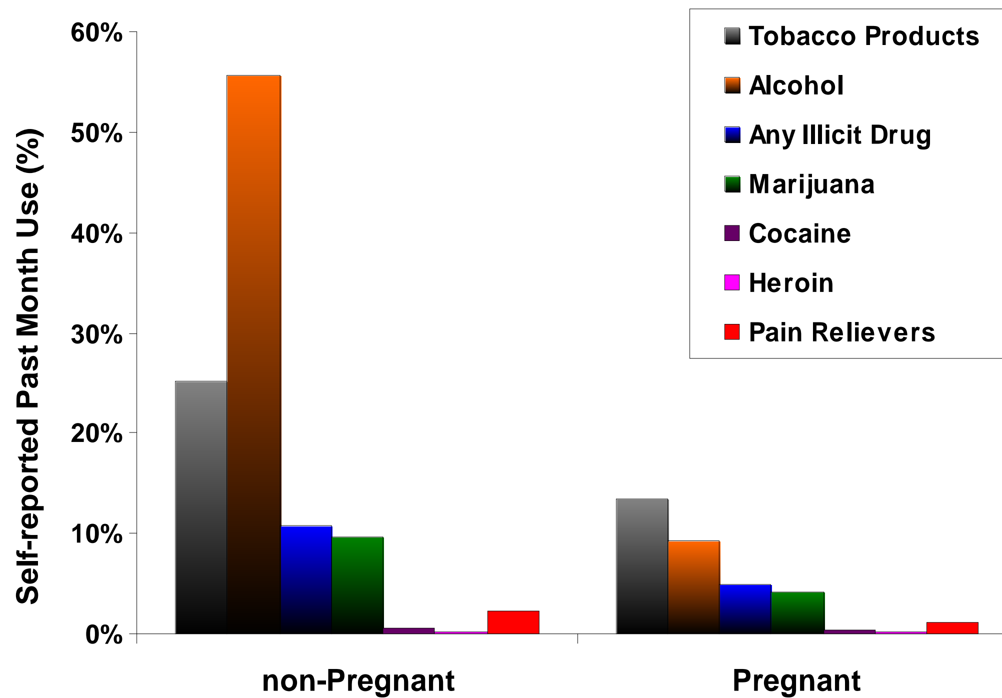
- **report chronic pain**
- **be prescribed prescription pain relievers**
- **be given higher doses**
- **use them for longer time periods than men**
- **have a shorted duration between opioid use initiation and seeking help for an opioid use disorder**
- **Less likely to receive naloxone for an overdose**

Specific risks for the misuse of prescription opioid medication among women include: experience of violence and trauma, being a native minority, adolescent, young, older, pregnant, a sexual minority, and being a transwoman

http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/

Sumner SA et al., *Prehosp Emerg Care*. 2016
Hemsing N, et al. *Pain Res Manag*. 2016; Khan SS et al., *Drug and Alcohol Dependence* 2013;
Randall C et al., *J Stud Alcohol*. 1999

Current Context of Substance Use during Pregnancy



- The two most common drugs used by non-pregnant women have been alcohol and tobacco
- This same statement is true for pregnant women
  - *Among pregnant women, approximately .2% used heroin, and 1.1% used pain relievers non-medically in the past month*

SAMHSA Office of Applied Statistics

Current Prevalence of OUD During Delivery

Opioid abuse or dependence per 1,000 deliveries, overall and by age: United States, 1998–2011.

Frequencies per 1,000 deliveries

5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
-

1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011

Study Year

<20
20-34
35-39
>=40
Overall

Maeda, A., et al. *Anesthesiology* 2014.

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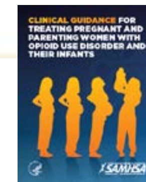


History: Defining Neonatal Abstinence Syndrome (NAS)

Results when a pregnant woman regularly uses opioids (e.g., heroin, oxycodone) during pregnancy

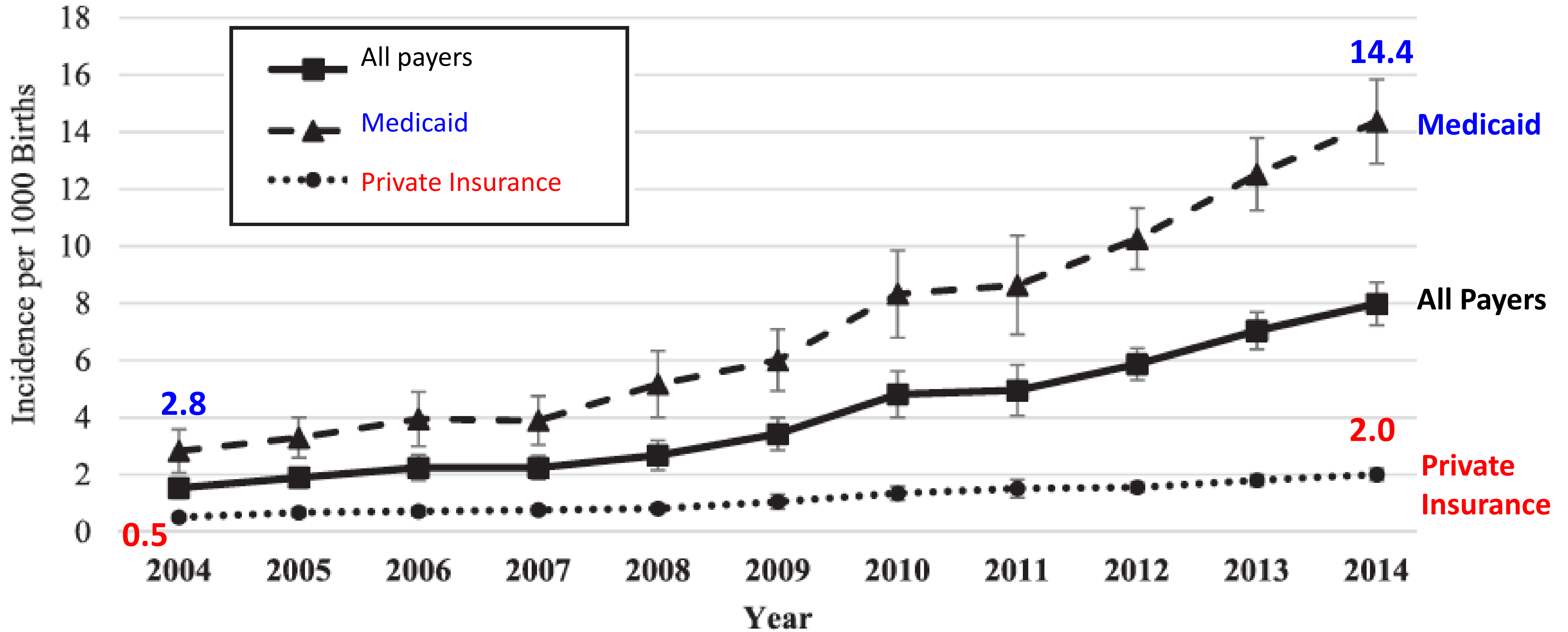
NAS defined by alterations in the:

- ***Central nervous system***
  - **high-pitched crying, irritability**
  - **exaggerated reflexes, tremors and tight muscles**
  - **sleep disturbances**
- ***Autonomic nervous system***
  - **sweating, fever, yawning, and sneezing**
- ***Gastrointestinal distress***
  - **poor feeding, vomiting and loose stools**
- ***Signs of respiratory distress***
  - **nasal congestion and rapid breathing**

> - **NAS is *not* Fetal Alcohol Syndrome (FAS)**
> - **NAS is treatable**
> - **NAS and its treatment are not known to have long-term effects; interactions between the caregiver and child can impact resiliency/risk with potential long-term effects in some cases.**

Finnegan et al., *Addict Dis,* 1975; Desmond & Wilson, *Addict Dis,* 1975; Jones & Fielder, *Preventive Medicine,* 2015.

Current Context: Opioids, Pregnancy, and NAS



Winkelman et al. Incidence and cost of neonatal abstinence syndrome among infants with Medicaid: 2004-2014. Pediatrics. 2018 Apr;141(4).

Pregnancy: A Unique Treatment Opportunity

- **Mothers with substance use disorders have a mortality rate 8.4 times that of US women of similar age**
- **Pregnant women who use illicit substances may delay prenatal care and miss more healthcare visits than women who do not use substances**
- **Prenatal care may help to reduce the negative impact of illicit drug use on birth outcomes**
- **Lower prenatal care utilization may be due to a diverse set of barriers to seeking and obtaining care, including fear of child custody issues**
- **After childbirth, ongoing substance use disorders by caregivers and the dysfunctional home environment may create detrimental effects on children's psychological growth and development**
- **Maternal well-being has been recognized as a key determinant of the health of the next generation**

e.g., Hser et al, 2012; Funai et al., 2003 Staton et al., 2003 and Wagner et al., 1998; El-Mohandes et al., 2003; Roberts and Pies, 2011; Schempf and Strobino, 2009; Chatterji and Markowitz, 2001.

Salient Maternal Categories Related to Neonatal Abstinence Syndrome

1. Women using opioid analgesics for medical condition who do not have a substance use disorder

2. Women using opioid analgesics for medical condition and who also have a substance use disorder

3. Women receiving pharmacotherapy for the treatment of an opioid use disorder

4. Women with an (unrecognized) untreated opioid use disorder

(Thank you Mishka Terplan and Borrowed from National Center on Substance Abuse and Child Welfare)

NAS is Not Addiction

- Newborns can’t be “born addicted”
- NAS is withdrawal – due to physical dependence
- Physical dependence is not addiction
- Addiction is brain illness whose visible signs are behaviors
- Newborn do not have the life duration or experience to meet the addiction definition

Jones & Fielder, *Preventive Medicine,* 2015.

NAS: Various Substances

STATE-OF-THE-ART REVIEW ARTICLE

Neonatal Abstinence Syndrome

AUTHOR: Prabhakar Kocherlakota, MD

Pediatrics 2014;134:e547–e561

TABLE 1 Onset, Duration, and Frequency of NAS Caused by Various Substances

Drug	Onset, h	Frequency, %	Duration, d
Opioids			
Heroin	24–48	40–80[27]	8–10
Methadone	48–72	13–94[37]	Up to 30 or more
Buprenorphine	36–60	22–67[46,48]	Up to 28 or more
Prescription opioid medications	36–72	5–20[56,60]	10–30
Nonopioids			
SSRIs	24–48	20–30[64]	2–6
TCAs	24–48	20–50[64]	2–6
Methamphetamines	24	2–49[101]	7–10
Inhalants	24–48	48[70]	2–7

NAS: Factors

Other factors that contribute to severity of NAS in neonates exposed to opioid agonists in utero:

- **Genetics**
- **Other Substances**
  - **Tobacco use**
  - **Benzodiazepines**
  - **SSRIs**
- **Birth weight**
- **Hospital Protocols**
  - **NICU setting**
  - **The NAS assessment choice**
  - **NAS medication choice**
  - **Initiation and weaning protocols**
  - **Not breastfeeding**
  - **Separating mother and baby**

MOTHER NAS Predictors

Receipt of NAS treatment for infants was predicted by:

- **Higher infant birthweight**
- **Greater maternal nicotine use**

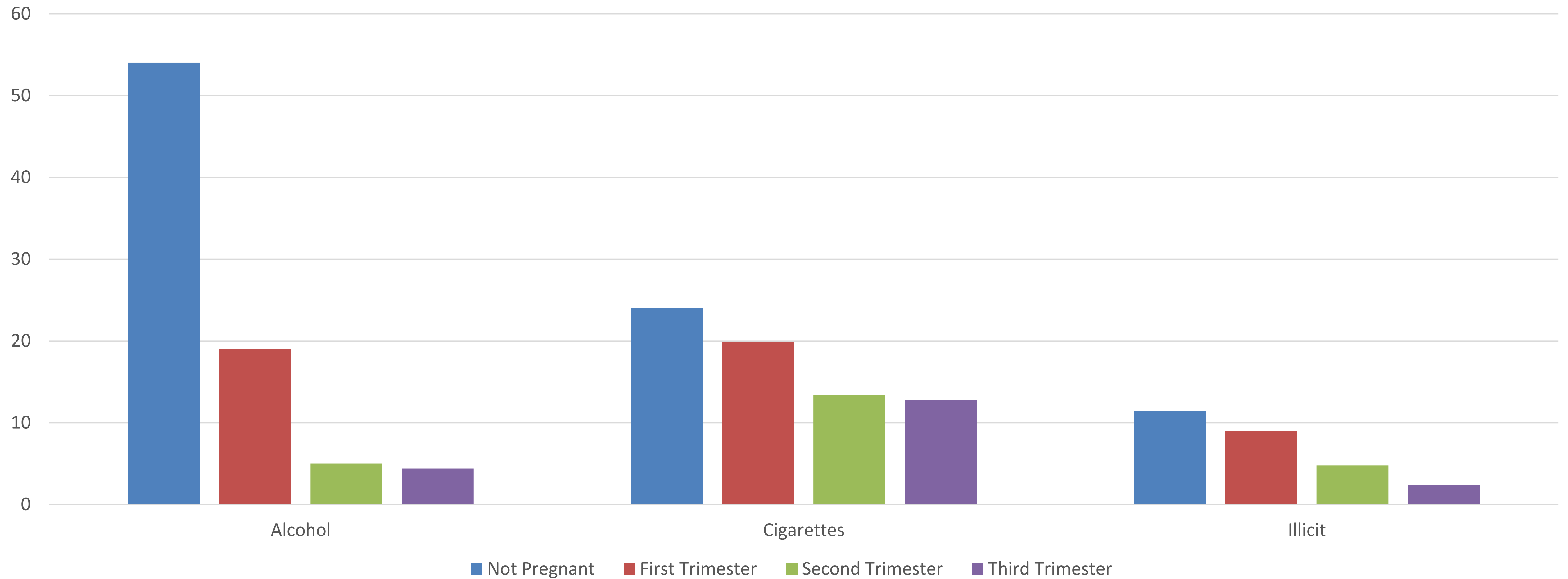
Total medication dose needed to treat NAS was predicted by:

- **Maternal use of SSRIs**
- **Greater nicotine use**
- **Fewer days of study medication received**

Methadone or buprenorphine dose is not consistently related to NAS severity

Kaltenbach et al., *Addiction*, 2012 Jansson and Velez, *Curr Opin Pediatrics*, 2012

What Happens When Women Who Use Drugs Get Pregnant?



National Survey Drug Use and Health 2013/2014 Past Month Use Data

All pregnant women are motivated to maximize their health and that of their developing baby

Those who can’t quit or cut back – likely have a substance use disorder

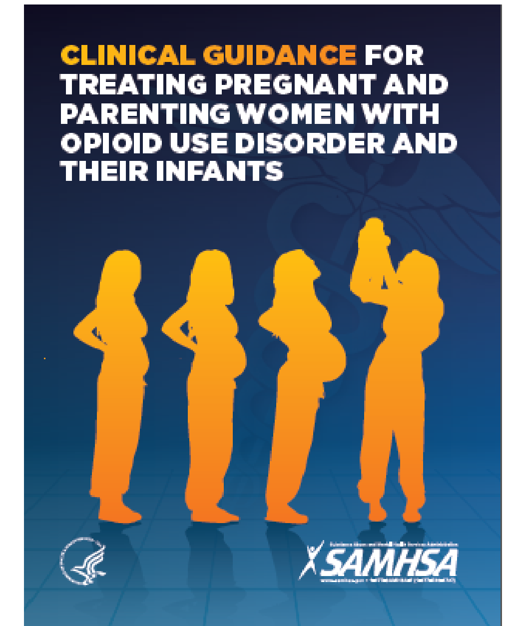
Continued use in pregnancy is pathognomonic for addiction

Addiction: A Brain-Centered Condition Whose Symptoms are Behaviors

Salient Feature: Continued use in spite of adverse consequences

SAMHSA Clinical Guide Recommendations

- Medication assisted withdrawal is not recommended during pregnancy
- Buprenorphine and methadone are the safest medications for managing OUD during pregnancy
- Transitioning from methadone to buprenorphine or from buprenorphine to methadone during pregnancy is not recommended
- Breastfeeding is recommended for women on buprenorphine and methadone
- Neonatal abstinence syndrome (NAS) should not be treated with dilute tincture of opium



The *Clinical Guide* consists of 16 factsheets that are organized into 3 sections: Prenatal Care (Factsheets #1–8); Infant Care (Factsheets #9–13); and Maternal Postnatal Care (Factsheets #14–16).

SAMHSA's Guidance: Medically Supervised Withdrawal is *Not* Recommended

- Pharmacotherapy is the recommended standard of care

- Pharmacotherapy helps pregnant women with OUD avoid a return to substance use, which has the potential for overdose or death
  - A decision to withdraw from pharmacotherapy should be made with great care on a case-by-case basis.

  - A pregnant woman receiving treatment for OUD may decide to move forward with medically supervised withdrawal if
    - It can be conducted in a controlled setting.
    - The benefits to her outweigh the risks.

Pregnant patients should be advised that withdrawal during pregnancy increases the risk of relapse without fetal or maternal benefit.

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CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS

SAMHSA

ACOG Guidance: Treating Women for Opioid Use Disorders during Pregnancy

- Medication-assisted treatment remains the preferred treatment
- Relapse is associated with serious risks, such as transmission of infectious agents, accidental overdose as a result of decreased tolerance, lack of prenatal care, and obstetric complications
- Medically supervised withdrawal may be considered in women who do not accept treatment with an opioid agonist or when treatment is unavailable. In that case, a physician experienced in treating perinatal addiction should supervise care, with informed consent of the woman.
- Multidisciplinary long-term follow-up should include medical, developmental, and social support
- Universal screening starting at the first prenatal visit and using a validated verbal screening tool, which is preferable to urine testing.
- If a woman screens positive, the guidelines recommend a brief intervention and referral to treatment.

Opioid Use and Opioid Use Disorder in Pregnancy. Committee on Obstetric Practice. American Society of Addiction Medicine (ASAM). American College of Obstetricians and Gynecologists (ACOG) Committee Opinion. Number 711, August 2017
(Replaces Committee Opinion Number 524, May 2012)

ACOG Guidance: Screening Differs from Testing

All screens and tests for the mother require informed consent and neither diagnose a Substance Use Disorder

	Screening with an Instrument	Maternal Urine Testing
Purpose	To detect possible illness indicators	To establish presence/absence of a recent substance use
Test method	Simple, quick, acceptable to patients and staff	May take days for results and must be GC/MS or other confirmed test
Positive result threshold	Generally chosen towards high sensitivity not to miss potential disease	Chosen towards high specificity (true negatives). More weight given to accuracy and precision
Cost	Cheap, benefits should justify the costs since large numbers of people will need to be screened to identify a small number of potential cases	Higher costs associated with test ; cost may be justified to establish specific result

Adapted from: https://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/screening-diagnostic-case-finding

When We Ask: What is our Response?

- **Do not use as sole assessment of substance use/use disorder (ACOG 2017)**
  - Short detection window
  - Might not capture binge or intermittent use
  - Rarely detects alcohol
  - Doesn't capture prescription opioids (without confirmation testing)

- **Essential component of SUD treatment**

- **Ethical issues:**
- **Robinson v. California (1962)** - Addiction is an illness, and that criminalizing it is a violation of the 8th Amendment, prohibiting cruel and unusual punishment
- **Ferguson v. City of Charleston (2001)** - Drug-testing pregnant women without their knowledge or consent constituted unlawful search and seizure in violation of the 4th Amendment

Possible Implications of Punitive Measures

- No evidence supporting punitive responses decrease drug use in pregnancy
- Unnecessary stressful child welfare involvement
- Loss of parental rights
- Disruption of critical parent/infant bonding time—used as evidence-based treatment of Neonatal Opioid Withdrawal (NOW)
- Deters pregnant people from seeking healthcare and social support
- Long-term consequences of being convicted of a drug-related crime
  - Loss of financial aid
  - Housing restrictions
  - Employment challenges
- Fails to recognize the inadequacies in the healthcare system and other supportive services for pregnant people who use drugs

Patrick, S. W., & Schiff, D. M. (2017). A Public Health Response to Opioid Use in Pregnancy. Pediatrics, 139(3)

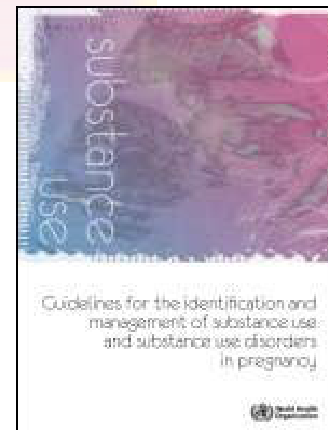
Treatment Access and Effectiveness

- Capacity is inadequate
  - Only 15% of treatment centers offer specified services
  - Access is limited
  - For those in poverty, rural areas, uninsured, or insured through Medicaid
- Quality of treatment ranges dramatically
- Barriers in treatment for opioid use disorder
- Engagement in prenatal care is effective regardless of continued drug use

Patrick, S. W., & Schiff, D. M. (2017). A Public Health Response to Opioid Use in Pregnancy. Pediatrics, 139(3)

World Health Organization: 18 Recommendations in their Guidelines

No.	Recommendation	Strength of recommendation
Pharmacological treatment (maintenance and relapse prevention) for substance dependence in p		
9	Pharmacotherapy is not recommended for routine treatment of dependence on amphetamine-type stimulants, cannabis, cocaine, or volatile agents in pregnant patients.	Conditional
10	Given that the safety and efficacy of medications for the treatment of alcohol dependence has not been established in pregnancy, an individual risk-benefit analysis should be conducted for each woman.	Conditional
11	Pregnant patients with opioid dependence should be advised to continue or commence opioid maintenance therapy with either methadone or buprenorphine.	Strong



http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/

World Health Organization, ACOG and ASAM: Medication Option Guidance

- Methadone
- Buprenorphine alone
- Buprenorphine + naloxone
- *Naltrexone*

Methadone and Buprenorphine: Advantages

	Methadone	Buprenorphine
Advantages		
Reduces/eliminates cravings for opioid drugs	●	●
Prevents onset of withdrawal for 24 hours	●	●
Blocks the effects of other opioids	●	●
Promotes increased physical and emotional health	●	●
Higher treatment retention than other treatments	●	
Lower risk of overdose Fewer drug interactions Office-based treatment delivery Shorter NAS course		●

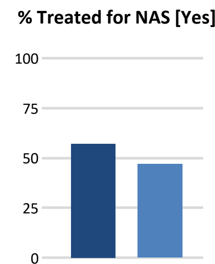
Methadone and Buprenorphine: Disadvantages

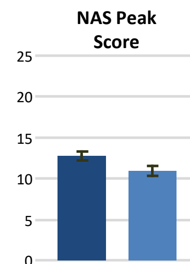
- Methadone Disadvantages
  - ❑ Achieving stable dose could take days to weeks
  - ❑ Increased risk of overdose
  - ❑ Usually requires daily visits to federally certified opioid treatment programs
  - ❑ Longer neonatal abstinence syndrome (NAS) duration than other treatments

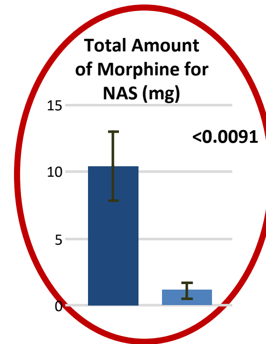
- Buprenorphine Disadvantages
  - ❑ Limited efficacy in patients with high opioid debt
  - ❑ Demonstrated clinical withdrawal symptoms
  - ❑ Increased risk of diversion

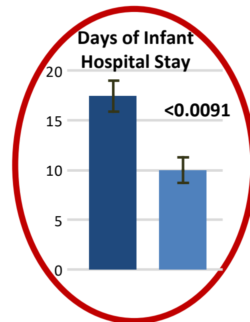
MOTHER: Buprenorphine *v.* Methadone

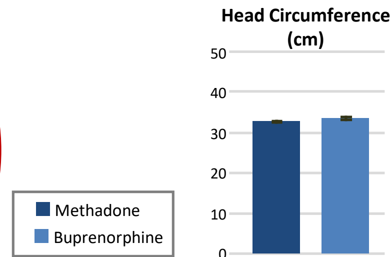
Primary Outcomes











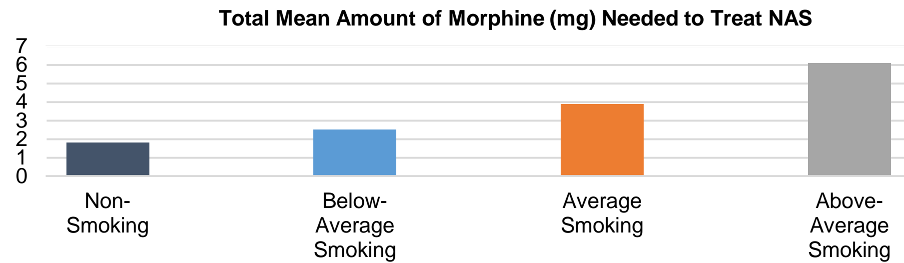
- **Compared with methadone-exposed neonates, buprenorphine-exposed neonates**
  - **Required 89% less morphine to treat NAS**
  - **Spent 43% less time in the hospital**
  - **Spent 58% less time in the hospital being medicated for NAS**

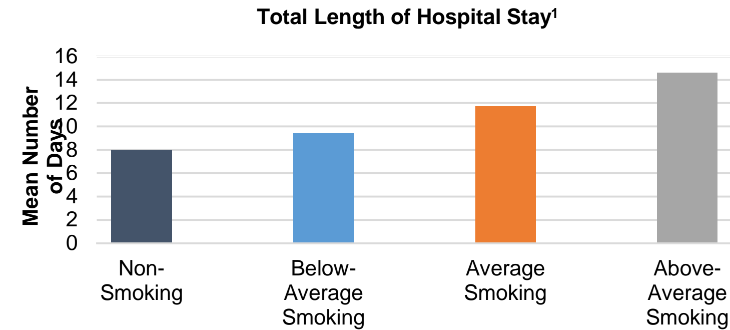
Both medications in the context of comprehensive care produced similar maternal treatment and delivery outcomes

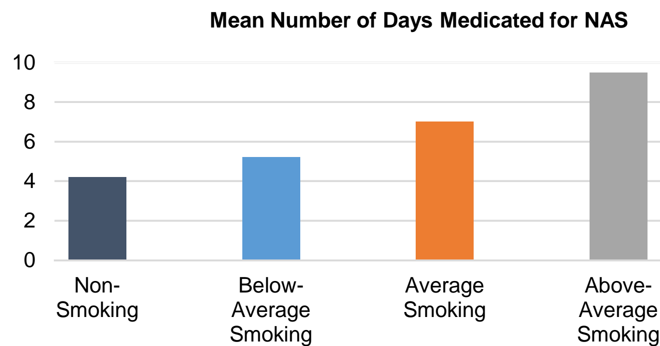
Notes: **Significant results are encircled. Site was a blocking factor in all analyses. The O'Brien-Fleming α spending function resulted in α=0.0091 for the inferential tests of the Medication Condition effect for the 5 primary outcome measures at the conclusion of the trial.**

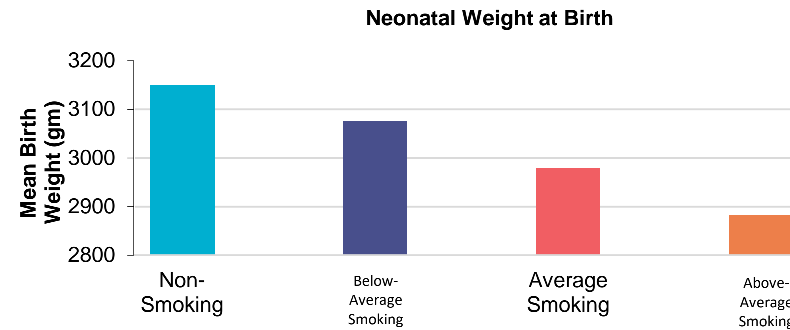
Jones HE, Kaltenbach K, Heil SH, et al. *N Engl J Med.* 2010

MOTHER: Smoking and NAS









Ordinary least squares and Poisson regression analyses were used to test average daily number of cigarettes smoked in the past 30 days at α=0.05, adjusting for both Medication Condition and Site.
Below-average cigarette smoking was defined as 6 cigarettes/day (-1 *SD*), average cigarette smoking as 14 cigarettes/day (Mean), and above-average cigarette smoking as 21 cigarettes/day (+1 *SD*).

Jones HE, et al. *Drug Alcohol Depend.* 2013

Methadone Vs. Buprenorphine: 12 study Meta-analysis

N=515 neonates born to mothers receiving methadone and N=855 neonates born to mothers receiving buprenorphine in 12 studies

In buprenorphine compared with methadone-exposed neonates:

- **The unadjusted NAS treatment risk was lower (risk ratio 0.90, 95% confidence interval [CI] 0.81–0.98)**
- **The mean length of hospital stay shorter (-7.23 days, 95% CI -10.64 to -3.83)**

In treated neonates, NAS treatment duration was shorter (-8.46 days, 95% CI -14.48 to -2.44) and total morphine dose was lower (-3.60 mg, 95% CI -7.26 to 0.07)

Buprenorphine-exposed neonates also had:

- **higher mean gestational age**
- **greater weight**
- **length**
- **head circumference at birth.**

Fewer women treated with buprenorphine used illicit opioids near delivery (risk ratio 0.44, 95% CI 0.28–0.70)

Brogly SB et al. *Am J Epidemiol* 2014.

Buprenorphine+Naloxone *v.* Buprenorphine or Methadone

- Collective data comparing buprenorphine+naloxone to methadone show:
  - Similar maternal outcomes as those seen with buprenorphine alone
  - Similar reductions in NAS severity
- Collective data comparing buprenorphine+naloxone to buprenorphine alone show:
  - Similar maternal outcomes
  - Similar birth outcomes including NAS severity

Wiegand SL, et al., *Obstet Gynecol.* 2015;125(2):363-368.

Lund IO, et al. *Subst Abuse.* 2013

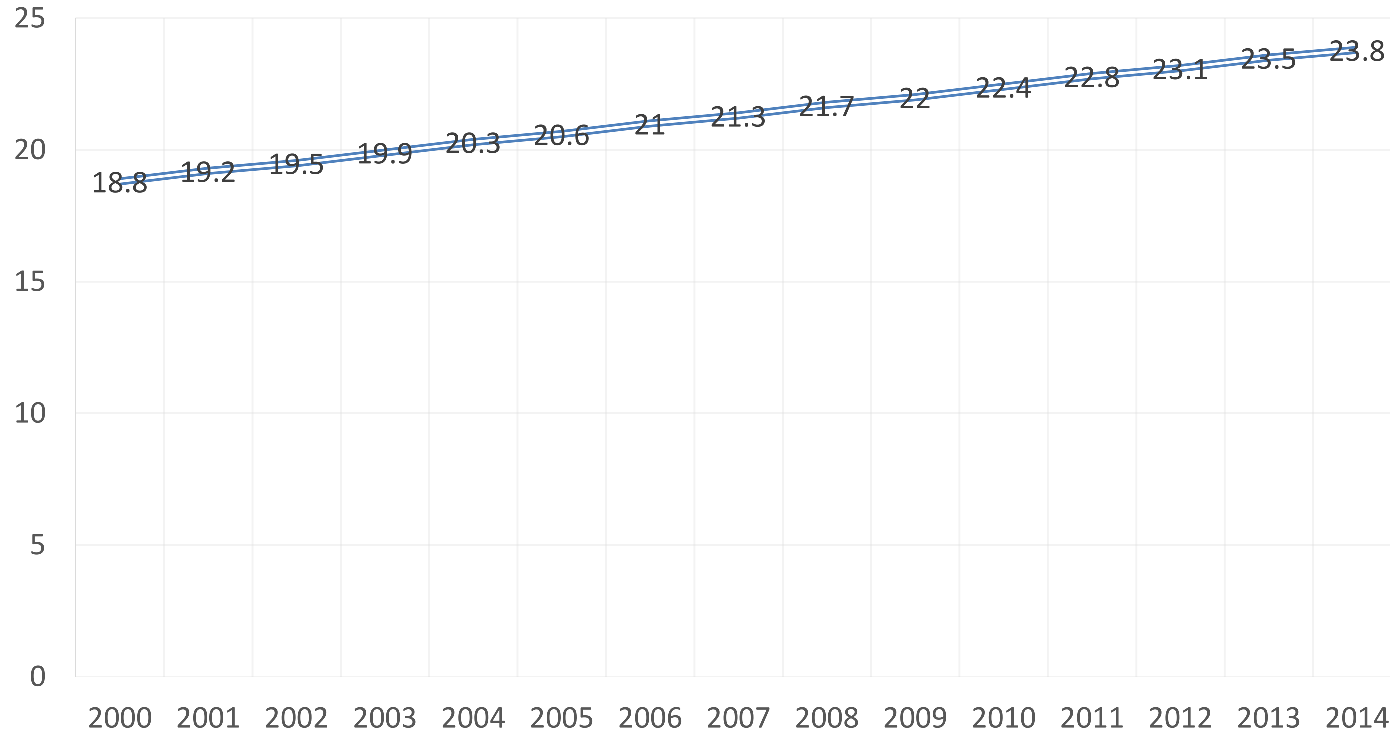
Gawronski KM, et al. *SAGE Open Med.* 2014

The 4th Trimester - Postpartum

- Critical Period
  - Newborn care, breastfeeding, maternal/infant bonding
  - Mood changes, sleep disturbances, physiologic changes
  - Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn

- Neglected Period
  - Care shifts away from frequent contact with PNC provider – to pediatrician
  - Care less “medical” (for mom) and shifts to other agencies (WIC)
  - Insurance and welfare realignment
  - SUD treatment provider(s) – care is constant

Maternal Mortality is Increasing



Possible Factors

Drug use with homicide/suicide

Overdose

Medicaid coverage loss at 6 weeks postpartum

"Detox" during pregnancy to prevent NAS

Inadequate Access to drug treatment/MAT

*Excludes California and Texas California showed a declining trend, whereas Texas had a sudden increase in 2011-2012.

MacDorman MF et al *Ob/Gyn* 2016

KC PERINATAL RECOVERY COLLABORATIVE

Missouri Responds with Help

- Women who access treatment for substance use disorder with 60 days of giving birth will be eligible for continued treatment for up to 1 year through MO Healthnet

- Such action holds promise to dramatically increase access to treatment for women

What are the Long Term Outcomes of Children Prenatally Exposed to Opioids?

Issues to consider when reading the literature

- **Population of Interest definitions**
- **Comparison group? What kind?**
- **Prospective data collection in the perinatal period?**
- **Masked assessment?**
- **Include a substantial proportion of subjects exposed in utero other substance?**
- **Matching**
- **Statistical**
- **Inferential**

"Addiction, illegality, prenatal toxicity and poor outcomes are linked in the public and professional mind. In reality, scientific evidence for prenatal toxicity and teratogenicity is equivocal for some drugs and stronger for others. Inaccurate public expectations of correspondence between illegality and toxicity lead to distortions in interpreting and applying scientific findings."

Jones et al., in preparation; Zuckerman B, Frank DA, Mayes L. JAMA. 2002 Apr 17;287(15):1990-1

MOTHER Child Outcomes up to 36 months

_N_=96 children

- **No pattern of differences in physical or behavioral development to support medication superiority**
- **No pattern of differences for infants treated for NAS v. infants who did not receive treatment for NAS**
- **No pattern of differences when children were compared to norms on tests**

Results indicate children born in the MOTHER study are following a path of normal development in terms of growth, cognitive and psychological development

Kaltenbach, K. et al., Drug and Alcohol Dependence 2018

Model Programs Described in TIP 2: Pregnant, Substance-Using Women: Treatment Improvement Protocol (TIP) Series 2

The goal of the program - provide comprehensive services that are appropriate and sensitive to the needs of the target population -- services that will enable women to secure prenatal care and other support throughout pregnancy, to achieve a successful delivery, and to receive months of postpartum care.

Services will be provided by a multidisciplinary team of health professionals

All health care services will be provided in one setting

If the patient needs to undergo medical withdrawal or be hospitalized, referrals will be made to the appropriate programs.

The model program will provide:

- outreach services
- laboratory workups
- obstetrical and gynecological physicals
- social work intervention
- appropriate follow-up services
- diagnosis, evaluation, and short-term clinical interventions, along with medical management

A case management model is used

The woman's transition into providing child care and parenting will be facilitated by a complete and thorough assessment of her needs and the development of a comprehensive treatment plan.

DHHS Publication No. (SMA) 95-3056, 1993

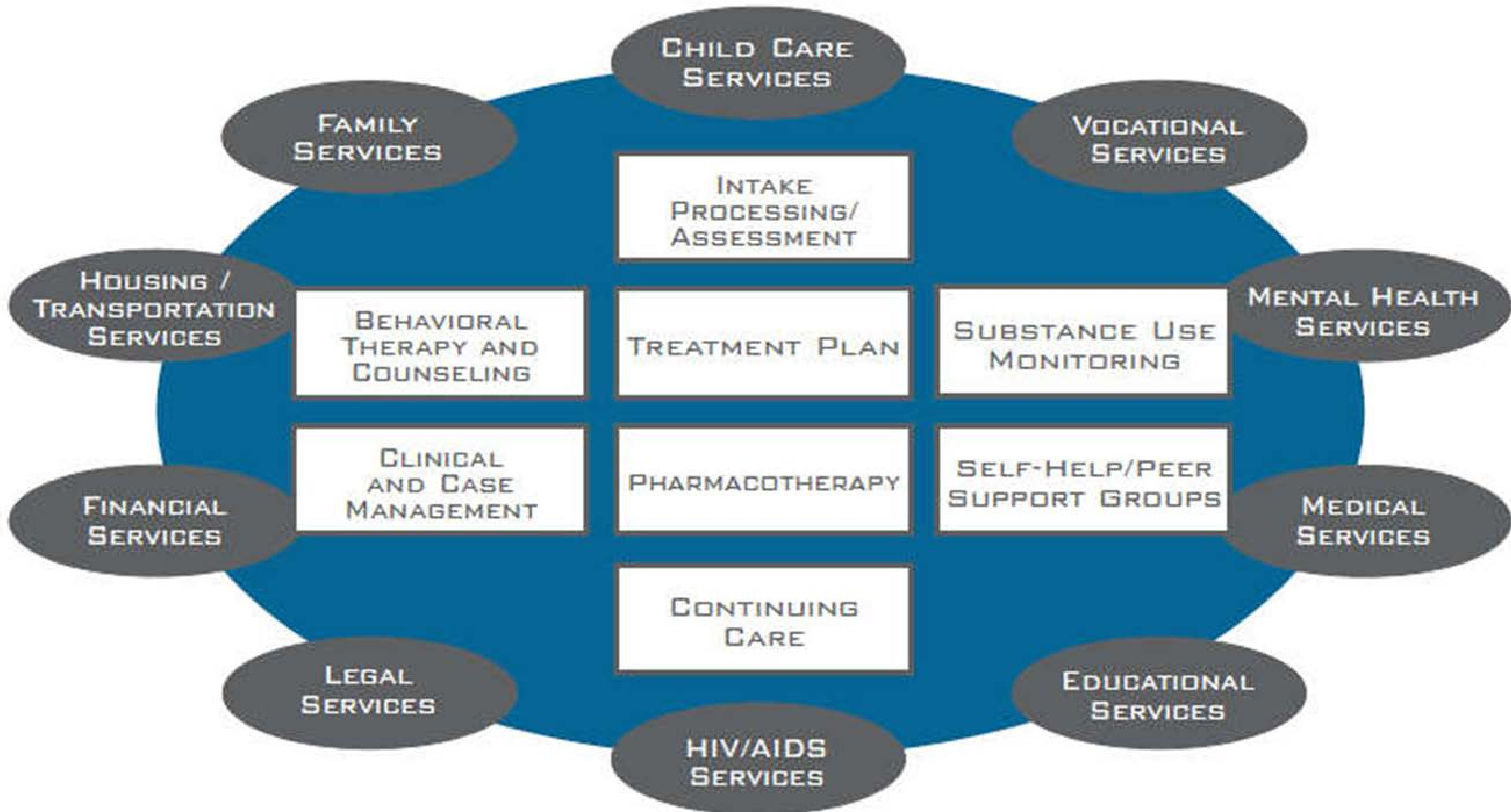
Star Programs: Kansas City Metro Area

DCCCA- Treatment

Shawnee Mission Medical Center- Mother-child Dyad NAS care

Amethyst Place- Recovery Supports for dyad

TIES- intensive home-based partnership



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

NIDA: Principles of Drug Addiction Treatment

UNC Horizons: Model of Care for Women and Children

Medication Assisted Treatment

Trauma and SUD Treatment

Residential and/or Outpatient Care

Childcare and Transportation

Medical Care OB/GYN Psychiatry

Vocational Rehabilitation Housing Legal aid

Parenting Education and Early Intervention

2016-2017 Treated 266 women

- **62% Primary OUD**
- **24% reported TBI**
- **Age of first substance use started at 5 years old (mean 15 years old)**
- **Babies born at term and normal birth weight**
- **77% employed at completion**
- **100% CPS outcomes were positive at completion**

Unified Philosophy Informed by Social Learning, Relationship and Empowerment Theories

Other Example Model Programs

CHARM Collaborative

Dartmouth Hub and Spoke Model

SHIELDS for family Program

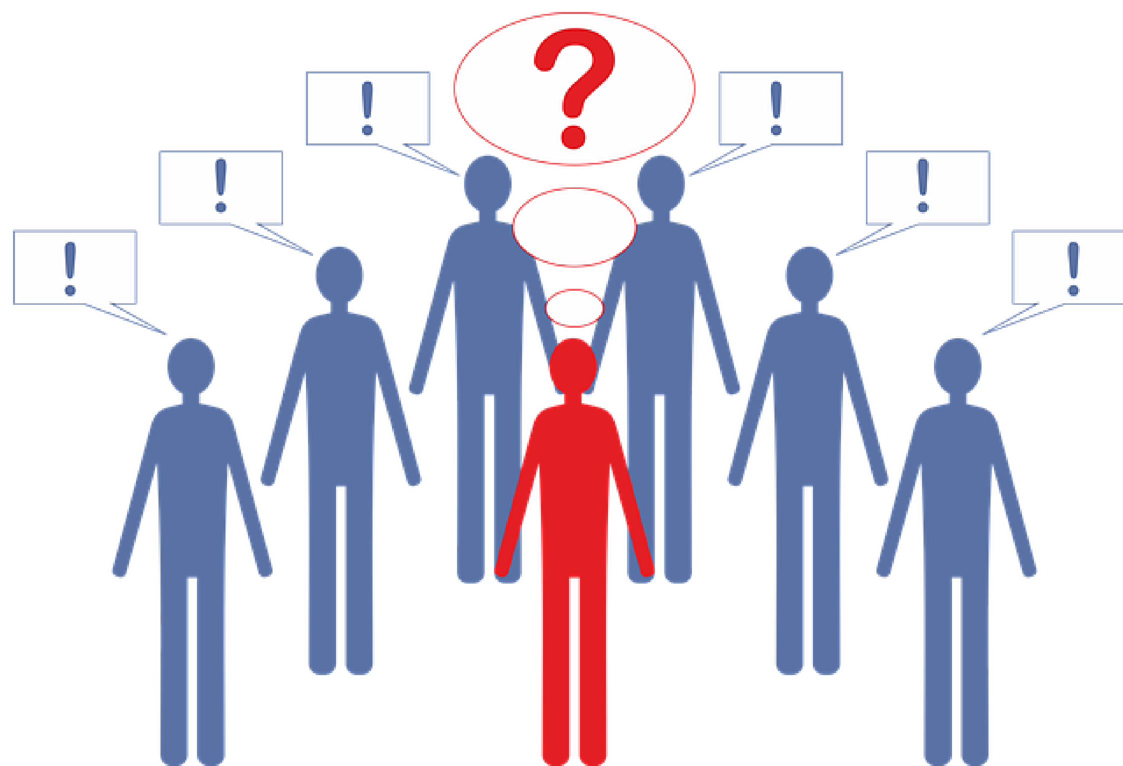
Defining Terms

Discrimination

Prejudice

Stigma

- Enacted
- Perceived
- Self-stigma



https://pixabay.com/en/bullying-exclusion-prejudices-2171865/

Prejudice and Stigma Transmitted

- Stereotyping
- Reinforcing the Stereotype
- Historical Associations
- Ignorance
- Abuse
- Language

Credit: johnhain / 471 images angst

LANGUAGE MATTERS:

Using Affirmative Language to Inspire Hope and Advance Recovery

Stigmatizing Language	Preferred Language
abuser	a person with or suffering from, a substance use disorder
addict	person with a substance use disorder
addicted infant	infant with neonatal abstinence syndrome (NAS)
addicted to [alcohol/drug]	has a [alcohol/drug] use disorder
alcoholic	person with an alcohol use disorder
clean	abstinent
clean screen	substance-free
co-dependency	term has not shown scientific merit
crack babies	substance-exposed infant
dirty	actively using
dirty screen	testing positive for substance use
drug abuser	person who uses drugs
drug habit	regular substance use
experimental user	person who is new to drug use
lapse / relapse / slip	resumed/experienced a recurrence
medication-assisted treatment (MAT)	medications for addiction treatment (MAT)
opioid replacement	medications for addiction treatment (MAT)
opioid replacement therapy (ORT)	medications for addiction treatment (MAT)
pregnant opiate addict	pregnant woman with an opioid use disorder
prescription drug abuse	non-medical use of a psychoactive substance
recreational or casual user	person who uses drugs for nonmedical reasons
reformed addict or alcoholic	person in recovery
relapse	reoccurrence of substance use or symptoms
slip	resumed or experienced a reoccurrence
substance abuse	substance use disorder

Prejudice, Stigma and Babies

By: Elaine QuijanoCBS NEWS JULY 8, 2015, 6:03 PM

Life begins with agony of withdrawal for opiate-addicted babies

BOSTON -- America's heroin problem is getting worse. A new report from the Center for Disease Control says that in just six years heroin use has risen 150 percent to more than a half-million Americans Over a decade use by women alone is up 100 percent. The most innocent victims of drug abuse are babies.

LOUISVILLE, Ky. — Shortly after he was born, tremors wracked Leopoldo Bautista's tiny body as he suffered through the pain of drug withdrawal — pain his mother understands.

Born into suffering: More babies arrive dependent on drugs
LAURA UNGAR, USA TODAY 7:10 P.M. EDT JULY 8, 2015

Drug-addicted babies on rise in Tennessee
October 12th, 2013 7:58 pm *by* Becky Campbell

A PIECE OF MY MIND

Collateral Damage

JAMA. 2018;319(11):1093.

C. Nicholas Cuneo, MD
Department of Medicine, Brigham and Women's Hospital, Boston, Massachusetts; Department of Medicine, Boston Children's Hospital, Boston, Massachusetts; and Department of Pediatrics, Boston Medical Center, Boston, Massachusetts.

Your cry is more of a whimper, as if you quickly learned to dampen it in fear of retaliation. Alone in your crib, your tiny body makes the private room where I come to examine you each day seem gigantic. Even before they banned your parents from the hospital, I never once saw them visit you.

The nurses tell me that hospital volunteers hold you at times during the day, but I've never seen them either. I wonder if one of them left that pink ribbon in your hair. It gives the impression that you are loved and cared for, when the reality is much more complicated. I recall the

The image of your discharge from that initial hospitalization is haunting. Like many babies with NAS, you ended up going home with your biological parents, despite the harm you had already endured. In some cases, these new parents rise to the challenge, shedding harmful addictions with a newfound sense of external responsibility or continuing to dutifully adhere to prescribed opioid replacement therapies. Sadly, treatments like methadone and buprenorphine can also lead to NAS, punishing even those recovering mothers who have done everything they have been told to do during their pregnancies.

Positive Action Example

Editorials

Why would Missouri treat pregnant women struggling with drug addiction like criminals?

By The Kansas City Star Editorial Board February 23, 2018 05:12 PM

Updated February 23, 2018 06:14 PM

"The opioid epidemic is damaging families, and yes, it is harming babies. Legislators should focus on funding recovery programs and abandon efforts to treat pregnant women struggling with addiction like criminals."

Read more here: http://www.kansascity.com/opinion/editorials/article201879119.html#storylink=cpy

Prejudice and Stigma Stopped

- **The Benefits of Language**
- **Valuing People with Disorders**
- **Changing the Expectations**

Credit:[johnhain / 471 images couple]

What You Can Do To Reduce Prejudice and Stigma

- **One of the most powerful tools you can use to overcome and reduce stigma is to practice empathy**

Merriam Webster *Empathy*

The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner

- **Empathy is the most important skill you can practice**

- **It will lead to greater success personally and professionally and will allow you to become happier the more you practice**

Credit: jclk8888 / 21 images hands

How To Increase Your Empathy

Practical tips to consider for increasing empathy:

- Listen
- Don't interrupt people
- Tune in to non-verbal communication
- Practice the "93 percent rule"
- Use people's name
- Be fully present when you are with people
- Smile at people
- Take a personal interest in people

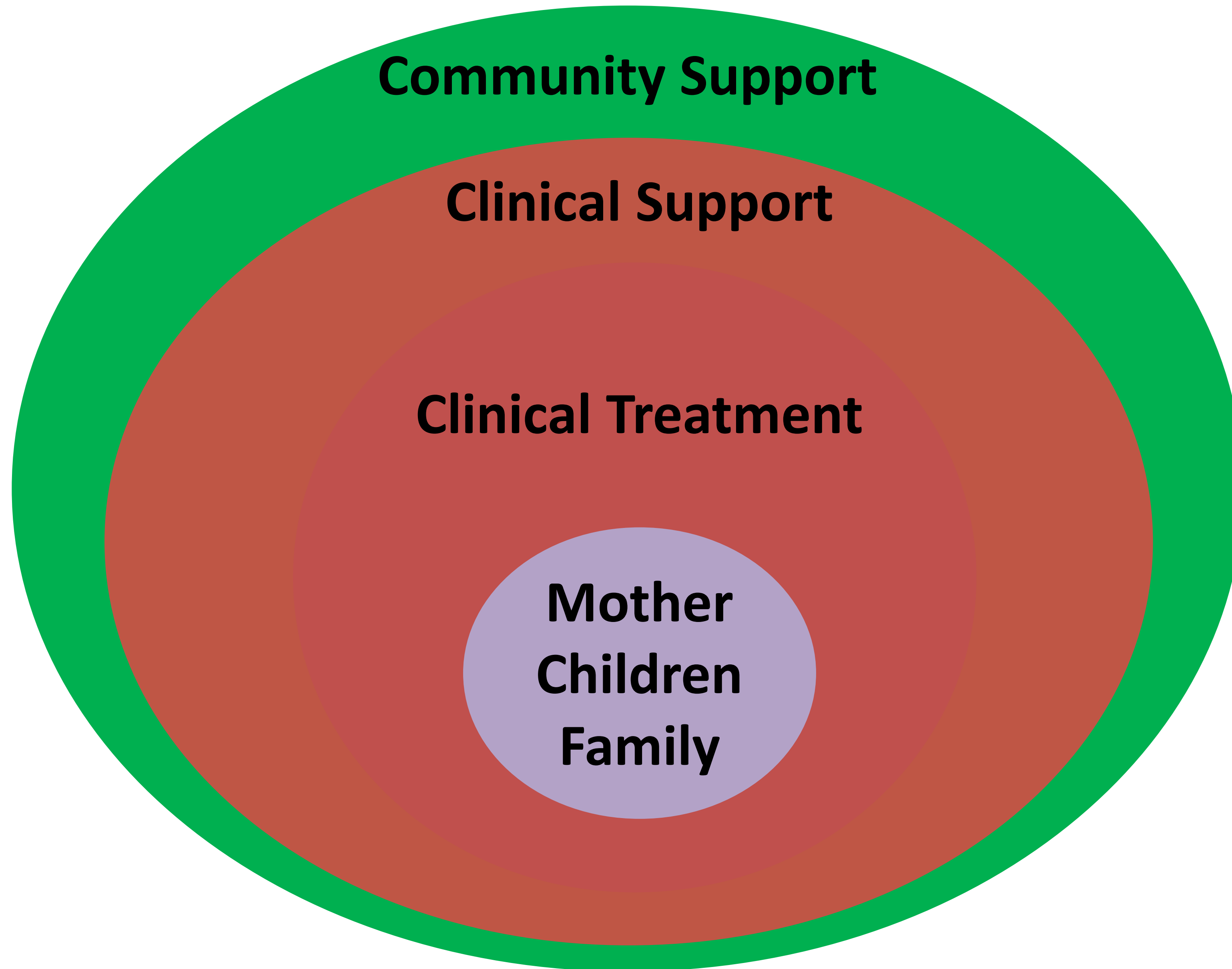
Increasing Empathy Protects You

Four skills decrease the likelihood of malpractice suits and improve patient outcomes and greater patient compliance:

1. ***Engage the patient***
2. ***Display empathy***
3. ***Educate the patient***
4. ***Enlist the patient***

Spiegel, A.D., & Kavaler, F. Better Patient Communications Mean Lower Liability Exposure. MANAGED CARE August 1997.
https://pixabay.com/en/baby-hand-child-keep-birth-human-717680/

ROSC for Families



What You Can Do

Individual Level

- Mothers, children and families need strength-based support
- Help tell stories of recovery and success
- Consider mother and child not mother vs. child
- Be familiar with toolkits from NC and SAMHSA

Structural Level

- Access to whole health care
- Responsible prescribing by providers and training in substance use disorders and their treatments
- Create or engage in local networks to foster ROSCs that support families

Summary

- Opioid use disorder is a concerning medical illness that has radiating effects on the life of the person and those around the person
- Those who have this illness deserve the most appropriate medical care – medication in only one part of a complete treatment approach
- Patients are best served by having choices in medication treatment options
- Structured, evidence-based behavioral treatment is needed to help support the mother, child and family
- Women who have opioid use disorders and their prenatally opioid exposed children are best served with a strength-based perspective

See Klaman SL, Isaacs K, Leopold A, Perpich J, Hayashi S, Vender J, Campopiano M, Jones HE.J Addict Med. 2017 for a full list of unanswered research questions for mother, fetus, child and the mother-child dyad