Caring for Perinatal People with Substance Use

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Disclosures

• I have no research, financial, or commercial disclosures
• I will attempt to use only generic medication names; use of any brand name pharmaceuticals is for audience recognition only, not promotion of any brand name or pharmaceutical company.
• I will identify my own opinions and anecdotal experience from guidelines or best practice recommendations.
• These slides contain deidentified quotes from patients; please do not share these slides without my/their permission.
Objectives

• Recognize the value in using person-first language when discussing substance use
• Develop increased comfort with starting screening conversations with birthing people and families regarding substance use
• Anticipate and prepare to respond to common concerns/fears patients or families may have when discussing substance use
• Increase knowledge of specific considerations related to opioid use disorder and treatment in the perinatal and neonatal period
• Explore strengths-based philosophy of care, and how this applies to families impacted by substance use
• Foster a safe space for questions, concerns, and dialogue
“Why did this happen to me?”
Chronic Disease Model of Substance Use Disorder

- “Addiction is defined as a primary, chronic, relapsing and remitting disease of brain reward, motivation, memory, and related circuitry”. (ASAM)

- We are hard-wired for reward: food, water, intimacy, nurturing young, exercise, etc.

- Teach the brain what to prioritize and attend to, repeat
Substance Use Disorder: Learning Theory Model

Positive and Negative Reinforcement

- Reward is a positive reinforcement
- Negative Reinforcement
  - Encourages the behavior to continue
  - Different than punishment: punishment tries to extinguish the behavior by providing consequence (criminal justice system)
- Substance use is Both + and – reinforced
  - Positive: provides novel experiences, euphoria, potentially connection and community
  - Negative: removes painful, intolerable experiences
    - Physical symptoms (withdrawal, chronic pain, insomnia)
    - Emotions (guilt, shame, depression, anxiety)
    - Trauma (ongoing or past)
    - Poverty, Racism, Classism, Systemic Oppression
Substance Use Disorder: Environmental Adaptation Model

• Dr Bruce Alexander 1970s: “Rat Park”
  • The environment matters: a lot (Vietnam War)
  • Loneliness, isolation, boredom, and inability to access stimulating, enriching activity increased use of substances of misuse, even to the point of harm/death
  • Stimulation, connection, and a healthy community are protective against substance misuse, even with the same access to the substances
• Johann Hari: “The Opposite of Addiction is Not Sobriety; it is Connection”
• Substance Use Disorder conceptualized as an Attachment Disorder: increased thinking about how insecure attachment, ACEs, trauma, influence the development of a substance use disorder
How to Diagnose a Substance Use Disorder

The Takeaway: 5 Cs
- Craving
- Compulsive Use
- Continued Use Despite Harm
- Impaired Control
- Chronicity

Notably Absent from Criteria:
- Urine toxicology result
- Legal Consequences

<table>
<thead>
<tr>
<th>DSM V Diagnostic Criteria: Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEVERITY:</strong> 2-3: mild 4-5: moderate 6 or more: severe</td>
</tr>
<tr>
<td>1. Taking the substance in larger amounts or for longer than you meant to.</td>
</tr>
<tr>
<td>2. Wanting to cut down or stop using the substance but not managing to do so.</td>
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<td>3. Spending a lot of time getting, using, or recovering from use of the substance</td>
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<tr>
<td>4. Cravings and urges to use the substance</td>
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<td>5. Not managing to do what you should at home, work, or school because of substance use</td>
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<td>6. Continuing to use, even when it causes problems in relationships</td>
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<tr>
<td>7. Giving up important social, occupational, or recreational activities because of substance use</td>
</tr>
<tr>
<td>8. Using substances again and again, even when it puts you in danger</td>
</tr>
<tr>
<td>9. Continuing to use, even if you have a physical or psychological problem that could have been caused or made worse by the substance</td>
</tr>
<tr>
<td>*10. Needing more of the substance to get the effect you want (tolerance)</td>
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<tr>
<td>*11. Development of withdrawal symptoms, which can be relieved by taking more of the substance</td>
</tr>
<tr>
<td>*Criteria not met if taking prescribed drugs under supervision</td>
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</table>
How **Not** to Diagnose a Substance Use Disorder

- Chart Review or second-hand information
- Prescription Drug Monitoring Database Search
- Person’s appearance, demeanor, or family history
- Defensiveness when asked about substance use
- Urine/Blood Toxicology Test
1) Which of the following is the recommend term to describe a person with substance use?

   a) Addict

   b) Abuser

   c) Person with substance use

   d) Alcoholic
C) Person with Substance Use
• **Person-First**
  
  • Person-first language maintains the integrity of individuals as whole human beings by removing language that equates people to their condition or has negative connotations.\(^1\) For example, “person with a substance use disorder” has a neutral tone and distinguishes the person from his or her diagnosis.\(^2\)
  
  • Stigma against pregnant women and mothers with substance use disorder appears in many forms, such as:
    • the use of erroneous language and terminology
    • delivery and belief of misinformation about substance use
    • punishment of substance use
    • belittling of a mother’s relationship with her child\(^3\)
How Stigma Harms

• People may publicly blame and condemn pregnant women with substance use disorder (SUD) because of a misbelief that having a substance use disorder is a choice versus a medical condition—and that they are, therefore, choosing to harm their unborn baby.⁴

• Women themselves often internalize this stigma and feel deep shame as a result.

• Shame can sound like:
  • “I’m not a good mother”
  • ”I’m not worthy of this child”
  • “I don’t deserve to get better”
  • ”I am a bad person”

• Overwhelming shame is intolerable; substance use is an effective (temporarily) and understandable adaptive response to quiet the shame
<table>
<thead>
<tr>
<th>Words to Avoid</th>
<th>Words to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict</td>
<td>Person with substance use disorder</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>Person with alcohol use disorder</td>
</tr>
<tr>
<td>Drug problem, drug habit</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Drug misuse, harmful use</td>
</tr>
<tr>
<td>Drug abuser</td>
<td>Person with substance use disorder</td>
</tr>
<tr>
<td>Clean</td>
<td>Abstinent, not actively using</td>
</tr>
<tr>
<td>Dirty</td>
<td>Actively using</td>
</tr>
<tr>
<td>A clean drug screen</td>
<td>Testing negative for substance use</td>
</tr>
<tr>
<td>A dirty drug screen</td>
<td>Testing positive for substance use</td>
</tr>
<tr>
<td>Former/reformed addict/alcoholic</td>
<td>Person in recovery, person in long-term recovery</td>
</tr>
<tr>
<td>Opioid replacement, methadone</td>
<td>Medication assisted treatment</td>
</tr>
<tr>
<td>maintenance</td>
<td></td>
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Even better: “MOUD”: Medications for Opioid Use Disorder”
How Person-First Language Helps

• Places the person with the substance use first, not their disorder
• Reinforces use of accurate medical terminology, not colloquial language
• Clarifies that we are connecting with a person/pregnant person/mother/infant/family, which is our area of expertise
• Consistent use of person-first language by health care providers can start to make amends for the ways in which people with substance use have been mistreated by the health care community
• Retrains ourselves and colleagues towards reducing harms

Screening: Start A Conversation


Set up for success: check with person that this is a good time to talk, give a time estimate (5 min?), ask if they need to do anything first (shower, eat, take a nap, etc)

Arrange the room: ideally sit down at eye level, or lower, than your patient

Engage your skills: calm body, calm mind, delay distractions as much as possible (phone, etc)
Universal Screening

• Every person:
  • "We are working as a hospital/unit/team, etc to take better care of our patients as whole people. This includes asking questions about physical and emotional health, including substance use."
  • 4/5 Ps
  • SBIRT
  • NIDA Quick Screen
  • AUDIT
4/5 Ps

- Parents
  - “When you were growing up, did the people who raised you use substances? If so, how did that impact you?”

- Peers
- Partner
- Past
  - “Before you knew you were pregnant, were you a person with any substance use? Do you consider yourself a person in recovery from substance use?”

- Present
  - “Since you learned you were pregnant, how are you doing with any substance use?”
Screening, cont.

- Possible history of substance use (from medical chart, sign out from other provider, etc)
  - “I was reading your medical chart/file/talked with your last case worker, etc in preparation for coming to see you today, and I saw a mention of substance use. Sometimes information I receive from other sources is not accurate or complete. Are you a person with any substance use history?”
    - “Yes” → proceed to more indepth screening tool or “Could you tell me a bit about your story with substance use?”
    - “No” → proceed to universal screening tool “Ok, thanks for telling me that. I’m going to ask you our screening questions that we ask everyone admitted to labor and delivery/mom-baby, etc”)
• Known history of substance use, directly from patient report/positive screening:
  • “Thank you for telling me a bit about yourself, including substance use. Can we talk more about that now, or should I come back in a little while?” (outpatient: “can we talk about that today, or should we plan to follow up at another visit?”)
  • Be transparent about what will happen with this information:
    • “When a person has a history of substance use during pregnancy, they often have a lot of questions. In the state of Colorado, I am not required to report substance use during pregnancy unless you are at risk of harm to yourself or others, or your current substance use is putting minors at risk of harm or neglect.”
Substance Use During Pregnancy: Reporting

• Although county specific, most counties (including Denver) will not accept a report of open a case regarding parental substance use until there is a live-born infant.

• This is not the case in many other states:
  • 24 states plus DC consider substance use during pregnancy to be child abuse under civil child welfare statutes
  • 3 states consider substance use during pregnancy grounds for civil commitment
  • 19 states have specifically funded substance treatment for pregnant people and 17 consider pregnant people a “priority population”
  • Only 10 states prohibit publicly funded treatment programs from discriminating against pregnant people seeking treatment
Question #2

3) The goal of motivational interviewing is:

a) Obtaining a commitment from patient to stop using substances

b) Obtaining consent for toxicology testing

c) Providing time/space for a person to explore their ambivalence about substance use

d) Documenting use of substances to make a CPS report
c) Providing time/space for a person to explore their ambivalence about substance use
Known History/Positive Screen for Substance Use

• Toxicology
  • “When a person has a history of substance use, we will ask for your permission to send a small sample of the umbilical cord for toxicology testing. This is not invasive or painful for you or your baby. If the umbilical cord is positive for any non-prescribed substances, including THC, this could be reported to Child Protective Services. This report means you will likely talk with someone from the CPS office and come up with a plan but does not equal immediate removal of custody”.

• Breastfeeding
  • “When a person has a history of substance use, we want to help make sure breastfeeding is as safe as possible. While treatment medications such as methadone or buprenorphine are completely safe for breastfeeding, we do not recommend breastfeeding if a person has had substance use in the past 30/60/90 days, or THC use in the past two weeks, or plans to continue to use THC or other substances. What questions do you have about this?”

• Referrals
  • “When a person has a history of substance use, we want to make sure you have all the information you need to decide if/what kind of treatment is right for you. What do you know about treatment options already?”
Responding to Concerns/Fears

- In disclosing history of or ongoing substance use during pregnancy, a person with substance use is demonstrating exceptional bravery and selflessness.

- Honor a person’s vulnerability with a brief comment of connection and affirmation:
  - “Thank you for sharing this deeply personal information with me”
  - “I’m honored to hear this part of your story; thank you for sharing”
  - “I can only imagine how hard it is to talk about some of these things, and I really appreciate your honesty and strength”
  - Whatever feels right to you: take a minute to jot down an affirming response in your own words
Question #3

• True or False: Infants who test positive for _____ are legally required be reported to CPS:

  • Opioids: True or False
  • Methamphetamine: True or False
  • THC: True or False
  • Methadone: True or False
• Opioids: False
• Methamphetamine: False
• THC: False
• Methadone: False
CAPTA: The Devil in the (lack of?) Details

• There is no legal requirement to report maternal or infant toxicology to Child Protective Services.

• CAPTA states “must have policies and procedures to address the needs of infants born...affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder”

• Positive toxicology is not enough to be “affected by”; need to demonstrate some additional health impact or risk to infant’s wellbeing beyond positive test.

• If report is made to CPS, is it not supposed to be to investigated in the same manner as a child abuse or neglect report.

• What is required: a plan of safe care to communicate and link people to services that provide support to an entire family with an identified infant.

• There is no requirement that states rely on the existing CPS system for the monitoring of the plan of safe care.
• “Will you take my baby away?”
  • If you are the person to respond to this question, do so, and explain the process for toxicology testing, CPS reporting, and possible outcomes of a CPS report.
  • If you are not the person to respond to this question, it is better to explain what you do and don’t know, rather than to guess. Providing assurance that “since you are in treatment CPS will not be involved” may be more negatively impacting if CPS does end up involved after birth.
  • If you have no idea how to answer this question: “I am not sure what may or may not happen with CPS, and I will help find out more information/connect you to the right person. No matter what, I’m here to support you and be on your team”. 
Common Questions/Concerns

- “Can I breastfeed?”
  - Become familiar with hospital/unit breastfeeding policies
  - Affirm that methadone and buprenorphine (without any ongoing substance use) are safe and recommended for breastfeeding
  - Explain that breastfeeding is one of the most effective ways to help reduce withdrawal symptoms in infants with prenatal opioid exposure
• How will you control my pain?
  • Epidural will work just as well for a person with opioid tolerance, or receiving MOUD
  • Fentanyl may be less effective, or need a higher dose to be effective
  • Explain that avoiding/minimizing opioids is now standard for everyone after an uncomplicated vaginal delivery
  • Advocate for patient to have adequate pain relief after c-section or complicated vaginal delivery.
  • Maximize opioid-sparing protocols
  • It is ok to give opioids for pain on top of treatment medication, AND/OR for people with Opioid Use Disorder. Treating pain does not make addiction worse.
  • People with opioid tolerance will need higher doses of opioids to receive adequate pain relief compared with opioid naïve people.
• “Did I harm my baby?”
  • This is a complicated question, and the answer may depend on which class of substance use a person had during pregnancy.
  • Alcohol is by far the most likely substance to cause permanent physical, cognitive, and emotional changes in development.
  • Tobacco is highly associated with a variety of infant health outcomes, including increased risk for SIDS.
  • THC is increasingly though to contribute to changes in brain development and possible increased risk for behavioral or cognitive challenges in later childhood.
  • Stimulants (methamphetamine, cocaine), opioids (fentanyl, heroin), benzodiazepines (alprazolam, clonazepam) are less strongly associated with long-term developmental concerns.
  • Opioids>benzodiazepines>alcohol>nicotine>stimulants>THC associated with NOWS/NAS, which is temporary and treatable without data suggesting long-term harm.
• “Did I harm my baby?”
  • “There may be some longer-term effects that are subtle or just not known about at this time, however, the data is very clear that parenting in sobriety and wellness, and being present in your child’s life long-term, is protective and associated with better growth and development.”
• Emphasize that parent being alive and consistently present in their child’s life is more important for long-term development and wellness than prenatal substance exposure(s).
• “There is no data suggesting that infants exposed to substances before birth are at higher risk for substance use. However, there is research showing that at least some part of substance use is genetic. As a person with family history of substance use, we need to be extra attentive to educating our kids about that history and their vulnerability based on their genetics.”
Defining Strength-Based Family Approaches

“Strengths-based practice has been defined as seeing people as “having potential and power” rather than being “at risk.” It emphasizes opportunities, hopes, and solutions, with the (health care/clinician, etc) as a partner to the family (Hammond, 2010).”

• Key features include:
  – Avoiding Pathology-Focused Approaches
  – Nurturing Protective Factors
  – Supporting Families Navigating Multiple Challenges
  – Connecting to the Stories of Families

The “Crack Baby” Crisis

Current research shows that parents have reason to resist the stigmatizing focus on the impact of addiction on children

- “During the 80’s and 90’s, the nation’s health specialists panicked over the growing number of so-called “crack babies” —children exposed to crack cocaine in utero. These children were said to be doomed to lives of physical and mental disability. But, 20 years later, many of the children who were perceived to be “at-risk” are proving the predictions wrong as young adults.” NPR: Crack Babies: Twenty Years Later
- “Born on drugs: Predictions about crack babies didn’t come true, offering hope for opioid era” Center for Health Journalism
- “Top Medical Doctors and Scientists Urge Major Media Outlets to Stop Perpetuating the Crack Baby Myth” National Advocates for Pregnant Women
Oxytots

Instead of learning from the unfounded hysteria of the crack baby era, we’re repeating it.
### Key Feature: Nurturing Protective Factors

**PARENTS/FAMILY**
- Parent sensitively and consistently responds to their children’s needs
- Strong family relationships, good connections with friends and community
- Supportive cultural traditions
- Ability to access concrete support in times of need
- Availability of quality childcare

**COMMUNITY**
- Safe neighborhoods
- Safe and high-quality schools
- Stable and safe housing
- Access to nutritious food
- Access to job opportunities and transportation
- Access to medical care, including behavioral health and wellness care
What We Expect Families to be Responsible For:

PARENTS/FAMILY
- Parent sensitively and consistently responds to their children’s needs
- Strong family relationships, good connections with friends and community
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- Ability to access concrete support in times of need
- Availability of quality childcare
- Safe neighborhoods
- Safe and high-quality schools

COMMUNITY
- Stable and safe housing
- Access to nutritious food
- Access to job opportunities and transportation
- Access to medical care, including behavioral health and wellness care
What most Families Can Realistically Control:

**PARENTS/FAMILY**
- Parent sensitively and consistently responds to their children’s needs

**COMMUNITY**
- Safe neighborhoods
- Safe and high-quality schools
- Stable and safe housing
- Access to nutritious food
- Access to job opportunities and transportation
- Access to medical care, including behavioral health and wellness care
- Strong family relationships, good connections with friends and community
- Supportive cultural traditions
- Ability to access concrete support in times of need
- Availability of quality childcare
• “Since the day the COVID-19 crisis started, I have been saying that ‘we are all in this together.’ But the truth is, as was recently pointed out to me, ‘We are not all in the same boat. We are all in the same storm.’ Some folks are on ocean liners while many others are tossed about, holding on to life preservers.”

• –Yasmina Vinci, National Head Start Association
Impact of Adverse Childhood Experiences (ACEs)

- ACEs are linked to numerous negative health outcomes including cardiovascular disease, liver disease, and mental health disorders.
- Those with unresolved or untreated childhood trauma may be more likely to become habitual opioid users.

Key Feature: Connecting to the Stories of Families

Ari, an Early Head Start parent, describes her journey in substance use recovery.

- Relapse may happen, but can be overcome
- Offer non-judgmental support
- Reassurance from professionals can be meaningful
- Recognize and celebrate all progress

## Identifying Strategies: Provide Concrete Support in Times of Need

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<thead>
<tr>
<th>Encouraging</th>
<th>Encouraging help seeking behavior</th>
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<tbody>
<tr>
<td>Working</td>
<td>Working with the family to understand their past experiences with service systems</td>
</tr>
<tr>
<td>Helping</td>
<td>Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need</td>
</tr>
<tr>
<td>Helping</td>
<td>Helping the parent understand their role as an advocate for themselves and their child(ren)</td>
</tr>
<tr>
<td>Giving</td>
<td>Giving parents opportunities to help meet concrete needs of other families in the program or the community, to encourage reciprocity</td>
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Identifying Strategies: Questions to Ask When a Family is in Need

- What do you need to __________ (get or stay housed, get or keep your job, pay your heating bill etc.)?
- What have you done already? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does working on these issues impact the way you parent?

Identifying Strategies: Connecting Families to Preventive Programs

- Evidence-based home visiting programs
  - Early Head Start
  - Parents as Teachers
  - Nurse-Family Partnerships
  - Healthy Families America
- High quality childcare/Help families who qualify register for CCCAP
- Parenting Workshops/Support Groups
  - Circle of Parents in Recovery
- Plans of Safe Care: best if started prenatal!
In Summary

- Blaming parents does not work, supporting them does.
- Community matters, collaboration between systems matters.
- It is meaningful to parents to have the support and acknowledgment of professionals and service providers.
- Invest time in training your team to use strength-based strategies that support families.
Harm Reduction: Not the Last Resort, and the Secret Sauce of Care

Keep the door open!
• Continuing to provide medical, mental health, and other supportive care not contingent upon sobriety is one of the best ways we can help a person who is not ready for treatment.

Harm reduction is not condoning use
• Referral to syringe access programs
• Prescribe Naloxone (Narcan)
• Offer infectious disease screening
• Pre-Exposure Prophylaxis (PrEP)
A Great Starting Place
Open Discussion

- What is working for you in your role now?
- What is not working?
- What needs to happen to help all health care providers adopt person-first language when interacting with birthing families?
- How have you navigated challenging interactions with patients/families?
Thank you!

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UCH PeAR clinic: Perinatal Addiction & Recovery
720-848-1060
SW: 720-553-4659

Denver Health OB Addiction Medicine clinic:
303-602-9000

CeDAR Outpatient Addiction Medicine clinic
(for non-pregnant people, too!)
720-848-3037
References


