



April 6, 2020

Welcome to

BASICS OF MAT AND PREGNANT WOMEN

The webinar will begin at 4:00pm ET.

The webinar:

- Your audio is muted during the webinar.
- The webinar will be recorded and posted on the RJOI website (www.ncsc.org/rjoi).
- Questions can be submitted through the **chat function** and will be held until the end of the webinar and answered as time allows.

Webinar Support:

This webinar is supported in part by Grant No. 2017-PM-BX-K037 awarded by the Bureau of Justice Assistance (BJA). BJA is a component of the Department of Justice's Office of Justice Programs. Points of view or opinions provided are those of the speakers and do not necessarily represent the official position or policies of the U.S. Department of Justice.



Panel



Dr. Stephen Loyd
Tennessee



Dr. Barbara Howes
Michigan



Judge Duane Slone
Tennessee



Judge Sue Dobrich
Michigan



Background



National Judicial Opioid Task Force

Treating Pregnant Women with Opioid Use Disorder

This summary highlights the important evidence-based practices recommended in the Substance Abuse and Mental Health Services Administration's (SAMHSA) latest and most comprehensive guidance regarding pregnant women with opioid use disorders.

In February 2018, SAMHSA released the new *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*¹ (<https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>).

The *Clinical Guidance* provides reliable, useful and accurate information for professionals working to treat opioid dependent mothers and their children.

The guidance consists of 16 fact sheets on prenatal, infant, and maternal postnatal care that are directed at healthcare professionals. We believe the evidence-based practices found in SAMHSA's guidance can inform judges, court administrators, executive branch leaders, legislators, behavioral health treatment providers, community supervision agencies, medical experts, prescription drug monitoring program managers, regulatory agencies, child welfare representatives, among others. The fact that many non-medical professionals, including judges, can potentially affect treatment decisions for pregnant women with Opioid Use Disorder (OUD) can further exacerbate the care of women and their infants if

those non-medical professionals do not understand the best practices laid out in this guidance.

Background

Treatment decisions for a mother and her fetus/infant are complex because they require balancing the needs of both patients (referred to as the maternal-fetal dyad or mother-infant dyad).² Effective interventions for OUD exist and include medication-assisted treatment (MAT). Healthy outcomes can occur for both the mother and the infant, but only when professionals can recognize and effectively treat OUD.

It is important to review the terms used in the guidelines. In clinical practice, prenatally substance-exposed infants are typically exposed to multiple substances (tobacco, alcohol, prescription medications, and illicit substances). Additionally, the research publications relied on to support SAMHSA's guidance almost universally studied pregnant women with substance use disorders (SUDs), rather than OUD only. As such, the guidelines use the term neonatal abstinence syndrome (NAS) when referring to the withdrawal symptoms expressed by infants, as opposed to the more narrow term neonatal opioid withdrawal syndrome (NOWS).³



¹ Substance Abuse and Mental Health Services Administration. *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. HHS Publication No. (SMA) 08-5054. Rockville, MD.

Substance Abuse and Mental Health Services Administration, 2018. Hereinafter *Clinical Guidance*.
² *Clinical Guidance*, Part A: Introduction.
³ *Id.*

Opioids and the Courts Resource Center

~National Judicial
Opioid Task Force~



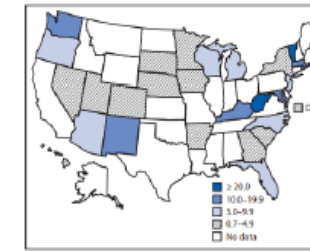
National Judicial Opioid Task Force

Prenatal Substance Exposure: Improving Outcomes for Women and Infants

Background

In the United States, the prevalence of opioid use among pregnant women more than quadrupled from 1999 to 2014.¹ An infant is born with neonatal abstinence syndrome (NAS) approximately every 15 minutes in the United States. Newborns with NAS require specialized care and typically have longer hospital stays after birth and increased healthcare costs.

Prevalence of opioid use disorder per 1,000 delivery hospitalizations, 2013-2014²



Neonatal abstinence syndrome is a postnatal drug withdrawal syndrome exhibited by some opioid-exposed infants that is characterized by hyperactivity of the central and autonomic nervous system and gastrointestinal tract. The incidence of NAS among infants who were exposed prenatally has been estimated to be between 34 and 94 percent.³ While we cannot yet predict which infants will manifest signs of withdrawal, studies have connected polysubstance exposure - particularly antidepressants, benzodiazepines, and gabapentin - to the incidence and severity of neonatal drug withdrawal.⁴ The onset of withdrawal symptoms occurs within 24 and 72 hours after birth and can last up to five days.⁵ The severity of NAS is affected by factors including gestational age, and gestational exposure to benzodiazepines.

IDENTIFYING OUD IN PREGNANT WOMEN

Stephen Loyd, MD

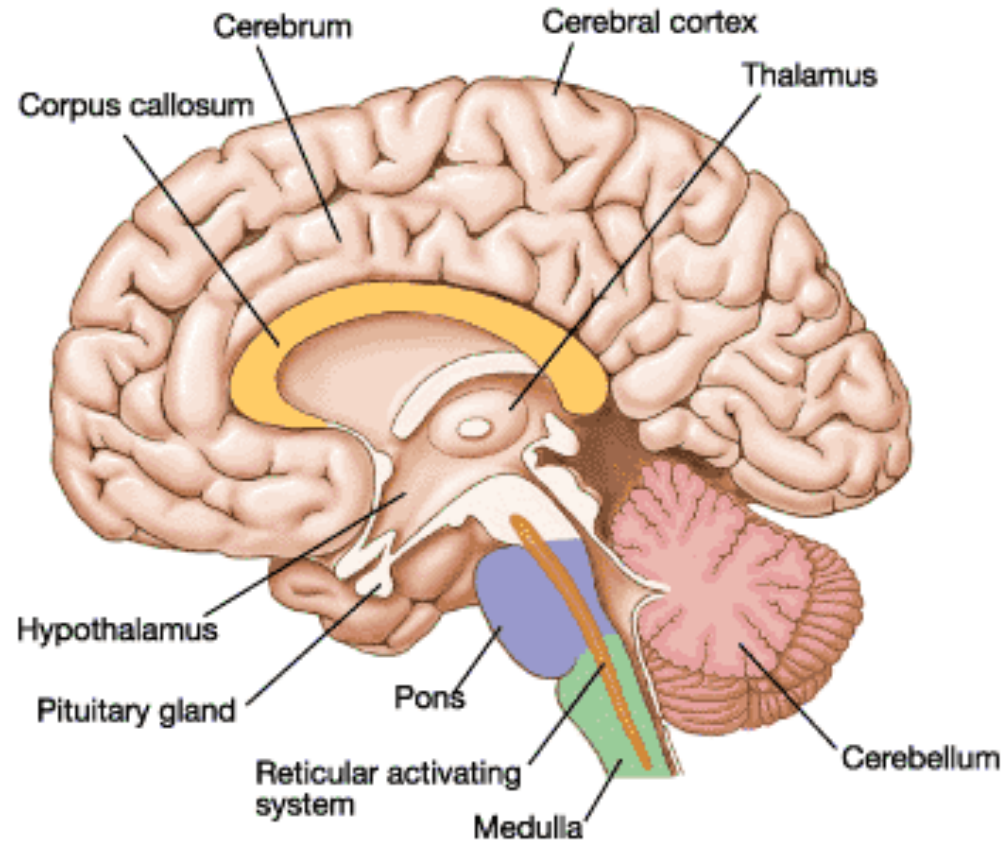
Dependence vs. Addiction

- **Dependence** – once the drug is stopped, a predictable physiological withdrawal syndrome occurs.
- **Addiction** – the compulsive use, loss of control and continued use despite adverse consequences; hallmark is **cravings**.





Hi-Jacking of the Limbic System (Rewards)





Thumb?



Underground Healthcare



Pregnancy Substance Abuse Red Flags

- **Seek prenatal care late in pregnancy**
- Poor adherence to their appointments
- Poor weight gain
- Sedation, intoxication, withdrawal symptoms, erratic behavior
- Track marks, abscesses, cellulitis (injection sites)
- Positive serology for Hepatitis B&C, HIV



BENEFITS OF PHARMACOTHERAPY DURING PREGNANCY

Dr. Stephen Loyd

Treatment

- Methadone – standard of care since the 1970's
- Rationale for treatment – prevent complications of illicit opioid use and narcotic withdrawal
- Goals – encourage prenatal care and drug treatment
- Reduce criminal activity
- Avoid risks associated with the drug culture
- ***Comprehensive opioid-assisted therapy that includes prenatal care reduces the risk of obstetric complications***
(SAMSHA/CSAT February 9, 2012)



Neonatal Abstinence Syndrome

- Methadone/buprenorphine (Subutex/Suboxone) **do not** prevent NAS
- **NAS is an expected and treatable condition** – need collaboration among treating specialties
- Hyperactivity of the central and autonomic nervous systems
 - Uncontrolled suckling reflexes – leads to poor feeding
 - Irritability
 - High-pitched cry



Timing of NAS

- Methadone – symptoms appear within 72 hours and can last for days and weeks
- Buprenorphine (Subutex/Suboxone) – symptoms appear within 12-48 hours and usually resolve within 7 days

(Drug Alcohol Depend 2003; 70:S87-101)



MAT in Pregnancy

- Should be titrated until the woman is asymptomatic – withdrawals and cravings
- Systematic literature review – ***severity of NAS does not appear to differ based on the maternal dosage of methadone****
- Buprenorphine is the only approved opioid for the treatment of opioid dependence in an office-based setting



Buprenorphine vs. Methadone

- **Advantages** – lower risk of overdose, fewer drug interactions, ability to treat as an outpatient, evidence of less severe NAS*
- **Disadvantages** – liver dysfunction, lack of long-term data, dropout rate due to dissatisfaction with the drug, risk of precipitated withdrawal, increased risk of diversion

*(N Eng J Med December 2010; 363:2320-31)



2010 NEJM (N Eng J Med 2010; 363:2320-31)

- Buprenorphine (*Subutex/Suboxone*) or methadone in 175 opioid-dependent pregnant women
- Buprenorphine neonates required:
 - *89% less morphine to treat NAS*
 - *43% shorter hospital stay*
 - *58% shorter duration of medical treatment for NAS*



Forced Tapering During Pregnancy

- Goal – relief of withdrawal symptoms and cravings;
PREVENT RELAPSE
- ***Not recommended during pregnancy because of association with high relapse rates****
- If attempted, 2nd trimester under the supervision of a physician experienced in perinatal addiction treatment
- Coordination between the ObGyn and Addiction Medicine specialist is important

*(Am J Addict 2008; 17:372-86)



In Summary

- Early ID of pregnant opiate-addicted women improves mother and infant outcomes
- **Contraception counseling should be routine**
- Should be co-managed by the ObGyn & Addiction Medicine specialist
- **Medically supervised withdrawal should be discouraged during pregnancy**
- Monitor infants for NAS



COMPONENTS OF PRE- AND POSTNATAL CARE TO INCLUDE MAT

Barbara M. Howes, PhD, LMSW

What is Integrated Care?

SAMHSA's Definition:

“The systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”

Women, families, and children affected by prenatal opioid use and are involved across multiple systems, i.e., healthcare, behavioral health (mental health and/or substance use disorder (SUD) treatment), education, child welfare, human services, civil and criminal justice, probation/parole....



Think broadly about the definition of a “provider.”

- All professionals involved in coordinated/integrated care for women, families, and children affected by prenatal opioid use are part of an inter-disciplinary team of service providers or “partners” bringing expertise to the table.
- Every partner brings valuable expertise to the table – brings a “piece of the puzzle.”
- No one partner has “all the pieces.”



Why Integrated Care?

- Providers and partners in multiple systems share significant concerns about pregnant women who misuse opioids, newborns with NAS, and other problems related to in utero drug or alcohol exposure.
- A single system does not have sufficient resources, information, or influence to adequately serve pregnant women with opioid use disorders and their infants and families – it takes a coordinated, multi-system approach.
- The 2016 Title V, Section 503, “*Infant Plan of Safe Care*” of S. 524, “Comprehensive Addiction and Recovery Act of 2016” requires the development of a Plan of Safe Care to address the treatment needs of the mother, infant, and affected family or caregivers – apply this across disciplines, systems, providers....



Why Integrated Care? (cont.)

- Providers and partners in multiple systems share significant concerns about pregnant women who misuse opioids, newborns with NAS, and other problems related to in utero drug or alcohol exposure.
- Providers and partners need to develop plans for safe integrated care for the infant and family's well-being prior to and following the baby's birth in the following areas: Physical health, mental health, SUD treatment needs, developmental....
- When states, tribes, and communities recognize the positive and often cost-effective impact of a collaborative approach, public agencies and private providers have a powerful incentive to work together in alternative and innovative ways towards joint accountability and shared outcomes.



How Do We Provide Integrated Care?

- Coordinate the goals and efforts of an array of partners.
- Communicate (including listening) effectively with all partners as a standard mode of operations.
- Provide access to ongoing cross-disciplinary education for all partners – increased understanding can decrease challenges and conflicts.
- Build knowledge, skills, and expertise within the healthcare (including obstetrics, pediatrics, substance abuse treatment, and mental health), child welfare, and judicial systems, and tribal communities to improve the quality of integrated care.

A valuable resource: SAMHSA's *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf



Components of Integrated Pre- and Postnatal Care

1. Comprehensive, multi-disciplinary screening & assessment (initial and ongoing throughout all of the following components)
2. Safeguard against discrimination and stigmatization
3. Respect patient autonomy
4. Prevention
5. Comprehensive care using evidence-based practices (EBP)
6. Postnatal care including: Neonatal Abstinence Syndrome (NAS)
7. Maintenance & prevention



1. Comprehensive, Multi-disciplinary Screening & Assessment (Initial and Ongoing)

- Medical examination, thorough medical and behavioral health history, and a multi-disciplinary bio-psycho-social assessment identifying consumer/family risk factors AND resiliency/protective bio-psycho-social factors.
- Conduct universal screening for SUD – Brief Intervention; and Referral to Treatment Services (SBIRT) for prenatal care, child welfare, healthcare, pre-trial, jails....
- All team partners need to:
 - Be familiar with effective and evidence-based treatments,
 - Be aware of the primary risk and protective factors, and
 - Understand the different contexts of opioid use by a pregnant woman to accurately assess her distinct needs and those of her family members.



2. Safeguard Against Discrimination and Stigmatization

- Access to affordable and integrated prevention, treatment services, and interventions delivered with special attention to confidentiality, legal, and human rights.
- Promote and facilitate family, community, social support, and inclusion in all interventions and services, i.e., MAT-specific support groups....
- Foster strong links with available childcare, economic supports, education, housing, and relevant services – refer to team partners with expertise.
- Reduce stigma associated with receiving MAT behavioral health and recovery-related supportive services at micro, mezzo, and macro levels.



3. Respect Autonomy and Individualize Services

- Fully-informed consent – understanding of the risks and benefits for herself and for her fetus or infant of available treatment options including MAT.
- Individualize interventions to mitigate risk and to build on the individual's and family's strengths and protective factors.
- Providers and partners should ask questions and interact with consumers (even the “difficult” ones) in an honest/direct, non-judgmental, respectful manner – or defer to a professional trained in Motivational Interviewing when possible.



4. Prevention

- Services to prevent, reduce and cease the use of alcohol, tobacco and illicit drugs before/during pregnancy and postpartum period are essential for optimizing the health and well-being of women and their children.
- Ensure access to highly effective birth control methods.
- Connecting consumers, including family members, with evidence-based SUD services can reduce/prevent child abuse/neglect, domestic violence, criminal activity for themselves and future generations.
- Provide referrals and assist with access to services based on ongoing multi-disciplinary screening & assessment results.



5. Comprehensive Care Using Evidence-Based Practices (EBP)

Provide advance planning through a “system of care” to address the five stages of intervention:

1. Pre-pregnancy
2. Prenatal
3. Birth
4. Neonatal
5. During child development

*Provide for “warm hand-offs” between stages



5. Comprehensive Care Using EBP (cont.)

- Create “wraparound” models with a network of community providers.
- Address comprehensive needs of pregnant women, parents, and their children, especially in geographic areas that do not have residential programs for women and children.
- Integrate intensive outreach case management for each of the 5 stages of intervention with team partners including: Medical, insurance providers, childcare (including while in treatment), housing, transportation/access, education and vocational services, assistance meeting basic living needs, and recovery supports.
- Ongoing multi-disciplinary screening & assessment, communicate the results to partners and providers, and make adjustments to the plan of care.



5. Comprehensive Care Using EBP (cont.)

All team members need to know:

- Decisions to use opioid agonist medications in pregnant women with opioid use disorder revolve around balancing the risks and benefits to maternal and infant health.
- Women with opioid use disorder (OUD) who are not in treatment should be encouraged to start MAT rather than withdrawal management or abstinence as early in the pregnancy as possible.
- At the very least, communication between health providers and mental health/SUD providers is crucial.
- We must be careful not to “relapse” into our old, traditional, conventional ways of doing business. Stay teachable.



5. Comprehensive Care Using EBP (cont.)

All team members need to know:

- Pregnancy in women with OUD should be co-managed by an obstetrician and an addiction specialist physician in close collaboration with the woman's behavioral healthcare clinician.
- Pregnant women who are physically dependent on opioids should receive treatment using agonist medications rather than withdrawal management or abstinence as these approaches may pose a risk to the fetus.
- Work closely with behavioral health providers regarding "switching addictions," polysubstance use – learn each other's language and COMMUNICATE.



6. Postnatal Care

- Understand distinctions between risk and safety for infants exposed to opioids as a result of the mother's opioid use or misuse v. infants exposed to opioids as a result of the mother's MAT.
- Provide family-centered care for all through each stage of intervention addressing:
 1. The parent/caregiver's need for clinical treatment for SUD and mental health disorders;
 2. Support to provide appropriate care for infants experiencing NAS; and
 3. Supports that strengthen the parents' capacity to nurture and care for the infant and to ensure continued safety, well-being, and healthy child development.



Neonatal Abstinence Syndrome

Symptoms

Central Nervous System	Gastro-Intestinal	Autonomic Nervous System
Inconsolability – Irritability	Poor feeding	Sweating
Excessive and/or high-pitched crying	Excessive suckling	Fever
Sleep problems	Diarrhea	Nasal stuffiness
Skin excoriation (redness, broken, bleeding skin...)	Vomiting	Tachypnea (rapid breathing)
Hyperactive reflexes		Excessive sneezing
Increased muscle tone and/or tremors		Excessive yawning
Seizures		

7. Maintenance and Prevention

- Create and support implementation of Relapse PREVENTION Plans – remember relapse can be in the way of thinking or behaving....
- Create and support implementation of Relapse RESPONSE Plans – what to do when there is a relapse?
- Decrease stigma and increase accessibility to services to prevent or respond to relapses – avoid shaming, “I’m disappointed in you,” “how could you...?” messages.
- Preventing, reducing and ceasing the use of alcohol, tobacco and illicit drugs before and during pregnancy and in the postpartum period are essential for optimizing the health and well-being of women, children and families.



TEN STEPS FOR JUDGES

Judge Duane Slone

Ten Steps for Judges to
Improve Outcomes for
Substance-Exposed
Infants and
Their Families

Off the **Bench**

1. Convene healthcare providers, along with child welfare and the treatment community and other service providers, to talk about the needs of this population and strategize on how to collectively improve outcomes.
2. As a convener and community leader, work to expand the availability of family-centered treatment and recovery supports in their jurisdiction.
3. Learn and share the latest research on treating and supporting pregnant moms, families, and NAS in infants.
4. Learn more about the implementation of a Plan of Safe Care (POSC) in their state and local jurisdiction. For example, has their state or local jurisdiction developed a POSC template?

Ten Steps for Judges to
Improve Outcomes for
Substance-Exposed
Infants and
Their Families

On the Bench

5. Where relevant, ask “Has a POSC been developed in this case?” And ask to see it.
6. Ensure reasonable efforts were made in individual child protection cases. This includes ensuring that POSC were established when required, and strengths, needs, resources, and supports were identified to help keep parents and infants safely together.
7. Encourage building a network of support for mom and infant, including family finding efforts and father engagement to include locating fathers, the early establishment of paternity, and engaging fathers in case planning, visitation, and services.

Ten Steps for Judges to
Improve Outcomes for
Substance-Exposed
Infants and
Their Families

On the Bench

8. Maximize the utilization of the court's touchpoints with pregnant women to identify substance use disorders as early in the pregnancy as possible.
9. Use the tools and levers available to the court to improve outcomes for the mom, fetus, infant and family.
10. Let the moms know that you care. Relationship is the opposite of addiction.

Q&A

Join us May 4, 2020 at 4 PM (ET) for Part 2:
**Trauma-Informed Care for Pregnant
Women and Postnatal Care**



Resources

National Judicial Opioid Task Force, June 2019. *Treating Pregnant Women with OUD*. https://www.ncsc.org/~media/Files/PDF/Topics/Opioids-and-the-Courts/NJOTF%20Resources/Treating_Pregnant_Women_with_OUD.ashx

National Judicial Opioid Task Force, July 2019. *Prenatal Substance Exposure: Improving Outcomes for Women and Infants*. <https://www.ncsc.org/~media/58F2FC0DA2BC4D5E8330A81B868A21CB.ashx>

NIDA, 2017. *Treating Opioid Use During Pregnancy*. <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy>

SAMHSA, 2016. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf

SAMHSA, Jan 2018. *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants*. <http://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>

SAMHSA Summary 2017 Policy Academy: *Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers*. https://ncsacw.samhsa.gov/files/Policy_Academy_Dissemination_Brief.pdf

Casey.org, 2017. *Information Packet–Safe Children: What are infant plans of safe care and examples of state responses to infants affected by substance abuse?* https://caseyfamilypro-wpengine.netdnassl.com/media/SC_Infant-Plans-of-Care.pdf

