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Care Coordination for Families with Infants Prenatally Exposed to Substances: A Focus on Infants with Neonatal Abstinence Syndrome

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Disclosures

Dr. Jones has no disclosures related to the content of this presentation

Objectives

1. **Substance Use Disorder (SUD) and Medication-Assisted Treatment (MAT) and pregnancy**

2. Symptoms of Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS)

3. Plans of Safe Care and Family-Centered Treatment

4. Care coordination basics and community partner linkages

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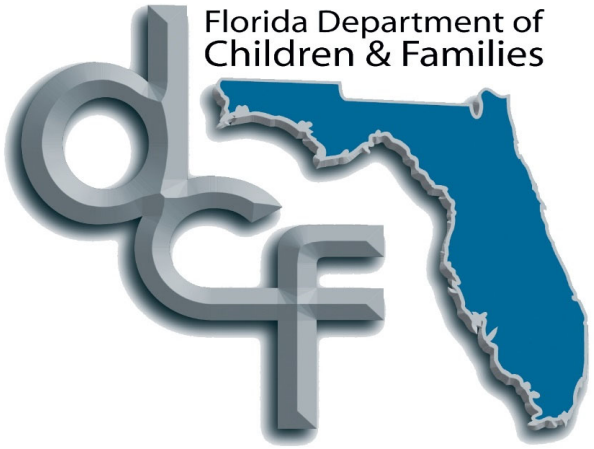
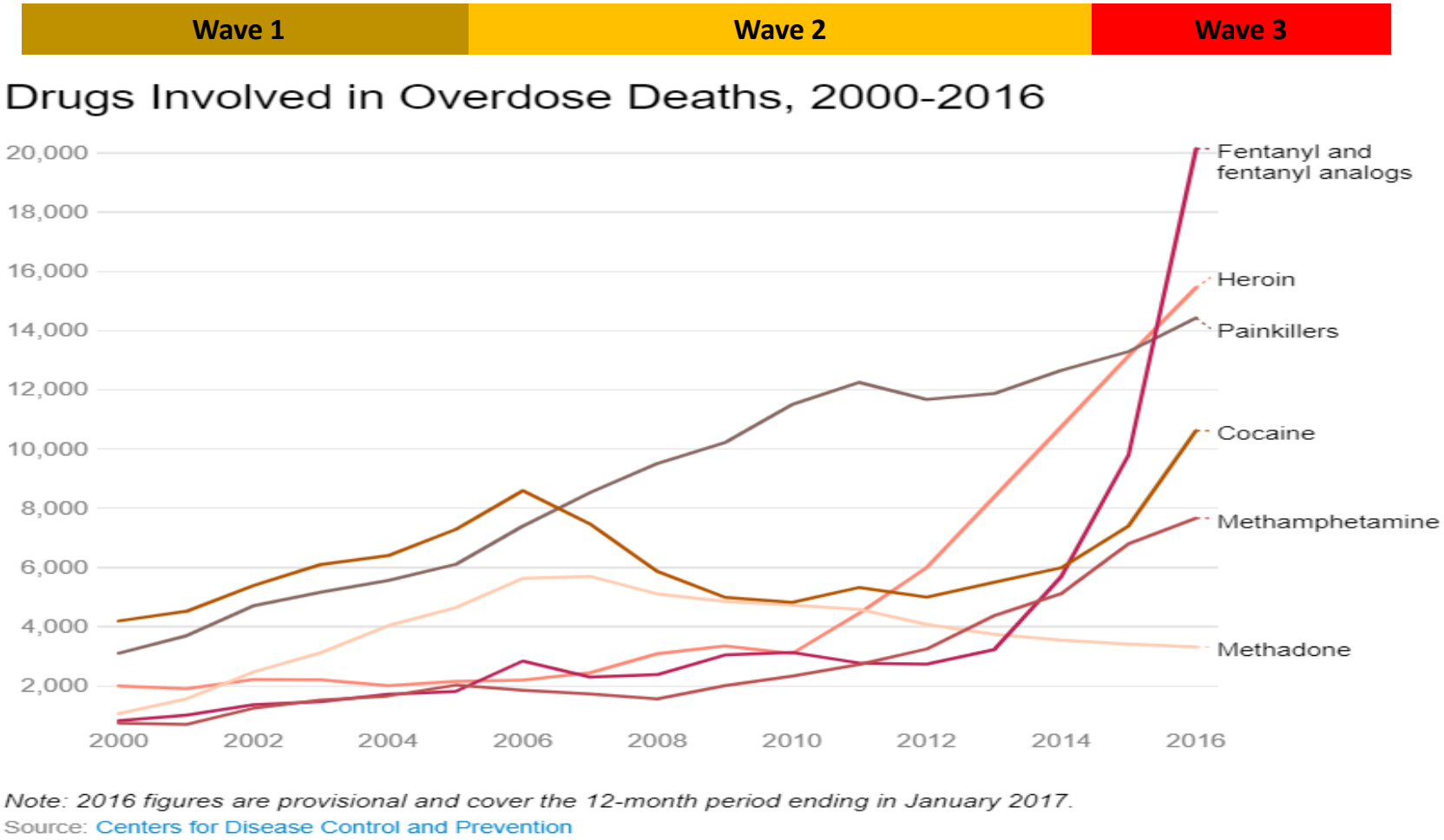
Pregnant and Postpartum Women

Priority population for Florida!

- SUD maternal deaths
  - #1 cause of maternal death
- Child removals
  - highest rate of removals involve SUDs
- Often touched by multiple systems

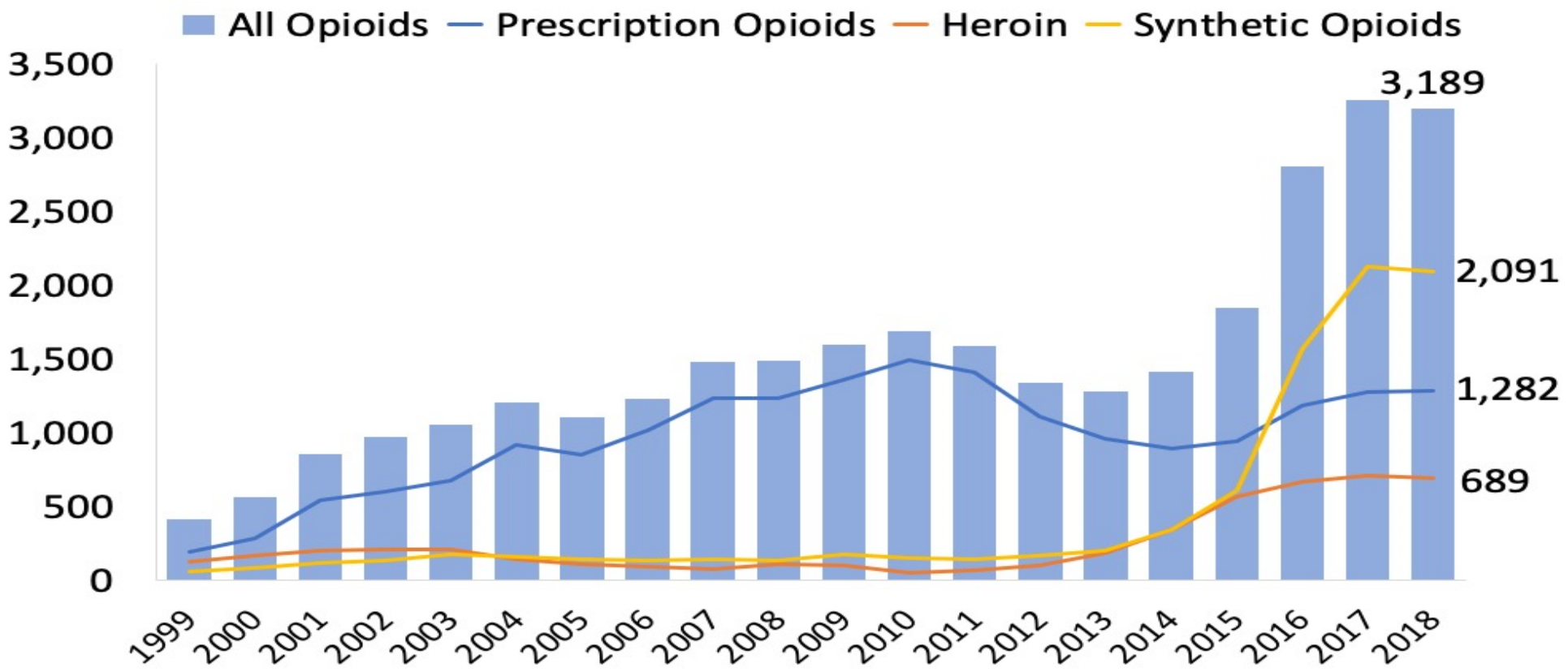


The Triple Wave of Overdose Deaths



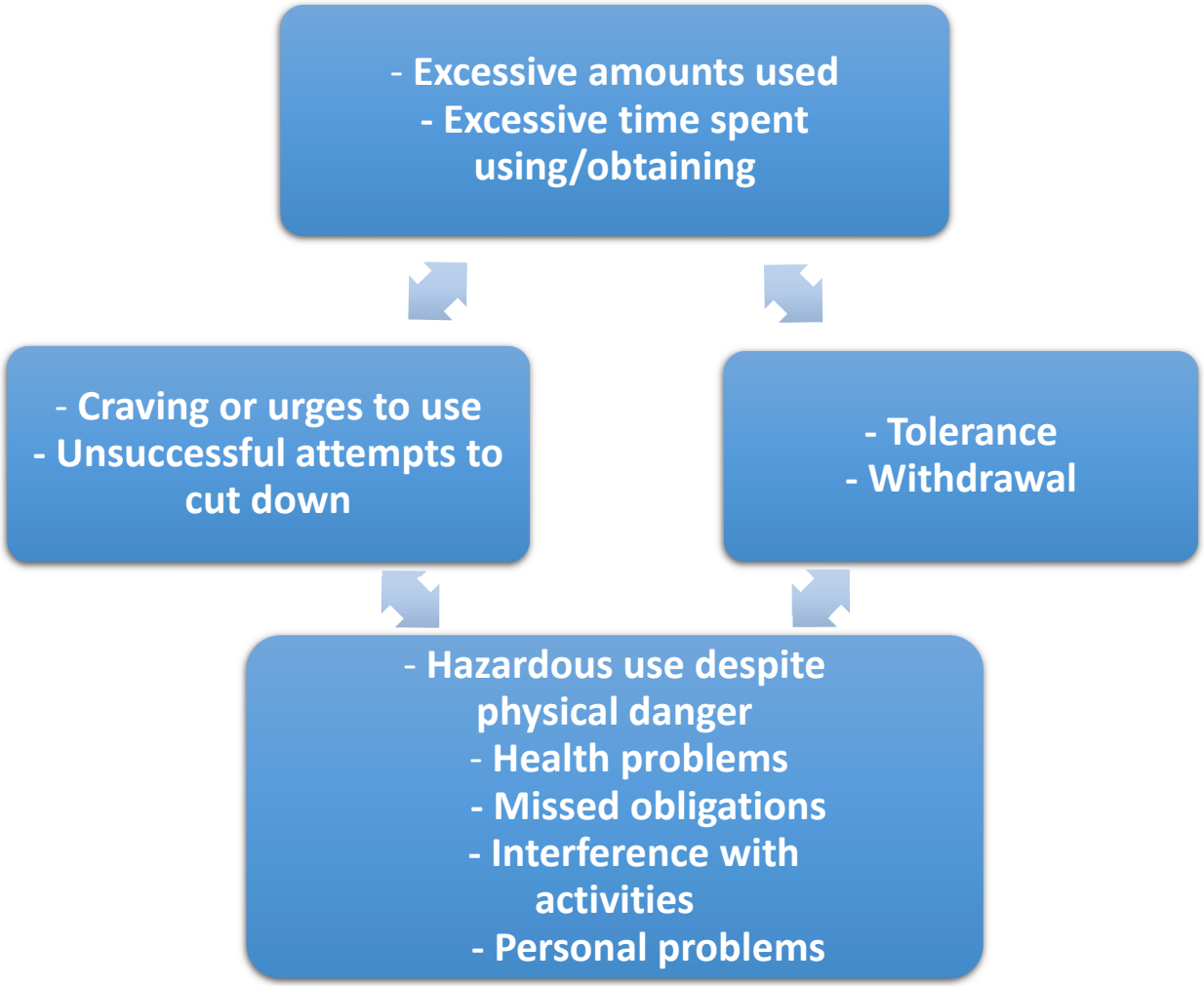
Note: 2016 figures are provisional and cover the 12-month period ending in January 2017.
Source: Centers for Disease Control and Prevention

Drug Overdose Deaths in Florida



Drug categories presented are not mutually exclusive, and deaths may have involved more than one substance. Source: CDC WONDER, 2020. https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/florida-opioid-involved-deaths-related-harms

11 Signs of Substance Use Disorders



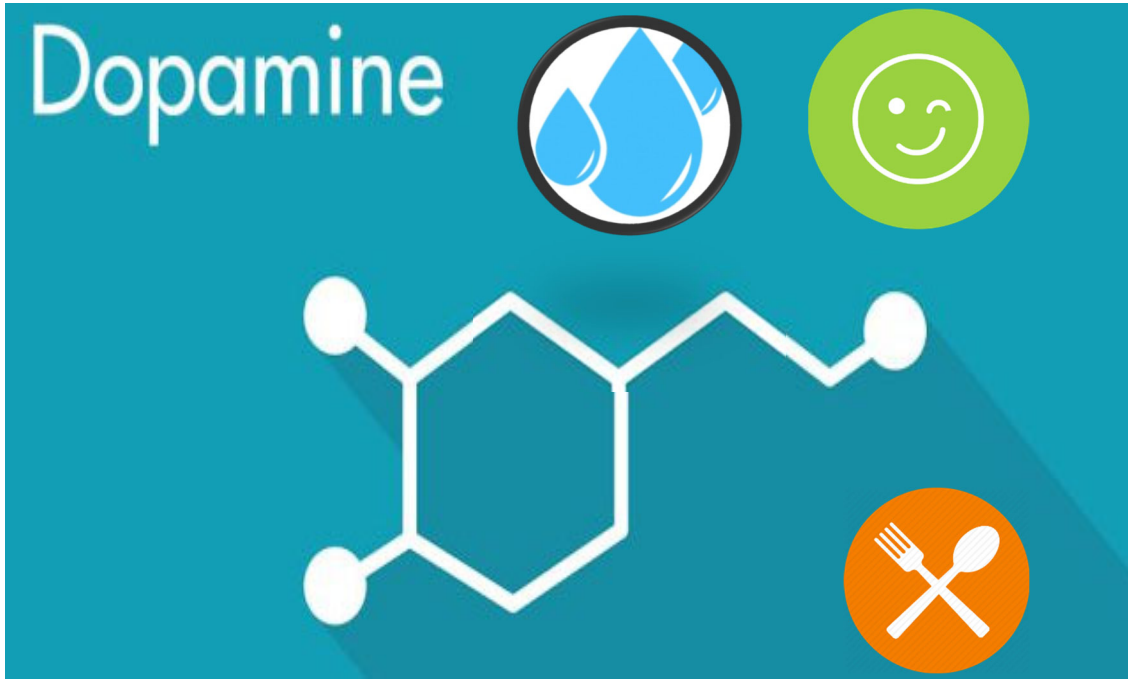
Diagnostic and Statistical Manual Mental Health Disorders, 5th Edition (DSM-5) released May 2013

"Substance Use Disorder" terminology

11 diagnostic criteria over a 12-month period:

- **Mild:** *2-3 symptoms*
- **Moderate:** *4-5 symptoms*
- **Severe:** *6 or more symptoms*

Why “Addiction” Matters



nanograms/deciliter	
40	Worst Day
50	Average Day
100	Great Day!
500- 1,100	Drugs

Addiction Neuroscience 101 with Dr. R. Corey Waller
https://www.youtube.com/watch?app=desktop&v=bwZcPwlRRcc

Dopamine Matters!

Repeated Drug Use

nanograms/deciliter for drugs

500- 1,100

600

500

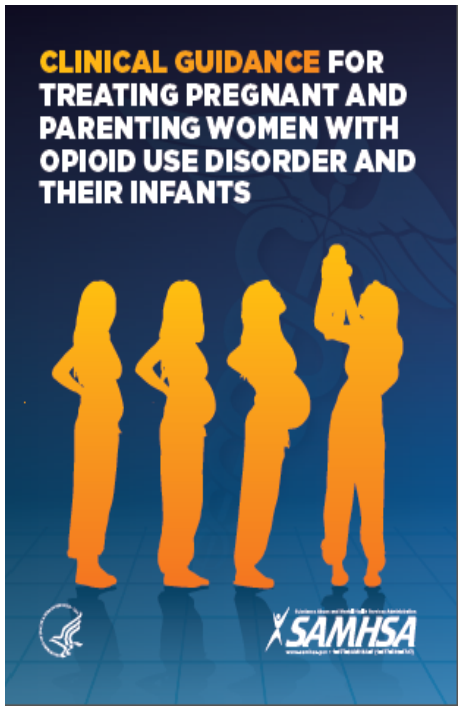
400

50

10 nanograms/deciliter every day

Addiction Neuroscience 101 with Dr. R. Corey Waller
https://www.youtube.com/watch?app=desktop&v=bwZcPwlRRcc

Opioid Medication Guidance: Perinatal Patients



- 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.
- Neonatal abstinence syndrome should **not** be treated with diluted tincture of opium.

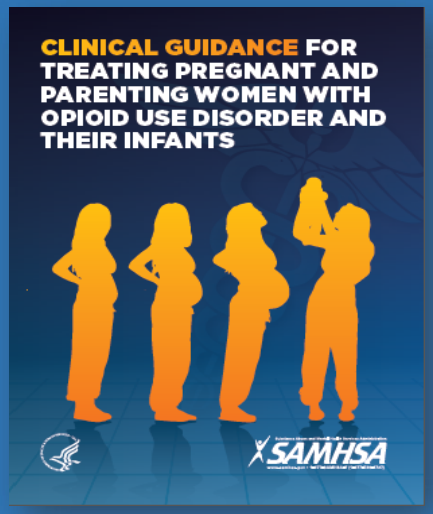
The *Clinical Guide* consists of 16 factsheets that are organized into 3 sections: Prenatal Care (Factsheets #1–8); Infant Care (Factsheets #9–13); and Maternal Postnatal Care (Factsheets #14–16).

Medication to Treat Opioid Use Disorder

- Reduces opioid use
- Protects against opioid-related overdoses
- Prevents injection behaviors
- Reduces criminal behavior

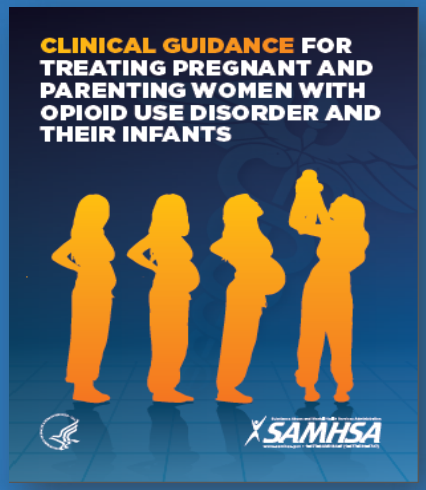
e.g., Connock M et al., Health Technol Assess. 2007 Mar;11(9):1-171, iii-iv.

Methadone and Buprenorphine Advantages



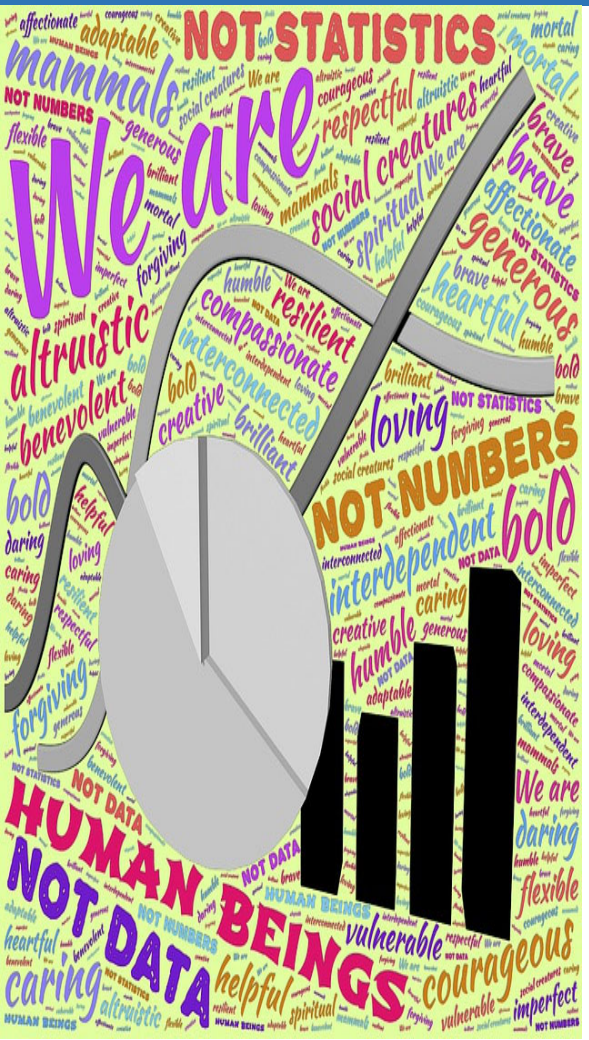
	Methadone	Buprenorphine
Advantages		
Reduces/eliminates cravings for opioid drugs	●	●
Prevents onset of withdrawal for 24 hours	●	●
Blocks the effects of other opioids	●	●
Promotes increased physical and emotional health	●	●
Higher treatment retention than other treatments	●	
Lower risk of overdose Fewer 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
  - Demonstrated clinical withdrawal symptoms
  - Increased risk of diversion (sold or given to others)

Care Must Be Responsive



- Pregnant people with OUD may present for care at medical system points like health departments, primary or prenatal care, labor & delivery, and emergency rooms
- They may present at system points such as WIC offices and other community services
- Maternity care providers are the front line
- Providers need a plan to initiate OUD treatment promptly
- Obstetric services should initiate buprenorphine
- Coordinate treatment through collaboration with community-based providers

Rizk AH et al., J Midwifery yWomens Health 2019;64:532–544; Higgins T. Et al., Preventive Medicine 128 (2019) 105786

The most recent guidelines from the BC Ministry of Health recommended that *buprenorphine + naloxone* is as safe and effective as *buprenorphine monotherapy* during pregnancy

British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions, & Perinatal Services BC. A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement. Published June 1, 2018. Available at: http://www.bccsu.ca/care-guidance-publications/

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Compassionate Post-Pregnancy Care: NAS Response

Neonatal Abstinence Syndrome (NAS) often results when a pregnant person uses opioids (e.g., heroin, oxycodone) during pregnancy

NAS is defined by alterations in the:

- *Central nervous system*
- *Autonomic nervous system*
- *Gastrointestinal distress*
- *Signs of respiratory distress*

- NAS is *not* Fetal Alcohol Syndrome (FAS)
- NAS is treatable
- NAS and 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.

What NAS is and is Not

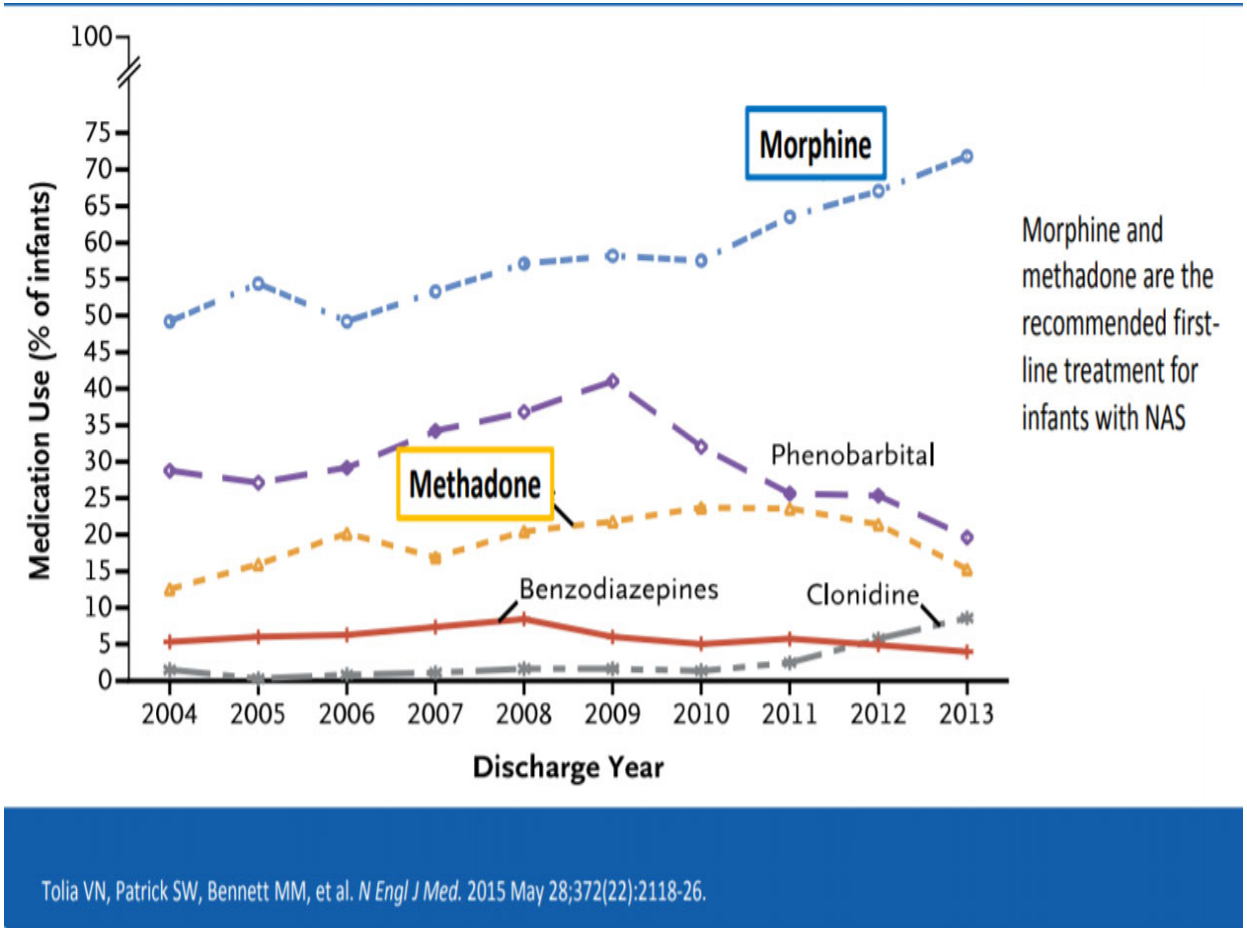
- Newborns can't be "born addicted"
- NAS is withdrawal – due to physical dependence
- Physical dependence is *not addiction*
- Addictions' visible signs are behaviors
- Newborns do not have the life duration or experience to meet the addiction definition
- Addiction is chronic disease – chronic illness can't be present at birth

Jones & Fielder, *Preventive Medicine,* 2015; See https://tonic.vice.com/en_us/article/bj75n5/baby-opioid-addicts-dont-exist
.

NAS Factors Providers Control

Other factors that contribute to NAS, need for medication, and length of stay in neonates exposed to opioid agonists in utero:

- Protocols
- NAS Treatment setting
- NAS assessment choice
- Breastfeeding
- Rooming-in



•Source: Kaltenbach et al., *Addiction*, 2012; Jansson and Velez, *Curr Opin Pediatrics*, 2012; Hall ES et al., *Pediatrics*, 2014; Patrick S et al., *Pediatrics*, 2016; Davis JM, et al. *JAMA Pediatr*, 2018; Kraft WK, et al. *N Engl J Med*, 2017

NAS Factors

Other factors that contribute to NAS need for medication and length of stay in neonates exposed to opioid agonists in utero:

Factors providers can't control:

- Genetics
- Other Substances
  - Tobacco use
  - Benzodiazepines
  - SSRIs
- Birth weight

Methadone or buprenorphine dose is not consistently related to NAS severity

Kaltenbach et al., *Addiction*, 2012

Jansson and Velez, *Curr Opin Pediatrics*, 2012

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Plans of Safe Care

- History
- Definition
- Elements
- Examples

How is Family Defined?

- Traditional families
- Single parents
- Blood relatives
- Adoptive families
- Foster relationships
- Grandparents raising grandchildren
- Stepfamilies
- Extended families
- Elected families

For practical purposes, family can be defined according to the individual's *closest emotional connections.*

Substance Abuse Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series, No. 39. Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2004

Treatment that Supports Families

- Treatment that supports the family as a unit has proved to be effective for maintaining maternal drug abstinence and child well-being.
- A woman must not be unnecessarily separated from her family in order to receive appropriate treatment.

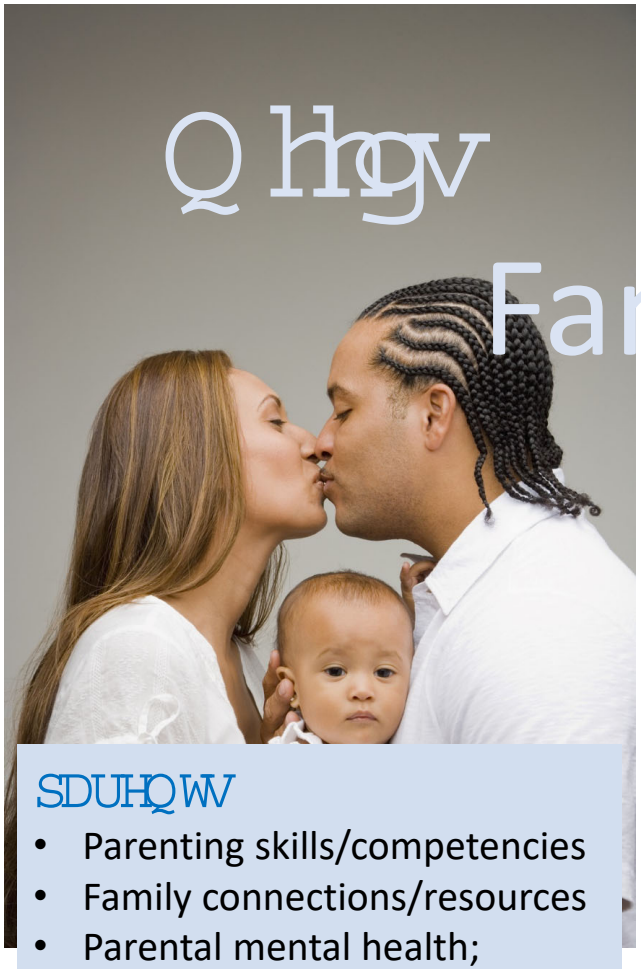
Sharon Amatetti, Family-Centered Treatment for Parents with Substance Use Disorders 2007

Key Concepts
Family-Centered Treatment

- Substance use disorders are *treatable.*
- Women define their families.
- Families are dynamic with complex needs; treatment must be dynamic.
- Conflict happens and can be resolved.

Safety first!

Family Treatment



SDUHQWV

- Parenting skills/competencies
- Family connections/resources
- Parental mental health; co-occurring
- Medication management
- Parental substance use
- Domestic violence

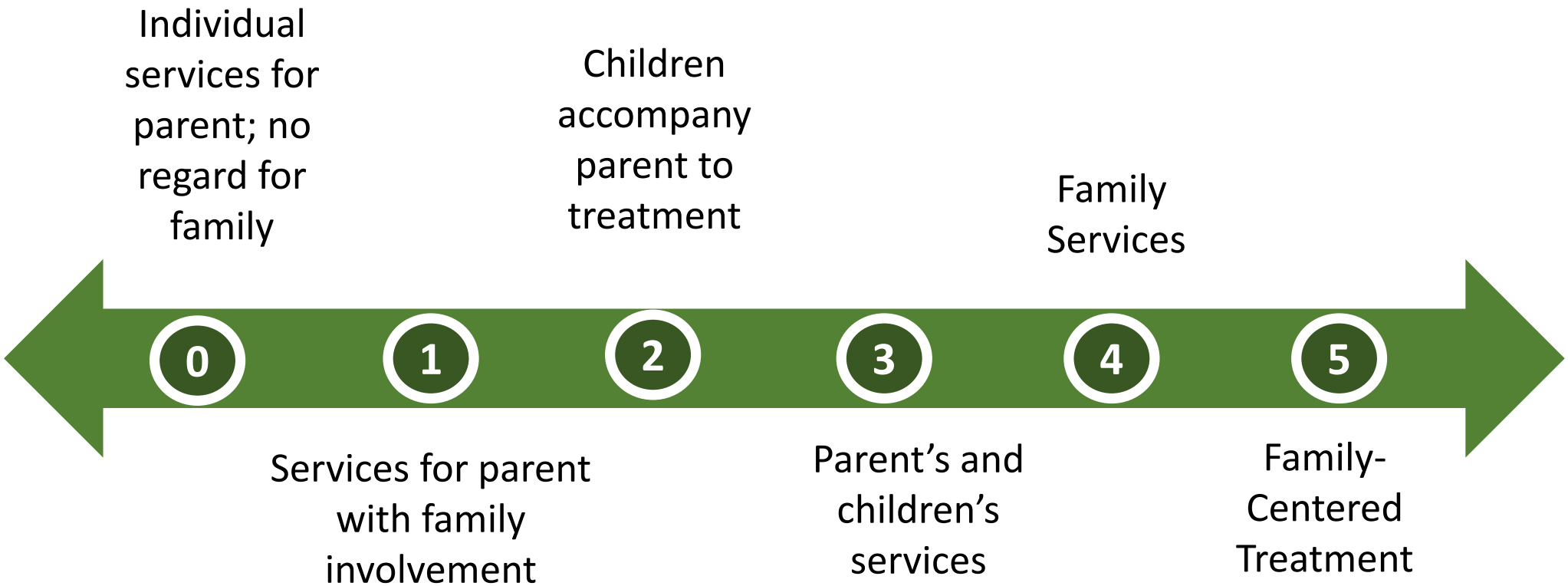
IDP IO\

- Basic necessities
- Employment
- Housing
- Childcare
- Transportation
- Family counseling

FKIOG

- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance abuse
- At-risk youth prevention

Family-Centered Treatment Continuum



https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenges
» http://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

Family-Centered Treatment and Recovery Outcomes

Mothers who took part in Celebrating Families! Program and received integrated case management showed significant improvements in recovery, including reduced mental health symptoms, reduction in risky behaviors and longer program retention.

Women who participated in programs that included a “high” level of family and children’s services were twice as likely to reunify with their children as those who participated in programs with a “low" level of these services.

Retention and completion of comprehensives substance use treatment have been found to be the strongest predictors of reunification with children for parents with substance use disorders.

Zweben JE, et al. Child Welfare. 2015;94(5):145-66; Grella CE, et al., J Subst Abuse Treat. 2009 Apr;36(3):278-93.; Rockhill A, et al... Is the adoption and safe families act influencing child welfare outcomes for families with substance abuse issues? Child

The Dyad's Background Matters

What is a Dyadic Relationship?

- Social and Emotional Exchanges
- Reciprocal
- Can be “healthy” or “unhealthy”
- Quality Matters!
- Developmental perspective
- Attachment = history of a dyadic relationship

Attachment is where the child
uses the primary caregiver as a
secure base from which to explore
and when necessary, as a
haven of safety and a source of comfort

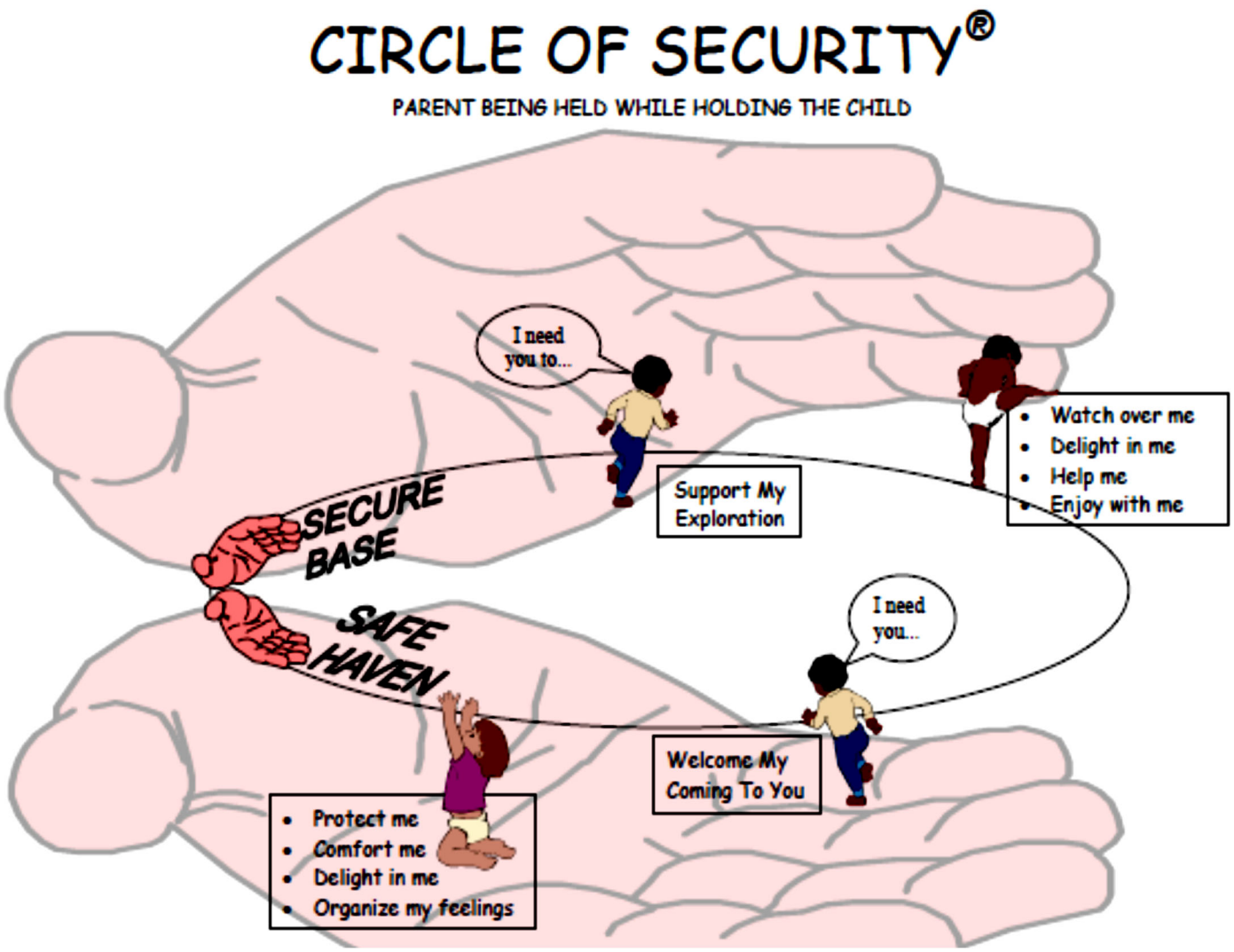
What is a Dyadic Relationship?

- Securely-attached infants would develop a "secure base script" that explains how attachment-related events happen….for example:

"When I am hurt, I go to my mother and receive comfort"

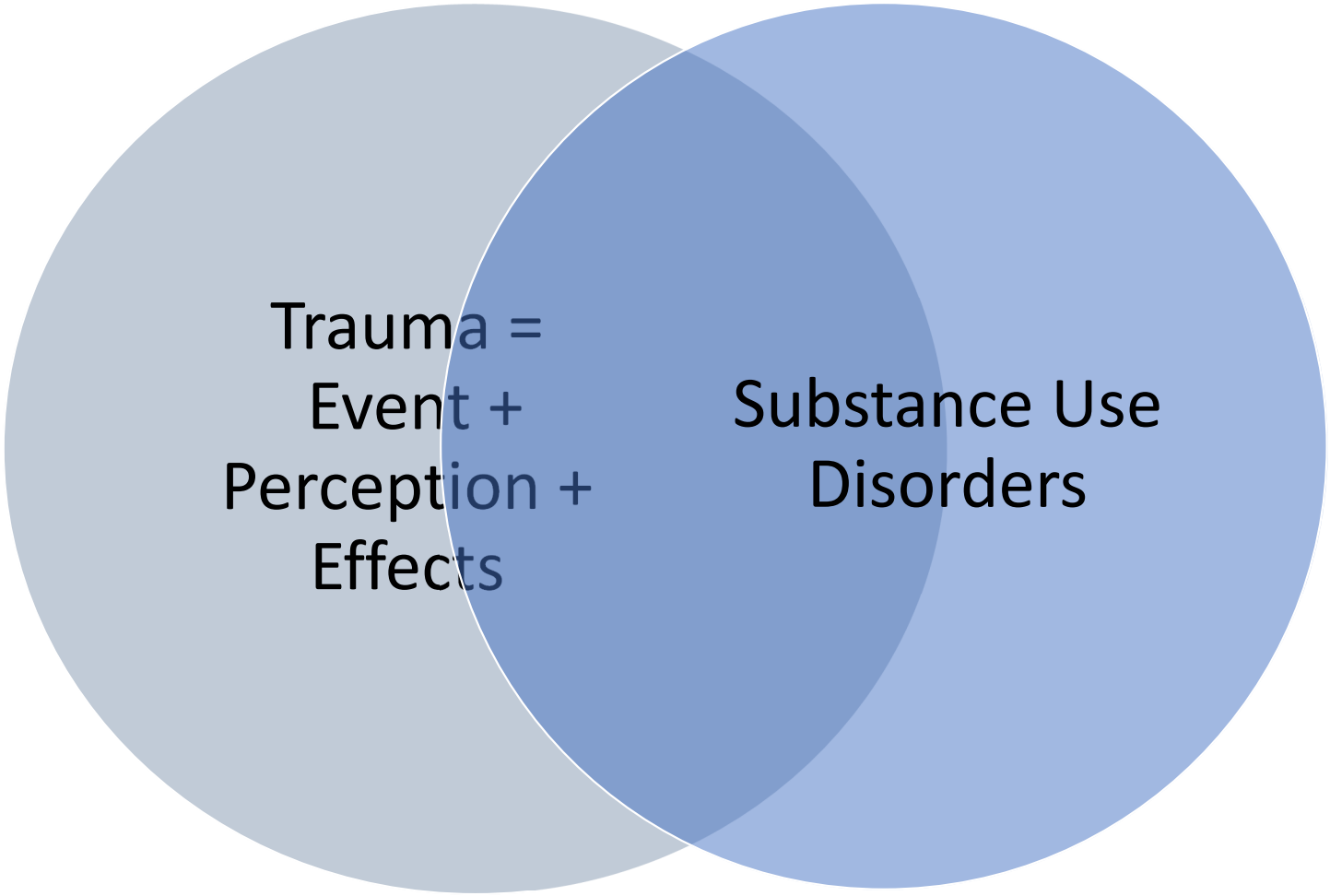
- Children with an insecure attachment and an Internal Working Model that says that the caregiver will be unavailable and/or rejecting when the child needs him/her may develop a chronic activation of the physiological stress-response system

Understanding a Dyadic Relationship



https://www.youtube.com/watch?v=cW2BfxsWguc&t=2s

Intersection: Trauma and Substance Use Disorder



What Makes Parents Feel Rejected?

A. Irritability

B. Hypertonia (tight muscles)

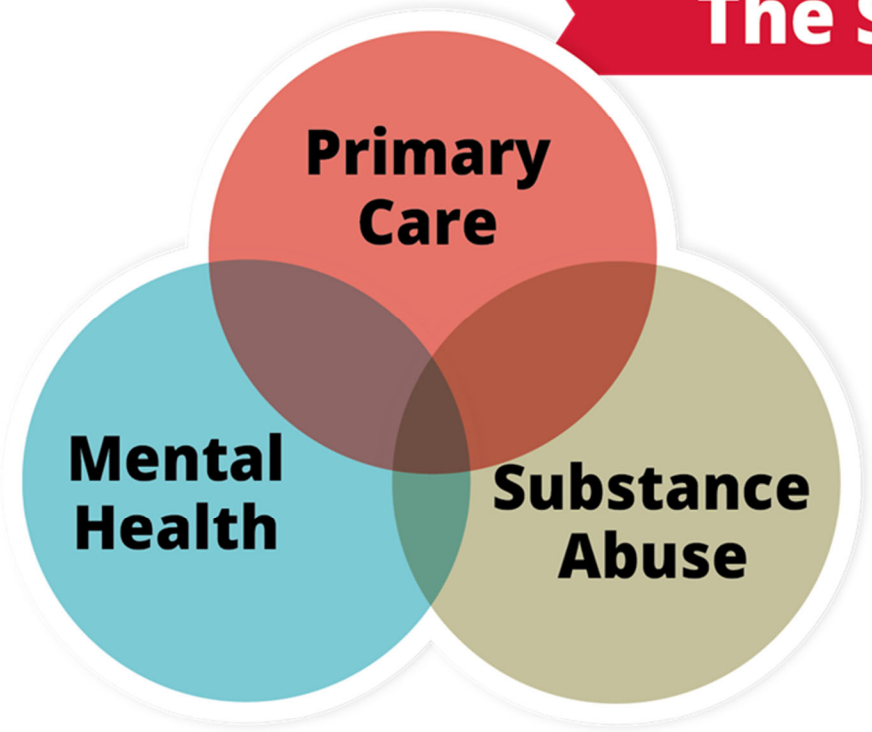
C. Avoidance of eye/face contact

D. Poor/uncoordinated suck

E. All of the above

What is Integrated Care?

The SOLUTION



The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

For mother, child and/or dyad

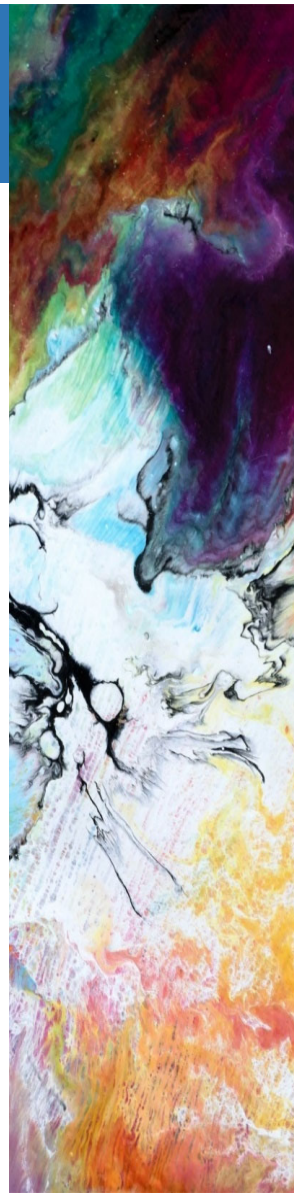
What is Integrated Care?

ROSC
Recovery Oriented System of Care

Recovery-oriented systems of care (ROSC) are networks of *formal* and *informal* systems; *clinical* and *non-clinical* services and supports developed and mobilized to sustain long-term community-based recovery for individuals and families.

Characteristics of Children Entering UNC Horizons

- Behavioral problems
- Frequent crying
- Difficult separations from caregivers that last longer than typical separation issues.
- Difficult to soothe
- Developmental delays
- Difficulty following routines
- Attachment difficulties

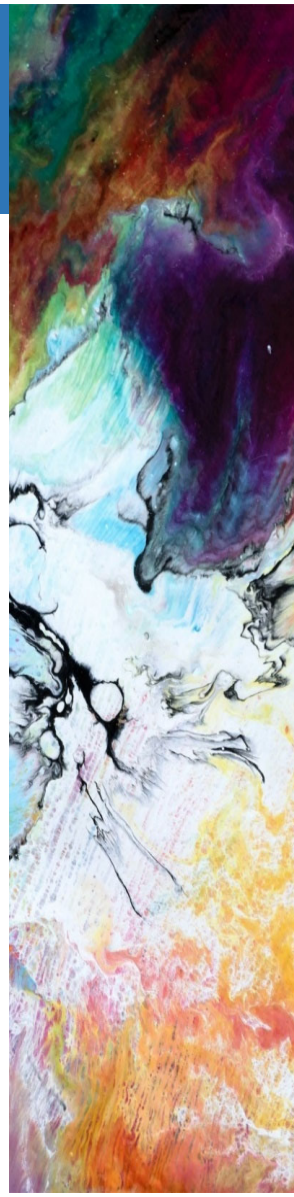


Clinical Responses To Dyads *Must* Be…

- Trauma-informed
- Attachment-based
- Non-punitive
- Supportive….*"I am on your side!"*
- Hopeful…."*You CAN do this!"*
- Able to view substance abuse as a brain disease

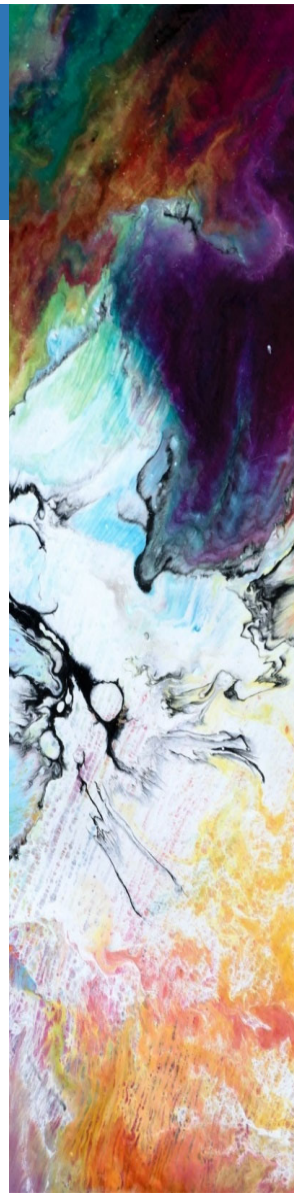
"Healing the family begins with ensuring timely, appropriate, and effective services for both parents and children to treat substance abuse and trauma."

Otero & Archer 2013



What Can You Do To Help Children?

- When I come to the appointment with my mom, I need you to:
  - Greet me by name
  - Greet me on my level
  - Watch over me
  - Enjoy the play with me
  - Help me if I get frustrated or need to learn how to interact with others
- When I'm upset, I need you to help my mom know how to:
  - Comfort me
  - Help me understand my feelings
  - Work things out



“Teachable Moment”

- The birth of a child is a considered the greatest change in the family life cycle.

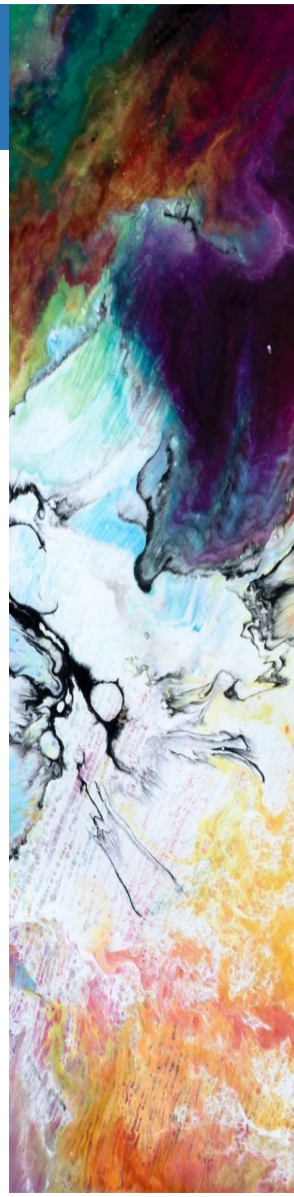
(Nystrom & Ohrling, 2004)

- North American women receive a great deal of medical attention and advice during pregnancy, but much less in the postpartum.

(Ayoola et al., 2010)

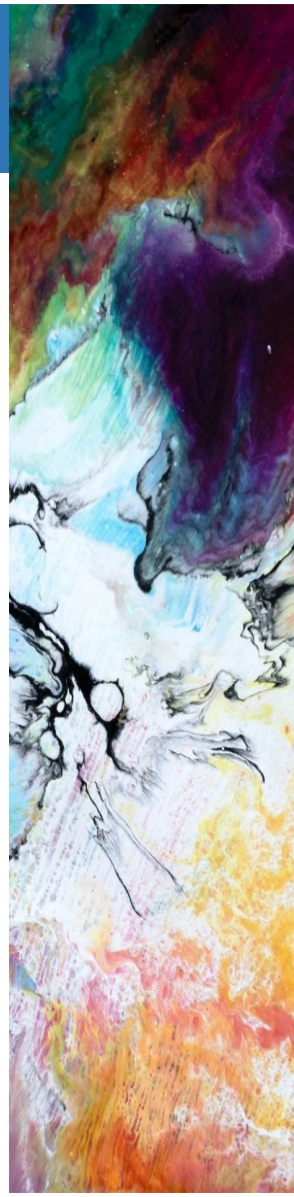
- The perinatal period is generally a time of reduced substance use; however, approximately 8-18% of childbearing women continue use of illicit and licit drugs.

(Connelly et al., 2014)



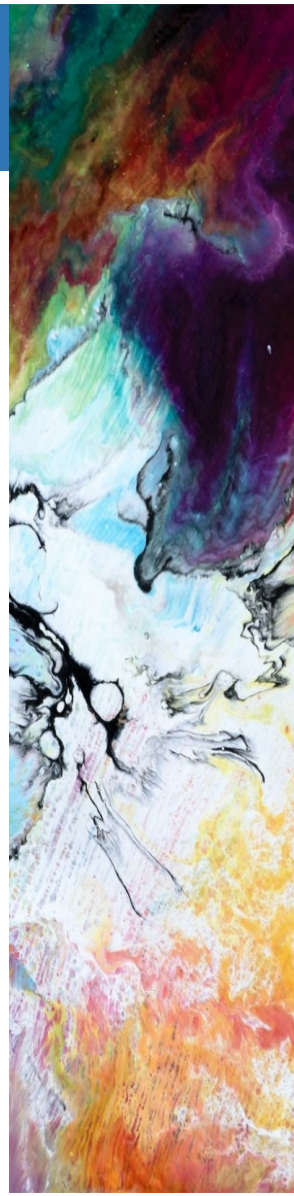
Supporting Mothers

- Encourage mom's attempts to bond with infant
- Encourage family involvement
- Support mom's recovery efforts
- Therapeutic communication techniques
- Empathy - Supportive attitudes and compassionate care
- Positive maternal/family reinforcement can balance maternal guilt & low self-esteem



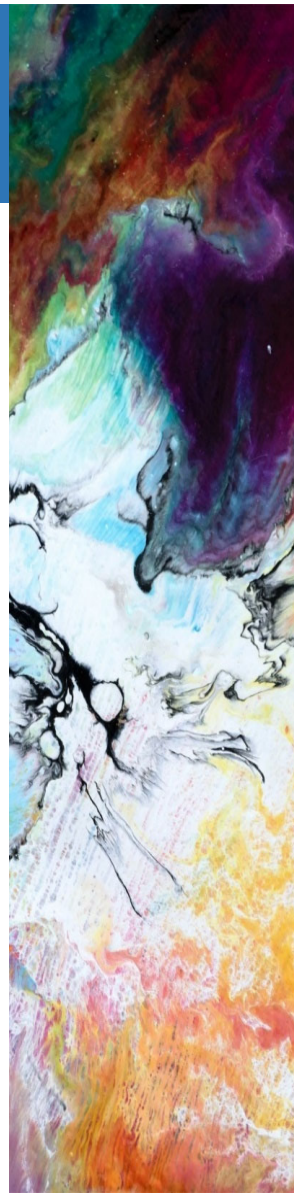
Mother-Infant Co-regulation Supports Healing

- Skin-to-skin
- Mutual eye gaze
- Breast feeding
- What would the baby say?
- Safe co-sleeping
- Similar routines for mother and child



Supporting a Healthy Dyadic Attachment Relationship

- Work with caregiver and infant *together.*
- Point out signs the infant is orienting to the caregiver.
- Provide specific infant development information that supports attachment.
- Ask caregiver *what positive memories they want the infant to have as he/she grows up.*
- Discuss co-regulation.



Involving Fathers in the Newborn Period

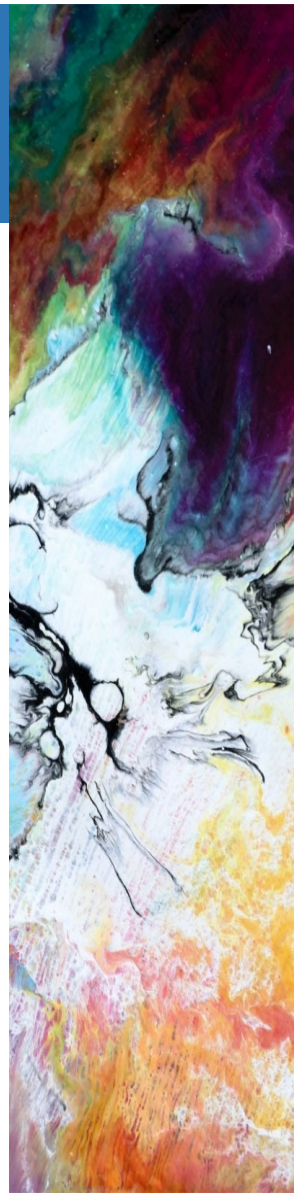
Invite	Invite their involvement
Seek	Seek father's opinions to explore cultural traditions, beliefs about child rearing
Encourage	Encourage participation in prenatal visits and delivery
Screen	Screen for perinatal depression
Educate	Educate father about importance of his role in child development and child outcomes
Discuss	Discuss the stresses of parenting

Addressing Trauma in the Dyadic Relationship

1. Provide psychoeducation around attachment, infant and child development, and brain changes in substance use disorders.

2. Provide a “safe haven” to discuss “ghosts” (aka, voices) from the past.

3. Provide in-the-moment support to social and emotional cues from both mother and infant/child.



Supporting Dyads During Infancy

- Empower and normalize breastfeeding for all patients including those who are incarcerated.
- Teach strategies to help console the newborn and promote sleep and bonding.
- Discuss hormonal changes that may lead to postpartum anxiety and depression and interfere with bonding.
- Integrate community-centered and family-centered approaches.
- Refer dyads to infant mental health providers trained in evidence-based interventions.

All Babies Have a “Fussy” Phase

PEAK OF CRYING

Your baby may cry more each week, the most in month 2, then less in months 3-5

UNEXPECTED

Crying can come and go and you don't know why

RESISTS SOOTHING

Your baby may not stop crying no matter what you try

PAIN-LIKE FACE

A crying baby may look like they are in pain, even when they are not

LONG LASTING

Crying can last as much as 5 hours a day, or more

EVENING

Your baby may cry more in the late afternoon and evening

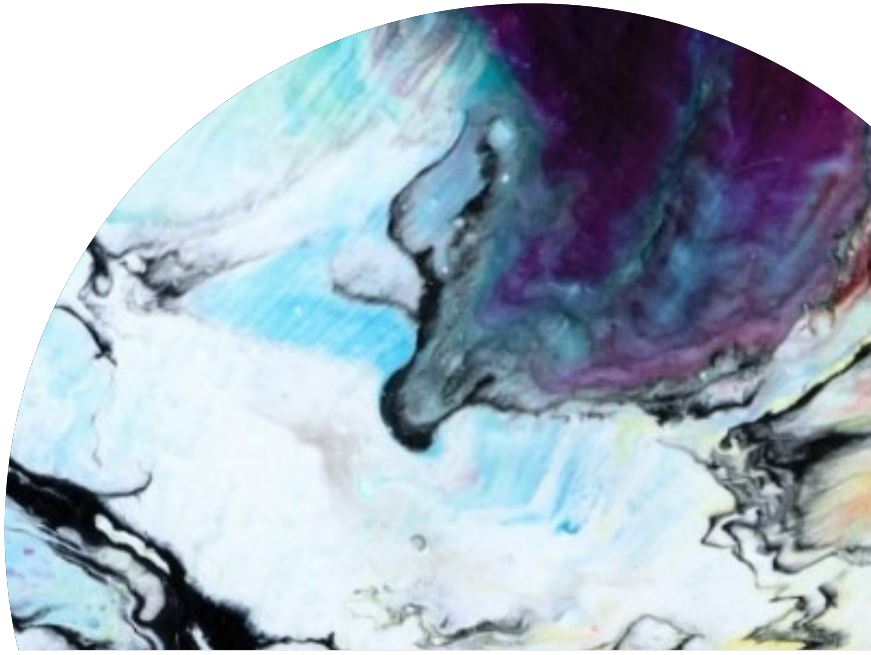
How Can We Support Dyads During Tough Times?

- Empower and support mothers when calls to CPS need to be made.
- When appropriate, help advocate for additional support rather than child separation.
- When child separation occurs, encourage phone calls, letter writing to offer a connection, provide updates.
- When separation occurs, allow fictive kin, communal supports, and other cultural influences/wishes of the parent to be embedded in the treatment plan.

H[HUFLVH

How you would promote maternal-child bonding in response to the case?

- Mara delivered Oliver three days ago.
- You walk into the hospital room and she is crying.
- She says *“My baby does not love me.”* and *“He is greedy just like his father.”*



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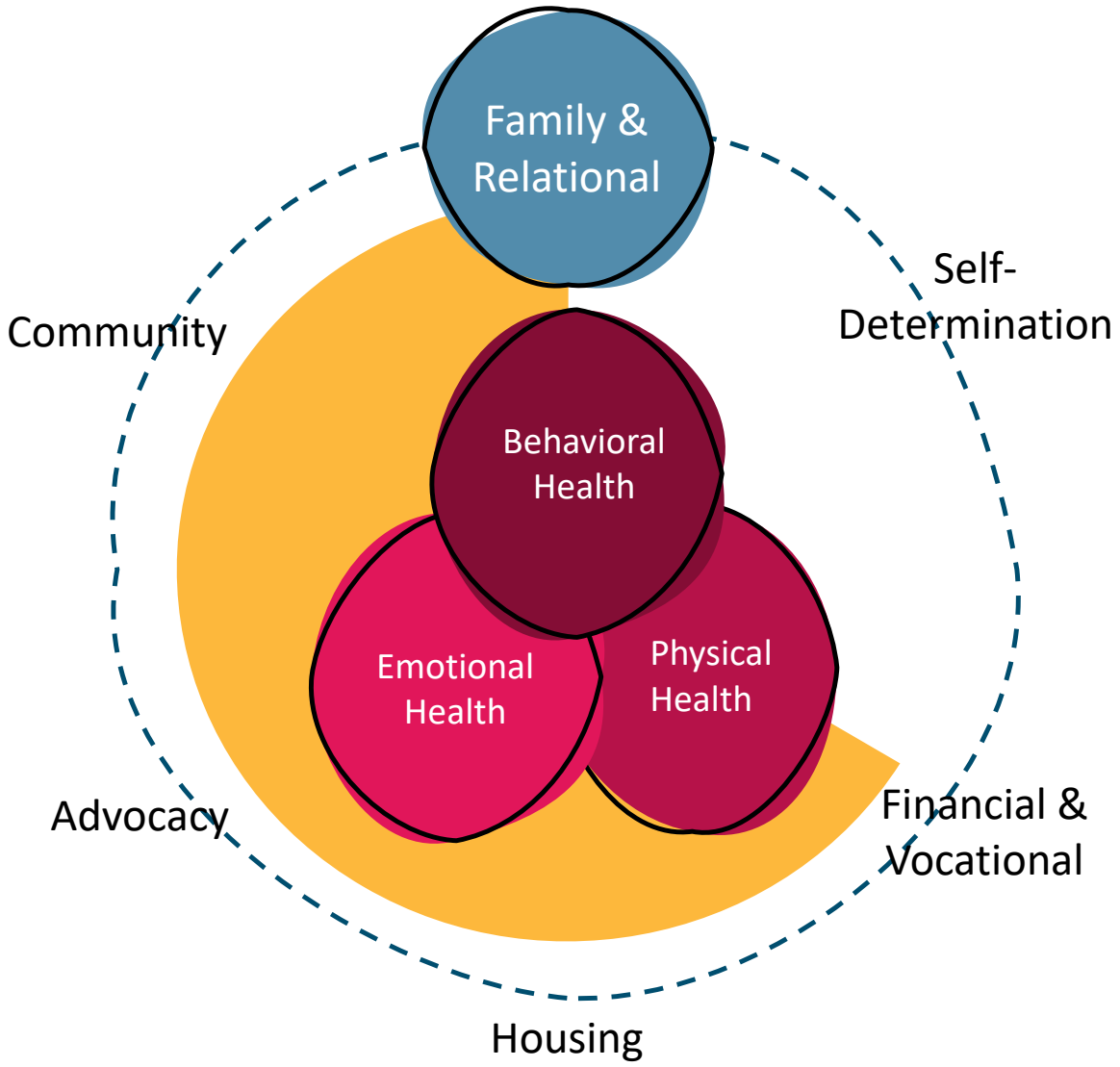
https://pixabay.com/photos/family-woman-children-female-child-2149453/

Care Coordination is Key in Treatment for Women with Substance Use Disorders



Improving Engagement and Retention

- Develop relationships early.
- Use motivational strategies.
- Understand and address individual barriers.
- Provide feedback to collaborators.
- Ensure a positive environment – physically and emotionally.
- Address co-occurring disorders.
- Engage women in improving services.
- Ensure services are a good fit.

Research to Practice Brief. National Infants Assistance Resource Center. UC Berkeley.

Supporting Postpartum Patients with Opioid Use

- Breast/chest feeding is recommended for birthing parents prescribed buprenorphine and methadone.
- Extended skin-to-skin contact with birthing parent is recommended.
- Mothers and infants rooming together at hospital is associated with reduced need for medication and shorter hospital stays.

SAMHSA 2018, HHS Publication No. (SMA) 18-5054

Care Coordinators Can Support Postpartum Patients

- Highlight what is going well.
- Listen to what is *being said* and what is *not said.*
- Help support medication choices.
- Support family planning choices.
- Screen and provide compassionate responses to psychological/mental health challenges.
- Support obtaining survival needs.

All mothers needs support with babies!

Care Coordination Assessment Checklist

Background and current status:

1) Family situation and relationships
2) Medical issues (including dental and head-to-toe)
3) Trauma history
4) Legal involvement
5) Financial and work status/Education
6) Housing status
7) Substance use patterns, treatment, recovery supports, and family history
8) Emotional/behavioral/cognitive status (including suicidal thoughts and behaviors)
9) General ability to function
10) Food/clothing
11) Transportation
12) Strengths and resources

Identify and Assess Community Supports

- Care coordination is focused on acquiring resources that are external to the patient, such as obtaining housing, medical services, or income assistance.
- It is critical that care coordinators identify community supports in their local area.
- A care coordinator should cultivate knowledge of services, assess the values and accessibility to their patients, and when possible, relationships with providers of these services.
- Care coordinators need to develop a referral database or community resource guide.

Florida Supports

- Department of Children and Families Office of Substance Abuse and Mental Health
  - Substance exposed newborn care coordinator
    - Program Office - 1
    - Regional - 6
- Managing Entity
  - Network Service Provider - 1
    - Housing Coordinator
    - Peer Specialist
    - Care Coordinator

Practical Considerations for Care Coordination

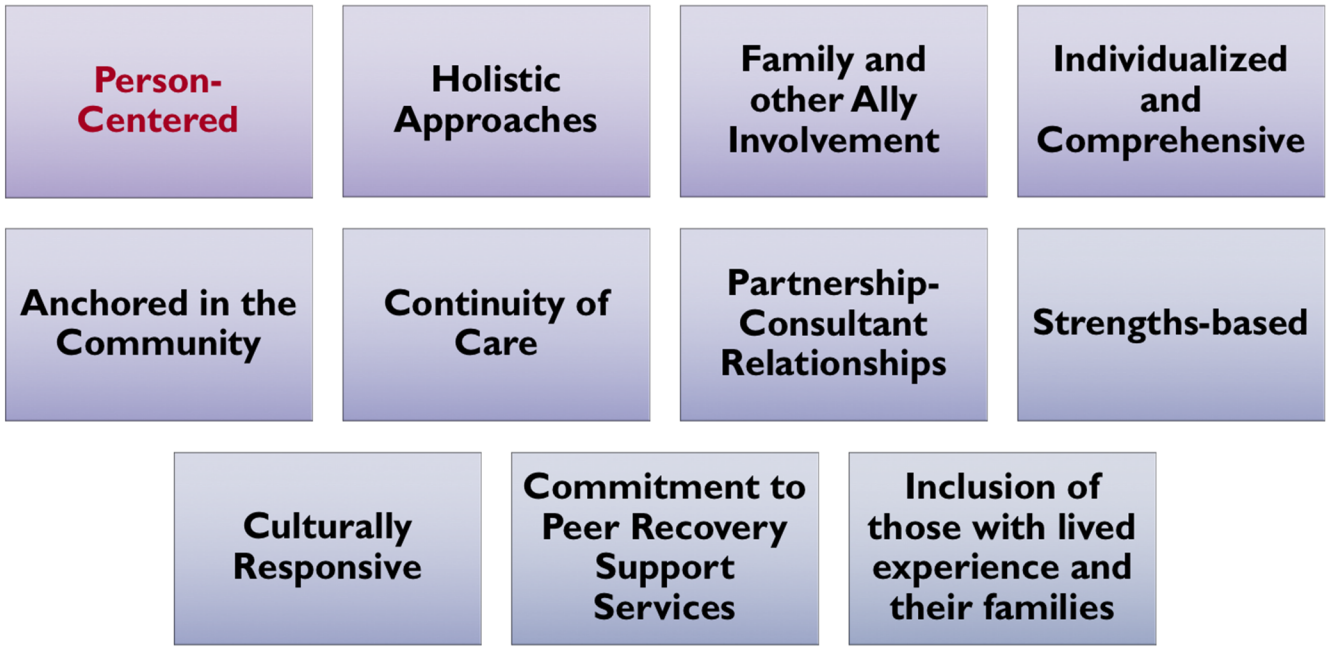
- Transportation issues
- Level of concrete expectations and explanations
- Collaboration with Child Protective Services
- Partnerships (HUD, Public Health)- releases of information
- Identifying and addressing needs of other family members
- Financial debt, criminal records prevent safe housing and employment

Never underestimate the power of stigma and discrimination!

More Practical Considerations for Care Coordination

- Shared decision making
- Concrete language and specific actions
- Confidentiality
- Cultural responsivity
- Ensuring information needed is received in a way that is accessible
- Care Coordination among infant and maternal health care providers, hospitals, substance use treatment provider and child welfare (when needed)

Recovery Management: Values and Guiding Principles Snapshot

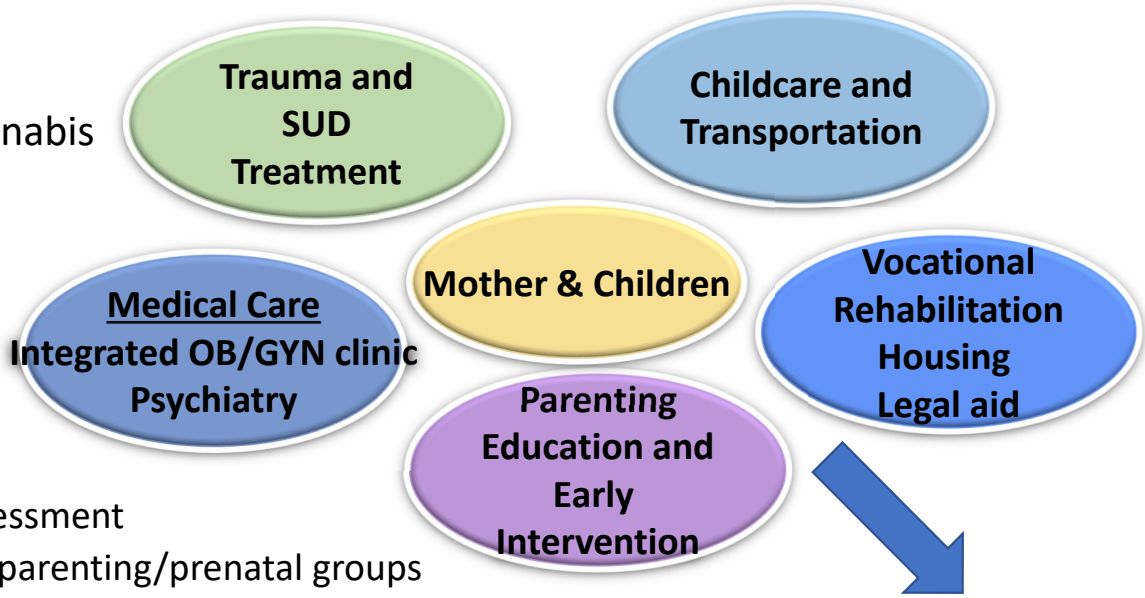


"Recovery Management" (RM) is a philosophical framework for organizing behavioral health treatment and recovery support services across the stages of pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and quality of life enhancement for individuals and families affected by behavioral health conditions.

Outpatient Family-Centered Care Coordination

Patient Example: Mother is 25 years old

- Prescription opioid use disorder and smokes cannabis
- Pregnant, first child
- Unemployed
- Living with mother and step-father



- Screened over the phone
- Assessed and intake completed the next day
- Outpatient induction onto medication assisted treatment
- Care Coordination at first prenatal visit
- Every 2 week visit with provider and care coordinator + therapist

- Based on assessment
  - General parenting/prenatal groups
  - Tour L&D and Newborn areas
  - Plan of Safe Care developed
  - Individual Counseling- Motivational Interviewing and Cognitive Behavioral Therapy
  - Car seat, materials for baby, transportation plan
  - Postnatal Horizons care coordination protocol

- Outpatient completion based on goals being met
- *Continuing care includes peer support specialist and parenting support as needed*

State and National Connections

- Healthy Families
- Healthy Start
- Prevent Child Abuse Florida
- Ounce of Prevention
- Birth Parent National Network
- Community Cafes and Parent Leaders
- NAMI

Summary

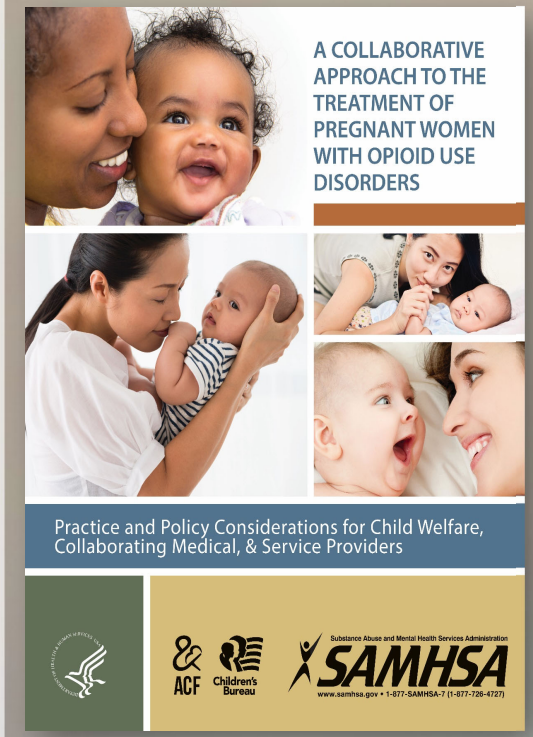
Integrated care a must!

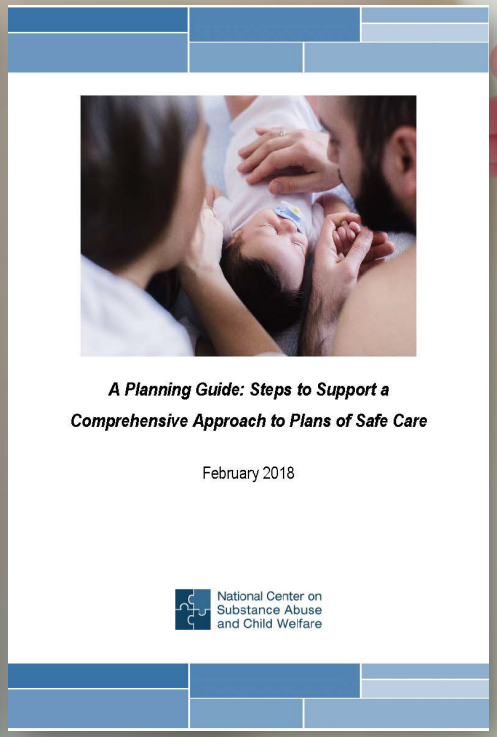
- Clinical responses to families impacted by the substance abuse *must be*:
  - Trauma-informed
  - Attachment-based
  - Able to look at the whole family
  - Able to hold the hope *for and with* the family
  - Non-punitive
  - Non-stigmatizing
  - Supportive…. *"I am on your side!"*
  - Hopeful…. *"You CAN do this!"*

"Healing the family begins with ensuring timely, appropriate, and effective services for both parents and children to treat substance abuse and trauma."

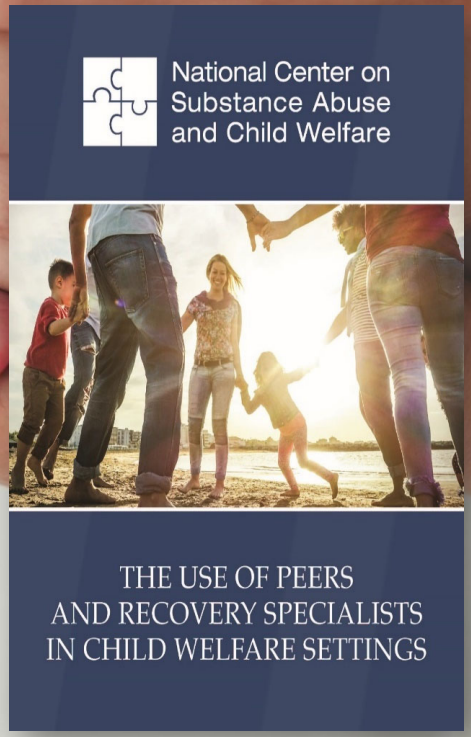
Otero & Archer 2013

Resources


A COLLABORATIVE APPROACH TO THE TREATMENT OF PREGNANT WOMEN WITH OPIOID USE DISORDERS
Practice and Policy Considerations for Child Welfare, Collaborating Medical, & Service Providers
ACF
Children's Bureau
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)


A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care
February 2018
National Center on Substance Abuse and Child Welfare


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


National Center on Substance Abuse and Child Welfare
THE USE OF PEERS AND RECOVERY SPECIALISTS IN CHILD WELFARE SETTINGS

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