INCLUSION OF PERINATAL SERVICES IN MEDICALLY ASSISTED TREATMENT

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PERINATAL SUBSTANCE ABUSE
SOCIETY’S YOUNGEST VICTIMS:

- Each year, an estimated 400,000 – 440,000 infants (10 – 11% of all births) are affected by prenatal alcohol and/or illicit drug exposure.

  *National Center on Substance Abuse and Child Welfare*

- Prenatal screening studies document 15-20% of newborns are prenatally exposed to alcohol, tobacco or illegal drugs

  *Linda Carpenter, Project Director, National Center on Substance Abuse and Child Welfare, June 23, 2010*
• **Zygote**: The combined sperm and egg (Conception – Week 3 of pregnancy)

• **Blastocyst**: The zygote travels down the Fallopian tube for a few days and divides to form a ball of cells called the blastocyst (Week 3 of pregnancy). The blastocyst will implant in the uterus during the 4th week of pregnancy

• **Embryonic Period (Week 5)**: All the baby’s major systems and structures develop
  - Embryo’s cells multiply and start to take on specific functions
  - Embryo grows rapidly
  - Blood, kidney and nerve cells develop
  - The brain, spinal cord and heart begin to develop
  - This is the time most at risk for damage from teratogens, medications, *illegal drug use, alcohol use*, infections such as rubella and other factors
DEVELOPMENTAL TERMS

- Cephalo-Caudal and Proximal-Distal Development: The beginning of motor development:
- 10th Week of Pregnancy: At the end of the 10th week, the embryo is now a fetus, the stage of development until birth.
  - **Cephalo-Caudal:** Head to tail (bottom). Development from the head to bottom of the spine; the head comprises 50% of the total body length at the 3rd month of intrauterine development
  - **Proximo-Distal:** Near to far. From 5 months to birth when the fetus grows from the inside of the body outwards. When referring to motor development, refers to the development of motor skills from the center of the body outwards.
• **Neonate / Neonatal:** Newborn child less than 4 weeks / Four week period after the birth of the baby
• **Antepartum:** Before labor or childbirth
• **Postpartum:** After labor or childbirth
• **Prenatal:** Before birth, during or relating to pregnancy
• **Perinatal:** 20th to the 28th week of gestation and ends the 4th week after birth
• **Teratogen:** “Any agent that can disturb the development of an embryo or fetus. Teratogens may cause a birth defect in the child or may halt the pregnancy outright”
• **MotherToBaby California:** Medications and more during pregnancy and breastfeeding 866-626-6847
- **Opiate**: are narcotic drugs containing opium or its derivatives, used in medicine as a sedative that depresses activity of the central nervous system, reduces pain, and induces sleep.

- **Opioid**: are manmade substances that act on opioid receptors to produce morphine-like effects. Opioids include opiates, an older term that refers to such drugs derived from opium, including morphine itself.

- **Addiction**: is a state characterized by compulsive engagement in rewarding stimuli, despite adverse consequences. This is a **brain disease** or **biological process** that leads to such behaviors.
Dependence: is an adaptive state that develops from repeated drug administration, and which results in withdrawal upon cessation of drug use.

Tolerance: is a person's diminished response to a drug, which occurs when the drug is used repeatedly and the body adapts to the continued presence of the drug.

Methadone: Methadone is an opioid medication. Methadone reduces withdrawal symptoms in people addicted to heroin and/or dependent on other opiates without causing the "high" associated with drug addiction.
EFFECTS OF COMMONLY USED ILLICIT SUBSTANCES

“WHAT MAMA TAKES, BABY GETS”
## Prenatal Drug Exposure: Potential Effects on Birth and Pregnancy

<table>
<thead>
<tr>
<th>TOBACCO</th>
<th>MARIJUANA</th>
<th>STIMULANTS</th>
<th>HEROIN/OPIOIDS</th>
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</thead>
<tbody>
<tr>
<td>Pregnancy complications</td>
<td>No fetal growth effects</td>
<td>Cocaine</td>
<td>Stillbirth</td>
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<tr>
<td>Prematurity</td>
<td>No physical abnormalities</td>
<td>Prematurity</td>
<td>Prematurity</td>
</tr>
<tr>
<td>Decreased birth weight</td>
<td></td>
<td>Decreased birth weight</td>
<td>Decreased birth weight</td>
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<td>Decreased birth length</td>
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<td>Decreased birth length</td>
<td>Decreased birth length</td>
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<tr>
<td>Decreased birth head circumference</td>
<td></td>
<td>Decreased birth head circumference</td>
<td>Decreased birth head circumference</td>
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<tr>
<td>Sudden infant death syndrome (SIDS)</td>
<td>Intraventricular hemorrhage</td>
<td>Fetal and neonatal abstinence syndrome</td>
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</tr>
<tr>
<td>Increased infant mortality rate</td>
<td>Methamphetamine</td>
<td>Sudden infant death syndrome (SIDS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Small for gestational age</td>
<td></td>
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<tr>
<td></td>
<td>Decreased birth weight</td>
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<tr>
<td></td>
<td>SIDS</td>
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</tbody>
</table>
### Potential Effects on CNS Development, Cognitive Function and Behavior

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Marijuana</th>
<th>Stimulants</th>
<th>Opiates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disturbed maternal-infant interaction</td>
<td>Mild withdrawal symptoms</td>
<td><strong>Cocaine</strong>&lt;br&gt;Neonatal/Infancy&lt;br&gt;Early neurobehavioral deficits: Orientation, state regulation, autonomic stability, attention, sensory and motor asymmetry, jitteriness&lt;br&gt;Poor clarity of infant cues during feeding interaction&lt;br&gt;Delayed information processing&lt;br&gt;General cognitive delay&lt;br&gt;<strong>Childhood</strong>&lt;br&gt;Lower nonverbal perceptual reasoning&lt;br&gt;Lower weight for height&lt;br&gt;Lower weight curve trajectories&lt;br&gt;Attention problems&lt;br&gt;Disruptive behaviors by self-report and caregiver report</td>
<td>Neonatal abstinence syndrome&lt;br&gt;Less rhythmic swallowing&lt;br&gt;Strabismus&lt;br&gt;Possible delay in general cognitive function&lt;br&gt;Anxiety&lt;br&gt;Aggression&lt;br&gt;Feelings of rejection&lt;br&gt;Disruptive/inattentive behavior</td>
</tr>
<tr>
<td>Excitability</td>
<td>Delayed state regulation</td>
<td><strong>Methamphetamine</strong>&lt;br&gt;Poor movement quality (3rd trimester exposure)&lt;br&gt;Lower arousal&lt;br&gt;Increased lethargy&lt;br&gt;Increased physiological stress&lt;br&gt;No mental or motor delay (infant/toddler)</td>
<td></td>
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<tr>
<td>Hypertonia</td>
<td>Reading, spelling difficulty</td>
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<tr>
<td>Stress abstinence signs</td>
<td>Executive function impairment</td>
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<tr>
<td>Conduct disorder</td>
<td>Early tobacco and marijuana use</td>
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<tr>
<td>Reduced IQ</td>
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<td></td>
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<tr>
<td>Aggression</td>
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<tr>
<td>Antisocial behavior</td>
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<tr>
<td>Impulsivity</td>
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<td>ADHD</td>
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<tr>
<td>Tobacco use and dependence</td>
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**Effects may be subtle and transient**
FETAL ALCOHOL SPECTRUM DISORDER

- ALCOHOL IS A TERATOGEN
- Three Major Characteristics:
- Growth retardation
- Central nervous system abnormalities: developmental and mental retardation
  - Structural abnormalities: characteristic facial, skeletal and organ defects
FETAL ALCOHOL SPECTRUM DISORDER

- low nasal bridge
- epicanthal folds
- minor ear abnormalities
- indistinct philtrum
- micrognathia
- short palpebral fissures
- flat midface and short nose
- thin upper lip
CAFFEINE EFFECTS

- **Caffeine**: a stimulant that can affect mood by interrupting bodily functions by producing sleep disturbances and anxiety.
- The March of Dimes recommends no more than 200 mg of caffeine a day which is about the amount in 1½ 8-ounce cups of coffee or one 12-ounce cup of coffee. (2008)
THE DISEASE OF ADDICTION

• Opiate /opioid addiction is a brain disease.
• Like any many other diseases, it is:
  chronic
  progressive
  relapsing
  long term
  fatal
• It can be safely managed with FDA approved medications that are prescribed by licensed physicians.
• Pregnant women who are opiate / opioid dependent can be prescribed methadone during their pregnancy.
• Pregnant women who are not HIV positive can nurse their baby if prescribed methadone and using no other illicit drugs.
### Neurological Signs
- Hypertonia / Hypotonia / Mixed
- Fine motor tremors
- Hyper-reflexia
- High pitched cry
- Sleep disturbances
- Seizures

### Autonomic System Dysfunction
- Yawning
- Nasal stuffiness
- Sweating
- Sneezing
- Low Grade Fever
- Skin mottling

### Gastrointestinal Abnormalities
- Diarrhea
- Vomiting
- Poor feeding
- Regurgitation
- Swallowing problems
- Failure to thrive

### Respiratory Signs
- Tachypnea
- Apnea

### Neuro-behavioral Abnormalities
- Irritability
- Poor response to auditory visual stimulation
For the pregnant woman dependent on opioids:

- Well meaning individuals give out wrong information to a pregnant opiate dependent woman, putting her and her baby at risk.
- The pregnant patient must be monitored on methadone during her pregnancy – absolutely no detoxing!
- Seen by her OB-GYN for prenatal care and by the clinic MD for monthly follow-up appointments.
- The best AOD treatment (evidenced based) for the pregnant patient dependent on opiates is to refer her for MAT (medically assisted treatment) and concurrent psychotherapy.
Contraction of the uterus may increase the likelihood of fetal withdrawal.

Medication dose will increase as the woman nears delivery in order to ensure the growing baby has enough so that fetal withdrawal in utero does not occur.

Methadone is not a teratogen, it does not cause birth defects.

Methadone maintenance is more safe for the fetus than acute opiate detoxification.
The pregnancy is considered a “high-risk” pregnancy.

Methadone has been studied in pregnancy for safety since 1969 by Loretta Finnegan, MD.

Babies **are not born “addicted”** to their mother’s opiates/ opioids, they are born dependent on their mother’s drugs and as such, will go through withdrawal after birth.

To call them “addicted babies” is to assume the baby used drug-seeking behaviors to obtain the drugs in utero.
The newborn will be put on a prescription opiate / opioid (morphine) to manage his/her withdrawal symptoms; sometimes a barbiturate will be used to prevent seizures.

The newborn’s withdrawal symptoms and/or lack thereof, do not appear to be dose related.

During the pregnancy, the patient needs to be educated about how methadone will affect her unborn baby’s intrauterine growth and development, effects on the CNS, neonatal abstinence symptoms (NAS) and how these will be managed after birth.
Before a pregnant woman can be placed on methadone treatment, she will have to provide verification of being pregnant, having prenatal care and ability to pay (Medi-Cal or cash).

Once that has been ascertained the patient will see the medical director for a health assessment to determine methadone eligibility.

The patient will receive a low dose of methadone the first day, then be given more methadone over the next few days until she no longer craves opiates and/or experiences withdrawal symptoms.
Once the pregnant patient has proof of pregnancy and this has been documented in the patient’s chart, within 14 calendar days of documentation, the “medical director shall review, sign and date a confirmation of pregnancy” as well as document the following:

- Acceptance of medical responsibility for the patient’s prenatal care; or
- Verification that the patient is getting prenatal care by a physician licensed by the State of California and trained in obstetrics and/or gynecology
Within 14 calendar days, from the date the medical director confirmed the pregnancy, the counselor will update the patient’s treatment plan to reflect prenatal support, the number of counseling sessions (weekly face-to-face), random urine drug screens (weekly), and prenatal instructions:

- Risks to the pregnant patient and unborn child from continued use of both illicit and legal drugs, including premature birth.
- Benefits of replacement narcotic therapy and risks of abrupt withdrawal from opiates, including premature birth.
- Importance of attending all prenatal care visits.
- Need for evaluation for the opiate addiction-related care of both the patient and the newborn following the birth.
• If the pregnant patient refuses prenatal referrals or direct prenatal services offered by the program, the medical director shall document in the patient’s chart the repeated refusals and have the patient acknowledge in writing she has refused the treatment services.

• Within 14 calendar days after the birth of the baby, and/or termination of the pregnancy, the medical director will document in the patient’s chart the following:
  - Hospital’s or attending physician’s summary of delivery and treatment outcome for the patient and offspring; or
  - Evidence that a request for information was requested, but no response was received.
Fourteen (14) calendar days from the date of birth or termination of the pregnancy, the counselor will update the patient’s treatment plan to include the following information is to be reflected in subsequent plans until the child is at least 3-years-old:

- Nature of pediatric care
- Immunization record
INTERVENING WITH THE OPIATE/OPIOID DEPENDENT PREGNANT PATIENT

- Begin where the patient is . . . do not expect more than she can do.
- Separate the behavior from the individual.
- Know who your patient is . . . mother, unborn child, father?
- Remember, your patient is both the pregnant woman and her unborn child . . . you will do what is best for both.
- Assess for and work with the strengths of your patient.
- Congratulate the patient for her upcoming pregnancy.
- Assure the patient that she will receive support, education and advocacy throughout her pregnancy.
- Be empathetic with her situation
• Empower the patient’s strengths instead of using yourself as the patient’s measuring stick
• Give them power back to make their own decisions
• Use a person-centered non-punitive approach
• Leave your biases at home
• The tx counselor / clinic nurse will work directly with the pregnant patient on the following items:
  ➢ Ensuring your perinatal program is welcoming and culturally sensitive
  ➢ Avoiding all illicit opiates and other mood-altering substances, including marijuana
INTERVENING WITH THE OPIATE / OPIOID DEPENDENT PREGNANT PATIENT

- Attending treatment and prenatal care on a consistent and regular basis
- Submitting to UDS on a random basis
- Meeting with the clinic MD / physician on a monthly basis
- Obtaining the necessary forms from the prenatal provider verifying prenatal care
- Providing education on the following topics **using correct terminology:**
  - *Prenatal development during each trimester*
  - *Attachment behaviors with your unborn child*
INTERVENING WITH THE OPIATE / OPIOID DEPENDENT PREGNANT PATIENT

- Importance of skin-to-skin contact
- Importance of medicating daily
- Why it is not safe to detox off methadone during your pregnancy
- Methadone dose increases as the pregnancy progresses
- Importance of dental care during the pregnancy
- Signs and symptoms of neonatal abstinence syndrome (NAS)
- Breast-feeding
- How to care for your baby at the hospital
INTERVENING WITH THE OPIATE / OPIOID DEPENDENT PREGNANT PATIENT

- The importance of the meconium sample
- Hepatitis C issues: Breast feeding
- How to communicate with the hospital staff and the CWS worker, etc.

- Finally, develop a sense of HUMOR!
• The following is a statement from a CWS Status Review Report (2016) and explains what our opiate dependent pregnant women are up against after their baby is born:

“The Agency’s policy regarding Methadone Assisted Treatment (MAT) is as follows: Once participation in MAT is determined, the social worker shall provide the client with the option of participating in an Alcohol or Other Drug (AOD) treatment program {abstinence only} that works with MAT, or go to a program that provides detoxification from methadone prior to a regular AOD treatment.”

“Per CWS policy, MAT by itself, does not constitute substance abuse treatment.”

We have no other choice than to advocate for our pregnant patients and their newborn infants.
ADVOCATING FOR THE OPIATE / OPIOID DEPENDENT PREGNANT PATIENT

- Provide a letter for the patient prior to her delivery stating her treatment status, progress and prescribed methadone dose for her to share with the hospital staff
- Be honest
- Be realistic in what you can and cannot assist with
- You do not have to like the patient or what she does, **BUT** you do need to protect the patient’s dignity and self-respect
- Role model empathy
- Believe in and align with your patient
- Give a message of hope
- Provide empathy
It is discriminatory for CWS, the courts, drug treatment counselors/staff to tell a methadone dependent patient in order for reunification to occur, he/she has to detoxify off methadone.

Unless the person(s) telling the patient to reduce or detoxify off his/her medication is a California licensed physician, he/she is out of his/her scope of practice and is practicing medicine without a license.

If your clinic does not practice chain-of-custody procedures in the collection of urine samples, results should not be turned over to CWS, probation and/or parole for court purposes because **there is no paper trail.**
The U. S. Supreme Court has ruled that in all states, it is unlawful to test for drug use without the pregnant woman’s permission.” (Harris & Paltrow, 2003)

There is no requirement in the U. S. or in California to test a pregnant woman or her newborn for the presence of drugs at birth.

The patient has every right to ask the hospital nurse if chain-of-custody procedures were carried out when her baby’s meconium was collected . . . If not, and there is an impending CWS case, the patient needs to tell her attorney and alert CWS immediately.
• Individuals who are prescribed methadone are protected by the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 (Rehabilitation Act).
• The patient has the right to spend night and day at the hospital with her infant. The patient is there to:
  ➢ Care for her newborn
  ➢ Observe how the newborn is cared for by the medical staff
  ➢ Provide comfort and nourishment
  ➢ Begin the attachment process with her newborn
  ➢ Provide skin-to-skin contact
ADVOCATING FOR THE OPIATE DEPENDENT PREGNANT PATIENT
Most wrongly assume that addicts / opiate dependent parents do not love their children and put the drug/alcohol before the needs of the child.

Drug addiction is a chronic disease that needs to be addressed the same as any other long term chronic illness.
BENEFITS OF A PERINATAL PROGRAM IN MAT

- Well managed pregnant patients have better birth outcomes
- 2016 Statistics at SOAP MAT:

<table>
<thead>
<tr>
<th>Number of pregnant women</th>
<th>23</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women in prenatal care</td>
<td>14</td>
<td>61%</td>
</tr>
<tr>
<td>Number of births during 2016</td>
<td>17</td>
<td>100%</td>
</tr>
<tr>
<td>Number of births 2500 grams or greater</td>
<td>13</td>
<td>76%</td>
</tr>
<tr>
<td>Average weight: 3188 grams (7 lb .03 oz)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number born at 37 weeks GA or more</td>
<td>15</td>
<td>88%</td>
</tr>
<tr>
<td>Average: 38.4 weeks GA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average missed treatment days</td>
<td>10</td>
<td>59%</td>
</tr>
</tbody>
</table>
REFERENCES


REFERENCES

- Wetsman, H. C. (2015). What if We Really Treated Addiction Like the Disease It is? The Fix (https://thefix.com/content/what-if-we-really-treated-addiction-disease-it)
- NAS Symptoms: https://medlineplus.gov/ency/article/007313.htm
- California Code of Regulations Title IX Division 4, Chapter 4 (1998) 10360. Additional Requirements for Pregnant Patients. 9 CA ADC § 10360
- SAMHSA: Legal Action Center, Child Welfare System
Edinburgh Postnatal Depression Scale (EPDS). 
QUESTIONS AND ANSWERS

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GET CLEAN WITH SOAP!