A Collaborative Approach to Treating Pregnant & Postpartum Women with Opioid Use Disorders

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Faculty Disclosures

- Katlyn Monje, MSW, LMSW, has no financial relationships to disclose relating to the subject matter of this presentation.
Learning Objectives

Upon completion, participants will be able to:
• Describe the common barriers faced by pregnant and postpartum women with opioid use disorder.
• Identify the benefits of collaboration between substance use disorder treatment programs and community-based hospitals/Neonatal Intensive Care Units.
• Assess effective engagement and treatment strategies to serving pregnant women with opioid use disorder.

So, What’s the Issue?

• Opioid use and dependency comes with high costs.
  – Human lives and financial burdens
• Prevalence of pregnant women with OUD quadrupled from 1999-2014.
  – Maternal and infant hospitalizations related to SUD also climbed.
• Reproductive Health in Women with SUD
  – Unplanned pregnancies are as high as 86%.
  – Low rates of contraception use.
Some Data – Antepartum

• One study reported that **21.6%** of pregnant women enrolled in Medicaid receive a prescription for opioids.


• One study reported that **4.7%** of pregnant women reported using an illicit substance in the past month.

  (Substance Abuse and Mental Health Service Administration. Results From the 2015 National Survey on Drug Use and Health: Detailed Tables. 2016.)

Some Data – Post-partum

One study reported that **1 in 300** women will become dependent on opioids after a cesarean delivery.

Engagement in Prenatal Care and Treatment

• 1 in 20 women (5%) report taking drugs during pregnancy. (March of Dimes, 2020)
  – Rate is higher among 15-17 year olds
• OUD affects 6.2 in every 1,000 women at delivery. (Normille, Hanlon and Eichner, 2018)
• 4.5%-8.5% report Postpartum Drug Use
  – Marijuana and opioids most common (Chapman and Wu, 2013)

• Pregnant women using opioids for non-medical use were more likely to obtain opioids from doctors.
• Prescription pain reliever use more than doubles risks of stillbirth
• Women with OUD are significantly more likely to discontinue medication-assisted treatment in the postpartum period compared to during pregnancy.

Common Barriers Faced by Pregnant Women with OUD
Stigma: Creating Barriers to Care

A Mark of disgrace associated with a particular circumstance, quality, or person that often designates a person as flawed.

- Labels and stereotypes lead to dehumanization, discrimination and social exclusion.
  - Aggravates pre-existing shame and guilt.
  - Seen at micro, macro, and systemic levels.

The Impact

- Decreases the belief that SUDs are common, valid, and treatable medical conditions.
- Promotes discrimination.
- Prevents individuals from seeking help.
- Creates barriers within support systems.
- Deters the public from supporting or contributing to efforts to improve access to treatment.
What Society Tells Them

• “Replacing one drug for another (MAT).”
• “Choosing drugs over an unborn child.”
• “Using was more important.”
• “Baby born addicted.”
• “Will never change, can’t be trusted, beyond help.”
• “Just a criminal.”
• “To blame for their situation.”
• “Bad/unfit/unworthy mother.”

Likely To Encounter Issues With:

• Adequate housing for self and children.
• Obtaining and maintaining employment.
• Transportation.
• Childcare.
• Early child removals by DCS.
CODAC’s Long Standing Commitment

- Serving the Tucson Community for more than 50 years.
  - More than 30 dedicated to pregnant and postpartum women
- Initial focus was on opioid use disorder and pregnant and postpartum women with substance use disorders.
- Established MAT clinic and Residential Treatment Program.

CODAC’s SUD Clinic

- Now 24/7
- Integrated
  - SUD
  - Behavioral Health
  - Primary Care
  - OB
  - Women’s Health
CODAC’s SUD Clinic

- Acupuncture/
  Auricular Acupuncture
- Mindfulness: Meditation, Tai Chi
- Neighborhood Clean-Up Group
- Patient Advisory Group

Las Amigas
Residential Treatment Program

- 28 Bed Facility
- Children reside with moms
- Intensive Recovery Program
- Graduation Celebrations
Meet Brittney

• Active use, discovered pregnancy at 6 months.
  – First pregnancy
  – No established prenatal care

• Started MAT and admitted to residential at 8 months.
  – First attempt at treatment

• Gave birth 1.5 weeks into treatment.
  – Child welfare labeled discharge from residential as “unsuccessful”
  – Stigmatized for delay in seeking treatment, prenatal care

• Child welfare removal

The Aftermath

• Member declined to return to residential treatment.
  – Associated removal with discharge from program
  – Pressure to succeed in OP setting for a perceived quicker chance at reunification

• Relapse
  – Missed child visits
  – Struggled to make it to OP services
A Common Occurrence

- Patients “discharged” from residential upon inpatient stays for labor and delivery.
  - Discharges labeled as “unsuccessful” by local child welfare department.
- Subsequent child removals.
  - Patients decline to return to residential treatment.
  - Lack of wrap around support for moms.
  - Increased risk for relapse, continued use, overdose.

What We Knew

- Stigma, self-blame and shame and fear of reprisal were keeping women from treatment, prenatal care.
- Adequate prenatal care and support can define the difference between positive and negative birth experiences and pregnancy outcomes
  - Routine vs high risk pregnancies and deliveries
- CODAC was not alone in its mission to bridge the gap in services
The Proposal: Bring CODAC to the NICU

- CODAC approached Tucson Medical Center’s local Neonatal Intensive Care Unit (NICU).

- Proposed a collaborative approach to treating moms.

- Offered CODAC services in the hospital for pregnant and postpartum women.
  - Case Management, therapy, and family support

“Committed to ensuring that mothers, babies and their family members are offered the opportunity to receive substance use and mental health treatment services...”
**Project Goals**

- Reduce stigma.
- Improve family support & education.
- Increase parent-baby bonding.
- Improve access to services.
- Provide support.
- Reduce child removals.

**Strategy: Meet Families Where They’re At**

**Immediate Support and Service Provision**

*On-Site in NICU*

- Validation
- Person-Centered
- Non-Judgmental
- Strengths Based
- Family Focused
- Evidenced-Based
- Fact Over Fear
- Low Barrier
Continuum of Care

Assessment
Peer Recovery Support
Community Resources
Referrals to CODAC’s Integrated Care
Counseling & Case Management
In-Hospital Therapy
Family Support & Education
Follow-up

Project Evolution

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<thead>
<tr>
<th>2016</th>
<th>Today</th>
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| • Monday–Friday, 8a–5p  
  – Initial outreach during business hours only | • 24/7 Referrals and Outreach  
  – Initial outreach within 24 hours |
| • 1 Recovery Coach, 1 Therapist | • 4 Dedicated Outreach Engagement Specialists  
  + 1 PRN Therapist |
| • Single point of contact | • Direct lines of contact  
  – Secure email for referrals  
  – 24/7 direct phone line to OES |
Project Evolution

<table>
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<tr>
<th>2016</th>
<th>Today</th>
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<tbody>
<tr>
<td>• Case Management &amp; Group Therapy</td>
<td>• Initial Assessments, Referrals to Integrated Care</td>
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<tr>
<td>• Office Hours</td>
<td>• Office hours</td>
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<tr>
<td>• Excel for referral tracking = minimal data tracking</td>
<td>• EHR for data entry and tracking</td>
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<tr>
<td></td>
<td>• Stronger relationship with Child Welfare</td>
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Collaboration with Child Welfare

• **Team approach**, transparency and early intervention at TMC.
  – NICU tour
  – Provide comfort
  – Validate concerns

• **Support** to member during and after initial interview.

• **Family Support** and Education.
Collaboration with Child Welfare

• **Ease of coordination.**
  – Secure releases of information.
  – Establish points of contact at all levels of care.

• **Support throughout** the child welfare process.
  – Prepare member for various stages of process.
  – CODAC and social workers attend initial Team Decision Making Meetings.
  – Assign treatment and support team.
  – Advocate for the needs of both baby and parent.

• **Future Plans:** Incorporate into Pregnancy Protocol on site at CODAC.

Specialized Programming

• **Women’s Team**

• **Caseload for pregnant and postpartum members**

• **OB/GYN Coordination**

• **Pregnancy Protocols**
  – Medical provider, nurse, and recovery coach

• **Gender-specific Intensive Outpatient Program**

• **Childcare available for onsite appointments**

• **Quiet Room for breastfeeding**
Specialized Programming

- *Celebrating Families! Program*
- New Moms Group – Desert Nest
- Trauma Empowerment and Recovery Model
- Las Amigas Residential Treatment Program with ability to have child residents
- Hillman House Transitional Living Program
  - TMC Nursing Assistance for postpartum and breastfeeding support
- SABG funded position
  - Dedicated funding to ensure “non-billable” work can still be done

Maintaining the Relationship

- Accessibility
- Follow through
- Regular meetings with TMC and additional partners
  - Review successes, barriers
- Expand and adjust in-hospital services based on need
- Annual review of MOU
- Inviting new partners to the table
Project Challenges and Barriers

- Continued Stigma
- Insurance & Prior Authorizations
- COVID-19

Staying Connected During Global Pandemic

- Accessibility: Honoring the 24/7 hours of operation.
  - Staff and member safety, comfort
- Prioritizing in person services, offering telehealth when possible.
  - MAT and Pregnancy Protocol, access to Peer Support Specialists
- Extend reengagement efforts.
  - Closure protocol changes, increase in outreach and home visits
  - Distribution of Narcan and Naloxone
  - Communication with NICU
Meet Desiree

- TMC refers to CODAC during pregnancy, child welfare engages early.
- Assessment and referral to Las Amigas Residential Treatment Program.
- Child placed with family while member stabilizes.
- Discharges to Hillman House Transitional Living → child placed with mother!
- Recovery Continues in Outpatient Treatment.

Approach to Working with Our Patients

- Expectations
- Respect
- Non-Judgment
- Genuine Interest
- Advocacy
Treating the Whole Person

- Observation and feedback
- Safe environment
- Mood modulation
- Complete Assessment: Physical, Emotional, Social, Spiritual/Purposeful
- Referrals for all Needs

Adverse Childhood Experiences and Safety

- Adverse Childhood Experiences Questionnaire
  - Abuse
  - Neglect
  - Family & Household Challenges

- Various ways to treat the lasting impact of high ACE scores
Clearly define the approach to screening and testing pregnant patients for opioid use.

- An important first step is identifying available opioid treatment centers for pregnant women and locating buprenorphine prescribing providers.

Pregnancy Team-Pregnancy Protocol

- Integrated, educated team
- Regular communication and patient contact
- Safe space
  - Team must be committed to using therapeutic language and attitudes.
- Empowerment through education, choice
Avoid opioid withdrawal during pregnancy.

Maintain abstinence from heroin, opioids and other drugs.

MAT provides overall safety for the pregnant woman and the fetus.

Use of MAT During Pregnancy

Infants born to women who used opioids during pregnancy should be monitored for Neonatal Abstinence Syndrome (NAS) beginning shortly after birth.

- Engage patients early on in care and inform them to seek a Hospital using Skin-to-Skin Method.

- Ensure awareness of the signs and symptoms of NAS.

Neonatal Abstinence Syndrome (NAS)
Neonatal Abstinence Syndrome (NAS)

- Include interventions to decrease NAS severity (maternal-infant bonding and breastfeeding, smoking cessation).
- Symptoms can appear 3 hours to 12 days after birth.
- Babies stay minimum of 3 days.

Co-Management with

- Refer patients to an OB/GYN covered by their insurance.
- Essential that patient be given all supports needed for positive pregnancy and hospital experience.
Approximately 30%–70% of women who have given birth experience lowered self-esteem after childbirth due to various reasons.

Lowered self-esteem causes an array of social and psychological problems such as degraded marital relationships, depression, bulimia, and reduced childrearing competency.


**Bolstering Self-Esteem**

- Observe
- Listen
- Keep focus on recovery.
- Reassure parenting skills.
- Point out personal strengths.
**Improving Self-Esteem**

- Practicing Self-care
- Practicing Self-acceptance
- Practicing Self-responsibility
- Living purposefully
- Living authentically

**Staff Education**

- Recognize that pregnancy is a great window of opportunity to empower women to care for their baby and themselves.
- Educate on what opioid use disorder is and who is affected.
- Offer strategies to engage the patient and how to overcome barriers to successful outcomes.
- What medications are appropriate during pregnancy and why.
“I’m blessed. I don’t think I ever would have asked for help on my own. Part of me knew I needed it, but it was scary. I knew what people thought of me... it took a long time for me to believe I deserve better.”

Questions?
Let’s Connect!

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